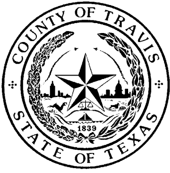
Item 32



Travis County Commissioners Court Agenda Request

Meeting Date: Tuesday, September 25, 2012
Prepared By/Phone Number: C.W. Bruner, 854-9760
Elected/Appointed Official/Dept. Head: Cyd Grimes
Commissioners Court Sponsor: Judge Biscoe

Approve twenty four-month extension (Modification No. 6) to Contract No. 4400001100 (HTE Contract No. 06T00061OJ), Life Insurance Co. of North America, Supplemental Employee Life and AD&D Coverage; Dependent Life Coverage; Employee Spouse Life Coverage; Retiree and Retiree Spouse Life Coverage; Stand-alone Accidental Death and Dismemberment Coverage; Short Term Disability and Long Term Disability coverage for Travis County Employees, Retirees, and Dependents.

- **Purchasing Recommendation and Comments:** Purchasing concurs with department and recommends approval of requested action. This procurement action meets the compliance requirements as outlined by the statutes.

  This contract provides for the provision of optional Supplemental Employee Life and AD&D Coverage; Dependent Life Coverage; Employee Spouse Life Coverage; Retiree and Retiree Spouse Life Coverage; Stand-alone Accidental Death and Dismemberment Coverage; Short Term Disability and Long Term Disability coverage for county employees, retirees and dependents; all beginning October 1, 2011. The product is completely optional and fully paid by employees. The Commissioners Court approved the initial contract award on November 1, 2005.

  Pursuant to the Request for Proposals Number P110149-OJ, this Modification No. 6 is issued as the extension and expansion of that Collateral Agreement which is collateral to and amends Policy Numbered OK 960892 for Voluntary Accidental Death or Dismemberment Coverage, which was issued to Travis County, Texas by Life Insurance Company of America and extends the Collateral Agreement to Policies Numbered FLX 964188, FLX 964189, OK

965800, VDT 960952, and VDT 960953 all to be issued to Travis County, Texas by Life Insurance Company of America and to be effective October 1, 2011. It amends the paragraph entitled TERM OF AGREEMENT of Agreement Collateral to Policy by giving the County a new two year term and the option to extend the policy for two additional one year periods. The policies to which the Agreement Collateral is extended provide the following coverage: Employee and Dependent Life Coverage; Retiree and Dependent Life Coverage; Accidental Death or Dismemberment Coverage associated with Employee and Dependent Life Coverage; and Short Term Disability and Long Term Disability for county employees that begins October 1, 2011.

Modification No. 5 was previously issued to extend the contract period for an additional twelve (12) months, through September 30, 2011. The rates, which have been the same for the past five (5) years, will remain unchanged for this period also.

Modification No. 4 was previously issued to extend the contract period for an additional twelve (12) months, through September 30, 2010. It was approved by the Commissioners Court on July 28, 2009.

Modification No. 3 was previously issued to extend the contract period for an additional twelve (12) months, through September 30, 2009. It was approved by the Commissioners Court on September 30, 2008.

Modification No. 2 was previously issued to extend the contract period for an additional twelve (12) months, through September 30, 2008. It was approved by the Commissioners Court on July 31, 2007.

Modification No. 1 was previously issued to extend the contract period for an additional twelve (12) months, through September 30, 2007. It was approved by the Commissioners Court on September 5, 2006.

There are no County funds expended on this contract. Funds are 100% paid by the County employees.

- **Contract Expenditures:** Within the last 12 months $0.00 has been spent against this requirement.

- **Contract Modification Information:**

  Modification Amount: Not Applicable

  Modification Type: Bilateral

  Modification Period: October 1, 2011 – September 30, 2013

- **Funding Information:**
  - ☐ Shopping Cart/Funds Reservation in SAP:
  - ☒ Comments: No County funds. This is 100% paid by County employees.

AGENDA REQUEST DEADLINE: All agenda requests and supporting materials must be submitted as a pdf to Cheryl Aker in the County Judge's office, Cheryl.Aker@co.travis.tx.us **by Tuesdays at 5:00 p.m.** for the next week's meeting.

MODIFICATION OF CONTRACT NUMBER: 06T00061OJ, Voluntary Benefit Coverage (CIGNA) PAGE 1 OF 12 PAGES		
ISSUED BY: PURCHASING OFFICE 700 LAVACA STREET, 8TH FLOOR AUSTIN, TX 78701	PURCHASING AGENT ASST: CW Bruner TEL. NO: (512) 854-9760 FAX NO: (512) 854-4211	DATE PREPARED: **August 24, 2012**
ISSUED TO: Life Insurance Co. of North America Attn: David T. Evans 1601 Chestnut Street Philadelphia, PA 19192-2235	MODIFICATION NO.: 6	EXECUTED DATE OF ORIGINAL CONTRACT: **November 1, 2005**
ORIGINAL CONTRACT TERM DATES: **October 1, 2005 – September 30, 2007**	CURRENT CONTRACT TERM DATES: **October 1, 2011 – October 1, 2013**	

FOR TRAVIS COUNTY INTERNAL USE ONLY:
Original Contract Amount: $ N/A   Current Modified Amount $ N/A .

DESCRIPTION OF CHANGES: Except as provided herein, all terms, conditions, and provisions of the document referenced above as heretofore modified, remain unchanged and in full force and effect.

This amendment number six to Collateral Agreement With Life Insurance Company of North America for Voluntary Accidental Death or Dismemberment Coverage is made by the following parties:
Life Insurance Company of North America, a Pennsylvania corporation ("Company") and Travis County, Texas ("County").

RECITALS

County and Company entered into a contract for Voluntary Accidental Death or Dismemberment Coverage for county employees that began October 1, 2005 and extended annually since then.

In March, 2011, County distributed a Request for Proposals (RFP # P110149-OJ) to qualified companies to provide group employee benefits, such as long term disability, and life and accidental death and dismemberment insurance. Company provided the best negotiated offer for coverages and services.

This modification 6 is the first novation of that Collateral Agreement which is collateral to and amends Policy Numbered OK 960892 for Voluntary Accidental Death or Dismemberment Coverage, which is issued to Travis County, Texas by Life Insurance Company of America and extends the Collateral Agreement to Policies Numbered FLX 964188, FLX 964189, OK 965800, VDT 960952, and VDT 960953 all issued to Travis County, Texas by Life Insurance Company of America. It amends the paragraph entitled TERM OF AGREEMENT of Agreement Collateral to Policy by giving the County a new two year term and the option to extend the policy for two additional one year periods. The policies to which the Agreement Collateral is extended provide the following coverage: Employee and Dependent Life Coverage; Retiree and Dependent Life Coverage; Accidental Death or Dismemberment Coverage associated with Employee and Dependent Life Coverage; and Short Term Disability and Long Term Disability for county employees that begins October 1, 2011.

Note to Vendor:
[X] Complete and execute (sign) your portion of the signature block section below for all copies and return all signed copies to Travis County.
[ ] DO NOT execute and return to Travis County. Retain for your records.

LIFE INSURANCE CO. OF NORTH AMERICA BY: Jeffrey Pugh SIGNATURE Jeffrey Pugh TITLE: Underwriting Operations Director ITS DULY AUTHORIZED AGENT	☐ DBA ☒ CORPORATION ☐ OTHER DATE: 8/28/12
TRAVIS COUNTY, TEXAS BY:__________ CYD V. GRIMES, C.P.M., TRAVIS COUNTY PURCHASING AGENT	DATE:
TRAVIS COUNTY, TEXAS BY:__________ SAMUEL T. BISCOE, TRAVIS COUNTY JUDGE	DATE:

AGREEMENT

1. AMENDMENT TO AGREEMENT COLLATERAL TO POLICIES

1.01 Pursuant to 13.01 of the Agreement Collateral, the following definitions are deleted: 1.02 Administrative Staff and 1.03 Agent, 1.07 Insurance Contract and the following is inserted in place of 1.07:

1.07 "Insurance Contract" and "Insurance Contracts" means one or more of the following contracts of insurance:

1.07.1 Policy Numbered OK 960892 for Voluntary Accidental Death or Dismemberment Coverage issued to County by Company effective October 1, 2005.

1.07.2 Policy Numbered FLX 964188 for Active full-time Employee and Dependent Voluntary Life Coverage issued to County by Company effective October 1, 2011.

1.07.3 Policy Numbered FLX 964189 for Retiree and Dependent Voluntary Life Coverage issued to County by Company effective October 1, 2011.

1.07.4 Policy Numbered OK 965800 for Accidental Death or Dismemberment Coverage, which is issued to County by Company effective October 1, 2011 and the coverage level for which is limited by County in the enrollment process to the coverage level selected by the insured for Active full-time Employee and Dependent Voluntary Life Coverage.

1.07.5 Policy Numbered VDT 960952 for Voluntary Short Term Disability Coverage issued to County by Company effective October 1, 2011.

1.07.6 Policy Numbered VDT 960953 for Voluntary Long Term Disability Coverage issued to County by Company effective October 1, 2011.

1.02 Pursuant to 13.01 of the Agreement Collateral, 2.0 TERM OF AGREEMENT is deleted and the following is inserted in its place:

2.01 The initial Agreement Collateral commenced at 12:01 a. m. on October 1, 2005 and ended at 12:01 a. m. on October 1, 2006. County exercised its options to extend the Agreement Collateral and the Policy for 5 additional one year periods. The First Novation of the Agreement Collateral and incorporation of the additional policies described in this modification commences at 12:01 a. m. on October 1, 2011 and ends at 12:01 a. m. on October 1, 2013 ("Agreement Period").

2.02 County has the option to extend the Agreement Collateral and all Policies associated with it for 2 additional one year periods. ("Annual Option Periods") and 3 additional one month periods ("Monthly Option Periods"). During each Option Period, all terms and conditions remained unchanged except the term of the Agreement Collateral and Policies being extended. The options, if exercised, must be executed by County no sooner than ninety days before the expiration of this agreement or any extension and no later than the final day of the agreement term. Failure by County to exercise either option to extend shall be deemed to be County's notice according to the terms of the affected Policy of County's intention to terminate the Policy for which the option has not been exercised and that the Policy must expire at the end of the then current Policy term. Failure by County to exercise an option to extend any of the Policies associated with this Agreement means that this Agreement must also expire at the end of the then current agreement period.

1.03 Pursuant to 13.01 of the Agreement Collateral, 5.03 is deleted and the following is inserted in its place:

5.03 Company must provide County with a copy of the certificate booklets, and claim forms for all services and coverages in an electronic format for both the annual open enrollment and "new employee" enrollment throughout the year. Company must send a representative to attend each annual open enrollment and each weekly new employee orientation.

1.04 Pursuant to 13.01 of the Agreement Collateral, 6.0 INSURANCE COVERAGE AND BENEFITS is deleted and the following is inserted in its place:

6.0 INSURANCE COVERAGE AND BENEFITS

6.01 During the agreement period and effective October 1, 2011, Company must provide

6.01.1 the services described in this Agreement and in Attachments 2 and G-1 for County and its employees and retirees, as applicable, in accordance with the terms and conditions of this agreement; in compliance with the assurances, certifications, and all other statements made by Company in Attachments 2 and G-1; and

6.01.2 the coverage for County employees and retirees, as applicable, who enroll, in a timely manner as agreed upon by Company and County, for one or more of the coverages described in the Insurance Contracts and this agreement in the manner established by County; in accordance with the terms and conditions of the Insurance Contract and this Agreement; in compliance with the assurances, certifications, and all other statements made by Company in Attachments 2 and G-1.

6.02 If Company does not provide the Account Management and Customer Services in compliance with Attachment G-2 Table of Services-Performance Measures, Company shall pay County the penalty indicated in the table for the service that is not in compliance. Company shall evaluate this management and these services for compliance with the standards semi-annually. The amount at risk is 2% of the total premium on all six policies and the maximum PG dollars at risk are $20,000 per year.

6.03 Company shall provide County specific enrollment communication and support including County brochures and applications.

6.04 Company shall provide County with specimen copies of (i) standard letter templates commonly used in adjudicating claims; and (ii) any materials intended for use in marketing or communicating the insurance benefits. No such materials described in (ii) shall be used without County's approval.

6.05 For Policy Number OK 960892, Company shall assist in the administration by responding to employee questions and providing beneficiaries with information for claims, upon request.

6.06 For Policy Number OK 965800, Policy Number FLX 964188, and Policy Number FLX 964189, Company shall assist in the administration by responding to employee questions and providing beneficiaries with information for claims, upon request.

6.07 In Policy Number VDT 960952 under Termination of Insurance on page 4, in the sentence "Any period of Disability, regardless of cause, that begins when the Employee is eligible under another group disability coverage provided by any employer, will not be covered." the word "eligible" means that the Employee is within an eligible class and has become insured and is eligible to file a claim for benefits unless the Employee is no longer employed by Travis County and in that case, the former employee need only eligible to enroll in the new employer's disability coverage but the former employee would be able to file a claim under this policy if the former employee has a successive period of disability.

6.08 For Policy Number VDT 960952 and Policy Number VDT 960953, Company shall provide Disability Program Support Services as shown in Attachment G-3 and the administration of these policies shall be as outlined in the CIGNA Administrative Services Overview for employer-administered plans, also as shown in Attachment G-3

6.09 Company shall provide County employees, retirees and the dependents of both who are enrolled in the following coverages with the following SERVICES:

SERVICE	AD&D (all)	Life		STD	LTD
		Employee/Retiree	Dependent		
Healthy Rewards ®	X	X	X	X	X
Will Preparation	X	X	X	X	X
CIGNAssurance ®	X	X	X		
CIGNA Identity Theft Program	X			X	X
CIGNA Secure Travel ®	X				

6.10 The SERVICES include the following additional services:

6.10.1 Healthy Rewards ® offers discounts on a range of heather and wellness-related services and products, including discounts on Weight Watchers and smoking cessation programs, chiropractic care, anti-cavity products, power toothbrushes, fitness club memberships, hearing and vision care, massage therapy, acupuncture, pharmacy vitamins and other products.

6.10.2 Will Preparation provides access to a website that has an interactive tool that helps covered employees and their covered spouses create a will and other legal documents and other valuable financial educational materials.

6.10.3 CIGNAssurance ® provides comprehensive beneficiary services including financial, bereavement and legal counseling and setting-up interest bearing accounts for balances of $5,000 or more.

6.10.4 CIGNA Identity Theft Program provides Identity Theft Resolution services for all types of identity theft and includes access to personal case managers who will work with employees and their covered family members to resolved identity theft issues with support available 24 hours a day, seven days a week as described more fully in Attachment G-6.

6.10.5 CIGNA Secure Travel ® offers travel assistance on trips more than 100 miles from home, including medical evacuation and repatriation with no maximum limits as described more fully in Attachment G-5.

6.11 Company must provide detailed reports on the experience each of the coverages at least quarterly.

1.05 Pursuant to 13.01 of the Agreement Collateral, 7.0 RATES FOR COVERAGE is amended to add the following after 7.01:

7.02 Company must give County notice of the rates applicable to Voluntary Short Term Disability Coverage for third option period no later than the March 1, 2014. Any change in these rates must be calculated based on the following formula:

Where:

Loss Ratio = Reserves for claims incurred but not paid plus Paid Claims all policies, 10-1-2011 to 1-31-2014
Premiums paid for all policies, 10-1-2011 to 1-31-2014

the increase in the composite rate shall not exceed the following percentage increases based on the following loss ratios:

Loss Ratio	Maximum Increase
Less than 80%	0%
Between 80-90%	10%
Between 90-95%	20%
Over 95%	30%

And the composite rate must be based on the following experience rated formula:

7.06.1 Incurred Claims from October 1, 2011 to January 31, 2014 are divided by Paid Premiums from October 1, 2011 to January 31, 2014 to determine the Loss Ratio.

7.06.3 The Loss Ratio is divided by Permissible Loss Ratio and then multiplied by the in force rate to determine the Experience Rate.

7.06.4 The Experience Rate is multiplied by the credibility factor to determine the portion of the composite rate determined by Travis County experience.

7.06.5 The Company manual rate is multiplied by [1 minus the credibility factor] to determine the portion of the composite rate determined by the overall experience of the Company.

7.06.6 The portion of the composite rate determined by Travis County experience as determined in step 7.06.4 is added to the portion of the composite rate determined by the overall experience of the Company as determined in 7.06.5 to determine the composite rate payable.

7.08 Company must give County notice of the rates applicable to any coverage for any additional option period no later than the March 1, of the calendar year in which the rates are to become effective.

1.06 Pursuant to 13.01 of the Agreement Collateral, 10.0 INDEMNIFICATION AND CLAIMS NOTIFICATION is deleted and the following is inserted in its place:

10.0 INDEMNIFICATION

10.01 Company, in its capacity as insurer of benefits under the Policies, shall be directly and solely responsible for the payment of benefit claims asserted under the Policies. Company agrees to assume responsibility for the defense, settlement and payment of such claims, whether they are asserted against the County, its employee benefit plans, or their respective officials, employees or agents. This obligation shall not include any liability or damages resulting from the acts or omissions of the County, its employee benefit plans, or their respective officials, employees or agents.

1.07 Pursuant to 13.01 of the Agreement Collateral, 18.0 ENTIRE AGREEMENT is deleted and the following is inserted in its place:

18.0 ENTIRE AGREEMENT

18.01 All oral and written agreements between the parties to this agreement relating to the subject matter of this agreement that were made prior to the execution of this agreement have been reduced to writing and are contained in this agreement.

18.02 The attachments numbered and named below are made a part of this agreement, and constitute promised performances by Company and County. If there is any conflict between this document and the attachments to it, the conflict must be resolved to give effect to the contents of the attachments and to disregard the conflicting portions of this document.

18.03 The Voluntary Personal Protection Optional AD&D Attachments include the following:

Attachment 1, Group Accident Policy (Policy number OK960892) Draft Policy

Attachment 2, Portions of Cigna's Response to Request for Proposals

Attachment 3, CIGNA Secure Travel® Emergency Travel Assistance Services by Worldwide Assistance Services, Inc. Corporate Service Agreement

Attachment 4, Affidavit and Proposer Certification Form (4 pages)

Attachment 5, Amendment (3 pages)

18.04 The General Attachments that apply to more than one Insurance Contract, are attached to this Modification 6, and include:

Attachment G-1,	Portions of Company's Response to Request for Proposals: -pages 1-3 Executive Summary; page 14 of 63 through page 43 of 63, except for top half of page 1, the answer to question 1 on page 14; the answer to question 7 on page 21; reference to EOI on page 38 and the answer to 6.6 and the 8 reference to EOI in question 7.2 on page 40.
Attachment G-2,	Table of Service-Performance Measures
Attachment G-3,	Disability Program Support Services and CIGNA Administrative Overview
Attachment G-4,	Agreement Concerning Designation of Beneficiaries Using Electronic Systems
Attachment G-5,	ERISA Coverage Worksheet
Attachment G-6,	CIGNA Secure Travel® Emergency Travel Assistance Services by Europ Assistance USA, Inc.
Attachment G-7,	CIGNA Identity Theft Program

18.05 The new Insurance Contract Attachments are attached to this Modification 6 and include the following:

Attachment IC-1,	Group Accidental Death or Dismemberment Policy limited by level of Employee Life Coverage (Policy number OK 965800) Policy
Attachment IC-2,	Group Active full-time Employee and Dependent Voluntary Life Policy (Policy number FLX 964188) Policy
Attachment IC-3,	Group Retiree and Dependent Voluntary Life Policy (Policy number FLX 964189) Policy
Attachment IC-4,	Group Voluntary Short Term Disability Policy (Policy number VDT 960952) Policy
Attachment IC-5,	Group Voluntary Long Term Disability Policy (Policy number VDT 960953) Policy

18.06 The Audit Attachment is attached to this Modification 6 and is as follows:

Attachment A-1, Claim Audit Agreement (2 pages)

18.07 The Ethics Attachment is attached to this Modification 6 and is as follows:

Attachment E-1, Affidavit and Proposer Certification Form (4 pages)

1.08 Pursuant to 13.01 of the Agreement Collateral, 19.02 is deleted and the following is inserted in its place:

19.02 The address of County for all purposes under this agreement shall be:

Cyd Grimes (or her successor in office)
Purchasing Agent
P.O. Box 1748
Austin, Texas 78767-1748

With copy to (registered or certified mail with return receipt is not required):

Honorable David A. Escamilla (or his successor in office)
Travis County Attorney
P.O. Box 1748
Austin, Texas 78767-1748

1.09 Pursuant to 13.01 of the Agreement Collateral, the following sections 22.0 RETIREE/SURVIVING SPOUSE ADMINISTRATION AND RATES through 34. CONFLICT OF INTEREST QUESTIONAIRE inclusive are added at the end of 21.08:

22.0 RETIREE/SURVIVING SPOUSE ADMINISTRATION AND RATES

22.01 Administrative Services for retirees and their surviving spouses who elect life insurance coverage shall consist of the following:

22.01.1 Company shall produce an annual billing to the Retiree directly to their residence or other address identified to Company by County.

22.01.2 Company shall accept payments of premiums as made directly from them and maintain accounting records of the payments.

22.01.3 Company shall send a late notice to their address if premiums not been paid within 30 days of the stated due date.

22.01.4 Company shall send a second notice will be sent to their address if premiums have not been paid within 60 days of the stated due date.

22.01.5 Company shall provide the Travis County Benefit Manager with reports, identifying Retirees described in 22.01.3. County shall, on Company's behalf, contact such Retirees to remind them of their premium payment deadline and to advise Company of any circumstances affecting payment of premiums. County acknowledges that, in performing this function, Company shall be required to disclose to it certain individually identifiable personal information which is subject to protection under insurance privacy laws. County acknowledges that such information is to be treated confidentially, and used solely for the purpose of performing the functions identified herein. County shall assume responsibility for any liability resulting from breach of this provision by County.

22.01.6 Notice will be sent to Retirees at their address notifying them of life insurance termination for non-payment following the end of the Policy's grace period for individual

premium payments. Prior to sending such notices, Company shall contact County to discuss the result of County's contacts made pursuant to paragraph 22.01.5.

22.01.7 Company shall provide an assigned 800 number available to retirees and surviving spouses with billing questions.

22.02 The administration of County retiree benefit premiums for life coverage for the first year, first option year and second option years of this agreement shall be included in the premium for the coverage.

23.0 FOB POINT

23.01 Delivery of all products, reports or services under this contract shall be Free on Board (FOB) to final destination at the address shown below.

Human Resources Management Department
Attn: Mr. Dan Mansour, Risk and Benefits Manager
700 Lavaca Street, 4th Floor
Austin, Texas 78701

24.0 DISPUTES AND APPEALS

24.01 The Purchasing Agent acts as the County representative in the issuance and administration of this contract in relation to disputes. Any document, notice, or correspondence not issued by or to the Purchasing Agent, or other authorized County person, in relation to disputes is void unless otherwise stated in this contract. If the Company does not agree with any document, notice, or correspondence issued by the Purchasing Agent, or other authorized County person, the Company must submit a written notice to the Purchasing Agent within ten (10) calendar days after receipt of the document, notice, or correspondence, outlining the exact point of disagreement in detail. If the matter is not resolved to the Company's satisfaction, Company may submit a written Notice of Appeal to the Commissioners Court, through the Purchasing Agent, if the Notice is submitted within ten (10) calendar days after receipt of the unsatisfactory reply. Company then has the right to be heard by Commissioners Court.

25.0 COVENANT AGAINST CONTINGENT FEES

25.01 The Company warrants that, except as disclosed, no persons or selling agency has been retained to solicit this contract upon an understanding for a commission, percentage, brokerage, or contingent fee, excepting bona fide employees or bona fide established commercial selling agencies maintained by the Company to secure business. For breach or violation of this warranty, County shall have the right to terminate this contract without liability, or in its discretion, as applicable, to add to or deduct from the contract price for consideration, or otherwise recover, the full amount of such commission, percentage, brokerage, or contingent fee.

26.0 COUNTY ACCESS

26.01 Company shall maintain and make available all books, documents, and other evidence pertinent to the costs and expenses of this contract for inspection, audit or reproduction by any authorized representative of County to the extent this detail will properly reflect these costs and expense. These include all costs; both direct and indirect costs, cost of labor, material, equipment, supplies, and services, and all other costs and expenses of whatever nature for which

reimbursement is claimed under this contract. All required records shall be maintained until an audit is completed and all required questions arising there from are resolved, or 3 years after completion of the contract term, whichever occurs first; however, the records shall be retained beyond the third year if an audit is in progress or the findings of a completed audit have not been resolved satisfactorily. If County decides to audit Company, County and Company shall enter into a Claim Audit Agreement in the form attached to this agreement.

27.0 MONITORING

27.01 County reserves the right to perform periodic on-site monitoring of Company's compliance with the terms of this contract, and of the adequacy and timeliness of Company's performance under this contract. After each monitoring visit, County shall provide Company with a written report of the monitor's findings. If the report notes deficiencies in Company's performances under the terms of this contract, it shall include requirements and deadlines for the correction of those deficiencies by Company. Company shall take action specified in the monitoring report prior to the deadlines specified.

28.0 GRATUITIES

28.01 County may terminate this contract if it is found that gratuities of any kind including entertainment, or gifts were offered or given by Company or any agent or representative of Company to any County Official or employee with a view toward securing favorable treatment with respect of this contract. If this contract is terminated by the County pursuant to this provision, County shall be entitled, in addition to any other rights and remedies, to recover from the Company at least three times the cost incurred by Company in providing the gratuities.

29.0 INSURANCE REQUIREMENTS

29.01 During the period of this contract, Company shall maintain at its expense, insurance with limits not less than those prescribed below. With respect to required insurance, Company shall:

29.01.1 Provide County a waiver of subrogation under Company's Worker's Compensation and Commercial General Liability insurance policies.

29.01.2 Endeavor to provide County with a thirty (30) calendar days advance written notice of cancellation in instances where policies are cancelled and not replaced with similar insurance programs.

29.01.3 Provide the County Purchasing Agent at the address shown on Page 1 of this contract, a Certificate of Insurance evidencing required coverage within ten (10) calendar days after receipt of Notice of Award and within ten (10) days of each renewal. **Also, please assure your certificate contains the contract number as indicated on the Contract Award form when issued by Travis County.**

29.01.4 Submit an original certificate of insurance reflecting coverage as follows:

Management Liability (Directors and Officers, Fiduciary) (aggregate limit available is not less than the stated amount)	$15,000,000.00

Professional Liability (Errors and Omissions) (aggregate limit available is not less than the stated amount)	$5,000,000.00
Fidelity (Crime) Bond (aggregate limit available is not less than the stated amount)	$20,000,000.00
Network Liability (Privacy) (aggregate limit available is not less than the stated amount)	$10,000,000.00

Worker's Compensation:............ ....Statutory

Employers Liability:

Accidental Bodily Injury (Each injury).........$100,000.00
By Disease..$100,000.00
Aggregate for disease...........................$5,000,000.00

Commercial General Liability (Including Contractual Liability):

Personal Injury, Bodily Injury, Property Damage.
(Combined Single Limit) $2,000,000.00

Security and Privacy Liability Coverage:

Intangible Property Loss of Personal Data Information and/or do not address perils.

29.02 Coverage may be layered as assigned by Company but the aggregate limit available shall not be less than the stated amounts. Policies for these coverage's except Professional liability must be issued by an insurance company that is authorized to do business in Texas and has an A M Best rating of at least A.

30.0 COMPLIANCE WITH LAW

30.01 Company must comply with all Federal and State laws and regulations, City and County ordinances, orders, and regulations, relating in any way to this contract.

31.0 DISBURSEMENTS PROHIBITED BY LOCAL GOVERNMENT CODE, § 154.045

31.01 In 31.0, "Debt" includes delinquent taxes, fines, fees, and indebtedness arising from written contracts with the County.

31.02 If notice of Debt has been filed with the County Auditor or County Treasurer evidencing the Debt of Company to the state, County or a salary fund, a check or warrant may not be drawn on a County fund in favor of the Company, or an agent or assignee of Company until the County Treasurer notifies Company in writing that the Debt is outstanding and the Debt is paid.

31.03 County may apply any funds County owes Company to the outstanding balance of Debt for which notice is made under section 32.02 if the notice includes a statement that the amount owed by the County to Company may be applied to reduce the outstanding Debt.

32.0 CERTIFICATION OF ELIGIBILITY

32.01 Company certifies that at the time of submission of its offer, it was not on the Federal Government's list of suspended, ineligible, or debarred contractors and that Company has not been placed on this list between the time of that its offer was submitted and the time of execution of this contract. If Company is placed on the list during the term of this contract, Company shall notify the Travis County Purchasing Agent. False certification or failure to notify may result in terminating this contract for default.

33.0 CONFLICT OF INTEREST QUESTIONNAIRE

33.01 If required under Chapter 176 Texas Local Government Code, Company shall file an updated, completed questionnaire with the Travis County Clerk not later than the seventh (7th) business day after the date of any event that would make a statement in the questionnaire filed previously incomplete or inaccurate. As between County and Company, Company shall be solely responsible for the preparation of its Conflict of Interest Questionnaire, the accuracy and completeness of the content contained therein and ensuring compliance with all applicable requirements of Chapter 176, Local Government Code.

2.0 INCORPORATION OF CONTRACT

2.01 County and Company incorporate this amendment into the Agreement with Life Insurance Company of America for Voluntary Accidental Death or Dismemberment Coverage. County and Company ratify all of the terms and conditions of the Agreement.

3.0 EFFECTIVE DATE

3.01 The changes in this modification are effective October 1, 2011.

Group Disability, Life and Accident Implementation Welcome Package

Welcome to CIGNA Group Insurance! This package contains a group of forms and documents necessary for the implementation of your CIGNA Group Insurance Disability, Life and/or Accident insurance benefits. We've included a chart that provides a description of each document and clarifies your action required. To assure operational readiness and accurate set-up of your benefit plan(s) please complete this application by signing in the space provided.

Applicant (Full Legal Name): County of Travis

Address: 314 W. 11th St., Room 400 **City:** Austin **State:** TX **Zip Code:** 78701

Taxpayer ID No.: 74-6000192

We acknowledge receipt of this Implementation Welcome Package. We confirm the accuracy of the proposal as described in the policies attached to Modification 6 of Contract #06T00061OJ from the underwriting company(ies) named below and hereby accept the terms and conditions of that proposal and any attachments or modifications made to the proposal.

Oma Claunch is the producer identified on the attached Authorization of Payment of Commission and Service Fees (Exhibit)

We acknowledge receipt of the Privacy Notice.

We understand that the following insurance policies may be issued to the Group Insurance Trust for Employers in the Public Administration Industry.

REQUESTED INSURANCE	REQUESTED EFFECTIVE DATE
COVERAGE: Group Term Life - Employee **UNDERWRITING COMPANY: Life Insurance Company of North America**	**10/1/2011**
COVERAGE: Group Term Life - Retiree **UNDERWRITING COMPANY: Life Insurance Company of North America**	**10/1/2011**
COVERAGE: Group Voluntary Accident **UNDERWRITING COMPANY: Life Insurance Company of North America**	**10/1/2011**
COVERAGE: Group Voluntary Short-Term Disability **UNDERWRITING COMPANY: Life Insurance Company of North America**	**10/1/2011**
COVERAGE: Group Voluntary Long-Term Disability **UNDERWRITING COMPANY: Life Insurance Company of North America**	**10/1/2011**

We hereby adopt the above-named trust as co-settlor and subscribe to that trust for the purpose of participating in these policies, which shall only cover our eligible employees, and, retirees and dependents. We confirm the appointment of Wilmington Trust Company as Trustee, and of Life Insurance Company of North America ("LINA") as trust administrator. We appoint LINA, in its capacity as trust administrator, to represent us in dealings with the Trustee related to the insurance trust. We understand that, in the event the policy(ies) are terminated for any reason, we will cease to be a participant in the insurance trust. We understand that no benefits are provided by the trust other than the benefits described in the insurance policy(ies).

Travis County, Texas

By: ______________________________ Samuel T. Biscoe, County Judge Date: ______________
(Signature and Title of Applicant's Authorized Representative)

Austin,TX
(City and State)

CIGNA Group Insurance
Life • Accident • Disability

Disclosure of Payment of Commissions and Service Fees

Oma Claunch is the broker/consultant of record in connection with the policy.

We acknowledge that the insurance company will pay commissions to the broker/consultant at the following rates:

Product	Policy Numbers
Life	FLX-964188, FLX-964189
Accident	OK-965800
STD	VDT-960952
LTD	VDT-960953

Product		Percentage
Life – Voluntary Effective Date: 10/1/2011	Case Specific	05%
Accident – Voluntary Effective Date: 10/1/2011	Case Specific	05%
STD – Voluntary Effective Date: 10/1/2011	Case Specific	05%
LTD – Voluntary Effective Date: 10/1/2011	Case Specific	05%

We understand and acknowledge that CIGNA Group Insurance companies may have entered into, or may enter into, an agreement with the broker/consultant, under which the insurance company compensates the broker/consultant for providing marketplace intelligence and other services intended to enhance the effectiveness of the insurance company's business. This additional compensation is contingent on meeting new business and persistency goals.

The following describes the compensation available under the program under which the broker is eligible to participate. Terms of the program are subject to change.

- **New Business.** Payments made are a percentage of total annualized premium, based on number of new cases sold and annualized premium for those eligible cases, and range from 1.5% to 4% of the amount of expected first year annualized premium (which is the maximum rate payable, if at least $10,000,000 in premium, is sold) depending on the specific program the broker is eligible to participate in. Brokers must write at least $200,000 of new business premium or sell three new cases to qualify.

- **New Premium Added to Inforce Policies.** Payments made are a percentage of total annualized premiums attributable to acquisitions requiring underwriting by the insurance company, and amendments to increase benefits or add eligible classes, and is calculated at 1.5% of the amount of expected first year annualized premium depending on the specific program the broker is eligible to participate in. Brokers must write at least $200,000 of new business premium or sell three new cases to qualify.

- **Persistency**. Persistency measures the number of policies (weighted by premium) which were in force at the beginning of the year which are still in force at the end of the year. Payments made are a percentage of total earned premium, and range from 0% to 2% of total aggregate premium for those eligible cases (which is the maximum rate payable, if persistency is 95% or greater) depending on the specific program the broker is eligible

to participate in. Brokers must have a book of business of at least $250,000 at the start of the year, and write at least $200,000 of new business premium or sell three new cases, to qualify.

- **Cross-Sell.** Payments made are a percentage of total annualized premium for business sold to an existing CIGNA Healthcare or CIGNA International Expatriate Benefits customer OR sold along with a new CIGNA Healthcare medical product or new CIGNA International Expatriate Benefits product to the same customer, and range from 1% to 1.5% of the amount of expected first year annualized premium (which is the maximum rate payable, if at least $1,000,000 in premium, is sold). Brokers must write at least $50,000 of new business premium to a cross-sell customer to qualify. In addition, your policies may be used to establish eligibility in the cross-sell programs of CIGNA Healthcare and/or CIGNA International Expatriate Benefits.

This compensation is funded from the insurance company's overhead and is based on the broker's overall book of business with the insurance company. Any such payments are separate from commissions and, if applicable, will be included in ERISA Form 5500, Schedule A information provided by the insurance company.

We also understand that the insurance company may invite the broker to participate in events sponsored by the insurance company for the same purposes.

Important Privacy Notice – Please Read

As a customer of a CIGNA company[1], we want to assure you that we recognize our obligation to keep our customers' protected information secure and confidential. This notice explains our privacy practices and it should answer questions about how we protect personal information. We will continue to safeguard the privacy of the information provided to us. Thank you for giving us the opportunity to serve you. (If you are an Employer or Group Sponsor, please make this information available for review by your employees or members as appropriate.)

This notice applies to insurance products underwritten, or administered by, the Life Insurance Company of North America and CIGNA Life Insurance Company of New York, Life and Disability products underwritten by Connecticut General Life Insurance Company, and insurance products underwritten by Insurance Company of North America administered by the CIGNA companies. Information is the key to our ability to provide you with best in class service. Regardless of whether you are a customer, applicant, insured, or former insured, we are committed to protecting and maintaining the privacy of any information in our possession.

COLLECTION AND USE OF INFORMATION

We may collect protected information about our customers for use in the processing and evaluation of applications or eligibility for insurance, investigating a claim for benefits, and in developing financial plans. This information will be used by authorized company personnel solely for these purposes, and it may be integrated into our databases for statistical and audit purposes. Protected information means any non-public, personally identifiable information including financial information, employment related information and medical information. Unless permitted by law, we will only collect information from sources other than our customers with authorization.

DISCLOSURE OF INFORMATION

We do not disclose any protected information about our customers or former customers to anyone except as permitted by law. We do not sell customer lists or other protected information. With some exceptions, we will not disclose protected information without written authorization. There are circumstances when we will disclose protected information related to medical underwriting or a claim investigation or other activities relating to your insurance plan without authorization to third parties or affiliates assisting us with these activities, as permitted by law. We will also disclose protected information to third parties without authorization as required by law, such as in the case of subpoenas and mandated governmental disclosures.

PROTECTING YOUR INFORMATION

We have internal policies to maintain the privacy of our customers' protected information. These include but are not limited to policies related to the transmission, storage and disposal of paper and electronic information; the prevention of unauthorized access and damage to systems, including damage due to environmental hazards; and assigning and terminating user IDs.

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[1] "CIGNA" is a registered trademark licensed for the use of insurance company subsidiaries of CIGNA Corporation. All products and services are provided by insurance company subsidiaries and not the corporation itself. As used herein, "CIGNA" refers to these subsidiaries, which include the Life Insurance Company of North America, CIGNA Life Insurance Company of New York and Connecticut General Life Insurance Company.

Working Together to Make a Difference

Your account management team will work closely with you to create a service plan that outlines all implementation, enrollment, and communications goals. We concentrate on providing consultative plan designs that emphasize health and wellness and affordable coverages to support your budgetary goals. From case installation to contract renewals, your account management team will work on your behalf to deliver seamless service.

When it comes to providing coverages and programs that protect individuals and their families, we believe education is key. Your account management team will work with you to develop a communications plan. This plan focuses on educating individuals on the advantages of services that are available to help keep them at their healthiest, all year long.

We can also offer any of the following administrative services: beneficiary administration, conversion/portability notice distribution, and/or online evidence of insurability.

Value-Added Programs and Services that Make a Difference to Your Employees

We want to be there for you all the time – not just when your employees need us. We automatically include the following programs with your coverage:

- **CIGNA Healthy Rewards®** – discounts of up to 60% on health and wellness products and services, such as weight management, nutrition, fitness and smoking cessation and more
- **CIGNA's Identity Theft Program** – provides access to personal case managers who give step-by-step assistance and guidance to individuals who have had their identity stolen
- **CIGNA's Will Preparation Program** – online forms, tools and advice to build state-specific customized wills, powers of attorney and other legal documents
- **CIGNAssurance Program℠ for Life and Accident Coverage*** – family bereavement counseling with certified specialists, financial information and legal consultation services

**Certain services are not available through CIGNA Life Insurance Company of New York.*

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- **Individual Customer Services** – online life and disability insurance calculators are available to help determine needs, and individuals on disability have access to myCIGNA.com, where claim status, payment, and claim manager contact information is available
- **CIGNA's Life Assistance**℠ – Offered with every long-term disability program (optional with Life Insurance), provides assessment and referrals to services and experts to help cope with the stress that often accompanies a disability or illness
- **CIGNA Secure Travel**® – Available with Personal Accident, provides emergency medical, financial, legal, and communications assistance to covered individuals who travel domestically and internationally.

Voluntary Services to Help You Do More with Less

CIGNA's voluntary offerings allow you to make coverages available to employees to purchase on their own. It's no secret that businesses are under pressure to decrease operating costs. We can help you do that. We offer several administrative options so that you can focus on your business, while we take care of your benefits programs.

If you offer at least one voluntary product, we provide the support you need. We offer communications to your employees, including our education portal, *CIGNA Trusted Advisor*. Enrollment and beneficiary administration (online or paper) is available to ease administrative. Online evidence of insurability and individual call center support is also available. Eligibility management and list billing capabilities (online, electronic, or paper) can help you better manage these programs. Distribution of conversion/portability notice is also included.

While we have the capabilities to offer the full range of administration, we understand that some customers may want to maintain some aspects of these activities. That's why our administrative services also are offered as stand-alone options.

Disability Claim Management Focuses on Return-to-Work

CIGNA's claim management process offers faster and smarter claim decisions. This helps individuals maintain their sense of security, so they can focus on recovery and return-to-work.

- **Quicker Claim Decisions** – During intake, an automated voice response system records the individual's permission to access medical records, making the process easier and faster.
- **Dedicated Claims Teams** – Our claim managers handle each claim individually to ensure that a successful return to work is made whenever possible.
- **Re-Employment Solutions** – Vocational rehabilitation counselors dedicated 100 percent to helping people get back to work, or find a new job that suits their personal situation.
- **Social Security Advocacy** – We help qualified individuals work through the complicated application process for Social Security Disability Insurance.
- **Reporting** – Secure, online reports, available to employers and individuals, give instant access to claim status, benefits and payment.

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Accident Protection for Employees and Families

We offer personal and business travel accident, so your employees can feel safe – both home and away.

- **Trained Accident Specialists** – Specialized training at Duquesne University's Institute of Forensic Science and Law ensures more accurate claim decisions in a shorter timeframe.
- **Specialized Benefits and Coverage** – Flexible contracts allow for industry-specific customization. For example, subject to state requirements, we can offer options, such as HIV and Hepatitis C benefits for hospital workers.
- **CIGNA Business Travel Accident Medical™** – Covers medical care costs for individuals traveling on company business outside of their country of primary residence.
- **War Risk Coverage** – Protection for individuals who travel on business to war risk areas outside of the Unites States.

Term Life Benefits Tailored to Meet Your Needs

Dealing with the death of a loved one is painful enough. We want to take some of that burden away. That's why we offer families bereavement counseling and financial and legal advice services through our CIGNAssurance® program*. Life claim specialists process and pay claims within 10 business days of receipt of all information and are a single point-of-contact for the employer and the beneficiary.

**Certain services are not available through CIGNA Life Insurance Company of New York.*

- **Transition Protection** – Our takeover provision ensures individuals maintain coverage when transitioning carriers.
- **Innovative Approach to Waiver of Premium (WOP)** – removes administrative burden and confusion typically experienced with WOP. We cover all disabled individuals from day one – without premium payment – as they satisfy the elimination period. Individuals remain covered even when the policy is cancelled. And, when we provide both Life and long-term disability coverage, the WOP process is managed at the same time, by one team. The need for redundant paperwork is eliminated.
- **Optional Coverage** – To help protect employees' sense of security and peace of mind, we offer two accelerated pay-out programs:
  - Critical Illness provision allows individuals to receive a portion of their life insurance proceeds if diagnosed with one of six specified diseases.
  - Terminal Illness provision allows individuals with 12 months or less to live to withdraw a portion of their life insurance coverage.

We Focus On You, So You Can Focus On Your Business

We look forward to this opportunity with Travis County.We continually look for new ways to help you better manage employee benefit costs and improve workforce productivity. Allow us to be experts in tailoring and providing benefits and services that work for you and your employees, so you can focus on what you do best – your business.

2.0 SUPPLEMENTAL LIFE, AD&D, LONG AND SHORT TERM DISABILITY (PACKAGE 1)

2.1 The current Supplemental Life and AD&D coverage is offered in $25,000 increments up to a maximum of $250,000 or four times an employee annual salary (rounded up to nearest multiple of $25,000. The maximum does not include the basic life $50,000).

CIGNA is matching the above benefits.

2.2 New Hires may select any amount (within the above guidelines) when they do their initial enrollment. At open enrollment each subsequent year an employee may increase their coverage by one $25,000 increment with no underwriting. There is a reduction schedule on the supplemental life and AD&D for active employees. See attachments for the current census, volume and rates and reduction schedule and plan summaries that include the reduction schedule.

CIGNA is matching the above benefits.

2.3 A full time active employee is eligible for coverage if they work a minimum of 20 hours a week in a benefited position. This is guarantee issue for active employees.

CIGNA is matching the above benefits.

3.0 DEPENDENT LIFE AND SPOUSE LIFE (PACKAGE 1)

3.1 An active employee may choose optional life coverage for their dependents (legal spouse and children up to age 26). See attached rates for dependent and spouse optional life.

CIGNA is matching the above benefits with the exception to the child age which will be 25.

3.2 Currently, it is not necessary to purchase employee life coverage in order to purchase dependent life coverage. This is guarantee issue. No AD&D coverage on dependents.

Confirmed.

3.3 The base benefit for this coverage is currently:

3.3.1 Basic Dependent Life currently has one inclusive rate of $1.54/month for the following types of coverage.

3.3.1.1 $10,000 spouse

3.3.1.2 Child $5,000 (6 months to age 26)

3.3.1.3 Infant $1,000 (14 days to 6 months)

CIGNA is matching the above benefits.

3.4 Additional Optional Spouse Life is currently age rated on age of spouse October 1st of each year.

3.4.1 $10,000

3.4.2 $20,000

CIGNA is matching the above benefits.

4.0 RETIREE LIFE (PACKAGE 1)

4.1 The current retiree and retiree spouse voluntary life product is divided into coverage for ages 70 or less, and, coverage for ages 71 and over. There are separate benefits and rates for these two categories. Spouse must be covered at the time of retirement to be eligible for coverage.

CIGNA is matching the above benefits.

4.2 The rate is currently determined by the age of the retiree not the spouse.

Confirmed.

4.3 No reduction schedule exists on retiree life products, other than the reduction at the time change of category to the over 71 applies.

Confirmed.

4.4 The benefits are currently as follows:

4.4.1 Age 70 or less: Retiree

Basic Benefit $15,000 guarantee issue, with an optional buy up option of $10,000 that requires underwriting based on an evidence of insurability form, submitted directly by the retiree.

4.4.2 Age 70 or less: Retiree Spouse

Basic Benefit is $7,500 guarantee issue, with an optional buy-up option of $5,000 that requires underwriting based on an evidence of insurability form submitted directly by the retiree.

4.4.3 Age 71 or over: Retiree

Basic Benefit $5,000 no buy-up option currently available.

4.4.4 Age 71or over: Retiree Spouse

Basic Benefit $2,500 no buy-up option currently available.

NOTE: Basic coverage amount decreases and optional buy-up amounts terminate at age 71.

CIGNA is matching the above benefits.

4.5 NOTE: The County is interested in increasing the coverage amount, or implementing a buy-up option for Age 71 and over retirees. Please respond with a buy-up option for this age group and the pricing.

We are not providing a buy up option for this retiree group at this time.

5.0 REDUCTION SCHEDULE FOR ACTIVE'S LIFE

5.1 The Proposer must indicate the reduction schedule that applies to active working employees, if any. The Reduction Schedule must not apply to the retiree and retiree spouse coverage.

Confirmed.

5.2 In the current policy, the reduction schedule for active employees is:

When you reach age 70	Benefit reduces to 65%
When you reach age 75	Benefit reduces to 45%
When you reach age 80	Benefit reduces to 30%
When you reach age 85	Benefit reduces to 15%

CIGNA is matching the above reduction schedule.

6.0 ADDITIONAL BENEFITS FOR ALL LIFE

6.1 Also included in the County's current supplemental life and AD&D coverage are the following benefits:

- **Accelerated Benefit**
- **Conversion**
- **Work Life Assistance Program**
- **Repatriation Benefit**
- **Seatbelt and airbag benefit**
- **Education Benefit**

Proposer must indicate if these coverages are included in the proposal and provide details. (See attachment #1 for Plan details).

Accelerated Benefit

CIGNA offers an employer-selected feature called terminal illness. This feature helps insureds cope with medical costs and household expenses during a terminal illness. This benefit pays the lower of 80% of the in-force death benefit, or $250,000 to any insured that is diagnosed with a terminal illness and is expected to live twelve months or less.

Terminal illness can be included in any employer or employee paid group term life insurance plan. The terminal illness benefit takes effect on the later of the date the group life policy takes effect, or the date the benefit is added. Pre-existing condition limitations do not apply, and all insureds (employees and spouses) are eligible regardless of age. Benefits are payable only once and reduce the death benefit. Payment of this benefit also terminates automatic coverage increases, if such a provision applies.

Conversion

All of CIGNA's standard group life insurance products include a conversion privilege.

Conversion allows an insured employee to elect individual whole life coverage should their group coverage end for any reason except failure to pay

premiums. The amount converted cannot be greater than the amount in force under the group contract. Premiums depend on the insured's age at the time of issuance.

If the policy is terminated, amended to terminate a particular class of employees, or if the employer cancels participation in the policy, conversion is available only to employees who have been covered under the group policy for at least three years. In that event, the amount that can be converted is limited to the amount of group coverage in force or $10,000, whichever is less. Certain parameters may vary by state. CIGNA will administer the conversion process in accordance with all applicable state regulations.

Individuals must apply for conversion within 31 days of the date their group coverage ends. If an insured dies during this 31 day period, his or her beneficiaries will receive a benefit equal to that which could have been converted, even if the employee did not apply for conversion.

Benefit options or riders other than pure life insurance, such as waiver of premium or accidental death and dismemberment (AD&D), are not available under the converted policy.

Repatriation

CIGNA's Secure Travel® program is a valuable benefit available to employees who are covered under CIGNA's accident plans and is included at no additional cost to the employer. The program offers comprehensive protection when traveling 100 miles or more from your home, including domestic travel, as well as coverage anywhere in the world. CIGNA Secure Travel® features include:

Emergency Medical Services

A key strength to our program is that CIGNA does not place coverage limits on these services.

- **Medical Evacuation** - If the covered individual experiences a medical emergency while traveling, we will provide transportation to the nearest hospital or medical facility where appropriate care can be given.
- **Travel Arrangements** - We will arrange and pay for the return of dependents or traveling companions, as well as roundtrip transportation for a family member or loved one to be at the insured's bedside.
- **Repatriation** - In the event of a fatality, we will arrange for and cover the cost of transporting the remains back to family members.
- **Medical Referrals** - We will put covered the individual in contact with local physicians, dentists, and medical treatment centers in the event of an accident or illness while traveling. We will also arrange for the first $5,000 of medical payments with confirmation of reimbursement.

- **Prescription Services** – We will provide assistance with refilling a prescription that has been lost, stolen, or depleted.

Emergency Travel Services

- cash advances
- assistance with travel arrangements
- emergency message relay
- assistance with lost or stolen items
- legal referrals
- translation and interpretation assistance

Pre-trip Planning

- immunization requirements
- visa and passport requirements
- foreign exchange rates
- embassy/consular referrals
- weather conditions
- cultural information

Seatbelt and Airbag Benefit

Covered Person dies directly and independently of all other causes from a Covered Accident while wearing a seatbelt and riding in a private passenger automobile.

If seatbelt benefit is payable, an additional benefit is provided if Covered Person was also positioned in a seat protected by a properly –functioning and properly deployed Supplemental Restraint System Airbag.

Seatbelt: Additional 10% of the principal sum to a maximum of $10,000.

7.0 CONVERSION FOR ALL LIFE

Proposer must include details of the conversion provision in the policy. Please specify the procedures involved in applying for conversion, and the responsibilities of the employer.

As previous stated, all of CIGNA's standard group life insurance products include a conversion privilege.

Conversion allows an insured employee to elect individual whole life coverage should their group coverage end for any reason except failure to pay premiums. The amount converted cannot be greater than the amount in force under the group contract. Premiums depend on the insured's age at the time of issuance.

If the policy is terminated, amended to terminate a particular class of employees, or if the employer cancels participation in the policy, conversion is available only to employees who have been covered under the group policy for at least three years. In that event, the amount that can be converted is limited to the amount of group coverage in force or $10,000, whichever is less. Certain parameters may vary by state. CIGNA will administer the conversion process in accordance with all applicable state regulations.

Individuals must apply for conversion within 31 days of the date their group coverage ends. If an insured dies during this 31 day period, his or her beneficiaries will receive a benefit equal to that which could have been converted, even if the employee did not apply for conversion.

Benefit options or riders other than pure life insurance, such as waiver of premium or accidental death and dismemberment (AD&D), are not available under the converted policy.

Employer Responsibilities

The employer is responsible for informing their employees of conversion privileges. We provide the employer with a supply of 'Notice of Right to Convert' materials, intended to be included in employee exit packages.

When your plan is fully administered by CIGNA, we can send conversion notices to eligible employees who are no longer employed or have had an employment status change that results in loss of eligibility for coverage.

8.0 WAIVER OF PREMIUM PROVISION FOR LIFE

The current policy does not include a waiver of premium provision for the term life and the AD&D.

CIGNA is offering 12 month continuation similar to inforce plan.

9.0 EMPLOYEE SHORT TERM DISABILITY (PACKAGE 1) The current short term disability coverage is shown in Part II Specific Requirements as it relates to eligibility, guaranteed issuance, weekly benefit amount, definition of disability, elimination period, benefit duration and pre-existing exclusion. See exclusions and other information on STD in attached plan highlights.

9.1 TAXATION: Benefits are not taxable, as this benefit is paid with post tax dollars.

CIGNA has matched the above package.

10.0 EMPLOYEE LONG TERM DISABILITY (PACKAGE 1) The current long term disability coverage is shown in Part II Specific Requirements as it relates to eligibility, guaranteed issuance, weekly benefit amount, definition of disability, elimination period, benefit duration and pre-existing exclusion. See exclusions and other information on LTD in attached plan highlights.

10.1 TAXATION: Benefits are not taxable, as this benefit is paid with post tax dollars.

CIGNA has matched the above package.

10.2 Various other benefits are included in the current LTD coverage. Proposer must indicate if these coverages are included in the proposal and provide details. (See attachment #1 for Plan details). These other benefits include:

10.2.1 Disability Plus- 20% of monthly earnings to a maximum benefit of the lesser of the LTD plan maximum monthly benefit OR $5,000.

The Disability Plus benefit has been matched.

10.2.2 Partial disability- where the employee can return to work part time and still receive a partial benefit.

We treat partial disabilities the same way we treat residual disabilities. Residually disabled individuals are those who are able to return to work for compensation while meeting the plan's definition of disability. Claimants receive benefits designed to encourage return to work, without jeopardizing benefits, should their efforts prove unsuccessful. Under CIGNA's plan, claimants are able to receive full disability benefits until income from all sources reaches 100 percent of indexed basic monthly earnings for the first two years.

By providing partial or residual earnings to offset a portion of the LTD benefits being paid, our results show 20 percent of our LTD claimants return to work in some capacity, versus the industry average of only 7 percent.

10.2.3 Survivor benefit- lump sum benefit equal to 3 months of gross disability payments.

We are matching the inforce survivor benefit.

10.2.4 Rehabilitation and Return to work Assistance- assists the employee in returning to work with a custom plan designed specifically for that employee.

Our vocational rehabilitation counselors manage rehabilitation services and return-to-work planning, working in conjunction with the claim manager and nurse case manager to determine if physical therapy or other treatment methods may be utilized to improve functional capacity. The vocational rehabilitation counselor also determines which rehabilitation services are appropriate given the employee's medical restrictions and overall progress.

Partnering with the employee's supervisor and the treating physician, a return-to-work plan is developed that can include a return to the same job, a modified job, or a different job with the current employer using transferable skills. When these options are not available, the vocational rehabilitation counselor examines job prospects with another employer in either the same job, modified job, or a new job using transferable skills, or may recommend self-employment. Retraining may include on-the-job training, a vocational-technical course, or a formal educational program.

The vocational rehabilitation counselor uses a number of tools to establish a dynamic rehabilitation plan, which changes according to the employee's ongoing progress and needs. Tools utilized include: vocational analyses, labor market surveys and functional capacity evaluations and independent medical examinations (IMEs).

On more complex claims, we may use:

- CIGNA behavioral health for employee assistance programs, psychiatric modalities, and evaluation of treatment plans

Additional services that may be provided include:

- vocational assessment, testing, counseling or job placement, provided by private vocational rehabilitation counselors
- résumé development, job search skills training, and techniques for conducting effective interviews provided by executive recruiters and business consultants
- additional funding for education, equipment, or supplies provided by state agencies or state vocational rehabilitation programs
- coordination with the workers' compensation carrier if the employee was injured on the job

10.2.5 If the employee is participating in the Rehabilitation and Return to Work program, the Insurer pays an additional 10% of the employee's gross disability payment to a maximum of $1,000/mo. In addition the Insurer makes monthly payments for 3 months following the date disability ends, and the employee is not able to find employment.

We are quoting are standard return to work provision which is not specific to benefits.

10.2.6 Dependent care expense benefit- if the employee is participating in the "rehabilitation and return to work program" the Insurer pays a dependent care expense benefit when the employee is disabled, and:

10.2.6.1 Incurs expenses to provide care to a child under 15;

10.2.6.2 And/or starts incurring expenses to provide care to a child age 15 or older, or a family member who needs personal care assistance.

We are matching the inforce benefit.

11.0 EMPLOYEE AND FAMILY AD&D (SEPARATE FROM AND IN ADDITION TO ABOVE COVERAGE (PACKAGE 2)

The current employee and family AD&D coverage is shown in Part II Specific Requirements as it relates.

CIGNA is matching the above package.

12.0 PROPOSER QUESTIONNAIRE: Please respond to all the questions listed below. Submit with your proposal.

1. Please indicate the full name of your company and the current AM best rating.

The Life Insurance Company of North America (LINA), a CIGNA company. LINA currently has an AM Best rating of "A".

2. Please indicate the name and title of the key persons that will be responsible for handling this account. Please provide a short summary of their experience in this field and what their responsibilities would be in the management of this account.

Pre-Sale

Jonathan Sheedy, Sales Representative, will be your contact during the sales process. Jonathan is located in our Houston sales office and joined CIGNA in 2007. He is a graduate of the Southwest Texas State University with a Bachelors degree in Business with a major in Finance. Prior to joining CIGNA Jonathan worked with MetLife and Sun Life and brings with him five years of industry experience.

Post- Sale

We assign your designated account management team to the account at the point we are named a finalist. This enables us to effectively manage caseloads and ensures our customers receive the high quality service they deserve. We will be pleased to provide you with the names of these individuals and a detailed biography at that point in time.

Your account is assigned to a specialized implementation coordinator, an account manager who serves as your field-based consultative resource, and an account service representative who provides your day-to-day support.

Working in conjunction with your sales representative and account management team, your implementation coordinator takes the lead to ensure the products and services you have purchased are accurate, consistent with your contract, and set up on time. Your implementation coordinator:

- develops the implementation schedule and clarifies roles/responsibilities and processes
- discusses the employee communications strategy and confirms the eligibility process
- verifies that the set-up tasks are completed and delivers the policy, certificates, and enrollment materials

As the implementation of your account nears completion, your account manager assumes primary responsibility for your CIGNA relationship and works with you throughout the year to make sure your plan runs smoothly. Your account manager also closely coordinates with your account service representative to make any necessary adjustments and helps with benefit plan set-up as needed.

Your account service representative is the point person for day-to-day activities such as inquires about billing, reporting, and our online tools. You can reach your account service representative by phone, voicemail, or email and receive immediate assistance when you need it.

Experience

Account Manager

All CIGNA account managers are experts on our products, the financial impact of benefits for your company, and the level of service you and your employees need. All our account managers have their bachelor's degree or a minimum of five years experience in a similar role, and are life and health agent licensed professionals.

We provide new account managers with structured, on-the-job experience that takes place in our field sales office and includes role-play; self-study; manager coaching and feedback; and job shadowing of experienced account managers.

Account Service Representative

CIGNA's account service representatives (ASR) have all earned college degrees or possess equivalent experience. Our initial on-site training program lasts approximately 12 weeks and provides the ASR with a thorough understanding of CIGNA policies and procedures; customer service expectations; and metrics and other position-related information. ASRs fully support the client's designated account manager and are trained on the client's benefit programs to ensure the highest level of quality customer service.

Implementation Manager

Our implementation coordinators have the following credentials:

- college degrees or equivalent work experience
- exemplary customer service skills
- excellent written and verbal communication skills to effectively communicate with clients, brokers and internal business partners;
- thorough knowledge of contract language for life, accident, and disability insurance products
- understanding of CIGNA's administrative processes and claim procedures
- understanding of CIGNA's internal functional areas

CIGNA's implementation coordinators have an average of 10 years of experience working with accounts varying in size, complexity, and service requirements.

3. Please indicate where the staff in question 2 is located.

Jonathan Sheedy is located in our Houston, TX sales office. You're designated account manager and implementation coordinator will be regionally located to Travis County, while you're designated account service representative is located in Bethlehem, PA.

4. Will you have a local representative on the team for Travis County?

Yes, you're designated account manager and implementation coordinator will be regionally located to Travis County.

5. Would the local representative be available every Monday to attend the County new employee orientation, and present the policy information?

Yes, Oma and Linda Claunch will be available every Monday to attend the County new employee orientation and present the policy information. If Oma or Linda Claunch are unable to attend these meetings, either Arbye Curtis, your Account Manager, or Jonathan Sheedy, your Sales Representative will be there to fill in during these times.

6. Do you anticipate being involved in an acquisition or merger in the next 12 months?

Proprietary and confidentiality concerns preclude any comment on planned activity, if any. However, CIGNA would take steps to ensure the continued, uninterrupted service to the individuals we serve should a merger, acquisition, or reorganization occur.

7. Please provide 4 references of entities that are similar to Travis County in size and that you provide coverage similar in nature to what is being requested. Please include contact information including a name and a phone number.

8. What customer service capability do you have?

The employer and their employees will receive quality customer service at the following locations:

National Intake Center

CIGNA's national intake center is located at our CIGNA Pointe service center in Plano, Texas, and has extended hours of operation from 7:00 a.m. to 7:00 p.m. (CST) Monday through Friday to readily accommodate various geographical client and employee locations.

Experienced claim intake specialists handle all life, AD&D, and disability insurance claims whether submitted telephonically, by fax, Internet, email, or regular mail.

Disability

During a telephonic disability insurance claim submission (our preferred method of intake), the intake specialist conducts an in-depth interview with the claimant to gather important information to help expedite the claim process. The intake specialist also answers basic questions, explains the next steps in the claim process, and sets a preliminary return-to-work date.

Life and AD&D

When the claim is submitted telephonically by the employer the intake specialist conducts an interview to gather critical claim information including:

- employee demographics, including names, date of birth, Social Security number (SSN), and home mailing address
- date of hire
- last day worked
- effective date of insurance
- amount of basic life insurance
- date of death
- beneficiary information, including name, date of birth, Social Security number (SSN), and home mailing address

At the conclusion of the interview, we let the employer know the claim specialist will contact them if additional information is needed.

If the life or AD&D claim is filed telephonically by someone other than the employer (such as a spouse, family member, or funeral home staff), we refer him/her to our Pittsburgh claims office to file their claim.

Customer Service in the CIGNA Claim Office

Pittsburgh, Pennsylvania, Life and AD&D Claim Office

The employee, beneficiary, or employer can contact the claim office to obtain claim-related information once a claim has been filed. Our life and AD&D insurance claim office is available, toll-free, between the hours of 8:00 a.m. and 5:00 p.m. (EST) Monday through Friday. Our claim form includes our 800 number and the extension of the assigned claim specialist is provided on correspondence sent after claim receipt.

Plano, Texas, Regional Disability Claim Office

Our CIGNA Pointe service center in Plano, Texas, is open from 9:00 a.m. to 6:00 p.m. (EST) Monday through Friday. The designated disability claim manager responds to employee and employer questions on employer's benefit plan design and plan coverage as well as benefit questions including STD claim status questions:

- when benefits checks will be issued
- check amount
- length of the benefit period
- confirmation of receipt of information

The claim manager also responds to more complex STD and LTD inquiries.

Additional Customer Service

Primary Account Management

Each of our clients is assigned to an account manager who is regionally located and is a product, plan design, and financial expert. Your account manager is focused on meeting your strategic and financial program objectives and works with you to review plan status, provide plan enhancement suggestions, and implement requested plan changes.

Day-to-Day Account Management

Additional client customer service is provided at our Lehigh Valley Service Center located in Bethlehem, Pennsylvania, with hours of operation from 8:00 a.m. to 8:00 p.m. (EST) Monday through Friday. This service center is staffed with CIGNA account service representatives who support your account manager and are dedicated to providing you with professional account service and immediate responses to inquiries regarding:

- premium remittance and administration
- plan forms and materials
- disability benefit tax reporting
- claims process inquiries

- application and medical underwriting processing
- policies and contracts

Every CIGNA account service representative is fully trained on CIGNA's life, AD&D, and disability insurance products and services. Our customer service professionals have a thorough understanding of your employee benefit plans and act as an extension of your human resources/benefit administrator resources.

9. How will County HRMD staff access customer service at the time of filing a claim or in case of an issue?

As detailed above, Travis County can contact the claim office to obtain claim-related information once a claim has been filed.

CIGNA provides your account manager with a blackberry device which has both phone and email capabilities. Your account manager will provide you with his or her cellular phone number and email address at the initial implementation meeting.

10. Is claim status etc. available to County staff online? Reporting?

Disability

CIGNA offers single log-on access to comprehensive online claim reporting tools to help our customers make informed decisions. Through these tools employers are able to evaluate results and identify actionable strategies to reduce incidence, durations, and the impact to their bottom line. Available at CIGNAaccess.com:

Disability Operational Reports

- on-demand, online access to claim information when employers want it, how they want it
- includes claim status reports, claim intake reports, an individual claimant information search tool, and an ad hoc report builder
- Provides access to historical reports and information
- features sort and filter tools to create a custom reusable view of the reports

Disability Analytical Reports

- on-demand access to the employer's STD and LTD claims experience
- includes normative data based on CIGNA's book of business, which enables employers to compare the employer's experience against our data to see how their program is running compared to companies with similar plan designs
- includes up to four years of claim experience with year over year comparisons, for quick identification of trends

Life & AD&D

Online claim status reports are currently unavailable; however your designated account manager can provide reports on demand.

11. Please explain the claim filing procedure for a life claim.

The initial notification of life and accident claims can be submitted telephonically, via the internet, by mail or fax.

During the internet or telephonic claim intake process the employer/administrator provides eligibility and beneficiary information and supporting documentation, such as:

- a certified copy of the death certificate
- a physician's statement (for other losses)
- original enrollment card or benefit election form
- all absolute assignment forms
- all change of beneficiary forms
- any applicable estate papers
- any applicable accident reports or medical records

If all necessary information is not provided, the claim office will generate an acknowledgement packet to send to the beneficiary or insured. The beneficiary or insured will complete their portion of the claim form and will send the information back to our Pittsburgh, Pennsylvania, claim office, including the appropriate supporting documentation.

If no additional information is needed, the claim office will begin their review and notify the insured or beneficiary of the claim decision.

12. What is your average turn around time for payment of a life claim?

We strive to provide the best service in the industry and the highest level of customer satisfaction. We have consistently met or surpassed our goals. Our standard for claim processing turnaround time is to approve or deny benefits on 95 percent of all life claims within 10 business days of receiving all required information.

In 2010, 99 percent of life claims decisions were made within 10 days of receiving all required information.

13. Is assignment of benefits available so that part of a beneficiary's payment can be assigned, for example to a funeral home? What is the procedure for that process?

Our beneficiary payment method is as follows:

Through our comprehensive CIGNAssurance® beneficiary program, life and personal accident benefit payments over $5,000 are automatically deposited into an interest bearing account with check writing privileges that is cleared through State Street Bank.

A book of drafts is provided to the beneficiary, who is able to write an unlimited number of drafts, at any time, until the account is cleared. Interest is compounded daily, credited monthly and begins to accrue when the claim is paid. The account earns competitive interest comparable to a money market checking account. Statements are provided on a quarterly basis. Additionally, there are no maintenance charges or penalties for withdrawals.

Beneficiary settlements of less than $5,000 are paid in a lump sum.

The beneficiary is able to use this settlement for any reason including funeral costs.

14. Please provide a sample of forms that are required at the time of claim.

Sample claim forms have been provided on CD attached within your proposal binder.

15. Can claims be submitted by fax, or online, or must they be mailed. Specify if life, disability or AD&D.

Yes. We offer a variety of claim reporting options for all claims at no additional cost to our customers. They include:

- toll-free telephone (preferred)
- web-based, 24 hours a day, 7 days a week access via CIGNA.com (preferred)
- email
- paper (mail or fax)

16. Do you require originals or accept copies or faxes of death certificates?

We will process the claim with a faxed copy of the death certificate, so long as there are no fraud indicators. We will request a certified copy from the beneficiary for completion of our records.

17. Please provide detailed procedures required of employer for remitting payment, filing a claim, and any other required duties of employer.

Disability

In a self-administered plan, the employer distributes materials, communicates the process for filing a claim, and assists us in verifying eligibility, either

through an employer verification form, or through an eligibility file feed. When we are notified of a claim, and a file feed is not in place, we may ask for additional information regarding employment status and history, salary history, premium contribution and history, physical demands of the job/job description, and any supplementary enrollment forms or beneficiary designations. When an employee has reached a level of functional capacity that allows them to return to work, we will coordinate this effort with the employer.

To help Travis County communicate with employees on disability, CIGNA provides our Manager's Disability Toolkit℠. This easy-to-use, web-based tool provides a practical guide to managing each phase of a disability absence from the initial report through return to work and every step in between. A link is emailed to your designated contact at intake and provides consistency during the claim management process. The toolkit provides many features including but not limited to:

- communication do's and don'ts
- sample scripts for speaking with the employee
- what to expect from your CIGNA disability claim manager
- information on FMLA
- suggestions for return-to-work

Life & AD&D

Although we will perform the majority of the administration requirements, there are a limited number of administrative duties required of the employer. Responsibilities include taking the deduction and remitting of premiums to CIGNA; providing employees' current employment status and updated salary information; and providing eligibility data to support enrollment, beneficiary administration, and portability/conversion notice distribution.

Our rates include all charges and costs associated with the implementation, communication, enrollment, and ongoing administration of your program.

NOTE: PARTS II, III, AND IV, ALONG WITH THE CONTRACTOR'S PROPOSAL, AND ANY DEVIATION TO WHICH TRAVIS COUNTY HAS AGREED, IN WRITING, WILL BECOME THE CONTRACT.

State insurance laws require that the policy of insurance be written on state insurance department approved forms and contain the entire contract. If awarded the business, we will issue policies on state approved forms that reflect the substantive terms stated in our proposal. While provisions of our proposal will be reflected, where appropriate, in the policy or in other related agreements, we cannot agree to incorporate our proposal in its entirety into the contract.

1.0 GENERAL REQUIREMENTS:

1.1 Travis County is seeking proposals to provide the following optional coverage's available on a 100% voluntary basis, all to be effective October 1, 2011:

1.1.1 Supplemental Term Life and Accidental Death & Dismemberment (AD&D) for the employees of Travis County,

1.1.2 Dependent Life and additional Spouse life Insurance for the employees of Travis County (legal spouse and children up to age 26)

1.1.3 Retiree Life Insurance for the Retirees of Travis County

1.1.4 Short Term Disability

1.1.5 Long Term Disability

1.1.6 Employee and dependant AD&D

Confirmed.

2.0 SUPPLEMENTAL LIFE AND AD&D FOR ACTIVE EMPLOYEES AND THEIR DEPENDENTS, AND RETIREES AND THEIR DEPENDENTS

ACTIVE EMPLOYEES

2.1 Supplemental Life and AD&D coverage must be offered in at least $25,000 increments up to at least a maximum of $250,000 or four times an employee annual salary (rounded up to nearest multiple of $25,000.

The above benefits have been matched.

2.2 AD&D must be in a matching amount to the life amounts chosen.

Confirmed.

2.3 New Hires must have the ability to select any amount (within the above guidelines) at their initial enrollment. At open enrollment each subsequent year an employee must be able to increase their coverage by one $25,000 increment with no underwriting. There cannot be a reduction schedule on the supplemental life and AD&D for active employees.

During approved enrollment periods, we require evidence of insurability (EOI) only for amounts that exceed the guaranteed issue amount. We require EOI for all coverage amounts requested outside of initial enrollment period, or within 31 days of becoming eligible for coverage, if eligibility does not coincide with an enrollment period.

2.4 A full time active employee must be eligible for coverage if the employee works a minimum of 20 hours a week in a benefited position.

Confirmed.

3.0 DEPENDENT LIFE AND SPOUSE LIFE

3.1 An active employee must be able to choose optional life coverage for their dependents (legal spouse and children up to age 26).

Confirmed.

3.2 Supplemental employee life coverage must not be required to purchase dependent life coverage. No AD&D coverage applies on dependents.

Confirmed.

3.3 The base benefit for this coverage must be at least:

3.3.1 Basic Dependent Life

3.3.1.1 $10,000 spouse

3.3.1.2 Child $5,000 (6 months to age 26)

3.3.1.3 Infant $1,000 (14 days to 6 months)

The above benefits have been matched.

3.4 Additional Optional Spouse Life must be at least available in the following amounts.

3.4.1 $10,000

3.4.2 $20,000

The above benefits have been matched.

3.5 Spouses that are also current active County employees must not be eligible to be covered as dependents

Noted.

4.0 RETIREE LIFE

4.1 The retiree and retiree spouse voluntary life coverage may be is divided into coverage for ages 70 or less, and coverage for ages 71 and over with separate benefits and age based rates determined by the age of the retiree for these two categories.

The above benefits have been matched.

4.2 Spouse must be covered at the time of retirement to be eligible for coverage.

Confirmed.

4.3 There must not be a reduction schedule on retiree life coverage, other than reducing to the over 71 amount at that age.

Confirmed.

4.4 The benefits must be at least:

4.4.1 Age 70 or less: Retiree

Basic Benefit $15,000 guarantee issue, with a buy up option of $10,000 that requires underwriting based on an evidence of insurability form, submitted directly by the retiree.

The above benefit has been matched.

4.4.2 Age 70 or less: Retiree Spouse

Basic Benefit is $7,500 guarantee issue, with a buy-up option of $5,000 that requires underwriting based on an evidence of insurability form submitted directly by the retiree.

The above benefit has been matched.

4.4.3 Age 71 or over: Retiree

Basic Benefit $5,000.

The above benefit has been matched.

4.4.4 Age 71or over: Retiree Spouse

Basic Benefit $2,500

The above benefit has been matched.

5.0 PORTABILITY

5.1 The supplemental life, AD&D and dependent life coverage for actives must have a portability feature, available at the time of termination or retirement with the right to increase coverage and add dependents at any time with evidence of insurability in accordance with company policy. Experience of personnel taking portable coverage must not be included in the Travis County experience.

Confirmed.

5.2 Acceptance of portability coverage by Contractor must be acknowledged to Insured at time of application, not at time of claim.

Confirmed.

6.0 EMPLOYEE SHORT TERM DISABILITY: The short term disability coverage must include at least the following or equivalent features:

6.1 ELIGIBILITY: Active employee working a minimum of 20 hours per week

Confirmed.

6.1 GUARANTEED ISSUANCE: New employees/new hires must elect coverage within their initial eligibility period. If they do not elect coverage within this period, they can only elect coverage during annual open enrollment or within 31 days of a qualifying family change in status. No medical underwriting is required.

During an approved open enrollment period, applications for disability insurance coverage are not medically underwritten and evidence of insurability (EOI) is not required.

6.3 WEEKLY BENEFITS AMOUNT: 60% of your weekly earnings to a maximum of $1500/week.

The above benefit has been matched.

6.4 DEFINITION OF DISABILITY:

6.4.1 Disability occurs when a carrier determines that the employee:

6.4.1.1 is limited from performing the material and substantial duties of his or her regular occupation due to sickness or injury; and

6.4.1.2 has a 20% or more loss in weekly earnings due to that sickness or injury.

We consider an employee disabled if, solely because of injury or sickness, he or she is unable to perform all the material duties of his or her regular occupation and, solely due to injury or sickness, he or she is unable to earn more than 80% percent of his or her indexed covered earnings from working in his or her regular occupation.

6.4.2 The loss of a professional or occupational license or certification does not, in itself, constitute disability.

Confirmed.

6.4.3 Employee may be required to be examined by a physician, other medical practitioner and/or vocational expert of insurer's choice. Insurer pays for this examination.

Confirmed.

6.4.4 Insurer can require an examination as often as it is reasonable to do so.

Confirmed.

6.4.5 Insurer may also require employee to be interviewed by its authorized Representative.

Confirmed.

6.4.6 This definition of disability that allows an employee to try to partially return to work after the elimination period.

Confirmed.

6.5 ELIMINATION PERIOD: Fourteen (14) day elimination period due to disability. Benefits begin the day after the elimination period is completed.

Confirmed.

6.6 BENEFIT DURATION: Up to a 13 week benefit period.

6.7 PRE-EXISTING CONDITIONS EXCLUSION: 3/12

Confirmed.

7.0 EMPLOYEE LONG TERM DISABILITY The long term disability coverage must include at least the following or equivalent features:

7.1 ELIGIBILITY: Active employee working a minimum of 20 hours per week.

Confirmed.

7.2 GUARANTEE ISSUE: New employees/new hires must elect coverage within their initial eligibility period. If coverage is not elected within this period, coverage can only be elected during annual open enrollment or within 31 days of a qualifying family change in status. No medical underwriting is required.

During an approved open enrollment period, applications for disability insurance coverage are not medically underwritten and evidence of insurability (EOI) is not required.

7.3 WEEKLY BENEFITS AMOUNT: 60% of monthly earnings to a maximum of $6,000.

The above benefit has been matched.

7.4 DEFINITION OF DISABILITY:

7.4.1 The employee is disabled when an Insurer determines that the employee:

7.4.1.1 is limited from performing the material and substantial duties of your regular occupation due to your sickness or injury; and

7.4.1.2 has a 20% or more loss in your indexed monthly earnings due to the same sickness or injury.

7.4.1.3 After 24 months of payments, the employee is disabled when Insurer determines that due to the same sickness or injury, the employee is unable to perform the duties of any gainful occupation for which the employee is reasonably fitted by education, training or experience.

After disability benefits have been payable for 24 months an employee is disabled if solely due to injury or sickness he or she is unable to perform all the material duties of any occupation for which he or she may reasonably become qualified based on education, training or experience; and solely due to injury or sickness, unable to earn more than 80 percent of his or her indexed covered earnings.

7.4.2 The loss of a professional or occupational license or certification does not, in itself, constitute disability.

Confirmed.

7.4.3 Insurer may require the employee to be examined by a physician, other medical practitioner and/or vocational expert of its choice. Insurer pays for this examination. Carrier can require an examination as often as it is reasonable to do so.

Confirmed.

7.4.4 Carrier may also require you to be interviewed by an authorized carrier Representative.

Confirmed.

7.5 ELIMINATION PERIOD: 90 day elimination period from date of disability or when employee's short term disability payments end, if any. Benefits begin the day after the elimination period is completed.

Confirmed.

7.6 BENEFIT DURATION: Based on the age when disability occurs. Payable for the period during which you continue to meet the definition of disability up to the social security normal retirement age. If your disability occurs at or after age 62, benefits would be paid for a reduced period of time.

Confirmed.

7.7 PRE-EXISTING CONDITIONS EXCLUSION: 6/12/24

Confirmed.

8.0 EMPLOYEE AND FAMILY AD&D

8.1 The employee and family AD&D coverage must be separate from and in addition to the life and AD&D coverage described in 2.0 through 5.0 above and available to active employees working 20 or more hours a week. Employees can cover themselves or self and family.

Confirmed.

8.2 Coverage must be available in amounts from $25,000 up to$500,000 in units of $25,000 up to a maximum of 10x annual salary.

Confirmed.

8.3 Family member's coverage must be a percentage of the benefit amount selected. A reduction schedule is acceptable on this policy.

Confirmed.

8.4 Dependents age 70 or more need not be eligible, and if a covered dependent reaches age 70, coverage may end for that dependent.

Confirmed.

8.5 Dependent children must be eligible up to age 26.

Confirmed.

8.6 The full amount of Employee benefit must be determined by type of loss.

Confirmed.

8.7 The full amount of Spouse benefit must be 50% of full employee amount if there are one or more dependents. If there are no dependent children, the full amount of the Spouse benefit must be 60% of the full employee amount with a maximum of $300,000.

Confirmed.

8.8 The full amount of Child benefit must be 10% of full employee amount if there is a spouse; if there is no spouse, the full amount of Child benefit must be 15% with a maximum of $25,000.

Confirmed.

Attachment G-2

Table of Services – Performance Measures

Table of Service Performance Measures

Client Name: Travis County

Policy Number:

Account Management

Performance Standard	Basis of Measurement	Evaluation Method	Evaluation Period	Penalty Amount
CIGNA guarantees that the account management services CIGNA provides in connection with the Plan will be satisfactory. Performance measurements will include: a. Acknowledge all telephone/e-mails from the Plan within one business day establishing a clear expectation for timely resolution of the request b. Communications (verbal & written) as well as face to face meetings with Plan are regular as defined by the plan and Account Manager c. Account Manager is consultative and solutions oriented utilizing knowledge of CIGNA's products & services to complement the Plan d. Concerns with the Plan are identified and addressed in a timely manner. e. Expert knowledge of the Plan including specific program requirements.	Customer Specific	Completion of the Standard Annual [Semi-Annual, Quarterly] Account Management Survey. A score of 'Satisfied' or better, as measured by an average of the designated members of the Client's staff is considered customer satisfaction.		5% of the total amount at risk The total amount payable during the Term of this Agreement for failure to meet Account Management performance standards shall not exceed $1,000.

Table of Service Performance Measures

Client Name: Travis County **Policy Number:**

Account Management - Continued

Performance Standard	Basis of Measurement	Evaluation Method	Evaluation Period	Penalty Amount
Renewal Management Provide the Plan with renewal notice [120, 150, or 180] days before each rate guarantee termination date. Complete renewal package justifying the proposed renewal action will be presented at that time.				5% of the total amount at risk The total amount payable during the Term of this Agreement for failure to meet Renewal Management performance standards shall not exceed $1,000.

Customer Service – Includes Disability, Life & FMLA Products

Performance Standard	Basis of Measurement	Evaluation Method	Evaluation Period	Penalty Amount
Average Speed to Answer: Calls will be answered in 30 seconds or less, based on an annual average and book of business.	Network Level based on all calls received in the Intake Center during the term of the agreement.			Average Speed of Answer: 5% of the overall PG dollars at risk. The total amount payable during the Term of this Agreement for failure to meet this performance standard shall not exceed $1,000.
Abandonment Rate: Abandonment Rate will be 3.5% or less (based on an annual average).	Network Level based on all calls received in the Intake Center during the term of the agreement.	Abandonment rate reflects those callers that disconnect their call prior to being connected to a representative [1].		Abandonment Rate: 5% of the overall PG dollars at risk. The total amount payable during the Term of this Agreement for failure to meet this performance standard shall not exceed $1,000.
Notes – Customer Service 1 Any call that abandons in 30 seconds or less (ASA Standard) will not be counted as an abandoned call since the caller did not give us the opportunity to answer the call within our standard.				

Client Name: Travis County **Policy Number:**

Customer Service – Includes Disability, Life & FMLA Products - Continued

Performance Standard	Basis of Measurement	Evaluation Method	Evaluation Period	Penalty Amount
Disability ***STD Decision Time*** For all STD claims received for the *Policy/Planholder* during the term of the agreement, initial decisions will be rendered within the following standards[1]: • 50% within 5 business days of receipt of claim. • 80% within 10 business days of receipt of claim.	**Customer Specific** Will be based on a report of all claims processed for the customer during the term of the agreement2.	Decision time will be measured as time from the date of initial submission of claim (telephone call, paper form, fax or e-mail), to the date of approval/ denial of claim.		10% of the overall PG dollars at risk. The total amount payable during the Term of this Agreement for failure to meet this performance standard shall not exceed $2,000.
STD Payment Accuracy For all STD claims received in the Field Claim Office servicing the Policy/Planholder during the term of the agreement, 95% of claim dollars will be paid correctly.	**Field Claim Office** level based on random audit of all STD files processed in the claim office during the term.	Will be calculated as the total correct dollars minus the total dollars that were paid incorrectly, including overpayments and under payments, divided by the total correct dollars.		5% of the overall PG dollars at risk. The total amount payable during the Term of this Agreement for failure to meet this performance standard shall not exceed $1,000.
STD Coding Accuracy For all STD claims received in the Field Claim Office servicing the Policy/Planholder during the term of the agreement, coding will be 95% correct.	**Field Claim Office** level based on random audit of all STD files processed in the claim office during the term.	Will be calculated by dividing the total correct coding items by the total number of coding items audited.		5% of the overall PG dollars at risk. The total amount payable during the Term of this Agreement for failure to meet this performance standard shall not exceed $1,000.

Table of Service Performance Measures

Client Name: Travis County **Policy Number:**

Customer Service – Includes Disability, Life & FMLA Products - Continued

Performance Standard	Basis of Measurement	Evaluation Method	Evaluation Period	Penalty Amount
LTD Decision Time For all LTD claims received for the *Policy/Planholder* initial decisions will be rendered within the following standards[3]: • 90% as of the LTD Benefit Start Date	**Customer Specific.** Will be based on a report of all claims processed for the customer during the term of the agreement.[4]	Date of decision will be considered the date the decision is reached and documented[5].		10% of the overall PG dollars at risk. The total amount payable during the Term of this Agreement for failure to meet this performance standard shall not exceed $2,000. .
LTD Offset Management (Social Security) For LTD claims received for the *Policy/Planholder*, 95 % of all claimants who meet our referral criteria will be offered assistance with their initial Social Security application within 30 days of their Long Term Disability claim approval[6].	**Customer Specific.** Will be based on a report of all claims processed for the customer during the term of the agreement.	Performance will be evaluated by system generated report and validation.		10% of the overall PG dollars at risk. The total amount payable during the Term of this Agreement for failure to meet this performance standard shall not exceed $2,000.
LTD Payment Accuracy For all LTD claims received in the Field Claim Office during the term of the agreement, 95% of claim dollars will be paid correctly.	**Field Claim Office** level based on random audit of all LTD files processed in the claim office during the term.	Will be calculated as the total correct dollars minus the total dollars that were paid incorrectly, including overpayments and under payments, divided by the total correct dollars.		5% of the overall PG dollars at risk. The total amount payable during the Term of this Agreement for failure to meet this performance standard shall not exceed $1,000.

Client Name: Travis County **Policy Number:**

Customer Service – Includes Disability, Life & FMLA Products - Continued

Notes – Disability

[1]*Claims where employer information is not provided within 5 business days from receipt of claim will be excluded from Evaluation of Performance.*
[2]*This measurement is only measured and evaluated if a valid eligibility feed is in place. For statistical purposes, this penalty will not be paid unless claim volume exceeds threshold of 50 claims.*
[3]*LTD decision time standard will not apply if CIGNA has not received the associated STD claim within 60 days of the LTD Benefit Start Date.*
[4]*This measurement is only measured and evaluated if a valid eligibility feed is in place. For statistical purposes, this penalty will not be paid unless claim volume exceeds threshold of 50 claims.*
[5]*Payment or letter communicating adverse decision will be released within 48 hours of decision.*
[6]*Qualified Claimants will be those who meet **all** of the following criteria:*

1 - As of the date of approval, are not expected to return to work within 9 months from the onset of disability.
2 - Are not within 6 months of Social Security full retirement age as of the Benefit Start Date.
3 - Are not making claim for disability based on a diagnosis of pregnancy.
4 - As of the Benefit Start Date, are not earning greater than the Social Security earnings threshold ($1000/month in 2010).

Attachment G-3

DISABILITY PROGRAM SUPPORT SERVICES FROM CIGNA

CIGNA's unique disability management model focuses on early identification and intervention, coupled with coordinated case management and extensive return-to-work support. CIGNA's disability plans have several competitive services at no cost and depending on workforce needs and budget requirements; employers can also choose to include valuable optional services.

Standard Services Provided at No Additional Cost	Insured STD	STD ASO w/Check Cutting	STD ATP Durational	STD ATP Financial	Insured LTD	Comments
Flexible Claim Notification: ***offers multiple methods to report claims, and the sooner claims are reported, the sooner employees return to work***						
Intake - telephonic with voice authorization, mail, web, and email	√	√	√	√	√	Verbal authorization enables quicker access to medical info and faster claim decisions
Expert Claims Management: ***develops coordinated return-to-work efforts to help employees return to work quickly and safely***						
Medical/nurse case management	√	√	√	√	√	
Vocational Rehabilitation Services	√	√	√	√	√	Rehabilitation counselors develop personalized plans for individuals and recommend assistive equipment, as needed
Social Security assessment & assistance services	√				√	More than 98% of CIGNA's LTD claims are awarded SSDI benefits before the first 36 months of coverage has ended
Overpayment recovery services	√				√	
Comprehensive Tax-Related Services & Reports: ***relieve administrative burden, save time and free up resources***						
Preparation of W2 statements for taxable disability benefit plans	√	√			√	
Employee FICA withholding & depositing	√	√			√	The employer self reports & self-pays employer FICA
Employer FICA Match (insurance)	Optional				√	Optional - requires an added cost
Comprehensive Claim Reporting: ***helps employers make informed decisions and manage costs***						
Online disability claim summary and trend reports	√	√	√	√	√	Available to clients with 200 or more employees
Online client administrative reporting system (CARS)	√	√	√	√	√	
CIGNA Express®	√	√	√	√	√	Requires 5,000+ employees
Consultative reporting package	√	√	√	√	√	Requires 10,000+ employees
myCIGNA.com online employee tool	√	√	√	√	√	
Expert Client Support Services: ***simplify administration and help with overall plan management***						
Client welcome package	√	√	√	√	√	
Account management and implementation services	√	√	√	√	√	
CIGNA's ADA Helpline	√	√	√	√	√	Expert ADA assistance/support
Online billing and payment	√	√	√	√	√	
Managers & Physicians Disability Toolkits℠	√	√	√	√	√	

Standard Services Provided at No Additional Cost	Insured STD	STD ASO w/ Check Cutting	STD ATP Durational	STD ATP Financial	Insured LTD	Comments
Value-Added Programs: ***help employees and their families maintain their health and well-being***						
CIGNA's Healthy Rewards®	√	√	√	√	√	Employee discounts of up to 60% on health/wellness services
CIGNA's Will Preparation Program	√	√	√	√	√	Employees save money by creating legal documents online
CIGNA's Disability & Healthcare Connect® (For clients with CIGNA disability and CIGNA health care): ***helps improve and maintain employee health, prevent and reduce costly medical and lost-time events***						
Early intervention based on medical condition	√	√	√	√	√	Employees have at least a 5% - and up to 37% - greater likelihood of returning to work as a result of CIGNA's integrated clinical activities
Disability & medical case management coordination	√	√	√	√	√	
Claim referrals to EAP, health advocacy and disease management	√	√	√	√	√	
Integrated activities report	√	√	√	√	√	
Optional Services Offered at an Additional Cost	**Insured STD**	**STD ASO w/ Check Cutting**	**STD ATP Durational**	**STD ATP Financial**	**Insured LTD**	**Comments**
Comprehensive FMLA/Leave Of Absence Administration (available to clients who have both STD and LTD): ***helps improve disability outcomes, track, manage and reduce employee absence for more efficient and compliant leave administration***						
Single point of intake	√	√	√	√	√	
Seamless integration with CIGNA's industry-leading disability management capabilities	√	√	√	√	√	
Customizable communications and real-time employer notifications	√	√	√	√	√	
Employer-dedicated leave managers and highly trained and experienced staff	√	√	√	√	√	
Clinical oversight of intermittent and family-related health absences	√	√	√	√	√	
Integrated operational and management summary reports	√	√	√	√	√	
Robust EAP Portfolio: ***offers industry-leading employee assistance programs which can help to reduce absences and improve productivity***						
CIGNA's Life Assistance Program[SM]					√	Accessing CIGNA's EAP services helped improve the work productivity of 94% of those employees who had productivity issues
Full Service EAP					√	
Comprehensive Tax-Related Services & Reports: ***relieve administrative burden, save time and free up resources***						
Employer FICA Reimbursement Service	√	√			√	
Employer FICA Match (insurance)	√					Standard on insured LTD

Other Helpful Services: ***offers solutions to relieve administrative burdens***						
Health & Welfare deductions	√	√			√	
Complex Claims management					√	Sold as an alternative to a traditional insured or self-insured STD program; requires CIGNA's insured LTD coverage
On-Site Disability Management					√	Available to clients with 10,000 or more employees
Return-to-Work Consulting Services	√	√	√	√	√	Available to clients with 10,000 or more employees
Integrated disability management and workers? compensation coordination	√	√	√	√	√	
California Voluntary Plan						Provides short term disability and paid family leave administrative services in lieu of the California State Disability Insurance (SDI) and Paid Family Leave Insurance plans provided by the state of California

Notes

- Where indicated above, optional services require an additional purchase by the client. This includes the ER FICA Match insurance offering available on insured STD;
- CIGNA's ADA Helpline is a free client resource staffed with trained professionals and provides access to other extensive support. Clients can call the toll-free at 800.435.7030, Monday through Friday, 9:00 am to 5:00 pm EST (excluding holidays)
- Some Healthy Rewards® programs are not available in all states. A discount program is not insurance, and the employee must pay entire discounted charge for any services accessed through the program;
- CIGNA's Social Security award rate is for employees identified as likely eligible for SSDI benefits and referred for SSDI claim application assistance;
- CIGNA's Disability & Healthcare Connect® return-to-work results are based on CIGNA's 2007 Integration Value Study, analyzing claim results of 40 customers with a total of 300,000 employees;
- The employee productivity improvement results for CIGNA's EAP Portfolio are based on a CIGNA 2009 EAP participant satisfaction telephonic survey.

CIGNA ADMINISTRATIVE SERVICES OVERVIEW

The following outlines services provided when Employer Administration or CIGNA Administration is elected. Please refer to the Proposal Voluntary Administrative Summary for the program being offered with the product(s) shown on the Schedule of Benefits Summary.

Service	EMPLOYER Administered Plan		CIGNA Administered Plan	
	What you will do	What CIGNA will do	What you will do*	What CIGNA will do
Employer Eligibility Information				
• Eligibility Feed (Full File Only)	√[1]		√	
Enrollment Event				
• Initial	√			√
• Ongoing	√			√
• Changes & Adjustments	√			√
Medical Underwriting Reporting to Employer				
• Paper - Weekly		√		N/A
• Online Reporting & Inquiry		√[2]		N/A
Billing & Reconciliation				
• Web based self-reporting of premium	√			N/A
• Calculate Premium Payable	√			√
• List Billing (Itemized Deductions and Product) - Paper, Electronic File & Web		N/A		√
Remittance				
• Consumer-level variance reporting	N/A		√	
• Policy Level Remittance	√		√	
Customer Service				
• Single 800 number		N/A		√
• Plan Detail Information	√			√
• Eligibility Verification	√			√
• Confirmation of Coverage	√			√
• Beneficiary Maintenance & Recordkeeping	√	√[2]		√
Consumer Administrative Changes				
• Address changes	√			√
• Dependent information updates	√			√
• Assignment Processing	√			√
Claim Processing				
• Verify Claim Eligibility	√			√
• Coordinate Waiver of Premium Claim	√			√
• Update billing, based upon claim status	√			√
Conversion/Portability Notices	√	√[2]		√

* While CIGNA manages the administration of your voluntary program, your ongoing endorsement and support of the program is essential to its success, specifically, in order to maximize both initial and ongoing employee participation. This support may come in the form of distributing enrollment materials, sponsoring enrollment meetings, providing materials to both current employees prior to enrollment, and to new employees to encourage their participation in the benefits program, as well as posting materials physically or electronically where your employees can access them easily. In addition, on an ongoing basis, you will need to provide information to CIGNA that will ensure accurate eligibility and billing.

[1] Eligibility feeds required if CIGNA providing portability and/or conversion service, beneficiary administration or online evidence of insurability services.
[2] For CIGNA to provide this service, you will be required to provide ongoing eligibility feeds.

Life Insurance Company of North America
1601 Chestnut Street
Philadelphia, Pennsylvania 19192-2235

AMENDMENT

Policyholder: Trustee of the Group Insurance Trust for Employers in the the Public Administration Industry

Subscriber: Travis County

Policy No.: OK 960892

This Amendment is attached to and made part of the Policy specified above. It is subject to all of the policy provisions that do not conflict with its provisions.

Effective October 1, 2011, Subscriber and We hereby agree that the Policy is amended as follows:

1. The attached form, TL-007152 (Modification of the Group Policy to Add Domestic Partner as an Eligible Dependent for Accident Insurance), is added to the Policy. It replaces any Domestic Partner provisions that may have been issued previously.

2. Effective October 1, 2011, the following rates will be in force for coverage under the Policy:

Premium Rate:	Voluntary Insurance	
	Employee Rate:	$0.02 per $1,000
	Family Rate:	$0.035 per $1,000

   No change in rates will be made until 36 months after the effective date of this Amendment. However, the Company reserves the right to change the rates at any time during a period for which the rates are guaranteed if the conditions described in the Changes in Premium Rates provision under the Administrative Provisions section of the Policy apply.

Except for the above, this Amendment does not change the Policy in any way.

Life Insurance Company of North America

Matthew G. Manders, President

Date: July 28, 2011(revised April 20, 2012)

Amendment No. 03

GA-00-4000.00

Life Insurance Company of North America
a stock insurance company

Rider to Group Policy No. OK 960892
Effective Date of Rider: October 1, 2011

Eligible Classes to which this Rider applies: All Classes

MODIFICATION OF GROUP ACCIDENT POLICY
TO ADD DOMESTIC PARTNER AS AN ELIGIBLE DEPENDENT
FOR ACCIDENT INSURANCE

The provisions of the Policy are modified as follows:

1. A. All references to the term "Spouse" are replaced with "Spouse or Domestic Partner", except for the following references:
   a. The definition of "Spouse" remains unchanged.
   b. Any reference to "lawful spouse", "legal spouse", "legal spouse" remains unchanged.
   c. The reference to "spouse" in the last paragraph of the section titled, "Beneficiary" under the Claim Provisions, remains unchanged.
   d. The item regarding when a Spouse's coverage will end in the paragraph titled, "Termination of Insurance" under the Eligibility and Effective Date Provisions, remains unchanged.

   B. In the paragraph titled, "Termination of Insurance" under the Eligibility and Effective Date Provisions, the following item regarding when a Domestic Partner's coverage will end is added:

   "6. with respect to a Domestic Partner, the date of the death of the covered Employee or the date such person no longer qualifies as a Domestic Partner, unless such person elects to continue insurance. See *Continuance of Insurance* section."

   C. Under the General Definitions, item number 3 in the last paragraph of the "Dependent Child(ren)" definition, is changed to:

   3. Stepchild who resides with the Employee, including a Domestic Partner's child who resides with and is financially dependent upon the Employee.

2. The following Domestic Partner definition is added to the General Definitions section of the Group Policy.

   Domestic Partner means a person of the same or opposite sex who meets all of the following criteria:

   a. Shares the covered Employee's permanent residence;
   b. Has resided with the covered Employee and is expected to continue to reside with the Employee;
   c. Is financially interdependent with the covered Employee and shares the common necessities of life with the Employee;
   d Has signed a domestic partner declaration with the covered Employee, if the covered Employee resides in a jurisdiction that provides for domestic partner declarations;
   e. Has not signed a domestic partner declaration with any other person within the last 12 months, if the Employee resides in a jurisdiction that provides for domestic partner declarations;
   f. Is no less than 18 years of age;
   g. Is not currently legally married to any other person; and
   h. Is not a blood relative any closer than would prohibit legal marriage.

In addition to the above requirements, consent of either party to the Domestic Partner relationship must not have been obtained by force, duress, or fraud, these have the same effects as on the validity of a marriage in Texas.

A covered Employee's Domestic Partner is eligible for Accident Insurance Benefits under the Policy on the later of the Employee's eligibility date or the date the person becomes the covered Employee's Domestic Partner and if all the following conditions are met.

a. The covered Employee has not been married to any person within the last 31 days.
b. The Domestic Partner is the only person meeting the Policy's definition of "Domestic Partner" with respect to the covered Employee.
c. The covered Employee and Domestic Partner furnish a notarized affidavit or signed statement reflecting these requirements, and an agreement to notify the Insurance Company if the requirements cease to be met, on a form acceptable to the Insurance Company.

3. To obtain insurance for a Domestic Partner, a covered Employee must request coverage in writing and agree to make any required premium contributions. Insurance will be effective for a Domestic Partner on the same date specified for a Spouse in the section titled "Effective Date for Individuals" under the Eligibility and Effective Date Provisions of the Policy.

The Principal Sum applicable to a Domestic Partner is the same Principal Sum applicable to a Spouse as shown in the Schedule of Benefits.

Benefits for a covered Domestic Partner will be paid in accordance with the Claim Provisions of the Policy.

Except for the above, this Rider does not change the Group Policy to which it is attached.

LIFE INSURANCE COMPANY OF NORTH AMERICA

Matthew G. Manders, President

TL-007152

Attachment G-4

CIGNA Group Insurance
Life · Accident · Disability

AGREEMENT
CONCERNING DESIGNATION OF BENEFICIARIES USING ELECTRONIC SYSTEMS

Between	X Life Insurance Company of North America ☐ CIGNA Life Insurance Company of New York ("Company")
And	Travis County ("Employer")
Concerning	FLX964188, FLX964189, OK965800 and OK960892 ("Policies")
Effective	October 1, 2011

WHEREAS, Company has issued the Policies, to insure certain employees of Employer; and

WHEREAS, such employees have the right under the terms of the Policies to designate a beneficiary with respect to death proceeds; and

WHEREAS, Employer wishes to employ electronic systems, including web-based or telephone interactive voice response systems, to obtain and maintain records of employees' designation of beneficiaries; and

WHEREAS, the Policies provide that such electronic systems may be used to obtain and maintain records of employees' designation of beneficiaries, with Company's consent, or otherwise to maintain records of beneficiary designations;

IN CONSIDERATION OF the promises contained herein, the parties agree as follows.

1. Employer may obtain and maintain beneficiary designations using a web-based system, and/or an interactive voice response telephone system, subject to the requirements of this Agreement. Company agrees to Employer's use of such system(s) and agrees to recognize beneficiaries made pursuant to the system(s) as valid beneficiaries under the Policies. Company and Employer agree that beneficiary designations made under the Policies must be designated using such system(s), or in writing signed by the employee.

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North America, a CIGNA company

2. Employer shall maintain suitable safeguards to assure that only authorized persons are permitted to access any electronic system for the purpose of designating beneficiaries. Employer represents and warrants that such system shall accept only designations made by authorized persons; and that, if required by the terms of the policy, that such designations will be deemed to be "in writing" and "signed," in accordance with the Electronic Signatures in Global and National Commerce Act (E-SIGN). Company assumes no responsibility for the design or operation of such system.

3. Nothing herein contained shall be construed as preventing Company from exercising its discretion, in good faith, to determine who is entitled to benefits under the terms of the Policies and applicable law.

4. Employer shall maintain records of all beneficiary designations and shall provide such records to Company upon request.

5. This Agreement shall be effective on the Effective Date stated above, even if signed prior or subsequent thereto. This Agreement shall be applicable with respect to claims under the Policies on account of deaths occurring on or after the Effective Date.

IN WITNESS WHEREOF, and intending to be legally bound, the parties have executed this agreement.

LIFE INSURANCE COMPANY OF NORTH AMERICA

____
("Employer")

Date____________________

____
By:
Title:

Attachment G-5

CIGNA Group Insurance
Life · Accident · Disability

ERISA COVERAGE WORKSHEET

Use this worksheet to determine whether a policy is issued in conjunction with ERISA. Where a policy is issued in conjunction with ERISA, the following will apply:

1. The insurance company will serve as the employer's named fiduciary for handling claims in accordance with ERISA regulations. The "Appointment of Claim Fiduciary" is required.
2. Certificates of insurance will be prepared with ERISA Summary Plan Description wording included.
3. Information will be provided for the ERISA Annual Report, Form 5500, Schedule A.
4. Claim-related correspondence will comply with ERISA requirements, including notification of rights granted by ERISA regulations.

Name of Policyholder: Travis County

		Effective Date:
Life Policy No(s):	FLX-964188, FLX-964189	10/1/2011
Accident Policy No(s):	OK-965800	10/1/2011
Disability Policy No(s):	VDT-960953, VDT-960952	10/1/2011

In general, any group insurance policy issued to an employer to insure employees, or to a labor union to insure union members, is subject to ERISA. **All policies will be considered to be subject to ERISA unless one of the following exemptions applies.**

- ☐ The policy is not issued to insure employees of an employer, or members of a labor union.
- ☐ The policy is a statutory disability policy (e.g. Hawaii, New Jersey, New York).
- ■ The policyholder is a government employer (e.g. state, county, city, special services district, public school district, public hospital, state college or university).
- ☐ The policyholder is a church group (religious organization, or hospital, school, or college operated by a religious organization) which has not made an election under IRC Section 410(d) to be subject to ERISA.
- ☐ The plan is a short-term, uninsured salary continuance plan funded with general assets of the employer.
- ☐ The plan is voluntary, funded entirely with employee contributions, and is not enrolled or endorsed by the employer; employer participation is limited to permitting the insurance company to conduct enrollments, and handling payroll deductions.
- ☐ None of the above exemptions apply. The policy is issued as part of an ERISA-covered employee benefit plan. If this is the case, then the Policyholder should sign the next page, "Appointment of Claim Fiduciary," instead of this page.

____
Implementation Coordinator

____
Policyholder Representative

Attachment G-6

CIGNA Secure Travel®

EMERGENCY TRAVEL ASSISTANCE SERVICES

Services provided by Europ Assistance USA, Inc.

Subscriber: Travis County

Membership No.: 57

The following is a description of the Emergency Travel Assistance Services ("Services") provided by Europ Assistance USA, Inc. ("EA") through the CIGNA Secure Travel® program. The cost of these services is included within the premium for the Policy identified above. Services will be provided only while the Policy is in force and while the master agreement between EA and Life Insurance Company of North America ("Insurance Company") is in effect. The Insurance Company reserves the right to modify the scope or availability of services, or to terminate the master agreement between EA and the Insurance Company, upon written notice to the Subscriber. Subscriber ("Subscriber") is defined as a company that has purchased the CIGNA Secure Travel Program for its employees.

Covered Members – Employees of the Subscriber insured under the Policy, including any dependents insured under the Policy, shall be eligible for CIGNA Secure Travel® services, whenever traveling 100 miles or more from their permanent residence ("Covered Members"). Service will also be available for pre-trip information just prior to a trip meeting the above requirements.

Access To Services – To gain access to CIGNA Secure Travel® services, a Covered Member must contact EA.

Eligibility for Services- EA will verify eligibility via a roster provided by the Insurance Company. If the Subscriber is not listed in the roster, EA will verify with the Insurance Company's designated official that the Subscriber's employees are eligible for services. Once eligibility is verified, EA is authorized to provide services and the Covered Member shall be responsible for all third party costs incurred by EA in providing authorized services, with the exception of those costs incurred for the medical evacuation and repatriation services covered under the CIGNA Secure Travel program.

If contact is made outside of business hours, EA will render services but shall not be responsible for any claim, damage, loss, cost, liability or expense which arises in whole or in part as a result of EA's inability to contact the Insurance Company's designated company official for any reason beyond EA's control.

24 Hour Access – Covered Members will be able to reach EA's multilingual coordination center in Washington, D.C. toll-free by telephone, telex, and facsimile 24 hours a day, 365 days a year to confirm coverage and obtain access to the following services.

I. Informational Assistance

Prior to a trip, Covered Members can contact EA for up-to-date information on the following:

- ☐ **Inoculation and Visa Information** – Information concerning visa and inoculation requirements of the foreign countries in which members are traveling.
- ☐
- ☐ **Cultural Information** – Information concerning cultural and special events, if available, in the areas to which Covered Members are traveling.
- ☐

- ☐ **Temperature and Weather Information** – Weather forecasts and temperatures for major cities around the world as well as domestic and international ski reports for major ski areas.
- ☐
- ☐ **Embassy and Consular Referral** – Addresses and telephone numbers of the nearest American Consulate and Embassies, as appropriate.
- ☐
- ☐ **Foreign Exchange Rates** – Information on foreign exchange rates between the U.S. and most major currencies. These rates are updated on a daily basis. The rates may vary slightly from rates posted by local financial institutions and are meant as general guidelines.

II. Emergency Medical Assistance

EA is responsible for providing the emergency medical assistance services described in this section. The Insurance Company is responsible for the reimbursement of all costs associated with the following services to EA: emergency medical transport, return of dependent children/ travel companion, visit of a family member/friend and repatriation services.

Location of Medical Providers – Upon a Covered Member's request, EA will provide the names, addresses and telephone numbers of physicians, hospitals, dentists, and dental clinics in the area in which the Covered Member is traveling. EA will also attempt to confirm the availability of the provider, ascertain required payments which a Covered Member will be required to pay, and make an appointment for a Covered Member with the medical provider of the Covered Member's choice. Except as specifically provided in this agreement, expenses of medical care are not insured by the Insurance Company.

Neither EA nor the Insurance Company guarantees the quality of the medical services provider or the medical facility and the final selection of a local physician or medical facility is the Covered Member's right and responsibility.

Medical Monitoring – When notified of a Covered Member's medical emergency resulting from an accident or sickness, EA's multilingual staff will, whenever appropriate in the judgment of EA or a physician designated by EA, attempt to contact the Covered Member and Covered Member's local attending medical personnel in order to attempt to obtain a full understanding of the Covered Member's situation and to attempt to monitor the Covered Member's condition.
EA will continue to monitor the Covered Member's condition and will remain in communication with the Covered Member's family until the Covered Member's medical problem is resolved or the Covered Member has returned home.

Emergency Medical Transport – In the event of a medical emergency, when a Covered Member requests, and a physician designated by EA in consultation with a local attending physician determines that it is medically necessary for a Covered Member to be transported under medical supervision to a different hospital or treatment facility or be repatriated to his/her place of residence for treatment, EA will arrange for the medical evacuation or repatriation under proper medical supervision.

As part of a medical evacuation, EA will also make all necessary arrangements for ground transportation to and from the hospital, as well as pre-admission arrangements, where possible, at the receiving hospital.

All decisions as to the medical need for evacuation or repatriation, the means and timing of any evacuation, the medical equipment and the medical personnel to be used and the final destination are medical decisions that will be made by EA's designated physicians in consultation with a local attending physician based on medical factors and their decisions shall be conclusive in determining the need for such services. Costs of medical evacuation or repatriation are covered under the CIGNA Secure Travel program, provided the foregoing requirements are met.

Return of Dependent Children – If any dependent children under the age of 16 traveling with a Covered Member are left unattended by an adult because the Covered Member is hospitalized, EA will arrange for their transportation home. Should transportation with an attendant be necessary, EA will arrange a qualified escort to accompany the children. The cost of these services are covered under the CIGNA Secure Travel program.

Return of Traveling Companion – If a Covered Member's traveling companion loses previously made travel arrangements due to a delay caused by the Covered Member's medical emergency, EA will help arrange for the traveling companion's return to the companion's original destination. The costs of these services are covered under the CIGNA Secure Travel program.

Visit of a Family Member or Friend – If a Covered Member is traveling alone and must be hospitalized for ten (10) or more consecutive days, EA will arrange for a round-trip economy class transportation for a member of the Covered Member's immediate family, or a friend designated by the Covered Member, from the family member's or friend's home to the place where the Covered Member is hospitalized. EA will also arrange for meals and accommodations (up to $100 per day for up to 7 days) for the family member or friend while they are visiting the hospitalized Covered Member. The costs of these services are covered under the CIGNA Secure Travel program.

Emergency Medical Payments – When necessary to obtain needed medical services for a Covered Member, upon request EA will advance up to $5,000.00 to cover on-site medical expenses, upon receipt of satisfactory guarantee of reimbursement from the Covered Member. Except as specifically provided in this agreement, expenses of medical care are not insured by the Insurance Company.

Repatriation Special Services – In the event a Covered Member dies, EA will arrange for all necessary government authorization required by law, including a container appropriate for transportation and arrange for the repatriation of the remains to the Covered Member's place of residence for burial. The costs of these services are covered under the CIGNA Secure Travel program.

Replacement of Medication – If a Covered Member has an unexpected need for prescription medication or loses, forgets, or runs out of prescription medication while traveling, EA will attempt to locate the medication or its equivalent and attempt to arrange for the Covered Member to obtain it locally, where it is available; or, if not available locally, to have it shipped to the Covered Member, at the Covered Member's expense, subject to local laws. The Covered Member will be provided with a cost estimate for the replacement medication and shipment costs, which shall be subject to Covered Member's approval. Except as specifically provided in this agreement, expenses of medical care are not insured by the Insurance Company.

III. Travel and Communication Assistance

Telephone Interpretation Service – If a Covered Member needs help communicating in an emergency, EA will provide telephonic interpretation services in all major languages. In emergency situations which require extensive translation, EA will make referrals to local translators.

Transmission and Retention of Urgent Messages – In an emergency, EA will use its best efforts to transmit an urgent message for a Covered Member to the Covered Member's family, friends, or business associates. EA will also accept and retain messages for Covered Members at the Worldwide Assistance North American Coordination Center for up to fifteen (15) days.

Travel Arrangements – In the event of an emergency, EA will help Covered Members make emergency travel arrangements, including airline, hotel, and car rental reservations. The Covered Member is responsible for payment for all tickets, accommodations and rentals arranged.

Lost Luggage, Documents and Personal Items – If a Covered Member's luggage, personal items or travel documents have been lost or stolen, EA will contact the appropriate authorities in order to locate the lost items and have them sent to

the Covered Member. If requested, EA will help a Covered Member secure replacement items from home. All shipping and replacement costs are the responsibility of the Covered Member.

Legal Assistance/Bail – In an emergency, EA will attempt to help a Covered Member secure and post bail bonds worldwide, where permitted by local law, from funds forwarded to EA from the Covered Member's family or representative, or with a satisfactory guarantee of reimbursement. EA will also use its best efforts to provide a Covered Member with the names, addresses and telephone numbers of lawyers in the area in which the Covered Member is traveling in case of a car accident, traffic violations, and other offenses. However, the selection of and the expenses associated with a particular attorney are the responsibility of the Covered Member.

Emergency Cash Advance – In an emergency situation, and with the consent of the Covered Member, EA will advance up to $250.00, upon satisfactory guarantee of reimbursement.

IV. Limitations

The services described here are available in every country. Some countries, however, may present political and other obstacles that may render assistance services difficult or impossible and services cannot always be guaranteed. Should a Covered Member travel in any area in which there is a rebellion, riot, military uprising, war, labor disturbance or strike, EA will endeavor to provide such services as EA believes it can safely perform under existing conditions.

The medical professionals or attorneys suggested or designated by EA who provide direct services pursuant to this agreement are not employees or agents of EA and, therefore, neither EA nor the Insurance Company is not responsible or liable for their negligence or other acts or omissions.

Available with CIGNA Accident Coverage

Identity Theft Program

Defending employees against damages caused by identity theft

Identity theft, America's fastest growing crime, victimizes almost 8.9 million consumers each year.[1] And it's a silent crime, often taking a year or more for victims to discover their identity has been stolen. As a result, victims can spend years attempting to restore their credit. With this in mind, CIGNA has developed extensive resolution services to help employers and employees deal with this difficult issue. Our program provides access to personal case managers who give step-by-step assistance and guidance to employees who have had their identity stolen.

Employees may spend, on average, 40 to 600 hours to resolve their identity theft issues.[1]

Valuable help when it's needed most:

- Review of credit information to determine if an ID theft has occurred
- A CIGNA Identity Theft Resolution Kit is provided to the employee
- An ID theft affidavit is furnished for use with credit bureaus and creditors
- Help in reporting ID theft to credit-reporting agencies
- Assistance with placing a fraud alert on credit reports
- Canceling lost or stolen credit cards
- Assistance with credit and charge card replacement
- Assistance with replacing lost or stolen documents
- Access to free credit reports
- Education on how to identify and avoid ID theft
- $1,000 cash advance to cover financial shortages if needed[2]
- Emergency message relay
- Help with emergency travel arrangements and translation services

Identity theft can compromise employee and business productivity

American citizens and businesses spend more than 300 million hours each year resolving identity theft issues. To an employer this may mean a savings of over $600 per employee due to lost productivity.

In addition to its difficult financial effects, identity theft can have a negative effect on employee productivity and morale. The financial hardship, emotional turmoil, and the process of resolving credit issues rob employees – and organizations – of valuable time and productivity.

Based on conservative estimates, an employer with 1,000 employees making an average of $40,000 per year would save $600,000 annually if they could help employees avoid identity theft and its related costs.[1]

Our program covers all types of identity theft such as credit card fraud, or financial or medical identity theft.

CIGNA

811355a 11/08

it's time *to feel better*

Identity Theft Program in action

CIGNA's Identity Theft Program can help employers help their employees resolve identity theft issues, thereby better managing at-work productivity. Our personal case managers offer one-on-one advice and take care of administrative tasks necessary to rectify identity theft issues employees may experience. Our personal case managers also take the lead in making necessary phone calls for employees. In the end employees are not only relieved of the burden and personal stress caused by identity theft, but they also don't spend valuable work hours on the phone canceling lost or stolen credit cards.

Regardless of where or when employees come under the attack of identity theft, CIGNA's wide range of valuable services are available. Employees have access to immediate, one-on-one assistance – 24 hours a day, 365 days a year – in every country in the world.[3] CIGNA's Identity Theft Program is available to individuals covered under a CIGNA accident plan, including family members who are enrolled in our Voluntary Accident coverage. And employers and employees can access our online site for weekly tips and useful information to learn how to reduce the risk of identity theft before it occurs.

Here's an example of how we can help:

While reviewing her monthly credit card statement, Louise made a troubling discovery – three charges from an unfamiliar Internet site were on her account. Fearing that someone was making unauthorized purchases on her credit card, Louise immediately called CIGNA's Identity Theft Program. Brian, the identity theft case manager, handled Louise's call. Louise's primary concern was getting the charges removed from her account and Brian knew they had to act fast to stop additional fraudulent activity.

Brian gave Louise an identity theft affidavit to alert the proper authorities, credit bureaus, and creditors. Brian also:

- Walked her through the process of filling out and sending the signed affidavit to Louise's bank as her sworn statement that there were unauthorized charges posted on her account;
- Called the credit card company on Louise's behalf, canceling her current card and requesting that a new card be issued to prevent future fraud on the compromised account;
- Assisted Louise with placing a fraud alert on her credit file with credit bureaus – giving Louise the ability to receive a free copy of her credit report verifying that all the information was accurate; and
- Arranged for Louise to have access to a $1,000 cash advance to use while waiting for her new credit card.

A CIGNA Identity Theft Resolution Kit containing useful information on how to reduce the risk of being a future victim was also e-mailed to Louise's home.

The bottom line – Louise was quickly provided with the tools, information and resources to help her deal with fraudulent activity and avoid it in the future.

What can you do to help employees guard against identity theft?

Call your CIGNA sales representative today to learn more about our Identity Theft Program.

[1] Javelin Strategy and Research January, 2006; [2] Privacy Rights Clearinghouse and the California Public Interest Research Group, 2005;
[4] Assistance with U.S. bank accounts only

This program does not include reimbursement of expenses for financial losses.

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Attachment IC-1

Policy Number OK965800
Life Limited Accidental Disability and Death

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Special Marketing Division's toll-free telephone number for information or to make a complaint at:

1-800-441-1832

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at

1-800-252-3439

You may write the
Texas Department of Insurance
P.O. Box 149091
Austin, TX 78714-9104
FAX #(512) 475-1771

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim you should contact the agent or company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para solicitar información o presentar una queja:

Llame a la línea gratuita de la División Especial de Marketing para obtener información o presentar una queja al:

1-800-441-1832

Puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos o quejas llamando al

1-800-252-3439

También puede escribir al Texas Department of Insurance (Departamento de Seguros de Texas)
P.O. Box 149091
Austin, TX 78714-9104
FAX #(512) 475-1771

CONFLICTOS POR PRIMAS O RECLAMACIONES: En caso de tener un conflicto relacionado con su prima o una reclamación, debe comunicarse primero con el agente o la compañía. Si el conflicto no se resuelve, usted puede comunicarse con el Departamento de Seguros de Texas.

UNA ESTE AVISO A SU POLIZA: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE, ACCIDENT, HEALTH AND HOSPITAL SERVICE INSURANCE GUARANTY ASSOCIATION

(For insurers declared insolvent or impaired on or after September 1, 2005)

Texas law establishes a system, administered by the Texas Life, Accident, Health and Hospital Service Insurance Guaranty Association (the "Association"), to protect Texas policyholders if their life or health insurance company fails. Only the policyholders of insurance companies which are members of the Association are eligible for this protection which is subject to the terms, limitations, and conditions of the Association law. (The law is found in the *Texas Insurance Code*, Chapter 463.)

It is possible that the Association may not cover your policy in full or in part due to statutory limitations.

ELIGIBILITY FOR PROTECTION BY THE ASSOCIATION

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas at that time **(irrespective of the policyholder's residency at policy issue)**
- Residents of other states, ONLY if the following conditions are met:

1) The policyholder has a policy with a company domiciled in Texas;
2) The policyholder's state of residence has a similar guaranty association; and
3) The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

LIMITS OF PROTECTION BY THE ASSOCIATION

Accident, Accident and Health, or Health Insurance:

- For each individual covered under one or more policies: up to a total of $500,000 for basic hospital, medical-surgical, and major medical insurance, $300,000 for disability or long term care insurance, and $200,000 for other types of health insurance.

Life Insurance:

- Net cash surrender value or net cash withdrawal value up to a total of $100,000 under one or more policies on any one life; or
- Death benefits up to a total of $300,000 under one or more policies on any one life; or
- Total benefits up to a total of $5,000,000 to any owner of multiple non-group life policies.

Individual Annuities:

- Present value of benefits up to a total of $100,000 under one or more contracts on any one life.

Group Annuities:

- Present value of allocated benefits up to a total of $100,000 on any one life; or
- Present value of unallocated benefits up to a total of $5,000,000 for one contractholder regardless of the number of contracts.

Aggregate Limit:

- $300,000 on any one life with the exception of the $500,000 health insurance limit, the $5,000,000 multiple owner life insurance limit, and the $5,000,000 unallocated group annuity limit.

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage.

Texas Life, Accident, Health and Hospital
Service Insurance Guaranty Association
6504 Bridge Point Parkway, Suite 450
Austin, Texas 78730
800-982-6362 or www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439 or www.tdi.state.tx.us

Life Insurance Company of North America
1601 Chestnut Street, Philadelphia, Pennsylvania 19192-2235
A Stock Insurance Company

GROUP ACCIDENT POLICY

POLICYHOLDER:	Travis County
POLICY NUMBER:	OK 965800
POLICY DESCRIPTION:	Employee Accidental Death & Disability Insurance
POLICY EFFECTIVE DATE:	October 1, 2011
POLICY ANNIVERSARY DATE:	October 1
STATE OF ISSUE:	Texas

This Policy describes the terms and conditions of insurance. This Policy goes into effect subject to its applicable terms and conditions at 12:01 AM on the Policy Effective Date shown above at the Policyholder's address. The laws of the State of Issue shown above govern this Policy.

We and the Policyholder agree to all of the terms of this Policy.

THIS IS A GROUP ACCIDENT ONLY INSURANCE POLICY.
IT DOES NOT PAY BENEFITS FOR LOSS CAUSED BY SICKNESS.

THIS IS A LIMITED POLICY.
PLEASE READ IT CAREFULLY.

Scott Kern, Corporate Secretary

Matthew G. Manders, President

Countersigned_______________________________
Where Required By Law

GA-00-1000.00

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SCHEDULE OF BENEFITS

This Policy is intended to be read in its entirety. In order to understand all the conditions, exclusions and limitations applicable to its benefits, please read all the policy provisions carefully.

The *Schedule of Benefits* provides a brief outline of the coverage and benefits provided by this Policy. Please read the *Description of Coverages and Benefits* Section for full details.

Policy: Group policy identified as Policy Number: OK-965800 on the policy cover page

Policyholder: Travis County

Effective Date of Policyholder Participation: October 1, 2011

Covered Classes:

Class 1 All active, Full-time Employees of the Employer regularly working a minimum of 20 hours per week.

SCHEDULE OF BENEFITS FOR CLASS 1

This *Schedule of Benefits* shows maximums, benefit periods and any limitations applicable to benefits provided in this Policy for each Covered Person unless otherwise indicated. Principal Sum, when referred to in this Schedule, means the Employee's Principal Sum in effect on the date of the Covered Accident causing the Covered Injury or Covered Loss unless otherwise specified.

Eligibility Waiting Period

The Eligibility Waiting Period is the period of time the Employee must be in a Covered Class to be eligible for coverage.

For Employees hired on or before the Policy Effective Date:
The first of the month following 30 calendar days after the date of hire.

For Employees hired after the Policy Effective Date:
The first of the month following 30 calendar days after the date of hire.

Time Period for Loss:

Any Covered Loss must occur within: 365 days of the Covered Accident

Maximum Age for Insurance: None

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Employee Principal Sum: An amount equal to the Employee's voluntary group life insurance benefit in effect under Policy Number FLX964188, underwritten by Life Insurance Company of North America.

Changes in the Covered Person's amount of insurance resulting from a change in the Employee's amount of Annual Compensation take effect on August 31, subject to any Active Service requirement.

SCHEDULE OF COVERED LOSSES

Covered Loss	Benefit
Loss of Life	100% of the Principal Sum
Loss of Two or More Hands or Feet	100% of the Principal Sum
Loss of Sight of Both Eyes	100% of the Principal Sum
Loss of One Hand or One Foot and Sight in One Eye	100% of the Principal Sum
Loss of Speech and Hearing (in both ears)	100% of the Principal Sum
Quadriplegia	100% of the Principal Sum
Paraplegia	75% of the Principal Sum
Hemiplegia	50% of the Principal Sum
Uniplegia	25% of the Principal Sum
Coma	
Monthly Benefit	1% of the Principal Sum
Number of Monthly Benefits	11
When Payable	At the end of each month during which the Covered Person remains comatose
Lump Sum Benefit	100% of the Principal Sum
When Payable	Beginning of the 12th month
Loss of One Hand or Foot	50% of the Principal Sum
Loss of Sight in One Eye	50% of the Principal Sum
Severance and Reattachment of One Hand or Foot	50% of the Principal Sum
Loss of Speech	50% of the Principal Sum
Loss of Hearing (in both ears)	50% of the Principal Sum
Loss of all Four Fingers of the Same Hand	25% of the Principal Sum
Loss of Thumb and Index Finger of the Same Hand	25% of the Principal Sum
Loss of all the Toes of the Same Foot	20% of the Principal Sum

Age Reductions
A Covered Person's Principal Sum will be reduced to the percentage of his Principal Sum in effect on the date preceding the first reduction, as shown below.

Age	Percentage of Benefit Amount
70 but less than 75	65%
75 but less than 79	45%
80 but less than 85	30%
85 or over	15%

ADDITIONAL ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGES
Accidental Death and Dismemberment benefits are provided under the following coverages. Any benefits payable under them are as shown in the *Schedule of Covered Losses* and are not paid in addition to any other Accidental Death and Dismemberment benefits.

EXPOSURE AND DISAPPEARANCE COVERAGE	Principal Sum multiplied by the percentage applicable to the Covered Loss, as shown in the *Schedule of Covered Losses*.
OWNED AIRCRAFT COVERAGE	Principal Sum multiplied by the percentage applicable to the Covered Loss, as shown in the *Schedule of Covered Losses*.

ADDITIONAL ACCIDENT BENEFITS
Any benefits payable under these *Additional Accident Benefits* shown below are paid in addition to any other Accidental Death and Dismemberment benefits payable.

SEATBELT AND AIRBAG BENEFIT

Seatbelt Benefit	10% of the Principal Sum subject to a Maximum Benefit of $10,000
Airbag Benefit	5% of the Principal Sum subject to a Maximum Benefit of $5,000
Default Benefit	None

SPECIAL EDUCATION BENEFIT

Surviving Dependent Child Benefit	5% of the Principal Sum subject to a Maximum Benefit of $5,000 per year.
Maximum Number of Annual Payments For Each Surviving Dependent Child	4
Default Benefit	$1,000

INITIAL PREMIUM RATES

Premium Rate:	Voluntary Insurance Employee Rate: $0.02 per $1,000
Mode of Premium Payment:	Monthly
Contributions:	The cost of the coverage is paid by the Employee
Premium Due Dates:	30 days after delivering the Policy and after that the last day of each succeeding month.

Premium rates are subject to change in accordance with the *Changes in Premium Rates* section contained in the *Administrative Provisions* section of this Policy.

GA-00-1100.00

GENERAL DEFINITIONS

Please note that certain words used in this Policy have specific meanings. The words defined below and capitalized within the text of this Policy have the meanings set forth below.

Active Service

An Employee will be considered in Active Service with his employer on any day that is either of the following:

1. one of the Employer's scheduled work days on which the Employee is performing his regular duties on a full-time basis, either at one of the Employer's usual places of business or at some other location to which the Employer's business requires the Employee to travel;
2. a scheduled holiday, vacation day or period of Employer-approved paid leave of absence, other than sick leave, only if the Employee was in Active Service on the preceding scheduled workday.

Age

A Covered Person's Age, for purposes of initial premium calculations, is his Age attained on the date coverage becomes effective for him under this Policy. Thereafter, it is his Age attained on his last birthday.

Aircraft

A vehicle which:

1. has a valid certificate of airworthiness; and
2. is being flown by a pilot with a valid license to operate the Aircraft.

Covered Accident

A sudden, unforeseeable, external event that results, directly and independently of all other causes, in a Covered Injury or Covered Loss and meets all of the following conditions:

1. occurs while the Covered Person is insured under this Policy;
2. is not contributed to by disease, Sickness, mental or bodily infirmity;
3. is not otherwise excluded under the terms of this Policy.

Covered Injury

Any bodily harm that results directly and independently of all other causes from a Covered Accident.

Covered Loss

A loss that is all of the following:

1. the result, directly and independently of all other causes, of a Covered Accident;
2. one of the Covered Losses specified in the *Schedule of Covered Losses*;
3. suffered by the Covered Person within the applicable time period specified in the *Schedule of Benefits*.

Covered Person

An eligible person, as defined in the *Schedule of Benefits*, for whom an enrollment form has been accepted by the Policyholder and Us and required premium has been paid when due and for whom coverage under this Policy remains in force.

Employee

For eligibility purposes, an Employee of the Employer who is in one of the Covered Classes.

Employer

The Policyholder and any affiliates, subsidiaries or divisions shown in the *Schedule of Covered Affiliates* and which are covered under this Policy on the date of issue or subsequently agreed to by Us.

He, His, Him

Refers to any individual, male or female.

Hospital

An institution that meets all of the following:
1. it is licensed as a Hospital pursuant to applicable law;
2. it is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;
3. it is managed under the supervision of a staff of medical doctors;
4. it provides 24-hour nursing services by or under the supervision of a graduate registered nurse (R.N.);
5. it has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available on a prearranged basis;
6. it charges for its services.

The term Hospital does not include a clinic, facility, or unit of a Hospital for:
1. rehabilitation, convalescent, custodial, educational or nursing care;
2. the aged, drug addicts or alcoholics;
3. a Veteran's Administration Hospital or Federal Government Hospital unless the Covered Person incurs an expense.

Inpatient

A Covered Person who is confined for at least one full day's Hospital room and board. The requirement that a person be charged for room and board does not apply to confinement in a Veteran's Administration Hospital or Federal Government Hospital and in such case, the term 'Inpatient' shall mean a Covered Person who is required to be confined for a period of at least a full day as determined by the Hospital.

Nurse

A person who is a licensed graduate Registered Nurse (R.N.), a licensed practical Nurse (L.P.N.) or a licensed vocational Nurse (L.V.N.) and is not:
1. employed or retained by the Policyholder;
2. living in the Covered Person's household; or
3. a parent, sibling, spouse or child of the Covered Person.

Outpatient

A Covered Person who receives treatment, services and supplies while not an Inpatient in a Hospital.

Physician

A licensed health care provider practicing within the scope of his license and rendering care and treatment to a Covered Person that is appropriate for the condition and locality and who is not:
1. employed or retained by the Policyholder;
2. living in the Covered Person's household;
3. a parent, sibling, spouse or child of the Covered Person.

Prior Plan

The plan of insurance providing similar benefits, sponsored by the Employer in effect immediately prior to this Policy's Effective Date.

Sickness

A physical or mental illness.

Totally Disabled or Total Disability

Totally Disabled or Total Disability means either:
1. inability of the Covered Person who is currently employed to do any type of work for which he is or may become qualified by reason of education, training or experience; or
2. inability of the Covered Person who is not currently employed to perform all of the activities of daily living including eating, transferring, dressing, toileting, bathing, and continence, without human supervision or assistance.

We, Us, Our

Life Insurance Company of North America.

GA-00-1200.00

ELIGIBILITY AND EFFECTIVE DATE PROVISIONS

Policy Effective Date
We agree to provide Accident Insurance Benefits described in this Policy in consideration of the Policyholder's application and payment of the initial premium when due. Insurance coverage begins on the Policy Effective Date shown on this Policy's first page.

Eligibility
An Employee becomes eligible for insurance under this Policy on the date he meets all of the requirements of one of the Covered Classes and completes any Eligibility Waiting Period, as shown in the *Schedule of Benefits.*

Effective Date for Individuals
Insurance becomes effective for an eligible Employee who applies and agrees to make required contributions subject to the *Deferred Effective Date* provision below:

1. New hires. Coverage is effective first of the month following 30 calendar days from the date of hire.
2. Life Status Change. Coverage will become effective first of the month following the date of the change.
3. Annual Enrollment. Coverage becomes effective on the Policy Anniversary Date.

DEFERRED EFFECTIVE DATE
Active Service
The effective date of insurance will be deferred for any Employee who is not in Active Service on the date coverage would otherwise become effective. Coverage will become effective on the later of the date he returns to Active Service and the date coverage would otherwise have become effective.

Effective Date of Changes
Any increase or decrease in the amount of insurance for the Covered Person resulting from:

1. a change in benefits provided by this Policy; or
2. a change in the Employee's Covered Class will take effect on the date of such change.

Increases will take effect subject to any Active Service requirement.

TERMINATION OF INSURANCE
The insurance on a Covered Person will end on the last day of the month after the earliest of the following dates:

1. the date this Policy or insurance for a Covered Class is terminated;
2. the next premium due date after the date the Covered Person is no longer in a Covered Class or satisfies eligibility requirements under this Policy;
3. the last day of the last period for which premium is paid;
4. the next premium due date after the Covered Person attains the maximum Age for insurance under this Policy.

Termination will not affect a claim for a Covered Loss or Covered Injury that is the result, directly and independently of all other causes, of a Covered Accident that occurs while coverage was in effect.

Continuation for Layoff, Medical Leave of Absence, Non-Medical Leave of Absence or Family Medical Leave
Insurance for an Employee may be continued until the earliest of the following dates if: (a) an Employee is on a temporary layoff, an Employer-approved non-medical leave of absence, an Employer-approved medical leave of absence or an Employer-approved family medical leave; and (b) required premium contributions are paid when due.

1. for an Employer-approved medical leave of absence: 12 months
2. for an Employer-approved non-medical leave of absence: 12 months
3. for an Employer-approved family medical leave: 12 weeks in a consecutive 12-month period.

GA-00-1300.00

COMMON EXCLUSIONS

In addition to any benefit-specific exclusions, benefits will not be paid for any Covered Injury or Covered Loss which, directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the *Description of Benefits* Section:

1. intentionally self-inflicted injury, suicide or any attempt thereat while sane or insane;
2. commission or attempt to commit a felony or an assault;
3. commission of or active participation in a riot or insurrection;
4. bungee jumping; parachuting; skydiving; parasailing; hang-gliding;
5. declared or undeclared war or act of war;
6. flight in, boarding or alighting from an Aircraft or any craft designed to fly above the Earth's surface:
   a. except as a passenger on a regularly scheduled commercial airline or as pilot or passenger in Employer owned aircraft;
   b. when the aircraft is being used for:
      i. crop dusting, spraying or seeding, giving and receiving flying instruction, sky writing, sky diving or hang-gliding, pipeline or power line inspection, aerial photography or exploration, racing, endurance tests, stunt or acrobatic flying;
   c. when the aircraft is designed for flight above or beyond the earth's atmosphere;
   d. when the aircraft is an ultra-light or glider;
   e. when the aircraft is being used for the purpose of parachuting or skydiving;
   f. when the aircraft is being used by any military authority, except an Aircraft used by the Air Mobility Command or its foreign equivalent;
7. Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;
9. a Covered Accident that occurs while engaged in the activities of active duty service in the military, navy or air force of any country or international organization. Covered Accidents that occur while engaged in Reserve or National Guard training are not excluded until training extends beyond 31 days;
10. operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the Covered Person has been provided a written warning against operating a vehicle while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Accident occurred;
11. voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage.

GA-00-1403.00

CONVERSION PRIVILEGE

1. If the Covered Person's insurance or any portion of it ends for any of the following reasons:
   a. employment or membership ends;
   b. eligibility ends (except for age for the Employee);

   the Covered Person may have Us issue converted accident insurance on an individual policy or an individual certificate under a designated group policy. The Covered Person may apply for an amount of coverage that is:
   a. in $1,000 increments;
   b. not less than $25,000, regardless of the amount of insurance under the group policy; and
   c. not more than the amount of insurance he had under the group policy, except as provided above, up to a maximum amount of $250,000.

   The Covered Person must be under age 70 to get a converted policy.

   If the Covered Person's insurance or any portion of it ends for non-payment of premium, he may not convert. If the Covered Person's insurance ends for a reason described in 2. below, conversion is subject to that section.

   The converted policy or certificate will cover accidental death and dismemberment. The policy or certificate will not contain disability or other additional benefits. The Covered Person need not show Us that he is insurable.

   If the Covered Person has converted his group coverage and later becomes insured under the same group plan as before, he may not convert a second time unless he provides, at his own expense, proof of insurability or proof the prior converted policy is no longer in force.

   The Covered Person must apply for the individual policy within 31 days after his coverage under this Group Policy ends and pay the required premium, based on Our table of rates for such policies, his Age and class of risk. If the Covered Person has assigned ownership of his group coverage, the owner/assignee must apply for the individual policy.

   If the Covered Person suffers a Covered Loss or dies during this 31-day period as the result of an accident that would have been covered under this Group Policy, We will pay as a claim under this Group Policy the amount of insurance that the Covered Person was entitled to convert. It does not matter whether the Covered Person applied for the individual policy or certificate. If such policy or certificate is issued, it will be in exchange for any other benefits under this Group Policy.

   The individual policy or certificate will take effect on the day following the date coverage under the Group Policy ended; or, if later, the date application is made.

   Exclusions
   The converted policy may exclude the hazards or conditions that apply to the Covered Person's group coverage at the time it ends. We will reduce payment under the converted policy by the amount of any benefits paid under the group policy if both cover the same loss.

2. If the Covered Person's insurance ends because this Group Policy is terminated or is amended to terminate insurance for the Covered Person's class, and he has been covered under this Group Policy or, any group accident insurance issued to the Employer which the Group Policy replaced, for at least five years, the Covered Person may have Us issue an individual policy or certificate of accident insurance subject to the same terms, conditions and limitations listed above. However, the amount he may apply for will be limited to the lesser of the following:
   a. coverage under this Group Policy less any amount of group accident insurance for which he is eligible on the date this Group Policy is terminated or for which he became eligible within 31 days of such termination, or
   b. $10,000.

Extension of Conversion Period
If the Covered Person is eligible to convert and is not notified of this right at least 15 days prior to the end of the 31 day conversion period, the conversion period will be extended. The Covered Person will have 15 days from the date notice is given to apply for a converted policy or certificate. In no event will the conversion period be extended beyond 90 days. Notice, for the purpose of this section, means written notice presented to the Covered Person by the Policyholder or mailed to the Covered Person's last known address as reported by the Policyholder.

If the Covered Person sustains a Covered Loss or dies during the extended conversion period, but more than 31 days after his coverage under the Group Policy terminates, benefits will not be paid under the Group Policy. If the Covered Person's application for a converted policy or certificate is received by Us and the required premium is paid, benefits may be payable under the converted policy or certificate.

GA-01-1505.00

CLAIM PROVISIONS

Notice of Claim
Written or authorized electronic/telephonic notice of claim must be given to Us within 31 days after a Covered Loss occurs or begins or as soon as reasonably possible. If written or authorized electronic/telephonic notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written or authorized electronic/telephonic notice was given as soon as was reasonably possible. Notice can be given to Us at Our home office in Philadelphia, Pennsylvania, such other place as We may designate for the purpose, or to Our authorized agent. Notice should include the Policyholder's name and policy number and the Covered Person's name, address, policy and certificate number.

Claim Forms
We will send claim forms for filing proof of loss when We receive notice of a claim. If such forms are not sent within 15 days after We receive notice, the proof requirements will be met by submitting, within the time fixed in this Policy for filing proof of loss, written or authorized electronic proof of the nature and extent of the loss for which the claim is made.

Claimant Cooperation Provision
Failure of a claimant to cooperate with Us in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Proof of Loss
Written or authorized electronic proof of loss satisfactory to Us must be given to Us at Our office, within 90 days of the loss for which claim is made. If (a) benefits are payable as periodic payments and (b) each payment is contingent upon continuing loss, then proof of loss must be submitted within 90 days after the termination of each period for which We are liable. If written or authorized electronic notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as reasonably possible. In any case, written or authorized electronic proof must be given not more than one year after the time it is otherwise required, except if proof is not given solely due to the lack of legal capacity.

Time of Payment of Claims
We will pay benefits due under this Policy for any loss other than a loss for which this Policy provides any periodic payment immediately upon receipt of due written or authorized electronic proof of such loss. Subject to due written or authorized electronic proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid monthly unless otherwise specified in the benefits descriptions and any balance remaining unpaid at the termination of liability will be paid immediately upon receipt of proof satisfactory to Us.

Payment of Claims
All benefits will be paid in United States currency. Benefits for loss of life will be payable in accordance with the Beneficiary provision and these Claim Provisions. All other proceeds payable under this Policy, unless otherwise stated, will be payable to the covered Employee or to his estate.

If We are to pay benefits to the estate or to a person who is incapable of giving a valid release, We may pay $1,000 to a relative by blood or marriage whom We believe is equitably entitled. Any payment made by Us in good faith pursuant to this provision will fully discharge Us to the extent of such payment and release Us from liability for that amount.

Payment of Claims to Foreign Employees
The Policyholder may, in a fiduciary capacity, receive and hold any benefits payable to covered Employees whose place of employment is other than the United States of America.

We will not be responsible for the application or disposition by the Policyholder of any such benefits paid. Our payments to the Policyholder will constitute a full discharge of Our liability for those payments under this Policy.

Physical Examination and Autopsy
We, at Our own expense, have the right and opportunity to examine the Covered Person when and as often as We may reasonably require while a claim is pending and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions
No action at law or in equity may be brought to recover under this Policy less than 60 days after written or authorized electronic proof of loss has been furnished as required by this Policy. No such action will be brought more than four years after the time such written proof of loss must be furnished.

Beneficiary
The beneficiary is the person or persons the Employee names or changes on a form executed by him and satisfactory to Us. This form may be in writing or by any electronic means agreed upon between Us and the Policyholder. Consent of the beneficiary is not required to affect any changes, unless the beneficiary has been designated as an irrevocable beneficiary, or to make any assignment of rights or benefits permitted by this Policy.

A beneficiary designation or change will become effective on the date the Employee executes it. However, We will not be liable for any action taken or payment made before We record notice of the change at our home office.

If more than one person is named as beneficiary, the interests of each will be equal unless the Employee has specified otherwise. The share of any beneficiary who does not survive the Covered Person will pass equally to any surviving beneficiaries unless otherwise specified.

If there is no named beneficiary or surviving beneficiary, or if the Employee dies while benefits are payable to him, We may make direct payment to the first surviving class of the following classes of persons:
1. spouse;
2. child or children;
3. mother or father;
4. sisters or brothers;
5. estate of the Covered Person.

Recovery of Overpayment
If benefits are overpaid, We have the right to recover the amount overpaid by either of the following methods.
1. A request for lump sum payment of the overpaid amount.
2. A reduction of any amounts payable under this Policy.

If there is an overpayment due when the Covered Person dies, We may recover the overpayment from the Covered Person's estate.

GA-00-1600.00

ADMINISTRATIVE PROVISIONS

Premiums
All premium rates are expressed in, and all premiums are payable in, United States currency. The premiums for this Policy will be based on the rates set forth in the *Schedule of Benefits*, the plan and amounts of insurance in effect. If a Covered Person's insurance amounts are reduced due to age, premium will be based on the amounts of insurance in force on the day after the reduction took place.

Changes in Premium Rates
We may change the premium rates from time to time with at least 180 days advance written notice to the Policyholder but only on the Policy Anniversary Date. No change in rates will be made until 48 months after the Policy Effective Date. An increase in rates will not be made more often than once in a 12-month period and only on the Policy Anniversary Date. However, We reserve the right to change rates at any time if any of the following events take place:

1. the terms of this Policy change;
2. the terms of the Policyholder's participation change;
3. a division, subsidiary, affiliated company or eligible class is added or deleted from this Policy;
4. there is a change in the factors bearing on the risk assumed;
5. any federal or state law or regulation is amended to the extent it affects Our benefit obligation.

Payment of Premium
The first premium is due within 30 days of delivering the Policy. Thereafter, premiums are due on the Premium Due Dates agreed upon between Us and the Policyholder. If any premium is not paid when due, the Policyholder's participation under this Policy will be terminated as of the Premium Due Date on which premium was not paid.

Grace Period
A Grace Period of 31 days will be granted for payment of required premiums under this Policy. This Policy will be in force during the Policy Grace Period. The Policyholder is liable to Us for any unpaid premium for the time its participation under this Policy was in force.

A Grace Period of 31 days will be granted for payment of required premiums under this Policy. A Covered Person's insurance under this Policy will remain in force during the Grace Period. We will reduce any benefits payable for any claims incurred during the grace period by the amount of premium due. If no such claims are incurred and premium is not paid during the grace period, insurance will end on the last day of the period for which premiums were paid.

GA-00-1701.00

GENERAL PROVISIONS

Entire Contract; Changes
This Policy, including the endorsements, amendments and any attached papers constitutes the entire contract of insurance. No change in this Policy will be valid until approved by one of Our executive officers and endorsed on or attached to this Policy. No agent of the Insurance Company or Employer has authority to change this Policy or to waive any of its provisions.

Misstatement of Fact
If the Covered Person has misstated any fact, all amounts payable under this Policy will be such as the premium paid would have purchased had such fact been correctly stated.

Certificates
Where required by law, We will provide a certificate of insurance for delivery to the Covered Person. Each certificate will list the benefits, conditions and limits of this Policy. It will state to whom benefits will be paid.

30 Day Right To Examine Certificate
If a Covered Person does not like the Certificate for any reason, it may be returned to Us within 30 days after receipt. We will return any premium that has been paid and the Certificate will be void as if it had never been issued.

Multiple Certificates
The Covered Person may have in force only one certificate at a time under this Policy. If at any time the Covered Person has been issued more than one certificate, then only the largest shall be in effect. We will refund premiums paid for the others for any period of time that more than one certificate was issued.

Assignment
We will be bound by an assignment of a Covered Person's insurance under this Policy only when the original assignment or a certified copy of the assignment, signed by the Covered Person and any irrevocable beneficiary, is filed with Us. The assignee may exercise all rights and receive all benefits assigned only while the assignment remains in effect and insurance under this Policy and the Covered Person's certificate remains in force.

Incontestability
1. Of This Policy or Participation Under This Policy
All statements made by the Policyholder to obtain this Policy or to participate under this Policy are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, or to deny the validity of this Policy or of participation under this Policy unless a copy of the instrument containing the statement is, or has been, furnished to the Policyholder.

After two years from the Policy Effective Date, no such statement will cause this Policy to be contested except for fraud.

2. Of A Covered Person's Insurance
All statements made by a Covered Person are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, unless a copy of the instrument containing the statement is, or has been, furnished to the claimant.

After two years from the Covered Person's effective date of insurance, or from the effective date of increased benefits, no such statement will cause insurance or the increased benefits to be contested except for fraud or lack of eligibility for insurance.

In the event of death or incapacity, the beneficiary or representative shall be given a copy.

Policy Termination
We may terminate coverage on or after the first anniversary of the policy effective date. Written notice must be given at least 180 days prior to such termination. The Policyholder may terminate coverage on any premium due date. Written or authorized electronic notice must be given at least 180 days prior to such premium due date.

Termination will not affect a claim for a Covered Loss that is the result, directly and independently of all other causes, of a Covered Accident that occurs while coverage was in effect.

Reinstatement
This Policy may be reinstated if it lapsed for nonpayment of premium. Requirements for reinstatement are written application of the Policyholder satisfactory to Us and payment of all overdue premiums. Any premium accepted in connection with a reinstatement will be applied to a period for which premium was not previously paid.

Clerical Error
A Covered Person's insurance will not be affected by error or delay by the Insurance Company or Employer in keeping records of insurance under this Policy. If such error or delay is found, We will adjust the premium fairly.

Conformity with Statutes
Any provisions in conflict with the requirements of any state or federal law that apply to this Policy are automatically changed to satisfy the minimum requirements of such laws.

Policy Changes
We may agree with the Policyholder to modify a plan of benefits without the Covered Person's consent.

Workers' Compensation Insurance
This Policy is not in place of and does not affect any requirements for coverage under any Workers' Compensation law.

Examination of the Policy
This Group Policy will be available for inspection at the Policyholder's office during regular business hours.

Examination of Records
We will be permitted to examine all of the Policyholder's records relating to this Group Policy. Examination may occur at any reasonable time while the Group Policy is in force; or it may occur:

1. at any time for two years after the expiration of this Group Policy; or, if later,
2. upon the final adjustment and settlement of all Group Policy claims.

The Policyholder is acting as an agent of the Covered Person for transactions relating to this insurance. The actions of the Policyholder will not be considered Our actions.

GA-00-1800.00

DESCRIPTION OF COVERAGES AND BENEFITS

This *Description of Coverages and Benefits* Section describes the Accident Coverages and Benefits provided by this Policy. Benefit amounts, benefit periods and any applicable aggregate and benefit maximums are shown in the *Schedule of Benefits.* Certain words capitalized in the text of these descriptions have special meanings within this Policy and are defined in the *General Definitions* section and on the Policy cover page. Please read these and the *Common Exclusions* sections in order to understand all of the terms, conditions and limitations applicable to these coverages and benefits.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Covered Loss

We will pay the benefit for any one of the Covered Losses listed in the *Schedule of Benefits*, if the Covered Person suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident within the applicable time period specified in the *Schedule of Benefits*.

If the Covered Person sustains more than one Covered Loss as a result of the same Covered Accident, benefits will be paid for the Covered Loss for which the largest available benefit is payable. If the loss results in death, benefits will only be paid under the Loss of Life benefit provision. Any Loss of Life benefit will be reduced by any paid or payable Accidental Dismemberment benefit. However, if such Accidental Dismemberment benefit equals or exceeds the Loss of Life benefit, no additional benefit will be paid.

Definitions

Loss of a Hand or Foot means complete Severance through or above the wrist or ankle joint.

Loss of Sight means the total, permanent loss of all vision in one eye which is irrecoverable by natural, surgical or artificial means.

Loss of Speech means total and permanent loss of audible communication which is irrecoverable by natural, surgical or artificial means.

Loss of Hearing means total and permanent loss of ability to hear any sound in both ears which is irrecoverable by natural, surgical or artificial means.

Loss of a Thumb and Index Finger of the Same Hand or Four Fingers of the Same Hand means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand).

Loss of Toes means complete Severance through the metatarsalphalangeal joint.

Paralysis or Paralyzed means total loss of use of a limb. A Physician must determine the loss of use to be complete and irreversible.

Quadriplegia means total Paralysis of both upper and both lower limbs.

Hemiplegia means total Paralysis of the upper and lower limbs on one side of the body.

Paraplegia means total Paralysis of both lower limbs or both upper limbs.

Uniplegia means total Paralysis of one upper or one lower limb.

Coma means a profound state of unconsciousness which resulted directly and independently from all other causes from a Covered Accident, and from which the Covered Person is not likely to be aroused through powerful stimulation. This condition must be diagnosed and treated regularly by a Physician. Coma does not mean any state of unconsciousness intentionally induced during the course of treatment of a Covered Injury unless the state of unconsciousness results from the administration of anesthesia in preparation for surgical treatment of that Covered Accident.

Severance means the complete and permanent separation and dismemberment of the part from the body.

Exclusions The exclusions that apply to this benefit are in the *Common Exclusions* section.
GA-00-2100.00

ADDITIONAL ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGES
Accidental Death and Dismemberment benefits are provided under the following coverages. Any benefits payable under them are shown in the *Schedule of Covered Losses* and will not be paid in addition to any other Accidental Death and Dismemberment benefits payable.

EXPOSURE AND DISAPPEARANCE COVERAGE
Benefits for Accidental Death and Dismemberment, as shown in the *Schedule of Covered Losses,* will be payable if a Covered Person suffers a Covered Loss which results directly and independently of all other causes from unavoidable exposure to the elements following a Covered Accident.

If the Covered Person disappears and is not found within one year from the date of the wrecking, sinking or disappearance of the conveyance in which the Covered Person was riding in the course of a trip which would otherwise be covered under this Policy, it will be presumed that the Covered Person's death resulted directly and independently of all other causes from a Covered Accident.

Exclusions The exclusions that apply to this coverage are in the *Common Exclusions* Section.
GA-00-2202.00

OWNED AIRCRAFT COVERAGE
Benefits for Accidental Death and Dismemberment, as shown in the *Schedule of Covered Losses,* will be payable if the Covered Person suffers a Covered Loss that results directly and independently of all other causes from a Covered Accident that occurs during travel or flight in, including getting in or out of, any Aircraft that is owned, leased, operated or controlled by the Policyholder or any of its subsidiaries or affiliates. A record of eligible Aircraft will be maintained by the Policyholder and available for review by Us at any time during normal business hours. An Aircraft substituted for an eligible Aircraft will also be eligible if it has no greater seating capacity and the original Aircraft is withdrawn from normal use due to breakdown, repair, servicing, loss or destruction.

GA-00-2205.00

ADDITIONAL ACCIDENT BENEFITS

Accidental Death and Dismemberment benefits are provided under the following Additional Benefits. Any benefits payable under them will be paid in addition to any other Accidental Death and Dismemberment benefit payable.

SEATBELT AND AIRBAG BENEFIT

We will pay the benefit shown in the *Schedule of Benefits,* subject to the conditions and exclusions described below, when the Covered Person dies directly and independently of all other causes from a Covered Accident while wearing a seatbelt and operating or riding as a passenger in an Automobile. An additional benefit is provided if the Covered Person was also positioned in a seat protected by a properly-functioning and properly deployed Supplemental Restraint System (Airbag).

Verification of proper use of the seatbelt at the time of the Covered Accident and that the Supplemental Restraint System properly inflated upon impact must be a part of an official police report of the Covered Accident or be certified, in writing, by the investigating officer(s) and submitted with the Covered Person's claim to Us.

Definitions — **For purposes of this benefit:**

Supplemental Restraint System means an airbag that inflates upon impact for added protection to the head and chest areas.

Automobile means a self-propelled, private passenger motor vehicle with four or more wheels which is a type both designed and required to be licensed for use on the highway of any state or country. Automobile includes, but is not limited to, a sedan, station wagon, sport utility vehicle, or a motor vehicle of the pickup, van, camper, or motor-home type. Automobile does not include a mobile home or any motor vehicle which is used in mass or public transit.

Exclusions — **The exclusions that apply to this benefit are in the *Common Exclusions* Section.**

GA-00-2251.00

SPECIAL EDUCATION BENEFIT
We will pay the benefit, up to the Maximum Benefit shown in the *Schedule of Benefits,* for each qualifying Dependent Child. The Covered Person's death must result, directly and independently of all other causes from a Covered Accident for which an Accidental Death Benefit is payable under this Policy. This benefit is subject to the conditions and exclusions described below.

A qualifying Dependent Child must:

1. a. be enrolled as a full-time student in an accredited school of higher learning beyond the 12th grade level on the date of the covered Employee's Covered Accident; *or*
   b. be at the 12th grade level on the date of the covered Employee's Covered Accident and then enroll as a full-time student at an accredited school of higher learning within 365 days from the date of the Covered Accident and continue his education as a full-time student.
2. continue his education as a full-time student in such accredited school of higher learning; and
3. incur expenses for tuition, fees, books, room and board, transportation and any other costs payable directly to, or approved and certified by, such school.

Payments will be made to each qualifying Dependent Child or to the child's legal guardian, if the child is a minor at the end of each year for the number of years shown in the *Schedule of Benefits.* We must receive proof satisfactory to Us of the Dependent Child's enrollment and attendance within 31 days of the end of each year. The first year for which a Special Education Benefit is payable will begin on the first of the month following the date the covered Employee died, if the surviving Dependent Child was enrolled on that date in an accredited school of higher learning beyond the 12th grade; otherwise on the date he enrolls in such school. Each succeeding year for which benefits are payable will begin on the date following the end of the preceding year.

If no Dependent Child qualifies for Special Education Benefits within 365 days of the covered Employee's death, We will pay the default benefit shown in the *Schedule of Benefits* to the covered Employee's beneficiary.

Definitions For the purposes of this benefit:

Dependent Child(ren) An Employee's unmarried child who meets the following requirements:

1. A child from live birth to 19 years old;
2. A child who is 19 or more years old but less than 25 years old, enrolled in a school as a full-time student and primarily supported by the Employee;
3. A child who is 19 or more years old, primarily supported by the Employee and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to Us within 31 days after the date the child ceases to qualify as a Dependent Child for the reasons listed above. During the next two years, We may, from time to time, require proof of the continuation of such condition and dependence. After that, We may require proof no more than once a year.

A child, for purposes of this provision, includes an Employee's:

1. natural child;
2. adopted child, beginning with any waiting period pending finalization of the child's adoption;
3. stepchild who resides with the Employee;
4. child for whom the Employee is legal guardian, as long as the child resides with the Employee and depends on the Employee for financial support. Financial support means that the Employee is eligible to claim the dependent for purposes of Federal and State income tax returns.

Exclusions The exclusions that apply to this benefit are in the *Common Exclusions* Section.

GA-00-2252a.00

Life Insurance Company of North America
1601 Chestnut Street
Philadelphia, Pennsylvania 19192-2235

MODIFYING PROVISIONS AMENDMENT

Policyholder:Travis County

Policy No.: OK 965800

Amendment Effective Date: October 1, 2011

This amendment is attached to and made part of the Policy specified above and the Certificates issued under it. Its provisions are intended to conform this Policy to the laws of the state in which the insured resides.

The Policy and any Certificates delivered under the Group Policy are amended as follows:

Arkansas residents:

Under the *General Definitions* section, the definition of Covered Accident does not include reference to an "external" event.

Missouri residents:

1. Under the *General Definitions* section, the definition of Covered Accident does not include reference to an "external" event.

2. Under the *General Definitions* section, the definition of *Totally Disabled or Total Disability* means either:
   a) the inability of the Covered Person who is currently employed to perform the material and substantial duties of the Covered Person's occupation for a period of at least twelve months. After the initial benefit period, total disability shall mean the Covered Person's inability to perform the material and substantial duties of any occupation for which the Covered Person is qualified by education, training or experience; or
   b) the inability of the Covered Person who is not currently employed to perform all of the activities of daily living including eating, transferring, dressing, toileting, bathing, and continence, without human supervision or assistance.

Montana residents:

Under the *General Definitions* section, the definition of *Sickness* is replaced with the following:

Sickness A physical or mental illness including pregnancy

New Hampshire residents:

1. Under the *General Definitions* section, the definition of Covered Accident does not include reference to an "external" event.

2. If applicable, the definition of Emergency Room Treatment is replaced with the following:

Emergency Room Treatment Emergency medical services and care given in a Hospital as an out or inpatient, for a sudden, unexpected onset of a medical condition that manifests itself by symptoms of sufficient severity that in the absence of immediate medical attention could be expected to result in any of the following:
1. serious jeopardy to the covered Employee's health;
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

3. The definition of Hospital is replaced with the following.

Hospital

An institution that meets all of the following:

1. it is operated pursuant to applicable law;
2. it is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;
3. it is managed under the supervision of a staff of medical doctors;
4. it provides 24-hour nursing services by or under the supervision of a graduate registered nurse (R.N.);
5. it has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available on a prearranged basis;
6. it charges for its services.

Hospital shall include a Veteran's Administration Hospital or Federal Government Hospital and the requirement that a patient must incur an expense as an Inpatient shall be waived.

The term Hospital does not include a clinic, facility, or unit of a Hospital for:

1. rehabilitation, convalescent, custodial, educational or nursing care;
2. the aged, drug addicts or alcoholics;
3. a Veteran's Administration Hospital or Federal Government Hospitals unless the Covered Person incurs an expense.

North Carolina residents:

1. If eligibility for insurance is not based on employment status, a Covered Person is considered in Active Service if confined at home under the care of a Physician for Sickness or Injury.

2. Under the *General Definitions* section, the definition of Covered Accident does not include reference to an "external" event.

3. Under the *General Definitions* section, the definition of Hospital is modified to include State tax-supported institutions.

4. Under the *Claim Provisions,* the following changes are made.
   a. *Proof of Loss* must be provided within 180 days of date of loss.
   b. The amount payable to an equitably entitled individual may not exceed $3,000.

South Carolina residents:

1. Under the *General Definitions* section, the definition of Covered Accident does not include reference to an "external" event.

2. Under the *Claim Provisions,* the following changes are made.
   a. The *Claimant Cooperation Provision* does not apply.
   b. The provision titled *Physical Examination and Autopsy* is replaced with the following:
   Physical Examination and Autopsy
   We, at Our own expense, have the right and opportunity to examine the Covered Person when and as often as We may reasonably require while a claim is pending. If an autopsy is performed, it will be in the State of South Carolina and during the period of contestability unless prohibited by law.
   c. The provision titled *Legal Actions* is replaced with the following:
   Legal Actions
   No action at law or in equity may be brought to recover under this Policy less than 60 days after written or authorized electronic proof of loss has been furnished as required by this Policy. No such action will be brought more than six years after the time such written proof of loss must be furnished.

3. Under the *General Provisions,* the following changes are made.
   The *Multiple Certificates* provision does not apply.

South Dakota residents:

Under the *Common Exclusions* section, the following changes are not permitted:

1. the Covered Person being legally intoxicated as determined according to the laws of the jurisdiction in which the Covered Accident occurred;
2. the Covered Person being Intoxicated. "Intoxicated" means having a blood alcohol level of .08 or higher;
3. the Covered Person operating a motorized vehicle while under the influence of alcohol or drugs as defined according to the laws of the jurisdiction in which the Accident occurred;
4. voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
5. occupational injuries for which benefits are not paid under the Workers' Compensation Law or any similar law;
6. operating any type of vehicle while under the influence of alcohol or any drug , narcotic or other intoxicant including any prescribed drug for which the Covered Person has been provided a written warning against operating a vehicle while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Accident occurred;
7. the Covered Person was driving a Private Passenger Automobile at the time of the Covered Accident that resulted in the Covered Loss; and he was intoxicated, as that term is defined by the laws of the state in which the Covered Accident occurred.

West Virginia residents:

1. Under the *General Definitions* section, the definition of Covered Accident does not include reference to an "external" event.

2. Under the *General Definitions* section, the definition of Hospital does not require that an institution be licensed as a Hospital pursuant to applicable law, but does require that an institution operate pursuant to applicable law.

3. Under the *General Definitions* section, the definition of Totally Disabled or Total Disability is replaced with the following:
   Totally Disabled or Total Disability
   Totally Disabled or Total Disability means either:
   1. inability of the Covered Person who is currently employed to perform substantially all of the material duties of his job, or any other job for which he is or may become qualified by reason of education, training or experience; or
   2. inability of the Covered Person who is not currently employed to perform all of the activities of daily living including eating, transferring, dressing, toileting, bathing, and continence, without human supervision or assistance.

Signed for the
Life Insurance Company of North America

Matthew G. Manders, President

GA-00-3000.00

LIFE INSURANCE COMPANY OF NORTH AMERICA
Philadelphia, PA 19192-2235

We, Travis County, whose main office address is Austin, TX, hereby approve and accept the terms of Group Policy Number OK 965800 issued by the LIFE INSURANCE COMPANY OF NORTH AMERICA.

This form is to be signed in duplicate. One part is to be retained by Travis County; the other part is to be returned to the LIFE INSURANCE COMPANY OF NORTH AMERICA.

Travis County

Signature and Title:____ Date: _________________________

(This Copy Is To Be Returned To Life Insurance Company of North America)

LIFE INSURANCE COMPANY OF NORTH AMERICA
Philadelphia, PA 19192-2235

We, Travis County, whose main office address is Austin, TX, hereby approve and accept the terms of Group Policy Number OK 965800 issued by the LIFE INSURANCE COMPANY OF NORTH AMERICA.

This form is to be signed in duplicate. One part is to be retained by Travis County; the other part is to be returned to the LIFE INSURANCE COMPANY OF NORTH AMERICA.

Travis County

Signature and Title:____ Date: _________________________

(This Copy Is To Be Retained By Travis County)

IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE, ACCIDENT, HEALTH AND HOSPITAL SERVICE INSURANCE GUARANTY ASSOCIATION

(For insurers declared insolvent or impaired on or after September 1, 2005)

Texas law establishes a system, administered by the Texas Life, Accident, Health and Hospital Service Insurance Guaranty Association (the "Association"), to protect Texas policyholders if their life or health insurance company fails. Only the policyholders of insurance companies which are members of the Association are eligible for this protection which is subject to the terms, limitations, and conditions of the Association law. (The law is found in the *Texas Insurance Code,* Chapter 463.)

It is possible that the Association may not cover your policy in full or in part due to statutory limitations.

ELIGIBILITY FOR PROTECTION BY THE ASSOCIATION

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas at that time **(irrespective of the policyholder's residency at policy issue)**
- Residents of other states, ONLY if the following conditions are met:

1) The policyholder has a policy with a company domiciled in Texas;
2) The policyholder's state of residence has a similar guaranty association; and
3) The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

LIMITS OF PROTECTION BY THE ASSOCIATION

Accident, Accident and Health, or Health Insurance:

- For each individual covered under one or more policies: up to a total of $500,000 for basic hospital, medical-surgical, and major medical insurance, $300,000 for disability or long term care insurance, and $200,000 for other types of health insurance.

Life Insurance:

- Net cash surrender value or net cash withdrawal value up to a total of $100,000 under one or more policies on any one life; or
- Death benefits up to a total of $300,000 under one or more policies on any one life; or
- Total benefits up to a total of $5,000,000 to any owner of multiple non-group life policies.

Individual Annuities:

- Present value of benefits up to a total of $100,000 under one or more contracts on any one life.

Group Annuities:

- Present value of allocated benefits up to a total of $100,000 on any one life; or
- Present value of unallocated benefits up to a total of $5,000,000 for one contractholder regardless of the number of contracts.

Aggregate Limit:

- $300,000 on any one life with the exception of the $500,000 health insurance limit, the $5,000,000 multiple owner life insurance limit, and the $5,000,000 unallocated group annuity limit.

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage.

Texas Life, Accident, Health and Hospital
Service Insurance Guaranty Association
6504 Bridge Point Parkway, Suite 450
Austin, Texas 78730
800-982-6362 or www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439 or www.tdi.state.tx.us

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Special Marketing Division's toll-free telephone number for information or to make a complaint at:

1-800-441-1832

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at

1-800-252-3439

You may write the
Texas Department of Insurance
P.O. Box 149091
Austin, TX 78714-9104
FAX #(512) 475-1771

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim you should contact the agent or company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para solicitar información o presentar una queja:

Llame a la línea gratuita de la División Especial de Marketing para obtener información o presentar una queja al:

1-800-441-1832

Puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos o quejas llamando al

1-800-252-3439

También puede escribir al Texas Department of Insurance (Departamento de Seguros de Texas)
P.O. Box 149091
Austin, TX 78714-9104
FAX #(512) 475-1771

CONFLICTOS POR PRIMAS O RECLAMACIONES: En caso de tener un conflicto relacionado con su prima o una reclamación, debe comunicarse primero con el agente o la compañía. Si el conflicto no se resuelve, usted puede comunicarse con el Departamento de Seguros de Texas.

UNA ESTE AVISO A SU POLIZA: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

Life Insurance Company of North America
1601 Chestnut Street, Philadelphia, Pennsylvania 19192-2235
A Stock Insurance Company

GROUP ACCIDENT POLICY

POLICYHOLDER:	Travis County
POLICY NUMBER:	OK 965800
POLICY DESCRIPTION:	Employee Accidental Death & Disability Insurance
POLICY EFFECTIVE DATE:	October 1, 2011
POLICY ANNIVERSARY DATE:	October 1
STATE OF ISSUE:	Texas

This Policy describes the terms and conditions of insurance. This Policy goes into effect subject to its applicable terms and conditions at 12:01 AM on the Policy Effective Date shown above at the Policyholder's address. The laws of the State of Issue shown above govern this Policy.

We and the Policyholder agree to all of the terms of this Policy.

THIS IS A GROUP ACCIDENT ONLY INSURANCE POLICY.
IT DOES NOT PAY BENEFITS FOR LOSS CAUSED BY SICKNESS.

THIS IS A LIMITED POLICY.
PLEASE READ IT CAREFULLY.

Scott Kern, Corporate Secretary

Matthew G. Manders, President

Countersigned_______________________________
Where Required By Law

GA-00-1000.00

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SCHEDULE OF BENEFITS

This Policy is intended to be read in its entirety. In order to understand all the conditions, exclusions and limitations applicable to its benefits, please read all the policy provisions carefully.

The *Schedule of Benefits* provides a brief outline of the coverage and benefits provided by this Policy. Please read the *Description of Coverages and Benefits* Section for full details.

Policy:	Group policy identified as Policy Number: OK-965800 on the policy cover page
Policyholder:	Travis County
Effective Date of Policyholder Participation:	October 1, 2011

Covered Classes:

Class 1 All active, Full-time Employees of the Employer regularly working a minimum of 20 hours per week.

SCHEDULE OF BENEFITS FOR CLASS 1

This *Schedule of Benefits* shows maximums, benefit periods and any limitations applicable to benefits provided in this Policy for each Covered Person unless otherwise indicated. Principal Sum, when referred to in this Schedule, means the Employee's Principal Sum in effect on the date of the Covered Accident causing the Covered Injury or Covered Loss unless otherwise specified.

Eligibility Waiting Period
The Eligibility Waiting Period is the period of time the Employee must be in a Covered Class to be eligible for coverage.

For Employees hired on or before the Policy Effective Date:
The first of the month following 30 calendar days after the date of hire.

For Employees hired after the Policy Effective Date:
The first of the month following 30 calendar days after the date of hire.

Time Period for Loss:
Any Covered Loss must occur within: 365 days of the Covered Accident

Maximum Age for Insurance: None

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Employee Principal Sum: An amount equal to the Employee's voluntary group life insurance benefit in effect under Policy Number FLX964188, underwritten by Life Insurance Company of North America.

Changes in the Covered Person's amount of insurance resulting from a change in the Employee's amount of Annual Compensation take effect on August 31, subject to any Active Service requirement.

SCHEDULE OF COVERED LOSSES

Covered Loss	**Benefit**
Loss of Life	100% of the Principal Sum
Loss of Two or More Hands or Feet	100% of the Principal Sum
Loss of Sight of Both Eyes	100% of the Principal Sum
Loss of One Hand or One Foot and Sight in One Eye	100% of the Principal Sum
Loss of Speech and Hearing (in both ears)	100% of the Principal Sum
Quadriplegia	100% of the Principal Sum
Paraplegia	75% of the Principal Sum
Hemiplegia	50% of the Principal Sum
Uniplegia	25% of the Principal Sum
Coma	
Monthly Benefit	1% of the Principal Sum
Number of Monthly Benefits	11
When Payable	At the end of each month during which the Covered Person remains comatose
Lump Sum Benefit	100% of the Principal Sum
When Payable	Beginning of the 12th month
Loss of One Hand or Foot	50% of the Principal Sum
Loss of Sight in One Eye	50% of the Principal Sum
Severance and Reattachment of One Hand or Foot	50% of the Principal Sum
Loss of Speech	50% of the Principal Sum
Loss of Hearing (in both ears)	50% of the Principal Sum
Loss of all Four Fingers of the Same Hand	25% of the Principal Sum
Loss of Thumb and Index Finger of the Same Hand	25% of the Principal Sum
Loss of all the Toes of the Same Foot	20% of the Principal Sum

Age Reductions
A Covered Person's Principal Sum will be reduced to the percentage of his Principal Sum in effect on the date preceding the first reduction, as shown below.

Age	Percentage of Benefit Amount
70 but less than 75	65%
75 but less than 79	45%
80 but less than 85	30%
85 or over	15%

ADDITIONAL ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGES
Accidental Death and Dismemberment benefits are provided under the following coverages. Any benefits payable under them are as shown in the *Schedule of Covered Losses* and are not paid in addition to any other Accidental Death and Dismemberment benefits.

EXPOSURE AND DISAPPEARANCE COVERAGE	Principal Sum multiplied by the percentage applicable to the Covered Loss, as shown in the *Schedule of Covered Losses.*
OWNED AIRCRAFT COVERAGE	Principal Sum multiplied by the percentage applicable to the Covered Loss, as shown in the *Schedule of Covered Losses.*

ADDITIONAL ACCIDENT BENEFITS
Any benefits payable under these *Additional Accident Benefits* shown below are paid in addition to any other Accidental Death and Dismemberment benefits payable.

SEATBELT AND AIRBAG BENEFIT	
Seatbelt Benefit	10% of the Principal Sum subject to a Maximum Benefit of $10,000
Airbag Benefit	5% of the Principal Sum subject to a Maximum Benefit of $5,000
Default Benefit	None
SPECIAL EDUCATION BENEFIT	
Surviving Dependent Child Benefit	5% of the Principal Sum subject to a Maximum Benefit of $5,000 per year.
Maximum Number of Annual Payments For Each Surviving Dependent Child	4
Default Benefit	$1,000

INITIAL PREMIUM RATES

Premium Rate:	Voluntary Insurance Employee Rate: $0.02 per $1,000
Mode of Premium Payment:	Monthly
Contributions:	The cost of the coverage is paid by the Employee
Premium Due Dates:	30 days after delivering the Policy and after that the last day of each succeeding month.

Premium rates are subject to change in accordance with the *Changes in Premium Rates* section contained in the *Administrative Provisions* section of this Policy.

GA-00-1100.00

GENERAL DEFINITIONS

Please note that certain words used in this Policy have specific meanings. The words defined below and capitalized within the text of this Policy have the meanings set forth below.

Active Service

An Employee will be considered in Active Service with his employer on any day that is either of the following:

1. one of the Employer's scheduled work days on which the Employee is performing his regular duties on a full-time basis, either at one of the Employer's usual places of business or at some other location to which the Employer's business requires the Employee to travel;
2. a scheduled holiday, vacation day or period of Employer-approved paid leave of absence, other than sick leave, only if the Employee was in Active Service on the preceding scheduled workday.

Age

A Covered Person's Age, for purposes of initial premium calculations, is his Age attained on the date coverage becomes effective for him under this Policy. Thereafter, it is his Age attained on his last birthday.

Aircraft

A vehicle which:

1. has a valid certificate of airworthiness; and
2. is being flown by a pilot with a valid license to operate the Aircraft.

Covered Accident

A sudden, unforeseeable, external event that results, directly and independently of all other causes, in a Covered Injury or Covered Loss and meets all of the following conditions:

1. occurs while the Covered Person is insured under this Policy;
2. is not contributed to by disease, Sickness, mental or bodily infirmity;
3. is not otherwise excluded under the terms of this Policy.

Covered Injury

Any bodily harm that results directly and independently of all other causes from a Covered Accident.

Covered Loss

A loss that is all of the following:

1. the result, directly and independently of all other causes, of a Covered Accident;
2. one of the Covered Losses specified in the *Schedule of Covered Losses*;
3. suffered by the Covered Person within the applicable time period specified in the *Schedule of Benefits*.

Covered Person

An eligible person, as defined in the *Schedule of Benefits*, for whom an enrollment form has been accepted by the Policyholder and Us and required premium has been paid when due and for whom coverage under this Policy remains in force.

Employee

For eligibility purposes, an Employee of the Employer who is in one of the Covered Classes.

Employer

The Policyholder and any affiliates, subsidiaries or divisions shown in the *Schedule of Covered Affiliates* and which are covered under this Policy on the date of issue or subsequently agreed to by Us.

He, His, Him

Refers to any individual, male or female.

Hospital

An institution that meets all of the following:
1. it is licensed as a Hospital pursuant to applicable law;
2. it is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;
3. it is managed under the supervision of a staff of medical doctors;
4. it provides 24-hour nursing services by or under the supervision of a graduate registered nurse (R.N.);
5. it has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available on a prearranged basis;
6. it charges for its services.

The term Hospital does not include a clinic, facility, or unit of a Hospital for:
1. rehabilitation, convalescent, custodial, educational or nursing care;
2. the aged, drug addicts or alcoholics;
3. a Veteran's Administration Hospital or Federal Government Hospital unless the Covered Person incurs an expense.

Inpatient

A Covered Person who is confined for at least one full day's Hospital room and board. The requirement that a person be charged for room and board does not apply to confinement in a Veteran's Administration Hospital or Federal Government Hospital and in such case, the term 'Inpatient' shall mean a Covered Person who is required to be confined for a period of at least a full day as determined by the Hospital.

Nurse

A person who is a licensed graduate Registered Nurse (R.N.), a licensed practical Nurse (L.P.N.) or a licensed vocational Nurse (L.V.N.) and is not:
1. employed or retained by the Policyholder;
2. living in the Covered Person's household; or
3. a parent, sibling, spouse or child of the Covered Person.

Outpatient

A Covered Person who receives treatment, services and supplies while not an Inpatient in a Hospital.

Physician

A licensed health care provider practicing within the scope of his license and rendering care and treatment to a Covered Person that is appropriate for the condition and locality and who is not:
1. employed or retained by the Policyholder;
2. living in the Covered Person's household;
3. a parent, sibling, spouse or child of the Covered Person.

Prior Plan

The plan of insurance providing similar benefits, sponsored by the Employer in effect immediately prior to this Policy's Effective Date.

Sickness

A physical or mental illness.

Totally Disabled or Total Disability

Totally Disabled or Total Disability means either:
1. inability of the Covered Person who is currently employed to do any type of work for which he is or may become qualified by reason of education, training or experience; or
2. inability of the Covered Person who is not currently employed to perform all of the activities of daily living including eating, transferring, dressing, toileting, bathing, and continence, without human supervision or assistance.

We, Us, Our

Life Insurance Company of North America.

ELIGIBILITY AND EFFECTIVE DATE PROVISIONS

Policy Effective Date
We agree to provide Accident Insurance Benefits described in this Policy in consideration of the Policyholder's application and payment of the initial premium when due. Insurance coverage begins on the Policy Effective Date shown on this Policy's first page.

Eligibility
An Employee becomes eligible for insurance under this Policy on the date he meets all of the requirements of one of the Covered Classes and completes any Eligibility Waiting Period, as shown in the *Schedule of Benefits.*

Effective Date for Individuals
Insurance becomes effective for an eligible Employee who applies and agrees to make required contributions subject to the *Deferred Effective Date* provision below:

1. New hires. Coverage is effective first of the month following 30 calendar days from the date of hire.
2. Life Status Change. Coverage will become effective first of the month following the date of the change.
3. Annual Enrollment. Coverage becomes effective on the Policy Anniversary Date.

DEFERRED EFFECTIVE DATE
Active Service
The effective date of insurance will be deferred for any Employee who is not in Active Service on the date coverage would otherwise become effective. Coverage will become effective on the later of the date he returns to Active Service and the date coverage would otherwise have become effective.

Effective Date of Changes
Any increase or decrease in the amount of insurance for the Covered Person resulting from:

1. a change in benefits provided by this Policy; or
2. a change in the Employee's Covered Class will take effect on the date of such change.

Increases will take effect subject to any Active Service requirement.

TERMINATION OF INSURANCE
The insurance on a Covered Person will end on the last day of the month after the earliest of the following dates:

1. the date this Policy or insurance for a Covered Class is terminated;
2. the next premium due date after the date the Covered Person is no longer in a Covered Class or satisfies eligibility requirements under this Policy;
3. the last day of the last period for which premium is paid;
4. the next premium due date after the Covered Person attains the maximum Age for insurance under this Policy.

Termination will not affect a claim for a Covered Loss or Covered Injury that is the result, directly and independently of all other causes, of a Covered Accident that occurs while coverage was in effect.

Continuation for Layoff, Medical Leave of Absence, Non-Medical Leave of Absence or Family Medical Leave
Insurance for an Employee may be continued until the earliest of the following dates if: (a) an Employee is on a temporary layoff, an Employer-approved non-medical leave of absence, an Employer-approved medical leave of absence or an Employer-approved family medical leave; and (b) required premium contributions are paid when due.

1. for an Employer-approved medical leave of absence: 12 months
2. for an Employer-approved non-medical leave of absence: 12 months
3. for an Employer-approved family medical leave: 12 weeks in a consecutive 12-month period.

GA-00-1300.00

COMMON EXCLUSIONS

In addition to any benefit-specific exclusions, benefits will not be paid for any Covered Injury or Covered Loss which, directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the *Description of Benefits* Section:

1. intentionally self-inflicted injury, suicide or any attempt thereat while sane or insane;
2. commission or attempt to commit a felony or an assault;
3. commission of or active participation in a riot or insurrection;
4. bungee jumping; parachuting; skydiving; parasailing; hang-gliding;
5. declared or undeclared war or act of war;
6. flight in, boarding or alighting from an Aircraft or any craft designed to fly above the Earth's surface:
    a. except as a passenger on a regularly scheduled commercial airline or as pilot or passenger in Employer owned aircraft;
    b. when the aircraft is being used for:
        i. crop dusting, spraying or seeding, giving and receiving flying instruction, sky writing, sky diving or hang-gliding, pipeline or power line inspection, aerial photography or exploration, racing, endurance tests, stunt or acrobatic flying;
    c. when the aircraft is designed for flight above or beyond the earth's atmosphere;
    d. when the aircraft is an ultra-light or glider;
    e. when the aircraft is being used for the purpose of parachuting or skydiving;
    f. when the aircraft is being used by any military authority, except an Aircraft used by the Air Mobility Command or its foreign equivalent;
7. Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;
9. a Covered Accident that occurs while engaged in the activities of active duty service in the military, navy or air force of any country or international organization. Covered Accidents that occur while engaged in Reserve or National Guard training are not excluded until training extends beyond 31 days;
10. operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the Covered Person has been provided a written warning against operating a vehicle while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Accident occurred;
11. voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage.

GA-00-1403.00

CONVERSION PRIVILEGE

1. If the Covered Person's insurance or any portion of it ends for any of the following reasons:
   a. employment or membership ends;
   b. eligibility ends (except for age for the Employee);

   the Covered Person may have Us issue converted accident insurance on an individual policy or an individual certificate under a designated group policy. The Covered Person may apply for an amount of coverage that is:
   a. in $1,000 increments;
   b. not less than $25,000, regardless of the amount of insurance under the group policy; and
   c. not more than the amount of insurance he had under the group policy, except as provided above, up to a maximum amount of $250,000.

   The Covered Person must be under age 70 to get a converted policy.

   If the Covered Person's insurance or any portion of it ends for non-payment of premium, he may not convert. If the Covered Person's insurance ends for a reason described in 2. below, conversion is subject to that section.

   The converted policy or certificate will cover accidental death and dismemberment. The policy or certificate will not contain disability or other additional benefits. The Covered Person need not show Us that he is insurable.

   If the Covered Person has converted his group coverage and later becomes insured under the same group plan as before, he may not convert a second time unless he provides, at his own expense, proof of insurability or proof the prior converted policy is no longer in force.

   The Covered Person must apply for the individual policy within 31 days after his coverage under this Group Policy ends and pay the required premium, based on Our table of rates for such policies, his Age and class of risk. If the Covered Person has assigned ownership of his group coverage, the owner/assignee must apply for the individual policy.

   If the Covered Person suffers a Covered Loss or dies during this 31-day period as the result of an accident that would have been covered under this Group Policy, We will pay as a claim under this Group Policy the amount of insurance that the Covered Person was entitled to convert. It does not matter whether the Covered Person applied for the individual policy or certificate. If such policy or certificate is issued, it will be in exchange for any other benefits under this Group Policy.

   The individual policy or certificate will take effect on the day following the date coverage under the Group Policy ended; or, if later, the date application is made.

   Exclusions
   The converted policy may exclude the hazards or conditions that apply to the Covered Person's group coverage at the time it ends. We will reduce payment under the converted policy by the amount of any benefits paid under the group policy if both cover the same loss.

2. If the Covered Person's insurance ends because this Group Policy is terminated or is amended to terminate insurance for the Covered Person's class, and he has been covered under this Group Policy or, any group accident insurance issued to the Employer which the Group Policy replaced, for at least five years, the Covered Person may have Us issue an individual policy or certificate of accident insurance subject to the same terms, conditions and limitations listed above. However, the amount he may apply for will be limited to the lesser of the following:
   a. coverage under this Group Policy less any amount of group accident insurance for which he is eligible on the date this Group Policy is terminated or for which he became eligible within 31 days of such termination, or
   b. $10,000.

Extension of Conversion Period
If the Covered Person is eligible to convert and is not notified of this right at least 15 days prior to the end of the 31 day conversion period, the conversion period will be extended. The Covered Person will have 15 days from the date notice is given to apply for a converted policy or certificate. In no event will the conversion period be extended beyond 90 days. Notice, for the purpose of this section, means written notice presented to the Covered Person by the Policyholder or mailed to the Covered Person's last known address as reported by the Policyholder.

If the Covered Person sustains a Covered Loss or dies during the extended conversion period, but more than 31 days after his coverage under the Group Policy terminates, benefits will not be paid under the Group Policy. If the Covered Person's application for a converted policy or certificate is received by Us and the required premium is paid, benefits may be payable under the converted policy or certificate.

GA-01-1505.00

CLAIM PROVISIONS

Notice of Claim
Written or authorized electronic/telephonic notice of claim must be given to Us within 31 days after a Covered Loss occurs or begins or as soon as reasonably possible. If written or authorized electronic/telephonic notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written or authorized electronic/telephonic notice was given as soon as was reasonably possible. Notice can be given to Us at Our home office in Philadelphia, Pennsylvania, such other place as We may designate for the purpose, or to Our authorized agent. Notice should include the Policyholder's name and policy number and the Covered Person's name, address, policy and certificate number.

Claim Forms
We will send claim forms for filing proof of loss when We receive notice of a claim. If such forms are not sent within 15 days after We receive notice, the proof requirements will be met by submitting, within the time fixed in this Policy for filing proof of loss, written or authorized electronic proof of the nature and extent of the loss for which the claim is made.

Claimant Cooperation Provision
Failure of a claimant to cooperate with Us in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Proof of Loss
Written or authorized electronic proof of loss satisfactory to Us must be given to Us at Our office, within 90 days of the loss for which claim is made. If (a) benefits are payable as periodic payments and (b) each payment is contingent upon continuing loss, then proof of loss must be submitted within 90 days after the termination of each period for which We are liable. If written or authorized electronic notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as reasonably possible. In any case, written or authorized electronic proof must be given not more than one year after the time it is otherwise required, except if proof is not given solely due to the lack of legal capacity.

Time of Payment of Claims
We will pay benefits due under this Policy for any loss other than a loss for which this Policy provides any periodic payment immediately upon receipt of due written or authorized electronic proof of such loss. Subject to due written or authorized electronic proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid monthly unless otherwise specified in the benefits descriptions and any balance remaining unpaid at the termination of liability will be paid immediately upon receipt of proof satisfactory to Us.

Payment of Claims
All benefits will be paid in United States currency. Benefits for loss of life will be payable in accordance with the Beneficiary provision and these Claim Provisions. All other proceeds payable under this Policy, unless otherwise stated, will be payable to the covered Employee or to his estate.

If We are to pay benefits to the estate or to a person who is incapable of giving a valid release, We may pay $1,000 to a relative by blood or marriage whom We believe is equitably entitled. Any payment made by Us in good faith pursuant to this provision will fully discharge Us to the extent of such payment and release Us from liability for that amount.

Payment of Claims to Foreign Employees
The Policyholder may, in a fiduciary capacity, receive and hold any benefits payable to covered Employees whose place of employment is other than the United States of America.

We will not be responsible for the application or disposition by the Policyholder of any such benefits paid. Our payments to the Policyholder will constitute a full discharge of Our liability for those payments under this Policy.

Physical Examination and Autopsy
We, at Our own expense, have the right and opportunity to examine the Covered Person when and as often as We may reasonably require while a claim is pending and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions
No action at law or in equity may be brought to recover under this Policy less than 60 days after written or authorized electronic proof of loss has been furnished as required by this Policy. No such action will be brought more than four years after the time such written proof of loss must be furnished.

Beneficiary
The beneficiary is the person or persons the Employee names or changes on a form executed by him and satisfactory to Us. This form may be in writing or by any electronic means agreed upon between Us and the Policyholder. Consent of the beneficiary is not required to affect any changes, unless the beneficiary has been designated as an irrevocable beneficiary, or to make any assignment of rights or benefits permitted by this Policy.

A beneficiary designation or change will become effective on the date the Employee executes it. However, We will not be liable for any action taken or payment made before We record notice of the change at our home office.

If more than one person is named as beneficiary, the interests of each will be equal unless the Employee has specified otherwise. The share of any beneficiary who does not survive the Covered Person will pass equally to any surviving beneficiaries unless otherwise specified.

If there is no named beneficiary or surviving beneficiary, or if the Employee dies while benefits are payable to him, We may make direct payment to the first surviving class of the following classes of persons:
1. spouse;
2. child or children;
3. mother or father;
4. sisters or brothers;
5. estate of the Covered Person.

Recovery of Overpayment
If benefits are overpaid, We have the right to recover the amount overpaid by either of the following methods.
1. A request for lump sum payment of the overpaid amount.
2. A reduction of any amounts payable under this Policy.

If there is an overpayment due when the Covered Person dies, We may recover the overpayment from the Covered Person's estate.

GA-00-1600.00

ADMINISTRATIVE PROVISIONS

Premiums

All premium rates are expressed in, and all premiums are payable in, United States currency. The premiums for this Policy will be based on the rates set forth in the *Schedule of Benefits*, the plan and amounts of insurance in effect. If a Covered Person's insurance amounts are reduced due to age, premium will be based on the amounts of insurance in force on the day after the reduction took place.

Changes in Premium Rates

We may change the premium rates from time to time with at least 180 days advance written notice to the Policyholder but only on the Policy Anniversary Date. No change in rates will be made until 48 months after the Policy Effective Date. An increase in rates will not be made more often than once in a 12-month period and only on the Policy Anniversary Date. However, We reserve the right to change rates at any time if any of the following events take place:

1. the terms of this Policy change;
2. the terms of the Policyholder's participation change;
3. a division, subsidiary, affiliated company or eligible class is added or deleted from this Policy;
4. there is a change in the factors bearing on the risk assumed;
5. any federal or state law or regulation is amended to the extent it affects Our benefit obligation.

Payment of Premium

The first premium is due within 30 days of delivering the Policy. Thereafter, premiums are due on the Premium Due Dates agreed upon between Us and the Policyholder. If any premium is not paid when due, the Policyholder's participation under this Policy will be terminated as of the Premium Due Date on which premium was not paid.

Grace Period

A Grace Period of 31 days will be granted for payment of required premiums under this Policy. This Policy will be in force during the Policy Grace Period. The Policyholder is liable to Us for any unpaid premium for the time its participation under this Policy was in force.

A Grace Period of 31 days will be granted for payment of required premiums under this Policy. A Covered Person's insurance under this Policy will remain in force during the Grace Period. We will reduce any benefits payable for any claims incurred during the grace period by the amount of premium due. If no such claims are incurred and premium is not paid during the grace period, insurance will end on the last day of the period for which premiums were paid.

GA-00-1701.00

GENERAL PROVISIONS

Entire Contract; Changes
This Policy, including the endorsements, amendments and any attached papers constitutes the entire contract of insurance. No change in this Policy will be valid until approved by one of Our executive officers and endorsed on or attached to this Policy. No agent of the Insurance Company or Employer has authority to change this Policy or to waive any of its provisions.

Misstatement of Fact
If the Covered Person has misstated any fact, all amounts payable under this Policy will be such as the premium paid would have purchased had such fact been correctly stated.

Certificates
Where required by law, We will provide a certificate of insurance for delivery to the Covered Person. Each certificate will list the benefits, conditions and limits of this Policy. It will state to whom benefits will be paid.

30 Day Right To Examine Certificate
If a Covered Person does not like the Certificate for any reason, it may be returned to Us within 30 days after receipt. We will return any premium that has been paid and the Certificate will be void as if it had never been issued.

Multiple Certificates
The Covered Person may have in force only one certificate at a time under this Policy. If at any time the Covered Person has been issued more than one certificate, then only the largest shall be in effect. We will refund premiums paid for the others for any period of time that more than one certificate was issued.

Assignment
We will be bound by an assignment of a Covered Person's insurance under this Policy only when the original assignment or a certified copy of the assignment, signed by the Covered Person and any irrevocable beneficiary, is filed with Us. The assignee may exercise all rights and receive all benefits assigned only while the assignment remains in effect and insurance under this Policy and the Covered Person's certificate remains in force.

Incontestability
1. Of This Policy or Participation Under This Policy
All statements made by the Policyholder to obtain this Policy or to participate under this Policy are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, or to deny the validity of this Policy or of participation under this Policy unless a copy of the instrument containing the statement is, or has been, furnished to the Policyholder.

After two years from the Policy Effective Date, no such statement will cause this Policy to be contested except for fraud.

2. Of A Covered Person's Insurance
All statements made by a Covered Person are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, unless a copy of the instrument containing the statement is, or has been, furnished to the claimant.

After two years from the Covered Person's effective date of insurance, or from the effective date of increased benefits, no such statement will cause insurance or the increased benefits to be contested except for fraud or lack of eligibility for insurance.

In the event of death or incapacity, the beneficiary or representative shall be given a copy.

Policy Termination
We may terminate coverage on or after the first anniversary of the policy effective date. Written notice must be given at least 180 days prior to such termination. The Policyholder may terminate coverage on any premium due date. Written or authorized electronic notice must be given at least 180 days prior to such premium due date.

Termination will not affect a claim for a Covered Loss that is the result, directly and independently of all other causes, of a Covered Accident that occurs while coverage was in effect.

Reinstatement
This Policy may be reinstated if it lapsed for nonpayment of premium. Requirements for reinstatement are written application of the Policyholder satisfactory to Us and payment of all overdue premiums. Any premium accepted in connection with a reinstatement will be applied to a period for which premium was not previously paid.

Clerical Error
A Covered Person's insurance will not be affected by error or delay by the Insurance Company or Employer in keeping records of insurance under this Policy. If such error or delay is found, We will adjust the premium fairly.

Conformity with Statutes
Any provisions in conflict with the requirements of any state or federal law that apply to this Policy are automatically changed to satisfy the minimum requirements of such laws.

Policy Changes
We may agree with the Policyholder to modify a plan of benefits without the Covered Person's consent.

Workers' Compensation Insurance
This Policy is not in place of and does not affect any requirements for coverage under any Workers' Compensation law.

Examination of the Policy
This Group Policy will be available for inspection at the Policyholder's office during regular business hours.

Examination of Records
We will be permitted to examine all of the Policyholder's records relating to this Group Policy. Examination may occur at any reasonable time while the Group Policy is in force; or it may occur:

1. at any time for two years after the expiration of this Group Policy; or, if later,
2. upon the final adjustment and settlement of all Group Policy claims.

The Policyholder is acting as an agent of the Covered Person for transactions relating to this insurance. The actions of the Policyholder will not be considered Our actions.

GA-00-1800.00

DESCRIPTION OF COVERAGES AND BENEFITS

This *Description of Coverages and Benefits* Section describes the Accident Coverages and Benefits provided by this Policy. Benefit amounts, benefit periods and any applicable aggregate and benefit maximums are shown in the *Schedule of Benefits*. Certain words capitalized in the text of these descriptions have special meanings within this Policy and are defined in the *General Definitions* section and on the Policy cover page. Please read these and the *Common Exclusions* sections in order to understand all of the terms, conditions and limitations applicable to these coverages and benefits.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Covered Loss

We will pay the benefit for any one of the Covered Losses listed in the *Schedule of Benefits*, if the Covered Person suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident within the applicable time period specified in the *Schedule of Benefits*.

If the Covered Person sustains more than one Covered Loss as a result of the same Covered Accident, benefits will be paid for the Covered Loss for which the largest available benefit is payable. If the loss results in death, benefits will only be paid under the Loss of Life benefit provision. Any Loss of Life benefit will be reduced by any paid or payable Accidental Dismemberment benefit. However, if such Accidental Dismemberment benefit equals or exceeds the Loss of Life benefit, no additional benefit will be paid.

Definitions

Loss of a Hand or Foot means complete Severance through or above the wrist or ankle joint.

Loss of Sight means the total, permanent loss of all vision in one eye which is irrecoverable by natural, surgical or artificial means.

Loss of Speech means total and permanent loss of audible communication which is irrecoverable by natural, surgical or artificial means.

Loss of Hearing means total and permanent loss of ability to hear any sound in both ears which is irrecoverable by natural, surgical or artificial means.

Loss of a Thumb and Index Finger of the Same Hand or Four Fingers of the Same Hand means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand).

Loss of Toes means complete Severance through the metatarsalphalangeal joint.

Paralysis or Paralyzed means total loss of use of a limb. A Physician must determine the loss of use to be complete and irreversible.

Quadriplegia means total Paralysis of both upper and both lower limbs.

Hemiplegia means total Paralysis of the upper and lower limbs on one side of the body.

Paraplegia means total Paralysis of both lower limbs or both upper limbs.

Uniplegia means total Paralysis of one upper or one lower limb.

Coma means a profound state of unconsciousness which resulted directly and independently from all other causes from a Covered Accident, and from which the Covered Person is not likely to be aroused through powerful stimulation. This condition must be diagnosed and treated regularly by a Physician. Coma does not mean any state of unconsciousness intentionally induced during the course of treatment of a Covered Injury unless the state of unconsciousness results from the administration of anesthesia in preparation for surgical treatment of that Covered Accident.

Severance means the complete and permanent separation and dismemberment of the part from the body.

Exclusions The exclusions that apply to this benefit are in the *Common Exclusions* section.
GA-00-2100.00

ADDITIONAL ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGES
Accidental Death and Dismemberment benefits are provided under the following coverages. Any benefits payable under them are shown in the *Schedule of Covered Losses* and will not be paid in addition to any other Accidental Death and Dismemberment benefits payable.

EXPOSURE AND DISAPPEARANCE COVERAGE
Benefits for Accidental Death and Dismemberment, as shown in the *Schedule of Covered Losses*, will be payable if a Covered Person suffers a Covered Loss which results directly and independently of all other causes from unavoidable exposure to the elements following a Covered Accident.

If the Covered Person disappears and is not found within one year from the date of the wrecking, sinking or disappearance of the conveyance in which the Covered Person was riding in the course of a trip which would otherwise be covered under this Policy, it will be presumed that the Covered Person's death resulted directly and independently of all other causes from a Covered Accident.

Exclusions The exclusions that apply to this coverage are in the *Common Exclusions* Section.
GA-00-2202.00

OWNED AIRCRAFT COVERAGE
Benefits for Accidental Death and Dismemberment, as shown in the *Schedule of Covered Losses*, will be payable if the Covered Person suffers a Covered Loss that results directly and independently of all other causes from a Covered Accident that occurs during travel or flight in, including getting in or out of, any Aircraft that is owned, leased, operated or controlled by the Policyholder or any of its subsidiaries or affiliates. A record of eligible Aircraft will be maintained by the Policyholder and available for review by Us at any time during normal business hours. An Aircraft substituted for an eligible Aircraft will also be eligible if it has no greater seating capacity and the original Aircraft is withdrawn from normal use due to breakdown, repair, servicing, loss or destruction.

GA-00-2205.00

ADDITIONAL ACCIDENT BENEFITS

Accidental Death and Dismemberment benefits are provided under the following Additional Benefits. Any benefits payable under them will be paid in addition to any other Accidental Death and Dismemberment benefit payable.

SEATBELT AND AIRBAG BENEFIT

We will pay the benefit shown in the *Schedule of Benefits*, subject to the conditions and exclusions described below, when the Covered Person dies directly and independently of all other causes from a Covered Accident while wearing a seatbelt and operating or riding as a passenger in an Automobile. An additional benefit is provided if the Covered Person was also positioned in a seat protected by a properly-functioning and properly deployed Supplemental Restraint System (Airbag).

Verification of proper use of the seatbelt at the time of the Covered Accident and that the Supplemental Restraint System properly inflated upon impact must be a part of an official police report of the Covered Accident or be certified, in writing, by the investigating officer(s) and submitted with the Covered Person's claim to Us.

Definitions For purposes of this benefit:

Supplemental Restraint System means an airbag that inflates upon impact for added protection to the head and chest areas.

Automobile means a self-propelled, private passenger motor vehicle with four or more wheels which is a type both designed and required to be licensed for use on the highway of any state or country. Automobile includes, but is not limited to, a sedan, station wagon, sport utility vehicle, or a motor vehicle of the pickup, van, camper, or motor-home type. Automobile does not include a mobile home or any motor vehicle which is used in mass or public transit.

Exclusions The exclusions that apply to this benefit are in the *Common Exclusions* Section.

GA-00-2251.00

SPECIAL EDUCATION BENEFIT
We will pay the benefit, up to the Maximum Benefit shown in the *Schedule of Benefits,* for each qualifying Dependent Child. The Covered Person's death must result, directly and independently of all other causes from a Covered Accident for which an Accidental Death Benefit is payable under this Policy. This benefit is subject to the conditions and exclusions described below.

A qualifying Dependent Child must:

1.
   a. be enrolled as a full-time student in an accredited school of higher learning beyond the 12th grade level on the date of the covered Employee's Covered Accident; *or*
   b. be at the 12th grade level on the date of the covered Employee's Covered Accident and then enroll as a full-time student at an accredited school of higher learning within 365 days from the date of the Covered Accident and continue his education as a full-time student.
2. continue his education as a full-time student in such accredited school of higher learning; and
3. incur expenses for tuition, fees, books, room and board, transportation and any other costs payable directly to, or approved and certified by, such school.

Payments will be made to each qualifying Dependent Child or to the child's legal guardian, if the child is a minor at the end of each year for the number of years shown in the *Schedule of Benefits.* We must receive proof satisfactory to Us of the Dependent Child's enrollment and attendance within 31 days of the end of each year. The first year for which a Special Education Benefit is payable will begin on the first of the month following the date the covered Employee died, if the surviving Dependent Child was enrolled on that date in an accredited school of higher learning beyond the 12th grade; otherwise on the date he enrolls in such school. Each succeeding year for which benefits are payable will begin on the date following the end of the preceding year.

If no Dependent Child qualifies for Special Education Benefits within 365 days of the covered Employee's death, We will pay the default benefit shown in the *Schedule of Benefits* to the covered Employee's beneficiary.

Definitions For the purposes of this benefit:

Dependent Child(ren) An Employee's unmarried child who meets the following requirements:

1. A child from live birth to 19 years old;
2. A child who is 19 or more years old but less than 25 years old, enrolled in a school as a full-time student and primarily supported by the Employee;
3. A child who is 19 or more years old, primarily supported by the Employee and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to Us within 31 days after the date the child ceases to qualify as a Dependent Child for the reasons listed above. During the next two years, We may, from time to time, require proof of the continuation of such condition and dependence. After that, We may require proof no more than once a year.

A child, for purposes of this provision, includes an Employee's:

1. natural child;
2. adopted child, beginning with any waiting period pending finalization of the child's adoption;
3. stepchild who resides with the Employee;
4. child for whom the Employee is legal guardian, as long as the child resides with the Employee and depends on the Employee for financial support. Financial support means that the Employee is eligible to claim the dependent for purposes of Federal and State income tax returns.

Exclusions The exclusions that apply to this benefit are in the *Common Exclusions* Section.

GA-00-2252a.00

Life Insurance Company of North America
1601 Chestnut Street
Philadelphia, Pennsylvania 19192-2235

MODIFYING PROVISIONS AMENDMENT

Policyholder: Travis County   Policy No.: OK 965800

Amendment Effective Date: October 1, 2011

This amendment is attached to and made part of the Policy specified above and the Certificates issued under it. Its provisions are intended to conform this Policy to the laws of the state in which the insured resides.

The Policy and any Certificates delivered under the Group Policy are amended as follows:

Arkansas residents:

Under the *General Definitions* section, the definition of Covered Accident does not include reference to an "external" event.

Missouri residents:

1. Under the *General Definitions* section, the definition of Covered Accident does not include reference to an "external" event.

2. Under the *General Definitions* section, the definition of *Totally Disabled or Total Disability* means either:
   a) the inability of the Covered Person who is currently employed to perform the material and substantial duties of the Covered Person's occupation for a period of at least twelve months. After the initial benefit period, total disability shall mean the Covered Person's inability to perform the material and substantial duties of any occupation for which the Covered Person is qualified by education, training or experience; or
   b) the inability of the Covered Person who is not currently employed to perform all of the activities of daily living including eating, transferring, dressing, toileting, bathing, and continence, without human supervision or assistance.

Montana residents:

Under the *General Definitions* section, the definition of *Sickness* is replaced with the following:

Sickness A physical or mental illness including pregnancy

New Hampshire residents:

1. Under the *General Definitions* section, the definition of Covered Accident does not include reference to an "external" event.

2. If applicable, the definition of Emergency Room Treatment is replaced with the following:

Emergency Room Treatment Emergency medical services and care given in a Hospital as an out or inpatient, for a sudden, unexpected onset of a medical condition that manifests itself by symptoms of sufficient severity that in the absence of immediate medical attention could be expected to result in any of the following:
1. serious jeopardy to the covered Employee's health;
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

3. The definition of Hospital is replaced with the following.

Hospital

An institution that meets all of the following:
1. it is operated pursuant to applicable law;
2. it is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;
3. it is managed under the supervision of a staff of medical doctors;
4. it provides 24-hour nursing services by or under the supervision of a graduate registered nurse (R.N.);
5. it has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available on a prearranged basis;
6. it charges for its services.

Hospital shall include a Veteran's Administration Hospital or Federal Government Hospital and the requirement that a patient must incur an expense as an Inpatient shall be waived.

The term Hospital does not include a clinic, facility, or unit of a Hospital for:
1. rehabilitation, convalescent, custodial, educational or nursing care;
2. the aged, drug addicts or alcoholics;
3. a Veteran's Administration Hospital or Federal Government Hospitals unless the Covered Person incurs an expense.

North Carolina residents:

1. If eligibility for insurance is not based on employment status, a Covered Person is considered in Active Service if confined at home under the care of a Physician for Sickness or Injury.

2. Under the *General Definitions* section, the definition of Covered Accident does not include reference to an "external" event.

3. Under the *General Definitions* section, the definition of Hospital is modified to include State tax-supported institutions.

4. Under the *Claim Provisions,* the following changes are made.
   a. *Proof of Loss* must be provided within 180 days of date of loss.
   b. The amount payable to an equitably entitled individual may not exceed $3,000.

South Carolina residents:

1. Under the *General Definitions* section, the definition of Covered Accident does not include reference to an "external" event.

2. Under the *Claim Provisions,* the following changes are made.
   a. The *Claimant Cooperation Provision* does not apply.
   b. The provision titled *Physical Examination and Autopsy* is replaced with the following:
      Physical Examination and Autopsy
      We, at Our own expense, have the right and opportunity to examine the Covered Person when and as often as We may reasonably require while a claim is pending. If an autopsy is performed, it will be in the State of South Carolina and during the period of contestability unless prohibited by law.
   c. The provision titled *Legal Actions* is replaced with the following:
      Legal Actions
      No action at law or in equity may be brought to recover under this Policy less than 60 days after written or authorized electronic proof of loss has been furnished as required by this Policy. No such action will be brought more than six years after the time such written proof of loss must be furnished.

3. Under the *General Provisions,* the following changes are made.
   The *Multiple Certificates* provision does not apply.

South Dakota residents:

Under the *Common Exclusions* section, the following changes are not permitted:

1. the Covered Person being legally intoxicated as determined according to the laws of the jurisdiction in which the Covered Accident occurred;
2. the Covered Person being Intoxicated. "Intoxicated" means having a blood alcohol level of .08 or higher;
3. the Covered Person operating a motorized vehicle while under the influence of alcohol or drugs as defined according to the laws of the jurisdiction in which the Accident occurred;
4. voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
5. occupational injuries for which benefits are not paid under the Workers' Compensation Law or any similar law;
6. operating any type of vehicle while under the influence of alcohol or any drug , narcotic or other intoxicant including any prescribed drug for which the Covered Person has been provided a written warning against operating a vehicle while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Accident occurred;
7. the Covered Person was driving a Private Passenger Automobile at the time of the Covered Accident that resulted in the Covered Loss; and he was intoxicated, as that term is defined by the laws of the state in which the Covered Accident occurred.

West Virginia residents:

1. Under the *General Definitions* section, the definition of Covered Accident does not include reference to an "external" event.

2. Under the *General Definitions* section, the definition of Hospital does not require that an institution be licensed as a Hospital pursuant to applicable law, but does require that an institution operate pursuant to applicable law.

3. Under the *General Definitions* section, the definition of Totally Disabled or Total Disability is replaced with the following:
   Totally Disabled or Total Disability
   Totally Disabled or Total Disability means either:
   1. inability of the Covered Person who is currently employed to perform substantially all of the material duties of his job, or any other job for which he is or may become qualified by reason of education, training or experience; or
   2. inability of the Covered Person who is not currently employed to perform all of the activities of daily living including eating, transferring, dressing, toileting, bathing, and continence, without human supervision or assistance.

Signed for the
Life Insurance Company of North America

Matthew G. Manders, President

GA-00-3000.00

LIFE INSURANCE COMPANY OF NORTH AMERICA
Philadelphia, PA 19192-2235

We, Travis County, whose main office address is Austin, TX, hereby approve and accept the terms of Group Policy Number OK 965800 issued by the LIFE INSURANCE COMPANY OF NORTH AMERICA.

This form is to be signed in duplicate. One part is to be retained by Travis County; the other part is to be returned to the LIFE INSURANCE COMPANY OF NORTH AMERICA.

Travis County

Signature and Title:______________________________ Date: ____________________

(This Copy Is To Be Returned To Life Insurance Company of North America)

LIFE INSURANCE COMPANY OF NORTH AMERICA
Philadelphia, PA 19192-2235

We, Travis County, whose main office address is Austin, TX, hereby approve and accept the terms of Group Policy Number OK 965800 issued by the LIFE INSURANCE COMPANY OF NORTH AMERICA.

This form is to be signed in duplicate. One part is to be retained by Travis County; the other part is to be returned to the LIFE INSURANCE COMPANY OF NORTH AMERICA.

Travis County

Signature and Title:______________________________ Date: ____________________

(This Copy Is To Be Retained By Travis County)

Attachment IC-2

Group Active full-time Employee and Dependent Voluntary Life Policy

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call the toll-free telephone number for information or to make a complaint at:

1-800-547-5515

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may write the
Texas Department of Insurance
P.O. Box 149091
Austin, TX 78714-9104
FAX # (512) 475-1771

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim you should contact the agent or company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para solicitar información o presentar una queja:

Usted puede llamar al numero de telefono gratis para información o pare someter una queja al:

1-800-547-5515

Puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos o quejas llamando al:

1-800-252-3439

También puede escribir al Texas Department of Insurance (Departamento de Seguros de Texas)
P.O. Box 149091
Austin, TX 78714-9104
FAX # (512) 475-1771

CONFLICTOS POR PRIMAS O RECLAMACIONES: En caso de tener un conflicto relacionado con su prima o una reclamación, debe comunicarse primero con el agente o la compañía. Si el conflicto no se resuelve, usted puede comunicarse con el Departamento de Seguros de Texas.

UNA ESTE AVISO A SU POLIZA: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE, ACCIDENT, HEALTH AND HOSPITAL SERVICE INSURANCE GUARANTY ASSOCIATION
(For insurers declared insolvent or impaired on or after September 1, 2005)

Texas law establishes a system, administered by the Texas Life, Accident, Health and Hospital Service Insurance Guaranty Association (the "Association"), to protect Texas policyholders if their life or health insurance company fails. Only the policyholders of insurance companies which are members of the Association are eligible for this protection which is subject to the terms, limitations, and conditions of the Association law. (The law is found in the *Texas Insurance Code*, Chapter 463.)

It is possible that the Association may not cover your policy in full or in part due to statutory limitations.

ELIGIBILITY FOR PROTECTION BY THE ASSOCIATION

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas at that time **(irrespective of the policyholder's residency at policy issue)**
- Residents of other states, ONLY if the following conditions are met:
  1) The policyholder has a policy with a company domiciled in Texas;
  2) The policyholder's state of residence has a similar guaranty association; and
  3) The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

LIMITS OF PROTECTION BY THE ASSOCIATION

Accident, Accident and Health, or Health Insurance:

- For each individual covered under one or more policies: up to a total of $500,000 for basic hospital, medical-surgical, and major medical insurance, $300,000 for disability or long term care insurance, and $200,000 for other types of health insurance.

Life Insurance:

- Net cash surrender value or net cash withdrawal value up to a total of $100,000 under one or more policies on any one life; or
- Death benefits up to a total of $300,000 under one or more policies on any one life; or
- Total benefits up to a total of $5,000,000 to any owner of multiple non-group life policies.

Individual Annuities:

- Present value of benefits up to a total of $100,000 under one or more contracts on any one life.

Group Annuities:

- Present value of allocated benefits up to a total of $100,000 on any one life; or
- Present value of unallocated benefits up to a total of $5,000,000 for one contractholder regardless of the number of contracts.

Aggregate Limit:

- $300,000 on any one life with the exception of the $500,000 health insurance limit, the $5,000,000 multiple owner life insurance limit, and the $5,000,000 unallocated group annuity limit.

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage.

Texas Life, Accident, Health and Hospital
Service Insurance Guaranty Association
6504 Bridge Point Parkway, Suite 450
Austin, Texas 78730
800-982-6362 or www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439 or www.tdi.state.tx.us

NOTICE

Any accelerated benefits payable under the policy will reduce the death benefit payable for life insurance. If you elect to accelerate your life insurance benefit, we will send you a statement explaining the amount of your benefit, and what effect (if any) accelerating your life insurance benefit will have on the death benefit face amount, specified amount, accumulation values, cash values, loan amounts, future charges, or future premiums.

Benefits payable under the Accelerated Benefits provision may be taxable. If so, the Employee or the Employee's beneficiary may incur a tax obligation. As with all tax matters, an Employee should consult with a personal tax advisor to assess the impact of this benefit. Accelerated Benefits are not payable if life insurance coverage under the Policy is not in force.

Any accidental death benefits that you may have under the policy will not be affected by the acceleration of life insurance benefits.

FL-00478R

LIFE INSURANCE COMPANY OF NORTH AMERICA
1601 CHESTNUT STREET
PHILADELPHIA, PA 19192-2235
(800) 732-1603 TDD (800) 552-5744
A STOCK INSURANCE COMPANY

GROUP POLICY

POLICYHOLDER: County of Travis

POLICY NUMBER: FLX-964188

POLICY DESCRIPTION: Employee Life Insurance

POLICY EFFECTIVE DATE: October 1, 2011

POLICY ANNIVERSARY DATE: October 1

This Policy describes the terms and conditions of coverage. It is issued in Texas and shall be governed by its laws. The Policy goes into effect on the Policy Effective Date, 12:01 a.m. at the Policyholder's address.

In return for the required premium, the Insurance Company and the Policyholder have agreed to all the terms of this Policy.

Scott Kern, Corporate Secretary

Matthew G. Manders, President

TL-004700

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SCHEDULE OF BENEFITS

Policy: Group Policy identified as Policy Number: FLX-964188 on the Policy cover page.

Premium Due Date: The last day of each month

Classes of Eligible Employees

On the pages following the definition of eligible employees there is a Schedule of Benefits for each Class of Eligible Employees listed below. For an explanation of these benefits, please see the Description of Benefits provision.

If an Employee is eligible under one Class of Eligible Employees and later becomes eligible under a different Class of Eligible Employees, changes in his or her insurance due to the class change will be effective on the first date the Employee is in Active Service on or after the date of the change in class.

Class 1 All active, Full-time Employees of the Employer regularly working a minimum of 20 hours per week.

Class 2 All Disabled Employees who were hired prior to October 1, 2011.

Terminally Ill: Having an illness with a prognosis of 12 months or less live as diagnosed by a Physician.

SCHEDULE OF BENEFITS FOR CLASS 1

Eligibility Waiting Period

The Eligibility Waiting Period is the period of time the Employee must be in Active Service to be eligible for coverage. It will be extended by the number of days the Employee is not in Active Service.

For Employees hired on or before the Policy Effective Date:
The first of the month following 30 calendar days after the date of hire.

For Employees hired after the Policy Effective Date:
The first of the month following 30 calendar days after the date of hire.

LIFE INSURANCE BENEFITS

Employee Benefits

Amount of Insurance	Amount Employee elected in multiples of the Benefit Level
Benefit Level:	$25,000
Maximum Amount of Insurance or Maximum Benefit:	4 times Annual Compensation, rounded to the next higher $25,000, with a maximum of $250,000

Guaranteed Issue Amount means the amount of insurance Employee can elect without providing medical evidence of insurability. This amount is limited by the Maximum Amount of Insurance or Maximum Benefit.

Guaranteed Issue Amount:
New Employee at hire: $250,000
Existing Employee at October 1, 2012:
an amount equal to the Life Insurance Benefit in effect at enrollment plus one Benefit Level ($25,000)

Age Based Reductions
Life Insurance Benefit for an Employee age 70 and over will reduce to:
65% of the Life Insurance Benefit at age 70
40% of the Life Insurance Benefit at age 75
25% of the Life Insurance Benefit at age 80
15% of the Life Insurance Benefit at age 85

Continuation Options

For Layoff
Maximum Benefit Period: To the end of the month in which the layoff begins

For Non-Medical Administrative Leave of Absence
Maximum Benefit Period: 12 months

For Medical Leave of Absence
Maximum Benefit Period: 12 months

For Family Medical Leave
Maximum Benefit Period: 12 weeks

For Disability	
Maximum Benefit Period:	12 months
Applicable Coverages:	Life Insurance Benefits for the Employee, his or her Spouse and Dependent Children, if any.
Portability Options	
For Employees	See the Former Employee and Spouse/Domestic Partner of a Former Employee sections in this Schedule of Benefits for the amounts of insurance an Insured is eligible to continue under this option.
Terminal Illness Benefit	100% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.

Annual Enrollment Period and Life Status Change
Benefit Levels and Guaranteed Issue Amounts as shown above.

During an Annual Enrollment Period, or within 31 days of a Life Status Change, an Employee currently insured under the Voluntary Life Insurance portion of this Policy may increase his or her Voluntary Life Insurance Benefit by one Benefit Level, without satisfying the Insurability Requirement, and an Employee who is eligible for the Voluntary Life Insurance portion of this Policy but who has not previously enrolled may become insured under the Policy for an amount equal to one Benefit Level without satisfying the Insurability Requirement.

Such increases will be effective on the Policy Anniversary following the Annual Enrollment Period or, for increases following a Life Status Change, first of the month following the date of the Life Status Change if the Employer or Insurance Company receives the completed request for a Benefit increases within 31 days of the Life Status Change.

An insured Employee may increase coverage, and an Employee who is eligible but has not enrolled, may become insured for a Benefit in excess of amounts described above only if he or she satisfies the Insurability Requirement. Any excess amounts will be effective on the later of the Policy Anniversary following the Annual Enrollment Period or the date the Insurance Company agrees in writing to insure the Employee.

A Spouse currently insured or who is eligible to be insured under the Voluntary Life Insurance portion of this Policy may increase his or her Voluntary Life Insurance Benefit in units of $10,000, to a Maximum of $30,000, without satisfying the Insurability Requirement. Such increases will be effective on the Policy Anniversary following the Annual Enrollment Period or, for increases following a Life Status Change, first of the month following the date of the Life Status Change if the Employer or Insurance Company receives the completed request for a Benefit increase within 31 day of the Life Status Change.

Reduction in Benefit
An Employee may reduce Insurance Benefits at any time. A request for a Benefit reduction received during an Annual Enrollment Period will become effective on the Policy Anniversary following the Annual Enrollment Period. Any other Benefit reduction will be effective on the date the Insurance Company or Employer receives the completed change form.

Spouse or Domestic Partner and Dependent Child Benefits

Amount of Insurance	Spouse $10,000
Guarantee Issue Amount:	$10,000
Maximum Benefit:	$10,000
	Dependent Child $5,000 Per child
	The Maximum Benefit for a Dependent Child who is 14 days or less than 6 months old is $1,000.
	All Dependent Child benefits are Guaranteed Issue.

Additional Spouse or Domestic Partner Benefits

Amount of Additional Insurance	Units of $10,000
Guaranteed Issue Amount:	$20,000
Maximum Benefit:	$20,000

The Spouse or Domestic Partner and Child Benefits Unit must be elected to be able to elect additional Spouse Benefits

Portability Options For Spouse or Domestic Partner	See the Former Spouse or Domestic Partner section in this Schedule of Benefits for the amounts of insurance an Insured is eligible to continue under this option.
Terminal Illness Benefit	100% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.
Portability Options For Dependent Children	See the Former Dependent Child section in this Schedule of Benefits for the amounts of insurance an Insured is eligible to continue under this option.

Former Employee Benefits

Amount of Insurance	An amount equal to the Life Insurance Benefit in force on the date he or she no longer qualifies as an Employee, less any amount of conversion insurance issued under the Conversion Privilege for Life Insurance.
Terminal Illness Benefit	100% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.

Spouse or Domestic Partner of Former Employee Benefits

Amount of Insurance	An amount equal to the Voluntary Life Insurance Benefits in force on the date the Former Employee no longer qualifies as an Employee.
Terminal Illness Benefit	100% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.

Former Spouse or Domestic Partner Benefits

Amount of Insurance	An amount equal to the Voluntary Life Insurance Benefits in force on the date the he or she no longer qualifies as a Spouse.
Terminal Illness Benefit	100% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.

Former Dependent Child Benefits

Amount of Insurance	Units of $25,000
Guaranteed Issue Amount:	$25,000
Maximum Benefit:	$50,000
Maximum Benefit Period	To Age 70

IL-004774

SCHEDULE OF BENEFITS FOR CLASS 2

Eligibility Waiting Period

The Eligibility Waiting Period is the period of time the Employee must be in Active Service to be eligible for coverage. It will be extended by the number of days the Employee is not in Active Service.

For Employees hired on or before the Policy Effective Date:
Closed Class

LIFE INSURANCE BENEFITS

Employee Benefits

Amount of Insurance	As on file with the Policyholder and the Insurance Company
Guaranteed Issue Amount:	As on file with the Policyholder and the Insurance Company
Maximum Benefit:	As on file with the Policyholder and the Insurance Company
Age Based Reductions	Life Insurance Benefit for an Employee age 70 and over will reduce to: 65% of the Life Insurance Benefit at age 70 40% of the Life Insurance Benefit at age 75 25% of the Life Insurance Benefit at age 80 15% of the Life Insurance Benefit at age 85
Continuation Options	
For Layoff	This option does not apply to this class of Employee.
For Leave of Absence	This option does not apply to this class of Employee.
For Family Medical Leave	This option does not apply to this class of Employee.
For Disability	This option does not apply to this class of Employee.
Terminal Illness Benefit	100% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.

Spouse or Domestic Partner Benefits

Amount of Insurance	As on file with the Policyholder and the Insurance Company
Guaranteed Issue Amount:	As on file with the Policyholder and the Insurance Company
Maximum Benefit:	As on file with the Policyholder and the Insurance Company
Terminal Illness Benefit	100% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.

Dependent Child Benefits

Amount of Insurance	As on file with the Policyholder and the Insurance Company

All Dependent Child benefits are Guaranteed Issue.

Former Employee Benefits

This option does not apply to this class of Employee.

Spouse or Domestic Partner of Former Employee Benefits

This option does not apply to this class of Employee.

Former Spouse or Domestic Partner Benefits

This option does not apply to this class of Employee.

Former Dependent Child Benefits

This option does not apply to this class of Employee.

TL-004774

ELIGIBILITY FOR INSURANCE

Classes of Eligible Persons
A person may be insured only once under the Policy as an Employee, Spouse or Dependent Child, even though he or she may be eligible under more than one class.

Employee
An Employee in one of the Classes of Eligible Employees shown in the Schedule of Benefits is eligible to be insured on the Policy Effective Date or the day after he or she completes the applicable Eligibility Waiting Period, if later. The Eligibility Waiting Period will not apply to an Employee, in Active Service on the Policy Effective Date, who was covered under the Prior Plan and satisfied the Eligibility Waiting Period, if any, of that plan. Credit will be given for any time that was satisfied.

If a person has previously converted his or her insurance under the Policy, he or she will not become eligible until the converted policy is surrendered. This does not apply to any amount of insurance that was previously converted under the Policy due to a reduction in the Employee's Life Insurance Benefits based on age or a change in class unless those conditions no longer affect the amount of coverage available to the Employee.

Except as noted in the Reinstatement Provision, if an Employee terminates coverage and later wishes to reapply, or if a former Employee is rehired, a new Eligibility Waiting Period must be satisfied. An Employee is not required to satisfy a new Eligibility Waiting Period if insurance ends because he or she is no longer in a Class of Eligible Employees, but continues to be employed by the Employer, and within one year becomes a member of an eligible class.

Spouse
If an Insured is eligible to elect Spouse coverage, the Spouse is eligible to be insured on the date the Employee is eligible or the date he or she becomes a Spouse of an Employee, if later.

For the purpose of eligibility, the Spouse must be the lawful Spouse of the Employee and not divorced from, or widowed by the Employee.

Dependent Child
If an Insured is eligible to elect Dependent Child coverage, the Dependent Child is eligible to be insured on the date the Insured is eligible or on the date the child qualifies as a Dependent Child, if later.

In no event will a Dependent Child be eligible to become insured more than once under the Policy.

TL-004710a (TX)

ENROLLING FOR INSURANCE

Initial Open Enrollment
During the Initial Open Enrollment Period, an Employee, his or her eligible Spouse or Dependent Child who were insured, or who were eligible to be insured, under the Prior Plan may become insured under the Voluntary Life Insurance Plan provided by this Policy for a Benefit up to this Policy's Guaranteed Issue Amount, as shown in the Schedule of Benefits, without satisfying any Insurability Requirement. Coverage will not become effective for an Employee, his or her eligible Spouse or Dependent Child if an Employee is not in Active Service, due to Injury or Sickness, on the date his or her coverage would otherwise become effective under this policy. Coverage will become effective on the date the Employee returns to Active Service.

If an Employee's eligible dependent is (a) an inpatient in a hospital, hospice, rehabilitation or convalescence center, or custodial care facility; or (b) confined to his or her home under the care of a Physician on the date insurance would otherwise be effective, coverage will be effective on the date the dependent is no longer an inpatient in these facilities or confined at home. If such dependent was covered by the Prior Plan immediately prior to the Policy Effective Date, this provision will not apply to the amount of coverage in effect immediately prior to the Policy Effective Date, but will apply to any increase in coverage.

An Employee or his or her eligible Spouse may become insured for an amount in excess of the Guaranteed Issue Amount only if he or she satisfies the Insurability Requirement. Any excess amount will be effective on the date the Insurance Company agrees in writing to insure that eligible person.

EFFECTIVE DATE OF INSURANCE

An Employee who is required to contribute to the cost of this insurance may elect insurance for himself or herself and an eligible Spouse or Dependent Child only by authorizing payroll deduction in a form approved by the Employer and the Insurance Company. The effective date of this insurance depends on the date and amount of insurance elected.

Insurance becomes effective for an eligible Employee who applies and agrees to make required contributions subject to the provision below:

1. New hires. Coverage is effective first of the month following 30 calendar days from the date of hire.
2. Life Status Change. Coverage will become effective first of the month following the date of the Life Status Change.
3. Annual Enrollment. Coverage becomes effective on the Policy Anniversary Date.

If enrollment information for Employee, Spouse or Dependent Child coverage is not received by either the Employer or the Insurance Company less than 32 days after becoming eligible to elect coverage, this insurance will be effective on the date the Insurance Company agrees in writing to insure that eligible person. The Insurance Company will require the eligible Employee and Spouse to satisfy the Insurability Requirement before it agrees to insure him or her.

If coverage for a Dependent Child is in force and another Dependent Child becomes eligible, coverage for that child is effective on the date the child qualifies as a Dependent Child.

If an eligible Employee is not in Active Service on the date insurance would otherwise be effective, it will be effective on the date he or she returns to Active Service.

If an eligible Spouse or Dependent Child is:

1. an inpatient in a hospital, hospice, rehabilitation or convalescence center, or custodial care facility; or
2. confined to his or her home under the care of a Physician

on the date insurance would otherwise be effective, it will be effective on the date he or she is no longer an inpatient in these facilities or confined at home. If such Spouse or Dependent Child was covered by the Prior Plan immediately prior to the Policy Effective Date, this provision will not apply to the amount of coverage in effect immediately prior to the Policy Effective Date, but will apply to any increase in coverage. This does not apply to a Dependent Child who is age 6 months or less.

TERMINATION OF INSURANCE

An Insured's coverage will end on the last day of the month after the earliest of the following dates:

1. the date the Employee is eligible for coverage under a plan intended to replace this coverage;
2. the date the Policy is terminated by the Insurance Company;
3. the date the Insured is no longer in an eligible class;
4. the date coinciding with the end of the last period for which premiums are paid;
5. the date an Employee is no longer in Active Service;
6. for an Employee, Spouse and Dependent Child, the date the Employer cancels participation under the Policy;
7. for any insured Spouse and Dependent Child, the date coverage for the Employee ends.

TL-004714a (TX)

CONTINUATION OF INSURANCE

If an Employee is no longer in Active Service, he or she may be eligible to continue insurance. The following provisions explain the continuation options available under the Policy. Please see the Schedule of Benefits to determine the applicability of these benefits on a class level.

Continuation for Layoff, Non-Medical Administrative Leave of Absence, Medical Leave of Absence, Temporary Leave of Absence or Family Medical Leave
Insurance will continue for up to the Maximum Benefit Period shown in the Schedule of Benefits, if the required premium is paid by the Employee directly to the Company.

Continuation for Disability
If an Employee's Active Service ends due to Disability, Life Insurance Benefits as shown in the Schedule of Benefits will continue until the earliest of the following dates.

1. The date the Employee is no longer Disabled.
2. The date the end of the Maximum Benefit Period for this benefit ends.
3. The day after the period for which premiums are paid by the Employee directly to the Company.

If the Employee dies during this period, the Insurance Company will pay the Life Insurance Benefit in effect on the day before he or she became Disabled. However, the Life Insurance Benefit payable will be subject to the provisions of the Policy that may reduce or terminate coverage on account of age, retirement, acceleration or a change in eligible class.

Portability Options
For Employees

If an Employee's coverage under the Policy ends for any of the following reasons:

a. termination of employment; or
b. termination of membership in an eligible class under the Policy;

Life Insurance Benefits may be continued up to the Maximum Benefit shown in the Schedule of Benefits for this option.

The Employee must apply to the Insurance Company and pay the required premium. If the Employee continues coverage, Spouse or Dependent Child coverage may also be continued by the Employee. The Spouse or Dependent Child must be covered under the Policy on the date coverage would otherwise end. The application must be submitted:

a. within 31 days of the Employee's termination of employment or membership in an eligible class under the Policy; or
b. during the time that the Employee has to exercise the Conversion Privilege.

Coverage under this option may not be elected at a later date.

When applying for this option, the Employee must name a beneficiary. Any beneficiary named previously under the Policy is no longer in effect. If there is no named or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives:

a. spouse;
b. child or children;
c. mother or father;
d. brothers or sisters; or
e. the executors or administrators of the Insured's estate.

When coverage is continued under this option, the Employee becomes a Former Employee. The Spouse becomes a Spouse of a Former Employee. The Dependent Child becomes a Dependent Child of a Former Employee.

If the Former Employee later acquires a Spouse or Dependent Child, he or she may elect coverage for them. The Former Employee must apply to the Insurance Company and pay the required premium. Coverage for the Spouse or Dependent Child will be effective on the date the Insurance Company agrees in writing to insure them. The Insurance Company may require that the Spouse or Dependent Child satisfy the Insurability Requirement before it agrees to insure him or her.

Coverage will end on the earliest of the following dates.

a. The date the Insurance Company cancels coverage for all Former Employees.
b. The end of the period for which premiums are paid.
c. The date the Maximum Benefit Period shown in the Schedule of Benefits for this option ends.

Also, coverage for any Dependent Child will end on any of the dates listed above or when he or she no longer qualifies as a Dependent Child, if earlier.

For Spouses

If a Spouse is:

a. legally separated, divorced; or
b. widowed

from an insured Employee or Former Employee, Life Insurance Benefits may be continued. Coverage may be continued up to the Maximum Benefit shown in the Schedule of Benefits for this option. The Spouse must apply to the Insurance Company and pay the required premium.

A Spouse who continues coverage may also continue coverage for a Dependent Child. The Dependent Child must be covered under the Policy on the date coverage would otherwise end. A Spouse must elect to continue insurance under this option within 31 days after coverage ends. Coverage may not be elected at a later date.

When applying for this option, a Spouse must name a beneficiary. Any beneficiary named previously under the Policy is no longer in effect. If there is no named or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives:

a. spouse;
b. child or children;
c. mother or father;
d. brothers or sisters; or
e. the executors or administrators of the Spouse's estate.

When coverage is continued under this option, the Spouse becomes a Former Spouse. A separate certificate of insurance will be issued to the Former Spouse. Coverage will be effective on the date after coverage as a Spouse ends if the required premium is paid.

Coverage will end on the earliest of the following dates.

a. The date the Insurance Company cancels coverage for all Former Spouses.
b. The end of the period for which premiums are paid.
c. The date the Maximum Benefit Period shown in the Schedule of Benefits for this option ends.

Also, coverage for a Dependent Child will end on any of the dates listed above or when he or she no longer qualifies as a Dependent Child, if earlier.

For Dependent Children

If a Dependent Child is insured under the Policy and is at least 19 years of age, Life Insurance Benefits may be continued under this option. Coverage may be continued up to the Maximum Benefit shown in the Schedule of Benefits for this option.

The Dependent Child must apply to the Insurance Company and pay the required premium. If a Dependent Child does not elect to continue insurance within 31 days after reaching age 19; or the date he or she no longer qualifies as a Dependent Child, if later, coverage under this option may not be elected at a later date.

When applying for this option, a Dependent Child must name a beneficiary. Any beneficiary named previously under the Policy is no longer in effect. If there is no named or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives:

a. spouse;
b. child or children;
c. mother or father;
d. brothers or sisters; or
e. the executors or administrators of the Dependent Child's estate.

When a Dependent Child continues coverage under this option, he or she becomes a Former Dependent Child. A separate certificate of insurance will be issued to the Former Dependent Child. Coverage for a Former Dependent Child will be effective on the following dates.

a. For any Guaranteed Issue Amount, immediately following the date his or her coverage as a Dependent Child ends, provided the Insurance Company receives the required premium.
b. For any amount of insurance that exceeds the Guaranteed Issue Amount, the date the Insurance Company agrees in writing to insure him or her. The Insurance Company will require the Former Dependent Child to satisfy the Insurability Requirement before it agrees to insure him or her.

Coverage will end on the earliest of the following dates.

a. The date the Insurance Company cancels coverage for all Former Dependent Children.
b. The end of the period for which premiums are paid.
c. The date the Former Dependent Child is age 70.
d. The date the Maximum Benefit Period shown in the Schedule of Benefits for this option ends.

TL-004716a (1X) as modified by TL-009330

DESCRIPTION OF BENEFITS

The following provisions explain the benefits available under the Policy. Please see the Schedule of Benefits for the applicability of these benefits on a class level.

LIFE INSURANCE BENEFITS

Death Benefit
If an Insured dies, the Insurance Company will pay the Life Insurance Benefit in force for that Insured on the date of his or her death.

TL-004730

Accelerated Benefits
Any benefits payable under this Accelerated Benefits provision will reduce the Death Benefit payable for Life Insurance. Any automatic increases in Life Insurance Benefits will end when benefits are payable under this provision.

Terminal Illness Benefit
The Insurance Company will pay a Terminal Illness Benefit to an Insured who has been determined by the Insurance Company to be Terminally Ill.

The Terminal Illness Benefit is payable only once in an Insured's lifetime.

Determination of Terminal Illness

For the purpose of determining the existence of a Terminal Illness, the Insurance Company will require the Insured submit the following proof.
1. A written diagnosis and prognosis by two Physicians licensed to practice in the United States.
2. Supportive evidence satisfactory to the Insurance Company, including but not limited to radiological, histological or laboratory reports documenting the Terminal Illness.

The Insurance Company may require, at its expense, an examination of the Insured and a review of the documented evidence by a Physician of its choice.

"Terminal Illness" means an illness for which a person has a prognosis of 12 months or less to live, as diagnosed by a Physician.

TI-004748

Conversion Privilege for Life Insurance
Each Insured may convert all or any portion of his or her Life Insurance that would end under the Policy due to:
1. termination of employment;
2. termination of membership in an eligible class under the Policy;
3. termination of the Policy.

The Insured may apply for any type of life insurance the Insurance Company offers to persons of the same age in the amount applied for, except the Insured may not:
1. choose term insurance;
2. apply for an amount of insurance greater than the coverage amount terminating under the Policy (also, the conversion policy will not provide accident, disability or other benefits); or
3. apply for more than $10,000 of insurance if the Policy is terminated or amended to terminate the insurance for any class of Insureds, or the Employer cancels participation under the Policy.

Conversion in these cases is only permitted if the Insured has been covered by the Policy or any group life insurance policy issued to the Employer which the Policy replaced for at least 3 years.

If the Insured becomes eligible for coverage under any group life policy within 31 days of termination of coverage under this Policy, the Insured may not convert an amount of insurance greater than the amount of coverage terminating under the Policy less the amount for which he or she may be covered under the other policy.

To apply for conversion insurance, the Insured must, within 31 days after coverage under the Policy ends:
1. submit an application to the Insurance Company; and
2. pay the required premium.

Evidence of insurability is not required.

Premium for the conversion insurance will be based on the age and class of risk of the Insured and the type and amount of coverage issued.

If the Insured has assigned ownership of his group coverage, the owner/assignee must apply for the individual policy.

Conversion insurance will become effective on the 31st day after the date coverage under the Policy ends provided the application is received by the Insurance Company and the required premium has been paid.

If the Insured dies during the 31-day conversion period, the Life Insurance benefits will be paid under the Policy regardless of whether he or she applied for conversion insurance. If a conversion policy is issued, it will be in exchange for any further benefits for that type and amount of insurance from this Policy.

Extension of Conversion Period
If an Insured is eligible for conversion insurance and is not notified of this right at least 15 days prior to the end of the 31-day conversion period, the conversion period will be extended. The Insured will have 15 days from the date notice is given to apply for conversion insurance. In no event will the conversion period be extended beyond 90 days. Notice, for the purpose of this section, means written notice presented to the Insured by the Insurance Company or mailed to the Insured's last known address as reported by the Employer.

If the Insured dies during the extended conversion period, but more than 31 days after his or her coverage under the Policy terminates, Life Insurance benefits:
1. will not be paid under the Policy; and
2. will be payable under the conversion insurance; provided:
    a. the Insured's application for conversion insurance has been received by the Insurance Company; and
    b. the required premium has been paid.

Prior Conversion Limitation
If an Insured is covered under a life insurance conversion policy previously issued by the Insurance Company, he or she will not be eligible for this Conversion Privilege unless the prior coverage has ended.

TL-009740

LIFE INSURANCE EXCLUSIONS

If an Insured commits suicide, while sane or insane, within 2 years from the date his or her insurance under the Policy becomes effective, Life Insurance Benefits will be limited to a refund of the premiums paid on the Insured's behalf. The suicide exclusion applies from the effective date of any additional benefits or increases in Life Insurance Benefits.

Except for any amount of benefits in excess of the Prior Plan's benefits, this exclusion will not apply to any person covered under the Prior Plan for more than two years. If a person was not insured for two years under the Prior Plan, credit will be given for the time he or she was insured.

If a Dependent Child commits suicide and is survived by other Dependent Children covered under the same certificate, no refund of premiums will be paid.

TL-004752

CLAIM PROVISIONS

Notice of Claim
Written notice, or notice by any other electronic/telephonic means authorized by the Insurance Company, must be given to the Insurance Company within 31 days after a covered loss occurs or begins or as soon as reasonably possible. If written notice, or notice by any other electronic/telephonic means authorized by the Insurance Company, is not given in that time the claim will not be invalidated or reduced if it is shown that notice was given as soon as was reasonably possible. Notice can be given at our home office in Philadelphia, Pennsylvania or to our agent. Notice should include the Employer's name, the Policy Number and the claimant's name and address.

Written notice or notice by any other electronic/telephonic means authorized by the Insurance Company of a diagnosis of a Terminal Illness on which claim is based must be given to us within 60 days after the diagnosis. If notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice or notice by any other electronic/telephonic means authorized by the Insurance Company was given as soon as reasonably possible.

Claim Forms
When the Insurance Company receives notice of claim, the Insurance Company will send claim forms for filing proof of loss. If claim forms are not sent within 15 days after notice is received by the Insurance Company, the proof requirements will be met by submitting, within the time required under the "Proof of Loss" section, written proof, or proof by any other electronic/telephonic means authorized by the Insurance Company, of the nature and extent of the loss.

Claimant Cooperation Provision
Failure of a claimant to cooperate with the Insurance Company in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Insurance Data
The Employer is required to cooperate with the Insurance Company in the review of claims and applications for coverage. Any information the Insurance Company provides in these areas is confidential and may not be used or released by the Employer if not permitted by applicable privacy laws.

Proof of Loss
Written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, must be given to the Insurance Company within 90 days after the date of the loss for which a claim is made. If written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, is not given in that 90 day period, the claim will not be invalidated nor reduced if it is shown that it was given as soon as was reasonably possible. In any case, written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, must be given not more than one year after that 90 day period. If written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, is provided outside of these time limits, the claim will be denied. These time limits will not apply while the person making the claim lacks legal capacity.

Written proof, or proof by any other electronic/telephonic means authorized by the Insurance Company, of loss for Accelerated Benefits must be furnished 90 days after the date of diagnosis. This proof must describe the occurrence, character and diagnosis for which claim is made.

In case of claim for any other loss, proof must be furnished within 90 days after the date of such loss.

If it is not reasonably possible to submit proof of loss within these time periods, the Insurance Company will not deny or reduce any claim if proof is furnished as soon as reasonably possible. Proof must, in any case, be furnished not more than a year later, except for lack of legal capacity.

Time of Payment
Benefits due under the Policy for a loss, other than a loss for which the Policy provides installment payments, will be paid within 60 days of receipt of due written proof of such loss to the extent of that payment.

Subject to the receipt of satisfactory written proof of loss, or proof by any electronic/telephonic mean authorized by the Insurance Company all accrued benefits for loss for which the Policy provides installments will be paid monthly; any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof, or proof by any electronic/telephonic mean authorized by the Insurance Company all, unless otherwise stated in the Description of Benefits.

To Whom Payable
Death Benefits will be paid to the Insured's named beneficiary, if any, on file at the time of payment. If there is no named beneficiary or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives: spouse; child or children; mother or father; brothers or sisters; or to the executors or administrators of the Insured's estate. The Insurance Company may reduce the amount payable by any indebtedness due.

All benefits payable under the Accelerated Benefits section are payable to the Insured, if living. If the Insured dies prior to the payment of an eligible claim for an Accelerated Benefit, benefits will be paid in accordance with the provisions applicable to the payment of Life Insurance proceeds, unless the Insured has directed us otherwise in writing. However, any payment made by us prior to notice of the Insured's death shall discharge us of any benefit that was paid.

All other benefits, unless otherwise stated in the Policy, will be payable to the Insured or the certificate owner if other than the Insured.

Any other accrued benefits which are unpaid at the Insured's death may, at the Insurance Company's option, be paid either to the Insured's beneficiary or to the executor or administrator of the Insured's estate.

If the Insurance Company pays benefits to the executor or administrator of the Insured's estate or to a person who is incapable of giving a valid release, the Insurance Company may pay up to $1,000 to a relative by blood or marriage whom it believes is equitably entitled. This good faith payment satisfies the Insurance Company's legal duty to the extent of that payment.

Change of Beneficiary
The Insured may change the beneficiary at any time by giving written notice to the Employer or the Insurance Company. The beneficiary's consent is not required for this or any other change which the Insured may make unless the designation of beneficiary is irrevocable.

No change in beneficiary will take effect until the form is received by the Employer or the Insurance Company. When this form is received, it will take effect as of the date of the form. If the Insured dies before the form is received, the Insurance Company will not be liable for any payment that was made before receipt of the form.

Physical Examination and Autopsy
The Insurance Company, at its expense, will have the right to examine any person for whom a claim is pending as often as it may reasonably require. The Insurance Company may, at its expense, require an autopsy unless prohibited by law.

Legal Actions
No action at law or in equity may be brought to recover benefits under the Policy less than 60 days after written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, has been furnished as required by the Policy. No such action shall be brought more than 4 years after the time satisfactory proof of loss is required to be furnished.

Time Limitations
If any time limit stated in the Policy for giving notice of claim or proof of loss, or for bringing any action at law or in equity, is less than that permitted by the law of the state in which the Employee lives when the Policy is issued, then the time limit provided in the Policy is extended to agree with the minimum permitted by the law of that state.

Physician/Patient Relationship
The Insured will have the right to choose any Physician who is practicing legally. The Insurance Company will in no way disturb the Physician/patient relationship.

1L-004724a (1X)

ADMINISTRATIVE PROVISIONS

Premiums
The premiums for this Policy will be based on the rates currently in force, the plan and the amount of insurance in effect.

If the Insured's coverage amount is reduced due to acceleration of his or her Death Benefit, his or her premium will be based on the amount of coverage he or she has in force on the day before the reduction took place. If the Insured's coverage amount is reduced due to his or her attained age, premium will be based on the amount of coverage in force on the day after the reduction took place.

Changes in Premium Rates
The premium rates may be changed by the Insurance Company from time to time with at least 180 days advance written notice but only on the Policy Anniversary Date. No change in rates will be made until 48 months after the Policy Effective Date. An increase in rates will not be made more often than once in a 12 month period, and only on the Policy Anniversary Date. However, the Insurance Company reserves the right to change the rates even during a period for which the rate is guaranteed if any of the following events take place.

1. The terms of the Policy change.
2. A division, subsidiary, affiliated company or eligible class is added or deleted from the Policy.
3. There is a change in the factors bearing on the risk assumed.
4. Any federal or state law or regulation is amended to the extent it affects the Insurance Company's benefit obligation.
5. The Insurance Company determines that the Employer has failed to promptly furnish any necessary information requested by the Insurance Company, or has failed to perform any other obligations in relation to the Policy.

Reporting Requirements
The Employer must, upon request, give the Insurance Company any information required to determine who is insured, the amount of insurance in force and any other information needed to administer the plan of insurance.

Payment of Premium
The first premium is due within 30 days of delivering the Policy. After that, premiums will be due monthly unless the Employer and the Insurance Company agree on some other method of premium payment.

If any premium is not paid when due, the plan will be canceled as of the Premium Due Date, except as provided in the Policy Grace Period section.

Notice of Cancellation
The Employer or the Insurance Company may cancel the Policy as of any Premium Due Date by giving 180 days advance written notice. If a premium is not paid when due, the Policy will automatically be canceled as of the Premium Due Date, except as provided in the Policy Grace Period section.

Policy Grace Period
A Policy Grace Period of 31 days will be granted for the payment of the required premiums under this Policy. This Policy will be in force during the Policy Grace Period. The Employer is liable to the Insurance Company for any unpaid premium for the time this Policy was in force.

Grace Period for the Insured
If the required premium is not paid on the Premium Due Date, there is a 31 day grace period after each premium due date after the first. If the required premium is not paid during the grace period, insurance will end on the last day for which premium was paid.

If benefits are not paid during the Grace Period for the Insured, the Insurance Company will deduct any overdue premium from the proceeds payable under the Policy.

Reinstatement of Insurance
Coverage may be reinstated without satisfying the Insurability Requirement, if an Employee's insurance ends because he or she is on an unpaid leave of absence or military service pursuant to the Uniformed Services Employment Act of 1994 (USERRA) and he or she applies for Reinstatement within 31 days of his return to Active Service.

After an Insured's coverage has ceased, it may be reinstated at any date prior to five years after the date of termination if the following conditions are met:

1. The Policy is still in force.
2. The Insured is eligible under the Policy.
3. A written request for reinstatement and a new enrollment form are sent to the Insurance Company.
4. The required premium is paid.
5. The Insurability Requirement, if any, is satisfied.

TL-004720

SCHEDULE OF RATES

The following monthly rates apply to all Classes of Eligible Persons unless otherwise indicated.

FOR EMPLOYEE BENEFITS

Voluntary Life Insurance

Monthly Rates are based on units of $1,000

Under Age 20	$.04	Age 60 - 64	$.67
Age 20 - 24	$.04	Age 65 - 69	$1.00
Age 25 – 29	$.04	Age 70 - 74	$1.76
Age 30 - 34	$.07	Age 75 - 79	$1.76
Age 35 - 39	$.07	Age 80 - 84	$1.76
Age 40 - 44	$.11	Age 85 - 89	$1.76
Age 45 - 49	$.17	Age 90 - 94	$1.76
Age 50 - 54	$.29	Age 95 and over	$1.76
Age 55 - 59	$.41		

A change in rates due to a change in the Employee's age will become effective on the Policy Anniversary Date coinciding with or following the Employee's birthday.

FOR SPOUSE OR DOMESTIC PARTNER AND DEPENDENT CHILD BENEFITS: $1.54

Any increase in benefit amounts of $10,000 for Spouse or Domestic Partner will be subject to age banded rates.

FOR ADDITIONAL SPOUSE OR DOMESTIC PARTNER BENEFITS

Voluntary Life Insurance

Monthly Rates are based on units of $1,000.

Under Age 20	$.04	Age 60 - 64	$.67
Age 20 - 24	$.04	Age 65 - 69	$1.00
Age 25 - 29	$.04	Age 70 - 74	$1.76
Age 30 - 34	$.07	Age 75 - 79	$1.76
Age 35 - 39	$.07	Age 80 - 84	$1.76
Age 40 - 44	$.11	Age 85 - 89	$1.76
Age 45 - 49	$.17	Age 90 - 94	$1.76
Age 50 - 54	$.29	Age 95 and over	$1.76
Age 55 - 59	$.41		

Spouse rates are based on the Spouse's date of birth. A change in rates due to a change in the Spouse's age will become effective on the Policy Anniversary Date coinciding with or following the Spouse's birthday.

RATES FOR PORTABLE COVERAGES
FOR FORMER EMPLOYEE BENEFITS

Monthly Rates are based on units of $1,000.

Under Age 20	$.153	Age 45 - 49	$.384
Age 20 - 24	$.144	Age 50 - 54	$.726
Age 25 - 29	$.153	Age 55 - 59	$1.347
Age 30 - 34	$.177	Age 60 - 64	$2.461
Age 35 - 39	$.19	Age 65 - 69	$4.065
Age 40 - 44	$.243		

A change in rates due to a change in the Former Employee's age will become effective on the Policy Anniversary Date coinciding with or following the Former Employee's birthday.

FOR FORMER SPOUSE OR DOMESTIC PARTNERS OR SPOUSE OR DOMESTIC PARTNERS OF FORMER EMPLOYEE BENEFITS

Monthly Rates are based on units of $1,000.

Under Age 20	$.153	Age 45 - 49	$.384
Age 20 - 24	$.144	Age 50 - 54	$.726
Age 25 - 29	$.153	Age 55 - 59	$1.347
Age 30 - 34	$.177	Age 60 - 64	$2.461
Age 35 - 39	$.19	Age 65 - 69	$4.065
Age 40 - 44	$.243		

Spouse rates are based on the spouse's date of birth. A change in rates due to a change in the Spouse's age will become effective on the Policy Anniversary Date coinciding with or following the Spouse's birthday.

FOR FORMER DEPENDENT CHILD BENEFITS

Rates are based on $25,000 per Month.

Under Age 20	$2.377	Age 45 - 49	$9.777
Age 20 - 24	$2.777	Age 50 - 54	$16.377
Age 25 - 29	$2.977	Age 55 - 59	$23.477
Age 30 - 34	$3.600	Age 60 - 64	$38.250
Age 35 - 39	$4.177	Age 65 - 69	$54.077
Age 40 - 44	$6.200		

Rates are based on $50,000 per Month

Under Age 20	$4.750	Age 45 - 49	$19.550
Age 20 - 24	$5.550	Age 50 - 54	$32.750
Age 25 - 29	$5.950	Age 55 - 59	$46.950
Age 30 - 34	$7.200	Age 60 - 64	$76.500
Age 35 - 39	$8.350	Age 65 - 69	$108.150
Age 40 - 44	$12.400		

A change in rates due to a change in the Former Dependent Child's age will become effective on the Policy Anniversary Date coinciding with or following the Former Dependent Child's birthday.

GENERAL PROVISIONS

Entire Contract
The entire contract will be made up of the Policy, the application of the Employer, a copy of which is attached to the Policy, and the applications, if any, of the Insureds.

Incontestability
All statements made by the Employer or by an Insured are representations not warranties. No statement will be used to deny or reduce benefits or as a defense to a claim, unless a copy of the instrument containing the statement is signed by and has been furnished to the claimant. In the event of death or legal incapacity, the beneficiary or representative must receive the copy.

After two years from an Insured's effective date of insurance, or from the effective date of any added or increased benefits, the validity of an Insured's coverage will not be contested using such statements.

Misstatement of Age
If an Insured's age has been misstated, the Insurance Company will adjust all benefits to the amounts that would have been purchased for the correct age.

Policy Changes
No change in the Policy will be valid until approved by an executive officer of the Insurance Company. This approval must be endorsed on, or attached to, the Policy. No agent of the Insurance Company or Employer may change the Policy or waive any of its provisions.

Workers' Compensation Insurance
The Policy is not in lieu of and does not affect any requirements for insurance under any Workers' Compensation Insurance Law.

Certificates
An individual certificate of insurance will be delivered to the Employer for delivery to Insureds. Each certificate will list the benefits, conditions and limits of the Policy. It will state to whom benefits will be paid.

Assignment of Benefits
The Insurance Company will not be affected by the assignment of an Insured's certificate until the original assignment or a certified copy of the assignment is filed with the Insurance Company. The Insurance Company will not be responsible for the validity or sufficiency of an assignment. An assignment of benefits will operate so long as the assignment remains in force provided insurance under the Policy is in effect. This insurance may not be levied on, attached, garnisheed, or otherwise taken for a person's debts. This prohibition does not apply where contrary to law.

Clerical Error
A person's insurance will not be affected by error or delay by the Insurance Company or Employer in keeping records of insurance under the Policy. If such an error is found, the premium will be adjusted fairly.

Agency
The Employer and Plan Administrator are agents of the Employee for transactions relating to insurance under the Policy. The Insurance Company is not liable for any of their acts or omissions.

TI-00472ba (TX)

DEFINITIONS

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout this document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits or the Policy cover page.

Active Service

An Employee will be considered in Active Service with the Employer on a day which is one of the Employer's scheduled work days if either of the following conditions are met.

1. He or she is actively at work. This means the Employee is performing his or her regular occupation for the Employer on a Full-time basis, either at one of the Employer's usual places of business or at some location to which the Employer's business requires the Employee to travel.
2. The day is a scheduled holiday, vacation day or period of Employer approved paid leave of absence, other than disability or sick leave after 7 days.

An Employee is considered in Active Service on a day which is not one of the Employer's scheduled work days only if he or she was in Active Service on the preceding scheduled work day.

Annual Compensation

An Employee's annual wage or salary as reported by the Employer for work performed for the Employer as of the date the covered loss occurs. It does not include amounts received as bonuses, commissions, overtime pay or other extra compensation.

Dependent Child

An Employee's unmarried child who meets the following requirements.

1. A child 14 days of age;
2. A child who is 14 days but less than 26 years old primarily supported by the Employee;
3. A child who is 14 days or more years old, primarily supported by the Employee and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to the Insurance Company within 31 days after the date the child ceases to qualify as a Dependent for the reasons listed above. During the next two years, the Insurance Company may, from time to time, require proof of the continuation of such condition and dependence. After that, the Insurance Company may require proof no more than once a year.

The term "child" means a child born to or legally adopted by the Employee. The term includes a child during any waiting period prior to the finalization of the child's adoption. It also means a stepchild, including a Domestic Partner's child, living with and financially dependent upon the Employee.

Disabled

An Employee is Disabled if, because of Injury or Sickness, he or she is unable to perform all the material duties of any occupation for which he or she may reasonably become qualified based on education, training or experience.

Employee

For eligibility purposes, an Employee is an employee of the Employer in one of the "Classes of Eligible Employees." Otherwise, Employee means an employee of the Employer who is insured under the Policy.

Employer

The Policyholder and any affiliates or subsidiaries covered under the Policy. The Employer is acting as an agent of the Insured for transactions relating to this insurance. The actions of the Employer shall not be considered the actions of the Insurance Company.

Full-time

Full-time means the number of hours set by the Employer as a regular work day for Employees in the Employee's eligibility class.

Initial Open Enrollment Period
The period in the calendar year when an eligible Employee who was hired on or before the Policy Effective Date may enroll for the first time for Insurance Benefits under this Policy. This period must be agreed upon by the Employer and the Insurance Company. Refer to Initial Open Enrollment under the Enrolling for Insurance section of the Policy.

Injury
Any accidental loss or bodily harm which results directly and independently of all other causes from an accident.

Insurability Requirement
An eligible person will satisfy the Insurability Requirement for an amount of coverage on the day the Insurance Company agrees in writing to accept him or her as insured for that amount. To determine a person's acceptability for coverage, the Insurance Company will require evidence of good health and may require it be provided at the Employee's expense.

Insurance Company
The Insurance Company underwriting the Policy is named on the Policy cover page.

Insured
A person who is eligible for insurance under the Policy, for whom insurance is elected, the required premium is paid and coverage is in force under the Policy.

Life Status Change
A Life Status Change is an event recognized by the Employer's Flexible Benefits Plan as qualifying an Employee to make changes in benefit selections at a time other than an Annual Enrollment Period.

If there is no Employer sponsored Flexible Benefits Plan, or if it is no longer in effect, the following events are Life Status Changes.

1. Marriage
2. Divorce, annulment or legal separation
3. Birth or adoption of a child
4. Death of a spouse
5. Termination of a spouse's employment
6. A change in the benefit plan available to the Employee's spouse
7. A change in the Employee's or his or her spouse's employment status that affects either person's eligibility for benefits

Physician
Physician means a licensed doctor practicing within the scope of his or her license and rendering care and treatment to an Insured that is appropriate for the condition and locality. The term does not include an Employee, an Employee's spouse, the immediate family (including parents, children, siblings or spouses of any of the foregoing, whether the relationship derives from blood or marriage), of an Employee or spouse, or a person living in an Employee's household.

Prior Plan
The Prior Plan refers to the plan of insurance providing similar benefits sponsored by the Employer in effect directly prior to the Policy Effective Date.

Sickness
Any physical or mental illness.

Spouse
The current lawful Spouse of an Employee.

Life Insurance Company of North America
a stock insurance company

Rider to Group Policy No. FLX-964188
Effective Date of Rider: October 1, 2011

Eligible Classes to which this Rider applies: All Classes

MODIFICATION OF GROUP POLICY TO ADD DOMESTIC PARTNER AS AN ELIGIBLE DEPENDENT UNDER THE GROUP POLICY FOR TERM LIFE INSURANCE

The provisions of the Policy are modified as follows:

1. All references to the term "Spouse" are replaced by "Spouse or Domestic Partner", except for the following references:
   a. The definition of "Spouse" remains unchanged.
   b. Any reference to "lawful spouse" or "legal spouse" remains unchanged.
   c. Any reference to "Spouse" remains unchanged in the paragraph entitled "To Whom Payable" under the Claims Provisions.
   d. Any reference to "Spouse" in the "Life Status Change" definition remains unchanged.

2. The following Domestic Partner definition is added to the Definitions section of the Group Policy.

   Domestic Partner means: a person of the same or opposite sex, who meets all of the following criteria:

   a. shares the Employee's permanent residence;
   b. has resided with the Employee and is expected to continue to reside with the Employee.
   c. is financially interdependent with the Employee and shares the common necessities of life with the Employee;
   d. has signed a domestic partner declaration with the Employee, if the Employee resides in a jurisdiction that provides for domestic partner declarations;
   e. has not signed a domestic partner declaration with any other person within the last 12 months, if the Employee resides in a jurisdiction that provides for domestic partner declarations;
   f. is no less than 18 years of age;
   g. is not currently legally married to any other person and
   h. is not a blood relative any closer than would prohibit legal marriage.

   In addition to the above requirements, if consent of either party to the Domestic Partner relationship was obtained by force, duress, or fraud, these have the same effects as on the validity of a marriage in Texas.

An Employee's Domestic Partner is eligible for Life Insurance Benefits under the Policy on the later of the Employee's or Former Employee's eligibility date or the date the person becomes the Employee's or Former Employee's Domestic Partner and if all the following conditions are met.

a. The Employee has not been married to any other person within the last 31 days.
b. The Domestic Partner is the only person meeting the Policy's definition of "Domestic Partner" with respect to the Employee.
c. The Employee and Domestic Partner furnish a notarized affidavit or signed statement reflecting these requirements, and an agreement to notify the Insurance Company if the requirements cease to be met, on a form acceptable to the Insurance Company.

To obtain insurance for a Domestic Partner, an Employee must request coverage in writing and agree to make any required premium contributions. Insurance will be effective for a Domestic Partner on the same date specified for a Spouse in the Effective Date of Insurance Provision.

The amount of insurance that applies to a Domestic Partner is shown in the Schedule of Benefits.

Death benefits with respect to any Domestic Partner will be payable to the beneficiary chosen by the Domestic Partner. If no beneficiary is named, benefits are payable to the Employee or Former Employee.

Except for the above, this Rider does not change the Group Policy to which it is attached.

Life Insurance Company of North America

Matthew G. Manders, President

TL-007152

IMPORTANT CHANGES FOR STATE REQUIREMENTS

If an Employee resides in one of the following states, the provisions of the certificate are modified for residents of the following states. The modifications listed apply only to residents of that state.

California Residents:

Conversion Privilege for Life Insurance
Insured Employees and Insured Spouses may convert to an individual policy of life insurance for an amount not greater than the Conversion Amount shown below when the Policy ends, without regard to any requirement that the person be insured under the policy for a specified period of time, if all of the following apply.

a. The Insured became Totally Disabled while covered for the Life Benefit of the Policy. Totally Disabled means the person is unable to perform all the material duties of any occupation for which he or she may reasonably be qualified based on training, education and experience.
b. The Insured remained Totally Disabled until the Policy ended while covered for the Life Benefit of this Policy.
c. The Policy does not provide a Waiver of Premium, Extended Death Benefit Provision or monthly payments to Totally Disabled Insureds for the Life Benefit.
d. The person meets all other conditions for converting the insurance.

Conversion Amount - Insured's life insurance amount under the Policy on the date the Policy ends minus the amount for which the Insured is insured under a group policy that provides life coverage to employees of the Insured Employee's Employer covered under this Policy. The dollar limit that applies to the amount for conversion at Policy termination does not apply.

The requirement that the Insured be covered under the Policy for the stated number of years in order to convert life insurance does not apply.

Georgia residents:

Special Terms Applicable to Previously Insured Employees Not in Active Service
If an Employee is not in Active Service on the Policy Effective Date, they are not covered under the Policy. However, the Insurance Company agrees to provide a death benefit equal to the lesser of:
1. the amount due under this Policy (without regard to the Active Service provision), or
2. the amount that would have been due under the Prior Plan had it remained in force.

The benefit amount will be reduced by any amount paid by the Prior Plan, or that would have been paid had this Policy not been issued and had timely filing of the claim been made under the Prior Plan.

These special terms will end on the earliest of the following dates:
1. the date the Employee meets the Active Service requirements;
2. the date insurance terminates for one of the reasons stated in the Termination of Insurance provision;
3. 12 months after the Policy Effective Date; or
4. the last day the Employee would have been covered under the Prior Plan if that plan was still in force.

Missouri residents:

Applicable to Voluntary Life Insurance Benefits
If an Insured commits suicide, while sane or insane, within 1 year from the date his or her insurance under the Policy becomes effective, Voluntary Life Insurance Benefits will be limited to a refund of the premiums paid on the Insured's behalf. The suicide exclusion applies from the effective date of any additional benefits or increases in Life Insurance Benefits.

Except for any amount of benefits in excess of the Prior Plan's benefits, this exclusion will not apply to any person covered under the Prior Plan for more than one year. If a person was not insured for one year under the Prior Plan, credit will be given for the time he or she was insured.

If a Dependent Child commits suicide and is survived by other Dependent Children covered under the same certificate, no refund of premiums will be paid.

North Dakota residents:

The Suicide exclusion, if any, is limited to one year from the effective date of insurance. The suicide exclusion with respect to any increase in death benefits which results from an application of the insured subsequent to the effective date, if any, is limited to one year from the effective date of the increase.

LIFE INSURANCE COMPANY OF NORTH AMERICA
PHILADELPHIA, PA 19192-2235

We, County of Travis, whose main office address is Austin, TX, hereby approve and accept the terms of Group Policy Number FLX-964188 issued by the LIFE INSURANCE COMPANY OF NORTH AMERICA.

This form is to be signed in duplicate. One part is to be retained by County of Travis; the other part is to be returned to the LIFE INSURANCE COMPANY OF NORTH AMERICA.

County of Travis

Signature and Title: ____ Date:__________________________

(This Copy Is To Be Returned To LIFE INSURANCE COMPANY OF NORTH AMERICA)

LIFE INSURANCE COMPANY OF NORTH AMERICA
PHILADELPHIA, PA 19192-2235

We, County of Travis, whose main office address is Austin, TX, hereby approve and accept the terms of Group Policy Number FLX-964188 issued by the LIFE INSURANCE COMPANY OF NORTH AMERICA.

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County of Travis

Signature and Title: ____ Date:__________________________

(This Copy Is To Be Retained By County of Travis)

Attachment IC-3

Group Retiree and Dependent Voluntary Life Policy

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call the toll-free telephone number for information or to make a complaint at:

1-800-547-5515

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may write the
Texas Department of Insurance
P.O. Box 149091
Austin, TX 78714-9104
FAX # (512) 475-1771

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim you should contact the agent or company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

IL-004426

AVISO IMPORTANTE

Para solicitar información o presentar una queja:

Usted puede llamar al numero de telefono gratis para información o pare someter una queja al:

1-800-547-5515

Puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos o quejas llamando al:

1-800-252-3439

También puede escribir al Texas Department of Insurance (Departamento de Seguros de Texas)
P.O. Box 149091
Austin, TX 78714-9104
FAX # (512) 475-1771

CONFLICTOS POR PRIMAS O RECLAMACIONES: En caso de tener un conflicto relacionado con su prima o una reclamación, debe comunicarse primero con el agente o la compañía. Si el conflicto no se resuelve, usted puede comunicarse con el Departamento de Seguros de Texas.

UNA ESTE AVISO A SU POLIZA: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE, ACCIDENT, HEALTH AND HOSPITAL SERVICE INSURANCE GUARANTY ASSOCIATION

(For insurers declared insolvent or impaired on or after September 1, 2005)

Texas law establishes a system, administered by the Texas Life, Accident, Health and Hospital Service Insurance Guaranty Association (the "Association"), to protect Texas policyholders if their life or health insurance company fails. Only the policyholders of insurance companies which are members of the Association are eligible for this protection which is subject to the terms, limitations, and conditions of the Association law. (The law is found in the *Texas Insurance Code,* Chapter 463.)

It is possible that the Association may not cover your policy in full or in part due to statutory limitations.

ELIGIBILITY FOR PROTECTION BY THE ASSOCIATION

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas at that time **(irrespective of the policyholder's residency at policy issue)**
- Residents of other states, ONLY if the following conditions are met:
  1) The policyholder has a policy with a company domiciled in Texas;
  2) The policyholder's state of residence has a similar guaranty association; and
  3) The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

LIMITS OF PROTECTION BY THE ASSOCIATION

Accident, Accident and Health, or Health Insurance:

- For each individual covered under one or more policies: up to a total of $500,000 for basic hospital, medical-surgical, and major medical insurance, $300,000 for disability or long term care insurance, and $200,000 for other types of health insurance.

Life Insurance:

- Net cash surrender value or net cash withdrawal value up to a total of $100,000 under one or more policies on any one life; or
- Death benefits up to a total of $300,000 under one or more policies on any one life; or
- Total benefits up to a total of $5,000,000 to any owner of multiple non-group life policies.

Individual Annuities:

- Present value of benefits up to a total of $100,000 under one or more contracts on any one life.

Group Annuities:

- Present value of allocated benefits up to a total of $100,000 on any one life; or
- Present value of unallocated benefits up to a total of $5,000,000 for one contractholder regardless of the number of contracts.

Aggregate Limit:

- $300,000 on any one life with the exception of the $500,000 health insurance limit, the $5,000,000 multiple owner life insurance limit, and the $5,000,000 unallocated group annuity limit.

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage.

Texas Life, Accident, Health and Hospital
Service Insurance Guaranty Association
6504 Bridge Point Parkway, Suite 450
Austin, Texas 78730
800-982-6362 or www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439 or www.tdi.state.tx.us

NOTICE

Any accelerated benefits payable under the policy will reduce the death benefit payable for life insurance. If you elect to accelerate your life insurance benefit, we will send you a statement explaining the amount of your benefit, and what effect (if any) accelerating your life insurance benefit will have on the death benefit face amount, specified amount, accumulation values, cash values, loan amounts, future charges, or future premiums.

Benefits payable under the Accelerated Benefits provision may be taxable. If so, the Retiree or the Retiree's beneficiary may incur a tax obligation. As with all tax matters, a Retiree should consult with a personal tax advisor to assess the impact of this benefit. Accelerated Benefits are not payable if life insurance coverage under the Policy is not in force.

Any accidental death benefits that you may have under the policy will not be affected by the acceleration of life insurance benefits.

TL-004788

LIFE INSURANCE COMPANY OF NORTH AMERICA
1601 CHESTNUT STREET
PHILADELPHIA, PA 19192-2235
(800) 732-1603 TDD (800) 552-5744
A STOCK INSURANCE COMPANY

GROUP POLICY

POLICYHOLDER:	County of Travis
POLICY NUMBER:	FLX-964189
POLICY DESCRIPTION:	Retiree Life Insurance
POLICY EFFECTIVE DATE:	October 1, 2011
POLICY ANNIVERSARY DATE:	October 1

This Policy describes the terms and conditions of coverage. It is issued in Texas and shall be governed by its laws. The Policy goes into effect on the Policy Effective Date, 12:01 a.m. at the Policyholder's address.

In return for the required premium, the Insurance Company and the Policyholder have agreed to all the terms of this Policy.

Scott Kern, Corporate Secretary

Matthew G. Manders, President

TL-004700

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SCHEDULE OF BENEFITS

Policy: Group Policy identified as Policy Number: FLX-964189 on the Policy cover page

Premium Due Date: The last day of each month

Classes of Eligible Retirees

On the pages following the definition of eligible retirees there is a Schedule of Benefits for each Class of Eligible Retirees listed below. For an explanation of these benefits, please see the Description of Benefits provision.

If a Retiree is eligible under one Class of Eligible Retirees and later becomes eligible under a different Class of Eligible Retirees, changes in his or her insurance due to the class change will be effective on the first Anniversary Date after the date of the change in class.

Class 1 All Retirees under the age of 71.

Class 2 All Retirees age 71 and over.

Class 3 All Surviving Spouses of Retirees who died when under the Age of 71.

Class 4 All Surviving Spouses of Retirees who died when age 71 and over.

Terminally Ill: Having an illness with a prognosis of 12 months or less to live as diagnosed by a Physician.

SCHEDULE OF BENEFITS FOR CLASS 1

Eligibility Waiting Period

The Eligibility Waiting Period is the period of time the Retiree must be a member of the class to be eligible for coverage.

For Employees who retired on or before the Policy Effective Date:	No Waiting Period.
For Employees who retire after the Policy Effective Date:	No Waiting Period.

LIFE INSURANCE BENEFITS

Retiree Benefits

Amount of Insurance

Option 1	$15,000
Option 2	$25,000
Guaranteed Issue Amount:	the greater of a) or b) below: a) $15,000, or b) an amount equal to the Life Insurance Benefit in effect on the termination date of the Prior Plan

Retiree*

A Retiree is a former employee of the Employer who is currently receiving benefits from the Texas County and District Retirement System and in one of the "Classes of Eligible Retirees." Otherwise, Retiree means a former employee of the Employer who is insured under the Policy.

Terminal Illness Benefit	100% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.

An eligible Retiree may enroll for or increase his or her Voluntary Term Life Insurance Benefits, at any time, only if he or she satisfies the Insurability Requirement. Any amount the Insurance Company approves is effective on the date the Insurance Company agrees in writing to insure the Retiree.

A Retiree may reduce Insurance Benefits at any time. The reduced amount will be effective on the date the Employer or the Insurance Company receives the completed change form.

Spouse or Domestic Partner Benefits

Amount of Insurance	
Option 1	$7,500
Option 2	$12,500
Guaranteed Issue Amount:	the greater of a) or b) below: a) $7,500, or b) an amount equal to the Life Insurance Benefit in effect on the termination date of the Prior Plan
Terminal Illness Benefit	100% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.

Spouse*

The current lawful spouse of a Retiree. Client wants language that would state the Spouse if defined throughout the policy.

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TL-004774

SCHEDULE OF BENEFITS FOR CLASS 2

Eligibility Waiting Period

The Eligibility Waiting Period is the period of time the Retiree must be a member of the class to be eligible for coverage.

For Employees who retired on or before the Policy Effective Date:	No Waiting Period.
For Employees who retire after the Policy Effective Date:	No Waiting Period.

LIFE INSURANCE BENEFITS

Retiree Benefits

Amount of Insurance	An amount elected in units of $5,000
Minimum Benefit:	$5,000
Guaranteed Issue Amount:	the greater of a) or b) below: a) $5,000, or b) an amount equal to the Life Insurance Benefit in effect on the termination date of the Prior Plan
Maximum Benefit:	$20,000

Retiree*
A Retiree is a former employee of the Employer who is currently receiving benefits from the Texas County and District Retirement System and in one of the "Classes of Eligible Retirees." Otherwise, Retiree means a former employee of the Employer who is insured under the Policy.

Terminal Illness Benefit	100% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.

An eligible Retiree may enroll for or increase his or her Voluntary Term Life Insurance Benefits, at any time, only if he or she satisfies the Insurability Requirement. Any amount the Insurance Company approves is effective on the date the Insurance Company agrees in writing to insure the Retiree.

An Retiree may reduce Insurance Benefits at any time. The reduced amount will be effective on the date the Insurance Company receives the completed change form.

Spouse or Domestic Partner Benefits

Amount of Insurance	$2,500
Guaranteed Issue Amount:	the greater of a) or b) below: a) $2,500, or b) an amount equal to the Life Insurance Benefit in effect on the termination date of the Prior Plan
Maximum Benefit:	$5,000
Terminal Illness Benefit	100% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.

Spouse*
The current lawful spouse of a Retiree.

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11-00477-4

SCHEDULE OF BENEFITS FOR CLASS 3

Eligibility Waiting Period

The Eligibility Waiting Period is the period of time the Insured must be a member of the class to eligible for coverage.

For Surviving Spouses who were widowed on or before the Policy Effective Date:
No waiting period.

For Surviving Spouses who were widowed after before the Policy Effective Date:
No waiting period.

LIFE INSURANCE BENEFITS

Surviving Spouse

Amount of Insurance	
Option 1	$ 7,500
Option 2	$12,500
Guaranteed Issue Amount	the greater of a) or b) below: a) $7,500, or b) an amount equal to the Life Insurance Benefits in effect on the termination date of the Prior Plan
Terminally Illness Benefit	100% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.

Surviving Spouse*
The former lawful spouse of a Retiree prior to the Retiree passing.

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SCHEDULE OF BENEFITS FOR CLASS 4

Eligibility Waiting Period

The Eligibility Waiting Period is the period of time the Insured must be a member of the class to eligible for coverage.

For Surviving Spouses who were widowed on or before the Policy Effective Date:
No waiting period.

For Surviving Spouses who were widowed after before the Policy Effective Date:
No waiting period.

LIFE INSURANCE BENEFITS

Surviving Spouse

Amount of Insurance	Amount elected by Insured in units of $2,500
Minimum Benefit	$2,500
Guaranteed Issue Amount	the greater of a) or b) below: a) $2,500, or b) an amount equal to the Life Insurance Benefits in effect on the termination date of the Prior Plan
Maximum Benefit:	$5,000
Terminally Illness Benefit	100% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.

Surviving Spouse*
The former lawful spouse of a Retiree prior to the Retiree passing.

****Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout this document. The definition of any word, if not defined in the text where it is used, may be found either in the Definitions section or in this Schedule of Benefits or on the Policy cover page.***

ELIGIBILITY FOR INSURANCE

Classes of Eligible Persons
A person may be insured only once under the Policy as a Retiree, Spouse or Surviving Spouse even though he or she may be eligible under more than one class.

Retiree
A Retiree in one of the Classes of Eligible Persons shown in the Schedule of Benefits is eligible to be insured on the Policy Effective Date or the day after he or she completes the applicable Eligibility Waiting Period, if later.

If a person has previously converted his or her insurance under this Policy, he or she will not become eligible until the converted policy is surrendered. This does not apply to any amount of insurance that was previously converted under the Policy due to a reduction in the Retiree's Life Insurance Benefits based on age or a change in class unless those conditions no longer affect the amount of coverage available to the Retiree.

Except as noted in the Reinstatement Provision, if a Retiree terminates coverage and later wishes to reapply, or if a Retiree is rehired, a new Eligibility Waiting Period must be satisfied. A Retiree is not required to satisfy a new Eligibility Waiting Period if insurance ends because he or she is no longer in a Class of Eligible Retirees, and within one year becomes a member of an eligible class.

Spouse
If an Insured is eligible to elect Spouse coverage, the Spouse is eligible to be insured on the date the Retiree is eligible or the date he or she becomes a Spouse of a Retiree, if later.

For the purpose of eligibility the Spouse must be the lawful Spouse of the Retiree and not legally divorced from, or widowed by the Retiree.

Surviving Spouse
If an Insured is eligible to elect Surviving Spouse coverage the Surviving Spouse is eligible to be insured on the date the Retiree is deceased. For the purposes of eligibility as a Surviving Spouse, the Surviving Spouse must have been the lawful Spouse of the deceased Retiree and not divorced from the Retiree at the time of his or her death and covered as a Spouse under the Policy or the Prior Plan.

TL-004710a (TX)

EFFECTIVE DATE OF INSURANCE

An Insured who is required to contribute to the cost of this insurance may elect insurance for himself or herself and an eligible Spouse only by completing and submitting the enrollment form in a manner approved by the Employer and the Insurance Company. The effective date of this insurance depends on the date and amount of insurance elected.

If an individual elects coverage within 31 days after becoming eligible to enroll, or for any increases, the Guaranteed Issue Amount will be effective on the latest of the following dates:

1. The Policy Effective Date.
2. The first of the month after the date of the event creating eligibility.
3. The date the Employer or Insurance Company receives the completed enrollment form.

If Retiree, Spouse or Surviving Spouse coverage is elected in an amount that exceeds the Guaranteed Issue Amount or an enrollment form is received more than 31 days after becoming eligible to elect coverage, this insurance will be effective on the date the Insurance Company agrees in writing to insure that eligible person. The Insurance Company will require the eligible person to satisfy the Insurability Requirement before it agrees to insure him or her.

If an eligible Retiree, Spouse or Surviving Spouse is:

1. an inpatient in a hospital, hospice, rehabilitation or convalescence center, or custodial care facility; or
2. confined to his or her home under the care of a Physician

on the date insurance would otherwise be effective, it will be effective on the date he or she is no longer an inpatient in these facilities or confined at home. If such Retiree or Spouse or Surviving Spouse was covered by the Prior Plan immediately prior to the Policy Effective Date, this provision will not apply to the amount of coverage in effect as of the Policy Effective Date, but will apply to any increase in coverage.

TL-004712a (TX)

TERMINATION OF INSURANCE

An Insured's coverage will end on the last day of the month after the earliest of the following dates:

1. the date the Insured is eligible for coverage under a plan intended to replace this coverage;
2. the date the Policy is terminated by the Insurance Company;
3. the date the Insured is no longer in an eligible class;
4. the date coinciding with the end of the last period for which premiums are paid;
5. the date the Employer cancels participation under the Policy; and
6. the date coverage for the Retiree ends, for any insured Spouse, unless coverage for the Retiree ends as a result of his or her death.

TL-004714a (TX)

DESCRIPTION OF BENEFITS

The following provisions explain the benefits available under the Policy. Please see the Schedule of Benefits for the applicability of these benefits on a class level.

LIFE INSURANCE BENEFITS

Death Benefit
If an Insured dies, the Insurance Company will pay the Life Insurance Benefit in force for that Insured on the date of his or her death.

TL-004730

Accelerated Benefits
This policy provides Accelerated Benefits. Terminal Illness is a qualifying condition for payment of Accelerated Benefits. Any benefits payable under the Terminal Illness Benefit provision will reduce the Death Benefit payable for Life Insurance

Terminal Illness Benefit
The Insurance Company will pay a Terminal Illness Benefit to an Insured who has been determined by the Insurance Company to be Terminally Ill.

The Terminal Illness Benefit is payable only once in an Insured's lifetime.

Determination of Terminal Illness

For the purpose of determining the existence of a Terminal Illness, the Insurance Company will require the Insured submit the following proof.

1. A written diagnosis and prognosis by two Physicians licensed to practice in the United States.
2. Supportive evidence satisfactory to the Insurance Company, including but not limited to radiological, histological or laboratory reports documenting the Terminal Illness.

The Insurance Company may require, at its expense, an examination of the Insured and a review of the documented evidence by a Physician of its choice.

"Terminal Illness" means an illness for which a person has a prognosis of 12 months or less to live, as diagnosed by a Physician.

TL-004748

Conversion Privilege for Life Insurance

Each Insured may convert all or any portion of his or her Life Insurance that would end under the Policy due to:

1. termination of membership in an eligible class under the Policy;
2. termination of the Policy.

The Insured may apply for any type of life insurance the Insurance Company offers to persons of the same age in the amount applied for, except the Insured may not:

1. choose term insurance;
2. apply for an amount of insurance greater than the coverage amount terminating under the Policy (also, the conversion policy will not provide accident, disability or other benefits); or
3. apply for more than $10,000 of insurance if the Policy is terminated or amended to terminate the insurance for any class of Insureds, or the Employer cancels participation under the Policy.

Conversion in these cases is only permitted if the Insured has been covered by the Policy or, any group life insurance policy issued to the Employer which the Policy replaced, for at least 3 years.

If the Insured becomes eligible for coverage under any group life policy within 31 days of termination of coverage under this Policy, the Insured may not convert an amount of insurance greater than the amount of coverage terminating under the Policy less the amount for which he or she may be covered under the other policy.

To apply for conversion insurance, the Insured must, within 31 days after coverage under the Policy ends:

1. submit an application to the Insurance Company; and
2. pay the required premium.

Evidence of insurability is not required.

Premium for the conversion insurance will be based on the age and class of risk of the Insured and the type and amount of coverage issued.

If the Insured has assigned ownership of his group coverage, the owner/assignee must apply for the individual policy.

Conversion insurance will become effective on the 31st day after the date coverage under the Policy ends provided the application is received by the Insurance Company and the required premium has been paid.

If the Insured dies during the 31-day conversion period, the Life Insurance benefits will be paid under the Policy regardless of whether he or she applied for conversion insurance. If a conversion policy is issued, it will be in exchange for any further benefits for that type and amount of insurance from this Policy.

Extension of Conversion Period

If an Insured is eligible for conversion insurance and is not notified of this right at least 15 days prior to the end of the 31-day conversion period, the conversion period will be extended. The Insured will have 15 days from the date notice is given to apply for conversion insurance. In no event will the conversion period be extended beyond 90 days. Notice, for the purpose of this section, means written notice presented to the Insured by the Employer or mailed to the Insured's last known address as reported by the Employer.

If the Insured dies during the extended conversion period, but more than 31 days after his or her coverage under the Policy terminates, Life Insurance benefits:

1. will not be paid under the Policy; and
2. will be payable under the conversion insurance; provided:
    a. the Insured's application for conversion insurance has been received by the Insurance Company; and
    b. the required premium has been paid.

Prior Conversion Limitation
If an Insured is covered under a life insurance conversion policy previously issued by the Insurance Company, he or she will not be eligible for this Conversion Privilege unless the prior coverage has ended.

TL-009740

LIFE INSURANCE EXCLUSIONS

If an Insured commits suicide, while sane or insane, within 2 years from the date his or her insurance under the Policy becomes effective, Life Insurance Benefits will be limited to a refund of the premiums paid on the Insured's behalf. The suicide exclusion applies from the effective date of any additional benefits or increases in Life Insurance Benefits.

Except for any amount of benefits in excess of the Prior Plan's benefits, this exclusion will not apply to any person covered under the Prior Plan as a, Retiree, Spouse or Surviving Spouse for more than two years. If a person was not insured for two years under the Prior Plan, credit will be given for the time he or she was insured.

TL-004752

CLAIM PROVISIONS

Notice of Claim
Written notice, or notice by any other electronic/telephonic means authorized by the Insurance Company, must be given to the Insurance Company within 31 days after a covered loss occurs or begins or as soon as reasonably possible. If written notice, or notice by any other electronic/telephonic means authorized by the Insurance Company, is not given in that time, the claim will not be invalidated or reduced if it is shown that notice was given as soon as was reasonably possible. Notice can be given at our home office in Philadelphia, Pennsylvania or to our agent. Notice should include the Employer's name, the Policy Number and the claimant's name and address.

Written notice or notice by any other electronic/telephonic means authorized by the Insurance Company of a diagnosis of a Terminal Illness on which claim is based must be given to us within 60 days after the diagnosis. If notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice or notice by any other electronic/telephonic means authorized by the Insurance Company was given as soon as reasonably possible.

Claim Forms
When the Insurance Company receives notice of claim, the Insurance Company will send claim forms for filing proof of loss. If claim forms are not sent within 15 days after notice is received by the Insurance Company, the proof requirements will be met by submitting, within the time required under the "Proof of Loss" section, written proof, or proof by any other electronic/telephonic means authorized by the Insurance Company, of the nature and extent of the loss.

Claimant Cooperation Provision
Failure of a claimant to cooperate with the Insurance Company in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Insurance Data
The Employer is required to cooperate with the Insurance Company in the review of claims and applications for coverage. Any information the Insurance Company provides in these areas is confidential and may not be used or released by the Employer if not permitted by applicable privacy laws.

Proof of Loss
Written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, must be given to the Insurance Company within 90 days after the date of the loss for which a claim is made. If written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, is not given in that 90 day period, the claim will not be invalidated nor reduced if it is shown that it was given as soon as was reasonably possible. In any case, written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, must be given not more than one year after that 90 day period. If written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, is provided outside of these time limits, the claim will be denied. These time limits will not apply while the person making the claim lacks legal capacity.

Written proof, or proof by any other electronic/telephonic means authorized by the Insurance Company, of loss for Accelerated Benefits must be furnished after the date of diagnosis. This proof must describe the occurrence, character and diagnosis for which claim is made.

In case of claim for any other loss, proof must be furnished within 90 days after the date of such loss.

If it is not reasonably possible to submit proof of loss within these time periods, the Insurance Company will not deny or reduce any claim if proof is furnished as soon as reasonably possible. Proof must, in any case, be furnished not more than a year later, except for lack of legal capacity.

Time of Payment
Benefits due under the Policy for a loss, other than a loss for which the Policy provides installment payments, will be paid within 60 days of receipt of due written proof of such loss.

Subject to the receipt of satisfactory written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, all accrued benefits for loss for which the Policy provides installments will be paid monthly; any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof, or proof by any other electronic/telephonic means authorized by the Insurance Company, unless otherwise stated in the Description of Benefits.

To Whom Payable
Death Benefits will be paid to the Insured's named beneficiary, if any, on file at the time of payment. If there is no named beneficiary or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives: spouse; child or children; mother or father; brothers or sisters; or to the executors or administrators of the Insured's estate. The Insurance Company may reduce the amount payable by any indebtedness due.

All benefits payable under the Accelerated Benefits section are payable to the Insured, if living. If the Insured dies prior to the payment of an eligible claim for an Accelerated Benefit, benefits will be paid in accordance with the provisions applicable to the payment of Life Insurance proceeds, unless the Insured has directed us otherwise in writing. However, any payment made by us prior to notice of the Insured's death shall discharge us of any benefit that was paid.

All other benefits, unless otherwise stated in the Policy, will be payable to the Insured or the certificate owner if other than the Insured.

Any other accrued benefits which are unpaid at the Insured's death may, at the Insurance Company's option, be paid either to the Insured's beneficiary or to the executor or administrator of the Insured's estate.

If the Insurance Company pays benefits to the executor or administrator of the Insured's estate or to a person who is incapable of giving a valid release, the Insurance Company may pay up to $1,000 to a relative by blood or marriage whom it believes is equitably entitled. This good faith payment satisfies the Insurance Company's legal duty to the extent of that payment.

Change of Beneficiary
The Insured may change the beneficiary at any time by giving written notice to the Employer or the Insurance Company. The beneficiary's consent is not required for this or any other change which the Insured may make unless the designation of beneficiary is irrevocable.

No change in beneficiary will take effect until the form is received by the Employer or the Insurance Company. When this form is received, it will take effect as of the date of the form. If the Insured dies before the form is received, the Insurance Company will not be liable for any payment that was made before receipt of the form.

Physical Examination and Autopsy
The Insurance Company, at its expense, will have the right to examine any person for whom a claim is pending as often as it may reasonably require. The Insurance Company may, at its expense, require an autopsy unless prohibited by law.

Legal Actions
No action at law or in equity may be brought to recover benefits under the Policy less than 60 days after written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, has been furnished as required by the Policy. No such action shall be brought more than 4 years after the time satisfactory proof of loss is required to be furnished.

Time Limitations
If any time limit stated in the Policy for giving notice of claim or proof of loss, or for bringing any action at law or in equity, is less than that permitted by the law of the state in which the Insured lives when the Policy is issued, then the time limit provided in the Policy is extended to agree with the minimum permitted by the law of that state.

Physician/Patient Relationship
The Insured will have the right to choose any Physician who is practicing legally. The Insurance Company will in no way disturb the Physician/patient relationship.

TL-004724a (1X)

ADMINISTRATIVE PROVISIONS

Premiums
The premiums for this Policy will be based on the rates currently in force, the plan and the amount of insurance in effect.

If the Insured's coverage amount is reduced due to acceleration of his or her Death Benefit, his or her premium will be based on the amount of coverage he or she has in force on the day before the reduction took place.

Changes in Premium Rates
The premium rates may be changed by the Insurance Company from time to time with at least 180 days advance written notice but only on the Policy Anniversary Date. No change in rates will be made until 48 months after the Policy Effective Date. An increase in rates will not be made more often than once in a 12 month period and only on the Policy Anniversary Date. However, the Insurance Company reserves the right to change the rates even during a period for which the rate is guaranteed if any of the following events take place.

1. The terms of the Policy change;
2. A division, subsidiary, affiliated company or eligible class is added or deleted from the Policy.
3. There is a change in the factors bearing on the risk assumed;
4. Any federal or state law or regulation is amended to the extent it affects the Insurance Company's benefit obligation or
5. The Insurance Company determines that the Employer has failed to promptly furnish any necessary information requested by the Insurance Company, or has failed to perform any other obligations in relation to the Policy.

Reporting Requirements
The Employer must, upon request, give the Insurance Company any information required to determine who is insured, the amount of insurance in force and any other information needed to administer the plan of insurance.

Payment of Premium
The first premium is due within 30 days of delivering the Policy. After that, premiums will be due monthly unless the Employer and the Insurance Company agree on some other method of premium payment.

If any premium is not paid when due, the plan will be canceled as of the Premium Due Date, except as provided in the Policy Grace Period section.

Notice of Cancellation
The Employer or the Insurance Company may cancel the Policy as of any Premium Due Date by giving 180 days advance written notice. If a premium is not paid when due, the Policy will automatically be canceled as of the Premium Due Date, except as provided in the Policy Grace Period section.

Policy Grace Period
A Policy Grace Period of 31 days will be granted for the payment of the required premiums under this Policy. This Policy will be in force during the Policy Grace Period.

Grace Period for the Insured
If the required premium is not paid on the Premium Due Date, there is a 31 day grace period after each premium due date after the first. If the required premium is not paid during the grace period, insurance will end on the last day for which premium was paid.

If benefits are paid during the Grace Period for the Insured, the Insurance Company will deduct any overdue premium from the proceeds payable under the Policy.

Reinstatement of Insurance
After an Insured's coverage has ceased, it may be reinstated at any date after the date of termination if the following conditions are met:

1. The Policy is still in force.
2. The Insured is eligible under the Policy.
3. A written request for reinstatement and a new enrollment form are sent to the Insurance Company.
4. The required premium is paid.
5. The Insurability Requirement, if any, is satisfied.

TL-004720

SCHEDULE OF RATES

The following monthly rates apply to all Classes of Eligible Persons unless otherwise indicated.

FOR RETIREE BENEFITS

Voluntary Life Insurance For Class I Only

Option 1	$15,000	$2.08
Option 2	$25,000	$6.92

Voluntary Life Insurance For Class 2 Only

Basic Benefit Amount	$5,000	$5.90
Increases in coverage	Units of $5,000	$8.80 per unit

FOR SPOUSE, SURVIVING SPOUSE OR DOMESTIC PARTNER BENEFITS

Voluntary Life Insurance For Class 1 and Class 3 Only

Basic Benefit Amount of $7,500	$2.08
Basic Benefit Amount of $12,500	$6.92

Voluntary Life Insurance For Class 2 and Class 4 Only

Basic Benefit Amount of $2,500		$2.95
Increases in coverage	Units of $2,500	$4.40 per unit

Spouse rates are based on the Retiree's date of birth. A change in rates due to a change in the Retiree's age will become effective on the Policy Anniversary Date coinciding with or following the Retiree's birthday.

Surviving Spouse rates are based on the Former Retiree's date of birth. A change in rates due to a change in the Former Retiree's age will become effective on the Policy Anniversary Date coinciding with or following the Retiree's birthday.

1L-004718

GENERAL PROVISIONS

Entire Contract
The entire contract will be made up of the Policy, the application of the Employer, a copy of which is attached to the Policy, and the applications, if any, of the Insureds.

Incontestability
All statements made by the Employer or by an Insured are representations not warranties. No statement will be used to deny or reduce benefits or as a defense to a claim, unless a copy of the instrument containing the statement is signed by and has been furnished to the claimant. In the event of death or legal incapacity, the beneficiary or representative must receive the copy.

After two years from an Insured's effective date of insurance, or from the effective date of any added or increased benefits, the validity of an Insured's coverage will not be contested using such statements.

Misstatement of Age
If an Insured's age has been misstated, the Insurance Company will adjust all benefits to the amounts that would have been purchased for the correct age.

Policy Changes
No change in the Policy will be valid until approved by an executive officer of the Insurance Company. This approval must be endorsed on, or attached to, the Policy. No agent of the Insurance Company or Employer may change the Policy or waive any of its provisions.

Certificates
An individual certificate of insurance will be delivered to the Employer for delivery to Insureds. Each certificate will list the benefits, conditions and limits of the Policy. It will state to whom benefits will be paid.

Assignment of Benefits
The Insurance Company will not be affected by the assignment of an Insured's certificate until the original assignment or a certified copy of the assignment is filed with the Insurance Company. The Insurance Company will not be responsible for the validity or sufficiency of an assignment. An assignment of benefits will operate so long as the assignment remains in force provided insurance under the Policy is in effect. This insurance may not be levied on, attached, garnisheed, or otherwise taken for a person's debts. This prohibition does not apply where contrary to law.

Clerical Error
A person's insurance will not be affected by error or delay by Insurance Company or Employer in keeping records of insurance under the Policy. If such an error is found, the premium will be adjusted fairly.

Agency
The Employer is the agent of the Insured for transactions relating to insurance under the Policy. The Insurance Company is not liable for any of their acts or omissions.

TL-004726a (TX)

DEFINITIONS

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout this document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits or on the Policy cover page.

Employer
The Policyholder and any affiliates or subsidiaries covered under the Policy. The Employer is acting as an agent of the Insured for transactions relating to this insurance. The actions of the Employer shall not be considered the actions of the Insurance Company.

Insurability Requirement
An eligible person will satisfy the Insurability Requirement for an amount of coverage on the day the Insurance Company agrees in writing to accept him or her as insured for that amount. To determine a person's acceptability for coverage, the Insurance Company will require evidence of good health and may require it be provided at the Retiree's expense.

Insurance Company
The Insurance Company underwriting the Policy is named on the Policy cover page.

Insured
A person who is eligible for insurance under the Policy, for whom insurance is elected, the required premium is paid and coverage is in force under the Policy.

Physician
Physician means a licensed doctor practicing within the scope of his or her license and rendering care and treatment to an Insured that is appropriate for the condition and locality. The term does not include an Insured, an Insured's spouse, the immediate family (including parents, children, siblings or spouses of any of the foregoing, whether the relationship derives from blood or marriage) of an Insured or Spouse, or a person living in an Insured's household.

Prior Plan
The Prior Plan refers to the plan of insurance providing similar benefits sponsored by the Employer in effect directly prior to the Policy Effective Date and includes Retiree coverage.

TL-004708a (TX)

Life Insurance Company of North America
a stock insurance company

Rider to Group Policy No. FLX-964189
Effective Date of Rider: October 1, 2011

Eligible Classes to which this Rider applies: All Classes

MODIFICATION OF GROUP POLICY
TO ADD DOMESTIC PARTNER AS AN ELIGIBLE DEPENDENT
UNDER THE GROUP POLICY FOR TERM LIFE INSURANCE

The provisions of the Policy are modified as follows:

1. All references to the term "Spouse" are replaced by "Spouse, Surviving Spouse or Domestic Partner", except for the following references:
   a. The definition of "Spouse" remains unchanged.
   b. Any reference to "lawful spouse" or "legal spouse" remains unchanged.
   c. Any reference to "Spouse" remains unchanged in the paragraph entitled "To Whom Payable" under the Claims Provisions.
   d. Any reference to "Spouse" in the "Life Status Change" definition remains unchanged.

2. The following Domestic Partner definition is added to the Definitions section of the Group Policy.

   Domestic Partner means: a person of the same or opposite sex, who meets all of the following criteria:

   a. shares the Retiree's permanent residence;
   b. has resided with the Retiree and is expected to continue to reside with the Retiree;
   c. is financially interdependent with the Retiree and shares the common necessities of life with the Retiree;
   d. has signed a domestic partner declaration with the Retiree, if the Retiree resides in a jurisdiction that provides for domestic partner declarations;
   e. has not signed a domestic partner declaration with any other person within the last 12 months, if the Retiree resides in a jurisdiction that provides for domestic partner declarations;
   f. is no less than 18 years of age;
   g. is not currently legally married to any other person and
   h. is not a blood relative any closer than would prohibit legal marriage.

   In addition to the above requirements, if consent of either party to the Domestic Partner relationship was obtained by force, duress, or fraud, these have the same effects as on the validity of a marriage in Texas.

An Retiree's Domestic Partner is eligible for Life Insurance Benefits under the Policy on the later of the Retiree's eligibility date or the date the person becomes the Retiree's Domestic Partner and if all the following conditions are met.

a. The Retiree has not been married to any other person within the last 31 days.
b. The Domestic Partner is the only person meeting the Policy's definition of "Domestic Partner" with respect to the Retiree.
c. The Retiree and Domestic Partner furnish a notarized affidavit or signed statement reflecting these requirements, and an agreement to notify the Insurance Company if the requirements cease to be met, on a form acceptable to the Insurance Company.

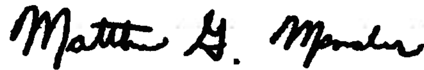
To obtain insurance for a Domestic Partner, a Retiree must request coverage in writing and agree to make any required premium contributions. Insurance will be effective for a Domestic Partner on the same date specified for a Spouse in the Effective Date of Insurance Provision.

The amount of insurance that applies to a Domestic Partner is shown in the Schedule of Benefits.

Death benefits with respect to any Domestic Partner will be payable to the beneficiary chosen by the Domestic Partner. If no beneficiary is named, benefits are payable to the Retiree.

Except for the above, this Rider does not change the Group Policy to which it is attached.

Life Insurance Company of North America



Matthew G. Manders, President

TL-007152

IMPORTANT CHANGES FOR STATE REQUIREMENTS

If a Retiree resides in one of the following states, the provisions of the certificate are modified for residents of the following states. The modifications listed apply only to residents of that state.

California Residents:

Conversion Privilege for Life Insurance
Insured Retirees and Insured Spouses may convert to an individual policy of life insurance for an amount not greater than the Conversion Amount shown below when the Policy ends, without regard to any requirement that the person be insured under the policy for a specified period of time, if all of the following apply.

a. The Insured became Totally Disabled while covered for the Life Benefit of the Policy. Totally Disabled means the person is unable to perform all the material duties of any occupation for which he or she may reasonably be qualified based on training, education and experience.
b. The Insured remained Totally Disabled until the Policy ended while covered for the Life Benefit of this Policy.
c. The Policy does not provide a Waiver of Premium, Extended Death Benefit Provision or monthly payments to Totally Disabled Insureds for the Life Benefit.
d. The person meets all other conditions for converting the insurance.

Conversion Amount - Insured's life insurance amount under the Policy on the date the Policy ends minus the amount for which the Insured is insured under a group policy that provides life coverage to retirees of the Insured Retiree's Employer covered under this Policy. The dollar limit that applies to the amount for conversion at Policy termination does not apply.

The requirement that the Insured be covered under the Policy for the stated number of years in order to convert life insurance does not apply.

Minnesota residents:

The following "Continuation of Life Insurance" provision is applicable to Minnesota residents if the Employer has a minimum of 25 Retirees who reside in Minnesota, the Minnesota Retirees represent at least 25% of all covered Retirees under the Policy, and the Policy does not offer Portability.

Continuation Of Life Insurance – This provision shall not apply to the extent that the Policy provides for the right of Retirees to continue insurance on a direct billed basis following termination of employment (Portability).

This provision shall apply with respect to Retirees whose coverage under the Policy is terminated due to: (i) voluntary or involuntary termination or layoff from employment, for any reason other than gross misconduct; or (ii) reduction in hours such that the Retiree is not eligible for insurance under the Policy. This provision shall only apply to Retirees who, on such date, are Minnesota residents.

For those Retirees subject to this provision, life insurance coverage may be continued under the Policy for 18 months or until the date that the Retiree becomes covered under another group policy, whichever is shorter. Coverage provided under this provision will also end if the Policy is terminated.

The premium required for continued coverage shall be the premium under the Policy applicable to the Retiree's class and amount of coverage. The Employer may charge an additional amount, not to exceed 2% of such premium, for collecting premium contributions from former Retirees. The Employer shall notify the Retiree of the right to continue and the required premium contribution. The Retiree may elect to continue within 60 days of termination by paying the required premium, and may continue coverage in force by paying the required premium, without demand, on a monthly basis, as of the first of each month, to the Employer. Coverage will end at the end of any month in which the Retiree has failed to pay premium to the Employer.

If continued coverage remains in force at the end of the 18 month period, or on termination of the Policy, the Retiree may choose any conversion right then available under the Policy.

In the event the Retiree dies during the 60 day right to elect period without having become insured under another group policy, or dies while continued coverage is in force, the death benefit will be paid to the beneficiary chosen by the Retiree under the terms of the Policy.

Continued coverage will include eligible dependents who were covered on the Retiree's date of termination, provided the dependent remains eligible as a dependent of the Retiree. In the event that the dependent ceases to be eligible, the dependent may choose any conversion right then available under the Policy.

Missouri residents:

Applicable to Voluntary Life Insurance Benefits

If an Insured commits suicide, while sane or insane, within 1 year from the date his or her insurance under the Policy becomes effective, Voluntary Life Insurance Benefits will be limited to a refund of the premiums paid on the Insured's behalf. The suicide exclusion applies from the effective date of any additional benefits or increases in Life Insurance Benefits.

Except for any amount of benefits in excess of the Prior Plan's benefits, this exclusion will not apply to any person covered under the Prior Plan for more than one year. If a person was not insured for one year under the Prior Plan, credit will be given for the time he or she was insured.

If a Dependent Child commits suicide and is survived by other Dependent Children covered under the same certificate, no refund of premiums will be paid.

North Dakota residents:

The Suicide exclusion, if any, is limited to one year from the effective date of insurance. The suicide exclusion with respect to any increase in death benefits which results from an application of the insured subsequent to the effective date, if any, is limited to one year from the effective date of the increase.

LIFE INSURANCE COMPANY OF NORTH AMERICA
PHILADELPHIA, PA 19192-2235

We, County of Travis, whose main office address is Austin, TX, hereby approve and accept the terms of Group Policy Number FLX-964189 issued by the LIFE INSURANCE COMPANY OF NORTH AMERICA.

This form is to be signed in duplicate. One part is to be retained by County of Travis; the other part is to be returned to the LIFE INSURANCE COMPANY OF NORTH AMERICA.

County of Travis

Signature and Title: ____ Date:__________________________

(This Copy Is To Be Returned To LIFE INSURANCE COMPANY OF NORTH AMERICA)

LIFE INSURANCE COMPANY OF NORTH AMERICA
PHILADELPHIA, PA 19192-2235

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County of Travis

Signature and Title: ____ Date:__________________________

(This Copy Is To Be Retained By County of Travis)

Attachment IC-4

Policy Number VDT 960952
Short Term Disability

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call the toll-free telephone number for information or to make a complaint at:

1-800-547-5515

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may write the
Texas Department of Insurance
P.O. Box 149091
Austin, TX 78714-9104
FAX # (512) 475-1771

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim you should contact the agent or company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

TL-004426

AVISO IMPORTANTE

Para solicitar información o presentar una queja:

Usted puede llamar al numero de telefono gratis para información o pare someter una queja al:

1-800-547-5515

Puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos o quejas llamando al:

1-800-252-3439

También puede escribir al Texas Department of Insurance (Departamento de Seguros de Texas)
P.O. Box 149091
Austin, TX 78714-9104
FAX # (512) 475-1771

CONFLICTOS POR PRIMAS O RECLAMACIONES: En caso de tener un conflicto relacionado con su prima o una reclamación, debe comunicarse primero con el agente o la compañía. Si el conflicto no se resuelve, usted puede comunicarse con el Departamento de Seguros de Texas.

UNA ESTE AVISO A SU POLIZA: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE, ACCIDENT, HEALTH AND HOSPITAL SERVICE INSURANCE GUARANTY ASSOCIATION
(For insurers declared insolvent or impaired on or after September 1, 2005)

Texas law establishes a system, administered by the Texas Life, Accident, Health and Hospital Service Insurance Guaranty Association (the "Association"), to protect Texas policyholders if their life or health insurance company fails. Only the policyholders of insurance companies which are members of the Association are eligible for this protection which is subject to the terms, limitations, and conditions of the Association law. (The law is found in the *Texas Insurance Code*, Chapter 463.)

It is possible that the Association may not cover your policy in full or in part due to statutory limitations.

ELIGIBILITY FOR PROTECTION BY THE ASSOCIATION

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas at that time **(irrespective of the policyholder's residency at policy issue)**
- Residents of other states, ONLY if the following conditions are met:
  1) The policyholder has a policy with a company domiciled in Texas;
  2) The policyholder's state of residence has a similar guaranty association; and
  3) The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

LIMITS OF PROTECTION BY THE ASSOCIATION

Accident, Accident and Health, or Health Insurance:

- For each individual covered under one or more policies: up to a total of $500,000 for basic hospital, medical-surgical, and major medical insurance, $300,000 for disability or long term care insurance, and $200,000 for other types of health insurance.

Life Insurance:

- Net cash surrender value or net cash withdrawal value up to a total of $100,000 under one or more policies on any one life; or
- Death benefits up to a total of $300,000 under one or more policies on any one life; or
- Total benefits up to a total of $5,000,000 to any owner of multiple non-group life policies.

Individual Annuities:

- Present value of benefits up to a total of $100,000 under one or more contracts on any one life.

Group Annuities:

- Present value of allocated benefits up to a total of $100,000 on any one life; or
- Present value of unallocated benefits up to a total of $5,000,000 for one contractholder regardless of the number of contracts.

Aggregate Limit:

- $300,000 on any one life with the exception of the $500,000 health insurance limit, the $5,000,000 multiple owner life insurance limit, and the $5,000,000 unallocated group annuity limit.

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage.

Texas Life, Accident, Health and Hospital
Service Insurance Guaranty Association
6504 Bridge Point Parkway, Suite 450
Austin, Texas 78730
800-982-6362 or www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439 or www.tdi.state.tx.us

LIFE INSURANCE COMPANY OF NORTH AMERICA
1601 CHESTNUT STREET
PHILADELPHIA, PA 19192-2235
(800) 732-1603 TDD (800) 552-5744
A STOCK INSURANCE COMPANY

GROUP POLICY

POLICYHOLDER:	Travis County
POLICY NUMBER:	VDT-960952
POLICY DESCRIPTION:	Short Term Disability Insurance
POLICY EFFECTIVE DATE:	October 1, 2011
POLICY ANNIVERSARY DATE:	October 1

This Policy describes the terms and conditions of coverage. It is issued in Texas and shall be governed by its laws. The Policy goes into effect on the Policy Effective Date, 12:01 a.m. at the Policyholder's address.

In return for the required premium, the Insurance Company and the Policyholder have agreed to all the terms of this Policy.

Scott Kern, Corporate Secretary

Matthew G. Manders, President

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SCHEDULE OF BENEFITS

Policy: Group policy identified as Policy Number: VDT-960952 on the policy cover page

Premium Due Date: The last day of each month

Classes of Eligible Employees

Class 1 All active, Full-time Employees of the Employer regularly working a minimum of 20 hours per week.

SCHEDULE OF BENEFITS FOR CLASS 1

Eligibility Waiting Period

For Employees hired on or before the Policy Effective Date:
The first of the month following 30 calendar days after the date of hire.

For Employees hired after the Policy Effective Date:
The first of the month following 30 calendar days after the date of hire.

Definition of Disability/Disabled

The Employee is considered Disabled if, solely because of Injury or Sickness, he or she is:

1. unable to perform the material duties of his or her Regular Occupation; and
2. unable to earn 80% or more of his or her Covered Earnings from working in his or her Regular Occupation.

The Insurance Company will require proof of earnings and continued Disability.

Definition of Covered Earnings

Covered Earnings means an Employee's wage or salary as reported as of August 31st of each year by the Employer for work performed for the Employer as in effect just prior to the date Disability begins. Covered Earnings are determined initially on the date an Employee applies for coverage. A change in the amount of Covered Earnings is effective on August 31st, if the Employer gives us written notice of the change and the required premium is paid.

It does not include amounts received as bonus, commissions, overtime pay or other extra compensation.

Any increase in an Employee's Covered Earnings will not be effective during a period of continuous Disability.

Elimination Period

For Accident: 14 calendar days
For Sickness: 14 calendar days

Gross Disability Benefit	The lesser of 60% of an Employee's weekly Covered Earnings rounded to the nearest dollar or the Maximum Disability Benefit.
Maximum Disability Benefit	$1,500 per week
Minimum Disability Benefit	$25 per week

Disability Benefit Calculation
Disability Benefits means either the Minimum Disability Benefit or what remains of the Gross Disability Benefit after the following disability benefit calculations are completed, whichever is larger.

The Weekly Benefit payable to the Employee for any week the Employee is Disabled is the Gross Disability Benefit minus Other Income Benefits.

"Other Income Benefits" means any benefits listed in the Other Income Benefits provision that an Employee receives on his or her own behalf.

Return to Work Incentive
An Employee may work for wage or profit while Disabled. In any week in which the Employee works and a Disability Benefit is payable, the Return to Work Incentive Benefit Calculation applies.

During any week the Employee has Disability Earnings, his or her benefits will be calculated as follows:

1. Add the Employee's Gross Disability Benefit and Disability Earnings.
2. Compare the sum from 1. to the Employee's Covered Earnings.
3. If the sum from 1. exceeds 100% of the Employee's Covered Earnings, then subtract the Covered Earnings from the sum in 1.
4. The Employee's Gross Disability Benefit will be reduced by the difference from 3., as well as by Other Income Benefits.
5. If the sum from 1. does not exceed 100% of the Employee's Covered Earnings, the Employee's Gross Disability Benefit will be reduced by Other Income Benefits.

No Disability Benefits will be paid, and insurance will end if the Insurance Company determines the Employee is able to work under a modified work arrangement and he or she refuses to do so without Good Cause.

Maximum Benefit Period

For Accident: The date the 13th Disability Benefit is payable.
For Sickness: The date the 13th Disability Benefit is payable.

Initial Premium Rates

$.30 per $10 of Weekly Benefit

TL-004774

ELIGIBILITY FOR INSURANCE

An Employee in one of the Classes of Eligible Employees shown in the Schedule of Benefits is eligible to be insured on the Policy Effective Date, or the day after he or she completes the Eligibility Waiting Period, if later. The Eligibility Waiting Period is the period of time the Employee must be in Active Service to be eligible for coverage. It will be extended by the number of days the Employee is not in Active Service.

Except as noted in the Reinstatement Provision, if an Employee terminates coverage and later wishes to reapply, or if a former Employee is rehired, a new Eligibility Waiting Period must be satisfied. An Employee is not required to satisfy a new Eligibility Waiting Period if insurance ends because he or she is no longer in a Class of Eligible Employees, but continues to be employed and within one year becomes a member of an eligible class.

TL-004710

EFFECTIVE DATE OF INSURANCE

An Employee who is required to contribute to the cost of this insurance may elect to be insured only by authorizing payroll deduction in a form approved by the Employer and the Insurance Company. The effective date of this insurance depends on the date coverage is elected.

Insurance becomes effective for an eligible Employee who applies and agrees to make required contributions subject to the provision below:

1. New hires. Coverage is effective first of the month following 30 calendar days from the date of hire.
2. Life Status Change. Coverage will become effective first of the month following the date of the change.
3. Annual Enrollment. Coverage becomes effective on the Policy Anniversary Date.

If an Employee is not in Active Service on the date insurance would otherwise be effective, it will be effective on the date he or she returns to any occupation for the Employer on a Full-time basis.

TL-004712

TERMINATION OF INSURANCE

An Employee's coverage will end on the last day of the month after the earliest of the following dates:

1. the date the Employee is eligible for coverage under a plan intended to replace this coverage;
2. the date the Policy is terminated;
3. the date the Employee is no longer in an eligible class;
4. the day after the end of the period for which premiums are paid;
5. the date the Employee is no longer in Active Service;
6. the date benefits end for failure to comply with the terms and conditions of the Policy.

Disability Benefits will be payable to an Employee who is entitled to receive Disability Benefits when the Policy terminates, if he or she remains disabled and meets the requirements of the Policy. Any period of Disability, regardless of cause, that begins when the Employee is eligible under another group disability coverage provided by any employer, will not be covered.

TL-007505.00

CONTINUATION OF INSURANCE

This Continuation of Insurance provision modifies the Termination of Insurance provision to allow insurance to continue under certain circumstances if the Insured Employee is no longer in Active Service. Insurance that is continued under this provision is subject to all other terms of the Termination of Insurance provisions.

Disability Insurance continues if an Employee's Active Service ends due to a Disability for which benefits under the Policy are or may become payable. If the Employee does not return to Active Service, this insurance ends when the Disability ends or when benefits are no longer payable, whichever comes first.

If an Employee's Active Service ends due to an approved leave pursuant to the Family and Medical Leave Act (FMLA), insurance will continue up to the later of the period of his or her approved FMLA leave or the leave period required by law in the state in which he or she is employed. Premiums are required for this coverage.

If an Employee's Active Service ends due to medical leave of absence approved in writing by the Employer, insurance will continue for an Employee for up to 12 months. Premiums are required for this coverage. An approved leave of absence does not include Furlough, Temporary Layoff or termination of employment.

If an Employee's Active Service ends due to non-medical administrative leave of absence approved in writing by the Employer in accordance with the Employer's reporting requirements, insurance will continue for an Employee for up to 12 months. Premiums are required for this coverage. An approved leave of absence does not include Furlough, Temporary Layoff or termination of employment.

If an Employee's Active Service ends due to Temporary Layoff, insurance will continue for an Employee for up to the end of the month in which the layoff begins. Premiums are required for this coverage.

If an Employee's Active Service ends due to any other excused short term absence from work that is reported to the Employer timely in accordance with the Employer's reporting requirements for such short term absence, insurance for an Employee will continue until the last day of the month in which the earliest of the following occurs:

a. the date the Employee's employment relationship with the Employer terminates;
b. the date premiums are not paid when due;
c. the end of the 30 day period that begins with the first day of such excused absence;
d. the end of the period for which such short term absence is excused by the Employer.

Notwithstanding any other provision of this policy, if an Employee's Active Service ends due to termination of employment or any other termination of the employment relationship, insurance will terminate and Continuation of Insurance under this provision will not apply.

If an Employee's insurance is continued pursuant to this Continuation of Insurance provision, and he or she becomes Disabled during such period of continuation, Disability Benefits will not begin until the later of the date the Elimination Period is satisfied or the date he or she is scheduled to return to Active Service.

TL-009970.00

TAKEOVER PROVISION

This provision applies only to Employees eligible under this Policy who were covered for short term disability coverage on the day prior to the Policy Effective Date under the Prior Plan provided by the Policyholder or by an entity that has been acquired by the Policyholder.

A. This section A applies to Employees who are not in Active Service on the day prior to the Policy Effective Date due to a reason for which the Prior Plan and this Policy both provide for continuation of insurance. If required premium is paid when due, the Insurance Company will insure an Employee to which this section applies against a Disability that occurs after the Policy Effective Date for the affected employee group. This coverage will be provided until the earlier of the date: (a) the Employee returns to Active Service, (b) continuation of insurance under the Prior Plan would end but for termination of that plan; or (c) the date continuation of insurance under this Policy would end if computed from the first day the Employee was not in Active Service. The Policy will provide this coverage as follows:

   1. If benefits for a disability are covered under the Prior Plan, no benefits are payable under this Plan.
   2. If the Disability is not a covered disability under the Prior Plan solely because the plan terminated, benefits payable under this Policy for that Disability will be the lesser of: (a) the disability benefits that would have been payable under the Prior Plan; and (b) those provided by this Policy. Credit will be given for partial completion under the Prior Plan of Elimination Periods and partial satisfaction of pre-existing condition limitations.

B. The Elimination Period under this Policy will be waived for a Disability which begins while the Employee is insured under this Policy if all of the following conditions are met:

   1. The Disability results from the same or related causes as a Disability for which weekly benefits were payable under the Prior Plan;
   2. Benefits are not payable for the Disability under the Prior Plan solely because it is not in effect;
   3. An Elimination Period would not apply to the Disability if the Prior Plan had not ended;
   4. The Disability begins within 14 days of the Employee's return to Active Service and the Employee's insurance under this Policy is continuous from this Policy's Effective Date.

C. Except for any amount of benefit in excess of a Prior Plan's benefits, the Pre-existing Condition Limitation will not apply to an Employee covered under a Prior Plan who satisfied the pre-existing condition limitation, if any, under that plan. If an Employee, covered under a Prior Plan, did not fully satisfy the pre-existing condition limitation of that plan, credit will be given for any time that was satisfied under the Prior Plan's pre-existing condition limitation.

   Benefits will be determined based on the lesser of: (1) the amount of the gross disability benefit under the Prior Plan and any applicable maximums; and (2) those provided by this Policy.

   If benefits are payable under the Prior Plan for the Disability, no benefits are payable under this Policy.

TL-005108

DESCRIPTION OF BENEFITS

The following provisions explain the benefits available under the Policy. Please see the Schedule of Benefits for the applicability of these benefits to each class of Insureds.

Disability Benefits
The Insurance Company will pay Disability Benefits if an Employee becomes Disabled while covered under this Policy. The Employee must satisfy the Elimination Period, be under the Appropriate Care of a Physician, and meet all the other terms and conditions of the Policy. He or she must provide the Insurance Company satisfactory proof of Disability before benefits will be paid. The Disability Benefit is shown in the Schedule of Benefits.

The Insurance Company will require continued proof of the Employee's Disability for benefits to continue.

Elimination Period
The Elimination Period is the period of time an Employee must be continuously Disabled before Disability Benefits are payable. The Elimination Period is shown in the Schedule of Benefits.

A period of Disability is not continuous if separate periods of Disability result from unrelated causes.

Disability Benefit Calculation
The Disability Benefit Calculation is shown in the Schedule of Benefits. Weekly Disability Benefits are based on the number of days in a normally scheduled work week for the Employee immediately before the onset of Disability. They will be prorated if payable for any period less than a week. If an Employee is working while Disabled, the Disability Benefit Calculation will be the Return to Work Incentive.

Return to Work Incentive
The Return to Work Incentive is shown in the Schedule of Benefits. An Employee may work for wage or profit while Disabled. In any week in which the Employee works and a Disability Benefit is payable, the Return to Work Incentive applies.

The Insurance Company will, from time to time, review the Employee's status and will require satisfactory proof of earnings and continued Disability.

Minimum Benefit
The Insurance Company will pay the Minimum Benefit shown in the Schedule of Benefits despite any reductions made for Other Income Benefits. The Minimum Benefit will not apply if benefits are being withheld to recover an overpayment of benefits.

Other Income Benefits

An Employee for whom Disability Benefits are payable under this Policy may be eligible for benefits from Other Income Benefits. If so, the Insurance Company may reduce the Disability Benefits by the amount of such Other Income Benefits.

Other Income Benefits include:

1. any proceeds payable under any group insurance or similar plan. If other insurance applies to the same claim for Disability, and contains the same or similar provision for reduction because of other insurance, the Insurance Company will pay for its pro rata share of the total claim. "Pro rata share" means the proportion of the total benefit that the amount payable under one policy, without other insurance, bears to the total benefits under all such policies.
2 any amounts received (or assumed to be received*) by the Employee under any workers' compensation, occupational disease, unemployment compensation law or similar state or federal law payable for Injury or Sickness arising out of work with the Employer, including all permanent and temporary disability benefits. This includes any damages, compromises or settlement paid in place of such benefits, whether or not liability is admitted.

*See the Assumed Receipt of Benefits provision

Increases in Other Income Benefits

Any increase in Other Income Benefits during a period of Disability due to a cost of living adjustment will not be considered in calculating the Employee's Disability Benefits after the first reduction is made for any Other Income Benefits. This section does not apply to any cost of living adjustment for Disability Earnings.

Lump Sum Payments

Other Income Benefits or earnings paid in a lump sum will be prorated over the period for which the sum is given. If no time is stated, the lump sum will be prorated over five years.

If no specific allocation of a lump sum payment is made, then the total payment will be an Other Income Benefit.

Assumed Receipt of Benefits

The Insurance Company will assume the Employee is receiving benefits for which they are eligible from Other Income Benefits if (assumed to be received*) is applicable to the benefit. The Insurance Company will reduce the Employee's Disability Benefits by the amount from Other Income Benefits it estimates are payable to the Employee.

The Insurance Company will waive Assumed Receipt of Benefits, except for Disability Earnings for work the Employee performs while Disability Benefits are payable, if the Employee:

1. provides satisfactory proof of application for Other Income Benefits;
2. signs a Reimbursement Agreement;
3. provides satisfactory proof that all appeals for Other Income Benefits have been made unless the Insurance Company determines that further appeals are not likely to succeed; and
4. submits satisfactory proof that Other Income Benefits were denied.

Recovery of Overpayment
The Insurance Company has the right to recover any benefits it has overpaid. The Insurance Company may use any or all of the following to recover an overpayment:

1. request a lump sum payment of the overpaid amount;
2. reduce any amounts payable under this Policy; and/or
3. take any appropriate collection activity available to it.

The Minimum Benefit amount will not apply when Disability Benefits are reduced in order to recover any overpayment.

If an overpayment is due when the Employee dies, any benefits payable under the Policy will be reduced to recover the overpayment.

Successive Periods of Disability
A separate period of Disability will be considered continuous:

1. if it results from the same or related causes as a prior Disability for which benefits were payable; and
2. if, after receiving Disability Benefits, the Employee returns to work in his or her Regular Occupation for less than 14 days; and
3. if the Employee earns less than the percentage of Covered Earnings that would still qualify him or her to meet the definition of Disability/Disabled during at least one week.

Any later period of Disability, regardless of cause, that begins when the Employee is eligible for coverage under another group disability plan provided by any employer will not be considered a continuous period of Disability.

For any separate period of disability which is not considered continuous, the Employee must satisfy a new Elimination Period.

LIMITATIONS

Pre-Existing Condition Limitation
The Insurance Company will not pay benefits for any period of Disability caused or contributed to by, or resulting from, a Pre-existing Condition. A "Pre-existing Condition" means any Injury or Sickness for which the Employee incurred medical expenses, received medical treatment, care or services including diagnostic measures, or took prescribed drugs or medicines within 3 months before his or her most recent effective date of insurance.

This limitation will not apply to a period of Disability that begins after an Employee is covered for at least 12 months after his or her most recent effective date of insurance, or the effective date of any added or increased benefits.

TL-007500.44

ADDITIONAL BENEFITS

Rehabilitation During a Period of Disability
If the Insurance Company determines that a Disabled Employee is a suitable candidate for rehabilitation, the Insurance Company may require the Employee to participate in a Rehabilitation Plan. The Insurance Company has the sole discretion to approve the Employee's participation in a Rehabilitation Plan and to approve a program as a Rehabilitation Plan. The Insurance Company will work with the Employee, the Employer and the Employee's Physician and others, as appropriate, to perform the assessment, develop a Rehabilitation Plan, and discuss return to work opportunities.

The Rehabilitation Plan may, at the Insurance Company's discretion, allow for payment of the Employee's medical expense, education expense, moving expense, accommodation expense or family care expense while he or she participates in the Rehabilitation Plan.

If an Employee fails to fully cooperate in all required phases of the Rehabilitation Plan and assessment without Good Cause, no Disability Benefits will be paid, and insurance will end.

TL-007501.00

TERMINATION OF DISABILITY BENEFITS

Benefits will end on the earliest of the following dates:

1. the date the Employee earns from any occupation, more than the percentage of Covered Earnings set forth in the definition of Disability;
2. the date the Insurance Company determines he or she is not Disabled;
3. the end of the Maximum Benefit Period;
4. the date the Employee dies;
5. the date the Employee refuses, without Good Cause, to fully cooperate in all required phases of the Rehabilitation Plan and assessment;
6. the date the Employee is no longer receiving Appropriate Care;
7. the date the Employee fails to cooperate with the Insurance Company in the administration of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Benefits may be resumed if the Employee begins to cooperate fully in the Rehabilitation Plan within 30 days of the date benefits terminated.

TL-007502.00

EXCLUSIONS

The Insurance Company will not pay any Disability Benefits for a Disability that results, directly or indirectly, from:

1. suicide, attempted suicide, or self-inflicted injury while sane or insane.
2. war or any act of war, whether or not declared.
3. active participation in a riot.
4. commission of a felony.
5. the revocation, restriction or non-renewal of an Employee's license, permit or certification necessary to perform the duties of his or her occupation unless due solely to Injury or Sickness otherwise covered by the Policy.
6. any cosmetic surgery or surgical procedure that is not Medically Necessary; "Medically Necessary" means the surgical procedure is: (a) prescribed by a Physician as required treatment of the Injury or Sickness; and (b) appropriate according to conventional medical practice for the Injury or Sickness in the locality in which the surgery is performed. (The Insurance Company will pay benefits if the Disability is caused by the Employee donating an organ in a non-experimental organ transplant procedure.)

In addition, the Insurance Company will not pay Disability Benefits for any period of Disability during which the Employee is incarcerated in a penal or corrections institution.

TL-007503.00

CLAIM PROVISIONS

Notice of Claim

Written notice, or notice by any other electronic/telephonic means authorized by the Insurance Company, must be given to the Insurance Company within 31 days after a covered loss occurs or begins or as soon as reasonably possible. If written notice, or notice by any other electronic/telephonic means authorized by the Insurance Company, is not given in that time, the claim will not be invalidated or reduced if it is shown that notice was given as soon as was reasonably possible. Notice can be given at our home office in Philadelphia, Pennsylvania or to our agent. Notice should include the Employer's Name, the Policy Number and the claimant's name and address.

Claim Forms

When the Insurance Company receives notice of claim, the Insurance Company will send claim forms for filing proof of loss. If claim forms are not sent within 15 days after notice is received by the Insurance Company, the proof requirements will be met by submitting, within the time required under the "Proof of Loss" section, written proof, or proof by any other electronic/telephonic means authorized by the Insurance Company, of the nature and extent of the loss.

Claimant Cooperation Provision

Failure of a claimant to cooperate with the Insurance Company in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Insurance Data

The Employer is required to cooperate with the Insurance Company in the review of claims and applications for coverage. Any information the Insurance Company provides in these areas is confidential and may not be used or released by the Employer if not permitted by applicable privacy laws.

Proof of Loss
Written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, must be given to the Insurance Company within 90 days after the date of the loss for which a claim is made. If written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, is not given in that 90 day period, the claim will not be invalidated nor reduced if it is shown that it was given as soon as was reasonably possible. In any case, written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, must be given not more than one year after that 90 day period. If written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, is provided outside of these time limits, the claim will be denied. These time limits will not apply while the person making the claim lacks legal capacity.

Written proof, or proof by any other electronic/telephonic means authorized by the Insurance Company, that the loss continues must be furnished to the Insurance Company at intervals required by us. Within 30 days of a request, written proof of continued Disability and Appropriate Care by a Physician must be given to the Insurance Company.

Time of Payment
Disability Benefits will be paid at regular intervals of not less frequently than once a month. Any balance, unpaid at the end of any period for which the Insurance Company is liable, will be paid at that time.

To Whom Payable
Disability Benefits will be paid to the Employee. If any person to whom benefits are payable is a minor or, in the opinion of the Insurance Company, is not able to give a valid receipt, such payment will be made to his or her legal guardian. However, if no request for payment has been made by the legal guardian, the Insurance Company may, at its option, make payment to the person or institution appearing to have assumed custody and support.

If an Employee dies while any Disability Benefits remain unpaid, the Insurance Company may, at its option, make direct payment to any of the following living relatives of the Employee: spouse, mother, father, children, brothers or sisters; or to the executors or administrators of the Employee's estate. The Insurance Company may reduce the amount payable by any indebtedness due.

Payment in the manner described above will release the Insurance Company from all liability for any payment made.

Physical Examination and Autopsy
The Insurance Company, at its expense, will have the right to examine any person for whom a claim is pending as often as it may reasonably require. The Insurance Company may, at its expense, require an autopsy unless prohibited by law.

Legal Actions
No action at law or in equity may be brought to recover benefits under the Policy less than 60 days after written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, has been furnished as required by the Policy. No such action shall be brought more than 4 years after the time satisfactory proof of loss is required to be furnished.

Time Limitations
If any time limit stated in the Policy for giving notice of claim or proof of loss, or for bringing any action at law or in equity, is less than that permitted by the law of the state in which the Employee lives when the Policy is issued, then the time limit provided in the Policy is extended to agree with the minimum permitted by the law of that state.

Physician/Patient Relationship
The Insured will have the right to choose any Physician who is practicing legally. The Insurance Company will in no way disturb the Physician/patient relationship.

TL-004724a (TX)

ADMINISTRATIVE PROVISIONS

Premiums
The premiums for this Policy will be based on the rates currently in force, the plan and the amount of insurance in effect.

Changes in Premium Rates
The premium rates may be changed by the Insurance Company from time to time with at least 180 days advance written notice but only on the Policy Anniversary Date. No change in rates will be made until 36 months after the Effective Date. An increase in rates will not be made more often than once in a 12 month period and only on the Policy Anniversary Date. However, the Insurance Company reserves the right to change the rates even during a period for which the rate is guarantee, if any of the following events take place.

1. The Policy terms change.
2. A division, subsidiary, eligible company, or class is added or deleted.
3. There is a change of more than 10% in the number of Insureds.
4. Federal or state laws or regulation affecting benefit obligations change.
5. Other changes occur in the nature of the risk that would affect the Insurance Company's original risk assessment.
6. The Insurance Company determines the Employer fails to furnish necessary information.

Reporting Requirements
The Employer must, upon request, give the Insurance Company any information required to determine who is insured, the amount of insurance in force and any other information needed to administer the plan of insurance.

Payment of Premium
The first premium is due within 30 day of the delivery of the Policy. After that, premiums will be due monthly unless the Employer and the Insurance Company agree on some other method of premium payment.

If any premium is not paid when due, the plan will be canceled as of the Premium Due Date, except as provided in the Policy Grace Period section.

Notice Of Cancellation
The Employer or the Insurance Company may cancel the Policy as of any Premium Due Date by giving 180 days advance written notice. If a premium is not paid when due, the Policy will automatically be canceled as of the Premium Due Date, except as provided in the Policy Grace Period section.

Policy Grace Period
A Policy Grace Period of 31 days will be granted for the payment of the required premiums under this Policy. This Policy will be in force during the Policy Grace Period. The Employer is liable to the Insurance Company for any unpaid premium for the time this Policy was in force.

Grace Period for the Insured
If the required premium is not paid on the Premium Due Date, there is a 31 day grace period after each premium due date after the first. If the required premium is not paid during the grace period, insurance will end on the last day for which premium was paid.

Reinstatement of Insurance
An Employee's insurance may be reinstated if it ends because he or she is on an unpaid leave of absence. If an Employee's Active Service ended due to an approved leave pursuant to the Family and Medical Leave Act (FMLA) and Continuation of Insurance is not applicable, an Employee's insurance may be reinstated at the conclusion of the FMLA leave.

If an Employee's Active Service ends due to an Employer approved unpaid leave of absence, other than an approved FMLA leave, insurance may be reinstated only:

1. If the reinstatement occurs within 12 weeks from the date insurance ends, or
2. When returning from military service pursuant to the Uniformed Services Employment Act of 1994 (USERRA).

For insurance to be reinstated the following conditions must be met:

1. An Employee must be in a Class of Eligible Employees.
2. The required premium must be paid.
3. The Insurance Company must receive a written request for reinstatement within 31 days from the date an Employee returns to Active Service.

An Employee's Insurance may be reinstated if it ends because he or she is terminated and later reinstated in his or her position as a result of a settlement in or judicial determination of an employment law claim and the reinstatement of benefits is a term of the settlement or judicial determination.

Reinstated insurance will be effective on the date the Employee returns to Active Service. If an Employee did not fully satisfy the Eligibility Waiting Period or the Pre-Existing Condition Limitation (if any) before insurance ended due to an unpaid leave of absence or Temporary Layoff, credit will be given for any time that was satisfied.

TL-009960.00

GENERAL PROVISIONS

Entire Contract
The entire contract will be made up of the Policy, the application of the Employer, a copy of which is attached to the Policy, and the applications, if any, of the Insureds.

Incontestability
All statements made by the Employer or by an Insured are representations not warranties. No statement will be used to deny or reduce benefits or as a defense to a claim, unless a copy of the instrument containing the statement is signed by and has been furnished to the claimant. In the event of death or legal incapacity, the beneficiary or representative must receive the copy.

After two years from an Insured's effective date of insurance, or from the effective date of any added or increased benefits, the validity of an Insured's coverage will not be contested using such statements.

Policy Changes
No change in the Policy will be valid until approved by an executive officer of the Insurance Company. This approval must be endorsed on, or attached to, the Policy. No agent of Ours or the Policyholder may change the Policy or waive any of its provisions.

Workers' Compensation Insurance
The Policy is not in lieu of and does not affect any requirements for insurance under any Workers' Compensation Insurance Law.

Certificates
An individual certificate of insurance will be delivered to the Employer for delivery to Insureds. Each certificate will list the benefits, conditions and limits of the Policy. It will state to whom benefits will be paid.

Assignment of Benefits
The Insurance Company will not be affected by the assignment of an Insured's certificate until the original assignment or a certified copy of the assignment is filed with the Insurance Company. The Insurance Company will not be responsible for the validity or sufficiency of an assignment. An assignment of benefits will operate so long as the assignment remains in force provided insurance under the Policy is in effect. This insurance may not be levied on, attached, garnisheed, or otherwise taken for a person's debts. This prohibition does not apply where contrary to law.

Clerical Error
A person's insurance will not be affected by error or delay by Insurance Company or Employer in keeping records of insurance under the Policy. If such an error is found, the premium will be adjusted fairly.

Agency
The Employer is the agent of the Employee for transactions relating to insurance under the Policy. The Insurance Company is not liable for any of their acts or omissions.

TL-004726a (TX)

DEFINITIONS

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout this document. The definition of any word, if not defined in the text where it is used, may be found in this Definitions section or in the Schedules of Benefits or on the Policy cover page.

Accident
An Accident is a sudden, unforeseeable external event that causes bodily Injury to an Insured while coverage is in force under the Policy.

Active Service
An Employee is in Active Service on a day which is one of the Employer's scheduled work days if either of the following conditions are met.

1. The Employee is performing his or her regular occupation for the Employer on a full-time basis. He or she must be working at one of the Employer's usual places of business or at some location to which the employer's business requires an Employee to travel.
2. The day is a scheduled holiday or vacation day and the Employee was performing his or her regular occupation on the preceding scheduled work day.

An Employee is in Active Service on a day which is not one of the Employer's scheduled work days only if he or she was in Active Service on the preceding scheduled work day.

Annual Enrollment Period
The period in each calendar year when an eligible Employee may enroll for or change benefit elections under the Policy. This period must be agreed upon by the Employer and the Insurance Company.

Appropriate Care
Appropriate Care means the Employee:
1. Has received treatment, care and advice from a Physician who is qualified and experienced in the diagnosis and treatment of the conditions causing Disability. If the condition is of a nature or severity that it is customarily treated by a recognized medical specialty, the Physician is a practitioner in that specialty.
2. Continues to receive such treatment, care or advice as often as is required for treatment of the conditions causing Disability.
3. Adheres to the treatment plan prescribed by the Physician, including the taking of medications.

Disability Earnings
Any wage or salary for any work performed for any employer during the Employee's Disability, including commissions, bonus, overtime pay or other extra compensation.

Employee
For eligibility purposes, an Employee is an employee of the Employer in one of the "Classes of Eligible Employees." Otherwise, Employee means an employee of the Employer who is insured under the Policy.

Employer
The Policyholder and any affiliates or subsidiaries covered under the Policy. The Employer is acting as an agent of the Insured for transactions relating to this insurance. The actions of the Employer shall not be considered the actions of the Insurance Company.

Full-time
Full-time means the number of hours set by the Employer as a regular work day for Employees in the Employee's eligibility class.

Furlough
Furlough means a temporary suspension or alteration of Active Service initiated by the Employer, for a period of time specified in advance not to exceed 30 days at a time.

Good Cause
A medical reason preventing participation in the Rehabilitation Plan. Satisfactory proof of Good Cause must be provided to the Insurance Company.

Injury
Any accidental loss or bodily harm which results directly and independently of all other causes from an Accident.

Insurance Company
The Insurance Company underwriting the Policy is named on the Policy cover page.

Insured
A person who is eligible for insurance under the Policy, for whom insurance is elected, the required premium is paid and coverage is in force under the Policy.

Physician
Physician means a licensed doctor practicing within the scope of his or her license and rendering care and treatment to an Insured that is appropriate for the condition and locality. The term does not include an Employee, an Employee's spouse, the immediate family (including parents, children, siblings or spouses of any of the foregoing, whether the relationship derives from blood or marriage) of an Employee or spouse, or a person living in an Employee's household.

Prior Plan
The Prior Plan refers to the plan of insurance providing similar benefits sponsored by the Employer in effect directly prior to the Policy Effective Date. A Prior Plan will include the plan of the Policyholder in effect on the day prior to the Policyholder's commencement of this Policy after the Policy Effective Date.

Regular Occupation
The occupation the Employee routinely performs at the time the Disability begins. In evaluating the Disability, the Insurance Company will consider the duties of the occupation as it is normally performed in the general labor market in the national economy. It is not work tasks that are performed for a specific employer or at a specific location.

Rehabilitation Plan
A written plan designed to enable the Employee to return to work. The Rehabilitation Plan will consist of one or more of the following phases:

1. rehabilitation, under which the Insurance Company may provide, arrange or authorize educational, vocational or physical rehabilitation or other appropriate services;
2. work, which may include modified work and work on a part-time basis.

Sickness
Any physical or mental illness.

Temporary Layoff
Temporary Layoff means a temporary suspension of Active Service for a period of time determined in advance by the Employer, other than a Furlough as defined. Temporary Layoff does not include the permanent termination of Active Service (including but not limited to a job elimination), which shall be treated as termination of employment.

TL-007500.44 as modified by TL-009980

IMPORTANT CHANGES FOR STATE REQUIREMENTS

If an Employee resides in one of the following states, the provisions of the certificate are modified for residents of the following states. The modifications listed apply only to residents of that state.

Louisiana residents:

The percentage of Covered Earnings, if any, that qualifies an insured to meet the definition of Disability/Disabled may not be less than 80%.

Minnesota residents:

The Pre-existing Condition Limitation, if any, may not be longer than 24 months from the insured's most recent effective date of insurance.

LIFE INSURANCE COMPANY OF NORTH AMERICA
PHILADELPHIA, PA 19192-2235

We, Travis County, whose main office address is Austin, TX, hereby approve and accept the terms of Group Policy Number VDT-960952 issued by the LIFE INSURANCE COMPANY OF NORTH AMERICA.

This form is to be signed in duplicate. One part is to be retained by Travis County; the other part is to be returned to the LIFE INSURANCE COMPANY OF NORTH AMERICA.

Travis County

Signature and Title: ______________________________ Date: ____________________

(This Copy Is To Be Returned To LIFE INSURANCE COMPANY OF NORTH AMERICA)

LIFE INSURANCE COMPANY OF NORTH AMERICA
PHILADELPHIA, PA 19192-2235

We, Travis County, whose main office address is Austin, TX, hereby approve and accept the terms of Group Policy Number VDT-960952 issued by the LIFE INSURANCE COMPANY OF NORTH AMERICA.

This form is to be signed in duplicate. One part is to be retained by Travis County; the other part is to be returned to the LIFE INSURANCE COMPANY OF NORTH AMERICA.

Travis County

Signature and Title: ______________________________ Date: ____________________

(This Copy Is To Be Retained By Travis County)

Attachment IC-5

Policy Number VDT 960953
Long Term Disability

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call the toll-free telephone number for information or to make a complaint at:

1-800-547-5515

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may write the
Texas Department of Insurance
P.O. Box 149091
Austin, TX 78714-9104
FAX # (512) 475-1771

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim you should contact the agent or company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

TL-004426

AVISO IMPORTANTE

Para solicitar información o presentar una queja:

Usted puede llamar al numero de telefono gratis para información o pare someter una queja al:

1-800-547-5515

Puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos o quejas llamando al:

1-800-252-3439

También puede escribir al Texas Department of Insurance (Departamento de Seguros de Texas)
P.O. Box 149091
Austin, TX 78714-9104
FAX # (512) 475-1771

CONFLICTOS POR PRIMAS O RECLAMACIONES: En caso de tener un conflicto relacionado con su prima o una reclamación, debe comunicarse primero con el agente o la compañía. Si el conflicto no se resuelve, usted puede comunicarse con el Departamento de Seguros de Texas.

UNA ESTE AVISO A SU POLIZA: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE, ACCIDENT, HEALTH AND HOSPITAL SERVICE INSURANCE GUARANTY ASSOCIATION
(For insurers declared insolvent or impaired on or after September 1, 2005)

Texas law establishes a system, administered by the Texas Life, Accident, Health and Hospital Service Insurance Guaranty Association (the "Association"), to protect Texas policyholders if their life or health insurance company fails. Only the policyholders of insurance companies which are members of the Association are eligible for this protection which is subject to the terms, limitations, and conditions of the Association law. (The law is found in the *Texas Insurance Code,* Chapter 463.)

It is possible that the Association may not cover your policy in full or in part due to statutory limitations.

ELIGIBILITY FOR PROTECTION BY THE ASSOCIATION

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas at that time **(irrespective of the policyholder's residency at policy issue)**
- Residents of other states, ONLY if the following conditions are met:
  1) The policyholder has a policy with a company domiciled in Texas;
  2) The policyholder's state of residence has a similar guaranty association; and
  3) The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

LIMITS OF PROTECTION BY THE ASSOCIATION

Accident, Accident and Health, or Health Insurance:

- For each individual covered under one or more policies: up to a total of $500,000 for basic hospital, medical-surgical, and major medical insurance, $300,000 for disability or long term care insurance, and $200,000 for other types of health insurance.

Life Insurance:

- Net cash surrender value or net cash withdrawal value up to a total of $100,000 under one or more policies on any one life; or
- Death benefits up to a total of $300,000 under one or more policies on any one life; or
- Total benefits up to a total of $5,000,000 to any owner of multiple non-group life policies.

Individual Annuities:

- Present value of benefits up to a total of $100,000 under one or more contracts on any one life.

Group Annuities:

- Present value of allocated benefits up to a total of $100,000 on any one life; or
- Present value of unallocated benefits up to a total of $5,000,000 for one contractholder regardless of the number of contracts.

Aggregate Limit:

- $300,000 on any one life with the exception of the $500,000 health insurance limit, the $5,000,000 multiple owner life insurance limit, and the $5,000,000 unallocated group annuity limit.

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage.

Texas Life, Accident, Health and Hospital
Service Insurance Guaranty Association
6504 Bridge Point Parkway, Suite 450
Austin, Texas 78730
800-982-6362 or www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439 or www.tdi.state.tx.us

LIFE INSURANCE COMPANY OF NORTH AMERICA
1601 CHESTNUT STREET
PHILADELPHIA, PA 19192-2235
(800) 732-1603 TDD (800) 552-5744
A STOCK INSURANCE COMPANY

GROUP POLICY

POLICYHOLDER: Travis County

POLICY NUMBER: VDT-960953

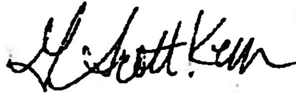
POLICY DESCRIPTION: Long Term Disability Insurance

POLICY EFFECTIVE DATE: October 1, 2011

POLICY ANNIVERSARY DATE: October 1

This Policy describes the terms and conditions of coverage. It is issued in Texas and shall be governed by its laws. The Policy goes into effect on the Policy Effective Date, 12:01 a.m. at the Policyholder's address.

In return for the required premium, the Insurance Company and the Policyholder have agreed to all the terms of this Policy.



Scott Kern, Corporate Secretary

Matthew G. Manders, President

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SCHEDULE OF BENEFITS

Policy: Group policy identified as Policy Number: VDT-960953 on the policy cover page

Premium Due Date: The last day of each month

Classes of Eligible Employees

Class 1 All active, Full-time Employees of the Employer regularly working a minimum of 20 hours per week.

SCHEDULE OF BENEFITS FOR CLASS 1

Eligibility Waiting Period

For Employees hired on or before the Policy Effective Date:
The first of the month following 30 calendar days after the date of hire.

For Employees hired after the Policy Effective Date:
The first of the month following 30 calendar days after the date of hire.

Definition of Disability/Disabled
The Employee is considered Disabled if, solely because of Injury or Sickness, he or she is:
1. unable to perform the material duties of his or her Regular Occupation; and
2. unable to earn 80% or more of his or her Indexed Earnings from working in his or her Regular Occupation.

After Disability Benefits have been payable for 24 months, the Employee is considered Disabled if, solely due to Injury or Sickness, he or she is:
1. unable to perform the material duties of any occupation for which he or she is, or may reasonably become, qualified based on education, training or experience; and
2. unable to earn 60% or more of his or her Indexed Earnings.

The Insurance Company will require proof of earnings and continued Disability.

Definition of Covered Earnings
Covered Earnings means an Employee's wage or salary as reported as of August 31st of each year by the Employer for work performed for the Employer as in effect just prior to the date Disability begins. Covered Earnings are determined initially on the date an Employee applies for coverage. A change in the amount of Covered Earnings is effective on August 31st, if the Employer gives us written notice of the change and the required premium is paid.

It does not include amounts received as bonus, commissions, overtime pay or other extra compensation.

Any increase in an Employee's Covered Earnings will not be effective during a period of continuous Disability.

Elimination Period	90 calendar days
Gross Disability Benefit	The lesser of 60% of an Employee's monthly Covered Earnings rounded to the nearest dollar or the Maximum Disability Benefit.
Maximum Disability Benefit	$6,000 per month
Minimum Disability Benefit	The greater of $100 or 10% of an Employee's Monthly Benefit prior to any reductions for Other Income Benefits.

Disability Benefit Calculation

Disability Benefits means either the Minimum Disability Benefit or what remains of the Gross Disability Benefit after the following disability benefit calculations are completed, whichever is larger.

The Disability Benefit payable to the Employee is figured using the Gross Disability Benefit, Other Income Benefits and the Return to Work Incentive. Monthly Benefits are based on a 30-day month. The Disability Benefit will be prorated if payable for any period less than a month.

During any month the Employee has no Disability Earnings, the monthly benefit payable is the Gross Disability Benefit less Other Income Benefits. During any month the Employee has Disability Earnings, benefits are determined under the Return to Work Incentive. Benefits will not be less than the minimum benefit shown in the Schedule of Benefits except as provided under the section Minimum Benefit.

"Other Income Benefits" means any benefits listed in the Other Income Benefits provision that an Employee receives on his or her own behalf.

Return to Work Incentive

During any month the Employee has Disability Earnings, his or her benefits will be calculated as follows.

The Employee's monthly benefit payable will be calculated as follows during the first 24 months disability benefits are payable and the Employee has Disability Earnings:

1. Add the Employee's Gross Disability Benefit and Disability Earnings.
2. Compare the sum from 1. to the Employee's Indexed Earnings.
3. If the sum from 1. exceeds 100% of the Employee's Indexed Earnings, then subtract the Indexed Earnings from the sum in 1.
4. The Employee's Gross Disability Benefit will be reduced by the difference from 3., as well as by Other Income Benefits.
5. If the sum from 1. does not exceed 100% of the Employee's Indexed Earnings, the Employee's Gross Disability Benefit will be reduced by Other Income Benefits.

After disability benefits are payable for 24 months, the monthly benefit payable is the Gross Disability Benefit reduced by Other Income Benefits and 50% of Disability Earnings.

No Disability Benefits will be paid, and insurance will end if the Insurance Company determines the Employee is able to work under a modified work arrangement and he or she refuses to do so without Good Cause.

Additional Benefits

Catastrophic Disability Benefit

Amount of Benefit:	20% of an Employee's monthly Covered Earnings to a maximum monthly benefit of $5,000.

Survivor Benefit

Amount of Benefit:	100% of the sum of the last full Disability Benefit plus the amount of any Disability Earnings by which the benefit had been reduced for that month.
Maximum Benefit Period	A single lump sum payment equal to 6 monthly Survivor Benefits.

Maximum Benefit Period
The later of the Employee's SSNRA* or the Maximum Benefit Period listed below.

Age When Disability Begins	Maximum Benefit Period
Age 62 or under	The Employee's 65th birthday or the date the 42nd Monthly Benefit is payable, if later.
Age 63	The date the 36th Monthly Benefit is payable.
Age 64	The date the 30th Monthly Benefit is payable.
Age 65	The date the 24th Monthly Benefit is payable.
Age 66	The date the 21st Monthly Benefit is payable.
Age 67	The date the 18th Monthly Benefit is payable.
Age 68	The date the 15th Monthly Benefit is payable.
Age 69 or older	The date the 12th Monthly Benefit is payable.

*SSNRA means the Social Security Normal Retirement Age in effect under the Social Security Act on the Policy Effective Date.

Initial Premium Rates

$.50 per $100 of Covered Payroll

Covered Payroll for an Employee will mean his or her Covered Earnings as reported as of the August 31st prior to the date the determination is made. However, an Employee's Covered Payroll will not include any part of his or her monthly Covered Earnings which exceed $10,000.

TL-004774

ELIGIBILITY FOR INSURANCE

An Employee in one of the Classes of Eligible Employees shown in the Schedule of Benefits is eligible to be insured on the Policy Effective Date, or the day after he or she completes the Eligibility Waiting Period, if later. The Eligibility Waiting Period is the period of time the Employee must be in Active Service to be eligible for coverage. It will be extended by the number of days the Employee is not in Active Service.

Except as noted in the Reinstatement Provision, if an Employee terminates coverage and later wishes to reapply, or if a former Employee is rehired, a new Eligibility Waiting Period must be satisfied. An Employee is not required to satisfy a new Eligibility Waiting Period if insurance ends because he or she is no longer in a Class of Eligible Employees, but continues to be employed and within one year becomes a member of an eligible class.

TL-004710

EFFECTIVE DATE OF INSURANCE

An Employee who is required to contribute to the cost of this insurance may elect to be insured only by authorizing payroll deduction in a form approved by the Employer and the Insurance Company. The effective date of this insurance depends on the date coverage is elected.

Insurance becomes effective for an eligible Employee who applies and agrees to make required contributions subject to the provision below:

1. New hires. Coverage is effective first of the month following 30 calendar days from the date of hire.
2. Life Status Change. Coverage will become effective first of the month following the date of the change.
3. Annual Enrollment. Coverage becomes effective on the Policy Anniversary Date.

If an Employee is not in Active Service on the date insurance would otherwise be effective, it will be effective on the date he or she returns to any occupation for the Employer on a Full-time basis.

TL-004712

TERMINATION OF INSURANCE

An Employee's coverage will end on the last day of the month after the earliest of the following dates:

1. the date the Employee is eligible for coverage under a plan intended to replace this coverage;
2. the date the Policy is terminated;
3. the date the Employee is no longer in an eligible class;
4. the day after the end of the period for which premiums are paid;
5. the date the Employee is no longer in Active Service;
6. the date benefits end for failure to comply with the terms and conditions of the Policy.

Disability Benefits will be payable to an Employee who is entitled to receive Disability Benefits when the Policy terminates, if he or she remains disabled and meets the requirements of the Policy. Any period of Disability, regardless of cause, that begins when the Employee is eligible under another group disability coverage provided by any employer, will not be covered.

TL-007505.00

CONTINUATION OF INSURANCE

This Continuation of Insurance provision modifies the Termination of Insurance provision to allow insurance to continue under certain circumstances if the Insured Employee is no longer in Active Service. Insurance that is continued under this provision is subject to all other terms of the Termination of Insurance provisions.

Disability Insurance continues if an Employee's Active Service ends due to a Disability for which benefits under the Policy are or may become payable. Premiums for the Employee will be waived while Disability Benefits are payable. If the Employee does not return to Active Service, this insurance ends when the Disability ends or when benefits are no longer payable, whichever occurs first.

If an Employee's Active Service ends due to an approved leave pursuant to the Family and Medical Leave Act (FMLA), insurance will continue up to the later of the period of his or her approved FMLA leave or the leave period required by law in the state in which he or she is employed. Premiums are required for this coverage.

If an Employee's Active Service ends due to medical leave of absence approved in writing by the Employer, insurance will continue for an Employee for up to 12 months. Premiums are required for this coverage. An approved leave of absence does not include Furlough, Temporary Layoff or termination of employment.

If an Employee's Active Service ends due to non-medical administrative leave of absence approved in writing by the Employer in accordance with Employer's reporting requirements, insurance will continue for an Employee for up to 12 months. Premiums are required for this coverage. An approved leave of absence does not include Furlough, Temporary Layoff or termination of employment.

If an Employee's Active Service ends due to Temporary Layoff, insurance will continue for an Employee for up to the end of the month in which the layoff begins. Premiums are required for this coverage.

If an Employee's Active Service ends due to any other excused short term absence from work that is reported to the Employer timely in accordance with the Employer's reporting requirements for such short term absence, insurance for an Employee will continue until the last day of the month in which the earliest of the following occurs:

a. the date the Employee's employment relationship with the Employer terminates;
b. the date premiums are not paid when due;
c. the end of the 30 day period that begins with the first day of such excused absence;
d. the end of the period for which such short term absence is excused by the Employer.

Notwithstanding any other provision of this policy, if an Employee's Active Service ends due to termination of employment or any other termination of the employment relationship, insurance will terminate and Continuation of Insurance under this provision will not apply.

If an Employee's insurance is continued pursuant to this Continuation of Insurance provision, and he or she becomes Disabled during such period of continuation, Disability Benefits will not begin until the later of the date the Elimination Period is satisfied or the date he or she is scheduled to return to Active Service.

TL-009970.00

TAKEOVER PROVISION

This provision applies only to Employees eligible under this Policy who were covered for long term disability coverage on the day prior to the Policy Effective Date under the Prior Plan provided by the Policyholder or by an entity that has been acquired by the Policyholder.

A. This section A applies to Employees who are not in Active Service on the day prior to the Policy Effective Date due to a reason for which the Prior Plan and this Policy both provide for continuation of insurance. If required premium is paid when due, the Insurance Company will insure an Employee to which this section applies against a Disability that occurs after the Policy Effective Date for the affected employee group. This coverage will be provided until the earlier of the date: (a) the Employee returns to Active Service, (b) continuation of insurance under the Prior Plan would end but for termination of that plan; or (c) the date continuation of insurance under this Policy would end if computed from the first day the Employee was not in Active Service. The Policy will provide this coverage as follows:

   1. If benefits for a disability are covered under the Prior Plan, no benefits are payable under this Plan.
   2. If the Disability is not a covered disability under the Prior Plan solely because the plan terminated, benefits payable under this Policy for that Disability will be the lesser of: (a) the disability benefits that would have been payable under the Prior Plan; and (b) those provided by this Policy. Credit will be given for partial completion under the Prior Plan of Elimination Periods and partial satisfaction of pre-existing condition limitations.

B. The Elimination Period under this Policy will be waived for a Disability which begins while the Employee is insured under this Policy if all of the following conditions are met:

   1. The Disability results from the same or related causes as a Disability for which monthly benefits were payable under the Prior Plan;
   2. Benefits are not payable for the Disability under the Prior Plan solely because it is not in effect;
   3. An Elimination Period would not apply to the Disability if the Prior Plan had not ended;
   4. The Disability begins within 6 months of the Employee's return to Active Service and the Employee's insurance under this Policy is continuous from this Policy's Effective Date.

C. Except for any amount of benefit in excess of a Prior Plan's benefits, the Pre-existing Condition Limitation will not apply to an Employee covered under a Prior Plan who satisfied the pre-existing condition limitation, if any, under that plan. If an Employee, covered under a Prior Plan, did not fully satisfy the pre-existing condition limitation of that plan, credit will be given for any time that was satisfied under the Prior Plan's pre-existing condition limitation.

   Benefits will be determined based on the lesser of: (1) the amount of the gross disability benefit under the Prior Plan and any applicable maximums; and (2) those provided by this Policy.

   If benefits are payable under the Prior Plan for the Disability, no benefits are payable under this Policy.

TL-005108

DESCRIPTION OF BENEFITS

The following provisions explain the benefits available under the Policy. Please see the Schedule of Benefits for the applicability of these benefits to each class of Insureds.

Disability Benefits
The Insurance Company will pay Disability Benefits if an Employee becomes Disabled while covered under this Policy. The Employee must satisfy the Elimination Period, be under the Appropriate Care of a Physician, and meet all the other terms and conditions of the Policy. He or she must provide the Insurance Company satisfactory proof of Disability before benefits will be paid. The Disability Benefit is shown in the Schedule of Benefits.

The Insurance Company will require continued proof of the Employee's Disability for benefits to continue.

Elimination Period
The Elimination Period is the period of time an Employee must be continuously Disabled before Disability Benefits are payable. The Elimination Period is shown in the Schedule of Benefits.

A period of Disability is not continuous if separate periods of Disability result from unrelated causes.

Disability Benefit Calculation
The Disability Benefit Calculation is shown in the Schedule of Benefits. Monthly Disability Benefits are based on a 30 day period. They will be prorated if payable for any period less than a month. If an Employee is working while Disabled, the Disability Benefit Calculation will be the Return to Work Incentive.

Return to Work Incentive
The Return to Work Incentive is shown in the Schedule of Benefits. An Employee may work for wage or profit while Disabled. In any month in which the Employee works and a Disability Benefit is payable, the Return to Work Incentive applies.

The Insurance Company will, from time to time, review the Employee's status and will require satisfactory proof of earnings and continued Disability.

Minimum Benefit
The Insurance Company will pay the Minimum Benefit shown in the Schedule of Benefits despite any reductions made for Other Income Benefits. The Minimum Benefit will not apply if benefits are being withheld to recover an overpayment of benefits.

Other Income Benefits
An Employee for whom Disability Benefits are payable under this Policy may be eligible for benefits from Other Income Benefits. If so, the Insurance Company may reduce the Disability Benefits by the amount of such Other Income Benefits.

Other Income Benefits include:

1. any amounts received by the Employee under:
   - the Canada and Quebec Pension Plans;
   - the Railroad Retirement Act;
   - any sick leave pay provided by Employer;
   - any work loss provision in mandatory "No-Fault" auto insurance
2. any amounts received (or assumed to be received*) by the Employee under:
   - any local, state, provincial or federal government disability plan or law payable for Injury or Sickness provided as a result of employment with the Employer;
   - any Social Security disability benefits the Employee receives on his or her own behalf because of his or her entitlement to such benefits.
3. any proceeds payable under any similar group insurance or similar plan. If other insurance applies to the same claim for Disability, and contains the same or similar provision for reduction because of other insurance, the Insurance Company will pay for its pro rata share of the total claim. "Pro rata share" means the proportion of the total benefit that the amount payable under one policy, without other insurance, bears to the total benefits under all such policies.
4. any amounts received (or assumed to be received*) by the Employee under any workers' compensation, occupational disease, unemployment compensation law or similar state or federal law payable for Injury or Sickness arising out of work with the Employer, including all permanent and temporary disability benefits. This includes any damages, compromises or settlement paid in place of such benefits, whether or not liability is admitted.
5. any amounts paid because of loss of earnings or earning capacity through settlement, judgment, arbitration or otherwise, where a third party may be liable, regardless of whether liability is determined.

*See the Assumed Receipt of Benefits provision

Increases in Other Income Benefits
Any increase in Other Income Benefits during a period of Disability due to a cost of living adjustment will not be considered in calculating the Employee's Disability Benefits after the first reduction is made for any Other Income Benefits. This section does not apply to any cost of living adjustment for Disability Earnings.

Lump Sum Payments
Other Income Benefits or earnings paid in a lump sum will be prorated over the period for which the sum is given. If no time is stated, the lump sum will be prorated over five years.

If no specific allocation of a lump sum payment is made, then the total payment will be an Other Income Benefit.

Assumed Receipt of Benefits
The Insurance Company will assume the Employee is receiving benefits for which they are eligible from Other Income Benefits if (assumed to be received*) is applicable to the benefit. The Insurance Company will reduce the Employee's Disability Benefits by the amount from Other Income Benefits it estimates are payable to the Employee.

The Insurance Company will waive Assumed Receipt of Benefits, except for Disability Earnings for work the Employee performs while Disability Benefits are payable, if the Employee:

1. provides satisfactory proof of application for Other Income Benefits;
2. signs a Reimbursement Agreement;
3. provides satisfactory proof that all appeals for Other Income Benefits have been made unless the Insurance Company determines that further appeals are not likely to succeed; and
4. submits satisfactory proof that Other Income Benefits were denied.

Social Security Assistance
The Insurance Company may help the Employee in applying for Social Security Disability Income (SSDI) Benefits, and may require the Employee to file an appeal if it believes a reversal of a prior decision is possible.

The Insurance Company will reduce Disability Benefits by the amount it estimates the Employee will receive, if the Employee refuses to cooperate with or participate in the Social Security Assistance Program.

Recovery of Overpayment
The Insurance Company has the right to recover any benefits it has overpaid. The Insurance Company may use any or all of the following to recover an overpayment:
1. request a lump sum payment of the overpaid amount;
2. reduce any amounts payable under this Policy; and/or
3. take any appropriate collection activity available to it.

The Minimum Benefit amount will not apply when Disability Benefits are reduced in order to recover any overpayment.

If an overpayment is due when the Employee dies, any benefits payable under the Policy will be reduced to recover the overpayment.

Successive Periods of Disability
A separate period of Disability will be considered continuous:
1. if it results from the same or related causes as a prior Disability for which benefits were payable; and
2. if, after receiving Disability Benefits, the Employee returns to work in his or her Regular Occupation for less than 6 consecutive months; and
3. if the Employee earns less than the percentage of Indexed Earnings that would still qualify him or her to meet the definition of Disability/Disabled during at least one month.

Any later period of Disability, regardless of cause, that begins when the Employee is eligible for coverage under another group disability plan provided by any employer will not be considered a continuous period of Disability.

For any separate period of disability which is not considered continuous, the Employee must satisfy a new Elimination Period.

LIMITATIONS

Limited Benefit Periods for Mental or Nervous Disorders
The Insurance Company will pay Disability Benefits on a limited basis during an Employee's lifetime for a Disability caused by, or contributed to by, any one or more of the following conditions. Once 24 monthly Disability Benefits have been paid, no further benefits will be payable for any of the following conditions.

a) Anxiety disorders
b) Delusional (paranoid) disorders
c) Depressive disorders
d) Eating disorders
e) Mental illness
f) Somatoform disorders (psychosomatic illness)

If, before reaching his or her lifetime maximum benefit, an Employee is confined in a hospital for more than 14 consecutive days, that period of confinement will not count against his or her lifetime limit. The confinement must be for the Appropriate Care of any of the conditions listed above.

Limited Benefit Periods for Alcoholism and Drug Addiction or Abuse
The Insurance Company will pay Disability Benefits on a limited basis during an Employee's lifetime for a Disability caused by, or contributed to by, any one or more of the following conditions. Once 24 monthly Disability Benefits have been paid, no further benefits will be payable for any of the following conditions.

1) Alcoholism
2) Drug addiction or abuse

If, before reaching his or her lifetime maximum benefit, an Employee is confined in a hospital for more than 14 consecutive days, that period of confinement will not count against his or her lifetime limit. The confinement must be for the Appropriate Care of any of the conditions listed above.

Pre-Existing Condition Limitation
The Insurance Company will not pay benefits for any period of Disability caused or contributed to by, or resulting from, a Pre-existing Condition. A "Pre-existing Condition" means any Injury or Sickness for which the Employee incurred medical expenses, received medical treatment, care or services including diagnostic measures, or took prescribed drugs or medicines within 6 months before his or her most recent effective date of insurance.

This limitation will not apply to a period of Disability that begins after an Employee has been in Active Service for a continuous period of 12 months during which the Employee has received no medical treatment, care or services in connection with the pre-existing conditions or is covered for at least 24 months after his or her most recent effective date of insurance, or the effective date of any added or increased benefits.

TL-007500.44

ADDITIONAL BENEFITS

Rehabilitation During a Period of Disability
If the Insurance Company determines that a Disabled Employee is a suitable candidate for rehabilitation, the Insurance Company may require the Employee to participate in a Rehabilitation Plan and assessment at its expense. The Insurance Company has the sole discretion to approve the Employee's participation in a Rehabilitation Plan and to approve a program as a Rehabilitation Plan. The Insurance Company will work with the Employee, the Employer and the Employee's Physician and others, as appropriate, to perform the assessment, develop a Rehabilitation Plan, and discuss return to work opportunities.

The Rehabilitation Plan may, at the Insurance Company's discretion, allow for payment of the Employee's medical expense, education expense, moving expense, accommodation expense or family care expense while he or she participates in the Rehabilitation Plan.

If an Employee fails to fully cooperate in all required phases of the Rehabilitation Plan and assessment without Good Cause, no Disability Benefits will be paid, and insurance will end.

TL-007501.00

Catastrophic Disability Benefit

Definitions
The definitions that follow apply to this benefit provision. They are in addition to those definitions in the General Definitions section.

"Activities of Daily Living" are:
1. Bathing (i.e., washing oneself in a shower or tub, including getting into or out of the tub or shower, or washing oneself by sponge bath.)
2. Dressing oneself by putting on and taking off from one's own body all items of clothing and needed braces, fasteners and artificial limbs.
3. Continence (i.e., the ability to maintain control of one's own bowel and bladder function; or when unable to maintain bowel or bladder function, the ability to perform associated hygiene, including caring for a catheter or colostomy bag).
4. Toileting oneself by getting to and from the toilet, getting on and off the toilet, and performing personal hygiene associated with toileting.
5. Feeding oneself by getting nourishment into the one's own body either from eating food that is made available to you in receptacle such as a plate, cup or table, or by feeding oneself by a feeding tube or intravenously.
6. Transferring (i.e., the ability to get oneself into or out of a bed, a chair or wheelchair; or the ability to move from place to place either by walking, use of a wheelchair, or some other means).

"Catastrophic Disability" means the Employee is:
1. Unable to perform, without Substantial Assistance, at least two Activities of Daily Living, or
2. Has a severe Cognitive Impairment that requires Substantial Supervision to protect the Employee or others from threats to health and safety.

"Cognitive Impairment" means the loss or deterioration in intellectual capacity that meets these requirements:
1. The loss or deterioration in intellectual capacity is comparable to and includes Alzheimer's disease and similar forms of irreversible dementia;
2. The loss or deterioration in intellectual capacity is measured by clinical evidence and standardized tests that reliably measure impairment in the individual's short-term and long-term memory, orientation as to person, place, or time and deductive or abstract reasoning.

"Substantial Assistance" means the physical assistance of another person without which the Employee would not be able to perform an activity of daily living; or the constant presence of another person within arm's reach that is necessary to prevent, by physical intervention, injury to the Employee while the Employee is performing an activity of daily living.

"Substantial Supervision" means continual oversight that may include cueing by verbal prompting, gestures, or other demonstrations by another person, and which is needed to protect the Employee from threats to health and safety.

Benefits Payable
Catastrophic Disability Benefits are payable when the Insurance Company determines that the Employee has a Catastrophic Disability that is due to the same sickness or injury for which Disability Benefits are payable under this Policy.

The benefits are payable only while these conditions are met:
1. The Employee is receiving monthly Disability Benefits under the Policy.
2. The Employee's Catastrophic Disability lasted for at least the Elimination Period duration shown in the Schedule of Benefits.
3. The Employee submits, at his/her own expense, satisfactory proof of Catastrophic Disability to the Insurance Company, when required by the Insurance Company.

Amount Payable
Benefits are payable monthly at the Catastrophic Disability Rate shown is the Schedule of Benefits. This benefit will not be reduced by any other source of income.

For periods of less than one month, the Insurance Company will pay $1/30^{th}$ of the monthly benefit for Catastrophic Disability for each day.

Termination of Benefits
Catastrophic Disability Benefits end on the earliest to occur of:
1. the date the Employee's Catastrophic Disability ends;
2. the date the Employee is no longer receiving monthly disability benefits under the Policy;
3. the date the Employee fails to submit proof of continuing Catastrophic Disability; or
4. the date the Employee dies.
5. the end of the Maximum Benefit Period shown in the Schedule of Benefits.

No survivor benefits are payable for the Catastrophic Disability Benefit.

TL-008895-1

Survivor Benefit
The Insurance Company will pay a Survivor Benefit if an Employee dies while Monthly Benefits are payable. The Employee must have been continuously Disabled before the first benefit is payable. These benefits will be payable for the Maximum Benefit Period for Survivor Benefits.

Benefits will be paid to the Employee's Spouse. If there is no Spouse, benefits will be paid in equal shares to the Employee's surviving Children. If there are no Spouse and no Children, benefits will be paid to the Employee's estate.

"Spouse" means an Employee's lawful spouse. "Children" means an Employee's unmarried children under age 21 who are chiefly dependent upon the Employee for support and maintenance. The term includes a stepchild living with the Employee at the time of his or her death.

TL-005107

TERMINATION OF DISABILITY BENEFITS

Benefits will end on the earliest of the following dates:

1. the date the Employee earns from any occupation, more than the percentage of Indexed Earnings set forth in the definition of Disability applicable to him or her at that time;
2. the date the Insurance Company determines he or she is not Disabled;
3. the end of the Maximum Benefit Period;
4. the date the Employee dies;
5. the date the Employee refuses, without Good Cause, to fully cooperate in all required phases of the Rehabilitation Plan and assessment;
6. the date the Employee is no longer receiving Appropriate Care;
7. the date the Employee fails to cooperate with the Insurance Company in the administration of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Benefits may be resumed if the Employee begins to cooperate fully in the Rehabilitation Plan within 30 days of the date benefits terminated.

TL-007502.00

EXCLUSIONS

The Insurance Company will not pay any Disability Benefits for a Disability that results, directly or indirectly, from:

1. suicide, attempted suicide, or self-inflicted injury while sane or insane;
2. war or any act of war, whether or not declared;
3. active participation in a riot;
4. commission of a felony or;
5. the revocation, restriction or non-renewal of an Employee's license, permit or certification necessary to perform the duties of his or her occupation unless due solely to Injury or Sickness otherwise covered by the Policy.

In addition, the Insurance Company will not pay Disability Benefits for any period of Disability during which the Employee is incarcerated in a penal or corrections institution.

TL-007503.00

CLAIM PROVISIONS

Notice of Claim

Written notice, or notice by any other electronic/telephonic means authorized by the Insurance Company, must be given to the Insurance Company within 31 days after a covered loss occurs or begins or as soon as reasonably possible. If written notice, or notice by any other electronic/telephonic means authorized by the Insurance Company, is not given in that time, the claim will not be invalidated or reduced if it is shown that notice was given as soon as was reasonably possible. Notice can be given at our home office in Philadelphia, Pennsylvania or to our agent. Notice should include the Employer's Name, the Policy Number and the claimant's name and address.

Claim Forms

When the Insurance Company receives notice of claim, the Insurance Company will send claim forms for filing proof of loss. If claim forms are not sent within 15 days after notice is received by the Insurance Company, the proof requirements will be met by submitting, within the time required under the "Proof of Loss" section, written proof, or proof by any other electronic/telephonic means authorized by the Insurance Company, of the nature and extent of the loss.

Claimant Cooperation Provision
Failure of a claimant to cooperate with the Insurance Company in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Insurance Data
The Employer is required to cooperate with the Insurance Company in the review of claims and applications for coverage. Any information the Insurance Company provides in these areas is confidential and may not be used or released by the Employer if not permitted by applicable privacy laws.

Proof of Loss
Written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, must be given to the Insurance Company within 90 days after the date of the loss for which a claim is made. If written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, is not given in that 90 day period, the claim will not be invalidated nor reduced if it is shown that it was given as soon as was reasonably possible. In any case, written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, must be given not more than one year after that 90 day period. If written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, is provided outside of these time limits, the claim will be denied. These time limits will not apply while the person making the claim lacks legal capacity.

Written proof, or proof by any other electronic/telephonic means authorized by the Insurance Company, that the loss continues must be furnished to the Insurance Company at intervals required by us. Within 30 days of a request, written proof of continued Disability and Appropriate Care by a Physician must be given to the Insurance Company.

Time of Payment
Disability Benefits will be paid at regular intervals of not less frequently than once a month. Any balance, unpaid at the end of any period for which the Insurance Company is liable, will be paid at that time.

To Whom Payable
Disability Benefits will be paid to the Employee. If any person to whom benefits are payable is a minor or, in the opinion of the Insurance Company, is not able to give a valid receipt, such payment will be made to his or her legal guardian. However, if no request for payment has been made by the legal guardian, the Insurance Company may, at its option, make payment to the person or institution appearing to have assumed custody and support.

If an Employee dies while any Disability Benefits remain unpaid, the Insurance Company may, at its option, make direct payment to any of the following living relatives of the Employee: spouse, mother, father, children, brothers or sisters; or to the executors or administrators of the Employee's estate. The Insurance Company may reduce the amount payable by any indebtedness due.

Payment in the manner described above will release the Insurance Company from all liability for any payment made.

Physical Examination and Autopsy
The Insurance Company, at its expense, will have the right to examine any person for whom a claim is pending as often as it may reasonably require. The Insurance Company may, at its expense, require an autopsy unless prohibited by law.

Legal Actions
No action at law or in equity may be brought to recover benefits under the Policy less than 60 days after written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, has been furnished as required by the Policy. No such action shall be brought more than 4 years after the time satisfactory proof of loss is required to be furnished.

Time Limitations
If any time limit stated in the Policy for giving notice of claim or proof of loss, or for bringing any action at law or in equity, is less than that permitted by the law of the state in which the Employee lives when the Policy is issued, then the time limit provided in the Policy is extended to agree with the minimum permitted by the law of that state.

Physician/Patient Relationship
The Insured will have the right to choose any Physician who is practicing legally. The Insurance Company will in no way disturb the Physician/patient relationship.

TL-004724a (TX)

ADMINISTRATIVE PROVISIONS

Premiums
The premiums for this Policy will be based on the rates currently in force, the plan and the amount of insurance in effect.

Changes in Premium Rates
The premium rates may be changed by the Insurance Company from time to time with at least 180 days advance written notice but only on the Policy Anniversary Date. No change in rates will be made until 48 months after the Effective Date. An increase in rates will not be made more often than once in a 12 month period and only on the Policy Anniversary Date. However, the Insurance Company reserves the right to change the rates even during a period for which the rate is guarantee, if any of the following events take place.

1. The Policy terms change.
2. A division, subsidiary, eligible company, or class is added or deleted.
3. There is a change of more than 10% in the number of Insureds.
4. Federal or state laws or regulation affecting benefit obligations change.
5. Other changes occur in the nature of the risk that would affect the Insurance Company's original risk assessment.
6. The Insurance Company determines the Employer fails to furnish necessary information.

If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a pro rata adjustment will apply from the date of the change to the next Premium Due Date.

Reporting Requirements
The Employer must, upon request, give the Insurance Company any information required to determine who is insured, the amount of insurance in force and any other information needed to administer the plan of insurance.

Payment of Premium
The first premium is due within 30 days of the delivery of the Policy. After that, premiums will be due monthly unless the Employer and the Insurance Company agree on some other method of premium payment.

If any premium is not paid when due, the plan will be canceled as of the Premium Due Date, except as provided in the Policy Grace Period section.

Notice Of Cancellation
The Employer or the Insurance Company may cancel the Policy as of any Premium Due Date by giving 180 days advance written notice. If a premium is not paid when due, the Policy will automatically be canceled as of the Premium Due Date, except as provided in the Policy Grace Period section.

Policy Grace Period
A Policy Grace Period of 31 days will be granted for the payment of the required premiums under this Policy. This Policy will be in force during the Policy Grace Period. The Employer is liable to the Insurance Company for any unpaid premium for the time this Policy was in force.

Grace Period for the Insured
If the required premium is not paid on the Premium Due Date, there is a 31 day grace period after each premium due date after the first. If the required premium is not paid during the grace period, insurance will end on the last day for which premium was paid.

Reinstatement of Insurance
An Employee's insurance may be reinstated if it ends because he or she is on an unpaid leave of absence. If an Employee's Active Service ended due to an approved leave pursuant to the Family and Medical Leave Act (FMLA) and Continuation of Insurance is not applicable, an Employee's insurance may be reinstated at the conclusion of the FMLA leave.

If an Employee's Active Service ends due to an Employer approved unpaid leave of absence, other than an approved FMLA leave, insurance may be reinstated only:

1. If the reinstatement occurs within 12 weeks from the date insurance ends, or
2. When returning from military service pursuant to the Uniformed Services Employment Act of 1994 (USERRA).

For insurance to be reinstated the following conditions must be met:

1. An Employee must be in a Class of Eligible Employees.
2. The required premium must be paid.
3. The Insurance Company must receive a written request for reinstatement within 31 days from the date an Employee returns to Active Service.

An Employee's Insurance may be reinstated if it ends because he or she is terminated and later reinstated in his or her position as a result of a settlement in or judicial determination of an employment law claim and the reinstatement of benefits is a term of the settlement or judicial determination.

Reinstated insurance will be effective on the date the Employee returns to Active Service. If an Employee did not fully satisfy the Eligibility Waiting Period or the Pre-Existing Condition Limitation (if any) before insurance ended due to an unpaid leave of absence or Temporary Layoff, credit will be given for any time that was satisfied.

TL-009960.00

GENERAL PROVISIONS

Entire Contract
The entire contract will be made up of the Policy, the application of the Employer, a copy of which is attached to the Policy, and the applications, if any, of the Insureds.

Incontestability
All statements made by the Employer or by an Insured are representations not warranties. No statement will be used to deny or reduce benefits or as a defense to a claim, unless a copy of the instrument containing the statement is signed by and has been furnished to the claimant. In the event of death or legal incapacity, the beneficiary or representative must receive the copy.

After two years from an Insured's effective date of insurance, or from the effective date of any added or increased benefits, the validity of an Insured's coverage will not be contested using such statements.

Misstatement of Age
If an Insured's age has been misstated, the Insurance Company will adjust all benefits to the amounts that would have been purchased for the correct age.

Policy Changes
No change in the Policy will be valid until approved by an executive officer of the Insurance Company. This approval must be endorsed on, or attached to, the Policy. No agent of the Insurance Company or Employer may change the Policy or waive any of its provisions.

Workers' Compensation Insurance
The Policy is not in lieu of and does not affect any requirements for insurance under any Workers' Compensation Insurance Law.

Certificates
An individual certificate of insurance will be delivered to the Employer for delivery to Insureds. Each certificate will list the benefits, conditions and limits of the Policy. It will state to whom benefits will be paid.

Assignment of Benefits
The Insurance Company will not be affected by the assignment of an Insured's certificate until the original assignment or a certified copy of the assignment is filed with the Insurance Company. The Insurance Company will not be responsible for the validity or sufficiency of an assignment. An assignment of benefits will operate so long as the assignment remains in force provided insurance under the Policy is in effect. This insurance may not be levied on, attached, garnisheed, or otherwise taken for a person's debts. This prohibition does not apply where contrary to law.

Clerical Error
A person's insurance will not be affected by error or delay by the Insurance Company or Employer in keeping records of insurance under the Policy. If such an error is found, the premium will be adjusted fairly.

Agency
The Employer is the agent of the Employee for transactions relating to insurance under the Policy. The Insurance Company is not liable for any of their acts or omissions.

DEFINITIONS

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout this document. The definition of any word, if not defined in the text where it is used, may be found in this Definitions section or in the Schedules of Benefits or on the Policy cover page.

Active Service
An Employee is in Active Service on a day which is one of the Employer's scheduled work days if either of the following conditions are met.

1. The Employee is performing his or her regular occupation for the Employer on a full-time basis. He or she must be working at one of the Employer's usual places of business or at some location to which the employer's business requires an Employee to travel.
2. The day is a scheduled holiday or vacation day and the Employee was performing his or her regular occupation on the preceding scheduled work day.

An Employee is in Active Service on a day which is not one of the Employer's scheduled work days only if he or she was in Active Service on the preceding scheduled work day.

Annual Enrollment Period
The period in each calendar year when an eligible Employee may enroll for or change benefit elections under the Policy. This period must be agreed upon by the Employer and the Insurance Company.

Appropriate Care
Appropriate Care means the Employee:
1. Has received treatment, care and advice from a Physician who is qualified and experienced in the diagnosis and treatment of the conditions causing Disability. If the condition is of a nature or severity that it is customarily treated by a recognized medical specialty, the Physician is a practitioner in that specialty.
2. Continues to receive such treatment, care or advice as often as is required for treatment of the conditions causing Disability.
3. Adheres to the treatment plan prescribed by the Physician, including the taking of medications.

Consumer Price Index (CPI-W)
The Consumer Price Index for Urban Wage Earners and Clerical Workers published by the U.S. Department of Labor. If the index is discontinued or changed, another nationally published index that is comparable to the CPI-W will be used.

Disability Earnings
Any wage or salary for any work performed for any employer during the Employee's Disability, including commissions, bonus, overtime pay or other extra compensation.

Employee
For eligibility purposes, an Employee is an employee of the Employer in one of the "Classes of Eligible Employees." Otherwise, Employee means an employee of the Employer who is insured under the Policy.

Employer
The Policyholder and any affiliates or subsidiaries covered under the Policy. The Employer is acting as an agent of the Insured for transactions relating to this insurance. The actions of the Employer shall not be considered the actions of the Insurance Company.

Full-time
Full-time means the number of hours set by the Employer as a regular work day for Employees in the Employee's eligibility class.

Furlough
Furlough means a temporary suspension or alteration of Active Service initiated by the Employer, for a period of time specified in advance not to exceed 30 days at a time.

Good Cause
A medical reason preventing participation in the Rehabilitation Plan. Satisfactory proof of Good Cause must be provided to the Insurance Company.

Indexed Earnings
For the first 12 months Monthly Benefits are payable, Indexed Earnings will be equal to Covered Earnings. After 12 Monthly Benefits are payable, Indexed Earnings will be an Employee's Covered Earnings plus an increase applied on each anniversary of the date Monthly Benefits became payable. The amount of each increase will be the lesser of:

1. 10% of the Employee's Indexed Earnings during the preceding year of Disability; or
2. the rate of increase in the Consumer Price Index (CPI-W) during the preceding calendar year.

Injury
Any accidental loss or bodily harm which results directly and independently of all other causes from an Accident.

Insurance Company
The Insurance Company underwriting the Policy is named on the Policy cover page.

Insured
A person who is eligible for insurance under the Policy, for whom insurance is elected, the required premium is paid and coverage is in force under the Policy.

Life Status Change
A Life Status Change is an event recognized by the Employer's Flexible Benefits Plan as qualifying an Employee to make changes in benefit selections at a time other than an Annual Enrollment Period.

If there is no Employer sponsored Flexible Benefits Plan, or if it is no longer in effect, the following events are Life Status Changes.

1. Marriage
2. Divorce, annulment or legal separation
3. Birth or adoption of a child
4. Death of a spouse
5. Termination of a spouse's employment
6. A change in the benefit plan available to the Employee's spouse
7. A change in the Employee's or spouse's employment status that affects either's eligibility for benefits

Physician
Physician means a licensed doctor practicing within the scope of his or her license and rendering care and treatment to an Insured that is appropriate for the condition and locality. The term does not include an Employee, an Employee's spouse, the immediate family (including parents, children, siblings or spouses of any of the foregoing, whether the relationship derives from blood or marriage), of an Employee or spouse, or a person living in an Employee's household.

Prior Plan
The Prior Plan refers to the plan of insurance providing similar benefits sponsored by the Employer in effect directly prior to the Policy Effective Date. A Prior Plan will include the plan of the Policyholder in effect on the day prior to the Policyholder's commencement of this Policy after the Policy Effective Date.

Regular Occupation
The occupation the Employee routinely performs at the time the Disability begins. In evaluating the Disability, the Insurance Company will consider the duties of the occupation as it is normally performed in the general labor market in the national economy. It is not work tasks that are performed for a specific employer or at a specific location.

Rehabilitation Plan
A written plan designed to enable the Employee to return to work. The Rehabilitation Plan will consist of one or more of the following phases:

1. rehabilitation, under which the Insurance Company may provide, arrange or authorize educational, vocational or physical rehabilitation or other appropriate services;
2. work, which may include modified work and work on a part-time basis.

Sickness
Any physical or mental illness.

Temporary Layoff
Temporary Layoff means a temporary suspension of Active Service for a period of time determined in advance by the Employer, other than a Furlough as defined. Temporary Layoff does not include the permanent termination of Active Service (including but not limited to a job elimination), which shall be treated as termination of employment.

TL-007500.44 as modified by TL-009980

IMPORTANT CHANGES FOR STATE REQUIREMENTS

If an Employee resides in one of the following states, the provisions of the certificate are modified for residents of the following states. The modifications listed apply only to residents of that state.

Louisiana residents:

The percentage of Indexed Earnings, if any, that qualifies an insured to meet the definition of Disability/Disabled may not be less than 80%.

Minnesota residents:

The Pre-existing Condition Limitation, if any, may not be longer than 24 months from the insured's most recent effective date of insurance.

LIFE INSURANCE COMPANY OF NORTH AMERICA
PHILADELPHIA, PA 19192-2235

We, Travis County, whose main office address is Austin, TX, hereby approve and accept the terms of Group Policy Number VDT-960953 issued by the LIFE INSURANCE COMPANY OF NORTH AMERICA.

This form is to be signed in duplicate. One part is to be retained by Travis County; the other part is to be returned to the LIFE INSURANCE COMPANY OF NORTH AMERICA.

Travis County

Signature and Title: ______________________________________ Date: ________________________

(This Copy Is To Be Returned To LIFE INSURANCE COMPANY OF NORTH AMERICA)

LIFE INSURANCE COMPANY OF NORTH AMERICA
PHILADELPHIA, PA 19192-2235

We, Travis County, whose main office address is Austin, TX, hereby approve and accept the terms of Group Policy Number VDT-960953 issued by the LIFE INSURANCE COMPANY OF NORTH AMERICA.

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Travis County

Signature and Title: ______________________________________ Date: ________________________

(This Copy Is To Be Retained By Travis County)

IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE, ACCIDENT, HEALTH AND HOSPITAL SERVICE INSURANCE GUARANTY ASSOCIATION

(For insurers declared insolvent or impaired on or after September 1, 2005)

Texas law establishes a system, administered by the Texas Life, Accident, Health and Hospital Service Insurance Guaranty Association (the "Association"), to protect Texas policyholders if their life or health insurance company fails. Only the policyholders of insurance companies which are members of the Association are eligible for this protection which is subject to the terms, limitations, and conditions of the Association law. (The law is found in the *Texas Insurance Code*, Chapter 463.)

It is possible that the Association may not cover your policy in full or in part due to statutory limitations.

ELIGIBILITY FOR PROTECTION BY THE ASSOCIATION

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas at that time **(irrespective of the policyholder's residency at policy issue)**
- Residents of other states, ONLY if the following conditions are met:

1) The policyholder has a policy with a company domiciled in Texas;
2) The policyholder's state of residence has a similar guaranty association; and
3) The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

LIMITS OF PROTECTION BY THE ASSOCIATION

Accident, Accident and Health, or Health Insurance:

- For each individual covered under one or more policies: up to a total of $500,000 for basic hospital, medical-surgical, and major medical insurance, $300,000 for disability or long term care insurance, and $200,000 for other types of health insurance.

Life Insurance:

- Net cash surrender value or net cash withdrawal value up to a total of $100,000 under one or more policies on any one life; or
- Death benefits up to a total of $300,000 under one or more policies on any one life; or
- Total benefits up to a total of $5,000,000 to any owner of multiple non-group life policies.

Individual Annuities:

- Present value of benefits up to a total of $100,000 under one or more contracts on any one life.

Group Annuities:

- Present value of allocated benefits up to a total of $100,000 on any one life; or
- Present value of unallocated benefits up to a total of $5,000,000 for one contractholder regardless of the number of contracts.

Aggregate Limit:

- $300,000 on any one life with the exception of the $500,000 health insurance limit, the $5,000,000 multiple owner life insurance limit, and the $5,000,000 unallocated group annuity limit.

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage.

Texas Life, Accident, Health and Hospital
Service Insurance Guaranty Association
6504 Bridge Point Parkway, Suite 450
Austin, Texas 78730
800-982-6362 or www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439 or www.tdi.state.tx.us

CLAIM AUDIT AGREEMENT

THIS AGREEMENT is made between ____ ("Employer"), and **LIFE INSURANCE COMPANY OF NORTH AMERICA** ("Company").

WHEREAS, Company desires to cooperate with requests by group Employers to permit the auditing of its claim administration; and

WHEREAS, Employer recognizes Company's legitimate interests in maintaining the confidentiality of claim information, protecting the proprietary nature of Company's systems and processes, preserving its business reputation, avoiding unnecessary disruption of its claim administration, and protecting itself from legal liability;

IN CONSIDERATION OF the premises and the mutual promises contained herein, Company and the Employer hereby agree as follows regarding an audit (the "Audit") of Company's claim administration:

1. **Audit Specifications.** The Employer will specify to Company in writing at least thirty (30) days prior to the commencement of the Audit the following "Audit Specifications":

   a. the name and title of the individual auditors;

   b. the Claim Office locations to be audited;

   c. the Audit objectives;

   d. the scope of the Audit (time period, lines of coverage and number of claims);

   e. the process by which claims will be selected for audit;

   f. the records/information required by the auditors for purposes of the Audit; and

   g. the length of the time contemplated as necessary to complete the Audit.

2. **Review of Specifications.** Company will have the right to review the Audit Specifications and to require any changes in, or conditions on, the Audit Specifications which may be necessary to protect Company's legal and business interests identified in Paragraph B above.

3. **Access to Information.** Company will make the records/information called for in the Audit Specifications available to the Employer at a mutually acceptable time and place.

4. **Audit Report.** The Employer will provide Company with a copy of its Audit Report.

5. **Comment on Audit Report.** Company reserves the right to provide the Employer with its comments on the Audit Report.

6. **Confidentiality.** The Employer understands that Company is permitting the Employer to review claim records/information solely for purposes of the Audit. Accordingly, the Employer will ensure that all information pertaining to individual insureds will be kept confidential in accordance with all applicable laws and/or regulations. Without limiting the generality of the foregoing, the Employer specifically agrees to adhere to the following conditions:

   a. The Employer shall not make photocopies or remove any of the claim records/information without the express written consent of Company;

   b. The Employer shall not disclose any of the claim records/information to any third party, or to any employee of the Employer not involved in the conduct of the Audit, without the express written consent of Company.

   c. The Employer agrees that its Audit Report or other summary prepared in connection with the Audit shall contain no individually identifiable information.

7. **Indemnification.** The Employer agrees to indemnify, defend and hold the Company, its officers, employees and agents harmless from any loss or damage resulting from the violation of Paragraph 6 hereof by Employer, its officers, employees or agents.

IN WITNESS WHEREOF, and intending to be legally bound, the parties have signed this Agreement.

____
("Employer")

Date______________________ ______________________________
By:
Title:

LIFE INSURANCE COMPANY OF NORTH AMERICA ("Company")

Date______________________ ______________________________
By:
Title:

ATTACHMENT E-1

STATE OF TEXAS}
COUNTY OF TRAVIS}

ETHICS AFFIDAVIT

Date:____

Name of Affiant:________________________________

Title of Affiant:_________________________________

Business Name of Proponent:_______________________

County of Proponent:_____________________________

Affiant on oath swears that the following statements are true:

1. Affiant is authorized by Proponent to make this affidavit for Proponent.
2. Affiant is fully aware of the facts stated in this affidavit.
3. Affiant can read the English language.
4. Proponent has received the list of Key Contracting Persons associated with this solicitation which is attached to this affidavit as Exhibit "A".
5. Affiant has personally read Exhibit "A" to this Affidavit.
6. Affiant has no knowledge of any Key Contracting Person on Exhibit "A" with whom Proponent is doing business or has done business during the 365-day period immediately before the date of this affidavit whose name is not disclosed in the solicitation.

____
Signature of Affiant

____
Address

SUBSCRIBED AND SWORN TO before me by ___________on_________, 20__.

Notary Public, State of

____
Typed or printed name of notary
My commission expires:______________________

Proposer acknowledges that Proposer is doing business or has done business during the 365-day period immediately prior to the date on which this proposal is due with the following key contracting persons and warrants that these are the only such key contracting persons:

____

____

____

____

____

____

If no one is listed above, Proposer warrants that Proposer is not doing business and has not done business during the 365-day period immediately prior to the date on which this proposal is due with any key contracting person.

EXHIBIT A

LIST OF KEY CONTRACTING PERSONS

June 6, 2012

CURRENT

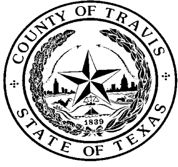
Position Held	Name of Individual Holding Office/Position	Name of Business Individual is Associated
County Judge	Samuel T. Biscoe	
County Judge (Spouse)	Donalyn Thompson-Biscoe	
Executive Assistant	Cheryl Brown	
Executive Assistant	Melissa Velasquez	
Executive Assistant	Josie Z. Zavala	
Executive Assistant	Cheryl Aker	
Commissioner, Precinct 1	Ron Davis	
Commissioner, Precinct 1 (Spouse)	Annie Davis	Seton Hospital
Executive Assistant	Deone Wilhite	
Executive Assistant	Felicitas Chavez	
Commissioner, Precinct 2	Sarah Eckhardt	
Commissioner, Precinct 2 (Spouse)	Kurt Sauer	Daffer McDaniel, LLP
Executive Assistant	Loretta Farb	
Executive Assistant	Joe Hon	
Executive Assistant	Peter Einhorn	
Commissioner, Precinct 3	Karen Huber	
Commissioner, Precinct 3 (Spouse)	Leonard Huber	Retired
Executive Assistant	Garry Brown	
Executive Assistant	Julie Wheeler*	
Executive Assistant	Jacob Cottingham	
Commissioner, Precinct 4	Margaret Gomez	
Executive Assistant	Edith Moreida	
Executive Assistant	Norma Guerra	
County Treasurer	Dolores Ortega-Carter	
County Auditor	Susan Spataro, CPA	
County Executive, Administrative	Vacant	
County Executive, Planning & Budget	Leslie Browder*	
County Executive, Emergency Services	Danny Hobby	
County Executive, Health/Human Services	Sherri E. Fleming	
County Executive, TNR	Steven M. Manilla, P.E.*	
County Executive, Justice & Public Safety	Roger Jefferies	
Director, Facilities Management	Roger El Khoury, M.S., P.E.	
Chief Information Officer	Joe Harlow	
Director, Records Mgnt & Comms	Steven Broberg	
Travis County Attorney	David Escamilla	
First Assistant County Attorney	Steve Capelle	
Executive Assistant, County Attorney	James Collins	
Director, Land Use Division	Tom Nuckols	
Attorney, Land Use Division	Julie Joe	
Attorney, Land Use Division	Christopher Gilmore	
Director, Transactions Division	John Hille	
Attorney, Transactions Division	Vacant	
Attorney, Transactions Division	Daniel Bradford	
Attorney, Transactions Division	Mary Etta Gerhardt	
Attorney, Transactions Division	Barbara Wilson	

Attorney, Transactions Division	Jim Connolly
Attorney, Transactions Division	Tenley Aldredge
Director, Health Services Division	Vacant
Attorney, Health Services Division	Prema Gregerson
Purchasing Agent	Cyd Grimes, C.P.M., CPPO
Assistant Purchasing Agent	Marvin Brice, CPPB
Assistant Purchasing Agent	Bonnie Floyd, CPPO, CPPB, CTPM
Purchasing Agent Assistant IV	Vacant
Purchasing Agent Assistant IV	Lee Perry
Purchasing Agent Assistant IV	Jason Walker
Purchasing Agent Assistant IV	Richard Villareal
Purchasing Agent Assistant IV	Patrick Strittmatter*
Purchasing Agent Assistant IV	Lori Clyde, CPPO, CPPB
Purchasing Agent Assistant IV	Scott Wilson, CPPB
Purchasing Agent Assistant IV	Jorge Talavera, CPPO, CPPB
Purchasing Agent Assistant IV	George R. Monnat, C.P.M., A.P.P.
Purchasing Agent Assistant IV	John E. Pena, CTPM
Purchasing Agent Assistant IV	Rosalinda Garcia
Purchasing Agent Assistant III	Shannon Pleasant, CTPM*
Purchasing Agent Assistant III	David Walch
Purchasing Agent Assistant III	Michael Long, CPPB
Purchasing Agent Assistant III	Loren Breland, CPPB
Purchasing Agent Assistant III	Nancy Barchus, CPPB
Purchasing Agent Assistant III	Jesse Herrera, CTP, CTPM, CTCM*
Purchasing Agent Assistant III	C.W. Bruner, CTP
Purchasing Agent Assistant II	Jayne Rybak, CTP*
HUB Coordinator	Sylvia Lopez
HUB Specialist	Betty Chapa
HUB Specialist	Jerome Guerrero
Purchasing Business Analyst	Scott Worthington
Purchasing Business Analyst	Jennifer Francis
HRMD Director	Diane Blankenship
Benefits Administrator	Cindy Purinton
Benefits Manager	John Rabb
Budget Director	Leroy Nellis
Budget Analyst Senior	Travis Gatlin
HRMD	Dan Mansour

FORMER EMPLOYEES

Position Held	Name of Individual Holding Office/Position	Date of Expiration
Purchasing Agent Assistant IV	Oralia Jones, CPPB	07/31/12
County Executive, Planning & Budget	Rodney Rhoades	08/19/12
Purchasing Agent Assistant IV	Diana Gonzalez	12/16/12
Director, Health Services Division	Beth Devery	03/09/13
Purchasing Agent Assistant III	Elizabeth Corey, C.P.M.	03/14/13
Attorney, Transactions Division	Tamara Armstrong	03/30/13
Executive Assistant	Lori Duarte	06/15/13

* - Identifies employees who have been in that position less than a year.



HRMD Human Resources Management

700 Lavaca Street, Suite 420 • P.O. Box 1748 • Austin, Texas 78767 • (512) 854-9165 / FAX(512) 854-6677

August 24, 2012

TO: C.W. Bruner, Purchasing Agent

FROM: Cindy Purinton, Benefit Administrator
John Rabb, Benefit Manager

SUBJECT: Contract # 06T000610 (SAP 4400001100)
Cigna Supplemental Life/AD&D
(Includes retiree life, dependent and spouse life)
Long and Short Term Disability
Cigna Voluntary Benefit Coverage (Stand Alone Ad&D)

Vendor services related to the above contract have been performed to the County's satisfaction. Please issue first novation under current contract, that will now include all of the coverages shown above.
This Employee funded contract is funded from liability account: 8001-220110

If you have any questions, please contact John Rabb at 854-2742 or Cindy Purinton at 854-9626.

Fund account number
Supplemental Life AD&D 8001-220110 coverage Paid by Employees
Short and Long Term Disability 8001-220110coverage Paid by Employees
Cigna Voluntary Benefit Coverage (stand alone AD&D) 8001-220110 Paid by Employees