SCHEDULE OF BENEFITS

Administrative

1. **Policyholder:** Anderson County Government

2. **Employer:** Anderson County Government

3. **Plan Number:** 9300-610

4. **Original Plan Effective Date:** July 1, 2016
   Revised Plan Effective Date: July 1, 2019

5. **Enrollment Period:** Not Applicable

6. **Eligible Class:** **Class 1** – *All Eligible Full-Time Employees*

7. **Minimum Hourly Work Requirement:** 30 hours per week

8. **Waiting Period for Insurance Coverage:** 1st of the month following coinciding with or next following 30 days of employment.

9. **Employee Premium Contribution:**

Employee Basic Life and AD&D	Not Required
Employee Supplemental Life and AD&D:	Required
Dependent Basic Life:	Not Required
Dependent Supplemental Life:	Required

10. **Insurance Reduction Schedule:**

Employee Basic Life and AD&D:	to 65% of the scheduled amount at age 65; to 50% of the scheduled amount at age 70
Employee Supplemental Life and AD&D:	to 65% of the scheduled amount at age 65; to 50% of the scheduled amount at age 70
Dependent (Spouse) Basic Life:	No reduction. Coverage terminates at age 70
Dependent (Spouse) Supplemental Life:	No reduction. Coverage terminates at age 70

11. **Evidence of Insurability Requirements:** Applies to Late Enrollees, and amounts over Guarantee Issue amount.

Employees insured for Employee Supplemental Life Insurance and Accidental Death & Dismemberment (AD&D) Insurance on each policy anniversary date, can increase their benefit by $10,000, up to the Guarantee Issue amount, without being subject to submitting Evidence of Insurability.

12. **Retirement Age:** Not Applicable

Basic Life Insurance

Employee Basic Life:	$50,000
Guarantee Issue:	$50,000
Maximum Issue:	$50,000

Spouse Basic Life:	$5,000
Guarantee Issue:	$5,000
Maximum Issue:	$5,000
Child Basic Life:	
Age: 15 days through 5 months:	$ 500
Age: 6 months through the Limiting Age:	$5,000
Guarantee Issue:	$500 / $5000
Maximum Issue:	$500 / $5,000

Supplemental Life Insurance

Employee Supplemental Life:	The amount You elect and We approve in $10,000 increments subject to a minimum of $10,000.
Guarantee Issue:	$100,000
Maximum Issue:	The lessor of $300,000 or 5 times Your Annual Salary rounded to the next lower $10,000.
Spouse Supplemental Life:	The plan Option amount You elect and We approve. This amount may not exceed 50% of the approved Employee Supplemental Life amount. Choice of: Option A-$5,000; Option B-$10,000; Option C-$15,000
Guarantee:	$5,000 / $10,000 / $15,000
Maximum:	$5,000 / $10,000 / $15,000
Child Supplemental Life:	
Age: 15 days through Limiting Age:	The plan Option amount You elect and We approve. This amount may not exceed 50% of the approved Employee Supplemental Life amount. Choice of: Option A-$5,000; Option B-$10,000; Option C-$15,000
Guarantee:	$5,000 / $10,000 / $15,000
Maximum:	$5,000 / $10,000 / $15,000

The total combined Spouse or Child Basic Life amounts and Spouse or Child Supplemental Life amounts cannot exceed 100% of the approved Employee Basic Life and Employee Supplemental Life amounts.

Additional Benefits

1. Conversion of Insurance Benefit:	Included
2. Waiver of Premium Benefit:	Included
3. Living Benefit:	Included
4. Portability Benefit:	Included

Accidental Death and Dismemberment (AD&D) Insurance

Employee Basic AD&D:	$50,000
Guarantee Issue:	$50,000
Maximum Issue:	$50,000

Additional AD&D Benefits

Seat Belt Benefit:	Included
Air Bag Benefit:	Included

Supplemental AD&D Insurance

Employee Supplemental AD&D:	Same amount as Employee Supplemental Life amount.
Guarantee Issue:	$100,000
Maximum Issue:	The lessor of $300,000 or 5 times Your Annual Salary rounded to the next lower $10,000.

GTL-C700-0608-TN

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
Administered by: North American Benefits Company (NABCO) • 20 Valley Stream Parkway, Suite 310, Malvern, PA 19355
Home Office: Madison, WI

GROUP TERM LIFE INSURANCE
CERTIFICATE OF INSURANCE

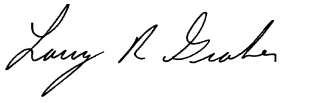
PLEASE READ THIS CERTIFICATE CAREFULLY.

This Certificate of Insurance (hereinafter referred to as "Certificate") is evidence of insurance provided under the Group Policy issued to the Group Policyholder (hereinafter referred to as "Policyholder"). This Certificate describes the essential features of such insurance.

Madison National Life Insurance Company, Inc., in performing its obligations under the Group Policy, is acting only as a life insurer with respect to the Group Policy and is not in any way acting as a plan administrator, a plan sponsor or a plan trustee for the purposes of the Employee Retirement Income Security Act or 1974 (ERISA), as amended, or any other federal or state laws.

No coverage under the Group Policy is in effect until approved in writing by Us and issued and delivered to the Policyholder. All terms, conditions and other provisions of the Group Policy are governed by the laws of the state in which the Policyholder is located. All provisions on this and the following pages are part of this Certificate. The Group Policy is on file and available for review at the main office of the Policyholder.

The President and Secretary of Madison National Life Insurance Company, Inc. witness this Certificate:



Larry R. Graber
President

Loan Nisser
Secretary

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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5. **Enrollment Period:** Not Applicable

6. **Eligible Class:** **Class 1** – *All Eligible Full-Time Employees*

7. **Minimum Hourly Work Requirement:** 30 hours per week

8. **Waiting Period for Insurance Coverage:** 1st of the month following coinciding with or next following 30 days of employment.

9. **Employee Premium Contribution:**

Employee Basic Life and AD&D	Not Required
Employee Supplemental Life and AD&D:	Required
Dependent Basic Life:	Not Required
Dependent Supplemental Life:	Required

10. **Insurance Reduction Schedule:**

Employee Basic Life and AD&D:	to 65% of the scheduled amount at age 65; to 50% of the scheduled amount at age 70
Employee Supplemental Life and AD&D:	to 65% of the scheduled amount at age 65; to 50% of the scheduled amount at age 70
Dependent (Spouse) Basic Life:	No reduction. Coverage terminates at age 70
Dependent (Spouse) Supplemental Life:	No reduction. Coverage terminates at age 70

11. **Evidence of Insurability Requirements:** Applies to Late Enrollees, and amounts over Guarantee Issue amount.

Employees insured for Employee Supplemental Life Insurance and Accidental Death & Dismemberment (AD&D) Insurance on each policy anniversary date, can increase their benefit by $10,000, up to the Guarantee Issue amount, without being subject to submitting Evidence of Insurability.

12. **Retirement Age:** Not Applicable

Basic Life Insurance

Employee Basic Life:	$50,000
Guarantee Issue:	$50,000
Maximum Issue:	$50,000

Spouse Basic Life:	$5,000
Guarantee Issue:	$5,000
Maximum Issue:	$5,000
Child Basic Life:	
Age: 15 days through 5 months:	$ 500
Age: 6 months through the Limiting Age:	$5,000
Guarantee Issue:	$500 / $5000
Maximum Issue:	$500 / $5,000

Supplemental Life Insurance

Employee Supplemental Life:	The amount You elect and We approve in $10,000 increments subject to a minimum of $10,000.
Guarantee Issue:	$100,000
Maximum Issue:	The lessor of $300,000 or 5 times Your Annual Salary rounded to the next lower $10,000.
Spouse Supplemental Life:	The plan Option amount You elect and We approve. This amount may not exceed 50% of the approved Employee Supplemental Life amount. Choice of: Option A-$5,000; Option B-$10,000; Option C-$15,000
Guarantee:	$5,000 / $10,000 / $15,000
Maximum:	$5,000 / $10,000 / $15,000
Child Supplemental Life:	
Age: 15 days through Limiting Age:	The plan Option amount You elect and We approve. This amount may not exceed 50% of the approved Employee Supplemental Life amount. Choice of: Option A-$5,000; Option B-$10,000; Option C-$15,000
Guarantee:	$5,000 / $10,000 / $15,000
Maximum:	$5,000 / $10,000 / $15,000

The total combined Spouse or Child Basic Life amounts and Spouse or Child Supplemental Life amounts cannot exceed 100% of the approved Employee Basic Life and Employee Supplemental Life amounts.

Additional Benefits

1. Conversion of Insurance Benefit:	Included
2. Waiver of Premium Benefit:	Included
3. Living Benefit:	Included
4. Portability Benefit:	Included

Accidental Death and Dismemberment (AD&D) Insurance

Employee Basic AD&D:	$50,000
Guarantee Issue:	$50,000
Maximum Issue:	$50,000

Additional AD&D Benefits

Seat Belt Benefit:	Included
Air Bag Benefit:	Included

Supplemental AD&D Insurance

Employee Supplemental AD&D:	Same amount as Employee Supplemental Life amount.
Guarantee Issue:	$100,000
Maximum Issue:	The lessor of $300,000 or 5 times Your Annual Salary rounded to the next lower $10,000.

GTL-C700-0608-TN

I. DEFINITIONS

Active Work and **Actively at Work** are defined in the "Eligibility for Insurance" section.

Annual Salary: Your current salary or wage from your Employer for the previous twelve months. Annual Salary does not include commissions, bonuses, overtime pay or any other extra compensation.

Contributory means that You pay all or a portion of the premium for insurance.

Disabled or **Disability** means that: as a result of Physical Disease or Injury, you are unable to perform with reasonable continuity a majority of the material duties of any occupation for which you are qualified by education, training and experience, and you are under the Regular Care and Attendance of a Physician.

Eligible Class means an employment classification defined by the Employer and specified in the "Schedule of Benefits." You must be a member of an Eligible Class in order to be eligible for insurance under the Group Policy.

Eligible Dependent is defined in the "Eligibility for Insurance" section.

Eligible Employee is defined in the "Eligibility for Insurance" section.

Employee is defined in the "Eligibility for Insurance" section.

Employer means an Employer (including approved affiliates and subsidiaries) to whom we have assigned a Plan Number and issued a Policy.

Evidence of Insurability

1. Providing Evidence of Insurability means that a person applying for coverage under the Group Policy must:
   a) complete and sign Our Evidence of Insurability application and return the original application to Us. The application must be received by Us no later than 60 days from the date of signing; and
   b) authorize Us to obtain information about the applicant's health; and
   c) undergo a physical examination, if required by Us, which may include diagnostic testing; and
   d) provide any additional information about the applicant's insurability that We may reasonably require.

2. If any applicant is required to provide Evidence of Insurability, the applicant will be responsible for all costs associated with providing Evidence of Insurability.

3. In each case where Evidence of Insurability is required, We base Our decision whether to approve coverage on the information provided during the underwriting process. If We learn that the information relied on to approve coverage was incorrect, or that relevant information was omitted, We may retroactively rescind coverage and deny claims.

Group Policy (Policy) means the group insurance Policy issued by Us to the Policyholder under a specified Plan Number.

Guarantee Issue is the amount of coverage provided which is not subject to Evidence of Insurability.

Hospital means a legally operated Facility providing full-time medical care and treatment under the direction of a full-time staff of licensed Physicians, but not including rest homes, nursing homes, convalescent homes, homes for the aged and facilities primarily affording custodial, educational, or rehabilitative care.

Injury: Bodily Injury due to an Accident which: (1) results directly and independently of disease, bodily infirmity or any other causes; (2) solely, directly and independently of all other causes results in medical expense; (3) occurs after the effective date of the Insured Person's coverage; and (4) occurs while the Insured Person's coverage is in force. All Injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these Injuries, are considered a single Injury.

Insured Person means an Eligible Employee, Eligible Dependent or Eligible Retiree whose coverage is in effect under the Group Policy.

Late Enrollee means an Employee or Dependent who applies for coverage under the Group Policy more than 31 days after becoming an Eligible Employee or Eligible Dependent.

Limiting Age means the Child age(s) shown in the definition of Child in the Eligibility for Insurance section.

Mental Disorder means any mental, emotional, behavioral, psychological, personality, cognitive, mood or stress related abnormality, disorder, disturbance, dysfunction or syndrome listed in the latest edition of the American Psychiatric Association Diagnostic and Statistical Manual or the International Classification of Disease. The term "Mental Disorder", however, does not include any condition diagnosed as Psychosis.

Noncontributory means the Employer pays the entire premium for insurance.

Physical Disease means a Physical Disease entity or process that produces structural or functional changes in the body as diagnosed by a Physician. Physical Disease includes pregnancy and Mental Disorder.

Physician means a licensed medical professional under the laws of a state of the United States of America, acting within the scope of such license, who is permitted by law to prescribe medications and practice independent of supervision.

For the purpose of this Group Policy, Physician will not include the Insured Person's Spouse, parent, brother, sister, or Child, including these members of a Spouse's family.

Plan Effective Date means the date on which the Group Policy, with respect to the Employer, becomes effective.

Plan Number means the number used by Us to reference an Employer and the terms of coverage specified under the Group Policy.

Prior Plan means the Employer's group life insurance plan in effect on the day immediately preceding the Plan Effective Date.

Proof of Loss is defined in the "Claims Provisions" section.

Regular Care and Attendance means observation and treatment by a Physician as required by current standards of medicine for the Injury or Physical Disease causing a Disability, but in any event not less than one such observation per year.

Retire and **Retirement Date** means the earlier of:

1. the date You Retire as such term is defined by Your Employer;
2. the date You receive or become eligible to receive, as defined by the Employer, retirement benefits under any pension plan to which the Employer contributes, or
3. the date You receive or become eligible to receive retirement benefits under, and as defined by, any state or federal retirement plan or under the Social Security Act or Railroad Retirement Act.
4. the date You reach the age defined in the "Schedule of Benefits".

You and Y**our** means the Eligible Employee.

Waiting Period for Insurance Coverage is defined in the "Eligibility for Insurance" and "Schedule of Benefits".

We, Us and **Our** means Madison National Life Insurance Company, Inc.

II. ELIGIBILITY FOR INSURANCE

A. Employee Life Insurance Eligibility.

1. Employee Basic Life Insurance. To be eligible for Employee Basic Life Insurance under the Group Policy You must satisfy the following requirements:

   a) You must be an **Eligible Employee**.
      (1) Employee means an individual who works for the Employer as a member of an Eligible Class and who is reported on the Employer's records for Social Security and tax withholding purposes.

   b) You must be a citizen or legal resident of the United States or Canada, and you must reside in the United States or Canada;

   c) You must be Actively at Work and capable of sustained Active Work.

      (1) **Active Work** and **Actively at Work** mean working at Your Employer's usual place of business, and satisfying the Minimum Hourly Work Requirement. Actively at Work will include regularly scheduled days off, holidays, or vacation days, so long as You are capable of sustained Active Work on those days.

      (2) **Minimum Hourly Work Requirement** means the work hours over a specified time period that are required of You by Your Employer in order to be eligible for coverage. Your Minimum Hourly Work Requirement is specified in the "Schedule of Benefits".

      (3) The Active Work requirement is waived during the time You are approved for benefits under the "Waiver of Premium Benefit" section.

   d) You must have satisfied Your Waiting Period for Insurance Coverage.

      (1) **Waiting Period** means the period of time that You must be Actively at Work as an Employee for Your coverage to become effective. Your Waiting Period is specified in the "Schedule of Benefits".

   e) You cannot be a member of more than one Eligible Class.

   f) You cannot be a part-time Eligible Employee, temporary or seasonal Eligible Employee, full-time member of the armed forces of any country, leased Eligible Employee, or independent contractor.

2. Employee Supplemental Life Insurance. To be eligible for Employee Supplemental Life Insurance under the Group Policy, an applicant must be an Eligible Employee and satisfy the additional eligibility requirements, if any, as listed herein.

B. Dependent Life Insurance Eligibility.

1. The Employee applying for Dependent Life Insurance must be an Eligible Employee insured under the Group Policy and a member of a class that provides for Dependent Life coverage under the Group Policy.

2. To become eligible for Dependent Life Insurance under the Group Policy, an **Eligible Dependent** applicant must meet one of the following definitions:

   a) **Dependent** means Your Spouse or Child who is not in a Period of Limited Activity. Dependent does not include a person who is a full-time member of the armed forces of any country. No person may be considered a Dependent of more than one Eligible Employee. No person can be covered under the Policy as an Employee and as a Dependent.

      (1) **Period of Limited Activity** means any period of time during which a person is confined in a

Hospital or nursing facility or if not confined, unable to carry on the regular and usual activities of a healthy person of the same age and sex.

b) **Spouse** means a person to whom You are legally married, who is under age 70, and from whom You are not legally separated.

c) **Child** means Your unmarried Child until age 19 or age 23 if a full-time student. Full-time student means a registered student in full-time attendance at an accredited educational institution, including vocational training. Child includes a stepchild or legal ward, a Child placed in the home for adoption and/or a legally adopted Child.

d) **Disabled Child** means Your unmarried adult Child who is, on and after the date on which insurance would end because of the Child's age, continuously incapable of self-sustaining employment because of mental or physical handicap; and chiefly dependent upon You for support and maintenance, or institutionalized because of mental or physical handicap. You must provide proof of Your Disabled Child's status within 31 days after the date on which insurance would otherwise end because of the Child's age. Thereafter, We may require further proof of Your Disabled Child's status, but not more often than annually. Costs associated with such proof will be Your responsibility.

3. Dependent Supplemental Life: To be eligible for Dependent Supplemental Life Insurance under the Group Policy, an applicant must be an Eligible Dependent and satisfy the additional eligibility requirements, if any, listed in the "Schedule of Benefits".

III. BECOMING INSURED

A. To become an Insured Person under the Group Policy, an applicant must meet the following requirements as each may apply:

1. If Evidence of Insurability is required, the applicant must provide such Evidence of Insurability and be approved for coverage by Us. The "Schedule of Benefits" specifies when Evidence of Insurability is required.

2. If the insurance is Contributory insurance, the applicant must apply in writing and remit the required premiums.

B. Effective Dates
1. Employee's Initial Enrollment
a) Noncontributory insurance not subject to Evidence of Insurability or which is subject to Evidence of Insurability and has been approved by Us, becomes effective on the date You become an Eligible Employee, or as specified by your Employer. However, if You initially waive participation in such coverage and then later wish to participate, applications for Noncontributory insurance will be subject to Evidence of Insurability and will become effective as shown below.

b) Contributory insurance subject to Evidence of Insurability, and Late Enrollee applications for coverage, become effective on the first day of the month immediately following the month in which the Evidence of Insurability is approved by Us, except that if such approval occurs on the first day of a month, such coverage becomes effective on that day.

c) Contributory insurance not subject to Evidence of Insurability, if You apply prior to, or within 31 calendar days commencing on, the date You become an Eligible Employee, Contributory insurance not subject to Evidence of Insurability becomes effective on the date You become an Eligible Employee. If You do not apply for Contributory insurance prior to, or within 31 days of becoming an Eligible Employee and subsequently wish to obtain such coverage, Evidence of Insurability will be required and Your coverage will become effective as provided in subsection b above.

2. Increases in Insurance
   a) Evidence of Insurability Required. An increase of insurance that is subject to Evidence of Insurability becomes effective on the first day of the month immediately following the month in which the Evidence of Insurability is approved by Us, except that if such approval occurs on the first day of a month, such coverage becomes effective on that day.

   b) Evidence of Insurability Not Required. An increase of insurance that is not subject to Evidence of Insurability becomes effective as follows:
      (1) Based on change in Your classification, age or earnings on the date of such change;

      (2) Addition of a Dependent: on the date the Dependent becomes an Eligible Dependent, if You apply within 31 days of such date. Applicant will be treated as a Late Enrollee if application is not made timely. However, while Your Dependent Life Insurance is in effect, each new Dependent becomes insured immediately.

3. Decreases in Insurance
   a) A decrease in life insurance based on a change in Your classification, earnings, age or Your Dependent's age, becomes effective on the date of the change.

   b) Any other decrease in insurance becomes effective on the date of change.

4. Delayed Effective Date. If You are incapable of sustained Active Work due to Injury or Physical Disease on the day before the scheduled effective date of Your insurance or the effective date of a change in Your insurance, such insurance will not become effective until the day after You are capable of sustained Active Work and complete one day of Active Work as an Eligible Employee.

5. If Your coverage ends, You may become covered again, subject to the following:

   a) If Your coverage ends because You fail to make the required contribution while on an approved Family Medical Leave of absence, and then You return to Active Work and enroll for coverage within 31 days of the earlier of a) the end of the period of leave You and Your Employer agreed upon, or b) the end of the 12-week period following the date Your leave began, then the Waiting Period will be waived. Coverage is limited to what You had in effect prior to coverage ending or the coverage that is now available for Your Class, as determined by Us.

   b) In all other cases, if Your coverage ends because You fail to make the required contribution, You must provide Evidence of Insurability to become covered again.

   c) In no event will insurance coverage be retroactive.

IV. WHEN COVERAGE ENDS

A. Except as otherwise provided for under this Certificate, coverage will cease on the earliest of the following to occur:
   1. the date the Group Policy terminates;
   2. the date You cease to be an Eligible Employee;
   3. if premium is not paid when required, the last day of the period for which premium was paid;
   4. Your Retirement Date;
   5. for Dependent coverage, the date a Dependent is no longer eligible for Dependent coverage.
   6. for AD&D coverage, the earlier of the date Your corresponding life insurance ends, the date you are no longer Actively at Work, the date Your Waiver of Premium Benefit begins or Your Retirement Date.

B. Approved FMLA Leave of Absence – Contributory or Noncontributory Coverage
   1. With regard to the Federal Family and Medical Leave Act (FMLA) of 1993, as amended, the Employer and Employee must be eligible for FMLA in order to receive it. If You are on an approved FMLA leave, coverage will continue until the later of the leave period required by FMLA or the leave period required by applicable state law, provided that :
      a) We receive written notice in advance of a leave approved by the Employer which includes the beginning and ending dates of the leave; and
      b) FMLA leaves of absence and the right to continue coverage during FMLA leaves are available to all Employees in the same Eligible Class under the Group Policy; and
      c) the Employer remits the required premium for coverage.

C. Paid Leave of Absence. If You are on a paid leave of absence, coverage will continue subject to the following:

   1. Noncontributory coverage
      a) Coverage will continue provided that:
         (1) We receive written notice in advance of a leave approved by the Employer which includes the beginning and ending dates of the leave; and
         (2) paid leaves of absence and the right to continue coverage during paid leaves are available to all Employees in the same Eligible Class under the Group Policy; and
         (3) the Employer remits the required premium for coverage.

      b) Unless You return to active, eligible status on or before the date the leave is scheduled to end, coverage extended during a paid leave will terminate on the earlier of the date the paid leave is scheduled to end or 3 months from the date the paid leave began.

   2. Contributory Coverage
      a) Coverage will continue provided that:
         (1) We receive written notice in advance of a paid leave of absence approved by the Employer which includes the beginning and ending dates of the leave; and
         (2) paid leaves of absence and the right to continue coverage during paid leaves of absence are available to all Employees in the same Eligible Class under the Group Policy; and
         (3) You continue to pay the required premium to the Employer without interruption and the Employer continues to remit premium to Us on Your behalf.

      b) Unless You return to active, eligible status on or before the date the paid leave of absence is scheduled to end, coverage extended during a paid leave of absence will terminate on:
         (1) the date the paid leave of absence is scheduled to end;
         (2) 3 months from the date the paid leave of absence began; or
         (3) the date You fail to pay the premium as required.

      c) If You choose not to continue coverage or Your coverage terminates during a paid leave of absence and You subsequently wish to obtain coverage, You will be treated as a Late Enrollee and be required to provide Evidence of Insurability.

D. Unpaid Leave of Absence - If You are on an unpaid leave of absence, coverage will continue subject to the following:
   1. Noncontributory Coverage
      a) Coverage will continue provided that:
         (1) We receive written notice in advance of an unpaid leave of absence approved by the Employer which includes the beginning and ending dates of the unpaid leave of absence; and
         (2) unpaid leaves of absence and the right to continue coverage during unpaid leaves of absence are available to all Employees in the same Eligible Class under the Group Policy; and
         (3) the Employer remits the required premium for coverage.

      b) Unless You return to active, eligible status on or before the date the unpaid leave of absence is scheduled to end, coverage extended during an unpaid leave of absence will terminate on the earlier of

the date the unpaid leave of absence is scheduled to end or 3 months from the date the unpaid leave of absence began.

2. Contributory Coverage
   a) Coverage will continue provided that:
      (1) We receive written notice in advance of an unpaid leave of absence approved by the Employer which includes the beginning and ending dates of the leave; and
      (2) unpaid leaves of absence and the right to continue coverage during unpaid leave of absence are available to all Employees in the same Eligible Class under the Group Policy; and
      (3) You continue to pay the required premium to the Employer without interruption and the Employer continues to remit premium to Us on Your behalf.

   b) Unless You return to active, eligible status on or before the date the unpaid leave of absence is scheduled to end, coverage extended during an unpaid leave of absence will terminate on the earlier of:
      (1) the date the unpaid leave of absence is scheduled to end;
      (2) 3 months from the date the unpaid leave of absence began; or
      (3) the date You fail to pay the premium as required.

   c) If You choose not to continue coverage or Your coverage terminates during an unpaid leave of absence and You subsequently wish to obtain coverage, You will be treated as a Late Enrollee and be required to provide Evidence of Insurability.

E. Layoffs - Contributory or Noncontributory Coverage
   1. If You are on a leave of absence due to a lay-off, coverage will continue through the end of the 3 month period following the date in which You last worked prior to the lay-off, provided that any premium for You is paid for that month.

F. Physical Disease or Injury – Contributory or Noncontributory Coverage
   1. If you are on a leave due to a Physical Disease or Injury, coverage will continue through the end of the 12 month period following the date in which You last worked prior to the leave, provided that any premium for You is paid during such leave.

G. Termination or Amendment of the Group Policy
   1. The Group Policy may be terminated, changed or amended in whole or in part by Us or the Policyholder according to the terms of the Group Policy. Any such change or amendment may apply to current or eligible persons covered under the Group Policy or to any separate classes or categories thereof.
   2. We may change the Group Policy in whole or in part: (i) when any change or clarification in law or governmental regulation affects Our obligations under the Group Policy, or (ii) with the Policyholder's consent.
   3. We may terminate an Employer's coverage on any premium due date by giving the Employer not less than 60 days advance notice. An Employer may terminate coverage under the Group Policy in whole, and may terminate insurance for any class or group of eligible persons, at any time by giving Us advanced written notice at least 60 days prior to such termination. Insurance will terminate automatically for nonpayment of premium.
   4. Benefits are limited to the terms of the Group Policy, including any valid amendments. No change or amendment of the Group Policy will be valid unless it is approved in writing by one of Our executive officers and delivered to the Policyholder. The Policyholder and their Eligible Employees or representatives have no right or authority to change or amend the Group Policy or to waive any terms or provisions thereof without Our signed, written approval.

V. LIFE INSURANCE - WAIVER OF PREMIUM BENEFIT

A. Waiver of Premium Definitions
   (1) **Elimination Period** means the period of 9 months beginning on the date You become Disabled.
   (2) **Life Insurance** under this Waiver of Premium Benefit means all of the Life Insurance, as listed in the Schedule of Benefits, in force under the Group Policy on the day before the day You become Disabled.
   (3) **Proof of Disability** means documented clinical findings that prove that You are Disabled.

B. Waiver of Premium does not apply to AD&D Insurance.

C. Your Life Insurance will be continued as provided for under this section without payment of premium, if all of the following conditions are met:
   (1) You become Disabled prior to age 60 while insured under the Group Policy;
   (2) You remain Disabled without interruption for the duration of the Elimination Period;
   (3) You provide Us with written notice of Your Disability within 30 days after the end of Your Elimination Period;
   (4) You provide Us with satisfactory written Proof of Disability within 3 months from the last day of the Elimination Period;
   (5) Your claim is approved by Us.

D. When the Waiver of Premium Benefit Begins. If You qualify and are approved for the Waiver of Premium Benefit, Your premium will be waived beginning on the first day of the month immediately following the end of Your Elimination Period.

E. When Waiver of Premium Ends. Waiver of Premium ends on the earliest to occur of the following:
   1. The date You cease to be Disabled;
   2. The 91st day following the date We mail to You a request for additional Proof of Disability with which You fail to comply;
   3. The date You refuse to submit to a medical examination or to cooperate with Our chosen health care provider;
   4. The date You refuse to submit to or undergo vocational rehabilitation (which determines employment opportunities, if any, for individuals with disabilities);
   5. The date at which You've resided outside of the United States of America, or one of its territories during any 6 consecutive months for which premium had been waived;
   6. The effective date of an individual life insurance policy issued to You under the "Life Insurance Conversion Benefit" section.
   7. The premium due date immediately prior to Your 65th birthday;
   8. The date You Retire, unless such Retirement is due to a Disability.

F. Premiums
   1. Premium payment must continue until the later of the end of Your Elimination Period or the date Your claim for the Waiver of Premium Benefit is approved by Us.
   2. If Your Waiver of Premium benefit terminates because You cease to be Disabled or You fail to submit to a medical exam or cooperate with the examiner, for coverage to continue, You must be an Eligible Employee and premiums must resume on the next premium due date, or You must continue coverage as provided for under the "Life Insurance Conversion Benefit" section.
   3. If We approve Your claim for the Waiver of Premium Benefit, We will refund up to 12 months of the premiums that were paid for Life Insurance in place after the date You became Disabled.

G. Amount of Insurance
   1. The amount of Life Insurance continued under the Waiver of Premium Benefit is the amount in effect on the day before You became Disabled, if you were Actively at Work.
   2. Insurance will be reduced or terminated according to the Group Policy provisions in effect on the day before You became Disabled.
   3. Your Life Insurance amount will not increase while Your Life Insurance premiums are being waived.

H. We will not waive premiums if Your Disability results from intentionally self-inflicted Injuries or Physical Diseases, while sane or insane, or from Your voluntary participation in an illegal activity.

I. If You die during the Elimination Period and are otherwise eligible for the Waiver of Premium Benefit, the Elimination Period will not apply.

J. We may require further Proof of Disability in intervals that are reasonable based on Your type of Disability.

K. Investigation Of Claim
With respect to benefits that are claimed during an Insured Person's lifetime, We may require him or her to undergo examination at reasonable intervals, at Our expense. Any such examinations will be conducted by appropriate Physician of Our choice. We may deny or suspend benefits if You fail to attend an examination, or do not give full effort and cooperation to the examiner.

GTL-C900-0608

VI. LIFE INSURANCE - LIVING BENEFIT

Terminally Ill and **Terminal Illness** mean a medical condition that is expected to result in Your death within 6 months.

A. If You become Terminally Ill while covered for life insurance under the Group Policy You may elect to receive the Living Benefit as provided for under this section.

B. The Living Benefit will be an amount equal to 50% of Your Employee Basic Life Insurance in effect on the date Your election is made, subject to a minimum of $5,000 and a maximum of $100,000. The amount payable will be equal to the Living Benefit less applicable amounts, if any, charged for an investment loss (interest) and administrative fees.

C. The payment will be made in one lump sum to You or to the payee You appropriately assign.

D. The Living Benefit will not be available if:
1. You have any portion of any Life Insurance or ownership rights thereof absolutely or irrevocably assigned or transferred;
2. You have made an irrevocable beneficiary designation;
3. the insurance proceeds are subject to a court order under a divorce decree, separate maintenance agreement or property settlement agreement;
4. You have filed for bankruptcy, unless You give Us written approval from the bankruptcy court for payment of the Living Benefit; and
5. Your Terminal Illness resulted from an intentionally self-inflicted Injury or suicide attempt within the first two years after Your effective date of coverage or an insurance increase.

E. No payment will be made under this election unless and until We receive and approve of all of the following:
1. Your signed and notarized election of this option on a form furnished by Us;
2. signed and witnessed written statements of all irrevocable beneficiaries and assignees (and Spouse in marital property states) consenting to Your election of this option; and
3. satisfactory written proof from a Physician other than Yourself or a member of Your or Your Spouse's immediate family that You have been diagnosed as being Terminally Ill and that You are of sound mind and under no constraint or undue influence.

F. We may require a second opinion and examination of Your condition at Our own expense by a Physician of Our choice.

G. Payment of the Living Benefit will reduce correspondingly the face amount of Your life insurance benefits under the Group Policy. This will result in reduced life insurance proceeds payable to Your beneficiary at Your death. Furthermore, any amount of insurance that would otherwise be continued under the "Waiver of Premium

Benefit" section will be reduced proportionately, as will the maximum face amount available under the "Life Insurance Conversion Benefit" section.

H. Premium payments must continue to be paid for Your life insurance unless You qualify to have Your life insurance premium waived. The premium due will be based on the amount of insurance remaining in force after deducting the amount of the Living Benefit.

I. Payment of the Living Benefit will not affect the amount of, or change an existing beneficiary designation for, the AD&D Benefit, if any, in effect and kept in force under the Group Policy.

J. Your election together with Our payment of the Living Benefit constitute a valid and effective beneficiary designation change, but only with respect to the specified life insurance benefits, and only to the extent affected by the Living Benefit payment, and applicable interest and fees, if any, charged thereon.

K. Payment of the Living Benefit will be exempt from the claims of creditors and from legal process to the extent permitted by law.

L. All other provisions of the Group Policy, including the effective date provisions of any benefit increases and the provisions on benefit reductions because of amendments to the plan or benefit classification changes or Your attained age, remain valid and in effect. Any such life insurance benefit reduction will be calculated based on Your life insurance amount in effect immediately before the Living Benefit payment.

M. You are responsible for any tax consequences related to this benefit.

GTL-C1000-0608

VII. LIFE EXCLUSIONS

A. Suicide Exclusion
   1. Except as provided for below, no death benefits will be payable for a death of an Insured Person occurring within 2 years from the Insured Person's effective date of coverage under the Group Policy, if such death was caused by suicide, attempted suicide, or any other intentionally self-inflicted Injury or Physical Disease, while sane or insane. This Suicide Exclusion shall reapply to increases of such insurance as of the effective date of the increase.
   2. We will refund all premiums paid for any coverage under which benefits are excluded from payment under this provision.
   3. If You were covered under the Prior Plan on the day before the Effective Date under the Group Policy, credit will be given for the time You were insured under the Prior Plan.
   4. This exclusion does not apply to insurance coverage which is 100% paid for by the Employer.

GTL-C1200-0608-TN

VIII. LIFE INSURANCE CONVERSION BENEFIT

A. When Coverage Ends.
   1. If an Insured Person's coverage under the Policy ends, the Insured Person may, as described below, apply for Our individual life insurance policy without submitting Evidence of Insurability.
      a) The Insured Person must complete an application, pay the first premium, and send them to Us within the 31-day period immediately following the date coverage ends under the Policy (the Conversion Period). If Your Employer does not notify You in writing of Your conversion right at least 15 days prior to the end of Your Conversion Period, Your Conversion Period will extend an additional 15 days from the date You receive the notice. This extension will allow you to purchase conversion coverage, but your coverage will not extend beyond the 31 day period herein unless conversion coverage is elected and premium is paid. In no event will the conversion period extend beyond 60 days after the date Your coverage ended. Written notice by Your Employer is required to be mailed to Your last known address.

b) The individual policy will become effective on the first day following the date coverage under the Policy ends.
c) The Insured Person may convert all or part of the amount of life insurance benefit, as shown in the "Schedule of Benefits".

2. If an Insured Person has been insured under the Policy for at least five years and is no longer eligible due to cancellation of the Policy or cancellation of the class of insureds in which the Employee belonged, an Insured Person may convert the lesser of: (1) $2,000 or (2) all or part of the amount for which the Insured Person is no longer eligible for under the Policy.

B. Premiums.
1. Premiums for such individual life policy will be based on: (1) Our usual rate for the amount and type of individual policy; (2) the Insured Person's class of risk; and (3) the Insured Person's attained age.
2. If an Insured Person dies during the Conversion Period, the maximum amount of life insurance to which he or she would have been entitled to under such individual policy shall be payable as a claim under the Group Policy, whether or not application for the individual policy or the payment of the first premium has been made.
3. The rights or benefits granted under this provision are in lieu of any other rights or benefits granted under the Group Policy.

IX. LIFE INSURANCE PORTABILITY BENEFIT

A. Schedule of Portable Coverage.
1. Portable Coverage is available for the following types of insurance You have in effect on the last day of Your employment with the Employer:
a) Employee Supplemental Life Insurance;

B. When Coverage Ends. If Your life insurance coverage under the Group Policy end because Your employment with the Employer terminates, You may be eligible to purchase portable group life insurance without submitting Evidence of Insurability. You may purchase all or some of Your life insurance in force at the time Your employment ends, but not less than a minimum of $10,000.

C. Eligibility. To be eligible for Portable Coverage, You must meet the following requirements on Your last day of employment with the Employer:

1. You must be under age 70;
2. Your termination of employment must not be due to Retirement;
3. You cannot be covered under any other group term life insurance plan.

D. Application and Premium Payment
1. You must apply in writing and pay the first premium within 31 days after Your last day of employment with the Employer.
2. Premium checks are payable to Madison National Life Insurance Company, Inc., and must be made directly to Us in a timely manner as specified by Us at the time coverage is ported.

E. Effective Date of Portable Coverage. Provided the above requirements are met, Portable Coverage will become effective the first day immediately following Your last day of coverage through the Employer.

F. The following Benefits/Sections are Excluded from being portable under this Section:
1. Any coverages not specifically listed under the "Schedule of Portable Coverage" subsection above;
2. Waiver of Premium;
3. Living Benefit;
4. Seat Belt Benefit;
5. Air Bag Benefit.

G. Other Portability Terms and Requirements.

1. If You do not purchase Portable Coverage for Yourself, You may not purchase Portable Coverage for any Dependent.
2. Refer to the "Life Insurance Conversion Benefit" section for information on eligibility to convert Your group insurance to an individual life insurance policy. The combined amounts of Portable Coverage and coverage obtained under the "Life Insurance Conversion Benefit" section cannot exceed the amount in effect under the Group Policy on the last day of Your employment with the Employer.
3. You may reduce Your amount of Portable Coverage at any time by providing Us with a written request. Such a reduction will be effective on the first day of the month following the month in which the request was received. You may not increase Your Portable Coverage.
4. Your Portable Coverage is governed by the terms of the Group Policy, and will be reduced or terminated according to the terms therein.
5. In the event of termination of the Group Policy, Your Portable Coverage will terminate on that date.
6. If You do not complete and submit a new beneficiary designation form with Your application for Portable Coverage, Your beneficiary designation on file under the Group Policy will apply to Your Portable Coverage.

GTL-C1500-0608

X. ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

A. If an Insured Person has an Accident while insured for Accidental Death and Dismemberment (AD&D) Insurance and the Accident results in a Loss (as defined below), We will pay benefits according to the terms of the Group Policy after We receive Proof of Loss.

B. Eligibility. An Insured Person must be a member of a class that is eligible for AD&D coverage under the Group Policy as specified in the "Schedule of Benefits".

C. Definitions for AD&D Insurance
1. **Loss** means Loss of one or more of the body parts or bodily functions listed under "AD&D Benefit" below, or as otherwise provided for under this "Accidental Death and Dismemberment Insurance" section, which:
   a) is caused solely and directly by an Accident;
   b) occurs independently of all other causes;
   c) occurs within 90 days after the Accident; and
   d) while the Insured Person is covered under the Group Policy.
2. **Accident:** A sudden, unexpected and unforeseen, identifiable event causing bodily Injury, directly produced by specific accidental contact with another body or object. The Accident must occur while You are covered under the Group Policy.
3. With respect to a hand or foot, Loss means actual and permanent severance from the body at or above the wrist or ankle joint.
4. With respect to sight, speech or hearing, Loss means entire and irrecoverable Loss of that function.

D. **AD&D Benefit.** The AD&D Benefit is equal to a percentage of the AD&D Insurance Amount in effect on the date of the Accident, subject to the AD&D Reduction Schedule provision set forth in the "Schedule of Benefits". The AD&D Insurance Amount is shown in the "Schedule of Benefits". The percentage is shown below.

Covered Losses:	Maximum Amount Payable
Loss of Life	100%
Loss of both Hands or both Feet	100%
Loss of one Hand or one Foot	50%
Loss of one Hand and one Foot	100%
Loss of Entire Sight of both Eyes	100%
Loss of Entire Sight in one Eye	50%
Loss of one Hand or one Foot and Entire Sight of one Eye	100%

Loss of Speech and of Hearing in both Ears 100%
Loss of Speech or Hearing in both Ears 50%
Loss of Thumb and Index Finger of the same Hand 25%
Loss of hearing in one ear 25%

E. Unless otherwise specified, no more than 100% of the applicable AD&D Insurance Amount will be paid for all Losses resulting from one Accident. If an age reduction applies, the benefit reduces on the date You attain that age.

F. Additional AD&D Benefits

1. Seat Belt Benefit.
Seat Belt means a properly installed Seat Belt, lap and shoulder restraint, or other restraint, approved by the National Highway Traffic Safety Administration.
Automobile means a motor vehicle licensed for use on public highways

a) We will pay a Seat Belt Benefit if:
(1) an Insured Person who is covered by the Seat Belt Benefit dies as a result of an Automobile Accident for which an AD&D Benefit is payable; and
(2) such Insured Person was wearing a Seat Belt at the time of the Accident, as evidenced by a police accident report.

b) We will not pay a Seat Belt Benefit with respect to an Insured Person if the Automobile Accident:
(1) occurs when the Automobile driven by such Insured Person is being used for racing, stunting or exhibition work;
(2) occurs when such Insured Person is in violation of any traffic laws of the jurisdiction in which the Automobile is being operated; or
(3) occurs while such Insured Person is driving legally intoxicated as defined by the laws of the jurisdiction in which the vehicle was being operated.

c) Amount of Benefit. The Seat Belt Benefit is paid in addition to the AD&D Benefit paid because of the Insured Person's accidental death and equals $10,000.

2. Air Bag Benefit
Air Bag means an Automobile safety device consisting of a bag designed to inflate automatically especially in front of an occupant in case of collision.

a) We will pay an Air Bag Benefit for an Insured Person if:
(1) the private passenger car was equipped with an airbag for the seat in which the Insured Person was seated; and
(2) the seatbelt(s) was in use and properly fastened at the time of the covered Accident.

b) We will not pay an Air Bag Benefit with respect to an Insured Person if:
(1) the Automobile Accident occurs when the Automobile driven by such Insured Person is being used for racing, stunting or exhibition work;
(2) the Automobile Accident occurs when such Insured Person is in violation of any traffic laws of the jurisdiction in which the Automobile is being operated; or
(3) the Automobile Accident occurs while such Insured Person is driving legally intoxicated as defined by the laws of the jurisdiction in which the vehicle was being operated.
(4) the Insured Person was the driver of the private passenger car and did not hold a valid driver's license at the time of the Accident;
(5) We determine that the airbag(s) had been disengaged prior to the Accident;

c) Amount of Benefit. The Air Bag Benefit is paid in addition to the AD&D Benefit paid because of the Insured Person's accidental death and equals $5,000.

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G. AD&D Insurance Exclusions. No AD&D Benefit is payable if the Loss is caused or contributed to by any of the following:

1. War or Act of War. War means death as a direct result of service in the military, naval or air forces, in time of war, including any ambulance, medical, hospital or civilian noncombatant unit serving actively with such military, naval or air forces;

2. Suicide, attempted suicide or other intentionally self-inflicted Injury, while sane or insane, within the first 2 years of coverage;

3. Committing or attempting to commit a felony or assault, or actively participating in a violent disorder or riot. Actively participating does not include being at the scene of a violent disorder or riot while performing Your official duties;

4. Any Injury sustained while under the voluntary use or consumption of any poison, illegal drugs, or controlled substance, unless used or consumed according to the directions of a Physician;

5. Physical Disease existing at the time of the Accident;

6. Medical negligence and malpractice;

7. Bacterial infections (except due to accidental food poisoning or caused by an accidental wound);]

8. Any Loss incurred while engaging in any aerial flight, except as a fare-paying passenger on a regularly scheduled flight of a duly licensed airline on an established air route.

GTL-C2100-0608-TN

XI. CLAIMS PROVISIONS

A. Filing A Claim

1. To file a claim for benefits under this Certificate, the claimant (depending on the benefit the claimant could be an Insured Person, a beneficiary or personal representative of an Insured Person) must provide Us with Proof of Loss in a timely manner. Or, upon receipt of written notice of claim, We will send the claimant a Claim Form for filing Proof of Loss. If the claimant does not receive such forms within 15 days after the giving of such notice, the claimant can send us, without the Claim Form, the written proof covering the occurrence.

2. Proof of Loss.
   a) Proof of Loss must be provided in writing to Us, at the claimant's expense, within 90 days after the date of the loss if reasonably possible. If that is not reasonably possible, Proof of Loss must be provided no later than one year after expiration of that 90-day period, or the claim will be denied. The time limits under this section shall not apply while the claimant lacks legal capacity.

   b) **Proof of Loss** means satisfactory written proof that a loss occurred for which the Group Policy provides benefits, which is not subject to any exclusion, and which meets all other conditions for benefits. Proof of Loss includes any other information We may reasonably require in support of a claim for benefits under the Group Policy.

B. Notice of Decision on Claim

1. We will evaluate a claim for benefits promptly after We receive it. Within 30 days after We receive the claim We will send the claimant:
   a) a written decision on the claim; or
   b) a notice that We are extending the period to decide the claim for an additional 45 days.

2. If the claim is approved, We will pay benefits within 30 days after the Proof of Loss requirement is satisfied.

3. If We extend the period to decide the claim, We will notify the claimant of the following:
   a) the reasons for the extension;
   b) when We expect to decide the claim; and
   c) any additional information We require to decide the claim.

4. If We request additional information, the claimant will have 45 days to provide the information. If the claimant does not provide the requested information within 45 days, We may decide the claim based on the information We have received.

5. If We deny any part of the claim, We will send the claimant a written notice of denial containing:
   a) the reasons for Our decision;
   b) reference to the parts of the Group Policy on which Our decision is based;
   c) a description of any additional information required to support the claim;
   d) information concerning the claimant's right to a review of Our decision.

C. Payment of Claims.

Upon receipt of proper Proof of Loss, benefits will be paid within 30 days. If any claims payment interest accrues, interest will be paid in the amount determined by the State in which the claims are incurred.

Death Claims: If an Insured Person dies while insured for life insurance under the Group Policy, We will pay benefits according to the "Schedule of Benefits", after We receive Proof of Loss, as follows.

1. The death benefit will be paid in a single sum or by any other method agreeable to Us and the beneficiary. Payment of the benefit will extinguish Our liability under the Group Policy for which the death benefit has been paid.

2. No Surviving Beneficiary. If You do not name a beneficiary, or if You are not survived by any named beneficiary, benefits will be paid to Your estate.

3. Dependent Benefits. Dependent Life Insurance benefits that are payable, but unpaid at the Insured Person's death, will be paid in equal shares to the first surviving class of the following, if the Eligible Employee is dead:
   a) The children of the Dependent.
   b) The parents of the Dependent.
   c) The Insured Person's estate.

   The following Dependent benefits, payable under the Group Policy, will be paid to the Eligible Employee if he or she is living:
   a) Life Insurance benefits;
   c) Supplemental Life Insurance benefits payable because of the death of Your insured Spouse or Child;

4. Facility of Payment. If the benefits provided by the Group Policy are payable to the Insured Person's estate or to a beneficiary who is a minor or otherwise not legally competent to give a valid release, We may pay up to $500 to any person related to the Insured Person by blood or marriage. Any payment made in good faith will fully release Us to the limit of the payment. If a beneficiary is a minor, or is not able to give a valid release for any payment of benefits made, We will pay the life proceeds to the legally appointed guardian. The guardian must provide Us with adequate written proof of such appointment. This provision

does not prevent Us from making payment to or for the benefit of a minor beneficiary in accordance with the applicable state law. Payment made before We have received written notice at Our home office of a valid claim by some other person releases Us from further obligation.

D. Review Procedure.

1. If all or part of a claim is denied, the claimant may request a review. The claimant must request a review in writing within 60 days after receiving notice of the denial.

2. The claimant may send Us written comments or other items to support the claim. The claimant may review and receive copies of any non-privileged information that is relevant to the request for review. There will be no charge for such copies. Our review will include any written comments or other items the claimant submits to support the claim.

3. We will review the claim promptly after We receive the request. Within 60 days after We receive the request for review We will send the claimant:
   a) a written decision on review; or
   b) a notice that We are extending the review period for 60 days. If the extension is due to the claimant's failure to provide information necessary to decide the claim on review, the extended time period for review of the claim will not begin until the claimant provides the information or otherwise responds.

4. If We extend the review period, We will notify the claimant of the following:
   a) the reasons for the extension;
   b) when We expect to decide the claim on review; and
   c) any additional information We require to decide the claim.

5. If We request additional information, the claimant will have 45 days to provide the information. If the claimant does not provide the requested information within 45 days, We may conclude Our review of the claim based on the information We have received.

6. If We deny any part of the claim on review, the claimant will receive a written notice of denial containing:
   a) the reasons for Our decision.
   b) references to the provisions of the Group Policy on which Our decision is based.
   c) information concerning the claimant's right to receive, free of charge, copies of non-privileged documents and records relevant to the claim.

7. The Group Policy does not provide voluntary alternative dispute resolution options.

GTL-C2200-0608

XII. GENERAL PROVISIONS

A. Naming a Beneficiary.

1. At the time You became insured under the Group Policy, You should have named a beneficiary of the proceeds of Your life insurance on the enrollment form.

2. You may have named primary beneficiaries and secondary beneficiaries. A secondary beneficiary will become a primary beneficiary if the named primary beneficiary is not living at the time of Your death. Two or more surviving primary beneficiaries will share equally, unless You specify otherwise.

3. AD&D Insurance death benefits will be distributed according to the beneficiary designation of Your corresponding life insurance.

4. You may change Your beneficiary designation at any time, subject to the following:
   a) The designation must be made in writing on a form suitable to Us;

b) The designation must be dated and signed by You (and by your Spouse where required by law);
c) The designation must relate and refer to the insurance provided under the Group Policy;
d) If applicable, We must have the written consent of all irrevocable beneficiaries;
e) You must not have assigned the ownership of Your insurance.

5. When a valid change of beneficiary is received by Us, the change will relate back to and take effect as of the date it was signed. This is the case whether You are alive or not when We receive the request. Even though the change of beneficiary will relate back to the date it was signed, it will be without prejudice to Us on account of any payment We have already made.

6. If We approve it, a written designation signed and dated by You under the Prior Plan will be accepted as Your beneficiary designation under the Group Policy.

B. Simultaneous Death Provision.

If a beneficiary dies on the same day You die, or within 120 hours from Your time of death, benefits will be paid as if that beneficiary had died before You, unless Proof of Loss with respect to Your death is delivered to Us before the date of the beneficiary's death.

C. Entire Contract, Changes

1. This Certificate, which is part of the Group Policy, including the Enrollment Form, Group Policy and any Riders, Amendment or attached papers, if any, constitutes the entire contract of Insurance. No change in this Certificate shall be valid until approved by an executive officer of Our company and unless such approval is endorsed hereon or attached hereto. No agent has authority to change this Certificate or waive any of its provisions.

2. Except for those functions which the Group Policy specifically reserves to the Policyholder or Employer, We have authority to control, manage, and interpret the Group Policy, to administer claims and to resolve all questions arising in the administration, interpretation and application of the Group Policy.

3. Our authority includes, but is not limited to the following:
a) the right to resolve all matters when a review has been requested;
b) the right to establish and enforce rules and procedures for the administration of the Group Policy and any claim under it;
c) the right to determine eligibility for insurance, entitlement to benefits, the amount of benefits payable and the sufficiency and the amount of information We may reasonably require to make determinations.

D. Incontestability of Insurance

1. Any statement made to obtain or to increase insurance is a representation and not a warranty.

2. No misrepresentation will be used as a basis for reducing or denying a claim or contesting the validity of insurance unless:
a) the insurance would not have been approved if We had known the truth; and
b) We have given You or any other person claiming benefits a copy of the signed written instrument which contains the misrepresentation.

3. After insurance has been in effect for 2 years, during the lifetime of the Insured Person, We will not use a misrepresentation as a basis for reducing or denying a claim, unless it was a fraudulent misrepresentation.

E. Incontestability of the Group Policy or Employer Coverage under the Group Policy

1. No misrepresentation by the Policyholder will be used as a basis for denying a claim, or for denying the validity of the Group Policy unless:

a) the Group Policy would not have been issued if We had known the truth; and
b) We have given the Policyholder or Employer a copy of a written instrument signed by the Policyholder or Employer which contains the misrepresentation.

2. The validity of the Group Policy will not be contested after it has been in force for 2 years, except for nonpayment of premium or fraudulent misrepresentations.

F. Clerical Error

1. Clerical error by Us, the Policyholder, Your Employer, or their respective Eligible Employees or representatives will not:
a) cause a person to become insured under the Group Policy or a provision of it.
b) invalidate insurance otherwise validly in force.
c) continue insurance otherwise validly terminated.
d) cause an Employer to obtain coverage under the Group Policy or a provision of it.

2. In the event that a clerical error results in an incorrect rate, We reserve the right to adjust the rate accordingly.

3. The payment of premium, by itself, will not obligate Us to provide benefits to anyone who is not eligible for coverage under the Group Policy.

4. Your Employer acts on its own behalf as Your agent, and not as Our agent. Your Employer has no authority to alter, expand or extend Our liability or to waive, modify or compromise any defense or right We may have under the Group Policy.

G. Misstatement

1. Age or Gender
If the age or gender, or both, of a person has been misstated, We will make an equitable adjustment of premiums, benefits or both. The adjustment will be based on:
a) the amount of insurance based on the correct age and gender; and
b) the difference between the premiums paid and the premiums which would have been paid if the age and gender had been correctly stated.

H. Legal Actions

A legal action may not be brought to recover on this Certificate within 60 days after written Proof of Loss has been given as required. No such action may be brought after 5 years from the time written proof was required to be given.

I. Assignment

An Insured may not assign any of his or her rights, privileges or benefits under the Group Policy, unless approved by Us.

J. Conformity With State Laws

If any provision of this Certificate is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of such law.

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE TENNESSEE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of Tennessee who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Tennessee Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted on the next page, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The state law that provides for this safety-net coverage is called the Tennessee Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverages, exclusions and limits. **This summary does not cover all provisions of the law or describe all of the conditions and limitations relating to coverage. This summary does not in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.**

COVERAGE

Generally, individuals will be protected by the life and health Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by an insurer authorized to conduct business in Tennessee. Health insurance includes disability and long term care policies. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Guaranty Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insured who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk. such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contractholder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated-annuity contract (which give rights to group contractholders, not individuals)

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Guaranty Association is obligated to payout. The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. For anyone insured life, the Guaranty Association guarantees payments up to a stated maximum no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. These aggregate limits per life are as follows:

- $300,000 for policies and contracts of all types, except as described in the next point
- $500,000 for basic hospital, medical and surgical insurance and major medical insurance issued by companies that become insolvent after January 1, 2010

Within these overall limits, the Guaranty Association cannot guarantee payment of benefit greater than the following:

- life insurance death benefits - $300,000
- life insurance cash surrender value - $100,000
- present value of annuity benefits for companies insolvent before July 1, 2009 - $100,000
- present value of annuity benefits for companies insolvent after June 30, 2009 - $250,000
- health insurance benefits for companies declared insolvent before January 1, 2010 - $100,000
- health insurance benefits for companies declared insolvent on or after January 1, 2010:
  - $100,000 for limited benefits and supplemental health coverages
  - $300,000 for disability and long term care insurance
  - $500,000 for basic hospital, medical and surgical insurance or major medical insurance

The Tennessee Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Tennessee. You should not rely on coverage by the Tennessee Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

TENNESSEE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION
150 Third Avenue South, Suite 1600
Nashville, Tennessee 37201

TENNESSEE DEPARTMENT OF COMMERCE AND INSURANCE
500 James Robertson Parkway
Nashville, Tennessee 37243

Madison National Life Insurance Company
A Member of The IHC Group

ABACUS

Supplemental Term Life and AD&D Benefits

Anderson County Government

Your Employer is providing **$50,000** of Basic Term Life and AD&D benefits.

Employee Benefits

Eligiblity: All current active full-time employees working 30 or more hours per week. New employees may purchase coverage within 31 days of their eligibility date. Future elections require Evidence of Insurability when declined at initial offering.

Benefit Amount: $10,000 to $300,000 in $10,000 increments, up to 5 times Basic Annual Earnings (rounded to next lower unit), not including bonuses, commissions or overtime.

Guarantee Issue: $100,000.

Reduction: To 65% at age 65 and to 50% at age 70.

Waiver of Premium: Provided for Term Life only if Disability begins prior to age 60 while insured under Policy, Disability is continuous for the duration of the 9 month Elimination Period, and if written notice and proof of Disability is provided in a timely manner.

Termination: The date of retirement.

Suicide Exclusion: 2 years.

Conversion: Included.

Portability: Included.

AD&D: Not automatically included, must be elected once Supplemental Life is elected.

Monthly Premiums

Age	$10,000	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000	$90,000	$100,000	
<30	0.50	1.00	1.50	2.00	2.50	3.00	3.50	4.00	4.50	5.00	0.05
30-34	0.70	1.40	2.10	2.80	3.50	4.20	4.90	5.60	6.30	7.00	0.07
35-39	0.80	1.60	2.40	3.20	4.00	4.80	5.60	6.40	7.20	8.00	0.08
40-44	1.40	2.80	4.20	5.60	7.00	8.40	9.80	11.20	12.60	14.00	0.14
45-49	2.00	4.00	6.00	8.00	10.00	12.00	14.00	16.00	18.00	20.00	0.20
50-54	3.60	7.20	10.80	14.40	18.00	21.60	25.20	28.80	32.40	36.00	0.36
55-59	6.00	12.00	18.00	24.00	30.00	36.00	42.00	48.00	54.00	60.00	0.60
60-64	9.60	19.20	28.80	38.40	48.00	57.60	67.20	76.80	86.40	96.00	0.96
65-69	15.10	30.20	45.30	60.40	75.50	90.60	105.70	120.80	135.90	151.00	1.51
70-74	24.10	48.20	72.30	96.40	120.50	144.60	168.70	192.80	216.90	241.00	2.41
75+	42.70	85.40	128.10	170.80	213.50	256.20	298.90	341.60	384.30	427.00	4.27

AD&D	0.40	0.80	1.20	1.60	2.00	2.40	2.80	3.20	3.60	4.00	0.04

Monthly rate per $1,000 of Benefit

The information provided here is only a summary of the plan. Refer to your certificate/policy for complete details and limitations of coverage.

Supplemental Term Life and AD&D Benefits

Dependent Benefits

Eligiblity:	Eligible spouse and children of all active full-time Employees.
Benefit Amount:	Option A: $5,000 Option B: $10,000 Option C: $15,000.
Guarantee Issue:	$15,000. Late entrants subject to EOI requirements.
Benefit Range:	$5,000 minimum to maximum of 50% of Employee's approved voluntary amount.
Age Range:	15 days to 19th birthday, or to age 23 if full-time student.
Termination:	Spouse coverage terminates at the earliest of age 70 or the date the employee retires or terminates.
Suicide Exclusion:	2 years.

Dependent's Non-Contributory and Contributory Life amount may never exceed 100% of the employee's combined Basic & Supplemental Life amount.

OPTION A

Benefit Amount:	Spouse:	$5,000
	Child(ren):	$5,000 for 15 days to 19th birthday, or to age 23 if full-time student. $0 for 0 days through 14 days

Monthly Cost per Unit:	$0.50

OPTION B

Benefit Amount:	Spouse:	$10,000
	Child(ren):	$10,000 for 15 days to 19th birthday, or to age 23 if full-time student. $0 for 0 days through 14 days

Monthly Cost per Unit:	$1.00

OPTION C

Benefit Amount:	Spouse:	$15,000
	Child(ren):	$15,000 for 15 days to 19th birthday, or to age 23 if full-time student. $0 for 0 days through 14 days

Monthly Cost per Unit:	$1.50

SCHEDULE OF BENEFITS

Administrative

1.	**Policyholder:**	Anderson County Government
2.	**Employer:**	Anderson County Government
3.	**Plan Number:**	9300-610
4.	**Original Plan Effective Date:** **Revised Plan Effective Date:**	July 1, 2016 July 1, 2019
5.	**Enrollment Period:**	Not Applicable
6.	**Eligible Class:**	**Class 2** – *All Elected County Commissioners*
7.	**Minimum Hourly Work Requirement:**	None
8.	**Waiting Period for Insurance Coverage:**	1st of the month coinciding with or next following 30 days from the date You become an Elected County Commissioner.
9.	**Employee Premium Contribution:** Employee Basic Life and AD&D	Not Required
10.	**Insurance Reduction Schedule:** Employee Basic Life and AD&D:	to 65% of the scheduled amount at age 65; to 50% of the scheduled amount at age 70 and 25% of the scheduled amount at age 75. Coverage terminates when You are no longer an Elected County Commissioner or in accordance with item A. under Section IV When Coverage Ends.
11.	**Evidence of Insurability Requirements:**	Applies to Late Enrollees and amounts over Guarantee Issue amount.
12.	**Retirement Age:**	Not Applicable

Basic Life Insurance

Employee Basic Life:	$50,000
Guarantee Issue:	$50,000
Maximum Issue:	$50,000

Additional Benefits

1. Conversion of Insurance Benefit:	Included
2. Waiver of Premium Benefit:	Included
3. Living Benefit:	Included

Accidental Death and Dismemberment (AD&D) Insurance

Employee Basic AD&D:	$50,000
Guarantee Issue:	$50,000
Maximum Issue:	$50,000

Additional AD&D Benefits

Seat Belt Benefit:	Included
Air Bag Benefit:	Included

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
Administered by: North American Benefits Company (NABCO) • 20 Valley Stream Parkway, Suite 310, Malvern, PA 19355
Home Office: Madison, WI

GROUP TERM LIFE INSURANCE
CERTIFICATE OF INSURANCE

PLEASE READ THIS CERTIFICATE CAREFULLY.

This Certificate of Insurance (hereinafter referred to as "Certificate") is evidence of insurance provided under the Group Policy issued to the Group Policyholder (hereinafter referred to as "Policyholder"). This Certificate describes the essential features of such insurance.

Madison National Life Insurance Company, Inc., in performing its obligations under the Group Policy, is acting only as a life insurer with respect to the Group Policy and is not in any way acting as a plan administrator, a plan sponsor or a plan trustee for the purposes of the Employee Retirement Income Security Act or 1974 (ERISA), as amended, or any other federal or state laws.

No coverage under the Group Policy is in effect until approved in writing by Us and issued and delivered to the Policyholder. All terms, conditions and other provisions of the Group Policy are governed by the laws of the state in which the Policyholder is located. All provisions on this and the following pages are part of this Certificate. The Group Policy is on file and available for review at the main office of the Policyholder.

The President and Secretary of Madison National Life Insurance Company, Inc. witness this Certificate:

Larry R. Graber
President

Loan Nisser
Secretary

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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SCHEDULE OF BENEFITS

Administrative

1.	**Policyholder:**	Anderson County Government
2.	**Employer:**	Anderson County Government
3.	**Plan Number:**	9300-610
4.	**Original Plan Effective Date:** **Revised Plan Effective Date:**	July 1, 2016 July 1, 2019
5.	**Enrollment Period:**	Not Applicable
6.	**Eligible Class:**	**Class 2** – *All Elected County Commissioners*
7.	**Minimum Hourly Work Requirement:**	None
8.	**Waiting Period for Insurance Coverage:**	1st of the month coinciding with or next following 30 days from the date You become an Elected County Commissioner.
9.	**Employee Premium Contribution:** Employee Basic Life and AD&D	Not Required
10.	**Insurance Reduction Schedule:** Employee Basic Life and AD&D:	to 65% of the scheduled amount at age 65; to 50% of the scheduled amount at age 70 and 25% of the scheduled amount at age 75. Coverage terminates when You are no longer an Elected County Commissioner or in accordance with item A. under Section IV When Coverage Ends.
11.	**Evidence of Insurability Requirements:**	Applies to Late Enrollees and amounts over Guarantee Issue amount.
12.	**Retirement Age:**	Not Applicable

Basic Life Insurance

Employee Basic Life:	$50,000
Guarantee Issue:	$50,000
Maximum Issue:	$50,000

Additional Benefits

1. Conversion of Insurance Benefit:	Included
2. Waiver of Premium Benefit:	Included
3. Living Benefit:	Included

Accidental Death and Dismemberment (AD&D) Insurance

Employee Basic AD&D:	$50,000
Guarantee Issue:	$50,000
Maximum Issue:	$50,000

Additional AD&D Benefits

Seat Belt Benefit:	Included
Air Bag Benefit:	Included

I. DEFINITIONS

Active Work and **Actively at Work** are defined in the "Eligibility for Insurance" section.

Annual Salary: Your current salary or wage from your Employer for the previous twelve months. Annual Salary does not include commissions, bonuses, overtime pay or any other extra compensation.

Contributory means that You pay all or a portion of the premium for insurance.

Disabled or **Disability** means that: as a result of Physical Disease or Injury, you are unable to perform with reasonable continuity a majority of the material duties of any occupation for which you are qualified by education, training and experience, and you are under the Regular Care and Attendance of a Physician.

Eligible Class means an employment classification defined by the Employer and specified in the "Schedule of Benefits." You must be a member of an Eligible Class in order to be eligible for insurance under the Group Policy.

Eligible Dependent is defined in the "Eligibility for Insurance" section.

Eligible Employee is defined in the "Eligibility for Insurance" section.

Employee is defined in the "Eligibility for Insurance" section.

Employer means an Employer (including approved affiliates and subsidiaries) to whom we have assigned a Plan Number and issued a Policy.

Evidence of Insurability

1. Providing Evidence of Insurability means that a person applying for coverage under the Group Policy must:
   a) complete and sign Our Evidence of Insurability application and return the original application to Us. The application must be received by Us no later than 60 days from the date of signing; and
   b) authorize Us to obtain information about the applicant's health; and
   c) undergo a physical examination, if required by Us, which may include diagnostic testing; and
   d) provide any additional information about the applicant's insurability that We may reasonably require.

2. If any applicant is required to provide Evidence of Insurability, the applicant will be responsible for all costs associated with providing Evidence of Insurability.

3. In each case where Evidence of Insurability is required, We base Our decision whether to approve coverage on the information provided during the underwriting process. If We learn that the information relied on to approve coverage was incorrect, or that relevant information was omitted, We may retroactively rescind coverage and deny claims.

Group Policy (Policy) means the group insurance Policy issued by Us to the Policyholder under a specified Plan Number.

Guarantee Issue is the amount of coverage provided which is not subject to Evidence of Insurability.

Hospital means a legally operated Facility providing full-time medical care and treatment under the direction of a full-time staff of licensed Physicians, but not including rest homes, nursing homes, convalescent homes, homes for the aged and facilities primarily affording custodial, educational, or rehabilitative care.

Injury: Bodily Injury due to an Accident which: (1) results directly and independently of disease, bodily infirmity or any other causes; (2) solely, directly and independently of all other causes results in medical expense; (3) occurs after the effective date of the Insured Person's coverage; and (4) occurs while the Insured Person's coverage is in force. All Injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these Injuries, are considered a single Injury.

Insured Person means an Eligible Employee, Eligible Dependent or Eligible Retiree whose coverage is in effect under the Group Policy.

Late Enrollee means an Employee or Dependent who applies for coverage under the Group Policy more than 31 days after becoming an Eligible Employee or Eligible Dependent.

Limiting Age means the Child age(s) shown in the definition of Child in the Eligibility for Insurance section.

Mental Disorder means any mental, emotional, behavioral, psychological, personality, cognitive, mood or stress related abnormality, disorder, disturbance, dysfunction or syndrome listed in the latest edition of the American Psychiatric Association Diagnostic and Statistical Manual or the International Classification of Disease. The term "Mental Disorder", however, does not include any condition diagnosed as Psychosis.

Noncontributory means the Employer pays the entire premium for insurance.

Physical Disease means a Physical Disease entity or process that produces structural or functional changes in the body as diagnosed by a Physician. Physical Disease includes pregnancy and Mental Disorder.

Physician means a licensed medical professional under the laws of a state of the United States of America, acting within the scope of such license, who is permitted by law to prescribe medications and practice independent of supervision.

For the purpose of this Group Policy, Physician will not include the Insured Person's Spouse, parent, brother, sister, or Child, including these members of a Spouse's family.

Plan Effective Date means the date on which the Group Policy, with respect to the Employer, becomes effective.

Plan Number means the number used by Us to reference an Employer and the terms of coverage specified under the Group Policy.

Prior Plan means the Employer's group life insurance plan in effect on the day immediately preceding the Plan Effective Date.

Proof of Loss is defined in the "Claims Provisions" section.

Regular Care and Attendance means observation and treatment by a Physician as required by current standards of medicine for the Injury or Physical Disease causing a Disability, but in any event not less than one such observation per year.

Retire and **Retirement Date** means the earlier of:

1. the date You Retire as such term is defined by Your Employer;
2. the date You receive or become eligible to receive, as defined by the Employer, retirement benefits under any pension plan to which the Employer contributes, or
3. the date You receive or become eligible to receive retirement benefits under, and as defined by, any state or federal retirement plan or under the Social Security Act or Railroad Retirement Act.
4. the date You reach the age defined in the "Schedule of Benefits".

You and Y**our** means the Eligible Employee.

Waiting Period for Insurance Coverage is defined in the "Eligibility for Insurance" and "Schedule of Benefits".

We, Us and **Our** means Madison National Life Insurance Company, Inc.

II. ELIGIBILITY FOR INSURANCE

A. Employee Life Insurance Eligibility.

1. Employee Basic Life Insurance. To be eligible for Employee Basic Life Insurance under the Group Policy You must satisfy the following requirements:

a) You must be an **Eligible Employee**.
(1) Employee means an individual who works for the Employer as a member of an Eligible Class and who is reported on the Employer's records for Social Security and tax withholding purposes. *The term Employee also includes Elected County Commissioners*.

b) You must be a citizen or legal resident of the United States or Canada, and you must reside in the United States or Canada;

c) You must be Actively at Work and capable of sustained Active Work.

(1) **Active Work** and **Actively at Work** mean working at Your Employer's usual place of business, and satisfying the Minimum Hourly Work Requirement. Actively at Work will include regularly scheduled days off, holidays, or vacation days, so long as You are capable of sustained Active Work on those days.

(2) **Minimum Hourly Work Requirement** means the work hours over a specified time period that are required of You by Your Employer in order to be eligible for coverage. Your Minimum Hourly Work Requirement is specified in the "Schedule of Benefits".

(3) The Active Work requirement is waived during the time You are approved for benefits under the "Waiver of Premium Benefit" section.

d) You must have satisfied Your Waiting Period for Insurance Coverage.

(1) **Waiting Period** means the period of time that You must be Actively at Work as an Employee for Your coverage to become effective. Your Waiting Period is specified in the "Schedule of Benefits".

e) You cannot be a member of more than one Eligible Class.

f) You cannot be a part-time Eligible Employee, temporary or seasonal Eligible Employee, full-time member of the armed forces of any country, leased Eligible Employee, or independent contractor.

III. BECOMING INSURED

A. To become an Insured Person under the Group Policy, an applicant must meet the following requirements as each may apply:

1. If Evidence of Insurability is required, the applicant must provide such Evidence of Insurability and be approved for coverage by Us. The "Schedule of Benefits" specifies when Evidence of Insurability is required.

2. If the insurance is Contributory insurance, the applicant must apply in writing and remit the required premiums.

B. Effective Dates
1. Employee's Initial Enrollment

a) Noncontributory insurance not subject to Evidence of Insurability or which is subject to Evidence of Insurability and has been approved by Us, becomes effective on the date You become an Eligible Employee, or as specified by your Employer. However, if You initially waive participation in such coverage and then later wish to participate, applications for Noncontributory insurance will be subject to Evidence of Insurability and will become effective as shown below.

b) Contributory insurance subject to Evidence of Insurability, and Late Enrollee applications for coverage, become effective on the first day of the month immediately following the month in which the Evidence of Insurability is approved by Us, except that if such approval occurs on the first day of a month, such coverage becomes effective on that day.

c) Contributory insurance not subject to Evidence of Insurability, if You apply prior to, or within 31 calendar days commencing on, the date You become an Eligible Employee, Contributory insurance not subject to Evidence of Insurability becomes effective on the date You become an Eligible Employee. If You do not apply for Contributory insurance prior to, or within 31 days of becoming an Eligible Employee and subsequently wish to obtain such coverage, Evidence of Insurability will be required and Your coverage will become effective as provided in subsection b above.

2. Increases in Insurance
   a) Evidence of Insurability Required. An increase of insurance that is subject to Evidence of Insurability becomes effective on the first day of the month immediately following the month in which the Evidence of Insurability is approved by Us, except that if such approval occurs on the first day of a month, such coverage becomes effective on that day.

   b) Evidence of Insurability Not Required. An increase of insurance that is not subject to Evidence of Insurability becomes effective as follows:
      (1) Based on change in Your classification, age or earnings on the date of such change;

3. Decreases in Insurance
   a) A decrease in life insurance based on a change in Your classification, earnings, age or Your Dependent's age, becomes effective on the date of the change.

   b) Any other decrease in insurance becomes effective on the date of change.

4. Delayed Effective Date. If You are incapable of sustained Active Work due to Injury or Physical Disease on the day before the scheduled effective date of Your insurance or the effective date of a change in Your insurance, such insurance will not become effective until the day after You are capable of sustained Active Work and complete one day of Active Work as an Eligible Employee.

5. If Your coverage ends, You may become covered again, subject to the following:

   a) If Your coverage ends because You fail to make the required contribution while on an approved Family Medical Leave of absence, and then You return to Active Work and enroll for coverage within 31 days of the earlier of a) the end of the period of leave You and Your Employer agreed upon, or b) the end of the 12-week period following the date Your leave began, then the Waiting Period will be waived. Coverage is limited to what You had in effect prior to coverage ending or the coverage that is now available for Your Class, as determined by Us.

   b) In all other cases, if Your coverage ends because You fail to make the required contribution, You must provide Evidence of Insurability to become covered again.

   c) In no event will insurance coverage be retroactive.

IV. WHEN COVERAGE ENDS

A. Except as otherwise provided for under this Certificate, coverage will cease on the earliest of the following to occur:
   1. the date the Group Policy terminates;
   2. the date You cease to be an Eligible Employee;
   3. if premium is not paid when required, the last day of the period for which premium was paid;
   4. Your Retirement Date;
   5. for AD&D coverage, the earlier of the date Your corresponding life insurance ends, the date you are no longer Actively at Work, the date Your Waiver of Premium Benefit begins or Your Retirement Date.

B. Approved FMLA Leave of Absence – Contributory or Noncontributory Coverage
   1. With regard to the Federal Family and Medical Leave Act (FMLA) of 1993, as amended, the Employer and Employee must be eligible for FMLA in order to receive it. If You are on an approved FMLA leave, coverage will continue until the later of the leave period required by FMLA or the leave period required by applicable state law, provided that :
      a) We receive written notice in advance of a leave approved by the Employer which includes the beginning and ending dates of the leave; and
      b) FMLA leaves of absence and the right to continue coverage during FMLA leaves are available to all Employees in the same Eligible Class under the Group Policy; and
      c) the Employer remits the required premium for coverage.

C. Termination or Amendment of the Group Policy
   1. The Group Policy may be terminated, changed or amended in whole or in part by Us or the Policyholder according to the terms of the Group Policy. Any such change or amendment may apply to current or eligible persons covered under the Group Policy or to any separate classes or categories thereof.
   2. We may change the Group Policy in whole or in part: (i) when any change or clarification in law or governmental regulation affects Our obligations under the Group Policy, or (ii) with the Policyholder's consent.
   3. We may terminate an Employer's coverage on any premium due date by giving the Employer not less than 60 days advance notice. An Employer may terminate coverage under the Group Policy in whole, and may terminate insurance for any class or group of eligible persons, at any time by giving Us advanced written notice at least 60 days prior to such termination. Insurance will terminate automatically for nonpayment of premium.
   4. Benefits are limited to the terms of the Group Policy, including any valid amendments. No change or amendment of the Group Policy will be valid unless it is approved in writing by one of Our executive officers and delivered to the Policyholder. The Policyholder and their Eligible Employees or representatives have no right or authority to change or amend the Group Policy or to waive any terms or provisions thereof without Our signed, written approval.

V. LIFE INSURANCE - WAIVER OF PREMIUM BENEFIT

A. Waiver of Premium Definitions
   (1) **Elimination Period** means the period of 9 months beginning on the date You become Disabled.
   (2) **Life Insurance** under this Waiver of Premium Benefit means all of the Life Insurance, as listed in the Schedule of Benefits, in force under the Group Policy on the day before the day You become Disabled.
   (3) **Proof of Disability** means documented clinical findings that prove that You are Disabled.

B. Waiver of Premium does not apply to AD&D Insurance.

C. Your Life Insurance will be continued as provided for under this section without payment of premium, if all of the following conditions are met:
   (1) You become Disabled prior to age 60 while insured under the Group Policy;
   (2) You remain Disabled without interruption for the duration of the Elimination Period;
   (3) You provide Us with written notice of Your Disability within 30 days after the end of Your Elimination Period;
   (4) You provide Us with satisfactory written Proof of Disability within 3 months from the last day of the Elimination Period;
   (5) Your claim is approved by Us.

D. When the Waiver of Premium Benefit Begins. If You qualify and are approved for the Waiver of Premium Benefit, Your premium will be waived beginning on the first day of the month immediately following the end of Your Elimination Period.

E. When Waiver of Premium Ends. Waiver of Premium ends on the earliest to occur of the following:
   1. The date You cease to be Disabled;
   2. The 91st day following the date We mail to You a request for additional Proof of Disability with which You fail to comply;
   3. The date You refuse to submit to a medical examination or to cooperate with Our chosen health care provider;
   4. The date You refuse to submit to or undergo vocational rehabilitation (which determines employment opportunities, if any, for individuals with disabilities);
   5. The date at which You've resided outside of the United States of America, or one of its territories during any 6 consecutive months for which premium had been waived;
   6. The effective date of an individual life insurance policy issued to You under the "Life Insurance Conversion Benefit" section.
   7. The premium due date immediately prior to Your 65th birthday;
   8. The date You Retire, unless such Retirement is due to a Disability.

F. Premiums
   1. Premium payment must continue until the later of the end of Your Elimination Period or the date Your claim for the Waiver of Premium Benefit is approved by Us.
   2. If Your Waiver of Premium benefit terminates because You cease to be Disabled or You fail to submit to a medical exam or cooperate with the examiner, for coverage to continue, You must be an Eligible Employee and premiums must resume on the next premium due date, or You must continue coverage as provided for under the "Life Insurance Conversion Benefit" section.
   3. If We approve Your claim for the Waiver of Premium Benefit, We will refund up to 12 months of the premiums that were paid for Life Insurance in place after the date You became Disabled.

G. Amount of Insurance
   1. The amount of Life Insurance continued under the Waiver of Premium Benefit is the amount in effect on the day before You became Disabled, if you were Actively at Work.
   2. Insurance will be reduced or terminated according to the Group Policy provisions in effect on the day before You became Disabled.
   3. Your Life Insurance amount will not increase while Your Life Insurance premiums are being waived.

H. We will not waive premiums if Your Disability results from intentionally self-inflicted Injuries or Physical Diseases, while sane or insane, or from Your voluntary participation in an illegal activity.

I. If You die during the Elimination Period and are otherwise eligible for the Waiver of Premium Benefit, the Elimination Period will not apply.

J. We may require further Proof of Disability in intervals that are reasonable based on Your type of Disability.

K. Investigation Of Claim
With respect to benefits that are claimed during an Insured Person's lifetime, We may require him or her to undergo examination at reasonable intervals, at Our expense. Any such examinations will be conducted by appropriate Physician of Our choice. We may deny or suspend benefits if You fail to attend an examination, or do not give full effort and cooperation to the examiner.

GTL-C900-0608

VI. LIFE INSURANCE - LIVING BENEFIT

Terminally Ill and **Terminal Illness** mean a medical condition that is expected to result in Your death within 6 months.

A. If You become Terminally Ill while covered for life insurance under the Group Policy You may elect to receive the Living Benefit as provided for under this section.

B. The Living Benefit will be an amount equal to 50% of Your Employee Basic Life Insurance in effect on the date Your election is made, subject to a minimum of $5,000 and a maximum of $100,000. The amount payable will be equal to the Living Benefit less applicable amounts, if any, charged for an investment loss (interest) and administrative fees.

C. The payment will be made in one lump sum to You or to the payee You appropriately assign.

D. The Living Benefit will not be available if:
1. You have any portion of any Life Insurance or ownership rights thereof absolutely or irrevocably assigned or transferred;
2. You have made an irrevocable beneficiary designation;
3. the insurance proceeds are subject to a court order under a divorce decree, separate maintenance agreement or property settlement agreement;
4. You have filed for bankruptcy, unless You give Us written approval from the bankruptcy court for payment of the Living Benefit; and
5. Your Terminal Illness resulted from an intentionally self-inflicted Injury or suicide attempt within the first two years after Your effective date of coverage or an insurance increase.

E. No payment will be made under this election unless and until We receive and approve of all of the following:
1. Your signed and notarized election of this option on a form furnished by Us;
2. signed and witnessed written statements of all irrevocable beneficiaries and assignees (and Spouse in marital property states) consenting to Your election of this option; and
3. satisfactory written proof from a Physician other than Yourself or a member of Your or Your Spouse's immediate family that You have been diagnosed as being Terminally Ill and that You are of sound mind and under no constraint or undue influence.

F. We may require a second opinion and examination of Your condition at Our own expense by a Physician of Our choice.

G. Payment of the Living Benefit will reduce correspondingly the face amount of Your life insurance benefits under the Group Policy. This will result in reduced life insurance proceeds payable to Your beneficiary at Your death. Furthermore, any amount of insurance that would otherwise be continued under the "Waiver of Premium Benefit" section will be reduced proportionately, as will the maximum face amount available under the "Life Insurance Conversion Benefit" section.

H. Premium payments must continue to be paid for Your life insurance unless You qualify to have Your life insurance premium waived. The premium due will be based on the amount of insurance remaining in force after deducting the amount of the Living Benefit.

I. Payment of the Living Benefit will not affect the amount of, or change an existing beneficiary designation for, the AD&D Benefit, if any, in effect and kept in force under the Group Policy.

J. Your election together with Our payment of the Living Benefit constitute a valid and effective beneficiary designation change, but only with respect to the specified life insurance benefits, and only to the extent affected by the Living Benefit payment, and applicable interest and fees, if any, charged thereon.

K. Payment of the Living Benefit will be exempt from the claims of creditors and from legal process to the extent permitted by law.

L. All other provisions of the Group Policy, including the effective date provisions of any benefit increases and the provisions on benefit reductions because of amendments to the plan or benefit classification changes or Your attained age, remain valid and in effect. Any such life insurance benefit reduction will be calculated based on Your life insurance amount in effect immediately before the Living Benefit payment.

M. You are responsible for any tax consequences related to this benefit.

GTL-C1000-0608

VIII. LIFE INSURANCE CONVERSION BENEFIT

A. When Coverage Ends.
   1. If an Insured Person's coverage under the Policy ends, the Insured Person may, as described below, apply for Our individual life insurance policy without submitting Evidence of Insurability.
      a) The Insured Person must complete an application, pay the first premium, and send them to Us within the 31-day period immediately following the date coverage ends under the Policy (the Conversion Period). If Your Employer does not notify You in writing of Your conversion right at least 15 days prior to the end of Your Conversion Period, Your Conversion Period will extend an additional 15 days from the date You receive the notice. This extension will allow you to purchase conversion coverage, but your coverage will not extend beyond the 31 day period herein unless conversion coverage is elected and premium is paid. In no event will the conversion period extend beyond 60 days after the date Your coverage ended. Written notice by Your Employer is required to be mailed to Your last known address.
      b) The individual policy will become effective on the first day following the date coverage under the Policy ends.
      c) The Insured Person may convert all or part of the amount of life insurance benefit, as shown in the "Schedule of Benefits".
   2. If an Insured Person has been insured under the Policy for at least five years and is no longer eligible due to cancellation of the Policy or cancellation of the class of insureds in which the Employee belonged, an Insured Person may convert the lesser of: (1) $2,000 or (2) all or part of the amount for which the Insured Person is no longer eligible for under the Policy.

B. Premiums.
   1. Premiums for such individual life policy will be based on: (1) Our usual rate for the amount and type of individual policy; (2) the Insured Person's class of risk; and (3) the Insured Person's attained age.
   2. If an Insured Person dies during the Conversion Period, the maximum amount of life insurance to which he or she would have been entitled to under such individual policy shall be payable as a claim under the Group Policy, whether or not application for the individual policy or the payment of the first premium has been made.
   3. The rights or benefits granted under this provision are in lieu of any other rights or benefits granted under the Group Policy.

GTL-C1300-0608-TN

X. ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

A. If an Insured Person has an Accident while insured for Accidental Death and Dismemberment (AD&D) Insurance and the Accident results in a Loss (as defined below), We will pay benefits according to the terms of the Group Policy after We receive Proof of Loss.

B. Eligibility. An Insured Person must be a member of a class that is eligible for AD&D coverage under the Group Policy as specified in the "Schedule of Benefits".

C. Definitions for AD&D Insurance
   1. **Loss** means Loss of one or more of the body parts or bodily functions listed under "AD&D Benefit" below, or as otherwise provided for under this "Accidental Death and Dismemberment Insurance" section, which:
      a) is caused solely and directly by an Accident;
      b) occurs independently of all other causes;
      c) occurs within 90 days after the Accident; and
      d) while the Insured Person is covered under the Group Policy.
   2. **Accident:** A sudden, unexpected and unforeseen, identifiable event causing bodily Injury, directly produced by specific accidental contact with another body or object. The Accident must occur while You are covered under the Group Policy.
   3. With respect to a hand or foot, Loss means actual and permanent severance from the body at or above the wrist or ankle joint.
   4. With respect to sight, speech or hearing, Loss means entire and irrecoverable Loss of that function.

D. **AD&D Benefit.** The AD&D Benefit is equal to a percentage of the AD&D Insurance Amount in effect on the date of the Accident, subject to the AD&D Reduction Schedule provision set forth in the "Schedule of Benefits". The AD&D Insurance Amount is shown in the "Schedule of Benefits". The percentage is shown below.

Covered Losses:	Maximum Amount Payable
Loss of Life	100%
Loss of both Hands or both Feet	100%
Loss of one Hand or one Foot	50%
Loss of one Hand and one Foot	100%
Loss of Entire Sight of both Eyes	100%
Loss of Entire Sight in one Eye	50%
Loss of one Hand or one Foot and Entire Sight of one Eye	100%
Loss of Speech and of Hearing in both Ears	100%
Loss of Speech or Hearing in both Ears	50%
Loss of Thumb and Index Finger of the same Hand	25%
Loss of hearing in one ear	25%

E. Unless otherwise specified, no more than 100% of the applicable AD&D Insurance Amount will be paid for all Losses resulting from one Accident. If an age reduction applies, the benefit reduces on the date You attain that age.

F. Additional AD&D Benefits

   1. Seat Belt Benefit.
      Seat Belt means a properly installed Seat Belt, lap and shoulder restraint, or other restraint, approved by the National Highway Traffic Safety Administration.
      Automobile means a motor vehicle licensed for use on public highways

      a) We will pay a Seat Belt Benefit if:

(1) an Insured Person who is covered by the Seat Belt Benefit dies as a result of an Automobile Accident for which an AD&D Benefit is payable; and
(2) such Insured Person was wearing a Seat Belt at the time of the Accident, as evidenced by a police accident report.

b) We will not pay a Seat Belt Benefit with respect to an Insured Person if the Automobile Accident:
(1) occurs when the Automobile driven by such Insured Person is being used for racing, stunting or exhibition work;
(2) occurs when such Insured Person is in violation of any traffic laws of the jurisdiction in which the Automobile is being operated; or
(3) occurs while such Insured Person is driving legally intoxicated as defined by the laws of the jurisdiction in which the vehicle was being operated.

c) Amount of Benefit. The Seat Belt Benefit is paid in addition to the AD&D Benefit paid because of the Insured Person's accidental death and equals $10,000.

2. Air Bag Benefit
Air Bag means an Automobile safety device consisting of a bag designed to inflate automatically especially in front of an occupant in case of collision.

a) We will pay an Air Bag Benefit for an Insured Person if:
(1) the private passenger car was equipped with an airbag for the seat in which the Insured Person was seated; and
(2) the seatbelt(s) was in use and properly fastened at the time of the covered Accident.

b) We will not pay an Air Bag Benefit with respect to an Insured Person if:
(1) the Automobile Accident occurs when the Automobile driven by such Insured Person is being used for racing, stunting or exhibition work;
(2) the Automobile Accident occurs when such Insured Person is in violation of any traffic laws of the jurisdiction in which the Automobile is being operated; or
(3) the Automobile Accident occurs while such Insured Person is driving legally intoxicated as defined by the laws of the jurisdiction in which the vehicle was being operated.
(4) the Insured Person was the driver of the private passenger car and did not hold a valid driver's license at the time of the Accident;
(5) We determine that the airbag(s) had been disengaged prior to the Accident;

c) Amount of Benefit. The Air Bag Benefit is paid in addition to the AD&D Benefit paid because of the Insured Person's accidental death and equals $5,000.

G. AD&D Insurance Exclusions. No AD&D Benefit is payable if the Loss is caused or contributed to by any of the following:

1. War or Act of War. War means death as a direct result of service in the military, naval or air forces, in time of war, including any ambulance, medical, hospital or civilian noncombatant unit serving actively with such military, naval or air forces;

2. Suicide, attempted suicide or other intentionally self-inflicted Injury, while sane or insane, within the first 2 years of coverage;

3. Committing or attempting to commit a felony or assault, or actively participating in a violent disorder or riot. Actively participating does not include being at the scene of a violent disorder or riot while performing Your official duties;

4. Any Injury sustained while under the voluntary use or consumption of any poison, illegal drugs, or controlled substance, unless used or consumed according to the directions of a Physician;

5. Physical Disease existing at the time of the Accident;

6. Medical negligence and malpractice;

7. Bacterial infections (except due to accidental food poisoning or caused by an accidental wound);]

8. Any Loss incurred while engaging in any aerial flight, except as a fare-paying passenger on a regularly scheduled flight of a duly licensed airline on an established air route.

XI. CLAIMS PROVISIONS

A. Filing A Claim

1. To file a claim for benefits under this Certificate, the claimant (depending on the benefit the claimant could be an Insured Person, a beneficiary or personal representative of an Insured Person) must provide Us with Proof of Loss in a timely manner. Or, upon receipt of written notice of claim, We will send the claimant a Claim Form for filing Proof of Loss. If the claimant does not receive such forms within 15 days after the giving of such notice, the claimant can send us, without the Claim Form, the written proof covering the occurrence.

2. Proof of Loss.
   a) Proof of Loss must be provided in writing to Us, at the claimant's expense, within 90 days after the date of the loss if reasonably possible. If that is not reasonably possible, Proof of Loss must be provided no later than one year after expiration of that 90-day period, or the claim will be denied. The time limits under this section shall not apply while the claimant lacks legal capacity.

   b) **Proof of Loss** means satisfactory written proof that a loss occurred for which the Group Policy provides benefits, which is not subject to any exclusion, and which meets all other conditions for benefits. Proof of Loss includes any other information We may reasonably require in support of a claim for benefits under the Group Policy.

B. Notice of Decision on Claim
1. We will evaluate a claim for benefits promptly after We receive it. Within 30 days after We receive the claim We will send the claimant:
   a) a written decision on the claim; or
   b) a notice that We are extending the period to decide the claim for an additional 45 days.

2. If the claim is approved, We will pay benefits within 30 days after the Proof of Loss requirement is satisfied.

3. If We extend the period to decide the claim, We will notify the claimant of the following:
   a) the reasons for the extension;
   b) when We expect to decide the claim; and
   c) any additional information We require to decide the claim.

4. If We request additional information, the claimant will have 45 days to provide the information. If the claimant does not provide the requested information within 45 days, We may decide the claim based on the information We have received.

5. If We deny any part of the claim, We will send the claimant a written notice of denial containing:
   a) the reasons for Our decision;
   b) reference to the parts of the Group Policy on which Our decision is based;

c) a description of any additional information required to support the claim;
d) information concerning the claimant's right to a review of Our decision.

C. Payment of Claims.

Upon receipt of proper Proof of Loss, benefits will be paid within 30 days. If any claims payment interest accrues, interest will be paid in the amount determined by the State in which the claims are incurred.

Death Claims: If an Insured Person dies while insured for life insurance under the Group Policy, We will pay benefits according to the "Schedule of Benefits", after We receive Proof of Loss, as follows.

1. The death benefit will be paid in a single sum or by any other method agreeable to Us and the beneficiary. Payment of the benefit will extinguish Our liability under the Group Policy for which the death benefit has been paid.

2. No Surviving Beneficiary. If You do not name a beneficiary, or if You are not survived by any named beneficiary, benefits will be paid to Your estate.

3. Dependent Benefits. Dependent Life Insurance benefits that are payable, but unpaid at the Insured Person's death, will be paid in equal shares to the first surviving class of the following, if the Eligible Employee is dead:
   a) The children of the Dependent.
   b) The parents of the Dependent.
   c) The Insured Person's estate.

   The following Dependent benefits, payable under the Group Policy, will be paid to the Eligible Employee if he or she is living:
   a) Life Insurance benefits;
   c) Supplemental Life Insurance benefits payable because of the death of Your insured Spouse or Child;

4. Facility of Payment. If the benefits provided by the Group Policy are payable to the Insured Person's estate or to a beneficiary who is a minor or otherwise not legally competent to give a valid release, We may pay up to $500 to any person related to the Insured Person by blood or marriage. Any payment made in good faith will fully release Us to the limit of the payment. If a beneficiary is a minor, or is not able to give a valid release for any payment of benefits made, We will pay the life proceeds to the legally appointed guardian. The guardian must provide Us with adequate written proof of such appointment. This provision does not prevent Us from making payment to or for the benefit of a minor beneficiary in accordance with the applicable state law. Payment made before We have received written notice at Our home office of a valid claim by some other person releases Us from further obligation.

D. Review Procedure.

1. If all or part of a claim is denied, the claimant may request a review. The claimant must request a review in writing within 60 days after receiving notice of the denial.

2. The claimant may send Us written comments or other items to support the claim. The claimant may review and receive copies of any non-privileged information that is relevant to the request for review. There will be no charge for such copies. Our review will include any written comments or other items the claimant submits to support the claim.

3. We will review the claim promptly after We receive the request. Within 60 days after We receive the request for review We will send the claimant:
   a) a written decision on review; or
   b) a notice that We are extending the review period for 60 days. If the extension is due to the claimant's failure to provide information necessary to decide the claim on review, the extended time period for review of the claim will not begin until the claimant provides the information or otherwise responds.

4. If We extend the review period, We will notify the claimant of the following:
   a) the reasons for the extension;
   b) when We expect to decide the claim on review; and
   c) any additional information We require to decide the claim.

5. If We request additional information, the claimant will have 45 days to provide the information. If the claimant does not provide the requested information within 45 days, We may conclude Our review of the claim based on the information We have received.

6. If We deny any part of the claim on review, the claimant will receive a written notice of denial containing:
   a) the reasons for Our decision.
   b) references to the provisions of the Group Policy on which Our decision is based.
   c) information concerning the claimant's right to receive, free of charge, copies of non-privileged documents and records relevant to the claim.

7. The Group Policy does not provide voluntary alternative dispute resolution options.

GTL-C2200-0608

XII. GENERAL PROVISIONS

A. Naming a Beneficiary.

1. At the time You became insured under the Group Policy, You should have named a beneficiary of the proceeds of Your life insurance on the enrollment form.

2. You may have named primary beneficiaries and secondary beneficiaries. A secondary beneficiary will become a primary beneficiary if the named primary beneficiary is not living at the time of Your death. Two or more surviving primary beneficiaries will share equally, unless You specify otherwise.

3. AD&D Insurance death benefits will be distributed according to the beneficiary designation of Your corresponding life insurance.

4. You may change Your beneficiary designation at any time, subject to the following:
   a) The designation must be made in writing on a form suitable to Us;
   b) The designation must be dated and signed by You (and by your Spouse where required by law);
   c) The designation must relate and refer to the insurance provided under the Group Policy;
   d) If applicable, We must have the written consent of all irrevocable beneficiaries;
   e) You must not have assigned the ownership of Your insurance.

5. When a valid change of beneficiary is received by Us, the change will relate back to and take effect as of the date it was signed. This is the case whether You are alive or not when We receive the request. Even though the change of beneficiary will relate back to the date it was signed, it will be without prejudice to Us on account of any payment We have already made.

6. If We approve it, a written designation signed and dated by You under the Prior Plan will be accepted as Your beneficiary designation under the Group Policy.

B. Simultaneous Death Provision.

If a beneficiary dies on the same day You die, or within 120 hours from Your time of death, benefits will be paid as if that beneficiary had died before You, unless Proof of Loss with respect to Your death is delivered to Us before the date of the beneficiary's death.

C. Entire Contract, Changes

1. This Certificate, which is part of the Group Policy, including the Enrollment Form, Group Policy and any Riders, Amendment or attached papers, if any, constitutes the entire contract of Insurance. No change in this Certificate shall be valid until approved by an executive officer of Our company and unless such approval is endorsed hereon or attached hereto. No agent has authority to change this Certificate or waive any of its provisions.

2. Except for those functions which the Group Policy specifically reserves to the Policyholder or Employer, We have authority to control, manage, and interpret the Group Policy, to administer claims and to resolve all questions arising in the administration, interpretation and application of the Group Policy.

3. Our authority includes, but is not limited to the following:
   a) the right to resolve all matters when a review has been requested;
   b) the right to establish and enforce rules and procedures for the administration of the Group Policy and any claim under it;
   c) the right to determine eligibility for insurance, entitlement to benefits, the amount of benefits payable and the sufficiency and the amount of information We may reasonably require to make determinations.

D. Incontestability of Insurance

1. Any statement made to obtain or to increase insurance is a representation and not a warranty.

2. No misrepresentation will be used as a basis for reducing or denying a claim or contesting the validity of insurance unless:
   a) the insurance would not have been approved if We had known the truth; and
   b) We have given You or any other person claiming benefits a copy of the signed written instrument which contains the misrepresentation.

3. After insurance has been in effect for 2 years, during the lifetime of the Insured Person, We will not use a misrepresentation as a basis for reducing or denying a claim, unless it was a fraudulent misrepresentation.

E. Incontestability of the Group Policy or Employer Coverage under the Group Policy

1. No misrepresentation by the Policyholder will be used as a basis for denying a claim, or for denying the validity of the Group Policy unless:
   a) the Group Policy would not have been issued if We had known the truth; and
   b) We have given the Policyholder or Employer a copy of a written instrument signed by the Policyholder or Employer which contains the misrepresentation.

2. The validity of the Group Policy will not be contested after it has been in force for 2 years, except for nonpayment of premium or fraudulent misrepresentations.

F. Clerical Error

1. Clerical error by Us, the Policyholder, Your Employer, or their respective Eligible Employees or representatives will not:
   a) cause a person to become insured under the Group Policy or a provision of it.
   b) invalidate insurance otherwise validly in force.
   c) continue insurance otherwise validly terminated.
   d) cause an Employer to obtain coverage under the Group Policy or a provision of it.

2. In the event that a clerical error results in an incorrect rate, We reserve the right to adjust the rate accordingly.

3. The payment of premium, by itself, will not obligate Us to provide benefits to anyone who is not eligible

for coverage under the Group Policy.

4. Your Employer acts on its own behalf as Your agent, and not as Our agent. Your Employer has no authority to alter, expand or extend Our liability or to waive, modify or compromise any defense or right We may have under the Group Policy.

G. Misstatement

1. Age or Gender

If the age or gender, or both, of a person has been misstated, We will make an equitable adjustment of premiums, benefits or both. The adjustment will be based on:

a) the amount of insurance based on the correct age and gender; and
b) the difference between the premiums paid and the premiums which would have been paid if the age and gender had been correctly stated.

H. Legal Actions

A legal action may not be brought to recover on this Certificate within 60 days after written Proof of Loss has been given as required. No such action may be brought after 5 years from the time written proof was required to be given.

I. Assignment

An Insured may not assign any of his or her rights, privileges or benefits under the Group Policy, unless approved by Us.

J. Conformity With State Laws

If any provision of this Certificate is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of such law.

GTL-C2300-0608-TN

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE TENNESSEE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of Tennessee who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Tennessee Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted on the next page, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The state law that provides for this safety-net coverage is called the Tennessee Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverages, exclusions and limits. **This summary does not cover all provisions of the law or describe all of the conditions and limitations relating to coverage. This summary does not in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.**

COVERAGE

Generally, individuals will be protected by the life and health Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by an insurer authorized to conduct business in Tennessee. Health insurance includes disability and long term care policies. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Guaranty Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insured who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk. such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contractholder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated-annuity contract (which give rights to group contractholders, not individuals)

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Guaranty Association is obligated to payout. The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. For anyone insured life, the Guaranty Association guarantees payments up to a stated maximum no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. These aggregate limits per life are as follows:

- $300,000 for policies and contracts of all types, except as described in the next point
- $500,000 for basic hospital, medical and surgical insurance and major medical insurance issued by companies that become insolvent after January 1, 2010

Within these overall limits, the Guaranty Association cannot guarantee payment of benefit greater than the following:

- life insurance death benefits - $300,000
- life insurance cash surrender value - $100,000
- present value of annuity benefits for companies insolvent before July 1, 2009 - $100,000
- present value of annuity benefits for companies insolvent after June 30, 2009 - $250,000
- health insurance benefits for companies declared insolvent before January 1, 2010 - $100,000
- health insurance benefits for companies declared insolvent on or after January 1, 2010:
  - $100,000 for limited benefits and supplemental health coverages
  - $300,000 for disability and long term care insurance
  - $500,000 for basic hospital, medical and surgical insurance or major medical insurance

The Tennessee Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Tennessee. You should not rely on coverage by the Tennessee Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

TENNESSEE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION
150 Third Avenue South, Suite 1600
Nashville, Tennessee 37201

TENNESSEE DEPARTMENT OF COMMERCE AND INSURANCE
500 James Robertson Parkway
Nashville, Tennessee 37243

$50,000 Face Amount
Basic Life Rates $ 0.09
Basic AD&D Rates $ 0.02 per $1,000
Basic Spouse/Child is $1.00 per unit $5,000

Group Name: Anderson County Government
Group Number: 129714
Effective Date: 07/01/2019

VisionBlue

Benefit	In-Network Member Cost	Out-of-Network Reimbursement	
VISION EXAMINATION			
Comprehensive Eye Examination	$20 Copayment	Up to $35	One exam within a 12 month period for each member covered under the plan.
Retinal Imaging	Up to $39	N/A	
Contact Lenses Fit and Follow-Up			
Standard	$55 Copayment	Up to $0	
Premium	10% off retail	Up to $0	
VISION MATERIALS			
Standard Plastic Lenses			One set of lenses within a 12 month period for each member covered under the plan.
Single Vision	$20 Copayment	Up to $30	
Bifocal	$20 Copayment	Up to $45	
Trifocal	$20 Copayment	Up to $60	
Frames	$0 Copayment up to $150 allowance, 20% off balance over allowance	Up to $75	One pair of frames within a 24 month period for each member covered under the plan.
Contacts			One set of lenses within a 12 month period for each member covered under the plan (In lieu of lenses + frames).
Conventional	$0 copay up to $150 allowance, 15% off balance over allowance	Out-of-network up to $120	
Disposable	$0 copay up to $150 allowance	Out-of-network up to $120	
Medically Necessary	Paid in Full	Up to $200	
Lens Options			One set of lenses within a 12 month period for each member covered under the plan.
Standard Polycarbonate	$40 Copayment	Up to $0	
Standard Polycarbonate *(For covered dependent children under 19 years of age)*	$0 Copayment	Up to $5	
UV Treatment	$15 Copayment	Up to $0	
Tint	$15 Copayment	Up to $0	
Standard Plastic Scratch Coating	$15 Copayment	Up to $0	
Standard Progressive Lenses (add on to Bifocal)	$65 Additional Copayment	$0 Additional *	
Premium Progressive Lenses (add on to Bifocal)	$65 Additional Copayment, 20% off retail price less $120 allowance	$0 Additional *	
Standard Anti-Reflective Coating	$45 Copayment	Up to $0	
Other Lens Options	20% off retail	N/A	

* $45 maximum reimbursement

Diabetic Eye Care *(Care and testing for diabetic members)*			Up to 2 services per year for each listed service.**
Exam	$0	Up to $77	
Retinal Imaging	$0	Up to $50	
Extended Ophthalmoscopy	$0	Up to $15	
Gonioscopy	$0	Up to $15	
Scanning Laser	$0	Up to $33	

**Some or all of the diagnostic services described above will be provided as deemed appropriate, subject to provider determination of service necessity and the benefit frequency limitations referenced above.

- This document serves as a summary of the benefits that are detailed in the Evidence of Coverage. These benefits are subject to the Covered Services and Limitations on Covered Services, Exclusions from Covered Services, and Schedule of Benefits sections of the Evidence of Coverage.
- When applicable benefits are paid after the Copayment listed above and to the allowance listed, members are responsible for amounts above the allowance.
- Members may see any vision care provider. However, contracted providers in our network have agreed to limit certain charges and provide additional discounts once the allowance has been reached. Because we have no contract with non-network providers, members are responsible for all charges that exceed the out-of-network reimbursement.

Nondiscrimination Notice

BlueCross BlueShield of Tennessee (BlueCross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BlueCross does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

BlueCross:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: (1) qualified interpreters and (2) written information in other formats, such as large print, audio and accessible electronic formats.
- Provides free language services to people whose primary language is not English, such as: (1) qualified interpreters and (2) written information in other languages.

If you need these services, contact a consumer advisor at the number on the back of your Member ID card (for TTY help, call 1-800-848-0298 or 711).

If you believe that BlueCross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance ("Nondiscrimination Grievance"). For help with preparing and submitting your Nondiscrimination Grievance, contact a consumer advisor at the number on the back of your Member ID card or call 1-800-565-9140 (TTY: 1-800-848-0298 or 711). They can provide you with the appropriate form to use in submitting a Nondiscrimination Grievance. You can file a Nondiscrimination Grievance in person or by mail, fax or email. Address your Nondiscrimination Grievance to: Nondiscrimination Compliance Coordinator; c/o Manager, Operations, Member Benefits Administration; 1 Cameron Hill Circle, Suite 0019, Chattanooga, TN 37402-0019; (423) 591-9208 (fax); Nondiscrimination_OfficeGM@bcbst.com (email).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1–800–368–1019, 800–537–7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

BCBST Logo

BlueCross BlueShield of Tennessee

VisionBlue Renewal Option

Issued For Michael W. Williams

Effective 07/01/2019

Name: Anderson County Government **Group ID:** 129714 - 1

VisionBlue

Base Vision

Employer Contribution	Participatory
Exam Copay	$20
Materials Copay	$20
Frames Frequency	24
Frames Allowance	$150

Three-Tier Coverage	Individual	2-Person	Family
Base Vision	$5.43	$10.86	$17.37

Services	In-Network	Out-Of-Network Allowance
Exam with Dilation as Necessary	$20 Copay	$35
Retinal Imaging	Up to $39	N/A
Exam Options		
Standard Contact Lens Fit and Follow-Up	$55 Copay	N/A
Premium Contact Lens Fit and Follow-Up	10% Off Retail	N/A
Frames	$0 Copay; $150 Allowance 20% Off Balance Over Allowance	$75.00
Standard Plastic Lenses		
Single Vision	$20 Copay	$30
Bifocal	$20 Copay	$45
Trifocal	$20 Copay	$60
Standard Progressive (Add onto Bifocal)	$65 Additional Copay	$0 Additional *
Premium Progressive (Add onto Bifocal)	$65 Additional Copay 20% Off Retail Price Less $120	$0 Additional *
Lens Options		
UV Coating	$15 Copay	N/A
Tint (Solid and Gradient)	$15 Copay	N/A
Standard Scratch Resistance	$15 Copay	N/A
Standard Polycarbonate (Adult)	$40 Copay	N/A
Standard Polycarbonate (Under Age 19)	$0 Copay	$5
Standard Anti-Reflective Coating	$45 Copay	N/A
Polarized Lenses and Other Lens Options	20% Off Retail	N/A
Contact Lenses		
Conventional	$0 Copay; $150 Allowance, 15% Off Balance Over Allowance	$120
Disposable	$0 Copay; $150 Allowance	$120
Medically Necessary	Paid-in-Full	$200
Frequency		
Examination	Once Every 12 Months	
Frame	Once Every 24 Months	
Lenses or Contact Lenses	Once Every 12 Months	

* $45 maximum reimbursement

Diabetic Eye Care (Care and testing for diabetic members)	Up to 2 services per year for each listed service**	
Exam	$0	Up to $77
Retinal Imaging	$0	Up to $50
Extended Ophthalmoscopy	$0	Up to $15
Gonioscopy	$0	Up to $15
Scanning Laser	$0	Up to $33

**Some or all of the diagnostic services described above will be provided as deemed appropriate, subject to provider determination of service necessity and the benefit frequency limitations referenced above.

Commission Disclosure: The rates presented in this proposal include commissions, and may include additional compensation. If you have questions, please contact your broker or BCBST representative.

COBRA Admin: Combined w/ other BCBST Product
Quote #: 134 Created on: 4/11/2019 by UVJ4XA000038 Status: Approved Rep: Wayne Webb
Total Group Size: Large

of Tennessee

Vision Benefits Contract Documents

of Tennessee
1 Cameron Hill Circle
Chattanooga, TN 37402
bcbst.com

June 06, 2019

Anderson County Government
Human Resources Dept
100 N Main Street Suite 102
Clinton, TN 37716

Dear Group Administrator:

Thank you for choosing BlueCross BlueShield of Tennessee for your organization's health benefit coverage. The attached flier contains step-by-step directions about how to view your Group Agreement that is now available at bcbst.com; please take time to review it carefully.

This document states the terms and conditions of the group insurance to be provided for your employees, and also includes the mutual rights and obligations for BlueCross BlueShield of Tennessee and your company.

As you review the Group Agreement and other documents including the EOC, please notify your BlueCross BlueShield of Tennessee sales or account executive within 15 days of receiving this letter if you have any changes or corrections. The Group Agreement goes into effect on the date listed on your Employer Group Application and/or its attachments.

Your employees can view their EOC at bcbst.com when they log in to BlueAccess. If your group is subject to ERISA, all employer notification requirements still exist.

If you have any questions about this document or any of its terms, please contact your broker, sales or account executive.

We appreciate your business.

Sincerely,

Membership Administration

Enclosures

cc: Wayne Webb, Account Executive

cc: Cole M Harris
CBIZ Benefits & Insurance
9648 Kingston Pike Suite 8
Knoxville, TN 37922

GROUP AGREEMENT

This GROUP AGREEMENT ("Agreement"), is entered into by and between BlueCross BlueShield of Tennessee, Inc. ("Plan") and Anderson County Government ("Group").

A. APPLICATION

The attached Employer Group Application ("EGA") is part of this Agreement and is incorporated by reference. It serves as the signature page of this Agreement. The terms of the EGA (e.g., the Group's eligibility requirements) will control any conflict between the terms of that EGA and this Agreement.

B. DEFINITIONS

Defined terms are capitalized in this Agreement. Those terms are defined in the Evidence of Coverage ("EOC"). The attached EOC is part of this Agreement and is incorporated by reference.

"Subscriber" means the individual to whom the Plan has issued the attached EOC. "Member" means a Subscriber or a Covered Dependent.

The Group's plan year begins on the effective date of this Agreement. The Group's plan year for any renewal of this Agreement (including any early renewal) begins on the renewal date.

C. COVERED SERVICES

The Plan provides Coverage to Members. The Coverage is subject to the terms and conditions of this Agreement and the EOC. The Group grants the Plan full discretionary authority to make Coverage decisions. These decisions are pursuant to this Agreement and include: (1) eligibility; (2) benefit; and/or (3) claim determinations. These decisions will be subject to the review standards applicable to ERISA plans, even if the Group is not otherwise subject to ERISA.

D. ENROLLMENT AND TERMINATION OF COVERAGE

1. Enrollment

The Group is responsible for determining the eligibility for and termination of Coverage for individuals in accordance with the EOC and EGA and applicable law, including but not limited to the Patient Protection and Affordable Care Act ("PPACA"). The EOC and EGA will determine the eligibility of Subscribers and their Dependents. The Plan relies on the Group to provide accurate information regarding hours worked or scheduled to work exclusively for the Group. The Group understands that the Patient Protection and Affordable Care Act ("PPACA") imposed limitations on eligibility terms and conditions. The Group agrees to abide by those terms and conditions and will notify the Plan immediately if a change to eligibility terms and conditions results in a violation of PPACA.

If the Group offers Coverage from the Plan and other group health benefit plans for like benefits, ("Other Health Plans") to eligible Persons and their eligible Dependents, the Group shall permit them to enroll in either plan. The Group will make equitable contributions to each plan. The Group will not promote one plan over another. The Group will not directly or indirectly encourage, discourage or otherwise attempt to influence eligible Persons or Dependents to enroll in the Plan's Coverage based upon: (1) health status; or (2) anticipated utilization of Covered Services.

a. The Group shall allow and eligible Persons can apply for Coverage for themselves and their eligible Dependents during: (1) the initial enrollment period; (2) an annual Open Enrollment Period; or (3) upon a Qualifying Event. The Parties may agree to an additional Open Enrollment Period.

b. The eligible Persons must complete and submit an Enrollment Form to the group administrator for transmittal to the Plan, or enroll through the Plan's secure website. The Group will submit Enrollment Forms to the Plan or complete electronic enrollment within 31 days after: (1) receiving that form from the eligible Persons; or (2) the end of the Open Enrollment Period during which that eligible Person applied for Coverage.

c. When the Group provides enrollment data and that data does not match the Plan's data, the Plan's data will be used to determine the premium. The Plan will work with the Group to resolve the discrepancy. If no agreement can be reached, the Plan's records will control. Until the dispute is resolved, the Group must pay the premium indicated, based on the Plan's records.

d. The Group's enrollment data shall not contain ineligible Persons and/or Dependents.

e. The Group may provide the Plan with enrollment data that includes individuals' telephone numbers or other contact information. The Group warrants that the Group obtained such information directly from the individuals and that the individuals are aware the Plan may contact them via this information for non-telemarketing and telemarketing calls and text messages.

f. The Group shall assign the effective dates of Coverage for eligible individuals and include such dates in the enrollment data it provides to the Plan. The Group is responsible for ensuring that the effective dates it assigns comply with the EOC and EGA and applicable law, including but not limited to PPACA's limitations on waiting periods.

2. Electronic Enrollment Program

If the Group transmits data electronically (Electronically Transmitted Data, or ETD) to the Plan for enrollment or termination of Members, the Group must abide by section D.1. of this Agreement and follow the Plan's guidelines.

a. Plan's Duties and Responsibilities:

(1) The Plan will work with the Group to initiate and complete acceptance of the ETD process.

(2) The Plan will assist the Group in correcting errors, as identified through the editing process administered by the Plan. The Plan may need to contact the Group to resolve such issues.

(3) After the initial transmission testing is successfully completed, for ongoing updates, valid ETD will be electronically uploaded into the Plan's system (FACETS) by the Plan within 3 calendar days of receipt of a valid file transmission.

(4) Exception errors will be worked by the Plan within 7 calendar days of upload of file transmission.

(5) The Plan reserves the right to terminate the ETD process with a Group when the Group's ETD does not meet a 99% validity/accuracy level, as determined by the Plan.

(6) The Plan will accept data and process enrollment, status change and termination requests as the Group directs in accordance with the eligibility guidelines outlined in the EGA.

b. Group's Duties and Responsibilities:

(1) The Group will specify which persons have authority to transmit data to the Plan on behalf of the Group.

(2) The Group must transmit data through Plan-approved medium. The parties shall agree on the medium the Group will use before the program starts.

(3) The Group will submit its ETD data in one of the following formats:

a. The Plan's standard format (supplied to the Group).

b. Custom format, subject to prior approval by the Plan.

c. HIPAA 834 layout with Plan specifications

d. On-line transactions through the Plan's secured website.

(4) The Group's ETD will contain the following information:

a. The appropriate Creditable Coverage data for each Member.

b. Medicare Secondary Payor enrollment information.

c. COB data is not required but should be supplied to avoid undue liability.

(5) The Group is responsible for issuing appropriate HIPAA Pre-Existing Waiting Period notices to Members when data is transmitted electronically, other than through the Plan's secured website.

(6) The Group is responsible for assuring all ETD are 99% accurate/valid.

(7) The Group shall indemnify the Plan to the extent permitted by applicable law in the state of Tennessee, including the Tennessee Governmental Tort Liability Act for damages or injuries to the Plan caused by the Plan's reliance on ETD from the Group.

3. Electronic Enrollment Through Secured Website

If the Group elects to submit enrollment and termination data through the Plan's secured website, the Group must abide by section D.1. of this Agreement and follow the Plan's guidelines:

a. Plan's Duties and Responsibilities

(1) The Plan will provide a PIN for website access.

(2) The Plan will accept data and process enrollment, status change and termination requests as the Group directs in accordance with the eligibility guidelines outlined in the EGA.

b. Group's Duties and Responsibilities

(1) The Group will submit data only on eligible Subscribers and/or eligible Dependents as outlined in the EGA.

(2) Group will assure that the data submitted is accurate.

(3) Group will assume responsibility for notifying the Plan when the group administrator or enrollment contact changes, so that the Plan can revoke that individual's website access. The Plan will revoke access within 5 business days of being notified. If the Group does not inform the Plan of any such change, the Group is responsible for any actions of a former group administrator or enrollment contact.

4. Notification of Termination of Coverage

The Group is responsible for determining if and when a Member's Coverage may or should be terminated in accordance with the EOC and EGA and applicable law. The Group will notify the Plan of the termination of a Member's Coverage not more than 15 days after the Member is no longer eligible for Coverage.

E. PREMIUMS

1. Amount

The initial Premium Amounts payable for Coverage under this Agreement are set out in the EGA. To begin Coverage, the Group must pay the Total Estimated Premium Amount to the Plan. The Total Estimated Premium Amount is an estimate of that amount of money necessary to fund the required Premiums to cover the total number of Members whom the Group estimates will enroll in the Plan's Coverage. Payment of the Total Estimated Premium Amount and execution of the EGA is acceptance of this Agreement. The Coverage will not begin until the Plan receives the Total Estimated Premium Amount.

The Aggregate Premium is the Premium required to fund Coverage for all Members. Aggregate Premiums are shown on all Premium Statements. Premium amounts are determined in a manner permissible under applicable laws.

When legally permissible, the Plan may change the Premium amounts upon 30 days written notice to the Group at renewal if one of the following occur: (1) the Group's claim experience has materially changed; or (2) the demographics of the Members Covered by the Plan have materially changed, including their age, sex, industry, geographic area, family composition, or number of Members. The Plan may also change the Premiums upon 30 days written notice due to any changes having a direct and material impact upon the cost of providing Coverage to Members. This includes: fluctuations in the number of Members; changes in applicable laws or regulations including, but not limited to, an increase in the premium tax or mandated benefits applicable to such coverage. If the Group requests any changes to the Covered Services provided by the Plan, the Plan may change the Premium amounts on the effective date of any changes. In the event of termination or addition of a subsidiary, operation or class of Subscribers Covered by the Plan, the Plan may change the Premium amounts on the effective date of such termination or addition.

The Group may reject any revised Premium by terminating this Agreement as of the date that the revised Premiums would become effective. To do so, the Group must provide written notice of termination not less than 30 days prior to the date that revised Premium would first become payable pursuant to this Agreement.

2. Premium Statement

The Plan will prepare and submit a monthly Premium statement ("Statement") to the Group, listing: (1) Subscribers shown on its records; (2) type of Coverage selected by each Subscriber (e.g., individual, family, etc.); and (3) the Aggregate Premium payable to the Plan for providing access to benefits for all Members for the next billing period. The Plan will prepare this statement not less than 15 days prior to the end of each billing period this Agreement remains in effect.

The Group must pay the Aggregate Premium for anyone Covered or added during the billing period.

3. Subscribers Listed on Premium Statement and Terminations

a. A Subscriber and his or her Covered Dependents will not have Coverage if the Subscriber is not listed on the statement. Any such Subscriber and his or her Covered Dependents may still have coverage if:

(1) The Plan receives the Enrollment Form from the Group within 31 days after the earlier of:

a. the date the Enrollment Form was executed; or

b. the end of the Open Enrollment Period during which the Subscriber is eligible to enroll in Coverage

and

a. the Group promptly submits the Enrollment Form; and

b. pays the applicable Premium to the Plan from the date that error occurred upon discovery of that error and a request for such payment from the Plan.

b. The Group may terminate a Subscriber's Coverage by submitting a termination request to the Plan. It is the Group's obligation to verify that any retroactive termination requests are compliant with PPACA. The Group will not request retroactive termination of a Member's Coverage for any time period during which the applicable premium was paid.

The Plan will retroactively terminate a Member's Coverage to the extent allowed by law, if:

(1) the Group notifies the Plan of a Member's termination from Coverage within 90 days after the Member's termination. The Plan will refund any remitted Premium.

(2) the Group does not notify the Plan of a Member's termination from Coverage within 90 days after the date of Member's termination. The Plan will only retroactively terminate the Member's Coverage for 90 days from the date of notice to the Plan. The Plan will not refund more than 3 months of Premium payments to the Group if it fails to notify the Plan of the termination of the Member's Coverage in a timely manner.

If after notification, the Plan fails to terminate that Member's Coverage; then, upon the Group's discovery of the Plan's failure to delete the Member, the Plan will:

(1) terminate the Member's Coverage retroactively; and

(2) credit the Group for Premiums paid during such time period when Coverage was retroactively terminated.

4. Determining Premium

On the fifteenth (15th) day of each billing period, the Plan will determine the number of Subscribers Covered under the Group's Coverage, and this will be the basis for the Premium charged by the Plan for the following billing period.

a. Additions

(1) If a Subscriber or Dependent becomes Covered under the Group's Coverage after the fifteenth (15th) day of any billing period, and the Premium would be affected by this change, there will not be a partial Premium charge for that billing period. The Group will pay Premium for that Subscriber for the first full billing period for Coverage.

(2) If a Subscriber or Dependent becomes Covered on or before the fifteenth (15th) day of any billing period, and the Premium would be affected by this change, the Group will pay a full month's Premium for that billing period.

b. Subscriber Terminations

(1) If a Subscriber's or a Dependent's Coverage terminates before the fifteenth (15th) day of any billing period, and the Premium would be affected by this change, the Plan will credit the Group for the Premium for that Subscriber for that entire billing period. That credit will appear on the Group's next Premium Statement generated after the Plan processes the termination.

(2) If a Subscriber's or a Dependent's Coverage terminates on or after the fifteenth (15th) day of any billing period, and the Premium would be affected by this change, the Group will pay full Premium for that billing period.

c. Qualifying Event

If a Member has been added or terminated as a result of a Qualifying Event, the addition or termination will be handled according to the statutory requirement for the Qualifying Event. Premiums will be determined in accordance with the provision outlined in Section E.4.a. and E.4.b above.

5. Payment of Premium

The Aggregate Premium is due in full at the Plan's office on or before the first day of each billing period.

After payment of the Total Estimated Premium Amount, subsequent payments have a grace period of 30 days following the Premium due date (the "Grace Period"). The Aggregate Premium may be paid to the Plan during that Grace Period without causing a lapse of the Group's Coverage. If the Aggregate Premium is paid after the Grace Period, the Plan's acceptance or depositing of such funds shall not be construed to mean or equate to a guarantee

of or acquiescence to reinstate Coverage, continue Coverage, or waive termination of Coverage by the Plan.

If the Group pays by check, the Group must remit the Aggregate Premium on or before the first day of each billing period.

If the Group pays electronically, the Group will transfer the amount specified in the statement into an account or the Plan's designated account so that such funds will be available through the ACH (Automated Clearing House) by the first day of each billing period.

There will be a charge of $40 for any checks for payment of premiums that are returned to the Plan for insufficient funds, closed accounts, or any other reason.

6. Failure to Pay Premiums

If the Aggregate Premium is not paid by the end of the Grace Period, the Plan, in its sole discretion, may: (1) notify the Group of such non-payment and termination date of Coverage and terminate the Coverage back to the last Premium due date; or (2) work with the Group to arrange payment of the Aggregate Premium, for a period of up to 90 days. If the Group fails to pay the Premium, the Plan will be entitled to recover Plan Expenses. Plan Expenses include: (1) the total outstanding Aggregate Premium; (2) the finance charge set forth below; and (3) a fee for any checks for payment of Premiums that are returned to BlueCross BlueShield of Tennessee, Inc. for insufficient funds, closed accounts, or any other reason; and (4) any expenses reasonably incurred in recovering the amount owed to the Plan including attorney's fees.

If the Plan terminates the Coverage back to the last Premium due date, the Plan may recoup benefit payments from Providers.

The Group is still obligated to reimburse the Plan for any charges which the Plan has to pay, as required by: (1) state or federal law; or (2) provider agreement, plus a reasonable administrative fee.

7. Termination for Non-Payment of Premium

If the payment received does not pay the Aggregate Premium, plus any other due charges in full, the Plan has the discretionary authority to terminate the Group's Coverage, or place an administrative hold on the Group. A payment of less than the full amount due will be deemed non-payment.

8. Reinstatement

If this Agreement is terminated and the Group requests reinstatement, the Group must remit: (1) the total outstanding Aggregate Premium; (2) the applicable finance charge or fee; and (3) the Aggregate Premium for the current billing period. The Group must do so within fifteen (15) calendar days following the termination date. The Group may be reinstated by the Plan as though this Agreement had remained continuously in effect. The Plan reserves the right to decline to reinstate this Agreement, however, upon refunding the Aggregate Premium for the current billing period to the Group.

If the Plan agrees to reinstatement, the Group also agrees to make all future payment of Premiums via electronic ACH Debit (automated bank draft) transaction. The Group understands that should any future draft of Premiums be rejected by the Group's financial institution, for any reason, the Group plan will immediately be terminated back to the last date for which payment in full had been posted in the Plan's records.

9. Finance Charge

The Plan may impose a finance charge of one and one-half percent (1 1/2 %) per month. This applies to the amount of any Aggregate Premiums not remitted to the Plan on or before the first day of any billing period after the expiration of the Grace Period. This applies through the duration of this Agreement.

F. TERM

The initial term of this Agreement is set forth in the EGA. The Agreement will automatically renew for an additional 12 month period unless terminated by the Group upon not less than 30 days advance written notice prior to the end of the Initial Renewal Date or any subsequent renewal date. The Plan shall give the Group not less than 30 days written notice of any: (1) change in the Premium for providing Coverage to Members; (2) material changes in the Covered Services; or (3) other material changes in the provisions of this Agreement; that will become effective on a renewal date. Payment of the applicable Aggregate Premium on or after that date shall constitute acceptance of those changes by the Group, individually and on behalf of all Members**.**

G. TERMINATION OF AGREEMENT

1. For Cause

a. If the Plan does not receive payment of any Aggregate Premium, when due, the Plan may terminate this Agreement in accordance with section D of this Agreement.

b. Either party may terminate this Agreement, with or without prior notice, effective as of midnight prior to the date that the other party: (a) ceases doing business as a going concern; (b) makes an assignment for the benefit of creditors; (c) admits in writing that it is unable to pay debts as they come due; or (d) consents to the appointment of a trustee or receiver; or if a trustee or receiver is appointed pursuant to applicable Federal or State bankruptcy, insolvency, or similar laws.

c. The Plan may terminate this Agreement, upon not less than 30 days prior written notice, if the Group fails to comply with a material Plan provision relating to the Group's contribution or group participation rules.

d. Upon written notice, the Plan may terminate or rescind the Group's Coverage under this Agreement for fraud or misrepresentation by the Group of a material fact concerning the Group or a Member.

e. Upon written notice, the Plan may terminate a Subscriber's or Member's Coverage under this Agreement for fraud or misrepresentation by the Group or the Member of a material fact concerning the Subscriber or Member. Termination of a Subscriber's Coverage automatically terminates Coverage for all of his or her Dependents.

2. For No Cause

The Group may terminate this Agreement upon providing 30 days notice in advance of the requested termination date. The Plan, at its option may agree to allow the Group to retroactively terminate the Agreement. Should the Plan agree to a retroactive termination date, the Group is still obligated to reimburse the Plan for any charges which the Plan has to pay, as required by: (1) state or federal law; or (2) provider agreement. The Group may be required to pay a reasonable administrative fee of 1 ½% of the Group's total annual Premium.

The Plan may terminate the Agreement if it is ceasing to offer this Coverage in the small or large group markets and provides notice to the Group consistent with state law.

3. Because of Inability to Perform Obligations

This Agreement may be immediately suspended or terminated by written notice to the other party if either party is unable to perform its obligations by reason of: (1) complete or partial destruction of facilities; (2) a material reduction in the number of Participating Providers; (3) lockout; (4) strike; (5) riot; (6) war; (7) act of God; or (8) by any ordinance, law, order or decree of any governmental authority. Neither party will be required to perform its duties nor be liable for any damages arising from the suspension or termination of this Agreement pursuant to this paragraph. The Plan shall refund any unearned Aggregate Premium to the Group for the period following the date of such suspension or termination of this Agreement.

The Plan, at its option may agree to allow the Group to retroactively terminate the Agreement. Should the Plan agree to a retroactive termination date, the Group is still obligated to reimburse the Plan for any charges which the Plan has to pay, as required by: (1) state or federal law; or (2) provider agreement, plus a reasonable administrative fee.

4. Effect Upon Incurred Obligations

The termination of this Agreement shall not relieve either party from any obligations incurred prior to the date of termination. The termination will not constitute an election of remedies by the terminating party. Any remedies available upon the termination of this Agreement will be cumulative.

If the Plan terminates the Coverage back to the last date through which the Group's Premium has been paid, the Plan may recoup benefit payments from Providers.

The Group is still obligated to reimburse the Plan for any charges which the Plan has to pay, as required by: (1) state or federal law; or (2) provider agreement, plus a reasonable administrative fee.

5. Post Termination Premium Balances

Within 120 days from the date the Plan is notified of the Group's Coverage termination, the Plan will conduct a final accounting. The final accounting will take into account all payments, funds transfers, etc, necessary to fulfill both parties' obligations under this Agreement.

If any outstanding payments, funds transfers, etc. due to the Plan or the Group total less than $100 when the Group's Coverage terminates: (1) the amount shall be forgiven; and (2) the parties agree that any financial obligation to the other party shall end.

6. Post Termination Reports

Upon termination of this Agreement, the Group must pay the reasonable charges for the cost of producing any report in advance of receiving the requested report. Among other things, this applies to post-termination audits, requests from replacement insurers or administrators, and requests from the Group itself.

H. CONTINUATION OF COVERAGE AND CONVERSION

1. Continuation Coverage

If a Member's Coverage terminates as the result of an event which permits that Member to elect to continue his or her Coverage in accordance with applicable Federal or State laws (a "Qualifying Event"), ("Continuation Coverage"), that Member will be entitled to remain Covered under this Agreement. The Member must comply with the requirements of the laws and pay the applicable Premium for the Coverage. Federal and state laws determine how long the Group is required to continue to provide Coverage to that Member. The EOC describes the terms and conditions of such Continuation Coverage in greater detail.

The Group will notify Members of their right to obtain Continuation Coverage following a Qualifying Event. The Group will collect and remit the Premium for the Coverage to the Plan. If Members do not enroll and pay the Premium for Continuation Coverage, on or before the date their Continuation Coverage would become effective, the Plan will terminate their Coverage. They may be reinstated if they subsequently enroll and pay the applicable Premiums within the enrollment period for Continuation Coverage specified by law. If the Group fails to notify a Member of his or her right to enroll for Continuation Coverage in accordance with applicable laws, the Plan will not extend the enrollment period beyond that required by law had the Group informed the Member of that right in a timely manner. The Plan may consent, in writing, to extend the enrollment period for Continuation Coverage for that Member.

2. Conversion Coverage

If Members are eligible to purchase individual conversion coverage from the Plan upon the termination of his or her Coverage under this Agreement, the Plan will offer those individuals the right to purchase the conversion coverage as outlined in the EOC.

I. RELATIONSHIPS WITH OTHER PARTIES

1. Between Network Providers and the Plan

The Plan may enter into agreements with health care providers, insurers, and any other individuals or entities, as it deems necessary to fulfill its obligations under this Agreement. Such parties are independent contractors. Network Providers are independent contractors who are solely responsible for any services rendered to their Member patients. The Plan makes no express or implied warranties or representations concerning the continued participation of any Network Provider. The Group acknowledges for itself and on behalf of Members that the Plan has established various arrangements to encourage Network Providers to render Covered Services in an appropriate and cost effective manner. Such arrangements include provider penalties.

Additionally, the Plan's contracts with Network Providers may include a variety of payment methodologies. These payment methods may obligate the Plan to pay an amount that is in addition to the underlying cost of the service rendered. These additional costs may include, but are not limited to, program fees, incentive payments, bonus payments, or quality payouts.

2. Between the Group and the Plan

The relationship between the Plan and the Group is a contractual relationship between independent contractors. Neither party is a partner, joint venturer, agent or employee of the other when performing its obligations pursuant to this Agreement.

Nothing in this Agreement shall be construed to make the Plan a sponsor, administrator or fiduciary of the Group's benefit plan pursuant to ERISA. The Plan is not and shall not be deemed to be a fiduciary of the Group's plan, except as necessary to exercise the discretionary authority granted to it by the Group in making authorization, eligibility and coverage determinations and construe the terms of Members' Coverage pursuant to this Agreement.

3. Between the Plan and the BlueCross BlueShield Association

The Group acknowledges for itself and on behalf of its Group Members that the Plan is an independent corporation operating under a license from the BlueCross BlueShield Association ("Association"). That license permits the Plan to utilize the Association's service marks within its service area. The Plan is not entering into this Agreement as a joint venturer, agent or representative of the Association nor any other independent licensee of the Association, including the Plan's affiliates ("Licensees"). Under no circumstances shall such Licensees have any rights or obligations to the Group, Members or third parties pursuant to this Agreement.

4. Between the Plan and Vendors or Other Third Parties

Some of the Plan's agreements with vendors or other third parties ("Vendors") that provide Covered Services to Members may allow for rebates, discounts, allowances, incentives, adjustments, settlements, or the like ("Vendor Rebates"). Vendor Rebates are for the sole benefit of the Plan. Accordingly, the Plan will retain all Vendor Rebates. When Vendors provide Covered Services to Members, all Claims submitted to the Plan for those services will have Member cost-sharing, when applicable, calculated according to the Vendors' charges for such services without regard to any Vendor Rebates, to the extent allowed by law.

J. INDEMNIFICATION

The Plan shall hold Group harmless against any vicarious liability actions, claims, lawsuits, settlements, judgments, and costs, including, but not limited to, attorneys' fees and court costs, arising directly from the gross negligence or wanton and reckless acts or failure to act by Plan, unless the cause of such liability was the result of the acts or failure to act of Group or resulted from direction given by Group,

including, but not limited to, Group's submission of a request for a retro-termination of Coverage that does not comply with PPACA. The Group shall indemnify, defend, and hold harmless, Plan, its directors, officers, employees, and agents against any and all liability, actions, claims, lawsuits, settlements, judgments, costs, interest, penalties, fines, expenses, and taxes, including, but not limited to, legal expenses, resulting from or arising out of, or in connection with, any actions, decisions, directions to the Plan, non-compliance with law, or failures to act by Group, including, but not limited to, any breach of this Agreement.

If the Group is a governmental entity, its liability is limited by the terms of and to the extent permitted by applicable law in the state of Tennessee, including the Tennessee Governmental Tort Liability Act. This provision shall survive the termination of this Agreement.

K. GROUP ADMINISTRATION ASSIGNMENT TO BROKER OR OTHER THIRD PARTY AND HOLD HARMLESS ARRANGEMENT

If the Group has assigned some or all of those functions, as indicated below, to a third party and if the Group has appointed such third party to act on its behalf for those functions, the Group understands and agrees that the third party is the contractor and/or agent of the Group and not the Plan. This Group is responsible and shall hold the Plan harmless as a result of any actions resulting from such delegation and appointment. The Group affirms that it has properly executed a Business Associate Agreement (as defined in 45 CFR Part 160) with such third party.

1. Third Party To Provide Enrollment Information

If the Group has contracted with a third party to provide enrollment information to the Plan on the Group's Members, the third party shall submit such enrollment information to the Plan in either paper or electronic form. The third party must submit the enrollment information using the Plan's approved forms or electronic guidelines. In the event the Group and the third party submit duplicate or conflicting information, the Plan will rely on the latest information provided.

If the third party submits such enrollment information to the Plan in electronic format (including but not limited to on-line enrollment via the web or other electronic media), then the Plan may provide a password for use by the third party in accessing the electronic system to provide enrollment information. If granted, this password is for the exclusive use of the third party and will expire, at the latest, when the Group's relationship with the third party expires. A separate and distinct password will be supplied to the Group. All access and activity to the electronic system will be monitored by the Plan. Such access may be limited or confined to certain information according to the agreement between the Group and the third party. The Plan reserves the right to block access to information contained in the electronic system.

The Group authorizes the Plan to accept such enrollment information. The Group shall be responsible for the validity and accuracy of the information provided to the Plan and shall indemnify and hold the Plan harmless from any and all liability, loss, damages, claims and expenses, including attorney's fees, as a result of the actions or inactions of the third party, including without limitation, any incorrect information provided.

2. Third Party To Receive Premium Statement and/or Make Premium Remittance

If the Group has contracted with a third party to receive the Premium Statement and/or make premium remittances to the Plan, the Group understands that this does not relieve the Group from remittance of the amount due by the due date. The Group will be held responsible for the premium remittance. The Group will be responsible for any late fees or finance charges imposed for late payment. Any payment delinquency notices or coverage termination notices for non-payment of premium will be sent to the third party for notice and delivery to Group Members.

The Group authorizes the Plan to send such Premium Statements to and receive and accept such premium remittances from the third party. The Group shall be responsible for the validity and accuracy of the information provided to the Plan and shall indemnify and hold the Plan

harmless from any and all liability, loss, damages, claims and expenses, including attorney's fees, as a result of the actions or inactions of the third party, including without limitation, any incorrect information provided.

If the Group assigns other functions to the third party, this Agreement shall control the performance of those functions.

The Plan is not a party to the agreement between the Group and the third party. The Plan may refuse to accept information from the third party.

The Plan shall make reasonable accommodation to assist the Group in the administration of its assigned duties and responsibilities.

With regard to Electronic Protected Health Information (as defined in 45 CFR Parts 160 and 162 ("Security Standards")), the Group shall:

(i) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Group creates, receives, maintains or transmits as required by the Security Standards;

(ii) ensure that any agent, including third party or any subcontractor to whom the Group provides such information agrees to implement reasonable and appropriate safeguards to protect it;

(iii) report to the Plan any Security Incident (as defined in the Security Standards) involving the Group's data of which the Group becomes aware within seven (7) days of the Security Incident.

This section will take effect on the effective date of the third party arrangement and will end on the earlier of:

- The date the Group's Plan terminates.
- The date the Group notifies the Plan in writing 31 days of the termination of such agreement that it has terminated the relationship with the third party.
- The information provided is consistently unusable by the Plan in the administration of the Group's Plan.
- The information provided is not in the format required by the Plan.
- The inability of the third party to perform obligation(s) of the agreement between it and the Group.

Any password provided to the third party will be blocked when this arrangement terminates. Any notice required to be sent to either the Plan or the Group may be sent to the address of that party as shown in this Agreement or its attachments.

L. DISPUTE RESOLUTION

The Group may agree that any dispute related to this Agreement must be submitted to non-binding arbitration. Unless the parties otherwise agree, such arbitration shall be conducted in accordance with applicable rules of the American Arbitration Association ("AAA") and the Tennessee Uniform Arbitration Act.

The arbitrator shall be required to issue a reasoned opinion explaining the basis of the decision and the manner of calculating any award. Once the parties agree to accept the arbitrator's decision, it

may be entered and enforced in any state or federal court. Once it has been agreed to by the parties, that decision may only be vacated, modified or corrected for the reasons set forth in section 10 or 11 of the Tennessee Uniform Arbitration Act, if the award contains material errors of law or is arbitrary and capricious.

Upon completion of arbitration, the parties may pursue other available legal remedies.

M. Plan's Right to Audit

The Plan has the right to randomly audit for participation and eligibility requirements. This audit will take place no more than twice a year.

The Plan has the right to randomly audit if misrepresentation or fraud is suspected.

The Group shall have the right to review the Plan's audit for participation and eligibility requirements to verify We have conducted the audit according to the Plan's guidelines.

N. Group's Right to Audit

During the term of this Agreement, the Group may perform a simple audit of the Plan once during the calendar year while this Agreement is in force. The Group has the right to audit the Plan's claims payment, eligibility, enrollment and termination services. Any such audit may be conducted up to two years after the affected plan year.

1. If the Group uses the services of a third party to perform all or any part of an audit, the Group and that third party must both execute the Plan's current audit agreement.

2. The Group's right to audit the Plan without any additional charge terminates with the termination of this Agreement.

3. The parties agree that the Group shall not hire a third party to conduct a contingent fee audit, where the third party's compensation is based on a percentage of errors (or savings, or "uncovered recoveries", etc.) which may be found by the third party in its audit. Should the Group err and so contract with a third party to perform such contingent fee audit, the Plan has no obligation under the terms of this Agreement to cooperate with said third party in the conduct of such contingent fee audit.

The Plan shall have the right to review the Group's audit for claims payment, eligibility enrollment and termination services.

O. MISCELLANEOUS

1. Information Request from Plan

Group shall promptly provide Plan with any and all information requested by Plan for the purposes of Plan's compliance with any state or federal law or regulation, including, but not limited to Group's Premium Contribution Rate and amount. **GROUP MUST IMMEDIATELY NOTIFY PLAN OF ANY AND ALL CHANGES IN GROUP'S PREMIUM CONTRIBUTION RATE AND CONFIRM THE CONTRIBUTION RATE AT RENEWAL. Plan may survey or request information from the Group.**

2. Entire Agreement

This Agreement, including the EGA, the EOC, any Riders, and any Amendments, Attachments or Exhibits, constitute the entire agreement between the parties. It supersedes all prior oral or written understanding or agreements between the parties.

3. Effective Date of This Agreement

This Agreement will be effective as of the date indicated after the Plan accepts the EGA and accepts the Total Estimated Premium Amount. The Group's execution of the EGA and payment of the Total Estimated Premium Amount will be its acceptance of this Agreement. Upon execution by the Plan, the EGA will be the signature page of this Agreement.

4. Renewals

The parties may agree to extend the term of this Agreement. The Group will indicate its acceptance of any change in terms of the Agreement by the payment of the next due Aggregate Premium. Unless implemented by amendment pursuant to subsection 6, below, all mandated benefit changes shall be implemented upon renewal of this Agreement.

5. Amendments

This Agreement may be amended, in writing, by an authorized representative of both parties. The Plan may also amend the Agreement, upon notice to the Group, as necessary to comply with: (1) applicable laws; (2) regulations; or (3) lawful orders of governmental agencies. Only an officer of the Plan has the authority to: (1) modify this Agreement; (2) waive any of its provisions; or (3) extend the time for taking any action required by this Agreement.

6. Claim Adjudication

The Plan adjudicates claims in accordance with its internal administrative guidelines. Any rebates or refunds on Member's Covered Services are credited against the Group's experience for rating purposes.

7. Clerical Errors

Clerical errors will not change the rights or obligations of either party under this Agreement. They also will not grant additional benefits to Members. The parties shall cooperate, in good faith, to promptly correct such errors.

8. Waiver

The terms or conditions of this Agreement may only be waived by express written consent of the party from whom such a waiver is requested. Any waiver of a breach of any provision shall not constitute a waiver of any subsequent breach of the same or any other provision of this Agreement.

9. Assignability

No rights or duties under this Agreement are assignable by the Group to any other party unless the Plan consents to such assignment in writing.

10. Notices

Any notice required or permitted under this Agreement shall be in writing. Such notice will be deemed to have been given on the date when: (1) delivered to the other party's most recent address in person; (2) mailed to the other party's most recent address by certified or overnight mail, return receipt requested; or (3) sent to the other party's most recent electronic mail address. The Plan may give any notice required or permitted by law through the foregoing methods or by any other method allowed by law. Notice from the Plan to the Group will be deemed to be notice to all Members.

11. Third Parties

This Agreement will not confer any rights or obligations on third parties except as specifically provided herein.

12. Construction

This Agreement will be construed without regard to the party that drafted it. Any ambiguity will not be interpreted against either party but will, instead, be resolved in accordance with other applicable rules concerning the interpretation of contracts.

13. Governing Law and Severability

This Agreement is executed and is to be performed in accordance with applicable federal and Tennessee laws. If any provision of this Agreement is deemed to be invalid or illegal by a court or regulatory agency having jurisdiction over such matters, the surviving provisions of this Agreement shall remain in effect unless the severance of that provision shall deprive a party of the material benefits of this Agreement.

14. Legal Action

No action at law or in equity shall be brought to recover on this Agreement until 60 days after written proof of loss has been furnished as required by this Agreement. No such action shall be brought beyond 3 years after the time written proof of loss is required to be furnished.

15. Confidentiality

The parties acknowledge that this Agreement and information that is identified as confidential information, including, but not limited to, reimbursement information, group membership lists, marketing information, case management notes, prognoses, medical statuses, treatment plans, and similar information created by or for the Plan, and information obtained from and/or about the Blue Cross and Blue Shield Association and its programs ("Confidential Information"); shall be treated as confidential, proprietary or trade secret information. A party may release Confidential Information to providers or its affiliates, or their respective directors, partners, officers, employees, advisors and other representatives ("Representatives") who: have a need to know such Confidential Information, for purposes of their participation in or oversight of matters within the scope of this Agreement; and are under a duty or obligation of confidentiality at least as restrictive as those set forth in this Agreement. Each party shall advise its Representatives of their obligation to maintain the confidentiality of such information. Each party is responsible if its Representative breaches this Section. Neither party shall otherwise release nor disclose such Confidential Information to third parties without the other party's prior written consent, except as required by law. This paragraph shall survive the termination of this Agreement.

Notwithstanding anything herein to the contrary, the following shall not constitute Confidential Information for the purposes of this Agreement: (a) Confidential Information that is or becomes generally available to the public other than as a result of a disclosure by a party or its Representatives; (b) Confidential Information that was available to the parties on a non-confidential basis prior to its disclosure by a party or its Representatives; or (c) Confidential Information that becomes available to the parties on a non-confidential basis from a third party, provided that third party is not known to be subject to any prohibition against transmitting that information.

The Plan reserves the right to refuse to release Confidential Information if the Plan determines, in its sole discretion, that such release has the potential to damage the Plan’s competitive position in the market.

Nothing in the section shall be deemed to prohibit a Member from requesting his or her own health information.

16. Creditable Coverage Statements

The Plan will provide Creditable Coverage statements to formerly covered Members.

17. Other Acceptable Forms of this Document and its Attachments.

The following shall have the same legal effect as an original: facsimile copy, imaged copy, scanned copy, and/or an electronic version, including a digital or electronic signature.

of Tennessee

Employer Group Application Change Form

- This legal document has been classified as confidential -

BCBST-EGA Change 3-2000-A (Revised 12/16)

Employer hereby applies to BlueCross BlueShield of Tennessee, Inc. to change its group insurance benefits (Medical, Dental and VisionBlue products). If BlueCross BlueShield of Tennessee accepts the changes, this form will become a part of the Group Agreement and its information.
When completing electronically, use tab key to move from field to field. When completing paper version, please type or print clearly with a ballpoint pen, using black or blue ink (no felt tip pens please).

Group Name: Anderson County Government Date: 5/9/2019

Effective Date of Change: 7/1/2019 Group Number: 129714

To comply with Federal regulations, list total number of employees (full-time, part-time, owners/partners, private contractors):

328

Did you have 51 or more employees in the preceding year (include **all** employees)? ☑ Yes ☐ No

Section A – General Information

Mark only the items that are changing or check this box if there is NO change from current ☑

1. Federal Employer Identification Number (FEIN): _____
2. Employer's Legal Name (as listed on your FEIN) ("Employer"): _____

   _____

   (2a) Health Benefit Plan Name (as listed on your Form 5500): _____

   _____
3. Subsidiaries or other companies to be: ☐ added ☐ deleted under this Group Agreement. List names and addresses below. Federal law requires BlueCross to report to the IRS annually who is covered under this Group Agreement. In that reporting, BlueCross must include the FEIN of each covered employee's employer. Please list the FEINs of the subsidiaries or other companies named below if they are part of either (a) a controlled group or (b) a multiple employer welfare arrangement (MEWA) in which the MEWA is both the plan sponsor and the employer (employer MEWA). Consult your legal counsel if you have questions about whether your company is part of a controlled group or employer MEWA.

   (If additional space is needed list name(s) and address(es) on separate page.)

   Name: _____ FEIN: _____
   Mailing Address: _____
   City: _____ State: _____ Zip: _____
   Name: _____ FEIN: _____
   Mailing Address: _____
   City: _____ State: _____ Zip: _____
4. Reset renewal date/plan year: _____ (To be completed by BlueCross BlueShield of Tennessee)

Section B – Rates and/or Benefits

Are Rates Changing? ☑ Yes ☐ No **Are Benefits Changing? ☑ Yes ☐ No**

If no changes, proceed to Section C.

Insert your Group Rate Proposal(s) page(s) at the end of this form. Clearly indicate the rate tier chosen.

Insured groups of 151 or more enrolled employees may require a custom EGA CF, based on elected benefits. Please call your BCBST representative for more information.

It is YOUR responsibility to comply with the notice requirements under PPACA and other applicable laws. Please consult your broker or legal counsel to assure any such change is compliant with these requirements.

A scanned, imaged or photocopied version of this completely executed form will have the same force and effect as the original document.

Section C – Organization (Employer) Authorized Signature (Signature required for any changes to the existing Group Agreement)

Payment of premiums constitutes Employer's acceptance of this change

The initial payment of these renewal rates constitutes Employer's acknowledgement and acceptance of these rates and benefits and makes them part of the Group Agreement with BlueCross BlueShield of Tennessee, Inc.

This is to certify that all statements contained herein are true and exact to the best of my knowledge. I understand that this change is subject to final approval and acceptance by BlueCross BlueShield of Tennessee. I also understand that BlueCross BlueShield of Tennessee Sales Representatives and Agents and/or Brokers are not authorized to approve this change. Only a legal representative of Employer, authorized to act on its behalf, should sign this application for a change to the Group's existing coverage.

I understand that my Broker will be paid a commission and/or other fee by BlueCross BlueShield of Tennessee for placing/encouraging the Group's coverage. For more information, I will contact my Broker. Once this Employer Group Application Change Form has been accepted by BlueCross BlueShield of Tennessee, the Employer's payment of the premium for the group membership covered by BlueCross BlueShield of Tennessee (the "Aggregate Premium") shall constitute acceptance by the Employer of the Group Agreement.

If FEINs were supplied in response to Section A, Question 7, above, I certify that the Policy Holder and other entities covered under this Group Agreement are part of a controlled group or an employer MEWA.

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage. An electronic signature will have the same force and effect as a manual signature.

By signing below, I certify that I am authorized by the Employer to execute this Employer Group Application Change Form. I also certify that Employer understands all limitations on eligibility terms and conditions (including limitations on waiting periods before coverage is effective for persons otherwise eligible to enroll) under the Affordable Care Act and agrees to abide by those terms and conditions. Employer agrees to notify BlueCross BlueShield of Tennessee immediately if a change to its eligibility terms and conditions results in a violation of the Affordable Care Act.

Signature: Electronic Signature on Record **Date:** 5/7/2019 5:04:32 PM

Print Name of Signee: Kim Jeffers-Whitaker **Title:** Diretor of Human Resources & Risk Management

Section D – Broker's Certification

I certify that I have met with the Employer named herein and have fully explained the requested change and the contents of this form. I have discussed eligibility, how changes will affect the employees, limitations, and the result of any misrepresentation.

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage. An electronic signature will have the same force and effect as a manual signature.

Broker Signature: _____ **Date:** _____

Section E – Company (BlueCross BlueShield of Tennessee) Acceptance

BlueCross BlueShield of Tennessee hereby accepts this application with the rates and benefits outlined in the attached.

By: Henry Smith **Title:** Sr. Vice President, Operations and Chief Marketing Officer **Date:** 5/8/2019

This Employer Group Application Change Form amends your current Employer Group Application and becomes a part of your Group Agreement.

A scanned, imaged or photocopied version of this completely executed form will have the same force and effect as the original document.

BlueCross BlueShield of Tennessee
An Independent Licensee of the BlueCross BlueShield Association

VisionBlue Renewal Option

Issued For Michael W. Williams

Effective 07/01/2019

Name: Anderson County Government **Group ID:** 129714 - 1

VisionBlue

Base Vision

Employer Contribution	Participatory
Exam Copay	$20
Materials Copay	$20
Frames Frequency	24
Frames Allowance	$150

Three-Tier Coverage	Individual	2-Person	Family
Base Vision	$5.43	$10.86	$17.37

Services	In-Network	Out-Of-Network Allowance
Exam with Dilation as Necessary	$20 Copay	$35
Retinal Imaging	Up to $39	N/A
Exam Options		
Standard Contact Lens Fit and Follow-Up	$55 Copay	N/A
Premium Contact Lens Fit and Follow-Up	10% Off Retail	N/A
Frames	$0 Copay; $150 Allowance 20% Off Balance Over Allowance	$75.00
Standard Plastic Lenses		
Single Vision	$20 Copay	$30
Bifocal	$20 Copay	$45
Trifocal	$20 Copay	$60
Standard Progressive (Add onto Bifocal)	$65 Additional Copay	$0 Additional *
Premium Progressive (Add onto Bifocal)	$65 Additional Copay 20% Off Retail Price Less $120	$0 Additional *
Lens Options		
UV Coating	$15 Copay	N/A
Tint (Solid and Gradient)	$15 Copay	N/A
Standard Scratch Resistance	$15 Copay	N/A
Standard Polycarbonate (Adult)	$40 Copay	N/A
Standard Polycarbonate (Under Age 19)	$0 Copay	$5
Standard Anti-Reflective Coating	$45 Copay	N/A
Polarized Lenses and Other Lens Options	20% Off Retail	N/A
Contact Lenses		
Conventional	$0 Copay; $150 Allowance, 15% Off Balance Over Allowance	$120
Disposable	$0 Copay; $150 Allowance	$120
Medically Necessary	Paid-in-Full	$200
Frequency		
Examination	Once Every 12 Months	
Frame	Once Every 24 Months	
Lenses or Contact Lenses	Once Every 12 Months	

* $45 maximum reimbursement

Diabetic Eye Care	(Care and testing for diabetic members)	Up to 2 services per year for each listed service**	
Exam		$0	Up to $77
Retinal Imaging		$0	Up to $50
Extended Ophthalmoscopy		$0	Up to $15
Gonioscopy		$0	Up to $15
Scanning Laser		$0	Up to $33

**Some or all of the diagnostic services described above will be provided as deemed appropriate, subject to provider determination of service necessity and the benefit frequency limitations referenced above.

Commission Disclosure: The rates presented in this proposal include commissions, and may include additional compensation. If you have questions, please contact your broker or BCBST representative.

COBRA Admin: None
Quote #: 135 Created on: 6/4/2019 by UVJ4XA000038 Status: Approved Rep: Wayne Webb
Total Group Size: Large

of Tennessee

Evidence of Coverage

VISION BENEFIT PLAN

COMM-664 (8/16)
Vision EOC - Members

Anderson County Government
129714
July 1, 2019

BCBST—VisionBlue
1/2010
Rev. 10/2016 SE rev 8/24/2017 SE

VisionBlue™

VISION EVIDENCE OF COVERAGE

BlueCross BlueShield of Tennessee

BlueCross BlueShield of Tennessee, Inc.,
an Independent Licensee of the
BlueCross BlueShield Association

If You have questions about this Evidence of Coverage or any matter related to Your membership in the Plan, please write or call us at:

Customer Service Department
BlueCross and BlueShield of Tennessee
1 Cameron Hill Circle
Chattanooga, Tennessee 37402
1-800-565-9140

BCBST—VisionBlue
1/2010
Rev. 10/2016 SE rev 8/24/2017 SE

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-565-9140 (TTY: 1-800-848-0298).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-565-9140 (رقم هاتف الصم والبكم: 1-800-848-0298

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-565-9140 (TTY:1-800-848-0298) 。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-565-9140 (TTY:1-800-848-0298).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-565-9140 (TTY: 1-800-848-0298) 번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-565-9140 (ATS : 1-800-848-0298).

ໂປດຊາບ: ຖ້າ ທ່ານ ເວົ້າ ພາສາ ລາວ, ການ ບໍ ລິ ການ ຊ່ ວຍ ເຫ ຼືອ ດ້ ານ ພາສາ, ໂດຍ ເສ ັ ຽ ຄ່ າ, ແມ ່ ນ ພ ້ ອມ ໃຫ ້ ທ ່ ານ. ໂທ 1-800-565-9140 (TTY: 1-800-848-0298).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-565-9140 (መስማት ለተሳናቸው: 1-800-848-0298).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-565-9140 (TTY: 1-800-848-0298).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-565-9140 (TTY:1-800-848-0298)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-565-9140 (TTY:1-800-848-0298) まで、お電話にてご連絡ください。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-565-9140 (TTY:1-800-848-0298).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-565-9140 (TTY:1-800-848-0298) पर कॉल करें।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-565-9140 (телетайп: 1-800-848-0298).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-565-9140 (TTY:1-800-848-0298) تماس بگیرید .

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-565-9140 (TTY: 1-800-848-0298).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-565-9140 (TTY: 1-800-848-0298).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-565-9140 (TTY: 1-800-848-0298).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti.Chiamare il numero 1-800-565-9140 (TTY: 1-800-848-0298).

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-565-9140 (TTY: 1-800-848-0298).

Table of Contents

Please Read Your Evidence of Coverage

This Vision Evidence of Coverage (this "EOC") is part of the Group Agreement between BlueCross BlueShield of Tennessee, Inc. (BCBST, or the "Plan") and Your Group. References in this Vision EOC to "We," "Us," or "Our" also mean BlueCross BlueShield of Tennessee, Inc., or where appropriate, its vision claims administrator. This EOC describes the terms and conditions of Your Vision Coverage from the Plan through the Group, and includes all riders and attachments, which are incorporated herein by reference. It replaces and supersedes any Vision EOC that You have previously received from the Plan.

Please read this EOC carefully. It describes Your rights and duties as a Member. It is important to read the entire EOC. Certain services are not Covered by the Plan. Other Covered Services are limited. The Plan will not pay for any service not specifically listed as a Covered Service, even if a Provider recommends or orders that non-Covered Service. (See Attachments A – D.)

The Group has delegated discretionary authority to the Plan to make any benefit determinations. It has also granted the authority to construe the terms of Your Coverage to the Plan. The Plan or its vision claims administrator shall be deemed to have properly exercised that authority unless it abuses its discretion when making such determinations, whether or not the Group's benefit plan is subject to ERISA. "ERISA" means the Employee Retirement Income Security Act. The Group retains the authority to determine whether You or Your dependents are eligible for Coverage.

Any Grievance related to Your Coverage under this EOC must be resolved in accordance with the Grievance Procedure section of this EOC.
Definitions: In order to make it easier to read and understand this EOC, defined words are capitalized. Those words are defined in the "DEFINITIONS" section of this EOC.
Questions: Please contact one of the Plan's consumer advisors at the number listed on Your membership ID card, if You have any questions when reading this EOC. Our consumer advisors are also available to discuss any other matters related to Your Coverage from the Plan.

How a PPO Plan Works

You have a PPO plan. Through its vision claims administrator, BlueCross BlueShield of Tennessee has an arrangement with a national network of Ophthalmologists, Optometrists and Opticians. These Providers, called Network Providers, agree to special pricing arrangements. Your PPO plan has two levels of benefits. By using Network Providers, You receive the highest level of benefits. However, You can choose to use Providers that are not Network Providers. These Providers are called Out-of-Network Providers. When You use Out-of-Network Providers, Your benefits will be lower. You will also be responsible for the full amount that an Out-of-Network Provider bills and will be reimbursed up to the amount of Your Out-of-Network Allowance.

The Attachment C: Schedule of Benefits, shows how Your benefits vary for services received from Network and Out-of-Network Providers. Attachment A details Covered Services, and Attachment B lists services excluded under the Plan.

Get the Most from Your Benefits

1. Always **carry Your membership ID card** and show it before receiving care.
2. **Always use Network Providers**. See Attachment A for an explanation of a Network Provider. Call the customer service department to verify that a Provider is a Network Provider.
3. Notify the Employer if changes in the following occur for You or any of Your dependents:

   - Name.
   - Address.
   - Telephone number.
   - Employment (change companies or terminate employment).
   - Status of any other vision insurance You might have.
   - Birth of additional dependents.
   - Marriage or divorce.
   - Death.
   - Adoption.
   - Change in student status.

Your BlueCross BlueShield of Tennessee Identification Card

Once Your Coverage becomes effective, You will receive a BlueCross BlueShield of Tennessee, Inc. membership identification (ID) card. Providers nationwide recognize it. The membership ID card is the key to receiving the benefits of the vision care plan. Carry it at all times. Please be sure to show the membership ID card each time You receive vision care services.
Our customer service number is on Your membership ID card. This is an important phone number. Call this number if You have any questions.
If a membership ID card is lost or stolen, or another card is needed for a Covered Dependent not living with the Subscriber, please visit bcbst.com, or call the toll-free number listed on the front page of this EOC. We will help You get a new one. You may want to record Your identification number in this book.

Enrolling in the Plan

Eligible Employees may enroll for Coverage for themselves and their eligible dependents as set forth in this section. No person is eligible to re-enroll if the Plan previously terminated his or her Coverage for cause. Your Group chooses the classes of Employees who are eligible for Coverage under the Plan. Please refer to Attachment D: Eligibility for details.

A. Initial Enrollment Period

Eligible Employees may enroll for Coverage for themselves and their eligible dependents within the first 31 days after becoming eligible for Coverage. The Subscriber must: (1) include all requested information; (2) sign; and (3) submit an Enrollment Form to the Plan during that initial enrollment period.

B. Open Enrollment Period

Eligible Employees shall be entitled to apply for Coverage for themselves and eligible dependents during the Group's Open Enrollment Period. The Subscriber must: (1) include all requested information; (2) sign; and (3) submit an Enrollment Form to the Plan during that Open Enrollment Period. Employees who become eligible for Coverage other than during an Open Enrollment Period may apply for Coverage for themselves and eligible dependents within 31 days of becoming eligible for Coverage, or during a subsequent Open Enrollment Period.

C. Adding Dependents

After the Subscriber is Covered, he or she may apply to add a dependent, who became eligible after the Subscriber enrolled as follows:

1. A newborn child of the Subscriber or the Subscriber's spouse is Covered from the moment of birth. A legally adopted child (including children placed with You for the purposes of adoption) will be Covered as of the date of adoption or placement for adoption. Children for whom the Subscriber or the Subscriber's spouse has been appointed legal guardian by a court of competent jurisdiction will be Covered from the moment the child is placed in the Subscriber's physical custody. The Subscriber must enroll the child within 31 days from the date that the Subscriber acquires the child.

   If the Subscriber fails to do so, and an additional Premium is required to cover the child, the Plan will not cover the child after 31 days from the date the Subscriber acquired the child. If no additional Premium is required to provide Coverage to the child, the Subscriber's failure to enroll the child does not make the child ineligible for Coverage.

   However, the Plan cannot add the newly acquired child to the Subscriber's Coverage until notified of the child's birth. This may delay claims processing.

2. Any other new family dependent, (e.g. if the Subscriber marries) may be added as a Covered Dependent if the Subscriber completes and submits a signed Enrollment Form to the Group representative within 31 days of the date that person first becomes eligible for Coverage.

3. An Employee or eligible dependent who did not apply for Coverage within 31 days of first becoming eligible for Coverage under this Plan may enroll if:

   a. he or she had other coverage at the time Coverage under this Plan was previously offered; and

b. he or she stated, in writing, at the time Coverage under this Plan was previously offered, that such other coverage was the reason for declining Coverage under this Plan; and

c. such other coverage is exhausted (if the other coverage was continuation coverage under COBRA) or the other coverage was terminated because he or she ceased to be eligible due to involuntary termination or employer contributions for such coverage ended; and

d. he or she applies for Coverage under this Plan and the administrator receives the change form within 31 days after the loss of the other coverage.

D. Late Enrollment

Employees or their family dependents who do not enroll when becoming eligible for Coverage under (A), (B) or (C), above, may be enrolled:

1. During a subsequent Open Enrollment Period; or
2. If the Employee acquires a new dependent, and the Employee applies for Coverage within 31 days.

E. Enrollment Upon Change in Status

If You qualify for a change in status, as outlined below, You may be eligible to change Your Coverage other than during the Open Enrollment Period. You must request the change within 31 days of the change in status. Any change in Your elections must be consistent with the change in status.

Subscribers must submit a change form to the Group representative to notify the Plan of any changes in their status or the status of a Covered Dependent within thirty-one (31) days from the date of the event causing that change of status. Such events include, but are not limited to: (1) marriage or divorce; (2) death of the Employee's spouse or dependent; (3) dependency status; (4) Medicare eligibility; (5) coverage by another Payor; (6) birth or adoption of a child of the Employee; (7) termination of employment, or commencement of employment, of the Employee's spouse; (8) switching from part-time to full-time, or from full-time to part-time status by the Employee or the Employee's spouse;

When Coverage Begins

If You are eligible, have enrolled and have paid or had the Premium for Coverage paid on Your behalf, Coverage under this EOC shall become effective on the earliest of the following dates, subject to the Actively at Work Rule set out below:

A. Effective Date of Group Agreement

Initial Coverage through the Plan shall be effective on the effective date of the Group Agreement, if all eligibility requirements are met as of that date; or

B. Enrollment During an Open Enrollment Period

Coverage shall be effective on the first day of the month following the Open Enrollment Period, unless otherwise agreed to by the Group and the Plan; or

C. Enrollment During an Initial Enrollment Period

Coverage shall be effective on the first day of the month following the Plan's receipt of the eligible Employee's Enrollment Form, unless otherwise agreed to by the Group and the Plan; or

D. Newly Eligible Employees

Coverage will be effective on the date of eligibility as specified in the Group Agreement; or

E. Newly Eligible Dependents

(1) Dependents acquired as the result of a marriage – Coverage will be effective on the day of the marriage unless otherwise agreed to by Group and the Plan;

(2) Newborn children of the Subscriber or the Subscriber's spouse - Coverage will be effective as of the date of birth;

(3) Dependents adopted or placed for adoption – Coverage will be effective as of the date of adoption or placement for adoption, whichever is first.

For Coverage to be effective, the dependent must be enrolled, and the Plan must receive any required Premium for the Coverage, as set out in the "Enrollment" section; or

F. Actively at Work Rule

If an eligible Employee, other than a retiree (who is otherwise eligible), is not Actively at Work on the date Coverage would otherwise become effective, Coverage for the Employee and all of his or her Covered Dependents will be deferred until the date the Employee is Actively at Work.

When Coverage Ends

A. Termination or Modification of Coverage by the Plan or the Group

The Plan or the Group may modify or terminate the Group Agreement. Notice to the Group of the termination or modification of the Group Agreement is deemed to be notice to all Members of the Group. The Group is responsible for notifying You of such a termination or modification of Your Coverage.

All Members' Coverage through the Agreement will change or terminate at 12:00 midnight on the date of such modification or termination. The Group's failure to notify You of the modification or termination of Your Coverage shall not be deemed to continue or extend Your Coverage beyond the date that the Group Agreement is modified or terminated. You have no vested right to Coverage under this EOC following the date of the termination of the Group Agreement.

B. Loss of Eligibility

Your Coverage will terminate if You do not continue to meet the eligibility requirements agreed to by the Group and the Plan during the term of the Group Agreement. See Attachment D for details regarding Loss of Eligibility.

C. Termination of Coverage For Cause

The Plan may terminate Your Coverage for cause, if:

1. The Plan does not receive the required Premium for Your Coverage when it is due. The fact that You have paid a Premium contribution to the Group will not prevent the Plan from terminating Your Coverage if the Group fails to submit the full Premium for Your Coverage to the Plan when due, or
2. You fail to make a required Member Payment; or
3. You fail to cooperate with the Plan as required by this EOC; or
4. You have made a material misrepresentation or committed fraud against the Plan. This provision includes, but is not limited to, furnishing incorrect or misleading information or permitting the improper use of the membership ID card.

D. Right To Request A Hearing

You may appeal the termination of Your membership for cause, as explained in the Grievance Procedure section of this EOC. The fact that You have appealed shall not postpone or prevent the Plan from terminating Your Coverage. If Your Coverage is reinstated as part of the Grievance Procedure, You may submit any claims for services rendered after Your Coverage was terminated to the Plan for consideration, in accordance with the "Claims Procedure" section of this EOC.

E. Payment For Services Rendered After Termination of Coverage

Services received after Coverage terminates are not Covered, even if those services are part of a series of treatments that started before Coverage terminated. If You receive Covered Services after the Coverage terminated, the Plan, the Provider who rendered those services, or Your Employer, may recover any charges for such services from You, plus any costs of recovering such charges, including attorney's fees.

Continuation of Coverage

A. Continuation of Coverage - Federal Law

If the Group Agreement remains in effect, but Your Coverage under this EOC would otherwise terminate, the Group may be required to offer You the right to continue Coverage. This right is referred to as "Continuation Coverage" and may occur for a limited time subject to the terms of this Section and the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

1. Eligibility

   If You have been Covered by the Plan on the day before a qualifying event, You and Your dependents may be eligible for COBRA Continuation Coverage. The following are qualifying events for such Coverage:

   a. Subscribers

      Loss of Coverage because of:

      (1) The termination of employment except for gross misconduct.

      (2) A reduction in the number of hours worked by the Subscriber.

   b. Covered Dependents

      Loss of Coverage because of:

      (1) The termination of the Subscriber's Coverage as explained in subsection (a), above.

      (2) The death of the Subscriber.

      (3) Divorce or legal separation from the Subscriber.

      (4) The Subscriber becomes entitled to Medicare.

      (5) A Covered Dependent reaches the limiting age.

2. Enrolling for COBRA Continuation Coverage

   The Group shall notify You of Your rights to enroll for COBRA Continuation Coverage after:

   a. the Subscriber's termination of employment, reduction in hours worked, death or entitlement to Medicare Coverage; or

   b. the Subscriber or Covered Dependent notifies the Group, in writing, within 60 days after any other qualifying event set out above.

   You have 60 days from the later of the date of the qualifying event or the date that You receive notice of Your right to COBRA Continuation Coverage to enroll for such Coverage. The Group will send You the forms that should be used to enroll for COBRA Continuation Coverage. If You do not send the Enrollment Form to the Group within that 60--day period, You will lose Your right to COBRA Continuation Coverage under this Section. If You are qualified for COBRA Continuation Coverage and receive services that would be Covered Services, before enrolling and paying the Premium for such Coverage, You will be required to pay for those services. The Plan will reimburse You for Covered Services, less required Member Payments, after You enroll and pay the Premium for Coverage, and submit a claim for those Covered Services as set forth in this EOC.

3. Premium Payment

You must pay any Premium required for COBRA Continuation Coverage to the Group, which will send that Premium to the Plan. The Group may also direct You to send Your Premium directly to the Plan, or a third party. If You do not enroll when first becoming eligible, the Premium due for the period between the date You first become eligible and the date You enroll for COBRA Continuation Coverage must be paid to the Group within 45 days after the date You enroll for COBRA Continuation Coverage. After enrolling for COBRA Continuation Coverage, all Premiums are due and payable on a monthly basis as required by the Group. If the Premium is not received by the Plan on or before the due date, whether or not the Premium was paid to the Group, Coverage will be terminated, for cause, effective as of the last day for which Premium was received as explained in the Termination of Coverage Section.

4. Coverage Provided

If You enroll for COBRA Continuation Coverage You will continue to be Covered under the Group Agreement and this EOC. The COBRA Continuation Coverage is subject to the conditions, limitations and exclusions of this EOC and the Group Agreement. The Plan and the Group may agree to change the Group Agreement, and/or this EOC, and the Group may also decide to change insurers. If this happens after You enroll for COBRA Continuation Coverage, Your Coverage will be subject to such changes.

5. Duration of Eligibility for COBRA Continuation Coverage

COBRA Continuation Coverage is available for a maximum of:

a. 18 months if the loss of Coverage is caused by termination of employment or reduction in hours of employment; or

b. 29 months of Coverage. If, as a qualified beneficiary who has elected 18 months of COBRA Continuation Coverage, You are determined to be disabled within the first 60 days of COBRA Continuation Coverage, You can extend Your COBRA Continuation Coverage for an additional 11 months, up to 29 months. Also, the 29 months of COBRA Continuation Coverage is available to all non-disabled qualified beneficiaries in connection with the same qualifying event. "Disabled" means disabled as determined under Title II or XVI of the Social Security Act. In addition, the disabled qualified beneficiary must:

(1) Notify the Employer or the administrator of the disability determination within 60 days after the determination of disability and before the close of the initial 18-month Coverage period; and

(2) Notify the Employer or the administrator within 30 days of the date of a final determination that the qualified beneficiary is no longer disabled; or

c. 36 months of Coverage if the loss of Coverage is caused by:

(1) the death of the Subscriber;

(2) loss of dependent child status under the Plan;

(3) the Subscriber becomes entitled to Medicare; or

(4) divorce or legal separation from the Subscriber; or

d. 36 months for other qualifying events. If, a Covered Dependent is eligible for 18 months of COBRA Continuation Coverage as described above, and there is a second

qualifying event (e.g. divorce), You may be eligible for 36 months of COBRA Continuation Coverage from the date of the first qualifying event.

6. Termination of COBRA Continuation Coverage

   After You have elected COBRA Coverage, Your COBRA Coverage will terminate either at the end of the applicable 18-, 29- or 36-month eligibility period or, before the end of that period, upon the date that:

   a. The Premium for such Coverage is not paid when due; or

   b. You become Covered as either a Subscriber or dependent by another group vision care plan, that does not exclude or limit coverage of Your Pre-existing Condition, if any; or

   c. The Group Agreement is terminated; or

   d. You become entitled to Medicare Coverage; or

   e. The date that a disabled Member, who is otherwise eligible for 29 months of COBRA Coverage, is determined to no longer be disabled for purposes of the COBRA law.

7. The Trade Adjustment Assistance Reform Act of 2002 (TAARA) may have added to Your COBRA rights. If You lost Your job because of import competition or shifts of production to other countries, You may have a second COBRA Continuation election period. If You think this may apply to You, check with Your Employer or the Department of Labor.

B. State Continuation Coverage

If the Group Agreement remains in effect, but Your Coverage under this EOC would otherwise terminate, the Group may offer You the right to continue Coverage for a limited period of time according to State law ("State Continuation Coverage"). If You are eligible for COBRA Continuation Coverage, You may elect either COBRA continuation or State Continuation Coverage, but not both.

1. Eligibility

   You have been continuously covered under the Group's plan, or a plan that the Group's plan replaced, for at least 3 months prior to the date prior to the termination of Your Coverage under the Group Agreement, for any reason, except for the termination of the Group Agreement.

2. Enrolling for State Continuation Coverage

   The Group will notify Members eligible for State Continuation Coverage about how to enroll for such Coverage on or before the date their Coverage would otherwise terminate under the Group Agreement. You must request State Continuation Coverage, in writing, and pay the Premium for that Coverage, in advance, as required by the Group.

3. Premium Payment

   You must pay the monthly Premium for State Continuation Coverage to the Group at the time and place specified by the Group.

4. Coverage Provided

   Members enrolled for State Continuation Coverage will continue to be Covered under the Group Agreement and this EOC, for the remainder of the month during which Coverage under the Group Agreement would otherwise end and the greater of:

a. 3 months; or

b. If Your Coverage under the Group Agreement would end while You are pregnant, 6 months after that pregnancy ends; or

c. If Your Coverage under the Group Agreement would end because of divorce or the death of the Subscriber, 15 months.

5. Termination State Continuation Coverage

State Continuation Coverage will terminate upon the earliest of the following:

a. The end of the applicable period specified in subsection 4, above;

b. The end of the period for which You paid the Premium for Coverage; or

c. The termination date of the Group Agreement; or

d. The date You become eligible for coverage under another group benefits plan; or

e. The date You become entitled to Medicare coverage.

C. Continued Coverage During a Family and Medical Leave Act (FMLA) Leave of Absence

Under the Family and Medical Leave Act, You may be able to take:

- up to 12 weeks of unpaid leave from employment due to certain family or medical circumstances; or
- in some instances, up to 26 weeks of unpaid leave if related to certain family members' military service related hardships.

Contact the Employer to find out if this provision applies. If it does, Members may continue Coverage during the leave, but must continue to pay the conversion options portion of the Premium that the Subscriber would pay if he or she were actively working. Coverage will be subject to suspension or cancellation if the Subscriber fails to pay the Premium on time. If the Subscriber takes a leave and Coverage is cancelled for any reason during that leave, Members may resume Coverage when the Subscriber returns to work without waiting for an Open Enrollment Period.

D. Continued Coverage During a Military Leave of Absence

A Subscriber may continue his or her Coverage and Coverage for his or her Dependents during military leave of absence in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994. When the Subscriber returns to work from a military leave of absence, the Subscriber will be given credit for the time the Subscriber was Covered under the Plan prior to the leave. Check with the Employer to see if this provision applies. If it does, Members may continue Coverage during the leave, but must continue to pay the conversion options portion of the Premium that the Subscriber would pay if he or she were actively working. Coverage will be subject to suspension or cancellation if the Subscriber fails to pay the Premium on time.

E. Continued Coverage During Other Leaves of Absence

Your Employer may allow Subscribers to continue their Coverage during other leaves of absence. Continuous Coverage during such leave of absence is permitted for up to 6 months.

A Subscriber will also have to meet these criteria to have continuous Coverage during a leave of absence:

1. Your Employer continues to consider the Subscriber an Employee, and all other Employee benefits are continued;
2. The leave is for a specific period of time established in advance; and
3. The purpose of the leave is documented.

You may apply for Federal or State Continuation or Conversion, if the Subscriber's leave lasts longer than the permitted amount of time.

Members may continue Coverage during the leave, but must continue to pay the conversion options portion of the Premium that the Subscriber would pay if he or she were actively working. Coverage will be subject to suspension or cancellation if the Subscriber fails to pay the Premium on time.

Claims and Payment

When You receive Covered Services from a Network Provider, the Provider will submit a claim to the Plan. If You receive Covered Services from an Out-of-Network Provider, You must submit a claim form to the Plan. We will review the claim, and let You, or the Provider, know if We need more information, before We pay or deny the claim.

A. Claims Billing

1. You should not be billed or charged for Covered Services rendered by Network Providers, except for required Member Payments. The Network Provider will submit the claim directly to Us.

2. You will be charged or billed by an Out-of-Network Provider for Covered Services rendered by that Provider. If You use an Out-of-Network Provider, You are responsible for payment of all charges and must submit an Out-of-Network claim form, including itemized receipts, to be reimbursed up to the Out-of-Network Allowance.

   To be reimbursed, You must submit the claim within 1 year from the date proof is otherwise required. If You do not submit a claim, within the 1 year time period, it will not be paid.

3. You may request a claim form from our customer service department. We will send You a claim form within 15 days. You must submit Your itemized receipt to Us with the claim form. We may also request additional information or documentation if it is reasonably necessary to make a Coverage decision concerning a claim.

4. A Network Provider or an Out-of-Network Provider may refuse to render a service, or reduce or terminate a service that has been rendered, or require You to pay for what You believe should be a Covered Service. If this occurs:

   a. You may submit a claim to Us to obtain a Coverage decision concerning whether the Plan will Cover that service.

   b. You may request a claim form from Our customer service department. We will send You a claim form within 15 days. We may request additional information or documentation if it is reasonably necessary to make a Coverage decision concerning a claim.

B. Payment

1. If You received Covered Services from a Network Provider, We will pay the Network Provider directly. These payments are made according to the Plan's agreement with that Network Provider. You authorize assignment of benefits to that Network Provider. Covered Services will be paid at the Network Benefit level.

2. If You received Covered Services from an Out-of-Network Provider, You must submit, in a timely manner, a completed claim form for Covered Services. If the claim does not require further investigation, We will reimburse You. Our payment fully discharges Our obligation related to that claim.

3. If the Group Agreement is terminated, all claims for Covered Services rendered prior to the termination date, must be submitted to the Plan within 1 year from the date the Covered Services was received.

4. We will pay benefits within 30 days after we receive a claim form that is complete. Claims are processed in accordance with current industry standards, and based on Our information at the time We receive the claim form.

5. When a claim is paid or denied, in whole or part, You will receive an Explanation of Benefits (EOB). This will describe how much was paid to the Provider, and Your out-of-pocket costs paid to the Provider. The Plan will send the EOB to the last address on file for You.

6. You are responsible for paying any applicable Copayment amount and amounts above the Plan allowance to the Provider. If We pay such amounts to a healthcare provider on Your behalf, We may collect those cost-sharing amounts directly from You.

Payment for Covered Services is more fully described in Attachment C: Schedule of Benefits.

C. Complete Information

Whenever You need to file a claim Yourself, We can process it for You more efficiently if You complete a claim form. This will ensure that You provide all the information needed. Most Providers will have claim forms or You can request them from Us by calling Our customer service department at the number listed on Your membership ID card.
Mail all claim forms to BCBST's vision claims administrator:
EyeMed Vision Care ®
ATTN.: OON CLAIMS
P.O. Box 8504
Mason, OH 45040

Grievance Procedure

I. INTRODUCTION

Our Grievance procedure (the "Procedure") is intended to provide a fair, quick and inexpensive method of resolving any and all Disputes with the Plan. Such Disputes include: any matters that cause You to be dissatisfied with any aspect of Your relationship with the Plan; any Adverse Benefit Determination concerning a Claim; or any other claim, controversy, or potential cause of action You may have against the Plan. Please contact the Customer Care Center, at the number listed on Your membership ID card: (1) to ask questions about a Claim; (2) if You have any questions about this EOC or other documents that You receive from Us (e.g. an explanation of benefits); or (3) to initiate a Grievance concerning a Dispute.

1. This Procedure is the exclusive method of resolving any Dispute. Exemplary or punitive damages are not available in any Grievance or litigation, pursuant to the terms of this EOC. Any decision to award damages must be based upon the terms of this EOC.
2. The Procedure can only resolve Disputes that are subject to Our control.
3. You cannot use this Procedure to resolve a claim that a Provider was negligent. Network Providers are independent contractors. They are solely responsible for making treatment decisions in consultation with their patients. You may contact the Plan, however, to complain about any matter related to the quality or availability of services, or any other aspect of Your relationship with Providers.
4. This Procedure incorporates the definitions of: (1) Adverse Benefit Determination; (2) urgent care; and (3) pre-service and post-service claims ("Claims"), that are in the *Employee Retirement Income Security Act of 1974* ("ERISA")*; Rules and Regulations for Administration and Enforcement; Claims Procedure* (the "Claims Regulation").

   An Adverse Benefit Determination is any denial, reduction, termination or failure to provide or make payment for what You believe should be a Covered Service.

   a. If a Provider does not render a service, or reduces or terminates a service that has been rendered, or requires You to pay for what You believe should be a Covered Service, You may submit a Claim to the Plan to obtain a determination concerning whether the Plan will cover that service. As an example, if a pharmacy does not provide You with a prescribed medication or requires You to pay for that prescription, You may submit a Claim to the Plan to obtain a determination about whether it is Covered by the Plan. Providers may be required to hold You harmless for the cost of services in some circumstances.

   b. Providers may also appeal an Adverse Benefit Determination through the Plan's Provider dispute resolution procedure.

   c. A Plan determination will not be an Adverse Benefit Determination if: (1) a Provider is required to hold You harmless for the cost of services rendered; or (2) until the Plan has rendered a final Adverse Benefit Determination in a matter being appealed through the Provider dispute resolution procedure.
5. You may authorize another person to act on Your behalf concerning a Dispute.
6. Any Dispute will be resolved in accordance with applicable Tennessee or Federal laws and regulations, the Group Agreement and this EOC.

II. DESCRIPTION OF THE REVIEW PROCEDURES

A. Inquiry

An Inquiry is an informal process that may answer questions or resolve a potential Dispute. You should contact a Customer Care Agent if You have any questions about how to file a Claim or to attempt to resolve any Dispute. Making an Inquiry does not stop the time period for filing a Claim or beginning a Dispute. You do not have to make an Inquiry before filing a Grievance.

B. Grievance

You must submit a written request asking the Plan to reconsider an Adverse Benefit Determination, or take a requested action to resolve another type of Dispute (Your "Grievance"). You must begin the Dispute process within 180 days from the date We issue notice of an Adverse Benefit Determination from the Plan or from the date of the event that is otherwise causing You to be dissatisfied with the Plan. If You do not initiate a Grievance within 180 days of when We issue an Adverse Benefit Determination, You may give up the right to take any action related to that Dispute.

Contact the Customer Care Center at the number listed on Your membership ID card for assistance in preparing and submitting Your Grievance. They can provide You with the appropriate form to use in submitting a Grievance. This is the first level Grievance procedure and is mandatory.

1. Grievance Hearing

After the Plan has received and reviewed Your Grievance, the Plan will review the Grievance and any additional information that You or others submit concerning that Grievance. In Grievances concerning urgent care or pre-service Claims, the Plan will appoint one or more qualified reviewer(s) to consider such Grievances. Individuals involved in making prior determinations concerning Your Dispute are not eligible to be voting members of the first level Grievance committee or reviewers. The reviewers have full discretionary authority to make eligibility, benefit and/or claim determinations, pursuant to the Group Agreement. Such determinations shall be subject to the review standards applicable to ERISA plans, even if the Group Agreement is not otherwise governed by ERISA.

2. Written Decision

The reviewers will consider the information presented, and You will receive a written decision concerning Your Grievance within 30 days of Your request for review.

The decision will be sent to You in writing and will contain:

(a) A statement of the Plan's understanding of Your Grievance;

(b) The basis of the decision; and

(c) Reference to the documentation or information upon which the Plan based its decision. The Plan will send You a copy of such documentation or information, without charge, upon written request.

No action at law or in equity shall be brought to recover on this EOC until 60 days after written proof of loss has been furnished as required by this EOC. No such action shall be brought beyond 3 years after the time written proof of loss is required to be furnished.

Definitions

Defined terms are capitalized. When defined words are used in this EOC, they have the meaning set forth in this section. Words that are defined in the Plan's Medical Policies and Procedures have the same meaning if used in this EOC.

1. **Actively At Work** - The performance of all of an Employee's regular duties for the Group on a regularly scheduled workday at the location where such duties are normally performed. An Employee will be considered to be Actively At Work on a non-scheduled work day (which would include a scheduled vacation day) only if he or she was Actively At Work on the last regularly scheduled workday. An Employee who is not at work due to a health-related factor shall be treated as Actively At Work for purposes of determining Eligibility.
2. **Benefit Period** –a 12-month period based on the last date of service during which any benefit limits accumulate/are counted.
3. **Billed Charges** – The amount that a Provider charges for services rendered.
4. **Coated Lenses** – A substance added to a finished lens on one or both surfaces.
5. **Contact Lenses:**
    a. **Cosmetic** – Contact Lenses that are not Medically Necessary and are constructed solely for cosmetic and/or convenience reasons.
    b. **Medically Necessary** – Contact Lenses that are constructed for the Medically Necessary conditions listed below: Reimbursement for these lenses will be considered as payment in full.
        - Aphakia (after cataract surgery). A pair of single vision lenses or multi-focal lenses and frames can be provided with the Contact Lenses.
        - When the visual acuity cannot be corrected to 20/70 in the better eye except through the use of Contact Lenses (must be 20/60 or better).
        - Anisometrophia of 4.0 diopters or more, provided visual acuity improves to 20/60 or better in the weaker eye.
        - Keratoconus.
6. **Copayment** – The dollar amount specified in Attachment C: Schedule of Benefits that You are required to pay directly to a Provider for certain Covered Services. You must pay such Copayments at the time You receive those Services.
7. **Covered Dependent** - A Subscriber's family members who: (1) meet the eligibility requirements of this EOC, (2) have been enrolled for Coverage; and (3) for whom the Plan has received the applicable Premium for Coverage.
8. **Covered Family Members** – A Subscriber and his or her Covered Dependents.
9. **Covered Services, Coverage or Covered** - Those Medically Necessary and Appropriate vision services and supplies that are set forth in Attachment A of this EOC, (that is incorporated by reference). Covered Services are subject to all the terms, conditions, exclusions and limitations of the Group Agreement and this EOC.
10. **Employee** - A person who fulfills all eligibility requirements established by the Group and the Plan.

11. **Enrollment Form** – A form or application that must be completed in full by the eligible Employee before he/she will be considered for Coverage under the Plan. Your Group may have You use an electric form to enroll, rather than a paper form.

12. **ERISA** - The Employee Retirement Income Security Act of 1974, as amended.

13. **Full-time Student** - A student who is enrolled in and attending an accredited or licensed high school, vocational or technical school, college or university, on a full time basis. The number of hours required for full-time status is dependent on that school's published requirements.

14. **Group Agreement or Agreement** – The arrangements between the Plan and the Group, including this EOC, the Employer Group Application, any Riders, any amendments, and any attachments to the Agreement or this EOC. If there is any conflict between the Group Agreement and this EOC, the Group Agreement shall be controlling.

15. **Group or Employer** – A corporation, partnership, union or other entity that is eligible for Group Coverage under State and Federal laws, and the Plan's Underwriting Guidelines; and that enters into an Agreement with the Plan to provide Coverage to its Employees and their eligible Dependents.

16. **Incapacitated Child** – an unmarried child who is, and continues to be, both (1) incapable of self-sustaining employment by reason of intellectual or physical disability (what used to be called mental retardation or physical handicap); and (2) chiefly dependent upon the Subscriber or Subscriber's spouse for economic support and maintenance.

    a. If the child reaches this Plan's limiting age while Covered under this Plan, proof of such incapacity and dependency must be furnished within 31 days of when the child reaches the limiting age.

    b. Incapacitated dependents of Subscribers of new groups, or of Subscribers who are newly eligible under this Plan, are eligible for Coverage if they were covered under the Subscriber's or the Subscriber's spouse's previous health benefit plan. We may ask You to furnish proof of the incapacity and dependency upon enrollment and for proof that the child continues to meet the conditions of incapacity and dependency, but not more frequently than annually.

17. **Late Enrollee** – An Employee or eligible Dependent who fails to apply for Coverage within: (1) 31 days after such person first became eligible for Coverage under this EOC; or (2) within a subsequent Open Enrollment Period.

18. **Medicare** - Title XVIII of the Social Security Act, as amended, and Coverage under this program.

19. **Member, You, Your** - Any person enrolled as a Subscriber or Covered Dependent under a Group Agreement.

20. **Member Payment** – The dollar amounts for Covered Services that You are responsible for as set forth in Attachment C: Schedule of Benefits, including Copayments. The Plan may require proof that You have made any required Member Payment.

21. **Network Benefit –** The Plan's payment level that applies to Covered Services received from a Network Provider. See Attachment C: Schedule of Benefits.

22. **Network Provider** - An Ophthalmologist, Optometrist or Optician who has contracted with the Plan to provide access to benefits to Members at specified rates.

23. **Open Enrollment Period** - Those periods of time agreed to by the Plan and the Group during which eligible Employees and their dependents may enroll as Members.

24. **Ophthalmologist** – A person or a doctor of medicine (M.D.) or osteopathy (D.O.) who specializes in the comprehensive care of the eyes and visual system to prevent, diagnose, and treat any eye disease, disorder, or injury.

25. **Optician** – One who is licensed to fit, adjust, and dispense eyeglasses and other optical devices on the written prescription of a licensed Ophthalmologist or Optometrist.

26. **Optometrist** – A doctor of Optometry (O.D.) who is trained to detect and correct vision problems primarily by prescribing eyeglasses or Contact Lenses.

27. **Oversized Lens** – Any lens with an eyesize of 61mm or greater.

28. **Out-of-Network Allowance** – The total dollar amount, as stated in Attachment C: Schedule of Benefits that You receive for services rendered by an Out-of-Network Provider.

29. **Out-of-Network Provider** – Any Provider who is an Eligible Provider type but who does not have a contract with the Plan to provide Covered Services.

30. **Payor(s)** - An insurer, health maintenance organization, no-fault liability insurer, self-insured group, or other entity that provides or pays for a Member's health care benefits.

31. **Premium** – The total payment for Coverage under the Group Agreement, including amounts paid by You and the Group for such Coverage.

32. **Prescription Change** – At least one of the following standards must be met to qualify as a Covered Prescription Change:

    - A change of 0.50 diopters minimum in one eye, or 0.50 diopters minimum total in both eyes.
    - A difference in vertical prism of greater than 1 prism diopter.
    - A change in axis or astigmatism of a minimum of 15 degrees.

33. **Provider** – A person or entity engaged in the delivery of vision care services who, or that is licensed, certified or practicing in accordance with applicable State or Federal laws.

34. **Qualified Medical Child Support Order** – A medical child support order, issued by a court of competent jurisdiction, that creates or recognizes the existence of a child's right to receive benefits for which a Subscriber is eligible under the Group Agreement. Such order shall identify the Subscriber and each such child by name and last known mailing address; give a description of the type and duration of coverage to be provided to each child; and identify each health plan to which such order applies.

35. **Standard Lens** – Standard glass or plastic (CR39) in clear or Rose Tint #1 or #2. Any lens that will fit any frame with an eyesize less than 61 mm.

36. **Standard Frame** – Any frame that has a retail value of $100.00 or less.

37. **Subscriber** – An Employee who meets all applicable eligibility requirements, has enrolled for Coverage and for whom the Plan has received the applicable Premium for Coverage from the Group.

38. **Vision Examination** – A comprehensive Ophthalmologic service as defined in the Current Procedural Technology (CPT) and the Documentation Guidelines listed under "Eyes – examination items." Comprehensive Ophthalmologic service describes a general evaluation

of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and Ophthalmologic examinations, gross visual fields and basic sensorimotor examination. It often includes, as indicated, biomicroscopy, examination with cyclopedia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment programs.

ATTACHMENT A: COVERED SERVICES

Plan benefits are based on the services and supplies described in this Attachment A and provided in accordance with the benefit schedules set forth in this EOC's Attachment C: Schedule of Benefits.

Please also read Attachment B: Exclusions.

Your benefits are greater when You use Network Providers. The Plan contracts with Network Providers. Network Providers have agreed to accept the Network amounts as stated in Attachment C: Schedule of Benefits as the basis for payment to the Provider for Covered Services. Network Providers have also agreed not to bill You for amounts above the Network amounts for Covered Services. However, if You select non-standard optional services or features, You will be required to pay for them, even if the amount exceeds the Network amounts stated in Attachment C: Schedule of Benefits.

Out-of-Network Providers do not have a contract with the Plan. This means they may be able to charge You more than the Maximum Allowable Charge (the amount set by the Plan in its contracts with Network Providers). When You use an Out-of-Network Provider for Covered Services, You will be responsible for any difference between what the Plan pays and what the Out-of-Network Provider charges. **This means that You may owe the Out-of-Network Provider a large amount of money.**

Obtaining services not listed as a Covered Service in this Attachment or not in accordance with the Plan's health Care Management policies and procedures may result in the denial of benefits or a reduction in reimbursement for otherwise eligible Covered Services.

Benefits paid under this Vision EOC do not apply to any maximums paid or owed for any other coverage You may have.

A. Vision Care

Medically Necessary and Appropriate routine vision care services.

1. Covered Services
   a. Routine vision services, including services and supplies to detect or correct refractive errors of the eyes.
2. Restrictions
   a. Sunglasses will be handled as any other lens.
   b. Benefits are not available more frequently than as specified in Attachment C: Schedule of Benefits.
   c. Allowances represent the maximum amount available to You for a Covered Service listed in Attachment C: Schedule of Benefits. If You do not use the entire allowance in a single instance, You will not be able to use any remaining balance for the rest of the Benefit Period.
   d. Discounts do not apply for benefits provided by other Group benefit plans.

EVIDENCE OF COVERAGE
ATTACHMENT B: EXCLUSIONS

This EOC does not provide benefits for the following services, supplies or charges:

1. Medical and/or surgical treatment of the eye, eyes, or supporting structure, including surgeries to detect or correct refractive errors of the eyes.
2. Eye exercises and/or therapy.
3. Visual training.
4. Charges for vision testing examinations, lenses and frames ordered while insured but not delivered within 60 days after Coverage is terminated.
5. Charges for sunglasses, photosensitive, anti-reflective or other optional charges when the charge exceeds the amount allowable for regular lenses.
6. Charges filed for procedures determined by the Plan to be special or unusual, (i.e. orthoptics, vision training, subnormal vision aids, aniseikonic lenses, tonography, corneal refractive therapy, etc.)
7. Charges for lenses that do not meet the Z80.1 or Z80.2 standards of the American National Standards Institute.
8. Charges in excess of the Out-of-Network Allowance as established by the Plan.
9. Oversized Lenses.
10. Corrected eyewear required by an employer as a condition of employment, and safety eyewear unless specifically Covered under the plan.
11. Non-prescription lenses and frames, and non-prescription sunglasses (except for 20% discount).
12. Services or materials provided by any other group benefit providing vision care.
13. Two pairs of glasses in lieu of bifocals.
14. Services or supplies not listed as Covered Services under Attachment A, Covered Service.
15. Services or supplies that are determined to be not Medically Necessary and Appropriate.
16. Self treatment or training.
17. Services that are free.
18. Services or supplies for the treatment of work related illness or injury, regardless of the presence or absence of workers' compensation coverage. This exclusion does not apply to injuries or illnesses of an employee who is (1) a sole-proprietor of the Group, unless required by law to carry worker's compensation insurance; (2) a partner of the Group, unless required by law to carry worker's compensation insurance; or (3) a corporate officer of the Group, provided the officer filed an election not to accept Workers' Compensation with the appropriate government department.
19. Services or supplies received before Your effective date for Coverage with this Plan.
20. Services or supplies received after Your Coverage under this Plan ceases, even if those expenses relate to a condition that began while You were Covered, except that this Plan will Cover charges for vision materials that were ordered before Your Coverage ended and are delivered within 31 days from the date of such order.
21. Services or charges to complete a claim form or to provide medical records or other administrative functions. We will not charge You or Your legal representative for statutorily required copying charges.
22. Charges for failure to keep a scheduled appointment.

23. Charges for telephone consultations, e-mail or web based consultations, or telemedicine services.
24. Court ordered examinations and treatment, unless Medically Necessary.
25. Charges for services performed by You or Your spouse, or Your or Your spouse's parent, sister, brother or child.
26. Any charges for handling fees.
27. Safety items, or items to affect performance primarily in sports-related activities.
28. Charges for replacement of broken, lost, or stolen lenses, Contact Lenses, or frames.
29. Charges for services or materials from an Ophthalmologist, Optometrist or Optician acting within the scope of his or her license.
30. Charges for any additional service required outside basic vision analyses for Contact Lenses, except fitting fees

ATTACHMENT C: SCHEDULE OF BENEFITS

Group Name: Anderson County Government
Group Number: 129714
Effective Date: July 1, 2019

Members have the right to obtain vision care from the Provider of their choice. However, payment of benefits varies depending on the type of Provider chosen. Benefits are payable as shown in the following Schedule of Benefits:

Benefit	In-Network	Out-of-Network Allowance	Benefit Frequency
VISION EXAMINATION			
Comprehensive Eye Examination	$20 Copayment	up to $35	Subscriber 12 months Dependent Spouse 12 months Dependent Children 12 months
Retinal Imaging	Up to $39	Up to $0	
and			
Contact Lenses Fit And Follow-Up			Subscriber 12 months Dependent Spouse 12 months Dependent Children 12 months
Standard	$55 Copayment	up to $0	
Premium	10% off retail price	up to $0	
VISION MATERIALS[1]			
Standard Plastic Lenses			Subscriber 12 months Dependent Spouse 12 months Dependent Children 12 months
Single Vision	$20 Copayment	up to $30	
Bifocal	$20 Copayment	up to $45	
Trifocal	$20 Copayment	up to $60	
Frames[2]	$0 Copayment up to $150 allowance	up to $75	Subscriber 24 months Dependent Spouse 24 months Dependent Children 24 months
Contacts In lieu of eyeglasses, frames and lenses[3]			Subscriber 12 months Dependent Spouse 12 months Dependent Children 12 months
Conventional	$0 Copayment up to $150 allowance	up to $120	
Disposable	$0 Copayment up to $150 allowance	up to $120	
Medically Necessary	Paid in full	up to $200	

Lens Options			Subscriber 12 months Dependent Spouse 12 months Dependent Children 12 months
Standard Polycarbonate	$40 Copayment	up to $0	
Standard Polycarbonate (For Covered Dependent children under 19 years of age.)	$0 Copayment	up to $5	
UV Treatment	$15 Copayment	up to $0	
Tint	$15 Copayment	up to $0	
Standard Plastic Scratch Coating	$15 Copayment	up to $0	
Standard Progressive Lenses (add on to Bifocal)	$65 Copayment	up to $0	
Premium Progressive Lenses (add on to Bifocal)	$65 Copayment 20% off retail price up to $120 allowance	up to $0	
Standard Anti-Reflective Coating	$45 Copayment	up to $0	
DIABETIC EYE CARE			Care and testing for diabetic members Up to two services per 12 month benefit period for each listed service.
Exam	$0 Copayment	up to $77	
Retinal Imaging	$0 Copayment	up to $50	
Extended Ophthalmoscopy	$0 Copayment	up to $15	
Gonioscopy	$0 Copayment	up to $15	
Scanner Laser	$0 Copayment	up to $33	

1. Additional complete pair eyeglasses purchases (frame, lens and lens options) receive 40% off retail price at Network Providers once benefit used.
2. Additional 20% off retail cost above allowance.
3. Additional 15% off balance over allowance on conventional Contact Lenses.

EVIDENCE OF COVERAGE

ATTACHMENT D: ELIGIBILITY

Any Employee of the Group and his/her family dependents, who meet the eligibility requirements of this Section, will be eligible for Coverage under the Group Agreement if properly enrolled for Coverage and upon payment of the required Premium for such Coverage. If there is any question about whether a person is eligible for Coverage, the Employer shall make final eligibility determinations in accordance with the requirements of this EOC and the Group Agreement. At the Group or Employer's request, this Plan may not cover Spouses or dependent children. If You qualify as a retiree, You may still be an eligible Employee under this EOC after You leave employment. Check with Your benefits representative for full details.

A. Subscriber

To be eligible to enroll as a Subscriber, You must:

1. Be a full-time Employee of the Group who is Actively at Work; and
2. Satisfy all eligibility requirements of the Employer and Group Agreement; and
3. Enroll for Coverage from the Plan by submitting a completed and signed Enrollment Form or other required documentation to Your Group representative;

For leaves of absence, please refer to the Continuation of Coverage section of this EOC.

B. Covered Dependents

You can apply for Coverage for Your dependents. You must list Your dependents on the Enrollment Form. To qualify as a Covered Dependent, each dependent must meet all dependent eligibility criteria established by the Employer, satisfy all eligibility requirements of the Group Agreement, and be either:

1. The Subscriber's current spouse as defined by the Employer, which may include a Domestic Partner;
2. The Subscriber's or Subscriber's spouse's: (1) natural child; (2) legally adopted child (including children placed with You for the purpose of adoption); (3) step-child(ren); or (4) children for whom You or Your spouse are legal guardians; who are less than 26 years old; or
3. A child of the Subscriber or the Subscriber's spouse for whom a Qualified Medical Child Support Order has been issued; or
4. An Incapacitated Child of the Subscriber or Subscriber's spouse.

Dependents who permanently reside outside the United States are not eligible for Coverage under the EOC.

Subscribers who are not U.S. citizens, do not reside in the United States, and work at an Employer's location not located in the United States, are not eligible for Coverage under the EOC.

The Employer's determination of eligibility under the terms of this provision shall be conclusive.

The Plan reserves the right to require proof of eligibility including, but not limited to, a certified copy of any Qualified Medical Child Support Order or certification of full-time student status.

C. Loss of Eligibility

Coverage for a Member who has lost his/her eligibility shall automatically terminate at 12:00 midnight on the day that loss of eligibility occurred.

EVIDENCE OF COVERAGE

ATTACHMENT E: STATEMENT OF ERISA RIGHTS

For the purposes of this Attachment E, the term, "Plan" means the employee welfare benefit plan sponsored by the Plan Sponsor (usually, Your Employer). The Employee Retirement Income Security Act of 1974 (ERISA) entitles You, as a member of the Group under this Plan, to:

1. Examine, without charge, at the office of the Plan Administrator (Plan Sponsor, usually Your Employer) and at other specified locations, such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration;

2. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator (Plan Sponsor, i.e., Your Employer). The Plan Administrator may make a reasonable charge for these copies; and

3. Receive a summary of the plan's annual financial report. The Plan Administrator (Plan Sponsor, usually Your Employer) is required by law to furnish each participant with a copy of this summary annual report.

4. Obtain a statement telling You whether You have a right to receive a pension at normal retirement age and if so, what Your benefits would be at normal retirement age if You stop working under the Plan now. If You do not have a right to a pension, the statement will tell You how many more years You have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The Plan must provide the statement free of charge.

5. Reduction or elimination of exclusionary periods of Coverage for preexisting conditions under the Plan. If you have Creditable Coverage from another plan, You should be provided a certificate of Creditable Coverage, free of charge, from Your group health plan or health insurance issuer when You lose Coverage under that Plan. Also, when You become entitled to elect COBRA continuation coverage, when Your COBRA continuation coverage ceases, if You request it before losing Coverage, or if You request it up to 24 months after losing Coverage. Without evidence of Creditable Coverage, You may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in Your Coverage.

In addition to creating rights for You and other employees, ERISA imposes duties upon the people who are responsible for the operation of Your employee benefit plan. The people who operate Your plan are called "fiduciaries" of the plan. They must handle Your plan prudently and in the interest of You and other plan participants and beneficiaries. No one, including Your Employer, Your union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit or exercising Your rights under ERISA. If Your claim for welfare benefits is denied, in whole or in part, You must receive an explanation of the reason for the denial. You have the right to have the Plan review Your claim and reconsider it.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request materials from the Plan and do not receive them within 30 days, You may file suit in a federal court. In such a case, the court may require the Plan Administrator

(Plan Sponsor, i.e., Your Employer) to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If Your claim for benefits is denied or ignored, in whole or in part, You may file suit in a state or federal court. If plan fiduciaries misuse the Plan's money or if You are discriminated against for asserting Your rights, You may seek assistance from the U. S. Department of Labor, or may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If You are successful, the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees; for example, it may order You to pay these expenses if it finds Your claim is frivolous.

If You have any questions about Your plan, You should contact the Plan Administrator (Plan Sponsor, i.e., Your Employer). If You have any questions about this statement or about Your rights under ERISA, You should contact the nearest Area Office of the U. S. Labor Management Services Administration, Department of Labor, or the Division of Technical Assistance and Inquiries, Pensions and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210.

ATTACHMENT F

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH PLAN INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

LEGAL OBLIGATIONS

BlueCross BlueShield of Tennessee, Inc. and some subsidiaries and affiliates (BlueCross) are required to maintain the privacy of all health plan information, which may include Your: name, address, diagnosis codes, etc. as required by applicable laws and regulations (hereafter referred to as "legal obligations"); provide this notice of privacy practices to all members, inform members of the company's legal obligations; and advise members of additional rights concerning their health plan information. BlueCross must follow the privacy practices contained in this notice from its effective date, until this notice is changed or replaced.

BlueCross reserves the right to change privacy practices and the terms of this notice at any time, as permitted by the legal obligations. Any changes made in these privacy practices will be effective for all health plan information that is maintained, including health plan information created or received before the changes are made. All members will be notified of any changes by receiving a new notice of the company's privacy practices.

You may request a copy of this notice of privacy practices at any time by contacting BlueCross at the address on the back of this notice.

ORGANIZATIONS COVERED BY THIS NOTICE

This notice applies to the privacy practices of BlueCross BlueShield of Tennessee, Inc. and its subsidiaries or affiliated covered entities. Medical information about Our subscribers and members may be shared with each other as needed for treatment, payment or health care operations.

USES AND DISCLOSURES OF MEDICAL INFORMATION

Your health plan information may be used and disclosed for treatment, payment, and health care operations, for example:

TREATMENT: Your health plan information may be disclosed to a health care provider that asks for it to provide treatment.

PAYMENT: Your health plan information may be used or disclosed to pay claims for services or to coordinate benefits, which are covered under Your health insurance policy.

HEALTH CARE OPERATIONS: Your health plan information may be used and disclosed to determine premiums, conduct quality assessment and improvement activities, to engage in care coordination or case management, accreditation, conducting and arranging legal services, fraud prevention and investigation, wellness, disease management, and for other similar administrative purposes.

AUTHORIZATIONS: You may provide written authorization to use Your medical information or to disclose it to anyone for any purpose. You may revoke Your authorization in writing at any time. That revocation will not affect any use or disclosure permitted by Your authorization while it was in effect. BlueCross cannot use or disclose Your health plan information except those described in this notice, without Your written authorization. Examples of where an authorization would be required: Most uses and disclosures of psychotherapy notes (if recorded by a covered entity), uses and disclosures for marketing purposes, disclosures that constitute a sale of PHI, other uses and disclosures not described in this notice.

PERSONAL REPRESENTATIVE: Your health plan information may be disclosed to a family member, friend or other person as necessary to help with Your health care or with payment for Your health care. You must agree that the company may do so, as described in the Individual Rights section of this notice.

PLAN SPONSORS: Your health plan information, and the health plan information of others enrolled in Your group health plan, may be disclosed to Your Plan sponsor in order to perform Plan administration functions. Please see Your Plan documents for a full description of the uses and disclosures the Plan sponsor may make of Your health plan information in such circumstances.

UNDERWRITING: Your health plan information may be received for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a health insurance or benefits contract. If the company does not issue that contract, Your health plan information will not be used or further disclosed for any other purpose, except as required by law; Additionally, health plans are prohibited from using or disclosing genetic information of an individual for underwriting purposes pursuant to the Genetic Information Nondiscrimination Act of 2008 (GINA).

MARKETING: Your health plan information may be used to provide information about health-related benefits, services or treatment alternatives that may be of interest to You. Your health plan information may be disclosed to a business associate assisting Us in providing that information to You. We will not market products or services other than health-related products or services to You unless You affirmatively opt-in to receive information about non-health products or services We may be offering. You have the right to opt out of fundraising communications.

RESEARCH: Your health plan information may be used or disclosed for research purposes, as allowed by law.

YOUR DEATH: If You die, Your health plan information may be disclosed to a coroner, medical examiner, funeral director or organ procurement organization.

AS REQUIRED BY LAW: Your health plan information may be used or disclosed as required by state or federal laws.

COURT OR ADMINISTRATIVE ORDER: Health plan information may be disclosed in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances.

VICTIM OF ABUSE: If You are reasonably believed to be a victim of abuse, neglect, domestic violence or other crimes, health plan information may be released to the extent necessary to avert a serious threat to Your health or safety or to the health or safety of others. Health plan information may be disclosed, when necessary, to assist law

enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

MILITARY AUTHORITIES: Health plan information of Armed Forces personnel may be disclosed to Military authorities under certain circumstances. Health plan information may be disclosed to authorized federal officials as required for lawful intelligence, counterintelligence, and other national security activities.

INDIVIDUAL RIGHTS

1. **DESIGNATED RECORD SET:** You have the right to look at or get copies of Your health plan information, with limited exceptions. You must make a written request, using a form available from the Privacy Office, to obtain access to Your health plan information. If You request copies of Your health plan information, You will be charged $.25 per page, $10 per hour for staff time required to copy that information, and postage if You want the copies mailed to You. If You request an alternative format, the charge will be based upon the cost of providing Your health plan information in the requested format. If You prefer, the company will prepare a summary or explanation of Your health plan information for a fee. For a more detailed explanation of the fee structure, please contact the Privacy Office. The company requires advance payment before copying Your health plan information.
2. **ACCOUNTING OF DISCLOSURES:** You have the right to receive an accounting of any disclosures of Your health plan information made by the company or a business associate for any reason, other than treatment, payment, or health care operations purposes within the past six years. This accounting will include the date the disclosure was made, the name of the person or entity the disclosure was made to, a description of the health plan information disclosed, the reason for the disclosure, and certain other information. If You request an accounting more than once in a 12-month period, there may be a reasonable cost-based charge for responding to those additional requests. Please contact the Privacy Office for a more detailed explanation of the fees charged for such accountings.
3. **RESTRICTION REQUESTS:** You have the right to request restrictions on the company's use or disclosure of Your health plan information. The company is not required to agree to such requests. The company will only restrict the use or disclosure of Your health plan information as set forth in a written agreement that is signed by a representative of the Privacy Office on behalf of the company.
4. **BREACH NOTICE:** You have the right to notice following a breach of unsecured protected health information. The notice of a breach of unsecured protected health information shall at a minimum include the following: The date of the breach, the type of data disclosed in the breach, who made the non-permitted access, use or disclosure of unsecured protected health information and who received the non-permitted disclosure, and what corrective business action was or will be taken to prevent further non-permitted access, uses or disclosures of unsecured protected health information.
5. **CONFIDENTIAL COMMUNICATIONS:** If You reasonably believe that sending health plan information to You in the normal manner will endanger You, You have the right to make a written request that the company communicate that information to You by a different method or to a different address. If there is an

immediate threat, You may make that request by calling a BlueCross BlueShield of Tennessee Customer Service Representative or the Privacy Officer at 1-888-455-3824. Follow up with a written request is required as soon as possible. The company must accommodate Your request if it is reasonable, specifies how and where to communicate with You, and continues to permit collection of Premium and payment of claims under Your health plan.

6. **AMENDMENT REQUESTS:** You have the right to make a written request that the company amend Your health plan information. Your request must explain why the information should be amended. The company may deny Your request if the health plan information You seek to amend was not created by the company or for other reasons permitted by its legal obligations. If Your request is denied, the company will provide a written explanation of the denial. If You disagree, You may submit a written statement that will be included with Your health plan information. If the company accepts Your request, reasonable efforts will be made to inform the people that You designate about that amendment. Any future disclosures of that information will be amended.
7. **RIGHT TO REQUEST WRITTEN NOTICE:** If You receive this notice on the company's web site or by electronic mail (e-mail), You may request a written copy of this notice, by contacting the Privacy Office.

QUESTIONS AND COMPLAINTS

If You want more information concerning the company's privacy practices or have questions or concerns, please contact the Privacy Office.

If You are concerned that: (1) the company has violated Your privacy rights; (2) You disagree with a decision made about access to Your health plan information or in response to a request You made to amend or restrict the use or disclosure or Your health plan information; (3) to request that the company communicate with You by alternative means or at alternative locations; please contact the privacy office.
You may also submit a written complaint to the U.S. Department of Health and Human Services. The company will furnish the address where You can file a complaint with the U.S. Department of Health and Human Services upon request.

The company supports Your right to protect the privacy of Your health plan information. There will be no retaliation in any way if You choose to file a complaint with BlueCross BlueShield of Tennessee or subsidiaries or affiliates, or with the U.S. Department of Health and Human Services.

BlueCross BlueShield of Tennessee, Inc.
The Privacy Office
1 Cameron Hill Circle
Chattanooga, TN 37402
(888) 455-3824
(423) 535-1976 FAX
privacy_office@bcbst.com

General Legal Provisions

The Plan is an Independent Licensee of the BlueCross BlueShield Association

The Plan is an independent corporation operating under a license from the BlueCross Blue Shield Association (the "Association"). That license permits the Plan to use the Association's service marks within its assigned geographical location. The Plan is not a joint venturer, agent or representative of the Association nor any other independent licensee of the Association.

Relationship with Network Providers

Network Providers are Independent Contractors and are not employees, agents or representatives of the Plan. Such Providers contract with the Plan, which has agreed to pay them for rendering Covered Services to You. Network Providers are solely responsible for making all medical treatment decisions in consultation with their Member-patients. The Plan does not make medical treatment decisions under any circumstances.

The Plan has the discretionary authority to make benefit or eligibility determinations and interpret the terms of Your Coverage to the Plan ("Coverage Decisions"). It makes those Coverage Decisions based on the terms of this EOC, the Group Agreement, its participation agreements with Network Providers and applicable State or Federal laws.

The Plan's participation agreements permit Network Providers to dispute the Plan's Coverage decisions if they disagree with those decisions. If Your Network Provider does not dispute a Coverage decision, You may request reconsideration of that decision as explained in the grievance procedure section of this EOC. The participation agreement requires Network Providers to fully and fairly explain the Plan's Coverage decisions to You, upon request, if You decide to request that the Plan reconsider a Coverage decision.

The Plan or a Network Provider may end their relationship with each other at any time. A Network Provider may also limit the number of Members that he, she or it will accept as patients during the term of this Agreement. The Plan does not promise that any specific Network Provider will be available to render services while You are Covered by the Plan.

Governing Laws

Tennessee laws govern Your benefits; however, if the extraterritorial laws of another state apply to Your benefits, We will administer Your benefits accordingly.

Nondiscrimination Notice

BlueCross BlueShield of Tennessee (BlueCross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BlueCross does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

BlueCross:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: (1) qualified interpreters and (2) written information in other formats, such as large print, audio and accessible electronic formats.
- Provides free language services to people whose primary language is not English, such as: (1) qualified interpreters and (2) written information in other languages.

If you need these services, contact a consumer advisor at the number on the back of your Member ID card (for TTY help, call 1-800-848-0298 or 711).

If you believe that BlueCross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance ("Nondiscrimination Grievance"). For help with preparing and submitting your Nondiscrimination Grievance, contact a consumer advisor at the number on the back of your Member ID card or call 1-800-565-9140 (TTY: 1-800-848-0298 or 711). They can provide you with the appropriate form to use in submitting a Nondiscrimination Grievance. You can file a Nondiscrimination Grievance in person or by mail, fax or email. Address your Nondiscrimination Grievance to: Nondiscrimination Compliance Coordinator; c/o Manager, Operations, Member Benefits Administration; 1 Cameron Hill Circle, Suite 0019, Chattanooga, TN 37402-0019; (423) 591-9208 (fax); Nondiscrimination_OfficeGM@bcbst.com (email).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1–800–368–1019, 800–537–7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

EMPLOYER BENEFIT SOLUTIONS FOR THE PUBLIC SECTOR

Anderson County

Jeff Wolters, District Manager
405-212-2602 / 770-316-4771
jeffrey.wolters@americanfidelity.com

Molly Wilson, Account Executive
405-212-2422 / 850-528-3219
molly.wilson@americanfidelity.com

AMERICAN FIDELITY
a different opinion

SB-29949-0917

AMERICAN FIDELITY
a different opinion

A Proposal to
Anderson County

American Fidelity Assurance Company is your source for benefits and services at both the employer and the employee level. We deliver expense management services and quality voluntary benefits, while providing a first-class customer experience for you and your employees.

As one of the few insurers in America that focuses on worksite benefits, American Fidelity uniquely understands the need for employers to maintain a competitive employee benefit package and control their benefit costs. American Fidelity is focused on serving the following select market segments: the public sector, healthcare facilities, the auto retail community, and the education community. Since 1960, we have employed this focus to provide worksite solutions to millions of customers across the nation.

Through our salaried, career Account Managers, you will have year-round support and your employees will have access to a complete benefit package that can be tailored to meet their needs. In addition, we provide you the administrative support and expense management services that can help both you and your employees maximize your tax saving opportunities.

We believe our comprehensive approach to providing benefits and services, while managing cost, will be a valuable asset to your organization. Thank you for considering American Fidelity Assurance Company and we look forward to the next step in the process of helping you transition into a new benefit program.

Jeff Wolters
District Manager
jeffrey.wolters@americanfidelity.com
405-212-2602 / 770-316-4771

Molly Wilson
Account Executive
molly.wilson@americanfidelity.com
405-212-2422 / 850-528-3219

Why American Fidelity

Specializing in the Public Sector

Proven History

Company Culture

Ratings and Financial Strength

Why American Fidelity

Not only is each public sector distinct, but your employees are a melting pot of different occupations, incomes, and types of labor with unique benefits needs. You deserve a partner who understands the need to adapt quickly and who leads the way, when needed. American Fidelity Assurance Company does just that by continually looking at the latest trends in employer benefit solutions for your industry and building strategic custom recommendations. Count on us for help with:

- Strategic Supplemental Benefits
- Tax-Favored Benefits Enrollment Support
- Employee Education and Year-Round Enrollment
- Affordable Care Act Compliance Support
- Simplifying Technology and Data

You Deserve a Specialist

American Fidelity is focused on helping the public sector overcome benefits administration challenges. In comparison, some other companies in the industry often provide a one-size-fits-all approach and their knowledge of your special circumstances only goes so deep. As a specialist in your industry, American Fidelity can provide you with a different perspective — a different opinion.

Proven History

Nationwide we serve nearly one million customers and 12,500 employer groups, including over 700 government employers. We take pride in delivering less worry, less work and using our 55+ years of expertise to provide you with top-notch benefits administration through our hands-on, simplifying approach.

Why choose American Fidelity?

- Providing insurance benefits and administration since 1960
- Rated A+ (Superior)[1] by A.M. Best Company since 1982
- Focused on serving the public sector
- One-stop shop for custom benefit plans and administration
- Salaried account managers, not commissioned brokers
- Focused on employee education before, during, and after enrollment
- Online enrollment platform and online account management
- Section 125 administration at no additional charge*

*[1] www.ambest.com/consumers (May 16, 2017) (A+ is the 2nd out of 16 with 1 being the highest.) *where permitted by law*

Company Culture

We strive for five core principals when serving each other and our customers:

1. Always Fair
2. Always Financially Secure
3. Always Flexible
4. Always Focused
5. Always Future-Oriented

These five principals help us make things easy for our customers and empower us to offer a different opinion in benefits administration.

American Fidelity values a positive and rewarding company culture because we believe this directly impacts our customer experience. Of our 1700+ colleagues, 36% have been with the company for 10 or more years, and 14% of colleagues have been with the company over 20 years.[1] We believe this long tenure represents our company's commitment to excellence in all areas, especially customer service. American Fidelity is listed on Fortune Magazine's "100 Best Companies to Work For" in 2017.[2]

Along with our commitment to our colleagues, we are committed to our community. Aligned with communities in our niche markets, American Fidelity and the American Fidelity Foundation focus on supporting education initiatives, health and human services, arts and culture, and civic projects.

Ratings and Financial Strength

When you partner with American Fidelity, you can be assured we have the financial strength to be there when you need us most.

A+ SINCE 1982

A.M Best Company rating

Since 1982, American Fidelity has been rated "A+" (Superior)[3] by A.M. Best Company, one of the nation's leading insurance company rating services. A.M. Best bases its ratings on an analysis of the financial condition and operating performance of insurance companies in such vital areas as: Competency of Underwriting, Control of Expenses, Adequacy of Reserves, Soundness of Investments, and Capital Sufficiency.

[1] *American Fidelity: Stafftistics American Fidelity by the Numbers; May 2016.*
[2] *https://www.greatplacetowork.com/best-workplaces/100-best/2017 (March 9, 2017)*
[3] *www.ambest.com/consumers (May 16, 2017) (A+ is the 2nd out of 16 with 1 being the highest.)*

EMPLOYER BENEFIT SOLUTIONS FOR THE PUBLIC SECTOR

Employer Administrative Services

Section 125 Plans

Dependent Verification Reviews

Section 125 Plans

Offering a Section 125 Plan (a.k.a. Cafeteria Plan) brings tax savings to both you and your employees; however the administration that comes with maintaining the Plan is time consuming and expensive. Keeping track of Plan changes, new regulations, and updating your employees along the way can be challenging. American Fidelity focuses on helping you stay compliant while educating both you and your employees.

No Charge* Administration

As a specialist for employers like you, we've been there when budgets have been tightened and staff reduced. Not only will we help take the plan complexities off your plate, but we also offer plan administration at no additional charge. This allows you to free up funds you may otherwise need for additional services.

Education

Once your Section 125 Plan is implemented, we'll educate your employees during the enrollment so they can select the best combination of benefits for their needs. Increased benefit knowledge often leads to increased participation, which results in a greater tax reduction for you. Through our experience in your industry, we've also found that teaching employees how your benefits program works often lessens the amount of support you must provide throughout the year.

Ongoing Support

Annual changes to your benefits program can result in the need to update your Section 125 Plan. Each year, we will work with you to update your Plan Document and provide annual non-discrimination testing worksheets. Your compliance needs aren't a one-time focus for us. We work with you year-round to make sure you are aware of requirements.

**where permitted by law*

Setting Up Your Plan

The first step to having a compliant Section 125 Plan is your Plan Document. American Fidelity will work with you to capture all of the details in your benefits offering. From there we will create a sample Plan Document that outlines how you will administer your Plan.

In addition to your sample Plan Document, we will also provide:

- Sample Board Resolution language to formally adopt the Section 125 Plan
- Annual 25% non-discrimination testing worksheets
- Access to employee's annual election forms which show pre-tax and post-tax elections
- Web-based resources, including a Section 125 Administration Guide
- A monthly email newsletter with compliance updates and other pertinent information

For small and large employers alike, the administration, compliance, and employee education responsibilities which come with operating a Section 125 Plan can quickly add up. We understand you are busy. We don't expect you to be a Section 125 expert. Let us help handle it for you.

Dependent Verification Reviews

With medical costs continuing to rise, it's important to ensure dependents covered on your company's medical, dental, or vision plans are eligible to participate according to your plan design. Verifying eligibility of dependents ensures employers are not paying coverage costs for ineligible dependents. To assist you with this process, American Fidelity offers dependent verification reviews (also known as dependent eligibility reviews or medical eligibility audits) through one-on-one benefit meetings during your enrollment.

American Fidelity is happy to offer this optional service at no additional cost. We have been conducting dependent verification reviews for over 10 years and offer a team of experienced agents to assist your group throughout the process.

Benefits of a Review

- Cost savings on employer premium costs by eliminating non-qualified dependents
- Removing ineligible dependents, potentially reducing risk experience
- Helping to ensure you are meeting carrier eligibility requirements
- Updating Social Security Numbers for dependents to help complete Patient Protection and Affordable Care Act (ACA) reporting
- Updating important employee information including emergency contact information and beneficiaries
- An opportunity to communicate and educate employees about benefit changes

American Fidelity can also assist in creating and obtaining signed Major Medical Plan Waivers to help prove you have provided an "offer of coverage" to the minimum number of full-time employees required to avoid triggering an ACA penalty.

Why American Fidelity

We know there are many providers out there who offer Dependent Verification Reviews, but this service can often be expensive and inefficient. American Fidelity can integrate this review into your existing annual enrollment, as well as offer many other valuable services at the same time:

On-site Meetings

Because American Fidelity is already on-site during your annual enrollment, we can perform these Dependent Verification Reviews at the same time. This saves you and your employees time, as well as provides an opportunity for further benefits education. During this meeting, we can also gather other important information for your organization including beneficiary updates, address changes, and more.

Privacy

We know personal information privacy is vital to your organization. By holding these meetings in person, your employees' information is less at risk in comparison to mail or fax reviews.

Immediate Feedback

Another advantage of in-person meetings is that we can provide immediate results. Your employees will know right then and there if their dependents are qualified, and if they have provided the correct information.

Employee Communication

Because these reviews can be a time consuming process, communicating this process to employees in a timely manner is vital to a successful review. We provide letters and group meetings to help communicate what information is needed upfront to help ease frustration. We will also follow up with anyone who hasn't completed the review with a letter and/or phone call.

EMPLOYER BENEFIT SOLUTIONS FOR THE PUBLIC SECTOR

Employee Benefits

Why You Should Offer Supplemental Benefits

Supplemental Voluntary Insurance Benefits

Premier Vendor Partner Benefits

Why You Should Offer Supplemental Benefits

With rising deductibles and larger gaps in coverage, supplemental benefits can provide financial relief for both you and your employees. Every year, employees are paying more in premiums, co-pays, and deductibles. All of this can lead to an additional workplace management challenge for leaders to combat — employees feeling stressed and distracted with efforts to manage out-of-pocket health-related costs.

Supplemental benefits can help give you peace of mind knowing your employees will have coverage when they need it. Additionally, comprehensive benefits packages can also be a great way to attract and retain quality employees.

Complement Your Major Medical Plan

As trends continue to lean toward High-Deductible Health Plans (HDHPs), it's more important than ever to offer supplemental benefits to help offset the additional out-of-pocket expenses your employees may experience. Even with traditional PPO or HMO plans, out-of -pocket expenses can be a burden.

American Fidelity's supplemental benefits pay directly to your employees, which can help them contribute to their deductible. They may even use the benefits to help pay expenses that their major medical plan may not cover, such as travel and lodging.

Allow Employees to Customize Coverage

Because supplemental benefits are voluntary, your employees can choose the benefits to complement their medical plan. Offering a well-rounded supplemental benefits package also lets them support their family's needs — whether they have active children who need accident coverage, or they are preparing for retirement.

Ultimately, a solid benefits program can help ease your worry and workload while also helping to provide employee job satisfaction.

88% of employees view voluntary benefits as a part of a comprehensive benefits package.[1]

[1]*Entrepreneur: Employee Demand Makes Voluntary Benefits Mandatory for Employers; November 9, 2015.*

Employee Benefits

No one understands your employees' needs like you do. And no one understands managing employee benefits in the public sector like American Fidelity. When designing our products and solutions, we focus on the specific needs of employers and employees in your industry. Whether you need unique pay modes, sick leave policies, or new hire eligibility requirements, we tailor our offerings to your organization. In addition to American Fidelity's insurance products, we also offer other carriers' benefits. This allows us to deliver a single source for comprehensive, customized benefits solutions for your employees.

Group Benefits

Our group benefits are designed with the entire public sector in mind. By looking at the entire industry across the country, we are able to design plans and premiums specifically for your niche market. This also allows for fewer health questions, making it easier for your employees to obtain coverage.

Individual Benefits

Like our group benefits, our individual product design relies on data from the entire nation in order to help provide options for you. These products are employee owned, meaning employees may take these benefits with them if they leave employment.

Group Benefits	• Disability Income Insurance • Critical Illness Insurance • Hospital Indemnity Insurance		
Individual Benefits	• Accident Only Insurance • Cancer Insurance	• Term Life Insurance • Whole Life Insurance	• Permanent Universal Life Insurance

Some products and services may be provided by third party contractors or affiliated companies. Some products may contain limitations, exclusions, and waiting periods. Some products may not qualify under Section 125 Plans. ***Some products are inappropriate for people who are eligible for Medicaid coverage.*** *Group Critical Illness is only offered on an after-tax basis.*

Disability Income Insurance

When a disabling injury or sickness happens to one of your employees, it can be difficult to know what to do. You want to help financially, but where do you draw the line? That is why offering disability insurance is so important to a comprehensive benefit package. It helps ensure that your employees' paychecks are protected when they need it the most.

American Fidelity's Disability Income Insurance has been designed specifically with your industry in mind. The plan design may be customized to meet the needs of each individual employee and complement your benefit offerings.

Short-Term and Long-Term Disability

The benefits package you provide to your employees will ultimately drive which disability insurance program you decide to offer. At American Fidelity, we offer ways for both you and your employees to customize the plan to meet specific needs.

Highlights

Eligibility

Each employee will have up to 13 months to apply for coverage without answering medical questions. Pre-existing conditions may apply.

Return-to-Work Incentive

Employees will receive partial benefit for coming to work part-time while still on disability.

Customized Benefit Amounts

Employees are allowed to select a benefit amount that meets their needs up to 60% of their income.

Special Condition Benefits

Mental illness, drug and alcohol addiction, and other special conditions benefit payments are available.

Employee Assistance Program

This value-added service is provided with the long-term disability product and provides your employees with access to telephonic life coaching, legal assistance, and more.

Customized with Your Employees in Mind

Not everyone's needs are the same. That is why we offer multiple elimination and benefit periods for each employee to choose from. This allows each disability plan to be customized to each employee's specific needs.

	Elimination Periods	Benefit Periods Up To	Benefit Amount
Short Term Disability	7 days or 14 days	90 days, 180 days, or 1 year	Up to 25% of monthly compensation

	Elimination Periods	Benefit Periods Up To	Benefit Amount
Long Term Disability	7, 14, 30, 60, 90 & 180 Days	5 Years	Up to 60% of monthly compensation

These products may contain limitations, exclusions and waiting periods.

Short Term Disability

Eligibility Requirements

All permanent employees

No Offsets Disability Plan Benefits

Benefit Schedule	Choice of benefit amount in increments of $50, from $300 to $5,000
Maximum Monthly Benefit	Not to exceed 25% of monthly earnings
Elimination Period Injury/Sickness	Choice of 7 or 14 Days
Maximum Benefit Period	Choice of 90 Days, 180 Days or 1 Year
Guarantee Issue Amount	$4,000
Minimum Participation	Greater of 20% or 10 lives
Own Occupation Period	Same as the benefit period
Pre-existing Condition Period	12/12
Mental & Nervous Limitation	Same as any other Sickness
Drug & Alcohol Limitation	15 days

Plan Rates per $100 of covered monthly benefit

Elimination Period	Under Age 40	Ages 40-49	Ages 50-59	Ages 60 & Over
Benefit Period 90 Days				
7 Days	$2.64	$2.64	$2.90	$3.54
14 Days	$2.26	$2.36	$2.54	$3.22
Benefit Period 180 Days				
7 Days	$2.88	$2.88	$3.16	$3.86
14 Days	$2.48	$2.58	$2.80	$3.52
Benefit Period 1 Year				
7 Days	$3.24	$3.24	$3.52	$4.34
14 Days	$2.78	$2.90	$3.14	$3.96

60 day notice of rate change

Disability Plan Riders

- A critical illness rider can help fill holes left by high deductible medical plans, it is guarantee issue up to $10,000 and does not require you to satisfy your disability elimination period to qualify for benefits.
- The hospital indemnity rider can pay a benefit of up to $150 a day and also does not require you to satisfy your disability elimination period to qualify for benefits.
- We also offer optional disability coverage for a spouse.

Short Term Disability

Disability Plan Highlights

- Benefits are paid directly to insured, not to a doctor or employer
- Convenient payroll deduction
- Benefit payments may be directly deposited into banking account
- Benefits are paid due to covered Injury or Sickness
- Benefits are payable year-round
- Secure online billing system available for your convenience
- Employees can file a claim, track the status of a claim, upload documentation and setup push notifications all within the AFMobile app available in the iTunes App store or Google Play store

Valuable Benefits Include

- Pregnancy Benefit
- Donor Benefit
- Worksite Accommodation Benefit Evaluation
- Social Security Filing Assistance
- Physician Expense Benefit Available up to $150 for Injury Up to 8 times per Year
- Accidental Death Benefit $10,000 Flat Amount if within 90 days of Covered Disability
- Conversion Option

Underwriting Guidelines

- Guaranteed Issue underwriting allows an applicant, regardless of health history, to be guaranteed disability coverage when they are first eligible
- For all new groups, Monthly Indemnity amounts above the Guarantee Issue limit will be Subject to Health Questions.
- Monthly indemnity amounts may be increased up to $400 annually without health questions.
- All increases in monthly indemnity will be subject to a new Pre-Existing Condition Limitation.
- Takeover Credit for a prior carrier is available upon request/approval from American Fidelity.

Learn More

For additional information about American Fidelity Assurance Company, click here: https://americanfidelity.com/about-af/

Long Term Disability

Eligibility Requirements

All permanent employees

Disability Plan Benefits

Benefit Schedule	Choice of benefit amount in increments of $100, from $500 to $10,000
Maximum Monthly Benefit	Not to exceed 60% of monthly earnings
Minimum Monthly Benefit	$100 or 10%, whichever is greater
Elimination Period Injury/Sickness	Choice of 7, 14, 30, 60, 90 & 180 Days
Maximum Benefit Period	Up to Social Security Normal Retirement Age (SSNRA) for Injury and 5 Years for Sickness
Guarantee Issue Amount	$4,000
Minimum Participation	Greater of 20% or 10 lives
Own Occupation Period	24 Months
Disabled and Working	Included
Pre-existing Condition Period	12/12
Mental & Nervous Limitation	24 months
Drug & Alcohol Limitation	15 days
Special Conditions Limitations	12 months

Plan Rates per $100 of covered monthly benefit

Elimination Period	Under Age 40	Ages 40-49	Ages 50-59	Ages 60 & Over
7 Days	$3.24	$3.46	$4.30	$5.60
14 Days	$2.92	$3.20	$4.00	$5.26
30 Days	$2.30	$2.80	$3.64	$4.74
60 Days	$1.88	$2.40	$3.38	$4.56
90 Days	$1.58	$2.00	$3.00	$4.12
180 Days	$1.00	$1.16	$1.74	$2.38

60 day notice of rate change

Disability Plan Riders

- A critical illness rider can help fill holes left by high deductible medical plans, it is guarantee issue up to $10,000 and doesn't require you to satisfy your disability elimination period to qualify for benefits.
- The hospital indemnity rider can pay a benefit of up to $150 a day and also does not require you to satisfy your disability elimination period to qualify for Benefits.
- We also offer optional disability coverage for a spouse, a survivor benefit rider and a COBRA rider which can help cover the cost of medical COBRA premiums.

Long Term Disability

Disability Plan Highlights

- Benefits are paid directly to insured, not to a doctor or employer
- Convenient payroll deduction
- Benefit payments may be directly deposited into banking account
- Benefits are paid due to covered Injury or Sickness
- Benefits are payable year-round
- Secure online billing system available for your convenience
- Employees can file a claim, track the status of a claim, upload documentation and setup push notifications all within the AFMobile app available in the iTunes App store or Google Play store

Valuable Benefits Include

- Pregnancy Benefit
- Donor Benefit
- Worksite Accommodation Benefit Evaluation
- Social Security Filing Assistance
- Physician Expense Benefit Available up to $150 for Injury Up to 8 times per Year
- Accidental Death Benefit $10,000 Flat Amount if within 90 days of Covered Disability
- Waiver of Premium 180 Days
- Conversion Option
- American Fidelity Offers an Employee Assistance Program for Disability Insureds. This program includes (3) Confidential Telephonic Coaching sessions per issue per person, 24/7 Online and mobile app resources that provide access to libraries with more than legal and financial topics, and work-life library to address issues on parenting, child care, and workplace issues.

Underwriting Guidelines

- Guaranteed Issue underwriting allows an applicant, regardless of health history, to be guaranteed disability coverage when they are first eligible
- For all new groups, Monthly Indemnity amounts above the Guarantee Issue limit will be Subject to Health Questions.
- Monthly indemnity amounts may be increased up to $400 annually without health questions.
- All increases in monthly indemnity will be subject to a new Pre-Existing Condition Limitation.
- Takeover Credit for a prior carrier is available upon request/approval from American Fidelity.

Learn More

For additional information about American Fidelity Assurance Company, click here: https://americanfidelity.com/about-af/

Disability Income Insurance

Optional Benefit Riders

Hospital Indemnity Limited Benefit Rider

This rider is designed to pay a daily benefit amount for a Hospital Confinement, up to a maximum of 90 days, if you are confined to a Hospital.

Daily Benefit Amount	Monthly Premium
$150	$9.00

Summary of Hospital Indemnity Limited Benefit Rider Benefits:

Benefits are not payable for Injury or Sickness incurred in the first 12 months of coverage due to a pre-existing condition as defined in the base policy. Patient must be confined to a Hospital for a minimum of 18 hours and charged room and board.

Spousal Accident Only Disability Benefit Rider

This rider is designed to provide a monthly benefit if your spouse suffers a Disability due to a non-occupational accident.

Monthly Benefit Amount	Monthly Premium
$1,500	$12.00

Summary of Accident Only Spousal Benefit Rider Benefits:

Pays a monthly benefit amount to you for your spouse who is disabled as a result of a non-occupational accident. Benefits begin on the 31st consecutive day after the Injury and will continue for up to two years.

COBRA Funding Rider *(not available on plans with less than a 1 year benefit period)*

This rider is designed to help cover the cost of COBRA premiums if you elect COBRA coverage while you are receiving Disability Benefits.

Monthly Benefit Amount	Monthly Premium
$300	$4.50
$600	$9.00

Summary of COBRA Funding Rider Benefits:

In order to receive benefits under this Rider, you must: be receiving benefits under your Disability base plan; elect medical COBRA coverage; and be paying medical COBRA premiums. This benefit will pay up to the end of the disability benefit period or to the end of your medical COBRA benefit period, whichever occurs first.

Survivor Benefit Rider *(not available on plans with less than a 1 year benefit period)*

This rider is designed to provide a benefit to your beneficiary or estate, if you die while receiving Disability Benefits.

Monthly Benefit Amount	Monthly Premium
$2,000	$6.80

Summary of Survivor Benefit Rider Benefits:

Benefits are payable if you have been disabled and not working for at least 90 days, and die while receiving Disability Benefits. Pays a monthly benefit up to one year or until the maximum disability period is exhausted, whichever occurs first.

Critical Illness Benefit Rider

This rider is designed to provide a lump sum benefit based on diagnosis of a certain critical illness.

Benefit Amount	Monthly Premium
$10,000	$14.12
$15,000	$19.00
$20,000	$23.88
$25,000	$28.76

Summary of Critical Illness Benefit Rider Benefits:

Benefits are payable at a one-time lump sum benefit amount based on diagnosis of the following conditions Heart Attack, Stroke, Kidney Failure, Paralysis, or Major Organ Failure. In the case of Heart Attack, a physician must make the diagnosis and treatment must occur within 72 hours of the onset of symptoms.

Limitations and Exclusions

Hospital Indemnity Limited Benefit Rider

The Hospital Confinement Benefit will not be payable for an Injury or Sickness incurred in the first 12 months of coverage if the Injury or Sickness is caused by or resulting from a Pre-Existing Condition as defined in the Policy. In addition to the Exclusions listed in the Policy, no benefits will be payable under this Rider for any Hospital Confinement that is caused by or resulting from Mental Illness or Drug or Alcohol Abuse. Benefits are reduced by 50% at age 70. Successive Hospital stays will be considered as one confinement if they are separated by less than 90 days of confinement to a Hospital.

The term "Hospital" shall not include an institution used by you as a place for rehabilitation; a place for rest or for the aged; a nursing or convalescent home; a long-term nursing unit or geriatrics ward; or as an extended care facility for the care of convalescent, rehabilitative, or ambulatory patients.

Critical Illness Benefit Rider

The Critical Illness Rider will not be payable for any loss caused by or resulting from: (a) a Critical Illness when the Date of Diagnosis occurs during the Waiting Period; (b) a Critical Illness diagnosed outside of the United States; or (c) a Sickness or Injury not specifically defined in this Rider.

No Critical Illness Benefit will be payable for a Critical Illness which is caused by or resulting from a Pre-Existing Condition when the Critical Illness Date of Diagnosis occurs before you have been continuously covered under this Rider for 12 consecutive months. Following 12 consecutive months this exclusion does not apply.

Pre-Existing Condition means a disease, Injury, Sickness, physical condition or mental illness for which you have experienced any of the following: (a) treatment; (b) incurred expense; (c) took medication; (d) received care or services including diagnostic testing or related measures; or (e) received a diagnosis or advice from a Physician, during the 12-month period immediately before the Effective Date of this Rider. The term Pre-Existing Condition will also include conditions which are related to such disease, Injury, Sickness, physical condition or mental illness. Benefits reduce by 50% at age 70. No benefits will be paid for a Critical Illness when the Date of Diagnosis occurs during the Critical Illness Waiting Period. The waiting period is 30 days from the Effective Date of this Rider.

COBRA Funding Benefit Rider

Proof of election of medical COBRA continuation must be provided to American Fidelity. Proof of continued medical COBRA participation will be required before benefits are paid under this Rider. Your employment must have terminated for the benefit to be payable.

Spousal Accident Only Disability Benefit Rider

This Rider does not provide benefits for your Spouse for any Disability, fatal or non-fatal, which results from any of the following: (a) Intentionally self-inflicted Injury while sane or insane; (b) An act of war, declared or undeclared; (c) Injury sustained or contracted while in the service of the armed forces of any country; (d) Committing a felony; (e) Penal incarceration. American Fidelity will not pay benefits during any period for which your Spouse is incarcerated in a penal or correctional institution or for any Injury that occurs while your Spouse is incarcerated in a penal or correctional institution; (f) Injury arising out of and in the course of any occupation for wage or profit or for which your Spouse is entitled to Workers' Compensation. The term "entitled to Workers' Compensation" shall also include Workers' Compensation claim settlements which occur via compromise and release. Further, no benefits will be paid under this Policy for any period during which your Spouse is entitled to Workers' Compensation benefits; (g) Participation in any sport for wage or profit; (h) Participation in any contest of speed in a power driven vehicle for wage or profit.

Spouse means the person you are lawfully married to who is less than age 70. No benefits are payable for your Spouse under this Rider for a Disability from an Injury that occurred outside of the United States or its territories. No benefit will be provided for any period in which your Spouse is not under the regular and appropriate care of a Physician. No benefits will be paid for any Injury to your Spouse which is caused by or resulting from spousal abuse.

Survivor Benefit Rider

The Policy does not cover any loss, fatal or non-fatal, which results from: intentionally self-inflicted injury while sane or insane; an act of war, declared or undeclared; Injury sustained or Sickness contracted while in the service of the armed forces of any country; committing a felony; penal incarceration. American Fidelity will not pay benefits for Disability or any other loss for any period for which you are incarcerated in a penal or correctional institution for a period of 30 consecutive days or longer; or Injury or Sickness arising out of and in the course of any occupation for wage or profit or for which you are entitled to Workers' Compensation. No Disability Payment will be provided for any period in which you are not under the regular and appropriate care of a physician.

Termination

Your coverage with respect to the riders listed above will end on the earliest of these dates: the end of the last period for which premium has been paid; the date you notify us in writing to terminate coverage; the date the rider is discontinued; the date the policy is discontinued; or the date your employment terminates. Your coverage can be terminated or premiums may be increased on any premium due date with 31 days advance notice.

Availability of riders may vary by state, employer and short-term coverage with a benefit period of less than 12 months. Additional riders are subject to our general underwriting guidelines and coverage is not guaranteed. Riders have limitations, exclusions, and waiting periods. Refer to your policy for complete details. This brochure must be used in conjunction with a G-120 brochure. These Riders will terminate on the same date as the Policy or Certificate to which it is attached.

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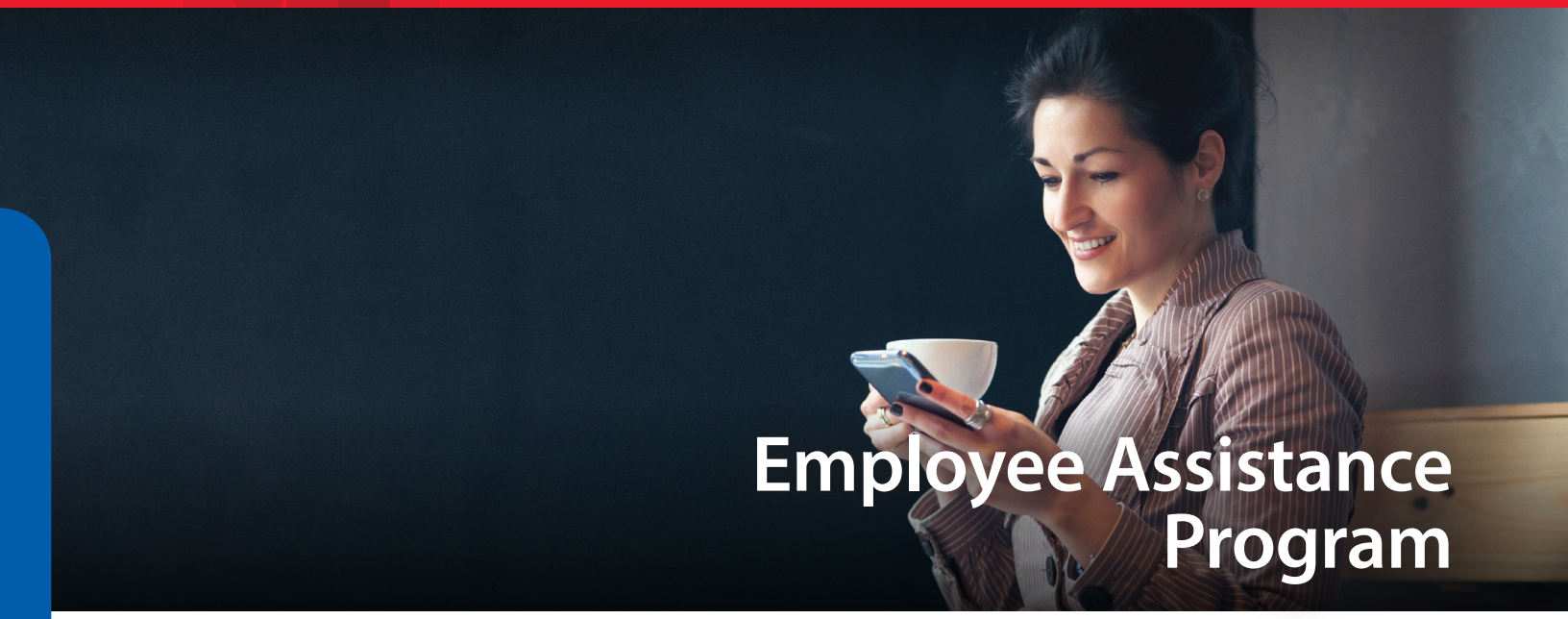

Employee Assistance Program

Help with everyday issues.

Your employer is offering you access to an Employee Assistance Program (EAP) to help you manage everyday issues from work-life balance to family concerns.

Telephonic Life Coaching

- Three phone sessions with a master's level certified life coach
- Participant and coach work together to develop personalized plan to meet participant's life goals
- Assist participant in exploring and identifying personal strengths and solutions
- Examples of life coaching issues include personal goals, relationship issues, adjusting to situations, career planning, and handling the workplace

24/7 Resources

- Online and mobile app
- Access to legal library on more than 900 legal topics, including legal guides, forms, and an interactive will program
- Access to financial library with 40 interactive tools and assessments, including articles, podcasts, and CDs on financial health topics
- Access to work-life library addressing issues on parenting, child care, elder care, and workplace issues

Work-Life Program

- Telephonic support for legal and financial issues
- Access to LifeWorks on-staff attorneys to discuss legal areas such as estate law, living wills/power of attorney, real estate law, family law, credit, and collections law
- Access and discount to network of 22,000 attorneys
- Access to LifeWorks on-staff financial counselors to discuss issues such as credit card debt, debt management, foreclosure, mortgage, budgeting, savings, and investing

This program is delivered by LifeWorks.

For More Information

800-456-0018
lifeworks.com
User ID: afac
Password: lifeworks

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SB-30187-1016

Marketed by American Fidelity Assurance Company

Limited Benefit Critical Illness Insurance

Being financially prepared for major medical events can be a challenge. Critical Illness Insurance may help provide relief for treatments that can cause financial hardship for your employees.

In addition to heart attack and stroke, Critical Illness Insurance offers benefits for other serious health events—including major organ failure, end stage renal failure, and major burns. Having the resources to cover these types of events can make all the difference for your employees' recovery.

Coverage Options

Coverage is available for everyone in your employees' immediate family—including their spouse—and eligible children are covered at no additional cost. Your employees can select a benefit amount for themselves up to $30,000. Spouses are covered at 50% of the employee's benefit amount, and children up to 25% of the benefit amount.

Premium rates are based on the Primary Insured's age, benefit amount, coverage level, and nicotine use.

Highlights

Health Screening Benefit

This benefit encourages early detection of serious illnesses by paying a benefit of $50 to the insured to help cover annual health screenings. This benefit also qualifies for our AFQuickClaims™ processing, which means policyholders may receive their benefit in as little as one day if enrolled in direct deposit.

Simplified Underwriting

No required medical exams during the application process, and only minimal health questions are asked.

Lump Sum Benefit

Many benefits are paid as a lump sum, so your employee can decide how the funds will be utilized.

Recurrent Diagnosis Benefit

Upon a second occurrence of certain illnesses, this benefit pays 50% of the amount previously paid under the policy.

About every 43 seconds, an American will suffer a heart attack.[2]

American Fidelity's Limited Benefit Group Critical Illness Insurance may contain limitations, exclusions and waiting periods. ***This product is inappropriate for people who are eligible for Medicaid coverage.*** *Group Critical Illness is only offered on an after-tax basis. [2]American Heart Association: Heart Disease and Stroke Statistics 2015 Update, p.e255. January 2015.*

Surviving a critical illness, such as heart attack or stroke, is becoming increasingly common with new medical technology. However, with advances in technology to treat these diseases, the cost of treatment rises more and more every year. Although many medical plans provide coverage for hospital stays and medical expenses arising from a critical illness, there are still out-of-pocket expenses that can affect anyone's finances.

Co-pays, transportation expenses, and lost income should be the last thing you or your family worries about if a critical illness were to occur. American Fidelity Assurance Company's Limited Benefit Group Critical Illness Insurance can help cover your out-of-pocket medical expenses and allow your family to focus on recovery.

Consider the Facts

About every 43 seconds, an American will suffer a heart attack.

American Heart Association: Heart Disease and Stroke Statistics p.e255. January 2015

Since 2015, more people with health insurance say they have a difficult time affording their health care costs, including their deductible. Council for Disability Awareness: Chances of Disability. Web. 19 Dec. 2016.

Kaiser Family Foundation: Beyond the ACA, the Affordability of Insurance Has Been Deteriorating Since 2015; March 2, 2017.

Critical Illness Insurance Proposal

Prepared for: **Anderson County**

Presented by: **American Fidelity**

Proposal Prepared on: **6/17/2019**

Proposed Effective Date: **7/1/2019**

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Group Critical Illness Insurance

How It Works

American Fidelity Assurance Company's Group Critical Illness Insurance is designed to pay a lump sum benefit amount to help your employees pay for the direct and indirect costs of a covered critical illness, including heart attack or stroke. Payments are made directly to employees, allowing them to decide how the funds will be utilized.

Approximately every 40 seconds, an American will have a heart attack.[1] American Fidelity's Group Critical Illness Insurance can help with the rising cost of treatment for a covered Critical Illness such as heart attack, stroke, or invasive cancer.

Critical Illness Features

- Benefit Amounts available up to $30,000. If elected, Spousal Benefit Amounts will be 50% of the Employee Benefit Amount.
- Eligible dependents are provided 25% of the Employee Benefit Amount at no additional cost.
- Lump sum benefit pays once per Covered Person for each Critical Illness. Critical Illness must be separated by at least 90 days following the first Critical Illness occurrence date.
- Pre-Existing Limitation of 12 months of continuous coverage and 12 months look back period.
- Coverage is portable.
- Wellness and health screening claims will receive quick processing when submitted through AFmobile® or americanfidelity.com. Benefit eligible claims can be received in as little as one day when employee is enrolled in direct deposit.
- Allows for convenient payroll deduction.
- Our Online Service Center (OSC) allows you to easily access employee data and billing information, helping you save time and the ability to manage all your benefits in one place.
- Compatible with a Health Savings Account.

WELLNESS SCREENING BENEFIT

This benefit covers several qualified tests, including, but not limited to,

- Electrocardiogram (EKG)
- Blood Glucose Testing
- Stress Test
- Echocardiogram

HEALTH SCREENING BENEFIT *(per calendar year per Covered Employee and Covered Spouse)*
$50

Underwriting

- Takeover Credit for prior coverage is available upon request / approval from American Fidelity.
- Guarantee Issue underwriting allows applicant to be guaranteed critical illness coverage when they are first eligible.
- Increases in coverage are Subject to Pre-Existing Limitations.
- No required medical exams are part of the application process.

[1] *American Heart Association: Heart Disease and Stroke Statistics 2017 At-a-Glance; January 25, 2017.*

Group Critical Illness Insurance

Critical Illness Benefits

Pays once per Covered Person for each Critical Illness shown below.

	Benefit Percentage	Recurrent Diagnosis Benefit
Heart Attack Benefit Pays full lump sum benefit amount.	100%	50%
Coronary Artery Bypass Surgery Pays 25% of benefit amount. Payment will reduce the Heart Attack Benefit.	25%	–
Stroke Benefit (Permanent damage due to a Stroke) Pays full lump sum benefit amount.	100%	50%
Paralysis Benefit (Permanent due to a Covered Accident) Pays full lump sum benefit amount.	100%	–
Major Organ Failure Benefit Pays full lump sum benefit amount.	100%	50%
End Stage Renal Failure Benefit Pays full lump sum benefit amount.	100%	–

EMPLOYEE MONTHLY RATES

	$10,000		$20,000		$30,000	
AGE	*Non-Tobacco*	*Tobacco*	*Non-Tobacco*	*Tobacco*	*Non-Tobacco*	*Tobacco*
18-29	$3.78	$5.98	$6.14	$10.54	$8.50	$15.10
30-39	$5.94	$9.42	$10.46	$17.42	$14.98	$25.42
40-49	$10.82	$17.06	$20.22	$32.70	$29.62	$48.34
50-59	$17.78	$28.18	$34.14	$54.94	$50.50	$81.70
60 & Over	$29.14	$46.14	$56.86	$90.86	$84.58	$135.58

SPOUSE MONTHLY RATES

	$5,000		$10,000		$15,000	
AGE	*Non-Tobacco*	*Tobacco*	*Non-Tobacco*	*Tobacco*	*Non-Tobacco*	*Tobacco*
18-29	$2.28	$3.96	$3.14	$6.50	$4.00	$9.04
30-39	$3.56	$6.24	$5.70	$11.06	$7.84	$15.88
40-49	$6.50	$11.36	$11.58	$21.30	$16.66	$31.24
50-59	$10.74	$18.74	$20.06	$36.06	$29.38	$53.38
60 & Over	$17.58	$30.70	$33.74	$59.98	$49.90	$89.26

Learn More

For additional information about American Fidelity Assurance Company, click here: http://americanfidelity.com/about-af/

Plans available to residents of: CO, ND, OH and TN. Products described in this proposal may not be available in all states. Specific policy provisions may vary by state. Proposal valid for 90 days or until the proposed effective date, whichever occurs later.

SB-32097 (GCI without Cancer)(CO, ND, OH, TN)-0319

Limited Benefit Hospital Indemnity Insurance

One of the challenges employers face is finding ways to help their employees cover the unexpected expenses that could arise from a hospital stay. With rising deductibles and as employees continue to take on more of the financial burden of medical expenses, the difficulty of paying for large, out-of-pocket costs is a challenge for most employees.

American Fidelity offers a solution with our hospital indemnity insurance.

AF™ Limited Benefit Group Hospital Indemnity Insurance is an HSA-qualified plan that pays benefits for expenses related to hospitalization, unexpected accidents, and certain high-dollar critical illnesses. It offers a way for employees to cover a portion of their healthcare costs without draining their HSA savings.

Coverage Options

We offer coverage for employees, their spouse, and children up to age 26. There are also three plan options to help your employees select the coverage that meets their family's needs.

Highlights

Health Screening Benefit

Pays a $50 benefit to help cover annual health screens. This benefit also qualifies for our AFQuickClaims™ processing.

HSA Compatible

Provides a way to help pay for large, out-of-pocket expenses, while allowing the tax benefit and potential savings of an HSA.

Guaranteed Issue

Obtain coverage without any health screenings or medical questions..

American Fidelity's Limited Benefit Hospital Indemnity Insurance may contain limitations, exclusions and waiting periods. ***This product is inappropriate for people who are eligible for Medicaid coverage.***

AF Hospital Assist™

Help pay for your stay

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EMPLOYER BENEFIT SOLUTIONS
FOR YOUR INDUSTRY

Are you financially prepared for a medical emergency?

If you experienced a medical emergency, would you be prepared to cover the out-of-pocket medical expenses? And, what about everything else that adds up, like bills, groceries, and housing?

Major medical insurance plans are designed to pay a large portion of your medical costs. But with a high deductible plan, you must pay out of your own pocket until you meet your deductible and plan maximum.

That's where AF Hospital Assist™ can help.

Health Savings Account Qualified Plan

This Health Savings Account (HSA) qualified plan provides a way to help pay for large, out-of-pocket expenses, like a hospital stay, while also getting the tax benefit and potential savings from an HSA.

Plan Highlights

- No health questions required to apply
- Benefits paid directly to you
- The treatment and surgical benefits included in this policy are for accident only
- Portable so you can take it with you even if you leave employment
- Health screening benefit
- Coverage available for you, your spouse, and your children up to age 26
- Online claims filing process

Cover your costs. Help protect your savings.

Help offset your high deductible, let your HSA savings grow, and give yourself a little protection for the unexpected.

Did you know?

Hospital stays in the United States average over $11,259.[1]

They're neither cheap nor predictable, but they happen. And often. In fact, over 35 million Americans were hospitalized in 2016.[2]

The premium and amount of benefits provided vary based upon the plan selected. This brochure highlights important features of the policy. Please refer to your certificate for complete details. If you reside in a state other than your employers state domicile, where required by law, policy provisions and benefits may vary.

Choose Your Coverage

Benefits are paid on a calendar year basis	Basic	Enhanced	Enhanced Plus
Hospital Admission 1 day/Covered Person	$500	$500	$500
Hospital Confinement Pays up to 30 days/ Covered Person	$150	$150	$150
ICU 10 days/Covered Person	$300	$300	$300
Rehab 10 days/Covered Person	$75	$75	$75
Accident Treatment - ER 3 days/Covered Person	-	$500	$500
Accident Treatment - Physician's Office or Urgent Care 6 days/Covered Person	-	$100	$100
Accident Surgery - Hospital or Ambulatory Surgical Center 3 days/Covered Person	-	$2,000	$2,000
Accident Surgery - Physician's Office or Urgent Care 6 days/Covered Person	-	$250	$250
Health Screening 1 day/Covered Person	$50	$50	$50
Critical Illness* 1 payment/Covered Person	-	-	$5,000

Refer to the Plan Benefit Highlights section for additional information.

Hospital Benefits

If hospitalized, you can get paid directly for the costs.

- Basic
- Enhanced
- Enhanced Plus

Hypothetical Example
You have a car accident and are rushed to the ER. You're admitted and stay 3 days for a back injury. Then, you complete 10 days of rehabilitation.

Cost of Care		Payable Plan Benefits		Your Deductible[3] $1,600
Confinement[4]	$11,259	Admission	$500	
Rehab[5]	$1,620	Confinement	$450	
		Rehab	$750	
Total	**$12,879**			Total benefit payment to you **$1,700**

Accident Benefits

Weekend warrior? Active family? Or a long daily commute? No matter your situation, accidents happen.

- Enhanced
- Enhanced Plus

Hypothetical Example
Your child fell on the playground and broke his arm. He went to the ER, then had surgery in the hospital to repair the broken arm.

Cost of Care		Payable Plan Benefits		Your Deductible[3] $1,600
ER Visit[6]	$1,233	ER Visit	$500	
Surgery[7]	$16,000	Surgery	$2,000	
Total	**$17,233**			Total benefit payment to you **$2,500**

Wellness Benefit/Health Screening

Are you putting your annual health screening off? With the $50, built-in wellness benefit, you get rewarded for taking care of yourself.

- Basic
- Enhanced
- Enhanced Plus

Critical Illness Benefit*

While no family history of an illness can be a factor, it's not a guarantee. Critical illnesses strike people of all ages and health types, regardless of family history. If diagnosed with cancer, heart attack, or stroke, you could help protect yourself with a lump sum for certain high-dollar illnesses.

- Enhanced Plus

AF Hospital Assist™ Premiums

Monthly Premium	Basic	Enhanced	Enhanced Plus
Employee	$16.12	$24.14	$31.12
Employee + Spouse	$31.26	$46.58	$65.32
Employee + Child	$29.56	$50.84	$58.34
Family	$44.70	$73.28	$92.54

Plan Benefit Highlights

Hospital Admission Benefit: We will not pay this benefit for outpatient treatment, emergency room treatment, or a stay of less than 18 hours in an observation unit. Successive hospital admissions will be considered as one admission if they are due to the same or related accident or sickness and separated by less than 90 days.

Hospital Confinement Benefit: We will not pay this benefit for outpatient treatment or a hospital stay of less than 18 hours. ***Hospital*** shall not include an institution used by you as a place for rehabilitation; a place for rest or for the aged; a nursing or convalescent home; a long-term nursing unit or geriatric ward; or an extended care facility for the care of convalescent, rehabilitative, or ambulatory patients.

Rehabilitation Facility Confinement Benefit: Confinement to the facility must be physician authorized for at least 18 continuous hours and begin immediately following a hospital confinement. Successive hospital admissions will be considered as one admission if they are due to the same or related accident or sickness and separated by less than 30 days.

Outpatient Accident Treatment Benefit: Pays a benefit when any covered person incurs an expense and receives treatment by a physician in an emergency room, physician's office or urgent care facility due to a covered accident. ***Accident*** means an event which results in bodily injury that is independent of disease or bodily infirmity or any other cause and occurs while coverage is in force.

Accident Surgical Procedure Benefit: Pays a benefit when any covered person incurs an expense and requires a surgical procedure due to a covered accident. The procedure must be performed by a Physician in a hospital, ambulatory surgical center, urgent care facility, or physician's office. We will pay for only one accident surgical procedure performed on the same day even if caused by more than one accident. We will not pay this benefit for colonoscopy or flexible sigmoidoscopy.

Critical Illness Benefit: Pays a benefit when any covered person is diagnosed with a covered Critical Illness. Benefits for a new occurrence of the same critical illness will only be provided if the critical illness is newly diagnosed during the calendar year in which a critical illness benefit hasn't been paid. ***Critical Illness*** means End Stage Renal Failure, Heart Attack, Major Organ Failure, Permanent Damage Due To a Stroke, Permanent Paralysis, Due to a covered Accident, Carcinoma In Situ or Invasive Cancer, as defined in the Policy, for which a positive diagnosis is made by a Physician. Metastasis of a previously diagnosed cancer will not be considered a new diagnosis of cancer.

Exclusions: We will not pay benefits resulting from or caused by:
(a) suicide or any attempt, while sane or insane;
(b) any intentionally self-inflicted injury or Sickness;
(c) voluntary abortion except, with respect to You or Your covered Dependent Spouse;
(1) where You or Your Dependent Spouse's life would be endangered if the fetus were carried to term; or
(2) where medical complications have arisen from abortion;
(d) participation in a riot, civil commotion, civil disobedience, or unlawful assembly. This does not include a loss which occurs while acting in a lawful manner within the scope of authority;
(e) commission of a felony;
(f) participation in a contest of speed in power driven vehicles, parachuting, or hang gliding;
(g) air travel, except:
(1) as a fare-paying passenger on a commercial airline on a regularly scheduled route; or
(2) as a passenger for transportation only and not as a pilot or crew member;
(h) elective procedures or cosmetic surgery, including complications of elective procedures or cosmetic surgery;
(i) experimental treatment, drugs, or surgery, except in connection with an approved cancer clinical trial;
(j) performance of military, naval, or air force service of any country;
(k) dental or routine vision services, unless:
(1) resulting from an Accident occurring while the Covered Person's coverage is in force and if performed within 12 months of the date of such Accident; or
(2) due to congenital disease or anomaly of a covered newborn child;
(l) immunizations, sports and routine annual physicals;
(m) artificial insemination, in vitro fertilization, test tube fertilization, sterilization, tubal ligation, or vasectomy, and reversal thereof;
(n) loss that takes place outside of North America;
(o) participation in any sport for pay or profit;
(p) alcoholism or drug use, unless such drugs were taken on the advice of a Physician and taken as prescribed;
(q) mental or emotional disorders without demonstrable organic disease;
(r) air or ground ambulance;
(s) Pre-Existing Conditions, unless the Covered Person has satisfied the Pre-Existing Condition Exclusion period of 12 months.
Pre-Existing Condition means a disease, Sickness, Accident, or physical condition for which you: had treatment; incurred expense; took medication; or received a diagnosis or advice from a physician, during the 12 month period immediately before your effective date of coverage. The term pre-existing condition will also include conditions which are related to such disease, Sickness, Accident, or physical condition.

*The critical illness benefit is only offered on an after-tax basis. This product may contain limitations, exclusions and waiting periods. **This product is inappropriate for people who are eligible for Medicaid coverage.** [1]AHRQ Healthcare Cost and Utilization Project, National Inpatient Sample as of November 10, 2017. [2]American Hospital Association: Fast Facts on U.S. Hospitals, 2018. [3]Deductible amount based on an average High Deductible Health Plan. [4]AHRQ Healthcare Cost and Utilization Project, National Inpatient Sample as of November 10, 2017. [5]MD Save: Procedures A to Z; accessed 10/3/2018 from MDsave.com. [6]Healthcare Bluebook: Emergency Room Visit – Moderate Problem; Accessed March 22, 2017 from www.healthcareblubook.com. [7]CostHelper: How Much Does a Broken Arm Cost?; accessed 10/3/2018 from health.costhelper.com. CostHelper: How Much Does a Broken Arm Cost?

Pregnancy Limitation:
For the Pregnancy Limitation Period, 10 months, the Company will not pay benefits due to any Covered Person giving birth as a result of a normal pregnancy, including cesarean section. Complications of Pregnancy will be covered to the same extent as any other covered benefit. Complications of Pregnancy includes but is not limited to, conditions requiring Confinement (when pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as preeclampsia, acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, ectopic pregnancy which is terminated, spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible, puerperal infection, eclampsia and toxemia.

Complications of Pregnancy shall not include false labor, occasional spotting, cesarean delivery unrelated to a diagnosed complication of pregnancy, Physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, and similar conditions associated with the management of a difficult pregnancy not constituting a classifiably distinct Complication of Pregnancy.

Termination of Insurance
Coverage for you and your covered dependent(s) may be continued during a layoff or leave of absence for up to a maximum period of 3 months. Coverage will continue as long as the group policy remains in force, the premiums are paid and you remain eligible for the coverage under the policy. Your coverage will end when you no longer qualify as an insured, you retire, you are not on active employment, or your employment terminates. Your coverage can be terminated or premiums may be increased on any premium due date with 31 days advance notice.

American Fidelity Assurance Company
9000 Cameron Parkway, Oklahoma City, Oklahoma 73114
800-662-1113 • **americanfidelity.com**

Limited Benefit Accident Only Insurance

Whether your employees are weekend warriors with active lifestyles or just have busy families, accidents can happen anytime. These unexpected injuries can be costly, and being prepared can make all the difference. American Fidelity's Accident Only Insurance provides your employees with a financial solution to cover the accidents that life sometimes delivers.

This plan offers a wide range of benefits including:

- Medical Imaging
- Inpatient Confinement
- Air and Ground Ambulance
- Transportation Benefits
- Family Member Lodging and Meals

Coverage Options

We offer coverage for employees, their spouse, and eligible children. There are also three plan options to help your employees select the coverage that meets their family's needs.

Highlights

Wellness Benefit

This benefit pays an annual benefit for a routine physical exam including immunizations and preventive testing. This benefit also qualifies for our AFQuickClaims™ processing, which means policyholders may receive their benefit in as little as one day if enrolled in direct deposit.

Sports-Related Injuries

Participating in recreational sports can often result in unexpected injuries. This plan is designed to give your employees and their family's peace-of-mind by covering many accidental sports-related injuries.

24-Hour Coverage

Accidents can happen anytime, on or off the job. Our 24-hour coverage ensures that eligible injuries are covered for your employees and their families.**

Accidental Death & Dismemberment

This benefit pays a lump sum amount for all covered persons in the event of death or dismemberment within 90 days of an accident.

Medical expenses average $4,425 per unintentional injury. [4]

This product may contain limitations, exclusions, and waiting periods. ***This product is inappropriate for people who are eligible for Medicaid Coverage.*** *** After satisfying the Elimination Period chosen at time of application. [4]National Safety Council, Injury Facts, 2016 Edition.*

Accident Only Insurance

Limited Benefit Accident Only Insurance

AMERICAN FIDELITY
a different opinion™

EMPLOYER BENEFIT SOLUTIONS FOR YOUR INDUSTRY

Life Provides the Accidents

Whether you're a weekend warrior with an active lifestyle or just a busy family, accidents can happen to you anytime, anywhere, without warning. Being prepared for the unexpected can make all the difference.

You cannot plan for when an accident will happen, but you can start preparing for an unexpected medical expense! American Fidelity Assurance Company's Limited Benefit Accident Only Insurance Plan provides coverage for you and your family to help with those unforeseen accident expenses. Start providing financial protection today for you and your family if an accident suddenly occurs.

How is an Accident Defined?

An Accident is defined as a sudden, unexpected and unintended event, which results in bodily injury, which is independent of disease or bodily infirmity or any other cause.*

How Would You Cover Your Out-of-Pocket Costs?

Just going for a walk around the block or heading to your driveway could lead to a twisted knee and torn meniscus, one of the more common claims submitted under this plan. See how it works!

Consider the facts

Medical expenses averaged $5,550 per unintentional injury in 2013.[1]

Plan Options

You can take advantage of the following options to extend coverage to your family:

- **Individual Plan**
  The Insured, age 18 through 64, at the date of policy issue, is the only Covered Person.
- **Individual and Spouse Plan**
  The Insured and your Spouse, age 18 through 64, at the date of policy issue.
- **Individual and Child(ren) Plan**
  The Insured, age 18 through 64, at the date of policy issue, and each Eligible Child, as defined in the policy.
- **Family Plan**
  The Insured and Spouse, age 18 through 64, at the date of policy issue, and Eligible Child, as defined in the policy.

WELLNESS BENEFIT

You can receive a benefit for your annual routine physical exam, including immunizations and preventative testing. Requires a 30 day waiting period before use.

BASIC
(once per policy per calendar year)
$50

ENHANCED & ENHANCED PLUS
(once per policy per calendar year)
$75

The premium and amount of benefits provided vary based upon the plan selected.

[1] *National Safety Council, Injury Facts, 2015 Edition, p. 2-6.*
** Policyholders please refer to your certificate for your state's specific policy definition.*

Schedule of Benefits for Policy and Benefit Enhancement Rider*, **

ACCIDENT BENEFIT	Basic	Enhanced	Enhanced Plus
EMERGENCY ACCIDENT TREATMENT			
Emergency Accident Treatment	$150	$200	$250
Emergency Accident Follow-up Treatment *(up to four treatments)*	$50	$50	$50
NON-EMERGENCY ACCIDENT TREATMENT			
Non-Emergency Accident Initial Treatment	$75	$100	$125
Non-Emergency Follow-up Treatment *(up to two treatments)*	$50	$50	$50
MEDICAL IMAGING			
MRI, CT, CAT, PET, US	$200	$200	$200
X-Rays	$50	$100	$150
HOSPITAL CONFINEMENT			
Hospital Admission	$500	$1,000	$1,500
Intensive Care Unit *(up to 15 days)*	$300	$600	$900
Hospital Confinement *(up to 365 days)*	$100	$200	$300
AMBULANCE			
Ground	$300	$300	$300
Air	$1,500	$1,500	$1,500
TREATMENT			
Outpatient Hospital or Ambulatory Surgical Center	$150	$250	$350
Anesthesia	$150	$200	$250
TRANSPORTATION BENEFITS			
Transportation *Patient only, per round trip for up to 3 round trips per calendar year*	$300	$300	$300
Family Member Lodging and Meals *Per day per accident; up to 30 days per confinement*	$100	$100	$100

ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT			
BASIC	**PRIMARY**	**SPOUSE**	**CHILD**
Common Carrier	$50,000	$50,000	$25,000
Other Accident	$15,000	$15,000	$7,500
Dismemberment	$1,000 to $15,000	$1,000 to $15,000	$500 to $7,500
ENHANCED	**PRIMARY**	**SPOUSE**	**CHILD**
Common Carrier	$100,000	$100,000	$50,000
Other Accident	$30,000	$30,000	$15,000
Dismemberment	$1,500 to $30,000	$1,500 to $30,000	$750 to $15,000
ENHANCED PLUS	**PRIMARY**	**SPOUSE**	**CHILD**
Common Carrier	$200,000	$200,000	$100,000
Other Accident	$60,000	$60,000	$30,000
Dismemberment	$2,000 to $60,000	$2,000 to $60,000	$1,000 to $30,000

Benefit amounts for the following Benefits are the same for Basic, Enhanced, and Enhanced Plus Plans for all covered persons.	Benefit Amounts
ACCIDENT TREATMENT BENEFITS	
Fractures Benefit *Depending on open or closed reduction, bone involved, or chip fracture*	$25 to $3,000
Lacerations Benefit *Not requiring sutures* *Sutured lacerations up to two inches* *Sutured lacerations totaling two to six inches* *Sutured lacerations totaling over six inches*	$25 $100 $200 $400
Appliances Benefit *Crutches, leg braces, etc.*	$100
Torn Knee Cartilage or Ruptured Disc Benefit	$500
Eye Injury Benefit *Injury with surgical repair, for one or both eyes* *Removal of foreign body by a physician, for one or both eyes*	$250 $50
Dislocations Benefit *Depending on open or closed reduction, with or without anesthesia and joint involved. No other amount will be paid under this benefit.*	$25 - up to $3,000
Concussion Benefit	$200
2nd & 3rd Degree Burns *Skin grafts are 25% of benefit*	$100 to $10,000
Internal Injuries Benefit *Resulting in open abdominal or thoracic surgery*	$1,000
Paralysis Benefit: Paraplegia / Quadriplegia	$5,000 / $10,000
Tendons, Ligaments, and Rotator Cuff Benefit *One tendon, ligament, or rotator cuff* *More than one tendon, ligament, or rotator cuff*	$500 $750
Blood, Plasma, and Platelets	$250
Exploratory Surgery without Surgical Repair	$250
Physical Therapy *Per treatment up to eight treatments*	$25
Prosthesis	$500
Emergency Dental Work *Broken teeth repaired with crown* *Extraction of broken teeth (regardless of number)*	$150 $50

*Refer to Plan Benefit Highlights section for more Benefit Descriptions on the Accident Only Insurance Policy and Benefit Enhancement Rider.
**The premium and amount of benefits provided vary based upon the plan selected.

Enhance Your Plan

Optional Catastrophic Accident Disability Income Rider***

This rider covers you 24-hours a day and pays a Monthly Benefit Amount if you become Totally Disabled due to Injuries received in a Covered Accident after satisfying the Elimination Period you choose at time of application.

COVERAGE OPTIONS		
MONTHLY BENEFIT AMOUNT	ELIMINATION PERIOD	COVERAGE OPTIONS
$1,500	0 Days or 14 Days	Individual or Individual & Spouse

Summary of Catastrophic Accident Disability Income Rider Benefits:

- To be eligible for this coverage, the Monthly Benefit Amount cannot exceed 60% of the Primary Insured's monthly salary.
- The maximum period of time that benefits will be paid for one period of Total Disability due to a Covered Accident is 12 months.
- Total Disability must begin within 90 days after such Covered Accident.
- If you choose to extend coverage to a Spouse, the Spouse's Monthly Benefit Amount is 50% ($750) of the Primary Insured's Benefit Amount. The spouse must be covered under base policy (AO-03 Series).

**Refer to Plan Benefit Highlights section for more Benefit Descriptions on the Accident Only Insurance Policy and Benefit Enhancement Rider. **The premium and amount of benefits provided vary based upon the plan selected. ***Rider(s) are subject to our general underwriting guidelines and coverage is not guaranteed. Guaranteed Renewable until the primary insured reaches age 70.*

Plan Benefit Highlights for Policy and Benefit Enhancement Rider

Wellness Benefit

After coverage is in force for the waiting period shown, you can receive a benefit for one Covered Person's annual routine physical exam, including immunizations and preventive testing. Services must be supervised by a Physician and a charge must be incurred for the service. The benefit does not apply to dental or eye exams and is payable once per policy per calendar year.

Accident Emergency Treatment Benefit

Payable for receiving emergency treatment in a Physician's office or emergency room within 72 hours, including physician fees and emergency services.

Accident Follow-up Treatment Benefit

Payable for necessary follow-up treatment of Injuries in addition to the emergency treatment administered within 72 hours for up to four treatments. Not payable for a visit in which a Physical Therapy Benefit or Non-Emergency Follow-Up Benefit is paid.

Non-Emergency Accident Initial Treatment Benefit

Payable for a Covered Person who receives initial medical treatment for Injuries sustained in a Covered Accident when such treatment is received more than 72 hours after the Covered Accident. Initial medical treatment must: (1) be received in a Physician's office or emergency room for Injuries sustained in a Covered Accident; and (2) be the first treatment received by the Covered Person for such Injuries; and (3) occur within 30 days following the Covered Accident. Payable once per Covered Person per Covered Accident.

Non-Emergency Accident Follow-up Treatment Benefit

Payable only if the Non-Emergency Accident Initial Treatment Benefit is payable and later a Covered Person requires additional treatment: we will pay over and above the initial medical treatment administered. We will pay for up to two treatments provided by a Physician per Covered Person per Covered Accident. Not payable for the same visit that the Physical Therapy Benefit or the Accident Follow-Up Benefit is paid.

Plan Benefit Highlights for Policy and Benefit Enhancement Rider Cont'd.

Hospital Admission Benefit

Pays an indemnity amount per admission when the Covered Person is confined to a Hospital as a result of a Covered Accident. Pays once per Covered Person per Covered Accident. This benefit does not pay for outpatient treatment, emergency room treatment, or a stay of less than 18 hours in an observation unit.

Intensive Care Confinement Benefit

Pays an indemnity amount per day for each day of confinement in an Intensive Care Unit, as defined in the policy, up to 15 days per Covered Person per Covered Accident. This benefit is paid in addition to the Hospital Confinement Benefit.

Hospital Confinement Benefit

Pays an indemnity amount per day of confinement when confined for at least 18 hours, up to 365 days per Covered Person per Covered Accident. A hospital is not an institution, or part thereof, used as: a hospice unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; a rehabilitative facility; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial, educational care, or care or treatment for persons suffering from mental diseases or disorders, or care for the aged, or drug or alcohol addiction.

Medical Imaging Benefit

Payable for a Covered Person who has either a Magnetic Resonance Imaging (MRI), a Computed Tomography (CT) scan, a Computed Axial Tomography (CAT) scan, a Positron Emission Tomography (PET) scan or an ultrasound when performed due to injuries received in a Covered Accident.

Ambulance Benefit

If air and ground ambulance transportation is required for the same Covered Accident, only the highest benefit will be paid.

Transportation Benefit

Payable for the transportation of a Covered Person who requires specialized treatment and Hospital Confinement in a non-local Hospital due to Injuries sustained in a Covered Accident. A non-local Hospital must be at least 50 miles away, one way, using the most direct route, from the closer of the Covered Person's residence or site of the Covered Accident. Travel must be by scheduled bus, plane, train, or by car. Ambulance service does not qualify for this benefit. The treatment must be prescribed by a Physician and not be available locally.

Family Member Lodging and Meals Benefit

Payable for lodging and meals for a family member to be near a Covered Person who is Hospital Confined in a non local Hospital. The Hospital must be at least 50 miles away, one way, using the most direct route from the closer of the Covered Persons residence or site of the Covered Accident.

Accidental Death and Dismemberment Benefit

The applicable benefits apply when a Covered Person's Accidental Death or Dismemberment occurs within 90 days of a Covered Accident. In the event that Accidental Death and Dismemberment result from the same Covered Accident, only the Accidental Death Benefit will be paid.

Fractures Benefit

Varies based on the bone involved, type of fracture and type of treatment. If the Covered Person fractures more than one bone in a Covered Accident, payment is made for all fractures up to two times the amount for the bone involved that has the highest benefit amount. All fractures must be treated by a Physician.

Lacerations Benefit

This benefit varies based on the severity of the laceration, due to a covered accident. The lacerations must be repaired or treated by a Physician.

Appliances Benefit

Payable for one of the following: crutches, leg braces, back braces, walkers, or wheel chairs. Not payable for Prosthetic Devices. This benefit is payable only once per Covered Person per Covered Accident.

Torn Knee Cartilage or Ruptured Disc Benefit

Payable for surgical repair performed by a Physician as a result of a Covered Accident.

Eye Injury Benefit

Payable for one or both eyes requiring treatment by a Physician due to a Covered Accident.

Plan Benefit Highlights for Policy and Benefit Enhancement Rider Cont'd.

Dislocations Benefit

Amount payable varies by the joint involved, type of treatment, and type of anesthesia. If a Covered Person receives more than one Dislocation in a Covered Accident, we will pay for all Dislocations up to two times the amount shown in the Schedule of Benefits for the Dislocation involved that has the highest benefit amount. No other amount will be paid under this benefit. Benefits are payable only for the first dislocation of a joint which occurs while this policy is in force.

Concussion Benefit

Payable for a Covered Person who sustains a concussion and is diagnosed by a Physician within 72 hours of the Covered Accident using any type of medical imaging.

Burns Benefit

Payable for 2nd and 3rd degree burns received in a Covered Accident when treated by a Physician within 72 hours.

Internal Injuries Benefit

Payable for an open abdominal or thoracic surgery performed within 72 hours of a Covered Accident.

Paralysis Benefit

The duration of the Paralysis must be a minimum of three consecutive months. Paid once per lifetime per Covered Person.

Tendons, Ligaments and Rotator Cuff Benefit

Pays an indemnity amount for the repair of one or more tendons, ligaments, or rotator cuffs per Covered Person per Covered Accident. The tendons, ligaments, or rotator cuff must be treated by a Physician and repaired through surgery.

Blood, Plasma and Platelets Benefit

Pays an indemnity benefit per Covered Person per Covered Accident for blood, plasma and platelets. This benefit does not provide benefits for immunoglobulins. This benefit is payable once per Covered Person per Covered Accident.

Emergency Dental Work Benefit

Pays an indemnity amount for a Covered Person for repair to natural teeth when treated by a Physician or dentist and that is a result of Injuries sustained in a Covered Accident. Initial dental treatment must be received within 72 hours of the Covered Accident. Benefits are paid only once per Covered Person per Covered Accident.

Exploratory Surgery Benefit

Pays an indemnity benefit per Covered Person per Covered Accident when an exploratory surgical operation without surgical repair is performed on a Covered Person for Injuries sustained in a Covered Accident. This benefit is payable for only one exploratory surgery without surgical repair per Covered Person per Covered Accident.

Prosthesis Benefit

Pays an indemnity benefit for a Covered Person who requires the use of a Prosthesis as a result of Injuries sustained in a Covered Accident. This benefit is payable only once per Covered Person per Covered Accident. This benefit is not payable for hearing aids; dental aids; eye glasses; false teeth; or for cosmetic aids such as wigs.

Physical Therapy Benefit

Pays an indemnity amount for one treatment per day for up to eight treatments by a caregiver licensed in physical therapy when advised by a Physician for Injuries sustained in a Covered Accident. This benefit is not payable for the same visit that the Accident Follow-up Treatment Benefit or Non-Emergency Follow-Up Benefit is paid.

Other Benefits include:

- Ambulatory Surgical Center Benefit
- X-ray
- Anesthesia Benefit

All benefits are only paid as a result of Injuries received in an Accident that occurs while coverage is in force. All treatment, procedures, and medical equipment must be diagnosed, recommended and treated by a Physician. All benefits are paid once per Covered Person per Covered Accident unless otherwise specified in the Schedule of Benefits or Plan Benefits section. Premium and amount of Benefits may vary dependent upon Plan selected.

See your policy for more information regarding the benefits listed above.

Plan Benefit Highlights for Policy and Benefit Enhancement Rider Cont'd.

Limitations and Exclusions

Base Policy and Benefit Enhancement Rider

An Accident is defined as a sudden, unexpected and unintended event, which results in bodily injury, which is independent of disease or bodily infirmity or any other cause. The policy will not pay benefits for injuries received prior to the Effective Date of coverage that are aggravated or re-injured by any event that occurs after the Effective Date.

No benefits will be provided if the Covered Person becomes totally disabled due to a Covered Accident that is caused by or occurs as a result of: intentionally self-inflicted bodily injury, suicide or attempted suicide, whether sane or insane; participation in any form of flight aviation other than as a farepaying passenger in a fully licensed/passenger-carrying aircraft; any act that was caused by war, declared or undeclared, or service in any of the armed forces; participation in any activity or event while under the influence of any narcotic unless administered by a Physician or taken according to the Physician's instructions; participation in, or attempting to participate in, a felony, riot or insurrection (A felony is as defined by the law of the jurisdiction in which the activity takes place.); participation in any sport for pay or profit; participation in any contest of speed in a power-driven vehicle for pay or profit; participation in parachuting, bungee jumping, rappelling, mountain climbing or hang gliding.

Benefits will not be paid for medical treatment for an Accident received outside the United States or its territories. Benefits will not be paid for services rendered by a member of the immediate family of a Covered Person.

Catastrophic Accident Disability Income Rider

An Accident is defined as a sudden, unexpected and unintended event, which results in bodily injury, which is independent of disease or bodily infirmity or any other cause. This policy will not pay benefits for Injuries received prior to the Effective Date of coverage that are aggravated or re-injured by any event that occurs after the Effective Date.

No benefits will be provided if the Covered Person becomes totally disabled due to an Accident that is caused by or occurs as a result of: intentionally self-inflicted bodily injury, suicide or attempted suicide, whether sane or insane; participation in any form of flight aviation other than as a fare-paying passenger in a fully licensed/passenger-carrying aircraft; any act that was caused by war, declared or undeclared, or service in any of the armed forces; participation in any activity or event while under the influence of any narcotic unless administered by a Physician or taken according to the Physician's instructions; participation in, or attempting to participate in, a felony, riot or insurrection (A felony is as defined by the law of the jurisdiction in which the activity takes place.); participation in any sport for pay or profit; participation in any contest of speed in a power-driven vehicle for pay or profit; participation in parachuting, bungee jumping, rappelling, mountain climbing or hang gliding.

Benefits will not be paid for services rendered or Total Disability verified by a member of the immediate family of a Covered Person. Benefits will not be provided for medical treatment or Total Disability for an Accident received outside the United States or its territories. Benefits provided by the Catastrophic Accident Disability Income Rider will only be paid for one disability at a time, even if the Covered Person becomes Totally Disabled due to more than one injury or more than one Covered Accident. Benefits are not payable due to an accident occurring during any period of time the Covered Person is incarcerated in any type of penal institution or due to an Accident that occurs while the Covered Person is incarcerated in any type penal institution.

The Covered Person must be age 69 or under; and Total Disability must begin within 90 days of the Covered Accident. For Covered Persons with full-time employment, Totally Disabled (Total Disability) means the Covered Person is unable to perform the material and substantial duties of his or her occupation due to injuries received in a Covered Accident. Full-time employment means the Covered Person works at a job an average of 15 or more hours per week for wages or benefits.

For Covered Persons without full-time employment, Totally Disabled (Total Disability) means that, due to Injuries received in a Covered Accident, the Covered Person is unable to safely perform one or more Activities of Daily Living without another person's stand-by assistance or verbal cueing. The inability to perform a task must be generally recognized by the medical profession as a consequence of the disabling Accident. Activities of Daily Living, as defined in the rider, are: Continence; Transferring; Dressing; Toileting; and Eating. The Covered Person also must be under the Regular Care and Attendance of a Physician for the Covered Person's condition.

If a break in Total Disability occurs during the Elimination Period without the Elimination Period being satisfied, no benefits will be considered for losses that recommence beyond the first 90 days following the Covered Accident.

The Maximum Benefit Period is the maximum number of months for which benefits will be paid for any one period of Total Disability or Successive Disability. Each new Maximum Benefit Period will require the satisfaction of a new Elimination Period.

Accident Only Insurance Premiums* for Policy and Benefit Enhancement Rider

MONTHLY PREMIUMS	Basic	Enhanced	Enhanced Plus
Individual	$19.90	$26.10	$33.40
Individual & Spouse	$28.30	$34.90	$41.90
Individual & Child(ren)	$31.50	$41.00	$51.30
Family	$39.90	$49.80	$59.90

Optional Catastrophic Accident Disability Income Rider Monthly Premiums*

ELIMINATION PERIOD	Individual	Individual & Spouse
0 Days	$18.76	$30.46
14 Days	$12.46	$20.26

**The premium and amount of benefits provided vary based upon the plan selected.*

Guaranteed Renewable

You are guaranteed the right to renew your base policy during your lifetime as long as you pay premiums when due or within the premium grace period. You cannot be singled out for a rate increase for any reason. Rates can be changed only if rates for all policies in this class change.

This is a brief description of the coverage. For complete benefits and other provisions, please refer to the policy. This coverage does NOT replace Workers' Compensation Insurance. **This product is inappropriate for people who are eligible for Medicaid coverage.** Availability of riders may vary by state and employer.

View and print your policies or file a claim at americanfidelity.com

American Fidelity's Online Service Center provides you convenient, secure access to manage your account.

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Policy Form Series AO-03 with AMDI-258 Rider and AMDI224 Rider
013-383, 013-384, 013-385

SB-26051(TN)-1116

Limited Benefit Cancer Insurance

Even with a high-quality medical insurance plan, a cancer diagnosis can be costly. That's why it is important to offer a Limited Benefit Cancer Insurance plan to help cover the rising costs of cancer treatment.

The plan has 30 benefits specifically designed to help your employees and their families with the financial aspect of being diagnosed with cancer, and allow them to focus on their treatment. These benefits extend beyond treatment, and cover other costs associated with a cancer diagnosis such as travel and lodging. All benefits are paid directly to the employee, which allows them to use the funds where they are needed most.

Examples of benefits include:

- Inpatient Confinement
- Drugs and Medicine
- Transportation and Lodging

Coverage Options

We offer coverage for employees, their spouses, and eligible children. There are three plan options—Basic, Enhanced and Enhanced Plus—so your employees can choose the plan that best fits their financial needs.

Highlights

Diagnostic Testing Benefit

This benefit encourages early detection of cancer by paying an benefit to the insured to help cover annual diagnostic testing, screening, or follow-up. This benefit also qualifies for our AFQuickClaims™ processing, which means policyholders may receive their benefit in as little as one day if enrolled in direct deposit.

Experimental Treatment Benefit

Traditionally, major medical insurance does not cover costs associated with experimental treatments and drugs related to cancer. This policy covers experimental treatment so your employees have the opportunity to receive the best available treatment to meet their needs.

Travel Expenses

Often, the best cancer treatments available require patients to travel far from home. Travel expenses can be costly and are generally not covered by major medical plans. This benefit may help pay for transportation and lodging expenses for the patient and family.

More than one-quarter of cancer patients can't afford to pay for their treatment. [5]

This product may contain limitations, exclusions, and waiting periods. ***This product is inappropriate for people who are eligible for Medicaid Coverage.*** *[5]UPI: Study: One-quarter of cancer patients can't afford treatment; June 3, 2016.*

Cancer Insurance

Limited Benefit Dread Disease
Cancer Indemnity Insurance

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a different opinion

EMPLOYER BENEFIT SOLUTIONS FOR YOUR INDUSTRY

Cancer can be a costly disease.

A cancer diagnosis may be both a physical and emotional drain. Thanks to advances in medicine and procedures to treat cancer, more and more people are beating the disease. However, with the arrival of these advances also comes the continuing rise in the cost of cancer treatment.

The financial impact of a cancer diagnosis can affect anyone's financial situation. American Fidelity Assurance Company's Limited Benefit Cancer Insurance may offer a solution to help you and your family focus on fighting the disease. This plan may assist with the expenses that may not be covered by other medical insurance.

Over 1.6 million new cases of cancer will be diagnosed this year.*

Did You Know?

According to the American Institute for Cancer Research about one-third of cases of the most common cancers in the U.S. could be prevented by eating healthy, being active, and staying lean.** It is essential to have a plan in place that could help if you were diagnosed.

How It Works

This plan is designed to help cover expenses, should you be diagnosed with cancer. With more than 25 built-in plan benefits, this plan provides benefits for the treatment of cancer, transportation, hospitalization, and more.

In addition, this is a portable plan, so you own the policy. You can take the coverage with you if you choose to leave your current job, and your premiums will not increase because you left your employment.

American Fidelity's Limited Benefit Cancer Insurance features:

- Benefits paid directly to you, to be used however you see fit.
- Policy is guaranteed renewable for as long as premiums are paid as required.
- The company has the right to change premium rates by class.
- Employee, Single Parent, and Family plans are available.

SCREENING BENEFIT+

Receive a benefit for your annual internal cancer screening test, including but not limited to Mammogram, PAP, Prostate-Specific Antigen Blood Test (PSA), Chest X-ray, Flexible Sigmoidoscopy, ThinPrep Pap test, and Colonoscopy.

DIAGNOSTIC AND PREVENTION BENEFIT *(per calendar year)*		
Basic	**Enhanced**	**Enhanced Plus**
$45	$60	$75

Plan Options

You can take advantage of the following options to extend coverage to your family:

- **Individual Plan**
  The Insured, age 18 through 70, at the date of policy issue, is the only Covered Person.
- **Single Parent Family Plan**
  The Insured, age 18 through 70, at the date of policy issue, and each Eligible Child, to age 26, or as defined in the policy.
- **Family Plan**
  The Insured and spouse age 18 through 70, at the date of policy issue, and Eligible Child, to age 26, or as defined in the policy.

**American Cancer Society: Cancer Facts and Figures 2017, pg. 1. **American Institute for Cancer Research: For Cancer Prevention Month; accessed at www.aicr.org January 31, 2017 +The premium and amount of benefits vary based upon the plan selected.*

Schedule of Benefits by Plan+

	Basic	Enhanced	Enhanced Plus
SCREENING BENEFITS			
Diagnostic and Prevention Benefit *(one per calendar year)*	$45	$60	$75
Cancer Screening Follow-Up Benefit *(one per calendar year)*	$45	$60	$75
TREATMENT BENEFITS			
Radiation Therapy/Chemotherapy/Immunotherapy Benefit Administered by Medical Personnel at a Medical Facility Self Injected/Oral/Pump/Implant *Maximum 4 days per calendar month*	$200 per day $200 per day;	$300 per day $300 per day;	$400 per day $400 per day;
Medical Imaging Benefit *(per image - max 2 per calendar year)*	$100	$200	$300
Hormone Therapy Benefit *(per treatment - max 12 treatments/calendar year)*	$50	$50	$50
Treatment Management/Lab Work Benefit *(per calendar month)*	$50	$75	$100
Blood, Plasma, and Platelets Benefit *(per day)* *(per calendar year max)*	$100 $5,000	$150 $7,500	$200 $10,000
Experimental Treatment Benefit	Paid as any non-experimental benefit		
Bone Marrow/Stem Cell Transplant Benefit **Autologous** *(Patient provided) (per calendar year)* **Non-autologous** *(Donor provided) (per calendar year)*	$500 $1,500	$1,000 $3,000	$1,500 $4,500
Donor Benefit	$1,000 per donation		
Inpatient Special Nursing Services Benefit *(benefit per day while Hospital Confined)*	$150	$150	$150
Dread Disease Benefit *(benefit per day for the first 30 days per Hospital Confinement)* *(benefit per day thereafter)*	$100 $200	$200 $400	$300 $600
HOSPITALIZATION BENEFITS			
Hospital Confinement Benefit*** *(per day for the first 30 days)* *(per day after the first 30 days of Hospital Confinement)*	$100 $200	$200 $400	$300 $600
Drugs & Medicine Benefit **Hospital Confinement** *(per Confinement)* **Outpatient** *(per prescription - $50 monthly max for Basic; $100 for Enhanced; $150 for Enhanced Plus) per calendar month*	$100 $50	$200 $50	$300 $50
Attending Physician Benefit *(per day while Hospital Confined)*	$30	$40	$50
U.S. Government/Charity Hospital or HMO Benefit *(per day in lieu of most benefits)* **Hospital Confinement** **Outpatient Services**	$100 $100	$200 $200	$300 $300
AMBULANCE, TRANSPORTATION, & LODGING BENEFITS			
Ambulance Benefit *(per trip - max 2 trips any combination per confinement)* **Ground** **Air**	$200 $2,000	$200 $2,000	$200 $2,000
Transportation & Lodging Benefit (Patient and/or Family) **Transportation** *($1,500 max per round trip; max 12 trips/calendar year)* **Outpatient Lodging** *(per day up to 90 days per calendar year)*	Coach fare or $.50/mile by car $40	Coach fare or $.50/mile by car $60	Coach fare or $.50/mile by car $80

Schedule of Benefits by Plan+ (continued)

	Basic	Enhanced	Enhanced Plus
SURGICAL TREATMENT BENEFITS			
Surgical Benefit *Unit Dollar Amount (per surgical unit)* *Maximum Per Operation*	 $20 $2,000	 $30 $3,000	 $40 $4,000
Anesthesia Benefit	25% of the amount paid for covered surgery		
Outpatient Hospital or Ambulatory Surgical Center Benefit *(per day)*	$200	$400	$600
Second & Third Surgical Opinion Benefit *(per diagnosis)* *(Additional $300 for 3rd if required)*	$300	$300	$300
CONTINUING CARE BENEFITS			
Prosthesis Benefit **Non-Surgical** *(per device - 1 per site, lifetime max of 3)* **Surgical Implantation** *(per device, includes surgical fee - 1 per site, lifetime max of 2)* **Hair Prosthesis** *(once per life)*	 $100 $1,000 $100	 $150 $1,500 $150	 $200 $2,000 $200
Extended Care Facility Benefit *(per day for up to the same number of days of paid Hospital Confinement)*	$50	$75	$100
Physical or Speech Therapy Benefit *(per visit up to 4 per calendar month - lifetime max of $1,000)*	$25	$25	$25
Hospice Care Benefit *ay - $9,000 lifetime max for Basic; $13,500 lifetime max for Enhanced; $18,000 lifetime max for Enhanced Plus)*	$50	$75	$100
Home Health Care Benefit *(per day for up to the same number of days of paid Hospital Confinement)*	$50	$75	$100

Refer to Plan Benefit Highlights for more complete Benefit Descriptions and limits on the Cancer Insurance Plan.

Enhance your plan++

Critical Illness Rider

Thanks to medical technology, more people are surviving critical illnesses. This rider is designed to help with the cost associated with surviving these types of illnesses.

Schedule of Benefits	
Cancer Benefit *(per unit - maximum $10,000)*	$2,500
Heart Attack/Stroke Benefit *(per unit - maximum $10,000)*	$2,500

Summary of Critical Illness Rider Benefits:

- Pays when diagnosed after 30-day Critical Illness Waiting Period with Internal Cancer or Heart Attack/Stroke, depending upon the Critical Illness coverage elected at time of application.
- Pays the specified Maximum Benefit Amount per Covered Critical Illness, as defined under this rider.
- Each benefit is a one-time paid benefit.
- All Critical Illness amounts reduce by 50% at age 70.

+The premium and amount of benefits provided vary based upon the plan selected.
++Availability of riders may vary by state and employer. Additional riders are subject to our general underwriting guidelines and coverage is not guaranteed.

Plan Benefit Highlights

Diagnostic, Prevention and Cancer Screening Follow-Up Benefits

Pays the indemnity amount for one generally medically recognized internal Cancer screening test per Covered Person per Calendar Year. Tests include but are not limited to Mammogram, ThinPrep Pap test, Prostate Specific Antigen Blood test (PSA), Colonoscopy, and Chest X-ray. Refer to the policy for a complete listing. Screening tests payable under this benefit will ONLY be paid under this benefit and does not include any test payable under the Medical Imaging Benefit. Benefits will only be paid for tests performed after the 30-day period following the Covered Person's effective date of coverage.

Cancer Screening Follow-Up Benefit pays the indemnity amount for a Covered Person to receive one invasive follow-up test needed due to an abnormal covered cancer screening result. Diagnostic surgeries which result in a positive diagnosis of Cancer will be paid under the Surgical Benefit.

Radiation/Chemotherapy/Immunotherapy Benefit

Pays the indemnity amount when a Covered Person receives Radiation Therapy, Chemotherapy, or Immunotherapy as defined in the policy. We will pay this benefit only once per day regardless of the number of treatment received on that day. Benefits for oral and topical Chemotherapy are only paid on the day the prescription is filled or if dispensed and administered by a pump on the day the pump is initially filled or refilled. Benefits for implants are only paid on the day of implantation. This benefit is payable in or out of the Hospital. Design and construction of treatment devices, radiation dosimetry calculation, lab tests, x-rays, and scans, are not covered under this benefit. Anti-nausea drugs are not covered under this benefit. This benefit does not include any drugs/medicines covered under the Drugs and Medicine Benefit or the Hormone Therapy Benefit.

Medical Imaging Benefit

Pays the indemnity amount for a Covered Person who has been diagnosed with Cancer who receives either an MRI; CT scan; CAT scan; or PET scan when done at the request of a Physician due to Cancer or the treatment of Cancer.

Hormone Therapy Benefit

Pays the indemnity amount for hormone therapy treatment as defined in the policy, prescribed by a Physician following a diagnosis of Cancer. This benefit covers drugs and medicines only and not associated administrative processes. This benefit does not include drugs/medicines covered under the Radiation Therapy/Chemotherapy/ Immunotherapy Benefit or the Drugs and Medicine Benefit.

Treatment Management/Lab Work Benefit

Pays the indemnity amount once per calendar month, when the Covered Person is receiving Radiation/Chemotherapy/Immunotherapy Treatment that month, for related procedures such as treatment planning, treatment management, etc. Medical supplies and equipment used in administration, such as IV solutions, needles, dressings, pumps and catheters, are not covered under this benefit.

Blood, Plasma, and Platelets Benefit

Pays the indemnity amount for blood, plasma and platelets. This does not include any laboratory processes. Colony stimulating factors are not covered under this benefit. Benefits for Blood, Plasma and Platelets are ONLY provided under this benefit.

Bone Marrow Benefit/Stem Cell Transplant Benefit

Pays the indemnity amount when a bone marrow transplant or peripheral blood stem cell transplant is performed on a Covered Person as treatment for a diagnosed Cancer. This benefit will not be paid for the harvest of bone marrow or stem cells from a donor.

Hospital Confinement Benefit

Pays the indemnity amount for a Covered Person while confined to a Hospital for at least 18 continuous hours for the treatment of Cancer. ***A Hospital is not an institution, or part thereof, used as: a hospice unit, including any bed designated as a hospice or swing bed; a convalescent home; a rest or nursing facility; a rehabilitative facility; an extended care facility; a skilled nursing facility; or a facility primarily affording custodial, educational care, or care or treatment for persons suffering from mental diseases or disorders, or care for the aged, or drug or alcohol addiction.

Drugs and Medicines Benefit

Pays the indemnity amount for anti-nausea and pain medication prescribed by a Physician for a Covered Person for treatment of Cancer, who is also receiving Radiation Therapy/Chemotherapy/ Immunotherapy, a covered surgery, or a Bone Marrow/ Stem Cell Transplant. This benefit does not cover associated administrative processes. This benefit does not include drugs/ medicines covered under the Radiation/Chemotherapy/ Immunotherapy Benefit or the Hormone Therapy Benefit.

Attending Physician Benefit

Pays the indemnity amount for one Physician's visit per day when a Covered Person requires the services of a Physician, other than a surgeon while Hospital Confined for the treatment of Cancer.

U.S. Government/Charity Hospital /HMO Benefit

If an itemized list of services is not available because a Covered Person is: confined in a charity Hospital or U.S. Government owned Hospital; or covered under a Health Maintenance Organization (H.M.O.) or Diagnostic Related Group (D.R.G.) where no charges are made to the Covered Person, the Primary Insured may convert benefits under the policy to pay the indemnity amount shown. This benefit will be paid in lieu of most benefits under the policy.

Ambulance Benefit

Pays the indemnity amount per day for either licensed air or ground ambulance transportation of a Covered Person to a Hospital or from one medical facility to another where the Covered Person is admitted as an Inpatient and confined for at least 18 consecutive hours for treatment of Cancer.

Transportation and Lodging Benefits

These benefits pay for the transportation of a Covered Person and/ or one adult family member when the Covered Person has been diagnosed with Cancer and receives covered Radiation Therapy, Chemotherapy, Immunotherapy, Bone Marrow/Stem Cell Transplant, or surgery due to Cancer in the nearest non-local Physician prescribed Hospital providing such treatment that is at least 50 miles away from the Covered Person's residence, using the most direct route. Travel must be by scheduled bus, plane or train, or by car and be within the United States or its Territories. Benefits will be provided for only one mode of transportation per round trip and will be paid for up to 12 round trips per Calendar Year. Benefits for travel of the Covered Person and/or family member will be paid: once per Covered Person's Hospital Confinement; or only on days of the Covered Person's outpatient specialized treatment. Benefits for lodging of the Covered Person and/or family member will be paid: once per Covered Person's Hospital Confinement; or only on days of the Covered Person's outpatient specialized treatment. If the family member and the Covered Person travel in the same car or lodge in the same room, benefits for travel and lodging will only be paid under the Transportation and Lodging Benefit for the patient.

Plan Benefit Highlights (continued)

Surgical Benefit

Pays an indemnity benefit up to the Maximum Per Operation amount shown in the Schedule of Benefits in the policy when a surgical operation is performed on a Covered Person for covered diagnosed Cancer, Skin Cancer, or reconstructive surgery due to Cancer. Benefits will be calculated by multiplying the surgical unit value assigned to the procedure, as shown in the most current Physician's Relative Value Table, by the Unit Dollar Amount shown in the Schedule of Benefits. Two or more surgical procedures performed through the same incision will be considered one operation and benefits will be limited to the most expensive procedure. Diagnostic surgeries that result in a negative diagnosis of Cancer are not covered under this benefit. Any diagnostic surgery covered under the Diagnostic and Prevention Benefit will not be covered under this benefit. Bone marrow surgeries are paid under the Bone Marrow Transplant Benefit. Surgeries required to implant a permanent prosthetic device are covered under the Prosthesis Benefit.

Anesthesia Benefit

The Anesthesia benefit pays 25% of the amount paid for a covered surgery for the services of an anesthesiologist. Services of an anesthesiologist for bone marrow transplants, Skin Cancer, or surgical prosthesis implantation are not covered under this benefit.

Outpatient Hospital or Ambulatory Surgical Center Benefit

Pays the indemnity amount shown towards the facility fee charges of an Ambulatory Surgical Center or Hospital for an outpatient surgical procedure of a diagnosed Cancer. Surgical procedures for Skin Cancer are not covered under this benefit.

Second and Third Surgical Opinion Benefit

Pays the indemnity amount once per diagnosis for a Covered Person's second surgical opinion and if the second disagrees with the first, a third opinion, when the attending Physician recommends surgery for the treatment of Cancer. Surgical opinions for reconstructive, Skin Cancer, or prosthesis surgeries are not covered under this benefit.

Prosthesis Benefits

Pays the indemnity amount for a prosthetic device received due to Cancer that manifested after the 30th day following the Effective Date, and it's surgical implantation if required as a direct result of surgery for Cancer. This benefit does not cover prosthetic related supplies. Temporary prosthetic devices used as tissue expanders are covered under the Surgical Benefit. **Hair Prosthesis** benefit pays the indemnity amount for a Covered Person's hair prosthesis needed as a direct result of Cancer or the treatment of Cancer. This benefit is payable once per Covered Person per lifetime.

Extended Care Facility Benefit

Pays the indemnity amount for each day room and board charges are incurred while a Covered Person is confined in an Extended Care Facility due to Cancer at the direction of a Physician that begins within 14 days after a covered Hospital Confinement. Paid for up to the same number of days benefits were paid or the Covered Person's preceding Hospital Confinement.

Physical or Speech Therapy Benefit

Pays the indemnity amount if a Physician advises a Covered Person to seek physical therapy or speech therapy. Physical or speech therapy must be performed by a caregiver licensed in physical or speech therapy and be needed as a result of Cancer or the treatment of Cancer. We will pay for one treatment per day up to four treatments per calendar month per Covered Person for any combination of physical or speech therapy treatments up to a lifetime maximum of $1,000.

Hospice Care Benefit

Pays the indemnity amount for Hospice Care directed by a licensed Hospice organization, as defined in the policy, of a Covered Person expected to live six months or less due to Cancer. This benefit does not include: well baby care; volunteer services; meals; housekeeping services; or family support after the death of the Covered Person.

Home Health Care Benefit

Pays the indemnity amount for a Covered Person's Home Health Care, as described in the policy, required due to Cancer when prescribed by a Physician in lieu of Hospital Confinement beginning within 14 days after a Hospital Confinement. This benefit does not include physical or speech therapy. This benefit does not include nutrition counseling; medical social services; medical supplies; prosthesis or orthopedic appliances; rental or purchase of durable medical equipment; drugs or medicines; child care; meals or housekeeping services. This benefit will be paid for up to the same number of days benefits were paid for the Covered Person's preceding Hospital Confinement. If the Covered Person qualifies for coverage under the Hospice Care Benefit, the Hospice Care Benefit will be paid in lieu of this benefit.

Waiver of Premium

If the Primary Insured becomes disabled due to Cancer and remains so for more than 90 continuous days, we will pay all premiums due after the 90th day so long as the Primary Insured remains disabled. "Disabled" means the Primary Insured's inability because of Cancer: to work at any job for which (s)he is qualified by education, training or experience; and under the care of a Physician for the treatment of Cancer. This policy must be in force at the time disability begins and the Primary Insured must be under age 65.

Experimental Treatment Benefit

We will provide coverage for Experimental Treatment prescribed by a Physician, as defined in the policy, the same as any other benefit covered under this policy. This benefit does not provide coverage for treatments received outside of the United States or its territories.

Donor Benefit

Pays the indemnity amount shown for a donor's expenses incurred on behalf of a Covered Person for a covered surgery due to organ transplant or a Bone Marrow/Stem Cell Transplant. Blood donor expenses are not covered under this benefit.

Dread Disease Benefit

Pays an indemnity amount for each period of Hospital Confinement for treatment of a Dread Disease as defined in the policy, including: Addison's Disease, Amyotrophic Lateral Sclerosis, Cystic Fibrosis, Diphtheria, Encephalitis, Grand Mal Epilepsy, Legionnaire's Disease, Meningitis, Multiple Sclerosis, Muscular Dystrophy, Myasthenia Gravis, Niemann-Pick Disease, Osteomyelitis, Poliomyelitis, Reye's Syndrome, Rheumatic Fever, Rocky Mountain Spotted Fever, Sickle Cell Anemia, Systemic Lupus Erythematosus, Tay-Sachs Disease, Tetanus, Toxic Epidermal Necrolysis, Toxic Shock Syndrome, Tuberculosis, Tularemia, Typhoid Fever, and Whipple's Disease. Benefits for Dread Disease are ONLY provided under this benefit.

Inpatient Special Nursing Services Benefit

Pays the indemnity amount shown for Full-time special nursing care (other than that regularly furnished by a Hospital) while a Covered Person is Hospital Confined for treatment of Cancer. "Full-time" means at least eight consecutive hours during a 24 hour period. Care must be provided by a Nurse, as defined by the Policy, be prescribed by a Physician and be Medically Necessary for the treatment of Cancer.

See your policy for more information regarding the benefits listed above.

Limitations and Exclusions

Eligibility

This policy will be issued only to those persons who meet American Fidelity's insurability requirements, which includes satisfactory responses to medical questions.

Cancer means a disease which is manifested by autonomous growth (malignancy) in which there is uncontrolled growth, function, or spread (local or distant) of cells in any part of the body. This includes Cancer in situ and malignant melanoma. It does not include other conditions which may be considered precancerous or having malignant potential such as: leukoplakia; hyperplasia; acquired immune deficiency syndrome (AIDS); polycythemia; actinic keratosis; myelodysplastic and non-malignant myeloproliferative disorders; aplastic anemia; atypia; non-malignant monoclonal gamopathy; carcinoid; or pre-malignant lesions, benign tumors or polyps.

This product is inappropriate for those people who are eligible for Medicaid Coverage.

Base Policy

All diagnosis of Cancer must be positively diagnosed by a legally licensed doctor of medicine certified by the American Board of Pathology or American Board of Osteopathic Pathology. This policy pays only for loss resulting from definitive cancer treatment including direct extension, metastatic spread or recurrence. Proof must be submitted to support each claim. This policy also covers other conditions or diseases directly caused by Cancer or the treatment of Cancer. This policy does not cover any other disease, sickness or incapacity even though after contracting cancer it may have been aggravated or affected by Cancer or the treatment of Cancer except for conditions specifically stated in the Dread Disease Benefit.

No benefits are payable for any Covered Person for any loss incurred during the first year of this policy as a result of a Pre-Existing Condition. A Pre-Existing Condition is a Cancer or Dread Disease for which, within 12 months prior to the Effective Date of coverage, medical advice, consultation or treatment, including prescribed medications, was recommended by or received from a member of the medical profession; or for which symptoms manifested in such a manner as would cause an ordinarily prudent person to seek diagnosis, medical advice or treatment. Conditions revealed in the application will be covered unless specifically excluded in the rider. Pre-Existing Conditions specifically named or described as excluded in any part of this contract are never covered.

This policy contains a 30-day waiting period during which no benefits will be paid under this policy. If any Covered Person has a Specified Disease diagnosed before the end of the 30-day period immediately following the Covered Person's Effective Date, coverage for that person will apply only to loss that is incurred after one year from the Effective Date of such person's coverage. If any Covered Person is diagnosed as having a Specified Disease during the 30-day period immediately following the Effective Date, you may elect to void the policy from the beginning and receive a full refund of premium. All benefits payable only up to the maximum amount listed in the Schedule of Benefits in the policy.

Critical Illness Rider

Benefits will only be paid for a Covered Critical Illness as shown on the Policy Schedule page in the policy. No benefits will be provided for any loss caused by or resulting from: intentionally self-inflicted bodily injury, suicide or attempted suicide, whether sane or insane; or intentional self-injury; or alcoholism or drug addiction; or act of war declared or undeclared or any act related to war; or military service for any country at war; or a Pre-Existing Condition during the 12 month period following the Covered Person's Effective Date under this rider (Pre-Existing Condition, as used in this rider means any sickness or condition for which, within 12 months prior to the Effective Date of coverage under this rider, medical advice, consultation or treatment, including prescribed medications, was recommended by or received from a member of the medical profession, or for which symptoms manifested in such a manner as would cause an ordinarily prudent person to seek diagnosis, medical advice or treatment.); or a Covered Critical Illness when the Date of Diagnosis occurs during the Waiting Period, if applicable; or participation in any activity or event while intoxicated or under the influence of any narcotic unless administered by a Physician or taken according to the Physician's instructions; or participation in, or attempting to participate in, a felony, riot or insurrection (A felony is as defined by the law of the jurisdiction in which the activity takes place.) Critical Illness Waiting Period will not exceed 30 days. Internal Cancer does not include: other conditions that may be considered pre-cancerous or having malignant potential such as: acquired immune deficiency syndrome (AIDS); or actinic keratosis; or myelodysplastic and non-malignant myeloproliferative disorders; or aplastic anemia; or atypia; or non-malignant monoclonal gamopathy; or pre-malignant lesions, benign tumors or polyps; or Leukoplakia; or Hyperplasia; or Carcinoid; or Polycythemia; or cancer in situ or any skin cancer other than invasive malignant melonoma into the dermis or deeper.

Termination of Insurance

This policy/rider(s) will terminate and coverage will end for all Covered Persons on the earliest of: the end of the grace period if the premium remains unpaid; or the end of the Policy/Rider(s) Month in which we receive a written request from you to terminate this policy/rider(s); or the date of your death, if this is an Individual Plan; or the date insurance has ceased on all persons covered under this policy/rider(s).

Guaranteed Renewable

You are guaranteed the right to renew your base policy during your lifetime as long as you pay premiums when due or within the premium grace period. We have the right to increase premiums by class.

Cancer Insurance Premiums

Base Plan Monthly Premiums*

	Basic			
	Age 18–40	Age 41–50	Age 51–60	Age 61+
Individual	$11.30	$16.10	$21.80	$29.30
Single Parent Family	$16.90	$23.90	$32.50	$43.70
Family	$22.00	$31.00	$42.20	$56.80

	Enhanced			
	Age 18–40	Age 41–50	Age 51–60	Age 61+
Individual	$15.70	$22.90	$31.60	$43.30
Single Parent Family	$23.30	$34.00	$47.10	$64.50
Family	$30.30	$44.20	$61.20	$84.00

	Enhanced Plus			
	Age 18–40	Age 41–50	Age 51–60	Age 61+
Individual	$20.10	$29.70	$41.50	$57.30
Single Parent Family	$29.90	$44.30	$61.90	$85.60
Family	$38.90	$57.50	$80.50	$111.30

View and print your policies or file a claim at americanfidelity.com

American Fidelity's Online Service Center provides you convenient, secure access to manage your account.

Optional Benefit Rider Monthly Premiums*

Critical Illness Rider

Rates based on One Unit *(One Unit = $2,500; Two Units = $5,000; Three Units = $7,500; Four Units = $10,000)*

	Age 18–40		Age 41–50		Age 51–60		Age 61+	
	Cancer	Heart Attack/ Stroke	Cancer	Heart Attack/ Stroke	Cancer	Heart Attack/ Stroke	Cancer	Heart Attack/ Stroke
Individual	$1.50	$0.80	$3.00	$2.10	$4.90	$3.10	$7.10	$4.60
Single Parent Family	$2.20	$1.20	$4.50	$3.10	$7.30	$4.60	$10.60	$6.90
Family	$2.90	$1.50	$5.80	$4.10	$9.40	$6.00	$13.80	$8.90

**The premium and amount of benefits provided vary based upon the plan selected.*

This is a brief description of the coverage. For complete benefits and other provisions, please refer to the policy and rider. This coverage does not replace Workers' Compensation Insurance. ***These products are inappropriate for people who are eligible for Medicaid Coverage.***

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9000 Cameron Parkway
Oklahoma City, Oklahoma 73114
800-654-8489
americanfidelity.com

Policy Form Series C12D
Plan Codes 013-753, 013-754, 013-755

SB-29620(TN)-0818

Life Insurance

Offering Group Life Insurance to your employees may not be enough to fully protect their loved ones in their absence. An individual life policy can increase the overall benefit amount while giving them a policy that they own. American Fidelity offers policies designed for your employees, spouses, and children – making it convenient for them to provide life insurance protection for their entire family. Only three health questions are required to issue coverage, and your employees don't have to participate in any medical exams.

Term Life Insurance

Often, your employees need life insurance coverage to help during a specific period when their expenses are usually at their highest. Making sure everyday living expenses, like home ownership and college tuition, are covered in their absence is paramount. With a Term Life insurance policy, your employees will have the ability to customize the plan that works best for their situation.

Whole Life Insurance

Whole Life insurance provides your employees a life insurance benefit to age 121 and will provide a cash benefit at time of maturity. There are also options for loans and partial surrender if needed. The cash value allows your employee the flexibility to stop paying premiums and still have some life insurance coverage in force.

Highlights

Interim Coverage*

Death Benefit coverage is issued immediately after the life insurance application has been signed and underwriting guidelines have been met.

Level Premium

American Fidelity's Term Life and Whole Life Premium rates are locked in at the time of purchase, and will not increase for the duration of the policy term.

Guaranteed Renewable

Our term life policies are guaranteed renewable, which means your employees can renew for another term period without reapplying. The renewal premium is subject to increase.

Interim coverage for death will be in force from the date your application is signed if on such date the proposed insured is insurable per our underwriting guidelines for the requested coverage in accordance with the terms of the policy. This interim coverage for death will remain in force until the earlier of: 1) the date a policy becomes effective; 2) the date we decline the application; or 3) the date we notify the proposed insured that they are ineligible for interim coverage. The employee and/or Spouse/Civil Union Partner must remain actively at work during the interim coverage period. If the death of the proposed insured occurs during the interim coverage period, the first month's premium will be subtracted from the policy proceeds.* ***Interim coverage is only for death benefits under the base policy, Children's Term Rider and Spouse Term Rider (Term Life Only). No interim coverage benefits are available under any Waiver of Premium Rider, Accidental Death and Dismemberment Rider, Accelerated Benefit Rider for Critical Illness (Whole Life Only) or Accelerated Benefit Rider for Long Term Illness (30YR Term Life and Whole Life Only).* *This product may contain limitations, exclusions, and waiting periods. Not generally qualified benefits under Section 125 Plans.*

Term Life Insurance

10, 20 & 30 Year Renewable & Convertible Term Life Insurance

For Illinois Applicants: We will treat a party to a civil union and a spouse in a marriage equally in our policies that are governed by your state. We will include a party to a civil union in any definition or use of the terms "spouse," "family," "immediate family," "dependent," "next of kin," and any other terms descriptive of spousal relationships in our policies. Any policies providing coverage for children will extend eligibility for coverage to children of civil unions.
DN88.R0916

SB-30355-0917 (AWD)

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EMPLOYER BENEFIT SOLUTIONS FOR YOUR INDUSTRY

Why Term Life Insurance

Life insurance is an important piece of a strong financial plan. While there is no complete replacement for the loss of a loved one, American Fidelity Assurance Company's Term Life Insurance can help protect your family in your absence. It provides short-term coverage at a very competitive price. For those on a limited budget, Term Life Insurance can help fill temporary needs.

62% of adults in the United States have no individual life insurance.[1]

Did You Know?

Almost **2 out of 3** people say the life insurance they receive from their employer is not enough.[2]

Life insurance provided by your employer is an important benefit. However, it may not be enough protection to provide for your loved ones.

A term life policy can help supplement your existing coverage and can assist in meeting financial demands, should you need it. Plus, this is an individual policy which means you own it and can take it with you to a different job or in retirement.

Financial Protection for You

American Fidelity's Term Life Insurance is a great option for your working and earning years when expenses are usually at their highest.

With our Term Life Insurance, premiums will remain the same for the initial term period selected.[3] The death benefit will not change for the life of the policy, and death benefits are generally paid tax free.

Why You Need Life Insurance

Consider the following expenses when choosing the right life insurance plan for you.

Final Expenses
Funeral Costs
Unpaid Medical Bills

Self Time
Time to Grieve
Housing Decision

Income Replacement
Mortgage/Rent
Other Loans

Nest Egg
Estate Planning
Income Replacement

Three Easy Steps to Get Covered

1 Select a Term Period
Choose from a 10, 20, or 30 year term.

2 Answer Three Health Questions[4]
Only three health questions are required to issue coverage, and you don't have to participate in any invasive medical exams.

3 Get Death Benefit Coverage Immediately[5]
Your death benefit coverage starts when you sign the application.

[1]LIMRA: 2015 Insurance Barometer Study; April 2015. [2]LIMRA: 2014 Insurance Barometer Study April 2014 [3]Premiums are subject to increase upon renewal. *[4]Issuance of the policy may depend on the answer to these questions. [5]Interim coverage for death will be in force from the date your application is signed if on such date the proposed insured is insurable per our underwriting guidelines for the requested coverage in accordance with the terms of the policy. This interim coverage for death will remain in force until the earlier of: 1) the date a policy becomes effective; 2) the date we decline the application; or 3) the date we notify the proposed insured that they are ineligible for interim coverage. The employee and/or spouse must remain actively at work during the interim coverage period. If the death of the proposed insured occurs during the interim coverage period, the first month's premium will be subtracted from the policy proceeds. Interim coverage is only for death benefits under the base policy, Children's Term Rider and Spouse Term Rider. No interim coverage benefits are available under any Waiver of Premium Rider, Accidental Death and Dismemberment Rider, or Accelerated Benefit Rider for Long Term Illness.*

EMPLOYEE ISSUE AGES
10 Year Term: 17-65* *20 Year Term: 17*-60* *30 Year Term: 17*-50*

EMPLOYEE ISSUE MAXIMUM
Ages 17-49: $200,000* *Ages 50-65: $100,000*

GUARANTEED LEVEL DEATH BENEFIT
You will receive the full face amount of your policy. (Provided no accelerated benefits are paid.)

SPOUSE ISSUE AGES AND MAXIMUMS
*Ages 17**-49: $50,000* *Ages 50-60: $25,000*

RATES BASED ON ISSUE AGE AND TOBACCO STATUS
Your premiums will be based on your age on the date your policy becomes effective. You can be eligible for reduced rates if you are a non-tobacco user.

RENEWABLE AND CONVERTIBLE[6]
You may renew your coverage to age 90. You may convert to a whole life policy prior to age 70.

Enhance Your Plan[8]

Waiver of Premium Rider

This rider waives the premium if the base Insured becomes totally disabled, as defined in the rider, for at least six consecutive months. Premiums are waived for the base policy and any attached riders. Issue age is 17-60. The rider terminates at age 65.

Accidental Death and Dismemberment Rider

This rider provides coverage upon death, dismemberment, or paralysis of the base Insured prior to age 70 if such death, dismemberment, or paralysis results from accidental causes, as defined in the rider. This rider also provides an additional seatbelt benefit, if the police accident report certifies the base Insured was wearing a properly fastened seatbelt at time of death. Benefits are payable once per Covered Accident.

Spouse Term Rider

This rider provides level Term Life Insurance coverage on your spouse. The premiums for this rider are based on the spouse's age and tobacco usage. Coverage may be renewed for each additional renewal period up to the spouse's age 90, while the base policy is in force. [6]Premiums adjust upon renewal. Face amount must be equal to or less than the base policy.

Children's Term Rider

This rider provides level Term Life Insurance protection for all your eligible children who are between the ages of one month through age 19 (in MI and PA age 17; MA and WA age 14). Coverage remains on each child until age 26 or marriage of the child prior to age 26. Your covered child may also convert this rider for up to five times the amount of coverage (subject to a $100,000 limit overall) to any form of permanent insurance offered by American Fidelity for conversions. One premium covers all eligible children. Three benefit levels are available: $10,000, $20,000, and $30,000 ($15,000 in WA).

Accelerated Benefit Rider for Long Term Illness

(Available with 30-Year Term Life Only)

This rider provides for two equal advances of a portion of the base policy's death benefit due to a Long Term Illness if we receive satisfactory proof of Long Term Illness prior to each annual payment. Coverage is available on the base Insured only.

SAMPLE 20-YEAR TERM NON-TOBACCO MONTHLY PREMIUM RATES[7]

	$25K+	$50K+	$100K	$150K
25	$8.25	$11.00	$20.00	$24.50
35	$9.25	$13.00	$24.00	$30.50
45	$14.50	$24.00	$46.00	$63.50
55	$30.25	$55.50	$109.00	n/a

+Shaded amounts available for spouse base policy purchases.

[6]Premiums remain level for the initial term period selected. If you choose the 10 or 20 Year Term Life Plan, the renewal date will be every 10 or 20 years until the policy anniversary following age 70 or 60 respectively. Thereafter, premiums are renewable annually. The 30 Year Term Life Plan is renewable annually after the initial term period. All term plans expire the policy anniversary following age 90. Rates will be adjusted on each renewed term period; [7]Example is based on a 20-year term, monthly, non-tobacco, base policy with no attached riders. For specific ages, rates, term periods or face amounts, see your American Fidelity account manager. [8]Additional riders are subject to our general underwriting criteria and coverage is not guaranteed. Rider availability may vary by state. ***In the states of AK, AR, CO, IA, KS, MN, MO, NH, OR, PA, RI, SC, TN and WI, the minimum issue age for younger employees is 18. **In the states of MO and PA, the minimum issue age for younger spouses is 18.**

Accelerated Benefit Summary and Disclosure Notice

Accelerated Benefit Summary and Disclosure Notice

THIS DOCUMENT SERVES ONLY AS A SUMMARY AND A DISCLOSURE NOTICE. PLEASE REFER TO YOUR POLICY OR RIDER FOR ACTUAL CONTRACT PROVISIONS.

THE POLICY/RIDER PROVIDES AN ACCELERATED BENEFIT OPTION. YOU SHOULD CONSULT WITH A PERSONAL TAX ADVISOR IF YOU ARE CONSIDERING ELECTING PAYMENT UNDER AN ACCELERATED BENEFIT PROVISION. BENEFITS AS SPECIFIED IN THE POLICY/RIDER WILL BE REDUCED UPON RECEIPT OF AN ACCELERATED BENEFIT PAYMENT. RECEIPT OF ACCELERATED BENEFIT PAYMENTS: 1) MAY BE TAXABLE; 2) MAY AFFECT YOUR ELIGIBILITY FOR BENEFITS UNDER STATE OR FEDERAL LAW; AND, 3) DO NOT AND ARE NOT INTENDED TO QUALIFY AS LONG-TERM CARE INSURANCE.

The policy and/or rider you are applying for has an Accelerated Benefit provision. The provision allows a portion of the death benefits to be advanced if certain conditions are met. Please see policy/rider for conditions and definitions, as applicable.

Prior to the payment of any Accelerated Benefit, the following conditions must be met:

- The minimum Accelerated Benefit available is $5,000. The maximums vary by policy/rider (see specific information below) and shall not exceed the Benefit Amount for the policy shown on the Policy Schedule.
- Only one Accelerated Benefit election will be made under the policy and/or each rider even if the Owner does not elect the full acceleration amount.
- If two or more Accelerated Benefits are payable on behalf of the Insured/Covered Person under the policy or any attached riders for the same or related sickness, injury or loss, benefits will be paid in the following order:
  1) Accelerated Benefit for Critical Illness, if this optional rider is attached to the policy;
  2) Accelerated Benefit for Long Term Illness, if this optional rider is attached to the policy; and
  3) Accelerated Benefit for Terminal Condition.
- Additional limitations and exclusions may apply, please read your policy/rider carefully.

Upon request to accelerate the policy/rider proceeds, and upon the payment of the accelerated benefit, the Owner and any irrevocable beneficiary shall be given a statement demonstrating the effect of the acceleration on the payment of policy proceeds, cash value, death benefit, premium, and policy loans, as applicable.

Accelerated Benefit for Terminal Condition

Prior to the payment of any Accelerated Benefit, the Insured/Covered Person must have a Terminal Condition, defined as an imminent death expected as a result of a non-correctable medical condition that with reasonable medical certainty will result in a drastically limited life span of the Insured/Covered Person of 12 months or less. The maximum payable is the lesser of: 50% of the eligible proceeds as defined in the policy/rider, or $100,000. There is no premium associated with this provision.

Payment of an Accelerated Benefit, if elected, will have the following effect on your contract:

- Upon payment of the Accelerated Benefit, the policy/rider will remain in force. Any premiums due to keep the policy/rider in force will be paid by us, and will be deducted from the policy proceeds upon death, unless you are currently exercising the Automatic Premium Loan option. If you are currently exercising the Automatic Premium Loan option, any premiums will continue to be paid under this option, until such time as this option is exhausted or discontinued.
- Policy proceeds which are payable on the death of the Insured/Covered Person will be reduced by the amount of the Accelerated Benefit, any outstanding policy loans, and any premiums paid by us on your behalf.
- Cash values, if any, will continue to accumulate as specified in your policy or rider. Access to the policy cash value may be restricted to the excess of the cash value over the sum of the amount accelerated and any premiums paid by us and any other outstanding policy loans.
- Any outstanding loan, including interest will not be deducted from the Accelerated Benefit payment.
- This Accelerated Benefit will be treated as a lien against the death benefit and applied at time of death.

Accelerated Benefit for Long Term Illness (optional rider)

Prior to the payment of any Accelerated Benefit, the Insured must have a Long Term Illness, which means the Insured has been certified within the last 12 months by a Licensed Health Care Practitioner as permanently unable to perform, without Substantial Assistance from another individual, at least two out of five Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity; or requiring Substantial Supervision due to permanent Severe Cognitive Impairment. The maximum payable is the lesser of 50% of the Eligible Proceeds available at the time of claim payable in two equal annual payments up to a maximum of 25% of the eligible proceeds per year for two consecutive years; or $100,000 payable in two equal annual payments up to a maximum of $50,000 per year for two consecutive years. Premium is required to keep this rider in force.

Payment of an Accelerated Benefit for Long Term Illness, if elected and/or Critical Illness, if elected, will have the following effect on your contract:

- Upon payment of the Accelerated Benefit, the rider will terminate and no additional benefits will be due under the rider, even for recurrence. The policy will remain in force and premiums will continue to be billed and payable as due.
- Policy proceeds which are payable on the death of the Insured will be reduced by the amount of the Accelerated Benefit.
- Cash values, if any, will continue to accumulate as specified in your policy or rider. The cash values will be adjusted proportionally by the percent accelerated.
- Any outstanding policy loan, including interest, will be proportionally reduced by the percent accelerated and will be deducted from the Accelerated Benefit payment.
- The Accelerated Benefit will reduce the Benefit Amount and will be applied immediately upon acceleration.

ICC14 DN111

This brochure does not constitute the full policy and is intended to provide basic information about American Fidelity Assurance Company's Renewable and Convertible Term Life Insurance product, ICC14 RCTL14 / RCTL14 For specific details, limitations and exclusions, please refer to your policy, riders. Please consult your tax advisor for your specific situation. This policy is not eligible under Section 125. Rider availability may vary by state.

We will not pay the policy proceeds if the insured commits suicide, while sane or insane for the period of time as described in the insured's policy, from the Effective date. Instead, we will return all premiums paid.

AMERICAN FIDELITY
a different opinion

9000 Cameron Parkway
Oklahoma City, Oklahoma 73114
800-654-8489
americanfidelity.com

SB-30355-0917 (AWD)

051-536, 051-537, 051-546,
051-547, 051-556, 051-557

Term Life Monthly Rate Sheets

AMERICAN FIDELITY
a different opinion™

EMPLOYER BENEFIT SOLUTIONS FOR YOUR INDUSTRY

ISSUE AGE	Death Benefit *Monthly Premium Including Policy Fee*								
	$25,000	$30,000	$50,000	$75,000	$100,000	$125,000	$150,000	$175,000	$200,000
17	8.25	9.50	11.50	16.25	21.00	20.75	24.50	28.25	32.00
18	8.25	9.50	11.50	16.25	21.00	20.75	24.50	28.25	32.00
19	8.25	9.50	11.50	16.25	21.00	20.75	24.50	28.25	32.00
20	8.25	9.50	11.50	16.25	21.00	20.75	24.50	28.25	32.00
21	8.25	9.50	11.50	16.25	21.00	20.75	24.50	28.25	32.00
22	8.25	9.50	11.50	16.25	21.00	20.75	24.50	28.25	32.00
23	8.25	9.50	11.50	16.25	21.00	20.75	24.50	28.25	32.00
24	8.25	9.50	11.50	16.25	21.00	20.75	24.50	28.25	32.00
25	8.25	9.50	11.50	16.25	21.00	20.75	24.50	28.25	32.00
26	8.25	9.50	11.50	16.25	21.00	20.75	24.50	28.25	32.00
27	8.25	9.50	11.50	16.25	21.00	20.75	24.50	28.25	32.00
28	8.25	9.50	11.50	16.25	21.00	20.75	24.50	28.25	32.00
29	8.25	9.50	11.50	16.25	21.00	20.75	24.50	28.25	32.00
30	8.25	9.50	11.50	16.25	21.00	20.75	24.50	28.25	32.00
31	8.25	9.50	11.50	16.25	21.00	20.75	24.50	28.25	32.00
32	8.50	9.80	12.00	17.00	22.00	22.00	26.00	30.00	34.00
33	8.50	9.80	12.00	17.00	22.00	22.00	26.00	30.00	34.00
34	8.75	10.10	12.50	17.75	23.00	23.25	27.50	31.75	36.00
35	8.75	10.10	12.50	17.75	23.00	23.25	27.50	31.75	36.00
36	9.00	10.40	13.00	18.50	24.00	24.50	29.00	33.50	38.00
37	9.25	10.70	13.50	19.25	25.00	25.75	30.50	35.25	40.00
38	9.50	11.00	14.00	20.00	26.00	27.00	32.00	37.00	42.00
39	10.00	11.60	15.00	21.50	28.00	29.50	35.00	40.50	46.00
40	10.25	11.90	15.50	22.25	29.00	30.75	36.50	42.25	48.00
41	10.75	12.50	16.50	23.75	31.00	33.25	39.50	45.75	52.00
42	11.00	12.80	17.00	24.50	32.00	34.50	41.00	47.50	54.00
43	11.50	13.40	18.00	26.00	34.00	37.00	44.00	51.00	58.00
44	12.00	14.00	19.00	27.50	36.00	39.50	47.00	54.50	62.00
45	12.50	14.60	20.00	29.00	38.00	42.00	50.00	58.00	66.00
46	13.25	15.50	21.50	31.25	41.00	44.50	53.00	61.50	70.00
47	13.75	16.10	22.50	32.75	43.00	48.25	57.50	66.75	76.00
48	14.50	17.00	24.00	35.00	46.00	52.00	62.00	72.00	82.00
49	15.50	18.20	26.00	38.00	50.00	55.75	66.50	77.25	88.00
50	16.25	19.10	27.50	40.25	53.00	--	--	--	--
51	17.00	20.00	29.50	43.25	57.00	--	--	--	--
52	17.75	20.90	31.50	46.25	61.00	--	--	--	--
53	18.75	22.10	34.00	50.00	66.00	--	--	--	--
54	19.50	23.00	36.50	53.75	71.00	--	--	--	--
55	20.50	24.20	39.00	57.50	76.00	--	--	--	--
56	22.50	26.60	43.00	63.50	84.00	--	--	--	--
57	25.00	29.60	48.00	71.00	94.00	--	--	--	--
58	27.50	32.60	53.00	78.50	104.00	--	--	--	--
59	30.25	35.90	58.50	86.75	115.00	--	--	--	--
60	33.50	39.80	65.00	96.50	128.00	--	--	--	--
61	36.50	43.40	71.00	105.50	140.00	--	--	--	--
62	39.75	47.30	77.50	115.25	153.00	--	--	--	--
63	43.50	51.80	85.00	126.50	168.00	--	--	--	--
64	47.50	56.60	93.00	138.50	184.00	--	--	--	--
65	51.75	61.70	101.50	151.25	201.00	--	--	--	--

Spouse Coverage Available[1]

This insert must be used in conjunction with SB-30355 and any state specific deviations thereof. *This is a brief description of the coverage and does not constitute the actual policy. For complete benefits, limitations, exclusions and other provisions, please refer to the policy. Not generally qualified Benefits under Section 125 plans. [1]Maximum face amount available is $50,000.*

10 Year Term
Tobacco User Rates

ISSUE AGE	Death Benefit *Monthly Premium Including Policy Fee*								
	$25,000	$30,000	$50,000	$75,000	$100,000	$125,000	$150,000	$175,000	$200,000
17	11.00	12.80	17.00	24.50	32.00	34.50	41.00	47.50	54.00
18	11.00	12.80	17.00	24.50	32.00	34.50	41.00	47.50	54.00
19	11.00	12.80	17.00	24.50	32.00	34.50	41.00	47.50	54.00
20	11.00	12.80	17.00	24.50	32.00	34.50	41.00	47.50	54.00
21	11.00	12.80	17.00	24.50	32.00	34.50	41.00	47.50	54.00
22	11.00	12.80	17.00	24.50	32.00	34.50	41.00	47.50	54.00
23	11.00	12.80	17.00	24.50	32.00	34.50	41.00	47.50	54.00
24	11.00	12.80	17.00	24.50	32.00	34.50	41.00	47.50	54.00
25	11.00	12.80	17.00	24.50	32.00	34.50	41.00	47.50	54.00
26	11.00	12.80	17.00	24.50	32.00	34.50	41.00	47.50	54.00
27	11.00	12.80	17.00	24.50	32.00	34.50	41.00	47.50	54.00
28	11.25	13.10	17.50	25.25	33.00	35.75	42.50	49.25	56.00
29	11.25	13.10	17.50	25.25	33.00	35.75	42.50	49.25	56.00
30	11.25	13.10	17.50	25.25	33.00	35.75	42.50	49.25	56.00
31	11.50	13.40	18.00	26.00	34.00	37.00	44.00	51.00	58.00
32	11.75	13.70	18.50	26.75	35.00	38.25	45.50	52.75	60.00
33	12.00	14.00	19.00	27.50	36.00	39.50	47.00	54.50	62.00
34	12.25	14.30	19.50	28.25	37.00	40.75	48.50	56.25	64.00
35	12.50	14.60	20.00	29.00	38.00	42.00	50.00	58.00	66.00
36	13.00	15.20	21.00	30.50	40.00	44.50	53.00	61.50	70.00
37	13.50	15.80	22.00	32.00	42.00	47.00	56.00	65.00	74.00
38	14.00	16.40	23.00	33.50	44.00	49.50	59.00	68.50	78.00
39	14.75	17.30	24.50	35.75	47.00	53.25	63.50	73.75	84.00
40	15.25	17.90	25.50	37.25	49.00	55.75	66.50	77.25	88.00
41	16.25	19.10	27.50	40.25	53.00	60.75	72.50	84.25	96.00
42	17.50	20.60	30.00	44.00	58.00	67.00	80.00	93.00	106.00
43	18.75	22.10	32.50	47.75	63.00	73.25	87.50	101.75	116.00
44	20.25	23.90	35.50	52.25	69.00	80.75	96.50	112.25	128.00
45	21.75	25.70	38.50	56.75	75.00	88.25	105.50	122.75	140.00
46	23.25	27.50	41.50	61.25	81.00	95.75	114.50	133.25	152.00
47	25.00	29.60	44.50	65.75	87.00	103.25	123.50	143.75	164.00
48	27.00	32.00	48.00	71.00	94.00	112.00	134.00	156.00	178.00
49	29.00	34.40	51.50	76.25	101.00	120.75	144.50	168.25	192.00
50	31.25	37.10	55.50	82.25	109.00	--	--	--	--
51	33.50	39.80	60.50	89.75	119.00	--	--	--	--
52	36.25	43.10	65.50	97.25	129.00	--	--	--	--
53	39.00	46.40	71.50	106.25	141.00	--	--	--	--
54	42.00	50.00	78.00	116.00	154.00	--	--	--	--
55	45.25	53.90	85.00	126.50	168.00	--	--	--	--
56	49.75	59.30	94.00	140.00	186.00	--	--	--	--
57	54.50	65.00	104.50	155.75	207.00	--	--	--	--
58	60.00	71.60	116.00	173.00	230.00	--	--	--	--
59	66.00	78.80	128.50	191.75	255.00	--	--	--	--
60	72.50	86.60	143.00	213.50	284.00	--	--	--	--
61	77.50	92.60	153.00	228.50	304.00	--	--	--	--
62	82.75	98.90	163.50	244.25	325.00	--	--	--	--
63	88.50	105.80	175.00	261.50	348.00	--	--	--	--
64	94.75	113.30	187.50	280.25	373.00	--	--	--	--
65	101.25	121.10	200.50	299.75	399.00	--	--	--	--

Spouse Coverage Available[1]

RIDER RATES

SPOUSE TERM RIDER: Use the rate sheet to find the spouse's coordinating age, face amount, and tobacco use and deduct $2.00.
CHILDREN'S TERM RIDER: $10,000: $4.80 / $20,000: $9.60 / $30,000: $14.40. Issue ages 1mo thru 19 (17 in MI and PA, 14 in MA and WA). Subject to the overall child maximum of $50,000 ($15,000 in WA). Grandchildren are not eligible for this rider.
ACCIDENTAL DEATH & DISMEMBERMENT RIDER: For the monthly rate, multiply .08 per $1,000 of coverage.
WAIVER OF PREMIUM RIDER: Add the base policy and all other riders and multiply by 7% to get the premium amount for the rider.

ISSUE AGE	Death Benefit *Monthly Premium Including Policy Fee*								
	$25,000	$30,000	$50,000	$75,000	$100,000	$125,000	$150,000	$175,000	$200,000
17	8.25	9.50	11.00	15.50	20.00	20.75	24.50	28.25	32.00
18	8.25	9.50	11.00	15.50	20.00	20.75	24.50	28.25	32.00
19	8.25	9.50	11.00	15.50	20.00	20.75	24.50	28.25	32.00
20	8.25	9.50	11.00	15.50	20.00	20.75	24.50	28.25	32.00
21	8.25	9.50	11.00	15.50	20.00	20.75	24.50	28.25	32.00
22	8.25	9.50	11.00	15.50	20.00	20.75	24.50	28.25	32.00
23	8.25	9.50	11.00	15.50	20.00	20.75	24.50	28.25	32.00
24	8.25	9.50	11.00	15.50	20.00	20.75	24.50	28.25	32.00
25	8.25	9.50	11.00	15.50	20.00	20.75	24.50	28.25	32.00
26	8.25	9.50	11.00	15.50	20.00	20.75	24.50	28.25	32.00
27	8.50	9.80	11.50	16.25	21.00	22.00	26.00	30.00	34.00
28	8.50	9.80	11.50	16.25	21.00	22.00	26.00	30.00	34.00
29	8.75	10.10	12.00	17.00	22.00	23.25	27.50	31.75	36.00
30	8.75	10.10	12.00	17.00	22.00	23.25	27.50	31.75	36.00
31	8.75	10.10	12.00	17.00	22.00	23.25	27.50	31.75	36.00
32	9.00	10.40	12.50	17.75	23.00	24.50	29.00	33.50	38.00
33	9.00	10.40	12.50	17.75	23.00	24.50	29.00	33.50	38.00
34	9.25	10.70	13.00	18.50	24.00	25.75	30.50	35.25	40.00
35	9.25	10.70	13.00	18.50	24.00	25.75	30.50	35.25	40.00
36	9.50	11.00	13.50	19.25	25.00	27.00	32.00	37.00	42.00
37	10.00	11.60	14.50	20.75	27.00	29.50	35.00	40.50	46.00
38	10.25	11.90	15.00	21.50	28.00	30.75	36.50	42.25	48.00
39	10.50	12.20	16.00	23.00	30.00	33.25	39.50	45.75	52.00
40	11.00	12.80	17.00	24.50	32.00	35.75	42.50	49.25	56.00
41	11.50	13.40	18.00	26.00	34.00	38.25	45.50	52.75	60.00
42	12.25	14.30	19.50	28.25	37.00	42.00	50.00	58.00	66.00
43	13.00	15.20	21.00	30.50	40.00	45.75	54.50	63.25	72.00
44	13.75	16.10	22.50	32.75	43.00	49.50	59.00	68.50	78.00
45	14.50	17.00	24.00	35.00	46.00	53.25	63.50	73.75	84.00
46	15.50	18.20	26.00	38.00	50.00	58.25	69.50	80.75	92.00
47	16.50	19.40	28.00	41.00	54.00	63.25	75.50	87.75	100.00
48	17.75	20.90	30.00	44.00	58.00	68.25	81.50	94.75	108.00
49	19.00	22.40	32.50	47.75	63.00	74.50	89.00	103.50	118.00
50	20.25	23.90	35.00	51.50	68.00	--	--	--	--
51	22.00	26.00	38.50	56.75	75.00	--	--	--	--
52	23.75	28.10	42.00	62.00	82.00	--	--	--	--
53	25.75	30.50	46.00	68.00	90.00	--	--	--	--
54	28.00	33.20	50.50	74.75	99.00	--	--	--	--
55	30.25	35.90	55.50	82.25	109.00	--	--	--	--
56	32.25	38.30	59.50	88.25	117.00	--	--	--	--
57	34.50	41.00	64.00	95.00	126.00	--	--	--	--
58	37.00	44.00	69.00	102.50	136.00	--	--	--	--
59	39.50	47.00	74.00	110.00	146.00	--	--	--	--
60	42.25	50.30	79.50	118.25	157.00	--	--	--	--

Spouse Coverage Available[1]

This insert must be used in conjunction with SB-30355 and any state specific deviations thereof. *This is a brief description of the coverage and does not constitute the actual policy. For complete benefits, limitations, exclusions and other provisions, please refer to the policy. Not generally qualified Benefits under Section 125 plans. [1]Maximum face amount available is $50,000.*

20 Year Term
Tobacco User Rates

ISSUE AGE	Death Benefit *Monthly Premium Including Policy Fee*								
	$25,000	$30,000	$50,000	$75,000	$100,000	$125,000	$150,000	$175,000	$200,000
17	11.00	12.80	16.00	23.00	30.00	33.25	39.50	45.75	52.00
18	11.00	12.80	16.00	23.00	30.00	33.25	39.50	45.75	52.00
19	11.00	12.80	16.00	23.00	30.00	33.25	39.50	45.75	52.00
20	11.00	12.80	16.00	23.00	30.00	33.25	39.50	45.75	52.00
21	11.00	12.80	16.00	23.00	30.00	33.25	39.50	45.75	52.00
22	11.00	12.80	16.00	23.00	30.00	33.25	39.50	45.75	52.00
23	11.25	13.10	16.50	23.75	31.00	34.50	41.00	47.50	54.00
24	11.25	13.10	16.50	23.75	31.00	34.50	41.00	47.50	54.00
25	11.25	13.10	16.50	23.75	31.00	34.50	41.00	47.50	54.00
26	11.25	13.10	16.50	23.75	31.00	34.50	41.00	47.50	54.00
27	11.25	13.10	16.50	23.75	31.00	34.50	41.00	47.50	54.00
28	11.50	13.40	17.00	24.50	32.00	35.75	42.50	49.25	56.00
29	11.50	13.40	17.00	24.50	32.00	35.75	42.50	49.25	56.00
30	11.50	13.40	17.00	24.50	32.00	35.75	42.50	49.25	56.00
31	12.00	14.00	18.00	26.00	34.00	38.25	45.50	52.75	60.00
32	12.25	14.30	18.50	26.75	35.00	39.50	47.00	54.50	62.00
33	12.75	14.90	19.50	28.25	37.00	42.00	50.00	58.00	66.00
34	13.25	15.50	20.50	29.75	39.00	44.50	53.00	61.50	70.00
35	13.75	16.10	21.50	31.25	41.00	47.00	56.00	65.00	74.00
36	14.50	17.00	23.00	33.50	44.00	50.75	60.50	70.25	80.00
37	15.25	17.90	24.50	35.75	47.00	54.50	65.00	75.50	86.00
38	16.25	19.10	26.00	38.00	50.00	58.25	69.50	80.75	92.00
39	17.00	20.00	28.00	41.00	54.00	63.25	75.50	87.75	100.00
40	18.00	21.20	30.00	44.00	58.00	68.25	81.50	94.75	108.00
41	19.25	22.70	32.50	47.75	63.00	74.50	89.00	103.50	118.00
42	20.75	24.50	35.50	52.25	69.00	82.00	98.00	114.00	130.00
43	22.25	26.30	38.50	56.75	75.00	89.50	107.00	124.50	142.00
44	24.00	28.40	42.00	62.00	82.00	98.25	117.50	136.75	156.00
45	25.75	30.50	45.50	67.25	89.00	107.00	128.00	149.00	170.00
46	27.50	32.60	49.00	72.50	96.00	115.75	138.50	161.25	184.00
47	29.50	35.00	53.00	78.50	104.00	125.75	150.50	175.25	200.00
48	31.50	37.40	57.00	84.50	112.00	135.75	162.50	189.25	216.00
49	33.75	40.10	61.50	91.25	121.00	147.00	176.00	205.00	234.00
50	36.25	43.10	66.50	98.75	131.00	--	--	--	--
51	39.00	46.40	72.00	107.00	142.00	--	--	--	--
52	42.00	50.00	78.00	116.00	154.00	--	--	--	--
53	45.25	53.90	84.50	125.75	167.00	--	--	--	--
54	48.75	58.10	91.50	136.25	181.00	--	--	--	--
55	52.50	62.60	99.00	147.50	196.00	--	--	--	--
56	57.00	68.00	108.00	161.00	214.00	--	--	--	--
57	62.00	74.00	118.00	176.00	234.00	--	--	--	--
58	67.50	80.60	129.00	192.50	256.00	--	--	--	--
59	73.75	88.10	141.00	210.50	280.00	--	--	--	--
60	80.25	95.90	154.50	230.75	307.00	--	--	--	--

Spouse Coverage Available[1]

RIDER RATES

SPOUSE TERM RIDER: Use the rate sheet to find the spouse's coordinating age, face amount, and tobacco use and deduct $2.00.
CHILDREN'S TERM RIDER: $10,000: $4.80 / $20,000: $9.60 / $30,000: $14.40. Issue ages 1mo thru 19 (17 in MI and PA, 14 in MA and WA). Subject to the overall child maximum of $50,000 ($15,000 in WA). Grandchildren are not eligible for this rider.
ACCIDENTAL DEATH & DISMEMBERMENT RIDER: For the monthly rate, multiply .08 per $1,000 of coverage.
WAIVER OF PREMIUM RIDER: Add the base policy and all other riders and multiply by 7% to get the premium amount for the rider.

Death Benefit
Monthly Premium Including Policy Fee

ISSUE AGE	$10,000		$25,000		$50,000		$75,000		$100,000		$150,000		$175,000		$200,000	
	Base	ABLTI	Base	ABLTI	Base	ABLTI	Base	ABLTI	Base	ABLTI	Base	ABLTI	Base	ABLTI	Base	ABLTI
17	4.60	0.12	8.50	0.29	11.50	0.59	16.25	0.88	21.00	1.17	26.00	1.76	30.00	2.05	34.00	2.34
18	4.60	0.12	8.50	0.29	11.50	0.59	16.25	0.88	21.00	1.17	26.00	1.76	30.00	2.05	34.00	2.34
19	4.60	0.12	8.50	0.29	11.50	0.59	16.25	0.88	21.00	1.17	26.00	1.76	30.00	2.05	34.00	2.34
20	4.60	0.12	8.50	0.29	11.50	0.59	16.25	0.88	21.00	1.17	26.00	1.76	30.00	2.05	34.00	2.34
21	4.60	0.12	8.50	0.31	12.00	0.61	17.00	0.92	22.00	1.22	27.50	1.83	31.75	2.14	36.00	2.44
22	4.70	0.13	8.75	0.32	12.00	0.63	17.00	0.95	22.00	1.26	27.50	1.89	31.75	2.21	36.00	2.52
23	4.70	0.13	8.75	0.33	12.50	0.66	17.75	0.98	23.00	1.31	29.00	1.97	33.50	2.29	38.00	2.62
24	4.80	0.14	9.00	0.34	12.50	0.68	17.75	1.01	23.00	1.35	29.00	2.03	33.50	2.36	38.00	2.70
25	4.80	0.14	9.00	0.35	13.00	0.70	18.50	1.05	24.00	1.40	30.50	2.10	35.25	2.45	40.00	2.80
26	4.80	0.15	9.00	0.38	13.00	0.77	18.50	1.15	24.00	1.53	30.50	2.30	35.25	2.68	40.00	3.06
27	4.90	0.17	9.25	0.42	13.50	0.84	19.25	1.25	25.00	1.67	32.00	2.51	37.00	2.92	42.00	3.34
28	4.90	0.18	9.25	0.45	13.50	0.90	19.25	1.35	25.00	1.80	32.00	2.70	37.00	3.15	42.00	3.60
29	5.00	0.19	9.50	0.49	14.00	0.97	20.00	1.46	26.00	1.94	33.50	2.91	38.75	3.40	44.00	3.88
30	5.00	0.20	9.50	0.51	14.00	1.02	20.00	1.52	26.00	2.03	33.50	3.05	38.75	3.55	44.00	4.06
31	5.10	0.22	9.75	0.54	14.50	1.08	20.75	1.62	27.00	2.16	35.00	3.24	40.50	3.78	46.00	4.32
32	5.20	0.23	10.00	0.58	15.00	1.15	21.50	1.73	28.00	2.30	36.50	3.45	42.25	4.03	48.00	4.60
33	5.30	0.24	10.25	0.61	15.00	1.22	21.50	1.82	28.00	2.43	36.50	3.65	42.25	4.25	48.00	4.86
34	5.40	0.26	10.50	0.64	15.50	1.29	22.25	1.93	29.00	2.57	38.00	3.86	44.00	4.50	50.00	5.14
35	5.50	0.28	10.75	0.70	16.00	1.40	23.00	2.09	30.00	2.79	39.50	4.19	45.75	4.88	52.00	5.58
36	5.70	0.30	11.25	0.74	17.00	1.49	24.50	2.23	32.00	2.97	42.50	4.46	49.25	5.20	56.00	5.94
37	5.90	0.32	11.75	0.79	18.00	1.58	26.00	2.36	34.00	3.15	47.00	4.73	54.50	5.51	62.00	6.30
38	6.20	0.33	12.50	0.83	19.50	1.67	28.25	2.50	37.00	3.33	50.00	5.00	58.00	5.83	66.00	6.66
39	6.40	0.35	13.00	0.88	20.50	1.76	29.75	2.63	39.00	3.51	54.50	5.27	63.25	6.14	72.00	7.02
40	6.70	0.37	13.75	0.93	22.00	1.86	32.00	2.78	42.00	3.71	59.00	5.57	68.50	6.49	78.00	7.42
41	7.00	0.40	14.50	0.99	23.50	1.98	34.25	2.96	45.00	3.95	63.50	5.93	73.75	6.91	84.00	7.90
42	7.30	0.42	15.25	1.05	25.00	2.09	36.50	3.14	48.00	4.18	68.00	6.27	79.00	7.32	90.00	8.36
43	7.60	0.44	16.00	1.10	26.50	2.20	38.75	3.30	51.00	4.40	72.50	6.60	84.25	7.70	96.00	8.80
44	7.90	0.46	16.75	1.15	28.50	2.30	41.75	3.45	55.00	4.60	78.50	6.90	91.25	8.05	104.00	9.20
45	8.30	0.47	17.75	1.18	30.50	2.36	44.75	3.54	59.00	4.72	84.50	7.08	98.25	8.26	112.00	9.44
46	8.90	0.50	19.25	1.25	33.50	2.49	49.25	3.74	65.00	4.98	93.50	7.47	108.75	8.72	124.00	9.96
47	9.50	0.52	20.75	1.31	36.50	2.62	53.75	3.93	71.00	5.24	102.50	7.86	119.25	9.17	136.00	10.48
48	10.20	0.55	22.50	1.37	40.00	2.74	59.00	4.10	78.00	5.47	113.00	8.21	131.50	9.57	150.00	10.94
49	10.90	0.57	24.25	1.43	44.00	2.85	65.00	4.28	86.00	5.70	123.50	8.55	143.75	9.98	164.00	11.40
50	11.70	0.59	26.25	1.48	48.00	2.95	71.00	4.43	94.00	5.90	--	--	--	--	--	--

Spouse Coverage Available[1]

This insert must be used in conjunction with SB-30355 and any state specific deviations thereof. *This is a brief description of the coverage and does not constitute the actual policy. For complete benefits, limitations, exclusions and other provisions, please refer to the policy. Not generally qualified Benefits under Section 125 plans. [1]Maximum face amount available is $50,000.*

30 Year Term
Tobacco User Rates

ISSUE AGE	Death Benefit *Monthly Premium Including Policy Fee*															
	$10,000		$25,000		$50,000		$75,000		$100,000		$150,000		$175,000		$200,000	
	Base	ABLTI	Base	ABLTI	Base	ABLTI	Base	ABLTI	Base	ABLTI	Base	ABLTI	Base	ABLTI	Base	ABLTI
17	5.60	0.18	11.00	0.44	17.00	0.88	24.50	1.32	32.00	1.76	42.50	2.64	49.25	3.08	56.00	3.52
18	5.60	0.18	11.00	0.44	17.00	0.88	24.50	1.32	32.00	1.76	42.50	2.64	49.25	3.08	56.00	3.52
19	5.60	0.18	11.00	0.44	17.00	0.88	24.50	1.32	32.00	1.76	42.50	2.64	49.25	3.08	56.00	3.52
20	5.60	0.18	11.00	0.44	17.00	0.88	24.50	1.32	32.00	1.76	42.50	2.64	49.25	3.08	56.00	3.52
21	5.60	0.19	11.00	0.46	17.00	0.93	24.50	1.39	32.00	1.85	42.50	2.78	49.25	3.24	56.00	3.70
22	5.60	0.19	11.00	0.49	17.00	0.97	24.50	1.46	32.00	1.94	42.50	2.91	49.25	3.40	56.00	3.88
23	5.70	0.20	11.25	0.51	17.50	1.02	25.25	1.52	33.00	2.03	44.00	3.05	51.00	3.55	58.00	4.06
24	5.70	0.21	11.25	0.53	17.50	1.06	25.25	1.59	33.00	2.12	44.00	3.18	51.00	3.71	58.00	4.24
25	5.70	0.21	11.25	0.53	17.50	1.06	25.25	1.59	33.00	2.12	44.00	3.18	51.00	3.71	58.00	4.24
26	5.80	0.23	11.50	0.58	18.00	1.15	26.00	1.73	34.00	2.30	45.50	3.45	52.75	4.03	60.00	4.60
27	6.00	0.25	12.00	0.62	19.00	1.24	27.50	1.86	36.00	2.48	48.50	3.72	56.25	4.34	64.00	4.96
28	6.20	0.27	12.50	0.67	19.50	1.33	28.25	2.00	37.00	2.66	50.00	3.99	58.00	4.66	66.00	5.32
29	6.30	0.28	12.75	0.71	20.00	1.42	29.00	2.13	38.00	2.84	51.50	4.26	59.75	4.97	68.00	5.68
30	6.50	0.30	13.25	0.74	21.00	1.49	30.50	2.23	40.00	2.97	54.50	4.46	63.25	5.20	72.00	5.94
31	6.80	0.32	14.00	0.80	22.50	1.60	32.75	2.40	43.00	3.20	59.00	4.80	68.50	5.60	78.00	6.40
32	7.00	0.34	14.50	0.86	23.50	1.71	34.25	2.57	45.00	3.42	62.00	5.13	72.00	5.99	82.00	6.84
33	7.30	0.37	15.25	0.91	25.00	1.83	36.50	2.74	48.00	3.65	66.50	5.48	77.25	6.39	88.00	7.30
34	7.70	0.39	16.25	0.97	27.00	1.94	39.50	2.90	52.00	3.87	72.50	5.81	84.25	6.77	96.00	7.74
35	8.00	0.41	17.00	1.04	28.50	2.07	41.75	3.11	55.00	4.14	77.00	6.21	89.50	7.25	102.00	8.28
36	8.50	0.45	18.25	1.12	31.00	2.23	45.50	3.35	60.00	4.46	84.50	6.69	98.25	7.81	112.00	8.92
37	9.00	0.48	19.50	1.19	33.50	2.39	49.25	3.58	65.00	4.77	92.00	7.16	107.00	8.35	122.00	9.54
38	9.50	0.51	20.75	1.27	36.00	2.55	53.00	3.82	70.00	5.09	99.50	7.64	115.75	8.91	132.00	10.18
39	10.20	0.54	22.50	1.35	39.00	2.70	57.50	4.05	76.00	5.40	108.50	8.10	126.25	9.45	144.00	10.80
40	10.80	0.55	24.00	1.38	42.50	2.77	62.75	4.15	83.00	5.53	119.00	8.30	138.50	9.68	158.00	11.06
41	11.40	0.59	25.50	1.48	45.50	2.96	67.25	4.43	89.00	5.91	128.00	8.87	149.00	10.34	170.00	11.82
42	12.10	0.63	27.25	1.57	49.00	3.14	72.50	4.70	96.00	6.27	138.50	9.41	161.25	10.97	184.00	12.54
43	12.80	0.66	29.00	1.66	52.50	3.31	77.75	4.97	103.00	6.62	149.00	9.93	173.50	11.59	198.00	13.24
44	13.60	0.70	31.00	1.74	56.50	3.48	83.75	5.21	111.00	6.95	161.00	10.43	187.50	12.16	214.00	13.90
45	14.40	0.72	33.00	1.80	60.50	3.59	89.75	5.39	119.00	7.18	173.00	10.77	201.50	12.57	230.00	14.36
46	15.60	0.77	36.00	1.92	66.50	3.84	98.75	5.75	131.00	7.67	191.00	11.51	222.50	13.42	254.00	15.34
47	16.90	0.81	39.25	2.04	73.00	4.07	108.50	6.11	144.00	8.14	209.00	12.21	243.50	14.25	278.00	16.28
48	18.40	0.86	43.00	2.15	80.00	4.30	119.00	6.44	158.00	8.59	231.50	12.89	269.75	15.03	308.00	17.18
49	20.00	0.90	47.00	2.25	88.00	4.51	131.00	6.76	174.00	9.01	255.50	13.52	297.75	15.77	340.00	18.02
50	21.70	0.94	51.25	2.36	96.50	4.72	143.75	7.08	191.00	9.44	--	--	--	--	--	--

Spouse Coverage Available[1]

RIDER RATES

SPOUSE TERM RIDER: Use the rate sheet to find the spouse's coordinating age, face amount, and tobacco use and deduct $2.00.

ACCELERATED BENEFIT FOR LONG TERM ILLNESS RIDER (ABLTI): Add the rate shown in the ABLTI column to the base rate.

CHILDREN'S TERM RIDER: $10,000: $4.80 / $20,000: $9.60 / $30,000: $14.40. Issue ages 1mo thru 19 (17 in MI and PA, 14 in MA and WA). Subject to the overall child maximum of $50,000 ($15,000 in WA). Grandchildren are not eligible for this rider.

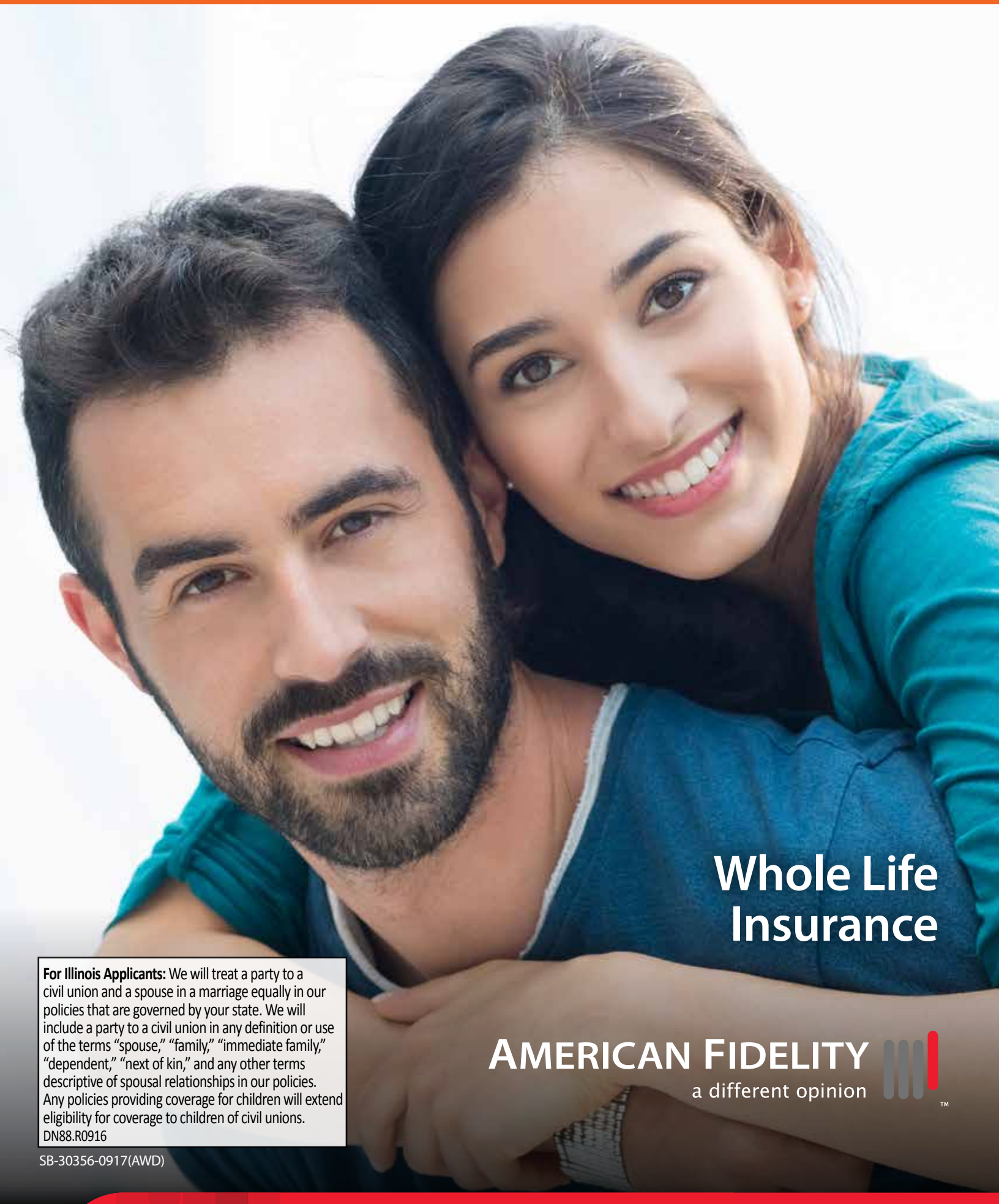
ACCIDENTAL DEATH & DISMEMBERMENT RIDER: For the monthly rate, multiply .08 per $1,000 of coverage.

WAIVER OF PREMIUM RIDER: Add the base policy and all other riders and multiply by 7% to get the premium amount for the rider.

American Fidelity Assurance Company
9000 Cameron Parkway • Oklahoma City, OK 73114
800-654-8489 • americanfidelity.com

AMERICAN FIDELITY
a different opinion™

SB-30355(Rate Insert-Monthly)-0417 (AWD)



Whole Life Insurance

For Illinois Applicants: We will treat a party to a civil union and a spouse in a marriage equally in our policies that are governed by your state. We will include a party to a civil union in any definition or use of the terms "spouse," "family," "immediate family," "dependent," "next of kin," and any other terms descriptive of spousal relationships in our policies. Any policies providing coverage for children will extend eligibility for coverage to children of civil unions.
DN88.R0916

SB-30356-0917(AWD)

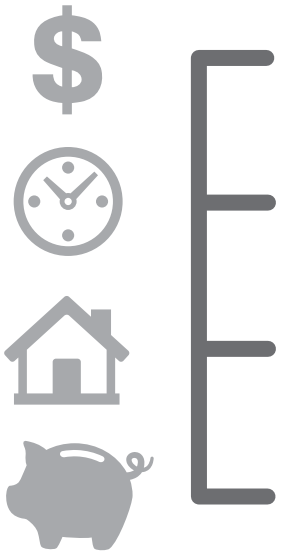
AMERICAN FIDELITY
a different opinion™

EMPLOYER BENEFIT SOLUTIONS FOR YOUR INDUSTRY

Why You Need Individual Whole Life Insurance

It's important to prepare for the unexpected and help ensure your loved ones will be financially protected in the event of a tragedy. Your life insurance benefit can help replace your income and help your family meet important financial needs like funeral expenses, everyday living costs, and college.

American Fidelity Assurance Company's Whole Life Insurance provides protection for your entire life. It's an individual policy, which means you own it and can take it with you when you leave employment or when you retire to age 121. The premium and amount of protection stay the same as long as the policy is in force, provided premiums are paid as required.



Final Expenses
Funeral Costs
Unpaid Medical Bills

Self Time
Time to Grieve
Housing Decision

Income Replacement
Mortgage/Rent
Other Loans

Nest Egg
Estate Planning
Income Replacement

Flexibility When You Need It

By choosing a Whole Life Policy, you have flexibility to adjust your benefits when needed. Cash value flexibility features include:

- Take a **Cash Surrender** and terminate your Policy. With this option, you will receive a check equal to your plan's current available cash value. In many situations, cash surrenders may be paid tax free.[1]
- **Partial Surrender:** You can withdraw a small portion of the policy's cash value in the form of cash, in exchange for a proportional reduction to the policy's available cash value and the face amount.
- **Loans:** You can borrow against your cash value at a competitive 8% loan interest rate.

Discontinue Your Premium While Keeping Your Coverage Active

- Same Amount of Coverage - Shorter Length of Time: Under the **Extended Term Insurance** provision, your policy's original face amount (minus outstanding loans or accelerated benefit payments) will be guaranteed for a specific term of time. In addition, your premium is "paid in full" until your new extended term period expires, terminating your policy.
- Coverage to Age 121 - Smaller Guaranteed Benefit Amount. You can rest easy knowing you are covered for your entire life by utilizing the **Reduced Paid-Up Provision** and reducing your original death benefit to a smaller amount. Enjoy being premium-free while having the security of guaranteed lifetime coverage, just at a reduced benefit amount. Plus your cash value will continue to accumulate.

Three Easy Steps to Get Covered

1 Select a Whole Life Plan
Add riders to cover you and your family!

2 Answer Three Health Questions[2]
There's no worry of participating in any invasive medical exams.

3 Get Death Benefit Coverage Immediately[3]
Your death benefit coverage starts when you sign the application.

[1]As long as the cash surrender does not exceed the total premiums received under the policy since inception. Please consult your tax consultant for your specific situation. [2]Issuance of the policy may depend on the answer to these questions. [3]Interim coverage for death will be in force from the date your application is signed if on such date the proposed insured is insurable per our underwriting guidelines for the requested coverage in accordance with the terms of the policy. This interim coverage for death will remain in force until the earlier of: 1) the date a policy becomes effective; 2) the date we decline the application; or 3) the date we notify the proposed insured that they are ineligible for interim coverage. The employee and/or spouse must remain actively at work during the interim coverage period. If the death of the proposed insured occurs during the interim coverage period, the first month's premium will be subtracted from the policy proceeds. Interim coverage is only for death benefits under the base policy and Children's Term Rider. No interim coverage benefits are available under any Waiver of Premium Rider, Accidental Death and Dismemberment Rider, Accelerated Benefit Rider for Long Term Illness or Accelerated Benefit for Critical Illness Rider.

EMPLOYEE ISSUE AGE AND MAXIMUM[4]
Ages 17-49: $200,000* *Ages 50-65: $100,000* *Ages 66-70: $10,000*
CHILD/GRANDCHILD ISSUE AGE AND MAXIMUM[4]
Ages 1 month - 26: (14 in MA, WA; 17 in MI, PA) *$50,000 ($15,000 in WA)*
RATES BASED ON ISSUE AGE AND TOBACCO STATUS
Your premiums will be based on your age on the date your policy becomes effective. You may be eligible for reduced rates if you are a non-tobacco user.

SPOUSE ISSUE AGE AND MAXIMUM[4]
*Ages 17**-49: $50,000* *Ages 50-60: $25,000*
ACCELERATED BENEFIT FOR TERMINAL CONDITION
You can receive a portion of the chosen death benefit if you are diagnosed with a Terminal Condition, as defined in the policy.
LEVEL PREMIUM AND DEATH BENEFIT[5]
Premiums and the death benefit are guaranteed to remain level for the life of the policy to age 121. Death benefits are generally paid tax free[8].

Enhance Your Plan[6]

Waiver of Premium Rider

This rider waives the premium if the base Insured becomes totally disabled, as defined in the rider, for at least six consecutive months. Premiums are waived for the base policy and any attached riders. Issue age is 17-60. The rider terminates at age 65.

Accidental Death and Dismemberment Rider

This rider provides coverage upon death, dismemberment or paralysis of the base Insured prior to age 70 if such death, dismemberment, or paralysis results from accidental causes, as defined in the rider. This rider also provides an additional 10% seatbelt benefit, if the police accident report certifies the base Insured was wearing a properly fastened seatbelt at time of death. Benefits are payable once per Covered Accident.

Children's Term Rider

This rider provides level term life insurance protection for all your eligible children who are between the ages of one month through age 19. Coverage remains on each child until age 26 or marriage of the child prior to age 26. Your covered child may also convert this rider for up to five times the amount of coverage (subject to a $100,000 limit overall) to any form of permanent insurance offered by American Fidelity for conversions. One premium covers all eligible children. Three benefit levels are available: $10,000, $20,000, and $30,000.

Accelerated Benefit Rider for Long Term Illness

This rider provides for two equal advances of a portion of the base policy's death benefit due to a Long Term Illness if we receive satisfactory proof of Long Term Illness prior to each annual payment. Coverage is available on the base Insured only.

Accelerated Benefit Rider for Critical Illness

This rider provides for an advance of a portion of the base policy's death benefit due to a Critical Illness, defined as a Heart Attack, Permanent Damage Due to Stroke, Invasive Cancer, Major Organ Failure, or End Stage Renal Disease. The rider is designed to provide for only one acceleration for one of the Critical Illnesses shown. Rider terminates upon acceleration.

SAMPLE NON-TOBACCO MONTHLY PREMIUM RATES FOR BASE WHOLE LIFE PLAN[7]

	$10K+	$50K+	$100K	$150K
25	$10.10	$36.50	$70.00	$102.00
35	$13.20	$52.50	$102.00	$150.00
45	$19.00	$82.00	$161.00	$238.50
55	$29.10	$132.50	$262.00	n/a

+Shaded amounts available for spouse base policy purchases.

[4]Face amounts vary based on issue age. Issuance of coverage may be subject to responses received to a few medical questions. [5]Provided no partial surrenders or accelerated benefits are taken. [6]Additional riders are subject to our general underwriting criteria and coverage is not guaranteed. Rider availability varies by state. [7]Example is based on monthly non-tobacco rates for a WL14 base plan only. For specific ages, rates or face amounts, contact your American Fidelity account manager. [8]Please consult your tax advisor for your specific situation. ***In the states of AK, AR, CO, IA, KS, MN, MO, NH, OR, PA, RI, SC, SD, TN and WI, the minimum issue age for younger employees is 18. **In the states of MO and PA, the minimum issue age for younger spouses is 18.**

Accelerated Benefit Summary and Disclosure Notice

Accelerated Benefit Summary and Disclosure Notice

THIS DOCUMENT SERVES ONLY AS A SUMMARY AND A DISCLOSURE NOTICE. PLEASE REFER TO YOUR POLICY OR RIDER FOR ACTUAL CONTRACT PROVISIONS.

THE POLICY/RIDER PROVIDES AN ACCELERATED BENEFIT OPTION. YOU SHOULD CONSULT WITH A PERSONAL TAX ADVISOR IF YOU ARE CONSIDERING ELECTING PAYMENT UNDER AN ACCELERATED BENEFIT PROVISION. BENEFITS AS SPECIFIED IN THE POLICY/RIDER WILL BE REDUCED UPON RECEIPT OF AN ACCELERATED BENEFIT PAYMENT. RECEIPT OF ACCELERATED BENEFIT PAYMENTS: 1) MAY BE TAXABLE; 2) MAY AFFECT YOUR ELIGIBILITY FOR BENEFITS UNDER STATE OR FEDERAL LAW; AND, 3) DO NOT AND ARE NOT INTENDED TO QUALIFY AS LONG-TERM CARE INSURANCE.

The policy and/or rider you are applying for has an Accelerated Benefit provision. The provision allows a portion of the death benefits to be advanced if certain conditions are met. Please see policy/rider for conditions and definitions, as applicable.

Prior to the payment of any Accelerated Benefit, the following conditions must be met:

- The minimum Accelerated Benefit available is $5,000. The maximums vary by policy/rider (see specific information below) and shall not exceed the Benefit Amount for the policy shown on the Policy Schedule.
- Only one Accelerated Benefit election will be made under the policy and/or each rider even if the Owner does not elect the full acceleration amount.
- If two or more Accelerated Benefits are payable on behalf of the Insured/Covered Person under the policy or any attached riders for the same or related sickness, injury or loss, benefits will be paid in the following order:
  1) Accelerated Benefit for Critical Illness, if this optional rider is attached to the policy;
  2) Accelerated Benefit for Long Term Illness, if this optional rider is attached to the policy; and
  3) Accelerated Benefit for Terminal Condition.
- Additional limitations and exclusions may apply, please read your policy/rider carefully.

Upon request to accelerate the policy/rider proceeds, and upon the payment of the accelerated benefit, the Owner and any irrevocable beneficiary shall be given a statement demonstrating the effect of the acceleration on the payment of policy proceeds, cash value, death benefit, premium, and policy loans, as applicable.

Accelerated Benefit for Terminal Condition

Prior to the payment of any Accelerated Benefit, the Insured/Covered Person must have a Terminal Condition, defined as an imminent death expected as a result of a non-correctable medical condition that with reasonable medical certainty will result in a drastically limited life span of the Insured/Covered Person of 12 months or less. The maximum payable is the lesser of: 50% of the eligible proceeds as defined in the policy/rider, or $100,000. There is no premium associated with this provision.

Payment of an Accelerated Benefit, if elected, will have the following effect on your contract:

- Upon payment of the Accelerated Benefit, the policy/rider will remain in force. Any premiums due to keep the policy/rider in force will be paid by us, and will be deducted from the policy proceeds upon death, unless you are currently exercising the Automatic Premium Loan option. If you are currently exercising the Automatic Premium Loan option, any premiums will continue to be paid under this option, until such time as this option is exhausted or discontinued.
- Policy proceeds which are payable on the death of the Insured/Covered Person will be reduced by the amount of the Accelerated Benefit, any outstanding policy loans, and any premiums paid by us on your behalf.
- Cash values, if any, will continue to accumulate as specified in your policy or rider. Access to the policy cash value may be restricted to the excess of the cash value over the sum of the amount accelerated and any premiums paid by us and any other outstanding policy loans.
- Any outstanding loan, including interest will not be deducted from the Accelerated Benefit payment.
- This Accelerated Benefit will be treated as a lien against the death benefit and applied at time of death.

Accelerated Death Benefit for Critical Illness (optional rider) Prior to the payment of any Accelerated Benefit, the Insured must have a Critical Illness, which means a Heart Attack, Permanent Damage Due To A Stroke, Invasive Cancer, Major Organ Failure, or End State Renal Failure for which an Occurrence Date is confirmed by a Physician. The maximum payable is the lesser of 25% of the Eligible Proceeds, or $50,000 if you are under age 65; or 15% of the eligible proceeds, or $25,000 if you are age 65 or older. Premium is required to keep this rider in force.

Accelerated Benefit for Long Term Illness (optional rider)

Prior to the payment of any Accelerated Benefit, the Insured must have a Long Term Illness, which means the Insured has been certified within the last 12 months by a Licensed Health Care Practitioner as permanently unable to perform, without Substantial Assistance from another individual, at least two out of five Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity; or requiring Substantial Supervision due to permanent Severe Cognitive Impairment. The maximum payable is the lesser of 50% of the Eligible Proceeds available at the time of claim payable in two equal annual payments up to a maximum of 25% of the eligible proceeds per year for two consecutive years; or $100,000 payable in two equal annual payments up to a maximum of $50,000 per year for two consecutive years. Premium is required to keep this rider in force.

Payment of an Accelerated Benefit for Long Term Illness, if elected and/or Critical Illness, if elected, will have the following effect on your contract:

- Upon payment of the Accelerated Benefit, the rider will terminate and no additional benefits will be due under the rider, even for recurrence. The policy will remain in force and premiums will continue to be billed and payable as due.
- Policy proceeds which are payable on the death of the Insured will be reduced by the amount of the Accelerated Benefit.
- Cash values, if any, will continue to accumulate as specified in your policy or rider. The cash values will be adjusted proportionally by the percent accelerated.
- Any outstanding policy loan, including interest, will be proportionally reduced by the percent accelerated and will be deducted from the Accelerated Benefit payment.
- The Accelerated Benefit will reduce the Benefit Amount and will be applied immediately upon acceleration.

ICC14 DN111

This brochure does not constitute the full policy and is intended to provide basic information about American Fidelity Assurance Company's Whole Life Insurance product, ICC14 WL14 series. For specific details, limitations and exclusions, please consult a complete policy, riders, and its provisions. Please consult your tax advisor for your specific situation. This policy is not eligible under Section 125.

We will not pay the policy proceeds if the insured commits suicide, while sane or insane for the period of time as described in the insured's policy, from the Effective date. Instead, we will return all premiums paid.

AMERICAN FIDELITY
a different opinion

9000 Cameron Parkway
Oklahoma City, Oklahoma 73114
800-654-8489
americanfidelity.com

Death Benefit

Monthly Premium Including Policy Fee

ISSUE AGE	$10,000			$25,000			$50,000			$100,000			$150,000			$200,000		
	Base	ABLTI	ABCI	Base	ABLTI	ABCI	Base	ABLTI	ABCI	Base	ABLTI	ABCI	Base	ABLTI	ABCI	Base	ABLTI	ABCI
1 mo	7.10	0.23	0.23	13.25	0.59	0.58	21.50	1.17	1.15	--			--			--		
1	7.20	0.23	0.23	13.50	0.59	0.58	21.50	1.17	1.15	--			--			--		
2	7.20	0.23	0.23	13.50	0.59	0.58	22.00	1.17	1.15	--			--			--		
3	7.30	0.23	0.23	13.75	0.59	0.58	22.00	1.17	1.15	--			--			--		
4	7.30	0.23	0.23	13.75	0.59	0.58	22.50	1.17	1.15	--			--			--		
5	7.40	0.23	0.23	14.00	0.59	0.58	22.50	1.17	1.15	--			--			--		
6	7.50	0.23	0.23	14.25	0.59	0.58	23.00	1.17	1.15	--			--			--		
7	7.70	0.23	0.23	14.75	0.59	0.58	24.00	1.17	1.15	--			--			--		
8	7.80	0.23	0.23	15.00	0.59	0.58	25.00	1.17	1.15	--			--			--		
9	8.00	0.23	0.23	15.50	0.59	0.58	25.50	1.17	1.15	--			--			--		
10	8.10	0.23	0.23	15.75	0.59	0.58	26.50	1.17	1.15	--			--			--		
11	8.30	0.23	0.23	16.25	0.59	0.58	27.50	1.17	1.15	--			--			--		
12	8.40	0.23	0.23	16.50	0.59	0.58	28.00	1.17	1.15	--			--			--		
13	8.60	0.23	0.23	17.00	0.59	0.58	29.00	1.17	1.15	--			--			--		
14	8.80	0.23	0.23	17.50	0.59	0.58	30.00	1.17	1.15	--			--			--		
15	9.00	0.23	0.23	18.00	0.59	0.58	31.00	1.17	1.15	--			--			--		
16	9.00	0.23	0.23	18.00	0.59	0.58	31.00	1.17	1.15	--			--			--		
17	9.00	0.23	0.23	18.00	0.59	0.58	31.00	1.17	1.15	59.00	2.34	2.30	85.50	3.51	3.45	113.00	4.68	4.60
18	9.00	0.23	0.23	18.00	0.59	0.58	31.00	1.17	1.15	59.00	2.34	2.30	85.50	3.51	3.45	113.00	4.68	4.60
19	9.00	0.23	0.23	18.00	0.59	0.58	31.00	1.17	1.15	59.00	2.34	2.30	85.50	3.51	3.45	113.00	4.68	4.60
20	9.00	0.23	0.23	18.00	0.59	0.58	31.00	1.17	1.15	59.00	2.34	2.30	85.50	3.51	3.45	113.00	4.68	4.60
21	9.20	0.24	0.25	18.50	0.61	0.62	32.00	1.22	1.24	61.00	2.43	2.48	88.50	3.65	3.72	117.00	4.86	4.96
22	9.40	0.25	0.27	19.00	0.63	0.67	33.00	1.26	1.33	63.00	2.52	2.66	91.50	3.78	3.99	121.00	5.04	5.32
23	9.60	0.26	0.28	19.50	0.64	0.71	34.00	1.28	1.42	65.00	2.56	2.84	94.50	3.84	4.26	125.00	5.12	5.68
24	9.90	0.26	0.30	20.25	0.65	0.76	35.50	1.31	1.51	68.00	2.61	3.02	99.00	3.92	4.53	131.00	5.22	6.04
25	10.10	0.27	0.32	20.75	0.66	0.80	36.50	1.33	1.61	70.00	2.65	3.21	102.00	3.98	4.82	135.00	5.30	6.42
26	10.30	0.28	0.35	21.25	0.70	0.88	37.50	1.41	1.75	72.00	2.81	3.50	105.00	4.22	5.25	139.00	5.62	7.00
27	10.60	0.30	0.38	22.00	0.74	0.95	39.00	1.48	1.90	75.00	2.96	3.79	109.50	4.44	5.69	145.00	5.92	7.58
28	10.90	0.31	0.41	22.75	0.78	1.02	40.50	1.56	2.04	78.00	3.11	4.08	114.00	4.67	6.12	151.00	6.22	8.16
29	11.10	0.32	0.44	23.25	0.81	1.09	41.50	1.62	2.19	80.00	3.24	4.37	117.00	4.86	6.56	155.00	6.48	8.74
30	11.40	0.35	0.46	24.00	0.86	1.16	43.00	1.73	2.32	83.00	3.45	4.64	121.50	5.18	6.96	161.00	6.90	9.28
31	11.70	0.37	0.50	24.75	0.91	1.25	44.50	1.83	2.50	86.00	3.65	5.00	126.00	5.48	7.50	167.00	7.30	10.00
32	12.10	0.38	0.54	25.75	0.96	1.34	46.50	1.92	2.68	90.00	3.83	5.36	132.00	5.75	8.04	175.00	7.66	10.72
33	12.40	0.40	0.57	26.50	1.00	1.43	48.50	2.01	2.86	94.00	4.01	5.72	138.00	6.02	8.58	183.00	8.02	11.44
34	12.80	0.42	0.61	27.50	1.04	1.52	50.50	2.09	3.04	98.00	4.17	6.08	144.00	6.26	9.12	191.00	8.34	12.16
35	13.20	0.43	0.65	28.50	1.07	1.62	52.50	2.15	3.23	102.00	4.29	6.46	150.00	6.44	9.69	199.00	8.58	12.92
36	13.70	0.45	0.70	29.75	1.13	1.75	55.00	2.25	3.49	107.00	4.50	6.98	157.50	6.75	10.47	209.00	9.00	13.96
37	14.20	0.47	0.75	31.00	1.18	1.88	57.50	2.35	3.75	112.00	4.70	7.50	165.00	7.05	11.25	219.00	9.40	15.00
38	14.70	0.49	0.80	32.25	1.22	2.01	60.00	2.44	4.01	117.00	4.88	8.02	172.50	7.32	12.03	229.00	9.76	16.04
39	15.20	0.51	0.85	33.50	1.26	2.14	62.50	2.53	4.27	122.00	5.05	8.54	180.00	7.58	12.81	239.00	10.10	17.08
40	15.80	0.52	0.90	35.00	1.31	2.26	65.50	2.62	4.52	128.00	5.24	9.04	189.00	7.86	13.56	251.00	10.48	18.08
41	16.40	0.56	0.97	36.50	1.39	2.43	68.50	2.78	4.87	134.00	5.56	9.73	198.00	8.34	14.60	263.00	11.12	19.46
42	17.00	0.59	1.04	38.00	1.47	2.61	71.50	2.93	5.21	140.00	5.86	10.42	207.00	8.79	15.63	275.00	11.72	20.84
43	17.60	0.61	1.11	39.50	1.53	2.78	75.00	3.07	5.56	147.00	6.13	11.11	217.50	9.20	16.67	289.00	12.26	22.22
44	18.30	0.64	1.18	41.25	1.60	2.95	78.50	3.20	5.90	154.00	6.39	11.80	228.00	9.59	17.70	303.00	12.78	23.60
45	19.00	0.66	1.25	43.00	1.66	3.13	82.00	3.31	6.26	161.00	6.62	12.51	238.50	9.93	18.77	317.00	13.24	25.02
46	19.80	0.70	1.33	45.00	1.75	3.33	86.00	3.49	6.67	169.00	6.98	13.33	250.50	10.47	20.00	333.00	13.96	26.66
47	20.60	0.73	1.42	47.00	1.83	3.54	90.00	3.66	7.08	177.00	7.31	14.15	262.50	10.97	21.23	349.00	14.62	28.30
48	21.50	0.76	1.50	49.25	1.90	3.74	94.50	3.81	7.49	186.00	7.61	14.97	276.00	11.42	22.46	367.00	15.22	29.94
49	22.40	0.79	1.58	51.50	1.97	3.95	99.00	3.94	7.90	195.00	7.87	15.79	289.50	11.81	23.69	385.00	15.74	31.58
50	23.30	0.81	1.66	53.75	2.03	4.16	103.50	4.05	8.32	204.00	8.10	16.63	--	--	--	--	--	--
51	24.30	0.89	1.76	56.25	2.23	4.39	108.50	4.47	8.78	214.00	8.93	17.55	--	--	--	--	--	--
52	25.40	0.97	1.85	59.00	2.42	4.62	114.00	4.85	9.24	225.00	9.69	18.47	--	--	--	--	--	--
53	26.60	1.04	1.94	62.00	2.59	4.85	120.00	5.18	9.70	237.00	10.36	19.39	--	--	--	--	--	--
54	27.80	1.10	2.03	65.00	2.74	5.08	126.00	5.48	10.16	249.00	10.96	20.31	--	--	--	--	--	--
55	29.10	1.15	2.12	68.25	2.88	5.31	132.50	5.76	10.61	262.00	11.52	21.22	--	--	--	--	--	--
56	30.40	1.21	2.19	71.50	3.03	5.47	139.00	6.05	10.93	275.00	12.10	21.86	--	--	--	--	--	--
57	31.70	1.26	2.25	74.75	3.15	5.63	145.50	6.30	11.25	288.00	12.59	22.50	--	--	--	--	--	--
58	33.10	1.30	2.31	78.25	3.25	5.79	152.50	6.50	11.57	302.00	12.99	23.14	--	--	--	--	--	--
59	34.60	1.33	2.38	82.00	3.33	5.95	160.00	6.65	11.89	317.00	13.30	23.78	--	--	--	--	--	--
60	36.10	1.35	2.44	85.75	3.38	6.11	167.50	6.77	12.21	332.00	13.53	24.42	--	--	--	--	--	--
61	37.60	1.48	2.46	89.50	3.70	6.15	175.00	7.41	12.31	347.00	14.81	24.61	--	--	--	--	--	--
62	39.10	1.59	2.48	93.25	3.97	6.20	182.50	7.95	12.40	362.00	15.89	24.80	--	--	--	--	--	--
63	40.70	1.68	2.50	97.25	4.19	6.25	190.50	8.38	12.50	378.00	16.76	24.99	--	--	--	--	--	--
64	42.40	1.74	2.52	101.50	4.35	6.30	199.00	8.71	12.59	395.00	17.41	25.18	--	--	--	--	--	--
65	44.20	1.79	2.54	106.00	4.47	6.35	208.00	8.95	12.69	413.00	17.89	25.38	--	--	--	--	--	--
66	46.40	1.87	2.65	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--
67	48.70	1.92	2.76	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--
68	51.20	2.11	2.87	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--
69	53.80	2.30	2.98	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--
70	56.50	2.49	3.09	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Spouse Coverage Available[1]

Child/ Grandchild Coverage Available[1,2]

This insert must be used in conjunction with SB-30356 and any state specific deviations thereof. *This is a brief description of the coverage and does not constitute the actual policy. For complete benefits, limitations, exclusions and other provisions, please refer to the policy. Not generally qualified Benefits under Section 125 plans. [1]Maximum face amount available is $50,000 (In WA $15,000 for child/grandchild coverage). [2]Child/grandchild coverage may be purchased through age 26 for base Whole Life coverage (In MI and PA 17. In MA and WA 14.)*

Whole Life Insurance
Tobacco User Rates

Death Benefit
Monthly Premium Including Policy Fee

ISSUE AGE	$10,000			$25,000			$50,000			$100,000			$150,000			$200,000		
	Base	ABLTI	ABCI	Base	ABLTI	ABCI	Base	ABLTI	ABCI	Base	ABLTI	ABCI	Base	ABLTI	ABCI	Base	ABLTI	ABCI
17	9.50	0.36	0.37	19.25	0.89	0.91	33.50	1.78	1.83	64.00	3.56	3.65	93.00	5.34	5.48	123.00	7.12	7.30
18	9.70	0.36	0.37	19.75	0.89	0.91	34.50	1.78	1.83	66.00	3.56	3.65	96.00	5.34	5.48	127.00	7.12	7.30
19	10.00	0.36	0.37	20.50	0.89	0.91	36.00	1.78	1.83	69.00	3.56	3.65	100.50	5.34	5.48	133.00	7.12	7.30
20	10.30	0.36	0.37	21.25	0.89	0.91	37.50	1.78	1.83	72.00	3.56	3.65	105.00	5.34	5.48	139.00	7.12	7.30
21	10.60	0.37	0.39	22.00	0.92	0.99	39.00	1.85	1.97	75.00	3.69	3.94	109.50	5.54	5.91	145.00	7.38	7.88
22	10.90	0.38	0.42	22.75	0.96	1.06	41.00	1.92	2.12	79.00	3.83	4.23	115.50	5.75	6.35	153.00	7.66	8.46
23	11.30	0.39	0.45	23.75	0.97	1.13	42.50	1.95	2.26	82.00	3.89	4.52	120.00	5.84	6.78	159.00	7.78	9.04
24	11.60	0.40	0.48	24.50	0.99	1.20	44.50	1.98	2.41	86.00	3.95	4.81	126.00	5.93	7.22	167.00	7.90	9.62
25	12.00	0.40	0.51	25.50	0.99	1.28	46.50	1.99	2.56	90.00	3.97	5.11	132.00	5.96	7.67	175.00	7.94	10.22
26	12.40	0.42	0.56	26.50	1.06	1.41	48.00	2.12	2.82	93.00	4.23	5.64	136.50	6.35	8.46	181.00	8.46	11.28
27	12.70	0.45	0.62	27.25	1.12	1.54	50.00	2.24	3.09	97.00	4.48	6.17	142.50	6.72	9.26	189.00	8.96	12.34
28	13.10	0.47	0.67	28.25	1.18	1.68	51.50	2.36	3.35	100.00	4.72	6.70	147.00	7.08	10.05	195.00	9.44	13.40
29	13.50	0.49	0.72	29.25	1.24	1.81	53.50	2.47	3.62	104.00	4.94	7.23	153.00	7.41	10.85	203.00	9.88	14.46
30	13.90	0.52	0.77	30.25	1.30	1.94	55.50	2.60	3.87	108.00	5.20	7.74	159.00	7.80	11.61	211.00	10.40	15.48
31	14.30	0.55	0.85	31.25	1.38	2.12	58.00	2.76	4.23	113.00	5.51	8.46	166.50	8.27	12.69	221.00	11.02	16.92
32	14.80	0.58	0.92	32.50	1.45	2.30	60.50	2.91	4.59	118.00	5.81	9.18	174.00	8.72	13.77	231.00	11.62	18.36
33	15.30	0.61	0.99	33.75	1.52	2.48	63.00	3.05	4.95	123.00	6.09	9.90	181.50	9.14	14.85	241.00	12.18	19.80
34	15.80	0.64	1.06	35.00	1.59	2.66	65.50	3.18	5.31	128.00	6.35	10.62	189.00	9.53	15.93	251.00	12.70	21.24
35	16.30	0.65	1.13	36.25	1.63	2.83	68.50	3.26	5.67	134.00	6.52	11.33	198.00	9.78	17.00	263.00	13.04	22.66
36	16.90	0.69	1.24	37.75	1.72	3.11	71.50	3.45	6.21	140.00	6.89	12.42	207.00	10.34	18.63	275.00	13.78	24.84
37	17.60	0.72	1.35	39.50	1.81	3.38	75.00	3.62	6.76	147.00	7.23	13.51	217.50	10.85	20.27	289.00	14.46	27.02
38	18.20	0.76	1.46	41.00	1.89	3.65	78.00	3.78	7.30	153.00	7.55	14.60	226.50	11.33	21.90	301.00	15.10	29.20
39	19.00	0.79	1.57	43.00	1.96	3.92	82.00	3.93	7.85	161.00	7.85	15.69	238.50	11.78	23.54	317.00	15.70	31.38
40	19.70	0.81	1.68	44.75	2.02	4.20	85.50	4.05	8.40	168.00	8.09	16.79	249.00	12.14	25.19	331.00	16.18	33.58
41	20.60	0.86	1.84	47.00	2.16	4.61	90.00	4.32	9.21	177.00	8.64	18.42	262.50	12.96	27.63	349.00	17.28	36.84
42	21.50	0.92	2.01	49.25	2.29	5.01	94.50	4.58	10.03	186.00	9.16	20.05	276.00	13.74	30.08	367.00	18.32	40.10
43	22.50	0.96	2.17	51.75	2.41	5.42	99.50	4.82	10.84	196.00	9.63	21.68	291.00	14.45	32.52	387.00	19.26	43.36
44	23.50	1.01	2.33	54.25	2.52	5.83	104.50	5.04	11.66	206.00	10.07	23.31	306.00	15.11	34.97	407.00	20.14	46.62
45	24.60	1.05	2.50	57.00	2.62	6.24	110.00	5.25	12.48	217.00	10.49	24.95	322.50	15.74	37.43	429.00	20.98	49.90
46	25.70	1.12	2.71	59.75	2.80	6.79	115.50	5.60	13.57	228.00	11.19	27.14	339.00	16.79	40.71	451.00	22.38	54.28
47	26.80	1.18	2.93	62.50	2.96	7.33	121.00	5.92	14.67	239.00	11.83	29.33	355.50	17.75	44.00	473.00	23.66	58.66
48	28.00	1.24	3.15	65.50	3.10	7.88	127.00	6.21	15.76	251.00	12.41	31.52	373.50	18.62	47.28	497.00	24.82	63.04
49	29.30	1.29	3.37	68.75	3.24	8.43	133.00	6.47	16.86	263.00	12.94	33.71	391.50	19.41	50.57	521.00	25.88	67.42
50	30.60	1.34	3.59	72.00	3.35	8.97	139.50	6.70	17.95	276.00	13.40	35.89	--	--	--	--	--	--
51	32.00	1.50	3.88	75.50	3.75	9.70	146.50	7.50	19.41	290.00	14.99	38.81	--	--	--	--	--	--
52	33.50	1.65	4.17	79.25	4.11	10.43	154.50	8.23	20.87	306.00	16.45	41.73	--	--	--	--	--	--
53	35.10	1.78	4.47	83.25	4.44	11.16	162.50	8.88	22.33	322.00	17.76	44.65	--	--	--	--	--	--
54	36.80	1.89	4.76	87.50	4.73	11.89	171.00	9.46	23.79	339.00	18.92	47.57	--	--	--	--	--	--
55	38.60	1.99	5.05	92.00	4.98	12.63	180.00	9.96	25.25	357.00	19.91	50.50	--	--	--	--	--	--
56	40.20	2.11	5.32	96.00	5.28	13.30	188.00	10.56	26.61	373.00	21.12	53.21	--	--	--	--	--	--
57	41.90	2.22	5.59	100.25	5.54	13.98	196.50	11.08	27.96	390.00	22.15	55.92	--	--	--	--	--	--
58	43.70	2.30	5.86	104.75	5.76	14.66	205.50	11.51	29.32	408.00	23.02	58.63	--	--	--	--	--	--
59	45.50	2.37	6.13	109.25	5.93	15.34	214.50	11.86	30.67	426.00	23.72	61.34	--	--	--	--	--	--
60	47.50	2.43	6.40	114.25	6.06	16.01	224.50	12.13	32.02	446.00	24.25	64.03	--	--	--	--	--	--
61	48.60	2.69	6.57	117.00	6.71	16.41	230.00	13.43	32.83	457.00	26.85	65.65	--	--	--	--	--	--
62	49.80	2.91	6.73	120.00	7.27	16.82	236.00	14.53	33.64	469.00	29.06	67.27	--	--	--	--	--	--
63	51.10	3.09	6.89	123.25	7.71	17.22	242.00	15.43	34.45	481.00	30.85	68.89	--	--	--	--	--	--
64	52.30	3.22	7.05	126.25	8.06	17.63	248.00	16.12	35.26	493.00	32.24	70.51	--	--	--	--	--	--
65	53.60	3.32	7.21	129.50	8.31	18.04	254.50	16.62	36.07	506.00	33.23	72.14	--	--	--	--	--	--
66	56.10	3.56	7.61	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--
67	58.70	3.72	8.00	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--
68	61.50	4.15	8.40	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--
69	64.40	4.57	8.79	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--
70	67.50	4.99	9.19	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Spouse Coverage Available[1]

Child/ Grandchild Coverage Available[1,2]

RIDER RATES

ACCELERATED BENEFIT FOR LONG TERM ILLNESS RIDER (ABLTI): Add the rate shown in the ABLTI column to the base rate.

ACCELERATED BENEFIT FOR CRITICAL ILLNESS RIDER (ABCI): Add the rate shown in the ABCI column to the base rate.

CHILDREN'S TERM RIDER: $10,000: $4.80 / $20,000: $9.60 / $30,000: $14.40. Issue ages 1mo thru 19 (17 in MI and PA, 14 in MA and WA). Subject to the overall child maximum of $50,000 ($15,000 in WA). Grandchildren are not eligible for this rider.

ACCIDENTAL DEATH & DISMEMBERMENT RIDER: For the monthly rate, multiply .08 per $1,000 of coverage.

WAIVER OF PREMIUM RIDER: Add the base policy and all other riders and multiply by 7% to get the premium amount for the rider.

American Fidelity Assurance Company
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AMERICAN FIDELITY
a different opinion

Premier Partner Carriers

We understand the importance employees place on core health and welfare benefits – including dental, vision, and group life insurance – in addition to their supplemental benefits. That's why we deliver a single source for comprehensive, customized benefit solutions for both employers and employees through the American Fidelity General Agency.

Instead of utilizing multiple vendors to acquire core benefit solutions for your employees, let American Fidelity General Agency provide assistance by evaluating available options from its network of trusted, premier carriers.

Here are some of the carriers we have a relationships with:

Always Care
Ameritas
AUL/One America
Boston Mutual
Cigna
Companion Life
Delta Dental (Multi-State)
Dental Care Plus
EyeMed
Foundation One
Guardian Life
Hartford
Health Resources Inc.
Life Secure
Lincoln Financial
Mass Mutual
MetLife
Mutual of Omaha
Principal Financial
Reliance Standard
Security Life
The Standard
Sunlife
Superior Dental
Superior Vision
Texas Life
Transamerica
Vision Care Direct
Vision Service Plan (VSP)
Voya
VPI Pet Insurance

Products offered by American Fidelity General Agency through Partner Carriers:

- Individual Worksite Life Insurance
- Group Life Insurance
- Group Accidental Death & Dismemberment Insurance
- Group Vision Insurance
- Group Dental Insurance
- Individual Long Term Care Insurance
- Hospital and other Medical Indemnity Insurance

Some products and services may be provided by third-party contractors or affiliated companies.

Underwritten By

TEXASLIFE INSURANCE COMPANY

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PURELIFE-PLUS

Flexible Premium Life Insurance to Age 121

Portable, Permanent Individual Life Insurance for the Employee and Family

Policy Form: ICC18-PRFNG-NI-18

Product Highlights

Permanent Life Insurance to Age 121

Minimal Cash Value Premiums Dedicated Primarily to Purchase Life Insurance

Level Premium Guarantees Coverage for a Significant Period of Time

Unique Limited Right to Partial Refund of Premium if Future Premium Required to Continue Coverage Increases

No Surrender Charges Apply

Accelerated Death Benefit Due to Terminal Illness Included

Convenient Premium Payments Through Payroll Deduction

Portable When You Leave Employment

Accidental Death Benefit Included for Selected Ages

Accelerated Death Benefit Due to Chronic Illness Included
For Employee Only

Marketed by

American Fidelity General Agency
a different opinion

Application for Life Insurance

Express Issue | Monthly Pay

FOR USE ONLY IN

Tennessee

Portable, Permanent, Individual Life Insurance for Employees and Their Families

As an employee, you can apply for valuable life insurance protection on you and your family under eligibility guidelines established for your employer. Your employer has conveniently agreed to permit you to pay premiums through payroll deduction. This is a summary only. Policy provisions prevail. This brochure is not a contract or an offer to contract.

Minimal Cash Values Buy this policy for its life insurance protection, not its cash value. The primary benefit is life insurance. Payment of the Table Premium produces a small cash value (Benchmark Cash Value).

Permanent Life Insurance Coverage Unlike group term life insurance, PureLife-plus is a personally owned, permanent individual life insurance policy to age 121 that can never be canceled or reduced as long as you pay the necessary premiums, even if your health changes.

Guaranteed Period Continuous, timely, and uninterrupted payment of the Table Premium guarantees coverage for the Guaranteed Period shown. Texas Life (We) cannot legally predict the premium required to continue coverage after the Guaranteed Period. It may be lower, the same, or higher than the Table Premium. However, if the premium to continue coverage is ever higher, We guarantee a limited right to a partial refund of premium (described below).

Guaranteed Limited Right to Partial Refund of Premium If a premium higher than the Table Premium is ever required to continue coverage after the Guaranteed Period, you have the choice to:

a. Pay the higher premium(s) required to continue coverage; or,
b. Surrender the policy and receive a partial refund of premium equal to 120 times the minimum monthly premium due at issue (ten years worth of Table Premium). You are eligible for this refund if the actual cash value equals or exceeds the Benchmark Cash Value and you have taken no prior partial surrenders.

Portable Once issued, continued employment is not a condition to continue coverage. Coverage is guaranteed as long as required premiums are paid, even after you retire or terminate employment. When employment ends, you can pay equivalent monthly premiums directly or by bank draft (for monthly direct payments we add a monthly fee not to exceed $2.00). Other modes are available.

Accelerated Death Benefit Due to Terminal Illness Rider This policy includes, at no additional premium, an Accelerated Death Benefit Due to Terminal Illness Rider (Form ICC07-ULABR-07). See details on next page.

Individual and Family Coverage is Easy to Apply For Subject to age and amount restrictions, you may apply for an individual policy on your life or your spouse's life (see chart next page for spouse's minimum/maximum amounts). An individual policy for $25,000 is also available on each of your children ages 15 days — 26, and even on each of your grandchildren ages 15 days — 18. Proof of insurability is required. Most policies are issued based upon the answers to three work and health related application questions.

Optional Benefits According to the guidelines established for your employer, your application will include the following benefit for an additional cost depending upon your issue age.

Accidental Death Benefit This benefit to age 65 (Issue Ages 17-59) doubles the coverage when death occurs by accidental bodily injury within 180 days of an accident. Maximum in-force limits and exclusions apply. (Form ICC07-ULCL-ADB-07).

Accelerated Death Benefit Rider For Chronic Illness For Employee Only This benefit provides an accelerated death benefit if an insured becomes chronically ill as defined in the rider. (Form ICC15-ULABR-CI-15). See details on next page.

Interim Insurance: Interim insurance will be in force on the application date if these conditions are met: (1) the insurance is purchased through payroll deduction; (2) the Salary Deduction Authorization is signed; and, (3) the proposed insured is insurable at standard rates under Our rules and usual practice. Interim insurance remains in effect until the earlier of: (a) the Policy Date; (b) the date We decline the application; (c) the date We notify the applicant that s/he is ineligible for interim insurance; or, (d) the 180th day after the application date.

Policy Mechanics and Other Important Details Premiums are flexible. However, we highly recommend payment of the Table Premium during the Guaranteed Period, and no partial surrenders or policy loans. Table Premium produces a small cash value (Benchmark Cash Value). Paying a lesser premium results in an actual cash value which is less than Benchmark Cash Value, causing the policy to lapse. Premiums less a premium load create cash value to pay monthly administrative loads and cost of insurance. Cash value is currently credited at the guaranteed interest rate of 3.00% per year. We may, at any time, credit higher than the guaranteed interest rate. Likewise, We may charge cost of insurance rates which are less than the policy's maximum rates, but only when actual cash value equals or exceeds Benchmark Cash Value. No surrender charges apply. Loads include 10.00% of premium, $2.03 per month and monthly administrative loads. Two year suicide and contestable clauses apply. The policy loan rate is 7.40% in advance. Surrenders and loans may be deferred for up to six months.

TEXAS**LIFE** INSURANCE COMPANY

A Summary of the Accelerated Death Benefit Rider

Terminal Illness - included at no additional cost

The policy includes an Accelerated Death Benefit Due to Terminal Illness Rider. If the Insured has a terminal illness, in lieu of the insurance proceeds otherwise payable at death, you may elect to claim an accelerated benefit while the Insured is still alive. The single sum benefit is 92% of the insurance proceeds less an administrative fee of the lesser of $150 or 7% of the insurance proceeds. Terminal Illness is an injury or sickness diagnosed and certified by a qualifying physician that, despite the appropriate medical care, is reasonably expected to result in death within 12 months. This benefit is intended to qualify for favorable income tax treatment and may not be subject to federal income tax. (See Important Notices below.)

Chronic Illness - included with an additional premium, for employee only

For an additional premium of 10% of the base policy premium, this policy may include an Accelerated Death Benefit Due to Chronic Illness Rider. If the Insured has a chronic illness, in lieu of the insurance proceeds otherwise payable at death, you may elect to claim an accelerated benefit while the Insured is still alive. The single sum benefit is 92% of the insurance proceeds less an administrative fee of the lesser of $150 or 7% of the insurance proceeds. Chronic Illness means the Insured permanently: (a) is unable to perform, without substantial assistance from another individual, at least two Activities of Daily Living due to a loss of functional capacity and will need services for the rest of his or her life; or (b) requires substantial supervision to protect the Insured from threats to health and safety due to severe cognitive impairment and will need services for the rest of his or her life. Activities of Daily Living include: bathing, continence, dressing, eating, toileting, and transferring. Severe cognitive impairment means deterioration or loss of intellectual capacity that: (1) places the Insured in jeopardy of harming himself or herself or others, and therefore, the Insured requires substantial supervision by another person; and (2) is measured by clinical evidence and standardized tests which reliably measure impairment in: (a) short or long term memory; (b) orientation to people, places or time; and (c) deductive or abstract reasoning.

This benefit will be calculated and paid as a lump sum only. This lump sum is intended to serve as a per diem accelerated death benefit as described under Section 101(g) of the Internal Revenue Code. You may be able to exclude certain portions of this accelerated death benefit (specifically, the greater of: (a) the lump sum equivalent of the per diem amount; or (b) the actual cost incurred for Services provided in the year the Accelerated Death Benefit is paid) from your taxable income. Your benefit for Chronic Illness will be calculated in accordance with the rider and you may, in some circumstances, be paid more than the excludable per diem amount.

Important Notices

Tax laws related to the acceleration of life insurance benefits are complex. The information presented in this Summary is general in nature. You should consult a qualified tax or legal advisor to determine the effect of receiving this benefit. Texas Life Insurance Company and its agents do not provide tax or legal advice.

Receipt of any accelerated death benefit under your policy may affect your, your spouse's and your family's eligibility for medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), Supplemental Social Security Income (SSI), and drug assistance programs. You should consult with a qualified tax or legal advisor and the relevant social service agencies to determine how receiving the benefit may affect your, your spouse's, and your family's eligibility for public assistance.

An accelerated death benefit is not long term care insurance. This summary provides a general description of any accelerated death benefit under your policy. Your policy and riders contain certain exclusions, limitations, and exceptions. Please refer to your policy and rider for details. The right to accelerate benefits under any accelerated death benefit does not extend to any Child Term Life Insurance Rider. However, if the accelerated death benefit under any rider is paid, any coverage provided under the Child Term Life Insurance Rider attached to this policy becomes a paid up term insurance policy on each covered child.

This paid up coverage on each child will terminate on each covered child's 25th birthday. Payment under any accelerated death benefit rider terminates the policy and all other optional benefits/riders and reduces all insurance proceeds, cash values and loan values to zero.

18P061 PLP18 CI

Representation of benefit payable - Terminal or Chronic Illness

The following chart shows the effect of exercising an accelerated benefit on the base policy. This example is using a $50,000 policy with a $2,000 policy loan balance and all premiums are current. This chart is for representation purposes only. Your benefits may be higher or lower, depending on your face amount of coverage, any unpaid policy loan balance, and any overdue premiums.

	Terminal Illness	Chronic Illness
Death Benefit	$50,000	$50,000
Policy Loan Balance	- $2,000	- $2,000
Available for Acceleration	= $48,000	= $48,000
Acceleration Percentage	x 92%	x 92%
Gross Benefit	= $44,160	= $44,160
Administration Fee	- $150	- $150
Overdue Premiums	- $0	- $0
Accelerated Benefit Payable	= $44,010	= $44,010

Note: The benefit will be paid for either Terminal Illness or Chronic Illness. In no instance will benefits be paid under both riders.

OPTIONAL BENEFITS MONTHLY COST:

Accidental Death Benefit ..... $0.08 per $1,000 of Face Amount
Accelerated Death Benefit Rider For Chronic Illness ..... 10% of Base Plan Table Premium

EXPRESS ISSUE AMOUNTS OF COVERAGE AVAILABLE ON SPOUSE

Spouse's Issue Age	Minimum Face Amount	Maximum Face Amount
17-34	$25,000	$50,000
35-39	15,000	50,000
40-49	10,000	50,000
50-60	10,000	25,000
61 & Older	N/A	N/A

Monthly Administrative Loads Per $1,000 of Face Amount for Issue Ages Shown

(Non-Tobacco Class)

Issue Age ⟶	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Highest Load	0.1975	0.1975	0.2067	0.2067	0.2167	0.2167	0.2167	0.2167	0.2167	0.2159	0.2150	0.2225	0.2184	0.2117	0.2017
Lowest Load	0.0292	0.0234	0.1892	0.1950	0.1642	0.1717	0.1792	0.1884	0.1992	0.0009	0.0250	0.0142	0.0609	0.1192	0.0009
Zero After Year	6	6	5	5	5	5	5	5	5	6	6	6	6	6	7

Issue Age ⟶	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29
Highest Load	0.1917	0.1792	0.1742	0.1734	0.1734	0.1750	0.1917	0.1959	0.2050	0.2067	0.2084	0.2175	0.2267	0.2267	0.2359
Lowest Load	0.0534	0.0959	0.1250	0.1392	0.1525	0.1617	0.1109	0.1100	0.0600	0.0600	0.0584	0.0084	0.1984	0.2134	0.2067
Zero After Year	7	7	7	7	7	7	7	7	7	7	7	7	6	6	6

Issue Age ⟶	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44
Highest Load	0.2417	0.2384	0.2500	0.2600	0.2675	0.2850	0.2909	0.3000	0.3209	0.3534	0.3825	0.4209	0.4767	0.5359	0.5950
Lowest Load	0.2034	0.0467	0.0167	0.2184	0.2084	0.1475	0.1317	0.1075	0.0392	0.2684	0.1859	0.0684	0.3667	0.2350	0.1042
Zero After Year	6	7	7	6	6	6	6	6	6	5	5	5	4	4	4

Issue Age ⟶	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59
Highest Load	0.6617	0.7275	0.7834	0.8467	0.9184	1.0067	1.1084	1.2342	1.3567	1.4350	1.5042	1.5750	1.6542	1.7417	1.8142
Lowest Load	0.6300	0.5509	0.4942	0.4267	0.3450	0.2417	0.1125	1.1984	1.1592	1.1684	1.1934	1.2217	1.2484	1.2742	1.3225
Zero After Year	3	3	3	3	3	3	3	2	2	2	2	2	2	2	2

Issue Age ⟶	60	61	62	63	64	65	66	67	68	69	70
Highest Load	1.9175	2.0117	2.1084	2.2075	2.3109	2.4184	2.5400	2.6734	2.8159	2.9534	3.0742
Lowest Load	1.3500	1.3950	1.4484	1.5092	1.5767	1.6525	1.7284	1.8067	1.8934	1.8875	1.7592
Zero After Year	2	2	2	2	2	2	2	2	2	2	2

Monthly Administrative Loads Per $1,000 of Face Amount for Issue Ages Shown

(Tobacco Class)

Issue Age ⟶	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Highest Load	0.3267	0.3242	0.3225	0.3209	0.3367	0.3342	0.3575	0.3575	0.3584	0.3675	0.3767	0.3850	0.3925	0.4600	0.4542
Lowest Load	0.3092	0.0067	0.0342	0.0625	0.0200	0.0517	0.3392	0.0017	0.0259	0.0150	0.0067	0.0059	0.0134	0.2392	0.2917
Zero After Year	4	5	5	5	5	5	4	5	5	5	5	5	5	4	4

Issue Age ⟶	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46
Highest Load	0.4659	0.4659	0.4650	0.5000	0.5159	0.5484	0.5600	0.5950	0.6567	0.7009	0.7625	0.8725	0.9317	1.0159	1.0875
Lowest Load	0.2959	0.3359	0.3800	0.3242	0.3267	0.2875	0.3125	0.2609	0.1325	0.0550	0.6934	0.5359	0.4892	0.3984	0.3342
Zero After Year	4	4	4	4	4	4	4	4	4	4	3	3	3	3	3

Issue Age ⟶	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61
Highest Load	1.1575	1.2250	1.3442	1.4142	1.5342	1.6867	1.8000	1.8800	1.9542	2.0392	2.1075	2.1942	2.2434	2.3075	2.4300
Lowest Load	0.2800	0.2350	0.0942	0.0559	1.4884	1.4517	1.4617	1.5125	1.5775	1.6409	1.7309	1.8117	1.9417	2.0675	2.1467
Zero After Year	3	3	3	3	2	2	2	2	2	2	2	2	2	2	2

Issue Age ⟶	62	63	64	65	66	67	68	69	70
Highest Load	2.5217	2.5917	2.6484	2.7000	2.7609	2.8300	2.8967	2.9625	3.0192
Lowest Load	2.2692	2.2692	2.2084	2.1534	2.0884	2.0150	1.9434	1.8725	1.8117
Zero After Year	2	2	2	2	2	2	2	2	2

TEXASLIFE INSURANCE COMPANY

EMPLOYEE MONTHLY PREMIUMS

PureLife-plus — Standard Risk Table Premiums — Non-Tobacco — Express Issue

Issue Age (ALB)	Monthly Premiums for Life Insurance Face Amounts Shown Includes Added Cost for Accidental Death Benefit (Ages 17-59) and Accelerated Death Benefit for Chronic Illness (All Ages) $10,000	$15,000	$25,000	$50,000	$75,000	$100,000	$125,000	$150,000	$200,000	GUARANTEED PERIOD Age to Which Coverage is Guaranteed at Table Premium
15D-1										83
2-3										83
4-10										79
11-16										75
17-20			11.40	20.55	29.70	38.85	48.00	57.15	75.45	73
21-22			11.68	21.10	30.53	39.95	49.38	58.80	77.65	73
23-25			11.95	21.65	31.35	41.05	50.75	60.45	79.85	71
26			12.23	22.20	32.18	42.15	52.13	62.10	82.05	72
27			12.50	22.75	33.00	43.25	53.50	63.75	84.25	72
28			12.50	22.75	33.00	43.25	53.50	63.75	84.25	71
29			12.78	23.30	33.83	44.35	54.88	65.40	86.45	71
30-31			13.05	23.85	34.65	45.45	56.25	67.05	88.65	70
32			13.60	24.95	36.30	47.65	59.00	70.35	93.05	70
33			14.15	26.05	37.95	49.85	61.75	73.65	97.45	71
34			14.70	27.15	39.60	52.05	64.50	76.95	101.85	72
35		10.22	15.53	28.80	42.08	55.35	68.63	81.90	108.45	73
36		10.55	16.08	29.90	43.73	57.55	71.38	85.20	112.85	73
37		10.88	16.63	31.00	45.38	59.75	74.13	88.50	117.25	73
38		11.37	17.45	32.65	47.85	63.05	78.25	93.45	123.85	74
39		12.03	18.55	34.85	51.15	67.45	83.75	100.05	132.65	75
40	9.21	12.69	19.65	37.05	54.45	71.85	89.25	106.65	141.45	76
41	9.76	13.52	21.03	39.80	58.58	77.35	96.13	114.90	152.45	77
42	10.53	14.67	22.95	43.65	64.35	85.05	105.75	126.45	167.85	78
43	11.30	15.83	24.88	47.50	70.13	92.75	115.38	138.00	183.25	80
44	12.07	16.98	26.80	51.35	75.90	100.45	125.00	149.55	198.65	81
45	12.95	18.30	29.00	55.75	82.50	109.25	136.00	162.75	216.25	82
46	13.83	19.62	31.20	60.15	89.10	118.05	147.00	175.95	233.85	83
47	14.60	20.78	33.13	64.00	94.88	125.75	156.63	187.50	249.25	83
48	15.48	22.10	35.33	68.40	101.48	134.55	167.63	200.70	266.85	84
49	16.47	23.58	37.80	73.35	108.90	144.45	180.00	215.55	286.65	85
50	17.68	25.40	40.83	79.40	117.98	156.55				86
51	19.11	27.54	44.40	86.55	128.70	170.85				87
52	20.87	30.18	48.80	95.35	141.90	188.45				88
53	22.63	32.82	53.20	104.15	155.10	206.05				90
54	23.84	34.64	56.23	110.20	164.18	218.15				90
55	24.94	36.29	58.98	115.70	172.43	229.15				91
56	26.04	37.94	61.73	121.20	180.68	240.15				91
57	27.25	39.75	64.75	127.25	189.75	252.25				91
58	28.57	41.73	68.05	133.85	199.65	265.45				91
59	29.78	43.55	71.08	139.90	208.73	277.55				91
60	30.63	44.82	73.20	144.15	215.10	286.05				91
61	32.28	47.30	77.33	152.40	227.48	302.55				91
62	34.04	49.94	81.73	161.20	240.68	320.15				92
63	35.91	52.74	86.40	170.55	254.70	338.85				92
64	37.89	55.71	91.35	180.45	269.55	358.65				92
65	39.98	58.85	96.58	190.90	285.23	379.55				92
66	42.29									92
67	44.82									92
68	47.57									92
69	50.43									93
70	53.29									93

PureLife-plus is permanent life insurance to Attained Age 121 that can never be cancelled as long as you pay the necessary premiums. After the Guaranteed Period, the premiums can be lower, the same, or higher than the Table Premium. See the brochure under "Permanent Coverage".

TEXASLIFE INSURANCE COMPANY — EMPLOYEE MONTHLY PREMIUMS

PureLife-plus — Standard Risk Table Premiums — Tobacco — Express Issue

Issue Age (ALB)	Monthly Premiums for Life Insurance Face Amounts Shown. Includes Added Cost for Accidental Death Benefit (Ages 17-59) and Accelerated Death Benefit for Chronic Illness (All Ages)									GUARANTEED PERIOD Age to Which Coverage is Guaranteed at Table Premium
	$10,000	$15,000	$25,000	$50,000	$75,000	$100,000	$125,000	$150,000	$200,000	
15D-1										83
2-3										83
4-10										79
11-16										75
17-20			16.08	29.90	43.73	57.55	71.38	85.20	112.85	70
21-22			16.63	31.00	45.38	59.75	74.13	88.50	117.25	70
23-25			17.45	32.65	47.85	63.05	78.25	93.45	123.85	69
26			17.73	33.20	48.68	64.15	79.63	95.10	126.05	69
27			18.00	33.75	49.50	65.25	81.00	96.75	128.25	68
28			18.28	34.30	50.33	66.35	82.38	98.40	130.45	68
29			18.55	34.85	51.15	67.45	83.75	100.05	132.65	68
30-31			20.75	39.25	57.75	76.25	94.75	113.25	150.25	69
32			21.30	40.35	59.40	78.45	97.50	116.55	154.65	69
33			21.58	40.90	60.23	79.55	98.88	118.20	156.85	69
34			21.85	41.45	61.05	80.65	100.25	119.85	159.05	68
35		14.84	23.23	44.20	65.18	86.15	107.13	128.10	170.05	69
36		15.33	24.05	45.85	67.65	89.45	111.25	133.05	176.65	69
37		16.16	25.43	48.60	71.78	94.95	118.13	141.30	187.65	70
38		16.65	26.25	50.25	74.25	98.25	122.25	146.25	194.25	70
39		17.64	27.90	53.55	79.20	104.85	130.50	156.15	207.45	70
40	13.50	19.13	30.38	58.50	86.63	114.75	142.88	171.00	227.25	72
41	14.27	20.28	32.30	62.35	92.40	122.45	152.50	182.55	242.65	73
42	15.26	21.77	34.78	67.30	99.83	132.35	164.88	197.40	262.45	74
43	16.80	24.08	38.63	75.00	111.38	147.75	184.13	220.50	293.25	76
44	17.68	25.40	40.83	79.40	117.98	156.55	195.13	233.70	310.85	77
45	18.89	27.21	43.85	85.45	127.05	168.65	210.25	251.85	335.05	78
46	19.99	28.86	46.60	90.95	135.30	179.65	224.00	268.35	357.05	79
47	21.09	30.51	49.35	96.45	143.55	190.65	237.75	284.85	379.05	79
48	22.19	32.16	52.10	101.95	151.80	201.65	251.50	301.35	401.05	80
49	23.95	34.80	56.50	110.75	165.00	219.25	273.50	327.75	436.25	82
50	25.16	36.62	59.53	116.80	174.08	231.35				82
51	27.03	39.42	64.20	126.15	188.10	250.05				83
52	29.34	42.89	69.98	137.70	205.43	273.15				85
53	31.21	45.69	74.65	147.05	219.45	291.85				87
54	32.75	48.00	78.50	154.75	231.00	307.25				87
55	34.29	50.31	82.35	162.45	242.55	322.65				87
56	36.05	52.95	86.75	171.25	255.75	340.25				87
57	37.70	55.43	90.88	179.50	268.13	356.75				87
58	39.68	58.40	95.83	189.40	282.98	376.55				87
59	41.33	60.87	99.95	197.65	295.35	393.05				87
60	42.51	62.64	102.90	203.55	304.20	404.85				87
61	45.37	66.93	110.05	217.85	325.65	433.45				88
62	48.01	70.89	116.65	231.05	345.45	459.85				88
63	50.54	74.69	122.98	243.70	364.43	485.15				88
64	53.07	78.48	129.30	256.35	383.40	510.45				89
65	55.71	82.44	135.90	269.55	403.20	536.85				89
66	58.57									89
67	61.65									89
68	64.84									89
69	68.25									89
70	71.88									90

PureLife-plus is permanent life insurance to Attained Age 121 that can never be cancelled as long as you pay the necessary premiums. After the Guaranteed Period, the premiums can be lower, the same, or higher than the Table Premium. See the brochure under "Permanent Coverage".

TEXASLIFE INSURANCE COMPANY

EMPLOYEE MONTHLY PREMIUMS

PureLife-plus — Standard Risk Table Premiums — Non-Tobacco — Express Issue

Issue Age (ALB)	Prem For $10,000 Face	Life Insurance Face Amounts for Monthly Premiums Shown Includes Added Cost for Accidental Death Benefit (Ages 17-59) and Accelerated Death Benefit for Chronic Illness (All Ages) $18.00	$20.00	$24.00	$28.00	$30.00	$32.00	$35.00	$40.00	GUARANTEED PERIOD Age to Which Coverage is Guaranteed at Table Premium
15D-1										83
2-3										83
4-10										79
11-16										75
17-20		43,033	48,498	59,427	70,356	75,820	81,289	89,480	103,143	73
21-22		41,778	47,083	57,687	68,313	73,608	78,913	86,870	100,133	73
23-25		40,589	45,748	56,057	66,366	71,521	76,676	84,411	97,304	71
26		39,474	44,487	54,512	64,537	69,549	74,563	82,081	94,612	72
27		38,417	43,293	53,050	62,813	67,684	72,561	79,879	92,074	72
28		38,417	43,293	53,050	62,813	67,684	72,561	79,879	92,074	71
29		37,411	42,162	51,663	61,164	65,920	70,666	77,791	89,668	71
30-31		36,453	41,088	50,348	59,607	64,234	68,866	75,811	87,385	70
32		34,691	39,097	47,908	56,719	61,124	65,529	72,137	83,150	70
33		33,089	37,292	45,694	54,097	58,299	62,500	68,803	79,307	71
34		31,627	35,645	43,675	51,707	55,723	59,739	65,764	75,804	72
35		29,662	33,428	40,961	48,494	52,260	56,027	61,677	71,093	73
36		28,482	32,098	39,331	46,565	50,181	53,803	59,220	68,265	73
37		27,392	30,870	37,827	44,783	48,261	51,740	56,957	65,656	73
38		25,907	29,195	35,774	42,352	45,642	48,931	53,864	62,089	74
39		24,157	27,221	33,359	39,494	42,563	45,629	50,231	57,899	75
40	9.21	22,630	25,503	31,250	36,998	39,871	42,745	47,055	54,239	76
41	9.76	20,973	23,636	28,959	34,288	36,951	39,614	43,609	50,267	77
42	10.53	19,023	21,437	26,269	31,100	33,515	35,934	39,554	45,592	78
43	11.30	17,404	19,614	24,034	28,454	30,663	32,873	36,188	41,713	80
44	12.07	16,039	18,076	22,149	26,222	28,259	30,299	33,351	38,442	81
45	12.95	14,720	16,589	20,327	24,062	25,938	27,806	30,608	35,281	82
46	13.83	13,602	15,329	18,783	22,237	23,964	25,688	28,282	32,600	83
47	14.60	12,754	14,373	17,612	20,851	22,470	24,090	26,520	30,566	83
48	15.48	11,905	13,417	16,438	19,464	20,976	22,487	24,755	28,536	84
49	16.47	11,076	12,483	15,296	18,109	19,515	20,923	23,031	26,548	85
50	17.68	10,206	11,504	14,096	16,687	17,985	19,282	21,225	24,466	86
51	19.11		10,528	12,901	15,273	16,460	17,646	19,425	22,391	87
52	20.87			11,683	13,830	14,905	15,978	17,589	20,275	88
53	22.63			10,673	12,635	13,617	14,598	16,070	18,524	90
54	23.84			10,075	11,929	12,854	13,781	15,170	17,485	90
55	24.94				11,349	12,231	13,112	14,435	16,638	91
56	26.04				10,824	11,665	12,506	13,767	15,868	91
57	27.25				10,300	11,100	11,900	13,100	15,100	91
58	28.57					10,544	11,304	12,441	14,342	91
59	29.78					10,080	10,807	11,897	13,713	91
60	30.63						10,483	11,540	13,302	91
61	32.28							10,906	12,571	91
62	34.04							10,302	11,875	92
63	35.91								11,216	92
64	37.89								10,593	92
65	39.98								10,006	92
66	42.29									92
67	44.82									92
68	47.57									92
69	50.43									93
70	53.29									93

PureLife-plus is permanent life insurance to Attained Age 121 that can never be cancelled as long as you pay the necessary premiums. After the Guaranteed Period, the premiums can be lower, the same, or higher than the Table Premium. See the brochure under "Permanent Coverage".

TEXASLIFE INSURANCE COMPANY — EMPLOYEE MONTHLY PREMIUMS

PureLife-plus — Standard Risk Table Premiums — Tobacco — Express Issue

Issue Age (ALB)	Prem For $10,000 Face	Life Insurance Face Amounts for Monthly Premiums Shown Includes Added Cost for Accidental Death Benefit (Ages 17-59) and Accelerated Death Benefit for Chronic Illness (All Ages) $26.00	$28.00	$30.00	$35.00	$40.00	$45.00	$50.00	$55.00	GUARANTEED PERIOD Age to Which Coverage is Guaranteed at Table Premium
15D-1										83
2-3										83
4-10										79
11-16										75
17-20		42,941	46,565	50,181	59,220	68,265	77,313	86,348	95,389	70
21-22		41,305	44,783	48,261	56,957	65,656	74,344	83,044	91,740	70
23-25		39,063	42,352	45,642	53,864	62,089	70,313	78,537	86,761	69
26		38,369	41,600	44,826	52,909	60,986	69,064	77,141	85,214	69
27		37,699	40,874	44,050	51,985	59,921	67,858	75,794	83,729	68
28		37,052	40,172	43,292	51,088	58,893	66,693	74,493	82,294	68
29		36,433	39,494	42,563	50,231	57,899	65,567	73,237	80,905	68
30-31		32,091	34,798	37,501	44,257	51,014	57,771	64,528	71,284	69
32		31,170	33,793	36,418	42,980	49,541	56,103	62,665	69,226	69
33		30,722	33,312	35,900	42,368	48,833	55,310	61,773	68,241	69
34		30,294	32,845	35,396	41,774	48,151	54,529	60,906	67,284	68
35		28,312	30,688	33,076	39,037	44,995	50,949	56,913	62,873	69
36		27,237	29,530	31,824	37,562	43,292	49,026	54,760	60,493	69
37		25,621	27,778	29,936	35,330	40,720	46,117	51,511	56,904	70
38		24,740	26,818	28,907	34,115	39,318	44,532	49,740	54,943	70
39		23,149	25,098	27,047	31,921	36,797	41,669	46,541	51,414	70
40	13.50	21,110	22,890	24,669	29,110	33,556	38,001	42,445	46,890	72
41	14.27	19,759	21,423	23,087	27,247	31,407	35,563	39,726	43,886	73
42	15.26	18,256	19,793	21,328	25,176	29,017	32,860	36,703	40,546	74
43	16.80	16,323	17,698	19,073	22,509	25,946	29,382	32,818	36,255	76
44	17.68	15,393	16,687	17,985	21,225	24,466	27,706	30,943	34,187	77
45	18.89	14,273	15,475	16,678	19,685	22,687	25,690	28,696	31,701	78
46	19.99	13,388	14,516	15,643	18,462	21,280	24,099	26,917	29,736	79
47	21.09	12,606	13,668	14,728	17,384	20,038	22,692	25,344	27,999	79
48	22.19	11,911	12,914	13,917	16,425	18,934	21,439	23,945	26,455	80
49	23.95	10,944	11,867	12,789	15,092	17,397	19,701	22,005	24,309	82
50	25.16	10,367	11,240	12,113	14,297	16,478	18,660	20,843	23,025	82
51	27.03		10,392	11,199	13,217	15,235	17,252	19,270	21,288	83
52	29.34			10,244	12,089	13,936	15,781	17,627	19,473	85
53	31.21				11,309	13,036	14,762	16,489	18,215	87
54	32.75				10,738	12,378	14,017	15,656	17,296	87
55	34.29				10,222	11,783	13,343	14,904	16,463	87
56	36.05					11,169	12,649	14,128	15,607	87
57	37.70					10,650	12,060	13,470	14,880	87
58	39.68					10,085	11,422	12,758	14,093	87
59	41.33						10,938	12,219	13,498	87
60	42.51						10,618	11,861	13,102	87
61	45.37							11,074	12,233	88
62	48.01							10,435	11,527	88
63	50.54								10,923	88
64	53.07								10,379	89
65	55.71									89
66	58.57									89
67	61.65									89
68	64.84									89
69	68.25									89
70	71.88									90

PureLife-plus is permanent life insurance to Attained Age 121 that can never be cancelled as long as you pay the necessary premiums. After the Guaranteed Period, the premiums can be lower, the same, or higher than the Table Premium. See the brochure under "Permanent Coverage".

TEXASLIFE INSURANCE COMPANY

EMPLOYEE/SPOUSE/CHILD MONTHLY PREMIUMS

PureLife-plus — Standard Risk Table Premiums — Non-Tobacco — Express Issue

Issue Age (ALB)	Monthly Premiums for Life Insurance Face Amounts Shown Includes Added Cost for Accidental Death Benefit (Ages 17-59) $10,000	$15,000	$25,000	$50,000	$75,000	$100,000	$125,000	$150,000	$200,000	GUARANTEED PERIOD Age to Which Coverage is Guaranteed at Table Premium
15D-1			8.00							83
2-3			8.25							83
4-10			8.50							79
11-16			8.75							75
17-20			10.75	19.25	27.75	36.25	44.75	53.25	70.25	73
21-22			11.00	19.75	28.50	37.25	46.00	54.75	72.25	73
23-25			11.25	20.25	29.25	38.25	47.25	56.25	74.25	71
26			11.50	20.75	30.00	39.25	48.50	57.75	76.25	72
27			11.75	21.25	30.75	40.25	49.75	59.25	78.25	72
28			11.75	21.25	30.75	40.25	49.75	59.25	78.25	71
29			12.00	21.75	31.50	41.25	51.00	60.75	80.25	71
30-31			12.25	22.25	32.25	42.25	52.25	62.25	82.25	70
32			12.75	23.25	33.75	44.25	54.75	65.25	86.25	70
33			13.25	24.25	35.25	46.25	57.25	68.25	90.25	71
34			13.75	25.25	36.75	48.25	59.75	71.25	94.25	72
35		9.60	14.50	26.75	39.00	51.25	63.50	75.75	100.25	73
36		9.90	15.00	27.75	40.50	53.25	66.00	78.75	104.25	73
37		10.20	15.50	28.75	42.00	55.25	68.50	81.75	108.25	73
38		10.65	16.25	30.25	44.25	58.25	72.25	86.25	114.25	74
39		11.25	17.25	32.25	47.25	62.25	77.25	92.25	122.25	75
40	8.65	11.85	18.25	34.25	50.25	66.25	82.25	98.25	130.25	76
41	9.15	12.60	19.50	36.75	54.00	71.25	88.50	105.75	140.25	77
42	9.85	13.65	21.25	40.25	59.25	78.25	97.25	116.25	154.25	78
43	10.55	14.70	23.00	43.75	64.50	85.25	106.00	126.75	168.25	80
44	11.25	15.75	24.75	47.25	69.75	92.25	114.75	137.25	182.25	81
45	12.05	16.95	26.75	51.25	75.75	100.25	124.75	149.25	198.25	82
46	12.85	18.15	28.75	55.25	81.75	108.25	134.75	161.25	214.25	83
47	13.55	19.20	30.50	58.75	87.00	115.25	143.50	171.75	228.25	83
48	14.35	20.40	32.50	62.75	93.00	123.25	153.50	183.75	244.25	84
49	15.25	21.75	34.75	67.25	99.75	132.25	164.75	197.25	262.25	85
50	16.35	23.40	37.50	72.75	108.00	143.25				86
51	17.65	25.35	40.75	79.25	117.75	156.25				87
52	19.25	27.75	44.75	87.25	129.75	172.25				88
53	20.85	30.15	48.75	95.25	141.75	188.25				90
54	21.95	31.80	51.50	100.75	150.00	199.25				90
55	22.95	33.30	54.00	105.75	157.50	209.25				91
56	23.95	34.80	56.50	110.75	165.00	219.25				91
57	25.05	36.45	59.25	116.25	173.25	230.25				91
58	26.25	38.25	62.25	122.25	182.25	242.25				91
59	27.35	39.90	65.00	127.75	190.50	253.25				91
60	28.05	40.95	66.75	131.25	195.75	260.25				91
61	29.55	43.20	70.50	138.75	207.00	275.25				91
62	31.15	45.60	74.50	146.75	219.00	291.25				92
63	32.85	48.15	78.75	155.25	231.75	308.25				92
64	34.65	50.85	83.25	164.25	245.25	326.25				92
65	36.55	53.70	88.00	173.75	259.50	345.25				92
66	38.65									92
67	40.95									92
68	43.45									92
69	46.05									93
70	48.65									93

PureLife-plus is permanent life insurance to Attained Age 121 that can never be cancelled as long as you pay the necessary premiums. After the Guaranteed Period, the premiums can be lower, the same, or higher than the Table Premium. See the brochure under "Permanent Coverage".

TEXASLIFE INSURANCE COMPANY — EMPLOYEE/SPOUSE/CHILD MONTHLY PREMIUMS

PureLife-plus — Standard Risk Table Premiums — Tobacco — Express Issue

Issue Age (ALB)	Monthly Premiums for Life Insurance Face Amounts Shown. Includes Added Cost for Accidental Death Benefit (Ages 17-59) $10,000	$15,000	$25,000	$50,000	$75,000	$100,000	$125,000	$150,000	$200,000	GUARANTEED PERIOD Age to Which Coverage is Guaranteed at Table Premium
15D-1										83
2-3										83
4-10										79
11-16										75
17-20			15.00	27.75	40.50	53.25	66.00	78.75	104.25	70
21-22			15.50	28.75	42.00	55.25	68.50	81.75	108.25	70
23-25			16.25	30.25	44.25	58.25	72.25	86.25	114.25	69
26			16.50	30.75	45.00	59.25	73.50	87.75	116.25	69
27			16.75	31.25	45.75	60.25	74.75	89.25	118.25	68
28			17.00	31.75	46.50	61.25	76.00	90.75	120.25	68
29			17.25	32.25	47.25	62.25	77.25	92.25	122.25	68
30-31			19.25	36.25	53.25	70.25	87.25	104.25	138.25	69
32			19.75	37.25	54.75	72.25	89.75	107.25	142.25	69
33			20.00	37.75	55.50	73.25	91.00	108.75	144.25	69
34			20.25	38.25	56.25	74.25	92.25	110.25	146.25	68
35		13.80	21.50	40.75	60.00	79.25	98.50	117.75	156.25	69
36		14.25	22.25	42.25	62.25	82.25	102.25	122.25	162.25	69
37		15.00	23.50	44.75	66.00	87.25	108.50	129.75	172.25	70
38		15.45	24.25	46.25	68.25	90.25	112.25	134.25	178.25	70
39		16.35	25.75	49.25	72.75	96.25	119.75	143.25	190.25	70
40	12.55	17.70	28.00	53.75	79.50	105.25	131.00	156.75	208.25	72
41	13.25	18.75	29.75	57.25	84.75	112.25	139.75	167.25	222.25	73
42	14.15	20.10	32.00	61.75	91.50	121.25	151.00	180.75	240.25	74
43	15.55	22.20	35.50	68.75	102.00	135.25	168.50	201.75	268.25	76
44	16.35	23.40	37.50	72.75	108.00	143.25	178.50	213.75	284.25	77
45	17.45	25.05	40.25	78.25	116.25	154.25	192.25	230.25	306.25	78
46	18.45	26.55	42.75	83.25	123.75	164.25	204.75	245.25	326.25	79
47	19.45	28.05	45.25	88.25	131.25	174.25	217.25	260.25	346.25	79
48	20.45	29.55	47.75	93.25	138.75	184.25	229.75	275.25	366.25	80
49	22.05	31.95	51.75	101.25	150.75	200.25	249.75	299.25	398.25	82
50	23.15	33.60	54.50	106.75	159.00	211.25				82
51	24.85	36.15	58.75	115.25	171.75	228.25				83
52	26.95	39.30	64.00	125.75	187.50	249.25				85
53	28.65	41.85	68.25	134.25	200.25	266.25				87
54	30.05	43.95	71.75	141.25	210.75	280.25				87
55	31.45	46.05	75.25	148.25	221.25	294.25				87
56	33.05	48.45	79.25	156.25	233.25	310.25				87
57	34.55	50.70	83.00	163.75	244.50	325.25				87
58	36.35	53.40	87.50	172.75	258.00	343.25				87
59	37.85	55.65	91.25	180.25	269.25	358.25				87
60	38.85	57.15	93.75	185.25	276.75	368.25				87
61	41.45	61.05	100.25	198.25	296.25	394.25				88
62	43.85	64.65	106.25	210.25	314.25	418.25				88
63	46.15	68.10	112.00	221.75	331.50	441.25				88
64	48.45	71.55	117.75	233.25	348.75	464.25				89
65	50.85	75.15	123.75	245.25	366.75	488.25				89
66	53.45									89
67	56.25									89
68	59.15									89
69	62.25									89
70	65.55									90

PureLife-plus is permanent life insurance to Attained Age 121 that can never be cancelled as long as you pay the necessary premiums. After the Guaranteed Period, the premiums can be lower, the same, or higher than the Table Premium. See the brochure under "Permanent Coverage".

TEXASLIFE INSURANCE COMPANY

EMPLOYEE/SPOUSE/CHILD MONTHLY PREMIUMS

PureLife-plus — Standard Risk Table Premiums — Non-Tobacco — Express Issue

Issue Age (ALB)	Prem For $10,000 Face	Life Insurance Face Amounts for Monthly Premiums Shown Includes Added Cost for Accidental Death Benefit (Ages 17-59) $18.00	$20.00	$24.00	$28.00	$30.00	$32.00	$35.00	$40.00	GUARANTEED PERIOD Age to Which Coverage is Guaranteed at Table Premium
15D-1										83
2-3										83
4-10										79
11-16										75
17-20		46,324	52,206	63,971	75,736	81,618	87,500	96,324	111,030	73
21-22		45,000	50,715	62,143	73,572	79,286	85,001	93,572	107,858	73
23-25		43,750	49,306	60,417	71,528	77,084	82,639	90,973	104,862	71
26		42,568	47,973	58,784	69,595	75,000	80,406	88,514	102,028	72
27		41,448	46,711	57,237	67,764	73,027	78,290	86,185	99,343	72
28		41,448	46,711	57,237	67,764	73,027	78,290	86,185	99,343	71
29		40,385	45,513	55,770	66,026	71,154	76,283	83,975	96,795	71
30-31		39,375	44,375	54,375	64,375	69,375	74,375	81,875	94,375	70
32		37,500	42,262	51,786	61,310	66,072	70,834	77,977	89,881	70
33		35,796	40,341	49,432	58,523	63,069	67,614	74,432	85,796	71
34		34,240	38,587	47,283	55,979	60,327	64,674	71,196	82,065	72
35		32,143	36,225	44,388	52,552	56,633	60,715	66,837	77,041	73
36		30,883	34,804	42,648	50,491	54,412	58,334	64,216	74,020	73
37		29,717	33,491	41,038	48,585	52,359	56,133	61,793	71,227	73
38		28,125	31,697	38,840	45,983	49,554	53,125	58,483	67,411	74
39		26,250	29,584	36,250	42,917	46,250	49,584	54,584	62,917	75
40	8.65	24,610	27,735	33,985	40,235	43,360	46,485	51,172	58,985	76
41	9.15	22,827	25,725	31,522	37,319	40,218	43,116	47,464	54,711	77
42	9.85	20,724	23,356	28,619	33,882	36,514	39,145	43,093	49,672	78
43	10.55	18,976	21,386	26,205	31,025	33,434	35,844	39,458	45,482	80
44	11.25	17,500	19,723	24,167	28,612	30,834	33,056	36,389	41,945	81
45	12.05	16,072	18,113	22,194	26,276	28,316	30,358	33,419	38,521	82
46	12.85	14,859	16,746	20,519	24,293	26,180	28,066	30,897	35,614	83
47	13.55	13,938	15,708	19,248	22,788	24,558	26,328	28,983	33,408	83
48	14.35	13,017	14,670	17,976	21,281	22,934	24,587	27,066	31,199	84
49	15.25	12,116	13,654	16,731	19,808	21,347	22,885	25,192	29,039	85
50	16.35	11,171	12,589	15,426	18,263	19,681	21,100	23,227	26,774	86
51	17.65	10,228	11,526	14,124	16,721	18,020	19,318	21,267	24,513	87
52	19.25		10,438	12,795	15,148	16,324	17,500	19,265	22,206	88
53	20.85			11,693	13,845	14,920	15,995	17,608	20,296	90
54	21.95			11,041	13,071	14,087	15,102	16,625	19,163	90
55	22.95			10,508	12,439	13,406	14,372	15,821	18,237	91
56	23.95			10,024	11,867	12,789	13,710	15,093	17,397	91
57	25.05				11,294	12,172	13,049	14,365	16,558	91
58	26.25				10,730	11,563	12,396	13,646	15,730	91
59	27.35				10,259	11,056	11,853	13,048	15,040	91
60	28.05					10,756	11,532	12,694	14,632	91
61	29.55					10,165	10,898	11,997	13,828	91
62	31.15						10,295	11,333	13,063	92
63	32.85							10,703	12,337	92
64	34.65							10,109	11,652	92
65	36.55								11,006	92
66	38.65									92
67	40.95									92
68	43.45									92
69	46.05									93
70	48.65									93

PureLife-plus is permanent life insurance to Attained Age 121 that can never be cancelled as long as you pay the necessary premiums. After the Guaranteed Period, the premiums can be lower, the same, or higher than the Table Premium. See the brochure under "Permanent Coverage".

TEXASLIFE INSURANCE COMPANY — EMPLOYEE/SPOUSE/CHILD MONTHLY PREMIUMS

PureLife-plus — Standard Risk Table Premiums — Tobacco — Express Issue

Issue Age (ALB)	Prem For $10,000 Face	Life Insurance Face Amounts for Monthly Premiums Shown. Includes Added Cost for Accidental Death Benefit (Ages 17-59) $26.00	$28.00	$30.00	$35.00	$40.00	$45.00	$50.00	$55.00	GUARANTEED PERIOD Age to Which Coverage is Guaranteed at Table Premium
15D-1										83
2-3										83
4-10										79
11-16										75
17-20		46,569	50,491	54,412	64,216	74,020	83,824	93,628	103,432	70
21-22		44,812	48,585	52,359	61,793	71,227	80,661	90,095	99,529	70
23-25		42,411	45,983	49,554	58,483	67,411	76,340	85,268	94,197	69
26		41,667	45,176	48,685	57,457	66,229	75,000	83,772	92,544	69
27		40,949	44,397	47,845	56,466	65,087	73,707	82,328	90,949	68
28		40,255	43,645	47,034	55,509	63,984	72,458	80,933	89,407	68
29		39,584	42,917	46,250	54,584	62,917	71,250	79,584	87,917	68
30-31		34,927	37,868	40,809	48,162	55,515	62,868	70,221	77,574	69
32		33,929	36,786	39,643	46,786	53,929	61,072	68,215	75,358	69
33		33,451	36,268	39,085	46,127	53,170	60,212	67,254	74,296	69
34		32,987	35,764	38,542	45,487	52,431	59,375	66,320	73,264	68
35		30,845	33,442	36,039	42,533	49,026	55,520	62,013	68,507	69
36		29,688	32,188	34,688	40,938	47,188	53,438	59,688	65,938	69
37		27,941	30,295	32,648	38,530	44,412	50,295	56,177	62,059	70
38		26,989	29,262	31,535	37,216	42,898	48,580	54,262	59,943	70
39		25,266	27,394	29,522	34,841	40,160	45,479	50,798	56,118	70
40	12.55	23,059	25,001	26,942	31,797	36,651	41,505	46,360	51,214	72
41	13.25	21,591	23,410	25,228	29,773	34,318	38,864	43,410	47,955	73
42	14.15	19,958	21,639	23,319	27,522	31,723	35,925	40,127	44,328	74
43	15.55	17,858	19,361	20,865	24,625	28,384	32,143	35,903	39,662	76
44	16.35	16,844	18,263	19,681	23,227	26,774	30,319	33,866	37,412	77
45	17.45	15,625	16,940	18,257	21,547	24,836	28,125	31,415	34,704	78
46	18.45	14,661	15,896	17,130	20,217	23,303	26,389	29,476	32,562	79
47	19.45	13,809	14,971	16,134	19,041	21,948	24,855	27,762	30,669	79
48	20.45	13,050	14,149	15,248	17,995	20,742	23,490	26,237	28,984	80
49	22.05	11,995	13,006	14,016	16,541	19,065	21,591	24,117	26,642	82
50	23.15	11,364	12,320	13,278	15,670	18,063	20,455	22,847	25,240	82
51	24.85	10,509	11,394	12,279	14,492	16,704	18,916	21,129	23,341	83
52	26.95		10,426	11,235	13,260	15,284	17,308	19,332	21,357	85
53	28.65			10,512	12,406	14,300	16,193	18,087	19,982	87
54	30.05				11,781	13,579	15,378	17,177	18,975	87
55	31.45				11,216	12,929	14,641	16,353	18,065	87
56	33.05				10,634	12,257	13,880	15,504	17,127	87
57	34.55				10,140	11,688	13,236	14,784	16,331	87
58	36.35					11,070	12,537	14,003	15,469	87
59	37.85					10,604	12,009	13,413	14,817	87
60	38.85					10,315	11,681	13,047	14,413	87
61	41.45						10,906	12,182	13,457	88
62	43.85						10,277	11,479	12,681	88
63	46.15							10,877	12,016	88
64	48.45							10,336	11,418	89
65	50.85								10,854	89
66	53.45									89
67	56.25									89
68	59.15									89
69	62.25									89
70	65.55									90

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TEXASLIFE INSURANCE COMPANY

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

INDIVIDUAL LIFE INSURANCE APPLICATION

FOR HOME OFFICE USE ONLY
Plan Name: PureLife-plus
Policy Number:__________

1st Deduction Date:__________ **Employer**:__________

Proposed Insured(s)		Sex	Birth Date	Age[1]	Within the past 12 months has the Proposed Insured age 17 or older used tobacco in any form?	Face Amount[2]	Premium
Employee Name							
Last		M/F			☐ **Yes** ☐ **No**		
First	MI						
Social Sec No							
Hire Date							
Beneficiary (Spouse is beneficiary unless otherwise stated here)					Relationship:		
Spouse Name							
Last		M/F			☐ **Yes** ☐ **No**		
First	MI						
Social Sec No							
Current Occupation							
Beneficiary (Employee is beneficiary unless otherwise stated here)					Relationship:		
Children's Names (not required if applying only for Child Term Rider)							
		M/F			☐ **Yes** ☐ **No**		
Social Sec No							
Beneficiary (Employee is beneficiary unless otherwise stated here)					Relationship:		
		M/F			☐ **Yes** ☐ **No**		
Social Sec No							
Beneficiary (Employee is beneficiary unless otherwise stated here)					Relationship:		
		M/F			☐ **Yes** ☐ **No**		
Social Sec No							
Beneficiary (Employee is beneficiary unless otherwise stated here)					Relationship:		
		M/F			☐ **Yes** ☐ **No**		
Social Sec No							
Beneficiary (Employee is beneficiary unless otherwise stated here)					Relationship:		
		M/F			☐ **Yes** ☐ **No**		
Social Sec No							
Beneficiary (Employee is beneficiary unless otherwise stated here)					Relationship:		

Select Riders to be added: Add Child Term Rider premium, if applied for: $

Child Term for $10,000 added to policy of: ☐ Employee ☐ Spouse **Total premium**: $

☐ Accidental Death[3] ☐ Waiver Premium[3] ☐ Chronic Illness

Payroll is per: ☐ Week ☐ Bi-Week ☐ Semi-Month ☐ Month ☐ Skip__________

Home Address

Street/P.O. Box:__________ City:__________ State:____ Zip:______

Phone — Day: (   ) Evening: (   ) Personal E-mail Address:

Will proposed coverage replace or change any existing insurance or annuity policy? (If "Yes", identify and complete replacement form.) Company:__________ Policy No:__________ ☐ Yes ☐ No

(1) Age as of Issue Date. (2) or Face Amount purchased by premium shown, if less. (3) For issue ages 17-59.

CONTINUE AND SIGN ON REVERSE SIDE

1. During the last six months, has the proposed insured:	Employee		Spouse		Children	
	Yes	No	Yes	No	Yes	No
a. Been actively at work on a full time basis, performing usual duties? If "No" furnish details below.	☐	☐	☐	☐	N/A	
b. Been absent from work due to illness or medical treatment for a period of more than five consecutive working days? If "Yes" furnish details below.	☐	☐	☐	☐	N/A	
c. Been disabled or received tests, treatment or care of any kind in a hospital or nursing home or received chemotherapy, hormonal therapy for cancer, radiation therapy, dialysis treatment, or treatment for alcohol or drug abuse? If "Yes" furnish details below.	☐	☐	☐	☐	☐	☐

QUES NO.	PROPOSED INSURED	DETAILS

REPRESENTATIONS: I represent to the best of my knowledge and belief that all statements and answers in this application are complete, true and correctly recorded, and are made as a consideration for the insurance applied for. I understand that Texas Life Insurance Company will rely on my statements and answers as being true and complete in deciding whether to issue insurance on the proposed insured(s). Insurance is effective under the policy only when it is delivered to the owner, if the full first premium is paid in cash and all of the statements in this application remain correct and complete.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

X _____ X _____

Employee (and policyowner) Signature — Spouse Signature (or Child over 18) if to be insured

Agent only: To the best of my knowledge the insurance applied for ☐ **is** ☐ **is not** to replace existing insurance or annuity.

X _____ _____ _____

Enroller/Agent Signature — Print Enroller/Agent Name — Agt No. — Date — City — State

TEXASLIFE INSURANCE COMPANY

Agent Certification

AGENT STATEMENT

I certify that I have: (a) delivered to the Applicant the Brochure Series form 18M049-ICC EXP-H-M-3AD and the Privacy Notice; and, (b) presented only guaranteed benefits and costs.

X _____ _____

Enroller/Agent Signature Date

Form: 04M006 R08-11

TEXAS**LIFE** INSURANCE COMPANY **REPLACEMENT FORM**

Tennessee

Notice Regarding Replacement
Replacing Your Life Insurance Policy or Annuity -- Two pages

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one–or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or the agent that sold your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

IF YOU SHOULD FAIL TO QUALIFY FOR THE LIFE INSURANCE FOR WHICH YOU HAVE APPLIED, YOU MAY FIND YOURSELF UNABLE TO PURCHASE OTHER LIFE INSURANCE OR ABLE TO PURCHASE IT ONLY AT **SUBSTANTIALLY** HIGHER RATES.

We are required by law to notify your existing company that you may be replacing their policy.

ADDITIONAL INFORMATION REGARDING REPLACEMENTS

This section is designed to provide you with additional information regarding positive and negative aspects of replacements. Since we cannot provide you with all of the relevant information, we recommend that you contact your existing insurance company. You should consider that:

a. If either the proposed policy or existing insurance you intend to replace is a participating policy, you should be aware that dividends may materially reduce the cost of insurance and are an important factor to consider. Dividends, however, are not guaranteed.
b. If the policy coverages are similar, the premiums for the new policy may be higher because premium rates increase as your age increases. Additionally, if your health has changed, you may no longer be insurable.
c. The period of time during which your existing insurance company could contest the policy because of a material misstatement or omission on your part (called the contestability period) or deny coverage because of suicide may have expired or expire earlier than it will under the proposed policy.
d. Your existing policy may have options or features that are not available under the policy being proposed to you or may not come into effect under the proposed policy until a later time during your life.
e. The cash value and dividends, if any, of the proposed policy may grow slower initially because the company will incur the cost of issuing your new policy.

Since 1901 | 900 WASHINGTON AVE | POST OFFICE BOX 830 | WACO, TEXAS 76703-0830 | 800-283-9233 | 254-752-6521 | www.texaslife.com

There are positive aspects to replacements as well. For example, the proposed policy may provide a better match of insurance coverage with insurable needs, more insurance coverage for a lower cost, or a faster accumulation of cash value than with the existing policy.

If you are considering borrowing against your existing policy to pay the premiums on the proposed policy, you should understand that in the event of your death, the amount of any unpaid loan, including unpaid interest, will be deducted from the benefits of your existing policy thereby reducing your total insurance coverage.

CAUTION

If after studying the information made available to you, you decide to replace your existing life insurance, you are urged not to take action to terminate or alter your existing life insurance coverage until after you have been issued the new policy, examined it, and found it to be acceptable to you. If you should terminate or otherwise materially alter your existing coverage and fail to qualify for the life insurance for which you have applied, you may find yourself unable to purchase other life insurance or able to purchase it only at substantially higher rates.

Information on policy being replaced

Policy Number: _____ Issuing Company: _____

Applicant Signature: _____ Date: _____

Agent Signature: _____ Date: _____

TEXAS**LIFE** INSURANCE COMPANY

Privacy Notice - Two pages

Thank you for your interest in our products and services. We will review what you told us and may get further information if needed.

READ THIS NOTICE CAREFULLY

It describes in broad terms how we learn about you and anyone else who is to be insured under the policy you applied for. It tells how we treat that information. If anyone else is to be insured under the policy you applied for, what we say here also applies to information about him or her. We are required by law to give you this notice.

WHY WE NEED INFORMATION

We need to know about you (and anyone else to be insured) to provide the insurance and other products and services you've asked for. We may also need it to administer your business with us, evaluate claims, process transactions and run our business. And we need information from you and others to help us verify identities in order to prevent money laundering and terrorism.

We need to know your address, age and other basic information. But we may need more information, including finances, employment, health, hobbies or business conducted with us, or with other companies.

HOW WE GET INFORMATION

What we know about you (and anyone else to be insured) we get mostly from you. But we may also have to find out more from others in order to make sure that what we know is correct and complete. This personal information may be collected from persons other than you, and may be disclosed in certain circumstances to third parties without your authorization. Other sources may include adult relatives, employers, consumer reporting agencies, health care providers and others. Some sources may give us reports and may disclose what they know to others. We may ask for medical information about you. The Authorization you signed when you applied for insurance permits these sources to tell us about you. So we may, for instance, at our expense:

— Ask for a medical exam — Ask for blood and urine tests

— Ask health care providers to give us health data, including information about alcohol or drug abuse

This will help us decide eligibility for insurance from us and what we should charge for it. We may also ask a consumer reporting agency for a "consumer report" about you (or anyone else to be insured). Consumer reports may tell us about a lot of things, like:

— Work and work history — Mode of living — Finances — Reputation — Dangerous sports activity — Driving record

If we ask an agency for an "investigative" report about you - which means that they will ask others about you - we will ask them to contact you as well. The information may be kept by the consumer reporting agency and given to others as permitted by law. The agency will give you a copy of the report it provides to us, if you ask the agency and can provide adequate identification. If you write to us, we will tell you if we have asked for a consumer report about you, and give you the name, address and phone number of the consumer reporting agency.

MIB, Inc. ("MIB") is a commonly used source of information. It is a not-for-profit association of life insurance companies. We and our reinsurers may give MIB health or other information about you. If you apply for life or health coverage from a member of MIB, or claim benefits from a member company, MIB may give that company any information it has about you. If you contact MIB, it will tell you what it knows about you. You have the right to ask MIB to correct its information about you. You may write to MIB, Inc., 50 Braintree Hill Park, Suite 400,Braintree, MA 02184-8734, call MIB at (866) 692-6901 or contact MIB at www.mib.com.

FORM: 09P012 R 08/18

HOW WE PROTECT WHAT WE KNOW

Because you entrust us with your personal information, we treat what we know about you confidentially. We tell our employees to carefully handle your information. They may get your information only with a good reason. We take steps to secure our computer databases and safeguard the information we have.

HOW WE USE AND DISCLOSE WHAT WE KNOW ABOUT YOU

We may use what we know about you to help us serve you better. We may use it, and disclose it to our affiliates and others, for any purpose allowed by law; for example, to:

— Help us evaluate your request for a product
— Process information for us
— Perform research for us
— Help us run our business
— Help us comply with the law
— Audit our business
— Confirm or correct what we know about you
— Help us prevent fraud and other crimes
— Help us process claims and other transactions

When we disclose information to others to perform business services for us, they must take appropriate steps to protect this information. And they may use the information only for the purposes of performing those business services.

Other reasons we may disclose what we know about you include:

- Doing what a court or government agency requires us to do; for example, complying with a search warrant or subpoena
- Telling another company what we know about you, if we are or may be selling all or any part of our business or merging with another company
- Giving information to the government so that it can decide whether you may get government-paid benefits
- Telling your health care provider about a medical problem that you have but may not be aware of
- Giving your information to a peer review organization if you have health insurance with us
- Giving your information to someone who has a legal interest in your insurance, such as someone who lent you money and holds a lien on your policy

Generally, we will disclose only the information we consider reasonably necessary to disclose and no more. We may use what we know about you in order to offer you our other products and services.

YOU CAN SEE AND CORRECT YOUR INFORMATION

Generally, we will let you review what we know about you if you ask us in writing. (Because of its legal sensitivity, we will not show you anything that we learned in connection with a claim or lawsuit.) Also, if the law allows us to do so, we may decide to disclose what we know about your health only through your health care provider. If you tell us that what we know about you is incorrect, we will review it. If we agree with you, we will correct our records. If we do not agree with you, you may tell us in writing, and we will include your statement when we give your information to anyone outside our company or affiliate.

YOU CAN GET OTHER MATERIAL FROM US

In addition to any other privacy notice we may give you, we must give you a summary of our privacy policy once each year. You may have other rights under the law. If you want to know more about our privacy policy, please contact us at our website, www.texaslife.com, or write to us, c/o Texas Life Privacy Officer, PO Box 830, Waco, Texas 76703.

Enrollment Solutions

Ideal Enrollment Timeline

Enrollment Methods

Communication and Education Strategies

Online Enrollment Platform: AFenroll®

Enrollment Solutions

Benefits enrollments continue to evolve and change with the introduction of new technology solutions. These solutions bring challenges surrounding the education and communication of your employee's benefits. At American Fidelity, we have developed a way to take advantage of the enrollment solutions available without your employees losing the education needed to make their benefit decisions.

Ideal Enrollment Implementation Timeline

Planning is critical when conducting a successful benefits enrollment. That is why we set aside time prior to the enrollment so that we can gather information and timelines to meet your expectations. Your Account Manager will setup meetings to discuss enrollment requirements, enrollment expectations, and finish with a post enrollment review. Our goal is to make sure there are no surprises along the way.

Enrollment Methods

Finding the right balance between educating your employees on their benefits and allowing them to self-enroll can be difficult. Many employers try to provide as much education as possible but time and resources can get in the way.

At American Fidelity, we work with you to relieve the stress that often comes with your benefits enrollment period. We offer multiple ways to enroll so your employees can have opportunities for benefit education while also having a convenient enrollment experience. Enrollment methods include:

- in-person,
- by phone,
- and online self-enrollment.

In-Person Enrollment

Your benefits enrollment period is often filled with educating and answering questions from your employees. Finding the time to assist everyone can be a challenge. At American Fidelity, we focus on taking that burden off of you by providing a one-on-one, in-person enrollment experience for each employee. With our salaried account managers, we help educate and enroll your employees in all of their benefit options in a personal setting.

By Phone

We also offer another convenient one-on-one enrollment option by phone through the American Fidelity Benefit Enrollment Center. Employees can call a 1-800 number to discuss their benefits options with an experienced representative as well as complete their benefits enrollment.

Online Self-Enrollment

Often, after learning about the benefits being offered, employees will want to discuss with their families prior to beginning their enrollment. With our online enrollment system, AFenroll®, your employees can enroll online when it is convenient for them. To preview the AFenroll®system, visit americanfidelity.com/ howtoenroll.

Communication and Education Strategies

Based on the enrollment method you select, we will customize a communications plan that may include the following strategies:

One-on-One Benefit Reviews

Our salaried account managers can provide one-on-one meetings with each of your employees to review your benefit options, evaluate their unique needs, and provide personalized benefit package recommendations.

Group Meetings

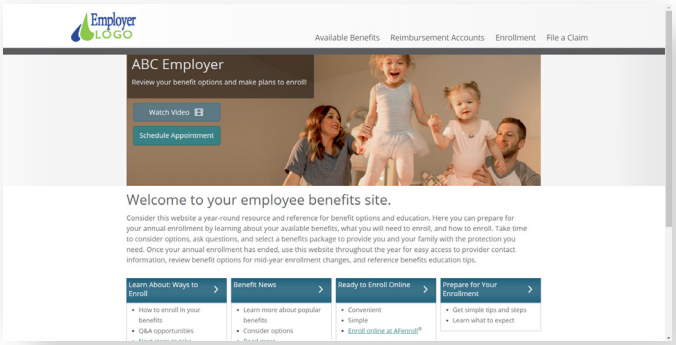
A more efficient enrollment means less time your employees are away from their work. We offer group meetings to educate employees and answer questions on their complete benefit offerings. When employees attend this meeting, they are more prepared going into their annual enrollment, often knowing exactly what benefits they will select.

Custom Enrollment Materials

To help educate and promote benefit offerings prior to enrollment, we also offer educational brochures, flyers, emails, and educational videos. American Fidelity will customize your educational materials to reflect your group's enrollment date, location, and benefit offerings.

Custom Benefits Site

We provide a custom benefits website to help your employees prepare for enrollment. This website gives your employees a single place to go to review all of their benefit offerings, including your medical, dental, and vision plans, and to get answers to common questions before enrolling.



Educational materials are also integrated within the custom benefits site, including:

- Educational videos about our insurance products and medical reimbursement accounts
- Section 125 Savings Calculator
- Health FSA Savings Calculator
- Customer Testimonials
- Educational Articles

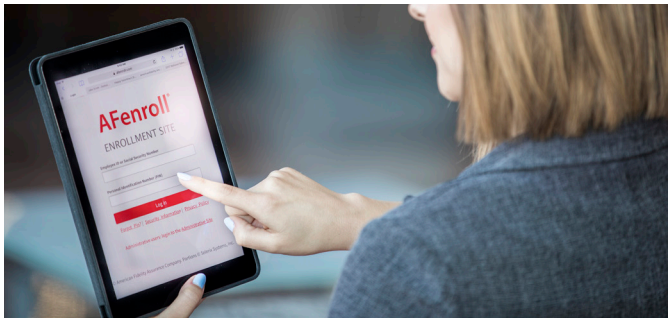
View a sample at americanfidelity.com/ABCemployer.

Online Enrollment Platform: AFenroll®

AFenroll®

From your annual enrollment to year-round updates, the platform you use to manage these changes is a crucial part of the enrollment process.

AFenroll® is a complete web-based enrollment, communication, and administration platform that can assist with your entire benefit enrollment process. In addition, AFenroll® can support new hire enrollments and life status event changes year-round.



Full-Benefits Enrollment Platform

AFenroll® provides you and your employees a single platform for enrolling in all of your benefits, such as medical, dental, vision and group life. We can work with your health plan carriers to incorporate their application processes into our web-based platform.

Employer Features

- Electronic payroll deduction upload
- View employee enrollment status
- Employee benefit participation reports
- Administrative changes, including terminations, leaves of absence, retirements and more
- Electronic, historic record of employee data
- View employee beneficiary information at any time

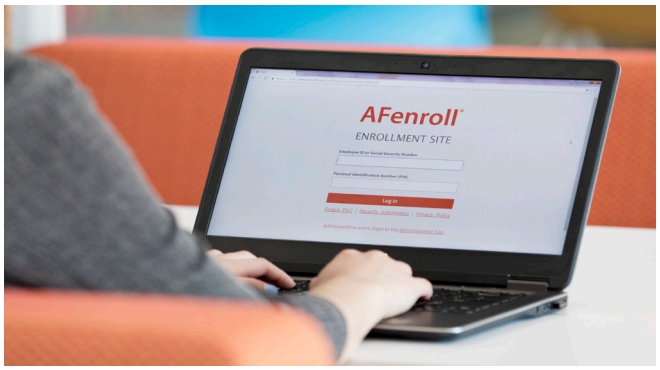
Employee Features

- Accessible from any desktop or tablet browser
- Customized enrollment based on demographic information and hire date
- Enroll in all available benefits
- View benefit confirmation statements
- View benefit materials, brochures, videos, and summary plan descriptions
- Benefit calculators and Section 125 worksheets

Security

AFenroll® uses 256-bit encryption and Secure Socket Layer (SSL) for personal information transmitted over the Internet. In addition, each user has a unique ID and password that is used to authenticate access to the system, and any backups of the system are encrypted before they are transmitted off-site. Our enrollment technology is designed to support the customers and employer groups to whom we provide our insurance products.

When you partner with American Fidelity, you get complete enrollment support, along with our robust online platform. We do it all with our salaried, career account managers who can educate and enroll your employees in their benefits.



Customer Experience

Claims, Resources and Support
Employer Billing and Administration

Claims, Resources and Support

Your employees expect quick service, knowledgeable staff, and dependable insurance coverage. At American Fidelity, we want to make it easy for your employees to file a claim, access account information, and get the support they need.

Easy Claim Filing

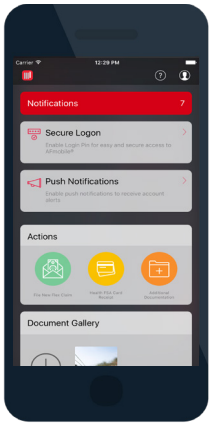
Participants can submit claims through a variety of options, including through our secure website, **americanfidelity.com**, utilizing our mobile app, or mailing or faxing a hard copy. Your dedicated account manager is also happy to meet with any employee needing claim support. For a complete video on claim filing instructions, visit americanfidelity.com/fileaclaim.

New AFQuickClaims™ Processing

Diagnostic testing, wellness exams and health screening claims are now processed immediately. Policyholders may receive their benefit in as little as one day if enrolled in direct deposit.

Mobile Convenience

Our mobile applications, AFreimburse™ and AFmobile®, allow you to manage your reimbursement accounts and insurance benefits, all from the palm of your hand. Snap photos of claim documentation with your phone, easily view premium and benefit information, and more! Both apps are available to download free on the Apple App Store and Google Play Store.



americanfidelity.com

Our website offers secured account access and educational resources for your employees.

Features

- View and file claims through an online submission form
- Download and print insurance policies
- Utilize Section 125 & FSA calculators
- Find answers to F.A.Q.s
- Watch educational videos

Customer Support

We are available to assist from both our home office and through our local account managers. Our customer service team is available from 7:00 a.m. to 7:00 p.m. CST, Monday through Friday, and can be contacted through our toll free number or through our website's contact form. Our call center offers a call back feature. Instead of waiting on hold, participants may opt in for a call back without losing their place in the queue.

After hours, we offer the option to leave a voicemail and our customer service team will return the call the next business day. In addition, your employees have 24/7 access to our toll-free automated phone system where they may check their FSA balance.

Employer Billing and Administration

We want to make managing your employees' benefits easy. That's why we created the Employer Online Service Center, where you can manage and reconcile your bill, view employee benefit information, update employee statuses, learn benefits management best practices through our employer blog, and more.

Billing and Reconciliation

The secure billing portal is a fast, easy, and secure way to reconcile your American Fidelity bill. The system allows bookkeepers to reconcile their flex and insurance bill entirely online, plus choose the payment method. This system helps eliminate paper bills and drastically cut the time it normally takes to reconcile.

Features include:

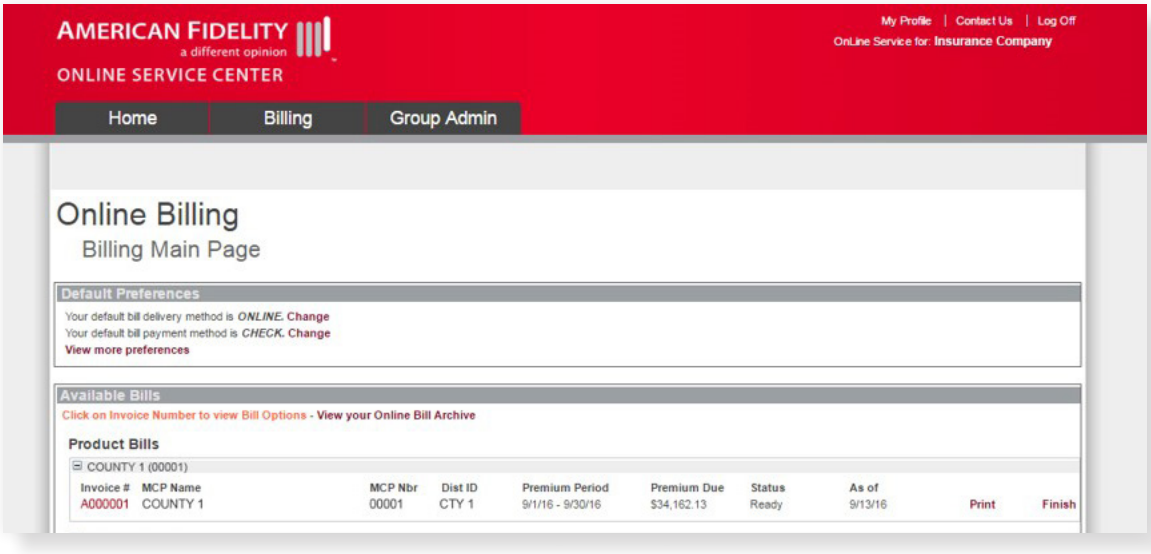
- View and print invoices
- Reconcile your bill
- Upload payroll register
- Change billing and payment preferences

Group Administration

Our employer Online Service Center is a secured employer portal that can be accessed in real-time. It offers a variety of tools and data to help with the administration of your benefit program.

Features include:

- Review or Terminate employees from your plan
- Update your organization's contact information
- Download sick pay reports
- Create and manage employer account logins
- Access employee election forms
- Upload census data
- Download Flex reports



Consulting Services

Affordable Care Act Support

AFcomply - ACA Compliance Tracking and Reporting Software

Health Plan Consulting

Leave of Absence Support

Affordable Care Act Support

The Patient Protection and Affordable Care Act (ACA) has presented employers with a once-in-a-generation challenge that is both complex and dynamic. Organizations need to understand their responsibilities and choices, assess whether costs are sustainable, develop their strategies, prepare for compliance, and implement their plans. In today's environment of needing to do more with less, the ACA is placing overwhelming demands on limited resources.

American Fidelity wants to be your partner and primary resource for managing the challenges and changes resulting from the ACA. We understand the requirements and how those responsibilities can impact employers and employees. We provide a variety of services to educate employers on the developing law, assist with implementation and ongoing compliance, and communicate plan changes to employees.

Education

Understanding all of the rules and staying on top of the developing law can be a daunting task. We provide a variety of resources to help you understand what you need to do today and what your choices are long term.

HCReducation.com

Our ACA website, HCReducation.com, has over 120 pages of content that we update as the rules change. You can always find the latest hot topics right on the home page. The site includes summaries of the key rules impacting employers, timelines, unique benefit calculators, and a wide variety of other tools and resources to help you.

Email Notification Service

On our website, you can sign up for complimentary emails about new guidance and receive reminders about upcoming compliance deadlines.

Presentations and Trainings

We offer presentations and trainings nationwide that give you interactive opportunities to learn about the ACA, such as conference presentations, lunch and learn seminars, webinar series and online videos, full-day training, presentations to insurance committees and board of directors, joint meetings for employers and unions in connection with collective bargaining, and personal benefit reviews with our consultants.

Communicate

Helping communicate benefit information to employees is key to a successful implementation of your strategy. Our communication services can help ensure your employees hear the messages you want to deliver.

Communication Strategy

Figuring out how to communicate health and welfare benefit plan changes to employees can be a challenge. We understand employees place great value on their benefits and want to understand upcoming plan changes, new options available, and any decisions they will be required to make. One of the most important factors influencing a new health and welfare benefit strategy will be if it is understandable to your employees.

As you modify your organization's health and welfare benefits plan(s) in response to the ACA, employees may look to you for answers regarding any changing health benefits, as well as information about the State-based Exchange (Marketplace), premium tax credits, and the individual mandate.

Our consultants will work with you to identify your organization's key messages, create a communication timeline, and determine appropriate ways to deliver your organization's message through a variety of methods.

Print and Digital Resources

Our marketing design team can assist you by creating print and digital communication resources and materials to help you deliver strategic messages and other benefits information to your employees. Materials can be customized with your organization's name and logo.

The following are examples of the services we provide:

- Print collateral including brochures and posters
- Electronic media including educational videos and email campaigns
- Full benefit enrollment guides
- Other online tools

Assistance

Beyond simply helping you understand the rules, we can help you manage your health and welfare benefit plans through a combination of consulting assistance and administrative services. We've created a menu of options to help you analyze how your plans could be impacted by different ACA provisions, help you make changes to your plans, and help you comply with the new requirements. Our analysis, consulting, and compliance assistance services are described on the following pages.

Some products and services may be provided by third party contractors or affiliated companies.

AFcomply™: ACA Compliance Tracking and Reporting Software

Complying with the requirements of the Patient Protection and Affordable Care Act (ACA) is complex, time-consuming, and often confusing. These requirements include the new ACA Tracking and Reporting responsibilities, which have recently been added to your workload. American Fidelity Administrative Services (AFAS) offers a software solution for both tracking and reporting in conjunction with ACA consulting services.

Employer Mandate Tracking Service

- Calculates whether each variable hour employee will be considered full-time under the law;
- Projects probability of part-time employees moving to full-time status;
- Captures whether each full-time employee is offered coverage;
- Monitors percentage of full-time employees who are eligible for coverage;
- Allows you to easily manage and resolve issues using system alerts; and
- Helps you manage the risk of triggering costly penalties.

Forms 1094/1095 Reporting Service

- Consolidates employee and coverage information from your various systems and vendors;
- Gathers required details per month for each employee and covered dependent to report on IRS Forms 1094-C and 1095-C;
- Completes and mails Form 1095-C to your employees; and
- Submits Forms 1094-C and 1095-C electronically to the IRS.

Your ACA Support Team

Employers will have access to a dedicated, year-round team composed of both ACA Consultants as well as Service Specialists.

Dedicated ACA Consultant:

- Initial session to review ACA requirements and your specific needs;
- Training and ongoing support on the AF Comply system;
- Expert guidance tailored to the unique needs of the workplace; and
- Hands-on support year round to assist with any questions you may have.

ACA Service Specialist Team:

- Assistance and support in understanding data needs and retrieving required data for various reporting and filings; and
- Dedicated call center team available as your first call resolution in answering questions, as well as providing system support and guidance.

A software system alone does not ensure compliance; if you do not understand how the data you enter will impact the calculation, the information generated may not be correct. Your consultant will help explain those parameters and assist you with creating a process to achieve the results you desire.

Sales tax may apply to some services or deliverables. American Fidelity Administrative Services, LLC does not provide tax or legal advice and, given the complexity of the ACA rules, we always recommend working with your own legal counsel to discuss how your plans could be affected and to review guidance provided by our AFAS consultants

Health Plan Consulting

Partnering with American Fidelity Administrative Services (AFAS) for your Health Plan Consulting needs can help you mitigate your compliance risk and improve employee communication while conserving valuable financial and human resources. We have provided a brief description of services below for your information. A full description and price quote can be provided upon request.

Variable Hour Employee Billing

If the employee enrolls in the employer's Minimal Essential Coverage but does not have enough wages in a given payroll period to cover the required premium, the employer can require the employee to pay his or her share of the premium out-of-pocket. We can eliminate the hassle of billing and collecting premiums from variable hour employees by collecting premiums, tracking payment deadlines, balance billing and more.

Employee Notice and Reporting Solution

A variety of federal laws require employers and plan sponsors of health and welfare benefit plans to provide periodic notice to individuals and reports to various federal agencies. Our employee notice and reporting solution provides a basic administrative guide to help make satisfying these obligations easier for you.

Enhanced Notice Service Options

Our enhanced services provide your benefits team relief from the administrative burdens created by the growing number of notice compliance requirements. This service includes notice fulfillment, Summary Plan Description (SPD), and enrollment materials to help you.

Nondiscrimination Testing

Federal law requires testing of certain health and welfare benefits to demonstrate the plan is not providing a greater benefit to highly compensated individuals than to non-highly compensated individuals. Our nondiscrimination testing services help you mitigate your compliance risk, streamline your processes, and conserve valuable financial and human resources.

ERISA Wrap Documents

An employer that has multiple plans (such as medical, dental, and vision insurance) may use one plan document for all benefits to meet the Employee Retirement Income Security Act (ERISA) plan requirements by utilizing a "wrap" plan document. AFAS can assist the employer in setting up the wrap plan document and a separate SPD for the employer to provide to the plan participants.

Basic Excise Tax on High Cost Plans (4980I) Analysis

This analysis will review the potential tax effect of IRC Section 4980I (Excise Tax on High Cost Plans or "Cadillac Plan" tax) on the current plan design offerings of the client. The analysis will show the potential tax liability and offer alternative solutions to avoid or mitigate the tax including a year-by-year strategy. Conducting this analysis in advance of the implementation of the excise tax allows for organizations to develop a multi-year strategy to address the cost impact and avoid making dramatic changes all in one year.

Basic Affordability (4980H(b)) Analysis

This analysis will assess the current cost of the client's plan designs against the IRC Section 4980H(b) Affordability provision under the Employer Mandate regulations of the ACA. The review will also include the recent guidance on flex credit, opt out and cash in lieu provisions. We will provide a summary of plan options and employee salary or hourly rate levels that may be at risk for triggering the Affordability penalties under the ACA and provide strategies to help eliminate or mitigate the risk of penalties under the law.

Plan Design Cost Modeling

AFAS can provide you with longer-term cost modeling of your current health and welfare benefit plan and cost structure to better help you understand how your current strategy will fair under ACA. This analysis will assess your risk of Employer Mandate penalties today and for the next six years as well as the impact of the High Cost Plan Excise Tax (Cadillac Plan tax). Additionally, we will model alternative scenarios for your consideration. This analysis is helpful in understanding your alternatives and making strategic changes now and incrementally over the next few years in anticipation of upcoming health care events (like the Excise Tax on High Cost Plans).

Health Plan Marketing for Fully-Insured and Self-Funded Plans

AFAS will manage a Request for Proposal (RFP) process for the client for their fully-insured health plan options (medical, prescription drug, dental, and vision plans) to assist in identifying potential new insurance plan offerings. This process may also be used to confirm the client is getting a desirable insurance cost and service from their existing insurer or trust.

Health Plan Analysis and Utilization Review

AFAS will help determine what is driving your costs from year to year, provide analyses to support our findings, and offer recommendations to manage costs while maintaining a high-quality program of benefits for employees. Our consultants will review available plan information, renewal documents, plan designs, employee contribution structures, and plan documents and provide strategies to manage costs, maintain compliance, and manage the risk of employer penalties.

Self-Funded Consulting Services

Self-funding your major medical plan can provide additional financial benefits over a fully-insured arrangement including better cash flow, greater flexibility in plan design to reduce cost, elimination of any state mandated benefits or premium taxes, and reduced risk and administrative charges. However, along with these advantages comes the risk of paying for unanticipated claim fluctuations and the need to manage your own health care expenditures. AFAS can provide the actuarial consulting support needed to understand your risks associated with self-funding.

ACA IRS Reporting (Section 6056) Review

AFAS will review your current process and information for completing the IRS Forms 1094-C and 1095-C and offer recommendations to align with the ACA regulations and instructions. We will assess your determination of full-time status under the ACA, review required coverage and affordability codes used on the 1095-C forms and check the information against the current benefit costs and plans for each employee group with different benefit options and/or contribution requirements.

Some products and services may be provided by third party contractors or affiliated companies. Sales tax may apply to some services or deliverables. American Fidelity nor AFAS provide tax or legal advice and, given the complexity of the Affordable Care Act rules, we always recommend working with your own legal counsel to discuss how your plans could be affected and to review guidance provided by our consultants. Consultants provide information for plan sponsors about health and welfare benefit plans but do not provide guidance on specific insurance products; AFAS can provide a referral to an insurance agency if you would like assistance implementing or revising an insurance product.

Renewal Analysis

Our Consultants have in-depth experience in assessing renewal documents and providing guidance on where to focus discussions with a health and welfare benefit plan to reduce the quoted rate increase (or identify additional cost reduction if experiencing a rate decrease) and quoted premiums. Using information provided during your renewal process along with any other available plan information from your health and welfare benefit plan, AFAS Consultants will conduct an analysis of the renewal information, identify the assumptions used and the administrative expense load that generated the rate adjustment, and provide you with information to use in discussion with your plan regarding the adjustment. We will compare these assumptions and administrative expense loads against those commonly used in other renewal analyses and markets and use that to identify opportunities to negotiate a better renewal outcome.

ACA Employer Mandate Compliance Planning

AFAS will meet with you to conduct an in-depth interview identifying your current administrative processes related to the ACA. Your consultant will prepare a draft "Decision Summary" documenting your current approach. During this meeting, we will review your existing ACA policies and procedures, suggest adjustments to those processes as necessary, and work with you to create an action plan to address your strategic goals.

Consulting Retainer

Many employers are concerned about staying on top of the changing ACA rules and want to have an expert available to answer questions as they come up during the year. For an affordable annual fee, you can continue to have access to your Consultant for assistance when you need it.

- Your Consultant will meet with you once a year to review and refine your strategy and compliance plans;
- Your Consultant remains available throughout the year to answer your questions and provide assistance for up to 10 hours per year, which you can save and utilize at your discretion; and
- You will also have access to our Educational Webinars on timely benefit topics, such as ACA developments.

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Leave of Absence Support

While it may seem straightforward to determine who qualifies for family medical leave (FML), most employers find it to be a very complex process. Managing leave requires an understanding of several different areas, including compliance and payroll.

American Fidelity Administrative Services (AFAS) offers a convenient alternative to internally administering FML. Our service provider, ComPsych, may help greatly reduce an organization's FML costs and liability risk. ComPsych provides guidance on FML requirements and employee eligibility, handles the administrative tasks, coordinates the leave benefit on behalf of the employer and trains and consults with the employer on how best to apply FML.

Features

ComPsych can provide employers, human resource professionals, and employees the following possible program benefits:

- Access to resources to answer FML questions
- Readily available expertise and consultation for managers/supervisors
- Lower administrative costs and improved efficiency
- Compliance assistance with state and federal FML regulations
- Decreased liability risk from the administration of FML benefits
- Reduced abuse of the FML benefit
- Consistent application of FML policies- a key requirement under the law
- Americans with Disabilities Act (ADA) leave review and administrative services fully integrated with FML processes and tools

Americans with Disabilities (ADA) Leave

ComPsych also offers a comprehensive solution to Americans with Disabilities (ADA) leave administration that seamlessly integrates with its FML services. Offering this service helps employers comply with leave of absence requests covered under both FML and ADA. ComPsych can assist with administering each law in accordance with its individual regulatory requirements.

AFAS understands the complexities associated with administering FML, and through our partner, ComPsych we can assist you with managing your FML responsibilities.

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EMPLOYER BENEFIT SOLUTIONS FOR THE PUBLIC SECTOR

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While you're busy serving your community, we'll take care of you. For more than 55 years, employers have turned to American Fidelity for employee benefits and administration they can trust. Maybe you should too? Consider American Fidelity for a different opinion.

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