Limited Partnership Benefits Endorsed by:

INTEGRATED INSURANCE PARTNERS

WHERE GREAT IDEAS COME TOGETHER

America's Consumers & Affiliates

BENEFITS

2021 Enrollment Guide

Coverage Made Easy

The America's Consumer's and Affiliates Limited Partnership is an opportunity for partners to earn a secondary income from online marketing programs and receive access to voluntary benefits. How it Works: Partners share specific browsing habits (Legend Browsing App for smartphones or Chrome or Firefox browsers) that are anonymous and secure that are limited to: website visited, time of visit and duration. Partners can provide 500 hours of service annually to be an active partner. In addition, your Partnership provides access to established Voluntary Insurance Benefits with National "A" Rated insurance carriers, in which you and your family may participate.

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SelectMed

Medical Options

SelectMed

	SelectMed Base	SelectMed Pro	SelectMed Max
Evidence of insurability	**Guaranteed Acceptance**	**Guaranteed Acceptance**	**Guaranteed Acceptance**
PPO Network	First Health®		
Deductible	**In-Network Provider (No Out of Network Coverage)**	**In-Network Provider (No Out of Network Coverage)**	**In-Network Provider (No Out of Network Coverage)**
Individual	n/a	n/a	$2,000
Family	n/a	n/a	$4,000
Out-of-Pocket Maximum	**In-Network Provider (No Out of Network Coverage)**	**In-Network Provider (No Out of Network Coverage)**	**In-Network Provider (No Out of Network Coverage)**
Individual	n/a	$8,150	$8,150
Family	n/a	$16,300	$16,300
SelectMed Medical Services	**In-Network Provider (No Out of Network Coverage)**	**In-Network Provider (No Out of Network Coverage)**	**In-Network Provider (No Out of Network Coverage)**
MedCall Now	Included (No Copay)	Included (No Copay)	Included (No Copay)
Preventative & Wellness*	100% Covered in Network-No copay and No deductibles		
Primary Care Visit to Treat Injury or Illness	Not Covered	$25.00 Copay Max 5 Visits Per Calendar Year [1]	$25.00 Copay per visit
Specialist Visit		$25.00 Copay Max 5 Visits Per Calendar Year [1]	$50.00 Copay per visit
Outpatient Diagnostic Test (X-Ray, Blood Work)		$25.00 Copay Max 5 Tests Per Calendar Year	$50.00 Copay per test
Prescription Benefit	No Copay for ACA Compliant covered prescription drugs	No Copay for ACA Compliant covered prescription drugs	No Copay for ACA Compliant covered prescription drugs
	Not Covered	20% Copay-Generic Only 12 Prescriptions Maximum 30 day supply Maximum	Brand/Generic, $10 Formulary Generic / $50 Formulary Brand; Mail $30 Formulary Generic / $150 Formulary Brand, $750 Per Primary / $1,500 Per Family Annual Maximum [2]
Urgent Care		$25.00 Copay Max 5 Visits Per Calendar Year [1]	$50.00 Copay per visit
Outpatient CT/MRI/Pet Scans		Not Covered	50% Coinsurance per test [3] Subject to deductible
Outpatient Services: Mental Health, Behavioral Health or Substance Abuse Services			$50.00 Copay per visit
Rehabilitation Services & Habilitation Services			$50.00 Copay per visit Combined limit for all therapies of 20 visits per plan year
Monthly Rates			
Primary	$84.78	$116.71	$207.25
Primary + Spouse	$139.69	$183.85	$346.11
Primary + Child	$130.12	$176.99	$354.87
Family	$184.03	$237.98	$516.17

Not available in Alaska, Hawaii, Massachusetts, and New Hampshire.
1. Combined 5 visits per year includes Primary Care Visit to Treat Injury or Illness, Specialist Visit and Urgent Care Visit.
2. The prescription provided by DataRx is not available in NY, SD, and WA. In the states noted, $20 co-pay generic only, 30 day supply max.
3. Pre-authorization required.
This plan is ACA Compliant. For additional information, visit: https://www.healthcare.gov/coverage/preventive-care-benefits/ as benefits are subject to change. Or reference the Summary Plan Document for a list of Wellness & Preventative services offered In-Network.
First Health is a brand name of First Health Group Corp., an indirect, wholly-owned subsidiary of Aetna Inc.

SelectMed: 2-5-21

Hospitalization Buy-Up for SelectMed Pro and Max Plans

The More You Know

This Plan covers limited inpatient hospital care in accredited hospitals for each enrolled participant. Coverage includes inpatient surgery, but not outpatient or elective surgeries. This Plan does not cover out of network services. This Plan is not subject to the Patient Protection and Affordable Care Act.

Hospitalization Buy-Up to SelectMed Pro/Max Plans	
Evidence of insurability	Guaranteed Acceptance
Annual Plan Year Limit	Choose $50,000 or $100,000 Per Participant
Participant Coinsurance	0%
TPA	HMA, LLC
PPO Network	First Health Network
Network Coverage	In-Network Only
Plan Provisions	Participating Providers (No Out-of-Network Providers)
Inpatient Hospital Benefits including MHSA (Mental Health and Substance Abuse)	$5,000 Deductible, then 0% Coinsurance
Limitations & Exclusions	Outpatient or elective surgery not covered. Pre-existing conditions within past twelve months excluded.

Monthly Rates				
$50,000 Plan	**Primary**	**Primary + Spouse**	**Primary + Child(ren)**	**Family**
Ages 18-34	$87.00	$131.00	$135.00	$195.00
Ages 35 - 64	$117.00	$193.00	$189.00	$279.00
$100,000 Plan	**Primary**	**Primary + Spouse**	**Primary + Child(ren)**	**Family**
Ages 18-34	$122.95	$217.08	$199.97	$294.10
Ages 35 - 64	$151.18	$276.78	$253.95	$379.54

The Hospitalization buy-up plan is available for purchase with SelectMed Pro or SelectMed Max.

SelectMed Metallic Plan Options

SelectMed Metallic Plan Options		SelectMed Bronze	SelectMed Silver
Evidence of insurability		**Guaranteed Acceptance**	**Guaranteed Acceptance**
PPO Network		PHCS Practitioner and Ancillary	
Deductible		**In Network Participating Providers (No Out of Network Coverage)**	**In Network Participating Providers (No Out of Network Coverage)**
Individual		$0	$0
Family		$0	$0
Out-of-Pocket Maximum		**In Network Participating Providers (No Out of Network Coverage)**	**In Network Participating Providers (No Out of Network Coverage)**
Individual		$8,150	$5,000
Family		$16,300	$10,000
Medical Services		**In Network Participating Providers (No Out of Network Coverage)**	**In Network Participating Providers (No Out of Network Coverage)**
PHYSICIAN SERVICES			
Primary Care Office Visit	Non-Hospital Based	$25 Copay *(Limited to 8 visits per calendar year)*	$15 Copay *(Limited to 10 visits per calendar year)*
	Hospital Based	Not Covered-100% paid by Member	
Specialist Office Visit	Non-Hospital Based	$50 Copay *(Limited to 8 visits per calendar year)*	$25 Copay *(Limited to 10 visits per calendar year)*
	Hospital Based	Not Covered-100% paid by Member	
Urgent Care		$50 Copay *(Limited to 2 visits per calendar year)*	$35 Copay *(Limited to 3 visits per calendar year)*
Telemedicine Services		$0	$0
PREVENTIVE & WELLNESS SERVICES			
(Non-Hospital Based)		$0 Copay *(Plan pays 100% of covered preventive and wellness services)*	
(Hospital Based)		Not Covered - 100% paid by Member	
HOSPITAL/FACILITY SERVICES (Subject to Referenced Based Pricing)			
Inpatient Hospitalization		$350 Copay per admission *(Limited to 5 days per calendar year)*	$350 Copay per admission *(Limited to 7 days per calendar year)*
Inpatient Visits - Physician		Included in Inpatient Hospitalization Copay *(Limited to visits up to 5 days per calendar year)*	Included in Inpatient Hospitalization Copay *(Limited to visits up to 7 days per calendar year)*
Inpatient Surgery[2]		Included in Inpatient Hospitalization Copay *(Second surgical opinion may be required; Limited to 2 surgeries per calendar year)*	Included in Inpatient Hospitalization Copay *(Second surgical opinion may be required; Limited to 3 surgeries per calendar year)*
Outpatient Hospital or Free Standing Facility Services and Surgery[2]		$350 Copay *(Limited to 1 visit per calendar year)*	$350 Copay *(Limited to 2 visit per calendar year)*
Anesthesia		Included in Inpatient Hospitalization or Outpatient Hospital or Free Standing Facility Services and Surgery Copay *(Limited to 2 inpatient and 1 outpatient anesthetic procedures per calendar year)*	Included in Inpatient Hospitalization or Outpatient Hospital or Free Standing Facility Services and Surgery Copay *(Limited to 3 inpatient and 2 outpatient anesthetic procedures per calendar year)*
Emergency Room Services		$350 Copay *(Limited to 1 visit per calendar year)*	
DIAGNOSTIC SERVICES			
Laboratory Services	Non-Hospital Based	$50 Copay *(Combined limit of 3 visits per calendar year with Radiology)*	
	Hospital Based	Not Covered - 100% paid by Member	
Radiology	Non-Hospital Based	$50 Copay *(Combined limit of 3 visits per calendar year with Laboratory Services)*	
	Hospital Based	Not Covered - 100% paid by Member	
CT/MRI/MRA/PET Scan	Non-Hospital Based[2]	$350 Copay *(Subject to RBP)* *(Limited to 1 per calendar year.)*	$350 Copay *(Subject to RBP)* *(Limited to 2 per calendar year.)*
	Hospital Based	Not Covered - 100% paid by Member	Not Covered - 100% paid by Member

SelectMed Metallic Plan Options

		SelectMed Bronze	SelectMed Silver
PREGNANCY BENEFITS			
Professional Services		Not Covered - 100% paid by Member	$350 Copay
Childbirth/Delivery (Considered Inpatient Hospital Stay)		Not Covered - 100% paid by Member	$350 Copay per admission *(Subject to RBP)*
OTHER SERVICES			
Allergy Services (Included in Primary Care Office Visit or Specialist Office Visit limits. The copay applies to the administration of the allergy service and is separate from the copay for the office visit)		$25 Copay	
Home Health Care		$25 Copay *(Limited to 10 visits per calendar year)*	$25 Copay *(Limited to 15 visits per calendar year)*
Treatment for Chemical Abuse & Dependency[2]	In-Patient	$250 Copay per day *(Subject to RBP) (Limited to 5 days per calendar year)*	$250 Copay per day *(Subject to RBP) (Limited to 7 days per calendar year)*
	Out-Patient	$25 Copay per day *(Limited to 5 days per calendar year)*	$25 Copay per day *(Limited to 7 days per calendar year)*
Rehabilitation/Habilitation Services		Not Covered - 100% paid by Member	
Emergency Medical Transportation		$250 Copay *(Subject to RBP) (By land only; Limited to 1 transport per calendar year)*	
PHARMACY BENEFITS		**Participating Pharmacies**	
Preventive Prescriptions - (Subject to Formulary)			
Pharmacy Retail – up to a 30 day supply		Generic - $0 Copay *(Limited to Preventive Generic)*	
Non-Preventive Prescriptions - (Subject to Formulary)			
Prescription Benefit		Brand/Generic, $10 Formulary Generic $50 Formulary Brand; Mail $30 Formulary Generic $150 Formulary Brand, $750 Per Primary $1,500 Per Family Annual Max[1]	
Monthly Rates		**SelectMed Bronze**	**SelectMed Silver**
Individual		$487.89	$589.48
Individual + Spouse		$853.26	$1,016.37
Individual + Child		$880.90	$1,047.49
Family		$1,308.36	$1,588.64

Not available in Alaska, Hawaii, Massachusetts, and New Hampshire.
Reinsurance coverage is provided through Providence Insurance Company II
1. The prescription provided by DataRx is not available in NY, SD, and WA.
For additional information reference the Summary Plan Document for a list of services offered In-Network.
To find a provider through the PHCS Practitioner and Ancillary: https://www.multiplan.com/webcenter/portal/ProviderSearch

SelectMed Metallic Plan Options

Preventive Health Services: Limitations, Intervals, and Requirements[1]

The following table represents the preventive services currently covered under the SelectMed Bronze and SelectMed Silver™ Plans as well as the permitted interval and any requirements of such preventive services.

Benefits are automatically subject to 29 CFR § 2590.715 -2713(a). Amendments to this section through legislative act or regulation are automatically incorporated into this document by reference. Preventive Services covered in this section are explained in more detail through the following official resources:

- Medical services with a rating of "A" or "B" from the current recommendations of the United States Preventive Services Task Force. See https://www.uspreventiveservicestaskforce.org
- Preventive care and screenings for infants, children, and adolescents provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. Guidelines can be found in https://www.hrsa.gov
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention for certain individuals only. See https://www.cdc.gov/vaccines/acip

Preventative and Wellness Services - Covered Benefits

Adults
- Adult Annual Standard Physical
- Alcohol Misuse: Unhealthy Alcohol Use Screening and Counseling
- Aspirin: Preventive Medication
- Blood pressure screening
- Breastfeeding interventions
- Chlamydia screening
- Colorectal Cancer Screening
- Dental cavities prevention: infants and children up to age 5 years
- Depression Screening
- Diabetes Screening
- Fall Prevention: Older Adults
- Healthy Diet and Physical Activity Counseling to Prevent Cardiovascular Disease
- Hemoglobinopathies screening
- Hepatitis B screening
- Hepatitis C virus (HCV) infection screening: born between 1945 and 1965.
- High Blood Pressure Screening
- HIV Preexposure Prophylaxis for the Prevention of HIV Infection
- HIV Screening
- Hypothyroidism screening
- Lung Cancer Screening
- Obesity screening and Counseling
- Sexually Transmitted Infections Counseling
- Skin Cancer Behavioral Counseling
- Statin Preventive Medication
- Tobacco Use Counseling and Interventions
- Syphilis Screening

Men
- Abdominal aortic aneurysm screening

Women
- Aspirin: Preventive Medication
- BRCA risk assessment and genetic counseling/ testing
- Breast Cancer Preventive Medications
- Breast Cancer Screening
- Cervical Cancer Screening: with Cytology (Pap Smear) Lung cancer screening
- Chlamydia Screening
- Contraceptive Methods and Counseling
- Folic Acid Supplementation
- Gonorrhea Screening
- Intimate Partner Violence Screening
- Osteoporosis Screening
- Well-Woman Visits

Pregnant Women
- Bacteriuria Screening
- Breastfeeding Support, Supplies and Counseling
- Depression Screening
- Gestational Diabetes Mellitus Screening
- Hepatitis B Screening
- HIV Screening
- Preeclampsia Screening
- Rh Incompatibility Screening: First Pregnancy Visit
- RH Incompatibility Screening: 24–28 Weeks' Gestation
- Syphilis Screening
- Tobacco Use Counseling and Interventions

Newborns
- Gonorrhea Prophylactic Medication
- Hemoglobinopathies Screening
- Hypothyroidism Screening
- Phenylketonuria Screening

Infants
- Dental Caries Prevention: Infants and Children Up to Age 5

Children
- Dental Caries Prevention: Infants and Children Up to Age 5
- Obesity screening and Counseling
- Skin Cancer Behavioral Counseling
- Tobacco Use Counseling and Interventions
- Vision Screening: Age 3 to 5
- Well-Child Visits

Adolescents
- Depression Screening
- Hepatitis B Screening
- HIV Screening
- Obesity screening and Counseling
- Sexually Transmitted Infections Counseling
- Skin Cancer Behavioral Counseling
- Tobacco Use Counseling and Interventions

Multiple Populations
- Tuberculosis Screening: all populations at risk
- Skin Cancer Behavioral Counseling: young adults, adolescents, children, and parents of young children

***See Schedule of Benefits for Limitations, Intervals and Requirements.**

Vaccines

IMMUNIZATIONS - recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention for routine use in children, adolescents, or adults*

Adults 19 Years or Older	Children From 7 Through 18 Years Old	Birth Through 6 Years Old
• IIV • RIV • LAIV • Tdap • MMR • VAR • RZV • ZVL • HPV - Female • HPV- Male • PCV13 • PPSV23	• Flu • Tdap • HPV • MenACWY • MenACWY	• HepB • DTaP • Hib • PCV13 • IPV • Flu • MMR • VAR • HepA • RV

1. None of the Preventive Health Services are covered if they are provided at a hospital.

* Immunization illustrations listed herein are based upon CDC recommendations contained in the following schedules: (i) Recommended Child and Adolescent Immunization Schedule (available at: https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html), and (ii) Recommended Adult Immunization Schedule (available at: https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html). Additional immunization scenarios not included in the aforementioned illustrations (such as catch-up immunization recommendations, immunization recommendations for certain high-risk groups, and immunization recommendations subject to individual clinical decision-making) may also be covered under this Plan pursuant to CDC recommendation. Information concerning these additional covered immunization scenarios (including vaccine type, age requirements, and frequency) is available online under the CDC schedule links listed above. Paper copies of these CDC schedules can also be obtained free of charge by written request to the Plan Administrator.

This plan is ACA Compliant. For additional information, visit: https://www.healthcare.gov/coverage/preventive-care-benefits/ as benefits are subject to change. Or reference the Summary Plan Document for a list of Wellness & Preventative services offered In-Network.

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Additional Options

Plans for Enhanced Coverage

Dental Insurance

Plan Maxes		Basic	Preferred
Annual Maximum		$500/yr	$1,000/yr
Plan Deductible		**Basic**	**Preferred**
Deductible		$50 Annual	$50 Annual
Deductible Limit		Max 3 per family	Max 3 per family
Services*	**Plan Coverage**	**Basic**	**Preferred**
Preventive Services	• Cleanings • Exams • Oral Cancer Screening (age 40+) • Radiographs - Bitewings • Radiographs - FMX • Fluoride (under age 16) • Sealants (under age 16) • Space Maintainers (under age 16)	Plan Pays 100% Deductible Waived	Plan Pays 100% Deductible Waived
Basic Services	• Emergency Pain • Restorations (Amalgams & Anterior Resin) • Restorations (Posterior Resin) • Crown Repairs • Bridge Repairs • Denture Repairs	Plan Pays 80%	Plan Pays 80%
Major Services[1]	• Simple Extractions • Surgical Extractions • Oral Surgery • Endodontics • Periodontal Maintenance • Non-Surgical Periodontics • Surgical Periodontics • Inlays • Onlays • Crowns • Bridges • Dentures • Implants • Anesthesia	Plan Pays 0%	Plan Pays 50%

Plan Tier	Primary	Primary + Spouse	Primary + Child(ren)	Family
Basic	$15.89/mo	$27.97/mo	$34.12/mo	$49.58/mo
Preferred	$22.30/mo	$40.79/mo	$42.77/mo	$65.06/mo

1. 12 month waiting period on Major services

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The information on this sheet is a brief summary of your dental plan and the services it covers. There are some limitations on the expenses for which your dental plan pays. If you have specific questions regarding benefit coverage, limitations, exclusions, or non-covered services, please refer to your certificate of coverage/dental benefit booklet or contact BrightBenefits.

Eligible partners must be working a minimum of 20 hours per week to qualify for insurance. Rates include insurance premiums and administrative fees for continuation, enrollment and marketing.

DENTPROP20

Vision Insurance

Benefit	Description	Copay	Frequency
Eye Exam	Focuses on your eyes, vision and wellness	$10	Every 12 months
Frame	Pay no more than $25 for Exclusive Collection frames at participating locations or $130 frame allowance at network locations or $180 frame allowance at Visionworks [1] Plus 20% off any amount over your allowance [2]	Included	Every 24 months
Lenses and enhancements[3]	Clear plastic single -vision, bifocal, trifocal or lenticular lenses Polycarbonate Lenses for dependent children Tinting of Plastic Lenses Scratch-Resistant Coating	$25	Every 12 months
Lens upgrades[3]	Polycarbonate lenses for adults	$30	Every 12 months
	High-Index Lenses 1.67	$55	
	High-Index Lenses 1.74	$120	
	Polarized Lenses	$75	
	Progressive Lenses (Standard / Premium / Ultra / Ultimate)	$50 / $90 / $140 / $175	
	Anti-Reflective (AR) Coating (Standard / Premium / Ultra / Ultimate)	$35 / $48 / $60 / $85	
	Ultraviolet Coating	$12	
	Plastic Photochromic Lenses (Transitions® Signature™)	$65	
	Premium Scratch -Resistant Coating	$30	
	Scratch-Protection Plan (Single -Vision / Multifocal)	$20 / $40	
	Digital Single Vision Lenses	$30	
	Trivex Lenses	$50	
	Blue Light Filtering	$15	
Prescription contacts [4] (instead of glasses)	15% off fitting, evaluation and follow-up $130 allowance for contacts Plus 15% off any amount over your allowance[2]		Every 12 months

Extra member savings (not insured benefits)

- 15% off standard laser vision correction or 5% off promotional prices at LasikPlus® locations nationwide.
- No more than $39 on routine retinal imaging as an enhancement to an eye exam .
- 30% off additional pairs of eye glasses.[2]
- Free 1-yr. breakage warranty on your glasses - limitations apply.

Out-of-network coverage

Exam.....$40	Single vision lenses.....$40	Trifocal lenses.....$80	Elective contacts.....$105
Frame.....$50	Bifocal/Progressive lenses.....$60	Lenticular lenses.....$100	Visually required contacts....$225

Vision Rates			
Primary	Primary + Spouse	Primary + Child(ren)	Family
$10.22/mo	$16.76/mo	$18.42/mo	$25.22/mo

1. Excludes Maui Jim® eyewear.
2. Some limitations apply to additional discounts; discounts not applicable at all in-network providers.
3. Spectacle lens options may not be available at all locations.
4. Contact lens coverage varies by product selection. Visually Required contacts are covered in full with prior approval. Davis Vision has done its best to accurately reflect plan coverage herein. If differences exist between this document and the plan contract, the contract will prevail. Products may vary by state.

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Eligible partners must be working a minimum of 20 hours per week to qualify for insurance. Rates include insurance premiums and administrative fees for continuation, enrollment and marketing.

NVIGRP-DV 2019| BVPROP20

Boston Mutual Accident Insurance

Eligibility And Key Features	
Coverage	Off the Job Accidents
Eligibility	All partners ages 18-70 and working a minimum of 20 hours a week are eligible for participation in the Accident Insurance plan; an enrolled partner may also insure their spouse* (ages 18-70). Children under the age of 26 are also eligible regardless of marital or dependency status.
Guaranteed Renewable	Coverage is guaranteed renewable for life as long as premiums are paid.
Policy Benefits	All benefits are limited to one benefit per covered accident, per insured, and are paid independently of one another unless specifically noted otherwise.
Portability	This policy is fully portable at the same rate and can be paid for directly if employment changes.
Policy Highlights	**Benefits**
Ambulance	**$500 benefit** for Air Ambulance: Within 48 hours after the covered accident. **$100 benefit** for Ground Ambulance: Within 90 days after the covered accident.
Appliance	**$100 benefit** within 90 days after the covered accident. For personal locomotion or mobility.
Blood, Plasma, Platelets	**$300 benefit** within 90 days after the covered accident.
Burns	**$750 to $10,000 benefit** when treated by a physician within 72 hours after the covered accident. Scheduled amount based on degree of burn. Skin grafts are 25% of the burn benefit.
Concussion	**$100 benefit** if diagnosed by a physician within 72 hours after the covered accident.
Dislocations (Separated Joint)	**$50 to $8,000 benefit** based on the type of surgery and joint involved.
Emergency Dental Work	**$50 to 150 benefit** based on whether tooth is extracted or crowned.
Emergency Room Treatment	**$50 benefit** if examination and treatment within 72 hours after the covered accident.
Eye Injury	**$200 benefit** for eye injury within 90 days after the covered accident.
Follow-Up Physician Treatment	**$50 benefit** within 90 days of the covered accident.
Fractures	**$25 to $10,000 benefit** based on the type of surgery and bone involved.
Hospital Admission	**$1,000 benefit** within 6 months after the covered accident. ($2,000 if immediately admitted into Intensive Care Unit)
Hospital Confinement	**$250 per day** up to 365 days within 6 months after the covered accident.
Hospital Intensive Care	**$500 per day** up to 30 days. The confinement must begin within 30 days after the covered accident.
Initial Physician's Office/ Urgent Care Visit	**$50 benefit** within 60 days after the covered accident.
Laceration	**$25 to $400 benefit** if repaired by a physician within 72 hours after the covered accident. Paid based on the total length of all lacerations received in any one covered accident.
Lodging	**$100 per night** up to 30 days per covered accident. Hospital must be more than 100 miles from the insured person's residence.
Major Diagnostic Exams	**$150 benefit** per calendar year for CT scan, MRI or EEG as the result of a covered accident.
Physical Therapy	**$25 per day** with a maximum of 6 days. Within 6 months of covered accident.
Prosthetic Device/Artificial Limb	**$500 to $1,000 benefit** within 1 year of the covered accident.
Rehabilitation Unit	**$150 per day** when confined in a rehab unit following hospitalization. Up to 30 days.
Ruptured Disc	**$400 benefit** when treated by a physician within 60 days after the covered accident and repaired through surgery within 1 year after the covered accident.
Surgery (Abdominal or thoracic)	**$1,000 benefit** within 72 hours after the covered accident. Benefit is $100 if exploratory surgery with no repair. Hernia repair will not be covered.
Tendon, Ligament, Rotator Cuff	**$150, $600 or $900 benefit** when repaired within 90 days after the covered accident. The benefit is based on the number of repairs needed and repaired through surgery.
Torn Knee Cartilage	**$750 benefit** when treated by a physician within 60 days and repaired through surgery within 6 months after the covered accident. Benefit is $150 if exploratory arthroscopic surgery with no repair.
Transportation	**$300 benefit per round trip** up to 3 round trips per covered accident. For treatment more than 100 miles round-trip from your home.

Boston Mutual Accident Insurance

Accidental Death and Dismemberment	
Accidental Death	Within 90 days from the date of a covered accident. • **$100,000** for Partner • **$100,000** for Spouse • **$20,000** for Children
Dismemberment Benefit	Benefit is paid based on the number of limbs lost and/or the specific limb(s) lost. • **$1,500 to $30,000 benefit** for Loss of Finger, Toe, Hand, Foot or Sight of Eye (schedule amount depending on loss)
Included Benefit Riders	
Enhanced Emergency Room Benefit Rider	We will pay an additional $100 benefit amount when an insured person is treated in a hospital emergency room within 72 hours after the covered incident. This amount is paid in addition to the base policy Emergency Room benefit of $50.
Wellness Benefit Rider	We will pay $50 for any one of the following health screening tests listed below performed by a Physician more than 30 days after the Rider Effective Date. Payable only once per calendar year per insured person. This benefit is not payable for health screening tests performed in the Emergency Room of a hospital. (Missouri - the 30 days does not apply) (District of Columbia - This Rider is not available)
	• Blood test for triglycerides • Bone marrow testing • Breast ultrasound • C-Reactive Protein • CA 15-3 (blood test for breast cancer) • CA 125 (blood test for ovarian cancer) • CEA (blood test for colon cancer) • Chest X-ray • Colonoscopy • Electron Beam Tomography • Fasting blood glucose test • Flexible Sigmoidoscopy • Hemocult stool analysis • Homocysteine level • Mammography • PSA (blood test for prostate cancer) • Pap Smear • Serum cholesterol test to determine level of HDL/LDL • Serum Protein Electophoresis (blood test for myeloma) • Stress test on a bicycle or treadmill • Thermography
	Wellness Benefit Rider Exclusions: CT, DC, GA, MA, NH, NY, OR, PA, VT, VA, WA.

Call for a personalized quote!

All benefits are subject to limitations as explained in the policy. They are payable once per covered accident and treatment and/or loss must occur within 90 days of the covered accident unless noted otherwise. This brochure provides a general description of the important features of Policy Form WS-ACC 8/08, EER-Rider 08, and WB-Rider 08/08.

This brochure is not the insurance contract and only the actual policy provisions will control. Before purchasing coverage, refer to the Policy or Outline of Coverage for state-specific description of benefit provisions, exclusions and limitations.

*Spouse means a person of the opposite or same sex recognized as the insured's spouse/partner under the laws of the state.

This plan is not available in the following jurisdictions: AK, HI, MN, NY, and PR. The benefits in this plan may vary by state.

Eligible partners must be working a minimum of 20 hours per week to qualify for insurance. Rates include insurance premiums and administrative fees for continuation, enrollment and marketing.

Boston Mutual Accident Coverage

EXCLUSIONS – WHAT WE WILL NOT PAY FOR:

1. practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received; *(Illinois - this exclusion does not apply)*
2. having any sickness or declining process caused by a sickness, including physical or mental infirmity. We also will not pay benefits to diagnose or treat the sickness. Sickness means any illness, infection, disease or any other abnormal physical condition which is not caused by any Injury; *(West Virginia - Sickness means any illness, infection, disease or any other abnormal physical condition which is not caused by any Injury; Any infection caused by an accidental injury will be a covered loss. Ptomaine poisoning will also be a covered loss)*; *(North Carolina - Sickness means any illness, infection, disease or any other abnormal physical condition which is not caused by any Injury, except Sickness does not include accidental ptomaine poisoning, bacterial infection resulting from accident injury, the involuntary inhalation of gas and fumes, the involuntary taking of poison or involuntary exposure to hazardous waste or other toxins or to nuclear energy, elements or explosion);*
3. intentionally self-inflicted Injury;
4. committing suicide or attempted suicide, while sane or insane; *(Missouri - committing suicide or attempted suicide)*
5. receiving injuries due to an act of declared or undeclared war;
6. actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or any Military Reserve;
7. driving any taxi for wage, compensation, or profit;
8. having Mental or Nervous Disorders; *(Arkansas - having Mental or Emotional Disorders)*
9. suffering from alcoholism or drug addiction;
10. suffering from a loss sustained or contracted as the result of being physically or mentally impaired due to being under the influence of alcohol or any illicit or Controlled Substance unless administered on the advice of a Physician; "Being under the influence of alcohol", for purposes of this Policy, means a blood alcohol level of 0.08 or more. The Insured Person's alcohol or illicit or Controlled Substance impairment must be the cause or contributing cause of his or her loss, irrespective of whether the loss occurred while the Insured Person was driving a motor vehicle or engaged in any other activity; *(Illinois - the last sentence reads: The Insured Person's alcohol or illicit or Controlled Substance impairment must be the cause of his or her loss, irrespective of the activity that the Insured Person was engaged in when the loss was sustained). (North Dakota - blood alcohol level of .10)*; Nevada - exclusion #10 reads: the voluntary taking of any drug or medication unless prescribed by a licensed physician, or the voluntary taking of any poison; Nevada - exclusion #11 reads: driving or operating a motor vehicle while intoxicated *(intoxication means that your blood alcohol content meets or exceeds the legal presumption of intoxication under the laws of the state where the accident occurred)*;
11. sustaining a loss to which a contributing cause was the commission of or an attempt to commit a felony. Nor will We be liable for any loss to which a contributing cause was being engaged in an illegal activity. *(Nebraska - the last sentence reads: Nor will We be liable for any loss to which a contributing cause was being engaged in an illegal occupation). (Nevada - this is exclusion #12)*; or
12. incurring an injury while the Insured Person is working for pay or profit. *(Kansas - Benefits will not be provided for services or injuries related to your job to the extent you are covered or required to be covered by the Workers' Compensation Law. If you enter into a settlement giving up your right to recover future benefits under a Workers' Compensation law, the policy will not pay those benefits that would have been payable in the absence of that settlement). (Nevada - this is exclusion #13).*

Missouri - NOTE: sickness, *(including but not limited to: pyogenic or bacterial infection, ingestion of poison or drugs taken as prescribed by a physician, and involuntary inhalation of gas)*, which is the direct result of an accidental bodily injury is not excluded from coverage.

Utah - We will not pay benefits for losses that are caused by or are the result of:

1. Aviation;
2. the use of controlled substances or alcohol where that use:
   a. substantially contributes to or causes the loss;
   b. is over the legal limit; or
   c. where the insured was in violation of the law;
3. Losses covered under Medicare or other governmental program, except Medicaid;
4. Felony, riot or insurrection, when the Insured Person is a voluntary participant;
5. Illegal activities, limited to losses related directly to an Insured Person's voluntary participation;
6. Mental or nervous disorders;
7. Service in the armed forces or units auxiliary to it;
8. Suicide, while sane or insane, attempted suicide or intentionally self-inflicted injury;
9. Terrorism, including acts of terrorism or
10. War or acts of war, whether declared or undeclared or
11. incurring an injury while the Insured Person is working for pay or profit.

All benefits are subject to limitations as explained in the policy. They are payable once per covered accident and treatment and/or loss must occur within 90 days of the covered accident unless noted otherwise. This brochure provides a general description of the important features of Policy Form WS-ACC 8/08.

This brochure is not the insurance contract and only the actual policy provisions will control. Before purchasing coverage, refer to the Policy or Outline of Coverage for state-specific description of benefit provisions, exclusions and limitations.

3

Life Insurance

Whole Life

Boston Mutual Whole Life Insurance

GUARANTEED ISSUE UP TO $100,000!

Policy Highlights	Permanent Whole Life Insurance Policy	
Whole Life is more than just life insurance at an affordable price. It combines the guaranteed premiums, coverage and values that have always been so attractive in whole life insurance with the advantages of cash accumulation at current interest rates. This coverage is an endowment at 95 life insurance policy with coverage to age 95.		
Eligibility	Age Partner: Minimum age 18; Max age 70 Spouse[1]: Minimum age 18; Max age 70 Children: Minimum age 15 days; Max age 25	Actively at work a minimum of 20 hours per week for at least 30 days following the date of employment at time of application.
Affordable, Flexible Protection	You choose the amount of insurance that best suits your needs and budget from $5,000 up to $100,000. Guaranteed Issue up to $100,000 for partner and up to $15,000 Guaranteed Issue for spouse. Child coverage is available with the Optional Child Term Rider and partners can choose between $10,000 or $25,000 term coverage for their children.	
Policy Values[2]	As long as premiums are paid, this coverage offers a guaranteed cash value that can grow over the years. While this value can never be less than the guaranteed 3% credited interest rate, this coverage gives the advantage of potential cash values in excess of the guaranteed amount. The current interest rate in effect when the policy is issued is guaranteed for the first year. On each policy anniversary date, the policyholder will receive an annual statement outlining the policy's accumulated value and changes in the interest rate, if any.	
Constant Coverage	Participants are protected worldwide, 24 hours a day. The policy is owned by the partner and supplements any other insurance they may have.	
Portable	The plan remains in force as long as premiums continue to be paid; and the permanent plan premiums cannot be increased. If the partner changes jobs or retires, as long as they continue to pay premiums, the insurance will remain in force without interruption.	
Accidental Death Benefit (ADB)	• The Accidental Death Benefit could double or even triple the death benefit. • This benefit pays an additional amount equal to the basic coverage to the beneficiary if the insured is killed accidentally. If accidental death occurs while the insured is a passenger on a bus, plane, train or any other common carrier, this benefit pays the ADB as above but will also pay an additional benefit of the basic coverage (up to a maximum of $100,000). • Any Basic Plan participant age 5 years through age 60 is eligible for this benefit.	
Optional Riders		
Children's Term Rider	• Rider provides level term coverage for $10,000 or $25,000 for all unmarried, dependent children, ages 15 days – up to and including age 25 years. • Future children will be automatically covered upon the attainment of 15 days with no increase in the premium. • This benefit may be added to any policy issued to a partner or spouse ages 18 to 55.	

Call for a personalized quote!

1. Spouse means a person of the opposite or same sex recognized as the insured's spouse/partner under the laws of the state.
2. The actual cash value may be decreased by loans or withdrawals.
This plan is not available in the following jurisdictions: AK, HI, NY, and PR
Eligible partners must be working a minimum of 20 hours per week to qualify for insurance.