

Cumberland County Government offers all full-time employees a comprehensive Cafeteria Benefits program. The Cafeteria Benefits program is arranged by Mark III Brokerage, an employee benefits firm that has worked in the public sector since 1973. The Cafeteria Benefits program allows you to pay for certain insurance premiums, work-related childcare, 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 Cafeteria Benefits program includes both pre-taxed and after-taxed benefits.

- The Plan Year is from July 1st to June 30th.
- A Mark III representative will be conducting individual meetings at all scheduled locations.

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*(This booklet highlights the benefits offered through your employer for the current plan year. This is **not** an Insurance Contract and only the actual policy provisions will prevail. All information in this booklet including premiums are subject to change. All policy descriptions are for informational purposes only. Please read your certificate for each product for the exact terms and conditions).*

## ***Key Points to Remember***

- The Plan Year for Cumberland County Government is July 1, 2009 thru June 30, 2010.
- Payroll deductions for this year's enrollment will start on July 10, 2009.
- Please remember that elections made during annual enrollment **cannot be changed once the enrollment period ends** unless you have a qualifying event such as marriage, divorce, death of a spouse or child, birth or adoption, termination of employment or change in employment hours from full-time to part-time or vice-versa.
- If you should have a qualifying event, you will have 30-days from the date of the qualifying event to request a change to your current benefit enrollments and FSA elections. All requests must be done in writing to Julie Crawford in the Cumberland County benefits office.
- You must re-elect your Gilsbar Medical Spending and Dependent Care Accounts each year. They do not automatically carry-over to the next year.
- For current Gilsbar participants, your existing Gilsbar account will be replenished as long as you re-elect the Medical Spending Account. You will NOT receive a new card as your existing card is good for 3 years from the issue date.
- For new Gilsbar participants, a card will be mailed to your home in a **plain white envelope** with no reference to Gilsbar. Again, this card will be good for three (3) years from issue date as long as you re-elect the Medical Spending Account each year.
- Medical Reimbursement and Dependent Care expenses must be incurred during the plan year to be eligible for reimbursement.
- Any questions regarding your Gilsbar Medical Reimbursement or Dependent Care Account can be directed to [www.myGilsbar.com](http://www.myGilsbar.com), or you can call Gilsbar's Customer Contact Center at 1-800-445- 7227 ext. 883.
- Any questions regarding all other benefits can be directed to Julie Crawford at 910-223-3327.

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## BCBS Medical Plan - Summary of Benefits

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Benefit period - July 1, 2009 through June 30, 2010

Benefit payments are based on where the services are received and how the services are billed.

	In-network	Out-of-network*
<b>Physician Office Services</b>		
See Outpatient Services for outpatient clinic or hospital based services. Office visits for the evaluation and treatment of obesity are limited to a combined in-and out-of-network maximum of four visits per benefit period.		
<u>Office Services</u>		
Primary Care Provider	\$20 copayment	70% after ded
Specialist	\$40 copayment	70% after ded
Includes office surgery, x-rays and lab tests. CT Scans, MRIs, MRAs and PET Scans		
	80% after ded	70% after ded
<u>Preventive Care</u>		
Primary Care Provider	100%	Benefits not available
Specialist	100%	Benefits not available
Includes routine physical exams, well baby, well-child care, and immunizations. The following preventive care benefits are available out-of-network: gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, and prostate specific antigen tests. See "Covered Services."		
<u>Short-term Rehabilitative Therapies</u>		
Chiropractic Services	\$40 copayment	70% after ded
	\$20 copayment	70% after ded
Combined in- and out-of-network benefit period maximums apply to home, office and outpatient settings. 30 visits per benefit period for physical/occupational therapy, including chiropractic services. 30 visits per benefit period for speech therapy.		
<u>Other Therapies</u>	100%	70% after ded
Includes chemotherapy, dialysis and cardiac rehabilitation provided in the office. See Outpatient Services for other therapies provided in an outpatient setting.		
<u>Infertility and Sexual Dysfunction Services</u>		
Primary Care Provider	\$20 copayment	70% after ded
Specialist	\$40 copayment	70% after ded
Combined in- and out-of-network lifetime maximum of \$5,000 per member, provided in all places of service.		
<u>Routine Eye Exam</u>	\$20 copayment	Benefits not available

*\*The following notice applies only when you go to an out-of-network provider.*

*NOTICE: Your actual expenses for covered services may exceed the stated coinsurance percentage or copayment amount because actual provider charges may not be used to determine the Plan's and member's payment obligations. For out-of-network benefits, you may be required to pay for charges over the allowed amount, in addition to any copayment or coinsurance amount.*

	<b>In-network</b>	<b>Out-of-network*</b>
<u><b>Urgent Care Centers and Emergency Room</b></u>		
Urgent Care Centers	\$40 copayment	\$40 copayment
Emergency Room Visit	\$150 copayment	\$150 copayment
If admitted to the hospital from the emergency room, inpatient hospital benefits apply to all covered services provided. If held for observation, outpatient benefits apply to all covered services provided. If you are sent to the emergency room from an Urgent Care Center, you may be responsible for both the emergency room copayment and the urgent care copayment.		
<u><b>Ambulatory Surgical Center</b></u>	80% after ded	70% after ded
<u><b>Outpatient Services</b></u>		
<i>Physician Services</i>	80% after ded	70% after ded
<i>Hospital &amp; Hospital-based Services</i>	80% after ded	70% after ded
<i>Outpatient Clinic Services</i>	80% after ded	70% after ded
<i>Outpatient Diagnostic Services:</i>		
<i>Outpatient lab tests and mammography, when performed alone</i>	100%	70% after ded
<i>Outpatient lab tests and mammography, when performed with another service</i>	80% after ded	70% after ded
<i>Outpatient xrays, ultrasounds, and other diagnostic tests, such as EEGs, EKGs and pulmonary function tests</i>	80% after ded	70% after ded
<i>CT scans, MRIs, MRAs and PET scans</i>	80% after ded	70% after ded
<i>Therapy Services</i>	80% after ded	70% after ded
Includes short-term rehabilitative therapies and other therapies including dialysis; see Physician Office Services for visit maximums.		
<u><b>Inpatient Hospital Services</b></u>		
<i>Physician Services</i>	80% after ded	70% after ded
<i>Hospital and Hospital-based Services</i>	80% after ded	70% after ded
Includes maternity delivery, prenatal and post-delivery care.		
<u><b>Skilled Nursing Facility</b></u>	80% after ded	70% after ded
Combined in- and out-of-network maximum of 60 days per benefit period. Services applied to the deductible count towards this day maximum.		
<u><b>Other Services</b></u>	80% after ded	70% after ded
Includes ambulance, durable medical equipment, hospice services, medical supplies, orthotic devices, private duty nursing, prosthetic appliances, and home health care. Orthotic devices for correction of positional plagiocephaly are limited to a lifetime maximum of \$600.		

*\*The following notice applies only when you go to an out-of-network provider.  
NOTICE: Your actual expenses for covered services may exceed the stated coinsurance percentage or copayment amount because actual provider charges may not be used to determine the Plan's and member's payment obligations. For out-of-network benefits, you may be required to pay for charges over the allowed amount, in addition to any copayment or coinsurance amount.*

**In-network**

**Out-of-network\***

**Lifetime Maximum, Deductible, and Coinsurance Maximum**

The following deductibles and maximums apply to the services listed above in the "Summary Of Benefits" unless otherwise noted.

<u>Lifetime Maximum</u>	\$5,000,000	\$5,000,000
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Limited to a combined in- and out-of-network lifetime maximum per member.

**Deductible**

Individual, per benefit period	\$500	\$1,000
Family, per benefit period	\$1,500	\$3,000

Charges for the following do not apply to the benefit period deductible:

- inpatient newborn care for well baby
- mental health and substance abuse services
- prescription drugs

**Coinsurance Maximum**

Individual, per benefit period	\$2,000	\$4,000
Family, per benefit period	\$6,000	\$12,000

Charges for the following do not apply to the benefit period coinsurance maximum:

- mental health and substance abuse services
- prescription drugs

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**Penalty For Failure To Obtain Certification**

Certain services require prior review and certification by BCBSNC in order to receive benefits. If you go to an in-network provider in North Carolina, your provider will request prior review when necessary. If you go to an out-of-network provider in North Carolina or to any provider outside of North Carolina, you are responsible for requesting or ensuring that your provider requests prior review by BCBSNC. **Failure to request prior review and receive certification may result in allowed charges being reduced by 25% or a full denial of benefits. See "Covered Services" and "Prospective Review/Prior Review" in "Utilization Management."**

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**Prescription Drugs**

Generic Drugs Tier 1	\$10 copayment	\$10 copayment
Preferred Brand Name Drugs Tier 2	\$35 copayment	\$35 copayment
Brand Name Drugs Tier 3	\$50 copayment	\$50 copayment
Diabetic Supplies	75%	75%
Spacers and Peak Flow Meters	75%	75%

One copayment for up to a 30-day supply. 31-90-day supply is two and one half copayments. Please refer to "Prescription Drugs" in "Covered Services" for more information. *Infertility drugs* are limited to a combined in- and out-of-network lifetime maximum of \$5,000 per member.

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*\*The following notice applies only when you go to an out-of-network provider.  
NOTICE: Your actual expenses for covered services may exceed the stated coinsurance percentage or copayment amount because actual provider charges may not be used to determine the Plan's and member's payment obligations. For out-of-network benefits, you may be required to pay for charges over the allowed amount, in addition to any copayment or coinsurance amount.*

**In-network****Out-of-network\*****Mental Health And Substance Abuse Services**

Prior review and certification by Magellan Behavioral Health are required only for in-patient and outpatient services received from an in-network provider. Please see the number in "Whom Do I Call?"

Mental Health Office Services           \$40 copayment           70%  
Combined in- and out-of-network limit of: 20 office visits per benefit period.

Mental Health Inpatient/  
Outpatient Services           80%                           70%  
Combined in- and out-of-network limit of 30 days per benefit period.

Substance Abuse Office Services       \$40 copayment           70%

Substance Abuse Inpatient/  
Outpatient Services           80%                           70%

Substance Abuse Benefit Period Maximum                           \$8,000

Substance Abuse Lifetime Maximum                                 \$16,000

*\*The following notice applies only when you go to an out-of-network provider.*

*NOTICE: Your actual expenses for covered services may exceed the stated coinsurance percentage or copayment amount because actual provider charges may not be used to determine the Plan's and member's payment obligations. For out-of-network benefits, you may be required to pay for charges over the allowed amount, in addition to any copayment or coinsurance amount.*

**What is not Covered**

Exclusions that are specific to a type of service are stated along with the benefit description in "Covered Services." Exclusions that apply to many services are listed in this section. To understand all of the exclusions that apply, read "Covered Services," "Summary Of Benefits" and "What Is Not Covered?" The following are summaries of some of the coverage restrictions. A full explanation and listing of restrictions will be found in your benefit booklet.

- Not medically necessary
- Investigational in nature or obsolete, including any service, drugs, procedure or treatment directly related to an investigational treatment
- Any experimental drug or any drug not approved by the Food and Drug Administration (FDA) for the applicable diagnosis or treatment. However, this exclusion does not apply to prescription drugs used in covered phases II, III and IV clinical trials, or drugs approved by the FDA for treatment of cancer, if prescribed for the treatment of any type of cancer for which the drug has been approved as effective in any one of the three nationally recognized drug reference guides:
  1. The American Medical Association Drug Evaluations
  2. The American Hospital Formulary Service Drug Information
  3. The United States Pharmacopoeia Drug Information.
- Side effects and complications of non-covered services, except for emergency services in the case of an emergency
- Not prescribed or performed by or upon the direction of a doctor or other provider
- For any condition, disease, illness or injury that occurs in the course of employment, if the employee, employer or carrier is liable or responsible (1) according to a final adjudication of the claim under a state's workers' compensation laws, or (2) by an order of a state Industrial Commission or other applicable regulatory agency approving a settlement agreement

- For a health care professional to administer injectable prescription drugs which can be self-administered, unless medical supervision is required
- For inpatient admissions primarily for the purpose of receiving diagnostic services or a physical examination. Inpatient admissions primarily for the purpose of receiving therapy services are excluded except when the admission is a continuation of treatment following care at an inpatient facility for an illness or accident requiring therapy.
- For care in a self-care unit, apartment or similar facility operated by or connected with a hospital
- For custodial care, domiciliary care or rest cures, care provided and billed for by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility, home for the aged, infirmary, school infirmary, institution providing education in special environments, in residential treatment facilities, except for substance abuse treatment, or any similar facility or institution
- For respite care except as specifically covered by the Plan
- Received prior to the member's effective date
- Received after the coverage termination date, regardless of when the treated condition occurred, and regardless of whether the care is a continuation of care received prior to the termination

***For a more detailed list of exclusions, please refer to your BCBS member guide.***

**WHOM DO I CALL?**

**BCBSNC Web Site**

To view your claims, get Plan information, claim forms, health and wellness information, drug formulary updates, find a doctor, change your address, and request new ID cards, visit the BCBSNC Web site: **bcbsnc.com**

**BCBSNC Customer Services**

For questions about your benefits or claims, ID card requests, or to voice a complaint: BCBSNC Customer Services . . . . . 1-877-258-3334 (toll free)

**Mental Health And Substance Abuse Services**

Companies who have signed contracts with BCBSNC administer these benefits. You must contact these vendors directly and request prior review for inpatient and outpatient services, except for office visit services and in emergencies. In the case of an emergency, please notify the vendor as soon as reasonably possible:

Magellan Behavioral Health . . . . . 1-800-359-2422 (toll free)

**Out Of North Carolina Care**

For help obtaining care outside of North Carolina and outside of the U.S., visit the national BCBS Web site at **bcbs.com** or call:

BlueCard PPO Program. . . . . 1-800-810-BLUE (2583) (toll free)

**HealthLine Blue<sup>SM</sup>**

To receive confidential, up-to-date health information 24 hours a day from specially trained nurses:

HealthLine Blue . . . . . 1-877-477-2424 (toll free)

**COBRA Administrator**

Interactive Medical Systems (IMS) . . . . . 1-800-426-8739 (toll free)

**Prior Review**

Some services require *prior review and certification* by BCBSNC. The list of these services may change from time to time. Please visit the BCBSNC Web site at **bcbsnc.com** or call BCBSNC Customer Services at the number given above for current information about which services require *prior review*. See "Prospective Review/Prior Review" in "Utilization Management" for information about the review process. To request *prior review*, call:

Providers . . . . . 1-800-214-4844 (toll free)

Members . . . . . 1-877-258-3334 (toll free)

The benefit highlights is a summary of BCBSNC benefits. This is meant only to be a summary. Final interpretation and a complete listing of benefits and what is not covered are in and governed by the group contract and benefit booklet. You may preview the benefit booklet by requesting a copy of the BCBSNC benefit booklet from BCBSNC Customer Services.

**BASE RATES WITHOUT HEALTH RISK ASSESSMENT / BIOMETRICS**

	<u>MONTHLY RATES</u>	<u>PER PAY PERIOD RATES</u>
Employee Only	\$51.00	\$25.50
Employee + Child	\$157.00	\$78.50
Employee + Children	\$254.00	\$127.00
Employee + Spouse	\$241.00	\$120.50
Employee + Family	\$326.00	\$163.00

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**DISCOUNTED RATES WITH HEALTH RISK ASSESSMENT / BIOMETRICS**

	<u>MONTHLY RATES</u>	<u>PER PAY PERIOD RATES</u>
Employee Only	\$21.00	\$10.50
Employee + Child	\$127.00	\$ 63.50
Employee + Children	\$224.00	\$112.00
Employee + Spouse	\$211.00	\$105.50
Employee + Family	\$296.00	\$148.00

**FOR CLAIMS/CUSTOMER SERVICE  
PLEASE CALL: 1-877-258-3334  
website address: [www.bcbsnc.com](http://www.bcbsnc.com)**

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## **Gilsbar Flexible Spending Accounts (General Overview)**

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***Plan Year: July 1, 2009 - June 30, 2010***

***Medical Reimbursement Plan Maximum: \$2,400***

***Dependent Care Account Maximum: \$5,000***

***Medical Reimbursement and Dependent Care Minimums: None***

***Run-out Period: 90-days***

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

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

General questions regarding Health Care and Dependent Care Accounts:

### **What is an FSA?**

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

### **Will I pay taxes on the money I set aside?**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Can I view my FSA balances online?**

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

**What if I have a question?**

If you have any questions regarding your account balance, claim reimbursement or eligible expenses, you can access your account information at myGilsbar.com or you can call our Customer Contact Center at 1-800-445-7227 ext. 883.

**How does participating in an FSA save me money?**

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

	<b>With FSA</b>	<b>Without FSA</b>
<b>Salary</b>	\$1000	\$1000
<b>Less Pre-Taxed Dollars:</b>		
Health Care Reimbursement	\$100	0
Dependent Day Care Reimbursement	\$150	0
Taxable Income	\$750	\$1000
<b>Less:</b>		
Federal Income Tax	\$82.00	\$121.00
State Income Tax	\$17.58	\$23.44
Social Security	\$57.37	\$76.50
<b>Net Take Home Pay</b>	\$593.05	\$779.06
<b>Less Health Care &amp; Dependent Care Expenses</b>	\$0.00	\$250.00
<b>Net After Expenses</b>	\$593.05	\$529.06
Tax Savings This Pay Period: \$63.99		
Annual Tax Savings: \$63.99 X 26 pay periods = \$1,663.74		

## **MEDICAL REIMBURSEMENT ACCOUNT**

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

### **How does the Health Care FSA Work?**

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

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

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

### **What is eligible for reimbursement under the Health Care FSA?**

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

### **How do I get reimbursed?**

For reimbursement of expenses covered under a health care plan:

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

**FAX CLAIMS AND PROOF OF EXPENSE TO 866-635-1329**

**How much will be reimbursed?**

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

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

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

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

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

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

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

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

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

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

If you have any questions, you can access your account information 24/7 at [myGilsbar.com](http://myGilsbar.com), or you can call Gilsbar's Customer Contact Center at 1-800-445-7227 ext. 883.

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

**Qualified Medical Expenses Eligible For Reimbursement:**

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

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

\* May require additional substantiation (documents of medical necessity)

### Expenses Not Eligible For Reimbursement

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

## OVER-THE-COUNTER DRUG/MEDICINE LIST

**Over-the-Counter Drugs Used Primarily for Medical Care.  
THE DRUGS/ MEDICINES LISTED BELOW ARE APPROVED WITH A RECEIPT FROM THE PROVIDER/ STORE. A RECOMMENDATION FROM A HEALTH CARE PROVIDER IS NOT NEEDED.**

The following is a brief summary of information and is intended to serve as a quick reference to help determine whether or not an expense may be eligible for reimbursement. This list is not all-inclusive. This information is not tax advice. Tax advice should be obtained from a professional tax advisor. IRS Publication 502 can be ordered from the IRS 1-800-TAX-FORM (1-800-829-3676).

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

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

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

**Dual Purpose OTC Drugs. THE ITEMS LISTED BELOW REQUIRE A THIRD-PARTY RECEIPT AND A NOTE FROM THE HEALTH CARE PROVIDER LISTING THE DIAGNOSIS OF THE MEDICAL CONDITION OR ILLNESS AND THE RECOMMENDATION OF THE OTC DRUG / MEDICINE.** This list is not all inclusive and is intended to give examples of the most common brand names of OTC drugs.

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

- Vitamins are not an eligible expense, unless prescribed by a physician to treat a specific medical condition (i.e. Iron to treat, not prevent anemia, Calcium Supplements to treat, not prevent Osteoporosis). A doctor's note detailing the specific medical condition will be required for reimbursement.
- Weight loss/dietary supplements must be for a specific medical condition such as obesity.

## Health Care FSA Expense Worksheet

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

### HEALTH CARE EXPENSES YOU PAID LAST YEAR COULD INCLUDE:

Deductibles	
(medical and dental)	\$ _____
Benefit percentage/co-insurance	
(The amount NOT paid by your insurance)	\$ _____
Amounts paid over plan limits	
Over reasonable and customary allowance	\$ _____
Over psychiatric limits	\$ _____
Over private room allowance	\$ _____
Expenses NOT covered by your insurance plan	
Physicals	\$ _____
Prescription drugs	\$ _____
Over-the-counter medications	\$ _____
Vision care	\$ _____
Hearing expenses	\$ _____
Psychiatric care	\$ _____
Dental and orthodontic care	\$ _____
Assistance for the handicapped	\$ _____
Therapy/treatments	\$ _____
Physician's fees/services	\$ _____
Medical equipment	\$ _____
Miscellaneous charges	\$ _____
My out-of-pocket health care (expenses last year)	\$ _____

## Flex Debit Cards

IRS rules have simplified the use of Flex Debit Cards. These rules now require drug stores and supermarkets to identify FSA-eligible items at checkout and require the drug store or super market to only use the card for FSA eligible items. This means that you can use your Card at participating stores that offer this feature for the total FSA-eligible amount and NO receipts are needed to verify the eligibility of the purchase! And of course, you can continue to use your Card at pharmacies and other health care providers.

Please visit <http://www.sig-is.org/en/index.asp> and click on **SIGIS Merchant List** for the latest list of participating merchants.

### **Here's an example:**

You have been purchasing prescriptions at a pharmacy in a local supermarket using your Card during 2007. On January 5, 2008, you go to the store to pick up a prescription. If the store has not made the change required by the IRS to identify FSA-eligible items, your Card may be declined at the point of purchase. In this case, you can transfer your prescriptions to a pharmacy in a participating discount store or supermarket, or to a freestanding pharmacy, or simply continue to turn in your paper receipts for reimbursement as you have previously.

### **Important point to remember:**

If you use your Card on or after January 1, 2008 in a discount store or supermarket that is not participating — even if you purchased FSA-eligible items in the store prior to January 1, 2008, your Card may decline.

Here's how your Flex Card works at participating stores:

1. Bring prescriptions and vision products, OTCs and other purchases to the register at checkout to let the clerk ring them up.
2. Present your Card and swipe it for payment.
3. If the Card swipe transaction is approved (e.g., there are sufficient funds in the account and at least some of the purchases are FSA eligible), the amount of the FSA-eligible purchases is deducted from the account balance and no receipt follow up is required. The clerk will then ask for another form of payment for the non-FSA-eligible items.
4. If the Card swipe transaction is declined, the clerk will ask for another form of payment for the total amount of the purchase.
5. The receipt will identify the FSA-eligible items and may also show a subtotal of the FSA-eligible purchases.

**How does the FSA Debit Card work?**

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

**Where can I use my FSA Debit Card?**

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

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

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

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

Starting on January 1, 2008, new special IRS rules allow you to use your FSA debit card in participating discount stores and supermarkets that can identify FSA-eligible items at checkout. This means that you can use your card at participating stores for the total FSA-eligible amount and NO receipts are needed to verify the eligibility of the purchase! Important point to remember: If you use your card on or after January 1, 2008 in a discount store or supermarket that is not participating in the IRA program, even if you purchased FSA-eligible items there before, your card may decline.

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

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

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

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

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

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

## **FSA Substantiation**

### **Documenting & Submitting Proof of FSA Eligible Purchases**

#### **FREQUENTLY ASKED QUESTIONS:**

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

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

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

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

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

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

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

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

#### **What should I do if I receive substantiation letters?**

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

*Mail: Employee Reimbursement Center /P.O. Box 26046 / Tampa, FL 33623 /  
Fax: 1-866-635-1329*

**What are acceptable forms of substantiation?**

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

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

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

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

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

Here are a few organization and record-keeping suggestions:

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

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

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

## DEPENDENT CARE REIMBURSEMENT ACCOUNT

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

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

### **How Does a Dependent Care FSA work?**

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

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

### **Am I eligible to use the Dependent Care FSA?**

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

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

### **Who is an eligible dependent?**

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

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

**What expenses are covered?**

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

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

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

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

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

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

**How do I get reimbursed?**

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

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

**FAX CLAIMS AND PROOF OF EXPENSE TO 866-635-1329 FOR PROCESSING.**

**Can I pay my in-home daycare provider through the Dependent Care FSA?**

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

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

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

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

If you have any questions, you can access your account information 24/7 at [myGilsbar.com](http://myGilsbar.com) or you can call Gilsbar's Customer Contact Center at 1-800-445-7227 ext. 883.

## Dependent Care FSA Expense Worksheet

Dependent care expenses you paid last year could include:

Costs of Child or Adult Care Facilities\*

Day Care Center / Nursery School \$ \_\_\_\_\_

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

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

\* The facility must follow all local and state laws.

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

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

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

**TOTAL ESTIMATED DEPENDENT CARE EXPENSES** \$ \_\_\_\_\_

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

PLEASE FAX CLAIMS AND PROOF OF EXPENSE TO 866-635-1329  
FOR PROCESSING.

(PLEASE KEEP YOUR ORIGINALS)

**Questions? Call Gilsbar's Customer Contact Center;  
1-800-445-7227, ext. 883**

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

Claims Processing Center, P.O. Box 26046, Tampa, FL 33623

(PLEASE KEEP YOUR ORIGINALS)

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## Ameritas Dental Plan (Incentive Plan with AMC)

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**Effective Date: July 1, 2009**

### **CALENDAR YEAR DEDUCTIBLE**

\$50.00 per individual for Type II (Basic) and Type III (Major) Procedures (3 times family limit). After the date that 3 members of a family have each satisfied their individual deductible, the entire deductible or any remaining portion of the deductible for any family member will be waived for the rest of that calendar year.

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

- Evaluations (Two per calendar year)
- Cleanings (Two per calendar year)
- Fluoride for Children (Under age 19)
- Space Maintainers
- Radiographs (Xrays)
- Bitewings (Two per calendar year)

**TYPE II - BASIC PROCEDURES** - Type II benefits are payable at **80-90-100%** U&C\*. \$50.00 deductible applies.

- Sealants (under 17)
- Limited Exams
- Restorative Amalgam & Resin (excluding inlays and crowns)
- Oral Surgery - Complex Extractions
- Oral Surgery - Simple Extractions
- Denture Repair
- Anesthesia

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

- Endodontics (Root Canal)
- Periodontics (Gum Disease)
- Crowns - Stainless Steel
- Restorative
- Prosthodontics - Removable Dentures, Partials
- Prosthodontics - Fixed Pontics or Abutment

**ORTHODONTIA (INCLUDES CHILDREN & ADULTS)** - Benefits are payable at 50% U&C with a lifetime maximum of \$1,000.00. No deductible applies.

Benefits will be payable when a Covered Expense is incurred. The Covered Expenses for a program are based on the estimated cost of the insured's program. They are pro-rated by quarter (three month periods) over the estimated length of the program, but not for more than eight quarters. The last quarterly payment for a program may be changed if the estimated and actual cost of the program differ.

*\*Usual and Customary Charge*

### **100% PREVENTIVE, 80-90-100% INCENTIVE**

Everyone insured on the effective date of the Company's policy begins with 100% coinsurance for Type I (Preventive) and 80% coinsurance level for Type II (Basic) procedures and will remain at that level until the next January 1.

If you visit a dentist during each Calendar Year and have at least one covered dental procedure performed while insured under the Company's policy, your Type II (Basic) procedures will advance to the 90% level on the following January 1 and to 100% on the next January 1. Your Type II (Basic) procedures will remain at 100% each year as long as you visit a dentist during each subsequent calendar year and have at least one covered dental procedure performed while insured under the Company's policy.

If you do not have at least one covered dental procedure performed during any calendar year while insured under the Company's policy, you will revert back to 80% coinsurance level during the next calendar year and must begin to progressively advance to the next levels as described above.

### **ANNUAL MAXIMUM BENEFIT**

- Type I, II, and III Procedures - \$1,000\* per calendar year per person.
- Orthodontia Procedures - \$1,000 Lifetime per person (carry over does not apply).

\*This plan includes a **maximum carryover** for dental. Each insured (employee and/or dependent) will qualify for a dental maximum carryover if they:

1. Visit a dentist between January 1 and December 31 of the plan year.
2. Submit a claim for payment prior to March 1 of the following year.
3. Total benefits paid for the Calendar Year must be less than \$500.

If you meet all 3 requirements you will have an additional \$250 available in the Annual Dental Maximum for the next plan year. In future years if you have benefits paid of less than \$500, additional amounts of \$250 will be added to the carryover. However, the most you can accumulate in the maximum carryover is \$1,000. Therefore, the maximum annual benefit may never exceed \$2,000 in any one year.

### **ELIGIBLE EMPLOYEES**

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

### **ELIGIBLE DEPENDENTS**

Provides Coverage On:

- Your Spouse
- Children up to age 19 and unmarried (Up to age 26 if wholly dependent upon you for maintenance and support and if enrolled as a full-time student in an accredited school or college.)

#### **DENTAL EXCLUSIONS (DEFERMENT PERIOD)**

During the first 36 months following your or your dependent's Dental Coverage Effective Date, the initial placement of dentures, partial dentures, or bridges, if it includes the replacement of teeth all of which are missing prior to the effective date. (For currently covered insureds, Ameritas will use the employees Date of Hire to determine the 36 month period.) This exclusion will not apply if the prosthesis replaces a sound natural tooth which is extracted while the patient is insured under this Dental Coverage and which is replaced within 12 months of the extraction. During the first 36 months of coverage, the replacement of bridges, partial dentures, dentures, inlays or crowns is excluded. **EXCEPTIONS** to this exclusion will be made if the replacement is made necessary by: a) accidental bodily injury to sound natural teeth (chewing injuries are not considered accidental bodily injuries), or b) the extraction of a sound natural tooth provided the replacement is completed within 12 months of the date of the injury or extraction.

#### **PREDETERMINATION OF BENEFITS**

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

#### **COORDINATION OF BENEFITS**

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

#### **CERTIFICATE OF INSURANCE**

The Certificate of Insurance issued to you describes in detail the benefits and limitations of this plan. This brochure is for general information only.

#### **LATE ENTRANT**

If you do not elect to participate in the dental program when first eligible, you will be considered a **Late Entrant** and you must wait 12 months for most benefits. If an employee or dependent does not elect to participate when initially eligible, and elects to participate at the policyholders next annual election period, they will become a **Late Entrant**. For a **Late Entrant**, benefits will be limited to exams, cleanings and fluoride applications for the first 12 months. The late entrant provision is waived if the employee comes on the plan as a result of a qualifying event.

#### **SECTION 125**

This policy is provided as part of the Policyholder's Section 125 Plan. Each member has the option under the Section 125 Plan of participating or not participating in this policy.

A member may change their election only during an annual election period, except for a change in family status. Examples of such events would be marriage, divorce, birth of a child, death of a spouse or child or termination of employment. Please see your plan administrator for details.

**ORTHODONTIA LIMITATIONS**

(This is not a complete list)

No benefit is payable for expenses incurred:

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

**LIMITATIONS/EXCLUSIONS**

(This is not a complete List)

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

**Ameritas Monthly Rates**

<b>Employee Only</b>	<b>\$26.58</b>
<b>Employee plus 1</b>	<b>\$53.68</b>
<b>Employee plus 2 or more</b>	<b>\$83.54</b>

This insurance is underwritten by Ameritas Life Insurance Corp.



**For Claims/Customer Service call Ameritas: 1-800-487-5553  
[www.ameritasgroup.com](http://www.ameritasgroup.com)**

## Cancer Can Affect Anyone

### ***Statistics Predict:***

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

### ***Are you prepared for the cost of cancer?***

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

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

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

***A 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.

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

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

### ***Plus, you get these unique features:***

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

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## **Assurity Cancer & Specified Disease Insurance Policy**

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Effective Date: July 1, 2009

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

### **BASIC BENEFITS**

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

### **RATE STRUCTURE**

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

### **PRE-EXISTING CONDITIONS**

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

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

### **ISSUE AGE**

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

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

#### **Hospital Indemnity**

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

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

Assurity will pay the actual charges, up to 25% of the Daily Hospital Confinement

benefit shown on the policy schedule per day for the hospital charges for the prescribed drugs and medicines taken during hospital confinement for an insured person. This benefit is limited to the first 75 days for each period of confinement.

**Surgical Benefit**

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

**Anesthesia**

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

**Additional Surgical Opinions**

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

**Artificial Limb and Prosthesis –**

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

**Attending Physician**

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

**Private Duty Nurse**

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

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

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

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

- antigenic preparations of immunosuppressive techniques.

**Experimental Treatment**

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

**Physical and Speech Therapy**

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

**Extended Care Facility**

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

**Bone Marrow Transplant for Cancer**

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

**Transportation and Lodging for Bone Marrow Donors**

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

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

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

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

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

- the actual charges for round trip coach fare on a common carrier to the facility that provides the prescribed treatment or 50 cents per mile for personal automobile expense in excess of 50 miles one way, not to exceed 700 miles round trip up to

a maximum of \$1,500 per calendar year. Mileage will be measured from the insured person's residence to the nearest facility where the treatment is administered; and

- the actual charges up to \$50 per day for lodging and meal expenses incurred by an insured person when staying at a hotel, motel or other accommodations acceptable to Assurity. Benefits will be paid up to the number of days covered treatment is received.

#### **Adult Companion Transportation and Lodging**

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

#### **Outpatient Positive Diagnostic Test**

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

#### **Outpatient Surgery Benefit**

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

#### **Skin Cancer**

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

#### **Ambulance**

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

#### **Hospice Care**

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

#### **Government or Charity Hospital**

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

**Blood and Blood Plasma**

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

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

The policy pays a benefit equal to the daily hospital confinement benefit for a minimum of 48 hours of inpatient care following a mastectomy and for a minimum of 24 hours of inpatient care following a lymph node dissection for the treatment of breast cancer. Lifetime maximum of \$2,500 per breast. Assurity will pay the actual charges incurred for an external breast prosthesis or an internal breast prosthesis and the surgeon's fee for implantation for an insured person. For natural tissue breast reconstruction surgery, Assurity will pay the actual charges incurred with a lifetime maximum of \$2,500 per breast. Assurity will pay the actual charges for reconstructive surgery and any adjustments made to the nondiseased breast if performed within 24 months (five years in TN) of reconstruction of the diseased breast for an Insured Person.

**Hairpiece Benefit**

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

**Cancer (Wellness) Screening Tests**

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

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

**Wellness Claims**

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

**Home Health Care Services**

When services are provided by a licensed Home Health Care Agency, when prescribed by a physician, policy pays (a) up to \$60 per day for services provided at home, not to exceed 180 days per calendar year, (b) up to \$100 per day for Private Duty Nursing, not to exceed 15 days per calendar year, and (c) pays actual

charges for a physician's visit up to \$40 per day not to exceed 15 days per calendar year. Care cannot be provided by a relative. This benefit is in lieu of all other benefits.

**Rental or Purchase of Durable Medical Equipment**

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

**Professional Mental Health Consultation**

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

**Extended Benefits**

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

**Waiver of Premium**

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

**Specified Disease Benefits**

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

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

### **Cancer or other Specified Disease Claims**

You may file a claim for cancer or specified diseases by completing an Assurity Claim Form. Please make sure to include all pertinent information as stated on the form. You can obtain a claim form by contacting Assurity, or by downloading one from [www.markiiibrokerage.com/cumberlandcountync](http://www.markiiibrokerage.com/cumberlandcountync). Should you have any questions on how to file or submit a claim or regarding the Assurity Cancer Plan, please call **(888) 358-8808 ext. 23**.

### **OPTIONAL RIDERS**

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

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

### **LIMITATIONS AND EXCLUSIONS**

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

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

#### **Exclusions**

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

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

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

To Call in a Wellness Claim: (888) 358-8808 Ext. 23

To Fax in a Claim/Toll Free: (800) 869-0368

Policy Form No. AAW-C120

Rider Form Nos. AAW-CR261, AAW-CR262, AAW-CR263, AAW-CR264

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

<b>Assurity Life Cancer &amp; Specified Disease Plan</b>				
		<b>\$150 Daily Benefit</b>	<b>\$250 Daily Benefit</b>	<b>\$350 Daily Benefit</b>
Base Policy (\$10,000 per month/\$100,000 lifetime maximum) (radiation/chemotherapy)	Individual	\$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

AAW-C120RAB (7/04)



## 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 Government Housing/Finance, Society of Actuaries*

## ***Could You Live Off Of Savings??***

## Standard Life Short-Term Disability

**Effective Date: July 1, 2009 pending underwriting approval**

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

### ACCIDENT & SICKNESS PROTECTION

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

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

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

## **ELIGIBILITY**

These benefit plans are optional and all permanent full-time employees that work at least 30 hours per week for more than a 6-month period and under 65 years of age may apply. The disability benefit is for **employees** only. Applications for new participants will be underwritten.

## **POLICY FEATURES**

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

### **Limits and Exclusions:**

Benefits will not be paid for any total disability which:

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

**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.

**Standard Life and Casualty**  
**Claims: 1-800-227-0251**  
**Customer Service: 1-800-327-0695**



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## Aetna Term Life and AD&D Insurance Plan

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**Policy Effective Date:** When approved by Aetna Life Insurance Company

### **BASIC EMPLOYEE LIFE AND AD&D INSURANCE**

This plan will pay as a Life Insurance benefit the amount of Life Insurance in force for you if you die while insured. You name your beneficiary.

### **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.

### **OPTIONAL EMPLOYEE LIFE INSURANCE**

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

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

### **OPTIONAL DEPENDENT LIFE INSURANCE**

Provides coverage on:

- Your Spouse
- Child(ren) from 14 days of age to age 19 (to age 26 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, as long as the child is covered prior to age 19 or to age 26 if a full-time student.

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

### **FEATURES**

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

### **ELIGIBILITY**

You will be eligible for this program if you are an active employee that works 20 hours or more per week.

### **ENROLLMENT**

Enrollment is simple - just fill out the election card provided by your employer. Make sure you supply all the required information and return the form where you work. That's all. 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.

**WHEN YOUR INSURANCE STARTS**

Your Basic Employee Life 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. Your Optional Employee Life Insurance will become effective on the date of your eligibility if you are then actively at work; otherwise, on the day you return to active work. If you enroll in Optional Dependent Life Insurance, that coverage will become effective on the date your Optional Employee Life Insurance becomes effective, provided the dependent is performing the usual and customary duties or activities of an individual in good health and of the same age and sex. If you or any dependents do not apply for Optional Employee Life Insurance and/or Optional Dependent Life Insurance within 31 days from date of hire, that person will not become insured until such person has furnished medical evidence of insurability satisfactory to Aetna Life Insurance Company.

**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. Nevertheless, if you should die within 31 days thereafter, your life insurance will still be paid to the beneficiary. If any of your covered dependents should die within such 31 day period, the amount of Life Insurance on account of such dependent will be paid to you.

**DISABILITY**

Your insurance may be continued during your disability provided the premium payments continue, and the policy remains in force. However, your insurance will be subject to reduction as shown under "Reductions at ages 65 & Over" below.

**REDUCTIONS AT AGE 65 AND OVER**

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

<u>Attained Age</u>	<u>Percent of Original Amount</u>
65	65%
70	40%
75	30%
80	25%

**CONVERSION**

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

This privilege applies to Supplemental Employee Life Insurance and Dependent Life Insurance as well as the Basic Employee Life Insurance.

#### **PORTABILITY**

If you terminate your employment, the portability provision allows you and your dependent spouse & children to take the optional life coverage with you, subject to the following provisions:

- You must apply for coverage within 31 days from the date your life coverage terminates.
- You must be actively at work prior to employment termination. Retirees & disabled employees are not eligible.
- Dependents are eligible for portable coverage if the employee participates.
- You may only port up to your current coverage amount.
- You cannot increase coverage or add new dependents.
- Employees are eligible up to age 98, spouses up to age 64 and children up to age 18, 22 if a full-time student.
- The minimum and maximum amounts to port are as follows:
  - Employee - \$5,000 / \$100,000
  - Spouse - \$1,000 / \$10,000
  - Children - \$1,000 / \$5,000

#### **SUICIDE EXCLUSION**

No optional employee life benefits are payable if you commit suicide within two years from the effective date of the coverage.

#### **ACCELERATED DEATH BENEFIT (ADB)**

Aetna Life Insurance Company 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 a portion of your group life benefits at such a difficult time. Please refer to your Group Certificate for details.

#### **CLAIMS PROCEDURE**

Claim forms needed to file for benefits under the group insurance program can be obtained from your employer who will also be ready to answer questions about the insurance benefits and to assist in filing claims. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully. If there is any question about a claim payment, an explanation can be requested from your employer, who is usually able to provide the necessary information.

#### **GROUP POLICY AND CERTIFICATE**

The insurance briefly described in this folder is subject to the terms and conditions of the Group Policy issued by Aetna Life Insurance Company. If you become insured, you will receive a certificate outlining your benefits under this policy.

#### **PLAN SPONSOR**

Cumberland County Government  
117 Dick Street  
Fayetteville, NC 28302-1829  
(910) 678-7700

This brochure has been prepared to give you the highlights of coverage now being offered by Cumberland County Government to meet your insurance needs. For details, please refer to the certificate of insurance that you will receive after you have signed up for protection.

**SCHEDULE OF BENEFITS**

**BASIC EMPLOYEE LIFE INSURANCE AND AD&D**

All eligible employees. . . . . \$5,000\* (No cost to you)

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

**OPTIONAL LIFE INSURANCE**

Your choice of the following amounts:

\$100,000, \$90,000, \$80,000, \$70,000, \$60,000, \*\*\$50,000, \$40,000, \$30,000, \$20,000 or \$10,000

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

\*\*To be eligible for more than \$50,000 of coverage you must furnish medical evidence of insurability satisfactory to Aetna Life Insurance Company.

**OPTIONAL DEPENDENT LIFE INSURANCE**

\$10,000 on your spouse

\$5,000 on each of your eligible children

**YOUR MONTHLY COST**

<u>Optional Employee Life Insurance</u>	<u>Monthly Payroll Deduction</u>
\$100,000	\$25.00
\$90,000	\$22.50
\$80,000	\$20.00
\$70,000	\$17.50
\$60,000	\$15.00
\$50,000	\$12.50
\$40,000	\$10.00
\$30,000	\$7.50
\$20,000	\$5.00
\$10,000	\$2.50
<u>Optional Dependent Life Insurance*</u>	
Family Coverage	\$3.20
Spouse Only Coverage	\$2.30
Child(ren) Only Coverage	\$ .90

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

Customer Service/Conversion: 800-523-5065

Portability: 800-826-7448

Evidence of Insurability Inquiries: 800-660-9913

This insurance is underwritten by Aetna Life Insurance Company.

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## Unum Voluntary Individual Universal Life Insurance

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**Effective Date: August 1, 2009 (pending underwriting approval)**

### **AFFORDABLE 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. This coverage is available to all eligible employees, ages 15-80 who are actively at work. 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 in all policies. It provides the option of requesting up to 100% 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. If you have to face a terminal illness, this option can provide additional financial assistance during a difficult time. Any payout of this benefit would reduce the death benefit.

### **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 work<sup>1</sup>, you may apply for coverage by completing an application and no physical exams are required! Your coverage becomes effective on the first day of the month in which payroll deductions begin. This means that you will receive the plan and coverage amount you applied for on the application unless it is determined to be unacceptable under Unum's rules, limits or standards. In such event, the plan and coverage amount may be modified or declined.

### **INDIVIDUALLY OWNED**

If you 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 3.0%. 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 at initial enrollment to employees and spouses ages 15-65.
- 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 a covered accident before age 70.
- Under certain conditions, the benefit will double if death occurs from accidental bodily injuries sustained while the insured is a fare-paying passenger via commercial transportation.
- Benefits increase by 25% if death occurs from accidental bodily injury while insured is driving or riding in a non-commercial automobile while insured is driving or riding in a non-commercial automobile while wearing a seat belt.

### **AUTOMATIC INCREASE RIDER**

- You pay no additional premium now to add the rider to your policy. Then, each year, an additional \$1 per week will be automatically added to your premium for up to ten consecutive years.
- Your policy's face amount will be increased by the amount of insurance coverage purchased by that additional premium.
- Increases are limited to attained ages of 70 or less.
- To continue receiving increases, you must be considered actively at work for the employer stated on the application, performing your normal duties and not disabled or having a monthly deduction credited as a monthly premium to your policy.
- Additionally, your policy must not have entered the grace period and you must not have requested that future automatic increases be discontinued.
- If you would like to add an additional amount of coverage above the amount provided by the rider, you will be required to provide health evidence.
- If the automatic increase rider is not added to your policy when it is first offered, future increases to your coverage may require evidence of insurability.

### **FAMILY COVERAGE**

#### **• Spouse Coverage**

Voluntary Individual Universal Life coverage is available for your spouse (ages 15-80) 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. A few additional health questions may be asked based on the level of coverage being applied for.

#### **• Children's Term Rider**

When applying for adult coverage, this rider is available for children, stepchildren and legally adopted children between the ages of 14 days and 24 years, who reside with and are dependent on you for at least half of their support, for one affordable premium. As each child reaches age 25, he or she has the right to purchase level premium coverage, other than term life, at current rates for up to five times the amount of coverage in force (subject to minimum policy requirements). This rider terminates when the adult insured reaches age 65 or when children reach age 25. This rider is available on either the employee or spouse policy, but not both.

- **Children's Standalone Coverage**

A standalone insurance policy is available to children, stepchildren, legally adopted children and grandchildren between the ages of 14 days and 24 years who reside in the United States. Coverage is available even if you decide not to purchase coverage for yourself.

#### **LONG TERM CARE RIDER**

If you're like most people, you've heard how important it is to prepare for your future and that of your family. You may have acquired a home, built a savings nest egg, begun contributing to retirement funds, and even made plans and preparations for your children's education. But is that enough? Are you financially prepared to cover the expenses of long term care should you or your spouse become ill or disabled, or need special medical treatment as you get older? Your employer is offering you the opportunity to add Unum's Long Term Care rider to complement your voluntary life insurance plan. Please see your Unum representative for more information.

**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 representative for more information and apply today!**

#### **FREQUENTLY ASKED QUESTIONS**

##### **Am I required 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.

##### **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 insure my spouse and/or my children even if I don't participate in this plan?**

Yes, coverage is available for your spouse and children even if you choose not to purchase coverage for yourself. Certain minimal underwriting requirements may apply. Ask your benefits representative for more details during enrollment.

##### **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. Any loan taken will affect the cash value on the policy.

**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 14 years of coverage, a surrender charge will apply. Beyond the 14th year, there is no surrender charge. A unique 14- year period applies to each increase in coverage.<sup>2</sup>

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

During enrollment, a benefits representative 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.**

<sup>1</sup> 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.

<sup>2</sup> Surrender charges may vary by state.

*Any person currently covered by Medicaid, except residents of Kentucky, will be excluded from eligibility.*

*This information is not intended to be a complete description of the insurance coverage available. 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. For complete details of coverage and availability, please refer to Policy Form L-21825 or contact your Unum representative.*

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**Underwritten by  
Provident Life and Accident Insurance Company  
1 Fountain Square, Chattanooga, TN 37402**

**unum.com  
1-800-635-5597**

CU-3039 (3-09)



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## Continuation of Benefits

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### **GILSBAR MEDICAL & DEPENDENT CARE REIMBURSEMENT ACCOUNTS**

If you have a positive balance (payroll deductions are greater than the amount you have received in reimbursement) in your Medical Reimbursement Account at the time of your termination, you may continue participation in the Plan for the remainder of the Plan year through COBRA by contacting **Interactive Medical Systems (IMS) at (800) 426-8739 ext: 3130**.

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 claims were not incurred prior to the date of termination. To obtain your balance, please call **Gilsbar at 800-445-7227, ext. 883**.

### **AMERITAS DENTAL PLAN**

Under the dental plan, you and your covered dependents are eligible to continue dental coverage through COBRA according to the following “qualifying events”. If you and your dependents are enrolled in the dental plan, 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 maybe eligible to continue dental coverage through COBRA. Also, while you are covered under the plan, your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA. Examples of an ineligible dependent would be when your child graduates from college, or turns 24 years old. To continue coverage thru COBRA, your employer would notify IMS of your termination and IMS will then send you a letter regarding COBRA. Should you have any questions you can contact **Interactive Medical Systems (IMS) at (800) 426-8739 ext: 3130**.

### **BLUECROSS / BLUESHIELD HEALTH PLAN**

Under the BlueCross/BlueShield health plan, you and your covered dependents are eligible to continue coverage through COBRA according to the following “qualifying events”.

If you and your dependents are enrolled in the health plan, 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 maybe eligible to continue health 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. You will receive notification with premium and continuation options shortly following your termination of employment. Should you have any questions you can contact **Interactive Medical Systems (IMS) at (800) 426-8739 ext: 3130**.

**ASSURITY CANCER PLAN**

When you leave your employment , you may continue your Assurity Cancer coverage by having the premiums that are currently deducted from your paycheck billed to your home address or drafted from your bank account. You can make arrangements for direct bill or bankdraft by contacting **Assurity at: 1-866-289-7337**.

**STANDARD LIFE SHORT TERM DISABILITY PLAN**

When you leave employment you may continue your disability coverage as long as continuous employment is maintained. Your new occupation must be within acceptable underwriting guidelines. Coverage expires at age 65. Please contact **Standard Life at: 1-800-327-0695** to set up a direct bill to your home.

**Unum UNIVERSAL LIFE**

When you leave your employment, you may continue your Unum Universal Life Insurance coverage by having the premiums that are currently deducted from your paycheck billed to your home address or drafted from your bank account. Unum will send you a letter explaining your options or you may make arrangements by contacting **Unum at 1-800-635-1049**.

**AETNA TERM LIFE**

When you leave your employment, you may convert the existing group term coverage you have through your employer to a guaranteed issue, individual whole life policy. You also have the option of porting your existing coverage as well. It is the responsibility of the employee to convert or port coverage. You must apply for conversion or portability within 31 days from the date your employer terminates your term life coverage. For more information and a quote, please contact Aetna direct at: 1-800-523-5065 for Conversion or 1-800-826-7448 for Portability.

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

**Important Phone Numbers:**

- Cumberland County Government - (910) 223-3327
- Mark III Brokerage, Inc. - (800) 532-1044, ext. 210
- BCBS Health Plan - 1-877-258-3334
- Gilsbar Flexible Spending Accounts - (800) 445-7227, ext. 883
- Ameritas Dental Plan - (800) 487-5553
- Assurity Cancer Plan - (888) 358-8808, ext. 23 or 866-289-7337
- Philadelphia American Cancer Plan (Formerly CSO) - (800) 554-0092
- Aetna Term Life Plan - (800) 660-9913 or (800) 523-5065
- Standard Life STD Plan - (800) 327-0695 or (800) 227-0251
- Unum Universal Life Plan - (800) 635-5597