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Health & Well-Being Plan Overview
COVERAGE PERIOD: 01 JULY 2013 - 30 JUNE 2014

This document is intended to provide a summary of the enrollment options available to eligible JLMI employees. Receipt of this document does not certify eligibility for benefits. For questions regarding eligibility, rates, election changes, or any other concerns, please contact the Human Resources Department at (804) 733-0933.

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Aflac: For plan details and enrollment options, please contact Dennis Jenkins via email at dennis_jenkins@us.aflac.com or by phone at (804) 852-8217.

Long Term Care (LTC): For plan details and enrollment options, please contact Jack Crocker via email at jack.crocker@prudential.com or by phone at (804) 733-0167.

HealthKeepers
Anthem HealthKeepers Value Advantage 25/500/30 POS Open Access / $10/$30/$50 or 20%

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 07/01/2013 - 06/30/2014

Coverage For: Individual/Family | **Plan Type:** POS

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-855-333-5735.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** single / **$1000** family for In-Plan Provider **$1000** single / **$2000** family for Out-of-Plan Provider Does not apply to Prescription Drugs, In-Plan Preventive Care, Copayments, Hospice, Manipulative Services, Office Based Lab and Routine Eye Exam. In-Plan Provider and Out-of-Plan Provider deductibles are separate and do not count towards each other.	You must pay all the costs up to the **deductible** amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the **deductible** starts over (usually, but not always, January 1st.) See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes; In-Plan Provider Single: **$3500**, Family: **$7000** Out-of-Plan Provider Single: **$5250**, Family: **$10500**	The **out-of-pocket limit** is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for health care expenses.

Important Questions	Answers	Why this Matters:
What is not included in the out-of-pocket limit?	Balance-Billed Charges, Pre-Authorization Penalties, Infertility Treatment Copays, Health Care This Plan Doesn't Cover, Premiums, Costs for Prescription Drugs in Tiers 1, 2, and 3, Prescription Drug Copays, Costs Related to Covered Prescription Drugs, Costs Related to Prescription Drugs Covered Under the Prescription Drug Plan, Out-of-Pocket Limit does not include Routine Vision Care.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the insurer pays?	No. This policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 3 describes any limits on what the insurer will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.anthem.com** or call **1-855-333-5735** for a list of participating providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Plans use the terms in-network, preferred, or participating to refer to providers in their network.
Do I need a referral to see a specialist?	No, you do not need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about excluded services.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **In-Plan Provider** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a In-Plan Provider	Your Cost If You Use a Out-of-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay	30% coinsurance	————none————
	Specialist visit	$50 copay	30% coinsurance	————none————
	Other practitioner office visit	Manipulative Therapy $25 copay Acupuncturist Not covered	Manipulative Therapy 30% coinsurance Acupuncturist Not covered	Manipulative Therapy Coverage is limited to 30 visits per yearper member. Failure to obtain preauthorization may result in non-coverage or reduced coverage. Services must be received by provider that participates in the American Specialty Health Network (ASHN).
	Preventive care/screening/ immunizations	No cost share	30% coinsurance	————none————
If you have a test	Diagnostic test (x-ray, blood work)	Lab - Office 30% coinsurance X-Ray - Office 30% coinsurance	Lab - Office 30% coinsurance X-Ray - Office 30% coinsurance	Lab - Office Copay does not apply when services are provided by the same provider on the same day as the office visit. A Specialist copay may apply.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	30% coinsurance	Failure to obtain preauthorization may result in non-coverage or reduced coverage.

Common Medical Event	Services You May Need	Your Cost If You Use a In-Plan Provider	Your Cost If You Use a Out-of-Plan Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.anthem.com/ pharmacyinformation/	Tier 1 – Typically Generic	$10 copay/ prescription (retail and mail order)	$10 copay/ prescription (retail and mail order)	Covers up to a 30 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)
	Tier 2 – Typically Preferred/Formulary Brand	$30 copay/ prescription (retail only) and $60 copay/prescription (mail order only)	$30 copay/ prescription (retail only) and $60 copay/prescription (mail order only)	If the member selects a brand drug when a generic equivalent is available the member is responsible for the generic copay plus the cost difference between the generic and brand equivalent even if the physician indicates no substitutions. Covers up to a 30 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)
	Tier 3 – Typically Non-preferred/ Non-formulary and Specialty Drugs	$50 or 20% coinsurance, whichever is the greater up to $200 per script maximum for retail. $150 or 20% coinsurance, whichever is the greater up to $400 per script maximum for mail order.	$50 or 20% coinsurance, whichever is the greater up to $200 per script maximum for retail. $150 or 20% coinsurance, whichever is the greater up to $400 per script maximum for mail order.	If the member selects a brand drug when a generic equivalent is available the member is responsible for the generic copay plus the cost difference between the generic and brand equivalent even if the physician indicates no substitutions. Covers up to a 30 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)
	See Tier 3 Benefits	Not covered	Not covered	$3500 annual out-of-pocket limit per member per benefit year ————none————

Common Medical Event	Services You May Need	Your Cost If You Use a In-Plan Provider	Your Cost If You Use a Out-of-Plan Provider	Limitations & Exceptions
If you have outpatient Surgery	Facility Fee (e.g., ambulatory surgery center)	30% coinsurance	30% coinsurance	————none————
	Physician/Surgeon Fees	30% coinsurance	30% coinsurance	————none————
If you need immediate medical attention	Emergency Room Services	30% coinsurance	30% coinsurance	No coverage for non emergency use of emergency room.
	Emergency Medical Transportation	30% coinsurance	30% coinsurance	————none————
	Urgent Care	$25 copay	30% coinsurance	————none————
If you have a hospital stay	Facility Fee (e.g., hospital room)	30% coinsurance	30% coinsurance	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Physician/surgeon fee	30% coinsurance	30% coinsurance	————none————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Mental/Behavioral Health Office Visit $25 copay Mental/Behavioral Health Facility Visit - Facility Charges 30% coinsurance	Mental/Behavioral Health Office Visit 30% coinsurance Mental/Behavioral Health Facility Visit - Facility Charges 30% coinsurance	————none————
	Mental/Behavioral health inpatient services	30% coinsurance	30% coinsurance	————none————
	Substance use disorder outpatient services	Substance Abuse Office Visit $25 copay Substance Abuse Facility Visit - Facility Charges 30% coinsurance	Substance Abuse Office Visit 30% coinsurance Substance Abuse Facility Visit - Facility Charges 30% coinsurance	————none————

Common Medical Event	Services You May Need	Your Cost If You Use a In-Plan Provider	Your Cost If You Use a Out-of-Plan Provider	Limitations & Exceptions
	Substance use disorder inpatient services	30% coinsurance	30% coinsurance	————none————
If you are pregnant	Prenatal and postnatal care	30% coinsurance	30% coinsurance	Your doctor's charges for delivery are part of prenatal and postnatal care.
	Delivery and all inpatient services	30% coinsurance	30% coinsurance	————none————
If you need help recovering or have other special health needs	Home Health Care	30% coinsurance	30% coinsurance	Coverage is limited to 100 visits per year.
	Rehabilitation Services	30% coinsurance	30% coinsurance	Coverage is limited to 30 visits per year for physical therapy and occupational therapy combined, 30 visits per year for speech therapy. Limit does not apply to autism services, if applicable. Services from In-Plan Provider and Out-of-Plan Provider count towards your limit.
	Habilitation Services	30% coinsurance	30% coinsurance	Rehabilitation and Habilitation visits count towards your Rehabilitation limit.
	Skilled Nursing Care	30% coinsurance	30% coinsurance	Coverage is limited to 100 days per stay. Services from In-Plan Provider and Out-of-Plan Provider count towards your limit.
	Durable medical equipment	30% coinsurance	30% coinsurance	————none————
	Hospice service	No cost share	30% coinsurance	————none————
If your child needs dental or eye care	Eye exam	Not covered	Not covered	————none————
	Glasses	Not covered	Not covered	————none————
	Dental check-up	Not covered	Not covered	————none————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Infertility treatment
- Long- term care
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide.
- Private-duty nursing
- Routine foot care Unless you have been diagnosed with diabetes. Consult your formal contract of coverage.
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Routine eye care (adult) Coverage is limited to 1 screening exam. Consult your formal contract of coverage.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-333-5735. You may also contact your state insurance department, the Department of Labor's Employee Benefits
Security Administration
1-866-444-EBSA (3272)
www.dol.gov/ebsa/healthreform.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

HealthKeepers
ATTN: Appeals
P.O. Box 27401
Richmond, VA 23279

Or Contact:

Department of Labor's Employee Benefits
Security Administration at
1-866-444-EBSA(3272) or
www.dol.gov/ebsa/healthreform

Virginia Bureau of Insurance
1300 East Main Street
P. O. Box 1157
Richmond, VA 23218
800-552-7945

A consumer assistance program can help you file your appeal. Contact:
Virginia State Corporation Commission
Life & Health Division, Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218

(877) 310-6560
http://www.scc.virginia.gov/boi
bureauofinsurance@scc.virginia.gov

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídííłkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

About These Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $4,840
- **Patient pays:** $2,700

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Total Deductibles	$500
Co-pays	$20
Co-insurance	$2,030
Limits or exclusions	$150
Total	**$2,700**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,840
- **Patient pays:** $1,560

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Total Deductibles	$500
Co-pays	$630
Co-insurance	$350
Limits or exclusions	$80
Total	**$1,560**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.anthem.com or 1-855-333-5735.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Anthem BlueCross BlueShield
Anthem KeyCare 30/2000 / $10/$30/$50 or 20%

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 07/01/2013 - 06/30/2014

Coverage For: Individual/Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-855-333-5735.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2000** single / **$4000** family for In-Network Provider **$3000** single / **$6000** family for Non-Network Provider Does not apply to Prescription Drugs, In-Network Preventive Care, Copayments and Routine Eye Exam. In-Network Provider and Non-Network Provider deductibles are separate and do not count towards each other.	You must pay all the costs up to the **deductible** amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the **deductible** starts over (usually, but not always, January 1st.) See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes; In-Network Provider Single: **$4500**, Family: **$9000** Non-Network Provider Single: **$6750**, Family: **$13500**	The **out-of-pocket limit** is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for health care expenses.

Important Questions	Answers	Why this Matters:
What is not included in the <u>out-of-pocket limit</u>?	Balance-Billed Charges, Pre-Authorization Penalties, Infertility Treatment Copays, Health Care This Plan Doesn't Cover, Premiums, Costs for Prescription Drugs in Tiers 1, 2, and 3, Prescription Drug Copays, Costs Related to Covered Prescription Drugs, Costs Related to Prescription Drugs Covered Under the Prescription Drug Plan, Out-of-Pocket Limit does not include Routine Vision Care.	Even though you pay these expenses, they don't count toward the **<u>out-of-pocket limit</u>**.
Is there an overall annual limit on what the insurer pays?	No. This policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 3 describes any limits on what the insurer will pay for specific covered services, such as office visits.
Does this plan use a <u>network</u> of <u>providers</u>?	Yes. See **www.anthem.com** or call **1-855-333-5735** for a list of participating providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Plans use the terms in-network, preferred, or participating to refer to providers in their network.
Do I need a referral to see a <u>specialist</u>?	No, you do not need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn’t cover are listed on page 7. See your policy or plan document for additional information about excluded services.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **In-Network Provider** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay	40% coinsurance	Not subject to the deductible.
	Specialist visit	$50 copay	40% coinsurance	Not subject to the deductible.
	Other practitioner office visit	Manipulative Therapy $25 copay Acupuncturist Not covered	Manipulative Therapy 40% coinsurance Acupuncturist Not covered	Manipulative Therapy Not subject to the deductible. Coverage is limited to 30 visits per yearper member.
	Preventive care/screening/ immunizations	No cost share	40% coinsurance	————none————
If you have a test	Diagnostic test (x-ray, blood work)	Lab - Office 20% coinsurance X-Ray - Office 20% coinsurance	Lab - Office 40% coinsurance X-Ray - Office 40% coinsurance	————none————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	————none————

Common Medical Event	Services You May Need	Your Cost If You Use a In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.anthem.com/pharmacyinformation/	Tier 1 – Typically Generic	$10 copay/ prescription (retail and mail order)	$10 copay/ prescription (retail and mail order)	Covers up to a 30 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)
	Tier 2 – Typically Preferred/Formulary Brand	$30 copay/ prescription (retail only) and $60 copay/prescription (mail order only)	$30 copay/ prescription (retail only) and $60 copay/prescription (mail order only)	If the member selects a brand drug when a generic equivalent is available the member is responsible for the generic copay plus the cost difference between the generic and brand equivalent even if the physician indicates no substitutions. Covers up to a 30 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)
	Tier 3 – Typically Non-preferred/ Non-formulary and Specialty Drugs	$50 or 20% coinsurance, whichever is the greater up to $200 per script maximum for retail. $150 or 20% coinsurance, whichever is the greater up to $400 per script maximum for mail order.	$50 or 20% coinsurance, whichever is the greater up to $200 per script maximum for retail. $150 or 20% coinsurance, whichever is the greater up to $400 per script maximum for mail order.	If the member selects a brand drug when a generic equivalent is available the member is responsible for the generic copay plus the cost difference between the generic and brand equivalent even if the physician indicates no substitutions. Covers up to a 30 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)
	Tier 4 – Typically Specialty Drugs	Not covered	Not covered	$3500 annual out-of-pocket limit per member per benefit year ————none————

Common Medical Event	Services You May Need	Your Cost If You Use a In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have outpatient Surgery	Facility Fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	————none————
	Physician/Surgeon Fees	20% coinsurance	40% coinsurance	————none————
If you need immediate medical attention	Emergency Room Services	20% coinsurance	40% coinsurance	————none————
	Emergency Medical Transportation	20% coinsurance	20% coinsurance	————none————
	Urgent Care	$30 copay	40% coinsurance	Not subject to the deductible.
If you have a hospital stay	Facility Fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	————none————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Mental/Behavioral Health Office Visit $30 copay Mental/Behavioral Health Facility Visit - Facility Charges 20% coinsurance	Mental/Behavioral Health Office Visit 40% coinsurance Mental/Behavioral Health Facility Visit - Facility Charges 40% coinsurance	Mental/Behavioral Health Office Visit Not subject to the deductible.
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	————none————
	Substance use disorder outpatient services	Substance Abuse Office Visit $30 copay Substance Abuse Facility Visit - Facility Charges 20% coinsurance	Substance Abuse Office Visit 40% coinsurance Substance Abuse Facility Visit - Facility Charges 40% coinsurance	Substance Abuse Office Visit Not subject to the deductible.

Common Medical Event	Services You May Need	Your Cost If You Use a In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	————none————
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	Your doctor's charges for delivery are part of prenatal and postnatal care.
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	Applies to inpatient facility. Other cost shares may apply depending on services provided.
If you need help recovering or have other special health needs	Home Health Care	20% coinsurance	40% coinsurance	Coverage is limited to 100 visits per year.
	Rehabilitation Services	20% coinsurance	40% coinsurance	Coverage is limited to 30 visits per year for physical therapy and occupational therapy combined, 30 visits per year for speech therapy. Limit does not apply to autism services, if applicable. Services from In-Network Provider and Non-Network Provider count towards your limit.
	Habilitation Services	20% coinsurance	40% coinsurance	Rehabilitation and Habilitation visits count toward your Rehabilitation limits.
	Skilled Nursing Care	20% coinsurance	40% coinsurance	Coverage is limited to 100 days per stay. Services from In-Network Provider and Non-Network Provider count towards your limit.
	Durable medical equipment	20% coinsurance	40% coinsurance	————none————
	Hospice service	No cost share	40% coinsurance	Not subject to the deductible.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	————none————
	Glasses	Not covered	Not covered	————none————
	Dental check-up	Not covered	Not covered	————none————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Infertility treatment
- Long- term care
- Routine foot care Unless you have been diagnosed with diabetes. Consult your formal contract of coverage.
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide.
- Private-duty nursing Outpatient services limited to $500 annually. Consult your formal contract of coverage.
- Routine eye care (adult) Coverage is limited to 1 screening exam. Consult your formal contract of coverage.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-333-5735. You may also contact your state insurance department, the Department of Labor's Employee Benefits
Security Administration
1-866-444-EBSA (3272)
www.dol.gov/ebsa/healthreform.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

Anthem BlueCross BlueShield
ATTN: Appeals
P.O. Box 27401
Richmond, VA 23279

Or Contact:

Department of Labor's Employee Benefits
Security Administration at
1-866-444-EBSA(3272) or
www.dol.gov/ebsa/healthreform

Virginia Bureau of Insurance
1300 East Main Street
P. O. Box 1157
Richmond, VA 23218
800-552-7945

A consumer assistance program can help you file your appeal. Contact:
Virginia State Corporation Commission
Life & Health Division, Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218

(877) 310-6560
http://www.scc.virginia.gov/boi
bureauofinsurance@scc.virginia.gov

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídííłkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

About These Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $4,320
- **Patient pays:** $3,220

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Total Deductibles	$2,000
Co-pays	$20
Co-insurance	$1,050
Limits or exclusions	$150
Total	**$3,220**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $2,690
- **Patient pays:** $2,710

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Total Deductibles	$2,000
Co-pays	$440
Co-insurance	$190
Limits or exclusions	$80
Total	**$2,710**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.anthem.com or 1-855-333-5735.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Medicaid and the Children's Health Insurance Program (CHIP)
Offer Free Or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of November 3, 2010. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	**CALIFORNIA** – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-800-362-1504	Website: http://www.dhcs.ca.gov/services/Pages/ TPLRD_CAU_cont.aspx Phone: 1-866-298-8443
ALASKA – Medicaid	**COLORADO** – Medicaid and CHIP
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943 CHIP Website: http:// www.CHPplus.org CHIP Phone: 303-866-3243
ARIZONA – CHIP	
Website: http://www.azahcccs.gov/applicants/default.aspx Phone (In state): 1-877-764-5437	
ARKANSAS – CHIP	**FLORIDA** – Medicaid
Website: http://www.arkidsfirst.com/ Phone: 1-888-474-8275	Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml Phone: 1-866-762-2237

GEORGIA – Medicaid	**MONTANA** – Medicaid
Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Telephone: 1-800-694-3084
IDAHO – Medicaid and CHIP	**NEBRASKA** – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://www.dhhs.ne.gov/med/medindex.htm Phone: 1-877-255-3092
INDIANA – Medicaid	**NEVADA** – Medicaid and CHIP
Website: http://www.in.gov/fssa/2408.htm Phone: 1-877-438-4479	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900 CHIP Website: http://www.nevadacheckup.nv.org/ CHIP Phone: 1-877-543-7669
IOWA – Medicaid	
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	
KANSAS – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: https://www.khpa.ks.gov Phone: 800-766-9012	Website: www.dhhs.nh.gov/ombp/index.htm Phone: 603-271-4238
KENTUCKY – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-342-6207	
MAINE – Medicaid	**NEW MEXICO** – Medicaid and CHIP
Website: http://www.maine.gov/dhhs/oms/ Phone: 1-800-321-5557	Medicaid Website: http://www.hsd.state.nm.us/mad/index.html Medicaid Phone: 1-888-997-2583 CHIP Website: http://www.hsd.state.nm.us/mad/index.html Click on Insure New Mexico CHIP Phone: 1-888-997-2583
MASSACHUSETTS – Medicaid and CHIP	
Medicaid & CHIP Website: http://www.mass.gov/MassHealth Medicaid & CHIP Phone: 1-800-462-1120	
MINNESOTA – Medicaid	**NEW YORK** – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone (Outside of Twin City area): 800-657-3739 Phone (Twin City area): 651-431-2670	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831

MISSOURI – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dss.mo.gov/mhd/index.htm Phone: 573-751-6944	Website: http://www.nc.gov Phone: 919-855-4100
NORTH DAKOTA – Medicaid	**UTAH** – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604	Website: http://health.utah.gov/medicaid/ Phone: 1-866-435-7414
OKLAHOMA – Medicaid	**VERMONT**– Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://ovha.vermont.gov/ Telephone: 1-800-250-8427
OREGON – Medicaid and CHIP	**VIRGINIA** – Medicaid and CHIP
Medicaid & CHIP Website: http://www.oregonhealthykids.gov Medicaid & CHIP Phone: 1-877-314-5678	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
PENNSYLVANIA – Medicaid	**WASHINGTON** – Medicaid
Website: http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm Phone: 1-800-644-7730	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
RHODE ISLAND – Medicaid	**WEST VIRGINIA** – Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: http://www.wvrecovery.com/hipp.htm Phone: 304-342-1604
SOUTH CAROLINA – Medicaid	**WISCONSIN** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.health.wyo.gov/healthcarefin/index.html Telephone: 307-777-7531

To see if any more States have added a premium assistance program since November 3, 2010, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

OMB Control Number 1210-0137 (expires 09/30/2013)

Delta Dental Premier

Benefits for Joint Logistics Managers, Inc.
Group Number: 400056
Effective Date: July 1, 2013

This sheet provides a brief description of important features of the Delta Dental Premier dental program. Under this program, you may use any dentist you wish. However, your out-of-pocket costs may be lower when you select a dentist who participates in the Delta Dental Premier plan.

Premier Dental Plan

Annual Deductible	**$50**	Limit of 3 per family per benefit period
Annual Benefit Maximum	**$1,250**	Per member, per benefit period
Annual MaxOver™ Amount**	**$300**	Per member, per benefit period
MaxOver™ Account Limit**	**$1,250**	Per member account limit

Covered Benefits and Coinsurance

(Delta Dental will pay the stated percentage of the plan allowance based on the dentist's participation with Delta Dental.)

Coverage	Coinsurance*	Benefit Limitations	Benefit Waiting Period
Diagnostic and Preventive Care (Type I)	**100%***	***(These services are exempt from the deductible)***	**None**
– Oral exams and cleanings		Twice each in a 12 consecutive month period. Periodontal cleaning is considered a regular cleaning and is subject to the benefit limits for regular cleanings.	
– Fluoride applications		Once each 12 consecutive month period for dependents under the age of 19.	
– Sealants		Only for non-carious, non restored 1st and 2nd permanent molars for dependents under age 16, one application per tooth.	
– Bitewing X-rays		Bitewing X-rays are limited to once in a12 consecutive month period, limited to a maximum of 4 films or a set (7-8 films) of vertical bitewings.	
– Full mouth/panelipse X-rays		Limited to once in a 3-year period.	
– Space maintainers		Once per lifetime for dependents under the age of 14.	
– Palliative treatment			
– Oral biopsies			
– Healthy Smile, Healthy You® Program		Enrolled members who have certain high risk cardiac conditions or are pregnant, diabetic, or undergoing cancer treatment via chemotherapy and/or radiation are entitled to an additional cleaning and exam (or periodontal maintenance visit, if the member has a history of periodontal surgery). Cancer patients are also entitled to an additional fluoride application beyond the age limitation of the group contract.	
Basic Dental Care (Type II)	**80%***	***(Deductible Applies)***	**None**
– Amalgam (silver) and composite (white) fillings		Composite (white) fillings are limited to upper and lower 6 front teeth. Retreatment limited to once per surface in a 24-month period.	
– Stainless steel crowns		Limited to primary (baby) teeth for participants under age 14.	
– Simple extractions			
– Denture repair and recementation of crowns, bridges and dentures		Cost limited to ½ the allowance of a new denture or prosthesis.	
– Complex Oral Surgery		Impactions and other surgical procedures.	
– Endodontic services/root canal therapy		Retreatment only after 2 years from initial root canal therapy treatment.	
– Periodontic services		Limitations of 2-3 years apply based on services rendered.	

*Please refer to <u>Choosing a Dentist</u>.

*** Eligibility for MaxOver benefits are determined 3 months after the end of the plan benefit period. Any claims processed or adjusted after a member's annual MaxOver eligibility is determined will not alter the individual's eligibility for the benefit. MaxOver benefits cease to be available when a member's coverage under the group contract terminates. See the evidence of coverage booklet for more details on this program.*

COVERAGE IS AVAILABLE FOR

- Enrollee and spouse
- Dependent children, only to the end of the month they reach age 26 (the "limiting age").

USING YOUR DELTA DENTAL PREMIER PROGRAM

To use the program, just call the dental office of your choice and make an appointment. Delta Dental Premier Participating dentist offices will have claim forms in the office and will complete and submit the form to Delta Dental of Virginia (Delta Dental). A complete list of Delta Dental Premier participating dentists is included on our website at www.deltadentalva.com.

The Delta Dental Premier Program allows you to:

- change dentists at any time without preapproval
- go to a specialist without preapproval

During your first appointment, provide your dentist with the following information:

- the employee's social security number
- inform the dentist that your program is through Delta Dental of Virginia.

CHOOSING A DENTIST

You may select the Dentist of your choice. However, you will receive the highest level of benefits available in your group's program by choosing a Delta Dental Premier Dentist. In addition, your out-of-pocket costs will usually be lower if you use a participating dentist.

If you choose a:

Delta Dental Premier Dentist	Non-Participating Dentist
• Payment will be made directly to the dentist. • Delta Dental's payment will be based on the Delta Dental Premier Allowance for covered services. • The dentist will accept Delta Dental's payment, plus any required coinsurance and deductible (if applicable) as payment in full.	• Payment will be made directly to you (unless Virginia law requires otherwise). • Delta Dental's payment will be based on Non-Participating Dentist Allowances for covered services. • You will be responsible for any required coinsurance and deductible (if applicable) as well as the difference between the non-participating dentist's charge and Delta Dental's payment. • The amount you would owe a Non-Participating Dentist may be higher than the amount you would owe a Delta Dental Premier Dentist for the same covered services.

EXCLUSIONS

The following are not covered benefits under any circumstances **unless specifically identified** as a covered benefit in the plan documents.

- Services or supplies that are not dental services; also services not specifically listed as covered in the plan documents.
- Services or treatment provided by someone other than a licensed dentist or a qualified licensed dental hygienist working under the supervision of a dentist.
- A dental service that Delta Dental, in its sole discretion (subject to any and all internal and external appeals available to an enrollee), determines is not necessary or customary for the diagnosis or treatment of your condition. In making this determination, Delta Dental will take into account generally accepted dental practice standards based on the dental services provided. In addition, each covered benefit must demonstrate dental necessity. Dental Necessity is determined in accordance with generally accepted standards of dentistry.
- Dental services for injuries or conditions that may be covered under workers compensation or similar employer liability laws or other medical plan coverage; also benefits or services that are available under any federal or state government program (subject to the rules and regulations of those programs) or from any charitable foundation or similar entity.
- Dental services for the diagnosis or treatment for illnesses, injuries or other conditions for which you are eligible for coverage under your hospital, medical/surgical, or major medical plan.
- Dental services started or rendered before the date enrolled under this dental plan. Also, except as otherwise provided in the plan documents, benefits for a course of treatment that began before you are enrolled under this dental plan.
- Except as otherwise provided in the plan documents, dental services provided after the date you are no longer enrolled or eligible for coverage under the plan documents.
- Except as otherwise provided in the plan documents, prescription and non-prescription drugs; pre-medications; preventive control programs, oral hygiene instructions, and relative analgesia.
- General anesthesia when less than three (3) teeth will be routinely extracted during the same office visit.
- Splinting or devices used to support, protect, or immobilize oral structures that have loosened or been reimplanted, fractured or traumatized.
- Charges for inpatient or outpatient hospital services; any additional fee that the dentist may charge for treating a patient in a hospital, nursing home or similar facility.
- Charges to complete a claim form, copy records, or respond to Delta Dental's requests for information; charges for failure to keep a scheduled appointment.
- Charges for consultations in person, by phone or by other electronic means.
- Charges for X-ray interpretation.
- Dental services to the extent that benefits are available or would have been available if the enrollee had enrolled, applied for, or maintained eligibility under Title XVIII of the Social Security Act (Medicare), including any amendments or other changes to that Act.
- Complimentary services or dental services for which you would not be obligated to pay in the absence of the coverage under the plan documents or any similar coverage.
- Services or treatment provided to an immediate family member by the treating dentist. This would include a dentist's parent, spouse or child.
- Dental services and supplies for the replacement device or repeat treatment of lost, misplaced or stolen prosthetic devices including space maintainers, bridges and dentures (among other devices).
- Dental services or other services that Delta Dental determines are for correcting congenital malformations; also, cosmetic surgery or dentistry for cosmetic purposes.
- Replacement of congenitally missing teeth by dental implant, fixed or removable prothesis whether the result of a medical diagnosis including but not limited to hereditary ectodermal dysplasia or not related to a medical diagnosis.

- Experimental or investigative dental procedures, services, supplies as well as services and/or procedures due to complications thereof. Experimental or investigative procedures, services or supplies are those which, in the judgment of the Delta Dental: (a) are in a trial stage; (b) are not in accordance with generally accepted standards of dental practice, or (c) have not yet been shown to be consistently effective for the diagnosis or treatment of the enrollee's condition.

- Dental services for restoring tooth structure lost from wear (abrasion, erosion, attrition, or abfraction), for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Such services include but are not limited to equilibration and periodontal splinting.

- Dental services, procedures and supplies that are needed because of harmful habits. An example of a harmful habit includes clenching or grinding of the teeth.

- Services billed under multiple dental service procedure codes that Delta Dental, in its sole discretion (subject to any and all internal and external appeals available to you), determines should have been billed under a single, more comprehensive dental service procedure code. Delta Dental bases its payment on the allowance for the more comprehensive code, not on the allowance(s) for the underlying component codes.

- Services billed under a dental service procedure code that Delta Dental, in its sole discretion (subject to any and all internal and external appeals available to you), determines should have been billed under a code that more accurately describes the dental service. Delta Dental's bases its payment on its determination of the more accurate dental service code.

- Amounts assessed on dental services and/or supplies by state or local regulation.

- Amounts that exceed the plan allowances as agreed to by the dentist for covered benefits.

The preceding information is offered as a brief description of the Delta Dental Premier program and what Delta Dental pays for services covered under the program. It is not intended for use as a summary plan description nor is it designed to serve as an Evidence of Coverage for the program. This Delta Dental Premier program is administered by Delta Dental of Virginia. If you have specific questions regarding benefit structure, limitations or exclusions, consult the plan document or call Delta Dental's Benefit Services Department at 800-237-6060.

Delta Dental of Virginia
Mission Statement

"To improve the public's health through market leadership as the dental experts by delivering quality dental benefits and superior service supported by evidence-based science and innovative technology."

Delta Dental of Virginia
4818 Starkey Road
Roanoke, Virginia 24018-8542
1-800-237-6060
www.deltadentalva.com

Your Vision Benefit Summary

Keep your eyes healthy with
JOINT LOGISTICS MANAGERS, INC. and VSP®
Vision Care.

Using your VSP benefit is easy.

- **Find an eyecare provider who's right for you.** With open access to see any eyecare provider, you can see the one who's right for you. Choose a VSP doctor or any other provider. To find a VSP doctor, visit **vsp.com** or call **800.877.7195**.
- **Review your benefit information.** Visit **vsp.com** to review your plan coverage before your appointment.
- **At your appointment, tell them you have VSP.** There's no ID card necessary.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP doctor.

Personalized Care

A VSP doctor provides personalized care that focuses on keeping you and your eyes healthy year after year. Plus, when you see a VSP doctor, you'll get the most out of your benefit, have lower out-of-pocket costs, and your satisfaction is guaranteed.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options for you and your family. You'll have access to great brands, like bebe®, Calvin Klein, Disney, FENDI, Nike, and Tommy Bahama®.

Plan Information

VSP Doctor Network: VSP Choice

Benefit	Description	Copay
Your Coverage with a VSP Doctor		
WellVision Exam	• Focuses on your eyes and overall wellness • Every plan year*	$10
Prescription Glasses		**$25**
Frame	• $130 allowance for a wide selection of frames • 20% off amount over your allowance • Every other plan year	Included in Prescription Glasses
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children • Every plan year	Included in Prescription Glasses
Lens Options	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average 20-25% off other lens options	$55 $95 - $105 $150 - $175
Contacts (instead of glasses)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every plan year	Up to $60
Extra Savings and Discounts	**Glasses and Sunglasses** • 20% off additional glasses and sunglasses, including lens options, from any VSP doctor within 12 months of your last WellVision Exam. **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities	

Your Coverage with Other Providers

Visit vsp.com for details, if you plan to see a provider other than a VSP doctor.

Exam	up to $45
Frame	up to $70
Single Vision Lenses	up to $30
Lined Bifocal Lenses	up to $50
Lined Trifocal Lenses	up to $65
Progressive Lenses	up to $50
Contacts	up to $105

*Plan year begins in July
VSP guarantees coverage from VSP doctors only.

Visit **vsp.com** or call **800.877.7195** for more details on your vision coverage and exclusive savings and promotions for VSP members.

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It’s easy for you to take control of your benefits!

Welcome to Sun Life!

We are pleased to offer you coverage from Sun Life Financial as part of your employee benefits program. When you enroll in insurance benefits from Sun Life, you have comprehensive insurance at competitive group rates with the convenience of automatic payroll deduction.

Your employer is offering you:

- Employee Optional Life Insurance
- Spouse Optional Life Insurance
- Child Optional Life Insurance
- Short Term Disability

Enrolling is easy! We’ll help you understand your choices, how Sun Life’s benefits can help you, and how much it costs.

If you have questions about your benefits plan, ask your benefits administrator. To learn more about Sun Life, visit www.sunlife.com/us.

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Group Life Insurance

When you buy **Life Insurance** from Sun Life Financial, know that:

- **You are taking care of your family.** When the time comes, life insurance will provide for your family financially when you can't.
- **You decide how much.** You choose the amount that works for you. Use the chart below to help you figure it out.
- **Paying is easy.** Your premium is automatically deducted from your paycheck.
- **You take it with you.** If you leave your current job you can take your life insurance with you. Simply ask your employer about the options available.
- **We pay quickly.** Our goal is to pay your beneficiary within 10 business days (we usually do it sooner).

How Much Should You Get?

You may use this worksheet to estimate how much additional life insurance coverage you may need.[1]

How Much Do I Need?

Identify your Annual Expenses: (enter amounts in gray box)	
Housing Costs	$
Car Payments	$
Health Care (including insurance and out of pocket)	$
Credit Card Debt	$
Personal Loans	$
Family Care Requirements	$
Educational Needs	$
Other Expenses	$
Total Annual Expenses:	$
How long will you need to cover these expenses?	years
Total Future Funds Needed: (Total Annual Expenses x Number of years needed)	$
Total Other Assets (401K, retirement funds, other life insurance):	$
Future Funds Needed – Total Other Assets = Amount of additional Life insurance coverage you might need:	$

[1]This worksheet is provided for informational purposes only. It should not be relied upon as financial advice or solicitation of insurance. You may wish to consult an independent financial professional for advice.

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frequently asked questions

Life Insurance

It's important to ask yourself—do you have enough life insurance to cover all of your financial responsibilities?

What is Group Life Insurance?

Group Life Insurance is term insurance that covers you for as long as you remain an eligible employee and continue to pay your premium. Because this coverage is term life insurance, it does not build any cash value for you to borrow against or receive upon policy cancellation.

Why should you purchase Life Insurance?

Life Insurance provides added financial protection at an affordable price. You can ensure your family's financial security in the event of an unexpected death. We have developed our plan to meet your needs through affordable features:

- You decide how much coverage you need.
- We offer the coverage amounts most individuals want.
- You may take advantage of group rates when enrolling through your employer.
- Accelerated benefits may be available. In most states, if you are terminally ill with 12 months or less to live, you may qualify for a portion of your total death benefit amount.

How much does it cost?

The cost is determined by your age. Rates are grouped into five-year age brackets and change as you get older. Your employer will provide you with rate information so that you can figure out your actual cost per month.

Can I keep my coverage if I no longer work for this employer?

Yes, you can convert your insurance to an individual policy without providing medical evidence of insurability, provided that you apply and pay your first premium within 31 days following the date your group coverage terminated or reduced. Your employer will tell you more about converting your coverage. Portability may also be available. Eligibility restrictions apply.[1] If you are eligible, this feature allows you to continue your Life Insurance coverage—at Group rates—if your employment terminates. Please check with your employer for more information.

[1]You may be ineligible for portability for any of the following reasons:
- You were not insured for Basic or Optional Life before your termination date.
- You are aged 65+ (age 70 for some policies).
- Your employer's group policy does not include portability.
- You remain in employment with your employer but not at full-time status.
- You retire or have an injury or sickness that would have a material effect on your life expectancy.

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Group Life Insurance Benefits

for Employees of Joint Logistics Managers, Inc-Policy #222850

A Worldwide Presence

Our parent company's operations currently service millions of people in the United States, Canada, the United Kingdom, Hong Kong, the Philippines, Japan, Indonesia, India, China and Bermuda.

Benefits

- Basic Group Term Life Insurance equal $25,000.
- Accidental Death and Dismemberment (AD&D) insurance which would pay an additional benefit, up to the amount of your Life benefit, if you suffer a covered loss due to an accident.
- Benefits are reduced to 65% at age 65 and to 50% at age 70. Coverage is discontinued at termination of employment or retirement.
- Accelerated Benefits that help offset expenses at a critical time. You may collect a portion of your benefits during your lifetime if you become terminally ill.
- If you leave Joint Logistics Managers, Inc., you may be able to convert or port your Group Life coverage to an Individual Life insurance policy.

No Cost to You

- Your employer pays your Group Life and AD&D premium.

How to Enroll

- Basic group term life coverage begins automatically when you meet the eligibility requirements. You'll need to designate beneficiaries for your basic life benefits using our Beneficiary Designation form or Group Enrollment form. Check with your employer for the necessary forms and for additional coverage options that may be available, or find the forms you need online at www.sunlife.com/us.

For Complete Plan Details

- This highlight flyer is intended to provide an overview of the benefits available from your employer, and is not a complete description of plan provisions. Receipt of this flyer does not certify eligibility for benefits under this plan.
- Your employer will provide you with the Sun Life Financial Group booklet containing complete plan details.

This Overview is preliminary to the issuance of the Policy and booklet certificate. It does not describe the specific benefits under the Policy.

Group insurance policies are underwritten by Sun Life Assurance Company of Canada (Wellesley Hills, MA) in all states, except New York, under Policy Form Series 93P-LH, 98P-ADD, 02P-STD TDB Policy-2006, 02-SL, 07-SL, and 01C-LH-PT. In New York, group insurance policies are underwritten by Sun Life Insurance and Annuity Company of New York (New York, NY) under Policy Form Series 93P-LH-NY, 06P-NYDBL, 02P-NYSTD, 98P-ADD-NY, 02-NYSL, 07-NYSL, and 01NYC-LH-PT. Product offerings may not be available in all states and may vary depending on state laws and regulations.

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SLPC 22009 06/10 (exp. 06/12) updated 08/10

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Optional Life Insurance Benefits

for Employees of Joint Logistics Managers, Inc-Policy #222850

A Worldwide Presence

Our parent company's operations currently service millions of people in the United States, Canada, the United Kingdom, Hong Kong, the Philippines, Japan, Indonesia, India, China and Bermuda.

Benefits

- **For you:**
  An amount between $10,000 and $250,000, in increments of $10,000, not to exceed 3x basic annual earnings. Guaranteed Issue Amount is $100,000. Benefits cease at retirement.
- **For your spouse:**
  An amount between $5,000 and $25,000, in increments of $5,000. Guaranteed Issue Amount is $25,000. Spouse Optional Life coverage may not exceed 50% of the employee's coverage. Coverage ends when employee turns 70.
- **For your dependent child(ren):**

  An amount of $5,000 for each eligible child who is 6 months to 19 years old (or 23 if a full-time student); $500 for a child who is 15 days to under 6 months. Child coverage cannot exceed 50% of the employee's coverage.

  You must elect Optional Life coverage for yourself in order to cover your spouse and/or children.

Features of the Plan

- The plan also includes many special features including Waiver of Premium and Accelerated Benefits.

How to Enroll

- Once you have selected the amount of coverage that's right for you, your spouse and your children, simply fill out the Optional Life enrollment form provided by your employer. Be sure to sign, date, and return the form to your employer. Please submit the form to your employer along with any Evidence of Insurability forms that may be required.

About Evidence of Insurability

- Evidence of Insurability – also called "proof of good health" – is required if:
  - You decline coverage during your initial eligibility period and then want coverage at a later date; or
  - You apply for Optional Life in excess of the Guaranteed Issue Amount.
- All late entrants and increases require Evidence of Insurability.

Your employer will advise you if you need to submit an Evidence of Insurability application. If so, Sun Life Financial may arrange for you to take a medical exam (at our expense) and/or complete a questionnaire. Coverage will not go into effect until Sun Life Financial approves the application.

Optional Life Rates

Employee		Spouse**		Child(ren)	
Age	Monthly cost per $1,000 of coverage	Age	Monthly cost per $1,000 of coverage	Monthly cost per $1,000 of coverage	
Under 25	$ 0.051	Under 25	$ 0.051		
25 – 29	$ 0.047	25 – 29	$ 0.047		
30 – 34	$ 0.050	30 – 34	$ 0.050		
35 – 39	$ 0.075	35 – 39	$ 0.075	All eligible children	$ 0.211
40 – 44	$ 0.116	40 – 44	$ 0.116		
45 – 49	$ 0.187	45 – 49	$ 0.187		
50 – 54	$ 0.317	50 – 54	$ 0.317		
55 – 59	$ 0.518	55 – 59	$ 0.518		
60 – 64	$ 0.693	60 – 64	$ 0.693		
65 – 69	$ 1.084	65 – 69	$ 1.084		
70 - 74	$ 1.886				
75 +	$ 3.234				

** Spouse rates are based on Employee's age.

*These are the rates in effect for July 1, 2013.

Cost to You

- You are responsible for paying the cost of voluntary Life coverage through payroll deduction. Calculate your cost by dividing your amount of optional life insurance by 1000 and multiplying the result by the appropriate rate above. Follow the example below to determine your monthly cost.

Example amount of insurance	Divided by 1000	Multiplied by rate	Example cost*	
$25000	/ 1000 = 25	x $0.05	$ 1.25	
Your volume of insurance	**Divided by 1000**	**Multiplied by rate**	**Your cost***	**Cost per pay period**
$	/ 1000 =	x $	$	$

*Contact your employer to confirm the portion of the cost for which you will be responsible.

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Age Reductions

- Amounts of Life Insurance are reduced at the following ages:

Age	Percentage
65	65%
70	50%

For Complete Plan Details

- This highlight flyer is intended to provide an overview of the benefits available from your employer, and is not a complete description of plan provisions. Receipt of this flyer does not certify eligibility for benefits under this plan.
- Your employer will provide you with the Sun Life Financial Group booklet containing complete plan details.

Exclusions

Where allowed by law, if the Employee's cause of death is suicide:

- No amount of contributory Life or contributory Dependent Life Insurance is payable if the suicide occurs within 24 months after the Employee's Insurance is effective. If there was prior coverage in place, any period of time the Employee was insured for the same amount of Life Insurance under the previous insurer's group Life policy will count towards completion of the 24 months.
- No increased or additional amount of Life Insurance is payable if the suicide occurs within 24 months after the increased or additional amount of Basic Life Insurance is effective.
- No amount of Life Insurance in excess of the Guaranteed Issue Amount is payable if the suicide occurs within 24 months after the amount in excess of the Guaranteed Issue Amount is effective.

This summary represents a general overview. Limitations and exclusions may vary depending on your specific benefit plan. Please review your Life booklet for complete information.

This Overview is preliminary to the issuance of the Policy and booklet certificate. It does not describe the specific benefits under the Policy.

Group insurance policies are underwritten by Sun Life Assurance Company of Canada (Wellesley Hills, MA) in all states, except New York, under Policy Form Series 93P-LH, 98P-ADD, 02P-STD TDB Policy-2006, 02-SL, 07-SL, and 01C-LH-PT. In New York, group insurance policies are underwritten by Sun Life Insurance and Annuity Company of New York (New York, NY) under Policy Form Series 93P-LH-NY, 06P-NYDBL, 02P-NYSTD, 98P-ADD-NY, 02-NYSL, 07-NYSL, and 01NYC-LH-PT. Product offerings may not be available in all states and may vary depending on state laws and regulations.

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Short Term Disability Insurance

When you buy **Short Term Disability** (STD) from Sun Life Financial, know that:

- **A portion of your salary is protected if you can't work.** You receive a percentage of your income when a covered disability prevents you from working.
- **We pay quickly.** Our goal is to process your payments within five business days (we usually do it sooner).
- **You get what you pay for.** Your benefit is a percentage of your salary, so you know exactly what you will receive every week, if your claim is approved.
- **Paying is easy.** Your premium is automatically deducted from your paycheck.
- **It may protect your savings.** By having a portion of your income coming in, you may avoid having to rely on your savings to cover expenses in case you become ill or get injured.

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frequently asked questions

Short Term Disability

What will STD do for me?

The way STD insurance works is simple: If you become Totally Disabled (as defined by your policy) due to a sickness or injury and cannot perform your job, you can still receive a percentage of your income.

Why do I need Short Term Disability? This sort of thing happens to other people, not me.

Statistics show that nearly a third of all Americans between the ages of 35 and 65 will suffer a disability that lasts at least 90 days.[1]

Couldn't I rely on my savings or Social Security?

Financial advisors stress the importance of setting aside at least three months of your salary in an "emergency fund." While most Americans agree, saving money takes time and determination. Dipping in to your investment savings may also be unrealistic – especially when they are often your primary retirement plans. Early withdrawal from retirement plans generally triggers stiff penalties and can have tax implications.

Social Security is another source of income associated with disability. But, Social Security only pays benefits when an illness or injury is expected to last at least one year. To qualify, you must be unable to perform any productive work at all; and benefits begin only after five continuous months of total disability.

How do I submit a claim?

It's easy. You can submit your claim:

- online at www.mysunlifebenefits.com
- fax us at 781-304-5599 (781-304-5519 for SunAdvisor)
- mail it to us at the address found in your STD claim packet available through your employer

Does my doctor need to be involved?

As part of the claim process, you will need your physician to fill out an Attending Physician Statement (APS). You can also download this form from www.mysunlifebenefits.com.

I submitted a claim. Now what?

Once we receive your APS, a claims professional will evaluate and certify your length of disability. Your claim may be referred to a nurse consultant to gather more information, and we may also contact your employer to learn about your occupational requirements. Once our review is complete, we will send you a letter letting you know whether your claim is approved or denied. If we deny your claim, we will provide a detailed explanation. If we approve your claim, we will tell you how long you will receive the benefit, and when you can expect to receive payments from Sun Life Financial. You also can check your claim and payment status or see if there are messages posted about your claim at www.mysunlifebenefits.com. You will need your claim number (which we'll send you) and your Social Security number to log in.

[1] www.disabilitycanhappen.org. Last accessed on 12/09.

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Group Short Term Disability Benefits

for Employees of Joint Logistics Managers, Inc-Policy #222850

Why Short Term Disability?

Receiving an income while you're disabled can make an enormous financial difference.

Benefits

- Available to all full-time employees working 30 hours or more per week.
- Covers accidents and sicknesses for up to 26 weeks.
- Weekly benefits are 60% of your weekly salary.
- Maximum benefits are $1,000 per week.
- Benefits begin on the 1st day for accidents and on the 8th day for sickness.

Cost to you

- STD coverage is contributory, meaning that you are responsible for paying for all or a portion of the cost through payroll deduction.
- Calculate your cost by dividing your weekly benefit by 10 and multiplying the result by the rate found in the chart below. Follow the example below to determine your cost.

Your Age	Rate	Your Age	Rate	Your Age	Rate	Your Age	Rate
Under 25	$ 0.27	35-39	$ 0.36	50-54	$ 0.44	65-69	$ 1.41
25-29	$ 0.46	40-44	$ 0.28	55-59	$ 0.45	70-74	$ 1.41
30-34	$ 0.42	45-49	$ 0.28	60-64	$ 0.46	75 +	$1.41

Example Weekly Benefit (60% of earnings)	Divided by 10	Multiplied by rate	Total cost	Example monthly cost*	Cost per pay period
$ 350	/ 10 = 35	x $0.42	=	$ 14.70	

Your Weekly Benefit (60% of earnings)	**Divided by 10**	**Multiplied by rate**	**Total cost**	**Your monthly cost***	**Your cost per pay period***
$	/ 10 =	x $	= $	$	

*The rate is in effect for July 1, 2013. Contact your employer to confirm the portion of the cost for which you will be responsible.

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How to enroll

- STD coverage begins once you meet the eligibility requirements, satisfy any waiting period applicable to your policy, and complete the enrollment process.
- To enroll, fill out the STD enrollment form available from your employer. Please submit the form to your employer along with any Evidence of Insurability application that may be required.

About Evidence of Insurability

- Evidence of Insurability – also called “proof of good health” – is required if:
  - you decline coverage during your initial eligibility period and then want coverage at a later date, or
- All late entrants and increases require Evidence of Insurability.
- Your employer will advise you if you need to submit an Evidence of Insurability application. If so, Sun Life Financial may arrange for you to take a medical exam (at our expense) and/or complete a questionnaire. Coverage will not go into effect until Sun Life Financial approves it.

For complete plan details

- This highlight flyer is intended to provide an overview of the benefits available from your employer and is not a complete description of plan provisions. Receipt of this flyer does not certify eligibility for benefits under this plan.
- Your employer will provide you with the Sun Life Financial Group booklet containing complete plan details.

Limitations

No STD benefit will be payable for any disability during any of the following periods:

- any period the employee is not under the regular and continuing care of a physician providing appropriate treatment by means of examination and testing in accordance with the disabling condition
- any period the employee fails to submit to any medical examination requested by Sun Life
- any period the employee engages in any occupation or employment for wage or profit, if partial disability is not included in the plan
- any period of total disability due to mental illness, unless the employee is under the continuing care of a specialist in psychiatric care
- any period of total disability due to drug and alcohol illness, unless the employee is actively supervised by a physician or rehabilitation counselor and is receiving continuing treatment from a rehabilitation center or a designated institution approved by Sun Life
- if a pre-existing condition limitation applies to the plan, then any period of disability that occurs within the exclusionary period and is caused by, contributed to by, or resulting from a pre-existing condition

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Exclusions

No STD benefit will be payable for any total disability that is due to:

- an intentionally self-inflicted injury,
- war, declared or undeclared, or any act of war,
- active participation in a riot, rebellion, or insurrection,
- committing or attempting to commit an assault, felony, or other illegal act,
- injury or sickness for which the employee is entitled to benefits under any workers' compensation, occupational disease or similar law, if coverage type is non-occupational, or
- injury or sickness sustained while doing any act or thing pertaining to any occupation for wage or profit, if coverage type is non-occupational.

This summary represents a general overview. Limitations and exclusions may vary depending on your specific benefit plan. Please review your STD booklet for complete information.

This overview is preliminary to the issuance of the policy and booklet certificate. It does not describe the specific benefits under the policy. This policy provides disability income insurance only. It does NOT provide basic hospital, basic medical, or major medical insurance as defined by the New York State Insurance Department.

Group insurance policies are underwritten by Sun Life Assurance Company of Canada (Wellesley Hills, MA) in all states, except New York, under Policy Form Series 93P-LH, 98P-ADD, 02P-STD TDB Policy-2006, 02-SL, 07-SL, and 01C-LH-PT. In New York, group insurance policies are underwritten by Sun Life Insurance and Annuity Company of New York (New York, NY) under Policy Form Series 93P-LH-NY, 06P-NYDBL, 02P-NYSTD, 98P-ADD-NY, 02-NYSL, 07-NYSL, and 01NYC-LH-PT. Product offerings may not be available in all states and may vary depending on state laws and regulations.

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Evidence of Insurability, or Proof of Good Health

If you're reading this, it's because you may need to submit Evidence of Insurability (EOI) to Sun Life Financial. This could be for any of the reasons below:

- You're applying for an amount of Life Insurance coverage that is higher than the Guaranteed Issue amount. (This is indicated on your enrollment form included in this packet.)
- You currently have Life and/or Disability Insurance and are increasing your coverage.
- You declined Group Life or Disability coverage during your initial eligibility period and are now applying for coverage at a later date.

Submit Your Medical Information Online

It's the quick, easy and smart way to submit Evidence of Insurability (EOI). And it's completely secure and confidential:

1. Have the following information ready:
   - Your group policy number and the amount of coverage.
   - Height, weight and recent medical history for you and any dependents included on your application.
2. Go to www.mysunlifebenefits.com
   - Click on Evidence of Insurability Application, follow the instructions, review your answers and sign your application electronically before you submit. You will receive an official acknowledgment that Sun Life Financial has received your EOI application. If you are approved, you may receive an e-mail that same day.

Submit Your Medical Information Via Paper

Printable EOI applications are available in this booklet and at www.mysunlifebenefits.com. Just click "View Insurance Forms." After Sun Life receives and processes your EOI application, you will receive either an approval or pending notification. If your application is pending, a Sun Life Financial Representative may contact you to arrange for you to take a medical exam (at Sun Life's expense). Coverage subject to EOI will not go into effect until Sun Life approves your application in writing.

About Privacy and Security

In accordance with Sun Life Financial's strict privacy practices, your answers to the Health History portion of the EOI application are completely confidential and are never shown to your employer. Also, we do not share your e-mail address or other personal information with any third parties except as permitted or required by law. The website includes state-of-the-art security; any information entered is encrypted and transmitted using Secure Socket Layers (SSL) technology.

Rate Sheet

Employee - Coverage and **Semi-monthly** Cost for Employee Optional Life Insurance

Rates are effective as of July 1, 201H

Coverage amounts	< 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$10,000	0.26	0.24	0.25	0.38	0.58	0.94	1.59	2.59	3.47	5.42	9.43	16.17
$20,000	0.51	0.47	0.50	0.75	1.16	1.87	3.17	5.18	6.93	10.84	18.86	32.34
$30,000	0.77	0.71	0.75	1.13	1.74	2.81	4.76	7.77	10.40	16.26	28.29	48.51
$40,000	1.02	0.94	1.00	1.50	2.32	3.74	6.34	10.36	13.86	21.68	37.72	64.68
$50,000	1.28	1.18	1.25	1.88	2.90	4.68	7.93	12.95	17.33	27.10	47.15	80.85
$60,000	1.53	1.41	1.50	2.25	3.48	5.61	9.51	15.54	20.79	32.52	56.58	97.02
$70,000	1.79	1.65	1.75	2.63	4.06	6.55	11.10	18.13	24.26	37.94	66.01	113.19
$80,000	2.04	1.88	2.00	3.00	4.64	7.48	12.68	20.72	27.72	43.36	75.44	129.36
$90,000	2.30	2.12	2.25	3.38	5.22	8.42	14.27	23.31	31.19	48.78	84.87	145.53
$100,000	2.55	2.35	2.50	3.75	5.80	9.35	15.85	25.90	34.65	54.20	94.30	161.70
$110,000	2.81	2.59	2.75	4.13	6.38	10.29	17.44	28.49	38.12	59.62	103.73	177.87
$120,000	3.06	2.82	3.00	4.50	6.96	11.22	19.02	31.08	41.58	65.04	113.16	194.04
$130,000	3.32	3.06	3.25	4.88	7.54	12.16	20.61	33.67	45.05	70.46	122.59	210.21
$140,000	3.57	3.29	3.50	5.25	8.12	13.09	22.19	36.26	48.51	75.88	132.02	226.38
$150,000	3.83	3.53	3.75	5.63	8.70	14.03	23.78	38.85	51.98	81.30	141.45	242.55
$160,000	4.08	3.76	4.00	6.00	9.28	14.96	25.36	41.44	55.44	86.72	150.88	258.72
$170,000	4.34	4.00	4.25	6.38	9.86	15.90	26.95	44.03	58.91	92.14	160.31	274.89
$180,000	4.59	4.23	4.50	6.75	10.44	16.83	28.53	46.62	62.37	97.56	169.74	291.06
$190,000	4.85	4.47	4.75	7.13	11.02	17.77	30.12	49.21	65.84	102.98	179.17	307.23
$200,000	5.10	4.70	5.00	7.50	11.60	18.70	31.70	51.80	69.30	108.40	188.60	323.40
$210,000	5.36	4.94	5.25	7.88	12.18	19.64	33.29	54.39	72.77	113.82	198.03	339.57
$220,000	5.61	5.17	5.50	8.25	12.76	20.57	34.87	56.98	76.23	119.24	207.46	355.74
$230,000	5.87	5.41	5.75	8.63	13.34	21.51	36.46	59.57	79.70	124.66	216.89	371.91
$240,000	6.12	5.64	6.00	9.00	13.92	22.44	38.04	62.16	83.16	130.08	226.32	388.08
$250,000	6.38	5.88	6.25	9.38	14.50	23.38	39.63	64.75	86.63	135.50	235.75	404.25

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Rate Sheet

Spouse - Coverage and **Semi-monthly** Cost for Spouse Optional Life Insurance
Rates are effective as of July 1, 2013

Coverage amounts	< 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
$5,000	0.13	0.12	0.13	0.19	0.29	0.47	0.79	1.30	1.73	2.71	4.72
$10,000	0.26	0.24	0.25	0.38	0.58	0.94	1.59	2.59	3.47	5.42	9.43
$15,000	0.38	0.35	0.38	0.56	0.87	1.40	2.38	3.89	5.20	8.13	14.15
$20,000	0.51	0.47	0.50	0.75	1.16	1.87	3.17	5.18	6.93	10.84	18.86
$25,000	0.64	0.59	0.63	0.94	1.45	2.34	3.96	6.48	8.66	13.55	23.58

Child - Coverage and **Semi-monthly** Cost for Child Optional Life Insurance
Rates are effective as of July 1, 201H

Amount	child cost
$5,000	0.53

Group Long Term Disability Benefits

for Employees of Joint Logistics Managers, Inc-Policy #222850

Disability Can Happen to Anyone.

Want to know more about your chances of becoming disabled? Sun Life Financial is a founding member of the Council for Disability Awareness. Visit **www.disabilitycanhappen.org** and find out your Personal Disability Quotient.

Benefits

- Available to all full-time employees working 30 or more hours per week.
- Coverage for accidents and sicknesses.
- Benefits are 60% of monthly earnings up to a maximum of $4,000 per month.
- Benefits may begin after the elimination period of 180 days of absences due to a covered accident or sickness.
- Employees must meet the definition of disability as defined in the policy to be eligible for the benefits described here.
- Benefits are not payable for pre-existing conditions as defined in the policy.

No cost to you

- Your employer pays your Group LTD premium.

How to enroll

- LTD coverage begins automatically when you meet the eligibility requirements.

For complete plan details

- This highlight flyer is intended to provide an overview of the benefits available from your employer and is not a complete description of plan provisions. Receipt of this flyer does not certify eligibility for benefits under this plan.
- Your employer will provide you with the Sun Life Financial Group booklet containing complete plan details.

This overview is preliminary to the issuance of the policy and booklet certificate. It does not describe the specific benefits under the policy. This policy provides disability income insurance only. It does not provide basic hospital, basic medical or major medical insurance as defined by the New York State Insurance Department.

Group insurance policies are underwritten by Sun Life and Health Insurance Company (U.S.) (Wellesley Hills, MA) in all states under Policy Forms Series GP-A and GP-D. Product offerings may not be available in all states and may vary depending on state laws and regulations.

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