

**Rabun County** 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 with 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 products listed below.

- **The Plan Year is from October 1st through September 30th.** Employees hired after the enrollment period must wait for the next annual enrollment period to enroll in the plan.
- All full-time employees who want to change their current benefits or who wish to participate in any of the Cafeteria Benefits Plan options must meet with a Mark III representative to review their benefits, and either accept or decline participation in the Cafeteria Benefits plan.

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## *Tucker Administrators* *Medical Spending Account*

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**Plan Year: October 1, 2008 - September 30, 2009**

**Medical Spending Account Maximum: \$2,000.00**

**Medical Spending Minimum: \$150.00**

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

### **WHO SHOULD ENROLL?**

The Medical Spending Account is beneficial for anyone who has eligible out-of-pocket medical, dental, vision, or hearing expenses beyond what their insurance plan covers.

### **IS THIS A GOOD PROGRAM FOR ME?**

It's easy to determine if the Medical Spending Account can save you money. Before the plan year begins, you will need to determine your annual election. It's a good idea to estimate the expenses that you will incur during the plan year.

You are allowed to include eligible out-of-pocket expenses for you, your spouse, and anyone claimed as a dependent for tax purposes. Review your health care expenses from the previous year. If you find you had \$150 or more in recurring or predictable expenses, this account can help you stretch your income.

A worksheet is provided in this booklet to help you calculate your estimated eligible expenses.

### **HOW DOES IT WORK?**

After you determine your annual expenses, identify an annual Medical Spending Account election that you are comfortable with. This amount will be deducted in even amounts from each of your paychecks. **You will need to plan carefully as the IRS requires that any unused money left in your account at the end of the plan year will be forfeited.**

## HOW IS A CLAIM FILED?

a. Please attach all back up documentation to your claim form. Make sure that the original date of service appears on your documentation. Balance due statements and paid on account receipts usually do not contain the original date of service, therefore you may need to include additional documentation to show when the service was incurred. Remember that you must incur the service within each applicable plan year. **The important date is when the service was incurred - not when it was paid.**

b. Make sure the claim form is signed when submitting a request for reimbursement. Claim forms are available from the website listed on the front cover of this booklet.

c. Some of the acceptable documentation for medical spending accounts would include the following:

- Explanations of Benefits from health plans
- Walk out statements from health providers
- Bills from medical providers and suppliers
- Copies of prescription receipts

**Note: Itemized cash register receipts would be acceptable documentation for contact lens solutions and other allowable Over The Counter items.**

d. Reimbursement Account checks are mailed out each week. Please have your requests to Tucker Administrators by the week before the check run to make sure your claim is processed and your check can be mailed to you on the following week.

e. Remember, you may submit claims for yourself and any dependent family members. You may submit claims for deductibles, coinsurance and doctor's office co-pays for your spouse's health insurance as long as those expenses have not been reimbursed by another pre-tax medical spending account.

You may send all requests for reimbursement directly to Tucker Administrators at the following address:

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

## CAN I CHANGE MY ELECTION?

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

## WHAT ARE THE ADVANTAGES OF THE MEDICAL SPENDING ACCOUNT?

Most important, the net cost of your required out-of-pocket health care expenses is reduced and made more affordable. The amount you contribute to your Medical Spending Account and the amount you are reimbursed from your Medical Spending Account are income tax-free. The amount you contribute to your Medical Spending Account is not subjected to Federal, State, or FICA taxes. Generally, this will mean a tax savings of 15% to 40% depending on your tax bracket. As a direct result of your personal tax savings, you will actually reduce the cost of required expenses and thus, increase your spendable income.

## HOW THE MEDICAL SPENDING ACCOUNT SAVES YOU MONEY...

Let's look at an example. As shown below, Ben E. Fits makes \$26,000 a year, and elects to contribute \$500 to his Medical Spending Account. He then files eligible claims for the \$500 in his account. As the example shows, Ben E. Fits will save \$139 in taxes.

	<b>Without</b> a Medical Spending Account	<b>With</b> a Medical Spending Account	Tax Savings <b>with</b> a Medical Spending Account
<b>Annual Pay</b>	\$26,000	\$26,000	
<b>Subtract Out-of-Pocket Medical Expense (Pretaxed)</b>	\$0	-\$500.00	
<b>Federal Taxes 15%</b>	\$3,900	\$3,825	\$75
<b>State Taxes (Based on 5.3%)*</b>	\$1,378	\$1,352	\$26
<b>FICA Taxes (Based on 7.65%)</b>	\$1,989	\$1,951	\$38
<b>Out-of-Pocket Medical Expense (After-Tax)</b>	-\$500	-\$0	
<b>Annual Tax Savings</b>			<b>\$139</b>
<i>The above figures assume taxes for an employee who is single, using the standard deduction, no dependents and only includes wage income.</i>			
<i>*State taxes where applicable.</i>			

## WHAT ARE THE DISADVANTAGES OF THE MEDICAL SPENDING ACCOUNT?

Generally speaking, there are none with a bit of careful planning. However, we do want you to know that when you reduce your FICA taxes, you will be reducing your Social Security contribution. Research studies on this matter indicate that your tax savings generally outweigh any Social Security benefit reduction.

Based on group participation, key employees' participation may be restricted. You will be notified if this applies to you.

**As required by law, any money in your Medical Spending Account not used by the end of the plan year will be forfeited. Therefore, it is in your best interest to be conservative when estimating your contribution.** But keep in mind that your tax savings may more than make up for any extra dollars you leave in your account at the end of the year.

If you are in doubt about an expense, please contact Tucker Administrators for assistance. You will want to have your annual election as much in line with your medical out-of-pocket costs as possible.

### Medical Spending Account Tax-Free Worksheet Illustration

*This worksheet will help you estimate your annual uninsured medical expenses for the upcoming plan year, and your estimated tax savings realized through your participation in your Medical Spending Account. Remember to estimate conservatively, considering only those expenses you are confident will be incurred during the plan year, and that will not be covered by any insurance plan.*

	<b>Projected Plan Year Expenses (not covered by insurance)</b>
1. Medical and Dental Deductible	\$ _____
Medical insurance co-payments and co-insurance	\$ _____
Dental insurance co-payments and co-insurance	\$ _____
Immunizations, injections and vaccinations	\$ _____
Routine examinations	\$ _____
Dental and orthodontic expenses not covered by insurance	\$ _____
Prescription drugs or co-payments	\$ _____
Eye examinations, glasses and contacts not covered by insurance	\$ _____
Hearing examinations	\$ _____
Transportation to and from medical provider	\$ _____
Medically necessary elective surgery	\$ _____
Other expenses	\$ _____
2. Total estimated, uninsured medical expenses for the plan year	\$ _____
	<b>Estimated Contribution and Tax Savings</b>
3. Write down your desired MSA plan year contribution.	\$ _____
4. You will have equal amounts taken out of each regular paycheck and deposited into your Medical Spending Account.	\$ _____
5. Multiply your per pay contribution by your total tax bracket (the sum of Federal, State, FICA tax rates). See the previous page for an example.	
Your Tax Rate: _____	\$ _____

**FLEXIBLE SPENDING ACCOUNT PLAN  
ELIGIBLE EXPENSES**

Medical care expenses are defined by the Internal Revenue Service (IRS) as amounts paid for the diagnosis, cure, mitigation or treatment of a disease, and for treatments affecting any part or function of the body. The expenses must be primarily to alleviate a physical or mental defect or illness.

With that in mind, we have listed below many of the medical expenses eligible for payment under the Medical Spending Account, to the extent such expenses are not covered by your medical or dental insurance. This list is not meant to be all-inclusive. Other expenses not specifically mentioned may also qualify. For additional information, please refer to IRS Publication 502 Medical and Dental Expenses. However, the two exceptions to be aware of are: 1) Insurance premiums are not reimbursable under a Medical Spending Account, and 2) The reimbursement under a Medical Spending Account is based only upon when the expense was incurred; i.e., date of service, not the date paid. To be eligible, the service has to be provided in your plan year.

**HEALTH CARE/MEDICAL**

**MEDICATIONS**

Aspirin, if plan allows  
Insulin  
Nicotine Gum or Patches, if plan allows  
OTC Medicines, if plan allows  
Prescribed Birth Control  
Prescribed Vitamins  
(to treat specific disease)  
Prescription Drugs

**OBSTETRIC SERVICES**

Mid-Wife Expenses  
OB/GYN Exams  
OB/GYN Prepaid Maternity Fees  
(reimbursable after date of birth)  
Post-Natal/Pre-Natal Treatment  
Pre-Natal Vitamins

**PRACTITIONERS**

Allergist  
Chiropractor  
Christian Science  
Dermatologist  
Homeopath  
Naturopath  
Osteopath  
Physician  
Psychiatrist  
Psychologist

**DENTAL SERVICES**

Crowns/Bridges  
Dental X-Rays  
Dentures  
Exams/Teeth Cleaning  
Extractions  
Fillings  
Gum Treatment  
Oral Surgery  
Orthodontia/Braces

**INSURANCE-RELATED ITEMS**

Co-pay Amounts  
Deductibles  
Pre-existing Condition Expenses  
(medical)  
Private Hospital Room Differential

**LAB EXAMS/TESTS**

Blood Tests  
Cardiographs  
Diagnostic  
Laboratory Fees  
Metabolism Tests  
Spinal Fluid Tests  
Urine/Stool Analyses  
X-Rays

**OTHER MEDICAL  
TREATMENTS/PROCEDURES**

Acupuncture  
Alcoholism (inpatient treatment)  
Cosmetic Surgery (if medically  
necessary)  
Drug Addiction  
Hearing Exams  
Hospital Services  
Infertility  
In-vitro Fertilization  
Norplant Insertion or Removal  
Patterning Exercises  
Physical Examination  
(not employment related)  
Physical Therapy  
Pregnancy Tests  
Rolfing  
Smoking Cessation Programs  
Speech Therapy  
Sterilization  
Transplants (includes organ donor)  
Treatment for Handicapped  
Vaccinations/Immunizations  
Vasectomy  
Well Baby Care

Syringes  
Transportation Expenses (essential to  
medical care)  
Tuition Fee at Special School for  
Disabled Child  
Wheelchair  
Wigs (hair loss due to disease)

**VISION SERVICES**

Artificial Eyes  
Contact Lenses  
Contact Lens Solution  
Eye Examinations  
Eyeglasses  
Laser Eye Surgeries  
Ophthalmologist  
Optometrist  
Prescription Sunglasses  
Radial Keratotomy

**OTHER MEDICAL EQUIPMENT,  
SUPPLIES and SERVICES**

Abdominal/Back Supports  
Ambulance Services  
Arches/Orthopedic Shoes  
Contraceptives  
Counseling  
Crutches  
Guide Dog (for visually/hearing  
impaired person)  
Hearing Aids & Batteries  
Hospital Bed  
Learning Disability (special school/  
teacher)  
Medic Alert Bracelet or Necklace  
Oxygen Equipment  
Prescribed Medical and  
Exercise Equipment  
Prosthesis  
Splints/Casts  
Support Hose (if medically  
necessary)

## INELIGIBLE EXPENSES

The IRS does not allow the following expenses to be reimbursed under the Medical Spending Account. Expenses to promote general health are not eligible expenses. This is not an inclusive listing.

Babysitting & Child Care	Lamaze Class***
Breast Pumps*	Marriage Counseling
Calcium Supplements	Massage Therapy**
Canceled Appointment Fees	Maternity Clothes
Contact Lens Insurance	Personal Trainer
Cosmetic Surgery/Procedures	Prescription Drug Discount
Custom Fitovers (clip-ons)	Program Premiums
Dancing Lessons	Retin-A*
Diaper Service	Rogaine*
Discounted Fees/Write-offs	Special Foods* (cost difference of common product)
Electrolysis	Student Health Fee
Exercise Equipment*	Swimming Lessons
Eyeglass Insurance	Tattoo Removal
Fitness Programs*	Teeth Whitening/Bleaching
Hair Loss Medication	Toiletries, Toothpaste, etc.
Hair Transplant	Varicose Vein Treatment*
Health Club Dues	Vision Discount Program
Treatment Program (at a Health Club)*	Premiums
Herbs & Herbal Medicines	Vitamins*
Homeopathic Drugs	Weight Loss Programs &/or Drugs*
Illegal Operation or Treatment	Prescription drugs purchased outside the United States
Insurance Premium Interest Charge	
Insurance Premiums	

*\*Eligible only with Doctor's certification identifying the medical condition and length of treatment program.*

*\*\*Eligible only with Doctor's certification identifying the physical nature of the medical condition and length of treatment program. Massage therapy for the sole purpose of tension/stress relief or depression (even with a Doctor's statement) does not qualify as an eligible expense.*

*\*\*\*Eligible expenses are limited to the mother's instruction related to birth.*

*Please be aware that the Internal Revenue Service looks to the reasonableness of the cost of the treatment.*

## Over the Counter Drug Ruling Questions & Answers

### **Q. Can I be reimbursed for all over-the-counter (OTC) drugs?**

A. No, only drugs for use by the participant, or the participant's spouse or dependents, to alleviate or treat personal injuries or sickness are eligible for reimbursement. Therefore, dietary supplements such as vitamins for general well-being are not eligible. Cosmetic purchases continue to be an ineligible expense.

### **Q. Why did the IRS make this change?**

A. The IRS realizes that many drugs that were available only by prescription have become available over-the-counter, and that this is likely to continue. Over-the-counter drugs could actually cost the participant more than the co-pay for the prescription. Therefore, allowing these types of expenses to be reimbursed on a pre-tax basis should help people manage their health care costs.

### **Q. If I don't have a headache and I buy a bottle of aspirin to put in my medicine cabinet (to have some on hand for my next headache), is the cost of the aspirin a reimbursable expense? Or must the participant, spouse, or dependent have a headache at the time the aspirin is purchased?**

A. Although the OTC Drug Ruling does not answer these questions, the Employee Benefits Institute of America states that the OTC Drug Ruling realizes that some sort of advance purchase of medicines and drugs for use in the near future is reasonable—that the advance purchase of medicines and drugs is permitted to treat a medical condition that has a strong likelihood of occurring.

### **Q. Can a reimbursement account reimburse a participant for the cost of 48 bottles of aspirin purchased at the end of the plan year?**

A. Again, the OTC Drug Ruling does not answer this question. However, IRS officials have informally indicated that participants may be reimbursed for a reasonable quantity of OTC drugs to have on hand for use during the plan year, if the OTC drugs qualify as an eligible medical expense. In fact, even year-end purchases should be permissible in small quantities.

### **Q. What are the substantiation requirements for eligible OTC drugs?**

A. It is permissible to reimburse with an adequate receipt and a participant's statement. The receipt must state the name of the medicine or drug, the date and the amount paid. The patient's name is not required on the receipt. But the participant statement needs to include the name of the employee, spouse or dependent.

### **Q. Is there a list of eligible and ineligible over-the-counter drugs that I can refer to?**

A. The IRS has not developed such a list. However, the list on the following pages should serve as a guide to the type of expenses that are ineligible, eligible, and those that may be eligible with a doctor's letter of medical necessity.

**The IRS has recently ruled that certain over-the-counter drugs can now be reimbursed through your Medical Spending Account. Following is a list of eligible and ineligible expenses:**

### **Over-the-Counter Drugs Eligible Expenses**

Eligible over-the-counter drugs include, but are not limited to the following:

- Allergy medicines
- Antacids
- Anti-diarrhea medicines
- Bactine
- BenGay, Tiger Balm and similar products for muscle or joint pain
- Bug bite medications
- Calamine lotion
- Cold medicines
- Cough drops, throat lozenges
- First aid creams
- Laxatives
- Menstrual cycle products for pain and cramp relief
- Motion sickness pills
- Nasal sinus sprays
- Nicotine gum or patches for stop-smoking purposes
- Pain relievers
- Pedialyte for ill child's dehydration
- Sinus medications
- Special diaper rash ointments
- Special ointments or creams for sunburn (not just regular skin moisturizers)
- Suppositories and creams for hemorrhoids
- Visine and other such eye products
- Wart remover treatments

### **Over-the-Counter Drugs - Dual Purpose Expenses Requiring a Letter of Medical Necessity**

Dual purpose over-the-counter drugs include, but are not limited to the following:

- Acne treatments
- Dietary supplements or herbal medicines to treat a specific medical condition
- Fiber supplements to treat a specific medical condition for a limited time
- Glucosamine/Chondroitin for arthritis or other medical condition
- Lactose intolerance pills
- Menopause treatments for hot flashes, night sweats
- Nasal sprays for snoring
- OTC hormone therapy
- Prenatal vitamins
- Sleeping aids
- Sunscreens
- St. John's Wort for depression
- Weight-loss drugs to treat obesity

### **Over-the-Counter Drugs Ineligible Expenses**

Ineligible over-the-counter expenses include, but are not limited to the following:

- Chapstick
- Deodorants
- Eye and facial makeup preparations
- Face creams
- Feminine hygiene products
- Fingernail polishes
- Hair colors
- Hand lotions
- Lipsticks
- Medicated shampoos
- Medicated soaps
- Perfumes
- Permanent waves
- Shaving creams
- Shaving lotions
- Skin moisturizers
- Suntan lotions
- Toothpaste
- Vitamins

## MEDICAL SPENDING ACCOUNT MOST QUESTIONED EXPENSES

IRS regulations periodically change, affecting the eligibility of certain expenses in Flexible Spending Account Plans. The following will assist you in making your elections for the plan year based on the **most current rulings** regarding some of the **most questioned expenses**. As a third party administrator, Tucker Administrators follows Internal Revenue Service Guidelines as provided in IRS Publication 502 Medical and Dental Expenses. There are two exceptions: 1) Insurance premiums are not reimbursable under a Medical Spending Account; and 2) The tax credit as outlined in IRS Publication 502 allows the tax credit in the year the expense is paid; **the reimbursement under a Medical Spending Account is based only upon when the expense was incurred; i.e., date of service, not the date paid.**

<b>Canceled Appointments</b>	Fees for missed appointments are <b>not eligible</b> .
<b>Cosmetic Treatments</b>	Only qualify if they are medically necessary. Electrolysis is <b>not</b> an eligible expense. Cosmetic surgery simply to enhance bodily features is <b>not eligible</b> . Cosmetic surgery which is necessary due to an accident, disease, illness or congenital abnormality <b>is eligible</b> .
<b>Custom Fitovers (Clip-Ons)</b>	Are <b>not eligible</b> as they do not correct vision.
<b>Counseling</b>	Family counseling is only eligible for the family member who is the patient with a specific medical condition. Marriage counseling is <b>not eligible</b> .
<b>Dentistry</b>	Monthly orthodontic expenses are eligible, but only for those months within the plan year. Only expenses for orthodontic services incurred in the plan year are eligible; the months before or after the plan year are not eligible. Reimbursement is available by providing a treatment plan. <b>Teeth Bleaching/Whitening is not eligible.</b>
<b>Diabetic Supplies</b>	Insulin, syringes, test tapes, and needle boxes <b>are eligible</b> .
<b>Dietary Needs/Special Foods</b>	Special foods are eligible if prescribed to treat a specific illness to the extent the cost exceeds cost of commonly available versions of the same product. Special foods to promote general health are <b>not eligible</b> .
<b>Discount Fees/Write Offs</b>	Are <b>not eligible</b> .
<b>Drugs</b>	Over-the-counter drugs such as aspirin, antacids, allergy medicines, pain relievers or cold medicines <b>are eligible, if allowed by your plan</b> . Dietary supplements without a medical condition <b>are not eligible</b> . Non-prescription drugs for general well being like vitamins, herbal supplements or cosmetic purchases <b>are not eligible</b> . <b>Date ordered is the date of service</b> . Drugs that are legal at state or local level, but illegal at federal level are not medical expenses and are <b>not eligible</b> .
<b>Health Club Membership Dues</b>	Are <b>not eligible</b> , even when prescribed by a physician. Treatment programs at a health club, exercise equipment, and exercise programs <b>are only eligible</b> if the doctor prescribes them to treat a disease or illness.

<b>Insurance Estimates</b>	Services must be incurred before reimbursement through the spending account. Pre-certification and estimates are <b>not eligible</b> for reimbursement under the HCRA.
<b>Insurance Premiums</b>	Your portion of a company sponsored and/or individual insurance premium is <b>not eligible</b> for reimbursement under a health care spending account. Your portion of premiums for employer sponsored insurance is pre-taxed through the Premium Expense Account, not the HCRA. Student health fees are similar to insurance premiums and are <b>not eligible</b> for reimbursement under the HCRA.
<b>Interest Charges</b>	Are <b>not eligible</b> .
<b>Lamaze Classes</b>	Only expenses for instruction related to the birth are eligible. Child rearing instruction is <b>not eligible</b> . The fee will have to be apportioned to exclude instruction in topics such as newborn care. Also, amounts for the coach or significant other are <b>not eligible</b> .
<b>Maternity Fees—Prepaid</b>	In line with insurance companies, the date of child's birth is considered date of service.
<b>Massage Therapy</b>	Is eligible with a doctor's statement of medical necessity. It is <b>not eligible</b> if therapy is solely for the purpose of tension/stress.
<b>Mileage</b>	Mileage is eligible for the miles driven to and from the doctor's office. The amount that can be reimbursed is twelve (12) cents per mile.
<b>Rogaine</b>	Is <b>not eligible</b> , unless accompanied by a letter of medical necessity.
<b>Vision</b>	Contact lens solution and sales tax are eligible expenses. Contact lens insurance is <b>not eligible</b> . The date the glasses or contacts are ordered, <b>not picked up</b> , is considered the date of service. Radial Keratotomy, LASIK and other laser eye surgeries are eligible. Vision Discount Program Fees are <b>not eligible</b> .
<b>Vitamins</b>	Dietary supplements (for example, vitamins) to maintain general health are <b>not eligible</b> . Dietary supplements or herbal medicines to treat a specific medical condition are <b>eligible with a doctor's letter stating medical necessity</b> .
<b>Weight Loss</b>	<b>Physician prescribed</b> weight loss programs necessary to treat <b>physician diagnosed</b> obesity is an eligible expense. Health clubs and spas are not viable treatment options. Weight loss programs attended to improve general health or appearance are <b>not eligible</b> . Special diet food that is a substitute for the food normally consumed is <b>not eligible</b> . If the same results can be obtained from a program that costs less, such as walking, the IRS may look to the reasonable cost of the prescribed exercise program.

## **MID-YEAR ELECTION CHANGES MEDICAL SPENDING ACCOUNT**

**You are allowed to change your annual election for a Medical Spending Account ONLY if you have a qualifying status change such as the following:**

- Change in employee's legal marital status
  - Marriage
  - Divorce
  - Death of a Spouse
  - Legal Separation or Annulment of Marriage
- Change in number of dependents (Note: gaining or losing an individual who is not a tax dependent does not allow an election change; this is in line with the tax definition of dependent under Section 152.)
- Change in employment status
  - Termination or Commencement of Employment by the Employee, Spouse or Dependent
  - Change in Work Schedule (reduction or increase in hours by employee, spouse or dependent, including a change between part-time and full-time, a strike or lockout, or commencement or return from unpaid Leave of absence)
- Dependent satisfies (or ceases to satisfy) dependent eligibility requirements
  - Attainment of limiting age, change in student status, or marriage
- Commencement or termination of adoption proceedings
- FMLA leave for you or your spouse
- Judgment, Decree or Order resulting from a divorce, legal separation, annulment or change in legal custody {includes a Qualified Medical Child Support Order (QMCSO)}
- Entitlement of Medicare or Medicaid

**PLEASE NOTE THAT SIGNIFICANT COST OR COVERAGE CHANGES DO NOT APPLY TO HEALTH FSAs!!**

The following are **NOT** qualifying events that trigger a mid-year change to a health FSA election:

- Over or under-estimated expenses for the year
- Services planned for the year are no longer needed
- A significant change in your insurance coverage
- Financial hardship

Two important facts must be considered when allowing a status change mid-year:

1. Participants may make changes to their elections “on account of, and corresponding with, a change in status that affects eligibility for coverage.” In other words, a change in status must have occurred.
2. The change in election must be “consistent with the reason that such change was permitted.” Example, increasing coverage due to a marriage, or decreasing coverage due to a death.

**ORTHODONTIA GUIDELINES - FLEXIBLE SPENDING ACCOUNT**

**Please read this notice before making your annual election**

Orthodontia expenses are reimbursed over the period of time the appliances are worn. The treatment plan and/or contract from the Orthodontist will state the length of time the appliances/braces will be worn by the patient. The IRS recognizes that orthodontia services are continuous from the installation to the removal of the appliances, therefore you may have services spanning 1-3 plan years. In line with those guidelines, your orthodontic reimbursements need to be in accordance with the length of time you will have services. The total fee owed to the Orthodontist will be pro-rated by the number of months the appliances will be worn. If you make a lump sum payment to receive a discount, the above still applies; therefore, you will not be reimbursed a lump sum payment. **You can be reimbursed monthly based on the expected length of treatment.**

**Example 1:** Plan year begins January, 2006. Orthodontia begins in January with treatment lasting 36 months. Total fee is \$4600.00. Down payment of \$1000.00 is due in January. \$3600.00 will be divided by 36 months. First payment is due February, 2006. The amount that can be reimbursed in the 2006 plan year is the \$1000.00 down payment plus eleven (11) monthly reimbursements of \$100.00 totaling \$1100.00.

**Example 2:** Orthodontist offers a 10% discount if you pay in one lump sum payment. Total fee is \$4140.00. There is no down payment. \$4140.00 will be divided by 36 months. The amount that can be reimbursed in the 2006 plan year is twelve (12) monthly reimbursements of \$115.00 totaling \$1380.00.

**\*\*Note\*\* Above example uses appliances placed in January. Appliances placed in a different month would need to be pro-rated using remaining months in the plan year. Example: For appliances placed in September, the amount that can be requested is the down payment and three months of Orthodontia payments. Reimbursements cannot be paid out prior to the services rendered, even if you paid up front.**

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**VISION EXPENSE GUIDELINES - FLEXIBLE SPENDING ACCOUNT**

**Please read this notice before making your annual election**

Vision bills/expenses must include the name of the patient and provider, the type of service, the date the service was incurred/provided, and your out-of-pocket expense. **Balance due statements, charge card receipts, and canceled checks are not acceptable documentation for reimbursement.** The date the glasses or contacts are ordered is considered the date of service, **not the pick up date.**

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## *Tucker Administrators* *Dependent Care Account*

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**Plan Year: October 1, 2008 - September 30, 2009**  
**Dependent Care Plan Maximum: \$5,000.00**

Extend your income by using the Dependent Care Account to pay for work-related dependent care expenses with income tax-free dollars. You can save a significant amount of money by participating in this account.

If you are paying for day care expenses now, you are paying in taxable dollars and probably taking the Federal Tax Credit at the end of the year. If you use the Dependent Care Account, you will pay these expenses in pre-tax dollars throughout the year, eliminating the need to use the tax credit at the end of the year.

### **WHO SHOULD ENROLL?**

The Dependent Care Account is generally beneficial to anyone who has a qualified dependent and eligible day care expenses.

### **WHO IS A QUALIFIED DEPENDENT?**

Dependents are defined as children under 13 years of age, or children 13 or over who are physically or mentally unable to care for themselves. A spouse or an elderly parent residing in your home, who is physically, or mentally unable to care for himself or herself, also qualifies.

### **WHAT EXPENSES ARE ELIGIBLE?**

Expenses incurred which allow you (and your spouse, if married) to work, look for work or attend school as a full-time student are eligible. Below are expenses which qualify.

- Day care facility fees (excluding transportation, lunches, educational services)
- Before-school and after-school care
- Local day camp
- In-home babysitting fees (income must be claimed by your care provider)
- Nursery school and preschool (preschool expenses are eligible if the amount you pay for schooling cannot be separated from the cost of care)

### **WHO IS AN ELIGIBLE PROVIDER?**

You may use any care provider you choose, except a dependent child who is claimed as a dependent and is under the age of 19. The care provider must meet the requirements of your state. The services may be as informal as care provided by your neighbor, as long as the provider claims the money received for services as income when determining their taxes at the end of the year. You will need to obtain the provider's federal identification/social security number for inclusion on your tax filing.

## HOW DOES IT WORK?

The program is simple. Decide how much money you want to place in your account based on your estimate of eligible or work related dependent care expenses for the coming plan year. Keep in mind the time in which your dependent is not receiving care, such as vacation or sick time. The amount to be deducted from your pay cannot be greater than your income or that of your spouse, whichever is lower. The maximum contribution allowed by the IRS is \$5,000 (\$2,500 each for married individuals filing separate returns). **You will need to plan carefully as the IRS requires that any unused money left in your account at the end of the plan year will be forfeited.** Identify an annual election that you are comfortable with. This amount will be deducted on a pre-tax basis each pay period and contributed to your Dependent Care Account.

When you have expenses to be reimbursed, simply complete a claim form indicating that the expense has been **incurred during the plan year**, along with a bill or *itemized* receipt from the provider. Copies of the bill or an itemized receipt are good examples of proof of your dependent care expenses. If none of these are available, you may have the care provider acknowledge receipt by having them sign directly on the claim form. That's it! Mail it to Tucker Administrators and your claim will be processed on your next reimbursement date. Advance reimbursement of future or projected dependent care expenses is not permitted. Accordingly, you will receive Dependent Care Reimbursement up to the amount that has been deducted from your payroll earnings and contributed to your Dependent Care Reimbursement Account.

## CAN I CHANGE MY ELECTION?

In line with Internal Revenue Service guidelines, you can change your election if you have a **qualifying change in status** during the plan year. This includes marriage, divorce, death, change in coverage, change in cost (except when the provider is a relative), dependent enrolled in school, birth/adoption or a change in employment. However, the adjustment in your election must be relevant to the change in status and the requested election change has to be in line and consistent with the event. All requests must be submitted to Tucker Administrators for approval.

## WHAT ARE THE ADVANTAGES OF THE DEPENDENT CARE REIMBURSEMENT ACCOUNT?

Most important, your personal taxes will be reduced. The amount you contribute to your Dependent Care Account is not subject to Federal, State, or FICA taxes. Generally, this will mean a tax savings of 15% to 40% depending on your tax bracket. As a direct result of the personal tax savings, you can actually increase your spendable income by changing the payment of those expenses from an after-tax to a pre-tax basis.

Participation in Dependent Care Account will reduce or in some cases, may eliminate the ability to use the Federal Tax Credit for Dependent Care. However, as you can determine from the comparison worksheets shown later in this booklet, for most taxpayers the Dependent Care Account results in a greater tax savings. **If you participate in a Dependent Care Reimbursement Account, IRS Form 2441 must be completed as part of your tax return.**

## WHAT ARE THE DISADVANTAGES OF THE DEPENDENT CARE REIMBURSEMENT ACCOUNT?

By not paying FICA taxes, you will be reducing your Social Security contribution. Studies on this matter have determined that your tax savings generally outweigh your Social Security benefit reduction.

Any money in your Dependent Care Account that is not used by the end of the plan year will be **forfeited**. Therefore, it is in your best interest to be conservative when estimating your contribution.

Based on group participation, highly compensated and/or key employees' participation may be restricted. You will be notified if this applies to you.

## DEPENDENT CARE WORKSHEETS

### ESTIMATE YOUR SAVINGS

The following worksheets allow you the opportunity to compare the potential tax savings available through the Dependent Care Account vs. Federal Income Tax Credit. The general rule of thumb is that if your adjusted gross family income exceeds approximately \$39,000 to \$41,000, you will receive a greater tax savings through the Dependent Care Account. The tax credit applies to federal taxes while the Dependent Care Account saves you federal income taxes, state and local income taxes, and Social Security (FICA) taxes. You are encouraged to discuss the Dependent Care Account with a tax expert to determine the method which best serves your needs. The better "value" must also consider number of dependents, amount of dependent care expenses, your Adjusted Gross Income, and the effect of state and local tax laws.

<b>Federal Income Tax Credit Worksheet</b>			
1. The amount of expenses for work related dependent care (cannot exceed your income or that of your spouse, whichever is less)			\$ _____
2. Maximum expenses eligible for tax credit (\$3,000 for one dependent; \$6,000 for more than one dependent)			\$ _____
3. Estimated Adjusted Gross Income for you (and spouse if applicable)			\$ _____
4. Percentage from table below based on Adjusted Gross Income			_____ %
5. Estimated tax credit (multiply line 4 by the smaller of line 1 or line 2)			\$ _____

Adjusted Gross Income	Percentage	Adjusted Gross Income	Percentage
Up to \$15,000	35%	\$29,001 - \$31,000	27%
\$15,001 - \$17,000	34%	\$31,001 - \$33,000	26%
\$17,001 - \$19,000	33%	\$33,001 - \$35,000	25%
\$19,001 - \$21,000	32%	\$35,001 - \$37,000	24%
\$21,001 - \$23,000	31%	\$37,001 - \$39,000	23%
\$23,001 - \$25,000	30%	\$39,001 - \$41,000	22%
\$25,001 - \$27,000	29%	\$41,001 - \$43,000	21%
\$27,001 - \$29,000	28%	\$43,001 and Over	20%

*This is for illustration purposes only.*

## Dependent Care Reimbursement Worksheet

1. The amount of deposit to your Dependent Care Account (must \$ \_\_\_\_\_ not exceed your income, your spouse's income, or \$5,000 or \$2,500, if married and filing a separate return)
  
2. Your Federal Tax Rate from the table below (using combined income for you and your spouse) \_\_\_\_\_ %
  
3. Social Security tax rate:
  - Enter 7.65% for earnings up to \$84,900\* (2002 limit) \_\_\_\_\_ %
  - Enter 1.45% for earnings over \$84,900\* (2002 limit) \_\_\_\_\_ %
  
4. State and City tax rate\*\* \_\_\_\_\_ %
  
5. Total tax rate savings (line 2 + line 3 + line 4) \_\_\_\_\_ %
  
6. Estimated tax savings (multiply line 5 by line 1) \$ \_\_\_\_\_

*The table amounts are based on Adjusted Gross Income (after exemptions and deductions). Do not confuse Adjusted Gross Income with gross income. NOTE – Based on 2002 Federal Income Tax Rates*

Federal Tax Rate	Single	Married Filing Jointly
15%	Up to \$27,950	Up to \$46,700
27%	\$27,951 - \$67,700	\$46,701 - \$112,850
30%	\$67,701 - \$141,250	\$112,851 - \$171,950

*\*This amount is adjusted annually by the Federal Government.*

*\*\*Deposits to your Dependent Care Account are generally exempt from state and city taxes. This exemption is dependent, however, on the state and city in which you reside.*

If line 6 on the Dependent Care Reimbursement Account Worksheet is larger than line 5 on the Federal Income Tax Credit Worksheet, then the Dependent Care Reimbursement Account can be expected to provide you a greater tax savings than the tax credit. These numbers are for illustration purposes only.

If your contributions to your Dependent Care Reimbursement Account are less than the amount of your actual dependent care expenses, you may, based on income, be able to use the Federal Income Tax Credit for the balance, however, the total amount of your expenses reimbursed under the plan and those claimed on the Tax Credit cannot exceed the limits set forth in the Tax Credit (\$3,000/\$6,000). Consult your tax adviser for further clarification.

## ***You Have a Choice to Make!***

### **DEPENDENT CARE ACCOUNT OR DEPENDENT CARE TAX CREDIT**

The increased dependent care tax credit, as provided under the Economic Growth and Tax Relief Reconciliation Act ( EGTRRA), became effective January 1, 2003.

#### **What are the changes to the dependent care tax credit?**

The maximum amount of dependent care expenses eligible for credit increased from \$2,400 to \$3,000 for one dependent and \$4,800 to \$6,000 for two or more dependents.

#### **How do I take advantage of this tax credit?**

The dependent care tax credit applies ONLY to federal taxes, so you calculate the tax credit with your income tax filings after year end.

**Good News! You may still choose the Dependent Care Account to provide a way to pay for dependent care expenses with income tax-free dollars. The maximum annual benefit remains at \$5,000 for one or more dependents.**

#### **How do I take advantage of the Dependent Care Account benefit?**

Decide how much money you would like placed in your dependent care account based upon your estimated work related dependent care expenses for the coming year. Simply make this election on your enrollment form, and it will be deducted on a pre-tax basis for each pay period and contributed to your dependent care account.

#### **Like the tax credit, will the Dependent Care Account save me from federal taxes?**

Yes, and it will do more than that! The Dependent Care Account may save you federal, state and local income taxes, and Social Security (FICA) taxes. In addition, you receive the pre-tax advantage immediately, lowering taxable income and providing timely reimbursements.

#### **How do I decide which benefit is right for me?**

The general rule is that if your adjusted gross income exceeds approximately \$39,000 you will receive a greater tax savings through the Dependent Care Account. However, since many other factors should also be considered, you are encouraged to seek the advice of a tax expert to determine which method is best for you.

## **MOST QUESTIONED EXPENSES DEPENDENT CARE ACCOUNT**

Dependent Care expenses are not considered incurred until the child care is actually provided. Reimbursement may not exceed year-to-date deductions. Divorced parents should be aware that the Dependent Care Reimbursement Account is only **available to the custodial parent**, as it can only be used to allow the parent to be gainfully employed.

Fees for the following are **not eligible**:

- Diaper Changing Fees
- Discounts
- Entertainment
- Expenses paid to child of participant – ineligible unless child is age 19 or older and cannot be claimed as a dependent of the participant or participant's spouse
- Fees for Lessons (i.e., dance, piano or swim, etc.)
- Field Trips
- Household Services (housekeeper, maid, cook) – generally ineligible, except where incidental to child care
- Kindergarten (IRS views Kindergarten as educational)
- Late Fees
- Lunches/Food
- Maternity Leave – If you, or your spouse, are on maternity leave and you place your other children in day care, those day care expenses are not eligible. Only day care expenses incurred while at work/school are eligible.
- Overnight Camp Expenses – The cost of sending your child to an overnight camp is not eligible. This is not considered a work-related expense.
- Transportation for day care

## MID-YEAR ELECTION CHANGES DEPENDENT CARE ACCOUNT

You are allowed to change your annual election for a Dependent Care Reimbursement Account **ONLY** if you have a qualifying status change such as the following:

Change in Status – changes generally restricted to events related to a gain or loss of coverage eligibility.

- Change in employee’s legal marital status
- Change in number of dependents
- Change in employment status
- Dependent satisfies (or ceases to satisfy) dependent eligibility requirements
- Commencement or termination of adoption proceedings
- FMLA leave for you or your spouse

Cost or Coverage Changes – changes generally allowed whenever scope of care or care provider changes. Please Note: Rate changes due to changing providers are eligible.

- Significant change in cost, except when a relative provides the service
- Curtailment or improvement of coverage
- Open enrollment under other employer plan

Two important facts must be considered when allowing a status change mid-year.  
1. Participants may make changes to their elections “on account of, and corresponding with, a change in status that affects eligibility for coverage.” In other words, a change in status must have occurred.

2. The change in election must be “consistent with the reason that such change was permitted.” Example, increasing coverage due to a marriage, or decreasing coverage due to a death.

**Reminders:** Canceled checks are not an acceptable receipt, as they do not satisfy the requirement that a statement be submitted from a third party provider.

Dependent care claims will not be processed based solely upon quarterly statements submitted by participants, unless documentation clearly indicates that the services have already been incurred. According to cafeteria plan regulations, an expense is “incurred” when the services have been performed, not when the bill or charge for such service is paid.

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



*If you have any questions concerning your Plan, please feel free to contact Tucker Administrators at (800) 347-1232.*

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## BlueCross BlueShield Of Georgia Medical Plan - High Option

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### In-Network Benefits

### Out-of-Network Benefits

**Calendar Year Deductible:** *one for employee, one for spouse, one for all eligible children combined*

- Individual	\$500	\$1,000
- Family	\$1,500	\$3,000

<b>Coinsurance;</b>	Plan pays 80% after deductible Member pays 20% after deductible	Plan pays 60% after deductible Member pays 40% after deductible
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<b>Lifetime Maximum:</b>	Unlimited	\$5,000.000
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**Out-of-Pocket Calendar Year Maximum\***

- Individual	\$1,000	\$4,000
- Family	\$3,000	\$12,000

### **COVERED SERVICES**

#### In-Network Benefits

#### Out-of-Network Benefits

#### **Office Visits (Preventive Care)**

• Well child care, immunizations <i>(deductible waived through age 5)</i>	\$25 copayment	60% after deductible
• Periodic health examination	\$25 copayment	60% after deductible
• Annual gynecological exam <i>(Must use in-network provider for in-network benefits)</i>	\$25 PCP copay or \$35 specialist copay	60% after deductible
• Prostate Screening	\$25 PCP copay or \$35 specialist copay	60% after deductible

#### **Illness or Injury**

• Primary Care Physician (PCP) Office visit (includes lab, radiology, and office surgery)	\$25 copayment	60% after deductible
• Primary Care Physician (after hours visit)	\$30 copayment	60% after deductible
• Specialty Care Physician office visit	\$35 copayment	60% after deductible
• Second Surgical Opinion	\$35 copayment	60% after deductible
• Allergy Care (office visit, testing, serum, and allergy shots)	\$25 PCP copay or \$35 specialist copay	60% after deductible
• Maternity Physician services (prenatal, delivery, postpartum)	\$100 copayment <i>(first office visit only)</i>	60% after deductible

**Illness or Injury (con't)****In-Network Benefits****Out-of-Network Benefits**

- |   |                |                      |
|---|----------------|----------------------|
| • Vision care services provided by a network ophthalmologist or optometrist for treatment of acute conditions | \$35 copayment | 60% after deductible |
| • Services provided by a network dermatologists   | \$35 copayment | 60% after deductible |

**Emergency Room Services**

- |   |                 |                 |
|---|-----------------|-----------------|
| • Life threatening illness, serious accident injury <i>(copay waived if admitted)</i> | \$100 copayment | \$100 copayment |
| • Non-emergency use of the emergency room   | Not Covered     | Not Covered     |

**Inpatient Services**

- |   |                       |                      |
|---|-----------------------|----------------------|
| • Daily room, board and general nursing care at semi-private room rate; ICU/CCU; other medically necessary hospital charges such as diagnostic x-ray and lab services, newborn nursery care | 80% after deductible  | 60% after deductible |
| • Physician services (surgeon, anesthesiologist, radiologist, pathologist, etc.)  | 100% after deductible | 60% after deductible |

**Outpatient Services**

- |  |                       |                      |
|--|-----------------------|----------------------|
| • Surgery facility (hospital charges)  | 80% after deductible  | 60% after deductible |
| • Diagnostic x-ray and lab services  | 80% after deductible  | 60% after deductible |
| • Physician services (surgeon, anesthesiologist, radiologist, pathologist, etc.) | 100% after deductible | 60% after deductible |

**Therapy Services**

- |  |                       |  |
|--|-----------------------|--|
| • Speech Therapy<br><i>(20 visits calendar year maximum)</i>                   | \$35 copayment        | 60% after deductible<br><i>(20 visits calendar year maximum)</i> |
| • Physical or Occupational Therapy<br><i>(20 visits calendar year maximum)</i> | \$35 copayment        | 60% after deductible<br><i>(20 visits calendar year maximum)</i> |
| • Respiratory Therapy<br><i>(30 visits calendar year maximum)</i>              | 100% after deductible | 60% after deductible<br><i>(30 visits calendar year maximum)</i> |
| • Radiation Therapy or Chemotherapy  | 100% after deductible | 60% after deductible   |

**In-Network Benefits****Out-of-Network Benefits****Mental Health/ Substance Abuse Services**

No Primary Care Physician referral required. Services must be authorized by calling **1-800-292-2879**

- Inpatient (facility and physician fee)
- Outpatient
- Inpatient Substance Abuse Detoxification

80% after deductible  
*(30 day calendar year maximum)*

\$35 copayment  
*(20 visits calendar year maximum)*

80% after deductible  
*(6 day calendar year maximum, part of the 30 days per calendar year Inpatient Behavioral Health benefit )*

Not Covered

Not Covered

Not Covered

**Other Services**

- Skilled Nursing Facility  
*(30 visits calendar year maximum)*
- Home Health Care  
*(In and out of network combined)*  
*(120 visits calendar year maximum)*
- Hospice Care  
*(\$10,000 lifetime maximum, not subject to deductible)*
- Ambulance *(when medically necessary)*

100% after deductible  
*(30 visits calendar year maximum)*

100% after deductible  
*(120 visits calendar year maximum)*

100%

100%

60% after deductible  
*(30 visits calendar year maximum)*

60% after deductible  
*(120 visits calendar year maximum)*

100%

100%

**Prescription Drugs**

To receive maximum coverage, have your prescriptions written by a network physician and filled at one of the pharmacies in our network. These include certain local independent pharmacies, as well as many national chain pharmacies: Bi-Lo, CVS, Eckerd, Ingles, Kmart, Kroger, Publix, Rite Aid, Target, Walgreens, Wal-Mart, Winn-Dixie/Save-Rite.

Unless otherwise indicated in the Certificate Booklet, each prescription has a 30 day supply limit. Each mail order maintenance prescription has a 90 day supply limit.

- Generic Preferred Drug
- Brand Preferred Drug
- Non-Preferred Drug
- Mail Order Maintenance Drug  
*(excludes non-preferred)*

\$15 copayment

\$30 copayment

\$60 copayment

\$60 copayment  
*(per prescription)*

60% after deductible

60% after deductible

60% after deductible

Not Available

**For a full disclosure of all benefits, exclusions, and limitations, please refer to your Certificate Booklet.**

**Bi-Weekly Premium - High Option**

**Employee Only - \$35 per pay period**  
**Family Coverage - \$200 per pay period**

## **PRE-EXISTING CONDITION LIMITATION AND CREDIT FOR PRIOR COVERAGE**

For in-network services, there is no pre-existing condition limitation. For out-of-network services, benefits are not available during a pre-existing limitation period for services for any illness, injury, or condition for which medical advice or treatment was recommended by, or received from, a health care provider within six months preceding the effective date of coverage. *The pre-existing limitation period may be reduced or eliminated by the submission of a certificate of prior creditable coverage.* The pre-existing limitation period does not apply to maternity services.

## **SUMMARY OF LIMITATIONS AND EXCLUSIONS**

Your Certificate Booklet will provide you with complete benefit coverage information. Some key limitations and exclusions, however, are listed as follows:

- Care or treatment that is not medically necessary;
- Cosmetic surgery, except to restore function altered by disease or trauma;
- Dental care and oral surgery, except for accidental injury to natural teeth, treatment of TMJ, and extraction of impacted teeth;
- Routine physical examinations necessitated by employment, foreign travel, or participation in school athletic programs;
- Occupational related illness or injury;
- Treatment, drugs, or supplies considered experimental or investigational;
- Surgical or medical care for: artificial insemination, in-vitro fertilization, reversal of voluntary sterilization, radial keratotomy, learning disabilities, mental retardation, hyperkinetic syndrome or autistic disease of childhood;
- Smoking cessation products.

## **SEE CERTIFICATE BOOKLET FOR COMPLETE DETAILS**

It is important to keep in mind that this material is a brief outline of benefits and covered services and is not a contract. Please refer to your Certificate Booklet Form #F-1681A.722 (the contract) for a complete explanation of covered services, limitations and exclusions.

**Blue Cross Blue Shield Healthcare Plan of Georgia**  
**3350 Peachtree Road, NE**  
**Atlanta, Georgia 30326**  
**1-800-441-2273**

*Underwritten by Blue Cross Blue Shield Healthcare Plan of Georgia, and Independent Licensee of the Blue Cross Blue Shield Association*



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## BlueCross BlueShield Of Georgia Medical Plan - Low Option

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### In-Network Benefits

### Out-of-Network Benefits

**Calendar Year Deductible:** *one for employee, one for spouse, one for all eligible children combined*

- Individual	\$1,500	\$1,500
- Family	\$4,500	\$4,500

<b>Coinsurance;</b>	Plan pays 80% after deductible Member pays 20% after deductible	Plan pays 60% after deductible Member pays 40% after deductible
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<b>Lifetime Maximum:</b>	Unlimited	\$5,000.000
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**Out-of-Pocket Calendar Year Maximum\***

- Individual	\$3,000	\$12,000
- Family	\$9,000	\$36,000

**COVERED SERVICES**

### In-Network Benefits

### Out-of-Network Benefits

**Office Visits (Preventive Care)**

• Well child care, immunizations <i>(deductible waived through age 5)</i>	\$40 copayment	60% after deductible
• Periodic health examination	\$40 copayment	Not Covered
• Annual gynecological exam <i>(Must use in-network provider for in-network benefits)</i>	\$40 PCP copay or \$50 specialist copay	60% after deductible
• Prostate Screening	\$40 PCP copay or \$50 specialist copay	60% after deductible

**Illness or Injury**

• Primary Care Physician (PCP) Office visit (includes lab, radiology, and office surgery)	\$40 copayment	60% after deductible
• Primary Care Physician (after hours visit)	\$45 copayment	60% after deductible
• Specialty Care Physician office visit	\$50 copayment	60% after deductible
• Second Surgical Opinion	\$50 copayment	60% after deductible
• Allergy Care (office visit, testing, serum, and allergy shots)	\$40 PCP copay or \$50 specialist copay	60% after deductible
• Maternity Physician services (prenatal, delivery, postpartum)	\$100 copayment <i>(first office visit only)</i>	60% after deductible

**Illness or Injury (con't)****In-Network Benefits****Out-of-Network Benefits**

- |   |                |                      |
|---|----------------|----------------------|
| • Vision care services provided by a network ophthalmologist or optometrist for treatment of acute conditions | \$50 copayment | 60% after deductible |
| • Services provided by a network dermatologists   | \$50 copayment | 60% after deductible |

**Emergency Room Services**

- |   |                 |                 |
|---|-----------------|-----------------|
| • Life threatening illness, serious accident injury <i>(copay waived if admitted)</i> | \$100 copayment | \$100 copayment |
| • Non-emergency use of the emergency room   | Not Covered     | Not Covered     |

**Inpatient Services**

- |   |                       |                      |
|---|-----------------------|----------------------|
| • Daily room, board and general nursing care at semi-private room rate; ICU/CCU; other medically necessary hospital charges such as diagnostic x-ray and lab services, newborn nursery care | 80% after deductible  | 60% after deductible |
| • Physician services (surgeon, anesthesiologist, radiologist, pathologist, etc.)  | 100% after deductible | 60% after deductible |

**Outpatient Services**

- |  |                       |                      |
|--|-----------------------|----------------------|
| • Surgery facility (hospital charges)  | 80% after deductible  | 60% after deductible |
| • Diagnostic x-ray and lab services  | 80% after deductible  | 60% after deductible |
| • Physician services (surgeon, anesthesiologist, radiologist, pathologist, etc.) | 100% after deductible | 60% after deductible |

**Therapy Services**

- |  |                       |  |
|--|-----------------------|--|
| • Speech Therapy<br><i>(20 visits calendar year maximum)</i>                   | \$50 copayment        | 60% after deductible<br><i>(20 visits calendar year maximum)</i> |
| • Physical or Occupational Therapy<br><i>(20 visits calendar year maximum)</i> | \$50 copayment        | 60% after deductible<br><i>(20 visits calendar year maximum)</i> |
| • Respiratory Therapy<br><i>(30 visits calendar year maximum)</i>              | 100% after deductible | 60% after deductible<br><i>(30 visits calendar year maximum)</i> |
| • Radiation Therapy or Chemotherapy  | 100% after deductible | 60% after deductible   |

**In-Network Benefits**

**Out-of-Network Benefits**

**Mental Health/ Substance Abuse Services**

No Primary Care Physician referral required. Services must be authorized by calling **1-800-292-2879**

• Inpatient (facility and physician fee)	80% after deductible <i>(30 day calendar year maximum)</i>	Not Covered
• Outpatient	\$50 copayment <i>(20 visits calendar year maximum)</i>	Not Covered
• Inpatient Substance Abuse Detoxification	80% after deductible <i>(6 day calendar year maximum, part of the 30 days per calendar year Inpatient Behavioral Health benefit )</i>	Not Covered

**Other Services**

• Skilled Nursing Facility	100% after deductible <i>(30 visits calendar year maximum)</i>	60% after deductible <i>(30 visits calendar year maximum)</i>
• Home Health Care <i>(In and out of network combined)</i>	100% after deductible <i>(120 visits calendar year maximum)</i>	60% after deductible <i>(120 visits calendar year maximum)</i>
• Hospice Care <i>(\$10,000 lifetime maximum, not subject to deductible)</i>	100%	100%
• Ambulance <i>(when medically necessary)</i>	100%	100%

**Prescription Drugs**

To receive maximum coverage, have your prescriptions written by a network physician and filled at one of the pharmacies in our network. These include certain local independent pharmacies, as well as many national chain pharmacies: Bi-Lo, CVS, Eckerd, Ingles, Kmart, Kroger. Publix, Rite Aid, Target, Walgreens, Wal-Mart, Winn-Dixie/Save-Rite.

Unless otherwise indicated in the Certificate Booklet, each prescription has a 30 day supply limit. Each mail order maintenance prescription has a 90 day supply limit.

• Generic Preferred Drug	\$15 copayment	60% after deductible
• Brand Preferred Drug	\$30 copayment	60% after deductible
• Non-Preferred Drug	\$60 copayment	60% after deductible
• Mail Order Maintenance Drug <i>(excludes non-preferred)</i>	\$60 copayment <i>(per prescription)</i>	Not Available

**For a full disclosure of all benefits, exclusions, and limitations, please refer to your Certificate Booklet.**

**Bi-Weekly Premium - Low Option**

**Employee Only - Paid by Rabun County  
Family Coverage - \$90 per pay period**

## **PRE-EXISTING CONDITION LIMITATION AND CREDIT FOR PRIOR COVERAGE**

For in-network services, there is no pre-existing condition limitation. For out-of-network services, benefits are not available during a pre-existing limitation period for services for any illness, injury, or condition for which medical advice or treatment was recommended by, or received from, a health care provider within six months preceding the effective date of coverage. *The pre-existing limitation period may be reduced or eliminated by the submission of a certificate of prior creditable coverage.* The pre-existing limitation period does not apply to maternity services.

## **SUMMARY OF LIMITATIONS AND EXCLUSIONS**

Your Certificate Booklet will provide you with complete benefit coverage information. Some key limitations and exclusions, however, are listed as follows:

- Care or treatment that is not medically necessary;
- Cosmetic surgery, except to restore function altered by disease or trauma;
- Dental care and oral surgery, except for accidental injury to natural teeth, treatment of TMJ, and extraction of impacted teeth;
- Routine physical examinations necessitated by employment, foreign travel, or participation in school athletic programs;
- Occupational related illness or injury;
- Treatment, drugs, or supplies considered experimental or investigational;
- Surgical or medical care for: artificial insemination, in-vitro fertilization, reversal of voluntary sterilization, radial keratotomy, learning disabilities, mental retardation, hyperkinetic syndrome or autistic disease of childhood;
- Smoking cessation products.

## **SEE CERTIFICATE BOOKLET FOR COMPLETE DETAILS**

It is important to keep in mind that this material is a brief outline of benefits and covered services and is not a contract. Please refer to your Certificate Booklet Form #F-1681A.722 (the contract) for a complete explanation of covered services, limitations and exclusions.

**Blue Cross Blue Shield Healthcare Plan of Georgia**  
**3350 Peachtree Road, NE**  
**Atlanta, Georgia 30326**  
**1-800-441-2273**

*Underwritten by Blue Cross Blue Shield Healthcare Plan of Georgia, and Independent Licensee of the Blue Cross Blue Shield Association*



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## *Rabun County Direct Reimbursement Dental Plan*

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**Plan Year: October 1, 2008 - September 30, 2009**

Rabun County provides dental coverage for the individual employee as part of the health insurance package. Family coverage for dental is available at an additional cost to the employee. Employees will be reimbursed for expenses incurred for the cost of dental care outlined below.

**The Plan:**

- Allows you to use the dentist of your choice.
- Has no waiting period before certain procedures are covered.
- Has no excluded procedures except cosmetic procedures (bleaching, veneers, etc.).
- No pre-approval is necessary.
- Has no maximum fee schedule for each procedure. The dentist's normal fees are allowable expenses.

**How The Plan Works:**

- Every year beginning January 1st, you and your covered dependents each have \$1000 to use for dental care. The plan reimburses you:
  - 100% of the first \$100 of eligible expenses, then the plan pays 50% of the next \$1800 of eligible expense to a maximum benefit of \$1000. Orthodontia is excluded.

If you do not enroll when first eligible, and elect benefits at a later time, you will have reduced benefits for the first year (50% reimbursement with a \$500 maximum benefit).

**How Direct Reimbursement is Used and How Reimbursements are Made**

1. The patient selects a dentist and agrees to a treatment plan.
2. The itemized bill is mailed by the employee or dentist along with a claim form.
3. The benefit check is mailed to the employee or to the dentist, if there is an assignment of benefits, within 10 days (including mail time).

**Your Cost**

- Employee Coverage - No cost to you
- Family Coverage - \$20.84 monthly or \$9.62 bi-weekly

Claim forms should be mailed to:  
Direct Reimbursement Benefits Plan, Inc.  
P.O. Box 2130, Alpharetta GA 30023  
(888) 745-32754

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## *Horizon Behavioral Services Employee Assistance Plan*

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Horizon Behavioral Services' Employee Assistance Program (EAP) provides the Rabun County employees with professional guidance in resolving issues that impact their personal and professional lives.

Counseling services are available from licensed professionals to address such issues as: stress, marital/relationship difficulty, parenting/child needs, family difficulty, alcohol and drug abuse, depression, grief, and more. Employees and their dependents are entitled to receive up to six visits with a counselor per issue per year.

Legal and financial counseling services are also available through the EAP. Access to an attorney in the employee's local area is available to address such needs as: estate planning, writing a last will and testament, child custody, divorce, and civil suits. The first 30 minutes of each consult with an attorney is free of charge, after which the employee will receive a 25% discount off each billable hour. Financial counseling is available by telephone to address financial planning, retirement planning, debt reduction/consolidation, budgeting, and home purchasing needs.

HBS recognizes the importance of offering a high quality, proactive program that fosters good mental health and prevents disruptive and unhealthy situations. Depression, domestic violence, and marital discord are but a few examples of issues that can affect an employee's workplace performance. Our EAP focuses on providing consultation, information, success planning, and referral to resources for a variety of concerns, including, but not limited to the following:

- Depression
- Daily living issues
- Wellness
- Relationship issues
- Child care
- Personal achievement
- Elder care
- Family
- Financial
- Emotional well-being
- Legal
- Substance abuse/chemical dependency
- Stress and anxiety
- Life improvement issues

## **MEMBER SERVICES**

Our EAP services are designed to meet the needs of all members. We offer a comprehensive array of Employee Assistance and WorkLife Program services that have proven to be effective in satisfying various levels of care for our members. HBS' Member Services include the following.

**24-Hour Member Advocate Line**—Support for members that provides connection to specialists for WorkLife, legal, financial, and clinical issues

**Goal and Success Planning Consultation**—Focuses on providing consultation and resource services to assist employees and families in achieving personal success and well-being

**Personalized Resource Materials**—Reinforcement for each consultation by providing members with informative materials, including educational literature that address the special needs of the employee as identified through the phone consultation

**Assessment and Counseling**—Up to allocated number of short-term, in-person counseling sessions for employees and family members for assessment, problem solving, and referrals to resources

**National Network**—Provider network coverage from anywhere in the United States (With more than 23,000 providers in our network, even employees with multi-state residences and college students away at school are covered by our services.)

**HorizonCareLink™ Online**—An innovative Web site that houses all of HBS' Employee Assistance services under one virtual roof, offering content, interactive tools, and educational guides for employees and managers

**Legal Consultation Services**—Guidance for members with legal issues such as will preparation, divorce, automobile accidents, and many other issues

**Financial Consultation Services**—Assistance in managing inheritance or estate taxes, retirement fund rollovers or transfers, and general tax or investment questions

**Telephonic and Online WorkLife Services**—Telephonic and online assistance with childcare, elder care, adoption, and other life events

**Telephonic Follow Up**—Personal follow-up contact with each member to ensure the services provided are meeting members' needs

**To access these Horizon services, call: (800) 955-6422**



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## *Superior Vision Plan*

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**Effective Date: October 1, 2008**

**Outline of Benefits – Gold Preferred Plan with Materials Discount  
Vision Plan – Preferred Provider (PPO / Indemnity)**

**Copayment:       \$10.00 Exam  
                      \$15.00 Materials  
                      \$35.00 Contact Lens Fitting Fee**

<b>BENEFITS</b>	<b>FREQUENCY</b>	<b>IN-NETWORK</b>	<b>NON-NETWORK</b>
<b>Comprehensive Exam</b> <i>(by an Ophthalmologist)</i>	12 Months	Covered in Full	Up to \$42.00
<b>Comprehensive Exam</b> <i>(by an Optometrist)</i>	12 Months	Covered in Full	Up to \$37.00
<b>Lenses (Standard) per Pair</b>			
Single Vision	12 Months	Covered in Full	Up to \$32.00
Bifocal	12 Months	Covered in Full	Up to \$46.00
Trifocal	12 Months	Covered in Full	Up to \$61.00
Lenticular	12 Months	Covered in Full	Up to \$84.00
<b>Contact Lenses (Per Pair)*</b>			
Medically Necessary	12 Months	Covered in Full	Up to \$210.00
Cosmetic (Elective)**	12 Months	Up to \$120.00	Up to \$100.00
Standard Contact Lens Fitting Fee***	12 Months	Covered in Full	Not Covered
Specialty Contact Lens Fitting Fee***	12 Months	Up to \$50.00	Not Covered
<b>Frames (Standard)**</b>	24 Months	Up to \$100.00	Up to \$48.00

*\*Contact lenses are in lieu of eyeglass lenses and frames benefits.*

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

*\*\*\*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. For the specialty fit, the member is responsible for any charges over \$50.*

### **DEFINITIONS OF CONTACT LENSES**

#### **Contact Lenses, Elective/Cosmetic**

Elective/Cosmetic contact lenses are those that are worn solely for cosmetic or convenience reasons. They are chosen because they are preferred over the wearing of conventional eyeglasses. Contact lenses covered by the Plan must contain a prescription for correcting a vision deficiency. Charges over the benefit allowance are paid directly to the provider.

#### **Contact Lenses, Medically Necessary**

These lenses must be specifically prescribed by the eye doctor to be used for the following reason or reasons. Reimbursement for these lenses will be considered as payment-in-full when utilizing an in-network provider.

- Aphakia (after cataract surgery without implant lens)  
A pair of prescription single vision or multifocal eye glass lenses and an eye frame can be provided along with contact lenses prescribed for this reason.

- When visual acuity cannot be corrected to 20/70 in the better eye except through the use of contact lenses (must be 20/60 or better).
- Anisometropia of 4.0 diopters or more, provided visual acuity improves to 20/60 or better in the weak eye.
- Keratoconus

Note: The narrowing of visual fields due to high minus or high plus corrections is not considered a reason for medically necessary contact lenses.

**Contact Lens Examining Fee:**

Most providers charge a fee for the fitting of contact lenses. This fee is separate from the eye examination and will vary depending on the provider's fee structure policies. It will also vary due to circumstances or complexities involving the physiological condition of the eyes, the lens prescription, and the type of lenses used. The contact lens exam/fitting fee may be included in the contact lens allowance.

**EXCLUSIONS (products & services not covered):**

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

- Professional Services and/or Materials in conjunction with:
  - blended bifocals, no line, or progressive lenses
  - compensated or special multi-focal lenses
  - plain (non-prescription) lenses
  - anti-reflective, scratch, UV400, or any coating or laminate applied to lenses
  - subnormal vision aids
  - tints, other than solid
  - orthoptics, vision training and developmental vision procedures
  - polycarbonate lenses
  - Medical or surgical treatment of the eyes
- Any eye examination or any corrective eyewear required by an Employer as a condition of employment
- Any injury or illness when covered under Workers Compensation or similar law
- Plain or prescription sunglasses, no-line bifocals, blended lenses are not covered; an Insured may elect to apply the maximum allowance for standard lenses toward his, or her cost of progressive lenses
- Subnormal vision aids
- Services rendered or Materials purchased outside the U.S. or Canada unless the member resides in the U.S. or Canada; and the charges are incurred while on a business or pleasure trip
- Charges in excess of the Usual, Customary and Reasonable charges for the Professional Service or Materials
- Experimental or non-conventional treatment or device
- Safety eyewear
- Spectacle lens styles, materials, treatments, or "add-ons" not shown in the Benefits Summary
- Services or Materials rendered by a provider other than an Ophthalmologist, Optometrist or Optician acting within the scope of his, or her license

- Any additional service required outside basic vision analysis for contact lenses except fitting fees
- Services rendered after the date an Insured ceases to be covered under this Certificate, except when vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured within 31 days from the date of such order
- Services rendered or Materials ordered before the date of coverage began under this Certificate
- Regardless of Optical Necessity, benefits are not available more frequently delivered, and the services rendered to the Insured within 31 days from the than that which is specified in the Benefits Summary

## **HOW TO USE YOUR BENEFIT**

### **Procedure when using a Superior Vision Plan in-network provider:**

- Identify yourself to the in-network provider as a member of the Superior Vision Plan. You can use your ID card for this purpose or simply give the provider your name, employer name, and your social security number. The provider will call SVS Member Services to verify your eligibility and obtain an authorization number. The ID card provided to you can be used for all covered family members.
- After eligibility is established, and an authorization number is received by the provider, services will be rendered. There is nothing else that you need to do except pay the provider directly for any appropriate copayments and charges above the covered benefits. The in-network provider handles all claims and paperwork.

### **Procedure when using a Superior Vision Plan non-network provider:**

- To receive services from a non-network provider, it is important that you first call Superior Vision Services Member Service Department at 800-507-3800 to receive your own authorization number. By doing so, you can be assured of your eligibility and reimbursement for money spent.
- After receiving services and paying in-full for the examination and/or materials (you do not pay a copayment to the non-network provider), submit your original itemized billing received from the provider, along with your authorization number, to the SVS Claims Administration office listed on the next page.
- You will be reimbursed according to the schedule of allowances for non-network providers, less any required copayments.

## DISCOUNTS ON ADDITIONAL PURCHASES

- Prescription eyeglass lenses 30% off retail prices
- Eyeframes 30% off retail prices
- Add-on charges to basic lenses 20% off retail prices
- Everyday "frame and lens package" pricing 20% off retail prices
- Contact lenses, standard hard or soft 20% off retail prices
- Disposable contact lenses 10% off retail prices
- All other prescription materials 20% off retail prices

## DISCOUNT SVP8-20

- Frames - 20% off the difference between the covered frame Allowance and the retail price of the selected frame

### Add-on charges to covered pair of lenses

### Member pays 20% off retail up to:

- Factory Scratch Coat \$13 (Single Vision & Standard Multifocal lenses)
- Ultraviolet Coat \$15 (Single Vision & Standard Multifocal lenses)
- Standard Anti-Reflective coat\* \$50 (Single Vision & Standard Multifocal lenses)
- High Index 1.6\* \$55 (Single Vision lenses only)
- Polycarbonate \$40 (Single Vision lenses only)
- Standard Photochromic \$80 (Single Vision lenses only)
- Glass coloring \$35 (Any Type lenses)
- Plastic Tints solid or gradient \$25 (Any Type lenses)

### Member pays:

- Power over 4.00 Sphere, 2.00D Cylinder & 5.00 Prism 20% off retail prices (any type lenses)
- Cosmetic finishing, Beveling, Edging, and Mounting 20% off retail prices (any type lenses)
- Miscellaneous Options 20% off retail prices (any type lenses)

\* Higher end or brand name lens upgrades are at an additional expense to the member. Apply maximum out of pocket expense toward upgraded lens retail cost and member is responsible for the difference less 20%.

## REFRACTIVE SURGERY DISCOUNTS

Superior Vision Services has contracted a network of over 500 refractive surgeons nationwide who specialize in the popular elective procedures of radial keratotomy (RK), photo-refractive keratotomy, (PRK), and LASIK. These providers offer Superior Vision Plan members a 20% discount off their usual and customary surgical fees for these procedures. Ophthalmic plastic surgeons are also contracted to provide the procedure of blepharoplasty (cosmetic eyelid surgery) to Superior Vision Plan members on the same discount basis.

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

**BI-WEEKLY COST**

Employee Only	\$ 4.50
Employee + 1 Dependent	\$ 8.72
Employee + Family	\$ 12.81

**Member Services, Provider Listings and Claims Services:**  
(800) 507-3800

**Member Services Fax:**  
(916) 852-2277

**Provider Nominations:**  
(800) 923-6766, ext. 254 or  
(800)507-3800

**Web Site:**  
[www.superiorvision.com](http://www.superiorvision.com)

**Address:**  
Superior Vision Services, Inc  
11101 White Rock Road, Ste. 150  
Rancho Cordova, CA 95670

**Non-network Claims Submission:**  
Superior Vision Services, Inc.  
P.O. Box 967  
Rancho Cordova, CA 95741



*The Superior Vision Plan is underwritten by National Guardian Life Insurance Company. P.O. Box 1191, Madison WI 53701-1191  
National Guardian Life Insurance Company is not affiliated with The Guardian Life Insurance Company of America, a/k/a The Guardian or Guardian Life*



*Aflac Personal Accident Indemnity Plan  
Accident-Only Insurance – Level 2  
Policy A-34200-GA*

**Effective Date: October 1, 2008**

**Aflac insurance policies are subject to health underwriting.**

*Benefits are payable for a covered person's death, dismemberment, or injury caused by a covered accident that occurs on or off the job.*

**ACCIDENT EMERGENCY TREATMENT BENEFIT**

*Aflac will pay \$120 for the insured and the spouse, and \$70 for children if a covered person receives treatment for injuries sustained in a covered accident. This benefit is payable for X-rays, treatment by a physician, or treatment received in a hospital emergency room. Treatment must be received within 72 hours of the accident for benefits to be payable. This benefit is payable once per 24-hour period and only once per covered accident, per covered person.*

**ACCIDENT FOLLOW-UP TREATMENT BENEFIT**

*Aflac will pay \$35 for one treatment per day for up to a maximum of six treatments per covered accident, per covered person for follow-up treatment received for injuries sustained in a covered accident. Treatment must begin within 30 days of the covered accident or discharge from the hospital. Treatments must be furnished by a physician in a physician's office or in a hospital on an outpatient basis. This benefit is not payable for the same visit that the Physical Therapy Benefit is paid.*

**INITIAL ACCIDENT HOSPITALIZATION BENEFIT**

*Aflac will pay \$1,000 when a covered person is confined to a hospital for at least 24 hours for injuries sustained in a covered accident. If the covered person is admitted directly to an intensive care unit, Aflac will pay \$2,000. This benefit is payable only once per hospital confinement\* or intensive care unit confinement and is payable only once per calendar year, per covered person.*

**ACCIDENT HOSPITAL CONFINEMENT BENEFIT**

*Aflac will pay \$250 per day for which a covered person is charged for a room for hospital confinement\* of at least 18 hours for treatment of injuries sustained in a covered accident. This benefit is payable up to 365 days per covered accident, per covered person. The Accident Hospital Confinement Benefit and the Rehabilitation Unit Benefit will not be paid on the same day; only the highest eligible benefit will be paid.*

*\*Hospital confinement is defined as a covered person's confinement to a bed in a hospital for which a room charge is made. The confinement must be on the advice of a physician and medically necessary. Benefits are also payable for confinement in hospitals operated by or for the United States government. Confinement must start within 30 days of the accident.*

**American Family Life Assurance Company of Columbus (Aflac)**

### **INTENSIVE CARE UNIT CONFINEMENT BENEFIT**

*Aflac will pay an additional \$400 per day for each day a covered person is receiving the Accident Hospital Confinement Benefit and is confined to and charged for a room in an intensive care unit. This benefit is payable up to 15 days per covered accident, per covered person. Confinements must start within 30 days of the accident.*

### **ACCIDENT SPECIFIC-SUM INJURIES BENEFIT**

*Aflac will pay \$35–\$12,500 for:*

- Dislocations
- Burns
- Skin Grafts
- Eye Injuries
- Lacerations
- Fractures
- Broken Teeth
- Comas
- Brain Concussions
- Paralysis
- Surgical Procedures

Treatment must be performed on a covered person for injuries sustained in a covered accident. We will pay for no more than two dislocations per covered accident, per covered person. Dislocations must be diagnosed by a physician within 72 hours after the covered accident. Benefits are payable for only the first dislocation of a joint. If a physician reduces a dislocation with local or no anesthesia, we will pay 25 percent of the amount shown for the closed reduction dislocation. A physician must treat burns within 72 hours after a covered accident. A total of 50 percent of the burn benefit will be paid for one or more skin grafts. Lacerations requiring sutures must be repaired under the attendance of a physician within 72 hours after the covered accident. Fractures must be diagnosed by a physician by X-ray within 14 days after a covered accident. For chip fractures and other fractures not reduced by open or closed reduction, we will pay 25 percent of the benefit amount shown for the closed reduction. We will pay for no more than two fractures per covered accident, per covered person. We will pay no more than one benefit for broken teeth per covered accident, per covered person. Coma duration must be at least seven days and must require intubation for respiratory assistance. Paralysis must result from spinal cord injuries that are received in a covered accident and that result in complete and total loss of use of two or more limbs for a period of at least 30 days, and the loss must be confirmed by a physician. Surgical procedures must be performed within one year of a covered accident. Two or more surgical procedures performed through the same incision will be considered one operation, and benefits will be paid based upon the most expensive procedure. Only one miscellaneous surgery benefit is payable per 24-hour period even though more than one procedure may be performed.

### **MAJOR DIAGNOSTIC EXAMS**

*Aflac will pay \$200 if a covered person requires one of the following exams for injuries sustained in a covered accident: CT (computerized tomography) scan, MRI (magnetic resonance imaging), or EEG (electroencephalogram). The exam must be performed in a hospital, a physician's office, or an ambulatory surgical center, and a charge must be incurred. This benefit is limited to one payment per calendar year, per covered person. No lifetime maximum.*

**PHYSICAL THERAPY BENEFIT**

*Aflac will pay \$35 for one treatment per day up to a maximum of ten treatments per covered accident, per covered person if a physician advises the person to seek treatment from a physical therapist. Physical therapy must be for injuries sustained in a covered accident and must start within 30 days of the covered accident or discharge from the hospital. Treatment must take place within six months after the accident. This benefit is not payable for the same visit that the Accident Follow-Up Treatment Benefit is paid.*

**REHABILITATION UNIT BENEFIT**

*Aflac will pay \$150 per day when a covered person is charged for confinement in a hospital and transferred to a bed in a rehabilitation unit of a hospital for a covered injury. This benefit is limited to 30 days for each covered person per period of hospital confinement and is limited to a calendar year maximum of 60 days. The Accident Hospital Confinement Benefit and the Rehabilitation Unit Benefit will not be paid on the same day; only the highest eligible benefit will be paid. No lifetime maximum.*

*A period of hospital confinement is a time period of confinement that starts while the policy is in force. If the confinement follows a previously covered confinement, it will be deemed a continuation of the first unless it is the result of an entirely unrelated injury or the confinements are separated by 30 days or more.*

**APPLIANCES BENEFIT**

*Aflac will pay \$125 if a covered person requires, as advised by a physician, the use of a medical appliance as an aid in personal locomotion resulting from injuries sustained in a covered accident. This benefit is payable for crutches, wheelchairs, leg braces, back braces, and walkers, and is payable once per covered accident, per covered person.*

**PROSTHESIS BENEFIT**

*Aflac will pay \$750 if a covered person requires a prosthetic device as a result of injuries sustained in a covered accident. This benefit is payable once per covered accident, per covered person and is not payable for hearing aids, wigs, or dental aids, to include false teeth.*

**BLOOD/PLASMA/PLATELETS BENEFIT**

*Aflac will pay \$200 if a covered person requires blood, plasma, or platelets for the treatment of injuries sustained in a covered accident. This benefit is not payable for immunoglobulins and is payable only once per covered accident, per covered person.*

**AMBULANCE BENEFIT**

*Aflac will pay \$200 for ground ambulance transportation or \$1,500 for air ambulance transportation if a covered person requires ambulance transportation to a hospital or emergency center for injuries sustained in a covered accident. A licensed professional ambulance company must provide the transportation within 72 hours of the covered accident.*

## **TRANSPORTATION BENEFIT**

*Aflac will pay \$600 per round trip to a hospital if a covered person requires special treatment and hospital confinement\* for injuries sustained in a covered accident. The hospital must be more than 100 miles from the covered person's residence or site of the accident. This benefit will be paid for only the covered person for whom the treatment is prescribed, or if the treatment is for a dependent child and commercial travel is necessary, one of the dependent child's parents or legal guardians who travels with the child will also receive this benefit. The local attending physician must prescribe the treatment, and the treatment must not be available locally. This benefit is payable for up to three round trips per calendar year, per covered person. This benefit is not payable for transportation by ambulance or air ambulance to the hospital.*

## **FAMILY LODGING BENEFIT**

*Aflac will pay \$125 per night for one motel/hotel room for a member of the immediate family to accompany the covered person if treatment of injuries sustained in a covered accident requires hospital confinement.\* The hospital and motel/hotel must be more than 100 miles from the covered person's residence. This benefit is payable up to 30 days per covered accident and only during the time the covered person is confined in the hospital.*

## **ACCIDENTAL-DEATH AND -DISMEMBERMENT BENEFITS**

*Aflac will pay the following benefit for death if it is the result of injuries sustained in a covered accident:*

	<b>Insured/Spouse</b>	<b>Child</b>
Common-Carrier Accidents	\$150,000	\$25,000

A covered person must be a passenger at the time of the common-carrier accident, and a proper authority must have licensed the vehicle to transport passengers for a fee. Common-carrier vehicles are limited to airplanes, trains, buses, trolleys, and boats that operate on a regularly scheduled basis between predetermined points or cities. Taxis are not included.

	<b>Insured/Spouse</b>	<b>Child</b>
Other Accidents	\$40,000	\$12,500

*(Other Accidents are accidents that are not classified as common-carrier accidents and that are not specifically excluded in the limitations and exclusions of the policy.)*

*Aflac will pay the following benefit for dismemberment resulting from injuries sustained in a covered accident:*

	<b>Insured/Spouse</b>	<b>Child</b>
Both arms and both legs	\$40,000	\$12,500
Two eyes, feet, hands, arms, or legs	\$40,000	\$12,500
One eye, hand, foot, arm, or leg	\$10,000	\$ 3,750
One or more fingers and/or one or more toes	\$ 2,000	\$ 625

Death or dismemberment must be independent of disease, bodily infirmity, or any other cause other than a covered accident and must occur within 90 days of the accident. Only the highest single benefit per covered person will be paid for accidental dismemberment. Benefits will be paid only once for any covered accident. If death and dismemberment result from the same accident, only the Accidental-Death Benefit will be paid. Loss of use does not constitute dismemberment, except for eye injuries resulting in permanent loss of vision such that central visual acuity cannot be corrected to better than 20/200.

### **WELLNESS BENEFIT**

*After the policy has been in force for 12 months, Aflac will pay \$60 if you or any one family member undergoes routine examinations or other preventive testing during the following policy year. Eligible family members are your spouse and the dependent children of you or your spouse. Services covered are: annual physical examinations, dental exams, mammograms, Pap smears, eye examinations, immunizations, flexible sigmoidoscopies, prostate-specific antigen tests (PSAs), ultrasounds, and blood screenings. This benefit will become available following each anniversary of the policy's effective date for service received during the following policy year and is payable only once per policy each 12-month period following the policy anniversary date. Service must be under the supervision of or recommended by a physician and received while your policy is in force, and a charge must be incurred.*

### **CONTINUATION OF COVERAGE BENEFIT**

Aflac will waive all monthly premiums due for the policy for up to two months if you meet all of the following conditions: (1) Your policy has been in force for at least six months; (2) we have received premiums for at least six consecutive months; (3) your premiums have been paid through payroll deduction and you leave your employer for any reason; (4) you or your employer notifies us in writing within 30 days of the date your premium payments cease because of your leaving employment; and (5) you re-establish premium payments, either through your new employer's payroll deduction process or direct payment to Aflac. You will again become eligible for this benefit after you re-establish your premium payments through payroll deduction for a period of at least six months, and we receive premiums for at least six consecutive months. (*Payroll deduction* means your premium is remitted to Aflac for you by your employer through a payroll deduction process.)

### **GUARANTEED-RENEWABLE**

The policy is guaranteed-renewable for your lifetime, subject to Aflac's right to change premiums by class upon any renewal date.

### **EFFECTIVE DATE**

The effective date of the policy is the date shown in the Policy Schedule, not the date the application is signed. The policy is available through age 64. The payroll rate may be retained after one month's premium payment on payroll deduction.

**Refer to the policy for complete details, limitations, and exclusions. This information is for illustration purposes only.**

## **WHAT IS NOT COVERED**

We will not pay benefits for services rendered by a member of the immediate family of a covered person or for an accident that occurs while coverage is not in force.

We will not pay benefits for an accident or sickness that is caused by or occurs as a result of a covered person's:

- Participating in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a physician and taken according to the physician's instructions) or while intoxicated (*intoxicated* means that condition as defined by the law of the jurisdiction in which the accident occurred);
- Driving any taxi for wage, compensation, or profit;
- Mountaineering using ropes and/or other equipment, parachuting, or hang gliding;
- Participating in, or attempting to participate in, an illegal activity that is defined as a felony, whether charged or not (*felony* is as defined by the law of the jurisdiction in which the activity takes place), or being incarcerated in any type penal institution;
- Intentionally self-inflicting bodily injury or attempting suicide, while sane or insane;
- Having cosmetic surgery or other elective procedures that are not medically necessary, or having dental treatment except as a result of injury;
- Being exposed to war or any act of war, declared or undeclared;
- Actively serving in any of the Armed Forces, or units auxiliary thereto, including the National Guard or Army Reserves;
- Participating in any form of flight aviation other than as a fare-paying passenger in a fully licensed, passenger-carrying aircraft;
- Participating in any sport or sporting activity for wage, compensation, or profit, including officiating or coaching; or racing any type vehicle in an organized event.

*Hospital* does not include any institution or part thereof used as a rehabilitation unit; a hospice unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial or educational care, care or treatment for persons suffering from mental disease or disorders, care for the aged, or care for persons addicted to drugs or alcohol.

## **FAMILY COVERAGE**

Family coverage includes the insured; spouse; and dependent, unmarried children to age 19 (25 if full-time students). Newborn children are automatically insured from the moment of birth. One-parent family coverage includes the insured and all unmarried, dependent children to age 19 (25 if full-time students). A dependent child must be under the age of 19 at the time of application to be eligible for coverage.

**PERSONAL ACCIDENT INDEMNITY PLAN**  
**Accident-Only Insurance – Level 2**

**14-Day Biweekly Premium Rates – Class B**

<b>Individual</b>	<b>\$11.12</b>
<b>One-Parent Family</b>	<b>\$16.20</b>
<b>Named Insured/Spouse Only</b>	<b>\$14.91</b>
<b>Two-Parent Family</b>	<b>\$19.98</b>

**The rates do not imply coverage.  
Refer to the policy for complete details, limitations, and exclusions.**

**American Family Life Assurance Company of Columbus (Aflac)**

**Worldwide Headquarters**

**1932 Wynnton Road**

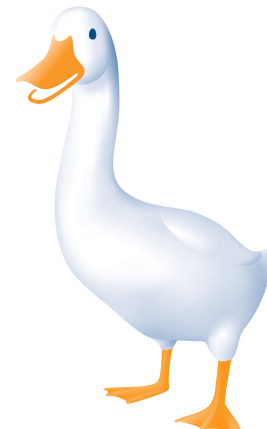
**Columbus, Georgia 31999**

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**En español:**

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**Visit our Web site at [aflac.com](http://aflac.com).**



***Aflac Hospital Intensive Care Protection  
Hospital Intensive Care Unit Insurance  
Policy A18400GA***

**Effective Date: October 1, 2008**

**Aflac insurance policies are subject to health underwriting.**

**Hospital Intensive Care Unit Benefit**

*Aflac will pay* the following benefits when a covered person incurs a charge for confinement in a hospital intensive care unit or a step-down intensive care unit for a covered sickness or injury:

**Confinement in a Hospital Intensive Care Unit:**

	Sickness	Injury
Days 1–7	\$ 700 per day	\$ 800 per day
Days 8–15	\$1,200 per day	\$1,300 per day

This benefit is limited to 15 days per period of confinement. No lifetime maximum.

**Confinement in a Step-Down Intensive Care Unit:**

*Aflac will pay* benefits for confinement in a step-down intensive care unit after exhaustion of benefits paid for confinement in a hospital intensive care unit or for Days 1–15 of a step-down intensive care unit confinement. This benefit is limited to 15 days per period of confinement.

	Sickness	Injury
Days 1–15 (Step-Down Intensive Care Unit)	\$350 per day	\$350 per day
or		
Days 16–30 (Hospital Intensive Care Unit)	\$350 per day	\$350 per day

Benefits payable for confinement in a hospital intensive care unit or for confinement in a step-down intensive care unit are not payable on the same day. If a covered person is charged for both on the same day, only the highest eligible benefit will be paid. Treatment or confinement in a U.S. government hospital does not require a charge for benefits to be payable. Benefits reduce by one-half for losses incurred on or after the policy anniversary date following the 70th birthday of a covered person. No lifetime maximum.

**Progressive Benefit for Hospital Intensive Care Unit/Step-Down Intensive Care Unit Confinement**

A \$2 indemnity will accumulate for the named insured and the covered spouse for each calendar month the policy remains in force after the effective date. This accumulated indemnity, if any, will be paid in addition to any benefits paid under the Hospital Intensive Care Unit Benefit. This progressive benefit will cease to build on the policy anniversary date following the 65th birthday of a covered

person. Any amount accrued at the time this benefit ceases to build for a covered person will continue to be added to the benefit amount for all hospital intensive care unit/step-down intensive care unit confinements commencing prior to the policy anniversary date following the 70th birthday of a covered person. This accumulated benefit will be reduced by one-half for hospital intensive care unit/step-down intensive care unit confinements commencing on or after the policy anniversary date following the 70th birthday of a covered person. This benefit is not applicable and will not accrue to any covered person who has attained age 65 prior to the effective date of the policy. The named insured and covered spouse, if any, are the only persons eligible for this benefit. Dependent children do not qualify for this benefit. When a spouse is added to an existing policy, this benefit will begin to accrue from the endorsement date adding such spouse, provided the spouse has not yet attained age 65.

### **Ambulance Benefit**

*Aflac will pay \$250 for ground ambulance transportation of a covered person to and from a hospital where the covered person is confined in a hospital intensive care unit or step-down intensive care unit. Aflac will pay \$2,000 if air ambulance transportation of a covered person is required to and from a hospital where the covered person is confined in a hospital intensive care unit or step-down intensive care unit. The ambulance service must be performed by a licensed professional or licensed volunteer ambulance company. This benefit is limited to two trips per confinement. No lifetime maximum.*

### **Major Human Organ Transplant Benefit**

*Aflac will pay \$25,000 as a result of a human organ transplant procedure when a covered person is confined in a hospital and receives one or more of the following human organs:*

- Kidney
- Liver
- Heart
- Lung
- Pancreas

Transplant procedures involving more than one organ will be considered one organ transplant procedure. This benefit is not payable for transplants involving mechanical or nonhuman organs and is limited to one procedure per 180-day period. No lifetime maximum.

### **Continuation of Coverage Benefit**

Aflac will waive all monthly premiums due for the policy for two months if you meet all of the following conditions: (1) Your policy has been in force for at least six months; (2) we have received premiums for at least six consecutive months; (3) your premiums have been paid through payroll deduction; (4) you or your employer has notified us in writing within 30 days of the date your premium payments ceased due to your leaving employment; and (5) you re-establish your premium payments through your new employer's payroll deduction process or direct payment to Aflac. You will again become eligible to receive this benefit after you re-establish your premium payments through payroll deduction for a period of at least six months and we receive premiums for at least six consecutive months. *Payroll deduction* means your premium is remitted to Aflac for you by your employer through a payroll deduction process.

**Refer to the policy for complete details, limitations, and exclusions.  
This information is for illustration purposes only.**

**Guaranteed-Renewable**

The policy is guaranteed-renewable for your lifetime with benefits reduced at age 70, subject to Aflac's right to change premiums by class upon any renewal date.

**Family Coverage**

Family coverage includes the insured; spouse; and dependent, unmarried children to age 26. Newborn children are automatically covered under the terms of the policy from the moment of birth. However, children born within ten months of the effective date of the policy will not be covered for any losses or confinements that occur or begin within the first 28 days of life.

**Effective Date**

The effective date is the date shown in the Policy Schedule, not the date you signed the application for coverage. The payroll rate may be retained after one month's premium payment on payroll deduction.

**Limitations and Exclusions**

Benefits payable under the policy will be reduced by one-half for losses that begin on or after the policy anniversary date following the 70th birthday of a covered person. Children born within ten months of the effective date of the policy will not be covered for any losses or confinements that occur or begin within the first 28 days of life. Benefits are not payable for losses or confinements that occur or begin before the policy effective date or after termination of the policy.

The policy does not cover losses caused by or resulting from:

- Intentionally self-inflicting bodily injury or attempting suicide;
- Participating in or attempting to participate in any illegal activity that is classified as a felony, whether charged or not (the term *felony* is as defined by the law of the jurisdiction in which the activity takes place);
- Being exposed to war or any act of war, declared or undeclared, or actively serving in any of the Armed Forces or units auxiliary thereto, including the National Guard or Reserves;
- Having treatment for a mental or nervous disorder or disease; alcoholism or drug dependency; any loss sustained or contracted due, directly or indirectly, to a covered person's being intoxicated or under the influence of alcohol, drugs, or any narcotic unless administered on the advice of a physician and taken according to the physician's instructions (the term *intoxicated* refers to that condition as defined by the law of the jurisdiction in which the injury or cause of the loss occurred);
- Confinement in units such as telemetry or surgical recovery rooms; postanesthesia care units; progressive care units; intermediate care units; private monitored rooms; observation units located in emergency rooms or outpatient surgery units; beds, wards, or private or semiprivate rooms with or without telemetry monitoring equipment; emergency rooms; labor or delivery rooms; or other facilities that do not meet the standards for a hospital intensive care unit or step-down intensive care unit.

A *hospital* does not include any institution, or part thereof, used as an emergency room; a rehabilitation unit; a hospice unit, including any bed designated as a hospice bed or a swing bed; a transitional care unit; a convalescent home; a rest or nursing facility; a psychiatric unit; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial or educational care, care or treatment for persons suffering from mental disease or disorders, care for the aged, or care for persons addicted to drugs or alcohol.

A *physician* does not include a member of your immediate family.

A *hospital intensive care unit* does not include telemetry or surgical recovery rooms, postanesthesia care units, progressive care units, intermediate care units, private monitored rooms, observation units located in emergency rooms or outpatient surgery units, step-down intensive care units, or other facilities that do not meet the standards for a hospital intensive care unit.

A *step-down intensive care unit* does not include telemetry or surgical recovery rooms; observation units located in emergency rooms or outpatient surgery units; postanesthesia care units; beds, wards, or private or semiprivate rooms with or without telemetry monitoring equipment; emergency rooms; or labor or delivery rooms.

## HOSPITAL INTENSIVE CARE PROTECTION

### Hospital Intensive Care Unit Insurance

#### 14-Day Biweekly Premium Rates

	Individual	Named Employee/ Spouse Only	One-Parent Family	Two-Parent Family
Ages 18–35	\$4.80	\$ 9.60	\$ 9.42	\$11.34
Ages 36–45	\$5.22	\$ 9.60	\$ 9.42	\$11.34
Ages 46–55	\$6.30	\$11.70	\$10.32	\$12.66
Ages 56–64	\$7.14	\$14.28	\$13.32	\$15.72

**The rates do not imply coverage.**

**Refer to the policy for complete details, limitations, and exclusions.**

American Family Life Assurance Company of Columbus (Aflac)

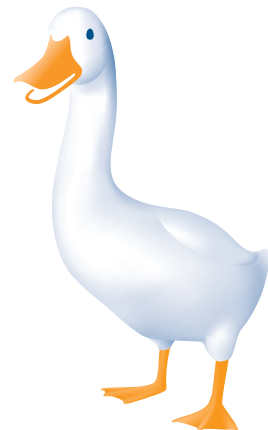
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# *Aflac Personal Sickness Indemnity Plan Hospital Confinement Sickness Indemnity Limited Benefit Insurance*

**Effective Date: October 1, 2008**

**Aflac insurance policies are subject to health underwriting.**

**The following three levels are available:**

- **Policy A-45100-GA (Level 1)**
- **Policy A-45200-GA (Level 2)**
- **Policy A-45300-GA (Level 3)**

*Aflac's Personal Sickness Indemnity policy pays cash benefits directly to you, unless assigned, regardless of any other insurance you may have.*

### **Physician Visits Benefit**

*Aflac will pay the following amount for the level chosen when a covered person incurs a charge for a physician visit. Services must be under the supervision of a physician. This is a health maintenance benefit; the sickness of a covered person is not required for this benefit to be payable. No lifetime maximum.*

	<b>Level 1 A-45100-GA</b>	<b>Level 2 A-45200-GA</b>	<b>Level 3 A-45300-GA</b>
Benefit Amount:	\$15	\$20	\$25
Number of Visits per Year:			
Individual	3	4	4
Family*	6	8	8

Covered physician visits include but are not limited to eye exams, well-baby visits, immunizations, periodic health exams, and routine physicals.

*The following benefits are payable for a covered sickness that occurs while coverage is in force. Treatment or confinement in a U.S. government hospital does not require a charge for benefits to be payable. All of the benefits listed below, except for the Hospital Confinement Benefit, are the same for Levels 1, 2, and 3 (Policies A-45100-GA, A-45200-GA, and A-45300-GA).*

### **Hospital Confinement Benefit**

*Aflac will pay the amount per day for level chosen when a covered person requires hospital confinement for 14 or more hours for a covered sickness and incurs a charge. Benefits are not payable for days beyond the 180th day in a period of hospital confinement.\*\* No lifetime maximum.*

\* Family includes two-parent family, one-parent family, and named insured/ spouse only.

\*\* A period of hospital confinement is the time period of hospital confinement that starts while the policy is in force. If the confinement follows a previously covered confinement, it will be deemed a continuation of the first confinement unless the later confinement is the result of an entirely unrelated sickness or the confinements are separated by 30 days or more.

	<b>Level 1</b> <b>A-45100-GA</b>	<b>Level 2</b> <b>A-45200-GA</b>	<b>Level 3</b> <b>A-45300-GA</b>
Benefit Amount:			
Days 1–15	\$ 50	\$ 75	\$100
Days 16–180	\$100	\$150	\$200

### **Initial Hospitalization Benefit**

*Aflac will pay \$250 per period of hospital confinement\*\* when a covered person is confined to a hospital for at least 24 hours for a covered sickness. This benefit is limited to one payment per calendar year, per covered person. No lifetime maximum.*

### **Major Diagnostic Exams**

*Aflac will pay \$150 when a covered person requires one of the following exams for a covered sickness:*

- CT Scan
- MRI (magnetic resonance imaging)
- EEG (electroencephalogram)
- Thallium stress test
- Myelogram
- Angiogram
- Arteriogram

These exams must be performed in a hospital, doctor's office, or ambulatory surgical center, and a charge must be incurred. This benefit is limited to one payment per calendar year, per covered person. No lifetime maximum.

### **Surgical Benefit**

*Aflac will pay \$100–\$2,000 when a covered person has surgery performed for a covered sickness in a hospital or ambulatory surgical center based upon the Schedule of Operations in the policy. Only one benefit is payable per 24-hour period for surgery even though more than one surgical procedure may be performed. We will pay the highest eligible benefit. Benefits are not payable for cosmetic or elective surgery that is not due to sickness. Surgical Benefits are not payable for surgery performed in a doctor's or dentist's office, clinic, or other such location. Surgery performed but not listed in the schedule will be paid according to the amount shown for the surgery most similar in severity and gravity. No lifetime maximum.*

### **Rehabilitation Unit Benefit**

*Aflac will pay \$50 per day for each day a covered person is charged when confined in a hospital and transferred to a bed in a rehabilitation unit of a hospital for a covered sickness. This benefit is limited to 15 days for each covered person per period of hospital confinement\*\* and is limited to a maximum of 30 days per calendar year. No lifetime maximum.*

The Hospital Confinement and the Rehabilitation Unit Benefits are not payable on the same day. We will pay the highest eligible benefit.

**Ambulance Benefit**

Aflac will pay \$100 for ground ambulance and \$1,000 for air ambulance if, because of a covered sickness, a covered person requires transportation to or from a hospital. A licensed professional ambulance company must provide the ambulance service. This benefit is limited to two trips per calendar year, per covered person. No lifetime maximum.

**Continuation of Coverage Benefit**

Aflac will waive all monthly premiums due for the policy for up to two months if you meet all of the following conditions: (1) Your policy has been in force for at least six months; (2) we have received premiums for at least six consecutive months; (3) your premiums have been paid through payroll deduction and you leave your employer for any reason; (4) you or your employer notifies us in writing within 30 days of the date your premium payments cease because of your leaving employment; and (5) you re-establish premium payments through your new employer's payroll deduction process or direct payment to Aflac. You will again become eligible to receive this benefit after you re-establish your premium payments through payroll deduction for a period of at least six months and we receive premiums for at least six consecutive months. *Payroll deduction* means your premiums are remitted to Aflac for you by your employer through a payroll deduction process.

**Guaranteed-Renewable**

The policy is guaranteed-renewable for your lifetime, subject to Aflac's right to change the applicable table of premium rates by class upon any renewal date.

**Effective Date**

The effective date is the date shown in the Policy Schedule, not the date the application is signed. Payroll rates may be retained after one month's premium payment on payroll deduction.

**Family Coverage**

Family coverage includes the insured; spouse; and dependent, unmarried children under age 19 (or 25 if they are enrolled as full-time students). Newborns are automatically covered under the terms of the policy from the moment of birth. One-parent family coverage includes the insured and all of the insured's unmarried, dependent children under age 19 (or 25 if they are enrolled as full-time students). A dependent child must be under the age of 19 at the time of application to be eligible for coverage.

**Pre-Existing Conditions**

A *pre-existing condition* is a sickness for which, within the 12-month period before the effective date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Care or treatment caused by a pre-existing condition will not be covered during the first six months after the effective date of coverage.

**Refer to the policy for complete details, limitations, and exclusions.  
This information is for illustration purposes only.**

A *sickness* is an illness, disease, or disorder diagnosed or treated 30 days or more after the effective date of coverage and while coverage is in force. Illnesses, diseases, or disorders that are diagnosed or treated within the 30-day waiting period will not be covered for six months from the effective date of coverage.

### **Limitations and Exclusions**

The sickness benefits of the policy are subject to a 30-day waiting period. Any sickness medically treated or diagnosed before coverage has been in force 30 days from the effective date of coverage will not be covered unless the loss begins more than six months after the effective date of coverage. Other than the Physician Visits Benefit, we will not pay benefits for losses incurred as a result of an injury. We will not pay benefits for a covered person's giving birth within the first ten months of the effective date of the policy as a result of a normal pregnancy, including cesarean (complications of pregnancy\* will be covered to the same extent as a sickness). EXCEPTION: Newborn children born within the first ten months of the policy effective date will be subject to a 30-day waiting period.

The policy does not cover losses caused by or resulting from:

- Receiving dental care or treatment;
- Intentionally self-inflicting bodily injury or attempting suicide;
- Participating in or attempting to participate in any illegal activity that is classified as a felony, whether charged or not (the term *felony* is as defined by the law of the jurisdiction in which the activity takes place);
- Being exposed to war or any act of war, declared or undeclared, or serving in the Armed Forces;
- Having treatment for a mental or nervous disorder or disease, including depression; alcoholism or drug dependency; sustaining or contracting any loss because of a covered person's being intoxicated or under the influence of alcohol, drugs, or any narcotic unless administered on the advice of a physician and taken according to the physician's instructions (the term *intoxicated* refers to that condition as defined by the law of the jurisdiction in which the injury or cause of the loss occurred);
- Having cosmetic surgery or elective surgery that is not due to sickness;
- Obtaining routine nursing or routine well-baby care for a newborn child (other than provided by the Physician Visits Benefit);
- Donating an organ within the first 12 months of the effective date of the policy.

*Hospital* does not include any institution, or part thereof, used as an ambulatory surgical center; a hospice unit (including any bed designated as a hospice bed or a swing bed); a convalescent home; a rest or nursing facility; a psychiatric unit; a rehabilitation unit; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial care, educational care, or care or treatment

for persons suffering from mental disease or disorders, or care for the aged, drug addicts, or alcoholics. Benefits for confinement in a rehabilitation unit are payable under the Rehabilitation Unit Benefit.

A *physician* does not include a member of your immediate family.

An *ambulatory surgical center* does not include a doctor's or dentist's office, clinic, or other such location.

\**Complications of pregnancy* do not include false labor, occasional spotting, physician-prescribed rest during pregnancy, morning sickness, and similar conditions associated with the management of a difficult pregnancy not constituting a classifiably distinct complication of pregnancy. Cesarean deliveries are not considered complications of pregnancy.

**PERSONAL SICKNESS INDEMNITY PLAN**  
**Hospital Confinement Sickness Indemnity**  
**Limited Benefit Insurance**

**14-Day Biweekly Premium Rates\***

	<b>Ages</b>	<b>Level 1</b>
Individual	18–39	\$ 9.18
	40–49	\$10.43
	50–59	\$12.97
	60–64	\$18.05
Named Insured/Spouse Only	18–39	\$16.75
	40–49	\$18.18
	50–59	\$22.89
	60–64	\$31.34
One-Parent Family	18–39	\$14.91
	40–49	\$15.60
	50–59	\$17.49
	60–64	\$21.28
Two-Parent Family	18–39	\$18.42
	40–49	\$20.35
	50–59	\$24.83
	60–64	\$32.35

\*Premium rates for Levels 2 or 3 available upon request

**The rates do not imply coverage.**  
**Refer to the policy for complete details, limitations, and exclusions.**

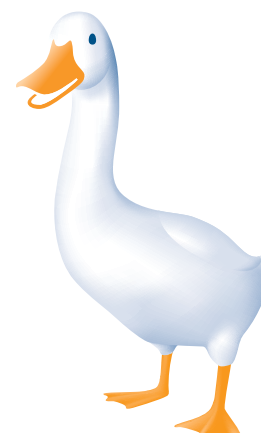
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# *Aflac Specified Health Event Protection Plan*

## *Specified Health Event Insurance*

### *Plan 2 – Policy A71200GA*

**Effective Date: October 1, 2008**

**Aflac insurance policies are subject to health underwriting.**

*The Specified Health Event Protection Policy provides hospital intensive care coverage for sickness and injury, and provides specified health event coverage for critical illness. Some benefits are payable for both hospital intensive care and specified health events, and some benefits apply only to specified health events. Some benefits reduce at age 70. Read each benefit carefully.*

#### **BENEFITS FOR HOSPITAL INTENSIVE CARE UNIT CONFINEMENTS**

##### **Hospital Intensive Care Unit Benefit**

*Aflac will pay the following benefits when a covered person incurs a charge for confinement in a hospital intensive care unit or a step-down intensive care unit for a covered sickness or injury:*

Confinement in a Hospital Intensive Care Unit:

	Sickness	Injury
Days 1–7	\$ 700 per day	\$ 800 per day
Days 9–15	\$1,200 per day	\$1,300 per day

This benefit is limited to 15 days per period of confinement. No lifetime maximum.

Confinement in a Step-Down Intensive Care Unit:

*Aflac will pay benefits for confinement in a step-down intensive care unit after exhaustion of benefits paid for confinement in a hospital intensive care unit or for Days 1–15 of a step-down intensive care unit confinement. This benefit is limited to 15 days per period of confinement. No lifetime maximum.*

	Sickness	Injury
Days 1–15 (Step-Down Intensive Care Unit)	\$350 per day	\$350 per day
or		
Days 16–30 (Hospital Intensive Care Unit)	\$350 per day	\$350 per day

Benefits payable for confinement in a hospital intensive care unit or for confinement in a step-down intensive care unit are not payable on the same day. If a covered person is charged for both on the same day, only the highest eligible benefit will be paid. Treatment or confinement in a U.S. government hospital does not require a charge for benefits to be payable. Benefits reduce by one-half for losses incurred on or after the policy anniversary date following the 70th birthday of a covered person.

**American Family Life Assurance Company of Columbus (Aflac)**

*Hospital intensive care units* include cardiac intensive care units and infant (neonatal) intensive care units. Hospital intensive care units do not provide benefits for telemetry or surgical recovery rooms, postanesthesia care units, progressive care units, intermediate care units, private monitored rooms, observation units located in emergency rooms or outpatient surgery units, step-down intensive care units, or other facilities that do not meet the standards for a hospital intensive care unit.

*Step-down intensive care units* do not provide benefits for telemetry or surgical recovery rooms; observation units located in emergency rooms or outpatient surgery units; postanesthesia care units; beds, wards, or private or semiprivate rooms with or without telemetry monitoring equipment; or emergency rooms, labor rooms, or delivery rooms.

### **Progressive Benefit for Hospital Intensive Care Unit/Step-Down Intensive Care Unit Confinement**

A \$2 indemnity will accumulate for the named insured and the covered spouse for each calendar month the policy remains in force after the effective date. This accumulated indemnity, if any, will be paid in addition to any benefits paid under the Hospital Intensive Care Unit Benefit. This progressive benefit will cease to build on the policy anniversary date following the 65th birthday of a covered person. Any amount accrued at the time this benefit ceases to build for a covered person will continue to be added to the benefit amount for all hospital intensive care unit/step-down intensive care unit confinements commencing prior to the policy anniversary date following the 70th birthday of a covered person. This accumulated benefit will be reduced by one-half for hospital intensive care unit/step-down intensive care unit confinements commencing on or after the policy anniversary date following the 70th birthday of a covered person. This benefit is not applicable and will not accrue to any covered person who has attained age 65 prior to the effective date of the policy. The named insured and covered spouse, if any, are the only persons eligible for this benefit. Dependent children do not qualify for this benefit. When a spouse is added to an existing policy, this benefit will begin to accrue from the endorsement date adding such spouse, provided the spouse has not yet attained age 65.

### **Benefits for Primary Specified Health Events**

Primary specified health events covered by the Specified Health Event Protection policy include:

- Coma
- Stroke
- Paralysis
- Heart Attack
- End-Stage Renal Failure
- Major Third-Degree Burns
- Persistent Vegetative State
- Coronary Artery Bypass Surgery
- Major Human Organ Transplant

**First-Occurrence Benefit**

*Aflac will pay \$5,000 for the named insured and spouse or \$7,500 for each dependent child covered under the policy when he or she is first diagnosed as having had a primary specified health event. This benefit is paid only once for each covered person and will be paid in addition to any other benefit in the policy. This benefit is intended to pay for accident and sickness expenses relating to covered primary specified health events. Lifetime maximum is \$5,000 per named insured and spouse, and \$7,500 per dependent child.*

**Reoccurrence Benefit**

*Aflac will pay \$2,500 if benefits have been paid to a covered person under the First-Occurrence Benefit and if such covered person is later diagnosed as having had a subsequent primary specified health event.*

For the Reoccurrence Benefit to be payable, the primary specified health event must occur more than 180 days after the date the First-Occurrence Benefit or the Reoccurrence Benefit becomes payable. No lifetime maximum.

**Hospital Confinement Benefit\***

*Aflac will pay \$300 per day for each day a covered person is charged as an inpatient and requires hospital confinement for the treatment of a covered primary specified health event. This benefit is limited to confinements for the treatment of a covered primary specified health event that occurs within 500 days following the occurrence of the most recent covered primary specified health event. This benefit is payable for only one covered primary specified health event at a time per covered person. This benefit includes confinement in a U.S. government hospital, and such treatment or confinement does not require a charge for benefits to be payable. No lifetime maximum.*

**Continuing Care Benefit\***

*Aflac will pay \$125 each day a covered person is charged for receiving any of the following treatments from a licensed physician as the result of a covered primary specified health event:*

- Dialysis
- Hospice Care
- Extended Care
- Physician Visits
- Speech Therapy
- Physical Therapy
- Home Health Care
- Nursing Home Care
- Respiratory Therapy
- Occupational Therapy
- Rehabilitation Therapy
- Dietary Therapy/Consultation

Treatment is limited to 60 days for continuing care received within 180 days following the occurrence of the most recent covered primary specified health event. Daily maximum for this benefit is \$125 regardless of the number of treatments received. No lifetime maximum.

\*If the Hospital Confinement Benefit and the Continuing Care Benefit are payable on the same day, only the highest eligible benefit will be paid.

### **Transportation Benefit**

*Aflac will pay 50 cents per mile for noncommercial travel or the costs incurred for commercial travel (coach class plane, train, or bus fare) for transportation of a covered person for the round-trip distance between the hospital or medical facility and the residence of the covered person, if a covered person requires special medical treatment that has been prescribed by the local attending physician for a covered primary specified health event. This benefit is not payable for transportation by ambulance or air ambulance to the hospital. Reimbursement will be made only for the method of transportation actually taken. This benefit will be paid only for the covered person for whom the special treatment is prescribed. If the special treatment is for a dependent child and commercial travel is necessary, Aflac will pay this benefit for up to two adults to accompany the dependent child. The benefit amount payable is limited to \$1,500 per occurrence of a covered primary specified health event. Transportation benefits are not payable beyond the 180th day following the occurrence of a covered primary specified health event. This benefit is not payable for transportation to any hospital located within a 50-mile radius of the residence of the covered person. No lifetime maximum.*

### **Lodging Benefit**

*Aflac will pay the charges incurred up to \$75 per day for lodging for you or any one adult family member when a covered person receives special medical treatment for a covered primary specified health event at a hospital or medical facility. The hospital, medical facility, and lodging must be more than 50 miles from the covered person's residence. This benefit is not payable for lodging occurring more than 24 hours prior to treatment or for lodging occurring more than 24 hours following treatment. This benefit is limited to 15 days per occurrence of a covered primary specified health event. Lodging benefits are not payable beyond the 180th day following the occurrence of a covered primary specified health event. No lifetime maximum.*

The Continuing Care Benefit, Transportation Benefit, and Lodging Benefit will be paid for care received within 180 days following the occurrence of a covered primary specified health event. Benefits are payable for only one covered primary specified health event at a time per covered person. If a covered person is eligible to receive benefits for more than one covered primary specified health event, we will pay benefits only for care received within the 180 days following the occurrence of the most recent event.

## **BENEFIT FOR SECONDARY SPECIFIED HEALTH EVENTS**

### **Secondary Specified Health Event Benefit**

*Aflac will pay \$250 for each covered person under the policy when he or she has a coronary angioplasty, with or without stents. This benefit is limited to one coronary angioplasty per 30-day period. No lifetime maximum.*

## MISCELLANEOUS BENEFITS

### Major Human Organ Transplant Benefit

*Aflac will pay \$25,000* as a result of a major human organ transplant procedure when a covered person is confined in a hospital and receives one or more of the following human organs:

- Lung
- Heart
- Liver
- Pancreas
- Kidney

Transplant procedures involving more than one major organ will be considered one organ transplant procedure. This benefit is not payable for transplants involving mechanical or nonhuman organs and is limited to one procedure per 180-day period. Benefits reduce by one-half for losses incurred on or after the policy anniversary date following the 70th birthday of a covered person. No lifetime maximum.

### Ambulance Benefit

*Aflac will pay \$250* if, due to a covered primary specified health event or confinement in a hospital intensive care unit or a step-down intensive care unit for a covered sickness or injury, a covered person requires ground ambulance transportation to or from a hospital. *Aflac will pay \$2,000* if air ambulance transportation is required due to a covered primary specified health event for a covered sickness or injury, or for confinement in a hospital intensive care unit or a step-down intensive care unit. A licensed professional or licensed volunteer ambulance company must provide the ambulance service. This benefit will not be paid for more than two times per occurrence of a primary specified health event or confinement in a hospital intensive care unit or step-down intensive care unit for a covered sickness or injury. Ambulance benefits are not payable beyond the 180th day following the occurrence of a covered primary specified health event. No lifetime maximum.

### Waiver of Premium Benefit

If you, due to a primary specified health event, are completely unable to do all of the usual and customary duties of your occupation [if you are not employed: are completely unable to perform three or more of the activities of daily living (ADLs) without the assistance of another person] for a period of 90 continuous days, Aflac will waive, from month to month, any premiums falling due during your continued inability. For premiums to be waived, Aflac will require an employer's statement (if applicable) and a physician's statement of your inability to perform said duties, and may each month thereafter require a physician's statement that total inability continues.

### Continuation of Coverage Benefit

Aflac will waive all monthly premiums due for the policy and riders for two months if you meet all of the following conditions: (1) Your policy has been in force for at least six months; (2) we have received premiums for at least six consecutive months; (3) your premiums have been paid through payroll deduction; (4) you or your employer has notified us in writing within 30 days of the date your premium payments ceased due to your leaving employment; and

(5) you re-establish your premium payments through your new employer's payroll deduction process or direct payment to Aflac. You will again become eligible to receive this benefit after you re-establish your premium payments through payroll deduction for a period of at least six months and we receive premiums for at least six consecutive months. *Payroll deduction* means your premium is remitted to Aflac for you by your employer through a payroll deduction process.

### **Definitions**

*The following specified health events must occur after the effective date of coverage for benefits to be payable:*

**Primary Specified Health Event:** heart attack, stroke, coronary artery bypass surgery, end-stage renal failure, major human organ transplant, major third-degree burns, persistent vegetative state, coma, or paralysis.

**Coma:** a continuous state of profound unconsciousness, diagnosed or treated after the effective date of the policy, lasting for a period of seven or more consecutive days and characterized by the absence of (1) spontaneous eye movement, (2) response to painful stimuli, and (3) vocalization. The condition must require intubation for respiratory assistance.

**Coronary Artery Bypass Surgery:** open-heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts, excluding procedures such as but not limited to coronary angioplasty, laser relief, or other nonsurgical procedures. This does not include valve replacement surgery.

**End-Stage Renal Failure:** permanent and irreversible kidney failure, not of an acute nature, requiring dialysis or a kidney transplant to maintain life.

**Heart Attack:** a myocardial infarction, coronary thrombosis, or coronary occlusion that is diagnosed or treated after the effective date of the policy. The attack must be positively diagnosed by a physician and must be evidenced by electrocardiographic findings or clinical findings together with blood enzyme findings. The definition of *heart attack* will not be construed to mean congestive heart failure, atherosclerotic heart disease, angina, coronary artery disease, or any other dysfunction of the cardiovascular system.

**Major Human Organ Transplant:** a surgery in which a covered person receives, as a result of a surgical transplant, one or more of the following human organs: kidney, liver, heart, lung, or pancreas. It does not include transplants involving mechanical or nonhuman organs.

**Major Third-Degree Burns:** an area of tissue damage in which there is destruction of the entire epidermis and underlying dermis and that covers more than 10 percent of total body surface. The damage must be caused by heat, electricity, radiation, or chemicals.

**Paralysis:** spinal cord injuries resulting in complete and total loss of use of two or more limbs (paraplegia, quadriplegia, or hemiplegia) for a continuous period of at least 30 days. The paralysis must be confirmed by your attending physician.

**Persistent Vegetative State:** a state of severe mental impairment in which only involuntary bodily functions are present and for which there exists no reasonable expectation of regaining significant cognitive function. The procedure for establishing a persistent vegetative state is as follows: two physicians, one of whom must be the attending physician, who, after personally examining the covered person, will certify in writing, based upon conditions found during the course of their examination, that (1) the covered person's cognitive function has been substantially impaired, and (2) there exists no reasonable expectation that the covered person will regain significant cognitive function.

**Secondary Specified Health Event:** coronary angioplasty, with or without stents, occurring after the effective date of coverage.

**Stroke:** apoplexy due to rupture or acute occlusion of a cerebral artery that is diagnosed or treated after the effective date of the policy. The apoplexy must cause complete or partial loss of function involving the motion or sensation of a part of the body and must last more than 24 hours. The stroke must be positively diagnosed by a physician based upon documented neurological deficits and confirmed by neuroimaging studies. *Stroke* does not mean head injury, transient ischemic attack (TIA), or cerebrovascular insufficiency.

#### **Guaranteed-Renewable**

The policy is guaranteed-renewable for your lifetime, with some benefits reduced at age 70, subject to Aflac's right to change premiums by class upon any renewal date.

#### **Family Coverage**

Family coverage includes the insured; spouse; and dependent, unmarried children to age 26. Newborn children are automatically insured as any other family member. One-parent family coverage includes the insured and dependent, unmarried children to age 26.

#### **Effective Date**

The effective date is the date shown in the Policy Schedule, not the date you signed the application for coverage. The payroll rate may be retained after one month's premium payment on payroll deduction.

#### **Pre-Existing Conditions**

A *pre-existing condition* is an illness, disease, disorder, or injury for which, within the six-month period before the effective date of coverage, medical advice, consultation, or treatment was recommended by or received from a physician. Benefits for a primary or secondary specified health event that is caused by a pre-existing condition will not be covered if the primary or secondary specified health event occurs during the first 30 days after the effective date. Any reoccurrence of a primary or secondary specified health event occurring more than 30 days after the effective date will be covered. The pre-existing condition DOES NOT apply to hospital intensive care benefits.

**Refer to the policy for complete details, limitations, and exclusions.  
This information is for illustration purposes only.**

## Limitations and Exclusions

Benefits payable under the Hospital Intensive Care Unit Benefit, Progressive Benefit for Hospital Intensive Care Unit/Step-Down Intensive Care Unit Confinement, and the Major Human Organ Transplant Benefit of the policy will be reduced by one-half for losses that begin on or after the policy anniversary date following the 70th birthday of a covered person.

Children born within ten months of the effective date of the policy will not be covered for any losses or confinements payable under the Hospital Intensive Care Unit Benefit, Progressive Benefit for Hospital Intensive Care Unit/Step-Down Intensive Care Unit Confinement, or the Major Human Organ Transplant Benefit that occur or begin during the first 28 days of life.

Benefits are not payable under the Hospital Intensive Care Unit Benefit or the Progressive Benefit for Hospital Intensive Care Unit/Step-Down Intensive Care Unit Confinement for confinement in units such as telemetry or surgical recovery rooms, postanesthesia care units, progressive care units, intermediate care units, private monitored rooms, observation units located in emergency rooms or outpatient surgery units, or other facilities that do not meet the standards for a hospital intensive care unit or step-down intensive care unit.

Benefits are not payable for losses or confinements that begin or occur before the policy effective date or after termination of the policy.

Benefits for a primary or secondary specified health event that is caused by a pre-existing condition will not be covered if the primary or secondary specified health event occurs during the first 30 days after the effective date. Benefits are payable for only one covered primary or secondary specified health event at a time per covered person.

The policy does not cover losses or confinements caused by or resulting from a covered person's:

- Participating in any sport or sporting activity for wage, compensation, or profit;
- Intentionally self-inflicting bodily injury or attempting suicide;
- Being exposed to war or any act of war, declared or undeclared, or actively serving in any of the Armed Forces or units auxiliary thereto, including the National Guard or Reserves;
- Participating in or attempting to participate in any illegal activity that is classified as a felony, whether charged or not (the term *felony* is as defined by the law of the jurisdiction in which the activity takes place);
- Having treatment for a mental or nervous disorder or disease;
- Sustaining or contracting any loss due, directly or indirectly, to being intoxicated or under the influence of alcohol, drugs, or any narcotic unless administered on the advice of a physician and taken according to the physician's instructions (the term *intoxicated* refers to that condition as defined by the law of the jurisdiction in which the injury or cause of the loss occurred).

*Hospital* does not include any institution or part thereof used as an emergency room; a rehabilitation unit; a hospice unit, including any bed designated as a hospice bed or a swing bed; a transitional care unit; a convalescent home; a rest or nursing facility; a psychiatric unit; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial or educational care, care or treatment for persons suffering from mental disease or disorders, care for the aged, or care for persons addicted to drugs or alcohol.

A *physician* does not include a member of your immediate family.

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**Please ask your Aflac agent about the riders available with this coverage at an additional cost. The riders are:**

- Optional Primary Specified Health Event Recovery Benefit Rider
- Optional First-Occurrence Building Benefit Rider

**SPECIFIED HEALTH EVENT PROTECTION**  
**Specified Health Event Insurance – Plan 2**

**14-Day Biweekly Premium Rates**

	<b>Ages</b>	<b>Plan 2</b>
<b>Individual</b>	18–35	\$ 7.56
	36–45	\$10.80
	46–55	\$14.70
	56–64	\$18.96
<b>Named Insured/Spouse Only</b>	18–35	\$14.58
	36–45	\$18.96
	46–55	\$25.50
	56–64	\$35.52
<b>One-Parent Family</b>	18–35	\$12.96
	36–45	\$15.24
	46–55	\$19.62
	56–64	\$25.80
<b>Two-Parent Family</b>	18–35	\$16.56
	36–45	\$21.00
	46–55	\$28.08
	56–64	\$38.58

**The rates do not imply coverage.**  
**Refer to the policy for complete details, limitations, and exclusions.**

American Family Life Assurance Company of Columbus (Aflac)

Worldwide Headquarters

1932 Wynnton Road

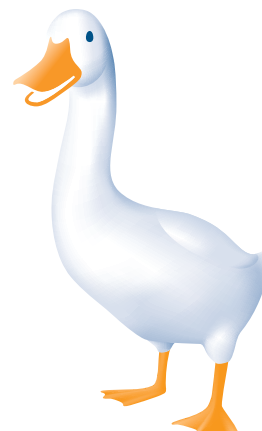
Columbus, Georgia 31999

1.800.99.AFLAC (1.800.992.3522)

En español:

1.800.SI.AFLAC (1.800.742.3522)

**Visit our Web site at [aflac.com](http://aflac.com).**



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***Aflac's Maximum Difference<sup>SM</sup> Plan***  
***Cancer Indemnity Insurance - Policy A76100GA***  
***Optional Initial Diagnosis Benefit Rider Summary - Rider A76050***  
***Optional Cancer Screening and Annual Care Benefit Rider Summary - Rider A76051***

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**Effective Date: October 1, 2008**

**Aflac insurance policies are subject to health underwriting.**

**As long as cancer is in this world,  
Aflac will innovate to fight it.**

*The fight against cancer has evolved. Aflac's coverage has as well.*

In 1958, Aflac introduced its first cancer policy. The goal was to help protect individuals and their families from the damage that cancer can do both physically and financially. By paying cash benefits to its policyholders, unless they designated otherwise, Aflac's coverage provided a level of freedom that many major medical insurance companies simply could not.

Today, millions of individuals and families are still battling cancer, but the fight has changed in many ways. Advances in pharmaceuticals, surgical procedures, and alternative treatments have improved the odds for those diagnosed with the disease. But with improved treatments, increased costs have arrived as well. Aflac's new Maximum Difference policy addresses these concerns with new benefits that reflect the new directions in which America's battle against this tenacious foe is headed.

The Maximum Difference policy continues Aflac's goal of providing groundbreaking coverage at affordable rates. One day, cancer will cease to be a threat. Until then, there's Aflac.

**American Family Life Assurance Company of Columbus (Aflac)**

# Understanding the Risk

**Despite the best efforts of doctors, researchers, and countless organizations, cancer remains a concern for many individuals and families. People from all walks of life are at risk regardless of age, sex, or ethnic background. Here are a few statistics to help you understand the role cancer plays in America's overall health. According to the American Cancer Society:\***

- In the United States, men have slightly less than a 1-in-2 lifetime risk of developing cancer; for women the risk is a little more than 1-in-3.
- About 1,444,920 new cancer cases were expected to be diagnosed in 2007.
- An estimated 10,400 new cases were expected to occur among children ages 0–14 in 2007.

**Advances in treatment also mean that Americans diagnosed with cancer are living longer than ever. The five-year relative survival rate for all cancers combined between 1996 and 2002 is 66 percent, up from 50 percent in 1975–77.\***

Although major medical insurance can help with the costs of cancer treatment, you still may have to cover deductibles and copayments on your own. Additionally, cancer treatment can necessitate out-of-pocket expenses that aren't covered by major medical insurance, including travel, food, lodging, long-distance calls, child care, and household help.

Meanwhile, living expenses such as car payments, mortgages or rent, and utility bills continue, whether or not you are able to work. If a family member has to stop working to take care of you, the loss of income may be doubled.

By paying cash benefits directly to you, unless you choose otherwise, Aflac's Maximum Difference<sup>SM</sup> policy allows you the freedom to use those funds as you see fit, helping you with the financial consequences of cancer that may not be covered by major medical insurance.

\*Cancer Facts and Figures 2007, American Cancer Society.

## Quick-Reference Chart of Benefits Information

Benefits are paid only for Covered Persons who receive Physician-prescribed treatment approved by the National Cancer Institute (NCI) or the Food and Drug Administration for Cancer (unless stated otherwise) or an Associated Cancerous Condition, as applicable. To be payable, the benefits listed below require a charge to be incurred for the applicable treatment or service, except for the Experimental Treatment Benefit (as detailed below), the Hospital Confinement Benefit (when confined in a U.S. government hospital), and the Hospice Care Benefit.

### DIRECT NONSURGICAL TREATMENT BENEFITS

Benefits are payable the calendar week or calendar month, as applicable, during which a Covered Person receives and incurs a charge for the applicable treatment. Benefits will not be paid for each week of continuous infusion of medications dispensed by pump, implant, or patch. Benefits will not be paid for each week a radium implant or radioisotope remains in the body. The Initial Treatment, Injected Chemotherapy, Radiation Therapy, and Experimental Treatment Benefits are not payable based on the number, duration, or frequency of the medication(s), therapy, or treatment received by the Covered Person.

#### **Initial Treatment Benefit:**

- Benefit Amount – \$3,000
- Lifetime Maximum Per Insured – \$3,000

Payable the first time Radiation Therapy, Injected Chemotherapy, or Oral Chemotherapy Benefits are received.

#### **Injected Chemotherapy Benefit:**

- Benefit Amount – \$900 once per calendar week
- Lifetime Maximum Per Insured – None

Limited to the calendar week in which the charge for medication(s) or treatment is incurred.

#### **Oral Chemotherapy Benefit:**

- Benefit Amount – *Nonhormonal* – \$400 per medication, per calendar month  
*Hormonal* – \$400 per medication, per calendar month up to 24 months or \$100 per medication, per calendar month after 24 months of paid benefits of hormonal oral chemotherapy
- Lifetime Maximum Per Insured – None

Total benefits (nonhormonal and hormonal) are payable for up to three different medications per calendar month, up to a maximum of \$1,200 per calendar month. Oral Chemotherapy Benefits are limited to the calendar month in which the charge for the medication(s) or treatment is incurred. Refills within the same calendar month are not considered a different chemotherapy medicine. Examples of hormonal oral chemotherapy are Nolvadex, Arimidex, Femara, and Lupron or generic versions such as Tamoxifen.

**Radiation Therapy Benefit:**

- Benefit Amount – \$500 once per calendar week
- Lifetime Maximum Per Insured – None

Benefit is limited to the calendar week in which the charge for the therapy is incurred.

**Experimental Treatment Benefit:**

- Benefit Amount – \$500 once per calendar week if charge incurred; \$125 once per calendar week if no charge incurred for inclusion in a clinical trial
- Lifetime Maximum Per Insured – None

Benefit does not pay for laboratory tests, diagnostic X-rays, immunoglobulins, immunotherapy, colony-stimulating factors, and therapeutic devices or other procedures related to these experimental treatments. Benefit is limited to the calendar week in which the charge for the treatment is incurred, if there is a charge.

**INDIRECT/ADDITIONAL THERAPY BENEFITS**

The Immunotherapy and Anti-Nausea Benefits are not payable based on the number, duration, or frequency of immunotherapy or anti-nausea drugs received by the Covered Person. The Immunotherapy and Anti-Nausea Benefits are limited to the calendar month in which a Covered Person receives and incurs a charge for the applicable treatment.

**Immunotherapy Benefit:**

- Benefit Amount – \$500 once per calendar month
- Lifetime Maximum Per Insured – \$2,500

Benefit is payable for an immunotherapy treatment regimen for Internal Cancer or an Associated Cancerous Condition. Not payable for medications paid under the Injected Chemotherapy, Oral Chemotherapy, Radiation Therapy, or Experimental Treatment Benefits.

**Anti-Nausea Benefit:**

- Benefit Amount – \$150 once per calendar month
- Lifetime Maximum Per Insured – None

Anti-nausea drugs must be prescribed while receiving Radiation Therapy Benefits, Injected or Oral Chemotherapy Benefits, or Experimental Treatment Benefits.

**Stem Cell Transplantation Benefit:**

- Benefit Amount – \$10,000
- Lifetime Maximum Per Insured – \$10,000

Payable for a peripheral stem cell transplantation for the treatment of Internal Cancer or an Associated Cancerous Condition. Does not include bone marrow transplantations.

**Bone Marrow Transplantation Benefit:**

- Benefit Amount – \$10,000 for Covered Person  
\$1,000 for Donor
- Lifetime Maximum Per Insured – \$10,000

Payable for a bone marrow transplantation for the treatment of Internal Cancer or an Associated Cancerous Condition. Donor benefit is payable to the Covered Person's bone marrow donor for expenses incurred as a result of the transplantation procedure. Does not include stem cell transplantations.

### **Blood and Plasma Benefit:**

- Benefit Amount – *Inpatient* – \$150 times the number of days paid under the Hospital Confinement Benefit

*Outpatient* – \$250 per day

- Lifetime Maximum Per Insured – None

Inpatient benefit is payable for blood and/or plasma transfusions during a covered Hospital confinement. Outpatient benefit is payable for blood and/or plasma transfusions for the treatment of Internal Cancer or an Associated Cancerous Condition as an outpatient in a Physician's office, clinic, Hospital, or Ambulatory Surgical Center. Does not pay for immunoglobulins, immunotherapy, antihemophilia factors, or colony-stimulating factors.

## **SURGICAL TREATMENT BENEFITS**

### **Surgical/Anesthesia Benefit:**

- Benefit Amount – \$140–\$5,000 (based on Schedule of Operations listed in the policy); 25 percent of the benefit amount shown in the Schedule of Operations will be paid for the administration of anesthesia during a covered surgical operation.

- Lifetime Maximum Per Insured – None

The maximum (Surgical/Anesthesia) daily benefit will not exceed \$6,250. Payable when a surgical operation is performed for a diagnosed Internal Cancer or an Associated Cancerous Condition. If any operation for the treatment of Internal Cancer or an Associated Cancerous Condition is performed other than those listed, Aflac will pay an amount comparable to the amount shown in the Schedule of Operations for the operation most nearly similar in severity and gravity. Two or more surgical procedures performed through the same incision will be considered one operation, and benefits will be paid based on the highest eligible benefit.

### **Skin Cancer Surgery Benefit:**

- Benefit Amount – \$50–\$600
- Lifetime Maximum Per Insured – None

Payable when a surgical operation is performed for a diagnosed skin Cancer, including melanoma or Nonmelanoma Skin Cancer. The indemnity amount includes anesthesia services. Maximum daily benefit: \$600.

## **HOSPITALIZATION BENEFITS**

### **Hospital Confinement Benefit:**

- Benefit Amount – *Days 1–30* – Named Insured/Spouse – \$300 per day  
Dependent Child – \$375 per day  
*Days 31+* – Named Insured/Spouse – \$600 per day  
Dependent Child – \$750 per day

- Lifetime Maximum Per Insured – None

For hospitalization of 30 days or less, Aflac will pay benefits for each day a Covered Person is confined to a Hospital for treatment and is charged for a room as an inpatient. During any continuous period of Hospital confinement for 31 days or more, Aflac will pay benefits as described for the first 30 days. Beginning with the 31st day of such continuous Hospital confinement, benefits for Days 31+ will be payable for each day a Covered Person is charged for a room as an inpatient. No charge is required for confinement in a U.S. government Hospital.

### **Outpatient Hospital Surgical Room Charge Benefit:**

- Benefit Amount – \$300 per day
- Lifetime Maximum Per Insured – None

Payable when a surgical operation is performed for treatment of a diagnosed Internal Cancer or an Associated Cancerous Condition. Benefit is not payable for any surgery performed in a Physician's office. Surgery must be performed on an outpatient basis in a Hospital or an Ambulatory Surgical Center. Benefit is payable once per day and is not payable on the same day as the Hospital Confinement Benefit. Benefit is payable in addition to the Surgical/Anesthesia Benefit. Benefit is also payable for Nonmelanoma Skin Cancer surgery involving a flap or graft. Maximum daily benefit: \$300.

## **CONTINUING CARE BENEFITS**

### **Extended-Care Facility Benefit:**

- Benefit Amount – \$150 per day
- Lifetime Maximum Per Insured – None

Payable when hospitalized and receiving Hospital Confinement Benefits and later confined, within 30 days of the covered Hospital confinement, to an Extended-Care Facility, a skilled nursing facility, a rehabilitation unit or facility, a transitional care unit or any bed designated as a swing bed, or to a section of the Hospital used as such (an *Extended-Care Facility*). For each day this benefit is payable, Hospital Confinement Benefits are NOT payable. If more than 30 days separates confinements in an Extended-Care Facility, benefits are not payable for the second confinement unless the Covered Person again receives Hospital Confinement Benefits and is confined as an inpatient to the Extended-Care Facility within 30 days of that confinement. Benefits are limited to 30 days per calendar year, per Covered Person.

### **Home Health Care Benefit:**

- Benefit Amount – \$150 per visit (Limit of ten visits per hospitalization and 30 visits per calendar year for each Covered Person)
- Lifetime Maximum Per Insured – None

Payable when hospitalized for the treatment of Internal Cancer or an Associated Cancerous Condition and then has either home health care or health supportive services provided by a licensed, certified, or duly qualified person, other than an immediate family member. Visits must begin within seven days of release from the Hospital. Benefit will not be payable unless the attending Physician prescribes such services to be performed in the home of the Covered Person and certifies that if these services were not available, the Covered Person would have to be hospitalized to receive the necessary care, treatment, and services. Benefit is not payable the same day the Hospice Care Benefit is payable.

### **Hospice Care Benefit:**

- Benefit Amount – *Day 1* – \$1,000 (one-time benefit)  
*Additional Days* – \$50 per day
- Lifetime Maximum Per Insured – \$12,000

Payable when diagnosed with Internal Cancer or an Associated Cancerous Condition

**The policy has limitations that may affect benefits payable.  
See the policy for complete details, limitations, and exclusions.  
This information is for illustration purposes only.**

and therapeutic intervention directed toward the cure of the disease is medically determined to be no longer appropriate. Medical prognosis must be one in which there is a life expectancy of six months or less as the direct result of Internal Cancer or an Associated Cancerous Condition. Benefit is not payable the same day the Home Health Care Benefit is payable.

**Nursing Services Benefit:**

- Benefit Amount – \$150 per day
- Lifetime Maximum Per Insured – None

Payable while confined in a Hospital and requires full-time private care and attendance by private nurses (other than an immediate family member) for services other than those regularly furnished by the Hospital. Benefit is limited to the number of days the Hospital Confinement Benefit is payable.

**Surgical Prosthesis Benefit:**

- Benefit Amount – \$3,000
- Lifetime Maximum Per Insured – \$6,000

Surgically implanted prosthetic devices must be prescribed as a direct result of surgery for Internal Cancer or an Associated Cancerous Condition treatment. Benefit does not include coverage for tissue expanders or a breast transverse rectus abdominis myocutaneous (TRAM) flap.

**Prosthesis Nonsurgical Benefit:**

- Benefit Amount – \$250 per occurrence
- Lifetime Maximum Per Insured – \$500

Nonsurgically implanted prosthetic devices (such as voice boxes, hairpieces, and removable breast prostheses) must be prescribed as a direct result of treatment for Internal Cancer or an Associated Cancerous Condition.

**Reconstructive Surgery Benefit:**

- Benefit Amount – \$350–\$3,000

25 percent of the benefit amount will be paid for administration of anesthesia during a covered reconstructive surgical operation.

- Lifetime Maximum Per Insured – None

The specified indemnity listed in the policy is payable when a listed reconstructive surgical operation is performed. If any reconstructive surgery is performed other than those listed, Aflac will pay an amount comparable to the specified indemnity amount for the operation most nearly similar in severity and gravity. Maximum daily benefit: \$3,000.

**AMBULANCE, TRANSPORTATION, AND LODGING BENEFITS**

**Ambulance Benefit:**

- Benefit Amount – *Ground* – \$250  
*Air* – \$2,000

- Lifetime Maximum Per Insured – None

Payable for ambulance transportation to or from a Hospital where confined overnight. Limited to two trips per confinement. The ambulance service must be performed by a licensed, professional ambulance company.

**Transportation Benefit:**

- Benefit Amount – 50 cents per mile, up to \$1,500
- Lifetime Maximum Per Insured – None

Payable for transportation of the Covered Person requiring treatment and a companion (if applicable), limited to the distance of miles between the Hospital or medical facility and the residence of the Covered Person. Benefit will pay for two adults if the Covered Person receiving treatment is a Dependent Child and commercial travel is necessary. Benefit is not payable for transportation to a facility located within a 50-mile radius of the Covered Person's residence. Does not cover transportation provided by ambulance.

**Lodging Benefit:**

- Benefit Amount – \$80 per day
- Lifetime Maximum Per Insured – None

Payable for lodging, in a room in a motel, hotel, or other commercial accommodation, for you or any one adult family member when a Covered Person receives treatment. Limited to 90 days per calendar year. Hospital or medical facility where treatment is received must be more than 50 miles from the Covered Person's residence. Benefit is not payable for lodging occurring more than 24 hours prior to treatment or more than 24 hours after treatment.

## PREMIUM WAIVER AND RELATED BENEFITS

**Waiver of Premium**

If you, due to having Cancer or an Associated Cancerous Condition, are completely unable to perform all of the usual and customary duties of your occupation [or if not employed: are unable to perform two or more activities of daily living (ADLs) without the assistance of another person] for a period of 90 continuous days, Aflac will waive, from month to month, any premiums falling due during your continued inability. For premiums to be waived, Aflac will require an employer's statement (if applicable) and a Physician's statement of your inability to perform said duties or activities and may each month thereafter require a Physician's statement that total inability continues. Aflac may ask for and use an independent consultant to determine whether you can perform an ADL while this benefit is in force. Aflac will also waive, from month to month, any premiums falling due while you are receiving Hospice Benefits.

**Continuation of Coverage**

Aflac will waive all monthly premiums due for the policy and riders for two months if you meet all the following conditions: your policy has been in force for at least six months; we have received premiums for at least six consecutive months; your premiums have been paid through payroll deduction; you or your employer has notified us in writing within 30 days of the date your premium payments ceased due to your leaving employment; and you re-establish premium payments with Aflac. You will again become eligible to receive this benefit after you re-establish your premium payments through payroll deduction for a period of at least six months, and we receive premiums for at least six consecutive months.

**Limitations and Exclusions:** We pay only for treatment of Cancer and Associated Cancerous Conditions diagnosed on or after the Effective Date of coverage, including direct extension, metastatic spread, or recurrence. Benefits are not provided for premalignant

conditions or conditions with malignant potential (unless specifically covered); complications of either Cancer or an Associated Cancerous Condition; or any other disease, sickness, or incapacity. The policy contains a 30-day waiting period. If a Covered Person has Cancer or an Associated Cancerous Condition diagnosed before his or her coverage has been in force for 30 days, benefits for treatment of that Cancer or Associated Cancerous Condition will apply only to treatment occurring after two years from the Effective Date of such person's coverage or, at your option, you may elect to void the coverage and receive a full refund of premium.

**Guaranteed-Renewable:** The policy is guaranteed-renewable for your lifetime, subject to Aflac's right to change premiums by class upon any renewal date.

**Effective Date:** The *Effective Date* is the date coverage begins, as shown in the Policy Schedule. It is not the date you signed the application for coverage.

**Covered Person:** A *Covered Person* is any person covered under individual (named insured listed in the Policy Schedule), named insured/Spouse only (named insured and Spouse), one-parent family (named insured and Dependent Children), or two-parent family (named insured, Spouse, and Dependent Children) coverage as applied for by you on the application. *Spouse* is defined as the person to whom you are legally married and who is listed on your application. Newborn children are automatically insured from the moment of birth. If coverage is for the individual or named insured/Spouse only, and you desire uninterrupted coverage, you must notify Aflac in writing within 31 days of the birth of your child, and Aflac will convert the policy to one-parent family or two-parent family coverage and advise you of the additional premium due. Coverage will include any other unmarried Dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who became so incapacitated prior to age 26 and while covered under the policy. *Department Children* are your natural children, stepchildren, or legally adopted children who are unmarried, under age 26, and legal dependents for federal tax exemption purposes. **A Dependent Child (including persons incapable of self-sustaining employment by reason of mental retardation or physical handicap) must be under age 26 at the time of application to be eligible for coverage.**

**Cancer:** *Cancer* is a disease manifested by the presence of a malignant tumor and characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. *Cancer* also includes, but is not limited to, leukemia, Hodgkin's disease, and melanoma. Cancer must receive a positive medical diagnosis.

1. *Internal Cancer* includes all Cancers other than Nonmelanoma Skin Cancer (see definition of Nonmelanoma Skin Cancer).
2. *Nonmelanoma Skin Cancer* is a Cancer other than a melanoma that begins in the upper part of the skin (epidermis).

Associated Cancerous Conditions, premalignant conditions, or conditions with malignant potential will not be considered Cancer.

**Associated Cancerous Condition:** An *Associated Cancerous Condition* is a myelodysplastic blood disorder, myeloproliferative blood disorder, or carcinoma in situ (in the natural or normal place, confined to the site of origin without having invaded

neighboring tissue). An Associated Cancerous Condition must receive a positive medical diagnosis. **Premalignant conditions or conditions with malignant potential, other than those specifically named above, are not considered Associated Cancerous Conditions.**

**Hospital:** *Hospital* does not include any institution or part thereof used as an emergency room; an observation unit; a rehabilitation unit; a hospice unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; a psychiatric unit; an Extended-Care Facility; a skilled nursing facility; or a facility primarily affording custodial or educational care, care or treatment for persons suffering from mental disease or disorders, care for the aged, or care for persons addicted to drugs or alcohol.

**Ambulatory Surgical Center:** An *Ambulatory Surgical Center* does not include a doctor's or dentist's office, clinic, or other such location.

**Physician:** A *Physician* is a person legally qualified to practice medicine, other than a member of your immediate family, who is licensed as a Physician by the state where treatment is received to treat the type of condition for which a claim is made.

### American Family Life Assurance Company of Columbus (Aflac)



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## Optional Initial Diagnosis Benefit Rider Summary

Rider A76050

Riders become a part of the policy and are subject to all policy provisions unless otherwise stated.

### Initial Diagnosis Benefit

Primary Insured/Spouse	<input type="checkbox"/> \$2,500	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$7,500	<input type="checkbox"/> \$10,000
Dependent Child	\$5,000	\$10,000	\$15,000	\$20,000

Aflac will pay the amount shown in the Policy Schedule when a Covered Person is diagnosed with Internal Cancer or an Associated Cancerous Condition while the rider is in force. This benefit is payable only once for each Covered Person. In addition to the positive medical diagnosis, additional information from the attending Physician and Hospital may be required.

### Initial Diagnosis Building Benefit

Aflac will increase the Initial Diagnosis Benefit by \$500 on each rider anniversary date. This benefit is payable under the same terms as the Initial Diagnosis Benefit. This benefit will cease to build for each Covered Person on the anniversary date of

the rider following the Covered Person's 65th birthday or at the time Internal Cancer or an Associated Cancerous Condition is diagnosed for that Covered Person, whichever occurs first. Regardless of the age of the Covered Person on the Effective Date of the rider, the benefit will accrue for a period of at least five years unless Internal Cancer or an Associated Cancerous Condition is diagnosed prior to the fifth year of coverage.

**National Cancer Institute (NCI) Evaluation/Consultation Benefit**

*Aflac will pay \$1,000* when a Covered Person seeks evaluation or consultation at an NCI-designated Cancer center as a result of receiving a diagnosis of Internal Cancer or an Associated Cancerous Condition. The purpose of the evaluation/consultation must be to determine the appropriate course of treatment. This benefit is also payable at the Aflac Cancer Center and Blood Disorders Service of Children's Healthcare of Atlanta. This benefit is payable only once per Covered Person and is not payable the same day the Additional Surgical Opinion Benefit is payable.

**Additional Surgical Opinion Benefit**

*Aflac will pay \$300 per day* when a charge is incurred for an additional surgical opinion by a Physician concerning surgery for a diagnosed Cancer or an Associated Cancerous Condition. This benefit is not payable the same day the NCI Evaluation/Consultation Benefit is payable. No lifetime maximum.

**Medical Imaging With Diagnosis Benefit**

*Aflac will pay \$200 per calendar year* when a charge is incurred for each Covered Person who receives an initial diagnosis or follow-up evaluation for Internal Cancer or an Associated Cancerous Condition using one of the following medical imaging exams: CT scans, MRIs, bone scans, thyroid scans, multiple-gated acquisition (MUGA) scans, positron emission tomography (PET) scans, transrectal ultrasounds, or abdominal ultrasounds. Exams must be performed in a Hospital, an Ambulatory Surgical Center, or a Physician's office. This benefit is limited to one payment per calendar year, per Covered Person. No lifetime maximum.

**Limitations and Exclusions**

The rider contains a 30-day waiting period. If Cancer or an Associated Cancerous Condition is diagnosed in a Covered Person before coverage has been in force 30 days from the Effective Date, benefits for treatment of that Cancer or Associated Cancerous Condition will apply only to treatment occurring two years after the Effective Date of the rider or, at your option, you may elect to void the rider from its beginning and receive a full refund of premium. The Initial Diagnosis Benefit and Initial Diagnosis Building Benefit of the rider are not payable for (1) any Internal Cancer or Associated Cancerous Condition diagnosed or treated before the Effective Date of the rider and the subsequent recurrence, extension, or metastatic spread of such Cancer or Associated Cancerous Condition; (2) Cancer or Associated Cancerous Conditions diagnosed during the rider's 30-day waiting period; or (3) the diagnosis of Nonmelanoma Skin Cancer. Any Covered Person who has had a previous diagnosis of Internal Cancer or an Associated Cancerous Condition will NOT be eligible for an Initial Diagnosis Benefit or an Initial Diagnosis Building Benefit under the rider for a recurrence, extension, or metastatic spread of that same Internal Cancer or Associated Cancerous Condition.

**Termination**

The rider will terminate if the policy to which it is attached terminates or if the premium for the rider is not paid.

**Effective Date**

The Effective Date of the rider is the Effective Date listed on the Policy Schedule.

**Refer to the policy and rider for complete details, limitations, and exclusions.**

**American Family Life Assurance Company of Columbus (Aflac)**

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**Optional Cancer Screening and Annual Care Benefit Rider Summary**

Rider A76051

Riders become a part of the policy and are subject to all policy provisions unless otherwise stated.

**Cancer Vaccine Benefit**

*Aflac will pay \$40* if a Covered Person incurs a charge for receiving any Cancer vaccine that is approved by the Food and Drug Administration for the prevention of Cancer. The vaccine must be administered by licensed medical personnel. This benefit is limited to one payment per Covered Person, per calendar year.

**Cancer Wellness Benefit**

\$50    \$75    \$100    \$125

*Aflac will pay* the amount shown in the Policy Schedule per calendar year when a Covered Person incurs a charge for one of the following:

- |   |   |
|---|---|
| •Mammogram                                | •CEA (blood test for colon Cancer)        |
| •Breast ultrasound                        | •CA 125 (blood test for ovarian Cancer)   |
| •Breast MRI                               | •PSA (blood test for prostate Cancer)     |
| •CA 15-3 (tumor marker for breast cancer) | •Testicular ultrasound                    |
| •Pap smear                                | •Thermography                             |
| •ThinPrep                                 | •Flexible sigmoidoscopy                   |
| •Biopsy                                   | •Colonoscopy                              |
| •Chest X-ray                              | •Virtual colonoscopy                      |
|   | •Hemoccult stool specimen (lab confirmed) |

This benefit is limited to one payment per calendar year, per Covered Person. Tests must be performed to determine whether Cancer or an Associated Cancerous Condition exists in a Covered Person and must be administered by licensed medical personnel. No lifetime maximum.

**Bone Marrow Donor Screening Benefit**

*Aflac will pay \$40* when a Covered Person provides documentation of participation in a screening test as a potential bone marrow donor. This benefit is limited to one benefit per Covered Person, per lifetime.

**Annual Care Benefit**

*Aflac will pay \$500* on the anniversary date of a Covered Person's Internal Cancer diagnosis upon proof that the Covered Person is still under the active care of a Physician. This benefit is not payable for Associated Cancerous Conditions or nonmelanoma skin Cancers. Lifetime maximum of five annual payments per Covered Person.

**Termination**

The rider will terminate if the policy to which it is attached terminates or if the premium for the rider is not paid.

**Effective Date**

The Effective Date of the rider is the Effective Date listed on the Policy Schedule.

**Refer to the policy and rider for complete details, limitations, and exclusions.**

**For premium rates, please contact your  
Aflac Agent, Gloria Camp, at (770) 535-8920.**

American Family Life Assurance Company of Columbus (Aflac)

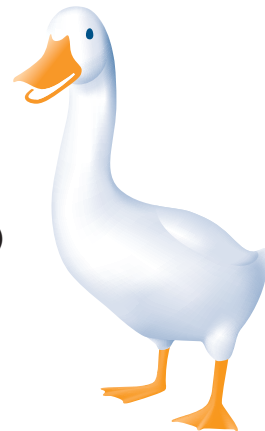
Worldwide Headquarters  
1932 Wynnton Road  
Columbus, Georgia 31999

1.800.99.AFLAC (1.800.992.3522)

En español:

1.800.SI.AFLAC (1.800.742.3522)

**Visit our Web site at [aflac.com](http://aflac.com).**



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## *Sun Life Financial* *Short Term Disability Insurance*

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### **ELIGIBILITY**

- Coverage is available for all full-time employees working 37.5 hours or more per week.
- An employee is eligible for coverage on the first day of employment.
- Application for coverage must be made within 31 days of eligibility, otherwise evidence of insurability must be submitted to, and approved by Sun Life.

### **AMOUNT OF INSURANCE**

- Weekly benefit is 60% of your weekly salary.
- Maximum benefit is \$500 per week.

### **ELIMINATION PERIOD**

- Benefits begin on the 1st day absent for accidents provided total disability occurs within 72 hours after an accident.
- Benefits begin on the on the 8th day for sickness.

### **MAXIMUM BENEFIT PERIOD**

- Maximum benefit period is 26 weeks while you are totally or partially disabled.

### **TOTAL WEEKLY EARNINGS**

- Your basic weekly earnings as reported by your Employer immediately before the first date your total disability begins. Total weekly earnings do not include overtime pay, bonuses, or any other extra compensation.
- If your amount of insurance increases or decreases due to a change in salary, your increase/decrease will take effect immediately upon the date of change, providing you are actively at work.

### **LIMITATIONS AND EXCLUSIONS**

No benefits are payable for any total or partial disability during any of the following periods:

- Any period you are not under the regular and continuing care of a physician
- Any period you don't submit to a medical examination requested by Sun Life
- Any period you engage in any occupation or employment for wage, other than partial disability employment with your employer
- Any disability that is due to mental illness unless you are under the continuing care of a psychiatric specialist
- Any period of disability due to drugs or alcohol unless receiving treatment from a rehabilitation center, or designated institution approved by Sun Life

No benefits are payable for any total or partial disability due to:

- intentionally self-inflicted injuries;
- active participation in a riot, rebellion, or insurrection;
- war, declared or undeclared, or any act or war;
- committing or attempting to commit an assault, felony, or other illegal act
- injury or sickness covered by Worker's Compensation or similar law;

### **COST TO YOU**

- The cost of Sun Life Short Term Disability is paid by the employees through payroll deduction.
- Benefits are tax-free.
- Your cost is determined by multiplying your weekly benefit by .0721.

Example: Weekly Benefit Total cost per pay period  
\$350 multiplied by .0721 x 12 divided by 26 = \$11.85

**For questions or information about your coverage, call Sun Life Group  
Customer Service Center at (800) 247-6875**



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www.sunlife-usa.com*

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## *Sun Life Financial*

### *Long Term Disability Insurance*

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#### **ELIGIBILITY**

- Coverage is available for all full-time employees working 37.5 hours or more per week.
- An employee is eligible for coverage on the first day of employment.
- Application for coverage must be made within 31 days of eligibility, otherwise evidence of insurability must be submitted to, and approved by Sun Life.

#### **AMOUNT OF INSURANCE**

- Monthly benefit is 50% of your monthly salary.
- Maximum benefit is \$5000 per month.
- Minimum benefit is \$100 per month.

#### **ELIMINATION PERIOD**

- You must be continuously totally or partially disabled for 180 days before long term disability benefits are payable.

#### **MAXIMUM BENEFIT PERIOD**

- The maximum benefit period is the period shown below, or normal retirement age whichever is longer.

<u>Age at Disability</u>	<u>Maximum Disability Period</u>
Less than age 60	To age 65 but not less than 60 months
60	60 Months
61	48 Months
62	42 Months
63	36 Months
64	30 Months
65	24 Months
66	21 Months
67	18 Months
68	15 Months
69 and over	12 Months

<u>Year of Birth</u>	<u>Normal Retirement Age</u>
Before 1938	Age 65
1938	Age 65 & 2 months
1939	Age 65 & 4 months
1940	Age 65 & 6 months
1941	Age 65 & 8 months
1942	Age 65 & 10 months
1943 through 1954	Age 66
1955	Age 66 & 2 months
1956	Age 66 & 4 months
1957	Age 66 & 6 months
1958	Age 66 & 8 months
1959	Age 66 & 10 months
After 1959	Age 67

## **TOTAL MONTHLY EARNINGS**

- Your basic monthly earnings as reported by your Employer immediately before the first date your total or partial disability begins. Total monthly earnings do not include overtime pay, bonuses, or any other extra compensation.
- If you are paid on an hourly basis, your total monthly earnings will be based on your hourly rate of pay, but will not exceed 40 hours per week.
- If your amount of insurance increases or decreases due to a change in salary, your increase/decrease will take effect immediately upon the date of change, providing you are actively at work.

## **LIMITATIONS AND EXCLUSIONS**

No benefits are payable for any total or partial disability during any of the following periods:

- Any period you are not under the regular and continuing care of a physician providing appropriate treatment and regular examination and testing in accordance with your disabling condition, unless you have reached your maximum point of recovery and are still totally or partially disabled.
- Any period you don't submit to a medical examination or clinical assessment requested by Sun Life.
- Any period you engage in any occupation or employment for wage, other than partial disability employment with your employer.
- Any disability that is due to mental illness unless you are under the continuing care of a psychiatric specialist. After you complete your elimination period, benefits are payable for 24 months. Benefits after the first 24 months are payable only if you are confined to a hospital or institution licensed to provide psychiatric treatment. Benefits can be continued for up to 90 days following discharge.
- Any period of disability due to drug or alcohol use, unless you are actively supervised by a physician or rehabilitation counselor and are receiving continuing treatment from a rehabilitation center or designated institution approved by Sun Life. Benefits are payable for 24 months, if during the elimination period, you become confined to a hospital or institution licensed to provide drug or alcohol treatment or begin participation in a drug or alcohol rehabilitation program acceptable to Sun Life. Benefits after 24 months are payable only if you are confined to a hospital or institution licensed to provide drug or alcohol treatment.
- Any period during which you are incarcerated.

- Any period of disability that is due to chemical or environmental illness unless you are under the continuing care of a physician providing appropriate treatment and regular examination and testing in accordance with your disabling condition. LTD benefits are payable for 24 months. Benefits after 24 months are payable only if you are confined to a hospital.
- Any period of total or partial disability that is due to chronic fatigue illness, unless you are under the continuing care of a physician providing appropriate treatment and regular examination and testing in accordance with your disabling condition. Benefits are payable for 24 months. Benefits after 24 months are payable only if you are confined to a hospital.
- Any period of total or partial disability that is due to musculoskeletal and connective tissue illness, unless you are under the continuing care of a physician providing appropriate treatment and regular examination and testing in accordance with your disabling condition. Benefits are payable for 24 months. Benefits after 24 months are payable only if you are confined to a hospital.

No benefits are payable for any total or partial disability due to:

- intentionally self-inflicted injuries;
- active participation in a riot, rebellion, or insurrection;
- war, declared or undeclared, or any act of war;
- committing or attempting to commit an assault, felony, or other illegal act;
- operation of any motorized vehicle while intoxicated;
- a pre-existing condition, which is a condition that during the 12 months prior to your effective date of coverage, you received medical treatment, consultation, care, or services, or took prescribed drugs, or had symptoms that would have caused an ordinarily prudent person to consult a health care provider for diagnosis, care or treatment.

**The pre-existing condition exclusion will not apply if your total or partial disability begins later than 12 months after your effective date of insurance.**

## **COST TO YOU**

- The cost of Sun Life Long Term Disability is paid by the employees through payroll deduction.
- Benefits are tax-free.
- The cost per pay period is determined by multiplying your monthly income by the rate found in the chart below (example: \$3,000 X .00135 X 12 divided by 26 = \$1.87 per pay period).

<u>Your Age</u>	<u>Rate</u>
Under 30	\$.00135
30-34	\$.00192
35-39	\$.00279
40-44	\$.00384
45-49	\$.00702
50-54	\$.00942
55-59	\$.01307
60-64	\$.01153
65-69	\$.00702
70-74	\$.00461
75-79	\$.00500

**For questions or information about your coverage, call Sun Life Group  
Customer Service Center at (800) 247-6875**

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## *Sun Life Financial Term Life Insurance*

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### **BASIC EMPLOYEE LIFE INSURANCE**

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

### **BASIC ACCIDENTAL DEATH AND DISMEMBERMENT**

Benefits under this coverage are payable as described in your booklet. All active employees have Basic Accidental Death and Dismemberment coverage.

### **OPTIONAL EMPLOYEE LIFE INSURANCE**

Your employer-sponsored basic life coverage provides important protection for you, but you may need to add to that protection.

### **OPTIONAL DEPENDENT LIFE INSURANCE**

Provides coverage on:

- Your spouse
- Child(ren) up to age 19 (to age 23 if wholly dependent upon you for maintenance and support if enrolled as a full-time student.)

To help meet this need, you have the opportunity to elect additional group life insurance under the optional portion of your program.

### **ELIGIBILITY**

You will be eligible for this program if you are a full-time Employee scheduled to work at least 37.5 hours per week.

### **ENROLLMENT**

Enrollment is simple - just fill out the election form provided by your employer.

### **STATEMENT OF HEALTH**

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

### **BENEFICIARY**

You have the right to designate the beneficiary of your choice. The beneficiary elected on your life enrollment form designates your beneficiary for basic and optional coverage. You are automatically the beneficiary under Dependent Life. It is the responsibility of the insured to update the beneficiary designation as necessary.

### **WHEN YOUR BASIC INSURANCE STARTS**

Your Basic Insurance begins on the first day of the calendar month following six months of employment, but only if you are actively at work on the date such insurance is to begin. If you are not actively at work on that date, such insurance will begin on the next date that you are actively at work.

### **WHEN YOUR OPTIONAL INSURANCE STARTS**

If you enroll for Optional Life Insurance on or before you become eligible for coverage, your insurance becomes effective on the date of your eligibility if you are actively at work. If you are not actively at work, your insurance will not be effective until you return to active full-time work.

### **WHEN YOUR DEPENDENT INSURANCE STARTS**

Your dependents are eligible for coverage on the date you are eligible to be insured or the date you acquire an eligible dependent, unless the dependent is confined to a hospital or confined at home and unable to perform normal activities.

### **WAIVER OF PREMIUM**

If you become totally disabled while insured, the Waiver of Premium Provision may continue your Life Insurance without any further payment of premium by you or your employers. You must become disabled prior to age 60 and prior to retirement. The amount of your insurance is subject to reductions in age. You must apply for benefits under the Waiver of Premium Provision within 12 months after you cease to be actively at work. This provision ceases when you reach age 70.

### **REDUCTIONS AT AGE 70 & OVER**

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

<u>Attained Age</u>	<u>Percent of Original Amount</u>
70	67%
75	50%

### **TERMINATION OF COVERAGE**

All insurance under this plan will terminate upon the earlier of:

- the date you retire.
- the date your employment terminates.
- the last date for which any required premium is paid.
- the date you request in writing to terminate your insurance.
- the date you enter active duty in any armed service during time of war (declared or undeclared).
- the date you cease to be actively at work.

Your insurance can be continued if you are on temporary layoff, leave of absence, or vacation as long as your employer pays the required premium for the length of time specified below.

- Layoff - for up to 1 month
- Leave of absence - for up to 1 month
- Vacation - up to 3 months

If you are absent from work due to an injury or sickness, your employer may continue your life insurance, by paying the required premium, for up to 12 months.

## **GROUP ACCELERATED BENEFITS**

The Accelerated Benefits provision gives terminally ill employees with a life expectancy of 12 months or less, access of up to 75% of their group life death benefit while they are alive. The minimum Accelerated Benefit available to employees is \$10,000 and the maximum is \$500,000.

## **PORTABILITY**

If prior to age 65, your Optional Life insurance ceases because you terminate employment, you may apply for portable coverage, during the 31 day conversion period instead of converting to an individual policy. Portable coverage is group term life insurance and may be continued for 10 years or to age 65, whichever comes first. At the end of that time, you may convert the coverage then in force, to an individual whole life policy under the conversion privilege.

## **CONVERSION**

If your employment terminates while you are covered under the plan, you may purchase, without evidence of insurability, a whole life policy issued by Sun Life. You must apply for this policy within 31 days after the date your employment terminates. This privilege applies to Optional Employee Life Insurance and Optional Dependent Life Insurance as well as the Basic Employee Life Insurance.

## **SUICIDE EXCLUSION**

No Optional Employee Life Benefits are payable if you commit suicide within 24 months from the date you became insured for Optional Life, or for any increased amount of Optional Life insurance. No Dependent Spouse Optional Life Insurance is payable if your Spouse commits suicide within 24 months from the date the dependent spouse became insured for Dependent Optional Life Insurance.

## **GROUP POLICY**

The insurance briefly described in this material is subject to the terms and conditions of the Group Policy issued by the Insurer. These terms and conditions are described in the booklet that will be furnished to you by the Insurer. Please refer to the booklet for a full description of your insurance.

## **BASIC EMPLOYEE LIFE INSURANCE AND AD&D\***

All Eligible Employees - \$25,000  
(Paid by Rabun County)

## **OPTIONAL EMPLOYEE LIFE INSURANCE\***

You may elect 1, 2, or 3 times your Basic Annual Earnings rounded to the next higher \$1,000, if not already a multiple of \$1,000, to a maximum of \$300,000.

## **OPTIONAL DEPENDENT LIFE INSURANCE**

- \$5,000 to \$30,000 in increments of \$5,000 on your spouse\*
- \$5,000 or \$10,000 on each of your eligible children\*\*

\* See "Reductions at age 70 and Over."

\*\* For children age 14 days but under 1 year, the amount is \$500, the amount for children under 14 days is none

**OPTIONAL LIFE RATES**

Employee Age	Cost Per \$10,000		Spouse Age	Cost Per \$10,000	
	Monthly	Bi-weekly		Monthly	Bi-weekly
<b>Under 30</b>	\$1.45	\$0.67	<b>Under 30</b>	\$0.84	\$0.39
<b>30-34</b>	\$1.67	\$0.77	<b>30-34</b>	\$0.94	\$0.43
<b>35-39</b>	\$2.09	\$0.96	<b>35-39</b>	\$1.16	\$0.51
<b>40-44</b>	\$3.32	\$1.53	<b>40-44</b>	\$1.78	\$0.82
<b>45-49</b>	\$5.81	\$2.68	<b>45-49</b>	\$3.06	\$1.41
<b>50-54</b>	\$9.82	\$4.53	<b>50-54</b>	\$5.04	\$2.33
<b>55-59</b>	\$16.00	\$7.38	<b>55-59</b>	\$7.88	\$3.64
<b>60-64</b>	\$20.80	\$9.60	<b>60-64</b>	\$11.23	\$5.18
<b>65-69</b>	\$36.40	\$16.80	<b>65-69</b>	\$21.54	\$9.94
<b>70-74</b>	\$63.03	\$29.09			
<b>75+</b>	\$194.80	\$89.91			

**Child(ren) - Monthly cost per \$1000 of coverage: \$0.10**  
**Bi-Weekly cost per \$1000 of coverage: \$0.05**

**Guaranteed Issue amount for Employee's optional life is:**  
**Under age 60 - the lesser of 3 times your Basic Annual Earnings or \$50,000**  
**Ages 60 to 69 - \$20,000**  
**Ages 70 to 79 - \$10,000**  
**Age 80 and over - \$1000**

**Guaranteed Issue amount for the Dependent Spouse is:**  
**Under age 60 - \$10,000**  
**Ages 60 to 69 - \$1000**

**For questions or information about your coverage, call Sun Life Group  
Customer Service Center at (800) 247-6875**



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## *Continuation of Benefits Options If You Leave Rabun County*

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### **TUCKER ADMINISTRATORS MEDICAL SPENDING ACCOUNTS**

If you have a positive balance (payroll deductions are greater than the amount you have received in reimbursement) in your Medical Spending 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. For information about continuing your Medical Reimbursement Account, you may contact **IMS** at **1-800-426-8739**. Interactive **Medical Systems** is the COBRA Administrator.

### **BLUECROSS BLUESHIELD OF GEORGIA MEDICAL INSURANCE PLAN**

Under the medical plan, you and your covered dependents are eligible to continue medical coverage through COBRA according to the following “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 maybe 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. Examples of an ineligible dependent would be when your child graduates from college, or turns 23 years old. Should you have any questions you can contact **IMS** at **1-800-426-8739**. Interactive **Medical Systems** is the COBRA Administrator.

### **DIRECT REIMBURSEMENT DENTAL PLAN**

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

If you and your dependents are enrolled in the dental plan, you will be eligible to continue coverage through COBRA after you leave your employment for a specified period. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents maybe eligible to continue dental coverage through COBRA. Also, while you are covered under the plan, your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA. Examples of an ineligible dependent would be when your child graduates from college, or turns 23 years old. Should you have any questions you can contact **IMS** at **1-800-426-8739**. Interactive **Medical Systems** is the COBRA Administrator.

### **SUPERIOR VISION PLAN**

Under the Superior Vision plan, you and your covered dependents are eligible to continue vision coverage through COBRA according to the following “qualifying events”.

If you and your dependents are enrolled in the vision plan, you will be eligible to continue coverage through COBRA after you leave 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 maybe eligible to continue vision 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. Should you have any questions you can contact **IMS** at **1-800-426-8739**. Interactive **Medical Systems** is the COBRA Administrator.

### **AFLAC PLANS**

You may continue your Aflac policies by having the premiums currently being deducted from your paycheck either drafted from your bank account or billed directly to your home. Contact **Aflac** at **800-992-3522** for more information.

### **SUN LIFE FINANCIAL TERM LIFE**

When you leave employment with Rabun County prior to age 65, you may apply for portable coverage during the 31 day conversion period, instead of converting to an individual policy. This coverage is group term life and may be continued for 10 years or to age 65 whichever comes first. You must provide a statement of good health in order to qualify for portable coverage.

You may also convert your life insurance to an individual policy. The application for conversion must be made within 31 days of your termination from employment. You do not have to submit Evidence of Insurability to convert to an individual policy. For details, please call Sun Life at (800) 247-6875.