

Dear Joe Smith,

04/01/2018

**Welcome to the Seniors Choice Group Retiree Medical and Prescription!**

Enclosed you will find your Seniors Choice fulfillment packet. Be sure to read through everything to familiarize yourself with the benefit program.

- Identification Card
- Schedule of Benefits
- Certificate of Insurance
- EPIC Hearing Benefits
- Outlook Vision Benefits

**Important Seniors Choice Medical Information:**

This packet contains your new Seniors Choice medical identification card. This identification card along with your Medicare card must be presented to the doctor and hospital for services received on or after your effective date. Please remember, if your name or Medicare Beneficiary Identifier (MBI#) changes with the Social Security Administration, you must notify MBA immediately to ensure proper eligibility and claims processing.

Please be advised that claims will be forwarded directly from Medicare to Guarantee Trust Life Insurance Company for processing. Should you have questions regarding medical claims, please contact Guarantee Trust Life Insurance Company at (800) 338-7452. Claims that have not been forwarded automatically to Guarantee Trust Life Insurance Company should be submitted to:

**Guarantee Trust Life Insurance Company**  
**P.O. Box 1148**  
**Glenview, IL 60025**

**Important Seniors Choice Part D Prescription Information:**

Your Seniors Choice Prescription Drug Plan identification card will be sent to you directly from Humana and will contain information regarding your drug program. Once enrolled, if you have questions regarding prescription claims, please call Humana at (866) 396-8810.

**Important Enhanced Benefits Information:**

- **Outlook Vision** is a program included as part of the Seniors Choice Plan. Presenting this card to participating providers will result in discounts on some services and vision products. Please contact Outlook Vision at (800) 342-7188 to obtain benefit information.
- **Epic Hearing** is a hearing health care program available to Seniors Choice members. Should you wish to take advantage of the services Epic offers, please contact them at (877) 606-3742.

**Important Premium Information:**

Please note, your premium is based on your age and a rate increase may be implemented the month in which you turn 66, 67, 68, 69, 70, 75, 80, and 85.

For information regarding eligibility, benefits, verification of coverage or premium payments, please contact Merchants Benefit Administration, Inc. at (888) 538-9333 or via email at

memberservices@mbaadmin.com. Representatives are available from 7:00 AM to 5:00 PM MST/PST, Monday through Friday.

Sincerely,

Seniors Choice Administration Team  
Merchants Benefit Administration, Inc.

Please remember to present your card  
to your medical service provider so that  
they may update their records.

Sample

Seniors  
Choice

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G•T•L

**GUARANTEE TRUST LIFE INSURANCE COMPANY**

**MEMBER NAME**

SMITH, JOE

**MEMBER ID #**

780XXXXXXX

**GROUP**

G1001

**EFFECTIVE DATE**

01/01/2018

# **Health Plan Identification Card**

**This card may be used to provide information regarding your coverage.**

**Do not present this card if your coverage has been terminated.**

**IMPORTANT! Please be sure your provider of service references your ID and group numbers when submitting benefits for payment.**

**FOR INFORMATION ON ELIGIBILITY, BENEFITS, VERIFICATION OF  
COVERAGE OR PREMIUM PAYMENT CONTACT:**

**MERCHANTS BENEFITS ADMINISTRATION, INC.**

**1-888-538-9333**

**FOR CLAIMS PAYMENT AND CLAIMS SUBMITTAL QUESTIONS CONTACT:**

**Guarantee Trust Life Insurance Company**

**P.O. BOX 1148**

**Glenview, IL 60025**

**(800) 338-7452 Member**

**(866) 851-0284 Provider**

## SCHEDULE

### POLICYHOLDER AND INSURED INFORMATION

<b>Policyholder:</b>	Merchant Industry Fund Group Insurance Trust (MIFGIT)
<b>Description of Eligible Persons:</b>	<p>Eligible Classes are:</p> <p><b>Class 1:</b> Current Retirees who enroll for coverage before the end of their Participating Employer's enrollment period.</p> <p><b>Class 2:</b> New Retirees who enroll for coverage within 30 days after retirement.</p> <p><b>Class 3:</b> Dependent Spouses (or Civil Union/Domestic Partners where allowed by law) of current and new Retirees, who enroll for coverage.</p> <p><b>Class 4:</b> In the event of replacement, all individuals currently covered under the prior carrier's policy.</p> <p>A Retiree and Dependent Spouse (or Civil Union/Domestic Partner where allowed by law) of a Retiree must:</p> <ul style="list-style-type: none"> <li>• be age 65 and older;</li> <li>• be covered under Medicare Parts A and B;</li> <li>• not be eligible for Medicaid;</li> <li>• not be covered under a Medicare Supplement policy or certificate;</li> <li>• not be covered by an employer's health plan which is primary to Medicare due to employment of such person; and</li> <li>• not be confined to a Hospital or Skilled Nursing Home on the effective date of coverage. If a Retiree or Dependent Spouse or Civil Union/ Domestic Partner is confined to a Hospital or Skilled Nursing Home on the effective date of coverage, coverage will be delayed until the day after the date of release from the Hospital or Skilled Nursing Home.</li> </ul>
<b>Effective Date:</b>	Subject to payment of the proper premium and the Eligibility requirements stated above, coverage takes effect on the first of the month that falls on or next follows Our receipt of Your completed enrollment form.

MCGSOBCA101

### BENEFITS

<b>Deductible per Covered Person (Applies only to Medicare Eligible Expenses):</b>	\$4,000
<b>Insured Percent</b>	100%

#### COVERED CHARGES (Copayments apply after the Plan Deductible is satisfied.)

<b>PART A - HOSPITALIZATION:</b>	
First 60 days	\$1,340 (Medicare Part A Deductible)
Days 61 – 90	\$335 per day per Medicare Benefit Period
Days 91 – 150	\$670 per day while using 60 Lifetime Reserve Days per Medicare Benefit Period
Additional 365 days (Lifetime)	100% of Medicare Eligible Expenses after the 60 Lifetime Reserve Days are used, per Medicare Benefit Period
<b>BLOOD PER CALENDAR YEAR (PART A):</b>	
First 3 pints	Plan pays 100% after Plan Deductible
Additional amounts	Covered by Medicare
<b>SKILLED NURSING CARE IN A SKILLED NURSING FACILITY:</b>	
First 20 days	Covered by Medicare at 100%
Days 21 – 100	Plan pays \$167.50 per day after Medicare payment
Days 101 +	Not Covered
Confinement in a Skilled Nursing Facility must follow a Hospital Confinement of at least 3 days.	

<b>PART B - MEDICAL EXPENSES:</b> Doctors Office Visits X-Ray and Lab Outpatient Services Durable Medical Equipment Emergency Room – Professional Services (Non-Hospital Admission)	Pays after Plan Deductible and \$10 Copayment Pays after Plan Deductible and \$10 Copayment Pays after Plan Deductible and \$20 Copayment Pays after Plan Deductible and \$10 Copayment Pays after Plan Deductible and \$100 Copayment
<b>BLOOD PER CALENDAR YEAR (PART B):</b> First 3 pints Additional amounts	Plan pays 100% Plan pays 20%
<b>PART B EXCESS CHARGES</b> Amounts above Medicare approved levels	Covered after Plan Deductible and applicable Copayment.
<b>FOREIGN TRAVEL EMERGENCY CARE WITHIN FIRST 60 CONSECUTIVE DAYS OF FOREIGN TRAVEL</b>	Pays 80% of Medicare approved amount up to a lifetime maximum of \$50,000. Subject to an annual \$250 deductible.

MCGSOBXX202

Sample

# GUARANTEE TRUST LIFE INSURANCE COMPANY

1275 Milwaukee Avenue  
Glenview, Illinois 60025

## CERTIFICATE OF INSURANCE

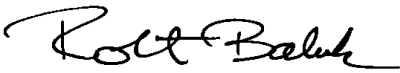
This is Your Certificate of Insurance (Certificate) while You are insured. It briefly explains the rights and benefits that are determined by the Master Policy (Policy). The Policy is a legal contract between the Policyholder and Us. The Policyholder is shown on the Schedule.

The Policy alone constitutes the agreement under which payments are made. We will pay the benefits set forth in the Policy. Benefit payment is governed by all the terms, conditions and limitations of the Policy. The Policy may be amended at any time without Your consent or notice to You. Any such amendment will not affect a claim starting before the amendment takes effect.

The Policy has been issued and delivered to the Policyholder. Except as otherwise stated in this Certificate, the Policy will be governed by the laws of the state where the Policy was issued. The Policy is held by the Policyholder. You may inspect it at any time during business hours at the office of the Policyholder.

This Certificate was issued on the basis that the information on Your enrollment form was correct and complete. If any information on the enrollment form was not correct, write to Us within ten (10) days of receipt of this Certificate. An error or omission in Your enrollment form may result in loss of coverage as of its Effective Date.

## READ YOUR CERTIFICATE CAREFULLY



Secretary



President

## GROUP SENIOR MEDICAL CERTIFICATE

### NON-PARTICIPATING

MCCCVXX100

### THIS COVERAGE IS NOT MEDICARE SUPPLEMENT COVERAGE.

**It will not cover all the cost of Your medical care. You will be financially responsible for some of Your medical expenses.**

**Refer to the Medical Expense Benefit provision which discusses how benefits are paid and to the Schedule of Benefits for details of benefit amounts.**

MCCCVXX200

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## GENERAL DEFINITIONS

*The terms listed below, if used, have the meaning stated.*

MCGDFX100

**Calendar Year:** The period of time beginning on January 1 and ending on December 31 of the same year. The first Calendar Year of the Certificate will begin on the date this Certificate becomes effective and end on the first December 31<sup>st</sup> after a covered Person's effective date of coverage.

MCGDFX200

**Company:** Guarantee Trust Life Insurance Company, a mutual company. Also hereinafter referred to as We, Us and Our.

MCGDFX400

**Copayment:** A fixed dollar amount which is paid by the Covered Person for certain Covered Charges. Copayments do not accumulate toward satisfaction of the Calendar Year Deductible. The Copayment is shown in the Schedule.

MCGDFX3400

**Covered Charge:** The portion of Medicare Eligible Expenses that are not covered by Medicare but are covered under the Policy. A Covered Charge is considered incurred on the date the treatment or service is rendered or the supply is furnished. Covered Charges are shown in the Schedule.

MCGDFX2600

**Covered Person:** A person:

- Who is eligible for coverage as the Insured or as a Dependent;
- Who has been accepted for coverage;
- Who has paid the required premium, if any; and
- Whose coverage has become effective and has not terminated.

MCGDFX500

**Deductible:** A dollar amount of Covered Charges a Covered Person must pay each Calendar Year before We pay any benefits for Medicare Eligible Expenses under Part A or Part B of Medicare. The Deductible is shown in the Schedule.

A new Deductible will apply each Calendar Year. However, Covered Expenses incurred during the last 3 months of a Calendar Year which are applied to that Covered Person's Calendar Year Deductible will also be applied toward that person's Deductible for the next Calendar Year and thus reduce that Calendar Year's Deductible.

MCGDFX2710

**Dependent:** A person who is the Insured's legally married spouse or Domestic Partner, residing with the Insured.

MCGDFX610

**Doctor:** A legally qualified person licensed in the healing arts and practicing within the scope of his or her license and is not a Family Member.

MCGDFX700

**Domestic Partner:** The Insured and the Insured's opposite or same sex partner who both meet the qualifications stated below. They must:

- Be at the age of consent to marry or, alternatively, at the age to enter into a contract, whichever is the older, in the state in which they reside;
- Not be related by blood closer than would bar marriage in the state in which they reside (first cousins or nearer);
- Not be legally married to any other person;
- Be the sole opposite or same sex partner of each other and have no other opposite or same sex partner;
- Be mutually financially responsible for their basic living expenses;
- Agree to immediately notify Us of any change/ termination in the status of the domestic partnership; and
- Both sign and have notarized an Affidavit of Domestic Partners in order for the opposite or same sex partner of the Insured to be eligible for coverage under the Policy.

MCGDFX2500

**Family Member:** A person who is related to the Covered Person in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted, step or foster child). A Family Member includes an individual who normally lives in the Covered Person's household.

MCGDFX800

**Hospice:** An agency which provides medical, health care services and medical social services for the palliative and supportive care and treatment of terminally ill individuals.

MCGDFXX2900

**Hospice Care:** Services provided by a Hospice providing care to a Covered Person for whom a certified medical prognosis has been made indicating a life expectancy of 6 months or less and who has elected to receive such care in lieu of other medical benefits provided herein.

MCGDFXX3000

**Hospital:** A hospital that is either approved for payment of Medicare benefits or could receive such approval if so requested

MCGDFXX900

**Hospital Confined/Hospital Confinement:** Confinement in a Hospital for at least 18 consecutive hours for which a room and board charge is made by reason of a Sickness or Injury for which benefits are payable.

MCGDFXX1000

**Injury:** Bodily injury due to an Accident which:

- Results solely, directly and independently of disease, bodily infirmity or any other causes;
- Occurs after the Covered Person's effective date of coverage;
- Occurs while coverage is in force.

All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single injury.

MCGDFXX1100

**Insured Percent:** The percentage of Covered Charges We pay for Covered Charges during each Calendar Year after the Deductible is satisfied. The Insured Percent only applies to Covered Charges for Medicare Eligible Expenses under Part B of Medicare. The Insured Percent is shown in the Schedule.

MCGDFXX3110

**Lifetime Reserve Days:** The number of days, per lifetime, of Hospital Confinement that is paid by Medicare after the Covered Person has reached the maximum number of days of Confinement covered by Medicare Part A. The number of Lifetime Reserve Days is stated in the Schedule.

MCGDFXX1200

**Medicaid:** The Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965 as Then Constituted or Later Amended.

MCGDFXX1300

**Medicare:** The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended.

MCGDFXX1400

**Medicare Benefit Period:** The time used to measure inpatient benefits. A Benefit Period begins the first day the Covered Person receives Medicare covered services in a hospital and it ends when the Covered Person has been out of a hospital or Skilled Nursing Facility for 60 consecutive days. If the Covered Person enters a hospital again after 60 days, a new Benefit Period begins.

MCGDFXX1500

**Medicare Eligible Expenses:** Expenses of the kinds covered by Medicare, to the extent recognized as medically necessary and reasonable by Medicare. These expenses may or may not be fully covered by Medicare.

MCGDFXX1600

**Policyholder:** The entity shown as the Policyholder on the Schedule.

MCGDFXX1800

**Sickness:** Illness and disease which begin after the effective date of a Covered Person's coverage.

MCGDFXX1900

**Skilled Nursing Care:** Services that are certified as medically necessary by a Doctor and are not intermediate, domiciliary, custodial or retirement care.  
MCGDFFX2000

**Skilled Nursing Facility:** A place that:

- Is legally operated as a Skilled Nursing Facility;
- Primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Care under the supervision of a Doctor;
- Provides continuous 24 hour a day nursing service by or under the supervision of a licensed nurse; and
- Maintains a daily medical record on each patient.

Skilled Nursing Facility also means a place which may not meet the above rules, but is a nursing facility that is either approved for payment of Medicare benefits or could get such approval if so requested.

A Skilled Nursing Facility does not mean or include any home or facility, or part thereof, used primarily for rest, residential, retirement or custodial care.  
MCGDFFX2100

**You, Your and Yours:** The Insured shown on the Schedule.  
MCGDFFX2200

**We, Ours and Us:** The Guarantee Trust Life Insurance Company.  
MCGDFFX2300

Male pronouns whenever used include female pronouns.  
MCGDFFX2400

## CONDITIONS OF INSURANCE

### ELIGIBILITY

**Insured:** You are eligible for coverage if You are a member of an eligible Class and complete a valid enrollment form. Eligible Classes are shown in the Schedule.

**Dependent:** When a Dependent is a member of an eligible Class, such Dependent is eligible for coverage on the later of:

- The date You become eligible for insurance; or
- The date You acquire the Dependent. A Dependent is deemed to be acquired on the date of the marriage to You or the date the Affidavit of Domestic Partnership is filed.

MCCCIXX110

### EFFECTIVE DATE

**Insured and Dependents, except Dependents Acquired After Effective Date:** Coverage is effective as stated on the Schedule.

#### Dependents Acquired After Effective Date

**Dependent Spouse:** A Dependent spouse who is age 65 and older, covered under Medicare Parts A and B, and not covered under any Medicare Supplement policy or certificate, is eligible for coverage on the date of marriage to You. Enrollment and premium must be received within 31 days of the marriage. Coverage is effective the first of the month following receipt of enrollment and premium by Us or Our authorized representative.

**Domestic Partner:** A Domestic Partner who is age 65 and older, covered under Medicare Parts A and B, and not covered under any Medicare Supplement policy or certificate, is eligible for coverage on the date of filing of the Affidavit of Domestic Partnership. Enrollment and premium must be received within 31 days of the filing date of the Affidavit of Domestic Partnership. Coverage is effective the first of the month following receipt of enrollment and premium by Us or Our authorized representative.

MCGCIXX110

## TERMINATION

**Covered Person:** Coverage with respect to a Covered Person will terminate at 12:01 a.m. standard time at Your residence on the earliest of:

- The date the Policy terminates;
- The date coverage is terminated by Us for all certificate holders in Your state;
- The date We receive Your written request to terminate coverage;
- The last day of the period for which the Premium is paid;
- The last date of the period for which Premium has been paid following the date a Dependent ceases to be a Dependent as defined.

At least 30 days prior written notice will be given to You if We terminate Your coverage for any reason, except for nonpayment of Premium.

## REPLACED PLAN

When this Certificate replaces the Employer's prior plan which terminated the day before the Policy's Effective Date, the following applies:

1. As to each Covered Person:
  - a. credit will be given under similar coverage of this Certificate for any of the following which was wholly or partially met under the Employer's prior plan:
    - Waiting Period;
    - Deductible (for the same year; and
    - Benefit Period.The Covered Person must provide Us with proper documentation before credit will be applied.
  - b. Any benefits paid under the Employer's prior plan can be applied towards any benefit maximum amount under this Certificate.
2. If the Covered Person is on Extension of Benefits under the Employer's prior plan, benefits under this Certificate will be paid secondary to those of the prior plan.

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## BENEFITS

### Medicare Part A and Part B

We will pay the following benefits for the expenses the Covered Person incurred because of an Injury or Sickness, subject to the Deductible and Coinsurance, if any. The Deductible and Coinsurance, if any, and specific benefit amounts are stated in the Schedule.

MCCCXX110

1. Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61<sup>st</sup> day through the 90<sup>th</sup> day in any Medicare Benefit Period.

MCGCXX200

2. Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

MCGCXX300

3. Upon exhaustion of Medicare benefits including Lifetime Reserve Days, We will pay the Medicare Eligible Expense incurred due to inpatient hospital care. This benefit starts on the day following the last day of coverage by Medicare. These expenses must be of the type Medicare would have covered if Medicare benefits were not exhausted. This benefit is subject to a lifetime maximum benefit of an additional 365 days.

MCGCXX400

4. Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells as defined under federal regulations) unless replaced in accordance with federal regulations.

MCGCXX500

5. Coverage for the Copayment amount of Medicare Eligible Expenses under Part B regardless of Hospital Confinement subject to the Medicare Part B deductible.

MCGCXX600

6. Coverage for all of the Medicare Part A inpatient hospital deductible amount per Medicare Benefit Period.

MCGCXX700

7. Coverage for all of the Medicare Part B deductible amount per Calendar Year regardless of Hospital Confinement.

MCGCXX800

8. Hospice benefits consisting of:

- a. Outpatient prescription drugs for pain relief or symptom management provided by the Hospice.
- b. Hospice Care received in a Hospice facility in order to provide a respite for the hospice care personnel, as shown in the Schedule.

MCGCXX1700

9. Coverage of the Medicare copayment for the actual billed charges up to the Skilled Nursing Facility Care benefit amount from the 21st day through the 100th day in a Medicare Benefit Period for post-hospital Skilled Nursing Facility Care eligible under Medicare Part A.

MCGCXX901

10. Coverage, to the extent not covered by Medicare, for eighty percent (80%) of the billed charges for Medicare Eligible Expenses for medically necessary emergency hospital, Doctor, and medical care received in a foreign country which care would have been covered by Medicare if provided in the United States, and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible and a lifetime maximum benefit.

For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

MCGCXX1000

Before these Part A and B Policy benefits are payable, benefits must be payable under Part A and Part B of Medicare for its part of the expenses.

MCGCXX1200

**NOTE: Medical providers, such as a Doctor, therapist or clinic, will send the Covered Person a statement of their charges. They may include charges for items and services not covered or paid for by either Medicare or Us. These "billed" charges may be higher than the Medicare Eligible Expense. Medicare Eligible Expense is defined in this Certificate.**

**Before We can pay any benefits for expenses covered under Medicare Part B, the Covered Person must file a claim with Medicare. Medicare's Benefit Department will send the Covered Person a copy of the Explanation of Medicare Benefits form. This form will show the Medicare Eligible Benefits. We'll need a copy of this form to pay Our Certificate benefits. We may get this form directly from Medicare; but if We don't, it will be the Covered Person's responsibility to send Us a copy.**

MCGCXX1300

#### **Changes in Medicare and Copayment Amounts**

If Medicare changes any deductibles or any of the co-payment percentage or limits for any benefits which are specifically covered by this Certificate, We will change the benefits of the Certificate to tie in with the new benefits provided by Medicare. We will not provide coverage for any type of expense We did not previously cover. We may change the premium to match the benefit change. Any premium change needed because of a change in benefits will only be made after We give the Covered Person appropriate notice.

MCGCXX1400

#### **Suspension of Benefits**

If You are entitled to receive medical assistance under Medicaid for a period of 2 years or less, You may suspend this coverage and premium payments by notifying Us within 90 days after Your medical assistance became effective. When You are no longer entitled to such medical assistance and You notify Us within 90 days after the loss of medical assistance, then if the Policy is still in effect, Your coverage will be reinstated and Your premiums will continue. Coverage will be effective as of the termination date of Your entitlement to medical assistance. The reinstated coverage shall not be subject to any waiting periods or pre-existing condition limitation. The premium will be the same as though the coverage has not been suspended.

MCGCXX1500

## EXCLUSIONS

Unless specifically stated otherwise, this Certificate does not cover or consider for payment any service or supply, or any portion of a service or supply that is not a Medicare Eligible Expense, nor will this Certificate duplicate any benefit paid by Medicare.

MCGEXXX100

## CLAIM PROVISIONS

**Notice of Claim:** Written Notice of Claim must be given to Us or Our authorized representative within 60 days after a covered loss starts, or as soon thereafter as is reasonably possible. Notice should include information sufficient to identify the Covered Person.

MCGCPXX100

**Claim Forms:** Upon Our receipt of written Notice of Claim, We will furnish to the claimant such forms as are usually furnished by Us for filing Proofs of Loss. If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this Policy as to Proof of Loss upon submitting, within the time fixed in this Policy for filing Proof of Loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

MCGCPXX200

**Proof of Loss:** Written Proof of Loss must be given to Us or Our authorized representative not later than 90 days after the covered loss. If Proof of Loss is not given within 90 days, the claim will not be denied or reduced for that reason if that proof was given as soon as reasonably possible.

MCGCPXX300

**Time of Payment of Claims:** Benefits will be paid as soon as We receive proper Proof of Loss unless the Policy provides for periodic payment. When the Policy provides for periodic payment, the benefits will accrue and will be paid monthly subject to proper Proof of Loss.

MCGCPXX400

**Payment of Claims:** Benefits will be payable to the Covered Person or the medical services provider if We have received a valid assignment by the Covered Person.

If any indemnity of this Policy shall be payable to the estate of the Covered Person or to a Covered Person who is not competent to give a valid release, We may pay such indemnity to his guardian or other person actually supporting him. Any payment made by Us in good faith pursuant to this provision shall fully discharge Us to the extent of such payment.

Subject to any written direction of the Covered Person or of the legal guardian of the Covered Person, if the Covered Person is incompetent to make such a direction, all or a portion of any indemnities provided by the Policy as a result of medical, surgical, dental, hospital or nursing service may, at Our option, and unless We are requested in writing not later than the time for filing Proofs of Loss, be paid directly to the Hospital or person rendering such services; but it is not requested that the services be rendered by a particular Hospital or person.

MCGCPXX500

**Physical Examination:** We, at Our own expense, shall have the right and opportunity to examine the Covered Person as it may reasonably require while a claim is pending.

MCGCPXX600

**Legal Actions:** A legal action may not be brought to recover on this Policy within 60 days after written Proof of Loss has been given as required. No such action may be brought after 3 years from the time written proof was required to be given.

MCGCPXX700

**Subrogation:** When benefits are paid to or for a Covered Person under the terms of the Policy, We shall be subrogated, unless otherwise prohibited by law, to the rights of recovery of such Covered Person against any person who might be acknowledged liable or found legally liable by a Court of competent jurisdiction for the Injury that necessitated the hospitalization or the medical or surgical treatment for which benefits were paid. Such subrogation rights shall extend only to Our recovery of the benefits We have paid for such hospitalization and treatment and We shall pay fees and costs associated with such recovery.

MCGCPXX800

## PREMIUM

**Payment of Premium/Due Date:** All premium, charges or fees (hereinafter "Premium") must be paid to Us at Our home office prior to the start of the term for which coverage is selected. In no event will coverage become effective prior to the date of enrollment and required premium are received at Our home office or by Our authorized representative.

**Returned or Dishonored Payment:** If a check in payment for the Premium is dishonored for insufficient funds, a reasonable service charge may be charged to the Policyholder which will not exceed the maximum specified under state law. A dishonored check shall be considered a failure to pay Premium and coverage shall not take effect.

MCGPPXX100

**Premium Rate Change:** Any reduction or increase in premium rates is subject to Our giving You at least 30 days prior written notice of such change.

MCCPRCCA100

**Grace Period:** We allow a grace period of 31 days for the payment of premium after the first premium. Coverage is in force during the Grace Period. If premium is not received before the Grace Period expires, Your coverage terminates as of the last day for which premium has been paid. If at least 60 days prior to the premium due date We send written notice to You of Our intent not to renew this Certificate, then the Grace Period will not apply to any period after the date the non-renewal is to be effective. If You send written notice to Us that You are not renewing Your coverage, then the Grace Period will not apply after the date the non-renewal is to be effective.

MCCPPXX101

## EXTENSION OF BENEFITS

### In the event of Total Disability

If a Covered Person is Totally Disabled on the date the Policy terminates, We will extend that Covered Person's benefits for the Injury or Sickness which caused the Total Disability. Benefits will be paid as if coverage had remained in effect.

Total Disability/Totally Disabled means, with respect to You, the complete inability to perform all of the substantial and material duties of Your occupation and any other gainful occupation in which You earn substantially the same compensation earned prior to disability. With respect to a covered Dependent, Total Disability/Totally Disabled means Hospital Confinement. At Our request a Doctor must certify in writing that the Covered Person continues to be Totally Disabled.

Extension of benefits will end at the earlier of:

1. the end of Total Disability;
2. the end of a 12 month period following the date the Policy terminates; or
3. the date the Lifetime Aggregate Maximum Amount is reached.

MCGCIXX300

## CONVERSION PRIVILEGE

The right to convert coverage under the Policy to conversion coverage is available to a Covered Person whose insurance under the Policy ceases for any reason except:

1. Termination of the Policy with replacement by similar medical coverage within 31 days;
2. Termination of the class of Covered Persons with replacement by similar medical coverage within 31 days;
3. Non-payment of the required premium.

The conversion coverage will cover the Covered Person and his insured Dependent.

MCCCIXX500

### **Dependent's Conversion Privilege**

The right to convert any insurance provided under the Policy to conversion coverage is also available to an insured spouse or an insured Domestic Partner who ceases to be a Dependent due to:

- a) Your death;
- b) Annulment or dissolution of marriage; or
- c) Termination of domestic partnership.

MCCCIXX610

## Conversion

The conversion coverage will be on a standardized Medicare Supplement form that provides benefits similar to the Policy's benefits. Conversion coverage will be issued without proof of good health subject to the following:

1. Written application must be made to Us at Our Home Office within 31 days after insurance under the Policy ceases. Premium payment must also be made within the 31 day period.
2. The effective date of coverage will be the day following the date such person's insurance under the Policy ceases.

Premium for the policy will be based on Our table of rates in effect on the date the individual policy begins, such person's age on the effective date of the new policy, and his or her rating class under this Policy. For any waiting periods under the new policy, We'll count from the effective date of such person's coverage under this Policy. We won't issue a new policy if it would result in over insurance under Our usual underwriting rules.

The jurisdiction where delivery of the conversion coverage is to be made and the availability of the form then available to individuals controls the form We issue. The laws of such jurisdiction may require a special plan be provided or be available. If that is the case, We will either provide the coverage or refer the person to the proper source for coverage.  
MCCCIXX700

## GENERAL PROVISIONS

**Entire Contract; Changes:** The Policy, including the Master Application, Certificate, if any, endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in the Policy shall be valid until approved by one of Our executive officers and unless such approval is endorsed hereon or attached hereto. No agent has authority to change the Policy or waive any of its provisions. The Policyholder is not Our agent.

Failure by Us to enforce any Policy provision shall not waive, modify or render such provision unenforceable at any other time; at any given time; or under any given set of circumstances, whether the circumstances are or are not the same.  
MCGGPXX100

**Incontestability:** All statements made in an application by You are, in the absence of fraud, representations and not warranties. No statement shall be used to contest this Certificate, the validity of coverage or reduce benefits, unless it is in writing, signed by You, and a copy of such statement is furnished to You.

After a Covered Person's coverage has been in force for 2 years under this Certificate, no statement of that Covered Person, except fraudulent misstatement, shall be used to void his insurance or to deny or reduce a claim for loss incurred after the 2 year period.

**Non-Participating:** This Certificate is non-participating. It does not share in Our profits or surplus earnings.

**Conformity With State Statutes:** If any provision of this Certificate is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of such law.

**Workers' Compensation:** This Certificate is not in lieu of and does not affect any requirement for coverage by Workers' Compensation Insurance.  
MCGGPXX100

**Other Insurance With Us:** A Covered Person may have coverage under only one group or individual policy like this one with Us. If We issue more than one like individual policy or certificate to a Covered Person, only one certificate or individual policy chosen by the Covered Person will stay in force. We'll return the premium paid for the duplicate coverage.  
MCGGPXX200

**Clerical Error:** If a clerical error is made so that an otherwise eligible person's coverage does not become effective, coverage may be in effect if: (a) the Policyholder makes a written request for coverage on a form approved by Us; and (b) any premium not paid because of the error is paid in full from the effective date of coverage. Company reserves the right to limit retroactive coverage to two months preceding the date the error was reported.

If a clerical error is made so that the coverage is in effect for a person who is not eligible, an adjustment will be made to correct the error. Any Premium refund will be reduced by any payment made for claims. If claims paid exceed the Premium refund, the Policyholder shall reimburse Us for the overpayment.



**Information and Records:** We shall have the right to inspect, at reasonable times, any of the Policyholder's records for the Policy. The Policyholder shall provide Us with information necessary to administer coverage and set premium under the Policy. Information is required when an eligible person becomes covered, when changes in amounts of coverage occur, and when a Covered Person's coverage terminates.  
MCGGPXX300

Sample

**GUARANTEE TRUST LIFE INSURANCE COMPANY**  
**1275 Milwaukee Avenue**  
**Glenview, Illinois 60025**  
**(847) 699-0600**

## **Policy /Certificate Endorsement**

### **Retain with your policy/certificate.**

**We certify that the policy/certificate identified below has been amended as shown. Copies of your authorization(s) and any additional provisions are attached. Any provision of the policy requiring that it be submitted for endorsement thereon is waived for the change(s) shown.**

### **CHANGE(S)**

The following provisions are added to the policy or certificate to which this rider is attached:

#### **EXTENSION OF BENEFITS**

##### In the event of Total Disability

If a Covered Person is Totally Disabled on the date the Policy terminates, We will extend that Covered Person's benefits for the Injury or Sickness which caused the Total Disability. Benefits will be paid as if coverage had remained in effect.

Total Disability/Totally Disabled means, with respect to You, the complete inability to perform all of the substantial and material duties of Your occupation and any other gainful occupation in which such person You earns substantially the same compensation earned prior to disability. With respect to a covered Dependent, Hospital Confinement. At Our request a Doctor must certify in writing that the Covered Person continues to be Totally Disabled.

Extension of benefits will end at the earlier of:

- the end of Total Disability;
- the end of a 12 month period following the date the Policy terminates; or
- the date the Lifetime Aggregate Maximum Amount is reached.

MCGCIX300

#### **CONVERSION PRIVILEGE**

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1. Termination of the Policy with replacement by similar medical coverage within 31 days;
2. Termination of the class of Covered Persons with replacement by similar medical coverage within 31 days;
3. Non-payment of the required premium.

The conversion coverage will cover the Covered Person and his insured Dependent.

MCCCIX500

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- a) Your death;
- b) Annulment or dissolution of marriage; or
- c) Termination of domestic partnership.

MCCCIX610

## Conversion

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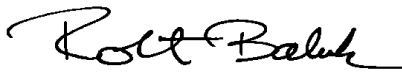
1. Written application must be made to Us at Our Home Office within 31 days after insurance under the Policy ceases. Premium payment must also be made within the 31 day period.
2. The effective date of coverage will be the day following the date such person's insurance under the Policy ceases.

Premium for the policy will be based on Our table of rates in effect on the date the individual policy begins, such person's age on the effective date of the new policy, and his or her rating class under this Policy. For any waiting periods under the new policy, We'll count from the effective date of such person's coverage under this Policy. We won't issue a new policy if it would result in over insurance under Our usual underwriting rules.

The jurisdiction where delivery of the conversion coverage is to be made and the availability of the form then available to individuals controls the form We issue. The laws of such jurisdiction may require a special plan be provided or be available. If that is the case, We will either provide the coverage or refer the person to the proper source for coverage.

MCCCIX700

The change(s) listed above was executed at the Home Office of the Company.



Secretary



President

Sample

**GUARANTEE TRUST LIFE INSURANCE COMPANY**  
**1275 Milwaukee Avenue**  
**Glenview, Illinois 60025**

**CERTIFICATE AMENDMENT RIDER**

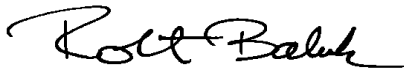
In consideration of the payment of the premium for the certificate to which this rider is attached, it is hereby agreed that the **PREMIUM** provision of the certificate is amended as follows:

A. The addition of the following provision:

**Premium Rate Change:** Any reduction or increase in premium rates is subject to Our giving You at least 30 days prior written notice of such change.

MCCPRCCA100

This rider is attached to and made a part of the certificate issued to Covered Persons of the Merchant Industry Fund Group Insurance Trust (MIFGIT). This rider takes effect on January 1, 2010 and expires at the same time as the certificate. It is subject to all the conditions, limitations and provisions of the certificate not inconsistent herewith.



Secretary



President

# **GUARANTEE TRUST LIFE INSURANCE COMPANY**

## **NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice tells you the different ways in which Guarantee Trust Life Insurance Company (“GTL”) may use and disclose your protected health information.

Among other things, the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) requires us to:

- Maintain the privacy of your protected health information.
- Provide notice of GTL’s legal duties and privacy practices with respect to your protected health information.
- Comply with the terms of the Notice currently in effect; and
- Provide you with this Notice.

You have a right to a paper copy of this Notice which will be provided to you upon request, even if this Notice was provided to you electronically.

**Protected health information** is information about you that is either held or transmitted by GTL, including demographic information, that identifies you (or can reasonably be used to identify you), and that relates to (i) your past, present or future physical or mental health or condition, (ii) the provision of health care to you, or (iii) the past, present or future payment for the provision of health care to you.

GTL understands that your protected health information is personal. We protect the privacy of that information in accordance with all federal and state privacy laws. If a use or disclosure of protected health information described within this Notice, which is required by federal law, is prohibited or materially restricted by state law, GTL will abide by the more stringent law.

### **USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION WITH YOUR WRITTEN AUTHORIZATION**

GTL will not use or disclose your protected health information without your written authorization unless the use or disclosure is described within this Notice.

If you have given us written authorization to use or disclose your protected health information, you have the right to revoke that authorization, at any time, except to the extent that: (1) we have already acted in reliance on the authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, other law provides us with the right to contest a claim under the policy or the policy itself. Your written request to revoke an authorization should be directed to the address listed in the “Contact Information” section below.

### **USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION**

#### **For Payment**

We may request, use and disclose your protected health information, as needed, to determine or fulfill our responsibility for coverage and reimbursement for the provision of benefits under your health plan. This may include, but is not limited to:

- determinations of eligibility of coverage (including coordination of benefits with other insurers or the determination of cost sharing amounts) and adjudication or subrogation of health benefit claims;
- risk adjusting based on enrollee health status and demographic characteristics;
- billing, claims management, collection activities, obtaining payment under a contract for reinsurance;
- review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care or justification of charges;
- utilization review activities, including pre-certification and pre-authorization of services, concurrent and retrospective review of services;

- disclosure to consumer reporting agencies of any of the following protected health information relating to collection of premiums or reimbursement: name and address; date of birth; social security number; payment history; policy/account number; and name and address of the health care provider and /or health plan.

For example, if your coverage has a coordination of benefits or other type of cost sharing provision, we may request and disclose protected health information about you to the other health plan carrier to determine the benefits due under the terms of your health plan with us. We may also contact your provider regarding your medical treatments and request details to determine if your coverage will pay for the treatments.

### **For Health Care Operations**

We may use and disclose protected health information about you to support our business operations or the business operations of another insurer. These uses and disclosures are necessary to run the company and make sure all of our policyholders receive the services and benefits provided by their health plan coverage. These activities include, but are not limited to:

- underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, however, we are prohibited from using or disclosing genetic information about you for underwriting purposes;
- ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);
- conducting or arranging for medical review, legal services, and auditing functions, including fraud investigations;
- business planning and development, such as conducting cost-management studies and analyses related to managing and operating the company, including development or improvement of methods of payment or coverage policies; and
- business management and general administrative activities of the company, including, but not limited to:
  - customer service, including the provision of data analyses for policyholders, plan sponsors, or other customers;
  - resolution of internal grievances; and
  - the offer of an enhancement or upgrade to your existing coverage.

### **To Individuals Involved in Your Care**

We may use and disclose your protected health information with your family, friends, personal representative or other individual you identify who are involved in your care or payment of a claim, unless you object. In addition, GTL may use and disclose your protected health information to persons requesting such information if we can reasonably infer from the circumstances that you would not object to the disclosure. If you are not available to give your consent to a disclosure, or in an emergency, we may disclose your protected health information that is directly relevant to such person's involvement in your care or payment for such care.

### **To Our Business Associates**

We may also share your protected health information to an affiliate or business associate outside of GTL if they need protected health information in order to provide services to us (e.g., billing, claim adjudication and underwriting services.) Whenever an arrangement between GTL and a business associate involves the use or disclosure of your protected health information we will have a written contract that sets forth the terms regarding the use and disclosure of your protected health information and will require them to follow the HIPAA rules relating to the protection of protected health information.

### **For Other Uses and Disclosures**

In addition to the above, we are permitted or required by law to use or disclose your protected health information, without your permission, for the following:

- **Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose protected health information about you in response to a court or administrative order. We may disclose protected health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- **Law Enforcement:** We may release medical information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons, or similar process. We may also disclose your protected health information if we suspect child abuse or neglect; we may also disclose your protected health information if we believe you to be a victim of abuse, neglect, or domestic violence.

- **Health Oversight Activities:** We may disclose protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

## **YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU**

You have the following rights with respect to the protected health information we maintain about you.

**You have the right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. To inspect and copy protected health information that may be used to make decisions about you, you must submit your request in writing to us or to the business associate who maintains the medical information. If we would prefer to send you a summary or explanation of your medical information rather than the actual records, we may do so only with your consent and your agreement in advance to the fees imposed, if any. You may request your records be in paper or electronic format. We may charge a fee for the costs of copying, mailing or other supplies associated with mailing or copying your protected health information. We may deny your request in whole or in part to inspect and copy records in certain circumstances. If you are denied access to medical information, we will provide a written notice explaining the basis for the denial. You may also request that the denial be reviewed. Such request for review will either be approved or denied based on the grounds for denial. If the initial denial is reviewable, the person conducting the review will not be the same person who denied your original request. We will comply with the determination of the representative performing the review.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to a restriction that you may request and we retain the right to terminate an agreed to restriction. Such termination is only effective with respect to protected health information created or received after GTL has informed the individual of its termination of the restriction. Additionally requesting certain limitations may affect payment of benefits under your health plan. To request restrictions, you must make your request in writing to our Customer Service Department. In your request, you must tell us: (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

**You have the right to request and receive confidential communications.** We will accommodate reasonable requests to send your protected health information to you at a different address, or other method of contact. We will not request an explanation from you as to the basis for the request. For example, you can ask that we only contact you at work or by mail. Requests for confidential communications must be made in writing, signed by you and sent to GTL. Your request must specify how or where you wish to be contacted.

**You have the right to request an amendment of your protected health information.** You may request an amendment of your health information contained in a designated record set for as long as the information is kept by GTL or any of our business associates. To request an amendment, you must send us your request in writing to the address included in the "Contact Information" section below, giving details of your request and why you are making it. If we deny your request for amendment in whole or in part, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement. We will provide you with a copy of any such rebuttal. In certain cases, we may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: (1) was not created by us, unless the person or entity that created the information is no longer available to make the amendment; (2) is not part of the designated record set kept by us; (3) is not part of the information which you would be permitted to inspect and copy; or (4) is accurate and complete.

**You have the right to receive an accounting of certain disclosures.** You have the right to request an accounting of most disclosures of protected health information made by us during the six years prior to the date the accounting is requested, subject to certain exceptions. Your request must be in writing. If you request such an accounting more than once in a 12-month period, we may charge a cost-based reasonable fee.

**You have the right to be notified following a breach of unsecured protected health information.** You have the right to and will receive a notification of a breach of your unsecured protected health from GTL, or one of its business associates.

**COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint in writing to us at the address shown below in the “Contact Information” section. You may also file a complaint in writing with the Secretary of the Department of Health and Human Services. You will not be retaliated against for filing a complaint.

**THIS NOTICE IS SUBJECT TO CHANGE**

We reserve the right to change the terms of this Notice and our privacy policies at any time. If we do, the new terms will be effective for all protected health information maintained by us, including protected health information received by GTL before the effective date of the new terms. If we do revise our privacy notice, a copy of the new notice will be posted on our web site at [www.gtlic.com](http://www.gtlic.com) and/or sent to you if the changes are material.

**EFFECTIVE DATE**

This Notice is effective September 23, 2013.

**CONTACT INFORMATION**

If you have questions regarding this Notice or require further information, you may contact our Customer Service Department at 1-800-338-7452. Any written complaints should be directed to Guarantee Trust Life Insurance Company, Attention: Privacy Office, 1275 Milwaukee Avenue, Glenview, Illinois 60025.

Sample





## YOUR HEARING SERVICE PLAN and How to Use It

### Contact EPIC

EPIC Hearing Healthcare  
3191 W. Temple Ave. Ste 200  
Pomona, CA 91768

Toll Free  
**1 866.956.5400**

Hearing impaired:  
Call **711** national relay service

FAX **909.348.0073**  
hear@epichearing.com  
www.epichearing.com

### HEAR BETTER • LIVE FULLY

Hearing is one of the five natural senses that allow us to enjoy life and the world around us. Music, radio, television, movies, and theater – all become less accessible and enjoyable without the benefits of hearing. And Hearing Loss can lead to more serious problems such as social disengagement, increased stress and even cognitive decline.

Hearing is a valued life asset that can be protected, treated and assisted through a program for hearing healthcare. [The EPIC Hearing Service Plan provides easy access to hearing health professionals](#) – primarily physicians and audiologists – who can help you achieve your maximum hearing potential throughout your life.

Hearing loss usually occurs gradually, without pain or discomfort. However, some more serious symptoms merit immediate attention by a physician:

- A sudden hearing loss
- Spinning and dizziness with vomiting
- Persistent ringing in one ear
- Blood or fluid draining from one or both ears
- Persistent pain in one or both ears

Hearing problems are fairly common: **12% of the US population has some form of hearing impairment and hearing loss is the #3 chronic health problem in the country.**

Source: National Institutes of Health



### EPIC's National Network Ensures Savings

EPIC's Hearing Service Plan offers you a national alliance of independent ear physicians and audiologists dedicated to high-quality hearing care.

Your EPIC benefit ensures substantial savings – **between 30% and 60%** – on [name-brand hearing aids and products](#) to protect and improve your hearing.

When to Call EPIC

If you experience any of the following, you may have a hearing problem that needs attention:

- **Difficulty understanding voices and words (especially those of women and children)**
- **Occasional ringing in one or both ears**
- **Itching in the ear canals**
- **Difficulty understanding in noisy situations**
- **Turning up the television volume to understand the dialogue**

How Often Should Your Hearing Be Checked?

Hearing tests should be part of your regular health maintenance plan. Hearing professionals recommend testing as follows:

Children 5 – 18	Every two years
Ages 20 – 50	Every two years
Ages 50 +	Annually
Everyone	Anytime you have a concern

The EPIC 5-Step Plan

Any symptom of hearing loss deserves expert evaluation and treatment by a trained hearing health care specialist.

The EPIC Hearing Service Plan starts with an evaluation of your ears and your hearing. Diagnostic tests and measures will determine the course of treatment most likely to help you hear better. The EPIC Hearing Plan’s 5 Basic Steps to Good Hearing include:

- STEP

1

**Pure Tone Hearing Test** to determine if a hearing problem exists.
- STEP

2

**Functional Assessment** to determine the magnitude of the problem and the technology best suited to treat it.
- STEP

3

**Hearing Aid Evaluation** to determine your ability to wear a hearing aid and select the best model and make.
- STEP

4

**Fitting and Programming** your hearing aid.
- STEP

5

**Therapy and Training** to fine-tune your device and maximize the benefits you receive.

How the EPIC Plan Works

- **Call EPIC today to start your hearing program.**
- **A hearing counselor will register you and assist in determining your hearing care needs.**
- **You will receive a Hearing Service Plan booklet outlining all plan services and pricing.**
- **A hearing counselor will coordinate a referral to a provider located near your home or work.**
- **Contact the provider; follow through with an appointment, examination and treatment.**
- **EPIC will coordinate and manage all payments, and assist you in coordinating insurance benefits or coverage when applicable.**
- **Our hearing counselors are available to help you, and to provide advice or additional information.**



**Call EPIC at**  
**866.956.5400**  
Call today to access hearing health services  
**Hearing impaired:**  
**Dial 711** national relay service



## Here's How Outlook Works



**OUTLOOK** is a discount program with a schedule of discount benefits and/or a percentage discount that provides substantial savings off the regular retail price for eyewear. **OUTLOOK** Vision Services is **NOT** an insurance program, therefore there is no risk exposure and NO PAPERWORK! Members make direct payment to the vision care specialist for services rendered after identifying themselves as an **OUTLOOK** member.

The **OUTLOOK** card is all you need to use your **OUTLOOK** discount benefit. Simply take your current vision prescription to any **OUTLOOK** provider to purchase your new eyewear and pay the discounted amount directly to the provider at the time of purchase. A nominal dispensing fee may apply in certain areas.

## Guarantee

The **OUTLOOK** Eyewear Guarantee.

- Highest Quality-All merchandise is covered by manufacturer's warranty for materials and workmanship.
- Price-Once a purchase is made, if you find the identical eyewear at a lower advertised price, the difference will be cheerfully refunded.
- Complete Satisfaction-If you are not completely satisfied with your eyewear purchase from a participating provider for any reason, it may be returned within 30 days to the point of purchase for a complete refund.

**This program is NOT insurance.** It is a discount program. You are responsible for the full cost of any health care services purchased. You will receive discounts for medical services at certain health care providers who have contracted with the program. Members have the right to cancel registration within a thirty-day period. This program does not make payments directly to health care providers. A list of all program providers within the prospective cardholder's service area which includes their name, city & state, and medical specialty is available prior to purchase, upon request. Discounts for hospital services are not available. This program is administered by Access One Consumer Health, 84 Villa Rd. Greenville, SC 29615, [www.accessonedmpo.com](http://www.accessonedmpo.com). The program and its administrators have no liability for providing or guaranteeing service or the quality of service rendered. Not available in AK, CT, MT, RI, VT & WA.



800.327.188 [www.outlookvision.com](http://www.outlookvision.com)

## Why Offer Vision Care

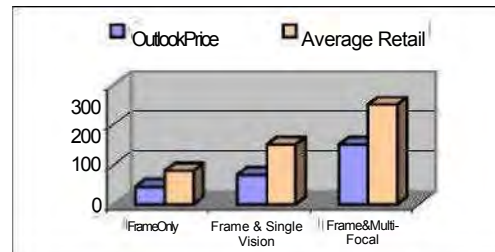


Research studies by the U.S. Department of Health and Human Services indicate that over 71% of the working population require some form of vision correction. Unfortunately, fewer than 20% of these individuals have any form of vision care insurance coverage or discount benefits. Early detection of vision problems and/or the need for prescription eyewear can help avoid potentially expensive health care costs.

As stated by the National Eye Institute in a news release April 12, 2004, "With the aging of the population, the number of Americans with major eye diseases is increasing, and vision loss is becoming a major public health problem." More and more people are seeking cost effective plans for the prevention, diagnosis and treatment of vision problems.

As health care costs continue to escalate, the need for cost-containment or "discount provider networks" also increases. Access to such discount benefit programs can save your family hundreds of dollars each year. With this in mind, **OUTLOOK** has designed and administers one of the nation's leading vision care cost-containment programs to help hold down the high cost of eyewear.

## Avoiding the High Cost of Eyewear



\*These prices are for comparison only. Actual prices may vary.

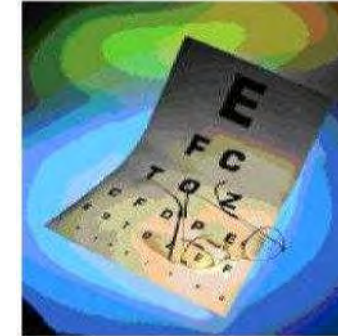
\*\* Figures obtained from actual OVS purchases

Due to the ever increasing cost of eyewear, many health care programs do not cover optical expenses. With an industry average mark-up of over 300% on eyewear, it's easy to see why. Frames, lenses, contact lenses, and solutions all contribute to some of the greatest out-of-pocket expenses in health care today.

The **OUTLOOK** vision care cost-containment program provides quality vision care and eyewear at the most affordable prices. **OUTLOOK** offers these discount benefits:

- + Save 10% to 50% off the retail price of eyewear including: prescription glasses, contact lenses, non-prescription sunglasses, and accessories.
- + Savings off standard fees on vision correction (Laser/Lasik) surgery at selected locations, where approved.
- + Membership includes your entire family.
- + Over 10,500 optical locations to choose from.
- + Mail order contact lens replacement program that offers a 10% discount on most lenses.
- + Special discounts on eye examinations at selected locations, where approved.
- + No limit on selection - no limit on quantities.
- + Minor eyewear adjustments included.

## The Provider Network



The **OUTLOOK** provider network is comprised of well-known national and regional vision care centers, independent optometrists or opticians, small and large retail optical centers and "one-hour" type optical centers, one or more which may be found in your community. Each approved provider is carefully selected through a stringent process to assure the program's standard of quality is not compromised. All locations are licensed and trained in the use of the latest equipment and techniques and offer the highest quality products and services. All providers carry up-to-date top of the line inventories from leading manufacturers.

As an **OUTLOOK** member, you may choose from our entire network of eye care professionals. With thousands of **OUTLOOK** eye care centers nationwide, chances are there is one near you. Simply call **OUTLOOK** toll free 1-800-342-7188 for the location nearest you and/or application information.

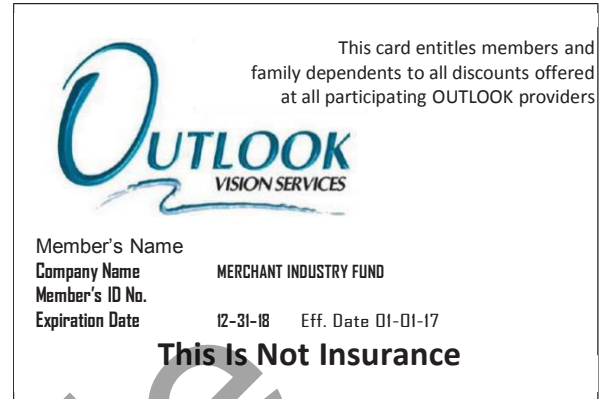
## WELCOME TO OUTLOOK VISION SERVICES

This card will give you and your family dependents a new OUTLOOK on SAVING MONEY on your vision care needs. Start SAVING TODAY on average of 10% to 50% off the regular retail price on:

Frames, lenses, contacts lenses and professional services (where approved). SEE BACK FOR DETAILS. OUTLOOK Vision is not insurance. Savings will vary by provider and/or the eyewear selected.

**MERCHANT INDUSTRY FUND**

**01/01/2017 12/31/2018**



### HOW TO USE OUTLOOK

1. Call 1-800-342-7188 or visit [www.outlookvision.com](http://www.outlookvision.com) to find the nearest provider and discounts offered.
2. Select the eyewear you want. present your OUTLOOK card.
3. Pay the provider the discounted amount. A minimal dispensing fee may apply.
4. Satisfaction guaranteed!

**THIS IS NOT INSURANCE  
IT IS A DISCOUNT PROGRAM**

Administered By AccessOne  
Consumer Health Inc.  
84 Villa Road, Greenville, SC 29615

### IMPORTANT FEATURES-PLEASE READ!

- CALL 1-800-342-7188 or visit [www.outlookvision.com](http://www.outlookvision.com) for the nearest OUTLOOK provider location and discounts offered.
- You and your family DEPENDENTS are automatically enrolled.
- Average savings of 10% to 50% off the regular retail price on: Frames, Lenses, Contact Lenses and Accessories. OUTLOOK is not insurance.
- Exam discounts are available in selected areas, where approved.
- No waiting periods, No quantity limits, No style restrictions (at most locations.)
- No claim forms, No insurance forms, No pre-authorizations.
- Pay the discounted amount to the provider AS FULL PAYMENT.
- Satisfaction guaranteed!