Agility®
fuel systems

2016 BENEFIT BOOK

4/1/2016 – 12/31/2016 Plan Year

CBIZ BenefitsDirect

Introduction

The effective date for these Agility Fuel Systems benefits is April 1, 2016. The elections you make will remain in place through December 31, 2016, unless you experience a Qualified Change in Family Status.

Qualifying events include:

- Marriage
- Divorce, legal separation or annulment
- Birth or adoption of a child
- Change in employment status on the part of the employee, employee's spouse or dependent
- A dependent fails to satisfy the requirements of eligibility under the employee benefit plans

Who is Eligible?

Unless other stipulated, you are eligible to participate in the Agility Fuel Systems benefit program if you are a full-time employee scheduled to work at least 30 hours per week. You may elect medical, dental, vision, and optional insurance coverage for you and your eligible dependents. Eligible dependents include:

- Your spouse or domestic partner (refer to Domestic Partner Benefit Policy)
- Your dependent children (as defined by each insurance carrier)

Availability of Summary Health Information

Summary of Benefits and Coverage (SBC) and other plan documents are available on the Benefits Direct benefit portal, http://benefits-direct.com/afs, or you can request a paper copy free of charge by contacting the Human Resources Department at 949-267-7735.

Special Note

The purpose of the Benefit Booklet is to summarize your benefit program. Your specific rights to benefits under the Plans are governed solely by the official plan documents and insurance contracts and not by this booklet. If there is any discrepancy between the descriptions of the Plans as outlined in this material and the office plan documents, the language of the plan documents shall govern.

Agility Fuel Systems also specifically reserves the right to revise, modify or terminate the Plans at any time.

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Contact Information

At Agility Fuel Systems, we are committed to offering a comprehensive and competitive employee benefits program which includes the following insurance plans:

- Medical
- Health Reimbursement Arrangement
- Dental
- Vision
- Life (employer-paid and voluntary)
- Short & Long Term Disability
- Supplemental Coverage
- Flexible Spending Account (Health & Dependent Care)
- Employee Assistance Program (EAP)

CBIZ Benefits & Insurance Services of TN
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BlueCross BlueShield of Tennessee
1 Cameron Hill Circle
Chattanooga, TN 37402
800-565-9140
www.bcbst.com

Principal Financial
Dental 800-247-4695
www.principal.com/dental

VSP
800-877-7195
www.vsp.com

TASC
800-422-4661
www.mytasc.com

Benefits Direct Customer Service
877-523-0176
info@benefits-direc.com

Eric Peterson – Account Manager
877-523-0176 x136
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Agility fuel systems

Employee Assistance Program

Focus on You

Providing you with the right tools, wherever you are in life

From simple questions like quick ways to de-stress or how to find more time in your schedule, to more difficult issues like finding support after the loss of a loved one, your program is there to work with you and offer suggestions, options and information.

A Confidential & Important Resource

Your program provides useful tools and resources that can help make the most out of your day or guide you through a difficult time. All confidential and at no cost to you. Some of the topics we can help with include:

- **Resiliency**—overcoming stress and crisis at home and at work.
- **Emotional Wellness**—addiction, depression, anxiety and assistance with other emotional wellness issues.
- **Workplace success**—career goals, team conflict, crisis, management support.
- **Wellness and balance**—work-life balance, stress, relaxation, personal well-being.
- **Personal and family goals**—relationship, children and teen or aging loved ones. Changes in finances or personal situations.

Your program includes up to 5 counseling sessions for you and your eligible dependents or household members at no cost to you.

Step into Action

It's quick and easy. You can access your program's tools and resources in many ways. And remember its completely confidential. We will connect you with the right resources or professionals to help you with your questions, challenges or needs. No situation is too big or too small.

Call your program's toll-free number to speak with a professional.

Visit MagellanHealth.com/member for online tools, articles, resources and more.

Additional Resources and Information

Health and Wellness Program

Our program makes it easy to bring healthy habits into your busy life. You can set daily goals and track progress online, via mobile app and through integration with fitness trackers. You can even get help and motivation from health coaches and peers.

Work-life Services

You have access to tools, resources and experts who can help with many of the day-to-day things that can happen in life. You also have access to the LifeMart® discount center which offers valuable discounts on things such as travel, clothing, restaurants, and more.

Employee Assistance Program
1-800-424-4039

Magellan HEALTHCARE℠

Plan Designs

Health Reimbursement Arrangements

A health reimbursement arrangement (HRA) is an employer-paid health care arrangement that reimburses employees for qualified medical expenses.

Agility will offer an HRA in conjunction with both BlueCross BlueShield of TN medical insurance plans. It is the desire of management to maintain an affordable, accessible health plan for our employees. Based on expected usage, Agility is committing to pay a portion for the individual or family deductible. Should the actual usage exceed expectations, the company contribution toward the medical deductible could be decreased in the future.

BASE MEDICAL PLAN – The HRA covers 50% of the deductible after the employee pays the first $500 for individual or $1,000 for family.

Plan year in-network deductible (4/1/16 – 12/31/16):
$5,000 for individual / $10,000 for family

You pay:
First $500 for individual coverage or $1,000 for family coverage
and 50% of the next $4,500 for individual ($2,250) or $9,000 for family (4,500)

HRA pays (after you pay the first $500 (individual) or $1,000 (family)
50% of next $4,500 for individual ($2,250) or next $9,000 for family ($4,500)

After the deductible is met, BCBST pays 80% (you pay 20%) of eligible expenses until the out-of-pocket (OOP) maximum is met ($6,000 for individual, $12,000 for family). BCBST will pay 100% of eligible expenses after the OOP is satisfied.

PREMIUM MEDICAL PLAN – The HRA covers $2,500 after the employee pays the first $500 for individual or $1,000 for family.

Plan year in-network deductible (4/1/16 – 12/31/16):
$3,000 for individual / $6,000 for family

You pay:
First $500 for individual coverage or $1,000 for family coverage

HRA pays:
Next $2,500 for individual or $5,000 for family

After the deductible is met, BCBST pays 80% (you pay 20%) of eligible expenses until the OOP is met ($5,000 for individual or $10,000 for family). BCBST will pay 100% of eligible expenses after the OOP maximum is satisfied.

(Prescription drug copays do not apply to the deductible and, therefore, are not included in the HRA. These drug copays do apply to the OOP maximum.)

PLAN COSTS as of April 1, 2016

Agility Fuel Systems will continue paying a portion of the medical, dental and vision plan premiums for you and your dependents.

	Employee Bi-Weekly Cost	Total Bi-Weekly Premium	Portion of Bi-Weekly Premium Paid by Agility
BASE MEDICAL PLAN BCBST			
Employee Only	$40.87	$166.81	$125.94
Employee + Spouse	$94.00	$350.31	$256.31
Employee + Child(ren)	$74.79	$305.27	$230.48
Employee + Family	$124.04	$506.28	$382.24
PREMIUM MEDICAL PLAN BCBST			
Employee Only	$57.21	$191.49	$134.28
Employee + Spouse	$132.42	$402.15	$269.73
Employee + Child(ren)	$104.70	$350.44	$245.74
Employee + Family	$173.64	$581.19	$407.55
PRINCIPAL DENTAL PLAN			
Employee Only	$3.64	$14.57	$10.93
Employee + Spouse	$8.36	$33.43	$25.07
Employee + Child(ren)	$8.02	$32.09	$24.07
Employee + Family	$13.52	$54.08	$40.56
VSP VISION PLAN			
Employee Only	$0.87	$3.49	$2.62
Employee + 1	$1.40	$5.59	$4.19
Employee + Children	$1.43	$5.71	$4.28
Employee + Family	$2.30	$9.20	$6.90

Agility Fuel Systems also provides $15,000 of term life insurance and short-term and long-term disability coverage at no cost to you.

Health Insurance

Base Plan

of Tennessee

Agility Fuel Systems, Inc.

Benefit Summary

Effective Date: 4/1/2016
Network: P
Option/Quote: 1/103

Health Reimbursement Arrangement (HRA)	Individual	Family
HRA Allocation [18]	$2,250	$4,500
HRA Covers	Medical Only Expenses	
HRA Eligible Expenses	Deductible	
HRA Reimbursement Order	Employee pays first $500 Individual/$1000 Family before the HRA reimburses.	
HRA Reimbursement Percentage	50%	
Benefit Plan Features	**Your Cost In-Network**	**Your Cost Out-Of-Network [1]**
Annual Deductible		
Individual/Family	$5000/$10000	$10000/$20000
Annual Out-of-Pocket Maximum		
Individual/Family	$6000/$12000	$18000/$36000
4th Quarter Carry-over	Excluded	
Covered Services		
Preventive Care Services [2] (see page 3 for a list)		
Well Child Care Services	Covered at 100%	40% after Deductible
Well Care Services [2]	Covered at 100%	40% after Deductible
Annual Well Women Exam, Mammogram	Covered at 100%	40% after Deductible
Practitioner Office Services		
Primary Care Office Visits	20% after Deductible	40% after Deductible
Specialist Office Visits	20% after Deductible	40% after Deductible
Office Surgery [4] [5] [6]	20% after Deductible	40% after Deductible
Routine Diagnostic Lab, X-Ray & Injections	20% after Deductible	40% after Deductible
Advanced Radiological Imaging [3] [5] [7]	20% after Deductible	40% after Deductible
Provider-Administered Specialty Drugs [11]	$100 Copay	40% after Deductible
Services Received at a Facility (includes professional and facility charges)		
Inpatient Services [3] [5]	20% after Deductible	40% after Deductible
Outpatient Surgery [4] [5] [6]	20% after Deductible	40% after Deductible
Routine Diagnostic Services - Outpatient	20% after Deductible	40% after Deductible
Advanced Radiological Imaging - Outpatient [3] [5] [7]	20% after Deductible	40% after Deductible
Other Outpatient Services [8]	20% after Deductible	40% after Deductible
Emergency Care Services [9]	20% after Deductible	20% after Deductible
Emergency Care Advanced Radiological Imaging [7]	20% after Deductible	20% after Deductible
Medical Equipment [4]		
Durable Medical Equipment	20% after Deductible	40% after Deductible
Prosthetics	20% after Deductible	40% after Deductible
Orthotic Appliances	20% after Deductible	40% after Deductible
Hearing Aids (under age 18)	20% after Deductible	40% after Deductible
Behavioral Health		
Inpatient: Unlimited days per annual benefit period [3][5]	20% after Deductible	40% after Deductible
Outpatient: Unlimited visits per annual benefit period	20% after Deductible	40% after Deductible
Therapy Services [10]		
Limited to 30-36 visits per annual benefit period per therapy type	20% after Deductible	40% after Deductible
Skilled Nursing Facility & Rehabilitation Facility Services [3] [5]		
Limited to 60 days combined	20% after Deductible	40% after Deductible
Home Health Care Services [3]		
Limited to 60 visits per annual benefit period	20% after Deductible	40% after Deductible

Benefit Plan Features:	Your Cost In-Network	Your Cost Out-Of-Network [1]
Hospice Services		
Inpatient [3]	Covered at 100%	40% after Deductible
Outpatient	Covered at 100%	40% after Deductible
Ambulance Service	20% after Deductible	20% after Deductible
Prescription Drugs [4]		
Prescription Contraceptives [16]	Covered at 100%	40% after Deductible
Retail RX04 Network - up to 30 day supply		
Generic [13] [15] [17]	$10.00	40% after Deductible
Preferred [13] [15] [17]	$35.00	40% after Deductible
Non-Preferred [13] [15] [17]	$50.00	40% after Deductible
Plus90 or Home Delivery Network - up to 90 day supply		
Generic [14] [15]	$30.00	40% after Deductible
Preferred [14] [15]	$105.00	40% after Deductible
Non-Preferred [14] [15]	$150.00	40% after Deductible
Self-Administered Specialty Drugs [11] [12] [15]		
Specialty Pharmacy Network - up to 30 day supply	$100.00	Not Covered

Notes:

1. Out-of-network benefit payment based on BlueCross BlueShield of Tennessee maximum allowable charge. You are responsible for paying any amount exceeding the maximum allowable charge.
2. Services include: annual physical, childhood immunizations, recommended adult immunizations, vision and hearing screenings performed by the physician during the preventive health exam.
3. Requires prior authorization.
4. Certain procedures, medication and equipment may require prior authorization.
5. If prior authorization is required, when using network providers outside Tennessee for physician and outpatient services and all services from out-of-network providers, benefits will be reduced by 10% based on out-of-network if prior authorization is not obtained and services are medically necessary. If services are not medically necessary, no benefits will be provided
6. Surgeries include incisions, excisions, biopsies, injection treatments, fracture treatments, applications of casts and splints, sutures, and invasive diagnostic services (e.g., colonoscopy, sigmoidoscopy and endoscopy).
7. CT scans, PET scans, MRIs, nuclear medicine and other similar technologies.
8. Includes services such as chemotherapy, radiation therapy and renal dialysis.
9. Copay, if applicable, waived if admitted to hospital.
10. Physical, speech, manipulative, and occupational therapies are limited to 30 visits per therapy type per annual benefit period. Cardiac and pulmonary rehabilitative therapies are limited to 36 visits per therapy type per annual benefit period.
11. Visit bcbst.com for the Specialty Drug List.
12. You have a distinct arrangement for Self-administered Specialty Drugs. To receive benefits, you must use a Specialty Pharmacy Network provider. Visit bcbst.com for a list of providers in the Specialty Pharmacy Network. Specialty drugs are limited to a 30-day supply.
13. Copay per prescription, up to 30 day supply.
14. Your plan requires you to receive long-term medications in a 90-day supply from home delivery or at a retail pharmacy in the Plus90 network. If you choose to use a retail pharmacy that is not part of the Plus90 Network, you are limited to a 30-day supply. Visit bcbst.com to find a list of pharmacies in the Plus90 network.
15. A financial penalty may be applied if you choose a brand name drug when a generic equivalent is available. Please refer to your Evidence of Coverage (EOC) for specific information.
16. This plan covers the following at 100%, in accordance with the Women's Preventive Services provision of the Affordable Care Act: generic contraceptives, vaginal ring, hormonal patch, emergency contraception available with a prescription. Visit bcbst.com for a complete list of covered prescription contraceptive drugs.
17. Vaccines administered at the pharmacy are covered at 100%.
18. HRA Plan: Your HRA allocation is embedded, which means each covered individual in a family plan has a per member limit up to the amount noted in the individual tier and to the family maximum for all members combined. If your BlueCross HRA becomes effective in month other than January, your annual allocation may be prorated.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your Evidence of Coverage (EOC) and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the EOC will govern. For a complete list of limitations and exclusions, please refer to your EOC.

Agility fuel systems

Summary of Preventive Health Services Covered at 100% In-Network

In-network preventive services that are covered with no cost share include:

- Primary care services with an A or B recommendation by the United States Preventive Services Task Force (USPSTF)
- Immunizations recommended by the Advisory Committee on Immunization Practices that have been adopted by the Centers for Disease Control and Prevention (CDC)
- Bright Futures recommendations for infants, children and adolescents that are supported by the Health Resources and Services Administration (HRSA)
- Preventive care and screening for women as provided in the guidelines supported by HRSA

The following preventive care services are covered. Coverage of some services may depend on age and/or risk exposure.

All Members:

- One-a-year preventive health exams. More frequent preventive exams are covered for children up to age 3
- All standard immunizations adopted by the CDC
- Screening for colorectal cancer (age 50 – 75), high cholesterol and lipids, high blood pressure, obesity, diabetes, and depression
- Screening for HIV and certain sexually transmitted diseases, and counseling for the prevention of sexually transmitted diseases
- Screening and counseling in primary care setting for alcohol misuse and tobacco use; tobacco cessation counseling in the primary care setting will be limited to eight visits per year
- Dietary counseling for adults with hyperlipidemia, hypertension, Type 2 diabetes, obesity, coronary artery disease and congestive heart failure; limited to six visits per year

Women:

- Annual well-woman visit, including annual sexually transmitted infection (STI) counseling and annual domestic violence screening & counseling
- Cervical Cancer Screening
- Screening of pregnant women for anemia, iron deficiency, bacteriuria, hepatitis B virus, Rh factor incompatibility, gestational diabetes
- Breastfeeding support/counseling & supplies (one lactation consultant visit and manual breast pump in conjunction with each birth)
- Counseling women at high risk of breast cancer for chemoprevention, including risks and benefits
- Mammography screening at age 40 and over, and evaluation for genetic testing for BRCA breast cancer gene
- Osteoporosis screening (age 60 or older)
- HPV testing once every 3 years, beginning at age 30
- Annual HIV screening and counseling
- FDA-approved contraceptive methods and counseling Medical plan: Injectable or implantable hormonal contraceptives and barrier methods, sterilization for women Rx plan: Generic oral & injectable contraceptives, vaginal contraceptive, patch, prescription emergency contraception

Men:

- Prostate cancer screening at age 50 and older
- Abdominal aortic aneurysm screening at age 65 – 75 (for men who have ever smoked)

Children:

- Newborn screening for hearing, phenylketonuria (PKU), thyroid disease, sickle cell anemia, and cystic fibrosis
- Development delays and autism screening
- Iron deficiency screening
- Vision screening
- Screening for major depressive disorders

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.bcbst.com or by calling 1-800-565-9140. Coverage documents are not available until after the effective date of your coverage, but you may obtain a sample at http://www.bcbst.com/samplepolicy/2016/LG . This sample may not match your benefits exactly, so you should review your coverage document once it is available.
Contributions made by you and/or your employer to health savings accounts (HSAs), flexible spending arrangements (FSAs), or health reimbursement arrangements (HRAs) may help pay your deductible or other out-of-pocket expenses.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: **$5,000** person/**$10,000** family Out-of-network: **$10,000** person/**$20,000** family Doesn't apply to preventive care. Copays do not apply to the deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 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 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. In-network: **$6,000** person/**$12,000** family Out-of-network: **$18,000** person/**$36,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premium, balance-billed charges, penalties, and health care this plan doesn't cover.	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 plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. This plan uses Network P. For a list of **in-network providers**, see www.bcbst.com or call 1-800-565-9140.	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. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Important Questions	Answers	Why this Matters:
Do I need a referral to see a specialist?	No. You don't 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 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** 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 **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% co-insurance	40% co-insurance	none
	Specialist visit	20% co-insurance	40% co-insurance	none
	Other practitioner office visit	20% co-insurance	40% co-insurance	Therapy visits limited to 30 per type per year. Cardiac/Pulmonary Rehab visits limited to 36 per type per year.
	Preventive care/screening/immunization	No Charge	40% co-insurance	none
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	40% co-insurance	none
	Imaging (CT/PET scans, MRIs)	20% co-insurance	40% co-insurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
If you need drugs to treat your illness or condition	Generic drugs	$10 co-pay	40% co-insurance	30-day supply retail; up to 90 day supply home delivery or Plus90 network. Co-pay per 30-day supply.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
More information about **prescription drug coverage** is available at www.bcbst.com.	Preferred brand drugs	$35 co-pay	40% co-insurance	30-day supply retail; up to 90 day supply home delivery or Plus90 network. Co-pay per 30-day supply. When a Brand Drug is chosen and a Generic Drug equivalent is available, Your cost share will increase by the difference between the cost of the Brand Drug and the Generic Drug.
	Non-preferred brand drugs	$50 co-pay	40% co-insurance	
	Self-Administered Specialty drugs	$100 co-pay	Not Covered	Up to a 30 day supply. Must use a pharmacy in Specialty pharmacy network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	40% co-insurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained.
	Physician/surgeon fees	20% co-insurance	40% co-insurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained.
If you need immediate medical attention	Emergency room services	20% co-insurance	20% co-insurance	——————none——————
	Emergency medical transportation	20% co-insurance	20% co-insurance	——————none——————
	Urgent care	See Limitations & Exceptions	See Limitations & Exceptions	Urgent Care benefits are determined by place of service, such as physician's office or ER.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	40% co-insurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
	Physician/surgeon fee	20% co-insurance	40% co-insurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% co-insurance	40% co-insurance	Prior Authorization required for electro-convulsive therapy (ECT). Your cost share may increase to 50% if not obtained.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
	Mental/Behavioral health inpatient services	20% co-insurance	40% co-insurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
	Substance use disorder outpatient services	20% co-insurance	40% co-insurance	Prior Authorization required for electro-convulsive therapy (ECT). Your cost share may increase to 50% if not obtained.
	Substance use disorder inpatient services	20% co-insurance	40% co-insurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
If you are pregnant	Prenatal and postnatal care	20% co-insurance	40% co-insurance	none
	Delivery and all inpatient services	20% co-insurance	40% co-insurance	none
If you need help recovering or have other special health needs	Home health care	20% co-insurance	40% co-insurance	Limited to 60 visits.
	Rehabilitation services	20% co-insurance	40% co-insurance	Therapy limited to 30 visits per type per year. Cardiac/Pulmonary Rehab limited to 36 visits per year.
	Habilitation services	20% co-insurance	40% co-insurance	
	Skilled nursing care	20% co-insurance	40% co-insurance	Skilled Nursing and Rehabilitation Facility limited to 60 days/year combined.
	Durable medical equipment	20% co-insurance	40% co-insurance	Prior Authorization may be required for certain durable medical equipment. Your cost share may increase to 60% if not obtained.
	Hospice service	No Charge	40% co-insurance	Prior Authorization required for Inpatient Hospice. Your cost share may increase to 60% if not obtained.
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	• Hearing aids for adults	• Routine eye care (Adult)
• Bariatric surgery	• Infertility treatment	• Routine eye care (Children)
• Cosmetic surgery	• Long-term care	• Routine foot care for non-diabetics
• Dental care (Adult)	• Private-duty nursing	• Weight loss programs
• Dental care (Children)		

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	• Hearing aids for children under 18	• Non-emergency care when traveling outside the U.S.

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 **1-800-565-9140**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at **1-866-444-3272** or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services at **1-877-267-2323 x61565** or **www.cciio.cms.gov**.

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:

- Your Plan at **1-800-565-9140** or **www.bcbst.com**.
- The Department of Labor's Employee Benefits Security Administration at **1-866-444-3272** or **www.dol.gov/ebsa/healthreform**.
- Consumer Insurance Services within the Tennessee Department of Commerce and Insurance at **1-800-342-4029** or visit **www.tn.gov/insurance/consumerRes.shtml**.

Additionally, a consumer assistance program can help you file your appeal. Contact the Tennessee Department of Commerce and Insurance (TDCI) at **1-800-342-4029**, https://sbs-tn.naic.org/Lion-Web/servlet/org.naic.sbs.ext.onlineComplaint.OnlineComplaintCtrl?spanishVersion=N, or email them at CIS.Complaints@state.tn.us. You may also write them at 500 James Robertson Pkwy, Davy Crockett Tower, 6th Floor, Nashville, TN 37243.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1-800-565-9140**.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-800-565-9140**.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码 1-800-565-9140**.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-800-565-9140**.

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

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** $2,050
- **Patient pays** $5,490

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:

Deductibles	$5,000
Copays	$60
Co-insurance	$400
Limits or exclusions	$30
Total	**$5,490**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,100
- **Patient pays** $2,300

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:

Deductibles	$900
Copays	$1,400
Co-insurance	$0
Limits or exclusions	$0
Total	**$2,300**

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**, **copayments**, 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 **copayments**, **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.

Agility fuel systems

Premium Plan

of Tennessee

Agility Fuel Systems, Inc.

Benefit Summary

Effective Date: 4/1/2016
Network: P
Option/Quote: 2/104

Health Reimbursement Arrangement (HRA)	Individual	Family
HRA Allocation [18]	$2500	$5000
HRA Covers	Medical Only Expenses	
HRA Eligible Expenses	Deductible	
HRA Reimbursement Order	Employee pays first $500 Individual/$1000 Family before the HRA reimburses.	
HRA Reimbursement Percentage	100%	

Benefit Plan Features	Your Cost In-Network	Your Cost Out-Of-Network [1]
Annual Deductible		
Individual/Family	$3000/$6000	$6000/$12000
Annual Out-of-Pocket Maximum		
Individual/Family	$5000/$10000	$15000/$30000
4th Quarter Carry-over	Excluded	
Covered Services		
Preventive Care Services [2] (see page 3 for a list)		
Well Child Care Services	Covered at 100%	40% after Deductible
Well Care Services [2]	Covered at 100%	40% after Deductible
Annual Well Women Exam, Mammogram	Covered at 100%	40% after Deductible
Practitioner Office Services		
Primary Care Office Visits	20% after Deductible	40% after Deductible
Specialist Office Visits	20% after Deductible	40% after Deductible
Office Surgery [4] [5] [6]	20% after Deductible	40% after Deductible
Routine Diagnostic Lab, X-Ray & Injections	20% after Deductible	40% after Deductible
Advanced Radiological Imaging [3] [5] [7]	20% after Deductible	40% after Deductible
Provider-Administered Specialty Drugs [11]	$100 Copay	40% after Deductible
Services Received at a Facility (includes professional and facility charges)		
Inpatient Services [3] [5]	20% after Deductible	40% after Deductible
Outpatient Surgery [4] [5] [6]	20% after Deductible	40% after Deductible
Routine Diagnostic Services - Outpatient	20% after Deductible	40% after Deductible
Advanced Radiological Imaging - Outpatient [3] [5] [7]	20% after Deductible	40% after Deductible
Other Outpatient Services [8]	20% after Deductible	40% after Deductible
Emergency Care Services [9]	20% after Deductible	20% after Deductible
Emergency Care Advanced Radiological Imaging [7]	20% after Deductible	20% after Deductible
Medical Equipment [4]		
Durable Medical Equipment	20% after Deductible	40% after Deductible
Prosthetics	20% after Deductible	40% after Deductible
Orthotic Appliances	20% after Deductible	40% after Deductible
Hearing Aids (under age 18)	20% after Deductible	40% after Deductible
Behavioral Health		
Inpatient: Unlimited days per annual benefit period [3][5]	20% after Deductible	40% after Deductible
Outpatient: Unlimited visits per annual benefit period	20% after Deductible	40% after Deductible
Therapy Services [10]		
Limited to 30-36 visits per annual benefit period per therapy type	20% after Deductible	40% after Deductible
Skilled Nursing Facility & Rehabilitation Facility Services [3] [5]		
Limited to 60 days combined	20% after Deductible	40% after Deductible
Home Health Care Services [3]		
Limited to 60 visits per annual benefit period	20% after Deductible	40% after Deductible

Benefit Plan Features:	Your Cost In-Network	Your Cost Out-Of-Network [1]
Hospice Services		
Inpatient [3]	Covered at 100%	40% after Deductible
Outpatient	Covered at 100%	40% after Deductible
Ambulance Service	20% after Deductible	20% after Deductible
Prescription Drugs [4]		
Prescription Contraceptives [16]	Covered at 100%	40% after Deductible
Retail RX04 Network - up to 30 day supply		
Generic [13] [15] [17]	$10.00	40% after Deductible
Preferred [13] [15] [17]	$35.00	40% after Deductible
Non-Preferred [13] [15] [17]	$50.00	40% after Deductible
Plus90 or Home Delivery Network - up to 90 day supply		
Generic [14] [15]	$30.00	40% after Deductible
Preferred [14] [15]	$105.00	40% after Deductible
Non-Preferred [14] [15]	$150.00	40% after Deductible
Self-Administered Specialty Drugs [11] [12] [15]		
Specialty Pharmacy Network - up to 30 day supply	$100.00	Not Covered

Notes:

1. Out-of-network benefit payment based on BlueCross BlueShield of Tennessee maximum allowable charge. You are responsible for paying any amount exceeding the maximum allowable charge.
2. Services include: annual physical, childhood immunizations, recommended adult immunizations, vision and hearing screenings performed by the physician during the preventive health exam.
3. Requires prior authorization.
4. Certain procedures, medication and equipment may require prior authorization.
5. If prior authorization is required, when using network providers outside Tennessee for physician and outpatient services and all services from out-of-network providers, benefits will be reduced by 10% based on out-of-network if prior authorization is not obtained and services are medically necessary. If services are not medically necessary, no benefits will be provided.
6. Surgeries include incisions, excisions, biopsies, injection treatments, fracture treatments, applications of casts and splints, sutures, and invasive diagnostic services (e.g., colonoscopy, sigmoidoscopy and endoscopy).
7. CT scans, PET scans, MRIs, nuclear medicine and other similar technologies.
8. Includes services such as chemotherapy, radiation therapy and renal dialysis.
9. Copay, if applicable, waived if admitted to hospital.
10. Physical, speech, manipulative, and occupational therapies are limited to 30 visits per therapy type per annual benefit period. Cardiac and pulmonary rehabilitative therapies are limited to 36 visits per therapy type per annual benefit period.
11. Visit bcbst.com for the Specialty Drug List.
12. You have a distinct arrangement for Self-administered Specialty Drugs. To receive benefits, you must use a Specialty Pharmacy Network provider. Visit bcbst.com for a list of providers in the Specialty Pharmacy Network. Specialty drugs are limited to a 30-day supply.
13. Copay per prescription, up to 30 day supply.
14. Your plan requires you to receive long-term medications in a 90-day supply from home delivery or at a retail pharmacy in the Plus90 network. If you choose to use a retail pharmacy that is not part of the Plus90 Network, you are limited to a 30-day supply. Visit bcbst.com to find a list of pharmacies in the Plus90 network.
15. A financial penalty may be applied if you choose a brand name drug when a generic equivalent is available. Please refer to your Evidence of Coverage (EOC) for specific information.
16. This plan covers the following at 100%, in accordance with the Women's Preventive Services provision of the Affordable Care Act: generic contraceptives, vaginal ring, hormonal patch, emergency contraception available with a prescription. Visit bcbst.com for a complete list of covered prescription contraceptive drugs.
17. Vaccines administered at the pharmacy are covered at 100%.
18. HRA Plan: Your HRA allocation is embedded, which means each covered individual in a family plan has a per member limit up to the amount noted in the individual tier and to the family maximum for all members combined. If your BlueCross HRA becomes effective in month other than January, your annual allocation may be prorated.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your Evidence of Coverage (EOC) and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the EOC will govern. For a complete list of limitations and exclusions, please refer to your EOC.

Agility fuel systems

Summary of Preventive Health Services Covered at 100% In-Network

In-network preventive services that are covered with no cost share include:

- Primary care services with an A or B recommendation by the United States Preventive Services Task Force (USPSTF)
- Immunizations recommended by the Advisory Committee on Immunization Practices that have been adopted by the Centers for Disease Control and Prevention (CDC)
- Bright Futures recommendations for infants, children and adolescents that are supported by the Health Resources and Services Administration (HRSA)
- Preventive care and screening for women as provided in the guidelines supported by HRSA

The following preventive care services are covered. Coverage of some services may depend on age and/or risk exposure.

All Members:

- One-a-year preventive health exams. More frequent preventive exams are covered for children up to age 3
- All standard immunizations adopted by the CDC
- Screening for colorectal cancer (age 50 – 75), high cholesterol and lipids, high blood pressure, obesity, diabetes, and depression
- Screening for HIV and certain sexually transmitted diseases, and counseling for the prevention of sexually transmitted diseases
- Screening and counseling in primary care setting for alcohol misuse and tobacco use; tobacco cessation counseling in the primary care setting will be limited to eight visits per year
- Dietary counseling for adults with hyperlipidemia, hypertension, Type 2 diabetes, obesity, coronary artery disease and congestive heart failure; limited to six visits per year

Women:

- Annual well-woman visit, including annual sexually transmitted infection (STI) counseling and annual domestic violence screening & counseling
- Cervical Cancer Screening
- Screening of pregnant women for anemia, iron deficiency, bacteriuria, hepatitis B virus, Rh factor incompatibility, gestational diabetes
- Breastfeeding support/counseling & supplies (one lactation consultant visit and manual breast pump in conjunction with each birth)
- Counseling women at high risk of breast cancer for chemoprevention, including risks and benefits
- Mammography screening at age 40 and over, and evaluation for genetic testing for BRCA breast cancer gene
- Osteoporosis screening (age 60 or older)
- HPV testing once every 3 years, beginning at age 30
- Annual HIV screening and counseling
- FDA-approved contraceptive methods and counseling Medical plan: Injectable or implantable hormonal contraceptives and barrier methods, sterilization for women Rx plan: Generic oral & injectable contraceptives, vaginal contraceptive, patch, prescription emergency contraception

Men:

- Prostate cancer screening at age 50 and older
- Abdominal aortic aneurysm screening at age 65 – 75 (for men who have ever smoked)

Children:

- Newborn screening for hearing, phenylketonuria (PKU), thyroid disease, sickle cell anemia, and cystic fibrosis
- Development delays and autism screening
- Iron deficiency screening
- Vision screening
- Screening for major depressive disorders

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.bcbst.com or by calling 1-800-565-9140. Coverage documents are not available until after the effective date of your coverage, but you may obtain a sample at http://www.bcbst.com/samplepolicy/2016/LG . This sample may not match your benefits exactly, so you should review your coverage document once it is available.
Contributions made by you and/or your employer to health savings accounts (HSAs), flexible spending arrangements (FSAs), or health reimbursement arrangements (HRAs) may help pay your deductible or other out-of-pocket expenses.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: **$3,000** person/**$6,000** family Out-of-network: **$6,000** person/**$12,000** family Doesn't apply to preventive care. Copays do not apply to the deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 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 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. In-network: **$5,000** person/**$10,000** family Out-of-network: **$15,000** person/**$30,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premium, balance-billed charges, penalties, and health care this plan doesn't cover.	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 plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. This plan uses Network P. For a list of **in-network providers**, see www.bcbst.com or call 1-800-565-9140.	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. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Important Questions	Answers	Why this Matters:
Do I need a referral to see a specialist?	No. You don't 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 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** 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 **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% co-insurance	40% co-insurance	none
	Specialist visit	20% co-insurance	40% co-insurance	none
	Other practitioner office visit	20% co-insurance	40% co-insurance	Therapy visits limited to 30 per type per year. Cardiac/Pulmonary Rehab visits limited to 36 per type per year.
	Preventive care/screening/immunization	No Charge	40% co-insurance	none
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	40% co-insurance	none
	Imaging (CT/PET scans, MRIs)	20% co-insurance	40% co-insurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
If you need drugs to treat your illness or condition	Generic drugs	$10 co-pay	40% co-insurance	30-day supply retail; up to 90 day supply home delivery or Plus90 network. Co-pay per 30-day supply.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
More information about **prescription drug coverage** is available at www.bcbst.com.	Preferred brand drugs	$35 co-pay	40% co-insurance	30-day supply retail; up to 90 day supply home delivery or Plus90 network. Co-pay per 30-day supply. When a Brand Drug is chosen and a Generic Drug equivalent is available, Your cost share will increase by the difference between the cost of the Brand Drug and the Generic Drug.
	Non-preferred brand drugs	$50 co-pay	40% co-insurance	
	Self-Administered Specialty drugs	$100 co-pay	Not Covered	Up to a 30 day supply. Must use a pharmacy in Specialty pharmacy network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	40% co-insurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained.
	Physician/surgeon fees	20% co-insurance	40% co-insurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained.
If you need immediate medical attention	Emergency room services	20% co-insurance	20% co-insurance	——————none——————
	Emergency medical transportation	20% co-insurance	20% co-insurance	——————none——————
	Urgent care	See Limitations & Exceptions	See Limitations & Exceptions	Urgent Care benefits are determined by place of service, such as physician's office or ER.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	40% co-insurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
	Physician/surgeon fee	20% co-insurance	40% co-insurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% co-insurance	40% co-insurance	Prior Authorization required for electro-convulsive therapy (ECT). Your cost share may increase to 50% if not obtained.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
	Mental/Behavioral health inpatient services	20% co-insurance	40% co-insurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
	Substance use disorder outpatient services	20% co-insurance	40% co-insurance	Prior Authorization required for electro-convulsive therapy (ECT). Your cost share may increase to 50% if not obtained.
	Substance use disorder inpatient services	20% co-insurance	40% co-insurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
If you are pregnant	Prenatal and postnatal care	20% co-insurance	40% co-insurance	none
	Delivery and all inpatient services	20% co-insurance	40% co-insurance	none
If you need help recovering or have other special health needs	Home health care	20% co-insurance	40% co-insurance	Limited to 60 visits.
	Rehabilitation services	20% co-insurance	40% co-insurance	Therapy limited to 30 visits per type per year. Cardiac/Pulmonary Rehab limited to 36 visits per year.
	Habilitation services	20% co-insurance	40% co-insurance	
	Skilled nursing care	20% co-insurance	40% co-insurance	Skilled Nursing and Rehabilitation Facility limited to 60 days/year combined.
	Durable medical equipment	20% co-insurance	40% co-insurance	Prior Authorization may be required for certain durable medical equipment. Your cost share may increase to 60% if not obtained.
	Hospice service	No Charge	40% co-insurance	Prior Authorization required for Inpatient Hospice. Your cost share may increase to 60% if not obtained.
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)
- Dental care (Children)
- Hearing aids for adults
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine eye care (Children)
- Routine foot care for non-diabetics
- 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
- Hearing aids for children under 18
- Non-emergency care when traveling outside the U.S.

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 **1-800-565-9140**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at **1-866-444-3272** or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services at **1-877-267-2323 x61565** or **www.cciio.cms.gov**.

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:

- Your Plan at **1-800-565-9140** or **www.bcbst.com**.
- The Department of Labor's Employee Benefits Security Administration at **1-866-444-3272** or **www.dol.gov/ebsa/healthreform**.
- Consumer Insurance Services within the Tennessee Department of Commerce and Insurance at **1-800-342-4029** or visit **www.tn.gov/insurance/consumerRes.shtml**.

Additionally, a consumer assistance program can help you file your appeal. Contact the Tennessee Department of Commerce and Insurance (TDCI) at **1-800-342-4029**, https://sbs-tn.naic.org/Lion-Web/servlet/org.naic.sbs.ext.onlineComplaint.OnlineComplaintCtrl?spanishVersion=N, or email them at CIS.Complaints@state.tn.us. You may also write them at 500 James Robertson Pkwy, Davy Crockett Tower, 6th Floor, Nashville, TN 37243.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-800-565-9140**.

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

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.

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See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $3,650
- **Patient pays** $3,890

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:	
Deductibles	$3,000
Copays	$60
Co-insurance	$800
Limits or exclusions	$30
Total	**$3,890**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,100
- **Patient pays** $2,300

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:	
Deductibles	$900
Copays	$1,400
Co-insurance	$0
Limits or exclusions	$0
Total	**$2,300**

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**, **copayments**, 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.

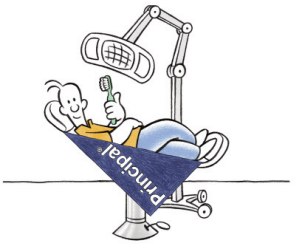
Can I use Coverage Examples to compare plans?

✓ **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 **copayments**, **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.

Dental Insurance



Policyholder: Agility Fuel Systems

Dental PPO Benefit Summary

Effective Date: 04/01/2016

Predetermination of Benefits: Before treatment begins for inlays, onlays, single crowns, prosthetics, periodontics and oral surgery, you may file a dental treatment plan with Principal Life Insurance Company. Principal Life will provide a written response indicating benefits that may be payable for the proposed treatment.

This chart provides you a brief summary of the key benefits of the dental coverage available from Principal Life Insurance Company. Following the chart, you will find additional information to answer questions you may have. For a complete list of all your dental coverage benefits and restrictions, please refer to your booklet or contact your employer.

Eligibility	
Job Class	ALL MEMBERS

Benefits Payable				
Network	Dental Preferred Provider Organization (PPO)			
	Calendar Year Deductible		**Coinsurance (Policy Pays)**	
	In-Network	Non-Network	In-Network	Non-Network
Unit 1 – Preventive	$0	$0	100%	100%
Unit 2 – Basic	$50	$50	80%	80%
Unit 3 – Major	$50	$50	50%	50%
Family Deductible Maximum	3 times the per person deductible amount			
Combined Deductible	In-network deductibles for basic and major procedures are combined. Non-network deductibles for basic and major procedures are combined.			
Combined Maximums	Maximums for preventive, basic, and major procedures are combined. In-network Calendar year maximums are $1,000 per person. Non-network Calendar year maximums are $1,000 per person.			
Maximum Accumulation	This allows for a portion of unused maximum benefit to carry over to next year's maximum benefit amount. To qualify, you must have had a dental service performed within the Calendar year and used less than the maximum threshold. The threshold is equal to the lesser of 50% of the maximum benefit or $1000. If qualification is met, 50% of the threshold is carried over to next year's maximum benefit. You can accumulate no more than four times the carry over amount.			
Additional Benefits				
	Lifetime Deductible		**Coinsurance (Policy Pays)**	
	In-Network	Non-Network	In-Network	Non-Network
Unit 4 - Orthodontia • **Child & Adult** **Lifetime Maximum:** **In-Network: $1,000** **Non-Network: $1,000**	$0	$0	55%	50%

DENTAL

How Are Dental Procedures Covered?

The list of common procedures shows what unit the procedure is included in and how often they are covered.

Unit 1 – Preventive Procedures	• Routine exams - two per calendar year • Routine cleaning (prophylaxis) - two per calendar year (Expectant mothers, diabetics and those with heart disease receive one additional routine or periodontal cleaning within a calendar year.) • Second Opinion Consultation • Fluoride – two treatments each calendar year (covered only for dependent children under age 19) • X-rays - Bitewing (one set every calendar year), occlusal, periapical • X-rays – Full mouth survey (one every 60 months), extraoral
Unit 2 – Basic Procedures	• Periodontal prophylaxis - if three months have elapsed after active surgical periodontal treatment; two per calendar year (Expectant mothers, diabetics and those with heart disease receive one additional routine or periodontal cleaning within a calendar year.) • Emergency exams – two per calendar year • Space maintainers - covered only for dependent children under age 19; repairs not covered • Sealants – on first and second permanent molars for dependent children under age 19; one each tooth each 36 months • Harmful Habit Appliance - covered only for dependent children under age 19 • Fillings and stainless steel crowns • Composite fillings on molars • Simple Oral Surgery
Unit 3 – Major Procedures	• General Anesthesia (covered only for specific procedures)/IV Sedation • Complex Oral Surgical Procedures • Non-surgical Periodontics, including scaling and root planing - once each quadrant each 24 months (For expectant mothers, diabetics and those with heart disease, this procedure is provided with no deductible and 100% coinsurance.) • Periodontal Surgical Procedures – one each quadrant each 36 months • Simple Endodontics (root canal therapy for anterior teeth) • Complex Endodontics (root canal therapy for molar teeth) • Repairs to Partial Denture, Bridge, Crown, Relines, Rebasing, Tissue Conditioning and Adjustment to Bridge/Denture, within policy limitations • Crowns – each 120 months per tooth if tooth cannot be restored by a filling. • Inlays, Onlays, Cast Post and Core, Core Buildup - each 120 months per tooth • Implants – each 120 months • Bridges - Initial placement / Replacement of bridges 120 months old. • Dentures - Initial placement of complete or partial dentures / Replacement of complete or partial dentures over 60 months old
Unit 4 - Orthodontic Procedures	• X-rays and other diagnostic procedures, fixed and removable appliances

There is Coordination of Benefits, which is a procedure for limiting benefits from two or more carriers to 100% of the claimant's covered expenses.

DENTAL

Understanding Your Dental Benefits

Am I Eligible For Coverage?

To be eligible for coverage, you must qualify as an eligible member and be considered actively at work.

You must be enrolled for dental coverage before it can be offered to your dependents. Eligible dependents include your spouse, qualified domestic partner and children, including those of your qualified domestic partner. Additional eligibility requirements may apply.

An annual enrollment applies. Members can enroll for dental coverage during the annual enrollment period and not be subject to the late entrant waiting period. Certain restrictions apply.

How Do I Find A Participating Provider?

Use the Provider Directory on www.principal.com to locate nearby dentists or see if your dentist participates in your network.

1	Visit www.principal.com/dentist.
2	Begin your search by picking the **state** where you would like to find a provider. Next, specify a **network**. Depending on the network chosen, you may be transferred to a partner site.
3	Enter the **name of the provider** you are looking for (if known). If you are looking for a nearby dentist, enter the **city and state and/or ZIP code**. Be sure to indicate **how far you are willing to travel**.
4	Select the **desired specialty** or use the No Specialty Preference default. Click **Continue**.
5	Select a **language** if your preference is other than English. Click **Continue**.

You may nominate your dentist for inclusion in our network. Please submit the dentist's name, address, phone and specialty by calling 1-800-832-4450, or submit through www.principal.com/refer-dental-provider.

What Are The Restrictions Of My Coverage?

This Benefit Summary is a summary only. For a complete list of benefit restrictions, please refer to your booklet.

DENTAL

Limitations & Exclusions	
Late Entrant Provision	Those members enrolling more than 31 days after becoming eligible will be subject to an individual benefit waiting period, subject to policy guidelines.
Missing Tooth	Benefits for the initial placement of bridges, partials and dentures are not covered if those teeth were missing prior to becoming insured under the Principal Life policy. When the policy replaces coverage under a prior plan, continuous coverage under the prior plan may be applied to the missing tooth provision requirement.
Orthodontia	If there is orthodontia (ortho) treatment in progress on the coverage effective date and you are covered under any prior group coverage for ortho, there will be immediate coverage for treatment if proof is submitted that shows: 1) The lifetime maximum under any prior group coverage has not been exceeded, 2) Ortho treatment was started and bands or appliances were inserted while insured under any prior group coverage, and 3) Ortho treatment has been continued while insured under this policy. Principal Life will credit payments made by the prior carrier toward the Principal Life lifetime ortho payment limit. You will not be covered if ortho treatment is in progress prior to the effective date with Principal Life and you are not covered under any prior group coverage for ortho.
Prevailing Charge	When using non-network providers, you pay any amount over the allowable charge.
Other Limitations	There are additional limitations to your coverage. A complete list is included in your booklet.

WE'LL GIVE YOU AN EDGE ®

Principal Life Insurance Company, Des Moines, Iowa 50392-0002, www.principal.com

This is a summary of dental coverage underwritten by or with administrative services provided by Principal Life Insurance Company. This benefit summary is for administrative purposes and is not a complete statement of benefits and restrictions. You'll receive a benefit booklet with details about your coverage. If there is a discrepancy between this summary and your benefit booklet, the benefit booklet prevails.

Agility fuel systems

Vision Insurance

Your Vision Benefits Summary

VSP Vision care for life

Get the best in eyecare and eyewear with AGILITY FUEL SYSTEMS, INC and VSP® Vision Care.

Using your VSP benefit is easy.

- **Register at vsp.com** Once your plan is effective, review your benefit information.
- **Find an eyecare provider who's right for you.** The decision is yours to make—choose a VSP doctor, a participating retail chain, or any out-of-network provider. To find a VSP provider, visit **vsp.com** or call **800.877.7195**.
- **At your appointment, tell them you have VSP.** There's no ID card necessary. If you'd like a card as a reference, you can print one on **vsp.com**.

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

Best Eyecare

You'll get the highest level of care, including a WellVision Exam®– the most comprehensive exam designed to detect eye and health conditions. Plus, when you see a VSP provider, 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. Choose from featured frame brands like Anne Klein, bebe®, Calvin Klein, Flexon®, Lacoste, Nike, Nine West, and more[1]. Visit **vsp.com** to find a VSP provider who carries these brands.

Plan Information

VSP Provider Network: VSP Signature

Benefit	Description	Copay
Your Coverage with a VSP Provider		
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 • $150 allowance for featured frame brands • 20% savings on the 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 Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 35-40% on other lens enhancements • Every plan year	$50 $80 - $90 $120 - $160
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	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam.	
	Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam	
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor	

Your Coverage with Out-of-Network Providers

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

Exam	up to $50	Lined Trifocal Lenses	up to $100
Frame	up to $70	Progressive Lenses	up to $75
Single Vision Lenses	up to $50	Contacts	up to $105
Lined Bifocal Lenses	up to $75		

*Plan year begins in April

VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location.

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

[1]Brands/Promotion subject to change.

Group Term Life

Policyholder: Agility Fuel Systems

Group Term Life Benefit Summary

Effective Date: 04/01/2016

This chart provides you a brief summary of the key benefits of the life coverage available from Principal Life Insurance Company. Following the chart, you will find additional information to answer questions you may have. For a complete list of all your life coverage benefits and restrictions, please refer to your booklet or contact your employer.

Within 30 days of delivery, an individual age 65 or older, if not satisfied for any reason, may return the booklet and have premium fully refunded and coverage terminated retroactive to the original effective date. Premium refund shall occur no later than 30 days following the date we receive the returned booklet.

Eligibility	
Job Class	ALL MEMBERS
Benefits Payable	
Employee Life Benefits	
Benefit Amount	$15,000
Proof of Good Health	Proof of good health is required for life insurance amounts greater than: If you are Under 70: $15,000 If you are 70 and older: The lesser of $15,000 or the amount with the prior carrier
Age Reductions	35% benefit reduction at age 70 with an additional 20% reduction at age 75. Age reductions apply to the benefit amount after proof of good health .
Additional Employee Benefits	
Coverage During Disability	If you become disabled before age 60, coverage will continue and premium may be waived.
Accelerated Death Benefit	If you are terminally ill, you may be able to receive a portion of your life coverage benefit as a lump sum.
Individual Purchase Rights	If you terminate employment, you may be able to convert coverage to an individual policy.
Limitations & Exclusions	
Coverage Outside of the US	Benefits will not be paid if you are outside the United States for certain reasons for more than six months.

GROUP TERM LIFE

Accidental Death & Dismemberment (AD&D) Coverage	
Benefit Amount	Your benefit is equal to your group term life benefit amount if loss is due to accident or injury. If loss is due to exposure to the elements or disappearance, your loss may be covered. You may be paid: • **Full benefit** when you lose: your life / both hands / both feet / sight of both eyes / one hand and sight of one eye / one foot and sight of one eye / one hand and one foot. • **Half of the benefit** when you lose: one hand / one foot / sight of one eye. • **One-fourth of the benefit** when you lose the thumb and index finger on the same hand. The loss must occur within 365 days of the accident.
Additional Benefits	
Seatbelt/Airbag	$10,000 if you are wearing a seatbelt or are protected by an airbag and die in an automobile accident
Education	$3,000 per year for up to four years for dependent(s) enrolled at an accredited post-secondary school at the time of your death
Repatriation	Up to $2,000 for preparation and transportation of your body if you die at least 100 miles from your permanent residence
Loss of Use/Paralysis	For total and irrevocable loss of voluntary movement for 12 consecutive months or paralysis that is permanent, complete and irreversible, the benefit is: 100% for quadriplegia; 50% for paraplegia, hemiplegia, loss of use of both hands or both feet, or loss of use of one hand and one foot; or 25% for loss of use of one arm, one leg, one hand or one foot
Loss of Speech and/or Hearing	When loss is irrevocable and continues for 12 consecutive months, the benefit is: 100% for loss of both speech and hearing; 50% for loss of speech or hearing; 25% for loss of hearing in one ear
Limitations & Exclusions	
Other Limitations	The Benefit Summary is a summary only. For a complete list of benefit restrictions, please refer to your booklet.

GROUP TERM LIFE

Understanding Your Life Coverage Benefits

Am I Eligible For Coverage?

To be eligible for coverage, you must qualify as an eligible member and be considered actively at work.

You will be considered actively at work if you are able and available for active performance of all of your regular duties. Short-term absence because of a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off is considered active work provided you are able and available for active performance of all of your regular duties and were working the day immediately prior to the date of your absence.

Spouse and child coverage is not available.

What Additional Benefits Are Included?

Coverage During Disability	If you become totally disabled before age 60, coverage will continue and premium will be waived. You must be totally disabled for 9 months before the waiver begins. Coverage continues without premium payment until you recover or turn age 65, whichever occurs first.
Accelerated Death Benefit	If you are terminally ill you can receive up to 75% of your benefit amount in a lump sum, not to exceed $250,000, as long as: • Your life expectancy is 12 months or less (as diagnosed by a physician), and • Your death benefit is at least $10,000. If you use the accelerated benefit, your death benefit is reduced by the accelerated benefit payment. There are possible tax consequences to receiving an accelerated benefit payment. You should contact your tax advisor for details. Receipt of accelerated benefits could also affect eligibility for public assistance. The charge for this benefit is included in the premium.
Individual Purchase Rights	If you terminate employment, you may be able to convert coverage to individual life coverage. Upon coverage termination your employer is required to inform you of your individual purchase rights to convert to an individual policy without proof of good health. The amount you can purchase varies depending on the termination situation. Contact Principal Life for details.
Claim Processing	Principal Life makes claim administration easy and convenient for employers by offering an online life claim form. Once the form is complete, employers submit the information directly over a secure, confidential Web site, expediting the claim review process. The employer can choose to use the online form or a printable version that can be faxed or mailed. Along with the online claim form, Principal Life also provides Express Claim Processing for claims that meet certain criteria. Through the Express Claim Process, decisions are reached within five working days without the employer or beneficiary submitting paperwork.

Group Voluntary Term Life

Policyholder: Agility Fuel Systems

Voluntary Term Life Benefit Summary

Effective Date: 04/01/2016

This chart provides you a brief summary of the key benefits of the life coverage available from Principal Life Insurance Company. Following the chart, you will find additional information to answer questions you may have. For a complete list of all your life coverage benefits and restrictions, please refer to your booklet or contact your employer.

Within 30 days of delivery, an individual age 65 or older, if not satisfied for any reason, may return the booklet and have premium fully refunded and coverage terminated retroactive to the original effective date. Premium refund shall occur no later than 30 days following the date we receive the returned booklet.

Eligibility			
Job Class	ALL MEMBERS		
Eligible Members	All active, full-time employees (except seasonal, temporary or contract workers) who work at least 30 hours per week. If you are covered as an employee, your dependents may also be eligible. Additional eligibility requirements may apply.		
Benefits Payable			
	Employee Life Benefits	**Spouse Life Benefits**	**Child Life Benefits**
Benefit Amount	You may choose to purchase benefits in increments of $10,000	You may choose to purchase benefits in $5,000 increments	For eligible children 14 days or older, you may choose to purchase a benefit of • $20,000 Eligible children under 14 days of age receive $1,000.
Minimum	$10,000	$5,000	Not Applicable
Maximum	$250,000	$50,000	Not Applicable
		Cannot exceed 100% of your benefit amount	
Proof of Good Health	Proof of good health is required for life insurance amounts greater than: If you are under age 70: $150,000 If you are age 70 and over: $10,000	Proof of good health is required for life insurance amounts greater than: If your spouse is under age 70: $50,000 If your spouse is age 70 and over: $10,000	Not Applicable
Age Reductions	35% benefit reduction at age 70, with an additional 20% reduction at age 75 Age reductions apply to the benefit amount after proof of good health.		Not Applicable

VOLUNTARY TERM LIFE

Additional Employee Benefits	
Coverage During Disability	If you become disabled before age 60, coverage will continue and premium may be waived for you and your covered dependents.
Accelerated Death Benefit	If you become terminally ill, you may be able to receive a portion of your life coverage benefit as a lump sum.
Open Enrollment	If you and your enrolled dependents have existing coverage you may be able to increase coverage one increment per year during your open enrollment period without proof of good health.
Individual Purchase Rights	If you terminate employment, you may be able to convert benefits to an individual policy.
Portability	If you cease to qualify as a member, you may be able to continue coverage for you and your covered dependents.
Limitations & Exclusions	
Suicide Exclusion	Benefits are not paid if you or your dependents commit suicide within the first 24 months of coverage (prior group voluntary life coverage applies towards the 24 month time period).
Coverage Outside of the US	Benefits will not be paid if you or your dependents are outside the United States for certain reasons for more than six months.

VOLUNTARY TERM LIFE

Accidental Death & Dismemberment (AD&D) Coverage	
Eligible Members	All active, full-time employees (except seasonal, temporary or contract workers) who work at least 30 hours per week. AD & D coverage does not apply to children.
Benefit Amount	Your employee benefit is equal to your voluntary term life benefit amount, if loss is due to accident or injury. Your spouse's benefit is equal to their voluntary term life benefit amount, if loss is due to accident or injury. If loss is due to exposure to the elements or disappearance, the loss may be covered. Benefits may be paid: • **Full benefit** when you or your spouse lose: your life / both hands / both feet / sight of both eyes / one hand and sight of one eye / one foot and sight of one eye / one hand and one foot. • **Half of the benefit** when you or your spouse lose: one hand / one foot / sight of one eye. • **One-fourth of the benefit** when you or your spouse lose the thumb and index finger on the same hand. The loss must occur within 365 days of the accident.
Additional Benefits	
Seatbelt /Airbag	$10,000 if wearing a seatbelt or are protected by an airbag and die in an automobile accident
Education	$3,000 per year for up to four years for dependent(s) enrolled at an accredited post-secondary school at the time of death
Repatriation	Up to $2,000 for preparation and transportation of the body if the insured dies at least 100 miles from their permanent residence
Loss of Use/Paralysis	For total and irrevocable loss of voluntary movement for 12 consecutive months or paralysis that is permanent, complete and irreversible, the benefit is: 100% for quadriplegia; 50% for paraplegia, hemiplegia, loss of use of both hands or both feet, or loss of use of one hand and one foot; or 25% for loss of use of one arm, one leg, one hand or one foot
Loss of Speech and/or Hearing	When loss is irrevocable and continues for 12 consecutive months the benefit is: 100% for loss of both speech and hearing; 50% for loss of speech or hearing; 25% for loss of hearing in one ear
Limitations & Exclusions	
Other Limitations	This Benefit Summary is a summary only. For a complete list of benefit restrictions, please refer to your booklet.

VOLUNTARY TERM LIFE

Understanding Your Voluntary Term Life Benefits

Am I Eligible For Coverage?

To be eligible for coverage, you must qualify as an eligible member and be considered actively at work.

You will be considered actively at work if you are able and available for active performance of all of your regular duties. Short term absence because of a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off is considered active work provided you are able and available for active performance of all of your regular duties and were working the day immediately prior to the date of your absence.

Are My Dependents Eligible For Coverage?

If you are covered as a member, your dependents may also be eligible. Additional eligibility requirements may apply.

Eligible dependents include your spouse, if not hospital or home confined and provided they do not elect benefits as an employee, and children.

Special eligibility requirements may exist for step, foster, adopted, legal age or other child relationships. Additional information may be necessary to determine child eligibility.

Additional eligibility requirements may apply.

What Additional Benefits Are Included?

Coverage During Disability	If you become totally disabled before age 60, coverage will continue and premium will be waived for you and your covered dependents. You must be totally disabled for 9 months before the waiver begins. Coverage continues without premium payment until you recover or turn age 65, whichever occurs first.
Accelerated Death Benefit	If you are terminally ill you can receive up to 75% of your benefit amount in a lump sum, not to exceed $250,000, as long as: • Your life expectancy is 12 months or less (as diagnosed by a physician), and • Your death benefit is at least $10,000. If you use the accelerated benefit, your death benefit is reduced by the accelerated benefit payment. There are possible tax consequences to receiving an accelerated benefit payment. You should contact your tax advisor for details. Receipt of accelerated benefits could also affect eligibility for public assistance. The charge for this benefit is included in your premium.
Open Enrollment	An open enrollment period will be available to you and your enrolled dependents each year during the calendar month prior to the policy anniversary. You and your dependents can request an increase of one benefit increment per year up to the guaranteed coverage amount without proof of good health. Once approved for coverage over the guaranteed coverage amount you can request an increase of one benefit increment per year up to the policy maximum benefit without proof of good health.

VOLUNTARY TERM LIFE

Individual Purchase Rights	If you terminate employment, you, your spouse and your children may be able to convert coverage to individual life coverage. Upon coverage termination, your employer is required to inform you of your individual purchase rights to convert to an individual policy without proof of good health. The amount you can purchase varies depending on the termination situation.
Claim Processing	Principal Life makes claim administration easy and convenient for employers by offering an online life claim form. Once the form is complete, employers submit the information directly over a secure, confidential Web site, expediting the claim review process. The employer can choose to use the online form or a printable version that can be faxed or mailed. Along with the online claim form, Principal Life also provides Express Claim Processing for claims that meet certain criteria. Through the Express Claim Process, decisions are reached within five working days without the employer or beneficiary submitting paperwork.
Portability	You may continue benefits for yourself and your covered dependents until age 70 if you cease to qualify as a member. You or your spouse must enroll within 60 days from the date you cease to qualify as a member. Refer to your benefit booklet for maximum age requirements.

WE'LL GIVE YOU AN EDGE ®

Principal Life Insurance Company, Des Moines, Iowa 50392-0002, www.principal.com

This is a summary of life coverage underwritten by or with administrative services provided by Principal Life Insurance Company.This benefit summary is for administrative purposes and is not a complete statement of benefits and restrictions. You'll receive a benefit booklet with details about your coverage. If there is a discrepancy between this summary and your benefit booklet, the benefit booklet prevails.

Agility Fuel Systems

VOLUNTARY TERM LIFE/AD&D

Estimated Employee Bi-Weekly Premium Amounts
End of Rate Guarantee Period: 03/31/2019

Benefit Amount	29 & Under	30-34	35-39	40-44	45-49	50-54	55-59	60-64
$10,000	$0.66	$0.70	$0.84	$1.21	$1.95	$3.10	$4.81	$7.40
$20,000	$1.32	$1.41	$1.68	$2.42	$3.90	$6.21	$9.62	$14.79
$30,000	$1.98	$2.12	$2.54	$3.64	$5.86	$9.32	$14.44	$22.20
$40,000	$2.64	$2.83	$3.38	$4.86	$7.81	$12.43	$19.26	$29.59
$50,000	$3.30	$3.53	$4.22	$6.07	$9.76	$15.53	$24.07	$36.99
$60,000	$3.96	$4.23	$5.06	$7.28	$11.71	$18.63	$28.88	$44.39
$70,000	$4.62	$4.95	$5.92	$8.50	$13.67	$21.75	$33.70	$51.79
$80,000	$5.28	$5.65	$6.76	$9.71	$15.62	$24.85	$38.51	$59.19
$90,000	$5.94	$6.35	$7.60	$10.92	$17.57	$27.95	$43.32	$66.59
$100,000	$6.60	$7.06	$8.44	$12.14	$19.52	$31.06	$48.14	$73.98
$110,000	$7.26	$7.77	$9.30	$13.36	$21.48	$34.17	$52.96	$81.39
$120,000	$7.92	$8.48	$10.14	$14.57	$23.43	$37.28	$57.77	$88.78
$130,000	$8.58	$9.18	$10.98	$15.78	$25.38	$40.38	$62.58	$96.18
$140,000	$9.24	$9.88	$11.82	$16.99	$27.33	$43.48	$67.39	$103.58
$150,000	$9.90	$10.59	$12.66	$18.20	$29.28	$46.59	$72.20	$110.97
$160,000	$10.56	$11.30	$13.52	$19.42	$31.24	$49.70	$77.02	$118.38
$170,000	$11.22	$12.01	$14.36	$20.64	$33.19	$52.81	$81.84	$125.77
$180,000	$11.88	$12.71	$15.20	$21.85	$35.14	$55.91	$86.65	$133.17
$190,000	$12.54	$13.41	$16.04	$23.06	$37.09	$59.01	$91.46	$140.57
$200,000	$13.20	$14.13	$16.90	$24.28	$39.05	$62.13	$96.28	$147.97
$210,000	$13.86	$14.83	$17.74	$25.49	$41.00	$65.23	$101.09	$155.37
$220,000	$14.52	$15.53	$18.58	$26.70	$42.95	$68.33	$105.90	$162.77
$230,000	$15.18	$16.24	$19.42	$27.92	$44.90	$71.44	$110.72	$170.16
$240,000	$15.84	$16.95	$20.28	$29.14	$46.86	$74.55	$115.54	$177.57
$250,000	$16.50	$17.66	$21.12	$30.35	$48.81	$77.66	$120.35	$184.96

Reduced Benefit	65-69
$6,500	$8.56
$13,000	$17.12
$19,500	$25.68
$26,000	$34.24
$32,500	$42.80
$39,000	$51.35
$45,500	$59.91
$52,000	$68.47
$58,500	$77.03
$65,000	$85.59
$71,500	$94.15
$78,000	$102.71
$84,500	$111.27
$91,000	$119.83
$97,500	$128.38
$104,000	$136.94
$110,500	$145.50
$117,000	$154.06
$123,500	$162.62
$130,000	$171.18
$136,500	$179.74
$143,000	$188.30
$149,500	$196.86
$156,000	$205.42
$162,500	$213.97

Reduced Benefit	70 & Over
$4,500	$10.56
$9,000	$21.12
$13,500	$31.68
$18,000	$42.22
$22,500	$52.78
$27,000	$63.34
$31,500	$73.90
$36,000	$84.46
$40,500	$95.02
$45,000	$105.57
$49,500	$116.12
$54,000	$126.68
$58,500	$137.24
$63,000	$147.80
$67,500	$158.36
$72,000	$168.92
$76,500	$179.47
$81,000	$190.02
$85,500	$200.58
$90,000	$211.14
$94,500	$221.70
$99,000	$232.26
$103,500	$242.81
$108,000	$253.36
$112,500	$263.92

NOTE: Proof of good health/evidence of insurability is required to apply for benefit amounts greater than those highlighted above.

If your age changes to a different rate band during the guarantee period, your monthly premium will change to reflect the new rate band effective on the next policy anniversary date.

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VOLUNTARY TERM LIFE/AD&D

Estimated Spouse Bi-Weekly Premium Amounts
End of Rate Guarantee Period: 03/31/2019

Benefit Amount	29 & Under	30-34	35-39	40-44	45-49	50-54	55-59	60-64
$5,000	$0.33	$0.36	$0.43	$0.61	$0.98	$1.56	$2.41	$3.70
$10,000	$0.66	$0.70	$0.84	$1.21	$1.95	$3.10	$4.81	$7.40
$15,000	$0.99	$1.06	$1.27	$1.82	$2.93	$4.66	$7.22	$11.10
$20,000	$1.32	$1.41	$1.68	$2.42	$3.90	$6.21	$9.62	$14.79
$25,000	$1.65	$1.76	$2.11	$3.03	$4.88	$7.76	$12.03	$18.50
$30,000	$1.98	$2.12	$2.54	$3.64	$5.86	$9.32	$14.44	$22.20
$35,000	$2.31	$2.47	$2.95	$4.25	$6.83	$10.87	$16.85	$25.89
$40,000	$2.64	$2.83	$3.38	$4.86	$7.81	$12.43	$19.26	$29.59
$45,000	$2.97	$3.18	$3.81	$5.47	$8.79	$13.98	$21.67	$33.30
$50,000	$3.30	$3.53	$4.22	$6.07	$9.76	$15.53	$24.07	$36.99

Reduced Benefit	65-69
$3,250	$4.28
$6,500	$8.56
$9,750	$12.84
$13,000	$17.12
$16,250	$21.40
$19,500	$25.68
$22,750	$29.96
$26,000	$34.24
$29,250	$38.52
$32,500	$42.80

Reduced Benefit	70 & Over
$2,250	$5.27
$4,500	$10.56
$6,750	$15.83
$9,000	$21.12
$11,250	$26.39
$13,500	$31.68
$15,750	$36.95
$18,000	$42.22
$20,250	$47.51
$22,500	$52.78

NOTE: Proof of good health/evidence of insurability is required to apply for benefit amounts greater than those highlighted above.

Child Deduction Schedule

$20,000 $1.85

If your age changes to a different rate band during the guarantee period, your monthly premium will change to reflect the new rate band effective on the next policy anniversary date.

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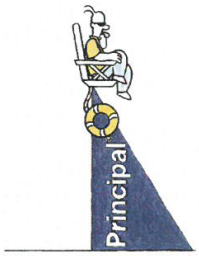
Group Short Term Disability



Policyholder: Agility Fuel Systems

Short Term Disability (STD) Benefit Summary

Effective Date: 04/01/2016

This chart provides you a brief summary of the key benefits of the short-term disability coverage available from Principal Life Insurance Company. Following the chart, you will find additional information to answer questions you may have. For a complete list of all your short-term disability coverage benefits and restrictions, please refer to your booklet or contact your employer.

Within 30 days of delivery, an individual age 65 or older, if not satisfied for any reason, may return the booklet and have premium fully refunded and coverage terminated retroactive to the original effective date. Premium refund shall occur no later than 30 days following the date we receive the returned booklet.

Eligibility	
Job Class	ALL MEMBERS
Eligible Members	All active, full time employees (except seasonal, temporary, or contract workers) who work at least 30 hours per week
Benefits Payable	
Primary Weekly Benefit	60% of your predisability earnings up to $2,000
Benefit Amount	Primary Weekly Benefit less other income sources
Definition of Earnings	Base wage
Benefit Qualification	
Elimination Period	Benefits begin on the 1st day for accident and 8th day for sickness
Benefit Payment Period	Up to 13 weeks after the elimination period is satisfied
Maternity	Treated the same as any other disability
Additional Benefits	
Rehabilitation Incentive Benefit	5% increase in the primary weekly benefit
Limitations & Exclusions	
Other Limitations	There are additional limitations to your coverage. A complete list is included in your booklet.

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SHORT-TERM DISABILITY

Understanding Your Short-Term Disability Benefits

Am I Eligible For Coverage?

To be eligible for coverage, you must qualify as an eligible member and be considered actively at work.

You will be considered actively at work if you are able and available for active performance of all of your regular duties. Short-term absence because of a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off is considered active work provided you are able and available for active performance of all of your regular duties and were working the day immediately prior to the date of your absence.

How Do I Qualify For Benefits?

1) **Meet the Definition of Disability**. Disabilities must be solely and directly caused by sickness, injury, or pregnancy.

During the elimination period and the benefit payment period, one of these situations must apply:	**Residual Disability** • You will be considered residually disabled if you are not totally disabled and while working in your own occupation, as a result of sickness or injury, you are unable to earn 80% or more of your predisability earnings. **Total Disability** • You will be considered totally disabled if as a result of sickness or injury you are unable to perform with reasonable continuity the substantial and material duties necessary to pursue your own occupation in the usual and customary way and you are not working in your own occupation.

2) **Satisfy the Elimination Period.** The amount of time you must be disabled before receiving benefits is called the elimination period. Benefits begin on the 1st day when due to injury and begin on the 8th day when due to sickness. The elimination period can be satisfied with days of total or partial disability.

How Much Weekly Benefit Will I Receive?

Your benefits will be determined by using your base wage.

The benefit payment period is the length of time you will receive benefits for a qualifying disability after the elimination period is satisfied. When you are unable to work in any capacity during the benefit payment period, your primary weekly benefit is equal to 60% of your predisability earnings, up to $2,000. Your primary weekly benefit less income from other sources is the benefit amount you will receive. Your benefit amount will never be less than the $25 minimum benefit.

SHORT-TERM DISABILITY

Benefits if Working If you are able to work while disabled, you may still be eligible to receive a disability benefit.

If you are working during the benefit payment period, your benefit amount is the lesser of:

- 100% of your predisability earnings, less income from other sources, less current earnings; or
- Your primary weekly benefit, less income from other sources.

Income you receive from other sources can be deducted from your primary weekly benefit. For a complete list of other sources, please refer to your booklet. Other sources may include: All retirement or disability benefits that you and your dependents receive from Social Security, Canadian Pension Plan, Quebec Pension Plan, Railroad Retirement Act or other government agencies / Salary continuance, personal time off or sick pay / Workers' Compensation benefits / Income from state disability plans / Disability or retirement benefits paid by pension plans sponsored by the policyholder / Income received from no-fault auto laws / All benefits received under the Jones Act or any government retirement system (CalPERS) / All benefits received as a result of the same disability from third party liability judgments, settlements or otherwise (less attorneys' fees) / All benefit amounts received as a result of the same disability by compromise or settlement of any claim for permitted offsets (less attorneys' fees).

How Long Will I Receive My Benefits?

You are eligible to receive short-term disability benefits for 13 weeks after the elimination period is satisfied.

Your disability benefits will end when you: Recover / Cease to be under the regular and appropriate care of a physician / Unreasonably fail to provide any required proof of disability / Unreasonably fail to submit to a required medical examination / Fail to report income from other sources, or any other required earnings information / Fail to pursue Social Security disability benefits / Die.

If you recover and return to work for less than 30 continuous days during the benefit duration and then again become disabled from the same or related cause, you are not required to complete a new elimination period.

What Additional Benefits Are Included?

Work Incentive Benefit	The Work Incentive Benefit is paid to you if you are disabled and you return to work on a limited or part-time basis. The Work Incentive Benefit equals the primary weekly benefit with no offset for work earnings unless the combination of work earnings, disability benefits and other income sources exceeds 100% of your predisability earnings. If this occurs, the Work Incentive Benefit will be reduced by the amount in excess of 100% of your predisability earnings.
Rehabilitation Plan	While disabled, you may qualify to participate in a rehabilitation plan. Our rehabilitation staff works with you, your physician(s) and your employer to create an individual rehabilitation plan to assist you in returning to work. If you are not disabled, but have a condition that could prevent you from performing the substantial and material duties of your own job, preventive rehabilitation services may be offered.
Rehabilitation Incentive Benefit	The Rehabilitation Incentive Benefit can increase the primary weekly benefit by 5% if you become totally disabled and participate in and satisfy the requirements of an individual rehabilitation plan.

SHORT-TERM DISABILITY

What Are The Restrictions Of My Coverage?

This Benefit Summary is a summary only. For a complete list of benefit restrictions, please refer to your booklet.

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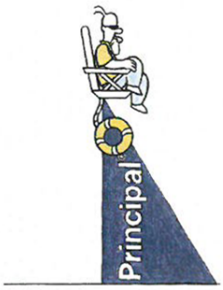
This is a summary of life coverage underwritten by or with administrative services provided by Principal Life Insurance Company. This benefit summary is for administrative purposes and is not a complete statement of benefits and restrictions. You'll receive a benefit booklet with details about your coverage. If there is a discrepancy between this summary and your benefit booklet, the benefit booklet prevails.

Group Long Term Disability



Policyholder: Agility Fuel Systems

Long Term Disability (LTD) Benefit Summary

Effective Date: 04/01/2016

This chart provides you a brief summary of the key benefits of the long-term disability coverage available from Principal Life Insurance Company. Following the chart, you will find additional information to answer questions you may have. For a complete list of all your long-term disability coverage benefits and restrictions, please refer to your booklet or contact your employer.

Within 30 days of delivery, an individual age 65 or older, if not satisfied for any reason, may return the booklet and have premium fully refunded and coverage terminated retroactive to the original effective date. Premium refund shall occur no later than 30 days following the date we receive the returned booklet.

Eligibility	
Job Class	**ALL MEMBERS**
Eligible Members	All active, full time employees (except seasonal, temporary, or contract workers) who work at least 30 hours per week
Benefits Payable	
Primary Monthly Benefit	60% of your predisability earnings up to $10,000.
Benefit Amount	Primary monthly benefit less other income sources
Definition of Earnings	Base wage
Benefit Qualification	
Elimination Period	90 days
Own Occupation Period	2 years
Maximum Benefit Payment Period	To age 65
Additional Benefits	
Rehabilitation Incentive Benefit	5% increase in the monthly benefit percentage
Survivor Benefit	Three times your primary monthly benefit less other income sources to your survivor.
Limitations & Exclusions	
Pre-Existing Conditions	3 months prior/12 months insured
Other Limitations	There are additional limitations to your coverage. A complete list is included in your booklet.

LONG-TERM DISABILITY

Understanding Your Long-Term Disability (LTD) Benefits

Am I Eligible For Coverage?

To be eligible for coverage, you must qualify as an eligible member and be considered actively at work.

You will be considered actively at work if you are able and available for active performance of all of your regular duties. Short term absence because of a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off is considered active work provided you are able and available for active performance of all of your regular duties and were working the day immediately prior to the date of your absence.

How Do I Qualify For Benefits?

1) **Meet the Definition of Disability**. Disabilities must be solely and directly caused by injury or sickness (including pregnancy).

During the elimination period and the own occupation period, one of these situations must apply:	**Residual Disability** • You are not totally disabled and while working in your own occupation, as a result of sickness or injury, you are unable to earn 80% or more of your predisability earnings. **Total Disability** • You are unable to perform with reasonable continuity, the substantial and material duties necessary to pursue your own occupation and you are not working in your own occupation.
After completing the own occupation period, one of these situations apply:	**Residual Disability** • You are not totally disabled and while working in an occupation, as a result of sickness or injury, you are unable to engage with reasonable continuity in any other occupation in which you could reasonably be expected to perform satisfactorily in light of your age, education, training, experience, station in life and physical and mental capacity. **Total Disability** • You are unable to perform with reasonable continuity in any occupation for which you are or could reasonably be expected to perform satisfactorily in light of your age, education, training, experience, station in life, and physical and mental capacity.

2) **Satisfy the Elimination Period.** The amount of time you must be disabled before receiving benefits is called the elimination period. Long-Term Disability benefits begin after you have been disabled for 90 days. The elimination period can be satisfied with days of total or partial disability.

If you recover and return to work during the elimination period and become disabled again, you may not have to satisfy a new elimination period. If you become disabled again, your elimination period will pick up at the point where it was left off when you recovered. You have a period twice as long as the elimination period to satisfy the required number of days of disability.

How Much Monthly Benefit Will I Receive?

Your benefits will be determined based on your Base wage.

LONG-TERM DISABILITY

When you are unable to work in any capacity during the benefit payment period, your **monthly benefit** equals your primary monthly benefit, less income from other sources.

Your primary monthly benefit is equal to 60% of your predisability earnings, but will not exceed $10,000.

Your monthly benefit will not be less than the minimum monthly benefit of $100.

Benefits if Working

If you are able to work while disabled, you may still be eligible to receive a disability benefit.

If you are working during the benefit payment period, your monthly benefit for the 12 month work incentive period is the lesser of:

- 100% of the indexed earnings you received before becoming disabled, less income from other sources, less current earnings; or
- Your primary monthly benefit, less income from other sources.

After the work incentive period, your monthly benefit equals your primary monthly benefit, less income from other sources and multiplied by your income loss percentage.

Income you receive from other sources can be deducted from your primary monthly benefit. Other sources include: All retirement or disability benefits that you and your dependents receive from Social Security, Canadian Pension Plan, Quebec Pension Plan, Railroad Retirement Act or other government agencies / Salary continuance, personal time off or sick pay / Workers' Compensation benefits / Income from state disability plans from policies that provide coverage for time away from work, if paid in part by or deducted from payroll by the policyholder / Income from other group disability coverage policies / Disability or retirement benefits paid by pension plans sponsored by the policyholder / Income received from no-fault auto laws / Renewal commissions received from the policyholder / All disability benefits received under the Jones Act or any government retirement system (CalPERS) / All benefits received as a result of the same disability from third party liability judgments, settlements or otherwise (less attorneys' fees) / All benefit amounts received as a result of the same disability by compromise or settlement of any claim for permitted offsets (less attorneys' fees) / Any income you receive for services rendered prior to your Date of Disability will not be considered Other Income Sources.

How Long Will I Receive My Benefits?

The benefit payment period is the length of time you'll receive benefits for a qualifying disability after the elimination period is satisfied. Your age at the time disability occurs determines the length of time you are eligible to receive disability benefits.

Age Disability Occurs	Benefits are Payable:
Under Age 62	*Until the later of the date you reach age 65 or 42 months*
Age 62	*42 months*
Age 63	*36 months*
Age 64	*30 months*
Age 65	*24 months*

LONG-TERM DISABILITY

Age Disability Occurs (continued)	Benefits are Payable (continued)
Age 66	*21 months*
Age 67	*18 months*
Age 68	*15 months*
Age 69 and over	*12 months*

Your disability benefits will end when you: Recover / Cease to be under the regular and appropriate care of a physician / Unreasonably fail to provide any required proof of disability / Unreasonably fail to submit to a required medical examination / Fail to report income from other sources, or any other required earnings information / Fail to pursue Social Security disability benefits / Die.

If you recover and return to work for six months or less during the benefit payment period and then again become disabled from the same or related cause, you are not required to complete a new elimination period.

What Additional Benefits Are Included?

Work Incentive Benefit	The Work Incentive Benefit is paid to you if you are disabled and you return to work on a limited or part-time basis. To receive benefits, you must be working. The Work Incentive Benefit equals the primary monthly benefit with no offset for work earnings unless the combination of work earnings, disability benefits and other income sources exceeds 100% of your predisability earnings. If this occurs, the Work Incentive Benefit will be reduced by the amount in excess of 100% of your predisability earnings.
Survivor Benefit	The Survivor Benefit is a lump sum payment issued to your survivors, should you die while receiving disability benefits. The benefit payment is equal to three times your primary monthly benefit less other income sources.
Rehabilitation Plan	While disabled, you may qualify to participate in a Rehabilitation Plan. Our rehabilitation staff works with you, your physician(s) and your employer to create an individual rehabilitation plan to assist you in returning to work. If you are not disabled, but have a condition that could prevent you from performing the substantial and material duties of your own occupation, preventive rehabilitation services may be offered.
Rehabilitation Incentive Benefit	The Rehabilitation Incentive Benefit can increase the benefit percentage by 5% if you become totally disabled and participate in and satisfy the requirements of an individual rehabilitation plan.
Return to Work Child Care Benefit	The Return to Work Child Care Benefit helps you remain on the job or return to work by helping you cover the cost of child care expenses. We will reimburse you for 100% of your child care expenses, up to $100 per month for up to twelve months. Return to work child care benefits begin after work incentive benefit payments end.

What Are The Restrictions Of My Coverage?

This Benefit Summary is a summary only. For a complete list of benefit restrictions, please refer to your booklet.

Preexisting Conditions	A preexisting condition is any sickness or injury for which you: • Received medical treatment, care or services for a diagnosed condition in the three month period before you became insured under this policy; or • Took prescribed medications for a diagnosed condition in the three month period before you became insured under this policy; or • Suffered from a physical or mental condition, whether diagnosed or undiagnosed, which was misrepresented or not disclosed in your application: • for which you recieved a physician's advice or treatment within 24 months before you became insured under this policy; or

Preexisting Conditions	• which caused symptoms within 12 months before you became insured under this policy for which a prudent person would usually seek medical advice or treatment; and Benefits will not be paid for a disability that is caused or substantially contributed by a preexisting condition unless, on the date you became disabled, you were actively at work for one full day after completing 12 consecutive months during which you were insured under this policy.
Treatment of Mental Health Conditions and Drug and Alcohol Abuse Conditions	A disability is considered due to alcohol, drug or chemical abuse, dependency or addiction or a mental health condition if the disability is caused by one of these condition(s) and not by other disabling conditions. Maximum benefit payment periods for: Mental health conditions – 24 months Alcohol, drug or chemical abuse conditions – 24 months The benefit payment period listed above is a lifetime maximum for all periods of disability. All disabilities from conditions with the same maximum benefit payment period contribute towards one lifetime maximum. However, if at the end of the benefit payment period, you are confined in a hospital or any other type of facility providing treatment for any of these conditions, the benefit payment period may be extended to include the time period you are confined for treatment.

Flexible Spending Account

2016 TASC Flexible Spending Account (FSA)

Employees have the option to enroll in a Flexible Spending Account through TASC effective April 1, 2016 through December 31, 2016. Employees can elect a maximum of $1,912.50 for eligible Medical, Dental and Vision costs for the 2016 short plan year. The maximum election for the Dependent Care FSA for 2016 is $3,750.

- More Information Online: www.tasconline.com

Flexible Spending Account Information:

The FSA is offered through your employer and administered by TASC FlexSystem. When you choose to enroll in a Healthcare FSA and/or Dependent Care FSA, you decide the dollar amount you want to contribute to each account based on your estimated expenses for the upcoming year. The funds will be deducted pre-tax in equal amounts from each paycheck throughout the plan year. For every dollar you put into these accounts, the more money you save by paying less in taxes.

As you incur eligible expenses, you simply submit a request for reimbursement to TASC FlexSystem to receive reimbursement from your FSA, up to the total amount for your annual contribution. TASC FlexSystem offers multiple methods to request reimbursement (paper form, online, and text messaging) and performs daily claim processing for reimbursements. By using Direct Deposit, reimbursements are forwarded to your bank within 48 to 72 hours of completed claim submission.

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FlexSystem®

Advantages of a Flexible Spending Account (FSA)

A valuable pre-tax benefit with innovative services!

FlexSystem FSA increases your take-home pay by reducing your taxable income. A Flexible Spending Account (FSA) allows you to save up to 30% on your eligible healthcare and/or dependent care expenses every year by using pre-tax dollars.

FlexSystem Healthcare FSA
FlexSystem Dependent Care FSA

Consider how much you spend on healthcare and/or dependent care expenses for you and your qualified dependents in one year:

- prescription drugs/medications.
- medical/dental office visit co-pays.
- eye exams and prescription glasses/lenses.
- vaccinations.
- daycare tuition.

Why not reduce these expenses by using pre-tax dollars instead of after-tax dollars? With rising healthcare costs, ***every penny counts!*** By using pre-tax dollars, you are taxed on a lower gross salary, thereby saving money that would otherwise be spent on federal, state and FICA taxes, and thereby you ***increase your take home pay!***

Employee salary reductions to a medical Flexible Spending Account (FSA) are limited to **$2,550** per Plan Year (2015), indexed for inflation. Check with your employer for your Plan's maximum annual election amount.

Putting money in an FSA is smart and safe! If you have medical FSA funds leftover at the end of the Plan Year and your employer has elected Carryover, you may carryover up to $500 from year to year with no cost or penalty.

Pre-Tax Savings Example

	Without FSA	*With FSA*
Gross Monthly Pay:	$3,500	$3,500
Pre-Tax Contributions		
Medical/Dental Premiums	$0	-$125
Medical Expenses	$0	-$75
Dependent Care Expenses	$0	-$400
TOTAL:	$0	-$600
Taxable Monthly Income	**$3,500**	**$2,900**
Taxes (federal, state, FICA):	-$968	-$802
Out-of-pocket Expenses:	-$600	$0
Monthly Take-home Pay:	**$1,932**	**$2,098**

Net Increase in Take-Home Pay = $166/mo!

For illustration only. Actual dollar amounts may vary.

How FlexSystem Works

FlexSystem FSA is offered through your employer and is adminstered by TASC. When you choose to enroll in a FlexSystem FSA Healthcare and/or Dependent Care, you choose the dollar amount you want to contribute to each account based on your estimated expenses for the upcoming Plan Year. Your contributions will be deducted in equal amounts from each paycheck, **pre-tax**, throughout the Plan Year. ***The more you contribute to these accounts, the more you save by paying less in taxes!***

Your total Healthcare FSA annual contribution amount is available immediately at the start of the Plan Year; Dependent Care FSA funds are available up to the current account balance only.

Reimbursements and the TASC Card

As you incur eligible expenses, simply swipe your TASC Card. The card automatically pays for and substantiates most eligible expenses at the point of purchase. If you do not use the TASC Card to pay for an eligible expense, simply submit a request for reimbursement via the MyTASC Mobile App, online Request for Reimbursement form in MyTASC, text message, fax, or mail.

Your reimbursement is deposited in your MyCash account. You can access your MyCash funds in three ways: (1) swipe your TASC Card at any merchant that accepts major credit cards, (2) withdraw at an ATM using your TASC Card (with PIN), or (3) transfer to a personal bank account from MyTASC.

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FX-4245-110314

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FSA Eligible Expenses

FlexSystem FSA funds may only be used for eligible expenses under your healthcare FSA and/or dependent care FSA. Some eligible expenses include:

- Medical care services
- Dental care services
- Vision care expenses
- Prescriptions
- Certain over-the-counter medications
- Daycare tuition

More detailed lists can be found at www.irs.gov in IRS Publications 502 & 503. Please note insurance premiums are NOT eligible for reimbursement.

33 million Americans
save up to 30%
every year
by participating
in an FSA.

2009 Nielson Consumer Research

Multiple Methods for Account Management

You may use any of the following self-service options to access your FlexSystem accounts and TASC Card transactions:

- **MyTASC Online**: www.tasconline.com.
- **MyTASC Mobile App:** Free download at www.tasconline.com/mobile.
- **MyTASC Text Messaging:** Elect through your MyTASC account online.

Online enrollment and account management.

Online tax-savings calculator to help determine how much to contribute.

Convenient pre-tax payroll deductions.

Benefits debit card for eligible purchases.

Mobile app for account access on the go.

Multiple self-service tools.

Fast reimbursements.

Important Considerations

FSA Funds do not Rollover:

It is important to be conservative in making elections because any unused funds left in your FSA at the close of the Plan Year are not refundable to you. (The only exception to this rule is for the Healthcare FSA where funds may carryover to the next Plan Year's healthcare FSA (up to $500) when elected by your employer.) You are urged to take precautionary steps, such as tracking account balances on the FlexSystem website and/or using the Interactive Voice Response System, to avoid having funds remaining in your account at year-end.

Changing Elections During the Plan Year:

You may change your FSA elections during the Plan Year only if you experience a change of status such as:

- a marriage or divorce
- birth or adoption of a child, or
- a change in employment status

Refer to the Change of Election Form (available from your employer) for a complete list of circumstances acceptable for changing elections mid-year.

Sign up for FlexSystem and keep more money in your pocket!

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Agility fuel systems™

FlexSystem®
Flexible Spending Accounts (FSA)

FSA Eligible Expenses

Healthcare expenses eligible for reimbursement.

Below is a sample list of permissible expenses reimbursable through a full scope Healthcare Flexible Spending Account (FSA) that are incurred by you, your spouse, or qualified dependents. Please note, a limited purpose Healthcare FSA only allows dental and vision expenses.

Section 125 Flexible Spending Accounts

Medical Expenses

- Acupuncture
- Artificial limbs
- Bandages
- Birth control, contraceptive devices
- Birthing classes/Lamaze – only the mother's portion (not the coach/spouse) and the class must be only for birthing instruction, not child rearing
- Blood pressure monitor
- Blood sugar test kits/test strips
- Chiropractic therapy/exams/adjustments
- Contact lens and contact lens solutions
- Co-payments
- Crutches (purchased or rented)
- Deductible and co-insurance
- Diabetic supplies
- Eye exams
- Eyeglasses, contacts, or safety glasses, prescription only (warranties are not reimbursable)
- Flu shots
- Hearing aids and hearing aid batteries (warranties are not reimbursable)
- Heating pad
- Incontinence supplies
- Infertility treatments
- Insulin
- Lactation expenses (breast pumps, etc.)
- Laser eye surgery; LASIK
- Legal sterilization
- Medical supplies to treat an injury or illness
- Mileage to and from doctor appointments
- Nasal strips
- Optometrist's or ophthalmologist's fees
- Orthopedic inserts
- Physicals
- Physical therapy (as medical treatment)
- Physician's fee and hospital services
- Pregnancy test
- Prescription drugs and medications
- Psychotherapy, psychiatric and psychological service
- Reading glasses
- Sales tax on eligible expenses
- Services connected with donating an organ
- Sleep apnea services/products (as prescribed)
- Smoking cessation programs
- Treatment for alcoholism or drug dependency
- Vaccinations
- Wrist supports, elastic wraps
- X-ray fees

OTC Medicines and Drugs

Over-the-counter (OTC) medicines and drugs, except for insulin, require a prescription from your physician to be reimbursable. The prescription will need to be included with each request for reimbursement.

- Bengay, Flexall, pain relieving creams or gels
- Calamine lotion
- Canker/cold sore relievers
- Cold medicines
- Corn removal
- Diaper rash ointment
- GasX, baby gas drops
- Hemorrhoid creams and treatments
- Hydrogen Peroxide or rubbing alcohol
- Indigestion or anti-acid relievers
- Laxatives
- Nicotine patch
- Pain relievers (Tylenol, Advil, Aspirin, etc.)

- Sinus medicines
- Suppositories
- Teething gel
- Wart removal medication

Dental Expenses

- Braces and orthodontic services
- Cleanings
- Crowns
- Deductibles, co-insurance
- Dental implants
- Dentures, adhesives
- Fillings

For the Disabled

- Automobile equipment and installation costs for a disabled person in excess of the cost of an ordinary automobile; device for lifting a mobility impaired person into an automobile
- Braille books/magazines in excess of cost of regular editions
- Note-taker for a hearing impaired child in school
- Seeing eye dog (buying, training, and maintaining)
- Special devices, such as a tape recorder or typewriter for a visually impaired person
- Visual alert system in the home or other items such as a special phone required for a hearing impaired person
- Wheelchair or autoette (cost of operating/maintaining)

Requiring Additional Documentation

The following expenses are eligible only when incurred to treat a diagnosed medical condition. Such expenses require a Letter of Medical Necessity from your physician, containing the medical necessity of the expense, diagnosed condition, onset of condition, and physician's signature.

- Ear plugs
- Massage treatments
- Nursing services for care of a special medical ailment
- Orthopedic shoes (excess cost of ordinary shoes)
- Oxygen equipment and oxygen
- Support hose
- Varicose vein treatment
- Veneers
- Vitamins and supplements
- Wigs (for mental health condition of individual who loses hair because of a disease)

Dependent Care Expenses

- Day camp (primary purpose must be custodial care and not educational in nature)
- Dependent care expenses that are necessary for you (and your spouse) to work, actively look for work, or attend school full-time
- Dependent care for children under the age of 13 or for elderly dependents who reside with you
- FICA/FUTA taxes of day care provider
- Late pick-up fees
- Nanny expenses attributed to dependent care
- Nursery school (preschool)
- Registration fees (allocated to dependent care services)
- Does not cover medical costs; use Healthcare FSA for medical expenses incurred by you or your dependents.

Ineligible Medical Expenses

- Athletic mouth guards
- Auto insurance providing medical coverage
- Chapstick/lip balm
- Contributions to state disability funds
- Cosmetic surgery, dentistry, or other cosmetic procedures
- Cosmetic supplies (makeup, cleansers, moisturizers, etc.)
- Deodorant
- Dental floss
- Diaper service
- Diet (cost of special foods taken as substitute for regular diet)
- Dietary and fiber supplements
- Divorce (when recommended by doctor or psychiatrist)
- Distilled water purchased to avoid drinking fluoridated city water or for use in medical equipment
- Domestic help (companion, babysitter, chauffeur who primarily renders services of a non-medical nature)
- Electrolysis/hair removal
- Exercise equipment and fees
- Eye drops for general comfort
- Eyeglass cases
- Hand sanitizer
- Health club or athletic club membership fees
- Herbal supplements
- Illegal treatment or medication
- Insurance premiums, all types
- Lanyards
- Lotions or skin moisturizers
- Marriage counseling
- Maternity clothes
- Mattress
- Medicare premiums
- Medicated shampoos, conditioners, and soaps
- Mobile telephone used for personal and physician calls
- Nursemaids or practical nurses who render general care for healthy infants
- Pajamas/slippers purchased to wear in hospital
- Personal use items (toothbrush, pillow, shampoo, mattress, etc.)
- Physical treatment unrelated to specific health problems (massage for general well-being, stress, depression, or chiropractic wellness)
- Premiums for coverage through other medical plans (spouse's employer-sponsored plan or individual plan)
- Safety glasses (non-prescription)
- Special foods purchased to replace nutrition or for general health needs (such as diet foods)
- Sunglasses (non prescription) and sun clips
- Teeth whitening products
- Toiletries
- Toothbrush (includes prescribed electric ones) and toothpaste
- Vacuum cleaner purchased by an individual with dust allergy
- Vitamins and supplements for well-being
- Warranties
- Weight loss drugs/programs for general well being

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FlexSystem®
Flexible Spending Accounts (FSA)

TASC Mobile Tools

Easily access your FlexSystem FSA while on the go!

TASC Mobile offers a mobile app and text messaging capabilities to you as a FlexSystem participant, giving you quick and easy access to your account(s) from anywhere and at any time from your mobile handheld device.

Now you can securely check real-time balances, request a reimbursement, upload receipts, view transaction details, and review plan information and contributions ***...all while on the go!***

MyTASC Mobile App

The MyTASC Mobile App is a free download from Amazon, Apple App Store,℠ and Android Google Play™ for smartphones and tablets. Once downloaded, securely log in using your current MyTASC username and password.

Conveniently perform the following functions with the MyTASC Mobile App:

- **Submit a request for reimbursement for out-of-pocket FSA expenses.**
- **Upload pictures of receipts with phone camera.**
- **View real-time account balances and transactions for active and closing plans and your MyCash account.**
- **Review FlexSystem Plan information and annual contributions.**
- **Securely log in with MyTASC username and password.**
- **Enable login memory for faster return access (per device).**
- **Access a help screen for system assistance.**

Download the MyTASC Mobile App on your mobile phone today for easy, secure and convenient account access. *It's free!*

To learn more about TASC Mobile, download the mobile app, and obtain texting instructions, please go to: www.tasconline.com/mobile.

TASC Mobile is available for the following FlexSystem Accounts (where applicable):

FlexSystem Healthcare FSA
FlexSystem Dependent Care FSA
FlexSystem Transit & Parking FSA

MyTASC Text Messaging (SMS)

MyTASC Text messaging (SMS) is available for convenient access to your FlexSystem account(s) from your mobile phone through instant two-way communication.

- Request your current account balance.
- Request a reimbursement.
- Receive automated reimbursement status alerts.

Activate MyTASC Text Messaging and/or email notifications online by logging in to your MyTASC account and clicking Set Notifications.

FlexSystem Text Notifications
FSA Account Text Messaging Instructions

Account Balance Check
Text TASC BAL to number 41411

Request for Reimbursement (RFR) Submission
Text TASC RFR <Service Code> <Store> <$Amount> to 41411
Example: TASC RFR MD Walgreens $5

Service Codes

MD-Medical	RX-Prescription	OT-Over the Counter	MP-Medical Preventive
DN-Dental	VS-Vision	DC-Dependent Care	
PK-Parking	MT-Mass Transit	IP-Individual Premiums	

TASC • 2302 International Lane • Madison, WI 53704-3140 • 800-422-4661 • Fax: 608-245-3623 • www.tasconline.com

FX-4688-1C1414

Accident Insurance

Schedule of Benefits[1]

Accident Insurance Provides 24-Hour Coverage

PREMIUM PLAN

Benefit	Amount
Initial Care	
Hospital Benefits	
Admission Benefit (per admission)	$2,250
Confinement Benefit (per day up to 365 days)	$500
ICU Benefit (per day up to 15 days)	$600
Emergency Room Treatment	$250
Ambulance	
Ground	$600
Air	$2,500
Initial Doctor's Office Visit	$150
Lodging (per night up to 30 days per accident)	$200
Surgery Benefit	
Open, abdominal, thoracic	$2,500
Exploratory	$250
Blood, Plasma and Platelets	$600
Emergency Dental Benefit	
Extraction	$150
Crown	$450
Follow-Up Care	
Accident Follow-Up Treatment	$150
Physical Therapy	
Up to six visits per person per accident	$75
Appliance	$225
Transportation	
100+ miles, up to three trips	$600
Prosthetic Device or Artificial Limb	
More than one	$2,000
One	$1,000
Skin Grafts	25% of applicable burn benefit
Accidental Death	
Employee	$100,000
Spouse[3]	$40,000
Child	$20,000
Accidental Death – Common Carrier	
Employee	$200,000
Spouse[3]	$80,000
Child	$40,000
Catastrophic Accident	
Employee	$100,000
Spouse[3]	$50,000
Child	$50,000

Benefit	Amount
Injuries	
Fractures	
Open reduction	Up to $12,500
Closed reduction	Up to $6,250
Chips	25% of applicable closed reduction
Dislocations	
Open reduction	Up to $8,000
Closed reduction	Up to $4,000
Laceration	Up to $1,200
Burns	
Flat amount for:	
Third-degree 35 or more sq. in.	$15,000
Third-degree 9-34 sq. in.	$2,250
Second-degree for 36% or more of body	$1,125
Concussion	$200
Eye Injury	
Requires surgery or removal of foreign body	$400
Herniated Disc	$1,000
Loss of Finger, Toe, Hand, Foot or Sight	
Loss of both hands, feet, sight of both eyes or any combination of two or more losses	$30,000
Loss of one hand, foot or sight of one eye	$15,000
Loss of two or more fingers, toes or any combination of two or more losses	$3,000
Loss of one finger or one toe	$1,500
Tendon/Ligament/Rotator Cuff Injury	
Repair of more than one	$1,800
Repair of one	$1,200
Exploratory surgery without repair	$300
Torn Knee Cartilage	$1,000
Exploratory surgery	$200
Health Screening Benefit	
One Per Person Per Year	$100
Routine health screening tests	

BI WEEKLY RATES
(assumes deductions 26 per year)

	Employee	Employee/Spouse	Employee/Children	Family
Rate	$10.78	$16.03	$20.30	$25.55

[1]Benefits are payable only as the result of a covered accident. Benefits may vary by state and additional benefits may be available in some states. Most benefits are paid once per person per covered accident unless otherwise noted. [3]In some states, spouse, domestic partner or civil union partner.

AP6-24-ADB-CAT-HSR100 Insert

Schedule of Benefits[1]

Accident Insurance Provides 24-Hour Coverage

STANDARD PLAN

Benefit	Amount
Initial Care	
Hospital Benefits	
Admission Benefit (per admission)	$1,500
Confinement Benefit (per day up to 365 days)	$200
ICU Benefit (per day up to 15 days)	$400
Emergency Room Treatment	$200
Ambulance	
Ground	$200
Air	$1,000
Initial Doctor's Office Visit	$100
Lodging (per night up to 30 days per accident)	$100
Surgery Benefit	
Open, abdominal, thoracic	$1,250
Exploratory	$125
Blood, Plasma and Platelets	$300
Emergency Dental Benefit	
Extraction	$50
Crown	$150
Follow-Up Care	
Accident Follow-Up Treatment	$100
Physical Therapy	
Up to six visits per person per accident	$50
Appliance	$150
Transportation	
100+ miles, up to three trips	$375
Prosthetic Device or Artificial Limb	
More than one	$1,000
One	$500
Skin Grafts	25% of applicable burn benefit
Accidental Death	
Employee	$25,000
Spouse[3]	$10,000
Child	$5,000
Accidental Death – Common Carrier	
Employee	$50,000
Spouse[3]	$20,000
Child	$10,000
Catastrophic Accident	
Employee	$100,000
Spouse[3]	$50,000
Child	$50,000

Benefit	Amount
Injuries	
Fractures	
Open reduction	Up to $7,500
Closed reduction	Up to $3,750
Chips	25% of applicable closed reduction
Dislocations	
Open reduction	Up to $4,000
Closed reduction	Up to $2,000
Laceration	Up to $800
Burns	
Flat amount for:	
Third-degree 35 or more sq. in.	$10,000
Third-degree 9-34 sq. in.	$1,500
Second-degree for 36% or more of body	$750
Concussion	$100
Eye Injury	
Requires surgery or removal of foreign body	$200
Herniated Disc	$600
Loss of Finger, Toe, Hand, Foot or Sight	
Loss of both hands, feet, sight of both eyes or any combination of two or more losses	$15,000
Loss of one hand, foot or sight of one eye	$7,500
Loss of two or more fingers, toes or any combination of two or more losses	$1,500
Loss of one finger or one toe	$750
Tendon/Ligament/Rotator Cuff Injury	
Repair of more than one	$1,200
Repair of one	$800
Exploratory surgery without repair	$200
Torn Knee Cartilage	$500
Exploratory surgery	$100
Health Screening Benefit	
One Per Person Per Year	$100
Routine health screening tests	

BI WEEKLY RATES
(assumes deductions 26 per year)

	Employee	Employee/Spouse	Employee/Children	Family
Rate	$6.56	$9.77	$12.45	$15.67

[1]Benefits are payable only as the result of a covered accident. Benefits may vary by state and additional benefits may be available in some states. Most benefits are paid once per person per covered accident unless otherwise noted. [3]In some states, spouse, domestic partner or civil union partner.

AP4-24-ADB-CAT-HSR100 Insert

Cancer Insurance

Why do I need Cancer Insurance?

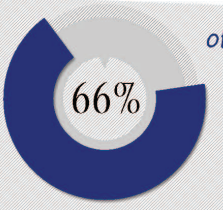
Because cancer hits people everyday....

1 in 2 men will be struck with cancer

1 in 3 women will be struck with cancer

Source: American Cancer Society

But isn't that why I have medical insurance?



of all cancer costs are

non-medical

and insurance won't cover things like:

- ✓ Child care
- ✓ Transportation
- ✓ Loss of Wages
- ✓ Living expenses
- ✓ Specialists

&

- ✓ Meals
- ✓ Lodging
- ✓ Special Diets
- ✓ Experimental treatments

BenefitsDirect helps you plan for the unexpected!

Our Cancer/Specified Disease Plan pays TAX FREE benefits directly to you so that you can focus on getting well, rather than being distracted by the cost of medical and personal bills.

Bi-Weekly Rates	Individual	Single Parent	Family
Base Cancer/Specified Diseases	$9.12	$11.26	$15.51
Intensive Care Rider	$1.29	$1.78	$2.45
Optional 1st Occurrence Rider			
($5,000 Benefit)	$2.54	$2.77	$4.67
($3,000 Benefit)	$1.52	$1.66	$2.33
CANCER PACKAGE (includes $5K for FOB & ICU RIDERS)	**$12.95**	**$15.80**	**$21.84**

The Cancer/Specified Disease Plan gives you another benefit...

peace of mind...

This page is an Insert to be used ONLY with Brochure Form L-6040-AD. If you do not have this Brochure, ask that your agent provide one for you. All exclusions, limitations, definitions and terms of renewability of the Limited Benefit Cancer Expense Policy (form L-6040) apply to this policy and related riders. LIMITED BENEFIT POLICY.

Agility fuel systems™

A New Dimension in Supplemental Cancer Insurance

Underwritten by:

Loyal American Life Insurance Company®

Administrative Office:
P.O. Box 1604 • Duncan, OK 73534-1604
Toll Free: 1-800-366-8354

The following is not an exhaustive list of terms and conditions but only serves as a depiction of benefits and exclusions. Interested parties should consult the contract for a complete listing of terms and conditions.

A Promise

In an era where many financial services companies are concerned with bottom- line results at the expense of customer service and loyalty, we come from the old school. We take great pride in providing the finest services to our employer groups, policyholders, business associates, agents - to everyone with whom we come in contact.

L-6040-AD-CA (06/12)

Agility fuel systems

BASE POLICY BENEFITS

No Lifetime Maximum for Majority of Benefits

BENEFIT PROVISIONS. We will pay the benefits described in the policy for the treatment of an Insured Person's Cancer, provided he or she is covered under an issued policy which remains in force. Payment will be made in accordance with all applicable policy provisions. Benefits are payable for a positive diagnosis that begins more than 30 days after the Effective Date. For policies issued on a payroll deduction basis, benefits are payable for a positive diagnosis that begins after the Effective Date. The positive diagnosis must be for Cancer as defined in the policy.

1. **POSITIVE DIAGNOSIS BENEFIT.** We will pay the actual charge but not to exceed **$300 per Calendar Year** for one test that confirms the Positive Diagnosis of Cancer in an Insured Person. This benefit is not payable for multiple diagnoses of the same Cancer or for Cancer that metastasizes or for recurrence of the same Cancer.

2. **NATIONAL CANCER INSTITUTE DESIGNATED COMPREHENSIVE CANCER TREATMENT CENTER EVALUATION/CONSULTATION BENEFIT** We will pay the actual charge, but not to exceed a **lifetime maximum of $750,** if an Insured Person is diagnosed with Internal Cancer and seeks evaluation or consultation from a National Cancer Institute designated Comprehensive Cancer Treatment Center. If the Comprehensive Cancer Treatment Center is located more than 30 miles from the Insured Person's place of residence, We will also pay the transportation and lodging actual charge but not to exceed a **lifetime maximum of $350.** This benefit is not payable on the same day a Second or Third Surgical Opinion Benefit is payable and is in lieu of the Non-Local Transportation and Lodging Expense Benefits of the Policy. **This benefit is payable one time during the lifetime of the Insured Person.**

3. **SECOND AND THIRD SURGICAL OPINION EXPENSE BENEFIT** We will pay the **actual charge** for a written second surgical opinion concerning the recommendation of Cancer surgery and if the second surgical opinion is in conflict with that of the Physician originally recommending the surgery and the Insured Person desires a third opinion, We will pay the actual charge for a written third surgical opinion. The Physician providing the second or third surgical opinion cannot be associated with the Physician who originally recommended the surgery. This benefit is not payable the same day the National Cancer Institute Evaluation/Consulting Benefit is payable.

4. **MEDICAL IMAGING, TREATMENT PLANNING AND MONITORING EXPENSE BENEFIT** We will pay the actual charge, but not to exceed **$1,000 per Calendar Year,** for laboratory tests, diagnostic X-rays, medical images, when used in Cancer treatment plannings related to Radiation Treatment, Chemotherapy or Immunotherapy.

5. **ANTI-NAUSEA MEDICATION EXPENSE BENEFIT** We will pay the actual charge for anti-nausea medication, but not to exceed **$150 per Calendar Month,** when an Insured Person is prescribed such medication as the result of Radiation Treatment, Chemotherapy or Immunotherapy treatments for Cancer.

6. **COLONY STIMULATING FACTOR OR IMMUNOGLOBULIN EXPENSE BENEFIT** We will pay the actual charge but not to exceed **$1,000 per Calendar Month** for Colony Stimulating Factor Drugs or Immunoglobulins prescribed by a Physician or Oncologist during an Insured Person's Cancer treatment regimen for which benefits are payable under the Radiation, Chemotherapy and Immunotherapy Benefit of this Policy or rider attached to it.

7. **OUTPATIENT HOSPITAL OR AMBULATORY SURGICAL CENTER EXPENSE BENEFIT** We will pay the **actual charge** from an Ambulatory Surgical Center or Outpatient department of a Hospital for the use of its facilities for the performance of a surgical procedure covered under this Policy but not to exceed **$350 per day.**

8. **PROSTHESIS EXPENSE BENEFIT**

   (A.) Surgically Implanted Breast Prosthesis We will pay the **actual charge** for a surgically implanted prosthetic device required and prescribed to restore normal body contour lost as the direct result of an Insured Person's breast removal for the treatment of Cancer. The Surgically Implanted Breast Prosthesis Benefit does not include coverage for breast reconstruction surgery which may be covered under the Surgical Schedule within the Surgical and Anesthesia Benefits Rider.

   (B.) Non-Surgically Implanted Prosthesis We will pay the actual charge **not to exceed $2,000 per amputation** for an artificial limb or other non-surgically implanted prosthetic device that is prescribed and required to restore normal body function lost as the direct result of an Insured Person's amputation for the treatment of Cancer . **We will pay a lifetime maximum of $2,000 per amputation.** The cost of replacement of a prosthetic device is not covered. Hairpieces or wigs are not covered under this benefit.

9. **NON-LOCAL TRANSPORTATION EXPENSE BENEFIT** We will pay the **actual charge, but not to exceed the coach fare on a Common Carrier for the Insured Person and one adult companion's travel** to a Hospital, Radiation Therapy Treatment Center, Chemotherapy Treatment Center, Oncology Clinic or any other specialized treatment center where the Insured Person receives treatment for Cancer. This benefit is payable only if the treatment is not available Locally but is available Non-Locally. The adult companion may include the live donor of bone marrow or stem cells used in a bone marrow or stem cell transplant for the Insured Person. At the option of the Insured Person, We will pay a single private **vehicle mileage allowance of $.50 per mile** for Non-Local transportation in lieu of the common carrier coach fare.

10. **LODGING EXPENSE BENEFIT** We will pay the actual charge **not to exceed $75 per day** for a room in a motel, hotel or other appropriate lodging facility (other than a private residence), when an Insured Person receives treatment for Cancer at a Non-Local Hospital, Radiation Therapy Treatment Center, Chemotherapy Treatment Center, Oncology Clinic or any other specialized treatment center. The room must be occupied by the Insured Person or an adult companion which may include the live donor of bone marrow or stem cells used in a bone marrow or stem cell transplant for the Insured Person. This benefit is not payable for lodging expense incurred more than 24 hours before the treatment nor for lodging expense incurred more than 24 hours following treatment. **This benefit is limited to 100 days per Calendar Year.**

11. **INPATIENT BLOOD, PLASMA AND PLATELETS EXPENSE BENEFIT** We will pay the actual charge **not to exceed $300 per day** for the procurement cost, administration, processing and cross matching of blood, plasma or platelets administered to an Insured Person in the treatment of Cancer while an Inpatient.

12. **OUTPATIENT BLOOD, PLASMA AND PLATELETS EXPENSE BENEFIT** We will pay **the actual charge not to exceed $300 per day** for the procurement cost, administration, processing and cross matching of blood, plasma or platelets administered to an Insured Person in the treatment of Cancer while an Outpatient.

13. **BONE MARROW DONOR EXPENSE BENEFIT** *We will pay the Daily Hospital Confinement Benefit shown on the Policy Schedule* for each day a live donor, other than the Insured Person, is confined in a Hospital for the harvesting of bone marrow or stem cells used in a bone marrow or stem cell transplant for the treatment of an Insured Person's Cancer.

14. **BONE MARROW OR STEM CELL TRANSPLANT EXPENSE BENEFIT** We will pay the actual charge not to exceed a **lifetime maximum of $15,000 for surgical and anesthesia procedures** (including the harvesting and subsequent re-infusion of blood cells or peripheral stem cells) performed for a bone marrow transplant and/or a peripheral stem cell transplant for the treatment of an Insured Person's Cancer. This benefit will be paid in lieu of the Surgical Expense Benefit and the Anesthesia Expense Benefit which may be described in a rider attached to an issued policy.

15. **AMBULANCE EXPENSE BENEFIT** We will pay the **actual charge** for ambulance service if an Insured Persons is transported to a Hospital where he or she is admitted as an inpatient for the treatment of Cancer . The ambulance service must be provided by a licensed professional ambulance company or an ambulance owned by the Hospital.

16. **INPATIENT OXYGEN EXPENSE BENEFIT** We will pay the actual charge **not to exceed $300 per Hospital confinement** for oxygen prescribed by a Physician and received by an Insured Person while confined in a Hospital for the treatment of Cancer.

17. **ATTENDING PHYSICIAN EXPENSE BENEFIT** We will pay the actual charge **not to exceed $40 per day** for the professional services of a Physician or Oncologist rendered to an Insured Person while he or she is confined in a Hospital for the treatment of Cancer. This benefit is payable only if the Physician or Oncologist personally visits the Hospital room occupied by the Insured Person and the amount stated is the maximum amount that will be payable for each day of Hospital confinement regardless of the number of visits made by one or more Physicians or Oncologists.

18. **INPATIENT PRIVATE DUTY NURSING EXPENSE BENEFIT** We will pay the actual charge **not to exceed $150 per day** for the full time service of a Nurse that is required and ordered by a Physician when an Insured Person is confined in a Hospital for the treatment of Cancer. The Nurse must provide services other than those normally provided by the Hospital and the Nurse may not be an employee of the Hospital or an Immediate Family Member of the Insured Person.

19. **OUTPATIENT PRIVATE DUTY NURSING EXPENSE BENEFIT** We will pay the actual charge **not to exceed $150 per day** limited to the same number of days of the prior Hospital confinement for the full time service of a Nurse that is required and ordered by a Physician when an Insured Person is confined indoors at home as the result of Cancer. This benefit is not payable if the services of the Nurse are custodial in nature or to assist the Insured Person in the activities of daily living. This benefit is not payable when the Nurse is a member of the Insured Person's Immediate Family. Charges must begin following a period of Hospital confinement for which benefits are payable under this Policy.

20. **CONVALESCENT CARE FACILITY EXPENSE BENEFIT** We will pay the actual charge **not to exceed $100 per day** for an Insured Person's confinement in a Convalescent Care Facility. The maximum number of days for which this benefit is payable will be the number of days in the last Period of Hospital Confinement that immediately preceded admission to a Convalescent Care Facility. The Convalescent Care Facility Confinement must: be due to Cancer ; begin within 14 days after the Insured Person has been discharged from a Hospital for the treatment of Cancer ; be authorized by a Physician as being medically necessary for the treatment of Cancer.

21. **RENTAL OR PURCHASE OF MEDICAL EQUIPMENT EXPENSE BENEFIT** We will pay the **lesser of the actual charge** not to exceed **$1,500 per Calendar Year** for either the rental or purchase of covered medical equipment designed for home use, required and ordered by the Insured Person's attending Physician as the direct result of the treatment of Cancer. Covered medical equipment includes wheel chair, oxygen equipment, respirator, braces, crutches or hospital bed.

22. HOME HEALTH CARE EXPENSE BENEFIT We will pay benefits for the following Covered Charges when a Insured Person requires Home Health Care for the treatment of Cancer.

1. **Home Health Care Visits** - We will pay the actual charge for Home Health Care Visits **not to exceed $75 for each day** on which one or more such visits occur. We will not pay this benefit for more than **60 days** in any Calendar Year.
2. **Medicine and Supplies** - We will pay the actual charge **not to exceed $450 in any Calendar Year** for drugs, medicine, and medical supplies provided by or on behalf of a Home Health Care Agency.
3. **Services of a Nutritionist** - We will pay the actual charge **not to exceed a lifetime maximum of $300** for the services of a nutritionist to set up programs for special dietary needs.

23. HOSPICE CARE EXPENSE BENEFIT We will pay the actual charge for Hospice Care **not to exceed $100 per day**, when such care is required because of Cancer. This benefit is payable whether confinement is required in a Hospice Center or services are provided in the Insured Person's home by a Hospice Team. Eligibility for payments will be based on the following conditions being met:(1) the Insured Person has been given a prognosis as being Terminally Ill with an estimated life expectancy of 6 months or less; and (2) We have received a written summary of such prognosis from the attending Physician. We will not pay this benefit while the Insured Person is confined to a Hospital or Convalescent Care Facility. **The lifetime maximum benefit is 365 days of Hospice Care**

24. HAIRPIECE EXPENSE BENEFIT We will pay the actual charge not to exceed **a lifetime maximum of $150** for the purchase of a wig or hairpiece that is required as the direct result of hair loss due to Cancer treatment.

25. PHYSICAL, SPEECH, AUDIO THERAPY AND PSYCHOTHERAPY EXPENSE BENEFIT

We will pay the actual charge **not to exceed $25 per therapy session** for:

1. Physical therapy treatments given by a license Physical Therapist, or
2. Speech therapy given by a licensed Speech Pathologist/Therapist; or
3. Audio therapy given by a licensed Audiologist; or
4. Psychotherapy given by a licensed Psychologist.

These sessions may be given at an institute of physical medicine and rehabilitation, a Hospital, or the Insured Person's home. These treatments must be given on an Outpatient basis unless the primary purpose of a Hospital confinement is for treatment of Cancer other than with physical, speech or audio therapy or psychotherapy. **Benefits may not exceed $1,000 per Calendar Year.**

26. WAIVER OF PREMIUM. We will waive the premiums starting on the first premium due date **following a 60 day period of Total Disability** of the Named Insured due to Cancer. The Named Insured must: (a) be receiving treatment for such Cancer for which benefits are payable under this Policy; and (b) remain disabled for 60 consecutive days. We will waive premiums for as long as the Named Insured remains Totally Disabled.

GUARANTEED RENEWABLE FOR LIFE. Except for fraud or material misrepresentation, the Named Insured has the right to renew this Policy as long as premiums are paid on time.

PREMIUMS SUBJECT TO CHANGE. On any premium due date after the first Policy Anniversary, We may change the premium rates for this policy only if We also change the rates for all other policies issued in the same Rating Class. No change in the premiums will be made because of the number of claims an Insured Person files nor because of a change in an Insured Person's health.

EXCLUSIONS AND LIMITATIONS. No benefits will be paid under the Policy or any attached riders for: 1. any loss due to any disease or illness other than Cancer, or a listed covered Specified Disease; 2. care and treatment received outside the territorial limits of the United States; 3. treatment by any program engaged in research that does not meet the criteria for Experimental Treatment as defined; 4. treatment that has not been approved by a Physician as being medically necessary; or 5. losses or medical actual charges prior to the Effective Date of an Insured Person's coverage regardless of the Date of Positive Diagnosis.

PRE-EXISTING CONDITIONS LIMITATION. We will not pay benefits for expenses resulting from Pre-existing Conditions during the first twelve months after coverage becomes effective.

"Pre-existing Condition" means Cancer, or a listed Specified Disease if that optional rider is issued, which was diagnosed by a Physician or for which medical consultation, advice or treatment was recommended by or received from or sought from a Physician within twelve months prior to the effective date of coverage for each Insured Person.

THIS IS A CANCER ONLY POLICY, which should be used to supplement your existing health care protection.

Insurance coverage is provided by form number series L-6040 and associated riders. This advertisement highlights some features of the policy and riders, but is not the insurance contract. An issued policy and riders set forth, in detail, the rights and obligations of both the insured and the insurance company. Please read the policy and riders for detailed coverage information.

ADDITIONAL BENEFITS INCLUDED	PLAN MAXIMUM
ANNUAL CANCER SCREENING BENEFIT RIDER (form L-6041) **A. Basic Benefit** We will pay the expense incurred, but not to exceed the maximum benefit amount shown on the Policy Schedule, once per calendar year per Insured Person for screening tests performed to determine whether Cancer exists in an Insured Person. Covered annual Cancer screening tests include but are not limited to: mammogram, pap smear, breast ultrasound, ThinPrep, biopsy, chest x-ray, thermography, colonoscopy, flexible sigmoidoscopy, hemocult stool specimen, PSA (blood test for prostate cancer), CEA (blood tests for colon cancer), CA125 (blood test for ovarian cancer), CA15-3 (blood test for breast cancer), serum protein electrophesis (blood test for myeloma). **B. Additional Benefit** We will pay the expense incurred, but not to exceed two times the maximum benefit amount per calendar year as shown on the Policy Schedule, for one additional invasive diagnostic procedure required as the result of an abnormal cancer screening test for which benefits are payable under the Basic Benefit above for an Insured Person. This additional benefit is payable regardless of the results of the additional diagnostic procedure. However, the amount payable will be reduced dollar for dollar for any amount payable under the Positive Diagnosis Benefit contained in the base Policy.	**$50** **Per Calendar Year** **$100** **Per Calendar Year**
ANNUAL RADIATION, CHEMOTHERAPY, IMMUNOTHERAPY and EXPERIMENTAL TREATMENT BENEFIT RIDER (form L-6045) We will pay the expense incurred, but not to exceed the maximum benefit amount shown on the Policy Schedule, per calendar year per Insured Person for Radiation Treatment, Chemotherapy, Hormonal Therapy, Immunotherapy or Experimental Treatment. The Radiation Treatment, Chemotherapy, Hormonal Therapy, Immunotherapy or Experimental Treatment must be for the treatment of an Insured Person's Cancer. The benefit amount shown on the Policy Schedule is the maximum calendar year benefit available per Insured Person regardless of the number or types of Cancer treatments received in the same year.	**$10,000** **Per Calendar Year**
SURGICAL BENEFIT RIDER (form L-6048) **Surgical Expense** We will pay the Surgical Expense benefit for a surgical procedure for the treatment of an Insured Person's Cancer (except Skin Cancer) according to the Surgical Schedule shown in this rider. However, in no event will the amount payable exceed the maximum Surgical Expense benefit shown on the Policy Schedule, nor will it exceed the expense incurred. **Anesthesia Expense** We will pay the anesthesia expense incurred, not to exceed 25% of the covered Surgical Expense benefit for the operation performed. This includes the services of an anesthesiologist or of an anesthetist under supervision of a physician for the purpose of administering anesthesia. **Breast Reconstruction** with transverse rectus adominis myocutaneous flap (TRAM), single pedicle, including closure of donor site, with microvascular anastomosis (supercharging) is one of the surgical procedures listed in the Surgical Schedule. If this procedure is performed on an Insured Person as the result of a mastectomy for which We paid a Surgical Expense benefit for the treatment of Breast Cancer, We will pay the expense incurred not to exceed $900 per $1,000 of the Surgical Benefit issued. **Skin Cancer Surgery Expense** We will pay the expense incurred, not to exceed the procedure amount listed in this rider ($125 to $750 depending on the procedure) when a surgical operation is performed on an Insured Person for treatment of a diagnosed Skin Cancer. This benefit is payable in lieu of any benefits for Surgical Expense and Anesthesia Expense which are not applicable to Skin Cancer.	**$4,000** **Procedure Maximum** **$1,000** **Procedure Maximum** **$3,600** **Procedure Maximum** **Per Procedure**
DAILY HOSPITAL CONFINEMENT BENEFIT RIDER (form L-6042) **Confinements of 30 Days or Less** We will pay the Daily Hospital Confinement benefit amount shown on the Policy Schedule for each of the first 30 days in each period of hospital confinement during which an Insured Person is confined to a hospital, including a government or charity hospital, for the treatment of Cancer. **Confinements of 31 Days or More** If an Insured Person is continuously confined to a hospital, including a government or charity hospital, for longer than 30 consecutive days for the treatment of Cancer, We will pay two times the Daily Hospital Confinement benefit amount shown on the Policy Schedule. This benefit payment will begin on the 31st continuous day of such confinement and continue for each day of confinement until the Insured Person is discharged from the Hospital. **Benefits for an Insured Dependent Child under Age 21** The amount payable under this benefit will be double the Daily Hospital Confinement benefit shown on the Policy Schedule if the Insured Person so confined is a dependent child under the age of 21.	**$150** **Per Day** **$300** **Per Day** **$300/** **$600** **Per Day**

SPECIFIED DISEASE BENEFIT RIDER (form L-6052)

If an Insured Person is first diagnosed with one or more covered Specified Diseases and is hospitalized for the definitive treatment of any covered Specified Disease, We will pay benefits according to the provisions of this rider.

COVERS THESE 38 SPECIFIED DISEASES

Addison's Disease, Amyotrophic Lateral Sclerosis, Botulism, Bovine Spongiform Encephalopathy, Budd-Chiari Syndrome, Cystic Fibrosis, Diptheria, Encephalitis, Epilepsy, Hansen's Disease, Histoplasmosis, Legionnaire's Disease, Lyme Disease, Lubus Erythematosus, Malaria, Meningitis, Multiple Sclerosis, Muscular Dystrophy, Myasthenia Gravis, Neimann-Pick Disease, Osteomyelitis, Poliomyelitis, Q Fever, Rabies, Reye's Syndrome, Rheumatic Fever, Rocky Mountain Spotted Fever, Sickle Cell Anemia, Tay-Sachs Disease, Tetanus, Toxic Epidermal Necrolysis, Tuberculosis, Tularemia, Typohoid Fever, Undulant Fever, West Nile Virus, Whipple's Disease, Whooping Cough.

BENEFITS

Initial Hospitalization Benefit We will pay a benefit of **$1,500 per unit of coverage** selected when an Insured Person is confined to a hospital (for 12 or more hours, not applicable in SD) as a result of receiving treatment for a Specified Disease. This benefit is payable only once per period of confinement and once per calendar year for each Insured Person.

Hospital Confinement Benefit We will pay a benefit of **$300 per day per unit of coverage** selected when an Insured Person is hospitalized during any continuous period of 30 days or less for the treatment of a covered Specified Disease. Benefits will **double per day beginning with the 31st day of continuous confinement.**

If the hospital confinement follows a previously covered confinement, it will be deemed a continuation of the first confinement unless it is the result of an entirely different Specified Disease, or unless the confinements are separated by 30 days or more.

ADDITIONAL BENEFIT AMOUNTS YOU MAY SELECT FOR ADDITIONAL PREMIUM

FIRST OCCURRENCE BENEFIT RIDER (form L-6043) If an Insured Person receives a positive diagnosis of Internal Cancer, We will pay the First Occurrence benefit amount shown on the Policy Schedule. If the Insured Person receiving the positive diagnosis of Internal Cancer is a child under the age of 21, we will pay one and one-half times the First Occurrence benefit amount shown on the Policy Schedule.	**$5,000/$3,000** **Per Lifetime** **$7,500/$4,500** **Once Per Lifetime**
HOSPITAL INTENSIVE CARE UNIT BENEFIT RIDER (form LG-6047) **Intensive Care Unit Benefit** We will pay the daily Hospital Intensive Care Unit Benefit shown on the Policy Schedule for an Insured Person's confinement in an ICU for sickness or injury. **Double Intensive Care Unit Benefit** We will pay double the daily Hospital Intensive Care Unit benefit amount shown on the Policy for an Insured Person's confinement in an ICU as a result of Cancer. We will also double this ICU benefit for only the initial ICU confinement resulting from an Insured Person's travel related injury, provided that the ICU confinement begins within 24 hours of the accident causing the travel related injury. A travel related injury includes being struck by an automobile, bus, truck, van, motorcycle, train or airplane; or being involved in an accident where the Insured Person was the operator or passenger in or on such vehicle. **Step Down Unit Benefit** We will pay one-half of the daily Hospital Intensive Care Unit benefit amount shown on the Policy Schedule for an Insured Person's confinement in a Step Down Unit for a sickness or injury.	**$600** **Per Day** **$1,200** **Per Day** **$300** **Per Day**

Additional Limitations and Exclusions for the Hospital Intensive Care Unit Benefit Rider If the rider is issued and coverage is in force, it will provide benefits if an Insured Person goes into a hospital Intensive Care Unit (including a Cardiac Intensive Care Unit or Neonatal Intensive Care Unit). Benefits start the first day of confinement in an ICU for sickness or injury. Any combination of benefits payable under this rider is limited to a maximum of 45 days per each period of confinement.

ALL BENEFITS CONTAINED IN THIS HOSPITAL INTENSIVE CARE UNIT BENEFIT RIDER REDUCE BY ONE-HALF AT AGE 75.

Benefits are not payable for any ICU or Step Down Unit confinement that results from intentional self-inflicted injury; or the Insured Person's being intoxicated or under the influence of alcohol, drugs or any narcotics, unless administered on and according to the advice of a medical practitioner.

This page is an Insert to be used ONLY with Brochure Form L-6040. If you do not have this Brochure, ask that your agent provide one for you. All exclusions, limitations, definitions and terms of renewability of the Limited Benefit Cancer Expense Policy (form L-6040) apply to these riders. THESE ARE LIMITED RIDERS

Agility fuel systems

Critical Illness Insurance

ASSURANT Employee Benefits

Choosing to plan for sudden illness

Critical Illness Insurance

Can your finances survive a serious illness?

Maybe it's happened to someone you know. A sudden illness such as a heart attack or stroke can cause devastating physical and financial consequences.

- 1.5 million Americans will declare bankruptcy this year, 60% due to medical bills.[1]
- An estimated 83.6 million American adults (greater than 1 in 3) have cardiovascular disease.[2]
- Fewer than 1 in 4 Americans (24%) have enough savings to cover at least 6 months' expenses.[3]

How can critical illness insurance help?

For many, a critical illness can expose an individual to an unexpected gap in protection. While health plans may help cover many of the direct costs associated with a critical illness, related expenses such as lost income, child care, travel to and from treatment, high deductibles and co-pays may quickly diminish savings.

Critical illness insurance pays a fixed benefit if you are diagnosed after your coverage effective date with a covered critical illness.

How do I know if I'm eligible to participate in this plan?

You can participate in this plan if you are a full-time employee of the policyholder or an associated company. Full-time means working 30 hours or more per week. Temporary or seasonal workers are not eligible.

This product is inappropriate for those persons who are eligible for Medicaid coverage.

Key Advantages of This Plan

- **Benefits are payable directly to you to be spent any way you choose.**
- **Pays in addition to any other coverage you may have.**
- **Flexible coverage options to meet your individual needs.**
- **Fast and accurate claims service.**
- **Coverage is fully portable - if you change jobs you can take your coverage with you.**

Sources: [1] Facts About Critical Illness Insurance Coverage and Costs, 2012
[2] American Heart Association 2013
[3] 2013 research from Bankrate.com

Critical Illness Q&A

Q. What benefits are provided under this plan?

A. If you are diagnosed with a covered critical illness, you could receive up to **$50,000 as a single sum payment** depending on the amount of coverage you elect. You must be diagnosed after your coverage effective date and qualify for the benefit as defined by the policy. Your plan also includes a Wellness Screening benefit. Each critical illness pays a specified percentage of your election amount as shown below:

Covered Illness or Procedure	Initial Diagnosis Benefit Percent of Elected Benefit Payable
• Heart Attack	100%
• Stroke	100%
• End Stage Kidney Disease	100%
• Major Organ Failure	100%
• Occupational HIV/Hepatitis, B,C or D	100%
• Coronary Bypass Surgery	25%
Your plan also includes expanded coverage for these additional conditions:	
• Blindness, Loss of Speech, or Loss of Hearing	100%
• Benign Brain Tumor, Paralysis or Coma	100%

Q. What if I am diagnosed with the same condition again?

A. If you have received benefits under this plan for a covered critical illness and are diagnosed a second time with the same critical illness, you may qualify for the recurrence benefit. Recurrence benefits are available only for the critical illnesses shown below:

Covered Illness or Procedure	Recurrence Benefit Percent of Elected Benefit Payable
• Heart Attack	100%
• Stroke	100%
• End Stage Kidney Disease	100%
• Major Organ Failure	100%
• Coronary Bypass Surgery	25%

The second diagnosis must occur at least 12 consecutive months after the initial diagnosis and you must not have been receiving treatment for the initial diagnosis for at least 12 consecutive months between the initial diagnosis and the second diagnosis. Once the recurrence benefit has been paid, no additional benefit will be paid for that critical illness

Q. What is the Annual Wellness Screening Benefit?

A. If you and your dependents enroll in the plan, each of you are eligible for $50 per benefit year for any one Wellness Screening test from a list of more than 20 covered tests. Covered tests include: cardiac exercise stress test; fasting blood glucose test; blood test for lipids including total cholesterol, LDL, HDL and triglycerides; breast ultrasound or mammography; CA15-3 (blood test for breast cancer); CA 125 (blood test for ovarian cancer); CEA (blood test for colon cancer); chest x-ray; colonoscopy; flexible sigmoidoscopy; hemocult stool analysis; pap smear; PSA (blood test for prostate cancer); serum protein electrophoresis; carotid doppler; electrocardiogram; echocardiogram. In order to receive this benefit, the wellness screening test must be performed after your coverage effective date.

Critical Illness Q&A

Q. Can I receive benefits for more than one of these critical illnesses?

A. Yes, you can receive benefits for any covered critical illness shown but there must be at least 6 consecutive months between the diagnosis dates. You can only claim benefits once for each critical illness unless a recurrence benefit is payable.

Q. Do I have to answer any health questions to enroll for this coverage?

A. Yes, you will need to complete a simple health questionnaire for yourself and any dependents you wish to cover.

Q. Is there a pre-existing condition limitation?

A. Yes, a pre-existing condition applies to you and your dependent's coverage.

A pre-existing condition means an injury, sickness, symptom or physical finding, or any related injury, sickness, symptom or physical finding, for which you or your covered dependent consulted with or received advice from a licensed medical or dental practitioner; or received medical or dental care, treatment or services, including taking drugs, medicine, insulin or similar substances in the 12 months that end on the day before you or your covered dependent became insured under the policy. We will not pay benefits for claims resulting, directly or indirectly, from a pre-existing condition unless you or your covered dependent are initially diagnosed with a critical illness or undergo a procedure after 12 consecutive months during which you or your covered dependent are continuously insured under this plan.

See your certificate for additional pre-existing condition details.

Q. When will my coverage become effective?

A. Your coverage starts on the entry date specified in the group policy, provided you are at active work on that date. Otherwise, your coverage will become effective on the day you return to full-time duties. If a family member is in a hospital on the day insurance would otherwise take effect, then insurance will take effect on the day after the family member leaves the hospital.

Q. Can I take my insurance with me if I leave my employer?

A. Yes. **Portability** allows you to continue this group critical illness coverage until age 70 after terminating current employment.

How much does Critical Illness Cost?

Your cost depends on:

- How much coverage you select
- Your age as of the effective date. Because issue age rating applies, your premiums will not increase due to age changes.
- Whether or not you or your spouse use tobacco

You may elect coverage for yourself in units of $5,000 up to $50,000. **Your benefit is subject to a 50% reduction, rounded to the next higher $1,000, when you turn age 70.**

Employee Critical Illness Insurance Bi-Weekly Premiums

Non-Tobacco User

Benefit / Issue Age	<30	30-39	40-49	50-59	60-69	70+
$5,000	$1.65	$1.97	$2.85	$4.28	$6.15	$13.74
$10,000	$2.69	$3.33	$5.09	$7.95	$11.69	$26.87
$15,000	$3.72	$4.69	$7.32	$11.62	$17.22	$40.00
$20,000	$4.76	$6.06	$9.56	$15.29	$22.76	$53.13
$25,000	$5.80	$7.42	$11.80	$18.96	$28.30	$66.26
$30,000	$6.84	$8.78	$14.04	$22.62	$33.84	$79.39
$35,000	$7.88	$10.14	$16.28	$26.29	$39.38	$92.52
$40,000	$8.92	$11.50	$18.52	$29.96	$44.92	$105.66
$45,000	$9.96	$12.86	$20.76	$33.63	$50.46	$118.79
$50,000	$10.99	$14.22	$22.99	$37.30	$55.99	$131.92

Employee Critical Illness Insurance Bi-Weekly Premiums

Tobacco User

Benefit / Issue Age	<30	30-39	40-49	50-59	60-69	70+
$5,000	$1.92	$2.59	$4.32	$6.86	$11.02	$20.92
$10,000	$3.24	$4.58	$8.04	$13.12	$21.42	$41.22
$15,000	$4.56	$6.56	$11.76	$19.37	$31.83	$61.53
$20,000	$5.87	$8.55	$15.47	$25.62	$42.24	$81.84
$25,000	$7.19	$10.53	$19.19	$31.88	$52.65	$102.15
$30,000	$8.50	$12.52	$22.90	$38.13	$63.06	$122.46
$35,000	$9.82	$14.50	$26.62	$44.39	$73.46	$142.76
$40,000	$11.13	$16.49	$30.33	$50.64	$83.87	$163.07
$45,000	$12.45	$18.47	$34.05	$56.89	$94.28	$183.38
$50,000	$13.76	$20.46	$37.76	$63.15	$104.69	$203.69

Can I buy coverage for my family?

If you cover yourself, you can also purchase Critical Illness insurance for your eligible family members.

Eligible family members include your spouse and children from live birth to less than age 26. See your certificate or group insurance policy for additional eligibility details.

You can buy spouse coverage in units of $2,500 up to the lesser of 50% of your own coverage amount or $25,000.

Spouse Critical Illness Insurance Bi-Weekly Premiums

Non-Tobacco User

Benefit / Issue Age	<30	30-39	40-49	50-59	60-69	70+
$2,500	$1.13	$1.29	$1.73	$2.44	$3.38	$7.17
$5,000	$1.65	$1.97	$2.85	$4.28	$6.15	$13.74
$7,500	$2.17	$2.65	$3.97	$6.11	$8.92	$20.31
$10,000	$2.69	$3.33	$5.09	$7.95	$11.69	$26.87
$12,500	$3.21	$4.01	$6.21	$9.78	$14.46	$33.44
$15,000	$3.72	$4.69	$7.32	$11.62	$17.22	$40.00
$17,500	$4.24	$5.37	$8.44	$13.45	$19.99	$46.57
$20,000	$4.76	$6.06	$9.56	$15.29	$22.76	$53.13
$22,500	$5.28	$6.74	$10.68	$17.12	$25.53	$59.70
$25,000	$5.80	$7.42	$11.80	$18.96	$28.30	$66.26

Spouse Critical Illness Insurance Bi-Weekly Premiums

Tobacco User

Benefit / Issue Age	<30	30-39	40-49	50-59	60-69	70+
$2,500	$1.27	$1.60	$2.47	$3.74	$5.81	$10.76
$5,000	$1.92	$2.59	$4.32	$6.86	$11.02	$20.92
$7,500	$2.58	$3.59	$6.18	$9.99	$16.22	$31.07
$10,000	$3.24	$4.58	$8.04	$13.12	$21.42	$41.22
$12,500	$3.90	$5.57	$9.90	$16.24	$26.63	$51.38
$15,000	$4.56	$6.56	$11.76	$19.37	$31.83	$61.53
$17,500	$5.21	$7.56	$13.61	$22.50	$37.04	$71.69
$20,000	$5.87	$8.55	$15.47	$25.62	$42.24	$81.84
$22,500	$6.53	$9.54	$17.33	$28.75	$47.44	$91.99
$25,000	$7.19	$10.53	$19.19	$31.88	$52.65	$102.15

Your spouse's premiums are based on **your** age and your **spouse's** tobacco use.

Can I buy coverage for my family? (continued)

You can buy coverage for your children too in units of $2,500 up to $5,000. A 50% limit also applies to child coverage.

Child Critical Illness Insurance Bi-Weekly Premiums		
Benefit	$2,500	$0.24
	$5,000	$0.48

For Critical Illness insurance for your children, choose the benefit you want for the corresponding premium. One premium covers all of your dependent children.

Critical Illness Definitions - *Core Covered Conditions*

Heart attack means that while insured under the policy, a covered person has been diagnosed with coronary artery disease that results in a current and new acute myocardial infarction due to blockage of one or more coronary arteries causing death of a portion of the heart muscle with loss of heart function. Diagnosis of the new myocardial infarction must be based on new changes consistent with an evolving infarction on electrocardiogram (EKG) and concurrent with serial measurement of cardiac biomarkers of a pattern and level of enzymes confirming an acute infarction. Old, established or silent myocardial infarctions are excluded.

Stroke means that while insured under the policy, a covered person has been diagnosed with *cerebral vascular disease* resulting in a brain tissue infarction. The basis of the diagnosis must include imaging documentation of new brain tissue infarction in association with acute onset of symptoms consistent with central nervous system neurological damage. For the purposes of this policy, stroke does not include: Transient Ischemic Attacks (TIAs); Transient Global Amnesia (TGA); or external trauma causing injury to the brain.

Cerebral vascular disease means subarachnoid hemorrhage, intracerebral hemorrhage, brain embolism, brain thrombosis, occlusion and stenosis of precerebral arteries or occlusion of cerebral arteries.

End-stage kidney disease means that while insured under the policy, a covered person has been diagnosed with a renal disease that has resulted in either: the chronic and irreversible failure of both kidneys to function and which requires regular dialysis for a minimum of 90 days; or the need for a kidney transplant. In the event a kidney is transplanted at the same time as other organs, only one benefit is payable.

Major organ failure means that while insured under the policy, a covered person is diagnosed with any end-stage disease as specified by the most current edition of the International Classification of Diseases (ICD) of the heart, liver, lung, small intestine, pancreas or bone marrow that has resulted in the chronic and irreversible failure of the organ to function and which requires the need for a transplant. In order for major organ failure resulting from an end-stage disease to be covered under this policy, the covered person must be registered with the United Network of Organ Sharing (UNOS) or be registered for matching a donor on the National Marrow Donor Program (NMDP). If multiple organs are to be replaced at the same time only one benefit is payable.

Occupational infectious disease means that a covered person is initially diagnosed while insured under the policy with Human Immunodeficiency Virus (HIV) infection or Hepatitis B, C and/or D resulting from accidental exposure to HIV or Hepatitis B, C and/or D by contaminated body fluids during the course of performing a covered person's regular occupation for which remuneration is earned. To prove occupational exposure, all of the following must be submitted: Documentation showing that within five days of the accidental exposure, the exposure was reported and recorded by the appropriate person according to legislation, regulations or standard guidelines that apply to the occupation; A negative antibody for HIV or Hepatitis B, C and/or D test, performed by a state certified and licensed laboratory within five days of exposure; and A positive antibody for HIV or Hepatitis B, C and/or D test, taken in the 90 to 180 days following the exposure. Occupational infectious disease does not include HIV or Hepatitis B, C and/or D that occurs as a result of IV drug use, sexual transmission or is determined not to be accidental. In order for a benefit to be paid, the initial diagnosis of occupational infectious disease must occur while insured under the policy.

Coronary bypass surgery means that while insured under the policy, a covered person has been diagnosed with *coronary artery disease* requiring a procedure to bypass one or more diseased, narrowed or blocked coronary arteries with arterial or venous grafts and is performed by a board certified cardiovascular surgeon. Other procedures such as percutaneous transluminal coronary angioplasty (PTCA) or laser procedures are excluded.

Coronary artery disease means acute coronary occlusion, coronary atherosclerosis, aneurysm and dissection of the coronary arteries or coronary atherosclerosis due to plaque. *Coronary bypass surgery* means that while insured under the policy, a covered person has been diagnosed with coronary artery disease requiring a procedure to bypass one or more diseased, narrowed or blocked coronary arteries with arterial or venous grafts and is performed by a board certified cardiovascular surgeon. Other procedures such as percutaneous transluminal coronary angioplasty (PTCA) or laser procedures are excluded.

Critical Illness Definitions - *Expanded Coverage for Additional Conditions*

Blindness means that while insured under the policy, a covered person has been initially diagnosed with an irreversible reduction in sight, lasting at least 180 days, that results in a corrected visual acuity of 20/400 or less or a visual field less than 20 degrees when testing both eyes together. Benefits for blindness are not payable if the condition is a consequence of another condition for which another critical illness benefit has been paid.

Loss of speech means a covered person is initially diagnosed with total, permanent and irreversible loss of the ability to speak. The loss must be: as a result of injury or sickness affecting the speech organs; and have continued without interruption for a period of at least 6 consecutive months. *Loss of speech* does not include any loss that could be restored, totally or partially, by use of a device or implant. Benefits for loss of speech are not payable if the condition is a consequence of another condition for which another critical illness benefit has been paid. In order for a benefit to be paid, the initial diagnosis of loss of speech must occur while insured under the policy.

Complete loss of hearing means that a covered person has been initially diagnosed with a condition that results in the total and irreversible loss of hearing in both ears to a point that a covered person is unable to hear sounds at or below 70 decibels. The diagnosis must be confirmed using audiometric testing. *Complete loss of hearing* does not include loss of hearing that can be corrected to above 70 decibels by the use of any hearing aid or device. Benefits for complete loss of hearing are not payable if the condition is a consequence of another condition for which another critical illness benefit has been paid. In order for a benefit to be paid, the initial diagnosis of complete loss of hearing must occur while insured under the policy.

Benign brain tumor means a covered person has been initially diagnosed with a meningioma, lipoma or glioma arising from the brain or its meninges and is: confirmed by the examination of tissue (biopsy or surgical excision) or specific neuroradiological examination; and resulting in persistent neurological deficits including but not limited to: loss of vision, loss of hearing or balance disruption. Other conditions, including the following, are not considered a *benign brain tumor*: hematomas, cysts or granulomas; or intracranial malformations of the arteries or veins; or tumors in the pituitary gland, spine or cranial nerves, including pituitary adenoma, acoustic neuroma or craniopharyngioma. In order for a benefit to be paid, the initial diagnosis of any benign brain tumor must occur while insured under the policy.

Paralysis means that while insured under the policy, a covered person has been diagnosed with total and irreversible loss of use of two or more limbs due to injury and that is continuously present for a period of at least 180 days. *Paralysis* shall not include any impairment caused by a stroke or other sickness.

Coma means that while insured under the policy, a covered person has been diagnosed with a condition from which a covered person cannot be aroused and which requires an external life support system, both of which have persisted continuously for at least 168 hours. A medically induced coma is excluded.

Limitations, exclusions, restrictions and reductions

Please carefully review the Other Important Plan Provisions section for additional important plan limitations, exclusions, restrictions and reductions that may apply.

Other Important Plan Provisions

ASSURANT Employee Benefits®

Critical Illness

We will not pay benefits for you or your covered dependent if the critical illness or procedure is related to or resulting directly or indirectly from: services or treatment not included in the Schedule; services or treatment for which you or your covered dependent are not charged, unless there is no charge because the facility is a United States government facility; services or treatment provided by a family member; any critical illness that is diagnosed outside the United States; services or treatment provided primarily for cosmetic purposes; treatment or complications of treatment not related to a critical illness or procedure; an autologous bone marrow transplant for you or your covered dependent in which the covered person's own bone marrow is used; service in the armed forces or related auxiliaries such as the National Guard or Army Reserve of any country, combination of countries, or international organization at war, whether declared or not; war or any act of war, whether declared or not; taking part in a riot or insurrection, or an act of riot or insurrection; committing or attempting to commit an assault or felony; incarceration in a penal institution of any kind; intoxication (intoxication means the blood alcohol level for you or your covered dependent exceeds the legal limit for operating a motor vehicle in the jurisdiction in which the injury occurs); use of any drug, unless used as prescribed by a doctor; intentionally self-inflicted injury, while sane or insane; suicide or attempted suicide, while sane or insane.

State variations can exist; please contact Assurant Employee Benefits for additional information.

Hospital Indemnity Insurance

AFLAC HOSPITAL ADVANTAGE

HOSPITAL CONFINEMENT INDEMNITY INSURANCE

POLICY SERIES A49000

PREFERRED

This brochure is for a hospital confinement indemnity policy providing limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.

This is a supplement to health insurance. It is not a substitute for hospital or medical expense insurance, a health maintenance organization (HMO) contract, or a major medical expense insurance.

A49275CA IC(3/13)

Aflac Hospital Advantage

HOSPITAL CONFINEMENT INDEMNITY INSURANCE

Policy Series A49000

OPTION 1 BENEFITS	
HOSPITAL CONFINEMENT	$1,000 PER COVERED PERSON
REHABILITATION FACILITY	$100 PER DAY
HOSPITAL EMERGENCY ROOM	$100 UP TO 2 TIMES PER YEAR, PER POLICY
HOSPITAL SHORT-STAY	$100 UP TO 2 TIMES PER YEAR, PER POLICY
WAIVER OF PREMIUM	YES
CONTINUATION OF COVERAGE	YES

OPTION 2 BENEFITS *ALL BENEFITS OF OPTION 1 PLUS THE FOLLOWING*	
PHYSICIAN VISIT	$25 PER VISIT
MEDICAL DIAGNOSTIC & IMAGING	$150 ONCE PER YEAR, PER COVERED PERSON
AMBULANCE	$100 – GROUND, $1,000 – AIR UP TO 2 TRIPS PER YEAR, PER COVERED PERSON

OPTION 3 BENEFITS *ALL BENEFITS OF OPTIONS 1 & 2 PLUS THE FOLLOWING*	
SURGICAL	$50–$1,000 SURGICAL SCHEDULE ONE BENEFIT PER 24-HOUR PERIOD
INVASIVE DIAGNOSTIC EXAMS	$100 ONE EXAM PER COVERED PERSON, PER 24-HOUR PERIOD

OPTION 4 BENEFITS *ALL BENEFITS OF OPTIONS 1, 2, & 3 PLUS THE FOLLOWING*	
DAILY HOSPITAL CONFINEMENT	$100 PER DAY UP TO 365 DAYS IN ADDITION TO THE HOSPITAL CONFINEMENT BENEFIT
HOSPITAL INTENSIVE CARE UNIT CONFINEMENT	$100 PER DAY UP TO 30 DAYS IN ADDITION TO HOSPITAL CONFINEMENT & DAILY HOSPITAL CONFINEMENT BENEFITS

The policy has limitations and exclusions that may affect benefits payable. This schedule is for illustrative purposes only. Refer to the policy for benefit details, definitions, limitations, and exclusions.

Agility fuel systems

Aflac will pay the following benefits, as applicable, for a covered sickness or accidental injury that occurs while coverage is in force. Treatment or confinement in a U.S. government hospital does not require a charge for benefits to be payable.

BENEFIT	BENEFIT AMOUNT	ADDITIONAL BENEFIT INFORMATION
OPTION 1 **HOSPITAL CONFINEMENT**	$1,000	Aflac will pay a Hospital Confinement Benefit of $1,000 when a covered person requires hospital confinement for 23 or more hours for a covered sickness or accidental injury and a charge is incurred. This benefit is payable once per period of hospital confinement, per covered person. Confinements must be separated by a minimum of 90 days from the previous covered hospital confinement for this benefit to be payable. No lifetime maximum.
REHABILITATION FACILITY	$100 per day	Aflac will pay $100 per day when a covered person is confined in a hospital and is transferred to a bed in a rehabilitation facility for a covered sickness or accidental injury and a charge is incurred. This benefit is limited to 15 days per period of hospital confinement and is limited to a calendar year maximum of 30 days per covered person. No lifetime maximum.
HOSPITAL EMERGENCY ROOM	$100	Aflac will pay $100 when a covered person receives treatment for a covered sickness or accidental injury in a hospital emergency room, including triage, and a charge is incurred. This benefit is payable twice per calendar year, per policy. The Hospital Emergency Room Benefit and the Hospital Short-Stay Benefit are not payable on the same day. No lifetime maximum.
HOSPITAL SHORT-STAY	$100	Aflac will pay $100 when a covered person receives treatment for a covered sickness or accidental injury in a hospital, including an observation room or an ambulatory surgical center, for a period of less than 23 hours and a charge is incurred. This benefit is not payable for treatment received in a hospital emergency room. This benefit is payable twice per calendar year, per policy. The Hospital Short-Stay Benefit and the Hospital Emergency Room Benefit are not payable on the same day. No lifetime maximum.
WAIVER OF PREMIUM	Upon written notice, Aflac will waive from month to month any premium(s) falling due during a continued period of hospital confinement for the named insured only. This benefit will begin after the period of hospital confinement for the named insured has exceeded 30 consecutive days. When such continued period of hospital confinement has ended, premium payments must be resumed. Once premium payments are resumed, any new period of hospital confinement must again satisfy the 30-day continued confinement for premiums to be waived.	
CONTINUATION OF COVERAGE	Aflac will waive all monthly premiums due for the policy and riders, if any, for up to two months if you meet all of the following conditions: • The policy was in force for at least six months. • We received premiums for at least six consecutive months. • Your premiums were paid through payroll deduction, and you left your employer for any reason. • You or your employer notified us in writing within 30 days of the date your premium payments ceased because of leaving employment. • You re-establish premium payments with Aflac. You will again become eligible to receive this benefit after you re-establish your premium payments through payroll deduction for a period of at least six months, and we receive premiums for at least six consecutive months.	
OPTION 2 *All benefits of Option 1 plus the following* **PHYSICIAN VISIT**	$25	Aflac will pay $25 when a covered person incurs a charge for a physician visit. Services must be under the supervision of a physician. If the type of coverage for the policy is individual, the benefit is limited to three visits per calendar year, per policy. If the type of coverage is named insured/spouse only, one-parent family, or two-parent family, the benefit is limited to a total of six visits per calendar year, per policy. The sickness or accidental injury of a covered person is not required for this benefit to be payable. Covered physician visits include but are not limited to eye exams, well-baby visits, immunizations, periodic health exams, and routine physicals. This benefit is not subject to the Pre-existing Condition Limitations or to the Limitations and Exclusions. No lifetime maximum.

BENEFIT	BENEFIT AMOUNT	ADDITIONAL BENEFIT INFORMATION
MEDICAL DIAGNOSTIC AND IMAGING	$150	Aflac will pay $150 per calendar year when a covered person requires one of the following exams and a charge is incurred: CT scan, MRI (magnetic resonance imaging), EEG (electroencephalogram), thallium stress test, myelogram, angiogram, or arteriogram. These exams must be performed in a hospital, a medical diagnostic imaging center, a physician's office, or an ambulatory surgical center. This benefit is limited to one payment per calendar year, per covered person. No lifetime maximum.
AMBULANCE	$100 – ground ambulance $1,000 – air ambulance	Aflac will pay the amount shown at left if, due to a covered sickness or accidental injury, a covered person requires ground ambulance transportation or air ambulance transportation to or from a hospital due to a covered sickness or accidental injury and a charge is incurred. A licensed professional ambulance company must provide the ambulance service. The Ambulance Benefit is limited to two trips per calendar year, per covered person. If the provider of service does not receive payment for services provided from any other source, and provided the benefit under the policy has not been paid, we will directly reimburse such provider of service. No lifetime maximum.
OPTION 3 *All benefits of Options 1 & 2 plus the following* **SURGICAL**	$50–$1,000 (based on the Schedule of Operations listed in the policy)	Aflac will pay according to the benefits listed in the Schedule of Operations in the policy when, due to a covered sickness or accidental injury, a covered person has a surgical operation, including a vaginal or cesarean delivery, performed in a hospital or an ambulatory surgical center and a charge is incurred. If any operation for the treatment of the covered sickness or accidental injury is performed other than those listed, Aflac will pay an amount comparable to the amount shown in the Schedule of Operations for the operation most nearly similar in severity and gravity. Only one benefit is payable per 24-hour period for surgery, even though more than one surgical procedure may be performed. The highest eligible benefit will be paid. Exams covered under the Invasive Diagnostic Exams Benefit are not payable under this benefit. The Surgical Benefit and the Invasive Diagnostic Exams Benefit are not payable on the same day. The highest eligible benefit will be paid. No lifetime maximum. IMPORTANT: Surgical Benefits are not payable for surgery performed in a physician's or dentist's office, a clinic, or other such location.
INVASIVE DIAGNOSTIC EXAMS	$100	Aflac will pay $100 when a covered person requires one of the following exams, with or without biopsy, and a charge is incurred: arthroscopy, bronchoscopy, colonoscopy, cystoscopy, gastroscopy, laparoscopy, laryngoscopy, sigmoidoscopy, or esophagoscopy. These exams must be performed in a hospital or an ambulatory surgical center. This benefit is limited to one exam per covered person, per 24-hour period. The Invasive Diagnostic Exams Benefit and the Surgical Benefit are not payable on the same day. The highest eligible benefit will be paid. No lifetime maximum.
OPTION 4 *All benefits of Options 1, 2, & 3 plus the following* **DAILY HOSPITAL CONFINEMENT**	$100 per day	Aflac will pay $100 per day for the period of hospital confinement when a covered person requires hospital confinement for a covered sickness or accidental injury and a charge is incurred. This benefit is payable in addition to the Hospital Confinement Benefit. The maximum benefit period for any one period of hospital confinement is 365 days. No lifetime maximum.
HOSPITAL INTENSIVE CARE UNIT CONFINEMENT	$100 per day	Aflac will pay $100 per day when a covered person incurs a charge for a period of hospital intensive care unit confinement for a covered sickness or accidental injury. This benefit is payable in addition to the Hospital Confinement Benefit and the Daily Hospital Confinement Benefit. Confinements must be separated by a minimum of 90 days from the previous covered period of hospital intensive care unit confinement for this benefit to be payable. The maximum benefit period for any one period of hospital intensive care unit confinement is 30 days. No lifetime maximum.

WHAT IS NOT COVERED

LIMITATIONS AND EXCLUSIONS

Aflac will not pay benefits for care or treatment that is: (1) caused by a pre-existing condition, unless it begins more than 12 months after the effective date of coverage, or (2) received prior to the effective date of coverage.

Aflac will not pay benefits whenever coverage provided by the policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.

Aflac will not pay benefits whenever fraud is committed in making a claim under this coverage or any prior claim under any other Aflac coverage for which you received benefits that were not lawfully due and that fraudulently induced payment.

The policy does not cover losses caused by or resulting from:

- Being pregnant or giving birth within the first ten months of the effective date of coverage (complications of pregnancy will be covered to the same extent as a sickness);
- Receiving routine nursing or routine well-baby care for a newborn child (other than provided by the Physician Visit Benefit);
- Using hallucinatory drugs, or voluntary inhalation of gas;
- Participating in, or attempting to participate in, an illegal activity that is defined as a felony (*felony* is as defined by the law of the jurisdiction in which the activity takes place);
- Being intoxicated or under the influence of any controlled substance, unless administered on the advice of a physician (the term *intoxicated* refers to that condition as defined by the law of the jurisdiction in which the cause of the loss occurred);
- Intentionally self-inflicting a bodily injury, or committing or attempting suicide, while sane or insane;
- Having dental treatment except as a result of accidental injury;
- Having cosmetic or elective surgery that is not medically necessary;
- Being exposed to war or any act of war, declared or undeclared, or actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve;
- Donating an organ within the first 12 months of the effective date of coverage;
- Having mental or emotional disorders, including but not limited to the following: bipolar affective disorder (manic-depressive syndrome), delusional (paranoid) disorders, psychotic disorders, somatoform disorders (psychosomatic illness), eating disorders, schizophrenia, anxiety disorders, depression, stress, or post-partum depression. The policy will pay, however, for covered losses resulting from Alzheimer's disease, or similar forms of senility or senile dementia, first manifested while coverage is in force.

An ambulatory surgical center does not include a physician's or dentist's office, a clinic, or other such location.

Complications of pregnancy do not include any of the following: premature delivery, multiple gestation pregnancy, false labor, occasional spotting, prescribed rest during pregnancy, morning sickness, and similar conditions associated with the management of a difficult pregnancy not constituting a classifiably distinct pregnancy complication. Cesarean deliveries are not considered complications of pregnancy.

The term *hospital* does not include any institution or part thereof used as an emergency room; a rehabilitation facility; a hospice unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; a psychiatric unit; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial or educational care, care or treatment for persons suffering from mental disease or disorders, care for the aged, or care for persons addicted to drugs or alcohol. Benefits for confinement in a rehabilitation facility are payable under the Rehabilitation Facility Benefit.

The term *hospital emergency room* does not include urgent care centers.

Benefits are not payable for confinement in a hospital intensive care unit under the Hospital Intensive Care Unit Confinement Benefit for confinement in units such as telemetry or surgical recovery rooms, postanesthesia care units, progressive care units, intermediate care units, private monitored rooms, observation units located in emergency rooms or outpatient surgery units, step-down intensive care units, or other facilities that do not meet the standards for a hospital intensive care unit.

A physician does not include you or a member of your extended family, or anyone who normally resides in your home or residence.

The term *rehabilitation facility* does not include a hospice unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; a psychiatric unit; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial or educational care, care or treatment for persons suffering from mental disease or disorders, care for the aged, or care for persons addicted to drugs or alcohol.

ILLEGAL OCCUPATION: Aflac shall not be liable for any loss to which a contributing cause was the covered person's commission of or attempt to commit a felony or to which a contributing cause was the covered person's being engaged in an illegal occupation.

INTOXICANTS AND NARCOTICS: Aflac shall not be liable for any loss sustained or contracted in consequence of the covered person's being intoxicated or under the influence of any narcotic, unless administered on the advice of a physician.

PRE-EXISTING CONDITION LIMITATIONS: A *pre-existing condition* is an illness, disease, infection, disorder, or injury for which, within the 12-month period before the effective date of coverage, prescription medication was taken or medical testing, medical advice, consultation, or treatment was recommended or received from a physician. Care or treatment caused by a pre-existing condition will not be covered unless it begins more than 12 months after the effective date of coverage.

TERMS YOU NEED TO KNOW

ACCIDENTAL INJURY: a bodily injury caused directly by an accident, independent of sickness, bodily infirmity, or any other cause, occurring on or after the effective date of coverage and while coverage is in force. See the Limitations and Exclusions section for injuries not covered by the policy.

COVERED PERSON: any person insured under the coverage type that you applied for on the application: individual (named insured listed in the Policy Schedule), named insured/spouse only (named insured and spouse), one-parent family (named insured and dependent children), or two-parent family (named insured, spouse, and dependent children). *Spouse* is defined as the person to whom you are legally married and who is listed on your application. This includes the relationship created by a domestic partnership. Newborn children are automatically insured from the moment of birth. If coverage is for individual or named insured/spouse only and you desire uninterrupted coverage for a newborn child, you must notify Aflac in writing within 31 days of the child's birth, and Aflac will convert the policy to one-parent family or two-parent family coverage and advise you of the additional premium due. Coverage will include any other dependent child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who became so incapacitated prior to age 26 and while covered under the policy. *Dependent children* are your natural children, stepchildren, or legally adopted children who are under age 26.

EFFECTIVE DATE: the date(s) coverage begins as shown in the Policy Schedule or on any attached endorsements or riders. The effective date is not the date you signed the application for coverage.

GUARANTEED-RENEWABLE: the right to renew the policy by payment of the premium due on or before the renewal date. The policy is guaranteed-renewable for your lifetime, subject to Aflac's right to change premiums by class upon any renewal date.

HOSPITAL CONFINEMENT: a stay of a covered person confined to a bed in a hospital for 23 or more hours for which a room charge is made. The hospital confinement must be on the advice of a physician, medically necessary, and the result of a covered sickness or accidental injury. The term *hospital confinement* does not include emergency rooms.

PERIOD OF HOSPITAL CONFINEMENT: the number of days a covered person is assigned to and incurs a charge for a bed in a hospital. Confinements must begin while coverage under the policy is in force. Covered confinements not separated by 90 days or more from a previously covered confinement are considered a continuation of the previous period of hospital confinement. Hospitalization that begins prior to the end of one calendar year and continues into the next calendar year will be considered one confinement.

PERIOD OF HOSPITAL INTENSIVE CARE UNIT CONFINEMENT: the number of days a covered person is assigned to and incurs a charge for a bed in a hospital intensive care unit. Confinements must begin while coverage under the policy is in force. Covered confinements not separated by 90 days or more from a previously covered confinement are considered a continuation of the previous period of hospital intensive care unit confinement. Hospitalization that begins prior to the end of one calendar year and continues into the next calendar year will be considered one confinement.

PREMIUMS.

	Annual	Semiannual	Quarterly	Monthly
Policy:	$_____	$_____	$_____	$_____

SICKNESS: an illness, disease, infection, or disorder, independent of injury, medically evaluated, diagnosed, or treated by a physician after the effective date of coverage and while coverage is in force.

Bi-Weekly Premium Rates

Hospital Advantage

Premiums

Coverage	Age	Premium	Total
INDIVIDUAL	18-64	$18.66	$18.66
INSURED/SPOUSE	18-64	$29.88	$29.88
ONE PARENT FAMILY	18-64	$27.24	$27.24
TWO PARENT FAMILY	18-64	$34.08	$34.08

Notices

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment‑based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after- tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Nicole Arvizu .

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

1 An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

Employer Name: Agility Fuel Systems, Inc.		Employer Identification Number (EIN) 27-3945150	
Employer Address: 1815 E. Carnegie Ave.		Employer Phone Number: 949-267-7735	
City: Santa Ana		State: CA	Zip Code: 92705
Who can we contact about employee health coverage at this job? Nicole Arvizu			
Phone Number (if different from above)	Email Address: narvizu@agilityfs.com		

Here is some basic information about health coverage offered by this employer: As an employer, we offer a health plan to

√ Some employees. Eligible employees are:

Full-time employees working at least 30 hours per week

With respect to dependents:

√ We do offer coverage. Eligible dependents are:

Legal spouse or common law spouse (in approved states) or domestic partners and dependent children to age 26

√ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

Important Notice from Agility Fuel Systems, Inc.
About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Agility Fuel Systems, Inc. and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Agility Fuel Systems, Inc. has determined that the prescription drug coverage offered by the BlueCross BlueShield of TN is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If you Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Agility Fuel Systems, Inc. coverage will not be affected. You can keep this coverage if you elect Part D and this plan will coordinate with Part D. See pages 7-9 of the CMA Disclosure of Creditable Coverage to Medicare Part D Eligible Individuals Guidance (available at http://www.com.hhs.gov/CreditableCoverage/) which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Agility Fuel Systems, Inc. and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact your plan administrator, Nicole Arvizu at 949-267-7735. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Agility Fuel Systems, Inc. changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage …

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

CMS Form 10182-CC Updated April 1, 2011