ATTACHMENT H

METLIFE 100% VOLUNTARY VISION

Coverage	Descr	Rate	Calc Basis
BSCL	Elected Officia	0.161	Per $1000 Benefits
BSCL	Employees	0.161	Per $1000 Benefits
PADD	Elected Officia	0.015	Per $1000 Benefits
PADD	Employees	0.015	Per $1000 Benefits
BSCL	All Retirees	2.199	Per $1000 Benefits

Coverage	Descr	Rate	Calc Basis
OPTL	OPTL/OADD <24	0.123	Per $1000 Benefits
OPTL	OPTL/OADD 25-29	0.127	Per $1000 Benefits
OPTL	OPTL/OADD 30-34	0.144	Per $1000 Benefits
OPTL	OPTL/OADD 35-39	0.158	Per $1000 Benefits
OPTL	OPTL/OADD 40-44	0.171	Per $1000 Benefits
OPTL	OPTL/OADD 45-49	0.24	Per $1000 Benefits
OPTL	OPTL/OADD 50-54	0.349	Per $1000 Benefits
OPTL	OPTL/OADD 55-59	0.642	Per $1000 Benefits
OPTL	OPTL/OADD 60-64	0.897	Per $1000 Benefits
OPTL	OPTL/OADD 65-69	1.79	Per $1000 Benefits
OPTL	OPTL/OADD 70+	2.848	Per $1000 Benefits
DEPL	DEPL/DADD <25	0.157	Per $1000 Benefits
DEPL	DEPL/DADD 25-29	0.163	Per $1000 Benefits
DEPL	DEPL/DADD 30-34	0.189	Per $1000 Benefits
DEPL	DEPL/DADD 35-39	0.211	Per $1000 Benefits
DEPL	DEPL/DADD 40-44	0.232	Per $1000 Benefits
DEPL	DEPL/DADD 45-49	0.336	Per $1000 Benefits
DEPL	DEPL/DADD 50-54	0.502	Per $1000 Benefits
DEPL	DEPL/DADD 55-59	0.92	Per $1000 Benefits
DEPL	DEPL/DADD 60-64	1.34	Per $1000 Benefits
DEPL	DEPL/DADD 65-69	2.704	Per $1000 Benefits
DEPL	DEPL/DADD 70+	4.322	Per $1000 Benefits
DEPL	CHILD	0.188	Per $1000 Benefits

Coverage	Descr	Rate	Calc Basis	
CIVEEUNI	CIVEEEPRU\0-24	0.13	Per $1000 Benefits	Employee
CIVEEUNI	CIVEEEPRU\25-29	0.15	Per $1000 Benefits	
CIVEEUNI	CIVEEEPRU\30-34	0.25	Per $1000 Benefits	
CIVEEUNI	CIVEEEPRU\35-39	0.44	Per $1000 Benefits	
CIVEEUNI	CIVEEEPRU\40-44	0.78	Per $1000 Benefits	
CIVEEUNI	CIVEEEPRU\45-49	1.39	Per $1000 Benefits	
CIVEEUNI	CIVEEEPRU\50-54	2.25	Per $1000 Benefits	
CIVEEUNI	CIVEEEPRU\55-59	3.56	Per $1000 Benefits	
CIVEEUNI	CIVEEEPRU\60-64	5.46	Per $1000 Benefits	
CIVEEUNI	CIVEEEPRU\65-69	8.35	Per $1000 Benefits	
CIVEEUNI	CIVEEEPRU\70-74	12.06	Per $1000 Benefits	
CIVEEUNI	CIVEEEPRU\75-79	16.94	Per $1000 Benefits	
CIVEEUNI	CIVEEEPRU\80-84	21.14	Per $1000 Benefits	
CIVEEUNI	CIVEEEPRU\85 +	22.65	Per $1000 Benefits	
CIVEEUNI	CIVEESPRU\0-24	0.13	Per $1000 Benefits	Spouse
CIVEEUNI	CIVEESPRU\25-29	0.15	Per $1000 Benefits	
CIVEEUNI	CIVEESPRU\30-34	0.25	Per $1000 Benefits	
CIVEEUNI	CIVEESPRU\35-39	0.44	Per $1000 Benefits	
CIVEEUNI	CIVEESPRU\40-44	0.78	Per $1000 Benefits	
CIVEEUNI	CIVEESPRU\45-49	1.37	Per $1000 Benefits	
CIVEEUNI	CIVEESPRU\50-54	2.19	Per $1000 Benefits	
CIVEEUNI	CIVEESPRU\55-59	3.38	Per $1000 Benefits	
CIVEEUNI	CIVEESPRU\60-64	5.08	Per $1000 Benefits	
CIVEEUNI	CIVEESPRU\65-69	7.66	Per $1000 Benefits	
CIVEEUNI	CIVEESPRU\70-74	11.14	Per $1000 Benefits	
CIVEEUNI	CIVEESPRU\75-79	15.91	Per $1000 Benefits	
CIVEEUNI	CIVEESPRU\80-84	20.09	Per $1000 Benefits	
CIVEEUNI	CIVEESPRU\85 +	21.64	Per $1000 Benefits	
CIVEEUNI	D	0.05	Per $1000 Benefits	Child

Coverage	Descr	Rate
VDVISION	EE ONLY	5.1
VDVISION	EE + SPOUSE	9.68
VDVISION	EE + CHILD(REN)	10.15
VDVISION	EE + FAMILY	15.62

Date	Total Lives	Total Premium
1/1/2024	3,951	$32,484.59
2/1/2024	3,950	$32,489.54
3/1/2024	3,951	$32,419.94
4/1/2024	3,937	$32,429.07
5/1/2024	3,958	$32,426.09
6/1/2024	3,963	$32,191.30
7/1/2024	3,981	$32,088.51
8/1/2024	3,986	$32,162.40
9/1/2024	3,947	$32,602.58
10/1/2024	3,943	$32,558.01
11/1/2024	3,920	$32,230.58
12/1/2024	3,920	$32,076.19
Grand Total	**3,951**	**$388,158.80**

Date	Total Lives	Total Premium
1/1/2025	3,999	$32,729.65
2/1/2025	3,992	$32,673.29
Grand Total	**3,996**	**$65,402.94**

MetLife

Versant Claim Trend Summary Report

Report Cover Page

Customer Number - Name: 0143258 - City of Baton Rouge/Parish of East Baton Rouge

Reporting Period: From Jan 1, 2024 To Dec 31, 2024

MetLife

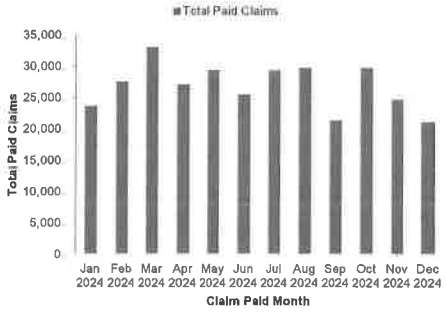
Versant Claim Trend Summary Report

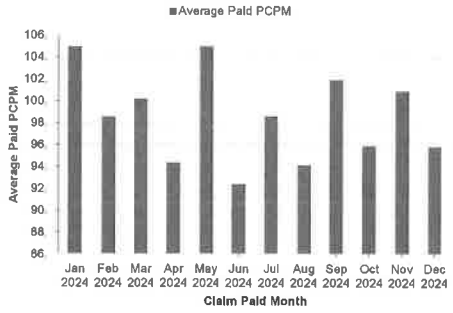
Paid Claim Period: From Jan 1, 2024 To Dec 31, 2024

Customer Number - Name: 0143258 - City of Baton Rouge/Parish of East Baton Rouge

Report Number: 0245061

Claim Paid Month	Number of Claims	Total Paid Claims	Average Paid PCPM
Jan 2024	226	$23,711.26	$104.92
Feb 2024	279	$27,501.88	$98.57
Mar 2024	330	$33,050.02	$100.15
Apr 2024	287	$27,072.11	$94.33
May 2024	280	$29,406.13	$105.02
Jun 2024	276	$25,487.21	$92.34
Jul 2024	299	$29,471.00	$98.57
Aug 2024	317	$29,824.21	$94.08
Sep 2024	209	$21,308.55	$101.95
Oct 2024	311	$29,824.38	$95.90
Nov 2024	245	$24,728.08	$100.93
Dec 2024	221	$21,181.38	$95.84
Summary	3,280	$322,566.21	$98.34





MetLife

Versant Claim Trend Summary Report

Report Cover Page

Customer Number - Name: 0143258 - City of Baton Rouge/Parish of East Baton Rouge

Reporting Period: From Jan 1, 2025 To Feb 28, 2025

MetLife

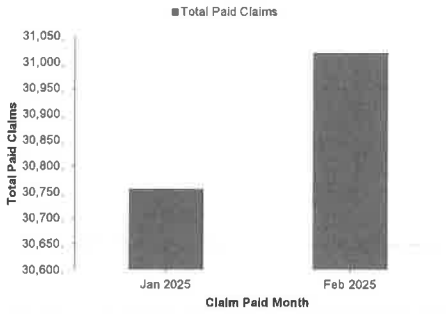
Versant Claim Trend Summary Report

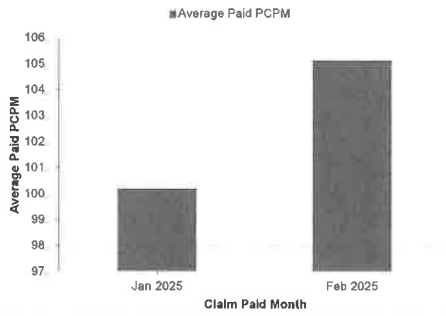
Paid Claim Period: From Jan 1, 2025 To Feb 28, 2025

Customer Number - Name: 0143258 - City of Baton Rouge/Parish of East Baton Rouge

Report Number: 0245061

Claim Paid Month	Number of Claims	Total Paid Claims	Average Paid PCPM
Jan 2025	307	$30,755.28	$100.18
Feb 2025	295	$31,018.49	$105.15
Summary	602	$61,773.77	$102.61





YOUR BENEFIT PLAN

City of Baton Rouge/Parish of East Baton Rouge

All Full-Time and Part-Time Employees

Vision Insurance for You and Your Dependents

Certificate Date: September 1, 2023

Certificate Number 11

City of Baton Rouge/Parish of East Baton Rouge
1755 Florida Blvd
Baton Rouge, LA 70802

TO OUR EMPLOYEES:

All of us appreciate the protection and security insurance provides.

This certificate describes the benefits that are available to you. We urge you to read it carefully.

City of Baton Rouge/Parish of East Baton Rouge

Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10166

CERTIFICATE OF INSURANCE

Metropolitan Life Insurance Company ("MetLife"), a stock company, certifies that You and Your Dependents are insured for the benefits described in this certificate, subject to the provisions of this certificate. This certificate is issued to You under the Group Policy and it includes the terms and provisions of the Group Policy that describe Your insurance. **PLEASE READ THIS CERTIFICATE CAREFULLY.**

This certificate is part of the Group Policy. The Group Policy is a legal contract between MetLife and the Policyholder and may be changed or ended without Your consent or notice to You.

Policyholder:	City of Baton Rouge/Parish of East Baton Rouge
Group Policy Number:	143258-1-G
Type of Insurance:	Vision Insurance
MetLife Toll Free Number(s): For Claim Information	FOR VISION CLAIMS: 1-833-EYE-LIFE (1-833-393-5433)

THIS CERTIFICATE ONLY DESCRIBES VISION INSURANCE.

FOR CALIFORNIA RESIDENTS: REVIEW THIS CERTIFICATE CAREFULLY. IF YOU ARE 65 OR OLDER ON YOUR EFFECTIVE DATE OF THIS CERTIFICATE, YOU MAY RETURN IT TO US WITHIN 30 DAYS FROM THE DATE YOU RECEIVE IT AND WE WILL REFUND ANY PREMIUM YOU PAID. IN THIS CASE, THIS CERTIFICATE WILL BE CONSIDERED TO NEVER HAVE BEEN ISSUED.

THE BENEFITS OF THE POLICY PROVIDING YOUR COVERAGE ARE GOVERNED PRIMARILY BY THE LAW OF A STATE OTHER THAN FLORIDA.

THE GROUP INSURANCE POLICY PROVIDING COVERAGE UNDER THIS CERTIFICATE WAS ISSUED IN A JURISDICTION OTHER THAN MARYLAND AND MAY NOT PROVIDE ALL THE BENEFITS REQUIRED BY MARYLAND LAW.

For Residents of North Dakota: If You are not satisfied with Your Certificate, You may return it to Us within 20 days after You receive it, unless a claim has previously been received by Us under Your Certificate. We will refund within 30 days of Our receipt of the returned Certificate any Premium that has been paid and the Certificate will then be considered to have never been issued. You should be aware that, if You elect to return the Certificate for a refund of premiums, losses which otherwise would have been covered under Your Certificate will not be covered.

For New Mexico Residents: This type of plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does NOT satisfy the individual mandate that You have health insurance coverage. If You do not have other health insurance coverage, You may be subject to a federal tax penalty.

For New Mexico Residents: If You are not satisfied with Your certificate for any reason, You may return it to Us within 30 days after You receive it, unless a claim has previously been received by Us under Your certificate. We will refund any premium that has been paid and the certificate will then be considered to have never been issued. You should be aware that, if You elect to return the certificate for a refund of premiums, losses which otherwise would have been covered under Your certificate will not be covered.

For New Hampshire Residents: 30 Day Right to Examine Certificate.
Please read this Certificate. You may return the Certificate to Us within 30 days from the date You receive it. If you return it within the 30 day period, the Certificate will be considered never to have been issued and We will refund any premium paid for insurance under this Certificate.

WE ARE REQUIRED BY STATE LAW TO INCLUDE THE NOTICE(S) WHICH APPEAR ON THIS PAGE AND IN THE NOTICE(S) SECTION WHICH FOLLOWS THIS PAGE. PLEASE READ THE(SE) NOTICE(S) CAREFULLY.

NOTICE FOR RESIDENTS OF TEXAS

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Metropolitan Life Insurance Company

To get information or file a complaint with your insurance company or HMO:

Call: Corporate Consumer Relations Department at 1-800-438-6388

Toll-free: 1-800-438-6388

Email: RTQA@versanthealth.com

Mail: Davis Vision
Attention: Complaints and Appeals
P.O. Box 791
Latham, NY 12110

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Metropolitan Life Insurance Company

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Departamento de Relaciones Corporativas del Consumidor al 1-800-438-6388

Teléfono gratuito: 1-800-438-6388

Correo electrónico: RTQA@versanthealth.com

Dirección postal: Davis Vision
Attention: Complaints and Appeals
P.O. Box 791
Latham, NY 12110

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

NOTICE FOR RESIDENTS OF ALASKA, CONNECTICUT, MINNESOTA, NEW HAMPSHIRE, NEW MEXICO, TEXAS, UTAH AND WASHINGTON

The Definition Of Child Is Modified For The Coverages Listed Below:

For Alaska Residents (Vision Insurance):

The term also includes newborns.

For Connecticut Residents (Vision Insurance):

The age limit for children will not be less than 26, regardless of the child's marital status, student status or full-time employment status. Your natural child, adopted child or stepchild under age 26 will not need to be supported by You to qualify as a Child under this insurance.

A Child's insurance will not end due to age until the end of the Year in which that Child attains age 26.

For Minnesota Residents (Vision Insurance):

The term also includes:

- Your grandchildren who are financially dependent upon You and reside with You continuously from birth;
- children for whom You or Your Spouse is the legally appointed guardian; and
- children for whom You have initiated an application for adoption.

The age limit for children and grandchildren will not be less than 25 regardless of the child's or grandchild's student status or full-time employment status. Your natural child, adopted child stepchild or children for whom You or Your Spouse is the legally appointed guardian under age 25 will not need to be supported by You to qualify as a Child under this insurance.

For New Hampshire Residents (Vision Insurance):

The age limit for children will not be less than 26, regardless of the child's marital status, student status or full-time employment status. Your natural child, adopted child or stepchild under age 26 will not need to be supported by You to qualify as a Child under this insurance.

For New Mexico Residents (Vision Insurance):

The age limit for children will not be less than 26, regardless of the child's student status or full-time employment status. Your natural child, adopted child or stepchild will not be denied vision insurance coverage under this certificate because:

- that child was born out of wedlock;
- that child is not claimed as Your dependent on Your federal income tax return; or
- that child does not reside with You.

For Texas Residents (Vision Insurance):

The term also includes Your grandchildren. The age limit for children and grandchildren will not be less than 25, regardless of the child's or grandchild's student status, full-time employment status or military service status. Your natural child, adopted child or stepchild under age 25 will not need to be supported by You to qualify as a Child under this insurance. In addition, grandchildren must be able to be claimed by You as a dependent for Federal Income Tax purposes at the time You applied for Insurance.

For Utah Residents (Vision Insurance):

The age limit for children will not be less than 26, regardless of the child's student status or full-time employment status. Your natural child, adopted child or stepchild under age 26 will not need to be supported by You to qualify as a Child under this insurance. The term includes an unmarried child who is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law and who has been continuously covered under a Vision plan since reaching age 26, with no break in coverage of more

NOTICE FOR RESIDENTS OF ALASKA, CONNECTICUT, MINNESOTA, NEW HAMPSHIRE, NEW MEXICO, TEXAS, UTAH AND WASHINGTON (continued)

than 63 days, and who otherwise qualifies as a Child except for the age limit. Proof of such handicap must be sent to Us within 31 days after:

- the date the Child attains the limiting age in order to continue coverage; or
- You enroll a Child to be covered under this provision;

and at reasonable intervals after such date, but no more often than annually after the two-year period immediately following the date the Child qualifies for coverage under this provision.

For Washington Residents (Vision Insurance):

The age limit for children will not be less than 26, regardless of the child's marital status, student status, or full-time employment status. Your natural child, adopted child or stepchild under age 26 will not need to be supported by You to qualify as a Child under this insurance.

NOTICE FOR RESIDENTS OF ALL STATES WHO ARE INSURED FOR VISION INSURANCE

Notice Regarding Your Rights and Responsibilities

Rights:

- We will treat communications, financial records and records pertaining to Your care in accordance with all applicable laws relating to privacy.
- Decisions with respect to vision treatment are the responsibility of You and the Vision Provider. We neither require nor prohibit any specified treatment. However, only certain specified services are covered for benefits. Please see the Vision Insurance sections of this certificate for more details.
- You may request a written response from MetLife to any written concern or complaint.

Responsibilities:

- You are responsible for the prompt payment of any charges for services performed by the Vision Provider not fully covered by your Vision Insurance.
- You should consult with the Vision Provider about treatment options, proposed and potential procedures, anticipated outcomes, potential risks, anticipated benefits and alternatives. You should share with the Vision Provider the most current, complete and accurate information about Your medical and vision history and current conditions and medications.
- You should follow the treatment plans and health care recommendations agreed upon by You and the Vision Provider.

NOTICE FOR RESIDENTS OF ARKANSAS

If You have a question concerning Your coverage or a claim, first contact the Policyholder or group account administrator. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page.

Policyholders have the right to file a complaint with the Arkansas Insurance Department (AID). You may call AID to request a complaint form at (800) 852-5494 or (501) 371-2640 or write the Department at:

Arkansas Insurance Department
Consumer Services Division
1 Commerce Way, Suite 102
Little Rock, Arkansas 72202

NOTICE FOR RESIDENTS OF CALIFORNIA

IMPORTANT NOTICE

TO OBTAIN ADDITIONAL INFORMATION, OR TO MAKE A COMPLAINT, CONTACT THE POLICYHOLDER OR METLIFE AT:

DAVIS VISION
ATTENTION: COMPLAINTS AND APPEALS
P.O. BOX 791
LATHAM, NY 12110

1-800-438-6388

IF, AFTER CONTACTING THE POLICYHOLDER AND/OR METLIFE, YOU FEEL THAT A SATISFACTORY SOLUTION HAS NOT BEEN REACHED, YOU MAY FILE A COMPLAINT WITH THE CALIFORNIA DEPARTMENT OF INSURANCE DEPARTMENT AT:

DEPARTMENT OF INSURANCE
CONSUMER SERVICES
300 SOUTH SPRING STREET
LOS ANGELES, CA 90013

WEBSITE: http://www.insurance.ca.gov/

1-800-927-4357 (within California)
1-213-897-8921 (outside California)

NOTICE FOR RESIDENTS OF THE STATE OF CALIFORNIA

California law provides that for vision insurance, domestic partners of California's residents must be treated the same as spouses. If the certificate does not already have a definition of domestic partner, then the following definition applies:

> **"Domestic Partner** means each of two people, one of whom is an employee of the Policyholder, a resident of California and who have registered as domestic partners or members of a civil union with the California government or another government recognized by California as having similar requirements."

If the certificate already has a definition of domestic partner, that definition will apply to California residents, as long as it recognizes as a domestic partner any person registered as the employee's domestic partner with the California government or another government recognized by California as having similar requirements.

Wherever the term **"Spouse"** appears in this certificate it shall, unless otherwise specified, be read to include Your Domestic Partner.

Wherever the term step-child appears, it is replaced by step-child or child of Your Domestic Partner.

NOTICE FOR RESIDENTS OF GEORGIA

IMPORTANT NOTICE

The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

NOTICE FOR RESIDENTS OF IDAHO

If You have a question concerning Your coverage or a claim, first contact the Policyholder. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page.

If You are still concerned after contacting both the Policyholder and MetLife, You should feel free to contact:

Idaho Department of Insurance
Consumer Affairs
700 West State Street, 3rd Floor
PO Box 83720
Boise, Idaho 83720-0043
1-800-721-3272 (for calls placed within Idaho) or 208-334-4250 or www.DOI.Idaho.gov

NOTICE FOR RESIDENTS OF ILLINOIS

IMPORTANT NOTICE

To make a complaint to MetLife, You may write to:

Davis Vision
Attention: Complaints and Appeals
P.O. Box 791
Latham, NY 12110

The address of the Illinois Department of Insurance is:

Illinois Department of Insurance
Public Services Division
Springfield, Illinois 62767

NOTICE FOR RESIDENTS OF INDIANA

Questions regarding your policy or coverage should be directed to:

Metropolitan Life Insurance Company
1-833-EYE-LIFE (1-833-393-5433)

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

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

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

Complaint can be filed electronically at www.in.gov/idoi

NOTICE FOR RESIDENTS OF MAINE

You have the right to designate a third party to receive notice if Your insurance is in danger of lapsing due to a default on Your part, such as for nonpayment of a contribution that is due. The intent is to allow reinstatements where the default is due to the insured person's suffering from cognitive impairment or functional incapacity. You may make this designation by completing a "Third-Party Notice Request Form" and sending it to MetLife. Once You have made a designation, You may cancel or change it by filling out a new Third-Party Notice Request Form and sending it to MetLife. The designation will be effective as of the date MetLife receives the form. Call MetLife at the toll-free telephone number shown on the face page of this certificate to obtain a Third-Party Notice Request Form. Within 90 days after cancellation of coverage for nonpayment of premium, You, any person authorized to act on Your behalf , or any covered Dependent may request reinstatement of the certificate on the basis that You suffered from cognitive impairment or functional incapacity at the time of cancellation.

NOTICE FOR MASSACHUSETTS RESIDENTS

CONTINUATION OF VISION INSURANCE

1. If Your Vision Insurance ends due to a Plant Closing or Covered Partial Closing, such insurance will be continued for 90 days after the date it ends.

2. If Your Vision Insurance ends because:

    - You cease to be in an Eligible Class; or
    - Your employment terminates;

for any reason other than a Plant Closing or Covered Partial Closing, such insurance will continue for 31 days after the date it ends.

Continuation of Your Vision Insurance under the CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT subsection will end before the end of continuation periods shown above if You become covered for similar benefits under another plan.

Plant Closing and **Covered Partial Closing** have the meaning set forth in Massachusetts Annotated Laws, Chapter 151A, Section 71A.

CONTINUATION OF VISION INSURANCE FOR YOUR FORMER SPOUSE

If the judgment of divorce dissolving Your marriage provides for continuation of insurance for Your former Spouse when You remarry, Vision Insurance for Your former Spouse that would otherwise end may be continued.

To continue Vision insurance under this provision:

1. You must make a written request to the employer to continue such insurance;
2. You must make any required premium to the employer for the cost of such insurance.

The request form will be furnished by the Employer.

Such insurance may be continued from the date Your marriage is dissolved until the earliest of the following:

- the date Your former Spouse remarries;
- the date of expiration of the period of time specified in the divorce judgment during which You are required to provide Vision Insurance for Your former Spouse;
- the date coverage is provided under any other group health plan;
- the date Your former Spouse becomes entitled to Medicare;
- the date Vision Insurance under the policy ends for all active employees, or for the class of active employees to which You belonged before Your employment terminated;
- the date of expiration of the last period for which the required premium payment was made; or
- the date such insurance would otherwise terminate under the policy.

If Your former Spouse is eligible to continue Vision Insurance under this provision and any other provision of this Policy, all such continuation periods will be deemed to run concurrently with each other and shall not be deemed to run consecutively.

NOTICE FOR RESIDENTS OF MISSISSIPPI

CLAIMS FOR VISION INSURANCE

Routine Questions on Vision Insurance Claims

If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-833-EYE-LIFE (1-833-393-5433).

Initial Determination

If Your claim for Vision Insurance benefits is a Clean Claim and it is approved, benefits will be paid within 25 days after We receive Proof in an electronic form of a covered loss, or within 35 days after receipt of Proof in paper form of a covered loss. Proof includes, but is not limited to, information essential for Us to administer coordination of benefits.

"Clean Claim" means a claim that:

- does not require further information, adjustment or alteration by You or the provider of the services in order to process and pay it;
- does not have any defects;
- does not have any impropriety, including any lack of supporting documentation; and
- does not involve a particular circumstance required special treatment that substantially prevents timely payments from being made on the claim.

A Clean Claim does not include a claim submitted by a provider more than 30 days after the date of service, or if the provider does not submit the claim on Your behalf, a claim submitted more than 30 days after the date the provider bills You. Errors, such as system errors, attributable to the insurer, do not change the clean claim status.

If We do not deny payment of such benefits to You by the end of the 25 day period for clean claims submitted in electronic form, or 35 day period for Clean Claims submitted in paper form, and such benefits remain due and payable to You, interest will accrue on the amount of such benefits at the rate of 3 percent per month until such benefits are finally settled. If We do not pay benefits to You when due and payable, You may bring action to recover such benefits, any interest which has accrued with respect to such benefits and any other damages which may be allowed by law. We will pay benefits when We receive satisfactory Proof of Your claim.

If We are unable to pay a claim for Vision Insurance benefits because additional information or documentation is required, or there is a particular circumstance requiring special treatment, within 25 days after the date We receive the claim if it is submitted in electronic form, or within 35 days after the date MetLife receives the claim if it is submitted in paper form, We will send You notice of what supporting documentation or information is needed. Any claim or portion of a claim for Vision Insurance benefits that is resubmitted with all of the supporting documentation requested in Our notice and becomes payable will be paid to You within 20 days after it is received.

NOTICE FOR RESIDENTS OF MISSISSIPPI

Claim Denial Appeals

If a claim is denied in whole or in part, under the terms of this certificate, a request may be submitted to Us by a Covered Person or a Covered Person's authorized representative for a full review of the denial. A Covered Person may designate any person, including their provider, as their authorized representative. References in this section to "Covered Person" include the Covered Person's authorized representative, where applicable.

Initial Appeal. All requests for review must be made within one hundred eighty (180) calendar days following denial of a claim. A Covered Person may review, during normal business hours, any documents used by Us pertinent to the denial. A Covered Person may also submit Written comments or supporting documentation concerning the claim to assist in Our review. Our response to the initial appeal, including specific reasons for the decision, shall be communicated to the Covered Person within thirty (30) calendar days after receipt of the request for the appeal.

Second Level Appeal. If a Covered Person disagrees with the response to the initial appeal of the denied claim, the Covered Person has the right to a second level appeal. A request for a second level appeal must be submitted to Us within sixty (60) calendar days after receipt of Our response to the initial appeal. We shall communicate Our final determination to the Covered Person within thirty (30) calendar days from receipt of the request, or as required by any applicable state or federal laws or regulations. Our communication to the Covered Person shall include the specific reasons for the determination.

Other Remedies. When a Covered Person has completed the appeals stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Additional information is available from the U.S. Department of Labor or the insurance regulatory agency for the Covered Persons' state of residency. Additionally, under the provisions of ERISA (Section 502(a)(1)(B) 29 U.S.C. 1132(a)(1)(B)), the Covered Person has the right to bring a civil action when all available levels of reviews, including the appeal process, have been completed. ERISA remedies may apply in those instances where the claims were not approved in whole or in part as the result of appeals under this Policy and the Covered Person disagrees with the outcome of such appeals.

Time of Action. No action in law or in equity shall be brought to recover on this Policy prior to the Covered Person exhausting his/her rights under this Policy and/or prior to the expiration of sixty (60) calendar days after the claim and any applicable documentation has been filed with Us. No such action shall be brought after the expiration of any applicable statute of limitations, in accordance with the terms of this Policy. No such action shall be brought after the expiration of three (3) years from the last date that the claim and any applicable invoices were submitted to Us, and no such action shall be brought at all unless brought within three (3) years from the expiration of the time within which such materials are required to be submitted in accordance with the terms of this Policy. If it is determined in such action that We acted in bad faith as evidenced by a repeated or deliberate pattern of failing to pay benefits and/or claims when due, You (or the provider, if You assigned the benefits to the provider) shall be entitled to recover any interest which may accrue plus damages in an amount up to three (3) times the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated.

Insurance Fraud: Any Covered Person who intends to defraud, knowingly facilitates a fraud, submits a claim containing false or deceptive information, or who commits any other similar act as defined by applicable state or federal law, is guilty of insurance fraud. Such an act is grounds for immediate termination of the coverage under this Policy of the Covered Person committing such fraud.

NOTICE FOR NEW HAMPSHIRE RESIDENTS

CONTINUATION OF YOUR VISION INSURANCE

If You are a resident of New Hampshire, Your Vision Insurance may be continued if it ends because Your employment ends unless:

- Your employment ends due to Your gross misconduct;
- this Vision Insurance ends for all employees;
- this Vision Insurance is changed to end Vision Insurance for the class of employees to which You belong;
- You are entitled to enroll in Medicare; or
- Your Vision Insurance ends because You failed to pay the required premium.

The Employer must give You written notice of:

- Your right to continue Your Vision Insurance;
- the amount of premium payment that is required to continue Your Vision Insurance;
- the manner in which You must request to continue Your Vision Insurance and pay premiums; and
- the date by which premium payments will be due.

The premium that You must pay for Your continued Vision Insurance may include:

- any amount that You contributed for Your Vision Insurance before it ended;
- any amount the Employer paid; and
- an administrative charge which will not to exceed two percent of the rest of the premium.

To continue Your Vision Insurance, You must:

- send a written request to continue Your Vision Insurance; and
- pay the first premium within 30 days after the date Your employment ends.

The maximum continuation period will be the longest of:

- 36 months if Your employment ends because You retire, and within 12 months of retirement You have a substantial loss of coverage because the employer files for bankruptcy protection under Title 11 of the United States Code;
- 29 months if You become entitled to disability benefits under Social Security within 60 days of the date Your Employment ends; or
- 18 months.

Your continued Vision Insurance will end on the earliest of the following to occur:

- the end of the maximum continuation period;
- the date this Vision Insurance ends;
- the date this Vision Insurance is changed to end Vision Insurance for the class of employees to which You belong;
- the date You are entitled to enroll for Medicare;
- if You do not pay the required premium to continue Your Vision Insurance; or
- the date You become eligible for coverage under any other group Vision coverage.

NOTICE FOR NEW HAMPSHIRE RESIDENTS (continued)

CONTINUATION OF YOUR DEPENDENT'S VISION INSURANCE

If You are a resident of New Hampshire, Your Vision Insurance for Your Dependents may be continued if it ends because Your employment ends, Your marriage ends in divorce or separation, or You die, unless:

- Your employment ends due to Your gross misconduct;
- this Vision Insurance ends for all Dependents;
- this Vision Insurance is changed, for the class of employees to which You belong, to end Vision Insurance for Dependents;
- the Dependent is entitled to enroll in Medicare; or
- Your Vision Insurance for Your Dependents ends because You fail to pay a required premium.

If Vision Insurance for Your Dependents ends because Your marriage ends in divorce or separation, the party responsible under the divorce decree or separation agreement for payment of premium for continued Vision Insurance must notify the employer, in writing, within 30 days of the date of the divorce decree or separation agreement that the divorce or separation has occurred. If You and Your divorced or separated Spouse share responsibility for payment of the premium for continued Vision Insurance, both You and Your divorced or separated Spouse must provide the notification.

The Employer must give You, or Your former Spouse if You have died or Your marriage has ended, written notice of:

- Your right to continue Your Vision Insurance for Your Dependents;
- the amount of premium payment that is required to continue Your Vision Insurance for Your Dependents;
- the manner in which You or Your former Spouse must request to continue Your Vision Insurance for Your Dependents and pay premiums; and
- the date by which premium payments will be due.

The premium that You or Your former Spouse must pay for continued Vision Insurance for Your Dependents may include:

- any amount that You contributed for Your Vision Insurance before it ended; and
- any amount the Employer paid.

To continue Vision Insurance for Your Dependents, You or Your former Spouse must:

- send a written request to continue Vision Insurance for Your Dependents; and
- must pay the first premium within 30 days of the date Vision Insurance for Your Dependents ends.

If You, and Your former Spouse, if applicable, fail to provide any required notification, or fail to request to continue Vision Insurance for Your Dependents and pay the first premium within the time limits stated in this section, Your right to continue Vision Insurance for Your Dependents will end.

NOTICE FOR NEW HAMPSHIRE RESIDENTS (continued)

CONTINUATION OF YOUR DEPENDENT'S VISION INSURANCE (Continued)

The maximum continuation period will be the longest of the following that applies:

- 36 months if Vision Insurance for Your Dependents ends because Your marriage ends in divorce or separation, except that with respect to a Spouse who is age 55 or older when your marriage ends in divorce or separation the maximum continuation period will end when the divorced or separated Spouse becomes eligible for Medicare or eligible for participation in another employer's group plan;
- 36 months if Vision Insurance for Your Dependents ends because You die, except that with respect to a Spouse who is age 55 or older when You die, the maximum continuation period will end when Your surviving Spouse becomes eligible for Medicare or eligible for participation in another employer's group vision coverage;
- 36 months if Vision Insurance for Your Dependents ends because You become entitled to benefits under Title XVIII of Social Security, except that with respect to a Spouse who is age 55 or older when You become entitled to benefits under Title XVIII of Social Security, the maximum continuation period will end when the divorced or separated Spouse becomes eligible for Medicare or eligible for participation in another employer's group vision coverage;
- 36 months if You become entitled to benefits under Title XVIII of Social Security while You are already receiving continued benefits under this section, except that with respect to a Spouse who is age 55 or older when You first become entitled to continue Your Vision Insurance the maximum continuation period will end when the divorced or separated Spouse becomes eligible for Medicare or eligible for participation in another employer's group vision coverage;
- 36 months with respect to a Dependent Child if Vision Insurance ends because the Child ceases to be a Dependent Child;
- 36 months if Your employment ends because You retire, and within 12 months of retirement You have a substantial loss of coverage because the employer files for bankruptcy protection under Title 11 of the United States Code;
- 29 months if Vision Insurance for Your Dependents ends because Your employment ends, and within 60 days of the date Your employment ends you become entitled to disability benefits under Social Security; or
- 18 months if Vision Insurance for Your Dependents ends because Your employment ends.

A Dependent's continued Vision Insurance will end on the earliest of the following to occur:

- the end of the maximum continuation period;
- the date this Vision Insurance ends;
- the date this Vision Insurance is changed to end Vision Insurance for Dependents for the class of employees to which You belong;
- the date the Dependent becomes entitled to enroll for Medicare;
- if You do not pay a required premium to continue Vision Insurance for Your Dependents; or
- the date the Dependent becomes eligible for coverage under any other group vision coverage.

NOTICE FOR RESIDENTS OF NEW MEXICO

Consumer Complaint Notice

If You are a resident of New Mexico, Your coverage will be administered in accordance with the minimum applicable standards of New Mexico law. If You have concerns regarding a claim, premium, or other matters relating to this coverage, You may file a complaint with the New Mexico Office of Superintendent of Insurance (OSI) using the complaint form available on the OSI website and found at: https://www.osi.state.nm.us/ConsumerAssistance/index.aspx.

NOTICE FOR RESIDENTS OF PENNSYLVANIA

Vision Insurance for a Dependent Child may be continued past the age limit if that Child is a full-time student and insurance ends due to the Child being ordered to active duty (other than active duty for training) for 30 or more consecutive days as a member of the Pennsylvania National Guard or a Reserve Component of the Armed Forces of the United States.

Insurance will continue if such Child:

- re-enrolls as a full-time student at an accredited school, college or university that is licensed in the jurisdiction where it is located;
- re-enrolls for the first term or semester, beginning 60 or more days from the child's release from active duty;
- continues to qualify as a Child, except for the age limit; and
- submits the required Proof of the child's active duty in the National Guard or a Reserve Component of the United States Armed Forces.

Subject to the Date Insurance For Your Dependents Ends subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS, this continuation will continue until the earliest of the date:

- the insurance has been continued for a period of time equal to the duration of the child's service on active duty; or
- the child is no longer a full-time student.

NOTICE FOR RESIDENTS OF TEXAS

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

NOTICE FOR RESIDENTS OF TEXAS

If You are a resident of Texas and live in a county where there is no In-Network Vision Provider and travel distance to an In-Network Dentist is more than 90 minutes travel time and 75 miles away, We will pay benefits for Covered Services provided by an Out-of-Network Vision Provider as if the service was provided by an In-Network Vision Provider. In order to ensure that the benefits are paid accordingly, We must be notified prior to receiving services from an Out-of-Network Vision Provider. Please call Us at 1-833-EYE-LIFE (1-833-393-5433) for assistance.

If You or a Dependent receive emergency or urgent vision care from an Out-of-Network Vision Provider, We will pay benefits for those Covered Services provided by an Out-of-Network Vision Provider as if the services were provided by an In-Network Vision Provider.

VISION INSURANCE: PROCEDURES FOR VISION CLAIMS

NOTICE FOR RESIDENTS OF TEXAS

If You reside in Texas, note the following Procedures for Vision Claims will be followed:

Routine Questions on Vision Insurance Claims

If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-833-EYE-LIFE (1-833-393-5433).

Claim Denial Appeals

If a claim is denied in whole or in part, under the terms of this certificate, a request may be submitted to Us by a Covered Person or a Covered Person's authorized representative for a full review of the denial. A Covered Person may designate any person, including their provider, as their authorized representative. References in this section to "Covered Person" include the Covered Person's authorized representative, where applicable.

Initial Appeal. All requests for review must be made within one hundred eighty (180) calendar days following denial of a claim. A Covered Person may review, during normal business hours, any documents used by Us pertinent to the denial. A Covered Person may also submit Written comments or supporting documentation concerning the claim to assist in Our review. Our response to the initial appeal, including specific reasons for the decision, shall be communicated to the Covered Person within thirty (30) calendar days after receipt of the request for the appeal.

Second Level Appeal. If a Covered Person disagrees with the response to the initial appeal of the denied claim, the Covered Person has the right to a second level appeal. A request for a second level appeal must be submitted to Us within sixty (60) calendar days after receipt of Our response to the initial appeal. We shall communicate Our final determination to the Covered Person within thirty (30) calendar days from receipt of the request, or as required by any applicable state or federal laws or regulations. Our communication to the Covered Person shall include the specific reasons for the determination.

Other Remedies. When a Covered Person has completed the appeals stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Additional information is available from the U.S. Department of Labor or the insurance regulatory agency for the Covered Persons' state of residency. Additionally, under the provisions of ERISA (Section 502(a)(1)(B) 29 U.S.C. 1132(a)(1)(B)), the Covered Person has the right to bring a civil action when all available levels of reviews, including the appeal process, have been completed. ERISA remedies may apply in those instances where the claims were not approved in whole or in part as the result of appeals under this Policy and the Covered Person disagrees with the outcome of such appeals.

Time of Action. No action in law or in equity shall be brought to recover on this Policy prior to the Covered Person exhausting his/her rights under this Policy and/or prior to the expiration of sixty (60) calendar days after the claim and any applicable documentation has been filed with Us. No such action shall be brought after the expiration of any applicable statute of limitations, in accordance with the terms of this Policy. No such action shall be brought after the expiration of three (3) years from the last date that the claim and any applicable invoices were submitted to Us, and no such action shall be brought at all unless brought within three (3) years from the expiration of the time within which such materials are required to be submitted in accordance with the terms of this Policy.

Insurance Fraud: Any Covered Person who intends to defraud, knowingly facilitates a fraud, submits a claim containing false or deceptive information, or who commits any other similar act as defined by applicable state or federal law, is guilty of insurance fraud. Such an act is grounds for immediate termination of the coverage under this Policy of the Covered Person committing such fraud.

NOTICE FOR RESIDENTS OF UTAH

Notice of Protection Provided by
Utah Life and Health Insurance Guaranty Association

This notice provides a brief summary of the Utah Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, health, or annuity insurance company becomes financially unable to meet its obligations and is taken over by its insurance regulatory agency. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
  - o $500,000 in death benefits
  - o $200,000 in cash surrender or withdrawal values
- Health Insurance
  - o $500,000 in hospital, medical and surgical insurance benefits
  - o $500,000 in long-term care insurance benefits
  - o $500,000 in disability income insurance benefits
  - o $500,000 in other types of health insurance benefits
- Annuities
  - o $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $500,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. Coverage is conditioned on residency in this state and there are substantial limitations and exclusions. For a complete description of coverage, consult Utah Code, Title 3 IA, Chapter 28.

Insurance companies and agents are prohibited by Utah law to use the existence of the Association or its coverage to encourage you to purchase insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between Utah law and this notice, Utah law will control.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.utlifega.org or contact:

Utah Life and Health Insurance Guaranty Assoc.
60 East South Temple, Suite 500
Salt Lake City UT 84111
(801) 320-9955

Utah Insurance Department
3110 State Office Building
Salt Lake City UT 84114-6901
(801) 538-3800

A written complaint about misuse of this Notice or the improper use of the existence of the Association may be filed with the Utah Insurance Department at the above address.

NOTICE TO RESIDENTS OF VIRGINIA

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event You need to contact someone about this insurance for any reason please contact Your agent. If no agent was involved in the sale of this insurance, or if You have additional questions You may contact the insurance company issuing this insurance at the following address and telephone number:

Davis Vision
Attention: Complaints and Appeals
P.O. Box 791
Latham, NY 12110

To phone in a claim related question, You may call Claims Customer Service at:
1-833-EYE-LIFE (1-833-393-5433)

If You have any questions regarding an appeal or grievance concerning the vision services that You have been provided that have not been satisfactorily addressed by this Vision Insurance, You may contact the Virginia Office of the Managed Care Ombudsman for assistance.

The Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218-1157
1-804-371-9691 - phone
1-877-310-6560 - toll-free
1-804-371-9944 - fax
www.scc.virginia.gov - web address
ombudsman@scc.virginia.gov - email

Or:

Office of Licensure and Certification
Division of Acute Care Services
Virginia Department of Health
9960 Mayland Drive
Suite 401
Henrico, Virginia 23233-1463
Phone number: 1-800-955-1819/ local: 804-367-2106
Fax: (804) 527-4503
MCHIP@vdh.virginia.gov

Written correspondence is preferable so that a record of Your inquiry is maintained. When contacting Your agent, company or the Bureau of Insurance, have Your policy number available.

NOTICE TO RESIDENTS OF VIRGINIA (continued)

VISION INSURANCE: PROCEDURES FOR VISION CLAIMS

Routine Questions on Vision Insurance Claims

If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-833-EYE-LIFE (1-833-393-5433).

Claim Denial Appeals

If a claim is denied in whole or in part, under the terms of this certificate, a request may be submitted to Us by a Covered Person or a Covered Person's authorized representative for a full review of the denial. A Covered Person may designate any person, including their provider, as their authorized representative. References in this section to "Covered Person" include the Covered Person's authorized representative, where applicable.

Initial Appeal. All requests for review must be made within one hundred eighty (180) calendar days following denial of a claim. A Covered Person may review, during normal business hours, any documents used by Us pertinent to the denial. A Covered Person may also submit Written comments or supporting documentation concerning the claim to assist in Our review. Our response to the initial appeal, including specific reasons for the decision, shall be communicated to the Covered Person within thirty (30) calendar days after receipt of the request for the appeal.

Second Level Appeal. If a Covered Person disagrees with the response to the initial appeal of the denied claim, the Covered Person has the right to a second level appeal. A request for a second level appeal must be submitted to Us within sixty (60) calendar days after receipt of Our response to the initial appeal. We shall communicate Our final determination to the Covered Person within thirty (30) calendar days from receipt of the request, or as required by any applicable state or federal laws or regulations. Our communication to the Covered Person shall include the specific reasons for the determination.

Other Remedies. When a Covered Person has completed the appeals stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Additional information is available from the U.S. Department of Labor or the insurance regulatory agency for the Covered Persons' state of residency. Additionally, under the provisions of ERISA (Section 502(a)(1)(B) 29 U.S.C. 1132(a)(1)(B)), the Covered Person has the right to bring a civil action when all available levels of reviews, including the appeal process, have been completed. ERISA remedies may apply in those instances where the claims were not approved in whole or in part as the result of appeals under this Policy and the Covered Person disagrees with the outcome of such appeals.

Time of Action. No action in law or in equity shall be brought to recover on this Policy prior to the Covered Person exhausting his/her rights under this Policy and/or prior to the expiration of sixty (60) calendar days after the claim and any applicable documentation has been filed with Us. No such action shall be brought after the expiration of any applicable statute of limitations, in accordance with the terms of this Policy. No such action shall be brought after the expiration of three (3) years from the last date that the claim and any applicable invoices were submitted to Us, and no such action shall be brought at all unless brought within three (3) years from the expiration of the time within which such materials are required to be submitted in accordance with the terms of this Policy.

Insurance Fraud: Any Covered Person who intends to defraud, knowingly facilitates a fraud, submits a claim containing false or deceptive information, or who commits any other similar act as defined by applicable state or federal law, is guilty of insurance fraud. Such an act is grounds for immediate termination of the coverage under this Policy of the Covered Person committing such fraud.

NOTICE FOR RESIDENTS OF WISCONSIN

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? - If You are having problems with Your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve Your problem.

Davis Vision
Attention: Complaints and Appeals
P.O. Box 791
Latham, NY 12110
1-833-EYE-LIFE (1-833-393-5433)

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517 outside of Madison or 608-266-0103 in Madison.

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SCHEDULE OF BENEFITS

This schedule shows the benefits that are available under the Group Policy. You and Your Dependents are only covered for insurance:

- for which You become and remain eligible;
- which You elect, if subject to election; and
- which are in effect.

In addition, You are eligible for Dependent Insurance only while You have Dependents who qualify.

BENEFIT	BENEFIT AMOUNTS AND HIGHLIGHTS
Provider Network:	**Davis Vision Network** **Davis Vision Plan Code X16**

Vision Insurance For You and Your Dependents

	Exam	Lenses	Frame	Contacts
Service Interval	Once per Calendar Year	Once per Calendar Year	Once Every Other Calendar Year	Once per Calendar Year

	In-Network	Out-of-Network
Exam Co-Payment *Co-Payment shall not apply to Retinal Imaging*	$10	$0
Materials Co-Payment *Co-Payment shall not apply to Contact Lenses*	$25	$0

	In-Network Coverage (Using an In-Network Vision Provider)	Out-of-Network Coverage (Using an Out-of-Network Vision Provider)
EYE EXAMINATION (one per frequency)	Covered in full after any applicable Co-Payment Comprehensive examination of visual functions and prescription of corrective eyewear.	$40 allowance after any applicable Co-Payment Comprehensive examination of visual functions and prescription of corrective eyewear.
LOW VISION Low Vision Services means the evaluation, diagnosis and prescription of Low Vision devices by an eyecare professional who specializes in low vision rehabilitation. Low Vision evaluation does not include orthoptics or vision training. It includes the initial Low Vision evaluation and follow-up visits	**Comprehensive Evaluation** $300 Allowance once every 60 months **Follow-up Evaluation** $100 Allowance for each follow-up visit up to four times every 60 months **Low Vision Aids** $600 Allowance per aid, $1,200 lifetime maximum	**Comprehensive Evaluation** $300 Allowance once every 60 months **Follow-up Evaluation** $100 Allowance for each follow-up visit up to four times every 60 months **Low Vision Aids** $600 Allowance per aid, $1,200 lifetime maximum

SCHEDULE OF BENEFITS (continued)

	In-Network Coverage (Using an In-Network Vision Provider)	Out-of-Network Coverage (Using an Out-of-Network Vision Provider)	
RETINAL IMAGING	Covered in full with a Co-Payment not to exceed $39. Coverage for retinal imaging is an enhancement to eye examination. Retinal imaging is not available at all provider locations – contact your In-Network Vision Provider to see if this technology (or equipment or service) is available.	Applied to the allowance for the eye examination	
STANDARD CORRECTIVE LENSES	Covered in full after any applicable Co-Payment Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular)	Single Vision	$40 allowance
		Lined Bifocal	$60 allowance
		Lined Trifocal	$80 allowance
		Lenticular	$80 allowance

SCHEDULE OF BENEFITS (continued)

	In-Network Coverage (Using an In-Network Vision Provider)		Out-of-Network Coverage (Using an Out-of-Network Vision Provider)
STANDARD LENS OPTIONS	Standard Polycarbonate (child up to age 18)	Covered in full	Applied to the allowance for the applicable corrective lens
These lens options are available with a "not to exceed" pricing/maximum member out of pocket amount.[1]	Tints/Dyes – Solid	Covered in full	Applied to the allowance for the applicable corrective lens
	Tints/Dyes – Gradient	Covered in full	
	Progressive – Standard	Covered in full	$50 allowance
	Progressive – Premium	$90	
	Progressive – Ultra	$140	
	Progressive – Ultimate	$175	
	Ultra Violet Coating	$12	Applied to the allowance for the applicable corrective lens
	Standard Polycarbonate (adult)	$30	
	Scratch Resistant Coating In-network providers offer a scratch protection plan that will replace lenses which have become scratched under normal usage within one year of dispensing, when scratch resistant coating was applied. This plan has a co-payment of: Single Vision - $0 Multifocal - $0	Tier 1 - $0 Tier 2 - $30	
	Anti-Reflective Coating	Tier 1 - $35 Tier 2 - $48 Tier 3 - $60 Tier 4 - $85	
	Photochromic	$65	
	Blue Light Filtering	$15	
	Digital Single Vision	$30	
	Polarized	$75	
	High Index (1.67/1.74)	$55/$120	

SCHEDULE OF BENEFITS (continued)

	In-Network Coverage (Using an In-Network Vision Provider)	Out-of-Network Coverage (Using an Out-of-Network Vision Provider)
FRAMES		
DAVIS VISION NETWORK COLLECTION **Fashion:** **Designer:** **Premier:**	 Covered in full Covered in full Covered in full after $25 Co-Payment	Not Applicable
NON-COLLECTION	Covered up to a $130 allowance after any applicable Co-Payment	$45 allowance after any applicable Co-Payment
CONTACT LENSES		
FITTING AND EVALUATION	**Standard and Premium Fit:** Covered in full after $25 Co-Payment	The allowance for contact lenses includes fitting and evaluation
ELECTIVE COLLECTION **Planned Replacement:** **Disposable:**	Covered in full 4 boxes (Standard Lens or Premium Lens) 8 boxes (Standard Lens or Premium Lens) Contact lenses are provided in place of lens and frame benefits available herein.	Not Applicable
ELECTIVE NON-COLLECTION CONTACT LENSES	$150 allowance Contact lenses are provided in place of lens and frame benefits available herein.	$150 allowance Contact lenses are provided in place of lens and frame benefits available herein.
NECESSARY	Covered in full – prior approval required Necessary contact lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's In-Network Vision Provider. Contact lenses are provided in place of lens and frame benefits available herein.	$210 allowance – prior approval required Necessary contact lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Out-of-Network Vision Provider. Contact lenses are provided in place of lens and frame benefits available herein.

SCHEDULE OF BENEFITS (continued)

[1] Not all providers participate in vision program discounts, including the member out-of-pocket features. Call your provider prior to scheduling an appointment to confirm if the discount and member out-of-pocket features are offered at that location. Discounts and member out-of-pocket are not insurance and subject to change without notice.

Value-Added Features Available At In-Network Vision Providers (These features are not insurance.)	
ADDITIONAL PAIR DISCOUNTS	Members may receive 50% off of additional complete pairs of eyeglasses and sunglasses at Visionworks and 30% off at other participating providers on the same transaction. Otherwise, a 20% discount off the providers usual and customary rate may be available. Contact lenses may be available at a 10% discount.
ADDITIONAL SAVINGS ON LENS ENHANCEMENTS	Average 20-25% savings on all lens enhancements not otherwise covered under the MetLife Vision Insurance program. [2]
ADDITIONAL SAVINGS ON FRAMES	20% off any amount over your frames allowance. [2]
BREAKAGE WARRANTY	All Davis Collection eyeglasses come with a breakage warranty for repair or replacement of the frame and/or lenses for a period of one year from the date of delivery. The one-year breakage warranty applies only to Davis Collection frames and lenses installed in them. Warranty does not apply to non-Collection frames.
ADDITIONAL SAVINGS ON CONTACTS	15% off any amount over your contact lens allowance. [2] 15% discount on additional contacts. [2]

[2] These features may not be available in all states and with all In-Network Vision Providers. Please check with Your In-Network Vision Provider.

DEFINITIONS

As used in this certificate, the terms listed below will have the meanings set forth below. When defined terms are used in this certificate, they will appear with initial capitalization. The plural use of a term defined in the singular will share the same meaning.

Actively at Work or Active Work means that You are performing all of the usual and customary duties of Your job on a Full-Time or Part-Time basis. This must be done at:

- the Policyholder's place of business;
- an alternate place approved by the Policyholder; or
- a place to which the Policyholder's business requires You to travel.

You will be deemed to be Actively at Work during weekends or Policyholder approved vacations, holidays or business closures if You were Actively at Work on the last scheduled work day preceding such time off.

Anisometropia means a condition of unequal refractive state of the two eyes, one eye requiring a different lens correction than the other.

Child means the following: (for residents of Alaska, Connecticut, Minnesota, New Hampshire, New Mexico, Texas, Utah and Washington, the Child Definition is modified as explained in the notice pages of this certificate - please consult the Notice)

Your natural or adopted child; Your stepchild (including the child of a Domestic Partner); Your grandchild who resides with You; or a child who resides with and is fully supported by You; and who, in each case, is under age 21 and unmarried.

The term also includes Your natural or adopted child, Your stepchild (including the child of a Domestic Partner); Your grandchild who resides with You; or a child who resides with and is fully supported by You; who is:

- under age 25;
- unmarried;
- not employed on a full-time basis; and
- a full-time student at an accredited school, college or university that is licensed in the jurisdiction where it is located.

An adopted child includes a child placed in Your physical custody for purpose of adoption. If prior to completion of the legal adoption the child is removed from Your custody, the child's status as an adopted child will end.

If You provide Us notice, a Child also includes a child for whom You must provide Vision Insurance due to a Qualified Medical Child Support Order as defined in the United States Employee Retirement Income Security Act of 1974 as amended.

For the purposes of determining who may become covered for insurance, the term does not include any person who:

- is in the military of any country or subdivision of any country; or
- is insured under the Group Policy as an employee.

Contributory Insurance means insurance for which the Policyholder requires You to pay any part of the premium.

Contributory Insurance includes: Vision Insurance for You and Vision Insurance for Your Dependents.

Co-Payment or Co-Pay means a fixed dollar amount for which We are not responsible, as shown in the Schedule of Benefits. You must pay Your Co-Payment at the time services are rendered or materials ordered.

Covered Person(s) means an Employee and/or a Dependent covered under this Certificate.

DEFINITIONS (continued)

Covered Services and Materials mean a vision service or materials used to treat Your or Your Dependent's vision condition which is:

- prescribed or performed by a Vision Provider while such person is insured for Vision Insurance;
- Necessary to treat the condition; and
- described in the SCHEDULE OF BENEFITS or VISION INSURANCE: DESCRIPTION OF COVERED SERVICES AND MATERIALS sections of this certificate.

Dependent(s) means Your Spouse or Domestic Partner and/or Your Child.

Domestic Partner means each of two people, one of whom is an employee of the Policyholder, who:

- have registered as each other's domestic partner, civil union partner or reciprocal beneficiary with a government agency where such registration is available; or
- are of the same or opposite sex and have a mutually dependent relationship so that each has an insurable interest in the life of the other. Each person must be:

    1. 18 years of age or older;
    2. unmarried;
    3. the sole domestic partner of the other;
    4. sharing a primary residence with the other; and
    5. not related to the other in a manner that would bar their marriage in the jurisdiction in which they reside.

  A Domestic Partner affidavit attesting to the existence of an insurable interest in one another's lives must be completed and Signed by the employee.

Full-Time means Active Work of at least 40 hours per week on the Policyholder's regular work schedule for the eligible class of employees to which You belong.

In-Network Vision Provider means an optometrist, ophthalmologist, or optician licensed and otherwise qualified to practice vision care and/or provide vision care materials who is contracted to provide Plan Benefits to Covered Persons of MetLife and accepts reimbursement at the negotiated rate.

Keratoconus means a development or dystrophic deformity of the cornea in which it becomes cone shaped due to a thinning and stretching of the tissue in its central area.

Maximum Benefit Allowance means the maximum amount We will allow for Covered Services and Materials provided by a Vision Provider.

Necessary means Covered Services and Materials that are necessary and meet with professionally recognized standards of practice. The fact that a Vision Provider may prescribe, order, recommend or approve a service or material does not, in itself, make it medically necessary, or make it a Covered Service and Material even though it is listed in the Group Policy or the Benefit Schedule as Covered Service and Material.

Out-of-Network Vision Provider/Non-Network Vision Provider means any optometrist, optician, ophthalmologist or other licensed and qualified vision care provider who has not contracted to provide vision care services and/or vision care materials to Covered Persons of MetLife.

Part-Time means Active Work of at least 20 hours per week but less than 40 hours per week on the Policyholder's regular work schedule for the eligible class of employees to which You belong.

Plan or Plan Benefits means the vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under this Certificate.

Progressive Lens means a multifocal lens that makes the transition from distance to near vision by a gradual, progressive addition of power. The result is a lens with a seamless appearance.

DEFINITIONS (continued)

Proof means Written evidence satisfactory to Us that a person has satisfied the conditions and requirements for any benefit described in this certificate. When a claim is made for any benefit described in this certificate, Proof must establish:

- the nature and extent of the loss or condition;
- Our obligation to pay the claim; and
- the claimant's right to receive payment.

Proof must be provided at the claimant's expense.

Service Interval or Frequency means a period of consecutive months, as shown in the SCHEDULE OF BENEFITS, in which You or Your Dependent may receive Covered Services and Materials. This period starts on Your or Your Dependent's effective date of coverage. A subsequent service interval starts after vision services or materials are received. Once Covered Services and Materials are received during any service interval, additional services are not covered during the same service interval and are subject to an additional charge.

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

Spouse means Your lawful spouse. Wherever the term "Spouse" appears in the certificate it shall, unless otherwise specified, be read to include Your Domestic Partner.

For the purposes of determining who may become covered for insurance, the term does not include any person who:

- is in the military of any country or subdivision of any country; or
- is insured under the Group Policy as an employee.

Vision Provider means an eye care professional who is an optometrist, ophthalmologist, or registered dispensing optician, who:

- Is licensed as such by the proper authorities in the jurisdiction where such services are performed;
- Is acting within the scope of such license.

We, Us and **Our** mean MetLife.

Written or **Writing** means a record which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

Year or **Yearly**, for Vision Insurance, means the 12 month period that begins January 1.

You and **Your** mean an employee who is insured under the Group Policy for the insurance described in this certificate.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU

ELIGIBLE CLASS(ES)

All Full-Time and Part-Time employees of the Policyholder.

DATE YOU ARE ELIGIBLE FOR INSURANCE

You may only become eligible for the insurance available for Your eligible class as shown in the SCHEDULE OF BENEFITS.

If You are in an eligible class on September 1, 2023, You will be eligible for the insurance described in this certificate on that date.

If You enter an eligible class after September 1, 2023, You will be eligible for the insurance described in this certificate on the date You enter that class.

ENROLLMENT PROCESS FOR VISION INSURANCE

If You are eligible for insurance, You may enroll for such insurance by completing the required form in Writing. If You enroll for Contributory Insurance, You must also give the Policyholder Written permission to deduct premiums from Your pay for such insurance. You will be notified by the Policyholder how much You will be required to contribute.

The Vision Insurance has a regular enrollment period established by the Policyholder. Subject to the rules of the Group Policy, You may enroll for Vision Insurance only when You are first eligible, during an annual enrollment period or if You have a Qualifying Event. You should contact the Policyholder for more information regarding the flexible benefits plan.

DATE YOUR INSURANCE TAKES EFFECT

Enrollment When First Eligible

If You complete the enrollment process within 31 days of becoming eligible for insurance, such insurance will take effect on the date You become eligible, provided You are Actively at Work on that date.

If You are not Actively at Work on the date the insurance would otherwise take effect, the insurance will take effect on the day You resume Active Work.

If You Do Not Enroll When First Eligible

If You do not complete the enrollment process within 31 days of becoming eligible, You will not be able to enroll for insurance until the next enrollment period for Vision Insurance, as determined by the Policyholder, following the date You first become eligible. At that time You will be able to enroll for insurance for which You are then eligible.

Enrollment During An Annual Enrollment Period

During any annual enrollment period as determined by the Policyholder, You may enroll for insurance for which You are eligible. The changes to Your insurance made during an enrollment period will take effect on the first day of the calendar year following the enrollment period, if You are Actively at Work on that date.

If You are not Actively at Work on the date the insurance would otherwise take effect, insurance will take effect on the date You resume Active Work.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)

Enrollment Due to a Qualifying Event

You may enroll for insurance for which You are eligible between annual enrollment periods only if You have a Qualifying Event.

If You have a Qualifying Event, You will have 31 days from the date of that change to make a request. This request must be consistent with the nature of the Qualifying Event. The insurance enrolled for, or changes to Your insurance made as a result of a Qualifying Event, will take effect on the date of the Qualifying Event, if You are Actively at Work on that date.

If You are not Actively at Work on the date the insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

Qualifying Event includes:

- marriage; or
- the birth, adoption or placement for adoption of a dependent child; or
- divorce, legal separation or annulment; or
- the death of a dependent; or
- a change in Your or Your dependent's employment status, such as beginning or ending employment, strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes You or Your dependent to gain or lose eligibility for group coverage; or
- a change in Your or Your dependent's residence, if it causes You or Your dependent to gain or lose eligibility for group coverage; or
- a significant curtailment in Your current option, a significant improvement in an option for which You are not enrolled, a significant increase or decrease in cost for one or more of the options under the Policyholder's plan or a new benefit option under the Policyholder's plan; or
- Your taking leave under the United States Family and Medical Leave Act; or
- Your dependent's ceasing to qualify as a dependent under this insurance or under other group coverage; or
- You previously did not enroll for Vision Insurance for You or Your dependent because You had other group coverage, but that coverage has ceased due to one or more of the following reasons:
  1. loss of eligibility for the other group coverage;
  2. termination of employer contributions for the other group coverage;
  3. COBRA Continuation of the other group coverage was exhausted; or
- a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody that requires either:
  - You to provide health coverage for Your child or dependent foster child; or
  - Your spouse, former spouse or other individual to provide coverage for Your child or foster child if that other person does in fact provide that coverage; or
- You or Your dependent become entitled to Medicare or Medicaid coverage (other than coverage solely for pediatric vaccines); or
- You or Your dependent lose entitlement to Medicare or Medicaid eligibility; or
- Your or Your dependent's loss of coverage under any group health coverage sponsored by a governmental or educational institution.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)

DATE YOUR INSURANCE ENDS

Your insurance will end on the earliest of:

1. the date the Group Policy ends;
2. the date insurance ends for Your class;
3. the last day of the calendar month in which You cease to be in an eligible class;
4. the end of the period for which the last premium has been paid for You;
5. the last day of the calendar month in which Your employment ends, Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT; or
6. the last day of the calendar month in which You retire in accordance with the Policyholder's retirement plan.

In certain cases insurance may be continued as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS

ELIGIBLE CLASS(ES) FOR DEPENDENT INSURANCE

All Full-Time and Part-Time employees of the Policyholder.

DATE YOU ARE ELIGIBLE FOR DEPENDENT INSURANCE

You may only become eligible for the Dependent insurance available for Your eligible class as shown in the SCHEDULE OF BENEFITS.

You will be eligible for Dependent insurance described in this certificate on the latest of:

1. September 1, 2023; and
2. the date You enter a class eligible for insurance; and
3. the date You obtain a Dependent.

No person may be insured as a Dependent of more than one employee.

ENROLLMENT PROCESS FOR DEPENDENT VISION INSURANCE

If You are eligible for Dependent Insurance, You may enroll for such insurance by completing the required form in Writing for each Dependent to be insured. If You enroll for Contributory Insurance, You must also give the Policyholder Written permission to deduct premiums from Your pay for such insurance. You will be notified by the Policyholder how much You will be required to contribute.

In order to enroll for Vision Insurance for Your Dependents, You must either (a) already be enrolled for Vision Insurance for You or (b) enroll at the same time for Vision Insurance for You.

The Vision Insurance has a regular enrollment period established by the Policyholder. Subject to the rules of the Group Policy, You may enroll for Dependent Vision Insurance only when You are first eligible, during an enrollment period or if You have a Qualifying Event. You should contact the Policyholder for more information regarding the flexible benefits plan.

DATE VISION INSURANCE TAKES EFFECT FOR YOUR DEPENDENTS

Enrollment When First Eligible

If You complete the enrollment process within 31 days of becoming eligible for Dependent Insurance, such insurance will take effect on the date You become eligible, provided You are Actively at Work on that date.

If You are not Actively at Work on the date the insurance would otherwise take effect, the insurance will take effect on the day You resume Active Work.

If You Do Not Enroll When First Eligible

If You do not complete the enrollment process within 31 days of becoming eligible, You will not be able to enroll for Dependent Insurance until the next enrollment period for Vision Insurance, as determined by the Policyholder, following the date You first become eligible. At that time You will be able to enroll for insurance for which You are then eligible.

Enrollment During An Annual Enrollment Period

During any enrollment period as determined by the Policyholder, You may enroll for Dependent Insurance for which You are eligible. The changes to Your Dependent Insurance made during an enrollment period will take effect on the first day of the calendar year following the enrollment period, if You are Actively at Work on that date.

If You are not Actively at Work on the date the insurance would otherwise take effect, insurance will take effect on the date You resume Active Work.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS (continued)

Enrollment Due to a Qualifying Event

You may enroll for Dependent Insurance for which You are eligible between annual enrollment periods only if You have a Qualifying Event.

If You have a Qualifying Event, You will have 31 days from the date of that change to make a request. This request must be consistent with the nature of the Qualifying Event. The insurance enrolled for or changes to Your insurance made as a result of a Qualifying Event will take effect on the date of the Qualifying Event, if You are Actively at Work on that date.

If You are not Actively at Work on the date the insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

Qualifying Event includes:

- marriage; or
- the birth, adoption or placement for adoption of a dependent child; or
- divorce, legal separation or annulment; or
- the death of a dependent; or
- a change in Your or Your dependent's employment status, such as beginning or ending employment, strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes You or Your dependent to gain or lose eligibility for group coverage; or
- a change in Your or Your dependent's residence, if it causes You or Your dependent to gain or lose eligibility for group coverage; or
- a significant curtailment in Your current option, a significant improvement in an option for which You are not enrolled, a significant increase or decrease in cost for one or more of the options under the 's plan or a new benefit option under the 's plan; or
- Your taking leave under the United States Family and Medical Leave Act; or
- Your dependent's ceasing to qualify as a dependent under this or under other group coverage; or
- You previously did not enroll for Vision for You or Your dependent because You had other group coverage, but that coverage has ceased due to one or more of the following reasons:
  1. loss of eligibility for the other group coverage;
  2. termination of employer contributions for the other group coverage;
  3. COBRA Continuation of the other group coverage was exhausted; or
- a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody that requires either:
  - You to provide health coverage for Your child or dependent foster child; or
  - Your spouse, former spouse or other individual to provide coverage for Your child or foster child if that other person does in fact provide that coverage; or
- You or Your dependent become entitled to Medicare or Medicaid coverage (other than coverage solely for pediatric vaccines); or
- You or Your dependent lose entitlement to Medicare or Medicaid eligibility; or
- Your or Your dependent's loss of coverage under any group health coverage sponsored by a governmental or educational institution.

Once You have enrolled one Child for Dependent Insurance, each succeeding Child will automatically be insured for such insurance on the date the Child qualifies as a Dependent.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS (continued)

DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS

A Dependent's insurance will end on the earliest of:

1. the date You die;
2. the date Vision Insurance for You ends;
3. the date the Group Policy ends;
4. the last day of the calendar month in which You cease to be in an eligible class;
5. the date insurance for Your Dependents ends under the Group Policy;
6. the date insurance for Your Dependents ends for Your class;
7. the last day of the calendar month in which Your employment ends; Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT;
8. the end of the period for which the last premium has been paid;
9. the date the person ceases to be a Dependent, except in the case of a Dependent Child who has reached the maximum age as defined in the DEFINITIONS section, Insurance will end on the last day of the calendar month;
10. the last day of the calendar month in which You retire in accordance with the Policyholder's retirement plan.

In certain cases insurance may be continued as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT

FOR MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN

Insurance for a Dependent Child may be continued past the age limit if the child is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law. Proof of such handicap must be sent to Us within 31 days after the date the Child attains the age limit and at reasonable intervals after such date.

Subject to the DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS, insurance will continue while such Child:

- remains incapable of self-sustaining employment because of a mental or physical handicap; and
- continues to qualify as a Child, except for the age limit.

FOR FAMILY AND MEDICAL LEAVE

Certain leaves of absence may qualify for continuation of insurance under the Family and Medical Leave Act of 1993 (FMLA), or other legally mandated leave of absence or similar laws. Please contact the Policyholder for information regarding such legally mandated leave of absence laws.

COBRA CONTINUATION FOR VISION INSURANCE

If Vision Insurance for You or a Dependent ends, You or Your Dependent may qualify for continuation of such insurance under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). Please refer to the COBRA section of Your summary plan description or contact the Policyholder for information regarding continuation of insurance under COBRA.

AT THE POLICYHOLDER'S OPTION

The Policyholder has elected to continue insurance by paying premiums for employees who cease Active Work in an eligible class for any of the reasons specified below. If Your insurance is continued, insurance for Your Dependents may also be continued.

Insurance will continue for the following periods:

1. if You cease Active Work due to any other Policyholder approved leave of absence, for a period in accordance with the Policyholder's general practice for an employee in Your job class;
2. if You cease Active Work due to layoff, for a period in accordance with the Policyholder's general practice for an employee in Your job class;
3. if You cease Active Work due to injury or sickness, for a period in accordance with the Policyholder's general practice for an employee in Your job class;
4. if You cease Active Work due to strike, for a period in accordance with the Policyholder's general practice for an employee in Your job class.

The Policyholder's general practice for employees in a job class determines which employees with the above types of absences are to be considered as still insured and for how long among persons in like situations.

At the end of any of the continuation periods listed above, Your insurance will be affected as follows:

- if You resume Active Work in an eligible class at this time, You will continue to be insured under the Group Policy;
- if You do not resume Active Work in an eligible class at this time, Your employment will be considered to end and Your insurance will end in accordance with the DATE YOUR INSURANCE ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOU.

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT (continued)

If Your insurance ends, Your Dependents' insurance will also end in accordance with the DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS.

VISION INSURANCE

Benefits are available for Covered Services and Materials provided by either In-Network Vision Providers or Out-of-Network Vision Providers. However, You may be able to reduce Your out-of-pocket costs by using In-Network Vision Providers because Out-of-Network Vision Providers have not entered into an agreement to limit their charges. You are always free to receive services from any Vision Provider. You do not need any authorization from Us before seeing a Vision Provider.

In-Network Vision Providers have agreed to provide Covered Services and Materials as listed in the SCHEDULE OF BENEFITS.

If You or a Dependent incur a charge for Covered Services and Materials from an Out-of-Network Vision Provider, Proof of such service must be sent to Us. When We receive such Proof, We will review the claim and if We approve it, will pay the insurance in effect on the date that service was completed.

The benefits available under this Vision Insurance are set forth on the SCHEDULE OF BENEFITS. In addition to the Co-Payment, if applicable, You may be responsible for:

- the cost of any services or materials that are not Covered Services and Materials; and
- the cost of any service or material that is in excess of the Maximum Benefit Allowance listed on the SCHEDULE OF BENEFITS.

We do not provide vision services. Whether or not benefits are available for a particular service does not mean You should or should not receive the service. You and Your Vision Provider have the right and are responsible at all times for choosing the course of treatment and services to be performed.

When requesting Covered Services and Materials from an In-Network Vision Provider, We recommend that You confirm that the Vision Provider is currently an In-Network Vision Provider at the time that the Covered Services and Materials are provided.

You can obtain a customized listing of MetLife's In-Network Vision Providers either by calling 1-833-EYE-LIFE (1-833-393-5433) or by visiting Our website at www.metlife.com/mybenefits.

PLAN BENEFITS

We will pay benefits for charges incurred by You or a Dependent for Covered Services and Materials as shown in the SCHEDULE OF BENEFITS, subject to the conditions set forth in this certificate.

If You receive Covered Services and Materials from an In-Network Vision Provider, We will pay the provider directly for all covered benefits.

If You or Your Dependent receive Covered Services and Materials from an Out-of-Network Vision Provider, and You assign payment of Vision Insurance benefits to Your or Your Dependent's Vision Provider, We will pay benefits directly to the Vision Provider. Otherwise, We will pay Vision Insurance benefits to You.

In-Network

If Covered Services and Materials are provided by an In-Network Vision Provider, We will base the benefit on the Plan Benefits listed on the SCHEDULE OF BENEFITS.

If an In-Network Vision Provider provides Covered Services and Materials, You will be responsible for paying:

- the Co-Payment, if applicable; and
- the cost of any service or material that is in excess of the Plan Benefits listed on the SCHEDULE OF BENEFITS.

VISION INSURANCE (continued)

Out-of-Network

If Covered Services and Materials are provided by an Out-of-Network Vision Provider, We will base the benefit on the Plan Benefits listed on the SCHEDULE OF BENEFITS, subject to the Maximum Benefit Allowance.

Out-of-Network Vision Providers may charge You more than the Maximum Benefit Allowance. If an Out-of-Network Vision Provider provides Covered Services and Materials, You will be responsible for paying any amount in excess of the Maximum Benefit Allowance charged by the Out-of-Network Vision Provider.

Necessary Contact Lenses

Necessary contact lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by a Covered Person's In-Network Vision Provider. Generally, coverage will be authorized for the following reasons:

- Aphakia—379.31 or 743.35.
- Nystagmus—379.50 through 379.56, 386.11, 386.12 or 386.2.
- Keratoconus—371.60, 371.61, 371.62, 743.41, or 743.42.
- Corneal transplant—V42.5.
- Corneal dystrophies—371.50 through 371.58.
- Anisometropia greater than or equal to 2.00 diopters difference in any meridian based on the spectacle prescription.
- High ametropia greater than or equal to ±10.00 diopters in either eye in any meridian based on the spectacle prescription.
- Irregular astigmatism—367.22.

The codes listed above are from the International Classification of Diseases, Ninth Revision, Clinical Modification and are used to describe diseases, injuries, symptoms and conditions. If You have questions about the diagnoses listed above or the codes included with the diagnoses, please contact Your Vision Provider.

VISION INSURANCE: DESCRIPTION OF COVERED SERVICES AND MATERIALS

Subject to the Service Intervals and Plan Benefits indicated in the SCHEDULE OF BENEFITS, the following will be Covered Services and Materials:

1. One complete visual examination, if indicated as a Covered Service on the SCHEDULE OF BENEFITS. Dilation is included as a Covered Service when provided by an In-Network Vision Provider.
2. Standard corrective lenses. We will cover a pair of standard single vision, lined bifocal, lined trifocal or lenticular lenses that are necessary to correct vision. Standard corrective lenses are as follows:
    - eyesizes up to and including 60mm;
    - multi-focal lenses in all segment widths;
    - prism and slab off;
    - base curves (regardless of curve);
    - lenses with the combined power in any meridian is +/- .50 diopters or greater in at least one eye; and
    - plastic or glass lenses.
3. The following lens options described in the SCHEDULE OF BENEFITS: tint (solid and gradient), standard plastic scratch coating, standard polycarbonate (if you are less than 18 years of age), standard anti-reflective coating, plastic photochromic, blue light filtering, digital single vision, polarized, high index (1.67/1.74).
4. Contact lenses.
    - A standard fitting and 1 follow-up visit by a Vision Provider.
    - The following contact lenses options, as described in the SCHEDULE OF BENEFITS: conventional, disposable, and Necessary.
5. Necessary low vision aids and evaluations.
6. We do not cover costs above the Maximum Benefit Allowance shown in the SCHEDULE OF BENEFITS for frames. If frames are selected that are more expensive than that amount, You will be charged the difference between the Maximum Benefit Allowance and the Vision Provider's charge for the more expensive frame.
7. Necessary contact lenses in lieu of all benefits for vision materials.

VISION INSURANCE: EXCLUSIONS

We will not pay Vision Insurance benefits for charges incurred for:

1. Services and/or materials not specifically included in the SCHEDULE OF BENEFITS as covered Plan Benefits.
2. Any portion of a charge in excess of the Maximum Benefit Allowance or reimbursement indicated in the SCHEDULE OF BENEFITS.
3. Plano lenses (lenses with refractive correction of less than ± .50 diopter).
4. Two pairs of glasses instead of bifocals.
5. Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost, stolen or damaged, except at the normal intervals when Plan Benefits are otherwise available.
6. Orthoptics or vision training and any associated supplemental testing.
7. Medical or surgical treatment of the eye.
8. Prescription or non-prescription medications.
9. Contact lens insurance policies and service agreements.
10. Refitting of contact lenses after the initial (90-day) fitting period.
11. Contact lens modification, polishing and cleaning.
12. Any eye examination or any corrective eyewear required as a condition of employment.
13. Services or supplies received by You or Your Dependent before the Vision Insurance starts for that person.
14. Missed appointments.
15. Services or materials resulting from or in the course of a Covered Person's regular occupation for pay or profit for which the Covered Person is entitled to benefits under any Workers' Compensation Law, Employer's Liability Law or similar law. You must promptly claim and notify the Company of all such benefits.
16. Local, state and/or federal taxes, except where MetLife is required by law to pay.
17. Services:
    - for which the employer of the person receiving such services is required to pay by law; or
    - received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.
18. Services or materials received as a result of disease, defect, or injury due to war or an act of war (declared or undeclared), taking part in a riot or insurrection, or committing or attempting to commit a felony.
19. Services and materials obtained while outside the United States, except for emergency vision care.
20. Services, procedures, or materials for which a charge would not have been made in the absence of insurance.

VISION INSURANCE: FILING A CLAIM

CLAIMS FOR VISION INSURANCE

If you select an In Network Vision Provider, You do not need to file a claim.

If you select an Out-of-Network Vision Provider, You may provide full payment to the Out-of-Network Vision Provider at the time of service and submit the invoice including an itemized statement of charges with Your claim form, or You may be able to assign the claim to the Out-of-Network Vision Provider. If the Out-of-Network Vision Provider accepts the assignment, the provider will submit the claim on your behalf. You will be responsible for any charges not covered by the Plan.

Out of network claim forms needed to file for benefits under the group insurance program can be obtained by calling MetLife at 1-833-EYE-LIFE (1-833-393-5433). Vision claim forms can also be downloaded from www.metlife.com/mybenefits. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim.

When We receive the claim form and Proof, Your claim will be paid subject to the terms and provisions of this certificate and the Group Policy.

CLAIMS FOR VISION INSURANCE BENEFITS

When a claimant files a claim for Vision Insurance benefits described in this certificate, both the notice of claim and the required Proof should be sent to Us within 180 days from the date of service. If it was not reasonably possible to give Written Proof within 180 days from the date of service, We will not reduce or deny the claim for this reason if the Proof is filed as soon as reasonably possible.

Claim and Proof may be given to Us by following the steps set forth below:

Step 1
A claimant can request a claim form by downloading it from www.metlife.com/mybenefits.

Step 2
Complete the claim form as instructed and return it with the invoice.

Step 3
The claimant must give Us Proof not later than one(1) year from the date of service, unless the claimant is legally incapacitated. In any event, the Proof required must be given no later than one (1) year from the time specified.

We will pay the claim as soon as We receive proper Written Proof of loss.

VISION INSURANCE: PROCEDURES FOR VISION CLAIMS

Routine Questions on Vision Insurance Claims

If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-833-EYE-LIFE (1-833-393-5433).

Claim Denial Appeals
If a claim is denied in whole or in part, under the terms of this certificate, a request may be submitted to Us by a Covered Person or a Covered Person's authorized representative for a full review of the denial. A Covered Person may designate any person, including their provider, as their authorized representative. References in this section to "Covered Person" include the Covered Person's authorized representative, where applicable.

Initial Appeal. All requests for review must be made within one hundred eighty (180) calendar days following denial of a claim. A Covered Person may review, during normal business hours, any documents used by Us pertinent to the denial. A Covered Person may also submit Written comments or supporting documentation concerning the claim to assist in Our review. Our response to the initial appeal, including specific reasons for the decision, shall be communicated to the Covered Person within thirty (30) calendar days after receipt of the request for the appeal.

Second Level Appeal. If a Covered Person disagrees with the response to the initial appeal of the denied claim, the Covered Person has the right to a second level appeal. A request for a second level appeal must be submitted to Us within sixty (60) calendar days after receipt of Our response to the initial appeal. We shall communicate Our final determination to the Covered Person within thirty (30) calendar days from receipt of the request, or as required by any applicable state or federal laws or regulations. Our communication to the Covered Person shall include the specific reasons for the determination.

Other Remedies. When a Covered Person has completed the appeals stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Additional information is available from the U.S. Department of Labor or the insurance regulatory agency for the Covered Persons' state of residency. Additionally, under the provisions of ERISA (Section 502(a)(1)(B) 29 U.S.C. 1132(a)(1)(B)), the Covered Person has the right to bring a civil action when all available levels of reviews, including the appeal process, have been completed. ERISA remedies may apply in those instances where the claims were not approved in whole or in part as the result of appeals under this Policy and the Covered Person disagrees with the outcome of such appeals.

Time of Action. No action in law or in equity shall be brought to recover on this Policy prior to the Covered Person exhausting his/her rights under this Policy and/or prior to the expiration of sixty (60) calendar days after the claim and any applicable documentation has been filed with Us. No such action shall be brought after the expiration of any applicable statute of limitations, from the time Written Proof of Loss is required to be given.

Insurance Fraud: Any Covered Person who intends to defraud, knowingly facilitates a fraud, submits a claim containing false or deceptive information, or who commits any other similar act as defined by applicable state or federal law, is guilty of insurance fraud. Such an act is grounds for immediate termination of the coverage under this Policy of the Covered Person committing such fraud.

GENERAL PROVISIONS

Assignment

The rights and benefits under the Group Policy are not assignable prior to a claim for benefits, except as required by law. We are not responsible for the validity of an assignment.

Upon receipt of a Covered Service, You may assign Vision Insurance benefits to the Vision Provider providing such service.

Vision Insurance: Who We Will Pay

If You assign payment of Vision Insurance benefits to Your or Your Dependent's Vision Provider, We will pay benefits directly to the Vision Provider. Otherwise, We will pay Vision Insurance benefits to You.

Entire Contract

Your insurance is provided under a contract of group insurance with the Policyholder. The entire contract with the Policyholder is made up of the following:

1. the Group Policy and its Exhibits, which include the certificate(s);
2. the Policyholder's application; and
3. any amendments and/or endorsements to the Group Policy.

Incontestability: Statements Made by You

Any statement made by You will be considered a representation and not a warranty.

Evidence of insurability will not be required nor will any statement made by You, which relates to insurability, be used:

1. to contest the validity of the insurance benefits; or
2. to reduce the insurance benefits.

Conformity with Law

If the terms and provisions of this certificate do not conform to any applicable law, this certificate shall be interpreted to so conform.

THE PRECEDING PAGE IS THE END OF THE CERTIFICATE.
THE FOLLOWING IS ADDITIONAL INFORMATION.

MetLife

Delaware American Life Insurance Company
MetLife Health Plans, Inc.
MetLife Legal Plans, Inc.
MetLife Legal Plans of Florida, Inc.
Metropolitan General Insurance Company
Metropolitan Life Insurance Company
Metropolitan Tower Life Insurance Company
SafeGuard Health Plans, Inc.
SafeHealth Life Insurance Company

Our Privacy Notice

We know that you buy our products and services because you trust us. This notice explains how we protect your privacy and treat your personal information. It applies to current and former customers. "Personal information" as used here means anything we know about you personally.

SECTION 1: Plan Sponsors and Group Insurance Contract Holders

This privacy notice is for individuals who apply for or obtain our products and services under an employee benefit plan, group insurance or annuity contract, or as an executive benefit. In this notice, "you" refers to these individuals.

SECTION 2: Protecting Your Information

We take important steps to protect your personal information. We treat it as confidential. We tell our employees to take care in handling it. We limit access to those who need it to perform their jobs. Our outside service providers must also protect it, and use it only to meet our business needs. We also take steps to protect our systems from unauthorized access. We comply with all laws that apply to us.

SECTION 3: Collecting Your Information

We typically collect your name, address, age, and other relevant information. We may also collect information about any business you have with us, our affiliates, or other companies. Our affiliates include life insurers, a legal plans company and a securities broker-dealer. In the future, we may also have affiliates in other businesses.

SECTION 4: How We Get Your Information

We get your personal information mostly from you. We may also use outside sources to help ensure our records are correct and complete. These sources may include consumer reporting agencies, employers, other financial institutions, adult relatives, and others. These sources may give us reports or share what they know with others. We don't control the accuracy of information outside sources give us. If you want to make any changes to information we receive from others about you, you must contact those sources.

We may ask for medical information. The Authorization that you sign when you request insurance permits these sources to tell us about you. We may also, at our expense:

- Ask for a medical exam
- Ask for blood and urine tests
- Ask health care providers to give us health data, including information about alcohol or drug abuse

We may also ask a consumer reporting agency for a "consumer report" about you (or anyone else to be insured). Consumer reports may tell us about a lot of things, including information about:

- Reputation
- Driving record
- Finances
- Work and work history
- Hobbies and dangerous activities

The information may be kept by the consumer reporting agency and later given to others as permitted by law. The agency will give you a copy of the report it provides to us, if you ask the agency and can provide adequate identification. If you write to us and we have asked for a consumer report about you, we will tell you so and give you the name, address and phone number of the consumer reporting agency.

Another source of information is MIB, Inc. ("MIB"). It is a not-for-profit membership organization of insurance companies which operates an information exchange on behalf of its Members. We, or our reinsurers, may make a brief report to MIB. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's

file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. You may do so by writing to MIB, Inc., 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734 or go to MIB website at www.mib.com.

SECTION 5: Using Your Information

We collect your personal information to help us decide if you're eligible for our products or services. We may also need it to verify identities to help deter fraud, money laundering, or other crimes. How we use this information depends on what products and services you have or want from us. It also depends on what laws apply to those products and services. For example, we may also use your information to:

- administer your products and services
- perform business research
- market new products to you
- comply with applicable laws
- process claims and other transactions
- confirm or correct your information
- help us run our business

SECTION 6: Sharing Your Information With Others

We may share your personal information with others with your consent, by agreement, or as permitted or required by law. We may share your personal information without your consent if permitted or required by law. For example, we may share your information with businesses hired to carry out services for us. We may also share it with our affiliated or unaffiliated business partners through joint marketing agreements. In those situations, we share your information to jointly offer you products and services or have others offer you products and services we endorse or sponsor. Before sharing your information with any affiliate or joint marketing partner for their own marketing purposes, however, we will first notify you and give you an opportunity to opt out.

Other reasons we may share your information include:

- doing what a court, law enforcement, or government agency requires us to do (for example, complying with search warrants or subpoenas)
- telling another company what we know about you if we are selling or merging any part of our business
- giving information to a governmental agency so it can decide if you are eligible for public benefits
- giving your information to someone with a legal interest in your assets (for example, a creditor with a lien on your account)
- giving your information to your health care provider
- having a peer review organization evaluate your information, if you have health coverage with us
- those listed in our "Using Your Information" section above

SECTION 7: HIPAA

We will not share your health information with any other company – even one of our affiliates – for their own marketing purposes. The Health Insurance Portability and Accountability Act ("HIPAA") protects your information if you request or purchase dental, vision, long-term care and/or medical insurance from us. HIPAA limits our ability to use and disclose the information that we obtain as a result of your request or purchase of insurance. Information about your rights under HIPAA will be provided to you with any dental, vision, long-term care or medical coverage issued to you.

You may obtain a copy of our HIPAA Privacy Notice by visiting our website at www.MetLife.com. For additional information about your rights under HIPAA; or to have a HIPAA Privacy Notice mailed to you, contact us at HIPAAprivacyAmericasUS@metlife.com, or call us at telephone number (212) 578-0299.

SECTION 8: Accessing and Correcting Your Information

You may ask us for a copy of the personal information we have about you. We will provide it as long as it is reasonably locatable and retrievable. You must make your request in writing listing the account or policy numbers with the information you want to access. For legal reasons, we may not show you privileged information relating to a claim or lawsuit, unless required by law.

If you tell us that what we know about you is incorrect, we will review it. If we agree, we will update our records. Otherwise, you may dispute our findings in writing, and we will include your statement whenever we give your disputed information to anyone outside MetLife.

SECTION 9: Questions

We want you to understand how we protect your privacy. If you have any questions or want more information about this notice, please contact us. A detailed notice shall be furnished to you upon request. When you write, include your name, address, and policy or account number.

Send privacy questions to:

MetLife Privacy Office
P. O. Box 489
Warwick, RI 02887-9954
privacy@metlife.com

We may revise this privacy notice. If we make any material changes, we will notify you as required by law. We provide this privacy notice to you on behalf of the MetLife companies listed at the top of the first page.

HIPAA Notice of Privacy Practices for Protected Health Information

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.

Dear MetLife Customer:

This is your Health Information Privacy Notice from Metropolitan Life Insurance Company or a member of the MetLife, Inc. family of companies, which includes SafeGuard Health Plans, Inc., SafeHealth Life Insurance Company, and Delaware American Life Insurance Company (collectively, "**MetLife**"). **Please read it carefully.** You have received this notice because of your Dental, Vision, Long-Term Care, Cancer and Specified Disease Expense Insurance, or Health coverage with us (your "**Coverage**"). MetLife strongly believes in protecting the confidentiality and security of information we collect about you. This notice refers to MetLife by using the terms "us," "we," or "our."

This notice describes how we protect the personal health information we have about you which relates to your MetLife Coverage ("**Protected Health Information**" or "**PHI**"), and how we may use and disclose this information. PHI includes individually identifiable information which relates to your past, present or future health, treatment or payment for health care services. This notice also describes your rights with respect to the PHI and how you can exercise those rights.

We are required to provide this notice to you by the Health Insurance Portability and Accountability Act ("**HIPAA**"). For additional information regarding our HIPAA Medical Information Privacy Policy or our general privacy policies, please see the privacy notices contained at our website, www.metlife.com. You may submit questions to us there or you may write to us directly at MetLife, Americas – U.S. HIPAA Privacy Office, P.O. Box 902, New York, NY 10159-0902.

NOTICE SUMMARY

The following is a brief summary of the topics covered in this HIPAA notice. Please refer to the full notice below for details.

As allowed by law, we may **use** and **disclose** PHI to:

- make, receive, or collect payments;
- conduct health care operations;
- administer benefits by sharing PHI with affiliates and Business Associates;
- assist plan sponsors in administering their plans; and
- inform persons who may be involved in or paying for another's health care.

In addition, we may use or disclose PHI:

- where required by law or for public health activities;
- to avert a serious threat to health or safety;
- for health-related benefits or services;
- for law enforcement or specific government functions;
- when requested as part of a regulatory or legal proceeding; and
- to provide information about deceased persons to coroners, medical examiners, or funeral directors.

You have the right to:

- receive a copy of this notice;
- inspect and copy your PHI, or receive a copy of your PHI;
- amend your PHI if you believe the information is incorrect;
- obtain a list of disclosures we made about you (except for treatment, payment, or health care operations);

- ask us to restrict the information we share for treatment, payment, or health care operations;
- request that we communicate with you in a confidential manner; and
- complain to us or the U.S. Department of Health and Human Services if you believe your privacy rights have been violated.

We are required by law to:

- maintain the privacy of PHI;
- provide this notice of our legal duties and privacy practices with respect to PHI;
- notify affected individuals following a breach of unsecured PHI; and
- follow the terms of this notice.

NOTICE DETAILS

We protect your PHI from inappropriate use or disclosure. Our employees, and those of companies that help us service your MetLife Coverage, are required to comply with our requirements that protect the confidentiality of PHI. They may look at your PHI only when there is an appropriate reason to do so, such as to administer our products or services.

Except in the case of Long-Term Care Coverage, we will **not use or disclose** PHI that is genetic information for underwriting purposes. For example, we will not use information from a genetic test (such as DNA or RNA analysis) of an individual or an individual's family members to determine eligibility, premiums or contribution amounts under your Coverage.

We will **not sell or disclose** your PHI to any other company for their use in marketing their products to you. However, as described below, we will use and disclose PHI about you for business purposes relating to your Coverage.

The main reasons we may **use** and **disclose** your PHI are to evaluate and process any requests for coverage and claims for benefits you may make or in connection with other health-related benefits or services that may be of interest to you. The following describe these and other uses and disclosures.

- **For Payment:** We may use and disclose PHI to pay benefits under your Coverage. For example, we may review PHI contained in claims to reimburse providers for services rendered. We may also disclose PHI to other insurance carriers to coordinate benefits with respect to a particular claim. Additionally, we may disclose PHI to a health plan or an administrator of an employee welfare benefit plan for various payment-related functions, such as eligibility determination, audit and review, or to assist you with your inquiries or disputes.

- For Health Care Operations: We may also use and disclose PHI for our insurance operations. These purposes include evaluating a request for our products or services, administering those products or services, and processing transactions requested by you.

- To Affiliates and Business Associates: We may disclose PHI to Affiliates and to business associates outside of the MetLife family of companies if they need to receive PHI to provide a service to us and will agree to abide by specific HIPAA rules relating to the protection of PHI. Examples of business associates are: billing companies, data processing companies, companies that provide general administrative services, health Information organizations e-prescribing gateways, or personal health record vendors that provide services to covered entities. PHI may be disclosed to reinsurers for underwriting, audit or claim review reasons. PHI may also be disclosed as part of a potential merger or acquisition involving our business in order that the parties to the transaction may make an informed business decision.

- To Plan Sponsors: We may disclose summary health information such as claims history or claims expenses to a plan sponsor to enable it to obtain premium bids from health plans, or to modify, amend or terminate a group health plan. We may also disclose PHI to a plan sponsor to help administer its plan if the plan sponsor agrees to restrict its use and disclosure of PHI in accordance with federal law.

- To Individuals Involved in Your Care: We may disclose your PHI to a family member or other individual who is involved in your health care or payment of your health care. For example, we may disclose PHI to a covered family member whom you have authorized to contact us regarding payment of a claim.

- Where Required by Law or for Public Health Activities: We disclose PHI when required by federal, state or local law. Examples of such mandatory disclosures include notifying state or local health authorities regarding particular communicable diseases, or providing PHI to a governmental agency or regulator with health care oversight responsibilities.

- To Avert a Serious Threat to Health or Safety: We may disclose PHI to avert a serious threat to someone's health or safety. We may also disclose PHI to federal, state or local agencies engaged in disaster relief, as well as to private disaster relief or disaster assistance agencies to allow such entities to carry out their responsibilities in specific disaster situations.

- For Health-Related Benefits or Services: We may use your PHI to provide you with information about benefits available to you under your current coverage or policy and, in limited situations, about health-related products or services that may be of

interest to you. However, we will not send marketing communications to you in exchange for financial remuneration from a third party without your authorization.

- **For Law Enforcement or Specific Government Functions:** We may disclose PHI in response to a request by a law enforcement official made through a court order, subpoena, warrant, summons or similar process. We may disclose PHI about you to federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- **When Requested as Part of a Regulatory or Legal Proceeding:** If you or your estate are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process, but only if efforts have been made to tell you about the request or to obtain an order protecting the PHI requested. We may disclose PHI to any governmental agency or regulator with whom you have filed a complaint or as part of a regulatory agency examination.

- **PHI about Deceased Individuals :** We may release PHI to a coroner or medical examiner to assist in identifying a deceased individual or to determine the cause of death. In addition, we may disclose a deceased's person's PHI to a family member or individual involved in the care or payment for care of the deceased person unless doing so is inconsistent with any prior expressed preference of the deceased person which is known to us.

- **Other Uses of PHI:** Other uses and disclosures of PHI not covered by this notice and permitted by the laws that apply to us will be made only with your written authorization or that of your legal representative. If we are authorized to use or disclose PHI about you, you or your legally authorized representative may revoke that authorization in writing at any time, except to the extent that we have taken action relying on the authorization or if the authorization was obtained as a condition of obtaining your Coverage. You should understand that we will not be able to take back any disclosures we have already made with authorization.

Your Rights Regarding Protected Health Information That We Maintain About You

The following are your various rights as a consumer under HIPAA concerning your PHI. Should you have questions about or wish to exercise a specific right, please contact us in writing at the applicable Contact Address listed on the last page.

- **Right to Inspect and Copy Your PHI:** In most cases, you have the right to inspect and obtain a copy of the PHI that we maintain about you. If we maintain the requested PHI electronically, you may ask us to provide you with the PHI in electronic format, if readily producible; or, if not, in a readable electronic form and format agreed to by you and us. To receive a copy of your PHI, you may be charged a fee for the costs of copying, mailing, electronic media, or other supplies associated with your request. You may also direct us to send the PHI you have requested to another person designated by you, so long as your request is in writing and clearly identifies the designated individual. However, certain types of PHI will not be made available for inspection and copying. This includes psychotherapy notes or PHI collected by us in connection with, or in reasonable anticipation of, any claim or legal proceeding. In very limited circumstances, we may deny your request to inspect and obtain a copy of your PHI. If we do, you may request that the denial be reviewed. The review will be conducted by an individual chosen by us who was not involved in the original decision to deny your request. We will comply with the outcome of that review.

- **Right to Amend Your PHI:** If you believe that your PHI is incorrect or that an important part of it is missing, you have the right to ask us to amend your PHI while it is kept by or for us. You must specify the reason for your request. We may deny your request if it is not in writing or does not include a reason that supports the request. In addition, we may deny your request if you ask us to amend PHI that:

  - is accurate and complete;
  - was not created by us, unless the person or entity that created the PHI is no longer available to make the amendment;
  - is not part of the PHI kept by or for us; or
  - is not part of the PHI which you would be permitted to inspect and copy.

- **Right to a List of Disclosures:** You have the right to request a list of the disclosures we have made of your PHI. This list will not include disclosures made for treatment, payment, health care operations, purposes of national security, to law enforcement, to corrections personnel, pursuant to your authorization, or directly to you. To request this list, you must submit your request in writing. Your request must state the time period for which you want to receive a list of disclosures. You may only request an accounting of disclosures for a period of time less than six years prior to the date of your request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. We may charge you for responding to any additional requests. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before you incur any cost.

- **Right to Request Restrictions:** You have the Right to request a restriction or limitation on PHI we

Use or disclose about you for treatment, payment, or health care operations, or that we disclose to someone who may be involved in your care or payment for your care, like a family member or friend. While we will consider your request, **we are not required to agree to it.** If we do agree to it, we will comply with your request. To request a restriction, you must make your request in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse or parent). We will not agree to restrictions on PHI uses or disclosures that are legally required, or which are necessary to administer our business.

- **Right to Request Confidential Communications :** You have the right to request that we communicate with you about PHI in a certain way or at a certain location if you tell us that communication in another manner may endanger you. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing and specify how or where you wish to be contacted. We will accommodate all reasonable requests.

- **Contact Addresses:** If you have any questions about a specific individual right or you want to exercise one of your individual rights, please submit your request in writing to the address below which applies to your Coverage:

MetLife or SafeGuard Dental & Vision
P.O. Box 14587
Lexington, KY 40512-4587

MetLife LTC Privacy Coordinator
1300 Hall Boulevard, 3rd Floor
Bloomfield, CT 06002

Delaware American Life Insurance Company
MetLife Worldwide Benefits
P.O. Box 1449
Wilmington, DE 19899-1449

Cancer and Specified Disease Expense Insurance
c/o Bay Bridge Administrators, LLC
P.O. Box 161690
Austin, TX 78716

- **Right to File a Complaint:** If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with us, please contact MetLife, Americas – U.S. HIPAA Privacy Office, P.O. Box 902, New York, NY 10159-0902. All complaints must be submitted in writing. You will not be penalized for filing a complaint. If you have questions as to how to file a complaint, please contact us at telephone number (212) 578-0299 or at HIPAAprivacyAmericasUS@metlife.com.

ADDITIONAL INFORMATION

Changes to This Notice: We reserve the right to change the terms of this notice at any time. We reserve the right to make the revised or changed notice effective for PHI we already have about you, as well as any PHI we receive in the future. The effective date of this notice and any revised or changed notice may be found on the last page, on the bottom right-hand corner of the notice. You will receive a copy of any revised notice from MetLife by mail or by e-mail, if e-mail delivery is offered by MetLife and you agree to such delivery.

Further Information: You may have additional rights under other applicable laws. For additional information regarding our HIPAA Medical Information Privacy Policy or our general privacy policies, please e-mail us at HIPAAprivacyAmericasUS@metlife.com or call us at telephone number (212) 578-0299, or write us at:

MetLife, Americas
U.S. HIPAA Privacy Office
P.O. Box 902
New York, NY 10159-0902

Effective Date: 10242022

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Uniformed Services Employment And Reemployment Rights Act

This section describes the right that you may have to continue coverage for yourself and your covered dependents under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Continuation of Group Vision Insurance:

If you take a leave from employment for "service in the uniformed services," as that term is defined in USERRA, and as a consequence your vision insurance coverage under your employer's group vision insurance policy ends, you may elect to continue vision insurance for yourself and your covered dependents, for a limited period of time, as described below.

The law requires that your employer notify you of your rights, benefits and obligations under USERRA including instructions on how to elect to continue insurance, the amount and procedure for payment of premium. If permitted by USERRA, your employer may require that you elect to continue coverage within a period of time specified by your employer.

You may be responsible for payment of the required premium to continue insurance. If your leave from employment for service in the uniformed services lasts less than 31 days, your required premium will be no more than the amount you were required to pay for vision insurance before the leave began; for a leave lasting 31 or more days, you may be required to pay up to 102% of the total vision insurance premium, including any amount that your employer was paying before the leave began.

Your and your covered dependents' insurance that is continued pursuant to USERRA will end on the earliest of the following:

- the end of 24 consecutive months from the date your leave from employment for service in the uniformed services begins; or
- the day after the date on which you fail to apply for, or return to employment, in accordance with USERRA.

You and your covered dependent may become entitled to continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act ("COBRA") while you have vision insurance coverage under your employer's group vision insurance policy pursuant to USERRA. Contact your employer for more information.

ATTACHMENT I
CITY-PARISH 2025
BENEFITS GUIDE

BR

CITY OF BATON ROUGE
PARISH OF EAST BATON ROUGE

2025 BENEFITS GUIDE

AMERILIFE BENEFITS

BR

TABLE OF CONTENTS

WELCOME

Welcome to the City of Baton Rouge Parish of East Baton Rouge (City-Parish) Open Enrollment for all benefits. As you review this guide, you will notice a full array of options for benefits. Having choices means you can select the plans and options best suited to your family's particular needs.

Professional Benefits Counselors from AmeriLife Benefits will be available to conduct one-on-one benefits enrollment sessions with each employee. These sessions will take place on-site. During the enrollment process, the Benefits Counselors will assist each employee in making changes to personal information, updating beneficiaries, and enrolling in the 2025 plan options.

SUPPORTING DOCUMENTATION

To add ANY dependents, the City-Parish Human Resources Department must have a copy of the social security card and the documentation to support the new dependent (birth certificates or a letter of verification of birth from the hospital if the birth certificate has not been received, certificate of adoption, or marriage license, etc.). Documentation must be presented to the Enrollment Representative and must be submitted with your changes or additions. The Enrollment Representatives are not allowed to process any changes to your benefits until such documentation is provided.

Every employee is asked to update their information, including but not limited to, address and phone numbers, with the Human Resources Department.

This is your Open Enrollment period. All changes must be submitted as instructed prior to the end of Open Enrollment. Remember, ALL CHANGES ARE FINAL! Deductions for newly elected benefits are effective January 1, 2025.

DEPENDENT CHILDREN

On health, dental, and vision insurance plans offered for dependent children are covered through the end of the month of their 26th birthday regardless of student or marital status.

Dependent age limitation for life coverage may vary. Check with a Benefits Counselor for details.

ACTIVE EMPLOYEES APPROACHING AGE 65

Active employees/spouses who are approaching age 65 should contact the Payroll and Benefits Division at 225-389-3134 before enrolling in Medicare.

FAMILY STATUS CHANGES – QUALIFYING EVENTS

The only time you may change your insurance coverage is during the annual Open Enrollment period, unless you experience a life-changing event or family status change as defined by the IRS. It is your responsibility to report any life changes (Qualifying Events) within 30 days of the family status change (marriage, divorce, birth, adoption, death, etc.). If you do not make these changes within 30 days of the Qualifying Event, your right to make changes is lost. You must come to Human Resources Payroll and Benefits to make this change with the necessary documents. If you have any questions, please contact us at 225-389-3134.

QUALIFYING EVENT REQUIRED DOCUMENTATION

QUALIFYING EVENT	REQUIRED DOCUMENTATION
MARRIAGE	Marriage License, Social Security Card
DIVORCE	Official Signed Divorce Decree
BIRTH	Birth Certificate or Hospital Certificate, Social Security Card
ADOPTION, CUSTODY OF CHILD	Adoption Papers, Final Signed Court Decree, Social Security Card
OVERAGE DEPENDENT	No documentation required
CHANGE IN SPOUSES EMPLOYMENT STATUS	Letter from Spouse's previous employer stating the type of coverage, who was covered and the date of cancellation.

FOR THOSE CONSIDERING RETIREMENT SOON

It is important for you to know what benefits can be taken with you. Please see the information below.

FSA – Once you are retired, you can no longer put funds into your FSA. Funds remaining in your FSA account must be spent prior to your retirement or they will be lost.

Basic Life Insurance – Your basic life reduces to 5,000 dollars at retirement.

Optional Life Insurance – You may elect to convert your policy within 30 days of your retirement date to allow plenty of time to review the offer to convert. After 30 days from your retirement date, your right to convert is lost.

Medical – You may elect to keep your medical plan. You must request to keep this plan through your retirement process. Please contact the Human Resources Payroll and Benefits Division at 225-389-3134 with any Medicare questions prior to retirement. You must have the coverage at least one year prior to retirement.

Dental – You may elect to keep your dental plan. You must request to keep this plan through your retirement process. You must have the coverage at least one year prior to retirement.

Vision – You may elect to keep your vision plan. You must request to keep this plan through your retirement process.

Cancer and Accident – You may elect to keep your cancer and accident insurance. You must request to keep this insurance through your retirement process.

INSURANCE VESTING PLAN

The Insurance Vesting Plan determines an employee's premium for health and dental insurance as a retiree. A retiree's premium will be based upon the total "actual" years worked for the City-Parish. Employees covered under health and/or dental insurance as of January 1, 2003 are "grandfathered" and not subject to this plan. Employees with 20 or more years of service are not subject to the Insurance Vesting Plan.

CLOSE TO RETIREMENT?

You must be enrolled in Medical and/or Dental Insurance twelve months prior to retirement in order to keep the insurance as a retiree.

Once you or your spouse are Medicare eligible, you must provide a copy of your Medicare card to the Human Resources Payroll & Benefits Division.

As a retiree, you must enroll in Medicare Part B if you are eligible for Medicare Part A.

BLUE CROSS HMO MEDICAL PLAN

	NETWORK
DEDUCTIBLE	Network Providers: $500 Individual; $1,500 Family
OUT-OF-POCKET LIMIT	Network Providers: $2,500 Individual; $5,000 Family
LIFETIME MAX	Unlimited
PHYSICIANS OFFICE VISIT	$25.00* per visit
SPECIALIST OFFICE VISIT	$35.00* per visit
EMPLOYEE ASSISTANCE COUNSELING	Up to 8 Visits (No Copay/Coinsurance)
URGENT CARE CENTER	$40.00* per visit
VISION CARE EXAM (1 PER 24 MONTHS)	$35.00* per visit
EMERGENCY ROOM	$150* (waived if admitted)
PHYSICIANS OUTPATIENT SURGICAL SERVICES	$100* Co-payment per Day
AMBULATORY SURGICAL FACILITY	$200* per Surgical Visit
INPATIENT HOSPITAL ADMISSION	$200* per day/5 day Max
PREGNANCY CARE	$50.00* Copay (first visit only)

*After Deductible

BLUE CROSS POS MEDICAL PLAN

	NETWORK	NON-NETWORK
DEDUCTIBLE	Network Providers: $500 Individual; $1,500 Family Out of Network: $1,000 Individual; $3,000 Family	
OUT-OF-POCKET LIMIT	Network Providers: $2,500 Individual; $5,000 Family Out of Network Providers: $6,000 Individual; $12,000 Family	
LIFETIME MAX	Unlimited	
PHYSICIANS OFFICE VISIT	$25.00* per visit	70%/30%*
SPECIALIST OFFICE VISIT	$35.00* per visit	70%/30%*
EMPLOYEE ASSISTANCE COUNSELING	Up to 8 Visits (No Copay/Coinsurance)	70%/30%*
URGENT CARE CENTER	$40.00* per visit	70%/30%*
VISION CARE EXAM (1 PER 24 MONTHS)	$35.00* per visit	$35.00 per visit
EMERGENCY ROOM	$150* (waived if admitted)	$150* (waived if admitted)
PHYSICIANS OUTPATIENT SURGICAL SERVICES	$100* Co-payment per Day	70%/30%*
AMBULATORY SURGICAL FACILITY	$200* per Surgical Visit	70%/30%*

*After Deductible

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PHARMACY BENEFITS (HMO AND POS ONLY)

NOTE: COMPOUND DRUGS COSTING $250 OR MORE REQUIRE A PRE-AUTHORIZATION	RETAIL CO-PAYMENT (30 DAY SUPPLY)	MAIL-ORDER CO-PAYMENT (90 DAY SUPPLY)
DEDUCTIBLE - $0 GENERIC/$250 BRAND NAME		
TIER 1–PRIMARILY GENERIC DRUGS, ALTHOUGH SOME BRAND DRUGS MAY FALL INTO THIS TIER.	$4.00	$12.00
TIER 2–PRIMARILY BRAND-NAME DRUGS, ALTHOUGH SOME GENERIC DRUGS MAY FALL INTO THIS TIER.	$30.00	$90.00
TIER 3–BRAND-NAME OR GENERIC DRUGS THAT MAY HAVE A THERAPEUTIC ALTERNATIVE AS A TIER 1 OR TIER 2 DRUG; COVERED COMPOUNDED DRUGS ARE INCLUDED IN THIS TIER.	$50.00	$150.00
TIER 4–A PRESCRIPTION DRUG THAT IS A MULTI-SOURCE BRAND DRUG.	$65.00	$195.00

BLUE CROSS HDHP MEDICAL PLAN

	NETWORK	NON-NETWORK
DEDUCTIBLE	$2,500 Individual; $5,000 Family	$5,000 Individual; $10,000 Family
OUT-OF-POCKET LIMIT	$2,500 Individual; $5,000 Family	$9,000 Individual; $18,000 Family
PHYSICIANS OFFICE VISIT	No charge after deductible	70% after Deductible
SPECIALIST OFFICE VISIT	No charge after deductible	70% after Deductible
PHYSICIANS OUTPATIENT SURGICAL SERVICES	No charge after deductible	70% after Deductible
INPATIENT HOSPITAL ADMISSION	No charge after deductible	70% after Deductible
PREGNANCY CARE	No charge after deductible	70% after Deductible
PRESCRIPTION DRUG (GENERIC & BRAND)	No charge after deductible	

OMADA: DIABETES PREVENTION PROGRAM

TAKE ADVANTAGE OF THIS HEALTH BENEFIT!

Omada is a digital behavior change program that inspires healthy habits you can live with long term. It combines the behavior change science an unwavering support you'll need to lose weight, keep it off and help reduce your risk for type 2 diabetes and heart disease.

OMADA INCLUDES:

- Wireless smart scale to monitor your progress
- Professional health coach to keep you on track
- Interactive program that adapts to you
- Weekly online lessons to educate and inspire
- Small group of participates for real-time support

More great news: If you or your adult dependent (18+) are at risk for type 2 diabetes or heart disease and enrolled in a City of Baton Rouge Blue Cross health plan, the cost of this program is covered with no extra cost to you - a $650 value.

Take a one-minute risk screener to see if you're eligible at www.omadahealth.com/brla.

AMERIFLEX FLEXIBLE SPENDING ACCOUNT (FSA)

An "FSA" is an employer-sponsored program offered as part of the Section 125 or Cafeteria Plan where an employee can pay certain expenses (medical or dependent care) on a pre-tax basis and be reimbursed by the program as those expenses are incurred.

If you currently have an FSA, you must re-enroll during open enrollment. Your FSA deduction will not carryover to 2025.

"USE IT OR LOSE IT" RULE

This term applies to FSA deductions accumulated in a plan year. If the funds are not used within a plan year, the employee loses this money. Careful planning helps to not "lose it."

MEDICAL EXPENSE

Qualified medical expenses include vision care, contacts and glasses, dental work, including orthodontics, medical insurance deductibles, co-pays, prescription drugs, and over-the-counter (OTC) medications. As a general rule, most expenses not reimbursed by your health carrier and expenses to prevent/treat an illness or disease may be qualified medical expenses.

Maximum deductions: $1,250 single or $2,500 if married and filing jointly.

OVER-THE-COUNTER (OTC)

Thanks to the Coronavirus Aid Relief and Economic Security (CARES) Act, you can use your FSA or Health Savings Account (HSA) funds to buy OTC medications without a prescription, like Tylenol and other pain relievers, heartburn medications, allergy relief and more, for the first time since 2011. You can also use your funds for feminine care products, including tampons, pads, liners, cups, sponges, etc., for the first time.

Today, take a few minutes to take stock of the medical supplies you need, any medical bills you have to pay, and how much you have and will contribute to your FSA or HSA this year. These accounts let you use pre-tax dollars on medical costs, which saves you money in the long run. Make a plan for how to get the most out of your contributions.

The changes to eligible expenses are effective retroactively to January 1, 2021. If you purchased OTC medications or feminine care products this year, contact your benefits department to see if you can get reimbursed now.

Of course, you can still use your funds for prescriptions, contact lenses, and medical bills including co-insurance, co-payments, and deductibles.

DEPENDENT CARE EXPENSES

A maximum of $5,000 in dependent care expenses can be paid per year through an FSA. Expenses paid by an employee for the care of dependent children, spouses, or parents while they work are governed by Code Sec. 129.

You must keep all receipts for the expenses incurred for tax purposes.

DEBIT CARD (FSA CONVENIENCE CARD)

Medical expenses may be paid for with the pre-loaded debit card you will receive once your account is open. Providers who accept Master Card can accept your FSA convenience card.

FSA FREQUENTLY ASKED QUESTIONS

Q: Can I participate in the FSA program while enrolled in the High Deductible Health Plan (HDHP)?

A: Yes, you can enroll in the FSA plan while enrolled in any health plan and can also enroll in the FSA without participating in any City of Baton Rouge health plans.

Q: Can I have both an FSA and HSA in the same plan year?

A: No, but you can have a Dependent Care FSA and an HSA.

Q: I am ending my employment, can I use my FSA until the end of the month as I could my HMO plan?

A: No, your FSA will end the day you resign. If you use your card after the term date, you will be responsible for repaying AmeriFlex for the claim that was incurred after the termination date.

Q: My spouse is also a City of Baton Rouge employee, can I elect an FSA and my spouse elect an HSA?

A: No

Q: My spouse is also a City of Baton Rouge employee, can we both enroll in an FSA?

A: Yes, however, you can only enroll in $1,250 each which will equal $2,500, which is the family maximum.

Q: Why am I receiving a Substantiation Request every time I use my FSA convenience card at the doctor's office, but I don't get them when I use my card at WalMart?

A: The pharmacies and WalMart have a smart reader (IIAS Merchants system) that automatically identifies FSA eligible items, whereas doctors do not have such capabilities.

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HEALTH EQUITY HEALTH SAVINGS ACCOUNT (HSA)

An "HSA" is a bank account set up with pre-tax money deducted from your paycheck and deposited on your behalf if you are enrolled in the High Deductible Health Plan (HDHP). On a voluntary basis, you may deposit up to 100% of your individual or family deductible on your medical plan.

CARRYOVER RULE:

Unlike the FSA, any unspent dollars in your account are rolled over from year to year.

MEDICAL EXPENSE:

Money in this account may be used toward your deductible, or may be used toward many other medically related items or procedures as approved by the Federal Government, which includes treatment or procedures not covered by your health plan, dental work, glasses or contacts, some OTC etc. Typically excluded are cosmetic or elective services. For more information on specifics of what these funds can and cannot be used for visit Health Equity's website: www.healthequity.com Maximum deductions: $4,300 single, or $8,550 if married and filing jointly.

OVER THE COUNTER (OTC):

Thanks to the Coronavirus Aid Relief and Economic Security (CARES) Act, you can use your FSA or HSA funds to buy OTC medications without a prescription, like Tylenol and other pain relievers, heartburn medications, allergy relief and more, for the first time since 2011. You can also use your funds for feminine care products, including tampons, pads, liners, cups, sponges, etc., for the first time.

Today, take a few minutes to take stock of the medical supplies you need, any medical bills you have to pay, and how much you have and will contribute to your FSA or HSA this year. These accounts let you use pre-tax dollars on medical costs, which saves you money in the long run. Plan for how to get the most out of your contributions.

The changes to eligible expenses are effective retroactively to January 1, 2021. If you purchased OTC medications or feminine care products this year, contact your benefits department to see if you can get reimbursed now.

Of course, you can still use your funds for prescriptions, contact lenses, and medical bills including co-insurance, co-payments, and deductibles.

"If you are eligible for Medicare and an active employee, you are not eligible to participate in the Health Savings Account feature.

HEALTH EQUITY FEE CHANGES

Effective September 1, 2011, Health Equity began charging a fee of $1.25 to all MySmartSaver HSA account holders who require paper statements. To avoid this fee, log on to your account at www.healthequity.com and navigate to "My Accounts> Statements>Change your statement delivery method.

Effective March 2011, Health Equity began charging an HSA account maintenance fee of $2.50 per month. This will be waived for the first three statement cycles after a new MySmartSaver HSA account opening.

This $2.50 fee will be waived for any statement cycle in which the account holder maintains:

- Balance over $1,500, if an electronic deposit is credited to the account that statement cycle; or,
- Balance over $2,500, regardless if an electronic deposit is credited to the account that statement cycle.

Although it may not be needed at the time of purchase, it is recommended that HSA account holders keep prescriptions along with receipts in their records in case of an audit.

HSA FREQUENTLY ASKED QUESTIONS

Q: Can I participate in an HSA while enrolled in the HMO plan?
A: No, you can only participate in HSA while enrolled in the HDHP plan.

Q: Can I contact Health Equity to cancel my account anytime during the year?
A: No, you are taking advantage of Section 125 of the Internal Revenue Code, which states that you can only make changes to tax-sheltered premiums during Open Enrollment or due to a qualifying event. That's why it is important to carefully estimate before electing an amount.

Q: My spouse is also a City of Baton Rouge employee, can I elect an HSA while he enrolls in the Family HDHP?
A: No, the person who will carry the plan has to carry the Health Savings Account.

Q: I am enrolling in the HDHP, and I am covered on my spouse's HMO plan that he has with his employer, can I elect an HSA?
A: No, an employee who is covered as a dependent under a comprehensive (PPO, HMO, POS, etc) health plan and elects an HDHP, cannot contribute to the HSA.

UNUM DENTAL PLAN (Previously AlwaysCare Dental Plan)

No Benefit Changes

OUTLINE OF BENEFITS	PLATINUM PLAN				
PARTICIPATING PROVIDER PLAN	Choose any dentist; however, you may select a Participating Provider (over 80 in the Baton Rouge area) for discounted fees and no balance billing.				
DEDUCTIBLE	$50 per calendar year, Maximum 3 per family. Applies to Class B & C.				
CARRYOVER BENEFIT	Included				
BENEFIT YEAR MAXIMUM	$1500 for Class A, B & C.				
COINSURANCE	PLAN PAYS:	CLASS A	CLASS B	CLASS C	CLASS D
	IN-NETWORK	100%	80%	60%	60%
	NON-NETWORK	100%	80%	60%	60%
CLASS A (NO WAITING PERIOD)	PREVENTIVE SERVICES:				
	• Routine Exams (2 per 12 months) • Prophylaxis* (2 per 12 months) • Bitewing X-rays (max) • 4 films) (1 per 12 months) • Emergency Pain		• Adjunctive Pre-Diagnostic Oral Cancer Screening (max 1 per 12 months for age 40+) • Full mouth/panoramic X-rays (1 per 24 months) • Sealants to age 16 (permanent molars only, 1 per 36 months) • Fluoride Treatment to age 16 (1 per 12 months) • Space Maintainers to age 16 (1 per 24 months)		
CLASS B (no waiting period)	BASIC SERVICES:				
	• Oral Surgery • Fillings	• Crown, Denture, Bridge Repair • Simple Periodontics	• Anesthesia • Simple Extractions	• Endodontics (root canals) • Surgical Periodontics	
CLASS C (12 month waiting period for new enrollees and their dependents only)	MAJOR SERVICES:				
	• Inlays and Onlays	• Crowns, Bridges, Dentures, and Endosteal Implants			
CLASS D (12 month waiting period for new enrollees and their dependents only)	ORTHODONTICS:				
	• Annual Maximum $750	• Separate Lifetime Maximum $1,500	• Dependent Children to age 19 only		
	• *Prophylaxis coverage is enhanced to include one additional cleaning or periodontal maintenance per year if member is in second or third trimester of pregnancy. Written proof must be submitted at the time of the claim.				

OUTLINE OF BENEFITS	SILVER PLAN				
PARTICIPATING PROVIDER PLAN	In-Network only. Members may only use Participating Providers.				
CARRYOVER BENEFIT	Not Included				
COINSURANCE	PLAN PAYS:	CLASS A	CLASS B	CLASS C	
	In-Network	80%	60%	30%	
	*A schedule of co-pay amounts will be published each year no later than January 1st.				
CLASS A (no waiting period)	PREVENTIVE SERVICES:				
	• Routine Exams (2 per 12 months) • Fluoride Treatment to age 16 (1 per 12 months)	• Bitewing X-rays (max 4 films) (1 per 12 months) • Space Maintainers to age 16 (1 per 24 months)	• Sealants to age 16 • Prophylaxis* (2 per 12 months)	• Adjunctive Pre-Diagnostic Oral Cancer Screening (max 1 per 12 months for age 40+) (permanent molars only, 1 per 36 months)	
CLASS B (no waiting period)	BASIC SERVICES:				
	• Anesthesia • Emergency pain • Simple Extractions	• Crown, Denture, Bridge Repair • Oral Surgery	• Full mouth/panoramic X-rays (1 per 24 months)	• Fillings	
CLASS C (no waiting period)	MAJOR SERVICES:				
	• Simple Periodontics • Inlays and Onlays	• Crowns, Bridges and Dentures	• Endodontics (root canals) • Surgical Periodontics		

METLIFE VISION PLAN (Previously Davis Vision Plan)

No Benefit Changes

IN-NETWORK BENEFITS	
EYE EXAMINATION	Every 12 months, Covered in full after $10 co-payment
EYEGLASSES	
SPECTACLE LENSES	Every 12 months, Covered in full For standard single-vision, lined bifocal, or trifocal lenses after $25 co-payment
FRAMES	Every 24 months, Covered in full
CONTACT LENSES	
CONTACT LENS EVALUATION, FITTING & FOLLOW UP CARE	Every 12 months, Covered in full Collection Contacts: after $25 copay or For Standard Contacts: after $25 copay or For Specialty Contacts: $60 allowance with 15% off balance less $25 co-payment
CONTACT LENSES (in lieu of eyeglasses)	Every 12 months, Covered in full

METLIFE BASIC TERM LIFE

Your employer provides Basic Term Life and Accidental Death and Dismemberment insurance coverage in the amount of $25,000 at no cost for non-elected officials and $50,000 for elected officials.

METLIFE OPTIONAL TERM LIFE INSURANCE COVERAGE OPTIONS

FOR YOU	Multiples of $10,000 to a maximum of the lesser of 6 times your basic annual earnings or $800,000
FOR YOUR SPOUSE	$5,000 to $250,000 in $5,000 increments, up to 50% of your coverage amount
FOR YOUR DEPENDENT	Children* $1,000 to $10,000 in increments of $1,000

*Child(ren)'s Eligibility: Dependent children from birth to 26 years old regardless of student status, marital status or full-time employment status.

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) COVERAGE OPTIONS

FOR YOU	Supplemental AD&D amount is equal to your Supplemental Term Life amount.
FOR YOUR SPOUSE AND CHILD(REN)	Dependents will be eligible for coverage amounts equal to their amounts of Dependent Term Life coverage.

SERVICES TO HELP NAVIGATE WHAT LIFE MAY BRING, AT NO ADDITIONAL COST TO YOU

Life insurance can be a critical first step in helping to ensure your family's financial wellbeing. With your MetLife group life insurance coverage, you get access to meaningful services to help you make the right decisions to manage what life may bring.

PLANNING FOR THE FUTURE

Funeral Discounts & Planning Services; Helping to alleviate the burden of making funeral arrangements from your loved ones. Get access to the largest network of funeral homes and cemeteries to pre-plan with a counselor and receive discounts on funeral services.

Dignity Memorial: Visit www.finalwishesplanning.com or call 1-866-853-0954

Will Preparation: Helping to ensure your final wishes are clear. Access the online will preparation services.

Visit www.willscenter.com

Retirement Planning: Retiring with confidence. Access workshops that offer comprehensive retirement and financial education to help you plan for the future, through our Retire wise program.

Contact your Human Resources team for more information

ASSISTING THROUGH LIFE'S CHANGES

Transition Solutions; Having assistance when moving on from a company. Receive help with time-sensitive benefit and financial decisions so you can make the right choices during employment transitions.

Email solutions@metlife.com or call 1-877-275-6387

Portability; Helping to prevent gaps in your coverage. Take your life insurance benefits with you at competitive group rates.

SUPPORTING YOU AND YOUR LOVED ONES THROUGH DIFFICULT TIMES

Grief Counseling: Accessing professional support in a time of need. Meet in-person or by phone with a licensed counselor to help cope with a loss or major life change.

Visit www.metlifegc.lifeworks.com or call 1-888-319-7819

User Name: metlifeassist Password: support

Funeral Assistance; Honoring a loved one's life. Work with compassionate counselors that assist with customizing funeral arrangements with personalized one-on-one service.

Dignity Memorial: Visit www.finalwishesplanning.com or call 1-866-853-0954

Beneficiary Claim Assistance: Making the claims process easy. Your beneficiaries get guidance from experts as they work through their options and financial needs with our Delivering The Promise services.

Delivering the Promise- Call 1-877-275-6387

Estate Resolution Services: Settling an estate with confidence. With unlimited consultations, either in person with an attorney or by phone, including court representations, you can feel confident you've made the right decisions.

Hyatt Legal Plans – Call 1-800-821-6400

Life Settlement Account: Reducing the pressure of immediate financial decisions. Your beneficiaries can take their time to make the right decision with the flexible settlement option that gives full access to policy funds while earning a guaranteed minimum interest rate.

Information on the account is distributed to the beneficiary at the point of claim payment.

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GROUP UNIVERSAL LIFE

The Allstate Benefits Group Universal Life product is a flexible premium adjusted life insurance plan, designed with a focus on death benefit amount.

- Premium rates are unisex and either tobacco or non-tobacco, offering employees the opportunity to qualify for the coverage they need.
- Portable coverage allows the insured's coverage to continue as long as premiums are paid to Allstate Benefits if an employees employment ends.
- Flexible optional riders allow employees to tailor coverage to help meet their specific needs.

GROUP VOLUNTARY DISABILITY

Group Short Term Disability (STD) coverage from Allstate Benefits provides a monthly cash benefit for disabilities due to non-occupational sickness or injury.

Having an income can take a lot of worry out of ordinary everyday living. With it, you cover bills, pay for your home and provide for your family. But what if you got sick or injured and couldn't work? How long could you afford expenses without a paycheck?

This disability coverage helps to offer peace of mind when an unexpected sickness or injury occurs.

TAKE CHARGE OF YOUR HEALTH TODAY!

Healthy Lives, offered by Our Lady of the Lake, is a comprehensive health and wellness program provided at no cost to all employees enrolled in the East Baton Rouge City-Parish (EBRCP) health plan. Working well begins with living well. We're pleased to be a partner for your health journey.

As an EBRCP benefit to employees enrolled in the health plan, we offer the Healthy Lives Wellness Plan to support and encourage individual health goals. Whether at home or work, these tools and personal coaching assist with helping each employee and their family identify what's important to their health and well-being with a plan to achieve results. Body, mind, and spirit – our comprehensive wellness approach complements your physician's care and personal health goals.

As a benefit of the Healthy Lives Wellness Program, eligible EBRCP employees can work with a Health Coach. Our Health Coaches are committed to helping you achieve your best health. We will work one-on-one with you and your healthcare provider, if you wish, to customize fitness, nutrition, and health goals that work specifically for you and support you in making healthy choices and changes through a holistic approach tailored to your lifestyle. Healthy Lives members can take their plan and track their progress using the Healthy Lives mobile app. This interactive tool helps members keep track of their total well-being and manage their healthy lifestyle choices. Members can stay connected to the Healthy Lives Wellness resources through the mobile app, including chats with a Health Coach. The app is free to download and compatible with all mobile devices.

To learn more about the East Baton Rouge City-Parish Wellness Program and Healthy Lives:

Call: 1 (855) I AM HEALTHY (426-4325) or email healthylives@fmolhs.org.

You can also create an account in the web-based portal; visit http://portal.inhealth4change.com, enter Company ID: **EBRCP** and continue to follow the directions.

LONG TERM DISABILITY INSURANCE

You are eligible for Long Term Disability (LTD) coverage offered by Unum if you are an active employee in the United States working a minimum of 30 hours per week.

MONTHLY BENEFIT AMOUNT

Either 50% or 60% of your monthly earnings to a maximum benefit of 6,000 dollars per month.

ELIMINATION PERIOD

You could begin receiving LTD benefits if, after 180 days of disability, you are still disabled (as described in the definition of disability). During the elimination period, the disability is considered continuous even if the disability stops (e.g., you return to work full time) for 30 days or less. You are not required to have a 20% or more loss in your indexed monthly earnings due to the same injury or sickness to be considered disabled during the elimination period.

MAXIMUM MONTHLY BENEFIT AMOUNT

Your total monthly benefit (including all benefits provided under this plan) will not exceed 100% of your monthly earnings. However, if you are participating in Unum's Rehabilitation and Return-To-Work Assistance Program, your total monthly benefit (including all benefits provided under this plan) will not exceed 110% of your monthly earnings.

If you are disabled, participating in the Rehabilitation and Return-To-Work Assistance Program, and have dependent care expenses, you may also receive the dependent care expense benefit — 350 dollars per dependent per month, to a monthly maximum of 1,000 dollars for all eligible dependents combined.

Worldwide emergency travel assistance is included with this LTD plan. Emergency travel assistance is available to you, your spouse, and your dependent children when you travel to any foreign country, including Canada or Mexico. It is also available anywhere in the United States when you travel just 100 or more miles from home.

Note: A spouse traveling on business for his or her employer is not covered by the program.

METLIFE CRITICAL ILLNESS INSURANCE

MetLife Critical Illness Insurance (CII) is a voluntary benefit designed to complement but not replace your current medical coverage. The coverage pays a lump-sum benefit if you experience one of the covered conditions. You can use the lump-sum to help pay additional expenses not covered by your medical insurance or for any day-to-day living expenses, such as medical plan copays and deductibles, out-of-network treatments, experimental treatments, mortgage and rent payments, utilities, and childcare or domestic help. It's up to you how you use the payment.

For additional information on the CII benefit, speak with an on-site Benefits Counselor during Open Enrollment Period.

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OFF-THE-JOB ACCIDENT INSURANCE

Off-The-Job Accident Insurance is offered by Transamerica Life Insurance Company

WHAT HAPPENS IF YOU GET HURT?

Accident insurance can help offset your medical deductible and help to reduce stress and recovery time.

ARE WE INSURED FOR THAT?

As one of your employer's most important assets, it is important to protect yourself and make sure you can recover from whatever life may throw at you. Transamerica Life Insurance Company's new AccidentAdvance℠ offers off-the-job insurance for accidents. It also offers features to promote healthier behavior in general, such as an auto accident benefit that pays more if the insured was wearing a seat belt and has airbags in the car. It is an advancement in accident insurance.

This coverage pays in addition to any other insurance and is Guaranteed Issue.

UNDERSTANDING ACCIDENTADVANCE℠

AccidentAdvance is a group voluntary off-the-job accident-only insurance policy. Individual and family insurance options are available, and as with all our products, is conveniently payroll deducted. Issue ages for employees and spouses are 18 through 64. Eligible children can have insurance through age 26. The base policy includes Accident Emergency Treatment, Follow-Up Visit and Physical Therapy.

Riders Included:

- Accidental Death and Dismemberment Rider
- Accident Hospital and ICU Income Rider
- Expanded Benefits Rider
- Wellness Benefits Rider

This is a brief summary of AccidentAdvance, off-the-job Accident Insurance underwritten by Transamerica Life Insurance Company, Cedar Rapids, Iowa, Policy Form Series CPACC100 and CCACC100. Limitations and Exclusions apply. Refer to the policy, certificate, and riders for complete details.

CANCER INDEMNITY INSURANCE

This coverage is offered by Transamerica Life Insurance Company

CAN STRESS SLOW RECOVERY?

Loss of income can only add to the stress of an unexpected illness. Wellness benefits included with this coverage can help aid early detection.

CancerSelect® Plus Cancer-Only Insurance is flexible, conveniently payroll deducted, and designed to provide you and your eligible family members with benefits for costs associated with cancer treatment. No physical exams or blood tests are required and your policy is 100% portable. Benefits are paid directly to you—or anyone you choose—in addition to any other insurance.

Acceptance will be upon answers to questions on the application. Varies by state.

UNDERSTANDING CANCERSELECT® PLUS BASE POLICY

CancerSelect Plus includes:

- Hospital Benefits
- Cancer Maintenance Therapy
- Surgery Benefits
- Radiation and Chemotherapy Benefits
- Wellness and Miscellaneous Benefits

Riders Included:

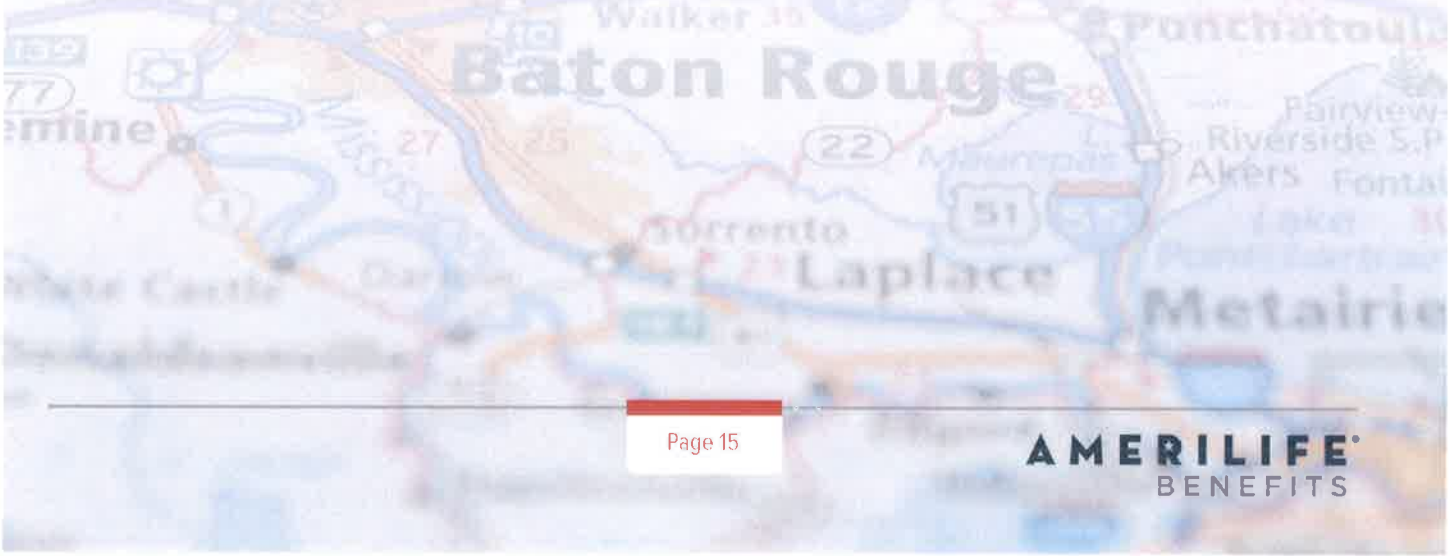
- First Occurrence Rider
- Intensive Care Rider
- Specified Illness and Disease Rider

This is a brief summary of CancerSelect Plus, Cancer-Only Insurance underwritten by Transamerica Life Insurance Company, Cedar Rapids, Iowa, Policy Form Series CPCAN200 and CCCAN200. Limitations and Exclusions apply. Refer to the policy, certificate, and riders for complete details.

RESOURCES

BENEFIT	CARRIER	PHONE NUMBER	WEBSITE
MEDICAL	Blue Cross Blue Shield Louisiana	1-225-293-2583 1-888-224-2583	www.bcbsla.com
FSA	Ameriflex	1-888-868-3539	www.Flex125.com
HSA	Health Equity	1-866-346-5800	www.healthequity.com memberservices@healthequity.com
DENTAL	Unum	1-800-858-6843	www.unum.com
VISION	Metlife	1-800-GET-MET8 1-(800-438-6388)	www.metlife.com
GROUP UNIVERSAL LIFE & GROUP VOLUNTARY DISABILITY	Allstate Benefits	1-800-521-3535	www.allstatebenefits.com
CRITICAL ILLNESS	Metlife	1-800-GET-MET8 1-(800-438-6388)	www.metlife.com
BASIC LIFE	Metlife	1-800-638-6420	www.metlife.com
ACCIDENT & CANCER	Transamerica Life Insurance Company	1-888-763-7474	www.transamericaemployeebenefits.com
HEALTHY LIVES		1-855-426-4325	www.OurHealthyLives.org
PHARMACY	Express Scripts	1-800-451-6245	www.express-scripts.com
DEFERRED COMP.	NationWide	1-888-401-5272	www.nrsforu.com
	Empower	1-225-681-0457	
EAP	Hidalgo	1-225-927-0160 or 1-800-448-4470	www.healthassociatesllc.com
LONG TERM DISABILITY	Unum	1-800-858-6843	www.unum.com

This Employee Benefits Brochure highlights the main features of your benefits programs and does not include all the rules and details, including limitations and exclusions. The terms of your benefits plans are governed by legal documents, including insurance contracts and the Summary Plan Description (SPD). If there is a conflict between the information in this brochure and the formal language of the SPD, the wording in the SPD will govern.



AMERILIFE BENEFITS

CITY OF BATON ROUGE
PARISH OF EAST BATON ROUGE

ATTACHMENT J

100% VOLUNTARY CANCER - TRANSAMERICA

TRANSAMERICA

Summary for: CITY OF BATON ROUGE

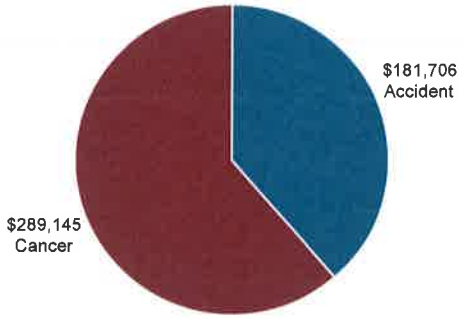
GET STARTED

(Data: 7/1/2023 through 6/30/2024)

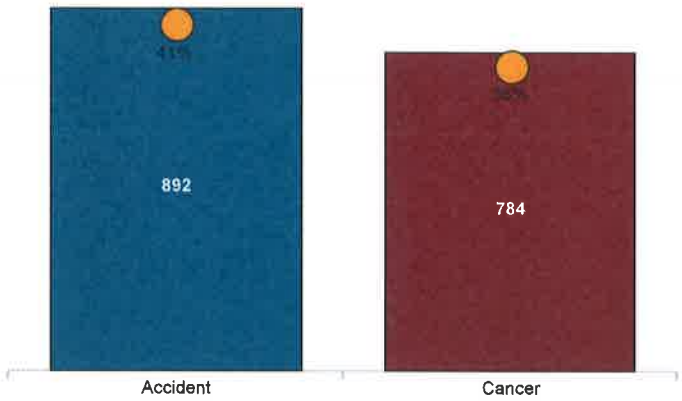
Transamerica recognizes how important it is to educate employees about the benefits available to them. As a carrier we want to support brokers and employers in efforts to best educate and inform employees to help them make the best decisions for themselves and their families.

Starting Policies (7/1/2023)	Added Policies	Terminated Policies	Ending Policies (6/30/2024)	Ending Premium (6/30/2024)
1,448	353	125	1,676	$470,851

Inforce Premium (as of 6/30/2024)



Inforce Policies & Participation Rate (as of 6/30/2024)



Transamerica believes that sharing how these benefits are utilized highlights the importance of our products.

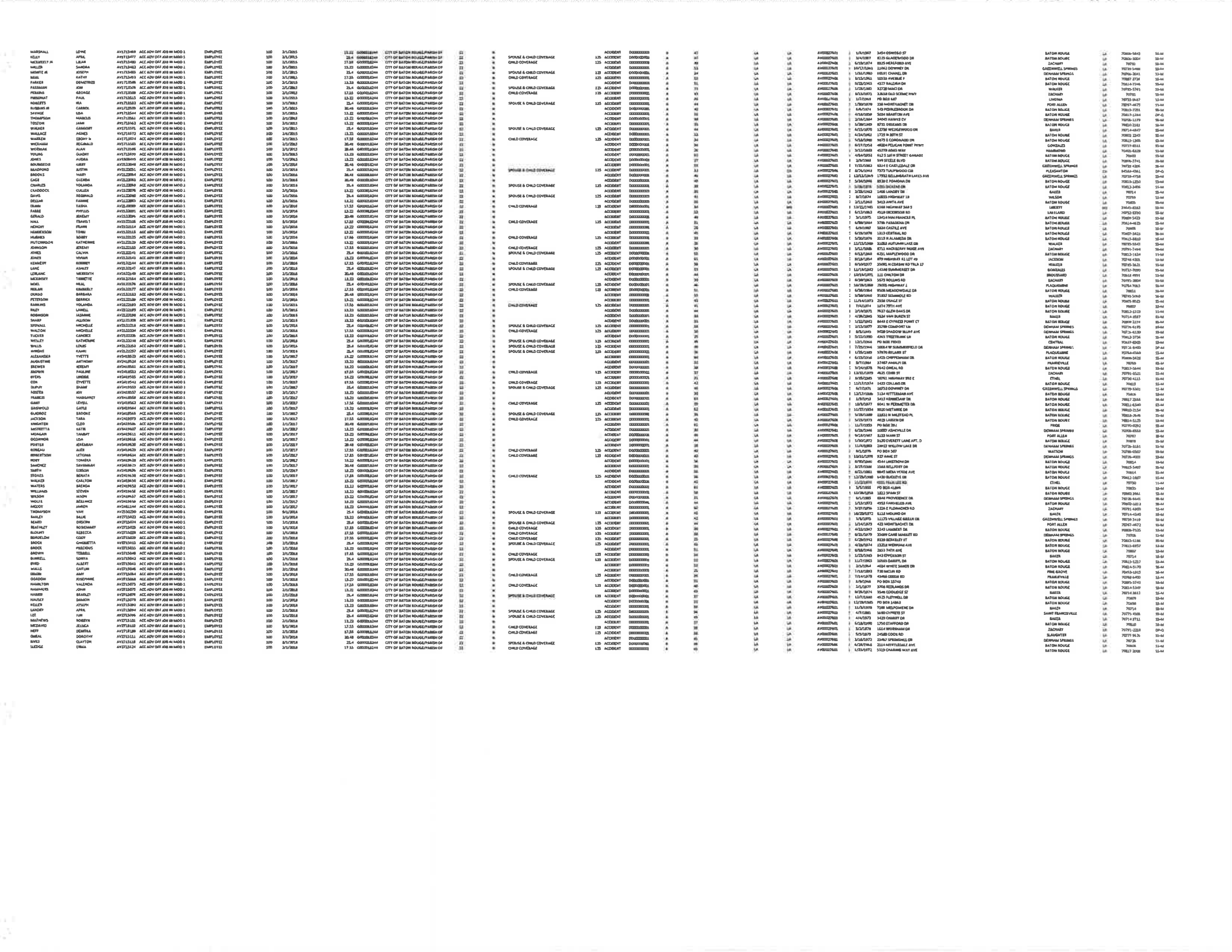
Utilization of Benefits

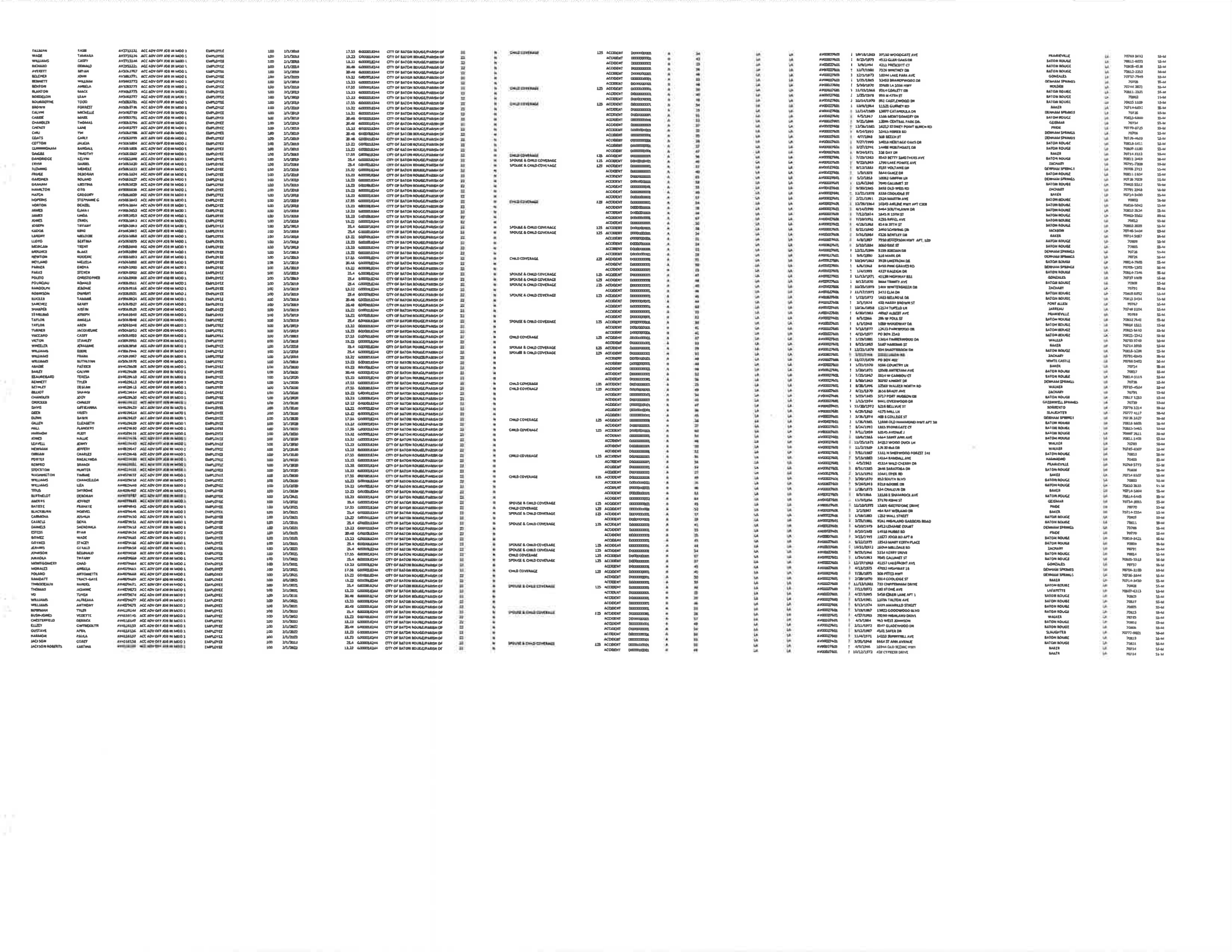
Line of Business	Claim Count 2022	Claim Count 2023	Claim Count 2024	Claim Count 2025	Paid Claims 2022	Paid Claims 2023	Paid Claims 2024	Paid Claims 2025
Accident	233	196	225	52	$21,964	$41,095	$23,594	$4,810
Cancer	324	285	294	79	$115,512	$137,271	$92,310	$13,251
Grand Total	**557**	**481**	**519**	**131**	**$137,476**	**$178,366**	**$115,904**	**$18,061**

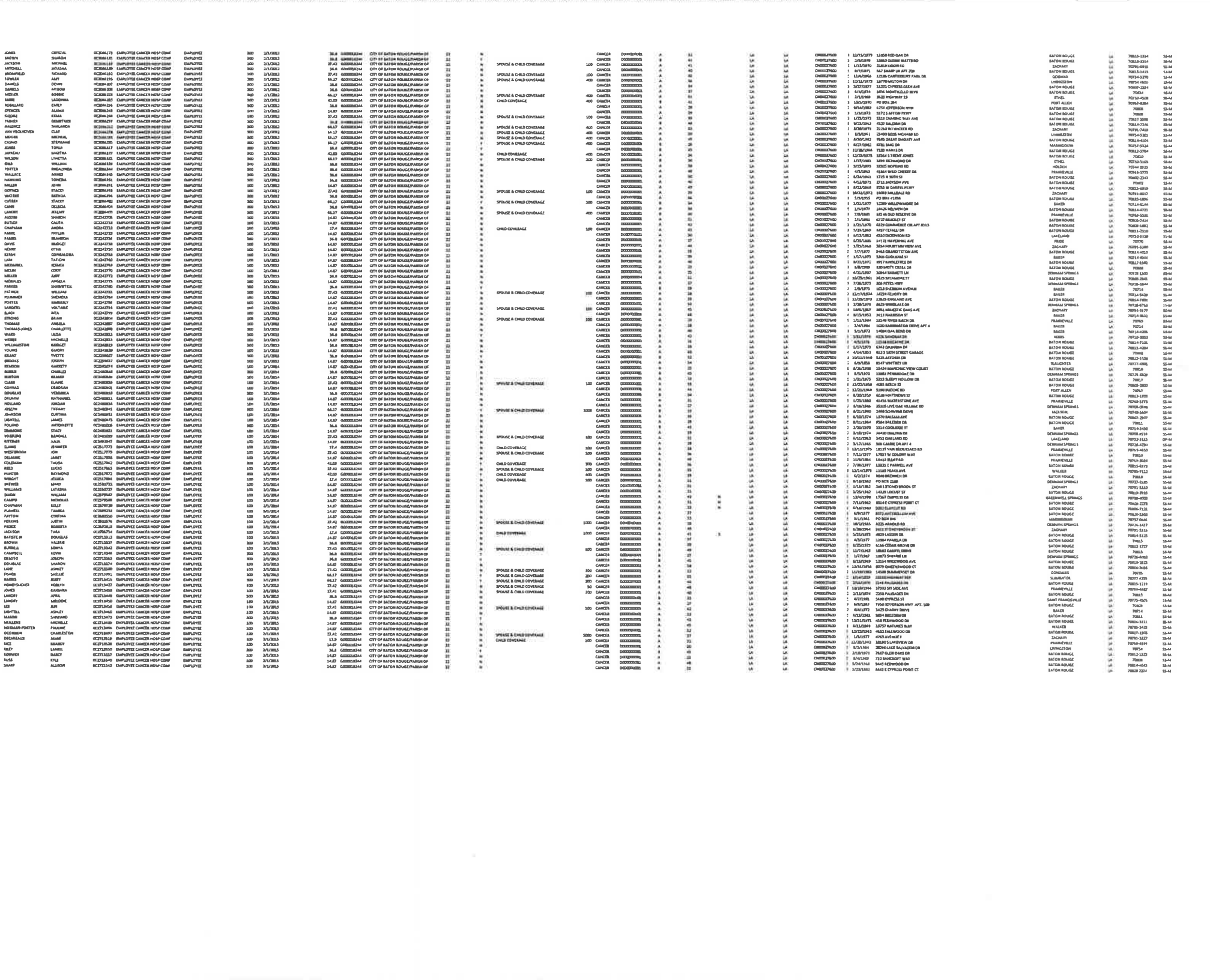
Wellness Claim Counts & Amounts Paid (7/1/2023 - 6/30/2024)

277589 04/21

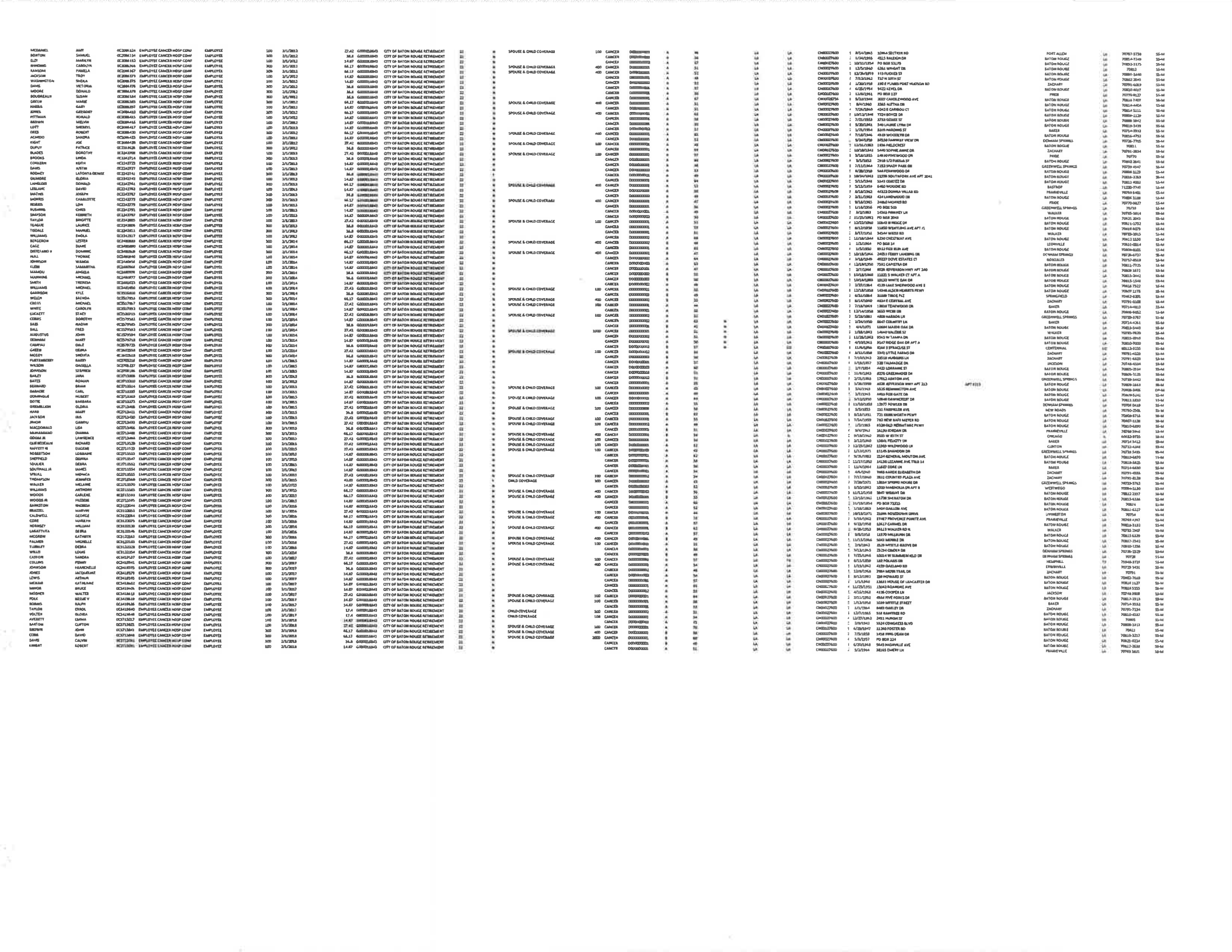
INS-LNAME	INS-FNAME	POLICY	COVERAGE	RELATIONSHIP	FACE AMOUNT	ISSUE DATE	MONTHLY PREMIUM	GROUP	GROUP NAME
MINOR	ANTHONY	[illegible]	ACC ADV OFF JOB IN MOD 1	EMPLOYEE	100	2/1/2012	25.4	[illegible]	CITY OF BATON ROUGE/PARISH OF
LEWIS	GREGORY	[illegible]	ACC ADV OFF JOB IN MOD 1	EMPLOYEE	100	2/1/2012	13.22	[illegible]	CITY OF BATON ROUGE/PARISH OF
BABIN	ELIZABETH	[illegible]	ACC ADV OFF JOB IN MOD 1	EMPLOYEE	100	2/1/2012	13.22	[illegible]	CITY OF BATON ROUGE/PARISH OF
NAQUIN	DANIEL	[illegible]	ACC ADV OFF JOB IN MOD 1	EMPLOYEE	100	2/1/2012	25.4	[illegible]	CITY OF BATON ROUGE/PARISH OF
ANDREWS	ANNA	[illegible]	ACC ADV OFF JOB IN MOD 1	EMPLOYEE	100	2/1/2012	25.4	[illegible]	CITY OF BATON ROUGE/PARISH OF
WILLIAMS	REGINALD	[illegible]	ACC ADV OFF JOB IN MOD 1	EMPLOYEE	100	2/1/2012	13.22	[illegible]	CITY OF BATON ROUGE/PARISH OF
DUNAWAY	MATTHEW	[illegible]	ACC ADV OFF JOB IN MOD 1	EMPLOYEE	100	2/1/2012	25.4	[illegible]	CITY OF BATON ROUGE/PARISH OF
STOKES	JACQUELINE	[illegible]	ACC ADV OFF JOB IN MOD 1	EMPLOYEE	100	2/1/2012	13.22	[illegible]	CITY OF BATON ROUGE/PARISH OF
GRIFFIN	SHONLETTA	[illegible]	ACC ADV OFF JOB IN MOD 1	EMPLOYEE	100	2/1/2012	17.55	[illegible]	CITY OF BATON ROUGE/PARISH OF
MATTHEWS	DONALD	[illegible]	ACC ADV OFF JOB IN MOD 1	EMPLOYEE	100	2/1/2012	17.55	[illegible]	CITY OF BATON ROUGE/PARISH OF
SPELTING	AARON	[illegible]	ACC ADV OFF JOB IN MOD 1	EMPLOYEE	100	2/1/2012	13.22	[illegible]	CITY OF BATON ROUGE/PARISH OF
HARRY	LEONARD	[illegible]	ACC ADV OFF JOB IN MOD 1	EMPLOYEE	100	2/1/2012	17.55	[illegible]	CITY OF BATON ROUGE/PARISH OF
WRIGHT	JESSICA	[illegible]	ACC ADV OFF JOB IN MOD 1	EMPLOYEE	100	2/1/2012	13.22	[illegible]	CITY OF BATON ROUGE/PARISH OF
ROGALLO	TRENT	[illegible]	ACC ADV OFF JOB IN MOD 1	EMPLOYEE	100	2/1/2012	25.4	[illegible]	CITY OF BATON ROUGE/PARISH OF
YATES	ALYCIA	[illegible]	ACC ADV OFF JOB IN MOD 1	EMPLOYEE	100	2/1/2012	20.48	[illegible]	CITY OF BATON ROUGE/PARISH OF
BABB	RUDOLPH	[illegible]	ACC ADV OFF JOB IN MOD 1	EMPLOYEE	100	2/1/2012	25.4	[illegible]	CITY OF BATON ROUGE/PARISH OF
FURA	JACOB	[illegible]	ACC ADV OFF JOB IN MOD 1	EMPLOYEE	100	2/1/2012	25.4	[illegible]	CITY OF BATON ROUGE/PARISH OF
KRAUSE	PATRICIA	[illegible]	ACC ADV OFF JOB IN MOD 1	EMPLOYEE	100	2/1/2012	20.48	[illegible]	CITY OF BATON ROUGE/PARISH OF
BUTLER	STEPHANIE	[illegible]	ACC ADV OFF JOB IN MOD 1	EMPLOYEE	100	2/1/2012	13.22	[illegible]	CITY OF BATON ROUGE/PARISH OF
SPEAKS JR	CLYDE	[illegible]	ACC ADV OFF JOB IN MOD 1	EMPLOYEE	100	2/1/2012	13.22	[illegible]	CITY OF BATON ROUGE/PARISH OF
FOURNET	DOUGLAS	[illegible]	ACC ADV OFF JOB IN MOD 1	EMPLOYEE	100	2/1/2012	13.22	[illegible]	CITY OF BATON ROUGE/PARISH OF
FONTENOT	CASEY	[illegible]	ACC ADV OFF JOB IN MOD 1	EMPLOYEE	100	2/1/2012	13.22	[illegible]	CITY OF BATON ROUGE/PARISH OF
WILKINSON	BRANDON	[illegible]	ACC ADV OFF JOB IN MOD 1	EMPLOYEE	100	2/1/2012	25.4	[illegible]	CITY OF BATON ROUGE/PARISH OF
WASHINGTON	KENDALL	[illegible]	ACC ADV OFF JOB IN MOD 1	EMPLOYEE	100	2/1/2012	[illegible]	[illegible]	CITY OF BATON ROUGE/PARISH OF
VAUGHN	DARLA	[illegible]	ACC ADV OFF JOB IN MOD 1	EMPLOYEE	100	2/1/2012	25.4	[illegible]	CITY OF BATON ROUGE/PARISH OF
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]







Last Name	First Name	Plan	Relationship	Units	Eff. Date	Premium	Group Name	Coverage	Amount	Product	DOB	Address	City	State	Zip	Age
FRANCOIS	ANDRE	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	64.17	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	400	CANCER	6/28/1941	9317 WILD VALLEY ROAD	BATON ROUGE	LA	70810	55-64
PERRY	LEROY	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	36.8	CITY OF BATON ROUGE RETIREMENT			CANCER	8/17/1954	9654 DEER RUN AVE	ZACHARY	LA	70791 7520	55-64
PAGE JR	JOE	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	14.87	CITY OF BATON ROUGE RETIREMENT			CANCER	[illegible]	[illegible]	WALKER	LA	70785	55-64
BEARDEN	JOYCE	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	36.8	CITY OF BATON ROUGE RETIREMENT			CANCER	1/6/1956	3714 CHRIS DR	ADDIS	LA	70710-2253	55-64
WHITLEY	RITA	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	36.8	CITY OF BATON ROUGE RETIREMENT			CANCER	8/18/1958	23620 PLANK RD	ZACHARY	LA	70791-6425	55-64
FONTENOT	THELMA	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	36.8	CITY OF BATON ROUGE RETIREMENT			CANCER	1/18/1970	13441 ROODWOOD BLVD	BATON ROUGE	LA	70815-6725	55-64
BABIN	RUDOLPH	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	64.17	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	400	CANCER	10/3/1953	4045 28TH AVE	BAY SAINT LOUIS	MS	39520-7518	55-64
WILLIAMS	KENNETH	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	36.8	CITY OF BATON ROUGE RETIREMENT			CANCER	2/5/1952	328 NAPOLEON ST	BATON ROUGE	LA	70802-5839	55-64
PINELL	KENNETH	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	27.42	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	100	CANCER	3/16/1961	16767 APACHE DR	GREENWELL SPRINGS	LA	70739-6238	55-64
FORD	CHERYL	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	36.8	CITY OF BATON ROUGE RETIREMENT			CANCER	4/28/1964	1223 TRAMMELL DR	BATON ROUGE	LA	70815	55-64
COLEMAN	MOZELLE	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	14.87	CITY OF BATON ROUGE RETIREMENT			CANCER	7/5/1953	6228 CALION DR	BATON ROUGE	LA	70812-1903	55-64
BULLION	RONALD	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	36.8	CITY OF BATON ROUGE RETIREMENT			CANCER	11/22/1938	7449 OAKMOUNT DR	BATON ROUGE	LA	70817 5820	55-64
DANEZOLA	DENISE	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	36.8	CITY OF BATON ROUGE RETIREMENT			CANCER	4/23/1955	29606 CHRISTOPHER BLVD	WALKER	LA	70785-9806	55-64
WOMACK	BONNIE	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	14.87	CITY OF BATON ROUGE RETIREMENT			CANCER	12/22/1942	1125 W LEE DR	BATON ROUGE	LA	70820 4920	55-64
HILL	ROBERT	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	64.17	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	[illegible]	CANCER	5/25/1954	2467 TOLEDO ST	BAKER	LA	70714 5606	55-64
WELSH III	CLARENCE	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	64.17	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	[illegible]	CANCER	9/6/1960	5830 LANIER DR	BATON ROUGE	LA	70812	55-64
WESLEY	ROBERT	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	64.17	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	[illegible]	CANCER	3/13/1964	PO BOX 73832	BATON ROUGE	LA	70817-3303	55-64
PINA PAUL	ROGER	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	64.17	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	[illegible]	CANCER	[illegible]	[illegible]	HOUSTON	TX	77054-3144	55-64
GERMANY	FREDERICK	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	14.87	CITY OF BATON ROUGE RETIREMENT			CANCER	10/23/1946	6147 N BRISTLE CONE CT	GREENWELL SPRINGS	LA	70739-8914	55-64
DAIGRE	CAROLYN	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	64.17	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	[illegible]	CANCER	11/1/1948	8446 MYRTLEWOOD DR	BATON ROUGE	LA	70812 1141	55-64
WASHINGTON	ALICE	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	36.8	CITY OF BATON ROUGE RETIREMENT			CANCER	6/28/1954	13021 MIDDLEWOOD DR	BAKER	LA	70714-4840	55-64
OGLE	CHARLEY	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	27.42	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	[illegible]	CANCER	10/22/1952	10448 SPRINGWIND CT	BATON ROUGE	LA	70810 7083	55-64
RUFFIN	PHILLIP	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	64.17	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	[illegible]	CANCER	4/10/1939	705 S EUGENE ST	BATON ROUGE	LA	70806	55-64
CAMPBELL	STACY	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	64.17	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	[illegible]	CANCER	6/30/1944	13543 SLALOM WAY DR	PRAIRIEVILLE	LA	70769-4489	55-64
ROSE	RONNIE	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	36.8	CITY OF BATON ROUGE RETIREMENT			CANCER	6/6/1955	11632 FLAMINGO DR	BATON ROUGE	LA	70814-7141	55-64
ALLEN	SHARON	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	27.42	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	[illegible]	CANCER	1/20/1958	1024 SINCLAIR DR	BATON ROUGE	LA	70815 3371	55-64
DARJEAN	JOHN	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	27.42	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	[illegible]	CANCER	7/28/1948	7055 MAPLEWOOD DR	BATON ROUGE	LA	70812	55-64
BRADLEY	MELISSA	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	64.17	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	[illegible]	CANCER	10/10/1951	1431 LAMORT DR	BAKER	LA	70714-2142	55-64
GILL	EVELYN	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	14.87	CITY OF BATON ROUGE RETIREMENT			CANCER	2/28/1956	4485 SAN JUAN DR	BATON ROUGE	LA	70811-4226	55-64
HICKS	DARYL	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	27.42	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	[illegible]	CANCER	10/18/1958	22478 BEDFORD DR	DENHAM SPRINGS	LA	70726-8483	55-64
CUTRER	JAMES	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	36.8	CITY OF BATON ROUGE RETIREMENT			CANCER	1/31/1963	3177 BIGMAN LN	TORBERT	LA	70762 4102	55-64
COMBS	LEWIS	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	27.42	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	[illegible]	CANCER	6/28/1955	6127 MALLARD CROSSING DR	ZACHARY	LA	70791-8346	55-64
BARGAS III	GORDON	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	27.42	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	[illegible]	CANCER	10/18/1971	PO BOX 80577	BATON ROUGE	LA	70898 0577	55-64
FRANKLIN	JEFFREY	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	27.42	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	[illegible]	CANCER	10/3/1949	1577 HECK YOUNG RD	BAKER	LA	70714 1544	55-64
JEFFERSON	CHARLES	[illegible]	EMPLOYEE	100	2/1/2012	27.42	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	[illegible]	CANCER	7/4/1954	4848 HAROLD DR	DENHAM SPRINGS	LA	70726-2128	55-64
COBB	CLINT	[illegible]	EMPLOYEE	300	2/1/2012	64.17	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	[illegible]	CANCER	12/20/1960	18404 EL RANCHITOS AVE	PRIDE	LA	70770 9758	55-64
SPURLOCK	DONALD	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	14.87	CITY OF BATON ROUGE RETIREMENT			CANCER	4/17/1957	3104 SLATE ST	BATON ROUGE	LA	70802 2545	55-64
LEBLANC	GLENN	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	36.8	CITY OF BATON ROUGE RETIREMENT			CANCER	11/12/1955	PO BOX 604	SAINT GABRIEL	LA	70776-0604	55-64
PERRY	PATRICIA	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	14.87	CITY OF BATON ROUGE RETIREMENT			CANCER	9/22/1943	1225 VICTORIA DR APT 2084	BATON ROUGE	LA	70808-7356	55-64
STONE	WILLIAM	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	64.17	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	400	CANCER	10/8/1956	13491 BLACKWATER RD	BAKER	LA	70714 6840	55-64
WOOD	JANE	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	14.87	CITY OF BATON ROUGE RETIREMENT			CANCER	8/30/1954	8121 MOSS POINT DR	BATON ROUGE	LA	70809-3431	55-64
COOK	BEVERLY	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	14.87	CITY OF BATON ROUGE RETIREMENT			CANCER	1/27/1951	2744 DALRYMPLE DR	BATON ROUGE	LA	70808-2040	55-64
BERTHELOT	JOHN	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	64.17	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	400	CANCER	3/14/1947	1878 DENVER DR	BATON ROUGE	LA	70810-3307	55-64
CORTINA	JEAN	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	14.87	CITY OF BATON ROUGE RETIREMENT			CANCER	4/13/1941	2231 S HURON PKWY APT 3	ANN ARBOR	MI	48104-5144	55-64
MACALUSO JR	NICK	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	36.8	CITY OF BATON ROUGE RETIREMENT			CANCER	1/2/1960	28575 RED OAK RD	LIVINGSTON	LA	70754 2605	55-64
COURTNEY	MICHELLE	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	36.8	CITY OF BATON ROUGE RETIREMENT			CANCER	11/19/1943	4823 E CENTRAL AVE	ZACHARY	LA	70791-3108	55-64
WHITE	BENJAMIN	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	64.17	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	400	CANCER	9/15/1946	574 E MOUNT PLEASANT RD	ZACHARY	LA	70791 7812	55-64
MITCHELL	ROOSEVELT	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	64.17	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	400	CANCER	5/4/1946	4444 SHERWOOD ST	BATON ROUGE	LA	70805-4329	55-64
SCOTT	ANDRE	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	36.8	CITY OF BATON ROUGE RETIREMENT			CANCER	1/14/1942	10316 SPRINGROSE AVE	BATON ROUGE	LA	70810-0777	55-64
PARRISH	BARRY	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	64.17	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	400	CANCER	1/28/1964	10804 DOOBER DR	DENHAM SPRINGS	LA	70726 1855	55-64
FREEMAN	LISA	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	36.8	CITY OF BATON ROUGE RETIREMENT			CANCER	8/15/1940	3952 N BLUEBONNET RD	BATON ROUGE	LA	70809	55-64
CHORESTER	MARTHA	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	64.17	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	400	CANCER	1/9/1941	13081 BEECH ST	CLINTON	LA	70722-3818	55-64
YATES	JEFFREY	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	64.17	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	400	CANCER	[illegible]	[illegible]	BATON ROUGE	LA	70817-1727	55-64
PRICE	LULA	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	27.42	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	100	CANCER	[illegible]	[illegible]	SAINT FRANCISVILLE	LA	70775-5248	55-64
HARRELL	WILLIAM	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	64.17	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	400	CANCER	11/16/1949	12754 MUSTANG AVE	BATON ROUGE	LA	70818 5835	55-64
CORNELIOUS	DAROLD	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	27.42	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	100	CANCER	[illegible]	10444 SPRINGBROOK AVE	BATON ROUGE	LA	70810	55-64
GLASCOCK	MELISSA	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	36.8	CITY OF BATON ROUGE RETIREMENT			CANCER	6/23/1967	7432 LAKE MEADOW DR	DENHAM SPRINGS	LA	70706-0949	55-64
CECILE	UTE	[illegible]	EMPLOYEE	100	2/1/2012	27.42	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	100	CANCER	6/4/1958	5948 GREENSIDE LN	BATON ROUGE	LA	70808-7141	55-64
HUSBAND	PATRICIA	[illegible]	EMPLOYEE	300	2/1/2012	36.8	CITY OF BATON ROUGE RETIREMENT			CANCER	8/28/1953	18273 OLD PERKINS PLACE AVE	PRAIRIEVILLE	LA	70769-3317	55-64
MARSHALL	LOVIE	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	36.8	CITY OF BATON ROUGE RETIREMENT			CANCER	1/8/1967	3454 OSWEGO ST	BATON ROUGE	LA	70808-1625	55-64
AUGUSTUS	EVELYN	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	36.8	CITY OF BATON ROUGE RETIREMENT			CANCER	11/4/1954	422 BAKER ST	BAKER	LA	70714-1426	55-64
GARRISON	CORINNE	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	14.87	CITY OF BATON ROUGE RETIREMENT			CANCER	3/17/1933	1808 SWAN AVE	BATON ROUGE	LA	70807 5036	55-64
DRAGO	ROBERT	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	27.42	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	100	CANCER	7/1/1945	7590 LINDA LEE DR	DENHAM SPRINGS	LA	70706-0916	55-64
JOHNSON	GEORGIANA	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	64.17	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	400	CANCER	6/3/1956	4226 LAKE LIMESTONE CT	BATON ROUGE	LA	70816-6410	55-64
BROCK	WALTER	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	36.8	CITY OF BATON ROUGE RETIREMENT			CANCER	2/22/1954	4780 DICKENS DR	BATON ROUGE	LA	70812 4118	55-64
PLUMMER	LOUTA	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	64.17	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	400	CANCER	3/21/1941	1606 STANDARD ST	BATON ROUGE	LA	70807 2041	55-64
SHERIDON	TANYA	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	27.42	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	100	CANCER	11/26/1963	2810 TOM DR	SLAUGHTER	LA	70777 3021	55-64
WARD	ANTHONY	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	36.8	CITY OF BATON ROUGE RETIREMENT			CANCER	8/14/1954	1258 N 44TH ST	BATON ROUGE	LA	70802-1208	55-64
RADFORD	ELIZABETH	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	36.8	CITY OF BATON ROUGE RETIREMENT			CANCER	9/27/1963	13705 JULIUS BARBER RD	DENHAM SPRINGS	LA	70726	55-64
KLEINPETER JR	JULIUS	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	14.87	CITY OF BATON ROUGE RETIREMENT			CANCER	3/6/1941	2432 77TH AVE	BATON ROUGE	LA	70807 3405	55-64
BOOKTER	ANNETTE	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	64.17	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	400	CANCER	11/11/1946	5422 ASPWOOD DR	BATON ROUGE	LA	70806	55-64
LANDRY	NANCY	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	36.8	CITY OF BATON ROUGE RETIREMENT			CANCER	8/21/1953	4138 DOWNING DR	BATON ROUGE	LA	70809-2342	55-64
PAYNE	PATRICIA	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	27.42	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	100	CANCER	12/22/1948	8127 BRANCHWOOD AVE	BATON ROUGE	LA	70811 4306	55-64
HENNESSY	RALPH	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	27.42	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	100	CANCER	3/30/1940	11938 PUEBLO	SAINT FRANCISVILLE	LA	70775 4148	55-64
BLACKWELL	GEORGE	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	64.17	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	400	CANCER	3/5/1951	10881 HIGHWAY 955 E	ETHEL	LA	70730-4118	55-64
HONEY	CLYDE	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	36.8	CITY OF BATON ROUGE RETIREMENT			CANCER	12/2/1949	25460 HOMESTEAD DR	DENHAM SPRINGS	LA	70726-6844	55-64
CHAMBERS	LINDA	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	36.8	CITY OF BATON ROUGE RETIREMENT			CANCER	11/21/1959	7912 ROD LAVER AVE	BATON ROUGE	LA	70810-1754	55-64
JOHNSON	CHRISTOPHER	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	14.87	CITY OF BATON ROUGE RETIREMENT			CANCER	1/18/1962	122 ROSEBUD DR	PORT ALLEN	LA	70767 5775	55-64
BLADES	GREGORY	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	14.87	CITY OF BATON ROUGE RETIREMENT			CANCER	4/24/1956	34140 NORFOLK AVE	DENHAM SPRINGS	LA	70706	55-64
HARBOR	BRENDA	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	36.8	CITY OF BATON ROUGE RETIREMENT			CANCER	10/17/1953	6014 E FAIRLANE CT	BATON ROUGE	LA	70812-1819	55-64
ALFORD	GARY	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	64.17	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	400	CANCER	8/5/1960	10846 HIGHWAY 955 E	ETHEL	LA	70730-4113	55-64
BYERS	DAVID	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	64.17	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	400	CANCER	7/1/1947	12075 E MILLBURN AVE	BATON ROUGE	LA	70815 6745	55-64
DAVIS	JAMES	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	36.8	CITY OF BATON ROUGE RETIREMENT			CANCER	1/31/1960	PO BOX 82231	BATON ROUGE	LA	70884 2231	55-64
SMITH	PAMELA	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	14.87	CITY OF BATON ROUGE RETIREMENT			CANCER	9/3/1958	1467 COLLINS DR	BATON ROUGE	LA	70815-2320	55-64
GLOVER	TRAS	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	14.87	CITY OF BATON ROUGE RETIREMENT			CANCER	8/3/1962	5657 DALANNA DR	BATON ROUGE	LA	70811-4006	55-64
KLEIN	JEROME	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	64.17	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	400	CANCER	2/14/1939	30440 MAYER ST	WALKER	LA	70785 6924	55-64
CAGE	JOAN	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	14.87	CITY OF BATON ROUGE RETIREMENT			CANCER	3/23/1957	10202 EL CAMINO AVE	BATON ROUGE	LA	70815 1316	55-64
PELTIER	MIEN	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	36.8	CITY OF BATON ROUGE RETIREMENT			CANCER	3/17/1946	1005 BLENVE DR	SAINT GABRIEL	LA	70776-5116	55-64
CAREY	JAMES	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	14.87	CITY OF BATON ROUGE RETIREMENT			CANCER	12/30/1957	4660 BEECH ST	BATON ROUGE	LA	70805-3001	55-64
HOLMES	KENNETH	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	14.87	CITY OF BATON ROUGE RETIREMENT			CANCER	12/18/1958	110 HAWTHORNE	HEMPHILL	TX	75948 4304	55-64
BANKSTON	LARRY	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	27.42	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	100	CANCER	10/18/1957	23938 EDWARDS RD	ZACHARY	LA	70791-6617	55-64
ANTOINE	TONIA	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	14.87	CITY OF BATON ROUGE RETIREMENT			CANCER	10/8/1948	152 S FOSTER DR APT 37	BATON ROUGE	LA	70806 4147	55-64
ROLLIN	DEANNA	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	14.87	CITY OF BATON ROUGE RETIREMENT			CANCER	11/20/1940	3245 OLD QUARTER DR	BATON ROUGE	LA	70809	55-64
ADAMS	PAMELA	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	14.87	CITY OF BATON ROUGE RETIREMENT			CANCER	11/11/1964	14942 EARLYN CT	PRIDE	LA	70770 9610	55-64
MITCHELL	CHERYL	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	14.87	CITY OF BATON ROUGE RETIREMENT			CANCER	[illegible]	[illegible]	ALEXANDRIA	LA	71301 8032	55-64
STUMPS	ELAINE	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	14.87	CITY OF BATON ROUGE RETIREMENT			CANCER	[illegible]	[illegible]	BAKER	LA	70714-3614	55-64
PATIN	LISE	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	27.42	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	100	CANCER	7/22/1963	6795 BELLE VALE DR APT 436	ADDIS	LA	70710-3032	55-64
MANNINO	DEBRA	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	36.8	CITY OF BATON ROUGE RETIREMENT			CANCER	1/25/1954	18172 VILLA TRACE AVE	GREENWELL SPRINGS	LA	70739-4463	55-64
MARSHBURN	KATHERINE	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	36.8	CITY OF BATON ROUGE RETIREMENT			CANCER	8/20/1962	14223 S ALDONDO DR	BATON ROUGE	LA	70815-1088	55-64
FORBES	JOYCE	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	14.87	CITY OF BATON ROUGE RETIREMENT			CANCER	5/20/1951	2365 BRISBANA ST	BATON ROUGE	LA	70802-8736	55-64
SIBERS	DEBBIE	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	27.42	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	[illegible]	CANCER	10/14/1958	1112 POMPEY DR	BATON ROUGE	LA	70816-1850	55-64
JONES	VERONICA	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	42.03	CITY OF BATON ROUGE RETIREMENT	CHILD COVERAGE	400	CANCER	8/15/1965	18292 MANCHAC PLACE DR	PRAIRIEVILLE	LA	70769 8855	55-64
GEORGE	MELINDA	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	36.8	CITY OF BATON ROUGE RETIREMENT			CANCER	2/23/1961	6844 CLINTON AVE	BATON ROUGE	LA	70805	55-64
HEAP	ROBYN	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	64.17	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	[illegible]	CANCER	7/3/1961	3735 TWELVE OAKS AVE	BATON ROUGE	LA	70820-3092	55-64
BOSSIER JR	LEO	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	27.42	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	[illegible]	CANCER	7/3/1955	6115 WILDFLOWER RD	BATON ROUGE	LA	70817	55-64
TRICHE	NATHAN	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	36.8	CITY OF BATON ROUGE RETIREMENT			CANCER	2/13/1951	14256 ACACIA ST	BATON ROUGE	LA	70819	55-64
WILKINSON	CHARLES	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	27.42	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	[illegible]	CANCER	7/10/1951	PO BOX 1103	BATON ROUGE	LA	70821 1103	55-64
BECNEL JR	CHARLES	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	36.8	CITY OF BATON ROUGE RETIREMENT			CANCER	6/3/1939	219 DELGADO DR	BATON ROUGE	LA	70808	55-64
ST ROMAIN	SHARON	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	64.17	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	[illegible]	CANCER	4/19/1965	4977 HERRERA DR	BATON ROUGE	LA	70817 2024	55-64
CARRAWAY	KENNETH	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	64.17	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	[illegible]	CANCER	7/27/1946	58175 DESOBRY ST	PLAQUEMINE	LA	70764 3625	55-64
SMITH	PATRICIA	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	64.17	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	[illegible]	CANCER	3/11/1951	2928 LAUREL PLANTATION AVE	BATON ROUGE	LA	70820 5753	55-64
CONRAD	ANTHONY	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	64.17	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	[illegible]	CANCER	1/31/1946	11831 COUNTRY ESTATES AVE	ZACHARY	LA	70791 8738	55-64
PALMER	RAMONA	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	14.87	CITY OF BATON ROUGE RETIREMENT			CANCER	10/26/1963	11515 E BLACK OAK DR	BATON ROUGE	LA	70815-2328	55-64
MARINO	ANTHONY	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	300	2/1/2012	64.17	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	[illegible]	CANCER	12/8/1948	5900 N SHORE DR	BATON ROUGE	LA	70817-3958	55-64
RUSSELL	VELMA	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	27.42	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	[illegible]	CANCER	12/25/1964	10916 TOLEDO BEND AVE	BATON ROUGE	LA	70814-5158	55-64
TRAMMELL	SUE	EMPLOYEE CANCER HOSP COMP	EMPLOYEE	100	2/1/2012	27.42	CITY OF BATON ROUGE RETIREMENT	SPOUSE & CHILD COVERAGE	[illegible]	CANCER	11/1/1940	8404 OLIVIA DR	DENHAM SPRINGS	LA	70726 0635	55-64



PROTECTION YOU CAN COUNT ON

CANCERSELECT® PLUS
CANCER-ONLY INSURANCE

***CancerSelect Plus*, underwritten by Transamerica Life Insurance Company, can help provide extra protection in the event of a cancer diagnosis.**

Nancy knows her family history may put her at a higher risk for a cancer diagnosis. When a coworker battled cancer and faced a financial strain due to his deductible, co-pays, and missed work, his situation hit close to home. She worries her medical insurance might not be enough.

GOOD MEDICAL INSURANCE HELPS, BUT IS IT ENOUGH?

While some people diagnosed with cancer have health insurance to help pay for some of their treatment, many face the prospect of significant out-of-pocket costs.

IF CANCER IS THE DISEASE YOU WORRY ABOUT MOST, YOU'RE NOT ALONE

If Nancy or one of her loved ones were to be diagnosed with cancer, how would she face that challenge? There's a way she can take simple steps now to help protect her and her family's Wealth + Health℠.

With this supplemental benefit, she'll have more resources to cope with any future cancer diagnosis, and have wellness benefits to help her detect cancer early — when it's most treatable.

HOW IT WORKS

- Pays benefits directly to you
- Spouse and dependent benefits available
- Payroll-deducted premiums
- Easy enrollment process

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YOU CAN INSURE YOURSELF OR ADD YOUR ELIGIBLE SPOUSE AND CHILDREN

If you are 18 years of age or older, you can purchase this valuable supplemental benefit. You can also choose to insure your eligible family members, including your spouse, age 18 or older, and your children from birth through age 25.

VALUABLE BENEFITS FOR YOUR LIFE

Review the attached benefits and costs for the insurance policy. It's a long list of benefits, but they're all important. As you read through the list, think about how you could possibly pay for all these costs on your own. Fighting cancer can be challenging both financially and emotionally, and the more resources you have, the better prepared you and your family will be.

Product Details

Hospital Benefits	Plan Option 1 - 1.00 Units	Plan Option 2 - 3.00 Units	Policy Pays
Hospital Confinement	$100	$300	per day of covered confinement
Extended Benefits	$200	$600	per day; begins on day 91 of continuous confinement; in lieu of all other benefits (except surgery and anesthesia)
Attending Physician	$20	$60	per day while hospital confined; one visit per 24-hour period
Inpatient Drugs and Medicines	$15	$45	per day while hospital confined
Private Duty Nurse	$100	$300	per day while hospital confined; must be authorized by the attending physician; cannot be hospital staff or a family member
Ambulance	$100	$300	for service by a licensed ambulance service for transportation to a hospital; admittance required
Extended Care Facility	$100	$300	per day; up to the number of days for the prior hospital stay; admittance must be within 14 days of hospital discharge
Government or Charity Hospital	$100	$300	per day of covered confinement; in lieu of all other benefits
Hospice Care	$100	$300	per day of hospice care; 100-day lifetime maximum; not payable while hospital confined
Surgery Benefits	**Plan Option 1 - 1.00 Units**	**Plan Option 2 - 3.00 Units**	**Policy Pays**
Surgery — Inpatient	$1,000	$3,000	maximum benefit; actual benefit is determined by the surgery schedule in the contract; for multiple procedures in same incision only the highest benefit is paid; for multiple procedures in separate incisions will pay highest benefit and then 50% for each lesser procedure
Surgery — Outpatient	$1,500	$4,500	
Anesthesia	25%	25%	of covered surgery benefit

Product Details

Prosthesis	$500	$1,500	maximum benefit; pays actual charges per device requiring implantation
Hair Prosthesis	$50	$150	maximum benefit; pays actual charges for wig to cover hair loss from cancer treatment
Reconstructive Surgery – Breast Cancer – simple or total mastectomy	$120	$360	for reconstructive surgery within 2 years of the initial cancer removal; excludes skin cancer and malignant melanoma; benefit not payable if paid under any other provision of the policy
Reconstructive Surgery – Breast Cancer – radical mastectomy	$170	$510	
Reconstructive Surgery – Cancers of the male or female genitalia	$170	$510	
Reconstructive Surgery – Cancer of the head, neck, or oral cancers	$250	$750	
Second Surgical Opinion	$100	$300	when surgery is prescribed; excludes skin cancer
Ambulatory Surgical Center	$150	$450	maximum per day; pays actual charges for outpatient surgery at an ambulatory surgical center
Skin Cancer – One removal	$75	$225	for removal of skin cancer (skin cancer does not include malignant melanoma or mycosis fungoides)
Skin Cancer – Per additional removal	$35	$105	
Radiation and Chemotherapy Benefits	**Plan Option 1 - 1.00 Units**	**Plan Option 2 - 3.00 Units**	**Policy Pays**
Radiation and Chemotherapy	$5,000	$15,000	maximum benefit per 12-month period; pays actual charges

Product Details

Associated Radiation & Chemo Expenses	$250	$750	maximum benefit per 12-month period; pays actual charges for treatment consultations and planning, adjunctive therapy, radiation management, chemotherapy administration, physical exams, checkups, and laboratory or diagnostic tests; transportation and lodging are not included as associated expenses
Blood, Plasma, Blood Components, Bone Marrow and Stem Cell Transplant	$5,000	$15,000	maximum benefit per 12-month period; pays actual charges
Associated Blood & Plasma Expenses	$250	$750	maximum benefit per 12-month period; pays actual charges for administration of blood, plasma and blood components, transfusions, processing and procurement, or cross-matching, treatment consultations and planning, physical exams, checkups, and laboratory or diagnostic tests; transportation and lodging are not included as associated expenses
New or Experimental Treatment	$5,000	$15,000	maximum benefit per 12-month period; pays actual charges for drugs or chemical substances approved by the FDA for experimental use on humans or surgery or therapy endorsed by either the NCI or ACS for experimental studies received in the US or its territories

Product Details

Wellness & Non-Medical Benefits	Plan Option 1 - 2.00 Units	Plan Option 2 - 3.00 Units	Policy Pays
Annual Cancer Screening	$100	$150	per calendar year for cancer screening tests: • mammogram • pap smear • flexible sigmoidoscopy • prostate-specific antigen test • chest x-ray • hemocult stool specimen • ultrasound • CEA • CA125 • biopsy • thermography • colonoscopy • serum protein electrophoresis • bone marrow testing • blood screening
Magnetic Resonance Imaging (MRI) Scan	$100	$150	per calendar year for MRI scan used as diagnostic tool for breast cancer
Non-Local Transportation	Included	Included	round-trip charges or private vehicle allowance, up to 750 miles at $0.40 per mile, when required non-local hospital confinement is more than 50 miles from residence for an insured person and an adult immediate family member during confinement; payable once per confinement
Family Member Lodging	$100	$150	per day (maximum 50 days per 12 month period) for lodging expenses for an adult immediate family member when non-local hospital confinement is required
Outpatient Lodging	$100	$150	per day (maximum 50 days per 12 month period) for lodging expenses for an insured person to receive radiation or chemotherapy on an outpatient basis if not available locally
Physical Therapy & Speech Therapy	$50	$75	per treatment; limit one treatment per day

Product Details

At-Home Nursing	$100	$150	per day, up to the number of days of the prior hospital stay when admitted within 14 days of hospital discharge
Waiver of Premium	Included	Included	waives premium for total disability due to cancer after 60 consecutive days of total disability; total disability must begin prior to the insured person's 70th birthday
Cancer Maintenance Therapy Benefit	**Plan Option 1 - 1.00 Units**	**Plan Option 2 - 1.00 Units**	**Policy Pays**
• Cancer Suppressive Therapy • Hematological Drugs • Anti-Nausea Drugs • Motility Agents	$1,000	$1,000	maximum benefit per 12-month period; pays actual charges
First Occurrence Rider (Rider Form Series CROCC100, 200 or 300)	**Plan Option 1 - 1.00 Units**	**Plan Option 2 - 2.00 Units**	**Policy Pays**
Initial Diagnosis Benefit	$1,000	$2,000	pays a one-time, lump-sum benefit when an insured person is initially diagnosed with cancer (except skin cancer), based on a microscopic examination of fixed tissue or preparations from the hemic system. Clinical diagnosis is accepted under certain conditions.
Intensive Care Rider (Rider Form Series CRICU100, 200 or 300)	**Plan Option 1 - 1.00 Units**	**Plan Option 2 - 4.00 Units**	**Policy Pays**
Maximum of 45 days per covered confinement — Intensive Care Unit	$100	$400	per day of confinement in an ICU such as a cardiac care unit, burn unit, or neonatal unit
Maximum of 45 days per covered confinement — Step-Down Unit	$50	$200	per day of confinement in a step-down unit for progressive, sub-acute or intermediate care
Ambulance Benefit	$200	$800	maximum benefit; pays actual charges; per period of ICU confinement for transportation between medical facilities by a licensed professional ambulance service; benefit is not payable if paid under the base contract provision

Product Details

Specified Illness and Disease Rider (Rider Form Series CRSPD200)	Plan Option 1 - 1.00 Units	Plan Option 2 - 3.00 Units	Policy Pays
Provides benefits for losses that are the direct result of a covered specified illness or disease.			
Hospital Confinement	$100	$300	per day of covered confinement
Extended Benefits	$200	$600	per day; begins on day 91 of continuous confinement; in lieu of all other benefits (except surgery and anesthesia)
Attending Physician	$20	$60	per day while hospital confined; one visit per 24-hour period
Inpatient Drugs and Medicines	$15	$45	per day while hospital confined
Private Duty Nurse	$100	$300	per day while hospital confined; must be authorized by the attending physician; cannot be hospital staff or a family member
Ambulance	$100	$300	for service by a licensed ambulance service for transportation to a hospital; admittance required
Extended Care Facility	$100	$300	per day; up to the number of days for the prior hospital stay; admittance must be within 14 days of hospital discharge
Government or Charity Hospital	$100	$300	per day of covered confinement; in lieu of all other benefits
Hospice Care	$100	$300	per day of hospice care; 100-day lifetime maximum; not payable while hospital confined
Surgery	$1,000	$3,000	per surgery; pays the lesser of the amount shown or an amount determined by multiplying the work relative value unit obtained from the Medicare Physician Fee Schedule by $25
Outpatient Surgery	$1,500	$4,500	per surgery; pays 150% of the surgery benefit
Anesthesia	25%	25%	per surgery; pays the selected percentage of the surgery benefit

Product Details

Second Surgical Opinion	$100	$300	for a second opinion when the first opinion prescribes surgery as treatment
Ambulatory Surgical Center	$150	$450	maximum per day; pays charges for surgery performed at an ambulatory surgical center or hospital as an outpatient; paid in addition to the outpatient surgery benefit

Covered Specified Illnesses and Diseases include:				
Adrenal Hypofunction (Addison's Disease)	Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)	Botulism	Brucellosis	Budd-Chiari Syndrome
Cerebral Palsy	Cholera	Cystic Fibrosis	Diphtheria	Encephalitis
Hansen's Disease	Hepatitis (Chronic B or Chronic C with liver failure or hepatoma)	Histoplasmosis	Huntington's Chorea	Legionnaires' Disease
Lupus	Lyme Disease	Mad Cow Disease	Malaria	Meningitis
Muscular Dystrophy	Myasthenia Gravis	Necrotizing Fascitis	Osteomyelitis	Poliomyelitis
Primary Biliary Cirrhosis	Primary Sclerosing Cholangitis (Walter Payton's Liver Disease)	Q Fever	Rabies	Reye's Syndrome
Rheumatic Fever	Rocky Mountain Spotted Fever	Scarlet Fever	Scleroderma	Sickle Cell Anemia
Tay-Sachs Disease	Tetanus	Thallasemia	Toxic Epidermal Necrolysis	Toxic Shock Syndrome
Trichinosis	Tuberculosis	Tularemia	Typhoid Fever	Whooping Cough (Pertussis)

Actual charges means the amount actually paid by or on behalf of the insured and accepted by the provider as payment in full for services provided.

Semi-Monthly Premium	Individual	Single Parent Family	Family
Plan Option 1	$7.43	$8.70	$13.71
Semi-Monthly Premium			
Plan Option 2	$18.40	$21.01	$33.08

Issue State: Louisiana
Rate generation date: October 2, 2017

Limitations and Exclusions

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

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

Pre-Existing Condition Limitation - No benefits are provided during the first 12 months for pre-existing conditions for which the insured person has been diagnosed, treated, or for which the insured person has incurred expense or has taken medication within 12 months prior to the effective date of such person's policy. Pre-existing condition also includes a condition that manifests itself in a way that would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment.

Total Disability means the inability to perform all of the material and substantial duties of the employee's regular occupation. Total Disability will be considered to exist when under the regular care and attendance of a physician for the necessary treatment of cancer. After the first two years of Total Disability, the employee will continue to be considered Totally Disabled if unable to engage in any employment or occupation for which he or she is or becomes qualified by reason of education, training, or experience. On or after age 65, Total Disability will mean that a physician has certified that the employee is unable to perform two or more Activities of Daily Living (continence, transferring, dressing, toileting, eating and bathing) without direct personal assistance as a result of cancer.

12-Month Benefit Period - The initial 12-Month Benefit Period is the 12-month period beginning on the date of positive diagnosis. Subsequent 12-Month Benefit Periods begin on the same month and day as the immediately preceding 12-Month Benefit Period; however, if the insured person incurs no covered loss during the 3 months after the end of any 12-Month Benefit Period, the next 12-Month Benefit Period will begin on the next date a covered loss is incurred. Benefit Periods are determined separately for each insured person.

First Occurrence Rider

Benefits are not payable:

- For cancer diagnosed prior to the Effective Date of this Rider;
- For any other illness or disease other than internal Cancer;
- For Skin Cancer or any Cancer excluded from insurance by name or specific description.

Intensive Care Rider

We will only pay one daily indemnity benefit per day. We will not pay any benefits for loss resulting from:

- Specifically excluded diseases or conditions in the Contract or in this Rider;
- An attempted suicide while sane or insane or an intentionally self-inflicted injury;
- Any act of war either declared or undeclared;
- Alcoholism or drug addiction;
- Mental or nervous disorders;
- An overdose of drugs, narcotics, hallucinogens, unless administered on the advice of a Physician;
- Intoxication, or being under the influence of any intoxicant or narcotic, unless administered on the advice of a Physician;
- Injury received while engaging in an illegal occupation or activity.

Limitations and Exclusions

Specified Illness and Disease Rider

This Rider provides benefits for the Initial Positively Diagnosed Specified Illness or Disease defined in this Rider on or after the Effective Date of this Rider. It does not provide benefits for any other illness or disease.

We will only pay for loss as a direct result of a Specified Illness or Disease. Proof of Positive Diagnosis must be submitted with each new claim. We will not pay for any disease or incapacity that has been caused, complicated, worsened, or affected by, or as a result of a Specified Illness or Disease or its treatment.

Benefits under "Waiver of Premium" of the Contract do not apply to this Rider for Total Disability due to a Specified Illness or Disease.

Termination of Insurance

Employee insurance will terminate on the earliest of:

- The date of the employee's death;
- The date on which the employee ceases to be eligible for insurance;
- The last date for which premium payment has been made to us;
- The last date on which employment terminates;
- The date the group master policy terminates; or
- The date the employee sends us a written notice to cancel insurance.

Dependent insurance will terminate on the earliest of:

- The date the employee's insurance terminates;
- The last date for which premium payment has been made to us;
- The date the dependent no longer meets the definition of dependent;
- The date the group master policy is modified so as to exclude dependent insurance; or
- The date the employee sends us a written notice to cancel dependent insurance.

We will have the right to terminate the insurance of any insured person who submits a fraudulent claim under the policy.

Portability Option

If an employee loses eligibility for this insurance for any reason other than nonpayment of premiums, insurance can be continued by paying the premiums directly to us within 31 days after termination. We will bill the employee directly once we receive notification to continue insurance.

Termination of the Group Master Policy

The policyholder may end the policy on any premium due date by submitting a 60-day advance written notice. A group will not be continued if it drops below the minimum required participation. The group master policy will be terminated and insurance of all remaining insureds will end, subject to the Portability Option.

Other Insurance with Us

An individual can only have one cancer policy or certificate with us. If a person already has cancer insurance with us, such person is not eligible to apply for this insurance.

Disclosures

GROUP BENEFITS DISCLOSURE POLICY

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

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

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

COMPENSATION DISCLOSURE NOTICE TO ALL POLICYHOLDERS

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

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

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

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

For up to date information regarding our compensation practices, please consult our website at: www.transamericaemployeebenefits.com.

TRANSAMERICA®

Revised April 30, 2024

NOTICE OF PRIVACY PRACTICES

This Notice is provided to you by the Transamerica companies listed at the end of this Notice. It is important to us that you understand how we use and share your personal information. This Notice describes the data we collect and how we use, share, and protect it. The types of data we collect and share depend on the type of product or service you have with us. We also provide notices and terms on our websites and applications. Those notices and terms provide further detail regarding data use on our websites or applications. If your relationship with us ends, we will continue to use your data as set forth in this Notice.

Data That We Collect: We collect the following types of data from the following sources:

Data	Typical Data Sources
Contact information (e.g., name, phone number, email and physical addresses, etc.), date of birth, government ID (e.g., social security, passport and driver's license numbers), security credentials (e.g., password, voiceprint, etc.), employment, financial and health data and history, other general information (e.g., marital status, gender, etc.)	• You directly, when you submit applications and forms and engage in communications with us • Our affiliates (companies under common ownership) • Employers, healthcare providers, other insurance companies and other authorized entities
Data about your transactions with us and/or Third Parties. ("Third Parties" are unaffiliated third parties. This includes agents, the company the agent represents, other financial organizations, and service providers.) Such transactional data can include, but is not limited to, account balances, accrued benefits, coverages, premiums, payment and claims history, financial transactions, and medical or health data	• Our affiliates • Third Parties • Transamerica's websites, digital platforms, and applications • Assistive technologies, mobile or wearable devices, or other similar technology
Credit history, employment information and other information about your creditworthiness, and medical or health data	• Consumer reporting agencies and other service providers we use such as third party data suppliers • Your employers, healthcare providers, insurance support organization (including reports prepared from such organizations which may retain and disclose such information), credit bureaus, other insurance companies and other authorized entities
Data about products and services you obtain or in which you might be interested	• You • Third Parties with whom we have joint marketing arrangements • Other Third Parties as allowed
Third party data, including data you provide to Third Parties when you have authorized the Third Party to share such data with other parties, such as data collected through Third Party applications, websites, or other digital interfaces, data you have authorized us to receive, or data you have authorized Third Parties to share with us	• Third Party applications, websites, or other digital interfaces where you have agreed to share your data • Assistive technologies, mobile or wearable devices, or other similar technology

How We Use Your Data: We use data to provide our services and as allowed by law. This includes use authorized by you. For example, we may use your data to:

- Process claims and transactions,
- Research, develop, and market products and services,
- Prevent and prosecute fraud or criminal activities,
- Maintain your accounts,
- Comply with applicable laws and for security purposes,
- Maintain, operate, and market our business, or
- Support online customer experiences, digital platforms, and/or applications in which you elect to participate.

Sharing Data: We may share your data with Third Parties and affiliates as permitted or required by law, or when you authorize us to do so. For example, we may share your data with:

- Those who provide services to support our business, including processing claims, account maintenance, and marketing and sales,
- Credit bureaus,
- Insurance regulators, law enforcement, governmental authorities, and other Third Parties in response to legal process or as required by law,
- Health care professionals, including to verify coverage or to provide information relating to a medical condition,

- Governmental agencies so they can decide if you are eligible for public benefits,
- Other financial companies in connection with joint marketing efforts,
- Other insurance companies (including successor insurers), agents and insurance support organizations to coordinate your benefits or in connection with insurance transactions involving you,
- Group policyholders, for example, regarding claims experience or to support service audits,
- Certificate or policyholders regarding the status of an insurance transaction,
- Those who have an interest in your assets (such as creditors with a lien on your account),
- Your employer or plan sponsor as needed to support the administration of employee accounts (but only as permitted by law and only if you have established an account in connection with your employer),
- Your representatives and lawyers,
- Those to prevent and prosecute fraud or criminal activities,
- Those to conduct actuarial or research studies, and
- Those in connection with the sale or merger of all or part of our business.

You do not have the right to opt out of our sharing data with Third Parties for these legally permitted purposes.

Our affiliates include a broad range of companies who provide financial services. These include insurance companies and agencies, investment advisors, and broker/dealers, some of whom may not be included in the scope of this Notice. You may have additional privacy notices from these professionals. We do not share information about your creditworthiness among our affiliates. However, we may share information about our transactions and experiences with you among affiliates for their everyday business purposes. For example, we may share your data with our affiliates:

- So they can tell you about products and services they offer,
- So they can determine which of their products and services may be of interest to you,
- So they can provide various services to us to support our business, such as claims processing, applying for insurance, opening and maintaining your account, or marketing products and services to you,
- So they can audit themselves or their agents, or
- So you can communicate with us or Transamerica affiliated companies about your accounts.

Your Choice to Limit Marketing by Transamerica Affiliates: You may limit our affiliates' use of certain types of data to market their own products and services to you ("Opt Out"). To do this, choose one of the Opt Out methods set forth below. This data includes information about your transactions and experiences with us. For example, this may include information about your account history. Your choice to limit marketing offers from our affiliates will apply for at least 5 years from when you Opt Out. Once that period expires, we may send you a renewal Notice. That renewal Notice will allow you to continue to limit marketing offers from our affiliates for at least another 5 years. If you have already provided an Opt Out, you do not need to Opt Out again until you receive a renewal Notice. If you hold a policy or account jointly with someone else, your Opt Out elections will apply to everyone on the account. When you are no longer our customer, we will continue to share your data as described in this Notice (subject to your Opt Out, if applicable). However, you may contact us at any time to elect to Opt Out.

To Opt Out: To limit our sharing of data with affiliates for marketing by affiliates as described above, you may:

- Call us at **877-257-4690** and our menu will prompt you through your choice(s), or
- Visit us online at **www.transamerica.com/optout**

Your Right of Access and Correction: You may have a right of access and correction with respect to data we collect. To exercise these rights, please list the account or policy numbers with the data you are requesting to access. If you tell us of an error in the data, we will review it. If we agree, we will correct our records. If we don't agree, you may dispute our findings in writing and send your statement to us. We will include your statement whenever we provide your disputed information to anyone outside Transamerica. This is a summary of your rights. For a copy of our more detailed Notice of Insurance Information Practices as applicable to your product or service, please send a written request to 6400 C St. SW, Cedar Rapids, IA 52499-0001.

Protecting Your Data: We maintain appropriate controls to limit access to data to persons who need access to it. These persons access your data so that they can do their jobs or provide products and services to you. We train our workforce to properly handle data. In addition, we maintain other physical, technical, and administrative or procedural safeguards to protect your data.

For Vermont Residents only: We will not share data we collect about you with Third Parties, except as permitted by Vermont law or authorized by you. We may still share data about our transactions or experiences with you with our affiliates.
For California Residents only: If you are a California resident, you will receive a separate notice with additional choices.

We may revise this Notice. If we make material changes, we will notify you as required by law. This Notice is provided by the Transamerica companies below. Transamerica companies that are not covered by this notice may make available other applicable notices.

Transamerica Capital, Inc
Transamerica Financial Life Insurance Company
Transamerica Casualty Insurance Company
Transamerica Life Insurance Company

SUMMARY OF THE LOUISIANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT AND NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS

Residents of Louisiana who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are required by law to be members of the Louisiana Life and Health Insurance Guaranty Association (LLHIGA). The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this happens, the Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state, and in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through the Association is limited. As noted in the disclaimer below, this protection is not a substitute for consumers care in selecting companies that are well-managed and financially stable.

DISCLAIMER

The Louisiana Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. *COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY.* Even if coverage is provided, there are significant limits and exclusions. Coverage is generally conditioned upon residence in this state. Other conditions may also preclude coverage.

Insurance companies and insurance agents are prohibited by law from using the existence of the Association or its coverage to sell you an insurance policy.

You should not rely on the availability of coverage under the Louisiana Life and Health Insurance Guaranty Association when selecting an insurer.

The Louisiana Life and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

LLHIGA
P.O. Box 3337
Baton Rouge, Louisiana 70821

Department of Insurance
P.O. Box 94214
Baton Rouge, Louisiana 70804-9214

The state law that provides for this safety-net coverage is called the Louisiana Life and Health Insurance Guaranty Association Law (the law), and is set forth at R.S. 22:2081 et seq. The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change any person's rights or obligations under the law or the rights or obligations of LLHIGA.

COVERAGE

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a direct non-group life, health insurance contract, or an annuity, policy or contract, a certificate under a direct group policy or contract for a supplemental contract to any of these, or an unallocated annuity contract, issued by an insurer authorized to conduct business in Louisiana. The beneficiaries, payees or assignees of insured persons may also be protected as well even if they live in another state unless they are afforded coverage by the guaranty association of another state, or other circumstances described under the law are applicable.

EXCLUSIONS FROM COVERAGE

A person who holds a direct non-group life, health, or annuity policy or contract, a certificate under a direct group policy or contract for a supplemental contract to any of these, or an unallocated annuity contract is not protected by LLHIGA if:

1. He is eligible for protection under the laws of another state (This may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
2. The insurer was not authorized to do business in this state;
3. His policy was issued by a profit or nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange an organization that issues charitable gift annuities as defined in R.S. 22:952(A)(3), or any entity similar to any of these.

LLHIGA also does not provide coverage for:

1. Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
2. Any policy or reinsurance (unless an assumption certificate was issued);
3. Interest rate or crediting rate yields, or similar factors employed in calculating changes in value, that exceed an average rate;
4. Dividends, premium refunds, or similar fees or allowances described under the Law;
5. Credits given in connection with the administration of a policy by a group contract holder;
6. Employers', associations' or similar entities' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them) or uninsured;
7. Unallocated annuity contracts (which give rights to group contract holders, not individuals), except unallocated annuity contracts and defined contribution government plans qualified under section 403(b) of the United States Internal Revenue Code (26 U.S.C. Subsection 403(b));
8. An obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the policy owner or contract owner, including but not limited to, claims described under the law;
9. A policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to "Medicare Part C coverage" or "Medicare Part D coverage" and any regulations issued pursuant to those parts;
10. Interest or other changes in values to be determined by the use of an index or other external references but which have not been credited to the policy or contract or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer, whichever is earlier.

LIMITS ON AMOUNTS OF COVERAGE

The Louisiana Life and Health Insurance Guaranteed Association Law also limits the amount that LLHIGA is obligated to pay out. The benefits for which the association may become liable shall in no event exceed the lesser of the following:

1. LLHIGA cannot pay more than what the insurance company would owe under a policy or contract if it were not an impaired or an insolvent insurer.
2. For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance.
3. For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of $500,000 in health insurance benefits, and LLHIGA will pay a maximum of $250,000 in present value of annuities, including net cash surrender and net cash withdrawal values.

In no event, regardless of the number of policies and contracts there were with the same company, and no matter how many different types of coverage, LLHIGA shall not be liable to expend more than $500,000 in the aggregate with respect to any one individual.

Effective November 2016

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, IA 52499
A Stock Company

Policyholder:	**CITY OF BATON ROUGE**
Address:	**1755 FLORIDA STREET** **BATON ROUGE LA 70821**
Policy Number:	**CN00027600**
Policy Effective Date:	**JANUARY 1 2012**
Policy Anniversary Date:	**FEBRUARY 1**
Premium Rate Guarantee Date:	**JANUARY 1 2013**
Governing Jurisdiction:	**LA**

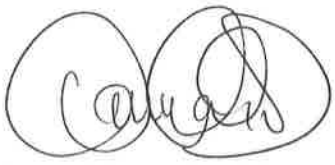
Transamerica Life Insurance Company ("the Company," "We," "Us," and "Our") agrees to pay the benefits described in this Group Master Policy ("Policy"), subject to all terms, conditions, and limitations, in consideration of:

1. The Policyholder Application, a copy of which is attached to and made a part of this Policy; and
2. The payment of the first premium.

By Our acceptance of the first premium paid by the Policyholder ("You," "Your," and "Yours") and by Your receipt of this Policy, You agree:

1. To be bound by the terms of this Policy; and
2. To pay all premiums to Us according to the terms of this Policy.

This Policy is subject to the laws of the governing jurisdiction in which it is issued. It is signed for the Company at Our Home Office to take effect on the Policy Effective Date.



General Counsel and Secretary

President

Group Master Policy for Cancer Only Insurance

BENEFITS LIMITED TO LOSS DUE TO CANCER ONLY
NO BENEFITS PROVIDED FOR ANY OTHER SICKNESS OR CONDITION
PRE-EXISTING CONDITIONS ARE NOT COVERED DURING THE FIRST 12 MONTHS
READ YOUR POLICY CAREFULLY
NONPARTICIPATING - NO ANNUAL DIVIDENDS

Administrative Office:
PO Box 219
Cedar Rapids, IA 52406-0219
Customer Service: 1-888-763-7474

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DEFINITIONS

The defined terms below are subject to the provisions of this Policy:

Active Service - The Insured is:
1. Performing in the usual manner all of the regular duties of his or her occupation on a scheduled work day; and
2. These duties are performed at one of the places of business where the Insured normally does such duties or at some location to which his or her employment sends the Insured.

The Insured is said to be in Active Service on a day which is not a scheduled work day only if he or she would be able to perform in the usual manner all of the regular duties of his or her occupation if it were a scheduled work day, and he or she were in Active Service on the last preceding regular work day.

Amendment, Endorsement, or Rider – Any form issued by Us which adds, modifies, changes, or deletes any Policy or Certificate provisions or benefits.

Application – The form completed and signed to apply or enroll for this insurance coverage.

Certificate – The document given to each Insured that describes the terms of the insurance made available to insured employees or members and their insured Spouses and/or insured Dependent Children, as defined in the Certificate, if applicable.

Effective Date or Policy Effective Date - The date coverage is in effect is shown on the cover page of this Policy. The Effective Date will start at 12:01 AM at the main place of business of the Policyholder.

Evidence of Insurability – The correct and complete answers to the questions in the Application and medical history, if necessary, which may be used by Us to base Our acceptance of any proposed Covered Person.

Group Master Policy or Policy – The complete contract of insurance, which includes the Policy as issued to You, as well as any Certificates issued to each Insured, including any Amendments, Endorsements, Riders, and Applications.

Insured – The eligible employee or member as defined by the Policyholder, and who has been approved by Us for coverage, and whose name appears on the Certificate's Schedule of Benefits.

Policyholder – The entity named on the cover page of this Policy.

ELIGIBILITY

EMPLOYEE OR MEMBER AND DEPENDENT ELIGIBILITY REQUIREMENTS

Employees or Members - To be eligible, an employee or member must:
1. Meet eligibility requirements as selected on the Policyholder's Application;
2. Provide satisfactory Evidence of Insurability to Us, if required; and
3. Be in Active Service on the Effective Date of coverage.

An Application must be completed, and any required premium paid, within 31 days of the date enrollment is offered to the employee or member. If such Application is not made within that 31-day period, the employee or member will be considered a late enrollee and may be required to submit satisfactory Evidence of Insurability in order for coverage to become effective.

Dependents - If Dependent coverage is available, a Dependent will be eligible for such coverage on the later of the following dates:
1. The day an employee or member becomes eligible for coverage; or
2. The day a Dependent first meets the definition of Dependent.

The Insured may elect Dependent coverage by:
1. Applying for Dependent coverage within 31 days of the date the Dependent becomes eligible; and
2. Completing any required form for payroll deduction.

If such Application for Dependent coverage is not made within that 31-day period, the Spouse or Child will be considered a late enrollee and may be required to submit satisfactory Evidence of Insurability in order for coverage to become effective.

If an employee or member and his or her Spouse are both eligible as an employee or member, the Children may be insured as Dependents of either the employee or member or his or her Spouse, but not both.

PREMIUMS

Premium Calculation And Due Dates - The premium due will be the sum of the premiums applicable for all Insureds. You must pay the premiums to Us at Our Administrative Office.

The premiums are due and payable to Us in advance by You on each premium due date. The first premium due date is the Policy Effective Date.

Premium Rate Guarantee - These premium rates are guaranteed until the date shown on the Policy's cover page and is subject to the Change in Premium Rates provision.

Grace Period - A Grace Period of 31 days will be allowed for each premium payment after the first premium. Coverage will stay in force during this time. This Policy will terminate at the end of the Grace Period if the premium has not been paid. You must still pay all unpaid premiums. This includes the premium due for the Grace Period.

If coverage is canceled on a premium due date and the premium has been paid through that date, the Grace Period will not apply. If cancellation is during the Grace Period, You will be liable for any unpaid premium including the pro rata premium for that part of the Grace Period during which coverage was in force.

Change in Premium Rates - We have the right to change the premium rates on any premium due date after the end of the Premium Rate Guarantee. If the rates are changed, We will give You at least a 31-day advance written notice. If an increase takes place on a date other than a premium due date, a pro rata premium for the increase will be due on the next premium due date. The pro rata premium will be for the period from the date of the increase to the next premium due date. If such premium is not paid when due, the coverage will automatically be terminated as of the date the pro rata premium was due. Any partial payment of premium will be refunded.

If the premiums increase because a change in benefits increases Our liability, premium rates may be changed on the date that Our liability is increased without regard to any Premium Rate Guarantee.

POLICY CHANGES

Who May Change This Policy - The terms of this Policy may be changed at any time by written agreement between You and Us. Only Our President, Vice President, Secretary, or an Assistant Secretary can authorize a change in this Policy. Such an authorization must be in writing and signed by an officer. The terms of this Policy can be changed only by endorsement or amendment signed by an officer of Transamerica Life Insurance Company. No agent has the right to change or waive any terms of this Policy. All changes are subject to the laws of the governing jurisdiction.

When Policy Changes Are Effective - Unless You and We agree otherwise in writing, the Effective Date of any change in benefits will be the first day of the calendar month that coincides with or next follows the date We send notice to You of the change in benefits and any corresponding change in premiums.

POLICYHOLDER PROVISIONS

Termination - This Policy will end on the earliest of the following events:

1. If You submit a 60-day advance written request to Us to terminate this Policy, this Policy will terminate on the date specified in that request;
2. If We give a 60-day advance written notice to You that We intend to terminate this Policy, this Policy will terminate on the date specified in that notice;
3. If any premium payable by You is not paid within its Grace Period, this Policy will terminate on the day after the end of the Grace Period;
4. If You fail to comply with any terms of this Policy or the Application, or otherwise fail to fulfill any obligations or duties under or pertaining to this insurance, or fail to comply with or cooperate with Us in satisfying the requirements of any applicable law or regulation pertaining to this insurance, this Policy will terminate on the 32nd day after We have given You written notice of Our intent to terminate; or
5. If the number of Insureds during any 12-month period does not meet the Minimum Participation Requirement shown in Your Application, this Policy may terminate at Our discretion on the 32nd day after We have given You written notice of Our intent to terminate.

Termination of an Insured's coverage that was effective prior to the date Your coverage terminated will be governed by the Termination of Insurance provision of the Certificate. You are required to notify Us of any such termination.

Duties - Your duties will include, but are not limited to, the following:

1. As required, give Us any and all information We determine to be necessary for the enrollment of Your employees or members (and their Spouses and/or Dependent Children, if such coverage is available and has been elected and approved by Us), and for the determination of their eligibility.
2. Receive and forward to Us, the Applications of Your employees or members.
3. Maintain records pertaining to the insurance of Your employees or members as We may reasonably require while this Policy is in force and for two years after this Policy terminates, and allow Us the opportunity to examine these records at any reasonable time during normal business hours.
4. Pay premiums to Us.
5. In the event that any of this insurance is to be stopped:
   a. You are required to notify the insured employees or members by either giving them a written notice or mailing a notice to their last known address as shown in Your records; and
   b. You are required to provide the insured employees or members with a notice of their right to opt for the Portability Option, as described in the Certificate.

Minimum Participation Requirement – You must maintain the participation levels described in the Policyholder Application. If participation falls below the minimum participation limit, We have the right to cancel this Policy.

GENERAL PROVISIONS

Certificates - A Certificate will be issued for delivery to each Insured. The Certificate will describe:

1. The benefits under this Policy;
2. To whom benefits will be paid;
3. The limitations and terms of this Policy; and
4. All other essential features of the Policy.

If more than one Certificate is issued to an Insured under this Policy, only the last one issued will be in effect.

Conformity With State Laws - A provision of the Policy and any Certificate that conflicts with a law of the governing jurisdiction is hereby changed to meet the minimum standards of that law.

Entire Contract - The entire contract consists of: this Policy; Policyholder Application; the Certificates; any attached Amendments, Endorsements, Riders; and Insureds' Applications.

Legal Action - No legal action may be brought to recover under the Policy and and any Certificate:

1. Within 60 days after written Proof of Loss has been furnished as required; or
2. More than three years from the time written Proof of Loss is required to be furnished.

New Insureds - The group originally insured may be modified from time to time to add eligible new persons in accordance with the terms of the Policy.
Time Limit On Certain Defenses - Misstatements in the Application - We will not use any statement, except fraudulent statements, to void or reduce benefits after this Policy has been in force for two years from the Effective Date of coverage. Any such statement would have to be in a signed form. This also applies to all Riders. Any increase in benefit amounts would be subject to a new two year contestable period for the increased amount only.

All statements made are considered representations and not warranties. No such statement will be used in any contest, unless a copy of such statement has been furnished to You.

The validity of this Policy cannot be contested after two years from its date of issue, except for nonpayment of premiums.

CERTIFICATE PROVISIONS MADE A PART OF THIS POLICY

The remainder of this Policy consists of the provisions that appear in the Certificate, including any Amendments, Endorsements, or Riders, that describe the insurance made available to the employees or members (and their Spouses and/or Dependent Children, if applicable) under this Policy.

TRANSAMERICA
LIFE INSURANCE COMPANY

Transamerica Life Insurance Company
Home Office: Cedar Rapids, IA
Administrative Office: P.O. Box 8063
Little Rock, Arkansas 72203-8063

Life and Health Group Application and Agreement

Multi-State Version

Name of Group (*you, your*):	Tax ID Number:	SIC Code:	Website Address:
City of Baton Rouge/Parish of EBR	726000137	9103	brgov.com
Street Address:	**City:**	**State:**	**ZIP Code:**
P.O. Box 1471	Baton Rouge	LA	70821
Contact Name:	**Email Address:**	**Phone #:**	**Fax #:**
Carla Peltier	cpeltier@brgov.com	225-389-3134	225-389-3139
Nature of Group:	**# of Employees/Members:**	**# Eligible for Coverage:**	**# of Years in Existence:**
Billing Address: *(if different)*	**City:**	**State:**	**ZIP Code:**
1755 Florida St.	Baton Rouge	LA	70802
Billing Contact Name: *(if different)*	**Email Address:**	**Phone #:**	**Fax #:**
Beverly Procell	bprocell@brgov.com	225-389-3134	225-389-3139

Billing Address is For: ☐ Group Policyholder ☐ Third Party Administrator ☐ Premium Collection Agency *(Requires a Premium Collection Agreement)*

You hereby authorize Transamerica Life Insurance Company, our authorized agents or our enrollers (collectively referred to as we, us, or our) to offer each of your eligible employees/members the opportunity to purchase insurance coverage as described in this form. This authorization is based upon the following agreements:

1. We customarily conduct an annual enrollment program for your eligible employees/members. You will provide us with census data if needed for us to determine proper enrollment eligibility.
2. The initial enrollment shall take place from 11-2-11 to 11-18-11. You will provide us direct access to your employees/members to obtain applications through group meetings and individual interviews in a suitable location on your property during normal business hours, or through other means mutually agreed upon between you and us. Participation in your group must meet our minimum participation requirements. We reserve the right to withdraw from the enrollment and cancel any applications already obtained if these conditions are not satisfied.
3. Unless otherwise agreed upon by you and us, you will collect premium contributions from your participating employees/members and forward to us when due. We customarily bill you each month. You will forward the premiums due to us within 15 days of the receipt of the monthly bill. You will maintain records of all premium contributions from your employees/members while this agreement remains in force and for two years after it terminates. These records will remain open to inspection and audit by us during normal business hours during this time.
4. In the event of any misappropriation by you, your employees or your agents, of funds owed to us, you will reimburse us for our entire loss including attorney fees and expenses incurred in collection, and any benefits we would not have had to pay but for such misappropriation.
5. Do benefit selections vary by class? ☒ No ☐ Yes *(define classes below)*

Definition of Class 1:	
Definition of Class 2:	
Definition of Class 3:	
Definition of Class 4:	

6. Eligibility for insurance:

	Class 1	Class 2	Class 3	Class 4	
a. Employer Groups - eligible employees are defined as those who work at least	30				hours per week for you,
and have been so employed for at least	---				days.

b. Member Groups - eligible members are defined as members of an eligible class of members, who are in good standing in accordance with your by-laws, who are not currently disabled and are able to perform the normal activities of a person of like age and gender.

7. Is dependent coverage being offered? ☒ Yes ☐ No
If yes, do you include same-sex partners? ☒ No ☐ Yes, state mandate *(Not applicable in TX)* ☐ Yes, corporate decision *(attach eligibility requirements)*

Billing Information

Pay periods per year: 26	Payments will be remitted: ☐ After each deduction ☒ Monthly ☐ Other
Payroll deductions per year: 24	Premium amount on bill should reflect: ☐ Levelized amount over 12 months ☒ Actual amount of deductions occurring each month
First payroll deduction date: 1-6-12	Preferred billing sequence: ☒ Alphabetical ☐ Social Security Number ☐ Employee/Member ID ☐ Other
First bill due date: 2/1/12	Preferred Billing Method: ☐ Paper ☐ Electronic *(via website)* ☒ Self-Bill — Multiple Billing Locations: ☐ No ☒ Yes *(attach listing)*

Name of Section 125 Plan Administrator *(if applicable)*	Plan Start Date	Plan Anniversary Date

☐ **myPack Group Term Life and Accident Package** *Product not available in VT.*

Group Contribution? ☐ Yes ☐ No *If yes, list amount or %:*

Requested Effective Date:

Coverage: ***This is a package containing 2 separate products in a combined sale to offer simplified rates and special underwriting.***

Group Term Life Base: Ages 18-39: $50,000, Ages 40-49: $30,000, Ages 50-64: $15,000
Accelerated Death Benefit for Critical Care (25%) included for all states except CT, FL or OR.
Continuation of Coverage included in all states.
Terminal Illness/Condition Accelerated Death Benefit included in all states except OR.
Waiver of Premium included in all states.

Accept	Decline	
☐	☐	Optional Dependent Coverage
☐	☐	Group Term Life Buy-up: Ages 18-39: $25,000, Ages 40-49: $15,000, Ages 50-64: $7,500
☐	☐	TransAccident Accident-Only Insurance *(not available in CT, FL, GU, ID, MD, MN, NH, NM, PA, PR or WA)* Off-the-Job Accident Disability Rider with 6-Month Benefit included. Sickness Disability Rider with 14-Day Elimination Period and 6-Month Benefit included.

Replacement: Are you replacing existing coverage? ☐ No ☐ Yes

IRS Type: ☐ Section 125 ☐ Welfare Benefit Plan ☐ ERISA ☐ 5500 Required ☐ Other *(please explain)* _____

Workers' Compensation: Are all employees/members covered under Workers' Compensation? ☐ Yes ☐ No *(explain below)*

☑ **Group Accident Insurance – AccidentAdvance** *Product not available in CA, CO, FL, KY, MN, NH, PR, VT, WA.*

Group Contribution? ☐ Yes ☑ No *If yes, list amount or %:*

Requested Effective Date: 10/1/17

Coverage: ☐ 24-Hour Coverage ☑ Off-the-Job Only Coverage ☐ HealthPak AccidentAdvance *(No Sickness DI Rider)*

Accept	Decline	Optional Riders	Plan 1	Plan 2	Plan 3
		Module 1 – Accident Emergency Treatment Benefits	4.0 Units	Units	Units
		Module 2 – Follow-Up Visits and Physical Therapy Benefits	5.0 Units	Units	Units
		Module 3 – Initial Accident Hospitalization	2.5 Units	Units	Units
☑	☐	Accidental Death and Dismemberment Rider	2.5 Units	Units	Units
☑	☐	Accident Hospital & ICU Income Rider	5.0 Units	Units	Units
☑	☐	Expanded Benefits Rider	8.0 Units	Units	Units
☑	☐	Wellness Benefit Rider *(Not available in CT, DC or MA)*	5.0 Units	Units	Units
☐	☑	Accident Only Disability Income Rider Elimination Period-0 Days Benefit Period: ☐ 6 ☐ 12 Months			
☐	☑	Sickness Only Disability Income Rider Elimination Period-14 Days Benefit Period: ☐ 6 ☐ 12 Months			
☐	☑	Spouse Off-the-Job Accident Only Disability Income Rider Elimination Period-0 Days Benefit Period: 6 Months			

Replacement: Are you replacing existing coverage? ☑ No ☐ Yes

IRS Type: ☐ Section 125 ☐ Welfare Benefit Plan ☐ ERISA ☐ 5500 Required ☐ Other *(please explain)* _____

Workers' Compensation: Are all employees/members covered under Workers' Compensation? ☐ Yes ☐ No *(explain below)*

☐ **Group Off-the-Job Accident – TransAccident** *Product not available in FL, GU, ID, MN, NH, NM, PA, PR, VT, WA.*

Group Contribution? ☐ Yes ☐ No *If yes, list amount or %:*

Requested Effective Date:

Coverage: ☐ Standard Plan ☐ Select Plan ☐ Custom Plan *(Attach Plan Design)* ☐ HealthPak TransAccident *(No Sickness DI Rider)*

Accept	Decline	
☐	☐	Accident Only Disability Income Rider Elimination Period-14 Days Benefit Period: ☐ 6 ☐ 12 Months
☐	☐	Sickness Only Disability Income Rider *(N/A in MD)* Elimination Period-14 Days Benefit Period: ☐ 6 ☐ 12 Months
☐	☐	Wellness Rider *(Not available in CT, IN or MA)*

Replacement: Are you replacing existing coverage? ☐ No ☐ Yes

IRS Type: ☐ Section 125 ☐ Welfare Benefit Plan ☐ ERISA ☐ 5500 Required ☐ Other *(please explain)* _____

Workers' Compensation: Are all employees/members covered under Workers' Compensation? ☐ Yes ☐ No *(explain below)*

☐ **Individual Accident Insurance – AccidentSelect**
Accident AnswerSelect in MN and OR
Product not available in CT, FL, GU, MA, NJ, VT, WV.

Group Contribution? ☐ Yes ☐ No *If yes, list amount or %:*

Requested Effective Date:

Coverage: ☐ Plan I ☐ Plan II

Accept	Decline	
☐	☐	Accident Only Disability Income Rider [illegible]

☑ **Group Cancer Insurance – CancerSelect Plus**
Product not available in FL, MN, NH, PR, or VT.
Available as an individual policy in CT, ID, MD, NJ, UT, WA.
Large Employer Group Only (51+) in MA.

Group Contribution? ☐ Yes ☑ No
If yes, list amount or %:

Requested Effective Date: 12/1/11

Coverage: ☐ CancerSelect Plus ☑ LIVESTRONG Cancer
☐ Assignment Offered (Blood Profile Option)

			Plan 1	Plan 2	Plan 3
		Module 1 – Hospital Benefits	1.0 Units	3.0 Units	Units
		Module 2 – Surgery Benefits	1.0 Units	3.0 Units	Units
		Module 3 – Radiation and Chemotherapy Benefits	1.0 Units	3.0 Units	Units
		Module 4 – Wellness and Miscellaneous Benefits	2.0 Units	3.0 Units	Units
		Module 5 – Drug-Related Expense Benefits	1.0 Units	1.0 Units	Units
Accept	**Decline**	**Optional Riders**			
☑	☐	First Occurrence Rider *(Lump Sum Diagnosis Rider in SD)*	1.0 Units	2.0 Units	Units
☑	☐	Intensive Care Rider *(Not available in CT, NJ or WA) (Module 6 in TN)*	1.0 Units	4.0 Units	Units
☑	☐	Specified Disease Rider *(Not available in OR, SD or WA)*	1.0 Units	3.0 Units	Units

Replacement: Are you replacing existing coverage? ☑ No ☐ Yes
IRS Type: ☐ Section 125 ☐ Welfare Benefit Plan ☐ ERISA ☐ 5500 Required ☐ Other *(please explain)*

☐ **Group CI Insurance – CriticalAssistance Plus**
Product not available in CT, FL, GA, MN, NH or PR.
Available as an individual policy in MD, NJ, TN, UT and WA.
Large Employer Group Only (51+) in MA.

Group Contribution? ☐ Yes ☐ No
If yes, list amount or %:

Requested Effective Date:

Coverage: ☐ CriticalAssistance Plus ☐ LIVESTRONG CI
☐ Assignment Offered (Blood Profile Option)

Accept	**Decline**	
☐	☐	Cancer Benefit Rider *(Includes $50 Wellness)*
☐	☐	Occupational HIV Benefit Rider *(Not available in GA, NJ or OR)*
☐	☐	Quality of Life Benefit Rider *(Not available in HI, MA, NC, OR, PA, TN, UT or WA)*
☐	☐	Cancer Screening Wellness Benefit Rider Additional Benefit: ☐ $50 ☐ $100

Replacement: Are you replacing existing coverage? ☐ No ☐ Yes
IRS Type: ☐ Section 125 ☐ Welfare Benefit Plan ☐ ERISA ☐ 5500 Required ☐ Other *(please explain)*

☐ **Group CI Insurance – CriticalAssistance Select**
Product not available in CT, GU, ID, MA, MN, NH, PR or WA.
Available as an individual policy in FL and MD.

Group Contribution? ☐ Yes ☐ No
If yes, list amount or %:

Requested Effective Date:

Coverage: ☐ With Benefit Reduction ☐ Without Benefit Reduction ☐ HealthPak CI ☐ LIVESTRONG CI *(Only available in GA)*

☐ Option A – Cancer, Heart Attack, Stroke, End Stage Renal Failure, and Major Organ Transplant
☐ Option B – Heart Attack and Stroke Only *(Not available in GA)*
☐ Option C – Cancer Only *(Not available in GA)*
☐ Option B and C – Heart Attack, Stroke, and Cancer Only *(Not available in GA)*

Replacement: Are you replacing existing coverage? ☐ No ☐ Yes
IRS Type: ☐ Section 125 ☐ Welfare Benefit Plan ☐ ERISA ☐ 5500 Required ☐ Other *(please explain)*

☐ **Group Dental Insurance – TransSmile**
Product not available in GU, NJ, PR or WA.

Group Contribution? ☐ Yes ☐ No
If yes, list amount or %:

Requested Effective Date:

Coverage: Attach Plan Design ☐ Freedom Network (Passive PPO-DentalMax Network) ☐ Select Network (MAC Network)

	Class 1	Class 2	Class 3	Class 4
Annual Individual Maximum	$	$	$	$
Annual Deductible per Person	$	$	$	$
Annual Family Maximum	$	$	$	$
Type 1 – Preventative & Diagnostic Services (Covered %)	%	%	%	%
Type 2 – Basic Restorative Services (Covered %)	%	%	%	%
Type 1 & 2 Waiting Period	Months	Months	Months	Months
☐ Type 3 – Major Restorative Services (Covered %)	%	%	%	%
Waiting Period	Months	Months	Months	Months
☐ Implants Benefit Rider (Covered %)	%	%	%	%
Waiting Period	Months	Months	Months	Months

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, IA 52499
A Stock Company

This Certificate explains the Group Master Policy for Cancer Only Insurance ("Policy") that is underwritten by Transamerica Life Insurance Company. Read it closely to become familiar with Your coverage.

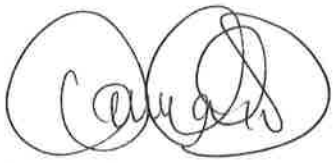
Terms important to understanding this Certificate are defined in the **Definitions** section or in separate Certificate Provisions and are capitalized in this Certificate.

Important Notice - Benefits are payable for loss due to Cancer while the Covered Person is insured under the Policy, subject to the provisions of this coverage. It does not provide benefits for any other sickness or condition.

The Policy under which this Certificate is issued may be amended or canceled, as stated in its provisions. Such an action may be taken without the consent of or notice to any Covered Person. Premiums are subject to periodic changes.

The benefits for Dependents described in this Certificate will be applicable to each of Your Dependents only if You are insured and You have applied for Dependent coverage. Such Application must be approved by Us, and the required premium paid for each Dependent.

This Certificate is signed for the Company at Our Home Office to take effect on the Certificate Effective Date.



General Counsel and Secretary

President

Certificate for Group Cancer Only Insurance

BENEFITS LIMITED TO LOSS DUE TO CANCER ONLY
NO BENEFITS PROVIDED FOR ANY OTHER SICKNESS OR CONDITION
PRE-EXISTING CONDITIONS ARE NOT COVERED DURING THE FIRST 12 MONTHS
READ YOUR CERTIFICATE CAREFULLY
NONPARTICIPATING - NO ANNUAL DIVIDENDS

Administrative Office:
PO Box 219
Cedar Rapids, IA 52406-0219
Customer Service: 1-888-763-7474

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SCHEDULE OF BENEFITS

INSURED: XXXXXXXXXX

AGE AT ISSUE: XX

CERTIFICATE NUMBER: XXXXXXXXX

EFFECTIVE DATE: XX/XX/XXXX

COVERAGE TYPE: [INDIVIDUAL, INSURED and DEPENDENT CHILDREN, or FAMILY]

TOTAL PREMIUM: $XX.XX

PREMIUM MODE: [MONTHLY]

TYPE OF COVERAGE	NUMBER OF UNITS	
	PLAN 1	**PLAN** 2
MODULE 1 - HOSPITAL BENEFITS	1 UNITS	3 UNITS
MODULE 2 - SURGERY BENEFITS	1 UNITS	3 UNITS
MODULE 3 - RADIATION AND CHEMOTHERAPY BENEFITS	1 UNITS	3 UNITS
MODULE 4 - WELLNESS AND MISCELLANEOUS BENEFITS	2 UNITS	5 UNITS
MODULE 5 - CANCER MAINTENANCE THERAPY BENEFITS	1 UNITS	1 UNITS
FIRST OCCURRENCE RIDER	1 UNITS	2 UNITS
INTENSIVE CARE RIDER	1 UNITS	4 UNITS
SPECIFIED DISEASE RIDER	1 UNITS	3 UNITS

DEFINITIONS

The defined terms below are subject to the provisions of the Policy and this Certificate:

Active Service - You are:
1. Performing in the usual manner all of the regular duties of Your occupation on a scheduled work day; and
2. These duties are performed at one of the places of business where You normally do such duties or at some location to which Your employer sends You.

You are said to be in Active Service on a day which is not a scheduled work day only if You would be able to perform in the usual manner all of the regular duties of Your occupation if it were a scheduled work day, and You were in Active Service on the last preceding regular work day.

Activities of Daily Living ("ADL") - Activities used in measuring levels of personal functioning capacity. Normally, these activities are performed without Direct Personal Assistance, allowing personal independence in everyday living.

The ADLs are:
1. Continence: Maintaining control of urination and bowel movements, including the ability to use ostomy supplies or other devices such as catheters;
2. Transferring: Moving between the bed and the chair, or the bed and a wheelchair;
3. Dressing: Putting on and taking off all necessary items of clothing and/or medically necessary braces and artificial limbs usually worn;
4. Toileting: Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene;
5. Eating: Performing all major tasks of getting food into the body; and
6. Bathing: Ability to bathe by a sponge bath or in a tub or shower, including the task of getting into and out of the tub or shower.

Actual Charge(s) - The amount actually paid by or on behalf of the Covered Person and accepted by the provider as payment for the particular goods or services provided.

Ambulatory Surgical Center - A licensed free-standing surgical facility consisting of an operating room, facilities for the administration of general anesthesia, and a post-surgery recovery room. It must also require that the patient be admitted, treated, and released during a 24-hour period.

Amendment, Endorsement, or Rider - Any form issued by Us which adds, modifies, changes, or deletes any Policy or Certificate provisions or benefits.

Anesthesiologist or Anesthetist - A licensed practitioner, other than a member of Your Immediate Family, who specializes in anesthesiology.

Application - The form completed and signed to apply or enroll for this insurance coverage.

Calendar Year - The period from January 1 through December 31 of the same year.

Cancer - A disease evidenced by the presence of a malignancy characterized by the uncontrolled and abnormal growth and spread of malignant cells in any part of the body. This includes carcinoma, sarcoma, malignant melanoma, lymphoma, leukemia, Hodgkin's Disease or any malignant tumor. Cancer does not include other conditions which may be considered precancerous including, but not limited to, leukoplakia, hyperplasia, polycythemia vera, moles, lesions, or similar diseases.

Certificate - This document that describes Your Cancer Only insurance coverage.

Chemotherapist - A licensed healthcare practitioner that authorizes or administers chemotherapy treatment.

Child - A Child of Yours who is unmarried; under the age of 25; dependent upon You for more than 50% of his or her support and maintenance; who lives with You; and is:
1. A natural Child; or
2. A legally adopted Child or a Child who has been placed for adoption with You; or
3. A stepchild, grandchild, or foster Child; or
4. A Child for whom You have been appointed legal guardian; or
5. A Child not living with You, but for whom You are legally required to provide support.

If a Covered Dependent Child has reached age 25, but is incapable of self-support because of mental retardation or physical impairment, We will continue the Child's coverage under the following conditions:
1. The Child must be incapacitated;
2. We must receive proof of incapacity within 31 days after coverage would otherwise terminate;
3. We may require additional proof of such incapacity from time to time, but not more often than once a year after the Child attains age 25; and
4. Your coverage must remain in force.

Common Carrier - Commercial airline, inter-city bus line, or passenger train.

Continuous Loss - Those losses which result from the same or related causes for which benefits are payable under the Policy.

Covered Person - Any or all of the following: You, Your Spouse or Your Child(ren), who have been accepted by Us for coverage.

Date of Positive Diagnosis - It is the day on which:
1. Tissue specimen is taken, or the definitive diagnostic test is performed which confirms Positive Diagnosis when performed by a Pathologist; or
2. Positive Diagnosis is pronounced when a clinical diagnosis is made.

Dependent - Your Child or Spouse as defined in this Certificate. "Family" includes coverage for Child and Spouse.

Direct Personal Assistance - The Covered Person needs physical assistance from another party each and every time they need to perform ADLs. The Covered Person is not able to perform the entire ADL alone even with supports and/or mechanical aids that are normally available.

Effective Date or Certificate Effective Date - The date coverage is in effect is shown on the Schedule of Benefits. The Effective Date will start at 12:01 AM at the main place of business of the Policyholder.

Evidence of Insurability - The correct and complete answers to the questions in Our Application and medical history, if necessary, which may be used by Us to base Our acceptance of any proposed Covered Person.

Extended Care Facility - An institution or that part of an institution licensed or accredited to provide nursing or rehabilitative care under the supervision of a Physician or a Registered Nurse which provides 24-hour skilled nursing service and maintains daily medical records on each patient. It does not include institutions or parts of institutions which are primarily for the care and treatment of the aged, drug addicts, or alcoholics.

Grace Period - The period of 31 days allowed for each premium payment after the first premium.

Group Master Policy or Policy - The complete contract of insurance, which includes the Policy as issued to the Policyholder, as well as any Certificates issued to Insureds, including any Amendments, Endorsements, Riders, and Applications.

Hospice Center - A facility which provides short periods of confinement for terminally ill patients. A Hospice Center must operate a program of hospice care which meets the standards set by the National Hospice Organization. It must also be directed by a Physician, supervised by a Nurse, and licensed or certified by the state in which it is located.

Hospice Team – A team of licensed professionals including a Physician and a Nurse. It may also include a social worker, clergyman, clinical psychologist, physical therapist, or counselor. It must exist primarily to administer a hospice care program meeting the standards of the National Hospice Organization in the patient's home with hospice care available 24 hours a day, 7 days a week.

Hospital - A licensed institution that has on its premises or in facilities available to the Hospital on a contractual prearranged basis and under the supervision of a staff of one or more duly licensed Physicians:
1. Laboratory, X-ray equipment and operating rooms where major surgical operations may be performed by licensed Physicians;
2. Permanent and full-time facilities for the care of overnight resident bed patients under the supervision of a licensed Physician;
3. 24-hour-a-day nursing service by graduate registered nurses; and
4. A patient's written history and medical records.

The term "Hospital" does not include an institution or that part of an institution operated as:
1. A place for rehabilitation;
2. A place for rest, or for the aged;
3. A nursing or convalescent home;
4. A long term nursing unit or geriatrics ward; or
5. An extended care facility for the care of convalescent, rehabilitative or ambulatory patients.

Hospital Confinement, Confinement, or Confined - That period of time the Covered Person is admitted into a medical facility on an inpatient basis in excess of 23 hours. Confinement does not include that period of time during which a Covered Person is in a Hospital emergency room, an observation room, or a freestanding surgical facility or outpatient facility. Successive Confinements separated by 30 days or less will be considered as one Confinement.

Immediate Family Member - You, Your Spouse, Child, mother, father, brother, sister, or other close family member of the Covered Person.

Insured - The employee or member covered for this insurance and named in the Schedule of Benefits.

Oncologist - A licensed Physician (MD) with a specialty in the treatment of Cancer.

Outpatient - A Covered Person who receives medical tests, treatment, or services from a Hospital, Ambulatory Surgical Center, or a medical clinic and is not charged for room and board.

Pathologist - A licensed Physician who has been certified by the American Board of Pathology or the Osteopathic Board of Pathology to practice pathological anatomy.

Physical Therapist - Anyone, other than You or Your Immediate Family Member, who is licensed and certified as a Physical Therapist to treat physically disabled or handicapped persons with physical agents and methods such as massage, manipulation, therapeutic exercises, cold, heat, hydrotherapy, electrical stimulation and light to assist in rehabilitation.

Physician - A licensed practitioner of the healing arts who:
1. Performs only those services permitted by his or her license; and
2. Is not an Immediate Family Member.

Policyholder - The entity named on the cover page of the Policy.

Positive Diagnosis/Positively Diagnosed - A diagnosis made by a Pathologist based on a microscopic examination of fixed tissue or preparations from the hemic system either during life or post mortem (i.e., a pathological diagnosis). The Pathologist's judgment for establishing the diagnosis will be based solely on the criteria of malignancy as accepted by the American Board of Pathology or the Osteopathic Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor or tissue specimen. We will accept a clinical diagnosis in lieu of a pathological diagnosis only when:
1. The pathological diagnosis cannot be made;
2. Medical evidence substantially documents the diagnosis; and
3. Definitive treatment is received for the Cancer; or
4. We pay benefits under Skin Cancer.

Pre-Existing Condition - A sickness or physical condition for which the Covered Person:
1. Had treatment; or
2. Incurred expense; or
3. Took medication; or
4. Received a diagnosis or advice from a Physician,

during the 12-month period immediately before the Effective Date of the Covered Person's coverage.

The term "Pre-Existing Condition" will also include a condition that manifests itself in a way that would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment.

Private Duty Nurse - Anyone, other than You or Your Immediate Family Member, who is a Licensed Practical Nurse (L.P.N.), a Licensed Vocational Nurse (L.V.N.), or a graduate Registered Nurse (R. N.).

Radiologist or Radiation Therapist - A Physician certified by the American Board of Radiology to administer therapeutic radiation.

Schedule of Benefits or Schedule - The benefit schedule set forth in this Certificate.

Skin Cancer - Basal cell epithelioma or squamous cell carcinoma. It does not include malignant melanoma or mycosis fungoides. These are not considered Skin Cancers under this Certificate for the purpose of paying benefits under the Skin Cancer provision.

Speech Pathologist/Therapist - Anyone, other than You or Your Immediate Family Member, who is licensed to practice speech pathology.

Spouse - Your legally married Spouse named in the Application. If You are not legally married, "Spouse" may include Your common law spouse if named in the Application and if legally recognized in the state in which You reside.

Total Disability or Totally Disabled - Through age 64, Total Disability will mean the inability to perform all of the material and substantial duties of Your regular occupation. Total Disability will be considered to exist when You are under the regular care and attendance of a Physician for the necessary treatment of Cancer. After the first two years of Total Disability, You will continue to be considered Totally Disabled if You are unable to engage in any employment or occupation for which You are or You become qualified by reason of education, training, or experience.

On Your 65th birthday and thereafter, Total Disability will mean that Your Physician has certified that You are unable to perform two or more Activities of Daily Living without Direct Personal Assistance as a result of Your Cancer.

Twelve-Month (12-Month) Benefit Period - The initial 12-Month Benefit Period is the 12-month period beginning on the Date of Positive Diagnosis. Subsequent 12-Month Benefit Periods begin on the same month and day as the immediately preceding 12-Month Benefit Period; however, if the Covered Person incurs no covered loss during the 3 months after the end of any 12-Month Benefit Period, the next 12-Month Benefit Period will begin on the next date a covered loss is incurred. Twelve-Month Benefit Periods are determined separately for each Covered Person.

We, Us, or Our - The Insurer that underwrites this coverage: Transamerica Life Insurance Company.

You, Your, or Yours - The Insured.

ELIGIBILITY AND EFFECTIVE DATE

Effective Dates are shown on the Schedule of Benefits. Coverage will start on such date at 12:01 AM at the main place of business of the Policyholder. Effective Dates for all persons added to coverage after this Certificate is issued will be reflected by an endorsement to the Certificate.

Employee or Member Eligibility - To be eligible for insurance You must:
1. Meet eligibility requirements as selected on the Policyholder's Application;
2. Satisfactorily answer all eligibility and other questions on the Application and must provide Evidence of Insurability satisfactory to Us, if We ask for it; and
3. Be in Active Service.

Employee or Member Effective Date - Your insurance will take effect on the Effective Date of the Policy if:
1. You completed an Application on or before said Effective Date; and
2. You are in Active Service; and
3. Your first premium is paid and received by Us.

If You are not eligible for this coverage on the Policy Effective Date, Your coverage will take effect on the first day of the month which coincides with or next follows the date You first become eligible and are approved for coverage. Additionally, Your first premium must have been received by Us, and all provisions listed in the Employee or Member Eligibility provision above, must be met.

If You are not in Active Service on what otherwise would be the Effective Date, Your coverage will be deferred until the first of the month following the date You are in Active Service.

Dependent Eligibility - If Dependent coverage is available, a Dependent will be eligible for such coverage on the later of the following dates:
1. The day You become eligible for coverage; or
2. The day he or she first meets the definition of Dependent.

You may elect Dependent coverage by:
1. Applying for Dependent coverage within 31 days of the date the Dependent becomes eligible; and
2. Completing any required form for payroll deduction.

You must complete an Application for enrollment of a Spouse or Child, and pay any required premium within 31 days of the date Your Spouse or Child meets these eligibility criteria. If such Application is not made within that 31-day period, Your Spouse or Child will be considered a late enrollee and may be required to submit satisfactory Evidence of Insurability in order for coverage to become effective.

Any eligible Dependent who does not become a Covered Person on Your Effective Date may be added to this Certificate subject to:
1. The completion of an Application;
2. Satisfaction of any Evidence of Insurability requirements; and
3. Payment of any additional premium, if required.

If You and Your Spouse are both eligible as an employee or member, the Children may be insured as Dependents of either You or Your Spouse, but not both.

Dependent Effective Date - The Effective Date of coverage for each eligible Dependent will be on the first day of the month that coincides with or next follows:
1. Our acceptance of the Application; and
2. Our receipt of the first premium.

However, if on such date Your coverage has not yet taken effect, the Effective Date for Dependent coverage will be the same as Your Effective Date.

Newborn Child Effective Date - A newborn Dependent Child will become insured for coverage automatically on the day he or she is born, as long as You have Family coverage in force on that date.

If You do not have Dependent coverage in force, the newborn Child's coverage will not continue past the 31-day period following birth, unless:
You have notified Us by the end of the 31-day period of the addition of such newborn Child; and
You have paid any applicable additional premium.

BENEFIT PROVISIONS

If a Covered Person has been Positively Diagnosed with Cancer, We will pay benefits according to the Benefit Provisions section of this Certificate, provided that the loss is incurred (e.g. treatment is received or the service is performed) while this Certificate is in force.

Benefits will begin on the Date of Positive Diagnosis, or as follows:
1. On the date the Covered Person is admitted to the Hospital, if Positive Diagnosis is made during the same Period of Hospital Confinement; but not more than 15 days prior to the Date of Positive Diagnosis; or
2. Not more than 30 days before the Date of Positive Diagnosis for benefits payable under Outpatient Surgery.

Benefit payments will be made directly to You, unless You assign benefits. Proof of Loss must be submitted to Us for each incurred expense.

Under no conditions will We pay any benefits for losses or medical expenses incurred prior to the Effective Date.

The following benefits are payable per Covered Person, and per unit, as shown below. The number of units selected by the Policyholder for each benefit is shown on the Schedule of Benefits.

Module 1 - Hospital Benefits

The following benefits are payable per Covered Person, per unit, per day, as described below.

Hospital Confinement
We will pay $100 per unit, per day, for 90 days for Hospital Confinement for the treatment of Cancer. The maximum number of days We will pay this benefit during a continuous Confinement will not exceed 90 days. Beginning on the 91st day, Our payments for Hospital Confinement will be made under "Extended Benefits."

Extended Benefits
We will pay $200, per unit, per day, for Hospital Confinement beyond 90 continuous days. This benefit will be paid in lieu of all other benefits under this Certificate, including any attached riders, except for Surgery and Anesthesia which will continue to be payable under their applicable benefit provisions.

Inpatient Drugs and Medicine
We will pay $15, per unit, per day, per Confinement, for drugs and medicines given to the Covered Person while Hospital Confined.

Attending Physician Benefit
We will pay $20, per unit, per day, when the attending Physician, other than a surgeon who performed surgery, visits the Covered Person while Hospital Confined.

A "visit" will mean a personal visit by the attending Physician. We will only pay for one visit in any one 24-hour period.

Private Duty Nursing
We will pay $100, per unit, per day, while Hospital Confined for services by a Private Duty Nurse. Services by a Private Duty Nurse must be:
1. Authorized by the attending Physician; and
2. Provided by a Private Duty Nurse who is not acting as a regular staff member of the Hospital in which the Covered Person is Confined.

Ambulance
We will pay $100, per unit, per continuous Confinement by a licensed professional ambulance service for:
1. Transportation to a Hospital to which the Covered Person is admitted; and
2. Transportation from a Hospital from which the Covered Person has been released to a different Hospital to which the Covered Person is admitted.

Extended Care Facility
We will pay $100, per unit, per day, for each day a Covered Person is Confined in an Extended Care Facility. This benefit is limited to the number of days of the prior continuous Hospital Confinement. Confinement in an Extended Care Facility must be at the direction of the attending Physician and must begin within 14 days of the Hospital Confinement.

Government or Charity Hospital
We will pay $100, per unit, per day, in lieu of all other benefits in this Certificate when the Covered Person is Hospital Confined in a government or charity Hospital.

Confinement must be in a Hospital owned or operated by the United States Government or a Hospital that does not charge the Covered Person for its services. Confinement must be primarily for the treatment of Cancer.

Hospice Care
We will pay $100, per unit, per day, for a Confinement in a Hospice Center or for Hospice Care at home by a Hospice Team. This benefit is limited to a lifetime maximum of 100 days per Covered Person. Our payments will be based on the following conditions being met:
1. The Covered Person has been given a prognosis as being terminally ill with an estimated life expectancy of 6 months or less; and
2. We have received a written summary of such prognosis by the attending Physician.

We will not pay this benefit while the Covered Person is Hospital Confined.

Module 2 - Surgery Benefits

The following benefits are payable per Covered Person as described below.

Surgery
With the exception of Skin Cancer, We will pay the amount shown on the Surgical Schedule, not to exceed $1,000 per unit while Hospital Confined. If two or more surgical procedures are performed through the same incision, We will only pay for the procedure having the highest benefit as determined by this provision. If two or more procedures are made in separate incisions, We will pay the highest benefit as the primary procedure and 50% for each of the lesser benefits.

For surgery performed for the treatment of Cancer that does not appear in the Surgical Schedule, We will pay the lesser of:
1. An amount, per unit, determined by multiplying the Work Relative Value Unit obtained from the Medicare Physician Fee Schedule in effect on the date of service by $25; or
2. $1,000 per unit.

Anesthesia
We will pay 25% of the surgery benefit for Anesthesia. It must be given by or under the direction of an Anesthesiologist or by an Anesthetist under the direction of a Physician.

Prosthesis
We will pay the Actual Charges, not to exceed $500, per unit, for a prosthetic device and its implantation. The prosthesis must be authorized by the attending Physician and must require surgical implantation.

Hair Prosthesis
We will pay a one time benefit per Covered Person for the Actual Charges, not to exceed $50, per unit, for a wig or hairpiece if the Covered Person experiences hair loss as a result of Cancer treatment.

Reconstructive Surgery
We will pay the amount shown, below, for reconstructive surgery, anesthesia, post-operative care, and any other related charges for the general forms of Cancer listed below.

General Form of Cancer	Per Unit
1. Breast Cancer-after simple or total mastectomy-each breast	$120
2. Breast Cancer-after radical mastectomy each breast	$170
3. Cancers of the male or female genitalia	$170
4. Cancers of the head or neck, including oral cancers, but excluding Skin Cancer and malignant melanoma	$250

Reconstructive surgery must be performed by a licensed plastic surgeon not more than two years following the initial surgery to remove the Cancer. If reconstructive surgery is performed on the same day as the implantation of a prosthetic device, We will pay only for the procedure having the higher benefit value. We will not pay benefits under this provision when they are paid under any other benefit.

Second Surgical Opinion
We will pay $100, per unit, for the opinion of a second surgeon payable when the prescribed treatment is surgery as determined by the first surgeon. The Covered Person may use this benefit at his or her discretion. None of the other benefits in this Certificate will be affected by this decision. This benefit is payable only after Positive Diagnosis has been made.

A second surgical opinion must be received before surgery is performed. This benefit is not payable for Skin Cancer. We will require a written copy of the initial surgical opinion in addition to the second surgical opinion.

Ambulatory Surgical Center
We will pay the surgical center charges, not to exceed $150, per unit, per day, for surgery performed at an Ambulatory Surgical Center or at a Hospital when the Covered Person is an Outpatient.

Outpatient Surgery
With the exception of Skin Cancer, surgeries performed on an Outpatient basis are paid at 150% of the scheduled benefit. For Outpatient Surgery performed for the treatment of Cancer that does not appear in the Surgical Schedule, We will pay the lesser of:
1. An amount, per unit, determined by multiplying the Work Relative Value Unit obtained from the Medicare Fee Schedule in effect on the date of service by $37.50; or
2. $1,500 per unit.

Skin Cancer (see Surgical Schedule for Melanoma Only)
If Positively Diagnosed with Skin Cancer, We will pay $75, per unit, per diagnosis for the initial removal of Skin Cancer by a Physician; and $35, per unit, for each additional removal.

Surgical Schedule

Procedure and Benefit Amount Per Unit	
EYE AND EAR	
Biopsy of external ear	$20
Biopsy of cornea	$40
Iridectomy	$250
Mastoidectomy	
1. Complete	$310
2. Radical	$340
Iridectomy with cyclectomy	$350
HEAD, NECK & SPINE	
Oropharynx biopsy, excisional	$40
Thyroid biopsy needle	$40
Laryngoscopy with biopsy	$80
Pharyngectomy limited	$470
Laryngectomy:	
1. Subtotal, with bilateral node Dissection	$760
2. Total, with radical neck dissection	$960

Procedure and Benefit Amount Per Unit	
HEAD, NECK & SPINE (cont'd)	
Adrenalectomy, partial or	
Complete thyroidectomy	$450
1. Subtotal, with limited neck Dissection	$550
2. Total, with radical neck dissection	$710
Laminectomy for Intraspinal malignancy	$560
Excision of Malignant Brain Tumor:	
1. All tumors except meningioma	$920
2. Menigioma	$1000
Hemispherectomy:	
1. Partial	$780
2. Total	$830
SKIN (MELANOMA ONLY) AND ORAL	
Biopsy:	
1. Skin surface	$20
2. Mouth or tongue	$40

Procedure and Benefit Amount Per Unit	
SKIN (MELANOMA ONLY) AND ORAL (cont'd)	
Excision of malignant lesion:	
1. Skin surface	$70
2. Lip or mouth with resection	$80
Glossectomy:	
1. Less than one half of tongue	$270
2. Complete or total	$720
3. With radical neck dissection	$940
THORAX	
Breast biopsy:	
1. Needle	$30
2. Incisional, unilateral	$80
Lung biopsy, needle	$50
Thoracoscopy with biopsy	$150
Bronchoscopy with biopsy	$80
Lumpectomy, unilateral	$150
Mastectomy, simple:	
1. Unilateral	$390
2. Bilateral	$590
Mastectomy, radical including:	
Axillary lymph nodes, unilateral	$430
Mastectomy, modified radical	
With axillary lymph nodes	$450
Partial mastectomy	$150
Partial mastectomy with anxilliary	
Lymphadectomy	$350
Lobectomy of Lung total or segmented	$640
Pneumonectomy	$680
ABDOMEN AND PELVIS	
Liver biopsy	$50
Colonoscopy with biopsy	$110
Upper GI Endoscopy with biopsy	$70
Enterectomy: resection of small intesting	
with anastomosis	$520
Gastrectomy:	
1. Partial	$610
2. Total, with intestinal anastomosis	$850
Hepatectomy, partial lobectomy	$970
Colectomy, partial with colostomy	$560
Colectomy, total abdominal, with ileostomy	
or ileoproctostomy	$750
Esophagectomy	$1000
Pancreatectomy, Whipple Type	$1000
Esophagomyotomy:	
1. Abdominal approach	$550
2. Thoracic approach	$570
UNIARY TRACT	
Cystoscopy with biopsy	$70
Ureteral endoscopy with biopsy	$170
Renal biopsy needle	$70

Procedure and Benefit Amount Per Unit	
UNIARY TRACT (cont'd)	
Cystectomy:	
1. Partial, simple	$430
2. Complete	$680
3. Complete, with uretero-cutaneous	$880
Transplant	
Urethrectomy, total with cystostomy	$340
Nephrectomy, radical with excision of	
regional lymph nodes	$590
Cystotomy with resection of bladder tumor	$340
TURB	$240
RECTUM	
Proctosigmoidoscopy with biopsy	$30
Rectal biopsy, incisional	$100
Proctectomy, complete	$760
MALE GENITALIA	
Biopsy of Penis, cutaneous	$50
Prostate biopsy	
1. Non-incisional	$70
2. Incisional	$120
Biopsy of Testis, incisional	
1. Unilateral	$90
2. Bilateral	$130
Orchiectomy, simple:	
1. Unilateral	$130
2. Bilateral	$200
Amputation of Penis	
1. Partial	$270
2. Complete	$360
Prostatectomy, radical	$760
TURP	$140
FEMAL GENITALIA	
Biopsy of Vulva	$30
Biopsy of Vaginal Mucosa	$30
Cervical biopsy	$60
Trachelectomy, partial, with dilation and	
Curettage	$130
Vaginectomy	$390
Vaginectomy:	
1. Partial	$370
2. Complete	$490
Oophorectomy	$200
Uterine Myomectomy, abdominal	
Approach	$390
Vulvectomy, radical with excision of	
regional lymph nodes	$620
Hysterectomy:	
1. Total abdominal	$430
2. Radical abdominal	$770
Dilation and Curettage	$90

Procedure and Benefit Amount Per Unit	
GENERAL AMPUTATIONS	
Finger, each	$150
Toe, each	$90
Foot, each	$220
Arm, each	$250
Lower leg, each	$280
Thigh	$330
Interpelviabdominal	$610

Procedure and Benefit Amount Per Unit	
MISCELLANEOUS	
Muscle biopsy, excisional:	
1. Superficial	$40
2. Deep	$60
Bone marrow aspiration with biopsy	$30
Superficial lymph node biopsy needle	$30
Sequestrectomy for osteomyelitis:	
1. Scapula or clavicle, with suction or irrigation	$180
2. Humeral head to surgical neck, with suction irrigation	$250
Laparotomy (exploratory procedure)	$310
Splenectomy:	
1. Laparoscopic	$420
2. Partial or total	$490

Module 3 - Radiation and Chemotherapy Benefits

The following benefits are payable per Covered Person as described below.

Radiation and Chemotherapy
Treatments - We will pay the Actual Charges, per 12-Month Benefit Period, for radiation or chemotherapy treatments authorized by a Radiologist, Chemotherapist, or Oncologist. The maximum benefit under this provision per Covered Person for any 12-Month Benefit Period will not exceed a total of $5,000, per unit, regardless of the treatment or combination of treatments received in that period.

Under this provision, We will not pay related expenses for: prescribed medications for side effects, physical exams, checkups, laboratory or diagnostic tests, treatment consultations and planning, or any similar such expenses. Radiation or chemotherapy does not include laser or stereotactic surgery.

Associated Expenses - We will pay $250, per unit, per 12-Month Benefit Period for the following radiation or chemotherapy-related expenses: treatment consultations and planning, adjunctive therapy, radiation management, chemotherapy administration, physical exams, checkups, and laboratory or diagnostic tests. We will only pay for this benefit when such charges have been submitted to Us and authorized by a Radiologist, Chemotherapist, or Oncologist. Transportation expenses are not included as associated expenses.

Blood, Plasma, Platelets, Bone Marrow Transplant, and Stem Cell Transplant
We will pay the Actual Charges, not to exceed a total of $5,000, per unit, per 12-Month Benefit Period, for:
1. Blood, plasma, and blood components;
2. Bone Marrow Transplant; or
3. Stem Cell Transplant.

We will not pay for the cost of donated blood if the Covered Person does not incur a charge for that blood. The maximum benefit under this provision for any 12-Month Benefit Period will not exceed a total of $5,000, per unit, regardless of the treatment or combination of treatments received in that period.

Associated Expenses - We will pay $250, per unit, per 12-Month Benefit Period, for Blood, Plasma, Platelets-related expenses, administration of blood, plasma and blood components, transfusions, processing and procurement, or cross-matching, treatment consultations and planning, physical exams, checkups, and laboratory or diagnostic tests. We will only pay for expenses incurred for the items listed when such expenses have been submitted to Us and authorized by the Covered Person's Physician. Transportation and Lodging expenses are not included as associated expenses.

New or Experimental Treatment
We will pay the Actual Charges, not to exceed $5,000, per 12-Month Benefit Period, beginning with the first day of benefit under this provision for experimental or investigational treatments of Cancer. This Certificate defines experimental or investigational treatment to be:

1. Drugs or chemical substances approved by the United States Food and Drug Administration for the experimental use on humans; and
2. Surgery or therapy endorsed by either the National Cancer Institute or the American Cancer Society for experimental studies.

The following restrictions and limitations will apply to this benefit:
1. Experimental treatment must be received in a Hospital in the United States or in one of its territories; and
2. The attending Physician has authorized the treatment.

Module 4 - Wellness and Miscellaneous Benefits

The following benefits are payable per Covered Person, and per unit, except for the Non-Local Transportation, Family Member Lodging, the Outpatient Lodging, and the Waiver of Premium, which are payable as described below.

Wellness Benefit
We will pay $50 per unit, per Calendar Year, for the following Cancer screening tests: mammograms, Pap smears, flexible sigmoidoscopy, prostate-specific antigen tests, chest x-rays, hemocult stool specimen, ultra sounds, CEA, CA125, biopsy, thermography, colonoscopy, serum protein electrophoresis, bone marrow testing, and blood screenings.

Services must be under the supervision of or recommended by a Physician, and a charge must be incurred.

Magnetic Resonance Imaging (MRI) Scans
In addition to the Wellness Benefit, We will pay $50, per unit, per Calendar Year, for an MRI Scan for a Covered Person who is deemed by a Physician to be at a higher than normal risk of developing breast cancer. Services must be under the supervision and recommended by a Physician, and a charge must be incurred.

Non-Local Transportation
If the prescribed treatment for the Covered Person is not available locally, within a 50 mile radius of the Covered Person's residence, and a non-local Hospital Confinement within the United States is authorized by the attending Physician, We will pay transportation expenses for the Covered Person and for one adult member of Your Immediate Family to be with the Covered Person during such Confinement. Our payments for such transportation expenses will be as follows:
1. The Actual Charge for one round trip by Common Carrier; or
2. Forty cents ($.40) per mile for one round trip by private vehicle. Mileage is to be measured by the most direct route from the individual's residence to the non-local Hospital. We will accept his or her mileage figures if reasonable. We will not pay for mileage less than 100 miles round trip, nor in excess of 750 miles, round trip.

We will only pay this benefit once per period of Hospital Confinement in a non-local Hospital.

Family Member Lodging
We will pay $50, per unit, per day, with a maximum of 50 days per 12-Month Benefit Period, for Lodging expenses for one adult member of Your Immediate Family to be with the Covered Person when Confined in a non-local Hospital in the United States. The Lodging benefit may be for a motel, hotel or other accommodations acceptable to Us and will be based on the same number of days the Covered Person is Hospital Confined.

Outpatient Lodging
We will pay $50, per unit, per day, with a maximum of 50 days per 12-Month Benefit Period, for Lodging expenses for the Covered Person receiving radiation or chemotherapy on an Outpatient basis, provided treatment is authorized by the attending Physician and cannot be obtained locally.

Physical or Speech Therapy
We will pay $25 per unit per day for therapy sessions, limited to one session per day, for:
1. Physical therapy treatments given by a licensed Physical Therapist at: An Institute of Physical Medicine and Rehabilitation, a Hospital, or Your home; or
2. Speech therapy given by a licensed Speech Pathologist/Therapist.

Physical therapy or speech therapy must be given on an Outpatient basis only; unless, the primary purpose of Your Hospital Confinement is for treatment of Cancer other than with physical therapy or speech therapy.

At Home Nursing
We will pay $50 per unit per day, limited to the number of days of prior Hospital Confinement, for private nursing care and attendance by a nurse at home. At home nursing services must be required and authorized by the Attending Physician and must begin within 14 days after Confinement as an inpatient in a Hospital.

Waiver of Premium
If the Insured has been Positively Diagnosed with Cancer and is Totally Disabled for a period of 60 consecutive days beginning on the Date of Total Disability due to such Cancer, We will waive each premium that becomes due after such 60 day period as long as the Insured is Totally Disabled.

During any period for which We have waived a premium, this Certificate will be subject to all of its other applicable provisions. Our waiver of premiums will end on any date premium would ordinarily be due when the Insured is not Totally Disabled. Upon the end of Total Disability, the Insured must resume payment of premiums.

This provision does not apply to Total Disability which begins on or after the Insured's 70th birthday.

Module 5 - Cancer Maintenance Therapy Benefits

The following benefits are payable per Covered Person as described below.

We will pay Actual Charges, not to exceed a total of $1,000, per unit, per 12-Month Benefit Period, for:
1. Cancer Suppressive Therapy - drugs used to keep Cancer in check or after acute chemotherapy treatment.
2. Hematological Drugs - drugs aimed to boost cell lines such as white blood cell counts, red blood cell counts, and platelets.
3. Anti-Nausea Drugs - drugs used to reduce the symptoms brought about as a result of chemotherapy or radiation.
4. Motility Agents - drugs used to improve motility or treat side effects caused by chemotherapy or radiation.

We will not pay benefits under this provision when they are paid under any other benefit.

The maximum benefit under this provision for any Twelve-Month Benefit Period will not exceed a total of $1,000 per unit, regardless of the treatment or combination of treatments received in that period.

EXCLUSIONS AND LIMITATIONS

This Certificate provides benefits only for Cancer as defined herein, which is Positively Diagnosed while this Certificate is in force. It does not provide benefits for any other illness or disease.
1. We may reduce or deny a claim or void the Certificate for loss incurred by a Covered Person:
   a. During the first 2 years from the Effective Date of such coverage for any misstatements in the Application which would have materially affected our acceptance of the risk; or
   b. At any time for fraudulent misstatements in the Application.
2. We will only pay for loss as a direct result of Cancer. Proof of Positive Diagnosis must be submitted to Us for each new claim. We will not pay for any other disease or incapacity that has been caused, complicated, worsened or affected by, or as a result of, Cancer.
3. If a covered Hospital Confinement is due to more than one covered disease or condition, benefits will be payable as though the Confinement or expense were due to one disease or condition. If a Hospital Confinement or expense is also due to a disease or condition that is not covered, benefits will be payable only for the part of the Hospital Confinement or expense due to the covered disease or condition.
4. Under no condition will We pay any benefits for losses or medical expenses incurred prior to the Effective Date.

Pre-Existing Condition Limitation - No benefits are provided during the first 12 months for any Cancer that has been diagnosed, treated, or for which the Covered Person has incurred expense or has taken medication within 12 months prior to the Effective Date of such person's coverage.

PREMIUMS

All premiums are payable on or before the date they are due.

We have the right to change the premium rates on any premium due date in accordance with the terms of the Policy. If the rates are changed, We will give at least a 31-day advance written notice to the Policyholder, or to You if the Portability Option is in effect. If an increase takes place on other than a premium due date, a pro rata premium for the increase will be due on the next premium due date. The pro rata premium will be for the period from the date of the increase to the next premium due date. If such premium is not paid when due, the coverage will automatically be terminated as of the date the pro rata premium was due. Any partial payment of premium will be refunded.

If the premiums increase because a change in benefits increases Our liability, premium rates may be changed on the date that Our liability is increased, without regard to any premium rate guarantee.

TERMINATION OF INSURANCE

Subject to the Portability Option, Your insurance will cease on the earliest of:
1. The last day of the payroll deduction period during which You cease to be eligible for coverage;
2. The end of the last period for which premium payment has been made to Us;
3. The last day of the payroll deduction period during which You terminate employment;
4. The date the Policy terminates; or
5. The date You send Us a written notice that You want to cancel coverage.

The insurance on a Dependent will cease on the earliest of:
1. The date Your coverage terminates;
2. The end of the last period for which premium payment has been made to Us;
3. The date the Dependent no longer meets the definition of Dependent;
4. The date the Policy is modified so as to exclude Dependent coverage; or
5. The date You send Us a written notice that You want to cancel Your Dependent's coverage.

We will have the right to terminate the coverage of any Covered Person who submits a fraudulent claim under the Policy.

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 began while coverage was in force; or
2. Any covered treatment or service for which benefits would be provided and which began while coverage was in force; provided, however, that the Covered Person is and continues to be Hospital Confined or receiving treatment.

Such Extension of Benefits will continue for up to the earlier of:
1. 30 days; or
2. The date on which the Covered Person is no longer hospitalized or receiving treatment.

PORTABILITY OPTION

If You lose eligibility for this insurance for any reason other than nonpayment of premiums, You will have the option to continue this Certificate (including any Riders, if applicable) by paying the premiums directly to Us at Our Administrative Office within 31 days after this insurance terminates. We will bill You for these premiums after You notify Us to continue this coverage. If You stop paying the premiums under this option, this coverage will continue, subject to the terms of the Grace Period.

CLAIMS PROVISIONS

Claim Forms - Claim forms should be used for filing Proof of Loss. We will send such form to the claimant within 15 days of receipt of notice of claim. If We fail to supply the proper claim forms within 15 days, You can give proof in writing, setting forth the nature and extent of the loss within the time stated in the Proof of Loss Provision.

Claims Procedure - Due Proof of Loss must be submitted to Us at Our Administrative Office. You or a personal representative may obtain a claim form by calling Our toll-free telephone number listed on the Cover Page.

Notice of Claim - Written notice of claim must be given to Us at Our Administrative Office, or to Our agent. Such notice should be made within 30 days after any loss covered by the Policy. If it is not reasonably possible to give notice within that time, the claim may not be denied or reduced due to the delay.

Payment of Claim Benefits - Benefits may be assigned to the provider(s) of such benefits. Otherwise, all benefits payable under the Policy will be paid to You. Accrued benefits that are not paid at Your death will be paid to Your Spouse, or if there is no Spouse, then to Your estate. We may pay up to $1,000.00 of such benefit to one of Your relatives at Our discretion. Such payment fully discharges Us to the extent of the payment.

Physical Examinations and Autopsy - We have the right to have a Covered Person examined by a Physician of Our choice as often as reasonably necessary while a claim is pending. We will pay for such examination. In case of death, We may request an autopsy where it is not forbidden by law.

Proof of Loss - Satisfactory written Proof of Loss must be given to Us at Our Administrative Office. In case of a claim for loss for which a periodic payment is provided contingent upon continuing loss, such satisfactory written Proof of Loss must be sent within 90 days after the termination of the period for which We are liable. For any other loss, proof must be sent within 90 days after the date of such loss.

Failure to furnish such proof within such time will not invalidate nor reduce any claim if it was not reasonably possible to furnish such proof and that it was furnished as soon as it was reasonably possible. In any event, the proof required must be given no later than one year from the time of loss, unless the claimant was legally incapacitated.

Time of Payment of Claims - Benefits for a covered loss will be paid after We receive satisfactory written Proof of Loss.

GENERAL PROVISIONS

Changes to this Certificate - Only Our President, Vice President, Secretary, or an Assistant Secretary may make any changes to this Certificate and then only in writing. No agent or Policyholder has authority to change the Policy or this Certificate or to waive any of its provisions. Any changes are subject to the laws of the governing jurisdiction.

Conformity with State Laws - A provision of the Policy and/or Certificate that conflicts with a law of the governing jurisdiction is hereby changed to meet the minimum standards of that law.

Entire Contract - The Entire Contract consists of the Policy, this Certificate, any attached Amendments, Endorsements, or Riders, the Policyholder's Application, and Your Application.

Grace Period - A Grace Period of 31 days will be allowed for each premium payment after the first premium is paid. Coverage will stay in force during this time. The coverage under the Policy and/or Certificate will terminate at the end of the Grace Period if the premium has not been paid. You must still pay all unpaid premium. This includes the premium due for the Grace Period.

If coverage is canceled on a premium due date and the premium has been paid through that date, the Grace Period will not apply. If coverage is canceled during the Grace Period, You will be liable for any unpaid premium including the pro rata premium for that part of the Grace Period during which coverage was in force. Benefits may be reduced by the amount of any due, but unpaid premiums.

Legal Action - No legal action may be brought to recover under the Policy and/or Certificate:
1. Within 60 days after written Proof of Loss has been furnished as required; or
2. More than three years from the time written Proof of Loss is required to be furnished.

Misstatement of Age - If the Covered Person's age has been misstated, the Covered Person's true age will be used to adjust the premium or adjust the benefits paid.

No Dividends Payable - This Certificate does not participate in the profits or surplus earnings of Our Company.

Other Insurance With Us - If You have more than one Cancer policy or certificate with Us, only the one chosen by You will remain in effect. We will refund all premiums paid for any other such coverage.

Time Limit on Certain Defenses
Misstatements in the Application - We will not use any statement, except fraudulent statements, to void or reduce benefits after this Certificate has been in force during Your lifetime for two years from the Effective Date of coverage. Any such statement would have to be in a signed form. This also applies to all Riders. Any increase in benefit amounts would be subject to a new two year contestable period for the increased amount only.

All statements made are considered representations and not warranties. No such statement will be used in any contest, unless a copy of such statement has been furnished to You.

Pre-Existing Conditions - No claim for loss incurred or disability that starts after 12 months from the Effective Date will be reduced or denied because a physical condition, not excluded by name or specific description before the date of loss, had existed before the Effective Date of coverage.

When Notice is to be Given by Us - Any notice to You will be sent to Your last known address.

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, IA 52499
Administrative Office: PO Box 219
Cedar Rapids, IA 52406-0219
(Hereinafter called "the Company," "We," "Us," or "Our")

AMENDMENT

This Amendment is attached to and made a part of the Contract, as defined below.

DEFINITIONS

The following definitions are added:

Contract - The Policy for Cancer Only Insurance and any Certificate, if applicable, to which this Amendment is attached.

Chemotherapy - Drugs and cytotoxic chemical substances which are used as curative or therapeutic treatment to destroy, reduce, or control malignant cancer cells. The United States Food and Drug Administration must approve such drugs or therapies specifically for use as anti-cancer treatment or therapy.

Radiation Therapy - The use of ionizing radiation as curative or therapeutic treatment to destroy, reduce or control malignant cancer cells. The United States Food and Drug Administration must approve such drugs or therapies specifically for use as anti-cancer treatment or therapy.

BENEFIT PROVISIONS

The following benefit provisions have been revised as follows:

Module 1 - Hospital Benefits
Hospital Confinement - First sentence - Delete reference to "90 days" for Hospital Confinement. This sentence now reads:

We will pay $100 per unit, per day, for Hospital Confinement for the treatment of Cancer.

Module 3 - Radiation and Chemotherapy Benefits
New or Experimental Treatment - First sentence - Add the words "per unit" after $5,000. This sentence now reads:

We will pay the Actual Charges, not to exceed $5,000, per unit, per 12-Month Benefit Period, beginning with the first day of benefit under this provision for experimental or investigational treatments of Cancer.

Module 4 - Wellness and Miscellaneous Benefits
The first paragraph has been revised to delete reference to each benefit as being "per unit" or "not per unit" as follows:

The following benefits are payable per Covered Person:

This Amendment does not waive, alter, or extend any condition or provision of the Contract, except to the extent shown above. It is subject to all the terms and limitations of the Contract. This Amendment takes effect and expires concurrently with the Contract to which it is attached and is signed for the Company at Our Home Office.

General Counsel and Secretary

President

TRANSAMERICA
WORKSITE MARKETING

Company which issued the Policy or Certificate (referred to as "Contract" herein) to which this form is attached:
Transamerica Life Insurance Company - Home Office: Cedar Rapids, Iowa

Administrative Office: PO Box 219, Cedar Rapids, IA 52406-0219

ENDORSEMENT

This Endorsement is made part of the Contract to which it is attached, and is subject to all its provisions which are not in conflict with the provisions of this Endorsement. The Effective Date of this endorsement is the same as the Effective Date of the Contract to which it is attached or January 1, 2011, whichever is later.

Beginning on January 1, 2011, the definition of Child is hereby amended as follows:

- The limiting age for a Child is now increased to cover Children through age 25.
- Any restriction that requires a Child be unmarried is now removed.
- Any restriction that requires a Child be a full-time student is now removed.
- Any restriction that requires a Child be living with you is now removed, with the exception of grandchildren (where available).
- Any restriction that requires a Child be financially dependent on you is now removed, with the exception of grandchildren (where available).

In all other respects the provisions and conditions of the Contract remain the same.

Signed for the Company at our Home Office on its Effective Date by:

General Counsel and Secretary

Accepted by:_____

Title: _____
(e.g. Insured, Owner, Guardian, or Officer Position if signing for a Group Policyholder)

Date: _____

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, IA 52499
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INTENSIVE CARE RIDER

This Rider is attached to and made part of the Contract, as defined below, as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. Except as shown in this Rider, the provisions of the Contract will prevail.

While this Rider is in force, We will pay benefits described in "What We Will Pay" section of this Rider for loss from sickness or injury resulting from the Covered Person's Confinement in an Intensive Care Unit or a Step Down Unit on or after the Effective Date, subject to all of its provisions, conditions, exceptions, and limitations.

DEFINITIONS

In addition to the definitions contained in the Contract, the following definitions apply to this Rider.

Contract - The Policy for Group Cancer Only Insurance or any Certificate, if applicable, to which this Rider is attached.

Effective Date - The Effective Date of the Contract or the date shown for this Rider if added to the Contract at a later date.

Intensive Care Unit ("ICU") - A specially designated area of a Hospital that provides the highest level of medical care restricted to those patients who are critically ill or critically injured. It must be separate and apart from the surgical recovery room and other rooms, wards, or beds normally used for patient Confinement. It must also:

1. Be provided with constant and continuous nursing care by nurses assigned on a full-time basis exclusive to such unit; and
2. Be under the full-time direction or supervision of either a Physician or a standing committee of the Hospital's medical staff; and
3. Contain special life-saving equipment.

ICU includes intensive cardiac and coronary care units, neonatal ICUs, and burn ICUs, if such units meet the conditions in this definition. ICU does not include any of the following lesser treatment units: private or semi-private rooms, private monitored/telemetry rooms, observation units, surgical recovery units, or other lesser treatment units.

Period of Intensive Care Confinement - A period of Hospital Confinement when the Covered Person is Confined to the ICU or a Step Down Unit and charged the Intensive Care or Step Down Unit rate for each day of such Confinement. If 30 days or less separates two Periods of Intensive Care Confinement, the second Period of Intensive Care Confinement will be considered a continuation of the first.

Step Down Unit - A specially designed area of the Hospital that provides medical care restricted to those patients who are critically ill or critically injured, providing a level of care just under that of an Intensive Care Unit. Step Down Unit includes: progressive care units; subacute intensive care units; and intermediate care units. This does not include lesser treatment units, such as: private or semi-private rooms; private monitored/telemetry rooms; observation units; or surgical recovery units.

WHAT WE WILL PAY

The following benefits are payable per unit as shown below. The number of units selected by the Policyholder for each benefit is shown on the Schedule of Benefits.

Daily Indemnity - We will pay $100, per unit, for each day the Covered Person is Confined in an ICU. We will pay 50% of this Daily Indemnity Benefit for treatment in a Step Down Unit when the Covered Person is Confined on an inpatient basis. During any one Period of Intensive Care Confinement, Our payments will not exceed 45 days for sickness or injury.

Ambulance - We will pay the Actual Charges for transportation by a licensed ambulance service, not to exceed $200 per unit, per Period of Intensive Care Confinement, to a Hospital for admission to an ICU or a Step Down Unit for a covered Confinement.

Ambulance transportation in excess of 100 miles from the point of origin must be to the nearest Hospital which contains an ICU and provides necessary medical care. We will not pay this benefit when it is paid under the Contract.

Benefit payments will be made directly to You, unless You assign benefits. Proof of Loss must be submitted to Us for each incurred expense.

WHAT WE WILL NOT PAY

1. We will not pay any benefits for loss resulting from:
   a. Specifically excluded diseases or conditions in the Contract or in this Rider; or
   b. An attempted suicide while sane or insane or an intentionally self-inflicted injury; or
   c. Any act of war either declared or undeclared; or
   d. Alcoholism or drug addiction; or
   e. Mental or nervous disorders; or
   f. An overdose of drugs, narcotics, hallucinogens, unless administered on the advice of a Physician; or
   g. Intoxication, or being under the influence of any intoxicant or narcotic, unless administered on the advice of a Physician; or
   h. Injury received while engaging in an illegal occupation or activity.
2. We may reduce or deny a claim or void this Rider for loss incurred by a Covered Person:
   a. During the first 2 years from the Effective Date of such coverage for any misstatements in the Application which would have materially affected our acceptance of the risk; or
   b. At any time for fraudulent misstatements in the Application.
3. We will pay only one daily indemnity benefit per day.
4. With respect to the benefits offered by this Rider, the "Time Limit on Certain Defenses" provision in the Contract will apply from the Effective Date of this Rider.

Under no conditions will We pay any benefits for losses or medical expenses incurred prior to the Effective Date.

WHEN THIS RIDER STARTS

This Rider becomes effective on the same date as the Contract Date unless We inform the Insured in writing of a different date.

WHEN THIS RIDER ENDS

This Rider will terminate for any one of the following reasons which occurs first:
1. The Contract terminates; or
2. Failure to pay the renewal premium before the end of the grace period; or
3. Our receipt of the Policyholder's written request to terminate this Rider.

Termination due to Item 3 will be on the next renewal date, after Our receipt of the written notice, or any later specified date, if the mode of premium payment is monthly. Otherwise, it will be on the date of our receipt of such written notice, or any later date as indicated by the Policyholder. Any premium paid in advance of the termination date due to Item 3 will be refunded to the Insured.

Signed for the Company at Our Home Office to take effect on the Rider Effective Date.

General Counsel and Secretary

President

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, IA 52499
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FIRST OCCURRENCE RIDER

This Rider is attached to and made part of the Contract, as defined below, as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. Except as shown in this Rider, the provisions of the Contract will prevail.

While this Rider is in force, We will pay benefits described in "What We Will Pay" section of this Rider when the Covered Person is Initially Positively Diagnosed with Cancer, other than Skin Cancer, subject to all of its provisions, conditions, exceptions, and limitations.

DEFINITIONS

In addition to the definitions contained in the Contract, the following definitions apply to this Rider.

Contract - The Policy for Group Cancer Only Insurance or any Certificate, if applicable, to which this Rider is attached.

Effective Date - The Effective Date of the Contract or the date shown for this Rider if added to the Contract at a later date.

Initial Positive Diagnosis/Initially Positively Diagnosed - A first time ever Positive Diagnosis made by a Pathologist based on a microscopic examination of fixed tissue or preparations from the hemic system either during life or post mortem (i.e., a pathological diagnosis). The Pathologist's judgment for establishing the diagnosis will be based solely on the criteria of malignancy as accepted by the American Board of Pathology or the Osteopathic Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor or tissue specimen. We will accept a clinical diagnosis in lieu of a pathological diagnosis only when:

1. The pathological diagnosis cannot be made;
2. Medical evidence substantially documents the diagnosis; and
3. Definitive treatment is received for the Cancer.

WHAT WE WILL PAY

When a Covered Person has been Initially Positively Diagnosed with Cancer (excluding Skin Cancer), and while this Rider is in force, We will pay a one time benefit of $1,000 per unit. The number of units selected by the Policyholder for each benefit is shown on the Schedule of Benefits. This benefit is payable only once per lifetime per Covered Person and is in addition to any other benefits payable under the Contract.

Benefit payment will be made directly to You, unless You assign benefits. Proof of the Initial Positive Diagnosis of Cancer must be submitted to Us.

WHAT WE WILL NOT PAY

Benefits are not payable:
1. For expenses incurred prior to the Effective Date of this Rider;
2. During the first 12 months for any Cancer diagnosed within 12 months prior to the Effective Date of such person's coverage;
3. For any other illness or disease other than internal Cancer; and
4. For Skin Cancer or any Cancer excluded from coverage by name or specific description.

We may reduce or deny a claim or void this Rider for loss incurred by a Covered Person:
1. During the first 2 years from the Effective Date of such coverage for any misstatements in the Application which would have materially affected Our acceptance of the risk; or
2. At any time for fraudulent misstatements in the Application.

WHEN THIS RIDER STARTS

This Rider becomes effective on the same date as the Contract Date unless We inform the Insured in writing of a different date.

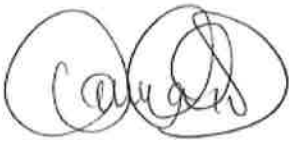
WHEN THIS RIDER ENDS

This Rider will terminate for any one of the following reasons which occurs first:

1. The Contract terminates;
2. Failure to pay the renewal premium before the end of the Grace Period; or
3. Our receipt of the Policyholder's written request to terminate this Rider.

Termination due to Item 3 will be on the next renewal date, after Our receipt of the written notice, or any later specified date, if the mode of premium payment is monthly. Otherwise, it will be on the date of our receipt of such written notice, or any later date as indicated by the Policyholder. Any premium paid in advance of the termination date due to Item 3 will be refunded to the Insured.

Signed for the Company at Our Home Office to take effect on the Rider Effective Date.



General Counsel and Secretary

President

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SPECIFIED ILLNESS AND DISEASE RIDER

This Rider is attached to and made part of the Contract, as defined below, as of the Rider Effective Date. It is issued in consideration of any statements made in the Application and payment of any required initial premium. Except as shown in this Rider, the provisions of the Contract will prevail.
While this Rider is in force, We will pay benefits described in the "What We Will Pay" section of this Rider for Hospital and Surgical-related benefits for any Specified Illness or Disease listed in the Definitions Section of this Rider. Benefit payments are subject to all of its provisions, conditions, exceptions, and limitations for loss when the Covered Person is Initially Positively Diagnosed for a Specified Illness or Disease.

DEFINITIONS

In addition to the definitions contained in the Contract, the following definitions apply to this Rider.

Contract - The Policy for Group Cancer Only Insurance and any Certificate, if applicable, to which this Rider is attached.

Effective Date - The Effective Date of the Contract or the date shown for this Rider if added to the Contract at a later date.

Initial Positive Diagnosis/Initially Positively Diagnosed - The first time a Covered Person has received a pathological diagnosis based on the medical criteria as accepted by the American Board of Pathology or the Osteopathic Board of Pathology for the specified illness or disease being investigated. We will accept a clinical diagnosis in lieu of a pathological diagnosis only when:

1. The latter cannot be made; or
2. When the generally accepted diagnosis is based on clinical observations and the Covered Person receives definitive treatment for the Specified Illness or Disease.

Specified Illness and/or Disease - Any one of the following illnesses or diseases which is first Positively Diagnosed after this Rider is in force.

1. Adrenal Hypofunction (Addison's Disease)
2. Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)
3. Botulism
4. Brucellosis
5. Budd-Chiari Syndrome
6. Cerebral Palsy
7. Cholera
8. Cystic Fibrosis
9. Diphtheria
10. Encephalitis
11. Hansen's Disease
12. Hepatitis (Chronic B or Chronic C with liver failure or hepatoma)
13. Histoplasmosis
14. Huntington's Chorea
15. Legionnaires' Disease
16. Lupus
17. Lyme Disease
18. Mad Cow Disease
19. Malaria
20. Meningitis
21. Muscular Dystrophy
22. Myasthenia Gravis
23. Necrotizing Fascitis
24. Osteomyelitis
25. Poliomyelitis
26. Primary Biliary Cirrhosis
27. Primary Sclerosing Cholangitis (Walter Payton's Liver Disease)
28. Q Fever
29. Rabies
30. Reye's Syndrome
31. Rheumatic Fever
32. Rocky Mountain Spotted Fever
33. Scarlet Fever
34. Scleroderma
35. Sickle Cell Anemia
36. Tay-Sachs Disease
37. Tetanus
38. Thallasemia
39. Toxic Epidermal Necrolysis
40. Toxic Shock Syndrome
41. Trichinosis
42. Tuberculosis
43. Tularemia
44. Typhoid Fever
45. Whooping Cough (Pertussis)

WHAT WE WILL PAY

If a Covered Person has received an Initial Positive Diagnosis, We will pay the benefits shown below on a per unit basis provided that the loss is incurred (e.g. treatment is received or the service is performed) while this Rider is in force. The number of units selected by the Policyholder for each benefit is shown in the Schedule of Benefits.

Benefits will begin on the date the Covered Person receives an Initial Positive Diagnosis, on or after the Effective Date of this Rider, or as follows:

1. On the date the Covered Person is admitted to the Hospital, if the Initial Positive Diagnosis is made during the same Hospital Confinement; but not more than 15 days prior to the Date of Positive Diagnosis; or
2. Not more than 30 days before the Date of Positive Diagnosis for benefits payable under Outpatient Surgery.

Benefit payments will be made directly to You, unless You assign benefits. Proof of Loss must be submitted to Us for each incurred expense.

Hospital Benefits (payable per unit)

Hospital Confinement
We will pay $100 per day for 90 continuous days of Hospital Confinement for the treatment of a Specified Illness or Disease. The maximum number of days We will pay this benefit during a continuous Confinement will not exceed 90 days. Beginning on the 91st day, Our payments for Hospital Confinement will be made under "Extended Benefits."

Extended Benefits
We will pay $200 per day for Hospital Confinement beyond 90 continuous days. This benefit will be paid in lieu of all other benefits under this Rider, except for the Surgery and Anesthesia benefits listed under the Surgery Benefits section, which will continue to be payable under its applicable benefit provisions.

Inpatient Drugs and Medicine
We will pay $15 per day per Confinement for drugs and medicines given to the Covered Person while Confined.

Attending Physician Benefit
We will pay $20 per day when the attending Physician visits the Covered Person while Hospital Confined.

A visit will mean a personal visit by the attending Physician. We will only pay for one visit in any one 24-hour period.

Private Duty Nursing
We will pay $100 per day while Hospital Confined for services by a Private Duty Nurse. Services by a Private Duty Nurse must be:

1. Authorized by the attending Physician; and
2. Provided by a Private Duty Nurse who is not acting as a regular staff member of the Hospital in which the Covered Person is Confined.

Ambulance
We will pay $100 per continuous Hospital Confinement by a licensed professional ambulance service for:

1. Transportation to a Hospital to which the Covered Person is admitted as an inpatient; and
2. Transportation is from a Hospital from which the Covered Person has been released to a different Hospital to which the Covered Person is admitted as an inpatient.

Extended Care Facility
We will pay $100 per day for each day a Covered Person is Confined in an Extended Care Facility. This benefit is limited to the number of days of the prior continuous Hospital Confinement. Confinement in an Extended Care Facility must be at the direction of the attending Physician and must begin within 14 days of the Hospital Confinement.

Government or Charity Hospital
We will pay $100 per day in lieu of all other benefits when the Covered Person is Hospital Confined in a government or charity Hospital.

Confinement must be in a Hospital owned or operated by the United States Government: or a Hospital that does not charge the Covered Person for its services. Confinement must be primarily for the treatment of one of the listed Specified Illnesses or Diseases. Benefits under this provision are paid in lieu of all other benefits in this Rider when the Covered Person is Confined in a government or charity Hospital.

Hospice Care
We will pay $100 per day for a Confinement in a Hospice Center or for Hospice Care at home by a Hospice Team. This benefit is limited to a lifetime maximum of 100 days per Covered Person. Our payments will be based on the following conditions being met:
1. The Covered Person has been given a prognosis as being terminally ill with an estimated life expectancy of 6 months or less; and
2. We have received a written summary of such prognosis by the attending Physician.

We will not pay this benefit while the Covered Person is Hospital Confined.

Surgery Benefits (payable per unit)

Surgery
For surgery performed for the treatment of Specified Illness or Disease, We will pay an amount not to exceed the lesser of:
1. An amount determined by multiplying the Work Relative Value Unit obtained from the Medicare Physician Fee Schedule in effect on the date of service by $25; or
2. $1,000 per unit.

Outpatient Surgery
Surgeries performed on an Outpatient basis are paid at 150% of the surgery benefit.

Anesthesia
We will pay 25% of the surgery benefit. Anesthesia must be given by or under the direction of an Anesthesiologist; or by an Anesthetist under the direction of a Physician.

Second Surgical Opinion
We will pay $100 for the opinion of a second surgeon payable when the prescribed treatment is surgery as determined by the first surgeon. The Covered Person may use this benefit at his or her discretion. None of the other benefits in this Rider will be affected by this decision. This benefit is payable only when an Initial Positive Diagnosis has been made per Covered Person.

A second surgical opinion must be received before surgery is performed. We will require a written copy of the initial surgical opinion in addition to the second surgical opinion.

Ambulatory Surgical Center
We will pay the Ambulatory Surgical Center charges not to exceed $150 per day for surgery performed at an Ambulatory Surgical Facility or at a Hospital when the Covered Person is an Outpatient.

WHAT WE WILL NOT PAY

1. This Rider provides benefits for the Initial Positively Diagnosed Specified Illness or Disease defined in this Rider on or after the Effective Date of this Rider. It does not provide benefits for any other illness or disease.
2. We will only pay for loss as a direct result of a Specified Illness or Disease. Proof of Positive Diagnosis must be submitted with each new claim. We will not pay for any disease or incapacity that has been caused, complicated, worsened, or affected by, or as a result of a Specified Illness or Disease or its treatment.
3. We may reduce or deny a claim or void this Rider for loss incurred by a Covered Person:
   a. During the first 2 years from the Effective Date of such coverage for any misstatements in the Application which would have materially affected Our acceptance of the risk; or
   b. At any time for fraudulent misstatements in the Application.
4. Benefits under "Waiver of Premium" of the Contract do not apply to this Rider for Total Disability due to a Specified Illness or Disease.
5. With respect to the benefits offered by this Rider, the "Time Limit on Certain Defenses" provision of the Contract will apply from the Effective Date of this Rider.

Under no condition will We pay any benefits for losses or medical expenses incurred prior to the Effective Date.

WHEN THIS RIDER STARTS

This Rider becomes effective on the same date as the Contract Date unless We inform the Insured in writing of a different date.

WHEN THIS RIDER ENDS

This Rider will terminate for any one of the following reasons which occurs first:

1. The Contract terminates; or
2. Failure to pay the renewal premium before the end of the Grace Period; or
3. Our receipt of the Policyholder's written request to terminate this Rider.

Termination due to Item 3 will be on the next renewal date, after Our receipt of the written notice, or any later specified date, if the mode of premium payment is monthly. Otherwise, it will be on the date of our receipt of such written notice, or any later date as indicated by the Policyholder. Any premium paid in advance of the termination date due to Item 3 will be refunded to the Insured.

This Rider is signed for the Company at Our Home Office to take effect on the Rider Effective Date.

General Counsel and Secretary

President

COMPENSATION DISCLOSURE NOTICE TO ALL POLICYHOLDERS

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

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

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

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

For up to date information regarding our compensation practices, please consult our website at: www.transamericaemployeebenefits.com.