

Greeneville City Schools 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 has worked in the public sector for the last 26 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 in this method may reduce your taxes and may increase your take home pay. The Cafeteria Benefits program includes the Flexible Spending Accounts, Ameritas Dental, Assurity Cancer Plan, Superior Vision, Standard Life Short Term Disability & Transamerica Universal Life Plan.

- The Plan Year is from January 1, 2006 to December 31, 2006

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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).

WageWorks HealthCare Reimbursement Account

Plan Year: January 1, 2006 - December 31, 2006

Medical Reimbursement Plan Maximum: \$5,000

Medical Reimbursement Plan Minimum: None

Waiting Period: 1 YEAR

The Health Care Reimbursement Account (HCRA) offers a real advantage for your pocketbook. Many people find this a cost effective way to pay for such items as medical and dental plan deductibles/co-payments, eyeglasses, contact lenses, orthodontics and other health-related expenses that may not be covered by insurance. Even taxpayers who do not itemize can take advantage of this tax break by using the Health Care Reimbursement Account.

MANAGING YOUR ACCOUNT

WageWorks makes it easy for you to track your money with real-time account access and frequent account statements.

Online Account Access

Access your account online anytime to check account activity and claims status. Log onto www.wageworks.com to view your account. A simple registration process is required the first time you visit. Or, you may be able to access this site through your employer's benefits portal.

Access by Phone

If you do not have Internet access, you can call our automated voice system to check your account status. Call toll free (877) 924-3967 and follow the prompts to check account balance, claims status and account activity. WageWorks Customer Service Representatives are available from 9am to 8pm Eastern Time and from 5am to 5pm Pacific Time.

Monthly Statements

Every month you will receive a statement that contains your account balance, payment history and helpful tips for using your accounts. This statement will be emailed to you if you have entered an email address in your Profile and mailed to you if you have not.

USING THE WAGEWORKS HEALTH CARE CARD

Why Use The Card?

By purchasing eligible health care items with the card, the cost of your purchases is automatically deducted from your Health Care Account. No claims to file. No waiting for reimbursement.

When To Use the Card

Use the card to pay for eligible health care expenses such as co-payments, prescriptions and glasses.

Where To Use the Card

In addition to doctors' and dentists' offices and pharmacies, you can use your card to purchase eligible merchandise at discount chain stores, supermarket pharmacies and wholesale clubs.

How To Use Your Card

1. Activate your card by calling (866) 363-4128.
2. Give your card to the service provider or swipe it yourself. If you are using a terminal, choose the credit option. Sign for your purchase.
3. Save the itemized receipt (not the credit card-like receipt) that describes what you paid for. You may be asked to submit this receipt to show you used the card for eligible health care expenses. Watch your monthly statement for details.

Call (877) 924-3967 if you have any questions about using your Health Care Card.

USING THE WAGEWORKS WEB SITE**Register**

If you have not already registered to use the WageWorks site, you can register at www.wageworks.com to access your account, schedule payments, download forms and update your personal information.

1. Go to www.wageworks.com and click on First Time User? Register Now.
2. Enter the information requested so we can identify you.
3. Confirm or update the contact information in your Profile.
4. Review the User Agreement and confirm your acceptance.

Download Forms

1. Log onto your account at www.wageworks.com, and choose the **Print Forms** button.
2. Select Health Care or Dependent Care.
3. Select the form you need.
4. Print or save the form.

Scheduling Payments

Use the WageWorks web site to schedule payments to your health care or dependent care provider. Here's how:

Pay My Provider—Health Care

1. Log onto your account at www.wageworks.com and choose the **Health Care** tab.
2. Click **Request Pay My Provider**.
3. Confirm or enter your email address.

4. Enter your provider information.
5. Enter patient information.
6. Enter your payment amount(s).
7. WageWorks will make the requested payment(s) from your account and mail it directly to your provider.**Pay My Provider—Dependent Care**

1. Log onto your account at www.wageworks.com and choose the **Dependent Care** tab.

2. Click **Request Pay My Provider**.

3. Confirm or enter your email address.

4. Enter your provider information.

5. Enter dependent care information.

6. Enter your payment amount(s).

7. WageWorks will make the requested payment(s) from your account and mail it directly to your provider.

HEALTH CARE ACCOUNT

Your WageWorks Health Care Account saves you money by allowing you to pay for your eligible health care costs with pre-tax dollars. Your election amount is deducted from your paycheck automatically by your employer. You have easy access to your account to pay for eligible health care expenses not covered by your health plan by using the convenient WageWorks payment options: the WageWorks Health Care Card, Pay My Provider or Pay Me Back.

Over-the-Counter Drugs and Medicine Are Eligible!

If you buy products like Advil®, Band-Aids®, Benedryl®, Claritin® or Tums®, you can now use your Health Care Account to pay for these items thanks to an IRS ruling in September 2003. Check the list of Health Care Expenses to find out which items are covered

Reimbursement for Over-the-Counter Drugs and Medicine

When you file a Pay Me Back claim, make sure the description you enter on your claim form clearly indicates the type of over-the-counter product you purchased such as indicated in the list of Health Care Expenses beginning on page 8. You must also submit an itemized receipt that indicates what you paid for, the date and the amount.

WAGEWORKS HEALTH CARE CARD

The WageWorks Health Care Card works like a credit card that you can use to purchase eligible health care services and items at qualified merchants who accept MasterCard®. Unlike a credit card, the cost of the purchases you make with the card is automatically deducted from your Health Care Account.

When To Use It

The WageWorks Card is a “limited-use” card, which means you can use it only at qualified medical offices and merchants to pay for eligible health care expenses. For full details of items that are and are not covered see the list of Health Care Expenses. Your card should be used only for eligible health care you receive while covered under the Health Care Account. You cannot use the card to pay for services you received before you were covered under this account this plan year or to pay for eligible health care you will receive any time in the future. The WageWorks Card is especially convenient for:

- Co-payments at your doctors, dentists and hospitals
- Prescriptions at the pharmacy counter or through a mail-order program
- Prescription eyeglasses, sunglasses or contact lenses
- Surgical and laboratory fees
- Medical supplies

How To Use It

- Give your card to the service provider or swipe it yourself at the point of purchase.
- If you are using a terminal, choose the *credit* option.
- Sign for your purchase.
- Keep your itemized receipt—the one that describes what you paid for.

Other Things You Need To Know

- **Be sure to keep your receipts and other records each time you use the card.** In most cases WageWorks receives enough information about your purchase when you pay with the card to confirm that it was for an eligible expense. Occasionally, we require more information to verify a payment. Your monthly statement will show you if more information is required.
- **You will be required to reimburse your account for any use of the card for ineligible expenses.** If you cannot show the card was used to pay for eligible health care expenses, then you will be required to reimburse your Health Care Account for the amount of the purchase. Your monthly statement will notify you of any payments due. If you fail to reimburse your account when requested, you may be subject to any of the following: (1) the amount due will be deducted from your next Pay Me Back reimbursement check, (2) your card privileges may be revoked and (3) other collection efforts may be taken in accordance with your employer’s policies.
- **Save your receipts** with your tax documents just as you should for other uses of your Health Care Account.
- **The card cannot be used to get cash value.** Keep the card safe like a credit card. All purchases will be charged against the account balance.

PAY MY PROVIDER

You tell us how much to pay your provider and we will write and mail a check directly from your account.

When To Use It

Pay My Provider is your most convenient payment option if you have:

- Regularly scheduled payments for eligible expenses such as orthodontic care or physical therapy
- Balance billing, which is when your provider bills your health plan and then bills you for the amount your insurance doesn't cover
- Invoices you receive after the date of service for eligible expenses that require only basic proof of service (See page 7 for more information on proof of service).

How To Use It

- Log onto your account at www.wageworks.com
- Click on Health Care tab
- Click on Request Pay My Provider
- Confirm or enter your email address
- Enter your provider information
- Enter patient information
- Enter your payment amount(s)
- WageWorks will make the requested payment(s) from your account and mail it directly to your provider

Other Things You Need To Know

- An email address is required to use Pay My Provider so we can send you time-sensitive payment information.
- WageWorks will send you an email if you use up all the money in your account before we can make your requested payment(s).
- As with all use of your Health Care Account, save your receipts or other proof of expense with your tax documents.

PAY ME BACK

Sometimes you will want to pay for your health care expenses yourself and have WageWorks pay you back with money from your Health Care Account.

When To Use It

Some expenses are easier to pay for first and then get reimbursed. For example:

- You must pay in advance. Pay for the service as required and then file your claim once you have received the service.
- Your provider does not accept credit cards.
- You purchase over-the-counter drugs and medications.
- The expense is listed as a Maybe in the Health Care Expense list and requires additional information to get approved.
- You receive a bill from your provider after your insurance pays and your portion is less than \$20, the minimum Pay My Provider payment amount.

How To Use It

- Pay for your eligible health care expense as you usually do and save your receipt.
- Complete a Health Care Pay Me Back form. There is one form included in this guide. Additional forms are available for download from www.wageworks.com, or you can request one from your benefits representative.
- Fax your form and photocopies of your proof of services to the toll free number (877) 353-9236.
- Or mail your form and photocopies of your proof of service to:

WageWorks Processing Center
Claims Administrator
PO Box 14053
Lexington, KY 40511

Other Things You Need To Know

- Remember to send us a photocopy of the proof, not your original. Keep your originals with your tax documents for the year.
- Check the proof of service definitions on this page and the list of Health Care Expenses beginning on page 8 to find which type of proof of service you need to provide.

WHOSE EXPENSES ARE ELIGIBLE?

You can use your Health Care Account to pay for health care expenses incurred by any of the following people - even if they are not covered by your employer's health coverage:

- You
- Your spouse, if you are legally married and file a joint tax return
- Your child, grandchild or any other child who you claim as a tax dependent regardless of age
- Your older child, elderly parent, domestic partner or any other person who you claim as a tax dependent

PROOF OF SERVICE DEFINITIONS

Basic Proof applies to the most common types of expenses, such as office visits, prescription and pharmacy items, over-the-counter drugs and medicine, balances not covered by your health plan, recurring expenses for ongoing treatment. For these types of expenses, you can provide doctor's receipts, pharmacy forms, an itemized receipt, a provider's bill or an explanation of benefits from your health plan provider.

Basic + Letter Proof is required for expenses that aren't as straightforward as those listed above. In addition to a receipt, you must provide a signed letter from your doctor. The letter must include your diagnosis, indicate that the expense is for a medically necessary service, and state the specific reason for the expense.

Basic + Letter + Cost Proof is for very specific expenses such as Braille books. In addition to the cost of the special item, you must also provide proof of the cost of the standard, unmodified item. Only the difference in cost between the standard item and the modified item is eligible to be paid through your Health Care Account.

Expense	Eligible	Proof of Service*	Best Way to Pay
Acupuncture	Yes	Basic	Card or Pay Me Back
Acne treatments (including over-the-counter)	Yes	Basic	Pay Me Back
Adoption (medical expenses related to)	Yes	Basic	Pay My Provider
Adoption fees	No		
Alcoholism treatment	Yes	Basic	Pay My Provider
Allergy products (including over-the-counter)	Yes	Basic	Pay Me Back
Allergy & sinus medicine (including over-the-counter)	Yes	Basic	Pay Me Back
Allergy treatments (including over-the-counter)	Yes	Basic	Pay Me Back
Alternative dietary substitutes	No		
Alternative drugs and medicines	Maybe	Basic + Letter	Pay Me Back
Alternative healers	Maybe	Basic + Letter	Pay Me Back
Ambulance	Yes	Basic	Any
Antacid (including over-the-counter)	Yes	Basic	Pay Me Back
Antibiotic ointment (including over-the-counter)	Yes	Basic	Pay Me Back
Aspirin (over-the-counter)	Yes	Basic	Pay Me Back
Asthma medicines or treatments (including over-the-counter)	Yes	Basic	Pay Me Back
Bandages and related items	Yes	Basic	Pay Me Back
Birth control (by prescription or over-the-counter)	Yes	Basic	Pay Me Back
Body scans and other diagnostic services (even if not prescribed)	Yes	Basic	Card or Pay Me Back
Braille books and magazines (difference in cost only)	Maybe	Basic+Letter+Cost	Pay Me Back
Canker & cold sore treatments (including over-the-counter)	Yes	Basic	Pay Me Back
Chest rubs (including over-the-counter)	Yes	Basic	Pay Me Back

****See page 7 for proof of service definitions***

Continued

Expense	Eligible	Proof of Service*	Best Way to Pay
Child or newborn care instruction	No		
Childbirth classes	Yes	Basic	Any
Chiropractic treatment	Yes	Basic	Any
Chiropractor (office visit)	Yes	Basic	Any
Christian Science practitioners	Yes	Basic	Pay My Provider
Co-insurance (medical, dental or vision)	Yes	Basic	Pay My Provider
Cold & flu prevention	No		
Cold & flu medicine (including over-the-counter)	Yes	Basic	Pay Me Back
Cold cream	No		
Condoms and spermicides	Yes	Basic	Pay Me Back
Contact lenses, cleaning solutions, etc.	Yes	Basic	Pay Me Back
Contraceptives (over-the-counter)	Yes	Basic	Pay Me Back
Co-payments (medical, dental or vision)	Yes	Basic	Card or Pay Me Back
Cord blood storage (for future treatment of a birth defect or known medical condition)	Maybe	Basic + Letter	Pay Me Back
Cord blood storage (for unidentified future use)	No		
Cosmetic surgery	No		
Cough drops & sore throat lozenges (including over-the-counter)	Yes	Basic	Pay Me Back
Cough syrup (including over-the-counter)	Yes	Basic	Pay Me Back
Counseling (for treatment of a medical condition)	Yes	Basic	Pay My Provider
Counseling (healthcare related)	Yes	Basic	Pay My Provider
Crutches (purchase or rental)	Yes	Basic	Card or Pay Me Back

****See page 7 for proof of service definitions***

Continued

Expense	Eligible	Proof of Service*	Best Way to Pa
Dancing lessons (for treatment of a medical condition)	Maybe	Basic + Letter	Pay Me Back
Deductibles (medical, dental or vision)	Yes	Basic	Pay My Provider
Dental products (excluding general health items)	Maybe	Basic + Letter	Pay Me Back
Dental treatments	Yes	Basic	Pay My Provider
Dental veneers	Maybe	Basic + Letter	Pay Me Back
Diagnostic services	Yes	Basic	Pay My Provider
Dietary supplements (for treatment of a medical condition)	Maybe	Basic + Letter	Pay Me Back
Drug addiction treatment	Yes	Basic	Pay My Provider
Drugs (prescription)	Yes	Basic	Card
Dyslexia treatment	Yes	Basic	Pay My Provider
Ear drops & wax removal	No		
Electrolysis	No		
Exercise equipment (for treatment of a medical condition)	Maybe	Basic + Letter	Pay Me Back
Eye examinations	Yes	Basic	Pay My Provider
Eye related equipment/materials	Yes	Basic	Pay Me Back
Eyeglasses (over-the-counter)	Yes	Basic	Pay Me Back
Eyeglasses (prescription)	Yes	Basic	Card or Pay Me
Face lifts	No		
Fertility monitor (over-the-counter)	Yes	Basic	Pay Me Back
Fertility treatment (for employee, spouse or dependent)	Yes	Basic	Pay My Provider
Fertility treatment (for non-dependent surrogate)	No		
Fitness programs	Maybe	Basic + Letter	

****See page 7 for proof of service definitions***

Continued

Expense	Eligible	Proof of Service*	Best Way to Pay
Flu shots	Yes	Basic	Pay My Provider
Funeral expenses	No		
Gastrointestinal medication (including over-the-counter)	Yes	Basic	Pay Me Back
Guide dog (dog, training, care)	Yes	Basic	Pay My Provider
Hair removal	No		
Hair transplant	No		
Hand lotion	No		
Health club dues	No		
Hearing aids and batteries	Yes	Basic	Pay Me Back
Herbal medicines	Maybe	Basic + Letter	
Herbal treatments (non-prescription)	Maybe	Basic + Letter	
Homeopathic medicines	Maybe	Basic + Letter	
Hospital services	Yes	Basic	Pay My Provider
Household help	No		
Illegal operations	No		
Illegal substances	No		
Immunizations	Yes	Basic	Pay My Provider
Infertility treatment (for employee, spouse or dependent)	Yes	Basic	Pay My Provider
Insulin	Yes	Basic	Card or Pay Me Back
Insulin testing materials and equipment	Yes	Basic	Pay Me Back
Insurance premiums	No		
Insurance premiums (employee portion or other)	No		
Laboratory fees	Yes	Basic	Pay My Provider

****See page 7 for proof of service definitions***

Continued

Expense	Eligible	Proof of Service*	Best Way to Pay
Lactose treatment (including over-the-counter)	Yes	Basic	Pay Me Back
Lamaze classes (childbirth instruction only)	Yes	Basic	Pay My Provider
Laser eye surgery	Yes	Basic	Card or Pay Me Back
Lasik	Yes	Basic	Card or Pay Me Back
Laxatives (including over-the-counter)	Yes	Basic	Pay Me Back
Learning disability treatments	Yes	Basic	Pay My Provider
Lice treatment (including over-the-counter)	Yes	Basic	Pay Me Back
Lodging (essential to receive medical care)	Maybe	Basic + Letter	Pay Me Back
Long-term care services	No		
Magnetic therapy	No		
Marriage counseling	No		
Massage therapy (for treatment of a medical condition)	Maybe	Basic + Letter	Pay Me Back
Mastectomy-related special bras	Yes	Basic	Card or Pay Me Back
Maternity clothes	No		
Medical abortion	Yes	Basic	Card or Pay Me Back
Medical equipment (for treatment of medical condition) and repairs	Yes	Basic	Pay My Provider
Medical monitoring and testing devices	Yes	Basic	Pay Me Back
Medical records charges	Yes	Basic	Pay My Provider
Medical savings accounts	No		
Medical supplies (for treatment of a medical condition)	Maybe	Basic + Letter	Pay Me Back
Medicines (over-the-counter)	Yes	Basic	Pay Me Back
Medicines (prescription; except for cosmetic purposes)	Yes	Basic	Card or Pay Me Back
Modified equipment	Maybe	Basic+Letter+Cost	Pay Me Back

****See page 7 for proof of service definitions***

Continued

Expense	Eligible	Proof of Service*	Best Way to Pay
Monitors & test kits	Yes	Basic	Pay Me Back
Motion & nausea (including over-the-counter)	Yes	Basic	Pay Me Back
Nasal sprays (including over-the-counter)	Yes	Basic	Pay Me Back
Nasal strips	No		
Non-prescription drugs and medicines	Yes	Basic	Pay Me Back
Norplant insertion or removal	Yes	Basic	Pay My Provider
Nursing services (wages and taxes)	Yes	Basic	Pay My Provider
Nutritional supplements (for treatment of a medical condition)	Maybe	Basic + Letter	Pay Me Back
OB/GYN fees	Yes	Basic	Pay My Provider
Occlusal guards to prevent teeth grinding	Yes	Basic	Pay My Provider
Office visits (medical, dental or vision)	Yes	Basic	Card or Pay Me Back
Operations (excluding cosmetic)	Yes	Basic	Pay My Provider
Optometrist / ophthalmologist fees	Yes	Basic	Pay My Provider
Oral care (over-the-counter)	No		
Organ transplants (recipient and donor)	Yes	Basic	Pay My Provider
Orthokeratotomy	Yes	Basic	Pay My Provider
Orthodontia	Yes	Basic	Pay My Provider
Over-the-counter medication	Yes	Basic	Pay Me Back
Ovulation monitor (over-the-counter)	Yes	Basic	Pay Me Back
Oxygen	Yes	Basic	Card or Pay Me Back
Pain reliever (including over-the-counter)	Yes	Basic	Pay Me Back
Personal use items (toothbrush, toothpaste, etc.)	No		
Physical exams	Yes	Basic	Pay My Provider
Physical therapy	Yes	Basic	Pay My Provider
Pregnancy tests (over-the-counter)	Yes	Basic	Pay Me Back

****See page 7 for proof of service definitions***

<i>Continued</i> Expense	Eligible	Proof of Service*	Best Way to Pay
Premiums (health plan or insurance)	No		
Prescription drugs (except for cosmetic purposes)	Yes	Basic	Card or Pay Me Back
Prosthesis	Yes	Basic	Pay My Provider
Psychiatric care	Yes	Basic	Pay My Provider
Psychoanalysis	Yes	Basic	Pay My Provider
Psychologist fees	Yes	Basic	Pay My Provider
Radial keratotomy (RK)	Yes	Basic	Card or Pay Me Back
Reading glasses (over-the-counter)	Yes	Basic	Pay Me Back
Reconstructive surgery (following mastectomy or other)	Maybe	Basic + Letter	Pay Me Back
Removal of benign mole, cyst or tumor	Yes	Basic	Pay My Provider
Retin-A (excluding cosmetic uses)	Maybe	Basic + Letter	Pay Me Back
Rogaine®	No		
Smoking cessation (programs / counseling)	Yes	Basic	Pay My Provider
Smoking cessation drugs (prescription)	Yes	Basic	Card or Pay Me Back
Smoking cessation gum or patches (including over-the-counter)	Yes	Basic	Pay Me Back
Special equipment	Maybe	Basic+Letter+Cost	Pay Me Back
Special foods (e.g., gluten-free or salt free diet)	Maybe	Basic+Letter+Cost	Pay Me Back
Speech therapy	Yes	Basic	Pay My Provider
Sterilization	Yes	Basic	Pay My Provider
Student health fees (for medical services)	Yes	Basic	Card or Pay Me Back
Sunglasses (over-the-counter)	No		
Sunglasses (prescription)	Yes	Basic	Card or Pay Me Back
Sunscreen	No		
Supplies (for treatment of a medical condition)	Maybe	Basic + Letter	Pay Me Back

***See page 7 for proof of service definitions**

Continued

Expense	Eligible	Proof of Service*	Best Way to Pay
Surgery (cosmetic)	No		
Surgery (excluding cosmetic)	Yes	Basic	Pay My Provider
Surgical abortion	Yes	Basic	Card or Pay Me Back
Swimming lessons (for treatment of a medical condition)	Maybe	Basic + Letter	Pay Me Back
Teeth bleaching or whitening	No		
Therapy (for treatment of a medical condition)	Yes	Basic	Pay My Provider
Toothpaste, toothbrush, floss	No		
Transgender treatments / surgery	No		
Transportation, parking and related travel expenses (essential to receive medical care)	Maybe	Basic + Letter	Pay Me Back
Tubal ligation	Yes	Basic	Pay My Provider
UV protection clothing	No		
Vaccinations	Yes	Basic	Pay My Provider
Varicose veins surgery	Yes	Basic	Pay My Provider
Vasectomy	Yes	Basic	Pay My Provider
Viagra® (prescription)	Yes	Basic	Card or Pay Me Back
Vitamins (over-the-counter)	No		
Vitamins (prescription)	Yes	Basic	Card or Pay Me Back
Weight loss counseling	Maybe	Basic + Letter	Pay Me Back
Weight loss program (to improve or maintain general health)	No		
Weight loss program and / or drugs (for treatment of a medical condition)	Maybe	Basic + Letter	Pay Me Back
Weight loss foods	No		
Wheelchair and repairs	Yes	Basic	Pay My Provider
X-ray fees	Yes	Basic	Pay My Provider

****See page 7 for proof of service definitions***

WageWorks Dependent Care Reimbursement Account

Plan Year: January 1, 2006 - December 31, 2006

Dependent Care Reimbursement Plan Maximum: \$5,000.00

Your WageWorks Dependent Care Account saves you money by allowing you to pay for your eligible dependent care costs with pre-tax dollars. Your election amount will be deducted automatically from your paycheck by your employer and used to fund your account. You have easy access to your account to pay for eligible dependent care expenses using the convenient WageWorks payment options: Pay My Provider or Pay Me Back. **(Debit Card does not apply to the Dependent Care Account).**

PAY MY PROVIDER

When To Use It

Pay My Provider is the most convenient payment option. You tell us how much to pay your provider and we'll write and mail a check directly from your account.

How To Use It

- Log onto your account at www.wageworks.com
- Click on **Dependent Care** tab
- Click on **Request Pay My Provider**
- Confirm or enter your email address
- Enter your provider information
- Enter dependent information
- Enter your payment amount(s)
- WageWorks will make the requested payment(s) from your account and mail it directly to your provider

Other Things You Need To Know

- Payment will be made in the amount requested or your account balance before the payment date, whichever is lower.
- WageWorks will send you an email if you use up all the money in your account before we can make your requested payment(s).
- An email address is required to use Pay My Provider so we can send you time sensitive payment information.
- As with all use of your Dependent Care Account, save your receipts or other proof of expense with your tax documents.

PAY ME BACK

When To Use It

If you like to pay for your dependent care expenses as you normally do and then get reimbursed for your expenses, then Pay Me Back is the option for you.

How To Use It

- Pay for your dependent care as you usually do.
- Complete a Dependent Care Pay Me Back form. There is one form included in this guide. Additional forms are available for download from www.wageworks.com, or you can request one from your benefits representative.
- Provide proof of service for each expense in the form of a photocopy of a receipt, statement or bill from your provider (formal or informal), or your provider's signature on the form.
- Fax your form and photocopies of your proof of services to the toll free number (877) 353-9236.
- Or mail your form and photocopies of your proof of service to:

**WageWorks Processing Center
Claims Administrator
PO Box 14053
Lexington, KY 40511**

Other Things You Need To Know

- Remember to send photocopies of your proof of service.
- Save your originals with your tax documents.

WHAT QUALIFIES

You can use your Dependent Care Account to pay for expenses to care for any eligible dependents:

- Your child, grandchild or any other child under the age of 13
- Your older child, spouse, elderly parent or any other person who is physically or mentally incapable of self care

All of the following must be true about this person:

- The person lives in your home at least eight hours on each day you pay for care
- You (and your spouse, if you are married) pay over half the cost of maintaining a household for the person
- You claim the person as a tax dependent, or you would be eligible to except:
 - (a) the person's income prevents you from doing so or
 - (b) the person is claimed by his non-custodial parent due to written decree

And, all of the following must be true about the care:

- The care is provided while you work or to enable you to work. If you are married, the care is provided while your spouse also works or to enable your spouse to work or go to school full-time (at least 5 months a year) or while your spouse is incapable of self care.
- The care may be provided by a relative or a non-relative but is not provided by a tax dependent.
- Your care provider must conform to state and local laws (including being licensed, if required) and be able to provide you with his/her Social Security or Tax ID number. You will need this to request a payment or file a claim.

DEPENDENT CARE EXPENSES

Child Care Expenses	Eligible?
After school programs	Yes
Babysitting (someone else's home)	Yes
Babysitting (your home)	Yes
Before school programs	Yes
Child care	Yes
Dance lessons	No
Educational services (other than pre-school)	No
Kindergarten	No
Language classes	No
Nursery school	Yes
Piano lessons	No
Preschool	Yes
Private school tuition (for kindergarten and up)	No
Sick child care	Yes
Sleep-away camp	No
Summer day camp	Yes
Tutoring	No

Elder Care Expenses	Eligible?
Adult day care center	Yes
Day nursing care	No
Elder care (in your home)	Yes
Elder care (outside your home)	Yes
Medical care	No
Nursing home care	No
Senior day care	Yes

FREQUENTLY ASKED QUESTIONS

Where can I get more Pay Me Back Forms?

Included with this guide is one Health Care Pay Me Back form and one Dependent Care Pay Me Back form. If you need additional forms, you can download them from www.wageworks.com, request one from your company benefits manager or contact WageWorks Customer Service at (877) 924-3967.

Can I change or cancel my plan once I have enrolled?

You may be eligible to change or cancel your enrollment after experiencing a qualified change (such as getting married or having a child) only if and as permitted by your employer's plan.

How long will it take to receive reimbursement for my claims?

You can expect to receive a reimbursement check for approved Pay Me Back claims within about one week.

What if my claim is denied?

You will be notified via mail or email within a week if your claim is denied and if additional information is needed to approve your claim. You can also view your claim status online at anytime.

How do I request a second Health Care Card?

You will receive a card with your name on it for your own use after you enroll. You may request a second card for use by one of your dependents (it will have their name on it). Both cards will automatically draw from funds in your Health Care Account. To request a second card, log into your account at www.wageworks.com and click on the Health Care tab. Select "Request a Second Card" and provide your dependent's first and last names and social security number, or send an email to help@wageworks.com. If you do not have Internet access, call WageWorks Customer Service at (877) 924-3967 Monday through Friday, 9am to 8pm Eastern Time and from 5am to 5pm Pacific Time.

What if I lose my Health Care Card?

If you lose your card, or if it's stolen, report it to WageWorks immediately by calling toll-free (877) 924-3967.

How do I know my personal information is kept secure and private?

WageWorks is committed to keeping your personal information safe by enforcing rigorous security and privacy procedures including SSL encryption on our web site. WageWorks' web site has been certified by the TRUSTe Privacy Program, and we are compliant with all current HIPAA regulations. WageWorks' full Privacy Policy is available online at www.wageworks.com.

What if I have additional questions?

If you can't find the answer to your question in this guide, browse the Help section of our web site at www.wageworks.com, send us an email at help@wageworks.com or call us at (877) 924-3967 (877-WageWorks). Our customer service representatives are here to assist you from 9am to 8pm Eastern Time and from 5am to 5pm Pacific Time.

THE RULES

The following rules are dictated by federal regulations. These apply when you participate in the Health Care Account or Dependent Care Account, employer-sponsored plans that allow you to pay for eligible health care or dependent expenses on a pre-tax basis.

Rules for Both Accounts

1. By enrolling, you authorize your employer to deduct your election amount from your paycheck on a pre-tax basis.
2. Your account can be used to pay for eligible expenses incurred while you are enrolled during the plan year. Expenses are considered incurred on the day of service for health care or on the day your dependent receives care for dependent care, not when you are billed or pay. Your account cannot be used to pay for expenses incurred before or after you are covered under this plan or that will be incurred in the future.
3. You cannot take a deduction or tax credit on your tax return for any health care or dependent care expenses paid for through your accounts.
4. You are responsible for maintaining documentation (receipts, etc.) to verify your expenses (the nature of each expense, the amount and the date incurred). Keep these with your other important tax papers for the calendar year. You may be requested to provide these per your monthly statement.
5. After the plan year ends, you will have a **90-day run-out period** to get reimbursed through the Pay Me Back feature for eligible expenses incurred while you were covered under in this plan during the plan year.
6. Be sure to incur eligible expenses totaling your election amount while you are covered under in this plan during the plan year. Any balance remaining in your account after the 90-day run-out period cannot be rolled over or paid out to you and will be forfeited.
7. If you want to participate in the plan during the next plan year, you will need to re-enroll during the next open enrollment period. We're not allowed to keep you enrolled or automatically re-enroll you.
8. You may be eligible to change or cancel your enrollment after experiencing a qualified change, only if and as permitted by your employer's plan.
9. Participation in this plan reduces your taxable income and may affect other compensation-based benefits such as life, disability and Social Security.
10. Consult a tax advisor if you have any questions regarding your personal situation.
11. You cannot use your dependent care account balance to pay for health expenses and vice versa.

Rules for Your Health Care Account

1. Your Health Care Account can be used to pay for only medically necessary and eligible health care expenses that are not covered by or reimbursed through insurance, a health plan or any other source.
2. When you use your WageWorks Card, you are certifying that the expenses paid for with the card are medically necessary and not covered by or reimbursable through any other source.

Rules for Your Dependent Care Account

1. Your Dependent Care Account can be used to pay for only work-related and eligible dependent care expenses that are not covered by any other source.
2. You will need to provide the Social Security or Tax ID number of your dependent care provider to request payments or get reimbursed from your Dependent Care Account.

DEFINITIONS**Coverage Period**

The period of time during which you are enrolled for the Health Care Account or Dependent Care Account during the plan year. You can use your Health Care Account to pay for eligible expenses incurred during your coverage period.

Dependent Care Account

An employer-sponsored plan that allows you to set aside pre-tax income from your paycheck to pay for eligible dependent care expenses incurred while you are enrolled during the plan year.

Eligible Expense

A health care or dependent care expense that you can pay for using your Health Care Account or Dependent Care Account. See the list of Health Care and Dependent Care Expenses.

Health Care Account

An employer-sponsored plan that allows you to set aside pre-tax income from your paycheck to pay for eligible health care expenses incurred while you are enrolled during the plan year.

Medically Necessary

For the diagnosis, cure, mitigation, treatment, or prevention of disease and/or for transportation primarily for and essential to receiving medical, dental or vision care.

Participant

A person enrolled for a Health Care Account or Dependent Care Account.

Plan Year

The period of time during which your employer offers the Health Care Account or Dependent Care Account. You can use your Health Care Account or Dependent Care Account to pay for eligible expenses incurred during your coverage period.

during the plan year. Check online at www.wageworks.com or with your employer for your plan year start and end dates.

Proof Of Service For Dependent Care

A provider's signature on your claim form, a receipt, or other record of a dependent care expense from a third party that specifies the type of care provided, the date care was provided, and the cost.

Proof Of Service For Health Care

A written record documenting your health care expense that describes the service you received or the item you purchased, the date of service and the amount. A credit card-like receipt that shows only the cost is not sufficient proof of service. See page 7 for more information.

Provider (Dependent Care)

A person or business who provides dependent care services. Can include daycare centers, preschools, and senior daycare.

Provider (Health Care)

A person or business providing health-related services or materials. Can include doctors, optometrists, pharmacists, dentists, orthodontists, and medical suppliers.

GUIDELINES:

1. Use Pay Me Back for any type of eligible expense.
2. Pay for your expenses any way you like and then get reimbursed for them directly from your Health Care Account. Do not file a claim for any expenses paid for with the WageWorks Card or Pay My Provider. (Remember, expenses do not have to be paid in order to qualify for reimbursement; they just have to be incurred.)
3. After you have received the service or made your purchase, complete and submit a Pay Me Back form with the appropriate required proof.
4. You can view the status of your claim online within 24 hours after we receive it.
5. Reimbursement checks are mailed twice a week for APPROVED claims. You can expect your check to be mailed to you within 5 days after we receive it (provided you have an available balance in your account).
6. Your Health Care Account balance will be automatically adjusted to reflect all payments made using Pay Me Back, Pay My Provider and your WageWorks Card.

PROOF OF SERVICE:

You will need to provide proof of service for each expense listed on the Pay Me Back form. Your proof should be appropriate for the type of expense:

- Pharmacy receipt for prescriptions and other pharmacy purchases
- Doctor's office receipt for office visit
- Explanation of Benefits (EOB) from your insurance or health plan, for covered medical and dental expenses
- Bill or invoice from doctor or dentist for expenses not covered by your insurance or health plan

- Payment contract, monthly payment coupon or statement from your orthodontist
- Receipt from your optometrist or other medical service provider

Note: Some expenses may require you to submit a letter or written statement from your doctor stating (1) the diagnosis and (2) the need for the expense and, if applicable, the difference in cost between (3) standard, unmodified item and (4) special or modified item. For a list of these expenses, go to www.wageworks.com or see your WageWorks Health Care and Dependent Care Guide.

ELIGIBLE DEPENDENTS:

You can use your Health Care Account to pay for health care expenses incurred by any of the following people (even if they are not covered by your employer's health coverage):

- You
- Your spouse (if you are legally married and file a joint tax return)
- Your child, grandchild or any other child who you claim as a tax dependent (regardless of age)
- Your older child, elderly parent, domestic partner or any other person who you claim as a tax dependent
- Your older child, elderly parent, domestic partner or any other person who you would be eligible to claim as a tax dependent except the person's income prevents you from doing so

GUIDELINES:

1. Pay for your expenses as usual and then get reimbursed (with pre-tax dollars) directly from your Dependent Care Account.
2. You will need to complete and submit a Pay Me Back form with the appropriate required proof.
3. You can view the status of your claim online within 24 hours after we receive it.
4. Reimbursement checks are mailed twice a week for APPROVED claims. You can expect your check to be mailed to you within 5 days after we receive it (provided you have an available balance in your account).
5. Your account is funded strictly through your payroll deductions. Your available balance at any time is the total of all amounts deducted from your paycheck (as reported to us by your employer) less any payments made to date.
6. There is no limit to the amount of claims you can file against your account at any time. However, payments will be limited to your available balance.
7. Once you have used your available balance, no additional benefits will be paid until your available balance again exceeds \$0 (as your payroll deductions are reported by your employer).
8. All unpaid claims will be held to await available funds from your payroll deductions. Each time a payroll deduction is reported by your employer, any unpaid claims will be paid up to the amount of your new available balance.
9. Your Dependent Care Account balance is automatically adjusted to reflect all payments made using Pay Me Back and Pay My Provider.
10. If you are using the Pay My Provider feature, you are not eligible to get reimbursed through Pay Me Back until all of your Pay My Provider payments have been made or cancelled.

PROOF OF SERVICE:

You will need to provide proof of service for each expense listed on your Pay Me Back form. Submit one of the following for each expense:

- Signature of your provider on this form
- Photocopy of your cancelled check (front and back)
- Photocopy of a receipt
- Statement or bill from your provider (formal or informal)

ELIGIBLE DEPENDENTS:

You can use your Dependent Care Account to pay for expenses to care for any eligible dependents:

- Your child, grandchild or any other child under the age of 13
- Your older child, spouse, elderly parent or any other person who is physically or mentally incapable of self care

All of the following must be true about this person:

- The person lives in your home at least eight hours on each day you pay for his care
- You (and your spouse, if you are married) pay over half the cost of maintaining a household for the person
- You claim the person as a tax dependent, or you would be eligible to except: (a) the person's income prevents you from doing so or (b) the person is claimed by his non-custodial parent due to written decree

And all of the following must be true about the care:

- The care is provided while you are working or enables you to work (and, if you are married, while your spouse is working or going to school full-time at least 5 months a year or incapable of self care)
- The care may be provided by a relative or a non-relative but is not provided by a tax dependent
- Your care provider must conform to state and local laws (including being licensed, if required) and be able to provide you with his/her Social Security or Tax ID number

HELPFUL TOOLS

WageWorks provides easy-to-use tools that help you figure out how much to contribute and how much you can save. Use the calculators and eligible expense lists to find out how much to enroll for.

Health Care Calculator:

www.wageworks.com/hccalculator

Health Care Eligible Expense List:

www.wageworks.com/hclist

Dependent Care Calculator:

www.wageworks.com/dccalculator

Dependent Care Eligible Expense List:

www.wageworks.com/dclist

Please remember as required by law, any money in your Health Care or Dependent Care Account not used by the end of the plan year will be forfeited. Therefore, it is in your best interest to be conservative when estimating your contribution. But keep in mind that your tax savings may more than make up for any extra dollars you leave in your account at the end of the year. If you are in doubt about an expense, please contact WageWorks for assistance.

Also, in line with Internal Revenue Service guidelines, you can change your election if you have a **qualifying status change** during the plan year. This includes change in legal marital status, change in number of tax dependents, termination or commencement of employment, dependent satisfies or ceases to satisfy dependent eligibility requirements, or a judgment, decree or order. However, the adjustment in your election must be relevant to the change in status and the requested election change has to be in line and consistent with the event. All requests must be submitted to WageWorks for approval.

There is a run off period with the reimbursement accounts. You will have **90 days** following the end of the plan year to file for services rendered during the plan year.

If you have any questions concerning your Plan please feel free to contact

**WageWorks at:
877-924-3967
877-353-9236 (fax for claim forms)**

Or mail your claim form and photocopies of your proof of service to:

**WageWorks Processing Center
Claims Administrator
PO Box 14053
Lexington, KY 40511**

Website address: www.wageworks.com

Email address: help@wageworks.com



Ameritas Dental Plan

Effective Date: January 1, 2006

COMBINED CALENDAR YEAR DEDUCTIBLE

\$50.00 per individual for Type I (Basic) and Type II (Major) Procedures (3 times family limit). After the date that 3 members of a family have each satisfied their individual deductible, the entire deductible or any remaining portion of the deductible for any family member will be waived for the rest of that calendar year.

TYPE I (A) - PREVENTIVE AND DIAGNOSTIC - Type (A) benefits are payable at 100% UCR. No deductible applies.

- Evaluations (Two per benefit period)
- Cleanings (Two per benefit period)
- Fluoride for Children (Under age 19)
- Space Maintainers
- Radiographs (X-rays)
- Bitewings (Two per benefit period)

TYPE I (B) - BASIC PROCEDURES * - Type (B) benefits are payable at 80% UCR \$50.00 deductible applies.

- Sealants (Under 17)
- Limited Exams
- Restorative Amalgam & Resin (excluding inlays and crowns)
- Oral Surgery - Simple Extractions
- Oral Surgery - Complex Extractions
- Anesthesia
- Denture Repair

TYPE II - MAJOR PROCEDURES** - Type II Benefits are payable at 50% UCR \$50.00 deductible applies.

- Endodontics (Root Canal)
- Periodontics (Gum Disease)
- Crowns
- Prosthodontics-Removable (Dentures & Partials)
- Restorative -Inlays and Crown
- Prosthodontics - Fixed Pontics or Abutments
- Crown Repair

ORTHODONTIA (Adult & Child) - Paid at 50% UCR with a \$1,000 lifetime maximum. No deductible applies.

UCR (Usual, Customary, and reasonable charge)

LATE ENTRANT CLAUSE

There is a 12 month waiting period on all services except for cleanings, exams, and fluoride applications for employees who do not enroll when first eligible for coverage. The waiting period will be waived for employees who enroll when first eligible.

ANNUAL MAXIMUM BENEFIT

- Type I (A)(B) and Type II Procedures - \$1,000 per calendar year per person.
- Orthodontia Procedures - \$1,000 Lifetime per person.

DENTAL EXCLUSIONS (DEFERMENT PERIOD)

During the first 36 months following your or your dependent's Dental Coverage Effective Date, the initial placement of dentures, partial dentures, or bridges, if it includes the replacement of teeth all of which are missing prior to the effective date. (For currently covered insureds, Ameritas will use the employee's Date of Hire to determine the 36 month period.) This exclusion will not apply if the prosthesis replaces a sound natural tooth which is extracted while the patient is insured under this Dental Coverage and which is replaced within 12 months of the extraction. During the first 36 months of coverage, the replacement of bridges, partial dentures, dentures, inlays or crowns is excluded. **EXCEPTIONS** to this exclusion will be made if the replacement is made necessary by: a) accidental bodily injury to sound natural teeth (chewing injuries are not considered accidental bodily injuries), or b) the extraction of a sound natural tooth provided the replacement is completed within 12 months of the date of the injury or extraction.

ELIGIBLE EMPLOYEES

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

ELIGIBLE DEPENDENTS

Provides Coverage On:

- Your Spouse
- Children up to age 24 and unmarried if wholly dependent upon you for maintenance and support.

PREDETERMINATION OF BENEFITS

A treatment plan MAY be filed if a proposed course of treatment will exceed \$200.00. With this information, Ameritas can determine the benefits payable under this policy prior to the work actually being done. It will give the insured the amount payable, along with an idea of the out of pocket expense.

COORDINATION OF BENEFITS

If you or any of your dependents incur charges which are covered by any other group plan, the benefits of this plan will be coordinated with the benefits of the other plan so that the total benefits received are not greater than the charges incurred.

CERTIFICATE OF INSURANCE

The Certificate of Insurance issued to you describes in detail the benefits and limitations of this plan. This brochure is for general information only.

SECTION 125

This policy is provided as part of the Policyholder's Section 125 Plan. Each member has the option under the Section 125 Plan of participating or not participating in this policy.

A member may change their election only during an annual election period, except for a change in family status. Examples of such events would be marriage, divorce, birth of a child, death of a spouse or child or termination of employment. Please see your plan administrator for details.

ORTHODONTIA LIMITATIONS

(This is not a complete list)

- No benefit is payable for expenses incurred:
- In connection with a Treatment Program which was begun before the individual became insured for orthodontic benefits.
- During any quarter of a Treatment Program if the individual was not continuously insured for orthodontic benefits for the entire quarter.
- After the individual's insurance for orthodontic benefits terminates.

LIMITATIONS/EXCLUSIONS

(This is not a complete List)

- For any treatment which is for cosmetic purposes. Facings on crowns or pontics behind the 2nd bicuspid are considered cosmetic.
- Charges incurred prior to the date the individual became insured under this plan, or following the date of termination of coverage.
- Services which are not recommended by a dentist or which are not required for necessary care and treatment.
- Expenses incurred to replace lost or stolen appliances.
- Expenses incurred by an insured because of a sickness for which he /she is eligible for benefits under Worker's Compensation Act or similar laws.

Rates (10 pay deductions)

Employee	\$3.95
Employee & Family	\$103.07



For Claims/Customer Service Questions call Ameritas: 1-800-487-5553

This insurance is underwritten by Americas Life Insurance Corp.

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.

CSO'S CANCER PLAN is designed to create a source of extra cash that will 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 unique 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.
- No lifetime maximum limits for most cash benefits.
- 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 Radioactive Isotopes Therapy
- Experimental Treatment
- Individual/Family Transportation and Lodging

*Cancer Facts & Figures, American Cancer Society, 2001.

**Report from the American Hospital Administration.

Assurity Cancer & Specified Disease Plan

Effective Date: January 1, 2006

BASIC BENEFITS

Provides medical expense benefits caused by cancer and certain other specified diseases by rider for the employee, spouse and covered children with continuous benefit and premium period for life. The Family Rider allows for the addition of family members to the employee's policy.

RATE STRUCTURE

Unisex Rates; Employee Issue Ages: 18-69, Family: Up to Age 69 on spouse and 25 on children if a full-time student in an accredited school. Issue Age is age of last birthday on the day policy is issued.

UNDERWRITING

Pre-existing conditions are not covered during the first two years the policy is in force. Persons with previous history of cancer will be excluded unless added by rider for those with simple skin cancers. Additional question regarding diagnostic tests that have been completed within last 30 days or are scheduled to be performed is also asked. No benefits will be paid during a 30-day waiting period. Conditions that manifest after the policy date will be payable beginning on the 31st day.

Policy will pay the following specified benefits for each unit for a covered injury:

Hospital Indemnity – pays benefits each day while confined in the hospital for cancer or certain other specified diseases for the first 75 days of each period of confinement. There are three options for the daily benefit amount: \$150, \$250, and \$350. (NOTE: The \$150 benefit amount is not available in Utah.)

Prescription Drugs and Medicines – pays actual charges up to 25% of daily hospital confinement benefit for the first 75 days of hospital confinement.

Surgical Benefit – pays up to \$7,500 for actual charges made by surgeon as shown in Surgical Table in policy.

Anesthesia – pays up to 25% of the amount payable under the Surgical Benefit. Limit of \$50 per skin cancer operation.

Additional Surgical Opinions – pays up to \$150 for a second opinion. If the second opinion differs from the first, up to \$150 for a third opinion.

Artificial Limb and Prosthesis – pays actual charges for prosthesis and reconstructive procedure to affix or implant it up to \$2,000 lifetime maximum.

Attending Physician – pays actual charges up to \$35 per day for in-hospital physician's visits.

Private Duty Nurse – pays actual charges up to \$150 per day while confined in the hospital when authorized by a physician when a Private Nurse is required.

Radiation, Chemotherapy or Immunotherapy – pays 50% of actual charges for treatments up to the maximum amount purchased.

The monthly option for this benefit is:

- **\$10,000 with a lifetime maximum of \$100,000**

Experimental Treatment – pays the actual charges up to \$25,000 per calendar year for such treatment received in the United States or its territories, except for experimental bone marrow transplants.

Physical and Speech Therapy – pays the actual charges up to \$25 per therapy session up to a lifetime maximum of \$1,000.

Extended Care Facility – pays up to \$60 per day for confinement in such a facility. Confinement must be recommended by a physician and begin within 14 days following a covered hospital stay. Benefits are limited to the number of days of the prior hospital confinement.

Bone Marrow Transplant for Cancer – pays actual charges up to a lifetime maximum of \$25,000 for bone marrow transplants or other forms of stem cell rescue and all related services or supplies. Payable in lieu of any other benefits payable under this policy, except Transportation and Lodging for Bone Marrow Donors.

Transportation and Lodging for Bone Marrow Donors - pays (a) actual charges up to \$2,500 for medical expenses directly related to such a transplant, (b) pays actual charges for a round trip coach fare on a common carrier or a personal automobile allowance of 50 cents per mile in excess of 50 miles one-way to the city where the transplant is performed, up to 700 miles round trip, and (c) pays actual charges up to \$50 per day for lodging and meal expenses when donor has to remain near the hospital. This payment is in lieu of any other benefit payable under this policy when the donor is a person insured under this policy.

Transportation for Non-local Treatment Which Requires Hospital Confinement – pays (a) actual charges for non-local round trip charges by common carrier to the nearest hospital that provides the prescribed treatment or (b) 50 cents per mile for personal automobile expenses in excess of 50 miles one way, up to 700 miles round trip.

Transportation for Non-local Treatment Which Does Not Require Hospital Confinement – pays (a) 50 cents per mile for personal automobile expenses in excess of 50 miles one way, up to 700 miles round trip with a maximum of \$1,500 per calendar year, (b) pays actual charges for round trip coach fare on a common carrier or a personal automobile allowance of 50 cents per mile in excess of 50 miles one-way to the city where the transplant is preformed, up to 700 miles round trip and (c) pays actual charges up to \$50 per day for lodging and meal expenses.

Adult Companion Transportation and Lodging - pays the following expenses for one adult companion to be near insured when insured is confined in a nonlocal hospital (a) up to a maximum of \$1,500 per calendar year for actual charges for non-local round trip coach fare by a common carrier to the nearest hospital that provides the prescribed treatment or 50 cents per mile for personal automobile expenses in excess of 50 miles one-way, up to 700 miles round trip and (b) pays actual charges up to \$50 per day for lodging and meal expenses limited to the number of days of each confinement.

Outpatient Positive Diagnostic Testing – pays actual charges up to \$250 for the diagnostic test that leads to a positive diagnosis within 90 days of the test.

Outpatient Surgery – pays a benefit equal to the daily hospital confinement benefit for outpatient surgery in a hospital or ambulatory surgical center.

Skin Cancer – pays up to \$150 for actual charges for the removal of skin cancer when diagnosis is made by a physician, other than a legally qualified pathologist.

Ambulance – pays actual charges up to \$75 per trip to transfer an insured person to the hospital for confinement as an inpatient.

Hospice – pays actual charges up to \$100 per day up to a lifetime maximum of \$7,500.

Government or Charity Hospital – pays actual charges up to \$200 per day for confinement in a government or charity hospital. Payment is in lieu of all other policy benefits.

Blood and Blood Plasma – pays the actual charges for blood, blood plasma and platelets. Policy does not pay for blood that is donated or replaced.

Breast Cancer / Breast Reconstruction / Breast Prosthesis – pays a benefit equal to the daily hospital confinement benefit for a minimum of 48 hours of inpatient care following a mastectomy and for a minimum of 24 hours following a lymph node dissection for the treatment of breast cancer. Lifetime maximum of \$2,500 per breast.

Cancer (Wellness) Screening Tests – pays up to \$100 per year for cancer screening test. Tests covered are:

- Mammography Screening
- Pap Smear (test only)
- CA125 (blood test for ovarian cancer)
- PSA (blood test for prostate cancer)
- Hemocult Stool Specimen
- Flexible Sigmoidoscopy
- CEA (blood test for colon cancer)
- Colonoscopy
- Chest X-ray
- Thermography
- Serum Protein Electrophoresis

Home Health Care Services – when services are provided by a Home Health Care Agency, policy pays (a) up to \$60 per day for services provided at home, not to exceed 180 days per calendar year, (b) up to \$100 per day for Private Duty Nursing, not to exceed 15 days per calendar year, and (c) pays actual charges for a physician's visit up to \$40 per day not to exceed 15 days per calendar year. Benefits herein are not payable under provisions of this policy.

Hairpiece Benefit – pays a one-time benefit of up to \$150 for a hairpiece when hair loss is a result of cancer treatment.

Rental or Purchase of Durable Medical Equipment – pays the actual charges up to \$1,000 per calendar year for (a) a respirator or similar medical device, (b) brace, (c) crutches, (d) hospital bed or (e) wheel chair.

Professional Mental Health Consultation – pays actual charges up to \$50 per session not to exceed a lifetime maximum of \$250.

Extended Benefits – If a covered hospital confinement lasts for more than 75 days in a row, policy pays usual and customary charges for hospital room and board, medicines, lab test and other normal charges, up to \$1,000 per day beginning on the 76th day. Payable after the 75th day in lieu of all other policy benefits.

Waiver of Premium – premiums of the insured person will be waived while that person is receiving treatment for cancer or specified disease for which benefits are payable.

Specified Disease Benefits - The benefits of the policy will be extended to pay for the loss that results from the following specified diseases :

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

Intensive Care Rider - Provides a Daily Benefit if an Insured Person is confined to a Hospital's Intensive Care Unit, up to a maximum of 20 days per period of confinement.

Internal Cancer First Occurrence Rider - pays \$2,500 or \$5,000 the first time an insured is diagnosed as having internal cancer.

Wellness Claims: You may file your wellness claim by faxing in the receipt to the number listed below. Your receipt must include the services performed, and must be on the list of covered tests. Also, make sure to write your policy number or social security number on the receipt.

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 seeing someone in your Payroll Department.

Should you have any questions on how to file or submit a claim, or regarding the Assurity Cancer Plan, please call **(888) 358-8808 Extension 36**

Assurity Life Insurance Company
PO Box 80926
Lincoln, NE, 68501-0926
www.assurityatwork.com

Fax: (402) 437-4592

To Call in a Wellness Claim: (888) 358-8808 Extension 36

To Fax in a Wellness Claim/ Toll Free: (800) 869-0368

Assurity Life Cancer & Specified Disease Plan

Tenthtly Rates		\$150 Daily Benefit	\$250 Daily Benefit	\$350 Daily Benefit
Base Policy (\$10,000 per month/\$100,000 lifetime maximum) (radiation/chemotherapy)	Individual	\$25.10	\$27.86	\$30.62
	EE & Spouse	\$38.45	\$42.74	\$47.03
	EE & Children	\$31.19	\$34.32	\$37.45
	Family	\$44.53	\$49.20	\$53.86
Base Policy with Intensive Care Rider (\$300 daily benefit)	Individual	\$27.62	\$30.38	\$33.14
	EE & Spouse	\$43.49	\$47.78	\$52.07
	EE & Children	\$35.15	\$38.28	\$41.41
	Family	\$51.01	\$55.68	\$60.34
Base Policy with Intensive Care Rider (\$600 daily benefit)	Individual	\$30.14	\$32.90	\$35.66
	EE & Spouse	\$48.53	\$52.82	\$57.11
	EE & Children	\$39.11	\$42.24	\$45.37
	Family	\$57.49	\$62.16	\$66.82
Base Policy with First Occurrence Benefit Rider (\$2,500 benefit)	Individual	\$28.50	\$31.26	\$34.02
	EE & Spouse	\$43.52	\$47.82	\$52.10
	EE & Children	\$35.29	\$38.42	\$41.56
	Family	\$50.32	\$54.98	\$59.64
Base Policy with First Occurrence Benefit Rider (\$2,500 benefit) and Intensive Care Rider (\$300 daily benefit)	Individual	\$31.02	\$33.78	\$36.54
	EE & Spouse	\$48.56	\$52.86	\$57.14
	EE & Children	\$39.25	\$42.38	\$45.52
	Family	\$56.80	\$61.46	\$66.12
Base Policy with First Occurrence Benefit Rider (\$2,500 benefit) and Intensive Care Rider (\$600 daily benefit)	Individual	\$33.54	\$36.30	\$39.06
	EE & Spouse	\$53.60	\$57.90	\$62.18
	EE & Children	\$43.21	\$46.34	\$49.48
	Family	\$63.28	\$67.94	\$72.60
Base Policy with First Occurrence Benefit Rider (\$5,000 benefit)	Individual	\$31.90	\$34.66	\$37.42
	EE & Spouse	\$48.60	\$52.90	\$57.18
	EE & Children	\$39.40	\$42.53	\$45.66
	Family	\$56.10	\$60.77	\$65.42
Base Policy with First Occurrence Benefit Rider (\$5,000 benefit) and Intensive Care Rider (\$300 daily benefit)	Individual	\$34.42	\$37.18	\$39.94
	EE & Spouse	\$53.64	\$57.94	\$62.22
	EE & Children	\$43.36	\$46.49	\$49.62
	Family	\$62.58	\$67.25	\$71.90
Base Policy with First Occurrence Benefit Rider (\$5,000 benefit) and Intensive Care Rider (\$600 daily benefit)	Individual	\$36.94	\$39.70	\$42.46
	EE & Spouse	\$58.68	\$62.98	\$67.26
	EE & Children	\$47.32	\$50.45	\$53.58
	Family	\$69.06	\$73.73	\$78.38

AAW-C120RAB (7/04)



CSO Cancer Plan (C09) - TN Wellness Claim Filing Instructions

****The C09 Cancer and Hospital Indemnity plans have been replaced with the Assurity Cancer plan. The following is informational only for those that still have the aforementioned plans.****

Cancer Screening Claims

Routine cancer screenings can play an important role in achieving and maintaining a healthy lifestyle. Early detection of cancer often leads to additional treatment options and a greater chance of fighting this disease. Because we care about you and know the importance of these screenings, we have made the claim filing process easy for You!

If you have one of the covered cancer screening tests listed below, you can elect to not submit a copy of the medical bill and simply complete a claim form and then fax or mail it to CSO. CSO will promptly review your claim for benefits! If your cost for the cancer screening test exceeds the amount shown below (up to \$100), you can send CSO a copy of the medical bill along with a claim form. *If you have a cancer screening test not listed below, a copy of the medical bill is needed for CSO to review for benefits. Please complete a separate claim form for each family member.

Your CSO Cancer policy will pay the amount charged up to a maximum of \$100 per calendar year for each insured person who has a cancer screening test performed while this policy is in force. Many of the common cancer screening tests are listed below with amount paid if you can not **or** do not send a copy of the medical bill. Please refer to your policy for benefits and limitations. ***Tennessee policies have a separate benefit for mammograms. The benefit is based on the expense incurred.** Please see your policy for details.

Mammography/breast ultrasound	\$75*
Pap smear/Thin Prep Pap (test only)	\$25
CA 125 (blood test for ovarian Cancer)	\$50
PSA (blood test for prostate Cancer)	\$50
Hemocult stool specimen	\$10
Flexible sigmoidoscopy	\$100
CEA (blood test for colon Cancer)	\$50
Colonoscopy	\$100
Chest X-ray	\$50
Thermography	\$50
Serum protein electrophoresis	\$25

To file your claim by Toll-free fax: (888) 453-5127
To file your claim by Phone: (866) 757-0794
The call in service requires all the information on the cancer claim form

Cancer screening test claims can be filed on line at www.cso.com under the Customer Service section of the website.

To file by Mail: **CSO**
PO Box 34952
Omaha NE, 68134-9832

If you have any questions, please feel free to call and speak to any of the CSO Customer Service Representatives at (800) 541-2363, extension 6001, from 7:30 a.m. to 5:00 p.m.

Superior Vision Plan

Effective Date: January 1, 2006

Outline of Benefits - Gold Preferred Plan With Materials Discount
 Vision Plan - Preferred Provider (PPO / Indemnity)

COPAYMENT AMOUNT

\$10.00 Exam, \$ 15.00 Materials

BENEFITS	FREQUENCY	IN-NETWORK	NON-NETWORK
Comprehensive Exam <i>(by an Ophthalmologist)</i>	12 Months	Covered in Full	Up to \$34.00
Comprehensive Exam <i>(by an Optometrist)</i>	12 Months	Covered in Full	Up to \$26.00
Lenses (Standard) per Pair:			
Single Vision	12 Months	Covered in Full	Up to \$32.00
Bifocal	12 Months	Covered in Full	Up to \$46.00
Trifocal	12 Months	Covered in Full	Up to \$57.00
Lenticular	12 Months	Covered in Full	Up to \$90.00
Contact Lenses (Per Pair)*:			
Medically Necessary	12 Months	Covered in Full	Up to \$210.00
Cosmetic (Elective)**	12 Months	Up to \$120.00	Up to \$100.00
Frames (Standard)**	24 Months	Up to \$100.00	Up to \$ 47.00

**Contact lenses are in lieu of eyeglass lenses and frames benefit.*

***The insured is responsible for paying any charges in excess of this allowance.*

HOW TO USE YOUR BENEFIT

IN-NETWORK

- Select a provider from the Superior Vision Services Provider Network.
- Use your personalized I.D. card to identify yourself. Provider will call SVS to verify eligibility. No paperwork is required from you.
- Pay the provider directly for the \$10 exam co-pay and the cost of any non-covered item.

OUT-OF-NETWORK

- Call SVS Member Services for your authorization number.
- Pay the non-network provider for all products and services.
- Submit your original itemized billing from the provider, along with your authorization number, to SVS Member Services for reimbursement in accordance with the Non-Network Schedule of Allowances less the \$10 exam co-pay if applicable.

DISCOUNT PROGRAMS

Discounts available from participating providers on additional pairs of eyeglasses and contact lenses.

Eyeframes	30% off
Lenses (uncoated std glass or plastic)	30% off
Add-on features	20% off
Everyday "Frames & Lenses" package pricing	20% off
Contact Lenses	20% off
Disposable Contacts	10% off
Other Items	20% off

20% Discount off the UCR surgical fee for refractive surgery procedures such as, Radial Keratotomy (RK), Photo-Refractive Keratotomy (PRK), and LASIK at a preferred provider.

Note: The discount benefit is available only from Superior Vision Plan in-network providers who are identified in the provider directory with a "DP." Discounts do not apply to the insured benefit underwritten by ReliaStar Life Insurance Company.

LIMITATIONS & EXCLUSIONS

Limitations (Options at Additional Cost):

The Superior Vision Plan is designed to provide your basic eyewear needs. It does not cover items that are considered cosmetic or elective. The following options will require an additional charge over the covered benefit. Pay any additional charges directly to your provider.

Example: Standard design bifocal lenses are a covered benefit. Blended (no line) bifocal lenses will require an additional charge.

- A frame that costs more than the Plan allowance.
- Additional costs for contact lenses (elective) over the allowance.
- Blended (no-line) and/or multifocal lenses
- Beveled and/or faceted lenses.
- Coating on lenses (anti-scratch, anti-reflective, sunglass colors)
- Cosmetic lenses
- Oversize charge for lenses larger than Plan allowance
- Polycarbonate lenses.
- Replacement frames and/or lenses.

Exclusions (Products & Services Not Covered)

There is no benefit coverage for the following products and services.

- Conditions covered by workers' compensation
- Eye exams required by the employer as a condition for employment
- Frame cases
- Low (subnormal) vision aids

- Non-prescription (plano) eyewear
- Orthoptics or vision training and any associated supplemental testing
- Progressive lenses
- Services and materials provided by another vision plan
- Tints (except Rose tint #1 and #2)

Note: This is only a summary of the benefit plan. You may review and/or obtain a copy of the Master Policy and Certificate of Coverage by contacting your Human Resources/Employee Benefits Office.

RATES (based on 10 pay periods)

Employee Only	\$11.28
Employee + 1	\$21.89
Employee + 2 or more	\$32.16

Member Services, Provider Listings and Claims Services:

1-800-507-3800

Member Services FAX:

916-852-2277

Provider Nominations:

Ann Warner @ 800-923-6766 X233

Web Site: www.superiorvision.com

Address:

Superior Vision Services, Inc.
111101 White Rock Road, Suite 150
Rancho Cordova, CA 95670

Network & Non-network Claims Submission:

Superior Vision Services, Inc.
P.O. Box 967
Rancho Cordova, CA 95741

*This plan is underwritten by Reliastar Insurance Company, Inc.
20 Washington Avenue South
Minneapolis, MN 55401*



Disability Is A Fact of Life

- ◆ 27,000,000 Americans are currently on disability.
- ◆ 6.85 out of 10 people between the ages of 20 and 35 will suffer a disability that lasts 3 months or longer.
- ◆ If a disability lasts longer than 3 months, its average duration is 2.9 years at age 30, 3.9 years at age 40 and 4.5 years at age 50.
- ◆ **48% of all home foreclosures done in this country today are a result of disabilities, only 3% are due to premature death.**
- ◆ Death rates are down; disability rates are up.
- ◆ At ages 35 - 40, your chances of being disabled are twice as great as those of dying.
- ◆ Worker's Compensation rates recently rose again. Analysts attribute this in part to the inclusion of stress on the job as a possible claim.
- ◆ Each year, the statistics average as follows:
 - ▶ 1 in 106 people die
 - ▶ 1 in 88 homes catch fire
 - ▶ 1 in 70 cars is involved in a serious accident
 - ▶ 1 in 8 people are disabled

Source: Commissioners Disability Trade, US Gov't Housing/Finance, Society of Actuaries

Could You Live Off Of Savings??!!

Standard Life Short Term Disability Plan

Effective Date: January 1, 2006 (pending underwriting approval)

- Payable in addition to sick leave
- Benefits payable regardless of other insurance
- Weekends and holidays are covered
- Benefits are paid directly to you
- Benefits are tax free
- Maternity is covered as any other sickness
- No change in premium due to age
- You may continue coverage if you leave your Employer, provided you maintain continuous employment.

ACCIDENT & SICKNESS PROTECTION

On or off the job, 24 hour a day coverage. Income is provided when you are disabled due to a sickness or as a result of an accident. Benefits begin on the **first day** if you are disabled due to an accident. Benefits begin on the **eighth day** if you are disabled due to sickness.

You can choose to insure up to 70% of your gross monthly income, up to a maximum of \$2,000.00 per month. Income will be provided for the benefit period you choose up to 365 days.

90 Days

Monthly Benefit	Tenthly Premium
\$500	\$13.50
\$600	\$16.20
\$700	\$18.90
\$800	\$21.60
\$900	\$24.30
\$1,000	\$27.00
\$1,100	\$29.70
\$1,200	\$32.40
\$1,300	\$35.10
\$1,400	\$37.80
\$1,500	\$40.50
\$1,600	\$43.20
\$1,700	\$45.90
\$1,800	\$48.60
\$1,900	\$51.30
\$2,000	\$54.00

180 Days

Monthly Benefit	Tenthly Premium
\$500	\$21.00
\$600	\$25.20
\$700	\$29.40
\$800	\$33.60
\$900	\$37.80
\$1,000	\$42.00
\$1,100	\$46.20
\$1,200	\$50.40
\$1,300	\$54.60
\$1,400	\$58.80
\$1,500	\$63.00
\$1,600	\$67.20
\$1,700	\$71.40
\$1,800	\$75.60
\$1,900	\$79.80
\$2,000	\$84.00

365 Days

Monthly Benefit	Tenthly Premium
\$500	\$27.00
\$600	\$32.40
\$700	\$37.80
\$800	\$43.20
\$900	\$48.60
\$1,000	\$54.00
\$1,100	\$59.40
\$1,200	\$64.80
\$1,300	\$70.20
\$1,400	\$75.60
\$1,500	\$81.00
\$1,600	\$86.40
\$1,700	\$91.80
\$1,800	\$97.20
\$1,900	\$102.60
\$2,000	\$108.00

ELIGIBILITY

These benefit plans are optional and all full-time employees under 65 years of age may apply. The disability benefit is for **employees** only. Applications for new participants will be underwritten.

POLICY FEATURES

Maternity: Benefits are covered provided conception occurs after the effective date of the policy.

Limits and Exclusions: Benefits will not be paid for any total disability which:

- 1) Occurs while the policy is not in force;
- 2) Does not require the regular care of a physician;
- 3) Is due to the use of intoxicants or narcotics, except on the advice of a physician;
- 4) Is on account of intentional self-inflicted injury;
- 5) Is a result of mental or nervous disorders;
- 6) Results from armed conflicts;
- 7) Arises out of aviation, except scheduled passengers on commercial airlines;
- 8) Results from traveling more than forty miles outside the US;
- 9) Results from the participation in a felony or working at an illegal job.
- 10) Results from a pre-existing condition, as defined in the policy.

Claims Submission: There is a **90 day filing period** after a sickness or accident to submit a claim to Standard Life.

This is a brief description of the important features of your policy. This is not an insurance contract; therefore, it is important that you read your policy carefully.

If you have any questions regarding the Standard Life Disability Plan:

Toll-Free Number is: 800-327-0695

Toll Free Claims Line: 800-227-0251



Transamerica Universal Life Plan

Effective Date: February 1, 2006 (pending underwriting approval)

TLIC-\$AVER PLUS UNIVERSAL LIFE INSURANCE

Universal Life = Protection + Portability

Voluntary Universal Life (UL) Insurance combines life insurance protection with an ability to grow cash value. You have the safety and security of a specified death benefit plus the opportunity to tailor your coverage to your personal situation. Individual or family coverage is available.

You 'll appreciate the convenience of automatic premium payments - through payroll deduction. If you retire or leave your group, you can take comfort in knowing the individual rate for your coverage won't change because you leave. You can choose direct bill or pre-authorized bank draft.

Coverage Continuation In Case Of Layoff

To address employee concerns about losing coverage because of a layoff, Transamerica includes a unique layoff feature in your TLIC-\$aver®Plus UL certificate. It protects your life insurance from lapse for up to six months if you're involuntarily laid off.

You must have been employed on a permanent, full-time basis. The layoff must be due to: a reduction in work force due to economic conditions; a decrease in your employer's production; or, a reorganization causing a discontinuation of your job or a resulting change in job aptitude or skills requirements. Other conditions and limitations are outlined in the Certificate.

PROTECTION AND OPTIONS TO SUIT YOUR NEEDS

Permanent Life Insurance Protection

- Simplified underwriting
- Death Benefit Protection
- Tax-Deferred, Cash Value Growth
- Coverage is Portable

Living Benefit Coverages

- Layoff Waiver
- Accelerated Death Benefit for Terminal Illness

Options for Family Protection

- Spouse's Coverage
- Children's Coverage

Employees Coverage Limits:

Guaranteed Issue (GI) or Conditional Guaranteed Issue (CGI) Maximum*: \$100,000 or five times the employee's annual base salary, whichever is less.

Simplified Issue (SI) Maximum**: \$150,000 or five times the employee's annual base salary, whichever is less.

Employee Eligibility:

An employee may apply for life insurance coverage subject to the satisfaction of the following eligibility requirements

General and Guaranteed Issue Requirements

1. An employee must be actively performing the regular duties of his/her job for at least 30 hours per week in the usual manner and at the usual place of employment or business. If he/she is not working due to an illness or injury, the applicant is not eligible until he or she returns to work

2. An employee must be between the ages of 16 & 70.

Conditional Guaranteed Issue Requirements

In the past six months prior to the application date, an employee: a) must not have been hospitalized at any time; and b) must have **not** missed more than five consecutive days of work due to accident or illness.

Simplified Issue Requirements

An employee must satisfactorily answer the required eligibility questions and the required evidence of insurability questions on the application and must provide additional evidence of insurability that is satisfactory to TAC, if TAC requests it.

Spouses Coverage Limits:

Conditional Guaranteed Issue (CGI)*: \$5,000 - \$25,000.

Simplified Issue (SI) Maximum** \$50,000.

An employee must participate in order for his or her eligible spouse to qualify for CGI coverage. SI underwriting applies if a spouse does not qualify for CGI coverage or applies for an amount in excess of the CGI limit. SI underwriting is based on an acceptable health history and is not guaranteed.

The spouse cannot apply also as an employee.

Spouse Eligibility:

An eligible employee may apply for life insurance coverage on his or her spouse, subject to the satisfaction of the following eligibility requirements:

General Requirements

1. A spouse must be legally married to the employee as determined by the laws of the state in which the employee resides.
2. The spouse must be between the ages of 16 and 65.
3. If employed, a spouse must be actively performing the regular duties of his or her job in the usual manner and at the usual place of employment or business. If the spouse is not working due to an illness or injury, the spouse is not eligible until he or she returns to work.
4. If not employed, a spouse must be able to perform the normal activities of a person of the same age and gender. **A spouse who is disabled is *not* eligible**

Dependent Children Coverage Limits:

Conditional Guaranteed Issue (CGI) *: \$12,500 or \$25,000

Simplified Issue Maximum**: \$25,000

If an employee participates, CGI is available for all eligible children.

All children in a family must be insured equally. An employee may elect to provide a Child's Term Rider in *lieu* of the individual UL on his or her children. If an applicant and his or her spouse are both eligible as employees, their child(ren) can be insured as dependents of either one, but not both

The child cannot apply also as an employee.

General Requirements

1. A dependent child is an unmarried child financially dependent upon his or her parent(s) for support, who is:
 - a. An employee's natural child, or a child for whom adoption proceedings have begun, or
 - b. An employee's legally adopted child, or a child for whom adoption
 - c. A stepchild who lives with the employee, or
 - d. A child for whom the employee has been appointed legal guardian who lives with the employee; and
 - e. Between the ages of **1** year and **21** years for individual UL coverage and between the ages of **15 days** and **18 years** for **Term Rider**.

CONDITIONAL AND SIMPLIFIED ISSUE REQUIREMENTS FOR DEPENDENTS:

***CGI-Conditional Guaranteed Issued Requirement - a)** must not have been hospitalized in the past six months prior to application date; **b)** must not have missed more than **five** consecutive days of work due to accident or illness, if employed.

****SI-Simplified Issue Requirements** - a dependent must satisfactorily answer the required eligibility questions and the required evidence of insurability questions on the application and must provide additional evidence of insurability that is satisfactory to TAC, if TAC request it.

A SPECIAL “LIVING BENEFIT” FOR TERMINAL ILLNESS

ACT NOW TO SECURE YOUR FINANCIAL FUTURE!

If you're looking for valuable life insurance protection backed by a company you can count on, Transamerica's Voluntary Life Insurance offers both...plus the advantage of living benefit coverages. Because it's Universal Life Insurance, it also offers you flexibility and the option to grow tax-deferred cash value accumulation. Ask your Transamerica representative how to get started.

IMPORTANT INFORMATION ABOUT THIS LIFE INSURANCE COVERAGE

For all insurance coverages (including any optional coverage described in supplements to this buyer's guide), benefits are not payable for a loss sustained after the contract lapses. Coverage ends on the earliest of: the date we receive a written request for surrender, the date you or another Insured reaches age 95, the Certificate lapses (subject to the Grace Period), or death. Generally, if suicide occurs during the first two years of coverage, the death benefit is limited to the return of premiums paid.

The Accelerated Death Benefit for Terminal Illness may or may not qualify for favorable tax treatment under the Internal Revenue Code. Whether such benefits qualify depends on factors such as your life expectancy at the time benefits are accelerated, or whether you use the benefits to pay for necessary care. If the acceleration-of-life-insurance benefits qualify for favorable tax treatment, the benefits will be excludable from your income and not be subject to federal taxation. Tax laws relating to acceleration-of-life-insurance benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which you could receive acceleration-of-life-insurance benefits excludable from income under Federal law.

Receipt of acceleration-of-life-insurance benefits may affect you, your spouse's, or your family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary Social Security Income (SSI) and drug assistance programs.

You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such payment will affect you, your spouse, and your family's eligibility for public assistance.

Coverage is subject to certain conditions, limitations and exclusions, which are detailed in the Master Policy, Certificate and Riders (or, in some states, in the

Policy and Riders); together, these constitute the legal contract. If there is a conflict between what is described in this brochure and the contract, the contract will govern.

ACCELERATED DEATH BENEFIT RIDER FOR LONG-TERM CARE WITH EXTENSION OF BENEFITS RIDER

Statistics show that 11.5 million Americans need long-term care. And though a majority (51%) of those needing care are elderly, 46% of those relying on long-term care are working-age adults. When you consider that the average cost of nursing home care is about \$46,000 annually, it's obvious what a financial impact long-term care can have.

To help with these often-exorbitant costs, our Accelerated Death Benefit Rider for Long-Term Care with the Extension of Benefits Rider allows an Insured to take an advance against his or her life insurance death benefit to pay for care, and extend the death benefit payments, if necessary.

ACTIVATION OF THE ACCELERATED DEATH BENEFIT RIDER FOR LONG-TERM CARE WITH EXTENSION OF BENEFITS RIDER

Benefits under the Accelerated Death Benefit Rider for Long-Term Care with the Extension of Benefits Rider can only be triggered by a chronically ill diagnosis that must be certified by a licensed Health Care Practitioner. Chronically ill means an Insured who has been certified by a licensed Health Care Practitioner as:

- (a) being unable to perform, without substantial human assistance, at least two of the six activities of daily living (ADLs) - bathing, continence, dressing, eating, toileting, and transferring - for a period of at least 90 days; or
- (b) being so severely cognitively impaired that the Insured requires substantial supervision to protect the Insured from threats to his or her health and safety.

Under the Accelerated Death Benefit Rider for Long-Term Care, the percentage of death benefit that is available each month is:

- up to 4% of the existing death benefit if you are confined to a licensed Nursing or Assisted Living Facility, payable for up to 25 months; or
- up to 2% of the existing death benefit if you are receiving Home Health Care or Adult Day Care, payable up to 50 months.

Payout Example: With a 4% death benefit advance, a 35-year-old nonsmoker with \$50,000 of coverage who is confined to a licensed Nursing or Assisted Living Facility would receive \$2,000 per month for up to 25 months. Each benefit payment will reduce the face amount of the policy by 4% if benefits are paid for confinement in a Nursing Facility or Assisted Living Facility. A 12-month benefit period would mean a \$24,000 reduction in coverage, and an adjusted face amount and death benefit of \$26,000. If all benefits are paid in 25 months, the death benefit is depleted and coverage will end. With a 2% death benefit advance, a 35-year-old nonsmoker with \$50,000 of coverage who is receiving Home Health Care or Adult Day Care services would receive \$1,000 per month for up to 50 months. A 12-month benefit period would mean a \$12,000 reduction in coverage, and an adjusted face amount and death benefit of \$38,000. If all

benefits are paid in 50 months, the death benefit is depleted and coverage will end. Additionally, if the Insured should die while this coverage is in force and while benefits are being paid, the remaining death benefit proceeds will be paid to the named beneficiary and no further payments will be made. Moreover, if the entire death benefit proceeds are paid prior to death, coverage will end and there will be no death benefit proceeds available upon death.

EXTENSION OF BENEFITS RIDER

If all of the benefits of the life insurance coverage have been depleted through the use of this Accelerated Death Benefit, the Rider allows for a benefit Extension. For example, under the Accelerated Death Benefit Rider for Long-Term Care, the percentage of death benefit available each month is 4% for confinement in a licensed Nursing or Assisted Living Facility and 2% for Home Health Care or Adult Day Care services. For a \$50,000 death benefit, this translates into \$2,000 per month for 25 months if the Insured is confined in a Nursing or Assisted Living Facility, and \$1,000 per month for 50 months for Home Health Care or Adult Day Care. The amount payable under this Extension feature cannot exceed 100% of the Universal Life death benefit.

If after 25 months the Insured is still confined in a licensed Nursing or Assisted Living Facility, and the death benefit has been depleted, the death benefit will be extended on a month-to-month basis (provided the Insured meets eligibility requirement) for up to an additional 25 months.

Similarly, if after 50 months the Insured still requires Home Health Care or Adult Day Care, and the death benefit has been depleted, the death benefit will be extended on a month-to-month basis (provided the Insured meets the eligibility requirement) for up to an additional 50 months. In this example, the \$50,000 policy could pay a \$100,000 benefit.

ACTIVATING MULTIPLE ACCELERATED DEATH BENEFITS

If an owner accelerates any death benefit under another Accelerated Death Benefit (ADB) Rider such as Critical Care and/or Terminal Illness while also accelerating the Accelerated Death Benefit Rider for Long-Term Care (LTC), the maximum we will pay under all of the ADB Riders will not exceed 100% of the death benefit for any one Insured.

Payout Example: With a 4% death benefit advance, a 35-year-old nonsmoker with \$50,000 of coverage who is confined to a licensed Nursing or Assisted Living Facility (as previously noted) would receive \$2,000 per month for up to 25 months. However, if the owner exercised another ADB option (such as Critical Care or Terminal Illness) three months into the LTC acceleration, the remaining death benefit available for future monthly payments for all exercised ADB options (combined) would be \$44,000 (22 months). Furthermore, if the owner exercised the Critical Care option and depleted \$22,000 of the remaining \$44,000, the owner would have \$22,000 (11 months) of death benefit remaining for long-term care. The total benefit period then for long-term care would have been 14 months.

EXCLUSIONS

All benefits are subject to a 90-day "Elimination Period." There is a "Waiting Period" of 30 days from the Rider Effective Date for sickness conditions. Benefits will only be paid for a sickness condition or Plan of Care that begins after the "Waiting Period." No benefits will be payable for any sickness condition or Plan of Care that begins during the "Waiting Period." There is no "Waiting Period" for accidents.

We will not pay Rider benefits for care that is received or loss incurred as a result of: **(a)** an intentionally self-inflicted injury, or attempted suicide; **(b)** war or any act of war, declared or undeclared, or service in the armed forces of any country; **(c)** treatment of the Insured's alcohol, drug, or other chemical dependency, except if the drug was sustained or acquired at the hands of a physician, or while under treatment for an injury or sickness; or **(d)** the Insured's commission of, or attempt to commit, a felony; or an injury that occurs because of the Insured's involvement in an illegal activity.

We will not pay Rider benefits if the Confinement or service: **(a)** is received outside the United States and its territories; **(b)** is provided by ineligible providers; **(c)** is rendered by members of the Insured's Immediate Family; **(d)** is reimbursed by a state or Federal worker's compensation plan, Medicare, any other health insurance or plan, or any other governmental program, except Medicaid; **(e)** would not be charged in the absence of insurance.

LIMITATIONS

We will not pay accelerated death benefits for Confinement or Home Health Care or Adult Day Care services simultaneously, even if the Insured otherwise qualifies for benefits. In any given month the Insured qualifies for both benefits, we will pay **either** the Monthly Accelerated Death Benefit for Confinement **or** the Monthly Accelerated Death Benefit for Home Health Care or Adult Day Care services, whichever is higher.

The death benefit that is the basis for the "extended benefit" is the death benefit amount at the time of the first acceleration of benefits under the Accelerated Death Benefit Rider for Long-Term Care. This may or may not be the death benefit at the time the extended benefit is utilized by the Insured.

This Accelerated Death Benefit Rider for Long-Term Care with Extension of Benefits Rider may not cover all of the costs associated with long-term care incurred during the period of coverage. Please carefully review all limitations of the Rider as well as those of the Contract to which it is attached.

TAX QUALIFICATION NOTICE

This rider is intended to provide a qualified accelerated death benefit that is excluded from gross income for Federal Income Tax purposes under the applicable provisions of the Internal Revenue Code in existence at the time this Rider is issued. To that end, the provisions of the Rider and the Contract are to be interpreted to ensure or maintain such tax qualification, notwithstanding any other provisions to the contrary. We reserve the right to amend this Rider or the Contract to reflect any clarifications that may be needed or are appropriate to maintain such tax qualification or to conform this Rider or the Contract

to any applicable changes in such tax qualification requirements. We will send you a copy of any such amendment. If you refuse such an amendment, it must be by giving us written notice, and your refusal may result in adverse tax consequences. Whether any tax liability may be incurred when benefits are paid under this Rider could depend on whether you are also the Insured and how the Internal Revenue Service interprets applicable provisions of the Internal Revenue Code. As with any tax matter, the Insured and any other recipient of this benefit should each consult a tax advisor to evaluate any tax impact of this benefit.

Receipt of an accelerated death benefit MAY AFFECT MEDICAID and SUPPLEMENTAL SECURITY INCOME (SSI). Without exercising this option, the mere fact that an Accelerated Death Benefit Rider is part of the Insured's Contract will not in of itself affect the eligibility for these government programs. However, exercising this option before applying for these programs, or while receiving government benefits, may affect the Insured's continued eligibility. Contact the Medicaid Unit of the local Department of Public Welfare and Social Security Administration Office for more information.

TAC-SaverPlus Universal Life Insurance is underwritten by
Transamerica Assurance Company.

**IF YOU HAVE ANY QUESTIONS ABOUT THE PLAN, PLEASE CALL
CUSTOMER SERVICE AT: 1-800-346-1608.**

Continuation of Benefits If You Leave Employment

WAGWORKS MEDICAL REIMBURSEMENT ACCOUNTS

If you have a positive balance (payroll deductions are greater than the amount you have received in reimbursement) in your Medical Reimbursement Account at the time of your termination, you may continue participation in the Plan for the remainder of the Plan year. If you want to remain in the Plan, you can do by selecting one of the COBRA options.

If you prefer to terminate your participation and contribution to the Plan, any balance in your account on the date of termination will be forfeited if expenses were not incurred prior to the date of termination. For more detailed information, please call **FlexBen at: (800) 582-9740**.

AMERITAS DENTAL PLAN & SUPERIOR VISION

Under the Ameritas Dental and Superior Vision plans, you and your covered dependents are eligible to continue coverage through COBRA according to the "qualifying events".

If you and your dependents are enrolled in the dental plan, you will be eligible to continue coverage through COBRA after you leave your employment for a specified period. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents may be eligible to continue dental coverage through COBRA. Also, while you are covered under the plan, your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA. Examples of an ineligible dependent would be when your child graduates from college, or reaches the age of not being eligible for dependent coverage. You will receive notification with premium and continuation options shortly following your termination of employment. Should you have any questions you may contact your **Benefits Department at: (252) 335-2981 x.116**

CSO CANCER

When you leave you may continue your Central States of Omaha CSO Cancer coverage by having the premiums that are currently deducted from your paycheck billed to your home address or drafted from your bank account. CSO will send you a letter explaining your options or you may arrange that by contacting **CSO at: (800) 541-2363**.

ASSURITY CANCER

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**.

STANDARD LIFE DISABILITY

When you leave employment you may continue your short term disability coverage as long as continuous employment is maintained and proof of employment has been sent to Standard Life. Coverage expires at age 65. Please contact Standard Life at **(800)- 227-0251** to set up direct bill to your home address.

TRANSAMERICA UNIVERSAL LIFE

When you leave you may continue your Transamerica Universal Life coverage by having the premiums that are currently deducted from your paycheck drafted from your bank account. **You may do that by contacting Transamerica at: (800)-400-3042.**