

Brunswick County Government is offering all full-time employees a comprehensive Cafeteria Benefits program. The Cafeteria Benefits program is being arranged by Mark III Brokerage, an employee benefits firm that Brunswick County Government has been working with for many years.

The Cafeteria Benefits program allows you to pay for certain insurance premiums, child-care, and unreimbursed medical expenses before taxes are taken out of your paycheck. Paying for these benefits by this method reduces your income & FICA taxes and increases your take home pay.

- The Plan Year is from July 1st, 2010 through June 30th, 2011.
- A Mark III representative will be conducting enrollment meetings in various departments outlining all of the benefits below. All eligible employees are asked to attend a group meeting. This will ensure that all employees understand what benefits are offered.

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All information in this booklet is a brief description of your coverage and is not a contract. Read your certificate for each product for the exact terms and conditions.

Flexible Benefit Administrators Spending Accounts

PLAN YEAR: JULY 1, 2010 - JUNE 30, 2011

HEALTH CARE FLEXIBLE SPENDING ACCOUNT MAXIMUM: \$2,400

HEALTH CARE FLEXIBLE SPENDING ACCOUNT MINIMUM: \$120

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT MAXIMUM: \$5,000

FLEXIBLE BENEFIT PLAN: THE BETTER YOU PLAN, THE MORE YOU SAVE!

It's more than a slogan. The Flexible Benefit Plan is a real solution to issues facing all of us. Simply stated, by taking advantage of tax laws, the Flexible Benefit Plan works with your benefits to save you money.

Your insurance programs are designed to help you and your family become financially secure as well as to protect you against the high cost of medical care including catastrophic events. However, almost everyone has a number of necessary, predictable expenses that are not covered by your insurance programs. The Flexible Benefit Plan will help you pay for these predictable expenses.

The Flexible Benefit Plan offers a unique way to help pay for some of your health care expenses and dependent care expenses.

The key to the Flexible Benefit Plan is that your eligible expenses are paid for with Tax Free Dollars. You will not pay any federal, state or social security taxes on funds placed in the Plan. You will save between, approximately, \$27.65 and \$37.65 on every \$100 you place in the Plan. The amount of your savings will depend on your federal tax bracket.

Using the Flexible Benefit Plan can save you a significant amount of money each year, however, it is important that you understand how the Plan works and how you can make the most of the advantages the Flexible Benefit Plan offers.

This chapter will help you understand the Flexible Benefit Plan. The chapter covers how the Plan works, describes the categories of the Plan, explains the rules governing the Plan, the reimbursement process and how you can elect to participate in the Flexible Benefit Plan. Prior to electing to participate in the Flexible Benefit Plan, it is important that you read and understand the Rules and Regulations section of this handbook.

After you read this material, if you have any questions please feel free to contact **Flexible Benefit Administrators, Inc. at (757) 340-4567 or (800) 437-FLEX.**

FLEX NOTE: FLEX is authorized by Section 125 of the Internal Revenue Code.

HEALTH CARE REIMBURSEMENT ACCOUNT

The Health Care Reimbursement Account allows you to pay for your uninsured medical expenses with pre-tax dollars. With this account, you can pay for your out of pocket medical expenses for yourself, your spouse and all of your dependents for medical services that are incurred during your Plan Year. The maximum you may place in this account for the upcoming Plan Year is \$1,200.

EXAMPLES OF ELIGIBLE HEALTH CARE EXPENSES: FEES/CO-PAYS/DEDUCTIBLES:

- Acupuncture
- Ambulance hire
- Anesthetist
- Chiropractor
- Dental Fees
- Diagnostic
- Eye Exams
- Prescription Eye glasses/
Contact lenses
- Psychiatrist
- Hospital
- Laboratory
- Nursing
- Obstetrician
- Laser Eye Surgery
- Physician
- Psychologist
- Erectile dysfunction
medication
- Sterilization Fee
- Surgery
- X-Rays
- Wheel Chair

OTHER ELIGIBLE EXPENSES:

- Prescription drugs
- Artificial limbs & breasts
(only if reconstructive)
- Birth control pills, patches
(e.g. Norplant)
- Orthopedic shoes/inserts
- Incontinence supplies
- Carpal tunnel wrist supports
- Vaccinations & Immunizations
- Elastic hose
(medically prescribed)
- Contact lens supplies
- Therapeutic care for drug
and alcohol addiction
- At home pregnancy test kits
- Smoking cessation programs and prescribed drugs designed to
alleviate nicotine withdrawal
- Mileage, parking and tolls (you may be reimbursed \$.24* a mile plus
parking and tolls when medical reasons make it necessary to travel)
- Tuition fees for medical care (if the college furnishes a breakdown of
medical charges)
- Orthodontic expenses (not for cosmetic purposes)
- Diabetic supplies
- Routine Physicals
- Condoms
- Dentures
- Oxygen
- Physical Therapy
- Fertility Treatments
- Hearing aids and batteries
- Reading glasses
- Medical equipment
- Pedialyte for dehydration
- Nicotine gum/patches
- Take-home screening kits (HIV,
colon cancer)

NOTE: ORTHODONTIC TREATMENT IS REIMBURSED ACCORDING TO YOUR PAYMENT PLAN WITH THE ORTHODONTIST. FOR EXAMPLE: If your payment plan is set up to pay \$100 a month for the orthodontic treatment, you can be reimbursed \$100 a month for the payments that become due during the Plan Year.

This above list is compiled from IRS publication 502. If you are unsure that your expected medical expense will be eligible under tax code regulations, please call Flexible Benefit Administrators at (757) 340-4567 or (800) 437-FLEX before making your election for the Plan Year. IRS publication 502 can be ordered by calling the IRS at (800) 829-3676.

* Mileage reimbursement rate is based on IRS regulation and subject to change.

OVER-THE-COUNTER DRUGS

PLEASE BE ADVISED THAT RECENT SENATE LEGISLATION HAS STATED THAT EFFECTIVE JANUARY 1, 2011, PARTICIPANTS ARE REQUIRED TO HAVE A PRESCRIPTION FOR OVER-THE-COUNTER (OTC) PRODUCTS TO BE ELIGIBLE UNDER THEIR FSA PLAN. BASED ON OUR CURRENT UNDERSTANDING OF HOW THE LEGISLATION WILL BE IMPLEMENTED, A PRESCRIPTION OR LETTER OF MEDICAL NECESSITY WOULD BE REQUIRED AFTER JANUARY 1, 2011 FOR OTC ITEMS.

ELIGIBLE OVER-THE-COUNTER EXPENSES

- Examples of eligible medications and drugs purchased in reasonable quantities:
 - Antacids
 - Pain relievers/aspirin
 - Ointments & creams for joint pain
 - Nicotine gum/patches to stop smoking
 - First aid creams (Bactine, diaper rash)
 - Allergy & sinus medication
 - Cough & cold medications
 - Laxatives
 - Anti-diarrhea medicine
 - Bug-bite medication

OVER-THE-COUNTER EXPENSES THAT ARE NOT ELIGIBLE

- The following examples are OTC items that are not eligible and will not be reimbursed under any circumstances because the items are considered dietary supplements, toiletries, cosmetic or personal use items:
 - Multi/Daily Vitamins
 - Weight loss products/foods
 - Face cream/moisteners
 - Mouthwash/toothpaste
 - Feminine hygiene products
 - Deodorant
 - Chapstick
 - Suntan lotion
 - Herbal/natural supplements
 - Acne creams/face cleanser
 - Medicated shampoo/soaps
 - Toothbrushes (even if dentist recommends a special one)
 - Eye/facial makeup/preparations
 - Rogaine

DUAL PURPOSE DRUGS & ITEMS

EXPENSES THAT NEED DOCUMENTATION FROM YOUR PHYSICIAN TO BE ELIGIBLE THROUGH THE HEALTH CARE ACCOUNT

- The following items are examples of products that are considered as having both a medical purpose and a general health, personal/cosmetic purpose and require a medical practitioner's note stating the name of the patient, the specific medical condition for which the OTC is recommended, the time frame of the treatment and that the treatment is not cosmetic:
 - Weight-loss drugs (to treat obesity)
 - Prenatal vitamins
 - Nasal sprays for snoring

- Pills for lactose intolerance
- Fiber supplements (to treat a medical condition for a limited time)
- OTC Hormone therapy (to treat menopausal symptoms)
- Glucosamine/Chondroitin (for arthritis)
- St. John's Wort (for depression)

EXPENSES FOR IMPROVEMENT OF GENERAL HEALTH are not eligible for reimbursement even if a doctor prescribes the program. However, if the program is prescribed for a specific medical condition (e.g. Obesity, Emphysema), then the expense would be eligible. We must have a letter from your doctor on file for each Plan Year stating specifically what illness or disease is being treated or prevented and the length of time you will be required to use this treatment in order to reimburse for any of these types of expenses.

- | | |
|------------------------|--------------------|
| • Health Club Dues | • Exercise classes |
| • Weight Loss Programs | • Breast Pumps |
| • Exercise equipment | • Wigs |

NOTE: For Weight Loss Programs, only the cost of the program is an eligible expense. Any cost for food or food supplements is not an eligible expense.

COSMETIC expenses, prescriptions and treatments are not eligible. This applies to any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat an illness or disease. If cosmetic treatment is necessary to correct a deformity or abnormality, a personal injury or a disfiguring disease, it must meet IRS eligibility guidelines outlined in IRS publication 502 and will require a physician's letter of medical necessity.

OTHER EXPENSES THAT ARE NOT ELIGIBLE FOR REIMBURSEMENT THROUGH THE HEALTH CARE ACCOUNT

ESTIMATES for medical expenses that have not been rendered cannot be reimbursed. Medical services do not have to be paid for, however, the services must have been rendered during the Plan Year, to be eligible for reimbursement.

PREMIUM EXPENSES for any insurance policies are not eligible for reimbursement through the Health Care Account. This includes contact lens insurance.

EXPENSES PAID BY AN INSURANCE COMPANY are not eligible for reimbursement through the Health Care Account. Only the portion you have to pay out of your pocket for your medical expenses is eligible for reimbursement.

CLAIMS SUBMISSION

OBTAINING A REIMBURSEMENT FROM YOUR HEALTH CARE ACCOUNT

To obtain a reimbursement from your Health Care Account, you must complete a Claim Form. This form is available from your employer's website (See sample Claim Form on page 17). You must attach a receipt or bill from the service provider which includes all the pertinent information regarding the expense:

- Date of service
- Patient's name
- Amount charged
- Provider's name
- Nature of the expense
- Amount covered by insurance (if applicable)

Cash register receipts, credit card receipts and canceled checks alone are not eligible forms of documentation for medical expenses. These items are not considered third party receipts because they only reflect that payment has been made and do not provide the required information listed above. Prescription documentation must include the name of the prescribed medication.

OBTAINING A REIMBURSEMENT FOR OVER-THE-COUNTER ITEMS

For the purchase of over-the-counter medications and items exclusively, cash register receipts will be accepted as documentation if the receipt is detailed and indicates the name of the service provider, the date of the purchase, the amount of the purchase and the name of the product purchased. If the receipt does not specifically reflect the name of the product we cannot accept the claim for reimbursement of that item. The name of the patient does not have to be on the receipt, however, the name of the patient must be listed on the claim form.

NOTE: In order to be eligible for reimbursement through the Health Care Account, the medical expense must be incurred during the Plan Year. IRS defines "incurred" as when the medical care is provided (or date of service), not when you are formally billed, charged for, or pay for the care. **FOR EXAMPLE:** If you go to the doctor on June 26th and your Plan Year begins on July 1st, this expense is not eligible in the new Plan Year. Even if you pay for this expense after July 1st, the "date of service" was before the Plan Year began and therefore is not eligible.

THE HEALTH CARE ACCOUNT IS A PRE-FUNDED ACCOUNT

This means that you can submit a claim for medical expenses in excess of your account balance. You will be reimbursed your total eligible expense up to your annual election. The funds that you are pre-funded will be recovered as deductions continue to be deposited into your account throughout the Plan Year.

DEPENDENT CARE REIMBURSEMENT ACCOUNT

The Dependent Care Reimbursement Account allows you to pay for day care expenses for your dependents with tax-free dollars.

ELIGIBLE DEPENDENT

- A child under 13 who qualifies as a dependent on your Federal Income Taxes
- Any other dependents, including a disabled spouse, disabled children over age 13 and elderly parents, who depend on you for financial support, qualify as dependents for tax purposes, and are incapable of self care
- Please refer to Page 12 for the latest definition of a dependent, as revised under Section 152 of the Code by the Working Families Tax Relief Act of 2005 (WFTRA)

ELIGIBLE DEPENDENT CARE EXPENSES

For dependent care expenses to be eligible for reimbursement, you must be working during the time your eligible dependents are receiving care. If you are married, your spouse must be:

- Working at the time the day care services are provided;
- A full-time student for at least five months during the year; or
- Mentally or physically disabled and unable to provide care for him or herself

EXPENSES FOR KINDERGARTEN are not eligible for reimbursement since they are generally for education, and not for custodial care. In order for an expense to be eligible for reimbursement from the Dependent Care Reimbursement Account, the primary purpose for the care of the qualifying individual must be to assure the individual's well-being and protection. Dependent care must still be primarily for custodial care, not education, in order to qualify as an eligible employment-related expense from the Dependent Care Reimbursement Account.

EXAMPLES OF DEPENDENT CARE EXPENSES

- Babysitters or Nannies that claim the child care as income on their taxes
- Licensed day care centers
- Private Preschool
- Before and after school care
- Day care for an elderly or disabled dependent

EXPENSES THAT WOULD NOT BE ELIGIBLE THROUGH THE DEPENDENT CARE ACCOUNT

- Kindergarten (kindergarten & above is considered an educational expense)
- Days you or your spouse are not working, including sick leave, vacation days, and maternity leave
- Transportation, books, clothing, or entertainment (Note: These expenses will be covered if provided by the nursery school or day care center as part of its preschool care services. If these types of expenses are billed separately, they are not an eligible expense.)
- Care provider may not be a child of yours under the age of 19 or anyone you claim as a dependent for federal income tax purposes

- Babysitting for social events
- Overnight camp is not an eligible expense, only DAY CAMPS are eligible.
Remember that this account is set-up so that you and your spouse are able to go to work and Overnight camp is 24-hour care.

ANNUAL MAXIMUM FOR THE DEPENDENT CARE REIMBURSEMENT ACCOUNT

Must Not Exceed The Lesser Of:

- \$5,000 for one or more children (\$2,500 if you are a married individual filing a separate tax return);
- Your wages or salary for the Plan Year; or
- The wages or salary of your spouse

If your spouse is either a full time student or is incapable of taking care of himself or herself then he or she is deemed to have monthly earnings of \$250 if there is one (1) child or dependent, and \$500 if there are two (2) or more children or dependents.

USING THE DEPENDENT CARE REIMBURSEMENT ACCOUNT VERSUS FILING FOR A TAX CREDIT ON YOUR TAXES

Under current IRS regulations, you may be eligible to receive a tax credit for dependent care costs. You may claim a credit for dependent care, up to \$3,000 for one child and \$6,000 for two or more children, on your income taxes through the child care tax credit. However, through the Dependent Care Reimbursement Account you may set aside up to \$5,000 per year, for one or more children, if you are married and filing a joint tax return or if you are a single parent. If you are married and filing separate tax returns, you may set aside only \$2,500.

Typically, more money is saved by paying for dependent care through the FSA Dependent Care Reimbursement Account than by taking the dependent care credit on your tax return. This is because the total for federal, state, and FICA savings usually exceeds the dependent care credit. At taxable incomes greater than \$14,000, participants will probably benefit more from taking reimbursement from the Flexible Benefit Plan. These assumptions are based on the inclusion of your state income tax.

You can also file for the tax credit while participating in the Dependent Reimbursement Care Account. If the amount you have placed through the reimbursement account does not meet the maximum allowed by the IRS, you can claim the difference between your Dependent Care deductions and the IRS maximum allowable expenses for the tax credit. You can claim a tax credit for any additional dependent care expenses incurred over the \$5,000 maximum FSA limit up to the \$6,000 child care tax credit limit on your taxes. You cannot claim the tax credit for any dependent care expenses paid from the Dependent Care Reimbursement Account. It is your responsibility to report the Dependent Care amount on your tax form 2441. The amount is listed on your W-2 under Dependent Care Benefit for the tax year.

If you are not sure about the eligibility of an expense, phone **Flexible Benefits Administrators at (757) 340-4567 or (800) 437-FLEX** or refer to IRS Publication 503: "Dependent Care Expenses". This publication can be ordered by calling the IRS at (800) 829-3676.

OBTAINING A REIMBURSEMENT FROM YOUR DEPENDENT CARE REIMBURSEMENT ACCOUNT

To obtain a reimbursement from your Dependent Care Reimbursement Account you must complete a Claim Form. This claim form is available from your employer's website (See sample Claim Form on page 17). You must attach a receipt from the service provider which includes all of the following:

- Name of dependent receiving care
- Date(s) care was provided (must match Claim Form)
- Name of service provider
- Social Security or Tax I.D. number of the provider
- Amount of the charge

NOTE: Dependent care expenses can only be reimbursed after the care is provided. This means that advance payments of dependent care expenses cannot be made. FOR EXAMPLE: If you pay for a summer day camp for your child in May but the camp is the first week in July, we cannot reimburse you for this expense until July when the service is provided.

THE DEPENDENT CARE REIMBURSEMENT ACCOUNT IS NOT A PRE-FUNDED ACCOUNT

This means that you will only be reimbursed up to your account balance at the time you submit your claim. If your claim is for more than your account balance, the unreimbursed portion of your claim will be tracked by Flexible Benefit Administrators. You will be automatically reimbursed as additional deductions are taken and deposited into your account, until your entire claim is paid out.

THE BENEFITS CARD

The Benefits Card system allows you to pay for eligible pre-tax account expenses electronically at approved service providers and merchants. The Benefits Card provides you with instant access to your pre-funded Health Care Reimbursement Account for many common regular eligible expenses. You may also enjoy the convenience of paying for your childcare expenses (up to your account balance at the time of the “swipe”) with the Benefits Card.

In order for you to get the most benefit from your Plan, we want to remind you of a few things concerning the Benefits Card:

- The Benefits Card works just like a debit card, only your “bank account” consists of the funds you elected to set aside in your pre-tax account(s). The card is not eligible for use at ATM’s or other unqualified merchant locations. The card will be denied at the point of sale when use at an ineligible location is attempted. If an eligible provider does not accept MasterCard®, you must file a proper claim. *When using the card at a self-service merchant terminal, select the **credit option**, not the debit option (**there is no PIN #**).
- Your card will be mailed to your home address via first class mail. Please allow up to two weeks for delivery of your card. If you do not receive your card two weeks after the start of your Plan Year, contact Flexible Benefit Administrators, Inc. so that a replacement card may be ordered. Any eligible expense incurred during that time may be reimbursed by mailing or faxing a claim form, and receipts to Flexible Benefit Administrators, Inc., following the customary claims filing procedure and cutoff times.
- When you receive your card, sign the back of the card prior to using it. Your card is activated upon the first swipe of the card.
- **Continue to save all receipts.** Flexible Benefit Administrators, Inc. may request them to verify expense eligibility.
- Flexible Benefit Administrators, Inc. will notify you by mail or e-mail if you incur an expense with the card that is or appears to be ineligible. Upon this notice you must send Flexible Benefit Administrators a Transaction Substantiation Form with the corresponding itemized documentation within 40 days of the transaction. If you do not send in those required items, your card will be deactivated until the documentation is received.
- Your transaction will be denied for any amount greater than your health care reimbursement account annual election or your dependent care reimbursement account posted balance at the time of the “swipe”.
- You should notify Flexible Benefit Administrators, Inc. immediately if your card is lost or stolen to deactivate the card. If your employment is terminated, you must surrender the card to your employer.
- You may monitor your account balance, transaction history or print a statement at any time, night or day on the Benefits Card website:
www.benefitspaymentsystem.com.
- Additional information regarding the Benefits Card is available on the website: **www.flex-admin.com**. You may also download the Transaction Substantiation Form from the website under Participant Forms.

Attention: Benefits Card Participant - Subject: Benefits Card Use

In light of IRS Rulings on Benefits Card use, it is important that you make yourself familiar with the cardholder agreement that accompanies your Benefits Card. Flexible Benefit Administrators, Inc. strongly suggests reviewing this document and making yourself and any dependent cardholders in your household aware of the terms.

Please be aware that upon receipt and signing of your Benefits Card, you, as the cardholder and employee participant of the Plan are ultimately responsible for using the card for eligible expenses. This also applies to any dependent that has use of the Benefits Card. By signing the back of the card, the employee/dependent is agreeing to the terms and conditions of this agreement.

As in the past, your responsibility as a participant in a tax-free plan, is to use the card for eligible expenses ONLY (such as prescriptions, eyeglasses and medical co-pays, etc.) As with paper claim submission, cosmetic prescriptions and procedures as well as over the counter medications and products are not eligible for reimbursement. Please remember that each time you use your card you are certifying that the expense is eligible. If you have any doubt as to whether an expense is eligible or not you should refer to your employee handbook, IRS Publication 502 or call our office to speak with one of our administrators. It is also your responsibility to acquire all documentation such as receipts, EOBs, etc. for the Plan Year's expenses and to retain the documentation for the entire Plan Year. If you are aware that you have paid for an expense with the card that is ineligible it is your responsibility to notify Flexible Benefit Administrators, Inc. immediately. You will need to submit a paper claim form with substantiating documentation along with repayment for the amount of the ineligible expense.

Flexible Benefit Administrators, Inc. may request documentation to substantiate your Benefits Card transactions to determine eligibility of the expense. Please be aware that documentation for all over-the counter drugs will be required, as per IRS regulations.

In the event that your documentation shows ineligible expenses were paid with your Benefits Card, Flexible Benefit Administrators, Inc. will request that you re-pay the amount of the ineligible expense. If the payment is not received in the allotted time frame your card will be de-activated. Also, Flexible Benefit Administrators, Inc. may offset future claims and notify your employer. IRS rulings allow your employer to withhold this amount from your wages if necessary. The Benefits Card is NOT PAPERLESS, just less paper and is a great convenience for the participants in the Plan if used properly.

PLEASE NOTE: Eligible items purchased at participating Inventory Information Approval System (IIAS) merchants will be automatically approved! When purchasing prescriptions and/or over-the-counter FSA-eligible items, the merchant's IIAS will verify the items and automatically approve the transaction with no follow-up request. Effective January 1, 2009, the Benefits Card will no longer be accepted at merchants who have not implemented IIAS. Please visit www.sig-is.com and select "IIAS Merchants List" for the most recent list of IIAS merchants.

RULES AND REGULATIONS

CLAIM FILING DATES

All claims received in the office of Flexible Benefit Administrators, Inc. will be processed within one week.

COMMON ERRORS TO AVOID WHEN FILING CLAIMS

- The claim form is not signed
- Canceled checks, cash register receipts or credit card receipts are sent in place of receipts or bills from the provider of service
- Cash register receipts for OTC item(s) do not indicate the specific name of the product(s) purchased
- Claim form has not been completed
- Insufficient postage on envelope
- "Previous balance" statements or "payment on account" receipts submitted in place of actual date of service itemized bills or receipts

Your claim form may be returned to you or delayed in processing for improper or insufficient documentation. If you have questions about your claims, you may contact Flexible Benefit Administrators, Inc. at **(757) 340-4567** or **(800) 437-FLEX**, from 8:30 a.m. to 5:00 p.m., Monday through Friday.

REIMBURSING THE PROVIDER OF SERVICE

All reimbursements will be sent to you directly. We cannot send payments to your doctors or day care providers. After receiving payment from your account, you are responsible for paying your providers.

ELIGIBLE DEPENDENTS

An individual is considered to be a dependent if he or she is a qualifying child or qualifying relative of the taxpayer. The following qualifying criteria now apply to be a "dependent child": the individual has a specific family type relationship to the taxpayer, the individual does not provide more than half of his or her own support, the individual has the same place of abode as the taxpayer for more than half of the year, and the individual does not turn age 19, (24 if full-time student), by the end of the Plan Year.

In addition, the following qualifying criteria apply to be a "dependent relative": the individual has a specific family type relationship to the taxpayer, the individual is not a qualifying child of any other taxpayer, the individual receives more than half of his or her support from the taxpayer, and the individual's annual gross income is less than the Section 151 limit (\$3,200 for 2005; this criteria does not apply to health plans).

RUNOFF PERIOD FOR FILING CLAIMS

You have the entire Plan Year plus 90 days to file all claims that were **incurred** during the Plan Year. All claims must be received in the office of Flexible Benefit Administrators, Inc. by 5:00 p.m. on the 90th day, following the end of your Plan Year. Therefore, for the Plan Year 7/01/10 - 06/30/11, all claims must be in our office by 5:00 p.m. on September 28, 2011. If claims are not received during this time frame for expenses incurred during the Plan Year, your remaining funds will be forfeited. (Remember "90 days" does not mean 3 months and "received in the office" does not mean the day it was postmarked). Please, do not delay; complete your claims early.

FORFEITING FUNDS

Any money you do not use from a reimbursement account for expenses incurred during a Plan Year will be forfeited. The forfeited funds will be returned to your employer to offset the cost of the program. If you plan carefully, you can avoid being affected by this IRS restriction.

CHANGES IN YOUR ELECTION

No, generally you cannot change the elections you have made after the beginning of the PLAN YEAR. However, there are certain limited situations when you can change your elections. You are permitted to change elections if you have a "change in status" and you make an election change that is consistent with the "change in status." Currently, Federal law considers the following events to be "changes in status":

- Marriage, divorce, death of a spouse, legal separation or annulment;
- Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent
- Any of the following events for you, your spouse or dependent: Termination or commencement of employment, a strike or lockout, commencement, or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that affects eligibility for benefits;
- One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance;
- A change in place of residence of you, your spouse, or your dependent. This applies ONLY to Dependent Care and ONLY if that change in residence results in a change of dependent care service provider and its cost.

In addition, if you are participating in the Dependent Care Reimbursement Account, then there is a "change in status" if your dependent no longer meets the qualifications to be eligible for dependent care.

There are detailed rules on when a change in election is deemed to be consistent with a "change in status." In addition, there are laws that give you rights to change accident and health coverage for you, your spouse, or your dependents. If you change coverage due to rights you have under the law, then you can make a corresponding change in your elections under the Plan. If any of these conditions apply to you, you should contact the Administrator.

If the cost of a benefit provided under the Plan increases or decreases during a Plan Year, then your salary redirection will increase or decrease accordingly. If the cost increases significantly, you will be permitted to either make corresponding changes in your payments or revoke your election and obtain coverage under another benefit package option with similar coverage.

If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, then you may revoke your elections and elect to receive, on a prospective basis, coverage under another plan with similar coverage. In addition, if a new coverage option is added or an existing option is eliminated, you may elect the newly-added option (or elect another option if an option has been eliminated) and make corresponding election changes to other options providing similar coverage. There are also certain situations when you may be able to change your elections on account of a change under the plan of your spouse's, former spouse's or dependent's employer.

These rules on change due to cost or coverage do not apply to the Health Care Reimbursement Plan, and you may not change your election to the Health Care Reimbursement Plan if you make a change due to cost or coverage for insurance.

You may not change your election under the Dependent Care Reimbursement Account if the cost change is imposed by a dependent care provider who is your relative.

To make a change in your elections, a STATUS CHANGE FORM must be completed within 30 days of the event. Flexible Benefit Administrators, Inc. or your benefits contact person will determine if your requests for an election change meets IRS Regulations.

TRANSFERRING FUNDS BETWEEN ACCOUNTS

IRS regulations do not allow money to be transferred between reimbursement accounts. If you elect funds to be placed in your Health Care Account, you must submit eligible medical expenses to be reimbursed from these funds. This IRS regulation also applies to the Dependent Care Reimbursement Account.

TERMINATION OF EMPLOYMENT

If you have funds in your Health Care Account and you submit receipts for expenses incurred prior to your termination, you can be reimbursed for funds remaining in your account up to your annual election. However, if you have money left in your Health Care Account and do not have receipts for expenses incurred prior to your termination, you cannot be reimbursed for the money remaining in your account unless you elect to participate in the federal program, COBRA. If you elect to participate in COBRA, you will need to continue to set aside dollars on an after tax basis to be deposited into your Health Care account. You can receive information concerning this program from the contact person in your company.

Your Dependent Care Reimbursement Account functions differently. If you have funds remaining in these accounts, this money will be reimbursed to you if appropriate receipts are submitted. You can receive reimbursement for expenses incurred during the Plan Year if receipts are submitted within the Plan Year and before the end of the 90-day grace period following the Plan Year end.

EFFECT ON SOCIAL SECURITY BENEFITS

As you are not paying social security tax on the portion of your income that has been placed in the Plan, your social security benefits may be slightly reduced. We suggest putting part of your tax savings into your Employer's Retirement Program or some other savings vehicle.

ACCOUNT BALANCES

You may call Flexible Benefit Administrators, Inc. at **(757) 340-4567** or **(800) 437-FLEX** from 8:30 a.m. to 5:00 p.m., Monday through Friday, to check your account balances. You may also access your personal account information at your convenience via our secure website: www.flex-admin.com. Each reimbursement check stub will show your contributions, request for reimbursements, and disbursements for each account. It will also show your annual election and the balance to request by the end of the Plan Year for each account. A reminder letter will be sent the month prior to the end of the Plan Year if you have funds left in your accounts.

ESTIMATING YOUR EXPENSES

This worksheet will help you determine your annual expenses for each reimbursement account. Good planning and careful estimating is the best way to take full advantage of your Flexible Benefit Plan. Keep in mind, your maximum annual elections cannot exceed \$2,400 for health care and \$5,000 for dependent care for the upcoming short plan year.

ESTIMATING YOUR QUALIFYING HEALTH CARE EXPENSES

Medical deductibles	_____
Medical co-payments	_____
Prescription drugs	_____
Vision Exams, Glasses, Contacts	_____
Dental/Orthodontia	_____
Routine exams and physicals	_____
Over-the-counter expenses	_____

TOTAL ESTIMATED HEALTH CARE EXPENSES FOR THE PLAN YEAR (Max. \$2,400) _____

ESTIMATING YOUR DEPENDENT CARE EXPENSES

Child day care expenses	_____
Pre-School expenses	_____
Summer Day Camp expenses	_____
Adult day care expenses	_____
Other eligible expenses	_____

TOTAL ESTIMATED DEPENDENT CARE EXPENSES FOR THE PLAN YEAR (Max. \$5,000) _____

ACCESSING YOUR FLEX ACCOUNT ONLINE

Our secure Online Inquiry System allows you to have 24/7 access to your account information, payment information and your available balance.

Completing your online account set-up is just a few clicks away!

Step 1. Log-on to our website at www.flex-admin.com.

Step 2. Select Participants.

Step 3. Select ACCOUNT LOG IN under the appropriate account type that you participate in. Please note that if you participate in more than one type of account, you do not have to set up a separate account for each one. You will be able to see all your account information under the one User ID and Password you create.

Step 4. Select Participant Login.

Step 5. Select Create Account.

Step 6. You will be prompted to enter your Name and Employee ID number (your social security number).

Step 7. You must then enter your Benefits Card Number or, if you do not have a Benefits Card, you may enter your Employer ID, which is: **FBABCG**.

Step 8. Create your User ID, Password, Security Word and Birth City and your e-mail address. Please note that your User ID will need to be between 4-10 characters. Your password needs to be between 7-10 characters and must include at least one letter and number.

Step 9. You are now ready to access your individual account!

Once you have completed these steps, you will have 24/7 access to current information regarding your Flexible Spending Account. It's that easy!

Problems logging into your Account?

E-mail to: flexdivision@flex-admin.com Include your Full Name, SS# or Employee ID#, Company Name, & Contact phone number.

Telephone: Local - **(757) 340-4567** or Toll Free - **(800) 437-3539** (Monday through Friday 8:30 am - 5:00 pm EST)


FBA ANNOUNCES ITS ONLINE PHARMACY!!

Busy day and don't have time to stop by the drugstore?

Do you have unspent money in your FSA?

Looking for savings from the comfort of your couch?

Here's how!

- Visit www.flex-admin.com
- Click on "More" at the top header announcing the online pharmacy – it's free to use!
- Shop and purchase items online at discounted pricing!
- You may use your FBA Benefits Card for eligible FSA items (marked )* and not have to submit receipts!



✓ Purchase non-eligible FSA items using your own personal payment method.

✓ All items are shipped directly to you!

✓ Free shipping on purchases over \$25.00!

Visit our website now to start making your life a little easier!

* Please note if you do not have a FBA Benefits Card, you may purchase FSA Approved items out of pocket and submit to FBA for reimbursement.

ADMINISTERED BY

FLEXIBLE BENEFIT ADMINISTRATORS, INC.

509 VIKING DRIVE, SUITE F

P.O. BOX 8188

VIRGINIA BEACH, VA 23450

(757) 340-4567 or (800) 437-FLEX (3539)

FAX: (757) 431-1155

FlexDivision@flex-admin.com

www.flex-admin.com



Cancer Can Affect Anyone

Statistics Predict:

- Cancer will strike one in every two men and one in every three women in the U.S.*
- One out of eight women will develop breast cancer in her lifetime*.
- One out of every six men will develop prostate cancer*.
- The number of people with cancer will double in this decade**.

Are you prepared for the cost of cancer?

Your medical insurance covers most of the direct charges such as hospital and physicians' bills, but may not cover these indirect costs:

- Loss of wages while caring for a family member
- Loss of wages while you receive treatment
- Everyday living expenses and bills
- Childcare
- Home health care expenses
- Transportation for non-local or specialized treatment centers
- Experimental treatment
- Meals eaten out, fast food for family at home
- Lodging during non-local treatment

In fact, non-medical costs account for 67 percent of all costs associated with cancer*. Many Americans find themselves financially strapped as the result of the battle against cancer or a specified disease, even with medical insurance.

Assurity's Cancer Plan is designed to create a source of extra cash that can help you and your family cope during the battle against cancer or a specified disease.

Extra cash when you need it. Here's how it works:

- We provide cash benefits to you.
- You use the money to meet your needs - loss of income, house and car payments, transportation for treatment, other bills, etc. These non-medical expenses of cancer may not be covered by your major medical insurance.

Plus, you get these distinctive features:

- Guaranteed renewable for life. You can't lose your coverage, as long as you continue to pay your premiums.
- Cash benefits paid to you regardless of any other medical insurance plan you may have.
- Provides cash to offset the costs of 30 other diseases.
- Coverage is portable. Employees can keep the coverage if they change jobs.

Selected benefits paying cash to you:

- Cancer Screening Tests
- Chemotherapy, Radiation, Immunotherapy, or hormone therapy
- Experimental Treatment
- Adult Companion Transportation and Lodging

*Cancer Facts & Figures, American Cancer Society, 2001
**Report from the American Hospital Administration.

Assurity Cancer & Specified Disease Plan

Policy availability, rates and provisions may vary by state. This policy contains limitations and exclusions. For more detailed and complete information, please contact Assurity Life Insurance Company and ask to review the policy contract.

BASIC BENEFITS

Provides benefits caused by cancer, and with a rider, certain other specified diseases for the employee, spouse and covered children with continuous benefit and premium policy for life.

RATE STRUCTURE

Age bands: 18-34, 35-49, 50-64 Employee Issue Ages: 18-64, Family: Up to Age 64 on spouse. Children Age 0-21 (if "dependent children" definition is met, coverage is available to Age 25). Issue Age is age of last birthday on the day policy is issued.

PRE-EXISTING CONDITIONS

Assurity will not pay benefits for any expenses incurred concerning a Pre-existing Condition unless the expenses are for services rendered after coverage has been in force for 12 months from the Issue Date.

A pre-existing condition means a sickness or physical condition for which, during the 12 months before the Issue Date, the Insured Person received medical consultation, advice or treatment from a Physician or had taken prescribed medication.

ISSUE AGE

The Assurity cancer policy is available for persons ages 18-64, including spouses. The issue age of children is 0 days through 21 years of age. The coverage is continued up to age 25 if "dependent children" definition is met.

Policy will pay the following specified benefits based on policy provisions:

HOSPITAL CONFINEMENT

Assurity will pay you benefits for each day while the Insured is confined in the hospital for cancer up to 75 consecutive days of each period of confinement. There are three options for the daily benefit amount: \$150, \$250, and \$350. This benefit is not payable for government or charity hospital confinements.

SURGICAL BENEFIT

For the treatment of, removal of, or destruction of Cancer, Assurity will pay the actual charges incurred up to the amount shown on the surgery schedule for surgical procedures in or out of a Hospital for an Insured Person. For operations not listed, a comparable reasonable benefit will be paid. If two or more surgical procedures are performed at the same time through the same incision or in the same body opening, Assurity will pay the greater of the surgical benefit amounts, but not both. The surgery can be performed in a Hospital, an ambulatory surgical center or a Physician's office. See policy for surgical schedule.

ANESTHESIA

Assurity will pay actual charges incurred up to 25% of the Surgical Benefit if a Surgical Benefit is paid and charges are made by a Physician for anesthesia administered in connection with such surgical procedure.

ADDITIONAL SURGICAL OPINIONS

Assurity will pay the actual charges incurred up to a maximum of \$200 for a second surgical opinion. If the second surgical opinion differs from the first, Assurity pays the actual charges incurred up to a maximum of \$200 for a third surgical opinion.

PROSTHESIS

The policy pays actual charges incurred up to \$1,000 per prosthetic device that are required to replace a body part lost due to Cancer as a direct result of surgery for Cancer treatment. This benefit has a maximum of \$2,500 per Calendar Year. This benefit does not include breast prosthesis.

ATTENDING PHYSICIAN

The policy pays actual charges incurred up to \$35 per day for in-hospital physician's visits, other than surgeon charges.

PRIVATE DUTY NURSE

The policy pays actual charges up to \$100 per day while confined in the hospital for treatment of cancer when authorized by a physician when a Private Nurse is required. Maximum of 60 days per calendar year.

RADIATION TREATMENT, CHEMOTHERAPY, HORMONE THERAPY OR IMMUNOTHERAPY

The calendar monthly and lifetime maximum benefit is \$10,000 per month and \$100,000 lifetime. Assurity will pay 50% of the actual charges incurred up to these calendar monthly and lifetime maximums for the following treatment techniques provided they are used for the purpose of modification or destruction of cancerous tissue:

- Radiation Treatment;
- Chemotherapy, Hormone Therapy and Immunotherapy drugs that are self-administered intravenously or administered directly by a Physician; or
- Chemotherapy, Hormone Therapy and Immunotherapy drugs that are self-administered or taken orally, up to a maximum of \$300 for each filled prescription or supply of drugs received from a medical provider. This benefit for self-administered or oral drugs is subject to a maximum of \$1,200 per Calendar Month.

Assurity will also pay for actual charges incurred up to maximum of \$500 per calendar year for the following services related to Radiation Treatment, Chemotherapy, Hormone Therapy and Immunotherapy:

- professional fees for administering the covered drugs;
- medical supplies, equipment and solutions;
- laboratory tests;

- x-rays, port films, MRIs, scans and ultrasounds; clinical treatment planning, clinical treatment management, medical radiation physics, dosimetry, treatment devices and special services;
- treatment consultation, planning and office visits; or
- Supportive and Protective Care Drugs

EXPERIMENTAL TREATMENT

Assurity pays actual charges up to \$4,000 per Calendar Year for experimental treatment that is approved by the Federal Drug Administration (FDA), National Cancer Institute (NCI) or American Cancer Society (ACS), for the purpose of modification or destruction of cancerous tissue.

BONE MARROW TRANSPLANT FOR CANCER

The policy pays the actual charges incurred up to a lifetime maximum of \$10,000 for bone marrow transplants or other forms of stem cell rescue (not to include any payments for donor expenses) and all related services and supplies. This benefit will pay for immunoglobulins, immunotherapy or colony-stimulating factors.

ADULT COMPANION TRANSPORTATION AND LODGING

The policy pays you the following expenses for one adult companion to be near the insured person when they are confined in a non-local hospital for specialized covered treatment prescribed by a physician as medically necessary: (a) the actual charges incurred up to \$40 per day for lodging incurred by the adult companion when staying at a hotel, motel or accommodation acceptable to Assurity, (b) the actual charges incurred up to \$15 per day for meals incurred by the adult companion (c) and the actual charges incurred up to \$500 per trip, for round trip coach fare on a common carrier to the nearest hospital that provides the prescribed treatment; or (d) \$.50 per mile for personal automobile expenses up to 700 miles round trip, provided that the destination is more than 50 miles one way from the city where the adult companion lives. This benefit is limited to two trips per calendar year.

This benefit is not payable for lodging occurring more than 24 hours prior to treatment nor for lodging occurring more than 24 hours following treatment. This benefit will not be paid for visits when an insured person receives non-covered treatments or periodic check-ups.

POSITIVE DIAGNOSIS TEST

Assurity will pay the actual charges incurred up to a lifetime maximum of \$500 for the diagnostic test that leads to a positive diagnosis of Cancer within 90 days of such test for an Insured Person. This benefit is not payable for non-melanoma skin Cancer.

OUTPATIENT SURGERY BENEFIT

Assurity will pay a benefit equal to the Daily Hospital Confinement benefit shown on the policy schedule for outpatient surgery due to cancer in a hospital or ambulatory surgical center for an insured person. This benefit is not payable for surgery in a Physician's office or clinic and is not available for non-melanoma skin Cancer treatment.

SKIN CANCER (NON-MELANOMA)

The policy pays up to \$100 for actual charges for the removal of non-melanoma skin cancer when diagnosis is made by a physician. This benefit is limited to two procedures per calendar year.

AMBULANCE

The policy pays actual charges up to \$200 per trip if a licensed professional ambulance company transports an insured person to or from a hospital or between medical facilities where the insured person is confined for cancer treatment. This benefit is limited to two trips per confinement.

HOSPICE CARE

Assurity will pay the actual charges incurred up to \$100 per day for care provided by a Hospice if the insured person has been diagnosed as terminally ill. This benefit is payable for a lifetime maximum of 120 days.

GOVERNMENT OR CHARITY HOSPITAL CONFINEMENT

The policy pays \$200 per day, up to 75 consecutive days, for an insured person confined for treatment of cancer in: (a) a hospital operated by or for the United States Government (including Veteran's Administration); (b) or a hospital that does not charge for the services it provides (charity). If this benefit is payable, no other benefits will be paid for the same time period and covered condition.

BLOOD AND BLOOD PLASMA

The policy pays the actual charges up to \$150 per day for an insured person requiring the transfusion, administration, cross-matching, typing and processing of blood and blood plasma due to cancer. This benefit is not payable for clerical, storage, and administration expenses associated with blood and blood plasma. This benefit does not pay for immunoglobulins, immunotherapy or colony-stimulating factors. There is a maximum of \$5,000 per calendar year for this benefit.

BREAST PROSTHESIS

Assurity will pay the actual charges incurred up to a lifetime maximum of \$2,500 per breast for an external breast prosthesis or an internal breast prosthesis due to cancer as a direct result of surgery for cancer treatment.

HAIRPIECE BENEFIT

The policy pays a one-time benefit of actual charges up to \$150 for a hairpiece when hair loss is the result of cancer treatment.

CANCER SCREENING TESTS

Assurity will pay the sum of the actual charges incurred for the following tests up to a maximum of \$100 per calendar year. Benefits are not payable for tests performed within the 30-day waiting period.

- biopsy for skin Cancer;
- CA 125 (blood test for ovarian Cancer);
- CEA (blood test for colon Cancer);
- chest x-ray;
- colonoscopy;

- flexible sigmoidoscopy;
- hemocult stool specimen;
- mammography screening;
- pap smear (test only);
- PSA (blood test for prostate Cancer);
- serum protein electrophoresis; or
- thermography.

WELLNESS CLAIMS

An employee can file a wellness claim by fax, call-in or mail. Employees can call Assurity to get a wellness claim form or download one from **www.markiiibrokerage.com/brunswickcountync**. Employees can also call in their wellness claim at **(888)-358-8808 ext. 23**. The call in service requires all the information on the wellness claim form. The wellness claim form must include the name and phone number of your physician. All claims are subject to verification.

HOME HEALTH CARE SERVICES

Assurity will pay up to \$100 per day of actual charges for services provided at home, up to a maximum of 60 days per calendar year, when an insured person is provided services by a licensed home health care agency. Such care must be prescribed by a physician and begin within seven days of release from a covered hospital confinement. The care cannot be provided by an immediate family member. This benefit will not be payable on the same day that Hospice Care is payable.

RENTAL OR PURCHASE OF DURABLE MEDICAL EQUIPMENT

Upon a physician's recommendation, Assurity will pay the sum of the actual charges incurred for the rental or purchase of the following pieces of durable medical equipment up to \$1,000 per Calendar Year:

- brace;
- crutches;
- hospital bed;
- respirator or similar mechanical device; or
- wheel chair.

EXTENDED BENEFITS

If an insured person is continuously confined in a Hospital for treatment of cancer for more than 75 consecutive days, the policy pays the actual charges incurred up to the minimum of the usual and normal charges or \$1,000 per day, beginning on the 76th day for:

- drugs and medicines;
- Hospital room and board;
- tests; and
- other Medically Necessary Hospital charges.

Periods of Confinement separated by more than 30 days shall not be considered consecutive days.

CANCER OR OTHER SPECIFIED DISEASE CLAIMS

You may file a claim for cancer or specified diseases by completing an Assurity Claim Form. Please make sure to include all pertinent information as stated on the form. You can obtain a claim form by contacting Assurity, or by downloading one from www.markiiibrokerage.com/brunswickcountync. Should you have any questions on how to file or submit a claim or regarding the Assurity Cancer Plan, please call (888) 358-8808 ext. 23.

SPECIFIED DISEASE BENEFIT RIDER

The benefits of the rider will be extended to pay for the loss that results from the following specified diseases:

Addison's Disease	Osteomyelitis
Botulism	Polio
Brucellosis	Q Fever
Budd-Chiari Syndrome	Reye's Syndrome
Cystic Fibrosis	Rheumatic Fever
Diphtheria	Rocky Mountain Spotted Fever
Encephalitis	Systemic Lupus Erythematosus
Histoplasmosis	Sickle Cell Anemia
Legionnaires Disease	Tay-Sachs Disease
Lou Gehrig's Disease (ALS)	Tetanus
Malaria	Trichinosis
Meningitis	Toxic Shock Syndrome
Multiple Sclerosis	Tuberculosis
Muscular Dystrophy	Typhoid Fever
Myasthenia Gravis	Whooping Cough

OPTIONAL RIDERS

Intensive Care Rider – pays a \$300 or \$600 daily benefit if an insured person is confined to a Hospital's Intensive Care Unit, up to a maximum of 30 days per period of confinement. The daily benefit amount reduces by 50% when that Insured Person reaches age 70. Benefits are not payable during the 30-day waiting period.

Cancer First Occurrence Rider -- pays \$2,500 or \$5,000 the first time an insured is diagnosed as having cancer. This benefit is not payable if diagnosed within the 30-day waiting period.

LIMITATIONS

Pre-existing Conditions. We will not pay benefits for any expenses incurred concerning a Pre-existing Condition unless the expenses are for services rendered after coverage has been in force for 12 months from the Issue Date.

Waiting Period. Charges incurred during the first 30 days of coverage are not eligible for payment.

EXCLUSIONS

We will not pay benefits for loss caused by or resulting from:

- Injuries;
- Noncancerous sickness;
- Any sickness, illness, bodily infirmity or incapacity that has been caused, complicated, worsened, or affected by Cancer or as a result of Cancer treatment;
- Expenses that are incurred prior to the Issue Date regardless of the date of positive diagnosis; or
- Care, and/or treatment received outside the United States.

Assurity Life Insurance Company
PO Box 82533, Lincoln, NE, 68501-2533
Assurity Customer Service: 1.866.289.7337
Website: www.assurity.com

To Call in a Wellness Claim: 1.888.358-8808 Ext. 23
To Fax in a Claim/Toll Free: 1.800.869-0368

Policy Form No. W C240
Rider Form Nos. R WC241, R WC242 & R WC243





**Cancer Policy and Specified Disease Benefit Rider
With Radiation/Chemotherapy**

SEMI-MONTHLY RATES (Ages 18 to 34)

Assurity Life Cancer & Specified Disease Plan				
		\$150 Daily Benefit	\$250 Daily Benefit	\$350 Daily Benefit
Base Policy with Specified Disease Benefit Rider (\$10,000 per month/\$100,000 lifetime maximum) (radiation/chemotherapy)	Individual	\$6.26	\$6.41	\$6.56
	EE & Spouse	\$11.10	\$11.40	\$11.70
	EE & Children	\$7.56	\$7.75	\$7.94
	Family	\$12.33	\$12.67	\$13.01
Base Policy with Specified Disease Benefit Rider with Intensive Care Rider (\$300 daily benefit)	Individual	\$7.52	\$7.67	\$7.82
	EE & Spouse	\$13.67	\$13.97	\$14.27
	EE & Children	\$9.95	\$10.14	\$10.33
	Family	\$16.11	\$16.45	\$16.79
Base Policy with Specified Disease Benefit Rider with Intensive Care Rider (\$600 daily benefit)	Individual	\$8.79	\$8.94	\$9.09
	EE & Spouse	\$16.24	\$16.54	\$16.84
	EE & Children	\$12.34	\$12.53	\$12.72
	Family	\$19.89	\$20.23	\$20.57
Base Policy with Specified Disease Benefit Rider with First Occurrence Benefit Rider (\$2,500 benefit)	Individual	\$6.60	\$6.75	\$6.90
	EE & Spouse	\$11.77	\$12.07	\$12.37
	EE & Children	\$7.97	\$8.16	\$8.35
	Family	\$13.05	\$13.39	\$13.73
Base Policy with Specified Disease Benefit Rider with First Occurrence Benefit Rider (\$2,500 benefit) and Intensive Care Rider (\$300 daily benefit)	Individual	\$7.86	\$8.01	\$8.16
	EE & Spouse	\$14.34	\$14.64	\$14.94
	EE & Children	\$10.36	\$10.55	\$10.74
	Family	\$16.83	\$17.17	\$17.51
Base Policy with Specified Disease Benefit Rider with First Occurrence Benefit Rider (\$2,500 benefit) and Intensive Care Rider (\$600 daily benefit)	Individual	\$9.13	\$9.28	\$9.43
	EE & Spouse	\$16.91	\$17.21	\$17.51
	EE & Children	\$12.75	\$12.94	\$13.13
	Family	\$20.61	\$20.95	\$21.29
Base Policy with Specified Disease Benefit Rider with First Occurrence Benefit Rider (\$5,000 benefit)	Individual	\$6.94	\$7.09	\$7.24
	EE & Spouse	\$12.43	\$12.73	\$13.03
	EE & Children	\$8.37	\$8.56	\$8.75
	Family	\$13.78	\$14.12	\$14.46
Base Policy with Specified Disease Benefit Rider with First Occurrence Benefit Rider (\$5,000 benefit) and Intensive Care Rider (\$300 daily benefit)	Individual	\$8.20	\$8.35	\$8.50
	EE & Spouse	\$15.00	\$15.30	\$15.60
	EE & Children	\$10.76	\$10.95	\$11.14
	Family	\$17.56	\$17.90	\$18.24
Base Policy with Specified Disease Benefit Rider with First Occurrence Benefit Rider (\$5,000 benefit) and Intensive Care Rider (\$600 daily benefit)	Individual	\$9.47	\$9.62	\$9.77
	EE & Spouse	\$17.57	\$17.87	\$18.17
	EE & Children	\$13.15	\$13.34	\$13.53
	Family	\$21.34	\$21.68	\$22.02

NC/SC



**Cancer Policy and Specified Disease Benefit Rider
With Radiation/Chemotherapy**

SEMI-MONTHLY RATES (Ages 35 to 49)

Assurity Life Cancer & Specified Disease Plan				
		\$150 Daily Benefit	\$250 Daily Benefit	\$350 Daily Benefit
Base Policy with Specified Disease Benefit Rider (\$10,000 per month/\$100,000 lifetime maximum) (radiation/chemotherapy)	Individual	\$12.61	\$13.00	\$13.39
	EE & Spouse	\$23.53	\$24.30	\$25.08
	EE & Children	\$13.81	\$14.24	\$14.67
	Family	\$24.77	\$25.58	\$26.40
Base Policy with Specified Disease Benefit Rider with Intensive Care Rider (\$300 daily benefit)	Individual	\$13.91	\$14.30	\$14.69
	EE & Spouse	\$26.13	\$26.90	\$27.68
	EE & Children	\$16.14	\$16.57	\$17.00
	Family	\$28.58	\$29.39	\$30.21
Base Policy with Specified Disease Benefit Rider with Intensive Care Rider (\$600 daily benefit)	Individual	\$15.20	\$15.59	\$15.98
	EE & Spouse	\$28.74	\$29.51	\$30.29
	EE & Children	\$18.48	\$18.91	\$19.34
	Family	\$32.38	\$33.19	\$34.01
Base Policy with Specified Disease Benefit Rider with First Occurrence Benefit Rider (\$2,500 benefit)	Individual	\$13.47	\$13.86	\$14.25
	EE & Spouse	\$25.16	\$25.93	\$26.71
	EE & Children	\$14.73	\$15.16	\$15.59
	Family	\$26.46	\$27.27	\$28.09
Base Policy with Specified Disease Benefit Rider with First Occurrence Benefit Rider (\$2,500 benefit) and Intensive Care Rider (\$300 daily benefit)	Individual	\$14.77	\$15.16	\$15.55
	EE & Spouse	\$27.76	\$28.53	\$29.31
	EE & Children	\$17.06	\$17.49	\$17.92
	Family	\$30.27	\$31.08	\$31.90
Base Policy with Specified Disease Benefit Rider with First Occurrence Benefit Rider (\$2,500 benefit) and Intensive Care Rider (\$600 daily benefit)	Individual	\$16.06	\$16.45	\$16.84
	EE & Spouse	\$30.37	\$31.14	\$31.92
	EE & Children	\$19.40	\$19.83	\$20.26
	Family	\$34.07	\$34.88	\$35.70
Base Policy with Specified Disease Benefit Rider with First Occurrence Benefit Rider (\$5,000 benefit)	Individual	\$14.33	\$14.72	\$15.11
	EE & Spouse	\$26.79	\$27.56	\$28.34
	EE & Children	\$15.66	\$16.09	\$16.52
	Family	\$28.15	\$28.96	\$29.78
Base Policy with Specified Disease Benefit Rider with First Occurrence Benefit Rider (\$5,000 benefit) and Intensive Care Rider (\$300 daily benefit)	Individual	\$15.63	\$16.02	\$16.41
	EE & Spouse	\$29.39	\$30.16	\$30.94
	EE & Children	\$17.99	\$18.42	\$18.85
	Family	\$31.96	\$32.77	\$33.59
Base Policy with Specified Disease Benefit Rider with First Occurrence Benefit Rider (\$5,000 benefit) and Intensive Care Rider (\$600 daily benefit)	Individual	\$16.92	\$17.31	\$17.70
	EE & Spouse	\$32.00	\$32.77	\$33.55
	EE & Children	\$20.33	\$20.76	\$21.19
	Family	\$35.76	\$36.57	\$37.39

NC/SC



**Cancer Policy and Specified Disease Benefit Rider
With Radiation/Chemotherapy**

SEMI-MONTHLY RATES (Ages 50 to 64)

Assurity Life Cancer & Specified Disease Plan		\$150 Daily Benefit	\$250 Daily Benefit	\$350 Daily Benefit
Base Policy with Specified Disease Benefit Rider (\$10,000 per month/\$100,000 lifetime maximum) (radiation/chemotherapy)	Individual	\$26.58	\$27.51	\$28.45
	EE & Spouse	\$52.78	\$54.70	\$56.62
	EE & Children	\$27.95	\$28.93	\$29.92
	Family	\$53.66	\$55.60	\$57.55
Base Policy with Specified Disease Benefit Rider with Intensive Care Rider (\$300 daily benefit)	Individual	\$28.67	\$29.60	\$30.54
	EE & Spouse	\$57.07	\$58.99	\$60.91
	EE & Children	\$30.86	\$31.84	\$32.83
	Family	\$58.80	\$60.74	\$62.69
Base Policy with Specified Disease Benefit Rider with Intensive Care Rider (\$600 daily benefit)	Individual	\$30.75	\$31.68	\$32.62
	EE & Spouse	\$61.36	\$63.28	\$65.20
	EE & Children	\$33.78	\$34.76	\$35.75
	Family	\$63.95	\$65.89	\$67.84
Base Policy with Specified Disease Benefit Rider with First Occurrence Benefit Rider (\$2,500 benefit)	Individual	\$28.63	\$29.56	\$30.50
	EE & Spouse	\$56.74	\$58.66	\$60.58
	EE & Children	\$30.10	\$31.08	\$32.07
	Family	\$57.65	\$59.59	\$61.54
Base Policy with Specified Disease Benefit Rider with First Occurrence Benefit Rider (\$2,500 benefit) and Intensive Care Rider (\$300 daily benefit)	Individual	\$30.72	\$31.65	\$32.59
	EE & Spouse	\$61.03	\$62.95	\$64.87
	EE & Children	\$33.01	\$33.99	\$34.98
	Family	\$62.79	\$64.73	\$66.68
Base Policy with Specified Disease Benefit Rider with First Occurrence Benefit Rider (\$2,500 benefit) and Intensive Care Rider (\$600 daily benefit)	Individual	\$32.80	\$33.73	\$34.67
	EE & Spouse	\$65.32	\$67.24	\$69.16
	EE & Children	\$35.93	\$36.91	\$37.90
	Family	\$67.94	\$69.88	\$71.83
Base Policy with Specified Disease Benefit Rider with First Occurrence Benefit Rider (\$5,000 benefit)	Individual	\$30.68	\$31.61	\$32.55
	EE & Spouse	\$60.69	\$62.61	\$64.53
	EE & Children	\$32.24	\$33.22	\$34.21
	Family	\$61.65	\$63.59	\$65.54
Base Policy with Specified Disease Benefit Rider with First Occurrence Benefit Rider (\$5,000 benefit) and Intensive Care Rider (\$300 daily benefit)	Individual	\$32.77	\$33.70	\$34.64
	EE & Spouse	\$64.98	\$66.90	\$68.82
	EE & Children	\$35.15	\$36.13	\$37.12
	Family	\$66.79	\$68.73	\$70.68
Base Policy with Specified Disease Benefit Rider with First Occurrence Benefit Rider (\$5,000 benefit) and Intensive Care Rider (\$600 daily benefit)	Individual	\$34.85	\$35.78	\$36.72
	EE & Spouse	\$69.27	\$71.19	\$73.11
	EE & Children	\$38.07	\$39.05	\$40.04
	Family	\$71.94	\$73.88	\$75.83

NC/SC

AUL Short Term Disability Plan

Effective Date: July 1, 2010

Why do you need Disability Insurance? Consider this . .

Statistics show you are much more likely to be injured in an accident than to die from one.

- A fatal injury occurs every 5 minutes, and a disabling injury occurs every 1.5 seconds.¹
- There is a death caused by a motor vehicle crash every 12 minutes; there is a disabling injury every 14 seconds.¹
- In the home, there is a fatal injury every 16 minutes and a disabling injury every 4 seconds.¹

While many people survive accidental injuries, many others live with serious illnesses.

- In the United States, men have a little less than a 1-in-2 lifetime risk of developing cancer; for women the risk is a little more than 1-in-3. The five year relative survival rate for all cancers combined is 63%.²
- One in five males and females has some form of cardiovascular disease. High blood pressure is the most common form of cardiovascular disease.³
- More than 35 million Americans are now living with chronic lung diseases, such as asthma, emphysema, and chronic bronchitis.⁴

Advances in medicine are allowing us to live longer. However, recovery from a serious illness or injury often requires time away from work.

- In the last 20 years, deaths due to the big three (cancer, heart attack, and stroke) have gone down significantly. But disabilities due to those same three diseases are up dramatically. Things that used to kill, now disable.⁵

**You have life insurance, home insurance and
automobile insurance.**

But is your income insured?

1 National Safety Council, Injury Facts, 2008 Edition

2 American Cancer Society, Cancer Facts & Figures 2008

3 American Heart Association, Heart Disease and Stroke Statistics – 2008 Update

4 American Lung Association, Lung Disease Data 2008

Class Description

All Full-Time Eligible Employees working a minimum of 30 hours per week, electing to participate in the Voluntary Short Term Disability Insurance

Disability

You are considered disabled if, because of injury or sickness, you cannot perform the material and substantial duties of your regular occupation.

Monthly Benefit

You can choose to insure up to 70% of an Employee's covered basic monthly earnings to a maximum monthly benefit of \$2,000.

Elimination Period

This means a period of consecutive days of disability for which no benefit is payable; the greater of seven (7) days for a sickness and one (1) day for injury. This is the period of time a disabled Employee must wait before weekly disability benefits begin.

Benefit Duration

This is the period of time that benefits will be payable for disability. You can choose a maximum STD benefit duration, if continually disabled, of thirteen (13) weeks, twenty-six (26) weeks or fifty-two (52) weeks.

Basis of Coverage

24 hour coverage, on or off the job.

Maternity Coverage

Benefits will be paid the same as any other qualifying disability, subject to any applicable pre-existing condition exclusion.

Partial Disability

When selecting 52 week benefit duration, benefits will continue to be paid, even if you work partial hours for your employer. AUL will offset with monies earned from your employer for your partial hours so that your total compensation will equal 80% of your pre-disability earnings based upon a set formula administered through AUL's Home Office.

STD Pre-Existing Condition Exclusion

3/12, If a person receives medical treatment, or service or incurs expenses as a result of an Injury or Sickness within 3 months prior to the Individual Effective Date, then the Group Policy will not cover any Disability which is caused by, contributed to by, or resulting from that Injury or Sickness; and begins during the first 12 months after the Person's Individual Effective Date.

Recurrent Disability

If you resume Active Work for 30 consecutive workdays following a period of Disability for which the Weekly Benefit was paid, any recurrent Disability will be considered a new period of Disability. A new Elimination Period must be completed before the Weekly Benefit is payable.

Exclusions and Limitations

This plan will not cover any disability resulting from war, declared or undeclared or any act of war; active participation in a riot; intentionally self-inflicted injuries; commission of an assault or felony; or a pre-existing condition for a specified time period.

This information is provided as a summary of the product. It is not a part of the insurance contract and does not change or extend AUL's liability under the group policy. If there are any discrepancies between this information and the group policy, the group policy will prevail.

**Customer Service:
800-553-5318**

**Disability Claims:
866-258-8744**

Fax: 207-591-3048

Disability Claims Email: claims@disabilityrms.com

www.employeebenefits.aul.com



**AMERICAN UNITED LIFE
INSURANCE COMPANY®**
a ONEAMERICA® company

AUL Life Short-Term Disability Semi-Monthly (24-Pay) Rates

**Benefit Duration:
13 Weeks**

Monthly Benefit	Semi Monthly Premium
\$500	\$5.18
\$600	\$6.21
\$700	\$7.25
\$800	\$8.29
\$900	\$9.32
\$1,000	\$10.36
\$1,100	\$11.39
\$1,200	\$12.43
\$1,300	\$13.46
\$1,400	\$14.50
\$1,500	\$15.54
\$1,600	\$16.57
\$1,700	\$17.61
\$1,800	\$18.64
\$1,900	\$19.68
\$2,000	\$20.71

**Benefit Duration:
26 Weeks**

Monthly Benefit	Semi Monthly Premium
\$500	\$7.50
\$600	\$9.00
\$700	\$10.50
\$800	\$12.00
\$900	\$13.50
\$1,000	\$15.00
\$1,100	\$16.50
\$1,200	\$18.00
\$1,300	\$19.50
\$1,400	\$21.00
\$1,500	\$22.50
\$1,600	\$24.00
\$1,700	\$25.50
\$1,800	\$27.00
\$1,900	\$28.50
\$2,000	\$30.00

**Benefit Duration:
52 Weeks**

Monthly Benefit	Semi Monthly Premium
\$500	\$9.86
\$600	\$11.83
\$700	\$13.80
\$800	\$15.77
\$900	\$17.74
\$1,000	\$19.71
\$1,100	\$21.69
\$1,200	\$23.66
\$1,300	\$25.63
\$1,400	\$27.60
\$1,500	\$29.57
\$1,600	\$31.54
\$1,700	\$33.51
\$1,800	\$35.49
\$1,900	\$37.46
\$2,000	\$39.43

Metlife Term Life Plan

BASIC EMPLOYEE LIFE INSURANCE

This insurance is payable for death from any cause to any person you name as beneficiary.

OPTIONAL EMPLOYEE LIFE INSURANCE

Your employer-sponsored basic life coverage provides important protection for you, but you may need to add to that protection. Now you can...at low group rates and through convenient payroll deductions.

To help meet this need, you have the opportunity to elect additional group life insurance under the optional portion of your program to go along with any personal insurance coverage you may have.

OPTIONAL DEPENDENT LIFE INSURANCE

Provides coverage on:

- Your Spouse
- Child(ren) from 15 days of age to age 19 (to age 25 if wholly dependent upon you for maintenance and support **and** if enrolled as a full-time student in an accredited school or college). Handicapped children can continue to be covered with no age limit.

It is the responsibility of the employee to notify payroll in writing when a dependent becomes ineligible for coverage. Examples of an ineligible dependent status are divorce, or a child graduates from college.

ACCIDENTAL DEATH AND DISMEMBERMENT

Benefits under this coverage are payable for accidental death or injury as described in your certificate. All active employees have Basic Accidental Death and Dismemberment coverage.

FEATURES

The plan features easy eligibility and simple enrollment procedures.

Furthermore, automatic payroll deductions simplify paperwork. This means less book-keeping for you and no worries about a lapse in coverage due to missed payments.

Increases in coverage, a re-entry in the plan and participants who enroll beyond 31 days of employment will be required to provide evidence of insurability satisfactory to MetLife.

LOW COST

Your cost is lower than for comparable insurance on an individual basis due to the "wholesale" economies inherent in group insurance. Additionally, the System absorbs the cost of administering the program which is underwritten by Metropolitan Life - a leader in the field of group coverage.

ELIGIBILITY

You will be eligible for this program if you are a full-time active employee working at least 30 hours per week.

ENROLLMENT

Enrollment is simple - just fill out the election card provided by your employer. Make sure you supply all the required information and return the form where you work. That's all. If a Statement of Health was completed, you will be notified as to when coverage starts.

BENEFICIARY

You have the right to designate the beneficiary of your choice under employee coverage. You are automatically the beneficiary under Dependent Life.

WHEN YOUR INSURANCE STARTS

Your Basic Employee Life Insurance becomes effective on the date of your eligibility (the day after the date you complete 30 days of continuous employment) if you are then actively at work; otherwise, on the day you return to active work. In order for your Optional Employee Life Insurance and Optional Dependent Life Insurance to become effective, it is necessary for you to certify that neither you nor any of your eligible dependents have been "hospitalized" in the last three months prior to your enrollment date. The term "hospitalized" includes inpatient hospital care, hospice care, care in an intermediate or long-term care facility and/or receipt of chemotherapy, radiation therapy or dialysis treatment. However, a confinement which is strictly due to pregnancy or childbirth will not be included in the term "hospitalized".

In addition, coverage will not become effective for you or any dependent who is hospitalized as defined above or who is not performing normal daily activities on the date coverage would otherwise become effective. Normal daily activities means that the individual is not confined at home under the care of a doctor for a sickness or injury or is not entitled to receive any disability income from any source.

If you meet the eligibility requirements described above for date of enrollment and for effective date of coverage, your Optional Employee Life Insurance, if you have enrolled for that coverage, will become effective on the date of your eligibility provided you are then actively at work; otherwise, on the day you return to active work. If you enroll for Optional Dependent Life Insurance, that coverage will become effective on the date your Optional Employee Life Insurance becomes effective, for any dependents who meet the eligibility requirements described above.

If you or any dependents do not satisfy the eligibility requirements described above for date of enrollment and for effective date of coverage, that person will not become insured for Optional Life Insurance until such person has furnished medical evidence of insurability satisfactory to Metropolitan Life.

REDUCTIONS AT AGE 65 & OVER

If you remain in active service beyond age 65 your combined amount of Basic, AD&D and Optional Employee Life Insurance will reduce as follows:

<u>Attained Age</u>	<u>Percent of Original Amount</u>
65	65%
70	50%

TERMINATION OF COVERAGE

All insurance under this plan will terminate upon the earlier of termination of employment, when the plan ceases or when you withdraw from the plan. Nevertheless, if you should die within 31 days thereafter, your life insurance will still be paid to the beneficiary. If any of your covered dependents should die within such 31 day period, the amount of Life Insurance on account of such dependent will be paid to you.

EXTENDED DEATH BENEFITS DURING DISABILITY

If an insured becomes totally disabled prior to age 65, the amount of life insurance will be continued without payment of premium provided evidence of disability is submitted annually. However, your insurance will be subject to reduction as shown under "Reductions at ages 65 & Over" above. Continued protection terminates at age 70.

CONVERSION

If your employment terminates while you are covered under the plan or when you are approved for long term disability, you may purchase without medical evidence of insurability, any individual insurance policy, except a term policy, issued by Metropolitan Life in any amount up to the amount of your coverage in effect on your date of termination. You must apply for this policy within 31 days after the date your employment terminates. This privilege applies to Optional Employee Life Insurance and Dependent Life Insurance as well as the Basic Employee Life Insurance.

SUICIDE EXCLUSION

No Optional Employee Life or Optional Dependent Life Benefits are payable if you commit suicide within two years from the effective date of the coverage.

THE ACCELERATED BENEFIT OPTION (ABO)

Metropolitan Life Insurance Company has included an Accelerated Benefit Option (ABO) as part of your group life benefits. Under this option, if you are diagnosed as having a terminal illness, you may be eligible to receive a portion of your group life benefits at such a difficult time. Please refer to your Group Certificate for details.

PORTABILITY

Portability allows employees whose coverage ends due to certain qualifying events to continue their current (or a lesser) amount of insurance. Portability applies to Employee Optional Life Insurance only.

Qualifying Events Include:

- Termination of Employment
- Retirement
- Change in employee class which results in the termination of Optional Life Benefits.

You must apply for this coverage within 31 days after your employment terminates. The minimum face amount which an employee may elect portability is \$10,000. Portable coverage reduces to 50% on January 1st of the year the insured attains age 70 and terminates on January 1st of the year the insured attains age 80. When portable coverage ends, insured individuals have the right to convert to an individual policy.

SCHEDULE OF BENEFITS

BASIC EMPLOYEE LIFE INSURANCE and AD&D (No cost to you)

<u>Annual Salary</u>	<u>Benefit Amount*</u>
Less than \$10,000	\$10,500
\$10,000 - 15,000	\$17,500
\$15,001 - Over	\$24,500
County Commissioners	\$10,500

OPTIONAL EMPLOYEE LIFE INSURANCE

Your choice of the following amounts:*

\$150,000, \$100,000, \$50,000, \$40,000, \$30,000, \$20,000, \$10,000

*See "Reductions at age 65 & Over."

OPTIONAL DEPENDENT LIFE INSURANCE

\$10,000 on your spouse
\$5,000 on each of your eligible children**

You choose either:

- ♦ Family coverage
- ♦ Spouse only coverage; or
- ♦ Child(ren) only coverage

**Children age 15 days up to 6 months have a death benefit of \$500.

Optional Dependent Life Insurance is available only to those eligible employees who are insured for Optional Employee Life Insurance.

YOUR SEMI-MONTHLY COST

<u>Optional Employee Life Insurance</u>	<u>Payroll Deduction 24 pay periods</u>
\$150,000	\$21.38
\$100,000	\$14.25
\$50,000	\$7.13
\$40,000	\$5.70
\$30,000	\$4.28
\$20,000	\$2.85
\$10,000	\$1.43

Optional Dependent Life Insurance (based on 24 Deductions)

Family Coverage	\$1.83
Spouse Only Coverage	\$1.23
Child(ren) Only Coverage	\$0.60*

*Regardless of the number of children. \$500 benefit for child(ren) age 15 days up to 6 months.

CLAIMS PROCEDURE

Claim forms needed to file for benefits under the group insurance program can be obtained from your employer who will also be ready to answer questions about the insurance benefits and to assist in filing claims. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully. If there is any question about a claim payment, an explanation can be requested from your employer, who is usually able to provide the necessary information.

This brochure has been prepared to give you the highlights of coverage now being offered by your employer, and is subject to the terms and conditions of the Master Policy.

This insurance is underwritten by Metropolitan Life Insurance
New York, New York 10010.

The MetLife logo is displayed in a bold, black, sans-serif font. The word "MetLife" is written in a single line, with a registered trademark symbol (®) positioned at the top right of the letter "e".

Texas Life Whole Life Plan

Common Issue Date: August 15, 2010 pending underwriting approval

This Voluntary Permanent Life Program will allow you to purchase permanent life insurance for you and your eligible dependents.

VPL- plus is an individual permanent life insurance product specifically designed for employees and their families. It provides a guaranteed level premium and death benefit for the life of the policy, and you can keep the life insurance even after you retire.

As an employee, you are eligible to apply if you have satisfied your employer's eligibility period. You may also apply for coverage on your spouse, minor children and grandchildren.

WHY VOLUNTARY COVERAGE

- Most employees are typically dependent on group term life insurance
- Today more adults than ever have only group life insurance obtained through their employers, but they carry the lowest average amount of coverage.¹
- On the other hand, adults with both individual life and group life policies have the highest life insurance protection.¹
- Most term policies generally expire before paying a death claim
- When do you want a life insurance policy in force?
— Answer: When you die
- Term is for IF you die; permanent is for WHEN you die
- Everybody dies

THE NEW PRODUCT: TEXAS LIFE'S VPL-plus

- Portable, permanent life insurance through the convenience of payroll deduction
- Whole life chassis
- Strong guarantees
- Popular features
- Coverage available for spouse, minor children and grandchildren

VPL-plus: PORTABLE AND PERMANENT

- Employee can keep policy, at same premium, if he/she retires or changes jobs
- Employee may apply for spouse, minor children and grandchildren at the worksite
- Permanent coverage: policy guaranteed to remain in force as long as premiums are paid

VPL-plus: THE GUARANTEES EMPLOYEES WANT

- Guaranteed level premium
- Guaranteed level death benefit*
- Guaranteed reduced paid-up insurance at retirement
- Guaranteed paid-up for face amount at age 70 (or after 20 years for insureds between ages 51 and 70)

¹ Trends in Life Insurance Ownership, LIMRA International (2006)

09M022-C 1003 (Expires 013111) Rev 08/09. See the VPL-plus brochure for complete details- Form PWLSEV-NI-05

*Guarantees are backed by the claims paying ability and financial strength of the issuing company.

VPL-plus: CGI (EXPRESS ISSUE) UNDERWRITING

Employee, spouse coverage require 3 health and employment related questions:

- During the last six months, has the proposed insured been actively at work on a full-time basis, performing usual duties?
- During the last six months, has the proposed insured been absent from work due to illness or medical treatment for a period of more than five consecutive working days?
- During the last six months, has the proposed insured been disabled or received tests, treatment or care of any kind in a hospital or nursing home or received chemotherapy, hormonal therapy for cancer, radiation therapy, dialysis treatment or treatment for alcohol or drug abuse?

Child coverage (ages 6 months -18 years old):

- During the last six months, has the proposed insured been disabled or received tests, treatment or care of any kind in a hospital or nursing home or received chemotherapy, hormonal therapy for cancer, radiation therapy, dialysis treatment or treatment for alcohol or drug abuse?

Express Issue Maximums

- employee
 - ages 17-49, \$100,000
 - ages 50-65, \$50,000
 - ages 66-70, \$10,000
- spouse (if employee applies)
 - ages 17-49, \$50,000
 - ages 50-65, \$25,000
 - ages 66-70, \$10,000
- spouse (if employee does not apply)
 - ages 17-24 \$25,000
 - ages 25-29 \$20,000
 - ages 30-39 \$15,000
 - ages 40-44 \$10,000
 - ages 45-49 \$7,500
 - ages 50-70 \$5,000
- children - ages 6 months -18 \$25,000
- grandchildren - ages 6 months -16 \$25,000

Simplified Issue**

- Use if proposed insured wants amounts over Express Issue maximums
- Coverage is dependent on answers to health-related and other questions contained in the application
- Answer all underwriting questions
- Blood required for amounts in excess of \$100,000
- Rates are unisex
- Rates are unismoke

**We retain the right to require a medical exam

Accelerated Death Rider

- Included on all policies (Employee, Spouse, Minor Children, Grandchildren)
- Pays 92% of death benefit, less \$150 processing fee, upon physician-certified diagnosis of condition expected to result in death within 12 months (conditions and limitations apply)
- No extra charge for rider
- Policy terminates when rider is exercised

Waiver of Premium

- Available for issue ages 17-55
- Benefit payable to insured through age 60
- Cost is included in premium

VPL-plus: Review

- Permanent and portable when you change jobs or retire
- Non-participating Whole Life chassis (no dividends)
- Guaranteed level death benefit*
- Guaranteed level premium
- Guaranteed reduced paid-up insurance at retirement
- Premiums cease at age 70 (or after 20 years, ages 51-70)
- Accelerated Death Benefit Rider included on all policies
- Waiver of Premium available issue ages 17-55
- Express Issue underwriting
- Unisex rates
- Unismoke rates
- Blood required for amounts over \$100,000
- Simplified issue for health reasons or for amounts over Express Issue maximums

This brochure has been prepared to give you the highlights of coverage now being offered through your employer to meet your insurance needs. The details will be provided during your individual meeting with a qualified Texas Life Enrollment Representative. Those employees who wish to participate will be provided a personal policy that spells out all policy provisions.

*If you have any questions regarding your Texas Life policy, please call
(800) 283-9233 prompt #3.*

TEXASLIFE INSURANCE
COMPANY

Since 1901 | 900 WASHINGTON | POST OFFICE BOX 830 | WACO, TEXAS 76703-0830

Continuing Your Benefits Upon Termination of Employment

MEDICAL REIMBURSEMENT ACCOUNT:

Under the Flexible Benefit Administrators Medical Spending Account plan, you are eligible to continue coverage through COBRA.

If you are enrolled in the Medical Reimbursement Account, you will be eligible to continue coverage through COBRA after you leave employment for a specified period. You will receive notification from Interactive Medical Systems (IMS) with your account balance and continuation options shortly following your termination of employment. You may call **IMS at (800) 426-8739**.

ASSURITY CANCER PLAN

When you leave employment you may continue your Assurity Cancer coverage by having the premiums that are currently deducted from your paycheck billed to your home address or drafted from your bank account. Assurity will send you a letter explaining your options or you may arrange that by contacting **Assurity at: (866) 289-7337**.

AUL SHORT TERM DISABILITY PLAN

When you leave employment you may continue your disability coverage as long as continuous employment is maintained. To set up direct bill to your home address, please contact **AUL at (800) 553-5318**,

TEXAS LIFE WHOLE LIFE INSURANCE

When you leave employment, you may continue your Whole Life coverage by having the premiums that are currently deducted from your paycheck billed to your home address or drafted from your bank account. You may do that by contacting **Texas Life at: (800) 283-9233 prompt #3**.

METLIFE TERM LIFE

Conversion: If your employment terminates while you are covered under the plan or when you are approved for long-term disability, you may purchase without medical evidence of insurability, any individual insurance policy, except a term policy. You must apply for conversion within 31 days after the date your coverage terminates. This applies to Optional Life and Dependent Life as well as the basic coverage.

Portability: If you terminate employment, the portability provision allows you to take your optional life coverage with you, subject to the following provisions:

- You must apply for coverage with 31 days from the date your life coverage terminates.
- You must be **ACTIVELY** at work prior to employment termination.
- You may only port up to your current coverage amount. You cannot increase or add dependents.
- Employees are eligible to age 74, spouses to age 64 and children up to age 18, 24 if a full-time student.

Your employer will advise MetLife of your termination and MetLife will in turn, contact you directly to assist with the conversion/portability process, and advise you of your options. You may also call **MetLife at (877) 275-6387** and request a conversion kit.

If you do not convert or port your group term life insurance, coverage will terminate.

Important Phone Numbers:

Mark III Brokerage, Inc. - (800) 532-1044, ext. 212
Flexible Benefit Administrators Spending Accounts - (800) 437-3539
Assurity Cancer Plan - (866) 289-7337
AUL Short Term Disability Plan - (800) 553-5318
Texas Life Whole Life Plan - (800) 283-9233, prompt #3.
MetLife Term Life Plan - (800) 638-6420 (ext. 2 for claims)