

**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 since 1973. 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, 2010 and ends December 31, 2010

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***This booklet highlights the benefits offered through your Employer for the current plan year. This is neither an Insurance Contract nor a Summary Plan Description and only the actual policy provisions will prevail. All information in this booklet including premiums are subject to change. All policy descriptions are for informational purposes only.***

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

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***Plan Year: January 1, 2010 to December 31, 2010***

***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 see, “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?***

To view your balance please visit [www.benefitspaymentsystem.com](http://www.benefitspaymentsystem.com). You can also contact the Flex Department at 919.877.9933 ext 5052.

***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 our website at [http://ims-tpa.com/documents/fsa\\_claim\\_form.pdf](http://ims-tpa.com/documents/fsa_claim_form.pdf). 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 attention Flex Department or it can be mailed to IMS at PO Box 19108, Raleigh, NC 27619 any time during the plan year. The claim should be in our office 5 working days prior to the schedule check run for processing.

## **The Benefits Card**

***Q: What is The Benefits Card***

The Benefits Card allows you to access your Flexible Spending Account to pay for eligible expenses without submitting a claim for reimbursement.

***Q: How can I use the Benefits Card?***

The Benefits Card can be used to pay for eligible goods and services covered by your FSA like prescription drug co-pays, office visit co-pays, or deductibles under your health, dental, and vision plans. This card can also be used for allowable dependent care expenses. The Benefits Card carries the MasterCard® logo and can be used wherever MasterCard is accepted

***Q: How does the card work?***

Once a cardholder swipes the card at an eligible merchant location, the transaction is screened to determine whether there are sufficient funds credited to your FSA account or only if there is enough money credited to the account or if it is an eligible expense is the transaction approved. At this point, the merchant will be paid and the amount is debited from the employee's FSA account to reflect payment of an approved expense. There is no direct payment or reimbursement to the participant.

***Q: Is there a "list" of eligible merchants/providers that accept the card?***

No, but most health care or dependent care related providers/merchants that accept MasterCard will accept your card. As far as the merchant/provider is concerned, your Benefits Card is no different than any other MasterCard.

***Q: How do I sign up for the Benefits Card?***

If you enroll in the Flexible Spending Account Plan, you will be mailed a card and a Cardholder Enrollment Agreement detailing policies and procedures for its use. By signing and activating the card when you use it for the first time, you are agreeing that all card transactions will be solely for qualified expenses of the Flexible Spending Account.

***Q: Once I use the card, do I have to use it all of the time?***

No. You may choose to use the card for pharmacy co-payments and file all other claims with Interactive Medical Systems. It is entirely up to you how frequently you want to take advantage of this extra convenience.

***Q: How many cards will I receive?***

You will be provided with one card and one extra card for a spouse or dependent please indicate on the enrollment form and include the spouse or dependent name, date of birth and Social Security number.

***Q: Do I need a PIN to use the card?***

No, there is no PIN associated with the Benefits Card. However, when using the card at self-service merchant terminals, select the "CREDIT" option. Please be aware that the Benefits Card is not a credit card, it is a debit card that uses funds from your Flexible Spending Account.

***Q: What do I do if I lose the card or the card is stolen?***

If you lose your card or it is stolen, contact Interactive Medical Systems immediately by calling 919.877.9933 extension 5052, IMS will deactivate your lost/stolen card and issue you a new card. There is a charge to the member for replacement cards. You will be issue one free extra card per plan year if it is lost or stolen. Every additional card will be at a cost of \$5.00 per card.

***Q: What if my card is rejected at the point of sale/service for any reason or my doctor, dentist or other provider/merchant doesn't accept MasterCard®,***

***what should I do?***

Pay for the charge, keep your itemized receipts and submit a claim reimbursement request to IMS. The card may only be used at medical facilities and pharmacies. **The card will not work at department/ discount grocery stores, If you are purchasing prescriptions or over the counter medication in this establishments, you will have use the pharmacy check out.**

*Note: You may request reimbursement for eligible expenses up to your maximum annual Health Care Spending Account election at any time during the plan year. You may request reimbursement for eligible Dependent Care Spending Account expenses only up to your current contribution balance.*

***Q: If I use my Benefits Card, will I still need to keep my receipts?***

Yes, always keep your itemized receipts for card transactions. There may be times when a transaction will require additional review and you will be asked to submit documentation to IMS. The Flexible Spending Account are IRS regulated and we will audit random transactions to make sure of the proper use of the funds.

***Q: If Interactive Medical Systems believes I used the card for an ineligible expense, what steps are taken? What if I don't respond or I don't have supporting documentation?***

IMS will make several attempts to contact you regarding the need to submit documentation for Benefits Card transactions that require review. If you do not respond to these requests or cannot provide adequate documentation of the expense, your card will be deactivated. The ineligible payment will be deducted from your future Flexible Spending Account claim reimbursement requests until your account is settled. You may also be asked to submit the ineligible reimbursement back to your employer via check or payroll deduction.

***Q: Can I use my Benefits Card to pay for the entire bill at my doctor's or dentist's office?***

No, the purpose of a Flexible Spending Account is to put aside pre-tax funds to pay for un-reimbursed medical and/or dependent care expenses. Your health, dental, or vision provider must bill your insurance carrier for their portion of the fee first. Your Benefits Card, however, may be used for charges that are not reimbursed by your health plan, like co-pays, coinsurance, and deductibles. After your health, dental, or vision plan has paid, you may use your Benefits Card to pay for the balance. Typically, physician, lab, or dental bills provide you the option to pay with a credit card. Select the MasterCard option and provide the card number and expiration date as you would with your personal credit card. You will then mail that information back to your provider who will process accordingly.

***Q: How can I review my Benefits Card transactions?***

You can review your Benefits Card transactions and account balances on the Internet at [www.benefitspaymentsystem.com](http://www.benefitspaymentsystem.com)

The content of this information has been prepared by Interactive Medical Systems solely to help you gain a better understanding of how Flexible Spending Accounts work and how you may best utilize the benefits of the Plan and does not constitute legal or tax advice. This information is an interpretation of selected portions of the Internal Revenue Code (IRC) as of 7/31/06 and is subject to continual revision. It is informational only and not plan specific. For details of your Plan, please refer to your Plan Document.

**Eligible OTC Expenses** include medicines or products that alleviate or treat injuries or illness for you and your dependents. You do not need to provide a statement from a medical provider or indicate a diagnosis in order to receive reimbursement.

Type/Class of Drug or Product	Examples
<b>Allergy Prevention and Treatment</b>	Actifed* Allerest* Benadryl* Chlor-Trimetron* Claritin Contac* Nasalcrom* Sudafed
<b>Analgesics/Antipyretics</b>	Aspirin* Advil* Alleve* Ibuprofen* Naprosyn* Tylenol Midol* Pamprin* PremysynPMS
<b>Antacids and Acid Reducers</b>	AXID AR* Gas-X* Maalox* Mylanta* Tums* Pepcid AC* OTC Prilosec* Tagamet HB* Zantac 75
<b>Anti-arthritics</b>	Glucosamine
<b>Antibiotics (topical)</b>	Bacitracin* Neosporin* Triple antibiotic ointment
<b>Anticandialn (yeast)</b>	Femstat 3* Gynelotrimin* Mycelex-7* Monistat 3* Vagistat-1
<b>Antidiarrheal &amp; Laxatives</b>	Ex-Lax* Immodium AD* Kaopectate* Pepto-Bismol
<b>Antifungal</b>	Lamisil AT* Lotramin AF* Micatin
<b>Antihistamines</b>	Actidil* Actifed* Allerest* Benadryl* Claritin* Chlor-Trimetron* Contac* Drixoral* Sudafed* Tavist* Triaminic
<b>Anti-itch Lotions &amp; Creams</b>	Bactine* Benadryl* Caldecort* Caladryl* Calamine* Cortaid* Hydrocortisone* Lanacort* Lamisil AT* Lotramin AF
<b>Asthma Medicine</b>	Bronitin Mist* Bronkaid* Bronkolixer* Primatene*
<b>Cold Sore/Fever Blister</b>	Abreva Cream* Herpecin
<b>Cold, Flu, Decongestant &amp; Sinus Remedies</b>	Actidil* Actifed* Advil Cold & Sinus* Afrin* Afrinol* Alka Seltzer Cold & Flu* Alleve Cold & Sinus* Children's Advil Cold* Contac* Dayquil* Dimetane* Dristan Long-Lasting* Drixoral* Neo-Synephrine 12-Hour* Nyquil* Orrivin* Pediacare* Sudafed* Tavist-D* Thera-flu* Triaminic* Tylenol Cold & Flu Cough Drops & Lozenges* Nasal Sprays
<b>Contraceptive / Family Planning</b>	Ovulation predictor kits* Pregnancy tests* Spermicides* Condoms
<b>Cough Suppressants or Expectorants</b>	Robitussin* Vicks 44* Chlorasptic* Mucinex* Cough drops* Throat lozenges
<b>Dehydration</b>	Pedialyte
<b>Dental/Denture Care</b>	Orajel* Anbesol* Poligrip
<b>Diaper Rash</b>	Aquaphor* Balmax* Desitin
<b>Ear Care</b>	Ear Drops* Ear wax removal
<b>Eye Care</b>	Contact lens supplies* Eye drops* Reading glasses* Eye patches

**Eligible OTC Expenses (continued)**

include medicines or products that alleviate or treat injuries or illness for you and your dependents. You do not need to provide a statement from a medical provider or indicate a diagnosis in order to receive reimbursement.

<b>Type/Class of Drug or Product</b>	<b>Examples</b>
<b>Foot Care</b>	Arch & insole supports* Callous removers* Athlete's Foot products (see anti-fungal)* Bunion* blister & corn treatments
<b>Hemorrhoidal Preparations</b>	Preparation H* Hemorrhoid* Tronolane
<b>Home Diagnostic Tests or Kits</b>	Blood pressure (monitor & related equipment)* Cholesterol* Diabetic equipment & supplies* Colorectal screenings* HIV test
<b>Lactose Intolerance</b>	DairyCare* Dairy Relief* Lactaid* Lacteeze* Lactrase
<b>Menstrual Cycle</b>	Midol* Pamprin* Premysyn PMS
<b>Migraine Relief</b>	Advil Migraine* Motrin Migraine* Excedrin
<b>Motion Sickness</b>	Dramamine* Marizine
<b>NSAIDS</b>	Advil* Alleve* Ibuprofen* Motrin* Naprosyn* Naproxen
<b>Pediculicide</b>	Nix* Rid
<b>Pre-natal Vitamins</b>	
<b>Skin Care</b>	Sunburn relief* Aloe Vera
<b>Sleeping Aids</b>	
<b>Smoking Cessation</b>	Commit* Nicoderm CQ* Nicorette* Nicotrol
<b>Teething/Toothaches</b>	Orajel* Anbesol
<b>Topical Steroids</b>	Hydrocortisone
<b>Wart Removal</b>	Compound W* Dr. Scholl's Clear Away* Wart-Off

**Dual-Purpose OTC Medicines and Products** may be reimbursed under an FSA with a licensed health care provider's LMN stating your specific diagnosis or medical condition, a recommendation to take the specific OTC medicine to treat your condition, and documentation of the product and cost.

Type/Class of Drug or Product	Examples	Reimbursable Use	Excluded Use
<b>Calcium</b>	Calcium Carbonate* Caltrate* Tricalcium Phosphate Calcium Citrate* Calcium Lactate* Calcium Gluconate	Diagnosis (e.g. osteoporosis) or at-risk for illness or injury based on physician note	Routine use for general health
<b>Dental Fluoride</b>			Routine use for general oral care
<b>Fiber Supplements</b>	Benefiber * Metamucil	Documented specific medical condition; short duration	Routine use for general health
<b>Homeopathic Remedies</b>			
<b>Incontinence</b>		Post-surgery	Infants and toddlers
<b>Joint Supplements</b>	Chondroitin	Diagnosis of Arthritis	Routine use for general health
<b>Minerals</b>	Calcium* Caltrate* Ferrous Sulfate* Feosol* Slow FE* Folic Acid	Diagnosis (e.g. osteoporosis, anemia) or at-risk for illness or injury based on physician note	Routine use for general health
<b>OTC Hormone Therapy</b>		Peri-menopausal or menopausal symptoms	Routine use for general health
<b>Dietary Supplements</b>	Protein bars* Power drinks* Ensure* Glucerna* Slimfast	Documented specific medical condition	Sports performance, general energy and health
<b>Snoring Cessation Aids</b>		Breathe Right* Snorezz	Sleep Apnea
<b>Vitamins</b>		Vitamin B for treatment of scurvy	Routine use for general health
<b>Weight Loss</b>		Diagnosis of obesity or other documented specific medical condition	General weight loss

**Excluded OTC Products (non-eligible expenses)**

Type/Class of Drug or Product	Examples
<b>Cosmetic Products</b>	Face soaps* Creams* Make-up* Perfumes* Hair Removal
<b>Dental Products</b>	Dental floss* Toothpaste* Toothbrushes* Teeth whitening kits Mouthwash
<b>Ear Care</b>	Ear plugs
<b>Herbal Supplements</b>	
<b>Toiletries</b>	Deoderant* Shampoo* Body sprays* Soaps* Moisturizers* Chapstick
<b>Vitamins</b>	Without a Letter of Medical Necessity

## Sample Expenses Eligible for Flexible Spending Account Reimbursement

### 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
- 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)
- Mentally handicapped persons' cost of special home therapy
- Nicotine Patches and Gum
- Obstetrical expenses
- Orthopedic shoes
- Over-the-counter medications purchased to treat or alleviate the symptoms of an illness or injury (see the chart on the following pages for eligible expenses)
- Oxygen
- Physical fees

- Sterilization (i.e., tubal ligation, vasectomy)
- Surgical fees (except cosmetic)
- 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

- Babysitters over the age of 19
- 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
- \*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 extension 5052.** Business hours are Monday through Friday 8:00 am to 5:00 pm EST.*

## How can I access my Flex Account Online?

Cardholders have access to online claim information and balances at:

**[www.benefitspaymentsystem.com](http://www.benefitspaymentsystem.com)**

To register for access on the BPS website simply follow the steps below:

- **Click on the Participant Log in**

**You must register first by creating your account. Simply click on the link named “Create Account” under the Log in button**

- **Enter your full name**
- **Employee Id: Your Social Security Number with no dashes or spaces**
- **Employer ID: Please leave that option blank**
- **Card Number: Your Benefits Master Card number, no dashes or spaces**
- **Then Create your Log in and password and answer the security questions.**

The next time you access your account, simply enter your personal user name and password to login.

\*Please note that the password will expire every 90 days for security purposes and the system will prompt you to create a new one.

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>***

**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, 2010***

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

***This plan Information is based on A34175BANC, dated IC(8/06).***

### **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.

**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.

*\*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.

## **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 Reserve;
- 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, 2010***

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

### **BASIC BENEFITS**

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

### **PRE-EXISTING CONDITIONS**

Assurity will not pay any benefits for loss caused by a pre-existing condition during the first two years (**one year in NC** and SC) following the Issue Date. Loss due to such conditions will be payable unless specifically excluded from coverage after this two year (**one year in NC** and SC) period.

A pre-existing condition is defined as cancer or a specified disease which first manifests itself within five years (**two years in NC**) prior to the issue date for each insured. Conditions which are fully disclosed to Assurity on the application and are not excluded or limited by Assurity are not considered pre-existing conditions. In GA, the policy does not contain a definition for pre-existing condition. In NC, pre-existing conditions for insureds age 65 or older shall include only conditions specifically excluded by rider.

### **ISSUE AGE**

The Assurity cancer policy is available for persons ages 18-69, including spouses. The issue age of children is 15 days through 18 years of age. The coverage is continued up to age 25 if the child is a fulltime student in an accredited school.

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

### **Hospital Indemnity**

Assurity will pay you benefits for each day while the Insured is confined in the hospital for cancer or certain other specified diseases for the first 75 days of each period of confinement. There are three options for the daily benefit amount: \$150, \$250, and \$350.

### **Prescription Drugs and Medicines**

Assurity will pay the actual charges, up to 25% of the Daily Hospital Confinement benefit shown on the policy schedule per day for the hospital charges for the prescribed drugs and medicines taken during hospital confinement for an insured person. This benefit is limited to the first 75 days for each period of confinement.

### **Surgical Benefit**

Assurity will pay up to \$7,500 for the actual charges made by a surgeon for a surgery in or out of a hospital up to the maximum amount shown in the Surgical Benefits Schedule. For operations not listed, a comparable reasonable benefit will be paid. Surgical procedures performed through the same incision or in the same body opening will be considered one operation.

### **Anesthesia**

Assurity will pay up to 25% of the amount payable under the Surgical Benefit for the administration of an anesthetic for an insured person. This amount does not apply to skin cancer operations. Assurity will pay the actual charges up to \$50 per skin cancer operation.

### **Additional Surgical Opinions**

Assurity will pay up to \$150 for a second opinion. If the second option differs from the first, pays up to \$150 for a third opinion.

### **Artificial Limb and Prosthesis**

The policy pays actual charges for artificial limb or reconstructive procedure to affix or implant it up to a 2,000 lifetime maximum per Insured.

### **Attending Physician**

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

### **Private Duty Nurse**

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

### **Radiation, Radio-Active Isotopes Therapy, Chemotherapy or Immunotherapy**

Assurity will pay 50% of the actual charges up to the monthly maximum and lifetime maximum shown in the Policy Schedule for the following treatment techniques, provided they are used for the purpose of modification or destruction of cancerous tissue. Benefits will also be provided for immunotherapy when used for treatment of covered specified diseases. •teleradio therapy using either natural or artificial propagated radiation. This includes actual charges for radiation treatment delivery only. It does not include charges for clinical treatment planning, clinical treatment management, medical radiation physics, dosiMetry, treatment devices or special services; •interstitial or intracavity application of radium or radioisotopes in sealed or non-sealed sources; •chemical substances and their administration including hormonal therapy. This includes the actual charges for only those chemical substances which modify or destroy cancerous tissue, and does not include other

drugs or medicines given in conjunction with this treatment; •antigenic preparations of immunosuppressive techniques.

### **Experimental Treatment**

Assurity pays the actual charges incurred up to \$25,000 per calendar year for experimental treatment, except for experimental bone marrow transplants for an insured person. This benefit is in lieu of all other benefits under this policy for the same treatment.

### **Physical and Speech Therapy**

The policy pays the actual charges up to \$25 per therapy session up to a lifetime maximum of \$1,000.

### **Extended Care Facility**

The policy pays up to \$60 per day for confinement in an extended care 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**

The policy 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. This benefit is 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**

The policy pays (a) actual charges up to \$2,500 for medical expenses for a donor when 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 stays at a hotel, motel or other accommodations acceptable to Assurity when the donor is asked 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**

For covered treatment, the policy pays (a) actual charges for non-local round trip charges by common carrier to the nearest hospital that provides the prescribed treatment or (b) 50 cents per mile for personal automobile expenses in excess of 50 miles one way, up to 700 miles round trip. Transportation benefits will not be paid for periodic checkups or when receiving non-covered treatments.

### **Transportation and Lodging for Non-local Treatment Which Does Not Require Hospital Confinement**

For non-local covered treatment prescribed by the attending physician as medically necessary which is not available locally, Assurity will pay for an insured person:

- the actual charges for round trip coach fare on a common carrier to the facility that provides the prescribed treatment or 50 cents per mile for personal automobile expense in excess of 50 miles one way, not to exceed 700 miles round trip up to a maximum of \$1,500 per calendar year. Mileage will be measured from the insured person's residence to the nearest facility where the treatment is administered; and
- the actual charges up to \$50 per day for lodging and meal expenses incurred by an insured person when staying at a hotel, motel or other accommodations acceptable to Assurity. Benefits will be paid up to the number of days covered treatment is received.

### **Adult Companion Transportation and Lodging**

The policy pays the following expenses for one adult companion to be near the insured when the insured is confined in a nonlocal hospital for specialized covered treatment (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 when staying at a hotel, motel or other accommodation acceptable to Assurity, limited to the number of days of each confinement.

### **Outpatient Positive Diagnostic Test**

Assurity will pay up to \$250 for the actual charges incurred for the diagnostic test that leads to a positive diagnosis within 90 days of such test for an insured person. This benefit is not payable if the same cancer or specified disease recurs.

### **Outpatient Surgery Benefit**

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

### **Skin Cancer**

The policy 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**

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

### **Hospice Care**

Assurity will pay the actual charges up to \$100 per day for care provided by a Hospice if the insured person has been diagnosed as terminally ill. This benefit is payable for confinement in a Hospice care center, including centers that are in designated areas of a Hospital, or in the insured person's home, limited to a policy maximum of \$7,500.

### **Government or Charity Hospital**

The policy pays \$200 per day for confinement in a government or charity hospital. Payment of this benefit is in lieu of all other policy benefits.

### **Blood and Blood Plasma**

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

### **Breast Cancer/Breast Reconstruction/Breast Prosthesis**

The policy 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 of inpatient care following a lymph node dissection for the treatment of breast cancer. Lifetime maximum of \$2,500 per breast. Assurity will pay the actual charges incurred for an external breast prosthesis or an internal breast prosthesis and the surgeon's fee for implantation for an insured person. For natural tissue breast reconstruction surgery, Assurity will pay the actual charges incurred with a lifetime maximum of \$2,500 per breast. Assurity will pay the actual charges for reconstructive surgery and any adjustments made to the nondiseased breast if performed within 24 months (five years in TN) of reconstruction of the diseased breast for an Insured Person.

### **Hairpiece Benefit**

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

### **Cancer (Wellness) Screening Tests**

The policy pays the amount charged up to \$100 per calendar year for cancer screening test. Tests covered are:

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

### **Wellness Claims**

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

### **Home Health Care Services**

When services are provided by a licensed Home Health Care Agency, when prescribed by a physician, 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. Care cannot be provided by a relative. This benefit is in lieu of all other benefits.

### **Rental or Purchase of Durable Medical Equipment**

The policy pays the actual charges up to \$1,000 per calendar year for purchase or rental of (a) a respirator or similar medical device, (b) brace, (c) crutches, (d) hospital bed or (e) wheel chair.

### **Professional Mental Health Consultation**

The policy pays actual charges up to \$50 per session not to exceed a lifetime maximum of \$250, when receiving treatment for cancer or a specified disease for which benefits are payable.

### **Extended Benefits**

If a covered hospital confinement lasts for more than 75 consecutive days, policy pays usual and customary charges for hospital room and board, medicines, lab tests and other medically necessary hospital charges, up to \$1,000 per day beginning on the 76th day. Payable after the 75th day in lieu of all other policy benefits for the same time period.

### **Waiver of Premium**

If while this policy is in force and before an insured person turns age 65, he or she becomes disabled due to cancer or a specified disease (as indicated on the Policy Schedule), and is receiving treatment for such cancer or specified disease for which benefits are payable under this policy and remains disabled for 90 consecutive days, Assurity will waive premiums starting with the first renewal premium following the 90-day period of disability. Assurity will waive premiums for as long as the insured person remains disabled. Premiums waived will be in accordance with the mode of payment in effect when treatment began.

### **Specified Disease Benefits**

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

Addison's Disease	Myasthenia Gravis
Botulism	Osteomyelitis
Brucellosis	Polio
Budd-Chiari Syndrome	Q Fever
Cystic Fibrosis	Reye's Syndrome
Diphtheria	Rheumatic Fever
Encephalitis	Rocky Mountain Spotted Fever
Histoplasmosis	Sickle Cell Anemia
Legionnaires' Disease	Tay-Sachs Disease
Lou Gehrig's Disease	Tetanus
Lupus Erythematosus	Trichinosis

Malaria  
Meningitis  
Multiple Sclerosis  
Muscular Dystrophy

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 or regarding the Assurity Cancer Plan, please call 888.358.8808 ext. 23.

### **OPTIONAL RIDERS**

**Intensive Care Rider** – pays a **\$300 or \$600** daily benefit if an insured person is confined to a Hospital's Intensive Care Unit, up to a maximum of 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.

### **LIMITATIONS AND EXCLUSIONS**

#### **30-Day Waiting Period**

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

#### **Exclusions**

Assurity will not pay any Benefits for loss caused by or resulting from:

1. Injuries;
2. Sickness, illness or bodily infirmity resulting from anything other than Cancer or Specified Disease;
3. Any sickness, illness, bodily infirmity or incapacity that has been caused, complicated, worsened, or affected by cancer or a specified disease or as a result of cancer or specified disease treatment (not applicable in SC);
4. Hospital confinement or expenses that are incurred prior to the Issue Date regardless of the date of positive diagnosis;
5. Experimental treatment, except as specifically provided in the experimental treatment benefit or bone marrow transplant benefit (Benefits for experimental treatment are limited to \$25,000 per calendar year. Benefits for bone marrow transplants are limited to a policy lifetime maximum of \$25,000. No other benefits are payable for such treatment.) In TN, benefits for experimental treatment will not be denied based solely on the fact that the insured was a participant in a clinical trial;
6. Care and/or treatment received outside the U.S. or its territories; or
7. Care, confinement and/or treatment in a government or charity hospital except as specifically provided in the government or charity hospital benefit.

Assurity Life Insurance Company  
PO Box 82533, Lincoln, NE, 68501-2533  
Assurity Customer Service: 1.866.289.7337  
Website: [www.assurity.com](http://www.assurity.com)

To **Call** in a Wellness Claim: 1.888.358-8808 Ext. 23

To **Fax** in a Claim/Toll Free: 1.800.869-0368

Policy Form No. AAW-C120

Rider Form Nos. AAW-CR261, AAW-CR262, AAW-CR263, AAW-CR264

A592-0909



## 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



# **Superior Vision Plan**

**Effective Date: January 1, 2010**

**Outline of Benefits - Gold Preferred Plan With Materials Discount**

**Vision Plan - Preferred Provider (PPO / Indemnity)**

**COPAYMENT-** \$10.00- Comprehensive 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.*

## **Items or Services Not Covered**

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

## **Items or Services Not Covered or Have Limited Coverage\***

- non-prescription (plano) lenses of any kind, sunglasses, or contact lenses
- any coating applied to lenses such as anti-reflective, scratch, UV, lamination, tints (except pink tint #1 and #2), and sunglass coloring
- any lens materials other than standard plastic or glass such as polycarbonate, hi-index, polaroid, and photochromic

- any special lens feature or treatment such as prisms, slab off, faceted, oversize lens greater than 61mm, polished bevel, groove, drill mount, notch, roll and polish, and blended bifocal
- progressive lenses (Though progressive lenses are not a covered benefit, the provider will apply the retail charge for standard trifocal lenses against the retail charge for the progressive lenses you selected. You are responsible for paying the provider the difference)
- replacement of broken, lost, or damaged frames and/or lenses
- orthoptics, vision training, and developmental vision procedures
- experimental or non-conventional treatment or device
- medical or surgical treatment of the eyes
- post-cataract lenses (intra-ocular)
- subnormal or low vision aids
- safety eyewear
- eye examination or corrective eyewear required by an employer as a condition of employment
- services or materials when covered under workers' compensation or similar third party coverage
- 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 services or procedures outside of a routine eye exam and contact lens fitting
- services or materials rendered after the date a member ceases to be covered by the benefits plan except when vision materials ordered before coverage ended are delivered AND the corresponding services are provided to the member within 31 days of the initial order

Regardless of optical necessity, benefits are not available more frequently than that which is specified in the Outline of Benefits.

\* Plans vary, so please refer to your own employer's specific coverage.

## **How to Use the Plan**

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

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

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

and start experiencing healthy eyes and healthy living.

## Discount Features

### Materials Discounts on Additional Purchases

Prescription eyeglass lenses	30% off retail prices
Eyeglass frames	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

### Materials Discount SVP8-20

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

Note: Discounts do not apply when prohibited by the manufacturer.

### Add-ons to the covered pair of lenses:

#### Lens Options and Upgrades\*

Factory scratch coat lenses)	<b>Member pays 20% off retail, up to:</b> \$13 (single vision & standard lined multifocal lenses)
Ultraviolet coat lenses)	\$15 (single vision & standard lined multifocal lenses)
Standard anti-reflective coat lenses)	\$50 (single vision & standard lined multifocal lenses)
High Index 1.6	\$55 (single vision lenses only)
Polycarbonate	\$40 (single vision lenses only)
Standard photochromic	\$80 (single vision lenses only)
Glass coloring	\$35 (any type lenses)
Plastic, tints, solid, or gradients	\$25 (any type lenses)

#### Lens Options and Upgrades

Power over 4.00D Sphere, 2.00D Cylinder & 5.00D Prism	<b>Member pays:</b> 20% discount off retail prices (any type lenses)
Cosmetic finishing, beveling, edging, and mounting	20% discount off retail prices (any type lenses)
Miscellaneous options	20% discount off retail prices (any type lenses)

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

### **Refractive Surgery Discounts**

Superior Vision Services has a nationwide network of refractive surgeons. These providers offer Superior Vision Plan members a discounted rate off the usual and customary prices for LASIK surgery. These discounts vary depending on the provider but are the best possible discounts available to Superior Vision.

### **Monthly Cost**

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

### **Customer Service**

1.800.507.3800  
1.916.852.2277 fax

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

### **Customer Service/Corporate Office**

11101 White Rock Rd., Ste. 150  
Rancho Cordova, CA 95670

### **Claims Administration**

P.O. Box 967  
Rancho Cordova, CA 95741

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

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



## **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, 2010 (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, 2010 (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, minor children and grandchildren.

- 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.<sup>1</sup>
- On the other hand, adults with both individual life and group life policies have the highest life insurance protection.<sup>1</sup>
- Most term policies generally expire before paying a death claim
- When do you want a life insurance policy in force?  
— Answer: When you die
- Term is for IF you die; permanent is for WHEN you die
- Everybody dies

### **TEXAS LIFE'S VPL-plus**

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

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

- Employee can keep policy, at same premium, if he/she retires or changes jobs
- Employee may apply for spouse, minor children and grandchildren at the worksite
- Permanent coverage: policy guaranteed to remain in force as long as 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>Trends in Life Insurance Ownership,  
09M022-C 1003 (Expires 013111) Rev 08/09

LIMRA International (2006)

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

\*Guarantees are backed by the claims paying ability and financial strength of the issuing company.

## **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 15 days -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

**\*\*We retain the right to require a medical examination.**

### **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

**\*\*We retain the right to require a medical examination.**

### **Accelerated Death Rider**

- Included on all policies (Employee, Spouse, Children, Grandchildren)
- Pays 92% of death benefit, (84% for Illinois) less \$150 processing fee, upon physician-certified diagnosis of condition expected to result in death within 12 months (24 Months in Illinois) (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
- 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.**



*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 1.800.283.9233 prompt #3.**

## **Important Phone Numbers**

Aflac Accident Plan- 1.800.992.3522

Assurity Cancer Plan - 1.866.289.7337

IMS Health and Dependent Care - 1.919.877.9933

Mark III Brokerage, Inc.- 1.800.532.1044

Scotland County Government Benefits Department- 1.910.277.2403

Superior Vision Plan - 1.800.507.3800

Standard Life Short Term Disability Plan - 1.800.327.0695 or

**CLAIMS- 1.800.227.0251**

Texas Life Whole Life Plan - 1.800.283.9233, press prompt #3.

