

The Benefit Alliance Plan

Dear Kelly Contract/Temporary Employee:

Thank you for your interest in the Leslie & Associates Benefit Alliance Plan. The program is designed to provide you access to a portfolio of group benefits, many of which are not usually available to individuals at group rates. We have enclosed the plan details, rates, and an enrollment form for the following benefits:

- **Group Term Life Insurance**

You may choose the amounts of group term life insurance that best suit your needs. Coverage is available for you, your spouse and your dependent children. No physical examinations or medical questions required! (You must have started your employment with Kelly Services within the prior 60 days to be eligible to enroll in the Group Term Life Insurance plan.)

- **Short-Term Disability Insurance**

Protect your most valuable asset - your income! You may insure up to 50% of your weekly pay to a \$1,000 maximum weekly benefit. Benefits start on the 1st day if you are disabled due to a non-occupational injury or on the 8th day if your disability is due to a sickness that is not job-related.

- **Critical Illness Plan**

Benefit amounts available from \$5,000 to \$50,000 for you and your spouse. Lump sum benefits are paid directly to the insured following the diagnosis of each covered critical illness such as a heart attack, stroke, cancer, etc.

- **Group Dental Plan**

You have a choice of two dental plan designs. You may choose your own dentist or specialist.

- **Group Limited Accident & Sickness Plan - STANDARD Tier 1 and Tier 2 Plans**

A limited benefits medical insurance plan with no deductibles. Provides reimbursement for doctor's office visits, emergency room treatment for sickness or accidents, and cash benefits for hospital confinement or surgical procedures. Includes a wellness benefit for physical exam or screening. (Important Notice for Massachusetts residents - None of the Group Limited Accident & Sickness plans meet the Massachusetts state mandated coverage requirements.)

- **Group Limited Accident & Sickness Plan - ENHANCED Tier 3 and Tier 4 Plans**

\$20 Co-Pay for physician office visits. Wellness and Well Child Care benefits for annual routine physical exams. Multiplan PPO Network access to reduce your costs and maximize plan benefits. Coverage is available in all 50 states. Enhanced Plan design includes out-patient Prescription drug benefits and PPO Network Access. (Important Notice for Massachusetts residents - None of the Group Limited Accident & Sickness plans meet the Massachusetts state mandated coverage requirements.)

- **Accident Plan**

24-Hour accident coverage for you and your family. Pays a scheduled benefit amount for specified injuries, hospital admission or confinement and medical fees. Includes accidental death and dismemberment benefits.

- **Group Prescription Drug Co-op Plan**

The greater of a \$20.00 Co-Pay or 40% benefit for most generic drugs. Also discounts savings on brand-name drugs at more than 55,000 pharmacies nationwide.

- **EyeMed Vision Care Plan**

A new vision care plan provides co-pays for eye exams, frames, lenses and contact lenses. Enjoy substantial savings at more than 30,000 providers including independent optometrists and over 850 LensCrafters locations nationwide.

You may choose any combination of one or more of the benefits offered. The monthly premiums for the plans you choose will be combined into a single payment amount and you may elect to pay it on a monthly direct bill basis or through the convenience of an automatic bank draft. A one-time \$20.00 initial enrollment fee applies to the first payment and a small monthly administrative fee (\$2.00 for bank drafts or \$3.00 for direct billing) will be added to the total premium due for the benefits you select.

PLEASE NOTE: Leslie & Associates must receive your completed, correct enrollment form and accompanying initial premium payment on or before the 20th of the month in order to have your coverage become effective on the 1st day of the following month.

- **Short Term Major Medical Plans & Individual Major Medical Plans (available in most states)**

Protection in the event of unexpected serious illness or injury (pre-existing conditions are not covered). Individual Major Medical plan design choices include "copay" plans utilizing a nationwide network of doctors and hospitals or lower premium, high deductible plans. Your choice of deductibles and co-insurance options for both Short Term and Individual Major Medical Plans. Short Term Major Medical plans typically available for 1-12 months. Convenient payment options including credit cards. Individual premiums are based on age, deductible, plan design and zip code. You must call Leslie & Associates at 1-800-644-6854 for a personalized Individual Major Medical Plan or Short Term Major Medical quote.

If you should have any questions regarding any of the enclosed information, please call Leslie & Associates Benefit Alliance on our toll-free customer service number 1-800-644-6854. Our Customer Service Representatives will be happy to assist you Monday through Friday 8:30 a.m. to 5:00 p.m. Central Standard Time.

Kelly Services assumes no authority over, no financial partnership in, or responsibility for these benefit plans.

Group Term Life Insurance Protection

This optional group term life insurance plan allows you to choose amounts of life insurance that best suit your family's needs.

Both you and your spouse can apply for life insurance and you can apply for life insurance for your dependent children.

Who's Eligible?

All employees working an average of at least 20 hours per week are eligible to apply for coverage.

Employees who purchase coverage on themselves may apply for coverage for their spouses (under age 70) and dependent children who are over 14 days of age and under 19 years of age. Children who are full-time students, wholly dependent upon you for support, are eligible up to age 25.

Amount of Insurance

You may elect an amount of life insurance which includes Accidental Death & Dismemberment benefits. Your insurance will reduce at age 70 and your spouse's insurance will terminate at age 70.

Guarantee Issue

No physical examinations are required for you, your spouse or your dependent children.

You are guaranteed up to \$100,000 of insurance on your life provided you are under age 70 and actively at work (not on leave of absence) on the day your insurance is to become effective.

Your spouse is guaranteed insurance (up to 50% of the employee coverage amount - not to exceed \$50,000) on his or her life provided he or she is under age 70 and not hospital-confined on the day the insurance becomes effective and is performing the normal activities of a person of like age and sex.

Your eligible dependent children are guaranteed up to \$10,000 of insurance provided they qualify under the same provisions applicable to a spouse (see above).

Effective Dates

When initial premiums are received by the insurance company on or before the 20th day of a given month, the insurance for you and your spouse will be effective the first day of the following month.

NOTE: You must be actively at work (not on leave of absence) on the day your insurance is to take effect. If you are not, your insurance will take effect on the day you resume such work. Your spouse and dependent children must not be hospital-confined and must be performing the normal duties of a person of like age and sex on the day their insurance is to take effect. If they are not, their insurance will take effect on the day they return to normal activities.

Accidental Death & Dismemberment Benefits

If death occurs due to an accidental injury, the AD&D benefit amount (equal to the basic life amount) will be paid to the beneficiary in addition to the basic life insurance amount.

If loss of a limb or eyesight occurs due to an accidental injury, a specific amount, related to the AD&D maximum amount, will be paid to the insured. The total payment for all losses due to any one accident will not be more than the full amount of insurance.

AD&D benefits are not payable for loss due to: intentional self-inflicted injury; war or act of war; participation in a riot or violent disorder; bodily or mental infirmity; medical or surgical treatment; poisoning of any form, inhalation of gas or fumes; the act of a felony; operating a motor vehicle under the influence of any intoxicant; travel or flight in any type of aircraft, except solely as a passenger in a licensed civil aircraft for the sole purpose of transportation only.

Dependent children are not eligible for AD&D benefits. The waiver of premium does not apply to AD&D.

Waiver of Premium*

If you become totally disabled prior to age 60, and remain so for six consecutive months, your insurance will remain in force without payment of premiums for a period of time as long as your total disability continues and you provide proof of disability as required.

Living Benefits*

A living (or accelerated) benefit provides terminally ill insureds under age 60 with the option of receiving up to 75% of their life insurance benefit while they are alive. An insured must have been insured at least 12 months and have a life expectancy of 12 months or less.

- The remaining death benefit amount will be reduced to reflect the cost of providing the accelerated death benefit.
- The minimum accelerated death benefit will be \$10,000, less the discount.

*These benefits are available for employees only – they do not apply to spouse and/or child coverage.

SEE MORE INFORMATION ON REVERSE SIDE

The Benefit Alliance Plan

 Leslie & Associates, Inc.

When Insurance Terminates

A sample of when insurance ends:

- Required premium remains unpaid after a due date;
- Upon termination of employment or retirement;
- The employee reaches age 80; spouse reaches age 70;
- Dependent children reach age 19 (25 for full-time students);
- The master group policy ends

Portability or Conversion Feature

If coverage ends due to termination of employment, you can apply to become insured subject to the Portability or Conversion Feature prior to the expiration of the 31 day period immediately following the date your insurance terminated under the group policy. You may choose to convert your coverage to an individual policy without evidence of good health.

This feature is not available if coverage ends because of non-payment of premium.

Exclusion

Benefit claims for deaths due to suicide are excluded for a period of two years from the insured's effective date of coverage. (may vary by state law).

A+ Rated Insurance Company

Your group term life insurance plan is underwritten by Lincoln National Life Insurance Co. A.M. Best Company, a leading independent analyst of insurance companies, has rated Lincoln National A+ (Superior), basing its opinion on the relative financial strengths and performances of insurers.

This is only a summary of the Group Term Voluntary Life Insurance Plan and is subject to the terms, conditions and limitations of the group policy. You may request a copy of the full text benefit information from Leslie & Associates.

GROUP TERM LIFE PLAN SCHEDULE

Employee Plan \$50,000, \$75,000 or \$100,000

Spouse Plan \$25,000 or \$50,000 (not to exceed 50% of Employee Coverage Amount)

NON-SMOKER

| BENEFIT | AGES 18-29 | AGES 30-34 | AGES 35-39 | AGES 40-44 | AGES 45-49 | AGES 50-54 | AGES 55-59 | AGES 60-64 | AGES 65-69 |
|------------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|
| \$25,000 | \$3.25 | \$3.25 | \$4.25 | \$5.50 | \$8.75 | \$13.25 | \$22.50 | \$23.50 | \$40.50 |
| \$50,000 | \$6.50 | \$6.50 | \$8.50 | \$11.00 | \$17.50 | \$26.75 | \$45.00 | \$46.75 | \$81.00 |
| \$75,000 | \$9.75 | \$9.75 | \$12.75 | \$16.50 | \$26.25 | \$40.00 | \$67.25 | \$70.00 | \$121.75 |
| \$100,000 | \$13.00 | \$13.00 | \$17.00 | \$22.00 | \$35.00 | \$53.25 | \$89.75 | \$93.50 | \$162.50 |

SMOKER

| BENEFIT | AGES 18-29 | AGES 30-34 | AGES 35-39 | AGES 40-44 | AGES 45-49 | AGES 50-54 | AGES 55-59 | AGES 60-64 | AGES 65-69 |
|------------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|
| \$25,000 | \$4.50 | \$5.00 | \$6.00 | \$8.75 | \$14.50 | \$23.50 | \$39.00 | \$41.25 | \$71.75 |
| \$50,000 | \$9.00 | \$9.75 | \$12.25 | \$17.50 | \$29.25 | \$46.75 | \$78.00 | \$82.50 | \$143.50 |
| \$75,000 | \$13.75 | \$14.50 | \$18.50 | \$26.25 | \$44.00 | \$70.00 | \$117.00 | \$123.75 | \$215.25 |
| \$100,000 | \$18.00 | \$19.50 | \$24.75 | \$35.00 | \$58.50 | \$93.50 | \$156.00 | \$165.00 | \$287.00 |

DEPENDENT CHILD COVERAGE

| AMOUNT | MONTHLY RATE |
|-----------------|--------------|
| \$5,000 | \$1.25 |
| \$7,500 | \$1.75 |
| \$10,000 | \$2.25 |

Coverage will be reduced by 50% at age 70 and will terminate at age 70 for spouses. All coverage terminates at retirement.

Group Limited Accident & Sickness Plan - Standard Tier 1

Benefits Include Wellness Visits for Adults and Children

Individual, comprehensive major medical health insurance can be expensive and beyond the means of many people. Although there may be alternatives that can provide benefits in the event of a catastrophic illness or accident, it is often the common health care services such as doctor's office visits for wellness, screening tests, sickness or well child care that are not covered.

ACE American Insurance Company offers a Group Limited Accident & Sickness Plan. This plan is a limited benefit insurance program designed to provide benefits for common medical services such as doctor's office visits, minor emergency room treatment for sickness, expenses for minor accidents as well as limited hospital confinement and surgical benefits.

STANDARD TIER 1 PLAN FEATURES

- No Deductibles or Co-Pays - See any doctor!
- Available for eligible Employees and Spouses (ages 18-69) & dependent children under age 19 (or under 25 if full-time student)
- Access to National Provider Network - Reduce your health care costs and maximize benefits
- Supplements and pays regardless of any other insurance program
- Provides benefits for non-occupational injury or sickness and an annual wellness visit
- Pregnancy is covered same as sickness

BENEFITS

UP TO \$200 PER VISIT
(MAXIMUM \$1,000 YEAR)

\$125
(1 VISIT PER YEAR)

\$100 PER VISIT
(3 VISITS PER YEAR)

\$500 PER DAY
(MAXIMUM \$1,000 YEAR)

\$400 PER DAY FOR ACCIDENTS
OR
\$200 PER DAY FOR SICKNESS

\$600 PER DAY

SEE MORE INFORMATION
ON REVERSE SIDE

Doctor's Office Visits

This benefit is payable for treatment, care or advice received in a Doctor's office due to a covered sickness or accident up to the maximum amount shown.

Wellness Benefit

This benefit is payable for an annual routine examination by a physician during the course of one visit. Covered services include a history, physical examination, X-rays and laboratory tests.

Screening Test Benefits

Mammogram – Pays \$120 according to the following age schedule: Age 35-39 - 1 per 5 year period; Age 40-49 - 1 every 2 years; Age 50 and above - 1 per calendar year.

Pap Smear – Pays \$30 per calendar year - 1 test per year.

Prostate Specific Antigens (PSA) Test – Pays \$30 per calendar year - 1 test per year.

Well Child Care (Available with Children or Family Coverage)

Pays for up to 3 visits per year per insured dependent child age 4 or younger.

Hospital Admission Benefit

This benefit is payable for the first 2 days of confinement per calendar year when you are admitted to a hospital as a direct result, from no other causes, of injuries sustained in a covered accident or a covered sickness.

Daily Hospital Confinement Benefit

This benefit will be paid when you are admitted to a hospital as a direct result, from no other causes, of injuries sustained in a covered accident or a covered sickness. Benefits begin the first day of confinement and continue for a period up to 30 days per calendar year. Confinement must begin within 7 days of a covered accident or sickness and last at least 24 consecutive hours.

Intensive Care Benefit

This additional daily benefit will be paid if you are confined in a hospital intensive care unit due to an injury in a covered accident or a covered sickness. This benefit begins the first day of confinement and lasts up to 30 days per confinement. This benefit is paid in addition to the Daily Hospital Confinement Benefit.

The Benefit Alliance Plan

 Leslie & Associates, Inc.

\$250
(1 VISIT PER YEAR)

\$500
PER ACCIDENT
(MAXIMUM 2 PER YEAR)

\$2,000
(INPATIENT)

\$1,000
(OUTPATIENT)

Emergency Room Benefit (Sickness Only)

This benefit is payable if a covered person requires Hospital emergency room treatment or services caused by a covered sickness. Covered expenses include the attending physician's charges, X-rays, laboratory procedures, use of the emergency room and supplies.

Emergency Accidents

This benefit is payable for usual and customary charges for medically necessary covered expenses incurred within 90 days after the date of a covered accident if the initial emergency medical treatment is rendered within 72 hours of the covered accident.

Surgical Benefits

Inpatient – Pays the entire amount shown if a covered person undergoes Surgery in a hospital as a result of a covered injury or sickness. Limited to one surgery per calendar year.

Outpatient – Pays the entire amount shown if a covered person undergoes Surgery in an ambulatory surgical center. Limited to one surgery per calendar year.

Limitations and Exclusions

No Benefits will be paid for any loss or injury that is caused by, or results from:

1. Pre-existing Conditions occurring within the first 6 months of coverage.
2. Intentionally self-inflicted injury; suicide or attempted suicide.
3. War or any act of war, whether declared or not.
4. Experimental or Investigational drugs, services, supplies or procedures.
5. Mental and Nervous Disorders (except as provided in the policy).
6. Elective Abortion.
7. Medical mishap or negligence, including malpractice.
8. Service in the military, naval or air service of any country or international organization.
9. Illegal Acts - Commission of, or attempt to commit, a felony. Commission of or active participation in a riot, or insurrection. Assault & battery committed by any covered person.
10. Intoxication – Alcoholism or being legally intoxicated; drug addiction or being under the influence of any narcotic, unless such is taken under the direction of a Doctor.
11. Traveling more than 40 miles outside the territorial limits of the United States, Canada, Mexico, Puerto Rico, the Bahamas, Virgin Islands, and Jamaica.
12. Covered medical expenses for which the covered person would not be responsible for in the absence of this Policy.
13. Hazardous Activities - Parachuting, skydiving, parasailing, hang-gliding, bungee-cord jumping, travel in or on any on-road or off-road motorized vehicle not requiring licensing as a motor vehicle.
14. Repair or replacement of existing dentures, partial dentures, braces, fixed or removable bridges, or other artificial dental restoration.
15. Repair, replacement, examinations for prescriptions or the fitting of eyeglasses or contact lenses.
16. Travel in an Aircraft owned, leased or controlled by the Policyholder, or any of its subsidiaries or affiliates.
17. Piloting or serving as a crew member or riding in any aircraft except as a fare-paying passenger on a regularly scheduled or chartered airline.
18. Flight in, boarding or alighting from an Aircraft except as a fare-paying passenger on a regularly scheduled commercial airline.
19. An accident if the covered person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license, except while participating in Driver's Education Program.
20. Medical expenses paid or payable under any mandatory no fault automobile insurance contract or mandatory basic reparations benefit of no fault.
21. Medical expenses and disability for which the Covered Person is entitled to benefits under any Worker's Compensation Act.
22. Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including complications.
23. Sexual reassignment surgery, Sexual transformation surgery, Sexual transgendering surgery.
24. Services related to sterilization, reversal of a vasectomy or tubal ligation. In vitro fertilization and any expenses incurred for diagnostic treatment of infertility or other problems related to the inability to conceive a child, unless such infertility is a result of a covered injury or sickness..
25. Cosmetic surgery, except for reconstructive surgery needed as the result of an injury or sickness.

This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit the insurance company from providing insurance, including, but not limited to, the payment of claims.

Pre-existing Condition Limitation

No benefits will be paid for Pre-existing Conditions for the first 6 months following a Covered Person's effective date of coverage under this Policy. A Pre-existing Condition is any illness, disease or other condition, that in the 6 month period before the Covered Person's coverage became effective under this policy (1) first manifested itself, worsened, became acute or exhibited symptoms that would have caused a person to seek diagnosis, care or treatment; or (2) required taking prescribed drugs or medicines, unless the condition for which the prescribed drug or medicine is taken remains controlled without any change in the required prescription; or (3) was treated by a Doctor or treatment had been recommended by a Doctor.

This limitation does not apply to pregnancy and coverage provided to newborn and adopted children. Genetic information shall not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to the genetic information.

Credit for Prior Coverage

A Covered Person whose coverage under prior Creditable Coverage ended not more than 63 days before his or her Effective Date of coverage under this policy will have any applicable Pre-existing Condition Limitation reduced by the total number of days the Covered Person was covered by such coverage. If there was a break in Creditable Coverage of more than 63 days, the insurance company will only credit the days of such coverage after the break. The Covered Person must provide proof of prior Creditable Coverage.

This is only a summary of the ACE American Insurance Company Limited Accident & Sickness Plan. All benefits are subject to the terms, conditions, state mandated benefits, exclusions & limitations of the master group policies. You may request a copy of the full text benefit information including definitions, limitations and exclusions from Leslie & Associates, Inc.

This Plan is not Comprehensive Major Medical Coverage or designed as a substitute for Comprehensive Major Medical Coverage

MONTHLY PREMIUMS - TIER 1

| | |
|--------------------------------|------------------|
| Employee Only | \$ 82.00 |
| Employee & Spouse | \$ 169.00 |
| Employee & Children | \$ 143.00 |
| Family | \$ 232.00 |

Group Limited Accident & Sickness Plan - Standard Tier 2

Benefits Include Wellness Visits for Adults and Children

Individual, comprehensive major medical health insurance can be expensive and beyond the means of many people. Although there may be alternatives that can provide benefits in the event of a catastrophic illness or accident, it is often the common health care services such as doctor's office visits for wellness, screening tests, sickness or well child care that are not covered.

ACE American Insurance Company offers a Group Limited Accident & Sickness Plan. This plan is a limited benefit insurance program designed to provide benefits for common medical services such as doctor's office visits, minor emergency room treatment for sickness, expenses for minor accidents as well as limited hospital confinement and surgical benefits.

STANDARD TIER 2 PLAN FEATURES

- No Deductibles or Co-Pays - See any doctor!
- Higher Benefit Levels than Standard Tier 1
- Available for eligible Employees and Spouses (ages 18-69) & dependent children under age 19 (or under 25 if full-time student)
- Access to National Provider Network - Reduce your health care costs and maximize benefits
- Supplements and pays regardless of any other insurance program
- Provides benefits for non-occupational injury or sickness and an annual wellness visit
- Pregnancy is covered same as sickness

BENEFITS

UP TO \$200 PER VISIT
(MAXIMUM \$1,400 YEAR)

\$125
(1 VISIT PER YEAR)

\$100 PER VISIT
(3 VISITS PER YEAR)

\$500 PER DAY
(MAXIMUM \$1,000 YEAR)

\$800 PER DAY FOR ACCIDENTS
OR
\$500 PER DAY FOR SICKNESS

\$800 PER DAY

SEE MORE INFORMATION
ON REVERSE SIDE

Doctor's Office Visits

This benefit is payable for treatment, care or advice received in a Doctor's office due to a covered sickness or accident up to the maximum amount shown.

Wellness Benefit

This benefit is payable for an annual routine examination by a physician during the course of one visit. Covered services include a history, physical examination, X-rays and laboratory tests.

Screening Test Benefits

Mammogram – Pays \$120 according to the following age schedule: Age 35-39 - 1 per 5 year period; Age 40-49 - 1 every 2 years; Age 50 and above - 1 per calendar year.

Pap Smear – Pays \$30 per calendar year - 1 test per year.

Prostate Specific Antigens (PSA) Test – Pays \$30 per calendar year - 1 test per year.

Well Child Care (Available with Children or Family Coverage)

Pays for up to 3 visits per year per insured dependent child age 4 or younger.

Hospital Admission Benefit

This benefit is payable for the first 2 days of confinement per calendar year when you are admitted to a hospital as a direct result, from no other causes, of injuries sustained in a covered accident or a covered sickness.

Daily Hospital Confinement Benefit

This benefit will be paid when you are admitted to a hospital as a direct result, from no other causes, of injuries sustained in a covered accident or a covered sickness. Benefits begin the first day of confinement and continue for a period up to 30 days per calendar year. Confinement must begin within 7 days of a covered accident or sickness and last at least 24 consecutive hours.

Intensive Care Benefit

This additional daily benefit will be paid if you are confined in a hospital intensive care unit due to an injury in a covered accident or a covered sickness. This benefit begins the first day of confinement and lasts up to 30 days per confinement. This benefit is paid in addition to the Daily Hospital Confinement Benefit.

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\$250
(1 VISIT PER YEAR)

\$750
PER ACCIDENT
(MAXIMUM 2 PER YEAR)

\$2,000
(INPATIENT)

\$1,000
(OUTPATIENT)

Emergency Room Benefit (Sickness Only)

This benefit is payable if a covered person requires Hospital emergency room treatment or services caused by a covered sickness. Covered expenses include the attending physician's charges, X-rays, laboratory procedures, use of the emergency room and supplies.

Emergency Accidents

This benefit is payable for usual and customary charges for medically necessary covered expenses incurred within 90 days after the date of a covered accident if the initial emergency medical treatment is rendered within 72 hours of the covered accident.

Surgical Benefits

Inpatient – Pays the entire amount shown if a covered person undergoes Surgery in a hospital as a result of a covered injury or sickness. Limited to one surgery per calendar year.

Outpatient – Pays the entire amount shown if a covered person undergoes Surgery in an ambulatory surgical center. Limited to one surgery per calendar year.

No Benefits will be paid for any loss or injury that is caused by, or results from:

1. Pre-existing Conditions occurring within the first 6 months of coverage.
2. Intentionally self-inflicted injury; suicide or attempted suicide.
3. War or any act of war, whether declared or not.
4. Experimental or Investigational drugs, services, supplies or procedures.
5. Mental and Nervous Disorders (except as provided in the policy).
6. Elective Abortion.
7. Medical mishap or negligence, including malpractice.
8. Service in the military, naval or air service of any country or international organization.
9. Illegal Acts - Commission of, or attempt to commit, a felony. Commission of or active participation in a riot, or insurrection. Assault & battery committed by any covered person.
10. Intoxication – Alcoholism or being legally intoxicated; drug addiction or being under the influence of any narcotic, unless such is taken under the direction of a Doctor.
11. Traveling more than 40 miles outside the territorial limits of the United States, Canada, Mexico, Puerto Rico, the Bahamas, Virgin Islands, and Jamaica.
12. Covered medical expenses for which the covered person would not be responsible for in the absence of this Policy.
13. Hazardous Activities - Parachuting, skydiving, parasailing, hang-gliding, bungee-cord jumping, travel in or on any on-road or off-road motorized vehicle not requiring licensing as a motor vehicle.
14. Repair or replacement of existing dentures, partial dentures, braces, fixed or removable bridges, or other artificial dental restoration.
15. Repair, replacement, examinations for prescriptions or the fitting of eyeglasses or contact lenses.
16. Travel in an Aircraft owned, leased or controlled by the Policyholder, or any of its subsidiaries or affiliates.
17. Piloting or serving as a crew member or riding in any aircraft except as a fare-paying passenger on a regularly scheduled or chartered airline.
18. Flight in, boarding or alighting from an Aircraft except as a fare-paying passenger on a regularly scheduled commercial airline.
19. An accident if the covered person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license, except while participating in Driver's Education Program.
20. Medical expenses paid or payable under any mandatory no fault automobile insurance contract or mandatory basic reparations benefit of no fault.
21. Medical expenses and disability for which the Covered Person is entitled to benefits under any Worker's Compensation Act.
22. Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including complications.
23. Sexual reassignment surgery, Sexual transformation surgery, Sexual transgendering surgery.
24. Services related to sterilization, reversal of a vasectomy or tubal ligation. In vitro fertilization and any expenses incurred for diagnostic treatment of infertility or other problems related to the inability to conceive a child, unless such infertility is a result of a covered injury or sickness..
25. Cosmetic surgery, except for reconstructive surgery needed as the result of an injury or sickness.

MONTHLY PREMIUMS - TIER 2

| | |
|--------------------------------|------------------|
| Employee Only | \$ 103.00 |
| Employee & Spouse | \$ 196.00 |
| Employee & Children | \$ 165.00 |
| Family | \$ 257.00 |

This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit the insurance company from providing insurance, including, but not limited to, the payment of claims.

Pre-existing Condition Limitation

No benefits will be paid for Pre-existing Conditions for the first 6 months following a Covered Person's effective date of coverage under this Policy. A Pre-existing Condition is any illness, disease or other condition, that in the 6 month period before the Covered Person's coverage became effective under this policy (1) first manifested itself, worsened, became acute or exhibited symptoms that would have caused a person to seek diagnosis, care or treatment; or (2) required taking prescribed drugs or medicines, unless the condition for which the prescribed drug or medicine is taken remains controlled without any change in the required prescription; or (3) was treated by a Doctor or treatment had been recommended by a Doctor.

This limitation does not apply to pregnancy and coverage provided to newborn and adopted children. Genetic information shall not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to the genetic information.

Credit for Prior Coverage

A Covered Person whose coverage under prior Creditable Coverage ended not more than 63 days before his or her Effective Date of coverage under this policy will have any applicable Pre-existing Condition Limitation reduced by the total number of days the Covered Person was covered by such coverage. If there was a break in Creditable Coverage of more than 63 days, the insurance company will only credit the days of such coverage after the break. The Covered Person must provide proof of prior Creditable Coverage.

This is only a summary of the ACE American Insurance Company Limited Accident & Sickness Plan. All benefits are subject to the terms, conditions, state mandated benefits, exclusions & limitations of the master group policies. You may request a copy of the full text benefit information including definitions, limitations and exclusions from Leslie & Associates, Inc.

This Plan is not Comprehensive Major Medical Coverage or designed as a substitute for Comprehensive Major Medical Coverage

Group Limited Accident & Sickness Plan - ENHANCED TIER 3

The Enhanced Tier 3 Group Limited Accident & Sickness Plan, underwritten by ACE American Insurance Company, is designed to provide affordable, guaranteed coverage for everyday medical expenses that can really add up during the year – doctor’s office visits for illnesses or physical exams, diagnostic lab and X-Rays, emergency room treatment for minor accidents. It also provides limited coverage for hospital & surgical expenses.

ENHANCED TIER 3 PLAN FEATURES

- Co-Pay for Physician Office Visits & Routine Physicals
- MultiPlan PPO Network makes coverage go further
- No Deductibles!
- Co-Pay Plan for Outpatient Prescription Drugs
- Limited Hospital & Surgical Benefits

Who Can Be Covered In the ENHANCED TIER 3 Plan?

Employees & Spouses (ages 18-69) and dependent children under age 19 (or under age 25 if a full-time student).

DEDUCTIBLES

There are NO deductibles in the ENHANCED TIER 3 Plan.

OFFICE VISIT CO-PAYS

In or Out-of-Network – you pay \$20 for each outpatient Doctor office visit and the Plan pays 100% of eligible expenses* up to \$2,000 per calendar year per covered family member.

Outpatient Eligible Expense & Screening Benefits

Doctor or Specialist Office Visit* for Illness or Injury
 Annual Wellness Visit - Adult
 Wellness Visits - Covered Children age 4 and under
 Screenings
 Mammogram
 Pap Smear
 Prostate Specific Antigens (PSA) Test
 Outpatient Diagnostic X-Ray and Labs for Sickness or Injury
 Outpatient Surgery Benefit

*All eligible office visit expenses are subject to usual and customary limits.

\$20 Co-Pay then 100% up to \$2,000 per Calendar Year
 \$150 per visit - 1 visit per Calendar Year
 \$100 per visit - 3 visits per Calendar Year
 \$120 - frequency according to age schedule
 \$30 - once per Calendar Year
 \$30 - once per Calendar Year
 \$80 per visit - 6 visits per Calendar Year
 \$1,000 per surgery - 1 surgery per Calendar Year

Emergency Room Visits or Accident Expenses

Emergency Room Visit for Sickness Only
 Accident Medical Expenses

\$350 per visit - 2 visits per Calendar Year
 \$1,000 per accident - 2 accidents per Calendar Year

Inpatient Eligible Hospital Expense Benefits

Hospital Admission Benefit
 Daily Hospital Confinement Benefit (Sickness or Accident)
 Intensive Care Benefit
 Inpatient Surgery Benefit

\$750 per day for first 2 days confined per Calendar Year
 \$750 per day, up to 30 days per Calendar Year
 Additional \$800 per day, up to 30 days per Calendar Year
 \$2,000 per surgery - 1 surgery per Calendar Year

Outpatient Prescription Drugs

The Plan includes a separate Co-pay plan for outpatient prescription drugs purchased at participating pharmacies. The plan, administered by Restat, utilizes a generic formulary with a preferred drug list. The formulary is a list of all products available at one co-pay level or another. You can visit www.restat.com to search for participating pharmacies. The current formulary list is available from the Leslie & Associates customer service department or website link. Please refer to the Certificate of Insurance for a complete list of exclusions and limitations.

| | Co-Pays |
|----------------------------|----------|
| Generic Formulary Drugs | \$10.00 |
| Generic Oral Contraceptive | \$15.00 |
| Brand Name Formulary Drug | \$50.00* |

* or 50% of the discounted cost of the prescription - whichever is greater

The retail dispensing limit is a 30 day supply
 Annual Maximum Rx Benefit - \$1,000 per insured

MONTHLY PREMIUMS

| | |
|-----------------------|-----------|
| Employee Only | \$ 154.00 |
| Employee & Spouse | \$ 319.00 |
| Employee & Child(ren) | \$ 257.00 |
| Employee & Family | \$ 428.00 |

Premiums include Insurance, Prescription Drug and Network Access Charges

SEE MORE INFORMATION ON REVERSE SIDE

The Benefit Alliance Plan



What Is A Usual And Customary Charge?

A “usual and customary charge” is the average amount most providers charge for medical services, medicines and supplies within a specific geographic area.

Is there a Pre-existing Condition Limitation?

YES. No benefits will be paid for Pre-existing Conditions for the first 6 months following a Covered Person’s effective date of coverage under this Policy. A Pre-existing Condition is any illness, disease or other condition, that in the 6 month period before the Covered Person’s coverage became effective under this policy (1) first manifested itself, worsened, became acute or exhibited symptoms that would have caused a person to seek diagnosis, care or treatment; or (2) required taking prescribed drugs or medicines, unless the condition for which the prescribed drug or medicine is taken remains controlled without any change in the required prescription; or (3) was treated by a Doctor or treatment had been recommended by a Doctor.

This limitation does not apply to pregnancy and coverage provided to newborn and adopted children. Genetic information shall not be treated as a Pre-existing Condition in the absence of a diagnosis of the condition related to the genetic information.

CREDIT FOR PRIOR COVERAGE

A Covered Person whose coverage under prior Creditable Coverage ended not more than 63 days before his or her Effective Date of coverage under this policy will have any applicable Pre-existing Condition Limitation reduced by the total number of days the Covered Person was covered by such coverage. If there was a break in Creditable Coverage of more than 63 days, the insurance company will only credit the days of such coverage after the break. The Covered Person must provide proof of prior Creditable Coverage.

EXCLUSIONS AND LIMITATIONS - No benefits will be paid for any loss, injury or sickness that is caused by, or results from:

1. Pre-existing conditions occurring within the first 6 months of coverage.
2. Intentionally self-inflicted injury, suicide or attempted suicide.
3. War or any act of war, whether declared or not.
4. Service in the military, naval or air service of any country or international organization.
5. Piloting or serving as a crew member or riding in any aircraft except as a fare-paying passenger on a regularly scheduled or charter airline.
6. Commission of, or attempt to commit, a felony, an assault or other illegal activity.
7. Commission of or active participation in a riot or insurrection.
8. Bungee cord jumping, parachuting, skydiving, parasailing, hang-gliding.
9. Flight in, boarding or alighting from any aircraft except as a fare-paying passenger on a regularly scheduled commercial airline.
10. Travel in or on any on-road and off-road motorized vehicle not requiring licensing as a motor vehicle.
11. An accident if the covered person is the operator of a motor vehicle and does not possess a valid motor vehicle operators license, except while participating in Driver’s Education Program.
12. Medical mishap or negligence, including malpractice.
13. Traveling more than 40 miles outside the territorial limits of the United States, Canada, Mexico, Puerto Rico, the Bahamas, Virgin Islands, Bermuda, and Jamaica.
14. Travel in an Aircraft owned, leased or controlled by the Policyholder, or any of its subsidiaries or affiliates. An Aircraft will be deemed to be “controlled” by the Policyholder if the Aircraft may be used by the Policyholder wishes for more than 10 straight days or more than 15 days in any year.
15. While the covered person is legally intoxicated as determined according to the laws of the jurisdiction in which the injury occurs.
16. Alcoholism, drug addiction or the use of any drug or narcotic except as prescribed by a Doctor unless specifically provided herein.
17. Repair or replacement of existing dentures, partial dentures, braces, fixed or removable bridges, or other artificial dental restoration.
18. Repair, replacement, examinations for prescriptions or the fitting of eyeglasses or contact lenses.
19. Medical expenses and disability for which the covered person is entitled to benefits under Worker’s Compensation Act.
20. Medical expenses paid or payable under any mandatory no fault automobile insurance contract or mandatory basic reparations benefit of no fault.
21. Assault and battery committed by any covered person.
22. Elective Abortion. Elective Abortion means an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed.
23. Mental and Nervous Disorders (except as provided in the Policy).
24. Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including complications.
25. Sexual reassignment surgery, Sexual transformation surgery, Sexual transgendering surgery.
26. Services related to sterilization, reversal of a vasectomy or tubal ligation. In vitro fertilization and any expenses incurred for diagnostic treatment of infertility or other problems related to the inability to conceive a child, unless such infertility is a result of a covered injury or sickness.
27. Covered medical expenses for which the covered person would not be responsible for in the absence of this Policy.
28. Cosmetic surgery, except for reconstructive surgery needed as the result of an injury or sickness.
29. Experimental or Investigational drugs, services, supplies or any procedures held to be experimental or investigatory by the insurance company at the time the procedure is done.

This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit the insurance company from providing insurance, including, but not limited to, the payment of claims.

This is only a summary of the ACE American Limited Accident and Sickness Insurance Plan & Restat Prescription Drug Plan; all benefits are subject to the terms, conditions, state mandated benefits, exclusions & limitations of the master group policies. You may request a copy of the full text benefit information including definitions, limitations and exclusions from Leslie & Associates, Inc.

This Plan is not Comprehensive Major Medical Coverage or designed as substitute for Comprehensive Major Medical Coverage

Group Limited Accident & Sickness Plan - ENHANCED TIER 4

The Enhanced Tier 4 Group Limited Accident & Sickness Plan, underwritten by ACE American Insurance Company, is designed to provide more coverage than other limited benefit plan choices. It provides affordable, guaranteed coverage designed to cover expenses such as doctor's office visits for illness or wellness exams including lab tests and X-Rays. It also provides higher levels of limited coverage for hospital & surgical expenses.

ENHANCED TIER 4 PLAN FEATURES

- Co-Pay for Physician Office Visits & Routine Physicals
- MultiPlan PPO Network makes coverage go further
- No Deductibles!
- Includes Co-Pay Plan for Outpatient Prescription Drugs
- Higher Levels of Limited Hospital & Surgical Benefits

Who Can Be Covered In the ENHANCED TIER 4 Plan?

Employees & Spouses (ages 18-69) and dependent children under age 19 (or under age 25 if a full-time student).

DEDUCTIBLES

There are NO deductibles in the ENHANCED TIER 4 Plan.

OFFICE VISIT CO-PAYS

In or Out-of-Network – you pay \$20 for each outpatient Doctor office visit and the Plan pays 100% of eligible expenses* up to \$2,400 per Calendar Year per covered family member.

Outpatient Eligible Expense & Screening Benefits

Doctor or Specialist Office Visit* for Illness or Injury
 Annual Wellness Visit - Adult
 Wellness Visits - Covered Children age 4 and under
 Screenings
 Mammogram
 Pap Smear
 Prostate Specific Antigens (PSA) Test
 Outpatient Diagnostic X-Ray and Labs for Sickness or Injury
 Outpatient Surgery Benefit
 Outpatient Physical Therapy

\$20 Co-Pay then 100% up to \$2,400 per Calendar Year
 \$150 per visit - 1 visit per Calendar Year
 \$100 per visit - 3 visits per Calendar Year
 \$120 - frequency according to age schedule
 \$30 - once per Calendar Year
 \$30 - once per Calendar Year
 \$100 per visit - 6 visits per Calendar Year
 \$2,000 per surgery - 1 surgery per Calendar Year
 \$50 per visit; 10 visits per Calendar Year after hospitalization

* All eligible office visit expenses are subject to usual and customary limits.

Emergency Room Visits or Accident Expenses

Emergency Room Visit for Sickness Only
 Accident Medical Expenses

\$500 per visit - 2 visits per Calendar Year
 \$1,000 per accident - 2 accidents per Calendar Year

Inpatient Eligible Hospital Expense Benefits

Hospital Admission Benefit
 Daily Hospital Confinement Benefit (Sickness or Accident)
 Intensive Care Benefit
 Inpatient Surgery Benefit

\$1,000 per day for first 2 days confined per Calendar Year
 \$2,000 per day, up to 30 days per Calendar Year
 Additional \$2,000 per day, up to 30 days per Calendar Year
 \$3,000 per surgery - 1 surgery per Calendar Year

Outpatient Prescription Drugs

The Plan includes a separate Co-pay plan for outpatient prescription drugs purchased at participating pharmacies. The plan, administered by Restat, utilizes a generic formulary with a preferred drug list. The formulary is a list of all products available at one co-pay level or another. You can visit www.restat.com to search for participating pharmacies. The current formulary list is available from the Leslie & Associates customer service department or website link. Please refer to the Certificate of Insurance for a complete list of exclusions and limitations.

| | Co-Pays |
|----------------------------|-----------|
| Generic Formulary Drugs | \$10.00 |
| Generic Oral Contraceptive | \$15.00 |
| Brand Name Formulary Drug | \$50.00 * |

* or 50% of the discounted cost of the prescription - whichever is greater

(The retail dispensing limit is a 30 day supply)
 Annual Maximum Rx Benefit - \$1,000 per insured

MONTHLY PREMIUMS

| | |
|-----------------------|-----------|
| Employee Only | \$ 280.00 |
| Employee & Spouse | \$ 586.00 |
| Employee & Child(ren) | \$ 471.00 |
| Employee & Family | \$ 787.00 |

Premiums include Insurance, Prescription Drug and Network Access Charges

SEE MORE INFORMATION ON REVERSE SIDE

The Benefit Alliance Plan



What Is A Usual And Customary Charge?

A "usual and customary charge" is the average amount most providers charge for medical services, medicines and supplies within a specific geographic area.

Is there a Pre-existing Condition Limitation?

YES. No benefits will be paid for Pre-Existing conditions for the first 6 months following a Covered Person's effective date of coverage under this Policy. A Pre-existing Condition is any illness, disease or other condition, that in the 6 month period before the Covered Person's coverage became effective under this policy (1) first manifested itself, worsened, became acute or exhibited symptoms that would have caused a person to seek diagnosis, care or treatment; or (2) required taking prescribed drugs or medicines, unless the condition for which the prescribed drug or medicine is taken remains controlled without any change in the required prescription; or (3) was treated by a Doctor or treatment had been recommended by a Doctor.

This limitation does not apply to pregnancy and coverage provided to newborn and adopted children. Genetic information shall not be treated as a Pre-existing Condition in the absence of a diagnosis of the condition related to the genetic information.

CREDIT FOR PRIOR COVERAGE

A Covered Person whose coverage under prior Creditable Coverage ended not more than 63 days before his or her Effective Date of coverage under this policy will have any applicable Pre-existing Condition Limitation reduced by the total number of days the Covered Person was covered by such coverage. If there was a break in Creditable Coverage of more than 63 days, the insurance company will only credit the days of such coverage after the break. The Covered Person must provide proof of prior Creditable Coverage.

EXCLUSIONS AND LIMITATIONS - No benefits will be paid for any loss, injury or sickness that is caused by, or results from:

1. Pre-existing conditions occurring within the first 6 months of coverage.
2. Intentionally self-inflicted injury, suicide or attempted suicide.
3. War or any act of war, whether declared or not.
4. Service in the military, naval or air service of any country or international organization.
5. Piloting or serving as a crew member or riding in any aircraft except as a fare-paying passenger on a regularly scheduled or charter airline.
6. Commission of, or attempt to commit, a felony, an assault or other illegal activity.
7. Commission of or active participation in a riot or insurrection.
8. Bungee cord jumping, parachuting, skydiving, parasailing, hang-gliding.
9. Flight in, boarding or alighting from any aircraft except as a fare-paying passenger on a regularly scheduled commercial airline.
10. Travel in or on any on-road and off-road motorized vehicle not requiring licensing as a motor vehicle.
11. An accident if the covered person is the operator of a motor vehicle and does not possess a valid motor vehicle operators license, except while participating in Driver's Education Program.
12. Medical mishap or negligence, including malpractice.
13. Traveling more than 40 miles outside the territorial limits of the United States, Canada, Mexico, Puerto Rico, the Bahamas, Virgin Islands, Bermuda, and Jamaica.
14. Travel in an Aircraft owned, leased or controlled by the Policyholder, or any of its subsidiaries or affiliates. An Aircraft will be deemed to be "controlled" by the Policyholder if the Aircraft may be used by the Policyholder wishes for more than 10 straight days or more than 15 days in any year.
15. While the covered person is legally intoxicated as determined according to the laws of the jurisdiction in which the injury occurs.
16. Alcoholism, drug addiction or the use of any drug or narcotic except as prescribed by a Doctor unless specifically provided herein.
17. Repair or replacement of existing dentures, partial dentures, braces, fixed or removable bridges, or other artificial dental restoration.
18. Repair, replacement, examinations for prescriptions or the fitting of eyeglasses or contact lenses.
19. Medical expenses and disability for which the covered person is entitled to benefits under Worker's Compensation Act.
20. Medical expenses paid or payable under any mandatory no fault automobile insurance contract or mandatory basic reparations benefit of no fault.
21. Assault and battery committed by any covered person.
22. Elective Abortion. Elective Abortion means an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed.
23. Mental and Nervous Disorders (except as provided in the Policy).
24. Covered medical expenses for which the covered person would not be responsible for in the absence of this Policy.
25. Cosmetic surgery, except for reconstructive surgery needed as the result of an injury or sickness.
26. Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including complications.
27. Sexual reassignment surgery, Sexual transformation surgery, Sexual transgendering surgery.
28. Services related to sterilization, reversal of a vasectomy or tubal ligation. In vitro fertilization and any expenses incurred for diagnostic treatment of infertility or other problems related to the inability to conceive a child, unless such infertility is a result of a covered injury or sickness.
29. Experimental or Investigational drugs, services, supplies or any procedures held to be experimental or investigatory by the insurance company at the time the procedure is done.

This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit the insurance company from providing insurance, including, but not limited to, the payment of claims.

This is only a summary of the ACE American Limited Accident and Sickness Insurance Plan & Restat Prescription Drug Plan; all benefits are subject to the terms, conditions, state mandated benefits, exclusions & limitations of the master group policies. You may request a copy of the full text benefit information including definitions, limitations and exclusions from Leslie & Associates, Inc.

This Plan is not Comprehensive Major Medical Coverage or designed as substitute for Comprehensive Major Medical Coverage

Group Dental Plan

AREA RATING 2 – AZ, CO, CT, DE, FL, GA, HI, IL, MA, MD, NH, OR, PA, RI, TX, UT, VT

We understand that today's employees demand choice. That's why we offer a voluntary dental program that allows you to choose between a basic and deluxe plan. The High-Low Choice provides you with the freedom to choose a dental plan that best fits your individual needs. Compare the cost and benefits of each plan, then determine which plan will work best for you and your family.

BOTH PLANS FEATURE

- Freedom of choice of dentists, including specialists
- Nationwide coverage
- Benefits are underwritten by Lincoln National Life Insurance Company
- Fast and accurate claims service

The Choice is Yours

Plan 1 (Low) provides coverage for the most common dental procedures. Plan 2 (High) also offers valuable protection, and provides increased benefits over Plan 1.

Your plan pays the indicated percentages of Allowable Charges for covered services that are listed here and described in your Group Certificate. Benefits are paid after any applicable deductible has been met, up to the Annual Maximum. Allowable Charges are based on the usual and customary charges being made by providers in the area where the dental services are performed.

Eligibility

Employees working an average of 24 hours per week, spouse and unmarried dependent children under age 19 (age 19 through 24 if full-time student).

DENTAL PLAN 1 (Low) Services

| | | | |
|------------------------------------------------------------------------------|---------------|----------------|----------------|
| Benefit Maximum, Per Person, Per Calendar Year | | | \$1,000 |
| Insured Percentage Allowable Charge Per Person, Per Calendar Year | Type I | Type II | |
| During 1st Year | 80% | *50% | |
| During 2nd Year & thereafter | 100% | 80% | |
| Deductible, Per Person, Per Calendar Year | | | \$50 |
| Family Deductible | | | \$150 |

*Initial benefits subject to 2 month waiting period after the effective date

DENTAL PLAN 2 (High) Services

| | | | | |
|------------------------------------------------------------------------------|---------------|----------------|-----------------|----------------|
| Benefit Maximum, Per Person, Per Calendar Year | | | | \$1,000 |
| Insured Percentage Allowable Charge Per Person, Per Calendar Year | Type I | Type II | Type III | |
| During 1st Year | 80% | *50% | *10% | |
| During 2nd Year | 100% | 80% | 25% | |
| During 3rd Year & thereafter | 100% | 80% | 50% | |
| Deductible, Per Person, Per Calendar Year | | | | \$50 |
| Family Deductible | | | | \$150 |

*Initial benefits subject to 2 month waiting period after the effective date

MONTHLY RATES

| | |
|--------------------------------|----------------|
| Employee Only | \$31.93 |
| Employee & Spouse | \$53.77 |
| Employee & Children | \$67.04 |
| Employee & Family | \$93.42 |

MONTHLY RATES

| | |
|--------------------------------|-----------------|
| Employee Only | \$49.05 |
| Employee & Spouse | \$96.57 |
| Employee & Children | \$99.51 |
| Employee & Family | \$147.01 |

See reverse side for dental service types, limitations and exclusions

DENTAL PLAN 1 (Low) Services

Type I Diagnostic & Preventative Dental Services, including:

- Routine Oral Examinations – up to 2 per Calendar Year
- Prophylaxis (routine cleanings) – up to 2 per Calendar Year
- Fluoride Treatment – one treatment per Calendar Year
Only for insured dependent children through age 15
- Space Maintainers – *Only for children through age 15*
(includes adjustments within 6 months of installation)
- X-Rays:
 - Bitewing films – up to 4 per Calendar Year
 - Panoramic or Full Mouth X-Rays – one complete full mouth series or panoramic film in any 5 consecutive years.
 - Other Dental X-Rays (needed to diagnose a specific dental condition) – Maximum of 6 per Calendar Year.

Type II Basic Dental Services, including:

- Sealants – once per permanent molar in any 3 Calendar Years
Only for insured dependent children through age 17
- Fillings
 - Benefits for composite fillings of posterior (back) teeth limited to amount payable for an equivalent amalgam filling.
 - Multiple restorations on one surface will be treated as a single filling
 - Replacement fillings for a tooth or tooth surface which was filled within the last 12 months are not covered
- Pin retention – included in addition to restoration
- Prefabricated stainless steel or resin crowns - one per tooth in any 5 consecutive years. *Only for insured dependent children through age 15*
- Emergency exams; treatment; injections of antibiotics
- Pathology – biopsy and examination of oral tissue
- Oral Surgery (*see policy for complete list of procedures*)
 - Simple extractions & Surgical removal of erupted teeth
 - Removal of impacted tooth (soft tissue or bony)
- Reimplantation of tooth or tooth bud due to accident
- Incision & drainage of abscess
- General Anesthesia or I.V. Sedation - in connection with a Necessary complex oral surgery or when medical condition or health factors render anesthesia a medical necessity
- Repair or recementation of inlays, crowns and bridges; Repair of partial dentures.
- Endodontics – including root canal therapy; pulpotomy; root amputation, hemisection; apexification; apicoectomy

Exclusions

General Exclusions

The plan does not cover services started before the coverage begins or after it ends. Services must be necessary and appropriate for the claimant's condition. Benefits are limited to services specifically shown on the List of Procedures, included in the policy, unless coverage for additional services is required by state law. Benefits are not payable for duplication of services or for treatment by a practitioner who lives with or is related to the employee.

Benefits are not payable for the initial placement of a prosthetic appliance or fixed bridge unless it is replacing teeth extracted or accidentally lost while covered. The policy does not cover the cost of implants, cosmetic procedures, athletic mouth guards, orthodontics, appliances to correct harmful habits or the replacement cost of lost or stolen dental appliances. The policy excludes the treatment of TMJ or congenital malformities, except as required by state law.

Benefits are not payable for services provided by an ambulatory surgical facility, hospital, any other facility; an anesthesiologist; for medications administered outside the dentist's office; for prescription drugs; or for analgesia, sedation, hypnosis or acupuncture administered for the purpose of alleviating anxiety or apprehension.

Plan benefits are not payable for a condition for which the claimant is eligible for benefits under Worker's Compensation or a similar law; or for a condition that is attributed to employment or military service. Coverage is not available for dental conditions caused by an act of war, self-inflicted injury, involvement in an illegal occupation, attempt to commit a felony, or active participation in a riot.

Benefit Adjustments

Benefits will be coordinated with any other dental coverage. Under the Optional Services provision, benefits will be payable for the most economical services or supplies meeting broadly accepted standards of dental care. If the cost of a proposed Dental Treatment Plan exceeds \$300, it should be submitted to the insurance company for an estimate of benefits payable.

This is not a Certificate of Coverage. This is a merely a summary of benefits. To review a more detailed explanation of benefits and limitations, you may request a copy of the full text benefit information from Leslie & Associates.

DENTAL PLAN 2 (High) Services

Type I Preventative Dental Services – Same as Plan 1

Type II Basic Dental Services – Same as Plan 1

Type III Major Dental Restorative Services, including:

- Periodontics (*see policy for complete list of procedures*)
 - Gingivectomy or gingivoplasty – one per site in each 36 consecutive months
 - Osseous Surgery - one per site in each 36 consecutive months
 - Soft Tissue Graft - one per site in each 36 consecutive months
 - Subepithelial connective tissue graft – one per site in each 36 consecutive months
 - Guided Tissue Regeneration
 - Crown Lengthening
 - Debridement – one treatment in each 24 consecutive months
 - Scaling and Root Planing – one treatment in each 24 consecutive months (not covered if performed in less than 3 months following periodontal surgery)
 - Periodontal Maintenance Cleanings - limited to 4 per Calendar Year (not covered if performed in less than 3 months following periodontal surgery)
 - Chemotherapeutics
- Major Restorations
 - Inlays and onlays
 - Crowns and posts (for claimants age 16 or older)
 - Crown Build-Up
 - Cast post and core
- Oral Surgery – Alveolar or Gingival Reconstruction
 - Alveolectomy
 - Vestibuloplasty
 - Removal of exostosis of the maxilla or mandible
 - Excision of hyperplastic tissue
- Prosthodontics – fixed or removable
 - Bridge abutment and pontics - limited to one time in any 8 consecutive years
 - Dentures, including adjustments made within 6 months of placement; replacement is limited to one time in any 5 consecutive years
 - Complete or partial denture - upper or lower
 - Special tissue conditioning
 - Reline of complete or partial denture
 - Rebase of complete or partial denture

Voluntary Short-Term Disability Insurance

HAWAII

Valuable Income Replacement at Affordable Group Rates

An accident or illness can strike anyone at any time. If you are unable to work because of a disabling sickness or injury, disability insurance can protect your most important asset – your income!

Eligibility

You are eligible to participate if you are actively working (not on leave of absence) an average of at least 24 hours a week at your usual place of employment.

Benefits Available

Short-term disability pays a specific weekly benefit if you become disabled due to an injury or sickness that is not job-related.

To receive total disability benefits, you must be totally disabled, under the regular care of a physician and unable to perform any work for pay or profit due to an injury or sickness that is not job-related. To receive partial disability benefits, you must become partially disabled, be engaged in partial disability employment earning at least 20% of your basic weekly earnings when partial disability employment begins and be under the regular care of a physician.

Basic Weekly Pay Definition

Basic Weekly Pay is defined as the weekly rate of pay from an employer in effect the day before the total disability begins. It excludes bonuses, overtime pay or other extra compensation.

Elimination Period & Benefit Duration

The elimination period is the number of days of continuous disability before benefits begin.

The benefit duration is the maximum number of weeks you may receive disability benefits.

Samples of when benefits will end: on the date you fail to give required proof of continuing disability; your disability ends; or the maximum benefit period ends. Required premium remains unpaid after a due date; you are no longer eligible; retirement. If the group policy ends and you are considered disabled by the insurance company, it will not act to end the maximum benefit period.

Pre-Existing Condition Exclusion

Benefits will not be payable for any disability which is caused by, contributed to by, or resulting from an injury, disease, sickness, pregnancy or mental disorder for which you have visited or consulted a physician, hospital or medical facility or took clinical tests or received treatment within the 12 months before becoming insured under this plan. This includes (but is not limited to) taking pills, injections or other medications to treat any condition. This exclusion will not apply after you have been insured under this policy for at least 12 months.

Reduction of Income Benefits

Any time the total of the weekly benefit you are receiving from this policy and your income from other sources exceeds 100% of your pre-disability weekly earnings, the weekly benefit under this policy will be reduced. Income from other sources includes but is not limited to: income received from any compulsory benefit act or law; any disability benefits or retirement benefits the Insured Person receives under a Retirement Plan; The Federal Social Security Act or the Railroad Retirement Act; unemployment insurance; and earnings the Insured Person earns or receives from any form of employment.

Successive Periods of Disability

Successive periods of disability will be considered one period and will allow continuation of benefits if you return to work for less than two weeks. A new elimination period does not need to be satisfied if the successive period of disability is the result of the same cause as the original disability. The maximum benefit duration continues to accumulate from the date disability recurs.

Maternity Benefits

Benefits for disability due to pregnancy or its complications will be paid the same as any other sickness, but will be subject to any pre-existing conditions limitation which applies to your plan.

Income Increase

If other income benefits are increased after the first week that benefits are paid for a period of disability, such increase will not be used to determine the weekly benefit reduction.

Exclusions

No weekly benefits will be paid for a disability due to: intentional self-inflicted injury or suicide attempt; result of a sickness or injury covered by Worker's Compensation; a job-related sickness or injury; any period you are no longer under the regular care of a physician; a war (declared or undeclared) or any act of war.

A+ Rated Insurance Company

The group disability plan is underwritten by Lincoln National Life Insurance Company, 8801 Indian Hills Drive, Omaha, NE 68114. A.M. Best Company, a leading independent analyst of insurance companies, has rated Lincoln National Life A+ (Superior), basing its opinion on the relative financial strengths and performances of insurers.

SEE MORE INFORMATION ON REVERSE SIDE

The Benefit Alliance Plan

 Leslie & Associates, Inc.

SHORT-TERM DISABILITY BENEFIT PROVISIONS

| | |
|----------------------------------|----------------------------------------------|
| Maximum Benefit Percentage | 50% of Weekly Pay |
| Maximum Weekly Benefit | \$1,000 |
| Day Benefits Begin | 1st Day for Accident; 8th Day for Sickness |
| Benefit Duration | 26 Weeks |
| Benefit Coordination | Standard STD; Coordinates with HI State Plan |
| Pre-Existing Condition Exclusion | 12 months |
| Occupation | Non-Occupational Disabilities Only |
| Coverage Ends | Upon Termination of Employment or Retirement |

PREMIUM COSTS PER MONTH

| Weekly Benefit | Ages 18-29 | Ages 30-34 | Ages 35-39 | Ages 40-44 | Ages 45-49 | Ages 50-54 | Ages 55-59 | Ages 60 + |
|----------------|------------|------------|------------|------------|------------|------------|------------|-----------|
| \$100 | \$2.47 | \$2.73 | \$2.99 | \$2.99 | \$3.25 | \$4.03 | \$4.81 | \$5.84 |
| \$150 | \$2.60 | \$2.87 | \$3.14 | \$3.14 | \$3.42 | \$4.23 | \$5.05 | \$6.14 |
| \$200 | \$4.94 | \$5.45 | \$5.97 | \$5.97 | \$6.49 | \$8.05 | \$9.61 | \$11.69 |
| \$250 | \$5.06 | \$5.60 | \$6.13 | \$6.13 | \$6.66 | \$8.26 | \$9.86 | \$11.99 |
| \$300 | \$7.40 | \$8.18 | \$8.96 | \$8.96 | \$9.74 | \$12.08 | \$14.42 | \$17.53 |
| \$350 | \$7.53 | \$8.32 | \$9.12 | \$9.12 | \$9.91 | \$12.29 | \$14.66 | \$17.83 |
| \$400 | \$9.87 | \$10.91 | \$11.95 | \$11.95 | \$12.99 | \$16.10 | \$19.22 | \$23.38 |
| \$450 | \$10.00 | \$11.05 | \$12.11 | \$12.11 | \$13.16 | \$16.32 | \$19.47 | \$23.67 |
| \$500 | \$12.34 | \$13.64 | \$14.94 | \$14.94 | \$16.23 | \$20.13 | \$24.03 | \$29.22 |
| \$550 | \$12.47 | \$13.78 | \$15.09 | \$15.09 | \$16.41 | \$20.33 | \$24.27 | \$29.52 |
| \$600 | \$14.81 | \$16.36 | \$17.92 | \$17.92 | \$19.48 | \$24.16 | \$28.83 | \$35.06 |
| \$700 | \$17.27 | \$19.09 | \$20.91 | \$20.91 | \$22.73 | \$28.18 | \$33.64 | \$40.91 |
| \$800 | \$19.74 | \$21.82 | \$23.90 | \$23.90 | \$25.97 | \$32.21 | \$38.44 | \$46.75 |
| \$900 | \$22.21 | \$24.55 | \$26.88 | \$26.88 | \$29.22 | \$36.23 | \$43.25 | \$52.60 |
| \$1,000 | \$24.68 | \$27.27 | \$29.87 | \$29.87 | \$32.47 | \$40.26 | \$48.05 | \$58.44 |

This is only a summary of benefits and is subject to the terms, conditions and limitations of the group policy. You may request a copy of the full text benefit information from Leslie & Associates.

Group Prescription Drug Plan

THE PROBLEM

Today's prescription medications are more effective than ever before – but they're also more expensive. The growing need for prescription drugs is putting tremendous financial pressure on many people who do not have prescription drug coverage.

- The cost of drugs is rising faster than any other health care cost.
- Many plans are now excluding or restricting the purchase of prescription drugs.
- Many plans require an annual deductible or cut-off benefits after a \$500 annual maximum.

THE SOLUTION

A non-profit prescription drug cooperative designed to provide worthwhile savings to members. Each member pays affordable monthly dues into a non-profit cooperative fund that subsidizes the purchase of prescription drugs for every member. The plan benefits include:

- \$20 co-pay for most generic drugs including generic oral contraceptives.
- Subsidized savings on brand name drugs – up to 35%.
- Over 54,000 participating retail pharmacies.
- Walgreens is the designated mail-order service pharmacy.

How the Co-op Works

Benefit Alliance members are eligible to join ActivaScripts – a non-profit membership cooperative established to allow individuals to pool monthly dues to partially subsidize the purchase of their generic prescription drugs. RESTAT is the pharmacy benefits manager for ActivaScripts. This program allows individuals to keep the cost of their prescription drugs at affordable levels. This is not an insurance plan.

Benefit Alliance ActivaScripts Benefits

Generic Prescription Drugs from a Retail Pharmacy

For each 30-day supply of a generic drug you will pay either a co-payment of \$20 or 60% of the discounted cost of the prescription (whichever is greater). According to a recent study of the current Benefit Alliance members' utilization, members would pay a maximum of the \$20 co-payment for approximately 75% of the generic drugs prescriptions.

Generic Prescription Drugs from the Mail-Order Pharmacy

For each 90-day supply of a generic drug you will pay either a co-payment of \$60 or 60% of the discounted cost of the prescription (whichever is greater).

Brand Name Drugs

When you obtain brand name drugs from any participating retail pharmacy or from the mail-order service pharmacy, you will pay the ActivaScripts discounted price or the pharmacy's usual & customary price; whichever is less.

MONTHLY FEE

| | |
|---------------------------------|---------|
| Employee Only | \$17.73 |
| Employee & Spouse | \$35.47 |
| Employee & Dependent Child(ren) | \$26.76 |
| Family | \$44.34 |

SEE MORE INFORMATION ON REVERSE SIDE

The Benefit Alliance Plan

 **Leslie & Associates, Inc.**

Easy to Use

Upon enrollment you will receive an ActivaScripts Certificate of Membership, which explains your benefits, along with your Benefit Alliance member identification card. You can visit www.RESTAT.com to locate convenient retail pharmacies or call the toll-free number provided with your membership certificate to order from the mail-order pharmacy.

Participating Retail Pharmacy

Simply present your Benefit Alliance identification card with the RESTAT logo to any participating pharmacy along with your prescriptions. The pharmacist enters the data and transmits it electronically to RESTAT's (the pharmacy benefit manager) computer that will calculate the appropriate co-payment for the pharmacist.

Walgreens Mail-Order Service Pharmacy

The mail-order service pharmacy may be accessed by using the toll-free 800 number included with your certificate of membership.

Membership Eligibility

Acceptance is guaranteed to anyone under the age of 65. All members are automatically eligible for benefits immediately upon the effective date of membership. Members previously enrolled who have terminated or canceled coverage must wait two years before enrolling again.

Monthly Membership Dues

The ActivaScripts non-profit prescription drug plan is not an insurance plan. Funding for the prescription drug benefits is derived exclusively from the membership dues paid by the member. Therefore, you should be aware that when you participate in this non-profit prescription drug cooperative, your monthly dues and/or benefits may change at any time without notice. This is the only way ActivaScripts can be certain that money will be available at all times to pay for the benefits provided by your membership in ActivaScripts. The monthly dues are established with the intention that they will not change for a period of one year or longer.

Limitations *(applies to generic drugs only)*

Benefits are not available with respect to the following:

Non-prescription (non-legend) drugs, injectable drugs, drugs or agents for impotency, anorexiant, cosmetic drugs, investigational or experimental drugs, syringes, disposable needles, therapeutic devices or appliances, support garments, biological sera, blood or blood plasma, oxygen (including administration), immunization agents, drugs administered where dispensed, refills in excess of the number authorized, and drugs dispensed more than one year after the date of prescription. Also not covered are drugs purchased in excess of a 30-day supply at a participating retail pharmacy or in excess of a 90-day supply at the mail-order service pharmacy. Finally, all prescriptions purchased must be obtained from a participating pharmacy in order to be eligible for any subsidy.

Maximum allowable supply for each prescription filled or refilled:

From a participating retail pharmacy: the lesser of a 30-day supply or 120 unit doses; a 90-day supply may also be purchased from any Walgreens retail pharmacy.

From the mail-order service pharmacy: the lesser of a 90-day supply or 360 unit doses.

Partial List of Participating Pharmacies:

Albertsons

Brooks Drug

CVS

Costco

Drug Emporium

Eckerd Drug

Farmco Drugs

Fry's Food & Drugs

Hook's

K-mart

Kroger

Long's

Medicine Shoppe

Payless

Phar-Mor

Publix

Revco

Rx Place

Safeway

Sam's Club

Savco, Inc.

Schnucks

Stop & Shop

Target

Thrift Drug

Von's

Walgreens

Wal-Mart

EyeMed Vision Care Plan

You and your dependents are eligible to participate in the EyeMed Vision Care Plan

The EyeMed network consists of private practice optometrists, ophthalmologists, and opticians who deliver high quality patient care. In addition to these eye care professionals, EyeMed also offers services through the country's leading optical retailers such as LensCrafters and most Sears Optical, Target Optical and most Pearle Vision locations.

| VISION CARE SERVICES | MEMBER COST | OUT-OF-NETWORK REIMBURSEMENT |
|-------------------------------------------------------------------------------------|-------------------------------------------------------|------------------------------|
| Exam with Dilation as Necessary | \$20 Co-Pay | Up to \$40 |
| Exam Options | | |
| Standard Contact Lens Fit & Follow-Up* | Up to \$55 | N/A |
| Premium Contact Lens Fit & Follow-Up** | 10% off retail price | N/A |
| Frames: | \$100 Allowance; 20% off Balance over \$100 | Up to \$50 |
| Standard Plastic Lenses: | | |
| Single Vision | \$20 Co-Pay | Up to \$25 |
| Bifocal | \$20 Co-Pay | Up to \$40 |
| Trifocal | \$20 Co-Pay | Up to \$65 |
| Standard Progressive (add-on to bifocal) | \$20 Co-Pay | Up to \$55 |
| Lens Options (paid by the member and added to the base price of the lens): | | |
| Tint (Solid & Gradient) | \$15 fee | N/A |
| UV Coating | \$15 fee | N/A |
| Standard Scratch-Resistance | \$15 fee | N/A |
| Standard Polycarbonate | \$40 fee | N/A |
| Standard Anti-Reflective | \$45 fee | N/A |
| Other Add-ons and Services | 20% off retail price | N/A |
| Contact Lenses: (covers materials only; in lieu of standard plastic lenses): | | |
| Conventional | \$115 allowance; 15% off balance over \$115 | Up to \$92 |
| Disposables | \$115 allowance; plus balance over \$115 | Up to \$92 |
| Medically Necessary | Paid in Full | Up to \$200 |
| **LASIK and PRK Vision Correction | 15% off retail price OR 5% off promotional pricing | |
| Frequency: | | |
| Examination | Once every 12 months | |
| Frames | Once every 12 months | |
| Lenses <u>or</u> Contact Lenses | Once every 12 months | |

Additional Purchases and Out-of-Pocket Discount

Member will receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses after initial benefit is exhausted. 20% discounts on items not covered by the plan at network Providers (does not apply to professional services or contact lenses)

MONTHLY FEE

| | |
|---------------------------------------------|----------------|
| Employee Only | \$8.00 |
| Employee & One (Spouse or Child) | \$14.50 |
| Employee & Family | \$21.50 |

SEE MORE INFORMATION ON REVERSE SIDE

**LASIK AND PRK **LASIK and PRK correction procedures are provided by the U.S. Laser Network, owned by LCA-Vision. Members must first call 1-877-5LASER6 for the nearest facility and to receive authorization for the discount. Discounts do not apply for benefits provided by other group plan. Allowances are one-time use of benefits; no remaining balance.

The Benefit Alliance Plan

 Leslie & Associates, Inc.

Network Providers

The EyeMed Vision Care network is national, with over 40,000 providers including private practice optometrists, ophthalmologists, opticians and LensCrafters, most Pearle Vision Centers, most Sears Optical and Target Optical locations throughout the country. You may call toll-free 1-866-723-0513 or visit www.eyemedvisioncare.com for the nearest EyeMed Provider.

Claim Forms

With EyeMed Vision Care, you do not need to obtain a claim form, so receiving your benefit is as easy as visiting the nearest participating eye care provider.

Referrals

Your vision care benefit can be accessed directly, without obtaining a referral from your primary care physician. If the optical provider detects a condition that requires further examination by your primary care physician, the provider will recommend that you see your primary care physician.

Exam Options - Contact Lens Fit and Follow-Up

Your plan gives every participant the opportunity to receive a frame and spectacle lenses or contact lenses. If you wear or would like to wear contact lenses, your eye care professional will perform additional services including contact lens fitting and follow-up care. *Standard Contact Lens Fitting - spherical clear contact lenses in conventional wear and planned replacement (i.e, disposables, frequent replacement). **Premium Contact Lenses Fitting - all lens designs, materials and speciality fittings other than standard contact lenses (i.e, toric, multifocal, etc.). Please refer to your benefit description to review the details for coverage for contact lenses.

Contact Lens Allowance

Your contact lens allowance applies to contact lens materials only. For conventional contact lenses, you will receive an additional 15% off the amount that exceeds the allowance. Please be advised that any balance resulting from the purchase of contact lenses are the responsibility of the member.

Coverage For An Out-of-Network Provider

Your vision care plan is designed to provide the best care at the most affordable cost to employees. It is for this reason that coverage for an exam, applies only to the services and products received from an EyeMed provider. If you choose to visit a doctor not in the EyeMed network, you may still receive eyeglass material from an EyeMed provider and apply them to your vision benefit. If you choose contact lenses, the EyeMed provider will perform additional services related to the purchases of contacts. You are responsible for any remaining balance related to these services.

Dependent Coverage

This plan covers both you and your dependents, if you choose that particular option when you enroll.

Benefit Descriptions And Exclusions

Lenses are single vision, bifocal (ST-25, 28 & 35), trifocals (7x28 & 7x35), and progressive, standard plastic, all powers, all sizes. Benefits shown can not be combined with any other promotional offers.

The following services are not included in your vision care benefit

- Orthoptic or vision training
- Aniseikonic lenses
- Plano non-prescription lenses (except for 20% discount)
- Two pairs of glasses instead of bifocals
- Free replacement or repair of lost or broken lenses or frames
- Medical or surgical treatment
- Services or materials covered under Workers' Compensation
- Services or materials provided by any other group benefit providing for vision care
- Eye examinations and material required as a condition of employment

A SAMPLE OF YOUR SAVINGS

| Service | Average Retail | You Pay | You Save |
|----------------------------------|-----------------|-----------------|-----------------|
| Comprehensive Exam | \$64.00 | \$20.00 | \$44.00 |
| \$100 Frame of your choice | \$100.00 | \$0 | \$100.00 |
| Pair of Single Vision Lenses | \$70.00 | \$20.00 | \$50.00 |
| UV Coating | \$20.00 | \$15.00 | \$5.00 |
| Tint | <u>\$20.00</u> | \$15.00 | <u>\$5.00</u> |
| Annual Premium for Employee Only | | <u>\$96.00</u> | |
| TOTAL | \$274.00 | \$166.00 | \$108.00 |
| Total Average Retail Cost | \$274.00 | | |
| Your Total Cost | | \$166.00 | |
| Your Total SAVINGS of 40% | | | \$108.00 |

Group Accident Insurance Plan

Accidents do happen and they happen fast. They happen without warning and most individuals are not prepared for the financial consequences of these occurrences. The Group Accident Indemnity Plan underwritten by ACE American Insurance Company can help protect you and your family against the additional, undesirable expenses associated with certain accidents.

PLAN FEATURES

- Pays in addition to any other coverage
- 24-Hour Coverage
- Specified injury and medical fee benefits
- Accidental Death & Dismemberment benefits

ACCIDENT BENEFITS PER INSURED

Complete Dislocations

| | |
|---------------------|---------|
| Hip | \$1,800 |
| Knee (not knee cap) | \$1,300 |
| Shoulder | \$1,000 |
| Foot/Ankle | \$800 |
| Hand | \$700 |
| Lower Jaw | \$600 |
| Wrist | \$500 |
| Elbow | \$400 |
| Finger/Toe | \$160 |

Complete Fractures

| | |
|-----------------------------|---------|
| Hip/Thigh | \$2,000 |
| Vertebrae | \$1,800 |
| Vertebral Processes | \$400 |
| Pelvis | \$1,600 |
| Skull (depressed) | \$1,500 |
| Skull (simple) | \$700 |
| Leg | \$1,200 |
| Forearm/Hand/Wrist | \$1,000 |
| Foot/Ankle/Knee Cap | \$1,000 |
| Shoulder Blade/Collar Bone | \$800 |
| Lower Jaw (mandible) | \$800 |
| Upper Arm/Upper Jaw | \$700 |
| Facial Bones (except teeth) | \$600 |
| Coccyx/Rib/Finger/Toe | \$160 |

Injuries Requiring Surgery

| | |
|-------------------------------------------|-------|
| Eye Injury | \$200 |
| Tendons/Ligaments | |
| Single | \$400 |
| Multiple | \$600 |
| Ruptured Disc | |
| Injury occurs during 1st certificate year | \$100 |
| Injury occurs after 1st certificate year | \$400 |
| Torn Knee Cartilage | |
| Injury occurs during 1st certificate year | \$100 |
| Injury occurs after 1st certificate year | \$400 |

Burns

| | |
|-----------------------------------------------------------------------------------------------------------------------------------------|-------|
| | \$600 |
| <i>(at a minimum, 2nd degree burns covering at least 25% of the body or 3rd degree burns covering at least nine inches of the body)</i> | |

Lacerations

| | |
|---------------|-------|
| Up to 2" long | \$50 |
| 2 - 5" long | \$100 |
| Over 5" long | \$200 |

Services

| | |
|---------------|-------|
| Air Ambulance | \$500 |
| Ambulance | \$200 |
| Blood/Plasma | \$100 |

Hospital Admission (per accident)

\$250

Hospital Confinement (up to 90 days)

\$125 per day

Medical Expense Benefits for Accidents

| | |
|-----------------------------------|-------------|
| Physician Charges | Up to \$150 |
| Emergency Room Charges & Supplies | Up to \$500 |
| X-rays | Up to \$150 |
| Appliances | Up to \$150 |

Accidental Death and Dismemberment*

| | |
|--------------------------------------------|----------|
| Single Dismemberment | \$10,000 |
| Accidental Death or Double Dismemberment | \$20,000 |
| Accidental Death (<i>common carrier</i>) | \$50,000 |

*Stated benefits for accidental death and dismemberment are for employee coverage. Covered spouses are eligible for a benefit equal to half of the stated benefit. Covered children may receive 25 percent of the benefit.

The benefits above are for fractures requiring closed reduction and dislocations requiring closed reduction with anesthesia. Multiple fractures or dislocations or those requiring open reduction would be payable at the rate of one and one-half times the amount shown. Chip fractures would be payable at 10 percent. Recurrent dislocations of the same joint are not covered. Stress fractures are not covered.

SEE MORE INFORMATION ON REVERSE SIDE

The Benefit Alliance Plan

 Leslie & Associates, Inc.

The Statistics are Dramatic...

- Unintentional injuries continued to be the fifth leading cause of death, exceeded only by heart disease, cancer, stroke, and chronic lower respiratory diseases*
- Nonfatal injuries affect millions of Americans. In 2007, 34.3 million people - about 1 out of 9 - sought medical attention for an injury*
- The economic impact of these unintentional injuries amounted to 701.9 billion in 2008*

Where would the finances come from to offset the unexpected expenses of dealing with untimely accidents? Could most individuals afford the costs? Statistics prove that most could not.

*Source: National Safety Council, Injury Facts 2010

MONTHLY PREMIUM RATES

| | |
|---------------------------------|---------|
| Employee Only | \$21.19 |
| Employee & Spouse | \$28.12 |
| Employee & Dependent Child(ren) | \$29.86 |
| Family | \$36.79 |

Limitation And Exclusions

We will not pay benefits for any loss or Injury that is caused by, results from, or is contributed to by:

1. Suicide or attempted suicide, intentionally self-inflicted injury.
2. War or any act of war, whether declared or not.
3. A Covered Accident that occurs while on active duty service in the military, naval or air force of any country or international organization. Upon receipt of proof of service, we will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days.
4. Sickness, disease, or any bacterial infection, except one that results from an accidental cut or wound or pyogenic infections that result from accidental ingestion of contaminated substances.
5. Piloting or serving as a crew member or riding in any aircraft except as a fare-paying passenger on a regularly scheduled or charter airline; bungee jumping, parachuting, skydiving, parasailing, hang-gliding.
6. Injury that occurs while the Covered Person is legally intoxicated (as determined by that state's law) or while under the influence of any drug unless administered under the advice and consent of a Doctor.
7. Medical or surgical treatment, diagnostic procedure, administration of anesthesia, or medical mishap or negligence, including malpractice.
8. Commission of, or attempt to commit, a felony.
9. Traveling more than 40 miles outside the territorial limits of the United States, Canada, Mexico, Puerto Rico, the Bahamas, Virgin Islands, Bermuda, and Jamaica, except as provided by the Common Carrier Benefit.
10. Participation in any motorized race or speed contest.
11. Commission of or attempted commission of a criminal act by an Insured.
12. Injury sustained while participating in any organized or professional or semi-professional sports.

This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit ACE American Insurance Company from providing insurance, including, but not limited to, the payment of claims.

Accident Medical Expense Benefits

Accident Medical Expense Benefits are only payable:

1. For usual and customary charges. "Usual and customary charge" means the average amount charged by most providers for treatment, service, or supplies in the geographic area where the treatment service, or supply is provided.
2. For those medically necessary covered expenses that the covered person receives; and
3. If the first incurred expenses are a result of an injury or covered accident occurring after the effective date of coverage.

Termination of the Certificate

An insured's individual's coverage will end on the earliest of the date the Policy terminates; the period ends for which premium is paid; or the date he or she is no longer eligible.

Portability

If you cease employment with your employer, you may elect to continue your coverage. You must have been continuously insured for at least 6 months under this plan and/or the prior plan just before the date your employment terminated. You may continue the coverage you had on the date employment was terminated, including dependent coverage then in effect.

1. Coverage may not be continued for any of the following reasons: a). you failed to pay the required premium; b). having attained age 70; c). this group policy terminates.
2. To keep the insurance in force you must: a). make a written application to the company within 31 days after the date your insurance would otherwise terminate; b). pay the premium to the company no later than 31 days after the date your insurance would otherwise terminate.
3. Insurance will cease on the earliest of these dates: a). the date you failed to pay any required premium; b). the date this group policy is terminated.

If you qualify for this portability privilege as described, then the same benefits, plan provisions, and premium rate as shown in the previously issued certificate will apply.

Short Term Major Medical Insurance Plan

Short Term Major Medical Insurance (STMM) coverage can protect you in the event of an unexpected serious illness or injury. STMM is designed to provide coverage for major hospital, medical and surgical expenses incurred as a result of medically necessary care for a covered illness or injury. Benefits may vary by state – request a custom quote for coverage available in your state of residence.

SPECIAL FEATURES

- Coverage for up to 12 months (in most states)
- Choose any doctor or hospital
- Affordable rates
- Convenient payment options: Check, money order, Visa/MasterCard, or automatic bank withdrawal

What Type Of Medical Expenses Are Covered?

- **Hospital Charges:** average semi-private room rate, medical care and treatment
- **Physician Services** for in-patient or out-patient diagnosis, treatment and surgery
- **Ambulatory Surgical Center** charges
- **Intensive Care:** up to three times the average semi-private room rate
- **X-Ray Exams, Laboratory** tests and analyses
- **X-Ray and Radioactive** isotope therapy, anesthesia, oxygen, casts, splints, crutches, braces, surgical dressings, artificial limbs or eyes, rental of medical supplies
- **Blood** or blood derivatives and their administration
- **Ambulance Services:** \$250 per emergency
- **Acquired Immune Deficiency Syndrome (AIDS):** \$10,000 lifetime maximum
- **Organ Transplants:** \$150,000 lifetime maximum
- **Surgeon Services** in the hospital or ambulatory surgical center

Detailed information about these and additional covered expenses is listed in the Policy. Not all covered expenses apply in every state, and additional expenses might be covered in your state. Consult the Policy for provisions in your state.

What Are The Benefits And How Do They Work?

FIRST

You pay the Plan Deductible – \$500 to \$5,000 for each insured depending on the Plan you choose. (Deductible applies per coverage period, not per cause; to a maximum of 3 per family)

THEN

The Plan pays 80% of the first \$10,000 of covered* expenses
You pay 20% of the first \$10,000 of covered* expenses

THEREAFTER

The Plan pays 100% of the next \$2,000,000 of covered* expenses

* reasonable and customary charges apply to covered expenses

What Is A Reasonable And Customary Charge?

A “reasonable and customary charge” is the charge typically made by physicians or suppliers of medical services, medicines and supplies within a specific geographic area.

Do I Need Precertification?

Pre-admission certification prior to eligible inpatient hospitalization or surgery by the covered individual within 48 hours is required. This is not a guarantee of benefits. Failure to precertify will result in benefit reductions.

Who Can Be Covered In The Short Term Major Medical Plan?

STMM is offered to you and your spouse (through age 64 and not eligible for Medicare) and your dependent children under age 19 (or under age 25 if a full-time student) who have a social security number and can answer “No” to seven health questions on the application. Children ages 19 and over should apply separately. Child-only coverage is available for ages 2 through 18.

Is There A Pre-existing Condition Limitation?

Yes. Pre-existing conditions are not covered. This includes any condition or complication that was treated or produced symptoms within five years prior to your STMM effective date.

SEE MORE INFORMATION ON REVERSE SIDE

The Benefit Alliance Plan

 **Leslie & Associates, Inc.**

How Do I Enroll In The Short Term Major Medical Plan?

Unlike the other benefit options offered through the Benefit Alliance Plan, your rate for STMM coverage is determined by your age, sex, state of residence and zip code. **Therefore, it is necessary for you to call Leslie & Associates via the TOLL FREE CUSTOMER SERVICE NUMBER: 1-800-644-6854. Leslie & Associates Customer Service Representatives will answer your questions regarding the STMM plan, provide individualized rate information and assist you with enrolling in the Plan if it meets your needs.** Health Plan Administrators (HPA), the Third Party Plan Administrator, underwrites the application, issues your policy upon approval, handles the premium billing and pays claims.

When Will My Short Term Major Medical Coverage Begin?

All STMM coverage is subject to approval of your application by the insurance company and payment of the first monthly premium. However, if you can answer "No" to the five health questions on the application and elect to pay your premium by VISA or MASTERCARD, your coverage can become effective within 24 hours. If you elect a different payment method, your coverage will begin as early as the day following the U.S. postmark stamp on your return envelope to Leslie & Associates. You can request a later effective date, but no more than 60 days after the application date.

How Long Will My Short Term Major Medical Coverage Last?

The STMM plan offers coverage for one to six months or even as much as twelve months in most states. If your need for health insurance coverage continues after your initial coverage period ends, you may apply (in most states) for another STMM Plan and coverage period. The next coverage period is not continuous and any condition that occurred during the prior coverage period will be excluded as a pre-existing condition.

What Services Are Not Covered?*

- Routine physical exams and tests, preventative care and immunizations
- Any services that are not medically necessary; experimental or investigational services
- Eye exams, eyeglasses, hearing aids and surgery
- Dental or orthodontic services
- Cosmetic surgery, treatment for acne, hair loss or varicose veins
- Treatment of foot conditions
- Medical care received outside of the United States, Canada or it's possessions
- Maternity and newborn treatment prior to discharge, any fertility treatments or sterilization treatments
- Over-the-counter medications and prescription drugs (*See Benefit Alliance Plan for prescription drug coverage*)
- Conditions resulting from an act of war, or any high-risk sports
- Services payable by Medicare or Worker's Compensation coverage
- Transplant services to the transplant donor
- Learning disorders, attention deficit disorder, hyperactivity or autism
- Obesity treatments; Sleep disorders; Alcohol or drug dependency and disorders
- Spinal manipulation or adjustment
- Participation in school or organized competitive sports
- Mental or nervous disorders, depression or suicide attempt
- Certain surgeries during the first six months

**Limitations and exclusions may vary by state. Please see the Policy/Certificate of Insurance for detailed information about these and other plan limitations and exclusions.*

About The Plan Administrator

Independence Holding Group (IHC, Inc) is comprised of affiliated insurance carriers, marketing and administrative companies and agencies committed to providing excellent service and competitive insurance products to groups and individuals. State of the art computer systems allow IHC Health solutions or provide superior service and flexibility to agent distributors and clients.

Satisfaction Guarantee

If you are not completely satisfied with this plan and you have not filed a claim, you may return the Certificate of Insurance and policy within 10 days of the policy delivery and receive a premium refund (less the initial enrollment fee).

Coverage Termination

Coverage ends when: the premium is not paid when due; you enter full-time active duty in the Armed Forces; you become eligible for Medicare; the elected coverage period expires; the insurance company determines fraud or misrepresentation has been made in filing a claim for benefits; or a dependent ceases to be eligible.

PLEASE NOTE – This is only a brief description of the Short Term Major Medical Plan benefits, exclusions and other policy provisions and is subject to change. It is not a contract. All coverage is subject to the terms, conditions and limitations of the insurance company issuing the policy. Individual state limitations and/or variations may apply.

Group Critical Illness Insurance Plan

The Group Critical Illness plan, underwritten by Continental American Insurance, an AFLAC company, is designed to help you and your family cope with and recover from the financial stress of surviving a critical illness or condition. The good news is that many people with critical illness survive these life-threatening battles. Unfortunately, as the recovery process begins, people become aware of the bills that have piled up. According to the 1998 Heart and Stroke Statistical Update by the American Heart Association:

STATISTICS

- **66%** of heart attack victims survive at least one year or longer. The death rate from heart attacks has declined more than half over the last 40 years.
- **75%** of stroke victims live at least one year following the stroke. The stroke survival rate has nearly tripled since 1950.
- **40%** of life-threatening cancer patients beat the disease and are alive five years from diagnosis.

KEY BENEFITS

- **First occurrence benefit** – lump sum benefits payable upon initial diagnosis of a covered illness or condition.
- **Additional occurrence benefit** – if an insured collects full benefits for a critical illness under the plan and later has one of the remaining covered illnesses or procedures, the policy will pay the full benefit amount for any additional illness. Occurrences must be separated by at least 6 months (benefits cannot be paid twice for the same critical illness).*
- **Child coverage at no additional cost** – each dependent child ages 0-19 (22 if full-time student) is covered at 10 percent of the primary insured amount at no additional charge.

Plan Features

- Your Choice of Benefit Amounts – Benefit amounts available from \$5,000 to \$50,000 for Employees ages 18-69 and Spouses ages 18-64. (*Spouse benefit amount not to exceed employee benefit amount.*)
- Lump-sum Benefit – Benefits are paid directly to the insured following the diagnosis of each covered critical illness. Use your lump-sum benefit any way you see fit – there are no restrictions.
- Limited Underwriting – Approval is based on answers to simple medical questions contained on the application form.
- Portable Coverage – Keep the plan if you leave your job for any reason.
- Health Screening Benefit – This benefit pays up to \$50 per year for tests such as mammography, colonoscopy, chest x-ray, cholesterol test, and pap smear.**

COVERED CRITICAL ILLNESS

Benefits are payable upon diagnosis of the following critical illnesses

| | Percentage of Face Amount Payable |
|---------------------------------------------|-----------------------------------|
| Heart Attack (Myocardial Infarction) | 100% |
| <i>Coronary Artery Bypass Surgery</i> | <i>25%</i> |
| Stroke | 100% |
| Major Organ Transplant | 100% |
| Renal Failure (End Stage) | 100% |
| Cancer | 100% |
| <i>Carcinoma in situ</i> | <i>25%</i> |

This plan is limited benefit supplemental coverage and is not intended as a substitute for medical insurance

* Coverage may be continued until benefits have been paid in full for each covered illness.

** Please refer to the certificate for a complete list of tests.

SEE MORE INFORMATION ON REVERSE SIDE

The Benefit Alliance Plan

 Leslie & Associates, Inc.

Definitions

Major Organ Transplant

Means undergoing surgery as a recipient of a transplant of a human heart, lung, liver, kidney, or pancreas.

Myocardial Infarction (Heart Attack)

Means the death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries. Heart attack does not include any other disease or injury involving the cardiovascular system. Cardiac Arrest not caused by a myocardial infarction is not a heart attack. The diagnosis must include all of the following criteria: 1). New and serial Electrocardiographic (EKG) findings consistent with Myocardial Infarction; and 2). Elevation of cardiac enzymes above generally accepted laboratory levels of normal [in case of creatine phosphokinase (CPK), a CPK-MB measurement must be used]. 3). Confirmatory imaging studies such as thallium scans, MUGA scans, or stress ecocardiograms. 4). Chest Pain.

Stroke

Means Apoplexy (due to rupture or acute occlusion of a cerebral artery), or a cerebral vascular accident or incident, which is first manifested on or after the policy date. Stroke does not include Transient Ischemic Attacks and attacks of Vertebrobasilar Ischemia. We will pay a benefit for Stroke which produces permanent clinical neurological sequela persisting for at least 30 days following an initial diagnosis made after any applicable Waiting Period. We must receive evidence of the permanent neurological damage provided from Computed Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI). Stroke does not mean head injury, transient ischemic attack or chronic cerebrovascular insufficiency.

Cancer

Means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of distant tissue. Cancer includes leukemia. Excluded are Cancers such as: 1). Pre-malignant tumors or polyps; 2). Carcinoma in Situ (non-invasion); 3). Any skin cancers except melanomas; 4). Stage I Hodgkin's Disease; 5). Stage A Prostate Cancer; or 6). Melanoma that is diagnosed as Clark's Level I or II or Breslow less than .77 mm; 7). Basal Cell carcinoma and squamous cell carcinoma of the skin.

Renal Failure

Means the end stage of renal failure presenting as chronic, irreversible failure of both of your kidneys to function. The Kidney failure must necessitate regular renal dialysis, hemo-dialysis or peritoneal dialysis (at least weekly); or which results in kidney transplantation. Renal failure is covered, provided it is not caused by a traumatic event, including surgical traumas.

Carcinoma in situ

Means Cancer that is in the natural or normal place, confined to the site without having invaded neighboring tissue. Cancer and/or carcinoma in situ must be diagnosed in one of two ways: 1). Pathological Diagnosis - A pathological diagnosis of cancer or carcinoma in situ is based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done a certified pathologist whose diagnosis of malignancy is in keeping with the standards set by the American Board of Pathology. 2). Clinical Diagnosis - A clinical diagnosis of cancer or carcinoma in situ is based on the study of symptoms. We will pay benefits for a clinical diagnosis only if (a) A pathological diagnosis cannot be made because it is medically inappropriate or life threatening; (b) There is medical evidence to support the diagnosis; and (c) A doctor is treating the insured for cancer and/or carcinoma in situ.

Coronary Artery Bypass Surgery

Means undergoing open heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts, but excluding procedures such as, but not limited to balloon angioplasty, laser relief, stints or other non-surgical procedures.

NON-SMOKER MONTHLY PREMIUMS

| AGE | \$5,000 | \$10,000 | \$15,000 | \$20,000 | \$25,000 | \$30,000 | \$35,000 | \$40,000 | \$45,000 | \$50,000 |
|-------|---------|----------|----------|----------|----------|----------|----------|----------|----------|----------|
| 18-39 | \$4.94 | \$8.71 | \$12.52 | \$16.34 | \$20.11 | \$23.92 | \$27.73 | \$31.50 | \$32.32 | \$39.13 |
| 40-49 | \$8.75 | \$16.42 | \$24.05 | \$31.72 | \$39.39 | \$47.02 | \$54.69 | \$62.31 | \$69.98 | \$77.61 |
| 50-54 | \$12.74 | \$23.92 | \$35.06 | \$46.19 | \$57.33 | \$68.51 | \$79.65 | \$90.78 | \$101.96 | \$113.10 |
| 55-59 | \$16.77 | \$31.89 | \$47.06 | \$62.18 | \$77.35 | \$92.52 | \$107.64 | \$122.81 | \$137.93 | \$153.10 |
| 60-64 | \$22.79 | \$43.98 | \$65.22 | \$86.41 | \$107.60 | \$128.79 | \$150.02 | \$171.21 | \$192.40 | \$213.59 |
| 65-69 | \$24.74 | \$47.88 | \$71.07 | \$94.21 | \$117.35 | \$140.49 | \$163.67 | \$186.81 | \$209.95 | \$233.09 |

SMOKER MONTHLY PREMIUMS

| AGE | \$5,000 | \$10,000 | \$15,000 | \$20,000 | \$25,000 | \$30,000 | \$35,000 | \$40,000 | \$45,000 | \$50,000 |
|-------|---------|----------|----------|----------|----------|----------|----------|----------|----------|----------|
| 18-39 | \$10.18 | \$19.24 | \$28.25 | \$37.31 | \$46.37 | \$55.42 | \$64.48 | \$73.54 | \$82.55 | \$91.61 |
| 40-49 | \$19.15 | \$37.22 | \$55.25 | \$73.32 | \$91.39 | \$109.42 | \$127.49 | \$145.51 | \$163.58 | \$181.61 |
| 50-54 | \$27.65 | \$53.69 | \$79.73 | \$105.82 | \$131.86 | \$157.91 | \$183.95 | \$209.99 | \$236.04 | \$262.08 |
| 55-59 | \$36.96 | \$72.28 | \$107.64 | \$143.00 | \$178.36 | \$213.72 | \$249.04 | \$284.40 | \$319.76 | \$355.12 |
| 60-64 | \$51.05 | \$100.49 | \$149.93 | \$199.42 | \$248.86 | \$298.31 | \$347.75 | \$397.19 | \$446.64 | \$496.08 |
| 65-69 | \$55.55 | \$109.50 | \$163.45 | \$217.40 | \$271.35 | \$325.30 | \$379.25 | \$433.20 | \$487.15 | \$541.10 |

Limitations And Exclusions

This plan contains a 30-day "waiting-period". This means that no benefits are payable for any covered person who has been diagnosed before coverage has been in force 30 days from the effective date of coverage. If a covered person is first diagnosed during the "waiting period", benefits for that Critical Illness will apply only to loss commencing after two years from the effective date of coverage, or the covered person may elect to void the certificate from the beginning and receive a full refund of premium.

Benefits will not be paid for loss due to: 1). Intentionally self-inflicted injury or action; 2). Suicide or attempted suicide while sane or insane; 3). illegal activities or participation in an illegal occupation; 4). War, declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence; or 5). Substance abuse.

Pre-Existing Condition Limitation

"Pre-existing Condition" means a sickness or physical condition which, within the 12-month period prior to the effective date, resulted in the insured receiving medical advice or treatment. We will not pay benefits for any condition or illness starting within 12 months of the effective date which is caused by, contributed to, or resulting from a pre-existing condition. A claim for benefits for loss starting after 12 months from the effective date will not be reduced or denied on the grounds that it is caused by a pre-existing condition. A condition will no longer be considered pre-existing at the end of 12 consecutive months starting and ending after the effective date.

Leslie & Associates Benefit Alliance Enrollment Form for Kelly Services Employees

Mail to: 17304 Preston Rd. Suite 1320 Dallas, TX 75252

Member Name _____ Social Security Number _____ / _____ / _____ Sex _____ Hire Date _____
First MI Last

Address _____ City _____ State _____ Zip _____

Telephone _____ Age _____ Birth Date _____ Birth State _____ Occupation _____
Area Code

Email Address _____ Cell Phone _____ Latest Assignment Date _____
Area Code

Spouse Name _____ Age _____ Birth Date _____ Sex _____ Social Security _____ / _____ / _____

Child #1 Name _____ Age _____ Birth Date _____ Sex _____ Social Security _____ / _____ / _____

Child #2 Name _____ Age _____ Birth Date _____ Sex _____ Social Security _____ / _____ / _____

Child #3 Name _____ Age _____ Birth Date _____ Sex _____ Social Security _____ / _____ / _____

GROUP TERM LIFE INSURANCE PLAN

Employee Only
 Employee & Spouse
 Employee & Children
 Family

Employee Coverage
 Smoker *Non-Smoker*
 \$50,000 \$75,000 \$100,000
Monthly Premium _____

Beneficiary Name _____ Beneficiary Relationship _____

Spouse Coverage
 Smoker *Non-Smoker*
 \$25,000 \$50,000
Monthly Premium _____

Beneficiary Name _____ Beneficiary Relationship _____

Dependent Children Coverage
 \$5,000 / at \$1.25 per month
 \$7,500 / at \$1.75 per month
 \$10,000 / at \$2.25 pr month
Monthly Premium _____

SHORT TERM DISABILITY INCOME PLAN

Weekly Kelly Salary \$ _____ X 50% = _____ = Maximum Weekly Benefit *(round down to nearest \$50 increment)*
Monthly Premium _____

\$100 \$150 \$200 \$250 \$300 \$350 \$400 \$450 \$500 \$550 \$600 Other _____

I understand and agree that no short-term disability benefits will be payable for any disability which is caused by, contributed to by, or resulting from a Pre-Existing Condition. A Pre-Existing Condition is any injury, disease, sickness, pregnancy or mental disorder for which you visited or consulted a physician, hospital or medical facility or took clinical tests or received treatment. This includes (but is not limited to) taking pills, injections or other medications.

GROUP DENTAL PLAN - Area 2

| | Plan 1 (Low) | Plan 2 (High) | |
|---------------------|-------------------------------------------|-------------------------------------------|------------------------------|
| Employee Only | <input type="checkbox"/> \$ 31.93 monthly | <input type="checkbox"/> \$ 49.05 monthly | |
| Employee & Spouse | <input type="checkbox"/> \$ 53.77 monthly | <input type="checkbox"/> \$ 96.57 monthly | |
| Employee & Children | <input type="checkbox"/> \$ 67.04 monthly | <input type="checkbox"/> \$ 99.51 monthly | |
| Employee & Family | <input type="checkbox"/> \$ 93.42 monthly | <input type="checkbox"/> \$147.01 monthly | Monthly Premium _____ |

EYEMED VISION CARE PLAN

Employee Only \$ 8.00 per month
 Employee & One *(Spouse or Child)* \$ 14.50 per month
 Employee & Family \$ 21.50 per month
Monthly Premium _____

GROUP ACCIDENT INSURANCE PLAN

Employee Only \$ 21.19 per month
 Employee & Spouse \$ 28.12 per month
 Employee & Dependent Child(ren) \$ 29.86 per month
 Employee & Family \$ 36.79 per month
Monthly Premium _____

GROUP LIMITED ACCIDENT & SICKNESS - ENHANCED PLANS (include separate Rx & co-pay provision)

| | <i>Tier 3</i> | <i>Tier 4</i> | |
|-----------------------|----------------------------------------------|----------------------------------------------|------------------------------|
| Employee Only | <input type="checkbox"/> \$ 154.00 per month | <input type="checkbox"/> \$ 280.00 per month | Monthly Premium _____ |
| Employee & Spouse | <input type="checkbox"/> \$ 319.00 per month | <input type="checkbox"/> \$ 586.00 per month | |
| Employee & Child(ren) | <input type="checkbox"/> \$ 257.00 per month | <input type="checkbox"/> \$ 471.00 per month | |
| Employee & Family | <input type="checkbox"/> \$ 428.00 per month | <input type="checkbox"/> \$ 787.00 per month | |

GROUP LIMITED ACCIDENT & SICKNESS - STANDARD PLANS (no Rx & no co-pay provision)

| | <i>Tier 1</i> | <i>Tier 2</i> | |
|-----------------------|----------------------------------------------|----------------------------------------------|------------------------------|
| Employee Only | <input type="checkbox"/> \$ 82.00 per month | <input type="checkbox"/> \$ 103.00 per month | Monthly Premium _____ |
| Employee & Spouse | <input type="checkbox"/> \$ 169.00 per month | <input type="checkbox"/> \$ 196.00 per month | |
| Employee & Child(ren) | <input type="checkbox"/> \$ 143.00 per month | <input type="checkbox"/> \$ 165.00 per month | |
| Employee & Family | <input type="checkbox"/> \$ 232.00 per month | <input type="checkbox"/> \$ 257.00 per month | |

I have read the Group Limited Accident & Sickness Plan enrollment materials and accept the terms and conditions outlined in them. I understand no benefits will be paid for any medical condition or illness due to a pre-existing condition for up to 6 months for myself or my dependents. The 6 month period will be reduced based on prior creditable coverage as shown by a Certificate of Prior Creditable Coverage which I must provide. A pre-existing condition is any disease, illness, sickness, or injury which was diagnosed or treated by a Doctor or required taking prescribed drugs or medicines within the 6 month period immediately preceding the effective date of coverage. The Limited Accident & Sickness Plan is group insurance underwritten by ACE American Insurance Company and the benefits will vary depending on the plan selected. I understand the policy is subject to exclusions, limitations. I understand it does NOT provide Major Medical or Comprehensive Medical coverage. The limitations are disclosed in the enrollment materials, policy and certificate which are made available at the time of enrollment.

Yes **No**

OPTIONAL STAND-ALONE ACTIVASCRIPTS PRESCRIPTION DRUG CO-PAY PLAN

| | | |
|----------------------------------------------|--------------------|------------------------------|
| <input type="checkbox"/> Employee Only | \$ 17.73 per month | Monthly Premium _____ |
| <input type="checkbox"/> Employee & Spouse | \$ 35.47 per month | |
| <input type="checkbox"/> Employee & Children | \$ 26.76 per month | |
| <input type="checkbox"/> Employee & Family | \$ 44.34 per month | |

I have enclosed a check or money order payable to Special Insurance Services, Inc., the authorized administrator of the Leslie and Associates Benefit Alliance Trust for Kelly Services Employees, for the first monthly premium due for the benefits I have selected. I understand I will incur a one-time enrollment fee of \$20.00. In addition, I agree to a monthly service charge of \$2.00 if I elect the Bank Draft Authorization method of premium payments or \$3.00 per month if I am billed directly by Special Insurance Services, Inc. (SIS).

Sub-Total for All Premiums _____

Add Enrollment Fee **+ \$20.00**

Add Administrative Fee + _____
(\$2.00 / Bank Draft or \$3.00 / Direct Bill)

INITIAL PAYMENT MUST BE ENCLOSED _____

(MAKE ALL PAYMENTS PAYABLE TO SPECIAL INSURANCE SERVICES, INC.)

Mail to: [Leslie & Associates Benefit Alliance](#) ♦ 17304 Preston Rd. Suite 1320 ♦ Dallas, TX 75252

CHOOSE YOUR FUTURE BILLING PREFERENCE

Monthly Direct Billing Bank Draft Authorization

*Complete and return the "Bank Draft Authorization Form"
 Attach "voided" check or copy of voided check*

I understand and acknowledge that by applying for this group insurance I am also becoming a member of the Leslie and Associates Benefit Alliance Trust. The trust is not the insurance company and has no responsibility for this insurance except to hold the master policy. This statement does not apply to the Limited Accident & Sickness Plans or Group Accident Plans underwritten by ACE American Insurance Company.

To the best of my knowledge and belief, all statements and answers are true and complete. They are offered as the basis for any insurance issued. Any person who with intent to defraud or knowingly submits an application or files a claim containing false or deceptive statements is guilty of insurance fraud. This enrollment form shall not bind the insurance company and I understand that no insurance will be in effect until my application is approved, certificate issued and the necessary premium is paid. It is understood and agreed that coverage will not become effective unless I am actively at work (not on a leave of absence) on the date of enrollment and the effective date of my coverage.

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information related to a claim was provided by the applicant.

Date _____ **Signature of Employee** _____ **Daytime Phone** () _____ **Kelly Branch Number** _____

The Benefit Alliance Plan

ENROLLMENT INSTRUCTIONS

Complete the top section of Benefit Alliance Enrollment Form with your personal information. Include information on spouse and/or dependent children if you choose to enroll them in any of the benefits offered.

- 1) **Group Term Life Plan** – If it is not a designated open enrollment period, you must have started employment with Kelly within the prior 60 days to be eligible to enroll in the Group Term Life plan. Check the appropriate box to indicate whom you wish to insure. You must purchase coverage for yourself in order to insure your spouse or dependent children.
- 2) For **employee coverage**, check the box to indicate whether you are a smoker or non-smoker. Check the box for the amount of coverage you choose. Find the corresponding monthly premium amount on the “Group Term Life Plan Schedule” and fill in this amount on the monthly premium line. Fill in the name and relationship of the beneficiary for your policy where indicated.
- 3) For **spouse coverage**, check the box to indicate whether your spouse is a smoker or non-smoker. Check the box for the amount of coverage for your spouse. *The amount of spouse coverage may not exceed 50% of the amount of employee coverage.* Find the corresponding monthly premium amount on the “Group Term Life Plan Schedule” and fill in this amount on the monthly premium line. Fill in the name and relationship of the beneficiary for the policy on your spouse where indicated.
- 4) For **dependent children (over 14 days of age & under 19 years of age) coverage**, check the box for the amount of coverage you choose and fill in the monthly premium amount accordingly. *One premium provides life insurance for all eligible dependent children covered by the rider.*
- 5) **Group Term Short Term Disability Plan** – Determine the maximum benefit you are eligible for by multiplying your weekly salary by 50%. If the amount falls between benefit choices, round down to the nearest \$50. (Example: Weekly salary = \$575 times 50% = \$287.50, which needs to be rounded down to \$250 as the maximum benefit amount). Check the box for the weekly benefit amount you choose and find the corresponding premium amount for your age on the “Short-Term Disability Rate Schedule”. Fill in this amount on the monthly premium line on your enrollment form.
- 6) **Group Dental Plan** – Choose one of the plans listed by checking the appropriate box and fill in the corresponding premium shown on the monthly premium line of the enrollment form.
- 7) **Group Prescription Drug Co-op Plan** – Choose one of the plans listed by checking the appropriate box and fill in the corresponding premium shown on the monthly premium line of the enrollment form.
- 8) **Group EyeMed Vision Care Plan** – Choose one of the plans listed by checking the appropriate box and fill in the premium shown on the monthly premium line of the enrollment form.
- 9) **Group Accident Plan** - Choose one of the plans listed by checking the appropriate box and fill in the premium shown on the monthly premium line of the enrollment form.
- 10) **Group Limited Accident & Sickness Plan STANDARD Tier 1 & 2** – Choose one of the plans listed by checking the appropriate box and fill in the corresponding premium shown on the monthly premium line of the enrollment form. **Read the “Pre-Existing” clause and check the “yes” box to indicate you understand and agree that limited accident & sickness plan benefits will be subject to this clause.**
- 11) **Group Limited Accident & Sickness Plan ENHANCED Tier 3 & 4** – Choose one of the plans listed (they include an outpatient prescription drug plan) by checking the appropriate box and fill in the corresponding monthly premium line of the enrollment form. **Read the “Pre-Existing” clause and check the “yes” box to indicate you understand and agree that limited accident & sickness plan benefits will be subject to this clause.**

Important Notice to Massachusetts Residents - None of the Group Limited Accident & Sickness plans meet the Massachusetts state mandated coverage requirements.

See Reverse Side

- 12) **Short Term Major Medical Plan** – You must call Leslie & Associates Customer Service (1-800-644-6854) for a personalized quote. *(not available in CT, ND, NY, NJ, MA, VT)*
- 13) **Individual Major Medical Plans** – You must call Leslie & Associates Customer Service (1-800-644-6854) for a personalized quote. *(not available in CA, HI, ID, MA, ME, MN, MT, ND, NH, NJ, NY, OR, RI, UT, VT, WA)*
- 14) **Group Critical Illness Plan** – You must complete the separate Continental American Insurance Co. Application Form #CAIC02-SI-KS including medical questions 1-3. Spouse coverage amount may not exceed employee coverage amount. For employee coverage amounts above \$30,000 or spouse coverage amounts above \$15,000, medical questions 4-8 must be answered. You may use additional paper if needed for explanation of any “YES” answers. The reverse side of the CAIC Application Form must be signed and dated. A separate check or money order in the amount of the monthly premium(s) for the plan(s) chosen, made payable to Special Insurance Services (SIS), must be submitted with the Critical Illness application. Return the completed Critical Illness application and corresponding initial critical illness premium payment to Leslie & Associates Benefit Alliance for processing.
- 15) **Billing Preference** – Check the appropriate box to indicate your preference for paying **future** premiums. You may choose to be billed monthly (\$3.00 administrative fee per month) or use the bank draft authorization method (\$2.00 administrative fee per month). Fill in the corresponding amount on the “add administrative fee” line on the enrollment form.
- 16) **Premium Payments** - Calculate your total monthly amount by **adding the monthly premiums for all chosen benefits, the \$20.00 initial enrollment fee and the appropriate administrative fee.** Fill in this amount on the “**total payment enclosed**” on the enrollment form. Please make sure your check or money order for your first premium payment is made **payable to Special Insurance Services, Inc.**
- 17) **Sign & Date** – Sign and date your enrollment form, and add your Kelly branch number, where indicated.
- 18) **Bank Draft Authorization Form** – If you choose the bank draft authorization method of your **future** premium payments, be sure to complete the enclosed authorization form. Attach a voided check or copy of a voided check; sign and date where indicated.
- 19) **Initial Premium Payment** – Make your check or money order **payable to Special Insurance Services, Inc.** in the amount that corresponds to the “Total Payment Enclosed” line on your enrollment form. This payment represents your initial premium payment(s) for the coverage(s) you have selected.
- 20) **Mail**– Mail your completed enrollment form, separate Application Form for Critical Illness (if chosen), initial premium payment (and bank draft authorization form if selected) in the return envelope enclosed. **When we receive your complete, correct enrollment form with the accompanying initial premium payments on or before the 20th day of a given month, the coverage you have selected will be effective the first day of the following month.**

If you should have any questions or need enrollment assistance, you may speak with a Leslie & Associates customer service representative by calling 1-800-644-6854 Monday through Friday 8:30 a.m. to 5:00 p.m. CST.

Please note: Make sure your check or money for the initial premium payment due is included with your completed enrollment form. The payment option you choose will coincide with the second premium due. We cannot process your enrollment form without the correct initial premium payment.

Mail enrollment forms to:
Leslie & Associates, Inc. – Benefit Alliance Plan
17304 Preston Rd., Suite 1320
Dallas, TX 75252-6018

***** IMPORTANT NOTE *** Your Benefit Alliance Plan does not automatically terminate if you should terminate employment with Kelly Services. You must notify Leslie & Associates in writing if you wish to change or cancel any benefit and/or automatic bank draft authorization.**

BENEFIT ALLIANCE PAYMENT AGREEMENT AND BANK DRAFT AUTHORIZATION

Applicant _____ PLEASE PRINT New Participant Change to Existing Plan
 Address _____
 City _____ State _____ Zip _____
 Social Security # _____ Home Telephone # _____
Area Code

I authorize Special Insurance Services, Inc. (SIS), as Premium Administrator to divide and distribute funds received on my behalf as follows:

| BENEFIT | MONTHLY AMOUNT |
|-------------------------------------------------------------------------------------|-----------------------|
| <input type="checkbox"/> Employee Group Term Life Insurance | \$ _____ |
| <input type="checkbox"/> Spouse Group Term Life Insurance | \$ _____ |
| <input type="checkbox"/> Children's Term Life Insurance Rider | \$ _____ |
| <input type="checkbox"/> Short Term Disability Plan | \$ _____ |
| <input type="checkbox"/> Dental Plan | \$ _____ |
| <input type="checkbox"/> Limited Accident & Sickness Plan - STANDARD - Level 1 or 2 | \$ _____ |
| <input type="checkbox"/> Limited Accident & Sickness Plan - ENHANCED - Level 3 or 4 | \$ _____ |
| <input type="checkbox"/> Accident Plan | \$ _____ |
| <input type="checkbox"/> Optional ActivaScripts Prescription Drug Co-Op Plan | \$ _____ |
| <input type="checkbox"/> Vision Care Plan | \$ _____ |
| <input type="checkbox"/> Critical Illness Plan | \$ _____ |
| Administrative Fee | + \$2.00 |
| TOTAL | \$ _____ |

This authorization is to honor checks drawn by Special Insurance Services, Inc. (SIS) to the Bank named below:

Bank Name _____
 Address _____

Bank Draft Date: *Circle Your Choice* **10th** **15th** **20th**
 (If no date chosen, bank draft will occur approximately the 15th of each month)

As a convenience to me, I hereby request and authorize you to charge my account and to pay checks or Electronic Funds Transfers drawn on my account by and payable to the order of Special Insurance Services, Inc. (SIS) provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in regard to such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing to either SIS (Premium Administrator) or Leslie & Associates, Inc. (Plan Administrator) and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check.

I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of such insurance.

This authorization is effective immediately unless otherwise specified. Furthermore, I authorize SIS to share information with Leslie & Associates, the Benefit Alliance Plan Administrator.

In addition, I hereby authorize you to disclose my address and phone number(s) on file to Special Insurance Services, Inc. and/or Leslie & Associates, Inc., the Benefit Alliance Plan Administrators for my benefit plans upon request.

YOU MUST ATTACH VOIDED CHECK OR COPY OF VOIDED CHECK HERE

INDICATE WHICH TYPE OF ACCOUNT

SIS WILL WRITE IN ROUTING AND ACCOUNT NUMBER

| | | | | | | | | | | | | | | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| STAPLE OR TAPE SAMPLE (VOID) CHECK HERE FOR CODING PURPOSES WITH THE FINANCIAL INSTITUTION'S NAME AND ADDRESS | | | | | | | | | | | | | | | | | | | | | |
| FOR SIS USE ONLY: | | | | | | | | | | | | | | | | | | | | | |
| Type of Account | <input type="checkbox"/> Checking <input type="checkbox"/> Savings | | | | | | | | | | | | | | | | | | | | |
| Transit Routing Numbers | <table style="border: none;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table> | | | | | | | | | | | | | | | | | | | | |
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| | | | | | | | | | | | | | | | | | | | | | |

I hereby authorize Special Insurance Services, Inc. (Company) to make variable charges to my (our) checking or savings account identified above, and authorize the financial institution name above to withdraw funds from (debit) such account to pay Company's order accordingly for the purpose of paying monies due on policies or plans issued. Special Insurance Services, Inc. reserves the right to revoke this plan. Special Insurance Services, Inc. may, at its discretion, withdraw by means of Electronic Funds Transfer in lieu of a paper check.

I accept that this authority will remain in effect until either Special Insurance Services, Inc. (Premium Administrator) or Leslie & Associates, Inc. (Plan Administrator) has received written, dated notice of termination from me. I understand that the Premium Administrator's duty is to divide and distribute my funds. Any funds received under this agreement shall be distributed to the insurance companies or benefit providers. I understand that the Premium Administrator receives an administrative fee, as indicated above, for services rendered by them on my behalf. If any checks I remit are not paid for any reason, the Premium or Plan Administrator will be under no liability whatsoever to me, even though such non-payment may result in lapse of insurance or plan coverage.

Nothing in this Payment Agreement and Bank Draft Authorization shall prevent me from increasing, decreasing or terminating future payments for the above-named benefits.

Signature (as it appears on bank account) _____ **Date** _____

CONTINENTAL AMERICAN INSURANCE COMPANY

APPLICATION FORM FOR CRITICAL ILLNESS

| | | | | | |
|-----------------|--------------|----------------------------|-----------------------|---------------------------------|---------------------|
| Name (Employee) | | Social Security Number | | Sex | Date of Birth |
| Street Address | Apt. # | City | State | Zip Code | Phone Number () |
| Occupation | Date of Hire | | Hours Worked per week | Beneficiary Name / Relationship | |
| Spouse Name | | Spouse Social Security No. | | Sex | Date of Birth |

Coverage: Employee Tobacco Non-Tobacco Face Amount \$ _____ * Premium \$ _____ monthly

Spouse Tobacco Non-Tobacco Face Amount \$ _____ * Premium \$ _____ monthly

Child(ren) Coverage (each dependent child may be insured at 10% of the primary insured amount at no additional charge)
(List Dependent Children)

| Dependent Name | Relationship | Date of Birth |
|----------------|--------------|---------------|
| | | |
| | | |
| | | |

MEDICAL QUESTIONS

1. Is any person to be insured now being treated for or has any person ever been treated for: (a) cancer or any malignancy which includes melanoma, carcinoma, sarcoma, Hodgkin's Disease, leukemia, lymphoma, or malignant tumor. Cancer does not include basal cell or squamous cell carcinoma; (b) a stroke; (c) a heart attack, a heart condition, heart trouble, or any abnormality of the heart (including artery disease); (d) diabetes; (e) any liver disorder; (f) kidney (renal) failure or end stage kidney (renal) disease; (g) organ transplant; (h) emphysema; (i) or now taking three or more medications for high blood pressure?

| | | |
|--------------------------------------------------------------------------|------------------------------------------------------------------------|----------------------------------------------------------------------------|
| Employee <input type="checkbox"/> Yes <input type="checkbox"/> No | Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No | Child(ren) <input type="checkbox"/> Yes <input type="checkbox"/> No |
|--------------------------------------------------------------------------|------------------------------------------------------------------------|----------------------------------------------------------------------------|
2. Is any person to be insured now being treated or has ever been treated or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or "AIDS" Related Complex (ARC) or ever been tested positive for antigens or antibodies to an "AIDS" virus?

| | | |
|--------------------------------------------------------------------------|------------------------------------------------------------------------|----------------------------------------------------------------------------|
| Employee <input type="checkbox"/> Yes <input type="checkbox"/> No | Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No | Child(ren) <input type="checkbox"/> Yes <input type="checkbox"/> No |
|--------------------------------------------------------------------------|------------------------------------------------------------------------|----------------------------------------------------------------------------|
3. Is any person be insured now hospitalized or unable to perform their normal duties and activities?

| | | |
|--------------------------------------------------------------------------|------------------------------------------------------------------------|----------------------------------------------------------------------------|
| Employee <input type="checkbox"/> Yes <input type="checkbox"/> No | Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No | Child(ren) <input type="checkbox"/> Yes <input type="checkbox"/> No |
|--------------------------------------------------------------------------|------------------------------------------------------------------------|----------------------------------------------------------------------------|

***Questions 4-8 must be completed if Employee is applying for benefits over \$30,000 and/or if Spouse benefits over \$15,000**

4. Employee Height / Weight _____ ft. ____ in. _____ lbs. Spouse Height / Weight _____ ft. ____ in. _____ lbs.
5. Has any person to be insured been hospitalized as an inpatient or outpatient for a sickness other than pregnancy at any time during the last five years?

| | | |
|--------------------------------------------------------------------------|------------------------------------------------------------------------|----------------------------------------------------------------------------|
| Employee <input type="checkbox"/> Yes <input type="checkbox"/> No | Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No | Child(ren) <input type="checkbox"/> Yes <input type="checkbox"/> No |
|--------------------------------------------------------------------------|------------------------------------------------------------------------|----------------------------------------------------------------------------|
6. Has any person to be insured been advised to have any diagnostic test, hospitalization, surgery or treatment which has not been completed?

| | | |
|--------------------------------------------------------------------------|------------------------------------------------------------------------|----------------------------------------------------------------------------|
| Employee <input type="checkbox"/> Yes <input type="checkbox"/> No | Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No | Child(ren) <input type="checkbox"/> Yes <input type="checkbox"/> No |
|--------------------------------------------------------------------------|------------------------------------------------------------------------|----------------------------------------------------------------------------|
7. Has any person to be insured had a weight loss of 10 pounds or more, other than by dieting, in the past 6 months?

| | | |
|--------------------------------------------------------------------------|------------------------------------------------------------------------|----------------------------------------------------------------------------|
| Employee <input type="checkbox"/> Yes <input type="checkbox"/> No | Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No | Child(ren) <input type="checkbox"/> Yes <input type="checkbox"/> No |
|--------------------------------------------------------------------------|------------------------------------------------------------------------|----------------------------------------------------------------------------|
8. Has any person to be insured ever had, or taken prescription drugs for high blood pressure?

| | | |
|--------------------------------------------------------------------------|------------------------------------------------------------------------|----------------------------------------------------------------------------|
| Employee <input type="checkbox"/> Yes <input type="checkbox"/> No | Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No | Child(ren) <input type="checkbox"/> Yes <input type="checkbox"/> No |
|--------------------------------------------------------------------------|------------------------------------------------------------------------|----------------------------------------------------------------------------|

Explanation of "YES" Answers:

CAIC02-SI-KS

This application is not complete unless signed and dated on the reverse side

IMPORTANT NOTICE

Required by Federal Law 91-508

(to be delivered to the applicant in connection with application(s) for insurance)

This is to inform you that as part of our normal underwriting procedure for processing your initial insurance application, an investigative consumer report may be prepared whereby information obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have a right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation. Please direct any such request to Continental American Insurance Company, 2801 Devine Street, Columbia, South Carolina 29205.

See Reverse Side

To the best of my knowledge and belief, the answers to the questions on this application are true and complete. They are offered to Continental American Insurance Company as the basis for any insurance issued. It is understood and agreed that coverage will not become effective unless I am actively at work on the date of enrollment and the effective date of coverage.

Do you understand and agree that no benefits are payable for loss or disability starting or occurring within 12 months of the effective date of coverage which is caused by, contributed to by, due to or resulting from a Pre-existing condition, unless you have gone 12 months without medical care, treatment or supplies for the Pre-Existing Condition **YES** **NO**

CERTIFICATION: The undersigned applicant has read the completed application and that the applicant realizes that any false statements or misrepresentation in the application may result in loss of coverage under the certificate. I understand that no insurance will be in effect until my application is approved and the necessary premium is paid.

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement maybe guilty of insurance fraud.

The authorization on this application form shall remain valid for two years from the date of this application.

Date _____ **Signature of Applicant** _____

| | | |
|--------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------|
| <i>HOME OFFICE USE ONLY</i> | | |
| <input type="checkbox"/> <i>Simplified Issue</i> | <input type="checkbox"/> <i>Simplified Underwritten - Issued</i> | <input type="checkbox"/> <i>Fully Underwritten</i> |
| <i>Requested Effective Date</i> _____ | <i>Plan Code(s)</i> _____ | <i>ID Number</i> _____ |
| <i>Effective Date</i> _____ | <i>Leslie & Associates Benefit Alliance Company Code #</i> _____ | |