

Employer Sponsored Benefits

Health: Priority Health

Dental: Delta Dental

Life Insurance: Harleysville Life Insurance

Voluntary Benefits

Alwayscare, AFLAC, & Colonial Life & Grange Life Insurance

PRIORITY HEALTH

HealthbyChoice IncentivesSM

CHOICE BENEFITS LEVEL

**Schedule of Copayments
And Deductibles**

POS

100% Preferred – 80% Alternate

Your Certificate of Coverage provides you with important information about your health care benefits, including prior approval requirements and your Coverage level choices. You may use your Primary Care Provider (PCP) or other Participating Physician as your personal health care manager and receive a higher level of benefits (the Preferred Benefits level), or you may choose to refer yourself for care to a Non-Participating Provider and have coverage under the Alternate Benefits level.

This Schedule of Copayments and Deductibles provides you with information about your costs at both benefit levels when you receive health care services and the maximum limitations of your health care benefits. Read the entire Certificate and Schedule of Copayments and Deductibles carefully.

In accordance with the terms and conditions of the Certificate, you are entitled to Covered Services when these services are:

- A. Medically/Clinically Necessary (as defined in the Certificate and according to Medical and Behavioral Health policies established by Priority Health with the input of physicians not employed by Priority Health or according to criteria developed by reputable external sources and adopted by Priority Health); and
- B. (i) For Preferred Benefits, provided by your PCP or provided by a Participating Provider and with approval in advance by us when we consider approval necessary (except in a Medical Emergency), or provided by a Non-Participating Provider (one not listed in our Provider Directory) upon referral from your PCP and with approval in advance by us (except in a Medical Emergency); or
(ii) For Alternate Benefits, approved in advance by us when prior approval is considered necessary (except in a Medical Emergency); and
- C. Not excluded in the Certificate or a rider or an amendment to the Certificate.

If you seek services that require prior approval, without receiving prior approval from us, you will be responsible for the cost of those services. You will also be responsible for those services that are beyond those approved, beyond the benefit maximums or excluded from Coverage.

Your plan may have a Deductible. A Deductible is the amount you must pay before Priority Health will pay for Covered Services under this Certificate. The following services are not subject to a Deductible:

- Services subject to a flat dollar Copayment on this Schedule of Copayments and Deductibles and on any rider to this Certificate,
- Routine maternity care (the deductible does apply to facility charges for delivery), and
- Certain preventive health care services provided and billed by a Participating Physician.

Deductibles, if any, are detailed in a rider attached to the Certificate.

Schedule of Copayments and Deductibles

| Services | Preferred Benefits | Alternate Benefits |
|--|--|---|
| Hospital Services (Including facility-based physician services, radiology examinations and laboratory services) (See Other Referral Care section below for additional Copayment information.) | | |
| Inpatient Hospital and Inpatient Longterm Acute Care Services (Including observation care) | <ul style="list-style-type: none"> • 100% Coverage • Prior approval is required except in emergencies or for hospital stays for a mother and her Newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section | <ul style="list-style-type: none"> • 80% Coverage of Reasonable and Customary Charges • Prior approval is required at least five working days in advance, except in emergencies or for hospital stays for a mother and her Newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section. Failure to obtain prior approval will result in a 20% reduction of benefits. |
| Outpatient Hospital Services (Including ambulatory surgery center facility charges) | <ul style="list-style-type: none"> • 100% Coverage • Prior approval is required for certain radiology examinations | <ul style="list-style-type: none"> • 80% Coverage Of Reasonable and Customary Charges. • Prior approval is required for certain radiology examinations • Failure to obtain prior approval will result in a 20% reduction of benefits |
| Medical Emergency and Urgent Care Services | | |
| Emergency Room Services | \$100.00 Copayment per visit. (Copayment waived only if you become confined in a Hospital as an inpatient) | Emergency room services with Participating and Non-Participating Providers are Covered at the Preferred Benefits level |
| Urgent Care Facility Services | \$45.00 Copayment per visit (Copayment applies to all Urgent Care visits) | 80% Coverage of Reasonable and Customary Charges |
| Ambulance Services | \$50.00 Copayment | \$50.00 Copayment |
| Physician Services (Primary and Referral Care) (See Other Referral Care and Other Services sections below for additional Copayment information.) | | |
| Office/Home Visits and Consultations | <ul style="list-style-type: none"> • \$15.00 Copayment per PCP visit (face-to-face, telephonic, or through secure electronic portal) • \$30.00 Copayment per other Participating Physician visit, including, Specialist Provider (face-to-face, telephonic, or through secure electronic portal) • Prescription drug Copayment may also apply when selected injectable drugs are provided | <ul style="list-style-type: none"> • 80% Coverage of Reasonable and Customary Charges for face-to-face visits only • Prescription drug Copayment may also apply when selected injectable drugs are provided |

| Services | Preferred Benefits | Alternate Benefits |
|--|---|--|
| Inpatient Hospital Visits and Professional Services | 100% Coverage | 80% Coverage of Reasonable and Customary Charges |
| Surgery | 100% Coverage | 80% Coverage of Reasonable and Customary Charges |
| Ambulatory Surgery Center Services | 100% Coverage for physician surgical charges in a hospital surgery center | 80% Coverage of Reasonable and Customary Charges |
| Maternity Services (Prenatal and postnatal) | \$15.00 Copayment per visit up to a maximum of four Copayments per pregnancy for routine prenatal and postnatal services only. Attendance at an approved maternity education program is Covered with one PCP office visit Copayment. | 80% Coverage of Reasonable and Customary Charges |
| Vasectomy | 100% Coverage for physician services when performed in physician's office or when in connection with other Covered inpatient or outpatient surgery | Not Covered (including Physicians' fees and any other related charges) |
| Tubal Ligation | <ul style="list-style-type: none"> • 100% Coverage for physician services and outpatient facility charges • 100% Coverage for inpatient facility charges only when in connection with delivery or other Covered inpatient surgery | Not Covered (including Physicians' fees and any other related charges) |
| Allergy Testing and Serum | Covered in full | 80% Coverage of Reasonable and Customary Charges |
| Allergy Injections | Covered in full | 80% Coverage of Reasonable and Customary Charges |

| Services | Preferred Benefits | Alternate Benefits |
|---|--|---|
| Other Referral Care (Copayments are for all medical services including, but not limited to, physician and hospital services) | | |
| Family Planning/Infertility Services (Limited Coverage) | 50% Coverage for diagnostic, counseling and planning services for treatment of the underlying cause of infertility (Prescription drugs for infertility treatment Covered only with prescription drug rider) | Not covered (including Physicians' fees and any other related charges) |
| Temporomandibular Joint Dysfunction or Syndrome | 50% Coverage | 50% Coverage of Reasonable and Customary Charges |
| Orthognathic Surgery | 50% Coverage | 50% Coverage of Reasonable and Customary Charges |
| Certain Surgeries and Treatments (Physician fees only) <ul style="list-style-type: none"> • <i>Bariatric surgery</i> • Reconstructive surgery <ul style="list-style-type: none"> ○ Blepharoplasty of upper lids ○ Breast reduction ○ <i>Panniculectomy</i> ○ <i>Rhinoplasty</i> ○ <i>Septorhinoplasty</i> ○ Surgical treatment of male gynecomastia • Skin disorder treatments <ul style="list-style-type: none"> ○ Scar revisions ○ Keloid scar treatment ○ Treatment of hyperhidrosis ○ Excision of lipomas ○ Excision of seborrhic keratoses ○ Excision of skin tags ○ Treatment of vitiligo ○ Port wine stain and hemangioma treatment ○ Varicose veins treatments ○ Sleep apnea treatment procedures | <ul style="list-style-type: none"> • Physician fees are Covered at 50% of the first \$2,000.00 for each certain surgery or treatment, 100% thereafter. If applicable, any hospital services Copayment also applies. • <i>Prior approval required for bariatric surgery, panniculectomy, rhinoplasty and septorhinoplasty. Coverage is limited to one bariatric surgery per lifetime unless Medically/Clinically Necessary to correct or reverse complications from a previous bariatric procedure.</i> | <ul style="list-style-type: none"> • Physician fees are Covered at 50% of the first \$3,000.00 for each certain surgery or treatment, 100% thereafter. If applicable, any hospital services Copayment also applies. • <i>Prior approval required for bariatric surgery, panniculectomy, rhinoplasty and, septorhinoplasty. Coverage is limited to one bariatric surgery per lifetime unless Medically/Clinically Necessary to correct or reverse complications from a previous bariatric procedure.</i> |
| Dietitian Services | \$30.00 Copayment per visit up to 6 visits per Contract Year.* | Not covered (including Physicians' fees and any other related charges) |

| Services | Preferred Benefits | Alternate Benefits |
|---|---|---|
| Behavioral Health Services (Short-term therapy and crisis intervention) Prior approval by our Behavioral Health Department is required as noted. Call 616 464-8500 or 800 673-8043 | | |
| Mental Health Inpatient (Including partial hospitalization) | <ul style="list-style-type: none"> • 100% Coverage up to 20 days per Contract Year * (Two partial hospitalization days count as one inpatient day) • Prior approval required | <ul style="list-style-type: none"> • 80% of Reasonable and Customary Charges up to 20 days per Contract Year * (Two partial hospitalization days count as one inpatient day) • Prior approval required. Failure to obtain prior approval will result in a 20% reduction of benefits |
| Mental Health Outpatient | <ul style="list-style-type: none"> • \$20.00 Copayment per visit up to 20 visits per Contract Year * (\$10.00 Copayment per group therapy visit – <u>Two</u> group therapy visits count as <u>one</u> outpatient visit) • Prior approval required | <ul style="list-style-type: none"> • 50% of Reasonable and Customary Charges per visit up to 20 visits per Contract Year * (Two group therapy visits count as one outpatient visit) |
| Substance Abuse Care | <ul style="list-style-type: none"> • 80% Coverage up to the minimum annual benefit of \$3,905 ** • Prior approval required | <ul style="list-style-type: none"> • 80% Coverage of Reasonable and Customary Charges up to the minimum annual benefit of \$3,905 ** • Prior approval required. Failure to obtain prior approval will result in a 20% reduction of benefits |
| Rehabilitative Medicine Services | | |
| Physical and Occupational Therapy (including osteopathic and chiropractic manipulation) | \$15.00 Copayment per visit up to a combined benefit maximum of 30 visits per Contract Year* | 50% Coverage of Reasonable and Customary Charges up to the combined benefit maximum of 30 visits per Contract Year* |
| Speech Therapy | \$15.00 Copayment per visit up to a benefit maximum of 30 visits per Contract Year* | 50% Coverage of Reasonable and Customary Charges up to the benefit maximum of 30 visits per Contract Year* |
| Cardiac Rehabilitation and Pulmonary Rehabilitation | \$15.00 Copayment per visit up to a combined benefit maximum of 30 visits per Contract Year* | 50% Coverage of Reasonable and Customary Charges up to the combined benefit maximum of 30 visits per Contract Year* |

| Services | Preferred Benefits | Alternate Benefits |
|--|--|---|
| Other Services | | |
| Advanced Diagnostic Imaging Services (such as CT, CTA, MRI, MRA, Nuclear Cardiology Studies, PET Scan) | <ul style="list-style-type: none"> • \$150.00 Copayment (Copayment waived if performed while confined in a Hospital as an inpatient) • Maximum 10 Copayments per individual per Contract Year for advanced imaging services • Prior approval is required for certain radiology examinations | <ul style="list-style-type: none"> • 80% Coverage of Reasonable and Customary Charges • Prior approval is required. Failure to obtain prior approval will result in a 20% reduction in benefits. |
| Standard Radiology Examinations and Laboratory Procedures (In a non-hospital facility or physician's office) | <ul style="list-style-type: none"> • Covered in full • Appropriate office visit Copayment (PCP or other Participating Physician) may apply for physician office services | <ul style="list-style-type: none"> • 80% Coverage of Reasonable and Customary Charges • Prior approval is required for certain radiology examinations. Failure to obtain prior approval will result in a 20% reduction of benefits. |
| Prosthetic and Orthotic/Support Devices | <ul style="list-style-type: none"> • 50% Coverage • Prior approval required for devices over \$1,000.00 | <ul style="list-style-type: none"> • 50% Coverage of Reasonable and Customary Charges • Prior approval required for devices over \$1,000.00 |
| Durable Medical Equipment (Rent, purchase or repair) | <ul style="list-style-type: none"> • 50% Coverage • Prior approval required for equipment over \$1,000.00 | <ul style="list-style-type: none"> • 50% Coverage of Reasonable and Customary Charges • Prior approval required for equipment over \$1,000.00 |
| Facility Services (Non-hospital) <ul style="list-style-type: none"> • Skilled Nursing • Subacute • Inpatient Rehabilitation • Hospice | <ul style="list-style-type: none"> • 100% Coverage up to the benefit maximum of 45 days per Contract Year * • Prior approval required except for Hospice | <ul style="list-style-type: none"> • 80% Coverage of Reasonable and Customary Charges up to the benefit maximum of 45 days per Contract Year* • Prior approval required except for Hospice. Failure to obtain prior approval will result in a 20% reduction of benefits |
| Home Health Care (Including Hospice Services, excluding Rehabilitatiiv Medicine) Note: Rehabilitative services provided in the home are subject to the limitations of the Rehabilitative Medicine Services benefits described above. | <ul style="list-style-type: none"> • Covered in full • Prior approval required | <ul style="list-style-type: none"> • 80% Coverage of Reasonable and Customary Charges • Prior approval required |

MAXIMUM LIMITATIONS

A. Benefit Maximums:

- * **Benefit Maximums:** Benefit maximums up to a certain number of days/visits per Contract Year are reached by combining either Preferred or Alternate Benefits up to the limit for one or the other, but not both. (Example: If Preferred Benefits is for 60 visits and Alternate Benefits is for 60 visits, the maximum benefit is 60 visits, not 120.) Benefit maximums apply even when continued care is Medically/Clinically Necessary beyond the benefit maximum.
- ** **Substance Abuse:** Coverage is provided up to a minimum annual benefit as determined by the State of Michigan per Contract Year. Coverage amount to be adjusted each March 31st in accordance with the average percentage increase in the "Consumer Price Index for All Urban Consumer-Revised" (CCPI). Coverage amount may be adjusted by a rider.

B. Out-of-Pocket Maximums:

The Out-of-Pocket Maximum applies to Covered Services except those listed below. The Out-of-Pocket maximum limits the total amount of Copayments that you will pay during a Contract Year, except as described below.

| Out-of-Pocket Maximums | Preferred Benefits | Alternate Benefits |
|------------------------|--------------------|---|
| Individual | \$0 | \$2,500 |
| Family | \$0 | \$5,000 (but not to exceed the Individual Out-of-Pocket Maximum per person) |

The Preferred Benefits Out-of-Pocket Maximums do not apply to the Alternate Benefits Out-of-Pocket Maximums, nor do the Alternate Benefits Out-of-Pocket Maximums apply to the Preferred Benefits Out-of-Pocket Maximums.

Amounts paid for any of the following will not apply toward the Out-of-Pocket Maximum:

- Durable Medical Equipment
- Prosthetic & Orthotic/Support Devices
- Temporomandibular Joint Dysfunction or Syndrome
- Orthognathic Surgery Services
- Family Planning/Infertility Services
- Mental Health Services
- Substance Abuse Services
- Rehabilitative Medicine Services
- Certain Surgeries and Treatments -- Physician Fees
- Any flat dollar Copayments, such as Copayments for office visits, ambulance and emergency services.
- Deductibles
- Penalties

Additionally, your Out-of-Pocket Maximum will not take into account:

- any monies you paid for non-Covered Services; and
- any monies you paid for Covered Services that exceed the annual day/visit or dollar benefit maximum for a specific benefit and therefore, denied as non-Covered Services; and
- any monies you paid to providers for Alternate Benefits that exceed Reasonable and Customary; and
- any monies you paid for Covered Services after the Lifetime Benefit Maximum is exhausted.

After meeting the Out-of-Pocket Maximums, the Copayments for these services still apply.

Schedule of Copayments and Deductibles

Note: Copayments made for any Covered Services obtained under a supplemental benefit rider may not be applied toward the above Out-of-Pocket Maximum. If your plan has a Deductible Rider, deductible amounts you pay will not apply toward the Out-of-Pocket Maximum.

Note: If the Alternate Benefits individual Out-of-Pocket Maximum is reached during a Contract Year, Priority Health will pay 100% of the Reasonable and Customary Charges for covered inpatient hospital expenses incurred by that person for the rest of the Contract Year, provided, however, the member will not be responsible for any balance billing. If the Alternate Benefits family Out-of-Pocket Maximum is reached during a Contract Year, Priority Health will pay 100% of the Reasonable and Customary Charges for covered inpatient hospital expenses incurred by you and all your covered dependents for the rest of the Contract Year, provided, however, the member will not be responsible for any balance billing.

Note: If the Alternate Benefits penalty applies, the percentage Priority Health pays will be reduced even if the Out-of-Pocket Maximum has been reached.

C. Maximum Individual Lifetime Benefit:

| | |
|---------------------|----------------|
| Preferred Benefits: | Not applicable |
| Alternate Benefits: | \$1,000,000 |

Filed in Michigan: 2010

Doc_1943



DeltaPremier
Summary of Dental Plan Benefits
For Group#0001494-0001
FOUNDATION FOR BEHAVIORAL RESOURCES

This Summary of Dental Plan Benefits should be read in conjunction with your Dental Care Certificate. Your Dental Care Certificate will provide you with additional information about your Delta Dental plan, including information about plan exclusions and limitations. In the event that you seek treatment from a dentist that does not participate in any of Delta Dental's programs, you may be responsible for more than the percentage indicated below.

Control Plan - Delta Dental Plan of Michigan

Benefit Year - January 1 through December 31

Covered Services -

| | Plan Pays | You Pay |
|---|-----------|---------|
| Class I Benefits | | |
| Diagnostic and Preventive Services - Used to diagnose and/or prevent dental abnormalities or disease (includes exams, cleanings and fluoride treatments) | 100% | 0% |
| Emergency Palliative Treatment - Used to temporarily relieve pain | 100% | 0% |
| Class II Benefits | | |
| Radiographs - X-rays | 80% | 20% |
| Oral Surgery Services - Extractions and dental surgery, including preoperative and postoperative care | 80% | 20% |
| Endodontic Services - Used to treat teeth with diseased or damaged nerves (for example, root canals) | 80% | 20% |
| Periodontic Services - Used to treat diseases of the gums and supporting structures of the teeth | 80% | 20% |
| Relines and Repairs - Relines and repairs to bridges and dentures | 80% | 20% |
| Minor Restorative Services - Used to repair teeth damaged by disease or injury (for example, fillings) | 80% | 20% |
| Major Restorative Services - Used when teeth can't be restored with another filling material (for example, crowns) | 80% | 20% |
| Class III Benefits | | |
| Prosthetic Services - Used to replace missing natural teeth (for example, bridges and dentures) | 50% | 50% |

Benefits for oral examinations, prophylaxes and fluoride treatment are payable twice per calendar year. Benefits for bitewing X-rays are payable once per calendar year.

Maximum Payment - \$1,000 per person total per benefit year on Class I, Class II and Class III Benefits.

Deductible - \$50 deductible per person total per benefit year limited to a maximum deductible of \$150 per family per benefit year on Class I, Class II and Class III Benefits.

Waiting Period - Employees who are eligible for dental benefits can be covered on the first day of the month following 30 days of employment.

Eligible People - All full-time employees of the contractor (your employer) working at least 30 hours per week who choose the dental plan and all individuals who are eligible for and elect continuation coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 if applicable.



Why Choose AlwaysVision?

AlwaysCare Benefits, one of the fastest-growing dental and vision insurance providers in the country, offers flexible, innovative dental and vision products to fit any employer's need.

AlwaysCare is focused on providing innovative solutions for employers who wish to maximize their employees' benefits and control costs. We accomplish this through a willingness to accommodate, unique benefit combinations and technology that provides its members access to consumer-driven web-based tools.

AlwaysVisionSM Plan Highlights include:

- Consumer-Driven Plan options with Freedom of Choice
- Comprehensive Vision plans, Materials Only Plan with Hearing Benefit,* and Exam Only Plans
- Fully Insured Progressive Lens Allowances
- Large National Vision PPO Networks available
- Plan features can include varying benefit frequencies, co-pay options, frame and contact lens allowances, out-of-network benefits and more
- First-Class Customer Service:
 - 95% Overall Member Satisfaction**
 - 92% Retention Rate
 - Extended Customer Service Hours
 - Monday – Friday: 7:30 am – 8:30 pm CST; 9:00 am – 3:00 pm CST
 - All administrative services handled in one location; one phone number for all service needs
- Interactive Online Tool for Group Administrators and Members

AlwaysCare Benefits strives to meet employer and employee needs by offering the flexible, affordable benefits they seek. So, check out a company whose benefits really measure up!

*Materials Only with Hearing Benefit Rider not available in all states. 10+ enrolled lives required.

**2007 Member Survey.



Group Name: _____
 Agent Name: _____
 Effective Date: _____

Elite Plan B

Welcome to AlwaysCare Benefits, Inc. This program has been specifically designed to provide you and your covered family members with quality professional vision care, all at a tremendous savings to you!

| Benefit Summary | | | |
|--|---|----------------|-----------------|
| Vision Care Services | In-Network | | Out-of-Network |
| Co-Pays: | | | |
| Exam (Once every 12 months) | \$10 | | Up to \$35 |
| Materials | \$10 | | see below |
| Standard Plastic Lenses: (Once every 12 Months) | | | |
| Single Vision | Covered by Co-pay | | Up to \$25 |
| Bifocal | Covered by Co-pay | | Up to \$40 |
| Trifocal | Covered by Co-pay | | Up to \$50 |
| Lenticular | \$80 allowance | | Up to \$50 |
| Progressive | \$70 allowance | | Up to \$40 |
| Lens Options: | | | |
| Scratch resistant coating | N/A | | N/A |
| Polycarbonate Lenses for children | N/A | | N/A |
| Frames: (Once every 24 Months) | \$120 retail frame. | | |
| Members choose from any frame available at provider locations. | Covers a wide selection of frames. (\$94 retail frame at Wal-Mart & Sam's Club) | | Up to \$50 |
| Contact Lenses: (Once every 12 Months) (Includes fit, follow-up and materials) | | | |
| In lieu of eyeglass lenses & frames | | | |
| Elective | Up to \$120 retail | | Up to \$100 |
| Medically Necessary | Up to \$210 retail | | Up to \$210 |
| Laser Vision Correction: | Membership provides access to preferred pricing. Transactions are handled directly between Members and Providers. Refractive surgery is an elective procedure and may involve potential risks to patients. This is not an insured benefit. AlwaysCare Benefits, Inc. cannot and does not guarantee the outcome of any refractive surgical procedure or a total elimination of the need for glasses or contacts. Providers may not be available in all metropolitan areas. Visit www.AlwaysCareBenefits.com for a list of participating laser vision correction providers. | | |
| Participation Requirements: | 20-49% | 50-79%* | 80-100%* |
| Employee Only | \$7.38 | \$6.64 | \$4.92 |
| Employee & Spouse | \$14.74 | \$13.28 | \$9.84 |
| Employee & Child(ren) | \$15.72 | \$14.14 | \$8.16 |
| Employee & Family | \$24.62 | \$22.16 | \$13.66 |
| Rate Guarantee: | 24 months from the effective date of coverage. | | |
| Administration Fee: | \$5.00 monthly fee for groups with 2-9 enrolled. No admin fee for groups with 10+ enrolled | | |
| Stand alone vision plans are available for groups with as few as 5 enrolled; available for groups with as few as 2 enrolled when combined with dental. | | | |
| *Must have 10 or more enrolled to qualify for the 50-79% or 80-100% rates. | | | |
| Rates are valid through 12/31/08. | | | |
| Limitations & Exclusions | | | |
| <p>Selection of Providers: AlwaysVisionSM offers a nationwide PPO network consisting of over 22,000 Providers nationwide. The Provider panel contains independent optometrists and ophthalmologists, as well as regional and national retail chains (including Wal-Mart, Pearle Vision, Target, Sears, JC Penney and Eyemasters). Members may choose different providers for vision exam and materials purchases. Out-of-network benefits are available, but members receive the best value in-network. Visit www.AlwaysCareBenefits.com or call 888-729-5433, Ext. 2013 for a list of participating providers. Most participating providers (excluding Wal-Mart & Sam's) offer discounts on items purchased after the insurance benefit has been used.</p> <p>Limitations: If you expect to require a vision service not included on this brochure, it may still be covered. Please contact customer service at 1-888-729-5433, ext 2013 to confirm your exact benefits. This is a primary vision care benefit and is intended to cover only eye examinations and corrective eyewear. Medical or surgical treatment of eye disease or injury is not provided under this plan. Coverage may not exceed the lesser of actual cost of covered services and materials or the limits of the policy. Covered materials that are lost or broken will be replaced only at normal service intervals indicated in the Plan Design; however, these materials and any items not covered below may be purchased at Preferred Pricing from a Participating Provider. In addition, benefits are payable only for expenses incurred while the Group and individual Member coverage is in force.</p> <p>Exclusions: This plan does not cover • Orthoptics or vision training and any supplemental testing; Plano (non-prescription) lenses; or two pair of eyeglasses in lieu of bifocals or trifocals; • Medical or surgical treatment of the eyes; • An eye exam or corrective eye wear required by an employer as a condition of employment; • Any injury or illness covered under Workers' Compensation or similar law, or which is work related; • Plain or prescription sunglasses or tinted lenses, and no-line bifocals and blended lenses (subject to allowance); • Sub-normal vision aids; • Services rendered or materials purchased outside the U.S. or Canada, unless the insured resides in the U.S. or Canada, and the charges are incurred while on a business or pleasure trip; • Charges in excess of Usual and Customary for services and materials; • Experimental or non-conventional treatments or devices; • Safety eyewear; • Spectacle lens styles, materials, treatments or "add-ons" not shown in the Schedule of Benefits.</p> | | | |

Underwritten by: National Guardian Life Insurance Company, Madison, WI
 Administered by: AlwaysCare Benefits, Inc.
 (a Starmount Life Insurance company), The Starmount Building, 7800 Office Park Blvd, Baton Rouge, LA 70809; PH: 1-888-729-5433, ext 2013.
 Policy Forms: Vision – NVIGRP.
 National Guardian Life Insurance Company is not affiliated with the Guardian Life Insurance Company of America a/k/a The Guardian or Guardian Life

Foundation for Behavioral Resources

If you or a family member were sick or injured, **WHO PAYS YOU?** For over 50 years, *Aflac* has been providing cash benefits to individuals and families to help with the unexpected cost of getting better.

The following are highlights of the programs offered through *Aflac*. **

EMPLOYEE ONLY

- 1) **PERSONAL DISABILITY INCOME PROTECTOR PLAN** - Our ability to earn an income is our greatest material asset. It pays our bills and builds our retirement account. Accidents and sickness; however, can reduce or even stop our income. Benefits start:
 1st Day - Accident
 8th Day - Sickness

EMPLOYEE AND FAMILY COVERAGE

- 2) **HOSPITAL PROTECTION** - Pays you a cash benefit when you or covered family members are confined in a hospital due to a covered sickness or injury. This includes outpatient surgery at an ambulatory center. Benefits include:

- * Annual Confinement Benefit: \$400 / \$500
- * Daily Confinement Benefit
- * Rehabilitation Unit Benefit
- * Optional Initial Hospitalization Benefit Rider

- * Invasive Diagnostic Exams Benefit (9)
- * Surgical Benefit
 Inpatient: \$50 ————— \$1,000
 Outpatient Surgical Room Charge: \$300 / \$100

- 3) **PERSONAL ACCIDENT INDEMNITY PLAN** - Pays you cash benefits when you or a covered family member is accidentally injured and seek medical treatment within the first 72 hours. Benefits include:

- * Medical Treatment
- * Major Diagnostic Tests
- * Fractures, Burns, Cuts, Dislocations
- * Ambulance Benefit

- * Initial Hospital/Daily Benefits
- * Initial ICU/Daily Benefits
- * Rehab Unit Benefit
- * Family Lodging Benefit

- * Physical Therapy
- * Follow-up Treatment
- * Life Insurance
- * Wellness Benefit

- 4) **PERSONAL CANCER INDEMNITY PLAN** - Provides cash benefits to your family to help with the medical and non-medical costs associated with fighting cancer. Benefits include:

- * First Occurrence Lump Sum
- * Building Benefits
- * Daily Hospital Benefit

- * Chemotherapy/Radiation
- * Skin Cancer
- * Bone Marrow Transplant

- * Transportation
- * Family Lodging
- * Hospice
- * Wellness Benefit

- 5) **SPECIFIED HEALTH EVENT/HOSPITAL INTENSIVE CARE PROTECTION** - Provides cash benefits to your family to help with the medical and non-medical costs associated with fighting cardio-vascular disease and catastrophic accidents. Covers Heart Attack, Stroke, Coronary Bypass Surgery, Major Organ Transplant, End-Stage Renal Failure, Paralysis, Coma, and Major Third-Degree Burns. Now includes Angioplasty/Stent Placement and Intensive Care Daily Benefits:

- * First Occurrence Lump Sum
- * Building Benefit

- * Reoccurrence Benefit
- * Daily Hospital Benefit

- * Continuing Care Benefit
- * Transportation and Lodging

* Monthly Recover Benefit Rider
 * Daily ICU Benefit (Day 1-7, \$700/\$800 per day — Day 8-15, \$1,200/\$1,300 per day)

- * Step-Down Unit Benefit

- * Ambulance

- * Progressive Benefit for ICU

- * Additional Major Human Organ Transplant

- 6) **VISION NOW** - Pays you cash benefits for eye exams and glasses, and also does much more:

- * Eye Examination
- * Vision Correction - three options
 \$50 \$120 \$210

- * Specific Eye Diseases/Disorders
- * Eye Surgery
- * Permanent Visual Impairment

These Programs:

Pay **CASH** directly to you in addition to any Group Health Plan.
 Can be **CONTINUED** beyond employment with **FULL BENEFITS** at your **GROUP DISCOUNT**.
 Are available even if you are **NOT** on the group medical plan.
 Cover you and your family.
 Provide **LIFETIME COVERAGE** - you can **NEVER** be canceled!

- 7) **DENTAL INSURANCE** - No deductible - No Pre-certification - Pays scheduled benefits to your provider- Wellness Benefits are paid twice per year per person.

**Please refer to brochures for specific details

Employee Supplemental Benefits Open Enrollment – Full-Time Employee

Have we got news for you! As a valued employee of the Foundation of Behavioral Resources you have the opportunity to participate in additional benefits. You can choose benefits that meet your individual needs.

Open Enrollment: This is your opportunity to add coverage from Colonial Life. It is very important that you review the selections below and meet with you Colonial Life representative to complete your open enrollment process. If you do not wish to participate you still need to meet with a representative to electronically waive certain coverages as there are special offers of guarantee issue only offered at this initial enrollment.

Please take the time to review the following so that when you meet with your benefit representative, you are prepared to ask questions on the one or two programs that make sense for you.

Colonial Supplemental Benefits:

- ❑ **Disability Income Protection – employee only**
Helps you pay everyday living expenses and out-of-pocket expenses not covered by major medical plans. Provides income replacement if you're unable to work due to a covered injury or sickness. Guarantee Issue available for up to \$3000 /month in benefit. Also if you have existing individual coverage you may be eligible to have the pre-existing conditions waived. Wellness rider available.
- ❑ **Supplemental Life Insurance – employee, spouse and children (ask for details)** Term is either 10 year or 20 year fixed periods and provides lower initial costs for higher levels of coverage. Individual plans for employee and family members.
- ❑ **Medical Bridge – employee, spouse, or family coverage levels.** Pays directly to you if you experience a hospital confinement or covered out patient surgery. Wellness benefits included.
- ❑ **Accident Care Program – employee, spouse, children or any combination eligible.** Helps offset unexpected medical, such as deductibles and co-payments that can result from expenses due to injuries, emergencies and hospitalization for any covered member of the family. Wellness rider available.
- ❑ **Critical Illness and Wellness Benefit – employee or spouse eligible** Choose from \$5,000 to \$50,000 lump sum benefit for a covered critical illnesses, complimenting your major medical coverage and helping with direct and indirect costs. Includes a wellness benefit.
- ❑ **Cancer Security and Wellness Benefit – employee, spouse, or family coverage levels.** Helps pay the direct and indirect out-of-pocket expenses not covered by major medical plans. This coverage also provides wellness benefits for specified cancer screening tests.

***You are not covered until you complete an application
with a Colonial Representative and a policy is issued.
If you need assistance contact us at 877-846-3745, thank you.***

Supplemental Employee Benefits

Sample Semi-Monthly MI Rates for Foundation for Behavioral Resources

Short Term Disability Income Protection

AA Risk Class

(For illustration only - other elimination periods and monthly benefits are available)

| | Age Bands (EE Only) | |
|---|---------------------|----------|
| | 17-49 | 50-69 |
| 3 month benefit - 7 day elimination period - \$1000 monthly benefit | \$ 16.25 | \$ 21.00 |
| 6 month benefit - 14 day elimination period - \$1000 monthly benefit | \$ 15.75 | \$ 22.00 |
| 12 month benefit - 30 day elimination period - \$1000 monthly benefit | \$ 14.00 | \$ 21.00 |
| 24 month benefit - 60 day elimination period - \$1000 monthly benefit | \$ 15.50 | \$ 26.00 |

* Wellness rider available

Term Life Insurance (non-tobacco)

| | Employee Age | | |
|---|--------------|---------|----------|
| | 25 | 40 | 50 |
| \$20,000 Term Life Insurance - 10 Year | \$ 3.13 | \$ 3.66 | \$ 5.83 |
| \$50,000 Term Life Insurance - 10 Year | \$ 4.83 | \$ 6.15 | \$ 11.56 |
| \$101,000 Term Life Insurance - 10 Year | \$ 7.30 | \$ 9.83 | \$ 15.68 |

Hospital Confinement - Medical Bridge 3000 w/ wellness

| | Employee Only | Employee + Children | Employee + Family |
|--|---------------|---------------------|-------------------|
| \$500 Hospital / \$500-1000 Outpatient Surgery - Age (17-49) | \$ 6.55 | \$ 11.13 | \$ 16.98 |
| \$500 Hospital / \$500-1000 Outpatient Surgery - Age (50-59) | \$ 9.05 | \$ 13.45 | \$ 21.93 |

AccidentCare Program

| | Employee Only | Employee + Spouse | Employee + Family |
|---|---------------|-------------------|-------------------|
| Comprehensive Plan - On/Off Job Accident with Catastrophic and AD&D | \$ 8.18 | \$ 10.90 | \$ 16.38 |

* Wellness rider available

Critical Illness with wellness benefits

| | Age Bands (EE or Spouse) | | |
|---|--------------------------|---------|----------|
| | 30-39 | 40-49 | 50-59 |
| \$10,000 Lump Sum Benefit (non-tobacco) | \$ 2.80 | \$ 4.40 | \$ 6.80 |
| \$25,000 Lump Sum Benefit (non-tobacco) | \$ 5.50 | \$ 9.50 | \$ 15.50 |

Cancer 1000 with wellness benefits

| | Employee Only | Employee + Children | Employee + Family |
|--------------|---------------|---------------------|-------------------|
| Plan Level 2 | \$ 10.25 | \$ 11.00 | \$ 17.00 |
| Plan Level 3 | \$ 13.25 | \$ 15.00 | \$ 22.50 |

Colonial's coverages share important features:

- Coverage is available to spouses and dependent children with most products.
- Benefits are paid directly to you, unless you specify otherwise.
- With most plans, you can continue coverage with no increase in premiums when you retire or change jobs.
- With most plans, you receive benefits regardless of any other insurance you may have with other companies.
- Premiums are payroll deducted, often pre-tax saving you 25-40%.

These rates are based on a payroll of 24 pay periods per year.

More detailed rates on these or other benefits available on request. Rates are subject to change and/or correction.

These rates are for illustration purposes only. This proposal is not a contract or guarantee of coverage