Underwritten by Transamerica Life Insurance Company

PROPOSAL FOR EMPLOYEES OF
Tulare County
2900 W. Burrel
Visalia, CA 93291

PROPOSAL DATE:
March 23, 2016

PRESENTED BY:
CHIMIENTI & ASSOCIATES
3400 W MINERAL KING AVE STE B
VISALIA, CA 93291

LICENSE NUMBER
Select

Administrative Office:
(800) 400-3042
PO Box 8063, Little Rock, AR 72203
www.transamericaemployeebenefits.com

Quoted rates are valid for 90 days, then they are subject to change without notice. This proposal describes coverage highlights only. This is not an offer. Limitations and exclusions apply. No contract will result until an application is submitted and approved by the insurance company and a policy or certificate is issued.

ABOUT CancerSelect® Plus CANCER INSURANCE

Why Should You Offer Your Employees Cancer Only Insurance?

Chances are someone in your company has been diagnosed with cancer. When those medical emergencies occur, oftentimes employees are suddenly faced with lengthy medical treatment, drastic lifestyle changes and uncertain futures. At the same, many employees are also not equipped to handle the mountain of medical bills and associated expenses that their current employer-sponsored insurance policy may not cover.

On the other hand, you can help your employees prepare for just such an occurrence by offering them a supplemental cancer only insurance policy that is specifically designed to pay benefits to help defray the costs of cancer treatment.

CancerSelect Plus pays indemnity benefits in the event of a cancer diagnosis.

Designed as a supplemental policy, CancerSelect Plus provides meaningful direct and indirect medical benefits to your employees to help pay the costs of cancer treatment. CancerSelect Plus benefits are paid in addition to any other insurance your employees may have. Benefits are paid directly to the employee or directly to anyone else he or she chooses.

CancerSelect Plus also includes a cancer screening wellness rider that pays a benefit amount per calendar year to each insured for specific tests performed to determine whether cancer exists in a covered person.

Highlights of CancerSelect Plus:

Individual and family insurance available
Guaranteed issue available, subject to group size and participation
Offers a variety of enrollment methods including a simplified process for Guaranteed Issue amounts
No physical exams or blood tests required[1]
Premiums collected through the convenience of payroll deduction
Fully portable if an employee leaves the group

See Plan Design for more details.
[1]If offer is not guaranteed issue, acceptance will be based upon answers to questions on the proposed insured's application for insurance.

This is a brief summary of CancerSelect® Plus cancer-only insurance underwritten by Transamerica Life Insurance Company, Cedar Rapids, Iowa. Policy Form Series CPCAN200 and CCCAN200 or CPCAN300 and CCCAN300. Forms and numbers may vary. Coverage may not be available in all jurisdictions. Limitations and exclusions apply. Refer to the policy, certificate and riders for complete details.

Employee Eligibility
To be eligible for coverage, an employee must be between the age of 18 and 64 and must:

- be on active service, performing in the usual manner all of the regular duties of his or her occupation at one of the places of business where he or she normally works or at some location directed by the employer; and
- be continuously employed for the minimum number of and working the minimum number of hours per week as you require to be eligible for benefits. These requirements will be defined on the Life and Health Group Application and Agreement.
- not be covered by any Title XIX program such as Medicaid.

Spouse Eligibility
To be eligible for coverage, a spouse must:

- be between the ages of 18 and 64;
- be a legally married spouse, common law spouse, domestic partner, or civil union partner if legally recognized in the governing jurisdiction or as otherwise agreed upon between you and us;
- not be disabled;
- not be covered by any Title XIX program such as Medicaid.

Child Eligibility
To be eligible for coverage, a child must be through age of 25 and is:

- a natural child;
- a legally adopted child or child who has been placed for adoption;
- a stepchild or foster child;
- a child for whom the employee has been appointed legal guardian;
- not disabled;
- a grandchild living with the employee and dependent for support and maintenance;
- not covered by any Title XIX program such as Medicaid.

Once coverage is in force, newborn or newly-adopted children will automatically be covered from the date of birth, placement, or court order for a period of 31 days. In order for such coverage to continue, family coverage must be in force.

Minimum Participation
At least 2 insured employees are required to establish and maintain an employer group. Other group types may require higher participation.

Evidence of Insurability
All applications are underwritten on an accept/reject basis. If an employee answers "yes" to the questions on the application, we will decline the application for all persons for whom coverage is being requested. If there is a "yes" answer to the questions for the spouse, the spouse only will be declined coverage. If there is a "yes" answer to the questions for a dependent child, that one child will be declined coverage.

Underwriting Limits for groups with 2000 benefit-eligible employee
Guaranteed Issue Underwriting is only available the first time an employee is eligible to apply. Coverage applied for at a later date is subject to Simplified Issue Underwriting.

Underwriting Guidelines for Plan 1	
Guaranteed Issue (GI) Participation	**Simplified Issue (SI) Participation**
Employee	
10 issuable employee applications of a benefit-eligible class	5 issuable employee applications of a benefit-eligible class

Other Considerations

Please be aware of the following:

- Employees residing in California, Georgia, Massachusetts, Minnesota or Vermont are required to have major medical coverage in order to apply for CancerSelect Plus. Coverage cannot be issued to anyone who does not have comprehensive medical coverage.
- This proposal is based on employer groups with 2000 eligible employees only and may not be available to other group types or sizes.
- Coverage and rates for employees residing in Maryland or New York may differ.

PRODUCT DETAILS

Hospital Benefits	Plan 1 - 3.00 Units	Policy Pays
Hospital Confinement	$300	per day of covered confinement
Extended Benefits	$600	per day; begins on day 91 of continuous confinement; in lieu of all other benefits (except surgery and anesthesia)
Attending Physician	$60	per day while hospital confined; one visit per 24-hour period
Inpatient Drugs and Medicines	$45	per day while hospital confined
Private Duty Nurse	$300	per day while hospital confined; must be authorized by the attending physician; cannot be hospital staff or a family member
Ambulance	$300	for service by a licensed ambulance service for transportation to a hospital; admittance required; we may pay all or a portion of the benefits directly to the provider if the bill has not been paid prior to submitting a claim.
Extended Care Facility	$300	per day; up to the number of days for the prior hospital stay; admittance must be within 14 days of hospital discharge
Government or Charity Hospital	$300	per day of covered confinement; in lieu of all other benefits
Hospice Care	$300	per day of hospice care; 100-day lifetime maximum; not payable while hospital confined

Surgery Benefits	Plan 1 - 5.00 Units	Policy Pays
Surgery — Inpatient	$5,000	maximum benefit; actual benefit is determined by the surgery schedule in the contract; for multiple procedures in same incision only the highest benefit is paid; for multiple procedures in separate incisions will pay highest benefit and then 50% for each lesser procedure
Surgery — Outpatient	$7,500	
Anesthesia	25%	of covered surgery benefit
Prosthesis	$2,500	maximum benefit; pays actual charges per device requiring implantation
Hair Prosthesis	$250	maximum benefit; pays actual charges for wig to cover hair loss from cancer treatment

Reconstructive Surgery	Breast Cancer – simple or total mastectomy	$600	for reconstructive surgery within 2 years of the initial cancer removal; excludes skin cancer and malignant melanoma; benefit not payable if paid under any other provision of the policy
	Breast Cancer – radical mastectomy	$850	
	Cancers of the male or female genitalia	$850	
	Cancer of the head, neck, or oral cancers	$1,250	
Second Surgical Opinion		$500	when surgery is prescribed; excludes skin cancer
Ambulatory Surgical Center		$750	maximum per day; pays actual charges for outpatient surgery at an ambulatory surgical center
Skin Cancer	One removal	$375	for removal of skin cancer (skin cancer does not include malignant melanoma or mycosis fungoides)
	Per additional removal	$175	

Radiation and Chemotherapy Benefits	Plan 1 - 2.00 Units	Policy Pays
Radiation and Chemotherapy	$10,000	maximum benefit per 12-month period; pays actual charges
Associated Radiation & Chemo Expenses	$500	maximum benefit per 12-month period; pays actual charges for treatment consultations and planning, adjunctive therapy, radiation management, chemotherapy administration, physical exams, checkups, and laboratory or diagnostic tests; transportation and lodging are not included as associated expenses
Blood, Plasma, Blood Components, Bone Marrow and Stem Cell Transplant	$10,000	maximum benefit per 12-month period; pays actual charges
Associated Blood & Plasma Expenses	$500	maximum benefit per 12-month period; pays actual charges for administration of blood, plasma and blood components, transfusions, processing and procurement, or cross-matching, treatment consultations and planning, physical exams, checkups, and laboratory or diagnostic tests; transportation and lodging are not included as associated expenses

New or Experimental Treatment	$10,000	maximum benefit per 12-month period; pays actual charges for drugs or chemical substances approved by the FDA for experimental use on humans or surgery or therapy endorsed by either the NCI or ACS for experimental studies received in the US or its territories
Wellness & Non-Medical Benefits	**Plan 1 - 1.00 Units**	**Policy Pays**
Annual Cancer Screening	$50	per calendar year for cancer screening tests: • pap smear • flexible sigmoidoscopy • prostate-specific antigen test • chest x-ray • hemocult stool specimen • ultrasound • CEA • CA125 • biopsy • thermography • colonoscopy • serum protein electrophoresis • bone marrow testing • blood screening
Mammography Examinations	$200	one baseline mammogram between age 35-39 one mammogram every two years age 40-49 one mammogram every year age 50+
Magnetic Resonance Imaging (MRI) Scan	$50	per calendar year for MRI scan used as diagnostic tool for breast cancer
Non-Local Transportation	Included	round-trip charges or private vehicle allowance, up to 750 miles at $0.40 per mile, when required non-local hospital confinement is more than 50 miles from residence for a covered person and an adult immediate family member during confinement; payable once per confinement
Family Member Lodging	$50	per day (maximum 50 days per 12 month period) for lodging expenses for an adult immediate family member when non-local hospital confinement is required

PRODUCT DETAILS

Outpatient Lodging	$50	per day (maximum 50 days per 12 month period) for lodging expenses for a covered person to receive radiation or chemotherapy on an outpatient basis if not available locally
Physical Therapy & Speech Therapy	$25	per treatment; limit one treatment per day
At-Home Nursing	$50	per day, up to the number of days of the prior hospital stay when admitted within 14 days of hospital discharge
Waiver of Premium	Included	waives premium for total disability due to cancer after 60 consecutive days of total disability; total disability must begin prior to the covered person's 70th birthday
Cancer Maintenance Therapy Benefit	**Plan 1 - 3.00 Units**	**Policy Pays**
• Cancer Suppressive Therapy • Hematological Drugs • Anti-Nausea Drugs • Motility Agents	$3,000	maximum benefit per 12-month period; pays actual charges
First Occurrence Rider (Rider Form Series CROCC100, 200 or 300)	**Plan 1 - 5.00 Units**	**Policy Pays**
Initial Diagnosis Benefit	$5,000	pays a one-time, lump-sum benefit when a covered person is initially diagnosed with cancer (except skin cancer), based on a microscopic examination of fixed tissue or preparations from the hemic system. Clinical diagnosis is accepted under certain conditions.

Actual charges means the amount actually paid by or on behalf of the insured and accepted by the provider as payment in full for services provided.

Monthly Premium	Individual	Single Parent Family	Family
Plan 1	$31.94	$36.40	$57.48

Issue State: California
Rate generation date: March 23, 2016

GENERAL ADMINISTRATIVE ISSUES

How to Apply - Organization

Your organization can apply for this insurance by providing us with your completed Life and Health Group Application and Agreement together with a copy of this proposal. Before approving, we may request additional information about your group. Upon approval, we will notify you when insurance becomes effective.

Group Master Policy Effective Date

Subject to our receipt and review of all necessary information, the group master policy takes effect on the date requested on the Life and Health Group Application and Agreement. There is no policy backdating.

How to Apply - Employees

An applicant should elect insurance that best meets his or her needs and those of his or her family. All questions on the application should be completed accurately. All applications are subject to our review and approval.

Individual Insurance Effective Date

Insurance is effective on the effective date requested on the Life and Health Group Application and Agreement or first day of the month following the date an individual's application is approved by us, whichever is later. The employee must be on active service and any dependents cannot be disabled for insurance to become effective.

Beneficiary

Employees designate their own beneficiaries. In community property states (AZ, CA, ID, LA, NM, NV, TX, WA, and WI), when someone other than the spouse is designated as the beneficiary, the spouse's consent is required. The employee will automatically be the beneficiary of any dependent insurance.

Current Disability and/or Premium Waiver

We do not provide insurance to an individual currently disabled on a premium waiver. In this case, it is assumed that the previous carrier, if any, should continue to provide the individual's insurance coverage.

Premium Payment

Premiums are paid conveniently through payroll deduction. You'll receive a bill each month.

Grace Period

A grace period of 31 days will be allowed for each premium payment after the first premium. Insurance will stay in force during this time. The coverage under the policy will terminate at the end of the grace period if the premium has not been paid. You must still pay all unpaid premiums. This includes the premium due for the grace period.

LIMITATIONS AND EXCLUSIONS

We provide benefits only for cancer as defined herein, which is positively diagnosed while coverage is in force. It does not provide benefits for any other illness or disease.

- We may reduce or deny a claim or void coverage for loss incurred by a covered person:
  - During the first 2 years from the effective date of such coverage for any misstatements in the application which would have materially affected our acceptance of the risk;
  - At any time for fraudulent misstatements in the application.
- We will only pay for loss as a direct result of cancer. Proof of positive diagnosis must be submitted to us for each new claim. We will not pay for any conditions other than those due to a covered cancer or its treatment.
- If a covered hospital confinement is due to more than one covered condition, benefits will be payable as though the confinement or expense were due to one condition. If a hospital confinement or expense is also due to a disease or condition that is not covered, benefits will be payable only for the part of the hospital confinement or expense due to the covered disease or condition.
- Under no condition will we pay any benefits for losses or medical expenses incurred prior to the effective date.

Pre-Existing Condition Limitation - No benefits are provided during the first 12 months for pre-existing conditions for which the covered person has been diagnosed, treated, or for which the covered person has incurred expense or has taken medication within 12 months prior to the effective date of such person's policy. Pre-existing condition also includes a condition that manifests itself in a way that would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment.

Total Disability means the inability to perform all of the material and substantial duties of the employee's regular occupation. Total Disability will be considered to exist when under the regular care and attendance of a physician for the necessary treatment of cancer. After the first two years of Total Disability, the employee will continue to be considered Totally Disabled if unable to engage in any employment or occupation for which he or she is or becomes qualified by reason of education, training, or experience. On or after age 65, Total Disability will mean that a physician has certified that the employee is unable to perform two or more Activities of Daily Living (continence, transferring, dressing, toileting, eating and bathing) without direct personal assistance as a result of cancer.

12-Month Benefit Period - The initial 12-Month Benefit Period is the 12-month period beginning on the date of positive diagnosis. Subsequent 12-Month Benefit Periods begin on the same month and day as the immediately preceding 12-Month Benefit Period; however, if the covered person incurs no covered loss during the 3 months after the end of any 12-Month Benefit Period, the next 12-Month Benefit Period will begin on the next date a covered loss is incurred. Benefit Periods are determined separately for each covered person.

First Occurrence Rider

Benefits are not payable:
- For cancer diagnosed prior to the Effective Date of this Rider;
- For any other illness or disease other than internal Cancer;
- For Skin Cancer or any Cancer excluded from coverage by name or specific description.

Termination of Insurance

Employee insurance will terminate on the earliest of:

- The date of the employee's death;
- The date on which the employee ceases to be eligible for insurance;
- The last date for which premium payment has been made to us;
- The last date on which employment terminates;
- The date the group master policy terminates; or
- The date the employee sends us a written notice to cancel insurance.

Dependent insurance will terminate on the earliest of:

- The date the employee's insurance terminates;
- The last date for which premium payment has been made to us;
- The date the dependent no longer meets the definition of dependent;
- The date the group master policy is modified so as to exclude dependent insurance; or
- The date the employee sends us a written notice to cancel dependent insurance.

We will have the right to terminate the insurance of any insured person who submits a fraudulent claim under the policy.

Portability Option

If an employee loses eligibility for this insurance for any reason other than nonpayment of premiums, insurance can be continued by paying the premiums directly to us within 31 days after termination. We will bill the employee directly once we receive notification to continue insurance.

Termination of the Group Master Policy

The policyholder may end the policy on any premium due date by submitting a 60-day advance written notice. A group will not be continued if it drops below the minimum required participation. The group master policy will be terminated and insurance of all remaining insureds will end, subject to the Portability Option.

Other Insurance with Us

An individual can only have one cancer policy or certificate with us. If a person already has cancer insurance with us, such person is not eligible to apply for this insurance.

DISCLOSURES

GROUP BENEFITS DISCLOSURE POLICY

Transamerica Employee Benefits (TEB) is a unit of Transamerica Life Insurance Company and Transamerica Financial Life Insurance Company. TEB markets and administers voluntary insurance benefits through licensed insurance agents. These agents are typically appointed to sell our products, and products of other providers, and receive various forms of compensation from us for the services provided. We believe our compensation arrangements with our agents are conducted with honesty, fairness and integrity. In addition, we realize that having trusted relationships between our agents and our customers is essential to all involved. To ensure this trust continues and to address any concerns within the industry, we have outlined our policy on agent compensation disclosure.

TEB's policy supports transparency and full disclosure of agent compensation to our customers and prospective customers. In addition, we have put controls in place to facilitate this disclosure and obligate our agents to disclose compensation information to customers: 1) when asked by a customer; 2) when receiving both a fee from the customer and compensation from TEB; and 3) when otherwise required by law. Agents must comply with all applicable laws in the sale of TEB products, including any pertaining to the disclosure of compensation information.

TEB's Group Benefits Compensation Disclosure Notice (below) describes the various means by which agents may be compensated for the sale of our products. It is the responsibility of your agent to share specific information with you about his or her compensation arrangements with TEB. Accordingly, please direct any compensation disclosure questions directly to your agent.

COMPENSATION DISCLOSURE NOTICE TO ALL POLICYHOLDERS

Agents who sell and service our products are paid a commission. It varies by the type of insurance policy sold and the state where the policy was sold, and is based on a percentage of the premium received in the first year, and at policy renewal. Agents may receive advances or loans against anticipated commissions for cases sold or to be sold. These advances may or may not require the payment of interest, depending upon the agent's total business and historical experience with TEB.

Agents may receive other compensation from TEB in the form of cash or non-cash awards or prizes, based upon a variety of factors that may include the level of premium written or earned, persistency and growth of premium, or other performance measures. Agents who manage, supervise or recruit other agents or wholesale our products and services to other agents, may receive commission overrides on business that results from their efforts.

Some of our agents may receive additional payments for providing services in connection with the administration of our products. Fees for such services may be calculated on a per policy or per certificate basis or upon the premium volume associated with a specific case. TEB may additionally reimburse these agents/administrators for certain expenses, such as the cost of mailings.

Agents may occasionally obtain exclusive rights to market TEB products or services to agents, employers, employees, or members of associations or unions. Certain groups or associations may also agree to endorse TEB's products to their members. TEB may pay a fee for these exclusive marketing rights or endorsements. See your proposed plan documents or policy certificate package for more information on any such arrangements.

Up to date information regarding our compensation practices can be found in the Disclosures section of our website at: www.tebcs.com.