

PROPOSAL DEADLINE 6/22/2011 - 10:00 AM CST

# Voluntary Insurance RFP # A06-011

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Aubrey Independent School District

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REQUEST FOR PROPOSAL; PROPOSAL INSTRUCTIONS; GENERAL CONDITIONS AND  
SPECIFICATIONS/REQUIREMENTS FOR:  
FULLY INSURED DENTAL INSURANCE PLANS, DISCOUNT DENTAL PLANS, VOLUNTARY VISION INSURANCE  
PLANS, CANCER INSURANCE PLANS, ACCIDENT INSURANCE PLANS, CRITICAL ILLNESS INSURANCE PLANS,  
DISABILITY INSURANCE PLANS, VOLUNTARY TERM LIFE/AD&D INSURANCE PLANS, SECTION 125  
ADMINISTRATION AND FLEXIBLE SPENDING ACCOUNTS

June 22, 2011

## **NOTICE TO PROPOSERS**

**Proposal Deadline: June 22, 2011 – 10:00 AM CST**

**Voluntary Insurance RFP # A06-011:**

Fully Insured Dental Insurance Plans, Discount Dental Plans, Voluntary Vision Insurance Plans, Cancer Insurance Plans, Accident Insurance Plans, Critical Illness Insurance Plans, Disability Insurance Plans, Voluntary Term Life/AD&D Insurance Plans, Section 125 Administration and Flexible Spending Accounts

**All proposals must be sealed and addressed to Kyle James, Benefit Consultant at 2121 N. Glenville Drive in Richardson, Texas 75082.**

Proposals will not be publicly opened.

**All proposals must be plainly marked on the outside of the sealed envelope as follows:**

**Voluntary Insurance RFP # A06-011 for:**  
Voluntary Insurance Plans

**Attention: Do not open until 10:00 AM CST – June 22, 2011**

Any proposal received later than the specified time, whether delivered in person or by mail, shall be disqualified.

Proposals may be submitted on any/or all items unless stated otherwise. The District reserves the right to reject any/all proposals and to accept any proposal deemed most advantageous to the Aubrey Independent School District and to waive any formalities in the proposal process.

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Kyle James  
Benefit Consultant

June 22, 2011

**Voluntary Insurance RFP # A06-011 for:** Fully Insured Dental Insurance Plans, Discount Dental Plans, Voluntary Vision Insurance Plans, Cancer Insurance Plans, Accident Insurance Plans, Critical Illness Insurance Plans, Disability Insurance Plans, Voluntary Term Life/AD&D Insurance Plans, Section 125 Administration and Flexible Spending Accounts

### **Aubrey Independent School District**

You are hereby invited by Aubrey Independent School District to submit a proposal for Fully Insured Dental Insurance Plans, Discount Dental Plans, Voluntary Vision Insurance Plans, Cancer Insurance Plans, Accident Insurance Plans, Critical Illness Insurance Plans, Disability Insurance Plans, Voluntary Term Life/AD&D Insurance Plans, Section 125 Administration and Flexible Spending Accounts.

Proposals will be accepted at 2121 N. Glenville Drive in Richardson, Texas 75082 at 10:00 AM CST on June 22<sup>nd</sup>, 2011. The enclosed Proposal Response Form must be used to record and submit your Proposal. It and any other requested information shall be submitted within a sealed envelope clearly marked with **"Voluntary Insurance RFP #A06-011"** Fully Insured Dental Insurance Plans, Discount Dental Plans, Voluntary Vision Insurance Plans, Cancer Insurance Plans, Accident Insurance Plans, Critical Illness Insurance Plans, Disability Insurance Plans, Voluntary Term Life/AD&D Insurance Plans, Section 125 Administration and Flexible Spending Accounts.

### **STANDARD TERMS & CONDITIONS**

- 1) The Invitation to Propose terms and conditions, the specifications, the received proposal, and the subsequent Board Approval from the contract and they shall be fully part of the contract, as if thereto attached, or therein repeated. These documents represent the entire agreement between the successful proposer and the District and supersede any prior discussions or negotiations, representations or agreements, either written or oral.
- 2) Proposers are cautioned to read this invitation carefully, to complete all entries, and submit all documents or information requested. Failing to do so may be materially non-responsive and result in non-consideration of the proposal.
- 3) Prices and/or discounts submitted for this proposal will be held firm for the initial term of the contract. After the initial contract term, the District reserves the right to extend the contract for two additional one-year periods, upon the agreement of both the successful vendor and the District. Renewing the contract would imply doing so under the same terms and conditions. A price and/or discount re-determination may be considered by the District only at the anniversary date of the contract.
- 4) Proposal contracts are considered to be in force during the period stipulated by the proposal or until replaced by a subsequent proposal for the same product.
- 5) If for any fiscal year (currently September 1 thru August 31) of this contract, the Board of Trustees for any reason fails to appropriate funds for these goods, the District will notify the vendor immediately and will no longer be obligated under the contract.
- 6) The successful vendor(s) may cancel the contract only at the end of the plan year by giving the school district written notice ninety (90) days prior to the end of the plan year.
- 7) The District reserves the right to cancel a part or this entire contract at any time during the term with cause. Notification will be submitted in writing no less than sixty (60) days prior to the effective date.
- 8) Proposals received in the FBS Office after the date and time specified will not be considered. The District is not responsible for lateness or non-delivery of mail carrier, etc., and the date/time stamp in the FBS Office shall be the official time of receipt. Proposals may not be submitted or received by facsimile or email.

**June 22, 2011**

- 9) The District reserves the right to accept or reject any and all proposals and to waive any formalities or technicalities if deemed in the best interest of Aubrey Independent School District. The District also reserves the right as sole judge of quality and equality.
- 10) Proposals meeting the requirements of the Invitation to Propose shall be considered. Proposers taking exception to the specifications, or offering substitutions shall state these exceptions plainly on the proposal document.
- 11) Any interpretations, corrections, additions, or changes to the Invitation to Propose and the Specifications will be made by addenda or an amendment to the proposal. The sole issuing authority of addenda or amendment(s) shall be vested in the FBS Office. Addenda or amendment(s) will be emailed to all who are known to have received a copy of the Invitation to Propose.
- 12) No right or interest in this contract shall be assigned or delegation of any obligation made by the vendor to another vendor. Any attempted assignment or delegation by the vendor shall be wholly void and totally ineffective for all purposes.
- 13) Each Proposer, by making his proposal, represents that he has read and understands the Invitation to Propose. Failure to respond to this proposal may remove your company from future proposal notifications.
- 14) The District is exempt from payment of any Texas Sales Tax or Federal Excise Tax allowed by law.
- 15) All District's property and facilities are "drug free zones." No one may use, consume, carry, transport, or exchange tobacco, cigarettes, or illegal drugs while in a school district building or while on School District property. The proposing company and its employees shall adhere to this policy.
- 16) Each proposer must give notice to the District if a person, owner, or operator of the business has been convicted of a felony. The District may terminate a contract with a person or business if the District determines that the person or business failed to give such notice or misrepresented the conduct resulting in the conviction.
- 17) If, at any time, the vendor fails to fulfill or abide by the terms, conditions, or specifications of the contract, the District reserves the right upon written notice to the vendor to the following remedies (though not just limited to these): purchase the products elsewhere, cancel the contract, and/or award to the next qualified proposer.
- 18) Should the vendor fail to perform by providing the proposal product at the price submitted, and/or if the vendor is unable to provide the proposal product within a specified time frame, the District will recover by purchasing the product elsewhere. Damages will be assessed against the defaulting vendor for the difference between the costs paid for the product on the open market less the original proposal price, assuming the purchase price is higher than the original awarded proposal price. Damages may also be assessed for the cost of procuring the product elsewhere and expenses incurred due to the delay caused by not having the specified goods. If the open market price is less than the proposal price, damages for delay and interim substitutes may be assessed.
- 19) The Uniform Commercial Code shall govern the agreement between the seller and the District created by this proposal. Wherever the term "Uniform Commercial Code" is used, it shall be construed as meaning the Uniform Commercial Code as adopted in the State of Texas as effective and in force on the date of this agreement. Proposers are advised that all District contracts are subject to all legal requirements provided for in the Local, State, and Federal statutes.

**June 22, 2011**

- 20) Proposers shall submit all questions concerning this proposal to Kristin Roberson by facsimile to 469-385-4641 or by email at [kristinr@fbsbenefits.com](mailto:kristinr@fbsbenefits.com). A reply in the form of written addendum will be sent to all proposers known to have received an Invitation to Propose, if the answer provides clarification or will have an impact on the proposal responses.
- 21) VENDORS WHO DO NOT PROPOSE are requested to notify Aubrey Independent School District or Financial Benefit Services in writing if they wish to receive future proposals. Failure to do so may result in their being deleted from our vendor list.
- 22) EVALUATION OF PROPOSALS takes into account the following considerations: price, quality, and suitability for the intended use, probability of continuous availability, vendor's service and reputation, references and date of proposed delivery and placement. It is not the policy of Aubrey Independent School District to purchase on the basis of price alone.
- 23) By signing this proposal, a proposer affirms that he/she has not given, offered to give, nor intends to give at any time hereafter any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor or service to a public servant in connection with the proposal submitted.
- 24) By signing this proposal, a proposer affirms that, to the best of his/her knowledge, the proposal has been arrived at independently, and is submitted without collusion with anyone to obtain information or gain any favoritism that would in any way limit competition or give them an unfair advantage over other proposers in the award of this proposal.
- 25) PROPOSER SHALL NOTE any and all relationships that might be a conflict of interest and include such information with the proposal.
- 26) For an alternate product proposal item to be considered, a brochure or detailed specification must be attached to the specification price sheet explaining how the product deviates from the specifications. Aubrey Independent School District reserves the right to make final decisions as to comparable items.

## **SUBMISSIONS & EVALUATIONS**

- 1) Your proposal, in order to be considered, must include the properly executed Proposal Response Form, Felony Conviction Notification, References, Acknowledgement Form and those other items and/or attachments as specified in this proposal set. All responses must be legible and signed in order to be considered.
- 2) In evaluating proposals submitted, the following considerations will be taken into account (but not limited to): price, quality, suitability for intended use, probability of continuous availability, time of service, delivery and vendor reputation. It is not the policy of the Little Elm Independent School District to purchase on the basis of price alone. The District reserves the right to conduct any tests, evaluations or comparisons it deems necessary to complete the evaluation process.
- 3) Proposers may be required to furnish evidence in writing that they maintain a permanent and adequate place of business and have adequate equipment, finances, and personnel to furnish the products offered satisfactorily and expeditiously and that they are authorized agents and can provide the products they propose to furnish.
- 4) Vendors taking exception to the terms and conditions or specific actions of this proposal shall state the exceptions plainly on the exception page of this proposal document. If no exceptions are indicated on the submitted form, it will be assumed that your proposal complies with our document.

June 22, 2011

## **“NO PROPOSAL” RESPONSE FORM**

### **Voluntary Insurance RFP # A06-011 for:**

Fully Insured Dental Insurance Plans, Discount Dental Plans, Voluntary Vision Insurance Plans, Cancer Insurance Plans, Accident Insurance Plans, Critical Illness Insurance Plans, Disability Insurance Plans, Voluntary Term Life/AD&D Insurance Plans, Section 125 Administration and Flexible Spending Accounts

Aubrey Independent School District is interested in the reason(s) why you did not respond to our Invitation to Propose. Please fill out the information requested and return this form to Financial Benefit Services to the fax number or email address listed below:

*REASON(S) FOR NO RESPONSE - Please mark all those that apply to your circumstances.*

- ☐ Could not meet specification requirements.
- ☐ Do not supply this material or service.
- ☐ Did not have time to prepare a proposal response.
- ☐ Cannot take additional jobs due to present workload.
- ☐ Could not be price competitive.
- ☐ Could not propose due to illness.
- ☐ Could not set price with manufacturer.
- ☐ Could not meet insurance requirements.
- ☐ Could not meet bonding requirements.
- ☐ Job is too large.
- ☐ Other – Please explain: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Company

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
City/State/Zip

June 22, 2011

## PROPOSAL/OFFER FORM

**To: Aubrey Independent School District**

I, or we, the duly authorized undersigned, having carefully read the Proposal Requirements and Proposal Forms, do hereby agree to enter into a contract with the District by tendering this offer to perform the work required and/or provide the product(s) specified in this solicitation. I, or we, will deliver the product(s) per specifications found in this proposal document for the prices indicated.

I, or we, also certify to the accuracy of the certifications required (including, but not limited to, Felony Conviction Notice) which accompany this offer.

The prices in this offer have been determined independently, without consultation, communication, or agreement for the purpose of restricting competition, as to any matter related to such prices, with any other proposer or with any competitor. I, or we, are authorized to submit this offer and have not been a party to any collusion among offer/offers in restraint of freedom of competition by agreement to offer at a fixed price or to refrain from offering; or with any District employee, Board Member, or consultant as to quantity, quality, or price in the prospective contract, or in any terms of the prospective contract except in any authorized discussion(s) with the District's Purchasing personnel; or in any discussions or actions between offer/offers and any District employee, Board Member, or consultant concerning exchange of money or other things of value for special consideration in the award of this contract.

Date: \_\_\_\_\_

Name of Firm: \_\_\_\_\_

Signature: \_\_\_\_\_

Firm's Address: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

\_\_\_\_\_

Phone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

SS or Fed ID #: \_\_\_\_\_

Please complete this form and return to: Kristin Roberson (469) 385-4641 or [kristinr@fbsbenefits.com](mailto:kristinr@fbsbenefits.com).

June 22, 2011

## AFFIDAVIT

### Voluntary Insurance RFP # A06-011 for:

Fully Insured Dental Insurance Plans, Discount Dental Plans, Voluntary Vision Insurance Plans, Cancer Insurance Plans, Accident Insurance Plans, Critical Illness Insurance Plans, Disability Insurance Plans, Voluntary Term Life/AD&D Insurance Plans, Section 125 Administration and Flexible Spending Accounts

STATE OF \_\_\_\_\_)

COUNTY OF \_\_\_\_\_)

\_\_\_\_\_, of lawful age, being first duly sworn, on oath says, that (s) he is the agent authorized by the proposer to submit the attached proposal. Affiant further states that the proposer has not been a party to any collusion among proposals/proposers in restraint of freedom of competition by agreement to proposal at a fixed price or to refrain from proposing; or with any state official, District employee, Board Member, or benefit consultant as to quantity, quality, or price in the prospective contract, or any other terms of said prospective contract, or in any discussion or actions between proposals/proposers and any state official, District employee, Board Member, or benefit consultant concerning exchange of money or other things of value for special consideration in the letting of this contract.

Subscribed and sworn to before me this \_\_\_\_ day of \_\_\_\_\_, 2010.

\_\_\_\_\_  
Notary Public

State of \_\_\_\_\_

My Commission Expires: \_\_\_\_\_

Carrier/Administrator: \_\_\_\_\_

June 22, 2011

## STATEMENT OF COMPLIANCE

**RE: Aubrey Independent School District**

Please submit as a part of your proposal the following information:

We hereby acknowledge receipt of Request for Proposal for Fully Insured Dental Insurance Plans, Discount Dental Plans, Voluntary Vision Insurance Plans, Cancer Insurance Plans, Accident Insurance Plans, Critical Illness Insurance Plans, Disability Insurance Plans, Voluntary Term Life/AD&D Insurance Plans, Section 125 Administration and Flexible Spending Accounts, and certify that our proposal conforms to the RFP except as detailed below:

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\_\_\_\_\_  
Organization

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title

June 22, 2011

## FELONY CONVICTION NOTICE

Statutory citation covering notification of criminal history of contractor is found in the Texas Education Code Section 44.034. Following is an example of a felony conviction notice:

### FELONY CONVICTION NOTICE

State of Texas Legislative Senate Bill No. 1, Section 44.034, Notification of Criminal History, Subsection (a), states "a person or business entity that enters into a contract with a public entity must give advance notice to the public entity if the person or an owner or operator of the business entity has been convicted of a felony. The notice must include a general description of the conduct resulting in the conviction of a felony."

Subsection (b) states "a public entity may terminate a contract with a person or business entity if the public entity determines that the person or business entity failed to give notice as required by Subsection (a) or misrepresented the conduct resulting in the conviction. The public entity must compensate the person or business entity for services performed before the termination of the contract."

#### **THIS NOTICE IS NOT REQUIRED OF A PUBLICLY-HELD CORPORATION**

I, the undersigned agent for the firm named below, certify that the information concerning notification of felony convictions has been reviewed by me and the following information furnished is true to the best of my knowledge.

VENDOR'S NAME: \_\_\_\_\_

AUTHORIZED COMPANY OFFICIAL'S NAME (PRINTED): \_\_\_\_\_

- A. My firm is a publicly-held corporation; therefore, this reporting requirement is not applicable.

Signature of Company Official: \_\_\_\_\_

- B. My firm is not owned nor operated by anyone who has been convicted of a felony:

Signature of Company Official: \_\_\_\_\_

- C. My firm is owned or operated by the following individual(s) who has/have been convicted of a felony:

Name of Felon(s): \_\_\_\_\_

Detail of Conviction: \_\_\_\_\_

Signature of Company Official: \_\_\_\_\_

June 22, 2011

## GENERAL CONDITIONS

Proposers must complete all forms and provide all information asked for under each item. Failure to comply may result in rejection of the proposal at the District's option.

Proposals deposited with the District cannot be withdrawn prior to the time set for Proposal Deadline. Request for non-consideration of proposals must be made in writing to the Purchasing Agent and received by the District prior to the time set for opening proposals. After other proposals are opened, the proposal for which non-consideration is requested may be returned unopened. The proposal may not be withdrawn after the proposals have been opened, and the proposers, in submitting the same, warrants and guarantees that this proposal has been carefully reviewed and checked and that it is in all things true and accurate and free of mistakes and that such proposal will not and cannot be withdrawn because of any mistake or mistaken assumption of fact committed by the proposers.

Proposals will be tabulated for comparison on the basis of the proposal prices and guaranties shown in the proposal. Until final award of the Contract, the District reserves the right to reject any or all proposals, to waive technicalities, or proceed to do the work otherwise in the best interest of the District.

Proposals may be considered irregular if they show any omissions, alteration of form, additions, or conditions not called for, unauthorized alternate proposals or irregularities of any kind. However, the District reserves the right to waive any irregularities and to make the award in the best interests of the District.

The successful proposer may not assign his rights and duties under the award without the written consent from the District. Such consent shall not relieve the assignor of liability in event of default by his assignee.

Proposals will be received only at the following address:

**Financial Benefit Services  
Attn: Kyle James, Benefit Consultant  
2121 N. Glenville Drive  
Richardson, Texas 75082**

**All proposals must be at the above address by June 22, 2011 at 10:00 a.m. CST. An original and one copy must be provided.** All proposals received after the prescribed deadline, regardless of the mode of delivery, shall be returned unopened.

**Questions regarding the specifications must be faxed or e-mailed to Kristin Roberson at 469-385-4641 or emailed to kristinr@fbsbenefits.com. All questions should be submitted in writing.**

The District reserves the right to reject any or all proposals, in whole or in part, to waive any informality in any proposal, to declare inadequate or inappropriate any proposer failing to meet the specifications, and to accept the proposal which, in its discretion, is in the best interest of District.

June 22, 2011

## BACKGROUND INFORMATION

Aubrey Independent School District has approximately 280 full time employees. All full time employees and their dependents are eligible to participate in the benefits offered, including the Fully Insured Dental Insurance Plan, Discount Dental Plan, Voluntary Vision Insurance Plan, Cancer Insurance Plan, Accident Insurance Plan, Heart and Stroke Insurance Plan, Disability Insurance Plans, Section 125/403(b) Plans and Flexible Spending Accounts. The District is exploring the option of replacing all supplemental insurance products for the 2011 – 2012 plan year. Dental and Vision Insurance Plans are currently offered through Ameritas. Dental Discount Plan is currently offered through QCD. Long-Term Disability Insurance and Accident Insurance is currently offered through American Fidelity. Cancer Insurance Plans and Heart/Stroke Insurance Plans are currently offered through Allstate. A Voluntary Term Life/AD&D Insurance Plan is not currently in force, this would be implemented as a new product for the 2011-2012 plan year. All insurance is payroll deducted.

The District is soliciting proposals for Fully Insured Dental Insurance Plans, Discount Dental Plans, Voluntary Vision Insurance Plans, Cancer Insurance Plans, Accident Insurance Plans, Critical Illness Insurance Plans, Disability Insurance Plans, Base Life/AD&D Insurance Plans, Voluntary Term Life/AD&D Insurance Plans, Section 125 Administration and Flexible Spending Accounts. Commissions, fees, or other reimbursement arrangements must be disclosed. **Financial Benefit Services will be the named agent for Aubrey Independent School District and will receive commissions from the named products.**

The terms and conditions of this RFP will become part of any sub-sequent contract and in case of conflict; the terms/conditions of the RFP take precedence over the “standard” contract or binder regardless of any language to the contrary in the “standard” contract or binder.

Except as otherwise expressly provided, offeror shall defend, indemnify, and hold the District harmless from any and all claims, liability, loss and expenses, including reasonable costs, collection expenses, and attorneys’ fees, which arise by reason of the acts or omission of the offeror, its agents or employees in the performance of its obligations under the contract. This clause shall survive the termination of any contract.

Companies must accept self billing and if not must supply a monthly list billing by the 10<sup>th</sup> of the month. Changes made to the billing, including additions and terminations must be in a timely and prudent manner. Companies must agree to a 60 day grace period for premium payment.

The District shall have the right to terminate for default all of any part of this contract if proposer breaches any of the terms hereof or if the proposer becomes insolvent or files any petition in bankruptcy. Such right of termination is in addition to and not in lieu of any other remedies that the District may have in law or equity, specifically including, but not limited to the right to collect for damages or demand specific performance.

**Questions regarding the specifications must be faxed or e-mailed to Kristin Roberson at 469-385-4641 or emailed to [kristinr@fbsbenefits.com](mailto:kristinr@fbsbenefits.com). All questions should be submitted in writing. For an electronic copy of the RFP, Census or additional information in electronic format please email your request to Kristin Roberson at [kristinr@fbsbenefits.com](mailto:kristinr@fbsbenefits.com).**

June 22, 2011

## PROPOSAL SPECIFICATIONS

Recommended Time Table for Aubrey Independent School District

Mail Specifications

June 3, 2011

Proposal Deadline

June 22, 2011 - 10:00 AM CST

Proposal Analysis

June 2011

District Review

June/July 2011

Enrollment

August 2011

Effective Date

September 1, 2011

June 22, 2011

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**Section F - Critical Illness Insurance Plans**

**Section G - Disability Insurance Plans**

**Section H - Voluntary Term Life/AD&D Insurance Plans**

**Section I - Section 125 & Flexible Spending Accounts**

**Section J - Current Plan Information / Employee Census**

**June 22, 2011**

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## Section A – General Carrier Requirements

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June 22, 2011

## GENERAL CARRIER REQUIREMENTS

1) Transitional Process

The selected carrier shall be responsible for all claims incurred on/or after September 1, 2011. It is imperative that any exclusion, limitations or any other deviation be clearly outlined and discussed. A proposer is expected to explain, in detail, any limitations.

2) Commission

Commissions must be disclosed and payable to **Financial Benefit Services**.

3) Compliance with the Request for Proposal

All responses are to be prepared according to the Request for Proposal. Any item(s) your company cannot accommodate are to be disclosed in writing on the **Statement of Compliance Form**. After the District has made a commitment, the carrier/administrator will be held responsible for all items contained in the specifications.

4) Effective Date

**The effective date of the new contract(s) will be September 1, 2011.**

5) Enrollment

**The selected company or companies will responsible for reimbursing Financial Benefit Services for printing cost associated with open enrollment for benefit guides or other associated marketing materials.**

6) Plan Design

Please provide your proposal based on the current plan design. Alternative options are encouraged.

7) Quoted Rates

A minimum rate guarantee of 12 (twelve) months is required. Please confirm this guarantee in your response to the proposal and denote any additional guarantees your company may wish to extend to the District. It is the District's intent to establish a multi-year contract with the new carrier(s) provided renewal rates are acceptable and can be given within your proposal.

8) Renewal Rates

The selected carrier is required to deliver a rate proposal no later than 180 days before the anniversary date each year.

9) Ownership of Records

All records, member files and miscellaneous data necessary to administer the plan shall be the property of the District. The selected administrator will be asked to transfer records to the District within 30 days of notice of termination.

10) Master Contract

The master contract and/or summary plan descriptions shall be provided to the District no later than 30 days before effective date. Please confirm your ability to provide this service and meet the deadline in your proposal response.

**June 22, 2011**

11) Plan Changes and Amendments

If changes in the plan of benefits or servicing requirements are needed, such changes will be made in writing and deemed as an amendment to the contract. The District will review and accept or reject proposed changes.

12) Right to Audit

The District reserves the right to audit the claim records and other financial records of its insurers/providers, as they pertain to the employee benefit program whenever it is deemed appropriate. Such audits may be performed by the District's personnel or by outside auditors selected by the District. Claim data tapes/CDs may be requested for time periods of a year or more to be used in conjunction with an audit. These will be furnished within 10 calendar days of a written request at the Administrator's expense along with an applicable record file layout and/or any other file specifications deemed necessary to "read" the data on the tape/CD. The requested tape/CD will contain the data specified in the written request.

13) Data Caveat

The data contained in this section has been supplied by the District and each appropriate in-force carrier. It has been gathered and coordinated by the consultant and reviewed as to accuracy on a "best effort" manner. This request for proposal is qualified to the extent the data provided is accurate.

14) Awards

The award to the successful proposer will be based upon responses to questions outlined in these specifications and an estimate of the quality and effectiveness of each proposer's services in the following areas:

- 1) The purchase price;
- 2) The reputation of the vendor and the vendor's goods or services;
- 3) The quality of the vendor's goods or services;
- 4) The extent to which the goods or services meet the District's needs;
- 5) The vendor's past relationship with the District;
- 6) The total long-term cost to the District to acquire the vendor's goods or services;  
and
- 7) Any other relevant factor that a private business entity would consider in selecting a vendor.

**June 22, 2011**

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**Section B –Dental Insurance Plans (Fully Insured/Discount)**

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June 22, 2011

## **SECTION B – Dental Insurance Plans (Fully Insured / Discount)**

### **A. Vendor Information – Please explain in detail for each proposed plan.**

- 1) What are the full names of your Dental Insurance plan(s), the name and contact number of the person responsible for this proposal?
- 2) Who would be the District's contact regarding plan administration and customer service? Billing? Include name, address, email address, telephone number, fax number and experience for each contact.
- 3) What is the name of the network covering the plan(s) offered? Is there information located online? Provide web address.
- 4) What is the out-of-network percentage(s) of usual and customary charges?
- 5) Provide the number of providers available within 20 a mile radius of the following zip code 76227.
- 6) Is the District or benefit consultant notified if a provider has been cancelled from the network? Added to the network? Outline your policy for new provider submission.
- 7) Provide the top ten in-network ADA codes.
- 8) Outline your take-over and late entrant provisions.
- 9) The District is conducting enrollment through an online enrollment system. Will you accept an electronic identification as signature on all forms and will you accept electronic data on an ongoing basis?
- 10) Who will be the electronic data contact? Include name, address, email address, telephone and fax numbers.
- 11) What is your A.M. Best Co. rating?
- 12) Outline core covered services including waiting periods.
- 13) Outline your coverage for work in progress.
- 14) Outline how Orthodontia services are paid.
- 15) Outline covered services for implants including service category.
- 16) What is the maximum annual benefit? Is a rollover benefit offered?

**June 22, 2011**

17) Outline services covered under each option for each proposed plan(s).

i. Basic Services: \_\_\_\_\_

ii. Preventative Services: \_\_\_\_\_

iii. Major Services: \_\_\_\_\_

iv. Orthodontia Services: \_\_\_\_\_

18) Will there be a rate cap for subsequent plan years? Limiting Exclusions? Amendments? Extensions?

19) What is the participation requirement?

20) Outline benefits for Discount Only option, if proposed.

21) Provide 3 School District references that you are currently providing dental services for, including District name, contact name and telephone number.

**B. Administration Information – Please explain in detail for each proposed plan.**

- 1) Explain the process for supplying employees with I.D. Cards including turn- around time, where they will be sent and a contact phone number for replacement cards.
- 2) Is there a provider website where I.D Cards can be printed and/or ordered? Provide web address.
- 3) Do you provide an administrative portal where the administrator of the District and FBS as the benefit consultant can access reports, billing, forms and plan information?

**June 22, 2011**

### **C. District Requirements & Additional Information**

- 1) Special Note: District pays on a Bi-Weekly basis; rates must be divisible by 2.**
- 2) Aubrey Independent School District prefers multiple year rate guarantees for all plan options.
- 3) The District requires self-administered billing.
- 4) Annual maximums and deductibles should be based on calendar year not plan year.
- 5) Adult Fluoride Treatment options for adults and dependents are preferred.
- 6) Effective date of insurance should be first of the month following date of hire; termination date of insurance should be last day of the month following active employment.
- 7) Employee requirement must be actively at work for 20 or more hours a week.
- 8) Rates should include 12% level commission.
- 9) The District does not contribute to the Dental Insurance Plan, it is voluntary.
- 10) The below plan designs are required:**

**Option 1 – Fully Insured**  
**Match Current Plan Design**

**Option 2 – Discount Only**  
**Match Current Plan Design**

June 22, 2011

**D. Rate Information**

Provide a fully insured quote for Dental Insurance plan(s) by completing the following section, indicating the rates on a monthly basis for each of the following rate categories:

**Please provide quote structure in 4-Tier format.**

	<u>PPO Option 1</u>	<u>PPO Option 2</u>	<u>Discount Only Option</u>
<b>**Special Note: District pays on a Bi-Weekly basis; rates must be divisible by 2.</b>			
Employee Only	\$ _____	\$ _____	\$ _____
Employee + Spouse	\$ _____	\$ _____	\$ _____
Employee + Child(ren)	\$ _____	\$ _____	\$ _____
Employee + Family	\$ _____	\$ _____	\$ _____

**PPO Rate Guarantee:** \_\_\_\_\_

**Discount Plan Rate Guarantee:** \_\_\_\_\_

**Commission:** \_\_\_\_\_

**The below plan designs are required:**

**Option 1 – Fully Insured**  
Match Current Plan Design

**Option 2 – Discount Only**  
Match Current Plan Design

**June 22, 2011**

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## Section C – Voluntary Vision Insurance Plans

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June 22, 2011

## **SECTION C – Voluntary Vision Insurance Plans**

### **A. Vendor Information – Please explain in detail for each proposed plan.**

- 1) What are the full names of your Voluntary Vision Plan(s), the name and contact number of the person responsible for this proposal?
- 2) Who would be the District's contact regarding plan administration and customer service? Billing? Include name, address, email address, telephone number, fax number and experience for each contact.
- 3) What is the name of the network covering the plan(s) offered? Is there information located online? Provide web address.
- 4) Please provide the number of providers available within a 20 mile radius of the following zip code 76227.
- 5) Is the District or broker notified if a provider has been cancelled from the network? Added to the network? Outline your policy for new provider submission.
- 6) The District is conducting through an online enrollment system. Will you accept electronic identification as signature on all forms and will you accept electronic data on an ongoing basis?
- 7) Who will be the electronic data contact? Include name, address, email address, telephone and fax numbers.
- 8) Outline core covered services including waiting periods.
- 9) What is your A.M. Best Co. rating?
- 10) Is a discount option or Lasik benefit offered?
- 11) Will there be a rate cap for subsequent plan years? Limiting exclusions? Amendments? Extensions?
- 12) What is the participation requirement?

June 22, 2011

**B. Administrative Information – Please explain in detail for each proposed plan.**

- 1) Explain the process for supplying employees I.D. Cards including turn-around time, where they will be sent and a contact phone number for replacement cards.
- 2) Is there a provider website where I.D. Cards can be printed and/or ordered? Provide web address.
- 3) Do you provide an administration portal where the administrator of the District and FBS as the broker can access reports, billing, forms and plan information?

**C. District Requirements & Additional Information**

- 1) **Special Note: District pays on a Bi-Weekly basis; rates must be divisible by 2.**
- 2) Aubrey Independent School District prefers a multiple year rate guarantee for all plan options.
- 3) The District requires self-administered billing.
- 4) Open enrollment without underwriting is preferred for new employees joining the District throughout the plan year.
- 5) Effective date of insurance should be the first day of employment or first of the month following date of hire; termination date of insurance should be last day of the month following active employment.
- 6) Employee requirement must be actively at work for 20 or more hours a week.
- 7) Rates should include 12% level commission.
- 8) The District does not contribute to the Vision Insurance Plan, it is voluntary.
- 9) **The below plan designs are required:**

**Option 1**

**Match Current Plan Design**

June 22, 2011

#### D. Rate Information

Provide a quote for the Voluntary Vision Plan(s) by completing the following section, indicating rates on a monthly basis for each of the following categories:

**Please provide quote structure in 4-Tier format.**

**Eye Exam Frequency:**

Lenses \_\_\_\_\_

Frames \_\_\_\_\_

Contacts \_\_\_\_\_

**Provider Network:** \_\_\_\_\_

**Rates:**

**\*\*Special Note: District pays on a Bi-Weekly basis; rates must be divisible by 2.**

Employee Only \$ \_\_\_\_\_

Employee + Spouse \$ \_\_\_\_\_

Employee + Child(ren) \$ \_\_\_\_\_

Employee + Family \$ \_\_\_\_\_

**Rate Guarantee:** \_\_\_\_\_

**Commission:** \_\_\_\_\_

**The below plan designs are required:**

**Option 1**

**Match Current Plan Design**

**June 22, 2011**

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## Section D – Cancer Insurance Plans

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June 22, 2011

## **SECTION D – Cancer Insurance Plans**

### **A. Vendor Information – Please explain in detail for each proposed plan.**

- 1) What are the full names of your Cancer Insurance Plan(s), the name and contact number of the person responsible for this proposal?
- 2) Who would be District's contact regarding plan administration and customer service? Billing? Include name, address, email address, telephone number, fax number and experience for each contact.
- 3) Is this a group or individual plan(s)? Outline underwriting requirements and Guarantee Issue amounts.
- 4) The District is conducting through an online enrollment system. Will you accept an electronic identification as a signature on all forms and will you accept electronic data on an ongoing basis?
- 5) Who will be the electronic data contact? Include name, address, email address, telephone and fax numbers.
- 6) Outline your provisions for Pre-Existing Conditions and any waiting periods for each proposed plan(s). Specify how current employees who may be uninsurable will be handled.
- 7) What is the due date for applications after the effective date before they are stale-dated?
- 8) Outline your Portability and Conversion options including rate tables.
- 9) What is your A.M. Best Co. rating?
- 10) What is the participation requirement?

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**B. Administrative Information – Please explain in detail for each proposed plan.**

- 1) Explain the process of supplying policy booklets to the District and/or employees including turn-around time.
- 2) Do you provide an administration portal where the administrator of the District and FBS as the broker can access reports, billing, forms and plan information?
- 3) Do you offer electronic application submission? If so, is it a link that can be accessed on our online enrollment system or would it be an external web address? If not, is it in the business plan for the future?
- 4) Outline your process of notifying District members and FBS as the broker of any approvals, declinations, pending requests and general status updates. Include turn-around time.

**C. District Requirements & Additional Information**

- 1) **Special Note: District pays on a Bi-Weekly basis; rates must be divisible by 2.**
- 2) Aubrey Independent School District prefers a multiple year rate guarantee for all plan options.
- 3) The District requires self-administered billing.
- 4) Composite rates are preferred.
- 5) Annual benefits should be based on calendar year not plan year.
- 6) Age-Banded rate changes must be effective with the plan year.
- 7) The District requires Portability options with each proposed plan.
- 8) The District prefers electronic application submission with access to view as the administrator along with a representative from FBS as the broker.
- 9) Effective date of insurance should be the first day of employment or first of the month following date of hire; termination date of insurance should be last day of the month following active employment.
- 10) Employee requirement must be actively at work for 20 or more hours a week.
- 11) The District does not contribute to the Cancer Insurance Plan, it is voluntary.

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#### D. Rate Information

Provide a quote for the Cancer Insurance Plan(s) by completing the following section, indicating rates on a monthly basis for each of the following categories:

**Please provide quote structure in 4-Tier format.**

Employee Only                      \$ \_\_\_\_\_

Employee + Spouse                \$ \_\_\_\_\_

Employee + Child(ren)            \$ \_\_\_\_\_

Employee + Family                \$ \_\_\_\_\_

**Rate Guarantee:** \_\_\_\_\_

**Commission:** \_\_\_\_\_

**Additional Notes:**

\_\_\_\_\_  
\_\_\_\_\_

**June 22, 2011**

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## Section E – Accident Insurance Plans

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June 22, 2011

## **SECTION E – Accident Insurance Plans**

### **A. Vendor Information – Please explain in detail for each proposed plan.**

- 1) What are the full names of your Accident Insurance plan(s), the name and contact number for the person responsible for this proposal?
- 2) Who would be the District's contact regarding plan administration and customer service? Include name, address, email address, telephone number, fax number and experience for each contact.
- 3) Is this a group or individual plan(s)? Outline underwriting requirements and Guarantee Issue amounts.
- 4) The District is conducting through an online enrollment system. Will you accept electronic identification as signature on all forms and will you accept electronic data on an ongoing basis?
- 5) Who will be the electronic data contact? Include name, address, email address, telephone and fax numbers.
- 6) Will there be a rate cap on subsequent plan years? Limiting exclusions? Amendments? Extensions?
- 7) Outline core covered services for each proposed plan(s). Include base plan and additional riders.
- 8) Outline your provisions for Pre-Existing Conditions and any waiting periods for each proposed plan(s). Specify how current employees who may be uninsurable will be handled.
- 9) What is the due date for applications after the effective date before they are stale-dated?
- 10) What is your A.M. Best Co. rating?
- 11) Outline your Portability option including rate tables.
- 12) What is the participation requirement?

June 22, 2011

**B. Administrative Information – Please explain in detail for each proposed plan.**

- 1) Explain the process of supplying policy booklets to the District and/or employees including turn-around time.
- 2) Do you provide an administration portal where the administrator of the District and FBS as the broker can access reports, billing, forms and plan information?
- 3) Do you offer electronic application submission? If so, is it a link that can be accessed on our online enrollment system or would it be an external web address? If not, is it in the business plan for the future?
- 4) Outline your process of notifying the District members and FBS as the broker for any approvals, declinations, pending requests and general status updates. Include turn-around time.

**C. District Requirements & Additional Information**

- 1) **Special Note: District pays on a Bi-Weekly basis; rates must be divisible by 2.**
- 2) Aubrey Independent School District prefers multiple year rate guarantees for all plan options.
- 3) The District requires self-administered billing.
- 4) Composite rates are preferred.
- 5) Age-Banded rate changes should be effective with the plan year.
- 6) The District requires Portability options with each proposed plan.
- 7) The District prefers electronic application submission with access to view as the administrator along with a representative from FBS as the broker.
- 8) Effective date of insurance should be the first day of employment or first of the month following date of hire; termination date of insurance should be last day of the month following active employment.
- 9) Employee requirement must be actively at work for 20 or more hours a week.
- 10) To lower proposal rates we are open to optional plan changes.
- 11) The District does not contribute to the Accident plan, it is voluntary.

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June 22, 2011**D. Rate Information**

Provide a quote for the Accident Insurance Plan(s) by completing the following section, indicating rates on a monthly basis for each of the following categories:

**Please provide quote structure in 4-Tier format.**

**Rates:**

Employee Only \$ \_\_\_\_\_

Employee + Spouse \$ \_\_\_\_\_

Employee + Child(ren) \$ \_\_\_\_\_

Employee + Family \$ \_\_\_\_\_

**Additional Rates:**

Employee Only \$ \_\_\_\_\_

Employee + Spouse \$ \_\_\_\_\_

Employee + Child(ren) \$ \_\_\_\_\_

Employee + Family \$ \_\_\_\_\_

**Rate Guarantee:** \_\_\_\_\_**Commission:** \_\_\_\_\_**Additional Notes:**

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## Section F – Critical Illness Insurance Plans

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June 22, 2011

## **SECTION F – Critical Illness Insurance Plans**

### **A. Vendor Information – Please explain in detail for each proposed plan.**

- 1) What are the full names of your Critical Illness Insurance Plan(s), the name and contact number of the person responsible for this proposal?
- 2) Who would be District's contact regarding plan administration and customer service? Billing? Include name, address, email address, telephone number, fax number and experience for each contact.
- 3) Is this a group or individual plan(s)? Outline underwriting requirements and Guarantee Issue amounts.
- 4) The District is conducting through an online enrollment system. Will you accept an electronic identification as a signature on all forms and will you accept electronic data on an ongoing basis?
- 5) Who will be the electronic data contact? Include name, address, email address, telephone and fax numbers.
- 6) Outline your provisions for Pre-Existing Conditions and any waiting periods for each proposed plan(s). Specify how current employees who may be uninsurable will be handled.
- 7) What is the due date for applications after the effective date before they are stale-dated?
- 8) Outline your Portability and Conversion options including rate tables.
- 9) What is your A.M. Best Co. rating?
- 10) What is the participation requirement?

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**B. Administrative Information – Please explain in detail for each proposed plan.**

- 1) Explain the process of supplying policy booklets to the District and/or employees including turn-around time.
- 2) Do you provide an administration portal where the administrator of the District and FBS as the broker can access reports, billing, forms and plan information?
- 3) Do you offer electronic application submission? If so, is it a link that can be accessed on our online enrollment system or would it be an external web address? If not, is it in the business plan for the future?
- 4) Outline your process of notifying District members and FBS as the broker of any approvals, declinations, pending requests and general status updates. Include turn-around time.

**C. District Requirements & Additional Information**

- 1) **Special Note: District pays on a Bi-Weekly basis; rates must be divisible by 2.**
- 2) Aubrey Independent School District prefers a multiple year rate guarantee for all plan options.
- 3) The District requires self-administered billing.
- 4) Composite rates are preferred.
- 5) Annual benefits should be based on calendar year not plan year.
- 6) Age-Banded rate changes must be effective with the plan year.
- 7) The District requires Portability options with each proposed plan.
- 8) The District prefers electronic application submission with access to view as the administrator along with a representative from FBS as the broker.
- 9) Effective date of insurance should be the first day of employment or first of the month following date of hire; termination date of insurance should be last day of the month following active employment.
- 10) Employee requirement must be actively at work for 20 or more hours a week.
- 11) The District does not contribute to the Critical Illness Insurance Plan, it is voluntary.

**June 22, 2011**

#### **D. Rate Information**

Provide a quote for the Critical Illness Insurance Plan(s) by completing the following section, indicating rates on a monthly basis for each of the following categories:

**Please provide quote structure in 4-Tier format.**

Employee Only                      \$ \_\_\_\_\_

Employee + Spouse                \$ \_\_\_\_\_

Employee + Child(ren)            \$ \_\_\_\_\_

Employee + Family                \$ \_\_\_\_\_

**Rate Guarantee:** \_\_\_\_\_

**Commission:** \_\_\_\_\_

**Additional Notes:**

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**June 22, 2011**

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## Section G – Disability Insurance Plans

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June 22, 2011

## **SECTION G – Disability Insurance Plans**

### **A. Vendor Information – Please explain in detail for each proposed plan.**

- 1) What are the full names of your Disability Insurance plan(s), the name and contact number of the person responsible for this proposal?
- 2) Who would be the District's contact regarding plan administration and customer service? Billing? Include name, address, email address, telephone number, fax number and experience for each contact.
- 3) Outline underwriting requirements and Guarantee Issue amounts.
- 4) Outline your provisions for waiver of premium and pending claims.
- 5) The District is conducting through an online enrollment system. Will you accept electronic identification as signature on all forms and will you accept electronic data on an ongoing basis?
- 6) Who will be the electronic data contact? Include name, address, email address, telephone and fax numbers.
- 7) Will there be a rate cap for subsequent plan years? Limiting exclusions? Amendments? Extensions?
- 8) What is your A.M. Best Co. rating?
- 9) Outline your retirement rules and age restrictions for each proposed plan(s) including maximum age for disabled children.
- 10) Outline your process for coordinating with Employee Sick Leave.
- 11) Outline your process for Pre-Existing Conditions.
- 12) What is the participation requirement for each proposed plan(s)?

### **B. Administrative Information – Please explain in detail for each proposed plan.**

- 1) Explain the process of supplying policy booklets to the District and/or employees including turn-around time.
- 2) Do you provide an administration portal where the administrator of the District and FBS as the broker can access for reports, billing, forms, and plan information?

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### **C. District Requirements & Additional Information**

- 1) Special Note: District pays on a Bi-Weekly basis; rates must be divisible by 2.**
- 2) Aubrey Independent School District prefers multiple year rate guarantees for all plan options.
- 3) The District requires self-administered billing.
- 4) The current policy has waiver of premium.
- 5) Effective date of insurance should be the first day of employment or first of the month following date of hire; termination date of insurance should be last day of the month following active employment.
- 6) Employee requirement must be actively at work for 20 or more hours a week.
- 7) Rates should include 17% level commission.
- 8) The District does not contribute to the current Long-Term Disability plan, it is voluntary.

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**D. Rate Information**

Aubrey Independent School District wishes to implement a disability program that will be voluntary/employee paid; you may either propose a Short Term Disability, Long Term Disability or an Educator Disability plan. If you are proposing STD or LTD, please complete the below information in detail.

Fully Insured Short Term Disability**Plan Benefits:**

Percentage of Salary \_\_\_\_\_

Maximum Weekly Benefit \_\_\_\_\_

Minimum Weekly Benefit \_\_\_\_\_

Elimination Period \_\_\_\_\_

Duration \_\_\_\_\_

**Plan Features:**

Earnings Definition \_\_\_\_\_

Pre-Existing Provision \_\_\_\_\_

Return to Work Incentive \_\_\_\_\_

**Plan Ratings:**

Rating Methodology \_\_\_\_\_

Rate Guarantee \_\_\_\_\_

Participation Requirement \_\_\_\_\_

Premium per \$10 \_\_\_\_\_

**Monthly Volume** \_\_\_\_\_

**Estimated Monthly Premium** \_\_\_\_\_

**Estimated Annual Premium** \_\_\_\_\_

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Long Term Disability

**Plan Benefits:**

Benefit Percentage	_____
Maximum Benefit	_____
Guarantee Issue	_____
Minimum Benefit	_____
Social Security Integration	_____
Elimination Period	_____
Accumulation Feature	_____
Maximum Benefit Period	_____

**Outline Illness/Injury Benefit Limits:**

Mental & Nervous	_____
Substance Abuse	_____
Self Reported	_____

**Definition of Disability:**

Own Occupation Period	_____
Zero Day Residual	_____
Partial Disability Formula	_____
Income Test During Own Occupation Period	_____

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**Additional Benefits:**

Return to Work Incentive \_\_\_\_\_

Reasonable Accommodations \_\_\_\_\_

Vocational Rehabilitation \_\_\_\_\_

Survivor Benefit \_\_\_\_\_

Recurrent Disability \_\_\_\_\_

Prior Insurance Credited \_\_\_\_\_

Employee Assistance \_\_\_\_\_

Programs \_\_\_\_\_

**Plan Ratings:**

Rating Methodology \_\_\_\_\_

Rate Guarantee \_\_\_\_\_

Rate per \$100 of Benefit \_\_\_\_\_

**Number of Covered Employees** \_\_\_\_\_

**Monthly Covered Payroll** \_\_\_\_\_

**Estimated Monthly Volume** \_\_\_\_\_

**Estimated Monthly Premium** \_\_\_\_\_

**Estimated Annual Premium** \_\_\_\_\_

**Commission:** \_\_\_\_\_

**Additional Notes:**

\_\_\_\_\_

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**June 22, 2011**

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## Section H –Voluntary Term Life AD&D Insurance Plans

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June 22, 2011

## **SECTION H – Voluntary Term Life/AD&D Insurance Plans**

### **A. Vendor Information – Please explain in detail for each proposed plan.**

- 1) What are the full names of your Voluntary Term Life/AD&D Insurance Plans, the name and contact number of the person responsible for this proposal?
- 2) Who would be the District's contact regarding plan administration and customer service? Billing? Include name, address, email address, telephone number, fax number and experience for each contact.
- 3) Outline your take-over and late entrant provisions.
- 4) Do you offer true or modified open enrollment? Please explain in detail.
- 5) Outline your provisions for new employees joining the District throughout the plan year for each proposed plan(s). Are they allowed full open enrollment and guarantee issue amounts?
- 6) The District is conducting through an online enrollment system. Will you accept an electronic identification as signature on all forms and will you accept electronic data on an ongoing basis?
- 7) Who will be the electronic data contact? Include name, address, email address, telephone and fax numbers.
- 8) Will there be a rate cap for subsequent plan years? Limiting exclusions? Amendments? Extensions?
- 9) Outline your provisions for waiver of premium and pending claims.
- 10) Outline your portability and conversion options including rate tables.
- 11) Outline Guarantee Issue amounts.
- 12) What is your A.M. Best Co. rating?
- 13) State clearly if you will give the District a no-loss/no-gain letter for all existing covered persons.
- 14) What is the participation requirement for each proposed plan(s)?

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**B. Administration Information – Please explain in detail for each proposed plan.**

- 1) Explain the process of supplying policy booklets to the District including turn-around time.
- 2) Is there a provider website where policy booklets can be printed and/or ordered? If so, please list web address.
- 3) Do you provide an administrative portal where the administrator of the District and FBS as the broker can access reports, billing, forms and plan information?
- 4) Do you offer Electronic Evidence of Insurability submission? If so, is it a link that can be accessed on our online enrollment system or would it be an external web address? If not, is it in the business plan for the future?
- 5) Outline your process of notifying the District and FBS as the broker of any approvals, declinations, pending requests and general status updates. Include turn-around time.

**C. District Requirements & Additional Information**

- 1) **Special Note: District pays on a Bi-Weekly basis; rates must be divisible by 2.**
- 2) Aubrey Independent School District prefers multiple year rate guarantees for all plan options.
- 3) Guarantee Issue for all new employees joining the District throughout the plan year without additional underwriting or census information is preferred. No age restrictions for Guarantee Issue Amounts.
- 4) Age-banded rate changes must be effective with the plan year.
- 5) The current policy includes waiver of premium.
- 6) Actively at Work provision should be waived or letter of no-loss/no-gain.
- 7) The District requires portability and conversion options with each proposed plan.
- 8) The District prefers electronic Evidence of Insurability submission with access to view as the administrator along with a representative from FBS as the broker.
- 9) Employee and Spouse rates should be quoted at the same rate.

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- 10) Dependent child(ren) rates should be quoted as a flat, unified rate for all children as a \$10,000 benefit.
- 11) Benefits should be payable at death from any cause while insured.
- 12) An Incontestability Clause and Accelerated Death Benefit are preferred.
- 13) Monthly premiums will be paid in arrears.
- 14) Effective date of insurance should be the first day of employment or first of the month following date of hire; termination date of insurance should be last day of the month following active employment.
- 15) Employee requirement must be actively at work for 20 or more hours a week.
- 16) The District prefers self-administered billing.
- 17) The District prefers the same carrier for Voluntary Life/AD&D products.
- 18) Rates should include 17% level commission for all plan options.
- 19) AD&D Insurance must match Voluntary Term Life election, separate plans are **not** requested.
- 20) The District does not contribute to the Voluntary Term Life/AD&D Insurance plans, they are voluntary.

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**D. Rate Information**

Provide a quote for the Voluntary Term Life/AD&D Insurance Plan(s) by completing the following section, indicating rates on a monthly basis for each of the following categories:

**Employee Coverage**

Guarantee Issue Amount \$ \_\_\_\_\_

Maximum Times Salary \_\_\_\_\_  
(*Not Included with Basic Life*)

Reduction Schedule \_\_\_\_\_

**Spouse Coverage**

Guarantee Issue Amount \$ \_\_\_\_\_

% Allowed of Employee's Benefit \_\_\_\_\_ %

Reduction Schedule \_\_\_\_\_

**Dependent Coverage**

Guarantee Issue Amount \$ \_\_\_\_\_

Unified Rates per \$10,000 \$ \_\_\_\_\_

% Allowed of Employee's Benefit \_\_\_\_\_ %

**Rate Guarantee:** \_\_\_\_\_

**Commission:** \_\_\_\_\_

**\*\*Special Note: District pays on a Bi-Weekly basis; rates must be divisible by 2.**

**\*\*AD&D Insurance must match Voluntary Term Life election.**

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## Section I – Section 125 & Flexible Spending Accounts

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June 22, 2011

## **SECTION I – SECTION 125 / FLEX ADMINISTRATION**

### **A. Vendor Information – Please explain in detail for each proposed plan.**

- 1) Name, address, city, state, zip code and telephone number of home office of firm. Branch office location(s), if any.
- 2) Is your company a wholly-owned subsidiary or a division of another company? If so, please identify the company name and address. In addition, please list all owners (if not publicly owned), and all affiliated companies.
- 3) Have any principals of the firm ever been named in a lawsuit dealing with the management/administration of a Section 125 Cafeteria Plan?
- 4) What is the maximum processing time that will occur between receipt of claims and reimbursements to the members?
- 5) What guarantee will you provide to the District that this function will be completed within this time frame? Provide your guarantee turn-around time.
- 6) What is the size of your staff? How many clients are currently served? Please provide the largest group, the smallest group and the number of employees covered.
- 7) List staff experience of the employees that will be handling the District's account.
- 8) Is there a toll free number for employees and/or the District to speak to a customer service representative? If so, what are the hours of operation?
- 9) Is there an online portal where both employees and administrators of the District can access plan information, claims information and claims history? If so, please explain the District options in detail including web address.
- 10) If needed, does your firm perform discrimination studies as to eligibility, contributions and benefits under the plan? If so, how frequently?
- 11) Does your company offer debit card services? If so, please explain in detail including fees.
- 12) Is the debit card required for those enrolled in the Healthcare Reimbursement Account or is it voluntary?
- 13) Do employees request additional cards for dependents? Is there a fee involved? Please explain in detail the process of ordering lost/stolen and additional cards.

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**B. Claims Administration – Please explain in detail for each proposed plan.**

- 1) Describe the computerized system used to collect, assimilate and integrate the data of the program.

Web-based Enrollment Services:

Web-based Flex Administration Services:

Debit Cards:

Claims Processing:

Fees for Web-based Services:

- 2) Provide a sample of your Administrative Service Agreement.
- 3) Provide a sample of your Plan Document.
- 4) Describe your capabilities for Direct Deposit.
- 5) Provide samples of worksheets and/or any materials that will be provided to the District for education purposes.
- 6) Does your firm provide monthly, quarterly, or annual account statements directly to the participating employees? If so, please explain in detail the process and if there are any additional fees associated with Employee Account Status statements.
- 7) Provide a sample of Section 125 reports generated for employees and the District. Provide a sample of any other reports that you believe may be useful to the District on a regular basis. Please provide sample reports that would be utilized for bank reconciliation.
- 8) How much time is needed to effectively implement this program?

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**C. Organization Structure – Please explain in detail for each proposed plan.**

- 1) Any Administrator must have filed and be approved with the State of Texas. If a TPA is later rejected by the State, it will be considered grounds for dismissal. Provide current TPA Certification in Section F, Required Forms and Certifications.
- 2) Is your organization for profit or non-profit?
- 3) Are you an affiliate of an insurance carrier or independently owned and managed?
- 4) If you are a multiple site organization, are certain services delegated to specific locations or are all services available at any location? Which site will service the District?
- 5) The District is conducting enrollments through an online enrollment system. Will you accept electronic identification as signature on all forms and will you accept electronic data on an ongoing basis?

**D. Liability Protection & Banking Reference – Please explain in detail for each proposed plan.**

- 1) Please disclose the amount of liability insurance protection currently in force. The selected Administrator must provide confirmation of coverage.
- 2) Are the company and all employees bonded? If so, please provide details.

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**June 22, 2011****E. Prices/Fees – Please explain in detail for each proposed plan.**

- 1) Provide schedules of fees for each Plan using the Rate Sheet provided below. If Broker pays fees, are those fees negotiable?

<b>Section 125/Flex Administration Fees</b>	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3</b>
Set-Up Fees			
Annual Fees			
PEPM Fees			
Debit Card Fees			
Plan Document Fees			
Plan Amendment Fees			
Other Fees			

- 2) Are the fees due payable on the first of the month, quarterly, annually or a combination of these?
- 3) Is a fee structure available that incorporates various levels of participation?
- 4) Explain any methods to be utilized to control expense.
- 5) Provide a fee for administering the Medical and Dependent Care Spending Accounts with and without a Debit Card option.

**F. History – Please explain in detail for each proposed plan.**

- 1) Briefly explain the development of your organization and your corporate business objectives.
- 2) Explain how long you have been providing Section 125 and Flex Administration services, including Debit Card services.

June 22, 2011

**G. Unique Characteristics – Please explain in detail for each proposed plan.**

- 1) What do you feel is unique about your firm that will offer the best value to the District for Section 125 Administrative services?
- 2) Please comment on any other characteristics of your organization that are considered unique in the industry.

**H. References**

Provide the names, addresses, telephone numbers and contact names for five of your clients. For each client listed, provide the number of employees covered (on your capacity of a Section 125 Administrator). Also state whether or not any of the Section 125 Administration Agreement with these firms are on a fee for services rendered basis.

**I. District Requirements & Additional Information**

- 1) The District prefers a multiple year rate guarantee for all plan options.
- 2) The District prefers self-administered billing.
- 3) Effective date of insurance should be the first day of employment or first of the month following date of hire; termination date of insurance should be last day of the month following active employment.
- 4) Employee requirement must be actively at work for 20 or more hours a week.
- 5) The District does not contribute to the Section 125/Flex Plans, they are voluntary.

**June 22, 2011**

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## Section J – Current Plan Information / Employee Census

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**June 22, 2011**

## **Current Enrollment Count**

Fully Insured Dental	<u>76 Enrolled</u>
Discount Dental	<u>14 Enrolled</u>
Voluntary Vision	<u>33 Enrolled</u>
Long-Term Disability	<u>64 Enrolled</u>
Cancer	<u>10 Enrolled</u>
Accident	<u>1 Enrolled</u>
Heart & Stroke	<u>8 Enrolled</u>

**Plan 1: Dental Plan Summary**

**Policy # 400761 Effective Date: 10/1/2010**

<b>Coinsurance</b>	
Type 1	100%
Type 2	80%
Type 3	50%
<b>Deductible</b>	\$50/Calendar Year Type 2 & 3 Waived Type 1 3 Family Maximum \$1,000 per calendar year
<b>Maximum (per person)</b>	80th U&C
<b>Allowance</b>	Type 3 – 12 months
<b>Waiting Period</b>	

**Orthodontia Summary - Child Only Coverage**

<b>Allowance</b>	U&C
<b>Coinsurance</b>	50%
<b>Lifetime Maximum (per person)</b>	\$1,000
<b>Waiting Period</b>	12 months

**Sample Procedure Listing** (Current Dental Terminology © American Dental Association.)

Type 1	Type 2	Type 3
<ul style="list-style-type: none"> <li>• Routine Exam (1 in 6 months)</li> <li>• Bitewing X-rays (1 in 12 months)</li> <li>• Full Mouth/Panoramic X-rays (1 in 5 years)</li> <li>• Periapical X-rays</li> <li>• Cleaning (1 in 6 months)</li> <li>• Fluoride for Children 13 and under (1 per benefit period)</li> <li>• Sealants (age 13 and under)</li> </ul>	<ul style="list-style-type: none"> <li>• Space Maintainers</li> <li>• Restorative Amalgams</li> <li>• Restorative Composites</li> <li>• Denture Repair</li> <li>• Simple Extractions</li> <li>• Complex Extractions</li> <li>• Anesthesia</li> </ul>	<ul style="list-style-type: none"> <li>• Onlays</li> <li>• Crowns (1 in 10 years)</li> <li>• Crown Repair</li> <li>• Endodontics (nonsurgical)</li> <li>• Endodontics (surgical)</li> <li>• Periodontics (nonsurgical)</li> <li>• Periodontics (surgical)</li> <li>• Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 10 years)</li> </ul>

**Monthly Rates**

<b>Employee Only (EE)</b>	\$28.24
<b>EE + 1 Dependent</b>	\$53.32
<b>EE + 2 or more Dependents</b>	\$89.28

**Ameritas Information**

**We're Here to Help**

This plan was designed specifically for the associates of **Aubrey ISD**. At Ameritas Group, we do more than provide coverage - we make sure there's always a friendly voice to explain your benefits, listen to your concerns, and answer your questions. Our customer relations associates will be pleased to assist you 7 a.m. to midnight (Central Time) Monday through Thursday, and 7 a.m. to 6:30 p.m. on Friday. You can speak to them by calling toll-free: 800-487-5553. For plan information any time, access our automated voice response system or go online to [ameritasgroup.com/member](http://ameritasgroup.com/member).

### **Dental Rewards®**

This dental plan includes a valuable feature that allows qualifying plan members to carryover part of their unused annual maximum. A member earns dental rewards by submitting at least one claim for dental expenses incurred during the benefit year, while staying at or under the threshold amount for benefits received for that year. Employees and their covered dependents may accumulate rewards up to the stated maximum carryover amount, and then use those rewards for any covered dental procedures subject to applicable coinsurance and plan provisions. If a plan member doesn't submit a dental claim during a benefit year, all accumulated rewards are lost. But he or she can begin earning rewards again the very next year.

Benefit Threshold	\$500	Dental benefits received for the year cannot exceed this amount
Annual Carryover Amount	\$250	Dental Rewards amount is added to the following year's maximum
Maximum Carryover	\$1,000	Maximum possible accumulation for Dental Rewards

### **Contracted Provider Information**

Go online to [ameritasgroup.com/member](http://ameritasgroup.com/member) to find the contracted network providers who are most convenient for you. While using a contracted provider will almost always lower your out of pocket costs, every Ameritas Group plan gives you the freedom to visit any dentist you choose.

### **Pretreatment**

While we don't require a pretreatment authorization form for any procedure, we recommend them for any dental work you consider expensive. As a smart consumer, it's best for you to know your share of the cost up front. Simply ask your dentist to submit the information for a pretreatment estimate to our customer relations department. We'll inform both you and your dentist of the exact amount your insurance will cover and the amount that you will be responsible for. That way, there won't be any surprises once the work has been completed.

### **Late Entrant Provision**

We strongly encourage you to sign up for coverage when you are initially eligible. If you choose not to sign up during this initial enrollment period, you will become a late entrant. Late entrants will be eligible for only exams, cleanings, and fluoride applications for the first 12 months they are covered.

### **Section 125**

This plan is provided as part of the Policyholder's Section 125 Plan. Each employee has the option under the Section 125 Plan of participating or not participating in this plan. If an employee does not elect to participate when initially eligible, he/she may elect to participate at the Policyholder's next Annual Election Period.

**This document is a highlight of plan benefits provided by Ameritas Life Insurance Corp. as selected by your employer. It is not a certificate of insurance and does not include exclusions and limitations. For exclusions and limitations, or a complete list of covered procedures, contact your benefits administrator.**



QCD OF AMERICA®  
*More Choices ★ Higher Benefits ★ Lower Costs*



- Lowest monthly cost  
(Please see Rate Sheet)
- Use a QCD Affiliated Dentist of choice
- No claim forms, no deductibles and no maximums of coverage
- Pay at the time of service according to the QCD Schedule of Program Fees  
(Approximately 50% Savings)
- Household coverage for all regardless of age or relationship  
(Red Program Only)
- Vision benefits included

This summary is for overview purposes only. Please see the [Comprehensive Information Guide](#) for complete program details.



## THE “RED” PROGRAM

### A MANAGED COST DENTAL & VISION BENEFIT PROGRAM

(Not an Insurance Plan)

**No Claim Forms, Deductible or Coverage Maximums**



**Immediate Coverage for All Pre-Existing Conditions**



**Orthodontics (Braces) for Children and Adults**



**Large Affiliated Dentist Team in Each Market**

SAMPLE DENTAL PROCEDURE <sup>1</sup>	FEE PAID WITH QCD OF AMERICA <sup>®</sup>	NATIONAL AVERAGE DENTAL FEES <sup>2</sup>	SAVINGS WITH QCD OF AMERICA <sup>®</sup>
Oral Exam	\$9	\$35	74%
Full Mouth X-Ray	\$28	\$77	64%
Teeth Cleaning	\$24	\$54	56%
Amalgam (1Surface)	\$28	\$79	65%
Simple Extraction	\$36	\$80	55%
Root Canal (1Canal)	\$185	\$387	52%
Porcelain w/ Metal Crown (lab fees additional)	\$350	\$652	46%
Complete Upper or Lower Denture (lab fees additional)	\$400	\$770	48%

<sup>1</sup> A fee of \$8.00 is charge per appointment for infection control costs. There will be an additional charge for all lab fees less a 20% discount.

<sup>2</sup> The schedule represents a sample of highly utilized dental procedures. The average costs are estimated from data gathered by the U.S. Bureau of Labor Statistics, the American Dental Association, and the Chamber of Commerce Research Association.

- ◆ After you sign and turn in your enrollment form, QCD will send you a membership card.
- ◆ Please select any dentist within the QCD Affiliated Dentist Team and make an appointment.
- ◆ Please be sure to identify yourself as a QCD member and the reduced fee schedule will apply to all charges.
- ◆ Please call the QCD Member Services Department at 972.726.0444 or 1.800.229.0304 for assistance.
- ◆ Information may be obtained from the web site at [www.qcdofamerica.com](http://www.qcdofamerica.com)



**SCHEDULE OF PROGRAM FEES**  
**RED FEE SCHEDULE – MEMBER PAYS THE GENERAL DENTIST – 50% SAVINGS**  
**WHITE REIMBURSES THE MEMBER – ALL CODES BY GD – 100% (INCLUDES MAJOR)**

PROCEDURE NUMBER MEMBER FEE

**DIAGNOSTIC DENTISTRY**

D0120	Periodical Oral Examination	\$9.00
D0140	Limited Oral Examination, Problem Focused	\$12.00
D0150	Comprehensive Oral Examination	\$18.00
D0210	Intraoral X-Ray Complete Series	\$28.00
D0460	Pulp Vitality Test	\$15.00
D9999	Asepsis Fee (Infection Control)	\$8.00
All Bitewing / Single Film X-Rays		20% DISCOUNT

**PREVENTATIVE DENTISTRY**

D1110	Prophylaxis – Adult	\$24.00
D1120	Prophylaxis – Child	\$24.00
D1203	Application Topical Fluoride – Child	\$5.00
D1204	Application Topical Fluoride – Adult	\$5.00
D1351	Sealant – Per Tooth	\$14.00
D1510	Space Maintainer – Fixed Unilateral	\$60.00
D1515	Space Maintainer – Fixed Bilateral	\$75.00

A specific preventative treatment may present unusual circumstances requiring an additional cost. Please consult the Affiliated Dentist as to the total procedure cost prior to treatment.

**COSMETIC**

All Cosmetic Dentistry	20% DISCOUNT
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**RESTORATIVE DENTISTRY**

D2140	Amalgam – 1 Surface, Primary or Permanent	\$28.00
D2150	Amalgam – 2 Surface, Primary or Permanent	\$36.00
D2160	Amalgam – 3 Surfaces, Primary or Permanent	\$46.00
D2161	Amalgam – 4 or More Surfaces, Primary or Permanent	\$56.00
D2330	Composite Resin – 1 Surface, Anterior	\$38.00
D2331	Composite Resin – 2 Surfaces, Anterior	\$46.00
D2332	Composite Resin – 3 Surfaces, Anterior	\$56.00
D2335	Composite Resin – 4 or More Surfaces or Involving Incisal Angle, Anterior	\$66.00
D2391	Composite Resin – 1 Surface, Posterior	\$50.00
D2392	Composite Resin – 2 Surfaces, Posterior	\$65.00
D2393	Composite Resin – 3 Surfaces, Posterior	\$85.00
D2394	Composite Resin – 4 or More Surfaces, Posterior	\$95.00
D2750	Crown – Porcelain to High Noble Metal (Gold and Lab Fees Additional)	\$350.00
D2751	Crown – Porcelain to Base Metal (Lab Fees Additional)	\$320.00
D2920	Re-cement Crown	\$20.00
D2931	Prefabricated Stainless Steel Crown	\$48.00
D2940	Sedative Filling	\$16.00
D2950	Core Buildup (Including Any Pins)	\$55.00
D2951	Pin Retention – (Per Tooth)	\$20.00
D2952	Cast Post and Core in Addition to Crown	\$75.00
D2953	Each Additional Cast Post (Same Tooth)	\$40.00
D2954	Prefab Post / Core in Addition to Crown	\$60.00
D2970	Temporary Crown (Fractured Tooth)	\$40.00

PROCEDURE NUMBER MEMBER FEE

**ENDODONTICS**

D3110	Pulp Cap, Direct	\$19.00
D3120	Pulp Cap, Indirect	\$24.00
D3220	Pulpotomy	\$35.00
D3310	Root Canal, Anterior	\$185.00
D3320	Root Canal, Bicuspid	\$209.00
D3330	Root Canal, Molar	\$259.00
D3920	Hemisection	\$65.00

A specific root canal treatment or re-treatment may present unusual circumstances requiring additional cost. Please consult the Affiliated Dentist as to the total procedure cost prior to treatment.

**PERIODONTICS**

D4210	Gingivectomy/Gingivoplasty – (Per Quadrant)	\$180.00
D4211	Gingivectomy/Gingivoplasty – (Per Tooth)	\$50.00
D4240	Gingival Flap Procedure, Including Root Planing – (Per Quadrant)	\$200.00
D4260	Osseous Surgery – (Per Quadrant) (Including Flap Entry and Closure)	\$260.00
D4341	Periodontal Scaling and Root Planing – (Per Quadrant)	\$75.00
D4355	Full Mouth Debridement	\$70.00
D4910	Periodontal Maintenance Procedures Following Active Therapy	\$30.00

A specific periodontal treatment may present unusual circumstances requiring an additional cost. Please consult the Affiliated Dentist as to the total procedure cost prior to treatment.

**PROSTHODONTICS – REMOVABLE**

(Lab Fees Additional Cost)

D5110	Complete Upper Denture (Including Six Months Post Care)	\$400.00
D5120	Complete Lower Denture (Including Six Months Post Care)	\$400.00
D5130	Immediate Upper	\$420.00
D5140	Immediate Lower	\$420.00
D5211	Upper Partial Denture – Resin Base	\$250.00
D5212	Lower Partial Denture – Resin Base	\$250.00
D5213	Upper Partial – Predominantly Cast Base	\$400.00
D5214	Lower Partial – Predominantly Cast Base	\$400.00
D5410	Adjust Complete Denture	\$15.00
D5510	Repair Broken Complete Denture Base	\$40.00
D5610	Repair Resin Denture Base	\$35.00
D5630	Repair or Replace Broken Clasp	\$45.00
D5640	Replace Broken Teeth (Per Tooth)	\$30.00
D5650	Add Tooth to Existing Partial Denture	\$45.00
D5660	Add Clasp to Existing Partial Denture	\$65.00
D5730	Reline Complete Upper (Chairside)	\$75.00
D5731	Reline Complete Lower (Chairside)	\$75.00
D5740	Reline Upper Partial (Chairside)	\$75.00
D5741	Reline Lower Partial (Chairside)	\$75.00
D5810	Temporary Complete Upper Denture	\$200.00
D5811	Temporary Complete Lower Denture	\$200.00
D5820	Temporary Partial – Stay Plate Upper	\$180.00
D5821	Temporary Partial – Stay Plate Lower	\$180.00



## SCHEDULE OF PROGRAM FEES (CONTINUED)

### PROCEDURE NUMBER

### MEMBER FEE

#### PROSTHODONTICS – FIXED BRIDGES

D6241 Pontic–Porcelain Fused to Base Metal . . . . .	\$320.00
D6751 Crown–Porcelain Fused to Base Metal . . . . .	\$320.00
D6791 Crown–Full Cast Fused to Base Metal . . . . .	\$270.00
D6930 Re-Cement Bridge . . . . .	\$20.00
D6940 Stress Breaker . . . . .	\$90.00
D6950 Precision Attachment (Each) . . . . .	\$225.00

A specific prosthodontic treatment may present unusual circumstances requiring an additional cost. If precious metal (gold) is desired, the cost will be additional to the crown cost. Please consult the Affiliated Dentist as to the total cost prior to treatment.

#### ORAL SURGERY

D7110 Single Tooth Extraction . . . . .	\$36.00
D7120 Each Additional Tooth . . . . .	\$34.00
D7130 Root Removal – Exposed Roots . . . . .	\$48.00
D7210 Surgical Extraction – Erupted . . . . .	\$68.00
D7220 Removal of Impacted Tooth – Soft Tissue . . . . .	\$78.00
D7230 Removal of Impacted Tooth – Partially Bony . . . . .	\$109.00
D7240 Removal of Impacted Tooth – Completely Bony . . . . .	\$129.00
D7241 Removal of Impacted Tooth – Completely Bony with Unusual Surgical Complications . . . . .	\$189.00
D7250 Root Recovery . . . . .	\$72.00
D7280 Surgical Exposure Per Tooth . . . . .	\$66.00
D7310 Alveoloplasty (Per Quadrant With Extractions) . . . . .	\$78.00
D7320 Alveoloplasty (Per Quadrant Without Extractions) . . . . .	\$84.00
D7960 Frenectomy . . . . .	\$99.00

A specific oral surgery procedure may present unusual circumstances requiring an additional cost. Please consult the Affiliated Dentist as to the total procedure cost prior to treatment.

#### ORTHODONTICS (QCD GENERAL DENTIST ONLY)

D8999 Diagnostic Work Up Radiographs, Model, Records . . . . .	\$120.00
D8080 Child (QCD General Dentist) Class I or II For 24-Month Treatment . . . . .	\$2,200.00
D8090 Adult (QCD General Dentist) Class I or II For 24-Month Treatment . . . . .	\$2,400.00
D8680 Orthodontic Retention . . . . .	\$230.00

A specific orthodontic treatment may present unusual circumstances requiring an additional cost. During the orthodontic consultation appointment, the Affiliated Dentist will explain all needed procedures, length of treatment, required fees and payment schedule.

#### GENERAL SERVICES

D9999 Failed Appointment (Without 24-Hours Notice) . . . . .	\$30.00
D9999 Palliative (Emergency) Treatment of Dental Pain–Minor Procedures . . . . .	\$20.00
D9999 Office Visit–After Hours . . . . .	\$45.00

#### SPECIALTY CARE SERVICES

All scheduled charges listed are for services rendered by a QCD OF AMERICA® Affiliated General Dentist. All treatments provided by a QCD OF AMERICA® Affiliated Specialty Dentist (Advanced Degree) in Endodontics, Periodontics, Prosthodontics, Oral Surgery, Pediatric Dentistry or Orthodontics (Board Certified or Board Eligible only) will be charged at a 20% Discount from the Affiliated Specialty Dentist's usual and customary fee for the treatment.

#### OTHER PROCEDURES AND PAYMENT FOR SERVICES

Any procedure not listed on the QCD OF AMERICA® Schedule of Dental Program Fees is available at the Dentist's usual and customary fee less a 20% discount – this includes all lab fees. All fees included in the Schedule of Dental Fees are for payment at the time of service. The member may negotiate payment terms with the Affiliated Dentist; however, an additional charge may be added for payment terms.

#### ASEPSIS FEE

An sepsis fee of \$8.00 per patient appointment is charged by all Affiliated Dentists to insure proper infection control for all QCD OF AMERICA® members.

#### QCD OF AMERICA® – EXCLUSIONS AND LIMITATIONS

- The following exclusions and limitations apply:
  - Services covered under Workmen's Compensation or Employer's Liability Laws;
  - Cost of any dental care covered by any medical insurance;
  - Services, which in the opinion of the attending Dentist, are not necessary for the patient's dental health or cannot be performed because of the general health of the Patient.
  - General anesthesia, I.V. sedation, hospitalization, and hospital or medical charges of any type.
- QCD OF AMERICA® member fees apply to services rendered by Affiliated Dental offices and are subject to change in the future.
- QCD OF AMERICA® member fees do not apply to work in progress or if the Patient's membership is no longer valid.
- QCD OF AMERICA® assumes no responsibility or liability for services rendered by Affiliated Dentists.
- Any QCD OF AMERICA® member accepted for Orthodontic treatment must remain a member of the plan for the complete duration of the treatment or risk additional charges by the . . . Affiliated Dentist.
- Any procedure may present unusual circumstances requiring an additional cost. Please consult the Affiliated Dentist as to the total treatment cost prior to any service being rendered.

#### IMPORTANT NOTICE

The QCD OF AMERICA® Dental Benefit Program does not constitute dental insurance and is not a health maintenance organization contract. QCD OF AMERICA® does not reimburse the Affiliated Dentist or indemnify the member for the cost of dental services received by the member.

# FFGA Educators Eye Care Plan

## Aubrey ISD

Eye Care Highlight Sheet



### Focus® Plan

Policy # 400761 Effective Date 10/01/2010

	VSP Network	Out of Network
<b>Deductibles</b>		
Exam	\$10	\$10
Materials	\$25	\$25
<b>Annual Eye Exam</b>	Covered in full	Up to \$52
<b>Lenses (per pair)</b>		
Single Vision	Covered in full	Up to \$55
Bifocal	Covered in full	Up to \$75
Trifocal	Covered in full	Up to \$95
Lenticular	Covered in full	Up to \$125
<b>Contacts</b>		
Fit & Follow Up Exams	15% discount See Additional Focus Features.	No benefit
Elective	Up to \$105	Up to \$105
Medically Necessary	Covered in full	Up to \$210
<b>Frames</b>	\$105	Up to \$40
<b>Frequencies (months)</b>		
Exam/Lens/Frame	12/12/24 Based on date of service	12/12/24 Based on date of service

The minimum participation is 10 enrolled lives.

### Lens Options (member cost)\*

	VSP Network	Out of Network
<b>Progressive Lenses</b>	\$60-\$119	No benefit
<b>Std. Polycarbonate</b>	Covered in full for dependent children	No benefit
	\$25 - \$35 adults	
<b>High Luster Edge Polish</b>	\$14	No benefit
<b>Solid Plastic Dye</b>	\$13 (except Pink I & II)	No benefit
<b>Plastic Gradient Dye</b>	\$15	No benefit
<b>Photochromatic Lenses</b> (Glass & Plastic)	\$27-\$76	No benefit
<b>Scratch Resistant Coating</b>	\$15-\$29	No benefit
<b>Anti-Reflective Coating</b>	\$39-\$61	No benefit
<b>Ultraviolet Coating</b>	\$15	No benefit
<b>Lasik or PRK</b>	Average discount of 15% off retail. See Additional Focus Features.	No benefit

\*Lens Option member costs vary by prescription and option chosen.

### Monthly Rates

<b>Employee Only (EE)</b>	\$ 8.48
<b>EE +One Dependent</b>	\$16.53
<b>EE + Family</b>	\$23.20

# FFGA Educators Eye Care Plan

## Aubrey ISD

*Eye Care Highlight Sheet*



### Additional Focus® Features

<b>Contact Lenses Elective</b>	Cost of the fitting and evaluation is deducted from the allowance and any amount left is deducted from the material allowance. Allowance can be applied to disposables, but the dollar amount must be used all at once (provider will order 3 or 6 month supply). Applies when contacts chosen in lieu of glasses.
<b>Additional Glasses</b>	20% discount off the retail price on additional pairs of prescription glasses (complete pair).
<b>Laser VisionCare</b>	VSP offers an average discount of 15% on LASIK and PRK. The maximum out-of-pocket per eye for members is \$1,800 for LASIK and \$2,300 for custom LASIK using Wavefront technology, and \$1,500 for PRK. In order to receive the benefit, a VSP provider must coordinate the procedure.
<b>Low Vision</b>	With prior authorization, 75% of approved amount (up to \$1,000 is covered every two years).

### Eye Care Plan Member Service

Focus eye care from Ameritas Group features the money-saving eye care network of VSP. Customer service is available to plan members through VSP's well-trained and helpful service representatives. Call or go online to locate the nearest VSP network provider, view plan benefit information and more.

#### VSP Call Center: 1-800-877-7195

- Service representative hours: 6 a.m. to 7 p.m. PST Monday through Friday
- Interactive Voice Response available 24/7

**Locate a VSP provider at:** [ameritasgroup.com/provider](http://ameritasgroup.com/provider)

**View plan benefit information at:** [vsp.com](http://vsp.com)

### Section 125

This plan is provided as part of the Policyholder's Section 125 Plan. Each employee has the option under the Section 125 Plan of participating or not participating in this plan. If an employee does not elect to participate when initially eligible, he/she may elect to participate at the Policyholder's next Annual Election Period.



AMERICAN FIDELITY  
ASSURANCE COMPANY'S

# *Long-Term Disability* Income Insurance

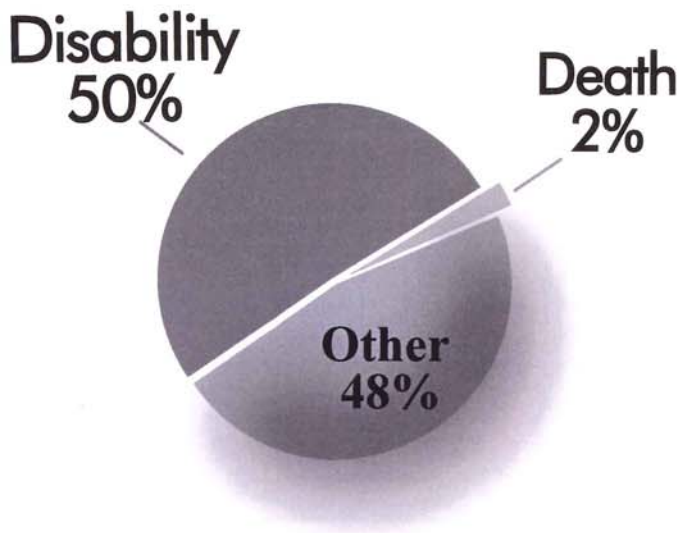


Plan Designed Specifically For:

**TEXAS SCHOOLS**

# Why Do You Need Disability Income Protection?

Disability causes nearly 50% of all mortgage foreclosures each year<sup>1</sup>.



## Are You Prepared If You Become Disabled?

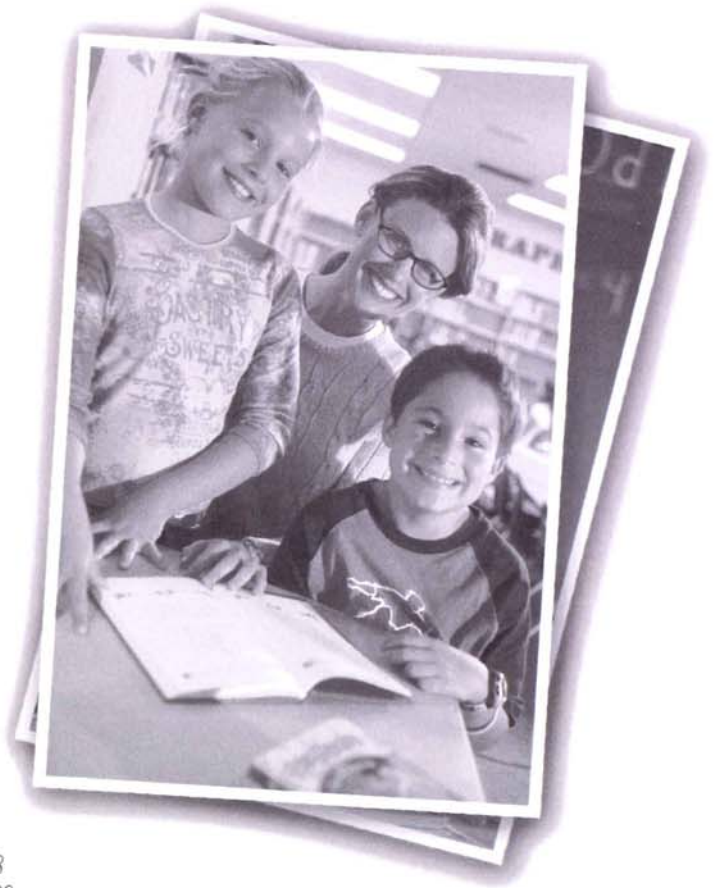
If your paycheck suddenly stopped today, what would you do? 70% of the working population live paycheck to paycheck<sup>2</sup>. The consequence of suffering a disabling Injury or Sickness could be a financial concern. And with research showing 1 in 7 employees will be disabled for 5 years or more<sup>2</sup>, American Fidelity's Disability Income Insurance may help you avoid becoming another statistic.

## Is Disability Insurance Right For You?

A Disability Plan is designed to offer income protection when you are disabled and cannot work. Consider it Insurance on your Income! If you become disabled due to a covered Injury or Sickness, disability income insurance will pay you a monthly income based on your covered benefit amount, once you satisfy your elimination period.

Plan benefits are paid directly to you and can be used however you'd like.

***Protect Your Paycheck Today with American Fidelity's Disability Income Insurance!***



<sup>1</sup> Council for Disability Awareness, worker Disability Planning & Preparedness Study, 2008

<sup>2</sup> Business Wire, Many Workers Would Rely on Credit or Family if Disabled or Ill; April 2009

# Plan Highlights

- Benefits are paid directly to you, not to a doctor or your employer.
- Benefits are payable year-round.
- Convenient payroll deduction.
- Benefit payments may be directly deposited into your bank account.
- Benefits are paid due to a covered Injury or Sickness.
- Several benefit plan options are available.
- Optional Riders available including: Critical Illness Rider, Accident Only Spousal Rider, Survivor Benefit Rider and COBRA Funding Rider.

## IMPORTANT BENEFITS INCLUDE:

- Pregnancy Benefit
- Donor Benefit
- Worksite Accommodation Evaluation
- Social Security Filing Assistance
- Waiver Of Premium
- Portability Conversion
- Return To Work Benefit: Disabled While Working
- Family Care Benefit
- Physician Expense Benefit
- Hospital Confinement Benefit
- Accidental Death Benefit

## Choose The Plan That's Right For You

### BENEFITS BEGIN

**Plan II** - On the 15th day of Disability due to a covered Injury or Sickness.

**Plan III** - On the 31st day of Disability due to a covered Injury or Sickness.

**Plan IV** - On the 61st day of Disability due to a covered Injury or Sickness.

**Plan V** - On the 91st day of Disability due to a covered Injury or Sickness.

**Plan VI** - On the 151st day of Disability due to a covered Injury or Sickness.

### BENEFITS ARE PAYABLE

Up to the period of time shown in the table below, based on your age as of the date Disability due to a covered Injury or Sickness begins.

Age	Maximum Benefit Period
Less than age 60	To Social Security Normal Retirement Age (SSNRA)*
60	60 months, or to SSNRA*, whichever is greater
61	48 months, or to SSNRA*, whichever is greater
62	42 months, or to SSNRA*, whichever is greater
63	36 months, or to SSNRA*, whichever is greater
64	30 months, or to SSNRA*, whichever is greater
65	24 months, or to SSNRA*, whichever is greater
66	21 months, or to SSNRA*, whichever is greater
67	18 months, or to SSNRA*, whichever is greater
68	15 months, or to SSNRA*, whichever is greater
Age 69 or older	12 months, or to SSNRA*, whichever is greater

\*Age at which you are entitled to unreduced Social Security benefits based on current Social Security Amendments.

# Plan Features

## HOSPITAL CONFINEMENT BENEFIT

The Hospital Confinement Benefit will be paid each day you are confined as a patient in a Hospital due to an Injury or Sickness, for up to 60 days. The amount payable is 1 times the Disability Benefit which will be pro-rated on a daily basis. This benefit will not be reduced by Deductible Sources of Income. The Hospital confinement must be at least 18 continuous hours in duration. This benefit will begin after your satisfaction of the elimination period.

## PREGNANCY BENEFIT

Pregnancy or related complications of pregnancy will be treated as any other Sickness under the terms of your plan.

## RETURN TO WORK INCENTIVE BENEFIT: DISABLED WHILE WORKING

We will provide a Disability Payment if you are Disabled and your monthly Disability Earnings, if any, are less than 20% of your Monthly Compensation due to the same Disability.

If you are Disabled and your Disability Earnings are greater than 20% of your Monthly Compensation due to the same Disability, we will figure your payment as follows:

During the first 24 months of payments while Disabled and Working:

- Your Disability Payment will not be reduced as long as the Disability Earnings plus the gross Disability Benefit does not exceed 80% of your Monthly Compensation.
- If the Disability Earnings plus the gross Disability Benefit exceeds 80% of your Monthly Compensation, the Disability Payment will be reduced by the amount exceeding 80% of your Monthly Compensation.

After 24 months of payments, while Disabled and Working, you will receive payments based on the percentage of Monthly Compensation you are losing due to Lost Earnings based on your Disability.

We will stop payments and your claim will end, if at any time you are no longer Disabled or if your Disability Earnings exceed 80% of your Monthly Compensation. The Elimination Period cannot be satisfied with days you are Disabled and Working.

## FAMILY CARE BENEFIT

If you are Disabled and Working, qualify to receive a Disability Payment from us, and have one or more eligible family members, you may be eligible to receive a Family Care Benefit. This may include payment for the care of an eligible family member by a licensed childcare provider or licensed caregiver who is not related to you by blood or marriage. We will provide a Family Care Benefit for expenses incurred of up to 25% of your monthly Disability Benefit provided the total of your Disability Earnings, the gross Disability Benefit, and the Family Care Benefit do not exceed 100% of your Monthly Compensation. Payment of the Family Care Benefit will end on the earlier of the following: the date you no longer incur Family Member expenses; or the date you no longer qualify as Disabled and Working; or the date Disabled and Working benefits have been paid for a total of 24 months.

## ACCIDENTAL DEATH BENEFIT

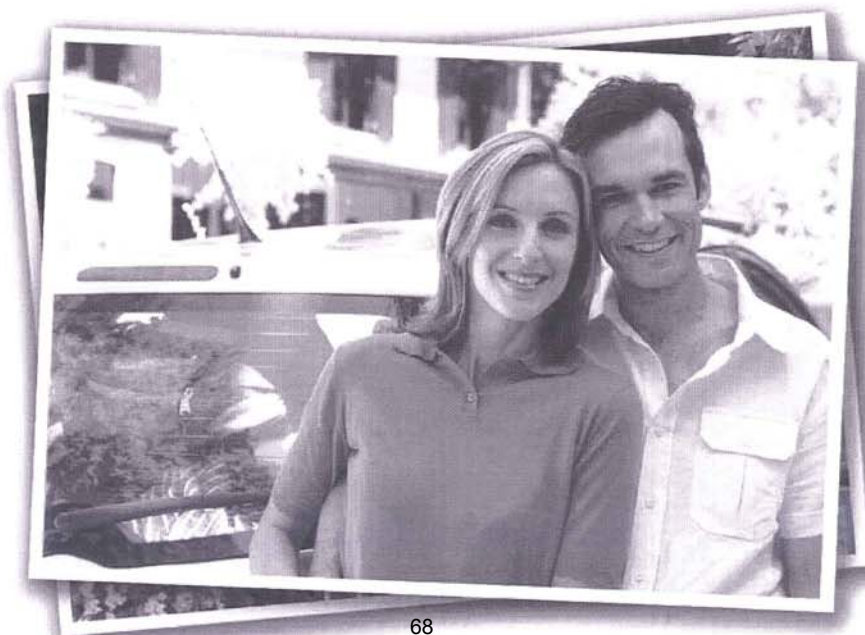
A lump sum of \$20,000.00 will be paid if you die as the direct result of an Injury and death occurs within 90 days after the Injury.

The benefit will be increased 1% for each full month that your Certificate was continuously in force just prior to death. The total increase shall not be more than 60% of the benefit amount.

## PHYSICIAN EXPENSE BENEFIT

- Injury - \$150.00 per Injury
- Sickness - \$50.00

If you need personal treatment by a Physician due to an Injury or Sickness, we will pay the amount shown above provided no other claim has been paid under the Policy. This benefit will be paid for Sickness only if the treatment is received during one full day of Disability during which you missed one full day of work. To be eligible for more than one payment for the same or related condition due to Sickness, you must have returned to Active Employment for at least 14 consecutive scheduled workdays. You are not required to miss one full day of work in order to receive the Injury benefit.



## DONOR BENEFIT

If you are Disabled as a result of being an organ or tissue donor, we will pay your benefit as any other Sickness under the terms of the plan.

## WORKSITE ACCOMMODATION

If worksite modifications may assist your return to work, we will evaluate your claim for appropriate action.

## DIRECT DEPOSIT DISABILITY BENEFITS

In the event you choose the direct deposit option on an approved claim, we will deposit your benefits directly into your bank account at no additional cost. This can accelerate access to your benefits by several days. We also have a toll-free fax that allows you instant transmission of your claim forms to our Benefits Department.

## SOCIAL SECURITY FILING ASSISTANCE

If we determine you are a likely candidate for Social Security Disability benefits, we can assist you with the application and appeal process.

## WAIVER OF PREMIUM

No premium payments are required while you are receiving payments under the plan after Disability Payments have been received under the plan for 180 consecutive days. We will require proof on an annual basis that you remain Disabled during this time.

## SUCCESSIVE DISABILITIES

Disabilities which result from the same or related causes will be considered one period of Disability unless the Disabilities are separated by your return to Active Employment or any other gainful occupation for at least 3 consecutive months.

## PORTABILITY CONVERSION

The Conversion Plan will be a separate group plan with a 30 day elimination period and 2 year benefit period. Certain other qualifications may apply. A brochure is available for this plan upon request after termination.

# Disability Insurance Needs Worksheet

Use this worksheet to get a general estimate of how much Disability Income Protection insurance you need. However, you should consult with a financial advisor before buying any insurance products.

## MONTHLY INCOME

Your Income \$ \_\_\_\_\_

Total Monthly Income \$ \_\_\_\_\_

## MONTHLY EXPENSES

Mortgage/Rent \$ \_\_\_\_\_

Car Payment \$ \_\_\_\_\_

Utilities \$ \_\_\_\_\_

Loan/Credit Card Payments \$ \_\_\_\_\_

Insurance (Home, Auto, Health, Life, etc.) \$ \_\_\_\_\_

Food/Clothing \$ \_\_\_\_\_

Child Care/Education \$ \_\_\_\_\_

Other Expenses \$ \_\_\_\_\_

Total Monthly Expenses

Are You Covered? \$ \_\_\_\_\_

# Important Policy Provisions

## ELIGIBILITY

All permanent employees in subscribing group working 20 hours or more per week. Proof of good health may be required by us in order to be eligible for disability coverage. We will rely on answers given on your application to determine if coverage can be issued. Regardless of your health at the time of application, if coverage is approved and issued, claims incurred while coverage is in force will be subject to all terms of the Policy including any Pre-Existing Condition limitation.

## WHEN COVERAGE BEGINS

Certificates will become effective on the requested effective date following the date we approve the application, providing you are on Active Employment and premium has been paid.

## IF YOU ARE DISABLED DUE TO A COVERED DISABILITY AND NOT WORKING

Your Disability Payment will be calculated as follows:

For the first 36 months Disability Payments are provided, the Disability Payment will be the lesser of:

- the Disability Benefit described in the Benefit Schedule; or
- 70% of your Monthly Compensation, less any Deductible Sources of Income you receive or are entitled to receive.

After 36 months your Disability Payment will be the Disability Benefit described in the Benefit Schedule less any Deductible Sources of Income you receive or are entitled to receive.

## OFFSETS WITH OTHER SOURCES OF INCOME

**Deductible Sources of Income include:**

- Other group disability income.
- Governmental or other retirement system, whether due to Disability, normal retirement or voluntary election of retirement benefits.
- United States Social Security Act or similar plan or act, including any amounts due your dependent(s) on account of your Disability.
- State Disability.
- Unemployment compensation.
- Workers' compensation law, occupational disease law or any similar act or law.
- Sick leave or other salary or wage continuance plans provided by the Employer which extend beyond 60 (Plans I, II, III, and IV), 90 (Plan V), or 150 (Plan VI) calendar days from the Date of Disability.

We reserve the right to estimate these Deductible Sources of Income that you may receive as defined in your Certificate.

## MINIMUM DISABILITY BENEFIT

The minimum Monthly Disability Benefit is 10% of the Monthly Disability Benefit or \$100.00, whichever is greater.

## INCREASE OF INCOME DUE TO COST OF LIVING ADJUSTMENTS

The Disability Payment will not be reduced due to a cost of living increase if the increase from a Deductible Source of Income takes effect after the onset of Disability and while benefits are payable under the Policy.

## MENTAL ILLNESS LIMITED BENEFIT

If you are Disabled due to a mental illness, regardless of the cause, Disability Payments will be provided for up to 2 years, not to exceed the Maximum Disability Period.

## ALCOHOLISM AND DRUG ADDICTION LIMITED BENEFIT

If you are disabled due to alcoholism or drug addiction, a limited benefit of up to 15 days for each Disability will be paid. Benefits will not be paid beyond the Maximum Benefit Period. If drug addiction is sustained at the hands of, or while under the regular and appropriate care of a physician in the course of treatment for Injury or Sickness, it will be covered the same as any other Sickness.

## PRE-EXISTING CONDITION LIMITATION

A limited benefit up to 1 month's Disability Benefit will be payable for Disability caused by or resulting from a Pre-Existing Condition. This provision will not apply if you have:

- gone treatment-free;
- incurred no expense;
- taken no medication; and
- received no diagnosis or advice from a Physician

for 12 consecutive months for such condition(s).

This limitation will not apply to a Disability resulting from a Pre-Existing Condition that begins after you have been continuously covered under the Policy for 24 months.

Any increase in benefits will be subject to this Pre-Existing Condition limitation. A new Pre-Existing Condition period must be satisfied with respect to any increase applied for and approved by us.

## EXCLUSIONS

The Policy does not cover any loss, fatal or non-fatal, resulting from:

- Intentionally self-inflicted injury while sane or insane.
- An act of war, declared or undeclared.
- Injury sustained or Sickness contracted while in the service of the armed forces of any country.
- Committing a felony.
- Penal incarceration. We will not pay benefits for Disability or any other loss during any period for which you are incarcerated in a penal or correctional institution for a period of 30 consecutive days or longer.

## LEAVE OF ABSENCE

Your coverage may be continued for up to 1 year during a Leave of Absence approved in writing by your Employer.

## TERMINATION OF INSURANCE

Your insurance coverage will end on the earliest of these dates:

- the date you do not meet the Eligibility requirements as defined in the Eligibility paragraph in this brochure;
- the date you retire;
- the date you cease to be on Active Employment, except as provided for under the Leave of Absence provision;
- the end of the last period for which premium has been paid;

- the date the Policy is discontinued; or
- the date your employment terminates.

If:

- your coverage ends as a result of your termination of Active Employment;
- such termination is caused by an Injury or Sickness for which Disability Benefits would be payable; and
- Disability is established prior to the termination of Active Employment,

then:

Disability Benefits will be paid as if such termination had not occurred.

Termination of the Policy will have no effect on Disability Payments which began before termination. We may end your coverage if you submit a fraudulent claim.

## DEFINITIONS

**ACTIVE EMPLOYMENT:** Means you are doing in the usual manner all of the regular duties of your employment on a full-time basis on a scheduled work day and these duties are being done at one of the places of business where you normally do such duties or at some location to which your employment sends you. You will be said to be on Active Employment on a day which is not a scheduled work day only if you are not Disabled and would be able to perform in the usual manner all the regular duties of your employment if it were a scheduled work day.

**DISABILITY:** Disability or Disabled for the first 12 months of Disability means that you are unable to perform the material and substantial duties of your Regular Occupation. After that, Disability means you are unable to perform the material and substantial duties of any Gainful Occupation for wage or profit for which you are reasonably qualified by training, education, or experience.

**DISABILITY EARNINGS:** Means the gross monthly earnings you receive while Disabled and Working.

**DISABILITY PAYMENT:** Means your Disability Benefit minus Deductible Sources of Income.

**ELIGIBLE FAMILY MEMBERS:** With regards to the Family Care Benefit, this means your child (natural, step, or adopted) living in your household and under age 13; or your family member who is:

- living in your household;
- dependent upon you for support; and
- in need of supervision or assistance due to physical or mental incapacity.

**HOSPITAL:** The term "Hospital" shall not include an institution used by you as:

- a place for rehabilitation;
- a place for rest or for the aged;
- a nursing or convalescent home;
- a long-term nursing unit or geriatrics ward; or
- as an extended care facility for the care of convalescent, rehabilitative, or ambulatory patients.

**LOST EARNINGS:** Means the percentage of Monthly Compensation you are losing due to your Disability while Disabled and Working. This is computed as follows:

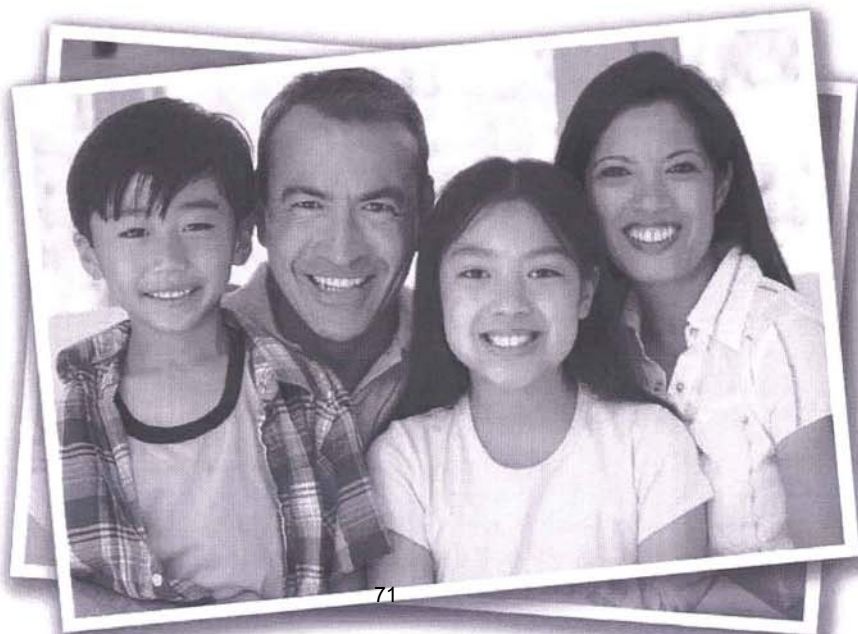
- subtract your Disability Earnings from your Monthly Compensation;
- divide this answer by your Monthly Compensation. This will be your percentage of lost earnings.
- multiply your Disability payment by your percentage of lost earnings.

**MONTHLY COMPENSATION:** Means for contracted employees, one-twelfth (1/12) of your contract salary through your Employer; or for non-contracted employees, one-twelfth (1/12) of your annual salary through your Employer, in effect on the date Disability began. It excludes any additional compensation including but not limited to, overtime pay, weekend or summer work compensation, bus or other allowances, bonuses or district-funded fringe benefits. If you become Disabled while on an approved leave of absence, we will use your gross Monthly Compensation from your Employer in effect just prior to the date your absence began.

**PRE-EXISTING CONDITION:** The term "Pre-Existing Condition" means a disease, Injury, Sickness, physical condition or mental illness for which you:

- had treatment;
- incurred expense;
- took medication;
- received care or services including diagnostic testing or related measures; or
- received a diagnosis or advice from a Physician,

during the 12-month period immediately before your Effective Date of coverage. The term Pre-Existing Condition will also include conditions which are related to such disease, Injury, Sickness, physical condition, or mental illness.



# Critical Illness Rider

## CONSIDER THE FACTS

- The cost of a two-year disability can equal one to two times an individual's or family's annual household income.

*AHIP and LIFE: The Impact of Disability prepared by Milliman, Inc; May 2009.*

CRITICAL ILLNESS RIDER	
Benefit Amount	Monthly Premium
\$10,000.00	\$9.80
\$15,000.00	\$13.18
\$20,000.00	\$16.56
\$25,000.00	\$19.94

We will pay a one-time lump sum benefit amount based on diagnosis of the following conditions:

- Heart Attack,
- Stroke,
- Kidney Failure,
- Paralysis, or
- Major Organ Failure.

In the case of Heart Attack, a physician must make the diagnosis and treatment must occur within 72 hours of the onset of symptoms.

# Accident Only Spousal Rider

## CONSIDER THE FACTS

- On average, one out of every 11 Americans suffered a disabling injury in 2007.

*National Safety Council, Injury Facts, 2009 Edition, p. 2*

- Total costs of accidental injuries averaged \$26,023 per injury in 2007.

*National Safety Council, Injury Facts, 2009 Edition, p. 4*

ACCIDENT ONLY SPOUSAL RIDER		
Monthly Indemnity Amount	Annual Salary	Monthly Premium
\$500.00	up to \$10,000.00	\$4.00
\$1,000.00	\$10,001.00 - \$20,000.00	\$8.00
\$1,500.00	\$20,001.00 - \$30,000.00	\$12.00
\$2,000.00	\$30,001.00 and over.	\$16.00

We will pay a monthly indemnity amount to you for your spouse who is disabled as a result of a non-occupational accident. Benefits will begin on the 31st consecutive day after the Injury and will continue for up to 2 years.

Coverage under this Rider will begin on the later of the requested Effective Date or the date we approve the written application, provided that your spouse has no other group disability income coverage in force; is less than age 70; is engaged in Full Time Employment on the date this Rider becomes effective; and is able to perform the material and substantial duties of his or her occupation on the date this Rider becomes

## CRITICAL ILLNESS RIDER LIMITATIONS

In addition to the Exclusions listed in the Base Plan to which this Rider is attached, no benefits will be paid for any loss caused by or resulting from: (a) a Critical Illness when the Date of Diagnosis occurs during the Waiting Period; (b) a Critical Illness diagnosed outside of the United States; or (c) a Sickness or Injury not specifically defined in this Rider.

No Critical Illness Benefit will be payable for a Critical Illness which is caused by or resulting from a Pre-Existing Condition when the Critical Illness Date of Diagnosis occurs before you have been continuously covered under this Rider for 12 consecutive months. Following 12 consecutive months this exclusion does not apply.

Pre-Existing Condition means a disease, Injury, Sickness, physical condition or mental illness for which you have experienced any of the following: (a) treatment; (b) incurred expense; (c) took medication; (d) received care or services including diagnostic testing or related measures; or (e) received a diagnosis or advise from a Physician, during the 12-month period immediately before the Effective Date of this Rider. The term Pre-Existing Condition will also include conditions which are related to such disease, Injury, Sickness, physical condition or mental illness.

Benefits reduce by 50% at age 70. No benefits will be paid for a Critical Illness when the Date of Diagnosis occurs during the Critical Illness Waiting Period. The waiting period is 30 days from the Effective Date of this Rider.

effective, and; your coverage under the Policy is in force and you are on Active Employment; and the required premium has been paid.

FULL TIME EMPLOYMENT (or Full Time) means your Spouse is employed an average of 25 or more hours per week for pay or benefits. Full Time Employment does not include any hours your Spouse is working while self-employed.

## ACCIDENT ONLY SPOUSAL RIDER LIMITATIONS

This Rider does not provide benefits for your Spouse for any Disability, fatal or non-fatal, which results from any of the following: (a) Intentionally self-inflicted Injury while sane or insane; (b) An act of war, declared or undeclared; (c) Injury sustained or contracted while in the service of the armed forces of any country; (d) Committing a felony; (e) Penal incarceration. We will not pay benefits during any period for which your Spouse is incarcerated in a penal or correctional institution or for any Injury that occurs while your Spouse is incarcerated in a penal or correctional institution; (f) Injury arising out of and in the course of any occupation for wage or profit or for which your Spouse is entitled to Workers' Compensation. The term "entitled to Workers' Compensation" shall also include Workers' Compensation claim settlements which occur via compromise and release. Further, no benefits will be paid under this Policy for any period during which your Spouse is entitled to Workers' Compensation benefits; (g) Participation in any sport for wage or profit; (h) Participation in any contest of speed in a power driven vehicle for wage or profit.

Spouse means the person you are lawfully married to who is less than age 70. No benefits are payable for your Spouse under this Rider for a Disability from an Injury that occurred outside of the United States or its territories. No benefit will be provided for any period in which your Spouse is not under the Regular and Appropriate Care of a Physician. No benefits will be paid for any Injury to your Spouse which is caused by or resulting from spousal abuse.

# Survivor Benefit Rider

If you have been Disabled and not working for at least 90 days; and die while receiving Disability Benefits, a Survivor Benefit will be paid to your beneficiary or estate.

The Survivor Benefit will be paid monthly up to 1 year or until the Maximum Disability Period is exhausted, whichever occurs first.

## SURVIVOR BENEFIT RIDER

Monthly Benefit Amount	Monthly Premium
\$2,000.00	\$6.80

# COBRA Funding Rider

## CONSIDER THE FACTS

- Currently, the average long-term disability absence lasts 2.5 years.

*Council for Disability Awareness, Worker Disability Planning & Preparedness Study, 2008*

- Half of bankruptcies are caused by unexpected illnesses, injuries, and medical bills.

*Business Wire: Many Workers Would Rely on Credit or Family if Disabled or Ill; April 2009*

- Many people suffering from a serious sickness or injury lose their job and their employer-provided medical insurance.

*Council for Disability Awareness, Worker Disability Planning & Preparedness Study, 2008*

In order to receive benefits under this Rider, you must:

- be receiving benefits under your Disability base plan;
- elect medical Cobra coverage; and
- be paying medical Cobra premiums.

This Benefit will pay up to the end of the disability benefit period or to the end of your medical COBRA benefit period, whichever occurs first.

## COBRA FUNDING RIDER

Monthly Benefit Amount	Monthly Premium
\$300.00	\$4.50

## COBRA FUNDING RIDER LIMITATIONS

Proof of election of medical COBRA continuation must be provided to us. Proof of continued medical COBRA participation will be required before benefits are paid under this Rider.



# Benefit Schedule

Several benefit options are available to you. You may participate in the Plan under any one of the benefit levels outlined below, provided the Monthly Disability Benefit level selected does not exceed 70% of your Monthly Compensation.

Monthly Salary	Monthly Disability Benefit	Accidental Death Benefit	Plan II (15th)	Plan III (31st)	Plan IV (61st)	Plan V (91st)	Plan VI (151st)
\$286.00 - \$428.99	\$200.00	\$20,000.00	\$7.28	\$5.80	\$4.92	\$4.16	\$3.12
\$429.00 - \$571.99	\$300.00	\$20,000.00	\$10.92	\$8.70	\$7.38	\$6.24	\$4.68
\$572.00 - \$714.99	\$400.00	\$20,000.00	\$14.56	\$11.60	\$9.84	\$8.32	\$6.24
\$715.00 - \$857.99	\$500.00	\$20,000.00	\$18.20	\$14.50	\$12.30	\$10.40	\$7.80
\$858.00 - \$999.99	\$600.00	\$20,000.00	\$21.84	\$17.40	\$14.76	\$12.48	\$9.36
\$1,000.00 - \$1,142.99	\$700.00	\$20,000.00	\$25.48	\$20.30	\$17.22	\$14.56	\$10.92
\$1,143.00 - \$1,285.99	\$800.00	\$20,000.00	\$29.12	\$23.20	\$19.68	\$16.64	\$12.48
\$1,286.00 - \$1,428.99	\$900.00	\$20,000.00	\$32.76	\$26.10	\$22.14	\$18.72	\$14.04
\$1,429.00 - \$1,571.99	\$1,000.00	\$20,000.00	\$36.40	\$29.00	\$24.60	\$20.80	\$15.60
\$1,572.00 - \$1,714.99	\$1,100.00	\$20,000.00	\$40.04	\$31.90	\$27.06	\$22.88	\$17.16
\$1,715.00 - \$1,857.99	\$1,200.00	\$20,000.00	\$43.68	\$34.80	\$29.52	\$24.96	\$18.72
\$1,858.00 - \$1,999.99	\$1,300.00	\$20,000.00	\$47.32	\$37.70	\$31.98	\$27.04	\$20.28
\$2,000.00 - \$2,142.99	\$1,400.00	\$20,000.00	\$50.96	\$40.60	\$34.44	\$29.12	\$21.84
\$2,143.00 - \$2,285.99	\$1,500.00	\$20,000.00	\$54.60	\$43.50	\$36.90	\$31.20	\$23.40
\$2,286.00 - \$2,428.99	\$1,600.00	\$20,000.00	\$58.24	\$46.40	\$39.36	\$33.28	\$24.96
\$2,429.00 - \$2,571.99	\$1,700.00	\$20,000.00	\$61.88	\$49.30	\$41.82	\$35.36	\$26.52
\$2,572.00 - \$2,714.99	\$1,800.00	\$20,000.00	\$65.52	\$52.20	\$44.28	\$37.44	\$28.08
\$2,715.00 - \$2,857.99	\$1,900.00	\$20,000.00	\$69.16	\$55.10	\$46.74	\$39.52	\$29.64
\$2,858.00 - \$2,999.99	\$2,000.00	\$20,000.00	\$72.80	\$58.00	\$49.20	\$41.60	\$31.20
\$3,000.00 - \$3,142.99	\$2,100.00	\$20,000.00	\$76.44	\$60.90	\$51.66	\$43.68	\$32.76
\$3,143.00 - \$3,285.99	\$2,200.00	\$20,000.00	\$80.08	\$63.80	\$54.12	\$45.76	\$34.32
\$3,286.00 - \$3,428.99	\$2,300.00	\$20,000.00	\$83.72	\$66.70	\$56.58	\$47.84	\$35.88
\$3,429.00 - \$3,571.99	\$2,400.00	\$20,000.00	\$87.36	\$69.60	\$59.04	\$49.92	\$37.44
\$3,572.00 - \$3,714.99	\$2,500.00	\$20,000.00	\$91.00	\$72.50	\$61.50	\$52.00	\$39.00
\$3,715.00 - \$3,857.99	\$2,600.00	\$20,000.00	\$94.64	\$75.40	\$63.96	\$54.08	\$40.56
\$3,858.00 - \$3,999.99	\$2,700.00	\$20,000.00	\$98.28	\$78.30	\$66.42	\$56.16	\$42.12
\$4,000.00 - \$4,142.99	\$2,800.00	\$20,000.00	\$101.92	\$81.20	\$68.88	\$58.24	\$43.68
\$4,143.00 - \$4,285.99	\$2,900.00	\$20,000.00	\$105.56	\$84.10	\$71.34	\$60.32	\$45.24
\$4,286.00 - \$4,428.99	\$3,000.00	\$20,000.00	\$109.20	\$87.00	\$73.80	\$62.40	\$46.80
\$4,429.00 - \$4,571.99	\$3,100.00	\$20,000.00	\$112.84	\$89.90	\$76.26	\$64.48	\$48.36
\$4,572.00 - \$4,714.99	\$3,200.00	\$20,000.00	\$116.48	\$92.80	\$78.72	\$66.56	\$49.92
\$4,715.00 - \$4,857.99	\$3,300.00	\$20,000.00	\$120.12	\$95.70	\$81.18	\$68.64	\$51.48
\$4,858.00 - \$4,999.99	\$3,400.00	\$20,000.00	\$123.76	\$98.60	\$83.64	\$70.72	\$53.04
\$5,000.00 - \$5,142.99	\$3,500.00	\$20,000.00	\$127.40	\$101.50	\$86.10	\$72.80	\$54.60
\$5,143.00 - \$5,285.99	\$3,600.00	\$20,000.00	\$131.04	\$104.40	\$88.56	\$74.88	\$56.16
\$5,286.00 - \$5,428.99	\$3,700.00	\$20,000.00	\$134.68	\$107.30	\$91.02	\$76.96	\$57.72
\$5,429.00 - \$5,571.99	\$3,800.00	\$20,000.00	\$138.32	\$110.20	\$93.48	\$79.04	\$59.28

# Benefit Schedule (con't)

Several benefit options are available to you. You may participate in the Plan under any one of the benefit levels outlined below, provided the Monthly Disability Benefit level selected does not exceed 70% of your Monthly Compensation.

Monthly Salary	Monthly Disability Benefit	Accidental Death Benefit	Plan II (15th)	Plan III (31st)	Plan IV (61st)	Plan V (91st)	Plan VI (151st)
\$5,572.00 - \$5,714.99	\$3,900.00	\$20,000.00	\$141.96	\$113.10	\$95.94	\$81.12	\$60.84
\$5,715.00 - \$5,857.99	\$4,000.00	\$20,000.00	\$145.60	\$116.00	\$98.40	\$83.20	\$62.40
\$5,858.00 - \$5,999.99	\$4,100.00	\$20,000.00	\$149.24	\$118.90	\$100.86	\$85.28	\$63.96
\$6,000.00 - \$6,142.99	\$4,200.00	\$20,000.00	\$152.88	\$121.80	\$103.32	\$87.36	\$65.52
\$6,143.00 - \$6,285.99	\$4,300.00	\$20,000.00	\$156.52	\$124.70	\$105.78	\$89.44	\$67.08
\$6,286.00 - \$6,428.99	\$4,400.00	\$20,000.00	\$160.16	\$127.60	\$108.24	\$91.52	\$68.64
\$6,429.00 - \$6,571.99	\$4,500.00	\$20,000.00	\$163.80	\$130.50	\$110.70	\$93.60	\$70.20
\$6,572.00 - \$6,714.99	\$4,600.00	\$20,000.00	\$167.44	\$133.40	\$113.16	\$95.68	\$71.76
\$6,715.00 - \$6,857.99	\$4,700.00	\$20,000.00	\$171.08	\$136.30	\$115.62	\$97.76	\$73.32
\$6,858.00 - \$6,999.99	\$4,800.00	\$20,000.00	\$174.72	\$139.20	\$118.08	\$99.84	\$74.88
\$7,000.00 - \$7,142.99	\$4,900.00	\$20,000.00	\$178.36	\$142.10	\$120.54	\$101.92	\$76.44
\$7,143.00 - \$7,285.99	\$5,000.00	\$20,000.00	\$182.00	\$145.00	\$123.00	\$104.00	\$78.00
\$7,286.00 - \$7,428.99	\$5,100.00	\$20,000.00	\$185.64	\$147.90	\$125.46	\$106.08	\$79.56
\$7,429.00 - \$7,571.99	\$5,200.00	\$20,000.00	\$189.28	\$150.80	\$127.92	\$108.16	\$81.12
\$7,572.00 - \$7,714.99	\$5,300.00	\$20,000.00	\$192.92	\$153.70	\$130.38	\$110.24	\$82.68
\$7,715.00 - \$7,857.99	\$5,400.00	\$20,000.00	\$196.56	\$156.60	\$132.84	\$112.32	\$84.24
\$7,858.00 - \$7,999.99	\$5,500.00	\$20,000.00	\$200.20	\$159.50	\$135.30	\$114.40	\$85.80
\$8,000.00 - \$8,142.99	\$5,600.00	\$20,000.00	\$203.84	\$162.40	\$137.76	\$116.48	\$87.36
\$8,143.00 - \$8,285.99	\$5,700.00	\$20,000.00	\$207.48	\$165.30	\$140.22	\$118.56	\$88.92
\$8,286.00 - \$8,428.99	\$5,800.00	\$20,000.00	\$211.12	\$168.20	\$142.68	\$120.64	\$90.48
\$8,429.00 - \$8,571.99	\$5,900.00	\$20,000.00	\$214.76	\$171.10	\$145.14	\$122.72	\$92.04
\$8,572.00 - \$8,713.99	\$6,000.00	\$20,000.00	\$218.40	\$174.00	\$147.60	\$124.80	\$93.60
\$8,714.00 - \$8,856.99	\$6,100.00	\$20,000.00	\$222.04	\$176.90	\$150.06	\$126.88	\$95.16
\$8,857.00 - \$8,999.99	\$6,200.00	\$20,000.00	\$225.68	\$179.80	\$152.52	\$128.96	\$96.72
\$9,000.00 - \$9,142.99	\$6,300.00	\$20,000.00	\$229.32	\$182.70	\$154.98	\$131.04	\$98.28
\$9,143.00 - \$9,285.99	\$6,400.00	\$20,000.00	\$232.96	\$185.60	\$157.44	\$133.12	\$99.84
\$9,286.00 - \$9,428.99	\$6,500.00	\$20,000.00	\$236.60	\$188.50	\$159.90	\$135.20	\$101.40
\$9,429.00 - \$9,570.99	\$6,600.00	\$20,000.00	\$240.24	\$191.40	\$162.36	\$137.28	\$102.96
\$9,571.00 - \$9,713.99	\$6,700.00	\$20,000.00	\$243.88	\$194.30	\$164.82	\$139.36	\$104.52
\$9,714.00 - \$9,856.99	\$6,800.00	\$20,000.00	\$247.52	\$197.20	\$167.28	\$141.44	\$106.08
\$9,857.00 - \$9,999.99	\$6,900.00	\$20,000.00	\$251.16	\$200.10	\$169.74	\$143.52	\$107.64
\$10,000.00 - \$10,142.99	\$7,000.00	\$20,000.00	\$254.80	\$203.00	\$172.20	\$145.60	\$109.20
\$10,143.00 - \$10,285.99	\$7,100.00	\$20,000.00	\$258.44	\$205.90	\$174.66	\$147.68	\$110.76
\$10,286.00 - \$10,428.99	\$7,200.00	\$20,000.00	\$262.08	\$208.80	\$177.12	\$149.76	\$112.32
\$10,429.00 - \$10,570.99	\$7,300.00	\$20,000.00	\$265.72	\$211.70	\$179.58	\$151.84	\$113.88
\$10,571.00 - \$10,713.99	\$7,400.00	\$20,000.00	\$269.36	\$214.60	\$182.04	\$153.92	\$115.44
\$10,714.00 - \$10,857.99	\$7,500.00	\$20,000.00	\$273.00	\$217.50	\$184.50	\$156.00	\$117.00

# The Company Behind Your Plan

American Fidelity Assurance Company is a third-generation, family-owned organization providing insurance products and financial services to education employees, trade association members and companies throughout the United States and across the globe.

Since 1982, American Fidelity has been rated "A+" (Superior)<sup>1</sup> by A.M. Best Company. Considered one of the nation's leading insurance company rating services, A.M. Best bases its ratings on an analysis of the financial condition and operating performance of insurance companies in such vital areas as: Competency of Underwriting, Control of Expenses, Adequacy of Reserves, Soundness of Investments and Capital Sufficiency.

Because of American Fidelity's fiscal strength and financial security, the company has been rated "A" (Excellent)<sup>2</sup> with Weiss Ratings. This places American Fidelity on the list of Weiss' Recommended Companies, an elite group of life, health and annuity companies. American Fidelity's rating represents the top 2.8 percent of insurance companies.

The 2010 Standard and Poor's Insurance Rating Report has given American Fidelity an "Api"<sup>3</sup> rating. The qualified solvency ratings assigned by S&P are based on the analysis of quantitative data such as Capital Strength, Quality of Assets, Profitability and Liquidity.

American Fidelity Assurance Company is proud to count itself among Fortune<sup>4</sup> magazine's "100 Best Companies to Work For" in America for the seventh straight year. We know that satisfied employees result in satisfied customers, which is an important foundation of American Fidelity's approach to business.

American Fidelity is founded on and driven by the principle of serving our customers and protecting their investment. We continue to grow steadily through calculated growth and conservative investment practices.

<sup>1</sup> *Best's Insurance Reports: Life/Health, 2010 Edition, Vol. 1, July 12, 2010 (A+ is the 2nd out of 16 with 1 being the highest.)*

<sup>2</sup> *Weiss Ratings' Guide to Life and Annuity Insurers, Summer 2010 (A is the 2nd out of 16 with 1 being the highest.)*

<sup>3</sup> *www.standardandpoors.com February, 2010 (Api is 6th out of 22 with 1 being the highest.)*

<sup>4</sup> *Fortune Magazine, February 8, 2010 Issue.*



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AMERICAN FIDELITY  
ASSURANCE COMPANY'S

# *Accident Only* Insurance Plan



This is not a policy of Workers' Compensation insurance. The employer does not become a subscriber to the Workers' Compensation system by purchasing this policy. And, if the employer is a non-subscriber, the employer loses those benefits which would otherwise accrue under the Workers' Compensation laws. The employer must comply with the Workers' Compensation law as it pertains to non-subscribers and the required notifications that must be filed and posted.

Accidents Happen...  
Are You Prepared?

# *Accident* Only Plan

Accidents can happen to anyone at any time.

Whether it's turning left when you should have gone right or just finding yourself in the wrong place at the wrong time, accidents happen. If you think you're immune, the numbers tell a different story.

## CONSIDER THE FACTS...

- *On average, a fatal injury occurred every 4 minutes in 2006.\**
- *On average, a disabling injury occurs every 1.2 seconds.\**
- *About 1 out of every 9 Americans sought medical attention for an injury in 2005.\**
- *Accidents continue to be the fifth leading cause of death for Americans.\**

\*National Safety Council, Injury Facts, 2008 Edition, pg 2.

You cannot predict when or if an accident will even happen, but you can protect yourself and your family against the high cost of accidental injury or death. American Fidelity will help you prepare for the expenses associated with accidental injury.

American Fidelity Assurance Company's (AFA) Limited Benefit Accident Only Insurance Policy lets you take precautions today to help keep you and your family from financial harm in the future.

## AFA's Accident Only Plan *provides:*

- Benefit payments made directly to you.
- Benefits regardless of other coverage.
- Individual and family plans.
- Guaranteed renewability for the base plan for as long as you pay your premiums as required.
- Accident Benefit Enhancement Rider available to primary insured, spouse and child(ren).

# Help When *You* Need It.

A Covered Person under AFA's Limited Benefit Accident Only Policy can expect the following benefits when a covered accident happens: (All benefits are only paid as a result of injuries received in an Accident that occurs while coverage is in force. All treatment, procedures, and medical equipment must be diagnosed, recommended and treated by a Physician. All benefits are paid once per Covered Person per Covered Accident unless otherwise specified.)

## ACCIDENT EMERGENCY TREATMENT BENEFIT

*Hospital Emergency Room*

*Basic Plan - \$100*

*Enhanced Plan - \$150*

*Doctor's Office*

*Basic Plan - \$75*

*Enhanced Plan - \$100*

These benefits are provided for a Covered Person who receives emergency treatment in a Physician's office or hospital emergency room within 72 hours of the Covered Accident, including physician fees, x-rays and emergency services.

## ACCIDENT FOLLOW-UP TREATMENT BENEFIT

*\$50 per treatment for both Basic and Enhanced Plans*

This benefit provides for necessary follow-up treatment of injuries in addition to the emergency treatment administered within 72 hours of a Covered Accident for up to four treatments per Covered Person per Covered Accident. This benefit is not payable for a visit in which a Physical Therapy Benefit is paid. This benefit is also not payable if the Non-Emergency Accident Follow-up benefit is paid under the Benefit Enhancement Rider.

## MEDICAL IMAGING BENEFIT

*\$150 for both Basic and Enhanced Plans*

You receive this benefit for a Covered Person who has either a Magnetic Resonance Imaging (MRI), a Computed Tomography (CT) scan, a Computed Axial Tomography (CAT) scan, a Positron Emission Tomography (PET) scan or an ultrasound.

## HOSPITAL CONFINEMENT BENEFITS

*Hospital Admission*

*Basic Plan - \$500*

*Enhanced Plan - \$1,000*

*Intensive Care Confinement*

*Basic Plan - \$300*

*Enhanced Plan - \$600*

*Hospital Confinement*

*Basic Plan - \$100*

*Enhanced Plan - \$200*

You will receive a one-time Hospital Admission Benefit per Covered Accident if a Covered Person is Hospital Confined due to accidental injuries (does not include emergency room and outpatient treatment). You will also receive a daily benefit for a Hospital Confinement that is longer than 18 hours for up to 365 days and an additional daily benefit for Confinement in an Intensive Care Unit up to 15 days.

A hospital is not an institution, or part thereof, used as: a hospice unit, including any bed designated as a swing bed; a convalescent home; a rest or nursing facility; a rehabilitative facility; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial, educational care, or care or treatment for persons suffering from mental diseases or disorders, or care for the aged, or drug or alcohol addiction.

## WELLNESS BENEFIT

*Basic Plan - \$50*

*Enhanced Plan - \$75*

After coverage is in force 12 months, you or any other Covered Person can receive a benefit for an annual routine physical exam, including immunizations and preventive testing. Services must be supervised by a Physician and a charge must be incurred for the service. The benefit does not apply to dental or eye exams and is payable once per policy per calendar year.



## AMBULANCE BENEFIT

*\$150 for ground ambulance transport for both Basic and Enhanced Plans*

*\$500 for air ambulance transport for both Basic and Enhanced Plans*

This benefit is provided when accidental Injuries due to a Covered Accident require a Covered Person to be transported by a licensed ambulance to a Hospital or emergency center. If air and ground ambulance transportation is required for the same Covered Accident, only the highest benefit amount will be paid.

## TRANSPORTATION BENEFIT

*\$300 per round trip for both Basic and Enhanced Plans*

You will receive this benefit for transportation of a Covered Person requiring specialized treatment and Hospital Confinement in a non-local Hospital. The non-local Hospital must be at least 100 miles away, one way (50 miles if Benefit Enhancement Rider is elected), using the most direct route, from the closer of the Covered Person's residence or site of the Covered Accident. Travel must be by scheduled bus, plane, train or car and excludes Ambulance service. The treatment must be prescribed by a Physician and not be available locally. Benefits are provided for up to three round trips per Calendar Year per Covered Person. Transportation benefit will only be provided for the Injured Covered Person.

## FAMILY MEMBER LODGING AND MEALS BENEFIT

*\$100 per day for of Confinement for both Basic and Enhanced Plans*

You will receive this benefit for lodging and meals for a family member to be near a Covered Person who is Confined in a non-local Hospital. The non-local Hospital must be at least 100 miles one way (50 miles if Benefit Enhancement Rider is elected) from the Covered Person's residence or site of the Covered Accident. This benefit is payable only during the period the Injured Covered Person is Hospital confined. This benefit is paid for up to 30 days of Hospital Confinement per Covered Accident.

## ACCIDENTAL DEATH OR DISMEMBERMENT BENEFIT

Accidental Death						
	Primary Insured		Spouse		Child	
	<i>Basic Plan</i>	<i>Enhanced Plan</i>	<i>Basic Plan</i>	<i>Enhanced Plan</i>	<i>Basic Plan</i>	<i>Enhanced Plan</i>
Common Carrier	\$50,000	\$100,000	\$25,000	\$50,000	\$10,000	\$20,000
Other Accident	15,000	30,000	7,500	15,000	5,000	10,000
Accidental Dismemberment						
	Primary Insured		Spouse		Child	
	<i>Basic Plan</i>	<i>Enhanced Plan</i>	<i>Basic Plan</i>	<i>Enhanced Plan</i>	<i>Basic Plan</i>	<i>Enhanced Plan</i>
Both arms and both legs	\$15,000	\$30,000	\$7,500	\$15,000	\$5,000	\$10,000
Both: eyes, hands, feet, legs or arms	7,500	15,000	3,750	7,500	2,500	5,000
One: arm, leg, eye, hand or foot	3,000	6,000	1,500	3,000	1,000	2,000
One or more fingers or toes	300	600	150	300	100	200

The applicable benefits above apply when a Covered Person's Accidental Death or Dismemberment occurs within 90 days of a Covered Accident. In the event that Accidental Death and Dismemberment result from the same Covered Accident, only the Accidental Death benefit will be paid. Accidental Death or Dismemberment must be independent of any disease or bodily infirmity or any other cause. Only the highest single benefit will be paid. Loss of use does not constitute dismemberment except as stated for eye injuries in the policy.

# Additional Medical Expense Benefits

## *Basic and Enhanced Plans*

### **APPLIANCES**

*\$100 for both Basic and Enhanced Plans*

This benefit provides for one of the following: crutches, leg braces, back braces, walkers, or wheel chairs. This benefit is not payable for Prosthetic Devices.

### **BLOOD, PLASMA AND PLATELETS**

*\$250 for both Basic and Enhanced Plans*

This benefit does not include payment for immunoglobulins.

### **BURNS**

*\$100-\$10,000 for both Basic and Enhanced Plans*

This benefit is provided for burns received in a Covered Accident when treated by a Physician within 72 hours.

### **SKIN GRAFT**

*25% of the covered Burn Benefit*

This benefit is based on burn severity and treatment must be provided by a Physician beginning within 72 hours of the Covered Accident.

### **DISLOCATIONS**

*\$100 - \$3,000 for both Basic and Enhanced Plans*

Benefit amount varies by the joint involved, type of treatment, and type of anesthesia. If a Covered Person receives more than one Dislocation in a Covered Accident, we will pay for all Dislocations up to two times the amount shown in the Schedule of Benefits for the Dislocation involved that has the highest benefit amount. No other amount will be paid under this benefit. Benefits are payable only for the first dislocation of a joint which occurs while this policy is in force and requires open or closed Reduction.

### **EXPLORATORY SURGERY WITHOUT SURGICAL REPAIR**

*\$250 for both Basic and Enhanced Plans*

This benefit is payable for only one exploratory surgery without surgical repair per Covered Accident per Covered Person.

### **EYE INJURY**

*\$250 for surgical repair; \$50 for removal of foreign body*

These benefits will be paid for one or both eyes requiring treatment by a Physician due to a Covered Accident. If permanent loss of use of one or both eyes occurs, benefits will be paid under the Accidental Dismemberment Benefit.

### **FRACTURES**

*\$100 - \$3,000*

Benefit varies based on the bone involved, type of fracture and type of treatment. If the Covered Person fractures more than one bone in a Covered Accident, payment is made for all Fractures up to two times the amount for the bone involved that has the highest benefit amount. All fractures must be treated by a Physician.

### **INTERNAL INJURIES**

*\$1,000 for both Basic and Enhanced Plans*

This benefit is provided for open abdominal or thoracic surgery performed within 72 hours of a Covered Accident.

### **LACERATIONS**

*\$25 - \$400 for both Basic and Enhanced Plans*

This benefit varies based on the severity of the laceration. The lacerations must be repaired or treated by a Physician.

### **CONCUSSION BENEFIT**

*\$200 for both Basic and Enhanced Plans*

This benefit is provided for a Covered Person who sustains a concussion and is diagnosed by a Physician within 72 hours of the Covered Accident using any type of imaging.

### **PHYSICAL THERAPY**

*\$25 per treatment for both Basic and Enhanced Plans*

This benefit is provided for up to one treatment per day for up to eight treatments per Covered Person per Covered Accident. The benefit is not payable for the same visit that the Accident Follow-up Treatment Benefit is paid. This benefit is also not payable if the Non-Emergency Accident Follow-up benefit is paid under the Benefit Enhancement Rider.

### **PROSTHESIS**

*\$500 for both Basic and Enhanced Plans*

This benefit is not payable for hearing aids; dental aids; false teeth; eye glasses; cosmetic aids such as hair wigs; joint replacements such as artificial hips or knees.

### **RUPTURED DISC OR TORN KNEE CARTILAGE**

*\$500 for both Basic and Enhanced Plans*

This benefit is provided for surgical repair performed by a Physician.

### **TENDONS, LIGAMENTS AND ROTATOR CUFF**

*\$500 for single surgical repair; \$750 for multiple surgical repair*

The tendons, ligaments or rotator cuff must be treated by a Physician and must be repaired through surgery.

### **EMERGENCY DENTAL WORK**

*\$150 for broken teeth repaired with crown;*

*\$50 for extraction of broken teeth regardless of number of teeth*

This benefit provides for repair to natural teeth when treated by a Physician or dentist. Initial dental treatment must be received within 72 hours of the Covered Accident. Benefits paid only once per Covered Person per Covered Accident.

### **PARALYSIS**

*Quadriplegia \$10,000; Paraplegia \$5,000*

The duration of the Paralysis must be a minimum of 3 consecutive months. This benefit is paid once per lifetime per Covered Person.



## FAMILY COVERAGE

You can take advantage of several options to extend coverage to your family:

- ***Individual and Spouse Plan*** – Covers you and your Spouse.
- ***Family Plan*** – Covers you, your Spouse and each Eligible Child, as defined in the policy.
- ***Single Parent Family Plan*** – Covers you and each Eligible Child, as defined in the policy.

## GUARANTEED RENEWABLE

You are guaranteed the right to renew your base policy during your lifetime as long as you pay premiums when due or within the premium grace period. Accident Disability Income Riders are Guaranteed Renewable until Primary Insured reaches age 70. You cannot be singled out for a rate increase for any reason. Rates can be changed only if rates for all policies in this class change.

## LIMITATIONS AND EXCLUSIONS

An Accident is defined as a sudden, unexpected and unintended event, which results in bodily injury, which is independent of disease or bodily infirmity or any other cause. The policy will not pay benefits for injuries received prior to the Effective Date of coverage that are aggravated or re-injured by any event that occurs after the Effective Date.

No benefits will be provided for an Accident or Total Disability that is caused by or occurs as a result of:

- intentionally self-inflicted bodily injury, suicide or attempted suicide, whether sane or insane;
- participation in any form of flight aviation other than as a fare-paying passenger in a fully licensed/passenger-carrying aircraft;
- any act that was caused by war, declared or undeclared, or service in any of the armed forces;
- participation in any activity or event while under the influence of any narcotic unless administered by a Physician or taken according to the Physician's instructions;
- participation in, or attempting to participate in, a felony, riot or insurrection. (A felony is as defined by the law of the jurisdiction in which the activity takes place.)
- participation in any sport for pay or profit;
- participation in any contest of speed in a power driven vehicle for pay or profit;
- participation in parachuting, bungee jumping, rappelling, mountain climbing or hang gliding.

Benefits will not be paid for services rendered or Total Disability verified by a member of the immediate family of a Covered Person.

Benefits will not be provided for medical treatment or Total Disability for an Accident received outside the United States or its territories.

Benefits provided by the Accident Disability Income Riders will only be paid for one disability at a time, even if the Covered Person becomes Totally Disabled due to more than one injury or more than one Covered Accident. Benefits are not payable due to an Accident occurring during a period of time the Covered Person is incarcerated in any type of penal institution.

# Accident Benefit Enhancement Rider

Enhance your benefit amount and options by adding the Accident Benefit Enhancement rider to your policy.

## NON-EMERGENCY ACCIDENT INITIAL TREATMENT BENEFIT

Basic Plan - \$75

Enhanced Plan - \$100

We will pay the amount shown in the Schedule of Benefits for a Covered Person who receives initial medical treatment for Injuries sustained in a Covered Accident when such treatment is received more than 72 hours after the Covered Accident. Initial medical treatment must: (1) be received in a Physician's office or emergency room for Injuries sustained in a Covered Accident; and (2) be the first treatment received by the Covered Person for such Injuries; and (3) occur within 30 days following the Covered Accident. This benefit is payable once per Covered Person per Covered Accident.

## NON-EMERGENCY ACCIDENT FOLLOW-UP TREATMENT BENEFIT

Basic & Enhanced Plan - \$50

This benefit provides for necessary follow-up treatment of Injuries in addition to the emergency treatment administered within 72 hours of a Covered Accident for up to two treatments per Covered Person per Covered Accident. This benefit is not payable for a visit in which a Physical Therapy Benefit or the Accident Follow-Up Treatment Benefit is paid.

## X-RAY BENEFIT

Basic Plan - \$50

Enhanced Plan - \$100

We will pay the amount shown in the Schedule of Benefits for a Covered Person who has an x-ray performed due to Injuries sustained in a Covered Accident. The x-ray must be done at the request of a Physician. This benefit is payable one time per Covered Person per Covered Accident. This benefit does not cover any tests payable under the Medical Imaging Benefit or any other screening or medical imaging tests.

## OUTPATIENT HOSPITAL OR AMBULATORY SURGICAL CENTER BENEFIT

Basic Plan - \$150

Enhanced Plan - \$250

When a surgical procedure is performed on an outpatient basis in a Hospital or at an Ambulatory Surgical Center on a Covered Person for Injuries sustained in a Covered Accident, we will pay the indemnity amount shown in the Schedule of Benefits for the facility fee charged by such Hospital or Ambulatory Surgical Center. We will only pay one Outpatient Hospital or Ambulatory Surgical Center Benefit per Covered Person in a 24-hour period even if more than one surgical procedure is performed. This benefit will not be paid for surgery performed in a Hospital emergency room or in a Physician's office.

## ANESTHESIA BENEFIT

Basic Plan - \$150

Enhanced Plan - \$200

We will pay the amount shown in the Schedule of Benefits for the services of an anesthesiologist received as a result of a surgery performed due to Injuries sustained in a Covered Accident. Hospital Confinement is not required to receive this benefit. We will only pay one Anesthesia Benefit per Covered Person in a 24-hour period even if more than one surgical procedure is performed. This benefit is not payable for local anesthesia.

## Additional Accident Emergency Treatment Benefit Amounts

HOSPITAL EMERGENCY ROOM BENEFIT		
	Additional Benefit	Total Benefit Amount
Basic Plan	\$50	\$150
Enhanced Plan	\$50	\$200
DOCTOR'S OFFICE BENEFIT		
	Additional Benefit	Total Benefit Amount
Basic Plan	\$75	\$150
Enhanced Plan	\$100	\$200

MEDICAL IMAGING BENEFIT		
	Additional Benefit	Total Benefit Amount
Basic and Enhanced Plans	\$50	\$200
AMBULANCE BENEFIT		
	Additional Benefit	Total Benefit Amount
Basic & Enhanced Plans		
Ground	\$150	\$300
Air	\$1,000	\$1,500

"Total Benefit Amount" equals the base policy benefit amount plus the additional amount of increase in rider.

# ACCIDENT BENEFIT ENHANCEMENT RIDER BENEFIT AMOUNTS

ACCIDENTAL DEATH						
	Spouse		Child			
<b>BASIC PLAN</b>	<i>Rider Benefit</i>	<i>Total Benefit Amount</i>	<i>Rider Benefit</i>	<i>Total Benefit Amount</i>		
Common Carrier	\$25,000	\$50,000	\$15,000	\$25,000		
Other Accident	\$7,500	\$15,000	\$2,500	\$7,500		
<b>ENHANCED PLAN</b>	<i>Rider Benefit</i>	<i>Total Benefit Amount</i>	<i>Rider Benefit</i>	<i>Total Benefit Amount</i>		
Common Carrier	\$50,000	\$100,000	\$30,000	\$50,000		
Other Accident	\$15,000	\$30,000	\$5,000	\$15,000		

ACCIDENTAL DISMEMBERMENT						
	Primary Insured		Spouse		Child	
<b>BASIC PLAN</b>	<i>Rider Benefit</i>	<i>Total Benefit Amount</i>	<i>Rider Benefit</i>	<i>Total Benefit Amount</i>	<i>Rider Benefit</i>	<i>Total Benefit Amount</i>
Both arms and both legs	\$0	\$15,000	\$7,500	\$15,000	\$2,500	\$7,500
Both: eyes, hands, feet, legs or arms	\$0	\$7,500	\$3,750	\$7,500	\$1,250	\$3,750
One: arm, leg, eye, hand or foot	\$750	\$3,750	\$2,250	\$3,750	\$500	\$1,500
One or more fingers or toes	\$700	\$1,000	\$850	\$1,000	\$400	\$500
<b>ENHANCED PLAN</b>	<i>Rider Benefit</i>	<i>Total Benefit Amount</i>	<i>Rider Benefit</i>	<i>Total Benefit Amount</i>	<i>Rider Benefit</i>	<i>Total Benefit Amount</i>
Both arms and both legs	\$0	\$30,000	\$15,000	\$30,000	\$5,000	\$15,000
Both: eyes, hands, feet, legs or arms	\$0	\$15,000	\$7,500	\$15,000	\$2,500	\$7,500
One: arm, leg, eye, hand or foot	\$1,500	\$7,500	\$4,500	\$7,500	\$1,750	\$3,750
One or more fingers or toes	\$900	\$1,500	\$1,200	\$1,500	\$550	\$750

"Total Benefit Amount" equals the base policy benefit amount plus the additional amount of increase in rider.

## ACCIDENT ONLY MONTHLY PREMIUMS - EDUCATION RATES

BASIC PLAN					ENHANCED PLAN				
	Individual (I)	Individual & Spouse (I & S)	Individual & Children	Family		Individual (I)	Individual & Spouse (I & S)	Individual & Children	Family
Plan	14.60	21.60	24.80	31.80	Plan	20.40	27.50	32.80	39.90
Rider	5.30	6.70	6.70	8.10	Rider	5.70	7.40	8.20	9.90

The premium and amount of benefits may vary dependent upon the plan selected. This is a brief description of the coverage. For actual benefits, limitations, exclusions and other provisions, please refer to the policy and optional rider, Accident Only Benefit Enhancement Rider, AMDI-258 Series. This coverage does NOT replace Workers' Compensation Insurance. This product is inappropriate for people who are eligible for Medicaid coverage.

