

Medical and Rx Plan Options

Lake County provides 2 different plan options, EPO and PPO, through Anthem to meet your needs. The EPO provides network only coverage while the PPO plan provides two levels of coverage (network and non-network). If the provider is in network (highlighted in blue print below), there is a higher level of coverage and lower costs to you. If the provider is non-network, there is a lower level of coverage which results in higher out of pocket costs to you. You choose which plan best fits your needs based on your utilization of services and contribution through payroll deduction. To find out if a provider is in network, go to www.anthem.com and select "Find a Doctor".

Plan Options		Option 1 - EPO		Option 2 - PPO	
		Network	Non-Network	Network	Non-Network
Deductible	Single	\$0	N/A	\$500	\$1,000
	Family	\$0	N/A	\$1,000	\$2,000
Coinsurance (after Ded)		100%	N/A	80%	60%
Coinsurance Lake Hospital ONLY		100%	N/A	\$150 copay – deductible does not apply	
Out-of-Pocket (Includes Ded)					
	Single	\$0	N/A	\$2,500	\$5,000
	Family	\$0	N/A	\$5,000	\$10,000
Office Visit– PCP/Specialist		\$20/\$30	N/A	\$20/\$40	60% after ded
Office Visit – Preventive Routine Services ONLY		100%	N/A	100%	60% after ded
Urgent Care Copay		\$20	N/A	\$50	60% after ded
ER Copay – waived if admitted		\$50	N/A	\$100	\$100
Outpatient Surgery, Diagnostic & Therapeutic Services		100%	N/A	80%	60%
				after ded	after ded
Caremark Prescription Drug		Retail (31 days)	Mail/CVS (90 days)	Retail (31 days)	Mail/CVS (90 days)
Generic		\$10	\$20	\$8	\$16
Preferred Brand		\$20	\$40	\$25	\$50
Non-Preferred Brand		\$35	\$70	\$45	\$90
Specialty		10% coinsurance to a max of \$1,500 annually		10% coinsurance to a max of \$1,500 annually	

IMPORTANT NOTES:

- Mandatory Mail Order on all maintenance medications.
- You can fill 90 day supply medication at any CVS Pharmacy.
- Women's preventive care services will be added to the growing list of services paid at 100% with no copay, no cost share. The following is a list of services for women (some are already covered by the County at 100%).
 - Screening for gestational diabetes
 - Testing for human papillomavirus (HPV)
 - Counseling for sexually transmitted infections
 - Screening and counseling for human immunodeficiency virus (HIV)
 - Screening and counseling for interpersonal and domestic violence
 - FDA-approved contraception methods and contraceptive counseling (includes oral contraceptives and contraceptive devices)
 - Breastfeeding support, supplies and counseling (including breast pumps – purchase or rental)



Dental & Vision Plan Options

GROUP DENTAL PLAN

Your dental coverage is through Sun Life and the name of the dental network is Dentemax. Network dentists agree to accept Sun Life's usual and customary (U&C) amounts as payment in full for covered services. Non-network dentists may bill you for any difference in cost between Sun Life's allowed amount and the dentist's fee. This is called balance billing. Please utilize network dentists to avoid balance billing. Frequency limitations apply to certain services. Please refer to your Sun Life certificate booklet for details.

Dental Benefit Provision	NAP		PPO	
	Network	Non-Network	Network	Non-Network
Calendar Year Deductible (Single/Family)	\$0	\$100/\$300	\$50/\$150	
Deductible waived for Type I Services	N/A	No	Yes	
Type I – Preventive	100%	50%	100%	100% of U&C
<ul style="list-style-type: none"> ➤ Oral Exams, Cleanings, Bite-Wing X-rays, Fluoride Treatment, Sealants, Space Maintainers 				
Type II – Basic	100%	20%	80%	80% of U&C
<ul style="list-style-type: none"> ➤ Fillings, Simple Extractions, Periodontics (non-surgical), Endodontics (root canal therapy) 				
Type III – Major	60%	20%	60%	60% of U&C
<ul style="list-style-type: none"> ➤ Crowns, Fixed Bridges, Dentures, Oral Surgery, Periodontics (Surgical) 				
Type IV – Orthodontic Procedures	40%	40%	60%	60% of U&C
<ul style="list-style-type: none"> ➤ Children under 19 ➤ Lifetime Benefit - \$800 				
Calendar Year Maximum (Per Person)	\$1,000	\$500	\$1,200	

BASIC VISION EXAM & BUY-UP VISION

Your vision coverage is provided through EyeMed. Lake County pays for your basic vision coverage when you elect medical coverage. Vision exams are allowed once every 12 months at \$0 copay in network and up to a \$50 reimbursement out of network. The basic vision also provides for discounts for lenses, frames, contacts, sunglasses and laser vision correction.

Your buy-up vision benefit that provides coverage for vision materials is outlined below. To find an EyeMed provider, go to <http://portal.eyemedvisioncare.com>. The EyeMed provider network is called Access. The EyeMed vision network now includes a network of retail providers such as LensCrafters, Pearle Vision, Sears Optical, Target Optical and JC Penney.

Vision Services	Network	Non-Network
Standard Plastic Lenses (once every 12 months)		
<ul style="list-style-type: none"> ➤ Single Vision ➤ Bifocal ➤ Trifocal ➤ Standard Progressive Lens ➤ Premium Progressive Lens 	\$25 copay \$25 copay \$25 copay \$90 \$90, 80% of charge less \$120 allowance	\$35 \$40 \$55
Frames (once every 24 months)	\$0 copay; \$120 allowance, 20% off balance over \$120	\$60
Contact Lenses (once every 12 months)		
<ul style="list-style-type: none"> Conventional Disposable Medically Necessary 	\$105 allowance, then 15% off excess \$105 allowance \$0 copay, paid-in-full	\$84 \$84 \$200



ENROLLMENT APPLICATION AND CHANGE FORM

BENEFIT ELECTIONS

NAME CHANGE

ADDRESS CHANGE

DEPARTMENT NAME: _____

EMPLOYEE # _____

Employee Information

Last Name _____ **First Name** _____ **Date of Birth** _____

Social Security Number _____ **Date of Hire** _____

Full Address _____

Marital Status **Single** **Married** (If married, Spousal Surcharge Form must be completed) **Spousal Surcharge Yes** **No**

(A) Add (T) TERM (C) CHANGE

EFFECTIVE DATE: _____

	Dependents Full Name	SSN	Date of Birth	Relationship	M/F
	Spouse				
	1.				
	2.				
	3.				
	4.				
	5.				
	6.				
	7.				

Medical and Rx Plan Election

Bi-Weekly Payroll Deductions

***New 4-tier rate structure** **EFFECTIVE INSURANCE DATE** _____

Please select one

ANTHEM	EPO	PPO
EMPLOYEE ONLY (EE)	<input type="checkbox"/>	<input type="checkbox"/>
EE & Spouse	<input type="checkbox"/>	<input type="checkbox"/>
EE & Child	<input type="checkbox"/>	<input type="checkbox"/>
Family	<input type="checkbox"/>	<input type="checkbox"/>

Decline Medical and Rx

Dental Plan Election

Bi-Weekly Payroll Deductions

Sun Life	NAP	PPO
EMPLOYEE ONLY (EE)	<input type="checkbox"/>	<input type="checkbox"/>
EE & Spouse	<input type="checkbox"/>	<input type="checkbox"/>
EE & Child	<input type="checkbox"/>	<input type="checkbox"/>
Family	<input type="checkbox"/>	<input type="checkbox"/>

Decline Dental

*Employees who completed health screenings at the Health Fair will be eligible for a discount on their medical premiums.

EyeMed Vision Election

Monthly Payroll Deductions

EyeMed	Voluntary Plan
EMPLOYEE ONLY (EE)	\$3.52 <input type="checkbox"/>
EE + 1	\$6.53 <input type="checkbox"/>
EE + Family	\$9.51 <input type="checkbox"/>
Decline EyeMed Vision	<input type="checkbox"/>

PLEASE CIRCLE SPOUSE OR CHILD



Lake County, Ohio

BENEFIT ELECTIONS CONTINUED

I understand that by signing this form, I make a binding election concerning my benefits for the next plan year. I also understand that I will not be able to change my election prior to next open enrollment period unless I have a qualified life event. In addition, I understand my duty to notify Personnel Division within 30 days of any changes that affect the eligibility of any of my covered dependents; for example, marriage, divorce, or change in dependent status.

I understand that enrolling a dependent that is not eligible or failing to provide notice of ineligibility can result in retroactive termination of health plan coverage for me and my dependents. I also understand that coverage of an ineligible dependent will result in liability on my part for costs by the Plan while my dependent was ineligible.

I certify that all information provided in this enrollment form is correct to the best of my knowledge and authorize release of any information to the appropriate vendors as requested with respect to this enrollment. I understand that Lake County, at its sole discretion, may rescind my coverage at any time on the basis of any untrue, inaccurate or incomplete information provided on this form, or any misrepresentation, omission or concealment on this form, whether intentional or otherwise. I further understand if coverage is issued, it will be issued by Lake County, in full reliance and in consideration of the information, answers and statements contained herein.

WARNING: Any person who, with intent to defraud or knowing that he is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Signature: _____

Name: _____

Date: _____



2013 Spousal Surcharge Employee Statement

Employee Name

Department

In an effort to control costs a spousal surcharge has been instituted for employees covered under the healthcare plan whose spouses are eligible for healthcare insurance through their employer, but opt to take Lake County's healthcare program. The criteria is as follows:

1. Spousal surcharge applies only to employees that cover their spouse on the County Healthcare Program.
2. Eligible employee's spouse maintains full time employment and is eligible for an employer sponsored health plan through their full time employment, but chooses to enroll under the County's Healthcare Program.

The spousal surcharge will be \$75.00 per month as long as the spouse remains eligible for other coverage.

Please check **only one** of the coverage options below:

- Does Not Apply* I am enrolled for single or employee + child(ren). (or)
My spouse is self-employed, (or)
My spouse is employed part-time, (or)
My spouse is not employed, (or)
My spouse is a County employee
I am waiving medical coverage.
- Spousal Waiver** I attest to the fact that my spouse is employed full-time and does not have access to employer-sponsored medical coverage and/or is not eligible for such coverage. Should these circumstances change, and my spouse does become eligible for employer-sponsored coverage under another employer, I must notify the County within 30 days of such occurrence. My spouse will be required to seek medical coverage under his/her current employer's plan at that time he/she becomes eligible or continue to stay on the County's healthcare plan with a spousal surcharge of \$75.00 per month.
- I agree to notify the County regarding my spouse's eligibility for another employer-sponsored medical plan, and I attest to the truth regarding my spouse's current eligibility.
***(MUST COMPLETE SPOUSE'S EMPLOYER STATEMENT OF COVERAGE)**
- Spousal Surcharge* I acknowledge that my spouse is eligible for coverage with her/his current employer but will cover my spouse as a dependent under my medical insurance policy. I understand that I will be charged a spousal surcharge of \$75 per month.
- Spousal Other Coverage* I acknowledge that my spouse is eligible for coverage with her/his current employer. I will not cover my spouse as a dependent under my medical insurance policy and will not be subject to the surcharge.

I agree to notify the County immediately if my above circumstances changes (i.e.: marriage, divorce, spouse becomes eligible for coverage elsewhere, etc.). I understand if I fail to notify the County of my change in eligibility status, I may be subject to any consequence set forth by in accordance with the County Health Insurance Guidelines.

Employee Signature

Date

Contributions

Medical Premiums 2013

<u>Description</u>	<u>Monthly Employer</u>	<u>Wellness</u>		<u>Wellness</u>	
		<u>EPO Monthly Employee</u>	<u>EPO Monthly Employee</u>	<u>PPO Monthly Employee</u>	<u>PPO Monthly Employee</u>
Sunlife (Single) Dental/No Hosp/Rx	\$24.58	\$15.42	\$14.50	\$15.42	\$14.50
Sunlife (Emp/Child)/ Dental/No Hosp/Rx	\$46.72	\$29.32	\$27.56	\$29.32	\$27.56
Sunlife (Emp/Spouse)/ Dental/No Hosp/Rx	\$51.62	\$32.40	\$30.46	\$32.40	\$30.46
Sunlife (Family 3) Dental/No Hosp/Rx	\$73.74	\$46.28	\$43.50	\$46.28	\$43.50
Anthem/Rx (Single)/No Dental	\$531.26	\$59.04	\$55.50	\$3.08	\$0.00
Anthem/Rx (Single)/Single-Dental	\$555.84	\$74.46	\$70.00	\$18.50	\$14.50
Anthem/Rx (Single)/Emp/Child-Dental	\$577.98	\$88.36	\$83.06	\$32.40	\$27.56
Anthem/Rx (Single)/Emp/Spouse-Dental	\$582.88	\$91.44	\$85.96	\$35.48	\$30.46
Anthem/Rx (Single)/Family 3-Dental	\$605.00	\$105.32	\$99.00	\$49.36	\$43.50
Anthem/Rx (Emp/Child)/No Dental	\$1,009.40	\$112.16	\$105.44	\$6.16	\$0.00
Anthem/Rx (Emp/Child)/Single-Dental	\$1,033.98	\$127.58	\$119.94	\$21.58	\$14.50
Anthem/Rx (Emp/Child)/Emp/Child-Dental	\$1,056.12	\$141.48	\$133.00	\$35.48	\$27.56
Anthem/Rx (Emp/Child)/Emp/Spouse-Dental	\$1,061.02	\$144.56	\$135.90	\$38.56	\$30.46
Anthem/Rx (Emp/Child)/Family 3-Dental	\$1,083.14	\$158.44	\$148.94	\$52.44	\$43.50
Anthem/Rx (Emp/Spouse)/No Dental	\$1,115.66	\$123.96	\$116.52	\$6.46	\$0.00
Anthem/Rx (Emp/Spouse)/Single-Dental	\$1,140.24	\$139.38	\$131.02	\$21.88	\$14.50
Anthem/Rx (Emp/Spouse)/Emp/Child-Dental	\$1,162.38	\$153.28	\$144.08	\$35.78	\$27.56
Anthem/Rx (Emp/Spouse)/Emp/Spouse-Dental	\$1,167.28	\$156.36	\$146.98	\$38.86	\$30.46
Anthem/Rx (Emp/Spouse)/Family 3-Dental	\$1,189.40	\$170.24	\$160.02	\$52.74	\$43.50
Anthem/Rx (Family 3)/No Dental	\$1,593.76	\$177.08	\$166.46	\$9.26	\$0.00
Anthem/Rx (Family 3)/Single-Dental	\$1,618.34	\$192.50	\$180.96	\$24.68	\$14.50
Anthem/Rx (Family 3)/Emp/Child-Dental	\$1,640.48	\$206.40	\$194.02	\$38.58	\$27.56
Anthem/Rx (Family 3)/Emp/Spouse-Dental	\$1,645.38	\$209.48	\$196.92	\$41.66	\$30.46
Anthem/Rx (Family 3)/Family 3-Dental	\$1,667.50	\$223.36	\$209.96	\$55.54	\$43.50
Adult Dependent Age 26-28 (ALL)		\$285.36		\$238.30	

Life Insurance & LTD

BASIC LIFE/AD&D

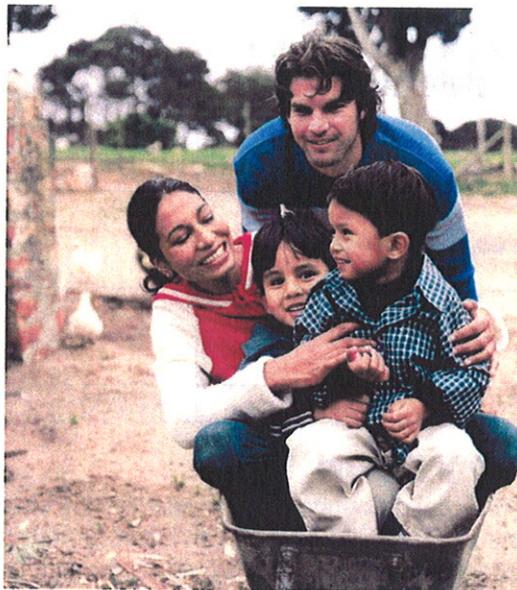
Your Basic Life/AD&D coverage is provided through Sun Life will continue to be offered at no cost to the employee. The premium is paid entirely by Lake County. All benefit eligible employees receive \$20,000 of coverage.

SUPPLEMENTAL LIFE/AD&D

You can purchase at full cost to the employee at any time during the year. You will be required to provide proof of good health by completing an Evidence of Insurability (EOI) form for any amount of supplemental coverage. You can purchase supplemental life insurance in increments of \$10,000 up to 5x your basic annual earnings.

DESIGNATION OF BENEFICIARY

It is your responsibility to notify your plan administrator with any changes in beneficiary designations. You may designate different beneficiaries for your Basic Life/AD&D and Supplemental Life/AD&D coverage.



Voluntary Long Term Disability (LTD)

You have the option to purchase LTD coverage through Sun Life. LTD coverage provides for a monthly benefit replacement of 60% of your total monthly earnings if you become disabled. The maximum monthly benefit payable is \$5,000. The minimum monthly benefit is \$100 or 15% of the gross monthly benefit, whichever is greater. There is a 180 day elimination period in which you must be disabled before benefits will begin paying.

L.C. Employees Health Plan

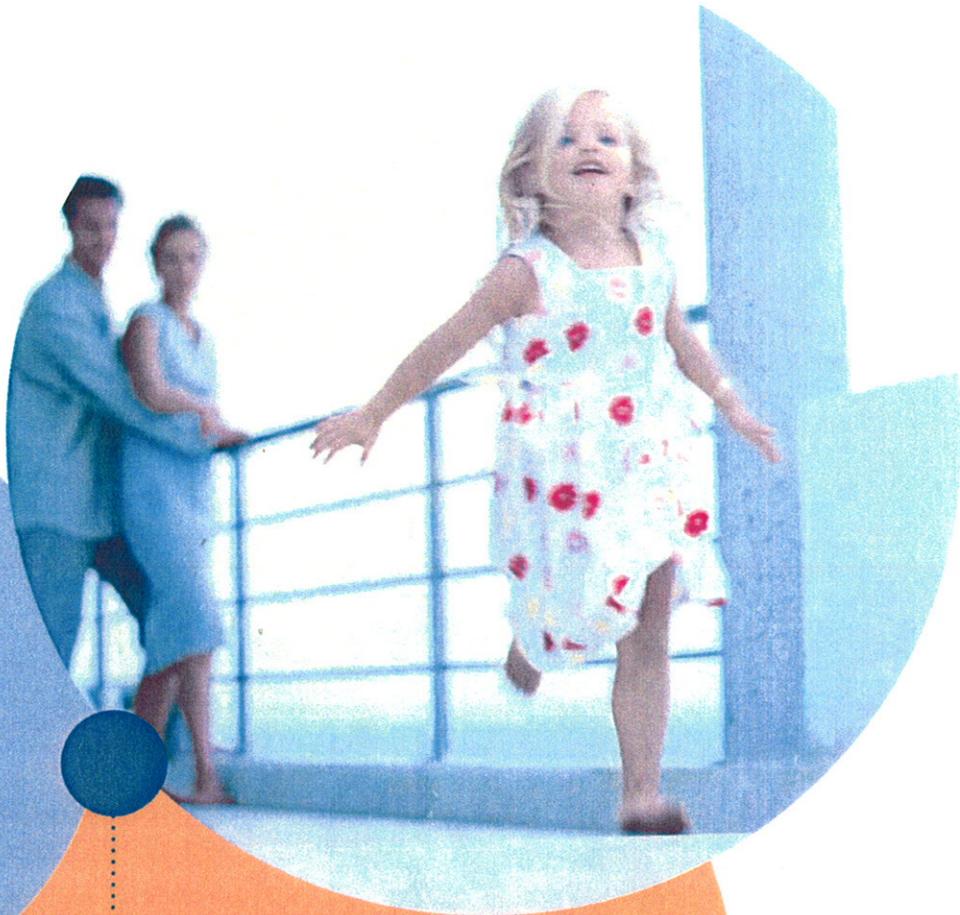
Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Frames	\$0 Copay; \$120 allowance; 80% of balance over \$120	Up to \$60
Standard Plastic Lenses		
Single Vision	\$25 Copay	Up to \$35
Bifocal	\$25 Copay	Up to \$40
Trifocal	\$25 Copay	Up to \$55
Lens Options <i>(paid by the member and added to the base price of the lens)</i>		
UV Treatment	\$15	N/A
Tint (Solid and Gradient)	\$15	N/A
Standard Plastic Scratch Coating	\$15	N/A
Standard Polycarbonate	\$40	N/A
Standard Anti-Reflective Coating	\$45	N/A
Standard Progressive (Add-on to Bifocal)	\$65	N/A
Other Add-Ons and Services	20% off retail price	N/A
Contact Lenses		
Conventional	\$0 Copay; \$105 allowance; 15% off balance over \$105	Up to \$84
Disposable	\$0 Copay; \$105 allowance; plus balance over \$105	Up to \$84
Medically Necessary	\$0 Copay, Paid In Full	Up to \$200
Laser Vision Correction		
Lasik or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	N/A
Frequency		
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 24 months	

Want to learn more?

- For a complete list of providers near you, use our Provider Locator on www.eyemedvisioncare.com and choose the ACCESS network or call 1-866-723-0596.
- For Lasik providers, call 1-877-5LASER6.

Additional Discounts and Features:

- 40% off additional eyewear purchases.
- 20% off non-prescription sunglasses.
- 20% off remaining balance beyond plan coverage.
- Laser vision correction - 15% off the retail price or 5% off the promotional price for LASIK or PRK procedures.

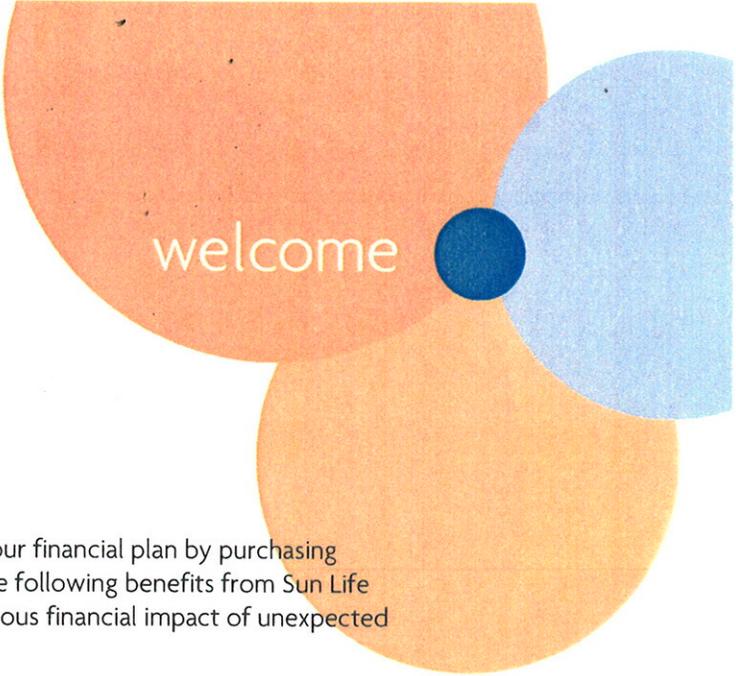


time to choose

● Benefits just for you

Lake County Board of Commissioners

Sun 
Life Financial®



welcome

Time

You have a unique opportunity to fill the gaps in your financial plan by purchasing additional insurance. We're pleased to offer you the following benefits from Sun Life Financial that can help protect you from the enormous financial impact of unexpected events.

Here are your choices:

Employee Optional Life Insurance
Long Term Disability

To

Inside this kit, you will find everything you need to learn about the benefits being offered to you. You should also know that Sun Life Financial is one of the largest, most financially strong companies in the world. This means your plan will be there for you when you need it most. To learn more about Sun Life, go to: www.sunlife-usa.com.

Choose!

If you have any questions, please don't hesitate to contact your human resources department.

So here's your plan. Put it into action today!

Group Life Insurance

When you buy **Life Insurance** from Sun Life Financial, know that:

- **You are taking care of your family.** When the time comes, life insurance will provide for your family financially when you can't.
- **You decide how much.** You choose the amount that works for you. Use the chart below to help you figure it out.
- **Paying is easy.** Your premium is automatically deducted from your paycheck.
- **You take it with you.** If you leave your current job you can take your life insurance with you. Simply ask your employer about the options available.

- **We pay quickly.** Our goal is to pay your beneficiary within 10 business days (we usually do it sooner).

How Much Should You Get?

Use the worksheet below to help you figure out how much coverage you can—and want—to buy. You can also use our online calculator by visiting www.sunlife-usa.com/grouplife.

How Much Do I Need?

Yearly Financial Obligations: (enter amounts in gray box)

Housing Costs	\$
Car Payments	\$
Credit Card Debt	\$
Personal Loans	\$
Medical Coverage	\$
Family Care Requirements	\$
Educational Needs	\$
Other Expenses	\$
Total Financial Obligations:	\$
How long will you need to cover these expenses?	_____ years
Total Need: (Total Financial Obligations x Number of years):	\$
Other life insurance currently in place:	\$
Amount of Optional Life insurance you might need (Total Need - Other life insurance):	\$

frequently asked questions

Life Insurance

Even if you already have a group life insurance policy with your employer, it's important to ask yourself—does it provide enough protection to cover all of your financial responsibilities?

What is Group Life Insurance?

Group Life Insurance is term insurance that covers you for as long as you remain an eligible employee and continue to pay your premium. Because this coverage is term life insurance, it does not build any cash value for you to borrow against or receive upon policy cancellation.

Why should you purchase Life Insurance?

Life Insurance provides added financial protection at an affordable price. You can ensure your family's financial security in the event of an unexpected death. We have developed our plan to meet your needs through affordable features:

- You decide how much coverage you need.
- We offer the coverage amounts most individuals want.
- You may take advantage of group rates when enrolling through your employer.
- Accelerated benefits are available. If you are terminally ill with 12 months or less to live, you may qualify for an amount up to 75% of your total death benefit amount.

How do I determine how much Life Insurance I need?

You'll want to think about your housing costs, car payments, credit card debt, personal loans, medical coverage and education needs. Because it gets complicated, we offer a Life Insurance calculator on our website. Go to: www.sunlife-usa.com/grouplife.

How much does it cost?

The cost is determined by your age. Rates are grouped into five-year age brackets and change as you get older. Your employer will provide you with rate information so that you can figure out your actual cost per month.

Can I keep my coverage if I no longer work for this employer?

Yes, you can convert your insurance to an individual policy without providing medical evidence of insurability. Your employer will tell you more about converting your coverage. Portability may also be available. If you are eligible, this feature allows you to continue your Life Insurance coverage—at Group rates—if your employment terminates. Please check with your employer for more information.

Optional Life Insurance Benefits

for Employees of Lake County Board of Commissioners #215188

A Worldwide Presence

Our parent company's operations currently service millions of people in the United States, Canada, the United Kingdom, Hong Kong, the Philippines, Japan, Indonesia, India, China and Bermuda.

Benefits

- An amount between \$10,000 and \$250,000, in increments of \$10,000, not to exceed 5x basic annual earnings. Guaranteed Issue Amount is \$150,000 if under age 60, \$10,000 if age 60-69, and \$1,000 if age 70 or over. Benefits cease at retirement.

Features of the Plan

- The plan also includes many special features including Waiver of Premium and Accelerated Benefits. For more information, ask your employer for a copy of the flyer entitled "Optional Life Means Added Financial Security."

How to Enroll

- Once you have selected the amount of coverage that's right for you, your spouse and your children, simply fill out the Optional Life enrollment form provided by your employer. Be sure to sign, date, and return the form to your employer. Please submit the form to your employer along with any Evidence of Insurability forms that may be required.

benefit highlights

continued

About Evidence of Insurability

- Evidence of Insurability – also called “proof of good health” – is required if:
 - You decline coverage during your initial eligibility period and then want coverage at a later date; or
 - You apply for Optional Life in excess of the Guaranteed Issue Amount.
- All late entrants and increases require Evidence of Insurability.

Your employer will advise you if you need to submit an Evidence of Insurability application. If so, Sun Life Financial may arrange for you to take a medical exam (at our expense) and/or complete a questionnaire. Coverage will not go into effect until Sun Life Financial approves the application.

Optional Life Rates

Employee	
Age	Monthly cost per \$1,000 of coverage
Under 25	\$.06
25 – 29	\$.06
30 – 34	\$.06
35 – 39	\$.09
40 – 44	\$.14
45 – 49	\$.22
50 – 54	\$.35
55 – 59	\$.51
60 – 64	\$.85
65 – 69	\$ 1.52
70 – 74	\$ 2.17
75 +	\$ 4.68

*These are the rates in effect for January 1, 2011

Cost to You

- You are responsible for paying the cost of voluntary Life coverage through payroll deduction. Calculate your cost by dividing your amount of optional life insurance by 1000 and multiplying the result by the appropriate rate above. Follow the example below to determine your monthly cost.

Example amount of insurance	Divided by 1000	Multiplied by rate	Example cost*	
\$25000	/ 1000 = 25	x \$0.05	\$ 1.25	
Your volume of insurance	Divided by 1000	Multiplied by rate	Your cost*	Cost per pay period
\$ []	/ 1000 = []	x \$ []	\$ []	\$ []

*Contact your employer to confirm the portion of the cost for which you will be responsible.

For Complete Plan Details

- This highlight flyer is intended to provide an overview of the benefits available from your employer, and is not a complete description of plan provisions. Receipt of this flyer does not certify eligibility for benefits under this plan.
- Your employer will provide you with the Sun Life Financial Group booklet containing complete plan details.

Exclusions

Where allowed by law, if the Employee's cause of death is suicide:

- No amount of contributory Life or contributory Dependent Life Insurance is payable if the suicide occurs within 24 months after the Employee's Insurance is effective. If there was prior coverage in place, any period of time the Employee was insured for the same amount of Life Insurance under the previous insurer's group Life policy will count towards completion of the 24 months.
- No increased or additional amount of Life Insurance is payable if the suicide occurs within 24 months after the increased or additional amount of Basic Life Insurance is effective.
- No amount of Life Insurance in excess of the Guaranteed Issue Amount is payable if the suicide occurs within 24 months after the amount in excess of the Guaranteed Issue Amount is effective.

This summary represents a general overview. Limitations and exclusions may vary depending on your specific benefit plan. Please review your Life booklet for complete information.

This Overview is preliminary to the issuance of the Policy and booklet certificate. It does not describe the specific benefits under the Policy.

Group insurance policies are underwritten by Sun Life Assurance Company of Canada (Wellesley Hills, MA) in all states, except New York, under Policy Form Series 93P-LH, 98P-ADD, 02P-STD TDB Policy-2006, 02-SL, 07-SL, and 01C-LH-PT. In New York, group insurance policies are underwritten by Sun Life Insurance and Annuity Company of New York (New York, NY) under Policy Form Series 93P-LH-NY, 06P-NYDBL, 02P-NYSTD, 98P-ADD-NY, 02-NYSL, 07-NYSL, and 01NYC-LH-PT. Product offerings may not be available in all states and may vary depending on state laws and regulations.

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SLPC 22007 06/10 (exp. 06/12)

Long Term Disability Insurance

When you buy **Long Term Disability (LTD)** Insurance from Sun Life Financial, know that:

- **You're making a smart financial decision.** If you become totally disabled and cannot go to work for an extended period of time, this coverage pays you a percentage of your salary.
- **You get personal service.** When you file a claim, you are assigned to a benefits expert who will guide you through the process and answer any questions.
- **You get a team of health experts for help.** If you become ill or injured, we want to help you get your life back. A certified rehabilitation counselor works with a team of health experts to create a return-to-work plan designed just for you.
- **It may protect your savings.** By having a portion of your income coming in, you may avoid having to rely on your savings to cover expenses should you become ill or get injured.
- **You get extra benefits if you become disabled and are hospitalized for 14 or more consecutive days.** Our Retro Disability Benefits® gives you an extra lump sum payment should you face a catastrophic illness or injury requiring an immediate and prolonged hospital stay.¹

¹To qualify for Retro Disability Benefits®, an employee must have been continuously hospitalized for 14 days or more at the onset of Total Disability.

frequently asked questions

Long Term Disability

Why do I need Long Term Disability? This sort of thing happens to other people, not me.

Statistics show that the number of U.S. workers experiencing a long-term disability continues to grow at an alarming rate. The latest U.S. Census estimated that there are over 30 million disabled Americans between ages 21 and 64.¹ Unfortunately, disability is a real and growing risk and is widespread.

What services are provided under Long Term Disability?

We understand that situations vary. Some disabled individuals require minimal job accommodations to return to work, while others may need retraining or a complete job change. Our specialists work with you and your employer to develop a case-specific plan that meets your needs. Some of our services may include:

- Adaptive equipment: do you need special equipment to do your job?
- Job site modification: can we help your employer change your work site to accommodate for your disability?
- Vocational interest testing: which new job would you be interested in?
- Aptitude testing: how well do your skills translate to a new position?
- Job research assistance: can we help you find a new job?
- Resume preparation: can we help you write a resume?

Can I still receive disability benefits if I return to work part time or at a lower salary?

This depends on your employer's group policy. Our Customer Service Department would be happy to review your benefits with you. Call 1-800-247-6875 for more information.

Who will help me return to work?

A Certified Rehabilitation Specialist will partner with you to examine your job responsibilities and medical situation and ultimately create a case-specific return-to-work plan.

What if I cannot physically return to my job?

We will work with you to find a more suitable solution. This may involve locating another position with your employer or helping you find work with another employer.

Case Studies

- **Luanne**, a 37-year-old financial analyst, suffered a stroke affecting the right side of her body. She could not write or use a computer properly. Sun Life Financial teamed up with her employer to create a part-time schedule for Luanne and paid for a special left-handed keyboard. Once Luanne adjusted to working with her left hand, she returned to work full-time.
- **Michael** injured his wrist so severely that he could never return to his job as an ore miner. A Sun Life Financial rehabilitation specialist worked with Michael and learned that he could still do the hobby he loved—building outdoor furniture. We provided Michael with the funds to purchase equipment to start his own business and Michael is now self-employed, earning more than he did as an ore miner.
- **Martha**, a 45-year-old packer at a manufacturing plant, was gradually losing her sight because of a degenerative eye disease. Martha's rehabilitation counselor referred her to a local chapter of Services for the Blind for support and training. Martha received job search counseling and eventually enrolled in a training program at a local supermarket. With our advice, the supermarket even enlarged the print on price labels.

¹www.disabilitycanhappen.org

benefit highlights

continued

About Evidence of Insurability

- Evidence of Insurability – also called “proof of good health” – is required if:
 - you decline coverage during your initial eligibility period and then want coverage at a later date, or
- All late entrants and increases in coverage require Evidence of Insurability.
- Your employer will advise you if you need to submit an Evidence of Insurability application. If so, Sun Life Financial may arrange for you to take a medical exam (at our expense) and/or complete a questionnaire. Coverage will not go into effect until Sun Life Financial approves the application.

For complete plan details

- This highlight flyer is intended to provide an overview of the benefits available from your employer and is not a complete description of plan provisions. Receipt of this flyer does not certify eligibility for benefits under this plan.
- Your employer will provide you with the Sun Life Financial Group booklet containing complete plan details.

Limitations

Limitations include but are not limited to the list below. Limitations may vary depending on your specific benefit plan. No LTD benefit will be payable for any Total or Partial Disability during any of the following periods:

- any period the employee is not under the regular and continuing care of a physician providing appropriate treatment and regular examination and testing in accordance with the disabling condition, unless the employee has reached his maximum point of recovery and is still totally or partially disabled
- any period the employee fails to submit to any medical examination or clinical assessment requested by Sun Life
- any period the employee is incarcerated

Exclusions

Exclusions include but are not limited to the list below. Exclusions may vary depending on your specific benefit plan. No LTD benefit will be payable for any Total or Partial Disability that is due to:

- an intentionally self-inflicted injury,
- war, declared or undeclared, or any act of war,
- active participation in a riot, rebellion, or insurrection, or
- committing or attempting to commit an assault, felony, or other criminal act.

This Overview is preliminary to the issuance of the Policy and booklet certificate. It does not describe the specific benefits under the Policy. This policy provides disability income insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Insurance Department.

Group insurance policies are underwritten by Sun Life Assurance Company of Canada (Wellesley Hills, MA) in all states, except New York, under Policy Form Series 93P-LH, 98P-ADD, 02P-STD TDB Policy-2006, 02-SL, 07-SL, and 01C-LH-PT. In New York, group insurance policies are underwritten by Sun Life Insurance and Annuity Company of New York (New York, NY) under Policy Form Series 93P-LH-NY, 06P-NYDBL, 02P-NYSTD, 98P-ADD-NY, 02-NYSL, 07-NYSL, and 01NYC-LH-PT. Product offerings may not be available in all states and may vary depending on state laws and regulations.

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XGR/2854

SLPC 21849 05/10 (exp. 05/12)

Group Long Term Disability Benefits

for Employees of Lake County Board of Commissioners #215188

Disability Can Happen to Anyone.

Want to know more
about your chances
of becoming disabled?

Sun Life Financial
is a founding member
of the Council for
Disability Awareness.

Visit
www.disabilitycanhappen.org

and find out your
Personal Disability
Quotient.

Benefits

- Available to all full-time employees working 32 or more hours per week.
- Covers accidents and sicknesses.
- Benefits are 60% of monthly earnings up to a maximum of \$5,000 per month.
- Benefits may begin after the elimination period of 180 days of absences due to a covered accident or sickness.
- Employees must meet the definition of disability as defined in the policy to be eligible for the benefits described here.
- Benefits are not payable for pre-existing conditions as defined in the policy.

Cost to you

- LTD coverage is contributory, meaning that you are responsible for paying for all or a portion of the cost through payroll deduction.
- Calculate your monthly cost by dividing your monthly covered earnings by 100 and multiplying the result by the rate found in the chart below. Your rate is determined on January 1 of each year and is based on your current age. Follow the example below to determine your monthly cost.

Your Age	Rate	Your Age	Rate	Your Age	Rate	Your Age	Rate
Under 25	\$.17	35-39	\$.28	50-54	\$.91	65-69	\$.92
25-29	\$.17	40-44	\$.40	55-59	\$ 1.19	70-74	\$.60
30-34	\$.23	45-49	\$.61	60-64	\$ 1.26	75-79	\$.60

These are the rates in effect for January 1, 2011

Example Monthly Earnings	Divided by 100	Multiplied by rate	Example cost*
\$ 3,500	/ 100 = 35	x \$0.40	\$ 14.00
Your Monthly Earnings	Divided by 100	Multiplied by rate	Your cost*
\$ []	/ 100 = []	x \$[]	\$ []

*Contact your employer to confirm the portion of the cost for which you will be responsible.

How to enroll

- Fill out the LTD enrollment form provided by your employer. Be sure to sign, date, and return the form to your employer.

Evidence of Insurability, or Proof of Good Health

If you're reading this, it's because you may need to submit Evidence of Insurability (EOI) to Sun Life Financial. This could be for any of the reasons below:

- You're applying for an amount of Life Insurance coverage that is higher than the Guaranteed Issue amount. (This is indicated on your enrollment form included in this packet.)
- You currently have Life and/or Disability Insurance and are increasing your coverage.
- You declined Group Life or Disability coverage during your initial eligibility period and are now applying for coverage at a later date.

Submit Your Medical Information Online

It's the quick, easy and smart way to submit Evidence of Insurability (EOI). And it's completely secure and confidential:

1. Have the following information ready:
 - Your group policy number and the amount of coverage.
 - Height, weight and recent medical history for you and any dependents included on your application.
2. Go to <http://www.sunlife-usa.com/planmembers>
 - Click on Evidence of Insurability Application, follow the instructions, review your answers and sign your application electronically before you submit. You will receive an official acknowledgment that Sun Life Financial has received your EOI. If you are approved, you may receive an e-mail that same day.

Submit Your Medical Information Via Paper

Printable EOI applications are available at www.sunlife-usa.com > Get a form > Employee benefits forms. After Sun Life receives and processes your EOI application, you will receive either an approval or pending notification. If your application is pending, a member of Sun Life Financial's Life Insurance team may contact you to arrange for you to take a medical exam (at Sun Life's expense). Coverage subject to EOI will not go into effect until Sun Life contacts your employer for verification and you meet all other eligibility requirements.

About Privacy and Security

In accordance with Sun Life Financial's strict privacy practices, your answers to the Health History portion of the EOI application are completely confidential and are never shown to your employer. Also, we do not share your e-mail address or other personal information with any third parties except as permitted or required by law. The website includes state-of-the-art security; any information entered is encrypted and transmitted using Secure Socket Layers (SSL) technology.

Group Enrollment Form

For use by: Sun Life Assurance Company of Canada and
Sun Life and Health Insurance Company (U.S.) outside of New York



Complete all sections of the Group Enrollment Form. Make sure you complete and sign the form during the enrollment period or within 31 days of your eligibility date. Benefits completely paid by your employer (also called non-contributory benefits) cannot be refused.

General Information

Employer Name Lake County Board of Commissioners	Account /Policy Number 215188	Location	Date Effective
Street Address	City	State	Zip code
Type of activity: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Change Reason:		Occupation	
Date employed: <input type="checkbox"/> Full-Time Date: <input type="checkbox"/> Part-Time Date: <input type="checkbox"/> Rehire <input type="checkbox"/> Return from layoff Date:			

Employee Information

Employee's Full Legal Name (First, MI, Last)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth	Marital Status	Social Security No.
Street Address	City	State	Zip code	
Current Active Employment Type ____# of hours <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	Employee Status: <input type="checkbox"/> Management <input type="checkbox"/> Salary <input type="checkbox"/> Hourly <input type="checkbox"/> Union <input type="checkbox"/> Non-Union <input type="checkbox"/> Retired			Salary

You must elect or refuse insurance coverage below within 31 days of your date of eligibility by placing a check mark in the appropriate box(es). Not all of the benefit options listed below may be available to you. Your employer will tell you which benefits are available and what your Maximum Guarantee Issue amount is. See "Evidence of Insurability" section for details.

Optional Life Insurance: Underwritten by Sun Life Assurance Company of Canada (Wellesley, MA)

	Elect	Refuse	
	Life	Life	Coverage amount elected
Employee coverage:	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____

Disability coverage: Underwritten by Sun Life Assurance Company of Canada (Wellesley, MA)

Employee Long Term Disability Elect Refuse

Primary Beneficiary Designation

Optional Life Insurance - On the lines below, list the individual(s) who should receive proceeds in the event of your death. You may specify as many individuals as you like, but the total proceeds must equal 100%. This is your primary beneficiary. Attach additional pages if necessary. If you do not name a beneficiary or if no beneficiary is alive at the time of your death, proceeds will be payable in accordance with your group insurance policy.

Name of Primary Beneficiary(ies) (First, M.I., Last)	Relationship to employee	Address	Social Security Number	Percent share of proceeds*
1			XXX-XX-	%
2			XXX-XX-	%

- On the lines below, list the individual(s) who should receive proceeds in the event of your death. You may specify as many individuals as you like, but the total proceeds must equal 100%. This is your primary beneficiary. Attach additional pages if necessary. If you do not name a beneficiary or if no beneficiary is alive at the time of your death, proceeds will be payable in accordance with your group insurance policy.

Name of Primary Beneficiary(ies) (First, M.I., Last)	Relationship to employee	Address	Social Security Number	Percent share of proceeds*
1			XXX-XX-	%
2			XXX-XX-	%

Secondary Beneficiary Designation

Optional Life Insurance - On the lines below, list the individual(s) who should receive the proceeds ONLY IF ALL of the individuals listed above are not living at the time of your death. This is your secondary (or contingent) beneficiary. The Secondary beneficiary is not paid if your primary beneficiary is alive at the time of your death. Attach additional pages if necessary.

Name of Secondary Beneficiary(ies) (First, M.I., Last)	Relationship to employee	Address	Social Security Number	Percent share of proceeds*
1			XXX-XX-	%
2			XXX-XX-	%

- On the lines below, list the individual(s) who should receive the proceeds ONLY IF ALL of the individuals listed above are not living at the time of your death. This is your secondary (or contingent) beneficiary. The Secondary beneficiary is not paid if your primary beneficiary is alive at the time of your death. Attach additional pages if necessary.

Name of Secondary Beneficiary(ies) (First, M.I., Last)	Relationship to employee	Address	Social Security Number	Percent share of proceeds*
1			XXX-XX-	%
2			XXX-XX-	%

*The total within each class (Primary and Secondary) must equal 100%. If you do not name a beneficiary or if no beneficiaries are alive at the time of your death, proceeds will be payable in accordance with your group insurance policy

Evidence of Insurability

A medical Evidence of Insurability ("EOI") application will be required for any employee who applies for coverage more than 31 days past his/her eligibility date. An EOI application is also needed if you:

- apply for a higher coverage than the Maximum Guaranteed Issue amount.
- want to increase your existing coverage now or at a later date, whether your existing coverage is with Sun Life Assurance Company of Canada, Sun Life and Health Insurance Company (U.S.) or a prior insurance carrier.
- decline coverage and then want it at a later date.

Coverage subject to evidence of insurability will not go into effect until Sun Life Assurance Company of Canada and/or Sun Life and Health Insurance Company (U.S.) approves it.

Fraud Warnings

Please read the fraud warning below before signing the Enrollment Form. State law requires that we notify you of the following:

General Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an Application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects that person to criminal and civil penalties.

I understand that:

- I am requesting coverage under a Group Insurance policy offered by my employer. This coverage will end when my employment terminates.
- My employer will deduct all or part of the premium for contributory coverage from my pay.
- If I decline coverage for myself or, if applicable, for my family now and want it at a later date, I/we will have to submit an Evidence of Insurability application which is acceptable to Sun Life Assurance Company of Canada and/or Sun Life and Health Insurance Company (U.S.).
- I have read the Evidence of Insurability notice.
- I have read the Fraud Warning above.
- If I am not actively at work due to injury, illness, layoff or leave of absence on the date that any initial or increased coverage is scheduled to start under the plan, such coverage will not start until the date I return to work.
- When required by the coverage, if my spouse or any of my dependent children are confined due to an injury or illness, as required by the coverage, on the date that any initial or increased coverage is scheduled to start under the plan, such coverage will not start until the date they are no longer confined and are able to perform their normal activities.

By signing below, I am verifying that the information I have provided is true and correct to the best of my knowledge and belief.

X

Employee Signature

Today's Date

To the Employee: Make a copy of this form for your records before submitting it to your employer.

To the Employer: This original enrollment form should remain at the employer's site. Family status, coverage, or beneficiary changes should be recorded on another copy of the Enrollment Form.

For Employer Use Only

Provide the employee's earnings amount below. Most employers should use the "All Coverages" box only. However, if your group policy requires that you calculate separate earnings amounts by coverage, please enter those amounts in the second set of boxes.

Indicate whether earnings amount is annual pay, or some other pay frequency. If hourly, please indicate the number of hours worked per week. Although most plans define earnings as **salary-only** (not including bonuses, commissions, etc.), you should check your group policy for the proper earnings definition to use.

All Coverage Earnings \$	<input type="checkbox"/> Annual <input type="checkbox"/> Monthly	<input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Hourly Number of hours worked per week: _____
Life Earnings \$	<input type="checkbox"/> Annual <input type="checkbox"/> Monthly	<input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Hourly Number of hours worked per week: _____
LTD Earnings \$	<input type="checkbox"/> Annual <input type="checkbox"/> Monthly	<input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Hourly Number of hours worked per week: _____

County of Lake Board of County Commissioners

Employee Monthly Payroll Deduction

<u>age brackets</u>	<u>rate per \$1000</u>	<u>\$10,000.00</u>	<u>\$20,000.00</u>	<u>\$30,000.00</u>	<u>\$40,000.00</u>	<u>\$50,000.00</u>
Under 30	\$0.06	\$0.60	\$1.20	\$1.80	\$2.40	\$3.00
30 - 34	\$0.06	\$0.60	\$1.20	\$1.80	\$2.40	\$3.00
35 - 39	\$0.09	\$0.90	\$1.80	\$2.70	\$3.60	\$4.50
40 - 44	\$0.14	\$1.40	\$2.80	\$4.20	\$5.60	\$7.00
45 - 49	\$0.22	\$2.20	\$4.40	\$6.60	\$8.80	\$11.00
50 - 54	\$0.35	\$3.50	\$7.00	\$10.50	\$14.00	\$17.50
55 - 59	\$0.51	\$5.10	\$10.20	\$15.30	\$20.40	\$25.50
60 - 64	\$0.85	\$8.50	\$17.00	\$25.50	\$34.00	\$42.50
65 - 69	\$1.52	\$15.20	\$30.40	\$45.60	\$60.80	\$76.00
70 - 74	\$2.17	\$21.70	\$43.40	\$65.10	\$86.80	\$108.50
75 - 99	\$4.68	\$46.80	\$93.60	\$140.40	\$187.20	\$234.00

<u>age brackets</u>	<u>rate per \$1000</u>	<u>\$60,000.00</u>	<u>\$70,000.00</u>	<u>\$80,000.00</u>	<u>\$90,000.00</u>	<u>\$100,000.00</u>
Under 30	\$0.06	\$3.60	\$4.20	\$4.80	\$5.40	\$6.00
30 - 34	\$0.06	\$3.60	\$4.20	\$4.80	\$5.40	\$6.00
35 - 39	\$0.09	\$5.40	\$6.30	\$7.20	\$8.10	\$9.00
40 - 44	\$0.14	\$8.40	\$9.80	\$11.20	\$12.60	\$14.00
45 - 49	\$0.22	\$13.20	\$15.40	\$17.60	\$19.80	\$22.00
50 - 54	\$0.35	\$21.00	\$24.50	\$28.00	\$31.50	\$35.00
55 - 59	\$0.51	\$30.60	\$35.70	\$40.80	\$45.90	\$51.00
60 - 64	\$0.85	\$51.00	\$59.50	\$68.00	\$76.50	\$85.00
65 - 69	\$1.52	\$91.20	\$106.40	\$121.60	\$136.80	\$152.00
70 - 74	\$2.17	\$130.20	\$151.90	\$173.60	\$195.30	\$217.00
75 - 99	\$4.68	\$280.80	\$327.60	\$374.40	\$421.20	\$468.00

<u>age brackets</u>	<u>rate per \$1000</u>	<u>\$110,000.00</u>	<u>\$120,000.00</u>	<u>\$130,000.00</u>	<u>\$140,000.00</u>	<u>\$150,000.00</u>
Under 30	\$0.06	\$6.60	\$7.20	\$7.80	\$8.40	\$9.00
30 - 34	\$0.06	\$6.60	\$7.20	\$7.80	\$8.40	\$9.00
35 - 39	\$0.09	\$9.90	\$10.80	\$11.70	\$12.60	\$13.50
40 - 44	\$0.14	\$15.40	\$16.80	\$18.20	\$19.60	\$21.00
45 - 49	\$0.22	\$24.20	\$26.40	\$28.60	\$30.80	\$33.00
50 - 54	\$0.35	\$38.50	\$42.00	\$45.50	\$49.00	\$52.50
55 - 59	\$0.51	\$56.10	\$61.20	\$66.30	\$71.40	\$76.50
60 - 64	\$0.85	\$93.50	\$102.00	\$110.50	\$119.00	\$127.50
65 - 69	\$1.52	\$167.20	\$182.40	\$197.60	\$212.80	\$228.00
70 - 74	\$2.17	\$238.70	\$260.40	\$282.10	\$303.80	\$325.50
75 - 99	\$4.68	\$514.80	\$561.60	\$608.40	\$655.20	\$702.00

continued on back

<u>age brackets</u>	<u>rate per \$1000</u>	<u>\$160,000.00</u>	<u>\$170,000.00</u>	<u>\$180,000.00</u>	<u>\$190,000.00</u>	<u>\$200,000.00</u>
Under 30	\$0.06	\$9.60	\$10.20	\$10.80	\$11.40	\$12.00
30 - 34	\$0.06	\$9.60	\$10.20	\$10.80	\$11.40	\$12.00
35 - 39	\$0.09	\$14.40	\$15.30	\$16.20	\$17.10	\$18.00
40 - 44	\$0.14	\$22.40	\$23.80	\$25.20	\$26.60	\$28.00
45 - 49	\$0.22	\$35.20	\$37.40	\$39.60	\$41.80	\$44.00
50 - 54	\$0.35	\$56.00	\$59.50	\$63.00	\$66.50	\$70.00
55 - 59	\$0.51	\$81.60	\$86.70	\$91.80	\$96.90	\$102.00
60 - 64	\$0.85	\$136.00	\$144.50	\$153.00	\$161.50	\$170.00
65 - 69	\$1.52	\$243.20	\$258.40	\$273.60	\$288.80	\$304.00
70 - 74	\$2.17	\$347.20	\$368.90	\$390.60	\$412.30	\$434.00
75 - 99	\$4.68	\$748.80	\$795.60	\$842.40	\$889.20	\$936.00

<u>age brackets</u>	<u>rate per \$1000</u>	<u>\$210,000.00</u>	<u>\$220,000.00</u>	<u>\$230,000.00</u>	<u>\$240,000.00</u>	<u>\$250,000.00</u>
Under 30	\$0.06	\$12.60	\$13.20	\$13.80	\$14.40	\$15.00
30 - 34	\$0.06	\$12.60	\$13.20	\$13.80	\$14.40	\$15.00
35 - 39	\$0.09	\$18.90	\$19.80	\$20.70	\$21.60	\$22.50
40 - 44	\$0.14	\$29.40	\$30.80	\$32.20	\$33.60	\$35.00
45 - 49	\$0.22	\$46.20	\$48.40	\$50.60	\$52.80	\$55.00
50 - 54	\$0.35	\$73.50	\$77.00	\$80.50	\$84.00	\$87.50
55 - 59	\$0.51	\$107.10	\$112.20	\$117.30	\$122.40	\$127.50
60 - 64	\$0.85	\$178.50	\$187.00	\$195.50	\$204.00	\$212.50
65 - 69	\$1.52	\$319.20	\$334.40	\$349.60	\$364.80	\$380.00
70 - 74	\$2.17	\$455.70	\$477.40	\$499.10	\$520.80	\$542.50
75 - 99	\$4.68	\$982.80	\$1,029.60	\$1,076.40	\$1,123.20	\$1,170.00