BENEFITS
ENROLLMENT
GUIDE 2016

Choose the coverage that’s right for you
## 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>
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<tbody>
<tr>
<td><strong>Farmers Agents’ Benefits Call Center</strong></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>
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<td>- Terminate Participant Benefits</td>
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<tr>
<td>- General Coverage Questions</td>
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<tr>
<td><strong>Aetna Medical Plans Member Services</strong></td>
<td>888.257.0403</td>
<td><a href="http://www.aetna.com/docfind/custom/farmersagents">www.aetna.com/docfind/custom/farmersagents</a></td>
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<tr>
<td>(Policy #810111)</td>
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<tr>
<td><strong>Aetna Hospital Plan (AHP)</strong></td>
<td>800.571.4015</td>
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<tr>
<td>(Policy #801907)</td>
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<tr>
<td><strong>MetLife Critical Illness Insurance (CII) Plan</strong></td>
<td>800.GET.MET8 (800.438.6388)</td>
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<tr>
<td><strong>Aetna Pharmacy</strong></td>
<td>800.227.5720 800.238.6279 866.782.2779</td>
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<tr>
<td>- Mail Order/Home Delivery</td>
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<tr>
<td>- Pharmacy Unit</td>
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<tr>
<td>- Specialty Pharmacy</td>
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<tr>
<td><strong>Dental Plans</strong></td>
<td>877.238.6200</td>
<td><a href="http://www.aetna.com/docfind/custom/farmersagents">www.aetna.com/docfind/custom/farmersagents</a></td>
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<tr>
<td>- Aetna Dental Plans (Policy #810111)</td>
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<tr>
<td>- MetLife Safeguard DHMO Plan (SG-185, Group #142143)</td>
<td>800.880.1800</td>
<td></td>
</tr>
<tr>
<td><strong>Vision Service Plan (VSP)</strong> (Policy #00109034)</td>
<td>800.877.7195</td>
<td><a href="http://www.vsp.com">www.vsp.com</a></td>
</tr>
<tr>
<td><strong>MetLife Life and AD&amp;D Insurance</strong> (Policy #110031-1-G)</td>
<td>800.638.6420 (prompts 1 &amp; 2) 877.275.6387 866.492.6983</td>
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<tr>
<td>- Medical Underwriting &amp; Claims Office</td>
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<td>- Conversion Unit</td>
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<td>- Portability Unit</td>
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<tr>
<td><strong>MetLife Long-term Disability (LTD)</strong> (Policy #110031-1-G)</td>
<td>888.463.2002 800.432.6761</td>
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<tr>
<td>- General LTD Questions Hotline/Claims Office</td>
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<tr>
<td>- Claim Form Request</td>
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<tr>
<td><strong>Unum</strong></td>
<td>800.347.8081 800.633.7490</td>
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<tr>
<td>- Enhanced LTD (ELTD) or Business Overhead Expense (BOE) Hotline</td>
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<tr>
<td>- ELTD or BOE Claim (not available in California)</td>
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<tr>
<td><strong>Employee Assistance Plan</strong> (MHN, Inc.)</td>
<td>800.511.3920</td>
<td><a href="http://www.members.mhn.com">www.members.mhn.com</a> (access code: metlife2)</td>
</tr>
<tr>
<td><strong>Travel Assistance and Identity Theft Program</strong> (AXA Assistance USA, Inc.)</td>
<td>800.454.3679</td>
<td></td>
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<tr>
<td><strong>Agents’ Errors &amp; Omissions</strong> (Policy #CAP0016497 08)</td>
<td>800.821.0540 866.893.1023</td>
<td><a href="http://www.farmersagentsbenefits.com">www.farmersagentsbenefits.com</a></td>
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<tr>
<td>- Report Claims (Lancer)</td>
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<td>- General Coverage Questions (CalSurance)</td>
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<td>- Request Certificates</td>
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<tr>
<td><strong>Deferred Compensation Plan</strong> (Mullin TBG)</td>
<td>800.487.0042</td>
<td></td>
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<tr>
<td>- Inquiries/Request Information</td>
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<tr>
<td><strong>Farmers Agents’ Benefits Dept.</strong></td>
<td>800.432.6761 877.771.1360 (fax)</td>
<td><a href="http://www.farmersagentsbenefits.com">www.farmersagentsbenefits.com</a></td>
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<tr>
<td>- Change Home Address</td>
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<td>- Change Status/Position</td>
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**IMPORTANT - PLEASE READ**

This brochure highlights the main features of the Farmers® Agents’ Group Benefits Program. This brochure does not include all plan rules and details. The terms of the 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 govern. Farmers reserves the right to change or discontinue benefit plans at any time.
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. The 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 support 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.

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

ELIGIBILITY

As of January 1, 2016, all participants (agents, district managers and staff members of agents and district managers) are eligible for benefits on the first day of the month following 30 days of full-time appointment (20 hours or more per week). For example, those with a March 1 appointment date are eligible on April 1. If the appointment date is March 2, the eligibility date is May 1.

The 30-day waiting period does not apply to E&O coverage. Newly appointed agents and district managers will be automatically enrolled in the Errors & Omissions Coverage Level 1 with limits of liability of $1,000,000 each claim/$2,000,000 annual aggregate.

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
- A disabled child dependent who exceeds the maximum age. Proof that the covered dependent is fully disabled 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 disabled 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.

WHO CAN I CALL?

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.
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 on the Aetna Medical Plans: If the child dependent is a resident of Ohio, the child may be covered to age 28. This provision only applies to the Aetna medical plans.

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, vision, group life, long-term disability (LTD), Aetna Hospital Plan, or Critical Illness Insurance 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>
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<tbody>
<tr>
<td>Agents, District Managers, Reserve Field Managers (RFM), Agency Business Consultants (ABCs), District Manager Training and Administrative Assistants (DMTAA), District Life Specialists (DLS) and District Commercial Specialists (DCS)</td>
<td>Medical, Aetna Hospital Plan (AHP), MetLife Critical Illness Insurance (CII) Plan, 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, Aetna Hospital Plan (AHP), MetLife Critical Illness Insurance (CII) Plan, dental, vision, life, AD&amp;D, and supplemental AD&amp;D</td>
</tr>
<tr>
<td>Other Agent and DM Office Staff Members</td>
<td>Medical, Aetna Hospital Plan (AHP), MetLife Critical Illness Insurance (CII) Plan, 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 four types of coverage available through Aetna:

- A preferred provider organization (PPO) plan, called Aetna Open Choice PPO Plan, with a deductible of $1,500 individual/$3,000 family.
- A choice of two Aetna high deductible health plans (HDHPs):
  - 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.

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 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
- Healthy Lifestyle Coaching program, including individual and group 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
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 In-Network 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 back of your member ID card.

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® 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 $1,500 individual/$3,000 family for in-network and out-of-network services. The deductible amount is counted towards the out-of-pocket maximum.

Eligible charges for in-network services generally are covered at 80% after you satisfy the 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 $3,000 individual/$6,000 family 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 deductible. Once the annual deductible has been met, and you have satisfied the $3,000 individual/$6,000 family out-of-pocket maximum, eligible charges will be covered at 100%.

Pharmacy expenses now apply toward the out-of-pocket maximum and are not subject to the deductible.

See the chart on page 7 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 eligible expenses 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 two Aetna HDHP options: the HDHP Medium Option plan and the HDHP Low Option plan. The options have different deductibles and out-of-pocket maximums.

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 9 for information on an HDHP option if you do not live in the network area.)

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 Medium Option plan and the HDHP Low Option plan have different deductibles and out-of-pocket maximums.

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 and colorectal cancer screening for members age 50 and over are considered preventive care by the HDHP; see the Plan summary for details.

Prescription drug benefits are generally covered only after the deductible is met. However, the deductible is waived for drugs that are on Aetna’s preventive maintenance drug list.

You should be aware that using out-of-network providers results 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.

If you enroll in an Aetna HDHP, you may set up a Health Savings Account (HSA) through an outside financial institution. An HSA is not currently offered through the Farmers Agents’ Group Benefits Program.

See the chart on page 8 for a partial listing of benefits under the two 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 HSA Statutory Contribution Maximum Limits, which are determined by the IRS annually. The Statutory Contributions Maximum Limits for 2015 are $3,350 for an Individual and $6,750 for a Family. HSAs are available through independent institutions; Farmers does not sponsor an HSA.

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

- Medical plan deductibles
- Most diagnostic services not covered by the plan
- Dental care, including braces
- LASIK eye surgery and contact lenses
- Some nursing services
- Hearing aids
- Wheel chairs used mainly for the relief of sickness or disability
- 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>In-Network</th>
<th>Out-of-Network</th>
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<tbody>
<tr>
<td><strong>Deductible per calendar year</strong></td>
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<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>
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<tr>
<td><strong>Coinsurance</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
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<tr>
<td><strong>Coinsurance (Out-of-Pocket) Limit per calendar year</strong></td>
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<tr>
<td>(the out-of-pocket limit includes copay and deductible amounts as well as pharmacy expenses)</td>
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<tr>
<td><strong>Lifetime Maximum</strong></td>
<td>Unlimited</td>
<td>Unlimited</td>
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<tr>
<td><strong>Preventive Care</strong></td>
<td>100%, deductible waived</td>
<td>60% after deductible</td>
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<tr>
<td>(routine exams/immunizations, subject to plan guidelines; see SPD for details)</td>
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<tr>
<td><strong>Inpatient Hospital</strong></td>
<td>80% after individual/family deductible and inpatient confinement deductible</td>
<td>60% after individual/family deductible and inpatient confinement deductible</td>
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<tr>
<td>(includes physician’s services)</td>
<td></td>
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<tr>
<td><strong>Inpatient per Confinement Deductible</strong></td>
<td>$100</td>
<td>$300</td>
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<tr>
<td><strong>Routine Maternity Care</strong></td>
<td>100%, deductible waived</td>
<td>60% after deductible</td>
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<tr>
<td>■ Preventive prenatal office visits</td>
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<tr>
<td>■ Delivery, postpartum care, ultrasounds or other maternity procedures, specialist visits and certain lab tests</td>
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<tr>
<td><strong>Prescription Drugs</strong></td>
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<tr>
<td>1 Retail (30-day supply)</td>
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<tr>
<td>■ Generic</td>
<td>You pay 30% ($40 min/$80 max)</td>
<td></td>
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<tr>
<td>■ Formulary Brand Name</td>
<td>You pay 30% ($60 min/$120 max)</td>
<td></td>
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<tr>
<td>■ Non-Formulary Brand Name</td>
<td>You pay 50% ($90 min/$180 max)</td>
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<tr>
<td>□ Mail order (31-day to 90-day supply)</td>
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<tr>
<td>■ Generic</td>
<td>You pay 30% ($80 min/$160 max)</td>
<td>Not covered</td>
</tr>
<tr>
<td>■ Formulary Brand Name</td>
<td>You pay 30% ($120 min/$240 max)</td>
<td></td>
</tr>
<tr>
<td>■ Non-Formulary Brand Name</td>
<td>You pay 50% ($180 min/$360 max)</td>
<td></td>
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<tr>
<td><strong>Emergency Room</strong></td>
<td>80% after deductible</td>
<td>80% after deductible</td>
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<tr>
<td>for a bona fide emergency2</td>
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<tr>
<td><strong>Outpatient Surgery Expenses</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
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<td><strong>Diagnostic X-ray &amp; Lab</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
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<td>(other than physician’s office)</td>
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<tr>
<td><strong>Physician Office Visit</strong></td>
<td>100% after $40 copay</td>
<td>60% after deductible</td>
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</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 between the generic and brand name drug, plus the copayment.

2 Non-emergency use of the emergency room covered at 50% after deductible.
### HDHP Medium Option

<table>
<thead>
<tr>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,500 individual</td>
<td>$3,000 individual</td>
</tr>
<tr>
<td>$5,000 family*</td>
<td>$6,000 family*</td>
</tr>
</tbody>
</table>

*For family coverage, only the family deductible applies.

- 80% after deductible
- 60% after deductible
- $3,400 individual
- $4,250 individual
- $6,800 family*
- $8,500 family*

Includes deductible

*For family coverage, only the family out-of-pocket limit applies.

- Unlimited
- 100%, deductible waived
- 80% after deductible
- 60% after deductible
- None
- 100%, deductible waived
- 80% after deductible
- 60% after deductible
- None
- 100%, deductible waived
- 80% after deductible
- 60% after deductible
- None

- You pay 30%* ($20 min/$40 max)*
- You pay 30%* ($40 min/$80 max)*
- You pay 50%* ($70 min/$140 max)*
- You pay 30%* ($40 min/$80 max)*
- You pay 50%* ($70 min/$140 max)*
- Not applicable
- You pay 30%* ($40 min/$80 max)*
- You pay 30%* ($80 min/$160 max)*
- You pay 50%* ($140 min/$280 max)*
- *after deductible
- You pay 30%* ($40 min/$80 max)*
- You pay 30%* ($80 min/$160 max)*
- You pay 50%* ($140 min/$280 max)*
- *after deductible
- 80% after deductible
- 60% after deductible
- 80% after deductible
- 60% after deductible
- 80% after deductible
- 60% after deductible
- 80% after deductible
- 60% after deductible
- 80% after deductible
- 60% after deductible

### HDHP Low Option

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

*For family coverage, an individual family member can meet the individual deductible.

- 80% after deductible
- 60% after deductible
- $5,950 individual
- $7,500 individual
- $11,900 family*
- $15,000 family*

Includes deductible

*For family coverage, an individual family member can meet the individual out-of-pocket limit.

- Unlimited
- 100%, deductible waived
- 80% after deductible
- 60% after deductible
- None
- 100%, deductible waived
- 80% after deductible
- 60% after deductible
- None
- 100%, deductible waived
- 80% after deductible
- 60% after deductible
- None

- You pay 30%* ($20 min/$40 max)*
- You pay 30%* ($40 min/$80 max)*
- You pay 50%* ($70 min/$140 max)*
- You pay 30%* ($40 min/$80 max)*
- You pay 50%* ($70 min/$140 max)*
- Not applicable
- You pay 30%* ($40 min/$80 max)*
- You pay 30%* ($80 min/$160 max)*
- You pay 50%* ($140 min/$280 max)*
- *after deductible
- You pay 30%* ($40 min/$80 max)*
- You pay 30%* ($80 min/$160 max)*
- You pay 50%* ($140 min/$280 max)*
- *after deductible
- 80% after deductible
- 60% after deductible
- 80% after deductible
- 60% after deductible
- 80% after deductible
- 60% after deductible
- 80% after deductible
- 60% after deductible
- 80% after deductible
- 60% after deductible

---

3 Exception: deductible is waived for drugs on Aetna's preventive maintenance drug list.
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 PPO network. 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. The deductible counts towards your annual out-of-pocket maximum. This plan covers eligible charges at 80% after you satisfy the deductible. After you pay $6,350 per individual and $12,700 per family in out-of-pocket expenses for eligible expenses during the calendar year, the plan covers eligible charges at 100% except for prescription copays.

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 network.

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 monthly premium payments. 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 6.

Enrolling in the plan
If you do not live in a ZIP Code area served by the Aetna PPO 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 ($3,400 individual/$6,800 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, with the exception that the deductible is waived for drugs that are on Aetna’s preventive maintenance drug list.

The percentage of covered expenses you pay, as well as pharmacy expenses and 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></td>
<td>$2,000 individual $4,000 family*</td>
<td>$2,500 individual $5,000 family*</td>
</tr>
<tr>
<td></td>
<td>*For family coverage, an individual family member can meet the individual deductible.</td>
<td>*For family coverage, only the family deductible applies.</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</strong></td>
<td>$6,350 individual $12,700 family* <strong>Includes deductible</strong></td>
<td>$3,400 individual $6,800 family* <strong>Includes deductible</strong></td>
</tr>
<tr>
<td></td>
<td>*For family coverage, an individual family member can meet the individual out-of-pocket limit.</td>
<td>*For family coverage, only the family out-of-pocket limit applies.</td>
</tr>
<tr>
<td><strong>Lifetime Maximum</strong></td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td><strong>Inpatient Hospital</strong></td>
<td>80% after deductible</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>(includes physician’s services)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Preventive Care</strong></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></td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Room</strong></td>
<td>80% after deductible</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>for bona fide emergency</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Routine Maternity Care</strong></td>
<td>100%, deductible waived</td>
<td>100%, deductible waived</td>
</tr>
<tr>
<td>■ Preventive Prenatal Office Visit</td>
<td>80% after deductible</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>■ Delivery, postpartum care, ultrasounds or other maternity procedures, specialist visits and certain lab tests</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Retail (30-day supply)</td>
<td><strong>You pay 30% ($40 min/$80 max)</strong></td>
<td><strong>You pay 30% ($20 min/$40 max)</strong></td>
</tr>
<tr>
<td>■ Generic</td>
<td><strong>You pay 30% ($60 min/$120 max)</strong></td>
<td><strong>You pay 30% ($40 min/$80 max)</strong></td>
</tr>
<tr>
<td>■ Formulary Brand Name</td>
<td><strong>You pay 50% ($90 min/$180 max)</strong></td>
<td><strong>You pay 50% ($70 min/$140 max)</strong></td>
</tr>
<tr>
<td>■ Non-Formulary Brand Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mail order (31-90 day supply)</td>
<td><strong>You pay 30% ($80 min/$160 max)</strong></td>
<td><strong>You pay 30% ($40 min/$80 max)</strong></td>
</tr>
<tr>
<td>■ Generic</td>
<td><strong>You pay 30% ($120 min/$240 max)</strong></td>
<td><strong>You pay 30% ($80 min/$160 max)</strong></td>
</tr>
<tr>
<td>■ Formulary Brand Name</td>
<td><strong>You pay 50% ($180 min/$360 max)</strong></td>
<td><strong>You pay 50% ($140 min/$280 max)</strong></td>
</tr>
<tr>
<td>■ Non-Formulary Brand Name</td>
<td></td>
<td></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></td>
<td>80% after deductible</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>(other than physician’s office)</td>
<td></td>
<td></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 Exception: deductible is waived for drugs on Aetna’s preventive maintenance drug list.

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.

See the chart on pages 7 and 8 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 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 drug 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 two times the monthly cost. (If you are in Arkansas or Alabama, there is no copay difference between retail and mail order.)

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.
AETNA HOSPITAL PLAN (AHP)

Help with costs due to an unexpected hospitalization
You can be better prepared for the costs of an unexpected hospitalization with the Aetna Hospital Plan.

This insurance plan pays a cash benefit in addition to any benefits you may receive under a medical plan. You can use the cash benefit for any purpose, including medical plan deductible, child care, groceries or for any other reasons.

Plan benefits
If you or a covered family member is admitted to the hospital for covered services, you receive:

■ A lump-sum payment of $1,500 for one inpatient hospital stay during the coverage year, plus
■ A daily benefit of $100 for up to 100 days in a coverage year as an inpatient in a hospital

These coverages apply to each covered family member.

If you are enrolled in an Aetna medical plan and the AHP through the Farmers Agents’ Group Benefits Program and are admitted to a hospital and charged room and board, the AHP will automatically pay you the cash benefit. Otherwise, you must submit a claim directly to Aetna for payment.

Eligibility
California residents need to be enrolled in a medical plan to join the Aetna Hospital Plan, although it does not need to be through the Farmers Agents’ Group Benefits Program.

If you elect coverage, you must participate in the plan until the end of the plan year, unless you experience a qualified status change.

Plan exclusions and limitations
This plan has a pre-existing condition exclusion. This means that if a member has a medical condition before coming to the plan, the member has to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 180 days prior to the member’s effective date of coverage under this plan. The pre-existing condition exclusion applies to pregnancy. This exclusion applies until the member has been covered under the plan for 365 days. In some states this exclusion may not apply to all conditions.

This plan does not cover all health care expenses and has exclusions and limitations. You should refer to your booklet certificate for what is covered and to what extent. The following is a partial list of non-covered services and supplies:

■ All medical or hospital services not specifically covered in, or which are limited or excluded in, the plan documents
■ An inpatient hospital stay specifically excludes time in the hospital for observation or in the emergency room unless this leads to an inpatient stay.
■ Cosmetic surgery, including breast reduction
■ Custodial care
■ Experimental and investigational procedures
■ Infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies
■ Non medically necessary services or supplies
■ Over-the-counter medications and supplies
■ Reversal of sterilization

Note that your plan may contain exceptions based on state mandates.

This limited health plan does not meet Massachusetts Minimum Creditable Coverage standards.

More about the plan
The Aetna Hospital plan is underwritten by Aetna Life Insurance Company (Aetna) and is administered by Strategic Resource Company (SRC).

Read the official plan Benefits Summary, available at www.farmersagentsbenefits.com for details. You may also call Aetna Customer Service at 800.571.4015 if you have questions.
METLIFE CRITICAL ILLNESS INSURANCE (CII)

Even if you have comprehensive medical insurance, there are still expenses associated with a critical illness that many medical plans are not designed to pay, such as co-pays, deductibles, out-of-network treatments, childcare, mortgage and utility payments. Critical Illness Insurance provides you with a lump-sum payment that can be used for any purpose in the event you or a covered family member is diagnosed with a covered condition.

Covered conditions

MetLife CII provides you with a lump-sum payment in the event a Covered Family Member is diagnosed with one of the following medical conditions (as they are defined by the group certificate):

- Full Benefit Cancer
- Partial Benefit Cancer
- Heart Attack
- Stroke
- Coronary Artery Bypass Graft
- Kidney Failure
- Alzheimer’s Disease
- 22 Listed Conditions

A Major Organ Transplant Benefit is also included, as well as an annual health screening benefit.

Plan benefits

You may elect coverage with an Initial Benefit Amount of $10,000, $20,000 or $30,000 of CII for yourself, spouse/domestic partner and/or dependent child(ren).

Your Initial Benefit provides a lump-sum payment upon the first diagnosis of a Covered Condition. A Recurrence Benefit is paid when a covered person is diagnosed with another occurrence of the same covered condition for which an Initial Benefit was previously paid. The maximum amount that you can receive through your CII plan for an Initial Benefit and Recurrence Benefits is called the Total Benefit (life time benefit) and is three times the amount of your Initial Benefit. This means that you can receive multiple Initial Benefit and Recurrence Benefit payments until you reach the maximum of 300% (see the payment example on the next page).

In addition to the Total Benefit amount, the plan pays:

- An additional lump-sum payment of 100% of your Initial Benefit Amount in the event of a covered Major Organ Transplant.

- An annual health screening benefit of $50 (for $10,000 of coverage) and $100 (for $20,000 and $30,000 of coverage) per calendar year for taking one of the eligible screening/prevention measures.
PAYMENT EXAMPLE

The example below illustrates an individual who elected an Initial Benefit Amount of $10,000 and has a Total Benefit of three times (300%) of the Initial Benefit Amount, or $30,000 (life time benefit). The Total Benefit paid is $25,000, leaving a $5,000 benefit remaining for any future Recurrence or Initial Benefit payments.

<table>
<thead>
<tr>
<th>Illness – Covered Condition</th>
<th>Payment</th>
<th>Total Benefit Remaining</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Attack – first diagnosis</td>
<td>Initial Benefit payment of $10,000 or 100%</td>
<td>$20,000</td>
</tr>
<tr>
<td>Heart Attack – second diagnosis, two years later</td>
<td>Recurrence Benefit payment of $5,000 or 50%</td>
<td>$15,000</td>
</tr>
<tr>
<td>Kidney Failure – first diagnosis, three years later</td>
<td>Initial Benefit payment of $10,000 or 100%</td>
<td>$5,000</td>
</tr>
</tbody>
</table>

Enrollment

Enrollment is guaranteed provided you are actively at work. There is no waiting period required for this coverage. You do not need to be covered by a medical plan to enroll for this coverage.

To elect CII for yourself and your dependents, log on to www.farmersagentsbenefits.com

Plan exclusions and limitations

Metlife CII is a limited group policy. Like most group accident and health insurance policies, MetLife’s CII policies contain certain exclusions, limitations and terms for keeping them in force. There is a pre-existing condition exclusion and there is a Benefit Suspension Period between Recurrences. A more detailed description of the benefits, limitations, and exclusions applicable to you can be found in the Disclosure Statement or Outline of Coverage/Disclosure Document available at the time of enrollment. Please review the notes and guidelines of the plan when applying, as there may be plan variances based on state residence.
THE DENTAL PLANS

The dental plans offer comprehensive dental coverage. 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 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 MetLife SafeGuard Dental Plan, a DMO dental plan, or
- **Aetna PPO Dental Plan**, which allows you to receive dental care from in-network or out-of-network dentists.
- **Aetna Out-of-Area PPO Dental Plan**, which is available if you live outside of the network service areas for the Aetna DMO or PPO 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.

The Aetna DMO Prepaid Dental Plan and MetLife SafeGuard Dental Plan are known as “dental maintenance organizations” or DMOs. That means that dental benefits are provided only if you see a dentist from the plan’s panel of participating dentists. To select an Aetna participating dentist, use DocFind® on www.aetna.com/docfind/custom/farmersagents/ or call Aetna Dental Customer Service toll-free at 877.238.6200. For a MetLife SafeGuard participating dentist, visit www.metlife.com/mybenefits or call MetLife SafeGuard Customer Service toll-free at 800.880.1800.
Aetna DMO Prepaid Dental Plan and MetLife SafeGuard Dental Plan

Under both the Aetna DMO Prepaid Dental Plan and the MetLife SafeGuard Dental Plan, you can select a different dental provider for each family member you enroll.

Dental benefits are payable only if you seek care from a participating network dentist.

If you are electing the Aetna DMO or MetLife SafeGuard Dental Plan, enter the Primary Care Dentist (PCD) code and name on the “Primary Care Physician Information” page when completing your online enrollment. You will need to enter this information for yourself and each dependent. 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 MetLife 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.

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

<table>
<thead>
<tr>
<th>Service</th>
<th>Aetna DMO Prepaid Dental Plan</th>
<th>MetLife 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 (oral exams, cleanings, x-rays)</td>
<td>100% after $10 office visit copay</td>
<td>100% after $5 office visit copay</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>$27 – $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>$185</td>
</tr>
<tr>
<td>■ Dentures</td>
<td>$275 – $350</td>
<td>$210 – $225</td>
</tr>
<tr>
<td>Orthodontia (children &amp; adults)</td>
<td>100% after $2,000 copay**</td>
<td>100% after $1,695 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. You must have a referral from your PCD in order to receive coverage for any services a specialist dentist provides.

** Includes copays for screening exam, diagnostic records, treatment, and retention. Members do not need a referral from their PCD for orthodontic services.

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

The Aetna PPO 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.

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 recognized 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.

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

The chart below is a partial list of services covered by the Aetna PPO 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>$75 individual</td>
<td>$75 individual</td>
<td>$225 family</td>
</tr>
<tr>
<td>Calendar Year Maximum</td>
<td>$1,000 per person</td>
<td>$1,000 per person</td>
<td>-</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>Deductible waived</td>
<td>Deductible waived</td>
<td>Deductible waived</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, 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.

Benefit coverage level can vary based on the nature of the services.
The terms of your benefit plans are governed by legal documents. Please refer to your Aetna SPD for more details and plan limitations.
Aetna Out-of-Area PPO Dental Plan

If you live outside of the network area that serves the Aetna DMO or Aetna PPO Dental Plans, dental coverage is offered under the Aetna Out-of-Area PPO Dental Plan.

You may use any licensed dental provider.

The chart below is a partial list of services covered by the Aetna Out-of-Area PPO 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% Deductible waived</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>

Benefit coverage level can vary based on the nature of the services.
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 the 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 use your VSP benefits at retail chain providers, including Costco Optical, Eye Care Centers of America, Inc., EyeMasters and Hour Eyes. Note that the allowance for an affiliate provider is different than for a VSP provider.

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
- Receive additional assistance from a customer service department representative

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.

HEARING AID DISCOUNTS

VSP members can also receive discounts on hearing aids through TruHearing. Go to www.vsp.com and click on special offers for more information.
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><strong>Annual Copay</strong></td>
<td><strong>$25</strong></td>
<td><strong>$25</strong></td>
</tr>
<tr>
<td><strong>Examination once per calendar year</strong></td>
<td><strong>100%</strong></td>
<td>Plan pays up to <strong>$50</strong></td>
</tr>
<tr>
<td><strong>Eyeglasses</strong>1</td>
<td>Plan pays up to <strong>$120</strong></td>
<td>Plan pays up to <strong>$70</strong></td>
</tr>
<tr>
<td>■ Frame every 2 calendar years</td>
<td>100% of VSP-approved fees</td>
<td>Plan pays: Up to <strong>$50/pair</strong></td>
</tr>
<tr>
<td>■ Lenses once per calendar year</td>
<td></td>
<td>Up to <strong>$75/pair</strong></td>
</tr>
<tr>
<td>- Single Vision</td>
<td></td>
<td>Up to <strong>$100/pair</strong></td>
</tr>
<tr>
<td>- Bifocal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Trifocal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1VSP provides 20% off additional complete pairs of glasses (lenses and frames) and non-prescription sunglasses; includes non-covered lens options. If you order the additional eyeglasses/sunglasses from the same VSP provider on the same day as your WellVision Exam, the discount is 30%.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Contact lenses</strong>2</td>
<td>Up to <strong>$120</strong></td>
<td>Plan pays up to <strong>$105</strong></td>
</tr>
<tr>
<td>(in lieu of frame and lenses)</td>
<td>100%</td>
<td>Plan pays up to <strong>$210</strong></td>
</tr>
<tr>
<td>■ Elective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Medically necessary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2VSP provides 15% off the cost of contact lens examination (evaluation and fitting). This discount does not apply to the contact lens materials.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diabetic Eyecare Plus</strong></td>
<td><strong>$20 copay</strong></td>
<td>N/A</td>
</tr>
<tr>
<td>(for those with Type 1 and Type 2 diabetes)</td>
<td></td>
<td></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 choose 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
- 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; these 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 MetLife. **If you elect coverage, you must participate in the plan until the end of the plan year, unless you experience a qualified status change.**

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 Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agents or District Managers</td>
<td>Life insurance: First year options of $25,000, $50,000 or $100,000; first year anniversary option $25,000 or $50,000 increments up to $1,200,000, not to exceed eight times annual commissions. Maximum benefit is the lesser of $1,200,000 or eight times annual commissions (age dependent).</td>
<td>Equal to life insurance coverage</td>
</tr>
<tr>
<td>Reserve Field Managers (RFM), Agency Business Consultants (ABCs), DMTAAs, DLSs, DCSs</td>
<td>Life insurance: $50,000</td>
<td>Equal to life insurance coverage</td>
</tr>
<tr>
<td>Eligible family members of Agents, District Managers, Reserve Field Managers (RFM), Agency Business Consultants (ABCs), DMTAAs, DLSs, and DCSs</td>
<td>Family life insurance: $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>Other Agent and DM office staff</td>
<td>Life insurance: $25,000</td>
<td>Equal to life insurance coverage</td>
</tr>
<tr>
<td>Eligible family members of Agent and DM office staff</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 Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agents or District Managers, Reserve Field Managers (RFM), Agency Business Consultants (ABCs), DMTAAs, DLSs, DCSs, APs, or other Agent and DM office staff</td>
<td>$50,000 to $300,000 in multiples of $50,000</td>
</tr>
<tr>
<td>Eligible family members of Agents, District Managers, Reserve Field Managers (RFM), Agency Business Consultants (ABCs), DMTAAs, DLSs, DCSs, APs, and other Agent and DM office staff</td>
<td>Family AD&amp;D insurance: Equal to your coverage for spouse, 10% of your coverage to a maximum of $30,000 for each child</td>
</tr>
</tbody>
</table>

* Provided they are unmarried, supported by you and not employed on a full-time basis.

You can enroll yourself and your dependents in the Life and supplemental AD&D plans within 31 days of your initial eligibility. If you don’t enroll within 31 days of your initial eligibility date, you’ll need to complete an Evidence of Insurability form and it is subject to approval by the insurance carrier.

The terms of your benefit plans are governed by legal documents. Please refer to your MetLife SPD for more details and plan limitations.
MetLife Basic Life and AD&D Insurance Plan

Coverage options for agents and district managers
During the first year that you are eligible for coverage as an agent or district manager, you may elect a maximum benefit of $25,000, $50,000 or $100,000 if you request this coverage within 31 days after you become eligible. On your first year anniversary, you will be able to elect insurance coverage in $25,000 or $50,000 increments up to $1,200,000 not to exceed 8 times annual commission (age dependent). 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.*

All other classes are eligible for the amounts of coverage indicated on page 21.

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. Also, 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.

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 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 (age dependent), 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.
**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, brain damage, 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 business 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, 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, but coverage cannot exceed $2,000,000, nor can it go below $10,000. 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 100.
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 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 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.

**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, brain damage, 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
Contact the Farmers Agents’ Benefits Department if you need to file a Supplemental AD&D insurance claim.

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
The LTD plan provides a monthly benefit if you become disabled. If you are an agent or district manager, in the first three years of your appointment agreement, you will have a 180-day elimination period plan. Otherwise, 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.

If you elect coverage, you must participate in the plan until the end of the plan year, unless you experience a qualified status change.

Agents or district managers in their first three years of appointment will have a 12/12 pre-existing condition clause. Otherwise, a 3/12 pre-existing clause will apply. Participants who have previously waived coverage will be subject to restrictions and the applicable 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.

In your first three years as an agent or district manager, your monthly LTD benefit is $1,250 per month (not to exceed 67% of your earnings). Otherwise, 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 12/12 or 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 12 (agents and DMs) or three months (non-agents) 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 any service fees you receive from Farmers.

### Work incentive benefit
For the first 12 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 pre-disability 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 12 (agents and DMs) or three months (non-agents) 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.
**Porting long-term disability insurance**

You can port your long-term disability insurance to an individual policy if you have been insured for at least 12 consecutive months under the Long-Term Disability Plan available through the Farmers Agents’ Group Benefits Program 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 work with an agent or DM ends,
- You are disabled under the terms of the plan,
- You recover from a disability and do not reinstate your appointment agreement or return to work, 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 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.

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**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 Long-Term 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% income 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 and a completed medical questionnaire. 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 the 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 staff members 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 and a completed medical questionnaire. 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.

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.
Summary
Errors and omissions insurance (E&O) is considered a necessity for licensed agents and district managers (DM). Farmers recognizes the value of a group plan for agents. The Farmers sponsored group E&O program is underwritten by Arch Insurance Company and administered by CalSurance Associates, A Division of Brown & Brown Program Insurance Services, Inc. Note, for New York agents, the E&O program is underwritten by Arch Specialty Insurance Company.

The group E&O insurance policy provides certain protection against claims arising out of an 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 Farmers Financial Solutions, LLC), expert witness, or notary public.

Who is covered?
The insured agent or DM shares their limits of liability with all agent and DM office staff (including, but not limited to: Reserve District Managers, Reserve Field Managers, District Manager Training and Administrative Assistants, District Life Specialists, District Commercial Specialists, agency producers, agent’s spouse, or CSRs). Such agency producers, and CSRs are covered while acting on behalf of the agent/DM at no additional premium. Each agent or DM pays one monthly premium. Note, Reserve agents are included for no additional premium with Coverage Level 1 and their own limits of $1M per claim/$2M aggregate per agent.

What is covered?
The policy offers three coverage levels. A brief description of each coverage level is included below. Coverage level availability is dependent upon your individual agent appointment date and agreement.

Coverage Level 1
Covered products include Farmers® business (e.g. Foremost®, Bristol West®, 21st Century), brokered health, business placed through Kraft Lake®, Insurance Noodle, or Couch Braunsdorf, securities through FFS, and business placed through other designated entities.

Coverage Level 2
Provides all coverage specified in Level 1 and adds certain coverage for claims arising out of personal lines brokered business. Personal lines brokered business is insurance that is sold to an individual and placed with a non-Farmers entity (e.g. Homeowners, Personal Auto, and Personal Umbrellas).

Coverage Level 3
Provides all coverage specified in Level 2 and adds certain coverage for claims arising out of commercial lines brokered business. Commercial lines brokered business is insurance that is sold to a business and placed with a non-Farmers entity (e.g. General Liability Policies, Commercial Property, Business Owner Packages, and Workers Compensation Insurance).

Note: If you previously were, or currently are, involved in the sale or servicing personal lines or commercial lines brokered business, you must maintain the appropriate coverage level continuously and have it in place at the time a claim is reported. A separate retroactive date applies to both the brokered personal lines and commercial lines coverage extensions. See policy for more details. Contact CalSurance Associates at 866.893.1023 for more information.
Limits of liability options

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

* Life Only Agents are offered the basic $1,000,000/$2,000,000 limits of liability unless higher limits were elected on January 1, 2011, and have been maintained continuously by the agent.

The policy includes sub-limits that may reduce the amount of coverage available. See policy for details.

Deductible waiver
If you have been continuously insured under the Farmers sponsored E&O program for the past five policy periods and have not reported any claim(s) during that time, the deductible will be waived for the first reported claim involving Farmers business provided certain conditions were met when the business was written. See policy for details.

Deductible buy-back
For $25 extra per month you can eliminate the out-of-pocket expenses associated with your deductible (for both Farmers and non-Farmers business). The Deductible Buy-Back eliminates a maximum of $10,000 each policy period for your agency/district office should an E&O claim (or multiple E&O claims) be brought against you. To ensure the deductible is waived, you must have elected this optional endorsement prior to the date that a claim is reported.

Additional program features

- **Network Security & Privacy Breach Coverage** — Includes: Privacy/Data Security Coverage, Network Security Breach or Privacy Violation; Crisis Management Expense; Credit Monitoring Services; and Data Restoration Costs. Sub-limits apply. Deductibles (which apply to Damages & Defense Costs) vary by coverage part. See policy for details.

- **Web Media Content Liability Coverage** — Includes coverage for acts arising out of Social Media Activities; defamation, libel, slander, trade libel (related to disparagement or harm to the reputation or character); invasion or Interference with an individual’s right of publicity, including commercial appropriation of name, persona, voice, or likeness; infringement of copyright, trademark, trade name, trade dress, logo, title, metatag, or slogan, service mark, or service name. Sub-limits apply. Deductibles (which apply to Damages & Defense Costs) vary by coverage part. See policy for details.

- **Broad Insolvency Carveback** — Provides coverage for companies rated B+ or better (P&C) and A- or better (Life and A&H) by A.M. Best. A $50,000 defense sub-limit is provided for other insolvency related claims. See policy for details.

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 that you have not already reported to Lancer Claims Services, you must report them prior to January 1, 2016. Claims can be reported online at [www.lancerclaims.com/reportaclaim](http://www.lancerclaims.com/reportaclaim) or by calling: 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 be responsible to pay 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, Inc.
- $5,000 per claim on all other covered business.
Retroactive date
The retroactive date is the later of:

- The date of inception of the agent’s or DM’s contract with Farmers Insurance Exchange; or
- The date of the first continuously maintained claims made errors and omissions liability coverage without interruption.

Note: If the insured Agent is a party to a Retail Agent Appointment Agreement, the agent can apply for Extended Prior Acts coverage. Contact CalSurance Associates for details.

Different retroactive dates may apply to claims arising from errors on brokered business if E&O coverage for those activities has not been maintained continuously.

Extended reporting period provisions
Agents and DMs are covered by the Group E&O Program for certain acts, errors, omissions, and personal injuries that occur while under contract with Farmers. Coverage under the policy ends on the date your contract terminates. However, the policy provides an Automatic Unlimited Extended Reporting Period following the termination 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;
- there is no other valid insurance available to pay the claim;
- the claim is otherwise covered by the policy; and
- your contract was not terminated for cause.

The policy also provides an Automatic Extended Reporting Period for ninety days for claims involving non-Farmers products and services. Agents who meet Farmers’ criteria of a retiree will receive a two year Automatic Extended Reporting Period for claims involving products and services of non-Farmers insurance companies. Options to extend the ninety day (or two year) period for three years, five years, or an unlimited period of time are available for an additional premium and must be purchased within sixty days of termination through CalSurance Associates provided that your contract has not been terminated for cause.

Changes to coverage or limits of liability
Changes to your coverage level or limits of liability can only be made during the Annual Enrollment period. Be sure to review your coverage and limit elections online and make any necessary changes during the Annual Enrollment period. Changes to limits may be allowed midterm if you have recently hired an agency producer or you have a contractual obligation to carry higher limits.

Newly appointed agents
New agents will be automatically enrolled in the Farmers Sponsored Group E&O Program with coverage Level 1 and basic limits of liability of $1,000,000 each claim/$2,000,000 aggregate each agency. Coverage Level 1 does not include coverage for brokered personal lines or commercial lines P&C business.

Agents and DMs have the option to change these automatic elections within 31 days of initial eligibility. If you don’t change your elections within 31 days, you must wait until the next Annual Enrollment period.

Need more information?
Visit: www.farmersagentsbenefits.com. Click on the “Errors & Omissions Information” link and follow the prompts. This site will give you access to the program highlights, Frequently Asked Questions, certificate reprint, and the policy. In addition, there are a number of loss control resources available, including the “E&O Loss Prevention Class” which provides industry practices to help reduce losses. These important resources are just a few examples of the online resources available for your use.

For additional questions, 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. It is a savings program that allows agents and district managers to save for their future on a tax-deferred basis. **New for the 2016 year,** agents and district managers who qualify for the new Profitable Growth Bonus will have the opportunity to defer some or all of their bonus in a variety of investment crediting choices.

The Plan gives eligible participants an additional way to help meet their financial planning needs.

The Plan allows you to:
- Save for short-term and long-term goals with pre-tax dollars
- Supplement your other savings programs
- Utilize tax-advantaged investment options

**How the plan works**

The Plan is completely voluntary. You may contribute as little as 10% to as much as 50% of your Auto new business commissions to the Plan and/or 5% of your Commercial new business commissions. In addition, beginning in 2016 for those who qualify, 10% to 100% of the new Profitable Growth Bonus (PGB) may also be contributed to the Plan. When you do so, you are deferring receipt of this portion of your compensation until a later date that you choose during annual enrollment — as early as three years from the beginning of the Plan year or as late as your contract termination.

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 2016 Plan year, you defer applicable commissions and/or PGB amounts from the March 2016 folio through the January 2017 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 2015 Agency Force Deferred Compensation Plan participants will automatically be enrolled into the 2016 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 at your current deferral percentage
Who is eligible?
Full-time agents and district managers, and Career agents who were appointed on or before June 30, 2015, are eligible to enroll in the 2016 Plan year. Reserve agents, agency business consultants, district commercial specialists, district life specialists, agency producers, and staff 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 an 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.

This next annual enrollment will again include an “evergreen” provision. This means that current Plan participants’ elections will be carried over automatically to the next Plan year, with the exception of the Scheduled In-Service election.

If you currently have a Scheduled In-Service election for the current Plan year, it will not rollover to the next Plan year. To have a Scheduled In-Service Withdrawal for the next Plan year’s balance, you will need to complete the online enrollment process and elect this option before the end of annual enrollment.

2016 election options
Deferral election:
Every year (starting with the 2016 Plan year), you may defer 10% to 50% of your Auto new business commissions, or 5% of your Commercial new business commissions, or both. Agents who qualify for the new Profitable Growth Bonus may elect to defer 10% to 100% of their Personal Lines or Commercial Lines bonus, or both. Eligible district managers may defer 10% to 100% of the Profitable Growth Bonus.

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

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

Your deferrals for the 2016 Plan year will start with your March 2016 folio and go through your January 2017 folio (there is no February deferral).

No deferral will be recorded for monthly contributions of less than $10.00 individually for Farmers, TCM, or Truck Insurance Exchange or collectively for MCA and Bristol West.

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
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. Sign in with your Participant ID and PIN. Go to the Resources tab and then select Deferred Compensation.

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. Sign in with your Participant ID and Password. Go to “Resources” tab, select “Deferred Compensation,” and then click on “View Account.”
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 the 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 2016 Plan year’s balance as early as 2019.

You may elect, and by meeting certain Plan requirements, will receive annual installments over a period of two to four years. Scheduled In-Service Withdrawal 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 2011, 2012 and 2013 that are all due to pay out in 2017. 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 will govern how the Plan year balance is paid in the event your contract is terminated prior to your Scheduled In-Service Withdrawal. You can choose to receive the Plan year’s balance at contract termination in a lump sum or in annual installments over 2 to 10 years. Some restrictions apply to receiving annual installments — see the Plan Summary & Highlights booklet for details.

3. **Hardship Distributions**: Hardship distributions may be available for “unforeseeable emergencies.” See the current Summary & Highlights booklet 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) with your Participant ID and Password
2. Go to the “Resources” tab and then select “Deferred Compensation”
3. Click on “View Account”
4. On the left navigation bar, click on “Beneficiaries” under Elections
5. Click on “Update Beneficiary”
6. Make your beneficiary designation or complete missing information

Complete beneficiary designation

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3. Click on “View Account”
4. On the left navigation bar, click on “Beneficiaries” under Elections
5. Click on “Update Beneficiary”
6. Make your beneficiary designation or complete missing information
Plan administration
This Plan is administered by the Farmers Agency Force Deferred Compensation 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. MulinTBG is the Plan record-keeper, responsible for maintaining and reporting your elections and account balances.

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.

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.
FIDELITY BOND

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

In general, the Farmers-sponsored agents’ fidelity bond protects the Companies and the financial institutions approved by Farmers against defalcations, shortages, or losses involving claims, premiums or any other Farmers property. Coverage is not provided for premiums belonging to non-Farmers insurers (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, can be provided to satisfy the Companies’ bonding requirements. The bond must be acceptable to the Companies and have all of the Farmers Companies listed as “named insureds,” not the agent or the agency.

In 2016, 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 Agency Services 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 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 Internal Audit at 818.936.7356.

A copy of the Farmers Agents’ Fidelity Bond policy is available online at www.farmersagentsbenefits.com. Sign in with your Participant ID and Password. Go to the “Resources” tab and then select “Benefit Plan Information.”
ENROLLING IN 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 worksheet 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 any correction is needed, contact the Farmers Agents’ Benefits Department.

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 42).

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 plan. 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 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 plans you elect begins 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 and your Password. 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 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 any time 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 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 is during the next annual enrollment period, unless you experience a qualified status change mid-year. (Refer to page 42 for more information on qualified status changes.)

There is no pre-existing condition exclusion associated with any of the medical plans.
HOW TO ADD A STAFF MEMBER (FOR AGENTS & DMS ONLY)

Since the Farmers Agents’ Benefits Department does not maintain data on your staff members who are not currently enrolled in the benefits program, you will need to add the staff member’s personal information to the benefits system. You have two methods available to add your staff members: 1) via the Agents Benefits website, or 2) by calling the Farmers Agents’ Benefits Call Center at 877.862.1237.

Adding staff members via the administration tab
1. Sign on to www.farmersagentsbenefits.com with your Participant ID and Password.
2. Go to the Admin tab and select “Add New Participant.” You will then be taken to the Participant Information page.
3. You will then need to enter all of the Participant information.
   - Use the “Agent Type” drop down menu to select the position.
   - In the “Current Salary” field, enter the annual salary of the participant.
4. When finished, click “Submit.”
5. A personalized enrollment email, based on the information you provide, will be sent to the staff member.

Adding staff members via the Farmers Agents’ Benefits Call Center
1. If you do not have an Internet connection, you may add the staff member 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 a staff member 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 staff member:
   - Social Security number
   - Last name, first name, middle initial
   - Staff type (reserve district manager, reserve field manager, district manager training and administrative assistant, district life specialist, district commercial specialist, agency producer, or office staff)
   - Sex
   - Marital status
   - Date of birth
   - Email address
   - Annual income
   - Date of hire/appointment
   - Home address
   - Home telephone number
5. A personalized enrollment email, based on the information you provide, will be sent to the staff members.
HOW TO TERMINATE A STAFF MEMBER’S BENEFITS

You may terminate one of your staff member’s benefits through the Agents’ Benefits website or by calling the Farmers Agents’ Benefits Call Center at 877.862.1237. It is the agent’s/DM’s responsibility to terminate the staff member’s benefits within 31 days of the staff member’s termination date. Benefit coverage will terminate effective the last day of the month of the termination. No retroactive terminations beyond 31 days will be processed.

1. Sign on to www.farmersagentsbenefits.com with your Participant ID and Password.
2. Go to the Admin tab and select “Participant Search.”
3. Use the drop down to select the search option. Enter the search criteria and click the “Search” button.
4. Find your staff member from the search results. In the “Actions” drop down menu, change “Impersonate” to “View Information,” then click “Go.”
5. On the Participant Information page, click the “Edit Employee” button.
6. Enter the termination date and then click the “Submit” button at the bottom of the screen to complete the termination.

HOW TO GET A RATE QUOTE (NEW PARTICIPANT MODELER)

You can get a benefit quote for a current or a prospective staff member by using the Agents Benefits website or by calling the Farmers Agents’ Benefits Call Center at 877.862.1237. To use the website:

1. Sign on to www.farmersagentsbenefits.com with your Participant ID and Password.
2. Go to the “Admin” tab and select “Model New Participant.”
3. Complete the required information to begin your model.
4. Once you have completed the model, you will have the option to email the results to a desired recipient, or open the results as a “.PDF” file and save them locally to your PC.

Note: The rate quote is an estimate based on the data entered. If the data entered was inaccurate, the rates may change to reflect the correct information.
QUALIFIED STATUS CHANGE

If you select medical, dental, vision, group life, long-term disability (LTD), AHP or Critical Illness insurance, 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 and has been approved by the Farmers Agents’ Benefits Department.

Each such participant needs to complete the QSC form available online at www.farmersagentsbenefits.com, along with the supporting documentation as indicated below, and submit the request for approval.

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 Occupation)</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 for approval.

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

If your request is approved, 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 and/or approved 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 BENEFITS
WHEN COVERAGE ENDS

You can continue certain benefits if:

- You meet the age and service requirements necessary to continue your medical and life insurance benefits as a Continuee. Please refer to page 45, the "Eligibility for Benefits Continuation" section, for details.
- You lose your coverage due to an event such as contract termination, death, divorce, legal separation, annulment, a covered dependent child who is no longer eligible or if you cease to satisfy the 20 hour work week requirement. You have the option to continue your medical, dental and vision coverage through COBRA continuation. Please refer to page 47, the "COBRA Continuation Coverage" section, for details.

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>Medical</td>
<td>Agents</td>
</tr>
<tr>
<td></td>
<td>District Managers</td>
</tr>
<tr>
<td></td>
<td>Agency Business Consultants (ABC)</td>
</tr>
<tr>
<td></td>
<td>District Manager Training and Administrative Assistants (DMTAAs)</td>
</tr>
<tr>
<td></td>
<td>District Life Specialists (DLSs)</td>
</tr>
<tr>
<td></td>
<td>District Commercial Specialists (DCSs)</td>
</tr>
<tr>
<td></td>
<td>Agency producers (APs)</td>
</tr>
<tr>
<td></td>
<td>Other agent and DM office staff</td>
</tr>
<tr>
<td></td>
<td>Eligible spouses and dependent children</td>
</tr>
<tr>
<td>Life Insurance</td>
<td>Agents</td>
</tr>
<tr>
<td></td>
<td>District Managers</td>
</tr>
<tr>
<td></td>
<td>Eligible spouses</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COBRA Benefits</th>
<th>Available To:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical, dental and/or vision</td>
<td>Agents</td>
</tr>
<tr>
<td></td>
<td>District Managers</td>
</tr>
<tr>
<td></td>
<td>ABCs</td>
</tr>
<tr>
<td></td>
<td>DMTAAs</td>
</tr>
<tr>
<td></td>
<td>DLSs</td>
</tr>
<tr>
<td></td>
<td>DCSs</td>
</tr>
<tr>
<td></td>
<td>APs</td>
</tr>
<tr>
<td></td>
<td>Other agent and DM office staff</td>
</tr>
<tr>
<td></td>
<td>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 certain medical and life insurance coverage.

Medical
You are eligible to continue your medical coverage if you are an agent, a district manager, reserve field manager (RFM), agency business consultant (ABC), a district manager training and administrative assistant (DMTAA), a district life specialist (DLS), a district commercial specialist (DCS), an agency producer (AP), or an office staff member of an agent or DM, and, at the time you leave, you meet one of the following requirements:

■ You are age 55-64, have at least 5 years of service, and are covered by a medical plan available through the Farmers Agents’ Group Benefits Program.

■ You are age 65 or older with no service requirement and are covered by a medical plan available through the Farmers Agents’ Group Benefits Program.

You may elect to continue medical coverage for your eligible dependents provided they are covered under the plan before you leave. 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. If you terminate your coverage at any time after leaving, you cannot re-enroll.

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

■ You are age 55-64, have at least 5 years of service, and are covered by a life insurance plan available through the Farmers Agents’ Group Benefits Program.

■ You are age 65 or older with no service requirement and are covered under the life insurance plan before your contract terminates.

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’s contract terminates.

You must elect to continue coverage for yourself and your spouse immediately after your contract terminates. If you terminate your coverage at any time after your contract terminates, 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.

How to continue medical and life insurance benefits
If you want to continue medical or life insurance coverage, follow these steps:

1. Once the Agents’ Benefits system is updated with your termination information and your eligibility to Continue benefits is verified, a Continuee newly eligible letter is mailed to your home address on file. The letter will give you instructions and information needed for you to log on to the benefits website and make your Continuee elections.

2. You will receive notices of premium due from the continuee administrator. Invoices are generated the 15th of each month and are mailed to the personal address on file. Payments are due the 1st of each month and should be sent directly to the continuee administrator’s address listed on the invoice.

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

The Farmers Agents’ Group Benefits Program 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 (see page 44)
- 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, under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). Please read this section carefully. It explains the conditions that apply to continuation of your 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, RFM, ABC, DMTAA, DLS, DCS, AP, or other agent or DM office staff member and covered spouse and dependent children (“qualified beneficiaries”) covered through 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 of an office staff member for any reason (other than for gross misconduct)</td>
<td>Covered agent, DM, RFM, ABC, DMTAA, DLS, DCS, AP, or other agent or DM office staff, covered spouse and/or covered dependent children</td>
<td>18 months</td>
</tr>
<tr>
<td>Reduction in hours of work to less than 20 hours per week</td>
<td>Covered agent or DM office staff, 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 agent, DM, RFM, ABC, DMTAA, DLS, AP, or other agent or DM office staff member’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 continuation coverage. For COBRA to apply, the event must cause a qualified beneficiary to lose health care coverage.
Important: The 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 termination. 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 47.

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 health care coverage ends because of termination of an appointment agreement or termination of an agent or DM office staff member (for reasons other than gross misconduct) or a reduction in hours of work of an agent or DM office staff member 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 work of an agent or DM office staff member (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 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 the 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 work of an agent or DM office staff member 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 through 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 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 52 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 work of an agent or DM office staff member. Failure to do so may result in loss of eligibility for COBRA continuation coverage.

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. 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 through 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, health care coverage will end on the date shown on the COBRA election form.**

**COBRA coverage choices**

Qualified beneficiaries who lost coverage through 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 45).
**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.

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 another 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 the continuation coverage period (whichever applies).
- The date that the qualified beneficiary becomes covered by Medicare.
- The date the Farmers Agents’ Group Benefits Program no longer offers medical, dental, or vision care coverage for active agents, DMs, RFMs, ABCs, DMTAAs, DLSs, DCSs, APs, or other agent or DM office staff members.
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<th>PAGE</th>
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<td>Business Address (Contact Agency Services at 877.411.1344, option 7)</td>
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