Table of Contents

Plan Arranged By:

Mark III Employee Benefits

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

The products described in this booklet are part of a Cafeteria Benefits Plan arranged by Mark III Brokerage for eligible Spotsylvania County Government employees. The Cafeteria Benefits Plan allows you to pay for certain insurance premiums before taxes are taken out of your paycheck. Paying for benefits in this method reduces your taxes and increases your take home pay.

The Plan Year is October 1, 2012 through September 30, 2013.

All products described in this booklet are deducted on a pre-tax basis **EXCEPT:**

- **CAIC Critical Illness Insurance**
- **AUL Short-Term Disability**
- **Texas Life Whole Life**

If you wish to add or make changes to your insurance coverage(s), please consult a Benefits Representative during your scheduled enrollment period. ***You will not be able to make any changes once the enrollment period is over*** unless you experience a qualified event outlined by the IRS (i.e., marriage, divorce, birth of a child, etc.) If you should experience a qualified event, you have 30 days from the date of the event to make any changes.

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

Frequently Asked Questions

Can I enroll in other Anthem benefits without the medical plan?
Spotsylvania County refers to their medical, dental, vision and prescription coverage as health insurance plan or coverage. One cannot have the medical plan without the others.

What is a Supplemental Benefits Plan?
A Supplemental Benefits Plan allows employees to select various employee benefits to match their specific needs. Under IRS Code Section "125", certain insurance premiums can be payroll deducted on a pre-tax basis.

Are you eligible?

Regular full-time employees	Eligible to participate in the County's health insurance coverage, Flexible Spending Accounts, Voluntary Benefit Programs and Opt-Out option.
Regular part-time employees scheduled 20 hours or more per week	Eligible to participate in Flexible Spending Accounts and the Voluntary Benefit Programs.

How does a Supplemental Benefits Plan help employees save money?
By electing to pay for qualified insurance premiums on a pre-tax basis, dollars are deducted for these elections and taxable payroll is reduced before state, federal and FICA withholding are taken out. In the example below, the employee is saving $120 per month, or $1,440 per year.

	With Plan	**Without Plan**
Salary (monthly)	$3000	$3000
Less Pre-Taxed Dollars:		
Flexible Spending Account (FSA)	$250	0
Qualified Insurance Premiums	$150	0
Taxable Income	$2600	$3000
Less:		
Taxes (30%)	$780	$900
Net Take Home Pay	$1820	$2100
Less FSA & Insurance Premiums	0	$400
Net After Expenses	$1820	$1700

Which taxable income is reduced and will these be taxable at a later date?
Premiums and money set aside for your FSA are subtracted from your pay check prior to ANY taxes prior to any taxes being taken out. As long as you use your FSA money for qualified expenses, you will not be taxed on these funds.

Who is considered a dependent?
A dependent is considered to be anyone you claim on your taxes as a dependent. Your dependent however, does not to have to be enrolled in your medical plan to be considered a dependent.

Who is considered a dependent for Medical Coverage?
Parents may insure their children/young adults up to December 31st of the year they turn age 26 as long as they have no other group health plan coverage available to them. For this purpose, a child includes a son, daughter, stepchild, adopted child or eligible foster child, married or unmarried.

How do I enroll in the Supplemental Benefits Plan?
Enrollment is held on an annual basis. During enrollment, employees can meet with a Benefits Representative to review current benefit elections and make changes to their benefits for the upcoming plan year. Any changes made during the enrollment period will become effective October 1st of the upcoming year.

Can I make changes to my benefits during the Plan Year?
Generally you cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections. You are permitted to change elections if you have a "change in status" and you make an election change that is consistent with the "change in status." If you need to make a change to your benefits due to a "change in status," you have 30 days from the date of status change to make appropriate changes. Currently, Federal law considers the following events to be "changes in status":

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

For additional details, please see "Changes in Your Election" on page 17.

What do I need to do if I terminate employment with the Government?
Please see Continuing Your Benefits on page 96.

Where do I get a claim form?
To download a claim form for any of your benefits, please visit
www.markiiibrokerage.com/scgva

What is the maximum amount of money I can elect or contribute annually to my Flexible Spending Account?
The maximum amount that you can contribute is $2,500.

Can I change my contribution amounts if I find that I am contributing too much or too little?
No, you can only change your contribution amount if you experience a qualifying event. Please see page 17.

Can I view my Flexible Spending Account online?
Yes, please see page 21 for instructions.

When can I use my flexible benefits card?
Qualifying purchases must be made between October 1 and September 30 with a 90 day time frame to file for reimbursement if the benefit card was not used.

Flexible Benefit Administrators
Flexible Spending Accounts

Plan Year: October 1, 2012 - September 30, 2013
• Healthcare Flexible Spending Account Maximum: $2,500.00
• Healthcare Flexible Spending Account Minimum: $260.00
• Eligibility: Regular full-time employees and regular part-time employees who work an average of 20 hours or more per week are eligible to participate in the Flexible Spending program.

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

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

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

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

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

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

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

After you read this material, if you have any questions please feel free to contact **Flexible Benefit Administrators, Inc. at (757) 340-4567 or (800) 437-FLEX.**
FLEX NOTE: FLEX is authorized by Section 125 of the Internal Revenue Code

Health Care Reimbursement Account

The Health Care Reimbursement Account allows you to pay for your uninsured medical expenses with pre-tax dollars. With this account, you can pay for your out-of-pocket medical expenses for yourself, your spouse and all of your dependents for medical services that are incurred during your Plan Year. The minimum you may place in this account for the Plan Year is $260. The maximum you may place in this account for the Plan Year is $2,500.

EXAMPLES OF ELIGIBLE HEALTH CARE EXPENSES

FEES/COPAYS/DEDUCTIBLES:

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

Other Eligible Expenses:

- Prescription drugs
- Artificial limbs & breasts (only if reconstructive)
- Birth control pills, patches (e.g. Norplant)
- Orthopedic shoes/inserts
- Incontinence supplies
- Carpal tunnel wrist supports
- Vaccinations & immunizations
- Elastic hose (medically prescribed)
- Contact lens supplies
- Therapeutic care for drug and alcohol addiction
- Diabetic supplies
- Routine physicals
- Condoms
- Dentures
- Oxygen
- Physical therapy
- Fertility treatments
- Hearing aids and batteries
- Reading glasses
- Medical equipment
- Pedialyte for dehydration
- Nicotine gum/patches
- Take-home screening kits (HIV, colon cancer)
- At home pregnancy test kits
- Smoking cessation programs and prescribed drugs designed to alleviate nicotine withdrawal
- Mileage, parking and tolls (you may be reimbursed $.23* a mile plus parking and tolls when medical reasons make it necessary to travel)
- Tuition fees for medical care (if the college furnishes a breakdown of medical charges)
- Orthodontic expenses (not for cosmetic purposes)

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

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

OVER-THE-COUNTER DRUGS

Please be advised that recent Senate legislation has stated that effective January 1, 2011, participants are required to have a prescription for Over-the-Counter ("OTC") products to be eligible under their FSA plan. Therefore a prescription or letter of medical necessity would be required after January 1, 2011 for OTC items.

OVER-THE-COUNTER EXPENSES

- Examples of medications and drugs that may be purchased in reasonable quantities **with a prescription or letter of medical necessity:**
  - Antacids
  - Pain relievers/aspirin
  - Ointments & creams for joint pain
  - First aid creams (Bactine, diaper rash)
  - Bug-bite medication
  - Allergy & sinus medication
  - Cough & cold medications
  - Laxatives
  - Anti-diarrhea medicine

OVER-THE-COUNTER EXPENSES THAT ARE NOT ELIGIBLE

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

DUAL PURPOSE DRUGS & ITEMS

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

- The following items are examples of products that are considered as having both a medical purpose and a general health, personal/cosmetic purpose and require a medical practitioner's note stating the name of the patient, the specific medical condition for which the OTC is recommended, the time frame of the treatment and that the treatment is not cosmetic:
  - Weight-loss drugs (to treat obesity)
  - Prenatal vitamins
  - Nasal sprays for snoring
  - Pills for lactose intolerance
  - Fiber supplements (to treat a medical condition for a limited time)
  - OTC Hormone therapy (to treat menopausal symptoms)
  - Glucosamine/Chondroitin (for arthritis)
  - St. John's Wort (for depression)

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

- Health Club Dues
- Exercise classes
- Weight Loss Programs
- Wigs
- Exercise equipment

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

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

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

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

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

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

Claims Submission

OBTAINING A REIMBURSEMENT FROM YOUR HEALTH CARE ACCOUNT

To obtain a reimbursement from your Health Care Account, you must complete a Claim Form. This form is available from your benefits website. You must attach a receipt or bill **from the service provider** which includes all the pertinent information regarding the expense:

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

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

OBTAINING A REIMBURSEMENT FOR OVER-THE-COUNTER ITEMS

For the purchase of over-the-counter medications, with a prescription or a letter of medical necessity, cash register receipts will be accepted as documentation **if the receipt is detailed and indicates the name of the service provider, the date of the purchase, the amount of the purchase and the name of the product purchased. You must also send in a copy of the Rx or letter of Medical necessity signed by a Physcian, along with your claim form.** If the receipt does not specifically reflect the name of the product we cannot accept the claim for reimbursement of that item. The name of the patient does not have to be on the receipt, however, the name of the patient must be listed on the claim form.

NOTE: In order to be eligible for reimbursement through the Health Care Account, the medical expense must be incurred during the Plan Year. IRS defines *"incurred"* as when the medical care is provided (or date of service), not when you are formally billed, charged for, or pay for the care.

EXAMPLE: If you go to the doctor on September 26th and your Plan Year begins on October 1st, this expense is not eligible in the new Plan Year. Even if you pay for this expense after October 1st, the "date of service" was before the Plan Year began and therefore is not eligible.

THE HEALTH CARE ACCOUNT IS A PRE-FUNDED ACCOUNT

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

Dependent Care Reimbursement Account

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

ELIGIBLE DEPENDENT

- A child under 13 who qualifies as a dependent on your Federal Income Taxes
- Any other dependents, including a disabled spouse, disabled children over age 13 and elderly parents, who depend on you for financial support, qualify as dependents for tax purposes, and are incapable of self care
- Please refer to Page 16 for the latest definition of a dependent, as revised under Section 152 of the Code by the Working Families Tax Relief Act of 2005 (WFTRA)

ELIGIBLE DEPENDENT CARE EXPENSES

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

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

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

EXAMPLES OF DEPENDENT CARE EXPENSES

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

EXPENSES THAT WOULD <u>NOT</u> BE ELIGIBLE THROUGH THE DEPENDENT CARE ACCOUNT

- Kindergarten (kindergarten & above is considered an educational expense)
- Days you or your spouse are not working, including sick leave, vacation days, and maternity leave
- Transportation, books, clothing, or entertainment (Note: These expenses will be covered if provided by the nursery school or day care center as part of its preschool care services. If these types of expenses are billed separately, they are **<u>not</u>** an eligible expense.)

Care provider may not be a child of yours under the age of 19 or anyone you claim as a dependent for federal income tax purposes

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

ANNUAL MAXIMUM FOR THE DEPENDENT CARE REIMBURSEMENT ACCOUNT

Must Not Exceed The Lesser Of:

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

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

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

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

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

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

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

OBTAINING A REIMBURSEMENT FROM YOUR DEPENDENT CARE REIMBURSEMENT ACCOUNT

To obtain a reimbursement from your Dependent Care Reimbursement Account you must complete a Claim Form. This claim form is available from your benefits website. You must attach a receipt **from the service provider** which includes all of the following:

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

NOTE: Dependent care expenses can only be reimbursed after the care is provided. **This means that advance payments of dependent care expenses cannot be made.**

FOR EXAMPLE: If you pay for a summer day camp for your child in May but the camp is the first week in July, we cannot reimburse you for this expense until July when the service is provided.

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

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

THE BENEFITS CARD

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

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

- The Benefits Card works just like a debit card, only your "bank account" consists of the funds you elected to set aside in your pre-tax account(s). The card is not eligible for use at ATM's or other unqualified merchant locations. The card will be denied at the point of sale when used at an ineligible location is attempted. If an eligible provider does not accept MasterCard®, you must file a paper claim. When using the card at a self-service merchant terminal, select the credit option, not the debit option (there is no PIN #).
- Your card will be mailed to your home address via first class mail. Please allow up to two weeks for delivery of your card. If you do not receive your card two weeks after the start of your Plan Year, contact Flexible Benefit Administrators, Inc. so that a replacement card may be ordered. Any eligible expense incurred during that time may be reimbursed by mailing or faxing a claim form, and receipts to Flexible Benefit Administrators, Inc., following the customary claims filing procedure and cutoff times.
- When you receive your card, sign the back of the card prior to using it. Your card is activated upon the first swipe of your card.
- Continue to save all receipts. Flexible Benefit Administrators, Inc. may request them to verify expense eligibility.
- Flexible Benefit Administrators, Inc. will notify you by mail or e-mail if you incur an expense with the card that is or appears to be ineligible. Upon this notice you must send Flexible Benefit Administrators, Inc. a Transaction Substantiation Form with the corresponding receipts within 10 business days. You may download and print a Transaction Substantiation Form from our website). If you do not send in those required items, your card will be deactivated until the documentation is received.
- Your transaction will be denied for any amount greater than your health care reimbursement account annual election at the time of the "swipe".
- You should notify Flexible Benefit Administrators, Inc. immediately if your card is lost or stolen to deactivate the card. If your employment is terminated, you must surrender the card to your employer.
- You may monitor your account balance, transaction history or print a statement at any time, night or day on the Benefits Card website: **www.benefitspaymentsystem.com**.
- Additional information regarding the Benefits Card is available on our website: **www.flex-admin.com**. You may also download the Transaction Substantiation Form from our website under Participant; FBA Benefit Cards; Forms.

Attention: *Benefits Card Participant*
Subject: *Benefits Card Use*

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

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

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

Flexible Benefit Administrators, Inc. may request documentation to substantiate your Benefits Card transactions to determine eligibility of the expense. In the event that your documentation shows ineligible expenses were paid with your Benefits Card, Flexible Benefit Administrators, Inc. will request that you re-pay the amount of the ineligible expense. If the payment is not received in the allotted time frame your card will be de-activated. Also, Flexible Benefit Administrators, Inc. may offset future claims and notify your employer. IRS rulings allow your employer to withhold this amount from your wages if necessary.

The Benefits Card is NOT PAPERLESS, just less paper and is a great convenience for the participants in the Plan if used properly.

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

CLAIM FILING DATES

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

COMMON ERRORS TO AVOID WHEN FILING CLAIMS

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

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

REIMBURSING THE PROVIDER OF SERVICE

All reimbursements will be sent to you directly. After receiving payment from your account, you are responsible for paying your providers.

ELIGIBLE DEPENDENTS

An individual is considered to be a dependent if he or she is a qualifying child or qualifying relative of the taxpayer. The following qualifying criteria now apply to be a "dependent child": the individual is a child to the participant, and the individual doesn't turn 27, regardless of any other status by the end of the taxable year.

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

GRACE PERIOD FOR FILING CLAIMS

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

FORFEITING FUNDS

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

CHANGES IN YOUR ELECTION

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

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

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

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

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

TRANSFERRING FUNDS BETWEEN ACCOUNTS

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

TERMINATION OF EMPLOYMENT

If you have funds in your Health Care Account and you submit receipts for expenses incurred prior to your termination, you can be reimbursed for funds remaining in your account up to your annual election. However, if you have money

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

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

EFFECT ON SOCIAL SECURITY BENEFITS

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

ACCOUNT BALANCES

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

ESTIMATING YOUR EXPENSES

These worksheets will help you determine your annual expenses for your Health Care and Dependent Care accounts. Good planning and careful estimating is the best way to take full advantage of your Flexible Benefit Plan.

ESTIMATING YOUR HEALTH CARE EXPENSES

Medical deductibles	_____
Medical co-payments	_____
Prescription drugs	_____
Vision Exams, Glasses, Contacts	_____
Dental/Orthodontia	_____
Routine exams and physicals	_____
Over-the-counter expenses	_____
TOTAL ESTIMATED MEDICAL EXPENSES FOR THE PLAN YEAR (Min. $260) (Max. $2,500)	_____

ESTIMATING YOUR DEPENDENT CARE EXPENSES

Child day care expenses	_____
Pre-School expenses	_____
Summer Day Camp expenses	_____
Adult day care expenses	_____
Other eligible expenses	_____
TOTAL ESTIMATED DEPENDENT CARE EXPENSES FOR THE PLAN YEAR (Max. $5,000)	_____

SAMPLE CLIENT FLEXIBLE BENEFIT PLAN – CLAIM FORM

Employee's name _____ SS# _____

HEALTH CARE EXPENSES I, the participant, hereby file claim for the medical expense(s) noted below and certify that each expense was incurred on the date and for the person and reason noted. The expense(s) listed below was incurred for medical care not general health purposes and exclude cosmetic and/or toiletries expense(s). I, the participant, certify that I have not been reimbursed for the expense(s) noted below and that I will not seek reimbursement under any other plan covering health benefits. I, the participant, further certify that the expense(s) noted below have not been previously paid for by use of my Benefits Card. A**ttached are receipts or bills as evidence of my expenses incurred during the Plan Year. *Please note: A doctor's note must be attached if considered a "dual purpose" drug.**

Date of Treatment	Person treated and Relationship	Type of eligible Expense	Amount of Expense
		Total	

DEPENDENT CARE EXPENSES **I, the participant, hereby file claim for the child or dependent care expense(s) noted below and certify that each expense was incurred on the dates and for the persons noted. I, the participant, certify that I have not been reimbursed for the expense(s) noted below and that I will not seek reimbursement under any other plan. I, the participant, further certify that the expense(s) below have not been previously paid for by use of my Benefits Card. Attached are receipts or bills as evidence of my expenses incurred during the Plan Year. Please note that receipts must come from the day care provider and have the dates of service, a description of the expense, the amount charged and the provider's SS# or Tax ID#.**

Care Provided By	Date Care Provided	Person Care for and Relationship	Amount of Expense
Name			
Address			
Tax ID # or SS#		**Total**	

I authorize the service provider to release any information requested by the Plan Administrator in connection with this request for reimbursement.

_____ _____

EMPLOYEE'S SIGNATURE DATE

Mail This Claim Form To:	Fax Claim Form To: (Please Include Cover Sheet)
Flexible Benefit Administrators, Inc.	Flexible Benefit Administrators, Inc.
P.O. Box 8188, Virginia Beach, VA, 23450	Fax Number: 757-431-1155

Scan and E-mail This Claim Form To:
Flexible Benefit Administrators, Inc.
FlexDivision@flex-admin.com

PLEASE:
- DO NOT mail your claim form if you fax it.
- KEEP a copy of all claim forms and receipts for your records
- NOTIFY Flexible Benefits Administrators, Inc. if you have a change in address

Accessing Your Flex Account Online

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

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

Step 1. Log-on to our website at www.flex-admin.com
Step 2. Select **Participants**
Step 3. Select **Account Log In** under the appropriate account type that you participate in. Please note that if you participate in more than one type of account, you do not have to set up a separate account for each one. You will be able to see all your account information under the one User ID and Password you create.
Step 4. Select **Participant Login**
Step 5. Select **Create Account**
Step 6. You will be prompted to enter your Name and Employee ID
Step 7. You must then enter your Benefits Card Number or, if you do not have a Benefits Card, you may enter your Employer ID, which is: **FBASPT**
Step 8. Create your User ID, Password, Security Word and Birth City and your email address. Please note that your User ID will need to be between 4-10 characters. Your password needs to be between 7-10 characters and must include at least one letter and number.
Step 9. You are now ready to access your individual account!

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

Problems Logging into your Account?
E-mail to: flexdivision@flex-admin.com
Include your Full Name, SS# or Employee ID#, Company Name, & Contact phone number
Telephone:
Local **757-340-4567 or Toll Free 800-437-3539** (Monday-Friday 8:30am-5:00pm EST)

ADMINISTERED BY
FLEXIBLE BENEFIT ADMINISTRATORS, INC.
509 VIKING DRIVE, SUITE F
P.O. BOX 8188
VIRGINIA BEACH, VA 23450
(757) 340-4567 or (800) 437-FLEX
FAX: (757) 431-1155
FlexDivision@flex-admin.com
www.flex-admin.com

Continental American Insurance Company
Group Accident Insurance Plan

Plan Description

Group accident insurance pays a benefit for the treatment of injuries suffered as the result of a covered accident. Benefits are paid regardless of any other health insurance benefits the insured may receive.

Why Offer Group Accident Insurance?

Most families don't budget for the costs associated with accidents. When an accident does occur the last thing on your mind are the charges accumulating while at the emergency room:

- The ambulance ride
- Casts
- Use of the emergency room
- Wheelchairs
- Surgery and Anesthesia
- Crutches
- Stitches
- Bandages

These costs add up fast. Most families have Medical Insurance that will cover a majority of the expenses. But, what about the out-of-pocket medical expenses, such as lost wages an employee or spouse loses when out of work or staying home to care for an injured family member? You hope that an accident never happens, but at some point you will probably take a trip to your local emergency room. If that time comes, wouldn't it be nice to have an insurance plan that pays you a benefit regardless of any other insurance you have? Group accident insurance does just that, providing a cash benefit to cover the costs associated with unexpected trips.

Plan Features

- No limit on the number of claims.
- Supplements and pays regardless of any other insurance programs.
- Benefits available for spouse and/or dependent children.
- Provides 24-hour protection.
- Benefits for both inpatient and outpatient treatment of covered accidents.
- Guaranteed Issue - No underwriting required to qualify for coverage.
- Payroll Deduction - Premiums are paid by convenient payroll deduction.

Group Eligibility

Product is only available through payroll deduction. Minimum group size is 25 approved employee applicants.

AGC00201SCG

Individual Eligibility

Issue Ages

Employee	18-69
Spouse	18-69
Children	under age 26

Full-time, regular, benefit eligible employees working at least 20 hours or more per week. We recommend that eligible employees have at least 90 days of continuous employment by the date of the enrollment. Seasonal and temporary employees are not eligible.

Spouse and Dependent Children Coverage Available

If the employee participates in the plan, then the employee's spouse and dependent children are eligible to participate. A dependent child is an employee's natural child, step-child, foster child, legally adopted child, or child placed for adoption who is under age 26.

The employee may purchase accident coverage for his/her spouse and/or dependent children. With exception of the specific benefits noted, the benefits for a covered spouse or dependent child are equal to the employee's benefit amounts.

The employee must participate in order to purchase spouse and/or dependent child coverage.

Underwriting Guidelines

No health questions are asked in order to participate.

Portability

When coverage would otherwise terminate because the employee ends employment with the employer, coverage may be continued. The employee will continue the coverage that is inforce on the date employment ends, including dependent coverage then in effect.

The employee will be allowed to continue the coverage until the earlier of the date the employee fails to pay the required premium at the end of the grace period, or the date the group master policy is terminated. Coverage may not be continued if the employee fails to pay any required premium, the employee attains age 70, or the group master policy terminates.

Accident Benefits

Complete Fractures (diagnosis and treatment within 90 day)				
	Employee Closed Reduction	**Employee Open Reduction**	**Spouse/ Child Closed Reduction**	**Spouse/ Child Open Reduction**
Hip/Thigh	$4,500	$6,750	$4,000	$6,000
Vertebrae	$4,050	$6,075	$3,600	$5,400
Pelvis	$3,600	$5,400	$3,200	$4,800
Skull (Depressed)	$3,375	$5,062	$3,000	$4,500
Leg	$2,700	$4,050	$2,400	$3,600
Forearm/Hand	$2,250	$3,375	$2,000	$3,000
Foot/Ankle/ Knee Cap	$2,250	$3,375	$2,000	$3,000
Shoulder Blade/Collar Bone	$1,800	$2,700	$1,600	$2,400
Lower Jaw (Mandible)	$1,800	$2,700	$1,600	$2,400
Skull (Simple)	$1,575	$2,362.50	$1,400	$2,100
Upper Arm/ Upper Jaw	$1,575	$2,362.50	$1,400	$2,100
Facial Bones (Except teeth)	$1,350	$2,025	$1,200	$1,800
Vertebral Processes	$900	$1,350	$800	$1,200
Coccyx/Rib/ Finger/Toe	$360	$540	$320	$480

A fracture is a break in a bone which can be seen by x-ray. If more than one fracture requiring either open or closed reduction occurs in any one covered accident, we will pay the scheduled benefit for each fracture, not to exceed 150 percent of the scheduled benefit amount with for the bone fractured with the highest dollar value. Benefits for chip fractures are payable at 10 percent of the scheduled amount shown for the affected bone. A chip fracture is a piece of bone which is completely broken off near a joint.

Complete Dislocations (diagnosis and treatment within 90 days)				
	Employee Closed Reduction	**Employee Open Reduction**	**Spouse/ Child Closed Reduction**	**Spouse/ Child Open Reduction**
Hip	$3,600	$5,400	$2,700	$4,050
Knee (not kneecap)	$2,600	$3,900	$1,950	$2,925
Shoulder	$2,000	$3,000	$1,500	$2,250
Foot/Ankle	$1,600	$2,400	$1,200	$1,800
Hand	$1,400	$2,100	$1,050	$1,575
Lower Jaw	$1,200	$1,800	$900	$1,350
Wrist	$1,000	$1,500	$750	$1,125
Elbow	$800	$1,200	$600	$900
Finger/Toe	$320	$480	$240	$360

A dislocation is a completely separated joint. If more than one dislocation requiring either open or closed reduction occurs in any one covered accident, we will pay the scheduled benefit for each dislocation, not to exceed 150 percent of the scheduled benefit amount for the joint dislocated which has the higher dollar value. Benefits for partial dislocations are payable at 25 percent of the scheduled amount shown for the affected joint. A partial dislocation is one in which the joint is not completely separated. If the insured fractures a bone and dislocates a joint in the same accident, we will pay for both. However, we will pay no more than 150 percent of the scheduled benefit amount for the bone fractured or joint dislocated with the highest dollar value. Benefits are payable for only the first dislocation of a joint. We will not pay benefits for a recurring dislocation of the same joint. Joints dislocated prior to the effective date of coverage will not be covered should they become dislocated while coverage is in force.

Paralysis (lasting more than 90 days, diagnosed by a Physician within 90 days)		
	Employee & Spouse	**Children**
Quadriplegia	$10,000	$10,000
Paraplegia	$5,000	$5,000

Paralysis means the permanent loss of movement of two or more limbs. If this benefit is paid and the insured later dies as a result of the same covered accident, we will pay the appropriate Death Benefit, less any amounts paid under the Paralysis Benefit.

Lacerations (treatment and repair within 72 hours)	
Up to 2” long	$50
2” - 6” long	$200
Over 6” long	$400

For lacerations not requiring stitches and treated by a physician, we pay $25. For multiple lacerations, we will pay for the largest single laceration requiring stitches.

Injuries Requiring Surgery	
Eye Injuries (treatment and surgery within 90 days)	$250
Removal of foreign body (requiring no surgery)	$50
Tendons/Ligaments (treatment within 60 days, surgical repair within 90 days) *Single* *Multiple* If the insured fractures a bone or dislocates a joint, and tears, severs, or ruptures a tendon or ligament in the same accident, we will pay one benefit. We will pay the largest of the scheduled benefit amounts for fractures, dislocations, or tendons and ligaments.	 $400 $600
Ruptured Disc (treatment within 60 days, surgical repair within one year) *Injury occurs during first certificate year* *Injury occurs after first certificate year*	 $100 $400
Torn Knee Cartilage (treatment within 60 days, surgical repair within one year) *Injury occurs during first certificate year* *Injury occurs after first certificate year*	 $100 $400

Burns (treatment within 72 hours)	
Second Degree	
Less than 10% of body surface covered	$100
At least 10%, but not more than 25% of body surface covered	$200
At least 25%, but not more than 35% of body surface covered	$500
More than 35% of body surface covered	$1,000
Third Degree	
Less than 10% of body surface covered	$500
At least 10%, but not more than 25% of body surface covered	$3,000
At least 25%, but not more than 35% of body surface covered	$7,000
More than 35% of body surface covered	$10,000
***First Degree burns are not covered.**	
Concussion (resulting in electroencephalogram abnormality)	$200
Coma (lasting 30 days or more)	$10,000
Internal Injuries (resulting in open abdominal or thoracic surgery)	$1,000
Exploratory Surgery (without repair, i.e. arthroscopy)	$250
Emergency Dental Work (sound natural teeth)	
Repaired with crown	$150
Resulting in extraction	$50

Medical Fees (for each accident)	
Employee or Spouse	$125
Child(ren)	$75

If an insured is injured in a covered accident and receives treatment within one year, we will pay up to the applicable amount for physician charges, emergency room services and supplies, and x-rays. The total amount payable will not exceed the maximum shown above per accident. Initial treatment must be received within 60 days from the date of the accident.

Accident Follow-up Treatment - $25.00
We will pay this benefit for up to six treatments per covered accident, per covered person for follow-up treatment. The insured must have received initial treatment within 72 hours of the accident and the follow-up treatment must begin within 30 days of the covered accident or discharge from the hospital.

Physical Therapy - $25.00
We will pay this benefit for up to six treatments (one per day) per covered accident, per covered person for treatment from a physical therapist. A physician must prescribe the physical therapy. The insured must have received initial treatment within 72 hours of the accident and physical therapy must begin 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.

Air Ambulance - $500 Ambulance - $100
If an insured requires transportation to a hospital by a professional ambulance service within 90 days after a covered accident, we will pay the amount shown above.

Transportation (within 90 days)
- Train or Plane - $300
- Bus - $150

If hospital treatment or diagnostic study is recommended by your physician and is not available in your city of residence, we will pay the amount shown above. The distance to the location of the hospital must be more than 50 miles from your residence.

Blood/Plasma - $100
If the insured receives blood and plasma within 90 days following a covered accident, we will pay the amount shown above.

Prosthesis - $500
If a covered accident requires the use of a prosthetic device, we will pay the amount shown above. Hearing aids, wigs, or dental aids, including (but not limited to) false teeth are not covered.

Appliance - $100
We will pay this benefit for use of a medical appliance due to injuries received in a covered accident. Benefits are payable for crutches, wheelchairs, leg braces, back braces and walkers.

Family Lodging Benefit (per night) - $100
If an insured is required to travel more than 100 miles for inpatient treatment of injuries received in a covered accident, We will pay this benefit for an immediate family member's lodging. Benefits are payable up to 30 days per accident and only while the insured is confined to the hospital. The treatment must be prescribed by the employee's local physician.

Wellness - $60
After 12 months of paid premium and while coverage is in force, we will pay this benefit for one covered person to undergo routine examinations or other preventative testing once each 12 month period. Benefits include, and are payable for: annual physical exams, mammograms, Pap smears, eye examinations, immunizations, flexible sigmoidoscopy, PSA, ultrasounds and blood screenings.

Hospital Admission - $1,000
We will pay this benefit when you are admitted to a hospital within 6 months and confined as a resident bed patient because of injuries received in a covered accident. We will pay this benefit once per calendar year per insured person. We will not pay this benefit for confinement to an observation unit, or for emergency room treatment or outpatient treatment.

Hospital Confinement (per day) - $200
We will provide this benefit on the first day of hospital confinement for up to 365 days. Hospital confinement must begin within 90 days from the date of the accident.

This benefit is payable once per hospital confinement even if the confinement is caused by more than one accidental injury.

Hospital Intensive Care (per day) - $400
Benefit paid up to 30 days per covered accident. Benefits are paid in addition to the hospital confinement.

Accidental Death & Dismemberment (within 90 days)			
	Employee	**Spouse**	**Children**
Accidental Death	$50,000	$10,000	$5,000
Accidental Common Carrier Death	$100,000	$50,000	$15,000
Single Dismemberment	$6,250	$2,500	$1,250
Double Dismemberment	$25,000	$10,000	$5,000

Loss of One or More Fingers and Toes	$1,250	$500	$250
Partial Amputation of Finger(s) or Toe(s) (including at least one joint)	$100	$100	$100

Dismemberment means:
1. Loss of a hand: the hand is cut off at or above the wrist joint; or
2. Loss of a foot: the foot is cut off at or above the ankle; or
3. Loss of sight: at least 80% of the vision in one eye is lost. Such loss of sight must be permanent and irrecoverable or
4. Loss of a finger/toe: the finger or toe is cut off at or above the joint where it is attached to the hand or foot.

If the employee does not qualify for the Dismemberment Benefit but loose at least one joint of a finger or toe, we will pay the Partial Dismemberment shown. If this benefit is paid and the employee later dies as a result of the same covered accident, we will pay the appropriate death benefit, less any amounts paid under this benefit.

Accidental Death - If the employee is injured in a covered accident and the injury causes him/her to die within 90 days after the accident, we will pay the Accidental Death Benefit shown. If the Accidental Death Benefit is paid, we will not pay the Accidental Common Carrier Death Benefit.

Accidental Common Carrier Death - If the employee is injured in a covered accident and the injury causes him/her to die within 90 days after the accident, we will pay the Accidental Common Carrier Death Benefit in the amount shown if the injury is the result of traveling as a fare-paying passenger on a common carrier, as defined below.

Common carrier means:
1. an airline carrier which is licensed by the United States Federal Aviation Administration and operated by a licensed pilot on a regular schedule between established airports;
2. a railroad train which is licensed and operated for passenger service only; or
3. a boat or ship which is licensed for passenger service and operated on a regular schedule between established ports.

If the Accidental Common Carrier Death Benefit is paid, we will not pay the Accidental Death Benefit.

Pre-existing Condition Limitation
Pre-existing Condition means within the 12-month period prior to the Effective Date of the Certificate and attached Riders, as applicable.

We will not pay benefits for any loss or injury which is caused by, contributed to by, or resulting from a pre-existing condition for 12 months after the Effective Date. would continue to apply to the prior level of Benefits.

A claim for benefits for loss starting after 12 months from the effective date of a certificate and attached riders, as applicable, will not be reduced or denied on the grounds that it is caused by a pre-existing condition.

A Certificate may have been issued as a replacement for a Certificate previously issued under the Plan. If so, then the Pre-existing Condition Limitation Provision of the Certificate applies only to any increase in benefits over the prior Certificate. Any remaining period of Pre-existing Condition Limitation of the prior Certificate would continue to apply to the prior level of Benefits.

Exceptions and Reductions

We will not pay benefits for loss caused by pre-existing conditions (except as stated in the previous provision). We will not pay benefits for loss, injury, or death contributed to, caused by, or resulting from:

- Participating in war or any act of war, declared or not, or participating in the armed forces of or contracting with any country or international authority. We will return the prorated premium for any period not covered when you are in such service.
- Operating, learning to operate, serving as a crew member on, or jumping or falling from any aircraft, including those which are not motor-driven.
- Participating or attempting to participate in an illegal activity or working at an illegal job.
- Committing or attempting to commit suicide, while sane or insane.
- Injuring or attempting to injure yourself intentionally.
- Traveling more than 40 miles outside the territorial limits of the United States, Canada, Mexico, Puerto Rico, The Bahamas, Virgin Islands, Bermuda and Jamaica except under the Accidental Common Carrier Death Benefit.
- Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.
- Participating in any organized sport, professional or semi-professional.
- Being legally intoxicated or under the influence of any narcotic unless taken under the direction of a physician.
- Driving any taxi or intrastate or interstate long-distance vehicle for wage, compensation or profit.
- Mountaineering using ropes and/or other equipment, parachuting or hang-gliding.
- Having cosmetic surgery or other elective procedures that are not medically necessary or having dental treatment except as a result of covered accident.
- Having any disease or bodily/mental illness or degenerative process. We also will not pay benefits for any related medical/surgical treatment or diagnostic procedures for such illness.

Semi-Monthly Premium Rates

Employee	$8.10
Employee and Spouse	$11.59
Employee and Dependent Child(ren)	$15.45
Employee, Spouse, and Dependent Child(ren)	$18.94

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2801 Devine Street, Columbia, South Carolina 29205.

Customer Service

800.433.3036

csc@caicworksite.com

Allstate Benefits (AB) Group Cancer Plan

In the United States, about 1,529,560 new cancer cases were expected to be diagnosed in 2010. [1]

Group Voluntary Cancer

If you suddenly become diagnosed with cancer, it can be difficult on your family's financial and emotional stability. Having the right coverage to help when you are sick and undergoing treatment or when you cannot work is important. Our cancer insurance can help provide security when you need it most.

Meeting Your Needs:

Our cancer coverage can help offer you and your family members financial support during a period of unexpected illness.

- Benefits will be paid directly to you unless otherwise assigned
- Coverage can be purchased for you and your entire family
- No evidence of insurability required at initial enrollment †
- Waiver of premium after 90 days of disability due to cancer for as long as your disability lasts*
- Includes coverage for 29 other specified diseases**
- Portable coverage

Benefit Coverage Highlights

Group Voluntary Cancer Insurance offers you coverage should you be diagnosed with cancer or 29 specified diseases. It helps protect you and your family 24 hours a day, seven days a week.

Each pre-packaged plan doesn't just cover you; if you choose, it also covers your dependents (which can include spouse, domestic partner and children). Our valuable coverage can help supplement your traditional medical insurance which may only cover a small portion of the non-medical expenses that can be incurred with such a diagnosis as cancer.

You and each covered family member can be sure they will receive:

- Benefits that can be used to help pay for treatment, hospital stays, transportation, and more!
- Easy enrollment without required evidence of insurability †

A cancer diagnosis can mean unforeseen expenses that may be difficult to pay. Hospital stays, medical or surgical treatments, and transportation by air or ground ambulance can add up quickly and be very costly. Our Group Voluntary Cancer Supplemental Insurance helps offset some of the expenses your health insurance may not cover, so you can focus on getting well.

***Primary insured only**

***List of covered diseases on page 33**

[1] Cancer Facts & Figures, American Cancer Society, 2010

† Enrolling after your initial enrollment period requires evidence of insurability

In the U.S., 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.[1]

Your Benefit Coverage

Benefits are paid for cancer and specified diseases and can help cover the costs of specific treatments and expenses as they happen. Terms and conditions for each benefit will vary.

Specified Diseases

Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease), Muscular Dystrophy, Poliomyelitis, Multiple Sclerosis, Encephalitis, Rabies, Tetanus, Tuberculosis, Osteomyelitis, Diphtheria, Scarlet Fever, Cerebrospinal Meningitis (bacterial), Brucellosis, Sickle Cell Anemia, Thallasemia, Rocky Mountain Spotted Fever, Legionnaire's Disease (confirmation by culture or sputum), Addison's Disease, Hansen's Disease, Tularemia, Hepatitis (Chronic B or Chronic C with liver failure or Hepatoma), Typhoid Fever, Myasthenia Gravis, Reye's Syndrome, Primary Sclerosing Cholangitis (Walter Payton's Liver Disease), Lyme Disease, Systemic Lupus Erythematosus, Cystic Fibrosis and Primary Biliary Cirrhosis.

Continuous Hospital Confinement

A $100 benefit will be paid for each day of continuous hospital confinement for the treatment of cancer or specified diseases.

Government or Charity Hospital

A $100 benefit will be paid for each day a covered person is confined to:
(1) a hospital operated by or for the U.S. Government (including the Veteran's Administration);
(2) a hospital that does not charge for the services it provides (charity).
This benefit is paid in lieu of all other benefits in the policy (except Waiver of Premium Benefit).

Surgery

Up to a $3,000 benefit will be paid** when a covered surgery (**amount per surgery depends on surgery) is performed on a covered person. This benefit pays the actual charges, up to the amount listed in the Schedule of Surgical Procedures for the specific procedure. Two or more procedures performed at the same time through one incision or entry point are considered one operation; AB pays the amount for the procedure with the greatest benefit. AB pays for a covered surgery performed on an outpatient basis at 150% of the scheduled benefit. This benefit does not pay for surgeries covered by other benefits in the Schedule of Benefits.

Second Opinion

A $400 benefit will be paid for a second opinion, if physician recommends surgery or treatment for covered condition. This second opinion must be rendered prior to surgery or treatment being performed, and obtained from a physician not in practice with the physician rendering the original recommendation.

1 Cancer Facts & Figures, American Cancer Society, 2010.

Physical or Speech Therapy
A $50 benefit will be paid per day for physical or speech therapy for restoration of normal body function.

Anesthesia
25% of the surgery benefit will be paid for anesthesia received by an anesthetist.

Ambulatory Surgical Center
A $500 benefit will be paid for the use of an Ambulatory Surgical Center, up to the amount shown each day for a surgical procedure covered under the surgery benefit that is performed at an ambulatory surgical center.

Radiation/Chemotherapy for Cancer
Up to a $10,000 (Low) or $20,000 (High) benefit will be paid per 12-month period for radiation therapy and chemotherapy received by a covered person. This benefit pays the actual cost and is limited to the amount shown per 12-month period beginning with the first day of benefit under this provision. Administration of radiation therapy or chemotherapy other than by medical personnel in a physician's office or hospital, including medications dispensed by a pump, will be limited to the costs of the drugs only, subject to the maximum amount payable per 12-month period.

Anti-Nausea Benefit
Up to a $200 benefit will be paid per calendar year for the actual cost of anti-nausea medication prescribed for a covered person by a physician. This benefit does not pay for medication administered while the covered person is an inpatient.

Inpatient Drugs and Medicine
A $25 benefit will be paid per day for drugs and medicine while continuously hospital confined. This benefit does not pay for drugs and/or medicine covered under the Radiation/Chemotherapy Benefit or the Anti-Nausea Benefit.

Hematological Drugs
Up to a $200 (Low) or $400 (High) benefit will be paid per year for the actual cost of drugs intended to boost cell lines such as white blood cell counts, red blood cell counts and platelets. This benefit is paid only when the Radiation/ Chemotherapy for Cancer benefit is paid.

Medical Imaging
Actual cost up to a $500 (Low) or $1,000 (High) benefit will be paid per calendar year if a covered person receives an initial diagnosis or follow-up evaluation based upon one of the following medical imaging exams: CT scan, Magnetic Resonance Imaging (MRI) scan, bone scan, thyroid scan, Multiple Gated Acquisition (MUGA) scan, Positron Emission Tomography (PET) scan, transrectal ultrasound, or abdominal ultrasound. This benefit is limited to 1 payment per calendar year per covered person.

Private Duty Nursing Services
A $100 benefit will be paid per day while hospital confined, if a covered person requires the full-time services of a private nurse. Full-time means at least 8 hours of attendance during a 24-hour period. These services must be required and authorized by a physician and must be provided by a nurse.

New or Experimental Treatment
Actual charges up to a $5,000 benefit will be paid per 12-month period, for new or experimental treatment. New or experimental treatment is covered for cancer and specified disease when: the treatment is judged necessary by the attending physician and no other generally accepted treatment produces superior results in the opinion of the attending physician. This benefit is limited to the maximum shown per 12-month period beginning with the first day of treatment under this provision. This benefit does not pay if benefits are payable for treatment covered under any other benefit in the Schedule of Benefits.

Blood, Plasma, and Platelets
Up to a $10,000 (Low) or $20,000 (High) benefit will be paid per 12-month period for the actual cost of blood, plasma and platelets (including transfusions and administration charges), processing and procurement costs and cross-matching. Does not pay for blood replaced by donors or immunoglobulins.

Physician's Attendance
A $50 benefit will be paid for a visit by a physician during hospital confinement. Benefit is limited to one visit by one physician per day of hospital confinement. Admission to the hospital as an inpatient is required.

At Home Nursing
A $100 benefit will be paid per day for private nursing care and attendance by a nurse at home. At-home nursing services must be required and authorized by the attending physician. Benefit is limited to the number of days of the previous continuous hospital confinement.

Prosthesis
Up to a $2,000 benefit will be paid per amputation, per covered person for the actual charges for prosthetic devices which are prescribed as a direct result of surgery and which require surgical implantation.

Hair Prosthesis
A $25 benefit will be paid every 2 years for a wig or hairpiece if the covered person experiences hair loss.

Nonsurgical External Breast Prosthesis
Up to a $50 benefit will be paid for the actual cost of the initial, nonsurgical breast prosthesis following a covered mastectomy or partial mastectomy that is paid for under the policy.

Ambulance
A $100 benefit will be paid per continuous hospital confinement for transportation by a licensed ambulance service or a hospital-owned ambulance to or from a hospital in which the covered person is confined.

Hospice Care
A $100 benefit will be paid for one of the following when a covered person has been diagnosed by a physician as terminally ill as a result of cancer or specified disease, is expected to live 6 months or less and the attending physician has approved services:
1. Freestanding Hospice Care Center – A benefit will be paid per day for confinement in a licensed freestanding hospice care center. Benefits payable for hospice centers that are designated areas of hospitals will be paid the same as inpatient hospital confinement; or
2. Hospice Care Team – A benefit will be paid per visit, limited to 1 visit per day, for home care services by a hospice care team. Home care services are hospice services provided in the patient's home. Benefit is payable only if: (a) the covered person has been diagnosed as terminally ill; and (b) the attending physician has approved such services. Does not pay for: food services or meals other than dietary counseling, services related to well-baby care, services provided by volunteers, or support for the family after the death of the covered person.

Extended Care Facility
A $100 benefit will be paid for each day a covered person is confined in an extended care facility for the treatment of cancer or specified disease. Confinement must be at the direction of the attending physician and must begin within 14 days after a covered hospital confinement. Benefit is limited to the number of days of the previous continuous hospital confinement.

Outpatient Lodging
A $50 benefit will be paid for lodging per day when a covered person receives radiation or chemotherapy treatment on an outpatient basis, provided the specific treatment is authorized by the attending physician and cannot be obtained locally. Benefit is for a single room in a motel, hotel, or other accommodations acceptable to AB during treatment, **up to the maximum $2,000** per 12 months beginning with the first day of benefit under this provision. Outpatient treatment must be received at a treatment facility more than 100 miles from the covered person's home.

Non-Local Transportation
$0.40 per mile or actual cost of round trip coach fare on a common carrier benefit will be paid for treatment at a hospital (inpatient or outpatient), radiation therapy center, chemotherapy or oncology clinic, or any other specialized freestanding treatment center nearest to the covered person's home, provided the same or similar treatment cannot be obtained locally. Benefit pays up to 700 miles for round trip in personal vehicle. "Non-Local" means a round trip of more than 70 miles from the covered person's home to the nearest treatment facility. Mileage is measured from the covered person's home to the nearest treatment facility as described above. Does not cover transportation for someone to accompany or visit the person receiving treatment, visits to a physician's office or clinic, or for services other than actual treatment.

Family Member Lodging and Transportation

Up to a $50 benefit per day will be paid for lodging and $0.40 per mile or the actual cost of round trip coach fare on a common carrier will be paid for one adult member of the covered person's family to be near the covered person, when a covered person is confined in a non-local hospital for specialized treatment.

1. Lodging - This benefit is for a single room in a motel, hotel, or other accommodations acceptable to AB. Benefit is limited to 60 days for each period of continuous hospital confinement.
2. Transportation - Benefit is limited to 700 miles per continuous hospital confinement if traveling in personal vehicle. Mileage is measured from the visiting family member's home to the hospital where the covered person is confined. Does not pay the Family Member Transportation Benefit if the personal vehicle transportation benefit is paid under the Non-Local Transportation Benefit, when the family member lives in the same city or town as the covered person.

Waiver of Premium (primary insured only)

If while coverage is in force the insured employee becomes disabled due to cancer first diagnosed after the effective date of coverage and remains disabled for 90 days, AB pays premiums due after such 90 days for as long as the insured employee remains disabled.

Bone Marrow or Stem Cell Transplant*

A 1. $1,000*, 2. $2,500*, 3. $5,000* benefit will be paid for the following types of bone marrow or stem cell transplants performed on a covered person.

1. A transplant which is other than non-autologous.
2. A transplant which is non-autologous for the treatment of cancer or specified disease, other than Leukemia.
3. A transplant which is non-autologous for the treatment of Leukemia.

***This benefit is payable only once per covered person per calendar year.**

ADDITIONAL BENEFITS

Wellness

A $100 benefit will be paid per calendar year per covered person for one of the following wellness tests: Biopsy for skin cancer; Blood test for triglycerides; Bone Marrow Testing; CA15-3 (cancer antigen 15-3 - blood test for breast cancer); CA125 (cancer antigen 125 – blood test for ovarian cancer); CEA (carcinoembryonic antigen – blood test for colon cancer); Chest X-ray; Colonoscopy; Doppler screening for carotids; Doppler screening for peripheral vascular disease; Echocardiogram; EKG (Electrocardiogram); Flexible sigmoidoscopy; Hemocult stool analysis; HPV (Human Papillomavirus) Vaccination; Lipid panel (total cholesterol count); Mammography, including Breast Ultrasound; Cervical Cancer Screening; PSA (prostate specific antigen – blood test for prostate cancer); Serum Protein Electrophoresis (test for myeloma); Stress test on bike or treadmill; Thermography; and Ultrasound screening of the abdominal aorta for abdominal aortic aneurysms. This benefit is paid regardless of the result of the test.

OPTIONAL BENEFITS

Cancer Initial Diagnosis (First Occurrence)

A one time benefit of $3,000 (Low and High) benefit will be paid when a covered person is diagnosed for the first time in their life as having cancer other than skin cancer. The first diagnosis must occur after the effective date of coverage for that covered person. Benefit is payable only once per covered person.

Intensive Care (Low and High Plans Only)

A benefit will be paid for each day for the following types of intensive care confinement:

1. **Hospital Intensive Care Unit Confinement $600*** - This benefit is for hospital intensive care unit confinement for any illness or accident.
2. **Step-Down Hospital Intensive Care Unit Confinement $300*** - This benefit is for step-down hospital intensive care unit confinement for any illness or accident.
3. **Ambulance - AB pays the actual charges** for transportation of a covered person by licensed air or surface ambulance service to a hospital for admission to an intensive care unit for a covered confinement. This benefit is not paid if an ambulance benefit is paid under the Ambulance benefit in the policy.

****This benefit is limited to 45 days for each period of such confinement. A day is a 24-hour period. If confinement is for only a portion of a day, then a pro-rata share of the daily benefit is paid.***

Certificates - Certificates under this plan are issued on a guaranteed basis only at the time of the initial enrollment. A completed Evidence of Insurability form is required for late entrants into the group plan.

Eligibility - Family members eligible for coverage include: you, your legal spouse or domestic partner; and your children who are under 26 years old, unless he or she continues to meet the definition of a dependent.

Portability Privilege - AB will provide portability coverage, subject to these provisions. Such coverage will not be available for you, unless: coverage under the policy terminates under the General Provision entitled “Termination of Coverage,” we receive a written request and payment of the first premiums for the portability coverage not later than 63 days after such termination and the request is made for that purpose. No portability coverage will be provided to you, if your insurance under the policy terminated due to your failure to make required premium payments.

Termination of Coverage - As long as you are insured, your coverage under the policy ends on the earliest of: the date the policy is canceled, the last day of the period for which you made any required premium payments, the last day you are in active employment except as provided under the “Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence” provision, the date you are no longer in an eligible class, or the date your class is no longer eligible. AB will provide coverage for a payable claim incurred while you are covered under the policy. If your spouse is a covered person, the spouse’s coverage ends upon valid decree of divorce or your death. If your domestic partner is a covered person, the

domestic partner's coverage ends upon termination of the domestic partnership or your death. If your child is a covered person, the child's coverage ends when the child reaches age 26, unless he or she continues to meet the requirements of an eligible dependent.

Coverage does not terminate on an incapacitated dependent child who:

1. is incapable of self-sustaining employment by reason of mental or physical incapacity; and
2. became so incapacitated prior to the attainment of the limiting age of eligibility under the coverage; and
3. is chiefly dependent upon you for support and maintenance.

Coverage for an incapacitated dependent child continues as long as the coverage remains in force and the child remains in such condition. Proof of the incapacity and dependency of the child must be furnished in writing when the child reaches the limiting age of eligibility. Thereafter, such proof must be furnished as frequently as may be required, but no more frequently than annually after the child's attainment of the limiting age for eligibility. If AB accepts a premium for coverage extending beyond the date, age or event specified for termination as to a covered person, such premium will be refunded, coverage will be refunded, coverage will terminate and claims will not be paid.

Limits, Exclusions, and Exceptions - We do not pay for any benefit due to, or caused by, a pre-existing condition, as defined, during the 12-month period beginning on the date that person became a covered person. This exclusion will not apply to your newborn child, adopted child or foster child under the age of 18 if AB is notified within 31 days of the child's birth or date of placement. A Pre-Existing Condition is a disease or physical condition for which medical advice or treatment was recommended or received from a member of the medical profession within the 12-month period prior to the effective date of coverage. AB does not pay for any loss except for losses due directly from cancer or specified disease. We do not pay for any other conditions or diseases caused or aggravated by cancer or a specified disease. Diagnosis must be submitted to support each claim. For the Surgery, New or Experimental Treatment and Prosthesis Benefits, if specific charges are not obtainable as proof of loss, AB will pay 50% of the applicable maximum for the benefits payable. Treatment must be received in the United States or its territories.

Intensive Care Exclusions and Limitations - The Hospital Intensive Care Unit Confinement benefit does not pay for intensive care if a covered person is admitted because of an attempted suicide, intentional self-inflicted injury, intoxication or being under the influence of drugs not prescribed or recommended by a physician, or alcoholism or drug addiction. AB does not pay for confinements in any care unit that does not qualify as a hospital intensive care unit. Progressive care units, sub-acute intensive care units, intermediate care units, and private rooms with monitoring, step-down units and any other lesser care treatment units do not qualify as hospital intensive care units. We do not pay for step-down hospital intensive care unit confinement if a covered person is admitted and confined in the following type of units: telemetry or surgical recovery rooms, post-anesthesia

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 semi-private rooms with or without telemetry monitoring equipment, an emergency room, labor or delivery rooms, or other facilities that do not meet the standards for a step-down hospital intensive care unit. We do not pay this benefit for continuous hospital intensive care unit confinements or continuous step-down hospital intensive care unit confinements that occur during a hospitalization that begins before the effective date of coverage.

Coverage Subject to the Policy - The coverage described in the certificate of insurance is subject in every way to the terms of the policy that is issued to the policyholder (your employer). It alone makes up the agreement by which the insurance is provided. The group policy may at any time be amended or discontinued by agreement between AB and the policyholder. Your consent is not required for this. AB is not required to give you prior notice.

The policy is Limited Benefit Cancer and Specified Disease Insurance. This is not a Medicare Supplement Policy. If eligible for Medicare, review Medicare Supplement Buyer's Guide available from American Heritage Life Insurance Company. Subject to COBRA continuation of coverage.

The coverage is provided by a limited benefit supplemental insurance policy. This material is valid as long as information remains current, but in no event later than January 15, 2015. Group Cancer and Specified Disease benefits are provided by policy GVCP3, or state variations thereof. This brochure highlights some features of the policy but is not the insurance contract. Only the actual policy provisions control. The policy sets forth in detail, the rights and obligations of both the policyholder (employer) and the insurance company. For complete details, call 1-800-521-3535. This is a brief overview of the benefits available under the Group Voluntary Policy underwritten by American Heritage Life Insurance Company. Details of the insurance, including exclusions, restrictions and other provisions are included in the certificate issued.

Low Option without Optional Benefits	
Insureds	**Semi-Monthly**
Employee	***$10.04***
Employee + Child(ren)	***$13.86***
Employee + Spouse	***$15.48***
Family	***$19.29***

Low Option with Optional Benefits	
Insureds	**Semi-Monthly**
Employee	***$13.03***
Employee + Child(ren)	***$18.41***
Employee + Spouse	***$20.75***
Family	***$26.12***

High Option without Optional Benefits	
Insureds	**Semi-Monthly**
Employee	***$15.55***
Employee + Child(ren)	***$21.83***
Employee + Spouse	***$23.76***
Family	***$30.02***

High Option with Optional Benefits	
Insureds	**Semi-Monthly**
Employee	***$18.54***
Employee + Child(ren)	***$26.38***
Employee + Spouse	***$29.03***
Family	***$36.85***

Allstate Benefits is the marketing name used by
American Heritage Life Insurance Company
(Home Office, Jacksonville, FL), a subsidiary of The Allstate Corporation.
Allstate Benefits, *The Workplace Marketer ©*
1776 American Heritage Life Drive, Jacksonville, Florida 32224
Customer Care Center: 1.800.521.3535
www.allstate.com or allstateatwork.com

Continental American Insurance Company Group Supplemental Hospital Indemnity Insurance

Plan Description

The Group Supplemental Hospital Indemnity Plan provides benefits for inpatient and outpatient services as a result of Covered Accidents and Sickness.

Why Offer Group Supplemental Hospital Indemnity Insurance?

Eventually, everyone visits their family Physician or the Hospital emergency room during each Calendar Year. The causes for these visits vary from the serious condition, the minor scrape or bruise, and the common cold. Major medical insurance plans are just that, major medical protection. Generally, these plans require some type of major Injury or Sickness, or an accumulation of minor Injuries and Sicknesses, before your employees realize any significant value from the coverage. Calendar year deductibles, co-insurance portions and co-payments can take their toll on your employee's family budget. The Group Supplemental Hospital Indemnity plan offers your employees a solution to the financial burdens created by unexpected trips to the Physician's office or Hospital emergency room. It also provides additional protection against the financial burden of a serious injury or illness. In short, the Group Supplemental Hospital Indemnity plan provides benefits for financial protection against the costs of both inpatient and outpatient services.

Plan Features

- Benefits available for spouse and/or dependent children.
- Pays regardless of any other insurance programs.
- Premiums are paid by convenient payroll deduction.
- Covers both Injuries and Sicknesses.
- Admission and per day Hospital Confinement Benefits included. Additional benefits paid for confinement to intensive care.
- Covers outpatient medical Treatment received in a Hospital emergency room or Physician's office.
- Prescription Drug Benefits included.
- Well Baby Care covered.
- Surgery and Anesthesia Benefits included.
- The plan is portable with certain stipulations

Group Eligibility
Product is only available through payroll deduction. Minimum group size is 25 approved employee applicants.

Individual Eligibility
Issue Ages
Employee 18-64
Spouse 18-64
Children under age 26

Full-time, benefit eligible employees working at least 20 hours or more per week. We recommend that eligible employees have at least 90 days of continuous employment by the date of the enrollment. Seasonal and temporary employees are not eligible.

Spouse and Dependent Children Coverage Available
The employee may purchase Group Supplemental Hospital Indemnity coverage for their spouse and/or dependent children. The spouse and dependent children cannot participate if the employee is not eligible for coverage or elects not to participate. If the employee is eligible then the employee's spouse and dependent children are eligible to participate. A spouse is the employee's legal spouse between the age of 18 and 64. A dependent child is an employee's natural child, step-child, foster child, legally adopted child, or child placed for adoption who is under age 26.

Guaranteed Issue
During the initial enrollment, coverage is Guaranteed Issue. Subsequent to the initial enrollment, evidence of insurability may be required.

Portability
When coverage is effective and would otherwise terminate because the employee ends employment with the employer, coverage may be continued. Employee will continue the coverage that is inforce on the date employment ends, including dependent coverage then in effect. The employee will be allowed to continue the coverage until the earlier of the date the employee fails to pay the required premium, or the date the group master policy is terminated. Coverage may not be continued if the employee fails to pay any required premium, the employee attains age 70, or the group master policy terminates.

Benefits

Hospital Confinement (per day)	
Plan I	**$150**

We will pay the Hospital Confinement Benefit when the insured is confined to a Hospital as a resident bed patient as the result of an injury or because of a Covered Sickness. In order to receive this benefit for an injury, the insured must be confined to a Hospital within 6 months of the date of the Covered Accident. The Hospital Confinement Benefit is payable for a maximum of 180 days for any one Covered Sickness or Covered Accident. The Hospital Confinement Benefit is

payable for only one Hospital confinement at a time even if caused by more than one Covered Accident, more than one Covered Sickness or a Covered Accident and a Covered Sickness.

Hospital Admission (per confinement)	
Plan I	**$250**

We will pay the Hospital Admission Benefit when the insured is admitted to a Hospital and confined as a resident bed patient because of an injury or because of a Covered Sickness. In order to receive this benefit for Injuries received in a Covered Accident, the insured must be admitted to a Hospital within 6 months of the date of the Covered Accident. The Admission Benefit is not payable for confinement to an observation unit, or for emergency room Treatment or outpatient Treatment. The benefit is paid only once for each Covered Accident or Covered Sickness. If an insured is confined to the Hospital because of the same or related Injury or Sickness, we will not pay the Hospital Admission Benefit again.

Hospital Intensive Care (per day)	
Plan I	**$150**

If an insured is confined in a Hospital Intensive Care Unit due to an Injury or because of a Covered Sickness, we will pay the daily Hospital Intensive Care Benefit amount. In order to receive this benefit for an injury, the insured must be admitted to a Hospital Intensive Care Unit within 6 months of the date of the Covered Accident. We will pay the daily Hospital Intensive Care Benefit amount for each day of confinement to a Hospital Intensive Care Unit, not to exceed the 30-day maximum during any one period of confinement. We will pay the Hospital Intensive Care Benefits for only one confinement in a Hospital's Intensive Care Unit at a time, even if it is caused by more than one Covered Accident, more than one Covered Sickness or a Covered Accident and a Covered Sickness. If we pay benefits for confinement in a Hospital's Intensive Care Unit and the insured become confined to a Hospital's Intensive Care Unit again within 6 months because of the same or related condition, we will treat this confinement as the same period of confinement.

Surgical Benefit (per procedure)	
Plan I	**up to $1,500**

If an insured has surgery performed by a Physician due to an Injury or because of a Covered Sickness, we will pay the appropriate Surgical Benefit amount shown in the Schedule of Operations. The Surgical Benefit paid will never exceed the maximum Surgical Benefit designated in the plan. The surgery can be performed in a Hospital (on an inpatient or outpatient basis), in an Ambulatory Surgical Center, or in a Physician's office. If an operation is not listed in the Schedule of Operations, we will pay an amount comparable to that, which would be payable for the operation listed in the Schedule of Operations, which is nearest in severity and complexity. If two or more surgical procedures are performed at the same time through the same or different incisions, only one benefit, the largest, will be provided.

Anesthesia Benefits	
Plan I	**up to $375**

When an insured receives benefits for a surgical procedure covered under the Surgical Benefit, we will pay the appropriate benefit amount shown in the Schedule of Operations for anesthesia administered by a Physician. However, the Anesthesia Benefit paid will not exceed 25 percent of the amount paid under Surgical Benefit.

Hospital Emergency Room/Physician Benefit (Maximum per visit)	
Plan I	**$50**

If an insured is Injured in a Covered Accident or has Treatment as the result of a Covered Sickness, we will pay the Hospital Emergency Room/Physician Benefit for Physician's charges ($50), laboratory fees ($25), x-rays ($50) and injections/ medications ($25). The amount paid for each of these services will not exceed the benefit amount per visit. The total paid for any combination of these services will not exceed the maximum benefit per visit. The Hospital Emergency Room/ Physician Benefit is limited to the calendar year maximum of $250 per insured or $1,000 per family.

Out-of-Hospital Prescription Drug Benefit (per prescription)	
Plan I	**$10**

We will pay the Out-of-Hospital Prescription Drug Benefit for each prescription filled for an insured. A prescription drug must meet three criteria: (1) be ordered by a Doctor; (2) be dispensed by a licensed pharmacist; and (3) be medically necessary for the care and Treatment of the patient. We will cover no more than 5 prescriptions per calendar year per insured. This benefit does not include benefits for:

(a) Therapeutic devices or appliances;

(b) Experimental drugs;

(c) Drugs, medicines or insulin used by or administered to an insured while they are confined to a Hospital, rest home, extended care facility, convalescent home, nursing home or similar institution;
(d) Immunization agents, biological sera, blood or blood plasma; or
(e) Contraceptive materials, devices or medications, or infertility medication, except where required by law.

Well Baby Care* (per visit)	
Plan I	**$25**

We will pay the Well Baby Care Benefit amount associated with each benefit plan option when an insured baby receives well baby care. We will cover no more than 4 visits per calendar year per insured baby. (Our definition of a baby is a dependent child 12 months of age or younger.)
*Available only with Employee & Dependent Children and Family coverages

Pre-Existing Condition Limitation
A Pre-Existing Condition means within the 12-month period prior to the insured's effective date those conditions for which medical advice or Treatment was received or recommended.

We will not pay benefits for any loss or Injury which is caused by, contributed to by, or resulting from a Pre-Existing Condition for 12 months after the insured's effective date, or for 12 months from the date medical care, Treatment, or supplies were received for the Pre-Existing Condition, whichever is less.

A claim for benefits for loss starting after 12 months from the effective date of the insured's certificate will not be reduced or denied on the grounds that it is caused by a Pre-Existing Condition.

Pregnancy is a "Pre-Existing Condition" if conception was before the effective date of this rider.

If certificate is issued as a replacement for a certificate previously issued under this Plan, then the Pre-Existing Condition limitation provision of the new certificate applies only to any increase in benefits over the prior certificate. Any remaining period of Pre-Existing Condition limitation of the prior certificate would continue to apply to the prior level of benefits.

Exclusions
We will not pay benefits for loss caused by Pre-Existing Conditions (except as stated in the Pre-Existing Condition limitation provision above).

We will not pay benefits for loss contributed to, caused by, or resulting from:
1. War - participating in war or any act of war, declared or not, or participating in the armed forces of or contracting with any country or international authority. We will return the prorated premium for any period not covered by this certificate when the insured is in such service.
2. Suicide - committing or attempting to commit suicide, while sane or insane.
3. Self-Inflicted Injuries - Injuring or attempting to Injure yourself intentionally.

4. Traveling - traveling more than 40 miles outside the territorial limits of the United States, Canada, Mexico, Puerto Rico, the Bahamas, Virgin Islands, Bermuda, and Jamaica.
5. Racing - Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.
6. Aviation - operating, learning to operate, serving as a crew member on, or jumping or falling from any aircraft, including those which are not motor-driven.
7. Intoxication - being legally intoxicated, or being under the influence of any narcotic, unless such is taken under the direction of a Physician.
8. Illegal Acts - participating or attempting to participate in an illegal activity, or working at an illegal job.
9. Sports - participating in any organized sport: professional or semi-professional.
10. Custodial care - This is care meant simply to help people who cannot take care of themselves.
11. Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including complications.
12. Routine physical exams and rest cures.
13. Services performed by a relative.
14. Services related to sex change, sterilization, in vitro fertilization, reversal of a vasectomy or tubal ligation.
15. A service or a supply furnished by or on behalf of any government agency unless payment of the charge is required in the absence of insurance.
16. Elective abortion.
17. Treatment, services, or supplies received outside the United States and its possessions or Canada.
18. Dental services or Treatment.
19. Cosmetic surgery, except when due to medically necessary reconstructive plastic surgery.
20. Injury or Sickness covered by Worker’s Compensation.
21. Mental or emotional disorders without demonstrable organic disease.
22. Alcoholism, drug addiction, or chemical dependency.

Semi-Monthly Rates

	Semi-Monthly Premium
Employee	**$17.52**
Employee & Spouse	**$34.84**
Employee & Dependent Children	**$27.04**
Family	**$44.37**

Continental American Insurance Company (CAIC) is a wholly-owned sub-sidiary of Aflac Incorporated. CAIC underwrites group coverage but is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. 2801 Devine Street, Columbia, South Carolina 29205.

Customer Service

800.433.3036

csc@caicworksite.com

Continental American Insurance Company
Group Critical Illness Insurance Plan

Group Critical Illness Benefits

First Occurrence Benefit

After the Waiting Period, an insured may receive up to 100% of the benefit selected upon the first diagnosis of each covered critical illness.

Covered Critical Illnesses*	
Illnesses Covered Under Plan	Percentage of Face Amount
Heart Attack	100%
Stroke	100%
Major Organ Transplant	100%
Kidney Failure (End Stage)	100%
Coronary Artery Bypass**	25%

*At age 70, benefits are reduced by 50%.

Additional Occurrence Benefit

We will pay benefits for each different Critical Illness in the order the events occur. We will pay benefits for any one Critical Illness once every six months. Therefore, no benefits are payable for each different Critical Illness after the first unless its date of diagnosis is separated from the prior Critical Illness by at least 6 months.

Re-Occurrence Benefits

We will pay benefits for the re-occurrence any Critical Illness once every twelve months. Therefore, once benefits have been paid for Critical Illness, no additional benefits are payable for that same Critical Illness unless the dates of diagnosis are separated by at least 12 months.

**Payment of the partial benefit for Carcinoma in Situ will reduce by 25% the benefit for internal Cancer. Payment of the partial benefit for Coronary Artery Bypass Surgery will reduce by 25% the benefit for a Heart Attack.

Health Screening Benefits

After the Waiting Period, an insured may receive a maximum of $100 for any one covered screening test per calendar year. We will pay this benefit regardless of the results of the test. Payment of this benefit will not reduce the amount payable for the diagnosis of a critical illness. There is no limit to the number of years the insured can receive the health screening benefit; it will be paid as long as the policy remains inforce. This benefit is payable for the covered employee and spouse. This benefit is not paid for dependent children. The covered health screening tests include but are not limited to:

- Stress test on a bicycle or treadmill
- Fasting blood glucose test, blood test for triglycerides or serum cholesterol test to determine level of HDL and LDL
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest x-ray
- Colonoscopy
- Flexible sigmoidoscopy
- Hemocult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum protein electrophoresis (blood test for myeloma)
- Thermography

Heart Benefit Rider

Covered Critical Illnesses*	
Illnesses Covered Under Plan	Percentage of Face Amount
Category 1	
Coronary artery bypass surgery	100%
Mitral valve replacement or repair	100%
Aortic valve replacement or repair	100%
Surgical Treatment of Abdominal aortic aneurysm	100%
Category 2**	
AngioJet Clot Busting	10%
Balloon Angioplasty (or Balloon valvuloplasty)	10%
Laser Angioplasty	10%
Atherectomy	10%
Stent implantation	10%

Cardiac catheterization	10%
Automatic Implantable (or Internal) Cardioverter Defibrillator (AICD)	10%
Pacemakers	10%

* At age 70, benefits are reduced by 50%.

We will pay the indicated percentages of the applicable Initial Maximum Benefit amount shown in the Rider Schedule that occurs while this Rider is in force. Benefits are not payable under this Rider for loss if these conditions result from another Specified Critical Illness.

**Benefits for Category II will reduce the benefit amounts payable for Category I benefits. Benefits will be paid only at the highest benefit level. If a Cat I and II are performed at the same time, benefits are only eligible at the 100% (higher) event and will not exceed the amount Initial Face Amount shown on the Rider Schedule. You are only eligible to receive one payment for each benefit category listed on the schedule page. The Dates of Loss for Covered Procedures must be separated by at least 6 months for benefits to be payable for multiple Covered Procedures. Subject to the re-occurrence benefit in the base plan, only one Category II benefit is payable. Benefits will not be paid for multiple procedures listed under the Category II benefit.

Additional Specified Critical Illnesses Rider

Covered Specified Critical Illnesses*	
Illnesses Covered Under Plan	**Percentage of Maximum Benefit**
Coma	**100%**
Paralysis	**100%**
Burns	**100%**
Loss of Sight	**100%**
Loss of Hearing	**100%**
Loss of Speech	**100%**

* At age 70, benefits are reduced by 50%.

We will pay the indicated percentages of the applicable Maximum Benefit Amount shown in the Certificate Schedule. Benefits are not payable for loss if these conditions result from another Specified Critical Illness. The Dates of Loss for Specified Critical Illnesses must be separated by at least 6 months for benefits to be payable for multiple Specified Critical Illnesses.

Individual Eligibility

Issue Ages:

Employee- 18-69

Spouse- 18-69

Children- under age 26

All full-time and part-time employees working at least 16 hours or more weekly with at least 90 days of continuous employment. If an employee is eligible, their spouse is eligible for coverage and all natural children, step-children, foster children, legally adopted children or children placed for adoption who are under age 26. Seasonal and temporary workers are not eligible to participate.

Spouse Coverage Available
The employee may elect to purchase spouse coverage. In order to apply for spouse coverage, the employee must also apply. The spouse amount may not exceed 50% of the employee amount, subject to the minimum face amount of $5,000. If the employee does not meet the underwriting requirements necessary to participate in the plan, the spouse can still obtain coverage. The spouse would then become the primary insured and is limited to face amounts between $5,000 and $25,000.

Dependent Children Coverage at No Additional Charge
Each eligible dependent child is covered at 25% of the primary insured amount at no additional charge. The payment of benefits for a dependent child does not reduce the face amount of the primary insured. Child coverage would end when benefits for the last remaining adult insured is paid in full. Children-only coverage is not available.

Portability
When coverage is effective and would otherwise terminate because the employee ends employment with the employer, coverage may be continued. The employee will continue the coverage that is inforce on the date employment ends, including dependent coverage then in effect. The employee will be allowed to continue coverage until the earlier of the date the employee fails to pay the required premium, the employee attains age 70, or the date the group master policy is terminated.

Exceptions and Reductions (also applies to optional benefits)
This plan contains a 30-day “waiting period.” This means that no benefits are payable for any insured before coverage has been in force 30 days from their effective date of coverage. If a covered person is first diagnosed during the “waiting period,” benefits for that Critical Illness will apply only to loss commencing after 12 months from the effective date of coverage, or the covered person may elect to void the certificate from the beginning and receive a full refund of premium.

The date of diagnosis of a Critical Illness must be separated from the date of diagnosis of a subsequent different Critical Illness by at least 6 months. The date of diagnosis of the same Critical Illness must be separated from the date of diagnosis of the subsequent same Critical Illness by at least 12 months.

The applicable benefit amount will be paid if: the date of diagnosis is after the waiting period; the date of diagnosis occurs while the policy and certificate are in force; and the cause of the illness is not excluded by name or specific description. Benefits will not be paid for loss due to:
1. Intentionally self-inflicted injury or action;
2. Suicide or attempted suicide while sane or insane;

3. Illegal activities or participation in an illegal occupation;
4. War, whether declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence;
5. Substance abuse; or
6. Pre-existing conditions.
Diagnosis must be made and treatment received in the United States.

Pre-existing Conditions Limitation & Exceptions
"Pre-existing Condition" means a sickness or physical condition which, within the 12-month period prior to an insured's effective date resulted in the insured receiving medical advice or treatment.

We will not pay benefits for any condition or illness starting within 12 months of an insured's effective date which is caused by, contributed to, or resulting from a pre-existing condition.

A claim for benefits for loss starting after 12 months from the effective date will not be reduced or denied on the grounds that it is caused by a pre-existing condition. A Critical Illness will no longer be considered pre-existing at the end of 12 consecutive months starting and ending after an insured's effective date.

Additional Benefit Exclusions
All limitations and exclusions that apply to the Critical Illness plan also apply to this rider. The Waiting Period and Pre-existing condition limitation apply from the date of this rider is effective.

No Benefits will be paid for loss which occurred prior to the effective date of the Rider. Benefits are not payable for Loss if these conditions result from another Specified Critical Illness.

Heart Benefit Exceptions
All limitations and exclusions that apply to the Critical Illness plan also apply to this rider. The Waiting Period and Pre-existing condition limitation apply from the date of this rider is effective.

Any Benefits for Coronary Artery Bypass Surgery denied under this rider due to Pre-existing conditions may be paid at the reduced benefit amount under the certificate, subject to the terms of the certificate.

No benefits will be paid for loss which occurred prior to the effective date of this Rider.

Actively At Work Requirement
If you are not Actively at Work on the last scheduled work day coincident with or preceding the date your insurance would otherwise become effective, insurance will not be effective until the date you return to and remain Actively at Work.
If an eligible spouse or dependent child is unable to engage in the normal activities of a person in good health of like age and sex on the date this rider would otherwise become effective, coverage will not be effective until the date such

person is able to engage in the normal activities of a person in good health of like age and sex. This will not apply to an eligible dependant child who is incapable of self-sustaining employment by reason of mental or physical incapacity, and who is primarily dependent on the Insured for support and maintenance.

Underwriting Guidelines - Guaranteed Issue

Guaranteed Issue

Guaranteed Issue is offered during the initial enrollment and for new hires thereafter are available for Guaranteed Issue.

- $10,000 employee and $5,000 spouse

Modified Guaranteed Issue

For employee amounts of $50,000 or less, and spouse amounts of $25,000 or less:

- All applicants are require to answer underwriting questions. These questions are knockout questions. Any “yes” response results in a declination. If participation requirements are met, employees who would otherwise be declined will be issued the lesser of the amount applied for or the Guaranteed Issue limit. Please refer to the application for these questions.

Continental American Insurance Company (CAIC) is a wholly-owned sub-sidiary of Aflac Incorporated. CAIC underwrites group coverage but is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. 2801 Devine Street, Columbia, South Carolina 29205.

Customer Service

800.433.3036

csc@caicworksite.com

CAIC Group Critical Illness Plan
Employee and Spouse Semi-Monthly Rates

NON-TOBACCO - Employee Semi-Monthly

	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	50,000
18-29	$2.68	$3.60	$4.53	$5.45	$6.38	$7.30	$8.23	$9.15	$10.08	$11.00
30-39	$3.28	$4.80	$6.33	$7.85	$9.38	$10.90	$12.43	$13.95	$15.48	$17.00
40-49	$4.85	$7.95	$11.05	$14.15	$17.25	$20.35	$23.45	$26.55	$29.65	$32.75
50-59	$6.73	$11.70	$16.68	$21.65	$26.63	$31.60	$36.58	$41.55	$46.53	$51.50
60-69	$9.75	$17.75	$25.75	$33.75	$41.75	$49.75	$57.75	$65.75	$73.75	$81.75

NON-TOBACCO - Spouse Semi-Monthly

	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000
18-29	$2.68	$3.14	$3.60	$4.06	$4.53	$4.99	$5.45	$5.91	$6.38
30-39	$3.28	$4.04	$4.80	$5.56	$6.33	$7.09	$7.85	$8.61	$9.38
40-49	$4.85	$6.40	$7.95	$9.50	$11.05	$12.60	$14.15	$15.70	$17.25
50-59	$6.73	$9.21	$11.70	$14.19	$16.68	$19.16	$21.65	$24.14	$26.63
60-69	$9.75	$13.75	$17.75	$21.75	$25.75	$29.75	$33.75	$37.75	$41.75

TOBACCO - Employee Semi-Monthly

	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	50,000
18-29	$3.15	$4.55	$5.95	$7.35	$8.75	$10.15	$11.55	$12.95	$14.35	$15.75
30-39	$4.18	$6.60	$9.03	$11.45	$13.88	$16.30	$18.73	$21.15	$23.58	$26.00
40-49	$7.90	$14.05	$20.20	$26.35	$32.50	$38.65	$44.80	$50.95	$57.10	$63.25
50-59	$11.58	$21.40	$31.23	$41.05	$50.88	$60.70	$70.53	$80.35	$90.18	$100.00
60-69	$17.05	$32.35	$47.65	$62.95	$78.25	$93.55	$108.85	$124.15	$139.45	$154.75

TOBACCO - Spouse Semi-Monthly

	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000
18-29	$3.15	$3.85	$4.55	$5.25	$5.95	$6.65	$7.35	$8.05	$8.75
30-39	$4.18	$5.39	$6.60	$7.81	$9.03	$10.24	$11.45	$12.66	$13.88
40-49	$7.90	$10.98	$14.05	$17.13	$20.20	$23.28	$26.35	$29.43	$32.50
50-59	$11.58	$16.49	$21.40	$26.31	$41.23	$36.14	$41.05	$45.96	$50.88
60-69	$17.05	$24.70	$32.35	$40.00	$47.65	$55.30	$62.95	$70.60	$78.25

AUL Short-Term Disability Plan

Effective Date: October 1, 2012

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

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

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

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

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

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

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

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

1 National Safety Council, Injury Facts, 2003 Edition
2 American Cancer Society, Cancer Facts & Figures 2004
3 American Heart Association, Heart Disease and Stroke Statistics – 2004 Update
4 American Lung Association, Lung Disease Data 2003
5 National Underwriter, May 2002

Class Description
All Eligible Employees working a minimum of 20 hours per week, electing to participate in the Voluntary Short Term Disability Insurance

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

Monthly Benefit
You can choose a benefit in $100 increments up to 70% of an Employee's covered basic monthly earnings to a maximum monthly benefit of $2,000. The minimum monthly benefit is $500.

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

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

Basis of Coverage
24 Hour Coverage, on or off the job

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

STD Pre-Existing Condition Exclusion
3/12, If a person receives medical treatment, or service or incurs expenses as a result of an Injury or Sickness within 3 months prior to the Individual Effective Date, then the Group Policy will not cover any Disability which is caused by, contributed to by, or resulting from that Injury or Sickness; and begins during the first 12 months after the Person's Individual Effective Date. This Pre-Existing Condition limitation will be waived for all Persons who were included as part of the final premium billing statement received by AUL/ OneAmerica from the prior carrier and will be Actively at work on the effective date.

Annual Enrollment
Enrollees that did not elect coverage during their initial enrollment are eligible to sign up for $500 monthly benefit without medical questions. Current participants may increase their coverage by $200 monthly benefit without medical questions. The maximum benefit cannot exceed 70% of basic monthly earnings.

Portability
Once an employee is on the AUL disability plan for 12 months, you may be eligible to port your coverage for one year at the same rate without evidence of insurability. You have 31 days from your date of termination to contact AUL and make application to port your coverage by calling 1.800.553.3522.

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

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

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

Customer Service
800-553-5318

Disability Claims
866-258-8744
Fax: 207-591-3048
Disability Claims Email: claims@disabilityrms.com

www.employeebenefits.aul.com

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

AUL Short-Term Disability
Semi-Monthly Rates

Benefit Duration:
13 weeks

Monthly Benefit	Semi-Monthly Premium
$500	$5.18
$600	$6.21
$700	$7.25
$800	$8.28
$900	$9.32
$1,000	$10.36
$1,100	$11.39
$1,200	$12.43
$1,300	$13.46
$1,400	$14.50
$1,500	$15.53
$1,600	$16.57
$1,700	$17.60
$1,800	$18.64
$1,900	$19.68
$2,000	$20.71

Benefit Duration:
26 weeks

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

Benefit Duration:
52 weeks

Monthly Benefit	Semi-Monthly Premium
$500	$9.86
$600	$11.83
$700	$13.80
$800	$15.77
$900	$17.74
$1,000	$19.72
$1,100	$21.69
$1,200	$23.66
$1,300	$25.63
$1,400	$27.60
$1,500	$29.57
$1,600	$31.54
$1,700	$33.52
$1,800	$35.49
$1,900	$37.46
$2,000	$39.43

Texas Life Whole Life Plan

<u>Common Issue Date</u>: November 15, 2012 (pending underwriting approval where applicable)

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

VPL- plus is an individual permanent life insurance product specifically designed for employees and their families. It provides a guaranteed level premium and death benefit for the life of the policy, and you can keep the life insurance even after you retire.[1] As an employee, you are eligible to apply if you have satisfied your employer's eligibility period. You may also apply for coverage on your spouse, children and grandchildren.[2]

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

TEXAS LIFE'S VPL-plus

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

VPL-plus: PORTABLE AND PERMANENT

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

VPL-plus: THE GUARANTEES EMPLOYEES WANT

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

VPL-plus: CGI (EXPRESS ISSUE) UNDERWRITING

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

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

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

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

Express Issue Maximums

- Employee
  — ages 17-49, $100,000
  — ages 50-65, $50,000
  — ages 66-70, $10,000

- Spouse (if employee applies)
  — ages 17-49, $50,000
  — ages 50-65, $25,000
  — ages 66-70, $10,000

- Spouse (if employee does not apply)
  — ages 17-24 $25,000
  — ages 25-29 $20,000
  — ages 30-39 $15,000
  — ages 40-44 $10,000
  — ages 45-49 $7,500
  — ages 50-70 $5,000

- Children - ages 6 months -26 years $25,000[2]
- Grandchildren - ages 6 months -16 years $25,000[2]

Simplified Issue[4]

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

Accelerated Death Rider

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

Waiver of Premium

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

VPL-plus: Review

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

[1]Guarantees are backed by the claims paying ability and financial strength of the issuing company.
[2]Policies not available on children & grandchildren in Washington.
[3]Generations at Risk LIMRA International (2008)
[4] We retain the right to require a medical exam.

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

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

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

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

Health Insurance Options and Premium Costs
Plan Year October 1, 2012- September 30, 2013

Coverage	KeyCare 20				KeyCare 15			
Employee Options:	**Total Monthly**	**Employer Monthly**	**Employee Monthly**	**Semi-Mo**	**Total Monthly**	**Employer Monthly**	**Employee Monthly**	**Semi-Mo**
Employee	$549	$496	$53	$26.50	$598	$496	$102	$51.00
Employee/One Child	$793	$671	$122	$61.00	$862	$671	$191	$95.50
Employee/Spouse	$1,194	$1,005	$189	$94.50	$1,299	$1,005	$294	$147.00
Employee/Family	$1,453	$1,226	$227	$113.50	$1,579	$1,226	$353	$176.50
Retiree Options:	**Total**	**County**	**Retiree**		**Total**	**County**	**Retiree**	
Retiree not Medicare Eligible	$549	$549	$0		$598	$549	$49	
Retiree Medicare Eligible	$565	$565	$0		$615	$565	$50	
Retiree's Spouse Medicare Eligible	$565	$0	$565		$615	$0	$615	
Retiree's Spouse not Medicare Eligible	$549	$0	$549		$598	$0	$598	
Retiree and Spouse not Medicare Eligible	$1,194	$549	$645		$1,299	$549	$750	
Retiree's Spouse & Child not Medicare Eligible	$793	$0	$793		$862	$0	$862	
Retiree, Spouse & Family not Medicare Eligible	$1,453	$549	$904		$1,579	$549	$1,030	
COBRA Options:								
Individual	$560				$610			
Individual/One Child	$809				$879			
Individual/Spouse	$1,218				$1,325			
Individual/Family	$1,482				$1,611			

NOTE: Premium costs include medical, dental, prescription drug and vision benefits through the option you select. Employee premiums are deducted 24 pay periods.

Anthem KeyCare 20 Plan Option 1

In-Network Services	*You Pay*
Preventive Care Services	
Preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations, and physician visits. •During the course of a routine screening procedure, abnormalities or problems may be identified that require immediate intervention, or additional diagnosis. If this occurs, and *your* provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by *your* provider, which will result in a member cost share.	**No charge ***
Routine Vision	
•Annual routine eye exam **Plus valuable discounts on eyewear**	**$15** for each visit
Doctor Visits	
•office visits •urgent care visit •home visits •pre- and postnatal office visits •in-office surgery •physical and occupational therapy in an office setting (30 combined visits)* •speech therapy visits in an office setting (30 visit limit)* •spinal manipulations and other manual medical intervention visits (30 visit limit)* **Limited to 30 combined visits per calendar year for physical therapy and occupational therapy services, and 30 separate visits each per calendar year for speech therapy and spinal manipulation services.*	**$20** for each visit to a family or general practitioner, internist, or pediatrician **$40** for each visit to a specialist
Mental Health and Substance Abuse	
•office visits	**$20** for each visit to a specialist
Labs, X-rays and Other Outpatient Services	
•diagnostic lab services •diagnostic x-rays •dialysis •chemotherapy (not given orally) •radiation therapy •durable medical equipment •respiratory therapy	**20%** of the amount the health care professionals in our network have agreed to accept for their services

•shots and therapeutic injections •medical appliances, supplies and medications including infusion medications •professional ground ambulance services	**20%** of the amount the health care professionals in our network have agreed to accept for their services
Autism Spectrum Disorder (ASD) - For children from age 2-6	
•diagnosis and treatment of autism spectrum disorder including: • behavioral health treatment* • psychiatric care • therapeutic care** • pharmacy care • psychological care ***Mental Health Services** ****Unlimited physical, occupational and speech therapy.***	Member cost shares will be dependent on the services rendered.
•applied behavioral analysis • limited to a $35,000 per member annual maximum	**20%** of the amount the health care professionals in our network have agreed to accept for their services
Early Intervention - For children from birth through age 2	
•limited to a $5,000 per member annual maximum* ***Unlimited physical, occupational and speech therapy**	Member cost shares will be dependent on the services rendered.
Outpatient Visits in a Hospital or Facility	
•physical therapy and occupational therapy* •speech therapy* *Limited to 30 combined visits per calendar year for physical therapy and occupation therapy services, and 30 visits per calendar year for speech therapy services.*	**$40 plus 20%** of the amount health care professionals in our network have agreed to accept for their services.
•emergency room •surgery ***For the services billed by the doctor, you will pay an additional $20 or $40 depending on the type of doctor who treats you.***	**$100 plus 20%** of the amount health care professionals in our network have agreed to accept for their services*

For the benefits listed with specific limits, all services received during the calendar year from January 1 to December 31 for that benefit (whether received in-network or out-of-network) are applied to that limit.

In-Network Services	*You Pay*
Care at Home	
•hospice care	**No charge**
•home health care visits by a nurse or aide (90 visits) •private duty nursing ($500 maximum)* ***Since there is no network for this service, you may be billed for the difference between what we pay for this service and the amount the private duty nursing service charged.**	**20%** of the amount the health care professionals in our network have agreed to accept for their services
Inpatient Stays in a Network Hospital or Facility	
•semi-private room, intensive care or similar unit ***You do not have to pay another $400 if you are readmitted within 90 days of the day you went home.**	**$400 plus 20%** of the amount the health care professionals in our network have agreed to accept for their services*
•physician, nursing and other medically necessary professional services in the hospital including anesthesia, surgical and maternity delivery services •skilled nursing facility care (100 days for each admission) •mental health and substance abuse partial-day treatment programs	**20%** of the amount the health care professionals in our network have agreed to accept for their services
Out-of-Network Services	
Using Doctors, Hospitals and Other Health Care Professionals not Contracted to Provide Benefits	
It's important to remember that health care professionals not in our network can charge whatever they want for their services. If what they charge is more than the fee our network health care professionals have agreed to accept for the same service, they will bill you for the difference between the two amounts. You will pay all the costs associated with the covered services outlined in this insert until you have paid $500 in on plan year. This is called your out-of-network deductible. •If two people are covered under your plan, each of you will pay the first $500 of the cost of your care ($1,000 total).	

•If three or more people are covered under your plan, together you will pay the first $1,000 of the cost of your care. However, the most one family member will pay is $500.

Once you have reached this amount, when you receive covered services we will pay 70% of the fee our network health care professionals have agreed to accept for the same service. You will pay for the rest, including any difference between the fee our network health care professionals have agreed to accept for the same service and the amount the health care professional not in our network charges. If you go to an eye care professional not in our network for your routine eye examination, we will pay $30 (whether or not you have reached the $500 out-of-network deductible) and you will pay the rest of what the professional charges.

Out-of-Pocket Maximums
What You Will Pay for Covered Services in One Calendar Year (January 1 - December 31)
When using network professionals If you are the only one covered by your plan, you will pay $3,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is $0, except for those services listed below that do not count toward the annual out-of-pocket maximum*. •If two people are covered under your plan, each of you will pay $3,000 ($6,000 total). •If three or more people are covered under your plan, together you will pay $6,000. However, no family member will pay more than $3,000 toward the limit. **When not using network professionals** If you are the only one covered by your plan, you will pay $4,500 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is $0, except for those services listed below that do not count toward the annual out-of-pocket maximum*. •If two people are covered under your plan, each of you will pay $4,500 ($9,000 total). •If three or more people are covered under your plan, together you will pay $9,000. However, no family member will pay more than $4,500 toward the limit. ***The following do not count toward the calendar year out-of-pocket maximum:** •your share of the cost of prescription drugs and routine vision care •the cost of care received when the benefit limits have been reached •the cost of services and supplies not covered under your Anthem KeyCare 20 plan •the additional amount health care professionals not in our network may bill you when their charge is more than what we pay

This benefits overview insert is only one piece of your entire enrollment package. See the enrollment brochure for a list of your plan's exclusions and limitations and applicable policy form numbers.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Anthem KeyCare 15 Plan Option 2

In-Network Services	*You Pay*
Preventive Care Services	
Preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations, and physician visits. •During the course of a routine screening procedure, abnormalities or problems may be identified that require immediate intervention, or additional diagnosis. If this occurs, and *your* provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by *your* provider, which will result in a member cost share.	**No charge ***
Routine Visit	
•annual routine eye exam *Plus valuable discounts on eyewear*	**$15** for each visit
Doctor Visits	
•office visits •urgent care visit •home visits •pre- and postnatal office visits •in-office surgery •physical and occupational therapy in an office setting (30 combined visits)* •speech therapy visits in an office setting (30 visit limit)* •spinal manipulations and other manual medical intervention visits (30 visit limit)* **Limited to 30 combined visits per calendar year for physical therapy and occupational therapy services, and 30 separate visits each per calendar year for speech therapy and spinal manipulation services.*	**$15** for each visit to a family or general practitioner, internist, or pediatrician **$30** for each visit to a specialist
Mental Health and Substance Abuse	
•office visits	**$15** for each visit to a specialist
Labs, X-rays and Other Outpatient Services	
•diagnostic lab services •diagnostic x-rays •dialysis •chemotherapy (not given orally) •radiation therapy •respiratory therapy	**20%** of the amount the health care professionals in our network have agreed to accept for their services

•mental health and substance abuse treatment including partial day •shots and therapeutic injections •medical appliances, supplies and medications including infusion medications •professional ground ambulance services •durable medical equipment	**20%** of the amount the health care professionals in our network have agreed to accept for their services
Autism Spectrum Disorder (ASD) - For children from age 2-6	
•diagnosis and treatment of autism spectrum disorder including: • behavioral health treatment* • psychiatric care • therapeutic care** • pharmacy care • psychological care ***Mental Health Services** ****Unlimited physical, occupational and speech therapy***	Member cost shares will be dependent on the services rendered.
•applied behavioral analysis • limited to a $35,000 per member annual maximum	20% of the amount the health care professionals in our network have agreed to accept for their services
Early Intervention - For children from birth through age 2	
•limited to a $5,000 per member annual maximum* ***Unlimited physical, occupational and speech therapy***	Member cost shares will be dependent on the services rendered.
Outpatient Visits in a Hospital or Facility	
•physical therapy and occupational therapy* •speech therapy* **Limited to 30 combined visits per calendar year for physical therapy and occupation therapy services, and 30 visits per calendar year for speech therapy services.*	**$30 plus 20%** of the amount health care professionals in our network have agreed to accept for their services.
•emergency room •surgery ***For the services billed by the doctor, you will pay an additional $15 or $30 depending on the type of doctor who treats you.***	**$100 plus 20%** of the amount the health care professionals in our network have agreed to accept for their services*

For the benefits listed with specific limits, all services received during the calendar year from January 1 to December 31 for that benefit (whether received in-network or out-of-network) are applied to that limit.

In-Network Services	*You Pay*
Care At Home	
•hospice care	**No charge**
•home health care visits by a nurse or aide (90 visits) •private duty nursing ($500 maximum)* ***Since there is no network for this service, you may be billed for the difference between what we pay for this service and the amount the private duty nursing service charged.***	**20%** of the amount the health care professionals in our network have agreed to accept or their services
Inpatient Stays in a Network Hospital or Facility	
•semi-private room, intensive care or similar unit ***If your physician submits one bill for prenatal, delivery, and postnatal care, services are covered as maternity delivery services.***	**$300 plus 20%** of the amount the health care professionals in our network have agreed to accept for their services*
•physician, nursing and other medically necessary professional services in the hospital including anesthesia, surgical and maternity delivery services •skilled nursing facility care (100 days for each admission) •mental health and substance abuse partial-day treatment programs	**20%** of the amount the health care professionals in our network have agreed to accept for their services

Out-of-Network Services
Using Doctors, Hospitals and Other Health Care Professionals not Contracted to Provide Benefits
It's important to remember that health care professionals not in our network can charge whatever they want for their services. If what they charge is more than the fee our network health care professionals have agreed to accept for the same service, they may bill you for the difference between the two amounts. You will pay all the costs associated with the covered services outlined in this insert until you have paid $400 in one calendar year. This is called your out-of-network deductible. •If two people are covered under your plan, each of you will pay the first $400 of the cost of your care ($800 total).

•If three or more people are covered under your plan, together you will pay the first $800 of the cost of your care. However, the most one family member will pay is $400.

Once you have reached this amount, when you receive covered services we will pay 70% of the fee our network health care professionals have agreed to accept for the same service. You will pay for the rest, including any difference between the fee our network health care professionals have agreed to accept for the same service and the amount the health care professional not in our network charges. If you go to an eye care professional not in our network for your routine eye examination, we will pay $30 (whether or not you have reached the $400 out-of-network deductible) and you will pay the rest of what the professional charges.

Out-of-Pocket Maximums

What You Will Pay for Covered Services in One Calendar Year (January 1-December 31)

When using network professionals

If you are the only one covered by your plan, you will pay $2,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is $0, except for services listed below that do not count toward the annual out-of-pocket maximum.*

•If two people are covered under your plan, each of you will pay $2,000 ($4,000 total).
•If three or more people are covered under your plan, together you will pay $4,000. However, no family member will pay more than $2,000 toward the limit.

When not using network professionals

If you are the only one covered by your plan, you will pay $4,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is $0, except for services listed below that do not count toward the annual out-of-pocket maximum.*

•If two people are covered under your plan, each of you will pay $4,000 ($8,000 total).
•If three or more people are covered under your plan, together you will pay $8,000. However, no family member will pay more than $4,000 toward the limit.

****The following do not count toward the plan year out-of-pocket maximum:***
•your share of the cost of prescription drugs and routine vision care
•the cost of care received when the benefit limits have been reached
•the cost of services and supplies not covered under your Anthem KeyCare 15 plan
•the additional amount health care professionals not in our network may bill you when their charge is more than what we pay

This benefits overview insert is only one piece of your entire enrollment package. See the enrollment brochure for a list of your plan's exclusions and limitations and applicable policy form numbers.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Anthem Prescription Drug Plan

Your Prescription Drug Benefits

Pharmacy network

Anthem's prescription drug program manages more than 400 million prescriptions each year. With a broad retail pharmacy network, home delivery and a specialty unit that dispenses high-cost, biotech therapies, our comprehensive approach helps you manage your pharmacy benefits.

Some members have a tiered drug list/formulary, or list of covered medications, which assigns drugs to specific tiers based on cost. Tier 1 drugs have the most affordable copay. Tier 2 drugs cost slightly more, and Tier 3 drugs have the highest copay amounts.

Your Prescription Drug 10-20-35 Plan	Tier 1 Copay	Tier 2 Copay	Tier 3 Copay
Up to a 30-day medication supply at participating retail pharmacies	$10	$20	$35
Up to a 90-day medication supply delivered to your home	$10	$40	$105

Retail pharmacies

Our retail pharmacy network includes more than 62,000 pharmacies throughout the United States. That means you have convenient access to your prescriptions wherever you are – at home, work or even on vacation. To find out if your pharmacy participates in our network, contact Customer Care at the phone number listed on your member ID card. Or, visit **anthem.com** for a list of participating pharmacies.

Most plans allow you to get up to a 30-day supply of covered medications at a retail pharmacy. Simply show your ID card at the pharmacy and pay the appropriate copay.

You'll get the most from your benefits by using a participating retail pharmacy. Choosing a non-network pharmacy means you'll pay the full cost of the prescription. Then, you must submit a claim form to our pharmacy program for reimbursement, based on your benefit.

Home delivery pharmacy

Home delivery is for people who take medications on an ongoing basis. Our preferred home delivery pharmacy delivers the medications you need, right to your door. You can easily refill home delivery prescriptions by phone, fax, mail or online. And, view benefit information 24/7 at anthem.com.

As a home delivery customer, you'll also enjoy:
• Free standard shipping
• Personal prescription counseling
• Direct access to licensed pharmacists
• Our 99.99 percent accuracy rate, plus multiple safety checks by licensed pharmacists
• Experienced Customer Care associates to answer benefit questions

Getting started with home delivery
Switching to home delivery is simple. Choose from one of the following methods:
• By phone: Call 866-281-4279, Monday through Friday, 8:30 a.m. to 8 p.m., Eastern Standard Time, to get your free cost-savings estimate. You'll find out how much your prescription will cost and how much you'll save. We'll even contact your doctor for a new prescription and arrange for delivery. Be sure to have the following information handy: prescription information, doctor's name, phone number, medication names/strengths and credit card information (including cardholder name, account number and expiration date).

• By mail: To get an order form, call the Customer Care number on your member ID card. Or, download a form from anthem.com. Click on the "Members" tab, and you'll find a link to the form under Members Spotlight. Print the form and mail your completed order form, original prescription and payment information to:

Home Delivery Pharmacy
PO Box 66785
St. Louis MO 63166-6785

• By fax: Have your doctor fax your prescription information to 800-600-8105. The prescription must be faxed directly from your doctor's office. If there is a question about your prescription(s), we'll contact your doctor.

Ordering home delivery refills
With home delivery, you don't have to worry about running out of medication. That's because we'll call to let you know when you're running low. You can easily reorder by phone, online or by mail:
• By phone: Have your prescription label and credit card ready. Call 866-281-4279 and select the "Automated Refill Order Line" option from the menu, or press zero at any time to speak to a care coordinator. If you are speech or hearing impaired, call 800-899-2114. Follow the prompts to place your order.

• Online: Go to anthem.com, log in and click on the "MyPharmacy" tab.

• By mail: Complete an order form and affix your label or write the prescription refill number in the area provided. Mail the order form with the proper payment to:

Home Delivery Pharmacy
PO Box 66785
St. Louis MO 63166-6785

Specialty pharmacy
Specialty medications are the fastest growing segment of U.S. drug spending today. These breakthrough biotech drugs are revolutionizing care for people with these medication needs. Anthem's specialty pharmacy offers a robust, personalized support program for people with chronic and complex conditions. These conditions may include but aren't limited to:
• Alpha1 antitrypsin deficiency
• Asthma
• Cancer
• Crohn's Disease
• Gaucher's Disease
• Hemophilia
• Hepatitis C
• HIV/AIDS
• Infertility
• Multiple sclerosis
• Primary immune deficiency
• Psoriasis
• Pulmonary arterial hypertension
• Rheumatoid arthritis
• Respiratory syncytial virus (RSV)
• Transplant

Our pharmacy care advocates, registered nurses and clinical pharmacists work together to provide disease-specific care management. We'll coordinate specialty pharmacy activities to help improve the quality and cost of care. And we'll do everything we can to help you achieve the best possible outcomes from your treatments.

Ordering specialty medications
You can order specialty medications by phone or fax:
• By phone: Call 800-870-6419 to verify your information. Pharmacy care advocates are available Monday through Friday, 8 a.m. to 10 p.m., Eastern Standard Time.

• By fax: You can have your doctor fax your prescription(s) and a copy of your ID card to 800-824-2642.

Drug list/formulary
Anthem's drug list/formulary is a list of brand and generic medications that are approved by the U.S. Food and Drug Administration (FDA) and covered by your plan. We're committed to providing you with access to quality medications at a price you can afford. Through detailed research, we find drugs with the highest success rates that also help lower the cost of care.

Our Pharmacy and Therapeutics (P&T) Committee then reviews and selects these medications for their safety, effectiveness and value. The P&T Committee includes a large group of doctors and pharmacists who are not employees of Anthem Blue Cross and Blue Shield. This group and other professionals are responsible for the decisions surrounding our drug list/formulary.

Medications on the drug list/formulary are subject to periodic review. Log in to **anthem.com** to view the most current list or call the phone number on your member ID card to check a specific drug.

Generic medications
Our drug list/formulary includes money-saving generics, as well as brand medications. By choosing a generic, you get the same effect as the brand drug – but normally at a lower cost.

Generic and brand drugs have the same active ingredient, strength and dose. The FDA requires generics to meet the same high standards for purity, quality, safety and strength.

Even though the active ingredient of a generic is identical to its brand counterpart, manufacturers may use different inactive ingredients. This could affect the color, shape and size. But because generics must meet the same FDA standards as brand drugs, you can feel confident the generic is just as safe and effective. Ask your doctor if a generic is right for you.

Prior authorization
Most prescriptions are filled right away when you take them to the pharmacy. However, some drugs need our review and approval before they're covered. This process, called prior authorization, helps ensure drugs are used as recommended by the FDA. Prior authorization focuses mainly on drugs that may have:

- Risk of serious side effects or dangerous drug interactions
- High potential for incorrect use or abuse
- Better alternatives that may cost you less
- Restrictions for use with very specific conditions

If your doctor prescribes a drug that requires prior authorization, we'll send an electronic notice to your pharmacy. This lets the pharmacist know that additional health information is needed for review.

By monitoring the use of certain drugs, prior authorization helps keep you safe and make your medications affordable. To check if your medication requires prior authorization, visit **anthem.com** or call the number on your member ID card.

Anthem Blue Cross and Blue Shield receives financial credits from drug manufacturers based on total volume of the claims processed for their product utilized by Anthem members. These credits are retained by Anthem as a part of its fee for administering the program for self-funded groups and used to help stabilize rates for fully-insured groups. Reimbursements to pharmacies are not affected by these credits.

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Anthem Blue View Vision

Welcome to Blue View Vision!
Good news - your vision plan is flexible and easy to use. This benefit summary outlines the basic components of your plan, including quick answers about what is covered, your discounts, and much more!

Your Blue View Vision network
Blue View Vision offer you one of the largest vision care networks in the industry, with a wide selection of experienced ophthalmologists, optometrists, and opticians. Blue View Vision's network also includes convenient retail locations, many with evening and weekend hours, including LensCrafters, Target Optical, JCPenney Optical, Sears Optical, and Pearle Vision locations. Best of all - when you receive care from a Blue View Vision participating provider, you receive the greatest benefits and money-saving discounts.

Out-of-network services
Did we mention we're flexible? You can choose to receive care outside of the Blue View Vision network. You simply get an allowance toward services and you pay the rest. (Network benefits and discounts will not apply.) Just pay in full at the time of service and then file a claim for reimbursement.

Your Blue View Vision Plan At-A-Glance

Vision Care Services	In-Network	Out-of-Network
Annual routine eye exam *(once every calender year)*	$15 copayment	$30 allowance
Eyeglass frames Each calender year you may select any eyeglass frame and receive the following allowance toward the purchase price: **Eyeglass lenses** (Standard) **Factory scratch coating included** •Polycarbonate lenses included for children under 19 years old. •Transittions lenses included for children under 19 years old You may receive any one of the following lens options: (once every calender year)	$130 allowance then 20% off remaining balance	$45 allowance
•Standard plastic single vision lenses (1 pair)	$15 copayment, then covered in full	$25 allowance
•Standard plastic bifocal lenses (1 pair)	$15 copayment, then covered in full	$40 allowance
•Standard plastic trifocal lenses (1 pair)	$15 copayment, then covered in full	$55 allowance

	In-Network	Out-of-Network
Eyeglass lens upgrades When receiving services from a Blue View Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Lense Options: •UV Coating •Tint (Solid and Gradient) •Standard Polycarbonate •Transitions lenses •Progressive Lenses[1] •Standard •Premium Tier 1 •Premium Tier 2 •Premium Tier 3 •Standard Anti-Reflective Coating[2] •Premium Tier 1 Anti-Reflective Coating[2] •Premium Tier 2 Anti-Reflective Coating[2] •Other add-ons and Services [1]Please ask your provider for his/her recommendation as well as the progressive brands by tier. [2]Please ask your provider for his/her recommendation as well as the coating brands by tier.	Member cost for upgrades $15 $15 $40 $75 $65 $91 $97 $103 $45 $57 $68 20% off retail price	Discounts on lens upgrades are not available out-of-network
Contact lenses Prefer contact lenses over glasses? You may choose to receive contact lenses instead of eyeglasses and receive an allowance toward the cost of a supply of contact lenses. (Once every calender year) •Elective Conventional Lenses •Elective Disposable Lenses •Non-Elective Contact Lenses	$130 allowance then 15% off the remaining balance $130 allowance (no additional discount) Covered in full	$105 allowance $105 allowance $210 allowance
Contact lens fitting and follow-up A contact lens fitting and two follow-up visits are available to you once a comprehensive eye exam has been completed. •Standard contact fitting* •Premium contact lens fitting**	Fitting and follow up visits covered in full 10% of retail price then apply $55 allowance	$35 allowance $35 allowance

*A standard contact lens fitting includes spherical clear contact lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.
**A premium contact lens fitting includes all lens designs, materials and specialty fittings other than standard

Discounts

Savings on additional eyewear and accessories

After you use your initial frame or contact lens allowance, you can take advantage of discounts on additional prescription eyeglasses, contact lenses, and eyewear accessories courtesy of Blue View Vision network providers.

Blue View Vision Additional Savings	Member Savings
Additional Pair of Complete Eyeglasses	40% discount off retail*
Contact Lenses *(Discount applied to materials only)* Conventional	15% off retail price
Eyeware Accessories Includes some non-prescription sunglasses, lens cleaning supplies, contact lens solution and eyeglass cases, etc. *Items purchased seperately are discounted 20% off the retail price. Blue View Vision's Additional Savings Program is subject to change without notice.	20% off retail price

Laser vision correction surgery

Glasses or contacts may not be the answer for everyone. That's why we offer further savings with discounts or refractive surgery. Pay a discounted amount per eye for LASIK Vision correction. For more information, go to SpeacialOffers at anthem.com and select vision care.

Using your Blue View Vision Plan

The Blue View Vision network is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care physician from your medical network.

Your out-of-pocket expenses related to the vision benefits do not count toward your annual out of pocket limit never waived, even if you annual out-of-pocket limit is reached.

Anthem Dental Complete

WELCOME TO YOUR DENTAL PLAN!
This benefit summary outlines how your dental plan works and provides you with a quick reference of your dental plan benefits. For complete coverage details, please refer to your Anthem benefits booklet.

Dental coverage you can count on.
Your Anthem dental plan lets you visit any licensed dentist or specialist you want—with costs that are normally lower when you choose one within our large network.

Savings beyond your dental plan benefits - you get more for your money.
You pay our negotiated rate for covered services from in-network dentists even if you exceed your annual benefit maximum.

Your Dental Plan At-A-Glance	***In-Network***	***Out-of-Network***
Annual Benefit Maximum (Calendar Year) • Per insured person ***Annual Maximum Carryover***	 ***$1,000*** ***No***	 ***$1,000*** ***No***
Orthodontic Lifetime Benefit Maximum • Per eligible insured person	 ***$1,000***	 ***$1,000***
Annual Deductible • Per insured person • Family maximum	 ***$0*** ***No Limit***	 ***$0*** ***No Limit***
Deductible Waived for Diagnostic/Preventative Services	***Yes***	***Yes***
Out-of-Network Reimbursement Options	***80th percentile***	***80th percentile***
Dental Services	***In-Network***	***Out-of-Network***
Following are examples of what is/is not covered by your plan	***Anthem Pays***	Anthem Pays
Diagnostic and Preventive Services, for example: • Periodic oral exam • Teeth cleaning (prophylaxis) • Bitewing X-rays: 1X per 12 months • Intraoral X-rays	***100% Coinsurance***	100% Coinsurance

Basic Services ***Fillings, for example:*** • Amalgam (silver-colored) • Front composite (tooth-colored) • Back composite, Alternated to Amalgam Benefit ***Basic or Major Services*** ***Crowns*** ***Prosthodontics, for example:*** • Dentures • Bridges • Dental implants- Not covered ***Prosthetic Repairs/Adjustments*** ***Endodontics, for example:*** • Root canal ***Periodontics, for example:*** • Scaling & root planning ***Oral Surgery*** ***Waiting Period for Basic Services:*** No Waiting Periods ***Waiting Period for Major Services:*** No Waiting Periods	***80% Coinsurance*** ***80% Coinsurance*** ***80% Coinsurance*** ***80% Coinsurance*** ***80% Coinsurance*** ***80% Coinsurance*** ***80% Coinsurance***	80% Coinsurance 80% Coinsurance 80% Coinsurance 80% Coinsurance 80% Coinsurance 80% Coinsurance 80% Coinsurance
Orthodontic Services •Adults & Dependent Children ***Waiting Period:*** No Waiting Periods	***50% Coinsurance***	50% Coinsurance

Emergency dental treatment for the international traveler

As an Anthem dental member, you and your eligible, covered dependents automatically have access to the International Emergency Dental Program.** With this program, you may receive emergency dental care from our listing of credentialed dentists while traveling or working nearly anywhere in the world.

** The International Emergency Dental Program is managed by DeCare Dental, which is an independent company offering dental-management services to Anthem Blue Cross Life and Health Insurance Company.

This is not a contract; it is a partial listing of benefits and services. All covered services are subject to the conditions, limitations, exclusions, terms and provisions of your employee benefits booklet. In the event of a discrepancy between the information in this summary and the employee booklet, the employee booklet will prevail.

*Child orthodontic coverage begins at age eight and runs through age 18. This means that the child must have been banded between the ages of eight and 19 in order to receive coverage. If children are dependents until age 19, they can continue to receive coverage, but they must have been banded before age 19.

Finding a dentist is easy.
To select a dentist by name or location, do one of the following:
- Go to anthem.com/ca/mydental
- Call Anthem dental Customer Service at 877-567-1804

TO CONTACT US:
Call: Refer to the toll-free number indicated on the back of your plan ID card to speak with a U.S.-based customer service representative during normal business hours. Calling after hours? We may still be able to assist you with our interactive voice-response system.

Write: Refer to the back of your plan ID card for the address.

Limitations & Exclusions
Limitations- Below is a partial listing of dental plan limitations when these services are covered under your plan. Please see your certificate of coverage for a full list.

Diagnostic and Preventive Services
Oral evaluations (exam)
Limited to two per Calendar Year

Teeth Cleaning (prophylaxis)
Limited to two per Calendar Year

Intraoral X-rays, single film
Limited to four films per 12-month period

Complete series X-rays (panoramic or full-mouth)
Coverage Every 3 Years

Topical fluoride application
Limited to once every 12 months for members through age 18

Sealants
Limited to first and second molars once every 24 months per tooth for members through age 15; sealants may be covered under Diagnostic and Preventive or Basic Services. Please see your dental proposal page to determine your coverage.

Space Maintainers
Limited to extracted primary posterior teeth once per lifetime per tooth for members through age 16

Basic and/or Major Services***
Fillings
Limited to once per surface per tooth in any 24 months

Crowns
Limited to once per tooth in a five-year-period

Fixed or removable prosthodontics - dentures, partials, bridges
Covered once in any five-year period; benefits are provided for the replacement of an existing bridge, denture or partial for members age 16 or older if the appliance is five years old or older and cannot be made serviceable.

Root canal therapy
Limited to once per lifetime per tooth; coverage is for permanent teeth only

Periodontal surgery
Limited to one complex service per single tooth or quadrant in any 36 months, and only if the pocket depth of the tooth is five millimeters or greater

Periodontal scaling and root planing
Limited to once per quadrant in 36 months when the tooth pocket has a depth of four millimeters or greater

***Waiting periods** for endodontic, periodontic and oral surgery services may differ from other Basic Services or Major Services under the same dental plan. There may be a waiting period of up to 24 months for replacement of congenitally missing teeth or teeth extracted prior to coverage under this plan.

ADDITIONAL LIMITATION FOR ORTHODONTIC SERVICES
Orthodontia Limited to one course of treatment per member per lifetime

Exclusions – Below is a partial listing of noncovered services under your dental plan. Please see your certificate of coverage for a full list.

Services provided before or after the term of this coverage
Services received before your effective date or after your coverage ends, unless otherwise specified in the employee benefits booklet

Orthodontics (unless included as part of your dental plan benefits)
Orthodontic braces, appliances and all related services

Cosmetic dentistry Services provided by dentists solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (cavities) exist

Drugs and medications
Intravenous conscious sedation, IV sedation and general anesthesia when performed with nonsurgical dental care***.*** Analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines or drugs for nonsurgical or surgical dental care except that intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.

Extractions Surgical removal of asymptomatic, nonpathologic third molars

Choice of dentists

While your dental plan lets you choose any dentist, you may end up paying more for a service if you visit an out-of-network dentist.

Here's why:

In-network dentists have agreed to payment rates for various services and cannot charge you more. On the other hand, out-of-network dentists don't have a contract with us and are able to bill you for the difference between the total amount we allow to be paid for a service – called the "maximum allowed amount" – and the amount they usually charge for a service. When they bill you for this difference, it's called "balance billing."

How Anthem decides on maximum allowed amounts:

For services from an out-of-network dentist, the maximum allowed amount is determined in one of the following ways:

- Out-of-network dental fee schedule/rate developed by Anthem, which may be updated based on such things as reimbursement amounts accepted by dentists contracted with our dental plans, or other industry costs for dental services
- Information provided by a third-party vendor that shows comparable costs for dental services
- In-network dentist fee schedule

Here's an example of higher costs for out-of-network dental services:

This is an example only. Your experience may be different, depending on your insurance plan, the services you receive and the dentist who provides the services.

Ted gets a crown from an out-of-network dentist, who charges $1,200 for the service and bills Anthem for that amount. Anthem's maximum allowed amount for this dental service is $800. That means there will be a $400 difference, which the dentist can "balance bill" Ted.

Since Ted will also need to pay $400 coinsurance, the total he'll pay the out-of-network dentist is $800.

Here's the math:

- Dentist's charge: $1,200
- Anthem's maximum allowed amount: $800
- Anthem pays 50%: $400
- Ted pays 50% (coinsurance): $400
- Balance Ted owes the provider: $1,200 - $800 = $400
- Ted's total cost: $400 coinsurance + $400 provider balance = $800

In the example, if Ted had gone to an in-network dentist, his cost would be only $400 for the coinsurance because he would not have been "balance billed" the $400 difference.

KeyCare Expanded EAP Services

Your EAP Services Summary

Anthem Employee Assistance Program (EAP) is a confidential service available to employees and household members – at no cost to you. Our trained professionals can easily refer you to the following resources:

Face-to-Face Counseling – Anthem EAP can put you in touch with a licensed counselor for face-to-face visits. You and your household members are eligible for up to four visits for each personal situation, as needed. If more than four sessions are needed, employees are referred to the health insurance company for potential health benefits or to community resources for ongoing care.

Crisis Consultation – 24/7 telephone access and crisis consultation are available to you through Anthem EAP. If you have an emergency, simply call the toll-free Anthem EAP phone number. We will put you in touch with a professional who can help or just listen, depending on your needs.

Legal Assistance – We also offer access to legal consultations up to 30 minutes face-to-face or telephonically at no charge. For services beyond the initial 30 minutes, your will receive a preferred discount rate of 25% off attorney's normal hourly fee. You have access to virtually all areas of law such as family/domestic matters, civil matters, criminal, real estate, etc. Matters involving disputes between members and their employer are specifically excluded from eligibility of this program.

Financial Assistance – Our financial professionals provide free telephonic consultation on the financial topics that are important to you, including bankruptcy protection, budgeting, debt reductions, estate planning, home purchases and long-term goal setting. Our counseling sessions have no time limitations, and are available without appointment during regular business hours, and by appointment at night on weekends. Online resources include an assortment of financial calculators and access to PocketSmith, a budgeting and management tool.

ID Recovery – Specialists are available 24/7 to assess your risk level and then identify steps to resolve potential identity theft. All services are provided to you free of charge. This may include completing any necessary paperwork, reporting to the consumer credit agencies, and negotiating with creditors to repair debt history. Our specialists will work with you to restore your financial identity to its pre-theft status.

Tobacco Cessation (Online and Coaching)

- **Online Program:** LivingFree™ is a free 10 session, online training program which will help you learn how to break the tobacco habit. The program focuses on the root emotional and physical causes of using tobacco.

- **Telephonic Coaching:** Tobacco cessation coaching is a free service provided via telephone or through instant messaging. The tobacco cessation Coach will help you address the triggers of your tobacco use and how to overcome them. In addition the coach will address issues related to weight management and fitness.

Dependent Care and Daily Living Resources – You and your household members can get information on child care, adoption, summer camps, college placement relocation, plus resources on elder care issues and assisted living. There is assistance with daily living such as household maintenance, moving and relocation, pet care, etc. Referrals are available through the Assisted Search feature on the Anthem EAP Web site (www.AnthemEAP.com) or by calling us toll free at1-800-346-5484.

Other Web Resources available through www.AnthemEAP.com – Informational articles on behavioral health and healthcare topics are available to you and your household members through our interactive web site. There are self-assessment tools and quizzes on topics such as health, depression and substance abuse. Legal information and financial calculators are also available.

To contact Anthem EAP, please call us toll-free at 1-800-346-5484. You can also visit www.AnthemEAP.com.

Minnesota Life Group Basic Term Life & AD&D Insurance Plan

ELIGIBILITY
All full time employees are enrolled in the program as a condition of employment.

COST OF COVERAGE*
Contributions have been suspended by VRS through June 30, 2013

EFFECTIVE DATE OF COVERAGE
Employee's full time hire date

DETAILS OF BENEFIT- BASIC TERM LIFE
This program provides life insurance during active employment;
•Natural death benefit – annual salary rounded to the next highest thousand and then doubled.

•**Accidental death benefit** – If a death is accidental, an additional benefit is payable equal to the amount of the natural death benefit.

•**Dismemberment benefit –**
•**1st Option** - Loss of one limb or sight of one eye – annual salary rounded to next highest thousand
•**2nd Option** – (a) Loss of two limbs, (b) total loss of eye sight or (c) loss of one limb and the sight of one eye – annual salary rounded to next highest thousand and doubled

•**Felonious Assault Benefit** – benefit equal to the lesser of $50,000 or 25% of the accidental death or dismemberment benefit amount if you die or suffer dismemberment because of a felonious assault. In addition, if death occurs due to a felonious assault, and if the employee has a dependent child or dependent children less than age 18 (or older, if still a high school student), we will provide for each such qualifying child a Virginia Education Savings Trust account that may be used for college tuition and mandatory fees at any accredited college or university in the country that is eligible to participate in federal student financial aid programs. The amount would be equivalent to the cost of a 4-year pre-paid university contract with the Virginia College Savings Plan.

•**Repatriation Benefit -** $5,000.00 or the cost of transportation to return your remains if you die in an accident at least 75 miles from home.

•**Safety Belt Benefit** –10% percent of accidental or dismemberment amount or $50,000- whichever is less if you are wearing your seat belt but die or suffer dismemberment in an accident.

Benefit examples for an employee with an annual salary of $25,200:

Benefit	Amount of Benefit	Calculation
Natural Death	$52,000	$26,000 x 2
Accidental Death	$52,000	$26,000 x 2
Natural + Accidental Double Indemnity combined	$104,000	
Dismemberment Benefit		
•1st Option	$26,000	
•2nd Option	$52,000	
Felonious Assault Benefit	$13,000	25% of accidental benefit
Repatriation Benefit	$2,675	Cost to return remains
Safety Belt Benefit	$5,200	10% of accidental benefit

Living benefit
Any insured may receive up to 100% of their life insurance while they are living, if they have been diagnosed with a terminal illness with a life expectancy of 12 months or less.

TERMINATION OF EMPLOYMENT
You no longer have life insurance if you (1) terminate employment with the Spotsylvania County and (2) do not meet the minimum age and service requirements to receive a retirement benefit with VRS at the time of separation.
If you retire through VRS or meet the minimum age and service requirements at the time of separation, your basic group life benefit remains in effect at no cost to you. However, the amount of Basic retiree insurance is reduced.

QUESTIONS
The VRS Group Life insurance provider is Minnesota Life. Questions about your life insurance coverage can be directed to:

Minnesota Life
P.O. Box 1193
Richmond, VA 23218-1193
1-800-441-2258

Benefit can also be accessed through MYVRS at **https://www.varetire.org/myVRS/ .**

NOTE: Please see the Certificate of Insurance for <u>Reduction</u> stipulations on both the Basic and Optional Term Life coverages.

MINNESOTA LIFE

A Securian Company

Minnesota Life Group Optional Term Life & AD&D Insurance Plan

The Virginia Retirement System (VRS) Optional Group Life insurance program gives you the opportunity to purchase additional insurance at favorable group rates on yourself and your family. Optional group life is term insurance. Term insurance generally provides the largest immediate death protection for your premium dollar. The program is administered by the Virginia Retirement System, and is provided under a group policy issued by the Minnesota Life Insurance Company.

ELIGIBILITY
All active full time employees

COST OF COVERAGE
Monthly premium is based on age and salary. Please see the Minnesota Life benefit book for more information.

EFFECTIVE DATE OF COVERAGE
An employee may apply for optional life insurance at any time. However, if the employee is enrolling within 31 days of employment, coverage is guaranteed and no medical underwriting is required. Insurance coverage is effective on the signature date. If an employee is enrolling after 31 days of employment coverage begins on the date of the approval.

What Amounts of Coverage are Available in Optional Life?
There are 4 options under the VRS Optional life plan. The amount of coverage a member and the family receives corresponds with the option selected.

	Employee	Spouse	Children
Option	Insurance Amount	Insurance Amount	15 days- Max. age
1	1x Salary	1/2 x Employee Salary	$10,000
2	2x Salary	1 x Employee Salary	$10,000
3	3x Salary	1 1/2 x Employee Salary	$20,000
4	4x Salary	2 x Employee Salary	$30,000

•An **Employee** may select coverage options for one, two, three or four times their salary (rounded to the next highest $1,000), up to a maximum of $700,000.

•Insurance for **Spouse** is one half of the amount of the employee's coverage, up to a maximum of $350,000.
--Approval is required for spouse coverage under Options 2-4 even if an application is completed within 31 days of eligibility.

•**Children's** coverage is based on the option the employee selects. The amount of insurance is for each eligible child.

In addition to these amounts selected to be paid upon a regular death, Optional life insurance also includes accidental death and dismemberment benefits, as well as an accelerated benefit.

•The accidental death benefit pays an additional benefit equal to the amount of Optional life coverage selected if death is a result of an accident.

•The dismemberment benefit pays an amount equivalent to either one-half or the entire amount of optional life insurance should an insured lose sight or suffer a severed limb as a result of an accident or a combination of both.

•The accelerated benefit allows an insured to receive all or a portion of their insurance while they are living. Any insured diagnosed with a terminal illness with a life expectancy of 12 months or less may apply to accelerate their benefit and receive payment while they are living.

What is the Cost of Optional Life?
Premiums for the Employee and the Spouse are based upon each individual insured's age. The rates in the table are per thousand dollars of coverage.

Employee and Spouse Rates

Age of Insured Member or Spouse	Rate per every thousand dollars
Under 30	$ .05
30-34	.06
35-39	.08
40-44	.09
45-49	.14
50-54	.21
55-59	.40
60-64	.66
65-69	1.27
70-74	2.06
75 & Over	2.06

Child(ren) Rates- unmarried dependents up to age 21; or up to age 25 if the unmarried dependent is a full-time student. There is no age limit if the unmarried dependent is disabled.

Option	Insurance Amount (each child)	Flat Monthly Rate
1	$10,000	$0.80
2	$10,000	$0.80
3	$20,000	$1.60
4	$30,000	$2.40

How to Apply for Optional Life?
•Complete an Optional Life Enrollment Application (VRS–39) and
•Send it in with an Evidence of Insurability (VRS-32) form.

If you apply for Optional life within 31 days from the date of employment, you may receive up to Option 4 on a guarantee issue basis, but not greater than $350,000, whichever is less. "Guarantee issue" means that the applicant will receive coverage without proof of insurability for any option that does not exceed $350,000. If an option is selected that provides coverage in excess of $350,000, the applicant will be required to submit an Evidence of Insurability form (VRS–32) to be reviewed by the Company. Coverage will be limited to the amount of the next lowest option not exceeding $350,000 until your VRS-32 is approved.

Likewise, Spouse coverage is guaranteed for Option 1 (1/2 of the employee's salary) if application is made within 31 days the spouse first becomes eligible for Optional life. If the employee selects Option 2, 3, or 4, the spouse will be asked to furnish evidence of insurability for the Company's approval before the spouse can be covered for the higher amount. If the Evidence of Insurability is not approved, your spouse will continue to be insured for the amount provided under Option 1 (half the employee's salary).

If both you and your spouse are eligible for Optional life as employees, you may not elect spouse coverage. Likewise, either you or your spouse, not both, may elect coverage for your children.

Child(ren) also may receive coverage at the level corresponding to the option you select. Children's coverage also does not require proof of insurability if their coverage is applied for within 31 days of their becoming eligible to be insured.

Application for Optional life may also be made at anytime more than 31 days after either the employment date or eligible date. The employee merely completes an enrollment application (VRS–39) and sends it in with their completed evidence of insurability (VRS-32) form.

Applications may be obtained either from your employer's benefits administrator or from Minnesota Life. Their address is PO Box 1193, Richmond, VA, 23218-1193. Minnesota Life's phone number is 1-800-441-2258.

NOTE: Any existing Employee (and or Dependents) which apply for term life coverage (did not apply when initially eligible) <u>MUST</u> complete a Health Statement.

Will I Be Able to Continue My Optional Life at Retirement?
Yes. You may continue your Optional life insurance if you are retiring, or terminating service but deferring retirement. You must have been insured with Optional life for 60 months before leaving service. Premiums to continue your coverage would be at the same rates as that for an active employee.

You may continue optional life as a retiree at either Option 1 or Option 2, subject to a maximum equal to the smaller of the amount of optional insurance in force on the eligible date, or $250,000.

Election to continue must be made within 31 days of leaving service. Optional coverage you are carrying above these amounts may be converted to an individual policy.

Insurance amounts and the corresponding maximums begin to reduce at age 65 and all insurance terminates at age 80.

Spouse coverage is also available at the corresponding Option 1 and Option 2 levels of insurance selected by the retiree to continue. The insurance on the spouse continues to be one half of the amount of the retiree's coverage. Premium is based on the same rates under the VRS group plan.

Dependent children may continue to be insured by the retiree at the same Options previously insured prior to retirement.

What Happens to My Optional Life With Termination?
If you terminate your employment, and are not eligible to continue Optional coverage as a retiree, your Optional insurance terminates. However, coverage may be converted to an individual policy. The conversion privilege may be exercised without proof of insurability if election to convert is made within 31 days of the termination.

Spouse and dependent children coverage also ends when your coverage terminates, but they can then be converted into an individual policy.

Who Are Beneficiaries for Optional Life?
The beneficiaries of an employee's Optional life insurance are the same as those designated for the VRS Basic group life insurance.

The employee is the beneficiary of the spouse and the children's optional life coverage.

Continuation of Benefits

Health and Dental Plans

Under the Anthem Health and Dental Plans, you and your covered dependents are eligible to continue coverage through COBRA according to the "qualifying events".

If you and your dependents are enrolled in the dental or health plans, you will be eligible to continue coverage through COBRA after you leave your employment for a specified period. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents may be eligible to continue dental coverage through COBRA. Also, while you are covered under the plan, your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA. Examples of an ineligible dependent would be when your child graduates from college, or reaches the age of not being eligible for dependent coverage. You will receive notification with premium and continuation options shortly following your termination of employment. Should you have any questions ***you may contact your Human Resources Department at 540.507.7290***

FBA Flexible Spending Accounts

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

If you prefer to terminate your participation and contribution to the Plan, any balance in your account on the date of termination will be forfeited if expenses were not inccurred prior to the date of termination. For more detailed information, please ***call your Human Resources Department at 540.507.7290 or Flexible Benefit Administrators at 1.800.437.3539.***

AUL Short-Term Disability

Once an employee is on the AUL disability plan for 12 months, you can port the coverage for one year at the same cost without evidence of insurability. You have 30 days from your date of termination to contact AUL to Port your coverage by calling ***1.800.553.5318***

Minnesota Term Life

To get information on converting or porting the term life coverage, ***please contact Minnesota Life at 1.800.441.2258 or Human Resources Department at 540.507.7290***

Texas Life Whole Life

When you leave employment, you may continue your Texas Life Whole Life coverage by having the premiums that are currently deducted from your paycheck drafted from your bank account. ***You may do that by contacting Texas Life at 1.800. 283.9233 prompt #3.***

To Continue Other Policies

You may continue your CAIC Accident, CAIC Hospital Indemnity, CAIC Critical Illness, and Allstate Benefits Cancer plans by having the premiums currently deducted from your paycheck drafted from you bank account or billed to your home.

For more information, contact:
Allstate Benefits at 1-800-521-3535
CAIC at 1-800-433-3036

Contact Information for Questions and Claims

Spotsylvania County Department of Human Resources

Please contact for Health and VRS Information
540-507-7291

Flexible Benefit Administrators

509 Viking Drive, Suite F
PO Box 8188
Virginia Beach, VA 23450
1-800-437-FLEX (1-800-437-3539)
Fax: (757) 431-1155
FlexDivision@flex-admin.com
www.flex-admin.com

Continental American Insurance Company (CAIC)

Continental American Insurance Company (CAIC) is a wholly-owned sub-sidiary of Aflac Incorporated. CAIC underwrites group coverage but is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. 2801 Devine Street, Columbia, South Carolina 29205.

Customer Service
1-800-433-3036
csc@caicworksite.com

Allstate Benefits (AB)

1776 American Heritage Life Drive
Jacksonville, Florida 32224
For questions concerning your policy please call:1-800-521-3535
For questions concerning claims please call:1-800-348-4489

American United Life (AUL)

Claims Toll-Free Number

1-866-258-8744

Customer Service

1-800-553-5318

Texas Life Insurance Company

PO Box 830

Waco, TX 76703-0830

1-800-283-9233

Mark III Brokerage

211 Greenwich Rd

Charlotte, NC 28211

1-800-532-1044

www.markiiibrokerage.com/scgva

Mark III Account Manager

Kiesha Congelosi

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800-532-1044 ext 213

Mark III New Hire Enrollment Manager

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tmc@markiiieb.com

800-532-1044 ext 216