




Limited Fixed Indemnity Benefit Plan

Limited Fixed Indemnity Benefit Plans are being offered by your employer to help meet the insurance needs of you and your family. This benefit summary is intended to give you a brief overview of the benefits and is not a guarantee of payment. Benefits are based on plan provisions outlined in the Certificate of Insurance.

2011 Renewal

<p>Claims & Customer Service (877) 685-2432</p> <p>Beech Street CORPORATION</p> <p>National PPO Network To locate a hospital or physician, visit www.beechstreet.com/beeplus/lbp or for assistance in English or Spanish please call (866) 907-3619</p> <p>dataRx The difference is visible</p> <p>Pharmaceutical Benefits www.century.data-rx.com or call Member Help Desk: (800) 454-9399 Pharmacy Help Desk: (888) 714-4422</p> <p>Careington Promoting Health and Well-Being</p> <p>24 Hour NurseLine (866) 796-1857; Pin: 526</p> <p>*Accident Medical & AD&D: <i>Please note: You must file a separate claim form for benefits to be paid.</i> To request a claim form, please call (877) 685-2432.</p> <p>Benefits Paid to Insured Unless Assigned To A Provider</p> <p>Coverage That Is Easy To Use</p> <p>Guaranteed Issue For Eligible Employees & Their Dependents</p> 	DESCRIPTION	SELECT	SELECT EHS	PREMIER	PREMIER EHS
	Doctor's Office Visit¹	Pays \$80 per visit (5 visits)	Pays \$80 per visit (5 visits)	Pays \$80 per visit (5 visits)	Pays \$80 per visit (5 visits)
	Wellness/Well Child¹	Pays \$100 per visit (1 visit)	Pays \$100 per visit (1 visit)	Pays \$100 per visit (1 visit)	Pays \$100 per visit (1 visit)
	Outpatient X-Ray & Lab¹	Pays \$50 per visit (3 visits)	Pays \$50 per visit (3 visits)	Pays \$50 per visit (3 visits)	Pays \$50 per visit (3 visits)
	Emergency Room Benefit¹	Pays \$100 per visit (1 sickness)	Pays \$100 per visit (1 sickness)	Pays \$100 per visit (1 sickness)	Pays \$100 per visit (1 sickness)
	In-Patient/Out-Patient Surgery Benefits¹	Pays \$750 per surgery (1 surgery)	Pays \$750 per surgery (1 surgery)	Pays \$750 per surgery (1 surgery)	Pays \$750 per surgery (1 surgery)
	In-Patient/Out-Patient Anesthesia Benefits¹	Pays \$188 per surgery (1 surgery)	Pays \$188 per surgery (1 surgery)	Pays \$188 per surgery (1 surgery)	Pays \$188 per surgery (1 surgery)
	Hospital Confinement¹	Pays \$200 per day (Maximum of 15 days)	Day 1: Pays \$1,300 Days 2-15: \$300 per day	Day 1: Pays \$1,000 Days 2-15: \$500 per day	Day 1: Pays \$2,100 Days 2-15: \$600 per day
	Maternity¹	Included	Included	Included	Included
	*Accident Medical² (\$100 deductible per occurrence)	Up to \$5,000 per occurrence	Up to \$5,000 per occurrence	Up to \$5,000 per occurrence	Up to \$5,000 per occurrence
	*Accidental Death & Dismemberment²				
	Employee	\$15,000	\$15,000	\$15,000	\$15,000
	Spouse	\$7,500	\$7,500	\$7,500	\$7,500
	Child	\$3,000	\$3,000	\$3,000	\$3,000
	Term Life³				
Employee	\$10,000	\$10,000	\$10,000	\$10,000	
Pharmaceutical Benefits⁴	Discount Drug	Discount Drug	Discount Drug	Discount Drug	
Discount Drug	Employees and their dependents pay the lesser of the pharmacy's usual and customary fee or the contract rate. Discounts are available on both generic and brand name drugs. Contraceptive drugs are included. Savings range from 15% to 80% based on the drug type (brand or generic) and the participating pharmacy filling the claim. No claim forms required. Prescriptions for 30-day supplies can be filled at more than 55,000 participating pharmacies nationwide including all of the national chains and over 90% of independent pharmacies. For additional savings, you may also utilize our mail order pharmacy for 90 day supplies.				
Beech Street PPO Network Access	All plan designs provide covered individuals access to a PPO Network that allows them to take advantage of network negotiated rates prior to the above benefits being applied.				
24 Hour NurseLine	All plan designs provide covered individuals 24-hour telephone access to nurses for medical decision support and patient advocacy (available in multiple languages with an audio health information library).				
Monthly Employee Cost⁵	Select*	Select EHS*	Premier*	Premier EHS*	
Employee	\$80.00	\$94.96	\$100.00	\$114.96	
Employee & Spouse	\$158.00	\$195.00	\$202.00	\$239.00	
Employee & Child(ren)	\$127.00	\$156.00	\$161.00	\$190.00	
Family	\$204.00	\$254.00	\$264.00	\$314.00	

All benefits, except Accident Medical Expense, AD&D and Term Life are subject to Plan Year maximums as shown above. Plan Year means the 12 consecutive months from the group's original effective date.

See Important Notices Page

***There will be additional \$5.00 administrative fee per billing/credit card transaction charged in addition to the rates shown.**

LFIBP-CHC2184-09/2011

Please be advised **members** are responsible for notifying CHC of any changes in eligibility, changes in account information or to request a termination. Please contact CHC Customer Service at (877) 685-2432 or send to anichols@centuryhealthcare.com

IMPORTANT NOTICE

This is a program highlight sheet and is not intended to be a complete or legal description of the program of benefits. Complete information will be provided to you in the certificate of insurance or member booklets for the various programs in which you choose to participate.

1. The Limited Accident & Sickness Indemnity insurance plan is underwritten by ACE American Insurance Company.
2. Fairmont Specialty, a division of Crum & Forster Insurance Company is the carrier for these benefits.
3. The Term Life insurance plan is underwritten by Standard Life Insurance.
4. Independence American Insurance Company is the underwriting manager on behalf of the carrier. DataRx is the Pharmacy Benefit Manager who manages the pharmacy benefits and processes the claims.
5. These rates assume eligible persons pay 100% of premium.

Exclusions: The following is a brief list of the exclusions and limitations for the Limited Accident & Sickness Indemnity Insurance plan. It is not a complete list. A complete list is available from the group's agent and will be included in the Certificate of Insurance issued to each participating employee.

- ❖ Treatment related to weight control
- ❖ Dental, eye or vision care
- ❖ Self inflicted injury, suicide or suicide attempt
- ❖ War, military service or riot
- ❖ Operating a motorized vehicle without a valid driver's license
- ❖ Cosmetic surgery or experimental treatment
- ❖ Mental Illness or Alcohol or Drug Abuse
- ❖ Elective abortion
- ❖ Claims incurred while intoxicated, under the influence of any drugs or while committing or attempting to commit a felony
- ❖ Treatment rendered outside of the US except in an emergency

In addition, a 6 month pre-existing conditions limitation applies to hospital and surgery benefits only.

A "pre-existing condition" is any condition occurring in the 6 month period prior to becoming insured under the plan for which a person has sought or received medical treatment or is taking prescription medication. It includes any condition that would cause an ordinarily prudent person to seek medical treatment.

This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit ACE American Insurance Company from providing insurance, including, but not limited to, the payment of claims.

This information is a brief description of the important features of the insurance plan provided under Policy Form Numbers AH-18088 and AH-10334. It is not a contract of insurance. Terms and conditions of coverage will be set forth in the group policy underwritten by ACE American Insurance Company and issued to the employer or, in some states, to the ACE USA Accident & Health Insurance Trust on behalf of the employer. The group policy is subject to the laws of the employer's state or, if issued through the Trust, the District of Columbia. Please keep this material as a reference and review your certificate carefully once you receive it.

IMPORTANT! *The Limited Accident & Sickness Indemnity Insurance Plan is not comprehensive major medical insurance. It is a package of services and fixed indemnity benefits that pays benefits for specified medical services and is designed to help take care of the basic medical care needs of insured employees and their families. This plan pays in addition to any other insurance in force. Please note, that this plan is not a Medicare Supplement plan.*



Limited Fixed Indemnity Benefit Programs

Voluntary Offerings



Description

Silver Dental Plan

\$1,000 / Plan Year Maximum
 \$500 maximum for periodontics
 \$500 maximum for orthodontia

CATEGORY	PLAN PAYS	CATEGORY	PLAN PAYS
Type 1: Preventive & Diagnostic		Type 5: Periodontics (\$500 Lifetime Maximum)	
a. Oral exams, including prophylaxis	\$36.00	a. Tissue grafts or bone surgery	\$96.00
b. Bitewings, per film	\$4.80	b. Gingivectomy (per quadrant), periodontal scaling, periodontal splinting, root planing	\$60.00
c. X-ray, panoramic or cephalometric	\$36.00	c. Gingival curettage (per quadrant)	\$36.00
d. Sealants / topical fluoride	\$10.20	d. Gingivectomy (per tooth)	\$24.00
e. Space maintainers	\$108.00		
Type 2: Major Restorative		Type 6: Oral Surgery	
a. Crowns, bridges & dentures	\$180.00	a. Surgeries Level 1 (ex. Removal of exostosis)	\$120.00
b. Pre-fabricated crowns	\$60.00	b. Surgeries Level 2 (ex. Removal of impacted tooth)	\$66.00
c. Crown build-up procedures	\$48.00	c. Surgeries Level 3 (ex. Simple extraction)	\$36.00
Type 3: Minor Restorative		Type 7: General Anesthesia and IV	
a. Fillings	\$42.00	a. IV, first half hour general, each additional 1/4 hour general	\$72.00
b. Crown, bridge and denture repairs	\$24.00		
c. Relining or rebasing dentures	\$60.00		
Type 4: Endodontics		Type 8: Orthodontia	
a. Root canals, apicoectomies	\$192.00		\$500.00
b. Root amputation	\$96.00		
c. Therapeutic pulpotomy, retrograde fillings, apexification, hemisection	\$48.00		

Types 1 through 7 subject to annual maximum of: \$1,000.00
Types 2, 5, 6a, 7 and 8 are subject to 12 month waiting period

VSP Free Exam

- Over 25,000 private practice optometrists and ophthalmologist nationwide.
- One free WellVision Exam per person per calendar year
- 20% discount off complete pair of lenses and frames
- 15% discount off contact lens fitting & evaluation exam.
- 15% average discount off the regular price or 5% off promotional price for Laser Vision Correction from contracted facilities.

To find doctors in your neighborhood visit:
www.vsp.com or call (800) 877-7195

Careington Dental PPO Network

To access a Careington Dental PPO provider:
<https://www.careington.com/search/search.aspx?gpId=PPO&agentcode=CENTURYPP056042P>

Monthly Premium	
Employee	\$21.63
Employee & Spouse	\$37.63
Employee & Children	\$50.63
Family	\$66.63

VSP Vision Plan

Your Coverage from a VSP Doctor

\$25 copayevery calander year

WellVision Exam® focuses on your eye health and overall wellness every plan year

Prescription Glasses

Lenses every plan year

- Single vision, lined bifocal, and lined trifocal lenses.
- Polycarbonate lenses for dependent children.

Frame every other plan year

- \$120 allowance for frame of your choice
- 20% off the amount over your allowance

~OR~

Contact Lens Care every plan year

\$120 allowance for contacts and the contact lens exam (fitting and evaluation). This additional exam ensures proper fit of contacts.

Current soft contact lens wearers may qualify for a special program that includes a contact lens evaluation and initial supply of replacement lenses. Effective January 1, 2009

Diabetic Eyecare Program – Allows you to obtain medical Eyecare services related to Type 1 diabetes. There is a \$5 copay for medical eyecare exams.

Extra Discounts and Savings

Glasses and Sunglasses

- Average 30% savings on lens options like progressives and scratch-resistant and anti-reflective coatings
- 20% off additional glasses and sunglasses, including lens options*

Contacts*

- 15% off cost of contact lens exam (fitting and evaluation)

Laser Vision Correction

- Average 15% off the regular price or 5% off the promotional price from contracted facilities.
- After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor

* Available from any VSP doctor within 12 months of your last eye exam

Your Monthly Contribution

Employee Only	\$10.05
Employee + Spouse	\$16.42
Employee + Child(ren).....	\$16.38
Employee + Family	\$26.43

You get the best value from your benefit when you see a VSP doctor. If you see a non-VSP provider, you'll typically pay more out-of-pocket. You'll pay the provider in full and have 6 months to submit a claim to VSP for partial reimbursement less copays. Before seeing a non-VSP provider, call us at 800.877.7195.

Out-of-Network Reimbursement Amounts:

Exam.....Up to \$45
Single vision lensesUp to \$45

***Dependent Spouse benefit level can not exceed the insured's coverage amount.**

Child(ren)'s benefit is in family units, the price is the same if there are more than one child.

Lined bifocal lensesUp to \$65
Lined trifocal lensesUp to \$85
FrameUp to \$47
Contacts.....Up to \$105

OPTIONAL LIFE

Optional Life Insurance helps provide financial protection by promising to pay a benefit in the event of an eligible employee's covered death.

	Option II	Option III
Benefit Schedule	\$25,000	\$50,000
Guarantee Issue	All Amounts Guaranteed	
Age Reduction	65% at age 65–69 50% at age 70–74 35% at age 75–79 25% at age 80–84 20% at age 85–89 15% at age 90–94 10% at age 95+	
Monthly Cost		
Age <=44	\$4.50	\$9.00
45-59	\$17.75	\$35.50
60+	\$84.50	\$169.00

DEPENDENT LIFE*

Dependent Life Insurance allows insured members to provide life insurance for their spouse and/or child(ren). This provides additional financial security for employees and their families.

	Option I	Option II
Spouse Benefit	\$10,000	\$25,000
Monthly Cost	\$5.28	\$13.20

	Option I	Option II
Child(ren) Benefit	\$2,000	\$10,000
Monthly Cost	\$0.36	\$1.80



Enrollment Form for Group Limited Accident & Sickness Indemnity Insurance

Employer - Please complete this section:	Indicate one of the following:	Is this:
Requested Effective Date: _____	<input type="checkbox"/> Initial Enrollment	<input type="checkbox"/> New Coverage
Date of Hire: _____	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Change in Coverage
	<input type="checkbox"/> New Hire	
	<input type="checkbox"/> Life Status Change	

EMPLOYER'S NAME: Lakeshore Consortium, Inc.

CHC GROUP No. CHC 2184

EMPLOYEE INFORMATION:

_____	_____	_____	_____	
Last Name	First Name	Middle Initial	Social Security No.	
_____		_____	_____	_____
Mailing Address		City	State	Zip Code
_____	_____	Sex:	Marital Status:	
Home Phone	Date of Birth	<input type="checkbox"/> Male	<input type="checkbox"/> Single	<input type="checkbox"/> Legally Separated
_____		<input type="checkbox"/> Female	<input type="checkbox"/> Married	<input type="checkbox"/> Widowed
Your Email Address			<input type="checkbox"/> Divorced	

Location of Employment				

BENEFIT PLAN SELECTION INFORMATION:

Limited Accident & Sickness Indemnity Insurance Plan Option:	Coverage Type:	Payment Method*:
<input type="checkbox"/> Select Plan	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Visa
<input type="checkbox"/> Select EHS Plan	<input type="checkbox"/> Employee & Spouse	<input type="checkbox"/> MasterCard
<input type="checkbox"/> Premier Plan	<input type="checkbox"/> Employee & Child(ren)	<i>*Complete authorization section on back. A \$5 administrative fee per transaction will be charged.</i>
<input type="checkbox"/> Premier EHS Plan	<input type="checkbox"/> Employee & Family	

DEPENDENT INFORMATION:

If you are enrolling any of your dependents (spouse or child(ren)), please be sure to include their information below; otherwise, their enrollment may be delayed or coverage declined.

Do you have an eligible spouse? Yes No How many eligible children do you have? _____

Please provide the following information for all eligible dependents to be insured under the plan:

_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____
Spouse's Full Name	Social Security No.	Date of Birth		Age
_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____
Child's Full Name	Social Security No.	Date of Birth		Age
_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____
Child's Full Name	Social Security No.	Date of Birth		Age
_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____
Child's Full Name	Social Security No.	Date of Birth		Age

Refusal of Coverage (check the box below if you are not enrolling in the plan; you do not need to sign/date the form):

I choose not to enroll in the **Limited Accident & Sickness Insurance Plan(s)** offered by my employer. I understand that, if at a later date, I wish to enroll in this plan, I will not be able to do so unless there is another open enrollment period or a life status event.

I have read the Limited Accident & Sickness Insurance Plan enrollment material and accept the terms and conditions of the coverage outlined in it. I understand the Limited Accident & Sickness Insurance Plan does not provide Major Medical or Comprehensive Medical coverage. I have read the enrollment material and understand my coverage is subject to the terms and conditions of the policy issued to my employer. I understand my coverage will go into effect on the date stated in the material only if I am in active service with my employer on that date. If I am not in active service on that date, my coverage will go into effect on the date I return to active service. If I have elected coverage for my dependents, their coverage will not go into effect prior to my effective date. I understand that hospital, surgery and/or disability benefits available under the plan may not be payable for any pre-existing condition until after coverage has been in effect for six months.

To the best of my knowledge and belief, all information I have provided is true and complete. I understand my information is protected by privacy laws and will be released only in accordance with these laws. The only people who have access to this information are employees of the Insurance Company who service my policy or claim and other third parties authorized by the Insurance Company. Information may be disclosed to those who have an insurance-related regulatory or legal need for the information. In other situations, the Insurance Company will ask me for written authorization to disclosed information about me.

WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

Employee's Signature

Date Signed

CREDIT CARD AUTHORIZATION

(Please Print)

Name _____

Address _____

Street

City

State

Zip Code

Mailing Address

(If different than above)

Street or P.O. Box

City

State

Zip Code

Visa MasterCard Name on Credit Card _____

Credit Card Number _____

Expiration Date _____

Telephone Number _____

Fax Number _____

I authorize Affinity Group Underwriters / Towers Affinity Benefit Services* to bill my Visa / MasterCard for insurance plan(s) provided by ACE American Insurance Company.

This authorization is to remain in force until Affinity Group Underwriters / Towers Affinity Services has received written notification from me of its termination in such time and in such manner as to afford Affinity Group Underwriters / Towers Affinity Benefit Services reasonable opportunity to act upon it.

**Century Healthcare utilizes Affinity Group Underwriters / Towers Affinity Benefit Services to administer billing and premium collection for Credit/Debit transactions.*



Return completed form to your employer

Enrollment Form for Group Insurance

EMPLOYER'S NAME: **Lakeshore Consortium, Inc.**

CHC GROUP NO. **CHC2184**

EMPLOYEE INFORMATION:

Last Name First Name Middle Initial Social Security No.

Phone

BENEFIT PLAN SELECTION INFORMATION:

Voluntary Benefit Plan Options:

- | | | | | |
|-----------------------------------|--|--|--|--|
| Hospital Supplement Plan | <input type="checkbox"/> Employee Only | <input type="checkbox"/> Employee & Spouse | <input type="checkbox"/> Employee & Child(ren) | <input type="checkbox"/> Employee & Family |
| Dental | <input type="checkbox"/> Employee Only | <input type="checkbox"/> Employee & Spouse | <input type="checkbox"/> Employee & Child(ren) | <input type="checkbox"/> Employee & Family |
| VSP Vision | <input type="checkbox"/> Employee Only | <input type="checkbox"/> Employee & Spouse | <input type="checkbox"/> Employee & Child(ren) | <input type="checkbox"/> Employee & Family |
| Optional Employee Life | <input type="checkbox"/> \$25,000 | <input type="checkbox"/> \$50,000 | | |
| Dependent Spouse Life* | <input type="checkbox"/> \$10,000 | <input type="checkbox"/> \$25,000 | | |
| Dependent Child(ren) Life* | <input type="checkbox"/> \$2,000 | <input type="checkbox"/> \$10,000 | | |

Refusal of Coverage (check the box below if you are not enrolling in the plan; you do not need to sign/date the form):

- I choose not to enroll in **The Standard Insurance Plan(s)** offered by my employer. I understand that, if at a later date, I wish to enroll in this plan; I will not be able to do so unless there is another open enrollment period.

BENEFICIARY INFORMATION:

Fairmont Specialty Services – Accidental Death & Dismemberment

Primary Beneficiary – Name & Address Social Security No. % of Benefit Relationship

Contingent Beneficiary – Name & Address Social Security No. % of Benefit Relationship

The Standard – Optional Life & Dependent Life

Primary Beneficiary – Name & Address Social Security No. % of Benefit Relationship

Contingent Beneficiary – Name & Address Social Security No. % of Benefit Relationship

If you have **selected Dependent Life**, please provide the following information for your spouse and/or child(ren):

Spouse's Full Name Child's Full Name

If you do not name a Beneficiary, or if you are not survived by one, benefits will be paid in equal shares to the first surviving class of the classes below.

- (1) Your Spouse (2) Your children (3) Your parents (4) Your brothers and sisters and (5) Your estate