



**EMPLOYEE
BENEFITS GUIDE**
March 1, 2021 to
February 28, 2022



Wendy's



Classic Food, Inc. March 1, 2021 - February 28, 2022 Employee Benefits Guide

If you have questions regarding...

Call

Click

Classic Foods, Inc.
1585 N Skyline Dr.
Idaho Falls, ID 83402

office@wendysidaho.com

Medical

Blue Cross of Idaho
Group #10037023

(800) 627-1188

www.bdidaho.com

TeleHealth

Blue Cross of Idaho MDLIVE
Group #10037023

(888) 920-2975

www.mdlive.com/bcidaho

Dental

Delta Dental of Idaho
Group #2309

(208) 489-3582

www.deltadentalidaho.com

Vision

United Heritage / VSP
Group #03761

(208) 493-6100

www.vsp.com

Basic Life Insurance

UNUM
Group #608164

(866) 679-3054

www.unum.com

Voluntary Benefits

Colonial Life
Group #C6081145

(800) 325-4368

www.coloniallife.com

**Open Enrollment, Escalated
Claims & Benefits Questions**
GBS Benefits of Idaho

(208) 529-3541

travis.argyle@gbsbenefits.com
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This communication highlights some of your benefit plans. Your actual rights and benefits are governed by the official plan documents. If any discrepancy exists between this communication and the official plan documents, the plan documents will prevail. We reserve the right to change any benefit plan without notice. Benefits are not a guarantee of employment.

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What's Inside

This guide provides information for consideration when newly enrolling, changing your elections, or reenrolling in our benefit programs.

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Classifications

Class III - Hourly Crew

Class II - Hourly Management / Shift Manager

Class I - Owners and Salaried Management



Important Information

Wendy's of Idaho

Wendy's of Idaho's Benefits and You

Welcome

We are committed to providing our employees with quality benefits programs that are comprehensive, flexible and affordable. Giving our employees the best in benefit plans is one way we can show you that as an employee, YOU are our most important asset. Eligible employees have many benefit plans to choose from, so we ask that you read this benefits guide carefully to help you make the benefit elections that are the best fit for you and your family.

Know Your Benefits

Making wise decisions about your benefits requires planning. By selecting benefits that provide the best care and coverage, you can optimize their value and minimize the impact to your budget. The best thing you can do is “shop” for benefits carefully, using the same type of decision-making process you use for other major purchases.

› Take Advantage Of The Tools Available

That includes this guide, access to plan information, provider directories, and enrollment materials. For up to date information, visit www.wendysidaho.com

› Be a Smart Shopper

If you were buying a car or purchasing a home, you would do a lot of research beforehand. You should do the same for benefits.

› Don't Miss the Deadline and Keep Record of Your Enrollment

Pay attention to the enrollment deadline and be sure to provide us with your benefit elections in a timely manner. It is important to review your paycheck to ensure the accuracy of payroll deductions. Notify us immediately if there are any discrepancies. **Remember:** Once the enrollment period has ended, you may not make or change your benefit elections, unless you experience a qualified life event.

Summary of Benefits and Coverage (SBC) and Uniform Glossary

In addition to the plan information in this Benefits Guide, you can also review a Summary of Benefits and Coverage for each medical plan. This requirement of the ACA standardizes health plan information so that you can better understand and compare plan features. We will automatically provide you a copy of the SBC annually during open enrollment.

For the most up-to-date information regarding the ACA, please visit www.healthcare.gov.

Enrollment & Eligibility

Who is Eligible?

If you are hired as a full-time Class III employee working 30 or more hours per week, coverage will begin on the first day of the month following 12 months of qualified employment. If you are hired as a full-time Class II employee working 30 or more hours per week, coverage will begin on the first day of the month following 60 days of qualified employment. If you are hired as a Class I employee, coverage will begin on date of hire. You may also enroll your eligible dependents in the same plans you choose for yourself.

Eligible dependents include your legal spouse and your natural, adopted or step-child(ren). The dependent age limit for children on your medical plan is age 26, but may vary for other benefits offered.

When to Enroll

You can enroll for coverage as a new hire, or during our annual open enrollment period. Outside of the annual open enrollment period, the only time you can change your coverage is if you experience a qualifying life event.

How to Make Changes

Once you enroll in or decline benefits, you will not be able to make any changes to your elections until our next annual open enrollment period, unless you experience a qualified life event. Qualified life events include, but are not limited to:

- › Change in your legal marital status
- › Birth, adoption, placement for adoption or legal guardianship of a child
- › Death of a dependent
- › Change in child's dependent status
- › You or your dependent(s) become eligible or lose eligibility for Medicaid or the Children's Health Insurance Program (CHIP)
- › Change in your dependent's employment resulting in loss or gain of eligibility for employer coverage
- › A court or administrative order

If your qualified life event is due to loss or gain of Medicaid or CHIP coverage, you have 60 days to complete the necessary enrollment forms and return them to us. All other qualified life events must be reported to us within 30 days of the event. It is your responsibility to notify us when you have a qualified life event and would like to make changes to your benefit elections. Please do not miss this important deadline!

When Coverage Ends

For most benefits, coverage will end on the last day of the month in which your regular work schedule is reduced to fewer than 30 hours per week, your employment ends, or you stop paying your share of the coverage. Your dependent(s) coverage ends when your coverage ends, or the last day of the month in which the dependent is no longer eligible. Certain benefits may terminate on the date of event.

Stretching Your Rx Dollar

GoodRx Comparison Tool

Stop paying too much for your prescriptions! With the GBS Benefits Rx Comparison Tool, you can compare drug prices at over 70,000 pharmacies, and discover free coupons and savings tips.

Isn't health insurance all I need?

Your health insurance provides valuable prescription and other health benefits, but a smart consumer can save much more, especially for drugs that are not covered by health insurance (weight-loss medications, some antihistamines, etc.), drugs that have limited quantities, drugs that can be found for less than your copay, or drugs with a lower priced generic.

How can I find these savings?

The GoodRx Comparison Tool provides you with instant access to current prices on more than 6,000 drugs at virtually every pharmacy in America.

› **On the Web:** <https://www.goodrx.com/>

Instantly look up current drug prices at CVS, Walgreens, Walmart, Costco, and other local pharmacies.

Please Note:

- Prescription drug pricing displayed on the GoodRx Comparison Tool may be more or less than your insurance drug card.
- Please be sure to compare all discount pricing options before you purchase.
- Check your insurance carrier's pharmacy benefit before purchasing a 90-day supply.

› **On Your Phone**

Available on the app store or with Android on Google play. Or, just go to m.goodrx.com from any mobile phone.

Generic Prescriptions

\$4 30-Day Supply or a \$10 90-Day Supply

These programs may assist you in paying a reduced amount for generic medications, as well as, reducing utilization of the medical prescription benefits.

Did You Know?

Even if the generic substitute for one of your prescription drugs is not on one of the \$4 lists, generic drugs are often 80% less expensive than brand name drugs, so switching to a generic will have a large impact on your pocketbook whether you switch pharmacies or not. To see if you would benefit from a switch to a generic drug, do some comparison shopping. One of the better places to do this is at www.crbestbuydrugs.org, a Consumer Reports site.

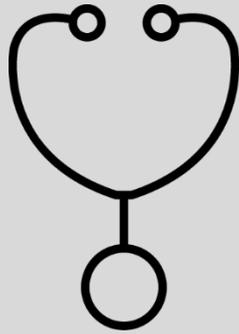
Tips

- When you receive a prescription from your doctor, ask if a generic equivalent is available.
- The member must present the written prescription to the pharmacist and request the \$4- Generic price.
- The member should not present the medical ID card. The pharmacy will not submit a claim to the insurance carrier.

How can I find out if my prescription is on the \$4-Generic Drug List?

Most of the generic programs offer approximately 150 to 300 generic drugs at a discounted price. The generic drugs offered cover most diseases and most chronic conditions such as arthritis, heart disease, high blood pressure, depression and diabetes.

You may search for the generic medication on the pharmacy's website or contact the pharmacy to inquire if the generic medication the provider prescribed is on the pharmacy's \$4-Generic Drug List.



Medical

Blue Cross of Idaho

Medical Plan Comparison

Plan Design	Gold 1500		
Provider Network	Choice PPO		
Benefit Period (Jan. 1 - Dec. 31)	In-Network You Pay		Out-of-Network You Pay
Annual Deductible	\$1,500 / Individual \$3,000 / Family		\$4,500 / Individual \$9,000 / Family
Annual Out-of-Pocket Maximum	\$6,700 / Person \$13,400 / Family		\$20,100 / Person \$40,200 / Family
Coinsurance	20% AD		50% AD
Coverage Levels	Choice Doctors	All Other In-Network	Out-of-Network
Office Visits			
Primary Care	\$10	\$30	50% AD
Specialist	\$30	\$50	50% AD
Urgent Care	\$50 copay	\$50 Copay	
TeleHealth (MDLIVE)	\$10 copay	\$10 copay	50% AD
Advanced Imaging (outpatient only)	\$250 Copay + 20% AD		\$250 Copay + 50% AD
Diagnostic Imaging (including mammograms)	80% AD		50% AD
Pediatric Physician Office Visit (Under 18 years old, Includes Urgent Care visits)	Covered at 100%		50% AD
Ambulance	80% AD		50% AD
Hospital Services			
Inpatient /Outpatient	20% AD		50% AD
Emergency Room - Facility	\$350 copayment AD		\$350 copayment AD
Emergency Room - Pro Services	20% AD		50% AD
Pharmacy - Retail			
Tier 1 - Preferred Generic			\$10
Tier 2 - Non-Preferred Generic			\$20
Tier 3 - Preferred Brand Name			\$35
Tier 4 - Non-Preferred			\$50
Tier 5 - Preferred Specialty & Generic Specialty			30% Coinsurance
Tier 6 - Non-Preferred Specialty			50% Coinsurance
ACA Preventative			No Charge



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **Note: Information about the cost of the [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit <https://members.bcoidaho.com/my-account/my-account-my-contract-page>. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-627-1188 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall Deductible ?	In-Network \$1,500 person/ \$3,000 family; Out-of-Network \$4,500 person/ \$9,000 family	Generally, you must pay all of the costs from Providers up to the Deductible amount before this Plan begins to pay. If you have other family members on the Plan , each family member must meet their own individual Deductible until the total amount of Deductible expenses paid by all family members meets the overall family Deductible .
Are there services covered before you meet your Deductible ?	Yes. Pharmacy, child vision, immunizations or In-Network hospice, services w/physician Copay and Preventive Care are covered before you meet your Deductible .	This Plan covers some items and services even if you haven't yet met the Deductible amount. But a Copayment or Coinsurance may apply. For example, this Plan covers certain Preventive Services without Cost Sharing and before you meet your Deductible . See a list of covered Preventive Services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other Deductibles for specific services ?	No. There are no other specific Deductibles .	You don't have to meet Deductibles for specific services.
What is the Out-of-pocket Limit for this Plan ?	In-Network \$6,700 person / \$13,400 family, Out-of-Network \$20,100 person / \$40,200 family.	The Out-of-pocket Limit is the most you could pay in a year for covered services. If you have other family members in this Plan , they have to meet their own Out-of-pocket Limits until the overall family Out-of-pocket Limit has been met.
What is not included in the Out-of-pocket Limit ?	Premiums , Balance-Billing charges and health care this Plan doesn't cover.	Even though you pay these expenses, they don't count toward the Out-of-pocket Limit .
Will you pay less if you use a Network Provider ?	Yes. See www.bcoidaho.com or call 1-800-627-1188 for a list of Network Providers .	You pay the least if you use a Provider on the ChoiceDocs In-Network Provider list. You pay more if you use all other Providers on the In-Network Provider list. You will pay the most if you use an Out-of-Network Provider , and you might receive a bill from a Provider for the difference between the Providers charge and what your Plan pays (Balance Billing). Be aware your Network Provider might use an Out-of-Network Provider for some services (such as lab work). Check with your Provider before you get services.
Do you need a Referral to see a Specialist ?	No.	You can see the Specialist you choose without a Referral .

All [copayments](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	ChoiceDocs = \$10 Copay/visit ; All other In-Network = \$30 Copay/visit ; Deductible does not apply	50% Coinsurance after Deductible	Copay does not apply to additional services. Cost Sharing may not apply to pediatric office visit. \$10 Copay/visit for qualifying non-emergency telehealth services provided by MDLIVE. Additional telehealth services may be provided by your Provider .
	Specialist visit	ChoiceDocs = \$30 Copay/visit ; All other In-Network = \$50 Copay/visit ; Deductible does not apply	50% Coinsurance after Deductible	Copay does not apply to additional services.
	Preventive Care/Screening/immunization	No charge for listed preventive, Screening and immunization services. Deductible does not apply	No charge for listed immunizations, 50% Coinsurance after Deductible for preventive and Screening	You may have to pay for services that aren't preventive. Ask your Provider if the services needed are preventive. Then check what your Plan will pay for.
If you have a test	Diagnostic Test (x-ray, blood work)	20% Coinsurance after Deductible	50% Coinsurance after Deductible	----- none -----
	Imaging (CT/PET scans, MRIs)	\$250 Copay/procedure , 20% Coinsurance after Deductible	\$250 Copay/procedure , 50% Coinsurance after Deductible	Preauthorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at https://members.bci.daho.com/resources/pdfs/pharmacy/20/Qualified-Health-Plan-Formulary.pdf	Generic drugs	Preferred=\$10 <u>Copay</u> /prescription Non-preferred=\$20 <u>Copay</u> /prescription (retail and mail order)	Preferred=\$10 <u>Copay</u> /prescription Non-preferred=\$20 <u>Copay</u> /prescription (retail and mail order)	<u>Deductible</u> does not apply. Covers up to a 90 day supply with multiple <u>Copays</u> . Additional <u>Out-of-Network</u> charges may apply.
	Preferred brand drugs	\$35 <u>Copay</u> /prescription (retail and mail order)	\$35 <u>Copay</u> /prescription (retail and mail order)	<u>Deductible</u> does not apply. Covers up to a 90 day supply with multiple <u>Copays</u> . Additional <u>Out-of-Network</u> charges may apply.
	Non-preferred brand drugs	\$50 <u>Copay</u> /prescription (retail and mail order)	\$50 <u>Copay</u> /prescription (retail and mail order)	<u>Deductible</u> does not apply. Covers up to a 90 day supply with multiple <u>Copays</u> . Additional <u>Out-of-Network</u> charges may apply.
	<u>Specialty Drugs</u>	Preferred=30% <u>Coinsurance</u> Non-preferred=50% <u>Coinsurance</u> (retail and mail order)	Preferred=30% <u>Coinsurance</u> Non-preferred=50% <u>Coinsurance</u> (retail and mail order)	<u>Deductible</u> does not apply. Coverage may include limitations and <u>Preauthorization</u> may be required. Additional <u>Out-of-Network</u> charges may apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>Coinsurance</u> after <u>Deductible</u>	50% <u>Coinsurance</u> after <u>Deductible</u>	<u>Preauthorization</u> required.
	Physician/surgeon fees	10% <u>Coinsurance</u> after <u>Deductible</u>	50% <u>Coinsurance</u> after <u>Deductible</u>	<u>Preauthorization</u> required.
	<u>Emergency Room Care</u>	\$350 facility <u>Copay</u> /visit after <u>Deductible</u> ; other services 20% <u>Coinsurance</u> after <u>Deductible</u>	\$350 facility <u>Copay</u> /visit after <u>Deductible</u> ; other services 50% <u>Coinsurance</u> after <u>Deductible</u>	<u>Out-of-Network</u> services paid at <u>In-Network</u> if <u>Emergency Medical Condition</u> . <u>Copay</u> waived if admitted.
If you need immediate medical attention	<u>Emergency Medical Transportation</u>	20% <u>Coinsurance</u> after <u>Deductible</u>	50% <u>Coinsurance</u> after <u>Deductible</u>	----- note -----
	<u>Urgent Care</u>	\$30 <u>Copay</u> /visit; <u>Specialist</u> : \$50 <u>Copay</u> /visit; <u>Deductible</u> does not apply	50% <u>Coinsurance</u> after <u>Deductible</u>	<u>Cost Sharing</u> may vary based on physician. <u>Copay</u> does not apply to additional services.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>Coinsurance</u> after <u>Deductible</u>	50% <u>Coinsurance</u> after <u>Deductible</u>	<u>Preauthorization</u> required.
	Physician/surgeon fee	20% <u>Coinsurance</u> after <u>Deductible</u>	50% <u>Coinsurance</u> after <u>Deductible</u>	<u>Preauthorization</u> required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <u>Copay</u> visit, <u>Deductible</u> does not apply; 20% <u>Coinsurance</u> after <u>Deductible</u> for facility and other services	50% <u>Coinsurance</u> after <u>Deductible</u>	<u>Cost Sharing</u> may not apply to pediatric outpatient psychotherapy. \$10 <u>Copay</u> /visit for qualifying non-emergency telehealth services provided by MDLIVE. Additional telehealth services may be provided by your <u>Provider</u> .
	Inpatient services	20% <u>Coinsurance</u> after <u>Deductible</u>	50% <u>Coinsurance</u> after <u>Deductible</u>	<u>Preauthorization</u> required.
	Office Visits	20% <u>Coinsurance</u> after <u>Deductible</u>	50% <u>Coinsurance</u> after <u>Deductible</u>	For pregnancy services, <u>Cost Sharing</u> does not apply to certain <u>Preventive Services</u> . Depending on the type of services, a <u>Copay</u> , <u>Coinsurance</u> or <u>Deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
If you are pregnant	Childbirth/delivery professional services	20% <u>Coinsurance</u> after <u>Deductible</u>	50% <u>Coinsurance</u> after <u>Deductible</u>	none
	Childbirth/delivery facility services	20% <u>Coinsurance</u> after <u>Deductible</u>	50% <u>Coinsurance</u> after <u>Deductible</u>	none
	<u>Home Health Care</u>	20% <u>Coinsurance</u> after <u>Deductible</u>	50% <u>Coinsurance</u> after <u>Deductible</u>	<u>Preauthorization</u> required.
If you need help recovering or have other special health needs	<u>Rehabilitation Services</u>	20% <u>Coinsurance</u> after <u>Deductible</u>	50% <u>Coinsurance</u> after <u>Deductible</u>	Coverage is limited to 20 visit annual max.
	<u>Habilitation Services</u>	20% <u>Coinsurance</u> after <u>Deductible</u>	50% <u>Coinsurance</u> after <u>Deductible</u>	Coverage is limited to 20 visit annual max.
	<u>Skilled Nursing Care</u>	20% <u>Coinsurance</u> after <u>Deductible</u>	50% <u>Coinsurance</u> after <u>Deductible</u>	Coverage is limited to 30 day annual max.
	<u>Durable Medical Equipment</u>	20% <u>Coinsurance</u> after <u>Deductible</u>	50% <u>Coinsurance</u> after <u>Deductible</u>	<u>Preauthorization</u> required.
	<u>Hospice Services</u>	No charge. <u>Deductible</u> does not apply.	50% <u>Coinsurance</u> after <u>Deductible</u>	none

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge. <u>Deductible</u> does not apply.	50% <u>Coinsurance</u> , <u>Deductible</u> does not apply	Under the age of 19 only. VSP limits will apply.
	Children's glasses	No charge. <u>Deductible</u> does not apply.	50% <u>Coinsurance</u> , <u>Deductible</u> does not apply	Under the age of 19 only. VSP limits will apply.
	Children's dental check-up	Not covered	Not covered	----- none -----

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of other [excluded services.](#))

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental check-up (Child)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Chiropractic care
- Eye exam (Child)
- Glasses (Child)
- Hearing aids (Child)
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage:

** Group health coverage -

There are agencies that can help if you want to continue coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-4444-EBSA(3272) or www.dol.gov/ebsa/healthreform; or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.ccio.cms.gov. Other coverage options may be available to you too, including buying individual insurance through Your Health Idaho. For more information about Your Health Idaho, visit www.YourHealthIdaho.org or call 1-855-944-3246.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your [plan](#) for a denial of [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact:

For any initial questions concerning a claim, or to appeal a claim or benefit decision, please contact Customer Service at 1-208-286-3828 or 1-800-627-1188, www.bcoidaho.com, or at P.O. Box 7408, Boise, ID 83707.

If your plan is subject to ERISA, you may contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA or www.dol.gov/ebsa/healthreform

If your plan is fully insured or self-funded and subject to the Idaho Insurance Code, you may also receive assistance from the Idaho Department of Insurance at 1-800-721-3272 or www.DOI.Idaho.gov

Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [Coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's overall deductible](#) \$1,500
- [Specialist copay](#) \$50
- [Hospital \(facility\) coinsurance](#) 20%
- [Other coinsurance](#) 20%

This EXAMPLE event includes services like:

- [Specialist](#) office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- [Diagnostic tests](#) (*ultrasounds and blood work*)
- [Specialist](#) visit (*anesthesia*)

Total Example Cost \$12,690

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$10
Coinsurance	\$2,210
What isn't Covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,780

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's overall deductible](#) \$1,500
- [Specialist copay](#) \$50
- [Hospital \(facility\) coinsurance](#) 20%
- [Other coinsurance](#) 20%

This EXAMPLE event includes services like:

- [Primary care physician](#) office visits (*including disease education*)
- [Diagnostic tests](#) (*blood work*)
- [Prescription drugs](#)
- [Durable medical equipment](#) (*glucose meter*)

Total Example Cost \$5,830

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$120
Copayments	\$980
Coinsurance	\$0
What isn't Covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,120

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's overall deductible](#) \$1,500
- [Specialist copay](#) \$50
- [Hospital \(facility\) coinsurance](#) 20%
- [Other coinsurance](#) 20%

This EXAMPLE event includes services like:

- [Emergency room care](#) (*including medical supplies*)
- [Diagnostic test](#) (*x-ray*)
- [Durable medical equipment](#) (*crutches*)
- [Rehabilitation services](#) (*physical therapy*)

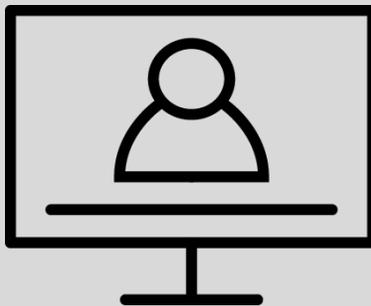
Total Example Cost \$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$450
Coinsurance	\$120
What isn't Covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,070

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Questions: Call 1-800-627-1188 or visit us at www.bcidaho.com/SBC.



TeleHealth Services

Blue Cross of Idaho - MDLIVE



Your life is 24/7. With Virtual Care, your doctor is, too.

AVOID THE WAIT! ACTIVATE YOUR BLUE CROSS OF IDAHO MDLIVE ACCOUNT TODAY AT mdlive.com/bcidaho.



When you can't see your primary care provider, you can consult with a board-certified doctor by phone, secure video or the MDLIVE app anytime, from anywhere. If you are in Idaho, you will need to use video to meet with the doctor.



MDLIVE doctors are available 24/7/365. Average wait time for medical consultations is less than 10 minutes. Therapists and psychiatrists require an appointment, with an average wait time of three to four days.



Your family members are eligible for virtual care, too. Pediatricians are available 24/7.

Activate your account online or by phone.

mdlive.com/bcidaho

888-920-2975

 **Download the MDLIVE App**

NON-EMERGENCY CONDITIONS WE TREAT:

- | | |
|---|--|
| <ul style="list-style-type: none"> • Acne • Allergies • Cold / Flu • Constipation • Cough • Diarrhea • Ear problems • Fever* • Headache • Insect bites • Nausea / Vomiting • Pink eye • Rash • Respiratory problems • Sore throats • Urinary problems / UTI* • Vaginitis • And more | <p>Behavioral Health</p> <ul style="list-style-type: none"> • Addictions • Bipolar disorders • Child and adolescent issues • Depression • Eating disorders • Gay/Lesbian/Bisexual/Transgender issues • Grief and loss • Life changes • Men's issues • Panic disorders • Parenting issues • Postpartum depression • Relationship and marriage issues • Stress • Trauma and PTSD • Women's issues • And more |
|---|--|

E-prescriptions can be sent to your preferred pharmacy (if required) for medical conditions. MDLIVE cannot prescribe medication for behavioral health conditions.

(continued)

**MDLIVE physicians may not treat any children with urinary symptoms. Parents/guardian will be required to complete a different medical history disclosure form for children under the age of 36-months prior to making an appointment with an MDLIVE physician. Children under 36 months who present with fever must be referred to their pediatrician (medical home), child-friendly urgent care center or emergency department for clinical evaluation and care.*

MDLIVE does not provide any healthcare services and is not an insurance product or a prescription fulfillment warehouse. MDLIVE does not replace your relationship with your primary care provider. MDLIVE operates subject to state regulation and may not be available in certain states. MDLIVE does not guarantee that a prescription will be written. MDLIVE does not prescribe DEA controlled substances, non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. Contents in this material are not a substitute for professional healthcare advice, diagnosis or treatment. MDLIVE healthcare professionals reserve the right to deny care for potential misuse of services. MDLIVE and the MDLIVE logo are registered trademarks of MDLIVE, Inc. and may not be used without written permission. For complete terms of use visit www.mdlive.com/pages/terms.html.

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Dental

Delta Dental

Benefit Summary

GENERAL BENEFIT PLAN SUMMARY

Classic Foods, Inc
 Group Number: 2309
 Contract Effective Date: 03/01/2021

Benefit Overview	PPO	Premier	Non-Participating
Per Person Deductible Excluding Diagnostic and Preventive services per benefit year	\$25	\$50	\$50
Family Deductible Excluding Diagnostic and Preventive services per benefit year	\$75	\$150	\$150
Maximum Benefit Per eligible person per benefit year	\$1,000	\$750	\$500

Services	You pay the % below		
Preventive & Diagnostic Services Examinations, X-rays, teeth cleaning	0%	0%	20%
Basic Services Fillings, root canals, extractions, oral surgery	20%	40%	60%
Major Services Crowns, onlays, bridges, dentures Late enrollee waiting period is 12 months	50%	100%	100%

PARTICIPATING AND NON-PARTICIPATING DENTISTS

If the dentist is a PPO or Premier participating dentist, Delta Dental will base payment on the lesser of the Submitted Amount or the Contract Fee. Delta Dental will send payment to the participating dentist and the subscriber will be responsible for any co-payment and/or any non-covered services.

If the dentist is a non-participating dentist, Delta Dental will base payment on the lesser of the Submitted Amount or Delta Dental's non-participating dentist Fee. It is the subscriber's responsibility to make full payment to the non-participating Dentist. For dental services rendered by an out-of-state dentist, Delta Dental will base payment on the lesser of the Submitted Amount or the Contract Fee in that area, if the out-of-state dentist is a participating dentist with a Delta Dental plan in the state in which the service is rendered.

Benefits and Limitations

Class I Preventive and Diagnostic Services
Examinations once every 6 months.
Cleanings once every 6 months (restricts against periodontal maintenance within the same time period).
Fluoride two times in any 12 consecutive month period for dependent children under age 19.
Full mouth series or panoramic X-rays once every 5 years.
Bitewing X-rays once every 12 months.
Class II Basic Services
Periodontal maintenance is allowed 4 times in 12 months if patient has had previously treated periodontal disease.
Scaling and root planing covered once per quadrant every 24 months. Periodontal surgery is payable once per quadrant in any 3 year period.
Fillings restricted to same tooth/surface once every 24 months.
Class III Major Restorative Services
Crowns, build-ups, stainless steel crowns, onlays, or bridges on same tooth once every 7 years.
Porcelain, porcelain substrate, and cast restorations are not payable for children less than 12 years.
Partials, or dentures 1 time per arch every 7 years, eligible for partials at age 16.
Implants
Implants are a covered benefit per tooth with a maximum lifetime benefit of \$1,200 or the plan's annual maximum, whichever is less (Ages 19 and over).
Dependents
Eligible children must be under age 26.

GENERAL PLAN INFORMATION

1. Optional treatment: If the subscriber or eligible dependent selects a more expensive service than is customarily provided. For example, if teeth can be restored satisfactorily with amalgam or composite material, the cost of inlays, onlays and crowns are not covered and the cost difference between the covered and the non-covered procedure is to be borne by the patient.
2. Payment provisions: The following guidelines will be used to determine the date on which a service shall be paid:
 - a. Full dentures or partial dentures: On the date the final impression is taken.
 - b. Fixed bridges, crowns, and onlays: On the date the tooth or teeth are prepared.
 - c. Root canal therapy: On the date the root canal is initiated.

3. Processing Policies may limit benefits. Processing Policies applied to a claim are noted on the Explanation of Benefits (EOB).
4. Predeterminations: If your dental treatment involves services of \$300 or greater, it is advisable to ask your dentist to submit a predetermination of benefits. A statement will be sent to you and your dentist estimating the amount of Delta Dental payment obligation and the amount that you will owe. These estimates will be subject to your continuing eligibility in the plan and the group contract remaining in effect. If claims for other completed dental services are received and processed prior to the completion date of the proposed treatment, this may reduce Delta Dental's estimated payment for the proposed treatment and increase your obligation to the dentist. Predeterminations are valid for ninety (90) days from the date issued by Delta Dental.

WHAT SERVICES ARE NOT COVERED?

No payment will be made by Delta Dental and all charges for the following services will be the responsibility of the subscriber:

1. Services for injuries or conditions payable under Workers' Compensation or Employer's Liability laws. Benefits or services that are available from any government agency, political subdivision, community agency, foundation, or similar entity. This provision does not apply to any programs provided under Title XIX Social Security Act, i.e., Medicaid.
2. Services for cosmetic surgery, or dentistry for aesthetic reasons.
3. Services or appliances started before an individual became eligible under the contract.
4. Prescription drugs, pre-medications and/or relative analgesia. General anesthesia and/or intravenous sedation other than for covered oral surgery. Charges for hospitalization, laboratory tests, and examinations and any additional fees charged by the dentist for hospital treatment.
5. Preventive control programs, including home care items.
6. Charges for failure to keep a scheduled visit with the dentist.
7. Repair, relines, or adjustments of occlusal guards.
8. Charges for completion of forms. A participating dentist may not make these charges to a subscriber or eligible dependent.
9. Prosthodontic services (Class III benefits), unless specified as a covered service in the Benefit Summary.
10. Orthodontic services (Class IV benefits), unless specified as a covered service in the Benefit Summary.
11. Lost, missing, or stolen appliances of any type and replacement or repair of orthodontic appliances.
12. Services for which no valid dental need can be demonstrated, that are specialized techniques, or that are experimental in nature as determined by the standards of generally accepted dental practice.
13. Appliances, surgical procedures, and restorations for increasing vertical dimension; for restoring occlusion; for replacing tooth structure loss resulting from attrition, abrasion, or erosion. If orthodontic benefits have been selected under this contract, this exclusion will not apply to the orthodontic services.
14. Treatment by other than a dentist, except for services performed by a licensed dental hygienist or denturist within the scope of his or her license.
15. Processing Policies may limit benefits. Processing Policies applied to a claim are noted on the Explanation of Benefits (EOB).
16. Services or supplies for which no charge is made, or for which the patient is not legally obligated to pay. This includes services or supplies furnished by a dentist who is related to the patient by blood or who is related to the patient by blood or marriage and who ordinarily dwells in the patient's household, the dentist providing service to him/her self, or services which would not have a charge in the absence of Delta Dental coverage.
17. Services or supplies received as a result of defect, or injury due to an act of war, declared or undeclared.
18. Services that are covered under a hospital, surgical/medical, or prescription drug program.
19. Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint (TMJ).
20. Myofunctional therapy.
21. Delta Dental is not obligated to pay claims received more than 12 months after the date of service.

22. Nutritional counseling, tobacco counseling and oral hygiene instruction are not covered benefits except for participants in Delta Dental's Health through Oral Wellness® (HOW®) program.

This is only a general summary of benefits. It provides a brief description about the important features of this policy and does not constitute a contract or guarantee of payment. Full terms and conditions are set forth in the policy provisions. If you have any questions about your plan's benefits or would like to submit a predetermination before services are performed, please call Delta Dental of Idaho customer service advisors at (208) 489-3580 or toll-free at (800) 356-7586. You may also log onto our website, www.deltadentalid.com, for benefit and eligibility information or up-to-date claim status.



Vision

United Heritage / VSP



Life is
better in
focus.™

Get access to the best in eye care and eyewear with UNITED HERITAGE LIFE INSURANCE COMPANY and VSP® Vision Care.



As a VSP member, you have access to care from great eye doctors, quality eyewear, and the affordability you deserve, all at the lowest out-of-pocket costs.

You'll like what you see with VSP.

- **Value and Savings.** You'll enjoy more value and the lowest out-of-pocket costs.
- **High Quality Vision Care.** You'll get the best care from a VSP network doctor, including a WellVision Exam®—the most comprehensive exam designed to detect eye and health conditions.
- **Choice of Providers.** The decision is yours to make—choose a VSP network doctor, a participating retail chain, or any out-of-network provider.
- **Great Eyewear.** It's easy to find the perfect frame at a price that fits your budget.

Using your VSP benefit is easy.

- **Create an account at vsp.com.** Once your plan is effective, review your benefit information.
- **Find an eye doctor who's right for you.** 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.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like bebe®, CALVIN KLEIN, Cole Haan, Flexon®, Lacoste, Nike, Nine West, and more.¹ Visit vsp.com to find a Premier Program location that carries these brands. Plus, save up to 40% on popular lens enhancements.² Prefer to shop online? Check out all of the brands at eyeconic.com®, VSP's preferred online eyewear store.

See why we're consumers' #1 choice in vision care³.

Contact us. 800.877.7195
vsp.com

Your VSP Vision Benefits Summary

United Heritage Life Insurance Company and VSP provide you with an affordable eye care plan.



VSP Provider Network: VSP Choice

Benefit	Description	Copay	Frequency
Your Coverage with a VSP Provider			
WellVision Exam	<ul style="list-style-type: none"> Focuses on your eyes and overall wellness 	\$10	Every 12 months
Prescription Glasses		\$25	See frame and lenses
Frame	<ul style="list-style-type: none"> \$130 allowance for a wide selection of frames \$150 allowance for featured frame brands 20% savings on the amount over your allowance \$70 Costco® frame allowance 	Included in Prescription Glasses	Every 12 months
Lenses	<ul style="list-style-type: none"> Single vision, lined bifocal, and lined trifocal lenses Polycarbonate lenses for dependent children 	Included in Prescription Glasses	Every 12 months
Lens Enhancements	<ul style="list-style-type: none"> Standard progressive lenses Premium progressive lenses Custom progressive lenses Average savings of 20-25% on other lens enhancements 	\$55 \$95 - \$105 \$150 - \$175	Every 12 months
Contacts (instead of glasses)	<ul style="list-style-type: none"> \$130 allowance for contacts; copay does not apply Contact lens exam (fitting and evaluation), billed amount not to exceed \$60 		Every 12 months
Extra Savings	<p>Glasses and Sunglasses</p> <ul style="list-style-type: none"> Extra \$20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. <p>Retinal Screening</p> <ul style="list-style-type: none"> No more than a \$39 copay on routine retinal screening as an enhancement to a WellVision Exam <p>Laser Vision Correction</p> <ul style="list-style-type: none"> Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities 		
Your Coverage with Out-of-Network Providers			
Get the most out of your benefits and greater savings with a VSP network doctor. Your coverage with out-of-network providers will be less or you'll receive a lower level of benefits. Visit vsp.com for plan details.			
Exam	up to \$45	Lined Bifocal Lenses	up to \$50
Frame	up to \$70	Lined Trifocal Lenses	up to \$65
Single Vision Lenses	up to \$30	Progressive Lenses	up to \$50
		Contacts	up to \$105
Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.			

This Benefit Summary is not part of your group's Policy or the Certificate of Coverage. The policy and certificate may contain certain Limitations and Exclusions not stated in this Benefit Summary. Please see the issued Policy and Certificate of Coverage for specific plan information.

Contact us. **800.877.7195** | vsp.com

1. Brands/Promotion subject to change.
 2. Savings based on network doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Available only through VSP network doctors to VSP members with applicable plan benefits. Ask your VSP network doctor for details.
 3. 2017 National Vision Plan Member Research.



Life Insurance

Unum



Term Life with Accidental Death & Dismemberment (AD&D) Insurance can provide money for your family if you die or are diagnosed with a terminal illness.

How does it work?

You keep coverage for a set period of time, or “term.” If you die during that term, the money can help your family pay for basic living expenses, final arrangements, tuition and more.

AD&D Insurance is also available, which can pay a benefit if you survive an accident but have certain serious injuries. It can pay an additional amount if you die from a covered accident.

Why choose Unum?

Your employer is contributing to the cost of this coverage. Unum is the leading provider of employee benefits, with more than 165 years of experience.¹ We’ll be there to back our benefits and provide you with the support you need.

What else is included?

A “Living” Benefit

If you are diagnosed with a terminal illness with less than 12 months to live, you can request 100% of your life insurance benefit (up to \$250,000) while you are still living. This amount will be taken out of the death benefit and may be taxable.

Waiver of premium

Your cost may be waived if you are totally disabled for a period of time.

Portability

You may be able to keep coverage if you leave the company, retire or change the number of hours you work.

Employees or dependents who have a sickness or injury having a material effect on life expectancy at the time their group coverage ends are not eligible for portability.

Who can get Term Life coverage?

If you are actively at work at least 30 hours per week, you can receive coverage for:

You:	You can receive a benefit amount of \$30,000.
Your spouse:	If eligible, (see delayed effective date), your spouse can receive the following coverage: Get \$2,000 of coverage for your spouse.
Your children:	If eligible, (see delayed effective date), your children can receive the following coverage: The maximum benefit for children from live birth to 6 months is \$1,000. The maximum benefit for children 6 months and older is \$2,000.

One policy covers all of your children until their 19th birthday - or until their 26th birthday if they are full time students**

Delayed Effective Date: if your spouse or child has a serious injury, sickness, or disorder, or is confined, their coverage may not take effect. Payment of premium does not guarantee coverage. Please refer to your policy contract or see your plan administrator for an explanation of the delayed effective date provision that applies to your plan.

Who can get Accidental Death & Dismemberment (AD&D) coverage?

You:	You can receive an AD&D benefit amount of \$30,000.
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No questions or health exams required for AD&D coverage.

Term Life Insurance with Accidental Death & Dismemberment (AD&D)

Exclusions and limitations

Actively at work

Eligible employees must be actively at work to apply for coverage. Being actively at work means on the day the employee applies for coverage, the individual must be working at one of his/her company's business locations; or the individual must be working at a location where he/she is required to represent the company. If applying for coverage on a day that is not a scheduled workday, the employee will be considered actively at work as of his/her last scheduled workday. Employees are not considered actively at work if they are on a leave of absence or lay off.

An unmarried handicapped dependent child who becomes handicapped prior to the child's attainment age of 26 may be eligible for benefits. Please see your plan administrator for details on eligibility.

Employees must be U.S. citizens or legally authorized to work in the U.S. to receive coverage.

Employees must be actively employed in the United States with the Employer to receive coverage. Employees must be insured under the plan for spouses and dependents to be eligible for coverage.

Exclusions and limitations

Life insurance benefits will not be paid for deaths that are caused by suicide occurring within 24 months after the effective date of coverage or the date that increases to existing coverage becomes effective. This exclusion standardly applies to all medically written amounts and contributory amounts that are funded by the employee including shared funding plans.

AD&D specific exclusions and limitations:

Accidental death and dismemberment benefits will not be paid for losses caused by, contributed to by, or resulting from:

- Disease of the body; diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM)
- Suicide, self-destruction while sane, intentionally self-inflicted injury while sane or self-inflicted injury while insane
- War, declared or undeclared, or any act of war
- Active participation in a riot
- Committing or attempting to commit a crime under state or federal law
- The voluntary use of any prescription or non-prescription drug, poison, fume or other chemical substance unless used according to the prescription or direction of your or your dependent's doctor. This exclusion does not apply to you or your dependent if the chemical substance is ethanol.
- Intoxication – "Being intoxicated" means your or your dependent's blood alcohol level equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the accident occurred.

Delayed effective date of coverage

Employee: Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

Delayed Effective Date: if your spouse or child has a serious injury, sickness, or disorder, or is confined, their coverage may not take effect. Payment of premium does not guarantee coverage. Please refer to your policy contract or see your plan administrator for an explanation of the delayed effective date provision that applies to your plan.

Age reduction

Coverage amounts for Life and AD&D Insurance for you and your dependents will reduce to 65% of the original amount when you reach age 70, and will reduce to 50% of the original amount when you reach age 75. Coverage may not be increased after a reduction.

Termination of coverage

Your coverage and your dependents' coverage under the policy ends on the earliest of:

- The date the policy or plan is cancelled
- The date you no longer are in an eligible group
- The date your eligible group is no longer covered
- The last day of the period for which you made any required contributions
- The last day you are actively employed (unless coverage is continued due to a covered layoff, leave of absence, injury or sickness), as described in the certificate of coverage

In addition, coverage for any one dependent will end on the earliest of:

- The date your coverage under a plan ends
- The date your dependent ceases to be an eligible dependent
- For a spouse, the date of a divorce or annulment
- For dependents, the date of your death

Unum will provide coverage for a payable claim that occurs while you and your dependents are covered under the policy or plan.

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form C.FP-1 et al or contact your Unum representative.

Life Planning Financial & Legal Resources services, provided by HealthAdvocate, are available with select Unum insurance offerings. Terms and availability of service are subject to change. Service provider does not provide legal advice; please consult your attorney for guidance. Services are not valid after coverage terminates. Please contact your Unum representative for details.

Unum complies with state civil union and domestic partner laws when applicable.

Underwritten by:

Unum Life Insurance Company of America, Portland, Maine

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Voluntary Accident, Cancer & Term Life Insurance

Colonial Life

Accidents happen in places where you and your family spend the most time – at work, in the home and on the playground – and they're unexpected. How you care for them shouldn't be.

In your lifetime, which of these accidental injuries have happened to you or someone you know?

- Sports-related accidental injury
- Broken bone
- Burn
- Concussion
- Laceration
- Back or knee injuries
- Car accidents
- Falls & spills
- Dislocation
- Accidental injuries that send you to the Emergency Room, Urgent Care or doctor's office

Colonial Life's Accident Insurance is designed to help you fill some of the gaps caused by increasing deductibles, co-payments and out-of-pocket costs related to an accidental injury. The benefit to you is that you may not need to use your savings or secure a loan to pay expenses. Plus you'll feel better knowing you can have greater financial security.

What additional features are included?

- Worldwide coverage
- Portable
- Compliant with Healthcare Spending Account (HSA) guidelines

Will my accident claim payment be reduced if I have other insurance?

You're paid regardless of any other insurance you may have with other insurance companies, and the benefits are paid directly to you (unless you specify otherwise).

What if I change employers?

If you change jobs or leave your employer, you can take your coverage with you at no additional cost. Your coverage is guaranteed renewable as long as you pay your premiums when they are due or within the grace period.

Can my premium change?

Colonial Life can change your premium only if we change it on all policies of this kind in the state where your policy was issued.

How do I file a claim?

Visit coloniallife.com or call our Customer Service Department at 1.800.325.4368 for additional information.

Benefits listed are for each covered person per covered accident unless otherwise specified.

Initial Care

- Accident Emergency Treatment.....\$125
- X-ray Benefit.....\$40
- Ambulance\$200
- Air Ambulance.....\$2,000

Common Accidental Injuries

Dislocations (Separated Joint)	Non-Surgical	Surgical
Hip	\$2,200	\$4,400
Knee (except patella)	\$1,100	\$2,200
Ankle – Bone or Bones of the Foot (other than Toes)	\$880	\$1,760
Collarbone (Sternoclavicular)	\$550	\$1,100
Lower Jaw, Shoulder, Elbow, Wrist	\$330	\$660
Bone or Bones of the Hand	\$330	\$660
Collarbone (Acromioclavicular and Separation)	\$110	\$220
One Toe or Finger	\$110	\$220

Fractures	Non-Surgical	Surgical
Depressed Skull	\$2,750	\$5,500
Non-Depressed Skull	\$1,100	\$2,200
Hip, Thigh	\$1,650	\$3,300
Body of Vertebrae, Pelvis, Leg	\$825	\$1,650
Bones of Face or Nose (except mandible or maxilla)	\$385	\$770
Upper Jaw, Maxilla	\$385	\$770
Upper Arm between Elbow and Shoulder	\$385	\$770
Lower Jaw, Mandible, Kneecap, Ankle, Foot	\$330	\$660
Shoulder Blade, Collarbone, Vertebral Process	\$330	\$660
Forearm, Wrist, Hand	\$330	\$660
Rib	\$275	\$550
Coccyx	\$220	\$440
Finger, Toe	\$110	\$220

Your Colonial Life policy also provides benefits for the following injuries received as a result of a covered accident.

- Burn (based on size and degree) \$1,000 to \$12,000
- Coma.....\$12,500
- Concussion \$60
- Emergency Dental Work \$100 Extraction, \$400 Crown, Implant, or Denture
- Lacerations (based on size).....\$30 to \$500

Requires Surgery

- Eye Injury.....\$300
- Tendon/Ligament/Rotator Cuff.....\$750 - one, \$1,500 - two or more
- Ruptured Disc\$750
- Torn Knee Cartilage\$750

Surgical Care

- Surgery (cranial, open abdominal or thoracic) \$1,500
- Surgery (hernia)\$150
- Surgery (arthroscopic or exploratory)\$200
- Blood/Plasma/Platelets\$300

Transportation/Lodging Assistance

If injured, covered person must travel more than 50 miles from residence to receive special treatment and confinement in a hospital.

- Transportation.....\$600 per round trip up to 3 round trips
- Lodging (family member or companion).....\$150 per night up to 30 days for a hotel/motel lodging costs

Accident Hospital Care

- Hospital Admission* \$1,000 per accident
 - Hospital ICU Admission* \$2,000 per accident
- * We will pay either the Hospital Admission or Hospital Intensive Care Unit (ICU) Admission, but not both.*
- Hospital Confinement \$225 per day up to 365 days per accident
 - Hospital ICU Confinement\$450 per day up to 15 days per accident

Accident Follow-Up Care

- Accident Follow-Up Doctor Visit \$50 (up to 4 visits per accident)
- Medical Imaging Study\$200 per accident
(limit 1 per covered accident and 1 per calendar year)
- Occupational or Physical Therapy \$35 per treatment up to 10 days
- Appliances \$100 (such as wheelchair, crutches)
- Prosthetic Devices/Artificial Limb \$750 - one, \$1,500 - more than 1
- Rehabilitation Unit.....\$150 per day up to 15 days per covered accident,
and 30 days per calendar year.
Maximum of 30 days per calendar year

Accidental Dismemberment

- Loss of Finger/Toe \$1,250 – one, \$2,400 – two or more
- Loss or Loss of Use of Hand/Foot/Sight of Eye \$12,000 – one, \$24,000 – two or more

Catastrophic Accident

For severe injuries that result in the total and irrecoverable:

- Loss of one hand and one foot
- Loss of both hands or both feet
- Loss or loss of use of one arm and one leg or
- Loss or loss of use of both arms or both legs
- Loss of the sight of both eyes
- Loss of the hearing of both ears
- Loss of the ability to speak

Named Insured \$25,000 Spouse\$25,000 Child(ren).....\$12,500

365-day elimination period. Amounts reduced for covered persons age 65 and over.

Payable once per lifetime for each covered person.

Accidental Death

	Accidental Death	Common Carrier
● Named Insured	\$50,000	\$200,000
● Spouse	\$50,000	\$200,000
● Child(ren)	\$10,000	\$40,000

My Coverage Worksheet (For use with your Colonial Life benefits counselor)

Who will be covered? (check one)

- Employee Only Spouse Only One Child Only Employee & Spouse
- One-Parent Family, with Employee One-Parent Family, with Spouse Two-Parent Family

When are covered accident benefits available? (check one)

- On and Off -Job Benefits Off -Job Only Benefits

We will not pay benefits for losses that are caused by or are the result of: elective abortion; felonies or illegal occupations; professional sports; sickness; suicide or self-inflicted injuries; war or armed conflict; in addition to the exclusions listed above, we also will not pay the Catastrophic Accident benefit for injuries that are caused by or are the result of: birth; intoxication.

For cost and complete details, see your Colonial Life benefits counselor. Applicable to policy form Accident 1.0-NS-ID. This is not an insurance contract and only the actual policy provisions will control.

Cancer Insurance

Level 2 Benefits

Cancer insurance helps provide financial protection through a variety of benefits. These benefits are not only for you but also for your covered family members.



For more information, talk with your benefits counselor.

BENEFIT DESCRIPTION	BENEFIT AMOUNT
Air ambulance Transportation to or from a hospital or medical facility <i>[max. of two trips per confinement]</i>	\$2,000 per trip
Ambulance Transportation to or from a hospital or medical facility <i>[max. of two trips per confinement]</i>	\$250 per trip
Anesthesia Administered during a surgical procedure for cancer treatment	
■ General anesthesia ■ Local anesthesia.....	25% of surgical procedures benefit \$30 per procedure
Anti-nausea medication Doctor-prescribed medication for radiation or chemotherapy <i>[\$160 monthly max.]</i>	\$40 per day administered or per prescription filled
Blood/plasma/platelets/immunoglobulins A transfusion required during cancer treatment <i>[\$10,000 calendar year max.]</i>	\$150 per day
Bone marrow donor screening Testing in connection with being a potential donor <i>[once per lifetime]</i>	\$50
Bone marrow or peripheral stem cell donation Receiving another person's bone marrow or stem cells for a transplant <i>[once per lifetime]</i>	\$500
Bone marrow or peripheral stem cell transplant Transplant you receive in connection with cancer treatment <i>[max. of two bone marrow transplant benefits per lifetime]</i>	\$4,000 per transplant
Cancer vaccine An FDA-approved vaccine for the prevention of cancer <i>[once per lifetime]</i>	\$50
Companion transportation Companion travels by plane, train or bus to accompany a covered cancer patient more than 50 miles one way for treatment <i>[up to \$1,000 per round trip]</i>	\$0.50 per mile
Egg(s) extraction or harvesting/sperm collection and storage Extracted/harvested or collected before chemotherapy or radiation <i>[once per lifetime]</i>	
■ Egg(s) extraction or harvesting/sperm collection ■ Egg(s) or sperm storage (cryopreservation)	\$700 \$200
Experimental treatment Hospital, medical or surgical care for cancer <i>[\$12,500 lifetime max.]</i>	\$250 per day
Family care Inpatient or outpatient treatment for a covered dependent child <i>[\$2,000 calendar year max.]</i>	\$40 per day
Hair/external breast/voice box prosthesis Prosthesis needed as a direct result of cancer	\$200 per calendar year
Home health care services Examples include physical therapy, occupational therapy, speech therapy and audiology; prosthesis and orthopedic appliances; rental or purchase of durable medical equipment <i>[up to 30 days per calendar year or twice the number of days hospital confined, whichever is greater]</i>	\$75 per day
Hospice (initial or daily care) An initial, one-time benefit and a daily benefit for treatment <i>[\$15,000 lifetime max. for both]</i>	
■ Initial hospice care <i>[once per lifetime]</i> ■ Daily hospice care	\$1,000 \$50 per day

Hospital confinement

Hospital stay (including intensive care) required for cancer treatment

- 30 days or less \$150 per day
- 31 days or more \$300 per day

Lodging \$50 per day

Hotel/motel expenses when being treated for cancer more than 50 miles from home
[70-day calendar year max.]

Medical imaging studies \$125 per study

Specific studies for cancer treatment *[\$250 calendar year max.]*

Outpatient surgical center \$200 per day

Surgery at an outpatient center for cancer treatment *[\$600 calendar year max.]*

Private full-time nursing services \$75 per day

Services while hospital confined other than those regularly furnished by the hospital

Prosthetic device/artificial limb \$1,500 per device or limb

A surgical implant needed because of cancer surgery *[payable one per site, \$3,000 lifetime max.]*

Radiation/chemotherapy

Weekly benefit *[max. once per week]*

- Injected chemotherapy by medical personnel \$500
- Radiation delivered by medical personnel \$500

Monthly chemotherapy benefit *[max. once per month]*

- Self-injected \$200
- Pump \$200
- Topical \$200
- Oral hormonal [1-24 months] \$200
- Oral hormonal [25+ months] \$100
- Oral non-hormonal \$200

Reconstructive surgery \$40 per surgical unit

A surgery to reconstruct anatomic defects that result from cancer treatment
[up to \$2,500 per procedure, including 25% for general anesthesia]

Second medical opinion \$200

A second physician's opinion on cancer surgery or treatment *[once per lifetime]*

Skilled nursing care facility \$100 per day

Confinement to a covered facility after hospital release *[up to the number of days paid for hospital confinement]*

Skin cancer initial diagnosis \$300

A skin cancer diagnosis while the policy is in force *[once per lifetime]*

Supportive or protective care drugs and colony stimulating factors \$100 per day

Doctor-prescribed drugs to enhance or modify radiation/chemotherapy treatments
[\$800 calendar year max.]

Surgical procedures \$50 per surgical unit

Inpatient or outpatient surgery for cancer treatment *[\$3,000 max. per procedure]*

Transportation \$0.50 per mile

Travel expenses when being treated for cancer more than 50 miles from home
[up to \$1,000 per round trip]

Waiver of premium Is available

No premiums due if the named insured is disabled longer than 90 consecutive days

The policy has limitations and exclusions that may affect benefits payable. Most benefits require that a charge be incurred. Policy may not be available in all states and may vary by state. For cost and complete details, see your benefits counselor.

This chart highlights the benefits of policy forms CanAssist-ID and CanAssist-MO. This chart is not complete without form 101505.



Cancer Insurance

Level 3 Benefits

Cancer insurance helps provide financial protection through a variety of benefits. These benefits are not only for you but also for your covered family members.



For more information, talk with your benefits counselor.

BENEFIT DESCRIPTION	BENEFIT AMOUNT
Air ambulance Transportation to or from a hospital or medical facility <i>[max. of two trips per confinement]</i>	\$2,000 per trip
Ambulance Transportation to or from a hospital or medical facility <i>[max. of two trips per confinement]</i>	\$250 per trip
Anesthesia Administered during a surgical procedure for cancer treatment	
■ General anesthesia ■ Local anesthesia.....	25% of surgical procedures benefit \$40 per procedure
Anti-nausea medication Doctor-prescribed medication for radiation or chemotherapy <i>[\$200 monthly max.]</i>	\$50 per day administered or per prescription filled
Blood/plasma/platelets/immunoglobulins A transfusion required during cancer treatment <i>[\$10,000 calendar year max.]</i>	\$175 per day
Bone marrow donor screening Testing in connection with being a potential donor <i>[once per lifetime]</i>	\$50
Bone marrow or peripheral stem cell donation Receiving another person's bone marrow or stem cells for a transplant <i>[once per lifetime]</i>	\$750
Bone marrow or peripheral stem cell transplant Transplant you receive in connection with cancer treatment <i>[max. of two bone marrow transplant benefits per lifetime]</i>	\$7,000 per transplant
Cancer vaccine An FDA-approved vaccine for the prevention of cancer <i>[once per lifetime]</i>	\$50
Companion transportation Companion travels by plane, train or bus to accompany a covered cancer patient more than 50 miles one way for treatment <i>[up to \$1,200 per round trip]</i>	\$0.50 per mile
Egg(s) extraction or harvesting/sperm collection and storage Extracted/harvested or collected before chemotherapy or radiation <i>[once per lifetime]</i>	
■ Egg(s) extraction or harvesting/sperm collection ■ Egg(s) or sperm storage (cryopreservation)	\$1,000 \$350
Experimental treatment Hospital, medical or surgical care for cancer <i>[\$15,000 lifetime max.]</i>	\$300 per day
Family care Inpatient or outpatient treatment for a covered dependent child <i>[\$2,500 calendar year max.]</i>	\$50 per day
Hair/external breast/voice box prosthesis Prosthesis needed as a direct result of cancer	\$350 per calendar year
Home health care services Examples include physical therapy, occupational therapy, speech therapy and audiology; prosthesis and orthopedic appliances; rental or purchase of durable medical equipment <i>[up to 30 days per calendar year or twice the number of days hospital confined, whichever is greater]</i>	\$100 per day
Hospice (initial or daily care) An initial, one-time benefit and a daily benefit for treatment <i>[\$15,000 lifetime max. for both]</i>	
■ Initial hospice care <i>[once per lifetime]</i> ■ Daily hospice care	\$1,000 \$50 per day

BENEFIT DESCRIPTION

BENEFIT AMOUNT

Hospital confinement

Hospital stay (including intensive care) required for cancer treatment

- 30 days or less \$250 per day
- 31 days or more \$500 per day

Lodging \$75 per day

Hotel/motel expenses when being treated for cancer more than 50 miles from home
[70-day calendar year max.]

Medical imaging studies \$175 per study

Specific studies for cancer treatment [\$350 calendar year max.]

Outpatient surgical center \$300 per day

Surgery at an outpatient center for cancer treatment [\$900 calendar year max.]

Private full-time nursing services \$125 per day

Services while hospital confined other than those regularly furnished by the hospital

Prosthetic device/artificial limb \$2,000 per device or limb

A surgical implant needed because of cancer surgery [payable one per site, \$4,000 lifetime max.]

Radiation/chemotherapy

Weekly benefit [max. once per week]

- Injected chemotherapy by medical personnel \$750
- Radiation delivered by medical personnel \$750

Monthly chemotherapy benefit [max. once per month]

- Self-injected \$300
- Pump \$300
- Topical \$300
- Oral hormonal [1-24 months] \$300
- Oral hormonal [25+ months] \$150
- Oral non-hormonal \$300

Reconstructive surgery \$60 per surgical unit

A surgery to reconstruct anatomic defects that result from cancer treatment
[up to \$3,000 per procedure, including 25% for general anesthesia]

Second medical opinion \$300

A second physician's opinion on cancer surgery or treatment [once per lifetime]

Skilled nursing care facility \$100 per day

Confinement to a covered facility after hospital release [up to the number of days paid for hospital confinement]

Skin cancer initial diagnosis \$400

A skin cancer diagnosis while the policy is in force [once per lifetime]

Supportive or protective care drugs and colony stimulating factors \$150 per day

Doctor-prescribed drugs to enhance or modify radiation/chemotherapy treatments
[\$1,200 calendar year max.]

Surgical procedures \$60 per surgical unit

Inpatient or outpatient surgery for cancer treatment [\$5,000 max. per procedure]

Transportation \$0.50 per mile

Travel expenses when being treated for cancer more than 50 miles from home
[up to \$1,200 per round trip]

Waiver of premium Is available

No premiums due if the named insured is disabled longer than 90 consecutive days

The policy has limitations and exclusions that may affect benefits payable. Most benefits require that a charge be incurred. Policy may not be available in all states and may vary by state. For cost and complete details, see your benefits counselor.

This chart highlights the benefits of policy forms CanAssist-ID and CanAssist-MO. This chart is not complete without form number 101505.





Term Life Insurance

Help protect the people who depend on you

If something happened to you, the last thing your family should have to worry about is financial burdens. Funeral expenses, medical bills and taxes could be just the beginning. How would they cover ongoing living expenses, such as a mortgage, utilities and health care?

Plan for the future with term life insurance from Colonial Life & Accident Insurance Company.

The advantages of term life insurance

- Level death benefit.
- Lower cost option compared with cash value insurance.
- Coverage for specified periods of time, which can be during high-need years.
- Benefit for the beneficiary that is typically free from income tax.

Benefits and features

- Guaranteed premiums do not increase during the term.
- Coverage is guaranteed renewable to age 95 as long as premiums are paid when due.
- You can convert it to cash value insurance.
- Portability allows you to take it with you if you change jobs or retire.
- An accelerated death benefit is included.



Your cost will vary based on the level of coverage you select.

Talk with your Colonial Life benefits counselor for information about what level of coverage would work best for you.

Benefits worksheet

For use with your Colonial Life benefits counselor

HOW MUCH COVERAGE DO YOU NEED?

YOU \$ _____
FACE AMOUNT

Select the term period

- 10-year term
- 20-year term
- 30-year term

SPOUSE \$ _____
FACE AMOUNT

Select the term period

- 10-year term
- 20-year term
- 30-year term

Select any optional riders:

- Spouse term life rider
\$ _____ face amount
for _____-year term period
- Children's term life rider
\$ _____ face amount
- Waiver of premium benefit rider
- Accidental death benefit rider

To learn more,
talk with your Colonial Life
benefits counselor.

ColonialLife.com

Cash value policy conversion

You can convert your policy to a Colonial Life cash value life insurance policy any time through age 75 (unless you have used the accelerated death benefit or waiver of premium benefit rider) with no evidence of insurability. Premiums will be based on your age at the time you convert your policy.

Accelerated death benefit

If you are diagnosed with a terminal illness, you can request up to 75% of the policy's death benefit, not to exceed \$150,000. We deduct a fee only if you use the benefit, and your death benefit will then be reduced by the amount you receive. In addition, there may be tax consequences for receiving the accelerated benefit; ask your tax advisor for advice. Please refer to your policy for details.

Spouse coverage options

Two options are available for spouse coverage at an additional cost:

1. **Spouse term life policy:** Offers guaranteed premiums and level death benefits equivalent to those available to you – whether or not you buy a policy for yourself.
2. **Spouse term life rider:** Add a term rider for your spouse to your policy, up to a maximum death benefit of \$50,000; 10-year and 20-year are available (20-year rider only available with a 20- or 30-year term policy).

Dependent coverage

You may add a children's term life rider to cover all of your eligible dependent children with up to \$10,000 in coverage each for one premium. The children's term life rider may be added to either the primary or spouse policy, not both.

Waiver of premium benefit rider

This rider waives all premiums (for the policy and any riders) if you become totally and permanently disabled before the age of 65. To be considered permanent, your total disability must continue with no interruptions for at least six consecutive months. Premiums waived by this rider do not have to be repaid. This rider is available for the spouse policy as well, subject to home office approval.

Accidental death benefit rider

This rider provides an additional benefit to the beneficiary if the insured dies as a result of an accident before age 70. The benefit doubles if the injury resulting in death occurs while insured is a fare-paying passenger on a public conveyance, such as a commercial aircraft or taxicab. An additional seatbelt benefit is also payable.

EXCLUSIONS AND LIMITATIONS

If the insured commits suicide within two years (one year in CO and ND) from the coverage effective date, whether he is sane or insane (not applicable in AZ), we will not pay the death benefit. We will terminate this policy and return the premiums paid, without interest. In MO, should death occur as a result of suicide, our company is responsible only for the return of premiums paid when application is made with intent to commit suicide.

You will receive a policy summary or illustration (whichever is applicable to your state) when your policy is issued if this policy has exclusions, limitations or reductions of benefits. For costs and complete details, call or write your Colonial Life benefits counselor or the company. This brochure is applicable to policy forms TERM1000, R-TERM1000-ADB, R-TERM1000-CTR, R-TERM1000-STR, R-TERM1000-WAIVER (and applicable state variations, for example: TERM1000-TX, R-TERM1000-ADB-TX-1, R-TERM1000-CTR-TX, R-TERM1000-STR-TX and R-TERM1000-WAIVER-TX-1). See your Colonial Life benefits counselor for additional information specific for your state. This coverage contains limitations and exclusions that may affect benefits payable. Product may vary by state.



Premiums

Premiums

Medical

Blue Cross of Idaho

Gold Choice PPO \$1,500				
Status	Total Premium Per Month	Employer Contribution Per Month	Employee Cost Per Month	Employee Cost Per Paycheck (24)
Employee	\$	\$	\$	\$
Employee & Spouse	\$	\$	\$	\$
Employee + Children	\$	\$	\$	\$
Family	\$	\$	\$	\$

Dental

Delta Dental

PPO / Premier Provider Network				
Status	Total Premium Per Month	Employer Contribution Per Month	Employee Cost Per Month	Employee Cost Per Paycheck (24)
Employee	\$37.49	\$	\$	\$
Employee + Spouse	\$73.75	\$	\$	\$
Employee + 1 Child	\$67.26	\$	\$	\$
Employee + Children	\$115.62	\$	\$	\$
Family	\$151.93	\$	\$	\$

Vision

United Heritage / VSP

PLAN TYPE				
Status	Total Premium Per Month	Employer Contribution Per Month	Employee Cost Per Month	Employee Cost Per Paycheck (24)
Employee	\$	\$0.00	\$	\$
Employee + 1	\$	\$0.00	\$	\$
Family	\$	\$0.00	\$	\$



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