

**Scotland County Government** is offering all employees that work at least 32 hours per week a comprehensive Cafeteria Benefits plan. The Cafeteria Benefits plan is being arranged by Mark III Brokerage, an employee benefits firm that has worked in the public sector for the last 35 years. The Cafeteria Benefits plan allows you to pay for certain insurance premiums before taxes are taken out of your paycheck. Paying for these benefits in this method may reduce your taxes and may increase your take home pay.

- The Plan Year begins January 1, 2009 and ends December 31, 2009

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***(All information in this booklet is a brief description of your coverage and is not a contract. Read your certificate for each product for the exact terms and conditions).***

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## ***Interactive Medical Systems (IMS) Health Care & Dependent Care Reimbursement Accounts***

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***Plan Year: January 1, 2009 to December 31, 2009***

***Health Care Reimbursement Plan Maximum: \$5,000.00***

***Health Care Reimbursement Plan Minimum: \$50.00***

***Run Off Period: 60 days following the end of the plan year to file for services rendered during the plan year***

***Waiting period: None***

### **WHAT IS AN FSA**

- A Flexible Spending Account (FSA) is a program that the Federal Government allows your employer to sponsor. It allows you (the employee) to save federal, state and social security taxes on the money you use to pay for eligible unreimbursed healthcare and daycare expenses, which will increase your take home pay. It is a widely used benefit that creates a “**Win - Win**” for employees and employers.
- A Valuable Benefit! If you choose to participate in this valuable program, you and your eligible dependents can “pay” for medical, dental, and vision expenses, and dependent daycare expenses on a tax-free basis.

### **HOW IT WORKS**

- At the time of enrollment, you must determine how much you would like to contribute to each account for the coming year. You may participate in the healthcare plan, the dependent day care plan or both.
- All monies that you put into the FSA will be deducted from your paycheck each pay period BEFORE taxes are calculated.
- Your spendable income increases because you contribute pretax dollars into the FSA plan. This lowers your taxable income; therefore you pay fewer taxes and increase your spendable income. Depending on your tax bracket, this plan can save you 30% to 40% on qualified, eligible expenses.

### **HEALTH CARE CLAIMS & REIMBURSEMENTS**

#### **Q: What are examples of eligible health care expenses?**

You can pay for a wide variety of health care expenses through your pre-tax FSA account. For a detailed listing, please see page 7, “Sample Expenses Eligible for Spending Account Reimbursements”.

#### **Q: Is the deductible on my major medical plan eligible for reimbursement?**

Yes, however, you must submit the Explanation of Benefits (EOB) statement from your healthcare plan which indicates when the deductible was met and verifies that expenses were incurred during the plan year. IMS cannot accept a statement that only indicates that the deductible has been met.

**Q: How do I file a claim for expenses that are covered by insurance?**

The claim must first be filed with the healthcare plan. After you receive an Explanation of Benefits statement indicating which expenses are eligible for payment and which are not, then submit a copy of the EOB with an FSA claim form to Interactive Medical Systems.

**Q: How do I file a claim for expenses not covered by insurance?**

If you are requesting reimbursement for expenses for which you do not have insurance coverage such as dental, vision, or hearing, simply submit a copy of the bill or receipt with an FSA claim form. The receipt should indicate the date of the services, the services provided, and charges.

**Q: What happens to the funds I set aside?**

If you participate in both the healthcare and dependent care FSAs, the funds you set aside are deposited into two separate accounts — one for out-of-pocket eligible health care expenses and one for dependent care expenses. The money allocated for your Health Care Spending Account is available for immediate reimbursement up to your annual election amount. Dependent Care Spending Account dollars are reimbursed as they accumulate in your account; simply submit the required documentation. You cannot transfer or “borrow” funds from one account to the other.

**Q: What happens if there is money left in my account at the end of the year and I have no more reimbursable expenses?**

Under IRS regulations, the money in your account will be forfeited and will be used to pay for administration costs of this Plan. This is known as the “use it or lose it” feature of an FSA. For this reason, you need to make conservative estimates of your reimbursable expenses prior to each plan year. You have a grace period at the end of each plan year in which to file claims for expenses incurred during the plan year.

*Note: An expense is “incurred” when the participant is provided with the medical care that gives rise to the medical expenses, or provided with the dependent care services and not when the participant is formally billed or charged for, or pays for, the medical care, or dependent care services.*

**Q: What happens if I leave my employment during the plan year and have money left in my account(s)?**

See your Human Resources Department for specifics regarding COBRA continuation of your Health Care FSA. The Dependent Care FSA is not eligible for COBRA continuation. If you choose not to participate in COBRA, any funds remaining in your Health Care FSA will be forfeited if you do not have sufficient eligible expenses incurred prior to termination.

**DEPENDENT CARE**

**Q: What are eligible dependent care expenses?**

This Plan follows IRS guidelines which allow you to use pre-tax dollars to pay for daycare services provided to your children under age 13, as well as for an incapacitated parent or spouse. You are eligible if you are a single working parent, you have a working spouse, your spouse is a full-time student for at least five

months during the plan year while you are working (refer to the IRS earned income limits for specific contribution levels), or your spouse or dependent parent is disabled and unable to provide for his or her own care.

Eligible expenses include services provided: (a) inside or outside of your home by anyone other than your spouse, one of your dependents, or one of your children under 19 years of age, (b) by a child care center, or (c) by a housekeeper whose services include dependent care. Day camps are eligible for reimbursement; however, overnight camps are not eligible.

**Q: Is it better to utilize the Dependent Care Flexible Spending Account or the federal income tax credit for dependent care expenses?**

Your individual circumstances and income will determine whether the federal, state (where eligible) and FICA tax savings under the Dependent Care Spending Account provide greater tax benefits than using the federal tax credit. Since individual tax situations vary, it is important for you to determine which approach offers the most favorable tax savings. Contributions to the Dependent Care Spending Account reduce your federal tax credit availability. As of January 1, 2003, you may combine the Dependent Care Spending Account with the federal tax credit amount for a maximum of \$3,000 for one dependent and \$6,000 for two or more dependents.

**Q: How much money can I set aside on a pre-tax basis for dependent care?**

You can set aside a maximum of \$5,000 per plan year (or the maximum contribution limit set by your employer) for dependent care expenses if you are a single parent or married and filing jointly; \$2,500 if you are married and filing separately. The legal maximum is also \$5,000 per calendar year in the event you have access to another FSA plan through your spouse or another employer. For the out-of-pocket Health Care Spending Account maximum, refer to your "Summary Plan Description" booklet.

**Q: Do I need to provide IMS with any documentation when I file a claim?**

Yes, if you participate in the dependent care account, you must provide IMS with the name(s) of your child(ren), the name and tax ID number of the daycare provider. This information is listed on the claim form which can be obtained from your employer or online at [www.ims-tpa.com](http://www.ims-tpa.com).

**A stipulation imposed by the IRS is that the service provider must be over 18 years of age, and cannot be an individual for whom a personal tax exemption is claimed.**

## **GENERAL ACCOUNT INFORMATION**

**Q: How will I know the balance in my Flexible Spending Plan?**

Interactive Medical Systems will print your available balance on the Explanation of Benefits (EOB) attached to any reimbursements that you receive. You may also call the IMS Flex department at (919) 877-9933 or (800) 426-8739 to check your outstanding balances.

**Q: If I participate in the Plan, will I reduce my Social Security benefits when I retire?**

Since your taxable income will be reduced, your FICA contribution for Social Security could also be slightly reduced. Usually the effect will not be great over the lifetime of your covered earnings. Check with your local Social Security office for possible impacts based upon your particular situation.

**Q: Can I change my elections in the Section 125 plan at anytime during the plan year?**

No. You cannot change your elections during the plan year, except in the event of specified status changes. The following events are considered eligible status changes; however, your election change must be consistent with the status event:

*Legal marital status; Number of dependents; Employment status; Dependent satisfies or ceases to satisfy eligibility requirements; Judgment or Order to cover a child; Entitlement to Medicare or Medicaid benefits. Unless you are subject to one of these qualifying events, your election is irrevocable for the plan year. If you experience one of the changes noted above, you are allowed to modify your election within 30 days of the event.*

**Q: Can I submit a claim after the plan year ends?**

You will have a “grace period” after the end of the plan year or the date your coverage period ends to submit claims that were incurred during the plan year. Your Plan Summary will indicate the exact amount of time your plan allows. The expense MUST be for services performed during the plan year.

**Q: What form do I use to file a claim?**

Your employer has a supply of claim forms you can use when you have a claim to be submitted. **You can also download a claim form via our website at [www.ims-tpa.com](http://www.ims-tpa.com).** Simply complete the form and read the claim-filing instructions on the reverse side of the form to ensure your claim is properly submitted. If the expense is qualified under the Plan and appropriate documentation is submitted, you will receive a reimbursement check.

**Q: How and when can I submit a claim?**

You can fax the claim and the appropriate claim substantiation information to **IMS at (919) 877-0615** or it can be mailed to **IMS at PO Box 19108, Raleigh, NC 27619** any time during the plan year.

## HOW DO I GET STARTED?

*How much money should I contribute?*

*How do I enroll?*

*How do I get my money back?*

*It's as easy as 1, 2, 3 ...*

### 1) DETERMINE THE AMOUNT OF YOUR CONTRIBUTIONS

During your annual open enrollment period, determine how much money you need to set aside for the year. Be conservative in your estimates because of the “use it or lose it” rule. Your employer deducts that amount from your pay on a pre-tax basis in equal amounts throughout the year. For example, if you are paid 52 times a year and you elect to contribute \$1,040 you would have \$20 deducted from each paycheck and credited to your FSA account.

### 2) ENROLL

Complete your employer’s FSA enrollment form.

### 3) SUBMIT YOUR CLAIM

When you have an eligible expense, submit a claim for reimbursement with the appropriate documentation to IMS by mail or fax and IMS will reimburse you by check.

## POINTS TO CONSIDER

- **How much to place in your FSA Benefits Plan**

After reviewing the list of qualified expenses, try to determine how much you expect to spend on these expenses during the plan year.

- **The “Use it or Lose it” Rule**

Remember if you contribute to a Flexible Reimbursement Account and do not use all of the monies you deposit, you will lose any remaining balance in the account at the end of the plan year.

Because of the tax advantages of a Flexible Spending Account plan, the IRS has established strict guidelines for monies not used by the end of the plan year. For this reason, plan carefully how much to place in your account. Only contribute an amount that you feel confident you will use to pay for qualified expenses incurred during the plan year.

- **Social Security Benefits**

Any reduction in your taxable pay for Social Security purposes may also lead to a reduction in your Social Security benefits. For most employees, the reduction in Social Security benefits will be insignificant compared to the value of paying lower taxes today.

- **Once enrolled, you may not change**

To comply with IRS regulations, you may only make a change in your elections during the open enrollment period each plan year. You may NOT make changes to your elections after the open enrollment period, unless you experience a family status change. Examples include – marriage, divorce, birth, adoption, death, loss of spouse’s employment, etc...

## SAMPLE EXPENSES ELIGIBLE FOR SPENDING ACCOUNT REIMBURSEMENTS

### Medical, Dental, Vision Expenses

- Acupuncture
- Alcoholism treatment
- Ambulance hire
- Artificial teeth
- Birth control pills
- Braces
- Braille-books & magazines
- Chiropractors
- Christian Science Practitioners' Fees
- Co-insurance amount you pay
- Co-pay amount you pay
- Contact lenses & eyeglasses plus eye examination
- Contact lens solution
- Cost of operations and related treatments
- Crutches
- Dental fees
- Drugs (by prescription) & medical supplies
- Fees for Practical Nurse
- Fees for healing services
- Handicapped persons' special schools
- Hearing devices & batteries
- Home improvements necessitated by medical considerations
- Hospital bills
- Insulin
- Laboratory fees
- Lead-base paint removal (for children with lead poisoning)
- Massage Therapy (medically necessary)
- Medical information plan
- Mentally handicapped persons' cost of special home therapy
- Nurses fees (including Nurses' board & social security tax paid by you)
- Obstetrical expenses
- Orthopedic shoes
- \* Over-the-counter medications purchased to *treat* or *alleviate* the symptoms of an illness or injury (i.e. Tylenol, Neosporin, Band-aids, etc...)
- Oxygen
- Physical fees
- Psychiatrists & Psychologists fees
- Radial Keratotomy and Lasik eye surgery
- Routine physical & other non-diagnostic services or treatments
- Seeing-eye dog and maintenance
- Smoking cessation (excluding patches and nicotine gum)
- Special education for the blind
- Special plumbing for the handicapped
- Sterilization (ie., tubal ligation, vasectomy)
- Surgical fees
- Telephone, special services for the deaf
- Television audio display equipment for the deaf
- Therapeutic care for drug & alcohol addiction
- Therapy treatments
- Transportation expenses primarily in the rendering of medical services
- Tuition at special school for handicapped
- Vitamins, by prescription only
- Weight loss program (if prescribed by Physician to treat existing disease)
- Wheelchair
- X-ray

### Dependent Care Expenses

- Baby-sitters over the age of 18
- Daycare Centers
- Nursery Schools
- After-School Programs
- Day Camp
- Eldercare

### Common Expenses Not Eligible for Reimbursement

- Cosmetic procedures
- Over the counter vitamins and dietary supplements (unless the claimant provides physician documentation that a medical condition validates the expense)
- Gym and fitness club memberships
- Nicotine Patches and Gum

\* **Some items may require physician documentation**

***If you are unsure if an expense is eligible for reimbursement, please call the Interactive Medical Systems Flex Department at 919-877-9933 or 800-426-8739. Business hours are Monday through Friday 8:00 am to 5:00 PM EST.***

**FLEXIBLE BENEFITS WORKSHEET**

**Instructions:** To estimate your potential unreimbursed health care and dependent care expenses for the coming year, be sure to review your "Explanation of Benefits" forms, tax receipts, expense vouchers, checkbook registry, etc., for the prior two years. Using these figures as a benchmark, conservatively estimate the amount of expenses you will most likely incur in the coming year in sections A & B below.

**A) Medical, Dental, Vision Expenses** (estimated unreimbursed annual health care expenses):

<u>MEDICAL</u>	(Annual)	<u>DENTAL</u>	(Annual)
Doctor Office Co-pays	\$ _____	Filings	\$ _____
Deductibles	_____	Bridges	_____
Routine OB-GYN Exam	_____	Crowns	_____
Physicals (school physicals, etc...)	_____	Dentures	_____
Co-Insurance	_____	Orthodontia	_____
Prescription/OTC Drugs	_____	Oral Exams	_____
Wheelchair, Crutches, and Medical Appliances	_____	Cleanings/X-Rays	_____
Other (miscellaneous) Costs	_____		

**VISION**

**HEARING**

Eye Exams	\$ _____	Exams	\$ _____
Eyeglass Lenses/Frames	_____	Hearing Aids	_____
Contact Lenses	_____		

**A) Total Annual Medical Expense** \$ \_\_\_\_\_

**B) Dependent Care (estimated dependent care expenses required for you and your spouse to continue working): (Annual)**

Child Care Center/Babysitting services	\$ _____
Pre-school/Nursery school tuition	\$ _____
After-school programs, Day Camp	\$ _____

**B) Total Annual Dependent Care Expense** \$ \_\_\_\_\_

**Total (A) + (B) = total annual election of \$ \_\_\_\_\_ divided by payroll cycle = \$ \_\_\_\_\_ / pay period**

If you are unsure if an expense is eligible for reimbursement, please call the IMS Flex department at (919) 877-9933.

PO Office Box 19108  
Raleigh, NC 27619

5621 Departure Drive, Suite 117  
Raleigh, NC 27616

Phone: 919- 877-9933 or 800-426-8739  
Fax: (919) 877-0615

**Website: [www.ims-tpa.com](http://www.ims-tpa.com)**



***Creating Healthier Benefits<sup>sm</sup>***

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# **Aflac Personal Accident Indemnity Plan Accident-Only Insurance – Level 1 Policy A-34100-NC**

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**Effective Date: January 1, 2009**

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

## **ACCIDENTS HAPPEN**

- Unintentional injuries are the fifth leading cause of death overall and first among persons in age groups from 1 to 44.
- A disabling injury occurs in the home every three seconds.
- On the average, there are 14 unintentional-injury deaths and about 2,990 disabling injuries every hour during the year.
- In 2005, about 36 percent of all hospital emergency department visits in the United States were injury-related.

*Injury Facts*, 2008 Edition, National Safety Council.

## **ACCIDENT EMERGENCY TREATMENT BENEFIT**

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

## **ACCIDENT FOLLOW-UP TREATMENT BENEFIT**

**Aflac will pay \$25** for one treatment per day for up to a maximum of six treatments per covered accident, per covered person for follow-up treatment received for injuries sustained in a covered accident. Treatment must begin within 30 days of the covered accident or discharge from the hospital. Treatments must be furnished by a physician in a physician's office or in a hospital on an outpatient basis. This benefit is not payable for the same visit that the Physical Therapy Benefit is paid.

## **INITIAL ACCIDENT HOSPITALIZATION BENEFIT**

**Aflac will pay \$1,000** when a covered person is confined to a hospital for at least 24 hours for injuries sustained in a covered accident. If the covered person is admitted directly to an intensive care unit, Aflac will pay \$1,500. This benefit is payable only once per hospital confinement\* or intensive care unit confinement and is payable only once per calendar year, per covered person.

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

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

### **ACCIDENT HOSPITAL CONFINEMENT BENEFIT**

**Aflac will pay \$200 per day** for which a covered person is charged for a room for hospital confinement\* of at least 18 hours for treatment of injuries sustained in a covered accident. This benefit is payable up to 365 days per covered accident, per covered person. The Accident Hospital Confinement Benefit and the Rehabilitation Unit Benefit will not be paid on the same day; only the highest eligible benefit will be paid.

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

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

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

**Aflac will pay \$25–\$10,000 for:**

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

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

## **MAJOR DIAGNOSTIC EXAMS**

**Aflac will pay \$150** if a covered person requires one of the following exams for injuries sustained in a covered accident: CT (computerized tomography) scan, MRI (magnetic resonance imaging), or EEG (electroencephalogram). The exam must be performed in a hospital, a physician's office, or an ambulatory surgical center, and a charge must be incurred. This benefit is limited to one payment per calendar year, per covered person. No lifetime maximum.

## **PHYSICAL THERAPY BENEFIT**

**Aflac will pay \$25** for one treatment per day up to a maximum of ten treatments per covered accident, per covered person if a physician advises the person to seek treatment from a physical therapist. Physical therapy must be for injuries sustained in a covered accident and must start within 30 days of the covered accident or discharge from the hospital. Treatment must take place within six months after the accident. This benefit is not payable for the same visit that the Accident Follow-Up Treatment Benefit is paid.

## **REHABILITATION UNIT BENEFIT**

**Aflac will pay \$100 per day** when a covered person is charged for confinement in a hospital and transferred to a bed in a rehabilitation unit of a hospital for a covered injury. This benefit is limited to 30 days for each covered person per period of hospital confinement and is limited to a calendar year maximum of 60 days. The Accident Hospital Confinement Benefit and the Rehabilitation Unit Benefit will not be paid on the same day; only the highest eligible benefit will be paid. No lifetime maximum.

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

## **APPLIANCES BENEFIT**

**Aflac will pay \$100** if a covered person requires, as advised by a physician, the use of a medical appliance as an aid in personal locomotion resulting from injuries sustained in a covered accident. This benefit is payable for crutches, wheelchairs, leg braces, back braces, and walkers, and is payable once per covered accident, per covered person.

## **PROSTHESIS BENEFIT**

**Aflac will pay \$500** if a covered person requires a prosthetic device as a result of injuries sustained in a covered accident. This benefit is payable once per covered accident, per covered person and is not payable for hearing aids, wigs, or dental aids, to include false teeth.

## **BLOOD/PLASMA/PLATELETS BENEFIT**

**Aflac will pay \$100** if a covered person requires blood, plasma, or platelets for the treatment of injuries sustained in a covered accident. This benefit is not payable

for immunoglobulins and is payable only once per covered accident, per covered person.

#### **AMBULANCE BENEFIT**

**Aflac will pay \$150 for ground ambulance transportation or \$1,000 for air ambulance transportation** if a covered person requires ambulance transportation to a hospital or emergency center for injuries sustained in a covered accident. A licensed professional ambulance company must provide the transportation within 72 hours of the covered accident.

#### **TRANSPORTATION BENEFIT**

**Aflac will pay \$400** per round trip to a hospital if a covered person requires special treatment and hospital confinement\* for injuries sustained in a covered accident. The hospital must be more than 100 miles from the covered person's residence or site of the accident. This benefit will be paid for only the covered person for whom the treatment is prescribed, or if the treatment is for a dependent child and commercial travel is necessary, one of the dependent child's parents or legal guardians who travels with the child will also receive this benefit. The local attending physician must prescribe the treatment, and the treatment must not be available locally. This benefit is payable for up to three round trips per calendar year, per covered person. This benefit is not payable for transportation by ambulance or air ambulance to the hospital.

#### **FAMILY LODGING BENEFIT**

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

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

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

	<u><b>Insured/Spouse</b></u>	<u><b>Child</b></u>
<b>Common-Carrier Accidents</b>	<b>\$100,000</b>	<b>\$15,000</b>

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

	<u><b>Insured/Spouse</b></u>	<u><b>Child</b></u>
<b>Other Accidents</b>	<b>\$25,000</b>	<b>\$7,500</b>

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

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

	<u>Insured/Spouse</u>	<u>Child</u>
<b>Both arms and both legs</b>	<b>\$25,000</b>	<b>\$7,500</b>
<b>Two eyes, feet, hands, arms, or legs</b>	<b>\$25,000</b>	<b>\$7,500</b>
<b>One eye, hand, foot, arm, or leg</b>	<b>\$6,250</b>	<b>\$1,875</b>
<b>One or more fingers and/or one or more toes</b>	<b>\$1,250</b>	<b>\$500</b>

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

#### **WELLNESS BENEFIT**

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

#### **CONTINUATION OF COVERAGE BENEFIT**

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

## **GUARANTEED-RENEWABLE**

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

## **EFFECTIVE DATE**

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

## **WHAT IS NOT COVERED**

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

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

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

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

- Participating in any sport or sporting activity for wage, compensation, or profit, including officiating or coaching; or racing any type vehicle in an organized event.

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

### **FAMILY COVERAGE**

Family coverage includes the insured; spouse; and dependent, unmarried children to age 19 (23 if full-time students). Newborn children are automatically insured from the moment of birth. One-parent family coverage includes the insured and all unmarried, dependent children to age 19 (23 if full time students). A dependent child must be under the age of 19 at the time of application to be eligible for coverage.

#### **Personal Accident Indemnity Plan Accident-Only Insurance – Level 1 Monthly Premium Rates – Class B**

Individual	\$19.80
Named Insured/Spouse Only	\$26.50
One-Parent Family	\$28.70
Two-Parent Family	\$35.60

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

**American Family Life Assurance Company of Columbus (Aflac)**  
Worldwide Headquarters  
1932 Wynnton Road  
Columbus, Georgia 31999

1.800.99.AFLAC (1.800.992.3522)  
En español:  
1.800.SI.AFLAC (1.800.742.3522)

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



# **Cancer Can Affect Anyone**

## **Statistics Predict:**

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

## **Are you prepared for the cost of cancer?**

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

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

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

***THIS CANCER PLAN is designed to create a source of extra cash that will help you and your family cope during the battle against cancer or a specified disease.***

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

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

## **Plus, you get these unique features:**

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

## **Selected benefits paying cash to you:**

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

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

\*\*Report from the American Hospital Administration.

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## ***Assurity Cancer & Specified Disease Plan***

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***Effective Date: January 1, 2009 (pending underwriting approval)***

### **BASIC BENEFITS**

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

### **RATE STRUCTURE**

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

### **UNDERWRITING**

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

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

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

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

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

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

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

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

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

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

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

The monthly option for this benefit is:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Wellness Claims** - An employee can file a wellness claim by fax, call-in or mail. Employees can call Assurity to get a wellness claim form or download one from [www.markiibrokerage.com/scotlandcountync](http://www.markiibrokerage.com/scotlandcountync). If a bill is not included with the claim form, a scheduled amount will be paid. (Scheduled amounts are listed on the claim form). Employees can also call in their wellness claim at (888)-358-8808 ext. 23. The call in service requires all the information on the wellness claim form. The wellness claim form must include the name and phone number of your physician. All claims are subject to verification. Claims must be filed within 12 months of the incurred date of the claim.

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

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

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

**Pre-Existing Conditions**

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

**30-Day Waiting Period**

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

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

Addison's Disease  
Botulism  
Brucellosis  
Budd-Chiari Syndrome  
Cystic Fibrosis  
Diphtheria  
Encephalitis  
Histoplasmosis  
Legionnaires Disease  
Lou Gehrig's Disease  
Lupus Erythematosus  
Malaria  
Meningitis  
Multiple Sclerosis  
Muscular Dystrophy

Myasthenia Gravis  
Osteomyelitis  
Polio  
Q Fever  
Reye's Syndrome  
Rheumatic Fever  
Rocky Mountain Spotted Fever  
Sickle Cell Anemia  
Tay-Sachs Disease  
Tetanus  
Trichinosis  
Toxic Shock Syndrome  
Tuberculosis  
Typhoid Fever  
Whooping Cough

**Cancer or other Specified Disease Claims:** You may file a claim for cancer or specified diseases by completing an Assurity Claim Form. Please make sure to include all pertinent information as stated on the form. You can obtain a claim form by contacting Assurity, or by downloading one from [www.markiibrokerage.com/scotlandcountync](http://www.markiibrokerage.com/scotlandcountync). Should you have any questions on how to file or submit a claim, please contact Assurity customer service at the number listed below.

#### **OPTIONAL RIDERS**

**Intensive Care Rider - Provides a Daily Benefit of \$300 or \$600** if an insured person is confined to a Hospital's Intensive Care Unit, up to a maximum of 20 days per period of confinement.

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

Assurity Life Insurance Company  
PO Box 82533, Lincoln, NE, 68501-0926  
**(Claims can also be mailed to this address)**

**Website: [www.assurityatwork.com](http://www.assurityatwork.com)**  
**Assurity Customer Service: 866- 289-7337**

To **Call** in a Wellness Claim: 888-358-8808 Ext. 23  
To **Fax** in a Wellness Claim: 800-869-0368



## Assurity Life Cancer & Specified Disease Plan- Monthly Rates

		\$150 Daily Benefit	\$250 Daily Benefit	\$350 Daily Benefit
Base Policy (\$10,000 per month/\$100,000 lifetime maximum) (radiation/chemotherapy)	Individual	\$20.92	\$23.22	\$25.52
	EE & Spouse	\$32.04	\$35.62	\$39.19
	EE & Children	\$25.99	\$28.60	\$31.21
	Family	\$37.11	\$41.00	\$44.88
Base Policy with Intensive Care Rider (\$300 daily benefit)	Individual	\$23.02	\$25.32	\$27.62
	EE & Spouse	\$36.24	\$39.82	\$43.39
	EE & Children	\$29.29	\$31.90	\$34.51
	Family	\$42.51	\$46.40	\$50.28
Base Policy with Intensive Care Rider (\$600 daily benefit)	Individual	\$25.12	\$27.42	\$29.72
	EE & Spouse	\$40.44	\$44.02	\$47.59
	EE & Children	\$32.59	\$35.20	\$37.81
	Family	\$47.91	\$51.80	\$55.68
Base Policy with First Occurrence Benefit Rider (\$2,500 benefit)	Individual	\$23.75	\$26.05	\$28.35
	EE & Spouse	\$36.27	\$39.85	\$43.42
	EE & Children	\$29.41	\$32.02	\$34.63
	Family	\$41.93	\$45.82	\$49.70
Base Policy with First Occurrence Benefit Rider (\$2,500 benefit) and Intensive Care Rider (\$300 daily benefit)	Individual	\$25.85	\$28.15	\$30.45
	EE & Spouse	\$40.47	\$44.05	\$47.62
	EE & Children	\$32.71	\$35.32	\$37.93
	Family	\$47.33	\$51.22	\$55.10
Base Policy with First Occurrence Benefit Rider (\$2,500 benefit) and Intensive Care Rider (\$600 daily benefit)	Individual	\$27.95	\$30.25	\$32.55
	EE & Spouse	\$44.67	\$48.25	\$51.82
	EE & Children	\$36.01	\$38.62	\$41.23
	Family	\$52.73	\$56.62	\$60.50
Base Policy with First Occurrence Benefit Rider (\$5,000 benefit)	Individual	\$26.58	\$28.88	\$31.18
	EE & Spouse	\$40.50	\$44.08	\$47.65
	EE & Children	\$32.83	\$35.44	\$38.05
	Family	\$46.75	\$50.64	\$54.52
Base Policy with First Occurrence Benefit Rider (\$5,000 benefit) and Intensive Care Rider (\$300 daily benefit)	Individual	\$28.68	\$30.98	\$33.28
	EE & Spouse	\$44.70	\$48.28	\$51.85
	EE & Children	\$36.13	\$38.74	\$41.35
	Family	\$52.15	\$56.04	\$59.92
Base Policy with First Occurrence Benefit Rider (\$5,000 benefit) and Intensive Care Rider (\$600 daily benefit)	Individual	\$30.78	\$33.08	\$35.38
	EE & Spouse	\$48.90	\$52.48	\$56.05
	EE & Children	\$39.43	\$42.04	\$44.65
	Family	\$57.55	\$61.44	\$65.32

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## **Superior Vision Plan**

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**Effective Date: January 1, 2009**

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

**COPAYMENT-**   \$10.00- Exam  
                   \$15.00- Materials  
                   \$35.00- Contact Lens Fitting

<b><u>BENEFITS</u></b>	<b><u>FREQUENCY</u></b>	<b><u>IN-NETWORK</u></b>	<b><u>NON-NETWORK</u></b>
<b>Comprehensive Exam</b> <i>(by an Ophthalmologist)</i>	12 Months	Covered in Full	Up to \$44.00
<b>Comprehensive Exam</b> <i>(by an Optometrist)</i>	12 Months	Covered in Full	Up to \$39.00
<b>Lenses (Standard) per Pair:</b>			
Single Vision	12 Months	Covered in Full	Up to \$34.00
Bifocal	12 Months	Covered in Full	Up to \$48.00
Trifocal	12 Months	Covered in Full	Up to \$64.00
Lenticular	12 Months	Covered in Full	Up to \$88.00
<b>Contact Lenses (Per Pair)*:</b>			
Medically Necessary	12 Months	Covered in Full	Up to \$210.00
Cosmetic (Elective)**	12 Months	Up to \$120.00	Up to \$100.00
<b>Standard Contact Lens</b>			
Fitting Fee***	12 Months	Covered in Full	Not Covered
<b>Specialty Contact Lens</b>			
Fitting Fee***	12 Months	Up to \$50.00	Not Covered
<b>Frames (Standard)**</b>	24 Months	Up to \$100.00	Up to \$50.00

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

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

*\*\*\*Standard contact lens fitting fee applies to an existing contact lens user who wears disposable, daily wear, or extended wear lenses only. The specialty contact lens fitting fee applies to new contact lens wearers and/or a member who wears toric, gas permeable, or multifocal lenses. For the specialty fit, the member is responsible for any charges over \$50.*

### **HOW TO USE YOUR BENEFIT**

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

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

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

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

**DEFINITIONS OF CONTACT LENSES**

**Contact Lenses, Elective/Cosmetic**

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

**Contact Lenses, Medically Necessary**

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

- Aphakia (after cataract surgery without implant lens)  
A pair of prescription single vision or multifocal eye glass lenses and an eyeframe can be provided along with contact lenses prescribed for this reason.
- When visual acuity cannot be corrected to 20/70 in the better eye except through the use of contact lenses (must be 20/60 or better).•  
Anisometriopia of 4.0 diopters or more, provided visual acuity improves to 20/60 or better in the weak eye.
- Kerataconus

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

**Contact Lens Examining Fee:**

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

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

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

- Professional Services and/or Materials in conjunction with:
  - blended bifocals, no line, or progressive lenses
  - compensated or special multi-focal lenses
  - plain (non-prescription) lenses
  - anti-reflective, scratch, UV400, or any coating or laminate applied to lenses
  - subnormal vision aids
  - tints, other than solid
  - orthoptics, vision training and developmental vision procedures
  - polycarbonate lenses
  
- Medical or surgical treatment of the eyes
- Any eye examination or any corrective eyewear required by an Employer as a condition of employment
- Any injury or illness when covered under Workers Compensation or similar law
- Plain or prescription sunglasses, no-line bifocals, blended lenses are not covered; an Insured may elect to apply the maximum allowance for standard lenses toward his, or her cost of progressive lenses
- Subnormal vision aids
- Services rendered or Materials purchased outside the U.S. or Canada unless the member resides in the U.S. or Canada; and the charges are incurred while on a business or pleasure trip
- Charges in excess of the Usual, Customary and Reasonable charges for the Professional Service or Materials
- Experimental or non-conventional treatment or device
- Safety eyewear
- Spectacle lens styles, materials, treatments, or “add-ons” not shown in the Benefits Summary
- Services or Materials rendered by a provider other than an Ophthalmologist, Optometrist or Optician acting within the scope of his, or her license
- Any additional service required outside basic vision analysis for contact lenses except fitting fees
- Services rendered after the date an Insured ceases to be covered under this Certificate, except when vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured within 31 days from the date of such order
- Services rendered or Materials ordered before the date of coverage began under this Certificate
- Regardless of Optical Necessity, benefits are not available more frequently than delivered, and the services rendered to the Insured within 31 days from that which is specified in the Benefits Summary

## DISCOUNTS ON ADDITIONAL PURCHASES

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

## DISCOUNT SVP8-20

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

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

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

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

### Member pays:

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

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

## REFRACTIVE SURGERY DISCOUNTS

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

## **MONTHLY RATES**

Employee Only	\$9.90
Employee + One	\$19.22
Employee + Family	\$28.24

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

To order contact lens via the internet go to this site: [www.SVContacts.com](http://www.SVContacts.com)

**Member Services FAX:**  
916-852-2277

**Provider Nominations:**  
Lee Sims @ 800-923-6766 x. 254

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

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

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

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

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



## **Disability Is A Fact of Life!**

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

## ***Could You Live Off Of Savings?***

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

## **Standard Life Short Term Disability**

**Effective Date: January 1, 2009 (pending underwriting approval)**

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

### **ACCIDENT & SICKNESS PROTECTION**

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

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

<b>Benefit Duration: 90 Days</b>		<b>Benefit Duration: 180 Days</b>		<b>Benefit Duration: 365 Days</b>	
<b>Monthly Benefit</b>	<b>Monthly Premium</b>	<b>Monthly Benefit</b>	<b>Monthly Premium</b>	<b>Monthly Benefit</b>	<b>Monthly Premium</b>
\$500	\$11.25	\$500	\$17.50	\$500	\$22.50
\$600	\$13.50	\$600	\$21.00	\$600	\$27.00
\$700	\$15.75	\$700	\$24.50	\$700	\$31.50
\$800	\$18.00	\$800	\$28.00	\$800	\$36.00
\$900	\$20.25	\$900	\$31.50	\$900	\$40.50
\$1,000	\$22.50	\$1,000	\$35.00	\$1,000	\$45.00
\$1,100	\$24.75	\$1,100	\$38.50	\$1,100	\$49.50
\$1,200	\$27.00	\$1,200	\$42.00	\$1,200	\$54.00
\$1,300	\$29.25	\$1,300	\$45.50	\$1,300	\$58.50
\$1,400	\$31.50	\$1,400	\$49.00	\$1,400	\$63.00
\$1,500	\$33.75	\$1,500	\$52.50	\$1,500	\$67.50
\$1,600	\$36.00	\$1,600	\$56.00	\$1,600	\$72.00
\$1,700	\$38.25	\$1,700	\$59.50	\$1,700	\$76.50
\$1,800	\$40.50	\$1,800	\$63.00	\$1,800	\$81.00
\$1,900	\$42.75	\$1,900	\$66.50	\$1,900	\$85.50
\$2,000	\$45.00	\$2,000	\$70.00	\$2,000	\$90.00

## ELIGIBILITY

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

## POLICY FEATURES

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

**Disability Due to Pregnancy:** Benefits are covered provided conception occurs after the effective date of the policy.

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

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

**Proof of Loss:** You must give us written proof of loss within ninety days after a period of disability for which we owe you benefits. If you are not **able** to give us written proof of loss within the time required, it will not have a bearing on your claim if proof is given to us as soon as it is reasonably possible. In any event, proof must be given no later than one year from the time specified.

**Portability:** When you leave employment, you may continue the short term disability coverage, subject to the renewability provision, provided you maintain continuous employment. Coverage is subject to occupational and income underwriting rules. **\*\*This coverage expires on the policy anniversary date following your 65th birthday.**

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

**If you have any questions regarding the Standard Life Disability Plan,  
please call 800- 327-0695  
Toll Free Claims Line: 800-227-0251**



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## **Texas Life Whole Life Plan**

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**Effective Date: February 1, 2009 (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. As an employee, you are eligible to apply if you have satisfied your employer's eligibility period. You may also apply for coverage on your spouse, children and grandchildren.

### **WHY VOLUNTARY COVERAGE**

- Most employees are dependent on group term
- Only 50% of U.S. Households have individually owned life insurance<sup>1</sup>
- 72% of life insurance policies are paid to beneficiaries of individually owned life plans<sup>1</sup>
- Most term policies expire before paying a death claim
- When do you want a life insurance policy in force? —Answer: When you die
- Term is for IF you die; permanent is for WHEN you die
- Everybody dies

### **THE NEW PRODUCT: TEXAS LIFE'S VPL-plus**

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

### **VPL-plus: PORTABLE AND PERMANENT**

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

### **VPL-plus: THE GUARANTEES EMPLOYEES WANT**

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

<sup>1</sup>LIMRA International, 2005

## **VPL-plus: CGI (EXPRESS ISSUE) UNDERWRITING**

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

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

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

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

### **Express Issue Maximums**

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

### **Simplified Issue**

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

### **Accelerated Death Rider**

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

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

*This 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, press prompt #3.**

**Texas Life Insurance Company<sup>®</sup>**  
A MetLife Company

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

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## ***Continuation of Benefits***

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### **IMS REIMBURSEMENT ACCOUNTS**

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

If you prefer to terminate your participation and contribution to the Plan, any balance in your account on the date of termination will be forfeited if expenses were not incurred prior to the date of termination. For more detailed information, please call **your Benefits Department at 1-910- 277-2403.**

### **SUPERIOR VISION**

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

If you and your dependents are enrolled in the vision plan, you will be eligible to continue coverage through COBRA after you leave employment for a specified period. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents may be eligible to continue vision coverage through COBRA. Also, while you are covered under the plan, your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA. Examples of an ineligible dependent would be when your child graduates from college, or turns 24 years old. For more detailed information, please call **your Benefits Department at 1-910-277-2403.**

### **AFLAC ACCIDENT INSURANCE**

When you leave employment, you may continue your Aflac Accident policy by having the premiums currently being deducted from your paycheck either billed directly to your home or drafted from your bank account. You may contact **Aflac at 1-800-992-3522.**

### **ASSURITY CANCER**

When you leave employment, you may continue your Assurity Cancer coverage by having the premiums that are currently deducted from your paycheck drafted from your bank account. Please call **Assurity at 1-866-289-7337.**

### **STANDARD LIFE SHORT TERM DISABILITY**

When you leave employment, you may continue your short term disability coverage as long as continuous employment is maintained. Continued coverage is subject to income and occupational underwriting guidelines. Coverage expires at age 65. You may continue the disability coverage by having the premiums that are currently deducted from your paycheck drafted from your bank account. Please call **Standard Life at 1-800-327-0695.**

## **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 800- 283-9233 prompt #3.**

### **Important Phone Numbers**

Scotland County Government Benefits Department- 1-910-277-2403

Mark III Brokerage, Inc.- 1-800-532-1044

IMS Health and Dependent Care - 1-919- 877-9933

Aflac Accident Plan- 1-800-992-3522

Assurity Cancer Plan - 1-888-358-8808, ext. 23

Superior Vision Plan - 1-800-507-3800

Standard Life Short Term Disability Plan - 1-800-327-0695 or  
1-800-227-0251

Texas Life Whole Life Plan - 1- 800- 283-9233, press prompt #3.

