Dear Participant:

Welcome to your **Transamerica TransChoice Advance Plan** provided by the **San Francisco Giants** in compliance with the San Francisco Health Care Security Ordinance! Due to the length of your employment and your hours worked, you have met the minimum requirements to be eligible for this benefit. You are automatically enrolled at no cost to you.

Included in this packet is your benefit overview, a brief outline of the medical, dental and prescription benefits provided by your new plan and an overview of the First Health Network, Careington Network, and CVS Caremark. Additionally, we have included the plan design which provides detailed information about how your benefits work, along with your ID card.

For questions regarding the **Transamerica TransChoice Advance Plan**, please call us toll free at **1-866-868-4139** or visit **www.boongroup.com.** Representatives are available to assist you Monday through Friday from 7:00 a.m. to 7:00 p.m. Central Time. To submit claims, please fax your itemized receipts to **512-339-6663 (Attn: Claims)**. For all other questions or to waive coverage, please contact the Giants Human Resources Department at hr@sfgiants.com.

Sincerely,

Boon Administrative Services, Inc.

San Francisco Health Care Security Ordinance

FAQ

(The following provides an overview of the benefits, please refer to the complete ordinance and plan summary for complete explanation of coverage).

1. **What is the San Francisco Health Care Security Ordinance?**
    a. City mandated ordinance that requires employers to provide a type of healthcare benefit to employees who meet certain requirements.
    b. Under this law employers must make required health care expenditures on behalf of covered employees. These can be in form of payments to health, dental and/or vision insurance; payments for the city option; or contributions to programs that reimburse employees for out-of-pocket health care costs.
    c. For a complete overview, please visit http://sfgov.org/olse/health-care-security-ordinance-hcso
2. **How do the Giants comply with the ordinance?**
    a. In 2009 and prior, the Giants participated the city plan Healthy SF.
    b. From 2010-2013, the Giants utilized BeneFlex to comply with the ordinance.
    c. Beginning in 2014 the Giants implemented the Transamerica/Boon Group coverage.
3. **Who is eligible for the ordinance benefit?**
    a. The ordinance requires coverage following a 90-day waiting period. San Francisco Giants employees are eligible on the 1st of the month following 60 days of hire.
    b. Employees paid for at least 32 hours in a month are eligible for coverage the following month.
    c. **Example:** If I want to see if I qualify for the Transamerica plan for the month of May I would look at my April 5th and April 20th paychecks and if I was paid for 32 hours or more, and if I have been employed for at least 60 days 1st of the month following my date of hire, then I would qualify.
4. **Who is not eligible for the ordinance?**
    a. If you are a public sector employee such as the City of San Francisco, SF Unified School District or the State and Federal government
    b. Employees who are eligible or covered by Medicare or Tricare
    c. Employees who already receive medical coverage through the Giants or respective work Union
    d. Employee who do not meet the minimum 32 hours requirement
    e. Dependents are not eligible

5. **What happened to BeneFlex and what if I still have funds?**
    a. BeneFlex will reimburse claims for 24 months following the quarter of the last deposit.
6. **How do I enroll in Transamerica coverage?**
    a. No enrollment form is necessary. Eligible employees are automatically enrolled in the benefits on their effective date after they've met the minimum requirements.
    b. The Giants provide Boon Group with the required information once you qualify.
7. **How do I obtain a packet from Boon Group for my Transamerica coverage?**
    a. Boon Group will mail a Packet and ID card once you meet eligibility requirements.
    b. You may contact Boon Group for a replacement packet and ID card.
    c. You may also contact the Giants Human Resources department for packets. They will not be able to process replacement ID cards.
8. **What is the difference between Transamerica and Boon Group?**
    a. Transamerica is the insurance company/plan.
    b. Boon Group is the administrator of your benefits.
9. **How will I know which class of benefits I fall into if I work fluctuating hours every month?**
    a. Hours paid in the prior month provide current month's benefits. For example, if an employee was paid 100 hours in December, they will have Class 2 coverage in January.
        i. Class 1: 32-90 hours
        ii. Class 2: 91-130 hours
        iii. Class 3: 131+ hours
10. **What happens when I don't make the hours paid in the month requirement?**
    a. You will receive a letter in the mail from Transamerica/Boon Group informing you that you have lost coverage for the following month and may elect Continuation of Coverage.
11. **What is my deductible and how will it affect my reimbursement?**
    a. There is no deductible for the Transamerica medical/dental plan.
12. **Do I need to choose an in-network doctor or dentist? What are the benefits of choosing an in-network doctor?**
    a. You do not have to choose an in-network provider. However, by utilizing network providers, pharmacies and facilities, your services are paid at the contracted amount thus lowering your out-of-pocket cost.
    b. The medical network is First Health, a national PPO medical network that provides access to more than 5,000 hospitals, over 90,000 ancillary facilities, and over 1 million health care professional service locations in the U.S. and Puerto Rico.
    c. The dental network is Careington, also a nationwide network.

13. How will I be reimbursed?

a. The Transamerica plan provides medical and dental benefits. You may present your ID card to your provider, the provider will submit a claim to Boon Group who will pay the provider, and any remaining balance will be billed to you. If you pay out-of-pocket at the time of service you can submit an itemized receipt printout from the provider (listing the CPT codes for the date of service) to Boon Group and a check will be sent to your home if the benefit is covered under the Transamerica plan.

14. If I have other insurance, may I still be reimbursed by the Transamerica plan for the payments I make on my medical and dental bills?

a. Yes. You will need to submit a claim (i.e. itemized receipt) to Boon Group that includes the applicable CPT codes from the provider. A check will be sent to your home typically within 10-12 business days. All claims need to be filed within 12 months of the date of service.

15. How do I submit a claim receipt for reimbursement?

a. You can mail claims to:

Boon Administrative Services / BAS

PO Box 559017

Austin, TX 78755

b. You can fax claims to 512-339-6663, Attn: Claims

c. Always keep a copy for your records.

16. What are the benefits of having a reimbursement account which limits the amount you can be reimbursed?

a. The Transamerica plan is an indemnity insurance policy that pays a specified amount for a defined set of services. There are no copays, coinsurance, deductibles or waiting periods. And benefits are paid in addition to other insurance (except workers compensation).

17. Will the Transamerica plan reimburse me for my insurance premiums?

a. The Transamerica plan will not reimburse premiums on other insurance plans.

18. What do I do with my Certificate of Insurance?

a. The Certificate of Insurance is to be kept for your records.

19. Does the Transamerica plan meet Individual Healthcare Mandate requirement under the ACA?

a. No, this coverage doesn't meet the minimum requirement for the individual healthcare requirement. It meets the requirements for the city mandate.

20. Can I apply for benefits through the California State Exchange even though I'm automatically enrolled in the Transamerica plan?

a. Yes, the Transamerica plan does not affect eligibility for a subsidy through Covered California.

21. What if I want to keep Transamerica plan coverage during the offseason?

a. Any month that you don't qualify for the plan you will receive a Continuation of Coverage notification giving you information on how you can pay to continue coverage.

22. Can I add my family to the Transamerica plan?

a. No, the benefit is only for the employee.

23. Is there a way to opt out of this plan and use the $2.64 per hour like an HRA account?

a. You may opt out of the plan and waive coverage by filling out the City of San Francisco's waiver form and providing proof of group major medical coverage.

b. However, the benefit cannot be paid out in cash or applied to an HRA if you choose to opt out.

IMPORTANT CONTACT INFORMATION & ADDITIONAL RESOURCES		
TransAmerica/ Boon Group	https://www.boongroup.com/OnlineRequests/Default.aspx	P: 866-868-4139
Transamerica (Claims)	Mail Claims To: Boon Administrative Services (BAS) P.O. Box 559017 Austin, TX 78755 Fax Claims To: (512) 339-6663 (Attn: Claims)	P: 866-868-4139
First Health Network	www.firsthealthlbp.com/LocateProvider/CustomPage	
Careington Network	www.careington1.com	
CVS Caremark	www.caremark.com	
Giants Human Resources		hr@sfgiants.com
Beneflex	www.beneflexhr.com	P: 800-631-3539 info@beneflexhr.com
Covered California	www.coveredca.com	
SF Health Care Security Ordinance	http://sfgov.org/olse/health-care-security-ordinance-hcso	

$2.64 San Francisco Employee Only Benefit Overview

Benefit Overview of plan features. Please see Plan Summary for detailed information about the benefits and exclusions and shall prevail over the terms of this benefit overview.

	Transamerica Advance All-Time		
	Class I	Class II	Class III
EMPLOYEE Plan	1 - 90 Hours	91 - 130 Hours	131+ Hours
Medical Outpatient			
Physician Office Visit			
Daily Benefit	$70	$90	$110
Maximum Days per Calendar Year	10	10	10
Lab and Diagnostic Testing			
Daily Benefit - Outpatient Diagnostic Lab	$30	$40	$50
Maximum Days per Calendar Year	5	5	5
Daily Benefit - Outpatient Select Diagnostic Testing	$150	$200	$250
Maximum Days per Calendar Year	2	2	2
Daily Benefit - Outpatient Advanced Studies	$600	$800	$1,000
Maximum Days per Calendar Year	2	2	2
Prescription Drug Benefit			
Daily Benefit - Generic	$15	$25	$30
Daily Benefit - Brand	$30	$50	$60
Combined Maximum Days per Calendar Year	24	36	36
Outpatient Surgical & Anesthesia Benefit			
Pays per day a patient undergoes surgery due to a covered accident or sickness	$900	$1,050	$1,150
Maximum number of surgical days per Calendar Year	1	1	1
If anesthesia is administered, pays an additional:	30%	30%	30%
Medical Inpatient			
Daily In-Hospital Benefit	$2,000	$2,300	$2,500
Maximum Days per Confinement	31	31	31
Intensive Care Daily Benefit	$2,000	$2,300	$2,500
Maximum Days per Calendar Year	30	30	30
Hospital Confinement Benefit	$3,000	$4,000	$5,000
Maximum Days per Calendar Year (Maximum 1 day per confinement)	1	2	2
Inpatient Mental and Nervous Disorder Benefit			
Pays per day of confinement	$300	$400	$500
Maximum Days per Calendar Year (Maximum 60 days per lifetime)	31	31	31
Inpatient Drug or Alcohol Addiction Benefit			
Pays per day of confinement	$300	$400	$500
Maximum Days per Calendar Year (Maximum 60 days per lifetime)	31	31	31
Additional Benefits			
Surgical & Anesthesia Indemnity Benefits			
Inpatient Surgical Benefit per day of surgery (Limit 1 surgical day per Calendar Year)	$1,800	$2,200	$2,400
Outpatient Surgical Benefit per day of surgery (Limit 1 surgical day per Calendar Year)	$900	$1,100	$1,200
Outpatient Minor Surgical Benefit per day of surgery (Limit 1 surgical day per Calendar Year)	$180	$220	$240
If anesthesia is administered, pays an additional:	30%	30%	30%
Emergency Room Sickness Benefit	$150	$200	$250
Maximum Days per Calendar Year	2	4	4
Accidental Injury Benefit	$600	$800	$1,000
Maximum Days per Calendar Year (Maximum 1 day per accident)	5	5	5
Ambulance Benefits			
Pays per day a person receives Ground Ambulance Transportation	$250	$400	$500
Pays per day a person receives Air Ambulance Transportation	$750	$1,200	$1,500
Maximum Days per Calendar Year (Maximum 6 days per lifetime)	3	3	3
First Health PPO Network	Included	Included	Included
MDLIVE Telehealth Services	Included	Included	Included
Ancillary Benefits			
Group Limited Dental			
Calendar Year Maximum for routine dental care	$2,000	$2,000	$2,000
Employee Hourly Contribution:	**$2.64**		

Transamerica Plan Information

Plan Summary
Terms and Conditions
Exclusions

TransChoice® Advance HOSPITAL INDEMNITY INSURANCE
Offered by Transamerica Life Insurance Company | SUMMARY OF BENEFITS

Highlights of TransChoice® Advance

- Benefits for full-time, part-time, hourly, seasonal and temporary workers
- No coinsurance, co-pays, waiting periods or deductibles
- Benefits paid in addition to any other insurance the insured may have[1]

[1] *The policy excludes from coverage any accident or sickness arising out of or in the course of any occupation.*

See Plan Design for more details.

How TransChoice® Advance Works

This policy pays a specified amount for each day a covered person is confined to the hospital, and can provide benefits for a range of other medical situations through a series of optional riders.

Benefits are paid directly to the covered employee unless they are assigned to a health care provider.

TransChoice® Advance Group Hospital Indemnity Insurance

This is a brief summary of **TransChoice® Advance** hospital indemnity insurance underwritten by Transamerica Life Insurance Company, Cedar Rapids, IA. Policy Form Series CPGHI400 and CCGHI400.

Forms and form numbers may vary. Coverage may not be available in all jurisdictions. Limitations and exclusions apply. Refer to the policy, certificate and riders for complete details. **THIS IS NOT MAJOR MEDICAL INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL INSURANCE. IT DOES NOT QUALIFY AS MINIMUM ESSENTIAL HEALTH COVERAGE UNDER THE FEDERAL AFFORDABLE CARE ACT.**

PRODUCT DETAILS | TransChoice® Advance PLAN DESIGN

FT $2.64 Employee Plan--San Francisco

The following benefits are included in the plan quoted. Unless otherwise noted, all benefits and maximums are per covered person.

Daily In-Hospital Indemnity Policy	Class I	Class II	Class III
Pays each day a covered person is confined to a hospital (but not an emergency room, outpatient stay or stay in an observation unit) as the result of a covered accident or sickness.	$2,000	$2,300	$2,500
Maximum	31 days per confinement	31 days per confinement	31 days per confinement

Additional Benefits Included:

Intensive Care Indemnity Benefit Rider (Rider Form Series CRCICU00)			
Pays each day a covered person is confined to an intensive care unit as the result of a covered accident or sickness.	$2,000	$2,300	$2,500
Calendar Year Maximum	30 days	30 days	30 days
Hospital Confinement Indemnity Benefit Rider (Rider Form Series CRHA0400)			
Pays each day a covered person is confined to a hospital (but not an emergency room, outpatient stay or stay in an Observation unit) as the result of a covered accident or sickness lasting a minimum of 24 continuous hours from time of admission. **Pays maximum of 1 day per confinement.**	$3,000	$4,000	$5,000
Calendar Year Maximum	1 day	2 days	2 days
Inpatient Mental & Nervous Disorder Indemnity Benefit Rider (Rider Form Series CRMN0400)			
Pays each day a covered person is confined, on an inpatient basis, to a hospital or mental health facility for a minimum of 24 continuous hours as the result of a mental or nervous disorder. Mental or nervous disorder includes neurosis, psychoneurosis, psychopathy, psychosis, or other mental or emotional disease or disorder of any kind.	$300	$400	$500
Maximum	31 days per calendar year | 60 days per lifetime		
Inpatient Drug & Alcohol Addiction Indemnity Benefit Rider (Rider Form Series CRDA0400)			
Pays each day a covered person is confined, on an inpatient basis, to a hospital or residential treatment facility for a minimum of 24 continuous hours as the result of drug or alcohol addiction.	$300	$400	$500
Maximum	31 days per calendar year | 60 days per lifetime		
Surgical & Anesthesia Indemnity Benefit Rider (Rider Form Series CRSRGP00)			
Pays each day a covered person undergoes surgery, as follows: **Inpatient** Surgery	$1,800	$2,200	$2,400
Calendar Year Maximum	1 day		
Outpatient Surgery	$900	$1,100	$1,200
Calendar Year Maximum	1 day		
Outpatient Minor Surgery	$180	$220	$240
Calendar Year Maximum	1 day		
If anesthesia is administered, pays an additional	30%	30%	30%
Outpatient Surgical Indemnity Benefit Rider (Rider Form Series CROPS400)			
Pays each day a covered person undergoes outpatient surgery as the result of a covered accident or sickness	$900	$1,050	$1,150
If anesthesia is administered, pays an additional:	30%	30%	30%
Calendar Year Maximum	1 day	1 day	1 day

Ambulance Indemnity Benefit Rider (Rider Form Series CRAMB400)			
Pays each day a covered person receives ambulance transportation as the result of a covered accident or sickness. Transportation must be provided by a licensed ambulance company within 96 hours of a covered accident or onset of sickness. **Air ambulance pays 3 times the amount shown.**	$250	$400	$500
Maximum	3 days per calendar year | 6 days per lifetime		
Emergency Room Sickness Indemnity Benefit Rider (Rider Form Series CRERS400)			
Pays each day a covered person receives treatment in the emergency room for a sickness. This rider does not pay benefits for emergency room treatments as the result of an accident.	$150	$200	$250
Calendar Year Maximum	2 days	4 days	4 days
Off-the-Job Accidental Injury Indemnity Benefit Rider (Rider Form Series CRACIN00)			
Pays each day a covered person receives treatment for a covered accident. Treatment must be provided by a physician within 96 hours of the accident.	$600	$800	$1,000
Maximum	1 day per accident | 5 days per calendar year		
Outpatient Physician Office Visit Indemnity Benefit Rider (Rider Form Series CROPV400)			
Pays each day a covered person receives outpatient treatment in a physician's office or at an urgent care facility as the result of a covered accident or sickness.	$70	$90	$110
Calendar Year Maximum	10 days	10 days	10 days
Outpatient Diagnostic Laboratory Test Indemnity Benefit Rider (Rider Form Series CRLAB400)			
Pays each day a covered person undergoes an outpatient laboratory test performed for the purpose of diagnosis for a covered accident or sickness. Does not include tests covered under any other rider.	$30	$40	$50
Calendar Year Maximum	5 days	5 days	5 days
Outpatient Select Diagnostic Test Indemnity Benefit Rider (Rider Form Series CRSDT400)			
Pays each day a covered person undergoes an outpatient X-ray, ultrasound, Electroencephalogram (EEG), or sleep study for the purpose of diagnosis for a covered accident or sickness.	$150	$200	$250
Calendar Year Maximum	2 days	2 days	2 days
Outpatient Advanced Studies Diagnostic Test Indemnity Benefit Rider (Rider Form Series CRASD400)			
Pays each day a covered person undergoes an outpatient Computer Tomography (CT) Scan, Magnetic Resonance Imaging (MRI), Myelogram, Positron Emission Tomography (PET), Angiogram, Arteriogram, or Thallium Stress Test for the purpose of diagnosis for a covered accident or sickness.	$600	$800	$1,000
Calendar Year Maximum	2 days	2 days	2 days
Prescription Drug Indemnity Benefit Rider (Rider Form Series CRRX0400)			
Pays each day a covered person fills a **Generic** prescription, prescribed as a result of a covered accident or sickness.	$15	$25	$30
Pays each day a covered person fills a **Brand** name prescription, prescribed as a result of a covered accident or sickness.	$30	$50	$60
Combined Maximum	**24** days per Calendar Year	**36** days per Calendar Year	**36** days per Calendar Year

Additional Included Insurance Policies:

TransSmile® Group Limited Dental Insurance (Policy Form Series CPDEN100 and CCDEN100)			
Pays for routine dental care. Calendar Year Maximum.	$2,000	$2,000	$2,000
Non-Insurance Benefits			
PPO Network Offered by the Boon Group	First Health	First Health	First Health
Telehealth Offered by the Boon Group	Included	Included	Included

EXCLUSIONS & LIMITATIONS

Confinement for the same or related condition within 30 days of discharge will be treated as a continuation of the prior confinement. Successive confinements separated by more than 30 days will be treated as a new and separate confinement.

No benefits under this contract will be payable as the result of the following:

- Suicide or attempted suicide, whether while sane or insane.
- Intentionally self-inflicted injury.
- Rest care or rehabilitative care and treatment.
- Immunization shifts and routine examinations such as: physical examinations, mammograms, Pap smears, immunizations, flexible sigmoidoscopy, prostate-specific antigen tests and blood screenings (unless Wellness Indemnity Benefit Rider is included).
- Any pregnancy of a dependent child including confinement rendered to her child after birth.
- Routine newborn care (unless Wellness Indemnity Benefit Rider is included).
- A covered person's abortion, except for medically necessary abortions performed to save the mother's life
- Treatment of mental or emotional disorder (unless Inpatient Mental and Nervous Disorder Indemnity Benefit Rider is included).
- Treatment of alcoholism or drug addiction (unless Inpatient Drug and Alcohol Addiction Indemnity Benefit Rider is included).
- Participation in a felony, riot, or insurrection.
- Any accident caused by the participation in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a physician or taken according to the physician's instructions) or while intoxicated (intoxicated means that condition as defined by the law of the jurisdiction in which the accident occurred).
- Dental care or treatment, except for such care or treatment due to accidental injury to sound natural teeth within 12 months of the accident and except for dental care or treatment necessary due to congenital disease or anomaly.
- Sex change, reversal of tubal ligation or reversal of vasectomy.
- Artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications or physician's services, unless required by law.
- Committing, attempting to commit, or taking part in a felony or assault, or engaging in an illegal occupation.
- Traveling in or descending from any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a commercial airline (other than a charter airline) on a regularly scheduled passenger trip.
- Any loss incurred on active duty status in the armed forces. (If you notify us of such active duty, we will refund any premiums paid for any period for which no coverage is provided as a result of this exception.)
- An accident or sickness arising out of or in the course of any occupation for compensation, wage or profit or for which benefits may be payable under an Occupational Disease Law or similar law, whether or not application for such benefits has been made.
- Involvement in any war or act of war, whether declared or undeclared.

Critical Illness Indemnity Benefit Rider

Invasive Cancer does not include: Carcinoma in Situ; pre-malignant conditions or conditions with malignant potential; prostatic cancers which are histologically described as TNM Classification T1 (including T1(a) or T1(b), or of other equivalent or lesser classification); any malignancy associated with the diagnosis of HIV; or Skin Cancer. Skin Cancer does not include malignant melanoma or mycosis fungoides. Stroke does not include cerebral symptoms due to: Transient Ischemic Attack (TIA); reversible neurological deficit; migraine; cerebral injury resulting from trauma or hypoxia; or vascular disease affecting the eye, optic nerve or vestibular functions.

The Subsequent Critical Illness Benefit is not payable for Skin Cancer or Carcinoma In Situ.

Off-the-Job Accidental Injury Indemnity Benefit Rider

Injuries which are caused by an accident that occurs while in the course of any legal or illegal occupation, activity, or employment for pay, benefit or profit are not covered.

Surgical and Anesthesia Indemnity Benefit Rider

As an exception to the dental care or treatment exclusion above, we will pay the following dental or oral surgery procedures under this rider:

- Excision of impacted third molars.
- Closed or open reduction of fractures or dislocation of the jaw.

Skilled Nursing Indemnity Benefit Rider

We will not pay benefits under this benefit if the confinement is located in a facility outside the United States or its territories, or is rendered in a facility owned or managed by an immediate family member.

Annual Individual Benefit Maximum

Class 1	Class 2	Class 3
$2,000	$2,000	$2,000

Deductible Limitations

None.

Coinsurance & Waiting Periods

	Coinsurance	Waiting Period
Diagnostic and Preventive Services	100%	None
Basic Restorative Services	80%	None
Major Restorative Services	50%	12 months

TYPE 1 SERVICES – Diagnostic and Preventive Services

- Routine periodic examinations not more than once in any six consecutive month periods, inclusive of an initial oral examination.
- Prophylaxis (cleaning) not more than once in any six consecutive month period.
- Bitewing X-rays one set in any 12 consecutive month period.
- Periapical X-rays four in any 12 consecutive month period.
- Topical application of fluoride once in any 12 consecutive month period for dependent children 15 years of age and under.
- Sealants once per tooth on permanent maxillary and mandibular first and second molars with no caries (decay) on the occlusal surface, for dependent children 14 years of age and under.
- Space maintainers for prematurely lost teeth of eligible dependent children 13 years of age and under.

TYPE 2 SERVICES– Basic Restorative Services

- Minor emergency treatment for the relief of pain.
- Full-mouth X-rays once in any five year period.
- Amalgam (silver) and composite/resin (white) fillings (composites are not a covered benefit on molars).
- Simple Extractions

TYPE 3 SERVICES – Major Restorative Services

- Endodontics includes pulpal therapy and root canal filling.
- Oral Surgery, including pre- and post-operative care and surgical and simple extractions, except TMJ surgery.
- Surgical Periodontics includes surgical procedures for the disease of the gums and bone supporting the teeth.
- Nonsurgical Periodontics includes treatment for the disease of the gums and bone supporting the teeth.
- Periodontal Maintenance once in any six-month consecutive benefit period following active periodontal treatment.
- Stainless Steel Crowns used as a restoration to natural teeth for Dependent children 15 years of age and under when the teeth cannot be restored with a filling material.
- Crowns, Inlays, Onlays, and Veneers are benefits for the treatment of visible decay and fractures of tooth structure when teeth are so badly damaged they cannot be restored with amalgam or composite restorations.
- Complete or Partial Denture Reline chair side or laboratory procedure to improve the fit of the appliance to the tissue (gums).
- Complete or Partial Denture Rebase laboratory replacement of the acrylic base of the appliance.
- Repairs to Complete and Partial Dentures
- Prosthodontics procedures for construction of fixed bridges, partial or complete dentures.
- Implants are payable as a less expensive alternative benefit to prosthodontics and only to replace a tooth or teeth that were extracted while covered under the Policy.

Careington Network

The Maximum Care Discount Network consists of over 200,000 credentialed dental access points contracted to provide dental services at reduced rates nationwide. The network combines the outstanding network management skills of two great organizations and results in discounts of 20% to 50% below the 80th percentile of Reasonable and Customary charges

EXCLUSIONS & LIMITATIONS

Dental services under the TransSmile plan are subject to certain limitations and exclusions that are detailed in the Policy and Certificate. Covered dental expenses do not include, and no benefits are provided, for the following:

- Services which are not included in the List of Covered Dental Services; which are not necessary; or for which a charge would not have been made in the absence of insurance.
- Any service which may not reasonably be expected to successfully correct the Insured Person's dental condition for a period of at least 3 years, as determined by us.
- Any Service provided primarily for cosmetic purposes. Facings on crowns or bridge units on molar teeth and composite resin restorations on molar teeth will always be considered cosmetic.
- Implants; charges for the insertion of implants or related appliances; or the surgical removal of implants (unless the Policy includes the Implant Benefits Rider).
- Athletic mouth guards; myofunctional therapy; infection control; precision or semi-precision attachments; denture duplication; oral hygiene instruction; separate charges for acid etch; broken appointments; treatment of jaw fractures; orthognathic surgery; completion of claim forms; exams required by a third party other than Transamerica; personal supplies (e.g., water pik, toothbrush, floss holder, etc.); or replacement of lost or stolen appliances.
- Charges for travel time; transportation costs; or professional advice given on the phone.
- Orthodontic treatment (unless the Policy includes the Orthodontic Benefits Rider).
- Services that are a covered expense under any other plan that is provided by the Policyholder and under which you are eligible for coverage.
- Services performed by a Dentist who is member of the Insured Person's family. Insured Person's family is limited to a spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents.
- Any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility.
- Any Service required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joints or their associated structures (unless the Policy includes the TMJ Benefits Rider).
- Any charge for a Service performed outside of the United States other than for Emergency Treatment. Benefits for Emergency Treatment performed outside of the United States are limited to a maximum of $100 per year per Insured Person.
- Any charge for a Service required as a result of disease or injury that is due to war or an act of war (whether declared or undeclared); taking part in an insurrection or riot; the commission or attempted commission of a crime; an intentionally self-inflicted injury or attempted suicide while sane or insane.
- Any charge for a Service for which benefits are available under Worker's Compensation or an Occupational Disease Act or Law, even if the Insured Person did not purchase the coverage that is available.
- Any Service for which the Insured Person is not required to pay, unless the payment of benefits is mandated by law and then only to the extent required by law.
- Benefits to correct congenital or developmental malformations.
- Charges for services when a claim is received for payment more than 12 months after services are rendered.
- Charges for complete occlusal guards, enamel microabrasion, odontoplasty and bleaching.
- For specialized techniques that entail procedure and process over and above that which is normally adequate, any additional fee is the participant's responsibility.
- Behavior management.
- Charges for general anesthesia/intravenous sedation are not covered, except when administered in conjunction with covered oral surgery and unusual medical circumstances require the use of general anesthesia as determined by Our Administrator's dental consultants.
- Charges for desensitizing medicines, home care medicines, premedications, stress breakers, coping, office visits before or after regularly scheduled hours, case presentations, and hospital-related services.
- Charges for treatment by other than a Dentist except that a licensed hygienist may perform services in accordance with applicable law. Services must be under the supervision and guidance of the Dentist in accordance with generally accepted dental standards.
- Benefits for services or appliances Started prior to the date the Person became eligible under this plan, including, but not limited to, restorations, prosthodontics, and orthodontics.
- Services for increasing the vertical dimension or for restoring tooth structure lost by attrition, for rebuilding or maintaining occlusal services, or for stabilizing the teeth.
- Experimental and/or investigational services, supplies, care and treatment which do not constitute accepted medical practice within the range of appropriate medical practice under the standards of the case and under the standards of a qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered. Drugs are considered experimental if they are not commercially available for purchase or are not approved by the Food and Drug Administration for general use.
- Services for the replacement of a missing tooth.

First Health PPO Network

The First Health PPO Network provides access to the largest national network with fair and reasonable costs with the flexibility and freedom to choose your preferred provider and minimize your out of pocket expenses by selecting a participating network provider within the network. First Health's national PPO network provides access to more than 5,000 hospitals, over 90,000 ancillary facilities, and over 1 million health care professional service locations in the United States, including Puerto Rico. The network covers over 98% of the U.S. population who are within 10 miles of a participating network physician and within 20 miles of a participating network hospital. Members of a group health plan using the First Health Network will be provided with the most current, innovative provider search tools available through our online web tools, 24 hours a day, and 7 days per week.

Caremark Prescription Benefits

Caremark offers a nationwide network of over 62,000 retail pharmacies and online prescription services. Caremark's website provides access to easy-to-use tools and services such as: view prescription history, research generic alternatives, look up copay information, find a network pharmacy, and more. Also, members will continue to receive discounts by using any of the in-network national chains, even after the calendar year benefits have been exhausted.

UNDERWRITING OFFER & ELIGIBILITY

Employee Eligibility

To be eligible for coverage, an employee must:

- Be at least 18 years old;
- Be on active service, performing in the usual manner all the regular duties of his/her occupation at one of the places of business where he/she normally works, or at some location directed by the employer; and
- Be continuously employee for the amount of time and working the minimum number of hours per week required to be eligible for benefits (as defined on the Life and Health Group Application and Agreement).

Minimum Participation

At least 10 eligible employee applications are required to establish and maintain an employer group.

Evidence of Insurability

Coverage is Guaranteed Issue when an applicant first becomes eligible for coverage.

Coverage applied for at a later date will be considered a Late Enrollee. Late Enrollee applications are underwritten on an accept/reject basis.

Other Considerations

Please be aware of the following:

- **For MASSACHUSETTS Residents: This product DOES NOT MEET CREDITABLE COVERAGE STANDARDS and WILL NOT SATISFY the Massachusetts individual mandate to have health insurance.**

GENERAL ADMINISTRATIVE ISSUES

How to Apply - Organization

Your organization can apply for this insurance by providing us with your completed Life and Health Group Application and Agreement together with a copy of this proposal. Before approving, we may request additional information about your group. Upon approval, we will notify you when coverage becomes effective.

Group Master Policy Effective Date

Subject to our receipt and review of all necessary information, the group master policy takes effect on the date requested on the Life and Health Group Application and Agreement. There is no backdating of a policy.

Individual Coverage Effective Date

Insurance is effective on the effective date requested on the Life and Health Group Application and Agreement or first day of the month following the date an individual's application is approved by us, whichever is later. The employee must be actively at work (performing regular duties at his/her usual place of employment) for insurance to become effective.

Beneficiary

Employees designate their own beneficiaries. In community property states (AZ, CA, ID, LA, NM, NV, TX, WA, and WI), when someone other than the spouse is designated as the beneficiary, the spouse's consent is required.

Current Disability and/or Premium Waiver

We do not provide coverage to an individual currently disabled on a premium waiver. In this case, it is assumed that the previous carrier, if any, should continue to provide the individual's coverage.

Grace Period

A grace period of 31 days will be allowed for each premium payment after the first premium. Insurance will stay in force during this time. The policy will terminate at the end of the grace period if the premium has not been paid. You must still pay all unpaid premiums. This includes the premium due for the grace period.

Termination of Insurance

The insurance terminates on the earliest of:

- The insured's death.
- The premium due date when we fail to receive a premium, subject to the grace period.
- The date of written notice to cancel coverage.
- The date the policy terminates.
- The date the insured ceases to be eligible for coverage.

The insurance company has the right to terminate the coverage of any insured who submits a fraudulent claim. Termination will not impact any claim which begins before the date of termination.

DISCLOSURES

GROUP BENEFITS DISCLOSURE POLICY

Transamerica Employee Benefits (TEB) is a unit of Transamerica Life Insurance Company and Transamerica Financial Life Insurance Company. TEB markets and administers voluntary insurance benefits through licensed insurance agents. These agents are typically appointed to see our products, and products of other providers, and receive various forms of compensation from us for the services provided. We believe our compensation arrangements with our agents are conducted with honesty, fairness and integrity. In addition, we realize that having trusted relationships between our agents and our customers is essential to all involved. To ensure this trust continues and to address any concerns within the industry, we have outlined our policy on agent compensation disclosure.

TEB's policy supports transparency and full disclosure of agent compensation to our customers and prospective customers. In addition, we have put controls in place to facilitate this disclosure and obligate our agents to disclose compensation information to customers: 1) when asked by a customer; 2) when receiving both a fee from the customer and compensation from TEB; and 3) when otherwise required by law. Agents must comply with all applicable laws in the sale of TEB products, including any pertaining to the disclosure of compensation information.

TEB's Group Benefits Compensation Disclosure Notice (below) describes the various means by which agents may be compensated for the sale of our products. It is the responsibility of your agent to share specific information with you about his or her compensation arrangements with TEB. Accordingly, please direct any compensation disclosure questions directly to your agent.

COMPENSATION DISCLOSURE NOTICE TO ALL POLICYHOLDERS

Agents who sell and service our products are paid a commission. It varies by the type of insurance policy sold and the state where the policy was sold, and is based on a percentage of the premium received in the first year, and at policy renewal. Agents may receive advances or loans against anticipated commissions for cases sold or to be sold. These advances may or may not require the payment of interest, depending upon the agent's total business and historical experience with TEB.

Agents may receive other compensation from TEB in the form of cash or non-cash awards or prizes, based upon a variety of factors that may include the level of premium written or earned, persistency and growth of premium, or other performance measures. Agents, who manage, supervise or recruit other agents or wholesale our products and services to other agents, may receive commission overrides on business that results from their efforts.

Some of our agents may receive additional payments for providing services in connection with the administration of our products. Fees for such services may be calculated on a per policy or per certificate basis or upon the premium volume associated with a specific case. TEB may additionally reimburse these agents/administrators for certain expenses, such as the cost of mailings.

Agents may occasionally obtain exclusive rights to market TEB products or services to agents, employers, employees or members of associations or unions. Certain groups or associations may also agree to endorse TEB's products to their members. TEB may pay a fee for these exclusive marketing rights or endorsements. See your proposed plan documents or policy certificate package for more information on any such arrangements.

Up-to-date information regarding our compensation practices can be found in the Disclosures Section of our website at www.tebcs.com.

Get the Most From Your Benefits With First Health Network Providers

As a member of a health plan that offers you the First Health Network for your medical care, you have access to a national network of providers and great savings. Using providers that participate in the First Health Network is the easiest way to maximize your benefits.

The First Health Network

By going to a First Health provider, you can reduce your out-of-pocket expenses and stretch your benefit dollars. In addition:

- The First Health Network provides access to one of the nation's largest and most respected networks. You have access to more than 5,000 hospitals, over 90,000 ancillary facilities, and over 1 million health care professionals across all 50 states, plus the District of Columbia and Puerto Rico.
- Network doctors are carefully selected to promote quality outcomes.
- You have no paperwork because network doctors and hospitals file claims for you.
- Your medical ID card displays the First Health Network logo so your provider identifies you as a participating plan member.

Maximize Your Benefits

Unlike non-participating doctors and hospitals, First Health Network providers have agreed to provide services for discounted fees. Therefore, you can stretch your benefits and reduce your out-of-pocket expenses by using participating First Health Network providers.

Compare network and non-network costs

The following example shows how benefits would be calculated when an in-network provider is used, versus an out-of-network provider. This example is for illustration purposes only and is not specific to your plan of benefits.

Example - Office Visit

	First Health provider	Non-network provider
Your office visit	$250.00	$250.00
Provider discount	- $150.00	$0
Total charge with discount applied	$100.00	$250.00
Plan covers	$80.00	$125.00
Your total responsibility	$20.00	$125.00

Find a Network Provider

The most convenient way to find a doctor, hospital or other health care service provider participating in the First Health Network is by searching our online provider directory at **www.firsthealthlbp.com**. The electronic provider directory, available 24 hours a day, 7 days a week, includes the most detailed provider information available and is constantly updated. You can also call your administrator for assistance in locating a provider, at **1-866-868-4139**.

Welcome!

As a valuable asset and complement to your employee experience with your employer, you and your eligible household dependents have, or will soon secure access to MDLIVE telehealth services. This most innovative service allows you to contact, speak with, and even teleconference with a board-certified and approved, licensed and insured physician within MDLIVE's network, 24 hours a day, 7 days a week, and 365 days annually! **There is no cost to you for use of this service…no deductible, co-pay – nothing!**

While not intended for physical emergencies, etc. MDLIVE doctors can diagnose and prescribe for most common ailments, including flu, various infections and many common ailments. They may also recommend and advise medical treatment outside their usual and normal services. There are even dedicated providers for pediatric issues. You may access MDLIVE as often as once daily, if need be.

To access MDLIVE's system, and learn more about how to navigate their site, simply go to www.mdlive.com/be, where you will activate your account and add or edit your and your dependents' personal data, all within their secure site. All you will need to proceed with initial registration your last name and your date of birth. Your MDLIVE service will be active the first calendar day of the month specified by your employer.

AFTER activating your account, you may also call 1-888-242-9296 to ask questions or arrange telephone consultations with a doctor, although that – and much more – can be accomplished directly on this website or through the MDLIVE mobile app, available through iTunes or Google Play.

As an additional benefit available in tandem with your MDLIVE service, you have access to a drug discount program at no extra cost to you. Simply go to http://familywize.org and click "Get A Free Card." Then, use at any of the 60,000 participating pharmacy chains and private pharmacies, nationwide, to save up to 75% on generic and name brand drugs.

Also, at www.mdlive.com/be, you can learn the MDLIVE story, and study the FAQ list to find much more information and detail.

We hope you appreciate and enjoy this cutting-edge medical system access, and **ENCOURAGE ITS USE**. The more you investigate the possibilities, the more comfortable you will become with its simplicity and usefulness.

MDLIVE™

The future of healthcare is here.

24/7/365 on-demand access to affordable, quality healthcare. Anytime, Anywhere.

With MDLIVE, you can visit with a doctor from your home, office, or on the go. Our network of Board Certified doctors is available 24/7 by phone or secure video to assist with non-emergency medical conditions.

MDLIVE App Now Available
Doctor visits are easier than ever with the new MDLIVE Mobile App!

Download on the App Store | ANDROID APP ON Google play

mdlive.com/getapp

When should I use MDLIVE?

- Instead of going to the ER or an urgent care center for a non-emergency issue
- During or after normal business hours, nights, weekends, and even holidays
- If your primary care physician is not available
- To request prescription refills when appropriate. See prescription policy*
- If traveling and in need of medical care

What can be treated?

- Acne
- Allergies
- Asthma
- Bronchitis
- Cold & Flu
- Constipation
- Diarrhea
- Ear Infection
- Fever
- Headache
- Insect Bite
- Joint Aches
- Nausea
- Rashes
- Sinus Infection
- Sore Throat
- UTI

And more!

Pediatric Care related to:

- Cold & Flu
- Constipation
- Ear Infection
- Fever
- Nausea & Vomiting
- Pink Eye

And more!

Who are our doctors?

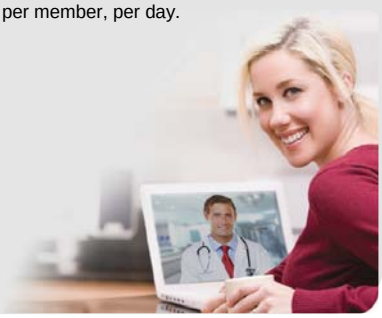
MDLIVE has the nation's largest network of doctors for telehealth services. On average, our doctors have 15 years of experience practicing medicine and are licensed in the state where patients are located. Their specialties include primary care, pediatrics, emergency medicine and family medicine. Our doctors are committed to providing convenient, quality care and always ready to take your call.

Are my children eligible?

Yes. MDLIVE has pediatricians on call 24/7/365. Please note, a parent or guardian must be present during any interactions involving minors.

How much does it cost?

Medical consults with a Doctor or Pediatrician are included in your plan without charge. Your plan allows 1 consult per member, per day.



MDLIVE.com | **1-888-632-2738** | **mdlive.com.getapp**

Disclaimers: MDLIVE does not replace the primary care physician. MDLIVE operates subject to state regulation and may not be available in certain states. *MDLIVE does not guarantee that a prescription will be written. MDLIVE does not prescribe DEA controlled substances, non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. MDLIVE physicians reserve the right to deny care for potential misuse of services. For complete terms of use visit www.mdlive.com/consumer/terms.html 010113

Getting started is easy!

1. If you need your prescription filled right away, ask your doctor to write two prescriptions for your long-term medicines:
   - The first for a short-term supply (e.g., 30 days) to be filled right away at a participating retail pharmacy
   - The second for the maximum days supply allowed (up to a 90-day supply) with as many as three refills (if appropriate) to be mailed to CVS Caremark
2. Complete the mail service order form. You can fill out and print the form online at **Caremark.com** by clicking on New Prescriptions. An incomplete form can cause a delay in processing.
3. Mail your order form along with your prescription(s) and payment in the envelope provided, or use your own envelope to mail the form and payment to the CVS Caremark Mail Service Pharmacy address printed on the form. You can pay using an electronic check, Bill Me Later®, or credit card (VISA®, MasterCard®, Discover® or American Express®). Or you can pay by check or money order. Do not send cash.
4. Allow up to 10 days from the day you submit your order for delivery of your medicine.

If you're not in a hurry to get your medicine, then just get a 90-day prescription from your doctor to send to CVS Caremark.

Tips for saving time and money.

1. Ask your doctor about generic medicines. Research shows that you can **save an average of 30% to 80%**** when you fill your prescriptions with a generic instead of a brand-name drug.
2. If your prescription benefit program has a Preferred Drug List, print a copy of the list from Caremark.com and take it with you to your doctor's office. Using medicines on this list may save you and your prescription plan money.
3. Make sure the prescription you receive from your doctor is legible. It should include the patient's full name, the prescribing doctor's contact information and the prescription details - including the date it was written.

Caremark.com puts the power in your hands.

- Order the fastest refills
- Check drug cost
- View prescription history
- Find a participating local pharmacy
- Contact a pharmacist

Register today at **Caremark.com** to actively manage your own health and wellness. You will need information from your benefit ID card to register.

CVS CAREMARK

www.caremark.com

*Copayment, copay or coinsurance means the amount a plan participant is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount, or other charge, with the balance, if any, paid by the Plan.

**The amount of your savings will be based on your benefit plan. Source: Generic Pharmaceutical Association's Web site: www.gphaonline.org

CVS Caremark Mail Service Pharmacy

A User's Guide

CVS CAREMARK

The advantages of mail service.

Your prescription benefit plan administered by CVS Caremark includes the use of a mail service pharmacy. If you take one or more maintenance medicines, you may save money and time with mail service and have your medicine conveniently delivered to your home, office or location of choice.

With the CVS Caremark Mail Service Pharmacy, you can:

- Receive an extended supply of medicine.
- Enjoy free regular delivery
- Speak to a registered pharmacist 24 hours a day, seven days a week
- Contact a pharmacist with your questions on Caremark.com
- Order prescription refills online or by phone anytime, day or night

Convenient refill options.

The information you receive with your medicine will show the date that you can request a refill and the number of refills you have remaining.

3 ways to refill:

- **Online** – Ordering refills at Caremark.com is convenient, fast and easy! Have your benefit ID card handy to register.
- **By Phone** – Call the toll-free Customer Care number on your prescription label for fully automated refill service. Have your benefit ID number ready.
- **By Mail** – You can also mail your refill request to CVS Caremark, but online and telephone orders tend to arrive sooner.

Allow up to 10 days from the day you submit your order for delivery of your medicine. Regular delivery is free. Overnight or second-day delivery is available for an additional charge.

Packaged for safety.

Your medicine will be mailed to you in plain, tamper-proof packaging. An order form and a return envelope are included with every delivery. All items in your order typically arrive in one package. If an item is not available, CVS Caremark will contact you to determine if you want the available items shipped or held until all items are ready.

Special handling.

Certain items require special handling and may be shipped by a faster method at no additional cost. In such cases, you may receive a call letting you know your order is being shipped.

- **Controlled substances and orders exceeding $1,200 in value** – shipped via two-day delivery service. An adult signature is required for delivery.
- **Temperature-sensitive items** – packaged and sent using special procedures, including ice packs, coolers, and/or express delivery when necessary.

What you will pay.

Your benefit materials explain your copayment* or coinsurance for mail service. You can receive up to a 90-day supply of your medicine for a copay that may be significantly less than you would pay at a participating retail pharmacy. If you are unsure of your cost, contact your benefit provider, call the toll-free number listed on your benefit ID card or in your Welcome Kit, or check drug costs on Caremark.com.

If you will be traveling.

If you need your medicine shipped to a temporary address, you can let us know by phone, on your order form or by updating your profile on Caremark.com. If you need more medicine while traveling than the quantity allowed by your prescriber or benefit plan (i.e., more than a 90-day supply), contact your benefit office for approval at least 30 days before you need a refill.

If your medicine looks different.

There may be times when a cost-saving generic drug is available to treat your condition. In this situation, you may receive the generic, unless your doctor tells us you must receive the brand-name medicine. A generic drug may look different, but all generic drugs are approved by the U.S. Food and Drug Administration to have the same active ingredients as the brand-name medicines

To learn more about your medicine.

Important information on common medicine uses, specific instructions and possible side effects is included with each order. If you need additional information, visit Caremark.com or call the toll-free number on your benefit ID card or in your Welcome Kit.

GENERAL NOTICE CONTINUATION COVERAGE RIGHTS

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to Continuation Coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains Continuation Coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** When you become eligible for Continuation Coverage, you may also be eligible for other coverage options that may cost less than Continuation Coverage.

Continuation Coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower-out-of-pocket costs. Additionally, you may qualify for a 30-day sepcial enrollment period for another group health plan for which you are eligible (such as a spouse's plan) even if that plan generally doesn't accept late enrollees.

What is Continuation Coverage?

Continuation Coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, Continuation Coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect Continuation Coverage must pay for Continuation Coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Elwood Staffing Services, Inc., and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is Coverage Available?

The Plan will offer Continuation Coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commncement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. The Plan Administrator is Elwood Staffing Services, Inc.. For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must send written notice of a qualifying event to the Plan Administrator at the following address: Elwood Staffing Services, Inc. 4111 Central Ave. Columbus, IN 47203 866.868.4139. The notice must identify the qualifying event and the date such event occurred and include any supporting documentation available (such as a divorce decree) and the name and address of all qualified beneficiaries whose coverage is affected by the qualifying event.

How is Continuation Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, Continuation Coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect Continuation Coverage. Covered employees may elect Continuation Coverage on behalf of their spouses, and parents may elect Continuation Coverage on behalf of their children.

Continuation Coverage is a temporary continuation coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in this 18-month period of Continuation Coverage can be extended:

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of Continuation Coverage and must last at least until the end of the 18-month period of continuation coverage. In the event that you become disabled prior to the 60th day of Continuation Coverage, you must provide a notice of such disability within 60 days of receiving a disability determination from the Social Security Administration, and in no event later than the expiration of the 18-month period of Continuation Coverage to the following:

Boon Administrative Services, Inc., Comerica Lock Box, P.O. Box 671227, Dallas, TX 75267-1227. Please include any available supporting documentation pertaining to the disability, including the Social Security Administration determination of disability.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of Continuation Coverage, the spouse and dependent children in your family can get up to 18 additional months of Continuation Coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving Continuation Coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. In the event that you experience a second qualifying event while you are receiving Continuation Coverage, within 30 days of such qualifying event, please provide notice to:

Boon Administrative Services, Inc., Comerica Lock Box, P.O. Box 671227, Dallas, TX 75267-1227. The notice must identify the qualifying event and the date such event occurred and include any supporting documentation available (such as a divorce decree) and the name and address of all qualified beneficiaries whose coverage is affected by the qualifying event.

Are there other coverage options besides Continuation Coverage?

Yes, instead of enrolling in Continuation Coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than Continuation Coverage. You can learn more about many of these options at www.healthcare.gov.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

For more information concerning your rights under Continuation Coverage, please contact:

Boon Administrative Services, Inc.
ATTN: COBRA Administration
Comerica Lock Box
P.O. Box 671227
Dallas ,TX 75267-1227
866.868.4139