

**TOWN OF WEBSTER
350 MAIN STREET
WEBSTER, MA. 01570
1-508-949-3800 EXT 1018
FAX 1-508-949-3837**

Congratulations and Welcome to The Town of Webster!

Enclosed is information regarding the benefits available to any permanent employees regularly scheduled to work 20 hours per week or more. Eligible employees have 30 days from their date of hire to sign up for benefits offered by the Town. Please note any changes to health insurance must occur within 30 days of a qualifying event, such as marriage, birth, adoption, or loss of coverage.

The Town offers the following benefits:

Health Insurance - **HPI - Harvard Pilgrim EPO - HPI - Harvard Pilgrim PPO**. The Town contributes 75% of the monthly cost towards both plans for active eligible employees. The remaining 25% comes out of your payroll.

Voluntary Dental Insurance - **Altus Dental Insurance Company**

Voluntary Vision Insurance - **Blue 20/20**

Group Life - **US Able \$5,000**

Voluntary Life - **US Able**

Flexible Spending Account - **Cafeteria Plan Advisors** Medical /Dental Account set aside up to \$2550 per plan year and Dependent Care Account set aside up to \$5,000 per plan year pre-tax!

Voluntary Worksite Benefits - **US Able** Accident, Critical Illness and Cancer Insurance

Smart Plan Massachusetts Deferred Compensation

If you are planning to cover yourself only:

- There is no documentation needed unless you are a retiree or survivor who is (and/or whose spouse is) age 65 or over (*see Additional Documents for Retirees and Survivors section below*).

If you are planning to cover a current and/or former spouse, you will need the following:

- If you are married – Copy of Certified Marriage Certificate

If you are divorced or legally separated, the following sections of the Separation Agreement are required

- Divorce Absolute Date
- Signature Page
- Health Insurance Provisions
- Your Former Spouse's Last Known Address

If you are planning to cover dependent children, you will need the following:

- Dependent Child Coverage – Copy of Certified Birth Certificate (*must have parent/child relationship listed*)
- Handicapped Dependent – complete Handicapped Dependent form
- Adoption – Copy of Adoption Placement Letter
 - Letter must be on Adoption Agency Letterhead and include the following:
 - Name of Adoptive Parents
 - Name of Adopted Child
 - Date Child Placed in the Home
- Grandchild – Copy of Court Guardianship Appointment
 - However, if grandchild is a dependent of a dependent under age 19, copy of grandchild's certified (*Long Form*) birth certificate

Documents such as marriage certificates and birth certificates can be obtained by contacting the Clerk's Office of the town in which the event occurred.

Adoption verification and Grandchild verification information can be obtained by contacting the adoption agency used or the Clerk of Court's office in the town in which the event occurred.

We encourage you to contact the appropriate offices as soon as possible. There may be a waiting period to obtain information.

If you have any questions feel free to contact Courtney Friedland or at (508)949-3800 ext. 1005.

**Town of Webster
350 Main Street
Webster, MA 01570**

Continuation Coverage Rights Under COBRA

Introduction

You are receiving this notice because you have recently become covered under a group health plan with the Town of Webster. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

What is COBRA Continuation Coverage?

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

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

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

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

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

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

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

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

You must provide this notice to: Town of Webster

How is COBRA Coverage Provided?

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

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

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

Are there other options besides COBRA Continuation Coverage?

Yes, Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period". Some of these options may cost less than COBRA continuation. You can learn more about many of these options at www.HealthCare.gov. or 1-800-318-2596.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website. For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

The Plan Administrator is the Town of Webster. Group Benefits Strategies is responsible for administering Cobra continuation Coverage. Group Benefits Strategies is located at 11 Midstate Drive, Suite 110, Auburn, MA 01501. (800) 229-8008.



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 3-31-2017)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

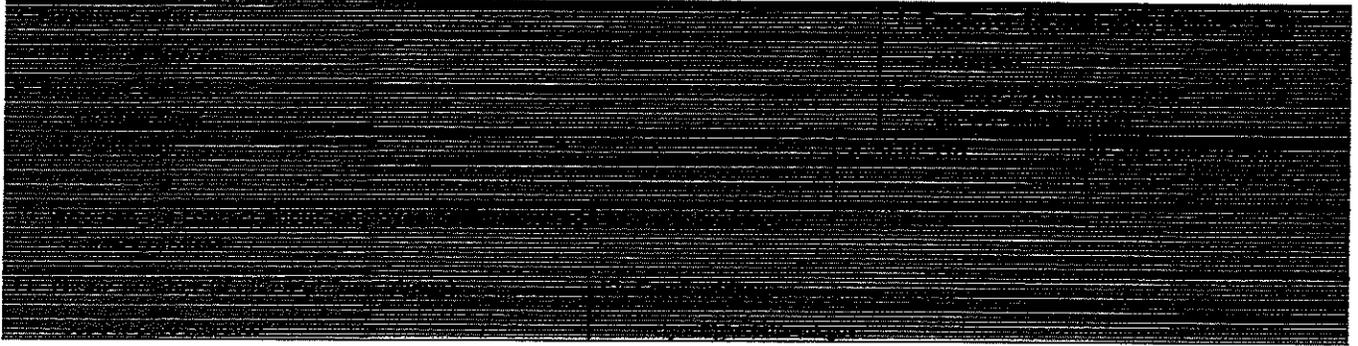
For more information about your coverage offered by your employer, please check your summary plan description or contact _____.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.



Here is some basic information about health coverage offered by this employer:

•As your employer, we offer a health plan to:

All employees. Eligible employees are:

Some employees. Eligible employees are:
Defined Under Massachusetts General Law 32B

•With respect to dependents:

We do offer coverage. Eligible dependents are:
Defined Under Massachusetts General Law 32B

We do not offer coverage.

If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

Town of Webster
350 Main Street
Webster, MA 01570

Courtney M. Friedland
Health Insurance Coordinator
(508) 949-3800 ext. 1005
ctyrrell@webster-ma.gov



Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ **See page 2** for more information on these rights and how to exercise them

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ **See page 3** for more information on these choices and how to exercise them

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ **See pages 3 and 4** for more information on these uses and disclosures

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.

***Example:** A doctor treating you for an injury asks another doctor about your overall health condition.*

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

***Example:** We use health information about you to manage your treatment and services.*

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.

***Example:** We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

.....
Help with public health and safety issues

- We can share health information about you for certain situations such as:
 - Preventing disease
 - Helping with product recalls
 - Reporting adverse reactions to medications
 - Reporting suspected abuse, neglect, or domestic violence
 - Preventing or reducing a serious threat to anyone's health or safety

.....
Do research

- We can use or share your information for health research.

.....
Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

.....
Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

.....
Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

.....
Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:
 - For workers' compensation claims
 - For law enforcement purposes or with a law enforcement official
 - With health oversight agencies for activities authorized by law
 - For special government functions such as military, national security, and presidential protective services

.....
Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.
-

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticeapp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

July 16, 2018

This Notice of Privacy Practices applies to the following organizations.

*Courtney M. Friedland
(508) 949-3800 ext. 1005
ctyrrell@webster-ma.gov*



Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2015. Contact your State for more information on eligibility –

MASSACHUSETTS – Medicaid and CHIP	MAINE – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.maine.gov/dhhs/ofl/public-assistance/index.html Phone: 1-800-977-6740 TTY: 1-800-977-6741
NEW HAMPSHIRE – Medicaid	RHODE ISLAND – Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 1-603-271-5218	Website: http://www.ohhs.ri.gov Phone: 1-401-462-5300
VERMONT – Medicaid	
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	

To see if any other states have added a premium assistance program since January 31, 2015, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
 Employee Benefits Security Administration
www.dol.gov/ebsa
 1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
 Centers for Medicare & Medicaid Services
www.cms.hhs.gov
 1-877-267-2323, Menu Option 4, Ext. 61565

Town of Webster
Open Enrollment Rates Effective 7/1/2019

*Active Employees and Non-Medicare Eligible Retirees
(7/1/2019 - 6/30/2020)*

	Funding Rate	Employee 25%		Employee Pay Periods		
		Retiree 50%	Employee 25%	52	26	39
HPI - Harvard Pilgrim EPO	Individual	\$717.80	\$179.45	\$41.41	\$82.82	\$55.22
	Family	\$1,863.64	\$465.91	\$107.52	\$215.04	\$143.36
HPI - Harvard Pilgrim PPO	Individual	\$946.68	\$236.67	\$54.62	\$109.23	\$72.82
	Family	\$2,356.12	\$589.03	\$135.93	\$271.86	\$181.24

Employee Pay Periods

	Monthly Rate	Employee Pay Periods	
		52	39
Altus Dental Plan (7/1/2019 - 6/30/2020)			
Individual	\$44.04	\$10.16	\$13.55
2-Person	\$90.13	\$20.80	\$27.73
Family	\$154.31	\$35.61	\$47.48
Blue 20/20 (7/1/2019- 6/30/2020)			
Employee	\$6.75	\$1.56	\$2.08
Emp. plus spouse	\$11.48	\$2.65	\$3.53
Employee plus one or more children	\$11.82	\$2.73	\$3.64
Family	\$18.57	\$4.29	\$6.97

USABLE Life Insurance Group Life and AD&D

(7/1/2019 - 6/30/2020) \$5000/\$5000 \$ 1.20/month

Senior Plans

Monthly Rate **Retiree 50%**

Medex 2 with MedicareBlue Rx Requires Medicare A & B (1/1/2019 - 12/31/2019)	\$339.66	\$169.83
Altus Dental Retiree Plan (7/1/2019 - 6/30/2020)	\$47.24	USABLE Life Insurance
	\$94.48	(7/1/2018 - 6/30/2019)
	\$165.34	\$ 0.45/month
		\$1,000

Town of Webster – Network Plan
 Medical Benefits for Group BP3 Effective 7/1/2019

Covered Services	Tier 1	Tier 2	Tier 3
Deductible & Out-of-Pocket			
Annual Plan Year Deductible	None	\$250	\$250
<i>Single</i>	None	\$750	\$750
<i>Family</i>			
Annual Out-of-Pocket Maximum <i>(includes Deductible, Co-Insurance, Copayments & Prescription Copayments)</i>	\$2,500	\$2,500	\$2,500
<i>Single</i>	\$5,000	\$5,000	\$5,000
<i>Family</i>			
Preventive Care			
Routine Physicals, Gynecological Exams & Family Planning	No Charge	No Charge	No Charge
Routine Hearing Exams & Routine Vision Exams <i>(one Vision Exam every 24 months)</i>	No Charge	No Charge	No Charge
Other Services			
Office Visit – Primary Care and Urgent Care	\$20 copay	\$20 copay	\$20 copay
Office Visit – Specialist Care	\$35 copay	\$35 copay	\$35 copay
Chiropractic Visit, Speech Therapy, Occupational & Physical Therapy <i>(up to 60 visits per Plan year for Occupational and Physical Therapy)</i>	\$25 copay	\$25 copay	\$25 copay
Diagnostic Lab & X-Ray	No Charge	Deductible then no charge	Deductible then no charge
CT, MRI, PET Scan & Nuclear Cardiac Imaging Tests <i>(done in general hospitals per category, per service date)</i>	\$100 copay	Deductible then \$100 copay	Deductible then \$100 copay
CT, MRI, PET Scan & Nuclear Cardiac Imaging Tests <i>(done by other covered providers)</i>	\$100 copay	\$100 copay	\$100 copay
Ambulatory Surgical Facility per Admission	\$150 copay	\$150 copay	\$150 copay
Inpatient Hospital & Surgical Day Care Unit per Admission	\$300 copay	Deductible then \$300 copay	Deductible then \$700 copay
Mental Health Hospital or Substance Abuse Facility	\$150 copay	\$150 copay	\$150 copay
Mental Health or Substance Abuse Treatment	\$15 copay	\$15 copay	\$15 copay
Home Health Care and Hospice	No Charge	No Charge	No Charge
Emergency Room <i>(copay waived if admitted)</i>	\$100 copay	\$100 copay	\$100 copay
Nurse Practitioner <i>(not billed by PCP)</i>	\$15 copay	\$15 copay	\$15 copay
Fitness Reimbursement & Weight Loss Reimbursement	\$150 per year each per category		
Prescription Drug Benefits			
Retail Pharmacy <i>(up to a 30-day supply)</i>	\$10 (Generic) / \$25 (Preferred Brand) / \$50 (Non-Preferred Brand)		
Mail Order <i>(up to a 90-day supply)</i>	\$20 (Generic) / \$50 (Preferred Brand) / \$110 (Non-Preferred Brand)		

NOTE: This Summary provides you with an overview of your Plan benefits and is not a complete statement of all Plan provisions, limitations and exclusions. Please refer to your Summary Plan Description and amendments for complete details. In the event of any inconsistency between this Summary and your Plan Document, the Plan Document and any applicable amendments will govern. Please refer to your Plan Document and Amendments for complete details as well as the services that require prior authorization. Hearing Aids up to \$2,000 per ear every 36 months for a member age 21 or younger is covered by the Plan.

Town of Webster — PPO Plan

Medical Benefits for Group BP3 Effective 7/1/2019

Covered Services	In-Network Providers	Out-of-Network Providers
Deductible & Out-of-Pocket		
Annual Plan Year Deductible	<i>Single</i> \$250 <i>Family</i> \$750	\$400 \$800
Annual Out-of-Pocket Maximum (<i>includes Deductible, Co-Insurance, Copayments & Prescription Copayments</i>)	<i>Single</i> \$2,000 <i>Family</i> \$4,000	\$3,000 per member
Preventive Care		
Routine Physicals, Gynecological Exams & Family Planning	No Charge	Deductible then 20%
Routine Hearing Exams & Routine Vision Exams (<i>one Vision Exam every 24 months</i>)	No Charge	Deductible then 20%
Other Services		
Office Visit – Primary Care and Urgent Care	\$20 copay	Deductible then 20%
Office Visit – Specialist Care	\$35 copay	Deductible then 20%
Chiropractic Visit, Speech Therapy, Occupational & Physical Therapy (<i>up to 60 visits per Plan year for Occupational and Physical Therapy and up to 20 visits per plan year for Chiropractic</i>)	\$20 copay	Deductible then 20%
Diagnostic Lab & X-Ray	Deductible then No Charge	Deductible then 20%
CT, MRI, PET Scan & Nuclear Cardiac Imaging Tests (<i>done in general hospitals per category, per service date</i>)	Deductible then \$100 copay	Deductible then 20%
CT, MRI, PET Scan & Nuclear Cardiac imaging Tests (<i>done by other covered providers</i>)	Deductible then \$150 copay	Deductible then 20%
Ambulatory Surgical Facility per Admission	Deductible then \$150 copay	Deductible then 20%
Inpatient Hospital & Surgical Day Care Unit per Admission	Deductible then \$300 copay Deductible then \$700 copay for certain hospitals	Deductible then 20%
Mental Health Hospital or Substance Abuse Facility	Deductible then \$200 copay	Deductible then 20%
Mental Health or Substance Abuse Treatment	Deductible then \$15 copay	Deductible then 20%
Home Health Care and Hospice	Deductible then no charge	Deductible then 20%
Emergency Room (<i>copay waived if admitted</i>)	\$100 copay	\$100 copay
Nurse Practitioner (<i>not billed by PCP</i>)	\$20 copay	Deductible then 20%
Fitness Reimbursement & Weight Loss Reimbursement	\$150 per year each per category	
Prescription Drug Benefits		
MaxorPlus		
Retail Pharmacy (<i>up to a 30-day supply</i>)	\$10 (Generic) / \$25 (Preferred Brand) / \$50 (Non-Preferred Brand)	
Mail Order (<i>up to a 90-day supply</i>)	\$20 (Generic) / \$50 (Preferred Brand) / \$110 (Non-Preferred Brand)	

NOTE: This Summary provides you with an overview of your Plan benefits and is not a complete statement of all Plan provisions, limitations and exclusions. Please refer to your Summary Plan Description and amendments for complete details. In the event of any inconsistency between this Summary and your Plan Document, the Plan Document and any applicable amendments will govern. Please refer to your Plan Document and Amendments for complete details as well as the services that require prior authorization.



Member Enrollment / Change Form

Employer Name: **Town of Webster**

Group Number: **BP3**

To Be Completed by Employer (this section must be completed prior to submitting to Health Plans)

Hire Date: _____ Effective Date: _____ Termination Date: _____ Change Effective Date: _____

Please Indicate: Active COBRA Department/Division/Location (if applicable): _____

Please Indicate reason(s) for change or enrollment: New Employee Open Enrollment Change of Address Special Enrollment
 Add Dependent Coverage - Reason: _____ if requesting coverage for employee's spouse: _____ date of marriage
 Terminate Dependent Coverage - Reason: _____
 Change of Status - Reason: _____ Other: _____

To Be Completed by Employee

Employee Last Name	First Name	MI	Social Security Number	Date of Birth
Mailing Address			City	ST
Gender	Marital Status	Email Address		Primary Phone
ZIP Code				

Health Coverage Election

Medical Plan Option (select one): Network Tiering Plan PPO Plan
Employee Only or Employee + : Spouse/Partner Child(ren) Family Ex-Spouse
 Medical Medical Medical Medical Medical

Dependents

Last Name	First Name	MI	Gender	Date of Birth	Relationship	Dependent Social Security Number (REQUIRED)	Add Dependent	Drop Dependent
							<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>

Are you or any of your dependents covered by another medical plan? Yes No Self Spouse/Partner Child(ren) Ex-Spouse

If yes, Medical Policy No. & Insurance Co.: _____ Policyholder: _____

Name/Address of Policyholder's Employer: _____

Election of Coverage

Important

To accept coverage, select YES, sign, and date this section.

YES • I wish to elect coverage under my employer's benefit plan for the coverage indicated above. I understand that my application will be subject to the terms of the Plan. I authorize any required deductions from my earnings. I authorize the release of medical records to Health Plans, Inc. or its representatives. A photocopy shall be as valid as the original. • I certify that the above information is accurate and complete and I am actively working the minimum number of hours required for coverage.

Signature: _____
Signature of Employee Date Signed

Waiver of Coverage

NO • If you are declining enrollment in the Plan for yourself and/or your dependents (including your spouse) because you and/or your dependents are covered under other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Signature: _____
Signature of Employee Date Signed

*** PLEASE RETURN COMPLETED FORM TO YOUR HUMAN RESOURCES DEPARTMENT ***

Health Plans, Inc. - Corporate Headquarters • PO Box 5199 • Westborough, MA 01581 • 800-532-7575

Enroll_Med_All_040118

AchieveHealth™

PROGRAMS FOR YOUR HEALTH



Your Health. Your Benefits.

Everyone has different needs when it comes to feeling their best. Sometimes a little encouragement, understanding and support is all you need to improve the way you feel. Whether you're actively trying to improve your wellbeing, or you're just thinking about it, you and your family have access to unlimited, confidential Health Coaching sessions to help you reach your goals.



What is my Health Coaching benefit?

- Unlimited Health Coaching sessions are available to you and your covered family members at no cost.
- Work with your own Health Coach to make a personalized plan to help you achieve success.
- Explore new ways of incorporating lifestyle changes that will help you maintain your goals for a lifetime such as:
 - I want to lose weight and keep it off
 - I want to quit using tobacco for good
 - I want to reduce stress in all areas of my life
 - I want to feel more physically fit
 - I want more control over my chronic condition (diabetes, high blood pressure, high cholesterol or asthma just to name a few)
 - I'm not ready to change, but talking to someone may help motivate me



How does Health Coaching work?

- Talk with your Health Coach over the phone at times convenient to you.
- Appointments can be up to one hour, depending on your needs.
- Coaches are available M-Th 8am-10pm and Friday, 8am- 6pm (EST).



Additional Health Programs

- Case management - support when you need it.
- Personalized preventive health report.



How do I get more information about talking with a Health Coach?

Call 1-866-234-4635 to speak to a Health Coach about enrolling in the program.
Or, enroll online at: <http://enroll.trestletree.com>

TOP 5 THINGS YOU NEED TO KNOW

Effective July 1, 2019, we're changing medical benefit coverage to Health Plans, Inc. (HPI), a Harvard Pilgrim company. Here's what you need to know:

Get ready to make the switch

Where can I get more info?

1

Continue Your Care

- Upcoming surgery
- Expecting a baby
- Condition Management



call

HPI
877-734-6995
weekdays 8am-5pm

2

Review Your Benefits

- Copayments and plan benefits remain the same as you had in the past



call

HPI
877-734-6995
weekdays 8am-5pm

3

Check Your Provider's Network Participation

- Harvard Pilgrim Health Care is your provider network in MA, NH and ME
- UnitedHealthcare Choice Plus is your provider network in all other states



visit us

healthplansinc.com/members
Click *Search for a Provider* and then *HPHC and UnitedHealthcare Choice Plus Network*.

Be on the lookout for a new website URL coming soon.

4

Swap Your Member ID Cards

- On July 1, show your new member ID card to your providers and pharmacies



watch

Your Mail
for new cards coming
to your home the last two
weeks of June

5

Get to Know HPI

- Medical benefits will stay the same
- No referral required for specialty care
- Not required to choose a primary care provider (PCP)
- Access to a national provider network
- Access to additional member discounts and savings programs



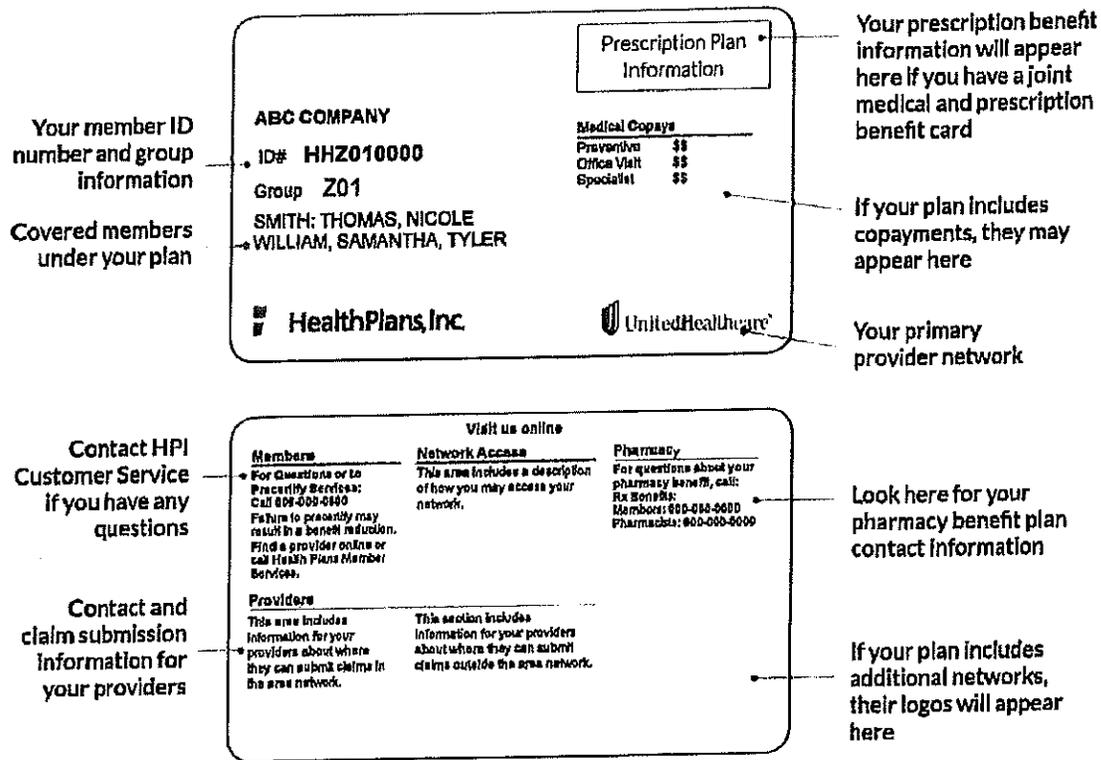
read

Your Welcome Kit

We're here for you

UNDERSTANDING YOUR ID CARD

Your member ID card includes useful information about your plan for both you and your providers. Always carry your member ID card with you and remember to present it to your healthcare providers during visits.



Need a new member ID card?

Download a mobile card, print a temporary copy, or request a new one on your desktop or mobile device.



Have questions? Call HPI Customer Service at the phone number or website listed on the back of your member ID card.

ABOUT YOUR EOB

An Explanation of Benefits (EOB) is a statement that shows how HPI processed a medical claim and applied your health benefits; it is not a bill. A sample EOB is pictured below. You may receive an EOB in the mail if you have financial responsibility for claim charges. You can also access EOBs online through your *My Plan* account.

HealthPlans, Inc.

Your Employer Name
PO Box 5199
Westborough, MA 01581

Forwarding Service Requested

MARY A. DOE
123 MAIN STREET
UNIT 21
ANYTOWN, MA 01000

PLEASE KEEP A COPY FOR YOUR RECORDS

THIS IS NOT A BILL

Customer Service
For more information, visit healthplansinc.com or call Customer Service at XXX-XXX-XXXX

Group Name: YOUR EMPLOYER PLAN NAME
Group Code: XXX-Z01
Process Date: 02/27/2016
Patient: JOHN W. DOE

Easy to locate Customer Service phone number

Patient: JOHN W. DOE Provider: ABC MRI DIAGNOSTICS, LLC
Claim #: 216268W8200 Member: MARY A. DOE

Treatment Dates	Procedure Code	Charge Amount	Not Covered	Reason Code	Allowable Amount	*Deductible Amount	*Co-pay Amount	Paid At 90%	Payment Amount
02/03-02/03/2016	70543	\$1700.00	\$0.00	HP	\$1472.85	\$558.15	\$0.00	\$0.00	\$823.23
Column Totals		\$1700.00	\$0.00		\$1472.85	\$558.15	\$0.00		\$823.23

*Patient's Responsibility: **\$649.62**

Other Insurance Credits or Adjustments: \$0.00
*Coinsurance Total: \$91.47
Total Payment Amount: \$823.23

The patient's responsibility is clearly labeled

Separate co-pay and deductible amounts

Reason Code/Description	Reason codes explain how a charge was processed
HP YOUR NETWORK DISCOUNT APPLIED	

2016 Year-to-Date Plan Accumulators	Satisfied to Date	Maximum
JOHN W. DOE Individual In-Network Deductible	\$760.00	\$760.00
JOHN W. DOE Individual In-Network Out of Pocket	\$841.47	\$2250.00
JOHN W. DOE Individual Out-of-Network Deductible	\$0.00	\$1250.00
JOHN W. DOE Individual Out-of-Network Out of Pocket	\$0.00	\$3000.00
Family In-Network Deductible	\$1500.00	\$1500.00
Family In-Network Out of Pocket	\$1972.05	\$4500.00
Family Out-of-Network Deductible	\$0.00	\$2500.00
Family Out-of-Network Out of Pocket	\$0.00	\$6000.00

Amounts applied toward your deductible and out-of-pocket maximum are shown here

Messages
You are entitled to appeal any denial or partial denial of a claim. See the back of this page for information about your appeal rights.
SPANISH (Español): Para obtener asistencia en Español, llame al 866-815-8388.

Comments
PER NETWORK AGREEMENT, THERE IS NO MEMBER RESPONSIBILITY FOR PRICING DISCOUNTS.

Have questions? Contact HPI Customer Service at the phone number or website listed on the back of your member ID card.



Altus Dental Insurance Company, Inc.

Benefit Highlights

Plus Plan

Welcome to Altus Dental

This overview highlights your dental benefits and explains how your Plus plan works. We look forward to providing you and covered family members with dental insurance. When your coverage begins, we will send you an ID card.

Register at altusdental.com to learn more about your benefits and choose to receive paperless communications from us through your secure and convenient online account.

How to Contact Us

ONLINE

You can access your account information online 24 hours a day, 7 days a week at www.altusdental.com.

INFOLINE

1.877.223.0588

Our automated telephone information system is available 24 hours a day, 7 days a week.

CUSTOMER SERVICE

1.877.223.0588

Our customer service representatives are available Monday – Thursday 8 am to 7 pm and Friday 8 am to 5 pm, ET.

TOWN OF WEBSTER

Your group number: 6401-0001

The annual maximum is: \$1200 per member per calendar year
The annual deductible is: \$50 per individual /\$150 per family
The maximum lifetime cap is: Unlimited

Pretreatment estimates are recommended for underlined procedures.

Plan pays 100%; Member Coinsurance 0% (exempt from calendar year maximum)

- Two oral exams per calendar year
- Two cleanings per calendar year
- One set of bitewing x-rays per calendar year
- One complete x-ray series or panoramic film every 36 months
- Single x-rays as required
- Fluoride treatment for children under age 19 twice per calendar year
- Sealants for children under age 16, once per unrestored permanent molar every 36 months

Plan pays 100%; Member Coinsurance 0%

- Space maintainers for lost deciduous (baby) teeth, replacement limited to once every 60 months

Plan pays 80%; Member Coinsurance 20% Deductible Applies

- Palliative treatment (minor procedures necessary to relieve acute pain) twice per calendar year
- Amalgam (silver) fillings. Composite (white) fillings on all teeth.
- Extractions and other routine oral surgery not covered by a patient's medical plan
- General anesthesia or intravenous (I.V.) sedation for complex surgical procedures
- Root canal therapy
- Repairs to existing partial or complete dentures once per calendar year
- Recementing crowns or bridges
- Rebasing or relining of partial or complete dentures; once every 60 months
- Periodontal maintenance following active therapy – two per year
- Root planing and scaling once per quadrant every 24 months
- Osseous (bone) surgery once per quadrant every 24 months (bone grafts are not covered)
- Gingivectomies once per site every 24 months
- Soft tissue grafts once per site every 60 months
- Crown lengthening once per tooth every 60 months

Plan pays 50%; Member Coinsurance 50% Deductible Applies

- Surgical placement of endosteal implant and abutment; replacement limited to once every 60 months
- Crowns over natural teeth, build ups, posts and cores - replacement limited to once every 60 months
- Bridges, build ups, posts and cores, crowns over implants - replacement limited to once every 60 months
- Partial and complete dentures - replacement limited to once every 60 months

Orthodontics:

Plan pays 50%; Member Coinsurance 50%

- Braces and related services for dependent children under the age of 19
Lifetime Maximum (orthodontics only): \$1000

Dependent Coverage – Dependent children are covered up until the end of the month that they turn age 26.

Monthly premium:	\$44.04 Individual	\$90.13 Two Person	\$154.31 Family
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How Your Plan Works

Receiving care from a participating network dentist will save you money. To make sure you get the maximum out of your dental plan, it's important to know how your plan works.

The Altus Dental network includes many dentists in your area. We are the largest Preferred Provider Organization (PPO) in the state. We also offer access to dentists nationwide through the CONNECTION Dental network. All of our network dentists pass our rigorous credentialing process.

How to Find a Dentist

Choose from Altus Dental's extensive network of dentists. With a continually expanding list of participating dentists, you're sure to find one that's right for you.

Visit altusdental.com to use our online Find a Dentist tool. You can see if your current dentist participates with us or look for a new dentist by searching by name, location or specialty. If your card displays the CONNECTION Dental logo, you have access to a national network of dentists and specialists. Enter your address or other criteria important to you (extended hours, languages spoken, etc.), and our tool will return a list of dentists that meet your needs — as well as maps and driving directions.

*Thanks for choosing
Altus Dental – we look forward
to providing you and any
covered family members
with quality dental benefits.*

Maximize your coverage with participating dentists

In-network care

When you receive care from a participating dentist, your out-of-pocket costs will be less. That's because the dentist has agreed to accept the allowance as full payment, minus any coinsurance and applicable deductibles, which means no "balance billing." Participating dentists also handle paperwork and inquiries directly with us.

Out-of-network care

You have the freedom to see a dentist who does not belong to our network. However, when you go to a non-participating dentist, it will usually cost you more money. That's because non-participating dentists expect you to pay for any difference between the amount Altus Dental allows and the amount the dentist charges.

You may also have to file the claim yourself and be reimbursed by Altus Dental.

Members Online

When you register at altusdental.com, you can log in to see your benefits, eligibility and claims information whenever it's convenient for you. And, you can choose to receive paperless communications from us through your secure and convenient online account. Visit www.altusdental.com today!

*Claims and correspondence
should be sent to:*

**Altus Dental
P.O. Box 1557
Providence, RI 02901-1557**

NOTICE OF NONDISCRIMINATION AND ACCESSIBILITY POLICY

Altus Dental Insurance Co. does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-223-0588.
Português (Portuguese): ATENÇÃO: Se fala português, encontramos disponíveis serviços linguísticos, grátis. Ligue para 1-877-223-0588.



ENROLLMENT FORM

P.O. Box 1557
 Providence, RI 02901-1557
 877-223-0588

Please print.

Employer Group Name		Altus Dental Group Number		Date of Hire	Location No. (if applicable)																									
Social Security No. / Subscriber ID No.		Subscriber Name: First - Last		Email Address																										
Date of Birth - MM/DD/YYYY		Street Address / P.O. Box No.																												
Effective Date of Action:	Apt. No.	City	State	Zip																										
QUALIFYING EVENT <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> New Hire/Re-Hire <input type="checkbox"/> Return From Leave of Absence <input type="checkbox"/> Marriage <input type="checkbox"/> Dependent's Loss of Coverage <input type="checkbox"/> Divorce <input type="checkbox"/> Full-Time/Part-Time Status <input type="checkbox"/> Birth or Adoption <input type="checkbox"/> Death of a Member			DEPENDENT INFORMATION																											
			First Name Only if last name differs, please indicate in "other remarks" below.	Date of Birth	Relationship	Check box if full-time student over 19. Group must have student rider. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																								
ACTION CODE (Check one. Changes must be made on the first of the month.) <input type="checkbox"/> New Subscriber <input type="checkbox"/> Add Dependent to Family <input type="checkbox"/> Reinstatement			DENTIST INFORMATION List the dentists you or your covered family members use: <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">Dentist(s) Last Name</td> <td style="width: 33%;">First Name</td> <td style="width: 33%;">City/Town</td> </tr> <tr><td> </td><td> </td><td> </td></tr> </table>				Dentist(s) Last Name	First Name	City/Town																					
Dentist(s) Last Name	First Name	City/Town																												
TERMINATION: <input type="checkbox"/> Remove Subscriber <input type="checkbox"/> Remove Dependent / Student			CORRECTIONS / OTHER REMARKS 																											
STATUS CHANGE: <input type="checkbox"/> Change "Type of Coverage" Please indicate (e.g. Individual to Family) under "Type of Coverage". <input type="checkbox"/> Name / Address Change <input type="checkbox"/> Transfer from Sublocation # _____ to # _____																														
COBRA: <input type="checkbox"/> Reinstatement of Subscriber <input type="checkbox"/> Addition of Dependent (From prior ID # _____)			TYPE OF COVERAGE (Check one) <input type="checkbox"/> Individual <input type="checkbox"/> 2 Person <input type="checkbox"/> Family																											
COORDINATION OF BENEFITS																														
DENTAL — Are You or Any of Your Dependents Covered by Another Dental Plan? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Please Complete the Section Below.																														
Other Dental Insurance Name: _____				Type of Coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Family																										
Other Dental Insurance Address: _____																														
Employer Name Through Which You / Your Dependents Have Other Insurance: _____																														
Group Policy No.	Policyholder Name		Policyholder ID No.																											
MEDICAL — Are You or Any of Your Dependents Covered by A Medical Plan? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Please Complete the Section Below.																														
Name of Medical Insurance Company / HMO: _____				Type of Coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Family																										
Name of Health Plan / Type of Coverage: _____																														
Employer Name Through Which You / Your Dependents Have Other Insurance: _____																														
Group Policy No.	Policyholder Name		Policyholder ID No.																											

I certify that all information is true and correct to the best of my knowledge. Also, I understand that the effective date and termination date of my membership will be determined by my employer or plan sponsor in accordance with the underwriting guidelines of Altus Dental. In addition, if my employer requires employee contributions for this coverage, I authorize the deductions of these amounts from my wages periodically.

Employee Signature _____ Date _____ Benefits Administrator Authorization _____ Date _____

NOTICE OF NONDISCRIMINATION AND ACCESSIBILITY POLICY
 Altus Dental does not discriminate on the basis of race, color, national origin, age, disability, or sex.
 Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-843-3582.
 Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-843-3582.



altus dental™

Altus Dental Insurance Company, Inc.

Register today at altusdental.com

Taking good care of your teeth and gums is an important part of keeping your whole body healthy.

When you register at altusdental.com, you can take charge of your oral health and:



Register for paperless communications



See if your dentist participates or locate a new one



Understand the costs of dental care in your area



See how you've used your dental benefits this year



Learn more about your Altus Dental plan



Get tips to keep your smile healthy

Registering at our site is easy. Follow these steps:

1

Go to altusdental.com to register

2

Under "Log In To Your Account," click on "Click Here to Register"

3

Click on "Member with Coverage"

4

Enter the subscriber's information



Once you've registered, we'll occasionally send you e-mails with information and quick tips that make it easy to have a healthy smile.

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Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-223-0588

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-223-0588.



Blue^{20/20}

A healthy view

Benefits you can see—from a company you trust

Save money on all your vision needs. With our Blue 20/20 plans, you can save on eyeglasses, contacts, and routine eye exams. We've partnered with EyeMed Vision Care[®], an independent vision benefits company, to bring you more choice, more value, and more flexibility, including:

- Access to one of the nation's largest vision networks
- Exclusive savings on designer frames, premium lenses and coatings, and contact lenses
- Award-winning customer service

Choose from thousands of independent providers and retailers, including:

- LensCrafters[®]
- Pearle VisionSM
- Target Optical[®]
- JCPenney Optical
- Sears Optical[®]

Plus, take a peek at these additional features and discounts:

- Laser vision correction—15 percent off the retail price or 5 percent off the promotional price for LASIK or PRK procedures
- 40 percent off additional eyewear purchases
- 20 percent off non-prescription sunglasses
- 20 percent off supplies like contact lens solution

Be seen at your convenience—when and where you want

As a Blue 20/20 member, you'll have access to thousands of independent providers and national retailers. With so many locations to choose from, you're sure to find a provider with a schedule that works for you.

For added convenience, shop online for glasses by visiting glasses.com, or shop for contacts by visiting contactsdirect.com.



Take advantage of this important benefit

Regular eye exams do more than identify vision problems, they can also provide the earliest detection of serious health conditions, such as high blood pressure or diabetes.¹

Look at how much you can save

Save \$290 on glasses with standard single-vision lenses

	With Blue 20/20*	Without*
Step 1: Get an Eye Exam	\$10	\$88
Step 2: Pick a Frame Member selected \$170 frame and has a \$130 allowance	\$40	\$170
Step 3: Pick a Lens	\$25	\$75
Upgrade to Std. Polycarbonate	\$40	\$62
Add Tint	\$15	\$25
Total Cost	\$130	\$420

→ **69%** savings

Save \$242 on disposable contact lenses

	With Blue 20/20*	Without*
Step 1: Get an Eye Exam	\$10	\$88
Fit and Follow-Up	\$40	\$74
Step 2: Purchase Contact Lenses. Member selected \$200 contact lenses and has a \$130 allowance	\$70	\$200
Total Cost	\$120	\$362

→ **67%** savings

Benefits are not provided for services or materials arising from: orthoptic or vision training; subnormal vision aids and any associated supplemental testing; anisotropic lenses; medical and/or surgical treatment of the eye, eyes, or supporting structures; any eye or vision examination, or any corrective eyewear required by a policyholder as a condition of employment, safety eyewear; services provided as a result of any workers' compensation law, or similar legislation, or required by any governmental agency or program whether federal, state, or subdivisions thereof; plano (non-prescription) lenses and/or contact lenses; non-prescription sunglasses; two pair of glasses in lieu of bifocals; services or materials provided by any other group benefit plan providing vision care, certain brand name vision materials in which the manufacturer imposes a no-discount policy; or services rendered after the date an insured person ceases to be covered under the policy, except when vision materials ordered before coverage ended are delivered, and the services rendered to the insured person are within 31 days from the date of such order. Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next benefit frequency when vision materials would next become available. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/premium progressive lens not covered. Fund as a bifocal lens. Standard progressive lens covered. Fund premium progressive as a standard.

* The above examples are based on a Blue 20/20 Plan with a \$10 Exam copay / \$25 Lens copay / \$130 Frame or Contact Allowance.
** Costs are based on industry averages. Retail prices and costs will vary by market and provider type. Premiums not included.

It's easy to save with Blue 20/20



1. Enroll through your employer.



2. Find an eye doctor.
Go to blue2020ma.com
or call 1-855-875-6948



3. Make an appointment.
All of our eye care providers offer great savings. Many offer evening and weekend appointments.



4. Show your card when you arrive.

Ask your employer how you can enroll in Blue 20/20 today!
Visit blue2020ma.com to find if your eye doctor is in the EyeMed network.

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. EyeMed Network/Patient Services at the number on your ID Card (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de EyeMed Network/Servicio al Paciente que figura en su tarjeta de identificación (TTY: 711).

ATENÇÃO: Se você não fala inglês, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para a EyeMed Network/Serviço ao Paciente usando o número no seu cartão de ID (TTY: 711).



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eye

55-0549 (08/17)



MASSACHUSETTS

Blue^{20/20}

Application / Change Form

New Enrollee
(Please Complete A, C, D and E)

Change Request
(For changes, complete Sections A, B and all other applicable sections. Plan changes can only be made at Open Enrollment or due to a qualifying event.)

Termination Date: _____

Please print clearly.
Please use a black or blue pen.

Blue 20/20 Group No. _____

A. Employee Information			
Name of Employer:		Effective Date:	Dept. / Division:
Social Security Number:	Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Last Name:	First Name:	MI:	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married
Mailing Address:		City:	State: _____ Zip Code: _____
Date of Hire:	Home Phone Number:	Work Phone Number:	E-Mail Address:

B. If Making a Change from Previous Enrollment		
Check All That Apply: <input type="checkbox"/> Name Change <input type="checkbox"/> Employee SSN Correction <input type="checkbox"/> Add/Remove Dependent <input type="checkbox"/> Address/Telephone Number Change <input type="checkbox"/> Date of Birth Correction <input type="checkbox"/> Late Enrollee <input type="checkbox"/> Other: _____	Add Dependent(s): <input type="checkbox"/> Marriage _____ <input type="checkbox"/> Domestic Partner _____ <input type="checkbox"/> Newborn (up to age 1) _____ <input type="checkbox"/> Adoption _____ <input type="checkbox"/> Court Order _____ <input type="checkbox"/> Loss of Coverage _____ <input type="checkbox"/> Other _____	Reinstate Coverage: Date: _____ Reason: _____ _____ _____
	<input type="checkbox"/> Remove Dependent(s) _____ Reason: _____ _____ _____	Terminate Coverage: Date: _____ Reason: _____ _____ _____

C. Coverage Selection

Options Selected: Employee Employee plus Spouse or Domestic Partner
 Employee plus Child Family

D. Family Information—Complete for anyone taking or dropping Blue 20/20 Coverage*

	Name (First, MI, Last Name)	Social Security Number	Date of Birth mm/dd/yyyy	Relationship	Sex
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> F <input type="checkbox"/> M
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> F <input type="checkbox"/> M
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> F <input type="checkbox"/> M
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> F <input type="checkbox"/> M
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> F <input type="checkbox"/> M
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> F <input type="checkbox"/> M
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> F <input type="checkbox"/> M

* Application does not guarantee enrollment.
Eligibility Notes:
 1. Employees are eligible for coverage if they meet the definition of an eligible employee as defined by their employer and Blue Cross Blue Shield of Massachusetts.
 2. Domestic Partners are eligible for coverage if they meet the definition of a Domestic Partner and if allowed by the employer.
 3. Dependent Children are eligible for coverage up to age 26.

E. Statement of Understanding

The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me and my dependents or to make changes to my membership. I understand that I should read the subscriber certificate or benefit booklet provided by my employer to understand my benefits and any restrictions that apply to my vision plan.

 Signature of Employee _____
 Date

Visit us at www.blue2020ma.com





Blue^{20/20}

Blue 20/20 is administered by EyeMed Vision Care[®], an independent company.



Save Your Eyesight by Saving Money on Sunglasses

Your eyes can be damaged by the sun's ultraviolet (UV) rays in the same way your skin gets sunburned. All it takes is one day's exposure to bright sunlight reflected off snow, sand, or water. More seriously, continuous exposure to UV rays can put you at risk of developing vision problems later in life.

The Right Sunglasses Are More Than Just a Fashion Statement

Mirrored sunglasses and tinted lenses may look stylish, but they don't offer protection from sun damage. Be sure to select sunglasses that block at least 99% of harmful UV rays.

Blue 20/20 Members Save at Sunglass Hut[™]

Don't forget your special code.

Get **\$20** off any purchase or **\$50** off a purchase of **\$200** or more.*

How to get your code:

- Log in to the Blue 20/20 member website at blue2020ma.com
- Click on Special Offers
- Click on Sunglass Hut EyeMed offer

American Optometric Association, Protecting Your Eyes from Solar Radiation, aoa.org/patients-and-public/caring-for-your-vision/uv-protection?ss=ny. Accessed 27 March 2017.

*Non-prescription sunglasses only. Redeemable at any Sunglass Hut store in the U.S. Chanel, Costa, Dior, Maui Jim, Oakley, Tiffany, Ray-Ban Jr., and Tom Ford or at sunglasshut.com. Limit one code per transaction. Not valid with any other coupons, discounts, or promotional offers. This offer is not good on gift card purchases, gift wrap, shipping & handling, taxes, returns or exchanges. No cash-back value, cannot be redeemed for cash, may not be sold or transferred, and will not be replaced if lost, stolen, or damaged. Valid in the U.S. only. Offer valid until 12/31/2018.

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call the EyeMed Network/Patient Services number on your ID card (TTY: 711).

ATENCIÓN: Si habla español, llene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de EyeMed Network/Servicio al Paciente que figura en su tarjeta de identificación (TTY: 711).

ATENÇÃO: Se você não fala inglês, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para a EyeMed Network/Serviços ao Paciente usando o número no seu cartão de ID (TTY: 711).

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178127M

(09/17)





Important Information About Your PREPAID BENEFITS CARD

If you're newly enrolled in the Flexible Spending Account Program, you will automatically receive the new blue Prepaid Benefits Card. You'll receive two cards at your home address for you and your family members to use. The Cards will arrive in a special envelope that looks like this – so please don't throw it out!



Your Prepaid Benefits Card is loaded with the value of your annual FSA\HSA election amount (less any amounts you have already spent in this plan year.) Using your Card helps you keep cash in your wallet and makes accessing your FSA funds easy. The Card can be used, instead of cash, to pay for qualified health care expenses such as:

- Prescription and health plan copayments, deductibles and coinsurance
- "Amount Due" on medical and dental statements
- Orthodontics
- Mail-order or online prescription invoices
- Vision services and eyeglasses
- LASIK surgery
- Eligible over-the-counter (OTC) items

You'll simply swipe your Card each time you incur a qualified health care expense and the amount of your purchase will be deducted from your FSA– automatically. You can also fill in your Card number on bills you receive from providers to pay the amount you owe. You'll have no claim forms to complete and you won't have to wait to get a check in the mail. You can check balances or account details anytime – online at www.cpa125.com or via the mobile app -- **CPA FLEX MOBILE**. It's that easy!

It's Important to Save Your Receipts!

Your Prepaid Benefits Card will definitely improve your cash flow. However, be aware that 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.

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.

Using Your Card is as Easy as 1-2-3!

Look for additional information about how to use your new Prepaid Benefits Cards included with your card packet in the mail. We hope you enjoy this new exciting feature of your plan! Remember, the Card will not work at gas stations or restaurants – only at health care related providers.

Save your card. Every year you re-enroll, the funds get loaded on to this card!

Cafeteria Plan Advisors, Inc.
420 Washington Street, Suite 100, Braintree, MA 02184 781.848.9848 www.cpa125.com



FSA Store

THE FLEXIBLE SPENDING ACCOUNT SITE



FSA Store Is the Only E-Commerce Site Exclusively Stocked with FSA-Eligible Products

-  Products FSA-eligible without a prescription
-  Products only FSA-eligible with a prescription

FSA Store Tools to Help Participants Better Manage their Funds



FSA Eligibility List

Eliminate Eligibility Guessing Games



FSA Deadline Tracker

Receive Deadline Reminders



FSA Learning Center

Get Answers to All Your FSA Questions!



Rx Process

Easily use Your FSA Card for OTC Items

FSA Store Features & Benefits

- Largest Selection of FSA-Eligible Products Online
- FREE Shipping on Orders \$50+

- Accepts All FSA, HSA and Major Credit Cards
- 24/7 Customer Support

To Access FSA Store Visit cpa125.com/fsaextras.htm



\$10 OFF

Code: OECPA

Expires 12/31/19 • 1 use per customer

Flexible Spending Benefits

► **SAVE \$\$ on Eligible Health & Dependent Care Expenses** ◀

Town of Webster

One of the Few Gifts the IRS Gives!

Discover the benefit that **SAVES YOU MONEY**. This perk allows you to set aside a portion of your pay—**BEFORE TAXES**—to cover out-of-pocket expenses in these categories:

- ◆ **HEALTH CARE.*** Includes co-pays (medical & prescription), deductible expenses, non-cosmetic dental work, orthodontics, prescription eyeglasses, contact lenses, laser eye surgery, alternative health therapies (e.g. acupuncture), mental health services, and **MORE!**

Max. Annual Election: **\$2,700.**

- ◆ **DEPENDENT CARE.**** For children under 13 and dependents with special needs. Eligible expenses include: day care, pre-school, before & after school care, summer day camp, elder day care.

Max. Annual Election per Family/Household: **\$5,000.**

Who's Covered? The Health Care FSA plan covers you, your spouse, and dependents as defined by the IRS, including children claimed on the employee's tax return and adult children to age 26 if covered under the employee's health plan.

HSA Ineligibility. If you or your spouse has a Health Savings Account ("HSA"), you are **NOT ELIGIBLE** for a Health Care FSA account.

* Not all Health Care expenses are FSA-eligible, such as cosmetic procedures or products, even if performed or dispensed by a doctor (i.e., Botox, teeth whitening, veneers, etc.), and general health expenses (i.e., toothbrushes, non-prescription sunglasses, etc.). Vitamins, supplements, non-prescription/over-the-counter medications, etc., require a physician's prescription to be FSA-eligible. Some expenses, such as medical equipment, may be FSA-eligible with a physician's Letter of Medical Necessity. You are advised to check on the eligibility of an item or service before incurring an expense. Visit <https://fsastore.com/FSA-Eligibility-List> and search the "Eligible Products and Services List" for more info. on FSA-eligible products and services, as well as criteria for eligibility.

** Overnight camp, school tuition, extra-curricular programs, etc., that aren't daycare/childcare-based, are not FSA-eligible.

Enroll within 30 days of your qualifying event

The **PLAN YEAR** is the date of your qualifying event through 6/30/2020

It's easy! Simply complete an "Authorization for Pre-Tax Deduction" form and send it to us within 30 days of your qualifying event

Note: Re-enrollment is not automatic.

Rollover Option

Up to \$500 in unused Health Care FSA monies can be rolled over to the next plan year if you re-enroll.

NEW! Track Your Account and File Claims 24/7!

Log in to your **employee portal** via our website (CPA125.com), or use our **handy app:**

CPA Flex Mobile.

Benefit Cards

New Health Care FSA enrollees will be sent **2 cards** that can be used at most medical and dental facilities, optical shops, and pharmacies for prescriptions. **Keep your cards!** They have a 5-year shelf life and will reload each time you enroll until they expire.



Flexible Spending Plans administered by...

CAFETERIA PLAN ADVISORS | 420 WASHINGTON ST., SUITE 100, BRAintree, MA 02184 | CPA125.COM



Cafeteria Plan Advisors, Inc.
420 Washington St. Suite 100
Braintree, MA 02184
Phone 781.848.9848
www.CPA125.com
Email: info@cpa125.com
Fax 781.848.8477

NEW HIRE/ CHANGE IN STATUS FLEXIBLE SPENDING PRE-TAX PAYROLL REDUCTION

**Form must be returned to CPA
within 30 days of change**

HR Use Only

First Payroll Deduction Date _____

New Hire or Change

Per Pay Period Amount \$ _____

Personal Information

Name: _____ **Employer:** TOWN OF WEBSTER

Mailing Address: _____ **Plan Year:** date of hire/eligibility – 6/30/2020

City, ST, Zip: _____ **SSN:** _____ **DOB:** _____

E-Mail: _____ **Phone:** _____

Payroll Information:

I am a: Town Employee School Employee
I am paid: Weekly 52 Bi-Weekly 26

The following qualified change in election for the Cafeteria Plan is the result of one of the following:

New Hire Date of Hire: _____ Qualifying Event Date: _____ Event: _____

New Benefit Elections:

FSA Health Care Account (\$2,700 maximum) Election for **Remainder of Plan Year:** \$ _____
FSA Debit Card Included for the Health Care Account. \$500 Roll Over option in effect for this plan year for available balance in the Health Care Account

FSA Dependent Care Account (\$5,000 maximum) Election for **Remainder of Plan Year:** \$ _____
Confirm eligibility requirements prior to enrolling

Direct Deposit Information (Required if not on file with Cafeteria Plan Advisors, Inc.)

I hereby authorize Cafeteria Plan Advisors, Inc. to deposit my claim reimbursements directly to my bank. I also authorize drafts to adjust any over deposits that were credited to my account in error. I will contact Cafeteria Plan Advisors, Inc. immediately with any bank information changes.

Name of Bank: _____ Checking Savings

Routing Number (9 digits): _____ **Account Number:** _____

Certification

I hereby authorize a salary reduction agreement for the amount(s) shown above. I understand that:

- Cafeteria Plan Advisors, Inc. will hold these funds until eligible expenses are incurred and a claim is submitted. Funds may be forfeited in accordance with IRS Publication 969 if eligible expenses are not submitted for reimbursement by plan year deadline or purchased utilizing the provided debit card (if applicable). If terminated, expenses may be incurred through termination date.
- Dependents must qualify under regulations set forth in IRC sections 152 and 129.
- Expenses generally must be consistent with allowable medical deductions under IRS Publication 969.
- This election cannot be revoked or changed during the plan year without a qualifying event as defined by the IRS and must be incurred during active employment.
- If you or your spouse are 'contributing' to a Health Savings Account (HSA), you are NOT ELIGIBLE for the FSA Health Care Account.
- Participants must re-enroll each plan year. Your plan has the Roll Over option. Eligible balances will roll over to the subsequent plan year for availability "after" the current plan run out period of 90 days. You must enroll in the subsequent plan year to utilize roll over funds.
- Dependent Care Plan Participants only: I, the undersigned, certify that I have read the Dependent Care Reimbursement Plan Guidelines (www.cpa125.com) and meet all requirements necessary to participate in the FSA Dependent Care plan. The undersigned agrees to notify the plan administrator in writing within 30 days should the undersigned no longer meet eligibility as mandated by the IRS. Dependents must qualify under IRC section 152.

Signature: _____ **Date:** _____

Return to your HR/ Payroll Department within 30 days of the qualifying event

USABLE Life
P.O. Box 1650
Little Rock, Arkansas 72203

Group Enrollment or Change Form

(Please print or type in Black ink.)

<input type="checkbox"/> New Employee	<input type="checkbox"/> Declination	<input type="checkbox"/> Class or Salary Change	Group # _____
<input type="checkbox"/> Beneficiary Change	<input type="checkbox"/> Change of Name	<input type="checkbox"/> Termination Date: _____	Class _____
<input type="checkbox"/> Dependent Status Change (Indicate reason _____)			Dept/Location _____
<input type="checkbox"/> Reinstatement (Complete Date of Rehire as Employment Date)			Eff Date _____

SECTION 1 - APPLICANT INFORMATION				
Employee Legal Name (First, M.I., Last)			For Name Change, Give Prior Last Name	
Home Address	City	State	Zip	Telephone No.
Social Security #	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status
Occupation	Hours worked weekly		Date Employed Full-time	
Employer's Name			Salary \$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annual	

SECTION 2 - Complete this Section if applying for Optional Coverage(s). Evidence of Insurability (EOI) may be required when applying for these coverage(s).				
	ADD <input type="checkbox"/>	Delete <input type="checkbox"/>		
LIFE	<input type="checkbox"/>	<input type="checkbox"/>		
AD&D	<input type="checkbox"/>	<input type="checkbox"/>		
STD	<input type="checkbox"/>	<input type="checkbox"/>		
LTD	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		

SECTION 3 - BENEFICIARY DESIGNATION /CHANGE ■ Check if Change Only					
This will revoke any existing beneficiary designations you may have for these benefits.					
PRIMARY BENEFICIARY(IES) (Will receive proceeds if living at death of Employee):					
Name (Last, First, MI)	Address	SSN	Birthdate	Relationship	Percentage
Total must equal 100%					= 0
CONTINGENT BENEFICIARY(IES) (Will receive proceeds if Primary Beneficiary(ies) are not living):					
Name (Last, First, MI)	Address	SSN	Birthdate	Relationship	Percentage
Total must equal 100%					= 0

I represent that the information provided above is true and correct. I understand that if I am not actively at work on the effective date of my coverage, my insurance will not begin until the day I return to work. For those coverages I have declined, I understand that if I choose to enroll at a later date, Evidence of Insurability may be required. If the Plan provides that any contributions be made by me, I authorize my employer to deduct them from my pay.

Warning - It is or may be a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company or other person. Penalties may include imprisonment, fines, and a denial of insurance benefits in accordance with applicable state law.

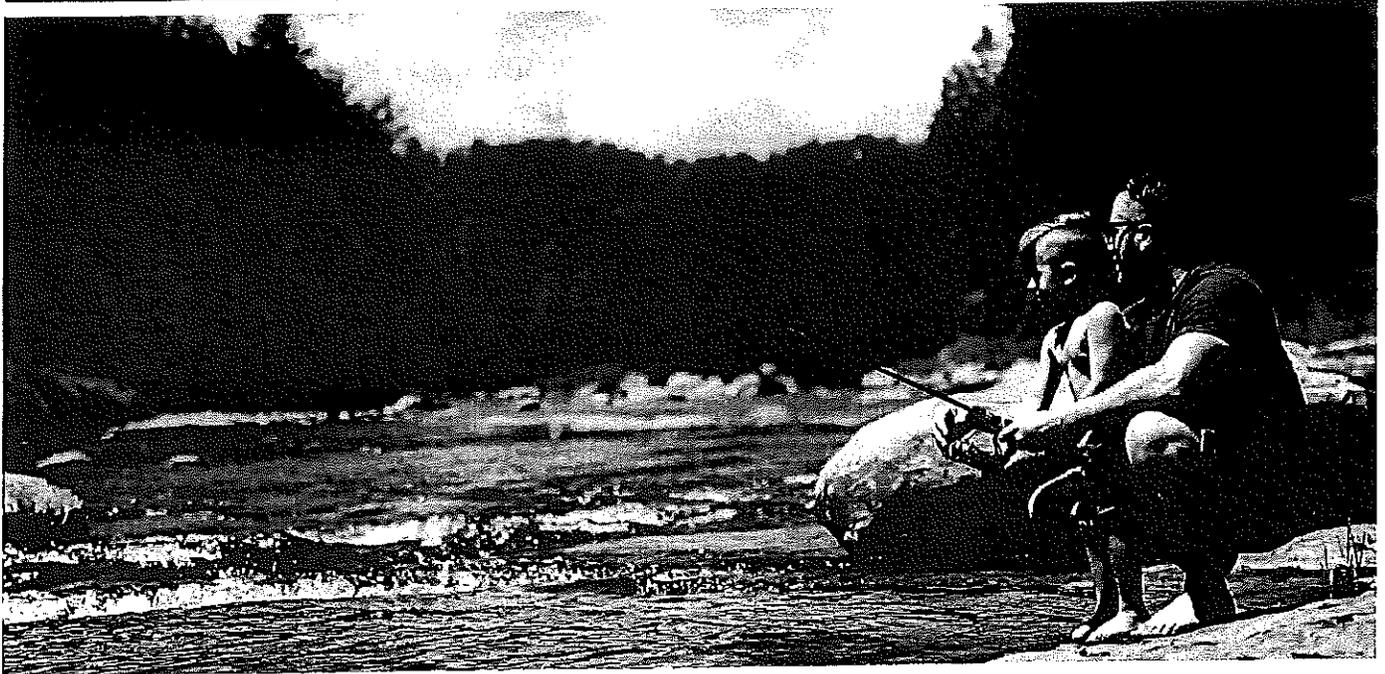
_____ Date _____ Signature of Employee _____

Date Received - Home Office

US^{ABLE} Life

AXA TRAVEL ASSISTANCE PROGRAM

Support before, during, and after travel



Live life. You're covered.®

Congratulations! You and your dependents now have access to the Travel Assistance Program provided by AXA Assistance USA, Inc. This program offers you a broad range of valuable travel and medical support services **24 hours a day, 365 days a year**. With one simple phone call to our response center, you will be connected to a global network of providers to assist you when you travel 100 miles or more from home.

Travel assistance services

- **Travel assistance**
 - Lost document and luggage assistance
 - Emergency cash/bail assistance
 - Emergency message transmission
 - Telephone interpretation
 - Legal referrals
 - Pre-trip and cultural information
 - Vaccination recommendations
 - General travel information
 - Vehicle return¹

Medical assistance services

- **Medical transportation assistance¹**
 - Emergency medical evacuation
 - Medical repatriation
 - Return of mortal remains
 - Return of traveling companion
 - Visit of a family member or friend
 - Return of minor children
 - Dispatch of physician
- **Medical assistance**
 - Medical and dental referrals
 - Coordination of hospital admission
 - Critical care monitoring
 - Dispatch of prescription medication



Do you need assistance?

If you have any questions about the services or require assistance, please contact us at:
1 (866) 384.2786 OR +1 (630) 616.4536 (collect) OR medassist-usa@axa-assistance.us

Just a phone call away

Travel information and medical assistance services can be accessed worldwide **24 hours a day, 7 days a week, 365 days a year.**

Travel web portal

Our web portal, WebCorp, offers travel information at your fingertips. Information available includes practical travel information, medical and security alerts, and our global medical provider search tool to help you before, during, and after your trip. Use the credentials below to log in today. Visit <https://webcorpsf.secure.force.com>:

- **Username:** travel@usablelife.com
- **Password:** LIFE#



US^{ABLE} Life

TRAVEL ASSISTANCE PROGRAM

Carry this card with you when you travel.

DID: 630.616.4536 | TFN: 866.384.2786

CALL AXA ASSISTANCE IF YOU REQUIRE:

- Medical and dental referrals
- Medical evacuation or repatriation
- Hospital admission and critical care monitoring
- Return of mortal remains
- Dispatch of prescription medication
- Lost document and luggage assistance
- Emergency cash and bail assistance
- General travel information

This is not a medical insurance card. All services must be authorized and provided by AXA Assistance USA, Inc. No reimbursements will be accepted.

Program guidelines

Services will not be provided or available for any loss or injury that is caused by, or a result of:

- A mental nervous condition or diagnosis
- Traveling against the advice of a physician
- Traveling for medical treatment
- Pregnancy and childbirth (exception: complications of pregnancy) or voluntary-induced abortion

¹Program Terms: When traveling 100 miles or more away from home for up to 120 days, medical emergency transportation services include the arrangement and payment for any reasonable and customary charges determined by AXA Assistance USA, Inc. Vehicle return service is applicable upon activation of medical emergency transportation.

No reimbursements for out-of-pocket expenses will be accepted.

All additional costs are the responsibility of the member. Services will be provided as permitted under applicable law. Services must be authorized and arranged by AXA Assistance. Travel assistance services are not insurance.



US^{ABLE} Life



competitive rates,
easy enrollment,
in a single call

CancerCare Elite

CancerCare Elite

CancerCare Elite provides extra protection when you need it most. Designed to supplement a current medical plan, CancerCare Elite offers peace of mind throughout the preventive, treatment, and recovery processes.

Why You Should Consider Cancer Care Insurance

Being diagnosed with cancer or illness can be scary, and also quite costly. Your Blue Cross Blue Shield of Massachusetts health plan will cover many of your medical bills, but other cancer-related costs—such as daily living expenses, copayments, and deductibles—can add up fast. Now you can lessen the financial burden with CancerCare Elite.

Get the Protection You Need with the Flexibility You Want

CancerCare Elite offers you the flexibility to select the coverage that best meets you and your family's needs.

Employees can rest assured that they will be covered for the diagnostic and treatment options that best suit their individual needs, such as:

- Surgical second opinion
- Medical supplies and equipment, such as braces, crutches, and wheelchairs
- Prostheses
- Stem cell transplant
- Bone marrow transplant
- New or experimental treatment services that are endorsed by the American Cancer Society
- National Cancer Institute (NCI) consultation
- Inpatient treatment for specified diseases, such as cystic fibrosis, Lou Gehrig's disease, tuberculosis, and more

When you choose a CancerCare Elite plan:

- Benefits are paid directly to you
- Benefits will be paid in addition to the benefits paid by your current health plan
- Money can be used toward your choice of expenses, including deductibles, co-insurance, copayments, and daily living costs
- Coverage is guaranteed renewable for your lifetime and is not dependent on your employment
- An At-Home Recovery Benefit pays a monthly amount to assist you with home maintenance expenses, such as yard work and house cleaning

You can choose from three plan options. Please see the enclosed USABLE brochure for additional information about these plans.



Multiple Plan Options for Financial Flexibility

CancerCare Elite offers three flexible plan options designed to meet an employee's financial needs. To review each plan's individual payment options and specific benefits, please refer to the chart below.

Plan I	Plan II	Plan III
Inpatient Hospital Confinement		
\$100 per day for first 60 days, \$200 for each subsequent day ¹	\$250 per day for first 60 days, \$500 each subsequent day ¹	\$300 per day for first 60 days, \$600 for each subsequent day ¹
Beginning on the first day of confinement, benefits double for covered children.		
Inpatient or Outpatient Radiation, Chemotherapy, and Blood Plasma Transfusion		
\$5,000 maximum per calendar year	\$10,000 maximum per calendar year	\$15,000 maximum per calendar year
Radiation, Radioactive Isotopes Therapy, and Physician Administered Chemotherapy Pays charges up to 100% of the calendar-year maximum selected.		
Self-Administered Chemotherapy, Anti-Nausea/Comfort or Relief, and Malignant Growth Prevention Substances Pays charges up to 10% of the calendar-year maximum selected.		
Blood and Blood Plasma Pays charges up to the calendar-year maximum selected.		
Inpatient or Outpatient Surgery and Anesthesia		
\$1,000 maximum per operation	\$2,000 maximum per operation	\$4,000 maximum per operation
Pays for surgery, including skin cancer, as detailed in the surgical schedule up to selected amount. Anesthesia pays 30% of the amount payable under the surgical benefit.		

1. Successive periods of confinement are the same period of confinement unless separated by more than 30 days.



What You Can Expect to Pay for Coverage

CancerCare Elite

The cost per month for the core plan options are:

	Individual	Individual + Child(ren)	Family
Plan I	\$12.70	\$15.60	\$23.46
Plan II	\$18.14	\$22.12	\$33.54
Plan III	\$21.72	\$26.62	\$42.74

Elective Benefit Riders

You can also gain added protection from the following benefit riders:

- **Cancer Disability Benefit Rider**—Pays an additional benefit if you are unable to work due to cancer treatments for up to one year.
- **Cancer Diagnosis Benefit Rider**—Pays a one-time payout for an election period of your choice, starting at the initial cancer diagnosis.

The costs of these additional benefit riders are per month, and are in addition to the CancerCare Elite plan option.

Cancer Disability Benefit Rider

Pays the selected monthly disability income benefit for one year due to internal cancer.

	Individual	Individual + Child(ren)	Family
\$250 Benefit	\$1.20	\$1.20	\$2.16
\$500 Benefit	\$2.40	\$2.40	\$4.32

Cancer Diagnosis Benefit Rider

Pays the amount selected below for the first diagnosis of internal cancer. Insured family members qualify for 100 percent of the primary insured benefit amount.

	Individual	Individual + Child(ren)	Family
\$1,000 Benefit	\$0.84	\$1.02	\$1.56
\$2,000 Benefit	\$1.68	\$2.04	\$3.12
\$3,000 Benefit	\$2.52	\$3.06	\$4.68
\$4,000 Benefit	\$3.36	\$4.08	\$6.24
\$5,000 Benefit	\$4.20	\$5.10	\$7.80

Please note that these rates are for Massachusetts residents only. Rates may vary slightly if you reside outside of Massachusetts. CancerCare Elite is an individual product, and therefore is filed with the Division of Insurance in each state. CancerCare Elite may not be available for purchase in every state.

To learn more about CancerCare Elite, please see the enclosed USABLE brochure that outlines the plan designs, any additional benefits, and all limitations. These pages summarize the benefits of your cancer care plan.

Your subscriber certificate and riders define the full terms and conditions in greater detail. For a complete list of limitations and exclusions, please refer to your subscriber certificate and riders.



Specified Disease Coverage

CancerCare Elite extends beyond cancer by including a Specified Disease Benefit that covers illnesses such as cystic fibrosis, multiple sclerosis, and more. Please see the enclosed USAble brochure for a complete list of conditions.

Wellness Benefit

When treating cancer, early detection is best. That's why CancerCare Elite offers the Wellness Benefit, which covers screenings to check for cancer before symptoms start.

This benefit pays a maximum of \$75 per calendar year, per insured, for the following cancer screening tests:

- Mammography
- Thermography
- Colonoscopy
- Hemoccult stool analysis
- PSA (blood test for prostate cancer)
- CA-125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Pap smear
- Flexible sigmoidoscopy
- Chest X-ray
- Any diagnostic procedure that can lead to the positive diagnosis of cancer



LANDMARK CENTER
401 PARK DRIVE
BOSTON MA 02215-3326
617.246.6500
WWW.INDIGO-INSURANCE.COM

Please note that all applications are individually underwritten by USABLE Life and if an employee and/or spouse and/or children have been diagnosed with cancer or other specified diseases prior to the effective date of coverage, he/she/they may be denied coverage. In addition, the policy includes a one-month waiting period. During this waiting period, if an employee is approved for coverage and is diagnosed with cancer or a specified disease as outlined in the enclosed brochure all paid premiums will be refunded and the policy will be terminated.

This benefit summary provides a very brief description of USABLE Life's insurance products. This is not an insurance contract and only the actual policy provisions of an issued policy control. USABLE Life's policies set forth the rights and obligations of covered persons and USABLE Life along with any limitations and exclusions that may apply. If you are approved for coverage, you will be provided with a policy. Please read your policy carefully.

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#104770M

55-0077 (2/11) 5C

products
underwritten by

USABLE Life



P.O. Box 1650
Little Rock, Arkansas 72203

Please Print Using Dark Ink

CANCER APPLICATION & CHANGE FORM

Office Use Only	
Policy Number	
Effective Date	
Group Number	
Dept./Loc	

New Business Change Form Replace USABLE Policy No. _____ Policy Lost Policy Attached

SECTION 1 - APPLICANT INFORMATION

Name (First, MI, Last)			For Name Change, Give Prior Last Name			Social Security #			
Home Address				City		State		Zip	County
Name of Employer				Date Employed Full-Time			Occupation		
Date of Birth		Birth State or Country		Sex	Work Phone			Home Phone	

SECTION 2 - SPOUSE & CHILDREN INFORMATION

Person Proposed for Insurance Show first, middle, last name	Relationship	Date of birth			Birth State or Country	Marital Status	Age	Sex
		mo.	day	yr.				
a.								
b.								
c.								
d.								
e.								

SECTION 3 - PLAN SELECTION

New Applicant Application for Change

I hereby apply for the following coverage: Applicant Applicant & Children Applicant, Spouse & Children

CEP Policy

<input type="checkbox"/> Plan I - (\$100 Hosp. Confinement, \$5,000 Radiation/Chemo/Blood, \$1,000 Surgical/Anesthesia, and Specified Disease Benefit)	<input type="checkbox"/> Add <input type="checkbox"/> Delete \$_____ Cancer Diagnosis Rider
<input type="checkbox"/> Plan II - (\$250 Hosp. Confinement, \$10,000 Radiation/Chemo/Blood, \$2,000 Surgical/Anesthesia, and Specified Disease Benefit)	<input type="checkbox"/> Add <input type="checkbox"/> Delete \$_____ Monthly Disability Rider:
<input type="checkbox"/> Plan III - (\$300 Hosp. Confinement, \$15,000 Radiation/Chemo/Blood, \$4,000 Surgical/Anesthesia, and Specified Disease Benefit)	Spouse Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No

Total Monthly Premium: \$ _____

- Is every person to be insured covered by a Health Plan? Yes No **If "No", this policy will not be issued.**
- REPLACEMENT:** Is this insurance to replace or change other insurance? Yes No **If "Yes", give details including name of company.** _____
- Is any person to be insured currently covered under any other specified disease policy that is not going to be replaced? Yes No Does anyone have specified disease applications pending with this or any other company? Yes No **If "yes" to either question, provide the following: Number of policies in force? _____ Number of applications pending? _____**
- OUTLINE:** Have you received the Outline of Coverage and Disclosure Statement? Yes No (check one)

In signing below, I (a) represent that the statements and answers given on all pages of this application are true, complete, and correctly recorded; (b) state that I have read and understand the "Important Note" on page 2 of this application; (c) authorize USABLE Life or its reinsurer to make a brief report of my personal health information to MIB; (d) authorize any physician, medical practitioner, hospital, clinic, or other medically related facility, insurance or reinsurance company, or Medical Information Bureau, Inc. having information on me or any member of my family (only those who have applied for coverage on this application) regarding our mental and physical health, other insurance coverage, hazardous activities, character, general reputation, finances, and vocation to give to USABLE Life, its reinsurers, or its legal representative any and all such information to use for underwriting insurance; (e) authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the company to collect and transmit such information in order to facilitate its rapid submission; (f) agree that this authorization shall be valid for two (2) years from the application date; (g) agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me or my representative upon request; (h) acknowledge receipt of written notification describing the use of the Medical Information Bureau as required by the Fair Credit Reporting Act; and (i) acknowledge receipt of the Information Practices Notice and the Insurance Fraud Warning. I have read and understand the above statements and agreements. In applying for insurance, I authorize my employer to make the necessary payroll deductions to pay for my insurance. I state no person to be insured is covered by any Title XIX program - Medicaid or any similar name. **Caution: If your answers are incorrect or untrue, USABLE Life has the right to deny benefits or rescind your policy.**

Be sure to complete the Medical Information on page 2 reverse side.

Signed at: _____ <small>(City and State)</small>	Date of Application _____ <small>(Month, Day, Year)</small>	Date Received Home Office _____
X _____ <small>Agent's Signature</small>	X _____ <small>Applicant's Signature</small>	

Name (First, MI, Last)	Social Security #	Employer
SECTION 4 – MEDICAL INFORMATION		
1. Has any person to be insured ever been diagnosed or treated by a member of the medical profession for: cancer or any malignancy, which includes carcinoma; sarcoma; Hodgkins Disease; leukemia; lymphoma; or malignant tumor? If "Yes," list person(s), and condition(s): Person(s) _____ Condition(s) _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Has any person to be insured ever been diagnosed or treated by a member of the medical profession for: Addison's Disease, Brucellosis, Budd-Chiari Syndrome, Cystic Fibrosis, Diphtheria, Encephalitis, Histoplasmosis, Legionnaires' Disease, Lou Gehrig's Disease, Malaria, Multiple Sclerosis, Muscular Dystrophy, Myasthenia Gravis, Osteomyelitis, Poliomyelitis, Q-Fever, Rabies, Reye's Syndrome, Rheumatic Fever, Rocky Mountain Spotted Fever, Scarlet Fever, Sickle Cell Anemia, Spinal Meningitis, Systemic Lupus Erythematosus, Tay-Sachs Disease, Tetanus, Toxic Shock Syndrome, Trichinosis, Tuberculosis, Tularemia, Typhoid Fever, Whooping Cough? If "Yes," list person(s), and condition(s): Person(s) _____ Condition(s) _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. Has any person to be insured ever been diagnosed or treated by a member of the medical profession for: Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); or the Human Immunodeficiency Virus (HIV)? If "Yes," list person(s), and condition(s): Person(s) _____ Condition(s) _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<p>The person(s) named above in questions 1, 2, or 3 may be excluded in part or in total from coverage by an Elimination Rider to be signed by the applicant prior to policy issuance.</p>		
4. Name, address, and phone number of your personal physician(s): _____ _____		

IMPORTANT NOTE: The entire contract will consist of this application and the insurance issued in response to it. **THE INSURANCE WILL NOT BE EFFECTIVE ON THE PROPOSED INSURED UNLESS:** (1) The policy is delivered to the Owner; (2) The first modal premium is paid; (3) There has been no change since the date of this application and the effective date of the policy in the health of the Proposed Insured as stated in this application; and (4) To satisfy premium deduction requirements of my employer and dating requirements of our Section 125 Plan, if applicable, I understand that my policy will be dated and become effective on the first day of the month following the Section 125 Plan effective date (anniversary date for resolicitation) or on the first day of the month following underwriting approval, whichever is later. There is no coverage until the effective date of the policy.

INSURANCE FRAUD WARNING. Any person who knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison.

Town Of Webster

Voluntary Term Life- Spousal Monthly Cost

With election of employee benefits, spouse's may select any amount desired in units of \$5,000 to a maximum of \$50,000.

Benefit	Age Brackets											AD&D All/Ages
	Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+	
\$ 5,000	\$0.35	\$0.35	\$0.45	\$0.65	\$1.05	\$1.95	\$3.10	\$4.75	\$7.45	\$13.85	\$24.05	\$0.75
\$ 10,000	\$0.70	\$0.70	\$0.90	\$1.30	\$2.10	\$3.90	\$6.20	\$9.50	\$14.90	\$27.70	\$48.10	\$0.80
\$ 15,000	\$1.05	\$1.05	\$1.35	\$1.95	\$3.15	\$5.85	\$9.30	\$14.25	\$22.35	\$41.55	\$72.15	\$0.45
\$ 20,000	\$1.40	\$1.40	\$1.80	\$2.60	\$4.20	\$7.80	\$12.40	\$19.00	\$29.80	\$55.40	\$96.20	\$0.60
\$ 25,000	\$1.75	\$1.75	\$2.25	\$3.25	\$5.25	\$9.75	\$15.50	\$23.75	\$37.25	\$69.25	\$120.25	\$0.75
\$ 30,000	\$2.10	\$2.10	\$2.70	\$3.90	\$6.30	\$11.70	\$18.60	\$28.50	\$44.70	\$83.10	\$144.30	\$0.90
\$ 35,000	\$2.45	\$2.45	\$3.15	\$4.55	\$7.35	\$13.65	\$21.70	\$33.25	\$52.15	\$96.95	\$168.35	\$1.05
\$ 40,000	\$2.80	\$2.80	\$3.60	\$5.20	\$8.40	\$15.60	\$24.80	\$38.00	\$59.60	\$110.80	\$192.40	\$1.20
\$ 45,000	\$3.15	\$3.15	\$4.05	\$5.85	\$9.45	\$17.55	\$27.90	\$42.75	\$67.05	\$124.65	\$216.45	\$1.35
\$ 50,000	\$3.50	\$3.50	\$4.50	\$6.50	\$10.50	\$19.50	\$31.00	\$47.50	\$74.50	\$138.50	\$240.50	\$1.50



Town Of Webster

Voluntary Term Life- Employee's Monthly Cost

Each employee may select any amount desired in units of \$10,000 to a maximum of \$350,000. Children up to age 26 may be covered in increments of either \$ 5,000 or \$10,000 guaranteed issue

Benefit	Age Brackets											AD&D All Ages
	Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+	
\$ 10,000	\$0.70	\$0.70	\$0.90	\$1.30	\$2.10	\$3.90	\$6.20	\$9.50	\$14.90	\$27.70	\$48.10	\$0.30
\$ 20,000	\$1.40	\$1.40	\$1.80	\$2.60	\$4.20	\$7.80	\$12.40	\$19.00	\$29.80	\$55.40	\$96.20	\$0.60
\$ 30,000	\$2.10	\$2.10	\$2.70	\$3.90	\$6.30	\$11.70	\$18.60	\$28.50	\$44.70	\$83.10	\$144.30	\$0.90
\$ 40,000	\$2.80	\$2.80	\$3.60	\$5.20	\$8.40	\$15.60	\$24.80	\$38.00	\$59.60	\$110.80	\$192.40	\$1.20
\$ 50,000	\$3.50	\$3.50	\$4.50	\$6.50	\$10.50	\$19.50	\$31.00	\$47.50	\$74.50	\$138.50	\$240.50	\$1.50
\$ 60,000	\$4.20	\$4.20	\$5.40	\$7.80	\$12.60	\$23.40	\$37.20	\$57.00	\$89.40	\$166.20	\$288.60	\$1.80
\$ 70,000	\$4.90	\$4.90	\$6.30	\$9.10	\$14.70	\$27.30	\$43.40	\$66.50	\$104.30	\$193.90	\$336.70	\$2.10
\$ 80,000	\$5.60	\$5.60	\$7.20	\$10.40	\$16.80	\$31.20	\$49.60	\$76.00	\$119.20	\$221.60	\$384.80	\$2.40
\$ 90,000	\$6.30	\$6.30	\$8.10	\$11.70	\$18.90	\$35.10	\$55.80	\$85.50	\$134.10	\$249.30	\$432.90	\$2.70
\$ 100,000	\$7.00	\$7.00	\$9.00	\$13.00	\$21.00	\$39.00	\$62.00	\$95.00	\$149.00	\$277.00	\$481.00	\$3.00
\$ 110,000	\$7.70	\$7.70	\$9.90	\$14.30	\$23.10	\$42.90	\$68.20	\$104.50	\$163.90	\$304.70	\$529.10	\$3.30
\$ 120,000	\$8.40	\$8.40	\$10.80	\$15.60	\$25.20	\$46.80	\$74.40	\$114.00	\$178.80	\$332.40	\$577.20	\$3.60
\$ 130,000	\$9.10	\$9.10	\$11.70	\$16.90	\$27.30	\$50.70	\$80.60	\$123.50	\$193.70	\$360.10	\$625.30	\$3.90
\$ 140,000	\$9.80	\$9.80	\$12.60	\$18.20	\$29.40	\$54.60	\$86.80	\$133.00	\$208.60	\$387.80	\$673.40	\$4.20
\$ 150,000	\$10.50	\$10.50	\$13.50	\$19.50	\$31.50	\$58.50	\$93.00	\$142.50	\$223.50	\$415.50	\$721.50	\$4.50
\$ 160,000	\$11.20	\$11.20	\$14.40	\$20.80	\$33.60	\$62.40	\$99.20	\$152.00	\$238.40	\$443.20	\$769.60	\$4.80
\$ 170,000	\$11.90	\$11.90	\$15.30	\$22.10	\$35.70	\$66.30	\$105.40	\$161.50	\$253.30	\$470.90	\$817.70	\$5.10
\$ 180,000	\$12.60	\$12.60	\$16.20	\$23.40	\$37.80	\$70.20	\$111.60	\$171.50	\$268.20	\$498.60	\$865.80	\$5.40
\$ 190,000	\$13.30	\$13.30	\$17.10	\$24.70	\$39.90	\$74.10	\$117.80	\$180.50	\$283.10	\$526.30	\$913.90	\$5.70
\$ 200,000	\$14.00	\$14.00	\$18.00	\$26.00	\$42.00	\$78.00	\$124.00	\$190.00	\$298.00	\$554.00	\$962.00	\$6.00
\$ 210,000	\$14.70	\$14.70	\$18.90	\$27.30	\$44.10	\$81.90	\$130.20	\$199.50	\$312.90	\$581.70	\$1,010.10	\$6.30
\$ 220,000	\$15.40	\$15.40	\$19.80	\$28.60	\$46.20	\$85.80	\$136.40	\$209.00	\$327.80	\$609.40	\$1,056.20	\$6.60
\$ 230,000	\$16.10	\$16.10	\$20.70	\$29.90	\$48.30	\$89.70	\$142.60	\$218.50	\$342.70	\$637.10	\$1,106.30	\$6.90
\$ 240,000	\$16.80	\$16.80	\$21.60	\$31.20	\$50.40	\$93.60	\$148.80	\$228.00	\$357.60	\$664.80	\$1,154.40	\$7.20
\$ 250,000	\$17.50	\$17.50	\$22.50	\$32.50	\$52.50	\$97.50	\$155.00	\$237.50	\$372.50	\$692.50	\$1,202.50	\$7.50
\$ 260,000	\$18.20	\$18.20	\$23.40	\$33.80	\$54.60	\$101.40	\$161.20	\$247.00	\$387.40	\$720.20	\$1,250.60	\$7.80
\$ 270,000	\$18.90	\$18.90	\$24.30	\$35.10	\$56.70	\$105.30	\$167.40	\$256.50	\$402.30	\$747.90	\$1,298.70	\$8.10
\$ 280,000	\$19.60	\$19.60	\$25.20	\$36.40	\$58.80	\$109.20	\$173.60	\$266.00	\$417.20	\$775.60	\$1,346.80	\$8.40
\$ 290,000	\$20.30	\$20.30	\$26.10	\$37.70	\$60.90	\$113.10	\$179.80	\$275.50	\$432.10	\$803.30	\$1,394.90	\$8.70
\$ 300,000	\$21.00	\$21.00	\$27.00	\$39.00	\$63.00	\$117.00	\$186.00	\$285.00	\$447.00	\$831.00	\$1,443.00	\$9.00

*Benefits reduce by 35% at age 65, by 50% of original amount at age 70 and terminate at retirement

Children's Benefit	Monthly
\$5,000.00	\$1.50
\$10,000.00	\$3.00



INSTRUCTIONS – How to Complete Section II

Initial Enrollment – Adding Coverage:

Check "Yes" by each coverage you want. Check "No" by each coverage you do not want.

If you checked "Yes" by a coverage, check the "Add New" box, and complete the "Total Amount of Coverage" for which you are applying.

For Example, you are applying for:

- Voluntary Group Life: \$50,000 on yourself, \$20,000 on your spouse, and no coverage on your children
- Voluntary AD&D: \$100,000 on yourself; \$50,000 on your spouse, \$5,000 on your children

SECTION II. VOLUNTARY COVERAGE(S)								
Complete this Section if applying for these coverages. Evidence of Insurability may be required.								
			Add New	Delete	Increase Existing	Decrease Existing	Total Amount of Coverage	Premium (Completed by Employer)
A. Voluntary Group Life:	Employee	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$50,000	
	Spouse	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$20,000	
	Children	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
B. Voluntary AD&D: (EOI not required)	Employee	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$100,000	
	Spouse	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$50,000	
	Children	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$5,000	

How To Change or Delete Coverage:

If you are changing any of your coverage, please complete the information for all of the coverage you have, so that we are sure we have everything correct. Be sure to check the appropriate "Add," "Delete," "Increase," or "Decrease" box.

For Example, you **currently** have:

- Voluntary Group Life: \$60,000 on yourself, \$30,000 on your spouse, and \$10,000 coverage on your children
- Voluntary AD&D: \$100,000 on yourself only

You want to **change** your coverage to:

- Voluntary Group Life: \$100,000 on yourself (increase), \$20,000 on spouse (decrease), and no coverage for children (delete)
- Voluntary AD&D: \$100,000 on yourself (no change), \$50,000 on spouse (add)

SECTION II. VOLUNTARY COVERAGE(S)								
Complete this Section if applying for these coverages. Evidence of Insurability may be required.								
			Add New	Delete	Increase Existing	Decrease Existing	Total Amount of Coverage	Premium (Completed by Employer)
A. Voluntary Group Life:	Employee	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	\$100,000	
	Spouse	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	\$20,000	
	Children	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
B. Voluntary AD&D: (EOI not required)	Employee	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$100,000	
	Spouse	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$50,000	
	Children	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		



Employee Insurance Application
 Home Office: P.O. Box 1650
 Little Rock, Arkansas 72203

For Home Office use only
Date Received: _____

Accident Recovery, Hospital Care, Critical Care, Cancer Care

Group #: _____		REASON FOR REQUEST:		Class: _____					
<input type="checkbox"/> New Hire/Enrollee		<input type="checkbox"/> Decline Coverage		<input type="checkbox"/> Other: _____					
<input type="checkbox"/> Initial Enrollment Event		<input type="checkbox"/> Change Request		<input type="checkbox"/> Qualifying Event; Date: _____ Event: _____					
SECTION I. EMPLOYEE INFORMATION (please print)									
Employer Name		Employer Address		Dept/Location					
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms (Check one)		Employee's Legal Name (First, MI, Last)		<input type="checkbox"/> M Social Security No. _____					
<input type="checkbox"/> Other: _____				<input type="checkbox"/> F					
Height: _____	Weight: _____	Have you used any tobacco products within the past 36 months? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Mailing Address			City	State	Zip				
Day Phone: _____	Evening Phone: _____	Work Phone: _____	Email Address: _____						
Birth Date: _____	Date of Hire: _____	Age: _____	Birth State: _____						
Occupation/Job Title		Regular Weekly Hours	Salary <input type="checkbox"/> Monthly <input type="checkbox"/> Annual <input type="checkbox"/> N/A	Employee ID					
			\$						
SECTION II. SPOUSE & CHILDREN INFORMATION									
Full Name		Domestic Partner	Occupation	Gender	Birth Date	Height	Weight	Social Security #	
First	Middle	Last			(Mo/day/Yr)	ft/in	Lbs		
Spouse		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> M <input type="checkbox"/> F					
Child				<input type="checkbox"/> M <input type="checkbox"/> F					
Child				<input type="checkbox"/> M <input type="checkbox"/> F					
Child				<input type="checkbox"/> M <input type="checkbox"/> F					
Has your spouse used any tobacco products within the past 36 months? <input type="checkbox"/> Yes <input type="checkbox"/> No						Spouse includes your legal married spouse, common law spouse, civil union partner, or domestic partner, if legally recognized in the governing jurisdiction or as otherwise agreed upon between the policyholder and the insurer.			
SECTION III. CITIZENSHIP INFORMATION:									
No.	Question				Employee		Spouse		
1.	Are you a US or Canadian citizen?				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
2.	If no to question 1, have you been issued a permanent residency VISA?				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
3.	If yes to question 2, have you lived continuously in the US or Canada for the last 6 months?				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
SECTION IV. BENEFICIARY <input type="checkbox"/> Name Beneficiary <input type="checkbox"/> Change of Beneficiary									
I hereby revoke the appointment of any existing beneficiary and designate the following beneficiary under this policy.									
Name		Date of Birth	Relationship	Primary or Secondary		Indicate % Distribution			
				<input type="checkbox"/> Primary or <input type="checkbox"/> Secondary		Primary	Secondary		
				<input type="checkbox"/> Primary or <input type="checkbox"/> Secondary					
Total must equal 100%						100%	100%		
SECTION V. ELIGIBILITY QUESTIONS (required for all applicants)									
No.	Question							Answer	
1.	Are you actively at work on a full time/part time basis and able to perform the regular duties of your occupation?							<input type="checkbox"/> Yes <input type="checkbox"/> No	
2.	If applying for spouse and/or child(ren) coverage, is any proposed insured currently disabled?							<input type="checkbox"/> Yes <input type="checkbox"/> No	
	If "yes", List name(s) _____ who will be excluded from coverage.								
3.	Is anyone proposed for coverage covered under Title XIX program (e.g. Medicaid)?							<input type="checkbox"/> Yes <input type="checkbox"/> No	
	If "yes", List name(s) _____ who will be excluded from coverage.								

SECTION V. ELIGIBILITY QUESTIONS (required for all applicants) - CONTINUED

No.	Question	Answer
Accident Coverage Only:		
4.	Within the past 3 years, has any applicant had their driver's license suspended or revoked? If "yes", List name(s) _____ who will be excluded from coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION VI. PLAN SELECTION

Type of Election: <input type="checkbox"/> Add New <input type="checkbox"/> Delete <input type="checkbox"/> Increase <input type="checkbox"/> Decrease Change to: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)			
Accident Recovery <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Plan Selection</u> <input type="checkbox"/> Basic <input type="checkbox"/> Select <input type="checkbox"/> Ultra	<u>Individual Coverage</u> <input type="checkbox"/> Employee only	<u>Family Coverage</u> <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Children <input type="checkbox"/> Employee & Family

Additional Riders: (Only available if included in the plan selected by the policyholder)

Optional Riders for Employee & Family	Amount Per Unit	Available Units
<input type="checkbox"/> Accidental Death & Dismemberment	\$20,000	5
<input checked="" type="checkbox"/> Accident Hospital/ICU Daily Benefit	\$25/\$50	10

Type of Election: Add New Delete Increase Decrease Change to: Employee Spouse Child(ren)

Cancer Care with Critical Care <input type="checkbox"/> Yes <input type="checkbox"/> No	Critical Care <input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer Care <input type="checkbox"/> Yes <input type="checkbox"/> No
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<u>Individual Coverage</u> <input type="checkbox"/> Employee only	<u>Family Coverage</u> <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Children <input type="checkbox"/> Employee & Family	<u>Elected Benefit Amount:</u> <input type="checkbox"/> Employee (\$5,000 to \$100,000 in \$5,000 increments) \$ _____ <input type="checkbox"/> Spouse* (\$5,000 to \$100,000 in \$5,000 increments) \$ _____ <input type="checkbox"/> Child(ren)* <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000
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Additional Rider: (Only available if included in the plan selected by the policyholder)

<input type="checkbox"/> Accumulation Benefit	<input type="checkbox"/> Yes <input type="checkbox"/> No
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*Dependent amounts cannot exceed the employee amount.

Type of Election: Add New Delete Increase Decrease Change to: Employee Spouse Child(ren)

Hospital Care <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Plan Selection</u> <input type="checkbox"/> Basic <input type="checkbox"/> Select <input type="checkbox"/> Ultra	<u>Individual Coverage</u> <input type="checkbox"/> Employee only	<u>Family Coverage</u> <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Children <input type="checkbox"/> Employee & Family
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SECTION VII. REPLACEMENT

Do you currently have insurance like or similar to the coverage applied for? Yes No If "yes" list the type of insurance, carrier, termination date and submit a copy of the prior billing: _____

Will the insurance applied for replace any existing insurance? Yes No If "yes" list the type of insurance, carrier, termination date and submit a copy of the prior billing: _____

SECTION VIII. UNDERWRITING AND MEDICAL QUESTIONS

Any person answering YES to the following questions is not eligible for coverage. If multiple children are to be covered, please list the first name of any child answering YES on the line provided in that area.

Conditional Guaranteed Questions

Applies to	Applicable Questions	Applicant	Spouse	Child(ren)
Critical Care; Hospital Care; Cancer Care	Have you or anyone proposed for coverage been treated for or diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Critical Care; Hospital Care; Cancer Care	Are you or anyone proposed for coverage currently disabled, or in the past 12 months have you been confined to a hospital, nursing home or rehab center, or has confinement been recommended?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Simplified Issue Questions

In addition to the questions above, the following questions must be completed. Any person answering YES to the following questions is not eligible for coverage. If multiple children are to be covered, please list the first name of any child answering YES on the line provided in that area.

Critical Care; Hospital Care; Cancer Care	Have you or anyone proposed for coverage, in the past 10 years, been diagnosed or treated by a member of the medical profession for:			
	Applicable Questions	Applicant	Spouse	Child(ren)
	1. Cancer or any malignancy which includes: carcinoma, sarcoma, melanoma, Hodgkins disease, leukemia, lymphoma, malignant tumor, or a pre-leukemic or pre-malignant condition or a condition with malignant potential?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	2. Heart disease, angina, heart attack, heart surgery, congestive heart failure, high blood pressure not controlled by medication or requiring more than two medications, any other abnormality of the heart or circulatory system including coronary artery disease, peripheral vascular disease, stroke, transient ischemic attack, or any other cerebrovascular disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	3. Cerebral palsy, Parkinson's disease, paralysis, amyotrophic lateral sclerosis (Lou Gehrig's disease), or other motor neuron disease; muscular dystrophy, myasthenia gravis or any other neuromuscular disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	4. Kidney disease, Diabetes (except during pregnancy), Lung or Respiratory disease or disorder, Pulmonary or Cystic Fibrosis, Liver or Pancreatic disorder, any chronic or progressive disease or disorder of the Blood or Bone Marrow?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Critical Care; Cancer Care	5. Multiple sclerosis, systemic lupus erythematosus or any other autoimmune disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	6. Do you or anyone proposed for coverage currently have scheduled, or been advised to have any screening tests, diagnostic tests, medical or surgical procedures, or are you awaiting results or being followed for any of the above?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	7. Memory loss, Alzheimer's disease, senile dementia or organic brain syndrome, or consulted a doctor or received advice for any of the above?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	8. Have you or anyone proposed for coverage been diagnosed or treated for alcohol or substance abuse in the past 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	9. Has any person to be insured or any two of their natural parents or siblings been diagnosed with the same disease before age 60, based on this list: heart disease, stroke, diabetes, cancer, kidney disease, or multiple sclerosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION IX - AUTHORIZATION:

REMARKS OR SPECIAL PROVISIONS:

In signing below, I (a) represent that the statements and answers given on all pages of this application are true, complete, and correctly recorded to the best of my knowledge and belief; (b) state that I have read and understand the "Important Note" and the "Insurance Fraud Warning" below; (c) authorize US Able Life or its reinsurer to make a brief report of my personal health information to MIB; (d) authorize any physician, medical practitioner, hospital, clinic, or other medically related facility, insurance or reinsurance company, or Medical Information Bureau, Inc. having information on me or any member of my family (only those who have applied for coverage on this application) regarding our mental and physical health, other insurance coverage, hazardous activities, character, general reputation, finances, and vocation to give to US Able Life, its reinsurers, or its legal representative any and all such information to use for underwriting insurance; (e) authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the company to collect and transmit such information in order to facilitate its rapid submission; (f) agree that this authorization shall be valid for two (2) years from the application date; (g) agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me or my representative upon request; (h) acknowledge receipt of written notification describing the use of the Medical Information Bureau as required by the Fair Credit Reporting Act and the Notice of Insurance Information Practices. I have read and understand the above statements and agreements. In applying for insurance, I authorize my employer to make the necessary payroll deductions to pay for my insurance. I understand failure to disclose a proposed insured person's true health condition may void this policy.

IMPORTANT NOTE: The entire contract will consist of this application and the insurance issued in response to it. **THE INSURANCE WILL NOT BE EFFECTIVE ON THE PROPOSED INSURED UNLESS:** (1) The policy is delivered to the Owner; (2) The first modal premium is paid; and (3) There has been no change since the date of this application and the effective date of the policy in the health of the Proposed Insured as stated in this application. There is no coverage until the effective date of the policy.

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

I have read and understand the above statements and agreements.

X _____
Applicant's Signature

Signed at: _____
(City and State)

Agent's Statement: I have accurately recorded the information supplied by the applicant.

Date of Application: _____
(Month, Day, Year)

X _____
Agent's Signature

Agent's License ID Number

Agent's Printed Name

Accident Recovery Rates

BASIC			
	No AD&D Rider (monthly)	With \$50k AD&D Rider (monthly)	With \$100k AD&D Rider (monthly)
Employee Only	\$11.74	\$15.07	\$18.39
Employee + Spouse	\$22.40	\$28.30	\$34.20
Employee + child(ren)	\$24.70	\$29.25	\$33.80
Family	\$35.36	\$42.49	\$49.61

SELECT			
	No AD&D Rider (monthly)	With \$50k AD&D Rider (monthly)	With \$100k AD&D Rider (monthly)
Employee Only	\$13.85	\$17.18	\$20.50
Employee + Spouse	\$26.42	\$32.32	\$38.22
Employee + child(ren)	\$29.56	\$34.11	\$38.66
Family	\$42.13	\$49.26	\$56.38

ULTRA			
	No AD&D Rider (monthly)	With \$50k AD&D Rider (monthly)	With \$100k AD&D Rider (monthly)
Employee Only	\$17.39	\$20.72	\$24.04
Employee + Spouse	\$33.23	\$39.13	\$45.03
Employee + child(ren)	\$37.45	\$42.00	\$46.55
Family	\$53.29	\$60.42	\$67.54

Your selections:

Coverage for: Employee only Employee + Spouse Employee + Child(ren) Family

Plan: Basic Select Ultra

Premium: \$ _____ per pay period per month



**EMPLOYEE BENEFITS SUMMARY | 50019104
TOWN OF WEBSTER**

FOR ALL FULL TIME ACTIVE EMPLOYEES

GROUP TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT | **EMPLOYER CONTRIBUTION: 50%**

AMOUNT OF COVERAGE: You may elect a benefit of \$5,000 without evidence of insurability.
Benefit does not reduce, and terminates when you are no longer eligible or your retirement, whichever occurs first.

GROUP TERM LIFE insurance is designed to provide benefits to your designated beneficiary for loss of life.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) is payable, if within 365 days of a covered accident, you suffer loss of life or dismemberment. AD&D provides protection for losses occurring on or off the job.

GROUP TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT ALSO INCLUDES THE FOLLOWING:

- Accelerated Benefit
- Extended Life Insurance Benefit (Waiver of Premium)
- Seat Belt/Air Bag Benefit
- Coma Benefit
- Exposure & Disappearance Benefit
- Repatriation Benefit
- Assist America
- Portability
- Special Education Coverage

DEPENDENT LIFE | **EMPLOYER CONTRIBUTION: 0%**

Spouse: You may purchase coverage for your eligible spouse in the amount of \$5,000.

Children: You may purchase coverage for your eligible children between the ages of 6 months and 26 years in the amount of \$1,000. Benefits are reduced to \$500 for children from Live Birth to 6 months.

VOLUNTARY GROUP TERM LIFE | **EMPLOYER CONTRIBUTION: 0%**

Employee: If you are age 69 or younger, you may purchase coverage in units of \$10,000 to a maximum of \$100,000 without evidence of insurability. Coverage over these amounts to a maximum of \$350,000 is available with evidence of insurability.
Benefits reduce to 65% at age 70, to 50% at age 75, to 35% at age 80, to 25% at age 85, to 20% at age 90, to 15% at age 95, and terminate when you are no longer eligible or your retirement, whichever occurs first.

Spouse: If you have purchased VGTL for yourself, you may purchase coverage for your eligible spouse, age 69 or younger, in units of \$5,000 to a maximum of \$30,000 without evidence of insurability. Coverage over these amounts to a maximum of \$50,000 is available with evidence of insurability.

Benefits reduce, based on spouse's age, to 65% at age 70, to 50% at age 75, to 35% at age 80, to 25% at age 85, to 20% at age 90, to 15% at age 95, and terminate when you are no longer eligible or your retirement, whichever occurs first.

Child: If you have purchased VGTL for yourself, you may purchase coverage for your eligible children between the ages of 6 months and 26 years in the amount of \$5,000 or \$10,000. Benefits reduce to \$1,000 for children from live birth to 6 months.

Benefits terminate when they are no longer eligible, or at the termination of your eligibility, whichever occurs first.

VOLUNTARY GROUP TERM LIFE (VGTL) If you need additional term life protection for you and your eligible family members, think about USABLE Life's low cost VGTL coverage. You select the benefit amounts to suit your specific situation and premium payments are made through payroll deduction.

VOLUNTARY GROUP TERM LIFE ALSO INCLUDES THE FOLLOWING:

- Portability
- Extended Life Insurance Benefit (Waiver of Premium)

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT**EMPLOYER CONTRIBUTION: 0%**

Employee: You may purchase coverage in units of \$10,000 to a maximum of \$350,000 without evidence of insurability.

Benefits reduce to 65% at age 70, to 50% at age 75, to 35% at age 80, to 25% at age 85, to 20% at age 90, to 15% at age 95, and terminate when you are no longer eligible or your retirement, whichever occurs first.

Spouse: If you have purchased AD&D for yourself, you may purchase coverage for your eligible spouse in units of \$10,000 to a maximum of \$50,000 without evidence of insurability.

Benefits reduce, based on spouse's age, to 65% at age 70, to 50% at age 75, to 35% at age 80, to 25% at age 85, to 20% at age 90, to 15% at age 95, and terminate when you are no longer eligible or your retirement, whichever occurs first.

Child: If you have purchased Voluntary ADD for yourself, you may purchase coverage for your eligible children between the ages of 6 months and 26 years in the amount of \$5,000 or \$10,000. Benefits reduce to \$1,000 for children from live birth to 6 months.

Benefits terminate when they are no longer eligible, or at the termination of your eligibility, whichever occurs first.

VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT (VAD&D) coverage allows you to purchase benefits to provide protection in the event of an unexpected loss of accidental death or dismemberment. Protection is issued on a 24-hour basis for you and your eligible family members and covers you as the result of a covered accident anywhere in the world.

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT ALSO INCLUDES THE FOLLOWING:

- Seat Belt/Air Bag Benefit
- Coma Benefit
- Exposure & Disappearance Benefit
- Repatriation Benefit
- Special Education Coverage

GROUP ACCIDENT RECOVERY**EMPLOYER CONTRIBUTION: 0%**

If you are age 64 or younger, you may purchase Accident Recovery Benefits. This benefit provides comprehensive coverage for accidental injuries including hospitalization, rehab and physical therapy. Benefits are paid directly to you and there is no coordination of benefits with your medical plan. Coverage is also available for your spouse and children.

HIGHLIGHTS OF THE BASIC PLAN INCLUDE:

- Physician Office Visit: \$125/2 visits
- Initial Hospitalization: \$1,000
- Ambulance (Air/Ground): \$1,250/\$200
- Physical Therapy: \$100/6 visits
- Transportation (for non-local treatment): \$400/5 Trips
- *Wellness Benefit: \$60

HIGHLIGHTS OF THE SELECT PLAN INCLUDE:

- Physician Office Visit: \$150/2 visits
- Initial Hospitalization: \$1,200
- Ambulance (Air/Ground): \$1,500/\$240
- Physical Therapy: \$140/6 visits
- Transportation (for non-local treatment): \$600/5 Trips
- *Wellness Benefit: \$75

HIGHLIGHTS OF THE ULTRA PLAN INCLUDE:

- Physician Office Visit: \$225/2 visits
- Initial Hospitalization: \$1,600
- Ambulance (Air/Ground): \$2,000/\$320
- Physical Therapy: \$160/6 visits
- Transportation (for non-local treatment): \$700/5 Trips
- *Wellness Benefit: \$105

Important Note

If you are not actively at work on the date your insurance or any increase in insurance is scheduled to take effect, the coverage or increase in coverage will take effect on the day you return to active work. This benefit summary provides a very brief description of USAbie Life's insurance products. This is not an insurance policy and only the actual provisions of an issued policy control. USAbie Life's policies set forth the rights and obligations of covered persons and USAbie Life. Please be aware that certain limitations and exclusions may apply, and certain coverage may reduce or terminate due to age or lack of eligibility. If you enroll and are approved for coverage, you will be furnished with a certificate of insurance. Please read your insurance documents carefully.