SECURITY BENEFIT℠
To and Through Retirement

Security Flex 125 Program®

Flexible Spending Accounts
Employer Benefits Administration Manual

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Flexible Spending Accounts

Overview

Flexible Spending Accounts allow the employee to pay eligible medical and dependent care expenses with tax-free dollars. This saves the employee money in federal income and Social Security taxes and, in most cases, state taxes.

Since Security Benefit is one of the few companies to generate and mail reimbursement checks to participants on a daily basis, requests for reimbursement for medical and dependent care expenses can be made at any time during the month. Medical reimbursement claims are processed in a three- to five-day turnaround time from the date the claim is received at Security Benefit if the claim is in complete and good order.

Note: Dependent care reimbursements will occur only after a deposit has been received by the employer and processed.

A Section 125 Flexible Benefit Plan Medical/Dependent Care Reimbursement Program Claim Form must accompany all requests for reimbursement from Flexible Spending Accounts. Claim forms must be signed. Reimbursements are subject to a minimum amount of $25. If reimbursement is requested for an amount less than $25, we will hold (make pending) the claim until reimbursement requests total at least $25. Faxed and e-mailed claim forms will be accepted with documentation.

Medical Reimbursement

Under the Security Benefit medical reimbursement plan, employees designate the amount of dollars that they plan to use at the beginning of the plan year. The employer forwards these dollars on a payroll basis to the participant's account at Security Benefit Life.

Please encourage your employees to review medical expenses thoroughly and only set aside those dollars that they are sure that they will be able to spend during each plan year. Expenses such as deductibles, co-payments, eye examinations and glasses, transportation, orthodontia and numerous other expenses may also be paid with "before-tax" dollars under a medical reimbursement plan. Effective January 1, 2011, over-the-counter medications, except insulin, are not eligible for reimbursement without a doctor's prescription.

Any account balance remaining after the plan year end will be refunded to the employer. This applies to both medical reimbursement and dependent care FSA accounts.

Debit Card

Security Benefit offers the MBI Debit Card for use in reimbursing medical expenses. An agreement with MBI must be executed and participants must use the debit card authorization form to sign up. There is a charge for this service.

Coverage Effective Dates

Individual Effective Dates – New Hires

Carefully check your plan documents to verify which of the following two options your group has elected.

- New employees hired after the plan anniversary date shall have elected coverage effective the first of the month coincident with or following their employment date.
- New employees hired after the plan anniversary date shall have coverage effective the first day of the following month if their employment date is on or before the 15th of the month. If their employment date is after the 15th, the program will be effective the first day of the second month.

Legal Documents

In order to establish a plan with Security Benefit, the following must be adopted, completed and received before contributions can be sent to Security Benefit:

- Plan Document
- Adoption Agreement
- HIPAA Addendum
- Service Agreement
- Grace Period Amendments, if applicable
- Debit Card Forms, if applicable

Plan Administration

Plan Implementation

In order to establish a plan with Security Benefit the following must be adopted, completed and received before contributions can be sent to Security Benefit.

- Plan Document
- Adoption Agreement
- HIPAA Addendum
- Service Agreement
- Grace Period Amendments, if applicable
- Debit Card Forms, if applicable

Employee Benefit Election Form

The Benefit Election Form is used to enroll participants for coverage. It is important that all information provided to Security Benefit on these forms be accurate and legible.

Please be sure the participant completes the home address section of the form. This information is used for participants enrolled in flexible spending accounts and as a confirmation for claims submitted with insufficient address information.

Because this is a pre-tax benefit, the Social Security number is used when setting up a participant's flexible spending account. Therefore, it is vital for both you and the employee to verify the Social Security number.

According to Section 125 regulations, once a participant has selected coverage options for the plan year, they may not change their elections until they re-enroll the next plan year unless there is a family status change, a significant change in a coverage option, or a change in coverage under the plan of a spouse or dependent's employer. See Participant Changes, page 4, for further information on family status changes.

Enrollment Process

For a successful enrollment process, employers need to provide Security Benefit with updated and accurate employee census information each year. This will enable us to process the enrollment quicker and provide information to you and your employees in a timely manner.

Once enrollment is completed, you will receive your enrollment information which includes the first billing and election report. Employers need to review the election report and report any errors immediately.

Each participant will receive a welcome packet which includes the election they have chosen and necessary information to submit claims. This information is mailed directly to participants unless a special request is made to send the packets to the employer.

Contribution Guidelines

Statements

Security Benefit provides a detailed group contribution statement. **The statement should be returned with your payment. This information can be electronically delivered or sent by mail.**

Payroll Contributions

Employers can submit the payroll spending instructions through a secure FTP website, e-mail or by paper. Any changes to contributions need to be clearly noted or marked to ensure quick accurate processing.

Some benefits of electronic payroll processing are:

- Replaces paper reports
- Eliminates postage
- Eliminates mail deliver time delays

If you are interested in establishing electronic payroll processing please contact us.

Contributions can be sent in by ACH, wire or by check. Please contact us for ACH/wire instructions.

Nine- & 10-Month Premiums

In some instances, you may have employees who receive payroll for only nine or 10 months during the 12-month plan year. For those employees, the employer must make arrangements to either reduce or deduct from the salary sufficient premiums during the nine- or 10-month payroll period to cover the premiums for the full 12-month plan year. Unless an employee terminates employment or coverage is terminated in accordance with the terms of the contract or the employer's plan, all coverage is for a 12-month period. It helps your payroll processing if nine- and 10-month insured arrangements are made before the first payroll.

Please note: *Security Benefit is not engaged in rendering legal or accounting services. If legal or accounting advice or other expert assistance is required, the services of a competent professional person should be sought.*

Service

The best possible service can be provided to you by following these procedures:

- If you have any questions concerning coverage, deposits or information on your bill, please do not hesitate to call. We will be more than willing to provide you with the information you need. Call 1.800.888.2461. You may also e-mail questions or requests to ebdept@securitybenefit.com.
- For your convenience, we will always provide you with a return envelope. When submitting a payment, **please use the envelope provided and include the statement with your check.**
- Please indicate all additions, terminations and changes on the last page of your statement. The following information is necessary for terminated employees: name, social security number, exact termination date, reason for coverage termination and current address. The sooner Security Benefit is notified, the more accurate your monthly statements will be.
- Deposits are due on the date shown on each statement and must be paid by the end of the grace period as described in your contract. Statements are mailed after receipt of your deposit.
- All deposits must be paid through the employer directly to Security Benefit. Security Benefit will not accept payments by individuals for their coverage. Any personal checks received by Security Benefit will be returned to the employer.

Participant Changes

Throughout the plan year, it may be necessary to notify Security Benefit of name changes or change of address. At the time a change occurs, please have the participant complete section one on the Employee Benefit Election Form. This form must be signed and dated by the participant.

Revision of Benefit Selections

Generally, once an employee has selected their coverage options for the plan year, elections may not be changed until they re-enroll the next plan year.
One exception to this rule is a change in family status. Regulations define family status changes as any one of the following:

- Change in employee's legal marital status
- Change in number of dependents
- Change in employment status
- Dependent satisfies (or ceases to satisfy) dependent eligibility requirements
- Commencement or termination of adoption proceedings

Election changes due to a change in family status must be necessary and appropriate to the requested coverage change and include changes in salary reduction under your Section 125 plan. **Election changes must be made within 30 days of the date of the family status change or change in coverage.**

Refer to the qualified status changes mentioned previously. If you have any questions concerning changes the participant may want to make, feel free to contact us for help in determining appropriate allowable changes. To request an election change, please return the completed Employee Benefit Election Form.

Coverage Changes

No changes in Security Benefit coverage will be allowed during the plan year unless a qualified family status change, a significant change in a coverage option, or a change in coverage under the plan of a spouse or dependent's employer has occurred.

This is an underwriting guideline that applies regardless of whether premiums are paid on a salary reduction or deduction basis.

Flexible Spending Accounts Summary

Medical Expenses*

The following is a partial listing of medical expenses which are allowed and disallowed through your FSA. Please refer to IRC Section 213(d) for a complete listing of allowed expenses.

ALLOWED MEDICAL EXPENSES

- Acupuncture
- Ambulance
- Chiropractor fees
- Coinsurance (co-pays and deductibles for health, dental and vision)
- Corrective eye surgery
- Crutches (purchase or rental)
- Hearing aids and hearing aid batteries
- Hospital services
- Immunizations
- Insulin and equipment needed to inject the insulin
- Laboratory fees
- Massage therapy with letter stating medical necessity
- Medicines (prescriptions)
- Nursing services-connected with caring for the patient
- Organ donation/transplantation
- Orthodontic fees
- Over the counter medicines (with prescription)
- Prescription eyeglasses, sunglasses, Contact Lenses and solutions associated with their care
- Physical, Dental and Eye exams
- Prosthesis
- Psychoanalysis, Psychiatric & Psychological treatment/fees
- Reading glasses
- Surgery/operations
- Transportation-amounts primarily for and essential to medical care
- Weight-loss program and/or drugs to induce weight loss when prescribed for a specific diagnosis
- Well-child care
- Wheelchair
- X-ray fees

DISALLOWED MEDICAL EXPENSES

- Chapped lip treatments
- Cosmetic surgery (expenses exceptions if medically necessary)
- Dancing lessons, swimming lessons, etc., even if recommended for the general improvement of your health
- Diaper service
- Electrolysis or hair removal
- Face creams, moisturizers, suntan lotions
- Funeral Expenses
- Hair transplant (i.e. Rogaine, Propecia)
- Health Club dues
- Household help
- Insurance premiums – for individual and/or spouses health, dental, and/or policies covering loss of earnings, loss of a limb or eyesight
- Maternity clothes
- Medicated shampoos and soaps (unless prescribed by a doctor)
- Psychoanalysis received as part of training to be a psychoanalyst
- Sunscreen
- Teeth Bleaching
- Toiletries
- Toothbrushes, toothpaste
- Vitamins and supplements for maintaining general good health

ALLOWED OVER-THE-COUNTER MEDICATIONS

Reimbursable:

- Bandaids, bandages, gauze pads, first aid kits
- Cold/hot packs for injuries, crutches
- Contact lens solution, cleaners
- Carpal tunnel wrist supports
- Condoms, spermicidal foam
- Insulin
- Nasal strips for snoring
- Orthopedic shoe inserts
- Pregnancy test kits
- Reading glasses
- Thermometers (ear or mouth)

Reimburseable with a doctor's prescription:

- Antacids
- Allergy medication
- Anti-diarrheal medication, laxatives
- Bug bite medication
- Calamine lotion
- Cough drops, throat lozenges, sinus medication, nasal sinus spray
- Cold medication, pain reliever
- Diaper rash ointment
- First aid creams and ointments, liquid adhesives, topical ointments
- Glucosamine/chondroitin for arthritis or other medical condition
- Health Club dues (requires a doctor's statement and must be to treat a disease, if the participant belonged to the health club before being diagnosed, then the dues would not be reimbursable)
- Hemorrhoid creams
- Incontinence supplies
- Joint/muscle pain medication
- Lactose intolerance pills
- Medicated shampoos and soaps
- Menstrual cycle products for pain and cramp relief
- Motion sickness pills
- Nicotine gum or patches for stop-smoking purposes
- Over the counter hormone therapy and treatment for menopausal symptoms (hotflashes, night sweats, etc.)
- Prenatal vitamins during pregnancy
- Rubbing alcohol
- Sleeping aids
- St John's Wort for depression
- Suppositories
- Sunburn cream or ointment
- Supplements, vitamins or herbal treatments to treat medical condition
- Wart remover treatments
- Weight loss drugs to treat medical condition or obesity

**It is possible that changes in the IRS rules can affect the Allowed and/or Disallowed Expenses categories.*

Dependent Care Reimbursement

Expenses for the care of a child or other eligible dependents may be done with "before-tax" dollars. The maximum dependent care expense allowed is $5,000 annually or $2,500 in the case of a separate return made by a married person.

Under the Security Benefit dependent care plan, your employee designates the amount of dollars that he or she plans to use at the beginning of the plan year. The employer forwards these dollars to the accounts at Security Benefit on a payroll basis.

Claims submitted for dependent care expenses are reimbursed up to the amount available in the participant's account. As the employer deposits money into the employee's account, reimbursement is made on any pending balance.

Costs for eligible benefits must be incurred during the designated plan year. Unused benefits may not be carried over to a succeeding plan year. Any monies not expended during the plan year are forfeited to the employer. Therefore, employees should carefully review their expected dependent care expenses and only set aside those dollars they are sure will be spent during each plan year.

All participants in the dependent care flexible spending account program are required to obtain certification of their dependent care provider's tax identification number and to report the correct name, address and tax identification number for their dependent care provider on the child and dependent care tax credit form when they file their tax return. The amount reported by the employer should be the amount effectively contributed by the employee for dependent care assistance under the program (plus any matching employer contributions attributable thereto) for the year.

Dependent/Day Care Expenses*

Dependent/day care expenses include payments you make for the care of a child under 13 and/or a dependent regardless of age who requires care due to an inability to care for him or herself, to enable you (and, if married, your spouse) to remain gainfully employed.

Those dependents unable to care for themselves must spend at least eight hours a day in your home for the care to be eligible, and you must declare them as a dependent (or have the ability to declare them as a dependent except for their level of gross income) on your federal tax return. Reimbursement for amounts cannot be claimed if paid to your spouse, anyone you claim as a tax dependent, or your child under age 19. Any expenses reimbursed through your account cannot be claimed for income tax purposes. *Please remember day care expenses must be incurred to be eligible for reimbursement.*

ALLOWED DEPENDENT/ DAY CARE EXPENSES	• Licensed day care facility • Preschool program • In-home child and dependent care services	• Day camp expenses • Elder care	• Any other qualified dependent care expenses as defined by the IRS
DISALLOWED DEPENDENT/ DAY CARE EXPENSES	• Overnight camp	• Services solely for the purpose of household cleaning	• Day care for children past their 13th birthday

**It is possible that changes in the IRS rules can affect the Allowed and/or Disallowed Expenses categories.*

COBRA

Continuing Coverage Immediately After a Qualifying Event

There are several qualifying circumstances that may allow an individual to continue medical flex coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).* Please refer to IRS regulations that apply to you as the employer regarding your obligations. If you have any questions concerning this, please contact our office.

In order for an employee to be eligible for continuation of group coverage, one of the following qualifying events generally must occur:

- Termination for reasons other than gross misconduct,
  or
- Working hours have been reduced so the employee is no longer eligible for coverage under the group policy.

If an individual elects to continue coverage under COBRA, a COBRA Continuation of Coverage Election Form must be completed and forwarded to Security Benefit. Within 30 days of the qualifying event, should the participant choose to continue their coverage, the employer shall provide the participant with the proper forms to complete.

**Dependent care is not eligible for COBRA.*

Payment of COBRA Premium

Participants electing COBRA should pay their premium directly to the group. The group should include the COBRA premium in its premium payment to Security Benefit. Security Benefit will not accept payments directly from COBRA participants.

The Health Insurance Portability and Accountability Act provides for the transporting of some medical flexible spending accounts to the next employer. The employee electing COBRA should obtain a certificate of coverage from his or her prior employer.

SECURITY BENEFIT®

COBRA Continuation of Coverage Election

Questions? Call 1-800-888-2461.

Instructions

Use this form to continue your COBRA coverage elections. Please type or print.

The completed form should be mailed to:

Security Benefit Life Insurance Company
Attn: Employer Benefits Administration
P.O. Box 750500
Topeka, KS 66675-0600

1. Provide Employer Information

Name of Employer _____

2. Provide Information for Persons Electing to Continue Coverage

Name of Employee _____ _____ _____
First MI Last

Mailing Address _____ _____ _____ _____
Street Address City State ZIP Code

Social Security Number _____ Date of Birth _____
(mm/dd/yyyy)

Name of Spouse or Former Spouse _____ _____ _____
First MI Last

Social Security Number _____ Date of Birth _____
(mm/dd/yyyy)

Name of Child(ren)	**Social Security Number**	**Date of Birth (mm/dd/yyyy)**

3. Provide Qualifying Event Information

Check all that apply:

- ❑ Termination or Reduction of Hours Work _____ Date (mm/dd/yyyy)
- ❑ Employee's Entitlement to Medicare _____ Date (mm/dd/yyyy)
- ❑ Dependent No Longer Eligible _____ Date (mm/dd/yyyy)
- ❑ Divorce _____ Date (mm/dd/yyyy)
- ❑ Employee's Death _____ Date (mm/dd/yyyy)

4. Provide Signatures

To the Employer: This is to inform you that I wish to continue my un-reimbursed medical coverage. I have enclosed my monthly premium or will forward the premium to you within 45 days.

I understand that:

- I must pay future premiums on a monthly basis by (date) _____, or my coverage will be terminated.
- I am entitled to a grace period of at least 30 days.
- I will not be eligible for continuation of coverage if I become covered under any other group health plan, whether by virtue of my employment or my spouse's.
- My eligibility for COBRA coverage will terminate on the date I become covered by any other group plan.
- I may continue my coverage if the other group plan I become covered under does not cover a pre-existing condition that applies to me or my dependents.

X_____ _____
Signature of Employee — Date (mm/dd/yyyy)

X_____ _____
Signature of Spouse or Former Spouse — Date (mm/dd/yyyy)

X_____ _____
Signature of Child over 18 Years of Age — Date (mm/dd/yyyy)

X_____ _____
Signature of Child over 18 Years of Age — Date (mm/dd/yyyy)

Mail to: Security Benefit Life Insurance Company • PO Box 750600 • Topeka, KS 66675-0600 or
Fax to: 1-866-477-6526
E-Mail to: ebdept@securitybenefit.com

SECURITY BENEFIT®

Employee Benefit Election Form

Questions? Call our National Service Center at 1-800-888-2461.

Instructions

Use this form to add or make changes to your employee benefit elections. Please type or print.

1. To initiate new election benefits, complete Sections 1, 2 and 4.
2. To make changes to your mailing address, complete Sections 1 and 4.
3. To change existing election benefits, complete Sections 1, 3 and 4.
4. To expedite changes to an employee's status, all changes must be submitted promptly to Security Benefit in order for accurate record keeping to be maintained.

The completed form should be mailed to:

Security Benefit Life Insurance Company
Attn: Employer Benefits Administration
P.O. Box 750600
Topeka, KS 66675-0600

1. Provide General Information

Name of Employer_____

Name of Employee_____ _____ _____
First MI Last

Mailing Address_____ _____ _____ _____
Street Address City State ZIP Code

Social Security Number _____ Date of Birth_____
(mm/dd/yyyy)

❑ **Check box if this is a name or change of address only**

2. Provide New Election Information

Initial Date Employed_____ Effective Date _____
(mm/dd/yyyy) (mm/dd/yyyy)

	Amount per Payroll		Number of Pays		Annual Election
Medical Care FSA	_____	x	_____	=	_____
Dependent Care FSA	_____	x	_____	=	_____
			TOTAL REDUCTIONS		_____

Please Continue ➲

3. Provide Election Revisions Information

No election changes in the Security Benefit elections will be allowed in the plan year unless a family status change has occurred.

Reason for Change (Select one):

❍ Birth / Adoption ❍ Death ❍ Marriage / Divorce
❍ Change in Employment Status of Spouse ❍ Sick / Disability ❍ Worker's Comp
❍ Severance from Employment ❍ Personal ❍ Other (specify)

Date of Change _____ (mm/dd/yyyy) Date of Last / New Reduction _____ (mm/dd/yyyy)

Amount of Last / New Reduction $_____

Election Revision	Previous Amount per Pay	New Amount per Pay		Number of Pays		New Annual Election
Medical Care FSA	_____	_____	x	_____	=	_____
Dependent Care FSA	_____	_____	x	_____	=	_____
				TOTAL REDUCTIONS		_____

4. Provide Signature

I understand, acknowledge and certify:

– That my benefit elections shall remain effective except for any changes listed above.
– I must make an election change within 30 days of the date the family status changes to be considered valid.
– That any benefit change requested due to change in family status must be necessary or appropriate as a result of the family status change indicated.
– I have received a summary of the material terms of the plan and authorize deduction from my salary by the above salary reduction amount to purchase employee fringe benefits under IRC Sec. 125.
– I understand that I may not change this reduction amount during the plan year except for the circumstances defined in IRC Sec. 125 regulations (definitive information in enrollment package)

X_____ _____
Signature of Employee Date (mm/dd/yyyy)

Mail to: Security Benefit Life Insurance Company • PO Box 750600 • Topeka, KS 66675-0600 or
Fax to: 1-866-477-6526
E-Mail to: ebdept@securitybenefit.com

SECURITY BENEFIT®

Questions? Call our National Service Center at 1-800-888-2461.

Security Flex 125 Program® Medical/Dependent Care Reimbursement Program Claim Form

Instructions

Use this form to request medical expense or dependent care reimbursement. Complete the entire form. Please type or print

1. Complete the worksheet on the back of this form to itemize expenses and attach legible copies of receipts.
2. Must sign **Section 3**.
3. Completion of **Section 4** is optional, but will speed the processing of your claim.
4. This completed form and all required attachments should be mailed to:
   Security Benefit
   P.O. Box 750600
   Topeka, KS 66675-0600

1. Provide Personal Information

Employer Name _____

Name of Employee _____ (First) _____ (MI) _____ (Last)

Mailing Address _____ (Street Address) _____ (City) _____ (State) _____ (ZIP Code)

Social Security Number _____

Daytime Phone Number _____ Home Phone Number _____

2. Select Type of Claim

Please select one:

❍ **Dependent Care Reimbursement**
Requested Amount: $ _____

❍ **Medical Expense Reimbursement**
Requested Amount: $ _____

❑ Requesting **check** payment option.

❑ Please provide your bank information below if you wish to have payments from Security Benefit made by direct deposit to your bank account. If any information is missing your request may be delayed. You may also attach a void check to ensure necessary information is provided. Receipt by said bank of such credit entries shall be deemed receipt by you.

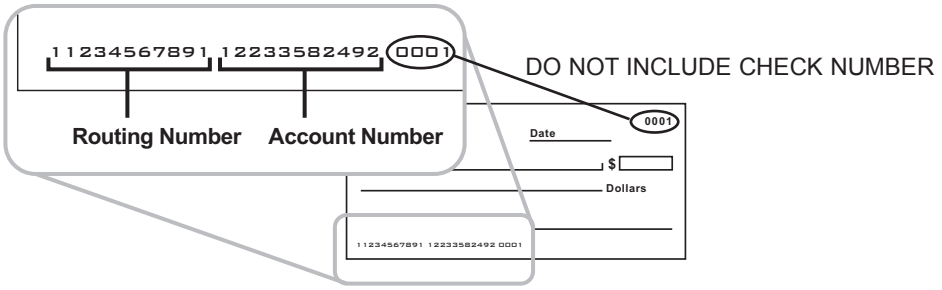
Bank Account Type (please check one): ❍ Checking ❍ Savings

Bank Name _____

Name on Bank Account _____

Bank Routing Number _____

Bank Account Number (Do not include the check number) _____



3. Provide Signatures

I agree:

- That this claim represents qualifying medical or dependent care expenses not covered/reimbursed by insurance.
- My signature below confirms my understanding and agreement with this requirement.
- I further understand that any claim that does not meet these requirements may result in this payment being considered a taxable payment by the IRS.
- I understand that the direct deposit arrangement will continue until Security Benefit receives written notification from me stating otherwise.
- This is to certify that I have incurred expenses that qualify for reimbursement under my employer's Security Benefit Medical/Dependent Care Reimbursement Program. None of these expenses have previously been submitted.
- I certify that these expenses will not be paid or reimbursed by any insurance company or from any other source or I may be subject to IRS fines and/or penalties of perjury. I hereby request reimbursement for these expenses to the extent allowable. I understand that at the end of the plan year all unpaid claims (even if less than $25.00) will be reimbursed in full and that any remaining fund balances at the end of the plan year will be forfeited to my employer.

X_____ _____

Signature of Employee | Date (mm/dd/yyyy)

4. Provide Summary of Itemized Bills

For each expense that you are submitting for reimbursement, you must provide all information below.

Name of Physician, Hospital Pharmacy or other Provider of Service	Description of service, if drug include name, days supply and quantity	Patient Name	Date of Service	Amount of Charge

Eligible expenses generally include health care expenses that are not covered, or only partly covered, by your health plans or, if you're married, by your spouse's health plans. Some of the expenses you can claim are:

Deductibles and co-payments under medical, dental, and prescription drug plans; Expenses for medical services or supplies not covered by your plans (for example, many plans do not cover routine physical or well-child care); Vision care expenses, including eye exams, eyeglasses, as prescribed by your doctor, and materials and equipment needed for using the eyeglasses such as eyeglass cleaner, contact lenses and contact lens supplies; Lasik, Laser eye surgery and Radial keratotomy; Hearing care expenses, including hearing exams and hearing aids; Expenses in excess of medical or dental plan limits (for example, orthodontic expenses greater than the limit set by your dental plan); Transportation expenses related to medical care; Nursing services not covered by your medical plan; Wheelchairs and crutches; Capital expenses for a personal residence to accommodate a disabled condition less the increase in your property value; Pregnancy test (over the counter); Certain over the counter drugs (with a prescription); Over the counter reading glasses when accompanied by a prescription; Smoking cessation program; Weight loss program when it is prescribed by your doctor for a specific diagnosis.

Expenses that are not Eligible

Most cosmetic surgery; Health club dues; Electrolysis; Over the counter vitamins, even when prescribed by a physician; Dietary supplements; Teeth whitening products; Insurance Premiums of any nature.

For expenses that are not listed you can refer to IRS Section 213 for more complete information or contact Security Benefit at 1-800-888-2461.

Mail to: Security Benefit • PO Box 750600 • Topeka, KS 66675-0600 or
Fax to: 1-866-477-6526
Visit us online at www.securityflex.com • E-mail: ebdept@securitybenefit.com

Our Pledge

Regarding Medical Information

We are committed to protecting your personal health information.

We are required by law to:

1 make sure that any health information that identifies you is kept private;

2 provide you with certain rights with respect to your health information;

3 give you a notice of our legal duties and privacy practices;

4 follow all privacy practices and procedures currently in effect.

Summary of Security Benefit Privacy Practices

Summary of Privacy Practices

This Summary of Privacy Practices summarizes how personal health information about you may be used and disclosed by the group health plan (the "Plan") offered or administered by Security Benefit (SB) in which you participate, or by others, in the administration of your claims. This Summary of Privacy Practices also summarizes certain rights that you have with respect to your personal health information. For a complete, detailed description of all privacy practices, as well as your legal rights, please refer to the accompanying Notice of Privacy Practices.

How We May Use and Disclose Health Information About You

We may use and disclose your personal health information without your permission to facilitate your medical treatment, for payment for any medical treatments, and for any other health care operation. We will disclose your health information to employees of SB for plan administration functions. We may also use and disclose your health information without your permission as allowed or required by law. Otherwise, we must obtain your written authorization for any other use and disclosure of your health information. We cannot retaliate against you if you refuse to sign an authorization or revoke an authorization you had previously given.

Your Rights Regarding Your Medical Information

You have the right to inspect and copy your health information, to request corrections of your health information and to obtain an accounting of certain disclosures of your health information. You also have the right to request that additional restrictions or limitations be placed on the use or disclosure of your health information, or that communications about your health information be made in different ways or at different locations. You may also restrict access to your Protected Health Information if you pay for your medical services in full, outside of the plan.

How to File Complaints

If you believe your privacy rights have been violated, you have the right to file a complaint with the Security Benefit Privacy Officer or with the U.S. Department of Health and Human Services – Office for Civil Rights. We will not retaliate against you for making a complaint.

Security Benefit Privacy Officer
James T. Janousek
Security Benefit
One Security Benefit Place
Topeka, Kansas 66636-0001
Telephone: 785-438-3038
Fax: 785-368-1353

Region VII – IA, KS, MO, NE
Office for Civil Rights
U.S. Department of Health & Human Services
East 12th Street – Room 248
Kansas City, MO 64106
Telephone: (816) 426-7278; (816) 426-7065 (TDD)
Fax: (816) 426-3686

SECURITY BENEFIT
NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2004
Last Updated: November 1, 2010

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice tells you about the ways in which Security Benefit (referred to as "the Company") may collect, use, and disclose your protected health information, and your rights concerning your protected health information. "Protected health information" is information about you, including demographic information, that can reasonably be used to identify you and that relates to your past, present, or future physical or mental health or condition, the provision of the health care to you, or the payment for that care. Protected Health Information also includes your genetic information as defined in Section 201 of the Genetic Information Nondiscrimination Act of 2008.

The Company is required by federal and state laws to provide you with this Notice about your rights and our legal duties and privacy practices with respect to your protected health information. We must follow the terms of this Notice while it is in effect. Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The Company may use and disclose your protected health information for different purposes. The examples below are provided to illustrate the types of uses and disclosures we may make without your authorization for payment, health care operations and treatment.

- Payment. We use and disclose your protected health information in order to pay for your covered health expenses. For example, we may use your protected health information to process claims or be reimbursed by another insurer that may be responsible for payment.
- Health Care Operations. We use and disclose your protected health information in order to perform our planned activities, such as quality assessment activities or administrative activities, including data management or customer service. In some cases, we may use or disclose the information for determining health care insurance premiums.
- Treatment. We may use and disclose your protected health information to assist your health care providers (doctors, mental health practitioners, pharmacies, hospitals, ambulance services and others) in your diagnosis and treatment. For example, we may disclose your protected health information to providers to provide information about alternative treatments.
- Plan Sponsor. If you are enrolled through a group health plan, we may provide enrollment/disenrollment information and summaries of claims and expenses for enrollees in a group health plan to the plan sponsor, who may also be an employer.
- Enrolled Dependents and Family Members. We will mail explanation of benefits forms and other mailings containing protected health information to the address we have on record for the subscriber of the health plan.

OTHER PERMITTED OR REQUIRED DISCLOSURES

- As Required by Law. We must disclose protected health information about you when required to do so by law.
- Public Health Activities. We may disclose protected health information to public health agencies for reasons such as preventing or controlling disease, injury or disability.
- Victims of Abuse, Neglect or Domestic Violence. We may disclose protected health information to government agencies about abuse, neglect or domestic violence.
- Health Oversight Activities. We may disclose protected health information to government oversight agencies (e.g., state insurance departments) for activities authorized by law.
- Judicial and Administrative Proceedings. We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information about you in certain cases in response to a subpoena, discovery request or other lawful process.
- Law Enforcement. We may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.
- Coroners, Funeral Directors, Organ Donation. We may release protected health information to coroners or funeral directors as necessary to allow them to carry out their duties. We may also disclose protected health information in connection with organ or tissue donation.
- Research. Under certain circumstances, we may disclose protected health information about you for research purposes, provided certain measures have been taken to protect your privacy.
- To Avert a Serious Threat to Health or Safety. We may disclose protected health information about you, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- Special Government Functions. We may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.
- Workers' Compensation. We may disclose protected health information to the extent necessary to comply with state law for workers' compensation programs.
- Health Information That is Not Protected. We may disclose health information about you that is not "protected health information;" that is, information used in a way that does not personally identify you or reveal who you are.

OTHER USES OR DISCLOSURES WITH AN AUTHORIZATION

Other uses or disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, except to the extent that we have already taken action on the information disclosed or if we are permitted by law to use the information to contest a claim or coverage under a health plan.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION
You have certain rights regarding protected health information that we maintain about you.

- Right to Access Your Protected Health Information. You have the right to review or obtain copies of your protected health information records, with some limited exceptions. Usually the records include enrollment, billing, claims payment, or case/medical management records. Your request to review and/or obtain a copy of your protected health information records must be made in writing. We may charge a fee for the costs of producing, copying and mailing your requested information, but we will tell you the cost in advance.
- Right to Amend Your Protected Health Information. If you feel that protected health information maintained by us is incorrect or incomplete, you may request that we amend the information. Your request must be made in writing and must include the reason you are seeking a change. We may deny your request if, for example, you ask us to amend information that was not created by us, or if you ask to amend a record that is already accurate and complete.
- Your Rights if a Request is Denied. If we deny your request to amend your protected health information, we will notify you in writing. You then have the right to submit to us a written statement of disagreement with our decision and we have the right to disagree with that statement.
- Right to an Accounting of Disclosures Made by Us. You have the right to request an accounting of disclosures we have made of your protected health information. The list will not include our disclosures related to your treatment, to payment, to health care operations, or disclosures made to you or with your authorization. The list may also exclude certain other disclosures, such as for national security purposes. Your request for an accounting of disclosures must be made in writing and must state a time for which you want an accounting. This time period may not be longer than six years and may not include dates before April 14, 2004. Your request should indicate in what form you want to receive the list (for example, on paper or electronically). The first accounting that you request within a 12-month period will be free. For additional lists within the same time period, we may charge for providing the accounting but we will tell you the cost in advance.
- Right to Request Restrictions on the Use and Disclosure of Your Protected Health Information. You have the right to request that we restrict or limit how we use or disclose your protected health information for treatment, payment or health care operations. We may not agree to your request. If we do agree, we will comply with your request unless the information is needed for an emergency. You may also restrict access to your Protected Health Information if you pay for your medical services in full, outside of the plan.
  Your request for a restriction must be made in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit how we use or disclose your information, or both; and (3) to whom you want the restrictions to apply.
- Right to Receive Confidential Communications. You have the right to request that we use a certain method to communicate with you, such as paper or electronic communication, or that we send information to a certain location if the communication could endanger you. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from us could endanger you. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- Right to Notice of Breach. You have the right to be notified of any breach of your Protected Health Information, except the unintentional acquisition, access, or use of information that does not meet the definition of "breach" pursuant to applicable guidance from the Department of Health and Human Services.
- Right to a Paper Copy of this Notice. You have a right at any time to request a paper copy of this Notice, even if you had previously agreed to receive an electronic copy.
- Contact Information for Exercising your Rights. You may exercise any of the rights described above by contacting our Privacy Office. See the end of this Notice for the contact information.

HEALTH INFORMATION SECURITY
Security Benefit requires its employees to follow the SB security policies and procedures that limit access to health information to those employees who need it to perform their responsibilities. In addition, SB maintains physical, administrative and technical security measures to safeguard your protected health information.

CHANGES TO THIS NOTICE
We reserve the right to change the terms of this Notice at any time, effective for protected health information that we already have about you as well as any information that we receive in the future. We will provide you with a copy of the new Notice whenever we make a material change to the privacy practices described in this Notice. We also post a copy of our current Notice on our intranet website. Any time we make a material change to this Notice, we will promptly revise and post the new Notice with the new effective date.

COMPLAINTS
If you believe that your privacy rights have been violated, you may file a complaint with us and/or the Secretary of the Department of Health and Human Services. All complaints to Security Benefit must be made in writing and sent to the privacy official listed at the end of this Notice. We support your right to protect the privacy of your protected health information. We will not retaliate against you or penalize you for filing a complaint.

CONTACT SECURITY BENEFIT
If you have any complaints or questions about this Notice or you want to submit a written request to Security Benefit as required in any of the previous sections of this Notice, please contact:

Security Benefit
James T. Janousek
Privacy/Compliance Officer
One Security Benefit Place
Topeka, Kansas 66636-0001
Phone: (785) 438-3038
Fax: (785) 368-1353

You may also Contact:
HHS Region 7 – Kansas City, MO
Office of Civil Rights
1201 Walnut, Suite 2334
Kansas City, MO 64106
Phone: 816-426-3697

Service Options

Web Access
The 24-hour website for your Section 125
Flexible Spending Account is **www.securityflex.com**
Click on the Security Flex 125 Program® icon.

Fax Access
For 24-hour toll-free fax access for flex reimbursement,
call: **1.866.477.6526.**

Phone Access
For personalized telephone support,
call **1.800.888.2461** toll free,
Monday-Friday from 8:00 am to 5:00 pm Central Time.

E-mail Access
To e-mail completed forms,
ebdept@securitybenefit.com

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One Security Benefit Place • Topeka, Kansas 66636-0001 • securitybenefit.com

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