

The City of Kannapolis is offering all full-time employees a comprehensive Cafeteria Benefits plan. The Cafeteria Benefits plan is being arranged by Mark III Brokerage, an employee benefits firm that has worked in the public sector for the last 35 years. The Cafeteria Benefits plan allows you to pay for certain insurance premiums and unreimbursed medical expenses before taxes are taken out of your paycheck. Paying for these benefits in this method reduces your taxes and increases your take home pay.

•The Plan Year begins July 1, 2008 and ends June 30, 2009

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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.

WageWorks HealthCare Choice Flexible Spending Account (formerly called FSA)

Plan Year: July 1, 2008 to June 30, 2009

- **HealthCare Reimbursement Account Maximum: \$2,400**
- **HealthCare Reimbursement Account Minimum: \$240**
- **Waiting Period: Eligible after 12 months of employment**
- **Run Off Period: 60 days following the end of the plan year to file for services rendered during the plan year**
- **If you participate in the HSA, (Option II health plan) you cannot contribute to the FSA (Health Care Choice Flexible Spending Account)**

THE HEALTH CARE CHOICE CARD

Use your card to pay for eligible products and services. Funds are deducted automatically from your Health Care Choice FSA.

Why Use the Card

- No claims to file; no need to get reimbursed
- Simply swipe your card and select "credit"—no PIN required
- Deducts automatically from your Health Care Choice FSA
- Most convenient way to pay for most eligible health care products and services

When to Use the Card

- Pay for eligible health care products and services received by you or an eligible dependent during your coverage period.
- Pay for products and services on the day you receive them. Regulations prohibit use of the card to pay for eligible expenses received in the past or to be received in the future.
- Your card expires on the expiration date printed on the card or the date you discontinue coverage, whichever comes first.

Where to Use the Card

- Doctor and dentist offices, pharmacies, discount chain and club stores—if their products and services are covered under your plan.
- At most merchants who sell health care products or services and accept either Visa or MasterCard debit cards.

How to Use the Card

- Separate your eligible items from your non-eligible items at the counter when you shop at pharmacies, drugstores, supermarkets or club stores.
- Use your Health Care Choice Card to pay for your eligible items, and another form of payment for the non-eligible items.
- Give your card to the merchant or service provider, or swipe it yourself.
- Select "credit" (No PIN required), and then sign for the transactions.

- Save your receipt or other documentation that describes the items you have paid for. It may be requested by WageWorks or the IRS to verify you used your account to pay for eligible products or services.

Additional Information About Using Your Health Care Choice Card

1. **You must activate your card** before you use it. Simply call (866) 363-4128 and enter the information requested.
2. **Use your card for eligible health care expenses only.** This card can only be used in places where health care products and services are likely to be sold.
3. **Do not use your card to pay for past or future services.** Tax regulations prohibit you from using this card to pay for services you received before your current coverage period or those you plan to receive in the future.
4. **Each time you use your card, you authorize that you are paying for eligible expenses** incurred by you or an eligible dependent during your current coverage period and that you have not and will not seek reimbursement for these expenses from any other health plan or source.
5. **Save all receipts that describe exactly what you paid for with your card.** We may ask you to submit these to show you used your card for eligible health care expenses.
6. **Debit or credit? Choose credit.** Even though this is not a credit card, choose the credit option. Your card has no PIN.
7. **Review your monthly statements.** They contain important information about your account, including if you are required to verify any purchases you made with the card.
8. **Your plan may require you to reimburse your account** in the amount of any card purchase if you cannot show the card was used for eligible health care products and services.

How to order additional cards

1. Log on to www.wageworks.com
 2. Enter your user name and password (or click on "First-Time User? Register Now" to complete the simple online registration process)
 3. Click on the "Health Care" tab
 4. Select "Request Additional Card"
 5. Provide first name, last name and Social Security Number of the person who will use the card
- The first additional card is provided free of charge
 - There is a charge for the second card
 - No more than three cards are available per account (one for you, the employee, and two for use by your eligible dependents)

If You Lose Your Card or if it is Stolen

Contact WageWorks immediately at our toll-free number: (877) 924-3967.

HEALTH CARE PAY MY PROVIDER

Pay your providers directly from your Health Care Choice FSA.

Why Use Pay My Provider

- No claims to file; no need to get reimbursed
- Works like a bill pay service
- Deducts automatically from your Health Care Choice FSA
- Most convenient way to pay for most recurring eligible health care services

When to Use Pay My Provider

- Regularly scheduled payments for eligible services such as orthodontic or chiropractic care
- When your doctor or dentist bills you for the amount not covered by your health plan
- To pay an invoice for an eligible service you already received and that expense requires only basic proof of service
- When you need to make a payment of \$20 or more

How to Use Pay My Provider

1. Log on to www.wageworks.com
2. Click on the "Health Care" tab
3. Click "Request Pay My Provider"
4. Confirm or enter your email address
5. Enter your provider information
6. Enter patient information
7. Enter your payment amount
8. WageWorks will make the requested payment from your account and mail it directly to your provider
9. WageWorks will send you an email each time a requested payment is made

HEALTH CARE PAY ME BACK

Get reimbursed from your Health Care Choice FSA for eligible products and services you pay for out of pocket.

When to Use Pay Me Back

Some products and services are easier to pay for first, and then get reimbursed. For example:

- When your provider requires you to pay before you receive the product or service. Pay for the service as required, and then file your claim after you have received the service.
- The expense is listed as a "Maybe" in the What's Covered list, meaning it requires additional information to get approved.
- You receive a bill from your provider after your health plan pays and your portion is less than \$20, the minimum Pay My Provider payment amount.

How to Use Pay Me Back

- Pay for your eligible products and services as you usually do and save your detailed receipt.
- Complete a Health Care Pay Me Back form. You can download a form after you log in to www.wageworks.com.
- Fax your form and appropriate proof of expense to the number indicated on the form.
- Or, mail your form and photocopies of your proof of expense to the address indicated on the form.
- Check your claims status online anytime by logging on to www.wageworks.com.
- All claims (including resubmissions) must be received no later than your Claim It by date (displayed on your monthly statement) to be eligible for reimbursement.

WHO'S COVERED BY YOUR HEALTH CARE CHOICE FSA?

You can use your Health Care Choice FSA to pay for health care expenses incurred by the following people (per the new IRS rules effective 01/01/05) even if they are not covered by your employer's health plan:

- Yourself
- Your spouse
- Your qualifying child*
- Your qualifying relative*

*Special rules allow a dependent to be eligible for this plan even when that dependent does not qualify to be claimed as your tax dependent on your tax return form. For more information, go to www.wageworks.com/forms/hcdependents.pdf and contact your personal tax advisor.

WHAT'S COVERED BY YOUR HEALTH CARE CHOICE FSA?

Product/Service	Category Covered?	
Acne treatments (over-the-counter)	Medical	Yes
Acupuncture	Medical	Yes
Adoption (medical expenses related to)	Medical	Yes
Adoption Fees	N/A	No
Alcoholism Treatment	Medical	Yes
Allergy and sinus medicine and products (over-the-counter)	Medical	Yes
Allergy Medication (prescription)	Pharmacy	Yes
Allergy Treatments	Medical	Yes
Alternative Dietary Supplements (for treatment of a medical condition)	Medical	Maybe
Alternative Drugs and Medicines (for treatment of a medical condition)	Medical	Maybe
Alternative Healers (for treatment of a medical condition)	Medical	Maybe
Ambulance and Emergency Health Services	Medical	Yes
Anesthesia (for non-cosmetic purposes)	Medical	Yes
Antacid (over-the-counter)	Medical	Yes
Antibiotic Ointment (over-the-counter)	Medical	Yes
Aspirin or Other Pain Reliever (over-the-counter)	Medical	Yes

Product/Service	Category Covered?	
Asthma Medicines or Treatments (over-the-counter)	Medical	Yes
Bandages and Related Items (over-the-counter)	Medical	Yes
Birth Control (over-the-counter)	Medical	Yes
Birth Control (prescription or other)	Medical	Yes
Blood Pressure Monitor	Medical	Yes
Body Scans	Medical	Yes
Braille Books and magazines (difference in cost only)	Vision	Maybe
Breast Pump (to compensate for a medical condition)	Medical	Maybe
Breastfeeding Classes	N/A	No
Cancer (fixed indemnity, \$XX per day) Insurance Premiums	N/A	No
Canker and Cold Sore Treatments (over-the-counter)	Medical	Yes
Chest Rubs (over-the-counter)	Medical	Yes
Child or Newborn Care Instruction	N/A	No
Childbirth Classes	Medical	Yes
Chiropractic Care	Medical	Yes
Chiropractic Office Visit or Treatment	Medical	Yes
Christian Science Practitioners	Medical	Yes
COBRA Premiums	N/A	No
Co-Insurance (dental)	Dental	Yes
Co-Insurance (medical)	Medical	Yes
Co-Insurance (prescription)	Pharmacy	Yes
Co-Insurance (vision)	Vision	Yes
Cold and Flu Medicine (over-the-counter)	Medical	Yes
Cold Cream (over-the-counter)	N/A	No
Compression or Anti-Embolism Socks, Stockings, or Hose	Medical	Yes
Condoms and Spermicides	Medical	Yes
Contact Lenses, Cleaning Solutions, Etc.	Vision	Yes
Contraceptives (prescription or over-the-counter)	Medical	Yes
Co-Payment (dental)	Dental	Yes
Co-Payment (medical)	Medical	Yes
Co-Payment (other)	Medical	Yes
Co-Payment (vision)	Vision	Yes
Cord Blood Storage (for unidentified future use)	N/A	No
Corneal Keratotomy	Vision	Yes
Cosmetic Surgery	N/A	No
Cough Drops and Sore Throat Lozenges (over-the-counter)	Medical	Yes
Cough Syrup (over-the-counter)	Medical	Yes
Counseling (for treatment of a medical condition)	Medical	Yes
CPR Classes (adult or child)	N/A	No
Crutches, Canes, or Like Equipment (purchase or rental)	Medical	Yes
Dancing Lessons (for treatment of a medical condition)	Medical	Maybe
Deductible for Dental Plan	Dental	Yes
Deductible for Medical Plan	Medical	Yes

Product/Service	Category Covered?	
Deductible for Prescription Plan	Pharmacy	Yes
Deductible for Vision Plan	Vision	Yes
Dental	Dental	Yes
Dental Care (for non-cosmetic purposes)	Dental	Yes
Dental Co-Payment	Dental	Yes
Dental Insurance or Plan Premiums	N/A	No
Dental Products (for treatment of a dental condition, not general health)	Dental	Maybe
Dental Reconstruction	Dental	Yes
Dental Veneers	Dental	Maybe
Dentures, Bridges, Etc.	Dental	Yes
Diabetic Monitor	Medical	Yes
Diagnostic Services	Medical	Yes
Dietary Supplements (for treatment of a medical condition)	Medical	Maybe
Drug Addiction Treatments	Medical	Yes
Drugs (experimental or imported)	N/A	No
Drugs (prescription)	Pharmacy	Yes
Dylexia Treatment	Medical	Yes
Ear Drops and Wax Removal (over-the-counter)	N/A	No
Educational Classes or Tuition	N/A	No
Electrolysis	N/A	No
Emergency Kits (over-the-counter)	N/A	No
Exercise Equipment (for treatment of a medical condition)	Medical	Maybe
Eye Examinations	Vision	Yes
Eye-Related Equipment/Materials	Vision	Yes
Eye Surgery or Treatment to Correct Vision	Vision	Yes
Eyeglasses (over-the-counter)	Vision	Yes
Eyeglasses (prescription)	Vision	Yes
Face Lifts	N/A	No
Fertility Monitor (over-the-counter)	Medical	Yes
Fertility Treatment (for employee, spouse, dependent)	Medical	Yes
Fertility Treatment (for non-dependent surrogate)	N/A	No
First Aid Kits (over-the-counter)	N/A	No
Fitness Programs	N/A	No
Flu Shots	Medical	Yes
Funeral Expenses	N/A	No
Gastrointestinal Medication (over-the-counter)	Medical	Yes
Guide Dog (dog, training, care)	Vision	Yes
Hair Regrowth Products	N/A	No
Hair Removal	N/A	No
Hair Transplant	N/A	No
Hair Treatments	N/A	No
Hand Lotion (over-the-counter)	N/A	No

Product/Service	Category Covered?	
Health Club Dues	N/A	No
Health Insurance or Plan Premiums	N/A	No
Health Savings Account (HAS) contributions	N/A	No
Hearing Aids and Batteries	Medical	Yes
Herbal or Homeopathic Medicines (over-the-counter)	N/A	No
Hospital (fixed indemnity, \$XX per day) Insurance Premiums	N/A	No
Hospital Fees	Medical	Yes
Hospital Services	Medical	Yes
Household Help	N/A	No
Illegal Operations or Substances	N/A	No
Immunizations	Medical	Yes
Infertility Treatment (for employee, spouse or dependent)	Medical	Yes
Insulin, Testing Materials and Supplies	Medical	Yes
Insurance or Health Plan Premiums	N/A	No
Lab (medical)	Medical	Yes
Laboratory Fees	Medical	Yes
Lactose Intolerance (over-the-counter)	Medical	Yes
Lamaze Classes	Medical	Yes
Laser Eye Surgery	Vision	Yes
Lasik	Vision	Yes
Late Payment Fees Charged by Health Care Provider	N/A	No
Laxatives (over-the-counter)	Medical	Yes
Learning Disability Treatments	Medical	Yes
Lice Treatment (over-the-counter)	Medical	Yes
Listening Therapy	Medical	Yes
Lodging (essential to receive medical care)	Medical	Maybe
Long-Term Care Premiums (up to IRS tax-free limit, \$490 in 2004)	N/A	No
Long-Term Care Services	Medical	No
Long-Term Disability Insurance Premiums	N/A	No
Magnetic Therapy (over-the-counter)	N/A	No
Marriage Counseling	N/A	No
Massage Therapy (for treatment of a medical condition)	Medical	Maybe
Mastectomy-Related Special Bras	Medical	Yes
Maternity Clothes	N/A	No
Medical Abortion	Medical	Yes
Medical Co-Insurance	Medical	Yes
Medical Co-Payment	Medical	Yes
Medical Equipment (for treatment of medical condition) and Repairs	Medical	Yes
Medical Insurance or Plan Premiums	N/A	No
Medical Literature, Books, Pamphlets or Audio	N/A	No
Medical Monitoring and Testing Devices	Medical	Yes
Medical Records Charges	Medical	Yes
Medical Savings Account (MSA) Contributions	N/A	No

Product/Service	Category Covered?	
Medical Supplies (for treatment of a medical condition)	Medical	Maybe
Medicare Premiums, Medicare Supplement, and Medicare Alternative Insurance or Plan Premiums	N/A	No
Medicines (over-the-counter)	Medical	Yes
Medicines (prescription)	Pharmacy	Yes
Mileage (\$.15 per documented mile for travel to/from eligible health care)	Medical	Yes
Modified Equipment (difference in cost only)	Medical	Maybe
Monitors and Test Kits (over-the-counter)	Medical	Yes
Motion and Nausea	Medical	Yes
Nasal Sprays	Medical	Yes
Nasal Strips (over-the-counter)	N/A	No
No-Show Fees Charged by Health Care Provider	N/A	No
Non-Prescription Drugs and Medicines (for non-cosmetic purposes)	Medical	Yes
Norplant Insertion or Removal	Medical	Yes
Nursing Services (wages and taxes)	Medical	Yes
Nutrition Supplements (for treatment of a medical condition)	Medical	Maybe
OB/GYN Fees	Medical	Yes
Occlusal Guards to Prevent Teeth Grinding	Dental	Yes
Occupational Therapy (related to a medical condition or disability)	Medical	Yes
Office Visits (medical)	Medical	Yes
Office Visits (chiropractic)	Medical	Yes
Office Visits (dental)	Dental	Yes
Office Visits (psych/therapy)	Medical	Yes
Office Visits (vision)	Vision	Yes
Operations (for non-cosmetic purposes)	Medical	Yes
Optometrist/ Ophthalmologist Fees	Vision	Yes
Oral Care (over-the-counter)	N/A	No
Organ Transplants (recipient and donor)	Medical	Yes
Ortho Keratotomy	Vision	Yes
Orthodontia	Dental	Yes
Orthodontia (braces and retainers)	Dental	Yes
Over-the-Counter (eligible medical)	Medical	Yes
Over-the-Counter Acne Treatments	Medical	Yes
Over-the-Counter Allergy and Sinus Medicine	Medical	Yes
Over-the-Counter Antacid	Medical	Yes
Over-the-Counter Antibiotic Ointment	Medical	Yes
Over-the-Counter Aspirin or Other Pain Reliever	Medical	Yes
Over-the-Counter Asthma Medicines or Treatments	Medical	Yes
Over-the-Counter Bandages and Related Items	Medical	Yes
Over-the-Counter Canker and Cold Sore Treatments	Medical	Yes
Over-the-Counter Chest Rubs	Medical	Yes
Over-the-Counter Cold and Flu Medicine	Medical	Yes

Product/Service	Category Covered?	
Over-the-Counter Cold and Flu Prevention	Medical	Yes
Over-the-Counter Cold Cream	N/A	No
Over-the-Counter Cough Drops and Sore Throat Lozenges	Medical	Yes
Over-the-Counter Cough Syrup	Medical	Yes
Over-the-Counter Health Care Products (eligible)	Medical	Yes
Over-the-Counter Health Care Products (non-eligible)	N/A	No
Over-the-Counter Medication	Medical	Yes
Over-the-Counter Products for Dental Ailments	Dental	Yes
Over-the-Counter Products for General Dental Care	N/A	No
Over-the-Counter Vision Products	Vision	Yes
Ovulation Monitor (over-the-counter)	Medical	Yes
Oxygen	Medical	Yes
Pain Reliever (over-the-counter)	Medical	Yes
Personal Use Items (toothbrush, toothpaste, etc.)	N/A	No
Physical Exams	Medical	Yes
Physical Therapy	Medical	Yes
Pregnancy Tests (over-the-counter)	Medical	Yes
Prescription Co-Insurance	Pharmacy	Yes
Prescription Co-Payment	Pharmacy	Yes
Prescription Drugs (for non-cosmetic purposes)	Pharmacy	Yes
Prescription Drugs for cosmetic purposes	N/A	No
Prescription Drugs for Hair Regrowth	N/A	No
Prescription Insurance or Plan Premiums	N/A	No
Propecia (for treatment of a medical condition)	Medical	Maybe
Prosthesis	Medical	Yes
Psych/Therapy	Medical	Yes
Psychiatric Care	Medical	Yes
Psychoanalysis	Medical	Yes
Psychologist Fees	Medical	Yes
Radial keratotomy (RK)	Vision	Yes
Reading Glasses (over-the-counter)	Vision	Yes
Reconstructive Surgery (following accident or medical procedure or condition)	Medical	Maybe
Removal of Benign Mole, Cyst or Tumor	Medical	Yes
Retin-A (for non-cosmetic purposes)	Medical	Maybe
Rogaine or Other Hair Regrowth Medications (even is prescribed)	N/A	No
Rx (prescription)	Pharmacy	Yes
Smoking Cessation (programs/counseling)	Medical	Yes
Smoking Cessation Drugs (prescription)	Medical	Yes
Smoking Cessation Gum or Patches (over-the-counter)	Medical	Yes
Special Equipment	Medical	Maybe
Special Foods (gluten-free, salt-free or other for treatment of medical condition)	Medical	Maybe

Product/Service	Category Covered?	
Special School (for mental and physical disabilities)	Medical	Maybe
Speech Therapy	Medical	Yes
Sterilization	Medical	Yes
Student Health Fees (for dental services)	Dental	Yes
Student Health Fees (for medical services)	Medical	Yes
Student Health Fees (for prescriptions)	Pharmacy	Yes
Student Health Fees (for vision services)	Vision	Yes
Sunglasses (over-the-counter)	N/A	No
Sunglasses (prescription)	Vision	Yes
Sunscreen (over-the-counter)	N/A	No
Supplies (for treatment of a medical condition)	Medical	Maybe
Surgery (for non-cosmetic purposes)	Medical	Yes
Swimming Lessons (for treatment of a medical condition)	Medical	Maybe
Teeth Bleaching or Whitening	N/A	No
Teeth Grinding Prevention Devices	Dental	Yes
Therapy (for treatment of a medical condition)	Medical	Yes
Toothpaste, toothbrush, floss, etc.	N/A	No
Transgender Treatments/Surgery	N/A	No
Transportation, Parking and Relative Travel Expenses (essential to receive medical care)	Medical	Maybe
Tubal Ligation	Medical	Yes
Tuition or Educational Classes	N/A	No
UV Protection Clothing	N/A	No
Vaccinations	Medical	Yes
Varicose Vein Removal Surgery	Medical	Yes
Vasectomy	Medical	Yes
Viagra and Similar Prescription Medications	Pharmacy	Yes
Vision	Vision	Yes
Vision Co-Insurance	Vision	Yes
Vision Co-Payment	Vision	Yes
Vision Insurance or Plan Premiums	N/A	No
Vitamins (over-the-counter, for general health purposes)	N/A	No
Vitamins (prescription)	Pharmacy	Yes
Weight Loss Counseling	Medical	Maybe
Weight Loss Foods	N/A	No
Weight Loss Program (to improve or maintain general health)	N/A	No
Weight Loss Program (for treatment of a medical condition)	Medical	Maybe
Wheelchair and Repairs	Medical	Yes
X-Ray (medical)	Medical	Yes
X-Ray Fees (dental)	Dental	Yes
X-Ray Fees (medical)	Medical	Yes

HEALTH CARE EXPENSES

You can pay for eligible expenses that require Basic proof using your Health Care Choice Card, Pay My Provider or Pay Me Back. For expenses requiring more than Basic proof, you will need to use an alternate payment method and then file a Pay Me Back claim - along with the required additional information - to get reimbursed.

PROOF OF EXPENSE

BASIC : Any product or service with “Yes” under “Covered?” on the previous pages.

You must provide proof for each expense listed on your Pay Me Back claim form. Your proof should be appropriate for the type of expense:

- Pharmacy receipt for prescriptions and other pharmacy purchases
- Doctor’s receipt for office visit
- Explanation of Benefits (EOB) from your insurance or health plan, for covered medical and dental expenses
- Bill or invoice from doctor or dentist for expenses not covered by your insurance or health plan
- Payment contract, monthly payment coupon or statement from your orthodontist
- Receipt from your optometrist or other medical service provider

BASIC + : Any product or service with “Maybe” under “Covered?” on the previous pages (that is not a special or modified item).

Same as Basic, plus a written statement from your provider indicating (1) the diagnosis and (2) the medical necessity of the product or service.

BASIC ++ : Any product or service with “Maybe” under “Covered?” on the previous pages that is a special or modified item. Same as Basic+, plus proof of difference in cost: (1) the cost of standard, unmodified item and (2) the cost of special or modified item. The reimbursable amount is the difference between these two.

HEALTH CARE CHOICE FSA RULES

The following rules are dictated by IRS regulations:

1. By enrolling in the plan, you authorize your employer to deduct your election amount from your paycheck on a pre-tax basis.
2. Your account can be used to pay for eligible expenses incurred while you are enrolled during the plan year. Expenses are considered incurred on the day of service, not when you are billed or pay.
3. Your account cannot be used to pay for expenses incurred before or after you are covered under this plan or for services your plan to receive in the future.
4. Your account can only be used to pay for medically necessary and eligible health care expenses for which you have not and will not seek reimbursement from any other health plan or source.
5. Each time you use the card, you authorize that you are paying for eligible expenses incurred by you or an eligible dependent during your current coverage period and that you have not and will not seek reimbursement for these expenses from any other health plan or source.
6. You cannot take a deduction or a tax credit on your tax return form for any health care expense paid for through this account.
7. You are responsible for maintaining documentation (e.g. detailed receipts) to verify your expenses (the nature of each expense, the amount and the date incurred). Keep these with your other important tax papers for the calendar year. You may be requested to submit these per your monthly statement.
8. You will have until your Claim It by date to get reimbursed from your account (by filing a Pay Me Back claim form) for eligible expenses incurred before your Spend It by date. Both dates are displayed online and on your monthly account statement and subject to change should you stop participating in this plan before the end of the plan year.
9. Be sure to incur eligible expenses totaling your election amount before your Spend It by date. Any balance remaining in your account after your Claim It by date cannot be rolled over or paid out to you and will be forfeited.
10. If you want to participate during the next plan year, you will need to re-enroll during the open enrollment period. We are not allowed to keep you enrolled or automatically re-enroll you.
11. You may be able to enroll, change or cancel your enrollment during the plan year if you have experienced a qualified change as defined and if allowed by your employer's plan.
12. Participation in this plan reduces your taxable income and may affect other compensation-based benefits such as life, disability and Social Security.
13. Consult a tax advisor if you have any questions regarding your personal situation.

Toll-Free Fax Number for Claims
(877) 353-9236

Customer Service
(877) 924-3967

Web
www.wageworks.com

E-mail Help
help@wageworks.com

Or mail your claim form and photocopies of your proof of service to:
WageWorks Processing Center
Claims Administrator
PO Box 14053
Lexington, KY 40511

REMINDER: Receipts for eligible expenses (including over the counter drugs) should be kept for the entire plan year in the event that WageWorks ask for documentation or the IRS requests a copy of a receipt.

Grace Period Benefit:

You now have an additional 2 1/2 months to spend the money in your account!

On May 18, 2005 the Internal Revenue Service changed the FSA rules to allow your employer to offer a grace period at the end of the plan year. The grace period provides you with more time to incur expenses against the plan. **This means you can continue to spend your current account funds during the new grace period after the end of our plan year. A run-out period will follow the new grace period, giving you time to file claims for those expenses incurred during this plan year and/or during the new grace period.**

The grace period applies only if you are covered on the last day of the plan year. Your coverage will be extended automatically; there's nothing you need to do to take advantage of the new grace period, except file Pay Me Back claims (including Automatic Health Plan claims) or request Pay My Provider payments for those expenses incurred during the grace period.

Example: If you are covered on the last day of the plan year, your coverage will automatically be extended to include the grace period. Any eligible products and services you receive during the new grace period are eligible for reimbursement from the current plan year account. If you re-enroll for the upcoming plan year, the expenses you incur during the grace period are also eligible to be paid from that new plan year account.



WageWorks Health Reimbursement Account (HRA)

Plan Year: July 1, 2008 thru June 30, 2009

- **Health Reimbursement Account Contribution: \$600**
- **Waiting Period: When insurance becomes effective**
- **Run Off Period: 60 days following the end of the plan year to file for services rendered during the plan year**

A Health Reimbursement Account (HRA) is a type of health plan that uses only **Employer** contributions to pay employee and dependent health care expenses. Basically all types of medical, dental, vision and other healthcare related expenses may be reimbursed by the HRA as defined by Code Section 213(d). In order to be an eligible **premium expense** under an HRA, the premium must qualify as a medical expense under Code Section 213(d).

Also health insurance premiums that have been paid with after tax dollars and long term care premiums are eligible HRA expenses.

Good news is that the HRA is a pre-taxed benefit which means you are not taxed on the reimbursements made from the plan.

If you have unused funds in the HRA at the end of the Plan Year, the unused amount will remain in the Reimbursement Account for reimbursement of eligible medical expenses in the next plan year. You may carry over \$3,000. If there is a carryover amount it is allocated to your reimbursement account annually as a lump sum. **The maximum account balance, including any carry over amount, plus Employer contribution is \$3,600.**

If you have both the Healthcare Reimbursement Account (formerly called FSA) and the Health Reimbursement Account (HRA) you decide which account to use at the point of purchase.

As a **retiree**, you must participate in the City's health insurance program to be eligible for the **Employer sponsored HRA**. Retirees who participate in the plan can pay aftertax medical premium for their personal health insurance from the HRA.

The HRA also includes a "spend-down" feature, which allows the HRA to continue to reimburse to former or retired employees, after termination of employment or retirement until the funds in the HRA are spent down.

You may be reimbursed for a 12 month period after retirement or termination of employment.

Toll-Free Fax Number for Claims

(877) 353-9236

Customer Service

(877) 924-3967

Web

www.wageworks.com

E-mail Help

help@wageworks.com

Or mail your claim form and photocopies of your proof of service to:

WageWorks Processing Center
Claims Administrator
PO Box 14053
Lexington, KY 40511



United Healthcare Choice Plus Plan- Option I

Effective Date: July 1, 2008

Choice Plus plan gives you the freedom to see any Physician or other health care professional from our Network, including specialists, without a referral. With this plan, you will receive the highest level of benefits when you seek care from a network physician, facility or other health care professional. In addition, you do not have to worry about any claim forms or bills.

You also may choose to seek care outside the Network, without a referral. However, you should know that care received from a non-network physician, facility or other health care professional means a higher deductible and Copayment. In addition, if you choose to seek care outside the Network, United Healthcare only pays a portion of those charges and it is your responsibility to pay the remainder. This amount you are required to pay, which could be significant, does not apply to the Out-of-Pocket Maximum. We recommend that you ask the non-network physician or health care professional about their billed charges **before you receive care**.

SOME OF THE IMPORTANT BENEFITS OF YOUR PLAN

You have access to a Network of physicians, facilities and other health care professionals, including specialists, without designating a Primary Physician or obtaining a referral.

Benefits are available for office visits and hospital care, as well as inpatient and outpatient surgery.

Care CoordinationSM services are available to help identify and prevent delays in care for those who might need specialized help.

- Emergencies are covered anywhere in the world
- Pap smears are covered
- Prenatal care is covered
- Routine check-ups are covered
- Childhood immunizations are covered
- Mammograms are covered
- Vision and hearing screenings are covered

CHOICE PLUS BENEFIT SUMMARY		
Types of Coverage	Network Benefits/ Copayment Amounts	Non-Network Benefits/ Copayment Amounts
<p>This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your health care expenses. More complete descriptions of Benefits and the terms under which they are provided are contained in the Certificate of Coverage that you will receive upon enrolling in the Plan.</p> <p>If this Benefit Summary conflicts in any way with the Policy issued to your employer, the Policy shall prevail.</p> <p>Terms that are capitalized in the Benefit Summary are defined in the Certificate of Coverage.</p> <p>Where Benefits are subject to day, visit and/or dollar limits, such limits apply to the combined use of Benefits whether in-Network or out-of-Network, except where mandated by state law.</p> <p>Network health care services under this benefit plan are covered only when provided, arranged or authorized by a Network Physician.</p> <p>*Prior Notification is required for certain services.</p>	<p>Annual Deductible: \$1000 per Covered Person per calendar year, not to exceed \$2,000 for all Covered Persons in a family.</p> <p>Out-of-Pocket Maximum: \$2,500 per Covered Person per calendar year, not to exceed \$5,000 for all Covered Persons in a family. The Out-of-Pocket Maximum does not include the Annual Deductible. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum as specified in Section 1 of the COC.</p> <p>Maximum Policy Benefit: No Maximum Policy Benefit</p>	<p>Annual Deductible: \$2,000 per Covered Person per calendar year, not to exceed \$4,000 for all Covered Persons in a family.</p> <p>Out-of-Pocket Maximum: \$5,000 per Covered Person per calendar year, not to exceed \$10,000 for all Covered Persons in a family. The Out-of-Pocket Maximum does not include the Annual Deductible. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum as specified in Section 1 of the COC.</p> <p>Maximum Policy Benefit: \$1,000,000 per Covered Person</p>
<p>1. Ambulance Services - Emergency only</p>	<p>Ground Transportation: 20% of Eligible Expenses</p> <p>Air Transportation: 20% of Eligible Expenses</p>	<p>Same as Network Benefit</p>
<p>2. Dental Services - Accident only</p>	<p>*20% of Eligible Expenses</p> <p>*Prior notification is required before follow-up treatment begins.</p>	<p>*Same as Network Benefit</p> <p>*Prior notification is required before follow-up treatment begins.</p>

CHOICE PLUS BENEFIT SUMMARY <i>CONTINUED</i>		
Types of Coverage	Network Benefits/ Copayment Amounts	Non-Network Benefits/ Copayment Amounts
3. Durable Medical Equipment Network and Non-Network Benefits for Durable Medical Equipment are limited to \$2,500 per calendar year.	*20% of Eligible Expenses	*30% of Eligible Expenses *Prior notification is required when the cost is more than \$1,000
4. Emergency Health Services	\$150 per visit	Same as Network Benefit *Notification is required if results in an Inpatient Stay.
5. Eye Examinations Refractive eye examinations are limited to one every other calendar year from a Network Provider.	\$25 per visit	30% of Eligible Expenses Eye Examinations for refractive errors are not covered.
6. Home Health Care Network and Non-Network Benefits are limited to 60 visits for skilled care services per calendar year.	*20% of Eligible Expenses	*30% of Eligible Expenses
7. Hospice Care Network and Non-Network Benefits are limited to 360 days during the entire period of time a Covered Person is covered under the Policy.	*20% of Eligible Expenses	*30% of Eligible Expenses
8. Hospital - Inpatient Stay	*20% of Eligible Expenses	*30% of Eligible Expenses
9. Injections Received in a Physicians Office	\$25 per visit	30% per injection
10. Maternity Services	Same as 8, 11, 12 and 13 No Copayment applies to Physician office visits for prenatal care after the first visit.	Same as 8, 11, 12 and 13 *Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
11. Outpatient Surgery, Diagnostic and Therapeutic Services		
Outpatient Surgery	20% of Eligible Expenses	*30% of Eligible Expenses
Outpatient Diagnostic Services	For lab and radiology/Xray: No Copayment For mammography testing: No Copayment	*30% of Eligible Expenses
Outpatient Diagnostic /Therapeutic Services – CT Scans, Pet Scans, MRI and Nuclear Medicine	20% of Eligible Expenses	*30% of Eligible Expenses
Outpatient Therapeutic Treatments	20% of Eligible Expenses	*30% of Eligible Expenses

CHOICE PLUS BENEFIT SUMMARY <i>CONTINUED</i>		
Types of Coverage	Network Benefits/ Copayment Amounts	Non-Network Benefits/ Copayment Amounts
12. Physician's Office Services	\$25 per visit. No Copayment applies when a Physician charge is not assessed.	30% of Eligible Expenses. No Benefits for preventive care, except for state mandates.
13. Professional Fees for Surgical and Medical Services	20% of Eligible Expenses	30% of Eligible Expenses
14. Prosthetic Devices Network and Non-Network Benefits for prosthetic devices are limited to \$2,500 per calendar year.	20% of Eligible Expenses	30% of Eligible Expenses
15. Reconstructive Procedures	Same as 8, 11, 12, 13 and 14	*Same as 8, 11, 12, 13 and 14
16. Rehabilitation Services - Outpatient Therapy Network and Non-Network Benefits are limited as follows: 20 visits of physical therapy; 20 visits of occupational therapy; 20 visits of speech therapy; 20 visits of pulmonary rehabilitation; and 36 visits of cardiac rehabilitation per calendar year.	\$25 per visit	30% of Eligible Expenses
17. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Network and Non-Network Benefits are limited to 60 days per calendar year.	20% of Eligible Expenses	*30% of Eligible Expenses
18. Transplantation Services	*20% of Eligible Expenses	*30% of Eligible Expenses Benefits are limited to \$30,000 per transplant.
19. Urgent Care Center Services	\$50 per visit	30% of Eligible Expenses

CHOICE PLUS BENEFIT SUMMARY <i>CONTINUED</i>		
Types of Coverage	Network Benefits/ Copayment Amounts	Non-Network Benefits/ Copayment Amounts
<u>ADDITIONAL BENEFITS</u>		
Dental - Anesthesia and Hospital or Facility Charges Benefits are limited for children under 9 with either serious mental/physical conditions or significant behavior problems.	*Same as 8, 11, 12 and 13	*Same as 8, 11, 12 and 13
Diabetes Services	20% of Eligible Expenses	30% of Eligible Expenses
Mental Health and Substance Abuse Services - Outpatient Must receive prior authorization through the Mental Health /Substance Abuse Designee. Network and Non-Network Benefits for Mental Health Services are limited to 20 visits per calendar year. Network and Non-Network Benefits for inpatient or outpatient Substance Abuse Services are limited to \$8,000 per calendar year.	\$25 per individual visit; \$20 per group visit	30% of Eligible Expenses
Mental Health and Substance Abuse Services - Inpatient and Intermediate Must receive prior authorization through the Mental Health/Substance Abuse Designee. Network and Non-Network Benefits for Mental Health Services are limited to 30 days per calendar year. Network and Non-Network Benefits for inpatient or outpatient Substance Abuse Services are limited to \$8,000 per calendar year.	20% of Eligible Expenses	30% of Eligible Expenses
Spinal Treatment Benefits include diagnosis and related services and are limited to one visit and treatment per day. Network and Non-Network Benefits are limited to 24 visits per calendar year.	\$25 per visit	30% of Eligible Expenses
Temporomandibular Jaw Joint Disorder	Same as 8, 11, 12, 13 and 14	Same as 8, 11, 12, 13 and 14

EXCLUSIONS

Except as may be specifically provided in Section 1 of the Certificate of Coverage (COC) or through a Rider to the Policy, the following are not covered:

A. Alternative Treatments

Acupressure; hypnotism; rolfing; massage therapy; aroma therapy; acupuncture; and other forms of Alternative Treatment.

B. Comfort or Convenience

Personal comfort or convenience items or services such as television; telephone; barber or beauty service; guest service; supplies, equipment and similar incidental services and supplies for personal comfort including air conditioners, air purifiers and filters, batteries and battery chargers, dehumidifiers and humidifiers; devices or computers to assist in communication and speech.

C. Dental

Except as specifically described as covered in Section 1 of the COC under the headings *Dental Services - Accident Only* and *Dental Services - Anesthesia and Hospital or Facility Charges*, dental services are excluded. There is no coverage for services provided for the prevention, diagnosis, and treatment of the teeth, jawbones or gums (including extraction, restoration, and replacement of teeth, medical or surgical treatments of dental conditions, and services to improve dental clinical outcomes). Dental implants and dental braces are excluded. Dental x-rays, supplies and appliances and all associated expenses arising out of such dental services (including hospitalizations and anesthesia) are excluded, except as might otherwise be required for transplant preparation, initiation of immunosuppressives, or the direct treatment of acute traumatic injury, cancer, or cleft palate. Treatment for congenitally missing, malpositioned, or super numerary teeth is excluded, even if part of a Congenital Anomaly.

D. Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self- injectable medications (with the exception of insulin). Non-injectable medications given in a Physician's office except as required in an Emergency. Over-the-counter drugs and treatments.

E. Experimental, Investigational or Unproven Services

Experimental, Investigational or Unproven Services are excluded. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition. This exclusion does not apply to Coverage of any drug solely on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the FDA, except as specifically described in Section 2 of the COC.

F. Foot Care

Routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting, or debriding; hygienic and preventive maintenance foot care;

treatment of flat feet or subluxation of the foot; shoe orthotics.

G. Medical Supplies and Appliances

Devices used specifically as safety items or to affect performance primarily in sports-related activities. Prescribed or non-prescribed medical supplies and disposable supplies including but not limited to elastic stockings, ace bandages, gauze and dressings, ostomy supplies, (diabetic supplies are covered. Please note that if you have an outpatient prescription drug rider that provides coverage for diabetic medications and supplies, Benefits are available under the Rider and not this medical plan). Orthotic appliances that straighten or re-shape a body part (including some types of braces). Tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 1 of the COC.

H. Mental Health/Substance Abuse

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention. Treatment of insomnia and other sleep disorders, dementia, neurological disorders, and other disorders with a known physical basis.

Treatment of Mental Illnesses which will not substantially improve beyond the current level of functioning, or for conditions not subject to favorable modification or management according to generally accepted standards of psychiatric care, as determined by the Mental Health/Substance Abuse Designee, including, but not limited to, conduct and impulse control disorders; personality disorder; and paraphilias.

Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements. Residential treatment services.

I. Nutrition

Megavitamin and nutrition based therapy; nutritional counseling for either individuals or groups. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk.

J. Physical Appearance

Cosmetic Procedures including, but not limited to, pharmacological regimens; nutritional procedures or treatments; salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and/or which are performed as a treatment for acne. Replacement of an existing breast implant is excluded if the earlier breast implant was a Cosmetic Procedure. (Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.)

Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs for

medical and non-medical reasons. Wigs, regardless of the reason for the hair loss.

K. Providers

Services performed by a provider with your same legal residence or who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.

L. Reproduction

Health services and associated expenses for infertility treatments. Surrogate parenting. The reversal of voluntary sterilization.

M. Services Provided Under Another Plan

Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements, including but not limited to coverage paid by workers' compensation, no-fault automobile insurance, or similar legislation. If coverage under workers' compensation. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

N. Transplants

Health services for organ or tissue transplants are excluded, except those specified as covered in Section 1 of the COC. Any solid organ transplant that is performed as a treatment for cancer. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. Health services for transplants involving mechanical or animal organs.

Transplant services that are not performed at a Designated Facility. Any multiple organ transplant not listed as a Covered Health Service in Section 1 of the COC.

O. Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered transplantation services may be reimbursed at our discretion. Travel and living expenses are reimbursed if you receive transplant services from a Designated Facility.

P. Vision and Hearing

Purchase cost of eye glasses, contact lenses, or hearing aids. Fitting charge for hearing aids, eye glasses or contact lenses. Eye exercise therapy. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

Q. Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see definition in Section 10 of the COC:

- Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations or treatments otherwise covered under the Policy, when such

services are: (1) required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption; (2) relating to judicial or administrative proceedings or orders; (3) conducted for purposes of medical research; or (4) to obtain or maintain a license of any type.

- Health services received as a result of war or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country.
- Health services received after the date your coverage under the Policy ends, including health services for medical conditions arising prior to the date your coverage under the Policy ends.
- Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy
- Charges in excess of Eligible Expenses or in excess of any specified limitation
- Orthognathic surgery or jaw alignment, except as a treatment for the temporomandibular joint or obstructive sleep apnea
- Surgical treatment and non-surgical treatment of obesity (including morbid obesity)
- Growth hormone therapy except as a Dependent child who requires growth hormones to treat a Congenital Anomaly; sex transformation operations; treatment of benign gynecomastia (abnormal breast enlargement in males); medical and surgical treatment of excessive sweating (hyperhidrosis); medical and surgical treatment for snoring, except when provided as part of treatment for documented obstructive sleep apnea. Oral appliances for snoring. Custodial care; domiciliary care; private duty nursing; respite care; rest cures
- Psychosurgery
- Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke or Congenital Anomaly

This Summary of Benefits is intended only to highlight your benefits and should not be relied upon to fully determine coverage. This plan may not cover all your health care expenses. Please refer to the Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Certificate of Coverage, the Certificate of Coverage prevails. Terms that are capitalized in the Benefit Summary are defined in the Certificate of Coverage.

MONTHLY RATES- OPTION I

Employee (City pays \$437.72)	\$30
Employee & Spouse	\$464.25
Employee & Children	\$394.03
Family	\$854.60

NOTES:

Employees will pay \$30 for individual coverage and 100% of dependent rates.

Premium may be discounted through the Alive & Well Program.

For customer service questions and claims, please call
United Healthcare Services*: 800-259-1605

***There should also be a Customer service number located on your I.D. card.**



United Healthcare HSA Choice Plus Plan- Option II

- **City Contribution to the High Deductible plan (HSA)- \$750.00**
- **If you participate in the HSA, you cannot contribute to the FSA (Health Care Choice Flexible Spending Account)**
- **There are no pharmacy co-pays after you have met the deductible since the deductible is the maximum out of pocket**

With this HSA Choice Plus high-deductible health plan coverage, you have the option to open a Health Savings Account (HSA). An HSA is a financial account that you can use to accumulate tax-free funds to pay for qualified health care expenses, as defined by the Internal Revenue Service. The account acts like a regular checking account with a debit card and accrues interest. All money in the account is owned by you and is fully vested as soon as it is deposited. Funds can accumulate over time and the account is portable among employers. If you use the funds for qualified health care expenses, you will pay no taxes. If you use the money for other expenses, you will pay a tax and a penalty fee.

Under the HSA Choice Plus high-deductible medical plan, your annual deductible and out of pocket maximum includes both medical expenses and pharmacy expenses. All expenses are your responsibility until the deductible is reached. HSA Choice Plus plan gives you the freedom to see any Physician or other health care professional from our Network, including specialists, without a referral. With this plan, you will receive the highest level of benefits when you seek care from a network physician, facility or other health care professional. In addition, you do not have to worry about any claim forms or bills.

You also may choose to seek care outside the Network, without a referral. However, you should know that care received from a non-network physician, facility or other health care professional means a higher deductible and Copayment. In addition, if you choose to seek care outside the Network, UnitedHealthcare only pays a portion of those charges and it is your responsibility to pay the remainder. This amount you are required to pay, which could be significant, does not apply to the Out-of-Pocket Maximum. We recommend that you ask the non-network physician or health care professional about their billed charges before you receive care.

Some of the Important Benefits of Your Plan:

You have access to a Network of physicians, facilities and other health care professionals, including specialists, without designating a Primary Physician or obtaining a referral. Benefits are available for office visits and hospital care, as well as inpatient and outpatient surgery.

Care CoordinationSM services are available to help identify and prevent delays in care for those who might need specialized help. Emergencies are covered anywhere in the world. Pap smears are covered. Prenatal care is covered. Routine check-ups are covered. Childhood immunizations are covered. Mammograms are covered. Vision and hearing screenings are covered.

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
<p>This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your health care expenses. More complete descriptions of Benefits and the terms under which they are provided are contained in the Certificate of Coverage that you will receive upon enrolling in the Plan.</p> <p>If this Benefit Summary conflicts in any way with the Policy issued to your employer, the Policy shall prevail. Terms that are capitalized in the Benefit Summary are defined in the Certificate of Coverage.</p> <p>Where Benefits are subject to day, visit and/or dollar limits, such limits apply to the combined use of Benefits whether in-Network or out-of-Network, except where mandated by state law.</p> <p>Network Benefits are payable for Covered Health Services provided by or under the direction of your Network physician.</p> <p>*Prior Notification is required for certain services.</p>	<p>Combined Medical and Drug Annual Deductible: For single coverage, the Annual Deductible is \$1,100 per Covered Person per calendar year. For family coverage, the Annual Deductible is \$2,200 per calendar year for all Covered Persons in a family. No one in the family is eligible for benefits until the family deductible is satisfied.</p> <p>Combined Medical and Drug Out-of-Pocket Maximum: For single coverage, the Out-of-Pocket Maximum is \$1,100 per Covered Person per calendar year. For family coverage, the Out-of-Pocket Maximum is \$2,200 per calendar year for all Covered Persons in a family. The Out-of-Pocket Maximum does include the Annual Deductible.</p> <p>Maximum Policy Benefit: No Maximum Policy Benefit.</p>	<p>Combined Medical and Drug Annual Deductible: For single coverage, the Annual Deductible is \$1,650 per Covered Person per calendar year. For family coverage, the Annual Deductible is \$3,300 per calendar year for all Covered Persons in a family. No one in the family is eligible for benefits until the family deductible is satisfied.</p> <p>Combined Medical and Drug Out-of-Pocket Maximum: For single coverage, the Out-of-Pocket Maximum is \$2,200 per Covered Person per calendar year. For family coverage, the Out-of-Pocket Maximum is \$4,400 per calendar year for all Covered Persons in a family. The Out-of-Pocket Maximum does include the Annual Deductible.</p> <p>Maximum Policy Benefit: \$1,000,000 per Covered Person.</p>
<p>1. Ambulance Services - Emergency only</p>	<p>Ground Transportation: 0% of Eligible Expenses Air Transportation: 0% of Eligible Expenses</p>	<p>Same as Network Benefit</p>
<p>2. Dental Services - Accident only</p>	<p>*0% of Eligible Expenses *Prior notification is required before follow-up treatment begins.</p>	<p>*Same as Network Benefit *Prior notification is required before follow-up treatment begins.</p>
<p>3. Durable Medical Equipment Network and Non-Network Benefits for Durable Medical Equipment are limited to \$2,500 per calendar year.</p>	<p>0% of Eligible Expenses</p>	<p>*20% of Eligible Expenses *Prior notification is required when the cost is more than \$1,000.</p>

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
4. Emergency Health Services	0% of Eligible Expenses	Same as Network Benefit *Notification is required if results in an Inpatient Stay.
5. Eye Examinations Refractive eye examinations are limited to one every other calendar year from a Network Provider.	0% of Eligible Expenses	20% of Eligible Expenses Eye Examinations for refractive errors are not covered.
6. Home Health Care Network and Non-Network Benefits are limited to 60 visits for skilled care services per calendar year.	0% of Eligible Expenses	*20% of Eligible Expenses
7. Hospice Care Network and Non-Network Benefits are limited to 360 days during the entire period of time a Covered Person is covered under the Policy.	0% of Eligible Expenses	*20% of Eligible Expenses
8. Hospital - Inpatient Stay	0% of Eligible Expenses	*20% of Eligible Expenses
9. Injections Received in a Physician's Office	0% per injection	20% per injection
10. Maternity Services	Same as 8, 11, 12 and 13	Same as 8, 11, 12 and 13 *Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
11. Outpatient Surgery, Diagnostic and Therapeutic Services		
Outpatient Surgery	0% of Eligible Expenses	20% of Eligible Expenses
Outpatient Diagnostic Services	For preventive diagnostic services: No Copayment For preventive mammography testing: No Copayment For sickness and injury related diagnostic services: 0% of Eligible Expenses	No Benefits for preventive care, except for state mandates. 20% of Eligible Expenses
Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine	0% of Eligible Expenses	20% of Eligible Expenses
Outpatient Therapeutic Treatments	0% of Eligible Expenses	20% of Eligible Expenses

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
12. Physician's Office Services	Preventive medical care: No Copayment Sickness & Injury: 0% of Eligible Expenses	No Benefits for preventive care, except for state mandates. 20% of Eligible Expenses
13. Professional Fees for Surgical and Medical Services	0% of Eligible Expenses	20% of Eligible Expenses
14. Prosthetic Devices Network and Non-Network Benefits for prosthetic devices are limited to \$2,500 per calendar year.	0% of Eligible Expenses	20% of Eligible Expenses
15. Reconstructive Procedures	Same as 8, 11, 12, 13 and 14	*Same as 8, 11, 12, 13 and 14
16. Rehabilitation Services - Outpatient Therapy Network and Non-Network Benefits are limited as follows: 20 visits of physical therapy; 20 visits of occupational therapy; 20 visits of speech therapy; 20 visits of pulmonary rehabilitation; and 36 visits of cardiac rehabilitation per calendar year.	0% of Eligible Expenses	20% of Eligible Expenses
17. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Network and Non-Network Benefits are limited to 60 days per calendar year.	0% of Eligible Expenses	*20% of Eligible Expenses
18. Transplantation Services	*0% of Eligible Expenses	*20% of Eligible Expenses Benefits are limited to \$30,000 per transplant.
19. Urgent Care Center Services	0% of Eligible Expenses	20% of Eligible Expenses
ADDITIONAL BENEFITS		
Dental - Anesthesia and Hospital or Facility Charges Benefits are limited for children under 9 and persons with either serious mental/physical conditions or significant behavior problems.	*Same as 8, 11, 12 and 13	*Same as 8, 11, 12 and 13
Diabetes Services	0% of Eligible Expenses	20% of Eligible Expenses

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
<p>Mental Health and Substance Abuse Services - Outpatient Must receive prior authorization through the Mental Health/Substance Abuse Designee. Network and Non-Network Benefits for Mental Health Services are limited to 20 visits per calendar year. Network and Non-Network Benefits for inpatient or outpatient Substance Abuse Services are limited to \$8,000 per calendar year.</p>	0% of Eligible Expenses	20% of Eligible Expenses
<p>Mental Health and Substance Abuse Services - Inpatient and Intermediate Must receive prior authorization through the Mental Health/Substance Abuse Designee. Network and Non-Network Benefits for Mental Health Services are limited to 30 days per calendar year. Network and Non-Network Benefits for inpatient or outpatient Substance Abuse Services are limited to \$8,000 per calendar year.</p>	0% of Eligible Expenses	20% of Eligible Expenses
<p>Spinal Treatment Benefits include diagnosis and related services and are limited to one visit and treatment per day. Network and Non-Network Benefits are limited to 24 visits per calendar year.</p>	0% of Eligible Expenses	20% of Eligible Expenses
<p>Temporomandibular Jaw Joint Disorder</p>	Same as 8, 11, 12, 13 and 14	Same as 8, 11, 12, 13 and 14

Exclusions

Except as may be specifically provided in Section 1 of the Certificate of Coverage (COC) or through a Rider to the Policy, the following are not covered:

A. Alternative Treatments

Acupressure; hypnotism; rolfing; massage therapy; aromatherapy; acupuncture; and other forms of alternative treatment.

B. Comfort or Convenience

Personal comfort or convenience items or services such as television; telephone; barber or beauty service; guest service; supplies, equipment and similar incidental services and supplies for personal comfort including air conditioners, air purifiers and filters, batteries and battery chargers, dehumidifiers and humidifiers; devices or computers to assist in communication and speech.

C. Dental

Except as specifically described as covered in Section 1 of the COC under the headings Dental Services -Accident Only and Dental Services - Anesthesia and Hospital or Facility Charges, dental services are excluded. There is no coverage for services provided for the prevention, diagnosis, and treatment of the teeth, jawbones or gums (including extraction, restoration, and replacement of teeth, medical or surgical treatments of dental conditions, and services to improve dental clinical outcomes).

Dental implants and dental braces are excluded. Dental x-rays, supplies and appliances and all associated expenses arising out of such dental services (including hospitalizations and anesthetics and anesthesia) are excluded, except as might otherwise be required for transplant preparation, initiation of immunosuppressives, or the direct treatment of acute traumatic Injury, cancer, or cleft palate. Treatment for congenitally missing, malpositioned, or super numerary teeth is excluded, even if part of a Congenital Anomaly.

D. Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Selfinjectable medications (with the exception of insulin). Please note that if you have an outpatient prescription drug rider that provides coverage for diabetic medications, Benefits are available under the Rider and not this medical plan. Non-injectable medications given in a Physician's office except as required in an Emergency. Over the counter drugs and treatments.

E. Experimental, Investigational or Unproven Services

Experimental, Investigational or Unproven Services are excluded. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition. This exclusion does not apply to Coverage of any drug solely on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the FDA, except as specifically described in Section 2 of the COC.

F. Foot Care

Routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting, or debriding; hygienic and preventive maintenance foot care; treatment of flat feet or subluxation of the foot; shoe orthotics.

G. Medical Supplies and Appliances

Devices used specifically as safety items or to affect performance primarily in sports-related activities. Prescribed or non-prescribed medical supplies and disposable supplies including but not limited to elastic stockings, ace bandages, gauze and dressings, ostomy supplies, (diabetic supplies are covered. Please note that if you have an outpatient prescription drug rider that provides coverage for diabetic medications and supplies, Benefits are available under the Rider and not this medical plan). Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces). Tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 1 of the COC.

H. Mental Health/Substance Abuse

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention.

Mental Health treatment of insomnia and other sleep disorders, neurological disorders, and other disorders with a known physical basis.

Treatment of conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee.

Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee. Residential treatment services. Services or supplies that in the reasonable judgment of the Mental Health/Substance Abuse Designee are not, for example, consistent with certain national standards or professional research further described in Section 2 of the COC.

I. Nutrition

Megavitamin and nutrition based therapy; nutritional counseling for either individuals or groups. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk.

J. Physical Appearance

Cosmetic Procedures including, but not limited to, pharmacological regimens; nutritional procedures or treatments; salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and/or

which are performed as a treatment for acne. Replacement of an existing breast implant is excluded if the earlier breast implant was a Cosmetic Procedure. (Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.) Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs for medical and non-medical reasons. Wigs, regardless of the reason for the hair loss.

K. Providers

Services performed by a provider with your same legal residence or who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider as further described in Section 2 of the COC (this exclusion does not apply to mammography testing).

L. Reproduction

Health services and associated expenses for infertility treatments. Surrogate parenting. The reversal of voluntary sterilization.

M. Services Provided under Another Plan

Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements, including but not limited to coverage required by workers' compensation, no-fault automobile insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Mental Illness or Sickness that would have been covered under workers' compensation or similar legislation had that coverage been elected. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

N. Transplants

Health services for organ or tissue transplants are excluded, except those specified as covered in Section 1 of the COC. Any solid organ transplant that is performed as a treatment for cancer. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. Health services for transplants involving mechanical or animal organs. Any multiple organ transplant not listed as a Covered Health Service in Section 1 of the COC.

O. Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered transplantation services may be reimbursed at our discretion.

P. Vision and Hearing

Purchase cost of eye glasses, contact lenses, or hearing aids. Fitting charge for hearing aids, eyeglasses or contact lenses. Eye exercise therapy. Surgery that

is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

Q. Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see definition in Section 10 of the COC.

Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations or treatments otherwise covered under the Policy, when such services are: (1) required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption; (2) relating to judicial or administrative proceedings or orders; (3) conducted for purposes of medical research; or (4) to obtain or maintain a license of any type.

Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

Health services received after the date your coverage under the Policy ends, including health services for medical conditions arising prior to the date your coverage under the Policy ends.

Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.

Charges in excess of Eligible Expenses or in excess of any specified limitation.

Orthognathic surgery or jaw alignment, except as treatment for tempormandibular joint or obstructive sleep apnea.

Surgical treatment and non-surgical treatment of obesity (including morbid obesity).

Growth hormone therapy, except as a Dependant child who requires growth hormones to treat a Congenital Anomaly; sex transformation operations; treatment of benign gynecomastia (abnormal breast enlargement in males); medical and surgical treatment of excessive sweating (hyperhidrosis); medical and surgical treatment for snoring, except when provided as part of treatment for documented obstructive sleep apnea. Oral appliances for snoring. Custodial care; domiciliary care; private duty nursing; respite care; rest cures.

Psychosurgery. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke or Congenital Anomaly.

This summary of Benefits is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This plan may not cover all your health care expenses. Please refer to the Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions

of coverage. If this description conflicts in any way with the Certificate of Coverage, the Certificate of Coverage prevails. Terms that are capitalized in the Benefit Summary are defined in the Certificate of Coverage.

04I_BS_HSAChcPIs NCLGFM3704 DDA 430-3540_1105

MONTHLY RATES- OPTION II

Employee (City pays \$425.47)	\$30
Employee & Spouse	\$452.88
Employee & Children	\$384.51
Family	\$833.02

NOTES:

Employees will pay \$30 for individual coverage and 100% of dependent rates.

Premium may be discounted through the Alive & Well Program.

For customer service questions and claims, please call
United Healthcare Services: 800-259-1605

For banking related questions on your account, please call
Exante Bank at 800-791-9361



UnitedHealthcare Pharmacy

Management Plan 036

UnitedHealthcare's pharmacy management program provides clinical pharmacy services that promote choice, accessibility and value. The program offers a broad network of pharmacies (more than 50,000 nationwide) to provide convenient access to medications.

While most pharmacies participate in our network, you should check first. Call your pharmacist or visit our online pharmacy service at www.myuhc.com. The online service offers you home delivery of prescriptions, ability to view personal benefit coverage, access health and well being information, and even location of network retail neighborhood pharmacies by zip code.

COPAYMENT PER PRESCRIPTION ORDER OR REFILL

For a single Copayment, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits. You are responsible for paying the lower of the applicable Copayment or the retail Network Pharmacy's Usual and Customary Charge, or the lower of the applicable Copayment or the mail order Pharmacy's Prescription Drug Cost.

Also note that some Prescription Drug Products require that you notify us in advance to determine whether the Prescription Drug Product meets the definition of a Covered Health Service and is not Experimental, Investigational or Unproven.

	Tier 1- Refer to the United Healthcare Pharmacy Management Plan	Tier 2- Refer to the United Healthcare Pharmacy Management Plan	Tier 3- Refer to the United Healthcare Pharmacy Management Plan
Retail Network Pharmacy For up to a 31 day supply	\$10	\$20	\$40
Mail Service Network Pharmacy For up to a 90 day supply	\$25	\$50	\$100
Retail Non-Network Pharmacy For up to a 31 day supply	\$10	\$20	\$40

*Our Preferred Drug List includes those drugs available to you at the most affordable cost. It is one of the best ways to maximize your prescription drug benefits. The drug list, developed by physicians and pharmacists on our national Pharmacy and Therapeutics committee, includes a wide selection of generic and

brand name prescription medications commonly prescribed by physicians. The Preferred Drug List is updated throughout the year. The most current version is available at our online pharmacy at www.myuhc.com.

OTHER IMPORTANT COST SHARING INFORMATION

NOTE: If you purchase Prescription Drug Product from a Non-Network pharmacy, you are responsible for any difference between what the Non-Network pharmacy charges and the amount we would have paid for the same Prescription Drug Product dispensed by a Network pharmacy.

ANNUAL DRUG DEDUCTIBLE FOR NETWORK AND NON-NETWORK PHARMACIES

\$100 per Covered Person per calendar year, not to exceed \$300 for all covered persons in a family.

EXCLUSIONS

Exclusions from coverage listed in the Certificate apply also to this Rider. In addition, the following exclusions apply:

- Outpatient Prescription Drug Products obtained from a non-Network Pharmacy.
- Coverage for Prescription Drug Products for the amount dispensed (days supply or quantity limit) which exceeds the supply limit.
- Drugs which are prescribed, dispensed or intended for use while you are an inpatient in a Hospital, Skilled Nursing Facility, or Alternate Facility.
- Experimental, Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental.
- This exclusion does not apply to any drug solely on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not yet been approved by the FDA as specifically described in Section 2 of the COC.
- Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
- Prescription Drug Products for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
- Any product dispensed for the purpose of appetite suppression and other weight loss products.

- Compounded drugs that do not contain at least one ingredient that requires a Prescription Order or Refill.
- Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed. Any drug that is therapeutically equivalent to an over-the-counter drug.
- A specialty medication Prescription Drug Product (such as immunizations and allergy serum) which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This does not apply to Depo Provera and other injectable drugs used for contraception.
- Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
- Prescription Drug Products when prescribed to treat infertility.
- Replacement Prescription Drug Products resulting from a lost, stolen, broken or destroyed Prescription Order or Refill.
- General and Injectable Vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
- Prescription Drug Products for smoking cessation.
- Unit dose packaging of Prescription Drug Products.
- Medications used for cosmetic purposes.
- New Prescription Drug Products and/or new dosage forms until they are reviewed and approved by our Pharmacy and Therapeutics Committee.
- Prescription Drug Products, including new Prescription Drug Products, or new dosage form that are determined to not be a Covered Health Service.

This Summary of Benefits is intended only to highlight your benefits for outpatient Prescription Drug Products and should not be relied upon to determine coverage. Your plan may not cover all your outpatient prescription drug expenses. Please refer to your Outpatient Prescription Drug Rider and the Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Outpatient Prescription Drug Rider or the Certificate of Coverage, the Outpatient Prescription Drug Rider and Certificate of Coverage prevail. Capitalized terms in the Benefit Summary are defined in the Outpatient Prescription Drug Rider and/or Certificate of Coverage.

City of Kannapolis Dental- Plan II

Effective Date: July 1, 2008

NOTE: Only employees covered at the time of their retirement are eligible for retiree coverage. Dependents can be covered under retiree coverage, **only if they have been covered no less than 12 months prior to the employees' retirement date.** Dependents acquired after retirement are not eligible for coverage.

LIMITATIONS** - Payment will be 50% of the normal allowed amount if the participant elects coverage for himself or a dependent more than one month after the date he or his dependent is eligible ***regardless of the enrollment reason, unless there is a qualifying event. The following dental services will be limited:

- Restorative
 - Prosthetic
 - Orthodontia (for governmental units which elected this benefit)
- This provision will not apply to covered dental expenses which are incurred after the Participant or his dependent has been continuously covered for 12 months.

***See a complete list of limitations in Certificate Booklet.**

OVERALL CALENDAR YEAR DEDUCTIBLE - \$50.00 Individual; \$100.00 Family
Deductible does not apply to preventive services.

MAXIMUM CALENDAR YEAR BENEFIT PER INSURED FOR PREVENTIVE, BASIC, AND MAJOR SERVICES - \$1,000.00

PREVENTIVE SERVICES - Covered at 100% UCR.

- Prophylaxis- 2 per calendar year
- Fluoride (for dependent children under age 14, once a year)
- Oral Exams- 2 per calendar year
- Bitewings- 2 per calendar year; Panorex or Complete Series- once every 3 Calendar years
- X-Rays
- Space Maintainers
- Sealants (for dependent children under age 14; for permanent teeth only; once every 3 years)

BASIC SERVICES - Covered at 80% UCR.

- Extractions, including wisdom teeth extractions
- Oral Surgery, including surgical extraction
- Amalgam, silicate, acrylic, synthetic, porcelain and composite filling restorations to restore diseased or fractured teeth
- General anesthetic- if determined to be medically or orally necessary
- Root canals and other endodontic treatment
- Periodontics
- Adjustments to partials or full dentures

MAJOR SERVICES - Covered at 50% UCR.

- Repair or recementing of crowns, inlays, onlays, bridgework or dentures, or relining or rebasing of dentures more than six months after the installation of an initial or replacement denture
- Initial installation of fixed bridgework, including inlays and crowns as abutments, except periodontal splinting
- Initial installation of partial or full removable dentures
- Replacement of an existing partial or full removable denture or fixed bridgework by a new denture or new bridgework, or the addition of teeth to an existing partial removable denture or to bridgework - please see limitations and exceptions in certificate booklet
- Inlays, onlays, gold fillings or crown restorations to restore diseased or fractured teeth, but only when the tooth, as a result of extensive caries or fracture cannot be restored to proper function with an amalgam, silicate, acrylic, synthetic, or porcelain composite restoration (see limitations)

ORTHODONTICS - Children up to age 19 are eligible (if a full-time student between the age of 19 through age 25, coverage still applies). The deductible does apply.

PRE-DETERMINATION OF BENEFITS

If covered expenses for a course of treatment are expected to be more than \$200, the Participant should submit a description of that course of treatment and an estimate of the Dentist's charges to the Plan Supervisor prior to the commencement of treatment.

SPECIAL CLAIMS FILING NOTE: Claims must be filed within one year from the date covered expense is incurred.

BENEFIT EXCLUSIONS (by way of example but not limited to):

- Treatment by anyone other than a Dentist or Physician, except of performed by a duly qualified technician under the direction of a Dentist or Physician;
- Services performed solely for cosmetic reasons;
- Replacement of a lost or stolen appliance;
- Replacement of a bridge or denture within five years following the date of its original installation;
- Replacement of a bridge or denture which can be made useable according to dental standards;
- Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of TMJ, stabilize periodontal involved teeth, or restore occlusion;
- Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molars;
- Bite registrations; precision or semi-precision attachments; splinting;
- Surgical implant of any type including any prosthetic device attached to it;
- Instruction for plaque control, oral hygiene and diet;
- Dental Services that do not meet common dental standards;
- Services that are deemed to be medical services;
- Services and supplies received from a hospital; medically necessary charges incurred by a participant during confinement in a hospital, including anesthetics, will be considered for payment as a medical expense.

- Charges which the person is not legally required to pay;
- Charges made by a hospital which performs services for the U.S. Government if the charges are directly related to a condition connected to a military service; Experimental or investigational procedures and treatments;
- Any injury resulting from, or in the course of, any employment for wage or profit;
- Any sickness covered under any workers' compensation or similar law;
- Charges in excess of the reasonable and customary allowances;
- Reasonable and customary other than the 90th percentile

Plan Sponsored by:
 NCLM Risk Management Services
 P O Box 1310
 Raleigh, NC 27602

Plan Supervised by:
 CIGNA HealthCare
 P O Box 188037
 Chattanooga, TN 37422-7534

Claims Filing Address:
 CIGNA HealthCare
 P O Box 188037
 Chattanooga, TN 37422-8037

**FOR ELIGIBILITY OR CLAIMS QUESTIONS CALL: 1-800-244-6224
 Group Account # 3211260**

PLAN II MONTHLY RATES

	<u>Total Premium</u>	<u>Employee Pays</u>
Employee Only	\$24.50	\$0
Employee + Spouse	\$49.00	\$24.50
Employee + Child(ren)	\$69.50	\$45.00
Employee + Family	\$78.50	\$54.00

NOTES: City of Kannapolis will pay the employee only premium rate for Plan II. Employees electing any level of coverage under Plan III will pay the difference in the individual rate (\$8.50) plus the dependent coverage.

Dental rates are pending North Carolina League of Municipalities Board of Director's approval, which is anticipated for May.

City of Kannapolis Dental- Plan III

Effective Date: July 1, 2008

NOTE: Only employees covered at the time of their retirement are eligible for retiree coverage. Dependents can be covered under retiree coverage, **only if they have been covered no less than 12 months prior to the employees' retirement date.** Dependents acquired after retirement are not eligible for coverage.

***LIMITATIONS** - Payment will be 50% of the normal allowed amount if the participant elects coverage for himself or a dependent more than one month after the date he or his dependent is eligible **regardless of the enrollment reason, unless there is a qualifying event.** The following dental services will be limited:

- Restorative
- Prosthetic
- Orthodontia (for governmental units which elected this benefit)

This provision will not apply to covered dental expenses which are incurred after the Participant or his dependent has been continuously covered for 12 months.

OVERALL CALENDAR YEAR DEDUCTIBLE - \$50.00 Individual; \$100.00 Family
Deductible does not apply to preventive services.

MAXIMUM CALENDAR YEAR BENEFIT PER INSURED FOR PREVENTIVE, BASIC, AND MAJOR SERVICES - \$1,500.00

PREVENTIVE & DIAGNOSTIC CARE - Covered at 100% UCR.- no deductible

- Oral Exams (Two per Calendar Year) Cleanings (Two per Calendar Year)
- Full Mouth X-rays (One complete set every 3 Calendar Years)
- Bitewing X-rays (Two per Calendar Year)
- Panoramic X-ray (One per every 3 Calendar Years)
- Fluoride Application (One per Calendar Year, up to age 14)
- Space Maintainers (Limited to non-orthodontic treatment)
- Sealants (Limited to permanent posterior teeth, up to age 14)
- Emergency Care to relieve pain

BASIC RESTORATIVE CARE - Covered at 80% UCR- after deductible

- Fillings Root
- Canal Therapy
- Osseous Surgery
- Periodontal Scaling and Root Planing
- Denture Adjustments and Repairs
- Extractions
- Anesthetics
- Oral Surgery

MAJOR RESTORATIVE CARE- Covered at 80% UCR- after deductible

- Crowns
- Dentures
- Bridges

ORTHODONTIA- (Limited to dependent children through age 25). Covered at 50% after plan deductible. Lifetime Maximum is \$1,000.

MISSING TOOTH PROVISION- Individual is covered at 50% until insured for 24 months.

PRE-DETERMINATION OF BENEFITS

If covered expenses for a course of treatment are expected to be more than \$200, the Participant should submit a description of that course of treatment and an estimate of the Dentist's charges to the Plan Supervisor prior to the commencement of treatment.

SPECIAL CLAIMS FILING NOTE: Claims must be filed within one year from the date covered expense is incurred.

BENEFIT EXCLUSIONS (by way of example but not limited to):

- Treatment by anyone other than a Dentist or Physician, except of performed by a duly qualified technician under the direction of a Dentist or Physician;
- Services performed solely for cosmetic reasons;
- Replacement of a lost or stolen appliance;
- Replacement of a bridge or denture within five years following the date of its original installation;
- Replacement of a bridge or denture which can be made useable according to dental standards;
- Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of TMJ, stabilize periodontal involved teeth, or restore occlusion;
- Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molars;
- Bite registrations; precision or semi-precision attachments; splinting;
- Surgical implant of any type including any prosthetic device attached to it;
- Instruction for plaque control, oral hygiene and diet;
- Dental Services that do not meet common dental standards;
- Services that are deemed to be medical services;
- Services and supplies received from a hospital; medically necessary charges incurred by a participant during confinement in a hospital, including anesthetics, will be considered for payment as a medical expense.
- Charges which the person is not legally required to pay;
- Charges made by a hospital which performs services for the U.S. Government if the charges are directly related to a condition connected to a military service;
- Experimental or investigational procedures and treatments;
- Any injury resulting from, or in the course of, any employment for wage or profit;
- Any sickness covered under any workers' compensation or similar law;
- Charges in excess of the reasonable and customary allowances;
- Reasonable and customary other than the 90th percentile

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Chattanooga, TN 37422-8037

FOR ELIGIBILITY OR CLAIMS QUESTIONS CALL: 1-800-244-6224
Group Account # 3211260

PLAN III MONTHLY RATES(ALTERNATE PLAN)

	<u>Total Premium</u>	<u>Employee Pays</u>
Employee Only	\$33.00	\$8.50
Employee + Spouse	\$66.00	\$41.50
Employee + Child(ren)	\$92.00	\$67.50
Employee + Family	\$103.00	\$78.50

NOTE: City of Kannapolis will pay the employee only premium rate for Plan II. Employees electing any level of coverage under Plan III will pay the difference in the individual rate (\$8.50) plus the dependent coverage.

Dental rates are pending North Carolina League of Municipalities Board of Director's approval, which is anticipated for May.

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.

THIS 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
- Coverage is portable. Employees can keep the coverage if they change jobs.

Selected benefits paying cash to you:

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

**Cancer Facts & Figures, American Cancer Society, 2001.*

***Report from the American Hospital Administration.*

Assurity Cancer & Specified Disease Plan

Effective Date: July 1, 2008

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 disease for the first 75 days of each period of confinement. There are three options for the daily benefit amount: \$150, \$250, and \$350. (NOTE: The \$150 benefit amount is not available in Utah.)

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 the maximum amount purchased.

The monthly option for this benefit is:

- **\$10,000 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 nonlocal 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 www.markiiibrokerage.com/cityofkannapolisnc. 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**.

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.

Issue Age- The Assurity cancer plan 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.

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/cityofkannapolisnc. 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**.

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.

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.

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.

Assurity Life Insurance Company
PO Box 80926, Lincoln, NE, 68501-0926
Assurity Customer Service: (866) 289-7337
Website: www.assurityatwork.com

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

Assurity Life Cancer & Specified Disease Plan- Monthly Rates

		\$150 Daily Benefit	\$250 Daily Benefit	\$350 Daily Benefit
Base Policy (\$10,000 per month/\$100,000 lifetime maximum) (radiation/chemotherapy)	Individual	\$20.92	\$23.22	\$25.52
	EE & Spouse	\$32.04	\$35.62	\$39.19
	EE & Children	\$25.99	\$28.60	\$31.21
	Family	\$37.11	\$41.00	\$44.88
Base Policy with Intensive Care Rider (\$300 daily benefit)	Individual	\$23.02	\$25.32	\$27.62
	EE & Spouse	\$36.24	\$39.82	\$43.39
	EE & Children	\$29.29	\$31.90	\$34.51
	Family	\$42.51	\$46.40	\$50.28
Base Policy with Intensive Care Rider (\$600 daily benefit)	Individual	\$25.12	\$27.42	\$29.72
	EE & Spouse	\$40.44	\$44.02	\$47.59
	EE & Children	\$32.59	\$35.20	\$37.81
	Family	\$47.91	\$51.80	\$55.68
Base Policy with First Occurrence Benefit Rider (\$2,500 benefit)	Individual	\$23.75	\$26.05	\$28.35
	EE & Spouse	\$36.27	\$39.85	\$43.42
	EE & Children	\$29.41	\$32.02	\$34.63
	Family	\$41.93	\$45.82	\$49.70
Base Policy with First Occurrence Benefit Rider (\$2,500 benefit) and Intensive Care Rider (\$300 daily benefit)	Individual	\$25.85	\$28.15	\$30.45
	EE & Spouse	\$40.47	\$44.05	\$47.62
	EE & Children	\$32.71	\$35.32	\$37.93
	Family	\$47.33	\$51.22	\$55.10
Base Policy with First Occurrence Benefit Rider (\$2,500 benefit) and Intensive Care Rider (\$600 daily benefit)	Individual	\$27.95	\$30.25	\$32.55
	EE & Spouse	\$44.67	\$48.25	\$51.82
	EE & Children	\$36.01	\$38.62	\$41.23
	Family	\$52.73	\$56.62	\$60.50
Base Policy with First Occurrence Benefit Rider (\$5,000 benefit)	Individual	\$26.58	\$28.88	\$31.18
	EE & Spouse	\$40.50	\$44.08	\$47.65
	EE & Children	\$32.83	\$35.44	\$38.05
	Family	\$46.75	\$50.64	\$54.52
Base Policy with First Occurrence Benefit Rider (\$5,000 benefit) and Intensive Care Rider (\$300 daily benefit)	Individual	\$28.68	\$30.98	\$33.28
	EE & Spouse	\$44.70	\$48.28	\$51.85
	EE & Children	\$36.13	\$38.74	\$41.35
	Family	\$52.15	\$56.04	\$59.92
Base Policy with First Occurrence Benefit Rider (\$5,000 benefit) and Intensive Care Rider (\$600 daily benefit)	Individual	\$30.78	\$33.08	\$35.38
	EE & Spouse	\$48.90	\$52.48	\$56.05
	EE & Children	\$39.43	\$42.04	\$44.65
	Family	\$57.55	\$61.44	\$65.32



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

Effective Date: July 1, 2008

AccidentSelect® According to the National Safety Council's *Accident Facts*, 2006 Edition, every two seconds someone in this country suffers an accidental injury. In addition, the Council points out that for people ages 1 to 34, accidents are the number one cause of death.

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

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

ASL EDGKP 0408

SCHEDULE OF BENEFITS (continued)

PLAN I PLAN II

<p>B. Tendons and Ligaments Tendons and ligaments must be torn, ruptured or severed and must be treated by a physician within 72 hours after the Covered Accident and repaired through surgery within six months after the Covered Accident. If a Covered Person receives a fracture and/or a dislocation and also tears, ruptures, or severs a tendon/ ligament in a Covered Accident, the Insurer will pay only one benefit. The Insurer will pay the largest of this benefit, the Fractures Benefit or the Dislocation Benefit.</p> <p>Repair of one Repair of all if more than one</p>	<p>\$330 \$665</p>	<p>\$665 \$1,330</p>
<p>C. Burns (Treated by a physician within 72 hours after the accident)</p> <p>1. Second-degree burns of at least 25% - 35% of body surface 2. Second-degree burns of more than 35% of body surface 3. Third-degree burns covering 6 through 9 square inches of body surface 4. Third-degree burns covering 10 through 25 square inches of body surface 5. Third degree burns covering more than 25 square inches of body surface</p>	<p>\$265 \$665 \$530 \$1,330 \$2,665</p>	<p>\$530 \$1,330 \$1,065 \$2,665 \$5,330</p>
<p>D. Ruptured Disc or Torn Knee Cartilage Must be treated by a physician within 72 hours after the accident and repaired through surgery within one year after the Covered Accident.</p> <p>Accident during first year of coverage Thereafter</p>	<p>\$130 \$400</p>	<p>\$265 \$800</p>
<p>E. Eye Injury With surgical repair</p>	<p>\$130</p>	<p>\$265</p>
<p>Accident Follow-up Treatment Benefit Pays for additional treatment of injuries sustained in a Covered Accident over and above emergency treatment administered within 72 hours following the accident. This benefit is payable for up to a maximum of three treatments per Covered Person per Covered Accident. Such treatment must begin within 30 days of the Covered Accident or discharge from the hospital or extended care facility, and be within the six-month period following the Covered Accident or discharge. Treatments must be furnished by a physician in a physician's office or in a hospital on an outpatient basis. (Benefits will not be paid for services rendered by a member of the immediate family of a Covered Person.)</p>	<p>\$25/visit</p>	<p>\$25/visit</p>
<p>Accident Emergency Treatment Benefit Pays for emergency treatment for a Covered Accident, we will pay the amount shown in the Policy Schedule for treatment received. This benefit is payable for treatment by a physician, x-rays or treatment received in a hospital emergency room. Treatment must be received within 72 hours of such accident for benefits to be payable. This benefit is payable once per Covered Accident. (Benefits will not be paid for services rendered by a member of the immediate family of a Covered Person.)</p> <p>Insured & Spouse Children</p>	<p>\$100 \$70</p>	<p>\$150 \$105</p>
<p>Initial Hospitalization For Injury Benefit When a Covered Person is hospital confined for 24 hours or more for a covered accidental bodily injury, the Insurer will pay the benefit amount shown in the Policy Schedule. This benefit is payable only once per Hospital Confinement and only once for each Covered Person per calendar year.</p>	<p>\$500</p>	<p>\$1,500</p>

SCHEDULE OF BENEFITS (continued)

PLAN I PLAN II

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

SCHEDULE OF BENEFITS (continued)

PLAN I PLAN II

<p>Family Lodging Benefit Pays for one motel or hotel room for a member (or members) of the immediate family to accompany the Covered Person for hospital confinement for the treatment of injuries sustained in a Covered Accident. This benefit is payable only during the same period of time the injured Covered Person is confined to the hospital. Benefit is not payable for the trip to the hospital. The hospital and the motel or hotel must be more than 100 miles from the residence of the Covered Person. The local attending physician must prescribe the treatment. This benefit is payable for up to 30 days per Covered Accident.</p>		\$100/day	\$100/day
<p>Wellness Benefit After 12 months of paid premium for this benefit, the Insurer will pay for an Insured to undergo routine examinations or other preventive testing. Benefits include and are payable for: annual physical exams; mammograms, pap smears, immunizations, flexible sigmoidoscopy, Prostatic Specific Antigen, and blood screenings. This benefit will become available following each anniversary of this Rider's Effective Date, and is payable only once each 12-month period. Family members include an insured employee's spouse and dependent children. Services must be under the supervision of, or recommended by a physician, and a charge must be incurred.</p>		\$60/year	\$60/year
<p>Accidental Death Benefit Death must occur as a result of a Covered Accident and must occur within 90 days of a Covered Accident.</p>			
PLAN I			
	Insured	Spouse	Child
Common-Carrier Accidents	\$35,000	\$17,500	\$3,500
Motorized-Vehicle or Pedestrian Accidents	25,000	\$12,500	\$2,500
Other Accidents	15,000	\$7,500	\$1,500
PLAN II			
Common-Carrier Accidents	\$70,000	\$35,000	\$7,000
Motorized-Vehicle or Pedestrian Accidents	50,000	25,000	\$5,000
Other Accidents	30,000	15,000	\$3,000
<p>Accidental Dismemberment Pays a percentage of the Accidental Death Benefit selected.</p>		PLAN I	PLAN II
Both arms and both legs		100%	100%
Two arms or two legs		50%	50%
Two eyes, hands, or feet		50%	50%
One eye, hand, foot, arm, or leg		20%	20%
One or more fingers and/or one or more toes		5%	5%

IMPORTANT INFORMATION

RENEWABILITY

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

EFFECTIVE DATE

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

ISSUE AGES

AccidentSelect is available to individuals 18 through 64. Coverage is available for your eligible dependent children under age 19, if living with the Insured, (through age 24 if the child is a full-time student). This may vary by state.

FAMILY COVERAGE

Spouse and dependent children coverage is available. Family Coverage includes the Insured, his or her spouse, and all dependent, unmarried children through age 24. Newborn children are automatically covered under the terms of the policy from the moment of birth. Single-Parent Coverage includes the Insured and all of his or her eligible dependent children who are unmarried and under 19. Coverage is extended to your eligible dependent children who are age 19 through 24 if they are full time students.

TIME LIMIT ON CERTAIN DEFENSES

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

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

FRAUDULENT MISSTATEMENT

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

ADDITIONAL LIMITATIONS AND EXCLUSIONS

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

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

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

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

This summary provides information about AccidentSelect I and II (Policy Form Series TPA0100 or CP500100 with Riders Form Series TRA0100, CR500100, TRA0200 or CR500200, TRA0300 or CR500300, TRA0400 or CR500400, TRA0500 or CR500500, TRA0700 or CR500700, TRW0100 or CR501000, and TRIH0200 or CR501100) underwritten by Transamerica Life Insurance Company, Home Office, Cedar Rapids, IA.

Form and number may vary and coverage may not be available in all jurisdictions.

**For Claims or Customer Service on your policy, please call
Transamerica Life Insurance Company at: (888) 763-7474**

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

Monthly Rates

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

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

Disability Is A Fact of Life

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

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

Could You Live Off Of Savings?

Standard Life Short Term Disability Plan

Effective Date: July 1, 2008 (pending underwriting approval)

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

ACCIDENT & SICKNESS PROTECTION

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

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

Benefit Duration: 90 Days

Monthly Benefit	Monthly Premium
\$500	\$11.25
\$600	\$13.50
\$700	\$15.75
\$800	\$18.00
\$900	\$20.25
\$1,000	\$22.50
\$1,100	\$24.75
\$1,200	\$27.00
\$1,300	\$29.25
\$1,400	\$31.50
\$1,500	\$33.75
\$1,600	\$36.00
\$1,700	\$38.25
\$1,800	\$40.50
\$1,900	\$42.75
\$2,000	\$45.00

Benefit Duration: 180 Days

Monthly Benefit	Monthly Premium
\$500	\$17.50
\$600	\$21.00
\$700	\$24.50
\$800	\$28.00
\$900	\$31.50
\$1,000	\$35.00
\$1,100	\$38.50
\$1,200	\$42.00
\$1,300	\$45.50
\$1,400	\$49.00
\$1,500	\$52.50
\$1,600	\$56.00
\$1,700	\$59.50
\$1,800	\$63.00
\$1,900	\$66.50
\$2,000	\$70.00

Benefit Duration: 365 Days

Monthly Benefit	Monthly Premium
\$500	\$22.50
\$600	\$27.00
\$700	\$31.50
\$800	\$36.00
\$900	\$40.50
\$1,000	\$45.00
\$1,100	\$49.50
\$1,200	\$54.00
\$1,300	\$58.50
\$1,400	\$63.00
\$1,500	\$67.50
\$1,600	\$72.00
\$1,700	\$76.50
\$1,800	\$81.00
\$1,900	\$85.50
\$2,000	\$90.00

Eligibility

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

POLICY FEATURES

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

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

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

Limits and Exclusions:

Benefits will not be paid for any total disability which:

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

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

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

If you have any questions regarding the Standard Life Disability Plan, **please call: 800-327-0695**

Toll Free Claims Line: 800-227-0251



Lincoln Financial Group Term Life

Effective Date: (pending underwriting approval)

This is only a summary of coverage and is not a binding contract. A certificate of coverage will be made available to you shortly, which describes the benefits in greater detail. Should there be differences between this summary and the contract, the contract will govern.

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. To help meet this need, you have the opportunity to elect additional group life insurance under the optional portion of your plan.

OPTIONAL DEPENDENT LIFE INSURANCE

Provides coverage on:

- Your Spouse
- Child(ren) from **14 days of age to age 19** (up 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 if handicap is diagnosed prior to age 19.

(It is your responsibility to notify payroll in writing when a dependent is ineligible for coverage. Examples of ineligible dependent status are divorce or a child graduates from college).

ACCIDENTAL DEATH AND DISMEMBERMENT

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

AD&D Exclusions: Benefits are not payable for any loss to which a contributing cause is:

- intentional self-inflicted injury or intentional self-destruction;
- disease, bodily or mental infirmity, or medical or surgical treatment of these; except for:
 - (a) a bacteria infection resulting from an accidental cut or wound;
 - (b) the accidental ingestion of a poisonous food substance;
- participation in a riot;
- duty as a member of any military, naval or air force;
- war or any act of war, declared or undeclared;
- participation in the commission of a felony;
- voluntary use of drugs; except when prescribed by a physician;
- voluntary inhalation of gas, including carbon monoxide;
- travel or flight in any aircraft, including balloons and gliders; except as a fare paying passenger on a regularly scheduled flight; or
- driving a vehicle while intoxicated.

ELIGIBILITY

You will be eligible for insurance if you are a permanent full-time employee.

ENROLLMENT

Enrollment is simple - just fill out the election card provided by your employer. You have 31 days to enroll yourself and dependents without evidence of insurability. You will be notified as to when coverage starts.

BENEFICIARY

You have the right to designate the beneficiary of your choice under employee coverage. The beneficiary elected on your life enrollment form designates your beneficiary for basic and optional coverage. You are automatically the beneficiary under Dependent Life. It is your responsibility to update the beneficiary designation as needed.

SUICIDE EXCLUSION

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

WHEN YOUR BASIC INSURANCE STARTS

If you enroll on or before the day you become eligible your insurance becomes effective on the date of your eligibility if you are then actively at work; otherwise on the day you return to active work.

WHEN YOUR OPTIONAL INSURANCE STARTS

If you meet the eligibility requirements 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 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 Lincoln Financial Group.

REDUCTIONS AT AGE 65 AND OVER ON BASIC TERM LIFE COVERAGE

If you remain in active service beyond age 65, your Basic Employee Life Insurance will reduce as follows:

<u>Attained Age</u>	<u>Reduction Schedule</u>
65	benefits will reduce by 35% of original amount
70	benefits will reduce an additional 20% of original amount
75	benefits will reduce an additional 15% of original amount

TERMINATION OF COVERAGE

All insurance under this plan will terminate upon the earlier of retirement, termination of employment, when the plan ceases or when you withdraw from the plan. Please see the "Death During Conversion Period" provision on the Conversion page of the Certificate Booklet.

DISABILITY- (Prior to age 60)

If an insured becomes totally disabled prior to age 60, the amount of group life coverage may be continued without payment of premium. After the first two years of Total Disability, the Company will not request proof or an exam more than once a year. Please refer to the Certificate Booklet for the Waiver of Premium provision at Social Security Normal Retirement Age.

STATEMENT OF HEALTH

Increases in coverage, a re-entry in the plan and participants who enroll 31 days beyond the eligibility period will be required to provide evidence of insurability satisfactory to Lincoln Financial Group.

APPROVED LEAVE OF ABSENCE

If you are on leave (off the payroll) you may continue your group term life insurance for a period of 3 months by paying the cost of your Basic Employee Life Insurance plus the cost of your Optional Life Insurance. Amounts of insurance may be continued for a period of not longer than the last day of the month following the month which leave occurs.

CONVERSION

If your employment terminates while you are covered under the plan, you may purchase without medical evidence of insurability, any individual insurance policy, (without AD&D) except a term policy, issued by Lincoln Financial Group 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 and Optional Dependent Life Insurance as well as the Basic Employee Life Insurance. Please refer to the Certificate Booklet for more details.

CONTINUATION OF COVERAGE

This option gives you the opportunity to continue your Term Life Insurance policy without submitting Evidence of Insurability, if employment or policy terminates due to anything other than sickness, injury or retirement. Coverage must be in force for at least 12 months in a row to be eligible. Continuation of coverage applies to Optional Employee Life Insurance and Accidental Death and Dismemberment.

THE ACCELERATED DEATH BENEFIT (ADB)

Lincoln Financial Group has included an Accelerated Death Benefit (ADB) 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 an advance payment of up to 75% or \$250,000, (whichever is less) of your Life Insurance benefit amount. Please refer to your Certificate Booklet for details.

CLAIMS PROCEDURE

Claim forms needed to file for benefits under the group insurance plan can be obtained from your employer who will also be ready to answer questions about the insurance benefits and to assist in filing claims. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully. 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. Please refer to the Certificate Booklet for more details.

SCHEDULE OF BENEFITS

BASIC EMPLOYEE LIFE INSURANCE & AD&D

All Eligible EmployeesOne Times your Base Annual Earnings, rounded to the next \$1,000. Maximum, \$100,000. (No Cost To You)

OPTIONAL EMPLOYEE LIFE INSURANCE AND AD&D*

Your choice of the following amounts: \$10,000, \$20,000, \$30,000, \$40,000, \$50,000, \$100,000

Guaranteed Issue Amounts:

A new employee can elect \$100,000 without submitting a Health Statement

Employee less than age 60: \$50,000

Employees age 60 to 69: \$20,000

Employees over age 70: No Guarantee Issue

OPTIONAL DEPENDENT LIFE INSURANCE*

- \$2,500 on your spouse
- \$2,500 on each of your eligible children (*Regardless of the number of children*)

Employee Optional Monthly Cost

\$100,000	\$24.00
\$50,000	\$12.00
\$40,000	\$9.60
\$30,000	\$7.20
\$20,000	\$4.80
\$10,000	\$2.40

Optional Dependent Monthly Cost

Family Coverage (Spouse & Children) \$1.06

*The payroll deductions for the term life is post-tax

For Questions regarding the status of your statement of health or life claim, please contact your Benefits Department at: 800-423-2765

Coverage is underwritten by Lincoln Financial Group company. Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

PLAN ADMINISTRATOR

City of Kannapolis
246 Oak Avenue
Kannapolis, NC 28082
(704) 920-4300

Unum Voluntary Individual Universal Life Insurance Plan

Effective Date: August 1, 2008 (pending underwriting approval)

VALUABLE INSURANCE PROTECTION

Unum's Voluntary Individual Universal Life Insurance can help provide the insurance protection you need, while also giving you the financial flexibility you want. This policy is designed to provide a death benefit to your beneficiaries if you pass away in addition to the life insurance coverage your employer may already be providing for you. For an affordable premium, you can help provide more financial protection for your family — now and into the future.

LIVING BENEFIT OPTION INCLUDED

This feature is automatically included for all eligible employees and spouses between the ages of 15 and 79 and children/grandchildren ages 14 days through 24 years for no additional premium. It provides the option of requesting up to 75% of the policy's death benefit, to a maximum of \$150,000, if the insured is diagnosed with a medical condition limiting life expectancy to 12 months or less. Any payout reduces the death benefit. If you have to face a terminal illness, this option can provide additional financial assistance during a difficult time.

CONVENIENT PAYROLL DEDUCTION

Your premiums are automatically deducted from your paycheck, so you don't have to worry about writing checks or mailing payments.

NO PHYSICALS REQUIRED

If you are actively at work¹, you may apply for coverage by completing an application and no physical exams are required! Your coverage becomes effective on the date you sign the application. You may be asked health-related questions which may affect issuance of coverage.

CONTINUATION OF COVERAGE

If you retire or leave your company, you can take your policy with you and still pay the same premium. Instead of paying your premiums through payroll deduction, Unum will bill you directly at home.

CASH VALUE ACCUMULATION FEATURE

Voluntary Individual Universal Life Insurance can build cash value that earns interest. The interest rate your policy is credited with will never be less than the guaranteed minimum rate of 4.0%. It is important for you to remember, as with all universal life policies, that the projected cash value of your policy may change over time. Such changes can result from fluctuations in interest rates, scheduled changes in the cost of insurance, or non-payment of premiums, policy loans and loan interest. We encourage you to maintain consistent premium payments and repay any outstanding loans in a timely fashion to avoid an early lapse in coverage or termination of your policy.

ADDITIONAL FEATURES

Accidental Death Benefit Rider

- Available to employees and spouse between the ages of 15 - 65 for an additional premium.
- Provides an additional death benefit equal to the face amount, up to a maximum of \$150,000, if the insured dies as a result of an accident before age 70.
- Under certain conditions, the benefit will double if death occurs from injuries sustained while the insured is a fare-paying passenger via commercial transportation.
- Benefits increase 25% if death occurs from accidental bodily injury sustained while wearing a seatbelt in a non-commercial automobile.

Long Term Care Rider

- Designed to provide access to your policy's death benefit to help cover the expenses related to long term care.
- Available at initial offering to employees and spouses ages 18 through 70. All newly eligible adult policies will automatically receive the Long Term Care rider with base policy face amounts of at least \$10,000.

FAMILY COVERAGE

• Spouse Coverage

Voluntary Individual Universal Life coverage is available for your spouse based on a qualifying health question. However, no physical exams are required and coverage is available even if you don't apply for coverage yourself.² A few additional health questions may be asked based on the level of coverage being applied for.

• Children's Standalone Coverage

Interest Sensitive Whole Life is offered to children, stepchildren, legally adopted children and grandchildren between the ages of 14 days and 24 years² who reside in the United States. Life is unpredictable. But you can take steps to help protect your family now and into the future with Unum's Voluntary Individual Universal Life insurance. Ask your benefits counselor for more information.

FREQUENTLY ASKED QUESTIONS

Am I required to apply to participate in this coverage?

No. Your coverage is voluntary, and you decide if it is right for you and your family's needs. It's your choice.

Who becomes the owner of the policy?

Unum's Voluntary Individual Universal Life Insurance policy is just that--voluntary and individual. This means that electing coverage is optional, and if you decide coverage is right for you, then you become the owner of your policy.

Does this policy automatically replace any of my existing group insurance coverage?

No. Voluntary Individual Universal life insurance is a supplemental insurance policy and can enhance your group coverage.

Does this policy automatically replace any of my existing group insurance coverage?

No. Voluntary Individual Universal life insurance is a supplemental insurance policy and can enhance your group coverage.

May I increase my coverage in the future?

Yes, your coverage can be increased to meet your changing needs. Once you have owned your policy for one year, you may apply for additional coverage up to the maximum amount available for your age.

May I take a loan on my policy?

Yes, you may borrow part of your cash value from the policy at an annual interest rate of 8.0% per year.

How will I be kept informed of my cash value?

Each year, Unum will mail you a policy statement outlining what you have paid, how much cash value you have, plus the status of any loans, interest credited and applicable administrative charges. These statements are designed to provide you with a valuable record of your policy activity.

Does my policy have a surrender charge?

If you surrender your policy during the first 10 years of coverage, a surrender charge will apply. Beyond the 10th year, there is no surrender charge. A unique 10- year period applies to each increase in coverage.³

Who can I contact if I have questions about my policy after enrolling?

During enrollment, a benefits counselor will be available one-on-one to answer any questions you may have about Voluntary Individual Universal Life Insurance.

If you have questions about your policy after enrolling, simply pick up the phone and call Unum at 1-800-635-5597.

Unum Group's insuring subsidiaries comply with all state civil union and domestic partners laws when applicable.

The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable.

¹ Being "actively at work" means that on the day you apply for coverage, you are working at one of your company's business locations, or you are working at a location where you are required to represent your company. If you are applying for coverage on a day that is not one of your scheduled workdays, then you will be considered actively at work if you meet this definition as of your last scheduled workday. You are not considered actively at work if your normal duties are limited or altered due to your health, or if you are on a leave of absence.

² Policy issue may depend upon answers to health questions contained in the application.

³ Surrender charge schedules may vary by state.

Underwritten by the following subsidiary of Unum Group:

Provident Life and Accident Insurance Company
1 Fountain Square, Chattanooga, TN 37402
www.unum.com

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CU-9127 (04-08)

You may reach Unum Customer Service at: 800-635-5597



Continuation of Benefits

WAGWORKS HEALTH CARE CHOICE SPENDING ACCOUNT

If you have a positive balance (payroll deductions are greater than the amount you have received in reimbursement) in your Health Care Spending 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 selecting one of the COBRA 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 the **City Of Kannapolis Benefits Department at 704- 920-4300.**

UNITED HEALTHCARE & CITY OF KANNAPOLIS DENTAL PLANS

Under the United Healthcare Medical and City of Kannapolis dental plans, you and your covered dependents are eligible to continue coverage through COBRA according to the “qualifying events”.

If you and your dependents are enrolled in either plans, you will be eligible to continue coverage through COBRA after you leave your employment for a specified period. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents may be eligible to continue dental coverage through COBRA. Also, while you are covered under the plan, your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA. Examples of an ineligible dependent would be when your child graduates from college, or reaches the age of not being eligible for dependent coverage. You will receive notification with premium and continuation options shortly following your termination of employment. Should you have any questions you may contact the **City Of Kannapolis Benefits Department at 704-920-4300.**

ASSURITY CANCER PLAN

When you leave employment you may continue your Assurity Cancer coverage by having the premium that is currently deducted from your paycheck drafted from your bank account. You may contact **Assurity at 888-358-8808, ext. 23.**

STANDARD LIFE SHORT TERM DISABILITY PLAN

When you leave employment, you may continue your disability coverage provided continuous employment is maintained. Your new occupation must be within acceptable underwriting guidelines. Coverage expires at age 65. You can have the premium that is currently deducted from your paycheck drafted from your bank account. You may contact **Standard Life at 800- 327-0695.**

LINCOLN FINANCIAL GROUP 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.

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

• CONTINUATION OF COVERAGE

This option gives you the opportunity to continue your Term Life Insurance policy without submitting Evidence of Insurability, if employment or policy terminates due to anything other than sickness, injury or retirement. Coverage must be in force for at least 12 months in a row to be eligible. Continuation of coverage applies to Optional Employee Life Insurance and Accidental Death and Dismemberment.

When you terminate coverage, you should receive a conversion and/or continuation form from your group administrator with the coverage volume and other group related information already completed.

To Continue your coverage, you will submit the necessary premium for a continued policy along with the signed continuation form.

To receive a conversion quote you may call Lincoln Financial Group at 800-423-2765 and one of their Client Management Representatives will assist you with the conversion process.

TRANSAMERICA ACCIDENT POLICY

When you leave employment you may continue your Accident Select coverage by having the premium that is currently deducted from your paycheck drafted from your bank account. **You may contact Transamerica at 800-400-3042.**

UNUM UNIVERSAL LIFE

When you leave employment you may continue your Unum Universal Life coverage by having the premium that is currently deducted from your paycheck drafted from your bank account. You may contact **Unum Life at 800- 635-5597.**

Important Phone Numbers:

City of Kannapolis Benefits Department- 704-920-4300

Mark III Brokerage, Inc.- 800- 532-1044

United HealthCare- 800-259-1605

WageWorks Health Care Choice Flexible Spending Account-877-924-3967

Assurity Cancer - 888-358-8808, ext. 23

Standard Life Short Term Disability - 800-327-0695

Transamerica- 800-400-3042

Lincoln Financial Group - 800-423-2765

Unum Individual Universal Life- 800-635-5597