

Polk County Government is offering all full-time employees a comprehensive Cafeteria Benefits program. The Cafeteria Benefits program is being arranged by Mark III Brokerage, an employee benefits firm that has worked in the public sector for many years. The Cafeteria Benefits program allows you to pay for certain insurance premiums, dependent day-care, and unreimbursed medical expenses before taxes are taken out of your paycheck. Paying for these benefits in this method reduces your taxes and increases your take home pay. The Cafeteria Benefits program includes the Flexible Spending Accounts, Group Employee Medical Plan, Group Employee Dental Program, Short-Term Disability, Cancer Expense Plan, Accident Plan, Voluntary Term Life, and Permanent Life Insurance.

- The Plan Year is from July 1, 2008 to June 30, 2009.
- Mark III representatives will be conducting enrollment meetings. All employees who wish to change coverage or enroll in a spending account must meet with a Mark III Consultant.

Table of Contents

PRE-TAX BENEFITS

Health Care Plan	Page 2
Tucker Administrators Flexible Spending Accounts.....	Page 6
Tucker Administrators Medical Spending Account	Page 8
Tucker Administrators Dependent Care Account	Page 16
Ameritas Dental Plan	Page 19
Cancer Fact Sheet.....	Page 22
Assurity Cancer Plan.....	Page 23
Assurity Accident Expense+ Plan.....	Page 29

AFTER-TAX BENEFITS

Disability Fact Sheet.....	Page 37
Standard Life Short Term Disability Plan	Page 38
Fort Dearborn Group Term Life Insurance Plan	Page 40
Texas Life Whole Life Plan	Page 44

CONTINUATION OF BENEFITS

Continuation of benefits when you leave the County	Page 47
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All information in this booklet is a brief description of your coverage, and is not a contract. Should a discrepancy arise, the Contract and all of its provisions will prevail. The Contract sets forth in detail the rights and obligations of the insurer and insured. Read your policy carefully.

*Polk County Government
Health and Welfare Benefit Plan*

For Benefit Plan Year July 1, 2008 through June 30, 2009

**MAXIMUM LIFETIME
BENEFIT AMOUNT** \$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	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Per Covered Person	\$500	\$1,000
Per Family Unit	\$1,500 (three persons)	\$3,000 (three persons)

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

- Preadmission testing
- PPO Wellness Benefit

COPAYMENTS	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
<u>Physician visits</u>		
Primary	\$25	N/A
Specialist	\$35	N/A
Hospital	N/A	\$250
Emergency Room	\$50	\$50

MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR	NETWORK	NON-NETWORK
Per Covered Person	\$2,500	\$3,500
Per Family Unit	\$7,500 (three persons)	\$10,500 (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)
- Outpatient substance abuse treatment charges
- Inpatient substance abuse treatment charges
- Cost containment penalties
- Copayments

COVERED SERVICES	NETWORK PROVIDERS	NON NETWORK PROVIDERS
<u>Hospital Services</u>		
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
Emergency Room	80% after deductible and copayment	50% after deductible and copayment
Outpatient Facility	80% after deductible	50% after deductible
<u>Skilled Nursing Facility</u>	80% after deductible, the facility's semiprivate room rate within 14 days of a three day stay 70 days Calendar Year maximum	50% after deductible the facility's semiprivate room rate within 14 days of a three day stay 70 days Calendar Year maximum
<u>Physician Services</u>		
Inpatient visits	80% after deductible	50% after deductible
Office visits	100% after \$25 or \$35 copayment	50% after deductible
Surgery	80% after deductible	50% after deductible
<u>Home Health Care</u>	80% after deductible \$10,000 Lifetime maximum	50% after deductible \$10,000 Lifetime maximum
<u>Outpatient Private Duty Nursing</u>		
	80% after deductible 70 days Calendar Year maximum	80% after deductible 70 days Calendar Year maximum
<u>Hospice Care</u>		
Bereavement Counseling	80% after deductible 80% after deductible	50% after deductible 50% after deductible
<u>Ambulance Service</u>	80% after deductible	80% after deductible
<u>Jaw Joint/TMJ</u>	80% after deductible \$5,000 Lifetime maximum	50% after deductible \$5,000 Lifetime maximum
<u>Wig After Chemotherapy</u>	80% after deductible	50% after deductible
<u>Occupational Therapy</u>	80% after deductible	50% after deductible
<u>Speech Therapy</u>	80% after deductible	50% after deductible
<u>Physical Therapy</u>	80% after deductible	50% after deductible
<u>Durable Medical Equipment</u>	80% after deductible	50% after deductible

COVERED SERVICES	NETWORK PROVIDERS	NON NETWORK PROVIDERS
<u>Prosthetics</u>	80% after deductible	50% after deductible
<u>Orthotics</u>	80% after deductible	50% after deductible
<u>Spinal Manipulation Chiropractic</u>	50% after deductible	50% after deductible
<u>Mental Disorders</u>		
Inpatient	80% after deductible 10 days Calendar Year maximum	50% after deductible 10 days Calendar Year maximum
Outpatient	80% after \$35 copayment 20 visits Calendar Year maximum	50% after deductible 20 visits Calendar Year maximum
<u>Substance Abuse</u>		
Inpatient	80% after deductible	50% after deductible
Outpatient	50% after deductible	50% after deductible
Inpatient / Outpatient Combined	\$8,000 Calendar Year maximum \$16,000 Lifetime maximum	\$8,000 Calendar Year maximum \$16,000 Lifetime maximum
<u>Preventive Care</u>		
Routine Well Adult Care	100% \$300 Calendar Year maximum	50% after deductible \$300 Calendar Year maximum
Includes: office visits, pap smear, mammogram, prostate screening, gynecological exam, routine physical examination, x rays, laboratory blood tests and immunizations/flu shots (Performed or billed by physician's office or independent facility)		
Frequency Limits for Mammogram Ages 40 and over annually		
Routine Well Newborn Care	80% after deductible	50% after deductible
Routine Well Child Care	100% \$300 Calendar Year maximum	50% after deductible \$300 Calendar Year maximum
Includes: office visits, routine physical examination, laboratory blood tests, x-rays and immunizations through age 18 or age 25 if a full time student (Performed or billed by physician's office or independent facility)		
<u>Organ Transplants</u>	80% after deductible	50% after deductible
<u>Pregnancy</u>	80% after deductible	50% after deductible
Employee and Dependent Spouse only, Dependent Daughters not covered		

PRESCRIPTION DRUG BENEFIT

Pharmacy Option

Generic drugs

Copayment \$10.00

Formulary Brand Name drugs

Copayment \$25.00

Non-Formulary Brand Name drugs

Copayment \$50.00

Mail Order Prescription Drug Option

Generic drugs

Copayment \$30.00

Formulary Brand Name drugs

Copayment \$75.00

Non-Formulary Brand Name drugs

Copayment \$150.00

**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, 2008- June 30, 2009
Medical Spending Account Maximum: \$2,400.00
Medical Spending Minimum: \$240.00
Dependent Care Account Maximum: \$5000.00

Tucker Administrators Flexible Spending Accounts allow you to use pre-taxed dollars towards health care expenses such as prescription and over-the-counter 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

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 visit, and over-the-counter medications 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: ex: over-the-counter medicines

- 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.

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. The following is a brief summary of information and is intended to serve as a quick reference to help determine whether or not an expense may be eligible for reimbursement. This list is not all-inclusive. This information is not tax advice. Tax advice should be obtained from a professional tax advisor. IRS Publication 502 can be ordered from the IRS 1-800-TAX-FORM (1-800-829-3676).

Qualified Medical Expenses Eligible For Reimbursement:

Alcoholism Treatment	FICA and FUTA tax for the handicapped	Organ transplant (including donor's expenses)
Ambulance	Guide dog	Orthodontist
Anesthetists	Gynecologist	Orthopedic shoes
Artificial limbs	Healing service	Orthopedist
Birth control pills (by prescription)	Hearing aid and batteries	Osteopath
Blood tests	Hospital bills	Oxygen
Braces	Hydrotherapy	Paid-for medical care service
Cardiographs	Insulin treatments	Pediatrician
Chiropractor	Lab tests	Physician
Christian Science Practitioner	Lead paint removal	Physiotherapist
Contact lenses	Legal fees (to authorize treatment for a mental illness)	Postnatal treatments
Contraceptive devices	Lodging away from home for outpatient care	Practical nurse
Convalescent home (for medical treatment only)	Medical services	Prenatal care
Crutches	Medical Testing	Prescription medicines
Dental treatment	Metabolism tests	Psychiatrist
Dental x-rays	Neurologist	Psychoanalyst
Dentures	Nursing (including board and meals)	Psychologist
Dermatologist	Obstetrician	Psychotherapy
Diagnostic fees	Operating room costs	Radium Therapy
Drug addiction therapy costs	Ophthalmologist	Registered nurse
Drugs (prescription)	Optician	Special School
Equipment (medical)	Oral surgery	Spinal fluid tests
Eyeglasses		

Splints	Therapy equipment	Vaccines
Sterilization	Transportation expenses relative to health care (Mileage is eligible for the miles driven to and from the doctor's office. The amount that can be reimbursed is nineteen (19) cents per mile.)	Vasectomy
Stop smoking programs		Vitamins (if prescribed)
Surgeon		Weight loss programs (Physician prescribed)
Telephone or TV equipment to assist the hearing impaired	Ultra-violet ray treatment	Wheelchair
		X-rays

Expenses Not Eligible For Reimbursement

Automobile Insurance	Funeral, cremation, or burial expenses	Scientology counseling
Athletic Club Membership	Expenses for sending a problem child to a special school	Social activities
Automobile Insurance		Special foods or beverages
Boarding school fees	Health programs offered by resorts	Specially designed car for handicapped other than autoette or special equipment
Bottled water	Hotels, health clubs, and gyms	Swimming pool
Commuting expenses of a disabled person	Illegal operations and treatments	Travel for general health improvement
Cosmetics, hygiene products, and similar items	Maternity clothes	Tuition and travel
Cosmetic surgery and procedures	Medical coverage	
Diaper service	Premiums for life insurance, income protection, disability, loss of limbs, sight, or similar benefits.	
Domestic help		

Over-the-Counter Drug/Medicine List

Over-the-Counter Drugs Used Primarily for Medical Care.

The Drugs/ Medicines listed below are approved with a receipt from the Provider/ Store. A recommendation from a health care provider is not needed.

The following is a brief summary of information and is intended to serve as a quick reference to help determine whether or not an expense may be eligible for reimbursement. **This list is not all-inclusive.** This information is not tax advice. Tax advice should be obtained from a professional tax advisor. IRS Publication 502 can be ordered from the IRS: 1-800-TAX-FORM (1-800-829-3676).

Drug / Medicine	Examples
Allergy Prevention & Treatment	Benadryl, Sudafed, Actifed, Claritin, Chloro Trimaton, and Nasalcrom
Antacids and Acid Reducers	Gas-X, Maalox, Mylanta, Tums, AXID AR, Pepcid AC, Prilosec OTC, Tagamet HB, Zantac 75
Anticandial	Femstat 3, Gyne-Lotrimin, Mycelrx-7, Monistat 3, 7, and Vagistat-1
Antihistamines	Actidil Syrup and Capsule, Actifed, Allerest, Benadyrl, Claritin, Chlor-Trimeton, Contac, Dimetane, Drixoral, Nyquil, Sudafed, Tavist-1, and Triaminic
Antidiarrheal and Laxatives	Ex-Lax, Pepto-Bismol, Immodium A.D. and Kaopectate
Anti-fungal	Lamisil AT, Lotramin AF, and Micatin
Anti-itch Lotions and Creams	Bactine, Caldecort, Cortaid, Hydrocortisone, and Lanacort, Calamine Lotion, Benadryl Cream, Caladryl, Lamisil AT, Lotramin AF and Micatin
Asthma	Primatene Mist
Cold Sore / Fever Blister	Abreva Cream, Carmex
Condoms and other contraceptive Devices	Trojans, Magnums, VGF Films, and Delfen Contraceptive Foam

Drug / Medicine	Example
Contact Lenses Solutions	Bausch & Lomb, Renu, Aosept, Allergan, Boston and Opti-Free
Cough Suppressants	Robitussin, Vicks 44, Chloraseptic
Decongestant / Nasal Decongestant and Cold Remedies	Advil Cold and Sinus, Afrin, Afrinol, Aleve Cold and Synus, Children's Advil Cold, Duration, Dristan Long Lasting, Neo-Synephrine-12 Hour, Orrivin, Sudafed, Tavist-D, Tylenol Cold and Flu, Thera-ful, Alka Seltzer Cold and Flu, Nyquil, Actidil Syrup and Capsules, Actifed, Allerest, Benadryl, Claritin, Chlor-Trimeton, Contac, Dimetane, Drixoral, Sudafed, Tavist-1, and Triaminic
Diaper Rash Ointments	Balmax and Destin
Eye Drops for Allergy / Cold Relief	Ocu Hist
First Aid Supplies	Ace Bandages, Band-Aids, Bandage Tapes, Thermometers, Medical Gloves, Gauze, Neosporin, Rubbing Alcohol, and Visine
Hemorrhoid Treatments	Preparation H, Hemroid, and Tronolane
Internal Analgesics / Antipyretic	Advil, Aleve, Children Motrin, Nuprin, Excedrin, Tylenol, and Bayer
Incontinence Supplies	Depends
Liniments	BenGay, Tiger Balm, and Flexall
Medical Monitoring	Services and Bracelets specifically for medical information
Medical Products and Devices	Blood Pressure Monitor, Glucose Tester, HIV Test, Cholesterol Test, Diabetic Supplies, Crutches, Ovulation Monitor and Pregnancy Testing Kit
Menstrual Cycle Medications	Midol, Pamprin, and Premysyn PMS

Drug / Medicine	Examples
Migraine	Advil Migraine Liqui-gels, Excedrin Migraine, Motrin Migraine Pain
Motion Sickness Medication	Dramamine and Marizine
Nicotine Gum or Patches and Smoking Cessation Aids	Nicorette, Nicotrol and Nicodin
Pediculicide (head lice)	Nix
Poison Ivy Protection	Ivy Block
Smoking Cessation	Commit, Nicoderm CQ, Nicorette, Nicotrol
Toothache and Teething Pain Relievers	Orajel
Wart Removal and Medications	Tinamed

Dual Purpose OTC Drugs.

The items listed below require a third-party receipt and a note from the health care provider listing the diagnosis of the medical condition or illness and the recommendation of the OTC drug/ medicine. This list is not all inclusive and is intended to give examples of the most common brand names of OTC drugs.

- Anti-baldness/hair loss/hair replacement, such as Rogaine, but only if to replace hair loss due to a medical condition (e.g. cancer treatment) and not for balding due to age.
- Fiber supplements such as Benefiber and Metamucil
- Glucosamine/Chondroitin for arthritis or other medical conditions (not reimbursable if taken for overall joint health)
- Herbal supplements used to treat a specific disease such as St. John's wort for depression
- Hormone therapy drugs
- Medicated shampoos used to treat a specific medical condition like psoriasis and only the amount in excess of the cost of normal shampoo
- No Doz (and other sleep prevention drugs)
- Nose strips for proper breathing or other medical conditions
- Pedialyte for a child's dehydration
- Retin-A and other acne medicines (not reimbursable if used for cosmetic purposes such as wrinkle reduction)
- Sleep Aids
- Snoring cessation aids and medications such as Breath Right Spray, Snorezz
- Sunscreen and Sunblock

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)

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, 2008

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)
- VSP Eye Exam
- 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
- Restorative Amalgam & Resin (excluding inlays and crowns)
- Periodontics (Gum Disease)
- Oral Surgery - Complex Extractions
- Anesthesia
- Denture Repair
- Endodontics (Root Canal) •
- Oral Surgery - Simple Extractions

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. Applies to both adults and children.

ANNUAL MAXIMUM BENEFIT

- Type 1, Type 2, and Type 3 Procedures - \$1,000 per calendar year per person.
- Orthodontia Procedures - \$1,000 Lifetime per person.

IMPORTANT NOTE: Late Entrant Notice: There is a 12 month waiting period on all procedures except cleanings, exams, and fluoride treatments - unless the employee (and/or his family members) enrolled in the plan when they were FIRST eligible to participate.

**Usual and Customary*

DENTAL EXCLUSIONS (DEFERMENT PERIOD)

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

- a) accidental bodily injury to sound natural teeth (chewing injuries are not considered accidental bodily injuries), or
- b) the extraction of a sound natural tooth provided the replacement is completed within 12 months of the date of the injury or extraction.

ELIGIBLE EMPLOYEES

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

ELIGIBLE DEPENDENTS

Provides Coverage On:

- Your Spouse
- Children up to age 19 and unmarried (Up to age 24 if wholly dependent upon you for maintenance and support and if enrolled as a full-time student in an accredited school or college.)

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 Corp.



Cancer Can Affect Anyone.

Statistics Predict:

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

Are you prepared for the cost of cancer?

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

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

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

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

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

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

Plus, you get these unique features:

- Guaranteed renewable for life. You can't lose your coverage, as long as you continue to pay your premiums.
- Cash benefits paid to you regardless of any other medical insurance plan you may have.

Selected benefits paying cash to you:

- Cancer Screening Tests
- Chemotherapy, Radiation, Immunotherapy,
- Experimental Treatment
- Individual/Family Transportation and Lodging

*Cancer Facts & Figures, American Cancer Society

**Report from the American Hospital Administration

Assurity Cancer & Specified Disease Plan

Effective Date: July 1, 2008, pending underwriting approval

BASIC BENEFITS

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

RATE STRUCTURE

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

UNDERWRITING

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

Definition of manifested: "Symptoms or visible indications that would put an ordinary prudent person on notice that diagnosis, care or treatment by a medical professional should be sought".

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

Hospital Indemnity – pays benefits each day while confined in the hospital for cancer or certain other specified diseases for the first 75 days of each period of confinement. There are three options for the daily benefit amount: **\$150, \$250, and \$350.**

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

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

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

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

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

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

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

Radiation, Chemotherapy or Immunotherapy – pays 50% of actual charges for treatments up to \$10,000 per month with a lifetime maximum of \$100,000.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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 your employer's website. If a bill is not included with the claim form, a scheduled amount will be paid. (Scheduled amounts are listed on the claim form). 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 - when services are provided by a Home Health Care Agency, policy pays (a) up to \$60 per day for services provided at home, not to exceed 180 days per calendar year, (b) up to \$100 per day for Private Duty Nursing, not to exceed 15 days per calendar year, and (c) pays actual charges for a physician's visit up to \$40 per day not to exceed 15 days per calendar year. Benefits herein are not payable under provisions of this policy.

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

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

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

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

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

30-Day Waiting Period

There is a 30-day waiting period during which no benefits will be paid during the first 30 days. Covered losses which manifest after the Issue Date will be payable starting on the 31st day.

Intensive Care Rider - If purchased, provides a Daily Benefit of your choice of either \$300 or \$600, if an Insured Person is confined to a Hospital's Intensive Care Unit, up to a maximum of 20 days per period of confinement.

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

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

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

Cancer or other Specified Disease Claims: You may file a claim for cancer or specified diseases by completing an Assurity Claim Form. Please make sure to include all pertinent information as stated on the form. You can obtain a claim form by contacting Assurity, or seeing someone in your Payroll Department. Should you have any questions on how to file or submit a claim, or regarding the Assurity Cancer Plan, please call **(888) 358-8808, Extension 23**.

Pre-Existing Conditions

We will not pay any Benefits for loss caused by a Pre-Existing Condition during the first year following the Issue Date; however loss due to such conditions will be payable unless specifically excluded from coverage after such 1 year period.

For Claims or Customer Service relating to your Assurity Cancer Plan:

Please call (866) 289-7337

For Wellness Claims by phone:

Please call (888) 358-8808, Ext. 23

Wellness Claims by facsimile at (800) 869-0368

or Mail claims to:

PO Box 80926

Lincoln, NE 68501



**Cancer and Specified Dread Disease Benefit
with Radiation/Chemotherapy**

SEMI-MONTHLY RATES

Assurity Life Cancer & Specified Disease Plan				
		\$150 Daily Benefit	\$250 Daily Benefit	\$350 Daily Benefit
Base Policy (\$10,000 per month/\$100,000 lifetime maximum) (radiation/chemotherapy)	Individual	\$10.46	\$11.61	\$12.76
	EE & Spouse	\$16.02	\$17.81	\$19.60
	EE & Children	\$13.00	\$14.30	\$15.61
	Family	\$18.56	\$20.50	\$22.44
Base Policy with Intensive Care Rider (\$300 daily benefit)	Individual	\$11.51	\$12.66	\$13.81
	EE & Spouse	\$18.12	\$19.91	\$21.70
	EE & Children	\$14.65	\$15.95	\$17.26
	Family	\$21.26	\$23.20	\$25.14
Base Policy with Intensive Care Rider (\$600 daily benefit)	Individual	\$12.56	\$13.71	\$14.86
	EE & Spouse	\$20.22	\$22.01	\$23.80
	EE & Children	\$16.30	\$17.60	\$18.91
	Family	\$23.96	\$25.90	\$27.84
Base Policy with First Occurrence Benefit Rider (\$2,500 benefit)	Individual	\$11.88	\$13.03	\$14.18
	EE & Spouse	\$18.14	\$19.93	\$21.71
	EE & Children	\$14.71	\$16.01	\$17.32
	Family	\$20.97	\$22.91	\$24.85
Base Policy with First Occurrence Benefit Rider (\$2,500 benefit) and Intensive Care Rider (\$300 daily benefit)	Individual	\$12.93	\$14.08	\$15.23
	EE & Spouse	\$20.24	\$22.03	\$23.81
	EE & Children	\$16.36	\$17.66	\$18.97
	Family	\$23.67	\$25.61	\$27.55
Base Policy with First Occurrence Benefit Rider (\$2,500 benefit) and Intensive Care Rider (\$600 daily benefit)	Individual	\$13.98	\$15.13	\$16.28
	EE & Spouse	\$22.34	\$24.13	\$25.91
	EE & Children	\$18.01	\$19.31	\$20.62
	Family	\$26.37	\$28.31	\$30.25
Base Policy with First Occurrence Benefit Rider (\$5,000 benefit)	Individual	\$13.29	\$14.44	\$15.59
	EE & Spouse	\$20.25	\$22.04	\$23.83
	EE & Children	\$16.42	\$17.72	\$19.03
	Family	\$23.38	\$25.32	\$27.26
Base Policy with First Occurrence Benefit Rider (\$5,000 benefit) and Intensive Care Rider (\$300 daily benefit)	Individual	\$14.34	\$15.49	\$16.64
	EE & Spouse	\$22.35	\$24.14	\$25.93
	EE & Children	\$18.07	\$19.37	\$20.68
	Family	\$26.08	\$28.02	\$29.96
Base Policy with First Occurrence Benefit Rider (\$5,000 benefit) and Intensive Care Rider (\$600 daily benefit)	Individual	\$15.39	\$16.54	\$17.69
	EE & Spouse	\$24.45	\$26.24	\$28.03
	EE & Children	\$19.72	\$21.02	\$22.33
	Family	\$28.78	\$30.72	\$32.66

AAW-C120RAB (7/04)

Assurity Accident Expense+ Plan (24 Hour Accident Plan)

Effective Date: July 1, 2008

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 one out of 12 people sought medical attention for an injury in 2004.†

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 2004 †

On-the-job..... 1 every 9 seconds

Off-the-job..... 1 every 5 seconds

At home..... 1 every 4 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 2006

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.

EXCLUSIONS

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;
- 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;
- 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;
- having cosmetic surgery or other elective procedures that are not medically necessary;
- who is a dependent child and receives injuries during birth;
- 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;
- 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.

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 Ground	To or from hospital or between medical facilities within 48 hours of accident To or from hospital or between medical facilities within 90 days of accident	\$500 any insured \$100 any insured	\$500 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 2 nd degree burns on at least 36% of body 3 rd degree burns on 1-19% of body 3 rd degree burns on at least 20% of body Skin graft for a burn	Within 72 hrs of accident	\$375 employee \$150 spouse/child \$750 employee \$300 spouse/child \$5,000 employee \$2,000 spouse/child 25% of the applicable burn benefit	\$750 employee \$300 spouse/child \$1,500 employee \$600 spouse/child \$10,000 employee \$4,000 spouse/child 25% of the applicable burn benefit

Benefits – paid once per accident (continued)

Benefit	Terms/Conditions/Limits	One-Unit Plan		Two-Unit Plan	
Dislocations	Requiring correction with anesthesia diagnosed by a physician within 90 days of accident	Any insured		Any insured	
		Closed Reduction	Open Reduction	Closed Reduction	Open Reduction
Hip		\$1,000	\$2,000	\$2,000	\$4,000
Knee (except patella)		\$500	\$1,000	\$1,000	\$2,000
Ankle or, bones of the foot (other than toes)		\$400	\$800	\$800	\$1,600
Collarbone (Sternoclavicular)		\$250	\$500	\$500	\$1,000
Collarbone (Acromioclavicular), one toe or finger		\$50	\$100	\$100	\$200
Lower jaw, shoulder, elbow, wrist, bones of hand (other than fingers)	\$150	\$300	\$300	\$600	
Dismemberment	Within 90 days of accident	\$15,000 employee \$10,000 spouse/child		\$30,000 employee \$20,000 spouse/child	
Both hands, both feet, sight in both eyes, or any combination of two or more hands, feet and/or eyes		\$7,500 employee \$5,000 spouse/child		\$15,000 employee \$10,000 spouse/child	
One hand, one foot or sight of one eye		\$1,500 employee \$1,000 spouse/child		\$3,000 employee \$2,000 spouse/child	
Two or more fingers or toes		\$750 employee \$500 spouse/child		\$1,500 employee \$1,000 spouse/child	
One finger or toe					
Emergency dental work	Paid once per accident, regardless of the number of teeth involved	\$150 any insured		\$300 any insured	
Any and all broken teeth repaired with crown		\$50 any insured		\$100 any insured	
Any and all broken teeth resulting in extractions					
Emergency room	Treatment within 72 hours of accident	\$200 any insured		\$200 any insured	
Eye injury	Requiring surgery or removal of a foreign object within 90 days of accident	\$200 any insured		\$200 any insured	

Benefits – paid once per accident (continued)

Benefit	Terms/Conditions/Limits	One-Unit Plan		Two-Unit Plan	
		Closed Reduction	Open Reduction	Closed Reduction	Open Reduction
Fractures	Requiring surgical or non-surgical realignment by a physician within 90 days of the accident	Any insured		Any insured	
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 (including sub-acute ICU)	Within 180 days of accident - not paid concurrent with benefits for: intensive care, emergency room, out-patient 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 Arthroscopic surgery without repair or with debridement Surgical repair	Treatment within 60 days and surgery, if required, within 180 days of accident	\$100 any insured \$500 any insured	\$200 any insured \$1,000 any insured
Laceration Total of all lacerations less than 3 inches (7.6 cm) Total of all lacerations 3-5 inches (7.6 to 12.5 cm) Total of all lacerations 5+ inches (12.5 cm)	Repaired within 72 hours of accident with stitches, staples or glue	\$50 any insured \$200 any insured \$400 any insured	\$100 any insured \$400 any insured \$800 any insured
Lodging	For companion to accompany insured to hospital 100 miles or more from home - 30-day max	\$100 per day, any insured	\$100 per day, any insured
Major diagnostic exams	Angiogram, CT Scan, CTA Scan, MRI, MRA, EEG	\$100 per year, any insured	\$200 per year, any insured
Physician's 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 three trips per accident	\$300 any insured	\$300 any insured

SEMI-MONTHLY RATES- 24 Hour Accident Plan

	<u>One Unit Plan</u>	<u>Two Unit Plan</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 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/polkcourtnc. 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.



Why do you need Disability Insurance? Consider this . .

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

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

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

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

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

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

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

1 National Safety Council, Injury Facts, 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

Standard Life Short Term Disability Plan

Effective Date: July 1, 2008, pending underwriting approval

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

ACCIDENT & SICKNESS PROTECTION

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

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

ELIGIBILITY

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

POLICY FEATURES

Pre-existing Conditions: If you received medical advice for treatment of a health condition within twelve months prior to the effective date of insurance, there will be no coverage for that condition until twelve consecutive month beyond the effective date.

Pregnancy: Benefits for disability related to pregnancy are covered provided conception occurs **after** the effective date of the policy, not the date the application was signed.

Portability: When an employee leaves the employment of Polk County Government, they may continue the short term disability coverage, subject to the renewability provision, as long as continuous employment is maintained. Your new occupation must be within the Company's underwriting guidelines.

This coverage expires on the policy anniversary date following your 65th birthday.

Semi-Monthly Rates

Benefit Duration: 90 Days		Benefit Duration: 180 Days		Benefit Duration: 365 Days	
Monthly Benefit	Semi- Monthly Premium	Monthly Benefit	Semi- Monthly Premium	Monthly Benefit	Semi- Monthly Premium
\$500	\$5.63	\$500	\$8.75	\$500	\$11.25
\$600	\$6.75	\$600	\$10.50	\$600	\$13.50
\$700	\$7.88	\$700	\$12.25	\$700	\$15.75
\$800	\$9.00	\$800	\$14.00	\$800	\$18.00
\$900	\$10.13	\$900	\$15.75	\$900	\$20.25
\$1,000	\$11.25	\$1,000	\$17.50	\$1,000	\$22.50
\$1,100	\$12.38	\$1,100	\$19.25	\$1,100	\$24.75
\$1,200	\$13.50	\$1,200	\$21.00	\$1,200	\$27.00
\$1,300	\$14.63	\$1,300	\$22.75	\$1,300	\$29.25
\$1,400	\$15.75	\$1,400	\$24.50	\$1,400	\$31.50
\$1,500	\$16.88	\$1,500	\$26.25	\$1,500	\$33.75
\$1,600	\$18.00	\$1,600	\$28.00	\$1,600	\$36.00
\$1,700	\$19.13	\$1,700	\$29.75	\$1,700	\$38.25
\$1,800	\$20.25	\$1,800	\$31.50	\$1,800	\$40.50
\$1,900	\$21.38	\$1,900	\$33.25	\$1,900	\$42.75
\$2,000	\$22.50	\$2,000	\$35.00	\$2,000	\$45.00

Limits and Exclusions:

Benefits will not be paid for any total disability which:

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

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

**For questions about your policy, call
Standard Life and Casualty at (800) 327-0695
For Claims call (800) 227-0251**



Fort Dearborn 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 Fort Dearborn - 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 waiver 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 Fort Dearborn 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

Fort Dearborn 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 Fort Dearborn 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 Fort Dearborn 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 Plan

Common Issue Date: August 1, 2008 pending underwriting approval

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

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

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

WHY VOLUNTARY COVERAGE

- Most employees are dependent on group term
- Only 50% of U.S. Households have individually owned life insurance¹
- 72% of life insurance policies are paid to beneficiaries of individually owned life plans¹
- Most term policies expire before paying a death claim
- When do you want a life insurance policy in force?
 - Answer: When you die
- Term is for IF you die; permanent is for WHEN you die
- Everybody dies

THE NEW PRODUCT: TEXAS LIFE'S VPL-plus

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

VPL-plus: PORTABLE AND PERMANENT

- Employee can keep policy, at same premium, if he/she retires or changes jobs
- Employee may apply for spouse, children and grandchildren at the worksite
- 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
- 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)

¹LIMRA International, 2005

07M014-C (Expires 022809)

See the VPL-plus brochure for complete details- Form PWLSEV-NI-05

VPL-plus: CGI (EXPRESS ISSUE) UNDERWRITING

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

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

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

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

Express Issue Maximums

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

Simplified Issue

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

Accelerated Death Rider

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

VPL-plus: Review

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

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

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

Since 1901 900 Washington Post Office Box 830 Waco, Texas 76703-0830

Texas Life Insurance Company[®]
A MetLife Company

*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**.

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**.

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.**

STANDARD LIFE SHORT TERM DISABILITY PLAN

When you leave employment, you may continue your disability coverage as long as continuous employment is maintained. Coverage expires on the policy anniversary date following your 65th birthday. Please contact **Standard Life at: (800) 327-0695** to set up bank draft or direct bill to your home address.

FORT DEARBORN 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 **Fort Dearborn 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 **Fort Dearborn Life 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.**