## Contact List

For any benefit questions or concerns, please contact us by phone or web.

<table>
<thead>
<tr>
<th>Benefit Resource</th>
<th>Phone</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Farmers Agents Benefits Call Center</td>
<td>877-862-1237</td>
<td><a href="http://www.farmersagentsbenefits.com">www.farmersagentsbenefits.com</a></td>
</tr>
<tr>
<td>• Add A New Participant Profile</td>
<td></td>
<td></td>
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<tr>
<td>• Terminate Participant Benefits</td>
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<tr>
<td>• General Coverage Questions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aetna Medical Plans Member Services (Policy #810111)</td>
<td>888-257-0403</td>
<td><a href="http://www.aetna.com/docfind/custom/">www.aetna.com/docfind/custom/</a></td>
</tr>
<tr>
<td>• Aetna Managed Choice (POS)</td>
<td></td>
<td>farmersagents/</td>
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<tr>
<td>• Aetna Open Choice (PPO)</td>
<td></td>
<td></td>
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<tr>
<td>• Aetna PPO High Deductible Health Plans (HDHP)</td>
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<td></td>
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<tr>
<td>• Aetna Traditional Choice Indemnity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Aetna Indemnity High Deductible Health Plan (HDHP)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aetna Pharmacy</td>
<td>800-227-5720</td>
<td><a href="http://www.aetna.com/aetnarxhomedelivery">www.aetna.com/aetnarxhomedelivery</a></td>
</tr>
<tr>
<td>• Mail Order/Home Delivery</td>
<td>800-238-6279</td>
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</tr>
<tr>
<td>• Pharmacy Unit*</td>
<td>866-782-2779</td>
<td></td>
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<tr>
<td>• Specialty Pharmacy</td>
<td></td>
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<tr>
<td>Dental Plans</td>
<td>877-238-6200</td>
<td><a href="http://www.aetna.com/docfind/custom/">www.aetna.com/docfind/custom/</a></td>
</tr>
<tr>
<td>• Aetna DMO Dental Plan (Policy #810111)</td>
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<td>farmersagents/</td>
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<tr>
<td>• Aetna PPO/Indemnity Plan (Policy #810111)</td>
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<tr>
<td>• Aetna Out-of-Area Indemnity Dental Plan (Policy #810111)</td>
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<tr>
<td>• Safeguard DMO Plan (Group #142143)</td>
<td>800-880-1800</td>
<td><a href="http://www.safeguard.net">www.safeguard.net</a></td>
</tr>
<tr>
<td>Vision Service Plan (VSP) (Policy #00109034)</td>
<td>800-877-7195</td>
<td><a href="http://www.vsp.com">www.vsp.com</a></td>
</tr>
<tr>
<td>MetLife Life Insurance (Policy #110031-1-G)</td>
<td>800-638-6420 (prompts 1 &amp; 2)</td>
<td></td>
</tr>
<tr>
<td>• Medical Underwriting &amp; Claims Office</td>
<td>877-275-6387</td>
<td></td>
</tr>
<tr>
<td>• Conversion Unit</td>
<td>866-492-6983</td>
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<tr>
<td>• Portability Unit</td>
<td></td>
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<tr>
<td>MetLife AD&amp;D Insurance (Policy #110031-1-G)</td>
<td>800-638-6420 (prompt 2)</td>
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<tr>
<td>• Basic &amp; Supplemental (Claims)</td>
<td></td>
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<tr>
<td>MetLife Long Term Disability (LTD) (Policy #110031-1-G)</td>
<td>888-463-2002</td>
<td></td>
</tr>
<tr>
<td>• General LTD Questions Hotline/Claims Office</td>
<td>323-932-3904</td>
<td></td>
</tr>
<tr>
<td>• Claim Form Request</td>
<td>800-347-8081</td>
<td></td>
</tr>
<tr>
<td>• LTID or BoE Hotline (Unum)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Assistance Plan (MHN, Inc.)</td>
<td>800-511-3920</td>
<td><a href="http://www.members.mhn.com">www.members.mhn.com</a></td>
</tr>
<tr>
<td>(AXA Assistance USA, Inc.)</td>
<td></td>
<td>(access code: metlife2)</td>
</tr>
<tr>
<td>Travel Assistance and Identity Theft Program</td>
<td>800-454-3679</td>
<td></td>
</tr>
<tr>
<td>(AXA Assistance USA, Inc.)</td>
<td></td>
<td></td>
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<tr>
<td>Agents’ Errors &amp; Omissions (Policy #CAP0016497 02)</td>
<td>800-821-0540</td>
<td></td>
</tr>
<tr>
<td>• Report Claims (Lancer)</td>
<td>866-893-1023</td>
<td></td>
</tr>
<tr>
<td>• General Coverage Questions (CalSurance)</td>
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<tr>
<td>• Request Certificates (<a href="http://www.farmersagentsbenefits.com">www.farmersagentsbenefits.com</a>)</td>
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<tr>
<td>Deferred Compensation Plan (Mullin TBG)</td>
<td>800-487-0042</td>
<td></td>
</tr>
<tr>
<td>• Inquiries/Request Information</td>
<td>888-866-8242</td>
<td></td>
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<tr>
<td>• Continuum Advisory Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Farmers Agents’ Benefits Dept</td>
<td>323-932-3904</td>
<td><a href="http://www.farmersagentsbenefits.com">www.farmersagentsbenefits.com</a></td>
</tr>
<tr>
<td>• Change Home Address</td>
<td>877-771-1360 (fax)</td>
<td></td>
</tr>
<tr>
<td>• Change Status/Position</td>
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For any benefit questions or concerns, please contact us by phone or web.
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This brochure highlights the main features of the Farmers® Agents’ Group Benefits Program. It is intended to help you choose the benefit programs that are best for you. This brochure does not include all plan rules and details. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be any inconsistencies between this brochure and the legal plan documents, the plan documents are the final authority. Farmers reserves the right to change or discontinue its benefit plans at any time.
Your Farmers® Agents’ Group Benefits Program

The Farmers® Agents’ Group Benefits Program consists of many plans that, together, provide valuable protection for you and your family. Your benefits program includes plans that help pay for medical, dental, and vision expenses, provide income if you’re ill or injured and unable to work, and provide financial security for your family in case you die or are seriously injured in an accident.

This brochure has been developed to serve as a guide for enrolling in the Farmers Agents’ Group Benefits Program. Your enrollment guide provides information about the benefit programs available to you and how to enroll in them.

If you want more detailed information about the individual plans, you can request a summary plan description (SPD) directly from the Farmers Agents’ Benefits Department. You may also access the SPDs online at www.farmersagentsbenefits.com after you have enrolled.

This brochure is merely an overview of the benefit plans available through the Program. Please refer to the carrier-specific SPD for coverage details.

Eligibility

All agents, district managers, reserve district managers (RDM), reserve field managers (RFM), district manager training and administrative assistants (DMTAA), district life specialists (DLS), district commercial specialists (DCS), agency producers (AP) and office employees are eligible for the benefits program as soon as their status becomes full-time. Office employees of district managers and agents are eligible for medical, dental, vision and life insurance coverage on the first day of the month following 30 days of full-time employment (20 hours or more per week). For example, those with a March 1 hire date are eligible on April 1. If hired on March 2, the eligibility date is May 1.

Your Eligible Dependents

Dependents that may be covered are your spouse, registered domestic partner, and eligible children as described below:

- A natural child
- An adopted child (including a child from the date of placement with adopting parents until the legal adoption)
- A stepchild (including the child of a domestic partner)
- A foster child

WHO CAN I CALL?

We have contracted with a third-party, Aliquant, to provide you the convenience of having one place to call for most of your benefit needs. The Farmers Agents’ Benefits Call Center at 877-862-1237 can answer questions about:

- Enrollment process
- Status of your enrollment
- Eligibility
- COBRA coverage and administration
- Continuation coverage

See the Contact List on the inside front cover of this guide for other important phone numbers.
A handicapped child dependent who exceeds the maximum age. Proof that the covered dependent is fully handicapped must be submitted to the carrier no later than 31 days after the date the child reaches the maximum age. For more information on what constitutes a handicapped child, please refer to your SPD.

**Note:** Coverage will not be extended to the spouse or child(ren) of an adult child for any available plans.

**For the Aetna medical and dental plans and the Vision Service Plan (VSP)**

An adult child may be covered to age 26, and does not need to be a full-time student, does not need to receive at least 50% of support from you, does not need to be unmarried, and does not need to reside with you.

**Special note for Ohio residents:**
If the participant and the dependent child are residents of Ohio, the child may be covered to age 28 provided they are unmarried and not employed by an employer that offers a health benefit plan for which the child is eligible. If the participant is a resident of Ohio but the dependent child is not, the child must also be a full-time student at an accredited public or private institution of higher learning in order to be eligible for coverage to age 28.

**For MetLife Life Insurance and the Safeguard Dental Plan**
An adult child may be covered to age 26, provided they are unmarried, supported by you, and not employed on a full-time basis. The child does not need to be a full-time student.

**AGREEMENT TO PARTICIPATE**
If you select medical, dental, or vision coverage, you must participate in the plan for the entire year unless you experience a qualified status change.

<table>
<thead>
<tr>
<th>Position</th>
<th>Plans For Which You Are Eligible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agents, District Managers, Reserve District Managers (RDM), Reserve Field Managers (RFM), District Manager Training and Administrative Assistants (DMTAA), District Life Specialists (DLS), and District Commercial Specialists (DCS)</td>
<td>Medical, dental, vision, life, accidental death and dismemberment (AD&amp;D), supplemental AD&amp;D, long-term disability (LTD), Enhanced LTD Plan*, E&amp;O*, and Business Overhead Expense Plan (BOE)*</td>
</tr>
<tr>
<td>Agency Producers (APs)</td>
<td>Medical, dental, vision, life, AD&amp;D, and supplemental AD&amp;D</td>
</tr>
<tr>
<td>Office Employees</td>
<td>Medical, dental, vision, life, AD&amp;D, and supplemental AD&amp;D</td>
</tr>
<tr>
<td>Reserve Agents</td>
<td>Fidelity Bond only</td>
</tr>
</tbody>
</table>

* Available only for DMs and Agents.
The Medical Plans

The medical plan coverage available to you depends on where you live. If you elect coverage, you must participate in the plan until the end of the plan year, unless you experience a qualified status change. There are five types of coverage available through Aetna:

- A point-of-service plan, called Aetna Managed Choice Point-of-Service (POS) Plan, with a deductible of $750 individual/$2,250 family in-network and $1,500 individual/$4,500 family out-of-network.

- A preferred provider organization (PPO) plan, called Aetna Open Choice PPO Plan, with a deductible of $750 individual/$2,250 family in-network and $2,000 individual/$6,000 family out-of-network.

- A choice of three Aetna high deductible health plans (HDHPs):
  - HDHP High Option deductibles are $1,250 individual/$2,500 family
  - HDHP Medium Option deductibles are $2,500 individual/$5,000 family in-network; $3,000 individual/$6,000 family out-of-network
  - HDHP Low Option deductibles are $5,000 individual/$10,000 family in-network; $6,000 individual/$12,000 family out-of-network

- An out-of-area high deductible health plan, called Aetna Indemnity HDHP, with an individual deductible of $2,500 and a family deductible of $5,000.

- An out-of-area indemnity plan, called Aetna Traditional Choice Indemnity Plan, with a deductible of $2,000 individual/$4,000 family.

Read more about each of the medical options on the next pages.

If you live in a ZIP code area served by the Aetna Managed Choice POS Plan, you can enroll in that plan, the Aetna PPO HDHP or the Aetna Open Choice PPO Plan.

If you live in the Aetna Open Choice PPO Plan service area, you can enroll in that plan or the Aetna PPO HDHP.

It is your responsibility to ensure that network providers are available in your ZIP code before choosing a plan that provides in-network benefits.

For those participants who do not have access to an Aetna POS or PPO network, you may enroll in an Aetna Traditional Choice Indemnity Plan or the Aetna Indemnity HDHP.

For those eligible for Medicare

If you are an active participant and are enrolled in an Aetna medical plan, your Aetna medical coverage is primary and Medicare is secondary.

If you are a continuee who is 65 years and older, and enrolled in an Aetna medical plan, Medicare is primary and Aetna medical coverage is secondary.

There is no pre-existing condition exclusion associated with any of the medical plans.

MANAGE YOUR HEALTH AND YOUR HEALTHCARE

Aetna offers important resources to help you and your family achieve a healthier lifestyle, enjoy improved health and manage existing health conditions.

Be sure to take advantage of the following Aetna programs:

- Online Health Assessments to alert you to health risks and opportunities for improvement
- Quit Tobacco program, including individual counseling, and nicotine replacement therapy
- Health information, research and support tools to make informed decisions

To find out more, call Aetna Member Services at 888-257-0403 or log on to www.aetna.com
Here are the features of the medical plans.

**Aetna Managed Choice Point-of-Service (POS) Plan***

Under a point-of-service plan, you may elect to seek care either through your primary care physician (PCP) and receive in-network benefits or see any doctor you wish (out-of-network) and receive reduced benefits. You decide to seek care through the network or outside of the network each time you or your covered dependents need medical care. **You receive higher benefits when you see a network physician.**

**Enrolling in the Plan**

You must live in a ZIP code area served by the Aetna Managed Choice POS Plan to enroll in this medical plan. Please contact the Farmers Agents' Benefits Call Center at 877-862-1237 to confirm whether your home ZIP code is serviced by the Aetna Managed Choice POS Plan. If you live in a ZIP code area served by the Aetna Managed Choice POS Plan, you may enroll in the Aetna Managed Choice POS Plan, the Aetna PPO HDHP or the Aetna Open Choice PPO Plan.

With Internet access, you can use DocFind®, the Aetna online provider directory on the Aetna website [www.aetna.com/docfind/custom/farmersagents/](http://www.aetna.com/docfind/custom/farmersagents/) to find Aetna Managed Choice POS participating physicians, hospitals, and other providers in your area. Physicians can be located by geographic location, medical specialty, or hospital affiliation. If you do not have access to a computer, you may call Aetna at 888-257-0403 for assistance or to receive a provider directory by mail.

If you have dependents who do not reside with you, but live in another Aetna Managed Choice POS Plan area, you can enroll them in the Aetna Managed Choice POS Plan.

If you have dependents who do not reside with you and they live in an area where an Aetna Managed Choice POS Plan network is not available, you can enroll them in the Aetna Traditional Choice Plan. It is your responsibility to write to the Farmers Agents' Benefits Department to alert them of this matter. Be sure

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*Special Note For Texas Members:*

Texas does not require you to select a primary care physician (PCP) to coordinate your medical care. Therefore, when care is required, as long as you select a participating provider in the Open Choice PPO network, you will receive the in-network level of benefits. The POS Plan in Texas is known as the “Open Choice PPO Plus Plan” and all contracted physicians and facilities are listed in DocFind® under the Open Choice PPO product.
to indicate your dependents' full names, their dates of birth, Social Security numbers, their new home address, and their guardian's full name. Aetna will keep this information and pay your dependents' claims accordingly. Your cost for health care coverage will not change. You will continue to pay for your dependents under the Aetna Managed Choice POS Plan.

Females age 13 and older may elect a primary care physician, as well as an obstetrician/gynecologist (OB/GYN) who is in the same medical group as their PCP.

**In-Network Benefits**

To receive in-network benefits, you and your family members must each select a primary care physician (PCP) from the Aetna Managed Choice POS provider directory. Your PCP will coordinate all of your medical care, including referrals to specialists and inpatient hospital authorizations, if necessary.

If you receive in-network care from your PCP, benefits generally are paid at 90% to 100% after an annual deductible of $750 per person/$2,250 per family. Office visits are covered at 100% after a $25 co-pay for PCP ($40 co-pay for specialist); a deductible does not apply. In-network preventive care is covered at 100%; a deductible does not apply.

When you receive treatment from an Aetna Managed Choice POS Plan network provider or hospital, no claim forms are required.

**Out-of-Network Benefits**

If you receive medical care out-of-network or if your care is not authorized by your PCP, benefits generally are paid at 70% after an annual deductible of $1,500 per person/$4,500 per family.

When you receive treatment from an out-of-network provider, you must complete your own claim form, which you can obtain by calling Aetna at 888-257-0403. Completed claim forms should be sent for processing to the address listed on the form.

**Identification Card**

When you enroll in the Aetna Managed Choice POS Plan, you will receive two identification cards that cover you and your dependents (up to five names can be printed on one Family ID Card). Additional cards can be obtained by calling Aetna at 888-257-0403. The cards will verify your eligibility for coverage and list the names and telephone numbers of your PCPs.

See the chart on page 9 for a partial listing of benefits under the POS Plan.
Aetna Open Choice Preferred Provider (PPO) Plan

The Aetna Open Choice PPO Plan gives you the freedom to choose the doctor or hospital you want to see for covered services. You may use a doctor or hospital in the Aetna PPO provider network, or you may use any doctor, hospital, or licensed provider of your choice. You do not have to select a primary care physician (PCP) to direct your care when you enroll in the Open Choice PPO Plan. **You will, however, receive higher benefits when you use participating Aetna PPO providers.**

You will need to file a claim form to receive benefits when you receive services from an out-of-network provider. You should submit your claims to Aetna at the address shown on the claim form.

Enrolling in the Plan

You may enroll in the Aetna Open Choice PPO Plan if you live in a ZIP code area that is served by the Aetna PPO network.

With Internet access, you can use DocFind®, the Aetna online provider directory on the Aetna website [www.aetna.com/docfind/custom/farmersagents/](http://www.aetna.com/docfind/custom/farmersagents/) to find Aetna PPO physicians, hospitals, and other participating providers in your area. Physicians can be located by geographic location, medical specialty, or hospital affiliation. If you do not have access to a computer, you may call Aetna at 888-257-0403 for assistance or to receive a provider directory by mail.

**PPO Plan Benefits**

Under the PPO Plan, there is an annual deductible of $750 individual/$2,250 family for in-network services, or $2,000 individual/$6,000 family for out-of-network services.

Eligible charges for in-network services generally are covered at 80% after you satisfy the $750 deductible. However, in-network preventive care is covered at 100% without a deductible. The plan will cover eligible charges at 100% after you satisfy the deductible and pay $2,500 in out-of-pocket expenses for eligible charges during the calendar year.

Out-of-network services generally are covered at 60% after you satisfy the $2,000 deductible, and then will cover eligible charges at 100% after you pay the deductible and $8,000 in additional out-of-pocket expenses for eligible charges during the calendar year.

See the chart on page 9 for a partial listing of benefits under the PPO plan.
Aetna PPO High Deductible Health Plan (HDHP)

The HDHP allows you to select care from in-network and out-of-network providers each time you or a covered dependent needs medical care. You do not need to select a primary care physician (PCP) to direct your care.

You will receive reduced benefits when you seek care from out-of-network providers. Note that you will need to file a claim to receive benefits from an out-of-network provider. You should submit your claims to the address shown on the Aetna claim form.

The Aetna HDHP features a high annual deductible for those wishing to minimize their monthly premium. Participation in the HDHP allows you to set up a Health Savings Account (HSA) so that you may pay for expenses that qualify for the plan deductible on a tax-advantaged basis. See more information on HSAs on the next page.

Depending on where you live, you may have the choice between three Aetna HDHP options: the HDHP High Option plan, the HDHP Medium Option plan, and the HDHP Low Option plan. The options have different deductibles, out-of-pocket maximums and benefits levels.

Enrolling in the Plan

You must live in a ZIP code area served by the Aetna PPO network to enroll in an HDHP Plan. (See page 11 for information on an HDHP option if you do not live in the network area). Please contact the Farmers Agents’ Benefits Call Center at 877-862-1237 to confirm whether your home ZIP code is served by either of those networks.

With Internet access you can use DocFind®, the Aetna online provider directory on the Aetna website www.aetna.com/docfind/custom/farmersagents/, to find Aetna network providers in your area. Physicians can be located by geographic area, medical specialty, or hospital affiliation. If you do not have access to a computer, you may call Aetna at 888-257-0403 for assistance or to receive a provider directory by mail.

Plan Benefits

After satisfying the plan’s annual deductible, you pay a percentage of most eligible expenses, up to your annual out-of-pocket maximum. The HDHP High Option plan, the HDHP Medium Option plan and the HDHP Low Option plan have different deductibles, out-of-pocket maximums and benefits levels.

Note that eligible in-network preventive care expenses such as routine physical exams and immunizations are covered at 100% without a deductible, subject to the plan’s limitations on frequency. Well-child exams and immunizations, gynecological care, mammograms, digital rectal/prostate specific antigen test for males age 40 and over and colorectal cancer screening for members age 50 and over are considered preventive care by the HDHP; see the SPD for details.

Prescription drug benefits are covered only after the deductible is met.

You should be aware that using out-of-network providers result in significantly reduced benefits.

The percentage of covered expenses you pay as well as the annual deductible, count toward your out-of-pocket maximum. Once you pay the out-of-pocket maximum, the plan will pay 100% of covered charges.

See the chart on page 10 for a partial listing of benefits under the three HDHP options.
Health Savings Accounts

If you enroll in an HDHP, you may want to set up a Health Savings Account (HSA). This account will allow you to make tax-deductible contributions each year up to the Plan’s annual deductible amount. HSAs are available through independent institutions; Farmers does not sponsor an HSA.

You may use HSA funds for qualified medical expenses. Typical qualified expenses are listed below:

- Medical plan deductibles
- Diagnostic services not covered by the plan
- Dental care, including braces
- LASIK eye surgery and contact lenses
- Some nursing services
- Hearing aids
- Wheel chairs
- Organ transplants
- Over-the-counter drugs, if prescribed by a doctor

A complete list of qualified expenses can be found on the Aetna website, [www.aetna.com](http://www.aetna.com), or by requesting IRS Publications 502 by calling the IRS at 800-829-3676 or visiting their website at [www.irs.gov](http://www.irs.gov) and clicking on “Forms and Publications.”

You never lose your HSA account balance. Your account balance remains available until you use it for qualified expenses.
# Medical Plan Comparisons

<table>
<thead>
<tr>
<th>Benefit Provisions</th>
<th>Aetna Managed Choice POS Plan</th>
<th>Aetna Open Choice PPO Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible per calendar year</td>
<td>$750 individual $2,250 family</td>
<td>$750 individual $2,250 family</td>
</tr>
<tr>
<td>(once the family deductible has been met, all family members will be considered as having met their deductible for the remainder of the calendar year)</td>
<td>$1,500 individual $4,500 family</td>
<td>$2,000 individual $6,000 family</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>90% after deductible</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>70% after deductible</td>
<td>60% after deductible</td>
<td></td>
</tr>
<tr>
<td>Coinsurance (Out-of-Pocket) Limit per calendar year</td>
<td>$4,000 individual $8,000 family*</td>
<td>$2,500 per individual $8,000 per individual</td>
</tr>
<tr>
<td>(does not include deductible)</td>
<td>$15,000 individual $30,000 family*</td>
<td></td>
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<tr>
<td>Lifetime Maximum</td>
<td>Unlimited</td>
<td>Unlimited</td>
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<tr>
<td>Preventive Care</td>
<td>100%, deductible waived</td>
<td>100%, deductible waived</td>
</tr>
<tr>
<td>(routine exams/immunizations, subject to plan guidelines; see SPD for details)</td>
<td>70% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>90% after deductible</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>(includes physician’s services)</td>
<td>70% after individual/family deductible and inpatient confinement deductible</td>
<td>60% after individual/family deductible and inpatient confinement deductible</td>
</tr>
<tr>
<td>Inpatient per Confinement Deductible</td>
<td>None</td>
<td>$100</td>
</tr>
<tr>
<td>Routine Maternity Care</td>
<td>100% after $25 copay 90% after deductible</td>
<td>100% after $25 copay 80% after deductible</td>
</tr>
<tr>
<td>■ Initial office visits</td>
<td>70% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>■ Inpatient hospital</td>
<td>70% after individual/family deductible and inpatient confinement deductible</td>
<td>60% after individual/family deductible and inpatient confinement deductible</td>
</tr>
<tr>
<td>Prescription Drugs4,5</td>
<td>You pay 30% ($40 min/$80 max)</td>
<td>You pay 30% ($40 min/$80 max)</td>
</tr>
<tr>
<td>Retail (30-day supply)</td>
<td>You pay 30% ($60 min/$120 max)</td>
<td>You pay 30% ($60 min/$120 max)</td>
</tr>
<tr>
<td>■ Generic</td>
<td>You pay 30% ($90 min/$180 max)</td>
<td>You pay 30% ($90 min/$180 max)</td>
</tr>
<tr>
<td>■ Formulary Brand Name</td>
<td>You pay 30% ($120 min/$240 max)</td>
<td>You pay 30% ($120 min/$240 max)</td>
</tr>
<tr>
<td>■ Non-Formulary Brand Name</td>
<td>You pay 30% ($180 min/$360 max)</td>
<td>You pay 30% ($180 min/$360 max)</td>
</tr>
<tr>
<td>Mail order (31-day to 90-day supply)</td>
<td>You pay 30% ($270 min/$540 max)</td>
<td>You pay 30% ($270 min/$540 max)</td>
</tr>
<tr>
<td>■ Generic</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>■ Formulary Brand Name</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>■ Non-Formulary Brand Name</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Emergency Room for a bona fide emergency</td>
<td>100% after $100 copay; waived if admitted</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Outpatient Surgery Expenses</td>
<td>100% after $100 copay; waived if admitted</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Diagnostic X-ray &amp; Lab (other than physician’s office)</td>
<td>90% after deductible</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Primary Care Physician Office Visit</td>
<td>90% after deductible</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Specialist’s Office Visit</td>
<td>90% after deductible</td>
<td>80% after deductible</td>
</tr>
</tbody>
</table>

---

1 In Texas, this plan is known as “Open Choice PPO Plus Plan.”

2 80% coverage for services not available within the network. Includes services such as Skilled Nursing Facility, Private Duty Nursing, Home Health Care, Hospice, DME, etc.

3 Once the family coinsurance limit is met, all family members will be considered as having met their coinsurance for the remainder of the calendar year.
### Medical Plan comparisons

<table>
<thead>
<tr>
<th></th>
<th>Aetna Managed choice</th>
<th>Pos Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network</td>
<td>$1,250 individual</td>
<td>$2,500 family*</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>$2,500 individual</td>
<td>$5,000 family</td>
</tr>
<tr>
<td></td>
<td>*If two or more participants are enrolled in this plan, only the family deductible applies.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Aetna open choice</th>
<th>PPo Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network</td>
<td>$2,500 individual</td>
<td>$3,000 individual</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>$3,000 individual</td>
<td>$6,000 family</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>hDhP high option</th>
<th>hDhP Medium option</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network</td>
<td>$5,000 individual</td>
<td>$10,000 family</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>$6,000 individual</td>
<td>$12,000 family</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>hDhP Low option</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network</td>
<td>$5,950 individual</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>$7,500 individual</td>
</tr>
</tbody>
</table>

### Deductible

- **Routine Maternity care**: Deductible
- **Primary care Physician office Visit** (includes physician’s services)
- **Preventive care** coinsurance
- **outpatient surgery Expenses** deductible for the remainder of the calendar year)
- **inpatient confinement** family deductible

### Coinsurance

- **Inpatient hospital**
  - 90% after deductible
  - 80% after deductible
  - 70% after deductible
  - 60% after deductible

### Prescriptions

- **Generic**
  - 100% after $25 copay
  - 70% after deductible
  - 60% after deductible
- **Non-Formulary Brand Name**
  - 90% after deductible
  - 70% after deductible
  - 80% after deductible
- **Formulary Brand Name**
  - 100% after $25 copay
  - 70% after deductible
  - 80% after deductible

### Lifetime Maximum

- **Unlimited Unlimited Unlimited Unlimited Unlimited Unlimited Unlimited Unlimited Unlimited Unlimited**

### Other Information

- If a generic drug is available and a brand-name drug is dispensed without your doctor indicating “dispense as written” on the prescription, you must pay the difference in cost between the generic and brand name drug, plus the copayment.
- After two refills of a maintenance prescription, you must use the mail service in order to have plan coverage for the drug.

The terms of your benefit plans are governed by legal documents. Please refer to your Aetna SPD for more details and plan limitations.

---

<table>
<thead>
<tr>
<th></th>
<th>HDHP High Option</th>
<th>HDHP Medium Option</th>
<th>HDHP Low Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-of-Network</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4 If a generic drug is available and a brand-name drug is dispensed without your doctor indicating “dispense as written” on the prescription, you must pay the difference in cost between the generic and brand name drug, plus the copayment.

5 After two refills of a maintenance prescription, you must use the mail service in order to have plan coverage for the drug.
**Aetna Traditional Choice Indemnity Plan (Out-of-Area Plan)**

The Aetna Traditional Choice Indemnity Plan is an out-of-area plan for those participants who do not live in an area served by the Aetna POS or PPO networks. With an indemnity plan, you may use the doctor, hospital, or licensed provider of your choice.

You will need to file a claim form to receive benefits. You should submit your claims to Aetna at the address shown on the claim form.

**Plan Benefits**

The Out-of-Area Plan has an annual deductible of $2,000 individual/$4,000 family. This plan covers eligible charges at 80% after you satisfy the deductible. After you pay $8,000 per individual in out-of-pocket expenses for eligible expenses during the calendar year, the plan covers eligible charges at 100% except for prescription copays.

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**Aetna Indemnity High Deductible Health Plan (HDHP) Out-of-Area**

The Indemnity HDHP is available to those who wish to take advantage of a High Deductible Health Plan, but who do not live in a ZIP code serviced by the Aetna PPO or POS networks.

You may seek care from a doctor, hospital or licensed provider of your choice.

The Aetna Indemnity HDHP features a high annual deductible for those wishing to minimize their folio deductions. Participation in the HDHP allows you to set up a Health Savings Account (HSA) so that you may pay for expenses that qualify for the plan deductible on a tax-advantaged basis. See more information on HSAs on page 8.

**Enrolling in the Plan**

If you do not live in a ZIP code area served by the Aetna PPO or POS network, you may enroll in the Indemnity HDHP. Please contact the Farmers Agents’ Benefits Call Center at 877-862-1237 to confirm whether your home ZIP code is served by either of those networks.

**Plan Benefits**

After satisfying the plan’s annual deductible ($2,500 individual/$5,000 family), you pay 20% of most eligible expenses, up to your annual out-of-pocket maximum ($3,500 individual/$7,000 family). Note that eligible preventive care expenses are covered at 100% without a deductible. Prescription drug benefits are covered only after the deductible is met.

The percentage of covered expenses you pay as well as the annual deductible, count toward your out-of-pocket maximum. Once you pay the out-of-pocket maximum, the plan will pay 100% of covered charges.

See the chart on the next page for a partial listing of benefits under the two Out-of-Area plans.
### Out-of-Area Medical Plan Options

<table>
<thead>
<tr>
<th>Benefit Provisions</th>
<th>Aetna Traditional Choice Indemnity Plan</th>
<th>Aetna Indemnity HDHP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible per calendar year</strong> (once the family deductible has been met, all family members will be considered as having met their deductible for the remainder of the calendar year)</td>
<td>$2,000 individual</td>
<td>$2,500 individual</td>
</tr>
<tr>
<td></td>
<td>$4,000 family</td>
<td>$5,000 family</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>80% after deductible</td>
<td>80% after deductible</td>
</tr>
<tr>
<td><strong>Coinsurance (Out-of-Pocket) Limit per calendar year; does not include deductible</strong></td>
<td>$8,000 individual</td>
<td>$3,500 individual</td>
</tr>
<tr>
<td></td>
<td>None for family</td>
<td>$7,000 family</td>
</tr>
<tr>
<td><strong>Lifetime Maximum</strong></td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td><strong>Inpatient Hospital</strong> (includes physician’s services)</td>
<td>80% after deductible</td>
<td>80% after deductible</td>
</tr>
<tr>
<td><strong>Preventive Care</strong> (routine exams/immunizations, subject to plan guidelines; see SPD for details)</td>
<td>100%, deductible waived</td>
<td>100%, deductible waived</td>
</tr>
<tr>
<td><strong>Emergency Room</strong> for bona fide emergency</td>
<td>80% after deductible</td>
<td>80% after deductible</td>
</tr>
<tr>
<td><strong>Routine Maternity Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><a href="#">Office Visit</a></td>
<td>80% after deductible</td>
<td>80% after deductible</td>
</tr>
<tr>
<td><a href="#">Inpatient Hospital</a></td>
<td>80% after deductible</td>
<td>80% after deductible</td>
</tr>
<tr>
<td><strong>Prescription Drugs[1,2]</strong> Retail (30-day supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><a href="#">Generic</a></td>
<td>You pay 30% ($20 min/$40 max)</td>
<td>You pay 30% ($20 min/$40 max)*</td>
</tr>
<tr>
<td><a href="#">Formulary Brand Name</a></td>
<td>You pay 30% ($40 min/$80 max)</td>
<td>You pay 30% ($40 min/$80 max)*</td>
</tr>
<tr>
<td><a href="#">Non-Formulary Brand Name</a></td>
<td>You pay 50% ($70 min/$140 max)</td>
<td>You pay 50% ($70 min/$140 max)*</td>
</tr>
<tr>
<td><strong>Mail order (31-90 day supply)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><a href="#">Generic</a></td>
<td>You pay 30% ($60 min/$120 max)</td>
<td>You pay 30% ($60 min/$120 max)*</td>
</tr>
<tr>
<td><a href="#">Formulary Brand Name</a></td>
<td>You pay 30% ($120 min/$240 max)</td>
<td>You pay 30% ($120 min/$240 max)*</td>
</tr>
<tr>
<td><a href="#">Non-Formulary Brand Name</a></td>
<td>You pay 50% ($210 min/$420 max)</td>
<td>You pay 50% ($210 min/$420 max)*</td>
</tr>
<tr>
<td><strong>Outpatient Surgery Expenses</strong></td>
<td>80% after deductible</td>
<td>80% after deductible</td>
</tr>
<tr>
<td><strong>Diagnostic X-ray &amp; Lab</strong> (other than physician’s office)</td>
<td>80% after deductible</td>
<td>80% after deductible</td>
</tr>
<tr>
<td><strong>Physician’s Office Visit</strong></td>
<td>80% after deductible</td>
<td>80% after deductible</td>
</tr>
</tbody>
</table>

---

[1] If a generic drug is available and a brand-name drug is dispensed without your doctor indicating “dispense as written” on the prescription, you must pay the difference in cost between the generic and brand name drug, plus the copayment.

[2] After two refills of a maintenance prescription, you must use the mail service in order to have plan coverage for the drug.

The terms of your benefit plans are governed by legal documents. Please refer to your Aetna SPD for more details and plan limitations.
**Prescription Drug Coverage**

You receive prescription drug coverage with each of the medical plan options. The amount you pay depends on whether the drug is a generic, brand name drug on the “formulary” list, or a brand name drug not on the formulary list. You should also know that if you are taking a “maintenance” drug for more than two 30-day fills, you must use the mail service in order to have coverage for the drug.

See the chart on pages 9 and 10 to see the amount you pay for each category of prescription drug. You can obtain a copy of the formulary list or get more information on the mail service online at www.aetna.com/docfind/custom/farmersagents/ or by calling 800-227-5720.

**Generic Drugs**

Generic drugs can save you money. They are proven by the Food and Drug Administration (FDA) to be safe and effective. Generic drugs have the same active ingredients, dosage, safety, strength, quality and performance as their brand name counterparts. Not all brand name drugs have generic equivalents since the patent on a brand name drug must expire before a generic equivalent can be produced; most drug patents are protected for 17 years.

**Important:** A prescription for a brand name drug will automatically be filled with a generic drug (if available), unless your doctor writes “Dispense as Written” on the prescription for a brand name drug. If the doctor does not include that instruction and you insist on a brand name drug, you will pay the difference between the cost of the generic and the brand as well as the coinsurance amount.

**Formulary Drugs**

A formulary is a preferred drug list containing both generic and brand name drugs commonly prescribed by physicians. To be on the Aetna formulary list, drugs must be FDA approved and proven safe and effective. Non-formulary refers to any prescription drug, brand name or generic, that does not appear on the formulary list. Non-Formulary Brand refers to brand name prescription drugs that do not appear on the formulary list. Non-Formulary Brand drugs are available at the Non-Formulary Brand pharmacy copay level.

**Mail Order Drugs**

The Aetna Rx Home Delivery prescription drug service offers a convenient and cost-effective way to obtain your longer-term (maintenance) prescriptions. Mail order generally provides a three-month (90 day) supply for three times the monthly cost. (If you are in Arkansas or Alabama, there is no copay difference between retail and mail order.)

**Important:** You must use the mail service after two 30-day refills of the prescription at your local pharmacy (original 30 days plus one 30 day refill) to receive plan benefits for the drug.

Infusion and injectable therapies that are administered in your doctor’s office are supplied by Aetna Specialty Pharmacy. Your doctor can fax new prescriptions to 866-329-2779 or mail them to Aetna Specialty Pharmacy, 503 Sunport Lane, Orlando, FL 32809. You or your doctor may call 866-782-2779 for more information.
The Dental Plans

If you elect coverage, you must participate in the plan until the end of the year unless you experience a qualified status change. There are two types of dental plans to choose from if you live in an area served by their networks, and an out-of-area plan if you live outside those network areas:

- Aetna DMO Dental Plan (a prepaid dental plan). If you live in California, you also have the option to choose coverage under the SafeGuard Dental Plan, a DMO dental plan, or
- Aetna PPO/Indemnity Dental Plan, which allows you to receive dental care from in-network or out-of-network dentists.

- Aetna Out-of-Area Indemnity Dental Plan, which is available if you live outside of the network service areas for the Aetna DMO or PPO/Indemnity Dental Plans; you may use any dentist.

It is your responsibility to determine if you live in a plan’s network area before you choose coverage under that plan.

Here is a partial list of services covered by the Aetna DMO Prepaid Dental Plan and the SafeGuard Dental Plan.

<table>
<thead>
<tr>
<th>Service</th>
<th>Aetna DMO Prepaid Dental Plan</th>
<th>SafeGuard Dental Plan (Only available in California)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Calendar Year Maximum</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>100% after $5 office visit copay</td>
<td>100% after $5 office visit copay</td>
</tr>
<tr>
<td>(oral exams, cleanings, x-rays)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic Treatment*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Fillings</td>
<td>$10 – $35</td>
<td>$10 – $80</td>
</tr>
<tr>
<td>▪ Root Canals</td>
<td>$70 – $340</td>
<td>$105 – $275</td>
</tr>
<tr>
<td>▪ Extractions</td>
<td>$11 – $100</td>
<td>$0 – $130</td>
</tr>
<tr>
<td>▪ Periodontics</td>
<td>$30 – $300</td>
<td>$38 – $300</td>
</tr>
<tr>
<td>Major Procedures*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Inlays/crowns</td>
<td>$180 – $220</td>
<td>$165 – $225</td>
</tr>
<tr>
<td>▪ Dentures</td>
<td>$275 – $350</td>
<td>$210 – $300</td>
</tr>
<tr>
<td>Orthodontia (children &amp; adults)</td>
<td>100% after $2,000 copay**</td>
<td>100% after $2,195 copay**</td>
</tr>
<tr>
<td>Waiting Period for Major Procedures</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

* Dentist determines the amount you pay for services  ** Includes copays for screening exam, diagnostic records, treatment, and retention.

The terms of your benefit plans are governed by legal documents. Please refer to your Aetna or Safeguard SPD for more details and plan limitations.
To indicate which dentist you have chosen, fill in his/her name and code number on the enrollment form. The dentist that you choose will provide routine care — checkups, cleanings, etc. — and refer you to a specialist, if necessary. If you would like to change the dentist that you have selected, you may call the dental plan’s toll-free number and give them the new dentist’s code number. This toll-free number is listed on your dental I.D. card.

Most diagnostic and preventive services are covered at 100% after you pay the office visit copayment. For other services, you pay a copayment directly to the participating dentist. The amount depends on the procedure performed. The SPD tells you the specific copayment for each service.

Both plans cover diagnostic and preventive care, including full-mouth x-rays, office visits, and cleanings. Also covered are basic services such as fillings, crowns, periodontal (gum) treatments, root canals, dentures, and oral surgery. Both the Aetna DMO and SafeGuard plans provide limited orthodontia coverage for children and adults.

You do not have to file a claim for dental expenses; all you have to do is pay the dentist the copayment for the dental service at the time you receive treatment.

PLEASE NOTE:
Orthodontia is not covered under the Aetna PPO/Indemnity Dental Plan.

Aetna PPO/Indemnity Dental Plan
The Aetna PPO/Indemnity Dental Plan is a dual-option plan. This means that you can receive your dental care from any dentist you choose. However, you can reduce your out-of-pocket dental expenses if you use a provider in the Aetna PPO dental network.

The plan pays a higher level of benefits for in-network dental services. In addition, Aetna network dentists are paid for services based on reduced negotiated fees.

The chart below is a partial list of services covered by the Aetna PPO/Indemnity Dental Plan.

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>Out-of-Area Texas*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible</td>
<td></td>
<td>$75 individual</td>
<td>$75 individual</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$225 family</td>
<td>$225 family</td>
</tr>
<tr>
<td>Calendar Year Maximum</td>
<td></td>
<td>$1,000 per person</td>
<td>$1,000 per person</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>100%</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td>(oral exams, cleanings, x-rays)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic Treatment</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
</tr>
<tr>
<td>(fillings, extractions, periodontics)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major Procedures</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>(inlays, crowns, fixed bridgework, dentures,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>general anesthesia)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthodontia</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Waiting Period for Major Procedures</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

* The state of Texas does not allow for an active dental PPO plan.

The terms of your benefit plans are governed by legal documents. Please refer to your Aetna SPD for more details and plan limitations.
When you use a dentist outside the Aetna dental network, you may receive a balance bill, as the plan only covers benefits up to the usual and prevailing charge limits in your area. You will also have to file a claim.

The plan covers preventive, basic, and major services. After you pay a $75 calendar year deductible per person, $225 per family, the plan pays a calendar year maximum of $1,000 for covered services.

The chart below is a partial list of services covered by the Aetna Out-of-Area Indemnity Dental Plan.

<table>
<thead>
<tr>
<th>Service</th>
<th>Any Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible</td>
<td>$75 individual</td>
</tr>
<tr>
<td></td>
<td>$225 family</td>
</tr>
<tr>
<td>Calendar Year Maximum</td>
<td>$1,000 per person</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>100%</td>
</tr>
<tr>
<td>(oral exams, cleanings, x-rays)</td>
<td></td>
</tr>
<tr>
<td>Basic Treatment</td>
<td>80%</td>
</tr>
<tr>
<td>(fillings, extractions, periodontics)</td>
<td></td>
</tr>
<tr>
<td>Major Procedures</td>
<td>50%</td>
</tr>
<tr>
<td>(inlays, crowns, fixed bridgework, dentures, general anesthesia)</td>
<td></td>
</tr>
<tr>
<td>Orthodontia</td>
<td>Not covered</td>
</tr>
<tr>
<td>Waiting Period for Major Procedures</td>
<td>None</td>
</tr>
</tbody>
</table>

The terms of your benefit plans are governed by legal documents. Please refer to your Aetna SPD for more details and plan limitations.
The Vision Plan

You can receive coverage for annual eye examinations and the purchase of eyeglasses or contact lenses through Vision Service Plan (VSP). If you elect vision coverage, you must participate in the plan until the end of the plan year, unless you experience a qualified status change.

VSP Open Access provides the flexibility for members to use VSP Vision Care benefits at any location, including specialty optical boutiques or retail chains. While 95% of members choose a VSP Preferred Provider for the enhanced benefits, the plan also includes a generous open access schedule.

VSP offers members discounts on laser vision correction surgery to correct such visual acuity problems as nearsightedness, farsightedness and even astigmatism. For more details, visit VSP's new Laser VisionCareSM home page through www.vsp.com or call 888-354-4434.

Finding a VSP Provider

VSP offers different ways to help you find a participating doctor in your area, or to verify that your current provider is a VSP doctor. You should always call a doctor to confirm participation in the VSP network. If you require assistance in locating a VSP doctor, use one of the following methods:

To find a VSP provider on the web:

- Go to the VSP website at www.vsp.com
- Find the “Members & Consumers” section
- Follow the directions to register as a site user, or fill in your UserID and password
- Select the “Find a VSP Doctor” tab

You can search for a VSP doctor by entering your ZIP code or a doctor’s specific address or last name. Either option provides you with a geographical map and doctor’s office location and contact information.

VSP also offers an automated member service system accessible via a toll-free number. You just call 800-VSP-7195 (877-7195), and you can:

- Enter a doctor’s telephone number to verify the office’s participation in VSP’s network
- Locate a doctor by a ZIP code and obtain a doctor’s location information and telephone number
- Request a list of VSP participating doctors that will be mailed to you
- If you need additional assistance, a customer service department representative is available.

When you need vision care contact VSP directly by using one of the methods described above. Then, call a VSP participating doctor to schedule an appointment. You’ll need to identify yourself as a VSP member and a participant in the Farmers Agents’ Group Benefits Program and provide your Social Security number.

After you’ve scheduled your appointment, the VSP participating doctor will contact VSP to verify your eligibility and plan coverage. You will not receive a VSP ID card.
The following is a chart showing benefits for both VSP and non-VSP providers.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>VSP Provider</th>
<th>Non-VSP Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Copay</td>
<td>$25</td>
<td>$25</td>
</tr>
<tr>
<td>Examination once per calendar year</td>
<td>100%</td>
<td>Plan pays up to $50</td>
</tr>
<tr>
<td>Eyeglasses&lt;sup&gt;1&lt;/sup&gt; Frame every 2 calendar years</td>
<td>Plan pays up to $120 100% of VSP-approved fees</td>
<td>Plan pays up to $70 Plan pays: Up to $50/pair Up to $75/pair Up to $100/pair</td>
</tr>
<tr>
<td>Eyeglasses&lt;sup&gt;1&lt;/sup&gt; Lenses once per calendar year - Single Vision - Bifocal - Trifocal</td>
<td>Plan pays up to $120 100% of VSP-approved fees</td>
<td>Plan pays up to $70 Plan pays: Up to $50/pair Up to $75/pair Up to $100/pair</td>
</tr>
<tr>
<td>Contact lenses&lt;sup&gt;2&lt;/sup&gt; once per calendar year (in lieu of frame and lenses) Elective Medically necessary</td>
<td>Up to $120 100%</td>
<td>Plan pays up to $105 Plan pays up to $210</td>
</tr>
<tr>
<td>Contact lenses&lt;sup&gt;2&lt;/sup&gt; VSP provides a 15% off cost of contact lens examination (evaluation and fitting). This discount does not apply to the contact lens materials. New and current soft contact lens wearers may qualify for a program that includes a contact lens evaluation and initial supply of lenses with discounts on 65% of lenses on the market.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetic Eyecare Program (for those with Type 1 diabetes)</td>
<td>$20 copay</td>
<td>N/A</td>
</tr>
</tbody>
</table>

The terms of your benefit plans are governed by legal documents. Please refer to your VSP SPD for more details and plan limitations.

**What’s Not Covered**

You may incur additional charges if you chose cosmetic options not covered under the plan, such as:

- Blended lenses
- Contact lenses (if purchased in addition to frames and lenses in the same service plan year)
- Oversize lenses
- Photochromic or tinted lenses other than Pink 1 or 2
- Coated or laminated lenses
- Progressive multifocal lenses
- A frame that costs more than the plan allowance
- Certain limitations on low vision care
- Cosmetic lenses
- Optional cosmetic processes
- UV protected lenses

The plan does not include coverage for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing
- Plano lenses (non-prescription)
- Two pairs of glasses in lieu of bifocals
- Lenses and frames furnished under this program that are lost or broken will not be replaced, except at normal intervals when services are otherwise available
- Medical or surgical treatment of the eyes
- Any eye examination or any corrective eye wear required as a condition of your job
- Corrective vision services, treatments, and materials of an experimental nature
Life and AD&D Insurance Plans

These plans provide life insurance and accidental death and dismemberment (AD&D) insurance for you and your family. Life and AD&D insurance is underwritten by our carrier, MetLife.

The amount of life and accidental death and dismemberment (AD&D) insurance you may buy depends on your position.

### Basic Group Life and AD&D Insurance

<table>
<thead>
<tr>
<th>Category</th>
<th>Life insurance:</th>
<th>AD&amp;D:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agents or District Managers</td>
<td>$50,000 first year; after first year, able to increase amount in $50,000 increments up to $1,200,000, not to exceed 8 times annual commissions. Maximum benefit is the lesser of $1,200,000 or 8 times annual commissions</td>
<td>Equal to life insurance coverage</td>
</tr>
<tr>
<td>Reserve District Managers, Reserve Field Managers, DMTAAs, DLSS, DCSs, or APs</td>
<td>$50,000</td>
<td>Equal to life insurance coverage</td>
</tr>
<tr>
<td>Eligible family members of Agents, District Managers, Reserve District Managers, Reserve Field Managers, DMTAAs, DLSS, DCSs, and APs</td>
<td>$25,000 for spouse; $5,000 for each child from birth to age 26*</td>
<td>Equal to life insurance coverage</td>
</tr>
<tr>
<td>Office Employees</td>
<td>$25,000</td>
<td>Equal to life insurance coverage</td>
</tr>
<tr>
<td>Eligible family members of office employees</td>
<td>$12,500 for spouse; $1,500 for each child from birth to age 26*</td>
<td>Equal to life insurance coverage</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>Family life insurance:</th>
<th>AD&amp;D:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible family members of Agents, District Managers, Reserve District Managers, Reserve Field Managers, DMTAAs, DLSS, DCSs, and APs</td>
<td>$25,000 for spouse; $5,000 for each child from birth to age 26*</td>
<td>Equal to life insurance coverage</td>
</tr>
<tr>
<td>Office Employees</td>
<td>$25,000</td>
<td>Equal to life insurance coverage</td>
</tr>
<tr>
<td>Eligible family members of office employees</td>
<td>$12,500 for spouse; $1,500 for each child from birth to age 26*</td>
<td>Equal to life insurance coverage</td>
</tr>
</tbody>
</table>

### Supplemental AD&D Insurance

<table>
<thead>
<tr>
<th>Category</th>
<th>AD&amp;D:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agents or District Managers, Reserve District Managers, Reserve Field Managers, DMTAAs, DLSS, DCSs, APs, or Office Employees</td>
<td>Equal to your coverage for spouse</td>
</tr>
<tr>
<td>Eligible family members of Agents, District Managers, Reserve District Managers, Reserve Field Managers, DMTAAs, DLSS, DCSs, APs, and Office Employees</td>
<td>10% of your coverage to a maximum of $30,000 for each child</td>
</tr>
</tbody>
</table>

$50,000 to $300,000 in multiples of $50,000

* The terms of your benefit plans are governed by legal documents. Please refer to your MetLife SPD for more details and plan limitations.

* Provided they are unmarried, supported by you and not employed on a full-time basis.
MetLife Basic Life and AD&D Insurance Plan

Coverage Options
During the first year that you are eligible for coverage as an agent or district manager, you may elect a maximum benefit of $50,000 if you request this coverage within 31 days after you become eligible. After your first year, you will be eligible to elect insurance coverage of more than $50,000, based on your prior year’s earnings (maximum of $500,000 without evidence of insurability) only if you enroll within 31 days of your first anniversary. If you apply for more than $500,000, you must complete a MetLife Evidence of Insurability Form and/or carrier approval for the requested amount must be granted. MetLife will notify you of its decision regarding your request.* If you want to change the amount of your life insurance, call the Farmers Agents’ Benefits Call Center for information. You may be required to submit evidence of insurability. You may also be required to submit medical evidence at your expense.

Covering Your Family
You can select life insurance for your spouse or child(ren) only if you elect life insurance for yourself.

For spouse coverage, life and AD&D insurance terminates at age 70. The termination of coverage will occur on the January 1 following your spouse’s 70th birthday. Spouse and child(ren) benefits will also terminate upon the death of the active or former agent or district manager.

The monthly cost for child life insurance is a flat rate, regardless of the number of children that you cover.

Additional Benefits
When you enroll for life and AD&D insurance, you are automatically covered for an additional 100% of AD&D insurance if your death is caused by an accident while riding in a common carrier. The AD&D benefit is payable in addition to life benefits.

If you die in a covered accident while driving or riding in a private passenger car and you were properly using a seat belt, an additional 10% of the principal sum of AD&D coverage is payable (not to exceed $25,000).

Evidence of Insurability
If you do not return the Evidence of Insurability form, depending on what you have requested, you will be prevented from increasing your amount of coverage until the form is received and approved. However, if you do not apply for benefits within the first 31 days of eligibility and do not return the Evidence of Insurability form, then you will not have coverage until that form has been submitted and approved.

* If you apply for any increase after the 31-day window following your first year anniversary, you must complete a MetLife Evidence of Insurability form for any request, and carrier approval for the requested amount must be granted. Your increase request can be made in $50,000 increments up to a maximum request of $1,200,000, and is subject to a limit of eight times your prior year’s annual net commissions. MetLife will notify you of its decision regarding your request.

THE ACCELERATED BENEFIT OPTION:
Under MetLife’s Accelerated Benefit Option, if you become terminally ill (as determined by the plan), you may be eligible to receive a portion of your group life insurance benefits while you are still living. Benefits not paid in advance will remain with the plan and will be payable to your beneficiary.

If you’re an agent or district manager, you can increase your life insurance amounts at anytime after you’ve been enrolled in the plan for 12 months. After your first year as an agent or district manager, you will be eligible to elect insurance coverage of more than $50,000, based on your prior year’s earnings (maximum of $500,000 without evidence of insurability) only if you enroll within 31 days of your first anniversary.*

All other classes are eligible for the amounts of coverage indicated on page 19.

If you’re an agent or district manager, you can increase your life insurance amounts at anytime after you’ve been enrolled in the plan for 12 months. After your first year as an agent or district manager, you will be eligible to elect insurance coverage of more than $50,000, based on your prior year’s earnings (maximum of $500,000 without evidence of insurability) only if you enroll within 31 days of your first anniversary.*

All other classes are eligible for the amounts of coverage indicated on page 19.
AD&D Insurance
This insurance is payable for loss of limb, eyesight, speech, hearing, life, or paralysis caused by an accident. The full amount is paid for loss of life, total and irreversible paralysis of all four limbs, and loss of speech and hearing. A percentage of the full amount is paid for loss of limb, eyesight, speech, or hearing and loss of the thumb and index finger of the same hand.

Total Disability Benefits
You are eligible to continue the amount of your group life insurance without premium payment if you become totally disabled under the “extended death benefits during total disability” provision of the plan.

Coverage continued under the “extended death benefits during total disability” provision is subject to reductions.

Submitting a Claim
Contact the Farmers Agents’ Benefits Department if you need to submit a life insurance claim. If the Farmers Agents’ Benefits Department is not notified of a claim, premiums will continue to be charged. In most cases, basic life insurance claims should be processed by the carrier within 10 days after receipt of all required paperwork.

Portability
Portability is a feature available with your life insurance and AD&D benefits. If you are eligible and you choose to port your coverage when you leave Farmers, you can continue group coverage at your own expense. This group insurance is administered through MetLife, and the premium is submitted directly to MetLife on a monthly basis. You can continue this same amount or a lesser amount of coverage that you
had with Farmers, but coverage cannot exceed $1,000,000, nor can it go below $20,000. The application period for portable term coverage is 31 days from the date of termination of benefits. You must elect portable coverage in order for your dependents to elect portable coverage. Michigan residents can port a maximum of $173,400, and portability coverage reduces by 50% at age 70 and terminates at age 80.

In the event of your death, your spouse is eligible to port up to age 70 and dependent children are eligible to port until age 26, provided they are unmarried, supported by you, and not employed on a full-time basis. In addition, if you elect benefit continuation coverage, you cannot port your coverage (only continue or convert coverage).

**Converting Life Insurance**

You may convert the amounts of life insurance you lose when you leave Farmers to an individual whole life insurance policy by purchasing the policy at standard rates from MetLife. You will not have to submit evidence of insurability if you choose to convert your coverage. However, you must apply for conversion within 31 days of when your coverage ends, or else you will not be eligible for conversion. You will receive a conversion notice from the Farmers Agents’ Benefits Call Center when you leave Farmers.

**Travel Assistance**

Participants in MetLife’s AD&D plan automatically receive the emergency travel assistance program, provided by AXA Assistance USA. This plan provides professional assistance for travelers (including spouse/registered domestic partner and eligible dependents) who are traveling on business or pleasure almost anywhere in the world and at least 100 miles or more from home.

AXA’s Travel Assistance program provides a wide range of services through a network of highly qualified professionals who are multilingual and board-certified physicians. Some of the services available include assistance 24 hours a day for medical emergencies, emergency prescription services, evacuation, return of mortal remains, care for minor children, legal and interpreter referrals, as well as assistance to locate lost luggage.

**Will Preparation Service**

Participants in MetLife’s AD&D plan are automatically eligible for the Will Preparation Service provided by Hyatt Legal Plans, a MetLife company.

Fees for a participating attorney to prepare or update a will for you and your spouse are fully covered, including telephone and office consultations. If you use a non-network attorney, you will receive reimbursement for eligible services up to a set dollar amount.

To find out more, call the Hyatt Legal Plans’ toll free number at 800-821-6400.

**Identity Theft Program**

Participants in MetLife’s AD&D plan are automatically covered by Identity Theft Solutions, provided by AXA Assistance USA.

This no-cost service provides you and your dependents with assistance in obtaining free credit reports, educational materials on identity theft and help placing “fraud alerts” with credit bureaus, as well as 24/7 access to case managers.

Case managers can provide assistance with taking inventory of lost or stolen items and directing you to the appropriate contacts for resolution. They will help you with police and credit reports, contacting credit or fraud departments, government agencies and local law enforcement, as well as filing complaints with the Federal Trade Commission.
MetLife Supplemental AD&D Insurance

This insurance is payable for loss of limb, eyesight, speech, hearing, life, or paralysis caused by an accident. The full amount is paid for loss of life, total and irreversible paralysis of all four limbs, and loss of speech and hearing. A percentage of the full amount is paid for loss of limb, eyesight, speech, or hearing and loss of the thumb and index finger of the same hand.

You may purchase MetLife Supplemental AD&D insurance whether or not you buy group life and AD&D insurance.

Coverage Options

You can elect from $50,000 to $300,000 of supplemental AD&D coverage in multiples of $50,000. You also can elect to cover your spouse for an equal amount and your children for 10% of your insurance amount, to a maximum of $30,000 per child. Your spouse's coverage terminates at the end of the calendar year in which he or she reaches age 70.

Submitting a Claim

When filing a claim for Supplemental AD&D insurance, you need to complete a separate claim form (other than the one for life insurance).

You can obtain the form from the Farmers Agents’ Benefits Department.

What the Supplemental AD&D Plan Does Not Cover

The Supplemental AD&D Insurance Plan does not cover certain types of losses, including those associated with the following:

- Intentionally self-inflicted injury while sane or insane, suicide, or attempted suicide
- Disease of the body, bodily or mental infirmity, or any bacterial infection other than bacterial infection due directly to an accidental cut or wound
- War or any act of war, declared or undeclared

These are not the only exclusions under this plan. For information on other limitations and exclusions, and for more details on those listed here, please review the SPD.

Disability Insurance Plans

MetLife Long-Term Disability (LTD) Insurance Plan

LTD provides a monthly benefit if you become disabled. You have the option to choose a 90-day or 180-day elimination period. If you currently have coverage, you can change your coverage by applying for a different option only during the annual enrollment period. Note: Elimination period means the period of your disability during which MetLife does not pay benefits. The elimination period begins on the date that you become medically disabled and continues for either 90 or 180 days, depending on the plan you have selected.

A 3/12 pre-existing condition clause will apply. Participants who have previously waived coverage will be subject to evidence of insurability restrictions and a 3/12 pre-existing condition clause.

You are disabled when MetLife determines that you are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury, and you have a 20% or more loss in your monthly earnings due to the same sickness or injury. After your elimination period (90 or 180 days) plus the following 24 months of continuous disability, you are disabled when MetLife determines that due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience.
Your monthly LTD benefit is 50% of your monthly earnings. The highest benefit payable is $10,000 per month.

LTD coverage does not require an "evidence of insurability" form, if you enroll within 31 days of becoming eligible. If you wish to enroll at any time after that, you will need to complete the form, and it is subject to approval by the insurance carrier.

**Pre-existing Condition Clause**
Coverage under the LTD plan is subject to a 3/12 pre-existing condition clause. This means that a pre-existing condition review will be conducted if you submit an LTD claim within the first 12 months of your coverage effective date. If it is determined that you received care, treatment, or consultation for the disabling condition within the three months prior to the effective date of your coverage, then this condition will not be covered under the policy.

**Benefits Limitation**
In addition, benefit coverage for disabilities due to mental illness, alcoholism, drug abuse, neuromusculoskeletal/Soft Tissue Disorder and Chronic Fatigue Syndrome is limited to a maximum of two years, unless the patient is confined to a hospital. Benefits are not paid for disabilities resulting from intentionally self-inflicted injuries, active participation in a riot, loss of a professional license or certification, or commission of a crime for which you have been convicted under state or federal law. Your plan will not cover a disability due to war, declared or undeclared, or any act of war.

Your LTD benefit will be reduced by any disability benefits you receive or are eligible to receive, including workers' compensation, federal or state benefits, Social Security, other group disability plans, and by commissions and service fees you receive from Farmers.

After benefits are paid for 12 months, you will be eligible to receive an LTD benefit that is equal to 50% of your predisability monthly earnings minus any and all commissions and service fees received from Farmers and any other income that you are eligible to receive (for example, Social Security).

**Work Incentive Benefit**
For the first six months of being disabled and receiving a disability payment, your monthly disability payment will not be reduced as long as your earnings plus the gross disability payment do not exceed 100% of your predisability monthly earnings.

**WHAT IS A PRE-EXISTING CONDITION?**
You have a pre-existing condition if:

- You received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the three months just prior to your effective date of coverage; or you had symptoms for which an ordinarily prudent person would have consulted a healthcare provider in the three months just prior to your effective date of coverage; and

- The disability begins in the first 12 months after your effective date of coverage.
The length of time LTD benefits can be paid depends on your age when you become disabled, as shown in the chart below.

<table>
<thead>
<tr>
<th>Your Age At Disability</th>
<th>Maximum Benefit Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than age 60</td>
<td>To age 65</td>
</tr>
<tr>
<td>Age 60</td>
<td>60 months</td>
</tr>
<tr>
<td>Age 61</td>
<td>48 months</td>
</tr>
<tr>
<td>Age 62</td>
<td>42 months</td>
</tr>
<tr>
<td>Age 63</td>
<td>36 months</td>
</tr>
<tr>
<td>Age 64</td>
<td>30 months</td>
</tr>
<tr>
<td>Age 65</td>
<td>24 months</td>
</tr>
<tr>
<td>Age 66</td>
<td>21 months</td>
</tr>
<tr>
<td>Age 67</td>
<td>18 months</td>
</tr>
<tr>
<td>Age 68</td>
<td>15 months</td>
</tr>
<tr>
<td>Age 69 and over</td>
<td>12 months</td>
</tr>
</tbody>
</table>

A family survivor benefit pays your spouse, registered domestic partner or children a lump sum benefit equal to six months of your gross disability payment following your death. This benefit is payable if your disability had continued for at least six months prior to your death, and you were receiving or were entitled to receive payments under the plan.

**Employee Assistance Plan**

If you participate in the MetLife LTD Plan, you automatically receive the added advantage of MHN’s employee assistance program. All of us, at one time or another, experience problems that are difficult to handle. MHN provides trained and experienced counselors that can help you identify and resolve your problems and those of any family member in a professional, confidential manner.

Some of the issues MHN can help you with include stress, financial issues, parenting, legal concerns, workplace issues, childcare, elder care, alcohol and/or drug abuse, communication skills and other matters of concern.

You and the members of your household are allowed up to three counseling sessions per incident per year and services can be received in any of three ways — by calling the EAP’s toll-free number, by making an appointment with an EAP counselor or by visiting the EAP’s website. The program is available 24 hours a day, 7 days a week, 365 days a year through MHN’s toll-free number 800-511-3920.

**Terminal Illness Benefit**

If you become terminally ill while you are disabled and are not expected to live more than 12 months, you may be eligible for a terminal illness benefit. The terminal illness benefit increases your monthly disability payment to 80 percent of your pre-disability earnings. You also may elect to receive a single lump sum benefit.

You or your legal representative must send MetLife a signed physician’s certification documenting your terminal illness. In addition, MetLife may request an examination by a physician of their choice, at their expense.
Converting Long-Term Disability Insurance

You can convert your long-term disability insurance to an individual policy if you have been insured for at least 12 consecutive months under the Farmers Agents’ Long-Term Disability Plan and your coverage ends for any reason except for the following:

■ You are or become insured under another group long-term disability plan within 31 days after your appointment agreement or employment ends,

■ You are disabled under the terms of the plan,

■ You recover from a disability and do not reinstate your appointment agreement with the policyholder or return to work for your employer, or

■ Your coverage under the plan ends because:
  — The plan is cancelled,
  — The plan is changed to exclude the group of participants to which you belong,
  — You are no longer in an eligible group,
  — You end your working career or retire and receive payment from any employer’s retirement plan, or
  — You fail to pay the required premium under this plan.

To continue coverage as an individual, you must apply in writing and pay your first premium within 31 days after your group coverage ends.

Unum Enhanced Long-Term Disability Plan

Your group Long-Term Disability (LTD) policy insures 50% of your income to a maximum of $10,000 a month ($120,000 a year); however, if your income is in excess of $240,000, you would not be receiving a full 50% income replacement benefit. The individual Enhanced Disability plan provides the opportunity to fill that gap.

If this is your first opportunity to enroll in this program, the enhanced plan will replace up to an additional $5,000 a month without medical evidence of insurability not to exceed 60% total benefit (group LTD and enhanced LTD combined). Amounts greater than $5,000 a month will require evidence of insurability up to an overall monthly maximum of $15,000.

To be eligible for the enhanced LTD plan, you must first be enrolled in the group LTD plan.

In addition to the increased income replacement, this plan will also pay an additional 40% replacement (up to $10,000 a month) for a disability that is catastrophic in nature. In total, this could result in a 100% income replacement. Also, upon retirement, the entire individual plan can be converted to a Long Term Care policy without medical evidence of insurability.

Note: To convert to the Long Term Care policy, retirement needs to occur from ages 60 through 70.

Evidence of Insurability (EOI)

If you currently have an individual Enhanced Disability Plan and qualify for additional coverage, the enhanced plan will increase your coverage up to a total of $5,000 a month without medical evidence of insurability. Amounts greater than $5,000 a month will require evidence of insurability up to an overall monthly maximum of $15,000.

If you were previously eligible for this coverage and did not choose to enroll, all elected amounts are subject to evidence of insurability.
This evidence consists of a copy of your most recent Schedule C’s, a completed medical questionnaire, and a paramedical exam. In some cases, to assist in issuing a policy, an Attending Physician Statement from your primary physician may be ordered from the insurance carrier as well.

If evidence is required, once your selections are received by the Farmers Agents’ Benefits Department, any required forms and instructions for completing these forms will be sent to you automatically. If you do not return the EOI form, you will not have coverage under the requested plan until the insurance company receives the form and approves your application for coverage.

The Farmers Agents’ Benefits Call Center can also tell you if you must complete an EOI form. Refer to the appropriate benefit sections in this booklet for more information.

**Note:** If you qualify for the Enhanced Disability Plan based on your 1099 income, a personalized enrollment kit will be sent directly to you. Also, the Enhanced Disability Plan is independent of the group disability plan.

**Converting Enhanced Disability**

The Enhanced Disability Plan is fully portable. Once you are no longer part of Farmers Agents’ Group Benefits Program you will receive notification from Unum on your options of continuing coverage.

**Unum Business Overhead Expense Plan**

If a disability were to occur, not only would your net income be diminished, but how would you afford to keep your agency going? Just because you are no longer coming into work each day doesn’t mean that the expenses stop. The office lease is still due and your employees still need to get paid.

Agents and district managers (ages 18 to 60) are eligible to enroll in the Unum Business Overhead Expense Insurance Plan. This plan is fully underwritten (evidence of insurability is required) and independent of the group LTD and the Enhanced LTD plans. The Overhead Expense plan will pay a benefit directly to you to cover overhead expenses associated with running your agency for up to 12 months should you become disabled (a minimum monthly benefit of $500 up to a $25,000 maximum monthly benefit).

**Note:** The Business Overhead Expense Insurance Plan cannot be offered to California Agents and District Managers.

**Evidence of Insurability (EOI)**

Evidence of Insurability is required for the Business Overhead Expense Plan. This evidence consists of a copy of your most recent Schedule C’s, a completed medical questionnaire, and a paramedical exam. In some cases, to assist in issuing a policy, an Attending Physician Statement from your primary physician may be ordered from the insurance carrier as well.

If evidence is required, once your selections are received by the Farmers Agents’ Benefits Department, any required forms and instructions for completing these forms will be sent to you automatically. If you do not return the EOI form, you will not have coverage under the requested plan until the insurance company receives the form and approves your application for coverage.

The Farmers Agents’ Benefits Call Center can also tell you if you must complete an EOI form. Refer to the appropriate benefit sections in this booklet for more information.

**Converting Business Overhead Expense Plan**

The Business Overhead Expense Plan is fully portable. Once you are no longer part of the Farmers Agents’ Group Benefits Program you will receive notification from Unum on your options of continuing coverage.
Errors and Omissions Insurance (E&O)

Agents’ Group Summary

Errors and omissions insurance coverage (E&O) is considered a necessity for any licensed agent, district manager and their employees. Because Farmers recognizes the value of a group plan for our agents rather than an individual plan, we sponsor a Group E&O Program. Coverage is underwritten by Arch Insurance Company, and the program is administered by CalSurance Associates, a division of Brown and Brown of California, Inc.

The Group E&O Program is voluntary; however, all district managers and agents are automatically included for coverage unless participation is specifically rejected in writing.

The Group E&O insurance policy provides protection against claims arising out of any act, error, omission, or personal injury of the insured agent, or any other covered person for whom the insured agent is legally liable, in the rendering of or failing to render professional services for others in the capacity of an insurance agent, registered representative (if appointed with FFS, LLC), expert witness, or notary public.

New Coverage Features

- Network Security & Privacy Breach Coverage has been added to the basic coverage. This feature includes coverage for Privacy/Data Security Coverage, Network Security Breach or Privacy Violation; Crisis Management Expense; Credit Monitoring Services; and Data Restoration Costs. Sublimits of liability apply to each coverage part. Deductibles (which apply to Damages & Defense costs) vary by coverage part.

- Broad insolvency carveback that provides coverage for companies rated B+ (P&C) and A- (Life and A&H) by A.M. Best. A $50,000 defense sublimit is provided for other insolvency related claims.

Who is Covered?

The agent or district manager and all office employees including, but not limited to reserve district managers, reserve field managers, district manager training administrative assistants, district life specialists, district commercial specialists, agency producers, agent’s spouse or, CSRs working in the agency/district office share a per claim limit and annual policy limits of liability. Such employees, Agency Producers and CSRs are covered while acting on behalf of the agent/DM at no additional premium. However, if an Agency Producer (AP) has a direct contract with insurance companies other than Farmers, the group E&O policy will not provide coverage for any claims that arise out of transactions with those companies. Each agent or district manager pays one monthly premium. If you add any employees acting on your behalf during the policy year, they are automatically covered and you do not need to notify CalSurance Associates or Farmers of staffing changes and there is no additional premium due.

What is Covered?

Coverage is afforded under the errors and omissions policy for any service necessary or incidental to the conduct of the insurance business of the agent or DM. Covered services shall include services rendered in connection with programs authorized by Farmers Insurance Exchange or its affiliated companies, which are part of the strategic alliance or affinity partners as product or service providers. Covered products shall include personal lines, life insurance and/or securities sold through FFS. Commercial lines sold through Farmers is also covered.

Commercial brokered business is insurance that is sold to a business and is placed with a company other than Farmers. Examples would be General Liability Policies, Commercial Property and Business Owner Packages, including Workers Compensation Insurance.
For career agents contracted prior to May 1, 2009, commercial brokered business products are covered if the insured’s error giving rise to the claim occurred prior to January 1, 2004; however, coverage for Commercial Brokered Business after January 1, 2004 is subject to whether this coverage has been waived. If you elect to exclude this coverage by “opting out” and you report a claim involving commercial lines brokered business where the error occurred on or after January 1, 2004, the E&O carrier will deny the claim. Please remember, to ensure coverage for commercial brokered business in the event of a claim, this optional coverage must be maintained continuously.

For agents contracted as career agents on or after May 1, 2009, the basic coverage provided to you upon conversion does not include coverage for commercial brokered business other than an Assigned Risk Plan, Fair Plan or state-mandated placement facilities. Agents may apply for commercial brokered business coverage if they have been expressly authorized by Farmers to engage in this activity. Please contact Farmers Agents Benefits for instructions on how to apply for this coverage at 323-932-3904.

**Limits of Liability Options**

- $1,000,000/$2,000,000 Each Claim/Aggregate Each Agency or District office.
- $2,000,000/$2,000,000 Each Claim/Aggregate Each Agency or District office.
- $3,000,000/$3,000,000 Each Claim/Aggregate Each Agency or District office.
- $4,000,000/$4,000,000 Each Claim/Aggregate Each Agency or District office.
- $5,000,000/$5,000,000 Each Claim/Aggregate Each Agency or District office.

Certain agents that are sub-producers of Farmers Services Insurance Agency must carry minimum limits of $5,000,000/$5,000,000.

The policy includes sub-limits that may reduce the amount of coverage available, depending on the nature of the claim. There is a $15,000,000 Policy Aggregate for claims resulting from mutual funds, variable products, or other covered securities products involving multiple Named Insured Agents.

**Claims Made and Reported**

This policy is a “Claims Made and Reported” policy. This means that you must report claims made against you during the policy period in order for coverage to apply. If you are aware of any actual or potential E&O claims which you have not already reported to Lancer Claims Services, you must report them prior to January 1, 2011. Lancer Claims Services’ phone number is 800-821-0540.

**Deductibles**

All deductibles apply to damages only. If the E&O carrier incurs expenses and there is no loss payment, you will not owe a deductible.

- $1,000 per claim on all business placed with or through Farmers Insurance Exchange, Truck Insurance Exchange, Fire Insurance Exchange, Farmers Services Insurance Agency, Farmers Financial Solutions, LLC, and Kraft Lake Insurance Agency, or placed with or through a carrier or market approved by Farmers Insurance Exchange.
- $5,000 per claim on all other covered business.

**Deductible Waiver**

If you have not reported any claim(s) on Farmers business during the five policy periods preceding the date you report a claim, the deductible shall be waived for the first claim reported on Farmers business.

**Deductible Buy-back Arrangement**

For a small monthly premium you can eliminate the out of pocket expenses associated with your deductible (both Farmers, $1,000 and non-Farmers business, $5,000). The Deductible Buy-back eliminates up to a maximum of $10,000 each policy year for your agency/district office should an E&O claim be brought against you. Please remember, to ensure the deductible is waived in the event of a claim, you must have elected this optional coverage at the time you report a claim.
Retroactive Date
The Group E&O Program does not provide coverage for any activities prior to the policy’s retroactive date. The retroactive date is the later of:
- The date of inception of the agent’s or district manager’s contract with Farmers Insurance Exchange; or
- The date of the first continuous claims made errors and omissions liability coverage maintained without interruption.

Waiver of Coverage
The Group E&O Program is voluntary; however, all district managers and agents are automatically included for coverage unless participation is specifically rejected in writing. Requests for waiver of coverage should be faxed directly to the Farmers Agents’ Benefits Department at 877-771-1360. A confirmation will be sent upon receipt of your request.

Limits of Liability Changes
Limits of Liability changes may only be completed during the annual enrollment period. Be sure to review your personalized enrollment form and make the necessary changes online during the annual enrollment period.

 Newly Appointed Agents
Each new agent participating in the Farmers Agents’ Group Benefits program will be automatically enrolled in the Errors and Omissions Insurance Program with limits of liability of $1,000,000 each claim/$2,000,000 annual aggregate.

You have the opportunity to change this automatic coverage election within 31 days of your initial eligibility. If you don’t change your option within 31 days, you must wait until the next annual enrollment period. This basic policy coverage does not include coverage for commercial brokered business. In order to add it, you must be expressly authorized by Farmers to engage in this activity.

Continuation of the Errors and Omissions Policy
DMs, agents, APs, DMTAAs, RDMs, RFMs, DCS’ and DLS’ are covered by the Farmers Agents’ Errors and Omissions Program for acts, errors, omissions, and personal injuries that occur while under contract with Farmers. Coverage under this policy ends on the date your contract terminates. However, the policy provides an Automatic Extended Reporting Period for an unlimited amount of time following the end of your contract to report any claim involving Farmers’ products, as long as the act, error, omission, or personal injury:
- Occurred before your contract termination date; and there is no other valid insurance available to pay the claim; and
- The claim is otherwise covered by the policy; and
- Your contract has not been terminated for cause.

The policy also provides an Automatic Extended Reporting Period for 90 days for claims involving products and services of insurance carriers other than Farmers. Options to extend the 90-day period to three years, five years, or an unlimited period of time are available for purchase through CalSurance Associates provided that your contract has not been terminated for cause.

Questions?
Visit the Errors & Omissions reference page on the Agents’ Benefits website at: www.farmersagentsbenefits.com. This site will give you access to the program highlights and the plan policy. In addition, there are a number of loss control tools available, including the “E&O Loss Prevention Class” which provides industry best practices to help reduce losses against your agency and staff. These important resources, along with E&O Certificate Reprint are just a few examples of the online resources available for your use 24/7.

For additional questions about coverage provisions, contact CalSurance Associates:
- Phone: 866-893-1023
- Fax: 866-893-1198
- Email: farmers@calsurance.com
The Farmers Agency Force Deferred Compensation Plan

The Farmers Agency Force Deferred Compensation Plan (the “Plan”) began in June of 2004 and is currently in its seventh year of operation. It is a stable savings program that allows agents and district managers to save for the future on a tax-deferred basis. The Plan gives eligible participants an additional way to save to meet their financial planning needs.

The Plan allows you to:
- Decrease your income tax liability
- Save for short-term and long-term goals with pre-tax dollars
- Supplement your other savings efforts
- Utilize tax-advantaged investment options
- Enjoy higher equivalent rates of return than after-tax savings

How the Plan Works
The Plan is completely voluntary. You may contribute as little as 10% to as much as 50% of your net new Auto commissions to the Plan. When you do so, you are deferring receipt of this portion of your commissions until a later date that you choose — as early as three years from the beginning of the Plan year or as late as your contract separation.

Once you choose to defer, Farmers will create a bookkeeping account in your name and will pay you your balance according to your distribution elections, subject to the Plan’s distribution rules. Returns and deferrals credited to your account are not subject to income tax until your balance is distributed.

Your deferrals are credited to your account on the first business day of each month during the Plan year. For the 2011 Plan year, you defer commissions from the March 2011 folio through the January 2012 folio.

Please note: Each Plan year is treated separately and is independent of other Plan years; therefore, each Plan year can have different and unique elections.

IMPORTANT NOTE:
- Current active 2010 Agency Force Deferred Compensation Plan participants will automatically be enrolled into the 2011 Plan year
- If you are a current participant and you do not want to participate next year, you must opt out during annual enrollment
- Once annual enrollment has closed, you may not revoke your elections and must remain in the Plan for the entire Plan year.

Who is Eligible?
Full time agents and district managers, and career agents who were appointed on or before June 30, 2010, are eligible to enroll in the 2011 Plan year. Reserve agents, reserve district managers, life specialists, agency producers, and employees of agents or district managers are not eligible for the Plan.

If you are a career agent and are receiving subsidy, please note that your monthly match subsidy amount may be reduced by the amount of the deferral associated with the Plan each month.

For dual agents who write business under both SSN and Tax ID Number, you may defer to the Plan under either or both identification numbers. Please refer to the Plan Summary & Highlights brochure for further details.

Enrollment
You can only enroll in the Plan during annual enrollment. For the 2011 Plan year the annual enrollment period is from October 18, 2010 — November 7, 2010.

This next annual enrollment will again include an “evergreen” provision. This means that 2010 Plan participants’ elections will be carried over automatically to the 2011 Plan year, with the exception of the Scheduled In-Service election.
If you currently have a Scheduled In-Service election for the 2010 Plan year, it will not rollover to the 2011 Plan year. To have a Scheduled In-Service Withdrawal for the 2011 Plan year's balance, you will need to complete the online enrollment process and elect this option before the end of annual enrollment.

**2011 Election Options**

**Deferral Election:**
Every year, you may defer 10% to 50% of your net new Auto commissions.

- There is a minimum deferral amount of $10.00 each month for each of the Farmers companies that you write business for.

- Once annual enrollment closes, you cannot change your deferral election.

Please note: If you deferred commissions in the 2010 Plan year, your election will automatically carry forward to the 2011 Plan year unless you make a different deferral election during the annual enrollment period.

Your deferrals for the 2011 Plan year will start with your March 2011 folio and go through your January 2012 folio (there is no February deferral).

**Investment Choices**
You can invest your deferrals in a variety of investment crediting options.

- You may diversify your deferrals among an array of asset classes with a broad range of relative risks and returns.

- You may also choose a different asset allocation for each Plan year and make changes monthly.

**About Your Investments**
To preserve the tax-deferred status of deferred compensation plans, federal law requires that the investment alternatives be “deemed investments.” That means you have no ownership interest in the funds you select. The funds are only used to measure the gains or losses that will be attributed to your deferral account. The investment crediting choices are not publicly traded mutual funds and are only available through variable universal life insurance products. A description of the investment funds is available online at [www.farmersagentsbenefits.com](http://www.farmersagentsbenefits.com) under the Deferred Compensation tab.

**Distribution Elections**
The following are different distribution options that may be available to you:

1. **Scheduled In-Service Withdrawal:** This optional election (available only during annual enrollment for the upcoming Plan year) allows you to schedule a distribution of this Plan year’s balance as early as 3 years from the start of the Plan year, while you are still under contract. For instance, you may elect to receive your 2011 Plan year’s balance as early as 2014.

You may elect, and by meeting certain Plan requirements, will receive annual installments over a period of two to four years. Scheduled In-Service withdrawals are paid in March of the year you elect a distribution to commence.

You have the option to postpone receipt of your Scheduled In-Service Withdrawal; however, the postponement must be submitted by the last day in February one year prior to your elected distribution year, and it must be postponed for a minimum of 5 years.

Remember, each Plan year is treated separately and is independent of each other. For instance, you could have Scheduled In-Service Withdrawal distributions for Plan years 2007, 2008 and 2009 that are all due to pay out in 2013. If you want to change or postpone these distributions, you will need to change each Plan year election separately.

2. **After Contract Termination:** This is a mandatory election. The termination election can govern how the Plan year balance is paid in the event you leave Farmers prior to your Scheduled In-Service Withdrawal. You can choose to receive the Plan year’s balance at contract separation in a lump sum or in

**BENEFIT STATEMENTS**
Your statements will be updated monthly, but will not be mailed to you. However, once you have enrolled in the Plan, you may access your account details and print monthly or quarterly statements via the link to your account at [www.farmersagentsbenefits.com](http://www.farmersagentsbenefits.com) under the Deferred Compensation tab.
annual installments over 2 to 10 years. Some restrictions apply to receiving annual installments — see the Plan Summary & Highlights brochure for details.

3 **Hardship Distributions:** Hardship distributions may be available for “unforeseeable emergencies.” See the Summary & Highlights brochure for details.

4 **Death:** In the event of your death prior to the distribution of your entire account, the beneficiary(ies) you designate will receive your account balance as a lump sum.

**Complete Beneficiary Designation**
Each new Plan enrollee needs to designate a beneficiary for his/her account balance in the event of death.

If you are already a Plan participant, it’s a good idea to make sure your Plan beneficiary information is current and complete. A change in marital status or a new dependent can trigger a need for a new beneficiary.

You may change or update your beneficiary designation information at any time. Just follow these simple steps:

1. Sign on to [www.farmersagentsbenefits.com](http://www.farmersagentsbenefits.com)
2. Click on the “Deferred Compensation” icon
3. Click on “View Account”
4. Click on “Farmers Agency Force Deferred Compensation Plan” under Plan Name
5. On the left navigation bar, click on “Beneficiaries” under Elections
6. Click on “Update Beneficiary”
7. Make your beneficiary designation or complete missing information

**Plan Administration**
This Plan is administered by the Benefits Committee, which has discretionary authority to interpret the Plan provisions, as well as make the rules necessary for the Plan’s day-to-day operation. MullinTBG is the Plan record-keeper, responsible for maintaining and reporting your elections and account balances.

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**Tax Consequences**
No income taxes are withheld from deferrals; whatever you contribute to the Plan will not be included as income on your 1099. Income taxes are not assessed until there is a distribution from your account. Investment returns credited to your account are also not subject to income taxes or self-employment taxes, until distribution.

The Plan is a non-qualified plan and is not subject to most provisions of ERISA (the Employee Retirement Income Security Act of 1974). All distributions from the Plan (including investment returns) are treated as ordinary income, subject to income taxes (federal and most states) and self-employment taxes at the time of distribution. Consult your tax professional for your individual tax consequences and benefits related to participating in this deferred compensation plan.

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**Continuum Advisory Services**
- Only available to District Managers
- Free professional, objective financial and investment advice
- Call 888-866-8242 to speak with an advisor now

The Continuum Advisory Service was introduced in 2009. It’s a free service that provides professional, objective financial and investment advice to district managers. District managers who utilize the service get individualized portfolio review, asset allocation modeling, money manager and mutual fund due diligence, account distribution planning, and risk tolerance assessment.

These services are provided by highly experienced investment professionals from MullinTBG Advisors, a Registered Investment Adviser and subsidiary of MullinTBG. They provide ongoing financial counseling before, during transition to and after retirement. DMs can contact them at 888-866-8242 to speak with an advisor.
Risks of a Deferred Compensation Plan

Investment Risks
The value of your account will vary depending on the performance of the investment funds that you select.

Changes in Tax or other Applicable Laws
The Plan will be administered consistent with applicable regulations in order to allow deferral of income. If there are changes in tax laws, other regulations or legal interpretations, certain Plan features may no longer be available. Farmers makes no representation or guarantee concerning future tax treatments or the availability of any Plan features.

Changes in Contract Status
Neither your participation in the Plan, nor your rights to your account guarantees your continued contractual relationship with Farmers. Some changes in contract status, such as termination for cause, may result in your account being distributed earlier than you planned. This could result in a significant tax liability.

Irrevocable Trust
Farmers has placed assets to pay Plan benefits in an irrevocable trust. This trust provides you a measure of protection, shielding assets for your sole benefit in the event of a change of control in the ownership or management of Farmers. Furthermore, the trust partitions assets so that they may not be used for any purpose other than to pay out your account balance, except in the event of Farmers’ bankruptcy or insolvency. In those cases, trust assets are treated like all other corporate assets and are subject to the claims of Farmers’ general creditors.

Right to Amend/Terminate the Plan
Farmers has the right to amend or terminate the Plan, in whole or in part, at any time. No amendment or termination of the Plan will retroactively reduce any amounts allocated to your account.

Please note that the Plan has been redesigned to comply with the deferred compensation provisions of the JOBS Act enacted in October 2004 that went into effect the beginning of 2005. The description of this Plan in this and other materials, including enrollment materials, reflects the redesign in light of the new provisions. We reserve the right to modify Plan provisions as necessary to comply with these provisions, and we will promptly notify you of any changes.

If you have questions about the Plan, contact the Farmers Deferred Compensation Helpline at 800-487-0042, Monday — Friday, 6:00 a.m. — 6:00 p.m. Pacific Time.
**Fidelity Bond**

District managers, full-time agents and reserve agents and all of their respective employees, full-time, part-time, paid or unpaid, are required to be bonded at all times.

In general, the agents’ fidelity bond protects the Companies of the Farmers Insurance Group® and the financial institutions approved by Farmers against defalcations, shortages, or losses of any type involving claims, premiums or any other Farmers Insurance Group property. Coverage is not provided for premiums belonging to insurers other than the Farmers Insurance Group of Companies (see named insureds listed in the Fidelity Bond policy).

It is not mandatory for individuals to be bonded to participate in the Farmers Agents’ Fidelity Bond program (underwritten by Truck Insurance Exchange with limits of $100,000). Separate fidelity bond coverage, obtained at the individual’s own expense, which is acceptable to the Farmers Companies, can be provided to satisfy the Companies’ bonding requirements. The bond must have all of the Farmers Companies listed as “named insureds,” not the agent or the agency. The current list of the companies is listed in the current policy available online at www.farmersagentsbenefits.com.

In 2011, the premium for the Fidelity Bond is $60 per year for agents and district managers, and $25 for reserve agents. The entire annual premium is charged to the January folio. Newly appointed participants are automatically covered at no additional premium until January 1st of the following year. Also, there will be no premium returned for those who terminate during the course of the year.

**Shortages or Defalcations**

Shortages, defalcations, or losses can occur in many ways. For example, checks issued on insufficient funds, failure to remit premium collections promptly, customer complaints of unjustified lapses, or improper handling of claims payments are some of the more obvious signs of a shortage or defalcation. When a shortage or loss is suspected, immediately contact the Marketing department by telephone or fax. Or, if an agent has knowledge of the dishonest acts of another individual, it is the responsibility of the agent to report it. This is required as part of the terms and conditions of the Agents’ Fidelity Bond policy.

Any prior dishonest acts of an applicant for this bond or a bonded individual will be the basis for exclusion from coverage under this policy. In addition, bonding coverage ceases at the time of proof of loss for the responsible individual in the agency.

To report a claim, or when a loss is suspected, contact the Marketing Department at 913-564-6400, or Fax the information to 866-812-0736.

For a copy of the Farmers Agents’ Fidelity Bond policy go to the “Plan Information” section of the www.farmersagentsbenefits.com website.
Enrolling in Your Benefits

All participants in the Farmers Agents’ Group Benefits Program will use the online Enrollment System to enroll. You can enroll on the Internet using your personal computer.

Each year before annual enrollment, a personalized enrollment form will be sent to all eligible participants. If currently enrolled, this form will list your current coverages and your benefit options and their costs for the upcoming plan year.

Review your personalized worksheet to make sure your personal information (address, DOB, covered dependents, etc.) is correct. If you enroll over the Internet, you can update your dependent information online.

How to Enroll New and Existing Dependents in the Plans

To enroll a new dependent, you need to contact the Farmers Agents’ Benefits Department.

If you’re enrolling a new dependent for medical, dental, and vision coverage, you must enroll the person within 31 days of the date he or she becomes your dependent. If you do not enroll that person within 31 days, you must wait until the next annual enrollment period, unless you experience a qualified status change (a list of Qualified Status Changes is on page 40).

If you’re enrolling a new dependent in a life insurance plan (and you are already covered), you also must do so within 31 days of the date he or she becomes your dependent. If you wait more than 31 days, you must complete an Evidence of Insurability form, subject to approval by the insurance carrier to enroll the new dependent in the life insurance plans. The completion of an Evidence of Insurability form does not apply to eligible children.

If you want to enroll a new dependent in the supplemental AD&D plan, simply call the Farmers Agents’ Benefits Department to request enrollment information.

You should enroll your existing dependents at the same time you enroll — during your initial enrollment period or during the annual enrollment. If you do not enroll within these time periods, your existing dependents are subject to the same limitations as new dependents, as described in the previous paragraphs.

Keep in mind that coverage for new dependents is not automatic. To enroll, you need to contact the Farmers Agents’ Benefits Department.

When Coverage Begins

If you enroll during your initial eligibility period, coverage for Farmers Agents’ Group benefits plans you elect begins on your eligibility date. Folio deductions will occur on the next folio cycle.

However, if you either enroll in or make changes during the annual enrollment period, coverage in the Farmers agents’ plans begins on the January 1 following the annual enrollment period, unless otherwise specified in the annual enrollment notification.

Your dependents’ coverage will become effective on the date your coverage starts.

Please note that it is your responsibility to verify that folio deductions have begun and that the deduction amount is correct.

HOME ADDRESS UPDATE

To ensure that you get the current benefits information from the carriers, the Farmers Agents’ Benefits Department must be made aware of a change in your home address. If you have an address change, you must fax your request to the Farmers Agents’ Benefits Department at 877-771-1360.
Using the Enrollment System
The enrollment system is user-friendly and is set-up to help make your enrollment process simple and efficient. Log onto the Agents’ Benefits website at www.farmersagentsbenefits.com. Please have available your Participant ID Number (which is listed on the back of your personalized enrollment form), and your PIN. If you need to request this information, you may contact the Farmers Agents’ Benefits Call Center toll-free at 877-862-1237.

Once you access your account online, you will be able to review and enroll in coverages available to you and your eligible dependents. When adding dependents, please have their accurate information such as Social Security numbers and dates of birth since you will be able to enter this information only once. If you make an error in entering your dependents’ information, you will not be able to go back and modify it. You will need to contact the Farmers Agents’ Benefits Department. After dependent information is entered, you will be able to make your benefit elections, select a primary care physician and/or dentist, and designate beneficiaries (only if you enroll in group life coverage).

Finally, you can confirm your elections and if you are in agreement, you may click on the finish button which will save your elections. Print a copy of your confirmation statement for your records. If you need to make any changes, you may access the enrollment system anytime before your enrollment period ends.

Enrollment for New Participants
If you are a new participant in the Farmers Agents’ Group Benefits Program, you must enroll using the enrollment system described in the previous paragraphs. You can enroll yourself and your eligible dependents in the Farmers Agents’ medical plan within 31 days of your initial eligibility.

If you do not enroll for eligible coverages within 31 days of your initial eligibility period, your only opportunity to enroll in or make changes to your eligible plans (medical, dental, and vision) is during the next annual enrollment period, unless you experience a qualified status change mid-year. (Refer to page 40 for more information on qualified status changes.)

There is no pre-existing condition exclusion associated with any of the medical plans.
How to Add an Employee (for Agents & DMs Only)

Since the Farmers Agents’ Benefits Department does not maintain data on your employees who are not currently enrolled in the benefits program, it is not possible to generate personalized enrollment forms for these individuals. You have two methods available to add your employees: 1) via the Agents Benefits website, or 2) by calling the Farmers Agents’ Benefits Call Center at 877-862-1237.

Adding Employees Via the Administration Website

1. Enter the following website address into your computer (this site can also be accessed on the Agency Dashboard, under the Managing tab) — www.farmersagentsbenefits.com
   - Click on “DM/Agent Administration”
   - Enter your Participant ID Number and your PIN number.

2. Click the option to Add Participant. You will then be presented with options to start the wizard or to cancel. Click the “Start” button to continue.

3. The Create Participant wizard will start. Enter the participant’s Social Security number, last name, first name and middle initial, date of hire and email. When finished, click “Next.”

4. Next, complete the “Participant Profile” page, then click “Next.”
   - Select the “Participant type” from the drop down menu and complete all fields.
   - In the “Income” field, enter the annual salary of the participant.

5. On the “Participant Address” page, enter the requested information, then click “Next.”
   - Use Address Line 2 for apartment numbers.
   - You must enter the five-digit ZIP code, but you may enter the entire 9-digit ZIP code if available.
   - Be sure to include the area code when entering the telephone number.

6. You know you were successful when the newly added participant information appears in the light blue bar across the top of the screen. A personalized enrollment form, based on the information you provide, will be printed and sent to your office location.

Adding Employees Via the Farmers Agents’ Benefits Call Center

1. If you do not have an Internet connection, you may add the employee by calling the Farmers Agents’ Benefits Call Center at 877-862-1237.

2. Tell the Customer Service Representative that you are an agent or district manager, and you are calling to add an employee on the Farmers Agents’ Group Benefits Program.

3. In turn, the Customer Service Representative will ask you for your Participant I.D. Number.

4. Next, you will provide the Customer Service Representative with the following information about the employee:
   - Social Security number
   - Last name, first name, middle initial
   - Employee type (reserve district manager, reserve field manager, district manager training and administrative assistant, district life specialist, district commercial specialist, agency producer, or office employee)
   - Sex
   - Marital status
   - Date of birth
   - Email address
   - Annual income
   - Date of hire/appointment
   - Home address
   - Home telephone number

5. A personalized enrollment form, based on the information you provide, will be printed and sent to your office location.
How to Terminate an Employee’s Benefits

You may terminate an employee’s benefits through the Agents Benefits website or by calling the Farmers Agents’ Benefits Call Center. Benefit terminations occur at the end of the month the termination is processed. Credit for prior months cannot be given. If the folio has already closed for the upcoming month, credit will be given on the next folio.

To use the website (this site can also be accessed on the Agency Dashboard, under the Managing tab) — www.farmersagentsbenefits.com

1. Click on “DM/Agent Administration”

2. Enter your Participant ID Number and PIN Number

3. Select the participant-employee

4. Select terminate employee
   - Enter Date of Termination
   - Enter Reason
   - Click the “Save” button at bottom of screen
   - Log out of the website
   - If you cannot access the website, you may call the Farmers Agents’ Benefits Call Center at 877-862-1237.
   - Use your Participant I.D. Number to start the transaction
   - Give the representative the employee’s name and Social Security number
   - Give the representative the termination date and reason for termination

How to Provide a Rate Quote (Benefits Pricing Model)

You can provide a benefit quote for a current or a prospective employee by using the agents benefits website or by calling the Farmers Agents’ Benefits Call Center. To use this website (this site can also be accessed on the Agency Dashboard, under the Managing tab) — www.farmersagentsbenefits.com.

1. Click on “DM/Agent Administration”

2. Enter your Participant ID Number and PIN Number

3. Select a record (either an employee or the agent/DM)

4. Click on “Benefits Pricing Model”, make sure to indicate if the individual is a RDM, RFM, DMTAA, DLS, DCS, AP, or office employee.

5. Click on “Next” for the rate quote

It is recommended if the agent is changing the data values in the model to use the age of the participant as of the first of the year. Also use the first of the year for the enrollment effective date in which the benefits are to be effective.

Note: The rate quote is an estimate based on the data entered. If the data entered was inaccurate, the rates may change to reflect that information.
Qualified Status Change

If you select medical, dental or vision coverage, you must participate in the plan for the entire year unless you experience a qualified status change.

If you have experienced a Qualified Status Change (QSC), and have informed the Agents’ Benefits Department in writing within 31 days of the status change, you may be eligible to make changes to your benefit elections, as long as the change is consistent with and appropriate to the change in status.

Each participant requesting a QSC needs to complete the QSC form available online at www.farmersagentsbenefits.com along with the supporting documentation as indicated below.

The following table illustrates eligible status changes, and the supporting documentation required for each change:

<table>
<thead>
<tr>
<th>CHANGE IN STATUS</th>
<th>DOCUMENTATION NEEDED</th>
</tr>
</thead>
<tbody>
<tr>
<td>MARRIAGE</td>
<td>Copy of the marriage certificate</td>
</tr>
<tr>
<td>BIRTH OR ADOPTION</td>
<td>Copy of birth certificate or adoption paperwork</td>
</tr>
<tr>
<td>DIVORCE OR LEGAL SEPARATION</td>
<td>Copy of the final judgment, divorce decree, or separation document</td>
</tr>
<tr>
<td>LOSS / ADD OF GROUP COVERAGE</td>
<td>Copy of group coverage letter (with start or end date)</td>
</tr>
<tr>
<td>COURT ORDER</td>
<td>Copy of court order identifying court action</td>
</tr>
<tr>
<td>COBRA COVERAGE ENDING</td>
<td>Copy of loss of coverage letter (with end date)</td>
</tr>
<tr>
<td>(Prior Employment)</td>
<td></td>
</tr>
<tr>
<td>LARGE RATE INCREASE</td>
<td>Copy of coverage letter (showing proof of increase)</td>
</tr>
<tr>
<td>(Prior coverage other than Agents Benefits coverage)</td>
<td></td>
</tr>
<tr>
<td>RELOCATION</td>
<td>Copy of coverage letter showing proof of plan disruption or notice of change in home address</td>
</tr>
<tr>
<td>(Large Coverage Charges)</td>
<td></td>
</tr>
</tbody>
</table>

If you experience a Qualified Status Change (QSC) during the year, and you wish to add, delete, or change coverage for you or a dependent, you must fax a completed form to the Farmers Agents’ Benefits Department. The form must be submitted within 31 days from the date of the event. The QSC form is available at www.farmersagentsbenefits.com.
Adding, Deleting, or Changing Coverage

If you experience a qualified status change, you must fax the QSC form with your supporting documents to the Farmers Agents’ Benefits Department at (877) 771-1360 within 31 days of the event.

Be sure your QSC form includes:

- Your name, agent number, and signature
- The plan you want added, cancelled, or changed
- Proof of the qualified status change
- Dependent information including name, date of birth, and social security number

Coverage will be added effective the date of the status change event. If requesting a cancellation, coverage will be terminated effective the last day of the month of the status change date.

If there is a change in premium and your request is received after the folio close date, there will be an adjustment made to the following month’s folio. Credits and charges for benefits can only be done through your folio.
Continuing Your Benefits When Coverage Ends

There are two situations in which you can continue certain Farmers agents’ benefits:

- You meet the age and service requirements necessary to continue your medical and life insurance benefits (you’re eligible for Benefit Continuation).
- You lose your coverage due to an event such as termination, death, divorce, or loss of eligibility, and want to continue coverage through COBRA (you’re eligible for COBRA Continuation).

The age and service requirements necessary to continue your medical, life and AD&D insurance benefits are on page 43 in the “Eligibility for Benefit Continuation” section.

If you experience a circumstance leading to loss of coverage, you can continue your medical, dental, and vision benefits through COBRA.

The following are circumstances that may qualify you for COBRA benefits: leaving Farmers, death, divorce, legal separation, annulment, a covered dependent child who is no longer eligible for plan coverage, or if you cease to satisfy the 20-hour work week requirement if you are an office employee of a DM or agent. If you need information about continuing medical, dental or vision coverage through COBRA, turn to page 45, in the “COBRA Continuation Coverage” section.

The chart below is a summary of the various benefits that you may elect to continue, depending on your circumstances.

<table>
<thead>
<tr>
<th>Continuation Benefits</th>
<th>Available To:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical</strong></td>
<td>◼ Agents&lt;br&gt;◼ District Managers&lt;br&gt;◼ Reserve District Managers (RDMs)&lt;br&gt;◼ Reserve Field Managers (RFMs)&lt;br&gt;◼ District Manager Training Administrative Assistants (DMTAAs)&lt;br&gt;◼ District Life Specialists (DLSs)&lt;br&gt;◼ District Commercial Specialists (DCSs)&lt;br&gt;◼ Agency Producers (APs)&lt;br&gt;◼ Office employees&lt;br&gt;◼ Eligible spouses and dependent children</td>
</tr>
<tr>
<td><strong>Life Insurance</strong></td>
<td>◼ Agents&lt;br&gt;◼ District Managers&lt;br&gt;◼ Eligible spouses</td>
</tr>
<tr>
<td><strong>AD&amp;D</strong></td>
<td>◼ Agents&lt;br&gt;◼ District Managers</td>
</tr>
<tr>
<td><strong>Errors and omissions policy</strong></td>
<td>◼ Agents&lt;br&gt;◼ District Managers</td>
</tr>
<tr>
<td><strong>COBRA Benefits</strong></td>
<td><strong>Available To:</strong> ◼ Agents&lt;br&gt;◼ District Managers&lt;br&gt;◼ RDMs&lt;br&gt;◼ RFMs&lt;br&gt;◼ DMTAAs&lt;br&gt;◼ DLSs&lt;br&gt;◼ DCSs&lt;br&gt;◼ APs&lt;br&gt;◼ Office employees&lt;br&gt;◼ Eligible spouses and dependent children</td>
</tr>
</tbody>
</table>
Eligibility for Benefit Continuation

Read the following eligibility information carefully. If you meet the following age and service requirements, you may continue medical and life insurance coverage.

**Medical**

You are eligible to continue your agents’ group medical coverage if you are an agent, a district manager, a reserve district manager (RDM), a reserve field manager (RFM), a district manager training administrative assistant (DMTAA), a district life specialist (DLS), a district commercial specialist (DCS), an agency producer (AP), or an office employee of an agent or DM, and, at the time you leave Farmers, you meet one of the following requirements:

- You are age 55-64, have at least 5 years of service, and are covered by a Farmers-sponsored medical plan.
- You are age 65 or older with no service requirement and are covered by a Farmers-sponsored medical plan.

You may elect to continue medical coverage for your eligible dependents provided they are covered under the plan before you leave Farmers. Dependents that may be covered are your spouse, registered domestic partner, and eligible children as described below:

An adult child may be covered to age 26, and does not need to be a full-time student, does not need to receive at least 50% of support from you, does not need to be unmarried, and does not need to reside with you.

Eligible children include natural children, children placed with you for adoption and any other child who lives with you in a parent/child relationship (subject to approval by the insurance carrier).

You must elect to continue coverage for you and your eligible dependents immediately after you leave Farmers. **If you terminate your coverage at any time after leaving Farmers, you cannot re-enroll.**

You may elect to continue your current medical coverage or change to another Aetna group medical plan you are eligible for if you satisfy the eligibility requirements.

**Life Insurance**

You may continue your life insurance coverage if you are a district manager or agent, and, at the time you leave Farmers, you meet one of the following requirements.

- You are age 55-64, have at least 5 years of service, and are covered by a Farmers-sponsored life insurance plan.
- You are age 65 or older with no service requirement and are covered under the life insurance plan before leaving Farmers.

Life insurance coverage is available for spouses of DMs and agents. Spouse coverage ends when a spouse reaches age 70. Coverage for dependent children ends at the end of the month in which the DM or agent leaves Farmers. (Dependent children are covered to age 26 provided they are unmarried, supported by you, and not employed on a full-time basis.)
You must elect to continue coverage for yourself and your spouse immediately after you leave Farmers. **If you terminate your coverage at anytime after leaving Farmers, you cannot re-enroll.**

**Continuation of Life Insurance**
You can elect to continue $50,000 of life insurance for yourself. You will also receive AD&D coverage in the same amount.

You can also elect to continue $5,000 of life insurance for your spouse. However, your spouse is not eligible for the additional AD&D coverage. Age reductions will not apply to the $5,000 and this coverage will end when your spouse reaches age 70.

You can buy coverage to replace the life insurance amounts you lose because of your age. See the section titled “Converting Life Insurance” for details.

**Cost of Coverage**
The current cost to continue coverage under the various benefit plans is available from the Farmers Agents’ Benefits Call Center or the Farmers Agents’ Benefits Department. Farmers reserves the right to change benefit costs in the future and will notify you of any such changes.

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**How to Continue Your Medical and Life Insurance Benefits**
If you want to continue medical or life insurance coverage, follow these steps:

1. Notify the Farmers Agents’ Benefits Department of your request to continue your benefits 31 days before your expected termination date.

2. After your eligibility to continue benefits is verified, you will receive benefit continuation information that includes a notice showing the amount due for the first premium.

3. After you review the continuation materials, send the completed enrollment form and a check for the first premium to the Farmers Agents’ Benefits Call Center. You will have 60 days to elect continuation coverage and an additional 45 days, from your election date, to pay the premium.

4. You will receive subsequent notices of the premium due from the continuee administrator. Send your payments directly to the continuee administrator at the address listed on the notice.

**If Your Coverage Ends as a Continuee**
If your continuee coverage ends, you may be eligible to continue medical coverage under COBRA.
COBRA Continuation Coverage

VERY IMPORTANT NOTICE

Farmers offers participants and their dependents a temporary extension of health care coverage (called “continuation coverage”) at group rates in certain instances where coverage under the plan would otherwise end. **YOU, YOUR SPOUSE AND YOUR DEPENDENTS SHOULD READ THIS SECTION VERY CAREFULLY.** It is important that you and your dependents are aware of this plan provision, since you and your dependents will be required to take specific actions to exercise your and your dependents’ rights to continued coverage. Please review the following information carefully and save it for future reference. For additional information on continuation of coverages, see your summary plan description (SPD).

COBRA continuation coverage applies to you and/or your dependents if:

- You are not eligible for an extension of benefit coverage after you leave Farmers (see page 42)
- You experience a qualifying event that leads to loss of medical, dental, or vision coverage (see “Qualifying Events” below)

This section contains information about your right to elect continuation of health care coverage, as required under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). Please read this section carefully. It explains the conditions that apply to continuation of you and/or your dependents’ health care coverage under COBRA. **You and/or your dependents will lose the right to continue coverage if you and/or your dependents do not make a timely election.**

The right to continue health care coverage on your own (self-pay basis) applies to an agent, DM, RDM, RFM, DMTAA, DLS, DCS, AP, or office employee and covered spouse and dependent children (“qualified beneficiaries”) covered by the Farmers Agents’ Group Benefits Program who lose health care coverage as a result of a “qualifying event.” If your covered spouse and/or covered dependent child does not live with you when a qualifying event occurs, you must notify the Farmers Agents’ Benefits Call Center within 60 days following the qualifying event of his or her address so the Farmers Agents’ Benefits Call Center can provide him or her with COBRA information and a COBRA election form.

<table>
<thead>
<tr>
<th>Qualifying Events</th>
<th>Individuals Eligible For COBRA Coverage</th>
<th>COBRA Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Termination of appointment agreement or employment of an office employee for any reason (other than for gross misconduct)</td>
<td>Covered agent, DM, RDM, RFM, DMTAA, DLS, DCS, AP, or office employee; covered spouse and/or covered dependent children</td>
<td>18 months</td>
</tr>
<tr>
<td>Reduction in hours of employment to less than 20 hours per week</td>
<td>Covered office employee; covered spouse and/or covered dependent children</td>
<td>18 months</td>
</tr>
<tr>
<td>Death</td>
<td>Covered spouse and/or covered dependent children</td>
<td>36 months</td>
</tr>
<tr>
<td>Divorce, legal separation or annulment</td>
<td>Covered spouse and dependent children</td>
<td>36 months</td>
</tr>
<tr>
<td>Covered DM, agent, DMTAA, RDM, DLS, AP, or office employee’s becoming covered by Medicare</td>
<td>Covered spouse and dependent children</td>
<td>36 months</td>
</tr>
<tr>
<td>Covered dependent child no longer qualifies for coverage as dependent</td>
<td>Covered dependent child</td>
<td>36 months</td>
</tr>
</tbody>
</table>

The occurrence of one of these events does not in itself create any rights to COBRA. For COBRA to apply, the event must cause a qualified beneficiary to lose health care coverage.
**Important:** Farmers Agents’ Group Benefits Program currently treats the termination of an appointment agreement (other than for gross misconduct) as a qualifying event for COBRA purposes, even though this treatment is not required by law. Farmers reserves the right to change or terminate this treatment at any time.

To elect continuation coverage, you must complete a COBRA election form and send it to the address shown on the form within 60 days of the date health care coverage ends under the plan or the date of the COBRA notification, whichever is later.

COBRA coverage applies only to your group health care benefits (medical, dental and vision); it does not apply to life insurance, AD&D insurance or loss of income-related insurance, such as long-term disability coverage. However, you may be able to convert or port all or a portion of your life, AD&D, or long-term disability coverages to individual policies following your termination of employment. See the information about converting and porting these coverages described earlier in this guide.

**Qualifying Events**

A “qualifying event” is defined as any of the events that result in a loss of health care coverage listed on page 45.

**Duration of COBRA Coverage**

The duration of COBRA coverage depends on the type of qualifying event.

**General Rule: 18-Month Maximum**

COBRA coverage for a qualified beneficiary (including you) begins the day after your Farmers health care coverage ends because of termination of an appointment agreement or termination of employment of an office employee (for reasons other than gross misconduct) or a reduction in hours of employment of an office employee to less than 20 hours per week, and may continue for up to 18 months. This general 18-month rule, however, has important exceptions that may lengthen or shorten the 18-month period of COBRA coverage.

**COBRA Extension Due to Disability**

A qualified beneficiary may extend his or her COBRA continuation coverage for an additional 11 months beyond the original 18-month period, if he or she meets the following requirements:

- Eligible for 18 months of COBRA continuation coverage because he or she experienced a loss of health care coverage due to termination of an appointment agreement or termination of employment or reduction in hours of employment if an office employee (other than for gross misconduct); and

- The Social Security Administration determines the qualified beneficiary is totally disabled at the time of the qualifying event or becomes totally disabled during the first 60 days of COBRA continuation coverage.

To extend coverage for an additional 11 months beyond the original 18-month continuation coverage period, you and your dependents must notify the Farmers Agents’ Benefits Call Center of the Social Security Administration’s determination of disability. Evidence of the SSA’s determination of disability must be mailed to the Farmers Agents’ Benefits Call Center within 60 days of the SSA’s determination and before the end of the first 18 months of continuation coverage. Failure to comply with this deadline will result in the loss of all rights to the continuation coverage extension. The cost of continuation coverage for months 19 through 29 is 150% of the total premium rate of health care coverage.
In addition, you are required to notify the Farmers Agents’ Benefits Call Center within 31 days of the date that SSA determines that the disabled individual is no longer disabled.

**COBRA Extension Due to a Second Qualifying Event**

Your spouse and/or dependents may extend their COBRA continuation coverage for an additional 18 months beyond the original 18-month period, if they are enrolled in COBRA continuation coverage and a second qualifying event occurs during the original 18-month COBRA period — your death; your divorce, legal separation, or annulment; your becoming covered by Medicare; or your dependent child ceases to be eligible for health care coverage under the plan as a dependent child.

If a qualified beneficiary marries or acquires dependents during the COBRA continuation period, the new spouse or newly-acquired dependent may be covered under the plan as the qualified beneficiary’s dependent. However, the new spouse or newly-acquired dependent is not considered a qualified beneficiary, and does not have any independent right to continuation coverage under the plan. A subsequent death, divorce, or attaining the maximum age during this continuation period will not be considered a second qualifying event with respect to the new spouse or newly-acquired dependent.

You and your dependents are required to notify the Farmers Agents’ Benefits Call Center within 60 days of your divorce, legal separation, or annulment; or a dependent child ceasing to be eligible for health care coverage under the plan as a dependent child. **Failure to comply with this deadline will result in the loss of all rights to continuation coverage.** If one of these events occurs after termination of an appointment agreement or termination of employment or reduction in hours of employment of an office employee to less than 20 hours per week, and the qualified beneficiary is covered under the 18-month rule described above, his or her COBRA continuation coverage may be extended for up to 18 months after the original 18-month continuation coverage period ends.

**36-Month Period**

COBRA coverage for a qualified beneficiary (excluding you) begins the day after their coverage under the Farmers Agents’ Group Benefits Program ends because of your death; your divorce, legal separation, or annulment; or a dependent child ceasing to be eligible for health care coverage under the plan as a dependent and may continue for up to 36 months.

You and your dependents are required to notify the Farmers Agents’ Benefits Call Center within 60 days of your divorce, legal separation, or annulment; or a dependent child ceasing to be eligible for health care coverage under the plan as a dependent child. **Failure to comply with this deadline will result in the loss of all rights to continuation coverage.** If one of these events occurs after termination of an appointment agreement or termination of employment or reduction in hours of employment of an office employee to less than 20 hours per week, and the qualified beneficiary is covered under the 18-month rule described above, his or her COBRA continuation coverage may be extended for up to 18 months after the original 18-month continuation coverage period ends.

**36-Month Period If You Become Entitled to Medicare**

If you become covered by Medicare after COBRA continuation coverage begins, and before expiration of the original 18-month COBRA continuation coverage, the COBRA coverage period for your covered spouse and covered dependent children may be extended for up to 18 months beyond the original 18-month period of continuation coverage.
California Extension of COBRA
California Insurance Law

California insurance law allows for an extension of up to 18 months (to a maximum of 36 months) of continuation coverage once the original 18-month period of COBRA coverage has been exhausted. This extension only applies to medical coverage, and does not apply to dental or vision care coverages. The monthly COBRA premium during the extension period is 110% of the total premium rate of your medical care coverage. If you qualify, you will be notified of your right to the extension on or about 180 days before your COBRA continuation coverage is scheduled to end. Because the Farmers Agents’ Group Benefits Program is in California, this extension applies to all qualified beneficiaries receiving COBRA continuation coverage except those enrolled in the Texas Open Choice PPO Plus Plan (which is subject to Texas law instead).

Eligibility for COBRA Coverage

You and each of your covered dependents who were covered under the Farmers Agents’ Group Benefits Program on the day before the qualifying event have the right to continue health care coverage on a self-pay basis. However, the right to COBRA continuation coverage terminates when the covered individual, your spouse and/or dependent becomes covered under another group health care plan that does not limit or exclude coverage for pre-existing conditions.

If the covered individual becomes covered under another group health care plan and that plan contains a pre-existing condition limitation that affects you and/or your covered dependents, then COBRA continuation coverage for you and/or your covered dependents cannot be terminated.

See “When COBRA Coverage Ends” on page 50 for a complete listing of events that cause COBRA continuation coverage termination.

Whom to Notify About a COBRA Qualifying Event

A qualified beneficiary must notify the Farmers Agents’ Benefits Call Center within 60 days of the date of a COBRA qualifying event, except for loss of coverage due to termination of an appointment agreement or termination of employment or reduction in hours of employment of an office employee. Failure to do so may result in loss of eligibility for COBRA.

How to Sign Up for COBRA Coverage

When the Farmers Agents’ Benefits Call Center is notified on a timely basis that a qualifying event has occurred, they will send the qualified beneficiaries a COBRA package consisting of a cover letter, a notice and an election form. The information reflected on the forms will include the premium rates, which qualified beneficiaries were enrolled on the day before the qualifying event and what plans they were enrolled in (e.g. medical, dental and vision coverage).

60 Days to Decide

To elect COBRA continuation coverage, a qualified beneficiary must complete the COBRA election form and send it to the Farmers Agents’ Benefits Call Center, at the address listed on the form, within 60 days of the later of (i) the date that health care coverage is lost because of a qualifying event, or (ii) the date that the COBRA package was sent to the qualified beneficiaries. Failure to comply with this deadline will result in the loss of all rights to continuation coverage.

The initial payment for continuation coverage is due on the date that the COBRA election form is sent to the Farmers Agents’ Benefits Call Center. The initial payment must include ALL retroactive premiums due (going back to your last day of active coverage). The initial payment for continuation coverage is considered to be made on a timely basis only if it is sent to the Farmers Agents’ Benefits Call Center within 45 days of the date that the COBRA election form is sent to the Farmers Agents’ Benefits Call Center (i.e. by the initial due date). Failure to comply with this deadline will result in the loss of all rights to continuation coverage.
The 60-day election period is **not** an extension of benefits; you, your spouse, and your dependents are not covered during this time unless the COBRA election form is completed and received by the Farmers Agents’ Benefits Call Center on a timely basis, including the initial payment. Otherwise, coverage under the Farmers Agents’ Group Benefits Program ends on the date shown on the COBRA election form. COBRA coverage is implemented retroactively after a qualified beneficiary elects and pays for continuation coverage. Therefore, no break in coverage will occur if the COBRA election is made within the 60-day election period, and all COBRA premiums (current and retroactive) are paid in a timely manner. If these requirements are met, then claims for health care treatment and/or service during the 60-day election period will be processed.

If a qualified beneficiary does not elect continuation coverage, group health care coverage will end on the date shown on the COBRA election form.

**COBRA Coverage Choices**

Qualified beneficiaries who lost coverage under the Farmers Agents’ Group Benefits Program as a result of a qualifying event may elect continuation coverage. Each qualified beneficiary may separately elect COBRA coverage for himself or herself. Alternatively, one qualified beneficiary may elect COBRA coverage for the entire family.

During the 60-day COBRA election period, the qualified beneficiaries may only elect the medical, dental and/or vision plan(s) in which they were enrolled on the day prior to the qualifying event. The qualified beneficiaries may discontinue any coverage by not choosing them as part of the COBRA election. During the plan’s annual enrollment period, however, qualified beneficiaries may change their health care plan coverage, elect new health care coverages, and add or delete dependents, in the same way as similarly situated active participants in the Farmers Agents’ Group Benefits Program. Changes are not allowed at any other time unless a change in status has taken place, and the change is consistent with the change in status, or an event takes place that enables the qualified beneficiary to have a special enrollment period (see page 43).

**COBRA Coverage Premium**

The COBRA election package will show the current premiums for the health plans in which the qualified beneficiaries were enrolled prior to the qualifying event (i.e., medical, dental, and/or vision coverage). Continuation coverage is on a self-pay basis. Unless specified otherwise, the cost of continuation coverage is 102% of the total premium rate for the coverage.
How to Pay for COBRA Coverage
The initial COBRA payment is due on the date when the completed COBRA election form is sent to the Farmers Agents’ Benefits Call Center, subject to a grace period of 45 days. The initial COBRA payment must include all retroactive premiums due. If the COBRA election form is sent to the Farmers Agents’ Benefits Call Center without the initial COBRA payment, continuation coverage is not effective unless the retroactive and current monthly premiums are sent to the Farmers Agents’ Benefits Call Center on a timely basis. After the due date for the initial COBRA premium, all subsequent COBRA premiums are due on the first day of each month, subject to a grace period of 31 days. Failure to send the initial COBRA premium or a subsequent monthly COBRA premium to the Farmers Agents’ Benefits Call Center by the end of the applicable grace period will result in the loss of all rights to continuation coverage, retroactive to the last day for which continuation coverage has been paid for on a timely basis.

The Farmers Agents’ Benefits Call Center will periodically send the qualified beneficiary who elected COBRA coverage a notice regarding the COBRA premiums that are due. The qualified beneficiaries are responsible, however, for making sure that the COBRA payments are sent to the Farmers Agents’ Benefits Call Center on a timely basis, even if the periodic notice is not received. Be sure to send the COBRA payments promptly and directly to the Farmers Agents’ Benefits Call Center. Continuation coverage will be automatically terminated if payment is not sent to the Farmers Agents’ Benefits Call Center on a timely basis.

Filing Claims
Submit claims for health care expenses incurred during COBRA continuation coverage in the same way that you did prior to the qualifying event.

When COBRA Coverage Ends
COBRA continuation coverage ends on the earliest of the following dates:

- The date a qualified beneficiary becomes covered under this or another group health plan, provided that the plan does not subject the individual to a pre-existing condition exclusion or limitation.
- The last day of the month for which the qualified beneficiary made a COBRA payment on a timely basis, if the COBRA premium is not paid on a timely basis in the subsequent month. Once coverage is terminated for failure to pay the COBRA premium on a timely basis, continuation coverage cannot be reinstated.
- The last day of the 18th or 29th or 36th month of continuation coverage period (whichever applies).
- The date that the qualified beneficiary becomes covered by Medicare.
- The date Farmers no longer sponsors medical, dental, or vision care coverage for active agents, DMs, RDMs, RFMs, DMTAAAs, DLSs, DCSs, APs, or office employees.
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