

Table of Contents

PRE-TAX BENEFITS

| | |
|--|---------|
| Health Care Plan | Page 3 |
| Tucker Administrators Flexible Spending Accounts | Page 7 |
| Tucker Administrators Medical Spending Account | Page 9 |
| Tucker Administrators Dependent Care Account | Page 16 |
| Tucker Administrators Benny™ Prepaid Benefits Card | Page 19 |
| Ameritas Dental Plan | Page 21 |
| Superior Vision Plan 1 | Page 24 |
| Superior Vision Plan 2 | Page 27 |
| Assurity Accident Expense+ Plan | Page 30 |
| Assurity Cancer Plan | Page 39 |

AFTER-TAX BENEFITS

| | |
|--|---------|
| American United Life Short Term Disability Plan | Page 50 |
| Dearborn National Group Term Life Insurance Plan | Page 54 |
| Texas Life Whole Life Plan | Page 58 |

CONTINUATION OF BENEFITS

| | |
|--|---------|
| Continuation of benefits when you leave the County | Page 61 |
| Information for Benefits Available to Retirees | Page 63 |



* * * * * **NOTICE** * * * * *

The products described in this booklet are part of a Cafeteria Benefits Plan arranged by Mark III Brokerage for eligible Polk County Government employees.

The Cafeteria Benefits Plan allows you to pay for certain insurance premiums before taxes are taken out of your paycheck. Paying for benefits in this method reduces your taxes and increases your take home pay.

The plan year is July 1, 2012 through June 30, 2013

All products described in this booklet are pre-taxed **EXCEPT:**

- **AUL Short Term Disability**
- **Dearborn National Term Life Insurance**
- **Texas Whole Life Insurance**

If you wish to add or make changes to your insurance coverage(s), please consult a Benefits Representative during your scheduled enrollment period. ***You will not be able to make any changes once the enrollment period is over*** unless you experience a qualified event (i.e., marriage, divorce, birth of a child, etc.)

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

| |
|---|
| <p><i>Polk County Government Health and Welfare Benefit Plan</i></p> |
|---|

FOR BENEFIT PLAN YEAR JULY 1, 2012 THROUGH JUNE 30, 2013

| | <i>NETWORK PROVIDERS</i> | <i>NON-NETWORK PROVIDERS</i> |
|---|-------------------------------------|---|
| <i>MAXIMUM ANNUAL BENEFIT AMOUNT</i> | | \$1,000,000 |

Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers.

DEDUCTIBLE, PER CALENDAR YEAR

| | | |
|--------------------|--------------------------|--------------------------|
| Per Covered Person | \$1000 | \$2,000 |
| Per Family Unit | \$3,000 or three persons | \$6,000 or three persons |

The Calendar Year deductible is waived for the following Covered Charges:

- Preadmission testing
- PPO Network Wellness

COPAYMENTS

| | | |
|-------------------|------------------------------|-------|
| Hospital Services | N/A | \$250 |
| Physician visits | \$30 Primary/\$60 Specialist | N/A |

Copayments will cover charges incurred in the Physician's office and billed by the Physician or an independent facility unless otherwise indicated in the Schedule of Benefits

| | | |
|----------------|------|------|
| Emergency room | \$50 | \$50 |
|----------------|------|------|

The Emergency room copayment is never waived.

MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR

| | | |
|--------------------|--------------------------|---------------------------|
| Per Covered Person | \$2,500 | \$3,500 |
| Per Family Unit | \$7,500 or three persons | \$10,500 or three persons |

The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise

The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%.

- Deductible(s)
- Cost containment penalties
- Copayments

| | <i>NETWORK PROVIDERS</i> | <i>NON-NETWORK PROVIDERS</i> |
|---|--|--|
| <i>COVERED CHARGES</i> | | |
| Hospital Services | | |
| Room and Board | 80% after deductible - the semiprivate room rate | 50% after deductible and copayment - the semiprivate room rate |
| Intensive Care Unit | 80% after deductible Hospital's ICU Charge | 50% after deductible Hospital's ICU Charge |
| Outpatient Facility | 80% after deductible | 50% after deductible |
| Emergency Room Visit | | |
| Medical Emergency | 80% after deductible and copayment | 50% after deductible and copayment |
| Skilled Nursing Facility | 80% after deductible the facility's semiprivate rate within 14 days of a three day stay | 50% after deductible the facility's semiprivate rate within 14 days of a three day stay |
| Physician Services | | |
| Inpatient visits | 80% after deductible | 50% after deductible |
| Primary Office visits | 100% after \$30 copayment | 50% after deductible |
| Specialist office visits | 100% after \$60 copayment | 50% after deductible |
| Surgery | 80% after deductible | 50% after deductible |
| Allergy testing | 80% after deductible | 50% after deductible |
| Allergy serum and injections | 80% after deductible | 50% after deductible |
| Diagnostic Testing (X-ray & Lab) | | |
| | 80% after deductible | 50% after deductible |
| Home Health Care | | |
| | 80% after deductible \$10,000 Calendar Year maximum | 50% after deductible \$10,000 Calendar Year maximum |
| Inpatient Prescription Drugs | | |
| | 80% after deductible | 50% after deductible |
| Outpatient Private Duty Nursing | | |
| | 80% after deductible 70 days Calendar Year maximum | 80% after deductible 70 days Calendar Year maximum |
| Hospice Care | | |
| Bereavement | 80% after deductible | 50% after deductible |
| Counseling | 80% after deductible | 50% after deductible |
| Ambulance Service | | |
| | 80% after deductible | 80% after deductible |
| Jaw Joint/TMJ | | |
| | 80% after deductible | 50% after deductible |
| Wig After Chemotherapy | | |
| | 80% after deductible | 50% after deductible |

| | NETWORK PROVIDERS | NON-NETWORK PROVIDERS |
|--|------------------------------|---------------------------------------|
| Occupational Therapy | 80% after deductible | 50% after deductible |
| Speech Therapy | 80% after deductible | 50% after deductible |
| Physical Therapy | 80% after deductible | 50% after deductible |
| Durable Medical Equipment | 80% after deductible | 50% after deductible |
| Prosthetics | 80% after deductible | 50% after deductible |
| Orthotics | 80% after deductible | 50% after deductible |
| Spinal Manipulation Chiropractic | 50% after deductible | 50% after deductible |
| Mental Disorders | | |
| Inpatient | 80% after deductible | 50% after deductible and copayment |
| Outpatient Facility | 80% after deductible | 50% after deductible |
| Outpatient Office Visit | 80% after \$30 copayment | 50% after deductible |
| Substance Abuse | | |
| Inpatient | 80% after deductible | 50% after deductible and copayment |
| Outpatient Facility | 80% after deductible | 50% after deductible |
| Outpatient | 80% after \$25 copayment | 50% after deductible |
| Preventive Care | | |
| Routine Well Adult Care | 100% | 50% after deductible |
| <i>Includes: office visits, pap smear, mammogram, prostate screening, gynecological exam, routine physical examination, x-rays, laboratory tests and immunizations/ flu shots, as well as other preventative care and services required by applicable law if provided by a network provider. May be performed and billed by the Physician's office or an independent facility.</i> | | |
| <i>Frequency limits for mammogram Ages 40 and over annually</i> | | |
| Routine Colonoscopy | 100% | Not Covered |
| <i>50 years of age and over –one every 5 years. (Will be covered under 50 years of age if recommended by a Physician due to family history)</i> | | |
| <i>The benefit will also cover any removal of polyps and laboratory charges associated with the Scheduled Routine Colonoscopy and will cover conscious sedation only.</i> | | |
| Inpatient Routine Well | | |
| Newborn Care | 80% after deductible | 50% after deductible |
| Routine Well Child Care | 100% | 50% after deductible |
| <i>Includes: office visits, routine physical examination, laboratory tests, x-rays and immunizations as well as other preventative care and services required by applicable law. May be performed and billed by the Physician's office or an independent facility.</i> | | |
| Organ Transplants | 80% after deductible | 50% after deductible |
| Pregnancy | 80% after deductible | 50% after deductible |
| <i>Dependent daughters not covered.</i> | | |

PRESCRIPTION DRUG BENEFIT

Pharmacy Option

| | |
|--------------------------------|---------|
| Generic drugs | |
| Copayment | \$5.00 |
| Formulary Brand Name drugs | |
| Copayment | \$45.00 |
| Non-Formulary Brand Name drugs | |
| Copayment | \$60.00 |

Mail Order Prescription Drug Option

| | |
|--------------------------------|----------|
| Generic drugs | |
| Copayment | \$15.00 |
| Formulary Brand Name drugs | |
| Copayment | \$135.00 |
| Non-Formulary Brand Name drugs | |
| Copayment | \$180.00 |

***For Claims and Eligibility Questions, call:
Tucker Administrators, Inc.
800-347-1232***

This is a brief description of your coverage, and is not a contract. Should a discrepancy arise, the Plan Document and all of its provisions will prevail. The Plan Document sets forth in detail the rights and obligations of the insurer and insured.



Tucker Administrators Flexible Spending Accounts

Plan Year: July 1, 2012 - June 30, 2013

Medical Flexible Spending Account Maximum: \$2,400.00

Medical Spending Account Minimum: \$240.00

Dependent Care Account Maximum: \$5000.00

REMINDER: The Internal Revenue Service (IRS) requires review of all receipts for eligible expenses in an FSA, including debit card transactions. As a reminder, participants should keep all of their receipts for the entire plan year in the event that Tucker Administrators asks for documentation or the IRS requests a copy of a receipt.

Tucker Administrators Flexible Spending Accounts allow you to use pre-taxed dollars towards health care expenses such as prescription medication, certain medical procedures, copays, and more. With Flexible Spending Accounts (FSA), you can save a significant amount of money on your health and day care expenses using a Health Care and/or Dependent Care Flexible Spending Account (FSA). The frequently asked FSA questions below will help you understand how to make the most of this program and your paycheck.

General questions regarding Health Care and Dependent Care Accounts:

What is an FSA?

Provided by your employer, an FSA is a reimbursement account that allows you to set aside a certain amount of each paycheck, pre-tax, to help pay for your out-of-pocket medical expenses and/or dependent day care expenses. The amount you elect is deducted from gross earnings before federal and state taxes are calculated. By using your FSA to pay for qualified expenses you save on income tax...which means your take home pay increases!

Will I pay taxes on the money I set aside?

No. FSA contributions and reimbursements are exempt from Federal Income taxes, Social Security (FICA) taxes, and in most cases, state income taxes.

What kind of savings can I realize by participating in this program?

Actual savings depend on your tax bracket, but most people will save about 30% on their eligible health care and dependent care expenses.

Can I submit expenses I incurred before the beginning of the plan year?

No. Only expenses incurred during the plan year and while you are a participant are eligible for reimbursement.

How long do I have to file a claim with Tucker Administrators after the plan year ends?

You have a grace period (90 days) after the end of the plan year to submit expenses that were incurred during the plan year.

Can I change the amount of my election(s) in the FSA program during the plan year? (i.e. my glasses cost more than I anticipated, I miscalculated my daycare expenses for the year)

Generally, you may not change your FSA elections during the Plan Year. However, you may change during the annual enrollment period for the coming Plan Year. There is an exception to this rule: you may change or revoke your deferral rate in the FSA if you have a Change in Family Status. Examples of a qualifying status change may include:

- Marriage, divorce, or legal separation
- Birth, adoption or placement for adoption of a child
- Death of a dependent or spouse
- Change in employment status of yourself or your spouse
- A significant change caused by a third party in the cost of your dependent care coverage

Keep in mind, you have **30 days** from the date of the qualifying event to change your election.

If I terminate employment, or participation in the FSA, what happens to the money left in my account(s)?

You will be reimbursed only for expenses incurred prior to your termination date, and submitted within the termination grace period. **Any money remaining in your account(s) after the grace period will be forfeited.**

Can I view my FSA balances online?

Yes. Visit **tuckeradministrators.com** and login to access claims information and FSA balances online. Once you are logged in, you may view your account balances. If you are new to Tucker Administrators, when you log into the website, you will be asked to create your own user ID and password.

What if I have a question?

If you have any questions regarding your account balance, claim reimbursement or eligible expenses, you can access your account information at **tuckeradministrators.com** or you can call Customer Service at **1-800-347-1232**.

How does participating in an FSA save me money?

The following example illustrates how a FSA saves you money. This example shows the per period savings for an employee on a bi-weekly payroll, with a tax status of "single" with one exemption:

| | <u>With FSA</u> | <u>Without FSA</u> |
|--|-----------------|--------------------|
| Salary | \$1000 | \$1000 |
| Less Pre-Taxed Dollars: | | |
| Health Care Reimbursement | \$100 | 0 |
| Dependent Day Care Reimbursement | \$150 | 0 |
| Taxable Income | \$750 | \$1000 |
| Less: | | |
| Federal Income Tax | \$82 | \$121 |
| State Income Tax | \$17.58 | \$23.44 |
| Social Security | \$57.37 | \$76.50 |
| Net Take Home Pay | \$593.05 | \$779.06 |
| Less Health Care & Dependent Care Expenses | \$0 | \$250 |
| Net After Expenses | \$593.05 | \$529.06 |
| Tax Savings This Pay Period: \$63.99 | | |
| Annual Tax Savings: \$63.99 X 26 pay periods = \$1,663.74 | | |

Tucker Administrators Health Care Flexible Spending Account

The Health Care FSA is simple! Provided by your employer, a Health Care FSA is a reimbursement account that allows you to set aside a certain amount of each paycheck, pre-tax, to help you pay for your out-of-pocket medical expenses. The amount you elect is deducted from gross earnings before federal and state taxes are calculated. By using your FSA to pay for qualified medical expenses you save on income tax... which means your take home pay increases.

How does the Health Care FSA Work?

With a Health Care FSA, you must decide on your contribution amount at the beginning of the plan year. The amount you designate will be equally divided between pay periods. To estimate the out-of-pocket expenses that you, your spouse, and your dependents may incur, consider any standard co-pays, prescriptions, office visits, and planned medical expenses, i.e. braces or LASIK eye surgery. An expense worksheet has been provided at the end of this section to help you determine the amount of money to allocate to your Health Care FSA.

The IRS requires you to forfeit any money that is left in the FSA at the end of the year. Generally, it is better to underestimate the expenses and pay a little extra tax than to overestimate expenses and forfeit money. To help avoid forfeitures, check your balance prior to the end of each year.

Once you decide how much you want to contribute each paycheck, the money is automatically deposited into your account. As you incur eligible expenses, fax or mail your completed claim form and receipts to Tucker Administrators for reimbursement. Claim forms can be downloaded at tuckeradministrators.com.

What is eligible for reimbursement under the Health Care FSA?

Eligible health care expenses may include deductibles, co-payments and amounts over the maximum your plan pays, expenses for routine physicals and other expenses not covered by your health care plan. For more complete listing please refer to the "Qualified Medical Expenses Eligible for Reimbursement" on page 6.

How do I get reimbursed?

For reimbursement of expenses covered under a health care plan:

- Ensure your expenses are submitted to your health carrier
- If you also have coverage through a spousal plan, you must submit your expenses to both carriers before you submit your expenses for FSA reimbursement
- Once processed by your health carrier(s), complete the Health Care Expense Claim form and attach a copy of the "Explanation of Benefits" showing the unpaid expenses.

For reimbursement of expenses not covered under a health care plan:

- Complete the Health Care Expenses claim form and attach itemized bills for the expense

Fax claims and proof of expense to 704-525-9534 for processing.

How much will be reimbursed?

When you submit a health care expense, you will be reimbursed for that expense claim up to the maximum amount you elected for the plan year, minus any previous reimbursements.

Can I use my Health Care FSA for my family's expenses?

Eligible health care expenses incurred by you, your spouse, or any dependent that you claim as a dependent on your income tax returns are allowable for reimbursement.

If I don't have any medical insurance through my company, can I still participate in the Health Care FSA?

Yes. Out-of-pocket expenses for you and your dependents are eligible for reimbursement whether or not you are insured through your company. Health related expenses are reimbursable for your dependents, if you claim them as a dependent on your income tax returns (this definition of a dependent may be different than that used for your health insurance plan).

Is there anything I have to keep in mind when it comes time to file my taxes?

Expenses payable through your benefits program (or your spouse's, if applicable) are not eligible for reimbursement under the Health Care FSA. In addition, expenses reimbursed through your Health Care FSA cannot be claimed as a deduction on your income tax returns.

I am covered under both my health insurance plan and my spouse's. Do I have to submit medical expenses to both plans before I can file for reimbursement from my Health Care FSA?

Yes. IRS regulations do not permit reimbursement of expenses through the FSA that would otherwise be covered under your health insurance plan. Expenses should first be submitted to your health insurance plan(s), then send any remaining unpaid claims to Tucker Administrators for reimbursement.

If I have a question about my account, what should I do?

If you have any questions, you can access your account information at tuckeradministrators.com, or you can call **Tucker Administrators at 1-800-347-1232**.

Maximize the Value of Your Reimbursement Account

Your Health Care Flexible Spending Account (FSA) dollars can be used for a variety of out-of-pocket health care expenses. Qualified medical expenses are those expenses paid for medical care as described in Section 213(d) of the Internal Revenue Code. Insurance premiums are considered qualified medical expenses when they are for payment for a health plan as stated in Section 220(d) (2) of the code. IRS Publication 502, titled "Medical and Dental Expenses", provides more detailed information on eligible expenses.

QUALIFIED MEDICAL EXPENSES ELIGIBLE FOR REIMBURSEMENT

BABY/CHILD TO AGE 13

- Lactation Consultant*
- Lead-Based Paint Removal
- Special Formula*
- Tuition: Special School/Teacher for Disability or Learning Disability*
- Well Baby /Well Child Care

DENTAL

- Dental X-Rays
- Dentures and Bridges
- Exams and Teeth Cleaning
- Extractions and Fillings
- Oral Surgery
- Orthodontia
- Periodontal Services

EYES

- Eye Exams
- Eyeglasses and Contact Lenses
- Laser Eye Surgeries
- Prescription Sunglasses
- Radial Keratotomy

HEARING

- Hearing Aids and Batteries
- Hearing Exams

LAB EXAMS/TESTS

- Blood Tests and Metabolism Tests
- Body Scans
- Cardiograms
- Laboratory Fees
- X-Rays

MEDICAL EQUIPMENT/SUPPLIES

- Air Purification Equipment*
- Arches and Orthotic Inserts
- Contraceptive Devices

- Crutches, Walkers, Wheel Chairs
- Exercise Equipment*
- Hospital Beds*
- Mattresses*
- Medic Alert Bracelet or Necklace
- Nebulizers
- Orthopedic Shoes*
- Oxygen*
- Post-Mastectomy Clothing
- Prosthetics
- Syringes
- Wigs*

MEDICAL PROCEDURES/SERVICES

- Acupuncture
- Alcohol and Drug/Substance Abuse (inpatient treatment and outpatient care)
- Ambulance
- Fertility Enhancement and Treatment
- Hair Loss Treatment*
- Hospital Services
- Immunization
- In Vitro Fertilization
- Physical Examination (not employment-related)
- Reconstructive Surgery (due to a congenital defect, accident, or medical treatment)
- Service Animals
- Sterilization/Sterilization Reversal
- Transplants (including organ donor)
- Transportation*

MEDICATIONS

- Insulin
- Prescription Drugs

OBSTETRICS

- Doulas*
- Lamaze Class
- OB/GYN Exams
- OB/GYN Prepaid Maternity Fees (reimbursable after date of birth)
- Pre- and Postnatal Treatments

PRACTITIONERS

- Allergist
- Chiropractor
- Christian Science Practitioner
- Dermatologist
- Homeopath
- Naturopath*
- Optometrist

Note: This list is not meant to be all-inclusive, as other expenses not specifically mentioned may also qualify. Also, expenses marked with an asterisk (*) are "potentially eligible expenses" that require a Note of Medical Necessity from your health care provider to qualify for reimbursement.

- Osteopath
- Physician
- Psychiatrist or Psychologist

THERAPY

- Alcohol and Drug Addiction
- Counseling (not marital or career)
- Exercise Programs*
- Hypnosis
- Massage*
- Occupational
- Physical
- Smoking Cessation Programs*
- Speech
- Weight Loss Programs*

Expenses Not Eligible For Reimbursement

- Contact Lens or Eyeglass Insurance
- Cosmetic Surgery/Procedures
- Electrolysis
- Insurance Premiums and Interest
- Long Term Care Premiums
- Marriage or Career Counseling
- Personal Trainers
- Sunscreen
- Swimming Lessons
- Teeth Whitening/Bleaching

Note: This list is not meant to be all-inclusive.

The recently enacted Patient Protection and Affordable Care Act of 2010 (PPACA) made important changes to the regulations for the purchase of over the counter (OTC) products using your Flexible Spending Account (FSA) pre-tax funds.

As of January 1, 2011:

FSA funds can no longer be used to purchase OTC medicine and drugs unless a medicine or drug is prescribed.

The OTC items affected include items in the following categories:

- Acid controllers
- Acne medications
- Allergy & sinus
- Antibiotic products
- Antifungal (Foot)
- Antiparasitic treatments
- Antiseptics & wound cleansers
- Anti-diarrheals
- Anti-gas
- Anti-itch & insect bite
- Baby rash ointments & creams
- Baby teething pain
- Cold sore remedies
- Contraceptives
- Cough, cold & flu
- Denture pain relief
- Digestive aids
- Ear care (medication)
- Eye drops
- Feminine antifungal & anti-itch

- Fiber laxatives (bulk forming)
- First aid burn remedies
- Foot care treatment (i.e. athlete's foot)
- Hemorrhoidal preps
- Homeopathic remedies
- Laxatives (non-fiber)
- Medicated nasal sprays, drops, & inhalers
- Medicated respiratory treatments
- Motion sickness
- Oral remedies or treatments
- Pain relief (includes aspirin)
- Skin treatments
- Sleep aids & sedatives
- Smoking deterrents
- Stomach remedies
- Unmedicated nasal sprays, drops & inhalers
- Unmedicated vapor products

The new regulations state that a "prescription" means "a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state in which the medical expense is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state."

IMPORTANT: A Letter of Medical Necessity is NOT the same as a prescription, and can no longer be used for FSA OTC medicine or drug purchases on or after January 1, 2011

If you currently have a Letter of Medical Necessity for any of the items listed in the table above, you will not be able to purchase these items with FSA pre-tax funds, as of January 1, 2011. You will be required to obtain a prescription from your doctor to purchase these items with FSA pre-tax funds.

You can continue to use your FSA funds to purchase OTC items that are not considered a medicine or drug (e.g. bandages, splints, contact lens solution, etc.) Please note that insulin remains an eligible expense with or without a prescription.

You may continue to use your **Benny™ Prepaid Benefits Card** for OTC drugs and medication with certain restrictions at the following merchants:

- True drug stores (like CVS or Walgreens),
- Non-health care stores that have pharmacies such as Target and Wal-Mart,
- Mail-order and Web-based vendors (like drugstore.com) that sell prescription drugs

(Check with your pharmacist to make sure they can fill an OTC prescription)

These stores must satisfy the following requirements to accept debit cards:

1. Prior to purchase, the prescription for the over-the-counter medicine or drug is presented to the pharmacist;
2. The over-the-counter medicine or drug is dispensed by the pharmacist
3. An Rx number is assigned;
4. The pharmacy or other vendor retains a record of the Rx number, the name of the purchaser (or the name of the person for whom the prescription applies), and the date and amount of the purchase
5. All of these records are available to the employer or its agent upon request;
6. The debit card system will not accept a charge for an over-the-counter medicine or drug unless an Rx number has been assigned

If these requirements are met, the debit card transaction will be considered fully substantiated at the time and point-of-sale.

OTC items that are not medicines or drugs remain eligible for purchase with FSAs . You can use your benefits card for these items.

Eligible Over-the-Counter Items (Product categories are listed in bold face; common examples are listed in regular face.)

- **Baby Electrolytes and Dehydration**
Pedialyte, Enfalyte
- **Contraceptives**
Unmedicated condoms
- **Denture Adhesives, Repair, and Cleansers**
PoliGrip, Benzodent, Plate Weld, Efferdent
- **Diabetes Testing and Aids**
Ascencia, One Touch, Diabetic Tussin, insulin syringes; glucose products
- **Diagnostic Products**
Thermometers, blood pressure monitors, cholesterol testing
- **Ear Care**
Unmedicated ear drops, syringes, ear wax removal
- **Elastics/Athletic Treatments**
ACE, Futuro, elastic bandages, braces, hot/cold therapy, orthopedic supports, rib belts
- **Eye Care**
Contact lens care
- **Family Planning**
Pregnancy and ovulation kits
- **First Aid Dressings and Supplies**
Band Aid, 3M Nexcare, non-sport tapes
- **Foot Care Treatment**
Unmedicated corn and callus treatments (e.g., callus cushions), devices, therapeutic insoles
- **Hearing Aid/Medical Batteries**
- **Home Health Care (limited segments)**
Ostomy, walking aids, decubitis/pressure relief, enteral/parenteral feeding supplies, patient lifting aids, orthopedic braces/supports, splints & casts, hydrocollators, nebulizers, electrotherapy products, catheters, unmedicated wound care, wheel chairs
- **Incontinence Products**
Attends, Depend,
- **Prenatal Vitamins**
Stuart Prenatal, Nature's Bounty Prenatal Vitamins
- **Reading Glasses and Maintenance Accessories**

*For additional information, please contact Tucker Administrators at
704-525-9666
www.tuckeradministrators.com*

Health Care FSA Expense Worksheet

This worksheet has been prepared to help you determine the amount of money you wish to allocate to your Health Care FSA. You may want to review your checkbook register or credit card statements from last year to identify medical expenses you paid out of your own pocket. Compare last year's typical expenses to those eligible under your Health Care FSA and budget accordingly for the upcoming year, keep in mind to only budget for those expenses specifically eligible under your Health Care FSA.

| | |
|---|--------------------------------|
| HEALTH CARE EXPENSES YOU PAID LAST YEAR COULD INCLUDE: | |
| Deductibles | |
| (medical and dental) | \$ _____ |
| Benefit percentage/co-insurance | |
| (The amount NOT paid by your insurance) | \$ _____ |
| Amounts paid over plan limits | |
| Over reasonable and customary allowance | \$ _____ |
| Over psychiatric limits | \$ _____ |
| Over private room allowance | \$ _____ |
| Expenses NOT covered by your insurance plan | |
| Physicals | |
| \$ _____ | Prescription drugs |
| \$ _____ | Vision care |
| \$ _____ | Hearing expenses |
| \$ _____ | Psychiatric care |
| \$ _____ | Dental and orthodontic care |
| \$ _____ | Assistance for the handicapped |
| \$ _____ | Therapy/treatments |
| \$ _____ | Physician's fees/services |
| \$ _____ | Medical equipment |
| \$ _____ | Miscellaneous charges |
| \$ _____ | |
| My out-of-pocket health care expenses last year | |
| | \$ _____ |

Tucker Administrators Dependent Care Flexible Spending Account

The Dependent Care FSA helps you pay for child care services which make it possible for you and your spouse (if applicable) to work. It also may be used to help pay for the care of a disabled spouse or dependent.

The Dependent Care FSA creates tax savings on up to \$5,000 of daycare expenses. That can mean \$1,500 in tax savings enough to pay for weeks of eligible child or adult daycare!

How Does a Dependent Care FSA work?

A Dependent Care FSA is a reimbursement account that allows you to set aside a certain amount of each paycheck on a pre-tax basis to pay for your eligible dependent day care expenses. The amount you elect at the beginning of each plan year, is deducted from your gross earnings before federal and state taxes are calculated. By using your FSA to pay for qualified expenses you save on income tax...which means you have more money in your pocket!

To estimate your dependent care expenses, consider your expenses from last year. An expense worksheet is provided at the end of this section to help you determine the amount of money to allocate for your Dependent Care FSA. Remember, the IRS requires that all money in your account be used during the plan year. You can access balance information online via **tuckeradministrators.com**.

Am I eligible to use the Dependent Care FSA?

To be eligible, you must be at work during the time your eligible dependent receives care. You must also meet one of the following eligibility guidelines:

- You and your spouse are both employed;
- You are a single parent;
- Your spouse is a full-time student at least five months during the year while you are working;
- Your spouse is physically or mentally unable to provide his/her own care; or
- You are divorced or legally separated and have custody of your child most of the time even though your former spouse may claim the child for income tax purposes.

Who is an eligible dependent?

An eligible dependent is defined as any person who can be claimed as a dependent for federal tax purposes and who:

- Is a child under 13 years of age;
- Is a child over the age of 13 who is physically or mentally incapable of caring for himself or herself;
- Is your spouse who is physically or mentally incapable of caring for himself or herself,
- An elderly parent who resides with you and is physically or mentally incapable of caring for himself or herself.

What expenses are covered?

Eligible dependent care expenses are those which allow you and your spouse, if you are married, to work or attended school full- time. Below are some examples of eligible dependent care expenses:

- Day care facility fees
- Before/after school care
- Summer day camp (not overnight)
- Nursery school or preschool, if child is too young for kindergarten
- In home babysitting fees, if not provided by another dependent and claimed as income by the care provider
- Private school tuition, K4 and above is not eligible for reimbursement

Is there anything I have to keep in mind when it comes time to file my taxes?

You are required to provide the name, address and taxpayer identification (or Social Security number) of the dependent care provider on your income tax return. If you are unable to provide this information, both the tax credit and the exclusion for the spending account reimbursement may be denied by the IRS. Verify that this information is available before you elect to participate in the Dependent Care FSA.

Expenses reimbursed from this FSA cannot be used to claim a Federal Income Tax credit; therefore, you will have to determine which approach is best for you. You may even be able to combine the expense account and tax credits to reduce your overall dependent care expenses. However, the maximum expense you can claim when using both the tax credit and FSA is the tax credit limit (\$3,000 for one dependent or \$6,000 for two or more dependents), minus the amount reimbursed under the Dependent Care FSA. You may wish to consult your tax advisor to see if the Flexible Spending Account or the tax credit will be more advantageous to your family.

How do I get reimbursed?

As you incur eligible expenses you must submit a completed Dependent Care claim form to Tucker Administrators with proof of payment from your day care provider or from the individual who provides the care. Dependent Care FSA claims must include the federal tax identification number or Social Security number, name and address of the provider, dates of service, type of service rendered and name of dependent. The individual who provides the care cannot be your spouse or a dependent under the age of 19.

With a Dependent Care FSA, you will be reimbursed as you set funds aside. If you submit a claim for more than what has been set aside for that account, the unreimbursed claim portion will be placed in "pending" status until funds are received through payroll deduction at which time you will receive reimbursement.

Can I pay my in-home daycare provider through the Dependent Care FSA?

Yes. You can be reimbursed from your Dependent Care FSA for any qualified daycare expenses, whether performed in your home, the provider's home or a "daycare center". Receipts for the expenses and the caregiver's Tax ID number or Social Security number must be provided.

I'm divorced; my ex-spouse claims our child as a deduction for tax purposes.

I pay for child care. Can I use the Dependent Care FSA?

If your child resides with you most of the year, you can use the dependent care account to pay for child care services. However, you might want to call your tax advisor to discuss your particular circumstances before you elect to participate in the account.

If I have a question about my account, what should I do?

If you have any questions, you can call Tucker Administrators Customer Service at **1-800-347-1232**.

Dependent Care FSA Expense Worksheet

Dependent care expenses you paid last year could include:

Costs of Child or Adult Care Facilities*

Day Care Center / Nursery School \$ _____

Family Day Care / Adult Day Care Centers** \$ _____

Wages paid to a nanny or in home care provider*** \$ _____

* The facility must follow all local and state laws.

** These costs are eligible only if the adult dependent spends at least eight hours per day at home.

*** Please note these expenses are not eligible if the care services are provided by someone that you claim as a dependent.

Other dependent care expenses considered eligible by the IRS \$ _____

TOTAL ESTIMATED DEPENDENT CARE EXPENSES \$ _____

Compare last year's typical expenses to those eligible under your Dependent Care FSA and budget accordingly for the upcoming year.

FAX CLAIMS AND PROOF OF EXPENSE TO (704) 525-9534 FOR PROCESSING.

(PLEASE KEEP YOUR ORIGINALS)

Benny™ Prepaid Benefits Card Instructions

As an added benefit, the plan includes a debit card for your Health Care Flexible Spending Account (FSA). Please read this carefully to find out how the debit card can give you faster access to your Health Care FSA funds. Your card works in the same manner as a regular Visa® except the dollars are deducted from your Health Care Flexible Spending Account. Your card may be used at any medical provider who accepts Visa®. The card is issued to you, the employee. You will receive 2 cards so another eligible user can use the additional card. Only one has to be activated for both to work.

How does the Benny™ Prepaid Benefits Card work?

Shortly after the start of the plan year, you will receive your Benny™ Prepaid Benefits Card to use to pay for your eligible medical expenses. When you incur an eligible health care expense, you simply swipe your debit card at the point of purchase, select the “**CREDIT**” option on the card reader since there is no PIN, and the amount of the purchase is deducted directly from your Health Care FSA account balance. You do not have to pay cash, write a check or provide another means of payment. Your health care provider is paid automatically from your Health Care FSA.

What kinds of services can I purchase with the Benny™ Prepaid Benefits Card?

The debit card can be used to purchase health care services from many medical providers, including physician offices, pharmacies, dental providers, vision providers, hospitals and online service providers or retailers.

Where can I use my Benny™ Prepaid Benefits Card?

Your Debit Card will only be accepted at authorized vendors, i.e. medical clinics, hospitals, dental offices, vision care centers and pharmacies that have the appropriate merchant codes.

Do I have to apply for the Benny™ Prepaid Benefits Card?

No. If you participate in the Health Care FSA, you will receive a debit card by U.S. mail at your home address. If you do not want to use the card for your eligible health care expenses, simply destroy the card upon receipt.

Do I have to use the Benny™ Prepaid Benefits Card for all my health care expenses?

No, the Benny™ Prepaid Benefits Card is provided to you as a convenience. You make the choice every time you purchase health care products or services if you would like to use the debit card. If you do not use your debit card, you can submit any health care expenses manually for reimbursement to Tucker Administrators along with a completed claim form and receipts.

If I use my Benny™ Prepaid Benefits Card, is verification of claims still required?

Beginning January 1, 2008, new IRS rules simplified the use of Flex Debit Cards. These rules now require drug stores and pharmacies to identify FSA-eligible items at checkout and require the drug store or pharmacy to only use the card for FSA eligible items. That means you can use your Card at participating stores that offer this feature for the total FSA-eligible amount and NO receipts are needed to verify the eligibility of the purchase.

Tucker Administrators does however, recommend saving your receipts in the event there is a question of eligibility for your purchases.

Here's how your Benny™ Prepaid Benefits Card works at participating stores:

1. Bring prescriptions and vision products, and other purchases to the register at checkout to let the clerk ring them up.
2. Present your Card and swipe it for payment selecting the **CREDIT** key.
3. If the Card swipe transaction is approved (e.g. there are sufficient funds in the account and at least some of the purchases are FSA-eligible), the amount of the FSA-eligible purchases is deducted from the account balance and no receipt follow-up is required. The clerk will then ask for payment for the non-FSA eligible items.
4. If the Card swipe transaction is declined, the clerk will ask for another form of payment for the total amount of the purchase.
- 5 The receipt will identify the FSA-eligible items and may also show a subtotal of the FSA-eligible purchases.

What should I do to pay for an expense that is more than my account balance?

You should tell the merchant to swipe your card for the amount equal to what is left in your account, then use another payment method to pay the remaining balance.

Important Information Concerning Your Benny™ Prepaid Benefits Card

If you will be receiving a new debit card, whether you are a new participant or to replace your expired card, please be aware that it may take several days following your plan year effective date for your card to arrive. Your card will be delivered by mail in a plain white envelope. During this time, you may use manual claim forms which are available on Tucker Administrators' website at tuckeradministrators.com. Please note your debit card is good through the expiration date printed on the card as long as you remain in the program by reenrolling each plan year.

Whom do I contact if my card is lost or stolen, or if I have a problem with the card?

If you have any problems with your card, or if your card is lost or stolen, please contact the flex department at **Tucker Administrators, at 800-347-1232.**

*Tucker Administrators, Inc.
3800 Arco Corporate Dr., Suite 450
Charlotte, NC 28273
Telephone: (800) 347-1232
Fax: (704) 525-9534
www.tuckeradministrators.com*



Ameritas Dental Plan

Effective Date: July 1, 2012

COMBINED CALENDAR YEAR DEDUCTIBLE

\$50.00 per individual for Type 2 (Basic) and Type 3 (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 1 - PREVENTIVE AND DIAGNOSTIC

Type 1 benefits are payable at 100% U&C**. 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 2 - BASIC PROCEDURES

Type 2 benefits are payable at 80% U&C**. \$50.00 deductible applies.

- Sealants (Under 17)
- Limited Exams-problem focused
- Anesthesia
- Denture Repair
- Periodontics (Gum Disease)
- Oral Surgery - Complex and Simple Extractions
- Restorative Amalgam & Resin (excluding inlays & crowns)
- Endodontics (Root Canal)

TYPE 3 - MAJOR PROCEDURES

Type 3 Benefits are payable at 50% U&C**. \$50.00 deductible applies.

- Restorative - Inlays and Crowns
- Prosthodontics - Removable Dentures, Partial
- Prosthodontics - Fixed Pontics or Abutments
- Crown Repair

ORTHODONTIA

Paid at 50% U&C** with a \$1,000 lifetime maximum. No deductible applies.

Benefits will be payable when a Covered Expense is incurred. The Covered Expenses for a program are based on the estimated cost of the insured's program. They are pro-rated by quarter (three month periods) over the estimated length of the program, but not for more than eight quarters. The last quarterly payment for a program may be changed if the estimated and actual cost of the program differ.

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

***Usual and Customary Charge*

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 employees 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 26.

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.

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.

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.

SEMI-MONTHLY DENTAL RATES

| | |
|---------------------|---------|
| Employee Only | \$14.48 |
| Employee/Spouse | \$29.03 |
| Employee/Child(ren) | \$30.66 |
| Employee/Family | \$45.21 |

FOR CLAIMS / CUSTOMER SERVICE QUESTIONS

CALL AMERITAS AT: (800) 487-5553

This insurance is underwritten by Ameritas Life Insurance Corporation.



Superior Vision Plan 1- Full Services Plan

Effective Date: July 1, 2012

Outline of Benefits – Gold Preferred Plan with Materials Discount

*Copayment: \$15.00 Exam Copayment
 \$35.00 Contact Lens Fitting Fee
 No Copayment for Materials*

HOW TO USE THE PLAN

Welcome to Superior Vision's vision plan. Superior Vision provides primary vision care benefits including eye examinations, prescription eyewear, and contact lenses through a broad-based provider network consisting of ophthalmologists, optometrists, and opticians. The plan also contracts with a large number of national and regional optometric chain locations.

Your first step should be to choose an eye care provider, or ensure that your current provider is part of the Superior Vision network. Go to www.superiorvision.com and click on "Locate a Provider" for an updated list. You will learn about "in-network" and "out-of-network" providers – it is an important distinction when receiving your benefits. You will also learn more about how to use your benefits, as well as the discounts that are available to you.

Remember that a routine eye exam is important not only for correcting vision problems, but for maintaining healthy eyes and overall health wellness. Superior Vision eye care providers are trained to test for and diagnosis a variety of health issues – not just eye problems. Take the time to get to know your vision plan, and start experiencing healthy eyes and healthy living.

BENEFITS

| | <i>Frequency</i> | <i>In-Network¹</i> | <i>Out-of-Network¹</i> |
|---|------------------|-------------------------------|-----------------------------------|
| <i>Comprehensive Eye Exam</i> | | | |
| Ophthalmologist | 12 Months | Covered in Full | Up to \$44.00 |
| Optometrist | 12 Months | Covered in Full | Up to \$39.00 |
| <i>Standard Lenses (Per Pair):</i> | | | |
| Single Vision | 12 Months | Covered in Full | Up to \$34.00 |
| Bifocal | 12 Months | Covered in Full | Up to \$48.00 |
| Trifocal | 12 Months | Covered in Full | Up to \$64.00 |
| Lenticular | 12 Months | Covered in Full | Up to \$88.00 |
| <i>Contact Lenses (Per Pair)²</i> | | | |
| Medically Necessary | 12 Months | Covered in Full | Up to \$210.00 |
| Cosmetic (Elective) ³ | 12 Months | Up to \$120.00 | Up to \$100.00 |
| <i>Contact Lens Fitting⁴</i> | | | |
| Standard | 12 Months | Covered in Full | Not Covered |
| Specialty | 12 Months | Up to \$50.00 | Not Covered |
| <i>Frames-Standard³</i> | 24 Months | Up to \$100.00 | Up to \$50.00 |

¹ All in-network and out-of-network allowances are at the retail value.

² Contact lenses are in lieu of eyeglass lenses and frames benefits.

³ The insured is responsible for paying any charges in excess of this allowance.

⁴ Standard contact lens fitting fee applies to an existing contact lens user who wears disposable, daily wear, or extended wear lenses only. The specialty contact lens fitting fee applies to new contact lens wearers and/or a member who wears toric, gas permeable, or multifocal lenses.

DISCOUNT FEATURES

Look for providers in the Provider Directory who accept discounts; please verify their discounts prior to service.

Discounts on Covered Materials

| | |
|---------------|--|
| Frames: | 20% off amount over allowance |
| Lens options: | 20% off retail |
| Progressives: | 20% off amount over retail lined trifocal lens, including lens options |

The following options have out-of-pocket maximums⁵ on standard plastic single vision lenses, and select options are available on standard bifocal and trifocal lenses. Out-of-pocket maximums are not available on premium options or progressives.

Maximum Member Out-of-Pocket

| | Single Vision | Bifocal & Trifocal |
|---------------------------|---------------|--------------------|
| Scratch coat | \$13 | \$13 |
| Ultraviolet coat | \$15 | \$15 |
| Tints, solid or gradients | \$25 | \$25 |
| Anti-reflective coat | \$50 | \$50 |
| Polycarbonate | \$40 | 20% off retail |
| High-index 1.6 | \$55 | 20% off retail |
| Photochromic | \$80 | 20% off retail |

Discounts on Non-Covered Exam and Materials

Superior Vision offers discounts on an unlimited number of materials after the member has exhausted their covered benefit.

| | |
|---|----------------|
| Exams, frames, and prescription lenses: | 30% off retail |
| Lens options, contacts, other prescription materials: | 20% off retail |
| Disposable contact lenses: | 10% off retail |

Refractive Surgery

Superior Vision has a nationwide network of refractive surgeons and partnerships with leading LASIK networks (QualSight, TruVision, and LasikPlus) who offer members a discount. These discounts range from 20%-50%, and are the best possible discounts available to Superior Vision.

⁵ Discounts and maximums may vary by lens type. Please check with your provider.

*Higher end or brand name lens upgrades are at an additional expense. These upgrades will be available at a 20% discount off retail.

Items or Services Not Covered

While Superior Vision offers a variety of vision benefits, there are a few materials, services, and treatments that are generally not covered, or have limitations to their coverage. We do offer discounts on many of these items, as outlined in our discount plan coverage information. For a list of these, please see your benefits administrator. **Please confirm the details of your employer's plan prior to seeking services.**

SEMI-MONTHLY RATES - FULL SERVICES PLAN

| | |
|--------------------------|----------------|
| <i>Employee Only</i> | <i>\$5.40</i> |
| <i>Employee + One</i> | <i>\$10.48</i> |
| <i>Employee + Family</i> | <i>\$15.40</i> |

Customer Service
800-507-3800
916-852-2277 Fax

Explanation of benefits
Provider locator; provider nomination
Claims inquiries
Authorization numbers (out-of-network)
Grievance issues

Customer Service/Corporate Office
11101 White Rock Rd., Ste. 150
Rancho Cordova, CA 95670

Claims Administration
P.O. Box 967
Rancho Cordova, CA 95741

Disclaimer: All final determinations of benefits, administrative duties, and definitions are governed by the Certificate of Insurance Coverage for your vision plan. Please check with your Benefits Administrator or Human Resources department if you have any questions.



The Superior Vision Plan is underwritten by National Guardian Life Insurance Company. National Guardian Life Insurance Company is not affiliated with The Guardian Life Insurance Company of America, a/k/a The Guardian or Guardian Life



Superior Vision Plan 2 - Materials Only Plan

EFFECTIVE DATE: JULY 1, 2012

**OUTLINE OF BENEFITS – MATERIALS ONLY
VISION PLAN – PREFERRED PROVIDER (PPO / INDEMNITY)**

**COPAYMENT: \$15.00 MATERIALS
\$25.00 CONTACT LENS FITTING FEE**

HOW TO USE THE PLAN

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Remember that a routine eye exam is important not only for correcting vision problems, but for maintaining healthy eyes and overall health wellness. Superior Vision eye care providers are trained to test for and diagnosis a variety of health issues – not just eye problems. Take the time to get to know your vision plan, and start experiencing healthy eyes and healthy living.

BENEFITS

| | Frequency | In-Network¹ | Out-of-Network¹ |
|---|------------------|-------------------------------|-----------------------------------|
| <i>Comprehensive Eye Exam</i> | No Benefit | No Benefit | No Benefit |
| <i>Standard Lenses (Per Pair):</i> | | | |
| Single Vision | 12 Months | Covered in Full | Up to \$34.00 |
| Bifocal | 12 Months | Covered in Full | Up to \$48.00 |
| Trifocal | 12 Months | Covered in Full | Up to \$64.00 |
| Lenticular | 12 Months | Covered in Full | Up to \$88.00 |
| <i>Contact Lenses (Per Pair)²</i> | | | |
| Medically Necessary | 12 Months | Covered in Full | Up to \$210.00 |
| Cosmetic (Elective) ³ | 12 Months | Up to \$120.00 | Up to \$100.00 |
| <i>Contact Lens Fitting⁴</i> | | | |
| Standard | 12 Months | Covered in Full | Not Covered |
| Specialty | 12 Months | Up to \$50.00 | Not Covered |
| Frames-Standard³ | 24 Months | Up to \$100.00 | Up to \$50.00 |

¹ All in-network and out-of-network allowances are at the retail value.

² Contact lenses are in lieu of eyeglass lenses and frames benefits.

³ The insured is responsible for paying any charges in excess of this allowance.

⁴ Standard contact lens fitting fee applies to an existing contact lens user who wears disposable, daily wear, or extended wear lenses only. The specialty contact lens fitting fee applies to new contact lens wearers and/or a member who wears toric, gas permeable, or multifocal lenses.

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Discounts on Non-Covered Materials

Superior Vision offers discounts on an unlimited number of materials after the member has exhausted their covered benefit.

| | |
|----------------------------------|----------------|
| Frames, and prescription lenses: | 30% off retail |
| Lens options, contacts, other | |
| prescription materials: | 20% off retail |
| Disposable contact lenses: | 10% off retail |

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⁵ Discounts and maximums may vary by lens type. Please check with your provider.

*Higher end or brand name lens upgrades are at an additional expense. These upgrades will be available at a 20% discount off retail.

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While Superior Vision offers a variety of vision benefits, there are a few materials, services, and treatments that are generally not covered, or have limitations to their coverage. We do offer discounts on many of these items, as outlined in our discount plan coverage information. For a list of these, please see your benefits administrator. **Please confirm the details of your employer's plan prior to seeking services.**

SEMI-MONTHLY RATES - MATERIALS ONLY PLAN

| | |
|--------------------------|----------------|
| <i>Employee Only</i> | <i>\$ 3.39</i> |
| <i>Employee + One</i> | <i>\$ 6.59</i> |
| <i>Employee + Family</i> | <i>\$ 9.66</i> |

Customer Service

800-507-3800

916-852-2277 Fax

Explanation of benefits

Provider locator; provider nomination

Claims inquiries

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Superior Vision

Our Members. Our Mission.

***Assurity Accident Expense+ Plan
(24 Hour Accident Plan)***

Effective Date: July 1, 2012

Can you remember the last time you planned to get hurt? Many believe “it won’t happen” to them, but statistics tell a different story. What is your plan if you get hurt?

Accidents happen... Not just to people in cars or on slippery sidewalks — but to cooks in the kitchen, weekend athletes, do-it-yourselfers on ladders, and kids with footballs and bikes. Some injuries can be handled with a bandage and an ice pack, but 1 out of 9 people sought medical attention for an injury in 2008.[†]

You’re careful... Seatbelts, air bags, car seats, bike helmets and shin guards provide a level of protection for you and your family. You follow safety procedures at work. But, unfortunately, accidents can still result in injuries and unexpected expenses regardless of your precautions.

Disabling Injuries:

| | |
|-------------|--------------------------------|
| On-the-job | 1 every 9 seconds |
| Off-the-job | 1 every 3 seconds |
| At home | 1 every 2 seconds [‡] |

Costs are crippling... Recovering from an injury is tough enough, but out-of-pocket expenses for the emergency room, ambulance, hospital stay and doctors’ bills can cause a separate financial crisis. And, remember, while you’re laid-up — your monthly bills and expenses don’t stop!

The Accident Expense+ Policy solution... Assurity at Work, through Assurity Life Insurance Company, offers you the opportunity to protect your family and yourself from the cost of accidental injuries with the Accident Expense+ Policy. This plan pays you a fixed cash benefit for medical treatments associated with a covered accident. The benefits are paid regardless of any other insurance coverage.‡ Here’s the great news — you can extend this affordable protection to cover your spouse and children. This policy’s cash benefits will be handy for your child’s next trip to the emergency room for a playground or sports related injury.

Accident Expense+ Benefit Highlights...

- Accidental Death
- Accidental Death on – Common Carrier (plane bus, train, etc.)
- Hospital Admission
- Hospital Confinement
- Hospital Intensive Care Unit
- Major Diagnostic Exams,
- Physician’s Office and Urgent Care

[†]National Safety Council Injury Facts 2011

[‡]National Safety Council Injury Facts 2009

Also included: Benefits for ambulance, emergency room, burns, dislocations, fractures, dismemberment, skin grafts, unintentional gunshot wounds, emergency dental work, eye injuries, prosthetic devices, medical appliances, blood products, ruptured disc surgery, rotator cuff surgery, abdominal or thoracic surgery, exploratory surgery, lodging and transportation.

BENEFIT OPTION

24-hour coverage (Form W A200)

BENEFIT AMOUNT

One-unit and two-unit plans are available.

RATE STRUCTURE

- Employee, Employee/Spouse, Employee/Child, Family
- One age band
- Unisex, Unismoke

ISSUE AGE (varies by state)

- 18 through 64 (using Age Last Birthday as of policy issue date)
- Children: 0 through 21 if dependent children definition met with coverage to age 25; automatic coverage will be afforded any newborn or adopted dependent child if Assurity receives written notification within 30 days.

ELIGIBILITY

Coverage is available for the employee, spouse and dependent children. Eligible employees must be actively at work, performing all duties of their primary occupation for the last 90 days to apply for coverage and be employed at their current employer for at least 30 days. Some industries require a longer period.

New hires must be actively at work, working 30 hours or more per week for the last 30 days, unless the writing period is longer for that industry.

RENEWABILITY

Policy is guaranteed renewable (GR) for life.

EXCLUSIONS (varies by state)

We will not pay benefits for losses caused by or as the result of any insured person(s):

- operating, learning to operate or serving as a crew member of any aircraft;
- engaging in hang-gliding, hot air ballooning, bungee jumping, parachuting, scuba diving, sail gliding, parasailing, parakiting or any similar activities;
- riding in or driving any motor-driven vehicle in a race, stunt show or speed test;
- officiating, coaching, practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received;

- who has any sickness or condition caused by a sickness independent of the covered accident, including physical or mental infirmity. Sickness means any illness, infection, disease or any other abnormal physical condition which is not caused by any injury;
- being exposed to war or any act of war, declared or undeclared;
- actively serving in any of the armed forces, or auxiliary units, including the National Guard or Army Reserve;
- suffering from mental or nervous disorders;
- being addicted to drugs or suffering from alcoholism (N/A in Georgia);
- being under the influence of an excitant, depressant, hallucinogen, narcotic, or any other drug or intoxicant, including those prescribed by a physician that are misused (N/A in Georgia);
- receiving injuries caused directly or indirectly while under the influence of a controlled substance or by intoxication as defined by the laws and jurisdiction of the geographical area for which the loss or cause of loss was incurred (N/A in Georgia);
- who is a dependent child and receives injuries during birth;
- having cosmetic surgery or other elective procedures that are not medically necessary;
- having dental treatment except as the result of an injury;
- having a hernia;
- participating in or attempting to commit a felony;
- being incarcerated in a penal institution or government detention facility;
- driving any taxi for wages, compensation or profit (N/A in Georgia);
- engaging in an illegal activity or occupation;
- self-inflicting an injury intentionally;
- committing or attempting to commit suicide, while sane or insane; or
- traveling outside the U.S., except for those injuries that require emergency care in a hospital.

For NC residents: READ YOUR POLICY CAREFULLY. THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Care insurance for People with Medicare, which is available from Assurity.

Benefits - paid once per accident

| Benefit | Terms/Conditions/Limits | One-Unit Plan | Two-Unit Plan |
|--|---|--|---|
| Accidental death | Within 90 days of accident | \$25,000 employee \$10,000 spouse \$5,000 child | \$50,000 employee \$20,000 spouse \$10,000 child |
| Accidental death on common carrier (commercial airplane, bus, train, etc.) | Within 90 days of accident, not paid in addition to death benefit | \$50,000 employee \$20,000 spouse \$10,000 child | \$100,000 employee \$40,000 spouse \$20,000 child |
| Ambulance | | | |
| Air | To or from hospital or between medical facilities within 48 hours of accident | \$500 any insured | \$500 any insured |
| Ground | To or from hospital or between medical facilities within 90 days of accident | \$100 any insured | \$100 any insured |
| Appliances | As an aid in personal locomotion or mobility prescribed within 90 days of accident | \$100 any insured | \$100 any insured |
| Blood/Plasma/Platelets | For transfusion administration, cross matching, typing, and processing within 90 days of the accident | \$300 employee \$200 spouse/child | \$300 employee \$200 spouse/child |
| Burns | Within 72 hours of accident | | |
| 2nd degree burns on at least 36% of body | | \$375 employee \$150 spouse/child | \$750 employee \$300 spouse/child |
| 3rd degree burns on at least 1-19% of body | | \$750 employee \$300 spouse/child | \$1,500 employee \$600 spouse/child |
| 3rd degree burns on at least 20% of body | | \$5,000 employee \$2,000 spouse/child | \$10,000 employee \$4,000 spouse/child |
| Skin graft for burn | | 25% of the applicable burn benefit | 25% of the applicable burn benefit |

Benefits - paid once per accident (continued)

| Benefit | Terms/Conditions/Limits | One-Unit Plan | | Two-Unit Plan | |
|---|---|--|---------------------------|--|---------------------------|
| Dislocations | | Any Insured | | Any Insured | |
| Hip | Requiring correction with anesthesia, diagnosed by a physician within 90 days of accident | Closed reduction \$1,000 | Open reduction \$2,000 | Closed reduction \$2,000 | Open reduction \$4,000 |
| Knee (except patella) | Reduction without anesthesia paid at 25% of the closed reduction benefit | \$500 | \$1,000 | \$1,000 | \$2,000 |
| Ankle or bones of the foot, (other than toes) | Incomplete dislocations paid at 25% of the closed reduction benefit | \$400 | \$800 | \$800 | \$1,600 |
| Collarbone (Sternoclavicular) | | \$250 | \$500 | \$500 | \$1,000 |
| Collarbone (Acromioclavicular) | | \$50 | \$100 | \$100 | \$200 |
| one toe, or finger | | | | | |
| Lower jaw, shoulder, elbow, wrist, bones of hand (other than fingers) | | \$150 | \$300 | \$300 | \$600 |
| Dismemberment | Within 90 days of accident | | | | |
| Both hands, both feet, sight in both eyes, or any combination of two or more hands, feet, and/or eyes | | \$15,000 employee \$10,000 spouse/child | | \$30,000 employee \$20,000 spouse/child | |
| One hand, one foot, or sight of one eye | | \$7,500 employee \$5,000 spouse/child | | \$15,000 employee \$10,000 spouse/child | |
| Two or more fingers or toes | | \$1,500 employee \$1,000 spouse/child | | \$3,000 employee \$2,000 spouse/child | |
| One finger or toe | | \$750 employee \$500 spouse/child | | \$1,500 employee \$1,000 spouse/child | |
| Emergency dental work | Paid once per accident, regardless of the number of teeth involved | | | | |
| Any and all broken teeth repaired with crown | | \$150 any insured | | \$300 any insured | |
| Any and all broken teeth resulting in extractions | | \$50 any insured | | \$100 any insured | |
| Emergency room | Treatment within 72 hours of accident | \$200 any insured | | \$200 any insured | |

Benefits - paid once per accident (continued)

| Benefit | Terms/Conditions/Limits | One-Unit Plan | | Two-Unit Plan | |
|---|---|----------------------|----------------|----------------------|----------------|
| Eye Injury | Requiring surgery or removal of a foreign object within 90 days of accident | \$200 any insured | | \$200 any insured | |
| Fractures | Requiring surgical or non-surgical realignment by a physician with 90 days of the accident | Any Insured | | Any Insured | |
| | | Closed reduction | Open reduction | Closed reduction | Open reduction |
| Skull (depressed) | | \$1,250 | \$2,500 | \$2,500 | \$5,000 |
| Skull (non-depressed) | | \$500 | \$1,000 | \$1,000 | \$2,000 |
| Hip, thigh | | \$750 | \$1,500 | \$1,500 | \$3,000 |
| Vertebrae (excluding vertebral process), pelvis, leg, (tibia and/or fibula) | | \$400 | \$800 | \$800 | \$1,600 |
| Vertebral process | | \$150 | \$300 | \$300 | \$600 |
| Bones of face or nose, upper jaw (maxilla) upper arm (humerus) | | \$175 | \$350 | \$350 | \$700 |
| Lower jaw (mandible), shoulder blade (scapula), collar bone (clavicle, sternum), forearm (radius and/or ulna), hand, wrist (except fingers), kneecap (patella), foot (except toes), ankle | | \$150 | \$300 | \$300 | \$600 |
| Rib | | \$125 | \$250 | \$250 | \$500 |
| Coccyx | | \$100 | \$200 | \$200 | \$400 |
| Finger, toe | | \$25 | \$50 | \$50 | \$100 |
| Gunshot wound (unintentional) | Requiring hospital confinement within 24 hours and surgery within 72 hours for one or more wounds | \$500 any insured | | \$1,000 any insured | |
| Hospital Admission | Within 180 days of accident - not included: treatment in emergency room, outpatient facility or observation unit for less than 20 hours | \$500 any insured | | \$1,000 any insured | |

Benefits - paid once per accident (continued)

| Benefit | Terms/Conditions/Limits | One-Unit Plan | Two-Unit Plan |
|---|--|--|---|
| Hospital Confinement | Within 180 days of accident - not paid concurrent with benefits for intensive care. Does not provide benefits for emergency room, outpatient facility, or observation unit for less than 20 hours. | \$100 per day for up to 90 days, any insured | \$200 per day for up to 180 days, any insured |
| Hospital ICU Confinement | Within 30 days of accident -if patient is in ICU for more than 15 days, the hospital confinement benefit begins on the 16th day | \$200 per day for up to 15 days, any insured | \$400 per day for up to 15 days, any insured |
| Knee cartilage - torn | Treatment within 60 days of accident, and surgery, if required, within 180 days of accident | | |
| Arthroscopic surgery without repair or debridement | | \$100 any insured | \$200 any insured |
| Surgical repair | | \$500 any insured | \$1000 any insured |
| Laceration | Repaired within 72 hours of accident with stitches, staples, or glue | | |
| Total of all lacerations less than 3 inches (7.6 cm) | | \$50 any insured | \$100 any insured |
| Total of all lacerations 3 - 5 inches (7.6 cm to 12.5 cm) | | \$200 any insured | \$400 any insured |
| Total of all lacerations 5+ inches (12.5 cm) | | \$400 any insured | \$800 any insured |
| Lodging | For companion to accompany insured during hospital confinement more than 100 miles from home - 30 day max | \$100 per day - any insured | \$100 per day - any insured |
| Major diagnostic exams | Angiograms, CT Scan, CTA Scan, MRI, MRA, EEG | \$100 per year, any insured | \$200 per year, any insured |
| Physicians office or urgent care | Within 60 days of accident - initial treatment in physician's office or urgent care facility | \$50 any insured | \$50 any insured |

Benefits - paid once per accident (continued)

| Benefit | Terms/Conditions/Limits | One-Unit Plan | Two-Unit Plan |
|--|--|----------------------|----------------------|
| Prosthetic device/Artificial limb | Does not include hearing aids, dental aids including false teeth, eye glasses, cosmetic prosthesis such as wigs, joint replacement such as an artificial hip or knee | | |
| One prosthetic device or artificial limb | | \$500 any insured | \$500 any insured |
| More than one prosthetic device or artificial limb | | \$1,000 any insured | \$1,000 any insured |
| Ruptured disc | Treatment within 60 days and surgery within one year of accident | \$400 any insured | \$400 any insured |
| Surgery | Within 72 hours of accident - does not cover hernia repair | | |
| Open abdominal/thoracic surgery to repair injuries | | \$1,000 any insured | \$1,000 any insured |
| Open abdominal/thoracic exploratory surgery without repair | | \$100 any insured | \$100 any insured |
| Exploratory or other surgery without repair | | \$100 any insured | \$100 any insured |
| Tendon/ligament/rotator cuff | Surgical repair of any and all torn, ruptured, or severed tendons, ligaments, or rotator cuffs within 90 days of accident | | |
| Repair of tendon, ligament or rotator cuff | | \$500 any insured | \$500 any insured |
| Exploratory surgery without repair | | \$100 any insured | \$100 any insured |
| Transportation | Transportation for insured if traveling 100 miles or more round trip from home for medical treatment - maximum 3 trips per accident | \$300 any insured | \$300 any insured |

SEMI-MONTHLY RATES

| | <u><i>One Unit Plan</i></u> | <u><i>Two Unit Plan</i></u> |
|-------------------|-----------------------------|-----------------------------|
| Employee | \$7.02 | \$8.66 |
| Employee & Spouse | \$12.42 | \$15.47 |
| Employee & Child | \$10.77 | \$13.49 |
| Family | \$16.84 | \$21.19 |

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

*Assurity Life Insurance Company
PO Box 80926
Lincoln, NE, 68501-0926*

*Assurity Customer Service: (866) 289-7337
To Fax in a Claim/ Toll Free: (800) 869-0368*

This policy is underwritten by Assurity Life Insurance Company. For specific details, please review the policy or contact your insurance representative or Assurity Life Insurance Company. This policy's availability — along with its rates, benefits and provisions — may vary by state and are subject to state approval.

Policy Form #'s WA 200



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 cancer cases and deaths worldwide will nearly double by 2030.**

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

According to a 2009 study by the American Journal of Medicine, 62% of all bankruptcies have a medical cause. Additionally, most medical debtors were well-educated, middle class and 75% had health insurance.

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

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

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

Plus, you get these distinctive features:

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

Selected benefits paying cash to you:

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

*Cancer Facts & Figures, American Cancer Society. 2010

**My Health News Daily, Cancer Cases and Deaths Could Double Worldwide by 2030, Amanda Chan, Feb. 4, 2011

Assurity Cancer & Specified Disease Plan

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

BASIC BENEFITS

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

RATE STRUCTURE

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

PRE-EXISTING CONDITIONS

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

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

ISSUE AGE

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

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

HOSPITAL CONFINEMENT

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

SURGICAL BENEFIT

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

ANESTHESIA

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

ADDITIONAL SURGICAL OPINIONS

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

PROSTHESIS

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

ATTENDING PHYSICIAN

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

PRIVATE DUTY NURSE

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

RADIATION TREATMENT , CHEMOTHERAPY, HORMONE THERAPY OR IMMUNOTHERAPY

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

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

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

- professional fees for administering the covered drugs;
- medical supplies, equipment and solutions;
- laboratory tests;
- x-rays, port films, MRIs, scans and ultrasounds;
- clinical treatment planning, clinical treatment management, medical radiation physics, dosimetry, treatment devices and special services;
- treatment consultation, planning and office visits; or
- Supportive and Protective Care Drugs

EXPERIMENTAL TREATMENT

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

BONE MARROW TRANSPLANT FOR CANCER

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

ADULT COMPANION TRANSPORTATION AND LODGING

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

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

POSITIVE DIAGNOSIS TEST

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

OUTPATIENT SURGERY BENEFIT

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

SKIN CANCER (NON-MELANOMA)

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

AMBULANCE

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

HOSPICE CARE

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

GOVERNMENT OR CHARITY HOSPITAL CONFINEMENT

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

BLOOD AND BLOOD PLASMA

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

BREAST PROSTHESIS

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

HAIRPIECE BENEFIT

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

CANCER SCREENING TESTS

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

- biopsy for skin Cancer;
- CA 125 (blood test for ovarian Cancer);
- CEA (blood test for colon Cancer);
- chest x-ray;
- colonoscopy;
- flexible sigmoidoscopy;
- hemocult stool specimen;
- mammography screening;
- pap smear (test only);
- PSA (blood test for prostate Cancer);
- serum protein electrophoresis; or
- thermography.

WELLNESS CLAIMS

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

HOME HEALTH CARE SERVICES

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

RENTAL OR PURCHASE OF DURABLE MEDICAL EQUIPMENT

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

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

EXTENDED BENEFITS

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

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

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

CANCER OR OTHER SPECIFIED DISEASE CLAIMS

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

SPECIFIED DISEASE BENEFIT RIDER

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

| | |
|------------------------------|------------------------------|
| Addison's Disease | 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 (ALS) | Tetanus |
| Systemic Lupus Erythematosus | Trichinosis |
| Malaria | Toxic Shock Syndrome |
| Meningitis | Tuberculosis |
| Multiple Sclerosis | Typhoid Fever |
| Muscular Dystrophy | Whooping Cough |

OPTIONAL RIDERS

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

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

LIMITATIONS

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

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

EXCLUSIONS

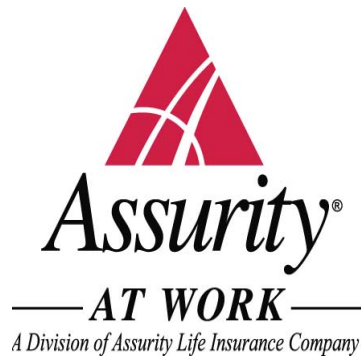
We will not pay benefits for loss caused by or resulting from:

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

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

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

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



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

SEMI-MONTHLY RATES (Ages 18 to 34)

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

NC/SC

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

SEMI-MONTHLY RATES (Ages 35 to 49)

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

NC/SC

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

SEMI-MONTHLY RATES (Ages 50 to 64)

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

NC/SC

AUL Short-Term Disability Plan

Effective Date: July 1, 2012

Why do you need Disability Insurance? Consider this . . .

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

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

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

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

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

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

***You have life insurance, home insurance, and automobile insurance.
But is your income insured?***

1 National Safety Council, Injury Facts, 2003 Edition

2 American Cancer Society, Cancer Facts & Figures 2004

3 American Heart Association, Heart Disease and Stroke Statistics – 2004 Update

4 American Lung Association, Lung Disease Data 2003

5 National Underwriter, May 2002

Class Description

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

Disability

You are considered disabled if, because of injury or sickness, you cannot perform the material and substantial duties of your regular occupation, you are not working in any occupation, and are under the regular attendance of a Physician for that injury or sickness.

Monthly Benefit

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

Elimination Period

This means a period of time a disabled Employee must be out of work and totally disabled before weekly benefits begin; seven (7) consecutive days for a sickness and zero (0) days for injury.

Benefit Duration

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

Basis of Coverage

24 hour coverage, on or off the job.

Maternity Coverage

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

STD Pre-Existing Condition Exclusion

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

Recurrent Disability

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

Exclusions and Limitations

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

Annual Enrollment

Enrollees that did not elect coverage during their initial enrollment are eligible to sign up for \$500 to \$1000 monthly benefit without medical questions. Current participants may increase their coverage up to \$500 monthly benefit without medical questions. The maximum benefit cannot exceed 70% of basic monthly earnings and must be in \$100 increments.

Portability

Once an employee is on the AUL disability plan for 12 months, you may be eligible to port your coverage for one year at the same rate without evidence of insurability. You have 31 days from your date of termination to submit an applications to port your coverage.

Please refer to the Mark III website for a copy of your certificate, a claim form or application to port form.

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

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

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

Fax: 207-591-3048

Disability Claims E-mail: claims@disabilityrms.com

www.employeenefits.aul.com



AMERICAN UNITED LIFE
INSURANCE COMPANY®
a ONEAMERICA® company

AUL Life Short-Term Disability
Semi-Monthly Rates

**Benefit Duration:
13 weeks**

| Monthly Benefit | Semi-Monthly Premium |
|-----------------|----------------------|
| \$500 | \$5.18 |
| \$600 | \$6.22 |
| \$700 | \$7.25 |
| \$800 | \$8.29 |
| \$900 | \$9.32 |
| \$1,000 | \$10.36 |
| \$1,100 | \$11.39 |
| \$1,200 | \$12.43 |
| \$1,300 | \$13.46 |
| \$1,400 | \$14.50 |
| \$1,500 | \$15.54 |
| \$1,600 | \$16.57 |
| \$1,700 | \$17.61 |
| \$1,800 | \$18.64 |
| \$1,900 | \$19.68 |
| \$2,000 | \$20.71 |

**Benefit Duration:
26 weeks**

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

**Benefit Duration:
52 weeks**

| Monthly Benefit | Semi-Monthly Premium |
|-----------------|----------------------|
| \$500 | \$9.86 |
| \$600 | \$11.83 |
| \$700 | \$13.80 |
| \$800 | \$15.77 |
| \$900 | \$17.75 |
| \$1,000 | \$19.72 |
| \$1,100 | \$21.69 |
| \$1,200 | \$23.66 |
| \$1,300 | \$25.63 |
| \$1,400 | \$27.60 |
| \$1,500 | \$29.58 |
| \$1,600 | \$31.54 |
| \$1,700 | \$33.52 |
| \$1,800 | \$35.49 |
| \$1,900 | \$37.46 |
| \$2,000 | \$39.43 |

Dearborn National Term Life Plan

BASIC EMPLOYEE LIFE INSURANCE

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

VOLUNTARY EMPLOYEE LIFE INSURANCE

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

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

VOLUNTARY DEPENDENT LIFE INSURANCE

Provides coverage on:

- Your Spouse
- Unmarried child(ren) between the ages of 15 days and 18 years (up to age 23 if wholly dependent upon you for maintenance and support and if enrolled as a full time student in an accredited school or college). Handicapped children can continue to be covered with no age limit. Children can only be covered by one parent.

It is your responsibility to notify Human Resources when a spouse or dependent child is no longer eligible for coverage. (ie. divorce, child no longer full-time college student, etc.)

FLEXIBILITY

Simply choose the amount of coverage that suits your needs from the selection provided, as outlined on the back of this folder.

FEATURES

The plan features easy eligibility and simple enrollment procedures.

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

LOW COST

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

ELIGIBILITY

You will be eligible for this program if you are a full-time active employee.

ENROLLMENT

Enrollment is simple -- just fill out the enrollment form provided by your employer. Make sure you supply all the required information and return the form where you work. That's all. You will be notified as to when coverage starts.

BENEFICIARY

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

WHEN YOUR INSURANCE STARTS

If you enroll on or before the day you become eligible, your employer provided insurance becomes effective on the date of your eligibility if you are then actively at work; otherwise, on the day you return to active work.

If you have elected Voluntary Employee or Dependent Life Insurance, you will be notified as to when that coverage begins. Anyone electing not to enroll when first eligible or within three months thereafter can enroll later only if evidence of insurability satisfactory to the Insurance Company is provided.

TERMINATION OF COVERAGE

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

REDUCTIONS AT AGES 65 & OVER

If you remain in active service beyond age 65 your amount of Basic Employee Life Insurance will be as follows:

| Attained Age | Percent of Original Amount |
|--------------|----------------------------|
| 65 | 65% |
| 70 | 50% |

(The above age reduction also applies to dependent spouse.)

FAMILY STATUS CHANGE

This provision allows you to increase your coverage by one times your basic annual salary without evidence of insurability within 31 days of the following:

- Marriage or divorce
- Death of a spouse or dependent child
- Birth or adoption of a dependent child
- Change in employment status for you or your spouse

WAIVER OF PREMIUM

Your Basic and Voluntary Life coverages include a wavier of premium provision. If an employee is unable to engage in any occupation as a result of injury or sickness for a minimum of 6 months, prior to age 60, premium will be waived for the employee's life insurance benefit until the employee is no longer disabled or reaches age 65, whichever occurs first. Your Voluntary Dependent Life Insurance may be continued provided you remit the applicable premium to your employer.

CONVERSION

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

PORTABILITY

Voluntary Life benefits are portable upon retirement or termination for the employee and/or his insured spouse. If an insured employee or spouse elects portability, he may also elect to continue Dependent Child(ren)'s coverage. Ported coverage terminates at age 70.

ACCELERATED BENEFITS OPTION

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

GROUP POLICY AND CERTIFICATE

The insurance briefly described in this folder is subject to the terms and conditions of the Group Policy issued by Dearborn National Life Insurance Company. If you become insured, you will receive a certificate outlining your benefits under the policy.

PLAN SPONSOR
Polk County Government
40 Courthouse Street
Columbus, NC 28722
(828) 894-3302

CLAIMS PROCEDURE

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

This is only a brief summary of the life insurance benefits available. Some restrictions may apply. For more specific information about the coverage details, including limitations, exclusions and other requirements, please refer to your certificate booklet or contact Human Resources.

This coverage is underwritten by Dearborn National Life Insurance Company.

SCHEDULE OF BENEFITS

BASIC LIFE AND AD&D INSURANCE

In the amount of \$15,000 at no cost to you; paid by the County

VOLUNTARY GROUP LIFE INSURANCE

You choose the following amounts on yourself and your spouse:

\$10,000, \$20,000, \$30,000, \$40,000, \$50,000, \$60,000, \$70,000, \$80,000, \$90,000, \$100,000, \$150,000, \$200,000, \$250,000, \$300,000, \$400,000, or \$500,000

***YOUR SEMI-MONTHLY COST FOR EMPLOYEE AND SPOUSE
VOLUNTARY GROUP LIFE INSURANCE***

(Spouse coverage based on spouse's age)

| Age | Rate Per \$1,000 |
|--------------|-------------------------|
| Less than 35 | .04 |
| 35-39 | .06 |
| 40-44 | .10 |
| 45-49 | .14 |
| 50-54 | .24 |
| 55-59 | .41 |
| 60-64 | .65 |
| 65-69 | 1.02 |
| 70-74 | 1.62 |
| 75+ | 2.86 |

VOLUNTARY DEPENDENT LIFE INSURANCE

\$10,000 on each of your eligible children - \$1.00/semi-monthly

\$ 5,000 on each of your eligible children - \$0.50/semi-monthly

- **Employees under age 60 must furnish evidence of insurability for amounts over \$100,000.**
- **Employees age 60-69 must furnish evidence of insurability for amounts over \$20,000.**
- **Employees age 70 and over must furnish evidence of insurability for all amounts of coverages.**
- **To be eligible for \$20,000 or more your spouse must furnish medical evidence of insurability.**

Texas Life Whole Life Policy - VPL Plus

Common Issue Date: August 1, 2012, pending underwriting approval (if indicated)

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

VPL- plus is an individual permanent life insurance product specifically designed for employees and their families. It provides a guaranteed level premium and death benefit for the life of the policy, and you can keep the life insurance even after you retire. ¹

As an employee, you are eligible to apply if you have satisfied your employer's eligibility period. You may also apply for coverage on your spouse, minor children and grandchildren. ²

- Most employees are typically dependent on group term life insurance
- Today more adults than ever have only group life insurance obtained through their employers, but they carry the lowest average amount of coverage.
- On the other hand, adults with both individual life and group life policies have the highest life insurance protection. ³
- Most term policies generally expire before paying a death claim
- When do you want a life insurance policy in force?
— Answer: When you die
- Term is for IF you die; permanent is for WHEN you die

TEXAS LIFE'S VPL-plus

- Portable, permanent life insurance through the convenience of payroll Deduction
- Whole life chassis
- Strong guarantees
- Popular features
- Coverage available for spouse, minor children and grandchildren ²

VPL-plus: PORTABLE AND PERMANENT

- Employee can keep policy, at same premium, if he/she retires or changes jobs
- Employee may apply for spouse, minor children and grandchildren at the worksite ²
- Permanent coverage: policy guaranteed to remain in force as long as necessary premiums are paid

VPL-plus: THE GUARANTEES EMPLOYEES WANT

- Guaranteed level premium
- Guaranteed level death benefit ¹
- Guaranteed reduced paid-up insurance at retirement
- Guaranteed paid-up for face amount at age 70 (or after 20 years for insureds between ages 51 and 70)

VPL-plus: CGI (EXPRESS ISSUE) UNDERWRITING

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

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

Child coverage (ages 6 months - 26 years old): ²

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

Express Issue Maximums

- employee
 - ages 17-49, \$100,000
 - ages 50-65, \$50,000
 - ages 66-70, \$10,000
- spouse (if employee applies)
 - ages 17-49, \$50,000
 - ages 50-65, \$25,000
 - ages 66-70, \$10,000
- spouse (if employee does not apply)
 - ages 17-24 \$25,000
 - ages 25-29 \$20,000
 - ages 30-39 \$15,000
 - ages 40-44 \$10,000
 - ages 45-49 \$7,500
 - ages 50-70 \$5,000
- children - ages 6 months - 26 \$25,000 ²
- grandchildren - ages 6 months -16 \$25,000 ²

Simplified Issue ⁴

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

Accelerated Death Rider

- Included on all policies (Employee, Spouse, Minor Children, Grandchildren) ²
- Pays 92% of death benefit, less \$150 processing fee, upon physician-certified diagnosis of condition expected to result in death within 12 months (conditions and limitations apply)
- No extra charge for rider
- Policy terminates when rider is exercised

Waiver of Premium

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

VPL-plus: Review

- Permanent and portable when you change jobs or retire
- Non-participating Whole Life chassis (no dividends)
- Guaranteed level death benefit ¹
- Guaranteed level premium
- Guaranteed reduced paid-up insurance at retirement
- Premiums cease at age 70 (or after 20 years, ages 51-70)
- Accelerated Death Benefit Rider included on all policies
- Waiver of Premium available issue ages 17-55
- Express Issue underwriting
- Unisex rates
- Unismoke rates
- Blood required for amounts over \$100,000
- Simplified issue for health reasons or for amounts over Express Issue maximums

¹ Guarantees are backed by the claims paying ability and financial strength of the issuing company

² Policies not available on children and grandchildren in WA

³ Generations at Risk LIMRA International (2008)

⁴ We retain the right to require a medical exam

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

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

**TEXASLIFE INSURANCE
COMPANY**

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

Continuation of Benefits Options If You Leave Polk County Government

POLK COUNTY HEALTH AND WELFARE BENEFIT PLAN (MEDICAL PLAN)

Under the group medical plan, you and your covered dependents are eligible to continue medical coverage through COBRA through “qualifying events”.

If you and your dependents are enrolled in the medical 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 also be eligible to continue medical 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. For more information, call Tucker Administrators: (800) 347-1232.

TUCKER ADMINISTRATORS MEDICAL REIMBURSEMENT ACCOUNT

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 through COBRA. 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 claims were not incurred prior to the date of termination. To obtain your balance, please call **Tucker Administrators: (800) 347-1232**.

AMERITAS DENTAL PLAN

Under the group dental plan, you and your covered dependents are eligible to continue dental coverage through COBRA according to the same qualifying events listed above. Should you have any questions you may contact **Ameritas at (800) 487-5553**.

SUPERIOR VISION PLAN

Under the group vision plan, you and your covered dependents are eligible to continue vision coverage through COBRA according to the same qualifying events listed above. Should you have any questions you may contact **Superior Vision at (800) 507-3800**.

ASSURITY ACCIDENT EXPENSE+ PLAN

When you leave employment, you may continue your Assurity Accident 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 make those arrangements by contacting **Assurity at (888) 358-8808, ext. 23**.

ASSURITY LIFE CANCER PLAN

When you leave employment, you may continue your Assurity Cancer coverage by having the premiums that are currently deducted from your paycheck billed to your home address or drafted from your bank account. Assurity will send you a letter explaining your options or you may make those arrangements by contacting **Assurity at (888) 358-8808, ext. 23.**

AUL SHORT TERM DISABILITY PLAN

Once an employee is on the AUL disability plan for 12 months, you can port the coverage for one year at the same cost without evidence of insurability. You have 30 days from your date of termination to contact AUL to port your coverage by calling **1-800-553-5318.**

DEARBORN NATIONAL TERM LIFE INSURANCE

When you leave employment, you may elect to continue your group term life in one of two ways:

1. You may “port” the existing group term coverage you have through your employer to a term policy. It is guaranteed issue, which means you do not have to answer any medical questions. You must apply for coverage within 31 days after the date your coverage terminates. For more information and a quote, please call **Dearborn National Life at (800) 348-4512.**
2. You may “convert” the existing group term coverage you have through your employer to an individual whole life policy. You must apply for coverage within 31 days after the date your coverage terminates. It is also guaranteed issue. For more information and a quote, please call **Dearborn National at (800) 348-4512.**

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

TEXAS LIFE WHOLE LIFE INSURANCE

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

***Benefits available to Retirees of North Carolina
State and Local Governments***

***MetLife Dental and Superior Vision Insurance Plans for
Retirees of State or Local Government Offered Through North
Carolina Retired Governmental Employees' Association, Inc.***

With over 54,000 members, the North Carolina Retired Governmental Employees' Association is the largest single group representing retirees before the N.C. General Assembly, the Retirement Systems Boards of Trustees, and the State Health Plan trustees. For retirees or future retirees of state or local governments in North Carolina (including teachers, legislators, National Guard, and judicial), NCRGEA is your voice for sustaining and increasing your benefits after retirement.

Additionally, there are many benefits included with membership at no additional cost (\$10,000 AD&D Insurance, bimonthly newsletter, weekly electronic legislative updates while the General Assembly is in session, a toll-free number to call for information and assistance, hearing assistance and vision care discount programs, and free district meetings).

The Association also offers optional MetLife Dental Insurance and Superior Vision Insurance plans for our members. Those premiums are conveniently deducted from your retirement benefit check monthly. Please contact us at NCRGEA, PO Box 10561, Raleigh, NC 27605, 1-800-356-1190, or go to our website, www.ncrgea.com, for further information.