

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.

- **Group Dental Plan**

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

- **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 heart attack, stroke, cancer, etc.

- **Supplemental Group Hospital & Medical Indemnity Plan - Choice of Basic or Premier Plan Designs!**

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. **Premier Plan design includes enhanced benefits and PPO Network Access!**

- **Group MID MED Limited Benefit Medical Insurance Plans**

Choice of 2 plan designs - Level 1 or Level 2. \$20 Co-Pay for physician office visits and routine physical exams. Level 2 offers many of the same features of comprehensive insurance plans at a more affordable cost. Coverage is available in all 50 states.

- **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 \$15.00 Co-Pay or 50% benefit for most generic drugs. Also discounts savings on brand-name drugs at more than 45,000 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

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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.

Voluntary Short-Term Disability Insurance

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

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SHORT-TERM DISABILITY BENEFIT PROVISIONS

Maximum Benefit Percentage	50% of Weekly Pay
Maximum Weekly Benefit	\$1,000
Day Benefits Begin	1st Day of disability for Accident; 8th Day for Sickness
Maximum Benefit Duration	26 Weeks
Benefit Coordination	Standard STD (see reduction of income benefits)
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	\$11.56	\$12.86	\$14.03	\$14.42	\$15.32	\$18.96	\$22.86	\$28.05
\$150	\$17.34	\$19.29	\$21.05	\$21.63	\$22.98	\$28.44	\$34.29	\$42.08
\$200	\$23.12	\$25.72	\$28.06	\$28.84	\$30.64	\$37.92	\$45.72	\$56.10
\$250	\$28.90	\$32.15	\$35.08	\$36.05	\$38.30	\$47.40	\$57.15	\$70.13
\$300	\$34.68	\$38.58	\$42.09	\$43.26	\$45.96	\$56.88	\$68.58	\$84.15
\$350	\$40.46	\$45.01	\$49.11	\$50.47	\$53.62	\$66.36	\$80.01	\$98.18
\$400	\$46.24	\$51.44	\$56.12	\$57.68	\$61.28	\$75.84	\$91.44	\$112.20
\$450	\$52.02	\$57.87	\$63.14	\$64.89	\$68.94	\$85.32	\$102.87	\$126.23
\$500	\$57.80	\$64.30	\$70.15	\$72.10	\$76.60	\$94.80	\$114.30	\$140.25
\$550	\$63.58	\$70.73	\$77.17	\$79.31	\$84.26	\$104.28	\$125.73	\$154.28
\$600	\$69.36	\$77.16	\$84.18	\$86.52	\$91.92	\$113.76	\$137.16	\$168.30
\$700	\$80.92	\$90.02	\$98.21	\$100.94	\$107.24	\$132.72	\$160.02	\$196.35
\$800	\$92.48	\$102.88	\$112.24	\$115.36	\$122.56	\$151.68	\$182.88	\$224.40
\$900	\$104.04	\$115.74	\$126.27	\$129.78	\$137.88	\$170.64	\$205.74	\$252.45
\$1,000	\$115.60	\$128.60	\$140.30	\$144.20	\$153.20	\$189.60	\$228.60	\$280.50

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 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

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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

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.

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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 Continental American Insurance Company can help protect you and your family against the additional, undesirable expenses associated with certain accidents.

PLAN FEATURES

- 24-Hour Coverage
- Specified injury and medical fee benefits
- Accidental death 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

(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)

Lacerations

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

Services

Air Ambulance	\$300
Ambulance	\$100
Blood/Plasma	\$100

Hospital Admission (per accident) \$250

Hospital Confinement (up to 90 days) \$125 per day

Medical Fees

(up to \$200 per accident subject to the following internal limits)

X-ray	\$75
Doctor Office Visit	\$75
Appliances	\$75
Emergency Room Treatment (up to)	\$200

Accidental Death and Dismemberment*

Single Dismemberment	\$5,000
Accidental Death or Double Dismemberment	\$10,000
Accidental Death (common carrier)	\$20,000

*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...

- In 2003, about 23.8 million people - about 1 out of 12 - sought medical attention for an injury*
- The economic impact of these fatal and non-fatal unintentional injuries amounted to 574.8 billion dollars in 2004. This is the equivalent to about \$2,000 per capita, or about \$5,100 per household*

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 2005-2006*

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 loss, injury, or death contributed to, caused by or resulting from:

1. War - Participating in war or any act of war, declared or not, or participating in the armed forces of or contracting with any country or international authority. We will return the prorated premium for any period not covered by this certificate when you are in such service.
2. Suicide - Committing or attempting suicide, while sane or insane.
3. Self-Inflicted Injuries - Injuring or attempting to injure yourself intentionally.
4. Traveling - Traveling more than 40 miles outside the territorial limits of the United States, Canada, Mexico, Puerto Rico, The Bahamas and Virgin Islands, Bermuda and Jamaica, except under the Accidental Common Carrier Death Benefit.
5. Racing - Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.
6. Aviation - Operating, learning to operate, serving as a crew member on, or jumping or falling from any aircraft, including those which are not motor-driven.
7. Illegal Acts - Participating or attempting to participate in an illegal activity or working at an illegal job.
8. Sports - Participating in any organized sport; professional or semi-professional.
9. Intoxication - Being legally intoxicated or under the influence of any narcotic, unless taken on the advice of a physician.
10. Sickness - Having any disease or bodily/mental illness or degenerative process. We also will not pay benefits for any related medical/surgical treatment or diagnostic procedures for such illness.

Termination of the Certificate

An Employee's insurance will terminate on the earliest of:

1. the date the Plan is terminated;
2. on the 31st day after the premium due date if the required premium has not been paid;
3. on the date an Employee ceases to meet the definition of an Employee as defined in the Plan;
4. on the premium due date which falls on or first follows the Employee's 70th birthday; or
5. on the date he or she is no longer a member of the class eligible.

Pre-existing Condition Limitation

No payment will be made for a loss due to a pre-existing condition if the loss begins within 12 months from the Effective Date of this certificate or attached riders, as applicable. A claim for benefits for loss starting after 12 months from the Effective Date of this certificate or attached riders, as applicable, will not be reduced or denied on the grounds that it is caused by a pre-existing condition unless it is excluded by name or specific description in this certificate or attached riders, as applicable.

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.

Pre-existing Condition

Pre-existing Condition means the 12 month period prior to the Effective Date of this Certificate and attached riders as applicable; an injury, a sickness or physical condition for which medical advice or treatment was recommended or received.

Group Critical Illness Insurance Plan

The Group Critical Illness plan, underwritten by Continental American Life Insurance 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 Verterbrobasilar 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.

Group Supplemental Hospital Indemnity BASIC Plan

Benefits Include Reimbursement For Visits To A Physician's Office For Sickness Or Annual Wellness Exam

Individual, comprehensive major medical health insurance can be expensive and beyond the means of many people. Although there are several 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 baby care that are not covered.

Continental American Insurance Company offers a Group Supplemental Hospital Indemnity Plan. This plan is a limited benefit insurance program designed to provide reimbursement for common medical services such as doctor's office visits, emergency room treatment for sickness or accidents as well as hospital confinement and surgical cash benefits.

BASIC PLAN FEATURES

- No Deductibles or Co-Pays - See any doctor!
- Benefits available for entire family
- 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

**UP TO \$200
PER SICKNESS**

Out-patient Doctor's Office for Sickness*

This benefit is payable for treatment received in an out-of-hospital facility (including a physician's office) due to a covered sickness up to the maximum amount shown.

**UP TO \$150
PER YEAR**

Wellness Benefit

This benefit is payable for an annual wellness visit to a physician or screening test.

**UP TO \$200
PER SICKNESS**

Out-Patient Emergency Room Benefit for Sickness*

This benefit is payable for treatment received in a hospital emergency room, or outpatient facility, including X-Rays and lab tests.

* The total amount payable for treatment of one sickness will not exceed the amount of the out-patient emergency room benefit per sickness. During a calendar year, a family may receive benefits up to the maximum amount per family. Maximum combined benefits per family per calendar year is \$2,000. Maximum calendar year benefits for employee only coverage is \$1,000.

\$50 PER VISIT

Well Baby Care (Available with Children or Family Coverage)

Pays for up to 4 visits per year per insured baby (dependent child 12 months or younger).

**\$400 PER DAY
PER ACCIDENT
\$200 PER DAY
PER SICKNESS**

Daily Hospital Confinement Benefit

This benefit will be paid when you are admitted to a hospital and confined as a resident bed patient because of injuries received in a covered accident or because of a covered sickness. Benefits begin the first day of confinement and continue for a period up to 180 days. Confinement due to covered accident must begin within 6 months of the date of the covered accident.

\$500

Hospital Admission Benefit

This benefit is payable when you are admitted to a hospital and confined as a resident bed patient because of injuries received in a covered accident or because of a covered sickness. This benefit will be paid once for each covered accident or covered sickness. This benefit is paid in addition to the Daily Hospital Confinement Benefit. Admission due to covered accident must be within 6 months of the date of the covered accident.

\$600 PER DAY

Intensive Care Benefit

This 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 20 days per confinement. This benefit is paid in addition to the Daily Hospital Confinement Benefit. Confinement due to accident must begin within 6 months of the covered accident.

SEE MORE INFORMATION
ON REVERSE SIDE

The Benefit Alliance Plan

 Leslie & Associates, Inc.

**UP TO \$300
PER ACCIDENT**

**UP TO \$3,000
BASED ON THE
SCHEDULE OF
OPERATIONS**

SCREENING TESTS

Emergency Accident

This benefit is payable if you are injured and receive initial emergency medical treatment within 72 hours of the covered accident by a Physician. We will pay up to the maximum amount of \$300 per accident, subject to the following internal limits.

Physician Charges	up to \$300.00
Emergency Room	up to \$300.00
Appliances	\$25.00
X-Rays	\$50.00

Surgical & Anesthesia Benefits

Surgical – Pays the amount shown on the schedule of operations for surgery performed by a Physician in a Hospital (on an in-patient or out-patient basis), in an Ambulatory Surgical Center, or in a Physician's office if due to a covered injury or sickness.

Anesthesia – Pays 25% of the surgery benefits for anesthesia administered by a Physician in connection with such surgical procedures.

Screening Test Benefits

Mammogram – Pays \$120 once between the ages of 35-39; once every two years for insured over the age of 40 (unless prescribed more frequently by a doctor); once every year for insured age 50 or older; and at least once per year or as recommended by a physician for any insured who has a personal history of biopsy-proven benign breast disease or breast cancer, a family (mother, sister, daughter) history of breast cancer or who has not given birth prior to age 30.

Pap Smear – Pays \$30 once per calendar year or more frequently if recommended by the insured's doctor.

Prostate Specific Antigens (PSA) Test – Pays \$30 when recommended by the insured's physician.

MONTHLY PREMIUMS

Employee Only	\$ 82.53
Employee & Spouse	\$ 169.04
Employee & Children	\$ 143.16
Family	\$ 232.68

Limitations and Exclusions

1. War – participating in war or any act of war, declared or not, or participating in the armed forces of or contracting with any country or international authority. We will return the pro-rated premium not covered by this certificate when you are in such service.
2. Traveling – traveling more than 40 miles outside the territorial limits of the United States, Canada, Mexico, Puerto Rico, the Bahamas, Virgin Islands, Bermuda, and Jamaica.
3. Self-Inflicted Injuries – injuries or attempting to injure yourself intentionally.
4. Illegal Acts – participating or attempting to participate in an illegal activity, or working at an illegal job.
5. Intoxication – being legally intoxicated or being under the influence of any narcotic, unless such is taken under the direction of a physician.
6. Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including complications.
7. Services performed by a relative.
8. Services related to sex change, sterilization, in vitro fertilization, reversal of a vasectomy or tubal ligation.
9. Elective abortion.
10. Injury or sickness for which benefits are paid or payable by Worker's Compensation.
11. Cosmetic surgery, except when due to medically necessary reconstructive plastic surgery.

Pre-existing Condition Limitation

If the employee or dependent has a Pre-existing Condition, we will not pay benefits for any claim or loss starting within 12 months of the effective date of the employee or dependent coverage, that is due to such Pre-existing Condition.

A claim for benefits starting after 12 months from the Effective Date of the employee's or dependent's coverage will not be reduced or denied on the grounds that it is caused by a Pre-existing Condition.

Pre-existing condition means those conditions for which medical advice, diagnosis, care or treatment were received or recommended within the 12 month period prior to the Effective Date of an insured's coverage.

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

Group Supplemental Hospital Indemnity PREMIER Plan

Benefits Include Reimbursement For Visits To A Physician's Office For Sickness Or Annual Wellness Exam

Individual, comprehensive major medical health insurance can be expensive and beyond the means of many people. Although there are several 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 baby care that are not covered.

This limited benefit insurance program is designed to provide reimbursement for common medical services such as doctor's office visits, emergency room treatment for sickness or accidents as well as hospital confinement and surgical cash benefits. The Premier Plan offered by Continental American Insurance Company provides access to network providers, enhanced hospital daily benefits and extra health care benefits. The goal is to make your insured health care benefits go further and provide additional beneficial health care services.

PREMIER PLAN FEATURES

- No Deductibles or Co-Pays - See any doctor!
- Access to National Provider Networks - Reduce your health care costs and maximize your benefits. Minimum 20% guaranteed savings for office visits to network providers
- Includes Patient Concierge Services
- Karis Group Patient Advocacy Benefits
- Provides benefits for non-occupational injury or sickness and an annual wellness visit
- Pregnancy is covered same as sickness

**UP TO \$200
PER VISIT**

Out-patient Doctor's Office for Sickness*

This benefit is payable for treatment received in an out-of-hospital facility (including a physician's office) due to a covered sickness up to the maximum amount shown.

**UP TO \$150
PER YEAR**

Wellness Benefit

This benefit is payable for an annual wellness visit to a physician or for a screening test listed in the policy.

**UP TO \$200
PER SICKNESS**

Out-Patient Emergency Room Benefit for Sickness*

This benefit is payable for treatment received in a hospital emergency room, or outpatient facility, including X-Rays and lab tests.

* The total amount payable for treatment of one sickness will not exceed the amount of the out-patient emergency room benefit per sickness. During a calendar year, a family may receive benefits up to the maximum amount per family. Maximum combined benefits per family per calendar year is \$2,000. Maximum calendar year benefits for employee only coverage is \$1,000.

\$50 PER VISIT

Well Baby Care (Available with Children or Family Coverage)

Pays for up to 4 visits per year per insured baby (dependent child 12 months or younger).

**\$800 PER DAY
PER ACCIDENT
\$600 PER DAY
PER SICKNESS**

Daily Hospital Confinement Benefit

This benefit will be paid when you are admitted to a hospital and confined as a resident bed patient because of injuries received in a covered accident or because of a covered sickness. Benefits begin the first day of confinement and continue for a period up to 30 days. Confinement due to covered accident must begin within 6 months of the date of the covered accident.

\$500

Hospital Admission Benefit

This benefit is payable when you are admitted to a hospital and confined as a resident bed patient because of injuries received in a covered accident or because of a covered sickness. This benefit will be paid once for each covered accident or covered sickness. This benefit is paid in addition to the Daily Hospital Confinement Benefit. Admission due to covered accident must be within 6 months of the date of the covered accident.

\$800 PER DAY

Intensive Care Benefit

This 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. Confinement due to accident must begin within 6 months of the covered accident.

SCREENING TESTS

Screening Test Benefits

Mammogram – Pays \$120 once between the ages of 35-39; once every two years for an insured over the age of 40 (unless prescribed more frequently by a doctor); once every year for an insured age 50 or older; and at least once per year or as recommended by a physician for any insured who has a personal history of biopsy-proven benign breast disease or breast cancer, a family (mother, sister, daughter) history of breast cancer or who has not given birth prior to age 30.

Pap Smear – Pays \$30 once per calendar year or more frequently if recommended by the insured's doctor.

Prostate Specific Antigens (PSA) Test – Pays \$30 when recommended by the insured's physician.

SEE MORE INFORMATION
ON REVERSE SIDE

The Benefit Alliance Plan

 Leslie & Associates, Inc.

**UP TO \$3,000
BASED ON THE
SCHEDULE OF
OPERATIONS**

**UP TO \$300
PER ACCIDENT**

Additional Non-Insurance Benefits*

***PPO NETWORK
ACCESS**

***PATIENT
CONCIERGE**

***PATIENT
ADVOCACY**

Surgical & Anesthesia Benefits

Surgical – Pays the amount shown on the schedule of operations for surgery performed by a Physician in a Hospital (on an in-patient or out-patient basis), in an Ambulatory Surgical Center, or in a Physician's office if due to a covered injury or sickness.

Anesthesia – Pays 25% of the surgery benefits for anesthesia administered by a Physician in connection with such surgical procedures.

Emergency Accident

This benefit is payable if you are injured and receive initial emergency medical treatment within 72 hours of the covered accident by a Physician. We will pay up to the maximum amount of \$300 per accident, subject to the following internal limits.

Physician Charges	up to \$300.00	Appliances	\$25.00
Emergency Room	up to \$300.00	X-Rays	\$50.00

Provider Network Access - 20% Guaranteed Savings on Physician Office Visit*

The Premier plan allows members access to a nationwide network of more than 250,000 primary care physicians and more than 4,100 hospitals who have agreed to offer eligible health care services at a network contracted rate. Members who choose to see a doctor in the network are guaranteed to save a minimum of 20% on the usual billed charges for the physician's office visit in turn making your specified insurance benefits go further. *(Some exclusions/imitations apply to 20% savings guarantee)*

Patient Concierge Services*

Members can call a dedicated toll-free number to access the personalized Patient Concierge Service. The Patient Concierge will answer any questions you may have about the networks. They will provide you with a list of participating physicians and hospitals in your area. In addition, the concierge will verify the participation of those providers before you make your appointment. This service offers members and providers the information needed to reduce confusion and maximize member savings at the time of service

Patient Advocacy from the Karis Group*

For members who find themselves unable to pay larger medical bills (in excess of \$7,500) before or after a service by any reasonable means, Karis comes alongside the member to advocate on their behalf working with the provider to provide a mutually agreeable solution. Karis' highly trained negotiators or Patient Advocates guide members through the tangled maze of medical billing and research the availability of entitlement or charity programs to help locate other sources of funding to satisfy the bill. If the member has some financial resources at their disposal, Karis will work to negotiate a settlement or payment plan with the provider that is acceptable to both the provider and the member.

- * 1. These products are not insurance.
- 2. These products provide discounts at certain health care providers for medical services.
- 3. These products do not make payments directly to providers of medical services.
- 4. The plan member is obligated to pay for all health care services but will receive a discount from those health care providers who have contracted with the network.
- 5. Providers are subject to change without notice and program may vary in some states. The non-insurance benefits may be discontinued or modified at any time.
- 6. Guarantee excludes physician fees for cosmetic, infertility, LASIK, global maternity, gastric bypass, ancillary labs & imaging and/or urgent care/hospital services.

This is only a summary of the Group Supplemental Hospital Indemnity 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.

Limitations and Exclusions

1. War – participating in war or any act of war, declared or not, or participating in the armed forces of or contracting with any country or international authority. We will return the pro-rated premium not covered by this certificate when you are in such service.
2. Traveling – traveling more than 40 miles outside the territorial limits of the United States, Canada, Mexico, Puerto Rico, the Bahamas, Virgin Islands, Bermuda, and Jamaica.
3. Self-Inflicted Injuries – injuries or attempting to injure yourself intentionally.
4. Illegal Acts – participating or attempting to participate in an illegal activity, or working at an illegal job.
5. Intoxication – being legally intoxicated or being under the influence of any narcotic, unless such is taken under the direction of a physician.
6. Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including complications.
7. Services performed by a relative.
8. Services related to sex change, sterilization, in vitro fertilization, reversal of a vasectomy or tubal ligation.
9. Elective abortion.
10. Injury or sickness for which benefits are paid or payable by Worker's Compensation.
11. Cosmetic surgery, except when due to medically necessary reconstructive plastic surgery.

Pre-existing Condition Limitation

If the employee or dependent has a Pre-existing Condition, we will not pay benefits for any claim or loss starting within 12 months of the effective date of the employee or dependent coverage, that is due to such Pre-existing Condition.

A claim for benefits starting after 12 months from the Effective Date of the employee's or dependent's coverage will not be reduced or denied on the grounds that it is caused by a Pre-existing Condition.

Pre-existing condition means those conditions for which medical advice, diagnosis, care or treatment were received or recommended within the 12 month period prior to the Effective Date of an insured's coverage.

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

PREMIER PLAN - MONTHLY RATES

Employee Only	\$ 103.54
Employee & Spouse	\$ 196.01
Employee & Children	\$ 165.00
Family	\$ 257.47

Rates include Insurance and Non-Insurance Benefits

MidMed Group Limited Benefit Medical Insurance Plan - LEVEL 1

The MidMed LEVEL 1 Group Limited Benefit Medical Insurance Plan, underwritten by Continental 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.

SPECIAL FEATURES

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

Who Can Be Covered In MidMed LEVEL 1 Medical Plan?

Employees & Spouses (ages 18-64) and dependent children under age 19 (or under age 25 if a full-time student).

DEDUCTIBLES

There are no deductibles in the MidMed Level 1 Plan.

CO-PAYS

In or Out-of-Network – you pay \$20 for each outpatient physician office visit and the Plan pays 100% of eligible expenses up to \$1,000 per calendar year per covered family member.

CO-INSURANCE

This is the amount of a covered expense that the MidMed Level 1 Plan will pay and the corresponding amount of the expense you would pay. For example, the MidMed Level 1 Plan will pay 80% of covered Inpatient Hospital Expenses and you would pay the remaining 20%.

Outpatient Eligible Expense Benefits

Physician or Specialist Office Visit for Illness, Injury, & Routine Physicals
 Outpatient Diagnostic X-Ray and Labs for Sickness or Injury
 Emergency Room Charges for Accidents
 Outpatient Surgical Expenses

\$20 Co-Pay then 100% up to \$1,000 per Calendar Year
 80% up to \$500 per Calendar Year
 100% up to \$1,500 per Calendar Year
 80% up to \$1,000 per Calendar Year

Inpatient Eligible Expense Benefits

Inpatient Hospital Expenses
 Inpatient Physician Charges
 Inpatient Surgical Expenses

80% up to \$5,000 per Calendar Year
 100% up to \$500 per Calendar Year
 80% up to \$1,000 per Calendar Year

All eligible expenses are subject to reasonable and customary limits.

Screening Tests

Mammogram - For insured women between the ages of 35 and 39 , pays \$120 for one screening mammography examination during that 5-year period; for insured women ages 40 or older, pays \$120 for one screening mammography examination every calendar year.

Pap Smear - Pays \$30 once per calendar year or more frequently if recommended by the insured’s doctor.

Prostate Specific Antigens (PSA) Test - Pays \$30 once per calendar year or more frequently if recommended by the insured’s doctor.

Outpatient Prescription Drugs

The Plan includes a separate Co-pay plan for outpatient prescription drugs purchased at participating pharmacies. The Catalyst^{rx} plan, underwritten by Fidelity Security Life Insurance Company, 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. The preferred drug list contains generic and select brand products available at lower co-pay levels. You can visit www.catalystrx.com (click “Clients” – user name & password = CONTGP) to search for participating pharmacies and the drug information & lookup center. Please refer to the Certificate of Insurance for a complete list of exclusions and limitations.

Generic Formulary Drugs	\$10.00
Generic Oral Contraceptive	\$15.00
Brand Formulary Drug	\$50.00

(The retail dispensing limit is a 30 day supply)

Annual Maximum Rx Benefit - \$1,000 per insured

MONTHLY PREMIUMS

Employee Only	\$ 153.75
Employee & One (Spouse or Child)	\$ 279.21
Employee & Family	\$ 377.29

Premiums include Insurance, Prescription Drug and Network Access Charges

SEE MORE INFORMATION ON REVERSE SIDE

The Benefit Alliance Plan

 Leslie & Associates, Inc.

Do I Need Pre-Certification?

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 pre-certify will result in benefit reductions.

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.

Is there a Pre-existing Condition Limitation?

YES. Expenses incurred for treatment of Pre-Existing Conditions are not covered for the first 6 months following an Insured's Effective Date of coverage under the Group Policy. This limitation will **not** apply if:

- a) The individual seeking coverage under the Group Policy has an aggregate of 12 months of Creditable Coverage and becomes eligible and applies for coverage, Credit will be given for the time the individual was covered under prior Creditable Coverage that is not separated by a break in coverage of 63 days or more; or
- b) The individual accepted and used up COBRA continuation of coverage or similar state coverage if it was offered to him or her.

A newborn child, a child placed for adoption, or a newly adopted child under the age 18 who begins dependent coverage hereunder within 30 days of birth, placement for adoption, or adoption (or who has creditable coverage from birth, placement for adoption, or adoption without a significant break in coverage) shall not be considered to have any pre-existing conditions.

Pre-existing condition means a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 month period prior to the enrollment date. 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. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended or received from an individual licensed or similarly authorized to provide such services under state law and who operates within the scope of practice authorized by the state law.

CREDIT FOR PRIOR COVERAGE: An insured whose coverage under prior Creditable Coverage ended not more than 63 days before the Insured's Effective Date under the Group Policy, will have any applicable Pre-Existing Condition limitation reduced by the total number of days the Insured was covered by such coverage. If there was a break in Creditable Coverage of more than 63 days, the Company will credit only the days of such coverage after the break. The Insured must provide proof of prior Creditable Coverage.

EXCLUSIONS AND LIMITATIONS - The following are not Eligible Expenses and will not be covered under the Group Policy:

1. Injury arising out of or in the course of employment, or activity for wage or profit, or which is compensable under Worker's Compensation or Occupational Disease Act or Law.
2. Experimental or investigational services, drugs, or supplies except to the extent required by law;
3. Educational testing or training related to learning disabilities or developmental delays;
4. Custodial care or personal items;
5. Any expense incurred before the Insured's Effective Date of coverage under the Policy or after the coverage termination date;
6. Eye surgery to correct refractive errors;
7. Therapy, supplies or counseling for sexual dysfunctions;
8. Performance, or lifestyle enhancement drugs or supplies;
9. Artificial insemination, in vitro fertilization, or embryo transfer or any related procedures except where required by law;
10. Routine physical, vision, or hearing exams, immunizations, or other preventative services or supplies, except to the extent that coverage is specifically provided under the Group Policy.
11. Dental care except for Injury to sound, natural teeth;
12. Elective Surgery;
13. Cosmetic Surgery other than Reconstructive Surgery incidental to or following surgery resulting from trauma, infection, or other Diseases of the involved part; or Reconstructive Surgery because of a congenital Disease or anomaly; or according to the requirements of the Women's Health and Cancer Rights Act.
14. Speech therapy except as otherwise specifically covered under the Group Policy;
15. Inpatient or outpatient treatment of alcoholism, drug abuse, and mental illnesses; except where required by law;
16. Private duty nursing;
17. An Injury sustained while the Insured is legally intoxicated or under the influence of alcohol as defined by the jurisdiction where the Accident occurred;
18. Charges made to treat a Sickness or Injury sustained while flying as a pilot or crew member;
19. Voluntary sterilization procedure or the reversal of a sterilization procedure;
20. Weight control services including surgical procedures, medical treatments, weight control/loss programs, food supplements, exercise programs or equipment;
21. Intentionally self inflicted injury or action unless the result of a medical condition;
22. War (declared or undeclared) or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence.
23. Services and supplies not medically necessary, recommended or approved by a physician for the diagnosis, care or treatment of any Disease or Injury;
24. Charges made for: manipulative (adjustive) treatment; or treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine;
25. Prescription drugs and medicines prescribed by a physician on an outpatient basis;
26. Charges in excess of the Recognized Charge, based on the 90th percentile of the Medicode Medical Data Research Tables;
27. Charges for any treatment received while in a skilled nursing facility;
28. Charges for any treatment for Home Health Care, except as covered under maternity;
29. Transportation charges, including ambulatory services;
30. Charges for biofeedback;
31. Any treatment received under hospice care;
32. Elective or voluntary abortions except in the case of rape, incest or congenital deformities;
33. Charges for Prosthetics and/or orthotics;
34. Charges for Temporomandibular Joint Disorder (TMJ).

This is only a summary of the Continental American MidMed Limited Benefit Medical Insurance & Fidelity Security Life CatalystRx 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.

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

MidMed Group Limited Benefit Medical Insurance Plan - LEVEL 2

The MidMed LEVEL 2 Group Limited Benefit Medical Insurance Plan, underwritten by Continental American Insurance Company, is designed to provide more coverage than most other limited benefit plan choices. It offers many of the same features of a comprehensive insurance plan at a more affordable cost.

SPECIAL FEATURES

- PHCS PPO Network
- Co-Pays for Physician Office Visits & Routine Physicals
- Hospital & Surgical Benefits

Who Can Be Covered In MidMed LEVEL 2 Medical Plan?

Employees & Spouses (ages 18-64) and dependent children under age 19 (or under age 25 if a full-time student).

What Are The Medical Benefits And How Do They Work?

DEDUCTIBLES

You pay the Calendar Year Plan Deductible – \$250 for each insured to a maximum of \$750 per family. Deductible applies to all expenses except Physician Office visits and Supplemental Accident Benefits.

CO-PAYS

Network Physician/Specialist Office Visit - \$20 Co-Pay & the Plan pays 100% of eligible expenses*
 Out-of Network Physician/Specialist Office Visit - \$40 Co-Pay & the Plan pays 80% of eligible expenses*
(Co-Pay does not apply to other services rendered in the physician's office)

PLAN MAXIMUMS

Annual Plan Maximum - \$25,000 per Insured and \$75,000 per Family
 Lifetime Plan Maximum - \$100,000 per Insured and \$300,000 per Family

Outpatient Expense Benefits

Physician or Specialist Office Visit for Illness & Injury
 Routine Physical Exams, Pap Smear, Mammogram, PSA Tests
(includes all related charges up to \$500 Calendar Year Benefit)
 Outpatient Diagnostic X-Ray, CAT Scan, MRI and Lab
 Other Services Provided During Office Visits
 Outpatient Surgery/Anesthesia Services
 Urgent Care Facility
 Emergency Room (if not admitted as in-patient)
 Supplemental Accident Benefit (is not subject to deductible)

Cardiac, Occupational, Physical, Pulmonary & Speech Therapies
 and Chiropractic Services *(subject to 10 visits per category per Calendar Year per insured)*

Inpatient Expense Benefits

Hospital Inpatient Room & Board, Intensive Care Unit
 Operating Room, Recovery Room
 Professional Fees of Doctors, Surgeons, and Anesthesiologists
 Other Covered Inpatient Services

Other Covered Services

Transplant-Related Expenses
 Maternity Care (Employee & Covered Spouse Only)

In-Network

\$20 Co-pay then 100%
 \$20 Co-pay then 100%
 80%
 80%
 80%
 80%
 \$100 Co-pay then 80%
 First \$400 per Accident is paid in full, then 80%
 80%
 80%
 80%
 80%
 80%

Out-of-Network

\$40 Co-pay then 80%
 \$40 Co-pay then 80%
 60%
 60%
 60%
 60%
 \$100 Co-pay then 60%
 First \$400 per Accident is paid in full, then 60%
 60%
 60%
 60%
 60%
 60%

The percentages shown are paid for eligible expenses AFTER you pay the deductible unless otherwise noted. *Expenses are subject to reasonable and customary limits.

What about Outpatient Prescription Drugs?

The Plan includes a separate Co-pay plan for outpatient prescription drugs purchased at participating pharmacies. The CatalystRx plan, underwritten by Fidelity Security Life Insurance Company, 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. The preferred drug list contains generic and select brand products available at lower co-pay levels. You can visit www.catalystrx.com (click "Clients" – user name & password = CONTGP) to search for participating pharmacies and the drug information & lookup center. Please refer to the Certificate of Insurance for a complete list of exclusions and limitations.

Generic Formulary Drugs	\$10.00
Generic Oral Contraceptive	\$15.00
Brand Formulary Drug	\$50.00

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

MONTHLY PREMIUMS

Employee Only	\$280.73
Employee & One (Spouse or Child)	\$516.73
Employee & Family	\$702.63

Premiums include Insurance, Prescription Drug and Network Access Charges

SEE MORE INFORMATION ON REVERSE SIDE

The Benefit Alliance Plan



Do I Need Pre-Certification?

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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.

Is there a Pre-existing Condition Limitation?

YES. Expenses incurred for treatment of Pre-Existing Conditions are not covered for the first 6 months following an Insured's Effective Date of coverage under the Group Policy. This limitation will **not** apply if:

- a) The individual seeking coverage under the Group Policy has an aggregate of 12 months of Creditable Coverage and becomes eligible and applies for coverage, Credit will be given for the time the individual was covered under prior Creditable Coverage that is not separated by a break in coverage of 63 days or more; or
- b) The individual accepted and used up COBRA continuation of coverage or similar state coverage if it was offered to him or her.

A newborn child, a child placed for adoption, or a newly adopted child under the age 18 who begins dependent coverage hereunder within 30 days of birth, placement for adoption, or adoption (or who has creditable coverage from birth, placement for adoption, or adoption without a significant break in coverage) shall not be considered to have any pre-existing conditions.

Pre-existing condition means a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 month period prior to the enrollment date. 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. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended or received from an individual licensed or similarly authorized to provide such services under state law and who operates within the scope of practice authorized by the state law.

CREDIT FOR PRIOR COVERAGE: An insured whose coverage under prior Creditable Coverage ended not more than 63 days before the Insured's Effective Date under the Group Policy, will have any applicable Pre-Existing Condition limitation reduced by the total number of days the Insured was covered by such coverage. If there was a break in Creditable Coverage of more than 63 days, the Company will credit only the days of such coverage after the break. The Insured must provide proof of prior Creditable Coverage.

EXCLUSIONS AND LIMITATIONS - The following are not Eligible Expenses and will not be covered under the Group Policy:

1. Injury arising out of or in the course of employment, or activity for wage or profit, or which is compensable under Worker's Compensation or Occupational Disease Act or Law.
2. Experimental or investigational services, drugs, or supplies except to the extent required by law;
3. Educational testing or training related to learning disabilities or developmental delays;
4. Custodial care or personal items;
5. Any expense incurred before the Insured's Effective Date of coverage under the Policy or after the coverage termination date;
6. Eye surgery to correct refractive errors;
7. Therapy, supplies or counseling for sexual dysfunctions;
8. Performance, or lifestyle enhancement drugs or supplies;
9. Artificial insemination, in vitro fertilization, or embryo transfer or any related procedures except where required by law;
10. Routine physical, vision, or hearing exams, immunizations, or other preventative services or supplies, except to the extent that coverage is specifically provided under the Group Policy.
11. Dental care except for Injury to sound, natural teeth;
12. Elective Surgery;
13. Cosmetic Surgery other than Reconstructive Surgery incidental to or following surgery resulting from trauma, infection, or other Diseases of the involved part; or Reconstructive Surgery because of a congenital Disease or anomaly; or according to the requirements of the Women's Health and Cancer Rights Act.
14. Speech therapy except as otherwise specifically covered under the Group Policy;
15. Inpatient or outpatient treatment of alcoholism, drug abuse, and mental illnesses; except where required by law;
16. Private duty nursing;
17. An Injury sustained while the Insured is legally intoxicated or under the influence of alcohol as defined by the jurisdiction where the Accident occurred;
18. Charges made to treat a Sickness or Injury sustained while flying as a pilot or crew member;
19. Voluntary sterilization procedure or the reversal of a sterilization procedure;
20. Weight control services including surgical procedures, medical treatments, weight control/loss programs, food supplements, exercise programs or equipment;
21. Intentionally self inflicted injury or action unless the result of a medical condition;
22. War (declared or undeclared) or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence.
23. Services and supplies not medically necessary, recommended or approved by a physician for the diagnosis, care or treatment of any Disease or Injury;
24. Charges made for: manipulative (adjustive) treatment; or treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine;
25. Prescription drugs and medicines prescribed by a physician on an outpatient basis;
26. Charges in excess of the Recognized Charge, based on the 90th percentile of the Medicode Medical Data Research Tables;
27. Charges for any treatment received while in a skilled nursing facility;
28. Charges for any treatment for Home Health Care, except as covered under maternity;
29. Transportation charges, including ambulatory services;
30. Charges for biofeedback;
31. Any treatment received under hospice care;
32. Elective or voluntary abortions except in the case of rape, incest or congenital deformities;
33. Charges for Prosthetics and/or orthotics;
34. Charges for Temporomandibular Joint Disorder (TMJ).

This is only a summary of the Continental American MidMed Limited Benefit Medical Insurance & Fidelity Security Life CatalystRx 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.

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

Limited Benefit Medical Insurance underwritten by Continental American Insurance Company - Applicable to CA11000KELLY
Outpatient Prescription Drug Plan underwritten by Fidelity Security Life Insurance Company - Policy Form Nos. M-9022/M-9031

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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 ActivaScrips – 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 ActivaScrips. This program allows individuals to keep the cost of their prescription drugs at affordable levels. This is not an insurance plan.

Benefit Alliance ActivaScrips 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 ActivaScrips 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

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 Supplemental Hospital Indemnity Plan – BASIC or PREMIER PLANS** – 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 group hospital and medical indemnity plan benefits will be subject to this clause.**
- 11) **Group MID MED Limited Benefit Medical Insurance – Level 1 or Level 2** – Choose one of the plans listed (they include the CatalystRx prescription drug plan) by checking the appropriate box and fill in the corresponding monthly premium line of the enrollment form. **Read the Pre-Existing and Plan Limitation clause. You must sign and date where indicated acknowledging you understand and agree that the Mid Med Plan benefits will be subject to this clause before coverage can be issued.**

See Reverse Side

- 12) **Short Term Major Medical Plan** – You must call Leslie & Associates Customer Service (1-800-644-6854) for a personalized quote. (*this product is not available in NY, NJ, MA, VT*)
- 13) **Individual Major Medical Plans** – You must call Leslie & Associates Customer Service (1-800-644-6854) for a personalized quote. (*products not available in HI, ID, MA, ME, MN, MT, ND, NH, NJ, NY, OR, RI, VT*)
- 14) **Critical Illness Plan** – You must complete the enclosed *separate* Continental American Insurance Co. Application Form #CAIC01-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 CAIG Application Form must be signed and dated to be complete. Fill in the insurance amount(s) you chose and the corresponding monthly premium on your Benefit Alliance Enrollment Form. Return the completed application form with your Enrollment Form in the envelope provided.
- 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 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. Central Standard Time.

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.**

GROUP SUPPLEMENTAL HOSPITAL INDEMNITY PLAN - BASIC PLAN

- Employee Only \$ 82.53 per month
- Employee & Spouse \$ 169.04 per month
- Employee & Children \$ 143.16 per month
- Employee & Family \$ 232.68 per month

Monthly Premium _____

Do you understand and agree that no benefits are payable for injury or loss during the 12 months after the effective date of coverage or from 12 months from the date medical care, treatment, or supplies were received for the pre-existing condition, whichever is less, which is caused by, contributed to by, or resulting from a pre-existing condition? A pre-existing condition means within the 12-month period prior to the effective date of the certificate and attached riders, as applicable; a condition for which medical advice, diagnosis, care or treatment was recommended or received. Yes No

GROUP SUPPLEMENTAL HOSPITAL INDEMNITY PLAN - PREMIER PLAN

- Employee Only \$ 103.54 per month
- Employee & Spouse \$ 196.01 per month
- Employee & Children \$ 165.00 per month
- Employee & Family \$ 257.47 per month

Monthly Premium _____

Do you understand and agree that no benefits are payable for injury or loss during the 12 months after the effective date of coverage or from 12 months from the date medical care, treatment, or supplies were received for the pre-existing condition, whichever is less, which is caused by, contributed to by, or resulting from a pre-existing condition? A pre-existing condition means within the 12-month period prior to the effective date of the certificate and attached riders, as applicable; a condition for which medical advice, diagnosis, care or treatment was recommended or received. Yes No

ACTIVASCRIPTS PRESCRIPTION DRUG CO-PAY PLAN

- Employee Only \$ 17.73 per month
- Employee & Spouse \$ 35.47 per month
- Employee & Children \$ 26.76 per month
- Employee & Family \$ 44.34 per month

Monthly Premium _____

MID MED - GROUP LIMITED MEDICAL INSURANCE

- | | <i>Level 1</i> | <i>Level 2</i> |
|-------------------|----------------------------------------------|----------------------------------------------|
| Employee Only | <input type="checkbox"/> \$ 153.75 per month | <input type="checkbox"/> \$ 280.73 per month |
| Employee Plus One | <input type="checkbox"/> \$ 279.21 per month | <input type="checkbox"/> \$ 516.73 per month |
| Employee & Family | <input type="checkbox"/> \$ 377.29 per month | <input type="checkbox"/> \$ 702.63 per month |

Monthly Premium _____

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 provider within the 6 month period immediately preceding the effective date of coverage. A pregnancy that exists on the day before the effective date of coverage will be considered a pre-existing condition. The Med-Med Plan is group insurance underwritten by Continental American Insurance Company and the benefits will vary depending on the plan selected. I understand the policy is subject to exclusions, limitations and a reduced annual and life time limit - it is not designated as a substitute for basic health insurance or major medical coverage. The limitations are disclosed in the enrollment materials, policy and certificate which are made available at the time of enrollment. I acknowledge I have read this notice and understand coverage cannot be processed unless this form is signed and dated here:

Required Signature for Mid Med Plan: _____ Date: _____

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)

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*

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

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.

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.

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

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"/> Critical Illness Plan	\$ _____
<input type="checkbox"/> Supplemental Hospital Indemnity Plan - Basic or Premier	\$ _____
<input type="checkbox"/> Mid Med Limited Benefit Medical Insurance - Level 1 or Level 2	\$ _____
<input type="checkbox"/> Accident Plan	\$ _____
<input type="checkbox"/> ActivaScripts Prescription Drug Co-Op Plan	\$ _____
<input type="checkbox"/> Vision Care 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.

**YOU MUST ATTACH VOIDED
 CHECK OR COPY OF VOIDED
 CHECK HERE**

STAPLE OR TAPE SAMPLE (VOID) CHECK HERE FOR CODING PURPOSES
 WITH THE FINANCIAL INSTITUTION'S NAME AND ADDRESS

FOR SIS USE ONLY:

INDICATE WHICH TYPE OF ACCOUNT

Type of Account	<input type="checkbox"/> Checking	<input type="checkbox"/> Savings
Transit Routing Numbers	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Bank Account Number	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

SIS WILL WRITE IN ROUTING AND
 ACCOUNT NUMBER

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:

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

CAIC01-SI-KS

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**

AUTHORIZATION: I hereby authorize any legally licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution, or person, that has any medical or non-medical record or knowledge of me, or members of my family for whom application has been made, to give Continental American Insurance Company any such information. A photographic copy of the authorization shall be as valid as the original. I hereby authorize all said sources, except the Medical Information Bureau, to give such records or knowledge to Equifax, Inc. This agency is employed by Continental American Insurance Company to collect and send such information.

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> _____	

CAIC01-SI-KS

DISCLOSURE NOTICE CONCERNING THE MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. Continental American Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim of benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is P.O. Box 105, Essex Station, Boston, Massachusetts, 02112, Telephone Number (617) 426-3660.

Continental American Insurance Company may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.