



Medical  
Voluntary GAP  
Dental  
Vision  
Flexible Spending Account  
Basic Life/AD&D  
Voluntary Term Life  
Short Term Disability  
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Long Term Care  
Voluntary Cancer  
Voluntary Critical Illness  
Voluntary 24-Hour Accident

# 2012 EMPLOYEE BENEFITS HANDBOOK



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## Welcome to the Amerisafe Employee Benefits Handbook

The benefits offered to you through your employment with Amerisafe are a valuable part of your compensation program, providing financial security and peace of mind to you and your dependents. This handbook will provide you with vital information you will need to help you maximize your benefits for the upcoming year. Please take the time to review the contents to make sure that you understand what is being offered and what steps you will need to take to make your elections.

### Who is eligible for benefits?

If you are employed with Amerisafe and are over the age of 18, you are eligible for company benefits if you work more than 30 hours per week on a regularly scheduled basis.

*For further information on eligibility for each line of coverage, see the specific coverage sections of this booklet.*



### When do I enroll?

**Existing employees:** For 2012, you will have just one opportunity to enroll during **Open Enrollment** - **October 21<sup>st</sup> through November 21<sup>st</sup>, 2011** (unless you have a qualifying event during the year).

**New hires:** AMERISAFE has a **90-day Waiting Period** with coverage effective the *first day of the month following 90 days*. If the first of the month coincides with the last day of your 90-day Waiting Period, your coverage will be effective that day.

### Can I make changes throughout the year?

No. Once you make your election, you cannot change your election until the following anniversary (January 1, 2013). Exceptions are qualifying events such as termination of employment, marriage, death, divorce, birth of a child, adoption, moving part time to full time or vice versa, spouse's open enrollment, etc.

### How do I notify Amerisafe that I want to make a change to my coverage due to a qualifying event?

Qualifying changes may be made by advising Amerisafe's Benefits Department of the event and providing any necessary documentation within 31 days of the event.

### What benefits are deducted from my paycheck on a pre-tax basis?



- Medical
- Voluntary GAP
- Dental
- Vision
- Voluntary Cancer
- Voluntary Critical Illness
- Voluntary 24-Hour Accident



### Do I need to complete new enrollment forms?

If you are **not** making **ANY** changes to your existing lines of coverage: NO, you do not need to re-enroll. Your coverage will continue into 2012. *Remember . . . the 24-Hour Accident is a NEW product and in order to enroll, you must go online.*

If you **do** need to make a change to any or all lines of coverage: YES, you will need to make your change online for each line of coverage that you wish to change, including adding a new dependent, changing your address, etc.

If you are currently enrolled but wish to terminate your coverage: YES, you will need to waive your coverage online, indicating your intention to decline your existing coverage.

If you are electing coverage for the first time: YES, you will need to complete your enrollment online. This is also true if you wish to elect a voluntary coverage for the first time. **REMEMBER:** If you are electing Voluntary Life or Long-Term Disability for the first time and were eligible to elect it in prior years, you will also be subject to Evidence of Insurability.

\*\*Because Long Term Care and GAP products are not an online process, appropriate forms for these lines of coverage must be completed by every employee wishing to elect either or both.\*\*

*For more information on how to apply for or change your coverage, refer to the Enrollment Information section at the back of this booklet.*

### How do I submit my enrollment and/or change forms?

All forms are electronic with online access to Amerisafe's Benefits Department -

<https://services.amerisafe.com/benefits/benefits.asp>. You will receive confirmation once you have completed your online enrollment. Feel free to contact AMERISAFE'S BENEFITS DEPARTMENT for online instructions/questions if you experience any difficulties with your online enrollment.

### When is the final date for electronic enrollment?

Online access is available from October 21, 2011 through November 21, 2011.

All paper forms **MUST** be submitted to the Benefits Department by the end of the day on November 21<sup>st</sup>. There will be **NO** exceptions.



### Who should I contact with any further questions regarding my benefits?

If you have reviewed the booklet and still have questions, please contact **Rebekah Fontenot**:

Benefits Department Contact	Email	Phone
Rebekah Fontenot	<a href="mailto:RFontenot@Amerisafe.com">RFontenot@Amerisafe.com</a>	(800) 256-9052



# CONTACTS



## MEDICAL

*Aetna*

For more information on:	Contact / Address	Phone / Fax
<ul style="list-style-type: none"> <li>&gt; Order ID cards</li> <li>&gt; Provider check</li> <li>&gt; General questions</li> <li>&gt; etc.</li> </ul>	Aetna Member Services <b>OR</b> Register for Aetna member account at <a href="http://www.aetna.com">www.aetna.com</a>	<b>Phone:</b> (888) 982-3862 <i>*Multilingual translational services available in 140 languages at request</i>
<ul style="list-style-type: none"> <li>&gt; Medical Claims</li> </ul>	Aetna Claims Department P.O. Box 14100 Lexington, KY 40512-4601	<b>Phone:</b> (888) 277-1054
<ul style="list-style-type: none"> <li>&gt; Pharmacy Questions</li> <li>&gt; Pharmacy Claims</li> </ul>	Aetna Pharmacy Assistance P.O. Box 398106 Minneapolis, MN 55439	<b>Phone:</b> (800) 238-6279
<ul style="list-style-type: none"> <li>&gt; Mail-Order Prescription Drug Program</li> </ul>	Aetna Rx Home Delivery P.O. Box 41719 Kansas City, MO 64179-9892  <b>Web:</b> <a href="http://www.aetnarxhomedelivery.com">www.aetnarxhomedelivery.com</a>	<b>Phone:</b> (866) 612-3862
<ul style="list-style-type: none"> <li>&gt; Pre-Authorization</li> </ul>	Aetna Pre-Authorization	<b>Phone:</b> (888) 982-3862

## VOLUNTARY GAP

*Allstate*

For more information on:	Contact / Address	Phone / Fax
<ul style="list-style-type: none"> <li>&gt; General questions</li> </ul>	Allstate Benefits 1776 American Heritage Life Dr. Jacksonville, FL 32224 <b>Web:</b> <a href="http://www.allstateatwork.com">www.allstateatwork.com</a> <b>Email:</b> <a href="mailto:AWDCustomerCare@Allstate.com">AWDCustomerCare@Allstate.com</a>	<b>Phone:</b> (800) 521-3535 8am to 8pm Eastern Time Monday – Friday <i>Spanish Speaking Customers:</i> <b>Phone:</b> (800) 211-5533



# CONTACTS



## DENTAL

*United Concordia*

For more information on:	Contact / Address	Phone / Fax
> <b>General questions</b>	United Concordia Customer Service	<b>Phone:</b> (800) 332-0366
> <b>Order new ID cards</b> > <b>Find a provider</b> > <b>Claims history, etc.</b>	<b>Web:</b> <a href="http://www.ucci.com">www.ucci.com</a>	
> <b>Dental Claims</b>	United Concordia Companies P.O. Box 69421 Harrisburg, PA 17106-9421	

## VISION

*Davis Vision*

For more information on:	Contact / Address	Phone / Fax
> <b>General questions</b>	Davis Vision Customer Service <b>OR</b> Log on to Open Enrollment/Discount Plan section online at <a href="http://www.davisvision.com">www.davisvision.com</a>	<b>Phone:</b> (877) 923-2847 *Enter Client Code <b>4835</b>
> <b>Find a provider</b>	<b>Web:</b> <a href="http://www.davisvision.com">www.davisvision.com</a> ("Find a Doctor Feature")	<b>Phone:</b> (800) 999-5431
> <b>Non-Network Claims</b>	Vision Care Processing Unit P.O. Box 1525 Latham, NY 12110	



## FLEXIBLE SPENDING ACCOUNT

*TASC*

For more information on:	Contact / Address	Phone / Fax
> <b>General questions</b>	TASC Customer Service Register for MyTASC account at <a href="http://www.tasconline.com">www.tasconline.com</a>	<b>Phone:</b> (800) 422-4661



# CONTACTS

## BASIC LIFE, VOLUNTARY LIFE, AND DEPENDENT LIFE

*Lincoln Financial*

For more information on:	Contact / Address	Phone / Fax
> <b>General questions</b>	Lincoln Financial Customer Service <b>Web:</b> <a href="http://www.LincolnFinancial.com">www.LincolnFinancial.com</a>	<b>Phone:</b> (800) 423-2765
> <b>Claims submission</b> > <b>Claims status</b> > <b>Claims appeal</b>	Lincoln Financial Group Attn: Life Benefits P.O. Box 2649 Omaha, NE 68103-2649 <b>OR</b> Lincoln Online Service Center <b>Web:</b> <a href="http://www.lincoln4benefits.com">www.lincoln4benefits.com</a>	<b>Phone:</b> (800) 423-2765  <b>Fax:</b> (800) 462-4660  <b>Email:</b> <a href="mailto:claims@LFG.com">claims@LFG.com</a>
> <b>Conversion</b> <b>(Mailing Address)</b>	Lincoln Financial Group Attn: Group Conversions P.O. Box 2616 Omaha, NE 68103-2616	



## SHORT TERM & LONG TERM DISABILITY

*Lincoln Financial*

For more information on:	Contact / Address	Phone / Fax
> <b>General questions</b>	Lincoln Financial Customer Service <b>Web:</b> <a href="http://www.LincolnFinancial.com">www.LincolnFinancial.com</a>	<b>Phone:</b> (800) 423-2765
> <b>Claims submission</b> > <b>Claims status</b> > <b>Claims appeals</b>	Lincoln Financial Group Attn: Claims Department 8801 Indian Hills Drive Omaha, NE 68114 <b>OR</b> Lincoln Online Service Center <b>Web:</b> <a href="http://www.lincoln4benefits.com">www.lincoln4benefits.com</a>	<b>Phone:</b> (800) 423-2765  <b>Fax:</b> (877) 843-3950  <b>Email:</b> <a href="mailto:claims@LFG.com">claims@LFG.com</a>



# CONTACTS

## LONG TERM CARE

*UNUM*

For more information on:	Contact / Address	Phone / Fax
<ul style="list-style-type: none"> <li>&gt; General questions</li> <li>&gt; Claims submission</li> <li>&gt; Claims status</li> </ul>	<b>Web:</b> <a href="http://www.unum.com">www.unum.com</a>	<b>Phone:</b> (866) 679-3054 8am to 8pm Eastern Time Monday - Friday



## CANCER, CRITICAL ILLNESS, AND ACCIDENT

*Allstate*

For more information on:	Contact / Address	Phone / Fax
> General questions	Allstate Benefits 1776 American Heritage Life Dr. Jacksonville, FL 32224 <b>Web:</b> <a href="http://www.allstateatwork.com">www.allstateatwork.com</a> <b>Email:</b> <a href="mailto:AWDCustomerCare@Allstate.com">AWDCustomerCare@Allstate.com</a>	<b>Phone:</b> (800) 521-3535 8am to 8pm Eastern Time Monday – Friday <i>Spanish Speaking Customers:</i> <b>Phone:</b> (800) 211-5533
> Claims submission & status	<b>Email:</b> <a href="mailto:AWDClaims@Allstate.com">AWDClaims@Allstate.com</a>	<b>Phone:</b> (800) 348-4489





# MEDICAL

## AETNA

### INTRODUCTION

The Amerisafe Employee Medical Plan provides you and your family with protection in the case of financial hardship due to injury or illness. Amerisafe is pleased to provide Medical coverage to all eligible employees at a competitive cost.



#### EMPLOYEE ELIGIBILITY

You are eligible to participate in the Medical Plan described in this section if you are over **18 years of age** and an **active, regular full-time employee working at least 30 hours/week**.

#### DEPENDENT ELIGIBILITY

*Dependents may only be covered if the employee is enrolled.*

If you are eligible to enroll in the Medical Plan, your legal spouse is also eligible to participate.

Dependent children may be covered if they fall under one of the following categories:

- A natural child, adopted child or stepchild, may be covered from **birth to age 26**, regardless of full-time student or marital status. *Exception: cannot be eligible under own employer plan*
- Mentally or physically handicapped children may be covered beyond the maximum age listed above, provided the child is primarily dependent upon the employee and proof of incapacity and dependency are furnished. (Approval required).

#### EMPLOYEE CONTRIBUTIONS

Your monthly employee contributions are as follows:

	Monthly Premium
Employee Only	\$75.00
Employee + Spouse	\$362.00
Employee + Child(ren)	\$279.00
Employee + Family	\$458.00

**Remember:** Your Medical contributions are deducted from your paycheck on a **pre-tax** basis, which means that your taxable pay is lower—and so is the amount you pay for Social Security, Medicare, and Federal and State Income Taxes.





## MEDICAL SUMMARY OF BENEFITS

Benefit	In-Network	Out-of-Network
<b>Aetna Health Fund (Annual member benefit)</b>	\$500 per benefit year/Single \$1,000 per benefit year/Family	N/A
<b>Annual Deductible:</b>	<b>Includes Aetna Health Fund</b>	
> Individual	\$2,000	\$2,000
> Family	\$4,000	\$4,000
<b>Out-of-Pocket Maximum</b>	<b>Includes Aetna Health Fund, Deductible, Coinsurance</b>	
> Individual	\$3,500	\$3,500
> Family	\$7,000	\$7,000
<b>Coinsurance</b>	90%	70%
<b>Preventive Care</b> <i>Including but not limited to: Annual physicals, routine child care, immunizations, mammograms, routine outpatient labs and x-rays, etc.</i>	100% deductible waived	Subject to Aetna Health Fund/Deductible/Coinsurance
<b>Physician Office Visits</b> > Primary Care Physician > Specialist	<b>Subject to Aetna Health Fund/Deductible/Coinsurance</b>	
<b>Emergency Room</b> <i>For true emergency</i>	90% after deductible	Same as in-network
<b>Behavioral Health</b> <i>Mental Health &amp; Substance Abuse</i>	Same as any other covered condition	
<b>Prescription Drugs</b> (30-day retail supply)	Level 1 = \$15 copay Level 2 = \$25 copay Level 3 = \$40 copay	70% of actual charges, after applicable in-network copay <i>*Member must pay 100% to pharmacy then file claim form with Aetna to receive reimbursement</i>
<b>Prescription Drugs</b> (90-day mail-order supply)	Level 1 = \$30 copay Level 2 = \$50 copay Level 3 = \$80 copay	
<b>Lifetime Maximum</b>	Unlimited	

**NOTE:** Please refer to your Aetna Certificate of Coverage for details. If this summary of benefits conflicts in any way with your Aetna Certificate of Coverage, the Certificate of Coverage shall prevail.



# VOLUNTARY GAP

## AMERICAN FIDELITY

### INTRODUCTION

The Amerisafe Voluntary GAP Plan helps you offset some of your expenses (i.e. deductible, out-of-pocket, etc.) The GAP has three major components—in-hospital, outpatient, and physician outpatient treatment. All active full-time employees who are working 18 hours or more per week, covered under Another Medical Plan,

### THE THREE MAJOR BENEFITS

Benefit	Description
<b>In-Hospital</b>	Pays the difference between the ACTUAL Hospital expenses you incur and the amount payable by your primary medical plan for the out-of-pocket covered charges. Pays up to \$1,000 per confinement
<b>Outpatient</b>	Pays the difference between the ACTUAL Out-Patient expenses you incur and the amount paid by your primary medical plan for the out-of-pocket covered charges, up to a maximum out-patient benefit of \$200
<b>Physician Visits</b>	Physician Visits up to \$25 per visit, for up to five visits (\$125) per family per calendar year



### MONTHLY PREMIUMS

Monthly Rates (12 Pay periods) for \$1,000 Plan Coverage Level	Under Age 55	Age 55-59	Ages 60+
Employee Only	\$17.00	\$24.00	\$36.00
Employee + Spouse	\$31.00	\$43.00	\$65.00
Employee + Child(ren)	\$28.00	\$35.00	\$47.00
Employee + Family	\$42.00	\$54.00	\$76.00

**NOTE: Please refer to your American Fidelity Certificate of Coverage for details. If this summary of benefits conflicts in any way with your American Fidelity Certificate of Coverage, the Certificate of Coverage shall**



# DENTAL

## UNITED CONCORDIA

### INTRODUCTION

The Amerisafe Employee Dental Plan provides you and your family with coverage for preventive dental care and both major and minor dental procedures to improve overall oral health. You also have a choice to elect either the Basic or Enhanced Dental option. **Remember... your preventive checkups twice a year do not apply towards your calendar year maximum!**



#### EMPLOYEE ELIGIBILITY

You are eligible to participate in the Dental Plan described in this section if you are over **18 years of age** and an **active, regular full-time employee working at least 30 hours/week**.

#### DEPENDENT ELIGIBILITY

*Dependents may only be covered if the employee is enrolled.*

If you are eligible to enroll in the Dental Plan, your legal spouse is also eligible to participate.

Dependent children may be covered if they fall under one of the following categories:

- A natural child, adopted child or stepchild, may be covered from **birth to age 26**, regardless of full-time student or marital status. *Exception: cannot be eligible under own employer plan*
- Mentally or physically handicapped children may be covered beyond the maximum age listed above, provided the child is primarily dependent upon the employee and proof of incapacity and dependency are furnished.

#### EMPLOYEE CONTRIBUTIONS

Your monthly employee contributions are as follows:

With Medical	Basic Plan Monthly Premium	Enhanced Plan Monthly Premium
Employee Only	\$14.31	\$17.90
Employee + One	\$32.00	\$39.19
Employee + Two or More	\$41.13	\$52.99

**Remember:** Your Dental contributions are deducted from your paycheck on a **pre-tax** basis, which means that your taxable pay is lower—and so is the amount you pay for Social Security, Medicare, federal and state income taxes.

Without Medical	Basic Plan Monthly Premium	Enhanced Plan Monthly Premium
Employee Only	\$0	\$3.59
Employee + One	\$0	\$7.19
Employee + Two or More	\$0	\$11.86



## DENTAL SUMMARY OF BENEFITS

Benefit	Basic Option	Enhanced Option
<b>Annual Deductible</b>	\$75/3x Family	
<b>Annual Maximum</b> <i>(Excludes Class I Services)</i>	\$1,000 per person per year	\$2,000 per person per year
<b>Class I – Diagnostic/Preventive</b> (Includes exams, x-rays, cleanings, fluoride, sealants & space maintainers)	80%, deductible waived	
<b>Class II – Basic Services</b> (Includes palliative treatment, basic restorative, extractions, endodontics, repairs, oral surgery & general anesthesia)	80% after deductible	
<b>Class III – Major Services</b> (non-surgical & surgical periodontics, inlays, onlays, crowns, prosthetics)	50% after deductible	
<b>Orthodontia</b> (Dependent children to age 19)	50% deductible waived	
<b>Lifetime Orthodontia Maximum</b>	\$1,000 per person	



**NOTE:** Please refer to your United Concordia Certificate of Coverage for details. If this summary of benefits conflicts in any way with your United Concordia Certificate of Coverage, the Certificate of Coverage shall prevail.



# VISION

## DAVIS VISION

### INTRODUCTION

The Amerisafe Employee Vision Plan provides you with coverage for eye exams, lenses and frames—vision care for the whole family. This coverage is offered to you on a voluntary basis.



#### EMPLOYEE CONTRIBUTIONS

**Good News!** There will be no increase to the employee Vision premiums for 2012.

The cost to employees on a monthly basis is as follows:

	Monthly Premium
Employee Only	\$8.60
Employee & Spouse	\$15.50
Employee & Child(ren)	\$16.34
Family	\$25.82

**Remember:** Your Vision contributions are deducted from your paycheck on a **pre-tax** basis, which means that your taxable pay is lower—and so is the amount you pay for Social Security, Medicare, federal and state income taxes.

#### EMPLOYEE ELIGIBILITY

You are eligible to participate in the Vision Plan described in this section if you are over **18 years of age** and an **active, regular full-time employee working at least 30 hours/week**.

#### DEPENDENT ELIGIBILITY

*Dependents may only be covered if the employee is enrolled.*

If you are eligible to enroll in the Vision Plan, your legal spouse is also eligible to participate.

Dependent children may be covered if they fall under one of the following categories:

- A natural child, adopted child or stepchild, may be covered from **birth to age 26**, regardless of full-time student or marital status. *Exception: cannot be eligible under own employer plan*
- Mentally or physically handicapped children may be covered beyond the maximum age listed above, provided the child is primarily dependent upon the employee and proof of incapacity and dependency are furnished. (Approval required).





## VISION SUMMARY OF BENEFITS

Benefit	In-Network	Out-of-Network
<b>Eye Exams</b> <i>(includes dilation of eyes)</i>	100% after \$10 copay (once every January 1st)	Up to \$30 reimbursement
<b>Frames</b>	100% after \$10 copay for Fashion Designer Premier Level: \$25 Non-collection allowance: up to \$130 plus 20% discount (once every other January 1st)	Up to \$30 reimbursement
<b>Lenses (Glasses)</b>	100% after: \$10 copay: Fashion & Designer level \$25 Copay: Premier Level (once every January 1st)	Single: Up to \$25 Bifocal: Up to \$35 Trifocal: Up to \$45 Lenticular: Up to \$60
<b>Contacts Lenses</b> <b>(in lieu of glasses)</b> > Elective > Medically Necessary	Once every January 1st  \$10 Copay <i>(includes fitting fee up to \$60)</i>	Up to \$75 reimbursement Up to \$225 reimbursement

**NOTE:** Please refer to your Davis Vision Certificate of Coverage for details. If this summary of benefits conflicts in any way with your Davis Vision Certificate of Coverage, the Certificate of Coverage shall prevail.

**REMEMBER:** If you choose to visit a non-network vision provider, the provider will not be able to file directly with Davis Vision. You will be required to pay for 100% of services at the time of your visit. You or your doctor will then manually file your claim with Davis Vision by completing the non-network claim form, available at [www.davisvision.com](http://www.davisvision.com) and submitting it to the address listed in the contact section of this booklet. Reimbursement will be processed according to the non-network schedule of benefits.





# FLEXIBLE SPENDING ACCOUNT

## TASC

### INTRODUCTION

The Amerisafe Flexible Spending Account provides you with a convenient way to set aside money to help pay for certain eligible medical expenses.

#### CONTRIBUTIONS TO YOUR FLEXIBLE SPENDING ACCOUNT

##### *Designed to save you money*

- Money in an FSA is never taxed
  - No federal income tax
  - No state income tax
  - No social security tax
- Every dollar you contribute is **pre-tax**, *reducing your taxable income and increasing your take-home pay.*

You should carefully consider what kind of medical costs you could face in the next year when deciding the amount of your FSA contributions for 2012.



#### REMEMBER...

Over-the-counter medications are no longer eligible for FSA reimbursement without a written prescription from your physician. Equipment such as crutches, bandages, blood sugar testing kits, etc., will still qualify for reimbursement since they are not considered “medications”.

***NOTE: For more details, please log on to***  
**[www.tasconline.com](http://www.tasconline.com)**



## Medical Reimbursement

You can contribute up to a maximum of \$3,600. Your initial debit card is provided free of charge, with the 2<sup>nd</sup> card provided free of charge upon request.

*\*All additional cards are \$10*

## Dependent Care

The IRS allows you to contribute \$5,000 if married and filing jointly. If filing separately, the plan maximum is \$2,500.

If the employee is married, the spouse must also be working or attending school

*\*Effective January 1, 2011: Dependent children up to the age of 26 are qualified dependents for certain FSA plan types*

*\*Effective January 1, 2013: \$2,500 annual contribution cap per individual for Healthcare FSA.*

## Examples of Eligible/Ineligible Expenses(Medical Reimbursement)

### Eligible Expenses

- >Co-pays and deductibles
- >Prescription drugs/medications
- >Dental/orthodontia care- cleanings, fillings, x-rays
- >Vision care—eyeglasses, contact lenses, solutions
- >Alternative medicine- acupuncture, naturopath
- >Weight-loss programs
- >Smoking Cessation Programs
- >Mileage to-and-from doctor appointments
- >Non-prescription glasses

### Ineligible Expenses

- >Insurance premiums
- >Non-prescription OTC items
- >Cosmetic procedures
- >Personal hygiene products
- >Vitamins/supplements
- >Diet products/food
- >Exercise equipment
- >Health Club fees

*\*Effective January 1, 2011: OTC drugs/medications require a prescription or Letter of Medical Necessity to be eligible for FSA reimbursement*

## Examples of Eligible/Ineligible Expenses (Dependent Care)

### Eligible Expenses

- >Day Camp-primary purpose must be custodial care and not educational in nature
- >Before and after school care
- >Nanny expenses
- >Nursery school
- >Registration fees
- >Elder care
- >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 a child under age 13

### Ineligible Expenses

- >Tuition
- >Transportation
- >Activity Fees/supplies
- >Field trips
- >Overnight camp



*\*For a complete list of eligible/ineligible expenses please visit [www.tasconline.com](http://www.tasconline.com)*



## FSA SUMMARY OF BENEFITS

Provision/Service	Description
<b>Reimbursement Methods</b> <i>Service related to the expense need only have taken place; it need not have been paid before reimbursement is requested</i>	<ul style="list-style-type: none"> <li>&gt; paper</li> <li>&gt; fax</li> <li>&gt; online at <a href="http://www.tasconline.com">www.tasconline.com</a></li> <li>&gt; text message</li> </ul>
<b>TASC Card</b> (point of purchase transactions)	<ul style="list-style-type: none"> <li>&gt; automatic and immediate reimbursements</li> <li>&gt; most specific dollar charges must be submitted by the participant</li> <li>&gt; you are responsible for any documentation that is requested for qualified medical expenses paid for with the card</li> <li>&gt; can order an additional card for spouse or child at no charge</li> </ul>
<b>Dependent Care FSA</b> <i>You can deposit up to the maximums shown for the purpose of dependent care reimbursement</i>	<ul style="list-style-type: none"> <li>&gt; \$5,000 if married and filing jointly</li> <li>&gt; \$2,500 if filing separate tax returns</li> </ul>
<b>MyTASC Account Access</b>	<ul style="list-style-type: none"> <li>&gt; 24/7 access</li> <li>&gt; online claims status</li> <li>&gt; can also access account via telephone and text message</li> <li>&gt; online tax savings calculator</li> </ul>
<b>Other Features</b>	<ul style="list-style-type: none"> <li>&gt; daily claims processing</li> <li>&gt; toll free customer service line</li> </ul>





# BASIC LIFE/AD&D

## LINCOLN FINANCIAL

### INTRODUCTION

The Amerisafe Basic Life / AD&D policy is an **employer-paid benefit** that provides your family with financial protection in the event of your death or the death of a covered dependent. This benefit is provided at **NO COST** to you.

#### EMPLOYEE ELIGIBILITY

You are eligible to participate in the Basic Life Plan described in this section if you are over **18 years of age** and an **active, regular full-time employee working at least 30 hours/week**

#### DEPENDENT ELIGIBILITY

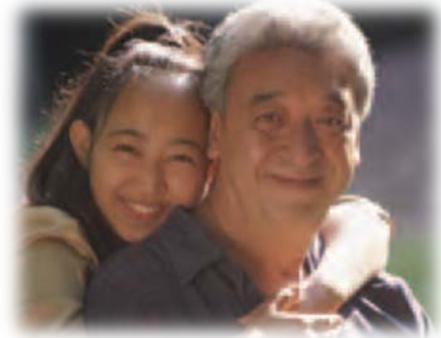
Dependent spouses and children are **not** eligible to participate in the Basic Life / AD&D policy.

#### EMPLOYEE CONTRIBUTIONS

Amerisafe contributes the **full cost** of this coverage.

#### ACCELERATED DEATH BENEFIT

If you are terminally ill, you can borrow up to a certain percentage of your life insurance proceeds upfront.



### BASIC LIFE / AD&D SUMMARY OF BENEFITS

Benefit	Coverage / Description
<b>Benefit Amount</b>	\$50,000 (Life); Double Indemnity for Accidental Death
<b>Age Reduction</b>	Benefits reduce to 50% at age 70 Terminates at Retirement
<b>Waiver of Premium</b>	Premiums waived if you become totally disabled before age 65
<b>Additional Accidental Death Benefits</b>	Safe Driver Benefit, Seatbelt Benefit, Air Bag Benefit, Common Carrier Benefit
<b>Actively at Work Provision</b>	You must be actively at work on your effective date of coverage in order for your policy to be in force

**NOTE:** Please refer to your Lincoln Financial Certificate of Coverage for details. If this summary of benefits conflicts in any way with your Lincoln Certificate of Coverage, the Certificate of Coverage shall prevail.



# VOLUNTARY TERM LIFE

LINCOLN FINANCIAL

## INTRODUCTION

The Amerisafe Voluntary Term Life plan allows employees to elect additional life coverage to supplement the Basic Life policy. This coverage is entirely optional and is paid for by the employee.

### EMPLOYEE CONTRIBUTIONS

Employees contribute the full cost of this coverage. The cost of this coverage will not change for 2012 and can be purchased based on your age category.



### EMPLOYEE ELIGIBILITY

You are eligible to participate in the Supplemental Life Plan described in this section if you are over **18 years of age** and an **active, regular full-time employee working at least 30 hours/week**

### DEPENDENT ELIGIBILITY

Dependent spouses and children are eligible to participate in the Voluntary Term Life plan.

## HOW TO CALCULATE YOUR MONTHLY COST FOR VOLUNTARY TERM LIFE

1. Choose your amount of Voluntary Term Life coverage (\$10,000 increments to a maximum of \$500,000)
2. Multiply coverage amount by the monthly rate based on your age (see rate chart below)
3. Divide by \$1,000 to get your **monthly** cost

**EXAMPLE:** An employee (age 39) elects \$100,000 in coverage:

$$\$100,000 \times \$0.12 = \$12,000$$

$$\$12,000 / \$1,000 = \$12.00 \text{ monthly}$$



## VOLUNTARY TERM LIFE SUMMARY OF BENEFITS

EMPLOYEE Benefit	Coverage / Description
<b>Benefit Amount</b>	\$10,000 increments to a maximum of \$500,000 (For Employees 70 and over, maximum is \$50,000)
<b>Age Reduction</b>	Benefits reduce to 50% at age 70
<b>Guarantee Issue</b>	Employees to age 69: \$200,000 Employees age 70-74: \$100,000 Employees 75+: Not eligible for GI
<b>Waiver of Premium</b>	Premiums waived if you become totally disabled up to age 65
<b>Accelerated Life Benefit</b>	Maximum of \$250,000 or 75% of insured person's life insurance coverage, whichever is less *Conversion available when insurance terminates
<b>Portability</b>	If you become ineligible or your employment ends, you may continue your coverage with Lincoln and pay your premiums directly to the carrier
<b>Actively at Work Provision</b>	You must be actively at work on your effective date of coverage in order for your policy to be in force

SPOUSE Benefit	Coverage / Description
<b>Benefit Amount</b>	\$5,000 increments to a maximum of \$250,000
<b>Guarantee Issue</b>	Spouses to age 69: \$50,000 Spouses age 70-74: \$25,000 Spouses 75+: Not eligible for GI
<b>Spousal Rate Basis</b>	Spousal rate is based on Employee's date of birth





CHILD(REN) Benefit	Coverage / Description
<b>Benefit Amount</b>	\$5,000 increments to a maximum of \$250,000
<b>Guarantee Issue</b>	14 days to 6 months: \$250 6 months to 19 years (25 if unmarried and FT Student): \$10,000

**NOTE:** Please refer to your Lincoln Financial Certificate of Coverage for details. If this summary of benefits conflicts in any way with your Lincoln Financial Certificate of Coverage, the Certificate of Coverage shall prevail.

At annual enrollment, employees can elect an additional \$40,000 (in \$10,000 increments) with no EOI regardless of the GI limit. Spouses can elect an additional \$20,000 (in \$5,000 increments) with no EOI regardless of the GI limit. Late enrollees (who previously waived coverage) must complete an Evidence of Insurability Form (subject to underwriting approval)

Employee Age	Monthly Rate (12 Pay Periods) per \$1,000 of Benefit
0 to 29	\$0.090
30 to 34	\$0.100
35 to 39	\$0.120
40 to 44	\$0.180
45 to 49	\$0.310
50 to 54	\$0.540
55 to 59	\$0.840
60 to 64	\$1.120
65 to 69	\$1.960
70 to 74	\$3.110
75+	\$4.840
<b>Child(ren) Rate (Regardless of # of Children)</b>	<b>\$2.00 for \$10,000 of coverage</b>



# SHORT TERM DISABILITY

## LINCOLN FINANCIAL



### INTRODUCTION

The Amerisafe Short Term Disability (STD) plan will provide you a percentage of your salary if you become temporarily disabled and you are not able to work for a short period of time due to illness or injury.

#### EMPLOYEE ELIGIBILITY

You are eligible to participate in the STD Plan described in this section if you are over **18 years of age** and an **active, regular full-time employee working at least 30 hours/week**

#### DEPENDENT ELIGIBILITY

Dependent spouses and children are **not** eligible to participate in the STD plan.

#### EMPLOYEE CONTRIBUTIONS

Employees contribute towards the Short Term Disability coverage at a monthly rate of **\$0.53 per \$10 of covered benefit**.

*Your benefit is non-taxable.*

#### HOW TO CALCULATE YOUR MONTHLY COST FOR SHORT TERM DISABILITY

1. Indicate your weekly earnings. If your weekly earnings are greater than \$2,083.33, indicate \$2,083.33. Otherwise, indicate your actual weekly earnings.
2. Multiply your weekly earnings by .60 (60% benefit).
3. Multiply the amount in Step 2 by the weekly rate of \$0.53.
4. Divide your total from Step 3 by 10 to obtain your **monthly** cost.

**All Annual Salaries of \$108,333 and above have a monthly cost of \$66.25**

**Initial enrollees can elect coverage without Evidence of Insurability (EOI). Late enrollees (who previously waived coverage) must complete an EOI Form (subject to underwriting approval)**

### SHORT TERM DISABILITY SUMMARY OF BENEFITS

Plan Provision	Coverage / Description
<b>Weekly Benefit</b>	60% of weekly earnings
<b>Maximum Weekly Benefit</b>	\$1,250
<b>Maximum Duration of Benefits</b>	11 weeks
<b>Elimination Period</b>	14 Days for accident or illness
<b>Pre-existing Condition</b>	None
<b>Additional Information</b>	Partial Disability Non-Occupational Coverage

**NOTE: Please refer to your Lincoln Financial Certificate of Coverage for details. If this summary of benefits conflicts in any way with your Lincoln Financial Certificate of Coverage, the Certificate of Coverage shall prevail.**



# LONG TERM DISABILITY

## LINCOLN FINANCIAL

### INTRODUCTION

The Amerisafe Long Term Disability (LTD) plan will provide a portion of your monthly income if you cannot work for an extended period of time (longer than 180 days) due to an illness or injury.

#### EMPLOYEE ELIGIBILITY

You are eligible to participate in the LTD Plan described in this section if you are over **18 years of age** and an **active, regular full-time employee working at least 30 hours/week**

#### DEPENDENT ELIGIBILITY

Dependent spouses and children are **not** eligible to participate in the LTD plan.

#### EMPLOYEE CONTRIBUTIONS

Employees contribute towards the Long Term Disability coverage at a monthly rate of **\$0.58 per \$100 of covered earnings.**

*Your benefit is non-taxable.*

#### HOW TO CALCULATE YOUR MONTHLY COST FOR LONG TERM DISABILITY

5. Indicate your monthly earnings. If your monthly earnings are greater than \$8,333.33, indicate \$8,333.33. Otherwise, indicate your actual monthly earnings.
6. Multiply monthly earnings by the monthly rate of \$0.58
7. Divide your total from Step 2 by 100 to obtain your **monthly cost**

**All Annual Salaries of \$100,000 and above have a monthly cost of \$48.33**





## LONG TERM DISABILITY SUMMARY OF BENEFITS



Plan Provision	Coverage / Description
Monthly Benefit	60% of monthly earnings
Maximum Monthly Benefit	\$5,000
Minimum Monthly Benefit	\$50
Elimination Period	90 calendar days of Disability caused by the same or a related Sickness or Injury, which must be accumulated within a 180 calendar day period
Pre-existing Condition Limitation	3 / 12
Social Security Offset	Full Family
Own Occupation	24 months
Maximum Duration of Benefits	Later of age 65 or Social Security Normal Retirement Age (SSNRA)
Mental & Nervous	24 months
Survivor Benefit	3 x your last Monthly Benefit, provided the disability continued for 180 or more consecutive days
Partial Disability	Pays for 24 months if Partial Disability income is less than 99% of pre-disability income; Continues benefit payment after 24 months if you earn less than 60% of pre-disability income <i>Subject to all other terms and conditions of the Policy</i>
Additional Benefits	10% Progressive Income Benefit Family Care Expense Benefit

**NOTE:** Please refer to your Lincoln Financial Certificate of Coverage for details. If this summary of benefits conflicts in any way with your Lincoln Financial Certificate of Coverage, the Certificate of Coverage shall prevail.

Initial enrollees can elect coverage without Evidence of Insurability (EOI). Late enrollees (who previously waived coverage) must complete an Evidence of Insurability Form (subject to underwriting approval)



# VOLUNTARY LONG TERM CARE UNUM



## INTRODUCTION

The Amerisafe Long Term Care plan provides a monthly benefit for expenses incurred if you can no longer function independently due to aging or an illness or injury. Depending on the plan you choose, benefits may include the following: professional home-care, long-term care facility, adult day-care, assisted living facility.

### EMPLOYEE ELIGIBILITY

You are eligible to participate in the Long Term Care Plan described in this section if you are over **18 years of age** and an **active employee** or retiree.

### DEPENDENT ELIGIBILITY

The following dependents are eligible to be covered: spouse, siblings, children, parents of employee or spouse, grandparents of employee or spouse, sibling of spouse, spouse of the employee's sibling, spouse of the spouse's sibling, and spouse of employee's adult child.

### EMPLOYEE CONTRIBUTIONS

Employees contribute the full cost of this coverage. Please see the **rate sheet on the following page** to calculate your monthly cost according to the plan you wish to elect. *Rates are guaranteed based on date of issue up to the guarantee issue amount. Amounts over the guarantee issue are subject to underwriting approval.*

**NOTE: Plans 3 and 4 offer richer benefits. Please refer to your UNUM Certificate of Coverage for details. If this summary of benefits conflicts in any way with your UNUM Certificate of Coverage, the Certificate of Coverage shall prevail.**

## LONG TERM CARE SUMMARY OF BENEFITS

Plan Provision	Plan 1	Plan 2
Facility Monthly Benefit	\$1,000	\$1,000 but will increase each year on January 1 <sup>st</sup> by 5% of the Monthly Benefit in effect on that January 1st
LTC Facility	100% of Monthly Benefit	
Home Monthly Benefit	\$500	
Home Care Level	Professional	
Inflation Protection	Not Included	5% compound inflation with no cap
Facility Benefit Duration	6 years	
Elimination Period	90 Days	
Guarantee Issue	Up to \$4,000/month for employees within initial eligibility	
Lifetime Maximum	\$72,000	

**Plan 1:** Non-forfeiture: If your coverage lapses due to nonpayment of premium after your coverage has been **in force for 3 years**, you will be eligible for a Non-forfeiture Benefit. This means your coverage will **continue in-force with the same level of benefits**, except for a reduction in Lifetime Maximum Amount

**Plan 2:** Your remaining Lifetime Maximum Benefit Amount will also increase. Increases will be automatic and will occur **regardless of your health** and whether or not you are Disabled. Your **premium will not increase** due to automatic increases in your Monthly Benefit Amount



## LONG TERM CARE RATE SHEET - MONTHLY RATES

LONG TERM CARE

Age	Plan 1	Plan 2	Plan 3	Plan 4
18-30	3.00	3.60	9.60	11.60
31	3.10	3.80	9.90	12.00
32	3.10	3.80	10.10	12.20
33	3.20	3.90	10.40	12.60
34	3.30	4.00	10.60	12.90
35	3.40	4.20	11.00	13.30
36	3.50	4.30	11.20	13.60
37	3.70	4.50	11.60	14.00
38	3.80	4.60	12.00	14.50
39	4.00	4.80	12.30	14.70
40	4.10	5.00	12.60	15.10
41	4.30	5.10	12.90	15.50
42	4.50	5.40	13.40	15.90
43	4.70	5.60	13.80	16.40
44	5.00	5.90	14.30	17.00
45	5.30	6.20	14.70	17.40
46	5.50	6.50	15.20	17.90
47	5.80	6.80	15.50	18.30
48	6.10	7.10	16.00	18.80
49	6.30	7.40	16.50	19.30
50	6.60	7.80	16.90	19.80
51	7.00	8.20	17.50	20.50
52	7.40	8.70	18.20	21.20
53	7.90	9.10	18.70	21.70
54	8.30	9.60	19.40	22.50
55	8.90	10.30	20.20	23.50
56	9.40	10.90	21.00	24.40
57	10.10	11.70	22.00	25.50
58	10.80	12.50	23.10	26.80
59	11.60	13.40	24.10	28.00
60	12.40	14.40	25.20	29.20
61	13.60	15.80	27.10	31.40
62	14.90	17.10	29.10	33.50
63	16.30	18.80	31.00	35.70
64	17.90	20.60	33.40	38.40
65	20.30	23.30	37.00	42.60
66	22.550	25.60	40.00	45.60
67	24.90	28.40	43.60	49.70
68	27.60	31.40	46.90	53.50
69	30.50	34.70	50.70	57.80
70	33.70	38.40	54.60	62.30
71	37.40	42.30	59.70	67.50
72	41.40	46.80	64.90	73.30
73	45.80	51.30	70.10	78.50
74	50.60	56.70	76.00	85.10
75	60.90	67.60	89.60	99.50
76	66.90	74.20	97.20	107.90
77	73.30	80.70	104.60	115.00
78	80.40	88.40	113.00	124.30
79	88.10	96.90	121.40	133.50
80	96.60	106.30	131.30	144.50



# VOLUNTARY CANCER

## ALLSTATE

### INTRODUCTION

The Amerisafe Voluntary Cancer Plan can help you avoid financial hardship if you or a family member is diagnosed with cancer. This plan supplements your income and offsets expenses not covered under your Major Medical plan. You can elect a High or Low coverage plan and both include the annual cancer screening benefit—you receive \$100 annually just for routine tests such as mammograms, pap smears and prostate exams.



### EMPLOYEE CONTRIBUTIONS

Employees contribute the full cost of this coverage. Rates on a **monthly** basis are as follows:

	Low Option	High Option
Employee Only	\$11.08	\$19.50
Family	\$18.52	\$32.56

**Remember:** Your Cancer contributions are deducted from your paycheck on a **pre-tax** basis, which means that your taxable pay is lower—and so is the amount you pay for Social Security, Medicare, federal and state income taxes. Rates are **guaranteed based on date of issue**.

### EMPLOYEE ELIGIBILITY

You are eligible to participate in the Cancer plan described in this section if you are over **18 years of age** and an **active, regular full-time employee working at least 30 hours/week**

### DEPENDENT ELIGIBILITY

*Dependents may only be covered if the employee is enrolled.*

If you are eligible to enroll in the Cancer plan, your legal spouse is also eligible to participate.

Dependent children may be covered if they fall under one of the following categories:

- An **unmarried** natural child, adopted child or stepchild, may be covered from **birth to age 22**
- An **unmarried** natural child, adopted child or stepchild, may be covered from **age 22 to 26**, if attending an accredited educational institution as a **full-time student**
- Mentally or physically handicapped children may be covered beyond the maximum age listed above, provided the child is primarily dependent upon the employee and proof of incapacity and dependency are furnished. (Approval required).

The Cancer coverage includes a **pre-existing condition limitation**: there is a 12 month waiting period from your effective date for any condition for which symptoms existed within the 12 months prior to your effective date.

The Cancer coverage also includes a **conversion privilege**: if coverage is terminated, the covered person can convert to an individual policy without having to completed evidence of insurability. Premiums would be paid directly to Allstate.



## CANCER SUMMARY OF BENEFITS

Plan Provision	Low Option	High Option
<b>Cancer Screening Benefit</b>	\$100 per person per year	\$100 per person per year
<b>Continuous Hospital Confinement</b>	\$100 each day (70 day max.)	\$200 each day (70 day max.)
<b>Extended Hospital Stay</b>	Up to \$100 each day	Up to \$200 each day
<b>Surgery</b>	Up to \$1,500 surgery schedule	Up to \$3,000
<b>Anesthesia</b>	Up to 25% of surgery benefit	Up to 25% of surgery benefit
<b>Radiation/Chemotherapy</b>	Up to \$5,000 each 12 months	Up to \$10,000 each 12 months
<b>Comfort/Anti-Nausea</b>	Up to \$200 each year	Up to \$200 each year
<b>Inpatient Drugs &amp; Medicine</b>	Up to \$25 each day	Up to \$25 each day
<b>Private Duty Nursing</b>	Up to \$100 each day	Up to \$200 each day
<b>New or Experimental Treatment</b>	Up to \$5,000 each 12 months	Up to \$5,000 each 12 months
<b>Blood, Plasma &amp; Platelets</b>	Up to \$5,000 each 12 months	Up to \$10,000 each 12 months
<b>Physician's Attendance</b>	Up to \$50 each day	Up to \$50 each day
<b>Prosthesis</b>	Up to \$2,000 each amputation	Up to \$2,000 each amputation
<b>Ambulance</b>	Up to \$100	Up to \$100
<b>Hospice Care</b>	Up to \$100 each day	Up to \$200 each day
<b>Outpatient/Family Member Lodging</b>	Up to \$50 each day	Up to \$50 each day
<b>Non-Local/Family Member Transportation</b>	Coach fare, <u>or</u> \$0.40 each mile	Coach fare, <u>or</u> \$0.40 each mile
<b>Extended Care Facility</b>	Up to \$100 each day	Up to \$200 each day
<b>Bone Marrow/Stem Cell Transplant</b>		
> Other than non-autologous	Up to \$500	Up to \$1,000
> Non-autologous, except Leukemia	Up to \$1,250	Up to \$2,500
> Leukemia	Up to \$2,500	Up to \$5,000

**Initial enrollees can elect coverage without Evidence of Insurability (EOI). Late enrollees (who previously waived coverage) must complete an Evidence of Insurability Form (subject to underwriting approval)**

***NOTE: Please refer to your Allstate Certificate of Coverage for details. If this summary of benefits conflicts in any way with your Allstate Certificate of Coverage, the Certificate of Coverage shall prevail.***



# VOLUNTARY CRITICAL ILLNESS

## ALLSTATE

### INTRODUCTION

The Allstate Voluntary Critical Illness Plan offers a lump sum benefit if you or a covered family member is diagnosed with a covered critical illness. The benefit is paid directly to you when you file a claim and can be used to pay for treatments not covered under major medical, help care for your family in your absence, or even pay unrelated household expenses—it's up to you.

#### EMPLOYEE ELIGIBILITY

You are eligible to participate in the Critical Illness Plan described in this section if you are over **18 years of age** and an **active, regular full-time employee working at least 30 hours/week**

#### DEPENDENT ELIGIBILITY

*Dependents may only be covered if the employee is enrolled.*

If you are eligible to enroll in Critical Illness, your legal spouse is also eligible to participate.

Dependent children may be covered if they fall under one of the following categories:

- An **unmarried** natural child, adopted child or stepchild, may be covered from **birth to age 22**
- An **unmarried** natural child, adopted child or stepchild, may be covered from **age 22 to 26**, if attending an accredited educational institution as a **full-time student**
- Mentally or physically handicapped children may be covered beyond the maximum age listed above, provided the child is primarily dependent upon the employee and proof of incapacity and dependency are furnished. (Approval required).

### CRITICAL ILLNESS BENEFIT SUMMARY

Benefit	Coverage / Description
<b>Coverage</b>	\$10,000 or \$15,000
<b>Dependent Benefit</b>	50% of employee benefit
<b>Covered Illnesses (% of Benefit)</b>	
> Heart Attack	100%
> Heart Transplant	100%
> Stroke	100%
> Coronary Artery By-pass	25%
> Major Organ Transplant	100%
> End Stage Renal Failure	100%
> Paralysis	100%
> Alzheimer's Disease	25%
<b>Reoccurrence Benefit</b>	25% of previously paid benefit

The Critical Illness coverage includes a **conversion privilege**: the covered person can elect to take their policy with them should their employment terminate. Premiums would be paid directly to Allstate.





## CRITICAL ILLNESS RATE SHEET (MONTHLY RATES)

Coverage	Coverage Level	Non-Tobacco	Tobacco
<b>\$10,000</b>	Employee Only	\$14.19	\$23.39
	Employee + Spouse	\$21.59	\$35.21
	Employee + Child(ren)	\$14.43	\$23.62
	Family	\$21.85	\$35.44
<b>\$15,000</b>	Employee Only	\$19.29	\$33.09
	Employee + Spouse	\$29.12	\$49.55
	Employee + Child(ren)	\$19.65	\$33.43
	Family	\$29.51	\$49.90



EACH FULL TIME EMPLOYEE IS ELIGIBLE FOR A **\$10,000 OR \$15,000** BENEFIT.

EACH INSURED SPOUSE AND DEPENDENT CHILD IS ELIGIBLE FOR **50%** OF EMPLOYEE BENEFIT.

WELLNESS BENEFIT: **\$100** LIMITED TO **1 TEST PER CALENDAR YEAR** PER PERSON

*COVERED WELLNESS SCREENINGS INCLUDE: BONE MARROW TESTING, CA15-3, CA125, CEA, CHEST X-RAY, COLONOSCOPY, MAMMOGRAPHY, PAP SMEAR, BIOPSY FOR SKIN CANCER, STRESS TEST ON BIKE OR TREADMILL, ETC.*

RECURRENCE BENEFIT (18 MONTHS CORRIDOR) **\$2,500**

**INITIAL ENROLLEES:** GUARANTEE ISSUE. **LATE ENROLLEES:** SUBJECT TO EOI

***BENEFITS DO NOT REDUCE AS YOU GET OLDER!***

The Critical Illness coverage includes a **pre-existing condition limitation**: there is a 12 month waiting period from your effective date for any condition for which symptoms existed within the 12 months prior to your effective date.

**NOTE:** Please refer to your *Allstate Certificate of Coverage for details. If this summary of benefits conflicts in any way with your Allstate Certificate of Coverage, the Certificate of Coverage shall prevail.*



# VOLUNTARY 24-HOUR ACCIDENT

ALLSTATE . . . **NEW!**

## INTRODUCTION

The Allstate Voluntary Accident Plan offers coverage for both you and your family that corresponds with treatment for both on and off-the-job accidental injuries and is guaranteed at initial enrollment, no medical exams or tests. The benefit is paid directly to you when you file a claim and is portable upon termination.

### EMPLOYEE ELIGIBILITY

You are eligible to participate in the Accident Plan described in this section if you are over **18 years of age** and an **active, regular full-time employee working at least 30 hours/week**

### DEPENDENT ELIGIBILITY

*Dependents may only be covered if the employee is enrolled.*

Your legal spouse is eligible to participate. Dependent children may be covered if they fall under one of the following categories:

- An **unmarried** natural child, adopted child, or stepchild may be covered from **birth to age 22 (to age 26 if a full-time, unmarried student)**
- Mentally or physically handicapped children may be covered beyond the maximum age listed above, provided the child is primarily dependent upon the employee and proof of incapacity and dependency are furnished. (Approval required).



### EMPLOYEE CONTRIBUTIONS

Employees contribute the full cost of this coverage. Rates on a monthly basis are as follows:

Coverage Plan	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Low Option	\$17.99	\$33.86	\$36.84	\$44.89
High Option	\$24.67	\$47.22	\$51.68	\$63.45

**Remember:** Your 24-Hour Accident contributions are deducted from your paycheck on a **pre-tax** basis, which means that your taxable pay is lower—and so is the amount you pay for Social Security, Medicare, federal and state income taxes. **Rates are guaranteed based on date of issue.**



## VOLUNTARY ACCIDENT BENEFIT SUMMARY

Benefit	Low Option	High Option
<b>Accidental Death</b>		
➤ Employee	\$ 40,000	\$ 60,000
➤ Spouse	\$ 20,000	\$ 30,000
➤ Child(ren)	\$ 10,000	\$ 15,000
<b>Common Carrier Accidental Death</b>		
➤ Employee	\$ 200,000	\$ 300,000
➤ Spouse	\$ 100,000	\$ 150,000
➤ Child(ren)	\$ 50,000	\$ 75,000
<b>Dismemberment</b>		
➤ Employee	Up to \$ 40,000	Up to \$ 60,000
➤ Spouse	Up to \$ 20,000	Up to \$ 30,000
➤ Child(ren)	Up to \$ 10,000	Up to \$ 15,000
<b>Dislocation &amp; Fracture</b>		
➤ Employee	Up to \$ 4,000	Up to \$ 6,000
➤ Spouse	Up to \$ 2,000	Up to \$ 3,000
➤ Child(ren)	Up to \$ 1,000	Up to \$ 1,500
<b>Initial Hospital Confinement</b>	\$ 1,000	\$ 1,500
<b>Hospital Confinement</b>	\$ 200 / Day	\$ 300 / Day
<b>Intensive Care</b>	\$ 400 / Day	\$ 600 / Day
<b>Ambulance</b>	\$ 200 (Regular) \$ 400 (Air)	\$ 300 (Regular) \$ 900 (Air)
<b>Medical Expenses</b>	Up to \$ 500	Up to \$ 750
<b>Outpatient Physician's Treatment</b>	\$ 50 / Visit	\$ 75 / Visit
<b>Hospital Admission</b>	\$ 500	
<b>Burns</b>	\$ 100 (<15% of body surface) \$ 500 (>15%)	
<b>Paralysis</b>	\$ 7,500 (Paraplegia) \$ 15,000 (Quadriplegia)	
<b>Coma with Respiratory Assistance</b>	\$ 10,000	
<b>Open Abdominal / Thoracic Surgery</b>	\$ 1,000	
<b>Prosthesis</b>	\$ 500 (One Device) \$ 1,000 (Two or More)	



# ENROLLMENT INFORMATION

All Amerisafe employees will enroll in or change coverage by going online:

<https://services.amerisafe.com/benefits/benefits.asp>

Exceptions: **Long Term Care and GAP** enrollment forms **must be completed on paper** and submitted to Amerisafe's Benefit Department.



## **REMEMBER**

*You are responsible for completing your online enrollment within **90 days** of your date of hire (New Enrollments) or within **31 days** from the date of the qualifying event (Change Enrollment).*

*You are also responsible for ensuring that all dependents enrolled are eligible according to the rules of each plan (see specific coverage sections for details) and providing evidence of eligibility if requested.*

