



City of Peoria, Arizona

Notice of Request for Proposal



Request for Proposal No	P09-0074	Proposal Due Date	August 10, 2009
Materials and/or Services	Flexible Spending Account (FSA) Administration	Proposal Time	5 00 P M AZ Time
		Contact	Lisa Houg, CPPB
Project No	Location City of Peoria, Materials Management	Phone	(623) 773-7115
	Mailing Address 8314 West Cinnabar Avenue, Peoria, AZ 85345		

In accordance with City of Peoria Procurement Code competitive sealed proposals for the material or services specified will be received by the City of Peoria Materials Management at the specified location until the date and time cited above. Proposals shall be in the actual possession of the City of Peoria Materials Management on or prior to the exact date and time indicated above. Late proposals will not be considered, except as provided in the City of Peoria Procurement Code. **Proposals shall be submitted in a sealed envelope with the Request for Proposal number and the offeror's name and address clearly indicated on the front of the envelope.** All proposals shall be completed in ink or typewritten. Offerors are strongly encouraged to carefully read the *entire* Request for Proposal Package.

OFFER

To the City of Peoria The undersigned on behalf of the entity, firm, company, partnership, or other legal entity listed below offers on its behalf to the City a proposal that contains all terms, conditions, specifications and amendments in the Notice of Request for Proposal issued by the City. Any exception to the terms contained in the Notice of Request for Proposal must be specifically indicated in writing and are subject to the approval of the City prior to acceptance. The signature below certifies your understanding and compliance with Paragraph 1 of the City of Peoria Standard Terms and Conditions (form COP 202) contained in the Request for Proposal package issued by the City.

For clarification of this offer contact

Name <u>Linda Willoughby</u>	Telephone <u>706.596.3982</u> Fax <u>706.320.4659</u>
<u>Aflac</u> Company Name	 Authorized Signature for Offer
<u>1932 Wynnton Road</u> Address	<u>Deborah B. Griffin</u> Printed Name
<u>Columbus</u> <u>GA</u> <u>31999</u> City State Zip Code	<u>Second Vice President</u> Title

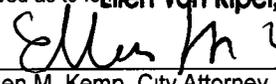
ACCEPTANCE OF OFFER AND CONTRACT AWARD (For City of Peoria Use Only)

Your offer is accepted by the City, subject to approval of each written exception that your proposal contained. The contract consists of the following documents: 1) Request for Proposal issued by the City, 2) Your offer in Response to the City's Request for Proposal, 3) This written acceptance and contract award.

As the contractor, you are now legally bound to sell the materials and/or services listed by the attached award notice, based on the solicitation of proposals, including all terms, conditions, specifications, amendments and your offer as now accepted by the City. The Contractor shall not commence any billable work or provide any material, service or construction under this contract until the Contractor receives an executed Purchase Order or written Notice to Proceed.

Attested by 
Mary Jo Kief, City Clerk

City of Peoria, Arizona Effective Date 9/26/09
Approved as to for Ellen Van Riper, Assistant City Attorney

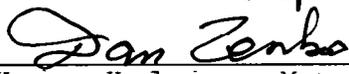

Stephen M Kemp, City Attorney



CC _____

Contract Number
ACON 48009

Official File _____

Contract Awarded Date September 25, 2009

Herman Koebergen, Materials Manager
for _____



SOLICITATION AMENDMENT (1)

Materials Management Procurement

8314 West Cinnabar Avenue
Peoria, Arizona 85345-6560
Telephone (623) 773-7115
Fax: (623) 773-7118

Solicitation No: P09-0074
Description: FSA Administration
Amendment No: One (1)
Solicitation Due Date: August 12, 2009
Solicitation Due Time: 5.00 p.m

Buyer: Jennifer Miller

A signed copy of this Amendment shall be received by the City of Peoria, Materials Management no later than the Solicitation Due Date and Time.

The solicitation due date has been extended from August 10, 2009 to August 12, 2009. The time remains the same at 5:00 p.m. Arizona time

Price Sheet is deleted and replaced with the revised Price Sheet. Please submit revised Price Sheet with your proposal

All other provisions of this Solicitation shall remain in their entirety.

Vendor hereby acknowledges receipt and agreement with the amendment

Deborah B. Griffin 8/6/09
Signature Date

Deborah B. Griffin, 2nd Vice President, Sales Administration
Typed Name and Title

Aflac
Company Name

1932 Wynnton Road
Address

Columbus, GA 31999
City State Zip

The above referenced Solicitation Amendment is hereby Executed

August 8, 2009

at Peoria, Arizona

Jennifer Miller
Jennifer Miller, Contract Administrator



REQUEST FOR PROPOSAL

INSTRUCTIONS TO OFFEROR

Materials Management Procurement

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1. **PREPARATION OF PROPOSAL:**
 - a All proposals shall be on the forms provided in this *Request for Proposal* package. It is permissible to copy these forms if required. Telegraphic (facsimile) or mailgram proposals will not be considered.
 - b The Offer and Contract Award document (COP Form 203) shall be submitted with an original ink signature by a person authorized to sign the offer.
 - c Erasures, interlineations, or other modifications in the proposal shall be initialed in original ink by the authorized person signing the Vendor Offer.
 - d If price is a consideration and in case of error in the extension of prices in the proposal, the unit price shall govern. No proposal shall be altered, amended, or withdrawn after the specified proposal due date and time.
 - e Periods of time, stated as a number of days, shall be calendar days.
 - f It is the responsibility of all Offerors to examine the entire *Request for Proposal* package and seek clarification of any item or requirement that may not be clear and to check all responses for accuracy before submitting a bid. Negligence in preparing a Proposal confers no right of withdrawal after proposal due date and time.
2. **INQUIRIES:** Any question related to the *Request for Proposal* shall be directed to the Buyer whose name appears on the front. The Offeror shall not contact or ask questions of the department for which the requirement is being procured. Questions should be submitted in writing when time permits. The Buyer may require any and all questions be submitted in writing at the Buyer's sole discretion. Any correspondence related to a *Request for Proposal* should refer to the appropriate *Request for Proposal* number, page, and paragraph number. However, the Offeror shall not place the *Request For Proposal* number on the outside of any envelope containing questions since such an envelope may be identified as a sealed proposal and may not be opened until after the official *Request For Proposal* due date and time.
3. **PROSPECTIVE OFFERORS CONFERENCE:** A prospective offerors conference may be held. If scheduled, the date and time of this conference will be indicated on the cover page of this document. The purpose of this conference will be to clarify the contents of this *Request for Proposal* in order to prevent any misunderstanding of the City's position. Any doubt as to the requirements of this *Request for Proposal* or any apparent omission or discrepancy should be presented to the City at this conference. The City will then determine if any action is necessary and may issue a written amendment to the *Request for Proposal*. Oral statements or instructions will not constitute an amendment to this *Request for Proposal*.
4. **LATE PROPOSALS:** Late Proposals will not be considered, except as provided by the **City of Peoria Procurement Code**. A vendor submitting a late proposal shall be so notified.
5. **WITHDRAWAL OF PROPOSAL:** At any time prior to the specified proposal due date and time, a Vendor (or designated representative) may withdraw the proposal. Telegraphic (facsimile) or mailgram proposal withdrawals will not be considered.
6. **AMENDMENT OF PROPOSAL:** Receipt of a Solicitation Amendment (COP Form 207) shall be acknowledged by signing and returning the document prior to the specified proposal due date and time.
7. **PAYMENT:** The City will make every effort to process payment for the purchase of goods or services within thirty (30) calendar days after receipt of goods or services and a correct notice of amount due, unless a good faith dispute exists as to any obligation to pay all or a portion of the account. Any proposal that requires payment in less than thirty (30) calendar days shall not be considered.
8. **NEW:** All items shall be new, unless otherwise stated in the specifications.
9. **DISCOUNTS:** Payment discount periods will be computed from the date of receipt of material/service or correct invoice, whichever is later, to the date Buyer's payment is mailed. Unless freight and other charges are itemized, any discount provided will be taken on full amount of invoice. Payment discounts of thirty (30) calendar days or more will be deducted from the proposal price in determining the low bid. However, the Buyer shall be entitled to take advantage of any payment discount offered by the Vendor provided payment is made within the discount period.
10. **TAXES:** The City of Peoria is exempt from Federal Excise Tax, including the Federal Transportation Tax. Sales tax, if any, shall be indicated as a separate item.
11. **VENDOR REGISTRATION:** After the award of a contract, the successful Vendor shall have a completed Vendor Registration Form (COP Form 200) on file with the City of Peoria Materials Management Division.
12. **AWARD OF CONTRACT:**
 - a Unless the Offeror states otherwise, or unless provided within this *Request For Proposal*, the City reserves the right to award by individual line item, by group of line items, or as a total, whichever is deemed most advantageous to the City.
 - b Notwithstanding any other provision of this *Request for Proposal*, The City expressly reserves the right to
 - (1) Waive any immaterial defect or informality or
 - (2) Reject any or all proposals, or portions thereof, or
 - (3) Reissue a *Request For Proposal*
 - c A response to a *Request for Proposal* is an offer to contract with the City based upon the terms, conditions and specifications contained in the City's *Request for Proposal* and the written amendments thereto, if any. Proposals do not become contracts unless and until they are accepted by the **City Council**. A contract is formed when written notice of award(s) is provided to the successful Offeror(s). The contract has its inception in the award document, eliminating a formal signing of a separate contract. For that reason, all of the terms and conditions of the procurement contract are contained in the *Request for Proposal*, unless modified by a Solicitation Amendment (COP Form 207) or a Contract Amendment (COP Form 217).



STANDARD TERMS AND CONDITIONS

Materials Management Procurement

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THE FOLLOWING TERMS AND CONDITIONS ARE AN EXPLICIT PART OF THE SOLICITATION AND ANY RESULTANT CONTRACT.

1. **CERTIFICATION:** By signature in the Offer section of the Offer and Contract Award page (COP Form 203), the Vendor certifies:
 - a. The submission of the offer did not involve collusion or other anti-competitive practices
 - b. The Vendor shall not discriminate against any employee or applicant for employment in violation of Federal Executive Order 11456
 - c. The Vendor has not given, offered to give, nor intends to give at any time hereafter any economic opportunity, future employment, gift, loan, gratuity, special discount, trip favor, or service to a public servant in connection with the submitted offer. Failure to sign the offer, or signing it with a false statement, shall void the submitted offer or any resulting contracts, and the vendor may be debarred.
2. **GRATUITIES:** The City may, by written notice to the Contractor, cancel this contract if it is found by the City that gratuities, in the form of entertainment, gifts or otherwise, were offered or given by the Contractor or any agent or representative of the Contractor, to any officer or employee of the City with a view toward securing an order, securing favorable treatment with respect to the awarding, amending, or the making of any determinations with respect to the performing of such order. In the event this contract is cancelled by the City pursuant to this provision, the City shall be entitled, in addition to any other rights and remedies, to recover or withhold from the Contractor the amount of the gratuity. Paying the expense of normal business meals which are generally made available to all eligible city government customers shall not be prohibited by this paragraph.
3. **APPLICABLE LAW:** In the performance of this agreement, contractors shall abide by and conform to any and all laws of the United States, State of Arizona and City of Peoria including but not limited to federal and state executive orders providing for equal employment and procurement opportunities, the Federal Occupational Safety and Health Act and any other federal or state laws applicable to this agreement.

Contractor specifically understands and acknowledges the applicability to it of the Americans with Disabilities Act, the Immigration Reform and Control Act of 1986, and the Drug Free Workplace Act of 1989. In addition, if this agreement pertains to construction, Contractor must also comply with A.R.S. § 34-301, as amended (Employment of Aliens on Public Works Prohibited) and A.R.S. § 34-302, as amended (Residence Requirements for Employees)

Under the provisions of A.R.S. § 41-4401, Contractor hereby warrants to the City that Contractor and each of its subcontractors ("Subcontractors") will comply with, and are contractually obligated to comply with, all Federal immigration laws and regulations that relate to their employees and A.R.S. § 23-214(A) (hereinafter, "Contractor Immigration Warranty")

A breach of the Contractor Immigration Warranty shall constitute a material breach of this agreement and shall subject Contractor to penalties up to and including termination of this agreement at the sole discretion of the City. The City may, at its sole discretion, conduct random verification of the employment records of Contractor and any Subcontractors to ensure compliance with the Contractor Immigration Warranty Contractor agrees to assist the City in regard to any random verification performed.

Neither Contractor nor any Subcontractor shall be deemed to have materially breached the Contractor Immigration Warranty if Contractor or the Subcontractor establishes that it has complied with the employment verification provisions prescribed by §§ 274A and 274B of the Federal Immigration and Nationality Act and the E-Verify requirements prescribed by A R S §23-214(A)

The provisions of this Paragraph must be included in any contract Contractor enters into with any Subcontractors who



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provide services under this agreement or any subcontract. "Services" is defined as furnishing labor, time or effort in the State of Arizona by a contractor or subcontractor. Services include construction or maintenance of any structure, building or transportation facility or improvement to real property.

Contractor warrants, for the term of this agreement and for six months thereafter, that it has fully complied with the requirements of the Immigration Reform and Control Act of 1986 and all related or similar legal authorities.

This contract shall be governed by the City and Contractor shall have all remedies afforded each by the Uniform Commercial Code, as adopted in the State of Arizona, except as otherwise provided in this contract or in statutes pertaining specifically to the City. This contract shall be governed by the laws of the State of Arizona and suit pertaining to this contract may be brought only in courts in the State of Arizona

This contract is subject to the provisions of ARS §38-511; the City may cancel this contract without penalty or further obligations by the City or any of its departments or agencies if any person significantly involved in initiating, negotiating, securing, drafting or creating the contract on behalf of the City or any of its departments or agencies, is at any time while the contract or any extension of the contract is in effect, an employee of any other party to the contract in any capacity or a consultant to any other party of the contract with respect to the subject matter of the contract.

4. **LEGAL REMEDIES:** All claims and controversies shall be subject to resolution according to the terms of the City of Peoria Procurement Code
5. **CONTRACT:** The contract between the City and the Contractor shall consist of (1) the Solicitation, including instructions, all terms and conditions, specifications, scopes of work, attachments, and any amendments thereto, and (2) the offer submitted by the Vendor in response to the solicitation. In the event of a conflict in language between the Solicitation and the Offer, the provisions and requirements in the Solicitation shall govern. However, the City reserves the right to clarify, in writing, any contractual terms with the concurrence of the Contractor, and such written contract shall govern in case of conflict with the applicable requirements stated in the Solicitation or the Vendor's offer. The Solicitation shall govern in all other matters not affected by the written contract.
6. **CONTRACT AMENDMENTS:** This contract may be modified only by a written Contract Amendment (COP Form 217) signed by persons duly authorized to enter into contracts on behalf of the City and the Contractor.
7. **CONTRACT APPLICABILITY:** The Offeror shall substantially conform to the terms, conditions, specifications and other requirements found within the text of this specific Solicitation. All previous agreements, contracts, or other documents, which have been executed between the Offeror and the City, are not applicable to this Solicitation or any resultant contract.
8. **PROVISIONS REQUIRED BY LAW:** Each and every provision of law and any clause required by law to be in the contract will be read and enforced as though it were included herein, and if through mistake or otherwise any such provision is not inserted, or is not correctly inserted, then upon the application of either party, the contract will forthwith be physically amended to make such insertion or correction.
9. **SEVERABILITY:** The provisions of this contract are severable to the extent that any provision or application held to be invalid shall not affect any other provision or application of the contract which may remain in effect without the invalid provision or application.
10. **RELATIONSHIP TO PARTIES:** It is clearly understood that each party will act in its individual capacity and not as an agent, employee, partner, joint venture, or associate of the other. An employee or agent of one party shall not be deemed or construed to be the employee or agent of the other for any purpose whatsoever. The Contractor is advised that taxes or Social Security payments will not be withheld from any City payments issued hereunder and that the Contractor should make arrangements to directly pay such expenses, if any.



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11. **INTERPRETATION-PAROL EVIDENCE:** This contract represents the entire agreement of the Parties with respect to its subject matter, and all previous agreements, whether oral or written, entered into prior to this contract are hereby revoked and superseded by this contract. No representations, warranties, inducements or oral agreements have been made by any of the Parties except as expressly set forth herein, or in any other contemporaneous written agreement executed for the purposes of carrying out the provisions of this contract. This contract may not be changed, modified or rescinded except as provided for herein, absent a written agreement signed by both Parties. Any attempt at oral modification of this contract shall be void and of no effect.
12. **ASSIGNMENT-DELEGATION:** No right or interest in this contract shall be assigned by Contractor without prior written permission of the City and no delegation of any duty of Contractor shall be made without prior written permission of the City.
13. **SUBCONTRACTS:** No subcontract shall be entered into by the contractor with any other party to furnish any of the material, service or construction specified herein without the advance written approval of the City. The prime contractor shall itemize all sub-contractors which shall be utilized on the project. Any substitution of sub-contractors by the prime contractor shall be approved by the City and any cost savings will be reduced from the prime contractor's bid amount. All subcontracts shall comply with Federal and State laws and regulations which are applicable to the services covered by the subcontract and shall include all the terms and conditions set forth herein which shall apply with equal force to the subcontract and if the Subcontractor were the Contractor referred to herein. The Contractor is responsible for contract performance whether or not Subcontractors are used.
14. **RIGHTS AND REMEDIES:** No provision in this document or in the vendor's offer shall be construed, expressly or by implication, as waiver by the City of any existing or future right and/or remedy available by law in the event of any claim of default or breach of contract. The failure of the City to insist upon the strict performance of any term or condition of the contract or to exercise or delay the exercise of any right or remedy provided in the contract, or by law, or the City's acceptance of and payment for materials or services, shall not release the Contractor from any responsibilities or obligations imposed by this contract or by law, and shall not be deemed a waiver of any right of the City to insist upon the strict performance of the Contract.
15. **INDEMNIFICATION:** To the fullest extent permitted by law, the Contractor shall defend, indemnify and hold harmless the City, its agents, representatives, officers, directors, officials and employees from and against all claims, damages, losses and expenses (including but not limited to attorney fees, court costs, and the cost of appellate proceedings), relating to, arising out of, or alleged to have resulted from the acts, errors, mistakes, omissions, work or services of the Contractor, its employees, agents, or any tier of subcontractors in the performance of this Contract. Contractor's duty to defend, hold harmless and indemnify the City, its agents, representatives, officers, directors, officials and employees shall arise in connection with any claim, damage, loss or expense that is attributable to bodily injury, sickness, disease, death, or injury to, impairment, or destruction of property including loss of use resulting there from, caused by any acts, errors, mistakes, omissions, work or services in the performance of this Contract including any employee of the Contractor or any tier of subcontractor or any other person for whose acts, errors, mistakes, omissions, work or services the Contractor may be legally liable.
- The amount and type of insurance coverage requirements set forth herein will in no way be construed as limiting the scope of the indemnity in this paragraph.
16. **OVERCHARGES BY ANTITRUST VIOLATIONS:** The City maintains that, in practice, overcharges resulting from antitrust violations are borne by the purchaser. Therefore, to the extent permitted by law, the Contractor hereby assigns to the City any and all claims for such overcharges as to the goods and services used to fulfill the Contract.
17. **FORCE MAJEURE:** Except for payment for sums due, neither party shall be liable to the other nor deemed in default under this Contract if and to the extent that such party's performance of this Contract is prevented by reason of force



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Majeure. The term "*force majeure*" means an occurrence that is beyond the control of the party affected and occurs without its fault or negligence. Without limiting the foregoing, force majeure includes acts of God, acts of the public enemy; war; acts of terror, hate crimes affecting public order; riots; strikes; mobilization; labor disputes; civil disorders; fire; floods; lockouts, injunctions-intervention-acts, or failures or refusals to act by government authority; events or obstacles resulting from a governmental authority's response to the foregoing; and other similar occurrences beyond the control of the party declaring force majeure which such party is unable to prevent by exercising reasonable diligence. The force majeure shall be deemed to commence when the party declaring force majeure notifies the other party of the existence of the force majeure and shall be deemed to continue as long as the results or effects of the force majeure prevent the party from resuming performance in accordance with this Contract.

Force majeure shall not include the following occurrences:

- a. Late delivery of equipment or materials caused by congestion at a manufacturer's plant or elsewhere, an oversold condition of the market, inefficiencies, or similar occurrences.
- b. Late performance by a subcontractor unless the delay arises out of a force majeure occurrence in accordance with this Force Majeure term and Condition.

Any delay or failure in performance by either party hereto shall not constitute default hereunder or give rise to any claim for damages or loss of anticipated profits if, and to the extent that such delay or failure is caused by force majeure. If either party is delayed at any time in the progress of the work by force majeure, then the delayed party shall notify the other party in writing of such delay within forty-eight (48) hours commencement thereof and shall specify the causes of such delay in such notice. Such notice shall be hand delivered or mailed *Certified-Return Receipt* and shall make a specific reference to this article, thereby invoking its provisions. The delayed party shall cause such delay to cease as soon as practicable and shall notify the other party in writing. The time of completion shall be extended by contract modification for a period of time equal to the time that the results or effects of such delay prevent the delayed party from performing in accordance with this contract.

18. **RIGHT TO ASSURANCE:** Whenever one party to this contract in good faith has reason to question the other party's intent to perform he may demand that the other party give a written assurance of this intent to perform. In the event that a demand is made and no written assurance is given within five (5) days, the demanding party may treat this failure as an anticipatory repudiation of the Contract.
19. **RIGHT TO AUDIT RECORDS:** The City may, at reasonable times and places, audit the books and records of any Contractor as related to any contract held with the City. This right to audit also empowers the City to inspect the papers of any Contractor or Subcontractor employee who works on this contract to ensure that the Contractor or Subcontractor is complying with the Contractor Immigration Warranty made pursuant to Paragraph 3 above.
20. **RIGHT TO INSPECT PLANT:** The City may, at reasonable times, inspect the part of the plant or place of business of a Contractor or Subcontractor which is related to the performance of any contract as awarded or to be awarded.
21. **WARRANTIES:** Contractor warrants that all material, service or construction delivered under this contract shall conform to the specifications of this contract. Unless otherwise stated in Contractor's response, the City is responsible for selecting items, their use, and the results obtained from any other items used with the items furnished under this contract. Mere receipt of shipment of the material/service specified and any inspection incidental thereto by the City shall not alter or affect the obligations of the Contractor or the rights of the City under the foregoing warranties. Additional warranty requirements may be set forth in the solicitation.
22. **INSPECTION:** All material and/or services are subject to final inspection and acceptance by the City. Materials and/or services failing to conform to the specifications of this Contract will be held at Contractor's risk and may be returned to the Contractor. If so returned, all costs are the responsibility of the Contractor. The City may elect to do any or all:



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- a. Waive the non-conformance.
- b. Stop the work immediately.
- c. Bring material into compliance

This shall be accomplished by a written determination for the City.

23. **TITLE AND RISK OF LOSS:** The title and risk of loss of material and/or service shall not pass to the City until the City actually receives the material or service at the point of delivery, unless otherwise provided within this Contract.
24. **NO REPLACEMENT OF DEFECTIVE TENDER:** Every tender of materials shall fully comply with all provisions of the Contract. If a tender is made which does not fully conform, this shall constitute a breach of the Contract as a whole.
25. **DEFAULT IN ONE INSTALLMENT TO CONSTITUTE TOTAL BREACH:** Contractor shall deliver conforming materials in each installment of lot of this Contract and may not substitute nonconforming materials. Delivery of nonconforming materials or a default of any nature, at the option of the City, shall constitute a breach of the Contract as a whole.
26. **SHIPMENT UNDER RESERVATION PROHIBITED:** Contractor is not authorized to ship materials under reservation and no tender of a bill of lading will operate as a tender of the materials
27. **LIENS:** All materials, service or construction shall be free of all liens, and if the City requests, a formal release of all liens shall be delivered to the City
28. **LICENSES:** Contractor shall maintain in current status all Federal, State and Local licenses and permits required for the operation of the business conducted by the Contractor as applicable to this Contract.
29. **PATENTS AND COPYRIGHTS:** All services, information, computer program elements, reports and other deliverables, which may be patented or copyrighted and created under this contract are the property of the City and shall not be used or released by the Contractor or any other person except with the prior written permission of the City.
30. **PREPARATION OF SPECIFICATIONS BY PERSONS OTHER THAN CITY PERSONNEL:** All specifications shall seek to promote overall economy for the purposes intended and encourage competition and not be unduly restrictive in satisfying the City's needs. No person preparing specifications shall receive any direct or indirect benefit from the utilization of specifications, other than fees paid for the preparation of specifications.
31. **COST OF BID/PROPOSAL PREPARATION:** The City shall not reimburse the cost of developing presenting or providing any response to this solicitation. Offers submitted for consideration should be prepared simply and economically, providing adequate information in a straightforward and concise manner.
32. **PUBLIC RECORD:** All offers submitted in response to this solicitation shall become the property of the City and shall become a matter of public record available for review, subsequent to the award notification, in accordance with the City's Procurement Code. However, subsequent to the award of the contract, any information and documents obtained by the City during the course of an audit conducted in accordance with Paragraph 19 above for the purpose of determining compliance by Contractor or a Subcontractor with the Contractor Immigration Warranty mandated by Paragraph 3 above shall remain confidential and shall not be made available for public review or produced in response to a public records request, unless the City is ordered or otherwise directed to do so by a court of competent jurisdiction.



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33. **ADVERTISING:** Contractor shall not advertise or publish information concerning this Contract, without prior written consent of the City.
34. **DELIVERY ORDERS:** The City shall issue a Purchase Order for the material and/or services covered by this contract. All such documents shall reference the contract number as indicated on the Offer and Contract Award (COP Form 203).
35. **FUNDING:** Any contract entered into by the City of Peoria is subject to funding availability. Fiscal years for the City of Peoria are July 1 to June 30. The City Council approves all budget requests. If a specific funding request is not approved, the contract shall be terminated
36. **PAYMENT:** A separate invoice shall be issued for each shipment of material or service performed, and no payment will be issued prior to receipt of material and/or services and correct invoice.



SPECIAL TERMS AND CONDITIONS

Solicitation Number: **P09-0074**

Materials Management Procurement

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1. **Purpose:** Pursuant to provisions of the City Procurement Code, the City of Peoria, Materials Management Division intends to establish a contract for **Flexible Spending Account (FSA) Administration**.
2. **Authority:** This Solicitation as well as any resultant contract is issued under the authority of the City. No alteration of any resultant contract may be made without the express written approval of the City Materials Manager in the form of an official contract amendment. Any attempt to alter any contract without such approval is a violation of the contract and the City Procurement Code. Any such action is subject to the legal and contractual remedies available to the City inclusive of, but not limited to, contract cancellation, suspension and/or debarment of the contractor.
3. **Offer Acceptance Period:** In order to allow for an adequate evaluation, the City requires an offer in response to this Solicitation to be valid and irrevocable for ninety (90) days after the opening time and date.
4. **Cooperative Purchasing:** Any contract resulting from this solicitation shall be for the use of the City of Peoria. In addition, specific eligible political subdivisions and nonprofit educational or public health institutions may also participate at their discretion. In order to participate in any resultant contract, a political subdivision or nonprofit educational or public health institution must have been invited to participate in this specific solicitation and the contractor must be in agreement with the cooperative transaction. In addition to cooperative purchasing, any eligible agency may elect to participate (piggyback) on any resultant contract; the specific eligible political subdivision, nonprofit educational or public health institution and the contractor must be in agreement.
Any orders placed to the successful contractor will be placed by the specific agencies participating in this purchase. Payment for purchases made under this agreement will be the sole responsibility of each participating agency. The City shall not be responsible for any disputes arising out of transactions made by others.
5. **Contract Type:** Fixed Price Term
6. **Term of Contract:** The term of any resultant contract shall commence on the date of award and shall continue for a period of one (1) year thereafter, unless terminated, cancelled or extended as otherwise provided herein.
7. **Contract Extension:** By mutual written contract amendment, any resultant contract may be extended for supplemental periods of up to a maximum of forty-eight (48) months
8. **Affirmative Action Report:** It is the policy of the City of Peoria that suppliers of goods or services to the City adhere to a policy of equal employment opportunity and demonstrate an affirmative effort to recruit, hire, and promote regardless of race, color, religion, gender, national origin, age or disability. The City of Peoria encourages diverse suppliers to respond to solicitations for products or services.
9. **Proposal Format:** Proposals shall be submitted in one (1) original and five (5) copies on the forms and in the format as contained in the Request for Proposal. Proposals shall be on 8 1/2" & 11" paper with the text on one side only. All submittal information must contain data for only the local office(s) which will be performing the work.
10. **Interview Guidelines:** During any requested interview, which would be scheduled in the future, be prepared to discuss your firm's proposal, staff assignments, project approach and other pertinent information
11. **Evaluation:** In accordance with the City of Peoria Procurement Code, awards shall be made to the responsible offeror whose proposal is determined in writing to be the most advantageous to the City, based upon the evaluation criteria listed below. The evaluation factors are listed in their relative order of importance
 - a. Response to Questionnaire.
 - b. Experience & Qualifications
 - c. Overall Cost.
 - d. Conformance to Request for Proposal



SPECIAL TERMS AND CONDITIONS

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12. **Discussions:** In accordance with the City of Peoria Procurement Code, after the initial receipt of proposals, discussions may be conducted with offerors who submit proposals determined to be reasonably susceptible of being selected for award
13. **Proposal Opening:** Proposals shall be submitted at the time and place designated in the request for proposals. All information contained in the proposals shall be deemed as exempt from public disclosure based on the City's need to avoid disclosure of contents prejudicial to competing offerors during the process of negotiation. The proposals shall not be open for public inspection until after contract award. After contract award, the successful proposal and the evaluation documentation shall be open for public inspection
14. **Permits and Approvals:** Contractor agrees and undertakes to obtain necessary permits and approvals from all local, state and federal authorities for the project.
15. **Investigation of Conditions:** The Contractor warrants and agrees familiarity of the work that is required, is satisfied as to the conditions under which is performed and enters into this contract based upon the Contractor's own investigation.
16. **Compensation:** Compensation for services shall be based upon fees negotiated, including all approved costs and expenses incurred in connection with the project; including but not limited to, telephone and other communications, reproduction of documents, special consultants (as approved by the City) and computer costs
17. **Acceptance:** Determination of the acceptability of work shall be completed in a responsive and professional manner and in accordance with the specifications, schedules, or plans which are incorporated in the Scope of Work.
18. **Insurance Requirements:** The Contractor, at Contractor's own expense, shall purchase and maintain the herein stipulated minimum insurance with companies duly licensed, possessing a current A.M. Best, Inc Rating of A-, or approved unlicensed in the State of Arizona with policies and forms satisfactory to the City.

All insurance required herein shall be maintained in full force and effect until all work or service required to be performed under the terms of the Contract is satisfactorily completed and formally accepted; failure to do so may, at the sole discretion of the City, constitute a material breach of this Contract

The Contractor's insurance shall be primary insurance as respects the City, and any insurance or self-insurance maintained by the City shall not contribute to it.

Any failure to comply with the claim reporting provisions of the insurance policies or any breach of an insurance policy warranty shall not affect coverage afforded under the insurance policies to protect the City.

The insurance policies, except Workers' Compensation, shall contain a waiver of transfer rights of recovery (subrogation) against the City, its agents, representatives, directors, officers, and employees for any claims arising out of the Contractor's acts, errors, mistakes, omissions, work or service.

The insurance policies may provide coverage which contains deductibles or self-insured retentions. Such deductible and/or self-insured retentions shall not be applicable with respect to the coverage provided to the City under such policies. The Contractor shall be solely responsible for the deductible and/or self-insured retention and the City, at its option, may require the Contractor to secure payment of such deductibles or self-insured retentions by a Surety Bond or an irrevocable and unconditional letter of credit.

The City reserves the right to request and to receive, within 10 working days, certified copies of any or all of the herein required insurance policies and/or endorsements. The City shall not be obligated, however, to review same or to advise Contractor of any deficiencies in such policies and endorsements, and such receipt shall not relieve Contractor from, or be deemed a waiver of the City's right to insist on, strict fulfillment of Contractor's obligations under this Contract



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The insurance policies, except Workers' Compensation and Professional Liability, required by this Contract, shall name the City, its agents, representatives, officers, directors, officials and employees as Additional Insured's.

19. Required Insurance Coverage:

a. Commercial General Liability

Contractor shall maintain Commercial General Liability insurance with a limit of not less than \$1,000,000 for each occurrence with a \$2,000,000 Products/Completed Operations Aggregate and a \$2,000,000 General Aggregate Limit. The policy shall include coverage for bodily injury, broad form property damage, personal injury, products and completed operations and blanket contractual coverage including, but not limited to, the liability assumed under the indemnification provisions of this Contract which coverage will be at least as broad as Insurance Service Office, Inc. Policy Form CG 00011093 or any replacements thereof. The coverage shall not exclude X, C, U.

Such policy shall contain a severability of interest provision, and shall not contain a sunset provision or commutation clause, or any provision which would serve to limit third party action over claims.

The Commercial General Liability additional insured endorsement shall be at least as broad as the Insurance Service Office, Inc.'s Additional Insured, Form B, CG 20101185, and shall include coverage for Contractor's operations and products and completed operations.

Any Contractor subletting any part of the work, services or operations awarded to the Contractor shall purchase and maintain, at all times during prosecution of the work, services or operations under this Contract, an Owner's and Contractor's Protective Liability insurance policy for bodily injury and property damage, including death, which may arise in the prosecution of the Contractor's work, service or operations under this Contract. Coverage shall be on an occurrence basis with a limit not less than \$1,000,000 per occurrence, and the policy shall be issued by the same insurance company that issues the Contractor's Commercial General Liability insurance.

b. Automobile Liability

Contractor shall maintain Commercial/Business Automobile Liability insurance with a combined single limit for bodily injury and property damage of not less than \$1,000,000 each occurrence with respect to the Contractor's any owned, hired, and non-owned vehicles assigned to or used in performance of the Contractor's work. Coverage will be at least as broad as coverage code 1, "any auto", (Insurance Service Office, Inc. Policy Form CA 00011293, or any replacements thereof). Such insurance shall include coverage for loading and off loading hazards. If hazardous substances, materials or wastes are to be transported, MCS 90 endorsement shall be included and \$5,000,000 per accident limits for bodily injury and property damage shall apply.

c. Workers' Compensation

The Contractor shall carry Workers' Compensation insurance to cover obligations imposed by federal and state statutes having jurisdiction of Contractor's employees engaged in the performance of the work or services; and, Employer's Liability insurance of not less than \$100,000 for each accident, \$100,000 disease for each employee, and \$500,000 disease policy limit.

In case any work is subcontracted, the Contractor will require the Subcontractor to provide Workers' Compensation and Employer's Liability to at least the same extent as required of the Contractor.

d. Professional Liability



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The Contractor retained by the City to provide the work or service required by this Contract will maintain Professional Liability insurance covering acts, errors, mistakes and omissions arising out of the work or services performed by the Contractor, or any person employed by the Contractor, with a limit of not less than \$1,000,000 each claim.

20. **Certificates of Insurance:** Prior to commencing work or services under this Contract, Contractor shall furnish the City with Certificates of Insurance, or formal endorsements as required by the Contract, issued by Contractor's insurer(s), as evidence that policies providing the required coverage's, conditions and limits required by this Contract are in full force and effect.

In the event any insurance policy(ies) required by this contract is(are) written on a "Claims made" basis, coverage shall extend for two years past completion and acceptance of the Contractor's work or services and as evidenced by annual Certificates of Insurance.

If a policy does expire during the life of the Contract, a renewal certificate must be sent to the City fifteen (15) days prior to the expiration date.

All Certificates of Insurance shall be identified with bid serial number and title. A \$25.00 administrative fee will be assessed for all certificates received without the appropriate bid serial number and title.

21. **Cancellation and Expiration Notice:** Insurance required herein shall not expire, be canceled, or materially changed without thirty (30) days prior written notice to the City

22. **Independent Contractor:**

a. General

- i. The Contractor acknowledges that all services provided under this Agreement are being provided by him as an independent contractor, not as an employee or agent of the City Manager or the City of Peoria.
- ii. Both parties agree that this Agreement is nonexclusive and that Contractor is not prohibited from entering into other contracts nor prohibited from practicing his profession elsewhere.

b. Liability

- i. The City of Peoria shall not be liable for any acts of Contractor outside the scope of authority granted under this Agreement or as the result of Contractor's acts, errors, misconduct, negligence, omissions and intentional acts.
- ii. To the fullest extent permitted by law, the Contractor shall defend, indemnify and hold harmless the City, its agents, representatives, officers, directors, officials and employees from and against all claims, damages, losses and expenses (including but not limited to attorney fees, court costs, and the cost of appellate proceedings), relating to, arising out of, or alleged to have resulted from the acts, errors, mistakes, omissions, work or services of the Contractor, its employees, agents, or any tier of subcontractors in the performance of this Contract Contractor's duty to defend, hold harmless and indemnify the City, its agents, representatives, officers, directors, officials and employees shall arise in connection with any claim, damage, loss or expense that is attributable to bodily injury, sickness, disease, death, or injury to, impairment, or destruction of property including loss of use resulting there from, caused by any acts, errors, mistakes, omissions, work or services in the performance of this Contract including any employee of the Contractor or any tier of subcontractor or any other person for whose acts, errors, mistakes, omissions, work or services the Contractor may be legally liable.

The amount and type of insurance coverage requirements set forth herein will in no way be construed as limiting the scope of the indemnity in this paragraph



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c. Other Benefits

The Contractor is an independent contractor; therefore, the City Manager will not provide the Contractor with health insurance, life insurance, workmen's compensation, sick leave, vacation leave, or any other fringe benefits. Further, Contractor acknowledges that he is exempt from coverage of the Comprehensive Benefit and Retirement Act (COBRA). Any such fringe benefits shall be the sole responsibility of Contractor.

23. **Key Personnel:** It is essential that the Contractor provide adequate experienced personnel, capable of and devoted to the successful accomplishment of work to be performed under this contract. The Contractor must agree to assign specific individuals to the key positions.

- a. The Contractor agrees that, once assigned to work under this contract, key personnel shall not be removed or replaced without written notice to the City.
- b. If key personnel are not available for work under this contract for a continuous period exceeding 30 calendar days, or are expected to devote substantially less effort to the work than initially anticipated, the Contractor shall immediately notify the City, and shall, subject to the concurrence of the City, replace such personnel with personnel of substantially equal ability and qualifications.

24. **Confidential Information:**

- a. If a person believes that a bid, proposal, offer, specification, or protest contains information that should be withheld, a statement advising the Materials Supervisor of this fact shall accompany the submission and the information shall be identified.
- b. The information identified by the person as confidential shall not be disclosed until the Materials Supervisor makes a written determination
- c. The Materials Supervisor shall review the statement and information and shall determine in writing whether the information shall be withheld.
- d. If the Materials Supervisor determines to disclose the information, the Materials Supervisor shall inform the bidder in writing of such determination

25. **Confidentiality of Records:** The contractor shall establish and maintain procedures and controls that are acceptable to the City for the purpose of assuring that information contained in its records or obtained from the City or from others in carrying out its functions under the contract shall not be used or disclosed by it, its agents, officers, or employees, except as required to efficiently perform duties under the contract. Persons requesting such information should be referred to the City. Contractor also agrees that any information pertaining to individual persons shall not be divulged other than to employees or officers of contractor as needed for the performance of duties under the contract.

26. **Ordering Process:** Upon award of a contract by the City of Peoria, Materials Management Division may procure the specific material and/or service awarded by the issuance of a purchase order to the appropriate contractor. The award of a contract shall be in accordance with the City of Peoria Procurement Code and all transactions and procedures required by the Code for public bidding have been complied with. A purchase order for the awarded material and/or service that cites the correct contract number is the only document required for the department to order and the contractor to delivery the material and/or service.



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Any attempt to represent any material and/or service not specifically awarded as being under contract with the City of Peoria is a violation of the contract and the City of Peoria Procurement Code. Any such action is subject to the legal and contractual remedies available to the City inclusive of, but not limited to, contract cancellation, suspension and/or debarment of the contractor.

27. **Licenses:** Contractor shall maintain in current status all Federal, State and Local licenses and permits required for the operation of the business conducted by the Contractor.
28. **Cancellation:** The City reserves the right to cancel the whole or any part of this contract due to failure by the contractor to carry out any obligation, term or condition of the contract. The City will issue written notice to the contractor for acting or failing to act as in any of the following:
- The contractor provides material that does not meet the specifications of the contract;
 - The contractor fails to adequately perform the services set forth in the specifications of the contract;
 - The contractor fails to complete the work required or to furnish the materials required within the time stipulated in the contract;
 - The contractor fails to make progress in the performance of the contract and/or gives the City reason to believe that the contractor will not or cannot perform to the requirements of the contract.

Upon receipt of the written notice of concern, the contractor shall have ten (10) days to provide a satisfactory response to the City. Failure on the part of the contractor to adequately address all issues of concern may result in the City resorting to any single or combination of the following remedies:

- Cancel any contract;
 - Reserve all rights or claims to damage for breach of any covenants of the contract;
 - Perform any test or analysis on materials for compliance with the specifications of the contract. If the results of any test or analysis find a material non-compliant with the specifications, the actual expense of testing shall be borne by the contractor;
 - In case of default, the City reserves the right to purchase materials, or to complete the required work in accordance with the City Procurement Code. The City may recover any actual excess costs from the contractor by:
 - Deduction from an unpaid balance;
 - Any combination of the above or any other remedies as provided by law
29. **Project Travel Reimbursable Expenses:** If travel expenses are allowed as part of the contract the reimbursable expenses will be as follows. All expenses will be billed to the City at cost without markup. Copies of bills for expenses are to be submitted with the invoice. Travel time to and from job site is excluded from this contract. There will be no allowances for parking or personal car mileage. No incidentals for travel of any kind are allowed under this contract.

The following is a list of allowable travel expenses under this contract agreement:

- Transportation:
 - Air Transportation – coach class fares, minimum 14 days advanced purchase, unless otherwise agreed upon.
 - Car Rental – mid size car, gas for rental car (City assumes no liability regarding additional insurance costs).



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b. Lodging and Meals:

- i. Meals – three meals per day, at the current federal per diem rate for Maricopa County.
- ii. Lodging – not to exceed the current federal rate for Maricopa County. Vendors are encouraged to stay in hotels located within the City of Peoria when practical. A listing of accommodations within Peoria can be found on the following website: <http://visitpeoriaaz.com/accommodations.php>



SCOPE OF WORK

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The City is seeking proposals to administer a FSA for its employees. The plan quoted should have a \$5,000 maximum on the Medical Care Reimbursement Account and \$5,000 for the Dependent Care Reimbursement Account. The minimum reimbursement should be \$50, unless close of account.

Please submit your proposal to administer a FSA for the employer based on the following services to be provided:

- Initial set-up of employee accounts.
- Processing of dependent care requests for reimbursement once per week.
- Ongoing record-keeping of accounts.
- Issuance of reimbursement drafts and pertinent documentation.
- Employee notification of account balances on a quarterly basis.
- Monthly accounting and statistical reports for the employer.
- Update participation and account deposits from a hard copy on a weekly basis.
- Discrimination testing.
- Preparation of W-2's for the Dependent Care Account participants.

If your proposal does not include **all** of these services, or includes additional services, please describe in detail. As part of your proposal, you must provide samples of the following material:

- Communication material
- Management reports
- Reimbursement drafts
- Debit Card Sample

Your proposal should outline how contributions, accounting and reimbursements are handled by your system. If a debit card is available, please note the cost separately.



SUBMITTAL REQUIREMENTS

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The Submittal Requirements are as follows:

1. Proposal Format

Proposals shall be submitted in one (1) original and five (5) copies on the forms and in the format as contained in the Request for Proposal. The Questionnaire and Price Sheets are available in Word format. Please send your request to Lisa Houg at Lisa.Houg@peoriaaz.gov.

2. Proposal Content

The following items shall be addressed in the proposal submission:

a. Complete Questionnaire.

b. Experience and Qualifications.

- Indicate how long your company has been in business and how long you have been acting as a FSA Administrator in the State of Arizona.
- Provide resume and service location for each assigned individual who would be directly involved with the account. Include background information, education and related experience.
- Provide company name, contact name, location, phone number, number of employees and contract state date for three (3) current client references.
- Provide company name, contact name, phone number, termination reason and termination date for three (3) recently terminated clients.

c. Complete Price Sheet.

d. Additional Data Support, provide the following:

- Samples of reports that will be available to the City on a monthly, quarterly and annual basis.

3. Proposal Submittal Information and Critical Dates

The proposal shall be due no later than **5:00 p.m. on August 10, 2009.**

Proposals will be delivered to:

City of Peoria, Materials Management
8314 W. Cinnabar, Peoria, AZ 85345

Interviews with selected top ranked firms will be held **August 20, 2009.**

All questions regarding the proposal should be directed to Lisa Houg at Lisa.Houg@peoriaaz.gov



QUESTIONNAIRE

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GENERAL INFORMATION AND HIPAA (ALL OFFERORS)

VENDOR RESPONSE

GENERAL INFORMATION QUESTIONS

1. Are the rates or fees quoted in your proposal firm and will not be recalculated based on actual enrollment?	
2. a. Are your quoted rates guaranteed for a minimum of 12 months?	
b. If so, are you willing to guarantee rates for more than 12 months?	
3. The City's contract is valid for a 5 year term, renewable each calendar year. Can you provide the renewal rates for each calendar year period from 2010 through 2014?	
4. Do you agree to give the City at least 150 days advance written notice of any change in fees/premium?	
5. Your proposal is to be submitted net of commissions. Is your quotation consistent with this request?	
6. Identify those individuals who would be responsible for the day to day service contact with the City.	
7. If your company is awarded this business, how soon after notification of the award would you be able to have a draft of the contract?	
8. What are the most recent ratings for your company by the following:	Rating Date
Standard and Poors	
Duff and Phelps	
A M Best	
Moody's	



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GENERAL INFORMATION AND HIPAA (ALL OFFERORS)

VENDOR RESPONSE

9. If you were provided any individually identifiable health information (IIHI) by the City in order to price this proposal, do you understand that you are prohibited from using the IIHI for any purpose other than as required by law **and** further, agree to promptly destroy such data if you are **NOT** the successful Offerors?

10. Enclose a copy of claims and appeals text you would like the City to consider adding to their Plan Document/SPD to outline the process for claims filing/payment and appeals with your organization.

HIPAA QUESTIONS

11. Indicate the **name of the staff member(s)** you have assigned as responsible for assuring your organization's HIPAA EDI, Privacy and Security compliance.

12. Indicate any vendors to whom you will **subcontract** all or part of HIPAA EDI, Privacy or Security compliance, including system vendors, consultants, and clearinghouses, etc.

13. Indicate which of the HIPAA EDI transactions listed below **you will be performing as part of the services you offer** for this Client?

- a. Eligibility and coverage verification 270/271 or NCPDP for PBMs
- b. Enrollment and disenrollment 834
- c. Premium payment 820
- d. Claims and/or encounters 837 or NCPDP for PBMs
- e. Coordination of Benefits and provider claims 837 or NCPDP for PBMs
- f. Claims status and inquiry 276/277
- g. Referrals, preauths, certification appeals 278 or NCPDP for PBMs
- h. Claims payment and EOBs 835



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GENERAL INFORMATION AND HIPAA (ALL OFFERORS)

	VENDOR RESPONSE		
<p>14. Indicate your current HIPAA EDI status by checking the appropriate column for each row:</p> <p>a. Eligibility and coverage verification 270/271 or NCPDP for PBMs</p> <p>b. Enrollment and disenrollment 834</p> <p>c. Premium payment 820</p> <p>d. Claims and/or encounters 837 or NCPDP for PBMs</p> <p>e. Coordination of Benefits and provider claims 837 or NCPDP for PBMs</p> <p>f. Claims status and inquiry 276/277</p> <p>g. Referrals, preauths, certification, appeals 278 or NCPDP for PBMs</p> <p>h. Claims payment and EOBs 835</p>	<p>Tested and ready to perform using HIPAA EDI format and content.</p>	<p>We currently are not HIPAA EDI ready for this transaction and operate under a contingency plan.</p>	<p>Not a transaction we plan to perform.</p>
<p>15. Is your organization accredited for any HIPAA services (e.g ,via Claredi)?</p>			
<p>16. a Are there any HIPAA transactions between this Client and your organization that you will require to be conducted using HIPAA EDI format and content?</p> <p>b. If your answer to the above question is yes, which transactions?</p> <p>c. If this Client currently does not have the transactions you require in a HIPAA EDI ready format, how will you assist this Client?</p>			



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GENERAL INFORMATION AND HIPAA (ALL OFFERORS)

VENDOR RESPONSE

<p>17. a. Do you have a website that details information about your policies and procedures for accepting and sending EDI transactions?</p> <p>b. If this client, or a provider, wants a copy of your Companion Guide for HIPAA EDI transactions, where does this document reside?</p>	
<p>18. Will you need the client to amend their health care ID card(s) to include information about how to submit HIPAA electronic transaction to your organization?</p>	
<p>19. List the clearinghouses who register your organization as a participating payer.</p>	
<p>20. For the clearinghouses you work with, who is paying the “click charges” for transactions conducted with these clearinghouses?</p>	
<p>21. What problems do you experience with the daily use of EDI transactions?</p>	
<p>22. Are you aware of any complaints that have been filed against your organization regarding HIPAA EDI or Privacy with the Centers for Medicare and Medicaid (CMS)?</p>	
<p>23. Indicate the name and title of your firm’s Privacy Officer.</p>	
<p>24. a. If you are offering fully insured benefits to this Client, is your organization going to create and distribute the required HIPAA Privacy “Notice of Privacy Practice” to this Client’s plan participants as required by law?</p> <p>b. If you are offering fully insured benefits to this Client, do the plan documents you distribute to plan participants include the required HIPAA Privacy text including a discussion of the uses and disclosures of protected health information?</p>	



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GENERAL INFORMATION AND HIPAA (ALL OFFERORS)

VENDOR RESPONSE

25. Have you **performed or had an outside agency perform a Security Risk Assessment** of your organization in the past 6 months to assess your current system and/or determine how it compares with the final HIPAA Security regulation with respect to administrative, physical and technical procedures, services, controls or safeguards?

26. List the **5 most important steps** your firm has/is taking in order to comply with the final HIPAA Security regulations.

27. If this **Client wants to transmit or receive electronic protected health information (ePHI)**, with your organization (such as may be part of an e-mail correspondence or eligibility inquiry), what protocol or methods will be required?

28. Are you willing to sign a contract with this Client that indicates **your firm will pay fines** the Client may be assessed as a result of your firm's noncompliance with HIPAA EDI, Privacy and Security regulations?

29. Outline the key steps you have taken to implement **contract revisions** that address HIPAA EDI, Privacy and Security regulation responsibilities of covered entities, business associates and trading partners with the various clients and firms with whom your firm interacts

30. If you anticipate a **contract amendment** or newly executed contract will be needed to address HIPAA compliance responsibilities, please attach a copy and highlight the text that addresses HIPAA.

31. From what company has your firm purchased **additional liability insurance** in anticipation of HIPAA compliance responsibilities?

32. How do you remain **current** on the latest HIPAA developments/changes?



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FLEXIBLE SPENDING ACCOUNT (FSA) ADMINISTRATION

VENDOR RESPONSE

1. Does your company charge an initial start-up fee?	
a. If so, please describe what services are provided in this fee	
b. Is this a one-time charge or an annual fee?	
2. How often would reimbursements be made to participants?	
a. Healthcare reimbursement account?	
b. Dependent care reimbursement accounts?	
3. Do you recommend a minimum reimbursement level? If so, how much?	
4. Does your proposal have a minimum participation requirement?	
a. What happens if minimum is not achieved?	
5. How long after receipt of dependent care account deposit information are funds available to the participant for reimbursement?	
6. a. Do you agree to provide monthly management reports to the City?	
b. Are you capable of occasionally providing reports more frequently, when requested?	
7. Does your company require that the City provide access to employees to promote the sale of voluntary insurance products that can be included under the FSA plan?	
8. Will you agree to perform nondiscrimination testing to ensure the plan is in compliance with IRS Code Section 125 on an annual basis?	



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FLEXIBLE SPENDING ACCOUNT (FSA) ADMINISTRATION

VENDOR RESPONSE

<p>9. a. Do your fees include the preparation of the plan document/summary plan description?</p> <p>b. Does your fee include the preparation and mailing of W-2 forms to participants for dependent care?</p>	
<p>10. Are the rates or fees quoted in your proposal firm and will not be recalculated based on actual enrollment?</p>	
<p>11. Indicate if your proposal includes the following and if access to these reports is on-line:</p> <p>a. Confirmation of enrollment statement.</p> <p>b. Year-end statement of account balance.</p> <p>c. Quarterly statement of account balances.</p> <p>d. Monthly Statement of account balances.</p> <p>e. Termination report.</p> <p>If not, describe any variations.</p>	
<p>12. a. Does your proposal include on-site enrollment meetings?</p> <p>b. Is there an additional charge for the enrollment meetings? If so, please describe.</p>	
<p>13. a. Do you provide communication materials?</p> <p>b. Is there an additional charge?</p> <p>c. If the City reproduced your communication material, will there be a charge?</p>	
<p>14. a. Do you require an initial deposit?</p> <p>b. If so, how much?</p>	
<p>15. Describe the cash flow from the time the City withholds funds from the employees' paycheck.</p>	



QUESTIONNAIRE

Solicitation Number: P09-0074

**Materials Management
Procurement**
8314 West Cinnabar Avenue
Peoria, Arizona 85345-6560
Phone: (623) 773-7115
Fax: (623) 773-7118

FLEXIBLE SPENDING ACCOUNT (FSA) ADMINISTRATION

VENDOR RESPONSE

16. Is your proposal based on the assumption that checks/statements are mailed directly to the participant's address? If not, is there an additional fee?	
17. Do you offer direct deposit to participants?	
18. Describe the alternatives for dealing with terminated employees.	
19. a. Do you provide performance guarantees? a. If so, provide information.	
20. What is the process for requiring support documentation and deactivating of debit card?	
21. Describe your process and what types of situations require supporting documentation on a debit card?	
22. a. Can a dependent get a debit card? a. If so, is there an additional fee?	
23. What is the cost for additional cards?	
24. If a card is inactivated how soon can it be re-activated?	
25. Do you have the ability to contact the City prior to inactivating a card?	



PRICE SHEET

Solicitation Number: P09-0074

Materials Management Procurement

8314 West Cinnabar Avenue
Peoria, Arizona 85345-6560
Phone: (623) 773-7115
Fax: (623) 773-7118

FSA ADMINISTRATION

	2010	2011	2012	2013	2014
Health Care Reimbursement Account (HCRA)	\$	\$	\$	\$	\$
Dependent Care Reimbursement Account (DCRA)	\$	\$	\$	\$	\$
Both Accounts (Monthly)	\$	\$	\$	\$	\$
Debit Card (Monthly)	\$	\$	\$	\$	\$
Total Monthly Premium	\$	\$	\$	\$	\$
Initial Start-up Fee (If any)	\$	\$	\$	\$	\$
Annual Fee (If any)	\$	\$	\$	\$	\$
Participation Requirements					

Assumptions: (Please Complete)

Health Care Reimbursement Account (HCRA)	
Dependent Care Reimbursement Account (DCRA)	

REIMBURSEMENT SERVICES AGREEMENT

This Agreement, effective upon execution for the Plan Year, by and between CITY OF PEORIA (the "Employer") and American Family Life Assurance Company ("Aflac")

WITNESSETH:

WHEREAS, the Employer has adopted a Medical Care Expense Reimbursement ("URM") Plan and/or a Dependent Care Expense Reimbursement ("DDC") Plan for its Employees in conjunction with its Flexible Benefits Plan (collectively referred to as the "Plan" and attached hereto) to be adopted and administered in accordance with Sections 105, 125, and 129 of the Internal Revenue Code of 1986, as amended (the "Code"), and

WHEREAS, the Employer will serve as the Plan Administrator, and

WHEREAS, the Employer desires that Aflac, as its agent, furnish reimbursement services within a framework of policies, interpretations, rules, practices and procedures (the "reimbursement practices and procedures") made and established by the Employer in (i) receiving and processing requests for benefits under the Plan ("Requests") and (ii) disbursing benefit payments from Employer funds (as provided for in Section II A) for eligible expenses under the flexible spending account provisions of the Plan; (if Self-Pay Option is selected in Section II.A below, Aflac shall convey its initial benefit determinations to Employer so the Employer can disburse reimbursement payments for eligible expenses under the Flexible Spending Agreement provisions of the Plan); and

WHEREAS, the Employer is to pay all plan benefits owed or established under the Plan to its Participants, and Aflac is to provide the agreed upon services to the Plan without assuming any such liability,

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, it is hereby agreed as follows.

Section I. Enrollment and Determination of Eligibility

A The Employer shall

- (1) be responsible for interpreting the Plan and its provisions, its terms, conditions and operation, and
- (2) notify Plan Participants of their ability to apply for reimbursement benefits and supply them with Request forms (to be provided by Aflac) and Request filing instructions, and
- (3) provide Aflac with the names, addresses, Social Security Numbers, and elected amounts of all participants in the Plan, and
- (4) upon the occurrence of events that would change a Participant's status under the Plan (e.g. termination, Change in Status, Change in Cost or Coverage for DDC, etc.) immediately provide Aflac with updates (via Telefax) which identify eligible Participants in each of the respective reimbursement Plans and/or the amount of reimbursement benefits for which they are eligible, and
- (5) immediately inform Aflac (via Telefax) as to any new Participants in either of the reimbursement Plans, any Change in Status affecting a Participant's election, or any Qualified Beneficiary electing coverage under COBRA and the amount of such election (if COBRA applies to the Employer), or of any other change which will affect Aflac's responsibilities hereunder

B In determining any person's right to benefits under the Plan, Aflac shall rely on the eligibility information furnished by the Employer, and any signed statements by Participants regarding the eligibility of their Requests under the respective Plan. It is mutually understood that the effective performance of this Agreement by Aflac will require that it be advised on a timely basis by the Employer during the continuance of this Agreement of the identity of individuals eligible for benefits under each of the respective reimbursement Plans. Information modifying a Participant's eligibility or status/election under either reimbursement Plan shall identify the effective date of eligibility and the termination date of eligibility and shall be provided to Aflac (via Telefax) prior to the effective date of such modification in order to be considered by Aflac in making benefit determinations hereunder. Aflac shall not be responsible for Requests paid in error where the Employer has failed to inform Aflac (in a form and with such information as may reasonably be required by Aflac) of a Participant's eligibility or status change prior to the release of the benefit payment.

Section II. Funding and Payment of Requests for the Plan Benefits

A Daily Processing Option The Employer shall

- (i) make sufficient funds available from its general assets for amounts allocable to eligible reimbursement benefits under its plan by depositing a "Maintenance Deposit" (in amounts specified by Aflac from time to time) in an Employer-owned and named account (the "Account") in a financial institution selected by the Employer and Aflac to facilitate the timely processing of Requests under the Plan [Note the Account should not be opened in the Plan's name], and

- (ii) grant Aflac withdrawal authority over the Account sufficient to enable it to pay benefits under the Employer's FSA Plans, and
- (iii) deposit additional funds (at the request of Aflac) in order to reestablish the Maintenance Deposit at the end of each request processing cycle (or such earlier time specified by Aflac), and
- (iv) (iv) telefax copies of all deposit verification receipts, Account Statements, and other correspondence relating to the Account to Aflac upon receipt of such correspondence from the financial institution; and
- (v) during the term of this Agreement, the Employer shall not withdraw funds from the Account; except at the request of, or to the extent approved by Aflac. The Employer bears sole responsibility for any fees imposed with respect to the Account by the financial institution, including but not limited to: Account maintenance fees, insufficient funds fees, fees with respect to voided checks, etc., and
- (vi) authorize Aflac to access the Account by

[] entering into a Withdrawal Agreement with CB&T, or

[X] if a Financial Institution other than CB&T is designated below, the Employer hereby authorizes Aflac to: a) draw benefit checks directly on the Account; b) electronically transfer benefit payments from the Account, c) electronically access Account information, and d) execute the financial institution's standard Deposit/Account Agreement on the Employer's behalf (subject to the terms and conditions set forth herein and as Aflac may otherwise establish) Name, address and contact person at other financial institution

JP Morgan Chase
Jasmine Pecenkovic
201 N. Central, 21st Floor - Mail Code AZ1-1178
Phoenix, AZ 85001 - 602-221-1891

If, at any time, the amount of reimbursement benefits payable under the applicable Plan provisions exceeds the amount deposited by the Employer in the Account, the Employer shall transfer an amount necessary to the Account to fulfill its reimbursement obligations under the applicable Plan before any further reimbursement benefit payment is made. Aflac is under no obligation to advance funds on behalf of the Employer.

B Aflac, as agent for the Employer, shall provide those services described in Appendix A (attached hereto)

Upon written request submitted to Aflac's Flex One Department, Aflac may provide limited assistance with certain of the nondiscrimination tests. The terms and conditions (including applicable fees) under which such services are provided are set forth in Appendix B "Nondiscrimination Testing Services". In providing services, Aflac shall assume that ERISA and COBRA apply to the Employer's Plan unless the Employer gives Aflac written direction otherwise.

C Aflac shall not be obligated or responsible for any duty with regard to the administration of the Plan (imposed by the Plan or otherwise) except as specifically provided above or in the attached appendices. Without limiting Employer's responsibilities described therein, it shall be the Employer's sole responsibility (as Plan Administrator) and duty to ensure compliance with COBRA, perform required nondiscrimination testing, amend the Plan as necessary to ensure ongoing compliance with applicable law, file any required tax or governmental returns (including Form 5500 returns to meet ERISA requirements) relating to the Plan, determine if and when a valid election change has occurred, handle Participant claim appeals, allow Aflac, by and through independent associates, a reasonable opportunity to discuss Aflac, URM, and DDC benefits, execute and retain required Plan and claims documentation, and take all other steps necessary to maintain and operate the Plan in compliance with applicable provisions of the Plan, ERISA, the Code and other applicable federal and state laws.

D In the event that Aflac overpays any person entitled to benefits under the Plan or pays benefits to any person who is not entitled to them, Aflac shall take all reasonable steps to recover the overpayment, except that Aflac shall not be required to initiate court proceedings to recover an overpayment. Aflac shall promptly notify the Employer if it is unsuccessful in recovering any overpayment.

E Aflac will optically scan and maintain electronic copies of all FSA Reimbursement Requests and supporting documentation for a period of seven (7) years after the claim is processed. Copies of FSA claim documents can be reproduced upon written request at Aflac's currently prevailing rate.

Section III. Liability and Indemnity

A In performing its obligations under this Agreement, Aflac neither assumes nor underwrites any liability of the Employer under the Plan, but with respect to the Employer, acts only as provider of those services specifically described in Section II B of this Agreement and with respect to Plan Participants, acts only as the agent of the Employer. The services to be performed by Aflac shall be ministerial in nature and shall be performed within the framework of policies, interpretations, rules, practices, and procedures made or established by the Employer. Aflac shall have no discretionary authority or discretionary control over any assets of the Employer, the Plan, or Plan Participants.

- B. Aflac shall have no duty or obligation to defend any legal action or proceeding brought to recover a Request for Plan Benefits. Aflac shall, however, make available to the Employer and its counsel, such evidence relevant to such action or proceeding as Aflac may have as a result of its processing of the contested benefit determination
- C. Except as otherwise explicitly provided in this Agreement, the Employer shall retain the liability for all Plan Benefit Requests and all expenses incident to the Plan and for any and all violations of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), if applicable, and agrees to indemnify Aflac for and hold it, its directors, officers, and employees, harmless from all amounts and expenses (including reasonable attorneys' fees and court costs) for which Aflac may become liable. This indemnity shall survive the termination of this Agreement.
- D. Aflac shall use ordinary and reasonable care in the performance of its duties, but shall not be liable to the Employer for mistakes of judgment or other actions taken in good faith unless such error results directly from a wrongful or negligent act of Aflac, its officers or employees.
- E. Aflac shall have no duty or obligation with respect to Requests incurred prior to the effective date of this Agreement (hereafter "Prior Reimbursement Requests") and/or Plan Administrator (or other) services arising prior to the effective date of this Agreement regardless of whether such services were/are to be performed prior to or after the effective date of this Agreement (hereafter "Prior Administration"). The Employer specifically acknowledge(s) and agree(s) that (i) Aflac has no responsibility or obligation with respect to Prior Reimbursement Requests and/or Prior Administration, (ii) the Employer will be responsible for processing Prior Reimbursement Requests (including any Run-Off Requests submitted after the effective date of this Agreement) and maintaining legally required records of all Prior Reimbursement Requests and Prior Administration sufficient to comply with applicable legal (e.g., IRS substantiation) requirements and (iii) the Employer agrees to indemnify and hold Aflac harmless for any liability relating to Prior Reimbursement Requests and/or Prior Administration.
- F. The Employer agrees that Aflac may communicate confidential, protected, privileged or otherwise sensitive information to Employer through the Named Contact (as designated on the applicable plan document request form) and specifically agrees to indemnify Aflac and hold it harmless i) for any such communications directed to the Employer through the Named Contact attempted via telefax, mail, telephone, e-mail or any other media, acknowledging the possibility that such communications may be inadvertently misrouted or intercepted, and ii) from any claim for the improper use or disclosure of any health information by Aflac where such information is used or disclosed in a manner consistent with its duties and responsibilities under this Agreement.

Section IV. Reimbursement Request Processing Service Fee

- A. The Employer shall pay Aflac a fee for services performed under this Agreement in the amount of \$0.00 per Participant per FSA benefit (DDC or URM) per month (max per Participant of \$0.00) with a minimum monthly fee of \$0.00 for the reimbursement Plans (URM and/or DDC) for which services are rendered. This amount shall be due by the tenth (10th) of each month (or portion thereof) for which this Agreement is in effect and is in addition to and separate from (i) any Account Establishment (or "Set-Up") fee assessed by Aflac of \$0.00 to initiate the reimbursement arrangement, and (ii) the Employer's obligation to make available sufficient funds to satisfy its obligations under the Plan and to make benefit disbursement in accordance with section II A. above. The Employer is responsible for paying the Service Fee to Aflac. Aflac is not authorized to withdraw the Service Fee from the Account. Failure to pay any applicable monthly Service Fee by the next monthly Request processing cycle shall result in a cessation of Request processing services until such fees are received by Aflac. If Request processing services are pending for an entire monthly processing cycle, Aflac may terminate this Agreement in accordance with Section VI.
- B. Aflac may revise the Service Fee for services performed under this Agreement effective on each Anniversary Date of this Agreement by giving the Employer written notice of the revised rate at least thirty (30) days prior to the applicable Anniversary Date.
- C. Notwithstanding any other agreement between the parties (and/or their agents), Aflac may revise the Service Fee set forth above at any time if revision is deemed necessary by Aflac by reason of (i) modification or amendment of the Plan by the Employer, (ii) a significant decrease in the number of Aflac policies purchased by Participants under the Plan below the number initially included in the Plan after the Service Fee was established (or if later, when the Service Fee was last revised), or (iii) a suspension, limitation, or revocation of the right of Employees or Participants to purchase Aflac policies under the Plan. Aflac shall advise the Employer of the revised Service Fee at least thirty (30) days prior to its implementation. If the Employer does not terminate this Agreement (by written notification pursuant to Section VI A 1.) within thirty (30) days after the receipt of a notice of such revision, the Employer shall be deemed to have agreed to such revision for the remainder of the term of the Agreement. Thereafter, the Service Fee on and after the implementation date shall be made on the basis of such revised Service Fee.
- D. Aflac may revise the Service Fee set forth above at any time if any change in law or regulations imposes on Aflac greater duties or obligations than contemplated by the Agreement in force at the time of such change.

Section V. Term of Agreement

The initial term of this Agreement shall be the initial Plan Year commencing on the effective date hereof, thereafter, this Agreement will automatically renew for successive periods of twelve (12) months unless, at least thirty (30) days prior to the

end of the then current term, the Employer or Aflac gives written notice to the other of its intention not to renew the Agreement. In the event of a short Plan Year (other than the first Plan Year) this Agreement shall automatically renew for an additional twelve (12) months unless the Employer or Aflac gives written notice to the other of its intention not to renew the Agreement within three (3) days after the Employer notifies Aflac of the short Plan Year.

Section VI. Termination of Agreement

- A This Agreement shall terminate upon the earliest of the following dates
- (1) The end of a term of the Agreement following the delivery of written notice of termination pursuant to Section V
 - (2) At the option of Aflac, the date upon which the Employer fails to transfer sufficient funds to Aflac (upon request by Aflac) (i) to pay all valid Requests pending under the Plan, or (ii) to pay the Service Fee (as provided in Section II A and IV A. above, respectively) Aflac shall promptly communicate its election of this option to the Employer
 - (3) Upon the implementation date for a proposed Service Fee increase deemed to be unacceptable by the Employer (after delivery of written notice of termination by the Employer) pursuant to Section IV.C
 - (4) At the option of Aflac, if no Plan Participant is an Aflac policyholder or if the Employer denies Aflac a reasonable opportunity (as determined by Aflac in its sole discretion) to meet with Employees, Aflac shall immediately communicate its election of this option to the Employer
 - (5) Any other date mutually agreeable to the Employer and Aflac
- B Upon termination of this Agreement, Aflac shall cease the processing of all Requests then in its possession, return any undistributed funds to the Employer, and make all records relating to Requests in process reasonably available to the Employer. If the termination occurs pursuant to VI A 1. (above), Aflac shall process all Run-Off claims provided any Service Fee(s) is current. Thereafter, the Employer and/or Plan Administrator shall be responsible for all aspects of Reimbursement Request processing and Plan administration.

Section VII. Miscellaneous

- (1) **Notices** Any notice required to be given hereunder to Aflac shall be sufficient if in writing and delivered personally or by prepaid first class mail to Aflac Benefit Services/Flex One, 1932 Wynnton Road, Columbus, GA 31999-9950, or if to the Employer, at the address of the Employer denoted on the signature page attached hereto
- (2) **Applicable Law** This Agreement shall be governed by, and shall be construed in accordance with the laws of the State of Arizona, to the extent they are not preempted by ERISA, the Code, or any other federal law
- (3) **Legal and Tax Status** The Employer acknowledges that neither Aflac nor its agents is providing legal or tax advice, and that neither Aflac nor its agents serves as the Plan Administrator or a fiduciary under the Plan. The Employer shall be the sole party responsible for determining the legal and tax status of the Plan under applicable law. Aflac shall have no power or authority to waive, alter, breach, or modify any terms or conditions of the Plan.
- (4) **Assignment** This Agreement may be assigned by Aflac to any other party, including any successor to the business of Aflac by merger, consolidation, purchase of assets, or otherwise, without the prior consent of the Employer. This Agreement shall be binding upon any corporation into which the Employer may be merged or with which it may be consolidated, or any corporation succeeding to all or substantially all of the business of the Employer.
- (5) **Entire Contract** This Agreement constitutes the entire contract between the parties and no modification or amendment hereto shall be valid unless in writing and signed by an officer of the Employer and an Officer or duly authorized representative of Aflac.
- (6) **Tax Reporting and Withholdings**. The Employer has ultimate control over the payment of Plan benefits and shall be the sole party responsible for income and employment tax reporting and withholding obligations imposed as a result of the includability of such payments in the gross income of recipients. Aflac is a mere agent of the Employer for the processing of benefit Requests.
- (7) **Confidential Information** The term "Confidential Information" as used in this Agreement means confidential or proprietary information of any party that is not generally known to the public, including, but not limited to compilations, lists of actual or potential customers or suppliers, hardware systems, software, or other documentation of any type, whether in printed or machine readable form, computer databases, forms and form letters, contracts, information regarding specific transactions, and marketing and business plans. For the purposes of this subsection, Confidential Information shall not include the personally identifiable information relating to any of Employer's employees.

The term "Trade Secrets" as used in this Agreement shall mean Confidential Information that (1) derives economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use; and (2) is the subject of efforts that are reasonable under the circumstances to maintain its secrecy. The terms "Confidential Information" and "Trade Secrets" do not include information that: (a) is known to the receiving party prior to its disclosure by the disclosing party, evidenced by the receiving party's written records, (b) is developed by the receiving party independently of any of the

Confidential Information or Trade Secrets received in confidence from disclosing party, evidenced by the receiving party's written records; (c) is rightfully received by the receiving party from a third party without restriction and without breach of any obligation of confidentiality running to the disclosing party

Each party agrees that it shall not disclose to others or use for any purpose other than performance of the Agreement any of the other party's Confidential Information or Trade Secrets any time during or after the term of this Agreement. Each party further agrees that it will disclose Confidential Information or Trade Secrets to its employees only as necessary for the performance of the Agreement, and only to employees with a need to know. Each party to this Agreement agrees that all Confidential Information and Trade Secrets are the property of the party disclosing it, and each agrees to promptly return to the disclosing party, upon demand, any Confidential Information or Trade Secrets furnished under this Agreement which is either received in or reduced to material form, and all copies thereof. The Employer agrees that Aflac may make lawful references to Employer in its marketing activities.

- (8) Individual Information Each party acknowledges that performance of the Agreement may involve the use and disclosure of personal information relating to the Employer's employees (including but not limited to names, addresses, benefit elections, *claims and health information*) Aflac agrees that it will not use any such information disclosed to it by Employer except as authorized by the individual to whom the information relates or as otherwise permitted by applicable state or federal law or regulation. Employer agrees that it will not use any such information disclosed to it by Aflac except for the purpose for which it received the information and will not further disclose such information without the written authorization of the individual to whom the information relates. This provision is not intended to create any third party beneficiary rights (in favor of Employer's employees or any other party).
- (9) Capitalized Terms shall have the same meaning as in the Plan documents.

[Remainder of page intentionally left blank]

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed and signed by an Officer of the Employer and an Officer or duly authorized Worldwide Headquarters Employee of Aflac to do so

Dated at Aflac this _____ day of _____

By _____
Jason A. Goodroe
Second Vice President
Aflac Benefit Services/Flex One

Dated at CITY OF PEORIA, AZ this 23 day of September 2009

By  _____ Herman Koebergen, Materials Manager

Street Address City of Peoria
8401 W. Monroe St.
Peoria, AZ 85345

Appendix A
Schedule of Services to Be Provided By Aflac

In accordance with attached Reimbursement Services Agreement Aflac shall provide the following services for the Employer:

General Plan Services:

- provide the Employer with a sample cafeteria plan document, including a medical care expense reimbursement ("URM") Plan and a dependent care expense reimbursement ("DDC") Plan to be reviewed by the Employer and its legal counsel, and
- provide the Employer with a sample flexible benefits summary plan description for distribution to each Plan Participant and employees and where may be required by a Change in Status, and
- upon receiving instructions from the Employer on a Change in Status, Aflac will make the change requested by the Employer

Additional Services if DDC or URM Benefits Are Offered:

- assist the Employer in explaining the URM and/or DDC features of the cafeteria plan to employees, and
- process the Employee-executed Salary Redirection Agreements as they relate to the URM and DDC components of the Employer's flexible spending account, and
- prepare an enrollment confirmation letter and send it to the Employer to verify URM and DDC elections, and
- provide each URM and/or DDC Participant with an Explanation of Benefits and account balance statement with each reimbursement request, at the end of each quarter (based on Plan Year) if no reimbursement requests are received, and at the end of each Plan Year, and
- provide the Employer with monthly written reports summarizing the previous period's URM and/or DDC and Account activities, and
- receive Requests for URM and/or DDC benefits, and expeditiously review such Requests to determine what amount, if any, is due and payable with respect thereto, and
- disburse the benefit payments it determines to be due (provided the Employer transfers sufficient funds to Aflac or has sufficient funds in the Account) or if Self-Pay is elected under Section II. A , notify the Employer of the benefit determination in accordance with the provisions of the Plan and the following procedures
 - valid reimbursement for URM and/or DDC benefits shall be paid by Aflac on the date funds are received from the Employer (with respect to such Requests) by mailing a check to the Participants at their addresses (unless otherwise requested by the Employer as allowed by the terms of the Plan) or by initiating a direct deposit transfer directly to the Participants in their respective bank accounts in the appropriate amount(s), and
 - if the amount of the (otherwise) reimbursable DDC Request exceeds the amount the Participant had withheld for DDC benefits, the excess shall be carried forward (within the same Plan Year) and treated as an Eligible Employment-Related Expense for that month, and
 - if the amount of URM Requests exceeds the amount the Participant has had withheld from URM benefits, the entire amount shall be processed to the extent of the Participant's annual election reduced by previous reimbursements made for expenses during the Plan Year (provided the Employer makes available sufficient funds for Aflac to satisfy the Request), and
 - Requests of less than \$15 00 may be carried forward and aggregated with future Requests until the reimbursable amount is greater than \$15 00, provided however, that the entire amount of the reimbursable Requests shall be paid after the close of the Plan Year (and any applicable grace period) without regard to the \$15 00 threshold, and
 - unless otherwise specified in writing by the Employer, Health FSA claims following a Change in Status impacting the Health FSA election shall be processed using a "blended approach" (i.e., the maximum Health FSA benefit for a period of coverage following a Change in Status will be limited to the lesser of (a) the annual Health FSA maximum set forth in the Plan document less any benefit payments made prior to the Change in Status, and (b) the sum of the Participant's Health FSA Account balance immediately before the Change in Status and any additional contributions made during the remaining period of coverage), and
 - notify claimants as to any Requests which are denied because of inadequate Request substantiation or improper Request form submission, and give affected claimants the opportunity to resubmit their Requests, and
 - provide to the claimant within thirty (30) days following receipt of a Request, written notification (a) as to the disposition of the Request, or (b) of an anticipated delay beyond thirty (30) days, not to exceed 15 days from the

end of the 30-day period, with respect to the disposition of the Request together with an explanation of the delay, and

- notify the claimant and refer to the Employer (with an analysis of the issues affecting the Request) for final decision, any Requests which Aflac deems not to be reimbursable pursuant to the terms of the Plan and/or the reimbursement practices and procedures established by the Employer, setting forth the applicable review procedure available to the claimant through the Employer

Appendix B
Nondiscrimination Testing Services
[Provided Upon Annual Request]

Nondiscrimination Testing:

The Employer, upon submission of an annual Employee Census Data Sheet, authorizes Aflac to compile nondiscrimination testing percentages based upon the employee census data provided. As consideration for this service, the Plan Sponsor/Administrator agrees to release and hold Aflac, its subsidiaries, affiliates, officers, directors, owners, shareholders, attorneys, successors and assigns harmless from any liability arising as a result of the provisions of, or reliance upon such testing percentages. In addition, the Employer understands and agrees that

- Aflac is not in the business of providing legal or tax advice, and the Employer, as the plan sponsor/administrator, will not construe the testing percentages provided by Aflac to be legal or tax advice. Accordingly, the Employer will seek the advice of its own tax or legal advisor to interpret and verify the testing percentages provided, and ensure compliance with applicable nondiscrimination requirements.
- The Employer bears a sole responsibility for nondiscrimination testing and the continued qualified status of its cafeteria plan under all applicable provisions of the Internal Revenue Code.
- The testing percentages provided by Aflac are merely an indicator of compliance with three of the applicable nondiscrimination tests – the Cafeteria Plan 25% Key Employee Concentration Test, the Dependent Care 5% Shareholder Test, and the Dependent Care 55% Average Benefits Test. Each Employer must also ensure compliance with the Eligibility Test and Contributions and Benefits Test applicable to the Cafeteria Plan. To ensure compliance with applicable provisions of the Internal Revenue Code, additional nondiscrimination testing and result verification must be undertaken by the Employer with the assistance of its tax or legal counsel.
- Discrimination testing should be conducted at least 180 days prior to the end of the Plan Year to which the data relates to ensure adequate time to make any required corrections. Aflac will assist with discrimination testing no less frequently than once per year and no more frequently than once every (30) days.

**Aflac Reimbursement Services Agreement
Card Service Appendix**

CITY OF PEORIA (the "Employer") has established a Medical Care Reimbursement Plan (the "URM Plan") to allow participants to be reimbursed for eligible URM medical expenses. Aflac has the capability, in conjunction with its card provider, to provide a prepaid debit card service that is designed to process certain transactions electronically in the Employer's URM Plan by allowing participating employees to use an electronic payment card (the "Card") to purchase certain health care services and products from hospitals, physicians, health care professionals, and other eligible health care providers and merchants, as designated under the Employer's URM Plan.

Employer has asked Aflac to assist it with its administrative obligations related to processing claims via electronic payment card under the URM Plan. Assistance will only be provided with respect to a URM Plan for which Aflac has provided the sample plan documentation or, if Aflac's sample plan documentation is not utilized, then only such URM plan identified by the Employer and agreed to by Aflac pursuant to separate written notice.

This Aflac Reimbursement Services Agreement Card Services Appendix (the "Card Services Appendix") is incorporated into and made a part of the Aflac Reimbursement Services Agreement (the "Agreement"). The effective date of this Card Services Appendix is the effective date of the Agreement or if later, the date indicated in this Card Services Appendix. The responsibilities of the parties set forth in this Card Services Appendix are in addition to any responsibilities set forth in the Agreement. If there is a conflict between this Card Services Appendix and the Agreement, the Agreement controls.

In consideration for the mutual promises set forth below, the Employer and Aflac agree as follows:

<p><u>I. Standard Services</u></p> <p>Aflac will provide services as outlined below in Sections 1, 2, 3 and 4.</p>
<p><u>Standard Fee</u></p> <p>The Employer shall pay Aflac the greater of the monthly fees set forth in the Agreement or the fees indicated below.</p> <p>The Employer shall pay Aflac a fee for services performed under the Agreement and this Card Services Appendix in the amount of \$0.00 per Participant per FSA per month (max per Participant of \$0.00) with a minimum monthly fee of \$0.00 for the reimbursement Plans (URM and/or DDC) for which services are rendered. In all other respects, the Agreement shall control.</p>

In consideration for the services provided by Aflac in accordance with this Card Services Appendix, Employer agrees to pay to Aflac the applicable fees set forth above. The employer will make sufficient funds available to pay the fees in accordance with the method set forth in the Agreement.

Section 1. Definitions

- A Card Transaction means when the Card is presented for payment of Qualified Expenses.
- B Qualified Expenses include any and all related goods and services as defined under Section 213(d) of the Internal Revenue Code relating to the URM Plan.
- C Benefit Plan Participants or Participants means employees and their dependents that are participating in the URM Plan.
- D Flexible Spending Account ("FSA") means a health flexible spending account, as provided through the URM Plan.
- E Employee means those employees eligible to participate in the URM Plan.
- F Account is the Employer-owned bank account from which reimbursements are made.
- G Card or Cards means the electronic payment card provided by Aflac or by the card processor.

Section 2. Aflac Responsibilities

- A. Unless a Card-related fee is specified above, Aflac shall automatically deduct the fee for the Card directly from each Participant's FSA.
- B. Aflac shall provide administrative services to employer on behalf of Participants, including updating Participant's records, maintaining accurate Account balances, and FSA contribution information, activating and deactivating Participant Cards,

responding to Participant inquiries and providing appropriate notices regarding Participant FSAs and actions taken in relation thereto

- C Aflac shall provide administrative services to Employer, including maintaining accurate URM Account balance information, providing reports of Account activities and initiating draws (either directly or through its authorized agent) against an Account designated by the Employer to fund reimbursement transactions and maintain Account balances at the agreed-upon levels
- D. Aflac will provide call center support, subject to its standard hours of operation, for Participants to report lost or stolen Cards, and resolve all servicing issues related to the Card, except transaction or merchant disputes
- E Aflac will make available to the Employer, for distribution to the Participants, information concerning proper use of the Card
- F Aflac will use its best efforts to operate the Electronic Payment Card Program (the "Card Program") in accordance with IRS guidance applicable to debit card processing of Qualified Expenses as set forth in Revenue Ruling 2003-43, IRS Notice 2006-69, and IRS Notice 2007-02. Aflac shall not be responsible for debit card processing that is conducted at the direction of the Employer or in accordance with card processor's standard procedures

Section 3. Employer Responsibilities

- A Employer acknowledges that Card services are not generally available to certain persons, including, but not limited to, those ineligible to participate in Employer's URM Plan, non-employees, terminated employees, persons participating through COBRA, and certain employees on leave from employment and on disability (collectively, "Ineligible Persons") Employer agrees to notify Aflac (as specified in the Agreement) if a Participant becomes an Ineligible Person
- B Employer agrees to sufficiently fund the Account, in advance, in an amount to be specified by Aflac from time to time) in a checking account in the Employer's name at a financial institution mutually agreeable to Employer and Aflac (the "Maintenance Deposit") to ensure adequate funding for the payment of Card Transactions as they occur The Maintenance Deposit may be increased depending on the timing and level of Card Transactions
- C The Employer shall deposit additional funds in the Account (at the request of Aflac) in order to reestablish the Maintenance Deposit at the end of each claim processing cycle
- D Each day that Card Transactions are paid from the Account, Employer authorizes Aflac to initiate a draw (either directly or through its authorized agent) from a designated Employer account to restore the Account to the Maintenance Deposit level
- E Employer will provide a mechanism to deduct any ineligible Card Transactions through payroll that have not been offset against other valid Qualified Expenses or repaid to the Account by the Participant through check or money order, or if this is prohibited by law, to alternatively agree to accept the loss as part of the risk of the URM Plan
- F. Employer agrees to notify Aflac of Employee termination in a timely manner
- G Employer agrees that the cost of all Card Transaction and claims arising under the URM Plan shall be paid by the Employer's contributions to the Account The liability for payment of claims falls on the Employer or the Plan Participant, and not on Aflac Any additional costs, including administrative costs and banking costs, shall be paid by the Employer or Plan Participant In no event shall Aflac be responsible for any such costs or charges If, at any time, the amount of reimbursement benefits payable under the applicable Benefit Plan provisions exceeds the amount deposited by the Employer in the Account, the Employer shall transfer an amount necessary to the Account to fulfill its reimbursement obligations under the applicable Plan before any further reimbursement benefit payment is made Aflac is under no obligation to advance funds on behalf of the Employer
- H. Employer agrees to notify Aflac immediately upon suspicion of inappropriate or fraudulent Card use. Plan Participants must comply with the terms outlined within their Cardholder Agreement relating to inappropriate or fraudulent Card use
- I Employer acknowledges that Card usage for the URM Plan is subject to IRS regulation, which may include, without limitation, restrictions on the amount a Participant may charge, which merchants may accept the Card, and the type of expense that may be charged and other legal requirements including, but not limited to those described in Revenue Ruling 2003-43, IRS Notice 2006-69 and IRS Notice 2007-02 Employer acknowledges that, despite such usage restrictions imposed by the IRS, the Card may cause payments to be issued for expenses that do not represent eligible URM Plan expenses Employer agrees Aflac may not be held responsible for Employer losses or any tax consequences due to payments for ineligible expenses Employer acknowledges that state or other laws may govern whether and to what extent it may recoup ineligible payments by withholding such amounts from Employee pay
- J Employer agrees that it may be liable for disputed Card payments if such disputes are subsequently resolved by VISA or MasterCard in favor of the merchant that provided the goods or services
- K Employer agrees to administer the URM Plan in accordance with the rules and regulations of the URM Plan
- L Employer agrees to provide to Aflac in a timely fashion all information for any reports or other documents required by law, including but not limited to the rules and regulations promulgated by the U.S. Department of Labor and the Internal Revenue Service It is Employer's responsibility to ensure that it complies with all applicable tax and other laws

Section 4. Administration

Aflac will administer the Card as follows

- A. Aflac or the Card service provider chosen by Aflac will provide a Card to each Participant in the URM Plan
- B. Aflac will provide each Participant with reimbursement forms and instructions for filing reimbursement Claims, and
- C. Aflac will provide each Participant with written monthly reports summarizing the previous period's URM Plan Card activities, and receive electronic and/or paper Claims, and expeditiously review such Claims to determine what amount, if any is due and payable with respect thereto, and
- D. Aflac will disburse the benefit payments it determines to be due (provided the Employer has sufficient funds in the Account) in accordance with the provisions of the URM and the following procedure(s)
 - (1) Valid reimbursement for FSA benefits shall be paid by authorizing a valid Card Transaction at point of sale, or by mailing a check to the Participants at their address (unless requested by the Employer as allowed by the terms of the Plan) or by initiating a direct deposit transfer directly to the Participants in their respective bank accounts in the appropriate amount(s), and
 - (2) Card transaction that have been authorized, but subsequently found to be ineligible shall be offset with valid paper Claims, or
 - (3) Card Transaction deemed ineligible shall be reimbursed by the Employee or deducted by the Employer via payroll system, or included in the Employee's tax income by the Employer
- E. Aflac agrees to reasonably ensure compliance with proper use of the Card and take whatever action is necessary to investigate and resolve errors in Card Transactions
- F. The Card will be deactivated upon notice from the Employer that the Participant is no longer employed by the Employer or has ceased to satisfy the eligible requirements of the URM Plan. Where Employer instructs Aflac to terminate eligibility, Aflac agrees to deactivate, as soon as practicable, but in no event more than three (3) business days of its actual receipt of a complete notice thereof, the Card of any Ineligible Person. If Aflac has deactivated the Card pursuant to the preceding sentence, Employer agrees that Aflac or the Card Service Provider may not be held responsible for all such ineligible expenses. Employer will use its best efforts to retrieve the Card from any Ineligible Person. Aflac may deactivate at its option and without prior notice to Employer or Participant, any Card for fraudulent activity or as outlined in the Cardholder Agreement. Aflac reserves the right to deactivate the Card any other time that it deems appropriate.
- G. Participants must agree to use the Card in accordance with the terms of the Cardholder Agreement that accompanies the Card. Aflac or the Card services provider will deactivate the portion of the Card that corresponds with the applicable URM Plan if the Participant fails to use the Card in accordance with the Cardholder Agreement.
- H. The Card may be used by Participants to pay for Qualified Expenses with merchants who have a category code associated with medical services (to the extent applicable). Aflac reserves the right to allow the Card to be used at merchants who do not have an appropriate category code provided such transactions are permissible under IRS Notice 2007-2 or as an IAS transaction consistent with IRS Notice 2006-69. Aflac will use its best efforts to ensure that the Card complies with IRS requirements, however, Aflac shall not be responsible for Card systems procedures established by the Card processor or directed by the Employer.
- I. Aflac will require substantiation of expenses paid with the Card in accordance with the requirements set forth in the applicable Treasury regulations and/or other applicable guidance. Aflac will notify claimants in writing as to any electronic or paper claims that are denied or deemed ineligible for reimbursement because of inadequate claim substantiation, improper claim form submission, or medical expense not meeting URM Plan requirements. The Card will be deactivated if the Participant fails to provide the requested substantiation. Aflac will make reasonable attempts to collect repayment of claims paid through the Card for ineligible expenses or offset the ineligible payment against any claims for future eligible expenses (made during the plan year where required). No more than two (2) requests for repayment will be made. If repayment or offset is not made, Employer will be informed and will be responsible for taking any necessary action required by law. Employer agrees to recover the funds from the Participant through an after-tax payroll deduction and send notice of the deducted funds to Aflac for credit to the Participant's Account.
- J. Aflac or the Card service provider will incur no liability for ineligible Card Payments. It is the Employer's responsibility to ensure that it complies with all applicable tax and other laws.
- K. All Cards will be deactivated on the date this Agreement is terminated. Aflac has the right to deactivate all Cards in the event the Employer fails to fund the Account as provided in Section 3 above. Aflac may also elect to terminate the Agreement as of such date.

L If a Card has been deactivated (other than for failure to properly fund), neither Aflac nor the Card service provider will reactivate the Card, until Aflac has reasonably determined that the reason for the deactivation has been resolved or promoted by written instructions from the Employer

Section 5. Transfer of Data

Aflac will establish a standard procedure for exchanging information Employer will furnish the information determined to be necessary to satisfy its responsibilities under this Card Service Appendix in a format, method, and time mutually agreed upon by the parties Aflac may exchange eligibility and adjudication data with the pharmacy benefits manager. Also, Aflac may interface with the Card processor on all Card activity and post data to system file

Section 6. Optional Services

<i>II. Optional Services</i>	<i>Optional Fees</i>
These are provided only upon written request of the Employer	
[Reserved]	[Reserved]

IN WITNESS WHEREOF, the parties hereto have caused this Card Services Appendix to be executed and signed by an Officer of the Employer and an Officer or duly authorized Worldwide Headquarters Employee of Aflac to be effective as of

Date at Aflac this _____ day of _____

By _____

Jason A Goodroe
Second Vice President
Aflac Benefit Services/Flex One®

Dated at CITY OF PEORIA, AZ this 23 day of September 2009

By [Signature] Herman Koebergen, Materials Manager

Street Address: City of Peoria
8401 W. Monroe St.
Peoria, AZ 85345

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
8/04/2009

PRODUCER J Smith Lanier & Co.-Columbus P. O. Box 1997 Columbus, GA 31902 706 324-6671	THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW	
	INSURED Aflac Incorporated Attn: Mr. Nelson Phillips 1932 Wynnton Road Columbus, GA 31999	INSURERS AFFORDING COVERAGE
	INSURER A St. Paul Guardian	24775
	INSURER B Travelers Casualty and Surety C	19038
	INSURER C Travelers Indemnity Company	25658
	INSURER D St. Paul Protective Insurance	19224
	INSURER E	

COVERAGES

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS

INSR ADD'L LTR	INSRD	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS	
A		GENERAL LIABILITY <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS MADE <input checked="" type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC	FS06804129	05/16/09	05/16/10	EACH OCCURRENCE	\$1,000,000
						DAMAGE TO RENTED PREMISES (Ea occurrence)	\$1,000,000
						MED EXP (Any one person)	\$10,000
						PERSONAL & ADV INJURY	\$1,000,000
						GENERAL AGGREGATE	\$10,000,000
						PRODUCTS - COMP/OP AGG	\$2,000,000
A		AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS <input checked="" type="checkbox"/> Comp-\$1,000 Ded <input checked="" type="checkbox"/> Coll-\$1,000 Ded	FS06804129	05/16/09	05/16/10	COMBINED SINGLE LIMIT (Ea accident)	\$1,000,000
						BODILY INJURY (Per person)	\$
						BODILY INJURY (Per accident)	\$
						PROPERTY DAMAGE (Per accident)	\$
		GARAGE LIABILITY <input type="checkbox"/> ANY AUTO				AUTO ONLY - EA ACCIDENT	\$
						OTHER THAN EA ACC AUTO ONLY	\$
						AGG	\$
A		EXCESS/UMBRELLA LIABILITY <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS MADE <input type="checkbox"/> DEDUCTIBLE <input checked="" type="checkbox"/> RETENTION \$ 10,000	FS06804129	05/16/09	05/16/10	EACH OCCURRENCE	\$10,000,000
						AGGREGATE	\$10,000,000
							\$
							\$
							\$
B		WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? If yes, describe under SPECIAL PROVISIONS below	HUYCKUB2547L61409 HACRUB5156N32309	05/16/09	05/16/10	<input checked="" type="checkbox"/> WC STATU-TORY LIMITS <input type="checkbox"/> OTH-ER	
						E L EACH ACCIDENT	\$500,000
						E L DISEASE - EA EMPLOYEE	\$500,000
						E L DISEASE - POLICY LIMIT	\$500,000
D		OTHER Property/EDP 25,000 Deductible Including Theft	FS06805682 Replacement Cost Special Form	05/16/09	05/16/10	Blanket Building / Contents / EDP Limit: \$385,025,698	

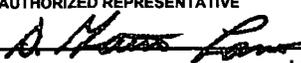
DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS

Re: City of Peoria, Arizona, Notice of Request for Proposal #P09-0074
 The City of Peoria, its agents, representatives, officers, directors, officials and employees are named as Additional Insureds with respects to the General Liability & Auto Liability coverage if required by written agreement or contract, but only with respects to the operations of the Named Insured, and subject to the (See Attached Descriptions)

CERTIFICATE HOLDER

City of Peoria
 8314 West Cinnabar Avenue
 Peoria, AZ 85345-6560

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL 30 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES
 AUTHORIZED REPRESENTATIVE


IMPORTANT

If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

DISCLAIMER

The Certificate of Insurance on the reverse side of this form does not constitute a contract between the issuing insurer(s), authorized representative or producer, and the certificate holder, nor does it affirmatively or negatively amend, extend or alter the coverage afforded by the policies listed thereon.

DESCRIPTIONS (Continued from Page 1)

provisions and limitations of the policy. The General Liability coverage will be primary per policy terms and conditions. A Waiver of Subrogation exists in favor of Certificate Holder with respects to the General Liability coverage.



We've got you under our wing.

***Aflac's Response to the City of
Peoria's Request for Proposal
(P09-0074) for Flexible Spending
Account Administration
Best and Final Offer***

A proposal prepared especially for you by:
American Family Life Assurance Company of Columbus (Aflac)

Authorized By: *Deborah B. Griffin*
Deborah B. Griffin
Second Vice President
Sales Administration
Phone Number: 706.596.3982
E-Mail Address: CorporateBids@aflac.com

Local Contact: **Diego Coronado** **Alfredo Vargas**
Phone Number: 623.932.9400 **Phone Number: 623.932.9400**
E-Mail Address: **diego_coronado@us.aflac.com** **E-Mail Address:** **alfredo_vargas@us.aflac.com**

The plans and services outlined in this proposal will be valid for a period of 90 days, subject to the availability of insurance policies currently being marketed.



We've got you under our wing.

City of Peoria

Best and Final Offer Questions

1. Please clarify if your firm can accept a PeopleSoft interface file for open enrollment, bi-weekly payroll deductions and weekly employee status updates.

Yes, we can accept a PeopleSoft interface file for open enrollment, bi-weekly payroll deductions, and weekly employee status updates. In the past, Aflac used PeopleSoft for our Human Resources and benefits and utilized the interface feature for our own open enrollments.

2. If the usual promised time for card reactivation is 24-48 hours, can exceptions be made to that timeframe by the plan administrator?

Yes.

- 3 Please specifically identify the management reports the City can access online and indicate how often we can access those reports.

Following are management reports we will make available to the City and the frequency of each:

- **Year-To-Date Analysis Report (monthly)**
- **Check Register (daily, weekly, or monthly)**
- **Bank Transaction Reconciliation Report (payment card) (daily, weekly, or monthly)**

4. In your proposal you provided sample copies of various agreements. Please clarify if you have an agreement that you would require the City to sign if awarded the contract. If so, please provide a copy of that agreement

Attached are the two agreements that we would require the City to sign:

- **Payroll Acknowledgement Agreement (required for our offer of voluntary plans)**
- **Reimbursement Services Agreement (required for our Flexible Spending Account and Aflac Now Card)**



We've got you under our wing.

5. The proposal asked for your firm to provide names and contact information for 3 recently terminated clients. This information was not provided. Please provide company name, contact name, phone number, termination reason and termination date for three (3) recently terminated clients.

Aflac, as an insurance company, is primarily regulated by state law, and many states have laws that regulate how insurers may treat customers' information. Due to privacy laws, Aflac is unable to provide the names of clients who have terminated their accounts.

- 6 The proposal indicates that Aflac will waive the fees for FSA for the first three (3) years of the contract and that all fees are subject to review for years 4 and 5 of the contract. In the interview, Aflac indicated that fees are typically waived for non-profit and governmental entities. Please indicate if you can waive the fees for years 4 and 5 of the contract or if you can provide a cap on any fees that may be assessed in years 4 and 5.

We can waive fees for years 4 and 5.

- 7 The proposal indicates that there are no premiums for the FSA if we offer accident and cancer plans to our employees. This is with the understanding that at least three (3) employees enroll in at least one of the accident or cancer plans. Please provide information regarding cost if the City does not have at least 3 employees enroll in the plans.

Since fees have been waived for the City, there are no costs for our Flexible Spending Accounts and Aflac Now Card. However, our Flexible Spending Accounts and Aflac Now Card are only available as long as one or more of Aflac's insurance policies are offered and purchased through payroll deduction.

8. Please clarify if your firm requires access to meet with "all" eligible employees or just those who are interested in signing up for ancillary benefits.

In order to increase participation, we prefer to have access to all eligible employees, including those only interested in ancillary benefits. Our goal is to improve participation in the City's Flexible Spending Account program through education on how this program works as well as information on our voluntary plans. Communication is key when it comes to providing benefits packages. Aflac realizes that and is here to assist you in communicating benefits consistently and strategically to each of your employees. We would like to assemble all employees in a group setting for a brief meeting and then meet one-on-one with individuals.

Payroll Account Acknowledgment

All applicable sections must be completed for processing.

INSTRUCTIONS

- ALL accounts must complete Section 9, the Authorization and Signatures section
- Accounts establishing or modifying a Flex One® cafeteria plan or offering an Aflac Now CardSM must complete Sections 5 & 6
- Accounts with another carrier's cafeteria plan must complete Section 7
- Fax completed form to 1-866-AFL-NASA (1-866-235-6272)

1. GENERAL ACCOUNT INFORMATION

New Aflac Payroll Account

Changes to an Existing Aflac Payroll Account

Split or Transferred Account

Broker Account Indicator

Group Number: _____

Broker Writing Number: _____

Broker Employee ID: _____

Does this account have multiple locations, each requiring an invoice? Yes No

Are there any existing policies to place on this account? Yes No (If yes, submit a list of the policies on a separate page with the Payroll Account Acknowledgment to Aflac WWHQ)

Name of Account _____

Type of Business _____ Tax ID No _____

Industry Classification (Contact SIC Team for correct classification) A B C D E SIC Record No _____

Affiliate/Subsidiary of (if applicable) _____ Master Account No _____

Mailing Address _____

City _____ State _____ ZIP _____

Location Address Check if same as mailing address (P O box is not acceptable) _____

City _____ State _____ ZIP _____

Phone () _____ Fax (if applicable) () _____ Total No of Employees _____

Total No of 1099 Workers _____ Total No of W-2 Employees _____ Will 1099 workers be applying for coverage? Yes No

If 1099 workers are applying for coverage, submit an exception request for payroll rates to WWHQ on Form **IN-02-05** prior to writing the business

Account Web Site Address (if applicable) _____

Enrollment Period Will the enrollment period exceed 90 days? Yes No If so, has this been approved by Sales Support? Yes No

What is the length of the enrollment period? _____

Is there an established Aflac New York account? Yes No

If yes, provide name and group number _____

What led your organization to begin offering Aflac products to your employees? (Check all that apply)

Employee/Member Request Benefit Package Improvement Benefit Advisor or Broker Recommendation

Sales Associate/Agent Commercial Advertising Aflac Products Are a Good Value Other _____

Please consult with employer's payroll contact to ensure accurate completion of next section.

American Family Life Assurance Company of Columbus (Aflac)
Worldwide Headquarters • 1932 Wynnton Road • Columbus, Georgia 31999 • 1 800 99.AFLAC (1 800 992 3522)

Account Name _____
Tax ID _____ Group No _____ Writing No _____

2. BILLING INFORMATION

2a. BILLING CONTACT INFORMATION

NOTE: Aflac will contact the designated Billing Contact to review information.

All accounts with fewer than 1,000 employees will receive their invoice via Aflac's Online Billing system. As an Online Billing account, you have the option of making payments and reconciling your account online. Once your account is established, you can submit your invoice and payment electronically when due from the bank account noted below. At that time, if you prefer, you may also choose to pay by mailing a check. Aflac will not debit your account until you have reconciled and submitted your invoice for payment. Any adjustments or requested changes you submit electronically will not be processed until payment is received and the transaction is complete.

Bank Routing No.: _____ Account No.: _____
Account Type: Checking Savings

Contact for Billing Inquiries: Mr. Ms. _____

Billing Contact Phone: () _____ Ext.: _____ Fax (if applicable): () _____

Billing Contact E-Mail (required): _____

2b. BILLING FREQUENCIES

Invoice Due Date: On what day of the month would you like your Aflac invoice to be due (1st or the 15th)? _____

How often would you like to receive your invoice from Aflac?

Monthly (Aflac will bill for the number of deductions made the previous month. Example: Deductions made January 1st through the 31st will be due in February.)

- 8-Month (8 invoices)
- 9-Month (9 invoices)
- 10-Month (10 invoices)

For 8-, 9- or 10-month, indicate months when no deductions will be made:

Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

- Quarterly (4 invoices)
- Semiannually (2 invoices)
- Annually (1 invoice)

For Quarterly, Semiannually, and Annually, initial premiums must be submitted with applications.

2c. BILLING FORMAT

Check if account uses Social Security number for employee number

In what order would you like your employees listed on your bill?

(If more than one is checked, please number your choices according to priority.)

EXAMPLE. to request a bill with employees listed alphabetically under their department numbers, you would mark

Alphabetic 2 Dept No 1 Employee No _____

Alphabetic _____ Department No _____ Employee No _____

Account Name _____
 Tax ID _____ Group No _____ Writing No. _____

3. DEDUCTION INFORMATION

Employer Contributions: Does the employer pay any portion of this benefit? Yes No

If yes, please provide percent _____% OR flat dollar amount \$ _____

Percent or dollar amount must be a whole number, such as "50%" or "\$10 "

Based on the information provided in this section, Aflac will determine the number of deduction periods billed each month (when the account selects monthly billing).

If you choose monthly billing frequency, indicate the number of payroll deductions made annually for insurance premiums. For all other billing frequencies, mark N/A: 52 26 24 12 N/A

Check if premiums are deducted at different frequencies for different employees (i.e., some employees are deducted weekly while others are deducted biweekly), and indicate the different frequencies that exist for the account on separate M-0138 applications

Initial Deduction: When will premium deductions begin?

Date of first deduction _____/_____/_____ Date of second deduction _____/_____/_____

The date of the first deduction should reflect the date the payroll account physically obtains funds from the employees. It does not necessarily equal the pay date for the employees.

4. INFORMATION CONCERNING TAX STATUS OF DISABILITY INSURANCE BENEFIT PAYMENTS

If disability coverage is funded by employer contributions, pre-tax employee contributions, or a combination of these two, then the disability benefits an employee receives upon becoming disabled will be includible in the employee's income and are fully taxable when paid. In addition, FICA taxes must be withheld and paid on all such benefits during the first six months after the disability. Where, as noted below, coverage is funded by employer contributions or employee pre-tax contributions, Aflac will notify the employer of the amount of disability benefits paid, from which the employee's portion of FICA taxes is withheld and will deposit such taxes with the government as required by the Internal Revenue Code. **The employer will be required to submit the employer's portion of applicable FICA and FUTA taxes and report the benefit payments on its Form 941 and the employee's Form W-2.**

Employer authorizes disability coverage to be included as part of this agreement: Yes No

- Authorized disability coverage types Accident/Disability Short-Term Disability Off-the-job
- Authorized riders Off-the-job On-the-job Sickness Spouse

Will any portion of disability premiums be funded by employer contributions? Yes No

If yes, please provide percent _____% OR flat dollar amount \$ _____

Percent or dollar amount must be a whole number, such as "50%" or "\$10 "

Will any portion of disability premiums be funded by pre-tax employee contributions? Yes No

This employer is a government employer exempt from FICA or exempt from a portion of FICA. Yes No

Employees of this employer are eligible for RRTA (Railroad Retirement Tax). Yes No

NOTE: Disability caused by or under certain circumstances will not be covered. Refer to each policy to determine specific coverage, exclusions, and limitations.

Please consult with employer's cafeteria plan contact to ensure accurate completion of next section.

Account Name. _____

Tax ID _____ Group No _____ Writing No _____

5. FLEX ONE® CAFETERIA PLAN: New Flex One Plan Flex One Plan Change Request
 Requesting Additional Payroll Account Number for Existing Flex One
Plan/Company Name: _____ Tax ID: _____

Plan Type *What type of Flex One Plan will this be? (Flexible Spending Account = FSA)*

Premium Only – no FSAs Self-Administered – has FSAs, employer processes FSA claims Full – has FSAs, Flex One processes FSA claims

Plan Year. What are the dates of this plan? Plan Start Date ____/____/____ Plan End Date ____/____/____

Plan Sponsor/Legal Representative: *List the plan sponsor and legal representative for this cafeteria plan.*

Plan Sponsor/Principal Contact _____ E-mail address _____

Phone () _____ Fax () _____

Legal Representative's Name/Title _____

Is this a leasing company or Professional Employee Organization (PEO)? Yes No

Business Type Corporation Sub S Corporation Partnership Sole Proprietorship Other _____

Eligibility *Indicate eligibility criteria (e.g., eligibility dates, exceptions) for your cafeteria plan*

- Employees will become eligible Immediately upon the first day of employment
 On the ____ day following commencement of employment
 On the first day of the month following ____ days of employment
Other _____

All employees will be eligible under the plan except _____

Cafeteria Plan Benefits *(To add, account must be qualified under Section 106 of the Internal Revenue Code)*

Check plans to add

- Medical Long-Term Disability Vision Care Intensive Care Short-Term Disability Accident
 Cancer Hospital Indemnity Dental Group Term Life Specified Health Event Personal Sickness Indemnity
 HSA (Section 223)

Affiliated Companies *List the names and tax ID numbers of all affiliated companies adopting this plan.*

Company Name	Tax Identification Number

6. FLEXIBLE SPENDING ACCOUNT (FSA) INFORMATION (not applicable to Premium-Only Plans)

FSA Type. *Which types of FSAs will be included in this cafeteria plan? (Complete for both self-administered and full plans.)*

- Section 105 Unreimbursed medical expense annual maximum per participant requested by employer \$ _____
 Select to include Grace Period option for this benefit
 Section 129 Dependent child care annual maximum per participant cannot exceed \$5,000 by law
 Select to include Grace Period option for this benefit

Medical Plan Copay Information: *(Complete this section only if participating in unreimbursed medical.)*

This information may be used to assist in adjudicating employee unreimbursed medical claim requests. Please select all copay amounts below that apply to your company's medical benefit plan(s)

Doctor/Office Visit Copays:

\$5 \$10 \$15 \$20 \$25 \$30 \$35 \$40 \$45 Other \$ ____ Other \$ ____

Pharmacy/Rx Copays

\$5 \$10 \$15 \$20 \$25 \$30 \$35 \$40 \$45 Other \$ ____ Other \$ ____

Complete account type only if Full Plan is selected in Section 5.

Account Type *If you selected Flex One to process your FSA claims, you must establish an account from which Flex One will draw funds for claim payments. No banking option is required for self-administered plans.*

Local Zero Balance Account. You establish a local bank account against which Flex One is authorized to write checks for the sole purpose of paying participant claims. With this option, reimbursements can be issued **within 2-3 business days.**

Aflac Now CardSM *(check to include FSA payment card feature).*

ACH Debit: You authorize Flex One to initiate funds transfers from a specified bank account for the sole purpose of paying participant claims. With this option, reimbursements can be issued **within 5-7 business days.** The Aflac Now card is not available with this option.

Self-Pay: Upon notification by Flex One, you issue reimbursement checks to participants. Reimbursements are issued according to your time frame because you are responsible for disbursement. Direct Deposit is not available through Flex One with this payment option. The Aflac Now card is not available with this option.

*Please note that the time frame for the issuance of reimbursements is subject to the processing schedule chosen by the employer and the employer's response time for funding payment amounts.

Please consult with employer's cafeteria plan contact to ensure accurate completion of next section.

Account Name _____
Tax ID _____ Group No _____ Writing No _____

7. OTHER CARRIER'S (not FLEX ONE®) CAFETERIA PLAN INFORMATION

Current plan year dates required _____ / _____ / _____ through _____ / _____ / _____

If short plan year, renewal dates required _____ / _____ / _____ through _____ / _____ / _____

Authorization to Add Benefits Mid-Year (Complete ONLY if adding benefits to a non-Flex One cafeteria plan at mid-year.)

Effective Start Date of Additional Benefits _____ / _____ / _____ Effective End Date _____ / _____ / _____

Benefits (check new benefits to be added)

- Medical Long-Term Disability Vision Care Intensive Care Short-Term Disability Accident
- Cancer Hospital Indemnity Dental Group Term Life Specified Health Event Personal Sickness Indemnity
- HSA (Section 223)

8. ASSOCIATE/AGENT

I acknowledge that Aflac has the sole and absolute right to determine who shall solicit and service payroll deduction accounts, and Aflac may assign and/or reassign any account for servicing and designate who may solicit applications from persons in the account. I confirm that I am not an employee, officer, director, owner, or relative of any of the foregoing (or otherwise a "party in interest" as defined under ERISA). I acknowledge that, for Key Accounts as defined in the Key Account Management Procedures, the proper guidelines will be followed to provide the most efficient service to the account. I confirm that I will register any such account with Key Account Management regardless of whether I use their assistance in the overall management and coordination of the enrollment. I understand that I am not authorized to collect premium from this account without specific written approval from Aflac.

Associate's/Agent's Signature _____ Date _____

Associate's/Agent's Name: _____

Writing Number _____ Sit Code: _____ Geographical Code: _____

Phone Number () _____ Fax Number () _____

Broker's Name (if applicable): _____

Broker's Number _____ Sit Code _____ Level _____

AMP. Yes No

**9. AUTHORIZATION AND SIGNATURES
EMPLOYER**

Aflac assures you that you will be reimbursed without question for premium you advance for any employee who terminates after the premium is remitted but before payroll deductions commence. Aflac also agrees to hold you harmless from any claims against you due to any disagreements between your employees and our company with respect to the coverage provided under our insurance policies issued to your employees except where caused by misconduct or negligence committed by you or any of your employees or violations of your responsibilities under state or federal laws.

The employer agrees to provide Aflac (and its agents) with certain personally identifiable information (including, but not limited to, compensation, Social Security numbers, addresses, etc.) regarding its officers and employees for Aflac (and its agents) to use in the administration of employer's cafeteria (including health and dependent care FSA) plan and Aflac products and services.

Aflac is authorized to offer this insurance program to our officers and employees. I understand that all applicants must qualify for coverage based on each product's underwriting requirements and that payments for such coverage will be deducted from wages and remitted by my organization to Aflac.

Check if Establishing Flex One Account The employer plans to establish/amend a flexible benefits plan in accordance with Section 125 of the Internal Revenue Code. The employer acknowledges that neither Aflac nor its agents are providing legal or tax advice, nor serving as the plan administrator or a plan fiduciary under the plan. The employer shall be the sole party responsible for establishment of the plan under applicable law. Aflac shall have no power or authority to waive, alter, breach, or modify any terms and conditions of the plan. The employer shall retain all responsibility and liability for the plan, except as may otherwise be specifically agreed to in writing by an officer of Aflac. The plan sponsor/administrator should consult its own tax advisor regarding the plan and any changes to the plan. The employer acknowledges receipt of the Summary of Plan Sponsor Responsibilities and agrees to fulfill its responsibilities as stated therein.

Authorizing Officer's Name/Title (please print). Mr. Ms _____

Authorizing Officer's Signature _____ Date: _____

Account Name _____
Tax ID _____ Group No _____ Writing No _____

Group Short-Term Disability Insurance

Number of Eligible Employees at Company _____ Participation Requirements (%) _____
(A minimum of 30 percent participation is required for all eligible employees.)

Guaranteed-Issue Only:

Benefit Amount	\$
Elimination Period (Injury/Sickness)	
Benefit Period	

Simplified-Issue Only:

Benefit Amount	\$
Elimination Period (Injury/Sickness)	
Benefit Period	

Group Short-Term Disability Approval Date _____ / _____ / _____

Group Short-Term Disability Withdrawal Date _____ / _____ / _____

Dental Requirements

Dental Plan Start Date _____ / _____ / _____

Dental Plan Stop Date _____ / _____ / _____

Number of Eligible Employees for Dental at Company _____ Participation Requirements _____

Long-Term Care Requirements

Long-Term Care Plan Start Date _____ / _____ / _____

Long-Term Care Plan Stop Date _____ / _____ / _____

Revised Personal Short-Term Disability

Exempt from Standard Salary Income Chart _____

Accident/Disability Revised Income Replacement

Exempt from Standard Salary Income Chart _____

REIMBURSEMENT SERVICES AGREEMENT

This Agreement, effective upon execution for the Plan Year, by and between [-----Group Name-----] (the "Employer") and American Family Life Assurance Company ("Aflac")

WITNESSETH:

WHEREAS, the Employer has adopted a Medical Care Expense Reimbursement ("URM") Plan and/or a Dependent Care Expense Reimbursement ("DDC") Plan for its Employees in conjunction with its Flexible Benefits Plan (collectively referred to as the "Plan" and attached hereto) to be adopted and administered in accordance with Sections 105, 125, and 129 of the Internal Revenue Code of 1986, as amended (the "Code"), and

WHEREAS, the Employer will serve as the Plan Administrator, and

WHEREAS, the Employer desires that Aflac, as its agent, furnish reimbursement services within a framework of policies, interpretations, rules, practices and procedures (the "reimbursement practices and procedures") made and established by the Employer in (i) receiving and processing requests for benefits under the Plan ("Requests") and (ii) disbursing benefit payments from Employer funds (as provided for in Section II A.) for eligible expenses under the flexible spending account provisions of the Plan, and

WHEREAS, the Employer is to pay all plan benefits owed or established under the Plan to its Participants, and Aflac is to provide the agreed upon services to the Plan without assuming any such liability,

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, it is hereby agreed as follows

Section I. Enrollment and Determination of Eligibility

A The Employer shall

- (1) be responsible for interpreting the Plan and its provisions, its terms, conditions and operation, and
- (2) notify Plan Participants of their ability to apply for reimbursement benefits and supply them with Request forms (to be provided by Aflac) and Request filing instructions, and
- (3) provide Aflac with the names, addresses, Social Security Numbers, and elected amounts of all participants in the Plan, and
- (4) upon the occurrence of events that would change a Participant's status under the Plan (e.g. termination, Change in Status, Change in Cost or Coverage for DDC, etc.) immediately provide Aflac with updates (via Telefax) which identify eligible Participants in each of the respective reimbursement Plans and/or the amount of reimbursement benefits for which they are eligible, and
- (5) immediately inform Aflac (via Telefax) as to any new Participants in either of the reimbursement Plans, any Change in Status affecting a Participant's election, or any Qualified Beneficiary electing coverage under COBRA and the amount of such election (if COBRA applies to the Employer), or of any other change which will affect Aflac's responsibilities hereunder

B In determining any person's right to benefits under the Plan, Aflac shall rely on the eligibility information furnished by the Employer and any signed statements by Participants regarding the eligibility of their Requests under the respective Plan. It is mutually understood that the effective performance of this Agreement by Aflac will require that it be advised on a timely basis by the Employer during the continuance of this Agreement of the identity of individuals eligible for benefits under each of the respective reimbursement Plans. Information modifying a Participant's eligibility or status/election under either reimbursement Plan shall identify the effective date of eligibility and the termination date of eligibility and shall be provided to Aflac (via Telefax) prior to the effective date of such modification in order to be considered by Aflac in making benefit determinations hereunder. Aflac shall not be responsible for Requests paid in error where the Employer has failed to inform Aflac (in a form and with such information as may reasonably be required by Aflac) of a Participant's eligibility or status change prior to the release of the benefit payment.

Section II. Funding and Payment of Requests for the Plan Benefits

A Daily Processing Option The Employer shall

- (i) make sufficient funds available from its general assets for amounts allocable to eligible reimbursement benefits under its plan by depositing a "Maintenance Deposit" (in amounts specified by Aflac from time to time) in an Employer-owned and named account (the "Account") in a financial institution selected by the Employer and Aflac to facilitate the timely processing of Requests under the Plan [Note the Account should not be opened in the Plan's name], and
- (ii) grant Aflac withdrawal authority over the Account sufficient to enable it to pay benefits under the Employer's FSA Plans, and

- (iii) deposit additional funds (at the request of Aflac) in order to reestablish the Maintenance Deposit at the end of each Request processing cycle (or such earlier time specified by Aflac), and
- (iv) telefax copies of all deposit verification receipts, Account Statements, and other correspondence relating to the Account to Aflac upon receipt of such correspondence from the financial institution, and
- (v) during the term of this Agreement, the Employer shall not withdraw funds from the Account, except at the request of, or to the extent approved by Aflac. The Employer bears sole responsibility for any fees imposed with respect to the Account by the financial institution, including but not limited to Account maintenance fees, insufficient funds fees, fees with respect to voided checks, etc., and
- (vi) authorize Aflac to access the Account by

entering into a Withdrawal Agreement with CB&T, or

if a Financial Institution other than CB&T is designated below, the Employer hereby authorizes Aflac to a) draw benefit checks directly on the Account, b) electronically transfer benefit payments from the Account, c) electronically access Account information, and d) execute the financial institution's standard Deposit/Account Agreement on the Employer's behalf (subject to the terms and conditions set forth herein and as Aflac may otherwise establish) Name, address and contact person at other financial institution

If, at any time, the amount of reimbursement benefits payable under the applicable Plan provisions exceeds the amount deposited by the Employer in the Account, the Employer shall transfer an amount necessary to the Account to fulfill its reimbursement obligations under the applicable Plan before any further reimbursement benefit payment is made. Aflac is under no obligation to advance funds on behalf of the Employer.

B Aflac, as agent for the Employer, shall provide those services described in Appendix A (attached hereto)

Upon written request submitted to Aflac's Flex One Department, Aflac may provide limited assistance with certain of the nondiscrimination tests. The terms and conditions (including applicable fees) under which such services are provided are set forth in Appendix B "Nondiscrimination Testing Services". In providing services, Aflac shall assume that ERISA and COBRA apply to the Employer's Plan unless the Employer gives Aflac written direction otherwise.

C Aflac shall not be obligated or responsible for any duty with regard to the administration of the Plan (imposed by the Plan or otherwise) except as specifically provided above or in the attached appendices. Without limiting Employer's responsibilities described therein, it shall be the Employer's sole responsibility (as Plan Administrator) and duty to ensure compliance with COBRA, perform required nondiscrimination testing, amend the Plan as necessary to ensure ongoing compliance with applicable law, file any required tax or governmental returns (including Form 5500 returns to meet ERISA requirements) relating to the Plan, determine if and when a valid election change has occurred, handle Participant claim appeals, allow Aflac, by and through independent associates, a reasonable opportunity to discuss Aflac, URM, and DDC benefits, execute and retain required Plan and Claims documentation, and take all other steps necessary to maintain and operate the Plan in compliance with applicable provisions of the Plan, ERISA, the Code and other applicable federal and state laws.

D In the event that Aflac overpays any person entitled to benefits under the Plan or pays benefits to any person who is not entitled to them, Aflac shall take all reasonable steps to recover the overpayment, except that Aflac shall not be required to initiate court proceedings to recover an overpayment. Aflac shall promptly notify the Employer if it is unsuccessful in recovering any overpayment.

E Aflac will optically scan and maintain electronic copies of all FSA Reimbursement Requests and supporting documentation for a period of seven (7) years after the claim is processed. Copies of FSA claim documents can be reproduced upon written request at Aflac's currently prevailing rate.

Section III. Liability and Indemnity

A In performing its obligations under this Agreement, Aflac neither assumes nor underwrites any liability of the Employer under the Plan, but with respect to the Employer, acts only as provider of those services specifically described in Section II B of this Agreement and with respect to Plan Participants, acts only as the agent of the Employer. The services to be performed by Aflac shall be ministerial in nature and shall be performed within the framework of policies, interpretations, rules, practices, and procedures made or established by the Employer. Aflac shall have no discretionary authority or discretionary control over any assets of the Employer, the Plan, or Plan Participants.

- B Aflac shall have no duty or obligation to defend any legal action or proceeding brought to recover a Request for Plan Benefits. Aflac shall, however, make available to the Employer and its counsel, such evidence relevant to such action or proceeding as Aflac may have as a result of its processing of the contested benefit determination.
- C Except as otherwise explicitly provided in this Agreement, the Employer shall retain the liability for all Plan Benefit Requests and all expenses incident to the Plan and for any and all violations of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), if applicable, and agrees to indemnify Aflac for and hold it, its directors, officers, and employees, harmless from all amounts and expenses (including reasonable attorneys' fees and court costs) for which Aflac may become liable. This indemnity shall survive the termination of this Agreement.
- D Aflac shall use ordinary and reasonable care in the performance of its duties, but shall not be liable to the Employer for mistakes of judgment or other actions taken in good faith unless such error results directly from an intentionally wrongful or grossly negligent act of Aflac, its officers or employees.
- E Aflac shall have no duty or obligation with respect to Requests incurred prior to the effective date of this Agreement (hereafter "Prior Reimbursement Requests") and/or Plan Administrator (or other) services arising prior to the effective date of this Agreement regardless of whether such services were/are to be performed prior to or after the effective date of this Agreement (hereafter "Prior Administration"). The Employer specifically acknowledge(s) and agree(s) that (i) Aflac has no responsibility or obligation with respect to Prior Reimbursement Requests and/or Prior Administration, (ii) the Employer will be responsible for processing Prior Reimbursement Requests (including any Run Off Requests submitted after the effective date of this Agreement) and maintaining legally required records of all Prior Reimbursement Requests and Prior Administration sufficient to comply with applicable legal (e.g., IRS substantiation) requirements and (iii) the Employer agrees to indemnify and hold Aflac harmless for any liability relating to Prior Reimbursement Requests and/or Prior Administration.
- F The Employer agrees that Aflac may communicate confidential, protected, privileged or otherwise sensitive information to Employer through the Named Contact (as designated on the applicable plan document request form) and specifically agrees to indemnify Aflac and hold it harmless (i) for any such communications directed to the Employer through the Named Contact attempted via telefax, mail, telephone, e-mail or any other media, acknowledging the possibility that such communications may be inadvertently misrouted or intercepted; and (ii) from any claim for the improper use or disclosure of any health information by Aflac where such information is used or disclosed in a manner consistent with its duties and responsibilities under this Agreement.

Section IV. Reimbursement Request Processing Service Fee

- A The Employer shall pay Aflac a fee for services performed under this Agreement in the amount of \$#.## per Participant per FSA benefit (DDC or URM) per month (max per Participant of \$#.##) with a minimum monthly fee of \$##.## for the reimbursement Plans (URM and/or DDC) for which services are rendered. This amount shall be due by the tenth (10th) of each month (or portion thereof) for which this Agreement is in effect and is in addition to and separate from (i) any Account Establishment (or "Set-Up") fee assessed by Aflac of \$###.## to initiate the reimbursement arrangement, and (ii) the Employer's obligation to make available sufficient funds to satisfy its obligations under the Plan and to make benefit disbursement in accordance with section II A above. The Employer is responsible for paying the Service Fee to Aflac. Aflac is not authorized to withdraw the Service Fee from the Account. Failure to pay any applicable monthly Service Fee by the next monthly Request processing cycle shall result in a cessation of Request processing services until such fees are received by Aflac. If Request processing services are pended for an entire monthly processing cycle, Aflac may terminate this Agreement in accordance with Section VI.
- B Aflac may revise the Service Fee for services performed under this Agreement effective on each Anniversary Date of this Agreement by giving the Employer written notice of the revised rate at least thirty (30) days prior to the applicable Anniversary Date.
- C Notwithstanding any other agreement between the parties (and/or their agents), Aflac may revise the Service Fee set forth above at any time if revision is deemed necessary by Aflac by reason of (i) modification or amendment of the Plan by the Employer, (ii) a significant decrease in the number of Aflac policies purchased by Participants under the Plan below the number initially included in the Plan after the Service Fee was established (or if later, when the Service Fee was last revised), or (iii) a suspension, limitation, or revocation of the right of Employees or Participants to purchase Aflac policies under the Plan. Aflac shall advise the Employer of the revised Service Fee at least thirty (30) days prior to its implementation. If the Employer does not terminate this Agreement (by written notification pursuant to Section VI A 1) within thirty (30) days after the receipt of a notice of such revision, the Employer shall be deemed to have agreed to such revision for the remainder of the term of the Agreement. Thereafter, the Service Fee on and after the implementation date shall be made on the basis of such revised Service Fee.
- D Aflac may revise the Service Fee set forth above at any time if any change in law or regulations imposes on Aflac greater duties or obligations than contemplated by the Agreement in force at the time of such change.

Section V. Term of Agreement

The initial term of this Agreement shall be the initial Plan Year commencing on the effective date hereof, thereafter, this Agreement will automatically renew for successive periods of twelve (12) months unless, at least thirty (30) days prior to the end of the then current term, the Employer or Aflac gives written notice to the other of its intention not to renew the Agreement. In the event of a short Plan Year (other than the first Plan Year) this Agreement shall automatically renew for an additional twelve (12) months unless the Employer or Aflac gives written notice to the other of its intention not to renew the Agreement within three (3) days after the Employer notifies Aflac of the short Plan Year.

Section VI. Termination of Agreement

A This Agreement shall terminate upon the earliest of the following dates:

- (1) The end of a term of the Agreement following the delivery of written notice of termination pursuant to Section V
- (2) At the option of Aflac, the date upon which the Employer fails to transfer sufficient funds to Aflac (upon request by Aflac) (i) to pay all valid Requests pending under the Plan, or (ii) to pay the Service Fee (as provided in Section II A and IV A above, respectively). Aflac shall promptly communicate its election of this option to the Employer.
- (3) Upon the implementation date for a proposed Service Fee increase deemed to be unacceptable by the Employer (after delivery of written notice of termination by the Employer) pursuant to Section IV C.
- (4) At the option of Aflac, if no Plan Participant is an Aflac policyholder or if the Employer denies Aflac a reasonable opportunity (as determined by Aflac in its sole discretion) to meet with Employees, Aflac shall immediately communicate its election of this option to the Employer.
- (5) Any other date mutually agreeable to the Employer and Aflac.

B Upon termination of this Agreement, Aflac shall cease the processing of all Requests then in its possession, return any undistributed funds to the Employer, and make all records relating to Requests in process reasonably available to the Employer. If the termination occurs pursuant to VI A 1 (above), Aflac shall process all Run-Off claims provided any Service Fee(s) is current. Thereafter, the Employer and/or Plan Administrator shall be responsible for all aspects of Reimbursement Request processing and Plan administration.

Section VII Miscellaneous

- (1) **Notices** Any notice required to be given hereunder to Aflac shall be sufficient if in writing and delivered personally or by prepaid first class mail to Aflac Benefit Services/Flex One, 1932 Wynnton Road, Columbus, GA 31999-9950, or if to the Employer, at the address of the Employer denoted on the signature page attached hereto.
- (2) **Applicable Law** This Agreement shall be governed by, and shall be construed in accordance with the laws of the State of Nebraska, to the extent they are not preempted by ERISA, the Code, or any other federal law.
- (3) **Legal and Tax Status** The Employer acknowledges that neither Aflac nor its agents is providing legal or tax advice, and that neither Aflac nor its agents serves as the Plan Administrator or a fiduciary under the Plan. The Employer shall be the sole party responsible for determining the legal and tax status of the Plan under applicable law. Aflac shall have no power or authority to waive, alter, breach, or modify any terms or conditions of the Plan.
- (4) **Assignment** This Agreement may be assigned by Aflac to any other party, including any successor to the business of Aflac by merger, consolidation, purchase of assets, or otherwise, without the prior consent of the Employer. This Agreement shall be binding upon any corporation into which the Employer may be merged or with which it may be consolidated, or any corporation succeeding to all or substantially all of the business of the Employer.
- (5) **Entire Contract** This Agreement constitutes the entire contract between the parties and no modification or amendment hereto shall be valid unless in writing and signed by an officer of the Employer and an Officer or duly authorized representative of Aflac.
- (6) **Tax Reporting and Withholdings** The Employer has ultimate control over the payment of Plan benefits and shall be the sole party responsible for income and employment tax reporting and withholding obligations imposed as a result of the includability of such payments in the gross income of recipients. Aflac is a mere agent of the Employer for the processing of benefit Requests.
- (7) **Confidential Information** The term "Confidential Information" as used in this Agreement means confidential or proprietary information of any party that is not generally known to the public, including, but not limited to, compilations, lists of actual or potential customers or suppliers, hardware systems, software, or other documentation of any type, whether in printed or machine readable form, computer databases, forms and form letters, contracts, information regarding specific transactions, and marketing and business plans. For the purposes of this subsection, Confidential Information shall not include the personally identifiable information relating to any of Employer's employees.

The term "Trade Secrets" as used in this Agreement shall mean Confidential Information that (1) derives economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use, and (2) is the subject of efforts that are reasonable under the circumstances to maintain its secrecy. The terms "Confidential Information" and "Trade Secrets" do not include information that (a) is known to the receiving party prior to its disclosure by the disclosing party, evidenced by the receiving party's written records, (b) is developed by the receiving party independently of any of the Confidential Information or Trade Secrets received in confidence from disclosing party, evidenced by the receiving party's written records, (c) is rightfully received by the receiving party from a third party without restriction and without breach of any obligation of confidentiality running to the disclosing party.

Each party agrees that it shall not disclose to others or use for any purpose other than performance of the Agreement any of the other party's Confidential Information or Trade Secrets any time during or after the term of this Agreement. Each party further agrees that it will disclose Confidential Information or Trade Secrets to its employees only as necessary for the performance of the Agreement, and only to employees with a need to know. Each party to this Agreement agrees that all Confidential Information and Trade Secrets are the property of the party disclosing it, and each agrees to promptly return to the disclosing party, upon demand, any Confidential Information or Trade Secrets furnished under this Agreement which is either received in or reduced to material form, and all copies thereof. The Employer agrees that Aflac may make lawful references to Employer in its marketing activities.

- (8) Individual Information. Each party acknowledges that performance of the Agreement may involve the use and disclosure of personal information relating to the Employer's employees (including but not limited to names, addresses, benefit elections, claims and health information). Aflac agrees that it will not use any such information disclosed to it by Employer except as authorized by the individual to whom the information relates or as otherwise permitted by applicable state or federal law or regulation. Employer agrees that it will not use any such information disclosed to it by Aflac except for the purpose for which it received the information and will not further disclose such information without the written authorization of the individual to whom the information relates. This provision is not intended to create any third party beneficiary rights (in favor of Employer's employees or any other party).
- (9) Capitalized Terms shall have the same meaning as in the Plan Documents.

SAMPLE

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed and signed by an Officer of the Employer and an Officer or duly authorized Worldwide Headquarters Employee of Aflac to do so

Dated at Aflac this _____ day of _____

By __[SAMPLE - NOT AN EXECUTABLE CONTRACT] _____
Jason A Goodroe
Second Vice President
Aflac Benefit Services/Flex One

Dated at _____ this _____ day of _____

By __[SAMPLE - NOT AN EXECUTABLE CONTRACT] _____

Street Address _____

SAMPLE

**Appendix A
Schedule of Services to Be Provided By Aflac**

In accordance with attached Reimbursement Services Agreement Aflac shall provide the following services for the Employer:

General Plan Services

- provide the Employer with a sample cafeteria plan document, including a medical care expense reimbursement ("URM") Plan and a dependent care expense reimbursement ("DDC") Plan to be reviewed by the Employer and its legal counsel, and
- provide the Employer with a sample flexible benefits summary plan description for distribution to each Plan Participant and employees and where may be required by a Change in Status, and
- upon receiving instructions from the Employer on a Change in Status, Aflac will make the change requested by the Employer

Additional Services if DDC or URM Benefits Are Offered:

- assist the Employer in explaining the URM and/or DDC features of the cafeteria plan to employees, and
- process the Employee-executed Salary Redirection Agreements as they relate to the URM and DDC components of the Employer's flexible spending account, and
- prepare an enrollment confirmation letter and send it to the Employer to verify URM and DDC elections, and
- provide each URM and/or DDC Participant with an Explanation of Benefits and account balance statement with each reimbursement request, at the end of each quarter (based on Plan Year) if no reimbursement requests are received, and at the end of each Plan Year, and
- provide the Employer with monthly written reports summarizing the previous period's URM and/or DDC and Account activities, and
- receive Requests for URM and/or DDC benefits, and expeditiously review such Requests to determine what amount, if any, is due and payable with respect thereto, and
- disburse the benefit payments it determines to be due (provided the Employer transfers sufficient funds to Aflac or has sufficient funds in the Account), notify the Employer of the benefit determination in accordance with the provisions of the Plan and the following procedures
 - valid reimbursement for URM and/or DDC benefits shall be paid by Aflac on the date funds are received from the Employer (with respect to such Requests) by mailing a check to the Participants at their addresses (unless otherwise requested by the Employer as allowed by the terms of the Plan) or by initiating a direct deposit transfer directly to the Participants in their respective bank accounts in the appropriate amount(s), and
 - if the amount of the (otherwise) reimbursable DDC Request exceeds the amount the Participant had withheld for DDC benefits, the excess shall be carried forward (within the same Plan Year) and treated as an Eligible Employment-Related Expense for that month, and
 - if the amount of URM Requests exceeds the amount the Participant has had withheld from URM benefits, the entire amount shall be processed to the extent of the Participant's annual election reduced by previous reimbursements made for expenses during the Plan Year (provided the Employer makes available sufficient funds for Aflac to satisfy the Request), and
 - Requests of less than \$15 00 may be carried forward and aggregated with future Requests until the reimbursable amount is greater than \$15 00, provided however, that the entire amount of the reimbursable Requests shall be paid after the close of the Plan Year (and any applicable grace period) without regard to the \$15 00 threshold, and
 - unless otherwise specified in writing by the Employer, Health FSA claims following a Change in Status impacting the Health FSA election shall be processed using a "blended approach" (i.e., the maximum Health FSA benefit for a period of coverage following a Change in Status will be limited to the lesser of (a) the annual Health FSA maximum set forth in the Plan document less any benefit payments made prior to the Change in Status, and (b) the sum of the Participant's Health FSA Account balance immediately before the Change in Status and any additional contributions made during the remaining period of coverage), and

- notify claimants as to any Requests which are denied because of inadequate Request substantiation or improper Request form submission, and give affected claimants the opportunity to resubmit their Requests, and
 - provide to the claimant within thirty (30) days following receipt of a Request, written notification (a) as to the disposition of the Request, or (b) of an anticipated delay beyond thirty (30) days, not to exceed 15 days from the end of the 30-day period, with respect to the disposition of the Request together with an explanation of the delay, and
 - notify the claimant and refer to the Employer (with an analysis of the issues affecting the Request) for final decision, any Requests which Aflac deems not to be reimbursable pursuant to the terms of the Plan and/or the reimbursement practices and procedures established by the Employer, setting forth the applicable review procedure available to the claimant through the Employer
- Aflac will perform grace period administrative services in accordance with the following terms with regard to Requests received on or after the later of the effective date of the grace period as identified or the date this Agreement is received by Aflac. The grace period has been extended for
- Medical Care Reimbursement Plan ("URM") and/or
 - Dependent Care Reimbursement Plan ("DDC")
- The grace period applies to the Medical Care Reimbursement Plan ("URM") and/or Dependent Care Reimbursement Plan ("DDC") (as noted above)
 - The grace period will begin on the first day of the Plan Year following the Plan Year to which it relates and will end two (2) months and fifteen (15) days later. For example, if the Plan Year ends December 31st, the grace period begins January 1st and ends March 15th
 - Eligible Medical Expenses and/or Eligible Employment-Related Expenses incurred during the grace period (as noted above) and approved for reimbursement will be paid first from available amounts that were remaining at the end of the Plan Year to which the grace period relates and then from any amounts that are available to reimburse expenses incurred during the current Plan Year
 - Claims will be paid in the order in which they are received. Previous claims will not be reprocessed or recharacterized so as to change the order in which they were received
 - Expenses incurred during the grace period (as noted above) must be submitted before the end of the Run-off Period. This is the same Run-off Period for expenses incurred during the Plan Year to which the grace period relates
 - The Employer will not amend/change their Run-off Period without first notifying Aflac at least one (1) month prior to the end of the existing Run-off Period and that an amendment to the plan's existing Run-off Period may result in additional service fees. Aflac will continue to assume that your current Run-off Period still applies unless notified otherwise prior to the end of the Run-off Period. If your current Run-off Period does not extend past the grace period, Aflac will assume that there is no Run-off Period for grace period expenses. Failure to timely notify Aflac of any changes in the Run-off Period may result in an increase in the service fees as set forth in Section V of the RSA
 - Any unused amounts that are not used to reimburse eligible expenses incurred either during the Plan Year to which the grace period (as noted above) relates or during the grace period will be forfeited if not submitted for reimbursement before the end of the Run-off Period

Appendix B
Nondiscrimination Testing Services
[Provided Upon Annual Request]

Nondiscrimination Testing:

The Employer, upon submission of an annual Employee Census Data Sheet, authorizes Aflac to compile nondiscrimination testing percentages based upon the employee census data provided. As consideration for this service, the Plan Sponsor/Administrator agrees to release and hold Aflac, its subsidiaries, affiliates, officers, directors, owners, shareholders, attorneys, successors and assigns harmless from any liability arising as a result of the provision of, or reliance upon such testing percentages. In addition, the Employer understands and agrees that

- Aflac is not in the business of providing legal or tax advice, and the Employer, as the plan sponsor/administrator, will not construe the testing percentages provided by Aflac to be legal or tax advice. Accordingly, the Employer will seek the advice of its own tax or legal advisor to interpret and verify the testing percentages provided, and ensure compliance with applicable nondiscrimination requirements.
- The Employer bears sole responsibility for nondiscrimination testing and the continued qualified status of its cafeteria plan under all applicable provisions of the Internal Revenue Code.
- The testing percentages provided by Aflac are merely an indicator of compliance with three of the applicable nondiscrimination tests - the Cafeteria Plan 25% Key Employee Concentration Test, the Dependent Care 5% Shareholder Test, and the Dependent Care 55% Average Benefits Test. Each Employer must also ensure compliance with the Eligibility Test and Contributions and Benefits Test applicable to the Cafeteria Plan, the URM, and the DDC Plan, as well as other tests that may apply to the benefits offered through the Cafeteria Plan. To ensure compliance with applicable provisions of the Internal Revenue Code, additional nondiscrimination testing and result verification must be undertaken by the Employer with the assistance of its tax or legal counsel.
- Discrimination testing should be conducted at least 180 days prior to the end of the Plan Year to which the data relates to ensure adequate time to make any required corrections. Aflac will assist with discrimination testing no less frequently than once per year and no more frequently than once every thirty (30) days.

SAMPLE

**Aflac Reimbursement Services Agreement
Card Service Appendix**

[-----Group Name-----] (the "Employer") has established a Medical Care Reimbursement Plan (the "URM Plan") to allow participants to be reimbursed for eligible URM medical expenses. Aflac has the capability, in conjunction with its card provider, to provide a prepaid debit card service that is designed to process certain transactions electronically in the Employer's URM Plan by allowing participating employees to use an electronic payment card (the "Card") to purchase certain health care services and products from hospitals, physicians, health care professionals, and other eligible health care providers and merchants, as designated under the Employer's URM Plan.

Employer has asked Aflac to assist it with its administrative obligations related to processing claims via electronic payment card under the URM Plan. Assistance will only be provided with respect to a URM Plan for which Aflac has provided the sample plan documentation or, if Aflac's sample plan documentation is not utilized, then only such URM plan identified by the Employer and agreed to by Aflac pursuant to separate written notice.

This Aflac Reimbursement Services Agreement Card Services Appendix (the "Card Services Appendix") is incorporated into and made a part of the Aflac Reimbursement Services Agreement (the "Agreement"). The effective date of this Card Services Appendix is the effective date of the Agreement or if later, the date indicated in this Card Services Appendix. The responsibilities of the parties set forth in this Card Services Appendix are in addition to any responsibilities set forth in the Agreement. If there is a conflict between this Card Services Appendix and the Agreement, the Agreement controls.

In consideration for the mutual promises set forth below, the Employer and Aflac agree as follows:

<p><u>I. Standard Services</u></p> <p>Aflac will provide services as outlined below in Sections 1, 2, 3 and 4.</p>
<p><u>Standard Fee</u></p> <p>The Employer shall pay Aflac the greater of the monthly fees set forth in the Agreement or the fees indicated below.</p> <p>The Employer shall pay Aflac a fee for services performed under the Agreement and this Card Services Appendix in the amount of \$# ## per Participant per FSA per month (max per Participant of \$# ##) with a minimum monthly fee of \$## ## for the reimbursement Plans (URM and/or DDC) for which services are rendered. In all other respects, the Agreement shall control.</p>

In consideration for the services provided by Aflac in accordance with this Card Services Appendix, Employer agrees to pay to Aflac the applicable fees set forth above. The Employer will make sufficient funds available to pay the fees in accordance with the method set forth in the Agreement.

Section 1. Definitions

- A Card Transaction means when the Card is presented for payment of Eligible Medical Expenses.
- B Eligible Medical Expenses shall be defined in the URM Plan.
- C Benefit Plan Participants or Participants means employees and their dependents that are participating in the URM Plan.
- D Flexible Spending Account ("FSA") means a health flexible spending account, as provided through the URM Plan.
- E Employee means those employees eligible to participate in the URM Plan.
- F Account is the Employer-owned bank account from which reimbursements are made.
- G Card or Cards means the electronic payment card provided by Aflac or by the card processor.

Section 2. Aflac Responsibilities

- A Unless otherwise specified above, Aflac does not currently charge additional service fees to Participant FSA Accounts for its card-related services. Notwithstanding any provision in the Agreement or this Card Services Appendix, Aflac reserves the right to begin charging fees to Participant FSA Accounts upon ninety (90) days notice.
- B Aflac shall provide administrative services to Employer on behalf of Participants, including updating Participant's records, maintaining accurate Account balances, and FSA contribution information, activating and deactivating Participant Cards, responding to Participant inquiries and providing appropriate notices regarding Participant FSAs and actions taken in relation thereto.
- C Aflac shall provide administrative services to Employer, including maintaining accurate URM Account balance information, providing reports of Account activities and initiating draws (either directly or through its authorized agent) against an Account designated by the Employer to fund reimbursement transactions and maintain Account balances at the agreed-upon levels.
- D Aflac will provide call center support, subject to its standard hours of operation, for Participants to report lost or stolen Cards, and resolve all servicing issues related to the Card, except transaction or merchant disputes.
- E Aflac will make available to the Employer, for distribution to the Participants, information concerning proper use of the Card.

- F Aflac will use its best efforts to operate the Electronic Payment Card Program (the "Card Program") in accordance with IRS guidance applicable to debit card processing of Eligible Medical Expenses as set forth in Revenue Ruling 2003-43, IRS Notice 2006-69, IRS Notice 2007-02, and any applicable IRS regulations or additional guidance published by the IRS (collectively "IRS Card Guidance") Aflac shall not be responsible for debit card processing that is conducted at the direction of the Employer or in accordance with card processor's standard procedures If either Employer or Aflac has concerns that the card processor is not operating in accordance with IRS Card Guidance, either party may terminate this Card Services Appendix without penalty upon thirty (30) days notice

Section 3. Employer Responsibilities

- A Employer acknowledges that Card services are not generally available to certain persons, including, but not limited to, those ineligible to participate in Employer's URM Plan, non-employees, terminated employees, persons participating through COBRA, and certain employees on leave from employment and on disability (collectively, "Ineligible Persons") Employer agrees to notify Aflac (as specified in the Agreement) if a Participant becomes an Ineligible Person
- B Employer agrees to sufficiently fund the Account, in advance, in an amount to be specified by Aflac from time to time) in a checking account in the Employer's name at a financial institution mutually agreeable to Employer and Aflac (the "Maintenance Deposit") to ensure adequate funding for the payment of Card Transactions as they occur The Maintenance Deposit may be increased depending on the timing and level of Card Transactions
- C The Employer shall deposit additional funds in the Account (at the request of Aflac) in order to reestablish the Maintenance Deposit at the end of each claim processing cycle
- D Each day that Card Transactions are paid from the Account, Employer authorizes Aflac to initiate a draw (either directly or through its authorized agent) from a designated Employer account to restore the Account to the Maintenance Deposit level
- E Employer will provide a mechanism to deduct any ineligible Card Transactions through payroll that have not been offset against other valid Eligible Medical Expenses or repaid to the Account by the Participant through check or money order, or if this is prohibited by law, to alternative agree to accept the loss as part of the risk of the URM Plan
- F Employer agrees to notify Aflac of Employee termination in a timely manner
- G Employer agrees that the cost of all Card Transaction and claims arising under the URM Plan shall be paid by the Employer's contributions to the Account The liability for payment of claims falls on the Employer or the Plan Participant, and not on Aflac Any additional costs, including administrative costs and banking costs, shall be paid by the Employer or Plan Participant In no event shall Aflac be responsible for any such costs or charges If, at any time, the amount of reimbursement benefits payable under the applicable Benefit Plan provisions exceeds the amount deposited by the Employer in the Account, the Employer shall transfer an amount necessary to the Account to fulfill its reimbursement obligations under the applicable Plan before any further reimbursement benefit payment is made Aflac is under no obligation to advance funds on behalf of the Employer
- H Employer agrees to notify Aflac immediately upon suspicion of inappropriate or fraudulent Card use Plan Participants must comply with the terms outlined within their Cardholder Agreement relating to inappropriate or fraudulent Card use
- I Employer acknowledges that Card usage for the URM Plan is subject to the IRS Card Guidance, which may include, without limitation, restrictions on the amount a Participant may charge, which merchants may accept the Card, and the type of expense that may be charged and other legal requirements Employer acknowledges that, despite such usage restrictions imposed by the IRS, the Card may cause payments to be issued for expenses that do not represent eligible URM Plan expenses Employer agrees Aflac may not be held responsible for Employer losses or any tax consequences due to payments for ineligible expenses Employer acknowledges that state or other laws may govern whether and to what extent it may recoup ineligible payments by withholding such amounts from Employee pay
- J Employer acknowledges that Card Transactions will only be applied to the URM Plan's current plan year, unless otherwise formally communicated to the Employer, in writing by an officer of Aflac In the absence of such an election, Employer agrees to communicate to Participants that Card Transactions will only apply to the URM Plan's current plan year and the Card should not be utilized by Participants to exhaust any remaining FSA benefits for the previous plan year during any applicable grace period Employer will instruct Participants that grace period expenses must be submitted for consideration under the Plan utilizing the Request for Reimbursement form
- K Employer agrees that it may be liable for disputed Card payments if such disputes are subsequently resolved by VISA or MasterCard in favor of the merchant that provided the goods or services
- L Employer agrees to administer the URM Plan in accordance with the rules and regulations of the URM Plan and IRS Card Guidance
- M Employer agrees to provide to Aflac in a timely fashion all information for any reports or other documents required by law, including but not limited to the rules and regulations promulgated by the U S Department of Labor and the Internal Revenue Service It is Employer's responsibility to ensure that it complies with all applicable tax and other laws

Section 4. Administration

Aflac will administer the Card as follows

- A Aflac or the Card service provider chosen by Aflac will provide a Card to each Participant in the URM Plan
- B Aflac will provide each participant with reimbursement forms and instructions for filing requests for benefits under the URM Plan ("URM Requests"), and
- C Aflac will provide each Participant with written monthly reports summarizing the previous period's URM Plan Card activities, and receive electronic and/or paper URM Requests, and expeditiously review such URM Requests to determine what amount, if any, is due and payable with respect thereto, and
- D Aflac will disburse the benefit payments it determines to be due (provided the Employer has sufficient funds in the Account) in accordance with the provisions of the URM and the following procedure(s)
 - (1) Valid reimbursement for FSA benefits shall be paid by authorizing a valid Card Transaction at point of sale, or by mailing a check to the Participants at their address (unless requested by the Employer as allowed by the terms of the Plan) or by initiating a direct deposit transfer directly to the Participants in their respective bank accounts in the appropriate amount(s), and
 - (2) Card Transactions that have been authorized, but subsequently found to be ineligible shall be offset with valid paper URM Requests, or
 - (3) Card Transactions deemed ineligible shall be reimbursed by the Employee or deducted by the Employer via payroll system, or included in the Employee's tax income by the Employer, and
 - (4) Card Transactions will only be applied to the URM Plan's current plan year, unless elected by Aflac and formally communicated to the Employer, in writing by an officer of Aflac. Aflac reserves the right to apply Card Transactions to the grace period of a previous plan year of the URM Plan
- E Aflac agrees to reasonably ensure compliance with proper use of the Card and take whatever action is necessary to investigate and resolve errors in Card Transactions
- F The Card will be deactivated upon notice from the Employer that the Participant is no longer employed by the Employer or has ceased to satisfy the eligibility requirements of the URM Plan. Where Employer instructs Aflac to terminate eligibility, Aflac agrees to deactivate, as soon as practicable, but in no event more than three (3) business days of its actual receipt of a complete notice thereof, the Card of any Ineligible Person. If Aflac has deactivated the Card pursuant to the preceding sentence, Employer agrees that Aflac or the Card Service Provider may not be held responsible for all such ineligible expenses. Employer will use its best efforts to retrieve the Card from any Ineligible Person. Aflac may deactivate at its option and without prior notice to Employer or Participant, any Card for fraudulent activity or as outlined in the Cardholder Agreement. Aflac reserves the right to deactivate the Card any other time that it deems appropriate.
- G Participants must agree to use the Card in accordance with the terms of the Cardholder Agreement that accompanies the Card. Aflac or the Card services provider will deactivate the portion of the Card that corresponds with the applicable URM Plan if the Participant fails to use the Card in accordance with the Cardholder Agreement.
- H The Card may be used by Participants to pay for Eligible Medical Expenses with merchants who have a category code associated with medical services (to the extent applicable) or at merchants who have implemented an inventory information approval system (IIAS) as described in IRS Card Guidance. Aflac reserves the right to allow the Card to be used at merchants who do not have an appropriate category code provided such transactions are permissible under the IRS Card Guidance. Aflac will use its best efforts to ensure that the Card complies with IRS requirements, however, Aflac shall not be responsible for Card systems procedures established by the Card processor or directed by the Employer.
- I Aflac will require substantiation of expenses paid with the Card in accordance with IRS Card Guidance. Aflac will notify claimants in writing as to any electronic or paper URM Requests that are denied or deemed ineligible for reimbursement because of inadequate claim substantiation, improper claim form submission, or medical expense not meeting URM Plan requirements. The Card will be deactivated if the Participant fails to provide the requested substantiation. Aflac will make reasonable attempts to collect repayment of benefits paid through the Card for ineligible expenses or offset the ineligible payment against any URM Requests for future eligible expenses (made during the plan year where required). No more than two (2) requests for repayment will be made. If repayment or offset is not made, Employer will be informed and will be responsible for taking any necessary action required by law. Employer agrees to recover the funds from the Participant (as required by IRS Card Guidance and permissible under state or other laws) and send notice of the recovered funds to Aflac for credit to the Participant's Account.
- J Aflac or the Card service provider will incur no liability for ineligible Card payments. It is the Employer's responsibility to ensure that it complies with all applicable tax and other laws.
- K All Cards will be deactivated on the date this Agreement is terminated. Aflac has the right to deactivate all Cards in the event the Employer fails to fund the Account as provided in Section 3 above. Aflac may also elect to terminate the Agreement as of such date.
- L If a Card has been deactivated (other than for failure to properly fund), neither Aflac nor the Card service provider will reactivate the Card, until Aflac has reasonably determined that the reason for the deactivation has been resolved or promoted by written instructions from the Employer.

Section 5. Transfer of Data

Aflac will establish a standard procedure for exchanging information. Employer will furnish the information determined to be necessary to satisfy its responsibilities under this Card Service Appendix in a format, method, and time mutually agreed upon by the parties. Aflac may exchange eligibility and adjudication data with the pharmacy benefits manager. Also, Aflac may interface with the Card processor on all Card activity and post data to system file.

Section 6. Optional Services

<u>II. Optional Services</u> These are provided only upon written request of the Employer	<u>Optional Fees</u>
[Reserved]	[Reserved]

SAMPLE

IN WITNESS WHEREOF, the parties hereto have caused this Card Services Appendix to be executed and signed by an Officer of the Employer and an Officer or duly authorized Worldwide Headquarters Employee of Aflac to be effective as of _____

Dated at Aflac this _____ day of _____

By ____ [SAMPLE - NOT AN EXECUTABLE CONTRACT] _____
Jason A Goodroe
Second Vice President
Aflac Benefit Services/Flex One

Dated at _____ this _____ day of _____

By ____ [SAMPLE - NOT AN EXECUTABLE CONTRACT] _____

Street Address _____

SAMPLE



We've got you under our wing.

ORIGINAL

Aflac's Response to the City of Peoria's Request for Proposal (P09-0074) for Flexible Spending Account Administration

A proposal prepared especially for you by:
American Family Life Assurance Company of Columbus (Aflac)

Authorized By: *Deborah B. Griffin*
Deborah B. Griffin
Second Vice President
Sales Administration
Phone Number: 706.596.3982
E-Mail Address: CorporateBids@aflac.com

Local Contact:	Diego Coronado	Alfredo Vargas
	Phone Number: 623.932.9400	Phone Number: 623.932.9400
	E-Mail Address:	E-Mail Address:
	diego_coronado@us.aflac.com	alfredo_vargas@us.aflac.com

The plans and services outlined in this proposal will be valid for a period of 90 days, subject to the availability of insurance policies currently being marketed.



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Experience and Qualifications

Aflac was founded in 1955 by brothers John, Paul, and Bill Amos. Aflac operates in all 50 states and in U.S. territories. Today, Aflac is a leader in guaranteed-renewable insurance policies sold at the worksite in the United States. Aflac's more than 74,300 licensed independent agents sell its plans through more than 427,700 U.S. payroll accounts (company statistics, December 31, 2008). Insuring more than 40 million people worldwide, Aflac is the principal subsidiary of Aflac Incorporated, an international holding company based in Columbus, Georgia. Under the leadership of Chairman and CEO Daniel P. Amos, the Fortune 500 company has total assets of over \$79 billion, with annual revenues surpassing \$16.5 billion (Aflac Annual Report, December 31, 2008).

We are pleased to have the opportunity to offer the City of Peoria our Dependent Day Care and Unreimbursed Medical Flexible Spending Accounts and our Aflac Now Card. Please note that this service is available as long as one or more of Aflac's insurance policies are offered and purchased through payroll deduction. In view of this requirement, we are offering the City of Peoria our accident and cancer plans, which can be purchased on a pre-tax basis subject to the regulations under Section 125 of the Internal Revenue Code. We are also offering our Express Services to assist with the administration of our plans, and Employee Benefits Statements so employees can have a better understanding of the value of their benefits and contributions provided by you.

We have been offering Flexible Spending Account program to businesses since 1990. Aflac's largest account that makes our Flexible Spending Account program available has 22,000 employees. Of these, 2,085 employees have one or both of our Flexible Spending Accounts. This account also makes the Aflac Now Card available to their employees as well. We currently have approximately 8,000 accounts that Aflac Benefit Services currently processes Flexible Spending Account claims. Following are Aflac Benefit Services performance statistics for 2008:

Flexible Spending Account Claims Processing

- Number of Flexible Spending Account Claims Processed - 942,687 (Jan - Dec 08)
- Average Number of Claims Processed per day Per Processor - 100
- Flexible Spending Account Claims Financial Accuracy Percentage - 99.96%
- Flexible Spending Account Claims Procedural Accuracy Percentage - 99.96%
- Average Flexible Spending Account Claim Turnaround time - Goal within 48 hours of receipt; Average within 24 hours of receipt

Flex One Technical Call Center.

- Average Wait Time (in seconds) - ninety seconds
- Abandoned Call Rate - .99%
- Average Hold Time - three minutes, 10 seconds



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Aflac Benefit Services consists of 114 individuals who specialize in four functional sections of Section 125 administration. All sections perform separate, but inter-related functions. The mission of Aflac Benefits Services is to continually improve our levels of service and maintain our standing as a competitive provider of cafeteria plan services while maximizing fiscal efficiency. We accomplish this by: Re-engineering our processes and improving technology through strategic alliances and internal development; further gearing our staffing needs toward operations needs; and inspiring loyalty, integrity, and motivation among our employees

Full-time trainers are responsible for training all new Aflac Benefit Services employees. New employees participate in a 12-week classroom training program, which provides instruction regarding all departmental procedures and applicable regulatory information. Upon completion of the classroom training, senior processors are assigned to each trainee for additional on-the-job training. During on-the-job training, employees' responsibilities increase respectively according to their progress. In an effort to provide on-going information to all employees, monthly departmental meetings are held to provide them with updated information on procedures and any regulatory changes

Resumes

Diego Coronado

Mr. Coronado, located in Avondale, AZ, has been with Aflac since August 2008. In addition to his duties as an agent, he currently holds the position of training coordinator. Besides his experience as an Aflac agent, he was district loss prevention manager for Albertsons Drug Division (currently part of CVS), where he served as manager of 43 stores throughout Arizona, New Mexico, and Texas. He also supervised all Human Resources issues relating to sexual harassment, fraud, and employee theft. Furthermore, he held the position of division coordinator for the Emergency Response Team, Business Continuity and Disaster Recovery Team. Throughout his career, Mr. Coronado has always strived to provide the best possible customer service to Aflac policyholders.

Alfredo Vargas

Mr. Vargas, located in Avondale, AZ, has been with Aflac since March, 2008. In addition to his tenure with Aflac, he has worked in a variety of sales and communications positions in the fields of travel and communication. These previous positions have given him the opportunity to hone his skills in the customer service and sales arena. He takes pride in providing great customer service to ensure retention of clients.

Account Relations Executive

An Account Relations Executive, located in Columbus, GA, will be assigned to the City of Peoria. Your dedicated Account Relations Executive will assist you with three distinct phases of your Aflac experience as outlined below:

- Prospective Phase - Includes consultative calls and account visits
- Implementation Phase - Includes welcome communications, enrollment facilitation, and billing automation and payment reviews



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- Service Phase - Includes account audits and ongoing enrollment facilitation and billing automation

References

1. Company Name: City of Yuma
Address: P.O. Box 13012
Yuma, AZ 85366
Contact Name: Cindy Denison
Phone Number: 928.373.5000
Number of Employees: 3,000
Contract Start Date: 11/15/1975
2. Company Name: City of Surprise
Address: 16000 N. Civic Center Drive
Surprise, AZ 85374
Contact Name: April Reynolds
Phone Number: 623.222.3522
Number of Employees: 860
Contract Start Date: 3/31/2000
3. Company Name: City of Tolleson
Address: 9555 W. Van Buren
Tolleson, AZ 85353
Contact Name: Wendy Jackson
Phone Number: 623.936.7111
Number of Employees: 135
Contract Start Date: 7/15/2003



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OFFER

To the City of Peoria The undersigned on behalf of the entity, firm, company, partnership, or other legal entity listed below offers on its behalf to the City a proposal that contains all terms, conditions, specifications and amendments in the Notice of Request for Proposal issued by the City Any exception to the terms contained in the Notice of Request for Proposal must be specifically indicated in writing and are subject to the approval of the City prior to acceptance The signature below certifies your understanding and compliance with Paragraph 1 of the City of Peoria Standard Terms and Conditions (form COP 202) contained in the Request for Proposal package issued by the City

For clarification of this offer contact Name Linda Willoughby Telephone 706 596 3982 Fax 706 320 4659

Aflac Company Name

Authorized Signature for Offer

1932 Wynnton Road Address

Deborah B Griffin Printed Name

Columbus, GA 31999 City State Zip Code

Second Vice President, Sales Administration Title

ACCEPTANCE OF OFFER AND CONTRACT AWARD (For City of Peoria Use Only)

Your offer is accepted by the City, subject to approval of each written exception that your proposal contained The contract consists of the following documents 1) Request for Proposal issued by the City, 2) Your offer in Response to the City's Request for Proposal, 3) This written acceptance and contract award As the contractor, you are now legally bound to sell the materials and/or services listed by the attached award notice, based on the solicitation of proposals, including all terms, conditions, specifications, amendments and your offer as now accepted by the City The Contractor shall not commence any billable work or provide any material, service or construction under this contract until the Contractor receives an executed Purchase Order or written Notice to Proceed

Attested by Mary Jo Kief, City Clerk

City of Peoria, Arizona Effective Date

Approved as to form

CC

Stephen M Kemp, City Attorney

Contract Number

Contract Awarded Date

City Seal

Carl Swenson, City Manager

Official File:

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
8/04/2009

PRODUCER J Smith Lanier & Co.-Columbus P. O. Box 1997 Columbus, GA 31902 706 324-6671		THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.	
INSURED Aflac Incorporated Attn: Mr. Nelson Phillips 1932 Wynnton Road Columbus, GA 31999		INSURERS AFFORDING COVERAGE	NAIC #
		INSURER A St. Paul Guardian	24775
		INSURER B Travelers Casualty and Surety C	19038
		INSURER C Travelers Indemnity Company	25658
		INSURER D St. Paul Protective Insurance	19224
		INSURER E	

COVERAGES

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS

INSR ADD'L LTR	INSRD	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS
A		GENERAL LIABILITY <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS MADE <input checked="" type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC	FS06804129	05/16/09	05/16/10	EACH OCCURRENCE \$1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$1,000,000 MED EXP (Any one person) \$10,000 PERSONAL & ADV INJURY \$1,000,000 GENERAL AGGREGATE \$10,000,000 PRODUCTS - COMP/OP AGG \$2,000,000
A		AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS <input checked="" type="checkbox"/> Comp-\$1,000 Ded <input checked="" type="checkbox"/> Coil-\$1,000 Ded	FS06804129 Hired Physical Damage Coverage	05/16/09	05/16/10	COMBINED SINGLE LIMIT (Ea accident) \$1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
		GARAGE LIABILITY <input type="checkbox"/> ANY AUTO				AUTO ONLY - EA ACCIDENT \$ OTHER THAN AUTO ONLY EA ACC \$ AGG \$
A		EXCESS/UMBRELLA LIABILITY <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS MADE DEDUCTIBLE <input checked="" type="checkbox"/> RETENTION \$ 10,000	FS06804129	05/16/09	05/16/10	EACH OCCURRENCE \$10,000,000 AGGREGATE \$10,000,000 \$ \$ \$
B		WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? If yes, describe under SPECIAL PROVISIONS below	HUYCKUB2547L61409 HACRUB5156N32309	05/16/09	05/16/10	<input checked="" type="checkbox"/> WC STATU-TORY LIMITS <input type="checkbox"/> OTH-ER E L EACH ACCIDENT \$500,000 E L DISEASE - EA EMPLOYEE \$500,000 E L DISEASE - POLICY LIMIT \$500,000
D		OTHER Property/EDP 25,000 Deductible Including Theft	FS06805682 Replacement Cost Special Form	05/16/09	05/16/10	Blanket Building / Contents / EDP Limit: \$385,025,698

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS

Re: City of Peoria, Arizona, Notice of Request for Proposal #P09-0074

The City of Peoria, its agents, representatives, officers, directors, officials and employees are named as Additional Insureds with respects to the General Liability & Auto Liability coverage if required by written agreement or contract, but only with respects to the operations of the Named Insured, and subject to the (See Attached Descriptions)

CERTIFICATE HOLDER

City of Peoria
 8314 West Cinnabar Avenue
 Peoria, AZ 85345-6560

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL 30 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES

AUTHORIZED REPRESENTATIVE

[Signature]

IMPORTANT

If the certificate holder is an **ADDITIONAL INSURED**, the *policy(ies)* must be endorsed. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

If **SUBROGATION IS WAIVED**, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

DISCLAIMER

The Certificate of Insurance on the reverse side of this form does not constitute a contract between the issuing insurer(s), authorized representative or producer, and the certificate holder, nor does it affirmatively or negatively amend, extend or alter the coverage afforded by the policies listed thereon.

DESCRIPTIONS (Continued from Page 1)

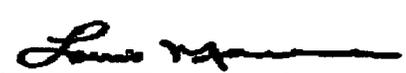
provisions and limitations of the policy. The General Liability coverage will be primary per policy terms and conditions. A Waiver of Subrogation exists in favor of Certificate Holder with respects to the General Liability coverage.

PRODUCER LOUIS MARINACCIO NAPA BENEFIT SERVICES 9024 TOWN CENTER PARKWAY LAKEWOOD RANCH, FL 34202		THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND, OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW	
INSURED CORONADO, DIEGO L 20507 N 94TH DR PEORIA, AZ 85382		INSURERS AFFORDING COVERAGE	
		INSURER A	CNA - CONTINENTAL CASUALTY COMPANY
		INSURER B	
		INSURER C	
		NAIC# 31127	

COVERAGES
 THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS

INST LTR	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS	
	GENERAL LIABILITY <input type="checkbox"/> CLAIMS MADE <input type="checkbox"/> OCCUR GENL AGGREGATE LIMITY APPLIES PER <input type="checkbox"/> POLICY <input type="checkbox"/> PROJECT <input type="checkbox"/> LOC				EACH OCCURANCE	\$
					FIRE DAMAGE (Any one fire)	\$
					MED EXP (Any one person)	\$
					PERSONAL & ADV INJURY	\$
					GENERAL AGGREGATE	\$
					PRODUCTS-COMP/OP AGG	\$
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> NON-OWNED AUTOS				COMBINED SINGLE LIMIT (Ea accident)	\$
					BODILY INJURY (per person)	\$
					BODILY INJURY (per accident)	\$
					PROPERTY DAMAGE (per accident)	\$
	GARAGE LIABILITY <input type="checkbox"/> ANY AUTO				AUTO ONLY-EA ACCIDENT (Ea accident)	\$
					OTHER THAN EA ACC	\$
					AUTO ONLY AGG	\$
	EXCESS LIABILITY <input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS MADE DEDUCTIBLE RETENTION \$				EACH OCCURANCE	\$
					AGGREGATE	\$
						\$
						\$
						\$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY				WC STATUTORY OTHER LIMITS	\$
					E L EACH ACCIDENT	\$
					E L DISEASE-EA EMPLOYEE	\$
					E L DISEASE-POLICY LIMIT	\$
A	LIFE/HEALTH INSURANCE AGENTS ERRORS AND OMISSIONS COVERAGE	169947227	2/1/2009	1/1/2010	Per Claim	\$1,000,000
					Annual Aggregate	\$2,000,000

This is a non-refundable individual agent's E&O claims made policy. In the case a business name appears on this certificate, coverage is extended from the individual insured to the corporation named but only for the covered acts of the individual insured. This policy includes coverage for products and services of all life and health companies including variable life, variable annuities, and mutual funds sales and servicing, subject to all terms, conditions, and exclusions of the policy. The following deductibles apply to this policy: \$0 for AFLAC product claims, \$1,500 for non-AFLAC product claims. Defense costs are provided and included within the limits of liability. All premium is earned as of the policy inception date. This policy cannot be cancelled by the insured. Coverage under this policy is in force only if the agent named above is actually appointed with the sponsoring company as of the coverage effective date. If agent's contract terminates with the sponsoring company, coverage ceases immediately for any new business. There is an automatic one-year extended reporting period only for products of the sponsoring company. Please contact your plan administrator for details of the E R P.

CERTIFICATE HOLDER ADDITIONAL INSURED, INSURED LETTER <p style="text-align: center; font-size: 1.2em;">PROOF OF INSURANCE</p>	CANCELLATION SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL WITHIN 30 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES. Authorized Representative 
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Hold Harmless Agreement

Aflac agrees to indemnify and hold the employer harmless from any claims by its employees who have applied for and been issued an Aflac policy or policies when the claim is attributable to the failure of Aflac to comply with the provisions of the policy or the disagreements between its employees and Aflac with respect to the coverage provided under the policy. This hold harmless shall not apply to any claims arising out of or related to any criminal misconduct by the employer or related to the employer's responsibilities under any applicable state and federal laws.

Deborah B. Griffin

Signature

August 11, 2009

Date

Second Vice President, Sales Administration

Title



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	QUESTIONNAIRE	Materials Management Procurement
	Solicitation Number: P09-0074	8314 West Cinnabar Avenue Peoria, Arizona 85345-6560 Phone (623) 773-7115 Fax (623) 773-7118

GENERAL INFORMATION AND HIPAA (ALL OFFERORS)	
	VENDOR RESPONSE
GENERAL INFORMATION QUESTIONS	
1. Are the rates or fees quoted in your proposal firm and will not be recalculated based on actual enrollment?	Neither rates nor fees will be calculated based on enrollment.
2. a. Are your quoted rates guaranteed for a minimum of 12 months?	Yes.
b. If so, are you willing to guarantee rates for more than 12 months?	Yes.
3. The City's contract is valid for a 5 year term, renewable each calendar year. Can you provide the renewal rates for each calendar year period from 2010 through 2014?	Employees will be given the option to apply for at least one Aflac insurance policy in addition to Flexible Spending Accounts. The policy offered will depend upon the employer's selection when establishing the program. Rates for the cancer and accident plans will be reviewed at the end of each 12-month period. Fees for the Flexible Spending Account program will remain waived for three years.
4. Do you agree to give the City at least 150 days advance written notice of any change in fees/premium?	Yes.



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GENERAL INFORMATION AND HIPAA (ALL OFFERORS)													
	VENDOR RESPONSE												
5. Your proposal is to be submitted net of commissions. Is your quotation consistent with this request?	No. Our proposal contains rates that are all inclusive. Aflac agents and brokers are compensated by the sale of our voluntary insurance plans. They are paid a set commission depending on the voluntary plan and the type of contract the agent and/or broker has with Aflac. In order to receive commissions, all personnel must be licensed in that state and appointed with Aflac.												
6. Identify those individuals who would be responsible for the day to day service contact with the City	Local agents Diego Coronado and Alfredo Vargas.												
7. If your company is awarded this business, how soon after notification of the award would you be able to have a draft of the contract?	Becoming an Aflac account is easy. Unlike other companies, we don't require formal contracts to implement our plans and services. Instead, you complete and sign a Payroll Account Acknowledgement form and then allow us to enroll three separate W-2 employees in at least one of our plans. That's it- we make it easy for you to do business with us.												
8. What are the most recent ratings for your company by the following. Standard and Poors Duff and Phelps A.M Best Moody's	<table border="1"> <thead> <tr> <th>Rating</th> <th>Date</th> </tr> </thead> <tbody> <tr> <td>AA-</td> <td>January, 2009</td> </tr> <tr> <td>Fitch* AA</td> <td>March, 2008</td> </tr> <tr> <td colspan="2">*Formerly Duff and Phelps</td> </tr> <tr> <td>A+(Superior)</td> <td>February, 2009</td> </tr> <tr> <td>Aa2 (Excellent)</td> <td>February, 2009</td> </tr> </tbody> </table>	Rating	Date	AA-	January, 2009	Fitch* AA	March, 2008	*Formerly Duff and Phelps		A+(Superior)	February, 2009	Aa2 (Excellent)	February, 2009
	Rating	Date											
	AA-	January, 2009											
	Fitch* AA	March, 2008											
	*Formerly Duff and Phelps												
A+(Superior)	February, 2009												
Aa2 (Excellent)	February, 2009												



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GENERAL INFORMATION AND HIPAA (ALL OFFERORS)	
	VENDOR RESPONSE
9. If you were provided any individually identifiable health information (IIHI) by the City in order to price this proposal, do you understand that you are prohibited from using the IIHI for any purpose other than as required by law and further, agree to promptly destroy such data if you are NOT the successful Offerors?	Yes.
10. Enclose a copy of claims and appeals text you would like the City to consider adding to their Plan Document/SPD to outline the process for claims filing/payment and appeals with your organization	The Sample Summary Plan Document, located in Section Four of this proposal, contain items that would be included in a notice of denial. These items are located in Question 17 of the Summary Plan Description Appendix I – Medical Care and Dependent Care Reimbursement Plan, Summary Plan Description.
HIPAA QUESTIONS	
11. Indicate the name of the staff member(s) you have assigned as responsible for assuring your organization's HIPAA EDI, Privacy and Security compliance	Brian McKeen – Privacy Officer Chris Ray – Data Security Officer Josh Hinton – Sr. Manager Claims, EDI
12. Indicate any vendors to whom you will subcontract all or part of HIPAA EDI, Privacy or Security compliance, including system vendors, consultants, and clearinghouses, etc.	SourceCorp & Emdeon & Mutual of Omaha
13. Indicate which of the HIPAA EDI transactions listed below you will be performing as part of the services you offer for this Client?	
a. Eligibility and coverage verification 270/271 or NCPDP for PBMs	Emdeon – performs on behalf of Aflac for Dental Plan



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**GENERAL INFORMATION AND HIPAA
(ALL OFFERORS)**

		VENDOR RESPONSE		
b. Enrollment and disenrollment 834		Mutual of Omaha (Med Supp)		
c. Premium payment 820		N/A		
d. Claims and/or encounters 837 or NCPDP for PBMs		837 claims		
e. Coordination of Benefits and provider claims 837 or NCPDP for PBMs		837 claims		
f. Claims status and inquiry 276/277		N/A		
g. Referrals, preauths, certification appeals 278 or NCPDP for PBMs		N/A		
h. Claims payment and EOBs 835		835 transactions upon request from the provider of service		
14. Indicate your current HIPAA EDI status by checking the appropriate column for each row:		Tested and ready to perform using HIPAA EDI format and content.	We currently are not HIPAA EDI ready for this transaction and operate under a contingency plan.	Not a transaction we plan to perform.
	a. Eligibility and coverage verification 270/271 or NCPDP for PBMs	X		
	b. Enrollment and disenrollment 834		X	
	c. Premium payment 820		X	
	d. Claims and/or encounters 837 or NCPDP for PBMs	X Claims		
	e. Coordination of Benefits and provider claims 837 or NCPDP for PBMs	X Claims		
	f. Claims status and inquiry 276/277		X	



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GENERAL INFORMATION AND HIPAA (ALL OFFERORS)	
	VENDOR RESPONSE
g. Referrals, preauths, certification, appeals <i>278 or NCPDP for PBMs</i>	X
h. Claims payment and EOBs 835	X EOBs
15. Is your organization accredited for any HIPAA services (<i>e.g., via Claredi</i>)?	No.
16 a. Are there any HIPAA transactions between this Client and your organization that you will require to be conducted using HIPAA EDI format and content ?	No.
b. If your answer to the above question is yes, which transactions?	N/A
c. If this Client currently does not have the transactions you require in a HIPAA EDI ready format, how will you assist this Client?	The Account Relations Executive assigned to the account will work with the City to assist the client and alleviate the problem if the transactions are not in a HIPAA EDI ready format.
17. a. Do you have a website that details information about your policies and procedures for accepting and sending EDI transactions?	No.
b. If this client, or a provider, wants a copy of your Companion Guide for HIPAA EDI transactions, where does this document reside?	Aflac does not at this time have a Companion Guide for HIPAA.
18. Will you need the client to amend their health care ID card(s) to include information about how to submit HIPAA electronic transaction to your organization?	No.



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GENERAL INFORMATION AND HIPAA (ALL OFFERORS)	
	VENDOR RESPONSE
19. List the clearinghouses who register your organization as a participating payer.	Emdeon and Mutual of Omaha
20 For the clearinghouses you work with, who is paying the "click charges" for transactions conducted with these clearinghouses?	Aflac pays for claim transaction fees billed by clearinghouses.
21. What problems do you experience with the daily use of EDI transactions?	None.
22. Are you aware of any complaints that have been filed against your organization regarding HIPAA EDI or Privacy with the Centers for Medicare and Medicaid (CMS)?	There was one informal complaint filed with CMS by a provider association that wanted to connect with Aflac for EDI claim submission. We referred them to Emdeon who is our clearinghouse for EDI Dental claim submissions.
23. Indicate the name and title of your firm's Privacy Officer.	Brian McKeen, Second Vice President, Privacy Officer
24. a. If you are offering fully insured benefits to this Client, is your organization going to create and distribute the required HIPAA Privacy "Notice of Privacy Practice" to this Client's plan participants as required by law?	Yes.
a. If you are offering fully insured benefits to this Client, do the plan documents you distribute to plan participants include the required HIPAA Privacy text including a discussion of the uses and disclosures of protected health information?	Yes.
25 Have you performed or had an outside agency perform a Security Risk Assessment of your organization in the past 6 months to assess your current system and/or determine how it compares	Yes. We have an annual HIPAA Compliance Audit of the Risk Management Department, which administers security procedures.



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GENERAL INFORMATION AND HIPAA (ALL OFFERORS)	
	VENDOR RESPONSE
with the final HIPAA Security regulation with respect to administrative, physical and technical procedures, services, controls or safeguards?	
26. List the 5 most important steps your firm has/is taking in order to comply with the final HIPAA Security regulations.	<ol style="list-style-type: none">1. Annual privacy and security training, including SOX training.2. Role-based access and annual assessments of security procedures.3. Data encryption and technical controls exist in the PC environment that prevent users from installing unapproved software and/or disabling security controls, such as antivirus software running on their computers.4. Enforcement of password security.5. RACF and claims application security along with operational and regulatory internal audits, based on an annual risk assessment. Additionally, our Risk Management Department administers procedures and performs annual audits on HIPAA compliance.
27. If this Client wants to transmit or receive electronic protected health information (ePHI), with your organization (such as may be part of an e-mail correspondence or eligibility inquiry), what protocol or methods will be required?	Aflac uses Wide Area Network technology to interconnect remote offices, such as Aflac's Nebraska call center facility to Aflac Worldwide Headquarters in Columbus, GA. These connections are achieved through point-to-point communication lines provided by various telecommunications providers.
28. Are you willing to sign a contract with this Client that indicates your firm will pay fines the Client may be assessed as a result of your firm's noncompliance with HIPAA EDI, Privacy and Security regulations?	Yes.



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**GENERAL INFORMATION AND HIPAA
(ALL OFFERORS)**

	VENDOR RESPONSE
<p>29. Outline the key steps you have taken to implement contract revisions that address HIPAA EDI, Privacy and Security regulation responsibilities of covered entities, business associates and trading partners with the various clients and firms with whom your firm interacts</p>	<p>Aflac maintains and implements the following security protocols for contractors, vendors, and third-party users:</p> <ul style="list-style-type: none"> • All vendors and contractors are managed by the Aflac Vendor Management Office. The Vendor Management Office works with IT Security to ensure that third parties can access the Aflac network only for the length of time of their respective contracts (or for the length of time that their duties require such access – whichever time period is shorter) and are granted access in a least privilege manner. • All remote connections from third parties are logged and restricted by the IT Security department • Vendors performing services at Aflac are contractually obligated to run background checks on their employees. <p>All contractors who come in contact with Aflac PHI (as that term is defined by HIPAA) must sign a Business Associate Agreement in conjunction with the other contracts that govern the business relationships</p> <p>Aflac requires Business Associate agreements, as required by HIPAA, for any third parties coming into contact with Personal Health Information. Aflac closely monitors all changes in HIPAA requirements and amends our Business Associate agreements to remain in full compliance. All HIPAA-covered third parties must have an executed copy of the most current version of the Business Associate</p>



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GENERAL INFORMATION AND HIPAA (ALL OFFERORS)	
	VENDOR RESPONSE
	agreement on file with Aflac in order to continue a relationship with the company.
30. If you anticipate a contract amendment or newly executed contract will be needed to address HIPAA compliance responsibilities, please attach a copy and highlight the text that addresses HIPAA.	As a client of Aflac, we do not require the execution of a contract regarding HIPAA requirements unless the client/employer will be providing services to assist in enrollment and may come into contact with PHI/EDI that a typical employer would never see.
31. From what company has your firm purchased additional liability insurance in anticipation of HIPAA compliance responsibilities?	Chubb (Federal Insurance Company)
32 How do you remain current on the latest HIPAA developments/changes?	Active participation between Aflac's Compliance, Claims, and Data Security Departments and industry trade and regulatory associations. As well as active monitoring regulatory guidelines and requirements.



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FLEXIBLE SPENDING ACCOUNT (FSA) ADMINISTRATION	
	VENDOR RESPONSE
1. Does your company charge an initial start-up fee? a. If so, please describe what services are provided in this fee. b. Is this a one-time charge or an annual fee?	Yes. However, this fee has been waived for the City of Peoria (the City). The initial start-up fee, which has been waived for the City, is for all services required to set-up the Flexible Spending Account for the City. One-time charge.
2. How often would reimbursements be made to participants? a. Healthcare reimbursement account? b. Dependent care reimbursement accounts?	The frequency of reimbursements is dependent on the processing and funding option chosen by the City. Aflac offers several processing and funding options from which you can choose. These options have been created to ensure prompt and efficient employee reimbursements, while allowing you an opportunity to tailor the program to meet specific financial and employee relations objectives. Frequency of payments would depend on the processing and funding option chosen by City. Frequency of payments would depend on the processing and funding option chosen by City.
3. Do you recommend a minimum reimbursement level? If so, how much?	Aflac's minimum reimbursement level is \$15.00; however, this minimum can be adjusted to meet the needs of City.
4. Does your proposal have a minimum participation	There is no minimum participation



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FLEXIBLE SPENDING ACCOUNT (FSA) ADMINISTRATION	
	VENDOR RESPONSE
requirement?	requirement for our Flexible Spending Account program or our plans. We only ask that the City establish an account with us by completing and signing a Payroll Account Acknowledgement form and allowing three separate W-2 employees to enroll in at least one of our plans.
a. What happens if minimum is not achieved?	N/A
5. How long after receipt of dependent care account deposit information are funds available to the participant for reimbursement?	The availability of funds to the participant for reimbursement is dependent on the funding method option chosen by the employer.
6. a. Do you agree to provide monthly management reports to the City?	We provide monthly and annual reports of account activity for the employer. The employee receives account information on Flexible Spending Account Activity Statement, which generates with each claim processed. If employees file no claims, quarterly reports with account information are provided.
b. Are you capable of occasionally providing reports more frequently, when requested?	Yes. (We can provide more frequent reports to the employer, but not the employee.)
7. Does your company require that the City provide access to employees to promote the sale of voluntary insurance products that can be included under the FSA plan?	Yes. Aflac's Flexible Spending Account program is only available as long as one or more of Aflac's insurance policies are offered and purchased through payroll deduction. We are offering the City of Peoria our Accident Indemnity Advantage and our Maximum Difference Indemnity Cancer Plans.



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FLEXIBLE SPENDING ACCOUNT (FSA) ADMINISTRATION	
	VENDOR RESPONSE
8. Will you agree to perform nondiscrimination testing to ensure the plan is in compliance with IRS Code Section 125 on an annual basis?	<p>Upon employer request, Aflac provides Nondiscrimination Testing Assistance in performing cafeteria plan nondiscrimination testing initially and for each consecutive plan year. To provide assistance, Aflac requires the employer to sign a release statement in favor of Aflac because the service is provided as assistance and not as advice. Nondiscrimination testing assistance provides the employer with testing percentages to take to the employer's tax and/or legal advisor for interpretation. These percentages are intended to assist the employer in determining whether the plan is in compliance with three of the relevant cafeteria plan nondiscrimination tests required by the IRS. These tests are:</p> <ul style="list-style-type: none">• The cafeteria plan (25%) concentration test for key employees.• The dependent-care assistance plan average benefits (55%) test.• The dependent-care assistance plan concentration test for 5% owners. <p>The employer, as plan sponsor, must also perform other applicable nondiscrimination tests (i.e., the eligibility, the contributions, and benefits tests for the cafeteria plan, and any other nondiscrimination tests applicable to the qualified benefits offered) and interpret the significance of the testing percentages provided, as required by the IRS.</p>



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FLEXIBLE SPENDING ACCOUNT (FSA) ADMINISTRATION	
	VENDOR RESPONSE
<p>9 a. Do your fees include the preparation of the plan document/summary plan description?</p>	<p>Our plan document/summary plan description documentation is provided at no direct cost to the City of Peoria. Fees for our Flexible Spending Account Program have been waived for the City.</p>
<p>b Does your fee include the preparation and mailing of W-2 forms to participants for dependent care?</p>	<p>Not applicable. Aflac Benefit Services does not prepare and mail W-2 forms.</p>
<p>10 Are the rates or fees quoted in your proposal firm and will not be recalculated based on actual enrollment?</p>	<p>The rates quoted in this proposal for our accident and cancer plans are firm and will not be recalculated for the next twelve months. Fees for our Flexible Spending Account program have been waived for the City. All fees are subject to review upon the plan anniversary date.</p>
<p>11. Indicate if your proposal includes the following and if access to these reports is on-line:</p>	
<p>a. Confirmation of enrollment statement</p>	<p>During open enrollment, each participant will receive a copy of the salary redirection agreement (SRA) from the agent/HR department. Policyholders can access their policy information online. Generally, the application and Salary Redirection Agreement is contained in the back of the policy.</p>
<p>b Year-end statement of account balance</p>	<p>The City will receive a monthly Flexible Spending Account Analysis Report that will run through the accounts 90-day run-off period. This statement cannot be accessed online.</p>
<p>c. Quarterly statement of account balances.</p>	<p>We do not provide quarterly statements to the employer — the</p>



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FLEXIBLE SPENDING ACCOUNT (FSA) ADMINISTRATION	
	VENDOR RESPONSE
	<p>employer receives monthly Flexible Spending Account Analysis Reports. We do provide quarterly statements to the participants, but only when they have not had any reimbursements for a three-month period.</p>
d. Monthly Statement of account balances	<p>Each month a Flexible Spending Account Analysis Report will be mailed to the point of contact for the account listing the name, last four digits of the Social Security number, annual election amount, plan year, and plan year type (DDC/URM). The participant will receive statements only when a reimbursement is distributed. This statement cannot be accessed online.</p>
e. Termination report	<p>We do not provide termination reports. It is the responsibility of the employer to maintain these records. We do provide the plan year begin and end date on the Flexible Spending Account Analysis Report. This report cannot be accessed online.</p>
If not, describe any variations.	
12. a. Does your proposal include on-site enrollment meetings?	Yes.
b. Is there an additional charge for the enrollment meetings? If so, please describe.	No.
13. a. Do you provide communication materials?	Yes.
b. Is there an additional charge?	There is no direct cost to the City.
c. If the City reproduced your communication	If more communication materials are needed, local agents, Diego Coronado



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FLEXIBLE SPENDING ACCOUNT (FSA) ADMINISTRATION	
	VENDOR RESPONSE
material, will there be a charge?	or Alfredo Vargas, will be happy to provide them at no direct cost.
14. a. Do you require an initial deposit?	The City is not required to submit an initial deposit as this fee has been waived.
b. If so, how much?	N/A
15. Describe the cash flow from the time the City withholds funds from the employees' paycheck.	The cash flow process will be dependent on the funding option chosen by the City.



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16. Is your proposal based on the assumption that checks/statements are mailed directly to the participant's address?	Yes.
If not, is there an additional fee?	There is no additional fee.
17 Do you offer direct deposit to participants?	Yes.
18. Describe the alternatives for dealing with terminated employees	It is the employer's responsibility to notify Aflac Benefit Services in the event an employee terminates. If an employee is participating in a Dependent Day Care or Unreimbursed Medical Flexible Spending Account and still has a positive balance, then the employee may continue their Flexible Spending Account through COBRA, if the employer extends COBRA to their employees.
19 a. Do you provide performance guarantees?	Our performance indicators are based on our average speed of answer, monitoring of blockage, and our quality audits that are performed monthly. These are benchmarked against our own historical data and industry standards. If the City requires additional performance guarantees, they will be established based on industry standards and will be acceptable to both the City and Aflac.
a. If so, provide information	N/A
20. What is the process for requiring support documentation and deactivating of debit card?	Participants will need to keep their receipt when using an Aflac Now Card. If we do not receive support documentation after a certain timeframe, the card will be deactivated. We send receipt notification letters to the participants reminding them of the required receipt(s) if applicable. A card will also be deactivated if it is reported lost or stolen.
21. Describe your process and what types of situations require supporting documentation	The participant uses the card for payment at his or her doctor's office, pharmacy, dentist or



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on a debit card?	<p>vision provider visits, or at a hospital. The transaction goes through a normal credit card-type exchange, and the systems are updated with a current daily balance.</p> <p>IRS regulations require receipt substantiation for all payment card transactions. Participants may use their payment card at IAS approved merchants, which will auto-substantiate their claims or they can submit a receipt or an Explanation of Benefits from their insurance carrier with details concerning their Flexible Spending Account usage.</p>
22. a. Can a dependent get a debit card?	<p>Yes. Benefit Services can provide dependent cards for the Aflac Now Card. In order to do this we need the complete name of the participant and the complete name of the dependent. The card can only be mailed to the participant's address.</p>
a If so, is there an additional fee?	<p>No.</p>
23 What is the cost for additional cards?	<p>There is no cost for additional cards.</p>
24. If a card is inactivated how soon can it be re-activated?	<p>When the participant renews his or her election each year, the card's account is also renewed. The card is re-useable for three years and a new card is not reissued each plan year. If the participant does not re-enroll, his or her card will be deactivated.</p>
25. Do you have the ability to contact the City prior to inactivating a card?	<p>Yes.</p>



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	PRICE SHEET	Materials Management Procurement 8314 West Cinnabar Avenue Peoria, Arizona 85345-6560 Phone (623) 773-7115 Fax (623) 773-7118
	Solicitation Number: P09-0074	

FSA ADMINISTRATION

	2010	2011	2012	2013	2014
Health Care Reimbursement Account (HCRA)	\$ Fees Waived	\$ Fees Waived	\$ Fees Waived	\$ All fees are subject to review upon the plan anniversary date.	\$ All fees are subject to review upon the plan anniversary date.
Dependent Care Reimbursement Account (DCRA)	\$ Fees Waived	\$ Fees Waived	\$ Fees Waived	\$ All fees are subject to review upon the plan anniversary date.	\$ All fees are subject to review upon the plan anniversary date.
Both Accounts (Monthly)	\$ Fees Waived	\$ Fees Waived	\$ Fees Waived	\$ All fees are subject to review upon the plan anniversary date.	\$ All fees are subject to review upon the plan anniversary date.
Debit Card (Monthly)	\$ Fees Waived	\$ Fees Waived	\$ Fees Waived	\$ All fees are subject to review upon the plan anniversary date.	\$ All fees are subject to review upon the plan anniversary date.



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<p>Total Monthly Premium</p>	<p>\$ There are no premiums for our Flexible Spending Account program. Premiums for the accident and cancer plans offered in this proposal can be found in in Section Five of this proposal.</p>	<p>\$ There are no premiums for our Flexible Spending Account program. Premiums for the accident and cancer plans offered in this proposal can be found in in Section Five of this proposal.</p>	<p>\$ There are no premiums for our Flexible Spending Account program. Premiums for the accident and cancer plans offered in this proposal can be found in in Section Five of this proposal.</p>	<p>\$ There are no premiums for our Flexible Spending Account program. Premiums for the accident and cancer plans offered in this proposal can be found in in Section Five of this proposal.</p>	<p>\$ There are no premiums for our Flexible Spending Account program. Premiums for the accident and cancer plans offered in this proposal can be found in in Section Five of this proposal.</p>
<p>Initial Start-up Fee (If any)</p>	<p>\$ Fees Waived</p>	<p>\$This is a one-time fee and has been waived.</p>	<p>\$This is a one-time fee and has been waived.</p>	<p>\$This is a one-time fee and has been waived.</p>	<p>\$This is a one-time fee and has been waived.</p>
<p>Annual Fee (If any)</p>	<p>\$ Fees Waived</p>	<p>\$Fees Waived</p>	<p>\$Fees Waived</p>	<p>\$ All fees are subject to review upon the plan anniversary date.</p>	<p>\$ All fees are subject to review upon the plan anniversary date.</p>



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Participation Requirements	There is no minimum participation requirement for our plan(s). We only ask that you establish an account with us by completing and signing a Payroll Account Acknowledgment form and allowing three separate W-2 employees to enroll in at least one of our plan(s).	There is no minimum participation requirement for our plan(s). We only ask that you establish an account with us by completing and signing a Payroll Account Acknowledgment form and allowing three separate W-2 employees to enroll in at least one of our plan(s).	There is no minimum participation requirement for our plan(s). We only ask that you establish an account with us by completing and signing a Payroll Account Acknowledgment form and allowing three separate W-2 employees to enroll in at least one of our plan(s).	There is no minimum participation requirement for our plan(s). We only ask that you establish an account with us by completing and signing a Payroll Account Acknowledgment form and allowing three separate W-2 employees to enroll in at least one of our plan(s).	There is no minimum participation requirement for our plan(s). We only ask that you establish an account with us by completing and signing a Payroll Account Acknowledgment form and allowing three separate W-2 employees to enroll in at least one of our plan(s).
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Scope of Work

The City is seeking proposals to administer a FSA for its employees. The plan quoted should have a \$5,000 maximum on the Medical Care Reimbursement Account and \$5,000 for the Dependent Care Reimbursement Account. The minimum reimbursement should be \$50, unless close of account.

The participant can choose their maximum amount of Unreimbursed Medical, subject to the maximum amount set by the employer. The maximum amount of Dependent Day Care reimbursement cannot exceed the maximum amount specified in Section 129 of the Internal Revenue Services code, which is currently set at \$5,000. Aflac Benefit Services' minimum reimbursement amount is \$15; however, this can be increased to meet the needs of the City of Peoria.

Please submit your proposal to administer a FSA for the employer based on the following services to be provided

- Initial set-up of employee accounts.
 - **The employees' accounts are set up automatically following receipt or download of the Salary Redirection Agreement.**
- Processing of dependent care requests for reimbursement once per week
 - **These care requests for reimbursement can be processed daily, bi-weekly, semi-monthly, and monthly, with the exception of accounts with the Aflac Now Card. These accounts are processed daily only.**
- Ongoing record-keeping of accounts
 - **The ongoing record-keeping of accounts are within the Year-to-Date Analysis Report that the employer receives.**
- Issuance of reimbursement drafts and pertinent documentation.
 - **Frequency of reimbursements and how they will be distributed will be dependent on the funding option chosen by the City.**
- Employee notification of account balances on a quarterly basis.
 - **Employees receive Flexible Spending Account and Aflac Now Card activity statements. The City and their employees can access their account information by calling our Flex One Interactive Voice Response number – 1-877-FLEX.IVR (1-877-353-9487).**
- Monthly accounting and statistical reports for the employer.
 - **The ongoing record-keeping of accounts are within the Year-to-Date Analysis Report that the employer receives.**



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- Update participation and account deposits from a hard copy on a weekly basis.
 - **The City will have an Account Relations Executive assigned from Aflac Worldwide Headquarters who will work the City and their staff to ensure all participation and account deposits are updated on a regular basis.**
- Discrimination testing.
 - **Upon request, based on information supplied by you and provided you execute a non-discrimination testing release in favor of Aflac, we will provide assistance in conducting non-discrimination tests to help ensure compliance of your cafeteria plan.**
- Preparation of W-2's for the Dependent Care Account participants.
 - **It is the responsibility of the employer to report this information. Aflac is not a legal and/or tax advisor and it is not our practice to provide this type of advice. We encourage you to seek the counsel of your own legal and/or tax advisor for any determination of suitability and/or taxability.**

If your proposal does not include **all** of these services, or includes additional services, please describe in detail. As part of your proposal, you must provide samples of the following material:

- Communication material
 - **Communication materials are in Section Four of this proposal.**
- Management reports
 - **A sample copy of an employer Year-to-Date Analysis Report is in Section Four of this proposal.**
- Reimbursement drafts
 - **A sample Request for Reimbursement form is in Section Four of this proposal.**
- Debit Card Sample
 - **A brochure depicting the Aflac Now Card is in Section Four of this proposal.**

Your proposal should outline how contributions, accounting and reimbursements are handled by your system. If a debit card is available, please note the cost separately.

How contributions, accounting, and reimbursements are handled will depend on the processing and funding method chosen by the City.

Following are the current funding/banking arrangements offered by Aflac Benefit Services:

- **Option One: Daily Local Account**
If you choose a Daily Local Account as your payment option, you open a bank account used only for holding and distributing employee and employer Flexible Spending



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Account contributions at a local bank of their choice. This account cannot be an interest-bearing account per IRS regulations. You give Aflac Benefit Services check-writing authority over the account for the sole purpose of paying claims, and Aflac Benefit Services prepares and issues all reimbursement payments to employees. With this option, reimbursements can be issued within two to three business days.

Note: To utilize the Aflac Now Card, this funding option must be selected.

Forms: If the Daily Local Account option is chosen, we require signature cards, but these forms come from your bank.

- **Option Two: ACH Credit**

At the time of processing, you will be provided a Checks Awaiting Printing Report that reflects the total amount due for all requests for reimbursement received. Your bank will send an ACH Credit for the requested funds to Aflac Benefit Services account at Columbus Bank & Trust. Once our bank has confirmed the transfer, Aflac Benefit Services will release the reimbursements. This normally takes 72 hours from the time the bank initiates the credit.

Forms: The ACH Debit Information Sheet must be completed and returned to Aflac Benefit Services.

- **Option Three: ACH Debit**

You must provide in writing to Aflac Benefit Services the routing (ABA or transit) number and account number for the account they wish to use for payment of reimbursements. Aflac Benefit Services will debit the account for the lump sum total at each processing. Accounts are established as ACH Debit Zero Balance Account. In this case, the account signs a Hold Harmless Agreement allowing funds to transfer automatically.

Upon notification by Aflac Benefit Services, you wire funds for the amount of reimbursement payments to Aflac Benefit Services for distribution to participants. Aflac Benefit Services is authorized to write checks and to initiate direct deposits to participants for the sole purpose of paying claims. With this option, reimbursements can be issued within eight to ten business days.

Forms: The ACH Debit Information Sheet must be completed and returned to Aflac Benefit Services.

- **Option Four: Self-Pay**

Upon notification from Aflac Benefit Services, you issue reimbursement checks to participants. Reimbursements are issued according to your time frame because you are responsible for disbursement. Direct deposit is not available through Aflac Benefit Services with this payment option.

The time frame for issuing participant reimbursements is subject to the claims processing schedule chosen by you and your response time for funding payment amounts.



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Forms: There are no forms for the self-pay option.



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Deviations

1. Under Standard Terms and Conditions, paragraph 19: Right to Audit Records:

Aflac retains records in compliance with the Department of Insurance and federal regulations. Aflac agrees to give the account access to information pertaining to the maintenance of your account to the extent that it does not violate privacy laws. Access to claim information cannot be granted, as this information is protected under the Medical Privacy Act

2. Under Scope of Work, the RFP states the City is seeking proposals to administer a FSA for its employees. The plan quoted should have a \$5,000 maximum on the Medical Care Reimbursement Account and \$5,000 for the Dependent Care Reimbursement Account. The minimum reimbursement should be \$50, unless close of account.

The participant can choose their maximum amount of Unreimbursed Medical, subject to the maximum amount set by the employer. The maximum amount of Dependent Day Care reimbursement cannot exceed the maximum amount specified in Section 129 of the Internal Revenue Services code, which is currently set at \$5,000. Aflac Benefit Services' minimum reimbursement amount is \$15; however, this can be increased to meet the needs of the City of Peoria.

3. Aflac does not act as a plan administrator or a plan sponsor. We are a plan service provider and you are the plan administrator and plan sponsor of the cafeteria plan



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Express Services

Express Services is the use of available technical resources to facilitate and support the functional areas of enrollment, premium changes, reconciliation, and billing. It includes the use of several different media options for the delivery of electronic files between Aflac and the payroll accounts capable of supporting the necessary technology. The objective is to fundamentally enhance the effectiveness and operational efficiency of Aflac's Express Services through the innovative use of new technology. New technology provides advanced business capabilities such as process management, workflow, and straight-through processing. This translates to improved productivity, quality, and customer satisfaction.

The primary processes of Express Services are Express Enrollment, Express Changes, and Express Reconciliation.

Express Enrollment

Express Enrollment is the way Aflac provides you with an electronic file containing the deduction amounts of each policy or policyholder. The file provides an electronic file that you can then translate into billable payroll deductions without the use of manual data entry. The delivery of the enrollment file is normally managed through a File Transfer Protocol (FTP) and requires advanced agreements between you and Aflac.

Express Change

Express Change is the process of reporting changes in premium to the account using the same format and media as the enrollment file. The change file relays premium changes as they relate to additions, deletions, conversions, policy transfers, and terminations. Terminations are typically communicated as a zero in the deduction amount column. Change file delivery will normally match your payroll deduction frequency.

Express Reconciliation

Express Reconciliation is the use of an electronic payroll deduction file provided by you to reconcile or balance against a given invoice. Payment associated with each reconciliation file is managed in one of two formats: paper check or electronic (Wire/Automated Clearing House) transfer. Wire transfer is the preferred method.



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Employee Benefits Statements

Employee Benefits Statements are communication tools designed to give your employees a better understanding of the value of their benefits and contributions provided by you. Most employees have no idea of the amount you contribute to the cost of their benefits. Using Info One statements will help employees understand and value the hidden portion of their total compensation package. The average employer spends approximately 30 percent to 40 percent above and beyond payroll on benefits.

You may add your logo, benefit descriptions, and employee information to the statements, and they will be generated within 30 working days from receipt of usable data from you. Most importantly, this a **free** service provided by Aflac.

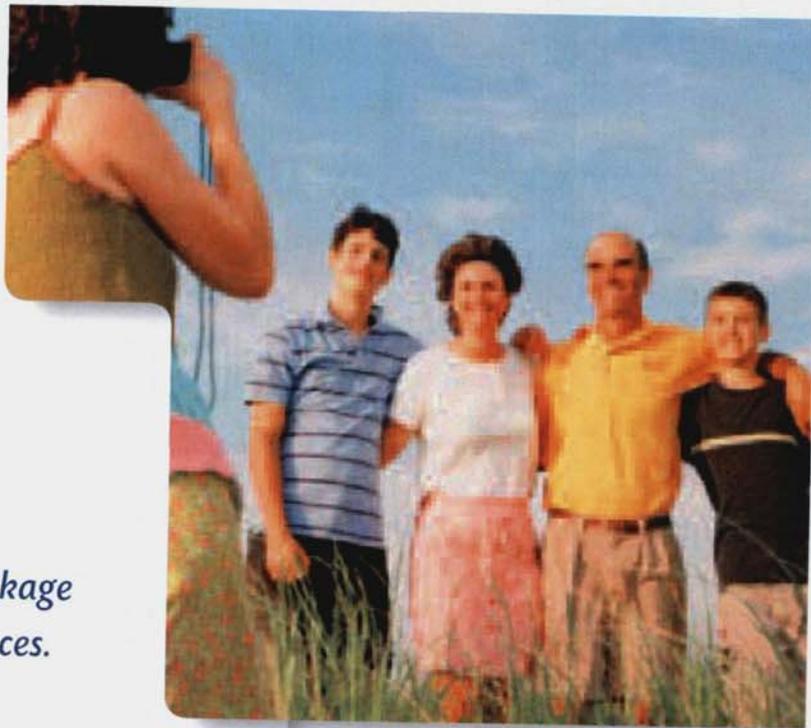
Frequently Illustrated Employer-Provided Benefits

Listed below are benefits that are commonly illustrated on employee benefit statements and can be used to assist in revealing what benefits you can provide to your employees.

- Group Medical
- Group Dental
- Vision Care Plan
- Credit Union
- United Way
- Dependent-Care Account
- Medical Reimbursement Plan
- Life Insurance
 - Term Life
 - Dependent Life
- Vacation
- Holidays
- Sick Days
- Personal Days
- 401 (k) Plan
- Profit-Sharing
- Disability Insurance
 - Long-Term Disability
 - Short-Term Disability
 - Accidental-Death and -Dismemberment
- Bonus
 - Christmas Bonus
 - Service Bonus
- **Voluntary Insurance**
 - **Aflac Policies**
- Company-Related Benefits

Flex One[®]

Supplement your employees' benefits package while adding valuable cafeteria plan services.



Plan Highlights

- Choose the easy way to save tax dollars on health care premiums.
- Add to your benefits or possibly receive a higher paycheck.

Introducing Flex One® From Aflac

This tax-advantaged plan allows employees to use pre-tax dollars to pay for certain benefit costs. And when you lower the taxable incomes of all participating employees, you may also reduce your overall share of FICA and FUTA taxes.

Not only is the potential tax savings of Flex One a real advantage, but each employee is also given the opportunity to select supplemental benefits that may fill gaps in traditional coverage.

We provide assistance in setting up premium-only plans and flexible spending accounts.

We make savings simple.

We provide sample documents.

We educate your employees.

*We handle the FSA reimbursement.**

We answer the questions.



*Let Aflac help
make tax savings
easy for you
and give your
employees the
savings they
deserve.*

*A monthly fee may be required for FSA services.

Flex One® for you ...

Tax Savings for You

You may reduce your employees' taxable incomes, thereby reducing your share of FICA and FUTA taxes, through Aflac's Flex One program. This may mean significant savings for you. Here's how:

Employer Savings Example

Per \$500,000 in payroll

Without Flex One		With Flex One	
\$ 500,000	Annual Payroll	\$ 500,000	Annual Payroll
- 0	Employee Contribution (pre-tax)	- 30,000	Employee Contribution (pre-tax)
500,000	Taxable Payroll	470,000	Taxable Payroll
x 7.65%	FICA	x 7.65%	FICA
\$ 38,250	Employer Tax	\$ 35,955	Employer Tax
\$2,295 Employer FICA Tax Savings			

Flex One for your employees.

Valuable Benefits for Your Employees

By giving them the possibility of tax savings, Aflac provides employees with a choice: increased take-home pay or additional benefits.

Employee Savings Example*

Per \$1,000 in salary

Without Flex One		With Flex One	
\$ 1,000	Gross Payroll	\$ 1,000	Gross Income
- 250	Taxes	- 100	Insurance Premiums
750	Paycheck	900	Adjusted Gross Income
- 100	Insurance Premiums	- 225	Taxes
\$ 650	Net Spendable	\$ 675	Net Spendable
\$25 Tax Savings			

*Savings over funding benefits on an after-tax basis; assumes an effective tax rate of 25 percent

Pre-tax dollars can be used to help pay for:

- ◆ Premiums for supplemental insurance.
- ◆ Premiums for major medical insurance.
- ◆ Deductibles and copayments.
- ◆ Medical care, such as physical exams and prescription drugs.
- ◆ Health-related supplies and services.
- ◆ Dental care, such as checkups, cleanings, orthodontics, and fillings.
- ◆ Vision care, such as exams, contact lenses and solution, glasses, and corrective surgery.
- ◆ Hearing care, such as hearing aids and batteries.
- ◆ Day care for a dependent child, incapacitated spouse, or other tax dependent.
- ◆ ... and more!

This brochure is for illustration purposes only.

Aflac is ...

Experienced With Section 125

Aflac's Flex One® program was established in January 1990. Since then, Flex One has assisted over 173,000 employers in establishing flexible benefits plans for their employees.

*Financially Strong**

Founded in 1955, Aflac is a Fortune 500 company. The common shares of Aflac Incorporated, the parent company, are traded primarily on the New York Stock Exchange. Standard & Poor's rates Aflac AA in insurer financial strength (April 2004). Fitch, Inc., rates Aflac AA in insurer financial strength (April 2005).

A Leader in Payroll Marketing

The employees of more than 349,000 payroll accounts in the United States participate in our program through list billing.

Number One Provider

Aflac is the number one provider of guaranteed-renewable insurance (National Underwriter, Life and Health Statistical Report, August 16, 2004).

**Ratings refer only to the overall financial status of Aflac and are not recommendations of specific policy provisions, rates, or practices.*

1-800-99-AFLAC

(1-800-992-3522)

En español:

1-800-SI-AFLAC

(1-800-742-3522)

For TTY service, call:

1-800-622-2345

For Flex One information, call:

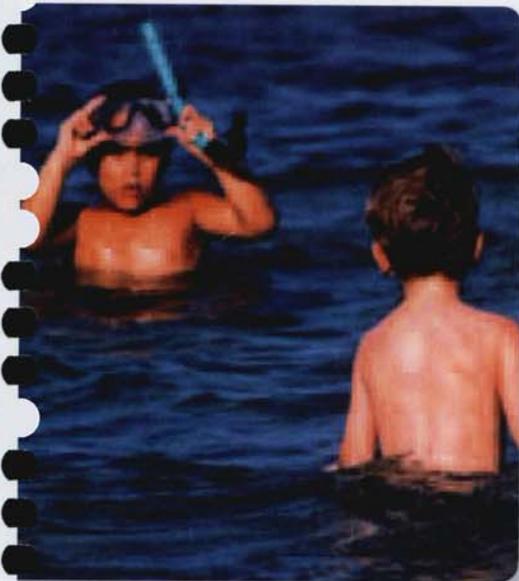
1-800-32-FLEX1

(1-800-323-5391)

IVR

1-877-FLEX-IVR

(1-877-353-9487)



For additional information,
contact your local Aflac representative:

Your local Aflac insurance agent/producer

Visit our Web site at aflac.com.

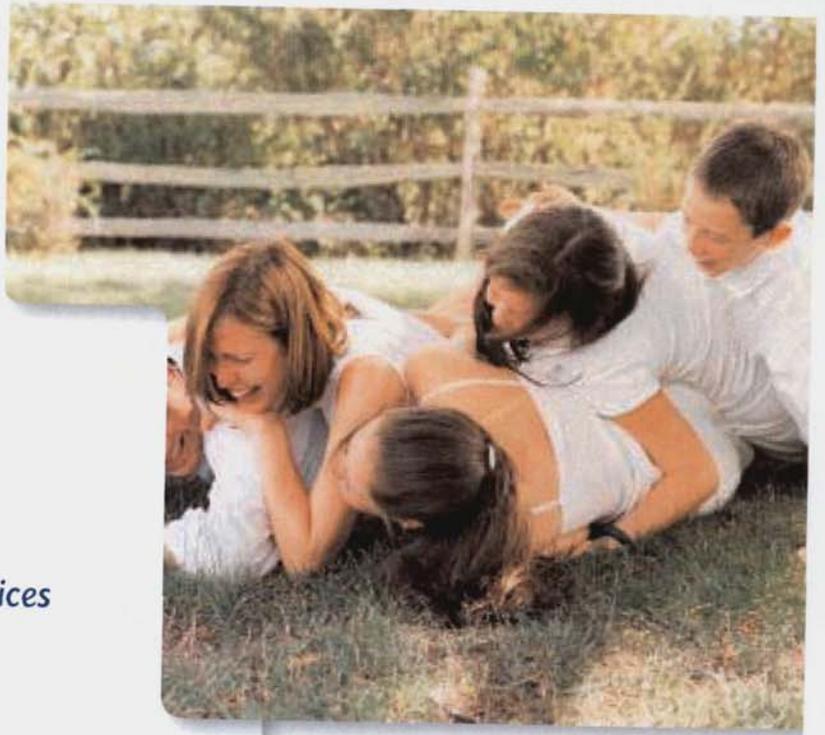


American Family Life Assurance Company of Columbus (Aflac)

Worldwide Headquarters · 1932 Wynnton Road · Columbus, Georgia 31999

Flex One®

A Leading Provider of Cafeteria Plan Services



Choose the easy way to
save tax dollars on health
care expenses.

Saving Tax Money

on out-of-pocket medical expenses ... through your company's new cafeteria plan

It's your money ...

How much do you spend on medical and dental expenses every year? Sure, you may have a major medical plan that helps, but what about deductibles and copayments? Aflac's Flex One® program may help you save tax dollars on these expenses by establishing a flexible spending account (FSA) for you.

Savings Example

Per \$1,000 in salary

Employee Savings Example

Without Flex Plan		With Flex Plan	
\$ 1,000	Gross Income	\$ 1,000	Gross Income
- 250	Taxes	- 100	Insurance Premiums
<hr/>	750 Paycheck	- 50	Medical Expenses
- 100	Insurance Premiums	<hr/>	850 Adjusted Gross Income
- 50	Medical Expenses	- 213	Taxes
<hr/>	\$ 600 Net Spendable Income/Paycheck	<hr/>	\$ 637 Net Spendable Income/Paycheck

\$37 Tax Savings!

This example is for illustration only and assumes a combined tax rate (income, FICA, and Medicare) of 25 percent. Your own personal tax situation may differ.

Without an FSA, you pay taxes on every dollar you earn—then you pay for medical expenses. **With an FSA**, you can set aside a portion of each paycheck for medical expenses. This amount is deducted from your paycheck before taxes are calculated, so the taxes you owe should decrease. In other words, **you won't pay taxes on the money you spend on qualified out-of-pocket medical expenses!**

Your benefits*

The potential tax savings you gain on medical expenses may give you the choice between adding to your benefits package and receiving a higher paycheck.

Use the money in your FSA for expenses such as:

- Insurance copayments and deductibles.
- Vision care (eye exams, eye glasses, contact lenses and solution, and corrective eye surgery).
- Drugs, legally obtained by prescription, or insulin plus over-the-counter drugs (if for medical care).
- Service fees for medical care (consultations, diagnostic lab work, etc.) provided by physicians, surgeons, specialists, or other medical providers.
- Diabetic supplies (blood sugar monitor, syringes, test strips, etc.).

Your choice!

Aflac's Flex One gives you a choice:

- Potential tax savings
- More complete coverage



*Cafeteria plan elections are generally irrevocable for an entire plan year and reduce Social Security compensation. Prior to participation, carefully review your summary plan description, salary redirection agreement, summary of tax rules, and reimbursement procedures for additional terms and conditions.

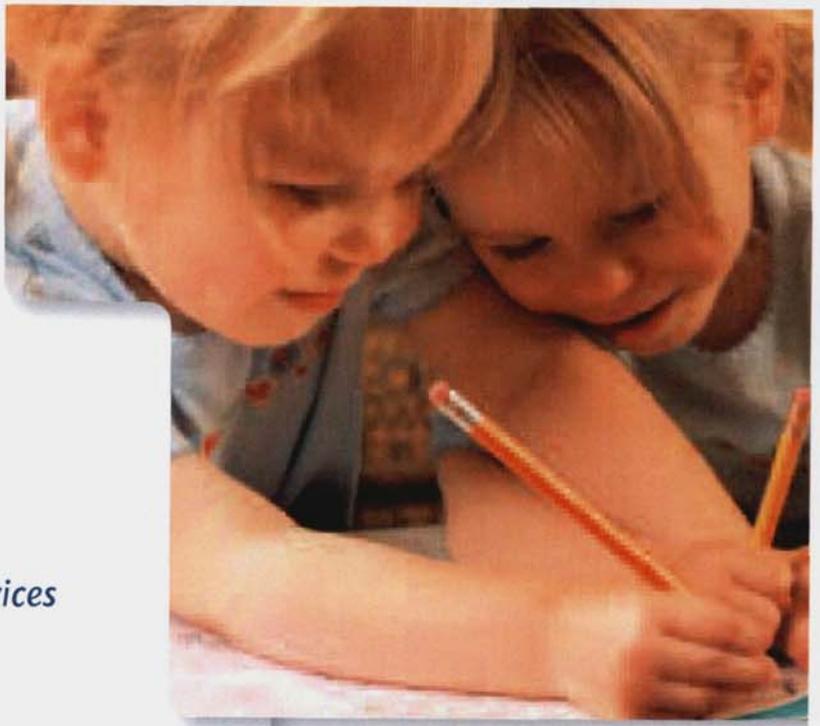
American Family Life Assurance Company of Columbus (Aflac)

Worldwide Headquarters · 1932 Wynnton Road · Columbus, Georgia 31999

1.800.99.AFLAC (1.800.992.3522) · aflac.com

Flex One[®]

A Leading Provider of Cafeteria Plan Services



Choose the easy way to
save tax dollars on money
you spend for dependent
day care.

Saving Tax Money

On dependent day-care expenses ... through your company's new cafeteria plan

It's your money ...

Dependent day care for children is expensive, but you may save tax money on this cost by participating in your company's cafeteria plan. This program may help you save taxes by establishing a flexible spending account (FSA) for you.* Here's how it works:

Savings Example

Per \$1,000 in Salary

Without Flex Plan		With Flex Plan	
\$ 1,000	Gross Income	\$ 1,000	Gross Income
- 250	Taxes	- 100	Insurance Premiums
<hr/>	750 Paycheck	- 200	Dependent Care
- 100	Insurance Premiums	<hr/>	700 Adjusted Gross Income
- 200	Dependent Care	- 175	Taxes
<hr/>	\$ 450 Net Spendable Income/Paycheck	<hr/>	\$ 525 Net Spendable Income/Paycheck

\$75 Tax Savings!

This example is for illustration only and assumes a combined tax rate (income, FICA, Medicare) of 25 percent. Your own personal tax situation may differ.

Without an FSA, you pay taxes on every dollar you earn—then you pay for dependent day care. **With an FSA**, you can set aside a portion of each paycheck for dependent day-care expenses. This amount is deducted from your paycheck **before** taxes are calculated, so the taxes you owe should decrease. In other words, **you won't pay taxes on the money you spend on qualified dependent day-care expenses!**

Your benefits** ...

The potential tax savings you gain from paying for dependent day-care expenses with pre-tax money may give you the choice between adding to your benefits package or receiving a higher paycheck.

A dependent care reimbursement account covers the cost of day care for:

1. Dependent children under age 13 who qualify as tax dependents.
2. Anyone claimed as a tax dependent because of physical or mental inability to care for himself/herself.

Your choice!

Aflac's Flex One® program gives you a choice:

- Potential tax savings
- More complete coverage



**For more specific details on the tax implications of using a dependent care reimbursement plan, contact your tax advisor. Some individuals may be better off using the dependent care tax credit due to recent tax changes and an increase in the amount of eligible child and dependent care expenses under the tax credit beginning in tax year 2003.*

***Cafeteria plan elections are generally irrevocable for an entire plan year and reduce Social Security compensation. Prior to participation, carefully review your summary plan description, salary redirection agreement, summary of tax rules, and reimbursement procedures for additional terms and conditions.*

American Family Life Assurance Company of Columbus (Aflac)

Worldwide Headquarters · 1932 Wynnton Road · Columbus, Georgia 31999

1.800.99.AFLAC (1.800.992.3522) · aflac.com

Aflac Now Card[®]



Aflac[®]

The Aflac Now Card®

Making your **Aflac Now Card** an experience you can talk about.

We want your experience with the Aflac Now Card to be exciting and trouble free. You now have the choice of sending a Request for Reimbursement or to use the Aflac Now Card to pay for eligible medical expenses with no upfront expense to you.



This brochure will instruct you on using the card correctly, preventing card denials, and knowing when to submit a Request for Reimbursement. The Internal Revenue Service (IRS) regulations still require substantiation for after-the-fact review for certain transactions, and for this reason we ask that you keep all receipts. **The card does not completely eliminate the need for receipts.**

The following tips will enhance your Aflac Now Card experience:

You can use your card at the following health care providers:

- o Doctors' offices/hospitals
- o Pharmacies*
- o Dental providers
- o Vision care providers

* As of January 1, 2009, pharmacies must use an inventory information approval system (IIAS) to access the Aflac Now Card. See more details in the Important Information section.

You can use your card to pay for the following (must be used at the point of sale or time of service):

- o Copayments/deductibles/coinsurance
- o Dental care/orthodontia (cosmetic services/supplies not included)

- o Vision care – Glasses and contacts (does not include nonprescription shades, shade clips, or items not used in conjunction with your eye care medical needs)
- o Over-the-counter (OTC) medical supplies and medications (does not include supplements/ vitamins, toiletry type items or items not classified as medical care)

We are here to help! If you have any questions or if you experience any problems with your Aflac Now Card, please contact our customer care representatives at 1-800-323-5391. They are available Monday through Friday from 8 a.m. to 7 p.m. Eastern time.

Important Information

Save your receipts!

While the Aflac Now Card[®] is an alternative for flexible spending account reimbursement, it does not eliminate the IRS requirement for claim substantiation. For some card transactions, the participant may be required to provide substantiation for after-the-fact review. Therefore, keep all receipts and documentation related to Aflac Now Card transactions.

Some drug stores and pharmacies sell a significant number of items that do not qualify as medical expenses; therefore, the IRS states they have to use an inventory information approval system (IIAS). The system will separate the FSA eligible items from the noneligible items, allow use of the Aflac Now Card, minimize card rejection, and minimize the need for receipts due to automatic claim approval at the point of sale.

We recommend not combining eligible and ineligible expenses in one transaction. If you combine all of your eligible and ineligible expenses and attempt to pay for them with your Aflac Now Card, your card may be rejected if the provider does not have the IIAS as part of its retail system. Misuse of the card can result in temporary deactivation of the card:

- o Not providing receipts when requested

- o Purchase of ineligible OTC products/paying for ineligible nonmedical services
- o Paying the balance on an account or bill received
- o Paying for service dates outside the current plan year

Things you need to know about your

Aflac Now Card:

- o No PIN is required.
- o You must select “Credit” instead of “Debit” at the point of sale.
- o The card can be used only at locations accepting MasterCard.
- o Activation is simple and does not require calling a toll-free number. When you have received your card in the mail, it will be activated at the time of your first purchase.
- o Using the card **does not** completely eliminate the need for receipts (keep all receipts for your records in case requested).

Managing your account information is easy.

You will receive a welcome letter that provides your payment card ID. You may access account information at www.benefitspaymentsystem.com. Click on **Participant Login** to create your user account. You will have the opportunity to review and maintain your flexible spending account (FSA) online in real time, including viewing your balance, reviewing transactions, and so much more.



The Aflac Now Card®

Why wait for your benefits when you can access them now? We have combined the benefit of your flexible spending account with the efficiency of a credit card, placing your flexible spending account (FSA) funds at your fingertips. The power of **now** is in your hands.



Advantages of using the Aflac Now Card:

- Access your FSA funds so you don't have to pay money out of your pocket.
- The card is reloadable for three years. When funds have been used for the current plan year, just keep the card.
- You can access your account balance and information online at www.benefitspaymentsystem.com.
- It minimizes the need for receipts.
- It reduces paper claim submission and having to wait for reimbursement via check or EFT.

Acceptable documentation/substantiation:

Cash register receipts for OTC items should show:

- Provider/company name and address
- Date of purchase
- Amount charged for expense incurred
- Description/name of item purchased



Prescription/Rx drug receipts, invoices, itemized bills, statements, Explanations of Benefits, etc., should show:

- Patient's name
- Provider's/company's name and address
- Date of purchase
- Amount charged for expense incurred
- Description of service

Note: If Rx name is not provided on the drug receipt, the Rx number, insured/patient name, and proof of insurance approval must be on the receipt

Direct deposit option

When submitting paper reimbursement claims for expenses not paid with your Aflac Now Card[®], don't wait for a check in the mail. Sign up for the direct deposit option and your claim reimbursement will be deposited into your account.

When submitting your receipts to substantiate your Aflac Now Card transactions, please use one of the following methods:

Fax to: 1.877.353.9256

Mail to: Aflac Benefit Services
1932 Wynnton Road
Columbus, GA 31999

(Always keep copies for your records.)

To obtain claim forms or a direct deposit enrollment form, go to **aflac.com** or **aflacny.com**.

Aflac Benefit Services
American Family Life Assurance Company of Columbus (Aflac)
Worldwide Headquarters • 1932 Wynnton Road
Columbus, GA 31999
1.800.323.5391 telephone • aflac.com • aflacny.com

Welcome to the Aflac Now Card®

Let us show you what your flexible spending account (FSA) can do for you now with the *Aflac Now Card*! Did you know that your FSA dollars are now at your fingertips? Your FSA will still operate the same way it did in the past, but now with the convenience of a pre-loaded card.

The Aflac Now Card is an electronic method for accessing your medical FSA benefits.

- It looks like a credit card and can be reused for up to three years. It is reloadable each year with your election; no new card is issued unless it is lost, stolen, or expired.
- It works like a credit card, requires no PIN, and is activated upon first use.
- Benefits are deducted from your FSA account immediately at the point of sale or at the time of service.
- It can be used to pay for eligible medical, dental, prescription, or over-the-counter expenses.
- You get 24-hour access to the card Web site at www.benefitspaymentsystem.com to obtain your balance for the current benefit year.



The card does not eliminate the need for receipt substantiation. IRS regulations require that you retain documentation to substantiate expenses. If you need to provide receipts for after-the-fact review, you will be notified by mail.

The simple, smart, and cashless way to access your FSA benefits



Quick Tip 1 – How Your Aflac Now Card® Works

With your Aflac Now Card, transactions will be processed immediately at the point of sale or at the time of service, and you will not be asked to provide a receipt. This will happen when a transaction matches a copy amount to one supplied by your employer or when the merchant uses the inventory information approval system (IIAS). This system will automatically adjudicate the transaction at the point of sale based upon the eligible FSA information contained in the merchant's system. When transactions are not automatically approved, you will be required to provide substantiation. A letter will be sent to you if additional information is required.

Quick Tip 2 – Save Your Receipts

While having the Aflac Now Card is an alternative to flexible spending account reimbursement, it does not eliminate the IRS requirement for claim substantiation. For some card transactions, you may be required to provide substantiation for after-the-fact review. Therefore, keep all receipts and documentation related to your Aflac Now Card transactions.

Quick Tip 3 – Submitting Substantiation

Complete a claim form or locate the letter requesting additional information. Then attach a legible receipt(s) or an Explanation of Benefits showing:

- The patient's name,
- The service provider's name,
- A description of the service or a list of items purchased,
- The charge(s) for each service or item, and
- The date(s) of service.

Note: Credit card receipts typically do not have all information required. This may result in the denial of your transaction if no other form of acceptable substantiation is provided.

Use discretion when faxing your documentation to
Benefit Services to prevent any inappropriate use or disclosure.

Possible misuse of the card can result in temporary deactivation of the card:

- Not providing substantiation when requested
- Purchasing ineligible OTC products/paying for ineligible nonmedical services
- Paying the balance on an account or bill received for service dates outside the current plan year

Inquiries, Claim Form, or Direct Deposit Form

1.877.353.9487 or aflac.com

Fax Number for Claim Forms/Aflac Now Card Receipts

1.877.353.9256

Information on Your Aflac Now Card Account

www.benefitspaymentsystem.com



Payroll Account Acknowledgment

All applicable sections must be completed for processing.

INSTRUCTIONS

- ALL accounts must complete Section 9, the Authorization and Signatures section
- Accounts establishing or modifying a Flex One® cafeteria plan or offering an Aflac Now CardSM must complete Sections 5 & 6.
- Accounts with another carrier's cafeteria plan must complete Section 7.
- Fax completed form to 1-866-AFL-NASA (1-866-235-6272).

1. GENERAL ACCOUNT INFORMATION

- New Aflac Payroll Account
 Changes to an Existing Aflac Payroll Account
 Split or Transferred Account
 Broker Account Indicator

Group Number: _____

Broker Writing Number: _____

Broker Employee ID: _____

Does this account have multiple locations, each requiring an invoice? Yes No

Are there any existing policies to place on this account? Yes No (If yes, submit a list of the policies on a separate page with the Payroll Account Acknowledgment to Aflac WWHQ)

Name of Account _____

Type of Business _____ Tax ID No _____

Industry Classification (Contact SIC Team for correct classification) A B C D E SIC Record No _____

Affiliate/Subsidiary of (if applicable) _____ Master Account No _____

Mailing Address _____

City _____ State _____ ZIP _____

Location Address Check if same as mailing address (P O box is not acceptable) _____

City _____ State _____ ZIP _____

Phone () _____ Fax (if applicable) () _____ Total No of Employees _____

Total No of 1099 Workers _____ Total No of W-2 Employees _____ Will 1099 workers be applying for coverage? Yes No

If 1099 workers are applying for coverage, submit an exception request for payroll rates to WWHQ on Form **IN-02-05** prior to writing the business

Account Web Site Address (if applicable) _____

Enrollment Period Will the enrollment period exceed 90 days? Yes No If so, has this been approved by Sales Support? Yes No

What is the length of the enrollment period? _____

Is there an established Aflac New York account? Yes No

If yes, provide name and group number _____

What led your organization to begin offering Aflac products to your employees? (Check all that apply.)

- Employee/Member Request Benefit Package Improvement Benefit Advisor or Broker Recommendation
 Sales Associate/Agent Commercial Advertising Aflac Products Are a Good Value Other _____

Please consult with employer's payroll contact to ensure accurate completion of next section.

American Family Life Assurance Company of Columbus (Aflac)
Worldwide Headquarters • 1932 Wynnton Road • Columbus, Georgia 31999 • 1 800 99.AFLAC (1 800.992.3522)

Account Name: _____
Tax ID: _____ Group No _____ Writing No : _____

2. BILLING INFORMATION

2a. BILLING CONTACT INFORMATION

NOTE: Aflac will contact the designated Billing Contact to review information.

All accounts with fewer than 1,000 employees will receive their invoice via Aflac's Online Billing system. As an Online Billing account, you have the option of making payments and reconciling your account online. Once your account is established, you can submit your invoice and payment electronically when due from the bank account noted below. At that time, if you prefer, you may also choose to pay by mailing a check. Aflac will not debit your account until you have reconciled and submitted your invoice for payment. Any adjustments or requested changes you submit electronically will not be processed until payment is received and the transaction is complete.

Bank Routing No.: _____ Account No.: _____
 Account Type: Checking Savings

Contact for Billing Inquiries: Mr. Ms. _____

Billing Contact Phone: () _____ Ext.: _____ Fax (if applicable): () _____

Billing Contact E-Mail (required): _____

2b. BILLING FREQUENCIES

Invoice Due Date: On what day of the month would you like your Aflac invoice to be due (1st or the 15th)? _____

How often would you like to receive your invoice from Aflac?

Monthly (Aflac will bill for the number of deductions made the previous month. Example: Deductions made January 1st through the 31st will be due in February.)

- 8-Month (8 invoices)
- 9-Month (9 invoices)
- 10-Month (10 invoices)

For 8-, 9- or 10-month, indicate months when no deductions will be made:

- Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

- Quarterly (4 invoices)
- Semiannually (2 invoices)
- Annually (1 invoice)

For Quarterly, Semiannually, and Annually, initial premiums must be submitted with applications.

2c. BILLING FORMAT

Check if account uses Social Security number for employee number

In what order would you like your employees listed on your bill?
 (If more than one is checked, please number your choices according to priority)

EXAMPLE: to request a bill with employees listed alphabetically under their department numbers, you would mark

Alphabetic 2 Dept No 1 Employee No _____

Alphabetic _____ Department No. _____ Employee No _____

Account Name: _____
 Tax ID. _____ Group No.: _____ Writing No.: _____

3. DEDUCTION INFORMATION

Employer Contributions: Does the employer pay any portion of this benefit? Yes No

If yes, please provide percent: _____% OR flat dollar amount: \$ _____
 Percent or dollar amount must be a whole number, such as "50%" or "\$10"

Based on the information provided in this section, Aflac will determine the number of deduction periods billed each month (when the account selects monthly billing).

If you choose monthly billing frequency, indicate the number of payroll deductions made annually for insurance premiums. For all other billing frequencies, mark N/A: 52 26 24 12 N/A

Check if premiums are deducted at different frequencies for different employees (i.e., some employees are deducted weekly while others are deducted biweekly), and indicate the different frequencies that exist for the account on separate M-0138 applications.

Initial Deduction: When will premium deductions begin?

Date of first deduction: _____/_____/_____ Date of second deduction: _____/_____/_____

The date of the first deduction should reflect the date the payroll account physically obtains funds from the employees. It does not necessarily equal the pay date for the employees.

4. INFORMATION CONCERNING TAX STATUS OF DISABILITY INSURANCE BENEFIT PAYMENTS

If disability coverage is funded by employer contributions, pre-tax employee contributions, or a combination of these two, then the disability benefits an employee receives upon becoming disabled will be includible in the employee's income and are fully taxable when paid. In addition, FICA taxes must be withheld and paid on all such benefits during the first six months after the disability. Where, as noted below, coverage is funded by employer contributions or employee pre-tax contributions, Aflac will notify the employer of the amount of disability benefits paid, from which the employee's portion of FICA taxes is withheld and will deposit such taxes with the government as required by the Internal Revenue Code. **The employer will be required to submit the employer's portion of applicable FICA and FUTA taxes and report the benefit payments on its Form 941 and the employee's Form W-2.**

Employer authorizes disability coverage to be included as part of this agreement: Yes No

- Authorized disability coverage types: Accident/Disability Short-Term Disability Off-the-job
- Authorized riders: Off-the-job On-the-job Sickness Spouse

Will any portion of disability premiums be funded by employer contributions? Yes No

If yes, please provide percent: _____% OR flat dollar amount \$ _____
 Percent or dollar amount must be a whole number, such as "50%" or "\$10"

Will any portion of disability premiums be funded by pre-tax employee contributions? Yes No

This employer is a government employer exempt from FICA or exempt from a portion of FICA. Yes No

Employees of this employer are eligible for RRTA (Railroad Retirement Tax). Yes No

NOTE: Disability caused by or under certain circumstances will not be covered. Refer to each policy to determine specific coverage, exclusions, and limitations.

Please consult with employer's cafeteria plan contact to ensure accurate completion of next section.

Account Name: _____
 Tax ID: _____ Group No.: _____ Writing No.: _____

7. OTHER CARRIER'S (not FLEX ONE®) CAFETERIA PLAN INFORMATION

Current plan year dates required _____ / _____ / _____ through _____ / _____ / _____

If short plan year, renewal dates required _____ / _____ / _____ through _____ / _____ / _____

Authorization to Add Benefits Mid-Year (Complete ONLY if adding benefits to a non-Flex One cafeteria plan at mid-year.)

Effective Start Date of Additional Benefits _____ / _____ / _____ Effective End Date _____ / _____ / _____

Benefits (check new benefits to be added)

- Medical Long-Term Disability Vision Care Intensive Care Short-Term Disability Accident
- Cancer Hospital Indemnity Dental Group Term Life Specified Health Event Personal Sickness Indemnity
- HSA (Section 223)

8. ASSOCIATE/AGENT

I acknowledge that Aflac has the sole and absolute right to determine who shall solicit and service payroll deduction accounts, and Aflac may assign and/or reassign any account for servicing and designate who may solicit applications from persons in the account. I confirm that I am not an employee, officer, director, owner, or relative of any of the foregoing (or otherwise a "party in interest" as defined under ERISA). I acknowledge that, for Key Accounts as defined in the Key Account Management Procedures, the proper guidelines will be followed to provide the most efficient service to the account. I confirm that I will register any such account with Key Account Management regardless of whether I use their assistance in the overall management and coordination of the enrollment. I understand that I am not authorized to collect premium from this account without specific written approval from Aflac.

Associate's/Agent's Signature: _____ Date: _____

Associate's/Agent's Name: _____

Writing Number: _____ Sit. Code: _____ Geographical Code: _____

Phone Number: () _____ Fax Number: () _____

Broker's Name (if applicable): _____

Broker's Number: _____ Sit. Code: _____ Level: _____

AMP: Yes No

**9. AUTHORIZATION AND SIGNATURES
 EMPLOYER**

Aflac assures you that you will be reimbursed without question for premium you advance for any employee who terminates after the premium is remitted but before payroll deductions commence. Aflac also agrees to hold you harmless from any claims against you due to any disagreements between your employees and our company with respect to the coverage provided under our insurance policies issued to your employees except where caused by misconduct or negligence committed by you or any of your employees or violations of your responsibilities under state or federal laws.

The employer agrees to provide Aflac (and its agents) with certain personally identifiable information (including, but not limited to, compensation, Social Security numbers, addresses, etc.) regarding its officers and employees for Aflac (and its agents) to use in the administration of employer's cafeteria (including health and dependent care FSA) plan and Aflac products and services.

Aflac is authorized to offer this insurance program to our officers and employees. I understand that all applicants must qualify for coverage based on each product's underwriting requirements and that payments for such coverage will be deducted from wages and remitted by my organization to Aflac.

Check if Establishing Flex One Account: The employer plans to establish/amend a flexible benefits plan in accordance with Section 125 of the Internal Revenue Code. The employer acknowledges that neither Aflac nor its agents are providing legal or tax advice, nor serving as the plan administrator or a plan fiduciary under the plan. The employer shall be the sole party responsible for establishment of the plan under applicable law. Aflac shall have no power or authority to waive, alter, breach, or modify any terms and conditions of the plan. The employer shall retain all responsibility and liability for the plan, except as may otherwise be specifically agreed to in writing by an officer of Aflac. The plan sponsor/administrator should consult its own tax advisor regarding the plan and any changes to the plan. The employer acknowledges receipt of the Summary of Plan Sponsor Responsibilities and agrees to fulfill its responsibilities as stated therein.

Authorizing Officer's Name/Title (please print): Mr. Ms. _____

Authorizing Officer's Signature: _____ Date: _____

Account Name: _____
 Tax ID: _____ Group No.: _____ Writing No.: _____

Group Short-Term Disability Insurance

Number of Eligible Employees at Company: _____ Participation Requirements (%): _____
 (A minimum of 30 percent participation is required for all eligible employees.)

Guaranteed-Issue Only:

Benefit Amount	\$ _____
Elimination Period (Injury/Sickness)	_____
Benefit Period	_____

Simplified-Issue Only:

Benefit Amount	\$ _____
Elimination Period (Injury/Sickness)	_____
Benefit Period	_____

Group Short-Term Disability Approval Date: _____ / _____ / _____

Group Short-Term Disability Withdrawal Date: _____ / _____ / _____

Dental Requirements

Dental Plan Start Date: _____ / _____ / _____

Dental Plan Stop Date: _____ / _____ / _____

Number of Eligible Employees for Dental at Company: _____ Participation Requirements: _____

Long-Term Care Requirements

Long-Term Care Plan Start Date: _____ / _____ / _____

Long-Term Care Plan Stop Date: _____ / _____ / _____

Revised Personal Short-Term Disability

Exempt from Standard Salary Income Chart: _____

Accident/Disability Revised Income Replacement

Exempt from Standard Salary Income Chart: _____



Aflac Benefit Services Claim Form

- Please fax this signed and completed form to 1-877-353-9256.
- For Customer Service, call 1-877-353-9487.

1. Participant Information and Signature

By submitting this claim form, I (participant named below) request reimbursement from my Flexible Spending Account(s) as listed below. I agree to the Terms and Conditions stated below, I certify and warrant to Aflac that these are eligible Unreimbursed Medical and/or Dependent Care expenses (see back) that my dependents and I have incurred.

Participant's Name (please print): _____ Social Security Number: _____

Participant's Address (complete only if address has changed): _____
Street City State ZIP

Employer's Name: _____

How may we contact you during the day? E-mail: _____ Phone: _____

Participant's Signature: _____ Date: _____

2. Dependent Care

List each receipt separately. Use additional forms if necessary. Use the provider's certification space below only if no receipt is attached.

Dependent's Name	Age	Provider's Name	Date Service Provided	Requested Amount

Provider's Certification/Verification: I certify that the Dependent Care expenses listed above were incurred by the participant named above.

Provider's Address: Street _____ City _____ State _____ ZIP _____

Provider's Signature: _____ Date: _____

3. Unreimbursed Medical

List each receipt separately. Use additional forms if necessary. Use the provider's certification space below only if no receipt is attached.

Patient's Name	Provider's Name	Description of Service	Date Service Provided	Requested Amount

Provider's Certification/Verification: I certify that the Unreimbursed Medical expenses listed above were incurred by the participant named above.

Provider's Address: Street _____ City _____ State _____ ZIP _____

Provider's Signature: _____ Date: _____

4. Terms and Conditions

I (participant named above) understand and agree that:

- These expenses are not reimbursable from any other health plan, insurance, or other source, and will not be used to claim any federal income tax deduction or credit.
- The Unreimbursed Medical expenses listed above would be deductible medical expenses under Internal Revenue Code Section 213(d) and are allowed under Prop. Treas. Reg. 1.125-2.
- The Dependent Care expenses listed above qualify for the federal child care credit, and I will not be eligible to claim the tax credit for any Dependent Care expenses submitted.
- I will include the Taxpayer Identification/Social Security number(s) of any Dependent Care service provider(s) listed above on my annual tax return(s) using Form 2441.
- I am responsible for any inappropriate use or disclosure of my information that occurs due to my selected method of transmitting this information (e.g. fax, e-mail, or any other media).
- I authorize the Plan and its service provider (Aflac and Aflac Benefit Services), their respective agents, employees, subcontractors, and assigns to use and/or disclose the information provided above as they reasonably deem necessary to manage the Plan (including but not limited to disclosures to my employer for Plan administrative purposes, such as the evaluation of eligibility for reimbursement under the Plan) and to detect or prevent fraud or misrepresentation.
- I give up any claims related to the use, disclosure, or release of this information so long as the information is used for the purposes defined above.
- This authorization does not in any way limit any right that Aflac and Aflac Benefit Services, their respective agents, employees, subcontractors, and/or any assigns may have under applicable state or federal law or regulation regarding the use of such information.

5. Helpful Tips for Completing Your Flexible Spending Account Claim

- Complete, sign, and date the front of this form. Failure to complete all areas can result in a delay in processing and claim reimbursement. **Note:** All fields must be filled in completely, do not indicate "see attached" in any field.
 - Do not submit Dependent Care (DDC) or Unreimbursed Medical (URM) claims until after services are rendered.
 - Attach a legible receipt (or receipts) from the service provider showing
 - A description of the service or a list of supplies furnished
 - The charge(s) for each service
 - The date(s) of service
 - The name of person(s) receiving service
- Note: Drug receipts must clearly show the drug name.** Balance due statements and credit card receipts are not valid receipts unless they indicate all of the required information listed above. Never send in receipts without an accompanying claim form.
- The service provider's signature on the claim form can be substituted for a receipt.
 - Verify that the services received are eligible expenses. See below and/or refer to your *Flexible Spending Account Participant Handbook*.
 - If you carry group insurance, submit expenses to the insurance carrier first. Attach the Explanation of Benefits (EOB) to document any reimbursement or credit to your deductible and coinsurance amounts.
 - The deadline or run-off period(s) for submitting claims for each Plan Year are determined by your employer. Check with your employer to learn more about your run-off period.
 - Checks will not be written for less than \$15. Requests for less than \$15 will be applied to future requests.

You may find additional information and/or details in the *Flexible Spending Account Participant Handbook* you received.

6. Submitting Your Completed Form to Aflac Benefit Services

- Fax completed Aflac Benefit Services Claim Form to 1-877-353-9256

Please allow 48 hours for the receipt of your faxed form before calling to inquire about your reimbursement.

NOTE: Use discretion when faxing your personal medical information. You bear full responsibility for any inappropriate use or disclosure that may arise in connection with transmission of your information to Aflac.

OR

- Mail completed claim form to

Aflac Benefit Services
1932 Wynnton Road
Columbus, GA 31999-9950

For customer service, call 1-877-353-9487

7. General IRS Eligibility Guidelines

To qualify for reimbursement from Flexible Spending Accounts, expenses must be incurred during the Plan Year for which you are requesting reimbursement.

- **Unreimbursed Medical Account:** Used for medical expenses for you and your family that are not covered by any other health plan.
Items covered must be for medical care as defined in Section 213(d) of the IRS Code and allowed by the Plan, and may include but are not limited to
 - Major medical copayments and deductibles (excluding insurance premiums of any kind)
 - Certain medical, dental, hearing, and vision services (excluding cosmetic procedures)
 - Most prescribed drugs, contraceptives, insulin, and smoking cessation programs (herbal drugs and over-the-counter drugs may be eligible, if permitted by the Plan and used to treat a medical condition)
 - The purchase and rental of most medical devices, including diabetic-related supplies
 - Most medical assistance tools for disabilities, such as seeing-eye dogs and text telephones for hearing impairments
- **Dependent Care Account:** Used for reimbursement for the care of your child or other tax dependent while you are at work and for reimbursement of services at a dependent care center (the center must comply with all state and local laws).
Specifications for using this account
 - Your child must be age 12 or under and reside with you
 - Your child or other dependent over the age of 12 must be incapable of self-support and must spend eight or more hours per day in your home
 - The individual caring for your child (age 12 and under) or other dependent must not be a tax dependent
 - Reimbursement cannot exceed \$5,000 per year for single individuals or married couples filing tax returns jointly (\$2,500 if married filing separately) or the earned income of you or your spouse, whichever is less

You may find additional information and/or details in the *Flexible Spending Account Participant Handbook* you received.

S. SALARY REDIRECTION AGREEMENT

EMPLOYER: _____ **EMPLOYER TAX ID NUMBER:** _____
AFFILIATE NAME/LOCATION: _____ **AFFILIATE TAX ID NUMBER:** _____
FLEX ONE® FSA? Yes No **CAFETERIA PLAN YEAR:** / / - / /

Social Security Number: _____ **If new employee, indicate eligibility date:** _____
NAME: (Last) _____ **(First)** _____ **(Middle Initial)** _____
ADDRESS: _____ **CITY/STATE:** _____ **ZIP:** _____

Number of Payroll Cycles in Plan Year _____ Date of first deduction _____ Payroll Mode Weekly Bi-weekly Semi-monthly Monthly

On a separate benefit enrollment form(s), I have enrolled for certain insurance coverage(s) and understand that my insurance premiums and/or Flexible Savings Account(s)(FSA) election amounts will be deducted from my paycheck by my employer or Third Party Payroll Administrator. Unless this agreement is amended or terminated, these deductions will be continuous and in an equal amount to the insurance premiums and/or FSA account election amount for each payroll period throughout the plan year. The amount of my required contribution is set forth on a schedule that has been provided to me. In the event of a rate change, I authorize a corresponding change in the amount deducted from my salary without signing a new Salary Redirection Agreement. If the rate change is brought on by the third-party carrier (insurance company), the premium increase or decrease can be deducted pre-tax. "Employer-provided" non-elective benefits (if any) will not be deducted from my paycheck. In addition, pre-tax contributions reduce my compensation for Social Security tax purposes, therefore, my Social Security benefits could be decreased. I elect to receive the following coverage(s) under the Flexible Benefits Plan as elected in the pre-tax column. Any previous election and Salary Redirection Agreement under the Flexible Benefits Plan relating to the same benefits as selected below are hereby revoked. My employer's deduction of premium/contribution amounts hereunder shall evidence acceptance of this Agreement.

Check the desired coverage(s) below:

	<u>Pre-tax</u>	<u>After-tax</u>		<u>Pre-tax</u>	<u>After-tax</u>
Medical Coverage	_____	_____	Accident Insurance	_____	_____
Dental Insurance	_____	_____	Short-Term Disability Insurance	_____	_____
Vision Care Insurance	_____	_____	Long-Term Disability Insurance	_____	_____
Cancer Insurance	_____	_____	Hospital Indemnity Insurance	_____	_____
Intensive Care Insurance	_____	_____	Personal Sickness Indemnity	_____	_____
Group Term Life Insurance (if family, must be after-tax)	_____	_____	Other accident or health plan(s) under Section 106 of the Internal Revenue Service Code	_____	_____
Specified Health Event	_____	_____	List: _____	_____	_____

Complete the following section only if participating in a Medical or Dependent Care Reimbursement Plan:

Medical FSA plan: (\$ _____ per pay period) x (_____ number of deductions) = \$ _____ Annual Election
 Dependent Care FSA plan: (\$ _____ per pay period) x (_____ number of deductions) = \$ _____ Annual Election

I understand and agree that (initial all):

On or after the first day of the plan year, I cannot change or revoke this Salary Redirection Agreement with respect to pre-tax premiums before the next anniversary date of the plan unless a "change in family status" occurs (as defined under the Internal Revenue Code), and the change is caused by and consistent with the "change in family status." I understand that I cannot revoke any pre-tax election based on a Right to Examine provision as may be contained in any insurance plan or policy issued to me.

Execution of this Salary Redirection Agreement does not begin coverage under the component benefit plans or policies. The terms and conditions and actual coverage effective date of the underlying coverage will be determined under the separate benefit plans or insurance policies. Prior to the anniversary date each year, I will be offered the opportunity to add, drop or change coverage for the following plan year. If I do not complete and return a new Salary Redirection Agreement form at that time, benefit plans or policies currently in effect will continue. Elections under the Medical and Dependent Care FSA plans will not continue without my completing and submitting a new Salary Redirection Agreement prior to the beginning of each plan year.

In addition to and without limiting in any way my employer, the Plan, their service provider (AFLAC and FLEX ONE®) and their respective agents, employees, subcontractors and assigns may have under applicable state or federal law or regulation, I hereby specifically authorize those parties to use my personal information (including, but not limited to benefit elections, wages, employment status, number of dependents, marital status and health and dependent child care information) as is reasonably required to administer the Plan (including evaluating and processing requests for payment of claims) and detecting and preventing fraud or misrepresentation. I further authorize my employer, the Plan, their service provider (AFLAC and FLEX ONE®) and their respective agents, employees, subcontractors and assigns to further disclose any such personal information as is reasonably required for such purposes. I hereby expressly waive and release any claims related to the use, disclosure or release of such information so long as the information is used in furtherance of Plan administration or to detect or prevent fraud or misrepresentation.

Paying for coverage on a pre-tax basis may cause insurance claim payments under health and medical coverage to be subject to federal and state taxes if claim payments (combining the total from all health and medical policies/plans) are in excess of medical expenses. Paying for disability income policies with pre-tax premiums will cause the benefits payable thereunder to be taxable. Such coverage may be funded on an after-tax basis to preserve the excludability of policy benefits.

FOR MEDICAL AND DEPENDENT CARE FSA PARTICIPANTS: FOR MEDICAL AND DEPENDENT CARE FSA PARTICIPANT I verify that I have received a summary of the tax rules, operational guidelines and reimbursement procedures for use in Medical and Dependent Care FSA plans. I understand the plan document will control notwithstanding any contrary oral representation by any person. I understand that reimbursement will be available only for eligible expenses, and I agree to notify the employer if I receive reimbursement for an expense that does not qualify. I also agree, upon demand, to indemnify and reimburse the employer for any liability it may incur for failure to withhold taxes from any reimbursement I receive for non-qualified expenses, up to the amount of additional tax owed by me. Furthermore, I understand that any account surplus at the end of the plan year shall be retained by the employer to offset administrative expenses or future costs, and the obligation to make reimbursements is the responsibility of my employer and not any service provider hired by the employer to assist in processing claims. I understand that I may be responsible for a monthly service fee for Medical and Dependent Care FSA plans and authorize my employer to payroll deduct any required service fee amount.

WAIVER OF PRE-TAX BENEFITS UNDER THE FLEXIBLE BENEFITS PLAN:

I certify that the features and benefits under the Flexible Benefits Plan have been explained to me completely. I elect to waive all pre-tax benefits under the plan, and understand that the benefits may be elected on an after-tax basis. Except for a change in family status, I understand that I cannot elect pre-tax benefits until the next anniversary date, and that any after-tax coverage shall be outside the plan.

INITIAL

EMPLOYEE SIGNATURE: _____ **DATE:** _____



Dear Plan Administrator:

Welcome to Aflac's Flex One®, a leading provider of cafeteria plan services! Enclosed in this packet are the documents necessary to establish a cafeteria plan with the assistance of Flex One. Please carefully review the Flexible Benefits Plan Document and Summary Plan Description to verify that all of the information regarding benefits offered, eligibility, plan administration, and funding appear correctly. Please notice that the Plan Document refers to the Summary Plan Description with regard to many of the Plan's provisions. This approach eases administration and reduces the risk of inconsistency between the Plan Document provisions and the Summary Plan Description provisions. For example, if you have changes in the Plan, most of the plan changes will only require formal adoption by the governing body of the employer and distribution of a Summary of Material Modifications (discussed in more detail below). You should note that these documents are only sample documents typical of a plan intended to qualify as a Section 125 cafeteria plan with the terms and conditions thereof, and that they may need to be modified to conform to your individual circumstances.

Aflac has developed these documents with legal counsel, and it is Aflac's intent and belief that the documents in form satisfy the requirements of Code Section 125. However, Aflac is not in the business of offering legal counsel or tax advice, and, thus, Aflac cannot and does not make any representations about the legal or tax effect of these documents upon any particular employer. Therefore, it is each employer's responsibility to determine, with the assistance of the employer's own legal counsel, the suitability of these particular documents and the legal and tax effect of these plan documents upon the employer and its employees.

Since Aflac has no control over your subsequent modification and/or administration of the Plan, and the Internal Revenue Service will not render an opinion as to a plan's qualified status under IRS Code Section 125, Aflac makes no representation (express or implied) as to your Plan's qualification under IRS Code Section 125 and related provisions as it is adopted and subsequently amended by you.

You, as sponsoring employer, bear sole responsibility for amending your plan (as necessary) to comply with existing tax law and future changes, for meeting all reporting and disclosure requirements imposed by applicable law, and for the daily administration of your plan. As such, we recommend you review the following important information:

Important Compliance Issues

Nondiscrimination Testing is at the very core of the legal requirements imposed by Section 125 of the Internal Revenue Code. Failure to satisfy these requirements will cause adverse tax consequences to highly compensated and/or key employees and could possibly disqualify the plan. For details regarding your Nondiscrimination Testing requirements, please refer to the Flex One Account Establishment Information Checklist.

Certain Insurance Premiums which cover the employee (or in the case of accident or health coverage other than life insurance, the employee and tax dependents/family) may be included in the Flex One Plan Documents if adopted as part of your benefits plan. These include:

- Group Term Life Insurance covering the employee (Eligible under IRS Code Section 79) that is equal to or less than \$50,000 (life insurance coverage on dependents is not eligible for pre-tax treatment);
- Accidental Death and Dismemberment (AD&D) coverage;
- Medical, Dental, Hospital Indemnity, Cancer Insurance, Vision, Hearing and other qualified accident and health premiums.

Please Note: When including health, medical and disability income policies within the Flex One Plan. Paying for coverage on a pre-tax basis may cause insurance benefit payments under medical coverage to be subject to federal and state taxes if benefit payments from all medical policies/plans are in excess of actual medical expenses. Paying for disability income policies with pre-tax premiums will cause the benefits payable thereunder to be taxable.

Form 5500 Annual Reports. ERISA requires a Form 5500 annual return for Health FSA benefits where there are 100 or more participants in the Health FSA. For details regarding your Form 5500 annual reporting requirements, please refer to the Flex One Account Establishment Information Checklist.

Continuation of Coverage. Health benefits offered through a cafeteria plan may be subject to the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). See the Summary Plan Description (SPD) for more details.

Continuation of Coverage During FMLA Leave. Health benefits (including Health FSA benefits) and non-health benefits offered through a cafeteria plan are subject to the continuation and reinstatement provisions of the Family and Medical Leave Act of 1993 ("FMLA"). See Q-13 of the SPD for more details on coverage offered under the Plan during FMLA leave.

HIPAA Privacy and Security Requirements. During the course of providing participants with health coverage under the Health FSA (if applicable), the Plan will have access to information about covered individuals that is deemed to be "protected health information", or PHI, by the Health Insurance Portability and Accountability Act of 1996, or HIPAA. HIPAA Privacy and Security

Rules apply to health plans, including Health FSAs. The Employer is solely responsible for ensuring that the Employer and the Plan comply with HIPAA's rules. If you are a Health FSA Plan Sponsor, Aflac is providing an attached privacy packet ("Important Privacy Information"), which is an overview of the HIPAA Privacy Rules. Aflac has also included general HIPAA language in the sample documentation (Section 10.18 of the Plan Document and, for Full Plans only, Appendix II to the SPD). The privacy information provided in this Cafeteria Plan Packet is not provided with the intent of fully satisfying your HIPAA obligations. HIPAA's Privacy Rules are complicated, and its effects may vary for each plan. You should consult with your legal counsel regarding your required actions and plan language for your Company and Plan to achieve HIPAA compliance.

Plan Administration and Maintenance

Plan Document Maintenance. Each plan sponsor is responsible for reviewing the Flex One Plan documents to ensure that they are consistent with its desired plan design and any legal requirements that may apply in its state. For your added convenience and your future reference, the most current version of the sample Cafeteria Plan Packet will be available on the Aflac web site (aflac.com) and the Flex One IVR (877-353-9487). As we make changes to the sample Cafeteria Plan Documents to correspond with changes in applicable laws, you can access the updates quickly and easily.

Summary Plan Description. All plan sponsors are required to give each eligible employee a copy of the SPD within 120 days of the effective date of the initial plan year and within 90 days of the effective date of coverage for all subsequent plan years. If an employer makes a change in the plan, the employer must provide the employees with a summary of the changes (a Summary of Material Modifications or (SMM)) within 60 days of the adoption of the change. **Note:** While the Plan and related documents are copyrighted, Aflac gives you limited permission to copy the documents as necessary for distribution to your employees for use solely in the operation of your own cafeteria plan.

Payroll Instructions. Payroll instructions will be thoroughly reviewed with you or your payroll specialist by your Aflac agent.

Employee Eligibility and Elections

New Employees. For details regarding Employee eligibility, please refer to Section 2.01 of the Plan Document.

Employees of Affiliated Companies. If the requirements of IRS Code Section 414(b), (c), (m) or (o) are satisfied, the employees of an affiliated company may be able to participate in this plan. You should consult with your tax advisor concerning the potential impact of IRS Code Section 414(b), (c), (m) and (o).

Benefit Election Changes. Employees generally cannot change their election to participate in the Pre-tax Contribution payment option or vary the Pre-tax Contributions they have selected. For details regarding important exceptions to this general rule please refer to Section 3.04 of the Plan Document and Q-9 of the SPD.

Due to the complexity of cafeteria plans, we recommend that you consult with your accountant, attorney or other tax advisor concerning the plan provisions, administration and operation before executing the plan documents. Remember that your cafeteria plan will not be effective until your plan is adopted, and the Plan Documents must be signed **PRIOR TO THE EFFECTIVE DATE**. If your Plan Document is executed subsequent to the effective date, the IRS may attempt to challenge the qualified status of your Plan. We recommend you retain any evidence that you have that would establish your Plan was adopted and enrollments were completed prior to the effective date. In the event that there have been no pre-tax deductions taken thus far, you may consider changing the start date of your cafeteria plan.

Aflac will use its best efforts to provide employers information from time to time about developments concerning Section 125 plans. However, for reasons stated above, it is the employer's responsibility to maintain the qualified status of the Section 125 plan, in form and in operation. If you have any questions concerning the Flex One Cafeteria Plan Program, you may contact us toll-free at (877) 353-9487 Monday through Friday 8:00 a.m. to 7:00 p.m. Eastern Time.

We are pleased you've chosen Aflac Benefit Services/Flex One to help you meet your cafeteria plan needs, and we look forward to the opportunity to serve you.

Sincerely,

Michael D. Flock

Michael D. Flock
Second Vice President
Aflac Benefit Services/Flex One

FLEX ONE® ACCOUNT ESTABLISHMENT INFORMATION AND CHECKLIST

Important steps for establishing your Flex One account

For all Flex One Cafeteria Plans:

- Employer's Acknowledgment:** After executing and adopting your Plan Document, please sign and date the Employer's Acknowledgment in order to officially adopt and execute your plan. Place the signed and dated Employer's Acknowledgment in your files with a copy of your Plan Document Packet
- Summary Plan Description:** A copy must be provided to each eligible employee as soon as possible. Regulations require distribution within 120 days of the effective date of the initial plan year and within 90 days of the effective date of coverage for all subsequent plan years

For all Flex One plans with FSAs when Flex One is the claims processor:

To ensure that your account is established in a timely manner, the following documents must be returned to Flex One **at least 10 working days prior to the effective date of your plan**. You may return these documents by toll-free fax to (877) FLEX-SRA (877-353-9772) or by mail to Aflac Benefit Services/Flex One, 1932 Wynnton Road, Columbus, GA 31999-9950

- Salary Redirection Agreements (SRAs):** Completed SRAs for all Flexible Spending Account (FSA) participants must be returned to Flex One
- Reimbursement Services Agreement (RSA):** The RSA must be signed in the second signature block and returned to Flex One. It will be signed by Flex One and returned to you for your records

Important information for administering your Flex One account

- Plan Identification Number (PIN):** The Department of Labor regulations require that welfare benefit plan sponsors assign a three-digit PIN number to their welfare plans (including cafeteria plans) for identification purposes. Numbering for welfare plans should begin at 501 and proceed consecutively. If you have other plans (e.g., health coverage) assign the next open number. This number must be indicated on the Summary Plan Description.
- Affiliated Companies:** Only those companies described in Section 414(b), (c) or (m) of the Internal Revenue Code can participate in a cafeteria plan. In addition, if there are affiliated companies, nondiscrimination testing may be affected by affiliated companies. Consult your tax advisor.
- 5500 and Summary Annual Report:** There is no Form 5500 filing requirement for the cafeteria plan itself. IRS Notice 2002-24 suspended this requirement. Please note that Notice 2002-24 does not affect annual reporting requirements under ERISA. Thus, welfare benefit plans subject to ERISA, which may include Health Flexible Spending Accounts (FSAs), must continue to file Form 5500 and any applicable schedules (unless an applicable exception applies) even if the benefits are funded through the cafeteria plan. You should contact your tax or legal advisor to find out if your Plan is subject to ERISA and whether filing a Form 5500 (including any applicable schedules) for your Plan is required.
- Nondiscrimination Testing:** Tax nondiscrimination tests, including the Eligibility, Contributions and Benefits, and Concentration of Benefits tests, must be performed. In the case of Flexible Spending Accounts (FSAs), nondiscrimination tests must be performed for each FSA. Upon request, Aflac Benefit Services will assist you at no extra charge with the Cafeteria Plan Key Employee 25% Concentration Test, Dependent Care 55% Average Benefit Test, and Dependent Care 5% Shareholder Test.
- Health FSAs:** You, as Plan Sponsor, are responsible for ensuring that the Health FSA maximum, is in line with your risk tolerance. Remember, IRS Notice 2005-42 allows an additional 2 ½ month period (i.e., grace period) in which to incur additional medical expenses. If you have selected the grace period feature, the Aflac sample plan incorporates this extension for Health FSAs.
- Eligibility:** Any eligibility waiting period for pre-tax benefits should generally be uniformly applied. You, as Plan Sponsor, are responsible for ensuring that the eligibility period listed in your plan documents does not violate Internal Revenue Service or Department of Labor regulations.
- Privacy:** You, as Plan Sponsor, are responsible for ensuring that your plan does not violate the privacy requirements set forth in the Gramm-Leach-Bliley Act of 1999 (GLB) and, if applicable, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). GLB regulates the privacy of financial information and applies to all Flex One plans (see the attached "Privacy Practices"). HIPAA protects privacy by regulating the disclosure of protected health information (PHI), so Plan Sponsors of only Health FSAs must comply with HIPAA privacy requirements (Health FSA Plan Sponsors only, see the attached "Important Privacy Information").

* If you have any questions regarding this checklist, please contact Flex One toll-free at (877) FLEX-IVR (877-353-9487), and one of our Customer Service Representatives can assist you Monday through Friday from 8:00 A.M. to 7:00 P.M. EST.

Employer Acknowledgment: Your signature verifies that an Aflac sales representative has reviewed the above information with you

Signature

Printed Name

Date

IMPORTANT PRIVACY INFORMATION

As a leading provider of Cafeteria Plan Services, our primary goal is to provide you and all of our customers with the best possible service. In order to assist you in ensuring your plan's compliance, we want to inform you of **existing and upcoming compliance obligations under the privacy rules issued in the Gramm-Leach-Bliley Act of 1999 (GLB) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), respectively.** These laws require you and your Business Associates to protect the personal health and financial information of health plan participants.

To assist you in understanding the compliance obligations under GLB and HIPAA, **the following information is included in this privacy packet:**

- **GLB Privacy Practices** - Due to regulation by GLB, we are required to provide you with this information, which explains our policy regarding the sharing of our customers' personal information with affiliates and third parties.
- **Top HIPAA Privacy and Security Questions** - This Q&A provides basic introductory HIPAA Privacy and Security information. HIPAA protects privacy by regulating the use and disclosure of protected health information (PHI), and protects the security of electronic PHI by requiring implementation of administrative, physical and technical safeguards to minimize improper uses and disclosures. The HIPAA Privacy and Security Rules apply only to health plans (including Health FSAs) and define who is authorized to access PHI created, held and transmitted by the health plan. The Privacy Rules became effective either on April 14, 2003 or April 14, 2004, depending on whether your plan is a large or small health plan. The Security requirements are effective on April 20, 2005 for large plans and April 20, 2006 for small plans. (See Q-3 for guidelines on determining if your health plan is large or small.)
- **Summary of HIPAA Privacy and Security Rules** - This summary provides further valuable information and details regarding the Privacy and Security Rules under HIPAA.
- **Sample Business Associate Contract** - This contract addendum is intended to satisfy your HIPAA business associate requirements with respect to Aflac's Flex One® services. As explained in this privacy packet, one of your compliance obligations as Plan Sponsor is to ensure that companies and individuals that perform administrative functions on behalf of the plan (i.e., "business associates") agree to comply with the HIPAA Privacy and Security Rules. Compliance with the business associate requirements is obtained by entering into the business associate contract. Unless your plan is self-administered, we are a business associate of your Health FSA plan because we provide claims processing services. If you already have a business associate agreement in place with Aflac's Flex One to comply with the privacy rule requirements, this agreement needs to be updated to take into account additional compliance obligations imposed by the Security Rules by signing the attached addendum.

In addition, a sample HIPAA privacy notice is provided as Appendix II of the SPD. This sample notice outlines the minimum requirements of the required privacy notice under HIPAA, and it is intended to be used in conjunction with your specific HIPAA Privacy Notice. The Privacy Notice that you provide is already incorporated by reference into Appendix II and, upon distribution, becomes part of the Cafeteria Plan Document.

NOTE: As Aflac cannot provide you with tax or legal advice, the information in this privacy packet should not be construed as such. All information provided is general in nature and cannot address issues and concerns particular to your health plan administration. Before you use any of the sample documents in this privacy packet and/or Cafeteria Plan Packet, please review them with your legal counselor or benefits advisor to ensure they meet your plan's specific compliance requirements.

Health FSAs are health plans subject to HIPAA's Privacy and Security requirements. To the extent that you sponsor other health plans regulated by the Privacy and Security Rules and have access to health information, your compliance obligations for the Health FSA Plan are similar - and in many cases you need merely to include your Health FSA in your overall compliance initiative under the Privacy and Security Rules. However, as Plan Sponsor, you (and your legal advisor) are responsible for taking action to ensure that your health plans (including the URM FSA) are compliant with the HIPAA Privacy and Security Rules by the applicable effective date.

Action is required of you, as Plan Sponsor of a health FSA:

Although Aflac is taking steps to ensure that its internal operations comply with the requirements applicable in its role as a business associate, you have further HIPAA obligations. While the information contained in this privacy packet outlines certain Health FSA Plan Sponsor responsibilities, each Plan Sponsor should consult with their legal advisor(s) to determine the full effects of HIPAA. However, one of your HIPAA obligations concerns business associates, and Aflac fits the HIPAA definition of a business associate.

- Under the Privacy Rules, the Plan Sponsor must designate which employees are authorized to review PHI from the health plan. Generally, PHI is individually identifiable health information about participants in the health plan. As a business associate, we are only permitted to disclose PHI to your company to the specified contact who is authorized to receive PHI. We assume that these individuals are the "named contact" as listed in our current client files (see Section III F. of the Reimbursement Services Agreement). **If a different contact person should be used, contact Aflac Benefit Services/Flex One as soon as possible,** as all HIPAA compliance responsibilities lie with you, as Plan Sponsor.

All business associate agreements must be updated to comply with the Security Rule requirement if you as a Plan Sponsor have access to electronic PHI. To use the attached sample HIPAA Business Associate Agreement (Exhibit A) (which has been updated to comply with the Security Rule requirements) as your business associate contract with Aflac, sign and return the original copy to Aflac Benefit Services/Flex One, and the contract will become an addendum to your Reimbursement Services Agreement (RSA).

If you need additional assistance regarding the business associate agreement or any of the attached privacy or security material, please contact Aflac Benefit Services/Flex One toll-free at (877) 353-9487 Monday through Friday from 8 00 a.m to 7 00 p.m Eastern Time.

GLB PRIVACY PRACTICES

Protecting the privacy and confidentiality of employer and participant information through our Flex One cafeteria plan services is very important to American Family Life Assurance Company of Columbus (Aflac) and American Family Life Assurance Company of New York (Aflac New York). Throughout this notice when we use the name "Aflac," we will be referring to both organizations. Accordingly, we strive to comply with each of the following practices in everything we do:

- **We do not sell, rent, lease or otherwise disclose personal information about employers or employees of an employer for purposes unrelated to our products and services.** The personal information of our customers is of paramount importance to us. Therefore, we provide this information only to our employees, agents and third parties as required to allow them to help us develop and provide our insurance and employee benefit products and services.
- **We work to ensure information integrity and security.** We use technology tools and design our business practices to help ensure that the personal information of the employer and employees of the employer are properly gathered, stored and processed. We also work to maintain the security of, and internal and external access to, the personal information of our customers through the use of technology and our business practices.
- **We expect our agents and employees to respect the personal information of our customers.** Aflac has business policies and practices in place to help ensure that its employees and agents carry out these practices and otherwise protect the personal information. Both employees and agents are subject to censure, dismissal or termination for violation of these policies.

These Privacy Practices apply to our U.S. customers. Due to legal and cultural differences, our practices may vary outside the United States.

PRIVACY NOTICE

Aflac and our agents provide this notice to let you know about the current privacy practices of Aflac and our agents. You do not need to do anything in response to this notice. This notice is merely to inform you about how we safeguard your information.

Collection of Information

As part of Aflac's normal operating procedures, Aflac (and our agents acting on our behalf) need to obtain information from both the employer and the participant to service the flexible spending accounts. Aflac and our agents may collect nonpublic personal information (which includes both nonpublic personal financial information and nonpublic personal health information) about Aflac customers, including but not limited to:

- Information from the employer or the participant (including names, addresses, Social Security numbers, financial and marital status, and health and dependent child-care information);
- Information about the employer or the participants' transactions with Aflac or our agents (including claims, payment information and banking information);
- Information from the employer or the participants' health care providers (including drug receipts and medical information), employers (including benefit elections and employment information) and family members.

Disclosure of Information

Aflac may disclose the nonpublic personal financial information we collect, as described above, as well as information about your transactions with us (such as your election amounts, premiums, and payment history) to our agents or other third parties who perform services for us or functions on our behalf, including the marketing of Aflac services. Aflac may also disclose the nonpublic personal financial information we collect to other third parties as authorized by you, or as required or permitted by law.

Our agents will make disclosures of the employer or the participants' nonpublic personal financial information only while acting on Aflac's behalf and, furthermore, will make such disclosures only as Aflac itself is permitted to make.

Neither Aflac nor our agents will use or share with other parties any nonpublic personal health information about our customers for any purpose other than the servicing of the employer's flexible spending account plan by Aflac or on our behalf, or to which the customer consents.

Neither Aflac nor our agents will further disclose any nonpublic personal information about a former customer of Aflac other than as may be required or permitted by law.

Confidentiality and Security

Aflac and our agents will safeguard, according to strict standards of security and confidentiality, any information we collect, receive, or maintain about Aflac's customers. Aflac maintains administrative, technical, and physical safeguards to ensure the security and confidentiality of the employer and employees, and the employer information and records; to protect against anticipated threats or hazards to such records; and to protect against unauthorized access to or use of such information or records.

Internally, Aflac limits access to our customers' information to only those employees who need access to the information to perform their job functions. Employees who misuse information are subject to disciplinary actions. Externally, we do not disclose customer information to any third parties unless we have previously informed the customer of the disclosure, have been authorized to do so by the customer, or are required or permitted to make the disclosure by law or our regulators.

TOP HIPAA PRIVACY AND SECURITY QUESTIONS

Q-1. Does HIPAA apply to plans sponsors?

HIPAA applies to covered entities, a term that includes health plans (including health FSAs). In most instances, Plan Sponsors are not covered entities. Nevertheless, HIPAA requires Plan Sponsors to comply with certain administrative requirements in order to receive protected health information (PHI) from their health plans. If the Plan Sponsor does receive PHI from the plan, the Sponsor must amend its plan documents and certify that its plan has been amended and that it has implemented appropriate safeguards. Plan Sponsor personnel dealing with PHI are subject to HIPAA, and firewalls must be created between the Plan Sponsor and other employer functions. PHI may not be used for employment purposes or for administering any other plan such as disability or workers' compensation.

Q-2. How much time do Plan Sponsors have to comply?

Health plans had to comply with the HIPAA privacy requirements no later than April 14, 2004. The Security requirements are effective on April 20, 2005 for large plans and April 20, 2006 for small plans.

Q-3. How do I know if my plan is a large or small health plan?

Under HIPAA, a small health plan is a health plan with "receipts" of less than \$5 million. If your plan is fully insured, receipts are measured by the amount of insurance premiums you paid in the last full plan year prior to April 20, 2005. For self-insured plans, receipts are the amount of claims you paid for the last full plan year prior to April 20, 2005. For plans with both fully insured and self-insured elements, it is the aggregate amount of claims and premiums paid. HIPAA does not provide guidance on what constitutes a "plan," but a good rule of thumb is that each plan for which you file a Form 5500 is a separate plan. If you have a wrapped plan, then you would likely aggregate all of the claims or premiums paid for every health arrangement in the plan, i.e. dental and vision claims and medical insurance premiums.

Q-4. What is protected health information?

Protected health information (PHI) is individually identifiable health information in any form or medium, e.g., oral, written or electronic, that is held or transmitted by a covered entity. Individually identifiable health information is health information that relates to an individual's past, present, or future physical or mental health or condition, to the provision of health care to that person, or to the past, present, or future payment for that person's health care and that identifies the individual. Some common identifiers are name, address, birth date and Social Security number. Examples of PHI held or accessed by health plans are claims information and claims history. PHI in electronic form is subject to HIPAA's Security rules.

Q-5. What is a business associate?

A business associate is a person or entity to which the plan discloses PHI in order for that entity to perform functions or services on behalf of the health plan. Some examples are TPAs, claim auditors, consultants, attorneys, and Rx vendors. Business associates of a plan do not include the Plan Sponsor, or employees of the Plan Sponsor, or an insurer of a fully insured plan. The privacy rules require the plan to have a contract (called a business associate agreement) where the business associate agrees to abide by similar confidentiality rules as the plan.

Q-6. Who enforces the Privacy and Security Rules and what are the penalties for a violation?

The Department of Health and Human Services' Office of Civil Rights has authority to accept and investigate complaints and also conduct compliance reviews for the Privacy Rules. Likewise, the Centers for Medicare and Medicaid Services (CMS) has similar authority for the Security Rules. Failure to comply with the Privacy or Security Rule requirements may result in a fine of up to \$100 per violation with the total amount for all violations of an identical requirement not to exceed \$25,000 per calendar year. Criminal fines and imprisonment may also apply if someone knowingly obtains or discloses individually identifiable health information in violation of HIPAA.

Q-7. How does HIPAA impact my duties under FMLA, ADA, OSHA, and workers' compensation?

HIPAA does not regulate health information you receive from your employees as their employer. For example, your employee can give you a physician's certification for FMLA leave. However, you cannot use PHI from the health plan such as claims data for purposes of administering your disability or workers' compensation plans. In addition, you must have an authorization from your employees to receive medical information directly from a health care provider for an employment-related purpose.

Q-8. EDI - what does it mean and how does it apply to my health plan?

EDI stands for electronic data interchange. It is another part of the Administrative Simplification provisions of HIPAA that applies in addition to Privacy and Security. These standards mandate that certain electronic health care transactions be conducted using a mandated HIPAA format. Generally, if a "covered entity" or its "business associate" electronically conducts a HIPAA-covered transaction with another covered entity, the entity must use standard formats and content, and uniform codes to communicate with the other entity. This is called a standard transaction. In most cases health FSAs conduct transactions exclusively with participants (not covered providers or other health plans). If this is the case with your health FSA the EDI obligation may be minimal. If your health FSA electronically conducts covered transactions with other covered entities (e.g., health care providers who transmit standard transactions electronically, other health plans and health care clearinghouses) you should notify Flex One immediately.

Q-9. What steps am I required to take to protect the security of my health plan's electronic PHI data?

While every plan sponsor must review its own operations, the HIPAA regulations clarify that health plans must appoint a security official (this may be the same person as the privacy official) and: (1) implement reasonable and appropriate safeguards for electronic PHI held or transmitted to or by the plan sponsor on behalf of the health plan; (2) ensure "firewalls" are in place to secure electronic PHI; (3) amend their plan documents to comply with the Security Rule and (4) ensure that all business associates with access to electronic PHI comply with the Security Rule.

SUMMARY OF HIPAA AND SECURITY PRIVACY RULES

I. Introduction

The HIPAA Privacy and Security rules regulate the use and disclosure of protected health information (PHI) by defining who is authorized to access PHI created, transmitted or held by covered entities and for what purposes.

A. Who is Covered

There are four types of covered entities under HIPAA: health plans (which includes Health FSAs), health care clearinghouses, Medicare prescription drug card sponsors, and health care providers if they transmit certain standard transactions electronically. Employers that are not in the health care services field normally are not covered entities. Nevertheless, employers, as health plan sponsors, must agree to comply with certain privacy requirements if they want to receive PHI from their health plans.

B. Basic Concepts

Health plan sponsors should understand and recognize the following basic concepts under the Privacy and Security Rules: (1) what PHI is; (2) which plans are considered health plans under the Privacy rules; and (3) what business associates are.

1. PHI

PHI is individually identifiable health information in any form, including oral, written and electronic, that is held, created, or transmitted by a covered entity. Individually identifiable health information is health information that relates to an individual's past, present, or future physical or mental health or condition, or to the provision of health care to that person, or to the past, present, or future payment for that person's health care; and that identifies the individual. Some common identifiers are name, address, birth date and Social Security number. Examples of PHI held, created, or maintained by health plans include claims information and claims payment history.

2. Health Plans

A health plan is defined in the Privacy rules as an individual or group plan that provides (or pays the cost of) medical care. In addition to Health FSAs, this definition includes virtually all arrangements that pay the cost of medical care, including group health plans, health insurers, Medicare and Medicaid

Some plans that may provide health care are excluded from the definition of a health plan under HIPAA. These include accident-only plans, disability plans, liability insurance plans, workers' compensation programs and on-site medical clinics. Also, self-administered and self-funded health plans that have fewer than 50 participants may be exempt. Note that this exclusion does not apply to a self-funded health plan that uses a third-party administrator

3. Business Associates

Service providers who receive or create PHI to assist health plans in connection with their health care functions are considered business associates under the HIPAA Privacy and Security Rules. Examples of business associates are TPAs, consultants, insurance agents and brokers, claim auditors, and utilization review companies. Employees of the Plan Sponsor and the Plan Sponsor itself are *not* business associates.

Business associates normally are not covered entities themselves under HIPAA. However, before a health plan may disclose PHI to a business associate, the HIPAA Privacy and Security Rules require the plan (through its Plan Sponsor) to enter into a contract (called a business associate agreement) with the business associate. This contract legally obligates the business associate to agree to restrictions on the use and disclosure of PHI. Health plans were required to have executed business associate agreements in place before the effective date of the Privacy Rule. Health plans must also execute updated business associate agreements with all of their service providers before the effective date of the Security Rules. (We have attached a sample "HIPAA Business Associate Contract" as Exhibit A, and it is intended to satisfy your HIPAA privacy and security business associate requirements with respect to Aflac's Flex One services.)

II. How the Privacy Rules Affect Sponsors of Self-Insured Health Plans

As mentioned above, Plan Sponsors are not covered entities under HIPAA. Nevertheless, if you are a Plan Sponsor of a self-insured plan, the Privacy Rules impose requirements on both you and your plan. These include the following:

- provide individuals with the rights to access and amend PHI and to receive an accounting of PHI (as described in Section II.A below),
- prepare and provide a privacy notice (as described in Section II.B below); and
- comply with the administrative safeguards applicable to covered entities (as described in Section II.C below)

Even if you retain a business associate to perform services for your plan, it is probable that you will have access to PHI. For example, most TPA arrangements require that the Plan Sponsor serve as the ultimate ERISA claims fiduciary for appeal purposes. You may also need access to PHI in order to respond to subpoenas for employee information. In order to disclose PHI to its Plan Sponsor, the health plan must be amended. Finally, note that the Plan Sponsor may not retaliate against health plan participants who exercise their privacy rights, or require individuals to waive their rights.

The following discussion examines three main compliance obligations for self-insured health Plan Sponsors: (A) the use and disclosure rules, (B) individual rights, and (C) administrative safeguards.

A. Use and Disclosure Rules

The Privacy Rules prohibit covered entities from using or disclosing PHI other than: (1) where the Privacy Rules permit or require disclosure; (2) if the covered entity obtains a specific authorization from the individual to whom the PHI relates. Some permitted uses and disclosure that do not require individual authorization are disclosures to an individual and uses and disclosures for treatment, payment and health care operations (i.e., operations related to claims payment and treatment).

Health plans are most likely to use PHI for payment and health care operations. "Payment" means an activity undertaken by a health plan to obtain contributions, to determine or fulfill its responsibility for provision of benefits under the health plan, or to obtain or provide reimbursement for health care. Payment includes eligibility and coverage determinations, billing, claims management, collection activities, and related health care data processing. "Health care operations" refers to activities compatible with and directly related to treatment or payment, such as: (1) internal quality oversight review; (2) credentialing and health provider evaluation; (3) underwriting, (4) insurance rating, and (5) other activities relating to creation, renewal, or replacement of a contract of health insurance or health benefits (including stop-loss insurance and excess insurance); medical review; legal services, and auditing functions (including fraud and abuse detection); business planning; management and general administration; and fundraising. Most self-insured health plans hire business associates to assist them in performing payment and health care operations functions.

In addition to the uses and disclosures for treatment, payment, and health care operations, plans may also use and disclose PHI for certain required disclosures without an individual's authorization, such as:

- Uses and disclosures required by law,
- Uses and disclosures for public health activities;
- Disclosures for judicial and administrative proceedings;
- Disclosures for law enforcement purposes;
- Uses and disclosures to avert a serious threat to health or safety;
- Disclosures for workers' compensation.

Any use or disclosure of PHI by a covered entity that is not permitted or required under the Privacy Rules requires an authorization from an individual. An authorization must have the following core elements in order to qualify as a valid authorization under HIPAA:

- Description of the information to be disclosed;
- Identification of person(s) authorized to use or disclose PHI and to whom PHI may be disclosed;
- Purpose of the requested disclosure;
- Expiration date or event that would terminate the authorization;
- Signatures by individual whose information is to be disclosed; and
- Statements regarding the right to revoke authorization, ability to condition treatment, payment, enrollment or eligibility for benefits on authorization, and potential for re-disclosure.

The authorization must be written in "plain language," and the individual must receive a signed copy of the authorization if such authorization was sought by the covered entity. Individuals may request to have their PHI disclosed by a health plan for a variety of reasons, including applications for life or disability insurance or for purposes of a lawsuit. The Plan Sponsor may request an authorization from an individual to allow the plan to disclose medical claims records for FMLA leave or a request for reasonable accommodation under the ADA. The Plan Sponsor must remember that it cannot use or disclose PHI for any employment purpose without the individual's authorization. A health plan may not condition treatment or payment on an authorization, except in very limited circumstances.

The Privacy Rules also require covered entities to make reasonable efforts to use, disclose and request only the minimum amount of PHI needed to accomplish the intended purpose of the use, disclosure or request. For example, a health plan cannot request an entire medical record, if it only needs information regarding an office visit for a particular day. The minimum necessary requirement does not apply in the following instances: (1) disclosures for treatment by a health care provider; (2) disclosure to individuals about their own PHI; (3) uses or disclosures made pursuant to authorization; and (4) uses or disclosures required by law.

B. Individual Rights and Privacy Notice

The Privacy Rules grant individuals certain rights with respect to their health information. Such rights include the ability to access and amend their PHI maintained by the covered entity, receive an accounting of disclosures of certain limited PHI, and receive a privacy notice. As Plan Sponsor, you need to coordinate with your TPA and any other business associates to satisfy these requirements. In response to any participant inquiries that you receive, Flex One will make available any PHI that it maintains for your plan.

1. Individual Rights

An individual has the right to inspect and copy his or her own PHI

An individual has the right to request an amendment or correction to any of his or her PHI that is inaccurate or incomplete.

- An individual also has the right to obtain an accounting of disclosure other than those made for treatment, payment or health care operations

2. Privacy Notice

The health plan is required to provide a notice of privacy practices for PHI notice to all individuals enrolled in the health plan. This notice must describe the uses and disclosures of PHI that may be made by the covered entity, the individual's rights, and the covered entity's legal duties with respect to the PHI. The Privacy notices must be provided to individuals at

the time of an individual's enrollment in the plan and within 60 days after a material change to the notice. In addition, plans must provide a notice of availability of the privacy notice at least once every three years

It is likely that you will be sending out Privacy Notices for other health plans that you sponsor where you have access to PHI. If this is the case, you might consider combining the Privacy Notices for plans where the information (e.g., who has access to PHI) is the same. If you do not otherwise have a Privacy Notice obligation, you must prepare and distribute a Privacy Notice for your Health FSA. *(For your convenience, we have attached a sample privacy notice as Appendix II to the Flex One Summary Plan Description (SPD). Review the sample notice with your legal advisor and make any necessary changes before distributing it to your employees as it will govern participant rights under the Privacy Rules.)*

C. Administrative Safeguards for the Privacy Rules

In implementing the administrative safeguard requirements, the Plan Sponsor must evaluate the roles of its employees to determine which employees (or classes of employees) will have access to PHI. The Plan Sponsor must then implement policies and procedures to ensure that only these designated employees (or classes of employees) have access to PHI, and even then, only to the minimum amount of PHI necessary to perform plan administration duties for the health plan. For example, PHI from the health plan may not be used to administer the disability program, which is not considered a health plan under the privacy rule. Finally, the Plan Sponsor must ensure that these employees do not use or dispose of PHI in a way prohibited by the final regulations. If you sponsor other health plans and have access to PHI you likely will have already begun to establish your HIPAA Policies and Procedures document.

A Plan Sponsor of a self-insured plan must satisfy the following administrative safeguard requirements:

- Designate a privacy official responsible for the development and implementation of policies and procedures;
- Designate a contact person or office for receiving complaints and providing additional information concerning the privacy notice (this may be but is not required to be the same person as the privacy official);
- Train all employees who will have access to PHI on privacy policies and procedures;
- Establish appropriate administrative safeguards (both technical and physical) to protect PHI from accidentally being used or disclosed in violation of HIPAA's requirements (for example, all PHI should be kept in locked file cabinets and computer systems should have adequate firewalls to protect electronically stored PHI);
- Create a process for individuals to lodge a complaint and a system for handling such complaints and recording their resolution;
- Design a system of written disciplinary policies and sanctions for workforce members who violate the privacy rules;
- Mitigate, to the extent possible, of any harmful effect that is known to the covered entity resulting from an improper use or disclosure of PHI;
- Refrain from taking retaliatory action against any individuals who exercise their rights under HIPAA;
- Do not require an individual to waive his or her rights under HIPAA;
- Implement policies and procedures designed to comply with the HIPAA Privacy Rules and have a written manual of such policies and procedures; and
- Amend the health plan document to include reference to the Privacy Rules *(the amended Flex One Cafeteria Plan Packet accomplishes this by reference to your Privacy Notice)*

III. How the HIPAA Security Rules Affect Sponsors of Self-Insured Health Plans

The HIPAA Security Regulations require plan sponsors who have access to electronic PHI to amend their plan documents to certify that they will comply with the Security Rule. For those plan sponsors with access to electronic PHI, the amendment must require the plan sponsor to:

- Implement reasonable and appropriate safeguards for electronic PHI created, received, maintained or transmitted to or by a plan sponsor on behalf of the group health plan;
- Ensure electronic "firewalls" are in place to secure the electronic PHI;
- Ensure that all business partners with access to electronic PHI comply with the Security requirements; and
- Report to the group health plan any security incident of which it becomes aware.

The HIPAA Security Regulations also require that language be added to the business associate agreement. Specifically, the agreement must provide that the business associate will:

- Implement safeguards to protect electronic PHI it creates, receives, maintains or transmits on behalf of the health plan;
- ensure that any agent or subcontractor to whom it provides the health plan's electronic PHI agrees to implement safeguards to protect the PHI;
- report to the covered entity any security incidents of which it becomes aware, and
- authorize termination of the agreement by the health plan, if the health plan determines that the business associate has violated material terms of the agreement. *(We have attached a sample "HIPAA Business Associate Agreement" as Exhibit A, and it is intended to satisfy your HIPAA business associate agreement requirements with respect to Aflac's Flex One services)*

Finally, the Security Regulations require all covered entities to appoint a security official and assign all the covered entity's security responsibilities to that individual. A specific person must be named, but the same person could be both the security and privacy official. The Security Official is responsible for conducting a risk analysis with regard to electronic PHI and addressing certain "implementation specifications" imposed by the regulations. More information can be obtained with regard to these requirements by visiting the HHS website at <http://www.cms.hhs.gov/hipaa/hipaa2>.

SAMPLE

Exhibit A
HIPAA
BUSINESS ASSOCIATE AGREEMENT

THIS APPENDIX, effective _____ by and between _____ ("Plan") and American Family Life Assurance Company of Columbus (Aflac) is incorporated into and made a part of the Reimbursement Services Agreement ("Agreement") between Aflac and ("Employer"). This Exhibit A is intended to comply with the business associate agreement provisions set forth in 45 CFR §§ 164.314 and 164.504(e), and any other applicable provisions of 45 CFR parts 160 and 164, issued pursuant to the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA").

Aflac recognizes that in the performance of services for the Plan under the Agreement it will have access to, create, and/or receive from the Plan or on its behalf Protected Health Information ("PHI") For purposes herein, PHI shall have the meaning given to such term in 45 CFR § 1640.103, limited to the information created or received from the Plan or on its behalf by Aflac. Whenever used in this Exhibit A other capitalized terms shall have the respective meaning set forth below, unless a different meaning shall be clearly required by the context In addition, other capitalized terms used in this Exhibit A but not defined herein, shall have the same meaning as those terms are defined under HIPAA

SECTION 1. AFLAC RESPONSIBILITIES

- 1 1 Aflac may use or disclose PHI, provided that such use or disclosure of PHI would not violate HIPAA, as follows: (a) as permitted or required in this Exhibit A and in the Agreement; (b) as Required by Law in accordance with 45 CFR § 164.512; (c) for the proper management and administration of Aflac; (d) to fulfill any present or future legal responsibilities; (e) for Data Aggregation services to the Plan (as defined in 45 CFR § 164.501); or (f) any use and disclosure of PHI that has been de-identified within the meaning of 45 CFR § 164.514.
- 1 2 Aflac agrees to implement commercially reasonable and appropriate safeguards to prevent the use or disclosure of PHI other than as provided for by this Exhibit A
- 1 3 Aflac agrees to implement commercially reasonable administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan.
- 1 4 Aflac agrees to report to the Plan any successful Security Incident that is material or any use or disclosure of PHI of which it becomes aware that is not provided for by this Exhibit A or in the Agreement
- 1 5 Aflac agrees to ensure that any agent, including a subcontractor, to whom it provides PHI agrees to similar restrictions and conditions that apply through this Exhibit A to Aflac with respect to such information
- 1 6 At the request of the Plan, and in a mutually agreeable time and manner, Aflac agrees to provide access to PHI it holds in a Designated Record Set (as defined in 45 CFR § 164.501), to the Plan, or as directed by the Plan, to an Individual in order to meet the requirements under 45 CFR § 164.524 Aflac shall have the right to charge the Individual a reasonable cost-based fee as permitted by 45 CFR § 164.524. Aflac assumes no obligation to coordinate the provision of PHI maintained by other business associates of the Plan
- 1 7 At the request of the Plan, and in a mutually agreeable time and manner, Aflac agrees to make any amendment(s) to PHI it holds in a Designated Record Set that the Plan directs or agrees to pursuant to 45 CFR § 164.526 at the request of the Plan or an Individual
- 1 8 At the request of the Plan, and in a mutually agreeable time and manner, Aflac agrees to make its internal practices, books and records relating to the use and disclosure of PHI received from, or created or received by Aflac on behalf of the Plan available to the Secretary (as defined in 45 CFR § 160.103), for purposes of the Secretary determining the Plan's compliance with the Privacy and Security Rules
- 1 9 Aflac agrees to document such disclosures of PHI and information related to such disclosures as would be required for the Plan to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.
- 1 10 Aflac agrees to provide to Plan or an Individual, in the time and manner designated by Plan, information collected in accordance with 1 09 to permit the Plan to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528
- 1 11 Except as provided for herein, or as required by law, upon termination of the Agreement, Aflac agrees to return to the Plan or destroy PHI and retain no copies in any form, if feasible In the event that Aflac determines that returning or destroying the PHI is infeasible, Aflac agrees to extend the protections, limitations and restrictions of this Exhibit A to such PHI and to

limit any further uses and/or disclosures of such PHI retained to the purposes that make the return or destruction of the PHI infeasible, for as long as Aflac maintains such PHI. Both parties agree that this Section 1.11 shall survive the expiration or termination of the Agreement and remain in full force and effect thereafter for so long as Aflac or any of Aflac's employees, subcontractors, or agents remain in possession of any PHI, and shall expire thereafter.

SECTION 2. PLAN AND EMPLOYER RESPONSIBILITIES

- 2.1 Employer acting as the Plan Sponsor agrees to comply with the administrative requirements set forth in 45 CFR §§ 164.530 and 164.504(f), including but not limited to amending the Plan to restrict uses and disclosures of PHI.
- 2.2 The Employer acknowledges and agrees that Aflac shall only disclose PHI in its possession to the Named Contact as designated (and through the modes specified) in Section III F of the Agreement. The employees who are identified on the applicable plan document request form (and in the Plan documents) shall be the Designated Persons in accordance with 45 CFR § 164.504(f), and disclosures to such persons by Aflac are solely for purposes of carrying out plan administration functions that the Employer performs for the Plan.
- 2.3 Employer shall timely notify Aflac in writing of any changes to the names or positions of employees listed in subsection 2.2 as Designated Persons. Aflac shall have no duty to inquire whether the list of Designated Persons is accurate.
- 2.4 Employer acknowledges and agrees that under the HIPAA Privacy Rules Designated Persons may only request the minimum amount of PHI necessary to accomplish the purpose of the request, use or disclosure. Aflac shall have no duty to ensure that the amount of PHI requested by the Designated Persons is the minimum amount necessary.
- 2.5 Aflac shall have no liability for uses or disclosures contemplated in the Agreement. Employer shall indemnify and hold harmless Aflac (and its employees) for any and all liability Aflac may incur as a result of any improper use or disclosure of PHI by the Plan, Employer or a Designated Person(s).
- 2.6 Plan shall not request Aflac to use or disclose PHI in any manner that would not be permissible under the Privacy and Security Rules if done by the Plan, except that Aflac may use or disclose PHI as provided in Section 1.1.
- 2.7 Plan shall provide Plan participants and beneficiaries with adequate notice of the uses and disclosures of PHI that may be made by the Plan, and of the individual's rights and the Plan's responsibilities with respect to PHI as required in 45 CFR § 164.520. The Plan further agrees to forward a copy of such notice to Aflac, as well as any changes to such notices.
- 2.8 Plan shall provide Aflac with any changes to, or revocation of, permission by a Participant or Beneficiary to use or disclose PHI, if such changes affect Aflac's permitted or required uses or disclosures.
- 2.9 Plan shall not agree to any special privacy restrictions requested by an Individual without Aflac's written approval, including those provided for 45 CFR § 164.522.
- 2.10 Notwithstanding any other provision of this Agreement, Aflac recognizes that the Plan may have other business associates and its sharing of PHI with such other business associates of the Plan will be reasonable and necessary to facilitate Plan administration. Aflac agrees to disclose PHI in its possession to such other entities as directed by the Plan, provided that such other business associates agree to comply with the Privacy and Security Rules with respect to the use and disclosure of such PHI. Plan shall be solely responsible for ensuring that it has entered into appropriate business associate agreements with its other business associates in accordance with 45 C.F.R. § 164.504(e).

SECTION 3. MISCELLANEOUS

- 3.1 Both parties agree that nothing express or implied in this Exhibit A is intended to confer, nor shall anything herein confer, upon any person other than Aflac, the Plan, the Employer, and their respective successors, or assigns, any rights, remedies, obligations, or liabilities whatsoever.
- 3.2 This Exhibit A shall be interpreted as broadly as necessary to implement and comply with HIPAA and the Privacy and Security Rules, and any ambiguity in this Exhibit A shall be resolved in favor of a meaning that complies and is consistent with HIPAA and the Privacy and Security Rules. Both parties agree that the provisions of this Exhibit A shall prevail over any provisions in the Agreement that may conflict or appear inconsistent with any provisions of this Exhibit A.
- 3.3 Both parties acknowledge that future changes to the requirements of HIPAA, the Privacy and Security Rules, and other applicable laws relating to the security or confidentiality of PHI may require amendment of this Exhibit A. Upon the written request of either party, the other party agrees to promptly enter into negotiations concerning the terms of an amendment to this Exhibit A. If either party disagrees with any such amendment, it shall so notify the other party in writing within 30 days of notice. If the parties are unable to agree on an amendment within 30 days thereafter, then any of the parties may terminate the Agreement in accordance with the termination section of the Agreement.

- 3 4 Notwithstanding Section 3 3 above and without limiting the rights of the parties under the Agreement, upon written notice of the existence of an alleged material breach of the terms of this Exhibit A, the Plan shall afford Aflac an opportunity to cure said breach upon mutually agreeable terms Failure to cure within 30 days shall be immediate grounds for termination of the Agreement
- 3 5 Section 1 11 shall survive the termination or expiration of the Agreement for the reasons stated therein The other provisions of this Exhibit A shall survive the termination of the Agreement and remain in full force and effect thereafter for so long as Aflac or any of its employees, agents or subcontractors remains in possession of PHI in accordance with Section 1.11 of this Exhibit A and shall expire thereafter.

IN WITNESS WHEREOF, the parties hereto have caused this Exhibit A to the Services Agreement to be executed and signed by an Officer of the Employer and an Officer or duly authorized Worldwide Headquarters Employee of Aflac to do so

Dated at Aflac this _____ day of _____, _____

By: _____

Michael D Flock
Second Vice President, Aflac Benefit Services

Dated at _____ this _____ day of _____, _____

By: _____ Title: _____

Street Address: _____

SAMPLE

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SAMPLE

PREAMBLE

The Employer hereby establishes a Flexible Benefits Plan ("Plan") for its Employees for purposes of providing eligible Employees with the opportunity to choose from among the fringe benefits available under the Plan. The Plan is intended to qualify as a cafeteria plan under the provisions of Code Section 125. The Dependent Care Expense Reimbursement Plan ("DDC") is intended to qualify as a Code Section 129 dependent care assistance plan, and the Medical Care Expense Reimbursement Plan ("URM") is intended to qualify as a Code Section 105 medical expense reimbursement plan. Although printed within this document, the DDC and URM Plans are separate written plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Sections 105 and 129 of the Code and all applicable provisions of ERISA. The DDC and the URM are available only if designated as a Benefit Plan or Policy in the Summary Plan Description (SPD).

FLEXIBLE BENEFITS PLAN

ARTICLE I - DEFINITIONS

- 1.01 **"Affiliated Employer"** means any entity who is considered with the Employer to be a single employer in accordance with Code Section 414(b), (c), or (m) of the Code
- 1.02 **"After-tax Contribution(s)"** means amounts withheld from an Employee's Compensation pursuant to a Salary Redirection Agreement (SRA) after all applicable state and federal taxes have been deducted. Such amounts are withheld for purposes of purchasing one or more of the Benefit Plans or Policies available under the Plan
- 1.03 **"Anniversary Date"** means the first day of any Plan Year
- 1.04 **"Benefit Plan(s) or Policy(ies)"** means those Qualified Benefits available to a Participant under this Plan as set forth in the SPD, as amended and/or restated from time to time
- 1.05 **"Board of Directors"** means the Board of Directors or other governing body of the Employer (the "Board") The Board, upon adoption of this Plan, appoints the Plan Administrator to act on the Employer's behalf in all matters regarding the Plan
- 1.06 **"Change in Status"** means any of the events described in the SPD, as well as any other events included under subsequent changes to Code Section 125 or regulations issued under Code Section 125, that the Plan Administrator (in its sole discretion) decides to recognize on a uniform and consistent basis as a reason to change the election mid-year Note: See the SPD for requirements that must be met to permit certain mid-year election changes on account of a Change in Status.
- 1.07 **"Code"** means the Internal Revenue Code of 1986, as amended.
- 1.08 **"Compensation"** means the cash wages or salary paid to an Employee by the Employer.
- 1.09 **"Dependent"** means any individual who is a tax dependent of the Participant as defined generally in Code Section 152; however, for health plan purposes, a Dependent shall also be defined as in Code Section 105(b) and for DDC purposes (if offered under the Plan), a Dependent shall also be defined as in Code Section 21(e)(5) (i.e. dependent of the custodial parent as defined in Code Section 152(e)).
- 1.10 **"Dependent Care Reimbursement"** shall have the meaning assigned to it by Section 5 01 of the Plan
- 1.11 **"Earned Income"** means all income derived from wages, salaries, tips, self-employment, and other Compensation (such as disability or wage continuation benefits), but only if such amounts are includable in gross income for the taxable year. Earned income does not include any other amounts excluded from earned income under Code § 32(c)(2), such as amounts received under a pension or annuity, or pursuant to workers' compensation.
- 1.12 **"Effective Date"** of this Plan is the effective date set forth in the SPD
- 1.13 **"Eligible Employment-Related Expenses"** means those Qualifying Employment-Related Expenses (as defined below) paid or incurred incident to maintaining employment after the date of the Employee's participation in the DDC and during the Plan Year, other than amounts paid to.
- (a) an individual with respect to whom a Dependent deduction is allowable under Code Sec 151(c) to the Participant or his Spouse,
 - (b) the Participant's Spouse; or

(c) a child of the Participant who is under 19 years of age at the end of the taxable year in which the expenses were incurred.

- 1.14 "Eligible Medical Expenses"** means those expenses incurred by the Employee, or the Employee's Spouse or Dependents, after the date of the Employee's participation in the URM and during the Plan Year (plus any applicable grace period extension as described in the SPD) to the extent that the expense satisfies the conditions set forth in the Summary Plan Description and are for "medical care" as defined by Code Section 213(d). For purposes of this Plan, the following expenses are not considered "Eligible Medical Expenses" even if they otherwise constitute "medical care" under Code Section 213(d): i) expenses for qualified long term care services (as defined in Code § 7702B(c)); and ii) expenses incurred for health insurance premiums. For purposes of this Plan, an expense is "incurred" when the Participant or beneficiary is furnished the medical care or services giving rise to the claimed expense, regardless of when the expense is paid.
- 1.15 "Employee"** means any individual who is considered to be in a legal employer-employee relationship with the Employer for federal tax-withholding purposes. Such term includes "former employees" for the limited purpose of allowing continued eligibility for benefits hereunder for the remainder of the Plan Year in which an employee ceases to be employed by the Employer. The term "Employee" shall not include any leased employee (as that term is defined in Code Section 414(n)) or any self-employed individual who receives from the Employer "net earnings from self-employment" within the meaning of Code Section 401(c)(2) unless such individual is also an Employee.
- 1.16 "Employer"** means the Employer and the Affiliated Employers named in the SPD provided, however, that when the Plan provides that the Employer has a certain power (e.g., the appointment of a Plan Administrator, entering into a contract with a third party insurer, or amendment or termination of the plan) the term "Employer" shall mean only that entity named on the first line of the Plan Information Summary of the SPD, and not any Affiliated Employer. Affiliated Employers who sign the Plan Information Summary and/or otherwise adopt the Plan shall be bound by the Plan as adopted and subsequently amended unless they clearly withdraw from participation herein.
- 1.17 "ERISA"** shall mean the Employee Retirement Income Security Act of 1974, as amended.
- 1.18 "Health Care Reimbursement"** shall have the meaning assigned to it by Section 5.01 of the Plan.
- 1.19 "Highly Compensated Individual"** means an individual defined under Code Section 105(h), 125(e), or 414(q), as amended, as a "highly compensated individual" or a "highly compensated employee."
- 1.20 "Key Employee"** means an individual who is a "key employee" as defined in Code Section 125(b)(2), as amended.
- 1.21 "Nonelective Contribution(s)"** means any amount that the Employer, in its sole discretion, may contribute on behalf of each Participant to provide benefits for such Participant and his or her Spouse and Dependents, if applicable, under one or more of the Benefit Plan(s) or Policy(ies) offered under the Plan. The amount of employer contribution that is applied towards the cost of the Benefit Plan(s) or Policy(ies) for each Participant and/or level of coverage shall be subject to the sole discretion of the Employer. The amount of Nonelective Contribution for each Participant may be adjusted upward or downward in the contributing Employer's sole discretion. The amount shall be calculated for each Plan Year in a uniform and nondiscriminatory manner and may be based upon the Participant's dependent status, commencement or termination date of the Participant's employment during the Plan Year, and such other factors as the Employer shall prescribe. To the extent set forth in the SPD or enrollment material, the Employer may make Nonelective Contributions available to Participants and allow Participants to allocate the Nonelective Contributions among the various Benefit Plans or Policies offered under the Plan in a manner set forth in the SPD of additional, taxable Compensation except as otherwise provided in the SPD or enrollment material.
- 1.22 "Participant"** means an Employee who becomes a Participant pursuant to Article II.
- 1.23 "Plan"** means the Flexible Benefits Plan, the SPD (defined in Section 1.35 herein) and (if applicable) the related Trust created by this document.
- 1.24 "Plan Administrator"** means the person(s) or Committee identified in the SPD that is appointed by the Employer with authority, discretion, and responsibility to manage and direct the operation and administration of the Plan. If no such person is named, the Plan Administrator shall be the Employer.
- 1.25 "Plan Year"** shall be the period of coverage set forth in the SPD (as extended by any applicable grace period as set forth in the SPD).
- 1.26 "Pre-tax Contribution(s)"** means amounts withheld from an Employee's Compensation pursuant to a Salary Redirection Agreement before any applicable state and federal taxes have been deducted. The amounts are withheld for purposes of purchasing one or more of the Benefit Plans or Policies available under the Plan. This amount shall not exceed the premiums or contributions attributable to the most costly Benefit Plan or Policy afforded hereunder, and for purposes of Code Section 125, shall be treated as an Employer contribution (this amount may, however, be treated as an Employee contribution for purposes of state insurance laws).

- 1.27 **"Qualified Benefit"** means any benefit excluded from the Employee's taxable income under Chapter 1 of the Code other than Sections 106(b), 117, 124, 127, or 132 and any other benefit permitted by the Income Tax Regulations (i.e., any life insurance coverage that is includable in gross income by virtue of exceeding the dollar limitation on nontaxable coverage under Code Sec 79) Notwithstanding the previous sentence, long-term care insurance is not a "Qualified Benefit"
- 1.28 **"Qualifying Employment-Related Expenses"** means those expenses that would be considered to be employment-related expenses under Section 21(b)(2) of the Code (relating to expenses for household and dependent care services necessary for gainful employment) if paid for by the Employee to provide Qualifying Services.
- 1.29 **"Qualifying Individual"** means an individual defined as a "Qualifying Individual" in the Summary Plan Description
- 1.30 **"Qualifying Services"** means services relating to the care of a Qualifying Individual that enable the Participant or his Spouse to remain gainfully employed which are performed:
- (a) in the Participant's home; or
 - (b) outside the Participant's home for (1) the care of a Dependent of the Participant who is under age 13, or (2) the care of any other Qualifying Individual who resides at least eight (8) hours per day in the Participant's household. If the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six (6) individuals not residing at the facility), the center must comply with all applicable state and local laws and regulations
- 1.31 **"Reimbursement Account(s)" or "Account(s)"** shall be the funding mechanism by which amounts are withheld from an Employee's Compensation and retained for future Health Care Reimbursement (as defined in Section 1.18 herein) and Dependent Care Reimbursement (as defined in Section 1.10 herein) to the extent adopted by the Employer as set forth in the SPD. No money shall actually be allocated to any individual Participant Account(s); any such Account(s) shall be of a memorandum nature, maintained by the Administrator for accounting purposes, and shall not be representative of any identifiable trust assets. No interest will be credited to or paid on amounts credited to the Participant Account(s).
- 1.32 **"Salary Redirection Agreement" or "SRA"** means the actual or deemed agreement pursuant to which an eligible Employee or Participant elects to contribute his share of the cost of chosen Benefit Plans or Policies with Pre-tax or After-tax Contributions and/or Benefit Credits (if offered under the Plan) in accordance with Article III herein. If the Employer utilizes an interactive voice response (IVR) system or web-based program for enrollment, the SRA may be maintained on an electronic database in accordance with all applicable federal and/or state laws.
- 1.33 **"Spouse"** means an individual who is legally married to a Participant (and who is treated as a spouse under the Code), but for purposes of the Dependent Care Reimbursement Plan provisions, shall not include an individual who, although married to the Participant, files a separate federal income tax return, maintains a separate, principal residence from the Participant during the last six months of the taxable year, and does not furnish more than one-half of the cost of maintaining the principal place of abode of the Qualifying Individual.
- 1.34 **"Student"** means an individual who, during each of five (5) or more calendar months during the Plan Year, is a full time student at any college or university, the primary function of which is the conduct of formal instruction, and which routinely maintains a regular faculty and curriculum and normally has an enrolled student body in attendance at the location where its educational activities are regularly presented
- 1.35 **"Summary Plan Description" or "SPD"** means the document attached as Attachment I to the Plan document that describes the term of Plan not set forth herein. The SPD and all applicable appendices are incorporated hereto by reference
- 1.36 **"Trustee"** (if applicable) means the person(s) or institution (and their successors) named on the signature page attached hereto, who have assented to being so named by their signature to this Agreement, otherwise empowered to hold and disburse the funds that are created hereunder

ARTICLE II - ELIGIBILITY AND PARTICIPATION

- 2.01 **Eligibility to Participate.** Each Employee who satisfies the eligibility requirements set forth in the SPD shall be eligible to participate in this Plan as of any applicable entry date set forth in the SPD. The provisions of this Article are not intended to override any eligibility requirement(s) or waiting period(s) specified in the applicable Benefit Plans or Policies and the terms of eligibility and participation for the Benefit Plan(s) or Policy(ies) offered under the Plan shall be subject to the requirements specified in the governing documents of the Benefit Plans or Policies.
- 2.02 **Termination of Participation** Participation shall terminate on the earliest of the dates set forth in the SPD

- 2.03 Eligibility to Participate in Reimbursement Accounts.** Each Employee who satisfies the eligibility requirements set forth in the SPD shall be eligible to participate in the Reimbursement Accounts, if adopted by the Employer, on the date set forth in the SPD. Participation in the Reimbursement Accounts shall be effective on the date set forth in the SPD
- 2.04 Qualifying Leave Under FMLA.** Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the Family and Medical Leave Act of 1993 (the "FMLA"), then to the extent required by the FMLA, the Participant will be entitled to continue the Participant's Benefit Plans or Policies that provide health coverage (including URM benefits to the extent offered under the Plan) on the same terms and conditions as if the Participant were still an active Employee. The requirements for continuing coverage, procedures for FMLA leave, and payment option(s) provided by the Employer (as described above) will be set forth in the SPD and will be administered in accordance with the regulations issued under Code Section 125 and in accordance with the FMLA
- 2.05 Non-FMLA Leave.** If a Participant goes on an unpaid leave of absence that does not affect eligibility under this Plan or the Benefit Plans or Policies chosen by the Participant, then the Participant will continue to participate and the contributions due for the Participant will be paid by one or more of the payment options described in the SPD. If a Participant goes on an unpaid leave that affects eligibility under this Plan or the Benefit Plans or Policies chosen by the Participant, the election change rules in Section 3 04 will apply. If such policy requires coverage to continue during the leave but permits a Participant to discontinue contributions while on leave, the Participant will, upon returning from leave, be required to repay the contributions not paid by the Participant during the leave

ARTICLE III - BENEFIT ELECTIONS

- 3.01 Election of Contributions.** A Participant may elect any combination of Pre-tax Contributions or After-tax Contributions (as set forth in the SPD) to fund any Benefit Plan or Policy available under the Plan, provided that only Qualified Benefits may be funded with Pre-tax Contributions. The Employer may, but is not required, to allocate Non-elective Contributions to one or more Benefit Plans or Policies offered under the Plan and to the extent set forth in the SPD or enrollment material, may allow the Participants to allocate his allotted share of Non-elective Contributions among the various Benefit Plans or Policies in a manner set forth in the SPD or enrollment material.
- 3.02 Initial Election Period.**
- (a) **Currently Eligible Employees.** An Employee who is eligible to become a Participant in this Plan as of the Effective Date must complete, sign and file an SRA with the Plan Administrator during the election period (as specified by the Plan Administrator) immediately preceding the Effective Date of the Plan in order to become a Participant on the Effective Date. The elections made by the Participant on this initial SRA shall be effective, subject to Section 3 04, for the Plan Year beginning on the Effective Date.
 - (b) **New Employees and Employees Who Have Not Yet Satisfied The Plan's Waiting Period.** An Employee who becomes eligible to become a Participant in this Plan after the Effective Date must complete, sign and file a SRA with the Plan Administrator (or its designated third party administrator as set forth on the SRA) during the Initial Election Period set forth in the SPD or the enrollment material. Participation will commence under this Plan as set forth in the SPD. Coverage under the component Benefit Plans or Policies will be effective in accordance with the governing provisions of such Benefit Plans or Policies.
 - (c) **Failure to Elect.** An eligible Employee who fails to complete, sign and file a SRA in accordance with paragraph (a) or (b) above during an initial election period may become a Participant on a later date in accordance with Section 3 03 or 3 04.
- 3.03 Annual Election Period.** Each Employee who is a Participant in this Plan or who is eligible to become a Participant in this Plan shall be notified, prior to each Anniversary Date of this Plan, of his right to become a Participant in this Plan, to continue participation in this Plan, or to modify or to cease participation in this Plan, and shall be given a reasonable period of time in which to exercise such right: such period of time shall be known as the Annual Election Period. The date that the Annual Election Period commences and ends will be set forth in the SPD or the enrollment material. An election is made during the Annual Election Period in the manner set forth in the SPD. The consequences of failing to make an election during the Annual Election Period will be set forth in the SPD.
- 3.04 Change of Elections.** A Participant shall not make any changes to the Pre-tax Contribution amount or, where applicable, to the Participant's elected allocation of Nonelective Contributions except for election changes permitted under this Section 3 04, and for changes made during the Annual Election Period (Section 3 03), changes caused by termination of employment (Section 3 05) and changes pursuant to the Family and Medical Leave Act (Section 2 04)

Except as provided in the SPD for HIPAA special enrollment rights arising from the birth, adoption, or placement for adoption of a child, all election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the first pay period coinciding with or immediately following the date that the election change was filed) but, as determined by the Plan Administrator, election changes may become effective later to the extent

the coverage in the applicable component plan commences later. The circumstances under which a Participant may change his election under this Plan are set forth in the SPD.

- 3.05 Impact of Termination of Employment on Election or Cessation of Eligibility.** Termination of employment or cessation of eligibility shall automatically revoke any SRA. Except as provided below, if revocation occurs under this Section 3.05, no new election with respect to Pre-Tax Contributions may be made by such Participant during the remainder of the Plan Year. Rules governing elections for former participants rehired during the same Plan Year shall be set forth in the SPD

ARTICLE IV - BENEFIT FUNDING AND CREDITS AND DEBITS TO ACCOUNTS

- 4.01 Source of Benefit Funding.** The cost of coverage under the component Benefit Plans or Policies shall be funded by the Participant's Pre-tax and/or After-tax Contributions and/or any Nonelective Contributions provided by the Employer. The required contributions for each of the Benefit Plans or Policies offered under the Plan shall be made known to employees in enrollment materials. Pre-tax or After-tax Contributions (as elected by the Employee on the SRA) shall equal the contributions required from the Participant less any available Nonelective Contributions allocated thereto by the Employer, or where applicable, the Participant for coverage of the Participant or the Participant's Spouse or Dependents under the Benefit Plans or Policies elected by the Participant under this Plan. Amounts withheld from a Participant's Compensation as Pre-tax Contributions or After-tax Contributions shall be applied to fund benefits as soon as administratively feasible. The maximum amount of Pre-tax Contributions plus any Nonelective Contributions made available by the Employer for Benefit Plan(s) or Policy(ies) offered under this Plan shall not exceed the aggregate cost of the Benefit Plan(s) or Policy(ies) elected by the Employee
- 4.02 Reduction of Certain Elections to Prevent Discrimination** If the Plan Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy for such Plan Year any requirement imposed by the Code or any limitation on Pre-tax Contributions allocable to Key Employees or to Highly Compensated Individuals, the Plan Administrator shall take such action(s) as he deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification or revocation of a Highly Compensated Individual's or Key Employee's election without the consent of such Employee.
- 4.03 Health Care Reimbursement.** To the extent offered under the Plan, each Participant's URM will be credited for Health Care Reimbursement with amounts withheld from the Participant's Compensation and any Nonelective Contributions allocated thereto by the Employer or where applicable, the Participant. The Account will be debited for Health Care Reimbursements disbursed to the Participant in accordance with Article V of this document. The entire amount elected by the Participant on the SRA as an annual amount for the Plan Year for Health Care Reimbursement less any Health Care Reimbursements already disbursed to the participant for Expenses incurred during the Plan Year (plus any grace period as set forth in the SPD) shall be available to the Participant at any time during the Plan Year without regard to the balance in the Health Care Account (provided that the periodic contributions have been made). Thus, the maximum amount of Health Care Reimbursement at any particular time during the Plan Year will not relate to the amount that a Participant has had credited to his URM. In no event will the amount of Health Care Reimbursements in any Plan Year (plus any grace period as set forth in the SPD) exceed the annual amount specified for the Plan Year in the SRA for Health Care Reimbursement. Any amount credited to the Health Care Account shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide Health Care Reimbursement within the Run-Off period set forth in the SPD. Amounts so forfeited shall be used in a manner that is permitted within the applicable Department of Labor ("DOL") or Internal Revenue Service ("IRS") regulations. The maximum annual reimbursement under the URM shall be set forth in the SPD. The Employer may establish a minimum annual reimbursement amount as set forth in the SPD.
- 4.04 Dependent Care Reimbursement.** To the extent offered under the Plan, each Participant's DDC will be credited for Dependent Care Reimbursement with amounts withheld from the Participant's Compensation, and any Nonelective Contributions allocated thereto by the Employer or where applicable, the Participant. The Dependent Care Account will be debited for Dependent Care Reimbursements disbursed to the Participant in accordance with Article V of this document. In the event that the amount in the Account is less than the amount of reimbursable claims at any time during the Plan Year, the excess part of the claim will be carried over into following months within the same Plan Year, to be paid out as the Dependent Care Account balance becomes adequate. In no event will the amount of Dependent Care Reimbursements exceed the amount credited to the Dependent Care Account for any Plan Year. Any amount allocated to the Dependent Care Account shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide Dependent Care Reimbursement for the Plan Year within the Run-Off period set forth in the SPD. Amounts so forfeited shall be used in a manner that is not prohibited by applicable federal or state law. The maximum annual reimbursement amount shall be set forth in the SPD. The Employer may establish a minimum annual reimbursement amount as set forth in the SPD.

ARTICLE V - BENEFITS

- 5.01 Qualified Benefits.** The maximum benefit a Participant may elect under this Plan shall not exceed the sum of i) the aggregate premium for all Benefit Plan(s) or Policy(ies) set forth in the SPD (other than Health and DDC); ii) the

maximum annual Health Care Reimbursement under the URM as set forth in the SPD (if offered under the Plan), and iii) the maximum annual Dependent Care Reimbursement under the DDC as set forth in the SPD (if offered under the Plan)

- (a) **Special Rules for Health Care Reimbursement.** To the extent offered under the Plan, payment shall be made to the Participant in cash as reimbursement for Eligible Medical Expenses incurred by the Participant or his Spouse or Dependents while he is a Participant during the Plan Year (plus any grace period as specified in the SPD) for which the Participant's election is effective provided that the substantiation requirements of Section 6 05 herein are satisfied
- (b) **Special Rules for Dependent Care Reimbursement.** To the extent offered under the Plan, payment shall be made to the Participant in cash as reimbursement for Eligible Employment Related Expenses incurred by him while a Participant, during the Plan Year for which the Participant's election is effective, provided that the substantiation requirements of Section 6 05 have been satisfied

- 5.02 **Cash Benefit.** To the extent that a Participant does not elect to have the maximum amount of his Compensation contributed as a Pre-tax Contribution or After-tax Contribution hereunder, such amount not elected shall be paid to the Participant in the form of normal Compensation payments; provided, however, that any applicable Nonelective Contributions may not be received in the form of cash compensation, except as otherwise provided for in the SPD or the enrollment material
- 5.03 **Repayment of Excess Reimbursements.** If, as of the end of any Plan Year, it is determined that a Participant has received payments under this Plan that exceed the amount of Eligible Medical Expenses and/or Eligible Employment Related Expenses that have been substantiated by such Participant during the Plan Year as required by Section 6 05 herein, the Plan Administrator shall give the Participant prompt written notice of any such excess amount, and the Participant shall repay the amount of such excess to the Employer within sixty (60) days of receipt of such notification
- 5.04 **Termination of Reimbursement Accounts.** Coverage under the URM and/or DDC shall cease as of the day in which a Participant is no longer employed by the Employer or when a premium payment for the respective plan(s) has been missed for any reason. Provided, however, that Participants may submit claims for reimbursement for Eligible Employment-Related Expenses arising during the Plan Year at any time until the end of the Run-Off period set forth in the SPD. Participants in the URM may submit claims for reimbursement for Eligible Medical Expenses arising during the Plan Year and before the date of separation from service at any time until the end of the Run-Off period set forth in the SPD. Unless a COBRA election is made as set forth in the SPD, Participants shall not be entitled to receive reimbursement for Eligible Medical Expenses incurred after employment ceases under this Section. Any unused reimbursement benefits at the expiration of the Plan Year (as set forth in the SPD) shall be treated in accordance with Sections 4.03 or 4.04. A special grace period may be applicable with regard to URM participation after the close of the Plan Year (see SPD)
- 5.05 **Coordination of Benefits Under the URM.** The URM is intended to pay benefits solely for otherwise unreimbursed medical expenses. Accordingly, it shall not be considered a group health plan for coordination of benefits purposes, and its benefits shall not be taken into account when determining benefits payable under any other plan.

ARTICLE VI - PLAN ADMINISTRATION

- 6.01 **Allocation of Authority.** The Board of Directors or applicable governing body (or an authorized officer of the Employer) appoints a Plan Administrator that keeps the records for the Plan and shall control and manage the operation and administration of the Plan. The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters arising thereunder, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD issued in connection with the Plan. In the case of an insured Benefit Plan or Policy, the insurer shall be the named fiduciary with respect to benefit claim determinations thereunder, and with respect to benefit claims shall have all of the powers of the Plan Administrator described herein. All determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following powers and duties:
 - (a) To require any person to furnish such reasonable information as he may request for the purpose of the proper administration of the Plan as a condition to receiving any benefits under the Plan,
 - (b) To make and enforce such rules and regulations and prescribe the use of such forms as he shall deem necessary for the efficient administration of the Plan;
 - (c) To decide on questions concerning the Plan and the eligibility of any Employee to participate in the Plan and to make or revoke elections under the Plan, in accordance with the provisions of the Plan;
 - (d) To determine the amount of benefits which shall be payable to any person in accordance with the provisions of the Plan, to inform the Employer or insurer as appropriate, of the amount of such benefits; and to provide a full and fair review to any Participant whose claim for benefits has been denied in whole or in part;

- (e) To designate other persons to carry out any duty or power which may or may not otherwise be a fiduciary responsibility of the Plan Administrator, under the terms of the Plan. Such entity will be referred to as a third party administrator and shall be identified in the SPD,
 - (f) To keep records of all acts and determinations, and to keep all such records, books of account, and data and other documents as may be necessary for the proper administration of the Plan; and
 - (g) To do all things necessary to operate and administer the Plan in accordance with its provisions
- 6.02 Payment of Administrative Expenses.** Except as otherwise provided in the SPD, the Employer currently pays all reasonable expenses incurred in administering the Plan.
- 6.03 Reporting and Disclosure Obligations.** Unless specified otherwise, it shall be the Employer and Plan Administrator's sole responsibility to comply with all filing, reporting, and disclosure requirements, imposed by the DOL and/or IRS, specifically including, but not limited to creating, filing and distributing Summary Annual Reports, Form 5500s, and SPDs. Furthermore, the Employer and Plan Administrator shall be required to amend the Plan as is necessary to ensure compliance with applicable tax and other laws and regulations
- 6.04 Indemnification.** The Plan Administrator shall be indemnified by the Employer against claims, and the expenses of defending against such claims, resulting from any action or conduct relating to the administration of the Plan except claims arising from gross negligence, willful neglect, or willful misconduct.
- 6.05 Substantiation of Expenses.** Each Participant must submit a written Claim Form to the Plan Administrator identified in the SPD or its designated plan service provider to receive reimbursements from the URM and/or DDC, on a form provided by the Plan Administrator accompanied by a written statement/bill from an independent third party stating that the expense has been incurred, and the amount thereof. The forms shall contain such evidence, as the Plan Administrator shall deem necessary as to substantiate the nature, the amount, and timeliness of any expenses that may be reimbursed.
- 6.06 Reimbursement.** Reimbursements shall be made as soon as administratively feasible after the required forms have been received by the Plan Administrator identified in the SPD or its designated plan service provider. Reimbursements of less than \$15 may be carried forward and aggregated with future reimbursements until the reimbursable amount is greater than \$15. However, claims for reimbursements outstanding at the end of the Plan Year (plus any grace period as set forth in the SPD) shall be reimbursed without regard to the \$15 threshold limit. Year-end expense reimbursements must be submitted to the Plan Administrator within 90 days of the close of the Plan Year for which the SRA is effective, and during which such expense was incurred, in order to be eligible for reimbursement
- 6.07 Annual Statements.** The Plan Administrator shall furnish each Participant with an annual statement, showing the amounts paid or expenses incurred by the Employer in providing Medical and/or Dependent Care Expense Reimbursement during the previous calendar year and the respective Reimbursement Account balance(s) on or before January 31 following the close of the applicable Plan Year

ARTICLE VII - FUNDING AGENT

The Plan shall be funded with amounts withheld from Compensation pursuant to SRAs, and/or Nonelective Contributions provided by the Employer, if any. The Employer will apply all such amounts, without regard to their source, to pay for the welfare benefits provided herein as soon as administratively feasible and shall comply with all applicable regulations promulgated by the DOL taking into consideration any enforcement procedures adopted by the DOL. If a Trust is designated Funding Agent in the SPD, an appropriate Trust Agreement shall be attached at the end of this Plan

ARTICLE VIII - CLAIMS PROCEDURES

The Plan has established procedures for reviewing claims denied under this Plan and those claims review procedures are set forth in the SPD. The Plan's claim review procedures set forth in the SPD shall only apply to issues germane to the pre-tax benefits available under this Plan (i.e., such as a determination of: a Change in Status; change in cost or coverage; or eligibility and participation matters under this Cafeteria Plan document), and to the extent offered under the Plan, claims for benefits under the Reimbursement Accounts

ARTICLE IX - AMENDMENT OR TERMINATION OF PLAN

- 9.01 Permanency.** While the Employer fully expects that this Plan will continue indefinitely, due to unforeseen, future business contingencies, permanency of the Plan will be subject to the Employer's right to amend or terminate the Plan, as provided in Sections 9.02 and 9.03 below. Nothing in this Plan is intended to be or shall be construed to entitle any Participant, retired or otherwise, to vested or non-terminable benefits
- 9.02 Employer's Right to Amend.** The Employer reserves the right to amend at any time any or all of the provisions of the Plan. All amendments shall be made in writing and shall be approved by the Employer in accordance with its normal

procedures for transacting business (e.g. by approval by the Board of Directors through a meeting or unanimous consent of all Board members). Such amendments may apply retroactively or prospectively as set forth in the amendment. Each Benefit Plan or Policy shall be amended in accordance with the terms specified therein, or, if no amendment procedure is prescribed, in accordance with this section. Any amendment made by the Employer shall be deemed to be approved and adopted by any Affiliated Employer.

9.03 Employer's Right to Terminate. The Employer reserves the right to discontinue or terminate the Plan without prejudice at any time and for any reason without prior notice. Such decision to terminate the Plan shall be made in writing and shall be approved by the Employer in accordance with its normal procedures for transacting business. Affiliated Employers may withdraw from participation in the Plan, but may not terminate the Plan.

9.04 Determination of Effective Date of Amendment or Termination. Any such amendment, discontinuance, or termination shall be effective as of such date as the Employer shall determine. No amendment, discontinuance or termination shall allow the return to any Employer of any Reimbursement Account balance for its use for any purpose other than for the exclusive benefit of the Participants and their beneficiaries except as provided in Section 4.03 and 4.04 herein.

ARTICLE X - GENERAL PROVISIONS

10.01 Not an Employment Contract. Neither this Plan nor any action taken with respect to it shall confer upon any person the right to continue employment with any Employer.

10.02 Applicable Laws. The provisions of the Plan shall be construed, administered and enforced according to applicable federal law and the laws of the state of the principal place of business of the Employer to the extent not preempted.

10.03 Post-Mortem Payments. Any benefit payable under the Plan after the death of a Participant shall be paid to his surviving spouse (if any), otherwise, to his estate. If there is doubt as to the right of any beneficiary to receive any amount, the Plan Administrator may retain such amount until the rights thereto are determined, without liability for any interest thereon.

10.04 Nonalienation of Benefits. Except as expressly provided by the Plan Administrator, no benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge, and any attempt to do so shall be void. No benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements, or torts of any person.

10.05 Mental or Physical Incompetency. Any person receiving or claiming benefits under the Plan shall be presumed to be mentally and physically competent and of age until the Plan Administrator receives a written notice, in a form and manner acceptable to it, that such person is mentally or physically incompetent or a minor, and that a guardian, conservator or other person legally vested with the care of his estate has been appointed.

10.06 Inability to Locate Payee. If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participants or other person after reasonable efforts have been made to identify or locate such person, such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited one year after the date any such payment first became due.

10.07 Requirement for Proper Forms. All communications in connection with the Plan made by a Participant shall become effective only when duly executed on any forms as may be required and furnished by, and filed with, the Plan Administrator.

10.08 Source of Payments. The Employer, the Trust fund (if selected as Funding Agent), and any insurance company contracts purchased or held by the Employer or funded pursuant to this Plan shall be the sole sources of benefits under the Plan. No Employee or beneficiary shall have any right to, or interest in, any assets of the Employer upon termination of employment or otherwise, except as provided from time to time under the Plan, and then only to the extent of the benefits payable under the Plan to such Employee or beneficiary.

10.09 Multiple Functions. Any person or group of persons may serve in more than one fiduciary capacity with respect to the Plan.

10.10 Tax Effects. Neither the Employer, its agents, the Plan Administrator, nor the Trustee makes any warranty or other representation as to whether any Pre-tax Premiums made to or on behalf of any Participant hereunder will be treated as excludable from gross income for local, state, or federal income tax purposes. If for any reason it is determined that any amount paid for the benefit of a Participant or Beneficiary is includable in an Employee's gross income for local, federal, or state income tax purposes, then under no circumstances shall the recipient have any recourse against the Plan Administrator or the Employer with respect to any increased taxes or other losses or damages suffered by the Employees as a result thereof. The Plan is designed and is intended to be operated as a "cafeteria plan" under Section 125 of the Code.

- 10.11 Gender and Number.** Masculine pronouns include the feminine as well as the neuter genders, and the singular shall include the plural, unless indicated otherwise by the context
- 10.12 Headings.** The Article and Section headings contained herein are for convenience of reference only, and shall not be construed as defining or limiting the matter contained thereunder
- 10.13 Incorporation by Reference.** Except for the Medical and Dependent Care Expense Reimbursement Plan(s), the actual terms and conditions of the separate component Benefit Plans or Policies offered under this Plan are contained in separate, written documents governing each respective benefit, and shall govern in the event of a conflict between the individual plan document, and this Plan as to substantive content. To that end, each such separate document, as amended or subsequently replaced, is hereby incorporated by reference as if fully recited herein. The provisions of the Medical and Dependent Care Expense Reimbursement Plan(s) are reproduced herein, but shall constitute separate plans for purposes of all applicable Code and ERISA provisions
- 10.14 Severability.** Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder thereof shall be given effect to the maximum extent possible
- 10.15 Effect of Mistake.** In the event of a mistake as to the eligibility or participation of an Employee, the allocations made to the account of any Participant, or the amount of distributions made or to be made to a Participant or other person, the Plan Administrator shall, to the extent it deems possible, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as will in its judgment accord to such Participant or other person the credits to the account or distributions to which he is properly entitled under the Plan. Such action by the Administrator may include withholding of any amounts due the Plan or the Employer from Compensation paid by the Employer.
- 10.16 Provisions Relating to Insurers.** No insurer shall be required or permitted to issue an insurance policy or contract that is inconsistent with the purposes of this Plan, nor be bound to take any action not in accordance with the terms of any policy or contract with this Plan. The insurer shall not be deemed to be a party to this Plan, nor shall it be bound to interpret the construction or validity of the Plan. The insurer shall be protected from its good faith reliance on the written representations and instructions of the Trustee and the Plan Administrator, and shall not be responsible for the initial or continued qualified status of the Plan
- 10.17 Forfeiture of Unclaimed Reimbursement Account Benefits.** Any Reimbursement Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Health or Dependent Care Expense was incurred shall be forfeited
- 10.18 HIPAA Privacy.** To the extent a URM is offered under the Plan, the rights and obligations of an individual covered under the URM, the Employer and Plan, with respect to permitted uses and disclosures of a covered individual's protected health information, set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will be summarized in the SPD.

ARTICLE XI - CONTINUATION COVERAGE UNDER COBRA

The SPD includes provisions that shall be applicable to the URM to the extent the URM is a "group health plan" as defined by Code §§ 4980B and 5009(b)(4) and the regulations promulgated thereunder and to the extent it is offered under the Plan. The intent of those provisions (as incorporated in this Article) is to extend continuation rights required by COBRA.

IN WITNESS WHEREOF, the Employer has executed this Plan as of the date set forth below

EMPLOYER'S ACKNOWLEDGMENT

As evidenced by the formal execution of this document, the undersigned Employer adopted and established this Plan on the Effective Date as the Flexible Benefits Plan of the undersigned Employer. In doing so, the undersigned Employer acknowledges that the Summary Plan Description ("SPD") and this Plan document are important legal instruments with significant legal and tax implications.

The Employer also acknowledges that it has read this SPD and the Plan document in their entirety, has consulted independent legal and tax counsel other than representatives of American Family Life Assurance Company of Columbus (Aflac), to the extent considered necessary, and accepts full responsibility for participation of Employees hereunder and the operation of the Plan. The Employer acknowledges that, as sponsor and Plan Administrator, it shall have sole responsibility to comply with all filing, reporting, and disclosure requirements imposed by the DOL, IRS, or any other government agency, specifically including, but not limited to, creating and filing Form 5500s and preparing and distributing SPDs and performing required nondiscrimination testing. Furthermore, the Employer further acknowledges that it shall bear sole responsibility for amending the Plan as necessary to ensure compliance with applicable tax, labor, and other laws and regulations. The Employer acknowledges receipt of the checklist of Plan Sponsor Responsibilities included provided with the applicable plan document request form and has agreed to the obligations set forth therein.

It is also understood and agreed that American Family Life Assurance Company of Columbus (Aflac), and its subsidiaries, agents, and representatives, are not providing legal or tax advice to the undersigned Employer in connection with this Plan and that no representations are made by it with respect to the operation of the Flexible Benefits Plan pursuant to the documents provided by American Family Life Assurance Company of Columbus (Aflac) to the Employer.

This Plan shall be construed and enforced according to the Internal Revenue Code of 1986, as amended from time to time, the applicable regulations thereto, and the laws of the state of the principal place of business of the Employer.

IN WITNESS WHEREOF, the Employer has caused this Plan and Summary Plan Description to be executed on the day of _____, _____ to ratify the adoption of the Plan adopted and effective as of the Effective Date.

WITNESS:

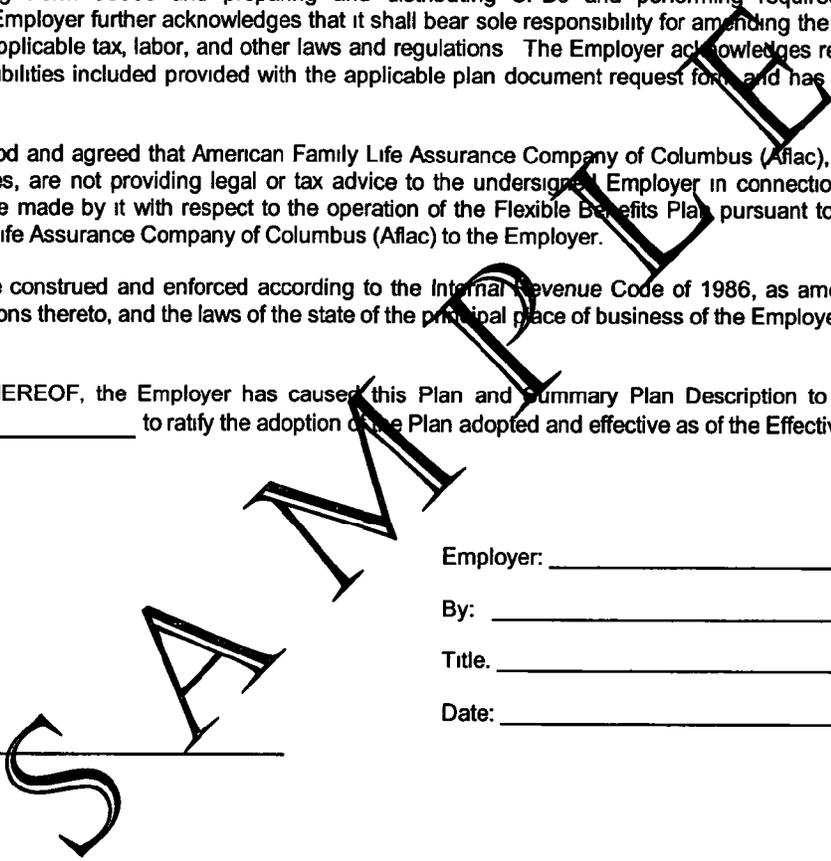
Employer: _____

By: _____

Title: _____

Date: _____

Corporate Officer



ATTACHMENT I - SUMMARY PLAN DESCRIPTION

FLEXIBLE BENEFITS PLAN SUMMARY PLAN DESCRIPTION

PLAN INFORMATION SUMMARY

The Employer named below establishes a Flexible Benefits Plan (the "Plan") as set forth in this Summary Plan Description ("SPD") as of the Effective Date set forth below. The purpose of the Plan is to provide eligible Employees a choice between cash and the specified welfare benefits described in this Plan Information Summary (see "Benefits Provided Under the Plan") Pre-tax Contribution elections under the Plan are intended to qualify for the exclusion from income provided in Section 125 of the Internal Revenue Code of 1986

FLEXIBLE BENEFITS PLAN **EMPLOYER INFORMATION**

1) Name and Address of Employer.

Plan Administrator:

The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and this SPD.

2) Employer's Telephone Number:

3) Employer's Federal Tax
Identification Number:

4) Plan Number Assigned to Cafeteria
Plan (e.g., 501 if this is the first ERISA
Plan Number assigned)

5) 125 Start Date: _____

6) Effective Date of this Plan:

7) Last Day of the Plan Year:

Subsequent Plan Years:

8) Name and Address of
FSA Claim Administrator:

9) Name and Address of registered
agent for service of legal process:

10) Affiliated Employers that will participate in the Plan (affiliates in excess of 29 are listed in Appendix 1).

SAMPLE

11) Employer's Type of Business: _____

ELIGIBILITY

All Employees employed by the Employer shall be eligible to participate under the Plan except the following _____

An eligible Employee may become a Participant in the Plan (check one):

- Immediately, upon the first day of employment (but not prior to the Effective Date of the Plan).
- On the _____ day following commencement of employment.
- On the first day of the month following _____ days of employment
- Other: _____
provided the Employee completes a Salary Redirection Agreement ("SRA"). However, eligibility for coverage under any given Benefit Plan or Policy shall be determined by the terms of that Benefit Plan or Policy, and reductions of the Employee's Compensation to pay Pre-tax or After-tax Contribution(s) shall commence when the Employee becomes covered under the applicable Benefit Plan or Policy.

An eligible Employee may become a Participant in the Dependent Care and/or Medical Expense Reimbursement Plan(s) (if elected below):

- On the same day such Employee is eligible for the Pre-Tax Contribution benefits under the Plan.
- On the _____ day following commencement of employment
- On the first day of the month following _____ days of employment
- Other: _____
provided the Employee completes a SRA selecting such benefits

BENEFITS PROVIDED UNDER THE PLAN

The following Benefit Plans and Policies subject to the terms and conditions of the Plan are available for election by eligible Employees. The maximum a Participant can contribute via the SRA is the maximum aggregate cost of the Benefit Plans or Policies elected minus any Nonelective Contribution made by the Employer. It is intended that such Pre-tax Contribution amounts shall, for tax purposes, constitute an Employer contribution, but may constitute Employee contributions for state insurance law purposes. Copies of the Benefit Plans or Policies (or a list of eligible Policy numbers) shall be attached as an appendix to this Plan

- Medical Coverage
- Vision Care Coverage
- Disability Income – Short Term (A&S)
- Cancer Insurance
- Group Dental Coverage
- Group Term Life Insurance
- Disability Income – Long Term (LTD)
- Intensive Care Insurance
- Accident Insurance
- Hospital Indemnity Insurance (HII)
- Specified Health Event
- Personal Sickness Indemnity (PSI)
- Medical Care Expense Reimbursement described in Appendix I to this SPD, not to exceed \$ _____ per Plan Year pursuant to the _____ Medical Care Expense Reimbursement Plan
Name and Address of Medical Care Expense Reimbursement Plan
COBRA Administrator (if applicable): _____

- Dependent Care Expense Reimbursement described in Appendix I to this SPD, not to exceed \$5,000 per Plan Year or \$2,500 for married filing separate returns pursuant to the _____ Dependent Care Expense Reimbursement Plan
- Health Savings Account (as defined in Code Section 223) established with the following Custodian/Trustee: _____
- Opt-out Option: See Employer enrollment material

THE FUNDING AGENT

The Employer selects the following Funding Agent for the Plan (check one).

- The Employer, which will comply with the requirements of Article VII of the Plan
- The Flexible Benefits Trust created concurrently with the execution of the Plan, which shall receive contributions under the Plan in accordance with Article VII of the Plan

ADMINISTRATIVE EXPENSES

Administrative Expenses incurred in operating the Plan shall be paid by (check one)

- The Employer, except as otherwise noted in the Plan
- The Participants, except as otherwise noted in the Plan

FLEXIBLE BENEFITS PLAN SUMMARY PLAN DESCRIPTION

Introduction

Your employer (the "Employer") is pleased to sponsor an employee benefit program known as a "Flexible Benefits Plan" (the "Plan") for you and your fellow employees. Under federal tax laws, it is also known as a "cafeteria plan." It is so called because it lets you choose from several different insurance and fringe benefit programs according to your individual needs. The Employer provides you with the opportunity to use pre-tax dollars to pay for them by entering into a salary redirection arrangement instead of receiving a corresponding amount of your regular pay. This arrangement helps you because the benefits you elect are nontaxable; you save Social Security and income taxes on the amount of your salary redirection. Alternatively, your Employer may allow you to pay for any of the available benefits with after-tax contributions on a salary deduction basis.

This Summary Plan Description ("SPD") describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. Information relating to the Plan that is specific to your Employer is described in the Plan Information Summary attached to the front of this SPD. You will be referred to the Plan Information Summary throughout the SPD. The Plan is also established pursuant to a plan document into which this SPD has been incorporated. If there is a conflict between the official plan document and the SPD, the plan document will govern.

In some cases, the Employer may adopt a Medical Care and/or Dependent Care Reimbursement Plan. If so, they will be listed in the Plan Information Summary as "Benefits Provided under the Plan," and the SPD for each Reimbursement Plan adopted by the Employer will be set forth in Appendix I to this SPD. To the extent that the Employer adopts a Medical Care Reimbursement Plan as indicated in the Plan Information Summary, a summary of your rights and obligations under HIPAA's privacy rules is attached to this SPD as Appendix II.

You may also be able to make pre-tax contributions to a Health Savings Account (as defined in Code Section 223) through this Plan if Health Savings Accounts are identified as an included benefit under "Benefits Provided under the Plan" in the Plan Information Summary. If Health Savings Accounts are identified as a benefit plan option offered under the Plan, your rights and obligations in regard to such contributions will be set forth in the Health Savings Account Contribution Appendix attached hereto.

Questions & Answers about the Flexible Benefits Plan

Q-1. What is the purpose of the Plan?

The purpose of the Plan is to allow eligible employees to pay for certain benefits offered under the Plan (called "Benefit Plans or Policies") with pre-tax dollars called "Pre-tax Contributions". Pre-tax Contributions are described in more detail in Q-8 of this SPD.

Q-2. What benefits can I purchase on a pre-tax basis through the Plan?

You will be able to choose to participate in the Plan's various pre-tax options by filling out any required enrollment form(s) for the component Benefit Plans or Policies offered under the Plan. The complete list of Benefit Plans or Policies offered under the Plan is located in the Plan Information Summary under "Benefits Offered Under the Plan." NOTE: You may only contribute with Pre-tax Contributions towards the cost of Benefit Plans or Policies that cover you, your legal Spouse, and/or your tax Dependents defined under Internal Revenue Code Section 152. Each Benefit Plan or Policy may define eligible Dependents more narrowly for purposes of coverage under the particular Benefit Plan or Policy.

Q-3. Who can participate in the Plan?

Each employee of the Employer (or an Affiliated Employer identified in the Plan Information Summary) who satisfies the eligibility requirements described in the Plan Information Summary and who is eligible to participate in any of the Benefit Plans or Policies offered under the Plan will be eligible to participate in this Plan as of the date described in the Plan Information Summary (see Q-5 of this SPD for instructions on how to become a Participant). Those employees who actually participate in the Plan are called "Participants." The terms of eligibility of this Plan do not override the terms of eligibility of each of the Benefit Plans or Policies offered under the Plan. For the details regarding eligibility provisions, benefit amounts, and premium schedules for each of the Benefit Plans or Policies, please refer to the plan summary for each of the Benefit Plans or Policies listed in the Plan Information Summary.

Only coverage for an Employee and the Employee's Dependents may be paid for under this Plan. A dependent is defined generally as an individual who would be considered the Employee's spouse under the federal income tax code or the Employee's tax dependents as defined in Code Section 152; however, for purposes of health benefits and Dependent Care Reimbursement ("DDC") benefits offered under the Plan, a dependent is defined as (i) for health plan purposes, as set forth in Code Section 105(b) and (ii) for DDC purposes, as any person who meets the requirements to be a "qualifying individual" as defined in the DDC component SPD.

Q-4. When does my participation in the Plan end?

You continue to participate in the Plan until (i) you elect not to participate in accordance with Q-9 of this SPD; (ii) you no longer satisfy the eligibility requirements described in the Plan Information Summary; (iii) you terminate employment with the Employer, or (iv) the Plan is terminated or amended to exclude you or the class of employees of which you are a member. If your employment with the Employer is terminated during the Plan Year or you otherwise cease to be eligible, your active participation in the Plan will automatically cease, and you will not be able to make any more Pre-tax Contributions under the Plan. If you are rehired within the same Plan Year or you become eligible again, you may make

new elections, provided that you are rehired or become eligible again more than 30 days after you terminated employment or lost eligibility. If you are rehired or again become eligible within 30 days or less, your prior elections will be reinstated and remain in effect for the remainder of the Plan Year unless you again lose eligibility

Q-5. How do I become a Participant?

You become a Participant by signing an individual Salary Redirection Agreement (“SRA”) on which you elect one or more of the Benefit Plans or Policies available under the Plan, as well as agree to a salary redirection to pay for those benefits so elected. You will be provided an SRA when you first become eligible to participate in this Plan. You must complete the form and turn it in to the Personnel Office during the applicable enrollment period described in Q-6 below

Q-6. What are the enrollment periods for entering the Plan?

If you are eligible on the effective date of the Plan, you must enroll during the enrollment period immediately preceding the effective date of the Plan. Otherwise, you must enroll during either the “Initial Enrollment Period” or the “Annual Enrollment Period” You will be notified of the dates that each enrollment period begins and ends in the enrollment material provided to you prior to each enrollment period. If you make an election during the Initial Enrollment Period, your participation in this Plan will begin on the later of your eligibility date described in the Plan Information Summary, the first pay period coinciding with or next following the date that your election is received by the Plan Administrator (or its designated claims administrator) or the date coverage under a Benefit Plan or policy that you elect begins. The effective date of coverage under the applicable Benefit Plan(s) or Policy(ies) is governed by the terms of each Benefit Plan or Policy, as set forth in the governing documents for each Benefit Plan or Policy. The election that you make during the Initial Enrollment Period is effective for the remainder of the Plan Year and generally cannot be revoked during the Plan Year unless you have a Change in Status event as described in Q-9 below. If you do not make an election during the Initial Enrollment Period, you will be deemed to have elected not to participate in this Plan for the remainder of the Plan Year. You may, however, be covered by certain Benefit Plans or Policies automatically (and be required to contribute with pre-tax dollars) even if you fail to make an election. These automatic Benefit Plans or Policies are called “Default Benefits” and will be identified in the enrollment material that you receive.

The election that you make during the Annual Enrollment Period is effective the first day of the next Plan Year and is irrevocable for the entire Plan Year unless you have a Change in Status event described in Q-9 below. A Participant who fails to complete, sign, and file an SRA during the Annual Enrollment Period as required shall be deemed to have elected to continue participation in the Plan with the same benefit elections as during the prior Plan Year (adjusted to reflect any increase/decrease in applicable premiums), and except for a Change in Status, will not be permitted to modify his election until the next Annual Enrollment Period. Notwithstanding the foregoing, annual elections for participation in the Medical Care and Dependent Care Expense Reimbursement Plans, if offered under the Plan, must be made by submitting an SRA prior to the beginning of each Plan Year. No deemed elections shall occur with respect to such benefits.

The Plan Year is generally a 12-month period (except during the initial or last Plan Year of the Plan). The beginning and ending dates of the Plan Year are described in the Plan Information Summary

Q-7. What tax advantages are available through the Plan?

Suppose your monthly gross pay is \$2,500 per month and your cost for coverage is \$140 per month. Also, suppose your total withholdings (income tax and Social Security) are 22.65%. After paying for coverage from your after-tax pay, your take home pay is \$1,794. However, under the pre-tax premium plan, you will be considered to have received \$2,360 gross pay rather than \$2,500 for tax purposes with \$140 contributed for medical coverage. This means your take home pay will be \$1,825 with the pre-tax premium plan rather than \$1,794 without it. Thus, you save \$31 per month (\$372 per year) by participating in the pre-tax premium plan. The Table below illustrates this savings.

	<u>With Cafeteria Plan</u>	<u>Without Cafeteria Plan</u>
Gross Monthly Pay	\$2,500	\$2,500
Pre-Tax Coverage Under Plan	140	–
Taxable Income	<u>2,360</u>	<u>2,500</u>
Estimated Federal Tax (15%)	354	375
FICA Tax	181	191
After-tax Coverage	–	<u>140</u>
Take Home Pay	1,825	1,794

Monthly Savings: \$31.00

Q-8. How are my contributions under the Benefit Plans or Policies made?

When you become a Participant, your share of the contributions for the elected Benefit Plan or Policy(ies) will be paid with Pre-tax Contributions elected on the SRA. Pre-tax Contributions are amounts withheld from your gross income before any applicable federal and state taxes have been deducted (some state tax laws do not recognize Pre-tax Contributions). In addition, all or a portion of the cost of the Benefit Plans or Policies may, in the Employer’s discretion, be paid with contributions made by the Employer on behalf of each Participant (these are called “Nonelective Contributions”). The amount of Nonelective Contribution that is applied towards the cost of the Benefit Plan(s) or Policy(ies) for each Participant and/or level of coverage is subject to the sole discretion of the Employer, and it may be adjusted upward or downward in the Employer’s sole discretion. The Nonelective Contribution amount will be calculated for each Plan Year in a uniform and

nondiscriminatory manner and may be based upon your Dependent status, commencement or termination date of your employment during the Plan Year, and such other factors that the Employer deems relevant. In no event will any Nonelective Contribution be disbursed to you in the form of additional, taxable Compensation except as otherwise provided in the enrollment material. To the extent set forth in the enrollment material, the Employer may make available a certain amount of Nonelective Contributions and then allow you to allocate the Nonelective Contributions among the various Benefit Plan(s) or Policy(ies) that you choose (subject to restrictions described in the enrollment material).

Q-9. Can I ever change my election during the Plan Year?

Generally, you cannot change your election to participate in the Plan or vary the Pre-tax Contribution amounts although your election will terminate if you are no longer working for the Employer or no longer eligible under the terms of the Plan. Otherwise, you may change your elections for Pre-Tax Contributions only during the Annual Enrollment Period, and then, only for the coming Plan Year. There are several important exceptions to this general rule: You may change or revoke your previous election during the Plan Year if you file a written request for change with the Plan Administrator (or its designated claims administrator) within 30 days of any of the following events:

1 Change in Status If one or more of the following "Changes in Status" occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status (as described below). Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Plan Administrator determines are permitted under subsequent IRS regulations:

- a change in your legal marital status (such as marriage, legal separation, annulment, or divorce or death of your Spouse);
- a change in the number of your tax Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent);
- any of the following events that change the employment status of you, your Spouse, or your Dependent that affect benefit eligibility under a cafeteria plan (including this Plan and the Plan of another employer) or other employee benefit plan of yours, your Spouse, or your Dependents. Such events include any of the following changes in employment status: termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, switching from salaried to hourly-paid, union to non-union, or part-time to full-time; incurring a reduction or increase in hours of employment; or any other similar change which makes the individual become (or cease to be) eligible for a particular employee benefit (NOTE: The specific rules governing election changes when you take a leave of absence are described in Q-13 of this SPD);
- an event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specified age, getting married, or ceasing to be a student);
- a change in your, your Spouse's or your Dependent's place of residence.

If a Change in Status occurs, and you want to make a corresponding election change, you must inform the Plan Administrator and complete a new election within 30 days from the date of the event. The election change must be on account of and correspond with the Change in Status event as determined by the Plan Administrator with the exception of special enrollment resulting from birth, placement for adoption or adoption, all election changes are prospective.

As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects eligibility or coverage. A Change in Status affects eligibility for coverage if it results in an increase or decrease in the number of Dependents who may benefit under the plan. In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status.

- **Loss of Dependent Eligibility** For accident and health benefits (e.g., health, dental and vision coverage, and Medical Care Reimbursement Plan), a special rule governs which types of election changes are consistent with the Change in Status. For a Change in Status involving your divorce, annulment or legal separation from your Spouse, the death of your Spouse or your Dependent, or your Dependent ceasing to satisfy the eligibility requirements for coverage, your election to cancel accident or health benefits for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements, would fail to correspond with that Change in Status. Hence, you may only cancel accident or health coverage for the affected Spouse or Dependent.

Example: Employee Mike is married to Sharon, and they have one child. The employer offers a calendar year cafeteria plan that allows employees to elect no health coverage, employee-only coverage, employee-plus-one-Dependent coverage, or family coverage. Before the plan year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the plan year, Sharon loses eligibility for coverage under the plan, while the child is still eligible for coverage under the plan. Mike now wishes to cancel his previous election and elect no health coverage. The divorce between Mike and Sharon constitutes a Change in Status. An election to cancel coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast, an election to change to employee-plus-one-Dependent coverage would be consistent with this Change in Status. However, there are instances in which you may be able to increase your Pre-tax Contributions to pay for COBRA coverage of a Dependent child or yourself.

- **Gain of Coverage Eligibility Under Another Employer's Plan** For a Change in Status in which you, your Spouse, or your Dependent gain eligibility for coverage under another employer's cafeteria plan (or Benefit Plan or Policy) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status *only* if coverage for that individual becomes effective or is increased under the other employer's plan
- **Dependent Care Reimbursement Plan Benefits (if offered under the Plan. See the list of Benefit Plans or Policies offered under the Plan in the Plan Information Summary).** With respect to the Dependent Care Reimbursement Plan benefit (if offered by the Plan), you may change or terminate your election only if (1) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under the Plan; or (2) your election change is on account of and corresponds with a Change in Status that affects the eligibility of Dependent care assistance expenses for the available tax exclusion

Example: Employee Mike is married to Sharon, and they have a 12 year-old daughter. The employer's plan offers a Dependent care expense reimbursement program as part of its cafeteria plan. Mike elects to reduce his salary by \$2,000 during a plan year to fund Dependent care coverage for his daughter. In the middle of the plan year when the daughter turns 13 years old, however, she is no longer eligible to participate in the Dependent care program. This event constitutes a Change in Status. Mike's election to cancel coverage under the Dependent care program would be consistent with this Change in Status.

- **Group Term Life Insurance, Disability Income, or Dismemberment Benefits (if offered under the Plan. See the list of Benefit Plans or Policies offered under the Plan in the Plan Information Summary).** For group term life insurance, disability income, and accidental death and dismemberment benefits, if you experience any Change in Status (as described above), you may elect either to increase or decrease coverage.

Example: Employee Mike is married to Sharon, and they have one child. The employer's plan offers a cafeteria plan which funds group-term life insurance coverage (and other benefits) through salary reduction. Before the plan year Mike elects \$10,000 of group-term life insurance. Mike and Sharon subsequently divorce during the plan year. The divorce constitutes a Change in Status. An election by Mike either to increase or to decrease his group-term life insurance coverage would each be consistent with this Change in Status.

2. **Special Enrollment Rights.** If you, your Spouse, and/or a Dependent are entitled to special enrollment rights under a Benefit Plan or Policy that is a group health plan, you may change your election to correspond with the special enrollment right. Thus, for example, if you declined enrollment in medical coverage for yourself or your eligible Dependents because of outside medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (i.e., due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period), you may be able to elect medical coverage under the Plan for yourself and your eligible Dependents who lost such coverage. Furthermore, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your Spouse, and your newly acquired Dependents, provided that you request enrollment within the Election Change Period. An election change that corresponds with a special enrollment must be prospective, unless the special enrollment is attributable to the birth, adoption, or placement for adoption of a child, which may be retroactive up to 30 days. Please refer to the group health plan description for an explanation of special enrollment rights.
3. **Certain Judgments, Decrees and Orders.** If a judgment, decree or order from a divorce, separation, annulment, or custody change requires your Dependent child (including a foster child who is your tax Dependent) to be covered under this Plan, you may change your election to provide coverage for the Dependent child identified in the order. If the order requires that another individual (such as your former Spouse) cover the Dependent child, and such coverage is actually provided, you may change your election to revoke coverage for the Dependent child.
4. **Entitlement to Medicare or Medicaid.** If you, your Spouse, or a Dependent becomes entitled to Medicare or Medicaid, you may cancel that person's accident or health coverage. Similarly, if you, your Spouse, or a Dependent who has been entitled to Medicare or Medicaid loses eligibility for such, you may, subject to the terms of the underlying plan, elect to begin or increase that person's accident or health coverage.
5. **Change in Cost.** If you are notified that the cost of your Benefit Plan or Policy coverage under the Plan *significantly* increases or decreases during the Plan Year, you may make certain election changes. If the cost significantly increases, you may choose either to make an increase in your contributions, revoke your election and receive coverage under another Benefit Plan or Policy that provides similar coverage, or drop coverage altogether if no similar coverage exists. If the cost significantly decreases, you may revoke your election and elect to receive coverage provided under the option that decreased in cost. For *insignificant* increases or decreases in the cost of Benefit Plans or Policies, however, your Pre-tax Contributions will automatically be adjusted to reflect the minor change in cost. The Plan Administrator will have final authority to determine whether the requirements of this section are met. (Please note that none of the above "Change in Cost" exceptions are applicable to a Medical Care Reimbursement Plan, to the extent offered under the Plan.)

Example: Employee Mike is covered under an indemnity option of his employer's accident and health insurance coverage. If the cost of this option significantly increases during a period of coverage, the Employee may make a corresponding increase in his payments or may instead revoke his election and elect coverage under an HMO option.

6. **Change in Coverage.** If you are notified that your Benefit Plan or Policy coverage under the Plan is significantly curtailed, you may revoke your election and elect coverage under another Benefit Plan or Policy that provides similar coverage. If the significant curtailment amounts to a complete loss of coverage, you may also drop coverage if no other similar coverage is available. Further, if the Plan adds or significantly improves a benefit option during the Plan Year, you may revoke your

election and elect to receive on a prospective basis coverage provided by the newly added or significantly improved option, so long as the newly added or significantly improved option provides similar coverage. Also, you may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or another employer), so long as: (a) the other employer plan permits its participants to make an election change permitted under the IRS regulations; or (b) the Plan Year for this Plan is different from the Plan Year of the other employer plan. Finally, you may change your election to add coverage under this Plan for yourself, your Spouse, or your Dependent if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution. The Plan Administrator will have final discretion to determine whether the requirements of this section are met. (Please note that none of the above "Change in Coverage" exceptions are applicable to the Medical Care Reimbursement Plan, to the extent offered under the Plan.)

Additionally, your election(s), may be modified downward during the Plan Year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

Q-10. How long will the Plan remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time for any reason. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly.

Q-11. What happens if my claim for benefits under this Plan is denied?

This SPD describes the basic features of the Plan. If your claim is for a benefit under one of the component Benefit Plans or Policies, you will generally proceed under the claims procedures applicable under the component Benefit Plan or Policy (see the plan summary for each of the Benefit Plans or Policies that you select). However, if you are denied a benefit under this Plan, the claims procedure under this Plan will apply. You will be notified if your claim under the Plan is denied. The notice of denial will be furnished to you within 30 days after receiving your claim. However, if additional time is needed to process your claim you will be notified before the initial 30-day period has expired. The notice will explain why an extension is necessary and the date a decision is expected to be rendered. In no event will an extension go beyond 15 days after the end of the initial 30-day period. The notice of the denial will include the specific reasons for the denial and the relevant plan provisions on which the denial was based.

If your claim is denied in whole or in part, you may appeal by requesting a review of the denied claim, as set forth in the notice of denial, within 180 days after you receive notice of the denial. If there are two levels of appeal (as indicated in the notice of denial), you will have a reasonable amount of time in which to request a second review and such time period will be identified in the notice of denial. As part of the appeal process (whether there is one or two appeals), you or your authorized representative may examine documents, records, and other information relevant to your claim and submit issues, documents and comments in writing. Within 60 days after the request for review is received, you will be notified in writing of the decision on review.

The notice of denial will indicate whether there are one or two levels of appeals and will contain the same type of information provided to you in the first notice of denial. If there are two levels of Plan appeals, the decisions on appeal will be made within 30 days after the request for each review is received. The Plan Administrator is the claims fiduciary for making the final decision under the plan.

In the event of your death, your beneficiary has the same rights and is subject to the same time limits and other restrictions that would otherwise apply to you under the claims procedures explained above.

Q-12. What effect will Plan participation have on Social Security and other benefits?

Plan participation will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability and life insurance) that are based on taxable compensation.

Q-13. What happens if I take a leave of absence?

- (a) If you go on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, the Employer will continue to maintain your Benefit Plans or Policies providing health coverage on the same terms and conditions as though you were still active (e.g., the Employer will continue to pay its share of the contribution to the extent you opt to continue coverage).
- (b) Your Employer may elect to continue all coverage for Participants while they are on paid leave (provided Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, with Pre-tax Contributions if that is what was used before the FMLA leave began).
- (c) In the event of unpaid FMLA leave (or paid leave where coverage is not required to be continued), if you opt to continue your group health coverage, you may pay your share of the contribution with after-tax dollars while on leave, or you may be given the option to pre-pay all or a portion of your share of the contribution for the expected duration of the leave with Pre-tax Contributions from your pre-leave compensation by making a special election to that effect before the date such compensation would normally be made available to you provided, however, that pre-payments of Pre-tax Contributions may not be utilized to fund coverage during the next Plan Year, or by other arrangements agreed upon.

between you and the Plan Administrator (for example, the Plan Administrator may fund coverage during the leave and withhold amounts from your compensation upon your return from leave) The payment options provided by the Employer will be established in accordance with Code Section 125, FMLA and the Employer's internal policies and procedures regarding leaves of absence Alternatively, the Employer may require all Participants to continue coverage during the leave. If so, you may elect to discontinue your share of the required contributions until you return from leave Upon return from leave, you will be required to repay the contribution not paid during the leave in a manner agreed upon with the Administrator.

- (d) If your coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter the Plan upon return from such leave on the same basis as you were participating in the Plan prior to the leave, or as otherwise required by the FMLA. Your coverage under the Benefit Plans or Policies providing health coverage may be automatically reinstated provided that coverage for Employees on non-FMLA leave is automatically reinstated upon return from leave
- (e) The Employer may, on a uniform and consistent basis, continue your group health coverage for the duration of the leave following your failure to pay the required contribution Upon return from leave, you will be required to repay the contribution in a manner agreed upon by you and Employer
- (f) If you are commencing or returning from unpaid FMLA leave, your election under this Plan for Benefit Plans or Policies providing non-health benefits shall be treated in the same manner that elections for non-health Benefit Plans or Policies are treated with respect to Participants commencing and returning from unpaid non-FMLA leave
- (g) If you go on an unpaid non-FMLA leave of absence (e.g., personal leave, sick leave, etc.) that does not affect eligibility in this Plan or a Benefit Plan or Policy offered under this plan, then you will continue to participate and the contribution due will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Administrator If you go on an unpaid leave that affects eligibility under this Plan or a Benefit Plan or Policy, the election change rules in Q-9 of this SPD will apply The Plan Administrator will have discretion to determine whether taking an unpaid non-FMLA leave of absence affects eligibility.

Q-14. Is there any other information that I should know about the Plan?

Participation in the Plan does not give any Participant the right to be retained in the employ of his or her Employer or any other right not specified in the Plan The Plan Administrator's name, address and telephone number appear in the Plan Information Summary attached to the front of this SPD. The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and this SPD. Other important information such as the Plan Number and Plan Sponsor's name and address has also been provided in the Plan Information Summary

APPENDIX I TO THE FLEXIBLE BENEFITS PLAN SUMMARY PLAN DESCRIPTION

Medical Care and Dependent Care Reimbursement Plan Summary Plan Description

To the extent elected by the Employer (indicated in the Plan Information Summary attached to this SPD), you will have the opportunity to elect to receive income tax-free reimbursement for some or all of your unreimbursed medical expenses under the Medical Care Reimbursement Plan ("URM") and/or some or all of your work-related Dependent care expenses under the Dependent Care Reimbursement Plan ("DDC") (collectively, the "Reimbursement Plans"). Under the URM and DDC, you purchase a specific level of reimbursement benefits and you provide a source of pre-tax funds to reimburse yourself for your Eligible Expenses. For both, you pay for coverage through the Salary Redirection Agreement ("SRA") with the Employer, in lieu of receiving a corresponding amount of current pay, which means the premiums you pay will be with pre-tax funds. This arrangement helps you because the level of coverage you elect is nontaxable, and you save Social Security and income taxes on the amount of your salary conversion.

By enrolling in either the URM or DDC option and submitting reimbursement claims you specifically authorize the Plan, Aflac and Aflac Benefit Services/Flex One®, and their respective agents, employees, sub-contractors, and assigns to use your personal health information in their possession to administer the Plan (including the evaluation of eligibility for reimbursement under the Plan) and to detect or prevent fraud or misrepresentation, and to further disclose such information as is reasonably required for those purposes. You further authorize any provider, insurer, or other entity to release any health or treatment information for the purpose of determining eligibility for Plan benefits or for detecting or preventing fraud or misrepresentation. You further waive and release any claims related to the use, disclosure, or release of such information so long as the information is used in furtherance of administering the Plan (including processing or evaluating a claim for benefits under the Plan) or to detect or prevent fraud or misrepresentation. This authorization does not and is not intended to in any way limit any right the Plan, Aflac and Aflac Benefit Services/Flex One, or their respective agents, employees, sub-contractors, and assigns may have under applicable state or federal law or regulation regarding the use of such information.

General Questions and Answers

Q-1. Who can participate in the URM and/or DDC?

Each employee who satisfies the eligibility requirements described in the Plan Information Summary is eligible to participate in the Reimbursement Plans as of the eligibility date described in the Plan Information Summary.

Q-2. How do I become a Participant?

You become a Participant by electing URM and/or DDC benefits during the Initial or Annual Enrollment Periods. (The Initial and Annual Enrollment Periods are described in Q-6 of the Flexible Benefits Plan SPD.) Your participation in the URM or DDC will be effective on the date that you make an election to participate or the eligibility date described in the Plan Information Summary, whichever is later. You may not change your election (either to participate or not to participate) during the Plan Year unless you experience an event described in Q-9 of the Flexible Benefits Plan SPD. Once you become a Participant, your "Eligible Dependents" also become covered. For purposes of the URM, Eligible Dependents are the following:

1. Your legal Spouse (as determined by state law to the extent consistent with the federal Defense of Marriage Act) and
2. Any other individual who would qualify as a tax Dependent under Code Section 105(b)

If the Plan Administrator receives a qualified medical child support order relating to the URM, the URM will provide the health benefit coverage specified in the order to the person or persons ("alternate recipients") named in the order. "Alternate recipients" include any child of the participant who the Plan is required to cover pursuant to a qualified medical child support order. A "qualified medical child support order" is a legal judgment, decree or order relating to medical child support that clearly specifies the type of coverage that is to be provided to one or more alternate recipients (or the manner in which such type of coverage is to be provided). Before providing any coverage to an alternate recipient, the Plan Administrator must determine whether the medical child support order is qualified. If the Plan Administrator receives a medical child support order relating to your Health Care Account (See Q-3 below), it will notify you in writing, and after receiving the order, it will inform you of its determination of whether or not the order is qualified. Upon request to the Plan Administrator, you may obtain, without charge, a copy of the Plan's procedures governing qualified medical child support orders.

Q-3. What are my "URM Account" and my "DDC Account"?

If you elect benefits under this portion of the Plan, a non-interest bearing account will be established under each Plan to keep a record of the reimbursements you are entitled to under each Plan, as well as the contributions you have made for such benefits during the Plan Year. No actual accounts are established; they are merely bookkeeping accounts.

Q-4. When does coverage under the URM and/or DDC end?

You continue to participate in the URM and/or DDC until the earlier of (i) you elect not to participate in accordance with Q-9 of Flexible Benefits Plan SPD; (ii) the end of the Plan Year unless you make an election during the annual election period; (iii) you no longer satisfy the eligibility requirements described in the Plan Information Summary; (iv) you terminate employment with the employer; or

(v) the Plan is terminated or amended to exclude you or the class of eligible employees of which you are a member are specifically excluded from the Plan. You are not eligible to receive reimbursement for otherwise Eligible Medical Expenses incurred during the Plan Year after you cease to be eligible unless you elect COBRA continuation coverage (as described below in Q-19 of this Appendix), provided you are eligible to elect COBRA. However, you will be eligible to receive reimbursement under the DDC for Eligible Employment-Related Expenses (as defined in Q-9 below) incurred during the Plan Year but after you cease to be eligible up to your account balance as of the date you cease to be eligible.

Coverage under the URM for your Eligible Dependents ends on earliest of the following to occur: (i) your coverage ends; (ii) the individual ceases to be an Eligible Dependent (e.g. divorce or legal separation from the spouse); or (iii) the Plan is terminated or amended to exclude individual or the class of individuals of which the individual is a member (spouse or dependent child) from coverage under the URM. Your Spouse and/or your Dependent children may also be entitled to COBRA continuation coverage if coverage is lost for certain reasons. See Q-19 of this Appendix for more information on COBRA.

Q-5. What happens to my URM Account and/or DDC Account if I take an approved leave of absence?

Generally, the rules described in Q-13 of your Flexible Benefits Plan SPD apply. However, if your URM coverage ceases during your FMLA leave, you will be entitled to elect whether to be reinstated in the URM at the same coverage level in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a URM reimbursement level that is reduced pro-rata for the period of FMLA leave during which you did not make any contributions. Under either scenario, expenses incurred during the period that your URM coverage was not in effect are not eligible for reimbursement under this URM.

Q-6. What is the maximum URM and/or DDC benefit I may elect?

For URM, you may choose any amount of annual reimbursement you desire subject to the maximum reimbursement amount set forth in the Employer Information Section of the Plan Information Summary.

For DDC, this is set forth in the Employer Information Section, however, this amount cannot exceed the maximum amount specified in Section 129 of the Internal Revenue Code. The maximum amount is currently \$5,000 per Plan Year if you -

- are married and file a joint return; or
- are married, but you furnish more than one-half the cost of maintaining those Dependents for whom you are eligible to receive tax-free reimbursements under the DDC, your Spouse maintains a separate residence for the last 6 months of the calendar year, and you file a separate tax return; or
- are single, or a head of household for tax purposes

If you are married and reside together but file a separate federal income tax return, the maximum DDC benefit you may elect is \$2,500

You will be required to pay the annual contribution equal to the coverage level you have chosen

Q-7. How is my Medical Care and/or Dependent Care Expense Reimbursement benefit paid for and what amounts will be available at any particular time during the Plan Year?

For URM and DDC, when you complete the SRA, you specify the amount of Medical Care and or Dependent Care Expense Reimbursement(s) you wish to pay for with your Pre-tax Contributions. Thereafter, you must make a contribution for such coverage by having an equal portion of the annual reimbursement amount deducted from each paycheck. Your employer will distribute benefit payments from its general assets.

For URM Benefits, the full amount of the coverage you have elected, reduced by the amount of prior reimbursements received during the Plan Year, will be available to reimburse you for your out-of-pocket medical expenses incurred at any time during the Plan Year and while you are a Participant. For DDC Benefits, the amount that is available for reimbursement at any particular time will be whatever has been credited to your Dependent Care Account less any reimbursements already paid.

Q-8. How do I receive reimbursement under the Plan?

If you elect to participate in URM or DDC, you will have to take certain steps to be reimbursed for your Eligible Medical and/or Eligible Employment-Related Expenses (as defined in Q-9 below) When you incur an expense that is eligible for payment, you submit a request to the Plan's Administrator on a Request for Reimbursement form that will be supplied to you

For URM and DDC, you must include written statement(s)/bill(s) from an independent third party(ies) stating that the eligible expenses have been incurred, and the amount of such expense(s) along with the Request for Reimbursement form. In addition, you must include for URM claims an Explanation of Benefits (EOB) form(s) from any primary medical and/or dental insurance carrier(s) indicating the amount(s) that you are obligated to pay

For DDC, if your reimbursement request is for an amount that is more than your current Account balance, the excess part of the reimbursement will be carried over into following months, to be paid out as your balance becomes adequate. Remember, though, that you can't be reimbursed for any total Dependent Care expenses above your available, annual credits to your Account

With respect to either DDC or URM benefits, you may not be reimbursed for any expenses that arise before your SRA becomes effective, or for any expense incurred after the close of the Plan Year.

To have your Request for Reimbursements processed as soon as possible, please read the reimbursement instructions on the back of the Request for Reimbursement form you have been furnished Please note that it is not necessary that you have actually paid an amount due for Eligible Medical and/or Eligible Employment-Related Expenses – only that you have incurred the expense, and that it is not being paid for or reimbursed from any other source In addition, you will have 90 days after the end of the Plan Year in which to submit a Request for Reimbursement form for Eligible Expenses incurred during the previous Plan Year (Run-off Period). You will be notified in writing if any Request for Reimbursement is denied.

Q-9. What is an "Eligible Expense?"

For URM, an "Eligible Medical Expense" is generally an expense that has been incurred by you and/or your eligible dependents that satisfies the following conditions.

- 1) The expense is for "medical care" as defined by Code Section 213(d) Whether an expense is for "medical care" is within the sole discretion of the Plan Administrator;
- 2) The expense has not been reimbursed by any other source and you will not seek reimbursement for the expense from any other source.

The Code generally defines "medical care" as any amounts incurred to diagnose, treat or prevent a specific medical condition or for purposes of affecting any function or structure of the body. This includes, but is not limited to, both prescription and over the counter drugs (and over the counter products and devices). Not every health related expense you or your eligible dependents incur constitutes an expense for "medical care" For example, an expense is not for "medical care", as that term is defined by the Code, if it is merely for the beneficial health of you and/or your eligible dependents (e.g., vitamins or nutritional supplements that are not taken to treat a specific medical condition) or for cosmetic purposes, unless necessary to correct a deformity arising from illness, injury, or birth defect. You may, in the discretion of the Third Party Administrator/Plan Administrator, be required to provide additional documentation from a health care provider showing that you have a medical condition and/or the particular item is necessary to treat a medical condition. Expenses for cosmetic purposes are also not reimbursable unless they are necessary to correct an abnormality caused by illness, injury or birth defect. Also, "stockpiling" of over the counter drugs and/or items is not permitted and expenses resulting from stockpiling are not reimbursable There must be a reasonable expectation that such drugs or items could be used during the Plan Year (as determined by the Plan Administrator)

For DDC, you may be reimbursed for work-related expenses ("Eligible Employment-Related Expenses") incurred on behalf of any Qualifying Individual described below Generally, these expenses must meet all of the following conditions for them to be Eligible Employment-Related Expenses:

- The expenses are incurred for services rendered after the date of your election to receive Dependent Care Expense Reimbursement, and during the calendar year to which it applies.
- Services are incurred for a Qualifying Individual. A Qualifying Individual is:
 - 1 An individual age 12 or under who is a "qualifying child" of the Employee as defined in Code Section 152(a)(1) Generally speaking, a "qualifying child" is a child (including brother, sister, step sibling) of the Employee or a descendant of such child (e.g., a niece, nephew, grandchild) who shares the same principal place of abode with you for more than half the year and does not provide over half of his/her support In addition, a child of an Employee who is also a Code Section 152 dependent of another individual cannot be a qualifying individual, or

- 2 A Spouse or other tax Dependent (as defined in Code Section 152) who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as you for more than half of the year
- There is a special rule for children of divorced parents. A child is the qualifying individual of the parent who has "custody."
 - The expenses are incurred for the care of a Dependent (as described above), or for related household services, and are incurred to enable you to be gainfully employed.
 - If the expenses are incurred for services outside your household and such expenses are incurred for the care of a Dependent who is age 13 or older, such Dependent regularly spends at least 8 hours per day in your home.
 - If the expenses are incurred for services provided by a Dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center must comply with all applicable state and local laws and regulations.

The expenses are not paid or payable to a child of yours who is under age 19 at the end of the year in which the expenses are incurred or an individual for whom you or your Spouse is entitled to a personal tax exemption as a Dependent.

This reimbursement (when aggregated with all other Dependent Care Reimbursements during the same year) may not exceed the least of the following limits:

- 1 \$5,000
- 2 \$2,500, if you are married but you and your Spouse file separate tax returns.
3. Your taxable compensation (after your Pre-tax Contributions have been deducted under the Plan).
4. If you are married, your Spouse's actual or deemed Earned Income.
- 5 For purposes of (4) above, your Spouse will be deemed to have Earned Income of \$250 (\$500 if you have two or more Dependents described in paragraph 2 above), for each month in which your Spouse is (i) physically or mentally incapable of caring for himself or herself or (ii) a full-time Student.

You are encouraged to consult your personal tax advisor or IRS Publication 17 "Your Federal Income Tax" for further guidance as to what is or is not an Eligible Expense if you have any doubts.

Q-10. When must the expenses be incurred?

Eligible Medical and Employment-Related Expenses must generally have been incurred during the Plan Year. You may not be reimbursed for any expenses arising before the Plan became effective, before your SRA becomes effective, or for any expenses incurred after the close of the Plan Year, or, except for Continuation Coverage and certain Eligible Employment-Related Expenses, after a separation from service. You may be reimbursed for Eligible Employment-Related Expenses that are incurred after a separation from service up to your account balance on the date of separation from service.

In addition, IRS regulations require that service or treatment be actually rendered prior to the time that the expense is reimbursed. Therefore, even if your doctor requires that an expense be paid in advance, you cannot be reimbursed until the service relating to the expense has been rendered. In order to ensure compliance with this IRS requirement, you (and/or your doctor) may be required to submit additional substantiation (such as a proposed treatment plan) with respect to certain long-term treatments (e.g., orthodontic or obstetric expenses). Failure to submit the required forms could result in your reimbursement being pended and/or denied.

Q-11. What if the Eligible Medical or Eligible Employment-Related Expenses I incur during the Plan Year are less than the annual amount I have elected for Medical Care and/or Dependent Care Expense Reimbursement?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Expenses you have incurred, on the one hand, and the annual coverage level you have elected and paid for, on the other. This is called the "Use-it-or-Lose-it" Rule. Any amount allocated to an Account shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide the elected benefit for any Plan Year by the ninetieth (90th) day following the end of the Plan Year for which the election was effective. Amounts so forfeited shall be used to offset administrative expenses and future costs.

Q-12. Will I be taxed on the DDC benefits I receive?

You will not normally be taxed on your DDC benefits, up to the limits set out in Q-4. However, to qualify for tax-free treatment, you will be required to list the names and taxpayer identification numbers on your annual tax return of any persons who provided you with Dependent care services during the calendar year for which you have claimed a tax-free reimbursement

Q-13. What is the household and Dependent care credit?

The household and dependent care credit is an allowance for a percentage of your annual, Eligible Employment-Related Expenses as a credit against your federal income tax liability under the U.S. Tax Code. In determining what the tax credit would be, you may take into account only \$3,000 of such expenses for one Qualifying Individual, or \$6,000 for two or more Qualifying Individuals. Depending on your adjusted gross income, the percentage could be as much as 35% of your Eligible Employment-Related Expenses (to a maximum credit amount of \$1050 for one Qualifying Individual or \$2100 for two or more Qualifying Individuals) to a minimum of 20% of such expenses. The maximum 35% rate must be reduced by 1% (but not below 20%) for each \$2,000 portion (or any fraction of \$2,000) of your adjusted gross income over \$15,000.

Illustration: Assume you have one Qualifying Individual for whom you have incurred Eligible Employment-Related Expenses of \$3,600, and that your adjusted gross income is \$21,000. Since only one Qualifying Individual is involved, the credit will be calculated by applying the appropriate percentage to the first \$3,000 of expenses. The percentage is, in turn, arrived at by subtracting one percentage point from 35% for each \$2,000 of your adjusted gross income over \$15,000. The calculation is: $35\% - [(\$21,000 - 15,000)/\$2,000 \times 1\%] = 32\%$. Thus, your tax credit would be $\$3,000 \times 32\% = \960 . If you had incurred the same expenses for two or more Qualifying Individuals, your credit would have been $\$3,600 \times 32\% = \1152 , because the entire \$3,600 expense would have been taken into account, not just the first \$3,000.

Q-14. If I participate in the DDC, will I still be able to claim the household and Dependent care credit on my federal income tax return?

You may not claim any other tax benefit for the tax-free amounts received by you under this Plan, although the balance of your qualified Dependent care expenses may be eligible for the Dependent care credit.

Q-15. When would I be better off to include the reimbursements in my income and claim the credit, rather than to treat the reimbursements as tax-free?

Generally, if you are in a lower income tax bracket, you may come out ahead by including the DDC benefits in income, and claiming the credits for Dependent care. On the other hand, it will generally be better to treat DDC benefits as tax-free if the more income taxes you are required to pay. Because the actual determination of the preferable method for treating benefit payments depends on a number of factors such as one's tax filing status (e.g., married, single, head of household), number of Dependents, etc., each Participant will have to determine his or her tax position individually in order to make the decision between taxable and tax-free benefits.

Q-16. What happens to unclaimed Reimbursements?

Any Reimbursement Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Eligible Medical and/or Employment-Related Expense was incurred shall be forfeited.

Q-17. What happens if a claim for Benefits under the URM or DDC is denied?

You will be notified if your claim under the Plan is denied. The notice will be furnished to you as soon as reasonably possible but no later than 30 days after the Plan Administrator (or its designated claims administrator identified in the reimbursement form) receives your claim. However, if for reasons beyond the control of the claims reviewer, more time for processing your claim is needed, the applicable claims reviewer may take an extension of not more than 15 days following the end of the 30-day period. You will be notified of this extension before the initial 30 days has expired, and the notice will explain why an extension is necessary and the date a decision is expected to be rendered. If the reason for the extension is because you failed to submit complete information necessary to decide the claim, you will have 45 days from the notice of the extension in which to provide the information. The time period for making a decision will be suspended until the earlier of the date that you submit the necessary information or the end of the 45-day period.

The notice of the denial will include the following:

- the specific reason or reasons for the denial;
- specific reference to pertinent Plan provisions on which the denial is based,
- a description of any additional material or information necessary for the claim to be approved and an explanation of why such material or information is necessary;

- instructions on how to appeal the denied claim (including the applicable time periods) and the identity of the individual(s) who will review the denied claim; and
- Any other information required by applicable law.

If your claim is denied in whole or in part, you may appeal by requesting a review of the denied claim. Your request must be in writing and must be submitted in accordance with the instructions set forth in the denial notice within 180 days after you receive notice of the denial. If there are two levels of appeal, you will have a reasonable amount of time described in the notice of denial in which to request a second review by the Plan Administrator. As part of the appeal process (whether there is one or two appeals), you or your authorized representative may examine documents, records, and other information relevant to your claim and submit issues, documents and comments in writing. You will be notified in writing of the decision on review as soon as reasonably possible but no later than 60 days after the request for review is received. The notice will contain the same type of information described above and it will indicate whether there are one or two levels of appeals. If there are two levels of appeals, the decisions on review will be made no later than 30 days after the request for each review is received. The reviews upon appeal (whether one level or two) will take into account all comments, documents, records and other information submitted by the claimant relating to the claim without regard to whether such information was submitted or considered in a previous review. In no event will a determination upon review be made by the same individual(s) who made previous determinations or someone who is a subordinate of any individual who made such previous determinations. The Plan Administrator is the claims fiduciary responsible for making final claim decisions under the Plan.

In the event of your death, your beneficiary has the same rights and is subject to the same time limits and other restrictions that would otherwise apply to you under the claims procedures explained above.

Q-18. What is COBRA continuation coverage?

Federal law requires most employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of health care coverage (called "continuation coverage") at group rates in certain instances where coverage under the plans would otherwise end. These rules apply to the URM only, unless the Employer is a small-employer within the meaning of the applicable regulations. The Plan Administrator can tell you whether the Employer is a small employer (and thus not subject to these rules).

When Coverage May Be Continued

If you are a Participant in the URM, then you have a right to choose continuation coverage under the URM if you lose your coverage because of a reduction in your hours of employment; or a voluntary or involuntary termination of your employment (for reasons other than gross misconduct).

If you are the Spouse of a Participant, then you have the right to choose continuation coverage for yourself if you lose coverage due to the death of your Spouse; a voluntary or involuntary termination of your Spouse's employment (for reasons other than gross misconduct) or reduction in your Spouse's hours of employment; or the divorce or legal separation from your Spouse.

In the case of a Dependent child of a Participant, he or she has the right to choose continuation coverage if coverage is lost because of the death of the employee, a voluntary or involuntary termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment; his or her parents' divorce or legal separation; or his or her loss of Dependent status. A child who is born to, or placed for adoption with, the employee during a period of continuation coverage is also entitled to continuation coverage under COBRA. Those who are entitled to continue coverage under COBRA are called "Qualified Beneficiaries."

NOTE: Notwithstanding the preceding paragraphs, you generally will not have the right to elect COBRA continuation if the amount you have contributed for URM at the time of the COBRA Qualifying Event is less than the amount of URM reimbursements you have received. You will be notified of your particular right to elect COBRA continuation coverage.

Type of Coverage

If you choose continuation coverage, you may continue the level of coverage you had in effect immediately preceding the qualifying event. However, if Plan benefits are modified for similarly situated active employees, then they will be modified for you and other Qualified Beneficiaries as well. You will be eligible to make a change in your benefit election with respect to the Plan upon the occurrence of any event that permits a similarly situated active employee to make a benefit election change during a Plan Year. If you do not choose continuation coverage, your coverage under the URM will end with the date you would otherwise lose coverage.

Notice Requirements

You or your covered Dependents (including your Spouse) must notify the COBRA Administrator identified in the Plan Information Summary in writing of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the later date of the event or the date on which coverage is lost because of the event. Your written notice must

identify the qualifying event, the date the qualifying event occurred, and the qualified beneficiaries impacted by the qualifying event. When the COBRA Administrator is notified that one of these events has occurred, the Plan Administrator will in turn notify you that you have the right to choose continuation coverage by sending you the appropriate election forms. Notice to an employee's Spouse is treated as notice to any covered dependents who reside with the Spouse. You may be required to provide additional documentation (e.g., a copy of the divorce decree).

An employee or covered dependent is responsible for notifying the COBRA Administrator if he or she becomes covered under another group health plan.

Election Procedures and Deadlines

Each qualified beneficiary is entitled to make a separate election for continuation coverage under the Plan if they are not otherwise covered as a result of another Qualified Beneficiary's election. In order to elect continuation coverage, you must complete the Election Form(s) within 60 days from the date you would lose coverage for one of the reasons described above or the date you are sent notice of your right to elect continuation coverage, whichever is later, and send it to the COBRA Administrator identified in the Plan Information Summary. Failure to return the Election Form(s) within the 60-day period will be considered a waiver of your continuation coverage rights.

Cost

You will have to pay the entire cost of your continuation coverage. The cost of your continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage. The first premium payment after electing continuation coverage will be due 45 days after making your election. Subsequent premiums must be paid within a 30-day grace period following the due date. Failure to pay premiums within this time period will result in automatic termination of your continuation coverage. Claims incurred during any period will not be paid until your premium payment is received for that period. If you timely elect continuation coverage and pay the applicable premium, however, then continuation coverage will relate back to the first day on which you would have had regular coverage.

When Continuation Coverage Ends

The maximum period for which coverage may be continued will be until the end of the Plan Year in which the qualifying event occurs. To the extent that Nonelective Employer contributions are provided, the maximum duration of coverage may be 18 or 36 months from the qualifying event, (depending on the type of qualifying event). You will be notified of the duration of continuation coverage when you have a qualifying event. However, continuation coverage may end earlier for any of the following reasons:

- The contribution for your continuation coverage is not paid on time or it is insufficient (Note: if your payment is insufficient by the lesser of 10% of the required COBRA premium, or \$50, you will be given 30 days to cure the shortfall);
- After you elect COBRA continuation coverage, the date that you first become covered under another group health plan under which you are not subject to a pre-existing condition exclusion limitation;
- After you elect COBRA continuation coverage, the date that you first become entitled to Medicare; or
- The date the employer no longer provides group health coverage to any of its employees.

Q-19. How long will the Plan remain in effect?

Although the Employer expects to maintain the URM and DDC indefinitely, it has the right to modify or terminate the programs at any time for any reason. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly.

Q-20. Will my health information be kept confidential?

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") group health plans such as the URM and the third party service providers are required to take steps to ensure that certain "protected health information" is kept confidential. Attached as Appendix II to this SPD (included in the HIPAA packet) is a summary of your rights and obligation under HIPAA. You may receive a separate notice that outlines the Employer's health privacy policies in more detail.

Q-21. Is there any other important information that I should know about the Reimbursement Plan?

Participation in the Plan does not give any Participant the right to be retained in the employ of his or her Employer or any other right not specified in the Plan. The Plan Administrator's name, address and telephone number appear in the Plan Information Summary attached to the front of this SPD. The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact and construe and

interpret possible ambiguities, inconsistencies, or omissions in the Plan and this SPD. Other important information such as the Plan Number and Plan Sponsor's name has also been provided in the Plan Information Summary.

ERISA Rights

The URM may be an ERISA welfare benefit plan (unless the employer is a governmental employer or the plan is a "church plan" as defined in the applicable regulations) As a Participant in an ERISA-covered benefit, you are entitled to certain rights and protections under the Employee Retirement Income Security Act ("ERISA") ERISA provides that all plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all documents governing the plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the plan with the U S Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration

Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated SPD The Plan Administrator may make a reasonable charge for the copies

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, Spouse or Dependent children if there is a loss of coverage under the Plan as a result of a qualifying event. You or your eligible dependents will have to pay for such coverage. You should review Q-19 of this appendix for more information concerning your COBRA continuation coverage rights.

(To the extent the URM is subject to HIPAA's portability rules:) You may be eligible for a reduction or elimination of exclusionary periods of coverage for preexisting condition under your group health plan, if you move to another plan and you have creditable coverage from this Plan. You will be provided a certificate of creditable coverage, free of charge, from the Plan Administrator when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage in another plan

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit from the Plan or from exercising your rights under ERISA

Enforce Your Rights

If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a federal court If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U S Department of Labor, or you may file suit in a federal court The court will decide who should pay court costs and legal fees If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator If you have any questions about this statement or about your rights under ERISA or if you need assistance obtaining documents from the Plan Administrator, you should contact the nearest office of the U S Department of Labor, Employee Benefits Security Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration; U.S Department of Labor, 200

Constitution Ave., NW; Washington, D C 20210 You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration

SAMPLE

APPENDIX II TO THE FLEXIBLE BENEFITS PLAN SUMMARY PLAN DESCRIPTION

Summary of URM HIPAA Privacy Policies and Procedures

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the URM claims reimbursed under the Plan for Plan administration purposes. This summary applies to all of the medical records we maintain with regard to the URM. Your personal doctor or health care provider will have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic. During the course of providing you with health coverage under the URM, the Plan will have access to information about you that is deemed to be "protected health information", or PHI, by the Health Insurance Portability and Accountability Act of 1996, or HIPAA. In accordance with Section 10.18 of the Plan, the following is a summary of procedures adopted by the Employer to ensure that both Employer and any third party service providers treat your PHI with the level of protection required by HIPAA. You may receive a separate notice that provides more detailed information regarding the procedures adopted by Employer.

This summary will provide you with a general overview of the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information. In the event this summary conflicts with the separate Privacy Notice from Employer, the separate Privacy Notice controls.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you, and
- follow the terms of the notice that is currently in effect.

Your PHI will be disclosed to certain employees of Employer. Except as otherwise provided in the separate Privacy Notice that may be provided to you, these employees consist of the members of the Personnel Benefits Department of Employer who assist in administration of URM claims. These individuals may only use your PHI for Plan administration functions including those described below, provided they do not violate the provisions set forth herein. Any employee of Employer who violates the rules for handling PHI established herein will be subject to adverse disciplinary action. Employer will establish a mechanism for resolving privacy issues and will take prompt corrective action to cure any violations.

By adoption of the SPD, Employer has certified that it will comply with the privacy procedures summarized herein and detailed in any separate privacy notice. Employer may not use or disclose your PHI other than as summarized herein or as required by law. Any agents or subcontractors who are provided your PHI must agree to be bound by the restrictions and conditions concerning your PHI found herein. Your PHI may not be used by Employer for any employment-related actions or decisions or in connection with any other benefit or employee benefit plan of Employer. Employer must report to the Plan any uses or disclosures of your PHI of which the Employer becomes aware that are inconsistent with the provisions set forth herein.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose medical information for purposes of URM administration. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment (as described in applicable regulations) We may use and disclose medical information about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage.

For Health Care Operations (as described in applicable regulations) We may use and disclose medical information about you for other Plan operations. These uses and disclosures are necessary to run the Plan.

As Required By Law We will disclose medical information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS

Disclosure to Health Plan Sponsor Information may be disclosed to another health plan maintained by Employer for purposes of facilitating claims payments under that plan. In addition, medical information may be disclosed to Employer personnel solely for purposes of administering benefits under the Plan.

Organ and Tissue Donation If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans If you are a member of the armed forces, we may release medical information about you as required by military command authorities.

Workers' Compensation We may release medical information about you for workers' compensation or similar programs.

Public Health Risks. We may disclose medical information about you for public health activities (e.g., to prevent or control disease, injury, or disability).

Health Oversight Activities We may disclose medical information to a health oversight agency for activities authorized by law.

Lawsuits and Disputes If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official for law enforcement purposes.

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. We may also release medical information about patients of the hospital to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Personnel/Benefits Office, except as otherwise set forth in any separate Privacy Notice provided to you by Employer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. HIPAA provides several important exceptions to your right to access your PHI. For example, you will not be permitted to access psychotherapy notes or information compiled in anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. Employer will not allow you to access your PHI if these or any of the exceptions permitted under HIPAA apply. If you are denied access to medical information, you may request that the denial be reviewed.

Right to Amend If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to the Personnel/Benefits Office. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Is not part of the medical information kept by or for the Plan;
- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete
- Employer must act on your request for an amendment of your PHI no later than 60 days after receipt of your request. Employer may extend the time for making a decision for no more than 30 days, but it must provide you with a written explanation for the delay. If Employer denies your request, it must provide you a written explanation for the denial and an explanation of your right to submit a written statement disagreeing with the denial.

Right to an Accounting of Disclosures You have the right to request an "accounting of disclosures" (other than disclosures you authorized in writing) where such disclosure was made for any purpose other than treatment, payment, or health care operations. You will be notified of where you can obtain an accounting of disclosure in the separate Privacy Notice. Your request must state a time period that may not be longer than six years and may not include dates before April 2003. Your request should indicate in what form you want the list (for example, on paper, or electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Note that HIPAA provides several important exceptions to your right to an accounting of the disclosures of your PHI. For example, Employer does not have to account for disclosures of your PHI (i) to carry out treatment, payment or healthcare operations, (ii) to correctional institutions or law enforcement officials, or (iii) for national security or intelligence purposes. Employer will not include in your accounting any of the disclosures for which there is an exception under HIPAA. Employer must act on your request for an accounting of the disclosures of your PHI no later than 60 days after receipt of the request. Employer may extend the time for providing you an accounting by no more than 30 days, but it must provide you a written explanation for the delay. You may request one accounting in any 12-month period free of charge. Employer will impose a fee for each subsequent request within the 12-month period.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Personnel Office except as otherwise provided in the separate privacy notice. We will not ask you the reason for your request. We will accommodate all requests we deem reasonable. Your request must specify how or where you wish to be contacted.

When Employer no longer needs PHI disclosed to it by the Plan for the purposes for which the PHI was disclosed, Employer must, if feasible, return or destroy the PHI that is no longer needed. If it is not feasible to return or destroy the PHI, Employer must limit further uses and disclosures of the PHI to those purposes that make the return or destruction of the PHI infeasible.

CHANGES TO THIS SUMMARY AND THE SEPARATE PRIVACY NOTICE

We reserve the right to change this summary and the separate Privacy Notice that may be provided to you. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. The notice will contain the effective date on the front page.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, contact the Personnel Office except as otherwise provided in the separate Privacy Notice. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION.

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. We are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

REIMBURSEMENT SERVICES AGREEMENT

This Agreement, effective upon execution for the Plan Year, by and between
and American Family Life Assurance Company ("Aflac")

WITNESSETH:

WHEREAS, the Employer has adopted a Medical Care Expense Reimbursement ("URM") Plan and/or a Dependent Care Expense Reimbursement ("DDC") Plan for its Employees in conjunction with its Flexible Benefits Plan (collectively referred to as the "Plan" and attached hereto) to be adopted and administered in accordance with Sections 105, 125, and 129 of the Internal Revenue Code of 1986, as amended (the "Code"); and

WHEREAS, the Employer will serve as the Plan Administrator; and

WHEREAS, the Employer desires that Aflac, as its agent, furnish reimbursement services within a framework of policies, interpretations, rules, practices and procedures (the "reimbursement practices and procedures") made and established by the Employer in: (i) receiving and processing requests for benefits under the Plan ("Requests") and (ii) disbursing benefit payments from Employer funds (as provided for in Section II A.) for eligible expenses under the flexible spending account provisions of the Plan, (if Self-Pay Option is selected in Section II A below, Aflac shall convey its initial benefit determinations to Employer so the Employer can disburse reimbursement payments for eligible expenses under the Flexible Spending Agreement provisions of the Plan); and

WHEREAS, the Employer is to pay all plan benefits owed or established under the Plan to its Participants, and Aflac is to provide the agreed upon services to the Plan without assuming any such liability;

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, it is hereby agreed as follows:

Section I. Enrollment and Determination of Eligibility

A The Employer shall:

- (1) be responsible for interpreting the Plan and its provisions, its terms, conditions and operation; and
- (2) notify Plan Participants of their ability to apply for reimbursement benefits and supply them with Request forms (to be provided by Aflac) and Request filing instructions; and
- (3) provide Aflac with the names, addresses, Social Security Numbers, and elected amounts of all participants in the Plan; and
- (4) upon the occurrence of events that would change a Participant's status under the Plan (e.g. termination, Change in Status, Change in Cost or Coverage for DDC, etc.) immediately provide Aflac with updates (via Telefax) which identify eligible Participants in each of the respective reimbursement Plans and/or the amount of reimbursement benefits for which they are eligible; and
- (5) immediately inform Aflac (via Telefax) as to any new Participants in either of the reimbursement Plans, any Change in Status affecting a Participant's election, or any Qualified Beneficiary electing coverage under COBRA and the amount of such election (if COBRA applies to the Employer), or of any other change which will affect Aflac's responsibilities hereunder

B In determining any person's right to benefits under the Plan, Aflac shall rely on the eligibility information furnished by the Employer, and any signed statements by Participants regarding the eligibility of their Requests under the respective Plan. It is mutually understood that the effective performance of this Agreement by Aflac will require that it be advised on a timely basis by the Employer during the continuance of this Agreement of the identity of individuals eligible for benefits under each of the respective reimbursement Plans. Information modifying a Participant's eligibility or status/election under either reimbursement Plan shall identify the effective date of eligibility and the termination date of eligibility and shall be provided to Aflac (via Telefax) prior to the effective date of such modification in order to be considered by Aflac in making benefit determinations hereunder. Aflac shall not be responsible for Requests paid in error where the Employer has failed to inform Aflac (in a form and with such information as may reasonably be required by Aflac) of a Participant's eligibility or status change prior to the release of the benefit payment.

Section II. Funding and Payment of Requests for the Plan Benefits

A. Select one below:

[] Daily Processing Option The Employer shall:

- (i) make sufficient funds available from its general assets for amounts allocable to eligible reimbursement benefits under its plan by depositing a "Maintenance Deposit" (in amounts specified by Aflac from time to time) in an Employer-owned and named account (the "Account") in a financial institution selected by the Employer and Aflac to facilitate the timely processing of Requests under the Plan [Note the Account should not be opened in the Plan's name], and

- (ii) grant Aflac withdrawal authority over the Account sufficient to enable it to pay benefits under the Employer's FSA Plans; and
- (iii) deposit additional funds (at the request of Aflac) in order to reestablish the Maintenance Deposit at the end of each Request processing cycle (or such earlier time specified by Aflac), and
- (iv) telefax copies of all deposit verification receipts, Account Statements, and other correspondence relating to the Account to Aflac upon receipt of such correspondence from the financial institution, and
- (v) during the term of this Agreement, the Employer shall not withdraw funds from the Account; except at the request of, or to the extent approved by Aflac. The Employer bears sole responsibility for any fees imposed with respect to the Account by the financial institution, including but not limited to: Account maintenance fees, insufficient funds fees, fees with respect to voided checks, etc., and
- (vi) authorize Aflac to access the Account by:

entering into a Withdrawal Agreement with CB&T, or

if a Financial Institution other than CB&T is designated below, the Employer hereby authorizes Aflac to: a) draw benefit checks directly on the Account; b) electronically transfer benefit payments from the Account, c) electronically access Account information; and d) execute the financial institution's standard Deposit/Account Agreement on the Employer's behalf (subject to the terms and conditions set forth herein and as Aflac may otherwise establish) Name, address and contact person at other financial institution:

Standard Option. The Employer shall:

- (i) make sufficient funds available from its general assets for amounts allocable to eligible reimbursement benefits under its Plan; and
- (ii) provide an amount equal to the aggregate amount of all Requests payable under the Employer's Plan and facilitate an electronic transfer to Aflac or submit, by first class mail, a check drawn on Employer's account and payable to Aflac/Flex One® within three (3) business days of receipt of a request for such funds from Aflac for which there are eligible outstanding Requests (pursuant to the terms of the Plan).

Aflac will not be responsible for paying claims to the extent sufficient funds are not provided to Aflac within 30 days of the receipt of the request for such funds from Aflac, and Employer must utilize the Self-Pay Option described below with respect to such unfunded claims. The Employer agrees to indemnify Aflac for all amounts and expenses resulting from the Employer's failure to provide sufficient funds and shall hold Aflac, its officers and directors, harmless for any liability for which Employer may become liable.

Self-Pay Option The Employer shall:

- (i) make sufficient funds available from its general assets for amounts allocable to eligible reimbursement benefits under its Plan; and
- (ii) review Aflac's initial reimbursement determinations and issue reimbursement checks from its general assets within seven days of the receipt thereof for those Requests which are reimbursable pursuant to the terms of its Plan; and
- (iii) upon request, provide Aflac with proof of timely benefit check disbursements in a form and manner deemed acceptable by Aflac (e.g., bank issued account statements or check register).

If, at any time, the amount of reimbursement benefits payable under the applicable Plan provisions exceeds the amount deposited by the Employer in the Account, the Employer shall transfer an amount necessary to the Account to fulfill its reimbursement obligations under the applicable Plan before any further reimbursement benefit payment is made. Aflac is under no obligation to advance funds on behalf of the Employer.

B Aflac, as agent for the Employer, shall provide those services described in Appendix A (attached hereto)

Upon written request submitted to Aflac's Flex One Department, Aflac may provide limited assistance with certain of the nondiscrimination tests. The terms and conditions (including applicable fees) under which such services are provided are set

forth in Appendix B "Nondiscrimination Testing Services". In providing services, Aflac shall assume that ERISA and COBRA apply to the Employer's Plan unless the Employer gives Aflac written direction otherwise

- C Aflac shall not be obligated or responsible for any duty with regard to the administration of the Plan (imposed by the Plan or otherwise) except as specifically provided above or in the attached appendices. Without limiting Employer's responsibilities described therein, it shall be the Employer's sole responsibility (as Plan Administrator) and duty to ensure compliance with COBRA; perform required nondiscrimination testing; amend the Plan as necessary to ensure ongoing compliance with applicable law; file any required tax or governmental returns (including Form 5500 returns to meet ERISA requirements) relating to the Plan; determine if and when a valid election change has occurred; handle Participant claim appeals; allow Aflac, by and through independent associates, a reasonable opportunity to discuss Aflac, URM, and DDC benefits; execute and retain required Plan and claims documentation, and take all other steps necessary to maintain and operate the Plan in compliance with applicable provisions of the Plan, ERISA, the Code and other applicable federal and state laws
- D In the event that Aflac overpays any person entitled to benefits under the Plan or pays benefits to any person who is not entitled to them, Aflac shall take all reasonable steps to recover the overpayment, except that Aflac shall not be required to initiate court proceedings to recover an overpayment. Aflac shall promptly notify the Employer if it is unsuccessful in recovering any overpayment
- E Aflac will optically scan and maintain electronic copies of all FSA Reimbursement Requests and supporting documentation for a period of seven (7) years after the claim is processed. Copies of FSA claim documents can be reproduced upon written request at Aflac's currently prevailing rate

Section III. Liability and Indemnity

- A In performing its obligations under this Agreement, Aflac neither assumes nor underwrites any liability of the Employer under the Plan, but with respect to the Employer, acts only as provider of those services specifically described in Section II B of this Agreement and with respect to Plan Participants, acts only as the agent of the Employer. The services to be performed by Aflac shall be ministerial in nature and shall be performed within the framework of policies, interpretations, rules, practices, and procedures made or established by the Employer. Aflac shall have no discretionary authority or discretionary control over any assets of the Employer, the Plan, or Plan Participants
- B Aflac shall have no duty or obligation to defend any legal action or proceeding brought to recover a Request for Plan Benefits. Aflac shall, however, make available to the Employer and its counsel, such evidence relevant to such action or proceeding as Aflac may have as a result of its processing of the requested benefit determination
- C Except as otherwise explicitly provided in this Agreement, the Employer shall retain the liability for all Plan Benefit Requests and all expenses incident to the Plan and for any and all violations of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), if applicable, and agrees to indemnify Aflac for and hold it, its directors, officers, and employees, harmless from all amounts and expenses (including reasonable attorneys' fees and court costs) for which Aflac may become liable. This indemnity shall survive the termination of this Agreement
- D Aflac shall use ordinary and reasonable care in the performance of its duties, but shall not be liable to the Employer for mistakes of judgment or other actions taken in good faith unless such error results directly from an intentionally wrongful or grossly negligent act of Aflac, its officers or employees
- E Aflac shall have no duty or obligation with respect to Requests incurred prior to the effective date of this Agreement (hereafter "Prior Reimbursement Requests") and/or Plan Administrator (or other) services arising prior to the effective date of this Agreement regardless of whether such services were/are to be performed prior to or after the effective date of this Agreement (hereafter "Prior Administration"). The Employer specifically acknowledge(s) and agree(s) that: (i) Aflac has no responsibility or obligation with respect to Prior Reimbursement Requests and/or Prior Administration; (ii) the Employer will be responsible for processing Prior Reimbursement Requests (including any Run-Off Requests submitted after the effective date of this Agreement) and maintaining legally required records of all Prior Reimbursement Requests and Prior Administration sufficient to comply with applicable legal (e.g., IRS substantiation) requirements and (iii) the Employer agrees to indemnify and hold Aflac harmless for any liability relating to Prior Reimbursement Requests and/or Prior Administration
- F The Employer agrees that Aflac may communicate confidential, protected, privileged or otherwise sensitive information to Employer through the Named Contact (as designated on the applicable plan document request form) and specifically agrees to indemnify Aflac and hold it harmless: i) for any such communications directed to the Employer through the Named Contact attempted via telefax, mail, telephone, e-mail or any other media, acknowledging the possibility that such communications may be inadvertently misrouted or intercepted; and ii) from any claim for the improper use or disclosure of any health information by Aflac where such information is used or disclosed in a manner consistent with its duties and responsibilities under this Agreement.

Section IV. Reimbursement Request Processing Service Fee

- A The Employer shall pay Aflac a fee for services performed under this Agreement in the amount of **##.##** per Participant per FSA benefit (DDC or URM) per month (max per Participant of **##.##**) with a minimum monthly fee of **##.##** for the reimbursement Plans (URM and/or DDC) for which services are rendered. This amount shall be due by the tenth (10th) of each month (or portion thereof) for which this Agreement is in effect and is in addition to and separate from: (i) any Account Establishment (or "Set-Up") fee assessed by Aflac of **##.##** to initiate the reimbursement arrangement; and (ii) the Employer's obligation to make available sufficient funds to satisfy its obligations under the Plan and to make benefit disbursement in accordance with section II A. above. The Employer is responsible for paying the Service Fee to Aflac. Aflac is not authorized to withdraw the Service Fee from the Account. Failure to pay any applicable monthly Service Fee by the next monthly Request processing cycle shall result in a cessation of Request processing services until such fees are received by Aflac. If Request processing services are pending for an entire monthly processing cycle, Aflac may terminate this Agreement in accordance with Section VI
- B. Aflac may revise the Service Fee for services performed under this Agreement effective on each Anniversary Date of this Agreement by giving the Employer written notice of the revised rate at least thirty (30) days prior to the applicable Anniversary Date
- C Notwithstanding any other agreement between the parties (and/or their agents), Aflac may revise the Service Fee set forth above at any time if revision is deemed necessary by Aflac by reason of: (i) modification or amendment of the Plan by the Employer; (ii) a significant decrease in the number of Aflac policies purchased by Participants under the Plan below the number initially included in the Plan after the Service Fee was established (or if later, when the Service Fee was last revised); or (iii) a suspension, limitation, or revocation of the right of Employees or Participants to purchase Aflac policies under the Plan. Aflac shall advise the Employer of the revised Service Fee at least thirty (30) days prior to its implementation. If the Employer does not terminate this Agreement (by written notification pursuant to Section VI A 1) within thirty (30) days after the receipt of a notice of such revision, the Employer shall be deemed to have agreed to such revision for the remainder of the term of the Agreement. Thereafter, the Service Fee on and after the implementation date shall be made on the basis of such revised Service Fee.
- D Aflac may revise the Service Fee set forth above at any time if any change in law or regulations imposes on Aflac greater duties or obligations than contemplated by the Agreement in force at the time of such change.

Section V. Term of Agreement

The initial term of this Agreement shall be the initial Plan Year commencing on the effective date hereof, thereafter, this Agreement will automatically renew for successive periods of twelve (12) months unless, at least thirty (30) days prior to the end of the then current term, the Employer or Aflac gives written notice to the other of its intention not to renew the Agreement. In the event of a short Plan Year (other than the first Plan Year) this Agreement shall automatically renew for an additional twelve (12) months unless the Employer or Aflac gives written notice to the other of its intention not to renew the Agreement within three (3) days after the Employer notifies Aflac of the short Plan Year

Section VI. Termination of Agreement

- A. This Agreement shall terminate upon the earliest of the following dates:
- (1) The end of the term of the Agreement following the delivery of written notice of termination pursuant to Section V
 - (2) At the option of Aflac, the date upon which the Employer fails to transfer sufficient funds to Aflac (upon request by Aflac): (i) to pay all valid Requests pending under the Plan; or (ii) to pay the Service Fee (as provided in Section II A' and IV.A. above, respectively) Aflac shall promptly communicate its election of this option to the Employer
 - (3) Upon the implementation date for a proposed Service Fee increase deemed to be unacceptable by the Employer (after delivery of written notice of termination by the Employer) pursuant to Section IV C.
 - (4) At the option of Aflac, if no Plan Participant is an Aflac policyholder or if the Employer denies Aflac a reasonable opportunity (as determined by Aflac in its sole discretion) to meet with Employees, Aflac shall immediately communicate its election of this option to the Employer
 - (5) Any other date mutually agreeable to the Employer and Aflac
- B Upon termination of this Agreement, Aflac shall cease the processing of all Requests then in its possession, return any undistributed funds to the Employer, and make all records relating to Requests in process reasonably available to the Employer. If the termination occurs pursuant to VI A 1 (above), Aflac shall process all Run-Off claims provided any Service Fee(s) is current. Thereafter, the Employer and/or Plan Administrator shall be responsible for all aspects of Reimbursement Request processing and Plan administration

Section VII. Miscellaneous

- (1) Notices Any notice required to be given hereunder to Aflac shall be sufficient if in writing and delivered personally or by prepaid first class mail to Aflac Benefit Services/Flex One, 1932 Wynnton Road, Columbus, GA 31999-9950, or if to the Employer, at the address of the Employer denoted on the signature page attached hereto.
- (2) Applicable Law. This Agreement shall be governed by, and shall be construed in accordance with the laws of the State of Nebraska, to the extent they are not preempted by ERISA, the Code, or any other federal law.
- (3) Legal and Tax Status The Employer acknowledges that neither Aflac nor its agents is providing legal or tax advice, and that neither Aflac nor its agents serves as the Plan Administrator or a fiduciary under the Plan. The Employer shall be the sole party responsible for determining the legal and tax status of the Plan under applicable law. Aflac shall have no power or authority to waive, alter, breach, or modify any terms or conditions of the Plan.
- (4) Assignment. This Agreement may be assigned by Aflac to any other party, including any successor to the business of Aflac by merger, consolidation, purchase of assets, or otherwise, without the prior consent of the Employer. This Agreement shall be binding upon any corporation into which the Employer may be merged or with which it may be consolidated, or any corporation succeeding to all or substantially all of the business of the Employer.
- (5) Entire Contract. This Agreement constitutes the entire contract between the parties and no modification or amendment hereto shall be valid unless in writing and signed by an officer of the Employer and an Officer or duly authorized representative of Aflac.
- (6) Tax Reporting and Withholdings. The Employer has ultimate control over the payment of Plan benefits and shall be the sole party responsible for income and employment tax reporting and withholding obligations imposed as a result of the includability of such payments in the gross income of recipients. Aflac is a mere agent of the Employer for the processing of benefit Requests.
- (7) Confidential Information. The term "Confidential Information" as used in this Agreement means confidential or proprietary information of any party that is not generally known to the public, including, but not limited to compilations, lists of actual or potential customers or suppliers, hardware systems, software, or other documentation of any type, whether in printed or machine readable form, computer databases, forms and form letters, contracts, information regarding specific transactions, and marketing and business plans. For the purposes of this subsection, Confidential Information shall not include the personally identifiable information relating to any of Employer's employees.

The term "Trade Secrets" as used in this Agreement shall mean Confidential Information that: (1) derives economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use; and (2) is the subject of efforts that are reasonable under the circumstances to maintain its secrecy. The terms "Confidential Information" and "Trade Secrets" do not include information that: (a) is known to the receiving party prior to its disclosure by the disclosing party, evidenced by the receiving party's written records; (b) is developed by the receiving party independently of any of the Confidential Information or Trade Secrets received in confidence from disclosing party, evidenced by the receiving party's written records; (c) is rightfully received by the receiving party from a third party without restriction and without breach of any obligation of confidentiality running to the disclosing party.

Each party agrees that it shall not disclose to others or use for any purpose other than performance of the Agreement any of the other party's Confidential Information or Trade Secrets any time during or after the term of this Agreement. Each party further agrees that it will disclose Confidential Information or Trade Secrets to its employees only as necessary for the performance of the Agreement, and only to employees with a need to know. Each party to this Agreement agrees that all Confidential Information and Trade Secrets are the property of the party disclosing it, and each agrees to promptly return to the disclosing party, upon demand, any Confidential Information or Trade Secrets furnished under this Agreement which is either received in or reduced to material form, and all copies thereof. The Employer agrees that Aflac may make lawful references to Employer in its marketing activities.

- (8) Individual Information. Each party acknowledges that performance of the Agreement may involve the use and disclosure of personal information relating to the Employer's employees (including but not limited to names, addresses, benefit elections, claims and health information). Aflac agrees that it will not use any such information disclosed to it by Employer except as authorized by the individual to whom the information relates or as otherwise permitted by applicable state or federal law or regulation. Employer agrees that it will not use any such information disclosed to it by Aflac except for the purpose for which it received the information and will not further disclose such information without the written authorization of the individual to whom the information relates. This provision is not intended to create any third party beneficiary rights (in favor of Employer's employees or any other party).
- (9) Capitalized Terms shall have the same meaning as in the Plan documents.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed and signed by an Officer of the Employer and an Officer or duly authorized Worldwide Headquarters Employee of Aflac to do so.

Dated at Aflac this _____ day of _____

By: _____
Michael D. Flock
Second Vice President
Aflac Benefit Services/Flex One

Dated at _____ this _____ day of _____

By: _____

Street Address: _____

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Appendix A
Schedule of Services to Be Provided By Aflac

In accordance with attached Reimbursement Services Agreement Aflac shall provide the following services for the Employer:

General Plan Services:

- provide the Employer with a sample cafeteria plan document, including a medical care expense reimbursement ("URM") Plan and a dependent care expense reimbursement ("DDC") Plan to be reviewed by the Employer and its legal counsel, and
- provide the Employer with a sample flexible benefits summary plan description for distribution to each Plan Participant and employees and where may be required by a Change in Status; and
- upon receiving instructions from the Employer on a Change in Status, Aflac will make the change requested by the Employer

Additional Services if DDC or URM Benefits Are Offered:

- assist the Employer in explaining the URM and/or DDC features of the cafeteria plan to employees, and
- process the Employee-executed Salary Redirection Agreements as they relate to the URM and DDC components of the Employer's flexible spending account; and
- prepare an enrollment confirmation letter and send it to the Employer to verify URM and DDC elections; and
- provide each URM and/or DDC Participant with an Explanation of Benefits and account balance statement with each reimbursement request, at the end of each quarter (based on Plan Year) if no reimbursement requests are received, and at the end of each Plan Year; and
- provide the Employer with monthly written reports summarizing the previous period's URM and/or DDC and Account activities; and
- receive Requests for URM and/or DDC benefits, and expeditiously review such Requests to determine what amount, if any, is due and payable with respect thereto; and
- disburse the benefit payments it determines to be due (provided the Employer transfers sufficient funds to Aflac or has sufficient funds in the Account) or if Self-Pay is elected under Section II. A., notify the Employer of the benefit determination in accordance with the provisions of the Plan and the following procedures:
 - valid reimbursement for URM and/or DDC benefits shall be paid by Aflac on the date funds are received from the Employer (with respect to such Requests) by mailing a check to the Participants at their addresses (unless otherwise requested by the Employer as allowed by the terms of the Plan) or by initiating a direct deposit transfer directly to the Participants in their respective bank accounts in the appropriate amount(s), and
 - if the amount of the (otherwise) reimbursable DDC Request exceeds the amount the Participant had withheld for DDC benefits, the excess shall be carried forward (within the same Plan Year) and treated as an Eligible Employment-Related Expense for that month; and
 - if the amount of URM Requests exceeds the amount the Participant has had withheld from URM benefits, the entire amount shall be processed to the extent of the Participant's annual election reduced by previous reimbursements made for expenses during the Plan Year (provided the Employer makes available sufficient funds for Aflac to satisfy the Request); and
 - Requests of less than \$15 00 may be carried forward and aggregated with future Requests until the reimbursable amount is greater than \$15 00, provided however, that the entire amount of the reimbursable Requests shall be paid after the close of the Plan Year without regard to the \$15 00 threshold, and
 - unless otherwise specified in writing by the Employer, Health FSA claims following a Change in Status impacting the Health FSA election shall be processed using a "blended approach" (i.e., the maximum Health FSA benefit for a period of coverage following a Change in Status will be limited to the lesser of (a) the annual Health FSA maximum set forth in the Plan document less any benefit payments made prior to the Change in Status, and (b) the sum of the Participant's Health FSA Account balance immediately before the Change in Status and any additional contributions made during the remaining period of coverage); and

- notify claimants as to any Requests which are denied because of inadequate Request substantiation or improper Request form submission, and give affected claimants the opportunity to resubmit their Requests, and
- provide to the claimant within thirty (30) days following receipt of a Request, written notification. (a) as to the disposition of the Request, or (b) of an anticipated delay beyond thirty (30) days, not to exceed 15 days from the end of the 30-day period, with respect to the disposition of the Request together with an explanation of the delay; and
- notify the claimant and refer to the Employer (with an analysis of the issues affecting the Request) for final decision, any Requests which Aflac deems not to be reimbursable pursuant to the terms of the Plan and/or the reimbursement practices and procedures established by the Employer, setting forth the applicable review procedure available to the claimant through the Employer

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**Appendix B
Nondiscrimination Testing Services
[Provided Upon Annual Request]**

Nondiscrimination Testing:

The Employer, upon submission of an annual Employee Census Data Sheet, authorizes Aflac to compile nondiscrimination testing percentages based upon the employee census data provided. As consideration for this service, the Plan Sponsor/Administrator agrees to release and hold Aflac, its subsidiaries, affiliates, officers, directors, owners, shareholders, attorneys, successors and assigns harmless from any liability arising as a result of the provision of, or reliance upon such testing percentages. In addition, the Employer understands and agrees that

- Aflac is not in the business of providing legal or tax advice, and the Employer, as the plan sponsor/administrator, will not construe the testing percentages provided by Aflac to be legal or tax advice. Accordingly, the Employer will seek the advice of its own tax or legal advisor to interpret and verify the testing percentages provided, and ensure compliance with applicable nondiscrimination requirements.
- The Employer bears sole responsibility for nondiscrimination testing and the continued qualified status of its cafeteria plan under all applicable provisions of the Internal Revenue Code.
- The testing percentages provided by Aflac are merely an indicator of compliance with three of the applicable nondiscrimination tests - the Cafeteria Plan 25% Key Employee Concentration Test, the Dependent Care 5% Shareholder Test, and the Dependent Care 55% Average Benefits Test. Each Employer must also ensure compliance with the Eligibility Test and Contributions and Benefits Test applicable to the Cafeteria Plan, the URM, and the DDC Plan, as well as other tests that may apply to the benefits offered through the Cafeteria Plan. To ensure compliance with applicable provisions of the Internal Revenue Code, additional nondiscrimination testing and result verification must be undertaken by the Employer with the assistance of its tax or legal counsel.
- Discrimination testing should be conducted at least 180 days prior to the end of the Plan Year to which the data relates to ensure adequate time to make any required corrections. Aflac will assist with discrimination testing no less frequently than once per year and no more frequently than once every thirty (30) days.

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FLEXIBLE BENEFITS PLAN SUMMARY PLAN DESCRIPTION

PLAN INFORMATION SUMMARY

The Employer named below establishes a Flexible Benefits Plan (the "Plan") as set forth in this Summary Plan Description ("SPD") as of the Effective Date set forth below. The purpose of the Plan is to provide eligible Employees a choice between cash and the specified welfare benefits described in this Plan Information Summary (see "Benefits Provided Under the Plan"). Pre-tax Contribution elections under the Plan are intended to qualify for the exclusion from income provided in Section 125 of the Internal Revenue Code of 1986.

FLEXIBLE BENEFITS PLAN EMPLOYER INFORMATION

- 1) Name and Address of Employer:
Plan Administrator:

The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and this SPD.

- 2) Employer's Telephone Number.
- 3) Employer's Federal Tax Identification Number:
- 4) Plan Number Assigned to Cafeteria Plan (e.g., 501 if this is the first ERISA Plan Number assigned) _____
- 5) 125 Start Date: _____
- 6) Effective Date of this Plan:
- 7) Last Day of the Plan Year:
Subsequent Plan Years:
- 8) Name and Address of FSA Claim Administrator:
- 9) Name and Address of registered agent for service of legal process
- 10) Affiliated Employers that will participate in the Plan (affiliates in excess of 29 are listed in Appendix 1):

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identify the qualifying event, the date the qualifying event occurred, and the qualified beneficiaries impacted by the qualifying event. When the COBRA Administrator is notified that one of these events has occurred, the Plan Administrator will in turn notify you that you have the right to choose continuation coverage by sending you the appropriate election forms. Notice to an employee's Spouse is treated as notice to any covered dependents who reside with the Spouse. You may be required to provide additional documentation (e.g., a copy of the divorce decree).

An employee or covered dependent is responsible for notifying the COBRA Administrator if he or she becomes covered under another group health plan.

Election Procedures and Deadlines

Each qualified beneficiary is entitled to make a separate election for continuation coverage under the Plan if they are not otherwise covered as a result of another Qualified Beneficiary's election. In order to elect continuation coverage, you must complete the Election Form(s) within 60 days from the date you would lose coverage for one of the reasons described above or the date you are sent notice of your right to elect continuation coverage, whichever is later, and send it to the COBRA Administrator identified in the Plan Information Summary. Failure to return the Election Form(s) within the 60-day period will be considered a waiver of your continuation coverage rights.

Cost

You will have to pay the entire cost of your continuation coverage. The cost of your continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage. The first premium payment after electing continuation coverage will be due 45 days after making your election. Subsequent premiums must be paid within a 30-day grace period following the due date. Failure to pay premiums within this time period will result in automatic termination of your continuation coverage. Claims incurred during any period will not be paid until your premium payment is received for that period. If you timely elect continuation coverage and pay the applicable premium, however, then continuation coverage will relate back to the first day on which you would have had regular coverage.

When Continuation Coverage Ends

The maximum period for which coverage may be continued will be until the end of the Plan Year in which the qualifying event occurs. To the extent that Nonelective Employer contributions are provided, the maximum duration of coverage may be 18 or 36 months from the qualifying event (depending on the type of qualifying event). You will be notified of the duration of continuation coverage when you have a qualifying event. However, continuation coverage may end earlier for any of the following reasons:

- The contribution for your continuation coverage is not paid on time or it is insufficient (Note: if your payment is insufficient by the lesser of 10% of the required COBRA premium, or \$50, you will be given 30 days to cure the shortfall);
- After you elect COBRA continuation coverage, the date that you first become covered under another group health plan under which you are not subject to a pre-existing condition exclusion limitation;
- After you elect COBRA continuation coverage, the date that you first become entitled to Medicare; or
- The date the employer no longer provides group health coverage to any of its employees.

Q-19. How long will the Plan remain in effect?

Although the Employer expects to maintain the URM and DDC indefinitely, it has the right to modify or terminate the programs at any time for any reason. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly.

Q-20. Will my health information be kept confidential?

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") group health plans such as the URM and the third party service providers are required to take steps to ensure that certain "protected health information" is kept confidential. Attached as Appendix II to this SPD (included in the HIPAA packet) is a summary of your rights and obligation under HIPAA. You may receive a separate notice that outlines the Employer's health privacy policies in more detail.

Q-21. Is there any other important information that I should know about the Reimbursement Plan?

Participation in the Plan does not give any Participant the right to be retained in the employ of his or her Employer or any other right not specified in the Plan. The Plan Administrator's name, address and telephone number appear in the Plan Information Summary attached to the front of this SPD. The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact and construe and

- instructions on how to appeal the denied claim (including the applicable time periods) and the identity of the individual(s) who will review the denied claim; and
- Any other information required by applicable law

If your claim is denied in whole or in part, you may appeal by requesting a review of the denied claim. Your request must be in writing and must be submitted in accordance with the instructions set forth in the denial notice within 180 days after you receive notice of the denial. If there are two levels of appeal, you will have a reasonable amount of time described in the notice of denial in which to request a second review by the Plan Administrator. As part of the appeal process (whether there is one or two appeals), you or your authorized representative may examine documents, records, and other information relevant to your claim and submit issues, documents and comments in writing. You will be notified in writing of the decision on review as soon as reasonably possible but no later than 60 days after the request for review is received. The notice will contain the same type of information described above and it will indicate whether there are one or two levels of appeals. If there are two levels of appeals, the decisions on review will be made no later than 30 days after the request for each review is received. The reviews upon appeal (whether one level or two) will take into account all comments, documents, records and other information submitted by the claimant relating to the claim without regard to whether such information was submitted or considered in a previous review. In no event will a determination upon review be made by the same individual(s) who made previous determinations or someone who is a subordinate of any individual who made such previous determinations. The Plan Administrator is the claims fiduciary responsible for making final claim decisions under the Plan.

In the event of your death, your beneficiary has the same rights and is subject to the same time limits and other restrictions that would otherwise apply to you under the claims procedures explained above.

Q-18. What is COBRA continuation coverage?

Federal law requires most employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of health care coverage (called "continuation coverage") at group rates in certain instances where coverage under the plans would otherwise end. These rules apply to the URM only, unless the Employer is a small-employer within the meaning of the applicable regulations. The Plan Administrator can tell you whether the Employer is a small employer (and thus not subject to these rules).

When Coverage May Be Continued

If you are a Participant in the URM, then you have a right to choose continuation coverage under the URM if you lose your coverage because of a reduction in your hours of employment; or a voluntary or involuntary termination of your employment (for reasons other than gross misconduct).

If you are the Spouse of a Participant, then you have the right to choose continuation coverage for yourself if you lose coverage due to the death of your Spouse; a voluntary or involuntary termination of your Spouse's employment (for reasons other than gross misconduct) or reduction in your Spouse's hours of employment; or the divorce or legal separation from your Spouse.

In the case of a Dependent child of a Participant, he or she has the right to choose continuation coverage if coverage is lost because of the death of the employee; a voluntary or involuntary termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment; his or her parents' divorce or legal separation; or his or her loss of Dependent status. A child who is born to, or placed for adoption with, the employee during a period of continuation coverage is also entitled to continuation coverage under COBRA. Those who are entitled to continue coverage under COBRA are called "Qualified Beneficiaries."

NOTE: Notwithstanding the preceding paragraphs, you generally will not have the right to elect COBRA continuation if the amount you have contributed for URM at the time of the COBRA Qualifying Event is less than the amount of URM reimbursements you have received. You will be notified of your particular right to elect COBRA continuation coverage.

Type of Coverage

If you choose continuation coverage, you may continue the level of coverage you had in effect immediately preceding the qualifying event. However, if Plan benefits are modified for similarly situated active employees, then they will be modified for you and other Qualified Beneficiaries as well. You will be eligible to make a change in your benefit election with respect to the Plan upon the occurrence of any event that permits a similarly situated active employee to make a benefit election change during a Plan Year. If you do not choose continuation coverage, your coverage under the URM will end with the date you would otherwise lose coverage.

Notice Requirements

You or your covered Dependents (including your Spouse) must notify the COBRA Administrator identified in the Plan Information Summary in writing of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the later date of the event or the date on which coverage is lost because of the event. Your written notice must

You will not normally be taxed on your DDC benefits, up to the limits set out in Q-4. However, to qualify for tax-free treatment, you will be required to list the names and taxpayer identification numbers on your annual tax return of any persons who provided you with Dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

Q-13. What is the household and Dependent care credit?

The household and dependent care credit is an allowance for a percentage of your annual, Eligible Employment-Related Expenses as a credit against your federal income tax liability under the U.S. Tax Code. In determining what the tax credit would be, you may take into account only \$3,000 of such expenses for one Qualifying Individual, or \$6,000 for two or more Qualifying Individuals. Depending on your adjusted gross income, the percentage could be as much as 35% of your Eligible Employment-Related Expenses (to a maximum credit amount of \$1050 for one Qualifying Individual or \$2100 for two or more Qualifying Individuals) to a minimum of 20% of such expenses. The maximum 35% rate must be reduced by 1% (but not below 20%) for each \$2,000 portion (or any fraction of \$2,000) of your adjusted gross income over \$15,000.

Illustration: Assume you have one Qualifying Individual for whom you have incurred Eligible Employment-Related Expenses of \$3,600, and that your adjusted gross income is \$21,000. Since only one Qualifying Individual is involved, the credit will be calculated by applying the appropriate percentage to the first \$3,000 of expenses. The percentage is, in turn, arrived at by subtracting one percentage point from 35% for each \$2,000 of your adjusted gross income over \$15,000. The calculation is: $35\% - [(\$21,000 - 15,000)/\$2,000 \times 1\%] = 32\%$. Thus, your tax credit would be $\$3,000 \times 32\% = \960 . If you had incurred the same expenses for two or more Qualifying Individuals, your credit would have been $\$3,600 \times 32\% = \1152 , because the entire \$3,600 expense would have been taken into account, not just the first \$3,000.

Q-14. If I participate in the DDC, will I still be able to claim the household and Dependent care credit on my federal income tax return?

You may not claim any other tax benefit for the tax-free amounts received by you under this Plan, although the balance of your qualified Dependent care expenses may be eligible for the Dependent care credit.

Q-15. When would I be better off to include the reimbursements in my income and claim the credit, rather than to treat the reimbursements as tax-free?

Generally, if you are in a lower income tax bracket, you may come out ahead by including the DDC benefits in income, and claiming the credits for Dependent care. On the other hand, it will generally be better to treat DDC benefits as tax-free the more income taxes you are required to pay. Because the actual determination of the preferable method for treating benefit payments depends on a number of factors such as one's tax filing status (e.g., married, single, head of household), number of Dependents, etc., each Participant will have to determine his or her tax position individually in order to make the decision between taxable and tax-free benefits.

Q-16. What happens to unclaimed Reimbursements?

Any Reimbursement Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Eligible Medical and/or Employment-Related Expense was incurred shall be forfeited.

Q-17. What happens if a claim for Benefits under the URM or DDC is denied?

You will be notified if your claim under the Plan is denied. The notice will be furnished to you as soon as reasonably possible but no later than 30 days after the Plan Administrator (or its designated claims administrator identified in the reimbursement form) receives your claim. However, if for reasons beyond the control of the claims reviewer, more time for processing your claim is needed, the applicable claims reviewer may take an extension of not more than 15 days following the end of the 30-day period. You will be notified of this extension before the initial 30 days has expired, and the notice will explain why an extension is necessary and the date a decision is expected to be rendered. If the reason for the extension is because you failed to submit complete information necessary to decide the claim, you will have 45 days from the notice of the extension in which to provide the information. The time period for making a decision will be suspended until the earlier of the date that you submit the necessary information or the end of the 45-day period.

The notice of the denial will include the following:

- the specific reason or reasons for the denial,
- specific reference to pertinent Plan provisions on which the denial is based;
- a description of any additional material or information necessary for the claim to be approved and an explanation of why such material or information is necessary,

2. A Spouse or other tax Dependent (as defined in Code Section 152) who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as you for more than half of the year
- There is a special rule for children of divorced parents. A child is the qualifying individual of the parent who has "custody."
 - The expenses are incurred for the care of a Dependent (as described above), or for related household services, and are incurred to enable you to be gainfully employed.
 - If the expenses are incurred for services outside your household and such expenses are incurred for the care of a Dependent who is age 13 or older, such Dependent regularly spends at least 8 hours per day in your home
 - If the expenses are incurred for services provided by a Dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center must comply with all applicable state and local laws and regulations

The expenses are not paid or payable to a child of yours who is under age 19 at the end of the year in which the expenses are incurred or an individual for whom you or your Spouse is entitled to a personal tax exemption as a Dependent

This reimbursement (when aggregated with all other Dependent Care Reimbursements during the same year) may not exceed the least of the following limits:

1. \$5,000
2. \$2,500, if you are married but you and your Spouse file separate tax returns
3. Your taxable compensation (after your Pre-tax Contributions have been deducted under the Plan)
4. If you are married, your Spouse's actual or deemed Earned Income.
5. For purposes of (4) above, your Spouse will be deemed to have Earned Income of \$250 (\$500 if you have two or more Dependents described in paragraph 4 above), for each month in which your Spouse is (i) physically or mentally incapable of caring for himself or herself or (ii) a full-time Student

You are encouraged to consult your personal tax advisor or IRS Publication 17 "Your Federal Income Tax" for further guidance as to what is or is not an Eligible Expense if you have any doubts.

Q-10. When must the expenses be incurred?

Eligible Medical and Employment-Related Expenses must generally have been incurred during the Plan Year. You may not be reimbursed for any expenses arising before the Plan became effective, before your SRA becomes effective, or for any expenses incurred after the close of the Plan Year, or, except for Continuation Coverage and certain Eligible Employment-Related Expenses, after a separation from service. You may be reimbursed for Eligible Employment-Related Expenses that are incurred after a separation from service up to your account balance on the date of separation from service.

In addition, IRS regulations require that service or treatment be actually rendered prior to the time that the expense is reimbursed. Therefore, even if your doctor requires that an expense be paid in advance, you cannot be reimbursed until the service relating to the expense has been rendered. In order to ensure compliance with this IRS requirement, you (and/or your doctor) may be required to submit additional substantiation (such as a proposed treatment plan) with respect to certain long-term treatments (e.g., orthodontic or obstetric expenses). Failure to submit the required forms could result in your reimbursement being pended and/or denied.

Q-11. What if the Eligible Medical or Eligible Employment-Related Expenses I incur during the Plan Year are less than the annual amount I have elected for Medical Care and/or Dependent Care Expense Reimbursement?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Expenses you have incurred, on the one hand, and the annual coverage level you have elected and paid for, on the other. This is called the "Use-it-or-Lose-it" Rule. Any amount allocated to an Account shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide the elected benefit for any Plan Year by the ninetieth (90th) day following the end of the Plan Year for which the election was effective. Amounts so forfeited shall be used to offset administrative expenses and future costs.

Q-12. Will I be taxed on the DDC benefits I receive?

If you elect to participate in URM or DDC, you will have to take certain steps to be reimbursed for your Eligible Medical and/or Eligible Employment-Related Expenses (as defined in Q-9 below) When you incur an expense that is eligible for payment, you submit a request to the Plan's Administrator on a Request for Reimbursement form that will be supplied to you.

For URM and DDC, you must include written statement(s)/bill(s) from an independent third party(ies) stating that the eligible expenses have been incurred, and the amount of such expense(s) along with the Request for Reimbursement form. In addition, you must include for URM claims an Explanation of Benefits (EOB) form(s) from any primary medical and/or dental insurance carrier(s) indicating the amount(s) that you are obligated to pay

For DDC, if your reimbursement request is for an amount that is more than your current Account balance, the excess part of the reimbursement will be carried over into following months, to be paid out as your balance becomes adequate. Remember, though, that you can't be reimbursed for any total Dependent Care expenses above your available, annual credits to your Account.

With respect to either DDC or URM benefits, you may not be reimbursed for any expenses that arise before your SRA becomes effective, or for any expense incurred after the close of the Plan Year.

To have your Request for Reimbursements processed as soon as possible, please read the reimbursement instructions on the back of the Request for Reimbursement form you have been furnished. Please note that it is not necessary that you have actually paid an amount due for Eligible Medical and/or Eligible Employment-Related Expenses – only that you have incurred the expense, and that it is not being paid for or reimbursed from any other source. In addition, you will have 90 days after the end of the Plan Year in which to submit a Request for Reimbursement form for Eligible Expenses incurred during the previous Plan Year (Run-off Period) You will be notified in writing if any Request for Reimbursement is denied.

Q-9. What is an "Eligible Expense?"

For URM, an "Eligible Medical Expense" is generally an expense that has been incurred by you and/or your eligible dependents that satisfies the following conditions:

- 1) The expense is for "medical care" as defined by Code Section 213(d). Whether an expense is for "medical care" is within the sole discretion of the Plan Administrator;
- 2) The expense has not been reimbursed by any other source and you will not seek reimbursement for the expense from any other source.

The Code generally defines "medical care" as any amounts incurred to diagnose, treat or prevent a specific medical condition or for purposes of affecting any function or structure of the body. This includes, but is not limited to, both prescription and over the counter drugs (and over the counter products and devices) Not every health related expense you or your eligible dependents incur constitutes an expense for "medical care." For example, an expense is not for "medical care", as that term is defined by the Code, if it is merely for the beneficial health of you and/or your eligible dependents (e.g., vitamins or nutritional supplements that are not taken to treat a specific medical condition) or for cosmetic purposes, unless necessary to correct a deformity arising from illness, injury, or birth defect. You may, in the discretion of the Third Party Administrator/Plan Administrator, be required to provide additional documentation from a health care provider showing that you have a medical condition and/or the particular item is necessary to treat a medical condition. Expenses for cosmetic purposes are also not reimbursable unless they are necessary to correct an abnormality caused by illness, injury or birth defect. Also, "stockpiling" of over the counter drugs and/or items is not permitted and expenses resulting from stockpiling are not reimbursable. There must be a reasonable expectation that such drugs or items could be used during the Plan Year (as determined by the Plan Administrator)

For DDC, you may be reimbursed for work-related expenses ("Eligible Employment-Related Expenses") incurred on behalf of any Qualifying Individual described below. Generally, these expenses must meet all of the following conditions for them to be Eligible Employment-Related Expenses:

- The expenses are incurred for services rendered after the date of your election to receive Dependent Care Expense Reimbursement, and during the calendar year to which it applies
- Services are incurred for a Qualifying Individual. A Qualifying Individual is:
 - 1 An individual age 12 or under who is a "qualifying child" of the Employee as defined in Code Section 152(a)(1). Generally speaking, a "qualifying child" is a child (including brother, sister, step sibling) of the Employee or a descendant of such child (e.g., a niece, nephew, grandchild) who shares the same principal place of abode with you for more than half the year and does not provide over half of his/her support. In addition, a child of an Employee who is also a Code Section 152 dependent of another individual cannot be a qualifying individual, or

Q-4. When does coverage under the URM and/or DDC end?

You continue to participate in the URM and/or DDC until the earlier of (i) you elect not to participate in accordance with Q-9 of Flexible Benefits Plan SPD; (ii) the end of the Plan Year unless you make an election during the annual election period; (iii) you no longer satisfy the eligibility requirements described in the Plan Information Summary, (iv) you terminate employment with the employer; or

(v) the Plan is terminated or amended to exclude you or the class of eligible employees of which you are a member are specifically excluded from the Plan. You are not eligible to receive reimbursement for otherwise Eligible Medical Expenses incurred during the Plan Year after you cease to be eligible unless you elect COBRA continuation coverage (as described below in Q-19 of this Appendix), provided you are eligible to elect COBRA. However, you will be eligible to receive reimbursement under the DDC for Eligible Employment-Related Expenses (as defined in Q-9 below) incurred during the Plan Year but after you cease to be eligible up to your account balance as of the date you cease to be eligible.

Coverage under the URM for your Eligible Dependents ends on earliest of the following to occur: (i) your coverage ends; (ii) the individual ceases to be an Eligible Dependent (e.g. divorce or legal separation from the spouse); or (iii) the Plan is terminated or amended to exclude individual or the class of individuals of which the individual is a member (spouse or dependent child) from coverage under the URM. Your Spouse and/or your Dependent children may also be entitled to COBRA continuation coverage if coverage is lost for certain reasons. See Q-19 of this Appendix for more information on COBRA.

Q-5. What happens to my URM Account and/or DDC Account if I take an approved leave of absence?

Generally, the rules described in Q-13 of your Flexible Benefits Plan SPD apply. However, if your URM coverage ceases during your FMLA leave, you will be entitled to elect whether to be reinstated in the URM at the same coverage level in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a URM reimbursement level that is reduced pro-rata for the period of FMLA leave during which you did not make any contributions. Under either scenario, expenses incurred during the period that your URM coverage was not in effect are not eligible for reimbursement under this URM.

Q-6. What is the maximum URM and/or DDC benefit I may elect?

For URM, you may choose any amount of annual reimbursement you desire subject to the maximum reimbursement amount set forth in the Employer Information Section of the Plan Information Summary.

For DDC, this is set forth in the Employer Information Section, however, this amount cannot exceed the maximum amount specified in Section 129 of the Internal Revenue Code. The maximum amount is currently \$5,000 per Plan Year if you -

- are married and file a joint return; or
- are married, but you furnish more than one-half the cost of maintaining those Dependents for whom you are eligible to receive tax-free reimbursements under the DDC, your Spouse maintains a separate residence for the last 6 months of the calendar year, and you file a separate tax return; or
- are single, or a head of household for tax purposes

If you are married and reside together but file a separate federal income tax return, the maximum DDC benefit you may elect is \$2,500.

You will be required to pay the annual contribution equal to the coverage level you have chosen.

Q-7. How is my Medical Care and/or Dependent Care Expense Reimbursement benefit paid for and what amounts will be available at any particular time during the Plan Year?

For URM and DDC, when you complete the SRA, you specify the amount of Medical Care and/or Dependent Care Expense Reimbursement(s) you wish to pay for with your Pre-tax Contributions. Thereafter, you must make a contribution for such coverage by having an equal portion of the annual reimbursement amount deducted from each paycheck. Your employer will distribute benefit payments from its general assets.

For URM Benefits, the full amount of the coverage you have elected, reduced by the amount of prior reimbursements received during the Plan Year, will be available to reimburse you for your out-of-pocket medical expenses incurred at any time during the Plan Year and while you are a Participant. For DDC Benefits, the amount that is available for reimbursement at any particular time will be whatever has been credited to your Dependent Care Account less any reimbursements already paid.

Q-8. How do I receive reimbursement under the Plan?

APPENDIX I TO THE FLEXIBLE BENEFITS PLAN SUMMARY PLAN DESCRIPTION

Medical Care and Dependent Care Reimbursement Plan Summary Plan Description

To the extent elected by the Employer (indicated in the Plan Information Summary attached to this SPD), you will have the opportunity to elect to receive income tax-free reimbursement for some or all of your unreimbursed medical expenses under the Medical Care Reimbursement Plan ("URM") and/or some or all of your work-related Dependent care expenses under the Dependent Care Reimbursement Plan ("DDC") (collectively, the "Reimbursement Plans") Under the URM and DDC, you purchase a specific level of reimbursement benefits and you provide a source of pre-tax funds to reimburse yourself for your Eligible Expenses For both, you pay for coverage through the Salary Redirection Agreement ("SRA") with the Employer, in lieu of receiving a corresponding amount of current pay, which means the premiums you pay will be with pre-tax funds This arrangement helps you because the level of coverage you elect is nontaxable, and you save Social Security and income taxes on the amount of your salary conversion

By enrolling in either the URM or DDC option and submitting reimbursement claims you specifically authorize the Plan, Aflac and Aflac Benefit Services/Flex One®, and their respective agents, employees, sub-contractors, and assigns to use your personal health information in their possession to administer the Plan (including the evaluation of eligibility for reimbursement under the Plan) and to detect or prevent fraud or misrepresentation, and to further disclose such information as is reasonably required for those purposes You further authorize any provider, insurer, or other entity to release any health or treatment information for the purpose of determining eligibility for Plan benefits or for detecting or preventing fraud or misrepresentation You further waive and release any claims related to the use, disclosure, or release of such information so long as the information is used in furtherance of administering the Plan (including processing or evaluating a claim for benefits under the Plan) or to detect or prevent fraud or misrepresentation This authorization does not and is not intended to in any way limit any right the Plan, Aflac and Aflac Benefit Services/Flex One, or their respective agents, employees, sub-contractors, and assigns may have under applicable state or federal law or regulation regarding the use of such information

General Questions and Answers

Q-1. Who can participate in the URM and/or DDC?

Each employee who satisfies the eligibility requirements described in the Plan Information Summary is eligible to participate in the Reimbursement Plans as of the eligibility date described in the Plan Information Summary

Q-2. How do I become a Participant?

You become a Participant by electing URM and/or DDC benefits during the Initial or Annual Enrollment Periods. (The Initial and Annual Enrollment Periods are described in Q-6 of the Flexible Benefits Plan SPD) Your participation in the URM or DDC will be effective on the date that you make an election to participate or the eligibility date described in the Plan Information Summary, whichever is later. You may not change your election (either to participate or not to participate) during the Plan Year unless you experience an event described in Q-9 of the Flexible Benefits Plan SPD. Once you become a Participant, your "Eligible Dependents" also become covered. For purposes of the URM, Eligible Dependents are the following:

1. Your legal Spouse (as determined by state law to the extent consistent with the federal Defense of Marriage Act) and
2. Any other individual who would qualify as a tax Dependent under Code Section 105(b)

If the Plan Administrator receives a qualified medical child support order relating to the URM, the URM will provide the health benefit coverage specified in the order to the person or persons ("alternate recipients") named in the order "Alternate recipients" include any child of the participant who the Plan is required to cover pursuant to a qualified medical child support order A "qualified medical child support order" is a legal judgment, decree or order relating to medical child support that clearly specifies the type of coverage that is to be provided to one or more alternate recipients (or the manner in which such type of coverage is to be provided). Before providing any coverage to an alternate recipient, the Plan Administrator must determine whether the medical child support order is qualified If the Plan Administrator receives a medical child support order relating to your Health Care Account (See Q-3 below), it will notify you in writing, and after receiving the order, it will inform you of its determination of whether or not the order is qualified. Upon request to the Plan Administrator, you may obtain, without charge, a copy of the Plan's procedures governing qualified medical child support orders

Q-3. What are my "URM Account" and my "DDC Account"?

If you elect benefits under this portion of the Plan, a non-interest bearing account will be established under each Plan to keep a record of the reimbursements you are entitled to under each Plan, as well as the contributions you have made for such benefits during the Plan Year No actual accounts are established, they are merely bookkeeping accounts

between you and the Plan Administrator (for example, the Plan Administrator may fund coverage during the leave and withhold amounts from your compensation upon your return from leave) The payment options provided by the Employer will be established in accordance with Code Section 125, FMLA and the Employer's internal policies and procedures regarding leaves of absence Alternatively, the Employer may require all Participants to continue coverage during the leave If so, you may elect to discontinue your share of the required contributions until you return from leave. Upon return from leave, you will be required to repay the contribution not paid during the leave in a manner agreed upon with the Administrator

- (d) If your coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter the Plan upon return from such leave on the same basis as you were participating in the Plan prior to the leave, or as otherwise required by the FMLA. Your coverage under the Benefit Plans or Policies providing health coverage may be automatically reinstated provided that coverage for Employees on non-FMLA leave is automatically reinstated upon return from leave
- (e) The Employer may, on a uniform and consistent basis, continue your group health coverage for the duration of the leave following your failure to pay the required contribution. Upon return from leave, you will be required to repay the contribution in a manner agreed upon by you and Employer
- (f) If you are commencing or returning from unpaid FMLA leave, your election under this Plan for Benefit Plans or Policies providing non-health benefits shall be treated in the same manner that elections for non-health Benefit Plans or Policies are treated with respect to Participants commencing and returning from unpaid non-FMLA leave
- (g) If you go on an unpaid non-FMLA leave of absence (e.g., personal leave, sick leave, etc.) that does not affect eligibility in this Plan or a Benefit Plan or Policy offered under this plan, then you will continue to participate and the contribution due will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Administrator. If you go on an unpaid leave that affects eligibility under this Plan or a Benefit Plan or Policy, the election change rules in Q-9 of this SPD will apply. The Plan Administrator will have discretion to determine whether taking an unpaid non-FMLA leave of absence affects eligibility.

Q-14. Is there any other information that I should know about the Plan?

Participation in the Plan does not give any Participant the right to be retained in the employ of his or her Employer or any other right not specified in the Plan. The Plan Administrator's name, address and telephone number appear in the Plan Information Summary attached to the front of this SPD. The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and this SPD. Other important information such as the Plan Number and Plan Sponsor's name and address has also been provided in the Plan Information Summary

election and elect to receive on a prospective basis coverage provided by the newly added or significantly improved option, so long as the newly added or significantly improved option provides similar coverage. Also, you may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or another employer), so long as: (a) the other employer plan permits its participants to make an election change permitted under the IRS regulations, or (b) the Plan Year for this Plan is different from the Plan Year of the other employer plan. Finally, you may change your election to add coverage under this Plan for yourself, your Spouse, or your Dependent if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution. The Plan Administrator will have final discretion to determine whether the requirements of this section are met (Please note that none of the above "Change in Coverage" exceptions are applicable to the Medical Care Reimbursement Plan, to the extent offered under the Plan.)

Additionally, your election(s), may be modified downward during the Plan Year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

Q-10. How long will the Plan remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time for any reason. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly.

Q-11. What happens if my claim for benefits under this Plan is denied?

This SPD describes the basic features of the Plan. If your claim is for a benefit under one of the component Benefit Plans or Policies, you will generally proceed under the claims procedures applicable under the component Benefit Plan or Policy (see the plan summary for each of the Benefit Plans or Policies that you select). However, if you are denied a benefit under this Plan, the claims procedure under this Plan will apply. You will be notified if your claim under the Plan is denied. The notice of denial will be furnished to you within 30 days after receiving your claim. However, if additional time is needed to process your claim you will be notified before the initial 30-day period has expired. The notice will explain why an extension is necessary and the date a decision is expected to be rendered. In no event will an extension go beyond 15 days after the end of the initial 30-day period. The notice of the denial will include the specific reasons for the denial and the relevant plan provisions on which the denial was based.

If your claim is denied in whole or in part, you may appeal by requesting a review of the denied claim, as set forth in the notice of denial, within 180 days after you receive notice of the denial. If there are two levels of appeal (as indicated in the notice of denial), you will have a reasonable amount of time in which to request a second review and such time period will be identified in the notice of denial. As part of the appeal process (whether there is one or two appeals), you or your authorized representative may examine documents, records, and other information relevant to your claim and submit issues, documents and comments in writing. Within 60 days after the request for review is received, you will be notified in writing of the decision on review.

The notice of denial will indicate whether there are one or two levels of appeals and will contain the same type of information provided to you in the first notice of denial. If there are two levels of Plan appeals, the decisions on appeal will be made within 30 days after the request for each review is received. The Plan Administrator is the claims fiduciary for making the final decision under the plan.

In the event of your death, your beneficiary has the same rights and is subject to the same time limits and other restrictions that would otherwise apply to you under the claims procedures explained above.

Q-12. What effect will Plan participation have on Social Security and other benefits?

Plan participation will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability and life insurance) that are based on taxable compensation.

Q-13. What happens if I take a leave of absence?

- (a) If you go on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, the Employer will continue to maintain your Benefit Plans or Policies providing health coverage on the same terms and conditions as though you were still active (e.g., the Employer will continue to pay its share of the contribution to the extent you opt to continue coverage).
- (b) Your Employer may elect to continue all coverage for Participants while they are on paid leave (provided Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, with Pre-tax Contributions if that is what was used before the FMLA leave began).
- (c) In the event of unpaid FMLA leave (or paid leave where coverage is not required to be continued), if you opt to continue your group health coverage, you may pay your share of the contribution with after-tax dollars while on leave, or you may be given the option to pre-pay all or a portion of your share of the contribution for the expected duration of the leave with Pre-tax Contributions from your pre-leave compensation by making a special election to that effect before the date such compensation would normally be made available to you provided, however, that pre-payments of Pre-tax Contributions may not be utilized to fund coverage during the next Plan Year, or by other arrangements agreed upon.

- **Gain of Coverage Eligibility Under Another Employer's Plan** For a Change in Status in which you, your Spouse, or your Dependent gain eligibility for coverage under another employer's cafeteria plan (or Benefit Plan or Policy) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status *only* if coverage for that individual becomes effective or is increased under the other employer's plan
- **Dependent Care Reimbursement Plan Benefits (if offered under the Plan** See the list of Benefit Plans or Policies offered under the Plan in the Plan Information Summary). With respect to the Dependent Care Reimbursement Plan benefit (if offered by the Plan), you may change or terminate your election only if (1) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under the Plan; or (2) your election change is on account of and corresponds with a Change in Status that affects the eligibility of Dependent care assistance expenses for the available tax exclusion.

Example: Employee Mike is married to Sharon, and they have a 12 year-old daughter. The employer's plan offers a Dependent care expense reimbursement program as part of its cafeteria plan. Mike elects to reduce his salary by \$2,000 during a plan year to fund Dependent care coverage for his daughter. In the middle of the plan year when the daughter turns 13 years old, however, she is no longer eligible to participate in the Dependent care program. This event constitutes a Change in Status. Mike's election to cancel coverage under the Dependent care program would be consistent with this Change in Status.

- **Group Term Life Insurance, Disability Income, or Dismemberment Benefits (if offered under the Plan.** See the list of Benefit Plans or Policies offered under the Plan in the Plan Information Summary) For group term life insurance, disability income, and accidental death and dismemberment benefits, if you experience any Change in Status (as described above), you may elect either to increase or decrease coverage

Example: Employee Mike is married to Sharon, and they have a child. The employer's plan offers a cafeteria plan which funds group-term life insurance coverage (and other benefits) through salary reduction. Before the plan year Mike elects \$10,000 of group-term life insurance. Mike and Sharon subsequently divorce during the plan year. The divorce constitutes a Change in Status. An election by Mike either to increase or to decrease his group-term life insurance coverage would each be consistent with this Change in Status.

- 2 **Special Enrollment Rights.** If you, your Spouse, and/or a Dependent are entitled to special enrollment rights under a Benefit Plan or Policy that is a group health plan, you may change your election to correspond with the special enrollment right. Thus, for example, if you declined enrollment in medical coverage for yourself or your eligible Dependents because of outside medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (i.e., due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period), you may be able to elect medical coverage under the Plan for yourself and your eligible Dependents who lost such coverage. Furthermore, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your Spouse, and your newly acquired Dependents, provided that you request enrollment within the Election Change Period. An election change that corresponds with a special enrollment must be prospective, unless the special enrollment is attributable to the birth, adoption, or placement for adoption of a child, which may be retroactive up to 30 days. Please refer to the group health plan description for an explanation of special enrollment rights.
- 3 **Certain Judgments, Decrees and Orders** If a judgment, decree or order from a divorce, separation, annulment, or custody change requires your Dependent child (including a foster child who is your tax Dependent) to be covered under this Plan, you may change your election to provide coverage for the Dependent child identified in the order. If the order requires that another individual (such as your former Spouse) cover the Dependent child, and such coverage is actually provided, you may change your election to revoke coverage for the Dependent child.
4. **Entitlement to Medicare or Medicaid.** If you, your Spouse, or a Dependent becomes entitled to Medicare or Medicaid, you may cancel that person's accident or health coverage. Similarly, if you, your Spouse, or a Dependent who has been entitled to Medicare or Medicaid loses eligibility for such, you may, subject to the terms of the underlying plan, elect to begin or increase that person's accident or health coverage.
5. **Change in Cost.** If you are notified that the cost of your Benefit Plan or Policy coverage under the Plan *significantly* increases or decreases during the Plan Year, you may make certain election changes. If the cost significantly increases, you may choose either to make an increase in your contributions, revoke your election and receive coverage under another Benefit Plan or Policy that provides similar coverage, or drop coverage altogether if no similar coverage exists. If the cost significantly decreases, you may revoke your election and elect to receive coverage provided under the option that decreased in cost. For *insignificant* increases or decreases in the cost of Benefit Plans or Policies, however, your Pre-tax Contributions will automatically be adjusted to reflect the minor change in cost. The Plan Administrator will have final authority to determine whether the requirements of this section are met. (Please note that none of the above "Change in Cost" exceptions are applicable to a Medical Care Reimbursement Plan, to the extent offered under the Plan.)

Example: Employee Mike is covered under an indemnity option of his employer's accident and health insurance coverage. If the cost of this option significantly increases during a period of coverage, the Employee may make a corresponding increase in his payments or may instead revoke his election and elect coverage under an HMO option.

- 6 **Change in Coverage** If you are notified that your Benefit Plan or Policy coverage under the Plan is significantly curtailed, you may revoke your election and elect coverage under another Benefit Plan or Policy that provides similar coverage. If the significant curtailment amounts to a complete loss of coverage, you may also drop coverage if no other similar coverage is available. Further, if the Plan adds or significantly improves a benefit option during the Plan Year, you may revoke your

nondiscriminatory manner and may be based upon your Dependent status, commencement or termination date of your employment during the Plan Year, and such other factors that the Employer deems relevant. In no event will any Nonelective Contribution be disbursed to you in the form of additional, taxable Compensation except as otherwise provided in the enrollment material. To the extent set forth in the enrollment material, the Employer may make available a certain amount of Nonelective Contributions and then allow you to allocate the Nonelective Contributions among the various Benefit Plan(s) or Policy(ies) that you choose (subject to restrictions described in the enrollment material).

Q-9. Can I ever change my election during the Plan Year?

Generally, you cannot change your election to participate in the Plan or vary the Pre-tax Contribution amounts although your election will terminate if you are no longer working for the Employer or no longer eligible under the terms of the Plan. Otherwise, you may change your elections for Pre-Tax Contributions only during the Annual Enrollment Period, and then, only for the coming Plan Year. There are several important exceptions to this general rule: You may change or revoke your previous election during the Plan Year if you file a written request for change with the Plan Administrator (or its designated claims administrator) within 30 days of any of the following events:

1 Change in Status If one or more of the following "Changes in Status" occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status (as described below). Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Plan Administrator determines are permitted under subsequent IRS regulations:

- a change in your legal marital status (such as marriage, legal separation, annulment, or divorce or death of your Spouse);
- a change in the number of your tax Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent);
- any of the following events that change the employment status of you, your Spouse, or your Dependent that affect benefit eligibility under a cafeteria plan (including this Plan and the Plan of another employer) or other employee benefit plan of yours, your Spouse, or your Dependents. Such events include any of the following changes in employment status: termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, switching from salaried to hourly-paid, union to non-union, or part-time to full-time; incurring a reduction or increase in hours of employment; or any other similar change which makes the individual become (or cease to be) eligible for a particular employee benefit (NOTE: The specific rules governing election changes when you take a leave of absence are described in Q-13 of this SPD);
- an event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specified age, getting married, or ceasing to be a student);
- a change in your, your Spouse's or your Dependent's place of residence

If a Change in Status occurs and you want to make a corresponding election change, you must inform the Plan Administrator and complete a new election within 30 days from the date of the event. The election change must be on account of and correspond with the Change in Status event as determined by the Plan Administrator with the exception of special enrollment resulting from birth, placement for adoption or adoption, all election changes are prospective.

As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects eligibility or coverage. A Change in Status affects eligibility for coverage if it results in an increase or decrease in the number of Dependents who may benefit under the plan. In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status.

- **Loss of Dependent Eligibility** For accident and health benefits (e.g., health, dental and vision coverage, and Medical Care Reimbursement Plan), a special rule governs which types of election changes are consistent with the Change in Status. For a Change in Status involving your divorce, annulment or legal separation from your Spouse, the death of your Spouse or your Dependent, or your Dependent ceasing to satisfy the eligibility requirements for coverage, your election to cancel accident or health benefits for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements, would fail to correspond with that Change in Status. Hence, you may only cancel accident or health coverage for the affected Spouse or Dependent.

Example: Employee Mike is married to Sharon, and they have one child. The employer offers a calendar year cafeteria plan that allows employees to elect no health coverage, employee-only coverage, employee-plus-one-Dependent coverage, or family coverage. Before the plan year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the plan year; Sharon loses eligibility for coverage under the plan, while the child is still eligible for coverage under the plan. Mike now wishes to cancel his previous election and elect no health coverage. The divorce between Mike and Sharon constitutes a Change in Status. An election to cancel coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast, an election to change to employee-plus-one-Dependent coverage would be consistent with this Change in Status. However, there are instances in which you may be able to increase your Pre-tax Contributions to pay for COBRA coverage of a Dependent child or yourself.

new elections, provided that you are rehired or become eligible again more than 30 days after you terminated employment or lost eligibility. If you are rehired or again become eligible within 30 days or less, your prior elections will be reinstated and remain in effect for the remainder of the Plan Year unless you again lose eligibility.

Q-5. How do I become a Participant?

You become a Participant by signing an individual Salary Redirection Agreement (“SRA”) on which you elect one or more of the Benefit Plans or Policies available under the Plan, as well as agree to a salary redirection to pay for those benefits so elected. You will be provided an SRA when you first become eligible to participate in this Plan. You must complete the form and turn it in to the Personnel Office during the applicable enrollment period described in Q-6 below.

Q-6. What are the enrollment periods for entering the Plan?

If you are eligible on the effective date of the Plan, you must enroll during the enrollment period immediately preceding the effective date of the Plan. Otherwise, you must enroll during either the “Initial Enrollment Period” or the “Annual Enrollment Period”. You will be notified of the dates that each enrollment period begins and ends in the enrollment material provided to you prior to each enrollment period. If you make an election during the Initial Enrollment Period, your participation in this Plan will begin on the later of your eligibility date described in the Plan Information Summary, the first pay period coinciding with or next following the date that your election is received by the Plan Administrator (or its designated claims administrator) or the date coverage under a Benefit Plan or policy that you elect begins. The effective date of coverage under the applicable Benefit Plan(s) or Policy(ies) is governed by the terms of each Benefit Plan or Policy, as set forth in the governing documents for each Benefit Plan or Policy. The election that you make during the Initial Enrollment Period is effective for the remainder of the Plan Year and generally cannot be revoked during the Plan Year unless you have a Change in Status event as described in Q-9 below. If you do not make an election during the Initial Enrollment Period, you will be deemed to have elected not to participate in this Plan for the remainder of the Plan Year. You may, however, be covered by certain Benefit Plans or Policies automatically (and be required to contribute with pre-tax dollars) even if you fail to make an election. These automatic Benefit Plans or Policies are called “Default Benefits” and will be identified in the enrollment material that you receive.

The election that you make during the Annual Enrollment Period is effective the first day of the next Plan Year and is irrevocable for the entire Plan Year unless you have a Change in Status event described in Q-9 below. A Participant who fails to complete, sign, and file an SRA during the Annual Enrollment Period as required shall be deemed to have elected to continue participation in the Plan with the same benefit elections as during the prior Plan Year (adjusted to reflect any increase/decrease in applicable premiums), and, except for a Change in Status, will not be permitted to modify his election until the next Annual Enrollment Period. Notwithstanding the foregoing, annual elections for participation in the Medical Care and Dependent Care Expense Reimbursement Plans, if offered under the Plan, must be made by submitting an SRA prior to the beginning of each Plan Year. No deemed elections shall occur with respect to such benefits.

The Plan Year is generally a 12-month period (except during the initial or last Plan Year of the Plan). The beginning and ending dates of the Plan Year are described in the Plan Information Summary.

Q-7. What tax advantages are available through the Plan?

Suppose your monthly gross pay is \$2,500 per month and your cost for coverage is \$140 per month. Also, suppose your total withholdings (income tax and Social Security) are 22.65%. After paying for coverage from your after-tax pay, your take home pay is \$1,794. However, under the pre-tax premium plan, you will be considered to have received \$2,360 gross pay rather than \$2,500 for tax purposes with \$140 contributed for medical coverage. This means your take home pay will be \$1,825 with the pre-tax premium plan rather than \$1,794 without it. Thus, you save \$31 per month (\$372 per year) by participating in the pre-tax premium plan. The Table below illustrates this savings.

	<u>With Cafeteria Plan</u>	<u>Without Cafeteria Plan</u>
Gross Monthly Pay	\$2,500	\$2,500
Pre-Tax Coverage Under Plan	140	—
Taxable Income	<u>2,360</u>	<u>2,500</u>
Estimated Federal Tax (15%)	354	375
FICA Tax	181	191
After-tax Coverage	—	<u>140</u>
Take Home Pay	1,825	1,794

Monthly Savings: \$31.00

Q-8. How are my contributions under the Benefit Plans or Policies made?

When you become a Participant, your share of the contributions for the elected Benefit Plan or Policy(ies) will be paid with Pre-tax Contributions elected on the SRA. Pre-tax Contributions are amounts withheld from your gross income before any applicable federal and state taxes have been deducted (some state tax laws do not recognize Pre-tax Contributions). In addition, all or a portion of the cost of the Benefit Plans or Policies may, in the Employer’s discretion, be paid with contributions made by the Employer on behalf of each Participant (these are called “Nonelective Contributions”). The amount of Nonelective Contribution that is applied towards the cost of the Benefit Plan(s) or Policy(ies) for each Participant and/or level of coverage is subject to the sole discretion of the Employer, and it may be adjusted upward or downward in the Employer’s sole discretion. The Nonelective Contribution amount will be calculated for each Plan Year in a uniform and

FLEXIBLE BENEFITS PLAN SUMMARY PLAN DESCRIPTION

Introduction

Your employer (the "Employer") is pleased to sponsor an employee benefit program known as a "Flexible Benefits Plan" (the "Plan") for you and your fellow employees. Under federal tax laws, it is also known as a "cafeteria plan." It is so called because it lets you choose from several different insurance and fringe benefit programs according to your individual needs. The Employer provides you with the opportunity to use pre-tax dollars to pay for them by entering into a salary redirection arrangement instead of receiving a corresponding amount of your regular pay. This arrangement helps you because the benefits you elect are nontaxable; you save Social Security and income taxes on the amount of your salary redirection. Alternatively, your Employer may allow you to pay for any of the available benefits with after-tax contributions on a salary deduction basis.

This Summary Plan Description ("SPD") describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. Information relating to the Plan that is specific to your Employer is described in the Plan Information Summary attached to the front of this SPD. You will be referred to the Plan Information Summary throughout the SPD. The Plan is also established pursuant to a plan document into which this SPD has been incorporated. If there is a conflict between the official plan document and the SPD, the plan document will govern.

In some cases, the Employer may adopt a Medical Care and/or Dependent Care Reimbursement Plan. If so, they will be listed in the Plan Information Summary as "Benefits Provided under the Plan," and the SPD for each Reimbursement Plan adopted by the Employer will be set forth in Appendix I to this SPD. To the extent that the Employer adopts a Medical Care Reimbursement Plan as indicated in the Plan Information Summary, a summary of your rights and obligations under HIPAA's privacy rules is attached to this SPD as Appendix II.

You may also be able to make pre-tax contributions to a Health Savings Account (as defined in Code Section 223) through this Plan if Health Savings Accounts are identified as an included benefit under "Benefits Provided under the Plan" in the Plan Information Summary. If Health Savings Accounts are identified as a benefit plan option offered under the Plan, your rights and obligations in regard to such contributions will be set forth in the Health Savings Account Contribution Appendix attached hereto.

Questions & Answers about the Flexible Benefits Plan

Q-1. What is the purpose of the Plan?

The purpose of the Plan is to allow eligible employees to pay for certain benefits offered under the Plan (called "Benefit Plans or Policies") with pre-tax dollars called "Pre-tax Contributions". Pre-tax Contributions are described in more detail in Q-8 of this SPD.

Q-2. What benefits can I purchase on a pre-tax basis through the Plan?

You will be able to choose to participate in the Plan's various pre-tax options by filling out any required enrollment form(s) for the component Benefit Plans or Policies offered under the Plan. The complete list of Benefit Plans or Policies offered under the Plan is located in the Plan Information Summary under "Benefits Offered Under the Plan." NOTE: You may only contribute with Pre-tax Contributions towards the cost of Benefit Plans or Policies that cover you, your legal Spouse, and/or your tax Dependents defined under Internal Revenue Code Section 152. Each Benefit Plan or Policy may define eligible Dependents more narrowly for purposes of coverage under the particular Benefit Plan or Policy.

Q-3. Who can participate in the Plan?

Each employee of the Employer (or an Affiliated Employer identified in the Plan Information Summary) who satisfies the eligibility requirements described in the Plan Information Summary and who is eligible to participate in any of the Benefit Plans or Policies offered under the Plan will be eligible to participate in this Plan as of the date described in the Plan Information Summary (see Q-5 of this SPD for instructions on how to become a Participant). Those employees who actually participate in the Plan are called "Participants." The terms of eligibility of this Plan do not override the terms of eligibility of each of the Benefit Plans or Policies offered under the Plan. For the details regarding eligibility provisions, benefit amounts, and premium schedules for each of the Benefit Plans or Policies, please refer to the plan summary for each of the Benefit Plans or Policies listed in the Plan Information Summary.

Only coverage for an Employee and the Employee's Dependents may be paid for under this Plan. A dependent is defined generally as an individual who would be considered the Employee's spouse under the federal income tax code or the Employee's tax dependents as defined in Code Section 152; however, for purposes of health benefits and Dependent Care Reimbursement ("DDC") benefits offered under the Plan, a dependent is defined as (i) for health plan purposes, as set forth in Code Section 105(b) and (ii) for DDC purposes, as any person who meets the requirements to be a "qualifying individual" as defined in the DDC component SPD.

Q-4. When does my participation in the Plan end?

You continue to participate in the Plan until (i) you elect not to participate in accordance with Q-9 of this SPD, (ii) you no longer satisfy the eligibility requirements described in the Plan Information Summary; (iii) you terminate employment with the Employer; or (iv) the Plan is terminated or amended to exclude you or the class of employees of which you are a member. If your employment with the Employer is terminated during the Plan Year or you otherwise cease to be eligible, your active participation in the Plan will automatically cease, and you will not be able to make any more Pre-tax Contributions under the Plan. If you are rehired within the same Plan Year or you become eligible again, you may make

11) Employer's Type of Business: _____

ELIGIBILITY

All Employees employed by the Employer shall be eligible to participate under the Plan except the following: _____

An eligible Employee may become a Participant in the Plan (check one):

- Immediately, upon the first day of employment (but not prior to the Effective Date of the Plan).
- On the _____ day following commencement of employment.
- On the first day of the month following _____ days of employment.
- Other: _____
provided the Employee completes a Salary Redirection Agreement ("SRA") However, eligibility for coverage under any given Benefit Plan or Policy shall be determined by the terms of that Benefit Plan or Policy, and reductions of the Employee's Compensation to pay Pre-tax or After-tax Contribution(s) shall commence when the Employee becomes covered under the applicable Benefit Plan or Policy

An eligible Employee may become a Participant in the Dependent Care and/or Medical Expense Reimbursement Plan(s) (if elected below):

- On the same day such Employee is eligible for the Pre-Tax Contribution benefits under the Plan
- On the _____ day following commencement of employment
- On the first day of the month following _____ days of employment.
- Other: _____
provided the Employee completes a SRA selecting such benefits.

BENEFITS PROVIDED UNDER THE PLAN

The following Benefit Plans and Policies subject to the terms and conditions of the Plan are available for election by eligible Employees. The maximum a Participant can contribute via the SRA is the maximum aggregate cost of the Benefit Plans or Policies elected minus any Nonelective Contribution made by the Employer. It is intended that such Pre-tax Contribution amounts shall, for tax purposes, constitute an Employer contribution, but may constitute Employee contributions for state insurance law purposes. Copies of the Benefit Plans or Policies (or a list of eligible Policy numbers) shall be attached as an appendix to this Plan.

- Medical Coverage
- Vision Care Coverage
- Disability Income – Short Term (A&S)
- Cancer Insurance
- Group Dental Coverage
- Group Term Life Insurance
- Disability Income – Long Term (LTD)
- Intensive Care Insurance
- Accident Insurance
- Hospital Indemnity Insurance (HII)
- Specified Health Event
- Personal Sickness Indemnity (PSI)
- Medical Care Expense Reimbursement described in Appendix I to this SPD, not to exceed \$ _____ per Plan Year pursuant to the _____ Medical Care Expense Reimbursement Plan.
Name and Address of Medical Care Expense Reimbursement Plan
COBRA Administrator (if applicable) _____

- Dependent Care Expense Reimbursement described in Appendix I to this SPD, not to exceed \$5,000 per Plan Year or \$2,500 for married filing separate returns pursuant to the _____ Dependent Care Expense Reimbursement Plan.
- Health Savings Account (as defined in Code Section 223) established with the following Custodian/Trustee: _____
- Opt-out Option: See Employer enrollment material

THE FUNDING AGENT

The Employer selects the following Funding Agent for the Plan (check one)

- The Employer, which will comply with the requirements of Article VII of the Plan
- The Flexible Benefits Trust created concurrently with the execution of the Plan, which shall receive contributions under the Plan in accordance with Article VII of the Plan

ADMINISTRATIVE EXPENSES

Administrative Expenses incurred in operating the Plan shall be paid by (check one):

- The Employer, except as otherwise noted in the Plan
- The Participants, except as otherwise noted in the Plan

interpret possible ambiguities, inconsistencies, or omissions in the Plan and this SPD. Other important information such as the Plan Number and Plan Sponsor's name has also been provided in the Plan Information Summary.

ERISA Rights

The URM may be an ERISA welfare benefit plan (unless the employer is a governmental employer or the plan is a "church plan" as defined in the applicable regulations). As a Participant in an ERISA-covered benefit, you are entitled to certain rights and protections under the Employee Retirement Income Security Act ("ERISA"). ERISA provides that all plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all documents governing the plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, Spouse or Dependent children if there is a loss of coverage under the Plan as a result of a qualifying event. You or your eligible dependents may have to pay for such coverage. You should review Q-19 of this appendix for more information concerning your COBRA continuation coverage rights.

(To the extent the URM is subject to HIPAA's portability rules:) You may be eligible for a reduction or elimination of exclusionary periods of coverage for preexisting condition under your group health plan, if you move to another plan and you have creditable coverage from this Plan. You will be provided a certificate of creditable coverage, free of charge, from the Plan Administrator when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage in another plan.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit from the Plan or from exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a federal court. If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance obtaining documents from the Plan Administrator, you should contact the nearest office of the U.S. Department of Labor, Employee Benefits Security Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration; U.S. Department of Labor, 200

00000100001



FSA ACTIVITY STATEMENT

Aflac



Cheryl Adams
7589 Old Moon Rd.
Columbus GA 31909-1737

Statement Date: October 03, 2014
Name: Cheryl Adams
SSN: XXX-XX-3153
Employer Plan Year: 01/01/2014 - 12/31/2014

Customer Service - 1-877-353-9487
Toll-Free Fax Number for Claims - 1-877-353-9256
24 hours a day / 7 days a week

Note: Your plan year ends 12/31/2014, and remaining plan contributions may be forfeited to your employer under the IRS "use it or lose it" rule. Verify with your employer the deadline for submitting claims.

Flexible Spending Account Balances:

Plan Type*	Annual Election	Payroll Deductions Made	Total Paid	Payroll Deductions Remaining	Annual Election Remaining	These balances do not reflect any claims received and not yet approved.
URM	\$5,000.00	\$0.00	\$75.00	\$5,000.00	\$4,925.00	

Messages:

Thank you for choosing Aflac's Flex One[®], a leading provider of Cafeteria Plan Services!

IMPORTANT NOTE: Your plan year will end soon. Remember that to be reimbursable, services must be incurred during the plan year, and claims must be submitted before the end of the runoff period.

*Claim Type / Plan Type:

DDC = Dependent Day Care
URM = Unreimbursed Medical

Reason Pending:

1 = Your balance is insufficient to pay the claim
2 = Your claim is for a future date

Helpful Tips:

- 1 Send claims on a completed and signed Request for Reimbursement form via either mail to the address at the top of the following page, or fax to 1-877-FLEXCLM (353-9256). Note: Blank forms may be obtained at aflac.com - Get a Claim Form - Flex One, or by calling 1-877-353-9487.
- 2 Please allow 48 hours for Flex One to receive your faxes.
- 3 Don't submit claims in advance of the service being rendered. Claims cannot be paid until after the service is rendered.
- 4 Submit a legible receipt from the provider showing (a) name of service provider, (b) name of person receiving service, (c) date of service, (d) description of service, Rx drug name, or a list of supplies furnished (description of service cannot be solely in prescription numbers (e.g., Rx#)), and (e) charge for service. Additional substantiation may still be required.
- 5 A service provider signature on the Request for Reimbursement form can serve as a substitute for your expense receipt when all blocks of the FSA area are completed in detail. Please make sure you use a detailed service description such as "Root Canal" rather than "Dental" OR "Individual Psychological Counseling" rather than just "Counseling".
- 6 Most participants have 90 days from the end of the plan year to submit claims with dates of service within the plan year. Check with your employer to be sure.
- 7 You can only receive DDC reimbursements up to the amount of your Payroll Deductions Made (listed above) less any prior reimbursements.

General IRS Eligibility Guidelines:

- 1 Medical copayments and deductibles are eligible. Claims require ample supporting information. See Tip 4 above.
- 2 Most medical services are eligible, excluding services that are for general health or for cosmetic/personal reasons.
- 3 Purchase and rental of most medical devices are eligible, including diabetic-related supplies.
- 4 Most prescribed drugs, contraceptives, insulin, and prescribed smoking cessation programs are eligible, including over-the-counter (OTC) drugs for medical care (dietary supplements and vitamins are usually ineligible unless prescribed by your physician to treat a specific medical condition).
- 5 Insurance premiums of any kind are not eligible.
- 6 Documentation is required from your physician in order to meet eligibility guidelines for weight loss drugs and associated programs.
- 7 For Dependent Day Care accounts, only expenses for a qualified individual that are work-related and primarily custodial in nature are eligible.

Customer Service
 1-877-353-9487 - 24 hours a day / 7 days a week
 1-800-323-5391 - Monday - Friday, 8:30 AM to 7:00 PM ET

Aflac Flex One
 1932 Wynnton Road
 Columbus, GA 31999

Explanation of Benefits:

Claim Type*	Claim Number	Dates of Service FROM - THRU	Amount Requested	Amount Pending	Reason Pending	Amount Denied	Reason Denied	Amount Paid
URM	0005	02/15/2014-02/15/2014	\$50.00	\$0.00		\$50.00	OSP	\$0.00
TOTALS			\$50.00	\$0.00		\$50.00		\$0.00

OSP Ineligible expense - over the counter (OTC) medication/supply stockpiling. The quantity purchased cannot be reasonably put into use within the remainder of the applicable plan year. The Medical Care Reimbursement Plan, in accordance with current IRS Code regulations, requires that an eligible expense be incurred, not simply paid for, within the plan year. IRS officials have commented that in regards to OTC medications/supplies, stockpiling of items that cannot be reasonably be put into use during the applicable plan year would not qualify as eligible expenses for medical care under IRC Section 213(d). Please refer to Q-9 of Appendix I in your Summary Plan Description (SPD).



FSA ACTIVITY STATEMENT

County OF Westmoreland

00000001



CHERYL A KNOR
211 CODY RD
HERMINIE PA 15637-1101

Check Date: June 06, 2005
Check Number: F001233464
Total Check Amount: \$121.15
Name: Cheryl A. Knor
SSN: XXX-XX-5936
Employer Plan Year: 01/01/2005 - 12/31/2005

Customer Service - 1-877-353-9487
Toll-Free Fax Number for Claims - 1-877-353-9256
24 hours a day / 7 days a week

Note: Your plan year ends 12/31/2005, and remaining plan contributions may be forfeited to your employer under the IRS "use it or lose it" rule. Verify with your employer the deadline for submitting claims.

Flexible Spending Account Balances:

Table with 6 columns: Plan Type*, Annual Election, Payroll Deductions Made, Total Paid, Payroll Deductions Remaining, Annual Election Remaining. Row 1: URM, \$800.00, \$333.30, \$578.76, \$466.70, \$221.24

These balances do not reflect any claims received and not yet approved.

Messages:

Thank you for choosing Aflac's Flex One®, a leading provider of Cafeteria Plan Services!
Did you know that FLEX ONE offers Direct Deposit? That means that your reimbursements can be deposited directly to your bank account, saving you the inconvenience associated with a check. Ask your employer if you are eligible to take advantage of Direct Deposit today!

*Claim Type / Plan Type:
DDC = Dependent Day Care
URM = Unreimbursed Medical

Reason Pending:
1 = Your balance is insufficient to pay the claim
2 = Your claim is for a future date

FLEXONE13 1

PLEASE FOLD AND DETACH CHECK

COLUMBUS BANK AND TRUST COMPANY
COLUMBUS, GA 31901

COUNTY OF WESTMORELAND
2 NORTH MAIN ST SUITE 108
GREENSBURG PA 15601

JUNE 06, 2005
NO. F 001233464

64-60
611



DOCUMENT FACE HAS A MULTICOLORED BACKGROUND

AMOUNT \$121.15

VOID AFTER 180 DAYS

PAY ****ONE HUNDRED TWENTY-ONE AND 15/100**** U.S. DOLLARS



TO
THE
ORDER
OF
CHERYL A KNOR
211 CODY RD
HERMINIE PA 15637-1101

A B C
AUTHORIZED SIGNATURES FOR
American Family Life Assurance Company of Columbus (Aflac)

001233464 061100606 2397862

Customer Service
1-877-353-9487 - 24 hours a day / 7 days a week
1-800-323-5391 - Monday - Friday, 8:30 AM to 7:00 PM ET

Aflac Flex One
1932 Wynnton Road
Columbus, GA 31999

Helpful Tips:

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- 3 Don't submit claims in advance of the service being rendered Claims cannot be paid until after the service is rendered
- 4 Submit a legible receipt from the provider showing: (a) name of service provider, (b) name of person receiving service, (c) date of service, (d) description of service, Rx drug name, or a list of supplies furnished (description of service cannot be solely in prescription numbers (e.g., Rx#)), and (e) charge for service Additional substantiation may still be required
- 5 A service provider signature on the Request for Reimbursement form can serve as a substitute for your expense receipt when all blocks of the FSA area are completed in detail Please make sure you use a detailed service description such as "Root Canal" rather than "Dental" OR "Individual Psychological Counseling" rather than just "Counseling"
- 6 Most participants have 90 days from the end of the plan year to submit claims with dates of service within the plan year Check with your employer to be sure
- 7 You can only receive DDC reimbursements up to the amount of your Payroll Deductions Made (listed above) less any prior reimbursements

General IRS Eligibility Guidelines:

- 1 Medical copayments and deductibles are eligible Claims require ample supporting information See Tip 4 above
- 2 Most medical services are eligible, excluding services that are for general health or for cosmetic/personal reasons
- 3 Purchase and rental of most medical devices are eligible, including diabetic-related supplies
- 4 Most prescribed drugs, contraceptives, insulin, and prescribed smoking cessation programs are eligible, including over-the-counter (OTC) drugs for medical care (dietary supplements and vitamins are usually ineligible unless prescribed by your physician to treat a specific medical condition)
- 5 Insurance premiums of any kind are not eligible
- 6 Documentation is required from your physician in order to meet eligibility guidelines for weight loss drugs and associated programs
- 7 For Dependent Day Care accounts, only expenses for a qualified individual that are work-related and primarily custodial in nature are eligible

Explanation of Benefits:

Claim Type*	Claim Number	Dates of Service FROM - THRU	Amount Requested	Amount Pending	Reason Pending	Amount Denied	Reason Denied	Amount Paid
URM	0048	05/03/2005-05/03/2005	\$4.26	\$0.00		\$0.00		\$4.26
URM	0049	05/03/2005-05/03/2005	\$6.37	\$0.00		\$0.00		\$6.37
URM	0050	05/06/2005-05/06/2005	\$6.20	\$0.00		\$6.20	03A	\$0.00
URM	0051	05/04/2005-05/04/2005	\$10.00	\$0.00		\$10.00	04D	\$0.00
URM	0052	05/10/2005-05/10/2005	\$10.00	\$0.00		\$0.00		\$10.00
URM	0053	05/10/2005-05/10/2005	\$10.00	\$0.00		\$0.00		\$10.00
URM	0054	05/10/2005-05/10/2005	\$25.00	\$0.00		\$0.00		\$25.00
URM	0055	05/10/2005-05/10/2005	\$25.00	\$0.00		\$0.00		\$25.00
URM	0056	05/10/2005-05/10/2005	\$25.00	\$0.00		\$0.00		\$25.00
URM	0057	05/11/2005-05/11/2005	\$6.20	\$0.00		\$6.20	03A	\$0.00
URM	0058	05/19/2005-05/19/2005	\$5.99	\$0.00		\$0.00		\$5.99
URM	0059	05/19/2005-05/19/2005	\$8.99	\$0.00		\$0.00		\$8.99
URM	0060	05/19/2005-05/19/2005	\$0.54	\$0.00		\$0.00		\$0.54
TOTALS			\$143.55	\$0.00		\$22.40		\$121.15

03A - The expenses submitted are not eligible for payment Please refer to the Eligibility Guidelines on this statement or consult the Participants Handbook

04D - The receipt did not show a description of the service See Helpful Tips 4 and 5

NOTICE OF APPEAL PROCESS

If all or a portion of your reimbursement request has not been paid, you may have the right to appeal. For more information on your appeal rights, please read your Plan's claim review procedures established in your Flexible Spending Account Summary Plan Description. When all procedures outlined in the SPD have been exhausted, then, you have the right to seek legal action. Along with your appeal, please provide any applicable information to support your claim.

To request a formal review of your denied claim, submit your written request for appeal, with any supporting documentation, within 180 days of the denial notice. Fax or mail your request for appeal form to:

(877)FLEX -CLM (353-9256) OR Aflac Flex One
Attn: Claim Appeals
1932 Wynnton Road
Columbus, GA 31999



00000100003

GRACE PERIOD TESTING 1
PRINCIPAL CONTACT
1999 WYNNTON ROAD
MO CITY, GA 31999

Flexible Spending Account Analysis Report

FSA Type - URM = Unreimbursed Medical, DDC = Dependent Day Care

Eligibility Period Start - the beginning date of the employee's coverage

Eligibility Period End - the end date of the employee's coverage

Election Amount - the employee's annual election amount

Deposits This Month - total of payroll deductions credited this month

Deposits Year To Date - total of payroll deductions credited for the plan year

Paid This Month - total of reimbursements paid to the employee this month

Paid Year To Date - total of reimbursements paid to the employee this plan year

Year To Date Analysis

- **Election minus Paid** - Election Amount minus Paid Year To Date
- **Deposits minus Paid** - Deposits Year To Date minus Paid Year To Date
- **Elections Yet To Be Deducted** - total of future scheduled payroll deductions

Flexible Spending Account Analysis Report



Employer Name: GRACE PERIOD TESTING 1
Plan Year: AUGUST 1, 2005 TO JULY 31, 2006
Reporting Period: AUGUST 1, 2005 TO JULY 31, 2006
Date Report Printed: JULY 31, 2006

Participant Information					Deposits		Paid		Year To Date Analysis			
Name	Social Security #	FSA Type	Eligibility Period		Election Amount	This Month	Year To Date	This Month	Year To Date	Election minus Paid	Deposits minus Paid	Election Yet To Be Deducted
			Start	End								
HARDWICK, REGGIE	XXX-XX-3454	DDC	08/01/05	07/31/06	2,500.00	.00	312.48	.00	312.48	2,187.52	.00	2,187.52
HART, DEON	XXX-XX-3452	URM	08/01/05	07/31/06	1,500.00	.00	887.50	.00	750.00	750.00	(62.50)	812.50
HEARD, THOMAS	XXX-XX-3450	URM	08/01/05	05/30/06	1,500.00	.00	500.00	.00	1,350.00	150.00	(850.00)	1,000.00
HENDERSON, GLORIA	XXX-XX-3451	DDC	08/01/05	07/31/06	800.00	.00	386.83	.00	386.83	433.37	.00	433.37
		URM	08/01/05	07/31/06	1,500.00	.00	887.50	.00	1,410.00	90.00	(722.50)	812.50
HOLLIDAY, TESTER	XXX-XX-2112	URM	08/01/05	07/31/06	1,200.00	.00	.00	.00	.00	1,200.00	.00	1,200.00
HOLSEN, WHITNEY	XXX-XX-3453	DDC	08/01/05	07/31/06	500.00	.00	229.13	.00	229.13	270.87	.00	270.87
		URM	08/01/05	07/31/06	1,000.00	.00	458.28	.00	1,000.00	.00	(541.74)	541.74

Plan Information Summary					
Total Plan		DDC Plan		URM Plan	
TOTAL ELECTION AMOUNT:	10,500.00	TOTAL ELECTION AMOUNT DDC:	3,800.00	TOTAL ELECTION AMOUNT URM:	6,700.00
TOTAL DEPOSITS THIS MONTH:	.00	TOTAL DEPOSITS THIS MONTH DDC:	.00	TOTAL DEPOSITS THIS MONTH URM:	.00
TOTAL DEPOSITS YEAR TO DATE:	3,241.50	TOTAL DEPOSITS YEAR TO DATE DDC:	908.24	TOTAL DEPOSITS YEAR TO DATE URM:	2,333.26
TOTAL PAID THIS MONTH:	.00	TOTAL PAID THIS MONTH DDC:	.00	TOTAL PAID THIS MONTH URM:	.00
TOTAL PAID YEAR TO DATE:	5,418.24	TOTAL PAID YEAR TO DATE DDC:	908.24	TOTAL PAID YEAR TO DATE URM:	4,510.00
TOTAL ELECTION MINUS PAID:	5,081.76	TOTAL ELECTION MINUS PAID DDC:	2,891.76	TOTAL ELECTION MINUS PAID URM:	2,190.00
TOTAL DEPOSITS MINUS PAID:	(2,176.74)	TOTAL DEPOSITS MINUS PAID DDC:	.00	TOTAL DEPOSITS MINUS PAID URM:	(2,176.74)
TOTAL ELECTION YET TO BE DEDUCTED:	7,258.50	TOTAL ELECTION YET TO BE DEDUCTED DDC:	2,891.76	TOTAL ELECTION YET TO BE DEDUCTED URM:	4,366.74

Essentials Plan

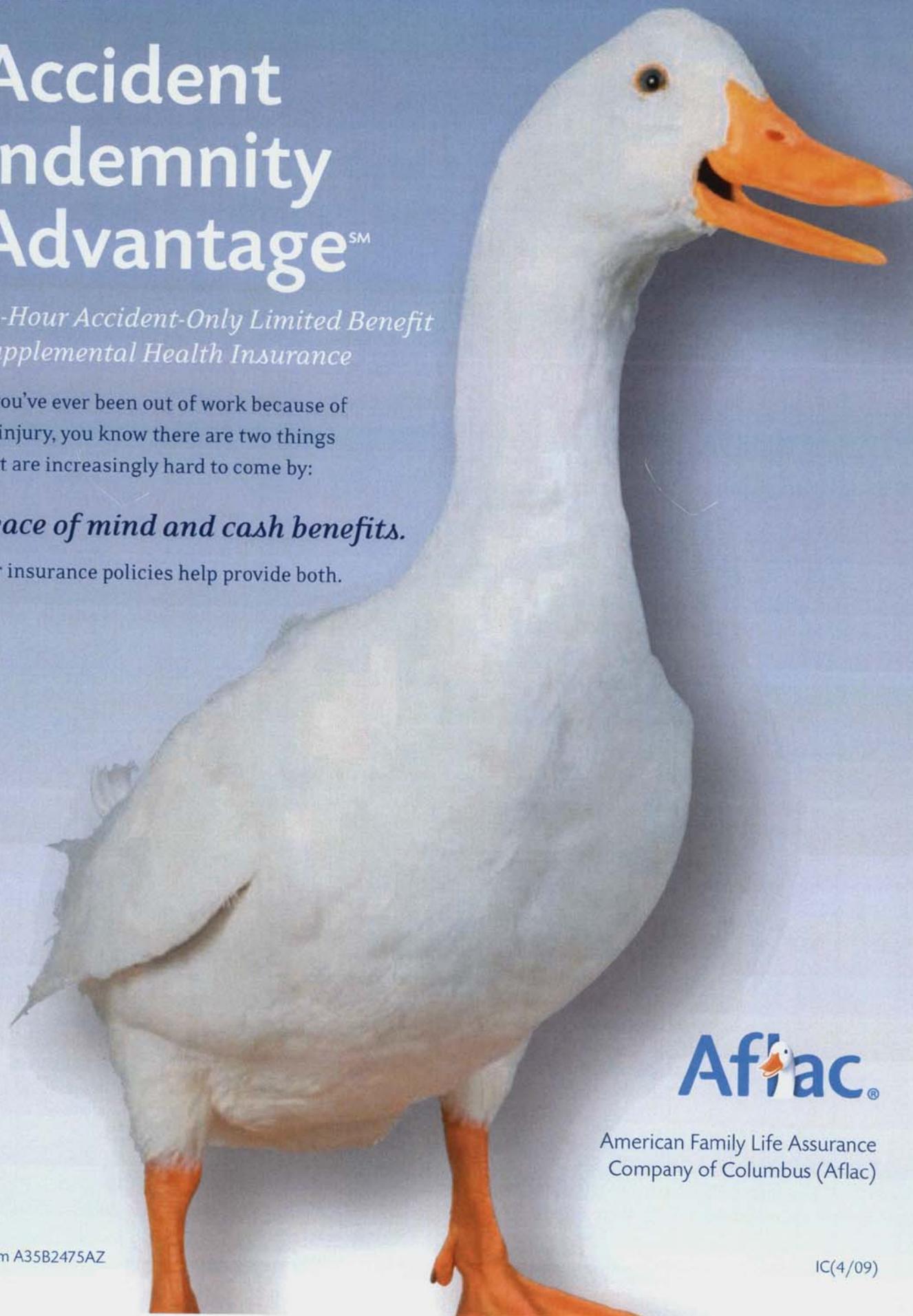
Accident Indemnity AdvantageSM

*24-Hour Accident-Only Limited Benefit
Supplemental Health Insurance*

If you've ever been out of work because of
an injury, you know there are two things
that are increasingly hard to come by:

Peace of mind and cash benefits.

Our insurance policies help provide both.



Aflac[®]

American Family Life Assurance
Company of Columbus (Aflac)

Essentials Plan

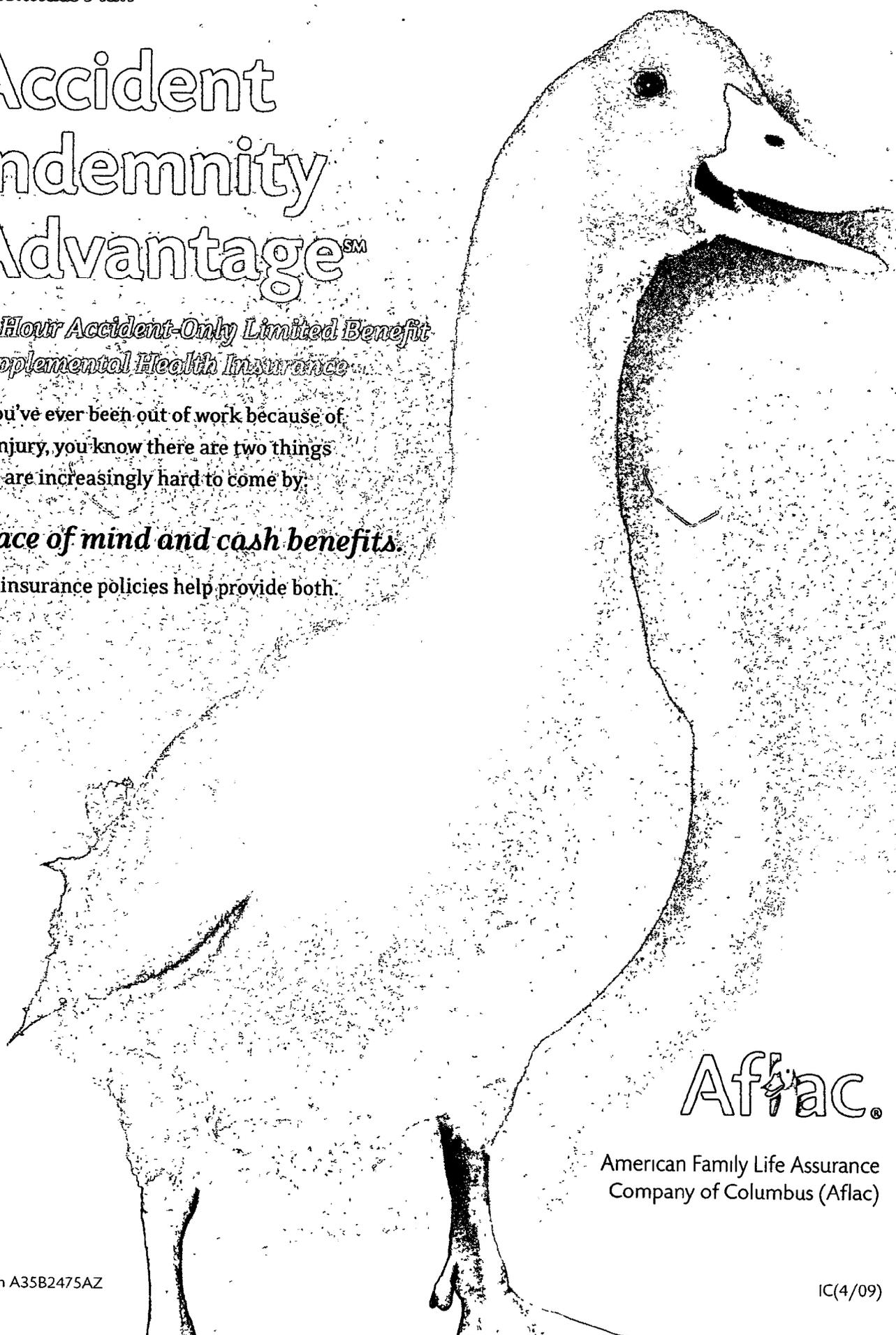
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American Family Life Assurance
Company of Columbus (Aflac)

Essentials Plan

Accident Indemnity AdvantageSM

24-Hour Accident-Only Limited Benefit Supplemental Health Insurance
Policy Series A35000

The Need

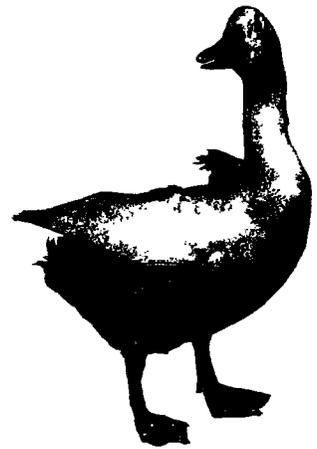
Accidents happen to all kinds of people every day. In 2005, over 30 million people sought medical attention for an injury and almost 3 million of these were hospitalized.*

What would the financial impact of an injury mean to your security? Are you prepared for medical debts in addition to everyday household expenditures and lost wages? Out-of-pocket expenses associated with an accident are unexpected and often burdensome; perhaps the accident itself could not have been prevented, but its impact on your finances and your well-being certainly can be reduced.

Aflac pays cash benefits directly to you, unless you choose otherwise. This means that you will have added financial resources to help with expenses incurred due to an injury, to help with ongoing living expenses, or to help with any purpose you choose. Aflac Accident Indemnity Advantage is designed to provide you with cash benefits throughout the different stages of care, regardless of the severity of the injury.

The Accident Indemnity Advantage Insurance Policy has:

- No deductibles and no copayments.
- No lifetime limits.
- No network restrictions—you choose your own medical treatment provider.
- No coordination of benefits—we pay regardless of any other insurance.



Aflac enables you to take charge and to help provide for an unpredictable future by paying cash benefits for accidental injuries. Your own peace of mind and the assurance that your family will have help financially are powerful reasons to consider Aflac.

When you consider the competitive cost of providing your family with Aflac, it's truly remarkable that this policy could potentially save you and your loved ones from financial uncertainty during a very stressful time. Knowing that you have prepared for the many financial consequences of an accident is an assurance in itself, yielding strength and confidence for uncertain possibilities.

Aflac is a market leader with more than 50 years in the insurance industry. We continue to be ranked the number one provider of individual health and guaranteed-renewable insurance in the United States ("Life and Health Statistical Report," *National Underwriter*, August 2008), and we work hard to help meet your insurance needs.

Out-of-pocket expenses associated with an accident are unexpected and often burdensome; perhaps the accident itself could not have been prevented, but its impact on your finances and your well-being certainly can be reduced.

The policy to which this sales material pertains is written only in English;
the policy prevails if interpretation of this material varies

Benefit

Benefit Amount

Additional Benefit Information

Wellness

\$40 once per policy, per 12-month period, payable after the policy has been in force for 12 months

Payable 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 either you or your Spouse. Services covered are annual physical examinations, dental examinations, mammograms, Pap smears, eye examinations, immunizations, flexible sigmoidoscopies, ultrasounds, prostate-specific antigen tests (PSAs), 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 your policy anniversary date. Service must be under the supervision of or recommended by a physician, received while your policy is in force, and a charge must be incurred

Aflac will pay the following benefits as applicable if a Covered Person's Accidental Death, dismemberment, or Injury is caused by a covered accident that occurs on or off the job. Accidental Death, dismemberment, or Injury must be independent of Sickness or the medical or surgical treatment of Sickness, or of any cause other than a covered accident. A covered Accidental Death, dismemberment, or Injury must also occur while coverage is in force and is subject to the limitations and exclusions. Treatment or confinement in a U.S. government hospital does not require a charge for benefits to be payable.

Accident
Emergency
Treatment

\$75 once per 24-hour period and once per covered accident, per Covered Person

Payable when a Covered Person receives treatment for Injuries sustained in a covered accident. This benefit is payable for 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.

X-Ray

\$20 once per covered accident, per Covered Person

Payable when a Covered Person requires an X-ray while receiving emergency treatment in a hospital or a hospital emergency room for Injuries sustained in a covered accident. This benefit is not payable for X-rays received in a physician's office. The X-Ray Benefit is not payable for exams listed in the Major Diagnostic Exams Benefit.

Accident
Follow-Up
Treatment

\$25 for one treatment per day, up to a maximum of six treatments per covered accident, per Covered Person

Payable when a Covered Person receives emergency treatment for Injuries sustained in a covered accident and later requires additional treatment over and above emergency treatment administered in the first 72 hours following the accident. The 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 payable for acupuncture when furnished by a licensed, certified acupuncturist. The Accident Follow-Up Treatment Benefit is not payable for the same days the Physical Therapy Benefit is paid

Initial
Accident
Hospitalization

\$500 once per period of Hospital Confinement or \$750 once when a Covered Person is admitted directly to an intensive care unit, payable once per calendar year, per Covered Person

Payable when a Covered Person is admitted for a Hospital Confinement of at least 18 hours for treatment of Injuries sustained in a covered accident or if a Covered Person is admitted directly to an intensive care unit of a hospital for treatment of Injuries sustained in a covered accident. Hospital Confinements must start within 30 days of the accident.

Accident
Hospital
Confinement

\$150 per day up to 365 days per covered accident, per Covered Person

Payable when a Covered Person is admitted for a Hospital Confinement of at least 18 hours for treatment of Injuries sustained in a covered accident. Hospital Confinements must start within 30 days of the accident. The Accident Hospital Confinement Benefit and the Rehabilitation Unit Benefit will not be paid on the same day. The highest eligible benefit will be paid

Intensive
Care Unit
Confinement

An additional \$300 per day for up to 15 days per covered accident, per Covered Person

Payable for each day a Covered Person receives the Accident Hospital Confinement Benefit, and is confined and charged for a room in an intensive care unit for treatment of Injuries sustained in a covered accident. Hospital Confinements must start within 30 days of the accident

Benefit	Benefit Amount	Additional Benefit Information
Accident Specific-Sum Injuries	\$20–\$7,500 (according to the policy) for: <ul style="list-style-type: none"> • Dislocations • Burns • Skin grafts • Eye injuries • Lacerations • Fractures • Concussions • Emergency dental work • Coma • Paralysis • Surgical procedures • Miscellaneous surgical procedures 	Treatment must be performed on a Covered Person for Injuries sustained in a covered accident. We will pay for no more than two dislocations per covered accident, per Covered Person. Benefits are payable for only the first dislocation of a joint. If a dislocation is reduced with local anesthesia or no anesthesia by a physician, we will pay 25 percent of the amount shown for the closed reduction dislocation. Burns must be treated by a physician within 72 hours after a covered accident. If a Covered Person receives one or more skin grafts for a covered burn, we will pay a total of 50 percent of the burn benefit amount that we paid for the burn involved. Lacerations must be repaired within 72 hours after the accident and repaired under the attendance of a physician. We will pay 25 percent of the benefit amount shown for the closed reduction of chip fractures and other fractures not reduced by open or closed reduction. We will pay for no more than two fractures per covered accident, per Covered Person. Emergency dental work does not include false teeth such as dentures, bridges, veneers, partials, crowns, or implants. We will pay for no more than one emergency dental work benefit per covered accident, per Covered Person. The duration of paralysis must be a minimum of 30 days, and this benefit will be payable once per Covered Person. Coma must last a minimum of seven days. Coma does not include any medically induced coma. Treatment for 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 surgical procedure may be performed.
Major Diagnostic Exams	\$100 once per calendar year, per Covered Person	Payable when a Covered Person requires one of the following exams for Injuries sustained in a covered accident and a charge is incurred: computerized tomography (CT scan), computerized axial tomography (CAT), magnetic resonance imaging (MRI), or electroencephalography (EEG). These exams must be performed in a hospital or a physician's office. Exams listed in the Major Diagnostic Exams Benefit are not payable under the X-Ray Benefit.
Epidural Pain Management	\$100 paid no more than twice per covered accident, per Covered Person	Payable when a Covered Person is prescribed, receives, and incurs a charge for an epidural administered for pain management in a hospital or a physician's office for Injuries sustained in a covered accident. This benefit is not payable for an epidural administered during a surgical procedure.
Physical Therapy	\$25 per treatment for one treatment per day, up to a maximum of ten treatments per covered accident, per Covered Person	Payable when a Covered Person receives emergency treatment for Injuries sustained in a covered accident and later a physician advises the Covered Person to seek treatment from a licensed 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. The treatment must take place within six months after the accident. The Physical Therapy Benefit is not payable for the same days that the Accident Follow-Up Treatment Benefit is paid.
Rehabilitation Unit	\$75 per day, limited to 30 days for each Covered Person per period of Hospital Confinement and limited to a calendar year maximum of 60 days	Payable when a Covered Person is admitted for a Hospital Confinement and is transferred to a bed in a rehabilitation unit of a hospital for treatment of Injuries sustained in a covered accident and a charge is incurred. The Rehabilitation Unit Benefit will not be payable for the same days that the Accident Hospital Confinement Benefit is paid. The highest eligible benefit will be paid. No lifetime maximum.
Appliances	\$50 once per covered accident, per Covered Person	Payable when a Covered Person receives a medical appliance, prescribed by a physician, as an aid in personal locomotion for Injuries sustained in a covered accident. Benefits are payable for the following types of appliances: a wheelchair, a leg brace, a back brace, a walker, and/or a pair of crutches.

The policy has limitations and exclusions that may affect benefits payable. This brochure is for illustrative purposes only. See the policy for complete details, definitions, limitations, and exclusions.

Benefit	Benefit Amount	Additional Benefit Information																
Prosthesis	\$250 once per covered accident, per Covered Person	Payable when a Covered Person requires use of a prosthetic device as a result of Injuries sustained in a covered accident. This benefit is not payable for repair or replacement of prosthetic devices, hearing aids, wigs, or dental aids, to include false teeth.																
Blood/ Plasma/ Platelets	\$100 once per covered accident, per Covered Person	Payable when a Covered Person receives blood/plasma and/or platelets for the treatment of Injuries sustained in a covered accident. This benefit does not pay for immunoglobulins.																
Ambulance	\$120 when a Covered Person requires ambulance transportation \$800 when a Covered Person requires air ambulance transportation	Payable when a Covered Person requires ambulance transportation or air ambulance transportation to a hospital for Injuries sustained in a covered accident. Ambulance transportation must be within 72 hours of the covered accident. A licensed professional ambulance company must provide the ambulance service.																
Transportation	\$200 per round trip, up to three round trips per calendar year, per Covered Person	Payable per round trip to a hospital when a Covered Person requires Hospital Confinement for medical treatment due to an Injury sustained in a covered accident. This benefit is also payable when a covered Dependent Child requires hospital confinement for medical treatment due to an Injury sustained in a covered accident if commercial travel is necessary and such Dependent Child is accompanied by any immediate family member. This benefit is not payable for transportation to any hospital located within a 50-mile radius from the site of the accident or the residence of the Covered Person. The local attending physician must prescribe the treatment requiring Hospital Confinement, and the treatment must not be available locally. This benefit is not payable for transportation by ambulance or air ambulance to the hospital.																
Family Lodging	\$75 per night, limited to one motel/hotel room per night, up to 30 days per covered accident	Payable for one motel/hotel room for a member of the immediate family who accompanies a Covered Person who is admitted for a Hospital Confinement for the treatment of Injuries sustained in a covered accident. This benefit is payable only during the same period of time the injured Covered Person is confined to the hospital. The hospital and motel/hotel must be more than 50 miles from the residence of the Covered Person.																
Accidental Death	<table border="1"> <thead> <tr> <th></th> <th>Common-Carrier Accident</th> <th>Other Accident</th> <th>Hazardous Activity Accident</th> </tr> </thead> <tbody> <tr> <td>Insured</td> <td>\$80,000</td> <td>\$20,000</td> <td>\$5,000</td> </tr> <tr> <td>Spouse</td> <td>\$80,000</td> <td>\$20,000</td> <td>\$5,000</td> </tr> <tr> <td>Child</td> <td>\$12,000</td> <td>\$6,000</td> <td>\$1,500</td> </tr> </tbody> </table>		Common-Carrier Accident	Other Accident	Hazardous Activity Accident	Insured	\$80,000	\$20,000	\$5,000	Spouse	\$80,000	\$20,000	\$5,000	Child	\$12,000	\$6,000	\$1,500	<p>We will pay the applicable lump sum benefit indicated for the Accidental Death of a Covered Person. Accidental Death must occur as a result of an Injury sustained in a covered accident and must occur within 90 days of such accident. Note: We do not recommend that you name a minor child as your beneficiary. If you name a minor child as your beneficiary, any benefits due your minor beneficiary will not be payable until a guardian for the financial estate of the minor is appointed by the court or such beneficiary reaches the age of majority as defined by your state. If there is no beneficiary, Aflac will pay any applicable benefit to your estate.</p> <p>Please see the Terms You Need to Know section of the brochure for more details about Common-Carrier Accidents, Other Accidents, and Hazardous Activity Accidents.</p>
	Common-Carrier Accident	Other Accident	Hazardous Activity Accident															
Insured	\$80,000	\$20,000	\$5,000															
Spouse	\$80,000	\$20,000	\$5,000															
Child	\$12,000	\$6,000	\$1,500															

Benefit	Benefit Amount	Additional Benefit Information
Accidental Dismemberment	\$400-\$20,000	We will pay the applicable lump sum benefit indicated in the policy for dismemberment. Dismemberment must occur as a result of Injuries sustained in a covered accident and must occur within 90 days of the accident. Only the highest single benefit per Covered Person will be paid for dismemberment. Benefits will be paid only once per Covered Person, per 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.
Continuation of Coverage	Waive all monthly premiums for up to two months	We will waive all monthly premiums due for the policy and riders 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 to receive this benefit after you re-establish your premium payments through payroll deduction for a period of at least six months, and we receive premiums for at least six consecutive months. (<i>Payroll deduction</i> means your premium is remitted to Aflac for you by your employer through a payroll deduction process.)

What Is Not Covered

Limitations and Exclusions

We will not pay benefits for services rendered by you or a member of the immediate family of a Covered Person. We will not pay benefits for treatment or loss due to Sickness, including (1) any bacterial, viral, or micro-organism infection or infestation, or any condition resulting from insect, arachnid, or other arthropod bites or stings; or (2) an error, mishap, or malpractice during medical, diagnostic, or surgical treatment or procedure for any Sickness. We will not pay benefits whenever coverage provided by the policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.

We will not pay benefits for an Injury, treatment, disability, or loss 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);
- Using any drug, narcotic, hallucinogen, or chemical substance (unless administered by a physician and taken according to the physician's instructions) or voluntarily taking any kind of poison or inhaling any kind of gas or fumes;
- Participating in, or attempting to participate in, an illegal activity that is defined as a felony (*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 a bodily injury, or committing or attempting suicide, while sane or insane;
- Having cosmetic surgery or other elective procedures that are not medically necessary;
- 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 Reserve.

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.

A physician or a physical therapist does not include you or a member of your immediate family

Terms You Need to Know

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 date(s) coverage begins as shown in the Policy Schedule. The Effective Date of the policy is not the date you signed the application for coverage

Covered Person: any person insured under the coverage type you applied for. individual (named insured listed in the Policy Schedule), named insured/Spouse only (named insured and Spouse), one-parent family (named insured and Dependent Children), or two-parent family (named insured, Spouse, and Dependent Children). *Spouse* is defined as the person to whom you are legally married and who is listed on your application. Newborn children are automatically covered under the terms of the policy from the moment of birth. If coverage is for individual/Spouse only, and you desire uninterrupted coverage, you must notify Aflac in writing within 31 days of the birth of your child, and Aflac will convert the policy to one-parent family or two-parent family coverage and advise you of the additional premium due. Coverage will include any other unmarried Dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who became so incapacitated prior to age 25 and while covered under the policy. *Dependent Children* are your natural children, stepchildren, or legally adopted children who are unmarried, under age 25, and your dependents. A Dependent Child (including persons incapable of self-sustaining employment by reason of mental retardation or physical handicap) must be under age 25 at the time of application to be eligible for coverage

Hospital Confinement: a stay of a Covered Person confined to a bed in a hospital for which a room charge is made. The Hospital Confinement must be on the advice of a physician, medically necessary, and the result of a covered Injury. Treatment or confinement in a U.S. government hospital does not require a charge for benefits to be payable

Sickness: an illness, disease, infection, or any other abnormal physical condition, independent of Injury, occurring on or after the Effective Date of coverage and while coverage is in force

Injury: a bodily injury caused directly by an accident, independent of Sickness, disease, bodily infirmity, or any other cause, occurring on or after the Effective Date of coverage and while coverage is in force. See the Limitations and Exclusions section for Injuries not covered by the policy.

Accidental Death: death caused by a covered Injury.

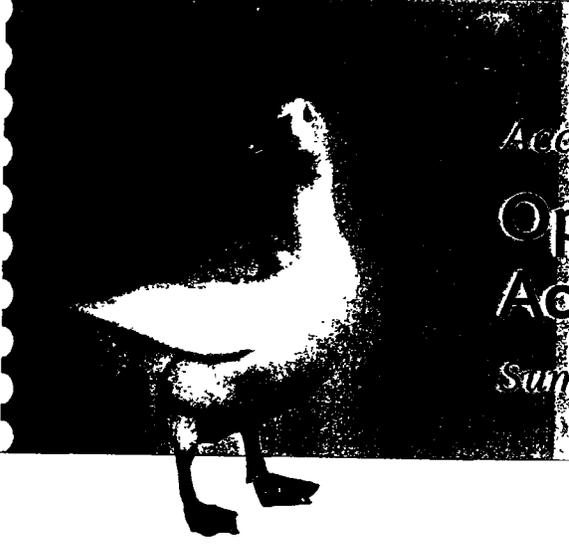
Common-Carrier Accident: an accident, occurring on or after the Effective Date of coverage and while coverage is in force, directly involving a common-carrier vehicle in which a Covered Person is a passenger at the time of the accident. A common-carrier vehicle is limited to only an airplane, train, bus, trolley, or boat that is duly licensed by a proper authority to transport persons for a fee, holds itself out as a public conveyance, and is operating on a posted regularly scheduled basis between predetermined points or cities at the time of the accident. A *passenger* is a person aboard or riding in a common-carrier vehicle other than (1) a pilot, driver, operator, officer, or member of the crew of such vehicle; (2) a person having any duties aboard such vehicle; or (3) a person giving or receiving any kind of training or instruction. A Common-Carrier Accident does not include any Hazardous Activity Accident or any accident directly involving private, on demand, or chartered transportation in which a Covered Person is a passenger at the time of the accident.

Hazardous Activity Accident: an accident that occurs on or after the Effective Date of coverage, while coverage is in force, and while a Covered Person is participating in sky diving, scuba diving, hang gliding, motorized vehicle racing, cave exploration, bungee jumping, parachuting, or mountain or rock climbing, or while a Covered Person is a pilot, an officer, or a member of the crew of an aircraft and has any duties aboard an aircraft, or while giving or receiving any kind of training or instruction aboard an aircraft. A Hazardous Activity Accident does not include any Common-Carrier Accidents

Other Accident: an accident occurring on or after the Effective Date of coverage and while coverage is in force that is not classified as either a Common-Carrier Accident or a Hazardous Activity Accident and that is not specifically excluded in the Limitations and Exclusions section.



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Accident Indemnity AdvantageSM

Optional Additional Accidental-Death Benefit Rider

Summary Page - Policy Rider Series A35000

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

What We Will Pay

Accidental-Death Benefit

Aflac will pay the applicable lump sum benefit indicated below for your Accidental Death. Accidental Death must occur as a result of an Injury sustained in a covered accident and must occur within 90 days of such accident.

	Insured	Spouse	Child
Common-Carrier Accident	\$35,000	\$35,000	\$7,000
Other Accident	35,000	35,000	7,000

In the event of the Accidental Death of a covered Spouse or Dependent Child, Aflac will pay you the applicable lump sum benefit indicated above. If you are disqualified from receiving the benefit by operation of law, then the benefit will be paid to the deceased Covered Person's estate unless Aflac has paid the benefit before receiving notice of your disqualification

In the event of your Accidental Death, Aflac will pay the applicable lump sum benefit indicated above for your Accidental Death to the beneficiary named in the application for the policy unless you subsequently change your beneficiary. If you change your beneficiary, then Aflac will pay this benefit to the beneficiary named in your last change of beneficiary request of record. Please see the rider for additional information regarding beneficiaries.

Note: We do not recommend that you name a minor child as your beneficiary. If you name a minor child as your beneficiary, any benefits due your minor beneficiary will not be payable until a guardian for the financial estate of the minor is appointed by the court or such beneficiary reaches the age of majority as defined by your state. If there is no beneficiary, Aflac will pay any applicable benefit to your estate.

Termination

The rider will terminate upon the earlier of the termination of the policy to which it is attached, your failure to pay the premiums for the rider, or your death.

Effective Date

The Effective Date of the rider is stated in the Policy Schedule.

What Is Not Covered

Aflac will not pay benefits under the rider for an Accidental Death that is caused by or occurs as a result of a Hazardous Activity Accident.

Refer to the policy for additional limitations and exclusions.

The rider to which this sales material pertains is written only in English; the rider prevails if interpretation of this material varies.

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



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Accident Indemnity AdvantageSM

Optional Off-the-Job Accident Disability Benefit Rider

Summary Page - Policy Rider Series A35000

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

Choose the Coverage You Need

Aflac's Accident Indemnity Advantage Off-the-Job Accident Disability Benefit Rider allows you to choose a level of coverage that best meets your individual financial needs.

- **Monthly Benefits:** From \$100 to \$2,000, subject to income requirements
- **Benefit Periods:** 6 or 12 months
- **Elimination Periods:** 0 or 7 days

What We Will Pay

Disability must begin within 90 days of your last treatment for the covered Off-the-Job Injury. Benefits are payable up to the benefit period selected and are subject to the elimination period shown in the Policy Schedule. *A Full-Time Job is your primary job at which you work 19 or more hours per week for pay or benefits*

Total Disability Benefit (ages 18 through 69): If you are working at a Full-Time Job while coverage is in force and a covered Off-the-Job Injury causes you to become totally disabled, we will pay you one-thirtieth of the monthly disability benefit shown in the Policy Schedule for each day of your disability or your successive periods of disability.

Total Disability is defined as being under the care and attendance of a physician due to a covered Off-the-Job Injury that causes you to be unable to perform the material and substantial duties of your Full-Time Job, and not working at any job. You will no longer be qualified to receive this benefit upon the earlier of your:

1. Being released by your physician to perform the material and substantial duties of your Full-Time Job or
2. Working at any job

Partial Disability Benefit (ages 18 through 69): If you are working at a Full-Time Job while coverage is in force and a covered Off-the-Job Injury causes you to be partially disabled, we will pay you one-thirtieth of the monthly disability benefit shown in the Policy Schedule for each day of your disability or your successive periods of disability.

Partial Disability is defined as being under the care and attendance of a physician due to a covered Off-the-Job Injury that causes you to be unable to perform the material and substantial duties of your Full-Time Job, but able to work at any job earning less than 80 percent of your Full-Time Job's Base Pay Earnings at the time you became disabled. You will no longer be qualified to receive this benefit upon the earlier of your

1. Being released by your physician to perform the material and substantial duties of your Full-Time Job or
2. Working at any job earning 80 percent or more of your Full-Time Job's predisability Base Pay Earnings at the time you became disabled.

Disability Benefit (without a Full-Time Job or at age 70 and above): If you do not have a Full-Time Job at the time of your Off-the-Job Injury, or if you are age 70 or above, we will insure you as follows while coverage is in force: If you require Hospital Confinement within 90 days of your last treatment for your covered Off-the-Job Injury, we will pay you one-thirtieth of the monthly disability benefit shown in the Policy Schedule multiplied by three for each day you are confined

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

American Family Life Assurance Company of Columbus (Aflac)

Provisions of Coverage

Disability benefits are available for ages 18 through 69 or for age 70 and above. If you have any other disability benefit in force with Aflac, only one disability benefit is payable.

Benefits will be paid for only one disability at a time, even if the disability is caused by more than one Injury. We reserve the right to meet with you during the pendency of a claim or to use an independent consultant and physician's statement to determine whether you are qualified to receive disability benefits. You must be under the care and attendance of a physician for these benefits to be payable. Benefits will cease on the date of your death.

The term *Base Pay Earnings* means your gross salary or wages for your Full-Time Job. This does not include variable pay such as overtime (unless contractual), bonuses, or other incentives. If you are self-employed, the term *Base Pay Earnings* means your business's gross income minus the allowable business deductions from that business. (For tax purposes, *Base Pay Earnings* is referred to as *net earnings*.)

Successive periods of disability, if caused by the same or a related condition and not separated by 180 days or more, are considered a continuation of the prior disability. Once the maximum benefit period has been paid, you will not be eligible for a new benefit period or any disability benefits due to the same or a related condition, unless you have been released by a physician from the prior disability and are no longer qualified to receive disability benefits for a period of 180 days. Separate periods of disability resulting from unrelated causes are considered a continuation of the prior disability unless they are separated by your returning to work at a Full-Time Job for 14 working days, during which you are performing the material and substantial duties of such job and are no longer qualified to receive disability benefits. Periods of disability meeting either of these separation requirements will begin a new benefit period, subject to a new elimination period.

Pre-Existing Condition Limitations

A *Pre-Existing Condition* is an Injury for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Disability or hospitalization caused by a Pre-Existing Condition or reinjuries to a Pre-Existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.

Termination

The rider will terminate upon the earlier of the termination of the policy to which it is attached, your failure to pay the premiums for the rider, or your death.

Effective Date

The Effective Date of the rider is stated in the Policy Schedule.

What Is Not Covered

- Aflac will not pay benefits for a disability that is being treated outside the territorial limits of the United States.
- Aflac will not pay benefits for an accident that occurs while you are working at any job for pay or benefits.
- Aflac will not pay benefits for any Sickness.

Refer to your policy for additional limitations and exclusions.

Coverage is provided for Off-the-Job Injuries only. The rider does not apply to the Spouse or dependents. An *Off-the-Job Injury* is an Injury that occurs while you are not working at any job for pay or benefits.

The rider to which this sales material pertains is written only in English; the rider prevails if interpretation of this material varies.



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Accident Indemnity AdvantageSM

Optional Sickness Disability Benefit Rider

Summary Page - Policy Rider Series A35000

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

Choose the Coverage You Need

Aflac's Accident Indemnity Advantage Sickness Disability Benefit Rider allows you to choose a level of coverage that best meets your individual financial needs.

- **Monthly Benefits:** From \$100 to \$2,000, subject to income requirements
- **Benefit Periods:** 6 or 12 months
- **Elimination Period:** 14 days

What We Will Pay

Disability must begin within 90 days of your last treatment for the covered Sickness. Benefits are payable up to the benefit period selected and are subject to the elimination period shown in the Policy Schedule. *A Full-Time Job is your primary job at which you work 19 or more hours per week for pay or benefits*

Total Disability Benefit (ages 18 through 69): If you are working at a Full-Time Job while coverage is in force and a covered Sickness causes you to become totally disabled, we will pay you one-thirtieth of the monthly disability benefit shown in the Policy Schedule for each day of your disability or your successive periods of disability.

Total Disability is defined as being under the care and attendance of a physician due to a covered Sickness that causes you to be unable to perform the material and substantial duties of your Full-Time Job, and not working at any job. You will no longer be qualified to receive this benefit upon the earlier of your:

1. Being released by your physician to perform the material and substantial duties of your Full-Time Job or
2. Working at any job

Partial Disability Benefit (ages 18 through 69): If you are working at a Full-Time Job while coverage is in force and a covered Sickness causes you to be partially disabled, we will pay you one-thirtieth of the monthly disability benefit shown in the Policy Schedule for each day of your disability or your successive periods of disability.

Partial Disability is defined as being under the care and attendance of a physician due to a covered Sickness that causes you to be unable to perform the material and substantial duties of your Full-Time Job, but able to work at any job earning less than 80 percent of your Full-Time Job's Base Pay Earnings at the time you became disabled. You will no longer be qualified to receive this benefit upon the earlier of your:

1. Being released by your physician to perform the material and substantial duties of your Full-Time Job or
2. Working at any job earning 80 percent or more of your Full-Time Job's predisability Base Pay Earnings at the time you became disabled.

Disability Benefit (without a Full-Time Job or at age 70 and above): If you do not have a Full-Time Job at the time of your Sickness, or if you are age 70 or above, we will insure you as follows while coverage is in force. If you require Hospital Confinement within 90 days of your last treatment for your covered Sickness, we will pay you one-thirtieth of the monthly disability benefit shown in the Policy Schedule multiplied by three for each day you are confined

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

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Provisions of Coverage

Disability benefits are available for ages 18 through 69 or for age 70 and above. If you have any other disability benefit in force with Aflac, only one disability benefit is payable.

Benefits will be paid for only one disability at a time, even if the disability is caused by more than one Sickness. We reserve the right to meet with you during the pendency of a claim or to use an independent consultant and physician's statement to determine whether you are qualified to receive disability benefits. You must be under the care and attendance of a physician for these benefits to be payable. Benefits will cease on the date of your death.

Disability due to pregnancy and childbirth is payable to the same extent as a covered Sickness. Disability benefits for childbirth will be payable only after the rider has been in force ten months. The maximum benefit period allowed for childbirth is six weeks for noncesarean delivery and eight weeks for cesarean delivery, less the elimination period, unless you furnish proof that your disability continues beyond these time frames.

The term *Base Pay Earnings* means your gross salary or wages for your Full-Time Job. This does not include variable pay such as overtime (unless contractual), bonuses, or other incentives. If you are self-employed, the term *Base Pay Earnings* means your business's gross income minus the allowable business deductions from that business. (For tax purposes, *Base Pay Earnings* is referred to as *net earnings*.)

Successive periods of disability, if caused by the same or a related condition and not separated by 180 days or more, are considered a continuation of the prior disability. Once the maximum benefit period has been paid, you will not be eligible for a new benefit period or any disability benefits due to the same or a related condition, unless you have been released by a physician from the prior disability and are no longer qualified to receive disability benefits for a period of 180 days. Separate periods of disability resulting from unrelated causes are considered a continuation of the prior disability unless they are separated by your returning to work at a Full-Time Job for 14 working days, during which you are performing the material and substantial duties of such job and are no longer qualified to receive disability benefits. Periods of disability meeting either of these separation requirements will begin a new benefit period, subject to a new elimination period.

Pre-Existing Condition Limitations

A *Pre-Existing Condition* is an illness, disease, infection, condition, or disorder for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Disability or hospitalization caused by a Pre-Existing Condition, including deliveries for children conceived prior to the Effective Date of coverage, will not be covered unless it begins more than 12 months after the Effective Date of coverage.

Termination

The rider will terminate upon the earlier of the termination of the policy to which it is attached, your failure to pay the premiums for the rider, or your death.

Effective Date

The Effective Date of the rider is stated in the Policy Schedule.

What Is Not Covered

The limitations and exclusions listed in the policy do not apply to the rider unless they are listed below.

Aflac will not pay benefits for services rendered by a member of the immediate family of a Covered Person.

Aflac will not pay benefits whenever coverage provided by the rider is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.

Aflac will not pay benefits for a disability that is being treated outside the territorial limits of the United States.

Aflac will not pay benefits for a disability that is caused by or occurs as a result of any bacterial, viral, or micro-organism infection or infestation, or any condition resulting from insect, arachnid, or other arthropod bites or stings as a "disability due to an Injury"; such disability will be covered to the same extent as a "disability due to Sickness."

Aflac will not pay benefits for a disability that is caused by or occurs as a result of your:

- Mental or emotional disorders, including but not limited to the following: bipolar affective disorder (manic-depressive syndrome), delusional (paranoid) disorders, psychotic disorders, somatoform disorders (psychosomatic illness), eating disorders, schizophrenia, anxiety disorders, depression, stress, or post-partum depression. The rider will pay, however, for covered disabilities resulting from Alzheimer's disease, or similar forms of senility or senile dementia, first manifested while coverage is in force;
- Pregnancy or childbirth within the first ten months of the Effective Date of coverage (complications of pregnancy will be covered to the same extent as a Sickness); or
- Donating an organ within the first 12 months of the Effective Date of the rider.

Complications of pregnancy do not include premature delivery without incidence, multiple gestation pregnancy, false labor, occasional spotting, prescribed rest during pregnancy, morning sickness, and similar conditions associated with the management of a difficult pregnancy not constituting a classifiably distinct complication of pregnancy. Elective cesarean deliveries are not considered complications of pregnancy.

Coverage is provided for Sickness only. The rider does not apply to the Spouse or dependents.

The rider to which this sales material pertains is written only in English; the rider prevails if interpretation of this material varies.





Accident Indemnity AdvantageSM

Optional Spouse Off-the-Job Accident Disability Benefit Rider

Summary Page - Policy Rider Series A35000

Riders are part of the policy and are subject to all policy provisions unless otherwise stated. In the rider, you, the Spouse, will be referred to as *you, your, or yours*.

Choose the Coverage You Need

Aflac's Accident Indemnity Advantage Spouse Off-the-Job Accident Disability Benefit Rider allows you to choose a level of coverage that best meets your individual financial needs.

- **Monthly Benefits:** From \$100 to \$700, subject to a minimum income requirement
- **Benefit Period:** 6 months
- **Elimination Period:** None

What We Will Pay

Disability must begin within 90 days of your last treatment for the covered Off-the-Job Injury. This benefit is payable up to the six-month benefit period shown in the Policy Schedule. *A Full-Time Job is your primary job at which you work 19 or more hours per week for pay or benefits*

Total Disability Benefit (ages 18 through 69): If you are working at a Full-Time Job while coverage is in force and a covered Off-the-Job Injury causes you to become totally disabled, we will pay you one-thirtieth of the monthly disability benefit shown in the Policy Schedule for each day of your disability or your successive periods of disability.

Total Disability is defined as being under the care and attendance of a physician due to a covered Off-the-Job Injury that causes you to be unable to perform the material and substantial duties of your Full-Time Job, and not working at any job. You will no longer be qualified to receive this benefit upon the earlier of your:

1. Being released by your physician to perform the material and substantial duties of your Full-Time Job or
2. Working at any job.

Partial Disability Benefit (ages 18 through 69): If you are working at a Full-Time Job while coverage is in force and a covered Off-the-Job Injury causes you to be partially disabled, we will pay you one-thirtieth of the monthly disability benefit shown in the Policy Schedule for each day of your disability or your successive periods of disability.

Partial Disability is defined as being under the care and attendance of a physician due to a covered Off-the-Job Injury that causes you to be unable to perform the material and substantial duties of your Full-Time Job, but able to work at any job earning less than 80 percent of your Full-Time Job's Base Pay Earnings at the time you became disabled. You will no longer be qualified to receive this benefit upon the earlier of your

1. Being released by your physician to perform the material and substantial duties of your Full-Time Job or
2. Working at any job earning 80 percent or more of your Full-Time Job's predisability Base Pay Earnings at the time you became disabled.

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

American Family Life Assurance Company of Columbus (Aflac)

Disability Benefit (without a Full-Time Job or at age 70 and above): If you do not have a Full-Time Job at the time of your Off-the-Job Injury or if you are age 70 or above, we will insure you as follows while coverage is in force: If you require Hospital Confinement within 90 days of your last treatment for your covered Off-the-Job Injury, we will pay you one-thirtieth of the monthly disability benefit shown in the Policy Schedule multiplied by three for each day you are confined

Provisions of Coverage

Disability benefits are available for ages 18 through 69 or for age 70 and above. If you have any other disability benefit in force with Aflac, only one disability benefit is payable.

Benefits will be paid for only one disability at a time, even if the disability is caused by more than one Injury. We reserve the right to meet with you during the pendency of a claim or to use an independent consultant and physician's statement to determine whether you are qualified to receive disability benefits. You must be under the care and attendance of a physician for these benefits to be payable. Benefits will cease on the date of your death

The term *Base Pay Earnings* means your gross salary or wages for your Full-Time Job. This does not include variable pay such as overtime (unless contractual), bonuses, or other incentives. If you are self-employed, the term *Base Pay Earnings* means your business's gross income minus the allowable business deductions from that business. (For tax purposes, *Base Pay Earnings* is referred to as *net earnings*.)

Successive periods of disability, if caused by the same or a related condition and not separated by 180 days or more, are considered a continuation of the prior disability. Once the maximum benefit period has been paid, you will not be eligible for a new benefit period or any disability benefits due to the same or a related condition, unless you have been released by a physician from the prior disability and are no longer qualified to receive disability benefits for a period of 180 days. Separate periods of disability resulting from unrelated causes are considered a continuation of the prior disability unless they are separated by your returning to work at a Full-Time Job for 14 working days, during which you are performing the material and substantial duties of such job and are no longer qualified to receive disability benefits. Periods of disability meeting either of these separation requirements will begin a new benefit period, subject to a new elimination period

Pre-Existing Condition Limitations

A *Pre-Existing Condition* is an Injury for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Disability or hospitalization caused by a Pre-Existing Condition or reinjuries to a Pre-Existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage

Termination

The rider will terminate upon the earlier of the termination of the policy to which it is attached, your failure to pay the premiums for the rider, or your death.

Effective Date

The Effective Date of the rider is stated in the Policy Schedule.

What Is Not Covered

- Aflac will not pay benefits for a disability that is being treated outside the territorial limits of the United States
- Aflac will not pay benefits for an accident that occurs while you are working at any job for pay or benefits
- Aflac will not pay benefits for any Sickness

Refer to your policy for additional limitations and exclusions.

Coverage is provided for Off-the-Job Injuries for the Spouse only. The rider does not apply to the named insured or dependents. An *Off-the-Job Injury* is an Injury that occurs while you are not working at any job for pay or benefits.

The rider to which this sales material pertains is written only in English; the rider prevails if interpretation of this material varies.



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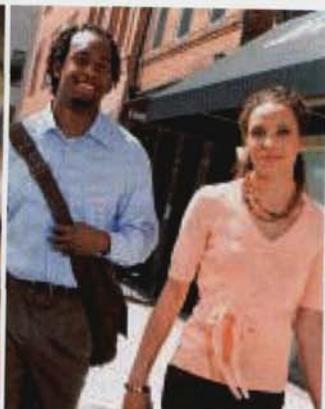
Maximum DifferenceSM

*Limited Benefit
Cancer Indemnity Insurance*

Policy Series A76000

American Family Life Assurance Company of Columbus (Aflac)





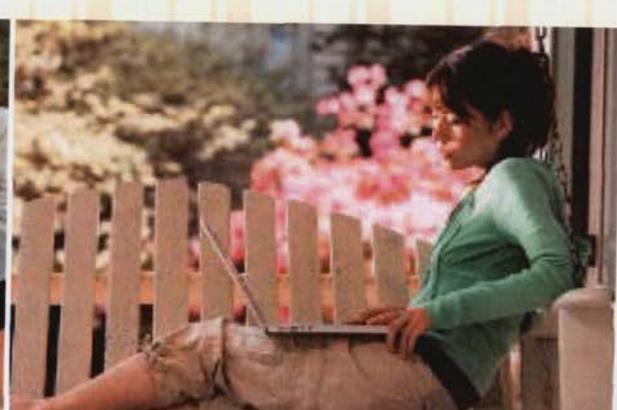
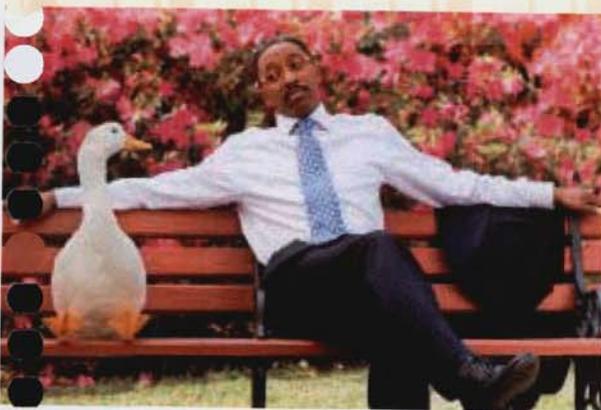
As long as cancer is in this world, Aflac will innovate to fight it.

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

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

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

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



Quick-Reference Chart of Benefits Information

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

BENEFIT	BENEFIT AMOUNT	LIFETIME MAX/INSURED	ADDITIONAL BENEFIT INFORMATION
DIRECT NONSURGICAL TREATMENT BENEFITS			

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

Initial Treatment	\$3,000	\$3,000	Payable the first time Radiation Therapy, Injected Chemotherapy, or Oral Chemotherapy Benefits are received.
Injected Chemotherapy	\$900 once per calendar week	None	Limited to the calendar week in which the charge for medication(s) or treatment is incurred.
Oral Chemotherapy	<p>Nonhormonal \$400 per medication, per calendar month</p> <p>Hormonal \$400 per medication, per calendar month up to 24 months</p> <p>\$100 per medication, per calendar month after 24 months of paid benefits of hormonal oral chemotherapy</p>	<p>None</p> <p>None</p>	Total benefits (nonhormonal and hormonal) are payable for up to 3 different medications per calendar month, up to a maximum of \$1,200 per calendar month. Oral Chemotherapy Benefits are limited to the calendar month in which the charge for the medication(s) or treatment is incurred. Refills within the same calendar month are not considered a different chemotherapy medicine. Examples of hormonal oral chemotherapy are Nolvadex, Arimidex, Femara, and Lupron or generic versions such as Tamoxifen.
Radiation Therapy	\$500 once per calendar week	None	Benefit is limited to the calendar week in which the charge for the therapy is incurred.
Experimental Treatment	\$500 once per calendar week if charge incurred; \$125 once per calendar week if no charge incurred for inclusion in a clinical trial	None	Benefit does not pay for laboratory tests, diagnostic X-rays, immunoglobulins, immunotherapy, colony-stimulating factors, and therapeutic devices or other procedures related to these experimental treatments. Benefit is limited to the calendar week in which the charge for the treatment is incurred, if there is a charge.

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

BENEFIT	BENEFIT AMOUNT	LIFETIME MAX/INSURED	ADDITIONAL BENEFIT INFORMATION
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INDIRECT/ADDITIONAL THERAPY BENEFITS

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

Immunotherapy	\$500 once per calendar month	\$2,500	Benefit is payable for an immunotherapy treatment regimen for Internal Cancer or an Associated Cancerous Condition. Not payable for medications paid under the Injected Chemotherapy, Oral Chemotherapy, Radiation Therapy, or Experimental Treatment Benefits.
Anti-Nausea	\$150 once per calendar month	None	Anti-nausea drugs must be prescribed while receiving Radiation Therapy Benefits, Injected or Oral Chemotherapy Benefits, or Experimental Treatment Benefits.
Stem Cell Transplantation	\$10,000	\$10,000	Payable for a peripheral stem cell transplantation for the treatment of Internal Cancer or an Associated Cancerous Condition. Does not include bone marrow transplantations.
Bone Marrow Transplantation Covered Person Donor	\$10,000 \$ 1,000	\$10,000	Payable for a bone marrow transplantation for the treatment of Internal Cancer or an Associated Cancerous Condition. Donor benefit is payable to the Covered Person's bone marrow donor for expenses incurred as a result of the transplantation procedure. Does not include stem cell transplantations.
Blood and Plasma Inpatient Outpatient	\$150 times the number of days paid under the Hospital Confinement Benefit \$250 per day	None	Inpatient benefit is payable for blood and/or plasma transfusions during a covered Hospital confinement. Outpatient benefit is payable for blood and/or plasma transfusions for the treatment of Internal Cancer or an Associated Cancerous Condition as an outpatient in a Physician's office, clinic, Hospital, or Ambulatory Surgical Center. Does not pay for immunoglobulins, immunotherapy, antihemophilia factors, or colony-stimulating factors.

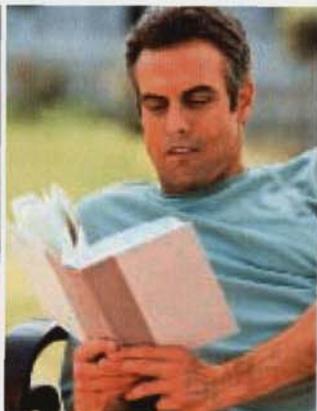
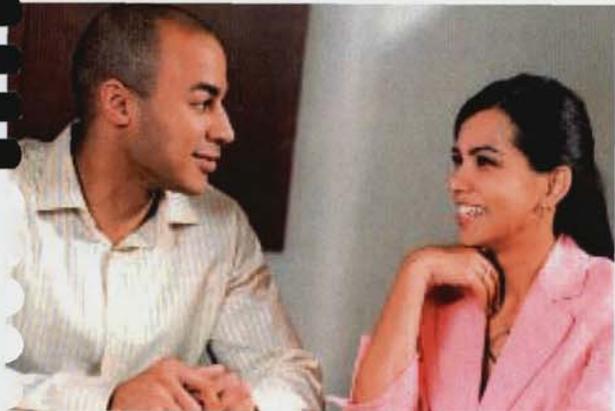
SURGICAL TREATMENT BENEFITS

Surgical/Anesthesia	\$140-\$5,000 (based on Schedule of Operations listed in the policy) 25% of the benefit amount shown in the Schedule of Operations will be paid for the administration of anesthesia during a covered surgical operation.	None	The maximum (Surgical/Anesthesia) daily benefit will not exceed \$6,250. Payable when a surgical operation is performed for a diagnosed Internal Cancer or an Associated Cancerous Condition. If any operation for the treatment of Internal Cancer or an Associated Cancerous Condition is performed other than those listed, Aflac will pay an amount comparable to the amount shown in the Schedule of Operations for the operation most nearly similar in severity and gravity. Two or more surgical procedures performed through the same incision will be considered one operation, and benefits will be paid based on the highest eligible benefit.
Skin Cancer Surgery	\$50-\$600	None	Payable when a surgical operation is performed for a diagnosed skin Cancer, including melanoma or Nonmelanoma Skin Cancer. The indemnity amount includes anesthesia services Maximum daily benefit: \$600.

BENEFIT	BENEF. AMOUNT	LIFETIME MAX/INSURED	ADDITIONAL BENEFIT INFORMATION
HOSPITALIZATION BENEFITS			
Hospital Confinement, Days 1-30 Named Insured/Spouse Dependent Child	\$300 per day \$375 per day	None	For hospitalization of 30 days or less, Aflac will pay benefits for each day a Covered Person is confined to a Hospital for treatment and is charged for a room as an inpatient. During any continuous period of Hospital confinement for 31 days or more, Aflac will pay benefits as described for the first 30 days. Beginning with the 31st day of such continuous Hospital confinement, benefits for Days 31+ will be payable for each day a Covered Person is charged for a room as an inpatient. No charge is required for confinement in a U.S. government Hospital.
Hospital Confinement, Days 31+ Named Insured/Spouse Dependent Child	\$600 per day \$750 per day	None	Payable when a surgical operation is performed for treatment of a diagnosed Internal Cancer or Associated Cancerous Condition. Benefit is not payable for any surgery performed in a Physician's office. Surgery must be performed on an outpatient basis in a Hospital or an Ambulatory Surgical Center. Benefit is payable once per day and is not payable on the same day as the Hospital Confinement Benefit. Benefit is payable in addition to the Surgical/Anesthesia Benefit. Benefit is also payable for Nonmelanoma Skin Cancer surgery involving a flap or graft. Maximum daily benefit: \$300.
Outpatient Hospital Surgical Room Charge	\$300 per day	None	Payable when a surgical operation is performed for treatment of a diagnosed Internal Cancer or Associated Cancerous Condition. Benefit is not payable for any surgery performed in a Physician's office. Surgery must be performed on an outpatient basis in a Hospital or an Ambulatory Surgical Center. Benefit is payable once per day and is not payable on the same day as the Hospital Confinement Benefit. Benefit is payable in addition to the Surgical/Anesthesia Benefit. Benefit is also payable for Nonmelanoma Skin Cancer surgery involving a flap or graft. Maximum daily benefit: \$300.
CONTINUING CARE BENEFITS			
Extended-Care Facility	\$150 per day	None	Payable when hospitalized and receives Hospital Confinement Benefits and is later confined, within 30 days of the covered Hospital confinement, to an Extended-Care Facility, a skilled nursing facility, a rehabilitation unit or facility, a transitional care unit or any bed designated as a swing bed, or to a section of the Hospital used as such (an <i>Extended-Care Facility</i>). For each day this benefit is payable, Hospital Confinement Benefits are NOT payable. If more than 30 days separates confinements in an Extended-Care Facility, benefits are not payable for the second confinement unless the Covered Person again receives Hospital Confinement Benefits and is confined as an inpatient to the Extended-Care Facility within 30 days of that confinement. Benefits are limited to 30 days per calendar year, per Covered Person.
Home Health Care	\$150 per visit (Limit of 10 visits per hospitalization and 30 visits per calendar year for each Covered Person)	None	Payable when hospitalized for the treatment of Internal Cancer or an Associated Cancerous Condition and then has either home health care or health supportive services provided by a licensed, certified, or duly qualified person, other than an immediate family member. Visits must begin within 7 days of release from the Hospital. Benefit will not be payable unless the attending Physician prescribes such services to be performed in the home of the Covered Person and certifies that if these services were not available, the Covered Person would have to be hospitalized to receive the necessary care, treatment, and services. Benefit is not payable the same day the Hospice Care Benefit is payable.

BENEFIT	BENEFIT AMOUNT	LIFETIME MAX/INSURED	ADDITIONAL BENEFIT INFORMATION
CONTINUING CARE BENEFITS			
Hospice Care		\$12,000	Payable when diagnosed with Internal Cancer or an Associated Cancerous Condition and therapeutic intervention directed toward the cure of the disease is medically determined to be no longer appropriate. Medical prognosis must be one in which there is a life expectancy of 6 months or less as the direct result of Internal Cancer or an Associated Cancerous Condition. Benefit is not payable the same day the Home Health Care Benefit is payable.
Day 1	\$1,000 (one-time benefit)		
Additional Days	\$50 per day		
Nursing Services	\$150 per day	None	Payable while confined in a Hospital and requiring full-time private care and attendance by private nurses (other than an immediate family member) for services other than those regularly furnished by the Hospital. Benefit is limited to the number of days the Hospital Confinement Benefit is payable.
Surgical Prosthesis	\$3,000	\$6,000	Surgically implanted prosthetic devices must be prescribed as a direct result of surgery for Internal Cancer or Associated Cancerous Condition treatment. Benefit does not include coverage for tissue expanders or a breast transverse rectus abdominis myocutaneous (TRAM) flap.
Prosthesis Nonsurgical	\$250 per occurrence	\$500	Up to two postoperative prosthetic devices (such as voice boxes, hairpieces, and removable breast prostheses) that are nonsurgically implanted.
Reconstructive Surgery	\$350-\$3,000 25% of the benefit amount will be paid for administration of anesthesia during a covered reconstructive surgical operation.	None	The specified indemnity listed in the policy is payable when a listed reconstructive surgical operation is performed. If any reconstructive surgery is performed other than those listed, Aflac will pay an amount comparable to the specified indemnity amount for the operation most nearly similar in severity and gravity. Maximum daily benefit: \$3,000.
AMBULANCE TRANSPORTATION AND LODGING BENEFITS			
Ambulance		None	Payable for ambulance transportation to or from a Hospital where confined overnight. Limited to 2 trips per confinement. The ambulance service must be performed by a licensed, professional ambulance company.
Ground	\$ 250		
Air	\$2,000		
Transportation	50 cents per mile, up to \$1,500	None	Payable for transportation of the Covered Person requiring treatment and a companion (if applicable), limited to the distance of miles between the Hospital or medical facility and the residence of the Covered Person. Benefit will pay for 2 adults if the Covered Person receiving treatment is a Dependent Child and commercial travel is necessary. Benefit is not payable for transportation to a facility located within a 50-mile radius of the Covered Person's residence. Does not cover transportation provided by ambulance.
Lodging	\$80 per day	None	Payable for lodging, in a room in a motel, hotel, or other commercial accommodation, for you or any one adult family member when a Covered Person receives treatment. Limited to 90 days per calendar year. Hospital or medical facility where treatment is received must be more than 50 miles from the Covered Person's residence. Benefit is not payable for lodging occurring more than 24 hours prior to treatment or more than 24 hours after treatment

Policy benefits continue on back panel



Understanding the Risk

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

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

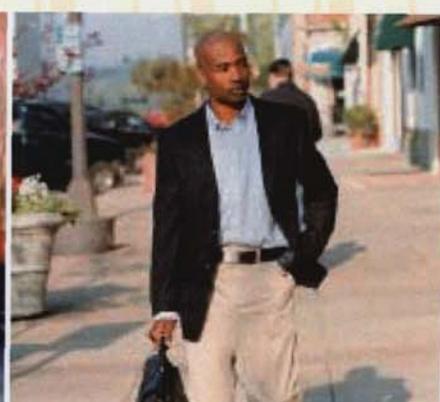
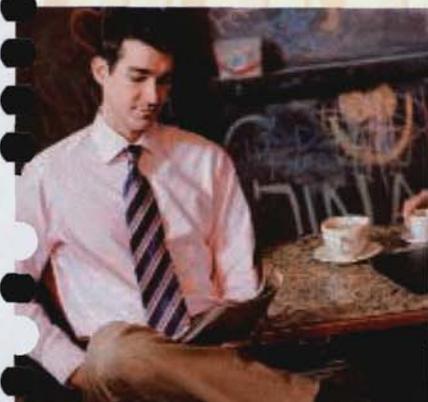
Advances in treatment also mean that Americans diagnosed with cancer are living longer than ever. The five-year relative survival rate for all cancers combined between 1996 and 2002 is 66%, up from 50% in 1975-77.*

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

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

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

**Cancer Facts and Figures 2007*



Waiver of Premium

If you, due to having Cancer or an Associated Cancerous Condition, are completely unable to perform all of the usual and customary duties of your occupation [or if not employed: are unable to perform 2 or more activities of daily living (ADLs) without the assistance of another person] for a period of 90 continuous days, Aflac will waive, from month to month, any premiums falling due during your continued inability. For premiums to be waived, Aflac will require an employer's statement (if applicable) and a Physician's statement of your inability to perform said duties or activities and may each month thereafter require a Physician's statement that total inability continues. Aflac may ask for and use an independent consultant to determine whether you can perform an ADL while this benefit is in force. Aflac will also waive, from month to month, any premiums falling due while you are receiving Hospice Benefits.

Continuation of Coverage

Aflac will waive all monthly premiums due for the policy and riders for 2 months if you meet all of the following conditions: your policy has been in force for at least 6 months; we have received premiums for at least 6 consecutive months; your premiums have been paid through payroll deduction; you or your employer has notified us in writing within 30 days of the date your premium payments ceased due to your leaving employment; and you re-establish premium payments with Aflac. You will again become eligible to receive this benefit after you re-establish your premium payments through payroll deduction for a period of at least 6 months, and we receive premiums for at least 6 consecutive months.

Limitations and Exclusions: We pay only for treatment of Cancer and Associated Cancerous Conditions diagnosed on or after the Effective Date of coverage, including direct extension, metastatic spread, or recurrence. Benefits are not provided for premalignant conditions or conditions with malignant potential (unless specifically covered); complications of either Cancer or an Associated Cancerous Condition; or any other disease, sickness, or incapacity.

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

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

Covered Person: A *Covered Person* is any person covered under individual (named insured listed in the Policy Schedule), named insured/Spouse only (named insured and Spouse), one-parent family (named insured and Dependent Children), or two-parent family (named insured, Spouse, and Dependent Children) coverage as applied for by you on the application. *Spouse* is defined as the person to whom you are legally married and who is listed on your application. Newborn children are automatically insured from the moment of birth. If coverage is for individual or named insured/Spouse only, and you desire uninterrupted coverage, you must notify Aflac in writing within 31 days of the birth of your child, and Aflac will convert the policy to one-parent family or two-parent family coverage and advise you of the additional premium due. Coverage will include any other unmarried Dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who became so incapacitated prior to age 25 and while covered under the policy. *Dependent Children* are your natural children, stepchildren, or legally adopted children who are unmarried, under age 25, and your dependents. **A Dependent Child (including persons incapable of self-sustaining employment by reason of mental retardation or physical handicap) must be under age 25 at the time of application to be eligible for coverage.**

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

1. *Internal Cancer* includes all Cancers other than Nonmelanoma Skin Cancer (see definition of Nonmelanoma Skin Cancer).

2. *Nonmelanoma Skin Cancer* is a Cancer other than a melanoma that begins in the upper part of the skin (epidermis).

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

Associated Cancerous Condition: An *Associated Cancerous Condition* is a myelodysplastic blood disorder, myeloproliferative blood disorder, or carcinoma in situ (in the natural or normal place, confined to the site of origin without having invaded neighboring tissue). An Associated Cancerous Condition must receive a positive medical diagnosis. **Premalignant conditions or conditions with malignant potential, other than those specifically named above, are not considered Associated Cancerous Conditions.**

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

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

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





OPTIONAL CANCER SCREENING AND ANNUAL CARE BENEFIT RIDER SUMMARY PAGE (Rider A76051)

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

Cancer Vaccine Benefit

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

Cancer Wellness Benefit

\$50 \$75 \$100 \$125

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

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

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

Bone Marrow Donor Screening Benefit

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

Annual Care Benefit

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

Termination

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

Effective Date

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

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



**OPTIONAL INITIAL DIAGNOSIS BENEFIT RIDER SUMMARY PAGE
(Rider A76050AZ)**

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

Initial Diagnosis Benefit

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

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

Initial Diagnosis Building Benefit

Aflac will increase the Initial Diagnosis Benefit by \$500 on each rider anniversary date. This benefit is payable under the same terms as the Initial Diagnosis Benefit. This benefit will cease to build for each Covered Person on the anniversary date of the rider following the Covered Person's 65th birthday or at the time Internal Cancer or an Associated Cancerous Condition is diagnosed for that Covered Person, whichever occurs first. Regardless of the age of the Covered Person on the Effective Date of the rider, the benefit will accrue for a period of at least five years unless Internal Cancer or an Associated Cancerous Condition is diagnosed prior to the fifth year of coverage.

National Cancer Institute (NCI) Evaluation/Consultation Benefit

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

Additional Surgical Opinion Benefit

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

Medical Imaging With Diagnosis Benefit

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

Limitations and Exclusions

The Initial Diagnosis Benefit and Initial Diagnosis Building Benefit of the rider are not payable for any Internal Cancer or Associated Cancerous Condition diagnosed or treated before the Effective Date of the rider and the subsequent recurrence, extension, or metastatic spread of such Cancer or Associated Cancerous Condition, or the diagnosis of Nonmelanoma Skin Cancer. Any Covered Person who has had a previous diagnosis of Internal Cancer or an Associated Cancerous Condition will NOT be eligible for an Initial Diagnosis Benefit or an Initial Diagnosis Building Benefit under the rider for a recurrence, extension, or metastatic spread of that same Internal Cancer or Associated Cancerous Condition.

Termination

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

Effective Date

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

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



**OPTIONAL SPECIFIED-DISEASE BENEFIT RIDER SUMMARY PAGE
(Rider A76052AZ)**

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

Specified-Disease Initial Benefit

Aflac will pay \$1,000 while coverage is in force if a Covered Person is first diagnosed with any of the covered Specified Diseases after the Effective Date of the rider. This benefit is payable only once per covered disease, per Covered Person. No other benefits are payable for any covered Specified Disease not provided for in the rider.

Hospital Confinement Benefits

Aflac will pay \$200 per day when a Covered Person is confined to a Hospital for 30 days or less for a covered Specified Disease. During any continuous period of Hospital confinement of 31 days or more for a covered Specified Disease, **Aflac will pay \$500 per day**, beginning on the 31st day of confinement.

Definition of Covered Diseases

Specified Disease means one or more of the diseases listed below:

- Adrenal hypofunction (Addison's disease)
- Amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease)
- Botulism
- Bubonic plague
- Cerebral palsy
- Cholera
- Cystic fibrosis
- Diphtheria
- Encephalitis (including encephalitis contracted from West Nile virus)
- Huntington's chorea
- Malaria
- Meningitis (bacterial)
- Multiple sclerosis
- Muscular dystrophy
- Myasthenia gravis
- Necrotizing fasciitis
- Osteomyelitis
- Polio
- Rabies
- Reye's syndrome
- Scleroderma
- Sickle cell anemia
- Systemic lupus
- Tetanus
- Toxic shock syndrome
- Tuberculosis
- Tularemia
- Typhoid fever
- Variant Creutzfeldt-Jakob disease (mad cow disease)
- Yellow fever

For benefits to be paid, these diseases must be first diagnosed by a Physician on or after the Effective Date of the rider. The diagnosis must be made by and upon a tissue specimen, culture, and/or titer.

Termination

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

Effective Date

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

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



We've got you under our wing.

Rates

Accident Indemnity Advantage Premiums

All rates are for illustration purposes only.

Essentials Plan Ages 18-70 B Industry Rating	
Coverage Type	Monthly Premiums
Individual	\$16.64
Insured/Spouse	\$22.36
One-Parent Family	\$25.22
Two-Parent Family	\$31.72

Monthly Premiums for Optional Riders

Rates Shown are for Two Units (\$200) of Monthly Benefits

Off-the-Job Accident Disability Rider B Industry Rating Benefits are for Primary Insured Only Ages 18-64 Minimum: 1 Unit (\$100)/ Maximum 20 Units (\$2,000)			
6-Month Benefit Period		12-Month Benefit Period	
0-Day Elimination Period	7-Day Elimination Period	0-Day Elimination Period	7-Day Elimination Period
\$1.04	\$0.91	\$1.17	\$1.04



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<p>Sickness Disability Rider</p> <p>B Industry Rating</p> <p>Benefits are for Primary Insured Only</p> <p>Ages 18-64</p> <p>Minimum: 1 Unit (\$100)/ Maximum 20 Units (\$2,000)</p>			
6-Month Benefit Period		12-Month Benefit Period	
14-Day Elimination		14-Day Elimination	
Ages 18-49	Ages 50-64	Ages 18-49	Ages 50-64
\$1.95	\$2.86	\$2.34	\$3.64

<p>Spouse Off-the-Job Disability Rider</p> <p>B Industry Rating</p> <p>Ages 18-64</p> <p>Minimum: 1 Unit (\$100)/ Maximum 7 Units (\$700)</p>	
<p>6-Month Benefit Period</p> <p>0-Day Elimination</p>	
\$1.17	

<p>Accidental Death Rider, Ages 18-70</p> <p>Premiums are for Industry Codes A, B, C, E</p>	
Coverage Type	Monthly Premiums
Individual	\$4.29
Insured/Spouse	\$5.98
One-Parent Family	\$4.81
Two-Parent Family	\$6.76



We've got you under our wing.

Maximum Difference Cancer Indemnity Premiums

☞ All rates are for illustration purposes only ☞

Maximum Difference Base Plan:		
Age	Coverage Type	Monthly Premium
18-35	Individual and One-Parent Family	\$16.12
	Insured/Spouse and Two-Parent Family	\$29.90
36-45	Individual and One-Parent Family	\$23.40
	Insured/Spouse and Two-Parent Family	\$42.12
46-55	Individual and One-Parent Family	\$33.02
	Insured/Spouse and Two-Parent Family	\$61.75
56-70	Individual and One-Parent Family	\$43.55
	Insured/Spouse and Two-Parent Family	\$85.67
Maximum Difference Initial Diagnosis Benefit Rider w/\$2,500 benefit:		
Age	Coverage Type	Monthly Premium
18-35	Individual and One-Parent Family	\$5.46
	Insured/Spouse and Two-Parent Family	\$13.52
36-45	Individual and One-Parent Family	\$8.71
	Insured/Spouse and Two-Parent Family	\$19.24
46-55	Individual and One-Parent Family	\$11.18
	Insured/Spouse and Two-Parent Family	\$24.18
56-70	Individual and One-Parent Family	\$11.83
	Insured/Spouse and Two-Parent Family	\$24.70



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Maximum Difference Initial Diagnosis Benefit Rider w/\$5,000 benefit:		
Age	Coverage Type	Monthly Premium
18-35	Individual and One-Parent Family	\$6.89
	Insured/Spouse and Two-Parent Family	\$16.90
36-45	Individual and One-Parent Family	\$11.31
	Insured/Spouse and Two-Parent Family	\$24.44
46-55	Individual and One-Parent Family	\$15.21
	Insured/Spouse and Two-Parent Family	\$32.24
56-70	Individual and One-Parent Family	\$17.42
	Insured/Spouse and Two-Parent Family	\$35.75
Premiums – Maximum Difference Annual Care/Wellness Rider w/\$75 Benefit:		
Age	Coverage Type	Monthly Premium
18-35	Individual and One-Parent Family	\$6.63
	Insured/Spouse and Two-Parent Family	\$10.53
36-45	Individual and One-Parent Family	\$8.06
	Insured/Spouse and Two-Parent Family	\$12.35
46-55	Individual and One-Parent Family	\$9.36
	Insured/Spouse and Two-Parent Family	\$14.69
56-70	Individual and One-Parent Family	\$10.27
	Insured/Spouse and Two-Parent Family	\$16.51

The monthly premiums for Aflac's Specified Disease Rider for ages 18-70 are:

- Individual/One Parent Family \$1.30
- Insured and Spouse/Two-Parent Family \$1.95



CONTRACT AMENDMENT

Materials Management Procurement

9875 N. 85th Ave., 2nd Fl.
Peoria, AZ 85345
Telephone: (623) 773-7115
Fax: (623) 773-7118

Solicitation No: P09-0074 Page 1 of 1
Description: Flexible Spending Account (FSA)
Amendment No: One (1) Date: 9/27/2010

Buyer: Lisa Houg

In accordance with Special Terms and Conditions, Contract Extension, the above referenced contract shall expire on 12/31/10.

THE NEW CONTRACT TERM: 01/01/11 to 12/31/11

Contractor hereby acknowledges receipt and agreement. A signed copy shall be filed with the City of Peoria, Materials Management Division.

Jeff Arrington, Second
Vice President of Finance
and Accounting

Aflac

[Signature]
Signature

Date

Typed Name and Title

Company Name

1932 Wynnton Rd.

Columbus

GA

31999

Address

City

State

Zip Code

Attested by:

[Signature]
for City Clerk

[Signature]
Director, Wynette Reed, Human Resources Director

[Signature] 8/11/10
Dept. Rep: Nancy Fantasia, Benefits Administrator



CC Number

ACON48009A

Contract Number:

Official File

[Signature]
Approved as to Form: Stephen M. Kemp, City Attorney

The above referenced Contract Amendment is hereby Executed
[Signature] 20, 2010, at Peoria, Arizona.

[Signature]
Herman F. Koebergen, Materials Manager

City Seal

A CON 48009A



CONTRACT AMENDMENT

Materials Management Procurement

9875 N. 85th Ave., 2nd Fl.
Peoria, AZ 85345
Telephone: (623) 773-7115
Fax: (623) 773-7118

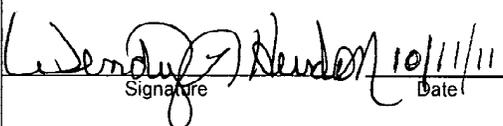
Solicitation No: P09-0074 Page 1 of 1
Description: Flexible Spending Account (FSA)
Amendment No: Two (2) Date: 9/26/2011

Buyer: Lisa Houg

In accordance with Special Terms and Conditions, Contract Extension, the above referenced contract shall expire on 12/31/2011.

THE NEW CONTRACT TERM IS: 1/1/2012 to 12/31/2012.

Contractor hereby acknowledges receipt and agreement. A signed copy shall be filed with the City of Peoria, Materials Management Division.

		Wendy Herndon, Second VP Product Development and Implementation		Aflac	
Date: 10/11/11		Typed Name and Title		Company Name	
1932 Wynnton Rd.		Columbus		GA 31999	
Address		City		State Zip Code	

Attested by: 

City Clerk

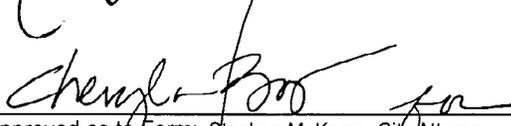


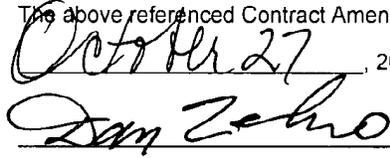
CC Number
ACON48009B
Contract Number:
Official File

City Seal


Director: Wynette Reed, Human Resources Director


Dept. Rep: Nancy Fantasia, Benefits Administrator


Approved as to Form: Stephen M. Kemp, City Attorney

The above referenced Contract Amendment is hereby Executed

October 27, 2011, at Peoria, Arizona.
Dan Zenko, Materials Management Supervisor