

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 1, 2009 to December 31, 2009
- 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.

Tucker Administrators Flexible Spending Accounts

Plan Year: January 1, 2009- December 31, 2009
Medical Spending Account Maximum: \$2,400.00
Medical Spending Minimum: \$240.00
Dependent Care Account Maximum: \$5,000.00

Tucker Administrators Flexible Spending Accounts allow you to use pre-taxed dollars towards health care expenses such as prescription and over-the-counter medication, 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 Tucker Administrators after the plan year ends?

You have a grace period (90 days) after the end of the plan year to submit expenses that were 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 Family 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

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 tuckeradministrators.com and login to access claims information and FSA balances online. Once you are logged in, you may view your account balances. If you are new to Tucker Administrators, when you log into the website, you will be asked to create your own user ID and password.

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 tuckeradministrators.com or you can call Customer Service at **1-800-347-1232**.

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:

	<u>With FSA</u>	<u>Without FSA</u>
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	\$121
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	\$250
Net After Expenses	\$593.05	\$529.06

Tax Savings This Pay Period: \$63.99

Annual Tax Savings: \$63.99 X 24 pay periods = \$1,535.76

Tucker Administrators Health Care Flexible Spending Account

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 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, check your balance prior to the end of each year.

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 or mail your completed claim form and receipts to Tucker Administrators for reimbursement. Claim forms can be downloaded at tuckeradministrators.com.

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" on page 6.

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 704-525-9534 for processing.

How much will be reimbursed?

When you submit a health care expense, you will be reimbursed for that expense 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 Tucker Administrators 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 at tuckeradministrators.com, or you can call Tucker Administrators at **(800) 347-1232**.

Qualified medical expenses are those expenses paid for medical care as described in Section 213(d) of the Internal Revenue Code. Insurance premiums are considered qualified medical expenses when they are for payment for a health plan as stated in Section 220(d) (2) of the code. IRS Publication 502, titled "Medical and Dental Expenses", provides more detailed information on eligible expenses. 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).

Qualified Medical Expenses Eligible For Reimbursement:

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

Splints	Therapy equipment	Vaccines
Sterilization	Transportation expenses relative to health care (Mileage is eligible for the miles driven to and from the doctor's office.	Vasectomy
Stop smoking programs	The amount that can be reimbursed is nineteen (19) cents per mile.)	Vitamins (if prescribed)
Surgeon	Ultra-violet ray treatment	Weight loss programs (Physician prescribed)
Telephone or TV equipment to assist the hearing impaired		Wheelchair
		X-rays

Expenses Not Eligible For Reimbursement

Automobile Insurance	Funeral, cremation, or burial expenses	Scientology counseling
Athletic Club Membership	Expenses for sending a problem child to a special school	Social activities
Automobile Insurance	Health programs offered by resorts	Special foods or beverages
Boarding school fees	Hotels, health clubs, and gyms	Specially designed car for handicapped other than autoette or special equipment
Bottled water	Illegal operations and treatments	Swimming pool
Commuting expenses of a disabled person	Maternity clothes	Travel for general health improvement
Cosmetics, hygiene products, and similar items	Medical coverage	Tuition and travel
Cosmetic surgery and procedures	Premiums for life insurance, income protection, disability, loss of limbs, sight, or similar benefits.	
Diaper service		
Domestic help		

Over-the-Counter Drug/Medicine List

Over-the-Counter Drugs Used Primarily for Medical Care.

The Drugs/ Medicines listed below are approved with a receipt from the Provider/ Store. A recommendation from a health care provider is not needed.

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	Examples
Allergy Prevention & Treatment	Benadryl, Sudafed, Actifed, Claritin, Chloral Trimeton, and Nasalcrom
Antacids and Acid Reducers	Gas-X, Maalox, Mylanta, Tums, AXID AR, Pepcid AC, Prilosec OTC, Tagamet HB, Zantac 75
Anticandial	Femstat 3, Gyne-Lotrimin, Mycelrx-7, Monistat 3, 7, and Vagistat-1
Antihistamines	Actidil Syrup and Capsule, Actifed, Allerest, Benadryl, Claritin, Chlor-Trimeton, Contac, Dimetane, Drixoral, Nyquil, Sudafed, Tavist-1, and Triaminic
Antidiarrheal and Laxatives	Ex-Lax, Pepto-Bismol, Immodium A.D. and Kaopectate
Anti-fungal	Lamisil AT, Lotramin AF, and Micatin
Anti-itch Lotions and Creams	Bactine, Caldecort, Cortaid, Hydrocortisone, and Lanacort, Calamine Lotion, Benadryl Cream, Caladryl, Lamisil AT, Lotramin AF and Micatin
Asthma	Primatene Mist
Cold Sore / Fever Blister	Abreva Cream, Carmex
Condoms and other contraceptive Devices	Trojans, Magnums, VGF Films, and Delfen Contraceptive Foam

Drug / Medicine	Example
Contact Lenses Solutions	Bausch & Lomb, Renu, Aosept, Allergan, Boston and Opti-Free
Cough Suppressants	Robitussin, Vicks 44, Chloraseptic
Decongestant / Nasal Decongestant and Cold Remedies	Advil Cold and Sinus, Afrin, Afrinol, Aleve Cold and Synus, Children's Advil Cold, Duration, Dristan Long Lasting, Neo-Synephrine-12 Hour, Orrivin, Sudafed, Tavist-D, Tylenol Cold and Flu, Thera-ful, Alka Seltzer Cold and Flu, Nyquil, Actidil Syrup and Capsules, Actifed, Allerest, Benadryl, Claritin, Chlor-Trimeton, Contac, Dimetane, Drixoral, Sudafed, Tavist-1, and Triaminic
Diaper Rash Ointments	Balmex and Destin
Eye Drops for Allergy / Cold Relief	Ocu Hist
First Aid Supplies	Ace Bandages, Band-Aids, Bandage Tapes, Thermometers, Medical Gloves, Gauze, Neosporin, Rubbing Alcohol, and Visine
Hemorrhoid Treatments	Preparation H, Hemroid, and Tronolane
Internal Analgesics / Antipyretic	Advil, Aleve, Children Motrin, Nuprin, Excedrin, Tylenol, and Bayer
Incontinence Supplies	Depends
Liniments	BenGay, Tiger Balm, and Flexall
Medical Monitoring	Services and Bracelets specifically for medical information
Medical Products and Devices	Blood Pressure Monitor, Glucose Tester, HIV Test, Cholesterol Test, Diabetic Supplies, Crutches, Ovulation Monitor and Pregnancy Testing Kit
Menstrual Cycle Medications	Midol, Pamprin, and Premysyn PMS

Drug / Medicine	Examples
Migraine	Advil Migraine Liqui-gels, Excedrin Migraine, Motrin Migraine Pain
Motion Sickness Medication	Dramamine and Marizine
Nicotine Gum or Patches and Smoking Cessation Aids	Nicorette, Nicotrol and Nicodin
Pediculicide (head lice)	Nix
Poison Ivy Protection	Ivy Block
Smoking Cessation	Commit, Nicoderm CQ, Nicorette, Nicotrol
Toothache and Teething Pain Relievers	Orajel
Wart Removal and Medications	Tinamed

Dual Purpose OTC Drugs.

The items listed below require a third-party receipt and a note from the health care provider listing the diagnosis of the medical condition or illness and the recommendation of the OTC drug/ medicine. This list is not all inclusive and is intended to give examples of the most common brand names of OTC drugs.

- Anti-baldness/hair loss/hair replacement, such as Rogaine, but only if to replace hair loss due to a medical condition (e.g. cancer treatment) and not for balding due to age.
- Fiber supplements such as Benefiber and Metamucil
- Glucosamine/Chondroitin for arthritis or other medical conditions (not reimbursable if taken for overall joint health)
- Herbal supplements used to treat a specific disease such as St. John's wort for depression
- Hormone therapy drugs
- Medicated shampoos used to treat a specific medical condition like psoriasis and only the amount in excess of the cost of normal shampoo
- No Doz (and other sleep prevention drugs)
- Nose strips for proper breathing or other medical conditions
- Pedialyte for a child's dehydration
- Retin-A and other acne medicines (not reimbursable if used for cosmetic purposes such as wrinkle reduction)
- Sleep Aids
- Snoring cessation aids and medications such as Breath Right Spray, Snorezz
- Sunscreen and Sunblock

Tucker Administrators Dependent Care Flexible Spending 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 online via **tuckeradministrators.com**.

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 (\$3,000 for one dependent or \$6,000 for two or more dependents), minus the amount reimbursed under the Dependent Care FSA. You may wish to consult your tax advisor to see if the Flexible Spending Account or the tax credit will be more advantageous to your family.

How do I get reimbursed?

As you incur eligible expenses you must submit a completed Dependent Care claim form to Tucker Administrators 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.

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 deduction 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 call Tucker Administrators Customer Service at **1-800-347-1232**.

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.

FAX CLAIMS AND PROOF OF EXPENSE TO 704 525-9534 FOR PROCESSING.

(PLEASE KEEP YOUR ORIGINALS)

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Telephone: (800) 347-1232
Fax: (704) 525-9534
www.tuckeradministrators.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, 2009, pending underwriting approval

BASIC BENEFITS

Provides medical expense benefits caused by cancer and certain other specified diseases by rider for the employee, spouse and covered children with continuous benefit and premium period 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.

UNDERWRITING

Pre-existing conditions are not covered during the first year the policy is in force. Persons with previous history of cancer will be excluded unless added by rider for those with simple skin cancers. Additional question regarding diagnostic tests that have been completed within last 30 days or are scheduled to be performed is also asked. **No benefits will be paid during a 30-day waiting period.** Conditions that manifest after the policy date will be payable beginning on the 31st day.

Definition of manifested: "Symptoms or visible indications that would put an ordinary prudent person on notice that diagnosis, care or treatment by a medical professional should be sought".

Policy will pay the following specified benefits for each unit for a covered illness:

Hospital Indemnity – pays benefits each day while 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 – pays actual charges up to 25% of daily hospital confinement benefit for the first 75 days of hospital confinement.

Surgical Benefit – pays up to \$7,500 for actual charges made by surgeon as shown in Surgical Table in policy.

Anesthesia – pays up to 25% of the amount payable under the Surgical Benefit. Limit of \$50 per skin cancer operation.

Additional Surgical Opinions – pays up to \$150 for a second opinion. If the second opinion differs from the first, up to \$150 for a third opinion.

Artificial Limb and Prosthesis – pays actual charges for prosthesis and reconstructive procedure to affix or implant it up to \$2,000 lifetime maximum.

Attending Physician – pays actual charges up to \$35 per day for in-hospital physician's visits.

Private Duty Nurse – 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, Chemotherapy or Immunotherapy – pays 50% of actual charges for treatments up to \$10,000 per month with a lifetime maximum of \$100,000.

Experimental Treatment – pays the actual charges up to \$25,000 per calendar year for such treatment received in the United States or its territories, except for experimental bone marrow transplants.

Physical and Speech Therapy – pays the actual charges up to \$25 per therapy session up to a lifetime maximum of \$1,000.

Extended Care Facility – pays up to \$60 per day for confinement in such a 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 – 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. 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 - pays (a) actual charges up to \$2,500 for medical expenses 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 has 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 – 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 for Non-local Treatment Which Does Not Require Hospital Confinement – pays (a) 50 cents per mile for personal automobile expenses in excess of 50 miles one way, up to 700 miles round trip with a maximum of \$1,500 per calendar year, (b) pays actual charges for 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.

Adult Companion Transportation and Lodging - pays the following expenses for one adult companion to be near insured when insured is confined in a non-local hospital (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 limited to the number of days of each confinement.

Outpatient Positive Diagnostic Testing – pays actual charges up to \$250 for the diagnostic test that leads to a positive diagnosis within 90 days of the test.

Outpatient Surgery – pays a benefit equal to the daily hospital confinement benefit for outpatient surgery in a hospital or ambulatory surgical center.

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

Hospice – pays actual charges up to \$100 per day up to a lifetime maximum of \$7,500.

Government or Charity Hospital – pays actual charges up to \$200 per day for confinement in a government or charity hospital. Payment is in lieu of all other policy benefits.

Blood and Blood Plasma – 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 – 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 following a lymph node dissection for the treatment of breast cancer. Lifetime maximum of \$2,500 per breast.

Cancer (Wellness) Screening Tests – pays up to \$100 per 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 your employer's website, www.markiiiibrokerage.com/brunswickcountync. If a bill is not included with the claim form, a scheduled amount will be paid. (Scheduled amounts are listed on the claim form). 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. ***Claims must be filed within 12 months of the incurred date of the claim.***

Home Health Care Services – when services are provided by a Home Health Care Agency, 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. Benefits herein are not payable under provisions of this policy.

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

Rental or Purchase of Durable Medical Equipment – pays the actual charges up to \$1,000 per calendar year for (a) a respirator or similar medical device, (b) brace, (c) crutches, (d) hospital bed or (e) wheel chair.

Professional Mental Health Consultation – pays actual charges up to \$50 per session not to exceed a lifetime maximum of \$250.

Extended Benefits – If a covered hospital confinement lasts for more than 75 days in a row, policy pays usual and customary charges for hospital room and board, medicines, lab test and other normal charges, up to \$1,000 per day beginning on the 76th day. Payable after the 75th day in lieu of all other policy benefits.

Waiver of Premium – premiums of the insured person will be waived while that person is receiving treatment for cancer or specified disease for which benefits are payable.

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.

Intensive Care Rider - If purchased, provides a Daily Benefit of your choice of either \$300 or \$600, 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 - If Purchased, pays your choice of either \$2,500 or \$5,000 the first time an insured is diagnosed as having internal cancer.

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

Pre-Existing Conditions

We will not pay any Benefits for loss caused by a Pre-Existing Condition during the first year following the Issue Date; however loss due to such conditions will be payable unless specifically excluded from coverage after such 1 year period.

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, downloading from your employer's website or from your benefits department. Should you have any questions on how to file or submit a claim, please contact Assurity customer service at the number listed below. Claims must be filed within 12 months of the incurred date.

For Claims or Customer Service relating to your Assurity Cancer Plan

Please call (866) 289-7337

For Wellness Claims by phone:

Please call (888) 358-8808, Ext. 23

Wellness Claims by facsimile at (800) 869-0368

Or mail claims to:

Assurity Life Insurance Company

PO Box 82533

Lincoln, NE 68501



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

SEMI-MONTHLY RATES (based on 24 Deductions)

Assurity Life Cancer & Specified Disease Plan				
		\$150 Daily Benefit	\$250 Daily Benefit	\$350 Daily Benefit
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.¹
- There is a death caused by a motor vehicle crash every 12 minutes; there is a disabling injury every 14 seconds.¹
- In the home, there is a fatal injury every 16 minutes and a disabling injury every 4 seconds.¹

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%.²
- One in five males and females has some form of cardiovascular disease. High blood pressure is the most common form of cardiovascular disease.³
- More than 35 million Americans are now living with chronic lung diseases, such as asthma, emphysema, and chronic bronchitis.⁴

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.⁵

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

But is your income insured?

1 National Safety Council, Injury Facts, 2003 Edition

2 American Cancer Society, Cancer Facts & Figures 2004

3 American Heart Association, Heart Disease and Stroke Statistics – 2004 Update

4 American Lung Association, Lung Disease Data 2003

5 National Underwriter, May 2002

Standard Life Short Term Disability Plan

Effective Date: January 1, 2009 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.

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**



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 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.

The MetLife logo is displayed in a bold, black, sans-serif font. The word "MetLife" is written in a single line, with a registered trademark symbol (®) at the end.

Continuing Your Benefits Upon Termination of Employment

TUCKER ADMINISTRATORS MEDICAL REIMBURSEMENT ACCOUNTS

If you have a positive balance (payroll deductions are greater than the amount you have received in reimbursement) in your Medical Reimbursement 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 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 Interactive Medical Systems (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**

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
Tucker Administrators Medical and Dependent Care - (800) 347-1232
Assurity Cancer Plan - (866) 289-7337
Standard Life STD Plan - (800) 327-0695 or (800) 227-0251
MetLife Term Life Plan - (800) 638-6420 (ext. 2 for claims)