ATTENTION – VERY IMPORTANT MESSAGE! To all hair professionals, barbers and cosmetologists. On behalf of our board of industry leaders, and myself, our trade association is pleased to bring real benefits and value to our profession. As independent business professionals, we have sought, and secured a guaranteed issue group health plan for our members. By working close with the leading life insurance company, Transamerica Life, we are now able to offer our members a lower cost group plan that will give you guaranteed coverage at a price you can afford.

We all know the difficulty in finding quality health care coverage at a reasonable cost. Most shop owners and operators do not qualify for traditional group health insurance coverage, and individual policies can be very expensive and difficult to qualify for. And even if you do, the annual price increases often make the coverage unaffordable in a few years.

So, we invite you to join the Barbers International's "PROFESSIONAL HAIR CARE HEALTH PLAN". We think you'll enjoy the excellent coverage, as outlined in the following pages, and you'll enjoy the peace of mind that your rates are stable.

Our plan does require you to be a member of Barbers International, an association of hair care professionals, just like you! Any licensed hair care professional, and related fields are welcome to join our association. Our regional conventions and workshops are all about bringing you up to date on industry trends and new products for your shop. So please join us and enjoy this benefit!

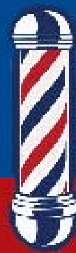
You don't have to struggle to find quality health insurance any longer. Transamerica Life has listen to us, and provided our industry with a great solution. You are welcome to keep this coverage if you move to another shop, or State! Coverage is available for yourself, spouse and even the whole family. And you don't have to worry about pre-existing medical conditions or waiting periods. You will be fully covered from your effective date, which will be the first of the month. And because this is a group plan, members of Barbers International will not be turned down for coverage.

On behalf of the staff at Barbers International, we welcome your membership, and we look forward to many years of professional service to you! Now, please take a few minutes and learn about us. We're easy to join, and with membership, you have access to our group plan. If you have trouble printing off the enrollment application, just give us a call and someone will assist you. Have a great and prosperous year!

Charles Kirkpatrick

Charles Kirkpatrick
Executive Director of Barbers International

Professional Hair Care Health Plan



Provided by The American Worker®

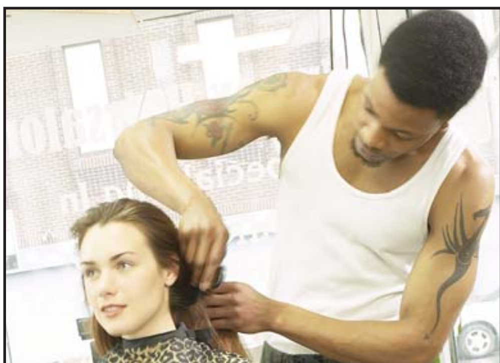
Attention Barber International Members
Do you need a clear solution to health insurance? National Association of Barber Boards approved the Transamerica Life Insurance Company's TransChoice Plus limited medical program that is designed to cover your basic healthcare needs.

Are you tired of high cost plans that pay very little? Do you want more than a discount plan?

You can now enjoy lower cost - guarantee issue **health insurance** from Transamerica Life Insurance Company designed for the Barber/Cosmetology Professional. Your rates do not increase with age.

KEY FEATURES OF THE PLAN

- Guarantee Issue
- First Dollar Coverage
- No Pre-existing Condition Limitations
- No Deductibles or Co-insurance
- No Networks Required for Medical Benefits
- No Benefit Waiting Periods
- No Coordination of Benefits - Plan pays in **addition** to other insurance you may have



COVERED SERVICES INCLUDE

- Doctor's Office Visits
- Diagnostic Tests, X-Rays, and Lab Work
- Wellness Exams
- Critical Illness
- Maternity
- Discounted Health Services
- Accidental Injury Care
- Hospital Stays
- Surgical Procedures
- Anesthetics
- PPO Benefit
- Prescription Benefits

For any questions that you may have on the program contact Alan Laney at 1-800-353-0059.

Open enrollment for a June 1, 2008 effective date ends on May 9, 2008.

Barber and Cosmetology Professionals will be required to complete the TransChoice Plus application and a Bank Draft Form to enroll in the program and mail to:

Barber Benefits
P.O. Box D
Camden, AR 71711

To All Barber International Members: We are very excited to introduce a new package of HEALTH BENEFIT PLANS. **The TransChoice® Voluntary Limited Benefit Medical Plan** provides **immediate first dollar coverage** with **no deductibles** and **no coinsurance requirements**. This health plan is **fully insured** with **limited network restrictions** (Network use is required for the Non-Insurance Prescription Card, New Benefits Discount Program, and PPO Network Benefit), offered by Key Benefits Administrator, Inc. Benefits are paid directly to the provider, unless the insured elects for reimbursement of medical benefits.

The first step in maintaining good health is having the ability to choose any family physician or medical facility for treatment. Please review the benefit summary below to find out which plan is most suitable for you and your family's current situation.

Included in both plans is the Prescription Card, New Benefits Discount Program, and PPO Network Benefit!

PHARMACEUTICAL BENEFITS - BEST Rx - Provided by Rx Options, Inc. - Network Use Required

Tier 1 - Pay up to $10 for Select Generic and Brand Name Drugs for a typical 30-day supply
Tier 2 - Pay up to $20 for Select Generic and Brand Name Drugs for a typical 30-day supply
Tier 3 - Pay up to $50 for Select Generic and Brand Name Drugs for a typical 30-day supply
Tier 4 - Discounts averaging 19% off the average wholesale price for Non-Select Generic and Brand Name Drugs for a typical 30-day supply
No Annual Maximum, No Deductibles, and No Claim Forms

"NEW BENEFITS" CARD - This program offers members discounts on health services and provides them with access to medical information

Health Service Discounts: **Vision** - Save up to 60% **Hearing** - Save up to 50% (Network use required)
Medical Information: Access to a 24 hour **Nurse Hotline** Access to **Counseling services** and **discounted referrals**

PPO BENEFIT - NATIONAL PREFERRED PROVIDER NETWORK (NPPN) - Members have access to a **PPO Network**, which provides discounts on **Hospital** and **Physician** services. Using the **PPO Network** may lower out-of-pocket medical expenses. The **NPPN network** is comprised of more than 450,000 **physician** locations, nearly 4,000 **acute care** facilities, and more than 65,000 **ancillary care** provider locations. Network use is required.

	STANDARD	PREFERRED
Doctor's Office Visits • Calendar Year Maximum	Pays $70 per Visit, Maximum 6 Visits	Pays $90 per Visit, Maximum 6 Visits
Preventive Care • Calendar Year Maximum	Pays $50 per Visit, Maximum 1 Visit	Pays $200 per Visit, Maximum 1 Visit
Accident Benefit • Calendar Year Maximum	Up to $500 per Occurrence, Maximum 5 Accidents	Up to $1,000 per Occurrence, Maximum 5 Accidents
Diagnostic, X-Ray, and Lab • Calendar Year Maximum	Pays $100 per Visit, Maximum 3 Testing Days	Pays $250 per Visit, Maximum 3 Testing Days
Emergency Room Sickness • Calendar Year Maximum	Pays $100 per Visit, Maximum 2 Visits	Pays $200 per Visit, Maximum 2 Visits
Surgical Benefit	Pays $1,000 per Surgery (According to a Schedule)	Pays $2,000 per Surgery (According to a Schedule)
Anesthesia Benefit	20% of Surgical Benefit	20% of Surgical Benefit
Critical and Subsequent Critical Illness	Pays $5,000	Pays $10,000
Daily In-Hospital • Calendar Year Maximum	Pays $300 per Day, 30 Days per Confinement	Pays $750 per Day, 30 Days per Confinement
Monthly Rates		
Member:	**$99.63**	**$174.66**
Member + Spouse:	**$158.48**	**$296.18**
Member + Child(ren):	**$143.40**	**$272.82**
Family:	**$202.84**	**$395.56**

IMPORTANT NOTICE

This is a Benefit Plan highlight sheet and is not intended to be a complete or legal description of the program of benefits. Complete information is available immediately upon request before you enroll through your association and will also be provided to you in the certificate of insurance or member benefit booklets for the various programs in which you may voluntarily choose to participate. This program is not intended to replace, nor do we recommend that it replace any comprehensive program of insurance in which you currently participate, or are considering participation in.

Frequently Asked Questions

Benefits Offered to Barber International Members

Question: Who is Key Benefit Administrators (KBA)?
Answer: KBA is a Third Party Administrator that handles all customer service and claims processing on behalf of Transamerica Life Insurance Company, the insurance carrier for the The Professional Hair Care Health Plan.

Question: Is there a PPO Network for Medical Benefits?
Answer: Yes, however its use is not required. Benefits are paid at the stated amounts in or out of the network. However, your claim will be repriced from the full price to a significantly reduced amount if you use a network provider, resulting in lower out of pockets costs.

Question: How do I find a network provider?
Answer: Go to www.nppn.com and click on the provider look up search tool and select which type of provider you were trying to identify.

Question: What is covered under the plan?
Answer: Doctor's office visits, diagnostic tests, prescription drugs, accidents, and more. See the schedule of benefits for more information.

Question: What happens if I need to go to the doctor more times than is covered?
Answer: You would be responsible for the cost of any visits that take place after you exceed the number allowed by the plan. If you use a network provider, you would still receive the benefit of network discounts for charges incurred after the plan limits are reached, which lowers your out of pocket costs.

Question: How are claims filed? Do I receive an Identification Card and Plan Certificate?
Answer: Yes, you will receive, in the mail, an Identification Card and Plan Certificate describing the benefits you have elected. Present your Identification card to the Provider – doctor, hospital, laboratory, etc. – most providers will file claims on your behalf.

Question: How can I find out what pharmacies are included in the discount pharmacy network?
Answer: Go to www.awpbestrx.com. You will be able to determine which pharmacy is located close to you by zip code. There is a lot of information on this website for you to review.

Question: Can I be turned away for a pre-existing condition?
Answer: No, members or their eligible dependents won't be turned down for coverage due to a pre-existing condition when enrolling during an open enrollment period. If you elect to enroll at a time other than the open enrollment period you will be subject to medical questions to determine insurability by the carrier. You will be notified if you are be accepted or rejected.

Question: Can I cancel or change the plan after I sign up?
Answer: You can only make Plan Selection changes once a year at open enrollment but you can cancel your coverage at anytime. However, you can make a change mid-year if you have a qualifying event, which includes the following. The change must be consistent with the qualifying event. Qualifying events include birth of a child, marriage, divorce/legal separation, adoption, death of a spouse/child, change in employment or group coverage status.

Question: Who do I call if I need help with or have questions about this Limited Medical plan?
Answer: Help is just a phone call away! Contact Alan Laney at 1-800-353-0059.

Question: How do I enroll in the health plan of benefits?
Answer: All current Barber International members will be required to complete the TransChoice Plus application and the bank draft form to enroll in the program and mail to Barber Benefits, P.O. Box D, Camden, AR 71711 by May 9, 2008 for an effective date of June 1, 2008.

TRANSAMERICA
LIFE INSURANCE COMPANY

Transamerica Life Insurance Company *("insurer")*
Home Office: Cedar Rapids, IA
Administration Provided By: **Key Benefit Administrators**
P.O. Box 1279, Fort Mill, SC 29716-1279
1-866-867-6883

TransChoice® Plus Employee Enrollment Form

☐ First Application ☐ Add Dependents – Certificate # ________ ☐ Increase Coverage – Certificate # ________

Group Name	Group Number	Location

Employee (Last, First, M.I.)	☐ Male ☐ Female	Social Security No.	Date of birth	Date of marriage***
Spouse** (Last, First, M.I.)	☐ Male ☐ Female	Social Security No.	Date of birth	

Date of hire	Avg hours worked per week	Annual salary	Occupation	Employee ID
Home address				Work phone/ext.
City	State	Zip code		Home phone

Child(ren) name	Date of birth	Gender	Full time student	Child(ren) name	Date of birth	Gender	Full time student
________	________	☐M ☐F	☐Yes ☐No	________	________	☐M ☐F	☐Yes ☐No
________	________	☐M ☐F	☐Yes ☐No	________	________	☐M ☐F	☐Yes ☐No

Primary Beneficiary: (Last, First, M.I.)	Relationship:
Contingent Beneficiary: (Last, First, M.I.)	Relationship:

*Employee will be the beneficiary for any spouse** and/or child(ren) coverage*

Payroll Mode: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other________

I Am Applying For: ☐ Employee ☐ Employee Plus Spouse** ☐ Employee Plus Children ☐ Employee Plus Family

	Coverage		Premium per pay period*
☐	TransChoice Plus Basic Coverage		$
	ADDITIONAL COVERAGE: ***(Only available if included in the plan selected by your employer)***		
☐	Short Term Disability	Monthly Benefit*: ☐ $400 ☐ $600 ☐ $800	$
☐	Term Life/AD&D – Employee	Coverage Amount*:	$
☐	Term Life/AD&D – Spouse**	Coverage Amount*:	$
☐	Term Life/AD&D – Child(ren)	Coverage Amount*:	$
		Total Premium	$

*If increasing coverage, enter the **TOTAL** Monthly Benefit, Coverage Amount and Premium.

Is anyone proposed for coverage covered by any Title XIX program (e.g. Medicaid)? *(Residents of KY or VA- do not answer.)* ☐ Yes ☐ No
If "Yes", List name(s)________________________________, who will be excluded from coverage.

APPLICANT'S STATEMENTS AND AGREEMENTS:

I represent that all statements and answers made on or attached to this application are true to the best of my knowledge and belief, and realize that any false statements herein which materially affect the acceptance of the risk or the hazard assumed may result in loss of coverage under the policy/certificate to which this application is attached.

All states except FL, LA, NJ, or VA- I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties (may be a crime and may subject such person to criminal and civil penalties in OR).

FL- I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

LA- I understand that any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NJ- I understand that any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

VA- I understand that any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements may have violated state law.

I also understand that coverage will become effective only after all of the following conditions have been met: a) I must be a member of an eligible class of employees; b) I must have satisfied the employer waiting period; c) the employer group must have met the insurer's minimum participation requirement; d) I must satisfactorily answer all questions on this form; e) I must be actively at work, and for my dependents, they must not be disabled, on the effective date (according to the insurer's rules); and f) the first months premium must have been received by the underwriting company at its administrative office.
Lastly, I understand that completion of this enrollment form in no way implies that I will be accepted for insurance coverage.

Signed in (City/State) ________________ This ________ Day of (Month/Year) ________________ .

Employee's Signature ________________ Spouse's** Signature (if applicable) ________________

Licensed Representative's Name ________________ Licensed Representative's Signature ________________ Agent # ________

**Spouse or equivalent, as defined by governing state law. ***Marriage or equivalent, as defined by governing state law.

Payment method ****Payment is made via Electronic Funds Transfer ONLY for Insurance Premium****

Please Select Choice of Monthly Payment: _____or Annual Payment: _____

Bank Routing Number: _________________Bank Account Number: ____________________

If you are now joining Barbers International, please enclose one check in the amount of the annual dues of $60.00. If you are also joining the Group Insurance Plan, please mark your selection. Your account will be *automatically drafted* the first week of the month for your insurance premium. If you are already a member of Barbers International, and are joining the Group Insurance, please enclose a VOIDED check with your enrollment application. Please sign below.

I authorize Barbers International, Inc. and the BANK indicated above to debit my health insurance premium from my checking or savings account listed above. This authority is to remain in full force and effective until my BANK has received written notification from me of the Pre-Authorized Bank Draft termination in such time and such manner as to afford the BANK a reasonable opportunity to act on my request, or until the BANK has sent me 10 days written notice of the bank's termination of this agreement. An un-honored draft request will result in the immediate termination of coverage.

I understand that by revoking the Pre-Authorized Bank Draft after I have agreed to it, I will also be terminating my health insurance coverage.

Signature of Applicant: ________________________________Date: ___________________