

Asheville City Schools is offering all full-time employees a comprehensive Cafeteria Benefits plan. The Cafeteria Benefits plan is being arranged by Mark III Brokerage, an employee benefits firm that has worked in the public sector since 1973. The Cafeteria Benefits plan allows you to pay for certain insurance premiums, child-care, and unreimbursed medical expenses before taxes are taken out of your paycheck. Paying for these benefits in this method may reduce your taxes and may increase your take home pay.

- The Plan Year begins October 1, 2011 and ends September 30, 2012

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This booklet highlights the benefits offered through your Employer for the current plan year. This is neither an Insurance Contract nor a Summary Plan Description and only the actual policy provisions will prevail. All information in this booklet including premiums are subject to change. All policy descriptions are for informational purposes only.

FSA's and Healthcare Reform

What The New Legislation Means To You

WILL HEALTHCARE REFORM LAWS AFFECT MY FLEXIBLE SPENDING ACCOUNT (FSA)?

Yes. The new healthcare reform legislation will significantly change the landscape of cafeteria plans, including FSAs.

CAN I STILL USE MY FSA FUNDS FOR OVER-THE-COUNTER (OTC) MEDICATIONS?

OTC medications and drugs (other than insulin) will not be reimbursed by an FSA unless they are accompanied by a doctor's prescription. Medication or drugs must meet one of the following criteria to be eligible for reimbursement.

1. The medicine or drug requires a prescription.
2. The medicine or drug is available without a prescription and the individual obtains a prescription.
3. The medicine or drug is insulin.

Not all OTC expenses are excluded from reimbursement. Items such as adult diapers, bandages, first aid kits, diabetes monitors, and test strips may still be purchased on a pre-tax basis, with reimbursable funds, without a doctor's prescription. A final list of approved OTC items has not been released by the U.S. Department of Health and Human Services.

AM I STILL ABLE TO USE MY FSA DEBIT CARD FOR ELIGIBLE EXPENSES?

Most retailers cannot distinguish which OTC medications and drugs are prescribed. Even though certain OTC expenses are still eligible for reimbursement with FSA funds, you may not use your FSA debit card for these eligible purchases. Individuals must submit an online claim for reimbursement of these items.

OTC medications must be substantiated by submitting the prescription (or a copy of the prescription or other documentation that a prescription has been issued) when the claim is filed with Gilsbar.

HOW CAN I SUBMIT AN ONLINE CLAIM?

1. Login to www.myGilsbar.com.
2. Select the *Reimbursement Account Center* link.
3. Click *New Reimbursement Request* found in the center box labeled Recent Reimbursement Requests.
4. Click *Request Reimbursement* for the appropriate account.
5. Select the Claim Category from the drop down menu and click *Next*.
6. Fill in the Claim Type, Amount, Provider, and Service From Date(s) fields. Click *Next*.
7. Review the data entered. If you need to make an edit, click *Modify*. If everything is correct, click *Finish*.
8. Repeat Steps 4 – 6 if you need to enter multiple claims. When finished, click *Submit all Entered Claims for Processing*.
9. Select the box next to the statement “I hereby certify that all items...” and click *Confirm*.
10. Print a copy of the confirmation page with transaction number for your records.
11. Download the Fax Coversheet by selecting the link labeled *Click Here*.
12. Fax a copy of the Fax Coversheet and your receipt(s) to 866.635.1329*.

* It is necessary to submit a faxed copy of your receipt(s) including a description of services in order to fully process the claim(s). Please attach a copy of your doctor's prescription or documentation that a prescription was issued when you submit your claim.

Because the majority of OTC medications and drugs are no longer eligible for reimbursement, this may affect how much you choose to contribute to your FSA. Remember, as a general rule, the IRS requires that all money in the account be used during the plan year.

Money cannot be returned to you or carried over to the following year. For this reason, it is better to underestimate your expenses at the beginning of the plan year when you decide your contribution amount.

Gilsbar HealthCare Flexible Spending Account

Plan Year: October 1, 2011 - September 30, 2012

Medical Reimbursement Plan Maximum: \$3,000.00

Medical Reimbursement Plan Minimum: \$240.00

Run Off Period: 90 days following the end of the plan year to file for services rendered during the plan year.

New Hire Waiting Period: 30 days

REMINDER: The Internal Revenue Service (IRS) requires review of all receipts for eligible expenses in a FSA, including debit card transactions and over the counter drugs. As a reminder, participants should keep all of their receipts for the entire plan year in the event that Gilsbar ask for documentation or the IRS requests a copy of a receipt.

Flexible Spending Accounts allow you to use pre-taxed dollars towards health care expenses such as prescription and over-the-counter medication (with a prescription or letter of medical necessity), certain medical procedures, copays, and more. With Flexible Spending Accounts (FSA), you can save a significant amount of money on your health and day care expenses using a Health Care and/or Dependent Care Flexible Spending Account (FSA). The frequently asked FSA questions below will help you understand how to make the most of this program and your paycheck.

General questions regarding Health Care and Dependent Care Accounts:

What is an FSA?

Provided by your employer, an FSA is a reimbursement account that allows you to set aside a certain amount of each paycheck, pre-tax, to help pay for your out-of-pocket medical expenses and/or dependent day care expenses. The amount you elect is deducted from gross earnings before federal and state taxes are calculated. By using your FSA to pay for qualified expenses you save on income tax... which means your take home pay increases!

Will I pay taxes on the money I set aside?

No. FSA contributions and reimbursements are exempt from Federal Income taxes, Social Security (FICA) taxes, and in most cases, state income taxes.

What kind of savings can I realize by participating in this program?

Actual savings depend on your tax bracket, but most people will save about 30% on their eligible health care and dependent care expenses.

Can I submit expenses I incurred before the beginning of the plan year?

No. Only expenses incurred during the plan year and while you are a participant are eligible for reimbursement.

How long do I have to file a claim with Gilsbar after the plan year ends?

You have a grace period (90 days) after the end of the plan year to submit expenses incurred during the plan year.

Can I change the amount of my election(s) in the FSA program during the plan year? (i.e. my glasses cost more than I anticipated, I miscalculated my daycare expenses for the year)

Generally, you may not change your FSA elections during the Plan Year.

However, you may change during the annual enrollment period for the coming Plan Year. There is an exception to this rule: you may change or revoke your deferral rate in the FSA if you have a Change in Dependent Status. Examples of a qualifying status change may include:

- Marriage, divorce, or legal separation
- Birth, adoption or placement for adoption of a child
- Death of a dependent or spouse
- Change in employment status of yourself or your spouse
- A significant change caused by a third party in the cost of your dependent care coverage

(You have 30 days from the date of the qualifying event to request a change to your FSA election. This must be done in writing to your benefits office).

If I terminate employment, or participation in the FSA, what happens to the money left in my account(s)?

You will be reimbursed only for expenses incurred prior to your termination date, and submitted within the termination grace period. Any money remaining in your account(s) after the grace period will be forfeited.

Can I view my FSA balances online?

Yes! Visit myGilsbar.com and login to access claims information and FSA balances online. Once you are logged in, select the FSA and HRA links on the left side of the screen to view your account balances. If you are new to myGilsbar, complete the brief site registration to login. You will need your group number, social security number, and a valid email address to complete this section.

What if I have a question?

If you have any questions regarding your account balance, claim reimbursement or eligible expenses, you can access your account information at myGilsbar.com or you can call our Customer Contact Center at 1.800.445.7227 ext. 883.

How does participating in an FSA save me money?

The following example illustrates how a FSA saves you money. This example shows the per period savings for an employee on a bi-weekly payroll, with a tax status of "single" with one exemption:

	With FSA	Without FSA
Salary	\$1000	\$1000
Less Pre-Taxed Dollars:		
Health Care Reimbursement	\$100	0
Dependent Day Care Reimbursement	\$150	0
Taxable Income	\$750	\$1000
Less:		
Federal Income Tax	\$82.00	\$121.00
State Income Tax	\$17.58	\$23.44
Social Security	\$57.37	\$76.50
Net Take Home Pay	\$593.05	\$779.06
Less Health Care & Dependent Care Expenses	\$0.00	\$250.00
Net After Expenses	\$593.05	\$529.06

Tax Savings This Pay Period: \$63.99
Annual Tax Savings: \$63.99 X 26 pay periods = \$1,663.74

The Health Care FSA is simple! Provided by your employer, a Health Care FSA is a reimbursement account that allows you to set aside a certain amount of each paycheck, pre-tax, to help you pay for your out-of-pocket medical expenses. The amount you elect is deducted from gross earnings before federal and state taxes are calculated. By using your FSA to pay for qualified medical expenses you save on income tax... which means your take home pay increases.

How does the Health Care FSA Work?

With a Health Care FSA, you must decide on your contribution amount at the beginning of the plan year. The amount you designate will be equally divided between pay periods. To estimate the out-of-pocket expenses that you, your spouse, and your dependents may incur, consider any standard co-pays, prescriptions, office visit, and over-the-counter medications (with a prescription or letter of medical necessity) and planned medical expenses, i.e. braces or LASIK eye surgery. An expense worksheet has been provided at the end of this section to help you determine the amount of money to allocate to your Health Care FSA.

The IRS requires you to forfeit any money that is left in the FSA at the end of the year. Generally, it is better to underestimate the expenses and pay a little extra tax than to overestimate expenses and forfeit money. To help avoid forfeitures, you will receive a notice of your balance prior to the end of each year.

You can access balance information online 24/7 via myGILSBAR.com. Select the "Reimbursement Account Center" link on the left side of the screen to view your balances. Once you decide how much you want to contribute each paycheck, the money is automatically deposited into your account. As you incur eligible expenses, fax your completed claim form and receipts to Gilsbar for reimbursement.

What is eligible for reimbursement under the Health Care FSA?

Eligible health care expenses may include deductibles, co-payments and amounts over the maximum your plan pays, expenses for routine physicals and other expenses not covered by your health care plan. For more complete listing please refer to the "Qualified Medical Expenses Eligible for Reimbursement" list below.

How do I get reimbursed?

For reimbursement of expenses covered under a health care plan:

- Ensure your expenses are submitted to your health carrier
- If you also have coverage through a spousal plan, you must submit your expenses to both carriers before you submit your expenses for FSA reimbursement
- Once processed by your health carrier(s), complete the Health Care Expense Claim form and attach a copy of the "Explanation of Benefits" showing the unpaid expenses
- For reimbursement of expenses not covered under a health care plan: (ex.: over-the-counter medicines) Complete the Health Care Expenses claim form and attach itemized bills for the expense.

FAX CLAIMS AND PROOF OF EXPENSE TO 866.635.1329

How much will be reimbursed?

When you submit a health care expense, you will be reimbursed for eligible expenses claim up to the maximum amount you elected for the plan year, minus any previous reimbursements.

Can I use my Health Care FSA for my family's expenses?

Eligible health care expenses incurred by you, your spouse, or any dependent that you claim as a dependent on your income tax returns are allowable for reimbursement.

If I don't have any medical insurance through my company, can I still participate in the Health Care FSA?

Yes. Out-of-pocket expenses for you and your dependents are eligible for reimbursement whether or not you are insured through your company. Health related expenses are reimbursable for your dependents, if you claim them as a dependent on your income tax returns (this definition of a dependent may be different than that used for your health insurance plan).

Is there anything I have to keep in mind when it comes time to file my taxes?

Expenses payable through your benefits program (or your spouse's, if applicable) are not eligible for reimbursement under the Health Care FSA. In addition, expenses reimbursed through your Health Care FSA cannot be claimed as a deduction on your income tax returns.

I am covered under both my health insurance plan and my spouse's. Do I have to submit medical expenses to both plans before I can file for reimbursement from my Health Care FSA?

Yes. IRS regulations do not permit reimbursement of expenses through the FSA that would otherwise be covered under your health insurance plan. Expenses should first be submitted to your health insurance plan(s), then send any remaining unpaid claims to Gilsbar for reimbursement.

If I have a question about my account, what should I do?

If you have any questions, you can access your account information 24/7 at myGilsbar.com, or you can call Gilsbar's Customer Contact Center at 1.800.445.7227 ext. 883.

The following is a brief summary of information and is intended to serve as a quick reference to help determine whether or not an expense may be eligible for reimbursement. This list is not all-inclusive. This information is not tax advice. Tax advice should be obtained from a professional tax advisor.

Qualified Medical Expenses Eligible For Reimbursement:

Acupuncture	Guide dog	Orthopedist
Alcoholism Treatment	Gynecologist	Osteopath
Ambulance	Healing service	Over-the-counter medications **
Anesthetists	Hearing aid and batteries	Oxygen
Artificial limbs	Hospital bills	Paid-for medical care service
Birth control pills (by prescription)	Hydrotherapy	Pediatrician
Blood tests	Immunizations	Physician
Braces	Insulin treatments	Physiotherapist
Braille books and magazines	Lab tests	Postnatal treatments
Cardiographs	Lead paint removal	Practical nurse
Chiropractor	Legal fees (to authorize treatment for a mental illness)	Prenatal care
Christian Science Practitioner	Lodging away from home for outpatient care	Prescription medicines
Contact lenses	Medical services	Psychiatrist
Contraceptive devices	Medical Testing	Psychoanalyst
Convalescent home (for medical treatment only)	Metabolism tests	Psychologist
Crutches	Neurologist	Psychotherapy
Dental treatment	Nursing (including board and meals)	Radium Therapy
Dental x-rays	Obstetrician	Registered nurse
Dentures	Operating room costs	Special School
Dermatologist	Ophthalmologist	Spinal fluid tests
Diagnostic fees	Optician	Splints
Drug addiction therapy costs	Oral surgery	Sterilization
Drugs (prescription)	Organ transplant (including donor's expenses)	Stop smoking programs
Equipment (medical)	Orthodontist	Surgeon
Eye exams and eyeglasses	Orthopedic shoes	
FICA and FUTA tax for the handicapped		

** Prescription required as of January 1, 2011.

Telephone equipment to assist the hearing impaired	Transportation expenses relative to health care (Mileage is eligible for the miles driven to and from the doctor's office. The amount that can be reimbursed is nineteen (19) cents per mile.)	Vasectomy
Television equipment for the hearing impaired		Vitamins (if prescribed)
Therapy equipment		Weight loss programs* (not food)
Transplants (organ)	Ultra-violet ray treatment	Wheelchair
	Vaccines	X-rays

* May require additional substantiation (documents of medical necessity)

Expenses Not Eligible For Reimbursement

Any expense not considered "medically necessary" by the IRS	Electrolysis	Laetrile
	Face lifts	Liposuction
Any expense for your general health, even if your doctor prescribes the program	Food	Marijuana used medically
	Funeral, cremation, or burial expenses	Maternity clothes
Babysitting and childcare	Hair transplants	Personal use items
Bleaching teeth (cosmetic)	Health club membership dues	Prescription drugs considered cosmetic
Cosmetic surgery	Household help	Rogaine
Dancing lessons	Illegal operations and treatments	Swimming lessons
Diaper service		
Dietary supplements	Insurance premiums	Vitamins

Over the Counter Drugs

Participants are required to have a prescription for Over-the-Counter (“OTC”) products to be eligible under their FSA plan. Therefore a prescription is required for OTC items.

The following is a brief summary of information and is intended to serve as a quick reference to help determine whether or not an expense may be eligible for reimbursement. This list is not all-inclusive. This information is not tax advice. Tax advice should be obtained from a professional tax advisor. IRS Publication 502 can be ordered from the **IRS 1-800-TAX-FORM (1.800.829.3676)**.

Drug/Medicine

Allergy Prevention & Treatment	First Aid Supplies
Antacids and Acid Reducers	Hemorrhoid Treatments
Anticandial	Internal Analgesics / Antipyretic
Antihistamines	Incontinence Supplies
Anti-diarrheal and Laxatives	Liniments
Anti-fungal	Medical Monitoring
Anti-itch Lotions and Creams	Medical Products and Devices
Asthma	Menstrual Cycle Medications
Cold Sore / Fever Blister	Migraine
Condoms and other contraceptive Devices	Motion Sickness Medication
Contact Lenses Solutions	Nicotine Gum or Patches and moking Cessation Aids
Cough Suppressants	Pediculicide (head lice)
Decongestant / Nasal Decongestant and Cold Remedies	Smoking Cessation
Diaper Rash Ointments	Toothache/Teething Pain Relievers
Eye Drops for Allergy / Cold Relief	Wart Removal and Medications

Health Care FSA Expense Worksheet

This worksheet has been prepared to help you determine the amount of money you wish to allocate to your Health Care FSA. You may want to review your checkbook register or credit card statements from last year to identify medical expenses you paid out of your own pocket. Compare last year's typical expenses to those eligible under your Health Care FSA and budget accordingly for the upcoming year, keep in mind to only budget for those expenses specifically eligible under your Health Care FSA.

HEALTH CARE EXPENSES YOU PAID LAST YEAR COULD INCLUDE:

Deductibles

(medical and dental) \$ _____

Benefit percentage/co-insurance

(The amount NOT paid by your insurance) \$ _____

Amounts paid over plan limits

Over reasonable and customary allowance \$ _____

Over psychiatric limits \$ _____

Over private room allowance \$ _____

Expenses NOT covered by your insurance plan

Physicals

Prescription drugs \$ _____

Over-the-counter medications \$ _____

Vision care \$ _____

Hearing expenses \$ _____

Psychiatric care \$ _____

Dental and orthodontic care \$ _____

Assistance for the handicapped \$ _____

Therapy/treatments \$ _____

Physician's fees/services \$ _____

Medical equipment \$ _____

Miscellaneous charges \$ _____

My out-of-pocket health care

(expenses last year) \$ _____

Flex Debit Cards

How does the FSA Debit Card work?

Shortly after the start of the plan year you will receive your FSA Debit Card to use for your eligible medical expenses. If you are a current participant, your card will reflect the new plan year contribution amount on the new effective date of the plan. As you incur expenses, use your FSA Debit Card to have the funds taken directly out of your account so you don't have to pay with cash out of your pocket.

Where can I use my FSA Debit Card?

Your FSA Debit Card will only be accepted at authorized vendors that have the appropriate merchant codes, such as medical clinics, hospitals, dental offices, vision care centers and pharmacies.

If I use my FSA Debit Card, is verification of claims still required?

Per IRS requirements, verification of claims is required for all debit card transactions. A large portion of debit card transaction can be verified using one of the IRS' approved electronic methods; however, not all transactions can be verified electronically. For any expense that cannot be verified electronically, you must provide supporting documentation upon request in the form of an itemized bill or receipt to Gilsbar. Verification should include the patient name, date of service, description of services rendered, cost and patient liability. If Gilsbar does not receive verification within 30 days of the date requested you will be asked to return the un-verified amounts to your employer, or they may be counted as taxable income to you.

Are there special rules that are related to prescriptions, over-the-counter (OTC) products, and vision expenses incurred at retail merchants?

Over the Counter (OTC) are only eligible with a prescription. You must submit the prescription with the receipt for reimbursement.

Can I use my FSA Debit Card for eligible Dependent Care expenses?

No. Your FSA Debit Card may not be used to pay for eligible Dependent Care expenses. Your card will only be accepted at authorized vendors that have the appropriate merchant codes, such as medical clinics, hospitals, dental offices, vision care centers and pharmacies.

What happens if the FSA Debit Card is used for an ineligible expense?

Gilsbar will review all charges and determine if the card was used for an ineligible expense, according to IRS guidelines. If it was, we will notify you for repayment of the invalid amount. Failure to repay within 30 days of the request can result in the loss of your debit card privileges.

What should I do to pay for an expense that is more than my account balance?

You should tell the merchant to swipe your card for the amount equal to what is left in your account, then use another payment method to pay the remaining balance.

FSA Substantiation

Documenting & Submitting Proof of FSA Eligible Purchases

FREQUENTLY ASKED QUESTIONS:

Previously, I never received notices asking for debit card receipts. Why am I now getting these notices?

The IRS changed the rules regarding how debit cards need to operate for an FSA. These rules took effect on January 1, 2008, so the process Gilsbar has to follow has changed and hence, you have seen a change. According to the new rules, there are five basic requirements that must be met for you to use a debit card for your FSA. These requirements are:

- Participants must provide certification each year that they will only use the debit card for FSA eligible items. This is done during the enrollment process.
- The participant must retain all receipts for all transactions.
- 100% of debit card transaction must be reviewed by a third party to ensure that the items purchased are FSA eligible.
- Sampling or employee "self-certification" is not allowed for an FSA.
- Debit cards can only be used at locations that are medical service providers or provide point of purchase review.

Fortunately, in the new rules, the IRS defines several electronic substantiation methods that we can follow to help with the adjudication process. These methods are:

- Co-pay Match – If a transaction equals a co-pay amount or multiples of co-pay amounts under the health plan, no additional information is needed to support a card transaction.
- Recurring Expense – For transactions that were previously substantiated, recurring expenses will also be considered substantiated provided they are incurred with the same provider at the same location for exactly the same amount.
- Real-Time or Merchant Substantiation – If a transaction can be matched against real-time data at the point of purchase identifying it as a medical expense, no additional substantiation is needed.

All in all, with the new rules, about 72% of all debit card transactions fit one of the electronic substantiation categories listed above. Meaning, Gilsbar is asking for detail on about 28% of all debit cards transactions.

Why does the IRS have these rules? Isn't it my money?

Yes, the money that you put into an FSA is your money; however, in order to receive this money WITHOUT paying taxes you must follow the rules that the IRS has provided for the receipt of an FSA pre-tax reimbursement. At the present time, these rules require all administrators to verify that the money in the FSA is being used for medical care purposes.

What should I do if I receive substantiation letters?

You should sign and return these notices to Gilsbar when you submit your receipts, and keep a copy of these letters for your records. Remember, you can mail or fax your receipts and forms to Gilsbar:

Mail: Employee Reimbursement Center/P.O. Box 25123 /Lehigh Valley, PA 18002-5123 / Fax: 1.866.635.1329

What are acceptable forms of substantiation?

Acceptable forms of substantiation include: Explanation of Benefits (EOBs) and register and/or provider receipts showing the date, item bought and dollar amount charged. Credit card receipts are not acceptable forms because they do not provide the specific item purchased; therefore, Gilsbar cannot determine if the expense was an FSA eligible item.

Is it a requirement that providers, pharmacies, hospitals, etc. provide a receipt with service?

No, it is not a requirement that they provide a receipt, but we suggest you always ask for and collect a receipt from medical providers and facilities. If you are ever audited by the IRS, they will require these receipts for validation of purchases.

In addition to sending my receipts to Gilsbar, should I also keep copies of my receipts?

Because FSAs are federally regulated accounts, we do encourage you to practice good record-keeping habits. Just like you track other items for tax purposes each year, consider your FSA documentation just as important. It is our recommendation that you keep these receipts for your personal records in addition to sending to Gilsbar.

Here are a few organization and record-keeping suggestions:

- Designate a folder to keep copies of only your FSA eligible receipts.
- In this same folder, keep copies of any information you receive from your employer or Gilsbar regarding FSAs. This includes marketing pieces, letters, or notices you may receive.
- Register on myGilsbar.com and start utilizing the Reimbursement Account Center to stay informed and up-to-date on your account. The reimbursement account center allows you to access the following:
 - Available balance
 - Submitted claims
 - Pending claims
 - Payments received
 - Lists of eligible expenses
 - Downloadable forms
 - And much more!

I thought purchases at certain vendors were automatically substantiated and considered approved purchases?

As of January 1, 2009, no additional substantiation is required for debit card transactions that are approved at the point of sale by merchants (specifically pharmacies) who have adopted the Inventory Information Approval System (IIAS). The IIAS system compares the SKU on the item being purchased to a list of FSA eligible items sold at the store. When a FSA debit card is used, the pharmacy will only allow the card to pay for the FSA eligible items and any non-FSA eligible items will need to be paid for using an alternative method of payment. After January 1, 2009, if merchants have not adopted this system, FSA debit cards might not work at their places of business. Until then, providing copies of receipts, even pharmacy purchases, is still required.

Gilsbar Dependent Care Flexible Spending Account

Plan Year: October 1, 2011 - September 30, 2012

- **Dependent Care Flexible Spending Account Maximum: \$5,000**
- **Waiting Period: Employees can apply during the Annual Enrollment**
- **Reminder: Debit card cannot be used with the Dependent Care account**

The Dependent Care FSA helps you pay for child care services which make it possible for you and your spouse (if applicable) to work. It also may be used to help pay for the care of a disabled spouse or dependent.

The Dependent Care FSA creates tax savings on up to \$5,000 of daycare expenses. That can mean \$1,500 in tax savings enough to pay for weeks of eligible child or adult daycare!

How Does a Dependent Care FSA work?

A Dependent Care FSA is a reimbursement account that allows you to set aside a certain amount of each paycheck on a pre-tax basis to pay for your eligible dependent day care expenses. The amount you elect at the beginning of each plan year, is deducted from your gross earnings before federal and state taxes are calculated. By using your FSA to pay for qualified expenses you save on income tax...which means you have more money in your pocket!

To estimate your dependent care expenses, consider your expenses from last year. An expense worksheet is provided at the end of this section to help you determine the amount of money to allocate for your Dependent Care FSA. Remember, the IRS requires that all money in your account be used during the plan year. You can access balance information 24/7 online via myGilsbar.com. Select the "Reimbursement Account Center" link on the left side of the screen to view your balances.

Am I eligible to use the Dependent Care FSA?

To be eligible, you must be at work during the time your eligible dependent receives care. You must also meet one of the following eligibility guidelines:

- You and your spouse are both employed;
- You are a single parent;
- Your spouse is a full-time student at least five months during the year while you are working;
- Your spouse is physically or mentally unable to provide his/her own care; or
- You are divorced or legally separated and have custody of your child most of the time even though your former spouse may claim the child for income tax purposes.

Who is an eligible dependent?

An eligible dependent is defined as any person who can be claimed as a dependent for federal tax purposes and who:

- Is a child under 13 years of age;
- Is a child over the age of 13 who is physically or mentally incapable of caring for himself or herself;
- Is your spouse who is physically or mentally incapable of caring for himself or herself,
- An elderly parent who resides with you and is physically or mentally incapable of caring for himself or herself.

What expenses are covered?

Eligible dependent care expenses are those which allow you and your spouse, if you are married, to work or attended school full- time. Below are some examples of eligible dependent care expenses:

- Day care facility fees
- Before/after school care
- Summer day camp (not overnight)
- Nursery school or preschool, if child is too young for kindergarten
- In home babysitting fees, if not provided by another dependent and claimed as income by the care provider
- Private school tuition, K4 and above is not eligible for reimbursement

Is there anything I have to keep in mind when it comes time to file my taxes?

You are required to provide the name, address and taxpayer identification (or Social Security number) of the dependent care provider on your income tax return.

If you are unable to provide this information, both the tax credit and the exclusion for the spending account reimbursement may be denied by the IRS. Verify that this information is available before you elect to participate in the Dependent Care FSA.

Expenses reimbursed from this FSA cannot be used to claim a Federal Income Tax credit; therefore, you will have to determine which approach is best for you. You may even be able to combine the expense account and tax credits to reduce your overall dependent care expenses. However, the maximum expense you can claim when using both the tax credit and FSA is the tax credit limit (\$2,400 for one dependent or \$4,800 for two or more dependents), minus the amount reimbursed under the Dependent Care FSA.

How do I get reimbursed?

As you incur eligible expenses you must submit a completed Dependent Care FSA claim form to Gilsbar with proof of payment from your day care provider or from the individual who provides the care. Dependent Care FSA claims must include the federal tax identification number or Social Security number, name and address of the provider, dates of service, type of service rendered and name of dependent. The individual who provides the care cannot be your spouse or a dependent under the age of 19.

With a Dependent Care FSA, you will be reimbursed as you set funds aside. If you submit a claim for more than what has been set aside for that account, the unreimbursed claim portion will be placed in "pending" status until funds are received through payroll deduction at which time you will receive reimbursement.

FAX CLAIMS AND PROOF OF EXPENSE TO 1.866.635.1329 FOR PROCESSING.**Can I pay my in-home daycare provider through the Dependent Care FSA?**

Yes. You can be reimbursed from your Dependent Care FSA for any qualified daycare expenses, whether performed in your home, the provider's home or a "daycare center". Receipts for the expenses and the caregiver's Tax ID number or Social Security number must be provided.

I'm divorced; my ex-spouse claims our child as a dependent for tax purposes. I pay for child care. Can I use the Dependent Care FSA?

If your child resides with you most of the year, you can use the dependent care account to pay for child care services. However, you might want to call your tax advisor to discuss your particular circumstances before you elect to participate in the account.

If I have a question about my account, what should I do?

If you have any questions, you can access your account information 24/7 at myGilsbar.com or you can call Gilsbar's Customer Contact Center at **1.800.445.7227 ext. 883**.

Dependent Care FSA Expense Worksheet

Dependent care expenses you paid last year could include:

Costs of Child or Adult Care Facilities*

Day Care Center / Nursery School \$ _____

Family Day Care / Adult Day Care Centers** \$ _____

Wages paid to a nanny or in home care provider*** \$ _____

* The facility must follow all local and state laws.

** These costs are eligible only if the adult dependent spends at least eight hours per day at home.

*** Please note these expenses are not eligible if the care services are provided by someone that you claim as a dependent.

Other dependent care expenses considered eligible by the IRS \$ _____

TOTAL ESTIMATED DEPENDENT CARE EXPENSES \$ _____

Compare last year's typical expenses to those eligible under your Dependent Care FSA and budget accordingly for the upcoming year.

PLEASE FAX CLAIMS AND PROOF OF EXPENSE TO 1.866.635.1329

FOR PROCESSING.

(PLEASE KEEP YOUR ORIGINALS)

Questions? Call Gilsbar's Customer Contact Center at 1.800.445.7227

ext. 883

If you prefer to submit your form by mail, please send claim form and receipts to:

Claims Processing Center

P.O. Box 25123

Lehigh Valley, PA 18002-5123

(PLEASE KEEP YOUR ORIGINALS)

REMINDERS:

- You should keep all of your receipts for the entire plan year in the event that Gilsbar ask for documentation or the IRS requests a copy of a receipt.
- Remember that you will have **90 days** following the end of the plan year to file for services rendered during the plan year. You may send all requests for reimbursement directly to Gilsbar.
- Participants are required to have a prescription for Over-the-Counter (“OTC”) items to be eligible under their FSA plan.

• WHEN DOES MY PARTICIPATION END?

If you terminate employment with your participating employer, your participation in this Plan will terminate on the last day you are actively at work unless you elect to continue your participation in accordance with the guidelines provided in the “COBRA continuation coverage” section. Any qualified medical flexible spending expenses or qualified dependent care flexible spending expenses incurred during the plan year prior to the date of termination will be reimbursed by the Plan in accordance with the guidelines in the section, “Benefits.” Your participation in this Plan will also terminate if the participating employer decides to terminate this Plan, or if you voluntarily decide not to participate under the terms of this Plan.

• RECEIVING YOUR DEBIT CARD

Debit cards are mailed to each new participant’s home address in a plain white envelope with reference to Reimbursement Account Center. There will be no reference to Gilsbar. Please check thoroughly before throwing mail away. Debit cards are good for three (3) years from the issue date and your account will be replenished only if you **re-elect** the Healthcare FSA each year.

If you have any questions concerning your Plan, please feel free to contact:

Gilsbar’s Customer Contact Center at 1.800.445.7227 ext. 883.

Fax Claims and Proof of expense to: **1.866.635.1329 for processing**

(PLEASE KEEP YOUR ORIGINALS)

If you prefer to submit your form by mail, please send claim form and receipts to:

Claims Processing Center

P.O. Box 25123 Lehigh Valley, PA 18002-5123

WEBSITE: www.myGilsbar.com



Gilsbar Welcome Letter

Thank you for choosing to participate in the Health Care or Dependent Care FSA. Your FSA plans are administered by Gilsbar, Inc.

Your Gilsbar group number is **S2552** (actual group # for Asheville City Schools)

Access the MyGilsbar.com Website to Manage your Account 24/7!

- View plan year balance
- Set up or edit ACH/Bank Draft information*
- Check claim status
- View claim/ receipt images within 24 hours
- Obtain claim forms
- Set up email messaging
- View payments and payment dates
- File appeals to denied claims

**To participate in the FSA Direct Deposit (ACH / Bank Draft) a valid email address is required.*

It's easy to get started:

Step 1: After your effective date, go to www.mygilsbar.com and register as a new participant.

You will complete a brief registration form to register with a valid email address and your group number.

Step 2: Once logged in, click on a selection under the FSA and HRA sections in the left navigation bar.

If you are a first time user, you will be prompted to enter your email address to sign up for our Reimbursement Account Center email service. This is an important step to ensure you will receive email updates when:

- a. A claim is received
- b. The claim/receipt images are ready to view online
- c. The claim is processed and posted for payment

Step 3: Click the Accounts tab at the top to confirm that your annual election(s) and address are accurate. Contact us with any discrepancies.

Step 4: Confirm that your ACH/Auto Bank Draft information is entered and accurate, (or to set up direct deposits into your bank account) click the Profile tab at the top and click **Edit** under the **Your ACH** section. To update your email address, click **Edit** under the **View / Edit Your Profile** section.

<p>For Fastest Processing, FAX Claims and Receipts to: 1.866.635.1329</p> <p>Mail Claims and Receipts to: Claims Processing Center PO Box 25123 Lehigh Valley, PA 18002-5123</p> <p><i>(Please keep your originals)</i></p>	<p>Customer Contact Center</p> <p>7:00 AM – 7:00 PM Central Time</p> <p>Phone: 1.800.445.7227 ext. 883 Email: flex@gilsbar.com</p> <p>(Please do not email claims/receipts)</p>
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Ameritas Dental Plan

Effective Date: October 1, 2011

COMBINED CALENDAR YEAR DEDUCTIBLE

\$50.00 per individual for Type II (Basic) and Type III (Major) Procedures

3 times family limit. After the date that 3 members of a family have each satisfied their individual deductible, the entire deductible or any remaining portion of the deductible for any family member will be waived for the rest of that calendar year.

TYPE I- PREVENTIVE AND DIAGNOSTIC - Type I benefits are payable at 100% U & C*. No deductible applies.

- Evaluations (Two per benefit period)
- Cleanings (Two per benefit period)
- Fluoride for Children (Under age 19)
- Space Maintainers
- Radiographs (X-rays)
- Bitewings (Two per benefit period)

TYPE II- BASIC PROCEDURES - Type II benefits are payable at 80% U & C*. \$50.00 deductible applies.

- Sealants (Age 16 and under)
- Limited Exams- problem focused
- Restorative Amalgam
- Oral Surgery- Simple Extractions
- Oral Surgery-Complex Extractions
- Anesthesia
- Denture Repair

TYPE III- MAJOR PROCEDURES - Type III Benefits are payable at 50% U & C*. \$50.00 deductible applies.

- Endodontics- (Root Canal)
- Endodontics- (Apicoectomy)
- Periodontics- (Non Surgical)
- Prosthodontics- Fixed Pontics or Abutments
- Crown Repair
- Restorative - Crowns
- Periodontics - (Surgical)
- Prosthodontics - Removable Dentures, Partial

ORTHODONTIA (CHILDREN AND ADULTS)

- Paid at 50% U & C*.
- No deductible applies.
- \$1,000 Lifetime maximum per person.

ANNUAL MAXIMUM BENEFIT

- Applies to Type I, Type II and Type III Procedures
- \$1,000 per calendar year per person

***Usual & Customary charges**

Ameritas Managed Care Products

- Employers achieve a balance between cost efficiency and employee choice.
- Plan members are free to receive care from any dentist they choose. Their out-of-pocket expenses are generally lower when using a PPO dentist who has agreed to provide dental care at contracted fees.
- Over 70,000 PPO provider access points are available nationwide.
- PPO network dentists must meet our credentialing and quality assurance evaluation requirements.

Passive PPO

In passive PPO, the coinsurance, deductible and maximum are the same for the member in and out-of-network. The only difference is the claim allowance. There is an incentive for the member to see an in network dentist; however, there is no penalty for seeing an out-of-network dentist. As with all Ameritas PPO Solutions, the member has the liberty to choose any dentist they wish. However, they will usually save out-of-pocket costs by seeing an in-network dentist.

Commonly Asked PPO Questions

The plan provides excellent coverage for you and your eligible dependents. Please refer to the plan highlight for more details. As an added bonus, our plan includes access to Ameritas' Participating Provider Organization (PPO).

Do I have to use an Ameritas PPO provider?

No, employees and their covered dependents may utilize any licensed dental provider that they choose.

Please note, there is no difference in the coinsurance, deductible, and maximums on either plan whether a PPO provider is utilized or not.

Why would I use an Ameritas PPO provider?

By using a PPO provider:

- A Participating Provider is a dentist who has entered into an agreement to provide services to insured members of Ameritas' plans for a specific fee. Any insured member who chooses to go to a PPO provider will receive this discounted fee for procedures performed by that provider.
- As part of their contractual agreement with Ameritas, the PPO provider cannot "back-bill" the patient for the difference between the dentists' normal charges and the discounted fees that the dentist agreed to charge as an Ameritas PPO provider.
 - PPO providers are required to file the claim for the patient.
 - PPO providers are required to wait for reimbursement from Ameritas before billing the patient for any balances owed for deductibles, coinsurance, any amounts exceeding the annual maximum benefits, etc.

PPO panels are available in many areas; please visit the Ameritas **website at www.ameritasgroup.com** to search for a provider in your area.

What happens if I don't use an Ameritas PPO provider?

For members that do not want to utilize an Ameritas PPO provider, or if a PPO provider is not available in your area:

- We want to ensure that employees that utilize non-panel providers receive exceptional benefits that reimburse claims for non-panel providers in the most optimal way. Non-panel providers can charge their standard fees for any service. **However, the amount Ameritas allows for each procedure for non-panel provider utilizes 90th percentile of U&C (Usual & Customary) which is considered to be one of the highest reimbursement levels in the industry. This means that 9 out of 10 dentist's charges will fall within the amount that Ameritas allows for each procedure.** In doing so, employees can feel comfortable that very little back billing will occur due to the amounts allowed by the plan.

- Non-panel providers have no specific requirements regarding filing of claims. However, we have found that many dentists will assist the patient with the paperwork needed to file the claim. If a dentist is not willing to file the claim on the patient's behalf, the patient can simply attach the dentist's bill to a claim form that includes the patient's name and identification number, and fax or mail the claim to Ameritas for processing. Ameritas will process the claim, typically within 7-10 working days. Claim payment can be made to the patient or directly to the dentist if noted on the claim form. The patient can use Ameritas' claim forms which are available in the Benefit's Department or on the Ameritas website (this will be available via our Intranet in the near future), or the patient can use any generic claim forms that the dental office may have available. Filing claims is fast and easy with Ameritas!

If you have any questions about the PPO or the plan, please call:
Ameritas Group Claims Department at 1.800.487.5553

DENTAL EXCLUSIONS (DEFERMENT PERIOD)

During the first 36 months following your or your dependent's Dental Coverage Effective Date, the initial placement of dentures, partial dentures, or bridges, if it includes the replacement of teeth all of which are missing prior to the effective date. (For currently covered insureds, Ameritas will use the employees Date of Hire to determine the 36 month period.) This exclusion will not apply if the prosthesis replaces a sound natural tooth which is extracted while the patient is insured under this Dental Coverage and which is replaced within 12 months of the extraction.

EXCEPTIONS to this exclusion will be made if the replacement is made necessary by: a) accidental bodily injury to sound natural teeth (chewing injuries are not considered accidental bodily injuries), or b) the extraction of a sound natural tooth provided the replacement is completed within 12 months of the date of the injury or extraction.

ANNUAL MAXIMUM CARRYOVER

1. Visit a dentist between January 1 and December 31 of each year.
2. Submit a claim for a covered procedure prior to **March 1** of the following year.
3. Total dental benefits paid for the calendar year must be less than \$500.00
If you meet all 3 requirements then you will be eligible for the Annual Maximum Carryover benefit. This benefit will provide you with an additional \$250 towards your annual dental maximum for the following year. In future years, if you continue to meet these requirements you will continue to see an increase in your annual maximum by \$250 until you have reached an annual maximum carryover limit of \$1,000. This benefit allows you to accumulate up to a \$2,000 annual dental maximum.

ELIGIBLE EMPLOYEES

You are eligible for insurance if you are a full-time active employee working at least 20 hours per week.

ELIGIBLE DEPENDENTS

Provides Coverage On:

- Your Spouse
- Children up to age 19 and unmarried (Up to age 24 if wholly dependent upon you for maintenance and support and if enrolled as a full-time student in an accredited school or college.)

PREDETERMINATION OF BENEFITS

A treatment plan MAY be filed if a proposed course of treatment will exceed \$200.00. With this information, Ameritas can determine the benefits payable under this policy prior to the work actually being done. It will give the insured the amount payable, along with an idea of the out of pocket expense.

COORDINATION OF BENEFITS

If you or any of your dependents incur charges which are covered by any other group plan, the benefits of this plan will be coordinated with the benefits of the other plan so that the total benefits received are not greater than the charges incurred.

SECTION 125

This policy is provided as part of the Policyholder's Section 125 Plan. Each member has the option under the Section 125 Plan of participating or not participating in this policy. A member may change their election only during an annual election period, except for a change in family status. Examples of such events would be marriage, divorce, birth of a child, death of a spouse or child or termination of employment. Please see your plan administrator for details.

ORTHODONTIA LIMITATIONS

(This is not a complete list)

No benefit is payable for expenses incurred:

- In connection with a Treatment Program which was begun before the individual became insured for orthodontic benefits.
- During any quarter of a Treatment Program if the individual was not continuously insured for orthodontic benefits for the entire quarter.
- After the individual's insurance for orthodontic benefits terminates.

LATE ENTRANT

If you or your dependents do not elect to participate in the dental plan when first eligible, you will be considered a **Late Entrant** and you must wait 12 months for most procedures. For a **Late Entrant**, benefits will be limited to **exams, cleanings, and fluoride treatments**. The late entrant provision is waived if the employee comes on the plan as a result of a qualifying event.

LIMITATIONS/EXCLUSIONS

(This is not a complete List)

- For any treatment which is for cosmetic purposes. Facings on crowns or pontics behind the 2nd bicuspid are considered cosmetic.
- Charges incurred prior to the date the individual became insured under this plan, or following the date of termination of coverage.
- Services which are not recommended by a dentist or which are not required for necessary care and treatment.
- Expenses incurred to replace lost or stolen appliances.
- Expenses incurred by an insured because of a sickness for which he /she is eligible for benefits under Worker's Compensation Act or similar laws.

Monthly Rates

Employee Only	\$42.68
Employee and Child(ren)	\$78.89
Employee and Spouse	\$73.57
Employee and Family	\$109.77

For Claims/Customer Service call Ameritas: 1.800.776.9446

Website: www.ameritasgroup.com

This insurance is underwritten by Ameritas Life Insurance Corp.



Allstate Benefits Group Cancer Plan

Effective Date: October 1, 2011

In the United States, about 1,529,560 new cancer cases were expected to be diagnosed in 2010. ¹

Group Voluntary Cancer

If you suddenly become diagnosed with cancer, it can be difficult on your family's financial and emotional stability. Having the right coverage to help when you are sick and undergoing treatment or when you cannot work is important. Our cancer insurance can help provide security when you need it most.

Meeting Your Needs: Our cancer coverage can help offer you and your family members financial support during a period of unexpected illness.

- Benefits will be paid directly to you unless otherwise assigned
- Coverage can be purchased for you and your entire family
- No evidence of insurability required at initial enrollment for new hires
- Waiver of premium after 90 days of disability due to cancer for as long as your disability lasts*
- Includes coverage for 29 other specified diseases**
- Convertible coverage

Benefit Coverage Highlights

Group Voluntary Cancer Insurance offers you coverage should you be diagnosed with cancer or 29 specified diseases. It protects you and your family 24 hours a day, seven days a week. Each pre-packaged plan doesn't just cover you; if you choose, it also covers your dependents (which can include spouse, domestic partner and dependent children.) Our valuable coverage can help supplement your traditional medical insurance which may only cover a small portion of the non-medical expenses that can be incurred with such a diagnosis as cancer.

You and each covered family member can be sure they will receive:

- Benefits that can be used to help pay for treatment, hospital stays, transportation, and more!
- Easy enrollment without required evidence of insurability for qualified employees
- Benefit coverage that includes 29 other specified diseases

A cancer diagnosis can mean unforeseen expenses that may be difficult to pay, especially if you aren't working. Hospital stays, medical or surgical treatments, and transportation by air or ground ambulance can add up quickly and be very costly. Our Group Voluntary Cancer Supplemental Insurance helps offset some of the expenses your health insurance may not cover, so you can focus on getting well.

***Primary insured only**

****List of covered diseases on page 28**

1 Cancer Facts & Figures, American Cancer Society, 2010

In the U.S., men have slightly less than a 1 in 2 lifetime risk of developing cancer; for women, the risk is a little more than 1 in 3.²

Your Benefit Coverage

Benefits are paid for cancer and specified disease and can help cover the costs of specific treatments and expenses as they happen. Terms and conditions for each benefit will vary.

Specified Diseases

Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease), Muscular Dystrophy, Poliomyelitis, Multiple Sclerosis, Encephalitis, Rabies, Tetanus, Tuberculosis, Osteomyelitis, Diphtheria, Scarlet Fever, Cerebrospinal Meningitis (bacterial), Brucellosis, Sickle Cell Anemia, Thalassemia, Rocky Mountain Spotted Fever, Legionnaire's Disease (confirmation by culture or sputum), Addison's Disease, Hansen's Disease, Tularemia, Hepatitis (Chronic B or Chronic C with liver failure or Hepatoma), Typhoid Fever, Myasthenia Gravis, Reye's Syndrome, Primary Sclerosing Cholangitis (Walter Payton's Liver Disease), Lyme Disease, Systemic Lupus Erythematosus, Cystic Fibrosis, and Primary Biliary Cirrhosis.

Continuous Hospital Confinement

A \$100 benefit will be paid for each day of continuous hospital confinement for the treatment of cancer or specified diseases.

Government or Charity Hospital

A \$100 benefit will be paid for each day a covered person is confined to: 1. a hospital operated by or for the U.S. Government (including the Veteran's Administration); or 2. a hospital that does not charge for the services it provides (charity). This benefit is paid in lieu of all other benefits in the policy (except Waiver of Premium Benefit).

Surgery**

Up to a \$3,000 benefit will be paid when a covered surgery (**amount per surgery depends on surgery) is performed on a covered person. This benefit pays the actual charges, up to the amount listed in the Schedule of Surgical Procedures for the specific procedure. Two or more procedures performed at the same time through one incision or entry point are considered one operation; Allstate Benefits pays the amount for the procedure with the greatest benefit. AB pays for a covered surgery performed on an outpatient basis at 150% of the scheduled benefit. This benefit does not pay for surgeries covered by other benefits in the Schedule of Benefits.

2 Cancer Facts & Figures, American Cancer Society, 2010.

Second Opinion

A \$400 benefit will be paid for a second surgical opinion, if physician recommends surgery for covered condition. This second opinion must be rendered prior to surgery or treatment being performed, and obtained from a physician not in practice with the physician rendering the original recommendation.

Physical or Speech Therapy

A \$50 benefit will be paid per day, for physical or speech therapy for restoration of normal body function.

Anesthesia

25% of the surgery benefit will be paid for anesthesia received by an anesthesiologist.

Ambulatory Surgical Center

A \$500 benefit will be paid for the use of an Ambulatory Surgical Center day for a surgical procedure covered under the Surgery benefit that is performed at an ambulatory surgical center.

Radiation/Chemotherapy for Cancer

Up to a \$10,000 (Low and Mid) or \$20,000 (High) benefit will be paid per 12 month period for radiation therapy and chemotherapy received by a covered person. This benefit pays the actual cost and is limited to the amount shown per 12 month period beginning with the first day of benefit under this provision.

Administration of radiation therapy or chemotherapy other than by medical personnel in a physician's office or hospital, including medications dispensed by a pump, will be limited to the costs of the drugs only, subject to the maximum amount payable per 12 month period.

Anti-Nausea Benefit

Up to a \$200 benefit will be paid per calendar year for the actual cost of anti-nausea medication prescribed for a covered person by a physician. This benefit does not pay for medication administered while the covered person is an inpatient.

Inpatient Drugs and Medicine

A \$25 benefit will be paid per day for drugs and medicine while continuously hospital confined. This benefit does not pay for drugs and/or medicine covered under the Radiation/Chemotherapy Benefit or the Anti-Nausea Benefit.

Hematological Drugs

Up to a \$200 (Low and Mid) or \$400 (High) benefit will be paid per year for the actual cost of drugs intended to boost cell lines such as white blood cell counts, red blood cell counts and platelets. This benefit is paid only when the Radiation/Chemotherapy for Cancer benefit is paid.

Medical Imaging

Actual cost up to a \$500 (Low and Mid) or \$1,000 (High) benefit will be paid per calendar year if a covered person receives an initial diagnosis or follow-up evaluation based upon one of the following medical imaging exams: CT scan; Magnetic Resonance Imaging (MRI) scan; bone scan; thyroid scan; Multiple Gated Acquisition (MUGA) scan; Positron Emission Tomography (PET) scan; transectal ultrasound; or abdominal ultrasound. This benefit is limited to 1 payment per calendar year per covered person.

Private Duty Nursing Services

A \$100 benefit will be paid per day while hospital confined, if a covered person requires the full-time services of a private nurse. Full-time means at least 8 hours of attendance during a 24 hour period. These services must be required and authorized by a physician and must be provided by a nurse.

New or Experimental Treatment

Actual charges up to a \$5,000 benefit will be paid per 12 month period, for new or experimental treatment. New or Experimental Treatment is covered for cancer and specified disease when: the treatment is judged necessary by the attending physician; and no other generally accepted treatment produces superior results in the opinion of the attending physician. This benefit is limited to the maximum shown per 12 month period beginning with the first day of treatment under this provision. This benefit does not pay if benefits are payable for treatment covered under any other benefit in the Schedule of Benefits.

Blood, Plasma, and Platelets

Up to a \$10,000 (Low and Mid) or \$20,000 (High) benefit will be paid per 12 month period for the actual cost of blood, plasma and platelets (including transfusions and administration charges); processing and procurement costs; and cross-matching. Does not pay for blood replaced by donors or immunoglobulins.

Physician's Attendance

A \$50 benefit will be paid for a visit by a physician during hospital confinement. Benefit is limited to one visit by one physician per day of hospital confinement. Admission to the hospital as an inpatient is required.

At Home Nursing

A \$100 benefit will be paid per day for private nursing care and attendance by a nurse at home. At home nursing services must be required and authorized by the attending physician. Benefit is limited to the number of days of the previous continuous hospital confinement.

Prosthesis

Up to a \$2,000 benefit will be paid per amputation, per covered person for the actual charges for prosthetic devices which are prescribed as a direct result of surgery and which require surgical implantation.

Hair Prosthesis

A \$25 benefit will be paid every 2 years, for a wig or hairpiece if the covered person experiences hair loss.

Nonsurgical External Breast Prosthesis

Up to a \$50 benefit will be paid for the actual cost of the initial, nonsurgical breast prosthesis following a covered mastectomy or partial mastectomy that is paid for under the policy.

Ambulance

A \$100 benefit will be paid per continuous hospital confinement for transportation by a licensed ambulance service or a hospital owned ambulance to or from a hospital in which the covered person is confined.

Hospice Care

A \$100 benefit will be paid for one of the following when a covered person has been diagnosed by a physician as terminally ill as a result of cancer or specified disease, is expected to live 6 months or less and the attending physician has approved services: 1. Freestanding Hospice Care Center – A benefit will be paid per day for confinement in a licensed freestanding hospice care center. Benefits payable for hospice centers that are designated areas of hospitals will be paid the same as inpatient hospital confinement; or 2. Hospice Care Team – A benefit will be paid per visit, limited to 1 visit per day, for home care services by a hospice care team. Home care services are hospice services provided in the patient's home. Benefit is payable only if: (a) the covered person has been diagnosed as terminally ill; and (b) the attending physician has approved such services. Does not pay for: food services or meals other than dietary counseling; or services related to well-baby care; or services provided by volunteers; or support for the family after the death of the covered person.

Extended Care Facility

A \$100 benefit will be paid for each day a covered person is confined in an extended care facility for the treatment of cancer or specified disease. Confinement must be at the direction of the attending physician and must begin within 14 days after a covered hospital confinement. Benefit is limited to the number of days of the previous continuous hospital confinement.

Outpatient Lodging

A \$50 benefit will be paid for lodging per day when a covered person receives radiation or chemotherapy treatment on an outpatient basis, provided the specific treatment is authorized by the attending physician and cannot be obtained locally. Benefit is for a single room in a motel, hotel, or other accommodations acceptable to AB during treatment, up to the maximum \$2,000 per 12 months beginning with the first day of benefit under this provision. Outpatient treatment must be received at a treatment facility more than 100 miles from the covered person's home.

Non-Local Transportation

\$0.40 per mile or actual cost of round trip coach fare on a common carrier benefit will be paid for treatment at a hospital (inpatient or outpatient); or radiation therapy center; or chemotherapy or oncology clinic; or any other specialized freestanding treatment center nearest to the covered person's home, provided the same or similar treatment cannot be obtained locally. Benefit pays up to 700 miles for round trip in personal vehicle. "Non-Local" means a round trip of more than 70 miles from the covered person's home to the nearest treatment facility. Mileage is measured from the covered person's home to the nearest treatment facility as described above. Does not cover transportation for someone to accompany or visit the person receiving treatment; visits to a physician's office or clinic; or for services other than actual treatment.

Family Member Lodging and Transportation

Up to a \$50 benefit per day will be paid for lodging and \$0.40 per mile or the actual cost of round trip coach fare on a common carrier will be paid for one adult member of the covered person's family to be near the covered person, when a covered person is confined in a non-local hospital for specialized treatment. 1. Lodging -This benefit is for a single room in a motel, hotel, or other accommodations acceptable to AB. Benefit is limited to 60 days for each period of continuous hospital confinement. 2. Transportation -Benefit is limited to 700 miles per continuous hospital confinement if traveling in personal vehicle. Mileage is measured from the visiting family member's home to the hospital where the covered person is confined. Does not pay the Family Member Transportation Benefit if the personal vehicle transportation benefit is paid under the Non-Local Transportation Benefit, when the family member lives in the same city or town as the covered person.

Waiver of Premium (primary insured only)

If, while coverage is in force the insured employee becomes disabled due to cancer first diagnosed after the effective date of coverage and remains disabled for 90 days, AB pays premiums due after such 90 days for as long as the insured employee remains disabled.

Bone Marrow or Stem Cell Transplant*

A 1. \$1,000*, 2. \$2,500*, 3. \$5,000* benefit will be paid for the following types of bone marrow or stem cell transplants performed on a covered person. 1. A transplant which is other than non-autologous. 2. A transplant which is non-autologous for the treatment of cancer or specified disease, other than Leukemia. 3. A transplant which is non-autologous for the treatment of Leukemia. ***This benefit is payable only once per covered person per calendar year.**

ADDITIONAL BENEFIT

Wellness

A \$100 benefit will be paid per calendar year per covered person for one of the following wellness tests: Biopsy for skin cancer; Blood test for triglycerides; Bone Marrow Testing; CA15-3 (cancer antigen 15 - 3 - blood test for breast cancer); CA125 (cancer antigen 125 – blood test for ovarian cancer); CEA (carcinoembryonic antigen – blood test for colon cancer); Chest X-ray; Colonoscopy; Doppler screening for carotids; Doppler screening for peripheral vascular disease; Echocardiogram; EKG (Electrocardiogram); Flexible sigmoidoscopy; Hemocult stool analysis; HPV (Human Papillomavirus) Vaccination; Lipid panel (total cholesterol count); Mammography, including Breast Ultrasound; Cervical Cancer Screening; PSA (prostate specific antigen – blood test for prostate cancer); Serum Protein Electrophoresis (test for myeloma); Stress test on bike or treadmill; Thermography; and Ultrasound screening of the abdominal aorta for abdominal aortic aneurysms. This benefit is paid regardless of the result of the test.

OPTIONAL BENEFITS

Cancer Initial Diagnosis (First Occurrence)

A one time benefit of \$3,000 (Low and High) or \$10,000 (Mid) benefit will be paid when a covered person is diagnosed for the first time in their life as having cancer other than skin cancer. The first diagnosis must occur after the effective date of coverage for that covered person. Benefit is payable only once per covered person.

Intensive Care (Low and High Plans Only)

A benefit will be paid for each day for the following types of intensive care confinement:

A. **Hospital Intensive Care Unit Confinement \$600*** - This benefit is for hospital intensive care unit confinement for any illness or accident.

B. **Step-Down Hospital Intensive Care Unit Confinement \$300***- This benefit is for step-down hospital intensive care unit confinement for any illness or accident.

C. **Ambulance - AB pays the actual charges for transportation of a covered person** by licensed air or surface ambulance service to a hospital for admission to an intensive care unit for a covered confinement. This benefit is not paid if an ambulance benefit is paid under the Ambulance benefit in the policy.

***This benefit is limited to 45 days for each period of such confinement. A day is a 24 hour period. If confinement is for only a portion of a day, then a pro-rata share of the daily benefit is paid.**

Your premiums consist of:

Low Option - 1 unit of Hospital Benefits; 4 units of Radiation/Chemotherapy Benefits; 2 units of Surgery and Related Benefits; 1 unit of Miscellaneous Benefits; 4 units of Additional Wellness Benefit; 3 units of Optional Cancer Initial Diagnosis (First Occurrence); and 6 units of Optional Intensive Care Benefit.

Mid Option - 1 unit of Hospital Benefits; 4 units of Radiation/Chemotherapy Benefits; 2 units of Surgery and Related Benefits; 1 unit of Miscellaneous Benefits; 4 units of Additional Wellness Benefit; 10 units of Optional Cancer Initial Diagnosis (First Occurrence).

High Option - 1 unit of Hospital Benefits; 8 units of Radiation/Chemotherapy Benefits; 2 units of Surgery and Related Benefits; 1 unit of Miscellaneous Benefits; 4 units of Additional Wellness Benefit; 3 units of Optional Cancer Initial Diagnosis (First Occurrence); and 6 units of Optional Intensive Care Benefit.

Issue Ages: 18 and older while actively at work.

Certificates - Certificates under this plan are issued on a guaranteed basis only at the time of the initial enrollment. A completed Evidence of Insurability form is required for late entrants into the group plan.

Low Option without Cancer Initial Diagnosis and Intensive Care

Insureds	12-Pay Rates
Employee	\$20.07
Employee + Child(ren)	\$27.71
Employee + Spouse	\$30.96
Family	\$38.57

Low Option with Cancer Initial Diagnosis and Intensive Care

Insureds	12-Pay Rates
Employee	\$26.06
Employee + Child(ren)	\$36.81
Employee + Spouse	\$41.50
Family	\$52.23

Mid Option with Cancer Initial Diagnosis

Insureds	12-Pay Rates
Employee	\$29.75
Employee + Child(ren)	\$42.16
Employee + Spouse	\$47.02
Family	\$59.39

High Option without Cancer Initial Diagnosis and Intensive Care

Insureds	12-Pay Rates
Employee	\$31.09
Employee + Child(ren)	\$43.65
Employee + Spouse	\$47.51
Family	\$60.04

High Option with Cancer Initial Diagnosis and Intensive Care

Insureds	12-Pay Rates
Employee	\$37.08
Employee + Child(ren)	\$52.75
Employee + Spouse	\$58.05
Family	\$73.70

Eligibility - Family members eligible for coverage include: you; your legal spouse or domestic partner; and your unmarried children including adopted children or foster children from the moment of placement in the residence, stepchildren, children of a domestic partner, or legal ward who are under 26 years of age, unless he or she continues to meet the definition of a dependent. Your children must be dependent on you for support or reside with you and be named on the enrollment or evidence of insurability form.

Portability Privilege -AB will provide portability coverage, subject to these provisions. Such coverage will not be available for you unless: coverage under the policy terminates under the General Provision entitled "Termination of Coverage"; and AB receives a written request and payment of the first premiums for the portability coverage not later than 63 days after such termination; and the request is made for that purpose. No portability coverage will be provided to you, if your insurance under the policy terminates due to your failure to make required premium payments.

Termination of Coverage - As long as you are insured, your coverage under the policy ends on the earliest of: the date the policy is canceled; or the last day of the period for which you made any required premium payments; or the last day you are in active employment except as provided under the "Temporary Layoff , Leave of Absence or Family and Medical Leave of Absence" provision; or the date you are no longer in an eligible class; or the date your class is no longer eligible. AB will provide coverage for a payable claim incurred while you are covered under the policy. If your spouse is a covered person, the spouse's coverage ends upon valid decree of divorce or your death. If your domestic partner is a covered person, the domestic partner's coverage ends upon termination of the domestic partnership or your death. If your child is a covered person, the child's coverage ends when the child reaches age 26, unless he or she continues to meet the requirements of an eligible dependent. Coverage does not terminate on a child who: 1. is incapable of self-sustaining employment by reason of mental or physical incapacity; and 2. became so incapacitated prior to the attainment of the limiting age of eligibility under the coverage; and 3. is chiefly dependent upon you for support and maintenance.

- Dependent coverage continues as long as the coverage remains in force and the dependent remains in such condition. Proof of the incapacity and dependency of the child must be furnished within 60 days of the child's attainment of the limiting age of eligibility. Thereafter, such proof must be furnished as frequently as may be required, but no more frequently than annually after the child's attainment of the limiting age for eligibility. If AB accepts a premium for coverage extending beyond the date, age, or event specified for termination as to a covered person, such premium will be refunded, coverage will terminate and claims will not be paid.

Pre-Existing Condition - AB does not pay for any benefit due to, or caused by, a pre-existing condition, as defined, during the 12 month period beginning on the date that person became a covered person. This exclusion will not apply to your newborn child, adopted child or foster child under the age of 18 if AB is notified within 31 days of the child's birth or date of placement. A Pre-Existing Condition is a disease or physical condition for which medical advice or treatment was recommended or received from a member of the medical profession within the 12 month period prior to the effective date of coverage.

Exclusions and Limitations - AB does not pay for any loss except for losses due directly from cancer or specified disease. AB does not pay for any other conditions or diseases caused or aggravated by cancer or a specified disease. Diagnosis must be submitted to support each claim. For the Surgery, New or Experimental Treatment and Prosthesis Benefits, if specific charges are not obtainable as proof of loss, AB will pay 50% of the applicable maximum for the benefits payable. Treatment must be received in the United States or its territories.

Intensive Care Exclusions and Limitations - The Hospital Intensive Care Unit Confinement benefit does not pay for intensive care if a covered person is admitted because of an attempted suicide; or intentional self-inflicted injury; or intoxication or being under the influence of drugs not prescribed or recommended by a physician; or alcoholism or drug addiction. AB does not pay for confinements in any care unit that does not qualify as a hospital intensive care unit. Progressive care units, sub-acute intensive care units, intermediate care units, and private rooms with monitoring, step-down units and any other lesser care treatment units do not qualify as hospital intensive care units. We do not pay for step-down hospital intensive care unit confinement if a covered person is admitted and confined in the following type of units: telemetry or surgical recovery rooms; post-anesthesia care units, progressive care units; intermediate care units; private monitored rooms; observation units located in emergency rooms or outpatient surgery units; beds, wards, or private or semi-private rooms with or without telemetry monitoring equipment; an emergency room; labor or delivery rooms; or other facilities that do not meet the standards for a step-down hospital intensive care unit. We do not pay this benefit for continuous hospital intensive care unit confinements or continuous step-down hospital intensive care unit confinements that occur during a hospitalization that begins before the effective date of coverage.

Coverage Subject to the Policy - The coverage described in the certificate of insurance is subject in every way to the terms of the policy that is issued to the policyholder (your employer). It alone makes up the agreement by which the insurance is provided. The group policy may at any time be amended or discontinued by agreement between AB and the policyholder. Your consent is not required for this. AB is not required to give you prior notice.

The policy is Limited Benefit Cancer and Specified Disease Insurance. The policy is not a Medicare Supplement Policy. If eligible for Medicare, review Medicare Supplement Buyer's Guide available from American Heritage Life Insurance Company. Subject to COBRA continuation of coverage.

The coverage is provided by a limited benefit supplemental insurance policy. This material is valid as long as information remains current, but in no event later than August 1, 2014. Group Cancer and Specified Disease benefits provided by policy GVCP3, or state variations thereof. The policy is underwritten by American Heritage Life Insurance Company. This brochure highlights some features of the policy but is not the insurance contract. Only the actual policy provisions control. The policy sets forth, in detail, the rights and obligations of both the policyholder (employer) and the insurance company. For complete details, contact your Insurance Agent, or call 1-800-521-3535. This is a brief overview of the benefits available under the Group Voluntary Policy underwritten by American Heritage Life Insurance Company. Details of the insurance, including exclusions, restrictions and other provisions are included in the certificate issued.

This information is for use in the Asheville City Schools enrollment which is situated in North Carolina.



**Allstate Benefits is the marketing name used by
American Heritage Life Insurance Company
(Home Office, Jacksonville, FL), the underwriting company and
a subsidiary of The Allstate Corporation.**

Allstate Workplace Division
The Workplace Marketer ©
1776 American Heritage Life Drive, Jacksonville, Florida 32224

Customer Care Center: 1.800.521.3535
www.allstate.com or
allstateatwork.com.

Assurity Critical Illness+ Plan

Effective Date: October 1, 2011

Critical Illness +

- Pays a benefit to you when you're struck with a covered illness.
- "You need critical illness insurance — not because you're going to die — but because you are going to survive." — Dr. Marius Barnard, Father of critical illness insurance

Could it happen to you?

Life can change in a heartbeat — an unanticipated critical illness could dramatically change your life. No one has immunity from life's risks.

Fortunately — if a critical illness like a heart attack, stroke or other serious illness strikes, you'll probably survive thanks to recent medical advances. But, recovery comes at a price. If you had to take an extended leave from your work or if you couldn't return to your job because of physical limitations, your bills would pile up while your income decreased.

Financial Impact...

62.1% of all U.S. bankruptcies are caused by soaring medical bills. According to a recent Harvard study, the average person who filed bankruptcy earned a middle-income salary and had health insurance but was financially crippled with out-of-pocket expenses for co-payments, deductibles and noncovered medical services.*

The Critical Illness+ Solution

Assurity at Work's Critical Illness+ Insurance can reduce the financial stress of a major illness by putting money directly into your pocket when you need it most. With the diagnosis of a covered illness, you receive a check for the benefit amount. The benefit is paid whether or not you're able to work — independent of any other health coverage. You choose how to spend the money, but many recipients pay down their home mortgage, clear up debt or supplement family income so that a care-giving spouse can be by their side.

Covered Illnesses

- Heart Attack
- Stroke
- Heart Transplant (or combination transplant including heart)
- Coronary Bypass Surgery
- Angioplasty
- Advanced Alzheimer's Disease
- Kidney (Renal) Failure
- Paralysis (other than from stroke)
- Severe Burns
- Loss of Independent Living
- Coma
- Occupational HIV
- Major Organ Transplant (other than heart)

The American Journal of Medicine, Medical Bankruptcy in the United States, 2007: Results of a National Study, 2010

Compliance Code: A-189-0811

Critical Illness+ Highlights...

- Lump-sum benefits available from \$5,000 to \$50,000!
- Multiple benefits — up to double the maximum benefit — are paid if you suffer from the category 1 and category 2
- Loss of Independent Living Benefit is paid (25 percent of policy benefit) when you're unable to perform two "activities of daily living" if you satisfy the waiting and elimination periods. This benefit terminates at age 75.
- If you leave your current employer, you may keep the policy in force by continuing to pay premiums.
- You may expand your policy to include coverage for your spouse and children. All of your eligible children are covered for one rate!

Critical Illness+ Features

- **Issue Ages-** Adults- 18 -64 years of age Children- 0-21 years of age
- **Renewability-** Guaranteed renewable for life, except for Loss of Independent Living Benefit which terminates at age 75.
- **Benefit Paid-** Lump-sum payment to you at diagnosis of covered illness or procedure.
- **Benefit Options-** Employee - \$5,000 to \$50,000 Spouse - \$5,000 to \$50,000 Child - \$10,000
- **Return of Premium Upon Death-** Returns 100% of primary insured premiums when you die of any cause (minus any benefits received).
- **Waiting Period** - None for any illness except for Loss of Independent Living Benefit, Cancer Rider and Wellness Rider each with a 30-day waiting period.
- **Pre-existing Condition-** Benefits are payable for a specified critical illness resulting from a pre-existing condition if the illness begins more than 12 months after the policy issue date.
- **Portable-** If you leave your current employer, you may keep the policy in force by continuing to pay premiums.

Preexisting Conditions

Pre-existing Condition - benefits are payable for a specified critical illness resulting from a pre-existing condition if the illness begins more than 12 months after the policy issue date. In **GA, SC and TN**: Pre-existing Condition means a sickness or physical condition for which, during the 12 months before the Issue Date, the Insured had symptoms which would cause an ordinary prudent person to seek diagnosis, care or treatment; or received medical consultation, advice or treatment from a Physician or had taken prescribed medication.

In **NC**: Preexisting Condition means a sickness or physical condition for which, during the 12 months before the Issue Date, the Insured received medical consultation, advice or treatment from a physician or had taken prescribed medication.

For NC residents: POLICY LIMITATION ON PREEXISTING CONDITIONS. No benefits are payable for 12 months after the issue date for specified critical illness due to a preexisting condition as defined in the policy.

Exclusions

We will not pay benefits under this policy for conditions caused by or as the result of an insured person:

- Being addicted to drugs or suffering from alcoholism;
- Being under the influence of an excitant, depressant, hallucinogen, narcotic, or any other drug or intoxicant, including those prescribed by a physician that are misused;
- Receiving injuries caused directly or indirectly while under the influence of a controlled substance or by intoxication as defined by the laws and jurisdiction of the geographical area in which the loss or cause of loss was incurred;
- Participating in or attempting to commit a felony;
- Being exposed to war or any act of war, declared or undeclared;
- Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Army Reserve;
- Being incarcerated in a penal institution or government detention facility;
- Engaging in an illegal activity or occupation;
- Self-inflicting an injury intentionally; or
- Committing or attempting to commit suicide, while sane or insane.

Wellness Benefit Rider (30-day waiting period from date of policy issue)

You and any insured person in your family are eligible for a \$50 benefit once per calendar year for health screening tests. Tests covered are:

- Biopsy for skin cancer
- Blood test for triglycerides
- Bone Marrow biopsy and aspiration
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 19-9 (blood test for pancreatic cancer)
- CA125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer and cervical cancer screening)
- Chest X-ray
- Colonscopy
- Fast blood glucose test
- Flexible sigmoidoscopy
- Hemocult stool analysis
- Mammography
- Pap Smear
- PSA (blood test for prostate cancer)
- Serum cholesterol- HDL & LDL
- Serum Protein Electrophoresis
- Thermography
- Stress Test (bicycle or treadmill)

Issue Ages: 18 through 64 (using Age Last Birthday as of policy issue date)

Dependent Children: 0 to age 21 and must meet the definition of a dependent.

Coverage will continue for a dependent child if the definition continues to be met to age 25 and automatic coverage will be afforded any newborn or adopted dependent child if Assurity receives written notification within 30 days of birth or adoption. (May vary by state)

Renewability: Guaranteed renewable for life

Waiting Period: 30 days

Availability: This rider is chosen at the employer level and included in packages to all employees.

READ YOUR POLICY CAREFULLY

This critical illness policy is not a Medicare supplement policy. If you are eligible for Medicare, review the guide to health insurance for people with Medicare, which is available from Assurity.

Critical Illness/Specified Diseases, Conditions, and Procedures Covered

Multiple Benefits — All of the illnesses in both categories are covered by your critical illness policy and pay the benefit indicated. You can only receive 100 percent of your benefit from within either category. But, beyond that, if you collect the benefit for an illness or procedure in the “heart/stroke” category and then are diagnosed with a condition in the “other illnesses” category (or vice versa), this policy will pay the full benefit indicated to you again. There must be 180 days separating the date of diagnosis of the two critical illnesses.

Heart/Stroke Category 1

Critical Illness	Percentage of Benefit Payable for each illness	Maximum Benefit for “Heart/Stroke” Category
Heart Attack	100%	100%
Stroke	100%	
Heart Transplant (or combination transplant including heart)	100%	
Coronary Bypass Surgery	25% (payable once per lifetime)	
Angioplasty	10% (payable once per lifetime)	

Other Illnesses Category 2

Critical Illness	Percentage of Benefit Payable for each illness	Maximum Benefit for “Other Illness” Category
Advanced Alzheimer’s Disease	100%	100%
Kidney (Renal) Failure	100%	
Paralysis (Other than from a stroke)	100%	
Severe Burns	100%	
Coma	100%	
Occupational HIV (Documented accidental injury)	100%	
Major Organ Transplant (Other than transplant covered in Category 1)	100%	
Loss of Independent Living	25% (payable once per lifetime)	

Cancer Coverage	Percentage of Benefit Payable for each Illness	Maximum Benefit for Rider
Invasive Cancer	100%	100%
Cancer in Situ	25% (payable once per lifetime)	

Employee- Non-Tobacco Monthly Rates with Wellness Rider								
Employee (ages)	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$40,000	\$50,000
18-29	\$2.27	\$3.45	\$4.64	\$5.83	\$7.02	\$8.20	\$10.58	\$12.95
30-39	\$3.16	\$4.89	\$6.63	\$8.37	\$10.11	\$11.84	\$15.32	\$18.79
40-49	\$5.23	\$8.44	\$11.66	\$14.88	\$18.09	\$21.31	\$27.74	\$34.18
50-59	\$9.25	\$15.74	\$22.23	\$28.73	\$35.22	\$41.71	\$54.69	\$67.67
60-64	\$16.68	\$30.24	\$43.81	\$57.37	\$70.93	\$84.49	\$111.62	\$138.74

Employee- Tobacco Monthly Rates with Wellness Rider								
Employee (ages)	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$40,000	\$50,000
18-29	\$2.75	\$4.42	\$6.09	\$7.76	\$9.43	\$11.10	\$14.45	\$17.79
30-39	\$4.37	\$7.33	\$10.28	\$13.24	\$16.19	\$19.14	\$25.05	\$30.96
40-49	\$8.15	\$14.29	\$20.43	\$26.58	\$32.72	\$38.86	\$51.14	\$63.42
50-59	\$15.98	\$29.20	\$42.42	\$55.64	\$68.86	\$82.08	\$108.52	\$134.96
60-64	\$30.76	\$58.41	\$86.05	\$113.70	\$141.34	\$168.99	\$224.28	\$279.57

Spouse- Non-Tobacco Monthly Rates with Wellness Rider								
Spouse (ages)	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$40,000	\$50,000
18-29	\$1.90	\$2.45	\$3.00	\$3.55	\$4.10	\$4.65	\$5.75	\$6.85
30-39	\$2.74	\$3.78	\$4.83	\$5.87	\$6.92	\$7.96	\$10.06	\$12.15
40-49	\$4.58	\$6.94	\$9.31	\$11.67	\$14.03	\$16.39	\$21.12	\$25.84
50-59	\$8.23	\$13.59	\$18.94	\$24.30	\$29.65	\$35.00	\$45.71	\$56.42
60-64	\$15.10	\$27.09	\$39.07	\$51.05	\$63.03	\$75.02	\$98.98	\$122.95

Spouse- Tobacco Monthly Rates with Wellness Rider								
Spouse (ages)	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$40,000	\$50,000
18-29	\$2.34	\$3.32	\$4.31	\$5.30	\$6.29	\$7.27	\$9.25	\$11.22
30-39	\$3.82	\$5.96	\$8.09	\$10.22	\$12.36	\$14.49	\$18.76	\$23.02
40-49	\$7.18	\$12.14	\$17.09	\$22.05	\$27.01	\$31.97	\$41.89	\$51.80
50-59	\$14.30	\$25.73	\$37.15	\$48.58	\$60.00	\$71.43	\$94.28	\$117.13
60-64	\$28.02	\$52.93	\$77.83	\$102.73	\$127.64	\$152.54	\$202.35	\$252.15

Child Coverage with Wellness Rider	
Issue Age Range	Benefit Amount
	\$10,000
0-21	\$0.69

Critical Illness/Specified Disease Claims: You may file a claim by completing an Assurity Claim Form. Please make sure to include all pertinent information as stated on the form. You can obtain a claim form by contacting Assurity. Should you have any questions on how to file or submit a claim, or regarding the Assurity Critical Illness/Specified Disease Plan, please call 1.888.358.8808.

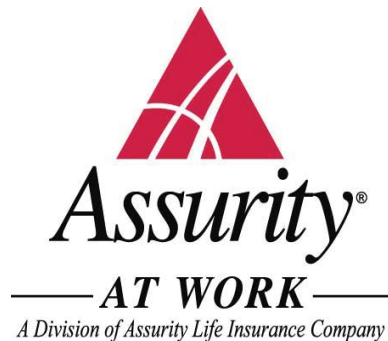
**Assurity Life Insurance Company
PO Box 82533
Lincoln, NE, 68501-0926**

**Assurity Customer Service: 1.866.289.7337
To Fax in a Claim/Toll Free: 1.800.869.0368**

Website: www.assurity.com

This policy is underwritten by Assurity Life Insurance Company. For specific details, please review the policy or contact your insurance representative or Assurity Life Insurance Company. This policy's availability — along with its rates, benefits and provisions — may vary by state and are subject to state approval.

Policy Form # W1220



**AccidentSelect® Plans I and II, An Accident-Only
Insurance Policy Underwritten by Transamerica
Life Insurance Company**

Effective Date: October 1, 2011

AccidentSelect® provides Insureds with several benefits to assist with the costs associated with certain accidents. More importantly, it helps give Insureds peace of mind in the event of a Covered Accident.

SCHEDULE OF BENEFITS	PLAN I	PLAN II
Accident Specific Sum Injuries Benefit Pays for dislocations, burns, ruptured discs and torn knee cartilage, eye injuries, lacerations, internal injuries, fractures, and blood and plasma. See Rider for specific amounts payable, definitions, and limitations for each specific accident. (Benefits will not be paid for services rendered by a member of the immediate family of a Covered Person.)	\$30 – \$2,000	\$60 – \$4,000
<i>The following is an example of the Policy Schedule Benefits.</i>		
A. Dislocations (reduced under general anesthesia)		
Hip		
Open reduction	\$2,000	\$4,000
Closed reduction	\$665	\$1,330
Knee or shoulder		
Open reduction	\$665	\$1,330
Closed reduction	\$265	\$530
Collar bone		
Open reduction	\$1,065	\$2,130
Closed reduction	\$200	\$400
Ankle or foot (excluding toes)		
Open reduction	\$665	\$1,330
Closed reduction	\$200	\$400
Lower jaw		
Open reduction	\$665	\$1,330
Closed reduction	\$330	\$665
Wrist or elbow		
Open reduction	\$530	\$1,065
Closed reduction	\$265	\$530
Toe or finger		
Open reduction	\$130	\$265
Closed reduction	\$65	\$130

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SCHEDULE OF BENEFITS (continued)

PLAN I PLAN II

<p>B. Tendons and Ligaments Tendons and ligaments must be torn, ruptured or severed and must be treated by a physician within 72 hours after the Covered Accident and repaired through surgery within six months after the Covered Accident. If a Covered Person receives a fracture and/or a dislocation and also tears, ruptures, or severs a tendon/ ligament in a Covered Accident, the Insurer will pay only one benefit. The Insurer will pay the largest of this benefit, the Fractures Benefit or the Dislocation Benefit.</p> <p>Repair of one Repair of all if more than one</p>	<p>\$330 \$665</p>	<p>\$665 \$1,330</p>
<p>C. Burns (Treated by a physician within 72 hours after the accident)</p> <ol style="list-style-type: none"> 1. Second-degree burns of at least 25% - 35% of body surface 2. Second-degree burns of more than 35% of body surface 3. Third-degree burns covering 6 through 9 square inches of body surface 4. Third-degree burns covering 10 through 25 square inches of body surface 5. Third degree burns covering more than 25 square inches of body surface 	<p>\$265 \$665 \$530 \$1,330 \$2,665</p>	<p>\$530 \$1,330 \$1,065 \$2,665 \$5,330</p>
<p>D. Ruptured Disc or Torn Knee Cartilage Must be treated by a physician within 72 hours after the accident and repaired through surgery within one year after the Covered Accident.</p> <p>Accident during first year of coverage Thereafter</p>	<p>\$130 \$400</p>	<p>\$265 \$800</p>
<p>E. Eye Injury With surgical repair</p>	<p>\$130</p>	<p>\$265</p>
<p>Accident Follow-up Treatment Benefit Pays for additional treatment of injuries sustained in a Covered Accident over and above emergency treatment administered within 72 hours following the accident. This benefit is payable for up to a maximum of three treatments per Covered Person per Covered Accident. Such treatment must begin within 30 days of the Covered Accident or discharge from the hospital or extended care facility, and be within the six-month period following the Covered Accident or discharge. Treatments must be furnished by a physician in a physician's office or in a hospital on an outpatient basis. (Benefits will not be paid for services rendered by a member of the immediate family of a Covered Person.)</p>	<p>\$25/visit</p>	<p>\$25/visit</p>
<p>Accident Emergency Treatment Benefit Pays for emergency treatment for a Covered Accident, we will pay the amount shown in the Policy Schedule for treatment received. This benefit is payable for treatment by a physician, x-rays or treatment received in a hospital emergency room. Treatment must be received within 72 hours of such accident for benefits to be payable. This benefit is payable once per Covered Accident. (Benefits will not be paid for services rendered by a member of the immediate family of a Covered Person.)</p> <p>Insured & Spouse Children</p>	<p>\$100 \$70</p>	<p>\$150 \$105</p>
<p>Initial Hospitalization For Injury Benefit When a Covered Person is hospital confined for 24 hours or more for a covered accidental bodily injury, the Insurer will pay the benefit amount shown in the Policy Schedule. This benefit is payable only once per Hospital Confinement and only once for each Covered Person per calendar year.</p>	<p>\$500</p>	<p>\$1,500</p>

SCHEDULE OF BENEFITS (continued)

PLAN I PLAN II

<p>Accident Hospital Income Benefit Pays for hospital confinement for treatment of a Covered Accident, the Insurer will pay the daily amount shown in the Policy Schedule for each day of such confinement. Such confinement must start within 30 days of the accident. The Insurer will pay this benefit for up to 365 days per Covered Accident.</p>	<p>\$100/day</p>	<p>\$200/day</p>
<p>Additional Intensive Care Unit Benefit Pays an additional benefit equal to three times the Accidental Hospital Income Benefit for each day the Covered Person is confined in an Intensive Care Unit (ICU). This ICU benefit is payable for up to 15 days per Covered Accident.</p>	<p>\$300/day</p>	<p>\$600/day</p>
<p>Ambulance Benefit Pays for ambulance transportation to a hospital or emergency center for injuries sustained in a Covered Accident. Ambulance transportation must be within 72 hours of the accident. Pays four times the Ambulance Benefit for transportation provided by an air ambulance. The hospital or emergency center must be within 100 miles of the site of the accident or residence of the Covered Person. A licensed professional ambulance company must provide the ambulance service. Benefit is limited to one trip per Covered Accident per Covered Person.</p> <p>Ground Ambulance Air Ambulance</p>	<p>\$150 \$600</p>	<p>\$150 \$600</p>
<p>Appliances Benefit Pays if a physician advises a Covered Person to use a medical appliance as an aid in personal mobility as a result of injuries sustained in a Covered Accident. Benefits include and are payable for: crutches, leg braces, wheelchairs, and walkers. This benefit is not payable for prosthetic devices. Benefit is payable once per Covered Accident per Covered Person.</p>	<p>\$100</p>	<p>\$150</p>
<p>Physical Therapy Benefit Pays if a physician advises a Covered Person to seek treatment from a physical therapist. Physical therapy must be for injuries sustained in a Covered Accident and must start within 30 days of such accident or discharge from the hospital. Pays for one treatment per day for up to six treatments per Covered Accident. The six treatments must take place within six months after the accident.</p>	<p>\$50/day</p>	<p>\$75/day</p>
<p>Prosthesis Benefit Pays if a Covered Person requires use of a prosthetic device as a result of a Covered Accident. This benefit is payable once per Covered Accident per Covered Person. Benefit is not payable for hearing aids or any dental aids (including false teeth).</p>	<p>\$500</p>	<p>\$750</p>
<p>Transportation Benefit Pays for transportation to a hospital for special treatment and confinement for injuries sustained in a Covered Accident. This benefit is payable for the trip to the hospital. The local attending physician must prescribe the treatment, and the treatment must not be available locally. This benefit is not payable for transportation to any hospital located within a 100-mile radius of the site of the accident or residence of the Covered Person. This benefit is payable for up to three trips per calendar year per Covered Person.</p>	<p>\$300</p>	<p>\$300</p>

SCHEDULE OF BENEFITS (continued)

PLAN I PLAN II

Family Lodging Benefit

Pays for one motel or hotel room for a member (or members) of the immediate family to accompany the Covered Person for hospital confinement for the treatment of injuries sustained in a Covered Accident. This benefit is payable only during the same period of time the injured Covered Person is confined to the hospital. Benefit is not payable for the trip to the hospital. The hospital and the motel or hotel must be more than 100 miles from the residence of the Covered Person. The local attending physician must prescribe the treatment. This benefit is payable for up to 30 days per Covered Accident.

\$100/day

\$100/day

Wellness Benefit

After 12 months of paid premium for this benefit, the Insurer will pay for an Insured to undergo routine examinations or other preventive testing. Benefits include and are payable for: annual physical exams; mammograms, pap smears, immunizations, flexible sigmoidoscopy, Prostatic Specific Antigen, and blood screenings. This benefit will become available following each anniversary of this Rider's Effective Date, and is payable only once each 12-month period. Family members include an insured employee's spouse and dependent children. Services must be under the supervision of, or recommended by a physician, and a charge must be incurred.

\$60/year

\$60/year

Accidental Death Benefit

Death must occur as a result of a Covered Accident and must occur within 90 days of a Covered Accident.

PLAN I

	Insured	Spouse	Child
Common-Carrier Accidents	\$35,000	\$17,500	\$3,500
Motorized-Vehicle or Pedestrian Accidents	25,000	\$12,500	\$2,500
Other Accidents	15,000	\$7,500	\$1,500

PLAN II

Common-Carrier Accidents	\$70,000	\$35,000	\$7,000
Motorized-Vehicle or Pedestrian Accidents	50,000	25,000	\$5,000
Other Accidents	30,000	15,000	\$3,000

Accidental Dismemberment

Pays a percentage of the Accidental Death Benefit selected.

PLAN I

PLAN II

Both arms and both legs	100%	100%
Two arms or two legs	50%	50%
Two eyes, hands, or feet	50%	50%
One eye, hand, foot, arm, or leg	20%	20%
One or more fingers and/or one or more toes	5%	5%

IMPORTANT INFORMATION

RENEWABILITY

You are guaranteed the right to renew this policy for your lifetime by the payment of premiums in effect at the beginning of each term. You can never be singled out for a rate increase. Rates can be changed only if the rate is changed for all policies of this class. While this policy is in force, no change will be made because of your age or physical condition.

EFFECTIVE DATE

The Effective Date of the policy and riders will be the date shown on the Policy Schedule or endorsement, not the date the application is signed.

ISSUE AGES

AccidentSelect is available to individuals 18 through 64. Coverage is available for your eligible dependent children under age 26.

FAMILY COVERAGE

Spouse and dependent children coverage is available. Family Coverage includes the Insured, his or her spouse, and all dependent, unmarried children through age 25. Newborn children are automatically covered under the terms of the policy from the moment of birth. Single-Parent Coverage includes the Insured and all of his or her eligible dependent children under 26.

TIME LIMIT ON CERTAIN DEFENSES

(1) Misstatements in the Application: After two years from the issue date only fraudulent misstatements in the application may be used to void the policy or deny any claim for loss incurred or disability that starts after the two-year period.

(2) Pre-Existing Conditions: No claim for loss incurred or disability that starts after two years from the issue date will be reduced or denied because of a physical condition not excluded by name or specific description before the date of loss, had existed before the Effective Date of coverage.

FRAUDULENT MISSTATEMENT

If a fraudulent misstatement is made in the application for this policy, the Insurer may reduce or deny any claim or void the policy at any time.

ADDITIONAL LIMITATIONS AND EXCLUSIONS

The Insurer will not pay benefits for a Covered Accident that is caused by or occurs as a result of:

- a) Driving any taxi or intrastate or interstate long-distance vehicle for wage, compensation or profit.
- b) Mountaineering, parachuting or hang gliding.
- c) Poison, gas or fumes voluntarily taken, administered, absorbed or inhaled;
- d) Alcoholism or drug addiction.

- e) Participating in any sport or activity for wage, compensation or profit; or racing any type vehicle in an organized event.
- f) Travel in, or descent from any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a commercial airline (other than a chartered airline) on a regularly scheduled passenger trip.
- g) War, or any act of war, whether declared or undeclared.
- h) Participating in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a physician or taken according to the physician's instructions), or committing an illegal act while intoxicated (intoxicated means that condition as defined by the law of the jurisdiction in which the accident occurred).
- i) Participating in, or an attempt to participate in, an illegal activity that is defined as a felony, whether charged or not. (A felony is defined by the law of the jurisdiction in which the activity takes place.)
- j) Intentionally self-inflicted bodily injury or attempting suicide, while sane or insane. In the event of suicide, the Company's liability may be limited to only the return of premiums paid.
- k) Any loss incurred while on active duty status in the armed forces. (If the Insurer is notified of such active duty, a refund will be provided for any premiums paid for any period for which no coverage is provided as a result of the exception.)

"Hospital" does not include an institution, or that part of an institution operated as a: 1) convalescent home or skilled nursing care facility or hospice care center; or 2) facility primarily affording custodial rehabilitative or educational care; or 3) facility for the aged, drug addicts, or alcoholics.

This summary provides information about AccidentSelect I and II (Policy Form Series TPA0100 or CP500100 with Riders Form Series TRA0100, CR500100, TRA0200 or CR500200, TRA0300 or CR500300, TRA0400 or CR500400, TRA0500 or CR500500, TRA0700 or CR500700 TRW0100 or CR501000, and TRIH0200 or CR501100) underwritten by Transamerica Life Insurance Company, Home Office, Cedar Rapids, IA. Form and number may vary and coverage may not be available in all jurisdictions.

**For Claims or Customer Service on your policy, please call
Transamerica Life Insurance Company at: 1.888.763.7474**

Home Office: Cedar Rapids, IA
Administrative Offices: Little Rock, Ar, 72211

Monthly Rates

Industry Class B - Plan I			
Individual	Single Parent Family	Two-Adult Family	Family
\$12.06	\$17.85	\$17.37	\$23.16

Industry Class B - Plan II			
Individual	Single Parent Family	Two-Adult Family	Family
\$20.33	\$31.55	\$30.46	\$41.68

Superior Vision Plan I - Full Services Plan

Effective Date: October 1, 2011

Outline of Benefits - Gold Preferred Plan With Materials Discount
Vision Plan- Preferred Provider (PPO / Indemnity)

CoPayment Amount - \$20.00 - Comprehensive Eye Exam
 \$0 - Materials
 \$35.00 - Contact Lens Fitting

How to Use the Plan

Welcome to Superior Vision's vision plan. Superior Vision provides primary vision care benefits including eye examinations, prescription eyewear, and contact lenses through a broad-based provider network consisting of ophthalmologists, optometrists, and opticians. The plan also contracts with a large number of national and regional optometric chain locations.

Your first step should be to choose an eye care provider, or ensure that your current provider is part of the Superior Vision network. Go to www.superiorvision.com and click on "Locate a Provider" for an updated list. You will learn about "in-network" and "out-of-network" providers – it is an important distinction when receiving your benefits. You will also learn more about how to use your benefits, as well as the discounts that are available to you.

Remember that a routine eye exam is important not only for correcting vision problems, but for maintaining healthy eyes and overall health wellness. Superior Vision eye care providers are trained to test for and diagnosis a variety of health issues – not just eye problems. Take the time to get to know your vision plan, and start experiencing healthy eyes and healthy living.

BENEFITS	FREQUENCY	IN-NETWORK¹	NON-NETWORK¹
Comprehensive Exam			
Ophthalmologist	12 Months	Covered in Full	Up to \$44.00
Optometrist	12 Months	Covered in Full	Up to \$39.00
Standard Lenses (Per Pair)			
Single Vision	12 Months	Covered in Full	Up to \$34.00
Bifocal	12 Months	Covered in Full	Up to \$48.00
Trifocal	12 Months	Covered in Full	Up to \$64.00
Lenticular	12 Months	Covered in Full	Up to \$88.00

(CONT.)

BENEFITS	FREQUENCY	IN-NETWORK¹	NON-NET WORK¹
Contact Lenses (Per Pair)²			
Medically Necessary	12 Months	Covered in Full	Up to \$210.00
Cosmetic (Elective) ³	12 Months	Up to \$100.00	Up to \$100.00
Contact Lens Fitting⁴			
Standard	12 Months	Covered in Full	Not Covered
Specialty	12 Months	Up to \$50.00	Not Covered
Frames (Standard)**	24 Months	Up to \$100.00	Up to \$50.00

¹ All in-network and out-of-network allowances are at the retail value.

² Contact lenses are in lieu of eyeglass lenses and frames benefits.

³ The insured is responsible for paying any charges in excess of this allowance.

Discount Features

Look for providers in the Provider Directory who accept discounts; please verify their discounts prior to service.

Discounts on Covered Materials

Frames:	20% off amount over allowance
Lens options:	20% off retail
Progressives:	20% off amount over retail lined trifocal lens, including lens options

The following options have out-of-pocket maximums on standard plastic single vision lenses, and select options are available on standard bifocal and trifocal lenses. Out-of-pocket maximums are not available on premium options or progressives.

Maximum Member Out-of-Pocket

	<u>Single Vision</u>	<u>Bifocal & Trifocal</u>
Scratch coat	\$13	\$13
Ultraviolet coat	\$15	\$15
Tints, solid or gradients	\$25	\$25
Anti-reflective coat	\$50	\$50
Polycarbonate	\$40	20% off retail
High-index 1.6	\$55	20% off retail
Photochromic	\$80	20% off retail

Discounts on Non-Covered Exam and Materials

Superior Vision offers discounts on an unlimited number of materials after the member has exhausted their covered benefit.

Exams, frames, and prescription lenses:	30% off retail
Lens options, contacts, other prescription materials:	20% off retail
Disposable contact lenses:	10% off retail

Refractive Surgery

Superior Vision has a nationwide network of refractive surgeons and partnerships with leading LASIK networks (QualSight, TruVision, and LasikPlus) who offer members a discount. These discounts range from 20%-50%, and are the best possible discounts available to Superior Vision.

⁴Discounts and maximums may vary by lens type. Please check with your provider.

*Higher end or brand name lens upgrades are at an additional expense. These upgrades will be available at a 20% discount off retail.

Items or Services Not Covered

While Superior Vision offers a variety of vision benefits, there are a few materials, services, and treatments that are generally not covered, or have limitations to their coverage. We do offer discounts on many of these items, as outlined in our discount plan coverage information. For a list of these, please see your benefits administrator. Please confirm the details of your employer's plan prior to seeking services.

Superior Vision Contacts

Customer Service
800-507-3800
916-852-2277 Fax

Explanation of benefits
Provider locator; provider nomination
Claims inquiries
Authorization numbers (out-of-network)
Grievance issues

Customer Service/Corporate Office
11101 White Rock Rd., Ste. 150
Rancho Cordova, CA 95670

Claims Administration
P.O. Box 967
Rancho Cordova, CA 95741

Disclaimer: All final determinations of benefits, administrative duties, and definitions are governed by the Certificate of Insurance Coverage for your vision plan. Please check with your Benefits Administrator or Human Resources department if you have any questions.



The Superior Vision Plan is underwritten by National Guardian Life Insurance Company. National Guardian Life Insurance Company is not affiliated with The Guardian Life Insurance Company of America, a/k/a The Guardian or Guardian Life

MONTHLY RATES

Employee Only	\$9.76
Employee + Family	\$24.52



Superior Vision Plan II - Materials Only Plan

Effective Date: October 1, 2011

Outline of Benefits - Gold Preferred Plan With Materials Discount
Vision Plan- Preferred Provider (PPO / Indemnity)

CoPayment Amount - \$0 - Materials
\$35.00 - Contact Lens Fitting

How to Use the Plan

Welcome to Superior Vision's vision plan. Superior Vision provides primary vision care benefits including eye examinations, prescription eyewear, and contact lenses through a broad-based provider network consisting of ophthalmologists, optometrists, and opticians. The plan also contracts with a large number of national and regional optometric chain locations.

Your first step should be to choose an eye care provider, or ensure that your current provider is part of the Superior Vision network. Go to www.superiorvision.com and click on "Locate a Provider" for an updated list. You will learn about "in-network" and "out-of-network" providers – it is an important distinction when receiving your benefits. You will also learn more about how to use your benefits, as well as the discounts that are available to you.

Remember that a routine eye exam is important not only for correcting vision problems, but for maintaining healthy eyes and overall health wellness. Superior Vision eye care providers are trained to test for and diagnosis a variety of health issues – not just eye problems. Take the time to get to know your vision plan, and start experiencing healthy eyes and healthy living.

BENEFITS	FREQUENCY	IN-NETWORK¹	NON-NETWORK¹
Comprehensive Exam			
Ophthalmologist	Not Covered	Not Covered	Not Covered
Optometrist	Not Covered	Not Covered	Not Covered
Standard Lenses (Per Pair)			
Single Vision	12 Months	Covered in Full	Up to \$34.00
Bifocal	12 Months	Covered in Full	Up to \$48.00
Trifocal	12 Months	Covered in Full	Up to \$64.00
Lenticular	12 Months	Covered in Full	Up to \$88.00

(CONT.)

BENEFITS	FREQUENCY	IN-NETWORK¹	NON-NET WORK¹
Contact Lenses (Per Pair)²			
Medically Necessary	12 Months	Covered in Full	Up to \$210.00
Cosmetic (Elective) ³	12 Months	Up to \$100.00	Up to \$100.00
Contact Lens Fitting⁴			
Standard	12 Months	Covered in Full	Not Covered
Specialty	12 Months	Up to \$50.00	Not Covered
Frames (Standard)**	24 Months	Up to \$100.00	Up to \$50.00

¹ All in-network and out-of-network allowances are at the retail value.

² Contact lenses are in lieu of eyeglass lenses and frames benefits.

³ The insured is responsible for paying any charges in excess of this allowance.

Discount Features

Look for providers in the Provider Directory who accept discounts; please verify their discounts prior to service.

Discounts on Covered Materials

Frames:	20% off amount over allowance
Lens options:	20% off retail
Progressives:	20% off amount over retail lined trifocal lens, including lens options

The following options have out-of-pocket maximums on standard plastic single vision lenses, and select options are available on standard bifocal and trifocal lenses. Out-of-pocket maximums are not available on premium options or progressives.

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Scratch coat	\$13	\$13
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Photochromic	\$80	20% off retail

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Superior Vision offers discounts on an unlimited number of materials after the member has exhausted their covered benefit.

Exams, frames, and prescription lenses:	30% off retail
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*Discounts and maximums may vary by lens type. Please check with your provider.

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Claims Administration
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Rancho Cordova, CA 95741

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MONTHLY RATES

Employee Only	\$6.20
Employee + Family	\$15.54



Disability Is A Fact of Life

- ◆ 27,000,000 Americans are currently on disability.
- ◆ 6.85 out of 10 people between the ages of 20 and 35 will suffer a disability that lasts 3 months or longer.
- ◆ If a disability lasts longer than 3 months, its average duration is 2.9 years at age 30, 3.9 years at age 40 and 4.5 years at age 50.
- ◆ **48% of all home foreclosures done in this country today are a result of disabilities, only 3% are due to premature death.**
- ◆ Death rates are down; disability rates are up.
- ◆ At ages 35 - 40, your chances of being disabled are twice as great as those of dying.
- ◆ Worker's Compensation rates recently rose again. Analysts attribute this in part to the inclusion of stress on the job as a possible claim.
- ◆ Each year, the statistics average as follows:
 - ▶ 1 in 106 people die
 - ▶ 1 in 88 homes catch fire
 - ▶ 1 in 70 cars is involved in a serious accident
 - ▶ 1 in 8 people are disabled

Source: Commissioners Disability Trade, US Gov't Housing/Finance, Society of Actuaries

Could You Live Off Of Savings?

Standard Life Short Term Disability Plan

Effective Date: October 1, 2011 (pending underwriting approval)

- Payable in addition to sick leave
- Benefits payable regardless of other insurance
- Weekends and holidays are covered
- Benefits are paid directly to you
- Benefits are tax free
- Disability from pregnancy is covered as any other sickness
- No change in premium due to age
- You may continue coverage if you leave your Employer, provided you maintain continuous employment.

ACCIDENT & SICKNESS PROTECTION

On or off the job, 24 hour a day coverage. Income is provided when you are disabled due to a sickness or as a result of an accident. Benefits begin on the **first day** if you are disabled due to an accident. Benefits begin on the **eighth day** if you are disabled due to sickness.

You can choose to insure up to **70% of your gross monthly income**, up to a maximum of \$2,000.00 per month. Income will be provided for the benefit period you choose up to 365 days.

Benefit Duration: 90 Days		Benefit Duration: 180 Days		Benefit Duration: 365 Days	
Monthly Benefit	Monthly Premium	Monthly Benefit	Monthly Premium	Monthly Benefit	Monthly Premium
\$500	\$11.25	\$500	\$17.50	\$500	\$22.50
\$600	\$13.50	\$600	\$21.00	\$600	\$27.00
\$700	\$15.75	\$700	\$24.50	\$700	\$31.50
\$800	\$18.00	\$800	\$28.00	\$800	\$36.00
\$900	\$20.25	\$900	\$31.50	\$900	\$40.50
\$1,000	\$22.50	\$1,000	\$35.00	\$1,000	\$45.00
\$1,100	\$24.75	\$1,100	\$38.50	\$1,100	\$49.50
\$1,200	\$27.00	\$1,200	\$42.00	\$1,200	\$54.00
\$1,300	\$29.25	\$1,300	\$45.50	\$1,300	\$58.50
\$1,400	\$31.50	\$1,400	\$49.00	\$1,400	\$63.00
\$1,500	\$33.75	\$1,500	\$52.50	\$1,500	\$67.50
\$1,600	\$36.00	\$1,600	\$56.00	\$1,600	\$72.00
\$1,700	\$38.25	\$1,700	\$59.50	\$1,700	\$76.50
\$1,800	\$40.50	\$1,800	\$63.00	\$1,800	\$81.00
\$1,900	\$42.75	\$1,900	\$66.50	\$1,900	\$85.50
\$2,000	\$45.00	\$2,000	\$70.00	\$2,000	\$90.00

Eligibility

These benefit plans are optional and all full-time employees under 65 years of age may apply. The disability benefit is for employees only.

POLICY FEATURES

Pre-existing Conditions: If you received medical advice for treatment of a health condition within twelve months prior to the effective date of insurance, there will be no coverage for that condition until twelve consecutive months beyond the effective date.

Disability Due to Pregnancy: Benefits are covered provided conception occurs **after** the effective date of the policy.

Portability: When you leave employment, you may continue the short term disability coverage, subject to the renewability provision, provided you maintain continuous employment. Coverage is subject to occupational and income underwriting rules. ****This coverage expires on the policy anniversary date following your 65th birthday.**

Limits and Exclusions:

Benefits will not be paid for any total disability which:

- Occurs while the policy is not in force;
- Does not require the regular care of a physician;
- Is due to the use of intoxicants or narcotics, except on the advice of a physician;
- Is on account of intentional self-inflicted injury;
- Is a result of mental or nervous disorders;
- Results from armed conflicts;
- Arises out of aviation, except scheduled passengers on commercial airlines;
- Results from traveling more than forty miles outside the US;
- Results from the participation in a felony or working at an illegal job.
- Results from a pre-existing condition, as defined in the policy.

Proof of Loss: You must give us written proof of loss within ninety days after a period of disability for which we owe you benefits. If you are not able to give us written proof of loss within the time required, it will not have a bearing on your claim if proof is given to us as soon as it is reasonably possible. In any event, proof must be given no later than one year from the time specified.

This is a brief description of the important features of your policy. This is not an insurance contract; therefore, it is important that you read your policy carefully.

If you have any questions regarding the Standard Life Disability Plan, **please call: 1.800.327.0695**

Toll Free Claims Line: 1.800.227.0251



MetLife Optional and Dependent Term Life Insurance Plan

Effective Date: *pending underwriting approval*

OPTIONAL EMPLOYEE LIFE INSURANCE

You now have the opportunity to elect group term life insurance coverage at low group rates and through payroll deductions.

OPTIONAL DEPENDENT LIFE INSURANCE

Provides coverage for:

- Your Spouse
- Child(ren) from 15 days of age up to 19 (to age 25 if wholly dependent upon you for maintenance and support and if enrolled as a full-time student in an accredited school or college). Handicapped children can continue to be covered with no age limit. It is your responsibility to notify payroll in writing when a dependent is ineligible for coverage. Examples of ineligible dependent status are divorce or a child graduates from college.

FEATURES

The plan features easy eligibility and simple enrollment procedures. Furthermore, automatic payroll deductions simplify paperwork. This means less bookkeeping for you and no worries about a lapse in coverage due to missed payments.

LOW COST

Your cost is lower than for comparable insurance on an individual basis due to the "wholesale" economies inherent in group insurance. Additionally, the system absorbs the cost of administering the program which is underwritten by MetLife - a leader in the field of group coverage.

ELIGIBILITY

You will be eligible for this plan if you are a full-time active employee.

ENROLLMENT

Enrollment is simple - just fill out the election card provided by your employer. Make sure you supply all the required information and return the form where you work. That's all. You will be notified as to when coverage starts.

WHEN YOUR INSURANCE STARTS

If you meet the eligibility requirements described above for date of enrollment and for effective date of coverage, your Optional Employee Life Insurance, if you have enrolled for that coverage, will become effective on the date of your eligibility provided you are then actively at work; otherwise, on the day you return to active work.

If you enroll for Optional Dependent Life Insurance, that coverage will become effective on the date your Optional Employee Life Insurance becomes effective, for any dependents who meet the eligibility requirements described above.

If you or any dependents do not satisfy the eligibility requirements described above for date of enrollment and for effective date of coverage, that person will not become insured for Optional Life Insurance until such person has furnished medical evidence of insurability satisfactory to MetLife.

TERMINATION OF COVERAGE

All insurance under this plan will terminate with the earliest of the following events: termination upon retirement, termination of employment, plan cessation or withdrawal from the plan. Nevertheless, if you should die within 31 days thereafter, your life insurance will still be paid to the beneficiary. If any of your covered dependents should die within such 31 day period, the amount of Life Insurance on account of such dependent will be paid to you.

WAIVER OF PREMIUM

The waiver benefit applies to disabilities beginning before age 60. MetLife must be notified of the disability within 12 months of the date the insured's disability begins. After inception of disability, there is a 9 month waiting period before benefits begin. During the waiting period, normal monthly deductions are taken, which are not refundable. This means that employees who become disabled on or after the effective date of coverage and before age 60 and whose application for disability is approved has continuing coverage without premium payment until death, or recovery or age 65, whichever is earliest. If the employee remains on disability at age 65, the death benefit will reduce to zero.

CONVERSION

If your coverage terminates while you are covered under the plan, you may purchase without medical evidence of insurability, any individual insurance policy, except a term policy, issued by MetLife in any amount up to the amount of your coverage in effect on your date of termination. You must apply for this policy within 31 days after the date your coverage terminates. This privilege applies to Optional Dependent Life Insurance as well.

PORTABILITY

Portability allows employees whose coverage ends due to certain qualifying events to continue their current (or a lesser) amount of insurance. Portability applies to Employee Optional Life Insurance, not dependent(s).

Qualifying Events Include:

- Termination of Employment
- Retirement
- Change in employee class which results in the termination of Optional Life Benefits.

The minimum face amount which an employee may elect portability is \$20,000. Portable coverage reduces to 50% on January 1st of the year the insured attains age 70 and terminates on January 1st of the year the insured attains age 80. When portable coverage ends, insured individuals have the right to convert to an individual policy.

THE ACCELERATED BENEFIT OPTION (ABO)

Metropolitan Life Insurance Company has included an Accelerated Benefit Option (ABO) as part of your group life benefits. Under this option, if you are diagnosed as having a terminal illness, you may be eligible to receive a portion of your group life benefits at such a difficult time. Please refer to your Group Certificate for details.

SUICIDE EXCLUSION

No Optional Employee Life Benefits or Dependent Life Benefits are payable if you commit suicide within two years from the effective date of the coverage.

CLAIMS PROCEDURE

Procedures for Presenting Claims for Benefits - Claim forms needed to file for benefits under the group insurance plan can be obtained from your employer who will also be ready to answer questions about the insurance benefits and to assist in filing claims.

The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully.

Routine Questions - If there is any question about a claim payment, an explanation can be requested from MetLife, who is usually able to provide the necessary

PLAN ADMINISTRATOR

Asheville City Schools
85 Mountain Street, Asheville, NC 28801

SCHEDULE OF BENEFITS

OPTIONAL EMPLOYEE LIFE INSURANCE

Employee-

\$5,000 to \$100,000 (in \$5,000 increments) and
\$110,00 to \$300,000 (in \$10,000 increments)

• ***Amounts over \$100,000 will require evidence of insurability***

OPTIONAL DEPENDENT LIFE INSURANCE

Spouse - \$5,000 up to \$50,000 (in \$5,000 increments)

• ***Amounts over \$10,000 will require evidence of insurability***

• ***Spouse maximum benefit cannot exceed the lesser of 100% of the Employee Optional Life Benefit or \$50,000.***

Child(ren) - \$5,000 or \$10,000 per child

• ***Child coverage is regardless of number of children covered.***

• Optional Dependent Life Insurance is available only to those eligible employees who are insured for Employee Optional Life Insurance. If both husband and wife are employees only one can cover the dependent children.

• If you do not elect Optional Employee or Dependent coverage when first hired, you will be required to submit a Statement of Health to MetLife if you later enroll for coverage. This applies to your dependents as well.

If you have any questions regarding your statement of health or life insurance claim, please call MetLife at: 1.800.638.6420.

MetLife®

Employee Optional Term Life Coverage

Coverage Amount	Monthly Cost	Coverage Amount	Monthly Cost
\$5,000	\$0.90	\$110,000	\$19.80
\$10,000	\$1.80	\$120,000	\$21.60
\$15,000	\$2.70	\$130,000	\$23.40
\$20,000	\$3.60	\$140,000	\$25.20
\$25,000	\$4.50	\$150,000	\$27.00
\$30,000	\$5.40	\$160,000	\$28.80
\$35,000	\$6.30	\$170,000	\$30.60
\$40,000	\$7.20	\$180,000	\$32.40
\$45,000	\$8.10	\$190,000	\$34.20
\$50,000	\$9.00	\$200,000	\$36.00
\$55,000	\$9.90	\$210,000	\$37.80
\$60,000	\$10.80	\$220,000	\$39.60
\$65,000	\$11.70	\$230,000	\$41.40
\$70,000	\$12.60	\$240,000	\$43.20
\$75,000	\$13.50	\$250,000	\$45.00
\$80,000	\$14.40	\$260,000	\$46.80
\$85,000	\$15.30	\$270,000	\$48.60
\$90,000	\$16.20	\$280,000	\$50.40
\$95,000	\$17.10	\$290,000	\$52.20
\$100,000	\$18.00	\$300,000	\$54.00

Dependent Optional Term Life Coverage

Spouse Coverage Amount	Monthly Cost	Child(ren) Coverage Amount	Monthly Cost
\$5,000	\$1.00	\$5,000	\$0.60
\$10,000	\$2.00	\$10,000	\$1.20
\$15,000	\$3.00		
\$20,000	\$4.00		
\$25,000	\$5.00		
\$30,000	\$6.00		
\$35,000	\$7.00		
\$40,000	\$8.00		
\$45,000	\$9.00		
\$50,000	\$10.00		

Texas Life Whole Life Plan

Common Issue Date: December 1, 2011 (pending underwriting approval)

This **Voluntary Permanent Life Program** will allow you to purchase permanent life insurance for you and your eligible dependents.

VPL- plus is an individual permanent life insurance product specifically designed for employees and their families. It provides a guaranteed level premium and death benefit for the life of the policy, and you can keep the life insurance even after you retire.* As an employee, you are eligible to apply if you have satisfied your employer's eligibility period. You may also apply for coverage on your spouse, children and grandchildren.¹

WHY VOLUNTARY COVERAGE

- Most employees are typically dependent on group term life insurance
- Today more adults than ever have only group life insurance obtained through their employers, but they carry the lowest average amount of coverage.²
- On the other hand, adults with both individual life and group life policies have the highest life insurance protection.²
- Most term policies generally expire before paying a death claim
- When do you want a life insurance policy in force? —Answer: When you die
- Term is for IF you die; permanent is for WHEN you die

TEXAS LIFE'S VPL-plus

- Portable, permanent life insurance through the convenience of payroll deduction
- Whole life chassis
- Strong guarantees
- Popular features
- Coverage available for spouse, children and grandchildren

VPL-plus: PORTABLE AND PERMANENT

- Employee can keep policy, at same premium, if he/she retires or changes jobs
- Employee may apply for spouse, minor children and grandchildren at the worksite
- Permanent coverage: policy guaranteed to remain in force as long as necessary premiums are paid

VPL-plus: THE GUARANTEES EMPLOYEES WANT

- Guaranteed level premium
- Guaranteed level death benefit*
- Guaranteed reduced paid-up insurance at retirement
- Guaranteed paid-up for face amount at age 70 (or after 20 years for insureds between ages 51 and 70)

¹ Policies not available for children & grandchildren in WA.

² Generations At Risk LIMRA International (2008)

10M163-C (exp 6/12) See the VPL-plus brochure for complete details- Form PWLSEV-NI-05

*Guarantees are backed by the claims paying ability and financial strength of the issuing company.

VPL-plus: CGI (EXPRESS ISSUE) UNDERWRITING

Employee, spouse coverage require 3 health and employment related questions:

- During the last six months, has the proposed insured been actively at work on a full-time basis, performing usual duties?
- During the last six months, has the proposed insured been absent from work due to illness or medical treatment for a period of more than five consecutive working days?
- During the last six months, has the proposed insured been disabled or received tests, treatment or care of any kind in a hospital or nursing home or received chemotherapy, hormonal therapy for cancer, radiation therapy, dialysis treatment or treatment for alcohol or drug abuse?

Child coverage (ages 6 months -18 years old):

- During the last six months, has the proposed insured been disabled or received tests, treatment or care of any kind in a hospital or nursing home or received chemotherapy, hormonal therapy for cancer, radiation therapy, dialysis treatment or treatment for alcohol or drug abuse?

Express Issue Maximums

- employee
 - ages 17-49, \$100,000
 - ages 50-65, \$50,000
 - ages 66-70, \$10,000
- spouse (if employee applies)
 - ages 17-49, \$50,000
 - ages 50-65, \$25,000
 - ages 66-70, \$10,000
- spouse (if employee does not apply)
 - ages 17-24 \$25,000
 - ages 25-29 \$20,000
 - ages 30-39 \$15,000
 - ages 40-44 \$10,000
 - ages 45-49 \$7,500
 - ages 50-70 \$5,000
- children - ages 6 months -18 \$25,000
- grandchildren - ages 6 months -16 \$25,000

Simplified Issue**

- Use if proposed insured wants amounts over Express Issue maximums
- Coverage is dependent on answers to health-related and other questions contained in the application
- Answer all underwriting questions
- Blood required for amounts in excess of \$100,000
- Rates are unisex
- Rates are unismoke

** We retain the right to require a medical exam

Accelerated Death Rider

- Included on all policies (Employee, Spouse, Minor Children, Grandchildren)
- Pays 92% of death benefit, 84% in IL, less \$150 processing fee, upon physician-certified diagnosis of condition expected to result in death within 12 months (conditions and limitations apply)
- No extra charge for rider
- Policy **terminates** when rider is exercised

Waiver of Premium

- Available for issue ages 17-55
- Benefit payable to insured through age 60
- Cost is included in premium

VPL-plus: Review

- Permanent and portable when you change jobs or retire
- Non-participating Whole Life chassis (no dividends)
- Guaranteed level death benefit*
- Guaranteed level premium
- Guaranteed reduced paid-up insurance at retirement
- Premiums cease at age 70 (or after 20 years, ages 51-70)
- Accelerated Death Benefit Rider included on all policies
- Waiver of Premium available issue ages 17-55
- Express Issue underwriting
- Unisex rates
- Unismoke rates
- Blood required for amounts over \$100,000
- Simplified issue for health reasons or for amounts over Express Issue maximums

This information has been prepared to give you the highlights of coverage now being offered through your employer to meet your insurance needs. The details will be provided during your individual meeting with a qualified Texas Life Enrollment Representative. Those employees who wish to participate will be provided a personal policy that spells out all policy provisions.

**If you have any questions regarding your Texas Life policy, please call
1.800.283.9233, press prompt #3.**

TEXASLIFE
INSURANCE COMPANY

Continuation of Benefits

ACCIDENT ONLY INSURANCE

When you leave employment you may continue your Transamerica Accident policy by having the premiums that are currently deducted from your paycheck drafted from your bank account. Please contact **Transamerica at 1.888.763.7474**.

ALLSTATE CANCER

When you leave employment, you may continue your Allstate Cancer policy by having the premiums currently being deducted from your paycheck either drafted from your bank account or billed directly to your home. **You may contact Allstate toll-free at 1.800.521.3535.**

AMERITAS DENTAL & SUPERIOR VISION

Under the Ameritas Dental & Superior Vision plans, you and your covered dependents are eligible to continue dental and vision coverage through COBRA according to the following "qualifying events".

If you and your dependents are enrolled in the dental or vision plan, you will be eligible to continue coverage through COBRA after you leave employment for a specified period. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents maybe eligible to continue dental coverage through COBRA. Also, while you are covered under the plan, your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA. Examples of an ineligible dependent would be when your child graduates from college, or turns 24 years old. For more detailed information, **please call your Benefits Department at 828.350.6164.**

ASSURITY CRITICAL ILLNESS

When you leave employment you may continue your Assurity Critical Illness coverage by having the premium that is currently deducted from your paycheck drafted from your bank account. Please contact **Assurity at 1.866.289.7337**.

GILSBAR HEALTH CARE & DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

If you have a positive balance (payroll deductions are greater than the amount you have received in reimbursement) in your Health Care Flexible Account at the time of your termination, you may continue participation in the Plan for the remainder of the Plan year.

If you want to remain in the Plan, you can do so by electing to continue on **COBRA** through your employer. You will receive notification from IMS (Cobra Administrator) of your continuation options. If you prefer to terminate your participation and contribution to the Plan, any balance in your account on the date of termination will be forfeited if expenses were not incurred prior to the date of termination. For more detailed information, please call **your Benefits Department at 828.350.6164.**

METLIFE TERM LIFE

Conversion: If your employment terminates while you are covered under the plan or when you are approved for long-term disability, you may purchase without medical evidence of insurability, any individual insurance policy. You must apply for conversion within 31 days after the date your coverage terminates. This applies to Optional Life and Dependent Life.

Portability: If you terminate employment, the portability provision allows you to take your optional life coverage with you, subject to the following provisions:

- You must apply for coverage with 31 days from the date your life coverage terminates.
- You must be ACTIVELY at work prior to employment termination.
- You may only port up to your current coverage amount. You cannot increase or add dependents.

To get information for **converting** coverage, please contact **MetLife at 1.877.275.6387.**

To get information for **porting** coverage, please contact **MetLife at 1.866.492.6983.**

STANDARD LIFE DISABILITY

When you leave employment you may continue your short term disability coverage as long as continuous employment is maintained and proof of employment has been sent to Standard Life. Coverage expires at age 65. Coverage is subject to occupational and income underwriting rules. You may continue coverage by having the premium that is currently deducted from your paycheck drafted from your bank account. Please contact **Standard Life at 1.800.327.0695.**

TEXAS LIFE WHOLE LIFE

When you leave employment, you may continue your Texas Life Whole Life coverage by having the premiums that are currently deducted from your paycheck drafted from your bank account. You may do that by contacting **Texas Life at 1.800.283.9233 prompt #3.**

BENEFITS NO LONGER ON PAYROLL DEDUCTION

• ALLSTATE WORKPLACE DIVISION UNIVERSAL LIFE

This benefit is no longer on payroll deduction. If you wish to keep your Allstate Universal Life plan, you may continue the coverage by having the premiums that are currently deducted from your paycheck drafted from your bank account. Please contact **Allstate Workplace Division at 1.800.521.3535.**

• ASSURITY CANCER

This benefit is no longer on payroll deduction. If you wish to keep your Assurity Cancer coverage please contact **Assurity at 1.866.289.7337**

Phone Directory

Allstate Workplace Division Universal Life - 1.800.521.3535

Allstate Group Cancer Plan - 1.800.521.3535

Ameritas Dental - 1.800.776.9446

Asheville City Schools Benefits Department- 1.828.350.6164

Assurity Cancer & Assurity Critical Illness - 1.866.289.7337

Gilsbar Health & Dependent Care Accounts- 1.800.445.7227, ext. 883

Mark III Brokerage, Inc.- 1.800.532.1044

MetLife Term Life- **Conversion**: 1.877.275.6387

MetLife Term Life- **Portability**: 1.866.492.6983

Standard Life Short Term Disability- 1.800.327.0695

Standard Life Short Term Disability **Claims Line**- 1.800.227.0251

• To **FAX** a Short Term Disability claim- 1.801.538.0392

Superior Vision - 1.800.507.3800

Texas Life Whole Life- 1.800. 283.9233 prompt #3

Transamerica Accident -1.888.763.7474

