

**BOARD OF PUBLIC WORKS AND SAFETY**

**RESOLUTION NO. 17-01**

**A RESOLUTION OF THE BOARD OF PUBLIC WORKS AND SAFETY OF THE CITY  
OF GREENWOOD ADOPTING EMPLOYEE HEALTH INSURANCE BENEFIT PLAN  
AND RELATED CONTRACTS FOR THE 2017-2018 POLICY YEAR**

WHEREAS, the Board of Public Works and Safety of the City of Greenwood, Indiana (the "Board") recognizes that health, dental, and vision insurance is an important benefit to the City's employees;

WHEREAS, health insurance represents a significant expenditure to the City's budget;

WHEREAS, the City's health insurance plan is renewed annual on April 1; and

WHEREAS, certain revisions and amendments are necessary to the City's Employee Health Insurance Benefit Plan due to market conditions, budgetary reasons, and the desire to change vision insurance providers.

NOW THEREFORE, BE IT RESOLVED BY THE BOARD OF PUBLIC WORKS AND SAFETY OF THE CITY OF GREENWOOD, INDIANA THAT:

1. Pierre Fox of Regions Insurance, Inc. shall serve as broker of record for the City for its health insurance benefit plan for the 2017-2018 policy year. The Board authorizes and delegates authority to the Mayor to sign all documents and contracts necessary to effectuate said relationship subject to approval of form by the City's Legal Department.

2. Anthem, Inc. shall serve as the medical stop loss provider for the City for its health insurance benefit plan for the 2017-2018 policy year. The Board authorizes and delegates authority to the Mayor to sign all documents and contracts necessary to effectuate said relationship subject to approval of form by the City's Legal Department.

3. Anthem, Inc. shall serve as the third party administrator for the City for its health insurance benefit plan for the 2017-2018 policy year. The Board authorizes and delegates authority to the Mayor to sign all documents and contracts necessary to effectuate said relationship subject to approval of form by the City's Legal Department.

4. Premiums for the 2016-2017 policy year shall be established as follows:

Category	Monthly Rate
Employee	\$80.00
Employee plus Children	\$145.00
Employee plus Spouse	\$160.00
Employee plus Family	\$185.00

Additionally, a \$20 monthly surcharge shall be applied to Employee plus Spouse accounts and Family accounts where the employee's spouse is employed full time at an employer who offers health insurance benefits.

5. The City's Employee Summary of Benefits is hereby approved in the form attached hereto as **Exhibit A**.

6. Delta Dental of Indiana shall serve as the provider for the City for its dental insurance benefit plan for the 2017-2018 policy year. The Board authorizes and delegates authority to the Mayor to sign all documents and contracts necessary to effectuate said relationship subject to approval of form by the City's Legal Department.

7. Anthem, Inc. shall serve as the provider for the City for its vision benefit plan for the 2017-2018 policy year. The Board authorizes and delegates authority to the Mayor to sign all documents and contracts necessary to effectuate said relationship subject to approval of form by the City's Legal Department.

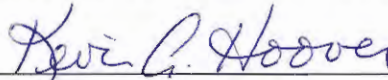
8. Key Benefit Administrators, Inc. shall serve as the provider for the City for its federal tax savings plans for health and childcare for the 2017-2018 policy year. The Board authorizes and delegates authority to the Mayor to sign all documents and contracts necessary to effectuate said relationship subject to approval of form by the City's Legal Department.

9. American United Life shall serve as the provider for the City for life insurance plans for the 2017-2018 policy year. The Board authorizes and delegates authority to the Mayor to sign all documents and contracts necessary to effectuate said relationship subject to approval of form by the City's Legal Department.

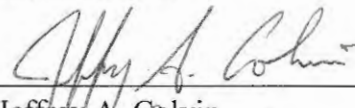
10. American United Life shall serve as the provider for the City for short term and long term disability programs for the 2017-2018 policy year. The Board authorizes and delegates authority to the Mayor to sign all documents and contracts necessary to effectuate said relationship subject to approval of form by the City's Legal Department.

PASSED BY THE BOARD OF PUBLIC WORKS AND SAFETY OF GREENWOOD, INDIANA this 8th day of February, 2017, by a vote of 3 ayes, 0 nays.

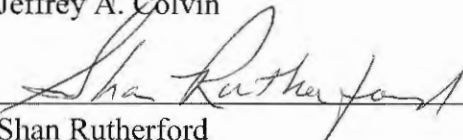
**BOARD OF PUBLIC WORKS AND SAFETY**



Kevin Hoover

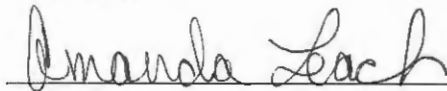


Jeffrey A. Colvin



Shan Rutherford

ATTEST:



Amanda Leach, Board Clerk

- Private Duty Nursing – limited to 82 visits/Calendar Year and 164 visits/lifetime.
- Elective abortions not covered unless otherwise noted in your Certificate of Coverage.
- Live Health Online (LHO) is covered at the PCP costshare

1 These covered services are not subject to the deductible/copayment if you have a flat dollar copayment and if rendered without an office visit.

2 We encourage you to review the Schedule of Benefits for limitations.

3 Kidney and Comea are treated the same as any other illness and subject to the medical benefits.

**Precertification:**

Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.

**Pre-existing Exclusion Period:** none

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

Authorized group signature (if applicable) 	Date 2/01/2017
Underwriting signature (if applicable)	Date



# Renewal Information Implementation Checklist



Group name <u>City of Greenwood</u>	Effective date (MM/DD/YYYY) <u>04/01/2017</u>
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1. Verify current number of eligible employees: 245
2. Verify current number of total employees (including part-time/seasonal): 120 pt/seasonal
3. Open enrollment changes format:  
☒ eMaintenance  
☐ Applications  
☐ Spreadsheet (plan changes only – not for addition of employees or dependents)
4. Date open enrollment applications/spreadsheet to be submitted: 10/30/2017 (MM/DD/YYYY)
5. Please confirm main group contact information to ensure our records are current:  
Name: Lisa Marie Vest  
Telephone number: (317) 8875604  
Email address: Vest1@greenwood.in.gov
6. Please confirm group authorized signer information to ensure our records are current:  
Name: Mayor Mark Myers  
Telephone number: (317) 8875000  
Email address: myersm@greenwood.in.gov
7. Employer contribution:  
Single: 90 %  
Dependent: 90 %
8. Section 125? ☒ Yes ☐ No
9. Is Group subject to ERISA? ☐ Yes ☒ No

Completed by <u>Lisa Marie Vest</u>	Date (MM/DD/YYYY) <u>02/01/2017</u>
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# Single-case Agreement Addendum to Broker Agreement



This Addendum ("Addendum") dated \_\_\_\_\_, is agreed to by and between Anthem Blue Cross and Blue Shield ("Anthem") and \_\_\_\_\_ ("Broker"). This Addendum shall be effective as of \_\_\_\_\_ and supersedes and replaces any prior Addendum, Single-case Agreement, or other agreements regarding the compensation between the parties with respect to the Group provided in Section 3 below.

## SECTION 1: EFFECT OF ADDENDUM

- 1.1 This Addendum constitutes an amendment and supplement to the Broker Agreement between Anthem and Broker in effect as of the date hereof (the "Broker Agreement") in accordance with the terms thereof, and supersedes and replaces the Commission portion of the Compensation Schedules attached to the Broker Agreement.
- 1.2 Except as expressly set forth herein, the Broker Agreement shall continue in full force and effect in accordance with its original terms, which terms shall also apply herein.

## SECTION 2: TERM AND TERMINATION

- 2.1 This Addendum shall automatically renew annually, unless earlier terminated as provided herein.
- 2.2 Either party may terminate this Addendum with at least thirty (30) days advance written notice to the other party without cause ("Termination without Cause").
- 2.3 Anthem may terminate this Addendum effective upon mailing of written notice to Broker in the event of any breach of the terms hereof by Broker, or for any of the reasons set forth in the Broker Agreement, or any other provision thereof providing for termination for cause.
- 2.4 This Addendum shall terminate automatically and without notice in the event that the Broker Agreement is terminated pursuant to its terms.

## SECTION 3: GROUP INFORMATION

3.1	Group name		Group ID no.	
3.2	<input type="checkbox"/> New group <input type="checkbox"/> Renewal	Renewal date	Association name	
3.3	Group location <input type="checkbox"/> IN <input type="checkbox"/> KY <input type="checkbox"/> MO <input type="checkbox"/> OH <input type="checkbox"/> WI		Number of current health contracts	
3.4	Broker to be paid	Commission split %	Broker Tax ID no.	Broker code
3.5	Broker to be paid	Commission split %	Broker Tax ID no.	Broker code

## SECTION 4: COMMISSION

Please complete Options 1, 2, 3 or 4 below:

- Complete Option 1 if per capita rate varies by lines of business
- Complete Option 4 if commission is to be paid on a percent of premium
- Complete all lines of business fields and use N/A if line of business does not apply

Per Capita Commission Rate per Subscriber Per Month (PSPM):				
1.	Health \$ _____	Dental \$ _____	Vision \$ _____	Life \$ _____
	Other: _____ \$ _____		Other: _____ \$ _____	
Per Capita Commission Rate for Administrative Service Only (ASO) Group (PSPM):				
2.	Health \$ _____ + _____ % Stop Loss = \$ _____ PSPM Dental \$ _____ Vision \$ _____ Other: _____ \$ _____			
3.	Flat Commission Rate for ASO Group of \$ _____ per month			
4.	Percent of Premium: Medical: _____ % Dental: _____ % Vision: _____ % Life: _____ % Other: _____ %			

Note: If a Commission split is indicated in Section 3 of this Addendum, then the rate(s) indicated in Section 4 will be split accordingly.

Life and Disability products underwritten by Anthem Life Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association. Anthem Blue Cross and Blue Shield is the trade name of: In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RHC), Healthy Alliance® Life Insurance Company (HALIC) and HMO Missouri, Inc. RHC and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RHC and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Ohio: Community Insurance Company. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), which underwrites or administers the PPO and indemnity policies; CompCare Health Services Insurance Corporation (CompCare), which underwrites or administers the HMO policies; and CompCare and BCBSWI collectively, which underwrite or administer the PDS policies. Independent licensees of the Blue Cross and Blue Shield Association. \*ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are the registered marks of the Blue Cross and Blue Shield Association.

**SECTION 5: ACCEPTANCE OF ADDENDUM — Signatures required**

Anthem may modify or amend this Addendum upon thirty (30) days' written notice to Broker.

By executing this Addendum below, the Broker attests that all compensation requested by this Addendum has been fully disclosed by the Broker to the Group. Further, by executing this Addendum, the parties agree to the terms hereof.

**Anthem Blue Cross and Blue Shield**

Regional Vice President or Regional Sales Director signature <b>X</b>	Name	Date
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**Sales Representative**

Sales representative signature <b>X</b>	Name	Date
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**Broker One**

Broker one signature <b>X</b>	Name	Date
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**Broker Two**

Broker two signature <b>X</b>	Name	Date
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**Group Representative**

Group name \_\_\_\_\_, group no. \_\_\_\_\_, through its authorized representative hereby certifies that Broker name(s) \_\_\_\_\_ is authorized to receive commission as described in Section 4.

Group representative signature <b>X</b>	Name	Date
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**Underwriting Approval**

Underwriter signature <b>X</b>	Name	Date
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## How to properly complete and submit a Single-case Agreement

Please note that ALL applicable information needs to be completed on the Single-case Agreement (SCA) in order to be valid.

### Completing Page 1

- A. All appropriate blanks appearing at the top of this page before Section 1 shall be completed including the SCA origin date, the Broker entering into the SCA, and the effective date of SCA.
- B. Section 3 contains the information pertinent to the group in which the SCA is being submitted along with the Broker who is to receive commissions for the group listed. All information should be provided and in the event that information is not applicable, please indicate N/A in the appropriate area.
- C. If information in Section 3 is not complete or if the Broker listed does not meet all Licensing & Contracting guidelines, the SCA will not be accepted and will need to be re-submitted once additional information is provided or guidelines have been met.
- D. Agents who assign commission to an agency should indicate the agency and their corresponding agent code in order to ensure commissions are paid correctly to the appropriate party.

### Completing Section 4

- A. The appropriate commission line is to be used dependent on the type of commission to be paid. Multiple lines should not be used.
- B. The specific commission rate to be paid on all lines of business need to be indicated on the SCA, even if one or more lines of business are deemed to be standard. "Standard" is not an appropriate answer as multiple "standard" rates exist dependent upon state and size of business.
- C. Per subscriber per month (PSPM) commissions are to be paid based on a flat dollar amount per line of business. If there is a line of business not listed, please use the Other category to define the line of business and PSPM commission rate.
- D. For an Administrative Service Only (ASO) group, if the commission rate includes a percentage of stop loss premium, the stop loss premium needs to be converted to a PSPM amount and the total PSPM rate should be indicated. If stop loss premium is not included in the commission rate, the stop loss percentage should be 0%.
- E. **Attention Sales and Underwriting:** For all ASO and National groups, Funding Documents are required to be submitted with the SCA. The commission section of the Funding Document should clearly show all commissions to be paid with all percentages converted to PSPM rates.
- F. If a flat monthly dollar amount is to be paid on an ASO group, indicate the monthly amount to be paid in Option 3.
- G. Percent of premium commissions are not applicable for Indiana, Kentucky, or Ohio business. Effective April 2003, all Ohio commissions transitioned from percent of premium to per subscriber per month or per capita. Effective April 2004, all Indiana and Kentucky commissions transitioned from percent of premium to per capita.
- H. **Missouri and Wisconsin business only:** If a percent of premium is to be paid, all lines of business to be paid need to be populated with the specific percentage to be paid. If there is a line of business not listed, please use the Other category to define the line of business and the commission percentage.

### Completing Section 5

- A. All SCAs require internal signatures by a Regional Vice President or Regional Sales Director of the state in which the policy is enforced, as well as the Sales Representative and Underwriter for the particular group.
- B. All SCAs require Broker's signature by all Brokers listed to be paid to acknowledge that the information listed on the SCA is correct.
- C. All SCAs require the group signature if any of the listed commission rates for any line of business is above the standard commission rate for the state and segment of business that the group is categorized.
- D. If a flat monthly dollar amount is indicated for an ASO group, the group signature is required if the monthly amount divided by the number of subscribers for the group equals a commission rate above the standard commission rate.

### Submitting Single-case Agreements

- A. All SCAs for new or renewal business shall be submitted to the following Sales Compensation mailbox:  
Sales.Comp.Central.Region.Internal.Inquiries@anthem.com
- B. While the existence of a Single-case Agreement is a prerequisite to any non-standard payment obligation by Company, the Single-case Agreement will only be honored if complete and properly submitted.
- C. An SCA shall only be submitted when at least one line of business is to be paid at a non-standard commission rate. If a group is to be NET of commission, meaning no commissions are to be paid, an SCA is not needed.
- D. Email notification of a group being NET of commission shall be forwarded to above shared mailbox by appropriate Sales Representative or Underwriter.





## **We share your vision to make life better**

There is great value, security and comfort in working with a name you know and trust. We want you to turn to us — to help with everything from handling day-to-day tasks to managing the complexities of coordinating patient-centered care models to reducing health care costs, so you can focus on the business of your business.

At the end of the day, it's our goal as your consultative and trusted partner, to offer best-in-class customer service and valued insights that help preserve your health care dollars. Our shared vision is clear, and we're well on our way to making life better for you and your employees, together.

## **Trust your health benefits to a recognized leader**

Serving Indiana for 71 years, Anthem is one of the largest health insurers in Indiana supporting nearly 4.8 million members<sup>1</sup>, unions and small employers. We combine our many years of local experience with extensive market penetration. This gives us unique insight into how local employers are meeting benefits challenges. It also provides us with the knowledge of what it takes to design a benefits package that's both competitive and affordable. We're steady, but like you, we're eager to lead change and innovation.

**We're proud to say we're the #1 health insurer in Indiana.<sup>3</sup>**

The Anthem name and brand are the benchmark for quality, innovative and affordable health plans. We have the proven expertise in administering our products with a high standard of customer service and member satisfaction.

## **Ready to serve all your needs, your dedicated account team is:**

- Locally based
- Responsive and consultative
- By your side when you need us for:
  - Implementation
  - Enrollment support
  - Day-to-day servicing
  - Renewal support

## **Our customer service exceeds expectations:**

- 87.5% customer satisfaction rating.<sup>2</sup>
- Claims status available 24/7 via phone or Internet.

1 Nearly 4.8 million includes medical and specialty members.

2 Member Satisfaction survey performed by Convergyis

3 Figure represents end of year 2013. Members include State Sponsored, Medicare, Individual, Local Group and National.

## Network value and financial advantages

Anthem offers access to the largest number of providers at significant savings compared to our competition. We also have the largest network available in the United States today. In fact, through our BlueCard® program, 96% of hospitals and 92% of doctors across the country are in the network.<sup>4</sup> That means easy access to health care providers for your employees — no matter where they live, work or travel.

The BlueCard program is a nationwide and worldwide network of participating Blue Cross and Blue Shield providers linking members to providers in communities across America and in more than 200 countries and territories worldwide.

We leverage the size of our network and the strength of our provider relationships to offer you unprecedented value, from higher overall discounts to new care delivery innovations that bring greater quality and cost efficiency to health care.

### See the difference:

- **Better discounts:** Here in Indiana, Anthem offers you 46% network discount on average.<sup>5</sup>
- **Higher in-network use reduces costs:** Our superior network access means that 93% of Anthem claims are paid at in-network rates, compared to our competitors' average of 88%.<sup>5</sup>
- **Lower claims cost potential:** Our deep network discounts combined with access to the broadest networks and highest in-network utilization means lower claims cost for you and your employees.

**1 in 3 Americans is covered by a  
Blue Cross or Blue Shield health plan.<sup>4</sup>**

**82% of Fortune 100 companies rely  
on Blue plans.<sup>4</sup>**

<sup>4</sup> Blue Cross and Blue Shield Blue Facts. September 2013.

<sup>5</sup> Discounts estimated based on Hewitt Fall 2013 Study which reflected CY 2012 PPO and POS experience of the participating carriers.



## Broad coverage = more savings

If you're offering only medical coverage to your employees, you're getting only part of the savings and benefits that could be available to you. Combine our dental, vision, life and disability benefits with Anthem medical coverage care to get best-in-class integrated care at significant savings.

### Dental

More value, less hassle — enjoy the advantages of more than 40 years of dental coverage experience. Dental Prime and Complete members have access to one of the nation's largest dental networks through the national Dental GRID.<sup>6</sup> The national Dental GRID links dental networks, including the dental networks of many of the nation's Blue plans, and includes dentists in all 50 states. So your employees can find a dentist wherever they live or visit.

### Blue View Vision<sup>SM</sup>

Our complete, cost-effective vision coverage is one of the most flexible vision plans you'll see. It gives your employees the coverage they need to help maintain healthy eyes, while helping you maintain a healthy bottom line. The Blue View Vision network has over 30,000 eye doctors and more than 25,000 locations. It includes the nation's leading retail stores like 1-800 CONTACTS®, LensCrafters®, Pearle Vision®, Sears Optical<sup>SM</sup>, Target Optical® and JCPenney® Optical.

**Companies with our combined medical and pharmacy benefits are linked to medical cost savings of \$8 to \$16 per employee per month.<sup>9</sup>**

**Learn more about all of our other plans you can add to your medical plan at [specialtybenefits.info](http://specialtybenefits.info).**

### Life and disability coverage

We offer strength, flexibility and service over a broad product portfolio (including voluntary) that includes multiple funding options and flexible features. Plus, our Productivity Solutions product combines your health and wellness programs with short-term disability coverage to help reduce disability and medical costs — and improve the overall employee experience.

### Pharmacy

When you combine our pharmacy and medical programs, we can help you manage your total benefit program and total costs. We'll connect the dots and focus on the big picture, not just one small part.

We coordinate our information, programs and interactions to help members manage their conditions and live healthier. And healthier members can mean increased productivity and lower health care costs for you. Our data is coordinated between doctors, pharmacists, members and our disease management teams, so we have the power to help ensure that good health doesn't fall through the cracks.

### Employee Assistance Program (EAP)<sup>7</sup>

Our EAP program helps employees navigate complex personal situations that may impact their health and productivity at work. It provides professional counseling to assist with financial, legal and personal issues. Absenteeism and tardiness are reduced by an average of 1.5 days;<sup>8</sup> and productivity is improved (up to 73%) from employees with past mental or physical health problems.<sup>8</sup>

6 The national Dental GRID is managed by the GRID Dental Corporation (GDC), a separate company that provides access to dental networks and services on behalf of Anthem Blue Cross and Blue Shield.

7 Optional for ASD and fully insured.

8 Journal of Employee Assistance using Federal Occupational Health data from 60,000 clients, 2nd Q 2004.

9 This internal analysis, which was independently verified, was conducted in 2011. The lower allowed medical cost savings that were associated with integration and coordination of our medical and pharmacy programs were confirmed in the general population, as well as common drug-dependent disease states that drive overall costs, including diabetes, coronary artery disease, congestive heart failure, hypertension, stroke and chronic kidney disease. While an association was validated, specific causality was not.



## Health and wellness solutions

We're driving stronger member engagement through smarter wellness strategies designed to help 100% of our members find optimal health. We provide members and employers with a powerful suite of integrated online, phone and onsite resources, connecting everyone to better health care.

### Health guidance

With the right support and guidance, your employees can better monitor their individual health needs and navigate the health care system:

- **24/7 NurseLine** — accurate information from experienced professionals is as close as the phone. Anthem's certified nurses are the link to someone who can help decide how to handle a medical problem and receive the right care at the right time from the right professional.
- **Future Moms** — experienced, professional nurses provide individualized care for pregnant members to help ensure a full-term, healthy delivery. Ninety-one percent of participants deliver normal birth weight babies.<sup>10</sup>
- **MyHealth Advantage<sup>11</sup>** — proactive outreach program identifying gaps in care, safety issues and opportunities for financial savings. Members who receive outreach show 46% increased compliance with clinical recommendations.<sup>12</sup>
- **Healthy Lifestyles<sup>7</sup>** — Web-based incentive platform helping members transform unhealthy habits by focusing on behaviors that improve health: weight, healthy eating, physical activity, tobacco use, stress and depression.
- **Other health guidance programs** — essential offering includes preventive reminders, predictive modeling, comprehensive health management and much more.

### Health management

Health management programs coordinate acute health services for members, and help them manage chronic health conditions:

- **ConditionCare<sup>11</sup>** — proactive engagement of members living with, or at risk for, certain chronic conditions. Nurse coaches and a supporting team of health professionals provide holistic, integrated and seamless health management. Ninety-seven percent of participants would recommend the program to an eligible member.
- **Case management** — Anthem's nurses are experts at helping members deal with their complex health issues. Backed by a team of physicians, pharmacists, exercise physiologists and others, Anthem's nurses have the latest information on members' treatment options.
- **Imaging solutions** — our Integrated Imaging Management service can help members save money by choosing the best-quality, most economical care for their circumstances. And when they save, it helps lower costs for everyone.

10 "Referenced Population" information is taken from a 2007 report to a client and was calculated internally by our informatics department. "National Norm" data is taken from the National Vital Statistics Report published September 2006 (noted on the tables).  
"Baseline vs. Year 1" graphs are results specific to clients included in the study. Baseline = January 1, 2004, through December 31, 2004. Year 1 = March 1, 2005, through December 31, 2006. (Actual program start date was September 1, 2005. March 1 allows for six-month ramp-up period.) \* Premature Delivery study base size: 4,150 births.

11 Optional for ASD (included for fully insured).

12 Based on internal review of members in the program. Member data was gathered from 2007-2008 and published in 2009. Results may vary by client based on specific population.

13 Internal Health and Wellness Solutions data study and Actuarial validation, 2009.

14 Internal company member survey, 2011.



## Employer health and wellness resources

- **Time Well Spent** — includes everything you'll need to start a wellness campaign right at your workplace. It includes posters, articles and more that cover a variety of health and wellness topics. Visit [TimeWellSpent.anthem.com](http://TimeWellSpent.anthem.com) to get started today.
- **Worksite Wellness** — offers a variety of onsite programs to help your employees make better health care decisions. We can provide everything from flu shot clinics to health screenings to educational seminars for your employees right at your worksite.

## Member online and mobile tools

At [anthem.com](http://anthem.com) you and your employees get 24/7 access to answers, a better understanding of coverage, claims details and status, health management information and an easy way to find in-network providers:

- **Estimate Your Cost** — provides facility cost information for nearly 400 inpatient, outpatient, diagnostic radiology and office-visit procedures, and includes out-of-pocket cost estimates for PPO members. In addition, quality measures (from WebMD®) for more than 150 inpatient procedures are included. All information is integrated with information from our *Find a Doctor* online tool to support value-based decisions.
- **Patient Ratings and Reviews** — offers members the opportunity to post reviews about their experiences with network providers and to read what other members have to say about their experiences.

- **Search and Price a Drug** — lets members compare the estimated cost at a retail pharmacy versus the price of the same drug using home delivery, as well as between brand and generic versions.
- **Health & Wellness** — offers health information, services and tools that are tailored to your employees' individual needs, such as online exercise programs, nutrition programs, health assessments and much more.
- **SpecialOffers@Anthem<sup>SM</sup>** — features many discounts on fitness center memberships, weight management programs, eyeglasses, LASIK vision correction, hearing aids, dental products, medications, as well as family and home products.
- **Preventive health care guidelines** — offers the most current listings for child and adult screenings and vaccines. There's also a section for pregnant women.
- **ID cards** — features the Customer Service number for easy reference. Can be requested anytime and temporary cards can be printed as needed.

## Mobile apps

Anthem makes it easy for members to manage their health coverage wherever they go with mobile apps for the iPhone or Android. We've also optimized our [anthem.com](http://anthem.com) website to offer members a better experience if they're accessing the site on a tablet. They'll be able to get a virtual ID card, find a doctor and even view claims details, all on the go with our Anthem app.

## Working for you 24/7

With [anthem.com](http://anthem.com), your employees can access their claims, find a doctor and more — anytime, day or night.



## A final word

As a leader in the health care industry, we can bring you:

- Access to the broadest and most cost-effective provider networks in the country.
- Innovative and flexible product designs.
- Leading care management and wellness programs.
- Dependable customer service.
- Excellent account management.

In our work each day, we emphasize the importance of health and wellness, member engagement, effective use of technology and partnership with health care providers. This focus on the wide number of facets in the health care industry today gives us a strong platform to serve you and your employees.

We share your vision for the future and look forward to **making life better** for your employees today and tomorrow.

### Important Information

The health benefit plan(s) reflected in this quote is not considered to be grandfathered under the provisions of the Patient Protection and Affordable Care Act ("PPACA"). Nongrandfathered plans are subject to additional provisions under the PPACA that do not apply to grandfathered plans. For further information, please contact your account representative.

This renewal rate includes changes to the standard medical plan to ensure compliance with the requirements of the federal health care reform legislation for nongrandfathered plans, including 100% coverage of in-network preventive care services.

The requirement to issue the *Summary of Benefits and Coverage* (SBC) begins with open enrollment periods occurring on or after September 23, 2012. You are responsible for distributing the SBC. Anthem can only create an accurate SBC if you provide us timely benefit changes. For fully insured business, ideally Anthem would like information related to benefit changes at least 30 days in advance of your open enrollment date.



## 2017 ABCs Certificate Language Updates Notification

(Effective 1/1/17)

The 2017 ABCs FACETS project includes updates to certificate language that is separate from the benefits and cost share changes impacted by ACA. There are additions, edits, deletions, and clarifications added to the standard Blue Products and some apply to all Blue Products versions. The areas impacted include but are not limited to employee rights, schedule of benefits, covered services section, health care management, exclusions, and definitions.

Please review the certificate for the explicit language and complete updates as this list is only intended to highlight some of the areas impacted.

The Language Changes/New Exclusions high level overview includes:

- **Behavioral Health and Substance Abuse/Online visit Vendor**
  - Benefit coverage was clarified Office Visits include Online Visits.
- **Covered services/ Prosthetics**
  - Updated Left Ventricular Artificial Devices (LVAD) text to remove “only when used as a bridge to a heart transplant” to align with medical policy.
- **Schedule of Benefits/Preventive Care**
  - Revised language per regulators and removed Iron Supplements covered over the counter, and updated introduction to the section.
- **Transgender Services exclusion**
  - Remove the exclusion for sex transformation services per the non-discrimination rules and services will be subject to general medical provisions.
  - No new coverage language is being added.
- **Exclusions**
  - Residential accommodations exclusion and exceptions added.
- **Subrogation**
  - This language has been updated based on Supreme Court decision. Please see your certificate language document.
- **Right of Recovery**
  - Revised language in general provisions per legal.

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- **Health Care Management**

- Rewrite of entire language section: Continued Stay Review, Health Plan Individual Case Plan, Voluntary Clinical Quality Program updates, and removed vague language for out of area provider criteria to be treated as network.

- **Definitions**

- Revised Emergency Care to include references to Mental Health.
- Added definitions for Intensive Outpatient Program and Partial Hospitalization Program.
- Revised Provider definitions regarding the following sub-terms: Facility, Hospital, Skilled Nursing Facility, and Residential Treatment Center.

- **Prescription Drugs**

- Schedule updated with language for 90 day retail supply (R90). Removed the preferred generic / brand (MAC) penalty for plans with narrow formularies.
- Blue 9.0 Covered Services update for Right Drug Right Channel program by adding "Prescription Drugs Administered by a Medical Provider," and Tier 1-5 description. See certificate for language.
- Prescription Drug various provisions clarified (e.g., prior authorization and therapeutic substitution).
- Exclusions - Several added under "Non-Covered Services" section. Removed the NDC block exclusion (Clinically Equivalent) for plans with narrow formularies (e.g., Essential)
- Definitions - minor update to the Prescription Drug definition regarding compound drugs. New terms were added Biosimilar / Biosimilars, Interchangeable Biologic Product, Maintenance Pharmacy, and Designated Pharmacy Provider. Some terms (e.g., Designated Pharmacy) will only be used in 9.0 plans.
- Compound Drug exclusion and limitations to be Medically Necessary and covered if criteria is met. Changed due to DOI objection on filings and reviews.
- Step Therapy Protocol Exceptions has multiple edits to clarify policy and procedure for an exception for a Prescription Drug not recommended according to a step therapy protocol. Added due to new legislation, SB41

**The following items have general language updates:**

Identity Protection Services, Claims payment section regarding out of area care, Appeals language minor edits, Care Coordination general provisions, Policies and Procedures, adding Program incentive language, and some HMO assorted minor clarifications. This is not an exhaustive list and the certificate language should be referred to for exact edits.

# Strong alone. Better together

Health. Dental. Vision. Life. Disability



Health · Dental · Vision · Life · Disability

**Thanks for choosing Anthem. Now imagine how easy your job could be if all your Health and Specialty benefits came from a single point of contact.**

We know it's not easy trying to offer employees a competitive benefits package while trying to balance company expenses. So as you get ready to renew, it's a great time to discover what our specialty benefits - dental, vision, life and disability - can do for you and your employees:

## Dental Prime and Dental Complete

- **Dental plans you can customize:** Increased plan flexibility allows employers to build the plans that work best for them.
- **More affordable pricing:** We're confident you'll find our new prices a fresh change that's better suited to today's leaner budgets.
- **Choice of networks:** Both of our networks are among the largest in Indiana and offer access to a large national network. You can choose from our Dental Prime network that offers access to over 91,000 dental locations nationwide, or our Dental Complete network that offers access to over 102,000 nationwide locations.
- **Unique benefits:** Our plans include a brush biopsy that aids in early cancer detection, an extra cleaning for diabetic and/or pregnant members, discounts beyond annual maximum and no waiting periods.

## Blue View Vision<sup>SM</sup>

- **Industry leading network:** Our network is one of the largest in the nation and in Indiana. It offers access to more than 50,000 provider and provider locations, resulting in more than 96% in-network utilization. Our network includes retail locations such as LensCrafters®, Sears Optical, Target® Optical, JCPenney Optical and Pearle Vision® locations.
- **Additional features:** Members save after their annual benefits are used up! Members will receive a 40% discount on unlimited additional complete pairs of eyeglasses, 15% on conventional contacts and 20% on items such as sunglasses.
- **Exceptional service:** We offer among the best customer service hours in the industry with access seven days a week.
- **Enhanced benefits:** Transitions® and polycarbonate lenses for children under 19 years old at no additional charge.

**Want a quote?  
Contact your broker or  
Anthem sales representative**

**For more information visit  
[anthem.com/specialty](http://anthem.com/specialty)**

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Health. Dental. Vision. Life. Disability



Health • Dental • Vision • Life • Disability

## Life & Disability

- **Strength and stability:** Over 50 years of industry experience and an A.M. Best financial rating of A (Excellent). We offer a broad portfolio of products including Term Life and AD&D, Short-Term Disability and Long-Term Disability.
- **Additional features:** Our plans provide more than just a benefit check – we provide support services to help employees get back to their regular life:
  - *Resource Advisor* gives employees counseling and consultations regarding emotional, financial and legal concerns. It also includes recovery services for Identity Theft and programs to help loved ones close accounts and finalize the estate.<sup>1</sup>
  - *Newborn Parenting Resources* provides eight weeks of personal life coaching services to help new mothers get back to work.<sup>2</sup>
  - *Travel assistance* services help employees and dependents with medical, repatriation and travel companion issues.<sup>3</sup>
- **A commitment to outstanding service:** We're proud to say we have set the standard in industry-leading disability claim services by processing disability claims in 6.5 days.<sup>4</sup>
- **Integrated 360° Health® and disability program:** Our Productivity Solutions program proactively integrates care management for employees who have a disability or are at-risk for a claim across healthcare and disability.

## Voluntary Products---Keeping it affordable

If benefit dollars are limited, then consider our Voluntary portfolio of dental, vision, life and disability plans where you pick the plan design, then let your employees purchase coverage at affordable group rates.

## Working better together

Our dental, vision and short-term disability products are integrated with Anthem's 360° Health programs which may help reduce claims, increase productivity and lower health care costs.

Want a quote?  
Contact your broker or  
Anthem sales representative

For more information visit  
[anthem.com/specialty](http://anthem.com/specialty)

1 Available with Life and Disability products  
2 Available with short-term disability  
3 Available with group term life  
4 Internal company metrics 2011



## Your introduction to Anthem's health and wellness programs

**Everything you need to know about our programs and services and how they can keep companies and employees at their healthy best.**

We understand that health and wellness needs to be a key part of health care. After all, the health of your employees has a great impact on the health of your business.

With Anthem Blue Cross and Blue Shield (Anthem), you and your employees get:

- Health care professionals who build relationships. The nurses and clinical professionals who are part of our health and wellness programs give every member the personal care and support they need.
- Best-in-class member resources, including mobile apps, live chat and online information. We use technology to help our members take care of — and responsibility for — their own health.
- The benefit of our smart data analysis. We identify gaps in care, opportunities for better health and potential high-risk events. That way, our health and wellness professionals can be more proactive and responsive.

Our health and wellness programs can result in:

- Higher engagement rates.
- Healthier employees.
- Higher employee satisfaction.
- Lower cost of care.

We help employees be as healthy as possible. So they can live full lives and help your business succeed.

# Programs

## 24/7 NurseLine

The toll-free 24/7 NurseLine gives your employees round-the-clock answers to health questions. Registered nurses help your employees get answers and help them decide if they should go to the doctor's office, emergency room or urgent care. The nurses can also help your employees find a nearby in-network facility. The result may be less absenteeism and lower health care costs.

**Fact:** 88% of members feel the program was there when they needed it.

*Source: Member Satisfaction Study, Q1 2015.*

## Behavioral Health

Just like physical well-being, your employees' emotional well-being can help your organization stay competitive. Employees who are dealing with depression, anxiety, stress or substance abuse need help.

Our Behavioral Health program is integrated with our health plans. It includes our extensive network of providers and facilities, including psychiatrists, social workers and residential treatment centers. This helps ensure that employees get the right kind of care for their personal situation.

## Case Management

Following a major hospitalization, our dedicated nurse care managers offer support, information and regular contact. The nurses can help to coordinate discharge instructions, coordinate follow-up care and arrange medical services like home health care firms. This program also identifies employees with complex health issues and, through our nurses, addresses them predictively before they become more serious. We take on these tasks and more so your employees can focus on getting better.

Case Management helps employees get healthier and return to work when the time is right. It's just one way we help reduce your costs and improve employees' health.

## ConditionCare

ConditionCare identifies, engages and supports employees and their covered dependents who are living with one or more chronic conditions such as asthma,

diabetes, coronary artery disease, heart failure and chronic obstructive pulmonary disease (COPD). Participants have access to a nurse care manager and a team of specialists who work to help employees better understand their condition and follow their doctor's plan of care. ConditionCare nurses gather information from employees and their doctors to create a personalized plan for better health.

**Fact:** Return on investment of at least 2:1 or better.

*Source: Anthem Health and Wellness Solutions data study and actuarial validation, 2009.*

## ConditionCare End-Stage Renal Disease (ESRD)

ConditionCare ESRD is a care management program for employees who have end-stage renal disease. The program helps reduce care costs by improving adherence to physician's plan of care and preventing avoidable hospitalizations. Employees are assigned a primary nurse care manager to educate them about their condition and guide them throughout the therapy process. Our experienced nurse care managers can also connect employees with appropriate caregivers, such as social workers and nutritionists specializing in ESRD.

## Future Moms

Future Moms offers education and support to help your employees have a healthy pregnancy. Moms-to-be get assessments to help spot any risks and are mailed educational materials and tools to help them track their pregnancy. A team of OB/GYN nurses and specialists follow up throughout the pregnancy to make sure moms-to-be are making healthy decisions and following their doctor's plan of care. Expecting moms can also call into their team of nurses for support or to ask questions during the pregnancy and after delivery. Taking part in the program may result in lower medical costs for both mother and baby.

**Facts:** A recent study showed that Future Moms participants are getting the help they need, resulting in:

- 30% fewer emergency room visits than those not in the program.
- Babies born to Future Moms participants spending 25% less time in the NICU, leading to a 50% reduction in NICU costs.

*Source: 2013 Anthem data from 450,000 member population.*

## MyHealth Advantage

MyHealth Advantage reviews your employees' claims for gaps in care and health risks that could lead to health problems and costs. When gaps or risks are identified, we mail a confidential MyHealth Note to the employee that outlines specific actions he or she can take to improve their health and help lower health care costs. The note may point out potential drug interactions, remind the employee about doctor's appointments or recommend health checkups and screenings.

### Facts:

- Return on investment of 1.63:1
- 46% of participants who received a MyHealth Note were brought back into clinical compliance.

Sources: *MyHealth Advantage Effectiveness Study 2009-2010, October 29, 2010 White Paper*. Magnitude of the savings may vary from client to client.

Based on a 2008 internal review of current participants; members acted within 12 months of receiving the initial MyHealth Note.

## Healthy Lifestyles Online

Healthy Lifestyles helps employees make healthy behavior changes that can positively affect their physical, social, emotional and financial well-being.

Employees complete the Well-Being Assessment and get their own customized Well-Being Plan. Healthy Lifestyles gives employees a suite of integrated tools, including nutrition and exercise trackers, smoking cessation program, online coaching and cool tools and rewards. Participants can connect with others to share their experiences, get social support and get tips on health topics. When employees take charge of their health, it helps lower their medical costs and improve their performance at work.

## Well-Being Assessment (WBA)

The WBA is a confidential health questionnaire that assesses physical and emotional health and identifies at-risk behaviors. It also looks at each person's overall well-being, giving insight to physical, emotional and social health.

Based on the employee's WBA responses, a personalized well-being report is generated, which offers actionable recommendations targeted to the individual. Fully integrated into the Healthy Lifestyles experience, the WBA selects from eight focus areas/behaviors:

- Tobacco cessation

- Exercise and fitness
- Weight management
- Healthy eating
- Stress management
- Appointment and medication adherence
- Self care
- Depression prevention

A personalized well-being plan is then customized to the employee's readiness to improve his or her health.

## LiveHealth Online

This online doctor visit connects employees with board-certified doctors through two-way live video from a smartphone, tablet or computer with a webcam. Doctors are available 24/7 with less than a 10-minute wait to help with common illnesses such as colds, allergies or the flu. With LiveHealth Online, you can get medical advice, a diagnosis and even a prescription (if needed) 24 hours a day, seven days a week. It's more convenient and less expensive than the emergency room or urgent care.

### Facts:

- 90% saved two or more hours of work time by using LiveHealth Online.
- 90% patient satisfaction rate.
- 85% report their medical issue was resolved.

Source: LiveHealth Online consumer post-visit survey results, August 2014.

Prescription availability is defined by physician judgment and state regulations. LiveHealth Online is available in most states and is expected to expand to more in the near future. Visit the home page of [livehealthonline.com](http://livehealthonline.com) to view the service map by state. LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of Anthem.

## Free tools and resources

We've got budget-friendly wellness tools that can help you kick-start wellness campaigns.

### anthem.com

anthem.com offers valuable health and wellness tools and resources to help employees stay healthy and make more informed choices about their care. Employees can keep track of their health with our confidential health record, get up-to-date health information, watch videos about health



and wellness topics and take advantage of health-related discounts.

### Engagement videos

Help drive awareness and engagement to health programs with free one- to three-minute, employee-facing videos.

#### Topics include:

- 24/7 NurseLine
- Future Moms
- ConditionCare
- MyHealth Advantage
- Employee Assistance Program
- MyHealth Coach
- Integrated Health Model

Each program video includes a high-level introduction of the wellness program, program benefits, what the employee can expect and how to enroll. Employers can post the videos on their intranet site or embed in an email to help increase awareness and engagement in health programs. Videos are available in English and Spanish. Contact your Empire Sales representative to request videos.

### Member DocTalk webinars

Free quarterly webinars can help inform your employees about hot health topics. Past webinars have been on topics like sleep, back pain, healthy eating and the sandwich generation. Content is presented by a medical practitioner to encourage your employees to take control of their health and use their health care benefits appropriately. Register at [doctalk.webex.com](http://doctalk.webex.com).

### SpecialOffers

Saving money is good. Saving money on things that are good for you — that's even better. With SpecialOffers, your employees can access over 50 discounts on products and services that help promote better health and wellbeing. Employees can find the discounts that are available to them by logging in to [anthem.com](http://anthem.com) and selecting **Discounts**.

### Wellness calendar

Use this simple yet powerful tool to lead your employees to better health. It gives you quick access to wellness resources and related health and wellness programs and

services, based on the month of the year. Plus, it's more than just a calendar. It's a library of resources. Use the topics any time, any way you want. Just go to [wellnesscalendar.anthem.com](http://wellnesscalendar.anthem.com).

### Time Well Spent

This is an online communications toolkit that covers a variety of health and wellness topics. It includes posters, articles and more. You can also find tools to help you build your wellness strategy and an interactive tutorial that will show you how to make the site work best for you. Time Well Spent includes everything you need to start a wellness campaign in your workplace. Visit [TimeWellSpent.anthem.com](http://TimeWellSpent.anthem.com) to get started today!

### Health Kits

A workplace wellness campaign you can use, each Health Kit is centered around an important health concern and includes key lifestyle information. Each comes with a variety of helpful resources and materials, such as fliers, posters, websites and articles to help educate your employees about various health conditions. It's all wrapped up in a workplace challenge to both motivate and inspire!

Health Kits are available free of charge and can be found in the **Plan** section on [TimeWellSpent.anthem.com](http://TimeWellSpent.anthem.com). Topics include men's and women's health, nutrition and fitness, diabetes, heart disease, back pain/musculoskeletal and more.

### LunchWell

Well is a fun and engaging communications campaign that helps create healthy eating habits by showing employees how to make small changes in how they eat — and think about — lunch. LunchWell includes fliers and posters that educate employees about the importance of healthy eating and how to choose wisely among lunch-time options.

The materials are broken into groups for ease of use and a comprehensive employer guide makes it simple for groups to roll this campaign out in the workplace.

The LunchWell campaign is available on [TimeWellSpent.anthem.com](http://TimeWellSpent.anthem.com) under the **Share** section.

### Wellness in the workplace

What you'll find inside this guide is the critical information to help build, grow, promote and measure your wellness program, including:

## Wellness in the workplace

What you'll find inside this guide is the critical information to help build, grow, promote and measure your wellness program, including:

- Nine steps to launch your wellness program
- How a top-down approach helps your company succeed
- Wellness program best practices
- The case for incentives
- How online toolsets help spread program dollars farther
- A communication strategy that works
- Ideas for measuring your program's success
- ROI vs. VOI: what to expect from your wellness program
- Handy Web links

To access the guide, visit the **Learn** section of [TimeWellSpent.anthem.com](http://TimeWellSpent.anthem.com).

## Wellness on the run webinars

These free events offer tools and information that can help boost wellness in the workplace. Topics are recorded and available for download on the Time Well Spent website. Events feature success stories from our clients, overviews of free online tools and strategies to inspire wellness in your workplace. Register for events and listen to past events by visiting the **Learn** section of [TimeWellSpent.anthem.com](http://TimeWellSpent.anthem.com).

## Screensavers

Looking for a simple way to empower your employees to make the right health care decisions? Download our free screensavers to your company computers. The screensavers feature lifestyle images with text that highlights our health

and wellness programs. They can be found at [TimeWellSpent.anthem.com](http://TimeWellSpent.anthem.com).



1 Based on internal review of current MyHealth participants; members acted within twelve months of receiving the initial MyHealth Note and may have been messaged more than once. These changes are associated with, but may not be exclusively caused by, the MyHealth Advantage Program.  
2 Results are from a recent, three-year internal analysis of diabetes, CAD and HF programs for CO and NY. For clients included in the study, service delivery began in September 2002. Asthma and COPD were added in 2007. (275,000 total members; 12,000 participating in Condition Management). Study Code: 140750.

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# Give your employees peace of mind when they need surgery

**Our new program lets us work with providers to optimize services**

Anthem and TurningPoint<sup>®</sup> Healthcare Solutions have teamed up to offer doctors an innovative **Surgical Quality and Safety Management Program**. This program helps improve the quality and safety of surgeries that require certain types of implants or devices.

When a device intensive surgical procedure is needed, TurningPoint collaborates with the surgeon so patients get the best results, may include:

- Faster recovery times
- Lower risk for more surgery
- Fewer complications
- Fewer infections
- Better surgical outcomes by reviewing upfront the member's health, comorbidities and lifestyle
- High-quality care at the most appropriate time for the member



## **Available now!**

Employees can benefit from the Surgical Quality and Safety Management Program right away to help them through certain surgeries. To sign up for the program or to opt out, please contact your local Anthem Blue Cross and Blue Shield Sales representative.

## This program helps you and your employees

You benefit when your employees can be their healthiest at work. This program can help your employees get through surgery and get back to work feeling their best. Here's how:

### Better safety and quality for your employees

- Appropriate use of the device being implanted during surgery
- Product recall and safety monitoring
- Device manufacturing accountability
- Evidence-based treatment plan management and interventions
- Clinical transparency and measurement tools

### Provider collaboration

- Reduced administrative work for the provider
- Pay-for-performance awards
- Enhanced network support

### Significantly reduced care costs

- Site-of-service optimization
- Lower device costs
- Best implant for the patient's health history and diagnosis
- Appropriate use of the device

## Why use TurningPoint?

Simply put, the best clinical practices used by local and national physicians help increase quality and safety of health care. These are captured in TurningPoint's protocols. We encourage doctors to follow these protocols

## Procedures covered in the Surgical Quality and Safety Management Program:

- Total knee replacement
- Partial knee replacement
- Total hip replacement
- Cervical fusion surgery
- Sacroiliac or thoracic fusion surgery
- Lumbar disc replacement surgery
- Knee revision surgery
- Hip revision surgery
- Spine revision surgery
- Hip resurfacing
- Shoulder replacement
- Shoulder revision
- Ankle replacement
- Ankle revision
- Elbow replacement
- Elbow revision
- Anterior cruciate ligament repair

## Here's how the fees work

Let's say one of your employees needs a total hip replacement or cervical fusion surgery. The employee's doctor works directly with TurningPoint. The program fee is \$300 for each case, per procedure, that the provider and TurningPoint discuss. Here's what happens next:

1. There will be a \$300 fee for the administration of the Surgical Quality and Safety Management Program added as a line item on the ASO group's bill.
2. The provider submits a claim following normal billing practices when a surgery is completed.
3. If the provider follows the suggested safety and quality protocols defined by TurningPoint, then the provider gets an enhanced reimbursement of up to \$250 for that member.
4. This enhanced reimbursement is billed as a claim by TurningPoint, on behalf of the provider.



\*TurningPoint is a voluntary program and is a tool and resource to help manage the quality of care and device costs related to device intensive surgical procedures.

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## Description of Anthem's Enhanced Personal Health Care Programs<sup>1</sup>

At Anthem Blue Cross and Blue Shield ("Anthem"), we believe that our health connects us all. We focus on developing long-term relationships that unite the siloes of healthcare—strengthening the bonds between patients and doctors, primary care providers, specialists, and hospitals — enabling seamless delivery of the right care at the right time.

We are committed to connecting our members to patient-centered care. What makes us unique is our approach to supporting delivery system transformation. Anthem incentivizes providers through value-based payment and couples these incentives with a robust support system designed to assist practices in their transformation to patient-centered care.

Although there is growing broad-based support for a patient-centered care model, we understand that this shift will not happen spontaneously. Rather, it requires a concerted effort and active support from all key stakeholders in the delivery system to create an environment conducive for change. This includes:

- A redesign of current payment models to align financial incentives and to provide compensation for important clinical interventions that occur outside of a traditional patient encounter;
- Support for risk-stratified care management;
- Sharing meaningful information regarding patients that goes beyond the information captured in the physicians' medical record; and
- Providing physicians with the knowledge, information and tools they need to leverage the benefits of new payment models, along with support services and information exchange to help them transform the way they deliver care.

Anthem's Enhanced Personal Health Care programs are based on years of experience. Anthem has championed the patient-centered care model through our participation in patient-centered medical home programs across the country. The compelling results we saw in quality improvement and cost of care reduction convinced us to cement our commitment to patient-centered care. In our studies to date, we have observed improvement in compliance with evidence-based guidelines and a reduction in avoidable, unnecessary admissions and ER visits, along with measured maintenance or improvements in the quality of health care services.

Our Enhanced Personal Health Care programs are built upon the success of our patient-centered medical home programs and foster a collaborative relationship between Anthem and the contracted Provider. This relationship enables both the health benefits administrator and the Provider to leverage the other party's unique assets whether through clinical, administrative, or data expertise; and together, this partnership supports coordinated care with a focus on risk stratified care management, wellness and prevention, improved access and shared decision-making with patients and their caregivers.

We offer this Program Description to give you important information regarding Enhanced Personal Health Care program operations, including the methodology used to charge the employer and details about the reconciliation process. Our intent is to provide you with an easy to understand description of the key elements of the Program.

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<sup>1</sup> This document is intended to be a description of the Payment Innovation Programs offered by Anthem Blue Cross Blue Shield. This document does not include a description of provider incentive programs offered or administered by the Blue Cross Blue Shield Association or any other Blue Cross and/or Blue Shield Plans.

**Program Description:**

- These programs reward Providers (which may include Vendors) for successfully managing the quality and overall health care costs of Anthem members.
- These programs pay performance incentives, rewards, or bonuses (including shared savings) to Providers based upon the Providers' achievement of certain cost, quality, efficiency, or service standards and/or metrics.
- Some providers may also receive a clinical coordination payment for the clinical services they provide outside of a traditional office visit. Those services could include care planning, maintaining health registries, enhancing access (such as responding to emails or offering web-based visits) or following up with patients via phone or email to make sure that they fill new prescriptions. To participate in the Enhanced Personal Health Care program, Providers must meet consistent value-based criteria, which include, but are not limited to, the following:
  - 24/7 availability through extended hours and/or after hours call
  - Participation in our aligned care management and disease management model
  - Established, dedicated roles within the practice to support this program
  - Use of the Anthem's Member Medical History Plus (MMH+) system that provides a picture of the services patients may have received outside of the provider's practice
  - Use of a registry function to effectively manage their patient population and support population health management
  - Use of generic Rx substitutes where clinically appropriate
  - Achievement of appropriate performance on nationally-endorsed quality measures
  - Encouragement of the use of electronic medical records (EMR)
  - Some larger and/or more sophisticated providers have the capability to take on increased accountability as well as an adequate pool of patients for purposes of the shared savings model. These organizations, which may call themselves accountable care organizations (ACOs) or integrated health systems, are willing to assume the full risk of managing their patients independently, and typically have the following attributes:
    - a formal legal structure to receive and manage risk sharing;
    - a well-documented plan for improving patient safety, health status and reducing the cost of medical care;
    - a commitment to deploying an IT platform, including an electronic medical record and care management solution, supporting the capture, electronic exchange and analysis of clinical information across ambulatory, inpatient and ancillary (lab, imaging, eRx, etc.) settings and sharing key clinical data with Anthem;
    - the capability to assume a primary role in care planning and care management with support from Anthem resources for more complex patients;
    - strong physician leadership committed to a patient-centered care model and empowered to drive change across the provider organization.

### Methodology Used To Charge The Employer:

- We use a method we call “attribution” to match members with their providers. The foundation of attribution is to recognize existing provider relationships.
  - Attribution is used to identify the provider’s patient population, defining which members the provider is responsible for and including those members on provider reports.
  - Attribution is the foundation for clinical coordination payments as well as shared savings calculations and payments.
- We use one of two processes for attribution, depending on the type of product in which the member is enrolled:
  - For products that do not require the selection of a primary care physician (PCP), such as Open Access PPO products, patients are attributed to the Provider they have seen most frequently in a 24-month period based on claims data. In case of a tie, priority will go to the Provider with whom the member has had the longest relationship. Attribution is updated quarterly based on updated claims and reconciled with eligibility each month.
  - For products that require the selection of a primary care physician, members will be attributed to the provider they select as a primary care physician. The attribution is updated monthly to reflect the selection.
- To understand how the Employer is charged, it is helpful to first understand how savings are calculated and how the Provider’s share of the savings is determined.
  - First, we project the expected cost of health care services for attributed members, to establish a Medical Cost Target (MCT), by reviewing risk-adjusted historical claims costs for the Provider or a group of Providers and trending those costs forward. We sometimes group Providers together to ensure that the medical cost target is calculated on the basis of a statistically valid pool of patients.
  - Then the actual risk-adjusted costs incurred during the year are compared with the medical cost target. If the actual costs are less than the medical cost target and the Provider meets a quality threshold, then the Provider becomes eligible to receive a portion of the savings. If a Provider does not meet the quality threshold, the provider is NOT entitled to any bonus payment, regardless of the savings generated.
  - If the Provider meets the quality threshold and therefore is eligible to earn a performance bonus, the amount of the bonus will vary based on the Provider’s performance on the quality measures. The higher a Provider’s quality scores, the larger the bonus the Provider will receive, subject to a maximum payment amount. The expectation is that the Employer will also benefit from the lower overall costs.
- Provider performance bonuses are funded by the Employer through a fixed Per Attributed Member Per Month (PaMPM):
  - This is the amount we actuarially determine to cover the cost of the provider performance bonus.
  - This amount will be updated periodically based on Anthem’s book of business.

## Reconciliation Process:

- All money collected for the Enhanced Personal Health Care programs will be used only for Enhanced Personal Health Care payments to Providers.
- Under the Fixed Per Attributed Member Per Month method, the charge to the Employer will be updated periodically based on experience and actuarial projections. Reconciliation will be completed periodically based on Anthem's self-insured book of business. Any surplus or shortfall will be applied to those forecasts when setting the future payment innovation payment.
  - Anthem may make additional payments to Providers or Anthem may receive payments from Providers based on the outcome of the measurement period. As a result of these periodic settlements with Providers, Anthem will adjust the fixed Per Attributed Member Per Month to reflect these settlements with Providers. Please note that member cost shares will not be affected by these settlements with Providers.

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Dear Valued ASO Client:

We're committed to helping our ASO (Administrative Services Only) clients save money whenever possible. One way we do this is by finding and recovering overpaid claims. While our payment accuracy rates are very high, we're always looking at ways to do better.

For years, we've worked with vendors who perform provider audits to look for recovery opportunities. Recently, we started to work with other specialized third-party vendors who use their expertise, knowledge and techniques to identify more recovery opportunities. Starting with renewals on or after July 2014, we will expand our work with these third-party vendors to our ASO customers.

Your administrative services agreement will change when your health plan renews (on or after July 1, 2014).

#### **ASO Client Questions & Answers:**

##### **Can you give me an overview of this change?**

After we finish our usual payment review, third-party vendors will look for recovery opportunities. If a vendor doesn't identify a recovery, you pay nothing.

When a vendor recovers funds, you'll get 75% of the recovery. To cover our costs for these vendors and administering the service, we'll keep 25% of the recovered funds.

##### **Doesn't Anthem already perform recovery services for us as an ASO client?**

Yes, we do. And there will be no change to our internal recovery services. We'll continue to provide these services using our staff. No extra charges or fees apply for Anthem's recovery services.

Our internal recovery services include:

- Internal data mining – including coordination of benefits (COB)
- Retro terminations
- Special Investigation Unit
- Certain provider audit functions

##### **I thought Anthem was already using third-party specialty vendors to find and recover overpaid claims for us?**

Yes, that's true. In the past, we conducted provider audits for hospital bills and credit balances using third-party vendors. During 2012 and 2013, we added other specialty vendors and used enhanced recovery techniques that have produced good results.

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**What will these third-party specialty vendors do?**

These vendors will conduct external recovery services including:

- Data mining, including COB
- Provider audits, including credit balance audits, hospital bill auditing, high-cost drugs and diagnosis-related group re-admissions

**How will the 75% of recoveries be shown on my statements?**

You will see the net recovery on your monthly invoice.

**What do I need to do to sign up?**

Your administrative services agreement will change when your health plan renews (on or after July 1, 2014).

**Are there any up-front fees or administrative and fixed costs for this initiative?**

No. Anthem will only deduct 25% of the recoveries – if and when the vendors collect them. You will incur no expense unless our vendors recover overpayments.

**When does this take effect?**

The program will start as ASO clients renew contracts on or after July 1, 2014. A client's specific effective date will be based on the contract renewal date and on the claims system used. Our administrative service agreement will change as shown in the attached amendment.

We are pleased to provide this enhanced service. If you would like to discuss this service further, or if you have any questions, please contact your account manager.

Sincerely,

Anthem Blue Cross and Blue Shield

# Blue 9.0 Benefit Plan Comparison Guide

Indiana  
Large Group



Benefit design	Grandfathered Blue 3.0	Grandfathered Blue 4.0	Nongrandfathered Blue 5.0	Nongrandfathered Blue 6.0	Nongrandfathered Blue 7.0	Nongrandfathered Blue 8.0 2015	Nongrandfathered Blue 8.0 2016	Nongrandfathered Blue 9.0 2017
Physician/Professional								
Lifetime maximum	No lifetime maximum for all plans (health care reform (HCR))	No lifetime maximum for all plans (HCR)	No lifetime maximum for all plans (HCR)	No lifetime maximum for all plans (HCR)	No lifetime maximum applies to ASO and fully insured. Three-year transitional max is no longer available.	No change from Nongrandfathered 7.0	No change from 2015	No change from Nongrandfathered 8.0
Out-of-pocket maximum			HCR guidance – All medical cost shares, copays, deductibles and percentage (%) coinsurance apply toward the out-of-pocket maximum.			All medical and prescription drug deductibles, copays and coinsurance apply toward the out-of-pocket maximum (excluding non-network human organ and tissue transplant [HOTT] services).	Effective 1/1/2016 – Anthem non-embedded deductible benefit plans are compliant with the Notice of Benefit and Payment Parameters (NBPP) for out-of-pocket maximum amounts.	No change from Nongrandfathered 8.0
Office visit	Products have the same cost shares for all network doctors, including primary care physicians (PCPs) and specialty care physicians (SCP).  No additional cost share for pharmaceutical injections and drugs dispensed/ administered in the office visit setting. Allergy injections are subject to a \$5 copay.	HMO and POS will have PCP and SCP copays. PCP/SCP definition aligns with the PPO products. Most options will have SCP copay higher than PCP copay.  Anthem Essential: Office visit copay applies to the office visit charge (E&M/surgery) and remaining services are subject to coinsurance.  PPO plans – Deductible and coinsurance applies to pharmaceutical injections and drugs dispensed/ administered in the doctor's office.	No change from Grandfathered 4.0	No change from Nongrandfathered 5.0	No change from Nongrandfathered 6.0  Low-cost plans apply a copay to the first three PCP/SCP office visit charges/surgeries. All other office visit charges are subject to a deductible and coinsurance.	No change from Nongrandfathered 7.0	No change from 2015	No change from Nongrandfathered 8.0
Office visit – LiveHealth Online (LHO)			100+ groups can request LHO via custom process.	LHO cost share is the same as PCP cost share.	No change from Blue 6.0	Allows members to get behavioral health online visits.	No change from 2015	Prescription writing coverage by "LHO" providers

Benefit design	Grandfathered Blue 3.0	Grandfathered Blue 4.0	Nongrandfathered Blue 5.0	Nongrandfathered Blue 6.0	Nongrandfathered Blue 7.0	Nongrandfathered Blue 8.0 2015	Nongrandfathered Blue 8.0 2016	Nongrandfathered Blue 9.0 2017
Preventive care services	<p>Hospital Surgical – Mandated Preventive Services Generic list of preventive services covered.</p> <p>All other products:</p> <p>Preventive care services follow the Legacy Anthem preventive definition and include some services based on recognized appropriate standard, which are not preventive care.</p> <p>Member cost share of preventive care services continues to be setting based.</p>	Preventive care services follow the Enterprise definition. The member cost share of preventive care services continues to be setting based.	<p>Preventive care services follow HCR definition. No cost shares apply for in-network preventive care services. Standard out-of-network cost shares apply for preventive care services.</p> <p>Anthem Essential: Preventive care services follow full preventive definition of covered services.</p>	Preventive care services follow HCR definition. No cost shares apply for in-network preventive care services. Standard out-of-network cost shares apply for preventive services.	No change from Nongrandfathered 6.0	No change from Nongrandfathered 7.0 Breast cancer drugs are defined.	All HCR preventive immunizations now available at network retail pharmacy setting, as well as medical.	No change from Nongrandfathered 8.0
Mammograms, diabetic education and medical nutritional therapy	All network mammograms (routine or nonroutine), diabetic education and medical nutritional therapy are paid at the physician home and office services copay regardless of the outpatient setting. Lumenos® health savings account products are not subject to deductible and coinsurance on network preventive services. Legacy definition of preventive care includes routine mammograms, diabetic education and network-only medical nutritional therapy (Big 3). Please note: some medical nutritional therapy pays at the preventive level; but, some may pay outside of preventive benefit depending on codes and diagnosis. Indiana mandates routine and diagnostic mammograms must be paid the same. ASD groups can opt out of this mandate.	All network mammograms (routine or nonroutine) are paid based at the physician home and office services copay regardless of the outpatient setting. Indiana mandates routine and diagnostic mammograms must be paid the same. ASD groups can opt out of this mandate.	HCR definition of preventive care includes routine and diagnostic mammograms paid at no copay/ coinsurance. Network/ non-network follows place of service coinsurance. The preventive care services cannot be changed. For preventive (routine) mammograms, no cost share applies for in-network, non-consumer-directed health plan (CDHP) diagnostic (nonroutine) mammograms. Diabetes education and medical nutritional therapy will be paid based on the setting where the services are received. These services are no longer considered preventive under the HCR definition of preventive care.	No change from Nongrandfathered 5.0	No change from Nongrandfathered 6.0	No change from Nongrandfathered 7.0	No change from 2015	No change from Nongrandfathered 8.0



Benefit design	Grandfathered Blue 3.0	Grandfathered Blue 4.0	Nongrandfathered Blue 5.0	Nongrandfathered Blue 6.0	Nongrandfathered Blue 7.0	Nongrandfathered Blue 8.0 2015	Nongrandfathered Blue 8.0 2016	Nongrandfathered Blue 9.0 2017
Routine vision	Central Region annual vision services are defined as a preventive service. Services include ophthalmological services, routine vision exams, preventive screenings and refraction.	No change from Grandfathered 3.0	No change from Grandfathered 4.0	To remain in compliance with HCR preventive definition, only network preventive screenings are covered under medical at no cost share.  Blue View Vision <sup>SM</sup> will offer a full-service vision product with medical in order to create a new vision opportunity.	No change from Nongrandfathered 6.0	No change from Nongrandfathered 7.0	No change from 2015	No change from Nongrandfathered 8.0
Cardiac rehab	No benefit limit is defined for cardiac rehabilitation.	Cardiac rehabilitation will be limited to 36 visits per benefit period.	No change from Grandfathered 4.0	No change from Nongrandfathered 5.0	No change from Nongrandfathered 6.0	No change from Nongrandfathered 7.0	No change from 2015	No change from Nongrandfathered 8.0
Pulmonary rehab	No benefit limit is defined for pulmonary rehabilitation.	Pulmonary rehabilitation visits will be limited to 20 visits per benefit period.	No change from Grandfathered 4.0	No change from Nongrandfathered 5.0	No change from Nongrandfathered 6.0	No change from Nongrandfathered 7.0	No change from 2015	No change from Nongrandfathered 8.0
Home care services	Limited to 90 visits. Private duty nursing limited to \$50,000 annual/\$100,000 lifetime.	No change from Grandfathered 3.0	No change from Grandfathered 4.0	Limited to 100 visits, excluding private duty nursing.	Private duty nursing limited to 82 visits/calendar year and 164 visits/lifetime.	No change from Nongrandfathered 7.0	No change from 2015	No change from Nongrandfathered 8.0
Hospice	Hospice is at the network level and at the network cost share.	Hospice is the network level and at the network cost share.	No change from Grandfathered 4.0	For non-CDHP: Hospice is covered at no cost share (network and non-network).  For CDHP (both core and Lumenos): Hospice treated at the network-level coinsurance.	No change from Nongrandfathered 6.0	No change from Nongrandfathered 7.0	No change from 2015	No change from Nongrandfathered 8.0
Accidental dental	No benefit limit is defined for accidental dental coverage.	Accidental dental (surgical and anesthesia) coverage will have a maximum of \$3,000 per benefit period.	No change from Grandfathered 4.0	No change from Nongrandfathered 5.0	Accidental dental (surgical and anesthesia) coverage will have a maximum of \$3,000 per accident.	No change from Nongrandfathered 7.0	No change from 2015	No change from Nongrandfathered 8.0
Prosthetic limb coverage	Maximum benefit limit is removed (HCR)	No change from Grandfathered 3.0	No change from Grandfathered 4.0	No change from Nongrandfathered 5.0	No change from Nongrandfathered 6.0	No change from Nongrandfathered 7.0	No change from 2015	No change from Nongrandfathered 8.0

Benefit design	Grandfathered Blue 3.0	Grandfathered Blue 4.0	Nongrandfathered Blue 5.0	Nongrandfathered Blue 6.0	Nongrandfathered Blue 7.0	Nongrandfathered Blue 8.0 2015	Nongrandfathered Blue 8.0 2016	Nongrandfathered Blue 9.0 2017
Durable medical equipment (DME)	Maximum benefit limit is removed (HCR)	No change from Grandfathered 3.0	No change from Grandfathered 4.0	No change from Nongrandfathered 5.0	No change from Nongrandfathered 6.0	No change from Nongrandfathered 7.0	No change from 2015	No change from Nongrandfathered 8.0
Wigs	All other plans – Wigs are covered one per benefit period.  CDH products – Wigs are covered at a \$500/year limit.	All other plans – Wigs are covered one per benefit period.  CDH products – Wigs are covered at a \$500/year limit.	All other plans – Wigs are covered one per benefit period.  CDH products – Wigs are covered at a \$500/year limit.	All other plans – Wigs are covered one per benefit period.  CDH products – Wigs are covered at a \$500/year limit.	All other plans – Wigs are covered one per benefit period.	No change from Nongrandfathered 7.0	No change from 2015	No change from Nongrandfathered 8.0
Office visit – maternity care	Routine maternity care global reimbursement (global prenatal/delivery/postpartum) is subject to cost share based on settings.	No change from Grandfathered 3.0	No change from Grandfathered 3.0	No change from Grandfathered 3.0	No change from Grandfathered 3.0	No change from Nongrandfathered 7.0	No change from 2015	No change from Nongrandfathered 8.0
Office visit – other office-based services	Physician home and office services exclude certain diagnostic tests; MRA; MRI; Pet CT scans; nuclear cardiology imaging study and nonmaternity-related ultrasound and allergy testing.	No change from Grandfathered 3.0	No change from Grandfathered 3.0	No change from Grandfathered 3.0	No change from Grandfathered 3.0	No change from Nongrandfathered 7.0	No change from 2015	No change from Nongrandfathered 8.0

Benefit design	Grandfathered Blue 3.0	Grandfathered Blue 4.0	Nongrandfathered Blue 5.0	Nongrandfathered Blue 6.0	Nongrandfathered Blue 7.0	Nongrandfathered Blue 8.0 2015	Nongrandfathered Blue 8.0 2016	Nongrandfathered Blue 9.0 2017
<b>Facility</b>								
<b>Urgent care services</b>	Minimum urgent care copay is \$50 for non-CDHP plans.  Services performed in the urgent care setting are covered under the urgent care copay except for DME/prosthetics.  Non-network urgent care services are paid at the network level.	Minimum urgent care copay is \$75 for non-CDHP plans.  Urgent care copay will apply to the facility charge and the following services performed in the urgent care setting will be subject to deductible and coinsurance: pharmacy charges except preventive immunizations, allergy testing, high-cost radiology charges and DME/prosthetics.  For plans with urgent care services copay, there is a \$5 allergy injection copay in the network setting when it's the only service billed.  Non-network urgent care services will be subject to the non-network cost shares.	No change from Grandfathered 4.0	No change from Nongrandfathered 5.0	No change from Nongrandfathered 6.0	No change from Nongrandfathered 7.0	No change from 2015	No change from Nongrandfathered 8.0
<b>Emergency room services</b>	Minimum emergency room (ER) copay available is \$150 for non-CDHP plans.	The minimum ER copay is increasing to \$200 for the 2-99 group size non-CDHP plans.	No change from Grandfathered 4.0	For most non-CDHP plans, the minimum ER copay is increasing to \$250.	For most plans, the minimum ER copay is increased to \$250.	No change from Nongrandfathered 7.0	No change from 2015	No change from Nongrandfathered 8.0
<b>Pharmacy</b>								
<b>Anthem Home Delivery – cost shares</b>	Cost share tier structure: Tier 1: 2x retail for a 90-day mail-order supply Tier 2: 2.5x retail for a 90-day mail-order supply Tier 3: 2.5x retail for a 90-day mail-order supply Tier 4: 25% coinsurance for a 30-day supply, with an overall annual out-of-pocket prescription maximum of \$2,500 retail and home delivery combined.	Cost share tier structure: Tier 1: 1x retail for a 90-day mail-order supply Tier 2: 2.5x retail for a 90-day mail-order supply Tier 3: 3x retail for a 90-day mail-order supply Tier 4: 25% coinsurance with a \$150 per prescription maximum for a 30-day supply, with an overall annual out-of-pocket prescription maximum of \$2,500, retail and home delivery combined. (Does not apply to options A, B, F, I, K, M, X and Y).	No change from Grandfathered 4.0	Cost share tier structure: Tier 1: 1x retail for a 90-day mail-order supply Tier 2: 2.5x retail for a 90-day mail-order supply Tier 3: 3x retail for a 90-day mail-order supply Tier 4: 25% coinsurance with a \$150 per prescription maximum for a 30-day supply, with an overall annual out-of-pocket prescription maximum of \$2,500, retail and home delivery combined. (Does not apply to options A, B, F, I, K, M, X and Y).	Cost share tier structure: Cost share structure stayed the same as Blue 6.0  Tier 4: 25% coinsurance with a \$200 per prescription maximum for a 30-day supply, with an overall annual out-of-pocket prescription maximum of \$2,500, retail and mail-order combined.	Tier 4: Annual out-of-pocket prescription maximum is eliminated. All pharmacy cost shares accumulate to the plan's overall out-of-pocket maximum.	Tier 1: 2x for 90-day supply; Tier 2: 3 x for 90-days; Tier 3: 3 x for 90-days; Tier 4: 25% coinsurance with \$250 per prescription max. for 30-day supply.  The 4th tier per prescription maximum has increased from \$200 to \$250 on both retail and home delivery.	Tier 4 (for example, Split Specialty Tier Implemented: 25% up to \$300): Preferred specialty is covered at a lower tier 4 cost share. Nonpreferred specialty is covered at tier 5 (for example, 25% up to \$500) cost share.

Benefit design	Grandfathered Blue 3.0	Grandfathered Blue 4.0	Nongrandfathered Blue 5.0	Nongrandfathered Blue 6.0	Nongrandfathered Blue 7.0	Nongrandfathered Blue 8.0 2015	Nongrandfathered Blue 8.0 2016	Nongrandfathered Blue 9.0 2017
Pharmacy mail service – refill by mail	Members can get refills at a retail or mail-service pharmacy.	Refill by mail (available only for ASO groups) requires that:  After the third refill at retail pharmacy, all following refills are managed by the mail-service pharmacy in order for benefits to be payable.  100+ size groups – This is available as a standard option on any standard Rx design.  2-99 size groups – This is available with the generic premium drug plan Option K.	No change from Grandfathered 4.0	Refill by mail (available only for ASO groups) requires that:  After the third refill at retail pharmacy, all following refills are managed by the mail-service pharmacy. Retail refills after the third fill are paid using non-network cost shares.  100+ group size – This is available as a standard option on any standard Rx design.	No change from Nongrandfathered 6.0	No change from Nongrandfathered 7.0	No change from 2015	No longer offered
Mandatory generic (dispense as written)	If member or provider selects a brand drug when a generic is available, the member pays the generic copay and the cost difference between the generic and brand drug.	If a member selects a brand drug when a generic is available, he or she pays the generic copay and the cost difference between the generic and brand drug (does not apply to options K or M).  If a doctor indicates “dispense as written,” the member will be responsible for the appropriate cost share.	No change from Grandfathered 4.0	If a member selects a brand drug when a generic is available, he or she pays the generic copay and the cost difference between the generic and brand drug.  NOTE: Rx Option K is not available to the 2-99 group sizes.  If a doctor indicates “dispense as written,” the member will be responsible for the appropriate cost share.	No change from Nongrandfathered 6.0	Mandatory generic substitution (DAW) applies, except for options K, M, and AQ.	No change from 2015	Not available on Essential formulary
90-day retail benefit using R 90 or Smart 90 Network							Up to a 90-day refill (R90) is available at the appropriate cost share/copay.	Up to a 90-day refill (R90) is available at the appropriate cost share/copay.  Smart90 is a 90-day retail maintenance supply through the Smart90 network.  Smart90 is for 100+ custom only.
Split pharmacy tier 1					Preferred and nonpreferred generics covered at tier 1 cost shares.			Tier 1 – Preferred generics are covered at a lower tier 1A copay. Nonpreferred generic is covered at a higher tier 1B copay.  Split tier 1 is for 100+ custom only.

Benefit design	Grandfathered Blue 3.0	Grandfathered Blue 4.0	Nongrandfathered Blue 5.0	Nongrandfathered Blue 6.0	Nongrandfathered Blue 7.0	Nongrandfathered Blue 8.0 2015	Nongrandfathered Blue 8.0 2016	Nongrandfathered Blue 9.0 2017
Split pharmacy tier 4					Preferred and nonpreferred specialty is covered at tier 4 cost shares.			Tier 4 (for example, 25% up to \$300): Preferred specialty is covered at a lower tier 4 cost share. Nonpreferred specialty is covered at tier 5 (for example, 25% up to \$500) cost share.
RxChoice tiered network								We are combining the state- specific network with our national network, which provides a tiered pharmacy network and cost share feature (available for 100+ custom accounts).
Right drug right channel								The Right Drug Right Channel program provides coverage and management of specialty drugs under the most appropriate medical or pharmacy benefit.  Doctor-administered drugs are covered under the medical benefit and excluded under the pharmacy benefit. This includes infused and doctor-administered specialty medications.  Self-administered drugs are covered under the pharmacy benefit and excluded under the medical benefit. This includes select oral, inhaled and injected self-administered specialty medications.
Generic premium formulary features							Rx Option (K, AR, AS AW, BQ, CA) Generic Premium uses a condensed preferred drug list. Non-preferred drugs are not covered.	It is not being renewed. Existing groups need to be moved over to one of the 2017 options.



Benefit design	Grandfathered Blue 3.0	Grandfathered Blue 4.0	Nongrandfathered Blue 5.0	Nongrandfathered Blue 6.0	Nongrandfathered Blue 7.0	Nongrandfathered Blue 8.0 2015	Nongrandfathered Blue 8.0 2016	Nongrandfathered Blue 9.0 2017
Pharmacy formulary features							National drug list is the standard formulary.	The national drug list (except for generic focused only option) is no longer standard. It may be available as case exception/option.  Essential is the standard formulary option for the Rx options (fully insured/ASO).
<b>Lumenos</b>								
Lumenos deductible structure	Combined network and non-network deductible.	Combined network and non-network deductible.  Deductible First HRA is effective July 1, 2011 on 5.0.	No change from Grandfathered 4.0	Separate network and non-network deductible with no cross accumulation.	No change from Nongrandfathered 6.0	No change from Nongrandfathered 7.0	No change from 2015	No change from Nongrandfathered 8.0
Lumenos 0% coinsurance plans – pharmacy benefits	With Lumenos 0% coinsurance plans, once the deductible is satisfied, there isn't additional member cost sharing for prescriptions. There isn't an incentive for a member to select generic over brand or retail over home delivery.	Some 4.0 Lumenos 0% coinsurance plans are offered with Rx Option Z. There is a copay structure added to pharmacy tiers 1-3, as well as a fourth tier added for specialty injectable drugs after the deductible has been satisfied. Deductibles, copays and coinsurance apply to the out-of-pocket limits.  Retail copays will be \$10/\$30/\$50.  Mail-order copays will be 1x/2.5x/3x retail copays for a 90-day mail-order supply.  Tier 4 has a 25% coinsurance with \$150 maximum per script.  Tier 4 is a 30-day supply and includes both retail and mail-order.	No change from Grandfathered 4.0	All Lumenos 0% coinsurance plans on the 6.0 platform in the 2-50 and 51-99 group size range are offered with some new Rx options. There will be a copay structure added to pharmacy tiers 1-3, as well as a fourth tier added for specialty injectable drugs after the deductible has been satisfied. Deductibles, copays and coinsurance apply to the out-of-pocket limits.  Retail copays will be \$10/\$30/\$50.  Mail-order copays will be 1x/2.5x/3x retail copays for a 90-day mail-order supply.  Tier 4 has a 25% coinsurance with \$150 maximum per script.  Tier 4 is a 30-day supply and includes both retail and mail-order.	No change from Nongrandfathered 6.0	No change from Nongrandfathered 7.0	No change from 2015	No change from Nongrandfathered 8.0

Benefit design	Grandfathered Blue 3.0	Grandfathered Blue 4.0	Nongrandfathered Blue 5.0	Nongrandfathered Blue 6.0	Nongrandfathered Blue 7.0	Nongrandfathered Blue 8.0 2015	Nongrandfathered Blue 8.0 2016	Nongrandfathered Blue 9.0 2017
Lumenos 20% member coinsurance plans — mail service	Lumenos plans with a 20% member coinsurance after deductible maintain both retail and mail-order prescriptions coinsurance at 20%. There isn't an incentive for members to select mail-order for their maintenance medication.	These plans will reduce the member mail-order prescription coinsurance from 20% to 10%.	No change from Grandfathered 4.0	No change from Nongrandfathered 5.0	No change from Nongrandfathered 6.0	No change from Nongrandfathered 7.0	No change from 2015	Lumenos plans with a 20% or greater member coinsurance after deductible will apply (match) the medical coinsurance for both retail and mail order, network and non-network prescriptions.
Lumenos pharmacy edits	Not applicable	Most deductible/coinsurance plans do not apply Rx edits.  All Lumenos 0% coinsurance plans with Rx Option Z apply step therapy and dose optimization.	No change from Grandfathered 4.0	All CDHP pharmacy plans (with or without copays) will apply the following Rx edits: prior authorization, quantity supply limits, dose optimization and step therapy.	No change from Nongrandfathered 6.0	No change from Nongrandfathered 7.0	No change from 2015	No change from Nongrandfathered 8.0
Lumenos deductible and Coinsurance Plans — Specialty Pharmacy network							Specialty medications were available at any pharmacy.	Specialty medications must be obtained via our Specialty Pharmacy network in order to receive network level benefits.
Product name change								
Product name change  Anthem Essential HMO and POS plan name revision	Hospital Surgical  Blue Preferred Primary HMO and Blue Preferred Primary Plus POS	Plan name: Anthem Essential PPO  The word "primary" is removed from our HMO and POS product names:  Blue Preferred (HMO) Blue Preferred Plus (POS)	No change from Grandfathered 4.0	No change from Nongrandfathered 5.0	No change from Nongrandfathered 6.0	No change from Nongrandfathered 7.0	No change from 2015	No change from Nongrandfathered 8.0
Exclusions								
DME and orthotics/prosthetic exclusion	There is coverage for repair or replacement of DME regardless of reason	Repair or replacement of DME or prosthetics due to misuse or carelessness is excluded. Replacement of lost or stolen items is also excluded.	No change from Grandfathered 4.0	No change from Nongrandfathered 5.0	No change from Nongrandfathered 6.0	No change from Nongrandfathered 7.0	No change from 2015	No change from Nongrandfathered 8.0

Benefit design	Grandfathered Blue 3.0	Grandfathered Blue 4.0	Nongrandfathered Blue 5.0	Nongrandfathered Blue 6.0	Nongrandfathered Blue 7.0	Nongrandfathered Blue 8.0 2015	Nongrandfathered Blue 8.0 2016	Nongrandfathered Blue 9.0 2017
Outpatient medical supplies exclusions	Coverage excludes certain outpatient medical supplies such as ACE bandages, gauze, alcohol wipes, etc.  Elastic stockings are covered.	Current exclusions are broadened to include outpatient (prescribed or nonprescribed) medical supplies including, but not limited to, elastic stockings, ACE bandages, gauze and like products.	No change from Grandfathered 4.0	No change from Nongrandfathered 5.0	No change from Nongrandfathered 6.0	No change from Nongrandfathered 7.0	No change from 2015	No change from Nongrandfathered 8.0
Massage therapy exclusion	The current exclusion for massage therapy applies.	Current exclusion is broadened to include any massage or medical massage service.	No change from Grandfathered 4.0	No change from Nongrandfathered 5.0	No change from Nongrandfathered 6.0	No change from Nongrandfathered 7.0	No change from 2015	No change from Nongrandfathered 8.0
Administrative policies								
Fourth quarter deductible carryover	There is a buy-up option on the 51-99 Group Optional rider.	There is a buy-up option on the 51-99 Group Optional rider.	No change from Grandfathered 4.0	Buy-up option is for 100+ groups only	No change from Nongrandfathered 6.0	No change from Nongrandfathered 7.0	No change from 2015	No change from Nongrandfathered 8.0
Future certificate language updates.								
Mandates								
Ohio oral chemotherapy	Compliant with Ohio's oral chemotherapy mandate	Compliant with Ohio's oral chemotherapy mandate	Compliant with Ohio's oral chemotherapy mandate	Compliant with Ohio's oral chemotherapy mandate	Compliant with Ohio's oral chemotherapy mandate	Compliant with Ohio's oral chemotherapy mandate	No change from 2015	No change from Nongrandfathered 8.0
Federal mental health parity	New provision now covers residential treatment centers.			New provision now covers residential treatment centers.	New provision now covers residential treatment centers.	New provision now covers residential treatment centers.	No change from 2015	No change from Nongrandfathered 8.0
CDH Plans — All medical cost shares, copays, deductible and percentage (%) coinsurance including prescription drug cost shares (excluding non-network Human Organ Tissue Transplant (HOTT)).								
Waiting periods	Eligibility waiting periods of more than 90 days are reduced or removed.	No change from Grandfathered 3.0	No change from Grandfathered 3.0	No change from Grandfathered 3.0	No change from Grandfathered 3.0	No change from Nongrandfathered 7.0	No change from 2015	No change from Nongrandfathered 8.0
Pre-existing	Pre-existing conditions, exclusions and any related waiting periods are removed.	No change from Grandfathered 3.0	No change from Grandfathered 3.0	No change from Grandfathered 3.0	No change from Grandfathered 3.0	No change from Nongrandfathered 7.0	No change from 2015	No change from Nongrandfathered 8.0
Abortions	Therapeutic and Elective are covered	No change from Grandfathered 3.0	No change from Grandfathered 3.0	No change from Grandfathered 3.0	No change from Grandfathered 3.0	No change from Grandfathered 3.0	Abortion coverage is limited to coverage in cases of rape or incest, or if it is necessary to avert the pregnant women's death or irreversible impairment of a major bodily function.	No change from Nongrandfathered 8.0

# New/Renewal Group Checklist



Thank you for selecting Anthem Blue Cross and Blue Shield!

## **ENROLLMENT APPLICATION/SPREADSHEET** **CHECKLIST**

*Please check that these “often missed” areas are completed on each Enrollment Application/Spreadsheet:*

- SSN FOR SUBSCRIBER AND DEPENDENTS
- DATE OF HIRE
- DATE OF BIRTH
- COBRA BEGIN DATE/QUALIFYING EVENT DATE
- HEALTH PLAN ELECTION (if more than 1 option is offered)
- SUBGROUP (if subgroups are being added)
- EMPLOYEE SIGNATURE
- If Plan Includes LIFE AND DISABILITY, provide the following:
  - Subscriber Salary (if any benefit is salary based)
  - Life and Disability Class Assignment
  - Benefit Elections for Dependent Life(including amount(s)elected if more than one option is offered)
  - Benefit Elections for Contributory Benefits(including amount(s)elected if more than one option is offered)
  - Evidence of Insurability for amounts above Guaranteed Issue

## ENROLLMENT APPLICATION CHECKLIST

*Please check that these “often missed” areas are completed on your Enrollment Application:*

- SSN FOR YOU AND YOUR DEPENDENTS
- DATE OF HIRE
- DATE OF BIRTH
- HEALTH PLAN ELECTION (if more than 1 option is offered)
- YOUR SIGNATURE
- If Plan Includes LIFE AND DISABILITY, provide the following:
  - Subscriber Salary
  - Life and Disability Class Assignment
  - Benefit Elections for Dependent Life





## Proposal for Blue View Vision<sup>SM</sup> Plan Option 58



City of Greenwood  
April 1, 2017  
249 Eligible

### We have a unique perspective on vision care

As part of one of the largest health carriers in the United States, Blue View Vision will give your employees a vision plan that really does care for their health. We recognize the importance of overall health management. In fact, when our medical and vision plans are packaged together, our members' entire health care team can work together to share information, even identify gaps in care. That's a real advantage and it's something that strongly differentiates us from stand-alone vision carriers. After all we're not just a vision plan, we're Anthem.

### Vision care doctors are often the first to identify chronic health conditions

During an exam, vision care doctors are able to see signs of a number of eye and other health conditions. This can lead to early detection of major health problems before they become more serious.



### When your employees have our medical and vision plans...

- Network doctors can see relevant medical diagnoses, lab results and prescription drug history in a secure and HIPAA-compliant online format
- Doctors have access to patient health profiles and can view care alerts in advance of the appointment, so they're better informed
- Nearly 100% of the vision care doctors we surveyed said having this data results in better care

### Enrollment & referrals into care management programs

Vision claims data is included in the risk categories that can trigger enrollment in disease management programs. Whether enrolled in a program or not, members can always access our nurse hotline 24/7.

### What else makes us better?

#### Combined administration

We can offer the power of packaging multiple product lines, such as health and vision. This allows for the convenience of one bill, one ID card, and one point of contact.

#### Award winning customer service

BenchmarkPortal bestows their Center of Excellence Certification, one of the most esteemed recognitions in the customer service arena, only to call centers that rank in the top 10% of those surveyed. Our members can reach the award winning customer care center – staffed by U.S. based representatives – 7 days a week.



#### Provider Network

Over **33,000 doctors** at more than **26,000 locations** nationwide, with independent doctors, convenient retail stores and **1-800 CONTACTS** – **all In-network** – makes it easy for employees to take care of their vision needs and they can do it outside of work hours. Plus, retail or independent, **every** network provider extends valuable discounts to our members.

#### Monthly ASO Rates

☒ Employer Paid      ☐ Voluntary  
Commission: Net      3 year rate guarantee  
ASO Fee: \$1.89 PEPM

INDEPENDENT  
PROVIDERS

1 800 CONTACTS



USCIB

PEARLE  
VISION

sears  
optical

OPTICAL

JCP  
optical

Accepted on behalf of Group

Mark W. Myers

Print Name

Mark W. Myers

Signature

2/01/2017

Date



City of Greenwood  
PROPOSED BLUE VIEW VISION PLAN DESIGN

VISION PLAN BENEFITS	IN-NETWORK	OUT-OF-NETWORK
<b>Routine eye exam</b> Once every 12 months	\$10 copay	\$42 allowance
<b>Eyeglass frame</b> One pair every 12 months	\$130 allowance, 20% off any remaining balance	\$45 allowance
<b>Eyeglass lenses</b> One pair every 12 months in standard plastic with choice of the following options:		
• Single vision lenses	\$25 copay	\$40 allowance
• Bifocal lenses	\$25 copay	\$60 allowance
• Trifocal lenses	\$25 copay	\$80 allowance
<b>Eyeglass lens enhancements</b> When obtaining covered eyewear from a Blue View Vision provider, members may choose to add any of the following lens enhancements at no extra cost.		
• <b>Transitions</b> Lenses (for a child under age 19)	\$0 copay	No allowance on lens enhancements when obtained out-of-network
• Standard Polycarbonate (for a child under age 19)	\$0 copay	
• Factory Scratch Coating	\$0 copay	
<b>Contact lenses</b> Once every 12 months Instead of eyeglass lenses	<ul style="list-style-type: none"> <li>• Elective Conventional Lenses; or</li> <li>• Elective Disposable Lenses; or</li> <li>• Non-Elective Contact Lenses</li> </ul>	\$130 allowance, 15% off any remaining balance  \$130 allowance (no additional discount)  Covered in full  \$105 allowance  \$105 allowance  \$210 allowance

ADDITIONAL SAVINGS AVAILABLE FROM IN-NETWORK PROVIDERS		In-network Member Cost (after any applicable copay)
<b>Retinal Imaging</b>	• At member's option can be performed at time of eye exam	Not more than \$39
<b>Eyeglass lens upgrades</b>	• <b>Transitions</b> lenses (Adults)	\$75
<i>When obtaining eyewear from a Blue View Vision provider, members may choose to upgrade their new eyeglass lenses at a discounted cost.</i>	• Standard Polycarbonate (Adults)	\$40
<i>Eyeglass lens copayment applies.</i>	• Tint (Solid and Gradient)	\$15
	• UV Coating	\$15
	• Progressive Lenses	
	• Standard	\$65
	• Premium Tier 1	\$85
	• Premium Tier 2	\$95
	• Premium Tier 3	\$110
	• Anti-Reflective Coating	
	• Standard	\$45
	• Premium Tier 1	\$57
	• Premium Tier 2	\$68
	• Other Add-ons and Services	20% off retail price
<b>Additional Pairs of Eyeglasses</b>	• Complete Pairs	40% off retail price
<i>Anytime from any Blue View Vision network provider</i>	• Eyeglass materials purchased separately	20% off retail price
<b>Eyewear Accessories</b>	• Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc.	20% off retail price
<b>Contact lens fit and follow-up</b>	• Standard contact lens fitting	Up to \$55
<i>Available following a comprehensive eye exam</i>	• Premium contact lens fitting	10% off retail price
<b>Conventional Contact Lenses</b>		
<i>After covered benefits have been used</i>	• Discount applies to materials only	15% off retail price

*Other discount offers on LASIK surgery and much more available through Anthem's SpecialOffers program.*

This information is intended to be a brief outline of plan benefits. The most detailed description of benefits, exclusions, and restrictions can be found in the Certificate of Coverage. Discounts are subject to change without notice. Laws in some states may prohibit network providers from discounting products and services that are not covered benefits under the plan.

*Transitions and the swirl are registered trademarks of Transitions Optical, Inc.*

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January 24, 2017

City of Greenwood - 882  
Lisa Vest

Dear Lisa:

Thank you for renewing your Flexible Benefits Plan administration services with Key Benefit Administrators (KBA). Your **2017** Section 125 Flexible Benefits Plan renewal paperwork is included. The new plan year will begin on **April 1, 2017**. This packet contains all of the necessary information to renew your plan. Please review the items from the "Plan Set-Up Options" check list so we can accurately build "The Plan" to your specifications. If you have plan changes, please include the applicable form requesting the specified change.

**A. Here are some important dates to remember:**

- Please return your completed Renewal Packet by **February 13, 2017**. Upon receipt of your completed Renewal Packet, we will generate your custom Employee Information Packet (EIP) used for enrollment and to maintain compliance with the Health Care Reform Notification Requirements (if any amendments are required). We will also provide a pre-populated spreadsheet using current participant information for your renewing convenience. As usual, we will request your Employees provide an email address whenever possible.
- Please return your completed enrollment spreadsheet by **March 10, 2017** to guarantee the debit cards (if applicable) are received by your **new participants** prior to **April 1, 2017**.

**B. How may we assist you with this process?**

• **Communication Options** (Choose one option):

- ☐ We will need assistance communicating the Section 125 Flexible Benefits Plan to our employees. **Please respond by February 13, 2017** in order for us to schedule accordingly.
- ☒ We will be communicating the Section 125 Flexible Benefits Plan to our employees.

• **Online Enrollment:**

- ☐ We would like to offer FlexPro's online enrollments. The timeframe you would like your employees to access the online enrollment website?

When is your open enrollment period?

to  (Midnight)

**C. Enrollment Packet Options:**

- ☒ I would like an electronic version of the Employee Information/Enrollment Packet.
- ☐ I would like  (# of packets needed) Employee Enrollment Packets sent to the address below by  (date) (A fee may be charged for the cost of these packets, please consult the fee schedule page of the enclosed packet)

Please indicate to whom we should send the EIPs:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Contact Name	Mailing Address	City	ST	Zip Code

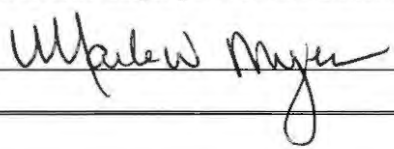


City of Greenwood - 882  
**Administrative Services Agreement of Flexible Benefits Plan**  
 KBA Schedule of Services and Fees  
 Section 125 Flexible Benefits Plan

<b>I. Monthly Administration services:</b>		<b>\$5.40 per participant</b>
Includes:		<b>Subject to a minimum monthly charge of \$50.00</b>
➤ Participant claim processing		
➤ All checks and correspondence sent to employer for distribution to Plan Participants		
➤ Toll-Free Phone/Fax for Participant and Employer		
➤ FlexPro Benefits Card: <b>(Where applicable)</b>		
<div style="display: flex; justify-content: space-between;"> <span>• Point-of-Purchase Access to FSA Account</span> <span>• Compliance with IRS guidelines on debit card usage</span> </div>		
➤ Online Account Management Services:		
<div style="display: flex; justify-content: space-between;"> <span>• FSA Balance Inquiries, Scheduled Employee Emails</span> <span>• FSA Balance Inquiries, Scheduled Employee Emails</span> </div>		
• Transaction History, Statements on demand		
<b>II. Annual Service Fee:</b>		
➤ Renewal Setup		<b>\$250.00</b>
• Enrollment Packets, E-file packets only		
• FSA Participant Set-Up, E-file election remittance only		
• Annual Non-Discrimination Testing 2		
➤ One On-Site Annual Enrollment Meeting		
<b>III. Additional Services, as requested: (Please check one)</b>		<b>YES NO</b>
➤ Participant Direct Mail Service - checks and correspondence sent directly to Participant's Home, Per Participant per month	\$ .50	You currently do not offer Direct Mail. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
➤ Participant Direct Deposit Option – Deposits made directly to employee's bank account. Charge is per participant per month but can be combined with Direct Mail or stand alone	\$0.50	You currently do not offer Direct Deposit. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
➤ Employee Information Packets – hard copies sent to employer, per packet, per year	\$1.00	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
➤ Hard copy enrollment forms returned to KBA for data entry – per participant, per enrollment form	\$2.00	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
➤ Form 5500 Preparation 3, fee per Form 5500	\$300.00	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
➤ Additional On Site Enrollment Meetings, Per Site, Per Day	\$250.00	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO

1. Fees reflected are Per Participating FSA Employee Per Month. Fees apply only to FSA participants, not to employees solely participating in the plan's pre-tax premium provision. Administration fees will be charged for 90 days past Plan termination including the grace period and run-off.
2. At least some Non-Discrimination testing is required for all entities each year. You will receive the necessary paperwork at the beginning of the plan year.
3. Many employers no longer have Form 5500 filing requirements for Flexible Benefits Plans. Effective April 2002, only Flexible Benefit plans with 100+ participants in the Health Care FSA are subject to the Form 5500 filing requirement. Upon request of the plan sponsor, KBA will prepare the Form 5500 as appropriate.

NOTE: Additional charges may apply if we are in receipt of incorrect banking information or draft is returned as a result of insufficient funds.

EMPLOYER/PLAN SPONSOR:	City of Greenwood	PLAN YEAR:	04/01/2017 - 03/31/2018
<b>Per the above schedule of services and fees, I hereby authorize Key Benefit Administrators to act as the third-party administrator of our employer flexible benefits plan.</b>			
Signature:		Date:	2/01/2017

## Section 125 Plan Specifics

City of Greenwood - 882

PLAN YEAR: 04/01/2017 - 03/31/2018

PLAN OPTIONS	PLAN MAXIMUMS
Premium Plan Option	Total Premiums
	2017 IRS Max \$2,600.00
Health FSA Plan Option Maximum:	\$ 2,550.00
Dependent Care FSA Plan Option:	\$ 5,000.00
Plan Maximum	\$ 7,550.00 + Total Premiums

Eligibility Requirements:	Employees must work 37.5 hours per week and may begin participation the first day of the month following 0 days of employment. Excluded Employees include: Contract workers and independent contractors.
Participation in the Premium Plan Option by New Hires:	Upon eligibility
Participation in the Health FSA Plan Option by New Hires:	Upon Eligibility
Participation in the Dependent Care FSA Plan Option by New Hires:	Upon Eligibility
Participation by Terminated Employees in the Health FSA:	Terminated employees will be allowed 0 days past termination to incur expenses and an additional 30 days to submit expenses.
Participation by Terminated Employees in the Dependent Care FSA:	Terminated employees will be allowed 30 days past termination to continue incurring expenses and an additional 30 days to submit expenses
Premium Deductions:	Premiums will automatically be deducted on a pre-tax basis unless a Waiver of Participation form is signed.
Claims Submission:	Claims must be submitted no later than noon E.S.T. Tuesday for check issuance bi weekly every other Friday. Checks issued Bi-Weekly.
Orthodontia Services:	Your Employer offers Up Front Orthodontia payments. The total reimbursement for orthodontia services may be made as services begin provided the participant actually paid for those service in full at the beginning of treatment.  or  At the time services begin, the initial down payment may be reimbursed. The remaining balance is reimbursed according to the monthly payment structure outline in the Orthodontia contract. A copy of the Orthodontic contract must be provided to KBA-Flexpro at time of reimbursement.
Carryover Option FSA:	If a balance remains in the account, an amount up to \$500 will be transferred to the next plan year. <b>Note:</b> Debit Cards may <u>not</u> be used to pay for prior year expenses.
Run Out Period FSA, DCA:	Claims must be submitted no later than 60 days after the end of the Plan Year. <b>Note:</b> Debit Cards may <u>not</u> be used to pay for prior year expenses during the 60 day run-out period. Paper claims may be submitted during this run out time.
Notification Timeframe for Status Changes:	Status changes must be submitted within 60 days of the Qualifying Event.

HEART ACT	
HEART Act - Qualified Reservist Distribution (QRD) Amount:	The amount contributed to the Health Care FSA as of the date of the QRD request minus any reimbursements (recommended).
HEART Act - Medical Expenses Incurred After the Qualified reservist distribution (QRD):	Terminate an employee's right to submit claims.



# Payroll Information

City of Greenwood - 882

PLAN YEAR: 04/01/2017 - 03/31/2018

**IMPORTANT NOTICE:** In order to correctly renew your plan, it is important to complete all requested information. Incomplete or unresolved issues will result in your Renewal processes being placed on hold until resolved.

**A. Employers with multiple Pay Schedules MUST create individual pages for each separate schedule.**

- Remember to allow for holidays, weekends or skipped deductions.
- Per IRS Regulations ALL deductions for a plan year must occur within dates for that plan year\*\*.

**B. Employee Annual elections may not evenly divide by the number of scheduled deductions for their individual payroll. SAMPLE :**  
\$2,500.00 / 26 = \$96.15384615

- KBA will be enrolling from the Employer Spreadsheet. We will match that data exactly.
- If the per pay multiplied by the # of deductions does not match the annual specified, the system will automatically adjust the last deposit date built in the system to match the indicated annual.
- If the per pay multiplied by the # of deductions does match the annual, employee account(s) will be set up accordingly.

**C. If Employers provide both AND there is a discrepancy between the pieces the Renewal will be placed on HOLD pending resolution.**

**D. Employer's NOT presenting specific dates are responsible for discrepancies between their systems and the WealthCare system set up.**

**E. Employers are required to provide at least one of the following.**

- MONTH \_\_\_\_ DATE \_\_\_\_ YEAR 20\_\_\_\_. Please provide the 1<sup>st</sup> deposit date of the plan\*\* for EACH payroll schedule utilized by Flex participants on individual pages.
- Please review your payroll schedules carefully and CIRCLE applicable dates below.
  - ✓ The circled dates represent in the WealthCare System the deductions taken by the Employer for the participant.
  - ✓ KBA will build **ONLY** the dates provided on this form. Any changes from past settings will be assumed to be Employer changes and will be implemented

**F. Here are the possible Pay Roll Schedule Frequencies available in WealthCare. Please review your current setup carefully and indicate what should be built for the upcoming renewal**

- ☐ Weekly (48 Standard)      ☒ Bi-weekly (26 Standard)      ☐ Monthly (12 Standard)  
☐ Weekly (52 Standard)      ☐ Bi-weekly (24 Standard)      ☐ Semi-monthly (24 Standard)  
☐ OTHER \_\_\_\_\_      ☐ Special Handling \_\_\_\_\_

## Calendar for 2017

January	February	March	April	May	June
S M T W T F S	S M T W T F S	S M T W T F S	S M T W T F S	S M T W T F S	S M T W T F S
1 2 3 4 5 6 7	1 2 3 4	1 2 3 4	1	1 2 3 4 5 6	1 2 3
8 9 10 11 12 13 14	5 6 7 8 9 10 11	5 6 7 8 9 10 11	2 3 4 5 6 7 8	7 8 9 10 11 12 13	4 5 6 7 8 9 10
15 16 17 18 19 20 21	12 13 14 15 16 17 18	12 13 14 15 16 17 18	9 10 11 12 13 14 15	14 15 16 17 18 19 20	11 12 13 14 15 16 17
22 23 24 25 26 27 28	19 20 21 22 23 24 25	19 20 21 22 23 24 25	16 17 18 19 20 21 22	21 22 23 24 25 26 27	18 19 20 21 22 23 24
29 30 31	26 27 28	26 27 28 29 30 31	23 24 25 26 27 28 29 30	28 29 30 31	25 26 27 28 29 30
July	August	September	October	November	December
S M T W T F S	S M T W T F S	S M T W T F S	S M T W T F S	S M T W T F S	S M T W T F S
1	1 2 3 4 5	1 2	1 2 3 4 5 6 7	1 2 3 4	1 2
2 3 4 5 6 7 8	6 7 8 9 10 11 12	3 4 5 6 7 8 9	8 9 10 11 12 13 14	5 6 7 8 9 10 11	3 4 5 6 7 8 9
9 10 11 12 13 14 15	13 14 15 16 17 18 19	10 11 12 13 14 15 16	15 16 17 18 19 20 21	12 13 14 15 16 17 18	10 11 12 13 14 15 16
16 17 18 19 20 21 22	20 21 22 23 24 25 26	17 18 19 20 21 22 23	22 23 24 25 26 27 28	19 20 21 22 23 24 25	17 18 19 20 21 22 23
23 24 25 26 27 28 29	27 28 29 30 31	24 25 26 27 28 29 30	29 30 31	26 27 28 29 30	24 25 26 27 28 29 30
30 31					31

## Calendar for 2018

January	February	March	April	May	June
S M T W T F S	S M T W T F S	S M T W T F S	S M T W T F S	S M T W T F S	S M T W T F S
1 2 3 4 5 6	1 2 3	1 2 3	1 2 3 4 5 6 7	1 2 3 4 5	1 2
7 8 9 10 11 12 13	4 5 6 7 8 9 10	4 5 6 7 8 9 10	8 9 10 11 12 13 14	6 7 8 9 10 11 12	3 4 5 6 7 8 9
14 15 16 17 18 19 20	11 12 13 14 15 16 17	11 12 13 14 15 16 17	15 16 17 18 19 20 21	13 14 15 16 17 18 19	10 11 12 13 14 15 16
21 22 23 24 25 26 27	18 19 20 21 22 23 24	18 19 20 21 22 23 24	22 23 24 25 26 27 28	20 21 22 23 24 25 26	17 18 19 20 21 22 23
28 29 30 31	26 27 28	25 26 27 28 29 30 31	29 30	27 28 29 30 31	24 25 26 27 28 29 30
July	August	September	October	November	December
S M T W T F S	S M T W T F S	S M T W T F S	S M T W T F S	S M T W T F S	S M T W T F S
1 2 3 4 5 6 7	1 2 3 4	1	1 2 3 4 5 6	1 2 3	1
8 9 10 11 12 13 14	5 6 7 8 9 10 11	2 3 4 5 6 7 8	7 8 9 10 11 12 13	4 5 6 7 8 9 10	2 3 4 5 6 7 8
15 16 17 18 19 20 21	12 13 14 15 16 17 18	9 10 11 12 13 14 15	14 15 16 17 18 19 20	11 12 13 14 15 16 17	9 10 11 12 13 14 15
22 23 24 25 26 27 28	19 20 21 22 23 24 25	16 17 18 19 20 21 22	21 22 23 24 25 26 27	18 19 20 21 22 23 24	16 17 18 19 20 21 22
29 30 31	26 27 28 29 30 31	23 24 25 26 27 28 29 30	28 29 30 31	25 26 27 28 29 30	23 24 25 26 27 28 29
		30			30 31

## Plan Set-Up Options

City of Greenwood - 882

PLAN YEAR: 04/01/2017 - 03/31/2018

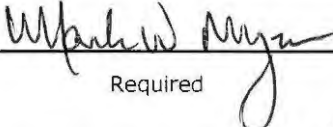
Below is a list of "options" where you may select "no change," "not applicable" or indicate you would like to change the Plan Set-Up Options. If there is a plan change or you would like to add a feature, please locate the corresponding page located in the Renewal Detail Explanations Section of this packet. Complete the applicable form and return with the Renewal Packet. If there are no changes, you only need to sign and return the 7 pages of this packet. All of the items included in this packet are used to build your plan and process the claims to your specific plan design. Please review carefully.

**Please help us remind your Employees to review their accounts online for pending or ineligible transactions. Unresolved pending or ineligible transactions will result in temporary deactivation of their Flex Benefit card until the transaction is resolved.**


REQUIRED			
No Changes	Yes, Changes	Not Applicable	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Group's Address</b> 300 South Madison Ave Greenwood, IN 46142
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Primary Contact</b> Lisa Vest vestl@greenwood.in.gov (317) 887-5604 <b>Additional Contact</b>
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Decision Maker</b> Lisa Vest vestl@greenwood.in.gov (317) 887-5604
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Billing Contact</b> Lisa Vest vestl@greenwood.in.gov; fritzkg@greenwood.in.gov
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Broker</b> Jon Pierre Fox pierre.fox@regions.com Regions Insurance
<b>In an effort to assist in increasing your medical matching and decrease substantiation, please provide carrier information so that we may review and work with those carriers.</b>			
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Major Medical:</b> Major Medical with KBA: <u>No</u> KBA Group #: <u>NA</u> Type of Major Medical with KBA: <u>NA</u> If not KBA, who is your Major Medical Carrier: <u>Anthem</u>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<b>Vision:</b> Vision with KBA: <u>No</u> KBA Vision Group #: <u>NA</u> If not KBA, who is your Vision Carrier: <u>VSP Anthem</u>
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Dental:</b> Dental with KBA: <u>No</u> KBA Dental Group #: <u>NA</u> If not KBA, who is your Dental Carrier: <u>Delta Dental</u>
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Gap:</b> Gap with KBA: <u>NO</u> Gap Group #: <u>NA</u> <b>Other:</b> Other Products with KBA: Other Group #:
<b>We show that you do not offer an HSA.</b>			
<input checked="" type="checkbox"/> There are no changes. <input type="checkbox"/> Yes, change. We now have an HSA and wish to amend our plan to allow a Limited Purpose FSA. Amendment to the plan required. <input type="checkbox"/> Yes, change. We now have an HSA but do not wish to amend our plan to allow a Limited Purpose FSA. No amendment to the plan required. <input type="checkbox"/> Yes, change. Amend our plan to allow a Limited Purpose FSA with No HSA. Adding this amendment will allow any employee whose spouse is participating in an HSA (with their employer) to participate in the Flex Plan on a limited basis.			
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>KBA Schedule of Services and Fees:</b> Fees are reviewed annually by the Flex Pricing Committee. Please review the fees that have been set for this plan year. This page requires a signature to authorize KBA to continue administering your Flexible Benefit Plan.



<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Section 125 Plan Specifics:</b> Please review the Plan Specific page, note changes where applicable, and note here that you require changes (or not).
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The <b>Banking Information for checks</b> has not changed from the prior plan year.
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Direct Deposit:</b> Group does not currently offer Direct Deposit. Employee checks can be issued with the Direct Deposit feature. If you have not set this up before, but would like to read more about it, please see the Direct Deposit section in the Renewal Detail Explanations Section.
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The <b>Banking Information for the Flex Card transactions</b> has not changed from the prior plan year. <b>Note:</b> This is the bank account used to pay for the flex card transactions.
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The <b>Co-pay/Medical Plan Schedule of Benefits</b> has not changed from the prior plan year. <b>Note:</b> Please make sure we have your current plan co-pays. Building your plan with your current plan co-pays will improve the automatic substantiation rate.
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>GRACE PERIOD:</b> <b>FSA Grace Period:</b> Our records indicate that you currently do not offer the FSA Grace Period. Your plan includes a 60 day runout off. <b>Note:</b> If you are interested in the new Carryover option, you must amend the plan to allow for the Carryover. <b>Important Note:</b> You currently offer the Carryover. Your plan is not permitted to have a FSA Grace period with the Carryover option. <b>DCA Grace Period:</b> Our records indicate that you currently do not offer the DCA Grace Period. Your plan includes a 60 day runout off.
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Year End Carryover:</b> Our records indicate that you offer the Carryover Option for a maximum of \$500.00. If you are interested in making changes please complete and return the Carryover Questionnaire. Please note: IRS does not permit the FSA/LPF Grace period if the Carryover is elected. Please note: Individuals not enrolling in the new plan with money at the end of the prior plan year will generate an account in the new plan year and will count in the monthly per employee per month (PEPM) billing.
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Ortho-Up Front:</b> Our records indicate that you accept claims for up-front payment of Orthodontia services.

Authorizing Signature:  Date: 2/01/2017

Required

If above you indicated "No Changes," you may  here and only return the pages up to this point. If you are making changes, please include only the pages indicating changes you would like to implement.

For assistance in completing any of the enclosed paperwork, please contact me.

Sincerely,

*Tirice Weddle, FCS*  
Tirice Weddle, FCS  
Account Manager  
(317)-284-7151  
Tweddle@keybenefit.com

## Section 125 Flexible Benefits Plan Renewal Detail Explanations and Change Forms

City of Greenwood

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### **Renewal Detail Explanations and Change Forms**

The "Plan Set-Up Options" included on the previous page is a simplified check list for renewing your plan.

The pages included in this section are to assist you with modifying your current plan or explanation of services offered. To modify your plan, complete and return the corresponding page applicable to the plan change request.

If there are no plan modifications, you may skip this section.

## Important Information

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- A. **KBA-FlexPro website:** Available to both the Employee and Employer 24 hours a day, 7 days a week. Please help us remind your Employees to periodically review their accounts online for pending or ineligible transactions. Pursuant to the IRS guidelines, unresolved pending or ineligible transactions will result in temporary deactivation of their Flex Benefit cards until the transaction is resolved, even from one plan year into the next.

Employee website: **[www.mywealthcareonline.com/flexpro](http://www.mywealthcareonline.com/flexpro)**

Employer website: **[www.wealthcareadmin.com](http://www.wealthcareadmin.com)**

B. **WealthCare Mobile is here for the Employee Accounts!**

Employees can download this new app by searching the App or Play store for "KBA" or "Key Benefit", then searching the Key Benefit Administrators WealthCare Mobile app. Employee Accounts must be registered with [www.mywealthcareonline.com/flexpro](http://www.mywealthcareonline.com/flexpro) in order to use this application on mobile devices. Once installed, employees can log in with the ID information used in their registered account.



C. **Direct Deposit:**

We encourage all Employers to consider the Direct Deposit feature. This feature allows your Employees quicker access to their Flex funds. At your scheduled reimbursement time, the lump sum amount of the direct deposits will be automatically deducted from your designated bank account and disbursed to the specific employee's designated bank account. In your bank account, this looks much like the Flex Card purchases do now.

**Online Enrollment**

1. KBA would like to receive a complete demographic overview of each eligible employee with SSN or their known employee number assigned, plus e-mail addresses for each; this information should be provided at least two weeks prior to the first date shown above. We can provide the listing for those currently enrolled, but new or non-participating members' information will need to be provided so the system will recognize them when they log-in.
2. Detailed instructions will be incorporated within the *Employee Information Packet* for your employees if you elect this option.
3. An e-mail will be sent to all eligible employees prior to the timeframe given for open enrollment as a reminder to them to elect this important tax-savings benefit.
4. When the employee either enrolls or waives the benefit, an acknowledging e-mail will be automatically sent when their enrollment process is completed.
5. Employees will have until the end of the open enrollment timeframe to go back in and make changes, if necessary.
6. A Summary of the on-line enrollment activity is sent to the employer contact after the timeframe ends; the listing will indicate the types of flexible benefits elected, the annual, and the per pay amount for each participant, as well as those employees who waived elections.



## Banking Information – Manual Check Reimbursement

City of Greenwood - 882

PLAN YEAR: 04/01/2017 - 03/31/2018

### ONLY COMPLETE IF THERE ARE CHANGES

☐ Yes, we are making bank changes as indicated below.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

A. Checking Options

☐ Checks printed by KBA using client bank account ☐ Checks not printed by KBA, printed by employer

B. If KBA is printing the checks, where do we mail the checks and the periodic reports?

☐ Individual's Home Address (A fee may apply for this service, please consult your fee schedule)

☐ Employer for Distribution

C. When would you prefer for us to run the check cycle (this applies even if KBA does not print the checks)?

1. FSA Reimbursement Checks shall be issued \_\_\_\_\_ (weekly, bi-weekly, monthly, or specified date)

2. FSA Checks shall be issued on \_\_\_\_\_ (Indicate a particular weekday: Monday, Tuesday, etc.)

3. Should the Employer Disbursement Report (EDR) be sent to you: ☐ Monthly or ☐ At time of check print

4. Who should the report be sent to? (Please include all names and emails to receive this report)

a. Name: \_\_\_\_\_

Email Address: \_\_\_\_\_

b. Name: \_\_\_\_\_

Email Address: \_\_\_\_\_

c. \_\_\_\_\_ Not required. Do not send.

Initials

D. If KBA is printing the checks, please complete this required checking information.

☐ The change will be effective the beginning of the plan year unless date specified here: \_\_\_\_\_

☐ Beginning check number: \_\_\_\_\_

☐ Name of person to appear on the checks (please print): \_\_\_\_\_

**In the "Signature Box" below, include the signature to appear on the checks. Please stay inside the lines for the signature to import properly.**

### SIGNATURE BOX

E. Please indicate the Bank Account Information:

Bank Name: \_\_\_\_\_

Bank Account #: \_\_\_\_\_

Bank Routing & Transit #: \_\_\_\_\_

**Please note:** If the authorized signature, bank name, bank account number or account name changes, Key Benefit Administrators must be notified immediately. Additional charges may apply if we are in receipt of incorrect banking information or draft is returned as a result of insufficient funds.

**If Possible, Attach Voided Check, Deposit Slip  
or Bank Account Verification Form.**

## Direct Deposit Set-up/Change

City of Greenwood - 882

PLAN YEAR: 04/01/2017 - 03/31/2018

### ONLY COMPLETE IF THERE ARE CHANGES

☐ Yes, we are making bank changes as indicated below.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

*Group does not currently offer Direct Deposit.*

### **ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR DIRECT DEPOSIT EMPLOYER FORM**

Direct Deposit allows employees to submit manual claims for payment directly into their bank accounts. It is a convenient feature for your employees.

#### How does this work?

At your scheduled reimbursement time, the lump sum amount of the direct deposits will be automatically deducted from your designated bank account (below) and disbursed to the specific employee's designated bank account. In your bank account, this looks much like the Flex Card purchases do now.

#### How will your Employees set this up?

Your employees may log into their account at [www.mywealthcareonline.com/flexpro](http://www.mywealthcareonline.com/flexpro) and sign up for the direct deposit feature or KBA can supply an Employee Direct Deposit forms within the Employee Information Packet (EIP).

Please complete this form if you are interested in offering Direct Deposit to your employees.

Bank Name: \_\_\_\_\_

Bank Account #: \_\_\_\_\_

Bank Routing & Transit #: \_\_\_\_\_

**Once direct deposit is set up for your company, your employees may update their direct deposit information online anytime. Information will be provided in the Employee Information Packet (EIP) giving the employee options. Note: Claims processed before the direct deposit is set up will be paid by check.**

As an authorized representative of the Company listed above, I hereby authorize the Key Family of Companies to initiate variable debit entries to the Company account indicated above. This authorization will remain in effect until written notice is received by the Key Family of Companies that terminates this authorization.

Signature \_\_\_\_\_

Date \_\_\_\_\_

## Flex Card ACH Authorization

City of Greenwood - 882

PLAN YEAR: 04/01/2017 - 03/31/2018

### ONLY COMPLETE IF THERE ARE CHANGES

☐ Yes, we are making bank changes for debit card transactions as indicated below.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

- A. The authorized representative at **City of Greenwood** hereby authorizes Alegeus Technologies/ WealthCare Administration or It's agent to initiate ACH (automated clearing house) transfer entries for the following depository:

**Note:** When the account is first established (including any bank changes), a one dollar "prenote" settlement is performed when linking the Physical Bank Account. Because this is an actual ACH settlement, any problems with the Physical Bank Account are detected right away and before card transaction activity begins. This early detection safe-guard saves significant manual processing and fees. The one dollar "prenote" is non-refundable.

Bank Name: \_\_\_\_\_

Bank Account #: \_\_\_\_\_ Bank Routing & Transit #: \_\_\_\_\_

Type of Account (Please check one): ☐ Checking Account ☐ Savings Account

- B. **Reporting:** How may we communicate the Debit Card Expenses?

1. **Flex Card Daily Settlement Activity.** The report will generate on a daily basis and indicate the settlement activity in total for the day including zero dollars for the settlement. Please note: ACH Failures will result in a **\$30.00** fee per transaction. (Please include all emails and names that should receive this report)

☐ Yes, I would like this report. ☐ No, I do not need this report at this time.

a. Name: \_\_\_\_\_ Email Address: \_\_\_\_\_

b. Name: \_\_\_\_\_ Email Address: \_\_\_\_\_

2. **Employer Disbursement Report (EDR)** as follows (please indicate one):

☐ Monthly, sent the 1st day of the month to include all transactions from the prior month.

☐ Weekly, please indicate the day of the week you would like to receive the report \_\_\_\_\_

Indicate a particular weekday: Monday, Tuesday, Wednesday, Thursday or Friday

Please include all emails and names that should receive this report

a. Name: \_\_\_\_\_ Email Address: \_\_\_\_\_

b. Name: \_\_\_\_\_ Email Address: \_\_\_\_\_

### **A few notes about the Flexible Benefits Payment Card:**

As an Employer, it is important you have access to [www.wealthcareadmin.com](http://www.wealthcareadmin.com). The access will allow you the ability to do many things such as check the balance of an employee's accounts or run reports. For example, you will have the ability to run a transaction report to see the pending transactions for your employees.

Please be sure to contact your Benefit Consultant to obtain your login. All contacts and report recipients may be granted USER level access to the debit card system which will grant access to various other reports and functionality. We will be glad to complete your setup and provide you with some helpful hints on how to best use the website.

	Generic Co-Pay	Brand Co-Pay	Formulary Co-Pay
Pharmacy Co-Pay:			
Mail Order Rx Co-Pay:			
Provider	In-Network	Non-Network	
Physician Co-Pay:			
Dental Co-Pay:			
Vision Co-Pay:			
Chiropractic Co-Pay:			
Emergency Room:			
Urgent Care:			
In-Patient Hospital			
Out-Patient Hospital			
Other Co-Pay: _____			
Other Co-Pay: _____			
Other Co-Pay: _____			
Other Co-Pay: _____			
Other Co-Pay: _____			

## Section 125 Orthodontia Policy and Grace Period Options

City of Greenwood - 882

PLAN YEAR: 04/01/2017 - 03/31/2018

### ONLY COMPLETE IF THERE ARE CHANGES

1. Our records indicate that you Accept claims for up-front payment of Orthodontia services.
2. **FSA Grace Period:** Our records indicate that you currently do not offer the FSA Grace Period. Your plan includes a 60 day runout off. Note: If you are interested in the new Carryover option, you must amend the plan to allow for the Carryover. **Important Note:** You currently offer the Carryover. Your plan is not permitted to have a FSA Grace period with the Carryover option.

**DCA Grace Period:** Our records indicate that you currently do not offer the DCA Grace Period. Your plan includes a 60 day runout off.

Please Initial: \_\_\_\_\_

**Please note changes below, if different.**

## Reimbursement for Orthodontia Services

Most orthodontia payments are paid on a monthly basis through the length of the service. Occasionally, Orthodontists will give the patient the opportunity to pay for the services at a discount if they pay the entire amount up front. A representative from the IRS has informally stated it may be permissible to accept full payment of orthodontia up front provided the patient has paid up front. Our standard procedure is to process orthodontia receipts on a monthly basis. If you would like us to change that procedure for your Flex participants who pay for the orthodontia services up front, you will need to complete this form. Please keep in mind that you, as the employer, are at risk for the participant's full annual pledge. Unless we receive this signed form from you, we will continue to process your participant's orthodontia services on a monthly basis.

Orthodontia Services will be processed in the manner indicated below until the direction from the Internal Revenue Service changes or the company revokes this option in writing.

- |   |   |
|---|---|
| <input type="checkbox"/> Please do <b>NOT</b> accept claims for up-front payment of Orthodontia Services. Payments should only be made as expenses are actually incurred and/or on a monthly basis. | <input type="checkbox"/> Please accept claims for <b>up-front</b> payment of Orthodontia services. We understand a participant in our company's Health FSA may pay up-front for Orthodontia Services for himself/herself or one of his/her eligible dependents, and the participant may file for reimbursement for the total amount he/she paid (up to the amount available in the participant's Health FSA). |
|---|---|

## Grace Period Options

The IRS issued guidance (IRS Notice 2005-42) in May 2005 allowing Flexible Benefits Plans to offer a grace period for up to 2 ½ months after the end of a plan year. The grace period allows participants to access unused funds from the previous plan year with expenses incurred during the grace period. This guidance modifies the use-it-or-lose-it rule and may reduce participants' forfeitures. Offering the grace period is optional. Flex Card expenses incurred in the new plan year during the grace period will be applied to the remaining balance in the previous plan year.

If you have not already added the grace period to your plan and you wish to do so, please indicate below the specifics. Please keep in mind that the grace period will apply to your current plan year, and future plan years and will require an amendment.

- ☐ Yes, we want to amend our flexible spending account plan now to include a "grace period."

A. Length of "grace period" can be up to 2½ months after end of current plan year (mark one):

- ☐ 1 month  
☐ 2 months  
☐ 2½ months

B. Length of time to file a claim after the end of the "grace period" (mark one):

- ☐ 30 days  
☐ 60 days  
☐ 90 days



# Carryover Questionnaire

**City of Greenwood - 882**

☒ Our records indicate that you currently offer Carryover.

Please Initial:   *SN*  

☐ Yes, amend our plan to **offer** the carryover option of up to \$500. The maximum carryover is \$500. We will default to \$500 unless otherwise specified \$\_\_\_\_\_.

☐ For the 2015 plan year, and each subsequent plan year.

☐ For the 2016 plan year, and each subsequent plan year.

☐ Yes, amend our current plan to **cancel** our Health Care FSA Grace Period option only and, instead, **offer** the carryover option of up to \$500. The maximum carryover is \$500. We will default to \$500 unless otherwise specified \$\_\_\_\_\_. **Note:** if you currently offer the Grace Period, this will only cancel the Healthcare FSA Grace Period, but will not cancel the Dependent Care Grace Period, unless specified.

☐ For the 2015 plan year, and each subsequent plan year.

☐ For the 2016 plan year, and each subsequent plan year.

☐ We would like to cancel the Grace Period for the Dependent Care.

☐ No changes should be made to our current setup. We do not want to offer the carryover option.

**Carryover definition:** The IRS-issued guidance (IRS Notice 2013-71) in November-2013 allowing Flexible Benefits Plans to offer a carryover option of up to \$500 after the end of a plan year. The carryover is optional and only applies to the Healthcare FSA. The carryover option allows participants to access up to \$500 of unused funds from the previous plan year with expenses in the future plan year. This guidance modifies the "use-it-or-lose-it" rule and may reduce participants' forfeitures. However, an Employer may not offer both the Grace Period and the Carryover Option. Flex Card expenses incurred in the new plan year during the runout period will be applied to the current plan year first, and then the remaining balance in a "carryover plan" with funds from the previous plan year.

Example, if the 2015 plan year is chosen to be amended to allow the carryover option:

- Employee has \$500 remaining at the end of the 2015 plan year account. The money will be automatically transferred to a separate "carryover plan". During the runout period, the carryover funds can be used for expenses in either the 2015 or 2016 plan year. Once the runout period is complete, any remaining funds in the "carryover plan" will be automatically transferred to the 2016 plan year to be used for current expenses throughout the rest of the year.
- Employee has \$700 remaining at the end of their 2015 plan year account. \$500 will be transferred to a separate "carryover plan". During the runout period, the carryover funds can be used for expenses in either the 2015 and 2016 plan year. However, \$200 will remain in the 2015 plan year to be used during the runout period only for 2015 expenses. Once the runout period is complete, any remaining funds in the "carryover plan" will be automatically transferred to the 2016 plan year to be used for 2016 expenses throughout the year. If any of the \$200 remains in the prior plan year, it will be subject to the "use it or lose it" rule and forfeited.
- **Note:** The Flex card cannot be used during the runout period for prior year expenses. Manual claims will need to be submitted.

**Grace Period definition:** The IRS-issued guidance (IRS Notice 2005-42) in May-2005 allowing Flexible Benefits Plans to offer a Grace Period for up to 2 ½ months after the end of a plan year. Offering the Grace Period is optional. The Grace Period allows participants to access unused funds from the previous plan year with expenses incurred during the Grace Period. Flex Card expenses incurred in the new plan year during the Grace Period will automatically be applied to the remaining balance in the previous plan year.

Example, if the 2015 plan year is chosen to be amended to allow the Grace Period:

- Employee has \$500 remaining at the end of their 2015 plan year; the money could be used for prior and current year expenses during the specified Grace Period dates only. Any remaining amount left in the prior plan year after the Grace Period and runout will be subject to the "use it or lose it" rule and forfeited.
- Employee has \$700 remaining at the end of their 2015 plan year; \$700 could be use for prior and current year expenses during the specified Grace Period dates only. Any remaining amount left in the prior plan year after the Grace Period and runout will be subject to the "use it or lose it" rule and forfeited.
- **Note:** The Flex card cannot be used during the runout period for prior year expenses. Manual claims will need to be submitted.

# Your Summary of Benefits



City of Greenwood  
Blue Access® (PPO)  
Effective April 1, 2016

Covered Benefits	Network	Non-Network
<b>Deductible (Single/Family) Plan Year</b> Deductible(s) must be satisfied before coinsurance applies	\$500/\$1,000	\$2,000/\$4,000
<b>Out-of-Pocket Limit (Single/Family) Plan Year</b>	\$2,000/\$4,000	\$5,000/\$10,000
<b>Physician Home and Office Services (PCP/SCP)</b> Primary Care Physician (PCP)/ Specialty Care Physician (SCP) Including Office Surgeries and allergy serum: <ul style="list-style-type: none"> <li>allergy injections (PCP and SCP)</li> <li>allergy testing</li> <li>MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, and pharmaceutical products</li> </ul>	\$20/\$35  \$5 20% 20%	30%  30% 30% 30%
<b>Preventive Care Services</b> Services included but not limited to: <ul style="list-style-type: none"> <li>Routine medical exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Hearing screenings and Vision screenings which are limited to Screening tests (i.e. Snellen eye chart) and Ocular Photo screening, and Newborn Exams</li> </ul>	NCS	30%
<b>Emergency and Urgent Care</b> <b>Emergency Room Services</b> <ul style="list-style-type: none"> <li>facility/other covered services (copayment waived if admitted)</li> </ul> <b>Urgent Care Center Services</b> <ul style="list-style-type: none"> <li>MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, and pharmaceutical products</li> <li>Allergy injections</li> <li>Allergy testing</li> </ul>	\$200  \$30 20%  \$5 20%	\$200  30% 30%  30% 30%
<b>Inpatient and Outpatient Professional Services</b> Include, but are not limited to: <ul style="list-style-type: none"> <li>Medical Care visits), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia</li> </ul>	20%	30%
Blue 8.0		

# Your Summary of Benefits

Covered Benefits	Network	Non-Network
<b>Inpatient Facility Services</b> (Network/Non-Network combined) Unlimited days except for: <ul style="list-style-type: none"> <li>60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)</li> <li>60 days for skilled nursing facility</li> </ul>	20%	30%
<b>Outpatient Surgery Hospital/Alternative Care Facility</b> <ul style="list-style-type: none"> <li>Surgery and administration of general anesthesia</li> </ul>	20%	30%
<b>Other Outpatient Services</b> (including but not limited to): <ul style="list-style-type: none"> <li>Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services.</li> <li>Home Care Services (Network/Non-Network combined) 100 visits (excludes IV Therapy)</li> <li>Durable Medical Equipment and Orthotics</li> <li>Prosthetic Devices</li> <li>Prosthetic Limbs</li> <li>Physical Medicine Therapy Day Rehabilitation programs</li> <li>Hospice Care</li> <li>Ambulance Services</li> </ul>	20%           NCS 20%	30%           NCS 20%
<b>Outpatient Therapy Services</b> (Combined Network & Non-Network limits apply) <ul style="list-style-type: none"> <li>Physician Home and Office Visits (PCP/SCP)</li> <li>Other Outpatient Services @ Hospital/Alternative Care Facility</li> </ul> Limits apply to: <ul style="list-style-type: none"> <li>Physical therapy: 60 visits</li> <li>Occupational therapy: 60 visits</li> <li>Manipulation therapy: 24 visits</li> <li>Speech therapy: 25 visits</li> <li>Cardiac Rehabilitation: 36 visits</li> <li>Pulmonary Rehabilitation: 20 visits</li> </ul>	\$20/\$35 20%	30% 30%
<b>Accidental Dental: Unlimited per occurrence</b> (Network and Non-network combined)	Copayments/Coinsurance based on setting where covered services are received	30%

# Your Summary of Benefits

Covered Benefits	Network	Non-Network
<b>Behavioral Health Services</b> <b>Mental Illness and Substance Abuse<sup>2</sup>:</b> <ul style="list-style-type: none"> <li>Inpatient Facility Services</li> <li>Inpatient Professional Services</li> <li>Physician Home and Office Visits (PCP/SCP)</li> <li>Other Outpatient Services, Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional</li> </ul>	20% 20% \$20/\$20 20%	30%
<b>Human Organ and Tissue Transplants<sup>3</sup></b> <ul style="list-style-type: none"> <li>Acquisition and transplant procedures, harvest and storage</li> </ul>	NCS	50%
<b>Prescription Drug Options:</b> <b>Network Tier structure equals 1/2/3 (and 4, if applicable)</b> <ul style="list-style-type: none"> <li><b>Network Retail Pharmacies:</b> (30-day supply) Includes diabetic test strip</li> <li><b>Home Delivery Service:</b> (90-day supply) Includes diabetic test strip</li> </ul> <p>Member may be responsible for additional cost when not selecting the available generic drug.</p> <p><b>Medicare Rx - Wrap</b></p> <p><b>Specialty Medications</b> must be obtained via our Specialty Pharmacy network in order to receive network level benefits</p> <p>Specialty medications are limited to 30 day supply regardless of whether they are retail or mail order.</p>	OTC \$5 Allergy - Acid Reflux \$10/\$25/\$40/\$60  \$20/\$50/\$80	50%, min \$60 <sup>5</sup>  Not covered
<b>Lifetime Maximum</b> Medical Surgical Treatment of Morbid Obesity	Unlimited Not covered	Unlimited Not covered

## Notes:

- All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services)
- Deductible(s) apply only to covered medical services listed with a percentage (%) coinsurance, including 0%. However, the deductible does not apply to Emergency Room Services where a copayment and coinsurance applies and may not apply to some Behavioral Health services where coinsurance applies.
- Dependent Age: to end of the month which the child attains age 26
- Specialist copayment is applicable to all Specialists excluding General Physicians, Internist, Pediatricians, OB/GYNs and Geriatrics or any other Network Provider as allowed by the plan.
- When allergy injections are rendered with a Physicians Home and Office Visit, only the Office Visit cost share applies. When the Office Visit cost share is a % coinsurance, deductible and coinsurance apply to allergy injections.
- NCS (No Cost Share) means no deductible/copayment/coinsurance up to the maximum allowable amount.
- PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network provider as allowed by the plan.
- SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.
- Certain diabetic and asthmatic supplies have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies.
- Benefit period = Plan Year
- Mammograms and colonoscopies (Diagnostic) are no copayment/coinsurance in Network office and outpatient facility settings.

# Your Summary of Benefits

- Behavioral Health Services: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.
- Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits are covered.
- Private Duty Nursing – limited to 82 visits/Calendar Year and 164 visits/lifetime.
- Elective abortions not covered unless otherwise noted in your Certificate of Coverage.

1 These covered services are not subject to the deductible/copayment if you have a flat dollar copayment and if rendered without an office visit.

2 We encourage you to review the Schedule of Benefits for limitations.

3 Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.

## **Precertification:**

Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.

## **Pre-existing Exclusion Period: none**

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

*This benefit overview is for illustrative purposes and some content may be pending Indiana Department of Insurance approval.*



City of Greenwood  
PROPOSED BLUE VIEW VISION PLAN DESIGN

VISION PLAN BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Routine eye exam Once every 12 months	\$10 copay	\$42 allowance
Eyeglass frame One pair every 12 months	\$130 allowance, 20% off any remaining balance	\$45 allowance
Eyeglass lenses One pair every 12 months in standard plastic with choice of the following options:		
• Single vision lenses	\$25 copay	\$40 allowance
• Bifocal lenses	\$25 copay	\$60 allowance
• Trifocal lenses	\$25 copay	\$80 allowance
Eyeglass lens enhancements When obtaining covered eyewear from a Blue View Vision provider, members may choose to add any of the following lens enhancements at no extra cost.		
• Transitions® Lenses (for a child under age 19)	\$0 copay	No allowance on lens enhancements when obtained out-of-network
• Standard Polycarbonate (for a child under age 19)	\$0 copay	
• Factory Scratch Coating	\$0 copay	
Contact lenses		
Once every 12 months	• Elective Conventional Lenses; or	\$130 allowance, 15% off any remaining balance
Instead of eyeglass lenses	• Elective Disposable Lenses; or	\$130 allowance (no additional discount)
	• Non-Elective Contact Lenses	Covered in full

ADDITIONAL SAVINGS AVAILABLE FROM IN-NETWORK PROVIDERS		In-network Member Cost (after any applicable copay)
Retinal Imaging	• At member's option can be performed at time of eye exam	Not more than \$39
Eyeglass lens upgrades	• Transitions® lenses (Adults)	\$75
When obtaining eyewear from a Blue View Vision provider, members may choose to upgrade their new eyeglass lenses at a discounted cost.	• Standard Polycarbonate (Adults)	\$40
Eyeglass lens copayment applies.	• Tint (Solid and Gradient)	\$15
	• UV Coating	\$15
	• Progressive Lenses	
	• Standard	\$65
	• Premium Tier 1	\$85
	• Premium Tier 2	\$95
	• Premium Tier 3	\$110
	• Anti-Reflective Coating	
	• Standard	\$45
	• Premium Tier 1	\$57
	• Premium Tier 2	\$68
Additional Pairs of Eyeglasses	• Other Add-ons and Services	20% off retail price
Anytime from any Blue View Vision network provider	• Complete Pairs	40% off retail price
	• Eyeglass materials purchased separately	20% off retail price
Eyewear Accessories	• Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc.	20% off retail price
Contact lens fit and follow-up	• Standard contact lens fitting	Up to \$55
Available following a comprehensive eye exam	• Premium contact lens fitting	10% off retail price
Conventional Contact Lenses	• Discount applies to materials only	15% off retail price
After covered benefits have been used		

Other discount offers on LASIK surgery and much more available through Anthem's SpecialOffers program

This information is intended to be a brief outline of plan benefits. The most detailed description of benefits, exclusions, and restrictions can be found in the Certificate of Coverage. Discounts are subject to change without notice. Laws in some states may prohibit network providers from discounting products and services that are not covered benefits under the plan.



## Delta Dental PPO (Point-of-Service)

### Summary of Dental Plan Benefits

**For Group# 0505-0007, 0100, 0110, 0135, 0150, 0160, 0200, 0210, 0211, 0222, 0272, 0300, 0460, 0485, 0500, 0600, 0750, 0760, 0770, 0790, 0900**  
**City of Greenwood**

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the dentist's network participation.\*

**Control Plan** – Delta Dental of Indiana

**Benefit Year** – April 1 through March 31

**Covered Services** –

	<b>Delta Dental PPO Dentist Plan Pays</b>	<b>Delta Dental Premier Dentist Plan Pays</b>	<b>Nonparticipating Dentist Plan Pays*</b>
<b>Diagnostic &amp; Preventive</b>			
<b>Diagnostic and Preventive Services</b> – exams, cleanings, fluoride, and space maintainers	100%	100%	100%
<b>Sealants</b> – to prevent decay of permanent teeth	100%	100%	100%
<b>Brush Biopsy</b> – to detect oral cancer	100%	100%	100%
<b>Radiographs</b> – X-rays	100%	100%	100%
<b>Basic Services</b>			
<b>Minor Restorative Services</b> – fillings and crown repair	80%	80%	80%
<b>Endodontic Services</b> – root canals	80%	80%	80%
<b>Periodontic Services</b> – to treat gum disease	80%	80%	80%
<b>Extractions</b> – removal of teeth	80%	80%	80%
<b>Major Restorative Services</b> – crowns	80%	80%	80%
<b>Other Basic Services</b> – misc. services	80%	80%	80%
<b>Major Services</b>			
<b>Emergency Palliative Treatment</b> – to temporarily relieve pain	50%	50%	50%
<b>Periodontal Maintenance</b> – cleanings following periodontal therapy	50%	50%	50%
<b>Other Oral Surgery</b> – dental surgery other than extractions	50%	50%	50%
<b>Relines and Repairs</b> – to bridges, implants, and dentures	50%	50%	50%
<b>Prosthodontic Services</b> – bridges, implants, and dentures	50%	50%	50%
<b>Orthodontic Services</b>			
<b>Orthodontic Services</b> – braces	50%	50%	50%
<b>Orthodontic Age Limit</b> –	No Age Limit	No Age Limit	No Age Limit

\* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. The Nonparticipating Dentist Fee may be less than what your dentist charges and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per benefit year.
- Prophylaxes (cleanings) are payable twice per benefit year.

- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Fluoride treatments are payable twice per benefit year with no age limit.
- Space maintainers are payable once per area per lifetime for people up to age 13.
- Bitewing X-rays are payable once per benefit year and full mouth X-rays (which include bitewing X-rays) are payable once in any four-year period.
- Sealants are payable once per tooth per lifetime for the occlusal surface of first and second permanent molars up to age 15. The surface must be free from decay and restorations.
- Composite resin (white) restorations are Covered Services on posterior teeth.
- Porcelain and resin facings on crowns are optional treatment on posterior teeth.
- Implants and implant related services are payable once per tooth in any five-year period.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

**Maximum Payment** – \$1,000 per person total per Benefit Year on all services, except oral exams, preventive services, X-rays, brush biopsy, sealants, and orthodontic services. \$1,000 per person total per lifetime on orthodontic services.

**Deductible** – None.

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

**Eligible People** – Any employee of the Contractor working at least 37.5 hours per week: Retiree (0007), Mayor's Office (0100), Fleet Maintenance (0110), Community Development Services (0135), Information Technology (0150), Human Resources (0160), Clerk (0200), Finance (0210), Airport (0211), Parks and Recreation (0222), Adult Probation (0272), City Court (0300), Fire Department (0460), Motor Vehicle Highway (0485), Board of Works (0500), Police Department (0600), Sanitation Billing (0750), Sanitation Field (0760), Waste Management (0770), Stormwater (0790), Law (0900) and COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) enrollees, if applicable. The Contractor pays the full cost of this plan.

Also eligible are your legal spouse and your children under age 26, including your children who are married, who no longer live with you, who are not your dependents for Federal income tax purposes, and/or who are not permanently disabled.

If you and your spouse are both eligible for coverage under this Contract, you may be enrolled together on one application or separately on individual applications, but not both. Your dependent children may only be enrolled on one application. Delta Dental will not coordinate benefits if you and your spouse are both covered under this Contract.

Benefits will cease on the last day of the month in which the employee is terminated.

Customer Service Toll-Free Number: (800) 524-0149 (TTY users call 711)  
[www.DeltaDentalIN.com](http://www.DeltaDentalIN.com)  
 February 12, 2016



March 8, 2016

Mr. Jon Pierre Fox  
Regions Insurance, Inc.  
PO Box 2224  
2701 Albright  
Kokomo, IN 46904-2224

Dear Mr. Fox,

Thank you for your continued support of Delta Dental. We value our relationship with you and your clients, and we appreciate your business. Please find enclosed a copy of the contract effective April 1, 2016 between Delta Dental and City of Greenwood, Client Number 0505-0007, 0100, 0110, etc.

Please review this contract with your client and return the signed contract to Delta Dental at your earliest convenience. If you have any questions or concerns, please contact me at (317) 348-1820. The signed contract may be sent to my attention at:

Delta Dental  
Attn: Melinda L Tyo  
225 S. East Street, Suite 358  
Indianapolis, IN 46202

If we are not in receipt of the signed contract by the effective date, we will consider remittance of payment as acceptance of the contract, and we will begin administering the client's dental benefits accordingly. By permitting us to do so, your client accepts the terms of this contract in full and agrees that this contract is binding, even if you do not return a signed copy of the contract to us.

Again, thank you for your business. We look forward to providing your client with the best dental benefits programs and services available.

Sincerely,



Melinda L Tyo  
Account Manager

CC: Ms. Marilyn Allen





**Delta Dental Contract  
For  
City of Greenwood**

This renewal ("Contract") is entered into by and between City of Greenwood (the "Contractor") and Delta Dental Plan of Indiana, Inc., an Indiana non-profit corporation ("Delta Dental"). This is a legally binding contract between the Contractor and Delta Dental and is effective on April 1, 2016, the ("Effective Date"), replacing any previous Declarations, Section I, with the balance of such Contract continued as if fully set forth herein.

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***SECTION I - DECLARATIONS***

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The Benefits afforded are only with respect to such benefits as are indicated in this Contract, including the Summary of Dental Plan Benefits. Delta Dental's liability is limited to the Benefits stated herein; subject to all the terms of this Contract having reference thereto. This Declarations Section and the Summary of Dental Plan Benefits supersedes any contrary provision of the subsequent sections of this Contract.

- A. **Effective Date:** 12:01 A.M. Standard Time, April 1, 2016
- B. **First Renewal Date:** April 1, 2017
- C. **Client Number:** 0505-0007, 0100, 0110, 0135, 0150, 0160, 0200, 0210, 0211, 0222, 0272, 0300, 0460, 0485, 0500, 0600, 0750, 0760, 0770, 0790, 0900

D. **Rate(s):**

Subscriber only - \$33.97 per month per Subscriber  
Subscriber and spouse - \$73.92 per month per Subscriber  
Subscriber and child(ren) - \$81.30 per month per Subscriber  
Subscriber, spouse and child(ren) - \$121.61 per month per Subscriber

These rates are contingent upon the enrollment of a minimum of 95 percent of the eligible members of the defined group and their eligible dependents with 100 percent of the cost paid by the Contractor. Rates do not include any applicable claims taxes.

These rates assume that claims from nonparticipating dentists will be paid using our national out-of-network fee table.



LISA EDWARDS  
NOTARY PUBLIC - INDIANA  
COMMISSION #676216  
JOHNSON COUNTY  
MY COMM. EXP. JANUARY 31, 2024

**DELTA DENTAL PLAN OF INDIANA, INC.**

**CONTRACTOR**

BY: *Shana E. Galada*  
President and CEO

BY: *Markus Myers*  
(Authorized Signature)  
*Mayor*  
(Title)

BY: *Lisa Edwards*  
(Witnessed By)  
*Administrative Assistant*  
(Title)

DATE: March 8, 2016

DATE: 3-10-16



## Delta Dental PPO (Point-of-Service)

### Summary of Dental Plan Benefits

For Group# 0505-0007, 0100, 0110, 0135, 0150, 0160, 0200, 0210, 0211, 0222, 0272, 0300, 0460, 0485, 0500, 0600, 0750, 0760, 0770, 0790, 0900

### City of Greenwood

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<b>Major Services</b>			
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<b>Orthodontic Services</b> – braces	50%	50%	50%
<b>Orthodontic Age Limit</b> –	No Age Limit	No Age Limit	No Age Limit

\* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. The Nonparticipating Dentist Fee may be less than what your dentist charges and you are responsible for that difference.

➤ Oral exams (including evaluations by a specialist) are payable twice per benefit year.

- Prophylaxes (cleanings) are payable twice per benefit year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
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- Space maintainers are payable once per area per lifetime for people up to age 13.
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- Sealants are payable once per tooth per lifetime for the occlusal surface of first and second permanent molars up to age 15. The surface must be free from decay and restorations.
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- Implants and implant related services are payable once per tooth in any five-year period.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

**Maximum Payment** – \$1,000 per person total per Benefit Year on all services, except oral exams, preventive services, X-rays, brush biopsy, sealants, and orthodontic services. \$1,000 per person total per lifetime on orthodontic services.

**Deductible** – None.

**Waiting Period** – Employees who are eligible for dental benefits are covered on the date of hire.

**Eligible People** – Any employee of the Contractor working at least 37.5 hours per week: Retiree (0007), Mayor's Office (0100), Fleet Maintenance (0110), Community Development Services (0135), Information Technology (0150), Human Resources (0160), Clerk (0200), Finance (0210), Airport (0211), Parks and Recreation (0222), Adult Probation (0272), City Court (0300), Fire Department (0460), Motor Vehicle Highway (0485), Board of Works (0500), Police Department (0600), Sanitation Billing (0750), Sanitation Field (0760), Waste Management (0770), Stormwater (0790), Law (0900) and COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) enrollees, if applicable. The Contractor pays the full cost of this plan.

Also eligible are your legal spouse and your children under age 26, including your children who are married, who no longer live with you, who are not your dependents for Federal income tax purposes, and/or who are not permanently disabled.

If you and your spouse are both eligible for coverage under this Contract, you may be enrolled together on one application or separately on individual applications, but not both. Your dependent children may only be enrolled on one application. Delta Dental will not coordinate benefits if you and your spouse are both covered under this Contract.

Benefits will cease on the date of termination.

Customer Service Toll-Free Number:  
(800) 524-0149 (TTY users call 711)  
[www.DeltaDentalIN.com](http://www.DeltaDentalIN.com)  
April 1, 2016



American United Life Insurance Company<sup>®</sup>  
P.O. Box 368, Indianapolis, Indiana 46206-0368  
www.oneamerica.com

City of Greenwood  
(Hereinafter called the Group Policyholder)

Group Policy Number: 00611217-0000-000

Class: 001

Change Effective Date: Does Not Apply

This certificate replaces any and all certificates previously issued to You under the Group Policy indicated above.

American United Life Insurance Company<sup>®</sup> (AUL) certifies that the Employee whose enrollment form is on file with the Group Policyholder as being eligible for insurance and for whom the required premium has been paid is insured under the above numbered Group Policy for group insurance benefits as designated in the Schedule of Benefits. Benefits are subject to change as described on the Schedule of Benefits page.

This certificate describes the coverage provided in the Group Policy. The Group Policy determines all rights and benefits in this certificate and may be amended, cancelled or discontinued at any time by agreement between AUL and the Group Policyholder without notice to You. The Group Policy may be examined at the main office of the Group Policyholder during the regular office hours.

Thomas M. Zurek  
Secretary

Dayton H. Molendorp  
President and Chief Executive Officer

**CERTIFICATE OF INSURANCE  
GROUP TERM LIFE INSURANCE  
WITH AN ACCELERATED LIFE BENEFIT**

**NOTE: RECEIPT OF THE ACCELERATED LIFE BENEFIT MAY BE TAXABLE.  
PLEASE SEEK ASSISTANCE FROM A PERSONAL TAX ADVISOR.**

GC 2510NN

(Class 001)  
(Basic)  
(Dependent Coverage: Not Included)  
(ALB)



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**SECTION 1 - SCHEDULE OF BENEFITS  
BASIC INSURANCE**

CLASS 001

**CLASSIFICATION:**

All Eligible Full-Time Employees

**LIFE AMOUNT:**

\$15,000

**AD&D PRINCIPAL SUM:**

\$15,000

**ACCELERATED LIFE BENEFIT (ALB):** You may request payment of 25%, 50% or 75% of the Life Amount shown above. This benefit is available on a Life Amount of \$10,000 or more. The maximum payment is limited to 25%, 50% or 75% of the Life Amount shown above or \$11,250, whichever is less. See Section 13.

**ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT:** This benefit is included in this certificate. See Section 12.

**ADDITIONAL ACCIDENTAL DEATH BENEFITS:**

SEAT BELT BENEFIT: This benefit is included in this certificate. See Section 12A.

AIR BAG BENEFIT: This benefit is included in this certificate. See Section 12B.

REPATRIATION BENEFIT: This benefit is included in this certificate. See Section 12C.

CHILD HIGHER EDUCATION EXPENSE BENEFIT: This benefit is included in this certificate. See Section 12D.

CHILD CARE BENEFIT: This benefit is included in this certificate. See Section 12E.

**ANNUAL BASE SALARY:** Annual Base Salary with no Commissions or Bonuses. Annual Base Salary excludes overtime.

**CHANGES IN INSURANCE COVERAGE:** First of the Month. See Section 6.

**CONTRIBUTIONS:** Employee premium contributions are not required. See Section 4.

**ELIGIBILITY:** Immediate. See Section 3.

**FULL-TIME EMPLOYEE REQUIREMENT:** 37.5 hours or more per week. See Section 2, Definitions - Employee, and Section 3, Eligibility.

**SECTION 1 - SCHEDULE OF BENEFITS**  
**BASIC INSURANCE**

CLASS 001

**GUARANTEED ISSUE AMOUNT:** \$15,000. Any amount of coverage for which You request greater than the Guaranteed Issue Amount will only be available following written approval by AUL. Approval will be based on Evidence of Insurability and information satisfactory to AUL. If coverage for amounts greater than the Guaranteed Issue Amount is approved, coverage will begin on the date identified in writing by AUL. See Section 4, Individual Effective Date.

**INDIVIDUAL EFFECTIVE DATE:** Immediate. See Section 4.

**INDIVIDUAL REINSTATEMENTS:** Immediate. See Section 11.

**INDIVIDUAL TERMINATIONS:** End of the Month. See Section 9.

**REDUCTIONS:** Upon attainment of the age 65, the Life Amount and AD&D Principal Sum will reduce by 35%. Upon attainment of the age 70, the Life Amount and AD&D Principal Sum will reduce by 60% of the original amount. Upon attainment of the age 75, the Life Amount and AD&D Principal Sum will reduce by 75% of the original amount.

Reductions will be based upon the Life Amount prior to the payment of any Accelerated Life Benefit.

**TERMINATIONS:** Terminations are governed by the Individual Terminations Section. See Section 9.

**TOTAL DISABILITY:** The definition for Total Disability and Totally Disabled included in this certificate is the standard any occupation definition. See Section 2.

**WAITING PERIOD** for Present Employees hired before the policy effective date: Immediately following 0 days. See Eligibility Section 3.

**WAITING PERIOD** for New Employees hired on or after the policy effective date: Immediately following 0 days. See Eligibility Section 3.

**WAIVER OF PREMIUM FOR TOTAL DISABILITY:** This benefit is included in this certificate. Reductions are applicable to this benefit. See Section 8.

## **SECTION 2 – DEFINITIONS**

**ACCIDENTAL BODILY INJURY** means an injury occurring, either directly or indirectly, as a result of an accident along with all other related conditions, sustained by You while insured under the policy.

**ACTIVE WORK** and **ACTIVELY AT WORK** mean the use of time, services, and energy by You for the Group Policyholder at the Group Policyholder's regular place of business, an alternate location approved by the Group Policyholder, or an alternate location to which the Group Policyholder requires You to travel. You must be physically and mentally capable of performing each of the material and substantial duties of Your regular position with the Group Policyholder for at least the minimum number of hours listed in the Eligibility Section of the policy. Active Work will include time off for vacation, jury duty, paid holidays, and funeral leave approved by the Group Policyholder when You could have been Actively at Work. Active Work does not include periods of time when You are not Actively at Work following an injury, Accidental Bodily Injury, Sickness, strike, lock-out, layoff, after Your employment has ended voluntarily or involuntarily, or periods of time during which You are entitled or are receiving accrued employment related benefits including but not limited to vacation time.

**Annual Base Salary with no commission or bonuses**

**ANNUAL BASE SALARY** means Your yearly gross wages received from the Group Policyholder based on a maximum forty (40) hour workweek. Annual Base Salary is based on the amount last reported in writing to AUL by the Group Policyholder and approved for coverage under this Policy by AUL before the date of death or the events shown in the AD&D provisions if AD&D coverage is included. Annual Base Salary does not include amounts received from commissions, bonuses, overtime or reimbursement for expenses.

**BASIC LIVING EXPENSES** include the cost of food, shelter, clothing and any other basic living expenses of the average American household. Each household member need not contribute equally or jointly to the payment of these expenses as long as each agrees both are responsible for the basic living expenses.

**BI-WEEKLY** means every two weeks or 26 times a year.

**CHILD** means any minor related by blood, marriage or court order that can be claimed as a dependent for federal income tax purposes, and may include:

- 1) any of Your natural born child(ren);
- 2) any of Your legally adopted child(ren) from the time of placement in Your home with the intent to adopt;
- 3) any stepchild(ren) who live with You;
- 4) any child(ren) for whom You have legal guardianship; or
- 5) any child(ren) for whom coverage must be provided in accordance with state law or court order.

**CONTRIBUTORY INSURANCE** means insurance for which You pay part or all of the premium.



## **SECTION 2 - DEFINITIONS**

### **Continued**

**COVERAGE MONTH** means that period of time beginning on the first day that the Group Policyholder's coverage is in force and ending on the day before that date of the next month.

**DATE OF DISABILITY** means the first day You are not Actively at Work due to an Accidental Bodily Injury or Sickness and results in Total Disability.

**DEPENDENT** means:

- 1) Your legal spouse under age 70;
- 2) Your Domestic Partner under age 70 whose relationship with You is recognized by and allowed under applicable state law provided both the Domestic Partner and You:
  - a) share the same regular and permanent residence;
  - b) have a close personal relationship similar to lawful marriage;
  - c) have agreed to be jointly responsible for Basic Living Expenses, incurred during the domestic partnership;
  - d) are not married to anyone;
  - e) are 18 years of age and older;
  - f) are not so closely related by blood to be prohibited under applicable state laws;
  - g) were mentally competent to consent to a contract when the domestic partnership began;
  - h) are each other's sole domestic partner; and
  - i) are responsible for each other's welfare;
- 3) Your unmarried Child from live birth and under the age of 19, if the Child:
  - a) is not eligible under the policy for Personal Insurance;
  - b) is not in the military of any country; and
  - c) is dependent upon You for principal support and is claimed as a dependent on Your federal income tax return;
- 4) Your unmarried Child under the age of 25, if the Child:
  - a) is registered at and attending an accredited educational institution on a full-time basis as defined by the regulations of the institution, and
  - b) is dependent upon You for principal support and is claimed as a dependent on Your federal income tax return; and
- 5) Your unmarried Child who is disabled and incapable of self-sustaining employment as a result of mental or physical disability. The Child must have been disabled prior to age 19. If the Child is at least age 19 on Your effective date, coverage is subject to AUL's receiving written proof of the disability on that date including but not limited to receipt of Social Security Administration disability benefits. If the Child is not at least age 19, extension of coverage is subject to AUL's receiving written proof of the disability not later than 120 days after the Child attains age 19. Proof of continued disability shall be required not more than once each year thereafter.

If Dependent Insurance is not included in the policy, then references to Dependents and Dependent Insurance are null and void.

**DEPENDENT INSURANCE** means the insurance provided under the policy covering Your Dependents, Section 20, if included in the policy.

**ELIMINATION PERIOD** see Waiver of Premium, Section 8, if included in the policy.

## **SECTION 2 - DEFINITIONS**

### **Continued**

EMPLOYEE means any individual who is a full-time, permanent Employee (including owner, member, partner, or shareholder) of the Group Policyholder:

- 1) who is legally authorized to work and reside in the United States under applicable state and federal laws; and
- 2) whose employment with the Group Policyholder constitutes his principal occupation; and
- 3) who regularly works at that occupation at the Group Policyholder's regular place of business a minimum of 37.5 hours or more per week; and
- 4) who is not temporarily or seasonally employed by the Group Policyholder; and
- 5) who is an employee, participant, person, or any member of any employee organization, who is or may become eligible to receive a benefit of any type from the Policyholder's employee welfare benefit plan; and
- 6) who is not an independent contractor.

EMPLOYER see GROUP POLICYHOLDER. Any references to Employer used in the policy shall include Insured Units.

EVIDENCE OF INSURABILITY means a signed statement of proof acceptable to AUL of an Employee's or Dependent's medical history provided at no expense to AUL, and, if requested by AUL, medical records, tests, and/or examinations at no expense to AUL. Satisfactory Evidence of Insurability must include information and documentation which can be used by AUL to determine if the individual is an acceptable underwriting risk and can be approved for coverage under AUL's guidelines.

GRANDFATHERED RETIREE, see Eligibility, Section 3A, if included in the policy.

GUARANTEED ISSUE AMOUNT means the amount of coverage that does not require Evidence of Insurability. This amount is selected by the Group Policyholder on the Application and later approved in writing by AUL.

GROUP POLICYHOLDER means the entity which applied for and was approved by AUL for coverage. Any references to Group Policyholder used in the policy shall include Insured Units.

MENTAL ILLNESS means a psychiatric or psychological condition classified in the most recent version of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM), published by the American Psychiatric Association as of the date of Total Disability and has been diagnosed by a Physician. Such disorders include, but are not limited to, psychotic, emotional, behavioral disorders, or disorders related to stress or to substance abuse or dependency. If the DSM is discontinued or replaced, Mental Illness will be determined based on the diagnostic manual then published by the American Psychiatric Association on the date of Total Disability.

NON-CONTRIBUTORY INSURANCE means insurance for which You pay no portion of the premium.

PERMANENT AND TOTAL DISABILITY/PERMANENTLY AND TOTALLY DISABLED means Your inability as determined by a Physician to engage, due to Accidental Bodily Injury or Sickness in any occupation for which You are fitted by training, education or experience. Permanent and Total Disability/Permanently and Totally Disabled must occur after You become insured under the Policy and it must be conclusively determined the Permanent And Total Disability will continue for Your lifetime.

## **SECTION 2 - DEFINITIONS**

### **Continued**

**PERSONAL INSURANCE** means the insurance provided under the policy for You.

**PHYSICIAN** means a qualified, licensed doctor of medicine or osteopathy, and any other licensed health care provider that state law requires to be licensed prior to engaging in the practice of medicine and who is, practicing within the scope of his specialty, license, and applicable law. Physician does not include any medical provider affiliated with the Group Policyholder, or anyone related by blood, marriage, or domestic partnership to an Employee.

**REGULAR ATTENDANCE** means that You or Your Dependent:

- 1) are receiving periodic medical treatment and services from a Physician when medically required and according to standard medical protocol to effectively manage and treat Your or Your Dependent's Disability;
- 2) are receiving the most appropriate treatment and care that will maximize Your medical improvement and aid in Your return to work; and
- 3) are receiving medical care and services from a Physician whose specialty or practice is related to the Disability.

**RETIREE** means an individual who, on his last day of Active Work prior to retirement, was an Actively at Work Employee and who is receiving benefits under the Group Policyholder's retirement plan. Retiree does not include an Employee who is receiving benefits under his retirement plan solely due to being Totally Disabled and who otherwise does not meet the Group Policyholder's retirement plan's criteria for receipt of benefits.

**SICKNESS** means illness, bodily disorder or disease, Mental Illness, normal pregnancy and complications of pregnancy. Complication of Pregnancy is defined as concurrent disease or abnormal conditions significantly affecting the usual medical management of pregnancy.

**TEMPORARY LAY-OFF** means a period of time during which You are not Actively at Work due to lack of work and are not terminated from employment with the Group Policyholder.

**TOTAL DISABILITY AND TOTALLY DISABLED** mean that because of Accidental Bodily Injury or Sickness You cannot engage in any occupation for which You are reasonably fitted by training, education, or experience. If You accept any type of employment, other than in a state-approved rehabilitation program or sheltered workshop, You will be considered fitted to that occupation.

**WE, OUR, US, and AUL** mean American United Life Insurance Company®.

**YOU and YOUR** means an Employee who meets the requirements of the Eligibility and Individual Effective Date Sections.

### **SECTION 3 - ELIGIBILITY**

#### **DEFINITIONS**

**NEW EMPLOYEE** means an Employee who is employed by the Group Policyholder on or after the Group Policyholder's Effective Date.

**PRESENT EMPLOYEE** means an Employee who is employed by the Group Policyholder before the Group Policyholder's Effective Date.

**WAITING PERIOD** means the period of days beginning on the Employee's hire date that an Employee must be continuously Actively at Work prior to becoming eligible for Personal Insurance. Present Employees will be given credit for time insured under the Group Policyholder's prior group life insurance contract if the policy replaces the same coverage available under the prior group life insurance contract. The Waiting Period is stated in the Schedule of Benefits.

On the effective date of the policy, an Employee becomes eligible for Personal Insurance if:

- 1) the Employee has fulfilled the Waiting Period, if any, and is Actively at Work; or
- 2) the Employee has fulfilled the Waiting Period, if any, and is not Actively at Work due to being on an Employer-approved leave of absence other than for injury or Sickness; or
- 3) the Employee has fulfilled the Waiting Period, if any, and is not Actively at Work due to being on Temporary Lay-off.

After the effective date of the policy and while the policy is in force, an Actively at Work Employee becomes eligible for Personal Insurance on the date following completion of the Waiting Period, if any.

**TO REMAIN ELIGIBLE FOR PERSONAL INSURANCE AND DEPENDENT INSURANCE, IF ANY, EMPLOYEES MUST CONTINUOUSLY MEET THE ABOVE REQUIREMENTS.**

*Refer to Your Basic Schedule of Benefits to determine to which coverage this page applies. When applicable, the Schedule of Benefits will indicate employee premium CONTRIBUTIONS are not required and INDIVIDUAL EFFECTIVE DATE is Immediate.*

#### **SECTION 4 - INDIVIDUAL EFFECTIVE DATE NON-CONTRIBUTORY INSURANCE**

The eligible Employee, prior to receiving coverage under the policy must make written election on a form approved by AUL and the Employer must contribute the required amount of premium to AUL on a timely basis.

For amounts of coverage that do not exceed the Guaranteed Issue Amount shown in the Schedule of Benefits, the effective date for an eligible Employee is the date the Employee becomes eligible.

To receive any amount of coverage exceeding the Guaranteed Issue Amount, the eligible Employee must make written request to AUL on a form approved by AUL and undergo medical underwriting. The effective date of insurance for an eligible Employee, subject to the further provisions of this Section, will be after the Employee submits satisfactory Evidence of Insurability to AUL and on the date AUL determines the Employee is approved for coverage. Satisfactory Evidence of Insurability, at no expense to AUL, must be provided prior to receiving any amount of coverage greater than the Guaranteed Issue Amount.

If an eligible Employee desires to decline coverage for which the Employer would pay 100% of the premium, the Employee must first notify the Employer in writing of this decision prior to coverage being declined. Once coverage is declined, the Employer is not responsible for paying premium for that Employee, and the Employee will not be eligible for any coverage under the policy. If an eligible Employee initially declines coverage and later desires to have coverage, the Employee will be required to undergo medical underwriting and submit satisfactory Evidence of Insurability at no expense to AUL prior to receiving any coverage. No coverage shall begin until the date AUL has approved the request for coverage in writing and the required amount of premium is received from the Employer.

Any eligible Employee who converted his insurance under the policy to an individual life insurance policy and if that individual life insurance policy is still in force, the Employee is required prior to becoming insured again under the policy to undergo medical underwriting and submit satisfactory Evidence of Insurability, at no expense to AUL. If the Employee does not wish to undergo medical underwriting and submit satisfactory Evidence of Insurability, the Life Amount under the policy will be reduced by the amount of coverage under the individual life insurance policy. No coverage shall begin until the date AUL has approved the request for coverage in writing and the required amount of premium is received from the Employer.

If an Employee is not Actively at Work on the date coverage would otherwise become effective, the effective date will be the date the eligible Employee returns to Active Work.

Contributions for Basic insurance are not required from Employees for Personal Insurance.

Also see Continuity of Coverage, Section 5, if included in the policy.



## **SECTION 5 - CONTINUITY OF COVERAGE**

This Section applies when coverage under the policy replaces prior group term life insurance issued to the Group Policyholder and the coverage under that policy terminated on the day before the effective date of AUL's policy.

Coverage will be extended under this Section to an Employee who:

- 1) was insured under the prior carrier's group term life insurance on its termination date; but
- 2) was not eligible for coverage on the effective date of the policy because:
  - a) in the case of an Employee, he was not Actively at Work.

Coverage may be extended if such Employee:

- 1) applies to AUL for coverage on or before the effective date of the policy;
- 2) pays the required amount of premium; and
- 3) is not eligible to continue coverage under the prior carrier's group term life insurance.

The amount of coverage extended will be the lesser of:

- 1) the coverage for which the Employee would have been eligible to receive under the policy; or
- 2) the coverage the Employee received under the prior carrier's group term life insurance policy minus the amount payable under that group term life policy.

The coverage under this Section will terminate on the earliest of the following dates:

- 1) the date for which any required premium was not received by AUL;
- 2) the date the Personal Insurance becomes effective under the policy;
- 3) the date the coverage would have terminated under the Individual Termination Section of the policy if the Personal Insurance had become effective; or
- 4) the date the Employee becomes eligible for coverage under the prior carrier's group term life insurance policy.

This coverage only includes the Life Amount.

## **SECTION 6 - CHANGES IN INSURANCE COVERAGE**

The amount of coverage for which You are eligible is shown in the Schedule of Benefits.

A change in coverage that does not increase the amount of coverage becomes effective the earlier of:

- 1) the first day of the Coverage Month following any scheduled reduction; or
- 2) the first day of the Coverage Month following AUL's written approval of the change.

Prior to a change in coverage that increases coverage, You must be Actively at Work and the required amount of premium must be paid.

A change increasing the amount of coverage equal to or less than Your Guaranteed Issue Amount takes effect on:

- 1) the first day of the Coverage Month if You become eligible for the change on the first day of the Coverage Month;  
or
- 2) the first day of the next Coverage Month following the date You become eligible for the change, if the date is after the first day of the Coverage Month.

A change in coverage increasing the amount of coverage above Your Guaranteed Issue Amount is subject to:

- 1) satisfactory Evidence of Insurability, at no expense to AUL; and
- 2) takes effect on the first day of the Coverage Month, following AUL's written approval of the change.

If You are not Actively at Work on the effective date of the approved increase, any increase in the amount of coverage takes effect on:

- 1) the first day of the Coverage Month, if You return to work on the first day of the Coverage Month; or
- 2) the first day of the Coverage Month following Your return to Active Work, if the date is after the first day of the Month.

## **SECTION 7 - CONTINUATION OF INSURANCE**

### **CONTINUATION OF INSURANCE**

While the policy is in force and if You have ceased Active Work due to:

- 1) Sickness or injury, Personal Insurance may be continued until 6 months following cessation of Active Work;
- 2) Temporary Lay-off, Personal Insurance may be continued until the 90th day following cessation of Active Work;
- 3) an Employer-approved leave of absence, Personal Insurance may be continued until the 90th day following cessation of Active Work; or
- 4) an Employer-approved leave of absence allowed under the Family and Medical Leave Act (FMLA) or state law. Personal Insurance may then be continued until the end of the period allowed under FMLA or state law, whichever is longer.

In all the above Continuation of Insurance situations, Personal Insurance will terminate on the earliest of the following:

- 1) the date You return to Active Work;
- 2) the date the required premium payments are not received by AUL;
- 3) the date You die;
- 4) the date You begin full or part-time employment;
- 5) the date the policy, or the Group Policyholder's coverage under the policy, terminates;
- 6) the date You notify the Group Policyholder that You will not be returning to Active Work;
- 7) the date Your class is no longer offered under the policy;
- 8) the date You are no longer a member in an eligible class;
- 9) the date You make written request for termination of coverage but not prior to the date of the request; or
- 10) the date You enter military service for any country, except for temporary duty not scheduled for more than 30 days.

If the Group Policyholder has approved more than one type of leave of absence during any one period, AUL will consider such leaves to be concurrent for the purpose of determining how long Your coverage may continue under the policy.

If You do not return to Active Work, Personal Insurance terminates at the end of Continuation of Insurance period. At the end of Continuation of Insurance period, You may apply, if eligible, for Waiver of Premium for Total Disability, see Section 8, if available; or may be eligible to apply to convert the Life Amount to an individual life insurance policy pursuant to Section 10.

## **SECTION 8 - WAIVER OF PREMIUM FOR TOTAL DISABILITY**

This Section applies to Basic Life Insurance.

### **DEFINITIONS**

**ELIMINATION PERIOD** means a 6 month period of consecutive days of Total Disability. The Elimination Period begins on the 1st day of Total Disability and ends on the last day of the 6 month period. You may not have more than three (3) days of Active Work during the Elimination Period.

### **WAIVER OF PREMIUM BENEFIT FOR TOTAL DISABILITY**

AUL will waive further premium payments for Your Life Amount if You:

- 1) become Totally Disabled before age 60 and while insured under the policy;
- 2) remain continuously Totally Disabled during the 6 month Elimination Period;
- 3) submit and AUL receives proof of Total Disability within the three (3) months prior to the end of the Elimination Period;
- 4) submit and AUL receives acceptable proof of continuous Total Disability at least annually and as requested by AUL; and
- 5) are under the Regular Attendance of a Physician.

AUL also may require that You be examined:

- 1) at AUL's expense;
- 2) by a Physician of AUL's choice.

The required amount of premium must continue to be received by AUL until AUL approves the request for Waiver of Premium Benefit for Total Disability and the Elimination Period has been fulfilled.

While You meet the conditions set forth above and are approved by AUL for the benefit, You will retain coverage without the need to make further premium payments until the first of the following occurs:

- 1) proof of Total Disability is not received by AUL;
- 2) You become employed, or are found able to be employed in an occupation for which You are reasonably fitted by training, education or experience;
- 3) You refuse to undergo a medical examination requested by AUL;
- 4) the date You are not under the Regular Attendance of a Physician;
- 5) proof of continuous Total Disability is not submitted within the twelfth month of any benefit period unless it was not possible to do so;
- 6) You attain the Full Retirement Age pursuant to Social Security Administration regulations; or
- 7) Your class terminates; or
- 8) You are no longer Totally Disabled.

## **SECTION 8 - WAIVER OF PREMIUM FOR TOTAL DISABILITY**

### **Continued**

Any Accidental Death and Dismemberment Insurance will continue until the earliest of the following dates:

- 1) the date of the final benefit determination by AUL;
- 2) 6 months following the Date of Disability; or
- 3) the date the required amount of premium was not received by AUL.

When You are approved for benefits under this Waiver of Premium Benefit for Total Disability, the coverage in force under the policy will be the Life Amount and:

- 1) will not include any Accidental Death and Dismemberment coverage You may have had; and
- 2) will reduce if:
  - a) the coverage for Your class is reduced; or
  - b) the Schedule of Benefits includes an automatic reduction for all Employees in Your class at a certain age.



## **SECTION 8 - WAIVER OF PREMIUM FOR TOTAL DISABILITY**

### **Continued**

Life and Accidental Death and Dismemberment Insurance premiums must be paid to and received by AUL during the Waiver of Premium Benefit for Total Disability Elimination Period. If the benefit request is approved, any unearned premium beyond the Elimination Period will be refunded.

If You are not approved for this benefit, You may apply to convert Your Life Amount to an individual life insurance policy pursuant to Section 10, Conversion Privilege within 31 days from notice of the adverse benefit determination. If You did not pay premiums during the Elimination Period, You are not eligible to convert Your coverage to an individual life insurance policy upon notice of an adverse benefit determination.

If You die during the Elimination Period and the required amount of premiums were not received by AUL, no benefit will be due under the policy.

If coverage under the Waiver of Premium Benefit for Total Disability terminates, You are entitled to apply to convert Your Life Amount to an individual life insurance policy within 31 days of cessation of such coverage pursuant to Section 10, Conversion Privilege.

If coverage under the Waiver of Premium Benefit for Total Disability terminates because You return to Active Work with the Group Policyholder and the policy is still in force, You are eligible to apply for all coverages available to Your class.

If benefits are payable under the policy after You are approved for Waiver of Premium and You have applied and been issued an individual life insurance policy under Section 10, Conversion Privilege, any amount payable under the policy will be reduced by the amount payable under the individual life insurance policy. **IN NO EVENT WILL A BENEFIT BE PAYABLE UNDER BOTH THE INDIVIDUAL LIFE INSURANCE POLICY AND THE POLICY GREATER THAN THE LIFE AMOUNT, NOR WILL ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS, IF ANY, BE PAYABLE BEYOND THE WAIVER OF PREMIUM BENEFIT FOR TOTAL DISABILITY ELIMINATION PERIOD.**

## **SECTION 9 - INDIVIDUAL TERMINATIONS**

Personal Insurance terminates on the earliest of the following dates:

- 1) the date the policy is terminated;
- 2) the last day of the Coverage Month in which You request termination but not prior to the date of the request;
- 3) the last day of the Coverage Month for which any required premium payment was not received by AUL;
- 4) the last day of the Coverage Month during which You cease to be eligible, see Eligibility, Section 3 and Section 3A, if any;
- 5) the last day of the Coverage Month during which You become a Retiree, unless the Schedule of Benefits includes a specific classification for Retirees;
- 6) the last day of the Coverage Month during which You enter active military service for any country except for temporary duty of 30 days or less;
- 7) the last day of the Coverage Month during which You cease Active Work, except for an event listed in the policy in Continuation of Insurance, Section 7; or
- 8) the date of an adverse benefit determination under the Waiver of Premium provisions, if applicable.

Accidental Death and Dismemberment coverage terminates when Personal Insurance terminates. Accidental Death and Dismemberment coverage also terminates on the earliest of the following dates:

- 1) the date of an adverse or positive benefit determination under the Waiver of Premium Benefit provisions;
- 2) the last day of the Coverage Month during which You become a Retiree, unless the Schedule of Benefits includes a specific classification for Retirees that includes AD&D Principal Sum Amounts;
- 3) the date Your Life Amount reduces to zero; or
- 4) the end of the Elimination Period.

## **SECTION 10 - CONVERSION PRIVILEGE**

If Your coverage, or a portion of it, terminates because You are no longer eligible for coverage under the policy, You may apply for an individual life insurance conversion policy without evidence of insurability. The coverage amount of the individual life insurance conversion policy shall not exceed the amount of life insurance that ceases because of loss of eligibility for coverage under the policy minus the amount of any group life coverage for which You become eligible within 31 days of termination.

If Your coverage ceases due to termination of the policy, You may apply for and receive an individual life insurance conversion policy if Your group life insurance has been in force with AUL for five (5) continuous years before the termination date. The coverage amount of the individual life insurance conversion policy may not exceed the LESSER of:

- 1) the amount of life insurance that ceases because of termination minus the amount of any group life coverage for which You become eligible within 31 days of termination; or
- 2) \$10,000.

The conversion privilege is subject to the following:

- 1) Written application must be made and the first premium must be paid within 31 days after the date of termination of insurance.
- 2) An individual life insurance policy, other than term life insurance, offered by AUL at the time of conversion, may be selected.
- 3) The premium on the individual policy must be at AUL's then customary rate applicable to the form and amount of the individual policy, to the class of risk to which You or Your dependent then belong, and to the individual age attained by You or Your dependent on the effective date of the individual policy.
- 4) The individual life insurance conversion policy takes effect on the last day of the application period and is in lieu of all benefits under the Policy.

If notice of the existence of the conversion right is not given at least 15 days before the expiration of the period during which the conversion application and payment of the first premium must be made under the terms of the policy, You have an additional period within which to exercise the conversion right. The additional conversion application period created to exercise a right of conversion expires 15 days after You are given notice of the conversion right. However, irrespective of the date on which notice is given or of the absence of any notice, the additional conversion application period may not extend beyond 60 days after the expiration date of the period within which conversion application period and payment of the first premium were to be made under the terms of the policy. For purposes of this section, notice of the right of conversion may be given to You in writing, presented to You; mailed by the Group Policyholder to Your last known address; or mailed by the insurer to Your last known address as furnished by the Group Policyholder.

If death occurs during the conversion application period, AUL will pay the Life Amount available for conversion whether or not the application or the first premium payment has been made. After the 31-day period, no conversion application will be accepted unless it is proven that it was not possible for You to apply in a timely fashion. The individual life insurance conversion policy will not include Accidental Death benefits or any other benefits currently in force under the policy.

Premium must be paid to and received by AUL for coverage during the conversion application period.

**IF DEATH OCCURS DURING THE CONVERSION APPLICATION PERIOD, IN NO EVENT WILL BENEFITS BE PAYABLE UNDER BOTH THE INDIVIDUAL CONVERSION POLICY AND THE POLICY. ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS, IF ANY, ARE NOT PAYABLE BEYOND THE DATES OUTLINED IN SECTION 9, INDIVIDUAL TERMINATIONS.**

## **SECTION 11 - INDIVIDUAL REINSTATEMENTS**

If Personal Insurance and Dependent Insurance, if any, terminate due to termination of Your employment, You can apply to reinstate that coverage following return to Active Work. The following conditions apply:

- 1) When return to Active Work occurs within 30 days of the termination of coverage, coverage becomes effective on the date of return to Active Work. Evidence of Insurability will not be required for any amount of coverage less than the Guaranteed Issue Amount.
- 2) When return to Active Work occurs after the period specified in paragraph 1 above, You will be considered a new employee and the requirements found in the Eligibility and Individual Effective Date Sections will apply.
- 3) When the Life Amount has been converted under the Conversion Privilege, Section 10, the Life Amount available for reinstatement under the policy will be reduced by the amount of coverage under the individual life insurance policy. In no event will the amount of coverage reinstated under this Section and the amount of coverage under the individual life insurance policy be greater than the Life Amount existing on Your termination of employment.
- 4) Prior to applying for reinstatement, AUL must have received the required amount of premium timely.
- 5) The maximum amount of coverage reinstated will not exceed the maximum amount of coverage which would have been available had Your coverage not terminated.

If reinstatement is requested for any reason other than returning to Active Work, medical underwriting and satisfactory Evidence of Insurability, at no expense to AUL, will be required prior to AUL's approval of coverage. The effective date of reinstatement will be the date determined by AUL in writing. Dependent Insurance cannot be reinstated without reinstatement of Personal Insurance.

## **SECTION 12 - ACCIDENTAL DEATH AND DISMEMBERMENT**

This Section applies to Basic Accidental Death Insurance.

### **DEFINITIONS**

**ACCIDENTAL DEATH** means death due to an accident, directly and independently of all other causes.

**ADDITIONAL ACCIDENTAL DEATH BENEFITS** mean the Seat Belt Benefit, the Air Bag Benefit, the Repatriation Benefit, the Child Higher Education Benefit and the Child Care Benefit. The total of the Additional Accidental Death Benefits payable will not exceed 100% of Your AD&D Principal Sum shown in the Schedule of Benefits.

**ACCIDENTAL DISMEMBERMENT** means loss of sight, speech or hearing or severance of a body member, Loss of Use of a limb of the body, or Severe Burn due to an accident, directly and independently of all other causes.

**AIR BAG** means an inflatable restraint device that is activated in an Automobile accident and

- 1) was installed by the Automobile manufacturer;
- 2) is not altered after the original installation by the Automobile manufacturer;
- 3) is functioning properly; and
- 4) complies with Federal Motor Vehicle Safety Standard Number 208 (49 C.F.R. Section 571.208) for the make, model and year of the Automobile.

**AUTOMOBILE** means a motor vehicle properly registered with local authorities and permitted under applicable laws for use on highways.

**CHILD** - see SECTION 2, DEFINITIONS.

**LOSS OF SIGHT** means total, permanent blindness.

**LOSS OF SPEECH** means total, permanent and irrecoverable loss of vocal communication.

**LOSS OF HEARING** means total, permanent deafness in both ears which cannot be restored by any means.

**LOSS OF HAND** means complete severance of the hand through or above the wrist.

**LOSS OF THUMB AND INDEX FINGER** means complete severance of both the thumb and index finger at or above the metacarpophalangeal joints on the same hand.

**LOSS OF FOOT** means complete severance of the foot through or above the ankle.

**LOSS OF USE OF UPPER AND LOWER LIMBS OF THE BODY** means a total, permanent and irrecoverable loss of voluntary movement of the upper and lower limbs of the body which has continued for 12 continuous months.

**LOSS OF USE OF BOTH LOWER LIMBS OF THE BODY** means a total, permanent and irrecoverable loss of voluntary movement of both lower limbs of the body which has continued for 12 continuous months.

**LOSS OF USE OF UPPER AND LOWER LIMBS ON ONE SIDE OF THE BODY** means a total, permanent and irrecoverable loss of voluntary movement of the upper and lower limbs on one side of the body which has continued for 12 continuous months.



## **SECTION 12 - ACCIDENTAL DEATH AND DISMEMBERMENT**

### **Continued**

**LOSS OF USE OF ONE LIMB OF THE BODY** means a total, permanent and irrecoverable loss of voluntary movement of one limb of the body which has continued for 12 continuous months.

**HEMIPLEGIA** means the total, permanent and irrecoverable paralysis of the upper and lower limbs on the same side of the body which has continued for 12 continuous months.

**MONOPLEGIA** means the total, permanent and irrecoverable paralysis of one limb of the body which has continued for 12 continuous months.

**PARAPLEGIA** means the total, permanent and irrecoverable paralysis of both lower limbs of the body which has continued for 12 continuous months.

**QUADRIPEGIA** means the total, permanent and irrecoverable paralysis of both upper and lower limbs of the body which has continued for 12 continuous months.

**SEAT BELT** means a properly installed safety belt meeting the standards stated in the Federal Motor Vehicle Safety Standard Number 208 (49 C.F.R. Section 571.208) for the make, model, and year of the Automobile.

**SEVERE BURNS** means third-degree burns on at least fifty percent of the body.

## SECTION 12 - ACCIDENTAL DEATH AND DISMEMBERMENT

### Continued

#### ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

If You have an accident while insured under the policy which results in a loss or condition shown below, AUL will pay the amount shown opposite the loss or condition if:

- 1) the loss or condition occurs within 365 days from the date of the accident; and
- 2) AUL receives acceptable proof of loss or condition.

FOR ACCIDENTAL LOSS OF	AMOUNT PAYABLE
Life	AD&D Principal Sum
Both Hands or Both Feet or Sight of Both Eyes	AD&D Principal Sum
Speech and Hearing	AD&D Principal Sum
One Hand and One Foot	AD&D Principal Sum
One Hand and Sight of One Eye	AD&D Principal Sum
One Foot and Sight of One Eye	AD&D Principal Sum
Sight of One Eye	One-half of the AD&D Principal Sum
One Hand or One Foot	One-half of the AD&D Principal Sum
Speech or Hearing	One-half of the AD&D Principal Sum
Thumb and Index Finger	One-quarter of the AD&D Principal Sum
FOR CONDITIONS OF	
Quadriplegia or Loss of Use of Upper and Lower Limbs of the Body	AD&D Principal Sum
Paraplegia or Loss of Use of Both Lower Limbs of the Body	One-half of the AD&D Principal Sum
Hemiplegia or Loss of Use of Upper and Lower Limbs on the Same Side of the Body	One-half of the AD&D Principal Sum
Monoplegia or Loss of Use of One Limb of the Body	One-quarter of the AD&D Principal Sum
Severe Burns	AD&D Principal Sum

The AD&D Principal Sum is shown in the Schedule of Benefits.

AUL will only pay a benefit for either paralysis or loss of a limb, but not a benefit for both

The total amount payable will never exceed the AD&D Principal Sum for all losses or conditions sustained by You. The amount payable for loss of life is paid according to Payment of Death Benefits, Section 15. Amounts payable for other losses are paid to You.

## **SECTION 12 - ACCIDENTAL DEATH AND DISMEMBERMENT**

### **Continued**

#### **LIMITATIONS**

Benefits are not payable for loss due directly or indirectly to:

- 1) suicide or attempted suicide, whether sane or insane;
- 2) air travel as a crew member;
- 3) participation in a riot or from war or an act of war, whether declared or undeclared;
- 4) caused or contributed to by the insured's commission of or attempt to commit a criminal act under relevant state law;
- 5) the voluntary taking of:
  - a) a prescription drug in a manner other than as prescribed by a Physician;
  - b) any other federally- or state-regulated substance in an unlawful manner;
  - c) non-prescription medicine, in a manner other than as indicated in the printed instructions; or
  - d) poison;
- 6) the voluntary inhaling of gas (unless due to occupational accident);
- 7) Sickness other than infection occurring as a result of accidental injury;
- 8) voluntary use of alcohol resulting in intoxication above the legal limit;
- 9) voluntary use of a hallucinogen or substance causing intoxication;
- 10) operating a vehicle while intoxicated above the legal limit or while under the influence of hallucinogen or substance causing intoxication;
- 11) violation of traffic laws other than an infraction, racing, stunt-driving, or engaging in other similar activity during the accident; or
- 12) participation in hang-gliding, bungee jumping, skydiving, rock climbing or mountain climbing.

Notice and Proof of Injury/Accidental Death: AUL's Home Office must receive written notice of the injury/Accidental Death on which the claim is based within 31 days of the date of the accident. AUL's Home Office must receive acceptable proof of loss within 90 days after the date of the loss. Acceptable proof of loss must be furnished as follows:

- 1) A certified death certificate;
- 2) A complete and accurate AUL death claim form and if available, a copy of the police, autopsy, and medical reports related to the death;
- 3) A statement by the Group Policyholder certifying the amount of coverage existing on the date of loss; and
- 4) At AUL's option, other documents or information as needed to investigate the loss and determine whether or not benefits are payable under the policy.

AUL has the right to examine You:

- 1) as often as necessary;
- 2) at AUL's expense; and
- 3) by a medical professional of AUL's choice.

**SECTION 12 - ACCIDENTAL DEATH AND DISMEMBERMENT**  
**Continued**

**TERMINATION OF ACCIDENTAL DEATH and DISMEMBERMENT BENEFIT**

Accidental Death and Dismemberment coverage for You will terminate as outlined in Section 9, Individual Terminations.

The Group Policyholder may terminate the insurance under this Section at the end of any Coverage Month by giving AUL 31 days prior written notice.

AUL may terminate the insurance under this Section at the end of any Coverage Month by giving 31 days prior notice to the Group Policyholder.

**AUL WILL STILL BE LIABLE FOR PAYMENT OF VALID CLAIMS INCURRED BEFORE THE TERMINATION DATE.**

**THIS COVERAGE AND ANY BENEFITS UNDER THIS SECTION ARE NOT AVAILABLE DURING THE CONVERSION APPLICATION PERIOD, DURING THE ELIMINATION PERIOD, OR WHILE ELIGIBLE FOR BENEFITS UNDER THE WAIVER OF PREMIUM PROVISIONS.**

## **SECTION 12 - ACCIDENTAL DEATH AND DISMEMBERMENT**

### **EXPOSURE**

If You are unavoidably exposed to heat or cold as a direct result of a covered accident, and as a direct result of the exposure, You suffer a loss for which benefits would be payable under this Section, an AD&D benefit will be paid. Any loss associated with exposure to heat or cold must occur within 365 days of the accident.

The total amount payable will never exceed the AD&D Principal Sum for all losses sustained by You.

This provision is subject to the further limitations and provisions of this Section 12.

### **DISAPPEARANCE**

If You are an occupant in a vessel, vehicle, or plane at the time of accidental destruction, sinking, or disappearance of the vessel, vehicle, or plane and Your body cannot be found within one year of the date of the accidental destruction, sinking, or disappearance, You will be presumed to have died. AUL will only presume Accidental Death if:

- 1) there is no evidence to the contrary;
- 2) there is a determination by the appropriate governmental authorities or court issuing a valid and legally binding determination that You have died;
- 3) a certified copy of the governmental authority findings or court order is provided to AUL; and
- 4) benefits would have been paid assuming a death certificate could have been issued if the body was recovered.

If You are later determined not to have died following AUL's payment of any benefits under the policy, the individuals and entities which received any portion of the amounts paid by AUL will immediately return all amounts received upon receiving information indicating You are alive.

If You are later located after AUL has paid an Accidental Death benefit, any other benefit that may be payable under the policy will be reduced by the amount of any benefit already paid.

Coverage under the policy must exist with AUL at the time of Accidental Death. The total amount payable will not exceed the AD&D Principal Sum. This provision is subject to further limitations and provisions of Section 12.



**SECTION 12 - ACCIDENTAL DEATH AND DISMEMBERMENT**  
**SECTION 12A - SEAT BELT BENEFIT**

This Section applies to Basic Accidental Death Insurance.

**SEAT BELT BENEFIT**

AUL will pay an Additional Accidental Death Benefit if You die as a result of a non-occupational Automobile accident while You are properly wearing a Seat Belt at the time of the accident. The following rules apply:

- 1) The Seat Belt Benefit equals the lesser of:
  - a) 10% of Your AD&D Principal Sum shown in the Schedule of Benefits; or
  - b) \$25,000.
- 2) AUL must receive satisfactory written proof that Your death resulted from an Automobile accident and that You were properly wearing a Seat Belt at the time of the accident. A copy of all police reports must be submitted with the claim, and must show conclusively the Seat Belt was properly worn.
- 3) This benefit will not be paid if You, while operating the Automobile, were legally intoxicated as defined by applicable laws, violating traffic laws other than an infraction, racing, stunt-driving, or engaging in other similar activity during the accident.

In no event will the total of all Additional Accidental Death Benefits payable exceed 100% of Your AD&D Principal Sum.

In addition to the above limitations, this benefit is subject to the further limitations and provisions of this Section 12.

**SECTION 12 - ACCIDENTAL DEATH AND DISMEMBERMENT**  
**SECTION 12B - AIR BAG BENEFIT**

This Section applies to Basic Accidental Death Insurance.

**AIR BAG BENEFIT**

AUL will pay an Additional Accidental Death Benefit if You die as a result of a non-occupational Automobile accident while You are properly wearing a Seat Belt at the time of the accident and the Air Bag deployed properly at the time of the accident. The following rules apply:

- 1) The Air Bag Benefit equals the lesser of:
  - a) 10% of Your AD&D Principal Sum shown in the Schedule of Benefits; or
  - b) \$5,000.
- 2) AUL must receive satisfactory written proof that Your death resulted from an Automobile accident and that You were properly wearing a Seat Belt at the time of the accident, You were positioned in a seat that is designed to be protected by an Air Bag, and that the Air Bag deployed at the time of the accident. A copy of all police reports must be submitted with the claim, and must show conclusively the Air Bag inflated properly at the time of the accident.
- 3) This benefit will not be paid if You, while operating the Automobile, were legally intoxicated as defined by applicable laws, violating traffic laws other than an infraction, racing, stunt-driving, or engaging in other similar activity during the accident.

In no event will the total of all Additional Accidental Death Benefits payable exceed 100% of Your AD&D Principal Sum.

In addition to the above limitations, this benefit is subject to the further limitations and provisions of this Section 12.

**SECTION 12 - ACCIDENTAL DEATH AND DISMEMBERMENT**  
**SECTION 12C - REPATRIATION BENEFIT**

This Section applies to Basic Accidental Death Insurance.

**DEFINITIONS**

**REASONABLE EXPENSES** means usual and customary fees or charges assessed in the marketplace for the services performed.

**REPATRIATION BENEFIT**

AUL will pay an Additional Accidental Death Benefit if You die either greater than 200 miles away from Your principal place of residence or are outside of the country at the time of Accidental Death. The following rules apply:

- 1) The Repatriation Benefit equals the lesser of:
  - a) Reasonable Expenses for transportation of Your body to a funeral home or mortuary near Your principal place of residence;
  - b) \$5,000; or
  - c) 10% of Your AD&D Principal Sum shown in the Schedule of Benefits.
- 2) AUL must receive satisfactory written proof documenting the location of Your Accidental Death. Any Repatriation Benefit will be paid following receipt that reasonable transportation expenses were paid.
- 3) Only one Repatriation Benefit will be paid to the beneficiary who has paid the cost for any covered expenses, regardless of any additional coverages for which You may be insured with AUL.
- 4) Acceptable written proof and documentation of the reasonable transportation expenses paid must be received by AUL within 12 months of Accidental Death.

In no event will the total of the Additional Accidental Death Benefits payable exceed 100% of Your AD&D Principal Sum.

In addition to the above limitations, this benefit is subject to the further limitations and provisions of this Section 12.

**SECTION 12 - ACCIDENTAL DEATH AND DISMEMBERMENT**  
**SECTION 12D - CHILD HIGHER EDUCATION BENEFIT**

This Section applies to Basic Accidental Death Insurance.

**DEFINITIONS**

**ACADEMIC YEAR** means the annual period of educational sessions of an accredited post-secondary educational institution.

**ELIGIBLE STUDENT** under this Section means Your unmarried Child under age 25, who on the date of Your Accidental Death:

- 1) is enrolled in and is attending an accredited post-secondary educational institution on a full-time basis; or
- 2) is at the 12th grade level and enrolls and attends an accredited post-secondary educational institution within 16 months from the date of Your death; and
- 3) is dependent upon You for principal support and is claimed as a dependent on Your federal income tax return.

**EDUCATION EXPENSES** means tuition that is assessed by the accredited post secondary educational institution and is required to be paid in order for the Child to be classified as a full time student.

**CHILD HIGHER EDUCATION BENEFIT**

AUL will pay an Additional Accidental Death Benefit subject to the following rules:

- 1) The Child Higher Education Benefit payment will be no more than \$4,000 for each Eligible Student per Academic Year for Education Expenses. The cumulative benefit payments for all eligible students will not exceed the lesser of:
  - a) \$20,000; or
  - b) 10% of Your AD&D Principal Sum Insurance shown in the Schedule of Benefits.
- 2) The Child Higher Education Benefit will be paid:
  - a) for Education Expenses that are incurred and paid after Your Accidental Death;
  - b) once annually at the conclusion of the Academic Year;
  - c) not for more than 5 consecutive years after the date of Your Accidental Death;
  - d) until such date that the Child no longer satisfies eligibility requirements under the policy or the accredited post-secondary educational institution;
  - e) following AUL's receipt of documentation showing proof of paying Education Expenses, the Child Higher Education Benefit will be paid to any named beneficiary who paid Education Expenses; and
  - f) in direct proportion to the amount of Education Expenses paid by each named beneficiary.
- 3) If there is no Eligible Student, no Child Higher Education Benefit will be paid.
- 4) Child Higher Education Benefits will only be paid based on enrollment in one accredited post-secondary educational institution.
- 5) No annual Child Higher Education Benefits will be paid beyond the date the policy terminates. If the policy terminates within 60 days of the end of the current Academic Year, a final Child Higher Education Benefit will be paid when eligible.

In no event will the total of the Additional Accidental Death Benefits payable exceed 100% of Your AD&D Principal Sum.

In addition to the above limitations, this benefit is subject to the further limitations and provisions of this Section.

**SECTION 12 - ACCIDENTAL DEATH AND DISMEMBERMENT**  
**SECTION 12E - CHILD CARE BENEFIT**

This Section applies to Basic Accidental Death Insurance.

**DEFINITIONS**

**CHILD CARE EXPENSES** mean any reasonable and customary weekly or monthly child-care fees assessed by a Child Care Facility.

**CHILD CARE FACILITY** means a properly state-licensed child-care center not owned or operated by a member of the Child's Family.

**ELIGIBLE CHILD(REN)** means Your Child(ren) under age 13.

**FAMILY** means any parent, step-parent, grandparent, brother, sister, uncle or aunt.

**CHILD CARE BENEFIT**

AUL will pay an Additional Accidental Death Benefit subject to the following rules:

- 1) The Child Care Benefit applies to each Eligible Child enrolled in a Child Care Facility on the date of Your Accidental Death or subsequently enrolls in a Child Care Facility within 12 months of Your Accidental Death.
- 2) Only Child Care Expenses incurred and paid after Your Accidental Death will be paid.
- 3) No more than \$4,000 will be paid for each Eligible Child per calendar year for Child Care expenses. The cumulative benefit payments for all Eligible Children will not exceed the lesser of:
  - a) \$20,000, or
  - b) 10% of Your AD&D Principal Sum shown in the Schedule of Benefits.
- 4) The Child Care Benefit will be paid once per year at the completion of the calendar year to the earlier of the following:
  - a) the date the Child no longer satisfies eligibility requirements;
  - b) the date the Child attains age 13; or
  - c) 5 consecutive years after the date of Your Accidental Death.
- 5) If there is no Eligible Child, no Child Care Benefit will be paid.
- 6) Following AUL's receipt of documentation showing proof of paying Child Care Expenses, the Child Care Benefit will be paid to any named beneficiary who paid Child Care Expenses, and in proportion to the amount of Child Care Expenses paid by each named beneficiary.
- 7) No Child Care Benefit will be paid beyond the date the policy terminates. If the policy terminates within 60 days of the end of the calendar year, a final Child Care Benefit will be paid when eligible.

In no event will the total of all Additional Accidental Death Benefits payable exceed 100% of Your AD&D Principal Sum.

In addition to the above limitations, this benefit is subject to the further limitations and provisions of this Section 12.

## **SECTION 13 - ACCELERATED LIFE BENEFIT**

This Section applies to Basic Life Insurance.

### **DEFINITION**

**TERMINAL CONDITION** means an injury or Sickness that, despite appropriate medical care, is conclusively established to AUL will result in Your death within 12 months from the date of claim. AUL may require that You be examined at AUL's expense by AUL's choice of Physician.

### **ACCELERATED LIFE BENEFIT**

If You are Permanently and Totally Disabled and are diagnosed with a Terminal Condition and are eligible for benefits under this Section, You may apply for payment of the Accelerated Life Benefit. The amount of Accelerated Life Benefit available is shown in the Schedule of Benefits, unless any portion of Your Life Amount has already been paid. The amount of Accelerated Life Benefit available will then be based on the amount remaining after payment of any portion of the Life Amount. Benefits will be paid in one lump sum to You.

### **CONDITIONS**

To be eligible to apply for the Accelerated Life Benefit:

- 1) You must have Personal Insurance;
- 2) You must be determined by AUL to be Permanently and Totally Disabled from any occupation;
- 3) You must be under age 60;
- 4) You must be diagnosed by a Physician with a Terminal Condition while eligible for benefits under this Section;
- 5) If You are subject to laws of a community property state, you must obtain Your spouse's written consent for payment to You of the Accelerated Life Benefit; and
- 6) You can receive an Accelerated Life Benefit only once.

### **PROOF REQUIRED FOR THE ACCELERATED BENEFIT**

Proof is a completed claim form and other information AUL requires in order to determine whether benefits are owed under this Section. AUL may require that You be examined by a Physician selected by AUL and at AUL's expense.

### **LIMITATIONS**

An Accelerated Life Benefit will not be paid if:

- 1) You have named an irrevocable Beneficiary or made an assignment of Your Life Amount;
- 2) all or a portion of Your Life Amount is to be paid to another person or entity pursuant to a valid court order;
- 3) Your coverage terminates; or
- 4) the policy terminates.



## SECTION 13 - ACCELERATED LIFE BENEFIT

### Continued

After payment of an Accelerated Life Benefit, Your Life Amount payable at death to Your Beneficiary equals:

- 1) Your Life Amount as if an Accelerated Life Benefit payment had not been made, minus
- 2) the amount of the Accelerated Life Benefit paid, minus
- 3) the interest charge.

The interest charge equals the Accelerated Life Benefit amount, times the number of days from the date of payment to Your date of death divided by 365, times the interest rate. The interest rate will be based on the current 90-day Treasury bill rate existing on the date of payment of the Accelerated Life Benefit.

NOTE: Your Accidental Death and Dismemberment Insurance, if any, terminated upon approval of the Waiver of Premium benefit.

The required amount of premiums must continue to be received by AUL on the original Life Amount, unless premiums have ceased due to coverage under the Waiver of Premium benefit of the policy.

The AD&D Principal Sum, if any, will not be reduced by payment of the Accelerated Life Benefit.

The following information is used for illustrative purposes only:

Example: Life insurance in force = \$100,000\*  
Date of receipt of proof of terminal condition = 10/31/05  
Date of payment of Accelerated Life Benefit = 11/1/05  
Date of death = 2/15/06  
Interest rate\*\* = 3.5%

- 1) Amount of Accelerated Life Benefit =  $.50 \times \$100,000 = \$50,000$
- 2) Interest Charge =  $\$50,000 \times (106 \text{ days} / 365 \text{ days}) \times .035 = \$508.22$
- 3) Death Benefit Payable =  $\$100,000 - \$50,000 - \$508.22 = \$49,491.78$

\*Your Life Insurance amount is shown in the Schedule of Benefits in Your insurance certificate.

\*\*The interest rate is equal to the 90-day Treasury bill rate on the date of the Accelerated Life Benefit payment.

NOTE: The Accelerated Life Benefit offered under the policy is intended to qualify for favorable tax treatment under the Internal Revenue Code of 1986. If the Accelerated Life Benefit qualifies for such favorable tax treatment, the benefit will be excludable from the Employee's income and not subject to federal taxation. The laws relating to Accelerated Life Benefits are complex. Employees are advised to consult with a qualified tax advisor about circumstances under which they could receive an Accelerated Life Benefit excludable under federal law. Eligibility for Public Assistance: Receipt of an Accelerated Life Benefit may affect the Employee's, their Dependent spouse's, or their family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. Employees are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect the Employee's, their Dependent spouse's, and their family's eligibility for public assistance.

## **SECTION 15 - PAYMENT OF DEATH BENEFITS**

If You die while insured under the policy, AUL will pay the benefits owed under the policy to the Beneficiary:

- 1) upon timely receipt of acceptable proof of death; and
- 2) subject to all other provisions of the policy and to Your dated and signed designation.

The following Sections describe the manner in which death benefits are paid.

## **SECTION 16 - NAMING OF BENEFICIARY**

BENEFICIARY means the individual, individuals or entity named by You to receive Your Life Amount.

Unless the policy provides otherwise, AUL will pay benefits according to Your Beneficiary designation.

When You apply for coverage on an AUL-approved form, You should:

- 1) designate the name of one or more Beneficiaries;
- 2) classify the Beneficiaries by order of preference, either primary or contingent; and
- 3) indicate distribution of the proceeds among members of the class of Beneficiaries.

If more than one primary Beneficiary is listed and no distributive share is indicated, then all primary Beneficiaries will share equally. If no primary Beneficiaries outlive You and there is no distributive share indicated among the contingent Beneficiaries, then all contingent Beneficiaries will share equally.

If the policy replaces insurance coverage of another carrier, AUL may, upon written request of the Group Policyholder, recognize Beneficiary designations in effect under the prior coverage as effective until a new designation is made with AUL, provided that prior designations are in a form acceptable to AUL and the Group Policyholder receives AUL's written approval of the form.

### **CHANGING A BENEFICIARY**

You may change a Beneficiary at any time by written request. The request must be completed, signed, dated and filed through the Group Policyholder.

AUL may recognize a beneficiary change as of the date the form was signed by You even if You are not alive when AUL receives it. However, AUL is not liable if benefits are paid according to the previous designation before AUL receives the change. If You apply for an individual life insurance conversion policy under Section 10, Conversion Privilege and name a new Beneficiary, AUL will use any beneficiary designated in that application when determining which beneficiary to pay.

AUL reserves the right to require that any Beneficiary designation be acceptable to it and be made pursuant to applicable laws.

## **SECTION 17 - THE DEATH CLAIM**

If You die while insured under the policy, proof of death should be furnished as soon as possible. The claim must be submitted within 12 months of the date of death. The claim may still be considered if it can be shown that timely submission of the claim was not possible due to events beyond the control of the beneficiary, but will not be considered after the applicable statute of limitations has passed.

Proof of death must include:

- 1) a certified death certificate; and
- 2) a completed claim form.

AUL, at its option, may also require:

- 1) return of Your insurance certificate;
- 2) submission of pertinent medical records, including an autopsy report;
- 3) police reports; or
- 4) any other documents AUL may deem reasonably necessary to determine what benefits and to whom benefits are owed.

If the cause of death cannot be clearly established by other means, AUL reserves the right to have a medical examination performed. The examination will be performed:

- 1) at AUL's expense; and
- 2) by a Physician of AUL's choice.

If the policy is no longer in force, proof furnished more than two (2) years from the date of loss must also include:

- 1) proof of employment at death; and
- 2) proof of coverage under the policy at death.

## **SECTION 18 - DETERMINATION OF BENEFICIARY**

Once acceptable proof of death is received, AUL will determine the Beneficiaries or payees in the following order:

- 1) If more than one primary Beneficiary is listed and no distributive share is indicated, then all primary Beneficiaries will share equally.
- 2) If no primary Beneficiaries outlive You and there is no distributive share indicated among contingent Beneficiaries, then all contingent Beneficiaries will share equally.
- 3) If no named Beneficiaries outlive You or none were named, then at AUL's option, the closest surviving heir(s) if the benefits could be paid to these heir(s) under applicable small estate laws. Heirs will be considered in descending order of preference as follows:
  - a) spouse;
  - b) child(ren);
  - c) parent(s); or
  - d) brother(s) and sister(s).
- 4) If no named Beneficiaries outlive You or none were named and the benefits could not be paid to the closest surviving heir(s) under applicable small estate laws, then Your estate.

AUL may, at its option, pay the proceeds in an amount up to \$2,000 to any individual appearing to AUL to be legally entitled to payment by reason of having paid funeral or other burial expenses related to Your death.

In the event You and Your Dependents should die simultaneously or if there is no clear evidence as to which individual died first, it shall be presumed that the Dependents should have predeceased You.

If any Beneficiary dies within 15 days after Your death, the Beneficiary will be treated as having died before You. This provision does not apply to any payment mailed to such Beneficiary during the 15 days following Your death, and any payment made in good faith shall fully discharge AUL.

## **SECTION 19 - SELECTION OF PAYMENT METHOD**

The proceeds will be paid in a lump sum unless another payment method is selected or changed by giving written notice to AUL prior to Your death. If no payment method is in effect at death, the payee may select a payment method. For information concerning payment method options, You or payee should contact AUL.

Benefits will be paid only if AUL decides in its discretion the person is entitled to them and after AUL approves the payment method. Any person who becomes entitled to receive any portion of the proceeds under the policy shall be entitled to receive payment of interest if any payment is not received by such person within 30 days after the event giving rise to the obligation and after all requested information is received by AUL. Interest payable shall be calculated at an annual rate after all requested information is received by AUL. The rate of interest payable shall be the lesser of 3% or that rate, as determined from time to time by AUL, applicable to proceeds of life insurance left on deposit with AUL and subject to withdrawal on demand. For the purposes of this section, payment shall be deemed to have been received by the person when deposited by AUL in United States mail, postage prepaid, and directed to the person's last known address or the Group Policyholder's address shown in AUL's records.

Other than lump sum payment, AUL reserves the right to specify the minimum periodic payment when a method is to become effective.

## **SECTION 21 - GENERAL POLICY PROVISIONS**

**ENTIRE CONTRACT:** The policy, the enrollment forms of the individuals, the application of the Group Policyholder, and any amendments made from time to time constitute the entire contract between the parties.

**AMENDMENT and CHANGES:** The policy may be amended by mutual agreement between the Group Policyholder and AUL but without prejudice to any valid claim incurred prior to the effective date of the amendment. The policy may be changed or corrected by AUL at any time. However, no change in the policy will be valid unless written notice is provided by AUL containing the signature of its Chief Executive Officer or Secretary. No other person can alter or waive the conditions of the policy or make any agreement that shall be binding upon AUL. No agent may or has the authority to waive, alter or change any terms and conditions of the policy or coverage.

**INCONTESTABILITY:** The validity of any coverage under the policy may not be contested, except for nonpayment of premiums, after the policy has been in force for two years after its date of issue, and other than a misrepresentation of a material fact, no statement made by Group Policyholder or You or Your Dependent relating to Your insurability may be used in contesting the validity of the insurance with respect to which the statement was made, unless: (1) the insurance has not been in force for a period of two years or longer; or (2) the statement is contained in a written instrument signed by the Group Policyholder or You or Your Dependent. However, AUL is not precluded from asserting at any time any defenses based upon provisions in the policy relating to eligibility for coverage. All statements made by the Group Policyholder or by the Employees or Dependents insured are to be deemed representations and not warranties, and that other than a misrepresentation of a material fact no statement made by any person insured may be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the Employees or Dependents or, in the event of death or incapacity of the Employee or Dependent, to the Employee's or Dependent's beneficiary or personal representative.

**INSURANCE FRAUD:** AUL wants to ensure that its customers do not incur additional insurance costs as a result of the act of insurance fraud. AUL promises to focus on all means necessary to support fraud detection, investigation and prosecution.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

**RELATIONSHIP:** AUL and the Group Policyholder are, and will remain, independent contractors. Nothing in the policy shall be construed as making the parties joint ventures or as creating a relationship of employer and employee, master and servant, or principal and agent. Neither party has any power, right or authority to bind the other or to assume or create any obligation or responsibility on behalf of the other. AUL and the Group Policyholder each retain exclusive control of their time and methods to perform their respective duties. AUL and the Group Policyholder will employ, pay and supervise their own employees and pay their own expenses during the term of the policy.

**DISCRETIONARY AUTHORITY:** Benefits under the policy will be paid only if AUL decides in its discretion that the applicant is entitled to them. Except for the functions the policy explicitly reserves to a Group Policyholder, AUL reserves the right to:

- 1) manage the policy and administer claims under it; and
- 2) interpret the provisions and resolve questions arising under it.

AUL's authority includes, but is not limited to, the right to:

- 1) establish and enforce procedures for administering the policy and claims under it;
- 2) determine applicant's eligibility for insurance and entitlement to benefits;
- 3) determine what information AUL reasonably requires to make such decisions; and
- 4) resolve all matters when a claim review is requested.

Any decision that AUL makes, in the exercise of its authority, will be conclusive; subject to Your or Your beneficiary's right to request reviews allowed under applicable laws.

## **SECTION 21 - GENERAL POLICY PROVISIONS**

### **Continued**

**GRACE PERIOD:** Premiums are due monthly and must be received by AUL within the required time frame for coverage to remain in force. You are entitled to a grace period of 31 calendar days for the payment of any premium due except the first. During the grace period, the insurance coverage shall continue in force, unless AUL has received written notice of termination in advance of date of termination and in accordance with the terms of the policy. Group Policyholder is liable to AUL for the payment of a pro rata premium for the time the policy was in force during the grace period. If the required amount of premium is not received by the end of the grace period, the insurance will terminate as of the last day of coverage for which premium was paid.

**LEGAL ACTION:** No legal action may be brought to obtain benefits under the policy:

- 1) for at least 60 days after proof of loss has been furnished and before arbitration is held pursuant to the arbitration provisions in the policy; or
- 2) after three (3) years from the time written proof of loss is required to have been furnished to AUL.

**CONFORMITY WITH STATE LAWS:** Any provision of the policy in conflict with the laws of the state in which it is delivered is amended to conform to the minimum requirements of those laws.

**DATA AND RECORDS:** The Group Policyholder must furnish information which AUL reasonably requires. The Group Policyholder's documents which may have a bearing on the insurance shall be open for inspection by AUL at all reasonable times.

**GENDER PRONOUNS:** Whenever the male pronoun is used, it shall also mean the female.

**CERTIFICATES:** If there is any discrepancy between the provisions of any certificate and the provisions of the policy, the provisions of the policy will govern.

**ASSIGNMENT:** You may make an absolute assignment of all benefits and rights of Your coverage. Any coverage is assignable to the extent permitted by law except that no collateral assignment is permitted. No assignment is binding unless filed with AUL in a form acceptable to it. AUL assumes no responsibility for the validity or effect of any assignment.

**CLAIMS OF CREDITORS:** The benefits paid under the policy will be exempt from the claims of creditors to the maximum extent permitted by law.

**CLERICAL ERROR:** Clerical error on the part of the Group Policyholder or AUL will not invalidate insurance otherwise in force or continue insurance otherwise validly terminated. Upon discovery of an error, an equitable adjustment will be made in the premiums and/or benefits, if appropriate.

**MISSTATEMENT OF AGE:** If Your age or Your Dependent has been misstated, the benefits will be payable based on the true facts. Premium adjustment will be made so that AUL will receive the actual premium required based on the true facts. Any adjustment of benefits due to the correction of age will also be made.



## **SECTION 21 - GENERAL POLICY PROVISIONS**

### **Continued**

**ARBITRATION:** Any controversy or claim arising out of or relating to the policy, the sale or solicitation of the policy, or its breach thereof whether in tort, contract, breach of duty (including but not limited to) any alleged fiduciary, good faith and fair dealing duties, shall be decided by arbitration in accordance with the Federal Arbitration Act, the procedures of the commercial arbitration rules of the American Arbitration Association, and this agreement. The Court of Arbitrators, which is to be held in the county seat where the Policyholder resides, shall consist of three (3) arbitrators familiar with group insurance and employee welfare benefit plans. The selection of the arbitrators shall be conducted within thirty (30) days after proper service of a demand for arbitration. One of the arbitrators shall be appointed by AUL, one by the insured, and the third shall be selected by the first two appointees prior to the beginning of arbitration. Should the two arbitrators be unable to agree upon the choice of a third, the appointment shall be left to the President or any Vice President of the American Arbitration Association. The arbitrators shall decide by a majority of votes, the award shall be in writing, the decision shall be signed by a majority of the arbitrators, and they shall include a statement regarding the reasons for the disposition of any claim. Judgment on the award rendered by the arbitrators may be entered by any court having jurisdiction thereof. The parties are not precluded from challenging the decision under the Federal Arbitration Act or applicable law. Unless not allowed under applicable law, each party shall bear the expense of its own attorney and arbitrator, and shall share equally with the other party the expenses of the third arbitrator and of the arbitration.

The parties agree that AUL is engaged in interstate commerce, and the transaction is governed by the Federal Arbitration Act, 9 U.S.C. Sections 1-16.

Consistent with the expedited nature of arbitration, each party will, upon the written request of the other party, promptly provide the other with copies of documents relevant to the issues raised by any claim or counterclaim on which the producing party may rely in support of or in opposition to any claim or defense. Any dispute regarding discovery, or the relevance or scope thereof, shall be determined by the arbitrator(s), which determination shall be conclusive. All discovery shall be completed within 60 days following the appointment of the arbitrator(s) or longer following mutual agreement by the parties.

**ERISA APPEAL GUIDELINES WHEN POLICY IS GOVERNED BY ERISA:** If a claimant wishes to appeal AUL's decision, claimants are allowed 60 days following receipt of a notification of an adverse benefit determination within which to appeal the determination. Claimants are allowed the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits. The claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of 29 C.F.R. Section 2560.503-1. AUL's review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. A claimant has a right to obtain the information about any voluntary appeal procedures offered by the plan described in paragraph (c)(3)(iv) of 29 C.F.R. Section 2560.503-1 and has a right to bring an action under section 502(a) of ERISA. A final determination will be provided pursuant to 29 C.F.R. Section 2560.503-1.

## **NOTICE TO POLICYHOLDERS**

**Questions regarding your policy or coverage should be directed to:**

**American United Life Insurance Company<sup>®</sup>  
a OneAmerica<sup>®</sup> Company  
(800) 553-5318**

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance  
Consumer Services Division  
311 West Washington Street, Suite 300  
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at [www.in.gov/idoi](http://www.in.gov/idoi).

# Rate Exhibit

Products and financial services provided by  
American United Life Insurance Company®  
a ONEAMERICA® company  
One American Square, P.O. Box 6123  
Indianapolis, IN 46206-6123  
www.employeebenefits.aul.com



**Policyholder:** City of Greenwood  
**Policyholder Number:** G 00611217-0000-000  
**Policy Effective:** 06/01/2011

Coverages	Class #	Opt #	Rate	Rate Eff Date
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Basic Life	1	1	\$0.1600	06/01/2011
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Coverages	Class #	Opt #	Rate	Rate Eff Date
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Basic AD&D	1	1	\$0.0300	06/01/2011
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Coverages	Class #	Opt #	From Age	Thru Age	Uni-Tobacco	Rate Eff Date
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Voluntary Term Life	1	1	0	29	\$0.0700	06/01/2011
			30	34	\$0.0800	
			35	39	\$0.1200	
			40	44	\$0.2100	
			45	49	\$0.3700	
			50	54	\$0.5800	
			55	59	\$0.9500	
			60	64	\$1.3900	
			65	69	\$2.3700	
			70	74	\$3.8300	
			75	99	\$3.8300	

Coverages	Class #	Opt #	From Age	Thru Age	Spouse	Family	Child	Rate Eff Date
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Voluntary Dependent Term Life	1	1	0	29	\$0.0700		\$2.0000	06/01/2011
			30	34	\$0.0800		\$2.0000	
			35	39	\$0.1200		\$2.0000	
			40	44	\$0.2100		\$2.0000	
			45	49	\$0.3700		\$2.0000	
			50	54	\$0.5800		\$2.0000	
			55	59	\$0.9500		\$2.0000	
			60	64	\$1.3900		\$2.0000	
			65	69	\$2.3700		\$2.0000	
			70	74	\$3.8300		\$2.0000	
			75	99	\$3.8300		\$2.0000	

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a ONEAMERICA® company  
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Indianapolis, IN 46206-6123  
[www.employeebenefits.aul.com](http://www.employeebenefits.aul.com)



**Policyholder:** City of Greenwood  
**Policyholder Number:** G 00611217-0000-000  
**Policy Effective:** 06/01/2011

Coverages	Class #	Opt #	From Age	Thru Age	Rate	Rate Eff Date
Voluntary Disability	1	1	0	29	\$0.2900	06/01/2014
			30	34	\$0.3500	
			35	39	\$0.4900	
			40	44	\$0.7200	
			45	49	\$1.2000	
			50	54	\$1.7300	
			55	59	\$1.9400	
			60	999	\$1.3300	

Coverages	Class #	Opt #	Rate	Rate Eff Date
STD	1	1	\$1.7200	06/01/2014