

Foundations...Benefits to Fit Your Life



Derrick has a family of four active children. Elaine is healthy, single and right out of college. Patty is in her fifties with diabetes...

Everyone has different healthcare needs. Each year you have the opportunity to elect the benefits that meet your changing needs. We provide you with a foundation - a competitive, solid benefits program that is flexible to meet your needs. It's up to you to **Explore** your options, **Choose** what's best for you and **Live** with the **Choice** that will help you make the most of your benefits program.

A solid benefits program that offers you flexible & competitive coverage.

Foundations

Flexible, customizable & comprehensive – designed to meet diverse and unique needs. You create a benefits package that works for your situation.

This Enrollment Guide is intended as a summary of the 2007 benefit plans available to you. In the event that any information is in conflict with the vendor contract or the policy, the contract or policy language will prevail. The employers intend to provide these programs on an ongoing basis; however, they reserve the right to amend or terminate any program at any time .

Your Enrollment To-Do List:

- Explore your enrollment materials, including this Guide, your price sheet, enrollment form and the additional information located in the front pocket.
- Check Out your enrollment resources, websites and other tools available to help you make a decision
- Study the information regarding the plans to determine what options can work for you and your family.
- Compare the total cost of each plan for you and your family by using the Medical Plan Decision Toolkit available at www.farmcredithealthcarehub.com.
- Choose your benefits and return your completed enrollment form.

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Eligibility

Working for an employer participating in the Farm Credit Foundations Benefit Plans, you're eligible for *Foundations* benefits if you are a full-time or part-time benefits eligible employee. Employers include AgriBank, FCB and affiliated Associations; Northwest, FCS; and U.S. AgBank, FCB and affiliated Associations. All plans provide coverage for you, and most offer coverage for your dependents, including your:

- Spouse, including domestic partner and common law spouse where legally recognized by the state of residence;
- Unmarried dependent children under age 19 including biological children, adopted children and stepchildren;
- Unmarried children, ages 19 to 25, who are full-time students at an accredited institution and who are dependent on you for support;* and
- Unmarried children of any age who are physically or mentally challenged and depend on you for support. A child will be considered to be physically or mentally challenged if he or she is incapable of self-sustaining employment because of a physical or mental disability.

For plan purposes, child(ren) means:

- Your own or legally adopted child;
- Children & stepchildren who live in a parent/child relationship with you at least half the time;
- Child not living in your home with coverage required by a Qualified Medical Child Support Order (QMCSO);
- Child other than the above with a court document granting guardianship.



You have the flexibility to decide who to cover under the Medical, Dental and Vision Plans.

1. Coverage for you;
2. Coverage for you and your spouse;
3. Coverage for you and your child(ren); and
4. Coverage for you and your family.

You can choose different coverage categories for each plan. For instance, you can choose Employee Only for medical and Employee plus Family for dental. You pick the category that's right for your and/or your family's needs.

* If your child is a college student, you may be required to certify and/or provide proof of full-time student status.

Terms of Enrollment

PRE-TAX PLAN OPTIONS

- Medical
- Dental
- Vision
- Flexible Spending Accounts
- Health Savings Account*
- Optional Basic Life and AD&D
- Voluntary AD&D
- AFLAC

AFTER-TAX PLAN OPTIONS

- Group Universal Life and Cash Accumulation Fund
- Long-Term Disability

Pre-Tax and After-Tax Plans

Pre-tax Plans: Pre-tax elections must remain the same for the entire calendar year unless you have a Qualified Status Change:

- Marriage, divorce or legal separation;
- Birth, adoption or placement for adoption;
- Death of your spouse or dependent;
- Loss or reinstatement of dependent status;
- Significant change in your spouse's coverage;
- Loss of your or your dependents' group coverage due to layoff or termination.

If you have a Qualified Status Change and would like to change your coverage, you must submit a change within 31 days of the qualified event. Your benefit changes will be effective the date of the event. Any changes made to coverage must be consistent with the Qualified Status Change under IRS Section 125.

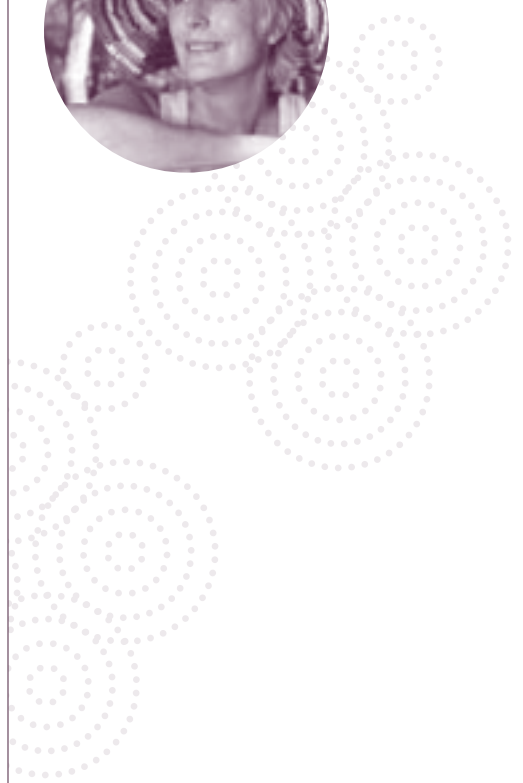
After-tax Plans: Premiums for these plans are taken from taxable income. You may make changes to your after-tax plans at any time. If you enroll or increase coverage after your initial enrollment period, evidence of insurability may be required or pre-existing condition exclusions may apply.

** A qualified status change is not required to change your Health Savings Account (HSA) contribution throughout the year.*

Benefits at a Glance

Foundations...Benefits to Fit Your Life includes benefit plans for today and tomorrow. For more information on the plans listed below as well as information regarding your retirement/savings plans, check out your benefits website at www.efoundations.biz (case sensitive id/password = foundations/HR).

Some benefits are Employer-Provided; your employer pays the entire cost for you. Other benefits are Employer-Subsidized; that is, your employer will pay a substantial portion of the cost of your coverage. Additional benefits are optional—you pay the full cost but save money by participating in group coverage provided by your employer.



EMPLOYER-PROVIDED

Basic Term Life and Accidental Death & Dismemberment (AD&D) Insurance Plans—You automatically receive Employer-provided coverage equal to one times your total compensation.*

Business Travel Accident Insurance—You automatically receive coverage equal to three times your total compensation at no cost to you.

Long-Term Disability (LTD) Insurance—You are automatically enrolled in coverage that provides 66 2/3 % of your monthly total compensation if you are disabled and unable to work.

EMPLOYER-SUBSIDIZED

Medical Coverage—Select from three levels of PPO coverage including a Consumer Choice PPO Plan and Health Savings Account (HSA). Depending on your work location, you may also have an HMO plan available. Your contributions are paid pre-tax.

Dental Coverage—Choose between two passive PPO options—Basic Plan and Comprehensive Plan. Your contributions are paid pre-tax.

OPTIONAL

Vision Plan—Coverage for eye exams, lenses, frames and contact lenses. Receive discounts on certain procedures. You pay for vision coverage on a pre-tax basis.

Flexible Spending Accounts—Contribute to one or both accounts available—Healthcare Account and/or Dependent Daycare Account on a pre-tax basis.

*Optional Basic Employee Term Life and Accidental Death & Dismemberment (AD&D) Insurance—Elect coverage for an additional one times your total compensation. You pay the full cost on a pre-tax basis.

*Group Universal Life (GUL) Insurance—Purchase benefits up to ten times your total compensation for yourself, up to \$250,000 for your spouse and up to \$25,000 for each child. You can also take advantage of the added benefit of building long-term savings via the cash accumulation fund option. You pay the full cost on a post-tax basis.

*Voluntary Accidental Death & Dismemberment (AD&D) Insurance—Elect coverage for you and/or your family up to ten times your base pay to a maximum of \$1,500,000. You pay on a pre-tax basis.

AFLAC - Elect supplemental cancer and other specified-disease coverage for you, your spouse or your family.

** Total compensation is current base salary plus previous year's variable pay (which includes incentive pay, commissions, overtime, intermittent pay, shift differential, retroactive pay adjustments, lump-sum merit pay, business/performance-based bonuses, deferrals, and salary continuation (e.g. sick pay and short-term disability)).*

Your Medical Options

What Medical Plan Choices are available

A PPO is a medical plan that uses a network of "Participating Providers" who charge discounted fees for medical services. You may choose to see any medical provider whether in or out-of-the-network – and no referrals are necessary. However, when you choose a participating provider, you will typically receive plan-negotiated discounts in addition to a higher level of in-network benefits.

Depending on your location, you may also be able to select coverage under a Health Maintenance Organization (HMO) or a fully insured PPO. If an HMO or a fully insured PPO is available to you, your Enrollment Kit will include more information on enrolling.

Preferred Provider Organization (PPO)

Your PPO Plan options are self-insured and administered by BlueCross BlueShield of Illinois. You have three PPO medical options to choose from:

- Premium PPO Plan;
- Standard PPO Plan;
- Consumer Choice PPO Plan and Health Savings Account (HSA).
 - The Consumer Choice PPO Plan is a qualified High Deductible Health Plan (HDHP).
 - If you elect the Consumer Choice PPO Plan for your medical coverage, you will automatically be enrolled in the Group HSA with Mellon Financial Corporation.

High Deductible Plan (HDHP): A High Deductible Health Plan (HDHP) is a health plan that when combined with a Health Savings Account (HSA) provides insurance coverage and a tax-advantage way to help save for future health care expenses.

The HDHP/HSA gives you greater flexibility and discretion over how you use your health care dollars.

Health Savings Account (HSA): An HSA is a health savings account that allows you to save money in a tax-free account. To be an eligible and qualify for an HSA, you must meet the following requirements:

- You participate in a high deductible health plan (HDHP), such as Consumer Choice;
- You have no other primary medical coverage;
- You are not enrolled in Medicare; and
- You are not claimed as a dependent on someone else's tax return.

The annual maximum HSA contribution allowed for 2007 is \$2,700 (single), \$5,450 (family). If you are over 55 you can contribute an additional \$800 "catch-up". Maximum contribution amounts include medical premium rebates but does not include any HSA rollover funds from previous years. Unused funds are not forfeited; money not used in the account will roll from year to year.

2007 Maximum HSA Contribution — New Hires & Enrollment

HSA annual maximums must be prorated per the calendar year beginning the first of the month after you enroll.

CONTRIBUTION ELIGIBLE DATE	SINGLE MAXIMUM DEDUCTIBLE	FAMILY MAXIMUM DEDUCTIBLE
Before 12/31/06	\$2,700.00	\$5,450.00
January 1, 2007	\$2,700.00	\$5,450.00
February 1, 2007	\$2,475.00	\$4,995.83
March 1, 2007	\$2,250.00	\$4,541.67
April 1, 2007	\$2,025.00	\$4,087.50
May 1, 2007	\$1,800.00	\$3,633.33
June 1, 2007	\$1,575.00	\$3,179.17
July 1, 2007	\$1,350.00	\$2,725.00
August 1, 2007	\$1,125.00	\$2,270.83
September 1, 2007	\$900.00	\$1,816.67
October 1, 2007	\$675.00	\$1,362.50
November 1, 2007	\$450.00	\$908.33
December 1, 2007	\$225.00	\$454.17

Single coverage = employee only. Family coverage = employee + spouse + child(ren)

The money in your HSA can be used on a tax-free basis to pay for:

- Your medical plan deductibles;
- Eligible health care expenses not covered by insurance (IRS Publication 502);
- Health expenses during retirement;
- You can use your money for any purpose; (subject to income and penalty tax if it's not an eligible expense)
- After reaching age 65, you can use HSA savings for any purpose (subject to normal income if it's not an eligible expense).

Wellness Benefits

All PPO Plans pay certain wellness benefits at 100% up to a \$500 annual maximum per covered participant. Wellness benefits include routine physical exams (no limit on visits), routine diagnostic tests (lab and xray), routine eye exams (includes contact lens fitting and refractions) and routine hearing exams.

In addition, the following wellness benefits are paid at 100% and do not count toward the annual maximum:

Routine sigmoidoscopy	beginning at age 50	once every three years
Routine colonoscopy	beginning at age 50	once every ten years
Bone mineral density	beginning at age 50	once every three years
Immunizations	any age	(immunizations for foreign travel are not covered)

If your enrollment begins any time other than the first of the month your annual contribution maximum is prorated.

EXAMPLE: *Hired June 23, 2007, you may contribute a maximum of \$1,350.00, which is the maximum for July through year end (single coverage).*

Qualified status change contribution amount is determined by the deductible amount and the month in which your qualifying status change occurs. If you experience a qualifying status change be sure to review your HSA contribution election amounts so you stay within IRS regulations. Contact Mellon Financial at www.hsamember.com for more information.

Note: *Medical claims must be submitted within 12 months from date of service in order to be considered.*

Network providers can be found on BlueCross BlueShield at, www.bcbsil.com/foundations.

For eligible HSA expenses visit www.irs.gov (publication 502).

For additional Wellness Benefits information, go to www.efoundations.biz (case sensitive id/password = foundations/HR).

2007 PPO Plan Highlights

	PREMIUM PPO PLAN		STANDARD PPO PLAN		CONSUMER CHOICE PPO PLAN	
Pre-existing condition exclusion	None		None		None	
Out-of-Pocket Expenses	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	Individual \$400 Family \$800 maximum		Individual \$1,000 Family \$2,000 maximum		Employee Coverage \$2,700 Family Coverage \$5,450 (full family deductible must be met before plan starts to pay)	
Annual Out-of-Pocket Maximum (includes deductible)	\$1,600 Indiv. \$3,200 Family	\$2,000 Indiv. \$4,000 Family	\$3,000 Indiv. \$6,000 Family	\$4,000 Indiv. \$8,000 Family	\$2,700 Indiv. \$5,450 Family	\$5,400 Indiv. \$10,900 Family
Benefits	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Coinsurance (paid after deductible) applies to all professional services except as noted below	You Pay 20%	You pay 40%	You Pay 20%	You pay 40%	Plan Pays 100%	You pay 40%
Office Visit Copays (Copays do not apply to deductible or out-of-pocket maximum)	You pay 35%	Subject to deductible & coinsurance	You pay 35%	Subject to deductible & coinsurance	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Labwork / Professional Services	Subject to deductible & coinsurance		Subject to deductible & coinsurance		Subject to deductible & coinsurance then plan pays 100%	
Emergency Room Visit Copayment	Subject to deductible & coinsurance		Subject to deductible & coinsurance		Subject to deductible & coinsurance then plan pays 100%	
Wellness Benefit (not subject to deductible)	100% up to \$500 annually		100% up to \$500 annually		100% up to \$500 annually	
Maximum Lifetime Benefit	Unlimited		Unlimited		Unlimited	

PRESCRIPTION DRUGS	PREMIUM PPO PLAN			STANDARD PPO PLAN			CONSUMER CHOICE PPO PLAN		
Coverage through Caremark network pharmacy or mail order only	Retail (30-day supply)	Retail (90-day supply)	Mail order (90-day supply)	Retail (30-day supply)	Retail (90-day supply)	Mail order (90-day supply)	Retail (30-day supply)	Retail (90-day supply)	Mail order (90-day supply)
Generic Copay	\$10	\$30	\$20	\$10	\$30	\$20	Subject to same deductible and coinsurance as other medical benefits		
Preferred Brand Copay	\$30	\$90	\$75	\$30	\$90	\$75			
Non-Preferred Brand Copay	\$60	\$180	\$150	\$60	\$180	\$150			

PRE-TAX ACCOUNTS	PREMIUM PPO PLAN		STANDARD PPO PLAN		CONSUMER CHOICE PPO PLAN	
Flexible Spending Healthcare Account – Use it or lose it	Maximum Annual Contribution up to \$5,000 pre-tax contribution		Maximum Annual Contribution up to \$5,000 pre-tax contribution		Not available	
Health Savings Account Unused funds rollover	Not Available		Not Available		Maximum contribution amount up to plan deductible minus employer premium rebate	

Your Dental Options

Your dental plan is administered by Delta Dental of Kansas. Two levels of coverage are offered:

- Basic Coverage; and
- Comprehensive Coverage.

The Basic Plan provides benefits for diagnostic, preventive & basic care eligible charges (include exams, cleanings, fillings and X-rays). The Comprehensive Plan offers coverage for a more extensive range of dental care including orthodontia.

Dental Highlights

	BASIC PLAN	COMPREHENSIVE PLAN
Deductible (per covered person)	\$50	\$100
Preventive/Diagnostic (2 cleanings per yr)	100% (not subject to deductible)	100% (not subject to deductible)
Basic Services	80% after deductible	80% after deductible
Major Services	Not covered	50% after deductible
Annual Benefit Maximum	\$750 (per person)	\$1,500 (per person)
Orthodontia	Not covered	50% after deductible (children and adults)
Lifetime maximum	(N/A)	\$2,000 (per person)

NETWORK PROVIDERS

A directory of network providers is available thru www.deltadentalks.com

NETWORK SAVINGS

Your dental plan includes a nationwide network; however, you can still go to any dentist. Benefits remain the same whether you are in- or out-of-network. When you go to an in-network provider, you will receive the plan-negotiated fees. If you use a non-network provider, you may be responsible for the amount charged above reasonable and customary fees.

Delta Dental Network

Your dental plan includes two networks

- Premier Network includes over 118,000 dentists nationwide. Going to a Premier dentist means:
 - no balance billing; and
 - no paper claim filing.
- PPO Network includes over 57,000 dentists nationwide. Going to a PPO Delta Dental provider means:
 - largest discounts;
 - no balance billing; and
 - no paper claim filing.

Note: Deadline for Filing Dental claims must be submitted within 12 months from date of service in order to be considered.

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Example: Let's assume you need a major dental service (i.e. crown - cost \$1,000). This chart illustrates your cost using network and non-network providers.

Network Comparison

	PPO NETWORK	PREMIER NETWORK	NON-NETWORK
Dentist Bills	\$1000	\$1000	\$1000
Delta's Maximum Allowance	\$650	\$700	\$650
Delta Payment	\$325	\$350	\$325
Balance Bill	\$0	\$0	\$350
Your Payment	\$325	\$350	\$675

Vision Service Plan (VSP)

Note: You will not receive an ID card if you elect VSP coverage. Access the Vision Service Plan website, www.vsp.com, to locate a participating provider and to access claim forms.

Your Vision Plan through VSP offers coverage for you and your eligible dependents for eye exams, lenses, frames and contact lenses. VSP will also cover laser vision correction surgery at a discounted fee when you use a participating provider. VSP pays for the majority of expenses for a number of services when you use a participating provider. Providers can be found on VSP's website, www.vsp.com. If you use a non-participating provider, you will generally pay more for services.

The following chart depicts VSP benefits under participating and non-participating providers.

Vision Benefits Summary

	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Vision Eye Exam (every 12 months)	\$10 copayment	Up to \$35 allowance
Lenses (1 set every 12 months)	\$25 copayment	Up to \$25 allowance for single lenses, \$40 for bifocal lenses, \$55 for trifocal lenses, and \$80 for lenticular lenses
Frames (1 frame every 24 months)	\$25 copayment	Up to \$45 allowance
Contact Lenses—evaluation and fitting (1 set every 12 months)	Up to \$130 allowance	Up to \$105 allowance
Elective Laser Vision Correction Surgery PRK and Lasik	You pay the lower amount of: up to 15% discount or 5% discount off reasonable and customary market price	Not Covered

Flexible Spending Accounts

These accounts are designed to help you pay out-of-pocket healthcare and dependent daycare expenses. The biggest advantage of the accounts is that your contributions are made on a pre-tax basis. This means you're using tax-free money and you're lowering your taxable income. Because these accounts have certain tax advantages, the IRS regulates them. Funds not used for services during the plan year will be lost—in other words, *you need to use the money in your account or you'll lose it.*

Important Tax Information

If you are reimbursed for an expense through your Flexible Spending Account, you cannot claim that expense as a deduction on your federal income tax return.

Healthcare Flexible Spending Account

You may contribute up to \$5,000 a year to the Healthcare Flexible Spending Account. You can then use the amount in your account to reimburse yourself for eligible healthcare expenses, which include:

- Deductibles and copayments not covered by insurance;
- Prescription drugs not covered by insurance;
- Eyeglasses and contact lenses;
- Hearing aids;
- Certain medically required supplies and equipment;
- Your portion of orthodontic expenses; and
- Certain over-the-counter drugs and supplies.

OVER-THE-COUNTER DRUGS

Over-the-counter drugs that are used to alleviate or treat personal injuries or sickness are eligible for reimbursement from your Flexible Spending Healthcare Account.

What is covered... Antacids, allergy medicines, pain relievers, and cold medicines.

What is not covered... Items to maintain general health (e.g., vitamins and dietary supplements) and personal hygiene items (e.g., cotton balls, cleansers, etc).

To be reimbursed, the drug/expense must be substantiated with a receipt specifying the item purchased, the price, and the date of purchase.



Special Note: *If you elect the Consumer Choice PPO Medical Plan, you are not eligible to participate in the Healthcare Flexible Spending Account.*

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FLEXIBLE SPENDING ACCOUNTS

If you currently participate in the Healthcare Spending Account or the Dependent Daycare Spending Account and would like to continue your contributions in 2007, you must complete your enrollment form and elect your contribution amount for 2007.

DEADLINE FOR FILING FLEXIBLE SPENDING ACCOUNT (FSA) CLAIMS:

FSA claims must be submitted by the earlier of— 90 days after your participation in the plan has terminated. March 31st of the year following the year in which the claim was incurred.

CHANGING YOUR COVERAGE

You must experience a Qualifying Status Change to change or enroll in a Flexible Spending Account. Visit www.efoundations.biz (case sensitive id/password – foundations/HR) for information on Qualifying Status Changes.

For more info: Visit the Farm Credit Health Care Hub at www.farmcredithealthcarehub.com or the IRS website at www.irs.gov for the complete list of eligible expenses.

Dependent Daycare Flexible Spending Account

The Dependent Daycare Flexible Spending Account reimburses you for expenses associated with the care of a dependent while you and/or your spouse works or attends school. You may contribute up to \$5,000 a year to this account. If you are married and file income taxes separately, your contributions to the Dependent Daycare Account are limited to \$2,500 annually. If you are married and file income tax jointly, the total amount both you and your spouse can contribute combined to a Dependent Daycare account is \$5,000, under IRS rules.

- Your eligible dependents include:
- Your dependent children under age 13;
- Your spouse who is physically or mentally unable to care for himself or herself; or
- Other dependents (such as elderly parents) who are physically or mentally unable to care for themselves.

Eligible Dependent Daycare expenses include:

- Daycare provided in a home, day care center or preschool, subject to certain legal requirements
- Adult day care facility;
- Before- and after-school expenses through grade school for children under age 13;
- Nanny or au pair;
- Care for children when they're sick and you're at work; and
- Summer day camp.



Your Life Insurance and Accidental Death & Dismemberment Insurance Options

Employer-Provided Benefits

Basic Employee Term Life and Accidental Death & Dismemberment (AD&D) Insurance Coverage: Your basic life insurance coverage is a term life policy. AD&D coverage pays benefits to you or your beneficiary(ies) if you die or are injured as a result of an accident. You automatically receive life and AD&D insurance coverage of one times your total compensation. This coverage is provided by your employer at no cost to you.

Business Travel Accident Coverage: Business Travel Accident coverage pays benefits to you or your beneficiary(ies) if you die or are injured as the result of an accident while you are traveling on business. You automatically receive business travel accident coverage of three times your total compensation. This coverage is provided by your employer at no cost to you.

Optional Benefits

Optional Basic Employee Term Life and AD&D Insurance Coverage: You can purchase a benefits package that includes additional life insurance and AD&D coverage for yourself of one times your eligible earnings.

Voluntary Optional AD&D Coverage: Employee Coverage: You can purchase optional coverage for yourself in increments of \$25,000 up to ten times your base salary, to a maximum of \$750,000. You may also choose family coverage, which includes coverage for yourself, your spouse and your dependent children.

Voluntary Optional AD&D Coverage: Dependent Coverage: Based on your Optional AD&D coverage and depending on your family situation at the time of the incident, the coverage percentage for your family would be as follows:

FAMILY STATUS	SPOUSE	CHILD(REN)
Spouse only	60%	—
Spouse and dependents	50%	15%
Dependents only	—	20%

* Maximum coverage is \$50,000 for each dependent child.

WHAT IS TOTAL COMPENSATION?

Total compensation is current base salary plus previous year's variable pay (which includes incentive pay, commissions, overtime, intermittent pay, shift differential, retroactive pay adjustments, lump-sum merit pay, business/performance-based bonuses, deferrals, and salary continuation (e.g. sick pay and short-term disability)).

PLAN MAXIMUMS

- Maximum coverage for Basic and Optional Basic Employee Term Life Insurance is \$1,500,000.
- Maximum coverage for Employer paid AD&D, Employee paid AD&D coverage is \$2,000,000 combined per insured person.

IS TERM LIFE INSURANCE TAXABLE?

Under current tax law, group term life insurance is tax-free up to \$50,000 per year. The IRS requires you to pay taxes on the value of any employer-provided coverage over \$50,000, called imputed income.

Imputed income is included as taxable wages each pay period (and will be included as earnings for tax-purposes).

Note: Evidence of insurability is required if you elect Optional Basic Employee Term Life coverage during Annual Enrollment. Coverage can only be elected mid-year with a qualified status change.

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Group Universal Life (GUL) Insurance

Group Universal Life Insurance offers two different coverages:

1. A death benefit of up to ten times your total compensation (maximum death benefit of \$1,500,000).
2. If you elect GUL coverage, you can also elect to contribute to the Cash Accumulation Fund, an interest earning savings account. Contributions are post-tax and taxes on earnings are deferred until you make withdrawals from your account.

Coverage is available to you and your eligible dependents. This coverage is portable which means you can take your Group Universal Life coverage and your savings account with you even if you leave your employment.

*Coverage of 1x total compensation will be guarantee issue up to \$500,000. All other coverage is subject to evidence of insurability. Go to www.efoundation.biz for forms.

EMPLOYEE COVERAGE LEVELS	SPOUSE COVERAGE LEVELS	CHILD(REN) COVERAGE LEVELS
Option..... Coverage	Option..... Coverage	Option..... Coverage
1 1 x total compensation*	1 \$25,000*	1 \$ 5,000*
2 2 x total compensation	2 \$50,000	2 \$10,000*
3 3 x total compensation	3 \$ 75,000	3 \$15,000*
4 4 x total compensation	4 \$100,000	4 \$20,000*
5 5 x total compensation	5 \$125,000	5 \$25,000*
6 6 x total compensation	6 \$150,000	
7 7 x total compensation	7 \$175,000	
8 8 x total compensation	8 \$200,000	
9 9 x total compensation	9 \$225,000	
10 10 x total compensation	10 \$250,000	

Long-Term Disability (LTD) Insurance

So that long-term disability benefits will be tax-free, an after tax deduction will be taken from your paycheck and your employer will "cancel out" your deduction with a reimbursement on the same paycheck.

Your employer provides you with LTD coverage equal to 66 2/3% of your total compensation to a maximum monthly benefit of \$20,000. You automatically receive this coverage and do not need to enroll.

LTD benefits begin after you have been disabled for six months. LTD benefits are offset by any disability benefits you receive from certain other sources, such as Social Security and Workers Compensation. Any benefit you receive will be increased each year you are disabled with a 3% cost-of-living adjustment (COLA).

AFLAC

Your employer offers a Supplemental Cancer Policy through AFLAC. You may elect coverage for yourself or your spouse [single coverage]; coverage for you or your spouse and child(ren) [1 parent coverage]; or coverage for your entire family [family coverage].

This coverage includes a Personal Cancer Indemnity Plan with Wellness Benefits as well as an Optional Specified-Disease Benefit Rider covering more than 30 specified conditions.

AFLAC coverage is offered as a group benefit, however, if you enroll you will be covered under an individual policy that is portable should you leave your employment. Payroll deductions for premiums will be taken on a pre-tax basis.

To enroll or learn more about AFLAC coverage, go to www.AFLAC-KS.com/foundations



Terms to Know

Basic Dental Services: Routine dental procedures such as root canals and cavity fillings.

Brand Drugs: A medication that has been patented for name and chemical content. Once the patent expires, generic drugs with a different name but the same chemical make-up usually become available. Brand drugs are all other prescription drugs that are not generic or on the list of Primary/Preferred drugs. The highest copay is charged for these drugs because they are either the most expensive and/or have a comparable drug that is either generic or on the preferred list.

Coinsurance: The benefit percentage for eligible medical expenses after you pay any deductible.

Copayment: A set amount you pay each time you receive certain medical services.

Deductible: The amount of money you pay each year before the plan pays a benefit.

Evidence of Insurability: Any statement of proof of a person's physical condition affecting his/her acceptance of insurance.

Eligible Charges: Charges for services that are covered under a benefit plan.

Primary/Preferred Drugs: These are prescription drugs that have been placed on a list of preferred drugs for a medical plan with a prescription copay. The copay for formulary drugs is generally less than non-formulary drugs but higher than a generic drug copay.

Generic Drugs: Generic drugs have the same chemical make-up of a corresponding brand drug whose patent has expired.

Health Maintenance Organization (HMO): A local medical plan option that provides discounted services to its members.

Health Savings Account (HSA): A Health Savings Account is the vehicle that allows employees in a high-deductible health plan (HDHP) to set aside tax-exempt contributions for current and future qualified medical expenses in an account made available through your employer or financial institution.

High Deductible Health Plan (HDHP): An HDHP allows you to save money on your insurance premium in exchange for a higher deductible. When you are covered under a traditional medical plan, you pay a substantial monthly premium, whether you use the plan or not.

Major Dental Services: Extensive dental procedures such as crowns, bridges and dentures.

Network: Healthcare providers and facilities who have contracted to render medical services or supplies at a pre-negotiated fee.

Participating Provider: A healthcare provider who has contracted to be part of the network to provide services or supplies at a pre-negotiated fee.

Preferred Provider Organization (PPO)—A medical plan option that offers services to its members from a network of health care providers who have negotiated discounted fees.

Preventive Dental Services—Routine services such as cleanings and checkups.

Pre-Existing Condition: A medical condition that could exclude you from receiving benefits associated with that condition for a defined period of time.

Qualified Status Change: An event that allows you to make coverage changes you could not otherwise make under a pre-tax plan as long as you make those changes within 31 days of the event.

Reasonable & Customary (R&C): The average fee charged by a particular type of health care provider

within a geographic area. Medical plans use this as the amount of money they will approve for a service.

Routine Care: Includes doctor visits, exams and other services for the purpose of monitoring a diagnosed condition.

Total Compensation: Total compensation is current base salary plus previous year's variable pay (which includes incentive pay, commissions, overtime, intermittent pay, shift differential, retroactive pay adjustments, lump-sum merit pay, business/performance-based bonuses, deferrals, and salary continuation (e.g. sick pay and short-term disability)). For commissioned employees, the minimum is \$15,000. These earnings are used to calculate the amount of coverage for Life, AD&D, Business Travel Accident and Long-Term Disability Insurance.

Wellness Benefits: Certain services whose priority is the prevention and early detection of conditions. It does not include care or monitoring of an existing condition.