

Brunswick County Government is offering all full-time employees a comprehensive Cafeteria Benefits program. The Cafeteria Benefits program is being arranged by Mark III Brokerage, an employee benefits firm that Brunswick County Government has been working with for many years.

The Cafeteria Benefits program 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 by this method reduces your income & FICA taxes and increases your take home pay.

- The Plan Year is from January 1st, 2010 through June 30th, 2010 in order to coincide with Brunswick County Government's Health Plan. Hereafter, the plan year will run from July 1st through June 30th each year.
- A Mark III representative will be conducting enrollment meetings in various departments outlining all of the benefits below. All eligible employees are asked to attend a group meeting. This will ensure that all employees understand what benefits are offered.

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*All information in this booklet is a brief description of your coverage and is not a contract. Read your certificate for each product for the exact terms and conditions.*

## Flexible Benefit Administrators Spending Accounts

**PLAN YEAR: JANUARY 1, 2010 - JUNE 30, 2010**  
**HEALTH CARE FLEXIBLE SPENDING ACCOUNT MAXIMUM: \$1,200**  
**HEALTH CARE FLEXIBLE SPENDING ACCOUNT MINIMUM: \$120**  
**DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT MAXIMUM: \$2,500**

### **FLEXIBLE BENEFIT PLAN: THE BETTER YOU PLAN, THE MORE YOU SAVE!**

It's more than a slogan. The Flexible Benefit Plan is a real solution to issues facing all of us. Simply stated, by taking advantage of tax laws, the Flexible Benefit Plan works with your benefits to save you money.

Your insurance programs are designed to help you and your family become financially secure as well as to protect you against the high cost of medical care including catastrophic events. However, almost everyone has a number of necessary, predictable expenses that are not covered by your insurance programs. The Flexible Benefit Plan will help you pay for these predictable expenses.

The Flexible Benefit Plan offers a unique way to help pay for some of your health care expenses and dependent care expenses.

The key to the Flexible Benefit Plan is that your eligible expenses are paid for with Tax Free Dollars. You will not pay any federal, state or social security taxes on funds placed in the Plan. You will save between, approximately, \$27.65 and \$37.65 on every \$100 you place in the Plan. The amount of your savings will depend on your federal tax bracket.

Using the Flexible Benefit Plan can save you a significant amount of money each year, however, it is important that you understand how the Plan works and how you can make the most of the advantages the Flexible Benefit Plan offers.

This chapter will help you understand the Flexible Benefit Plan. The chapter covers how the Plan works, describes the categories of the Plan, explains the rules governing the Plan, the reimbursement process and how you can elect to participate in the Flexible Benefit Plan. Prior to electing to participate in the Flexible Benefit Plan, it is important that you read and understand the Rules and Regulations section of this handbook.

After you read this material, if you have any questions please feel free to contact **Flexible Benefit Administrators, Inc. at (757) 340-4567 or (800) 437-FLEX.**

*FLEX NOTE: FLEX is authorized by Section 125 of the Internal Revenue Code.*

## HEALTH CARE REIMBURSEMENT ACCOUNT

The Health Care Reimbursement Account allows you to pay for your uninsured medical expenses with pre-tax dollars. With this account, you can pay for your out of pocket medical expenses for yourself, your spouse and all of your dependents for medical services that are incurred during your Plan Year. The maximum you may place in this account for the upcoming Plan Year is \$1,200.

### EXAMPLES OF ELIGIBLE HEALTH CARE EXPENSES: FEES/CO-PAYS/DEDUCTIBLES:

- Acupuncture
- Ambulance hire
- Anesthetist
- Chiropractor
- Dental Fees
- Diagnostic
- Eye Exams
- Prescription Eye glasses/  
Contact lenses
- Psychiatrist
- Hospital
- Laboratory
- Nursing
- Obstetrician
- Laser Eye Surgery
- Physician
- Psychologist
- Erectile dysfunction  
medication
- Sterilization Fee
- Surgery
- X-Rays
- Wheel Chair

### OTHER ELIGIBLE EXPENSES:

- Prescription drugs
- Artificial limbs & breasts  
(only if reconstructive)
- Birth control pills, patches  
(e.g. Norplant)
- Orthopedic shoes/inserts
- Incontinence supplies
- Carpal tunnel wrist supports
- Vaccinations & Immunizations
- Elastic hose  
(medically prescribed)
- Contact lens supplies
- Therapeutic care for drug  
and alcohol addiction
- At home pregnancy test kits
- Smoking cessation programs and prescribed drugs designed to  
alleviate nicotine withdrawal
- Mileage, parking and tolls ( you may be reimbursed \$.24\* a mile plus  
parking and tolls when medical reasons make it necessary to travel)
- Tuition fees for medical care (if the college furnishes a breakdown of  
medical charges)
- Orthodontic expenses (not for cosmetic purposes)
- Diabetic supplies
- Routine Physicals
- Condoms
- Dentures
- Oxygen
- Physical Therapy
- Fertility Treatments
- Hearing aids and batteries
- Reading glasses
- Medical equipment
- Pedialyte for dehydration
- Nicotine gum/patches
- Take-home screening kits (HIV,  
colon cancer)

**NOTE: ORTHODONTIC TREATMENT IS REIMBURSED ACCORDING TO YOUR PAYMENT PLAN WITH THE ORTHODONTIST.** FOR EXAMPLE: If your payment plan is set up to pay \$100 a month for the orthodontic treatment, you can be reimbursed \$100 a month for the payments that become due during the Plan Year.

*This above list is compiled from IRS publication 502. If you are unsure that your expected medical expense will be eligible under tax code regulations, please call Flexible Benefit Administrators at (757) 340-4567 or (800) 437-FLEX before making your election for the Plan Year. IRS publication 502 can be ordered by calling the IRS at (800) 829-3676.*

\* Mileage reimbursement rate is based on IRS regulation and subject to change.

## **OVER-THE-COUNTER DRUGS**

Participants may now be reimbursed from their Health Care FSA for medicines and drugs that are available without a prescription!

## **ELIGIBLE OVER-THE-COUNTER EXPENSES**

- Examples of eligible medications and drugs purchased in reasonable quantities without a prescription:
  - Antacids
  - Pain relievers/aspirin
  - Ointments & creams for joint pain
  - Nicotine gum/patches to stop smoking
  - First aid creams (Bactine, diaper rash)
  - Allergy & sinus medication
  - Cough & cold medications
  - Laxatives
  - Anti-diarrhea medicine
  - Bug-bite medication

## **OVER-THE-COUNTER EXPENSES THAT ARE NOT ELIGIBLE**

- The following examples are OTC items that are not eligible and will not be reimbursed under any circumstances because the items are considered dietary supplements, toiletries, cosmetic or personal use items:
  - Multi/Daily Vitamins
  - Weight loss products/foods
  - Face cream/moisteners
  - Mouthwash/toothpaste
  - Feminine hygiene products
  - Deodorant
  - Chapstick
  - Suntan lotion
  - Herbal/natural supplements
  - Acne creams/face cleanser
  - Medicated shampoo/soaps
  - Toothbrushes (even if dentist recommends a special one)
  - Eye/facial makeup/preparations
  - Rogaine

## **DUAL PURPOSE DRUGS & ITEMS**

### **EXPENSES THAT NEED DOCUMENTATION FROM YOUR PHYSICIAN TO BE ELIGIBLE THROUGH THE HEALTH CARE ACCOUNT**

- The following items are examples of products that are considered as having both a medical purpose and a general health, personal/cosmetic purpose and require a medical practitioner's note stating the name of the patient, the specific medical condition for which the OTC is recommended, the time frame of the treatment and that the treatment is not cosmetic:
  - Weight-loss drugs (to treat obesity)
  - Prenatal vitamins
  - Nasal sprays for snoring
  - Pills for lactose intolerance
  - Fiber supplements (to treat a medical condition for a limited time)
  - OTC Hormone therapy (to treat menopausal symptoms)
  - Glucosamine/Chondroitin (for arthritis)
  - St. John's Wort (for depression)

**EXPENSES FOR IMPROVEMENT OF GENERAL HEALTH** are not eligible for reimbursement even if a doctor prescribes the program. However, if the program is prescribed for a specific medical condition (e.g. Obesity, Emphysema), then the expense would be eligible. We must have a letter from your doctor on file for each Plan Year stating specifically what illness or disease is being treated or prevented and the length of time you will be required to use this treatment in order to reimburse for any of these types of expenses.

- Health Club Dues
- Weight Loss Programs
- Exercise equipment
- Exercise classes
- Breast Pumps
- Wigs

**NOTE:** For Weight Loss Programs, only the cost of the program is an eligible expense. Any cost for food or food supplements is not an eligible expense.

**COSMETIC** expenses, prescriptions and treatments are not eligible. This applies to any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat an illness or disease. If cosmetic treatment is necessary to correct a deformity or abnormality, a personal injury or a disfiguring disease, it must meet IRS eligibility guidelines outlined in IRS publication 502 and will require a physician's letter of medical necessity.

#### **OTHER EXPENSES THAT ARE NOT ELIGIBLE FOR REIMBURSEMENT THROUGH THE HEALTH CARE ACCOUNT**

**ESTIMATES** for medical expenses that have not been rendered cannot be reimbursed. Medical services do not have to be paid for, however, the services must have been rendered during the Plan Year, to be eligible for reimbursement.

**PREMIUM EXPENSES** for any insurance policies are not eligible for reimbursement through the Health Care Account. This includes contact lens insurance.

**EXPENSES PAID BY AN INSURANCE COMPANY** are not eligible for reimbursement through the Health Care Account. Only the portion you have to pay out of your pocket for your medical expenses is eligible for reimbursement.

#### **CLAIMS SUBMISSION**

##### **OBTAINING A REIMBURSEMENT FROM YOUR HEALTH CARE ACCOUNT**

To obtain a reimbursement from your Health Care Account, you must complete a Claim Form. This form is available from your employer's website (See sample Claim Form on page 17). You must attach a receipt or bill from the service provider which includes all the pertinent information regarding the expense:

- Date of service
- Patient's name
- Amount charged
- Provider's name
- Nature of the expense
- Amount covered by insurance (if applicable)

Cash register receipts, credit card receipts and canceled checks alone are not eligible forms of documentation for medical expenses. These items are not considered third party receipts because they only reflect that payment has been made and do not provide the required information listed above. Prescription documentation must include the name of the prescribed medication.

#### **OBTAINING A REIMBURSEMENT FOR OVER-THE-COUNTER ITEMS**

For the purchase of over-the-counter medications and items exclusively, cash register receipts will be accepted as documentation if the receipt is detailed and indicates the name of the service provider, the date of the purchase, the amount of the purchase and the name of the product purchased. If the receipt does not specifically reflect the name of the product we cannot accept the claim for reimbursement of that item. The name of the patient does not have to be on the receipt, however, the name of the patient must be listed on the claim form.

**NOTE:** In order to be eligible for reimbursement through the Health Care Account, the medical expense must be incurred during the Plan Year. IRS defines "incurred" as when the medical care is provided (or date of service), not when you are formally billed, charged for, or pay for the care. FOR EXAMPLE: If you go to the doctor on September 26<sup>th</sup> and your Plan Year begins on October 1<sup>st</sup>, this expense is not eligible in the new Plan Year. Even if you pay for this expense after October 1<sup>st</sup>, the "date of service" was before the Plan Year began and therefore is not eligible.

#### **THE HEALTH CARE ACCOUNT IS A PRE-FUNDED ACCOUNT**

This means that you can submit a claim for medical expenses in excess of your account balance. You will be reimbursed your total eligible expense up to your annual election. The funds that you are pre-funded will be recovered as deductions continue to be deposited into your account throughout the Plan Year.

## **DEPENDENT CARE REIMBURSEMENT ACCOUNT**

The Dependent Care Reimbursement Account allows you to pay for day care expenses for your dependents with tax-free dollars.

### **ELIGIBLE DEPENDENT**

- A child under 13 who qualifies as a dependent on your Federal Income Taxes
- Any other dependents, including a disabled spouse, disabled children over age 13 and elderly parents, who depend on you for financial support, qualify as dependents for tax purposes, and are incapable of self care
- Please refer to Page 12 for the latest definition of a dependent, as revised under Section 152 of the Code by the Working Families Tax Relief Act of 2005 (WFTRA)

### **ELIGIBLE DEPENDENT CARE EXPENSES**

For dependent care expenses to be eligible for reimbursement, you must be working during the time your eligible dependents are receiving care. If you are married, your spouse must be:

- Working at the time the day care services are provided;
- A full-time student for at least five months during the year; or
- Mentally or physically disabled and unable to provide care for him or herself

**EXPENSES FOR KINDERGARTEN** are not eligible for reimbursement since they are generally for education, and not for custodial care. In order for an expense to be eligible for reimbursement from the Dependent Care Reimbursement Account, the primary purpose for the care of the qualifying individual must be to assure the individual's well-being and protection. Dependent care must still be primarily for custodial care, not education, in order to qualify as an eligible employment-related expense from the Dependent Care Reimbursement Account.

### **EXAMPLES OF DEPENDENT CARE EXPENSES**

- Babysitters or Nannies that claim the child care as income on their taxes
- Licensed day care centers
- Private Preschool
- Before and after school care
- Day care for an elderly or disabled dependent

### **EXPENSES THAT WOULD NOT BE ELIGIBLE THROUGH THE DEPENDENT CARE ACCOUNT**

- Kindergarten (kindergarten & above is considered an educational expense)
- Days you or your spouse are not working, including sick leave, vacation days, and maternity leave
- Transportation, books, clothing, or entertainment (Note: These expenses will be covered if provided by the nursery school or day care center as part of its preschool care services. If these types of expenses are billed separately, they are not an eligible expense.)
- Care provider may not be a child of yours under the age of 19 or anyone you claim as a dependent for federal income tax purposes

- Babysitting for social events
- Overnight camp is not an eligible expense, only DAY CAMPS are eligible.  
Remember that this account is set-up so that you and your spouse are able to go to work and Overnight camp is 24-hour care.

### **ANNUAL MAXIMUM FOR THE DEPENDENT CARE REIMBURSEMENT ACCOUNT**

Must Not Exceed The Lesser Of:

- \$5,000 for one or more children (\$2,500 if you are a married individual filing a separate tax return);
- Your wages or salary for the Plan Year; or
- The wages or salary of your spouse

If your spouse is either a full time student or is incapable of taking care of himself or herself then he or she is deemed to have monthly earnings of \$250 if there is one (1) child or dependent, and \$500 if there are two (2) or more children or dependents.

### **USING THE DEPENDENT CARE REIMBURSEMENT ACCOUNT VERSUS FILING FOR A TAX CREDIT ON YOUR TAXES**

Under current IRS regulations, you may be eligible to receive a tax credit for dependent care costs. You may claim a credit for dependent care, up to \$3,000 for one child and \$6,000 for two or more children, on your income taxes through the child care tax credit. However, through the Dependent Care Reimbursement Account you may set aside up to \$5,000 per year, for one or more children, if you are married and filing a joint tax return or if you are a single parent. If you are married and filing separate tax returns, you may set aside only \$2,500.

Typically, more money is saved by paying for dependent care through the FSA Dependent Care Reimbursement Account than by taking the dependent care credit on your tax return. This is because the total for federal, state, and FICA savings usually exceeds the dependent care credit. At taxable incomes greater than \$14,000, participants will probably benefit more from taking reimbursement from the Flexible Benefit Plan. These assumptions are based on the inclusion of your state income tax.

You can also file for the tax credit while participating in the Dependent Reimbursement Care Account. If the amount you have placed through the reimbursement account does not meet the maximum allowed by the IRS, you can claim the difference between your Dependent Care deductions and the IRS maximum allowable expenses for the tax credit. You can claim a tax credit for any additional dependent care expenses incurred over the \$5,000 maximum FSA limit up to the \$6,000 child care tax credit limit on your taxes. You cannot claim the tax credit for any dependent care expenses paid from the Dependent Care Reimbursement Account. It is your responsibility to report the Dependent Care amount on your tax form 2441. The amount is listed on your W-2 under Dependent Care Benefit for the tax year.

If you are not sure about the eligibility of an expense, phone **Flexible Benefits Administrators at (757) 340-4567 or (800) 437-FLEX** or refer to IRS Publication 503: "Dependent Care Expenses". This publication can be ordered by calling the IRS at (800) 829-3676.

#### **OBTAINING A REIMBURSEMENT FROM YOUR DEPENDENT CARE REIMBURSEMENT ACCOUNT**

To obtain a reimbursement from your Dependent Care Reimbursement Account you must complete a Claim Form. This claim form is available from your employer's website (See sample Claim Form on page 17). You must attach a receipt from the service provider which includes all of the following:

- Name of dependent receiving care
- Date(s) care was provided (must match Claim Form)
- Name of service provider
- Social Security or Tax I.D. number of the provider
- Amount of the charge

**NOTE:** Dependent care expenses can only be reimbursed after the care is provided. This means that advance payments of dependent care expenses cannot be made. FOR EXAMPLE: If you pay for a summer day camp for your child in May but the camp is the first week in July, we cannot reimburse you for this expense until July when the service is provided.

#### **THE DEPENDENT CARE REIMBURSEMENT ACCOUNT IS NOT A PRE-FUNDED ACCOUNT**

This means that you will only be reimbursed up to your account balance at the time you submit your claim. If your claim is for more than your account balance, the unreimbursed portion of your claim will be tracked by Flexible Benefit Administrators. You will be automatically reimbursed as additional deductions are taken and deposited into your account, until your entire claim is paid out.

## THE BENEFITS CARD

The Benefits Card system allows you to pay for eligible pre-tax account expenses electronically at approved service providers and merchants. The Benefits Card provides you with instant access to your pre-funded Health Care Reimbursement Account for many common regular eligible expenses. You may also enjoy the convenience of paying for your childcare expenses (up to your account balance at the time of the “swipe”) with the Benefits Card.

In order for you to get the most benefit from your Plan, we want to remind you of a few things concerning the Benefits Card:

- The Benefits Card works just like a debit card, only your “bank account” consists of the funds you elected to set aside in your pre-tax account(s). The card is not eligible for use at ATM’s or other unqualified merchant locations. The card will be denied at the point of sale when use at an ineligible location is attempted. If an eligible provider does not accept MasterCard®, you must file a proper claim. \*When using the card at a self-service merchant terminal, select the **credit option**, not the debit option (**there is no PIN #**).
- Your card will be mailed to your home address via first class mail. Please allow up to two weeks for delivery of your card. If you do not receive your card two weeks after the start of your Plan Year, contact Flexible Benefit Administrators, Inc. so that a replacement card may be ordered. Any eligible expense incurred during that time may be reimbursed by mailing or faxing a claim form, and receipts to Flexible Benefit Administrators, Inc., following the customary claims filing procedure and cutoff times.
- When you receive your card, sign the back of the card prior to using it. Your card is activated upon the first swipe of the card.
- **Continue to save all receipts.** Flexible Benefit Administrators, Inc. may request them to verify expense eligibility.
- Flexible Benefit Administrators, Inc. will notify you by mail or e-mail if you incur an expense with the card that is or appears to be ineligible. Upon this notice you must send Flexible Benefit Administrators a Transaction Substantiation Form with the corresponding itemized documentation within 40 days of the transaction. If you do not send in those required items, your card will be deactivated until the documentation is received.
- Your transaction will be denied for any amount greater than your health care reimbursement account annual election or your dependent care reimbursement account posted balance at the time of the “swipe”.
- You should notify Flexible Benefit Administrators, Inc. immediately if your card is lost or stolen to deactivate the card. If your employment is terminated, you must surrender the card to your employer.
- You may monitor your account balance, transaction history or print a statement at any time, night or day on the Benefits Card website: **[www.benefitspaymentsystem.com](http://www.benefitspaymentsystem.com)**.
- Additional information regarding the Benefits Card is available on the website: **[www.flex-admin.com](http://www.flex-admin.com)**. You may also download the Transaction Substantiation Form from the website under Participant Forms.

**Attention: Benefits Card Participant - Subject: Benefits Card Use**

In light of IRS Rulings on Benefits Card use, it is important that you make yourself familiar with the cardholder agreement that accompanies your Benefits Card. Flexible Benefit Administrators, Inc. strongly suggests reviewing this document and making yourself and any dependent cardholders in your household aware of the terms.

Please be aware that upon receipt and signing of your Benefits Card, you, as the cardholder and employee participant of the Plan are ultimately responsible for using the card for eligible expenses. This also applies to any dependent that has use of the Benefits Card. By signing the back of the card, the employee/dependent is agreeing to the terms and conditions of this agreement.

As in the past, your responsibility as a participant in a tax-free plan, is to use the card for eligible expenses ONLY (such as prescriptions, eyeglasses and medical co-pays, etc.) As with paper claim submission, cosmetic prescriptions and procedures as well as over the counter medications and products are not eligible for reimbursement. Please remember that each time you use your card you are certifying that the expense is eligible. If you have any doubt as to whether an expense is eligible or not you should refer to your employee handbook, IRS Publication 502 or call our office to speak with one of our administrators. It is also your responsibility to acquire all documentation such as receipts, EOBs, etc. for the Plan Year's expenses and to retain the documentation for the entire Plan Year. If you are aware that you have paid for an expense with the card that is ineligible it is your responsibility to notify Flexible Benefit Administrators, Inc. immediately. You will need to submit a paper claim form with substantiating documentation along with repayment for the amount of the ineligible expense.

Flexible Benefit Administrators, Inc. may request documentation to substantiate your Benefits Card transactions to determine eligibility of the expense. Please be aware that documentation for all over-the counter drugs will be required, as per IRS regulations.

In the event that your documentation shows ineligible expenses were paid with your Benefits Card, Flexible Benefit Administrators, Inc. will request that you re-pay the amount of the ineligible expense. If the payment is not received in the allotted time frame your card will be de-activated. Also, Flexible Benefit Administrators, Inc. may offset future claims and notify your employer. IRS rulings allow your employer to withhold this amount from your wages if necessary. The Benefits Card is NOT PAPERLESS, just less paper and is a great convenience for the participants in the Plan if used properly.

**PLEASE NOTE:** Eligible items purchased at participating Inventory Information Approval System (IIAS) merchants will be automatically approved! When purchasing prescriptions and/or over-the-counter FSA-eligible items, the merchant's IIAS will verify the items and automatically approve the transaction with no follow-up request. Effective January 1, 2009, the Benefits Card will no longer be accepted at merchants who have not implemented IIAS. Please visit [www.sig-is.com](http://www.sig-is.com) and select "IIAS Merchants List" for the most recent list of IIAS merchants.

## **RULES AND REGULATIONS**

### **CLAIM FILING DATES**

All claims received in the office of Flexible Benefit Administrators, Inc. will be processed within one week.

### **COMMON ERRORS TO AVOID WHEN FILING CLAIMS**

- The claim form is not signed
- Canceled checks, cash register receipts or credit card receipts are sent in place of receipts or bills from the provider of service
- Cash register receipts for OTC item(s) do not indicate the specific name of the product(s) purchased
- Claim form has not been completed
- Insufficient postage on envelope
- "Previous balance" statements or "payment on account" receipts submitted in place of actual date of service itemized bills or receipts

Your claim form may be returned to you or delayed in processing for improper or insufficient documentation. If you have questions about your claims, you may contact Flexible Benefit Administrators, Inc. at **(757) 340-4567** or **(800) 437-FLEX**, from 8:30 a.m. to 5:00 p.m., Monday through Friday.

### **REIMBURSING THE PROVIDER OF SERVICE**

All reimbursements will be sent to you directly. We cannot send payments to your doctors or day care providers. After receiving payment from your account, you are responsible for paying your providers.

### **ELIGIBLE DEPENDENTS**

An individual is considered to be a dependent if he or she is a qualifying child or qualifying relative of the taxpayer. The following qualifying criteria now apply to be a "dependent child": the individual has a specific family type relationship to the taxpayer, the individual does not provide more than half of his or her own support, the individual has the same place of abode as the taxpayer for more than half of the year, and the individual does not turn age 19, (24 if full-time student), by the end of the Plan Year.

In addition, the following qualifying criteria apply to be a "dependent relative": the individual has a specific family type relationship to the taxpayer, the individual is not a qualifying child of any other taxpayer, the individual receives more than half of his or her support from the taxpayer, and the individual's annual gross income is less than the Section 151 limit (\$3,200 for 2005; this criteria does not apply to health plans).

### **RUNOFF PERIOD FOR FILING CLAIMS**

You have the entire Plan Year plus 90 days to file all claims that were **incurred** during the Plan Year. All claims must be received in the office of Flexible Benefit Administrators, Inc. by 5:00 p.m. on the 90th day, following the end of your Plan Year. Therefore, for the Plan Year 1/01/10 - 06/30/10, all claims must be in our office by 5:00 p.m. on September 28, 2010. If claims are not received during this time frame for expenses incurred during the Plan Year, your remaining funds will be forfeited. (Remember "90 days" does not mean 3 months and "received in the office" does not mean the day it was postmarked). Please, do not delay; complete your claims early.

### **FORFEITING FUNDS**

Any money you do not use from a reimbursement account for expenses incurred during a Plan Year will be forfeited. The forfeited funds will be returned to your employer to offset the cost of the program. If you plan carefully, you can avoid being affected by this IRS restriction.

### **CHANGES IN YOUR ELECTION**

No, generally you cannot change the elections you have made after the beginning of the PLAN YEAR. However, there are certain limited situations when you can change your elections. You are permitted to change elections if you have a "change in status" and you make an election change that is consistent with the "change in status." Currently, Federal law considers the following events to be "changes in status":

- Marriage, divorce, death of a spouse, legal separation or annulment;
- Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent
- Any of the following events for you, your spouse or dependent: Termination or commencement of employment, a strike or lockout, commencement, or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that affects eligibility for benefits;
- One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance;
- A change in place of residence of you, your spouse, or your dependent. This applies ONLY to Dependent Care and ONLY if that change in residence results in a change of dependent care service provider and its cost.

In addition, if you are participating in the Dependent Care Reimbursement Account, then there is a "change in status" if your dependent no longer meets the qualifications to be eligible for dependent care.

There are detailed rules on when a change in election is deemed to be consistent with a "change in status." In addition, there are laws that give you rights to change accident and health coverage for you, your spouse, or your dependents. If you change coverage due to rights you have under the law, then you can make a corresponding change in your elections under the Plan. If any of these conditions apply to you, you should contact the Administrator.

If the cost of a benefit provided under the Plan increases or decreases during a Plan Year, then your salary redirection will increase or decrease accordingly. If the cost increases significantly, you will be permitted to either make corresponding changes in your payments or revoke your election and obtain coverage under another benefit package option with similar coverage.

If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, then you may revoke your elections and elect to receive, on a prospective basis, coverage under another plan with similar coverage. In addition, if a new coverage option is added or an existing option is eliminated, you may elect the newly-added option (or elect another option if an option has been eliminated) and make corresponding election changes to other options providing similar coverage. There are also certain situations when you may be able to change your elections on account of a change under the plan of your spouse's, former spouse's or dependent's employer.

These rules on change due to cost or coverage do not apply to the Health Care Reimbursement Plan, and you may not change your election to the Health Care Reimbursement Plan if you make a change due to cost or coverage for insurance.

You may not change your election under the Dependent Care Reimbursement Account if the cost change is imposed by a dependent care provider who is your relative.

To make a change in your elections, a STATUS CHANGE FORM must be completed within 30 days of the event. Flexible Benefit Administrators, Inc. or your benefits contact person will determine if your requests for an election change meets IRS Regulations.

#### **TRANSFERRING FUNDS BETWEEN ACCOUNTS**

IRS regulations do not allow money to be transferred between reimbursement accounts. If you elect funds to be placed in your Health Care Account, you must submit eligible medical expenses to be reimbursed from these funds. This IRS regulation also applies to the Dependent Care Reimbursement Account.

#### **TERMINATION OF EMPLOYMENT**

If you have funds in your Health Care Account and you submit receipts for expenses incurred prior to your termination, you can be reimbursed for funds remaining in your account up to your annual election. However, if you have money left in your Health Care Account and do not have receipts for expenses incurred prior to your termination, you cannot be reimbursed for the money remaining in your account unless you elect to participate in the federal program, COBRA. If you elect to participate in COBRA, you will need to continue to set aside dollars on an after tax basis to be deposited into your Health Care account. You can receive information concerning this program from the contact person in your company.

Your Dependent Care Reimbursement Account functions differently. If you have funds remaining in these accounts, this money will be reimbursed to you if appropriate receipts are submitted. You can receive reimbursement for expenses incurred during the Plan Year if receipts are submitted within the Plan Year and before the end of the 90-day grace period following the Plan Year end.

#### **EFFECT ON SOCIAL SECURITY BENEFITS**

As you are not paying social security tax on the portion of your income that has been placed in the Plan, your social security benefits may be slightly reduced. We suggest putting part of your tax savings into your Employer's Retirement Program or some other savings vehicle.

#### **ACCOUNT BALANCES**

You may call Flexible Benefit Administrators, Inc. at **(757) 340-4567** or **(800) 437-FLEX** from 8:30 a.m. to 5:00 p.m., Monday through Friday, to check your account balances. You may also access your personal account information at your convenience via our secure website: [www.flex-admin.com](http://www.flex-admin.com). Each reimbursement check stub will show your contributions, request for reimbursements, and disbursements for each account. It will also show your annual election and the balance to request by the end of the Plan Year for each account. A reminder letter will be sent the month prior to the end of the Plan Year if you have funds left in your accounts.

### ESTIMATING YOUR EXPENSES

This worksheet will help you determine your annual expenses for each reimbursement account. Good planning and careful estimating is the best way to take full advantage of your Flexible Benefit Plan. Keep in mind, your maximum annual elections cannot exceed \$1,200 for health care and \$2,500 for dependent care for the upcoming short plan year.

#### ESTIMATING YOUR QUALIFYING HEALTH CARE EXPENSES

Medical deductibles \_\_\_\_\_

Medical co-payments \_\_\_\_\_

Prescription drugs \_\_\_\_\_

Vision Exams, Glasses, Contacts \_\_\_\_\_

Dental/Orthodontia \_\_\_\_\_

Routine exams and physicals \_\_\_\_\_

Over-the-counter expenses \_\_\_\_\_

**TOTAL ESTIMATED HEALTH CARE EXPENSES FOR THE PLAN YEAR (Max. \$1,200)** \_\_\_\_\_

#### ESTIMATING YOUR DEPENDENT CARE EXPENSES

Child day care expenses \_\_\_\_\_

Pre-School expenses \_\_\_\_\_

Summer Day Camp expenses \_\_\_\_\_

Adult day care expenses \_\_\_\_\_

Other eligible expenses \_\_\_\_\_

**TOTAL ESTIMATED DEPENDENT CARE EXPENSES FOR THE PLAN YEAR (Max. \$2,500)** \_\_\_\_\_

## **ACCESSING YOUR FLEX ACCOUNT ONLINE**

Our secure Online Inquiry System allows you to have 24/7 access to your account information, payment information and your available balance.

Completing your online account set-up is just a few clicks away!

Step 1. Log-on to our website at [www.flex-admin.com](http://www.flex-admin.com).

Step 2. Select Participants.

Step 3. Select ACCOUNT LOG IN under the appropriate account type that you participate in. Please note that if you participate in more than one type of account, you do not have to set up a separate account for each one. You will be able to see all your account information under the one User ID and Password you create.

Step 4. Select Participant Login.

Step 5. Select Create Account.

Step 6. You will be prompted to enter your Name and Employee ID number (your social security number).

Step 7. You must then enter your Benefits Card Number or, if you do not have a Benefits Card, you may enter your Employer ID, which is: **FBABCG**.

Step 8. Create your User ID, Password, Security Word and Birth City and your e-mail address. Please note that your User ID will need to be between 4-10 characters. Your password needs to be between 7-10 characters and must include at least one letter and number.

Step 9. You are now ready to access your individual account!

Once you have completed these steps, you will have 24/7 access to current information regarding your Flexible Spending Account. It's that easy!

Problems logging into your Account?

E-mail to: [flexdivision@flex-admin.com](mailto:flexdivision@flex-admin.com) Include your Full Name, SS# or Employee ID#, Company Name, & Contact phone number.

Telephone: Local - **(757) 340-4567** or Toll Free - **(800) 437-3539** (Monday through Friday 8:30 am - 5:00 pm EST)



ADMINISTERED BY

**FLEXIBLE BENEFIT ADMINISTRATORS, INC.**

509 VIKING DRIVE, SUITE F

P.O. BOX 8188

VIRGINIA BEACH, VA 23450

(757) 340-4567 or (800) 437-FLEX (3539)

FAX: (757) 431-1155

FlexDivision@flex-admin.com

www.flex-admin.com



## Cancer Can Affect Anyone

### Statistics Predict:

- Cancer will strike one in every two men and one in every three women in the U.S.\*
- One out of eight women will develop breast cancer in her lifetime\*.
- One out of every six men will develop prostate cancer\*.
- The number of people with cancer will double in this decade\*\*.

Are you prepared for the cost of cancer?

Your medical insurance covers most of the direct charges such as hospital and physicians' bills, but may not cover these indirect costs:

- Loss of wages while caring for a family member
- Loss of wages while you receive treatment
- Everyday living expenses and bills
- Childcare
- Home health care expenses
- Transportation for non-local or specialized treatment centers
- Experimental treatment
- Meals eaten out, fast food for family at home
- Lodging during non-local treatment

In fact, non-medical costs account for 67 percent of all costs associated with cancer\*. Many Americans find themselves financially strapped as the result of the battle against cancer or a specified disease, even with medical insurance.

**Assurity's cancer plan is designed to create a source of extra cash that will help you and your family cope during the battle against cancer or a specified disease.**

### Extra cash when you need it. Here's how it works:

- We provide cash benefits to you.
- You use the money to meet your needs - loss of income, house and car payments, transportation for treatment, other bills, etc. These non-medical expenses of cancer may not be covered by your major medical insurance.

### Plus, you get these unique features:

- Guaranteed renewable for life. You can't lose your coverage, as long as you continue to pay your premiums.
- Cash benefits paid to you regardless of any other medical insurance plan you may have.

### Selected benefits paying cash to you:

- Cancer Screening Tests
- Chemotherapy, Radiation, Immunotherapy,
- Experimental Treatment
- Individual/Family Transportation and Lodging

*\*Cancer Facts & Figures, American Cancer Society*

*\*\*Report from the American Hospital Administration*

## Assurity Cancer & Specified Disease Plan

**Effective Date: January 1, 2010**

Policy availability, rates and provisions may vary by state. This policy contains limitations and exclusions. For more detailed and complete information, please contact Assurity Life Insurance Company and ask to review the policy contract.

### **BASIC BENEFITS**

Provides benefits caused by cancer and certain other specified diseases for the employee, spouse and covered children with continuous benefit and premium policy for life. The Family Rider allows for the addition of family members to the employee's policy.

### **RATE STRUCTURE**

Unisex Rates; Employee Issue Ages: 18-69, Family: Up to Age 69 on spouse and 25 on children if a full-time student in an accredited school. Issue Age is age of last birthday on the day policy is issued.

### **PRE-EXISTING CONDITIONS**

Assurity will not pay any benefits for loss caused by a pre-existing condition during the first two years (one year in NC and SC) following the Issue Date. Loss due to such conditions will be payable unless specifically excluded from coverage after this two year (one year in NC and SC) period.

A pre-existing condition is defined as cancer or a specified disease which first manifests itself within five years (two years in NC) prior to the issue date for each insured. Conditions which are fully disclosed to Assurity on the application and are not excluded or limited by Assurity are not considered pre-existing conditions. In GA, the policy does not contain a definition for pre-existing condition. In NC, pre-existing conditions for insureds age 65 or older shall include only conditions specifically excluded by rider.

### **ISSUE AGE**

The Assurity cancer policy is available for persons ages 18-69, including spouses. The issue age of children is 15 days through 18 years of age. The coverage is continued up to age 25 if the child is a full-time student in an accredited school.

**Policy will pay the following specified benefits based on policy provisions:**

#### **Hospital Indemnity**

Assurity will pay you benefits for each day while the Insured is confined in the hospital for cancer or certain other specified diseases for the first 75 days of each period of confinement. There are three options for the daily benefit amount: \$150, \$250, and \$350.

#### **Prescription Drugs and Medicines**

Assurity will pay the actual charges, up to 25% of the Daily Hospital Confinement benefit shown on the policy schedule per day for the hospital charges for the prescribed drugs and medicines taken during hospital confinement for an insured person. This benefit is limited to the first 75 days for each period of confinement.

**Surgical Benefit**

Assurity will pay up to \$7,500 for the actual charges made by a surgeon for a surgery in or out of a hospital up to the maximum amount shown in the Surgical Benefits Schedule. For operations not listed, a comparable reasonable benefit will be paid. Surgical procedures performed through the same incision or in the same body opening will be considered one operation.

**Anesthesia**

Assurity will pay up to 25% of the amount payable under the Surgical Benefit for the administration of an anesthetic for an insured person. This amount does not apply to skin cancer operations. Assurity will pay the actual charges up to \$50 per skin cancer operation.

**Additional Surgical Opinions**

Assurity will pay up to \$150 for a second opinion. If the second opinion differs from the first, pays up to \$150 for a third opinion.

**Artificial Limb and Prosthesis**

The policy pays actual charges for artificial limb or reconstructive procedure to affix or implant it up to a \$2,000 lifetime maximum per Insured.

**Attending Physician**

The policy pays actual charges up to \$35 per day for in-hospital physician's visits, other than surgeon charges.

**Private Duty Nurse**

The policy pays actual charges up to \$150 per day while confined in the hospital when authorized by a physician when a Private Nurse is required.

**Radiation, Radio-Active Isotopes Therapy, Chemotherapy or Immunotherapy**

Assurity will pay 50% of the actual charges up to the monthly maximum and lifetime maximum shown in the Policy Schedule for the following treatment techniques, provided they are used for the purpose of modification or destruction of cancerous tissue. Benefits will also be provided for immunotherapy when used for treatment of covered specified diseases.

- teleradio therapy using either natural or artificial propagated radiation. This includes actual charges for radiation treatment delivery only. It does not include charges for clinical treatment planning, clinical treatment management, medical radiation physics, dosimetry, treatment devices or special services;
- interstitial or intracavity application of radium or radioisotopes in sealed or non-sealed sources;
- chemical substances and their administration including hormonal therapy. This includes the actual charges for only those chemical substances which modify or destroy cancerous tissue, and does not include other drugs or medicines given in conjunction with this treatment;
- antigenic preparations of immunosuppressive techniques.

**Experimental Treatment**

Assurity pays the actual charges incurred up to \$25,000 per calendar year for experimental treatment, except for experimental bone marrow transplants for an insured person. This benefit is in lieu of all other benefits under this policy for the same treatment.

**Physical and Speech Therapy**

The policy pays the actual charges up to \$25 per therapy session up to a lifetime maximum of \$1,000.

**Extended Care Facility**

The policy pays up to \$60 per day for confinement in an extended care facility. Confinement must be recommended by a physician and begin within 14 days following a covered hospital stay. Benefits are limited to the number of days of the prior hospital confinement.

**Bone Marrow Transplant for Cancer**

The policy pays actual charges up to a lifetime maximum of \$25,000 for bone marrow transplants or other forms of stem cell rescue and all related services or supplies. This benefit is payable in lieu of any other benefits payable under this policy, except Transportation and Lodging for Bone Marrow Donors.

**Transportation and Lodging for Bone Marrow Donors**

The policy pays (a) actual charges up to \$2,500 for medical expenses for a donor when directly related to such a transplant, (b) pays actual charges for a round trip coach fare on a common carrier or a personal automobile allowance of 50 cents per mile in excess of 50 miles one-way to the city where the transplant is performed, up to 700 miles round trip, and (c) pays actual charges up to \$50 per day for lodging and meal expenses when donor stays at a hotel, motel or other accommodations acceptable to Assurity when the donor is asked to remain near the hospital. This payment is in lieu of any other benefit payable under this policy when the donor is a person insured under this policy.

**Transportation for Non-local Treatment Which Requires Hospital Confinement**

For covered treatment, the policy pays (a) actual charges for non-local round trip charges by common carrier to the nearest hospital that provides the prescribed treatment or (b) 50 cents per mile for personal automobile expenses in excess of 50 miles one way, up to 700 miles round trip. Transportation benefits will not be paid for periodic checkups or when receiving non-covered treatments.

**Transportation and Lodging for Non-local Treatment Which Does Not Require Hospital Confinement**

For non-local covered treatment prescribed by the attending physician as medically necessary which is not available locally, Assurity will pay for an insured person:

- the actual charges for round trip coach fare on a common carrier to the facility that provides the prescribed treatment or 50 cents per mile for personal automobile expense in excess of 50 miles one way, not to exceed 700 miles round trip up to a maximum of \$1,500 per calendar year. Mileage will be measured from the insured person's residence to the nearest facility where the treatment is administered; and
- the actual charges up to \$50 per day for lodging and meal expenses incurred by an insured person when staying at a hotel, motel or other accommodations acceptable to Assurity. Benefits will be paid up to the number of days covered treatment is received.

**Adult Companion Transportation and Lodging**

The policy pays the following expenses for one adult companion to be near the insured when the insured is confined in a non-local hospital for specialized covered treatment (a) up to a maximum of \$1,500 per calendar year for actual charges for non-local round trip coach fare by a common carrier to the nearest hospital that provides the prescribed treatment or 50 cents per mile for personal automobile expenses in excess of 50 miles one-way, up to 700 miles round trip and (b) pays actual charges up to \$50 per day for lodging and meal expenses when staying at a hotel, motel or other accommodation acceptable to Assurity, limited to the number of days of each confinement.

**Outpatient Positive Diagnostic Test**

Assurity will pay up to \$250 for the actual charges incurred for the diagnostic test that leads to a positive diagnosis within 90 days of such test for an insured person. This benefit is not payable if the same cancer or specified disease recurs.

**Outpatient Surgery Benefit**

Assurity will pay a benefit equal to the Daily Hospital Confinement benefit shown on the policy schedule for outpatient surgery in a hospital or ambulatory surgical center for an insured person. This benefit is not payable for surgery in a physician's office or clinic, and is not available for skin cancer treatment.

**Skin Cancer**

The policy pays up to \$150 for actual charges for the removal of skin cancer when diagnosis is made by a physician, other than a legally qualified pathologist.

**Ambulance**

The policy pays actual charges up to \$75 per trip to transfer an insured person to the hospital for confinement as an inpatient.

**Hospice Care**

Assurity will pay the actual charges up to \$100 per day for care provided by a Hospice if the insured person has been diagnosed as terminally ill. This benefit is payable for confinement in a Hospice care center, including centers that are in designated areas of a Hospital, or in the insured person's home, limited to a policy maximum of \$7,500.

**Government or Charity Hospital**

The policy pays \$200 per day for confinement in a government or charity hospital. Payment of this benefit is in lieu of all other policy benefits.

**Blood and Blood Plasma**

The policy pays the actual charges for blood, blood plasma and platelets. Policy does not pay for blood that is donated or replaced.

**Breast Cancer/Breast Reconstruction/Breast Prosthesis**

The policy pays a benefit equal to the daily hospital confinement benefit for a minimum of 48 hours of inpatient care following a mastectomy and for a minimum of 24 hours of inpatient care following a lymph node dissection for the treatment of breast cancer. Lifetime maximum of \$2,500 per breast. Assurity will pay the actual charges incurred for an external breast prosthesis or an internal breast prosthesis and the surgeon's fee for implantation for an insured person. For natural tissue breast reconstruction surgery, Assurity will pay the actual charges incurred with a lifetime maximum of \$2,500 per breast.

Assurity will pay the actual charges for reconstructive surgery and any adjustments made to the non-diseased breast if performed within 24 months (five years in TN) of reconstruction of the diseased breast for an Insured Person.

#### **Hairpiece Benefit**

The policy pays a one-time benefit of up to \$150 for a hairpiece when hair loss is a result of cancer treatment.

#### **Cancer (Wellness) Screening Tests**

The policy pays the amount charged up to \$100 per calendar year for cancer screening test. Tests covered are:

- Mammography Screening
- Pap Smear (test only)
- CA125 (blood test for ovarian cancer)
- PSA (blood test for prostate cancer)
- Hemocult Stool Specimen
- Flexible Sigmoidoscopy
- CEA (blood test for colon cancer)
- Colonoscopy
- Chest X-ray
- Thermography
- Serum Protein Electrophoresis

#### **Wellness Claims**

An employee can file a wellness claim by fax, call-in or mail. Employees can call Assurity to get a wellness claim form or download one from [www.markiiibrokerage.com/brunswickcountync](http://www.markiiibrokerage.com/brunswickcountync). Employees can also call in their wellness claim at **(888)-358-8808 ext. 23**. The call in service requires all the information on the wellness claim form. The wellness claim form must include the name and phone number of your physician. All claims are subject to verification.

#### **Home Health Care Services**

When services are provided by a licensed Home Health Care Agency, when prescribed by a physician, policy pays (a) up to \$60 per day for services provided at home, not to exceed 180 days per calendar year, (b) up to \$100 per day for Private Duty Nursing, not to exceed 15 days per calendar year, and (c) pays actual charges for a physician's visit up to \$40 per day not to exceed 15 days per calendar year. Care cannot be provided by a relative. This benefit is in lieu of all other benefits.

#### **Rental or Purchase of Durable Medical Equipment**

The policy pays the actual charges up to \$1,000 per calendar year for purchase or rental of (a) a respirator or similar medical device, (b) brace, (c) crutches, (d) hospital bed or (e) wheel chair.

#### **Professional Mental Health Consultation**

The policy pays actual charges up to \$50 per session not to exceed a lifetime maximum of \$250, when receiving treatment for cancer or a specified disease for which benefits are payable.

**Extended Benefits**

If a covered hospital confinement lasts for more than 75 consecutive days, policy pays usual and customary charges for hospital room and board, medicines, lab tests and other medically necessary hospital charges, up to \$1,000 per day beginning on the 76th day. Payable after the 75th day in lieu of all other policy benefits for the same time period.

**Waiver of Premium**

If while this policy is in force and before an insured person turns age 65, he or she becomes disabled due to cancer or a specified disease (as indicated on the Policy Schedule), and is receiving treatment for such cancer or specified disease for which benefits are payable under this policy and remains disabled for 90 consecutive days, Assurity will waive premiums starting with the first renewal premium following the 90-day period of disability. Assurity will waive premiums for as long as the insured person remains disabled. Premiums waived will be in accordance with the mode of payment in effect when treatment began.

**Specified Disease Benefits**

The benefits of the policy will be extended to pay for the loss that results from the following specified diseases:

Addison's Disease	Myasthenia Gravis
Botulism	Osteomyelitis
Brucellosis	Polio
Budd-Chiari Syndrome	Q Fever
Cystic Fibrosis	Reye's Syndrome
Diphtheria	Rheumatic Fever
Encephalitis	Rocky Mountain Spotted Fever
Histoplasmosis	Sickle Cell Anemia
Legionnaires' Disease	Tay-Sachs Disease
Lou Gehrig's Disease	Tetanus
Lupus Erythematosus	Trichinosis
Malaria	Toxic Shock Syndrome
Meningitis	Tuberculosis
Multiple Sclerosis	Typhoid Fever
Muscular Dystrophy	Whooping Cough

**Cancer or other Specified Disease Claims**

You may file a claim for cancer or specified diseases 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, or by downloading one from [www.markiibrokerage.com/brunswickcountync](http://www.markiibrokerage.com/brunswickcountync). Should you have any questions on how to file or submit a claim or regarding the Assurity Cancer Plan, please call **(888) 358-8808 ext. 23**.

### **OPTIONAL RIDERS**

**Intensive Care Rider** – pays a \$300 or \$600 daily benefit if an insured person is confined to a Hospital's Intensive Care Unit, up to a maximum of 20 days per period of confinement.

**Internal Cancer First Occurrence Rider** – pays \$2,500 or \$5,000 the first time an insured is diagnosed as having internal cancer.

### **LIMITATIONS AND EXCLUSIONS**

#### **30-Day Waiting Period**

There is a 30-day waiting period during which no benefits will be paid during the first 30 days. Covered losses which manifest after the issue date will be payable starting on the 31st day.

#### **Exclusions**

Assurity will not pay any Benefits for loss caused by or resulting from:

1. Injuries;
2. Sickness, illness or bodily infirmity resulting from anything other than Cancer or Specified Disease;
3. Any sickness, illness, bodily infirmity or incapacity that has been caused, complicated, worsened, or affected by cancer or a specified disease or as a result of cancer or specified disease treatment (not applicable in SC);
4. Hospital confinement or expenses that are incurred prior to the Issue Date regardless of the date of positive diagnosis;
5. Experimental treatment, except as specifically provided in the experimental treatment benefit or bone marrow transplant benefit (Benefits for experimental treatment are limited to \$25,000 per calendar year. Benefits for bone marrow transplants are limited to a policy lifetime maximum of \$25,000. No other benefits are payable for such treatment.)  
In TN, benefits for experimental treatment will not be denied based solely on the fact that the insured was a participant in a clinical trial;
6. Care and/or treatment received outside the U.S. or its territories; or
7. Care, confinement and/or treatment in a government or charity hospital except as specifically provided in the government or charity hospital benefit.

**Assurity Life Insurance Company**  
PO Box 82533, Lincoln, NE, 68501-2533  
Assurity Customer Service: (866) 289-7337  
Website: [www.assurity.com](http://www.assurity.com)

To Call in a Wellness Claim: (888) 358-8808 Ext. 23  
To Fax in a Claim/Toll Free: (800) 869-0368

Policy Form No. AAW-C120  
Rider Form Nos. AAW-CR261, AAW-CR262, AAW-CR263, AAW-CR264

Compliance Code: A612-1009

**Cancer and Specified Dread Disease Benefit  
With Radiation/Chemotherapy**

**SEMI-MONTHLY RATES (based on 24 Deductions)**

<b>Assurity Life Cancer &amp; Specified Disease Plan</b>				
		<b>\$150 Daily Benefit</b>	<b>\$250 Daily Benefit</b>	<b>\$350 Daily Benefit</b>
Base Policy (\$10,000 per month/\$100,000 lifetime maximum) (radiation/chemotherapy)	Individual	\$10.46	\$11.61	\$12.76
	EE & Spouse	\$16.02	\$17.81	\$19.60
	EE & Children	\$13.00	\$14.30	\$15.61
	Family	\$18.56	\$20.50	\$22.44
Base Policy with Intensive Care Rider (\$300 daily benefit)	Individual	\$11.51	\$12.66	\$13.81
	EE & Spouse	\$18.12	\$19.91	\$21.70
	EE & Children	\$14.65	\$15.95	\$17.26
	Family	\$21.25	\$23.20	\$25.14
Base Policy with Intensive Care Rider (\$600 daily benefit)	Individual	\$12.56	\$13.71	\$14.86
	EE & Spouse	\$20.22	\$22.01	\$23.80
	EE & Children	\$16.30	\$17.60	\$18.91
	Family	\$23.96	\$25.90	\$27.84
Base Policy with First Occurrence Benefit Rider (\$2,500 benefit)	Individual	\$11.88	\$13.03	\$14.18
	EE & Spouse	\$18.14	\$19.93	\$21.71
	EE & Children	\$14.71	\$16.01	\$17.32
	Family	\$20.97	\$22.91	\$24.85
Base Policy with First Occurrence Benefit Rider (\$2,500 benefit) and Intensive Care Rider (\$300 daily benefit)	Individual	\$12.93	\$14.07	\$15.23
	EE & Spouse	\$20.24	\$22.03	\$23.81
	EE & Children	\$16.36	\$17.66	\$18.97
	Family	\$23.67	\$25.61	\$27.55
Base Policy with First Occurrence Benefit Rider (\$2,500 benefit) and Intensive Care Rider (\$600 daily benefit)	Individual	\$13.98	\$15.13	\$16.28
	EE & Spouse	\$22.34	\$24.13	\$25.91
	EE & Children	\$18.00	\$19.31	\$20.62
	Family	\$26.37	\$28.31	\$30.25
Base Policy with First Occurrence Benefit Rider (\$5,000 benefit)	Individual	\$13.29	\$14.44	\$15.59
	EE & Spouse	\$20.25	\$22.04	\$23.83
	EE & Children	\$16.42	\$17.72	\$19.03
	Family	\$23.38	\$25.32	\$27.26
Base Policy with First Occurrence Benefit Rider (\$5,000 benefit) and Intensive Care Rider (\$300 daily benefit)	Individual	\$14.34	\$15.49	\$16.64
	EE & Spouse	\$22.35	\$24.14	\$25.93
	EE & Children	\$18.07	\$19.37	\$20.68
	Family	\$26.08	\$28.02	\$29.96
Base Policy with First Occurrence Benefit Rider (\$5,000 benefit) and Intensive Care Rider (\$600 daily benefit)	Individual	\$15.39	\$16.54	\$17.69
	EE & Spouse	\$24.45	\$26.24	\$28.03
	EE & Children	\$19.72	\$21.02	\$22.33
	Family	\$28.78	\$30.72	\$32.66

AAW - C120RAB (7/05)



## **Why do you need Disability Insurance? Consider this . .**

**Statistics show you are much more likely to be injured in an accident than to die from one.**

- A fatal injury occurs every 5 minutes, and a disabling injury occurs every 1.5 seconds.<sup>1</sup>
- There is a death caused by a motor vehicle crash every 12 minutes; there is a disabling injury every 14 seconds.<sup>1</sup>
- In the home, there is a fatal injury every 16 minutes and a disabling injury every 4 seconds.<sup>1</sup>

**While many people survive accidental injuries, many others live with serious illnesses.**

- In the United States, men have a little less than a 1-in-2 lifetime risk of developing cancer; for women the risk is a little more than 1-in-3. The five year relative survival rate for all cancers combined is 63%.<sup>2</sup>
- One in five males and females has some form of cardiovascular disease. High blood pressure is the most common form of cardiovascular disease.<sup>3</sup>
- More than 35 million Americans are now living with chronic lung diseases, such as asthma, emphysema, and chronic bronchitis.<sup>4</sup>

**Advances in medicine are allowing us to live longer. However, recovery from a serious illness or injury often requires time away from work.**

- In the last 20 years, deaths due to the big three (cancer, heart attack, and stroke) have gone down significantly. But disabilities due to those same three diseases are up dramatically. Things that used to kill, now disable.<sup>5</sup>

**You have life insurance, home insurance and  
automobile insurance.**

**But is your income insured?**

1 National Safety Council, Injury Facts, 2008 Edition

2 American Cancer Society, Cancer Facts & Figures 2008

3 American Heart Association, Heart Disease and Stroke Statistics – 2008 Update

4 American Lung Association, Lung Disease Data 2008

## Standard Life Short Term Disability Plan

**Effective Date: January 1, 2010 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 due to 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. Continued coverage is subject to income and occupational guidelines.

### **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. Disability must be certified by a physician.

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, from 90 up to 365 days.

### **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. All applications will be underwritten.

### **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 month beyond the effective date

**Pregnancy:** Benefits for disability due to pregnancy are covered provided conception occurs **after** the effective date of the policy, not the date the application was signed.

**Portability:** When an employee leaves the employment of Brunswick County Government, they may continue the short term disability coverage, subject to the renewability provision, as long as continuous employment is maintained. Your new occupation must be within the Company's underwriting guidelines.

**This coverage expires on the policy anniversary date following your 65th birthday.**

**SEMI-MONTHLY RATES (based on 24 Deductions)**

Benefit Duration: 90 Days		Benefit Duration: 180 Days		Benefit Duration: 365 Days	
Monthly Benefit	Semi- Monthly Premium	Monthly Benefit	Semi- Monthly Premium	Monthly Benefit	Semi- Monthly Premium
\$500	\$5.63	\$500	\$8.75	\$500	\$11.25
\$600	\$6.75	\$600	\$10.50	\$600	\$13.50
\$700	\$7.88	\$700	\$12.25	\$700	\$15.75
\$800	\$9.00	\$800	\$14.00	\$800	\$18.00
\$900	\$10.13	\$900	\$15.75	\$900	\$20.25
\$1,000	\$11.25	\$1,000	\$17.50	\$1,000	\$22.50
\$1,100	\$12.38	\$1,100	\$19.25	\$1,100	\$24.75
\$1,200	\$13.50	\$1,200	\$21.00	\$1,200	\$27.00
\$1,300	\$14.63	\$1,300	\$22.75	\$1,300	\$29.25
\$1,400	\$15.75	\$1,400	\$24.50	\$1,400	\$31.50
\$1,500	\$16.88	\$1,500	\$26.25	\$1,500	\$33.75
\$1,600	\$18.00	\$1,600	\$28.00	\$1,600	\$36.00
\$1,700	\$19.13	\$1,700	\$29.75	\$1,700	\$38.25
\$1,800	\$20.25	\$1,800	\$31.50	\$1,800	\$40.50
\$1,900	\$21.38	\$1,900	\$33.25	\$1,900	\$42.75
\$2,000	\$22.50	\$2,000	\$35.00	\$2,000	\$45.00

**Limits and Exclusions:**

Benefits will not be paid for any total disability which:

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

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.

**For questions about your policy,  
call Standard Life and Casualty  
at (800) 327-0695  
For Claims call (800) 227-0251**



## Texas Life Whole Life Plan

### **Common Issue Date: February 15, 2010 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, minor children and grandchildren.

### **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.<sup>1</sup>
- On the other hand, adults with both individual life and group life policies have the highest life insurance protection.<sup>1</sup>
- 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
- Everybody dies

### **THE NEW PRODUCT: 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, minor 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 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)

<sup>1</sup> Trends in Life Insurance Ownership, LIMRA International (2006)

09M022-C 1003 (Expires 013111) Rev 08/09. 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, 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 brochure 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  
(800) 283-9233 prompt #3.*

**TEXASLIFE** INSURANCE  
COMPANY

Since 1901 | 900 WASHINGTON | POST OFFICE BOX 830 | WACO, TEXAS 76703-0830

## Metlife Term Life Plan

### **BASIC EMPLOYEE LIFE INSURANCE**

This insurance is payable for death from any cause to any person you name as beneficiary.

### **OPTIONAL EMPLOYEE LIFE INSURANCE**

Your employer-sponsored basic life coverage provides important protection for you, but you may need to add to that protection. Now you can...at low group rates and through convenient payroll deductions.

To help meet this need, you have the opportunity to elect additional group life insurance under the optional portion of your program to go along with any personal insurance coverage you may have.

### **OPTIONAL DEPENDENT LIFE INSURANCE**

Provides coverage on:

- Your Spouse
- Child(ren) from 15 days of age to age 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 the responsibility of the employee to notify payroll in writing when a dependent becomes ineligible for coverage. Examples of an ineligible dependent status are divorce, or a child graduates from college.

### **ACCIDENTAL DEATH AND DISMEMBERMENT**

Benefits under this coverage are payable for accidental death or injury as described in your certificate. All active employees have Basic Accidental Death and Dismemberment coverage.

### **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.

**Increases in coverage, a re-entry in the plan and participants who enroll beyond 31 days of employment will be required to provide evidence of insurability satisfactory to MetLife.**

### **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 Metropolitan Life - a leader in the field of group coverage.

### **ELIGIBILITY**

You will be eligible for this program if you are a full-time active employee working at least 30 hours per week.

### **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. If a Statement of Health was completed, you will be notified as to when coverage starts.

### **BENEFICIARY**

You have the right to designate the beneficiary of your choice under employee coverage. You are automatically the beneficiary under Dependent Life.

### **WHEN YOUR INSURANCE STARTS**

Your Basic Employee Life Insurance becomes effective on the date of your eligibility (the day after the date you complete 30 days of continuous employment) if you are then actively at work; otherwise, on the day you return to active work. In order for your Optional Employee Life Insurance and Optional Dependent Life Insurance to become effective, it is necessary for you to certify that neither you nor any of your eligible dependents have been "hospitalized" in the last three months prior to your enrollment date. The term "hospitalized" includes inpatient hospital care, hospice care, care in an intermediate or long-term care facility and/or receipt of chemotherapy, radiation therapy or dialysis treatment. However, a confinement which is strictly due to pregnancy or childbirth will not be included in the term "hospitalized".

In addition, coverage will not become effective for you or any dependent who is hospitalized as defined above or who is not performing normal daily activities on the date coverage would otherwise become effective. Normal daily activities means that the individual is not confined at home under the care of a doctor for a sickness or injury or is not entitled to receive any disability income from any source.

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 Metropolitan Life.**

### **REDUCTIONS AT AGE 65 & OVER**

If you remain in active service beyond age 65 your combined amount of Basic, AD&D and Optional Employee Life Insurance will reduce as follows:

<u>Attained Age</u>	<u>Percent of Original Amount</u>
65	65%
70	50%

### **TERMINATION OF COVERAGE**

All insurance under this plan will terminate upon the earlier of termination of employment, when the plan ceases or when you withdraw 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.

### **EXTENDED DEATH BENEFITS DURING DISABILITY**

If an insured becomes totally disabled prior to age 65, the amount of life insurance will be continued without payment of premium provided evidence of disability is submitted annually. However, your insurance will be subject to reduction as shown under "Reductions at ages 65 & Over" above. Continued protection terminates at age 70.

### **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, except a term policy, issued by Metropolitan Life 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 employment terminates. This privilege applies to Optional Employee Life Insurance and Dependent Life Insurance as well as the Basic Employee Life Insurance.

### **SUICIDE EXCLUSION**

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

### **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.

### **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 only.

**Qualifying Events Include:**

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

You must apply for this coverage within 31 days after your employment terminates. The minimum face amount which an employee may elect portability is \$10,000. 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.

**SCHEDULE OF BENEFITS**

**BASIC EMPLOYEE LIFE INSURANCE and AD&D (No cost to you)**

<u>Annual Salary</u>	<u>Benefit Amount*</u>
Less than \$10,000	\$10,500
\$10,000 - 15,000	\$17,500
\$15,001 - Over	\$24,500
County Commissioners	\$10,500

**OPTIONAL EMPLOYEE LIFE INSURANCE**

Your choice of the following amounts:\*

\$150,000, \$100,000, \$50,000, \$40,000, \$30,000, \$20,000, \$10,000

\*See "Reductions at age 65 & Over."

**OPTIONAL DEPENDENT LIFE INSURANCE**

\$10,000 on your spouse  
\$5,000 on each of your eligible children\*\*

You choose either:

- ♦ Family coverage
- ♦ Spouse only coverage; or
- ♦ Child(ren) only coverage

\*\*Children age 15 days up to 6 months have a death benefit of \$500.

**Optional Dependent Life Insurance is available only to those eligible employees who are insured for Optional Employee Life Insurance.**

### YOUR SEMI-MONTHLY COST

Optional Employee <u>Life Insurance</u>	Payroll Deduction <u>24 pay periods</u>
\$150,000	\$21.38
\$100,000	\$14.25
\$50,000	\$7.13
\$40,000	\$5.70
\$30,000	\$4.28
\$20,000	\$2.85
\$10,000	\$1.43

#### **Optional Dependent Life Insurance (based on 24 Deductions)**

Family Coverage	\$1.83
Spouse Only Coverage	\$1.23
Child(ren) Only Coverage	\$0.60*

\*Regardless of the number of children. \$500 benefit for child(ren) age 15 days up to 6 months.

#### **CLAIMS PROCEDURE**

Claim forms needed to file for benefits under the group insurance program 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. If there is any question about a claim payment, an explanation can be requested from your employer, who is usually able to provide the necessary information.

This brochure has been prepared to give you the highlights of coverage now being offered by your employer, and is subject to the terms and conditions of the Master Policy.

This insurance is underwritten by Metropolitan Life Insurance  
New York, New York 10010.

# MetLife®

## Continuing Your Benefits Upon Termination of Employment

### **MEDICAL REIMBURSEMENT ACCOUNT:**

Under the Flexible Benefit Administrators Medical Spending Account plan, you are eligible to continue coverage through COBRA.

If you are enrolled in the Medical Reimbursement Account, you will be eligible to continue coverage through COBRA after you leave employment for a specified period. You will receive notification from Interactive Medical Systems (IMS) with your account balance and continuation options shortly following your termination of employment. You may call **IMS at (800) 426-8739**.

### **ASSURITY CANCER PLAN**

When you leave employment you may continue your Assurity Cancer coverage by having the premiums that are currently deducted from your paycheck billed to your home address or drafted from your bank account. Assurity will send you a letter explaining your options or you may arrange that by contacting **Assurity at: (866) 289-7337**.

### **STANDARD LIFE DISABILITY PLAN**

When you leave employment you may continue your disability coverage as long as continuous employment is maintained and proof of such coverage is furnished to Standard Life. Coverage expires on the policy anniversary date following your 65th birthday. To set up direct bill to your home address, please contact **Standard Life at (800) 327-0659**

### **TEXAS LIFE WHOLE LIFE INSURANCE**

When you leave employment, you may continue your Whole Life coverage by having the premiums that are currently deducted from your paycheck billed to your home address or drafted from your bank account. You may do that by contacting **Texas Life at: (800) 283-9233 prompt #3**.

## **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, except a term policy. You must apply for conversion within 31 days after the date your coverage terminates. This applies to Optional Life and Dependent Life as well as the basic coverage.

**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.
- Employees are eligible to age 74, spouses to age 64 and children up to age 18, 24 if a full-time student.

Your employer will advise MetLife of your termination and MetLife will in turn, contact you directly to assist with the conversion/portability process, and advise you of your options. You may also call **MetLife at (877) 275-6387** and request a conversion kit.

If you do not convert or port your group term life insurance, coverage will terminate.

### **Important Phone Numbers:**

Mark III Brokerage, Inc. - (800) 532-1044, ext. 212  
Flexible Benefit Administrators Spending Accounts - (800) 437-3539  
Assurity Cancer Plan - (866) 289-7337  
Standard Life STD Plan - (800) 327-0695  
Texas Life Whole Life Plan - (800) 283-9233, prompt #3.  
MetLife Term Life Plan - (800) 638-6420 (ext. 2 for claims)