



Lubbock-Cooper Independent School District

2009-2010
Benefit Guide



Plan Year September 1, 2009 to August 31, 2010

Contact Information

Refer to this list when you need to contact one of your benefit vendors. For general information, please contact your Benefit Office, Financial Benefit Services, or log on to www.lcisdbenefits.com.

For questions, you may call (800) 583-6908 to speak to an insurance consultant.

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Lubbock-Cooper ISD Benefit Office Information

Benefit Specialist: **Delsey Vance**

Phone Number: **806.863.2282**

Online Enrollment & Benefit Plan Information

Provider Name: **Financial Benefit Services**

Provider Phone Number: **972.690.8500 / 800.583.6908**

Provider Web Address: www.fbsinc.com

MGM Flexible Spending Accounts (FSA)

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Provider Name: **Mass Group Marketing (MGM)**

Provider Phone Number: **972.881.2255 / 866.881.2255**

Provider Web Address: www.mgmflex.com

Met Life Dental Plan Information

p 20-24

Provider Name: **Met Life Dental**

Provider Phone Number: **800.ASK 4 MET**

Provider Web Address: www.metlife.com

Contact Information

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Block Vision Plan Information

p 25-26

Provider Name: **Block Vision of Texas**

Provider Phone Number: **800.914.9795**

Provider Web Address: www.blockvision.com

Unum Disability Plan Information

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Provider Name: **Unum Select**

Provider Contact Name: **Mass Group Marketing**

Contact Phone Number: **972.881.2255 / 866.881.2255**

Contact Web Address: www.mgmtpa.com

Transamerica Cancer Plan Information

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Provider Name: **TransAmerica**

Provider Phone Number: **800.852.4678**

Provider Web Address: www.transamerica.com

NEWAPL Accident Plan Information

p 48-50

Provider Name: **American Public Life**

Provider Phone Number: **800.256.8606**

Provider Web Address: www.ampublic.com



Lubbock-Cooper Independent School District

Benefit Web Address: www.lcisdbenefits.com

Contact Information

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For questions, you may call (800) 583-6908 to speak to an insurance consultant.

Group Term Life Plan Information

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Provider Name: **5 Star**

Provider Contact: **Financial Benefit Services**

Contact Phone Number: **972.690.8500 / 800.583.6908**

Contact Web Address: www.fbsinc.com

Tx Permanent Life Plan Information

p 53-54

Provider Name: **Texas Life**

Provider Contact: **Financial Benefit Services**

Contact Phone Number: **972.690.8500 / 800.583.6908**

Contact Web Address: www.fbsinc.com

Online Enrollment Instructions

p 55-57

Provider Name: **Financial Benefit Services**

Provider Phone Number: **972.690.8500 / 800.583.6908**

Provider Web Address: www.fbsinc.com

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- ⇒ **Important IRS Notice:** New mandated federal regulations require all dependent socials for any elections made for medical, dental, and/or vision. All employees are required to login and update their dependent information during open enrollment.
 - ⇒ New for 2009 open enrollment we are providing a toll free number with licensed agents and extended hours to assist you with any benefit questions or technical difficulties while self enrolling. Your toll free number from August 17th thru August 27th is **(866) 914-5202.**
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Section 125 Plan Information

INTRODUCTION

In this booklet you will find an overview of the Section 125 Cafeteria plan, along with the voluntary plans available through Financial Benefit Services.



WHAT IS A CAFETERIA PLAN?

It allows you to deduct certain premium amounts for benefits from your gross earnings before federal withholding taxes are figured. It is a way for you to pay for certain benefits while lowering your taxable income. Please see the following “sample paycheck” which illustrates the benefit of participating in Section 125.

WHAT BENEFITS ARE AVAILABLE?

A summary of available benefits follows. Please read all information carefully and always refer to the brochure on a particular coverage for more detailed information.

HOW DO I ENROLL?

An open enrollment period will take place at approximately the same time each year at which time you may make changes to your benefits or add new benefits.

CHANGES TO BENEFITS

Mid-year changes in benefit elections can occur only if you experience a family status change, as detailed in this benefit guide.

You must present proof of a family status change to your Benefit Office within 30 days of your family status change and meet with Benefit Office staff to complete and sign the necessary paperwork in order to make any benefit election changes.

Section 125 Plan Information

SECTION 125 PLAN

The example below shows how a married employee claiming 1 exemption saves taxes when she pays for her insurance coverages on a pre-tax basis.

<u>WITH SECTION 125</u>		<u>WITHOUT SECTION 125</u>	
Monthly Salary	\$2,000	Monthly Salary	\$2,000
Less TRS	- 128	Less TRS	- 128
Less Insurance	- 250		
	<hr/>		<hr/>
Taxable Income	\$1,622	Taxable Income	\$1,872
Less Taxes	- 186	Less Taxes	- 228
	<hr/>	Less Insurance	- 250
			<hr/>
TAKE HOME PAY	\$1,436	TAKE HOME PAY	\$1,394
	=====		=====

SAVINGS

You save \$42 per month in taxes by paying for your benefits on a pre-tax basis. This means more spendable income at the end of the month to use for additional benefits or to increase your take home pay.



Section 125 Plan Information

SPECIAL RULES REGARDING SECTION 125 CAFETERIA PLAN

There are three very important issues to keep in mind:

- ⇒ Although all coverage is voluntary (you may pick and choose), **every employee is required to sign his or her Section 125 Benefit Election Form**, even if he or she selects no benefits or chooses to keep current benefits the same.
- ⇒ **All benefit elections will remain in effect and cannot be revoked or changed during this plan year unless you have one of the following changes in family status:**
 - * Marriage
 - * Divorce
 - * Birth
 - * Adoption
 - * Death
 - * Termination or change in employee or spouse's employment (full-time to part-time / part-time to full-time status)
 - * Change in eligibility status of a dependent (attains maximum eligibility age / meets and/or ceases to meet full-time student status qualification)
 - * Loss or curtailment in health coverage of employee or spouse due to change in spouse's employment and upon meeting a required eligibility period
- ⇒ **New Hires must enroll in benefit elections within 30 days from their date of hire.** After 30 days, an employee will not be allowed to enroll in benefits until the next open enrollment period without a family status change.

TOLL-FREE HELP LINE AVAILABLE

In an effort to give you a faster response to questions concerning your benefits, there is a toll-free number to call. If you have a question concerning how your benefits work, how to file a claim, or if you need other policy information, call Financial Benefit Services, LLC at (972) 690-8500 / (800) 583-6908.

2009-2010 Benefit Summary

Medical Insurance—TRS-ActiveCare BC/BS

Contact BC/BS or the Lubbock-Cooper ISD Benefit Office for more information on your medical plan.

Medical & Dependent Care Reimbursement—MGM

p 10-19

These tax-sheltered flexible spending accounts allow an individual to set aside dollars to pay for future health care and dependent care expenses. Eligible expenses must be incurred and paid within the current plan year (09/01/2009-08/31/2010). The medical reimbursement maximum is \$2,400/year. The dependent care maximum is \$5,000/year. See plan summary for further information.

The *new* MGM Flex Card will be issued for all participants in the medical reimbursement plan. Participants can use the flex card like a credit card to pay for certain expenses like doctor visit co-pays and pharmacy prescriptions directly out of your flex spending account without having to file a paper claim form. See plan summary for card highlights and changes. Don't forget to keep your receipts!

Dental Insurance—MetLife

p 20-24

Met Life is the dental carrier for Lubbock-Cooper ISD. This is a PPO Dental Plan that gives you the freedom to choose any dentist. There is a \$50 annual deductible, maximum 3 per family. There are no waiting periods for Preventative, Basic or Major services. Met Life offers a \$1,000 plan annual maximum per covered person. **For plan providers in the new network, go to www.metlife.com** See plan summary for further information. **LCISD pays for employee only dental coverage.**

Vision Insurance—Block Vision

p 25-26

Block Vision is the provider for Lubbock-Cooper ISD. Members pay a co-pay for in-network benefits. Out-of-network vision services are reimbursed up to a certain dollar amount for covered expenses. Benefits provided are eye exams and lenses every 12 months, frames every 12 months. See plan summary for further information. **LCISD pays for employee only vision coverage.**

2009-2010 Benefit Summary

Disability Insurance—Unum Select

p 27-35

This insurance is designed to provide a monthly income to an individual that is disabled due to an accident or illness. There are different plans available with benefits becoming available from the 1st day of disability to as late as the 180th day. Benefits are payable to age 65 for injury and sickness. See plan brochure for further information.

*Employees who enroll in the disability insurance can enroll without evidence of insurability for up to a \$7500 monthly benefit, based on salary. **All new coverage or increases in coverage are subject to pre-existing condition exclusions.***

*Disability premiums are deducted on an after-tax basis.

Cancer Insurance—Transamerica

p 36-47

Cancer insurance is designed to be a supplement and pays for many of the costs not covered by your medical insurance. This plan pays in addition to other coverage you may have. Transamerica offers two options for cancer insurance. This plan offers benefits up to \$15,000 a year for Radiation and Chemotherapy, \$50 per year wellness screening test, \$2,000 first occurrence benefit, ICU benefit and specified disease benefit. See plan brochure for further information.

Group Term Life Insurance—5 Star

p 51-52

This plan offers you and your dependents an excellent opportunity to purchase affordable term life insurance on a payroll deduction basis. The important plan features are high limits, guaranteed acceptance for new employees, conversion, portability rights and the Accelerated Benefit Riders. Employees must enroll in this plan in order to cover spouse and dependent children. See plan summary for further information

New employees who enroll in the life insurance within the first 30 days of employment can enroll on a guarantee issue. This means that you can enroll without evidence of insurability for 5 times annual salary up to \$150,000 for employee, 100% of employee benefit up to \$50,000 for spouse and \$10,000 for dependent children, based on salary.

* Term Life premiums are deducted on an after tax basis.

2009-2010 Benefit Summary

NEW Accident Insurance—APL

p 48-50

American Public Life Accident is a new plan offered to Lubbock Cooper ISD this year. Accident insurance is a supplemental insurance policy designed to pay in addition to any other insurance you have. This plan pays for specific sum injuries, accident emergency treatment benefit, accident follow up treatments, hospital income benefit and ICU benefit. Plan is effective 10.1.09 - 9/30.2010. Accident Insurance can be deducted from your paycheck on a pre-tax basis.

Permanent Individual Life Insurance—Texas Life

p 53-54

The Texas Life plan offers individual life insurance to age 100 with the option to extend coverage to 110. Coverage is available for you, as well as other family members, (spouse, children and grandchildren). Important plan features are level premium guarantees for a significant period of time, portability rights and the Accelerated Death Benefit due to terminal illness.

Employees do NOT have to enroll in this plan to cover spouse or children/grandchildren. Children can be through age 18 and grandchildren age 16. See plan brochure for further information.

* Individual Life premiums are deducted on an after tax basis.

⇒ **Important IRS Notice: New mandated federal regulations require all dependent socials for any elections made for medical, dental, and/or vision. All employees are required to login and update their dependent information during open enrollment.**



Lubbock-Cooper Independent School District
Benefit Web Address: www.lcisdbenefits.com



*Welcome to Mass Group Marketing, Inc.
A third party administrator providing
services to school districts since 1980.*

Our long-term success is attributed to adhering to a basic business philosophy:

- We pride ourselves on our professionalism, integrity, and hard work
- We only offer products with lasting stability, strength, and performance
- We focus on the individual needs and financial goals of our clients

Our goal is to simply provide the best service available to employees in school districts. MGM is constantly abreast of market trends in order to remain on the cutting edge of plan serving.

MGM has a user friendly website for participants and employers to view information and complete claims and changes at their convenience. Participants with flexible spending accounts will be issued a personal identification number (PIN) to access their accounts. Claim, status change and deposit forms are available on the MGM website.

Contact Us:

Benefit counselors are available to assist you from 8 a.m. to 5:30 p.m. Central Standard Time, Monday through Thursday and 8 a.m. to 2:00 p.m. on Fridays.

Mail Claims: Mass Group Marketing, Inc.
 2121 N. Glenville Drive
 Richardson, TX 75082

Contact Phone: (800) 833-4028

Fax Claims: (800) 973-3702

Website: www.mgmflex.com

Questions: flex@massgroupmarketing.com



Guide to



Flexible



Spending Accounts

A Section 125 Cafeteria Plan offered by Mass Group Marketing, Inc.

Section 125 Plan is a part of the Internal Revenue Code that allows employees to convert a taxable cash benefit (salary) into non-taxable benefits. You may choose to pay for benefit premiums and other qualified expenses before any taxes are deducted from your paycheck.

Benefits Eligible for Your Section 125 Plan

Under Section 125, your employers Plan may offer the option to include the premium cost for your employee benefit plans. You may pay the premiums pre-tax for your medical, dental, cancer and vision insurances. Your plan may also offer flexible spending accounts for your health care and dependent care needs.

Flexible Spending Accounts

A Flexible Spending Account (FSA) is a special account for healthcare and dependent care expenses. When you enroll in an FSA, you decide how much to contribute to each account for the entire Plan Year. The money is then deducted in equal amounts from your paycheck, before Federal & State income taxes and FICA taxes are deducted. These "pre-taxed" funds are automatically deposited in your account through payroll deduction. Unless you have a qualifying event under Section 125 regulations, your election amount will not change during the year.

There are two kinds of Flexible Spending Accounts - Health FSA and Dependent Care FSA. You can choose to participate in both accounts, but funds may not be co-mingled. Expenses for these accounts must be incurred during your employer's plan year.

Health FSA

The Health Care FSA is a tax-free account that allows you to pay for essential health care expenses that are not covered, or are partially covered, by your medical, dental and vision insurance plans. These expenses may be incurred by you or your eligible dependents. Expenses include deductibles, co-insurance payments, office co-pays, orthodontics, glasses and contacts. Once enrolled in FSA's the money is available to you on the first day of the plan. You must spend the funds by the end of the plan year, or they will be forfeited from your account.



Orthodontic Expenses

IRS stipulates how orthodontic expenses can be reimbursed in a health care FSA. You should carefully plan when deciding on your annual election if it includes orthodontic expenses. The services must be performed and incurred within the plan year. Reimbursement of a lump sum payment to a dentist may not be eligible if any of the services will be performed in a subsequent plan year.

Over-the-Counter Items

The IRS allows that some over the counter (OTC) drugs and medications which are used to treat sickness may be reimbursed by Health Care Flexible Spending Accounts. Claiming these types of medications for

reimbursement can help participants meet their FSA allotments for the year, and minimize the fear of leaving money on the table due to the “use-it-or-lose-it” rule. Eligible expenses include medicines or products that alleviate or treat personal injuries or illness for you and your dependents. IRS also allows you to purchase qualified over-the-counter-drugs (OTC) through your pharmacy without a prescription. For most OTC’s, you are not required to provide a statement from a medical provider, or indicate a diagnosis in order to receive reimbursement. Receipts for reimbursement must state the place of purchase, date of purchase, dollar amount, name of the item, and can be claimed within reasonable quantities. We recommend that you retain copies of all OTC receipts for your records.

There are some medical items that may not be allowed unless you are diagnosed by a medical professional for a specific medical condition. Treatment for eligible expenses can not be for preventative purposes.

Dependent Care FSA

This account allows you to pay for day care expenses that enable you and your spouse to work and/or attend school fulltime. It may also include eligible expenses for children or elder dependents that rely on you for their care. Examples of eligible expenses are: care in and outside the home, day care, before and after school care, nursery school, preschool tuition, day care camps and facilities (if not primarily for educational purposes). Your care provider must report day care income on their taxes to be considered as eligible.

Dependent Care funds must be available in your account before you can be reimbursed.



The total amount you choose to contribute should be based on your expected child and/or dependent care expenses during the plan year.

A single parent, or employee that is married but filing separately is limited to \$2,500 for the Plan year.

If your spouse has a dependent care account through their employment, the two accounts cannot exceed \$5,000 during a given plan year.

How to File A Claim

For expenses not eligible for debit card payments, claim forms and receipts must be submitted to Mass Group Marketing, Inc. Legible receipts must be attached, and may be sent by fax or mail. For items subject to reimbursement from your medical plan, you must also include a copy of the explanation of benefits. Dependent care expenses must include the providers’ information and tax or social security number. For orthodontic claims, full payments for treatment will not be made, but are paid as service is incurred. Please include a copy of the contract or schedule of payments.

Only itemized receipts will be accepted. Receipts that only show the amount spent for a service or product will only delay your claim reimbursement. Acceptable itemized receipts have the name of provider, date and details of purchase.

Claim Processing

MGM’s standard commitment is a 72 hour business day turnaround, although claims are often processed within 48 hours.

Website Access

You may access the Mass Group Marketing Website at www.mgmtpa.com. Claim forms and change forms are available on the website.

Direct Deposit

MGM offers direct deposit for participant reimbursement checks. This form is also available on the MGM website. A deposit confirmation will be mailed to your address.

The *New* MGM Visa Card

Using your health FSA is quick and easy – just swipe it as payment for your eligible expenses and the funds are automatically deducted from your account.



The MGM Visa Card is an automatic way to pay for qualified health care/benefit expenses. It is not a credit card, but can be used to pay for your eligible health flexible spending account (FSA) purchases. The card is similar to a Visa Card and has your plan year account contribution loaded on it. Each time you swipe it, the amount of the qualified purchases is automatically deducted automatically from the account.

You may use the Card for co-pays at hospitals, physician offices, dental offices, vision service locations and pharmacies purchases wherever you can use MasterCard® or Visa® debit cards for purchases. *Only eligible expenses that have been incurred during the current plan year and/or grace period can be claimed as eligible expenses. The Card should only be used at health care related providers.*

Some over the counter products (OTC's) are eligible to purchase with the Card. These products must be used in treating symptoms of injury and illness. Some examples include: cold and allergy remedies, first aid supplies, pain remedies, etc. Personal care items are not eligible for Card use.

There still may be times when you will need to submit a manual claim. Participants may also pay expenses from their personal funds and then file a claim for reimbursement. This will be necessary if you choose a provider that is not a participating merchant. MGM reimburses manual claims within 72 hours (Monday-Friday) after the claim is received.

Only expenses incurred during the plan year are eligible for reimbursement. This is also true of manual claims submitted for reimbursement. For example, the Card cannot be used to pay off an outstanding account balance that existed prior to the plan effective date. In the event the Card is used to pay on a previous balance, you will be asked to reimburse your account. Failure to reimburse the account may result in the Card being suspended.

It's Important to Save Your Receipts! The IRS requires the Card be used only for eligible expenses. Most of the time, we can verify the eligibility of the expense automatically. Yet, there are instances when you'll receive a letter/notification asking you to furnish an itemized receipt to verify the expense.

When you receive such a request, make sure you submit the receipts as soon as possible to avoid having your Card suspended until receipts have been submitted and approved. In cases of accidental misuse of the card, you will be asked to provide substantiation of the expenses placed on the card. If expenses cannot be substantiated, you will be asked to repay the charged amount to your health FSA. The card will be suspended if expenses cannot be substantiated.

What is an itemized receipt? An itemized receipt must include: merchant or provider name, services received or item purchased, date of service, and amount of the expense. Cancelled checks, handwritten receipts, card transaction receipts or previous balance receipts cannot be used to verify an expense. We suggest that you keep their itemized receipts in one place so they're readily available when you receive a request.



Health Care Flexible Spending Accounts

- ◆ *Eligible Medical Expenses*
- ◆ *Over-The-Counter Items List*

Eligible Health Care Reimbursement Expenses

The following is a partial list of health care expenses that are eligible for reimbursement from your Health Care Spending Account. Some items may require a physician's order to qualify as an eligible expense.

Abdominal supports	Lodging (away from home for outpatient care)
Acupuncture	Metabolism tests
Air conditioner (relief from allergy or breathing difficulty; for medical treatment only)	Neurologist
Alcoholism treatment	Nursing (including board and meals)
Ambulance	Obstetrician
Anesthetist	Operating room costs
Arch supports	Ophthalmologist
Artificial limbs	Optician
Birth control pills (by prescription)	Optometrist
Blood tests	Oral surgery
Blood transfusions	Organ transplant (including donor's expenses)
Braces	Orthopedic shoes
Cardiographs	Orthopedist
Chiropractor	Osteopath
Christian Science Practitioner	Oxygen and oxygen equipment
Contact lenses	Pediatrician
Contraceptive devices (by prescription)	Physician
Convalescent home (for medical treatment only)	Physiotherapist
Crutches	Podiatrist
Dental treatment	Postnatal treatments
Dental X-rays	Practical nurse for medical services
Dentures	Prenatal care
Dermatologist	Prescription medication
Diagnostic fees	Psychiatrist
Diathermy	Psychoanalyst
Drug addiction therapy	Psychologist
Drugs (prescription)	Psychotherapy
Elastic hosiery (prescription)	Registered nurse
Eyeglasses	Special school costs for the handicapped
Fees paid to health institute prescribed by doctor	Spinal fluid test
Fluoridation unit	Splints
Guide dog	Sterilization
Gum treatment	Surgeon
Gynecologist	Telephone or TV equipment to assist the hard of-hearing
Healing services	Therapy equipment
Hearing aids and batteries	Transportation expenses (related to health care)
Hospital bills	Ultraviolet ray treatment
Hydrotherapy	Vaccines
Insulin treatments	Vasectomy
Lab tests	Wheelchair
Laser eye surgery	X-rays

Ineligible Expenses

The following is a partial list of health care expenses that are not eligible for reimbursement from the Health Care Spending Account.

- Dietary Supplements (e.g. vitamins)
- Electrolysis
- Exercise or health club memberships
- Insurance premiums
- Physical therapy treatments for general well-being
- Supplements prescribed by an alternative provider
- Teeth bleaching
- Weight reduction or smoking cessation program

Over The Counter (OTC) Drugs Used Primarily for Medical Care

These items typically are reimbursable with a proper receipt without authorization from a medical provider.

Type/Class of Drug or Product	Examples/Brand Names*
Allergy Prevention and Treatment	Actifed, Allerest, Benadryl, Chlor-Trimetron, Claritin, Contact, Sudafed
Analgesics/Antipyretics	Aspirin, Advil, Ibuprofen, Naprosyn, Tylenol, Midol, Pamprin, Premsyn PMS
Antacids and Acid Reducers	AXID AR, Gas-X, Maalox, Mylanta, Tums, Pepcid AC, Prilosec OTC, Tagamet HB, Zantac 75
Anti-arthritics	Excedrin Arthritis, Tylenol Arthritis
Antibiotics (topical)	Bacitracin, Triple Antibiotic Ointment, Neosporin, Polysporin
Anticandial (Yeast)	Femstat 3, Gyne-Iotri8min, Mycelrx-7, Monistate 3, Vagistat-1
Antidiarrheal and Laxatives	Ex-Lax, Immodium AD, Kaopectate, Pepto-Bismol
Antifungal	Lamisil AT, Lotramin AF, Micatin
Antihistamines	Actidil, Actifed, Allerest, Benadryl, Claritin, Chlor-Trimetron, Contact, Drixoral, Sudafed, Tavist-1, Tramitic
Anti-itch Lotions and Creams	Bactine, Benadryl, Caldecort, Caladryl, Calamine Lotin, Cortaid, Hydrocortisone, Lanacort, Lamisil AT, Lotramin AF, Micatin
Asthma Medicines	Primatene Mist
Cold Sore/Fever Blister	Abreva Cream, Blistex, CamphoPhenic, Carmex
Contraceptive Products	Pregnancy Tests, Spermicides
Cough Suppressants or Expectorants	Chloraseptic, Robitussin, Sucrets, Vicks 44
Decongestants/Cold and Flu Remedies	Actidil, Actifed, Advil Cold and Sinus, Afrin, Aleve Cold and Sinus, Alka Seltzer Cold and Flu, Afrinol, Children's Advil Cold, Dayquil, Dimetane, Dristan Long Lasting, Drixoral, Neo-Synephrine 12 Hour, Nyquil, Orrivin, Pedicacare, Sudafed, Tavist-D, Triaminic, Tylenol Cold and Flu
Dehydration	Pedialyte
Diaper Rash Ointments	Balmax, Destin
Eye Drops for Allergy/Cold Relief	Ocu Hist, Visine, Clear Eyes
First Aid Supplies	Bandages, First aid kits, Cold/hot packs for injuries, Rubbing alcohol, Ace wraps, Splints
Hemorrhoidal Preparations	Preparation H, Hemorid, Tronolane
Migraine Relief	Advil Migraine, Motrin Migraine, Excedrin Migrane, Tylenol Migrane
Motion Sickness	Dramamine, Marizine
Muscle and Joint Discomfort	Ben Gay, Icy Hot, Tiger Balm, Flexall
NSAIDS	Advil, Aleve, Ibuprofen, Motrin, Maprosyn, Naproxen
Pediculicide	Nix, Rid
Sinus Products	Nasal Sprays
Sleeping Aids	Tylenol P.M., Excedrin P.M.,
Smoking Cessation Aids	Commit, Nicoerm CQ, Nicorette, Nicotrol
Sunburn Relief	Solarcaine
Teething/Toothaches	Orajel, Little Teethers
Test Kits	Blood Pressure Kit, Cholesterol tests, Colorectal Cancer Screening, Diabetic Monitor and Supplies, Ovulation Indicators, Pregnancy Tests
Wart Removal	Compound W, Scholl Clear Away, Wart-Off

*The products listed here are examples, and do NOT constitute an endorsement or an exhaustive listing of reimbursable OTC products.

Dual Purpose Medicines and Products

These items may be reimbursed under a health care flexible spending account with a licensed health care provider's note indicating the specific medical condition; a recommendation to take the specific OTC medicine to treat the condition, that the medical item is not for cosmetic purposes, along with the documentation of the product and cost.

Type/Class of Drug or Product	Reimbursable Use	Excluded Use
Acne Products	Chronic acne under treatment by a physician	Occasional outbreak or blemish; cosmetic purposes
Contact Lens Supplies	Associated with vision health	Cosmetic contacts; non-related
Dental Fluoride Products	Treatment for gingivitis, special mouthwashes	Routine use for general oral care
Dietary Supplements	Vitamin B for treatment of scurvy	Routine use for general health
Feminine Hygiene Products	Post surgery or childbirth	Infants and toddlers
Fiber Supplements	Documented specific medical condition; short duration	Routine use for general health
Hair Loss Treatments	Replace hair loss from medical conditions	Balding due to age
Incontinence Products	Post surgery	Occasional use of incontinence items
Joint Supplements	Diagnosis of Arthritis	Routine use for overall joint health
Mineral Supplements	Calcium, Caltrate; Need doctor statement of medical necessity	Benefit or maintain general health
OTC Hormone Therapy	Specific medical conditions	General health maintenance
Pre- Natal Vitamins	Pregnancy or medical treatment	Routine use for general health
Snoring Cessation Aids	Sleep Apnea	Non-medical related conditions
Weight Loss Products	Specific medical condition such as Obesity	Routine use for general health

Excluded Products

These items and products are considered to be primarily for general health and well being, and are not eligible expenses.

Type/Class of Drug or Product	Examples/Brand Names*
Cosmetic Products	Creams, Face Soaps, Hair Removal, Lotions, Makeup, Perfumes
Dental Products	Dental Floss, Mouthwash, Toothpaste, Toothbrushes, Teeth Whitening Kits
Toiletries	Body Sprays, Lip Balms, Deodorant, Moisturizers, Shampoo, Soaps
Vitamins	Routine use for general health
Herbal Supplements	Routine use for general health
Dietary/Nutritional Supplements	Boost, Ensure, Glucema, Slimfast

Reimbursement for OTC medicines must still follow the existing rules regarding health care flexible spending accounts.

The expense(s) must:

- ✓ Be incurred during your period of coverage;
- ✓ Not be reimbursable through another plan; and
- ✓ Be substantiated through a detailed receipt.

* The products listed here are examples, and do NOT constitute an endorsement or an exhaustive listing of reimbursable OTC products.

Please Read Carefully

CLAIM FILING INSTRUCTIONS

Who Can File a Claim Form?

- \$ Only Employees participating in the Cafeteria Plan flexible spending accounts can file a reimbursement claim form.
- \$ Employees can file a claim form during the plan year and for a certain period after the plan year, in most cases 90 days. Contact your plan administrator for what is available under your plan.
- \$ Terminated employees can file a claim form for a certain period after the date of termination if allowed by the Plan.

What Expenses Can be Claimed?

- \$ Only expenses incurred during the plan year can be claimed for reimbursement.
- \$ Allowable expenses are the same as those allowed for tax purposes. A summary list is provided on the back of the claim form.

Completion of the Claim Form.

- \$ Complete all information on the claim form for each amount claimed for reimbursement. Be sure to include your social security number and your employer's name, date the form and sign it in ink.
- \$ Make sure the claim form does not include expenses incurred in more than one plan year. Use different claims forms for different plan year expenses.
- \$ All prescription, medical and dental expenses must first be submitted to the Health and/or Dental insurer, if any. Please submit a copy of the insurer's Explanation of Benefits for any covered expenses. If there is not an insurer, please submit the expenses directly to MGM. In either case, actual receipts or Doctor's statements must be submitted.
- \$ All claims being submitted for Dependent Care expenses must include the provider's name, address, phone number and tax or social security number. Cancelled checks may be submitted as receipts for Dependent Care expenses provided you include the name(s) of person(s) for whom the service was provided, actual date of service, and a breakdown of all charges.
- \$ For the first filing of orthodontic claims please include a copy of the contract or schedule of payments. Thereafter, simply submit a claim form with the receipt and indicate that it is for an Orthodontic treatment expense.
- \$ Always keep copies of any items submitted to MGM for reimbursement.

How Can I View My Account Online?

Go to www.mgmtpa.com to access your account. <http://www.mgmtpa.com> This takes you to the MGM log-in site for the flexible spending accounts online system. Your social security number is your User ID number. You will need to use the pin number provided to you enclosed in this claims procedural manual.

How to Find Flex Plan Forms Online?

The Mass Group Marketing website - www.mgmtpa.com has forms available for your use. Click on "Forms Online". Choose "CPS Claim Forms" and print the form to submit your Flexible Spending Account claims. Status change forms are also available.

Can you Automatically Deposit my Claim Check into my Checking Account?

By completing the enclosed direct deposit authorization agreement and mailing it to MGM, the next time you file a claim the money will automatically be sent to your bank account with a **confirmation of funds transferred mailed to your current mailing address.**

CLAIM REVIEW PROCEDURES

At some time during an employee's participation in a cafeteria plan a claim for benefits may be denied. If this happens, and the Participant wishes to appeal the decision, there are several safeguards in place to protect his rights as a Participant.

Processing The Claim

A participant will be advised within 90 days of filing his claim if it is going to be denied. MGM will notify the plan administrator as well as the Participant of the delay. Depending upon the circumstances, the 90 day period may be extended if there are exceptional problems in processing the claim.

Claim Rejections

If a Claim is rejected, it will fall into two categories:

- (1) A claim is filed for a benefit that does not qualify as an included benefit under the plan, and/or;
- (2) A claim form is improperly completed by the participant for an eligible benefit under the plan.

In both instances, MGM will tell the participant what action has been taken on their claim, and if additional paperwork or information is needed they will be given the extra time to get the necessary paperwork in.

The Appeals Procedure

If a participant is not satisfied and decides to appeal a claim decision, he has specific legal rights as a Participant.

- (1) The participant, or his representative, may request a review of his claim by submitting a written application to the Plan Administrator. This request must be submitted within 60 days of the date the Participant was first notified the claim was being denied.
- (2) The Participant may review any documents relating to his claim.
- (3) The Participant may submit a written statement concerning the claim.

It is the purpose of the Plan Administrator to settle claims in a fair and nondiscriminatory process. The Participant is entitled to specific rights outlined more in depth in the cafeteria plan document. These rights insure a Participant's involvement in the appeals process.

The Review Procedure

The Plan Administrator will make a decision concerning a Participant's claim within 60 days of written notification by the participant wishing to have his claim reviewed. In exceptional cases, the Participant will be notified if an extension is necessary. In no event can the decision be delayed longer than an additional 60 days.

The Participant will receive a written explanation of the final decision of the Plan Administrator. It will include the specific reasons for the Plan Administrator's decision.

Dental Benefits from MetLife

Dental coverage designed for the real world.



MetLife®

Network Primary Dental
Plan Design for: Lubbock Cooper ISD
Effective Date: October 1

Choice, Service, Savings.

To help you enroll, this overview includes rate information and a Q&A so you can make the most informed decision possible.

Coverage Type:	In-Network ¹	Out-of-Network ¹
Type A – Preventive	100% of PDP Fee ²	100% of R&C Fee ⁴
Type B - Basic Restorative	80% of PDP Fee ²	80% of R&C Fee ⁴
Type C - Major Restorative	50% of PDP Fee ²	50% of R&C Fee ⁴
Type D - Orthodontia	50% of PDP Fee	50% of R&C Fee
Deductible³		
Individual	\$50	\$50
Family	\$150	\$150
Annual Maximum Benefit:		
Per Person	\$1,000	\$1,000
Orthodontia Lifetime Max - Child Only \$1,000 per Person		
<p>¹“In-Network Benefits” means benefits under this plan for covered dental services that are provided by a Participating PDP Provider. “Out-of-Network Benefits” means benefits under this plan for covered dental services that are not provided by a Participating PDP Provider. ² PDP Fee refers to the fees that participating PDP dentists have agreed to accept as payment in full. ³ Applies to Type B and C services only. ⁴ Out-of-network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of: <ul style="list-style-type: none"> • the dentist’s actual charge (the 'Actual Charge'), • the dentist’s usual charge for the same or similar services (the 'Usual Charge') or • the usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). Services must be necessary in terms of generally accepted dental standards. </p>		

An Example of Savings When You Visit a Participating PDP Dentist			
Take a look at an example* that shows how receiving services from a participating PDP dentist can save you money:			
Your Dentist says you need a Crown, a Type C Service			
PDP Fee: \$400.00 R&C Fee: \$600.00			
Dentist’s Usual Fee: \$600.00			
* Please note: this example assumes that your annual deductible has been met.			
(IN-NETWORK)		(OUT-OF-NETWORK)	
When you receive care from a Participating PDP dentist...		When you receive care from a Non-Participating PDP dentist...	
The PDP Fee is:	\$400.00	Dentist's Usual Fee is:	\$600.00
Your Plan Pays:		Your Plan Pays:	
(50% x \$400 PDP Fee)	- \$200.00	(50% x \$600 R&C Fee)	- \$300.00
Your Out-of-Pocket Cost:	\$200.00	Your Out-of-Pocket Cost:	\$300.00

IMPORTANT RATE INFORMATION

Monthly (12 months) Premium Payment	
<u>Employee</u>	\$0.00
<u>Employee + 1 Dependent</u>	\$22.61
<u>Employee + 2 or More Dependents</u>	\$45.22

Cancellation/Termination of Benefits:

Coverage is provided under a group insurance policy (Policy form GPN99) issued by Metropolitan Life Insurance Company. In Pennsylvania, coverage is provided under a group insurance policy (Policy form G.2130P-S) issued by Metropolitan Life Insurance Company. Subject to the terms of the group policy, rates are effective for one year from your plan's effective date. Once coverage is issued, the terms of the group policy permit Metropolitan Life Insurance Company to change rates during the year in certain circumstances. Coverage terminates when your full-time employment ceases, when your dental contributions cease or upon termination of the group policy by the Policyholder. The group policy may also terminate if participation requirements are not met, a dependent ceases to be a dependent or on the date of the employee's death, if the Policyholder fails to perform any obligations under the policy, or at MetLife's option. There is a 30-day limit for the following services that are in progress: Completion of a prosthetic device, crown or root canal therapy after individual termination of coverage.

IMPORTANT ENROLLMENT INFORMATION

Benefits Plan Effective Date: Please see the enclosed cover sheet for specifics on your Plan's effective date.

Important Enrollment Provisions:

You may only enroll for dental coverage when you become first eligible or if an open enrollment period is declared. Once your coverage is effective, if it is terminated for any reason, you may not elect to re-enroll at a later date. Metropolitan Life Insurance Company reserves the right not to issue coverage in certain circumstances.

Qualifying Event:

You may change coverage outside of an open enrollment only when you have a Qualifying Event, which changes your family status (e.g. marriage, divorce, the birth or adoption of a child, death of a dependent, etc.). You may enroll or change your enrollment option for coverage within 31 days of the above Qualifying Events. You must currently be enrolled in the Plan in order to be eligible for changes in your Personal Benefits due to a Qualifying Event.

Like most life insurance policies, MetLife group insurance policies contain certain exclusions, waiting periods, reductions and terms for keeping them in force. For costs and complete details of coverage, call or write your MetLife representative. In addition, a full description of your dental benefits will be provided in the certificate of insurance.

MetLife Preferred Dentist Program (PDP) Overview Frequently Asked Questions

How does the MetLife PDP work?

With a dental benefit plan featuring the MetLife PDP, you receive benefits whether or not you and/or each eligible dependent visit a participating PDP dentist. But, when you visit a participating PDP dentist, you have the opportunity to maximize your benefit plan with access to lower, out-of-pocket expenses. The MetLife PDP is a Preferred Provider Organization, wherein you choose a provider at the time of treatment. You do not have to pre-select a primary dentist nor do you need an ID card or referrals for specialty care.

What is a participating PDP dentist?

A general dentist or specialist who meets MetLife's strict credentialing standards and accepts negotiated fees as payment-in-full for services rendered. There are more than 94,000 participating dentist locations nationwide, including more than 21,000 specialist locations. So you should have no problem finding a participating PDP dentist near your home or workplace, while you're away on vacation, or while your covered dependents are away at college.

How do I find a Participating PDP dentist?

You can call the PDP automated Computer Voice Response line to obtain an up-to-date directory of participating dentists in your area. The system prompts you to enter your Social Security Number and a home or work ZIP code. A list of up to 205 participating dentists in the requested ZIP code is then mailed to your home the next business day. To receive your personalized directory, call 1-800-474-PDP1 (7371) Mon.-Fri. 6:00am to 11:00 pm ET or Saturday 7 am to 4:00 pm ET. You can also conduct online provider searches (with direction and mapping capabilities) via MetLife's Dental Internet site at www.metlife.com/dental.

Please Note: Be sure to verify provider participation when you make your appointment.

What is a negotiated fee?

A negotiated fee refers to the PDP fee schedule which participating dentists agree to accept as payment in full. The fee is typically 10% to 35% below average fees of dentists in your area. Your plan may reimburse you for all or part of the PDP fee. When you use a participating PDP dentist, you are responsible only for the difference between MetLife's benefit payment amount and the PDP fee.

Do I need an ID card?

No, you do not need to present an ID card to confirm that you're eligible. You should notify your dentist that you participate in MetLife's PDP. Your dentist can easily verify information about your coverage through a toll-free automated Computer Voice Response system.

Do my dependents have to visit the same dentist that I select?

No, you and your dependents each have the freedom to choose any dentist.

My dentist does not participate in the PDP. Is there anything I can do to encourage my dentist to participate?

The MetLife PDP Network is continually expanding, and new providers may be added if they meet MetLife's credentialing standards. You may ask your dentist to complete a MetLife PDP nomination card or visit the dentist directory online at www.metlife.com/dental, and MetLife will send him or her information on how to apply for participation. The timing depends on how quickly MetLife receives the necessary information. Please note that there may be instances where a dentist chooses not to participate and others where MetLife does not accept the application under their stringent credentialing requirements.

Can I find out how much services will cost and obtain an estimate of what will be covered prior to treatment?

Yes, MetLife recommends that you have your dentist submit a request for a pre-treatment estimate for services in excess of \$300.00. This often applies to services such as: crowns, bridges, inlays, and periodontics. When your dentist suggests treatment, have him or her send an undated claim form, along with the proposed treatment plan, to MetLife. A pre-treatment estimate will be sent to you and the dentist detailing an estimate of what services Your Plan will cover and at what payment level.

How do I file a claim?

Claim forms are available from your human resources department or can be downloaded and printed out from MetLife's dental website at www.metlife.com/dental. Remember to bring one with you to your appointment. Complete the employee portion, and your dentist will assist you with the rest. You can use the same claim form whether or not your dentist is a participating PDP dentist. MetLife will mail you a concise explanation of benefits (EOB) statement after each claim submission. If you have a claim inquiry or benefit questions, please call MetLife's Dental Customer Service Department at 1-800-ASK - 4 - MET after your plan's effective date.

Dental Claims Address: MetLife Dental Claims, P.O. BOX 981282, El Paso, TX 79998-1282

If I do not enroll during my initial enrollment period can I still purchase Dental Insurance at a later date?

Yes, employees who do not elect coverage during their 31-day application period may still elect coverage later. Dental coverage would be subject to the following waiting periods.

- 6 months on Basic Restorative (Fillings)
- 12 months on all other Basic Services
- 24 months on Major Services
- 24 months on Orthodontia Services (if applicable)

The MetLife[®] Preferred Dentist Program (PDP) Exclusions

The following expenses are not Covered Dental Expenses

x Services or Supplies...

- related to teeth lost before dental benefits began or for congenitally missing natural teeth;
- received by a covered person before the dental expense benefits start for that person;
- which are covered by any worker's compensation laws or occupational disease laws;
- which are covered by any employer's liability laws;
- which an employer is required by law to furnish in whole or in part;
- received through the medical department or similar facility which is maintained by the covered person's employer;
- received by a covered person for which no charge would have been made in the absence of dental expense benefits for that covered person;²
- for which a covered person is not required to pay;¹
- which are not necessary, according to generally accepted dental standards, or which are not recommended or approved by a dentist;
- which do not meet generally accepted dental standards, including experimental treatment;
- received as a result of dental disease, defect, or injury due to an act of war, or warlike act in time of peace, which occurs while the dental expense benefits for the covered person are in effect;
- which are provided by any other plan which the employer (or an affiliate) contributes to or sponsors.²

x Services not performed by a dentist except for those of a licensed dental hygienist which are supervised and billed by a dentist and which are for cleaning and scaling of teeth or fluoride treatments.

x Cosmetic surgery or supplies. However, any such surgery or supply will be covered if it otherwise is a covered dental expense; it is required for reconstructive surgery that is incidental to or follows surgery that results from a trauma, an infection or other disease of the involved part; or is required for re-constructive surgery because of a congenital disease or anomaly of a dependent child that has resulted in a functional defect.

x Replacement of a lost, missing or stolen crown, bridge or denture.

x Repair or replacement of an orthodontic appliance.

x Adjustment of a denture or a bridgework which is made within six months after it is installed by the same dentist who installed it.

x Any duplicate appliance or prosthetic device.

x Use of materials or home health aids, to prevent decay, such as toothpaste or fluoride gels, other than the topical application of fluorides.

x Instruction for oral care such as hygiene or diet.

x Periodontal splinting.

x Myofunctional therapy or correction of harmful habits.

x Charges by a dentist for completing dental forms.²

x Charges for broken appointments.³

x Temporary or provisional restorations.

x Temporary or provisional appliances.

x Sterilization supplies.³

x Services or supplies furnished by a family member.³

x Treatment of temporomandibular joint disorders.

x Myofunctional therapy or correction of harmful habits.

x Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.

In Maryland:

x Services or supplies furnished as a result of a Referral prohibited by Section 1-302 of the Maryland Health Occupations Article. A prohibited Referral is one in which a Health Care Practitioner:

a. refers a covered person to; or

b. directs an employee or a person under contract with the Health Care Practitioner to refer a covered person to a Health Care Entity in which:

a. the Health Care Practitioner; or

b. the Health Care Practitioner's immediate family; or

c. both own a Beneficial Interest or have a Compensation Agreement.

For the purposes of this provision, the terms "Referral," "Health Care Practitioner," "Health Care Entity," "Beneficial Interest," and "Compensation Agreement" have the same meaning as provided in Section 1-301 of the Maryland Health Occupations

¹ In policies situated in **MD**, these exclusions do not apply to Medicaid.

² Not applicable in **MD**.

³ Not applicable in **FL, MD, NJ** and **TN**.



BLOCK VISION OF TEXAS BENEFIT ILLUSTRATION LUBBOCK-COOPER ISD

Platinum \$125 VISION PLAN

\$10 Exam/\$25 Eyewear Copayments Full Service – Illustration

<u>Service / Material</u>	<u>Participating Provider</u>	<u>Non-Participating Provider</u>
Vision Examination:	Paid in full*	Up to: \$35.00 Retail Value*
Frame:	Up to: \$125.00 Retail Value*	Up to: \$70.00 Retail Value*
Lenses: (Clear, Standard, Glass or Plastic)		
Single Vision (per pair)	Paid in full*	Up to: \$25.00 Retail Value*
Bifocal (per pair)	Paid in full*	Up to: \$40.00 Retail Value*
Trifocal (per pair)**	Paid in full*	Up to: \$45.00 Retail Value*
Lenticular (per pair)	Paid in full*	Up to: \$80.00 Retail Value*
Contact Lenses:***		
Elective	Up to \$150.00*	Up to: \$80.00 Retail Value*
Medically Required	Paid in full*	Up to: \$150.00 Retail Value*

* After applicable copayments listed above are fulfilled.

** Member pays difference in retail price between standard trifocal lenses and progressive lenses.

*** Contact lenses and related professional services (fitting, evaluation and follow-up) are covered *in lieu of* eyeglasses.

Coverage to include all contact lens types (i.e. standard daily wear, extended wear, disposable, toric, gas permeable, and bifocal).

Frequency:

Vision Examination	Once Each 12 Months
Frame	Once Each 12 Months
Lenses	Once Each 12 Months
Contact Lenses	Once Each 12 Months

Rates:

<u>Employer Paid for Employees; Voluntary for dependents</u>	<u>Monthly</u>
Employee	\$ 0.00
Employee + 1	\$ 8.15
Family	\$14.10

Non-Covered Eyewear Discount: Members may also receive a discount of 20% from a participating provider's usual and customary fees for eyewear purchases which exceed the benefit coverage (except disposable contact lenses, for which no discount applies). This includes eyeglass frames which exceed the selected benefit coverage, specialty lenses (i.e. progressives) and lens "extras" such as tints and coatings. Eyewear purchased from a Wal-Mart Vision Center does not qualify for this additional discount because of Wal-Mart's "Always Low Prices" policy.

WE FOCUS ON YOU SO YOU CAN FOCUS ON LIFE



**FOR MORE INFORMATION PLEASE CONTACT US TOLL-FREE AT
(866) 265-0517 OR VISIT OUR WEBSITE AT www.blockvision.com**

Vision Plan Questions & Answers

What plan options are available?

Lubbock-Cooper ISD employees are being offered our Platinum \$125 plan. The Platinum \$125 plan includes a routine/basic vision examination yearly. The eyewear benefit provides coverage for lenses or contacts every year and provides up to \$125 coverage for frames every year.

How do I enroll in this plan?

You must complete the enrollment form furnished to you. At enrollment, you should mark your coverage selection (i.e. employee, employee+ 1, or family). If you select employee+ 1, or family be sure to include all the information requested for covered dependents, including social security numbers and birth dates.

How do I use this plan?

With your vision benefit, choose a provider from the participating provider list. Present your ID card for services at the time of service. **EXCEPT FOR ANY APPLICABLE COPAYMENT, DO NOT PAY YOUR PARTICIPATING PROVIDER FOR SERVICES OR EYEWEAR COVERED BY YOUR BLOCK VISION OF TEXAS BENEFIT.**

If you choose a non-participating provider, you will be expected to pay the doctor for services received. You will then need to send the original receipt from your non-participating doctor to Block Vision for reimbursement. Block Vision will review your eligibility and send the appropriate reimbursement to you.

Contact lenses and related professional services with a retail value of up to \$150 are covered in lieu of eyeglasses. Coverage includes the complete contact lens package (contact lenses and related professional services specific to contact lens fitting, evaluation and follow-up). Members receive a \$150 retail allowance toward the purchase of contact lenses that retail for more than \$150.

Am I able to obtain eyeglasses and contact lenses in the same year?

No. Block Vision's plan provides coverage for eyeglasses or contact lenses, but not both, within the stated benefit period.

What is the difference between an Optometrist and Ophthalmologist?

Both are known as eye doctors and both perform eye examinations. An Optometrist is an eye specialist. An Ophthalmologist is an "eye surgeon." Some of our network Optometrists are now licensed to treat eye infections, prescribe medication and remove foreign bodies.

How will the Block Vision provider determine what I am eligible to receive?

Employees electing single coverage will receive 1 ID card. Employees electing employee+ spouse, employee+ child (ren), or family coverage will be issued 2 ID cards. The Block Vision ID card enables the Block Vision provider to access Block Vision's computer system to determine what you are eligible to receive. Please be aware that your eligibility with Block Vision is calculated on a date of service - to date of service method, not calendar year. For example, if you are entitled to an exam once each 12 months and receive your first exam on 3-11-08, you will become eligible again for a new exam on 3-11-09.

If I wear disposable contact lenses, must I use my entire benefit at one time?

No. You may continue to make use of the remaining amount of your contact lens benefit during the benefit frequency stated in your plan. For example, if you need disposable lenses once every three months, then that is the way you obtain your lenses in the Block Vision plan until such time as your benefit maximum has been reached. Any remaining benefit values at the end of the benefit period are not carried over to the next benefit period.

What type of eyeglass lenses am I eligible for? What about Progressive Lenses?

Tints?

All Block Vision's plans cover clear, standard glass or plastic lenses, with single vision, bifocal or trifocal prescriptions. You may choose to upgrade your lenses by paying the difference over and above the standard lens price. For example, if you want an anti-reflective coating on your lenses, the plan will pay for the standard lens and you are responsible for the cost of the anti-reflective coating. If you would like progressive lenses, your benefit will pay for standard trifocal lenses and you will pay any amount over and above the standard trifocal price. Tinting, coating and any other "additions" to your lenses are added at your own expense. Block Vision will pay for the clear, standard glass or plastic lenses with single vision, bifocal or trifocal prescriptions.

What if I have other questions?

You may call Block Vision's office toll-free at (866) 265-0517, Monday through Friday 8:00 AM to 5:30 PM (Central Time) with any questions you may have. If you call during evening or weekend hours, you will be able to leave a message on the Block Vision voice mail system. Your call will be returned as soon as possible.





**Lubbock-Cooper Independent School District
Policy # 131686**

Please read carefully the following description of your Unum Educator Select Income Protection Plan insurance.

Your Plan

Eligibility

You are eligible for disability coverage if you are an active employee in the United States working a minimum of 20 hours per week. The date you are eligible for coverage is the later of: the plan effective date; or the day after you complete the waiting period.

Guarantee Issue

Current Employees: Coverage is available to you without answering any medical questions or providing evidence of insurability. There are two separate enrollment periods. You may enroll on or before the enrollment deadline. After the initial enrollment period, you can apply only during an annual enrollment period.

Newly Hired Employees: Coverage is available to you without answering any medical questions or providing evidence of insurability. You may apply for coverage within 60 days after your eligibility date. If you do not apply within 60 days after your eligibility date, you can apply only during an annual enrollment period.

Benefits are subject to the pre-existing condition exclusion referenced later in this document.

Please see your Plan Administrator for your eligibility date.

Benefit Amount

You may purchase a monthly benefit in \$100 units, starting at a minimum of \$200, up to 66 2/3% of your monthly earnings rounded to the nearest \$100, but not to exceed a monthly maximum benefit of \$7,500. Please see your Plan Administrator for the definition of monthly earnings.

The total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 100% of your monthly earnings unless the excess amount is payable as a Cost of Living Adjustment. However, if you are participating in Unum's Rehabilitation and Return to Work Assistance program, the total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 110% of your monthly earnings (unless the excess amount is payable as a Cost of Living Adjustment).

Elimination Period

The Elimination Period is the length of time of continuous disability, due to sickness or injury, which must be satisfied before you are eligible to receive benefits.

You may choose an Elimination Period (injury/sickness) of 0/7, 14/14, 30/30, 60/60, 90/90 or 180/180 days.

If, because of your disability, you are hospital confined as an inpatient, benefits begin on the first day of inpatient confinement. Inpatient means that you are confined to a hospital room due to your sickness or injury for 23 or more consecutive hours. (Applies to Elimination Periods of 30 days or less.)

Benefit Duration

Your duration of benefits is based on your age when the disability occurs.

Plan: ADEA II: Your duration of benefits is based on the following table:

<u>Age at Disability</u>	<u>Maximum Duration of Benefits</u>
Less than age 60	To age 65, but not less than 5 years
Age 60 through 64	5 years
Age 65 through 69	To age 70, but not less than 1 year
Age 70 and over	1 year

Federal Income Taxation

The taxability of benefits depends on how premium was taxed during the plan year in which you become disabled. If you paid 100% of the premium for the plan year with **post-tax** dollars, your benefits **will not** be taxed. If premium for the plan year is paid with **pre-tax** dollars, your benefits **will** be taxed. If premium for the plan year is paid partially with post-tax dollars and partially with pre-tax dollars, or if you and your Employer share in the cost, then a portion of your benefits will be taxed.

Additional Benefits

***Work/Life Balance
Employee Assistance
Program¹***

Work-life balance is a comprehensive resource providing access to professional assistance for a wide range of personal and work-related issues. The service is available to you and your family members twenty-four hours a day, 365 days a year, and provides resources to help employees find solutions to everyday issues such as financing a car or selecting child care, as well as more serious problems such as alcohol or drug addiction, divorce, or relationship problems.

Services include: toll-free phone access to master's-level consultants, up to three face-to-face sessions to help with more serious issues; and online resources. There is no additional charge for utilizing the program. Participation is confidential and strictly voluntary, and employees do not have to have filed a disability claim or be receiving benefits to use the program.

However, if you become disabled and are receiving benefits, Unum's On Claim Support can provide additional resources including: coaching on how to communicate effectively with medical personnel, conducting consumer research for medical equipment and supplies, assessing emotional needs and locating counseling resources.

***Return to Work/
Work Incentive Benefit***

Unum supports efforts that enable a disabled employee to remain on the job or return to work as soon as possible. If you are disabled but working part time with monthly disability earnings of 20% or more of your indexed monthly earnings, during the first 12 months, the monthly benefit will not be reduced by any earnings until the gross disability payment plus your disability earnings, exceeds 100% of your indexed monthly earnings. The

monthly benefit will then be reduced by that amount.

Rehabilitation and Return to Work Assistance

Unum has a vocational Rehabilitation and Return to Work Assistance program available to assist you in returning to work. We will make the final determination of your eligibility for participation in the program, and will provide you with a written Rehabilitation and Return to Work Assistance plan developed specifically for you. This program may include, but is not limited to the following benefits:

- coordination with your Employer to assist your return to work;
- adaptive equipment or job accommodations to allow you to work;
- vocational evaluation to determine how your disability may impact your employment options;
- job placement services;
- resume preparation;
- job seeking skills training; or
- education and retraining expenses for a new occupation.

If you are participating in a Rehabilitation and Return to Work Assistance program, we will also pay an additional disability benefit of 10% of your gross disability payment to a maximum of \$1,000 per month. In addition, we will make monthly payments to you for 3 months following the date your disability ends, if we determine you are no longer disabled while:

- you are participating in a Rehabilitation and Return to Work Assistance program; and
- you are not able to find employment.

(This benefit is not allowed in New Jersey.)

Worksite Modification

If a worksite modification will enable you to remain at work or return to work, a designated Unum professional will assist in identifying what's needed. A written agreement must be signed by you, your employer and Unum, and we will reimburse your employer for the greater of \$1,000 or the equivalent of two months of your disability benefit.

Waiver of Premium

After you have received disability payments under the plan for 90 consecutive days, from that point forward you will not be required to pay premiums as long as you are receiving disability benefits.

Survivor Benefit

Unum will pay your eligible survivor a lump sum benefit equal to 3 months of your gross disability payment.

This benefit will be paid if, on the date of your death, your disability had continued for 180 or more consecutive days, and you were receiving or were entitled to receive payments under the plan. If you have no eligible survivors, payment will be made to your estate, unless there is none. In that case, no payment will be made. However, we will first apply the survivor benefit to any overpayment which may exist on your claim.

You may receive your survivor benefit prior to your death if you are receiving monthly payments and your physician certifies in writing that you have been diagnosed as terminally ill and your life expectancy has been reduced to less than 12 months. This benefit is only payable once and if you elect to receive this benefit, no survivor benefit will be payable to your eligible survivor upon your death. (Note this "Accelerated Survivor

Benefit” is not available in Connecticut.)

Dependent Care Expense Benefit

If you are disabled and participating in Unum’s Rehabilitation and Return to Work Assistance program, Unum will pay a Dependent Care Expense Benefit when you are disabled and you provide satisfactory proof that you:

- are incurring expenses to provide care for a child under the age of 15;
- and/or start incurring expenses to provide care for a child age 15 or older or a family member who needs personal care assistance.

The payment will be \$350 per month per dependent, to a maximum of \$1,000 per month for all dependent care expenses combined.

Education Benefit

If you are disabled and receiving monthly disability benefits, you may receive an additional monthly Education Benefit of \$200 for each child who is an *eligible student*. Benefits will be payable in between terms provided the eligible student is enrolled for the next scheduled term.

Eligible student means your unmarried dependent child(ren) who are:

- less than 25 years of age; and
- attending an accredited post-secondary school beyond the 12th grade level on a **full-time** basis.

***Worldwide
Emergency Travel
Assistance Services²***

Whether your travel is for business or pleasure, our worldwide emergency travel assistance program is there to help you when an unexpected emergency occurs. With one phone call anytime of the day or night, you, your spouse and dependent children can get immediate assistance anywhere in the world³. Emergency travel assistance is available to you when you travel to any foreign country, including neighboring Canada or Mexico. It is also available anywhere in the United States for those traveling more than 100 miles from home. Your spouse and dependent children do not have to be traveling with you to be eligible. However, spouses traveling on business for their employer are not covered by this program.

Other Important Provisions

Pre-existing Condition Exclusion

Benefits will not be paid for disabilities caused by, contributed to by, or resulting from a pre-existing condition. You have a pre-existing condition if:

- you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage; and
- the disability begins in the first 12 months after your effective date of coverage.

Continuity of Coverage

If you are actively at work at the time you convert to Unum’s plan and become disabled due to a pre-existing condition, benefits may be payable if you were:

-
- in active employment and insured under the plan on its effective date; and
 - insured by the prior plan at the time of change.

To receive a payment, you must satisfy the pre-existing condition under the Unum policy or the prior carrier's policy. If you satisfy Unum's pre-existing condition provision, payments will be determined by the Unum policy.

If you only satisfy the pre-existing condition provision for the prior carrier's policy, the claim will be administered according to the Unum policy. However,

- the payments will be the lesser of the benefit payable under the terms of the prior plan or the benefit under the Unum plan;
- the elimination period will be the shorter of the elimination period under the prior plan or the elimination period under the Unum plan; and
- benefits will end on the earlier of the end of the maximum period of payment under the Unum plan or the date benefits would have ended under the prior plan.

Definition of Disability

You are disabled when Unum determines that:

- you are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury;
- you have a 20% or more loss in indexed monthly earnings due to the same sickness or injury; and
- during the elimination period you are unable to perform any of the material and substantial duties of your regular occupation.

After benefits have been paid for 24 months, you are disabled when Unum determines that due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience.

You must be under the regular care of a physician in order to be considered disabled.

Gainful Occupation

Gainful occupation means an occupation that is or can be expected to provide you with an income within 12 months of your return to work, that exceeds 80% of your indexed monthly earnings if you are working or 60% of your indexed monthly earnings if you are not working.

Benefit Integration

Your disability benefit will be reduced by deductible sources of income and any earnings you have while disabled. Your gross disability payment will be reduced immediately by such items as disability income or other amounts you receive or are entitled to receive from workers compensation or similar occupational benefit laws, sabbatical or assault leave plans and the amount of earnings you receive from an extended sick leave plan as described in Louisiana Revised Statutes or any other act or law with similar intent.

After you have received monthly disability payments for 12 months, your

gross disability payment will be reduced by such items as additional deductible sources of income you receive or are entitled to receive under: state compulsory benefit laws; automobile liability insurance; legal judgments and settlements; certain retirement plans; salary continuation or sick leave plans; other group or association disability programs or insurance; and amounts you or your family receive or are entitled to receive from Social Security or similar governmental programs.

Regardless of deductible sources of income, an employee who qualifies for disability benefits is guaranteed to receive a minimum benefit amount of 25% of the gross disability payment.

Mental Illness/Self-Reported Symptoms

The lifetime cumulative maximum benefit period for all disabilities due to mental illness and disabilities based primarily on self-reported symptoms is 24 months. Only 24 months of benefits will be paid for any combination of such disabilities even if the disabilities are not continuous and/or are not related. Payments would continue beyond 24 months only if you are confined to a hospital or institution as a result of the disability.

Instances When Benefits Would Not Be Paid

Benefits will not be paid for disabilities caused by, contributed to by, or resulting from:

- intentionally self-inflicted injuries;
- active participation in a riot;
- commission of a crime for which you have been convicted;
- loss of professional license, occupational license or certification;
- pre-existing conditions (see definition).

Unum will not cover a disability due to war, declared or undeclared, or any act of war.

Unum will not pay a benefit for any period of disability during which you are incarcerated.

Termination of Coverage

Your coverage under the policy ends on the earliest of the following:

- The date the policy or plan is cancelled;
- The date you no longer are in an eligible group;
- The date your eligible group is no longer covered;
- The last day of the period for which you made any required contributions;
- The later of the last day you are in active employment except as provided under the covered layoff or leave of absence provision; or if applicable, the last day of your contract with your Employer but not beyond the end of your Employer's current school contract year.

Unum will provide coverage for a payable claim which occurs while you are covered under the policy or plan.

Next Steps

How to Apply/ Effective Date of Coverage

Current employees: To apply for coverage or make changes to your existing coverage, enroll on-line by the annual enrollment deadline. Your effective date of coverage is 10/1.

Newly Hired Employees: To apply for coverage, complete your enrollment form within 60 days of your eligibility date. Please see your Plan Administrator for your effective date.

If you do not enroll during the initial enrollment period, you may apply only during an annual enrollment.

Delayed Effective Date of Coverage

If you are absent from work due to injury, sickness, temporary layoff or leave of absence, your coverage will not take effect until you return to active employment. Please contact your Plan Administrator after you return to active employment for when your coverage will begin.

Questions

If you should have any questions about your coverage or how to enroll, please contact your Plan Administrator.

This plan highlight is a summary provided to help you understand your insurance coverage from Unum. Some provisions may vary or not be available in all states. Please refer to your certificate booklet for your complete plan description. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern. For complete details of coverage, please refer to policy form number C.FP-1, et al.

^{1,2} Work-life balance employee assistance program and On-Claim Support services are provided by Ceridian Corporation. Worldwide emergency travel assistance services are provided by Assist America, Inc. Services are available with selected Unum insurance offerings. Exclusions, limitations and prior notice requirements may apply, and service features, terms and eligibility criteria are subject to change. The services are not valid after termination of coverage and may be withdrawn at any time. Please contact your Unum representative for full details.

³ All Worldwide emergency travel assistance must be arranged by Assist America, which pays for all services it provides. Medical expenses such as prescriptions or physician, lab or medical facility fees are paid by the employee or the employee's health insurance.

Underwritten by: Unum Life Insurance Company of America 2211 Congress Street, Portland, Maine 04122, www.unum.com

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LUBBOCK-COOPER INDEPENDENT SCHOOL DISTRICT

*Costs below are based on a **Monthly** payroll deduction
(Employer billing mode is based on 12 Payments per year)*

Product:			Plan A					
Educator Select Income Protection Plan			ADEA II Duration of Benefits					
			Elimination Period (Days)					
Injury (Days)			0*	14*	30*	60	90	180
Sickness (Days)			7*	14*	30*	60	90	180
Annual Earnings	Monthly Earnings	Maximum Monthly Benefit						
3600	300	200	9.02	7.20	5.94	4.06	3.52	2.72
5400	450	300	13.53	10.80	8.91	6.09	5.28	4.08
7200	600	400	18.04	14.40	11.88	8.12	7.04	5.44
9000	750	500	22.55	18.00	14.85	10.15	8.80	6.80
10800	900	600	27.06	21.60	17.82	12.18	10.56	8.16
12600	1050	700	31.57	25.20	20.79	14.21	12.32	9.52
14400	1200	800	36.08	28.80	23.76	16.24	14.08	10.88
16200	1350	900	40.59	32.40	26.73	18.27	15.84	12.24
18000	1500	1000	45.10	36.00	29.70	20.30	17.60	13.60
19800	1650	1100	49.61	39.60	32.67	22.33	19.36	14.96
21600	1800	1200	54.12	43.20	35.64	24.36	21.12	16.32
23400	1950	1300	58.63	46.80	38.61	26.39	22.88	17.68
25200	2100	1400	63.14	50.40	41.58	28.42	24.64	19.04
27000	2250	1500	67.65	54.00	44.55	30.45	26.40	20.40
28800	2400	1600	72.16	57.60	47.52	32.48	28.16	21.76
30600	2550	1700	76.67	61.20	50.49	34.51	29.92	23.12
32400	2700	1800	81.18	64.80	53.46	36.54	31.68	24.48
34200	2850	1900	85.69	68.40	56.43	38.57	33.44	25.84
36000	3000	2000	90.20	72.00	59.40	40.60	35.20	27.20
37800	3150	2100	94.71	75.60	62.37	42.63	36.96	28.56
39600	3300	2200	99.22	79.20	65.34	44.66	38.72	29.92
41400	3450	2300	103.73	82.80	68.31	46.69	40.48	31.28
43200	3600	2400	108.24	86.40	71.28	48.72	42.24	32.64
45000	3750	2500	112.75	90.00	74.25	50.75	44.00	34.00
46800	3900	2600	117.26	93.60	77.22	52.78	45.76	35.36
48600	4050	2700	121.77	97.20	80.19	54.81	47.52	36.72
50400	4200	2800	126.28	100.80	83.16	56.84	49.28	38.08
52200	4350	2900	130.79	104.40	86.13	58.87	51.04	39.44
54000	4500	3000	135.30	108.00	89.10	60.90	52.80	40.80
55800	4650	3100	139.81	111.60	92.07	62.93	54.56	42.16
57600	4800	3200	144.32	115.20	95.04	64.96	56.32	43.52
59400	4950	3300	148.83	118.80	98.01	66.99	58.08	44.88
61200	5100	3400	153.34	122.40	100.98	69.02	59.84	46.24
63000	5250	3500	157.85	126.00	103.95	71.05	61.60	47.60
64800	5400	3600	162.36	129.60	106.92	73.08	63.36	48.96
66600	5550	3700	166.87	133.20	109.89	75.11	65.12	50.32
68400	5700	3800	171.38	136.80	112.86	77.14	66.88	51.68
70200	5850	3900	175.89	140.40	115.83	79.17	68.64	53.04
72000	6000	4000	180.40	144.00	118.80	81.20	70.40	54.40
73800	6150	4100	184.91	147.60	121.77	83.23	72.16	55.76
75600	6300	4200	189.42	151.20	124.74	85.26	73.92	57.12
77400	6450	4300	193.93	154.80	127.71	87.29	75.68	58.48
79200	6600	4400	198.44	158.40	130.68	89.32	77.44	59.84
81000	6750	4500	202.95	162.00	133.65	91.35	79.20	61.20
82800	6900	4600	207.46	165.60	136.62	93.38	80.96	62.56
84600	7050	4700	211.97	169.20	139.59	95.41	82.72	63.92
86400	7200	4800	216.48	172.80	142.56	97.44	84.48	65.28
88200	7350	4900	220.99	176.40	145.53	99.47	86.24	66.64
90000	7500	5000	225.50	180.00	148.50	101.50	88.00	68.00
91800	7650	5100	230.01	183.60	151.47	103.53	89.76	69.36
93600	7800	5200	234.52	187.20	154.44	105.56	91.52	70.72

REF #: 1875009

** If, because of your disability, you are hospital confined as an inpatient, benefits begin on the first day of inpatient confinement.*

Find your Annual/Monthly Earnings above to determine your Maximum Monthly Benefit. If your Annual/Monthly Earnings are not shown, use the next lower Annual/Monthly Earnings and corresponding Maximum Monthly Benefit. Or, you may refer to the Plan Highlights to calculate your Maximum Monthly Benefit based on your earnings.



LUBBOCK-COOPER INDEPENDENT SCHOOL DISTRICT

*Costs below are based on a **Monthly** payroll deduction
(Employer billing mode is based on **12 Payments** per year)*

Product: Educator Select Income Protection Plan			Plan A					
			ADEA II Duration of Benefits					
			Elimination Period (Days)					
Injury (Days)			0*	14*	30*	60	90	180
Sickness (Days)			7*	14*	30*	60	90	180
Annual Earnings	Monthly Earnings	Maximum Monthly Benefit						
95400	7950	5300	239.03	190.80	157.41	107.59	93.28	72.08
97200	8100	5400	243.54	194.40	160.38	109.62	95.04	73.44
99000	8250	5500	248.05	198.00	163.35	111.65	96.80	74.80
100800	8400	5600	252.56	201.60	166.32	113.68	98.56	76.16
102600	8550	5700	257.07	205.20	169.29	115.71	100.32	77.52
104400	8700	5800	261.58	208.80	172.26	117.74	102.08	78.88
106200	8850	5900	266.09	212.40	175.23	119.77	103.84	80.24
108000	9000	6000	270.60	216.00	178.20	121.80	105.60	81.60
109800	9150	6100	275.11	219.60	181.17	123.83	107.36	82.96
111600	9300	6200	279.62	223.20	184.14	125.86	109.12	84.32
113400	9450	6300	284.13	226.80	187.11	127.89	110.88	85.68
115200	9600	6400	288.64	230.40	190.08	129.92	112.64	87.04
117000	9750	6500	293.15	234.00	193.05	131.95	114.40	88.40
118800	9900	6600	297.66	237.60	196.02	133.98	116.16	89.76
120600	10050	6700	302.17	241.20	198.99	136.01	117.92	91.12
122400	10200	6800	306.68	244.80	201.96	138.04	119.68	92.48
124200	10350	6900	311.19	248.40	204.93	140.07	121.44	93.84
126000	10500	7000	315.70	252.00	207.90	142.10	123.20	95.20
127800	10650	7100	320.21	255.60	210.87	144.13	124.96	96.56
129600	10800	7200	324.72	259.20	213.84	146.16	126.72	97.92
131400	10950	7300	329.23	262.80	216.81	148.19	128.48	99.28
133200	11100	7400	333.74	266.40	219.78	150.22	130.24	100.64
135000	11250	7500	338.25	270.00	222.75	152.25	132.00	102.00

REF #: 1875009

** If, because of your disability, you are hospital confined as an inpatient, benefits begin on the first day of inpatient confinement.*

Find your Annual/Monthly Earnings above to determine your Maximum Monthly Benefit. If your Annual/Monthly Earnings are not shown, use the next lower Annual/Monthly Earnings and corresponding Maximum Monthly Benefit. Or, you may refer to the Plan Highlights to calculate your Maximum Monthly Benefit based on your earnings.

CancerSelect® Plus

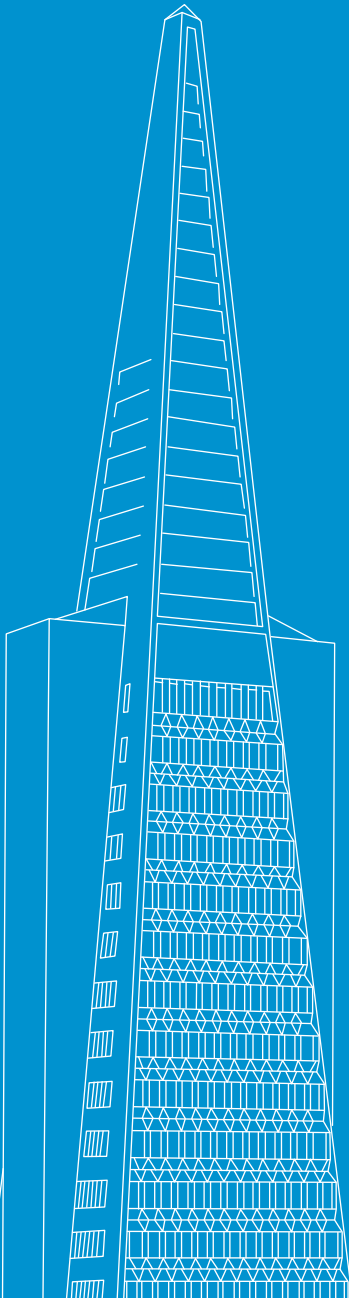
Voluntary Group Cancer-Only Insurance Policy

Employer Brochure

The Power of the Pyramid®



CancerSelect Plus – Consumer Brochure – CCP01C-B-0707
Underwritten by: **Transamerica Life Insurance Company**



®

CancerSelect[®] Plus

Voluntary Group Cancer-Only Insurance Policy

Why Offer CancerSelect Plus?

CancerSelect Plus provides your employees valuable health benefits by offering a voluntary group cancer-only insurance policy that helps you to:

- ▶ Provide a positive impact on worker recruitment
- ▶ Increase employee retention
- ▶ Improve the health status and productivity of your employees

*CancerSelect Plus is a voluntary group cancer-only insurance policy, **underwritten by Transamerica Life Insurance Company**, Home Office: Cedar Rapids, Iowa (Policy Form Series CPCAN200). Forms may vary and coverage may not be available in all jurisdictions. Benefits provided and premiums payable depend upon the coverage selected. This is a brief summary of the benefits of the coverage; please refer to the contract for complete information.*



A Voluntary Group Cancer-Only Insurance Policy With Flexible Plan Design Options

CancerSelect Plus is flexible, convenient and designed to provide employees with benefits for these common health care needs:

Hospital Benefits

- ▶ Hospital confinement
- ▶ Extended benefits
- ▶ Attending physician
- ▶ Government or charity hospital
- ▶ Private-duty nursing
- ▶ Inpatient drugs and medicines
- ▶ Ambulance
- ▶ Extended care facility
- ▶ Hospice care

Surgery Benefits

- ▶ Surgery
- ▶ Anesthesia
- ▶ Reconstructive surgery
- ▶ 2nd surgical opinion
- ▶ Outpatient surgery
- ▶ Ambulatory surgical center
- ▶ Prosthesis
- ▶ Hair prosthesis
- ▶ Skin Cancer

Cancer Maintenance Therapy Benefits

- ▶ Hematological drugs
- ▶ Anti-nausea drugs
- ▶ Motility agents
- ▶ Cancer suppressive therapy

Radiation and Chemotherapy Benefits

- ▶ Radiation and chemotherapy treatments
- ▶ Associated expenses with radiation and chemotherapy
- ▶ Blood, plasma, blood components (e.g., platelets), bone marrow and stem cell transplants
- ▶ Associated expenses with blood, plasma, and blood components (e.g., platelets)
- ▶ New or experimental treatment

Wellness and Miscellaneous Benefits

- ▶ Wellness screenings
- ▶ MRI scans
- ▶ Non-local transportation
- ▶ At home nursing
- ▶ Family member lodging
- ▶ Waiver of premium
- ▶ Physical therapy and speech therapy
- ▶ Outpatient lodging

Additional Information

- ▶ Limitations and exclusions apply
- ▶ Family coverage is available

Please refer to the following sections for additional information.

The Benefits of CancerSelect Plus

Medical Benefits

- ▶ Hospital room
- ▶ Radiation therapy/chemotherapy treatments
- ▶ Drugs and medicines
- ▶ Blood and plasma
- ▶ Bone marrow and stem cell transplants
- ▶ Physicians
- ▶ Anesthesia and surgery
- ▶ Prosthesis and physical therapy

Non-Medical Benefits

- ▶ Transportation
- ▶ Ambulance
- ▶ Family member lodging
- ▶ Waiver of premium

Pays in Addition to Other Insurance Directly to Employee

- ▶ Benefits are paid in addition to any other insurance the employee may have, including the employer's medical plan and Medicare (in most states).
- ▶ Benefits are paid directly to the employee —or directly to anyone else he/she chooses.

Easy and Convenient

- ▶ Employees may purchase CancerSelect Plus through the convenience of payroll deductions.
- ▶ CancerSelect Plus is also available for employees spouse* and eligible dependent children.
- ▶ CancerSelect Plus may be available by answering just a few health questions.
- ▶ No physical exams or blood tests are required.
- ▶ Coverage is 100% portable.

**Spouse or equivalent as defined by governing state law.*

Who is Eligible?

Employee Coverage*

To be eligible for coverage, an employee must:

- ▶ be of age 18 or over
- ▶ meet eligibility requirements as selected on the policyholder's application
- ▶ satisfactorily answer all eligibility questions, provide evidence of insurability satisfactory to us, if we ask for it; and
- ▶ be in active service, performing in the usual manner all of the regular duties of his or her occupation on a scheduled work day at one of the places of business where he or she normally does such duties or at some location to which the employer sends the employee.

* Issue ages may vary by state. The proposal for this product will reflect the correct issue ages for the employer's state.

Understanding CancerSelect Plus

Plan Design

The employer can select up to two plan design options for CancerSelect Plus to offer to employees. CancerSelect Plus is an optionally renewable group cancer only insurance policy issued on a group contract. It has 5 core modules including Hospital Benefits, Surgery Benefits, Radiation and Chemotherapy Benefits, Wellness and Miscellaneous Benefits & Cancer Maintenance Therapy Benefits. Within each module, the employer has the option of selecting a unit value for each of the 5 core modules along with optional riders.

Hospital Benefits (Module #1)

The employer has the option to select from 1 to 5 units for this module containing the following hospital benefits.

- ▶ **Hospital Confinement:** Pays \$100 per unit per day for up to 90 days of covered confinement.
- ▶ **Extended Benefits:** Beginning with the 91st day of continuous confinement, pays \$200 per unit per day of hospital confinement in lieu of all other benefits (except surgery and anesthesia, which remain the same).
- ▶ **Inpatient Drugs and Medicines:** Pays \$15 per unit per day for covered person during hospital confinement.
- ▶ **Attending Physician (other than the surgeon):** Pays \$20 per unit per day during hospital confinement.
- ▶ **Private-duty Nurse (other than staff member of the hospital or family member):** Pays \$100 per unit per day during hospital confinement.
- ▶ **Ambulance:** Pays \$100 per unit per continuous confinement for service by a licensed professional ambulance service for transportation to a hospital to which the covered person is admitted.
- ▶ **Extended Care Facility:** Pays \$100 per unit per day, up to the number of days of the hospital stay when admitted to the extended care facility within 14 days of hospital discharge.
- ▶ **Government or Charity Hospital:** Pays \$100 per unit per day—in lieu of all other benefits—for hospital treatment where the insured is not required to pay for most services.
- ▶ **Hospice Care:** Pays \$100 per unit per day when confined in a hospice center or for hospice care at home by a hospice team. Benefit is limited to a lifetime maximum of 100 days per covered person.

Surgery Benefits (Module #2)

The employer has the option to select from 1 to 5 units for this module containing the following surgery benefits.

- ▶ **Surgery:** Pays up to \$1,000 per unit for in-hospital surgery as scheduled in the certificate. For in-hospital surgery performed for the treatment of cancer not in the surgical schedule - pays the lesser of 1) amount determined by multiplying the work relative value unit obtained from the current Medicare fee schedule by \$25.00 or 2) \$1,000 per unit. Treatment must be approved by the attending physician.
- ▶ **Anesthesia:** Pays 25% of Surgery Benefit per unit as scheduled in the certificate.
- ▶ **Prosthesis:** Pays actual charges* not to exceed \$500 per unit for a prosthetic device and its implementation. The prosthesis must be authorized by the attending physician.
- ▶ **Hair Prosthesis:** Pays actual expenses* of up to \$50 per unit for wig or hair piece for hair loss from radiation or chemotherapy treatment.
- ▶ **Reconstructive Surgery:** Pays up to \$250 per unit for reconstructive surgery within two years after cancer removal.
- ▶ **2nd Surgical Opinion:** Pays \$100 per unit for a second opinion when the prescribed treatment is surgery as determined by the first opinion.
- ▶ **Ambulatory Surgical Center:** Pays up to \$150 per unit per day for surgery performed at an ambulatory surgical center or hospital as an outpatient. This benefit is paid in addition to outpatient surgery benefit
- ▶ **Outpatient Surgery:** Pays up to \$1,500 per unit for outpatient surgery as scheduled in the certificate. For outpatient surgery performed for the treatment of cancer not in the surgical schedule - pays the lesser of 1) Amount determined by multiplying the work relative value unit obtained from the current Medicare fee schedule by \$37.50 or 2) \$1,500 per unit). Treatment must be approved by the attending physician.
- ▶ **Skin Cancer:** Pays \$75 per unit per diagnosis for one removal of skin cancer; \$35 per unit for each additional removal.

Radiation and Chemotherapy Benefits (Module #3)

The employer has the option to select from 1 to 4 units for this module containing the following radiation and chemotherapy benefits.

- ▶ **Radiation and Chemotherapy:** Pays actual charges* not to exceed \$5,000 per unit for radiation and chemotherapy treatments per 12 month period.
- ▶ **Associated Radiation and Chemotherapy Expenses:** Pays \$250 per unit per 12 month period for treatment consultation and planning, radiation management, physical exams, checkups, laboratory or diagnostic tests when authorized by a radiologist, chemotherapist, or oncologist.
- ▶ **Blood, Plasma, Platelets, Bone Marrow and Stem Cell Transplant:** Pays actual charges* not to exceed \$5,000 per unit per 12 month period for bone marrow and stem cell transplants, blood, plasma, and blood components, (except when replaced by donated blood when there is a charge to the covered person).
- ▶ **Associated Blood, Plasma, and Platelets Expenses:** Pays \$250 per unit per 12 month period for treatment consultation and planning, administration of blood, physical exams, checkups, and laboratory or diagnostic tests and authorized by the covered person's physician.
- ▶ **New or Experimental Treatment:** Pays actual charges* not to exceed \$5,000 per unit for drugs, chemicals, surgery, or therapy approved by FDA and either the NCI or ACS. Treatment must be received in a US hospital when authorized by the attending physician.

** Pays actual charges as the amount actually paid by or on behalf of the insured, and accepted by a provider as payment in full for services provided.*



Wellness and Miscellaneous Benefits (Module #4)

The employer has the option to select from 1 to 3 units for this module containing the following wellness and miscellaneous benefits.

- ▶ **Wellness Benefit** — Pays \$50 per unit per calendar year for covered cancer screening tests: mammograms, pap smears, flexible sigmoidoscopy, prostate-specific antigen tests, chest x-rays, hemocult stool specimen, ultrasounds, CEA, CA125, biopsy, thermography, colonoscopy, serum protein electrophoresis, bone marrow testing, and blood screenings. Services must be under the supervision of or recommended by a physician, and charge must be incurred.
- ▶ **Magnetic Resolution Imaging (MRI) Scans** — In addition to Wellness Benefit, pays \$50 per unit per calendar year for an MRI Scan when used as a diagnostic tool for breast cancer.
- ▶ **Non-Local Transportation** — When prescribed treatment is not available locally and non-local hospital confinement (more than 50 miles from the covered person's residence) is required, we will pay either the actual roundtrip charges by a common carrier or a private vehicle allowance of \$.40 per mile (up to 750 miles, round-trip). Payable once per period of hospital confinement.
- ▶ **Family Member Lodging** — When non-local hospital confinement is required, we will pay for lodging expenses for an adult member of the insured's immediate family charges of \$50 per unit per day. This benefit is limited to the lesser of the number of days the covered person is hospital confined and 50 days per 12 month benefit period.
- ▶ **Outpatient Lodging** — Pays \$50 per unit per day for a maximum of 50 days per 12 month period at a motel, hotel or other accommodations, provided treatment is authorized by the attending physician and cannot be obtained locally.
- ▶ **Physical Therapy and Speech Therapy** — Pays \$25 per treatment (limited to one session per day).
- ▶ **At Home Nursing** — Pays \$50 per unit per day, up to the number of days of the prior hospital confinement when admitted within 14 days of hospital discharge.
- ▶ **Waiver of Premium** — We will waive each premium due during a period of total disability after 60 consecutive days of the insured employee's total disability due to cancer. This benefit applies only to the employee, not to the spouse* or children on family coverage. This benefit does not apply to total disability which begins on or after the insured's 70th birthday.

**Spouse or equivalent as defined by governing state law.*

Cancer Maintenance Therapy Benefits (Module #5)

The employer may select from 1 to 5 units for this module containing the following cancer maintenance therapy benefits. Pays actual charges* not to exceed \$1,000 per unit per 12 month period for any combination of the below listed drug-related expenses:

- ▶ **Cancer Suppressive Therapy** — Benefits for treatment to keep cancer in check or after acute chemotherapy treatment.
- ▶ **Hematological Drugs** — Benefits for drugs aimed to boost cell lines such as white blood cell counts, red blood cell counts, and platelets.
- ▶ **Anti-Nausea Drugs** — Benefits for drugs used to reduce the symptoms brought about as a result of chemotherapy or radiation.
- ▶ **Motility Agents** — Benefits for drugs used to improve motility or treat side effects caused by chemotherapy or radiation.



Important Information

Pre-Existing Conditions

No benefits are provided during the first 12 months for any cancer that has been diagnosed, treated, or for which the covered person has incurred expense or has taken medication within 12 months prior to the effective date of such person's coverage.

A Pre-existing Condition is defined as a sickness or physical condition for which the insured:

1. Had treatment;
2. Incurred expense;
3. Took medication; or
4. Received a diagnosis or advice from a physician, during the 12-month period immediately before the effective date of the insured's coverage. The term "Pre-existing Condition" will also include a condition that manifests itself in a way that would cause a person to seek medical advice, diagnosis, care or treatment.

Family Coverage

Family coverage includes the insured, his or her spouse*, and all eligible dependent children under age 25. Newborn children are automatically covered under the terms of the certificate from the moment of birth. Single-Parent Coverage includes the insured and all eligible dependent children under age 25. (The definition of children may vary by state.)

**Spouse or equivalent as defined by governing state law.*

Extension of Benefits

Whenever termination of coverage under this section occurs due to termination of the employee's employment or membership, such termination will be without prejudice to:

1. Any hospital confinement which began while coverage was in force; or
2. Any covered treatment or service for which benefits would be provided and which began while coverage was in force; provided, however, that the covered person is and continues to be hospital confined or receiving treatment. Such extension of benefits will continue for up to the earlier of:
 1. 30 days; or
 2. The date on which the covered person is no longer hospitalized or receiving treatment

Termination of Coverage

Subject to the Portability Option, the employee's insurance will cease on the earliest of:

1. The last day of the payroll deduction period during which the employee cease to be eligible for coverage;
2. The end of the last period for which premium payment has been made to us;
3. The last day of the payroll deduction period during which the employee terminates employment;
4. The date the group master policy terminates; or
5. The date the employee send us a written notice that you want to cancel coverage.

The insurance on a dependent will cease on the earliest of:

1. The date the employee coverage terminates; or
2. The end of the last period for which a premium payment has been made to us; We will have the right to terminate the coverage of any covered person who submits a fraudulent claim under the policy.

Portability Option

If the employee loses eligibility for this insurance for any reason other than nonpayment of premiums, the employee will have the option to continue the coverage (including any riders, if applicable) by paying the premiums directly to the company or at our administrative office within 31 days after this insurance terminates. We will bill the employee directly for these premiums after the employee notifies us to continue coverage. If the employee stops paying the premiums under this option, this coverage will continue, subject to the terms of the grace period.

Exceptions and Limitations

The certificate provides benefits only for cancer as defined herein, which is positively diagnosed while the certificate is in force. It does not provide benefits for any other illness or disease.

1. We may reduce or deny a claim or void the certificate for loss incurred by a covered person
 - a. During the first 2 years from the effective date of such coverage for any misstatements in the application which would have materially affected our acceptance of the risk; or
 - b. At any time for fraudulent misstatements in the application
2. We will only pay for loss as a direct result of cancer. Proof of positive diagnosis must be submitted to us for each new claim. We will not pay for any other disease or incapacity that has been caused, complicated, worsened or affected by, or as a result of, cancer.
3. If a covered hospital confinement is due to more than one covered disease or condition, benefits will be payable as though the confinement or expense were due to one disease or condition. If a hospital confinement or expense is also due to a disease or condition that is not covered, benefits will be payable only for the part of the hospital confinement or expense due to the covered disease or condition.
4. Under no condition will we pay any benefits for losses or medical expenses incurred prior to the effective date.

Pre-Existing Conditions

No benefits are provided during the first 12 months for any cancer that has been diagnosed, treated, or for which the covered person has incurred expense or has taken medication within 12 months prior to the effective date of such person's coverage.

CancerSelect® Plus is underwritten by:

Transamerica Life Insurance Company

Home Office: Cedar Rapids, Iowa

Administrative Office:

1400 Centerview Drive

Little Rock, AR 72211

(888) 763-7474



INSURANCE MARKETPLACE
STANDARDS ASSOCIATION



Custom Plan Design

Hospital Benefits	
Hospital Confinement	\$100 per day for up to 90 days of covered confinement
Extended Benefits	\$200 per day of hospital confinement in lieu of all other benefits (except surgery and anesthesia) beginning on 91st day of continuous confinement
Attending Physician	\$20 per day during hospital confinement
Inpatient Drugs and Medicines	\$15 per day during hospital confinement
Private-Duty Nurse	\$100 per day during hospital confinement
Ambulance	\$100 per continuous confinement
Extended Care Facility	\$100 per day, up to the number of days of the prior hospital stay when admitted within 14 days of hospital discharge
Government or Charity Hospital	\$100 per day of covered hospital confinement in lieu of all other benefits
Hospice Care	\$100 per day at hospice center or hospice home visit; 100 day lifetime maximum
Surgery Benefits	
Surgery	Up to \$2,000 for in-hospital and up to \$3,000 for outpatient surgeries as scheduled in the certificate
Anesthesia	25% of covered surgery benefit as scheduled in the certificate
Prosthesis	Actual charges* up to \$1,000 per prosthetic device that requires implantation
Hair Prosthesis	Actual charges* up to \$100 for wig, hair piece for hair loss from cancer treatment
Reconstructive Surgery	Up to \$500 for reconstructive surgery within two years of cancer removal
Second Surgical Opinions	\$200 when surgery is prescribed treatment
Ambulatory Surgical Center	Up to \$300 per day for surgery at an ambulatory surgical center
Skin Cancer	\$150 per diagnosis for removal of one skin cancer; \$70 per additional removal
Radiation and Chemotherapy Benefits	
Radiation and Chemotherapy	Actual charges* up to \$5,000 for radiation and chemotherapy treatments per 12 month period.
Associated Radiation and Chemotherapy Expenses	Actual charges* up to \$250 for consultation, planning, exams, checkup, diagnostic tests, etc. per 12 month period.
Blood, Plasma and Blood Components, Bone Marrow Transplant and Stem Cell Transplant	Actual charges* up to \$5,000 per 12 month period for blood, plasma, blood components, bone marrow transplant or stem cell transplant.
Associated Blood, Plasma and Blood Components Expenses	Actual charges* of up to \$250 for consultation, planning, exams, checkup, laboratory tests, etc. per 12 months.
New or Experimental Treatment	Actual charges* up to \$5,000 per 12 months for drugs, chemicals, surgery or therapy approved by FDA, NCI or ACS.
Wellness and Miscellaneous Benefits	
Wellness	\$50 per calendar year for cancer screening tests.
Magnetic Resonance Imaging (MRI) Scans	\$50 per calendar year for MRI scan when used as diagnostic tool for breast cancer, in addition to Wellness Benefit
Non-Local Transportation	Pays actual round-trip charges, up to 750 miles, by common carrier or private vehicle of \$.40 per mile when non-local hospital confinement more than 50 miles from residence is required and actual round-trip charges by common carrier for covered person and one adult member of the immediate family during confinement. Payable once per period of hospital confinement period.
Family Member Lodging	\$50 per day at motel, hotel or other accommodation for adult, immediate family when non-local hospital confinement is required; 50 day maximum

Physical Therapy and Speech Therapy	\$25 per treatment (limit one per day).
At-Home Nursing	\$50 per day, up to the number of days of the prior hospital stay when admitted within 14 days of hospital discharge.
Waiver of Premium	Waives premiums for remainder of total disability due to cancer for insured employee after totally disabled for 60 days.
Outpatient Lodging	\$50 per day for a 50 day maximum per 12 months at a motel, hotel or other accommodation.
Cancer Maintenance Therapy- <i>Actual charges* not to exceed \$1,000 per 12 month period for any combination of the following listed drug-related expenses</i>	
Cancer Suppressive Therapy	Treatment to keep cancer in check or after acute chemotherapy treatment
Hematological Drugs	Benefits for drugs aimed to boost cell lines such as white blood cell counts, red blood cell counts and platelets
Anti-Nausea Drugs	Benefits for drugs used to reduce the symptoms brought about as a result of chemotherapy or radiation
Motility Agent	Benefits for drugs used to improve motility or treat side effects caused by chemotherapy or radiation
Optional Riders	
First Occurrence Benefit	One-time lump sum benefit of \$1,000 when cancer is first diagnosed in an individual
Intensive Care Benefit	Provides benefits when the covered person is confined in an intensive care unit
Daily Benefit:	\$300 per day for up to 45 days of covered confinement
Step-Down Unit Benefit:	\$150 per day for progressive care, subacute care, and intermediate care in a step-down unit
Ambulance:	Actual charges* up to \$600 per confinement
Specified Illness and Disease Benefit	Provides benefits when diagnosed with a covered specified illness or disease
Hospital Confinement:	\$100 per day for up to 90 days of covered confinement
Extended Benefits:	\$200 per day of hospital confinement in lieu of all other benefits (except surgery and anesthesia) beginning on 91st day of continuous confinement
Attending Physician:	\$20 per day during hospital confinement
Inpatient Drugs and Medicines:	\$15 per day during hospital confinement
Private-Duty Nurse:	\$100 per day during hospital confinement
Ambulance:	\$100 per continuous confinement
Extended Care Facility:	\$100 per day, up to the number of days of the prior hospital stay when admitted within 14 days of hospital discharge
Government or Charity Hospital:	\$100 per day of covered hospital confinement in lieu of all other benefits
Hospice Care:	\$100 per day at hospice center or hospice home visit; 100 day lifetime maximum
Surgery:	Up to \$1,000 for in-hospital and up to \$1,500 for outpatient surgeries as scheduled in the certificate
Anesthesia:	25% of the covered surgery benefit
Second Surgical Opinions:	\$100 when surgery is prescribed treatment
Ambulatory Surgical Center:	Up to \$150 per day for surgery at an ambulatory surgical center
Monthly Premium Rates <i>Valid in the state of Texas</i>	
Individual	\$ 15.68
Individual + Child(ren)	\$ 17.76
Family	\$ 27.76

* Pays Actual Charge/Expenses defined as the amount actually paid by or on behalf of the Insured, and accepted by a provider for services provided

This custom plan is incomplete without a state-specific proposal or brochure, which describes the benefits, exclusions, and limitations of policy form CPCAN200 or state variations thereof.





Custom Plan Design

Hospital Benefits	
Hospital Confinement	\$100 per day for up to 90 days of covered confinement
Extended Benefits	\$200 per day of hospital confinement in lieu of all other benefits (except surgery and anesthesia) beginning on 91st day of continuous confinement
Attending Physician	\$20 per day during hospital confinement
Inpatient Drugs and Medicines	\$15 per day during hospital confinement
Private-Duty Nurse	\$100 per day during hospital confinement
Ambulance	\$100 per continuous confinement
Extended Care Facility	\$100 per day, up to the number of days of the prior hospital stay when admitted within 14 days of hospital discharge
Government or Charity Hospital	\$100 per day of covered hospital confinement in lieu of all other benefits
Hospice Care	\$100 per day at hospice center or hospice home visit; 100 day lifetime maximum
Surgery Benefits	
Surgery	Up to \$3,000 for in-hospital and up to \$4,500 for outpatient surgeries as scheduled in the certificate
Anesthesia	25% of covered surgery benefit as scheduled in the certificate
Prosthesis	Actual charges* up to \$1,500 per prosthetic device that requires implantation
Hair Prosthesis	Actual charges* up to \$150 for wig, hair piece for hair loss from cancer treatment
Reconstructive Surgery	Up to \$750 for reconstructive surgery within two years of cancer removal
Second Surgical Opinions	\$300 when surgery is prescribed treatment
Ambulatory Surgical Center	Up to \$450 per day for surgery at an ambulatory surgical center
Skin Cancer	\$225 per diagnosis for removal of one skin cancer; \$105 per additional removal
Radiation and Chemotherapy Benefits	
Radiation and Chemotherapy	Actual charges* up to \$15,000 for radiation and chemotherapy treatments per 12 month period.
Associated Radiation and Chemotherapy Expenses	Actual charges* up to \$750 for consultation, planning, exams, checkup, diagnostic tests, etc. per 12 month period.
Blood, Plasma and Blood Components, Bone Marrow Transplant and Stem Cell Transplant	Actual charges* up to \$15,000 per 12 month period for blood, plasma, blood components, bone marrow transplant or stem cell transplant.
Associated Blood, Plasma and Blood Components Expenses	Actual charges* of up to \$750 for consultation, planning, exams, checkup, laboratory tests, etc. per 12 months.
New or Experimental Treatment	Actual charges* up to \$15,000 per 12 months for drugs, chemicals, surgery or therapy approved by FDA, NCI or ACS.
Wellness and Miscellaneous Benefits	
Wellness	\$50 per calendar year for cancer screening tests.
Magnetic Resonance Imaging (MRI) Scans	\$50 per calendar year for MRI scan when used as diagnostic tool for breast cancer, in addition to Wellness Benefit
Non-Local Transportation	Pays actual round-trip charges, up to 750 miles, by common carrier or private vehicle of \$.40 per mile when non-local hospital confinement more than 50 miles from residence is required and actual round-trip charges by common carrier for covered person and one adult member of the immediate family during confinement. Payable once per period of hospital confinement period.
Family Member Lodging	\$50 per day at motel, hotel or other accommodation for adult, immediate family when non-local hospital confinement is required; 50 day maximum

Physical Therapy and Speech Therapy	\$25 per treatment (limit one per day).
At-Home Nursing	\$50 per day, up to the number of days of the prior hospital stay when admitted within 14 days of hospital discharge.
Waiver of Premium	Waives premiums for remainder of total disability due to cancer for insured employee after totally disabled for 60 days.
Outpatient Lodging	\$50 per day for a 50 day maximum per 12 months at a motel, hotel or other accommodation.
Cancer Maintenance Therapy- <i>Actual charges* not to exceed \$2,000 per 12 month period for any combination of the following listed drug-related expenses</i>	
Cancer Suppressive Therapy	Treatment to keep cancer in check or after acute chemotherapy treatment
Hematological Drugs	Benefits for drugs aimed to boost cell lines such as white blood cell counts, red blood cell counts and platelets
Anti-Nausea Drugs	Benefits for drugs used to reduce the symptoms brought about as a result of chemotherapy or radiation
Motility Agent	Benefits for drugs used to improve motility or treat side effects caused by chemotherapy or radiation
Optional Riders	
First Occurrence Benefit	One-time lump sum benefit of \$2,000 when cancer is first diagnosed in an individual
Intensive Care Benefit	Provides benefits when the covered person is confined in an intensive care unit
Daily Benefit:	\$600 per day for up to 45 days of covered confinement
Step-Down Unit Benefit:	\$300 per day for progressive care, subacute care, and intermediate care in a step-down unit
Ambulance:	Actual charges* up to \$1,200 per confinement
Specified Illness and Disease Benefit	Provides benefits when diagnosed with a covered specified illness or disease
Hospital Confinement:	\$100 per day for up to 90 days of covered confinement
Extended Benefits:	\$200 per day of hospital confinement in lieu of all other benefits (except surgery and anesthesia) beginning on 91st day of continuous confinement
Attending Physician:	\$20 per day during hospital confinement
Inpatient Drugs and Medicines:	\$15 per day during hospital confinement
Private-Duty Nurse:	\$100 per day during hospital confinement
Ambulance:	\$100 per continuous confinement
Extended Care Facility:	\$100 per day, up to the number of days of the prior hospital stay when admitted within 14 days of hospital discharge
Government or Charity Hospital:	\$100 per day of covered hospital confinement in lieu of all other benefits
Hospice Care:	\$100 per day at hospice center or hospice home visit; 100 day lifetime maximum
Surgery:	Up to \$1,000 for in-hospital and up to \$1,500 for outpatient surgeries as scheduled in the certificate
Anesthesia:	25% of the covered surgery benefit
Second Surgical Opinions:	\$100 when surgery is prescribed treatment
Ambulatory Surgical Center:	Up to \$150 per day for surgery at an ambulatory surgical center
Monthly Premium Rates <i>Valid in the state of Texas</i>	
Individual	\$ 29.88
Individual + Child(ren)	\$ 33.38
Family	\$ 52.58

* Pays Actual Charge/Expenses defined as the amount actually paid by or on behalf of the Insured, and accepted by a provider for services provided

This custom plan is incomplete without a state-specific proposal or brochure, which describes the benefits, exclusions, and limitations of policy form CPCAN200 or state variations thereof.



AMERICAN PUBLIC LIFE INSURANCE COMPANY

SUPPLEMENTAL ACCIDENT PLAN (A-3)

for:

LUBBOCK-COOPER INDEPENDENT SCHOOL DISTRICT

Presented By: Financial Benefit Services

BASE POLICY BENEFITS	1 Unit	2 Units	3 Units	4 Units
Accidental Injury We will pay the actual charges per accident (not to exceed maximum benefits for units selected) for physician's treatment, surgery, x-rays, reduction of fractures and dislocations or other emergency treatment expenses. In no case will the benefit exceed actual charges. There is a \$50 deductible for emergency room expenses, per occurrence, regardless of the number of units. Expenses must commence within 60 days of the covered accident.	\$500	\$1,000	\$1,500	\$2,000
Ambulance Benefit We will pay the actual charges (not to exceed maximum benefits for units selected) for emergency transportation for covered treatment (ground or air ambulance). Such emergency transportation must occur within 21 calendar days of the covered accident.	\$1,250	\$2,500	\$3,750	\$5,000
Hospital Confinement We will pay the daily hospital benefit, based upon the number of units selected, when a covered insured is confined to a hospital due to accident or injury. This benefit begins the first day of confinement and pays a maximum of 30 days per any one accident.	\$75	\$150	\$225	\$300
Accidental Death Benefit* We will pay the benefit shown for accidental death which results within 90 days of the accident, based upon the number of units selected.	\$5,000	\$10,000	\$15,000	\$20,000
Dismemberment* We will pay the following benefit, based upon the number of units selected, for dismemberment which results within 90 days of covered accident (dismemberment benefits are subject to a \$5,000 per unit cumulative maximum per accident).				
Single finger or toe	\$ 250	\$ 500	\$ 750	\$ 1,000
Multiple fingers or toes	\$ 500	\$ 1,000	\$ 1,500	\$ 2,000
Single hand, arm, foot or leg	\$2,500	\$ 5,000	\$ 7,500	\$10,000
Multiple hands, arms, feet or legs	\$5,000	\$10,000	\$15,000	\$20,000
Loss of Sight Benefit We will pay the benefit, based upon the number units selected shown, for the loss of sight due to Accidental Injury.				
Loss of sight in one eye	\$2,500	\$ 5,000	\$ 7,500	\$10,000
Loss of sight in both eyes	\$5,000	\$10,000	\$15,000	\$20,000

*Number of days may vary by state

BASE POLICY	MONTHLY PREMIUM			
	1 Unit	2 Units	3 Units	4 Units
Individual	\$10.80	\$17.10	\$21.50	\$24.50
Individual & Spouse	\$19.40	\$29.80	\$38.90	\$44.90
Individual & Children	\$21.20	\$34.90	\$45.20	\$52.00
Family (2 parents and children)	\$29.80	\$47.60	\$62.60	\$72.40

DEFINITIONS (Base Policy)

INJURY or ACCIDENTAL INJURY or ACCIDENTAL BODILY INJURY means physical damage to an Insured Person, sustained on or after the Effective Date, and while this Policy is in force, which is the direct cause of the loss, independent of disease, bodily infirmity or any other cause. All injuries sustained in any one accident and all complications arising therefrom and recurrence and complication shall be deemed to be a single "Injury."

DISABILITY means Your inability, as a result of covered Accidental Injury, to perform the substantial and material duties of Your occupation and You are not gainfully employed.

EXCLUSIONS AND LIMITATIONS (Base Policy)

Benefits otherwise provided by this Policy will not be payable for services or expenses or any such Loss resulting from or in connection with:

1. sickness, illness or bodily infirmity; except as covered by the Sickness Disability Rider;
2. suicide, attempted suicide or intentional self-inflicted Injury, whether sane or insane;
3. dental care or treatment due to accidental Injury to natural teeth;
4. war or any act of war (whether declared or undeclared) or participating in a riot or felony;
5. alcoholism or drug addiction;
6. travel or flight in or descent from any aircraft or device which can fly above the earth's surface in any capacity other than as a farepaying passenger on a regularly scheduled airline;
7. Injury originating prior to the effective date of the Policy;
8. Injury occurring while intoxicated (Intoxication means that which is determined and defined by the laws and jurisdiction of the geographical area in which the loss or cause of loss is incurred.);
9. voluntary inhalation of gas or fumes or taking of poison or asphyxiation;
10. voluntary ingestion or injection of any drug, narcotic or sedative, unless administered on the advice and taken in such doses as prescribed by a Physician;
11. Injury sustained or sickness which first manifests itself while on full-time duty in the armed forces. Upon notice, the company will refund the proportion of unearned premium while in such forces.
12. Injury incurred while engaged in an illegal occupation;
13. Injury incurred while attempting to commit a felony or assault;
14. mental or emotional disorders;
15. Injury to a covered person while practicing for or being a part of organized or competitive rodeo, sky diving, hang gliding, parachuting or scuba diving;
16. driving in any race or speed test or while testing an automobile or any vehicle on any racetrack or speedway;
17. charges incurred outside the U.S. if an insured traveled to the location for the purpose of receiving medical services, drugs or supplies;
18. hernia, carpal tunnel syndrome or any complication therefrom;
19. any bacterial infection (except pyogenic infections which shall occur with and through an accidental cut or wound).

If You are entitled to benefits under this policy as a result of sprained or lame back, or any intervertebral disk conditions, such benefits shall be payable for a maximum period of time, not exceeding in the aggregate three (3) months for any Injury.

These exclusions and limitations are not applicable for all states. Please refer to your policy or outline for applicable exclusions and limitations.

This coverage should be viewed as a supplement to other health insurance. This is not the insurance contract, and only the actual policy provisions will apply. It is therefore important that you read your policy carefully. All products are not available in all states.

In West Virginia: 18 and 19 above are changed and read as follows:

18. hernia, within six (6) months after the Effective Date;
19. carpal tunnel syndrome or any complication therefrom;
20. any bacterial infection (except pyogenic infections which shall occur with and through an accidental cut or wound).

In Idaho: Exclusions and Limitation

1. sickness, illness or bodily infirmity;
2. suicide, attempted suicide or intentional self-inflicted injury, whether sane or insane;
3. dental care or treatment due to accidental Injury to natural teeth;

4. war or any act of war (whether declared or undeclared) or participating in a riot or felony;
5. alcoholism or drug addiction;
6. participation in any form of flight aviation other than as a fare-paying passenger in a licensed, passenger-carrying aircraft;
7. a Pre-Existing Condition incurred within 12 months following the effective date of coverage;
8. Injury occurring while intoxicated or under the influence of any narcotic, unless administered on the advice and taken in such doses as prescribed by a Physician;
9. Injury sustained or sickness which first manifests itself while on full-time duty in the armed forces. Upon notice, the company will refund the proportion of unearned premium while in such forces.
10. Injury incurred while engaging in an illegal occupation;
11. Injury incurred while attempting to commit a felony;
12. mental or emotional disorders;
13. Injury to a covered person while participating as a professional as a part or organized competitive rodeo, sky diving, hang gliding, parachuting or scuba diving;
14. driving as a professional in any race or speed test or while testing an automobile or any vehicle on any racetrack or speedway;
15. charges incurred outside the U.S. if an Insured traveled to the location for the purpose of receiving medical services, drugs or supplies.

This proposal does not constitute the full contract and is intended to provide basic information about American Public Life Insurance Company's Form A-3B Supplemental Accident product.



P. O. Box 925
Jackson, Mississippi 39205

PROPOSAL IS BASED ON INFORMATION PROVIDED TO AMERICAN PUBLIC LIFE. FINAL RATES AND BENEFITS ARE SUBJECT TO VERIFICATION OF DATA ON WHICH THIS IS BASED. PROPOSAL IS VALID FOR 60 DAYS FROM DATE PROPOSED.

THIS PROPOSAL IS A BASIC OUTLINE OF THE BENEFITS AVAILABLE UNDER THE PLAN AND IS NOT A CONTRACT. THIS OUTLINE IS DESIGNED TO HIGHLIGHT THE MAIN FEATURES OF THE PLAN. PLEASE REFER TO THE POLICY FOR A COMPLETE DESCRIPTION OF BENEFITS AND EXCLUSIONS. PROVISIONS MAY VARY ACCORDING TO STATE REQUIREMENTS. DEFINITIONS, LIMITATIONS AND EXCLUSIONS ARE NOT APPLICABLE IN ALL STATES.

Lubbock Cooper ISD Voluntary Term Life Insurance

It may never be easier to add important coverage to your life insurance program—all you have to do is sign up now to receive a guaranteed amount of coverage without providing evidence of insurability (a completed health application and/or physical examination). This insurance is available to you at competitive group rates. And, you can buy this insurance through the convenience of automatic payroll deduction. By electing coverage during this initial enrollment period, you also protect your ability to buy additional insurance in the future. If your needs change due to marriage or divorce, adoption or birth of a child, death of a spouse, or a spouse's termination of employment, you can add coverage (up to the Guarantee Issue Limit) to your plan without a health application and/or physical examination. If coverage is waived during the initial enrollment period, satisfactory evidence of insurability, including a completed health application will be required. A physical examination may also be required.

***Fortunately, you don't have to die to discover you don't have enough life insurance.
Evaluate your life insurance needs today.***

Plan Description Life Insurance Coverage Guidelines

	Employee	Spouse	Child
Minimum	\$10,000	\$5,000	\$2,000
Maximum	5 times Annual Salary (up to) \$500,000	100% of Employee Benefit (up to) \$250,000	50% of Employee Benefit (up to) \$10,000
Guarantee Issue Limit	5 times Annual Salary (up to) \$150,000	100% of Employee Benefit (up to) \$50,000	50% of Employee Benefit (up to) \$10,000

Note: Securing coverage up to the guarantee issue limit amounts assumes at least 25% of eligible employees participate in the plan. Lower participation may cause guarantee issue amounts to be reduced, a rate adjustment, or benefit offer to be withdrawn from the group.

Your Employer has selected the following features to be included in your plan. A complete description of each provision will be provided in a certificate booklet, which will be issued to you, should you decide to select Voluntary Term Life coverage.

- Your plan includes the option to select **Spouse and Dependent Children** coverage. Dependent children include those 14 days old, up to age 21 (25 if a full-time student). Minimums, maximums and guarantee issue limits are listed above. To determine your cost, use the rate calculation worksheet provided in these materials.
- Your Plan includes **Continuation of Life Insurance Benefits Due to Total Disability**. If you became totally and continuously disabled through the Disability Elimination Period, this feature will keep your life insurance policy in force – without payment of premium.
- Your plan includes **Portability**. This feature allows you to continue this insurance program for you and your dependents should you leave your employer for any reason – without providing information about your health.
- Your plan includes an **Accelerated Death Benefit** of up to 50% of your life benefit not to exceed a maximum of \$50,000.
- Benefits are reduced when the insured reaches age 70, and will continue to decrease every five years thereafter. (See the chart below.) Spouse coverage, if available, terminates at age 70.

AGE	% PAYABLE
70	65%
75	45%
80	30%
85	20%
90	15%

Lubbock Cooper ISD VTL Rate Worksheet

To calculate monthly premium:

1. Locate the amount of coverage you wish to select along the top row of the Employee table. Then locate your age bracket along the left column of the table. Your monthly premium is the amount located where the row and column you have identified meet (down from top row and right from left column). If the amount you wish to select is greater than \$100,000, select one of the top row numbers that when multiplied by another number, results in your desired life amount (e.g. - selecting the rate for \$150,000 can be obtained by multiplying the appropriate rate for \$50,000 times 3). Enter the employee rate in the space provided below.
2. Follow the same method to determine your spouse rate. Use the Spouse table (below the Employee table). Enter the spouse rate in the space provided below.
3. Follow the same method to determine your child rate. Use the Child table (below the Spouse table). Make sure you multiply the child rate by the number of children to be covered. Enter the Child rate in the space provided below.
4. Total the **Employee, Spouse** (if any) and **Child** (if any) rates to obtain your **Total Monthly Premium**.

Employee	\$10,000	\$20,000	\$30,000	\$40,000	\$50,000	\$60,000	\$70,000	\$80,000	\$90,000	\$100,000
<30	0.50	1.00	1.50	2.00	2.50	3.00	3.50	4.00	4.50	5.00
30 - 34	0.70	1.40	2.10	2.80	3.50	4.20	4.90	5.60	6.30	7.00
35 - 39	0.90	1.80	2.70	3.60	4.50	5.40	6.30	7.20	8.10	9.00
40 - 44	1.20	2.40	3.60	4.80	6.00	7.20	8.40	9.60	10.80	12.00
45 - 49	2.10	4.20	6.30	8.40	10.50	12.60	14.70	16.80	18.90	21.00
50 - 54	2.60	5.20	7.80	10.40	13.00	15.60	18.20	20.80	23.40	26.00
55 - 59	5.50	11.00	16.50	22.00	27.50	33.00	38.50	44.00	49.50	55.00
60 - 64	8.60	17.20	25.80	34.40	43.00	51.60	60.20	68.80	77.40	86.00
65 - 69	14.60	29.20	43.80	58.40	73.00	87.60	102.20	116.80	131.40	146.00
70 - 74	22.90	45.80	68.70	91.60	114.50	137.40	160.30	183.20	206.10	229.00
75 - 79	40.80	81.60	122.40	163.20	204.00	244.80	285.60	326.40	367.20	408.00
80+	40.80	81.60	122.40	163.20	204.00	244.80	285.60	326.40	367.20	408.00

Employee	\$10,000	\$20,000	\$30,000	\$40,000	\$50,000	\$60,000	\$70,000	\$80,000	\$90,000	\$100,000
AD&D	0.30	0.60	0.90	1.20	1.50	1.80	2.10	2.40	2.70	3.00

Note: Spouse / Child coverage amounts cannot be more than 50% of the Employee coverage amounts selected.

Spouse	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
<30	0.25	0.50	0.75	1.00	1.25	1.50	1.75	2.00	2.25	2.50
30 - 34	0.35	0.70	1.05	1.40	1.75	2.10	2.45	2.80	3.15	3.50
35 - 39	0.45	0.90	1.35	1.80	2.25	2.70	3.15	3.60	4.05	4.50
40 - 44	0.60	1.20	1.80	2.40	3.00	3.60	4.20	4.80	5.40	6.00
45 - 49	1.05	2.10	3.15	4.20	5.25	6.30	7.35	8.40	9.45	10.50
50 - 54	1.30	2.60	3.90	5.20	6.50	7.80	9.10	10.40	11.70	13.00
55 - 59	2.75	5.50	8.25	11.00	13.75	16.50	19.25	22.00	24.75	27.50
60 - 64	4.30	8.60	12.90	17.20	21.50	25.80	30.10	34.40	38.70	43.00
65 - 69	7.30	14.60	21.90	29.20	36.50	43.80	51.10	58.40	65.70	73.00

Note: Spouse / Child coverage amounts cannot be more than 50% of the Employee coverage amounts selected.

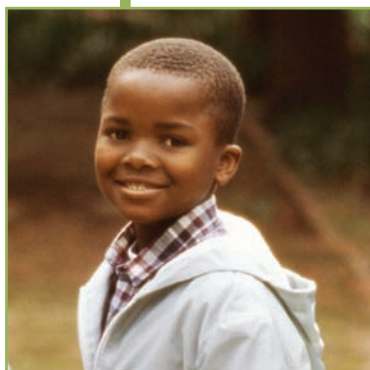
Child	\$1,000	\$2,000	\$3,000	\$4,000	\$5,000	\$6,000	\$7,000	\$8,000	\$9,000	\$10,000
Per Child	0.10	0.20	0.30	0.40	0.50	0.60	0.70	0.80	0.90	1.00

$$\begin{array}{r}
 \text{Employee Premium} \quad + \quad \text{Spouse Premium} \quad + \quad \text{Child(ren) Premium*} \quad = \quad \text{Total Monthly Premium} \\
 \text{(*child rate x no. of children)}
 \end{array}$$

LIFE INSURANCE HIGHLIGHTS

For the employee

*Flexible Premium Life Insurance to Age 121
Policy Form PRFNG-NI-07 or ICC-07-PRFNG-NI-07*



Voluntary permanent life insurance can be an ideal complement to the group term and optional term your employer might provide. Designed to be in force when you die, this voluntary universal life product is yours to keep, even when you change jobs or retire, as long as you pay the necessary premium. Group and voluntary term, on the other hand, typically is not portable if you change jobs and, even if you can keep it after you retire, usually costs more and declines in death benefit.

The policy, PURELIFE, is underwritten by Texas Life Insurance Company, and it has these outstanding features:

- **High Death Benefit.** With one of the highest death benefits available at the worksite,¹ PURELIFE gives your loved ones peace of mind, knowing there will be significant life insurance in force should you die prematurely.
- **Minimal Cash Value.** Designed to provide high death benefit, PURELIFE does not compete with the cash accumulation in your employer-sponsored retirement plans.
- **Long Guarantees.** Enjoy the assurance of a policy that has a guaranteed death benefit to age 121 and level premium that guarantees coverage for a significant period of time (after the guaranteed period, premiums may go down, stay the same, or go up).
- **Refund of Premium.** Unique in the marketplace, PURELIFE offers you a refund of five years' premium, should you surrender the policy if the premium you pay when you buy the policy ever increases. *(Conditions apply.)*
- **Accelerated Death Benefit Rider.** Should you be diagnosed as terminally ill with the expectation of death within 12 months, you will have the option to receive 92% of the death benefit (percentages lower in Massachusetts), minus a \$150 administrative fee. This valuable living benefit gives you peace of mind knowing that, should you need it, you can take the large majority of your death benefit while still alive. *(Conditions apply.)*

You may apply for this permanent, portable coverage, not only for yourself, but also for your spouse, minor children and grandchildren.

¹ Voluntary and Universal Whole Life Products, Eastbridge Consulting Group, October 2008

See the PURELIFE brochure for details.

TEXASLIFE INSURANCE COMPANY

Since 1901 | 900 WASHINGTON | POST OFFICE BOX 830 | WACO, TEXAS 76703-0830

TEXAS LIFE

If you wish to apply for a new Texas Life coverage, please contact Financial Benefit Services (FBS) at 972.690.8500 / 800.583.6908 for rates, plan information and the application required to apply for coverage.

EMPLOYEE GUIDE TO ENROLLING IN BENEFITS WITH THEbenefitsHUBSM

Through THEbenefitsHUBSM, you have access to your benefits information 24 hours a day, 7 days a week, at the click of a computer key. You can access this [information](#) from anywhere that you have access to the Internet... your home, office, Internet cafe or any mobile Internet device.

Step 1: log on!

Go to www.lcisdbenefits.com and click on the **ONLINE ENROLLMENT LOGIN** link. This will take you to your login screen.

Username:

Your **username** is the first 6 characters of your last name, followed by the first letter of your first name, followed by the last 4 digits of your Social Security Number.

Password:

Your **password** is your Social Security Number as shown below with no dashes.

Examples:

Renee Wills, 555111111

User name: willsr1111 Password: 555111111

John Doe 987-65-4321

User name: doej4321 Password: 987654321

Web Address: www.lcisdbenefits.com

Username: willsr1111

Password: 555111111

Step 2: now you can provide your own personal and benefits information!


THEbenefitsHUBSM will guide you through the simple enrollment process page by page.

employee usage agreement:


You will see this screen when you log in to the system as an employee. Be sure to take the time to read this section to ensure that you understand the terms of your "electronic signature" within THEbenefitsHUBSM. When you have reviewed and understand this information, click on **CONTINUE**.

employee data entry sections:

🔑 **Personal Information:** Please review current information for accuracy and enter in any new or missing information. All fields listed in **BOLD** are required. *Please enter an email address if you have one – if you ever forget your password, we can email it to you.*

🔑 **Dependent Information:** Please review current information for accuracy and enter in any new or missing information for each dependent (spouse, child/children). All fields listed in **BOLD** are required. *To edit a dependent's information, click on the pencil  or click on the **X** to delete a dependent. Please make sure to indicate if your child is a full-time student and/or is claimed on your tax return as this could affect their eligibility to be covered on some of the benefit plans.*

🔑 **Enrollment in Benefits:** Once all of your personal and dependent data is entered, you will have access to enroll *online* in the benefits for which you are eligible. Each **benefit plan type** (e.g. medical, dental, life) will appear individually for you to select the particular plan and coverage you want.

VIEW BENEFIT DESCRIPTIONS... To view a benefit description, click on the benefit plan name or on the  next to the name of the plan you would like to review. There you will find a plan summary and any available links to additional documentation or websites relevant to this plan.

VIEW PLAN COST... To quickly view a particular benefit Plan's cost to you, you may click on the circle to the left of the benefit name. Then click on the box next to each eligible family member or choose the coverage level that you are considering. Your cost will automatically show up in the box to the right of the members' names and will be updated with each member you add or remove from coverage.

VIEW TOTAL BENEFIT COST... As you select Plans, their cost will be continually added to the "Election Summary" box to the right of the Plan lists.

SELECT YOUR BENEFIT COVERAGE... After you have reviewed the Plan information and the costs of each Plan on each benefit type page:

- ☞ Click on the circle next to the appropriate plan (or next to "I waive enrollment..." at bottom of page if you do not want that type of coverage at all.)
- ☞ Click on the box next to each family member to be covered, if election made.
- ☞ If required under the Plan, enter primary provider information by clicking on the sentence at the bottom of the page. (If you don't know if one is required, click "Save & Continue" and the system will let you know if it's required.) *There may be a link to the directory if available online for that Plan. If so, you will be guided to this link when you go to make your selection.*

FORMS... One or more of your Benefit Plans may require a paper form to be submitted with the Insurance Carrier. If this is the case, *benefitsCONNECT*SM will prompt you to print the necessary forms at the end of your online enrollment session.

Step 3: beneficiary information

☞ **Beneficiary Information**

Choose your beneficiary(ies) for each applicable plan.

Step 4: consolidated enrollment form

☞ **Consolidated Enrollment Form:**

This form will display all of the data from each of the sections listed above, including both your personal and enrollment information. Please review for accuracy. You may make changes to anything that is incorrect by clicking on **click here to edit** next to that item or, when you are finished with the enrollment process, you will be sent to the Employee Menu where you may make changes. (See *Employee Menu section*)

**** Required Carrier Forms ****

If your Plans' carriers require paper forms, you will be prompted to print the appropriate forms at this point. Please complete the information on the form and sign and submit to your benefits/HR department!

When you have completed your benefit selections, click the



button, and then you will be automatically routed to the employee menu screen.

EMPLOYEE MENU

Once either you or your employer has entered your benefits enrollment information in the system, you will be shown the Employee Menu upon login.

The sections are as follows:



personal information

personal information: You may access and edit information from Sections 1-5 by selecting menu items under "Personal Information." You may also see information that the Employer has provided such as certain payroll details. You may also update the **directory information**, change your **password** and track the **forms** you've printed.



dependent information

dependent information: You may access and edit information regarding your **Dependents** in this section. Make sure that you let your HR Department know of any major changes here, as they may change your eligibility status or give you the opportunity to change your enrollment in certain benefits!



benefits plan information

benefits plan information: You may view your **enrollment** in benefits in this section. You should not be able to change benefit elections unless it is an open enrollment period for your company. See a **quick review** of all your information on the "**Consolidated Enrollment Form**"



company communications

company communications: Items such as **forms** that are commonly used by your company, **News & Bulletins**, and other **Human Resources/ Benefits information** reside here for the employees to access at any time from anywhere.

navigation and data entry tips...

HELP!... If you need assistance while working in **THEbenefitsHUBSM** don't hesitate to click on **help** at the upper right hand corner of the screen.

BACK AND FORTH... It is very important to try to avoid using your web browser's "back" and "forward" arrows while in the system. Use the navigation buttons in **THEbenefitsHUBSM**:



REQUIRED DATA... As noted on each screen, the **Bold** items are required for you to continue to the next page. Of course, the more information entered, the better the system will work for you; but you may skip non-bolded items if they are irrelevant or you do not wish to complete those items.

RESET... To clear all of the fields and "start over" on that particular page, click on



MOVING ON... When each page is completed, go to the bottom of the page and click on



UNABLE TO FINISH?... If you are unable to complete this process due to unavailability of data, time constraints, etc. you may simply **logout** and log in at another time. When you login again, you will be walked through the same process, but the data you entered will still be there.

"post-enrollment" tips

CHANGING YOUR PASSWORD... Go to "personal information," then select "Change Password." You may do this at any time after you have completed the enrollment process.

WHAT ARE THOSE SYMBOLS? If you just "hover" your cursor/arrow on the icons, the definition of the icons will be revealed. Here are some common ones:

 = Delete  = Edit  = Preview

LINKS... **words, names or phrases in bold red** that become underlined when you put your cursor/arrow on them, those are links that will bring you to that section or, if e-mail addresses, will create an e-mail to that person.

SCREEN NAVIGATOR... This line is at the top of your screen. You may click on the **red items** to quickly jump back to those previous screens.

[administration menu](#) ▶ [select insurance providers](#) ▶ [add/edit insurance provider](#)