

# Employee Benefits Enrollment Guide



For the employees of



CALL 855-347-3817 TO ASK QUESTIONS AND ENROLL  
YOU CAN ALSO VISIT [WWW.PROGBEN.COM/HIREYNAMICS](http://WWW.PROGBEN.COM/HIREYNAMICS)  
TO ENROLL AND LEARN MORE ABOUT THE OFFERINGS

## MINIMUM ESSENTIAL COVERAGE

*Self-Insured by your employer, this coverage is designed to satisfy the individual mandate under Health Care Reform*

Minimum Essential Coverage (MEC) covers **100%** of the CMS-listed Preventative and Wellness benefits when you visit a network provider (40% out-of-network).

An Employee can prevent being taxed the **“Individual Mandate”** coverage penalty by **purchasing Minimum Essential Coverage** through his/her employer. Beginning in 2014, Employees will face a tax of the greater of 1% of adjusted household income or \$95 per adult plus \$47.50 per child; in 2015, the greater of 2% of adjusted household income or \$325 per adult plus \$162.50 per child; thereafter, the greater of 2.5% of adjusted household income or \$695 per adult plus \$347.50 per child.

First dollar coverage with access to one of the largest national provider networks available (simple web portal for member’s local or out-of-town provider look up) with great discount savings for MEC benefits. Network savings can be used for services not covered by MEC.



### PPO NETWORK

The MEC plan utilizes the Multiplan PPO network for discounts on medical services. Multiplan provides access to over 525,000 healthcare professionals, 3,800 hospitals and more than 66,000 ancillary care facilities in every state contract directly to participate. Multiplan is the largest independent primary PPO in the nation.

The PPO discounts continue to apply to the member’s medical bills even after your benefits have been exhausted. Information on accessing either of these networks will be included in the fulfillment package that each insured Employee receives from KBA.

To check if your provider is in the network, go to **[www.multipan.com](http://www.multipan.com)** or speak to a representative at **1-866-680-7427**.

## 15 Covered Preventive Services for Adults

1. Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
2. Alcohol Misuse screening and counseling
3. Aspirin use for men and women of certain ages
4. Blood Pressure screening for all adults
5. Cholesterol screening for adults of certain ages or at higher risk
6. Colorectal Cancer screening for adults over 50
7. Depression screening for adults
8. Type 2 Diabetes screening for adults with high blood pressure
9. Diet counseling for adults at higher risk for chronic disease
10. HIV screening for all adults at higher risk
11. Immunization vaccines for adults--doses, recommended ages and populations vary:
  - o Hepatitis A
  - o Hepatitis B
  - o Herpes Zoster
  - o Influenza (Flu Shot)
  - o Human Papillomavirus
  - o Meningococcal
  - o Measles, Mumps, Rubella
  - o Pneumococcal
  - o Tetanus, Diphtheria, Pertussis
  - o Varicella
12. Obesity screening and counseling for all adults
13. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
14. Tobacco Use screening for all adults and cessation interventions for tobacco users
15. Syphilis screening for all adults at higher risk



## 22 Covered Preventive Services for Women, Including Pregnant Women

1. Anemia screening on a routine basis for pregnant women
2. Bacteriuria urinary tract or other infection screening for pregnant women
3. BRCA counseling about genetic testing for women at higher risk
4. Breast Cancer Mammography screenings every 1 to 2 years for women over 40
5. Breast Cancer Chemoprevention counseling for women at higher risk
6. Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women
7. Cervical Cancer screening for sexually active women
8. Chlamydia Infection screening for younger women and other women at higher risk
9. Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
10. Domestic and interpersonal violence screening and counseling for all women
11. Folic Acid supplements for women who may become pregnant
12. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
13. Gonorrhea screening for all women at higher risk
14. Hepatitis B screening for pregnant women at their first prenatal visit
15. Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women
16. Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older
17. Osteoporosis screening for women over age 60 depending on risk factors
18. Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
19. Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users
20. Sexually Transmitted Infections (STI) counseling for sexually active women
21. Syphilis screening for all pregnant women or other women at increased risk
22. Well-woman visits to obtain recommended preventive services

## MINIMUM ESSENTIAL COVERAGE

*Descriptions of Covered Services (continued)*

### 26 Covered Preventive Services for Children

1. Alcohol and Drug Use assessments for adolescents
2. Autism screening for children at 18 and 24 months
3. Behavioral assessments for children of all ages
  - o Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, & 15 to 17 years.
4. Blood Pressure screening for children
  - o Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, & 15 to 17 years.
5. Cervical Dysplasia screening for sexually active females
6. Congenital Hypothyroidism screening for newborns
7. Depression screening for adolescents
8. Developmental screening for children under age 3, and surveillance throughout childhood
9. Dyslipidemia screening for children at higher risk of lipid disorders
  - o Ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, & 15 to 17 years.
10. Fluoride Chemoprevention supplements for children without fluoride in their water source
11. Gonorrhea preventive medication for the eyes of all newborns
12. Hearing screening for all newborns
13. Height, Weight and Body Mass Index measurements for children
  - o Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, & 15 to 17 years.
14. Hematocrit or Hemoglobin screening for children
15. Hemoglobinopathies or sickle cell screening for newborns
16. HIV screening for adolescents at higher risk
17. Immunization vaccines for children from birth to age 18: doses, recommended ages, and recommended populations vary:
  - o Hepatitis A
  - o Hepatitis B
  - o Influenza (Flu Shot)
  - o Meningococcal
  - o Pneumococcal
  - o Varicella
  - o Diphtheria, Tetanus, Pertussis
  - o Human Papillomavirus
  - o Inactivated Poliovirus
  - o Measles, Mumps, Rubella
  - o Rotavirus
  - o Haemophilus influenzae type-b
18. Iron supplements for children ages 6 to 12 months at risk for anemia
19. Lead screening for children at risk of exposure
20. Medical History for all children throughout development
  - o Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, & 15 to 17 years.
21. Obesity screening and counseling
22. Oral Health risk assessment for young children
  - o Ages: 0 to 11 months, 1 to 4 years, & 5 to 10 years.
23. Phenylketonuria (PKU) screening for this genetic disorder in newborns
24. Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk
25. Tuberculin testing for children at higher risk of tuberculosis
  - o Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, & 15 to 17 years.
26. Vision screening for all children





OPTIONAL HOSPITAL INDEMNITY INSURANCE

Underwritten by Transamerica Life Insurance Company

TransChoice® Advance: Group Limited Benefit Hospital Indemnity Insurance		Plan 1
Daily In-Hospital Indemnity Benefit Pays per day, up to a max of 31 days per confinement		\$100
Outpatient Physician Office Visit Indemnity Benefit Pays per day, up to max days per calendar year per covered person		\$50 6 day max
Outpatient Diagnostic X-Ray and Laboratory Indemnity Benefit Pays benefit per day; 2 days per calendar year for Advanced Studies, 2 days per calendar year for Select Diagnostic tests, 3 days per calendar year for Diagnostic Laboratory tests.	Advance Studies Select Diagnostic Diagnostic Laboratory	\$200 \$50 \$10
Hospital Confinement 1 day of confinement per year		\$500
Daily Inpatient Drug and Alcohol Indemnity Benefit Pays per day, up to a max of 31 days per year		\$100
Daily Inpatient Mental and Nervous Indemnity Benefit Pays per day, up to a max of 31 days per year		\$100
Off-the-Job Accidental Injury Benefit Pays benefit per day of accident treatment (5 days per calendar year)		\$100

Non-Insurance Benefits Included

Employee Discount Card - Offered by New Benefits, LTD

Provides access to a discount Vision plan, Nurses Hotline, Counseling Services, and discounts on Hearing Aids

Patient Advocacy - Offered by The Karis Group

Services that provide employees with unparalleled diligence and dedication to find the best solutions for resolving their outstanding medical bills

This is a brief summary of TransChoice® Advance Group Limited Benefit Hospital Indemnity Insurance **underwritten by Transamerica Life Insurance Company**, Cedar Rapids, IA. Policy form series CPGHI400 and CCGHI400. Forms and form numbers may vary. Coverage may not be available in all jurisdictions. Limitations and exclusions apply. Refer to the policy, certificate and riders for complete details. **THIS IS NOT MAJOR MEDICAL INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL INSURANCE.**

ID CARDS

You will receive a separate ID card for the Transamerica product. Claims administration and customer service will be provided by Key Benefit Administrators. An explanation of benefits (EOB) will be provided on each claim to explain how it was processed.

## OPTIONAL HOSPITAL INDEMNITY INSURANCE

### **Summary of Benefits for TransChoice® Advance: Group Limited Benefit Hospital Indemnity Insurance** underwritten by Transamerica Life Insurance Company

#### **Daily In-Hospital Indemnity Benefit**

When a covered person is confined in a hospital as a result of an accident or sickness, this benefit pays the benefit amount for each day the insured is confined in a hospital, up to a maximum of 31 days per confinement.

#### **Off-the-Job Accidental Injury Benefit**

This benefit pays the selected amount per day accident (maximum of 5 days per covered person per calendar year), for x-rays used to diagnose an accidental injury and for treatment of a covered accident by a physician in the physician's office, clinic, urgent care facility, or hospital emergency room. Treatment must be received within 96 hours of the accident for benefits to be payable.

#### **Hospital Confinement**

This benefit pays an additional benefit per covered person per calendar year when he/she receives treatment or surgery while confined to a hospital as an inpatient as a result of a covered accident or sickness.

#### **Outpatient Physician Office Visit Indemnity Benefit**

This benefit pays the amount shown for the day of a physician's office visit as a result of a sickness or accident. Benefits are payable for a maximum number of days per calendar year per person.

#### **Outpatient Diagnostic X-Ray and Laboratory Indemnity Benefit**

This benefit pays the amount shown per testing day for tests performed for the purpose of diagnosis of a covered sickness or accident as indicated by symptoms that would suggest an injury or sickness had occurred. The benefit is limited to a number of days of testing per calendar year per covered person and is not payable while the insured is confined in a hospital (i.e. it applies to outpatient services only).

#### **Daily Inpatient Drug and Alcohol Indemnity Benefit**

This benefit pays per day if a covered person is confined as an inpatient in a rehabilitation facility for substance abuse. The maximum benefit per covered person per calendar year is 31 days. The lifetime maximum for this benefit is \$30,000.

#### **Daily Inpatient Mental and Nervous Indemnity Benefit**

This benefit pays per day if a covered person is confined as an inpatient in a rehabilitation facility for a mental or nervous condition. The maximum benefit per covered person per calendar year is 31 days. The lifetime maximum for this benefit is \$30,000.



### Employee Discount Card

This discount card is provided by New Benefits, LTD. It offers Employees access to a discount Vision Plan, a Nurses Hotline, Counseling Services and benefits for Hearing Aids. **This is not an insurance plan.** The discount Vision Plan through the Coast to Coast network allows the Employee to receive discounts of 20% to 60% on eyeglasses, non-prescription sunglasses, contact lenses (including disposables) and frames from over 10,000 independent retail optical locations nationwide. Providers include independent practitioners, regional chains, department store opticals, and the largest chains in the U.S. Some of these providers are LensCrafters, Pearle Vision, Sears Optical and JC Penney Optical (among others).\*

The Nurses Hotline allows access to experienced registered nurses 24 hours a day, 7 days a week, 365 days a year. These hotline nurses are an immediate, reliable and caring source of health information, education and support. Services provided by this plan include:

- o General information on all types of health concerns
- o Information based on physician-approved guidelines
- o Answers about medication usage and interaction
- o Information on non-medical support groups
- o Translation services for non-English speaking callers
- o Full time medical director on staff

The Counseling Services benefit allows the Employee to speak with a counselor 24 hours a day, 7 days a week regarding any personal problems they may be facing. In addition, if the Employee is referred to one of the 27,000 counseling providers nationwide, they will receive discounts of 25% to 30% off the normal billing charges from those providers.\*

The Hearing Aid benefit provides savings of up to 15% off the retail cost on over 70 models of hearing aids, and a free hearing test when utilizing one of the 1,200 participating Beltone® locations nationwide. Or, the Employees can realize savings of up to 50% off suggested retail price on over 90 models of hearing aids in over 1,000 locations nationwide.\*

Information on how to access the benefits of the Employee Discount card will be included in the fulfillment package that each insured Employee receives from KBA.

\* Discounts on professional services are not available where prohibited by law.

### Patient Advocacy

Even with exceptional PPO discounts and rich reimbursement schedules, employees of limited benefit medical plans may be left with unpaid medical bills in years when medical bills approach \$3,500 or more. For these individuals, Karis' Patient Advocacy service becomes the critical missing piece and an invaluable benefit for customers. Since we treat each employee, locality and provider as a unique combination of variables that leads to a customized solution for each employee, Karis delivers a customized and comprehensive solution that goes far beyond the benefits of a one size fits all PPO network discount. When reimbursement limits are reached, our services kick in and provide employees with unparalleled diligence and dedication to find the best solutions for resolving their outstanding medical bills.

For employees who find themselves unable to pay bills that exceed Limited Benefit Medical plan reimbursements, Karis can come alongside to advocate on their behalf, working with every provider to find a mutually agreeable solution. Karis' highly trained and experienced "Employee Advocates" guide employees through the tangled maze of medical billing. Initially, we research the availability of entitlement or financial assistance programs in an effort to locate outside funding sources to help pay their bills. If an employee qualifies for such programs, their Employee Advocate will hold their hand throughout what can be a lengthy process and will do everything for the employee from acquiring necessary paperwork to chasing decision makers. If an employee does not qualify for entitlement or financial assistance programs, their Employee Advocate will try to negotiate a reduced settlement or reduced/extended payment plan with providers that is acceptable to all parties.



## OPTIONAL HOSPITAL INDEMNITY INSURANCE

### **Limitations & Exclusions for TransChoice® Advance: Group Limited Benefit Hospital Indemnity Insurance** underwritten by Transamerica Life Insurance Company

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

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

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

#### **Termination of Insurance**

The insurance terminates on the earliest of:

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

Dependent coverage ends on the earliest of:

- The date the insured's coverage terminates for any of the reasons above.
- The date the dependent no longer meets the definition of a dependent.
- The premium due date when we fail to receive a premium, subject to the grace period.
- The date of written notice to cancel coverage.
- The date the policy is modified so as to exclude dependent coverage.

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

#### **Extension of Benefits**

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

1. Any Hospital Confinement which commenced while coverage was in force, with respect to Daily In-Hospital Indemnity Benefits; or,
2. Any covered treatment or service for which benefits would be provided and which commenced while coverage was in force; provided, however, that the Covered Person is and continues to be Hospital Confined or Disabled.

Such Extension of Benefits will continue for up to the earlier of:

1. 30 days; or
2. The date on which the Covered Person is no longer disabled.

**Massachusetts Residents: This product DOES NOT MEET MINIMUM CREDITABLE COVERAGE STANDARDS and WILL NOT SATISFY the Massachusetts individual mandate that you have health insurance.**

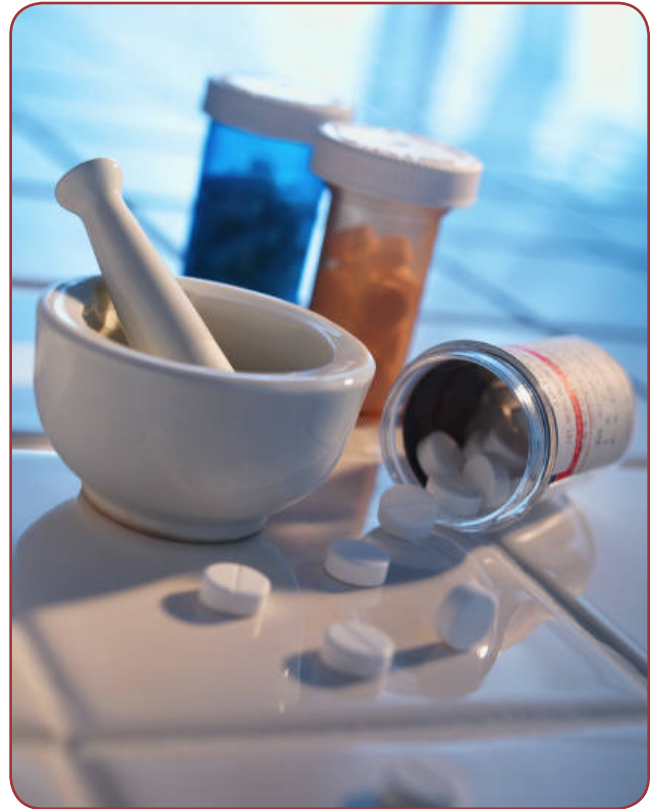


## MINIMUM VALUE PLAN

*Self-Insured and selected by your employer, this coverage is designed to satisfy the individual mandate under Health Care Reform*

The MVP offers strategically selected medical benefits including: a nationally acclaimed patented Chronic disease management (CDM) program, prescription drug coverage, online explanation of benefits, online plan summaries and much more. With copayments up to the \$1,850 out-of-pocket maximum, MVP members receive 100% coverage after reaching their out-of-pocket maximum on covered services.

The MVP coverage also includes the 63 preventive services required per the government for Minimum Essential Coverage. This list includes diabetes and cholesterol screenings, prenatal visits for pregnant women, and more. These benefits are covered at 100% when you visit a network provider. The benefits drop to 40% if you use an out-of-network provider.



As outlined under the new healthcare law (ACA), all individuals must have coverage beginning January 2014 or pay a penalty tax. Employees can prevent being taxed the “individual mandate” penalty tax by purchasing a Minimum Value Plan (MVP) through their employer.

An Employee can prevent being taxed the **“Individual Mandate”** coverage penalty by **purchasing a Minimum Value Plan** through his/her employer. Beginning in 2014, Employees will face a tax of the greater of 1% of adjusted household income or \$95 per adult plus \$47.50 per child; in 2015, the greater of 2% of adjusted household income or \$325 per adult plus \$162.50 per child; thereafter, the greater of 2.5% of adjusted household income or \$695 per adult plus \$347.50 per child. MVP is a **60%-equivalent bronze major medical** policy and provide substantially more coverage than Minimum Essential Coverage (MEC).

## MINIMUM VALUE PLAN

### Description of covered services

MVP Covered Benefits	MVP Plan Design	
	In-Network	Out-of-Network
Deductible	\$0 / \$0	\$500 / \$1,000
Coinsurance	100%	40%
Out-of-Pocket Maximum	\$1,850 / \$12,700	Deductible & Coinsurance
MVP Covered Benefits	In-Network	Out-of-Network
Emergency Room Services	\$400 copay	\$400 copay
Primary Care Visits to Treat an Injury or Illness	\$15 copay	Deductible & Coinsurance
Specialist Visit	\$25 copay	Deductible & Coinsurance
Imaging (CP, PET Scans, MRIs)	\$400 copay	Deductible & Coinsurance
Laboratory Outpatient and Professional Services	\$50 copay	Deductible & Coinsurance
X-rays and Diagnostic Imaging	\$50 copay	Deductible & Coinsurance
Preventative Care, Screening, & Immunization (Minimum Essential Coverage)	100% covered	Deductible & Coinsurance
Chronic Disease Management (CDM)	100% covered	Deductible & Coinsurance
Prescription Drugs		
Generic Drugs	\$15 copay	Deductible & Coinsurance
Preferred Brand Drugs	\$25 copay	Deductible & Coinsurance
Non-Preferred Brand Drugs	\$75 copay	Deductible & Coinsurance
Life Insurance with AD&D	\$10,000	\$10,000

### **What is covered in an emergency room visit?**

All services done in emergency room. Emergency room services will not be covered if admitted to hospital (stay over 24 hours). Emergency Room services are covered at the same rate for in and out of network providers.

### **What is covered when I go to the doctor's office?**

If it is an illness or injury visit, the exam would be covered under the physician benefit after a copay. There is a difference between Primary Care Physician or Specialist exam copays (see summary below or plan document). Lab and x-ray's done in the office, again for illness or injury, are a separate benefit and copay for each service line billed. Wellness exams are covered under the preventive care/wellness benefit at 100% in network. Some lab and x-rays related to wellness may also be considered under this benefit. Surgery will not be covered.

### **Are services rendered in an urgent care facility covered?**

Urgent Care is covered the same as the physician visit benefit. The exam and lab/x-ray benefit will be a separate copay as listed in the schedule of benefits. All surgeries including stitches, setting of broken bones, etc. are not covered.

### **Are maternity services covered? Pre-Post Natal Care? Ultrasound? Delivery?**

Services for pregnancy and pre-natal care are covered. The pregnancy services listed under preventive care will be covered at the preventive benefit. Preventive care for maternity would include (but not limited to) pre-natal care, breastfeeding support and supplies, folic acid supplements and gestational diabetes screening. Ultrasounds and non-routine pregnancy services will be covered the same as any other illness. Delivery and inpatient charges including nursery are not covered.

### **Are mental health and substance abuse services covered?**

Mental health and substance abuse services are not covered under the plan unless listed in the preventive care schedule (example, screenings for depression over age 12 are covered but treatment for depression is not covered).

### **Are contraceptives covered?**

Approved contraceptives would be covered in-network at 100% at the pharmacy, as they are considered part of the preventive/wellness benefit.

### **Is surgery covered?**

Surgery, whether inpatient, outpatient or in the office, is not covered under the plan unless it is listed under the preventive/wellness benefit, such as a routine colonoscopy. This includes stitches, removal of moles, setting of bones, etc.

### **How are MRI, CAT/CT, PET scans covered?**

MRI, CAT/CT and PET scans are covered with a \$400 copay and then at 100% per service. If rendered in an emergency room (ER) these would be covered under the ER copay and benefit. The \$400 copay will cover the physician and facility charge when rendered on an outpatient basis in a hospital, independent clinic or office setting. The inpatient facility charge of an MRI, CT, PET scans is not covered.

### **What preventive/routine services are covered?**

Preventive care/wellness services will be covered in-network at 100% based on the 63 CMS mandated preventive care listing. Please see the plan document for the complete listing.

## MINIMUM VALUE PLAN

### **Is durable medical equipment and prosthetics covered?**

All medical supplies, durable medical equipment and prosthetics are not covered under the plan.

### **Are biotech/specialty medication covered?**

All biotech and specialty medications through either the pharmacy or other setting/place are not covered under the plan. This includes specialty medications given through infusion.

### **Are ambulance services covered?**

Ambulance services are not covered. This includes ground, air, sea, etc.

### **Is chiropractic care covered?**

Chiropractic care is not covered. This includes exam and all services rendered by a chiropractic provider.

### **Is infusion therapy, chemotherapy, or radiation covered?**

Infusion, chemotherapy and radiation are not covered.

### **Are injections or shots covered?**

Injections, whether inpatient, outpatient or in the office, are not covered under the plan unless it is listed under the preventive/wellness benefit, such as a routine immunization. This includes antibiotics, steroids, allergy injections, etc.

### **Are inpatient services covered?**

Inpatient facility services are not covered. Physician visits performed while inpatient will be covered under the physician benefit with the copay stated in the schedule of benefits.

### **MVP Exclusions**

1. Hospital inpatient services are not covered by the plan. This means any inpatient service billed by the hospital.
2. Ambulatory Surgical Center Services are not covered.
3. Maternity services are not covered with the exception of services covered under the MEC benefits.
4. Mental/Behavioral Health and Substance Abuse disorder outpatient Services are not covered with the exception of services covered under the MEC benefits.
5. Rehabilitative Speech therapy services are not covered.
6. Rehabilitative occupational and rehabilitative Physical therapy services are not covered.
7. Skilled nursing Facility services are not covered.
8. Outpatient Surgery Physician/Surgical services are not covered.
9. Specialty drugs are not covered.
10. Charges that are not for the care or treatment of an accident or illness except as specifically provided for in this plan.
11. Treatment made necessary as the result of illegal use of narcotics or use of hallucinogens in any form unless prescribed by a physician or as provided herein.
12. Treatment made necessary by or a disability arising from war, declared or undeclared, or any act of war. An act of terrorism will not be considered an act of war, declared or undeclared.
13. Treatment or services provided by anyone other than a healthcare provider as defined herein unless specifically stated in the plan.
14. Investigatory and experimental treatment, services, and supplies.
15. Organ transplants.

Please refer to your plan document for a detailed description of all exclusions



OPTIONAL HOSPITAL INDEMNITY INSURANCE

Underwritten by Transamerica Life Insurance Company

TransChoice® Advance: Group Limited Benefit Hospital Indemnity Insurance		Plan 2
Daily In-Hospital Indemnity Benefit Pays per day, up to a max of 31 days per confinement		\$300
Surgical and Anesthesia Indemnity Benefit Pays benefit per day; 1 day per calendar year for Inpatient Surgery, 1 day per calendar year for Outpatient Surgery, 1 day per calendar year for Specified Outpatient Surgeries. Pays additional 20% of the surgical benefit for Anesthesia.		Inpatient \$700 Outpatient \$350 Specified Outpatient \$70
Hospital Confinement 1 day of confinement per year		\$500
Intensive Care Indemnity Benefit Pays per day, up to a max of 30 days per year		\$300
Daily Inpatient Drug and Alcohol Indemnity Benefit Pays per day, up to a max of 31 days per year		\$100
Daily Inpatient Mental and Nervous Indemnity Benefit Pays per day, up to a max of 31 days per year		\$100
Off-the-Job Accidental Injury Benefit Pays benefit per day of accident treatment (5 days per calendar year)		\$100
Critical Illness Indemnity Benefit and Subsequent Critical Illness Indemnity Benefit Lump sum benefit for the initial diagnosis of a covered critical illness and an additional lump-sum benefit of the same amount for subsequent and separate covered critical illness		\$2,500

Non-Insurance Benefits Included

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## OPTIONAL HOSPITAL INDEMNITY INSURANCE

### Summary of Benefits for TransChoice® Advance: Group Limited Benefit Hospital Indemnity Insurance underwritten by Transamerica Life Insurance Company

#### Daily In-Hospital Indemnity Benefit

When a covered person is confined in a hospital as a result of an accident or sickness, this benefit pays the benefit amount for each day the insured is confined in a hospital, up to a maximum of 31 days per confinement.

#### Surgical and Anesthesia Indemnity Benefit

We will pay the inpatient, an outpatient or an outpatient minor surgical benefit described for a covered person when a covered surgery is performed because of an accident or a sickness. The inpatient benefit is payable once per calendar year per covered person for any covered inpatient surgical procedure or for two or more inpatient procedures performed in the same surgical session. The outpatient benefit is payable once per calendar year for any covered outpatient surgical procedure or two or more outpatient procedures performed in the same surgical session. The outpatient minor benefit is payable once per calendar year per covered person for any covered outpatient minor surgical procedure or two or more such procedures performed in the same surgical session.

We will also pay the anesthesia benefit when anesthesia is administered during any covered surgery. The indemnity benefit will be a percentage of the amount paid under the surgical indemnity benefit. Please see the certificate for a list of codes that are considered outpatient minor surgical procedures.

#### Off-the-Job Accidental Injury Benefit

This benefit pays the selected amount per day accident (maximum of 5 days per covered person per calendar year), for x-rays used to diagnose an accidental injury and for treatment of a covered accident by a physician in the physician's office, clinic, urgent care facility, or hospital emergency room. Treatment must be received within 96 hours of the accident for benefits to be payable.

#### Hospital Confinement

This benefit pays an additional benefit per covered person per calendar year when he/she receives treatment or surgery while confined to a hospital as an inpatient as a result of a covered accident or sickness.

#### Intensive Care Indemnity Benefit

This benefit pays per day for confinement in an intensive care unit, for a maximum of 30 days per covered person per calendar year. This benefit is paid in addition to the Daily In-Hospital Indemnity Benefit.

#### Critical Illness Indemnity Benefits and Subsequent Critical Illness Indemnity Benefit

When a covered person is diagnosed with a covered critical illness, the selected amount will be paid. This amount is payable up to two times for each covered person, once under the Critical Illness Indemnity Benefit and once under the Subsequent Critical Illness Indemnity Benefit, and is paid in addition to any other benefits paid by the TransChoice® Advance policy. The Subsequent Critical Illness Indemnity Benefit is paid if the covered person is diagnosed as having a subsequent and separate covered critical illness more than sixty (60) days after the first covered illness.

For example: If covered person is diagnosed for the first time with a heart attack, and then is diagnosed with a stroke for the first time more than sixty (60) days later, he or she will receive the benefit amount selected for each illness. This benefit is payable one time for each covered person. The Subsequent Critical Illness Indemnity Benefit is not payable for Skin Cancer or Carcinoma in Situ.

Benefits are payable for the following critical illnesses:

- Cancer (including leukemia and Hodgkin's Disease, except Stage 1 Hodgkin's Disease)
- Heart Attack (diagnosis must be based on EKG changes consistent with injury elevation of cardiac enzymes, and confirmatory neuroimaging studies)
- Stroke (diagnosis must be based on documented neurological deficits and confirmatory neuroimaging studies)
- End Stage Renal Failure (chronic, irreversible failure of the function of both kidneys, such that a covered person must undergo regular hemodialysis or peritoneal dialysis at least weekly)
- Major Organ Transplant (undergoing surgery as a recipient of a transplant of a human heart, lung, liver, kidney, or pancreas)
- Skin cancer including basal cell epitheloma or squamous cell carcinoma; does not include malignant melanoma or mycosis fungoides
- Carcinoma In Situ (cancer that is confined to the site of origin without having invaded neighboring tissue)

Condition	% of Elected Benefit Amount
Cancer, Heart Attack, Stroke, Major Organ Transplant, End-State Renal Failure*	100%
Skin Cancer, Carcinoma In Situ	5%

\* Dependent coverage equal to 50% of this benefit

**Daily Inpatient Drug and Alcohol Indemnity Benefit**

This benefit pays per day if a covered person is confined as an inpatient in a rehabilitation facility for substance abuse. The maximum benefit per covered person per calendar year is 31 days. The lifetime maximum for this benefit is \$30,000.

**Daily Inpatient Mental and Nervous Indemnity Benefit**

This benefit pays per day if a covered person is confined as an inpatient in a rehabilitation facility for a mental or nervous condition. The maximum benefit per covered person per calendar year is 31 days. The lifetime maximum for this benefit is \$30,000.

**NON-INSURANCE BENEFITS:**

**Employee Discount Card**

This discount card is provided by New Benefits, LTD. It offers Employees access to a discount Vision Plan, a Nurses Hotline, Counseling Services and benefits for Hearing Aids. **This is not an insurance plan.** The discount Vision Plan through the Coast to Coast network allows the Employee to receive discounts of 20% to 60% on eyeglasses, non-prescription sunglasses, contact lenses (including disposables) and frames from over 10,000 independent retail optical locations nationwide. Providers include independent practitioners, regional chains, department store opticals, and the largest chains in the U.S. Some of these providers are LensCrafters, Pearle Vision, Sears Optical and JC Penney Optical (among others).\*

The Nurses Hotline allows access to experienced registered nurses 24 hours a day, 7 days a week, 365 days a year. These hotline nurses are an immediate, reliable and caring source of health information, education and support. Services provided by this plan include:

- o General information on all types of health concerns
- o Information based on physician-approved guidelines
- o Answers about medication usage and interaction
- o Information on non-medical support groups
- o Translation services for non-English speaking callers
- o Full time medical director on staff

The Counseling Services benefit allows the Employee to speak with a counselor 24 hours a day, 7 days a week regarding any personal problems they may be facing. In addition, if the Employee is referred to one of the 27,000 counseling providers nationwide, they will receive discounts of 25% to 30% off the normal billing charges from those providers.\*

The Hearing Aid benefit provides savings of up to 15% off the retail cost on over 70 models of hearing aids, and a free hearing test when utilizing one of the 1,200 participating Beltone® locations nationwide. Or, the Employees can realize savings of up to 50% off suggested retail price on over 90 models of hearing aids in over 1,000 locations nationwide.\*

Information on how to access the benefits of the Employee Discount card will be included in the fulfillment package that each insured Employee receives from KBA.

\* Discounts on professional services are not available where prohibited by law.



## OPTIONAL HOSPITAL INDEMNITY INSURANCE

### **Limitations & Exclusions for TransChoice® Advance: Group Limited Benefit Hospital Indemnity Insurance** underwritten by Transamerica Life Insurance Company

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

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

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

#### **Termination of Insurance**

The insurance terminates on the earliest of:

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

Dependent coverage ends on the earliest of:

- The date the insured's coverage terminates for any of the reasons above.
- The date the dependent no longer meets the definition of a dependent.
- The premium due date when we fail to receive a premium, subject to the grace period.
- The date of written notice to cancel coverage.
- The date the policy is modified so as to exclude dependent coverage.

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

#### **Extension of Benefits**

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

1. Any Hospital Confinement which commenced while coverage was in force, with respect to Daily In-Hospital Indemnity Benefits; or,
2. Any covered treatment or service for which benefits would be provided and which commenced while coverage was in force; provided, however, that the Covered Person is and continues to be Hospital Confined or Disabled.

Such Extension of Benefits will continue for up to the earlier of:

1. 30 days; or
2. The date on which the Covered Person is no longer disabled.

**Massachusetts Residents: This product DOES NOT MEET MINIMUM CREDITABLE COVERAGE STANDARDS and WILL NOT SATISFY the Massachusetts individual mandate that you have health insurance.**



## GROUP DENTAL INSURANCE

underwritten by Transamerica Life Insurance Company  
Policy Form Series CPDEN100 and CCDEN100

### Your Dental Plan:

- Type 1 - Diagnostic and Preventative Services - Pays 80%
- Type 2 - Basic Restorative Services - Pays 50%
- Type 3 - Major Restorative Services - Pays 50%

### Annual Individual Benefit Maximum

- \$1,000 Per Person Per Calendar Year

### Deductible Limitations

- Deductible does not apply to Type 1 Services
- \$50 Per Person Each Calendar Year on Type 2 and 3 Services.

### Waiting Period on Type 3

Type 3 Services will not be covered until after a person is enrolled in the dental plan for 12 consecutive months. If you are rolling over from the prior plan, you will receive credit for time served.

This is a brief summary of TransSmile®, Dental Insurance underwritten by Transamerica Life Insurance Company, Cedar Rapids, Iowa. Policy form series CPDEN100 and CCDEN100. Forms and form numbers may vary. This coverage may not be available in all jurisdictions. Limitations and exclusions apply. Refer to the policy, certificate and riders for complete details.

Choose any dentist! Routine, preventative services are available from the first day of coverage. Access to responsive, professional customer care personnel for assistance with claims questions. Use the extensive network of highly qualified providers to enjoy significant savings on out of pocket costs associated with dental services. Automated claims processing results in an average turnaround time of less than four days!

### Type 1 - Diagnostic and Preventative Services

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

### Type 2 - Basic Restorative Services

- Minor emergency treatment for the relief of pain as needed by the Participant.
- Amalgam (silver) and composite/resin (white) fillings (composites are not a covered benefit on molars).
- Periapical X-rays four in any 12 consecutive month period.
- Full-mouth X-rays once in any five year period.
- Simple Extractions

### Type 3 - Major Restorative Services

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

### *Limitations & Exclusions for TransSmile®: Group Dental Insurance* underwritten by Transamerica Life Insurance Company

Covered Dental Expenses do not include, and no benefits are provided, for the following:

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

# Vision Insurance

Benefit Frequency			
EXAMINATION	SPECTACLE LENSES	FRAME	CONTACT LENSES
12 months	12 months	24 months	12 months

Schedule of Benefits		
	IN NETWORK	OUT-OF-NETWORK
<b>EYE EXAMINATION</b>	Covered in full*	Reimbursed up to \$35.00
<b>SPECTACLE LENSES</b>		
Standard Single Vision	Covered in full*	Reimbursed up to \$25.00
Standard Bifocal	Covered in full*	Reimbursed up to \$40.00
Standard Trifocal	Covered in full*	Reimbursed up to \$50.00
Standard Lenticular	Covered in full*	Reimbursed up to \$80.00
Progressive	20% off U & C, plus a \$50 allowance	Reimbursed up to \$40.00
<b>SPECIALTY LENSES</b>	20% off U&C, minus the corresponding standard lens plan payment	Corresponding standard lens reimbursement
<b>LENS OPTIONS</b>	Preferred Pricing (20% off retail)	Reimbursed up to \$0.00
<b>FRAME</b>	\$35 wholesale allowance (approximate \$75 - \$100 retail value) Frames from participating Wal-Mart locations are covered up to a \$52 retail value.	Reimbursed up to \$45.00
<b>CONTACT LENSES</b>		
In lieu of frame and spectacle lenses		
Elective	\$110 allowance after an Avesis preferred discount	Reimbursed up to \$110.00
Medically Necessary	Covered in full	Reimbursed up to \$250.00
<b>LASIK</b>		
In lieu of all other services for the benefit year	\$100 onetime/lifetime refractive surgery allowance	\$100 onetime/lifetime refractive surgery allowance

Co-pays*	
Exam Co-pay	\$10.00
Materials Co-pay	\$10.00

Co-pays do not apply for contact lenses or out-of-network reimbursement.

# Plan Information

## OUT-OF-NETWORK

Avesis offers its members a better value when using its network of providers. However, Avesis offers reimbursement for out-of-network examinations, spectacle lenses (pair) and frame or contact lenses. Reimbursement is not available for cosmetic options such as tints, scratch coating, UV protection, etc. Members who elect to use an out-of-network provider must pay the provider in full at the time of service and submit a claim to Avesis for reimbursement. Reimbursement is made in accordance with the proposed out-of-network reimbursement schedule.

Out-of-network claim forms can be obtained by contacting Avesis' Customer Service Center, or by contacting the Group's Administrator or by visiting [www.avesis.com](http://www.avesis.com) for a downloadable version.

Co-payments are not applicable to out-of-network reimbursements. Out-of-network benefits are subject to the same eligibility, availability, frequency of benefits, limitation and exclusion provisions of the plan; and are in lieu of services provided by a participating Avesis provider.

### Members Find Our Plans Easy to Use

- To find a vision care provider, simply visit [www.avesis.com](http://www.avesis.com) or call Avesis' Customer Service Department at 1-800-828-9341 to choose from a list of over 32,000 providers.
- Schedule an appointment.
- Present ID card at the office visit; pay any applicable co-pays and any expenses not covered by the plan.

## LIMITATIONS AND EXCLUSIONS

The managed vision plan is designed to cover eye examinations and corrective eyewear. It is also designed to cover visual needs rather than cosmetic options. Should the member select options that are not covered under the plan, as shown in the schedule of benefits, the member will pay a discounted fee to the Avesis participating provider. Benefits are payable only for expenses incurred while the group and individual member's coverage is in force.

There are no benefits under the vision plan for professional services or materials connected with and arising from:

- Orthoptics or vision training;
- Subnormal vision aids and any associated supplemental testing;
- Plano (non-prescription) lenses or Plano sunglasses;
- Two pair of glasses in lieu of bifocals and blended lenses;
- Any medical or surgical treatment of the eyes or supporting structures;
- Replacement of lost or broken lenses, contact lenses or frames, except when the member is normally eligible for services;
- Any eye examination or corrective eyewear required by an employer as a condition of employment;
- Services or materials provided as a result of any Worker's Compensation Law, or similar legislation, required by any governmental agency whether federal, state or subdivision thereof.
- Some provisions, benefits, exclusions or limitations listed herein may vary depending on your state of residence.

Employees enrolling in the voluntary plan must agree to remain enrolled during the designated plan period.

Employees who elect not to enroll during the initial plan enrollment period must wait until the next plan enrollment period to enroll.



# FREQUENTLY ASKED QUESTIONS

## When am I eligible for the MEC (New Hire Plan)?

You are eligible to enroll in this plan from your date of hire. Your first deduction for this plan will take place when you are placed on your first assignment.

## When am I eligible for the MVP (Loyalty Plan)?

If over a 12 month measurement period you average a minimum of 30 hours of service per week, you will be eligible for this plan. Please see Branch Representative for more information.

## How Are Premium Payments Made?

Premiums will be taken through payroll deduction. If you miss a payroll deduction as a result of absence or lack of work, you will need to make up that premium with a direct payment to KBA. Employees will receive a reminder notice after their third cumulative week of unpaid premium. A letter will outline the terminations provisions and state that reinstatement is at the option of the carrier and is not guaranteed. Employees will be terminated for non-payment after missing a cumulative total of five payroll periods. KBA will provide a written termination notice to employees at that time. Reinstatement will require full repayment of outstanding premium and must be approved by the carrier.

## When Will My Insurance End?

Your insurance will end when you no longer qualify or when your premium payments end, whichever comes first. Insurance on dependents ends on either the date they no longer meet the definition of a dependent or, the date your insurance terminates, whichever comes first.

## What Is An Indemnity Benefit?

It means that the insurance company will pay a set amount each time the insured receives a covered service. The same amount is paid regardless of the fees charged by the provider.

## Is my doctor in the network?

To check if your provider is in the network, go to [www.multiplan.com](http://www.multiplan.com) or speak to a representative at 1-866-680-7427.

## Can I Sign Up For Insurance At Any Time?

No. You must sign up for insurance in the first 30 days of becoming eligible. If you do not elect to enroll in the first 30 days, you will not be able to enroll until the next open enrollment period unless you experience a qualifying event.

## Can I Cancel Insurance At Any Time?

Premiums are paid with pre-tax dollars through payroll deductions as part of a Section 125 Savings Plan. You will not be able to change these elections until the next annual enrollment period, unless you have a Qualifying Event.

## When can I expect to receive the Member Kit?

The member kit will typically be mailed to you approximately 7-10 business days after your first payroll deduction. Please allow three weeks for this kit to arrive in your mailbox.

## What if I do not enroll?

Group health benefits have been offered to you through an open enrollment. If you do not affirmatively elect benefits during this open enrollment, you will be unable to elect such insurance until the next open enrollment period unless you experience a change in status that entitles you to a special enrollment period.

## Does enrollment in these plans impact my ability to enroll and receive subsidized coverage from [Healthcare.gov](http://Healthcare.gov) or other public marketplaces?

There is no impact on your eligibility to enroll in a plan from the public marketplace(s) and, if you qualify, receive a subsidy.