

Edgecombe County Government is offering all full-time employees a comprehensive Cafeteria Benefits plan. The Cafeteria Benefits plan is being arranged by Mark III Brokerage, an employee benefits firm that has worked in the public sector since 1973. The Cafeteria Benefits plan allows you to pay for certain insurance premiums before taxes are taken out of your paycheck. Paying for these benefits in this method reduces your taxes and increases your take home pay.

- The Plan Year begins August 1, 2009 and ends July 31, 2010

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

Gilsbar HealthCare Flexible Spending Account

Plan Year: August 1, 2009 - July 31, 2010

- **HealthCare Flexible Spending Account Maximum: \$2,000.00**
- **HealthCare Flexible Spending Account Minimum: \$240.00**
- **Waiting Period: Newly hired employees must apply for the spending accounts during the Annual Enrollment period.**

NOTE: Edgecombe County Government will provide a \$100 Employer Contribution for the HealthCare Flexible Spending Account to all employees. This is in addition to the amount that you may select to participate in for the plan year.

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

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:

	<u>With FSA</u>	<u>Without FSA</u>
Salary	\$1000	\$1000
Less Pre-Taxed Dollars:		
Health Care Reimbursement	\$100	0
Dependent Day Care Reimbursement	\$150	0
Taxable Income	\$750	\$1000
Less:		
Federal Income Tax	\$82	\$121
State Income Tax	\$17.58	\$23.44
Social Security	\$57.37	\$76.50
Net Take Home Pay	\$593.05	\$779.06
Less Health Care & Dependent Care Expenses	\$0	\$250
Net After Expenses	\$593.05	\$529.06
Tax Savings This Pay Period: \$63.99		
Annual Tax Savings: \$63.99 X 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.

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 FOR PROCESSING.

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 www.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
- Alcoholism treatment
- Ambulance
- Artificial limbs
- Artificial teeth
- Birth control
- Braces
- Braille books and magazines
- Capital expenses
- Special car hand controls/special car equipment for a disability
- Chiropractor's fees
- Christian Science practitioners' fees
- Contact lenses
- Contact lens solution
- Crutches
- Dental fees (not considered cosmetic)
- Diagnostic fees
- Drug addiction
- Eyeglasses
- Eye exams
- Guide Dog
- Health Institute
- Hearing aids
- Hearing aid batteries
- Hospital services
- Immunizations

Insulin
Laboratory fees
Lead-based paint removal
Learning disability
Medical information plan
Medical services
Nursing services
Operations
Osteopathic Physicians
Over-the-counter medications*
Oxygen
Prescription drugs
Psychiatric care
Psychoanalyses
Psychologist
Sterilization
Stop Smoking programs
Telephone for hearing impaired
Television for hearing impaired
Therapy*
Transplants (organ)
Transportation
Weight loss programs* (not food)
Wheelchair
X-ray

Expenses Not Eligible For Reimbursement

Baby-sitting and childcare
Bleaching teeth (cosmetic)
Cosmetic surgery
Dancing lessons
Diaper service
Dietary supplements
Electrolysis
Face lifts
Food
Funeral expenses
Hair transplants
Health club membership dues
Household help
Illegal operations or treatments
Insurance premiums
Laetrile
Liposuction
Marijuana used medically
Maternity clothes
Personal use items
Prescription drugs

considered cosmetic, Rogaine
 Swimming lessons
 Vitamins
 Any expenses not considered "medically necessary" by the IRS
 Any expense for your general health, even if your doctor prescribes the program

OVER-THE-COUNTER LIST

	eligible	ineligible	dual purpose
Acne treatment	x		
Allergy medicines	x		
Antacids	x		
Anti-diarrhea medicine	x		
Bactine	x		
Bandages	x		
Band-aids	x		
Bug bite medication	x		
Calamine lotion	x		
Carpal tunnel wrist supports	x		
Chapstick		x	
Condoms	x		
Contact cleaning medicine	x		
Cough drops	x		
Cough or cold medicine	x		
Creams or ointments for muscle or joint pain	x		
Diaper rash ointments	x		
Dietary supplements to treat specific medical condition			x
Face Cream		x	
Feminine hygiene products			x
Fiber supplements			x
First aid cream	x		
First aid kits	x		
Food with weight loss programs		x	
Gauze pads	x		
Glucosamine/Chondroitin			x
Health club dues			x
Incontinence supplies	x		
Lactose intolerant pills			x
Laxative	x		
Liquid adhesives for small cuts	x		
Medicated shampoos		x	
Medicated soap		x	
Moisturizers		x	
Motion sickness pills or patches	x		
Nasal sinus sprays	x		
Nasal sprays for snoring			x

	eligible	ineligible	dual purpose
Nasal strips			x
Nicotine gum or patches for stop smoking purposes	x		
One-a-day vitamins		x	
Orthopedic shoes and inserts (only reimburse for cost above cost of regular shoes)			x
Over-the-counter home therapy and treatment for menopause to treat symptoms such as hot flashes night sweats, etc.			x
Pain relievers	x		
Pedialyte for ill children's hydration	x		
Pregnancy test kits	x		
Prenatal vitamins			x
Reading glasses	x		
Rubbing alcohol	x		
Shipping and sales tax for eligible item	x		
Sinus medications	x		
Sleeping aids	x		
Special ointment or creams for sunburn (not just regular skin moisturizers)	x		
Spermicidal foam	x		
St. John's Wort for depression			x
Sunscreen			x
Suntan lotion		x	
Suppositories and creams for hemorrhoids	x		
Thermometers (ear or mouth)	x		
Throat lozenges	x		
Toothbrushes (electric or otherwise) even if medical practitioner recommends special ones to treat a condition	x		
Toothpaste		x	
Visine tears and other such eye products	x		
Wart remover treatments	x		
Weight-loss drugs			x

* Primarily for medical care. The IRS allows reimbursement of reasonable quantities in the case of over-the-counter medicines, drugs and medical supplies.

** Never eligible for reimbursement under the IRS guidelines.

*** Items that may or may not be eligible for reimbursement. The expense is not eligible for reimbursement if it is for personal use, cosmetic or used for general health purposes.

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 check-book 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 Card

Beginning January 1, 2008, new IRS rules have simplified the use of Flex Debit Cards. These rules now require drugstores and supermarkets to identify FSA-eligible items at checkout and require the drugstore or supermarket 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 **IIAS 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 relate 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.

Gilsbar FSA Substantiation FAQ

Documenting & Submitting Proof of FSA Eligible Purchases

FREQUENTLY ASKED QUESTIONS:

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

The IRS changed the rules regarding how debit cards need to operate for an FSA. These rules took effect on January 1, 2008, so 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: 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.



Gilsbar Dependent Care Flexible Spending Account

Plan Year: August 1, 2009 - July 31, 2010

- **Dependent Care Flexible Spending Account Maximum: \$5,000**
- **The debit card does not apply to the Dependent Care account**

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.

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 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 attend 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. The Tax credit is up to \$3,000 for one qualifying individual and up to \$6,000 for two or more qualifying individuals. The percentage of dependent care expenses that can be used is 35%. The start of the phase out range from adjusted gross income is \$15,000. You may want to consult your tax advisor to see if the Flexible Spending Account or the tax credit will be more advantageous to your family.

How do I get reimbursed?

As you incur eligible expenses you must submit a completed Dependent Care

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.

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

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

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

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

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.

REMINDERS:

- 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.
- You will have **90 days** following the end of the plan year to file for services rendered during the plan year. You may send all requests for reimbursement directly to Gilsbar.

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

Gilsbar's Customer Contact Center at 1-800-445-7227 ext. 883

Fax Claims and Proof of expense to: **1-866-635-1329 for processing**

(PLEASE KEEP YOUR ORIGINALS)

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

Claims Processing Center

P.O. Box 26046, Tampa, FL 33623

(PLEASE KEEP YOUR ORIGINALS)

WEBSITE: myGilsbar.com

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 (S2591), social security number, and a valid email address to complete this section.



Gilsbar Welcome Letter (Example)

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

Your Gilsbar group number is S2591 (actual group # for Edgecombe County Government)

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

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

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

It's easy to get started:

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

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

Step 2: Once logged in, click on a selection under the Reimbursement Account Center section in the left navigation bar.

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

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

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

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

<p><u>For Fastest Processing,</u> FAX Claims and Receipts to: 1.866.635.1329</p> <p>Mail Claims and Receipts to: Claims Processing Center PO Box 26046 Tampa, FL 33623</p> <p><i>(Please keep your originals)</i></p>	<p><u>Customer Contact Center</u> 7:00 AM – 7:00 PM Central Time</p> <p>Phone: 1.800.445.7227 ext. 883 Email: flex@gilsbar.com</p> <p><i>(Please do not email claims/receipts)</i></p>
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County Health Plan (Open Access Plus Plan)

BENEFIT HIGHLIGHTS

	<u>In-Network</u>	<u>Out-of-Network</u>
PHYSICIAN OFFICE SERVICES		
Office Visit		
Includes Office Surgery if done in office		
Primary Care Provider	\$25 copayment	70% after deductible
Specialist	\$50 copayment	70% after deductible
Preventive Care		
Routine Examinations, Well-Child Care*		
Primary Care Provider	100 %	In-Network coverage only
Specialist	100 %	In-Network coverage only
*Pap Smears, Mammograms, and Prostate Specific Antigen Tests (PSA's) are covered Out-of-network.	100% no deductible if billed by independent diagnostic facility or outpatient hospital	70% after deductible
Therapies		
Short-term Rehabilitative Therapies (Maximums apply to Home, Office and Outpatient Settings): Physical/ Occupational/ Chiropractic: 30 visits per Contract Period/ Speech Therapy: 30 visits per Contract Period		
Primary Care Provider	\$25 copayment	70% after deductible
Specialist	\$50 copayment	70% after deductible
URGENT CARE CENTERS AND EMERGENCY ROOM		
Urgent Care Centers	\$50 copayment per visit	\$50 copayment per visit
Emergency Room Visit (<i>copayment waived if admitted</i>)	\$150 copayment per visit	\$150 copayment (70% after deductible if not true emergency)
AMBULATORY SURGICAL CENTER	80% after deductible	70% after deductible
INPATIENT AND OUTPATIENT HOSPITAL SERVICES		
Hospital Facility and Hospital Based Services	80% after deductible	70% after deductible
Outpatient Clinic Services	80% after deductible	70% after deductible
Professional Services	80% after deductible	70% after deductible
Hospital and Professional		
Outpatient Labs and Mammograms	100% no deductible	70% after deductible
All other Diagnostic services - X-rays, CAT/PET scans and MRIs	80% after deductible	70% after deductible
OTHER SERVICES		
Skilled Nursing Facility (60 days per Contract Period)	80% after deductible	70% after deductible

	<u>In-Network</u>	<u>Out-of-Network</u>
Home Health Care, Durable Medical Equipment and Hospice	80% after deductible	70% after deductible
Ambulance	80% after deductible (70% after deductible if not true emergency)	80% after deductible (70% after deductible if not true emergency)
Maternity		
Maternity Delivery includes Prenatal and Post-delivery care		
Hospital Services (Delivery)	80% after deductible	70% after deductible
Professional Services (Delivery)	80% after deductible	70% after deductible
Transplants		
Performed at LifeSource Center	100% no deductible	70% after deductible
Hospital Services	80% after deductible	70% after deductible
Professional Services	80% after deductible	70% after deductible

Infertility and Sexual Dysfunction Services

Up to \$5,000 per Lifetime***

Primary Care Provider	\$25 copayment	70% after deductible
Specialist	\$50 copayment	70% after deductible
Inpatient and Outpatient Facilities	80% after deductible	70% after deductible
Inpatient and Outpatient Professional Services	80% after deductible	70% after deductible

The following Deductibles and Coinsurance Maximums only apply to the services listed previously:

	UNLIMITED	UNLIMITED
Lifetime Benefit Maximum		
Deductibles		
Individual (per Contract Period)	\$850	\$1,700
Family (per Contract Period)	\$2,550	\$5,100
Coinsurance Maximum		
Individual (per Contract Period)	\$3,000	\$6,000
Family (per Contract Period)	\$9,000	\$18,000

The Deductibles and Coinsurance Maximums noted above do NOT apply to the services below:

Vision Care

Comprehensive Eye Exam (every 12 months) \$25 deductible per exam-any vision provider

(No Network applies to this benefit only)

Routine vision benefit includes one complete exam including basic vision screening and refraction. Expenses incurred for charges made for the purchase of eyeglasses, contact lenses (including fitting) and frames are excluded.

PRESCRIPTION DRUGS- Retail (up to 30 day supply)	Administered by Caremark	
Infertility Drugs up to \$5,000 Lifetime Maximum		
Tier 1 (Generic)	\$10 copayment	Copayment + charge over In-network allowed amount
Tier 2 (Preferred Brand)	\$45 copayment	Copayment + charge over In-network allowed amount
Tier 3 (Brand)	\$60 copayment	Copayment + charge over In-network allowed amount

PRESCRIPTION DRUGS- MAIL ORDER DRUG (MOD) **Administered by Caremark**
(90 day supply)

Tier 1 (Generic)	\$20 copayment	In-Network Coverage only
Tier 2 (Preferred Brand)	\$90 copayment	In-Network Coverage only
Tier 3 (Brand)	\$120 copayment	In-Network Coverage only

Mental Health Services

Office (30 visits per Contract Period)	\$50 copayment	70% coinsurance
Inpatient/Outpatient (30 Days per Contract Period)	80% coinsurance	70% coinsurance

Intensive Outpatient Mental Health (Maximum: up to 3 programs per contract year)	80% after \$50 per program copay	70% after \$50 per program deductible
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Substance Abuse Services

Office Visit	\$50 copayment	70% coinsurance
Inpatient/Outpatient	80% coinsurance	70% coinsurance

Intensive Outpatient Substance Abuse (Maximum: up to 3 programs per Contract year)	80% after \$50 per program copay	70% after \$50 per program deductible
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Substance Abuse Contract Period Maximum	\$8,000
Substance Abuse Lifetime Maximum	\$16,000

Routine Preventive Care for children under age 2 (including immunization):

(Covers for each member up to 24 months of age including periodic assessments and immunizations. Benefits are limited to six well-baby visits for members through 12 months old and three well-child visits for members 13 months up to 24 months.)

Routine Preventive Care for children and adults 2 & older:

(Covers one routine physical examination and related diagnostic services per benefit period).

****Coinsurance for Out-of-Network is based on Maximum Reimbursable Charge**

*****Infertility and Sexual Dysfunction Services- Coverage will be provided for the following services:**

- Testing and treatment services performed in connection with an underlying medical condition.
- Testing performed specifically to determine the cause of infertility. Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition)

EXCLUSIONS- What is not covered? (by way of example but not limited to):

Your plan provides coverage for medically necessary services. Your plan does not provide coverage for the following except as required by law:

1. Care for health conditions that are required by state or local law to be treated in a public facility.
2. Care required by state or federal law to be supplied by a public school system or school district.
3. Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
4. Treatment of an illness or injury which is due to war, declared or undeclared.

5. Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this Agreement.
6. Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
7. Any services and supplies for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Healthplan Medical Director to be: Not demonstrated, through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use; or The subject of review or approval by an Institutional Review Board for the proposed use
8. Cosmetic Surgery and Therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
9. The following services are excluded from coverage regardless of clinical indications: Acupuncture; Dance therapy, movement therapy; Applied kinesiology; Rolfing.
10. Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within 6 months of the accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
11. Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons, including but not limited to employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.
12. Court ordered treatment or hospitalization, unless such treatment is being sought by a Participating Physician
13. Infertility services, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
14. Reversal of male and female voluntary sterilization procedures.
15. Transsexual surgery, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
16. Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Agreement.
17. Non-medical counseling or ancillary services, including, but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return-to-work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, autism or mental retardation.
18. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including, but not limited to routine, long-term or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.

19. Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, and skin preparations
20. Private hospital rooms and/or private duty nursing
21. Personal or comfort items such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of illness or injury.
22. Artificial aids, including but not limited to corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
23. Hearing aids, including, but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
24. Aids or devices that assist with non-verbal communications, including, but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
25. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post cataract surgery).
26. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
27. Treatment by acupuncture.
28. All non-injectable prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs. Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
29. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs .Genetic screening or pre-implantation genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically-linked inheritable disease.
30. Dental implants for any condition. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Healthplan Medical Director's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
31. Blood administration for the purpose of general improvement in physical condition. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
32. Cosmetics, dietary supplements and health and beauty aids. All nutritional supplements and formulae are excluded, except for infant formula needed for the treatment of inborn errors of metabolism.
33. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
34. Telephone, e-mail & Internet consultations and telemedicine.
35. Massage Therapy
36. Cognitive Therapy

COUNTY HEALTH PLAN



Covering the counties that cover our state.

Preventive Health Benefits Wellness Exams & Immunizations

	Birth to 2 years	Ages 3 to 10	Ages 11 to 18	Ages 19 and older
Well-baby/Well-child/Well-person exams	Birth, 1, 2, 4, 6, 9, 12, 15, 18, & 24 months. Additional visit at 2-4 days for infants discharged less than 48 hours after delivery	Once a year for children ages 3-5 & every 2 years for children ages 6-10	Once a year	Periodic visits, depending on your age
Diphtheria, tetanus, and acellular pertussis (DTaP)	2, 4, & 6 months & between 15 & 18 months	Between ages 4 & 6	Tetanus - diphtheria - acellular pertussis (Tdap) given once, ages 11-64	Tetanus - diphtheria (Td) every 10 years; Tdap given once, ages 11-64
Haemophilus influenzae b (Hib)	2, 4, & 6 months & between 12 & 15 months			
Hepatitis A	Between 12 & 23 months			May be required for persons at risk
Hepatitis B virus (HBV)	At birth, 1-4 months & 6-8 months	Between ages 3 & 10 if not previously immunized	Between ages 11 & 18 if not previously immunized	May be required for persons at risk
HPV (Gardasil)		Girls 9 -10, as your doctor advises	Girls and women ages 11 - 12, catch up ages 13 -26	Catch up, women through age 26
Influenza vaccine	Annually between 6 & 23 months			Ages 19 & 49, as your doctor advises; age 50 & older, annually
Measles-mumps-rubella (MMR)	Between 12 & 15 months	Between ages 4 & 6 or 11 & 12 if not given earlier	If not already immune	Rubella (German measles) women of childbearing age if not immune
Meningococcal (MCV4)			Between ages 11-12 or prior to high school (age 15); college freshman living in dorms	
Pneumococcal conjugate (PCV) pneumonia	2, 4 & 6 months & between 12 & 15 months			Age 65 & older, once (or younger than 65 for those with risk factors)
Poliovirus (IPV)	2 & 4 months & between 6 & 18 months	Between ages 4 & 6		
Rotavirus (RotaTeq)	2, 4 & 6 months			

	Birth to 2 years	Ages 3 to 10	Ages 11 to 18	Ages 19 and older
Varicella (chickenpox)	Between 12 & 15 months	Between ages 4 & 6	Second dose catch up or if no evidence of prior immunization or chickenpox	Second dose catch up or if no evidence of prior immunization or chickenpox
Zoster				Age 60+
Blood pressure		At each visit	Once a year	Every 2 years or as your doctor advises
Cholesterol		Selective screening of children at risk due to family history		Complete lipoprotein profile, fasting non-fasting at ages 20 & older, every 5 years
Colon Cancer				Colorectal cancer screening at ages 50 and older: <ul style="list-style-type: none"> • Sigmoidoscopy once every 5 years • Colonoscopy once every 10 years • Fecal occult blood test annually • Barium enema once every 5 years
Diabetes				45 & older, or if history of risk factor, every 3 years
Fluoride	Evaluate for sufficient fluoride in drinking water			
Hearing	Newborn & as doctor advises	4, 5, 6, 8, & 10 or as doctor advises	12, 15 & 18 or as doctor advises	65 & older or as your doctor advises
Hemoglobin or hematocrit			Once a year for females after menarche	
PSA				Once a year for men 50+ or any age with risk factors
Size measurements	Weight, length & head circumference at each visit	Height and weight at each visit	Height and weight once a year	Height and weight periodically, include BMI
Vision		3, 4, 5, 6, 8 & 10 or as doctor advises	12, 15 & 18 or as doctor advises	By Snellen chart ages 65 & older, as often as your doctor advises

WOMEN'S HEALTH	
	Ages 19 and older
Chlamydia	Sexually active females under age 25
Mammogram	Women ages 40 & older, annually
Osteoporosis	Age 65 or older (or at 60 for women at risk)
Pap Test	Women ages 19-64 at least every 3 years

For additional information on what is covered by your plan, please review your Summary of Benefits. This summary contains highlights only. The specific terms of coverage, exclusions and limitations, including legislated benefits, are included in the Summary Plan Description or Insurance certificate.

These preventive health benefits are based on recommendations from the Advisory Committee on Immunization Practices, U.S. and other nationally recognized authorities. This document is a general guide. Always discuss your preventive care needs with your doctor.

County Health Plan (Indemnity Dental)

- **No network applies. Please go to the dental provider of your choice**
- **Contract Year Maximum (Class I, II, and III Expenses) - \$1,000**
- **Contract Year Deductible: Per Individual- \$50 Per Family- \$150**

Class I Expenses – Preventative and Diagnostic Care- 100%- No Deductible

- Oral Exams
- Cleanings
- Bitewing X-rays
- Fluoride Application
- Sealants
- Space Maintainers (limited to non-orthodontic treatment)
- Full Mouth X-rays-Panoramic X-Rays
- Emergency Care to Relieve Pain
- Histopathologic Exams

Class II Expenses – Basic Restorative Care- 80% after Deductible

- Fillings
- Oral Surgery - Simple Extractions
- Oral Surgery - All Except Simple Extraction
- Surgical Extraction of Impacted Teeth
- Anesthetics
- Major Periodontics
- Minor Periodontics
- Root Canal / Therapy
- Repairs - Bridges, Crowns, and Inlays
- Repairs – Dentures

Class III Expenses – Basic Restorative Care- 50% after Deductible

- Crowns
- Dentures
- Bridges

Class IV Expenses – Orthodontia (Not Covered)

Missing Tooth Provision- 12 Month Waiting Period

Pretreatment Estimate- Available on a voluntary basis when extensive work in excess of \$250 is proposed

Benefit Exclusions (by way of example, but not limited to):

- Services performed solely for cosmetic reasons
- Replacement of a lost or stolen appliance

- Replacement of a bridge or denture within five years following the date of its original installation
- Replacement of a bridge or denture which can be made useable according to accepted dental standards
- Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions TMJ, stabilize periodontally involved teeth, or restore occlusion
- Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molars
- Bite registrations; precision or semi-precision attachments; splinting
- Surgical implant of any type
- Instruction for plaque control, oral hygiene and diet
- Dental services that do not meet common dental standards
- Services that are deemed to be medical services
- Services and supplies received from a hospital
- Charges made by a hospital which performs services for the U.S. Government if the charges are directly related to a condition connected to a military service
- Experimental or investigational procedures and treatments
- Any injury resulting from, or in the course of, any employment for wage or profit
- Any sickness covered under any workers' compensation or similar law
- Charges in excess of the reasonable and customary allowances

COUNTY HEALTH PLAN MONTHLY RATES

Without Dental Coverage

*Employee & Spouse	\$441.00
Employee & Child	\$220.00
Employee & Children	\$342.00
Employee & Family	\$732.00

With Dental Coverage

Employee & Spouse	\$495.00
Employee & Child	\$246.00
Employee & Children	\$391.00
Employee & Family	\$815.00

* The \$30 Health Risk Assessment fee is waived if you participate.

* An additional \$30.00 is imposed if your spouse chooses not to participate in the Health Risk Assessment.

For Claims/Customer Service please call: 866-622-2288



CIGNA
A Business of Caring.

Cancer Can Affect Anyone

Statistics Predict:

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

Are you prepared for the cost of cancer?

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

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

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

THIS CANCER PLAN is designed to create a source of extra cash that will help you and your family cope during the battle against cancer or a specified disease.

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

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

Plus, you get these unique features:

- Guaranteed renewable for life. You can't lose your coverage, as long as you continue to pay your premiums.
- Cash benefits paid to you regardless of any other medical insurance plan 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
- Experimental Treatment
- Individual/Family Transportation and Lodging

*Cancer Facts & Figures, American Cancer Society, 2001
Report from the American Hospital Administration.*

Assurity Cancer & Specified Disease Plan

Effective Date: August 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 fulltime 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.markiiiibrokerage.com/edgecombecountync***. 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
Meningitis
Multiple Sclerosis
Muscular Dystrophy

Toxic Shock Syndrome
Tuberculosis
Typhoid Fever
Whooping Cough

Cancer or other Specified Disease Claims

You may file a claim for cancer or specified diseases by completing an Assurity Claim Form. Please make sure to include all pertinent information as stated on the form. You can obtain a claim form by contacting Assurity, or by downloading one from www.markiibrokerage.com/edgecombecountync. 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

To **Call** in a Wellness Claim: 1.888.358-8808 Ext. 23
To **Fax** in a Claim/Toll Free: 1.800.869-0368

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

A509-0609



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



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

Effective Date: August 1, 2009

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

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

WMD EDWEDGE 0609

SCHEDULE OF BENEFITS (continued)

PLAN I

PLAN II

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

SCHEDULE OF BENEFITS (continued)

PLAN I PLAN II

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

SCHEDULE OF BENEFITS (continued)

PLAN I

PLAN II

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

IMPORTANT INFORMATION

RENEWABILITY

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

EFFECTIVE DATE

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

ISSUE AGES

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

FAMILY COVERAGE

Spouse and dependent children coverage is available. Family Coverage includes the insured, his or her spouse, and or dependent children under age 19, if living with the insured (through 24 if the child is a full-time student. This may vary by state. Newborn children are automatically covered under the terms of the policy from the moment of birth. Single-Parent Coverage includes the insured and all of his or her dependent children who are unmarried and under 25.

TIME LIMIT ON CERTAIN DEFENSES

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

(2) Pre-Existing Conditions: Benefits for a loss that occurs more than two years after the date the policy is issued will not be reduced or denied because the condition causing the loss existed before the effective date, unless the condition is specifically excluded from coverage.

FRAUDULENT MISSTATEMENT

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

ADDITIONAL LIMITATIONS AND EXCLUSIONS

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

- a) Driving any taxi or intrastate or interstate long-distance vehicle for wage, compensation or profit.
- b) Mountaineering, parachuting or hang gliding.
- c) Poison, gas or fumes voluntarily taken, administered, absorbed or inhaled;
- d) Alcoholism or drug addiction.
- e) Participating in any sport or activity for wage, compensation or profit; or racing any type vehicle in an organized event.

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

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

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

**If you have any questions about the plan, please call
Customer Service at: 888-763-7474**

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

Plan I Monthly Rates - Industry Class B			
Individual	Single Parent Family	Two-Adult Family	Family
\$12.06	\$17.85	\$17.37	\$23.16
Plan II Monthly Rates - Industry Class B			
Individual	Single Parent Family	Two-Adult Family	Family
\$20.33	\$31.55	\$30.46	\$41.68



Superior Vision Plan

Effective Date: August 1, 2009

Outline of Benefits - Gold Preferred Plan With Materials Discount

CoPayment Amount - \$20.00 Exam Only

Contact Lens Fitting Fee- \$35.00

Vision Plan - Preferred Provider (PPO / Indemnity)

BENEFITS	FREQUENCY	IN-NETWORK	NON-NETWORK
Comprehensive Exam <i>(by an Ophthalmologist)</i>	12 Months	Covered in Full	Up to \$44.00
Comprehensive Exam <i>(by an Optometrist)</i>	12 Months	Covered in Full	Up to \$39.00
Lenses (Standard) per Pair			
Single Vision	12 Months	Covered in Full	Up to \$34.00
Bifocal	12 Months	Covered in Full	Up to \$48.00
Trifocal	12 Months	Covered in Full	Up to \$64.00
Lenticular	12 Months	Covered in Full	Up to \$88.00
Contact Lenses (Per Pair)*			
Medically Necessary	12 Months	Covered in Full	Up to \$210.00
Cosmetic (Elective)**	12 Months	Up to \$100.00	Up to \$100.00
Frames (Standard)**	24 Months	Up to \$100.00	Up to \$50.00
Standard Contact Lens Fitting Fee***	12 Months	Covered in Full	Not Covered
Specialty Contact Lens Fitting Fee***	12 Months	Up to \$50.00	Not Covered

*****Standard contact lens fitting fee applies to an existing contact lens user who wears disposable, daily wear, or extended wear lenses only. The specialty contact lens fitting fee applies to new contact lens wearers and/or a member who wears toric, gas permeable, or multifocal lenses. For the specialty fit, the member is responsible for any charges over \$50.**

***Contact lenses are in lieu of eyeglass lenses and frames benefit.**

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

HOW TO USE YOUR BENEFIT

IN-NETWORK

- Select a provider from the Superior Vision Services Provider Network.
- Use your personalized I.D. card to identify yourself. Provider will call SVS to verify eligibility. No paper work is required from you.
- Pay the provider directly for the \$20 exam co-pay and the cost of any non-covered item.

OUT-OF-NETWORK

- Call SVS Member Services for your authorization number.
- Pay the non-network provider for all products and services.
- Submit your original itemized billing from the provider, along with your authorization number, to SVS Member Services for reimbursement in

accordance with the Non-Network Schedule of Allowances less the \$20 exam co-pay if applicable.

DISCOUNT PROGRAMS

Discounts available from participating providers on additional pairs of eyeglasses and contact lenses.

DISCOUNT SVP8-20

Frames 20% off the difference between the covered frame allowance and the retail price of the selected frame.

Note: Discounts do not apply when prohibited by the manufacturer.

Add-on charges to the covered pair of lenses Member pays 20% off retail, up to:

•Factory Scratch Coat	\$13 (Single Vision & Standard Lined Multifocal Lenses)
•Ultraviolet Coat	\$15 (Single Vision & Standard Lined Multifocal Lenses)
•Standard Anti-Reflective Coat*	\$50 (Single Vision & Standard Lined Multifocal Lenses)
•High Index 1.6*	\$55 (Single Vision Lenses Only)
•Polycarbonate	\$40 (Single Vision Lenses Only)
•Standard Photochromic	\$80 (Single Vision Lenses Only)
•Glass coloring	\$35 (Any Type Lenses)
•Plastic Tints solid or gradient	\$25 (Any Type Lenses)
Power over 4.00D Sphere, 2.00D Cylinder & 5.00D Prism	20% discount off retail prices (Any Type Lenses)
•Cosmetic Finishing, Beveling, Edging & Mounting	20% discount off retail prices (Any Type Lenses)
•Miscellaneous Options	20% discount off retail prices (Any Type Lenses)

***Higher end or brand name lens upgrades are at an additional expense to the member. Apply maximum out of pocket expense toward the upgraded lens retail cost and the member is responsible for the difference less 20%.**

DISCOUNTS OF ADDITIONAL PURCHASES

•Prescription eyeglass lenses	30% discount off retail prices
•Eyeframes	30% discount off retail prices
•Add-on charges to basic lenses	20% discount off retail prices
•Contact lenses, standard hard or soft	20% discount off retail prices
•Disposable contact lenses	10% discount off retail prices
•All other prescription materials	20% discount off retail prices

Discounts are available for additional purchases of eyewear and contact lenses. Discounts are provided by Superior Vision Services contracted providers identified in the Provider Directory with a "DP". Discounts do not apply to the insured benefit underwritten by National Guardian Life Insurance Company.

Refractive Surgery Discounts & Cosmetic Eyelid Surgery Discounts are available: Superior Vision Services has a nationwide network of refractive surgeons who specialize in the popular elective procedures of radial keratotomy (RK),

photo-refractive keratotomy (PRK) and LASIK. These providers offer Superior Vision Plan members a 20% discount off their usual and customary surgical fees for these procedures. Ophthalmic plastic surgeons are also contracted to provide the procedure of blephoroplasty (cosmetic eyelid surgery) to Superior Vision Plan members on the same discount basis.

EXCLUSIONS (products & services not covered)

1. Professional Services and/or Materials in conjunction with:
 - a. **blended bifocals, no line, or progressive lenses**
 - b. **compensated or special multi-focal lenses**
 - c. **plain (non-prescription) lenses**
 - d. **anti-reflective, scratch, UV400 or any coating or lamination applied to lenses.**
 - e. **subnormal vision aids**
 - f. **tints other than solid**
 - g. **orthoptics, vision training and developmental vision procedures**
 - h. **polycarbonate lenses**
2. Medical or surgical treatment of the eyes
3. Any eye examination or any corrective eyewear required by an Employer as a condition of employment
4. Any injury or illness when covered under Workers' Compensation or similar law
5. Plain or prescription sunglasses, no-line bifocals, blended lenses are not covered, an Insured may elect to apply the maximum allowance for standard lenses toward his or her cost of progressive lenses.
6. Subnormal vision aids
7. Services rendered or Materials purchased outside the U.S. or Canada, unless:
 - a. **the Member resides in the U.S. or Canada; and**
 - b. **the charges are incurred while on a business or pleasure trip**
8. Charges in excess of the Usual, Customary and Reasonable charge for the Professional Service or Materials
9. Experimental or non-conventional treatment or device
10. Safety eyewear
11. Spectacle lens styles, materials, treatments or "add-ons" not shown in the Benefits Summary
12. Services or Materials rendered by a provider other than an Ophthalmologist, Optometrist or Optician acting within the scope of his or her license
13. Any additional service required outside basic vision analysis for contact lenses, except fitting fees.
14. Services rendered after the date an Insured ceases to be covered under this Certificate, except when vision Materials ordered before coverage ended are delivered and the services rendered to the Insured within 31 days from the date of such order.
15. Services rendered or Materials ordered before the date of coverage began under this Certificate
16. Regardless of Optical Necessity, benefits are not available more frequently than which is specified in the Benefits Summary

MONTHLY RATES

Employee Only	\$9.13
Employee + Spouse	\$17.70
Employee + Child	\$17.70
Employee + Family	\$25.98

Member Services, Provider Listings, and Claims Services:
800-507-3800

To order contact lens via the internet go to this site: www.SVContacts.com

Member Services FAX:
916-852-2277

Provider Nominations:
Lee Sims @ 800-923-6766 x 254

Web Site: www.superiorvision.com

Address:
Superior Vision Services, Inc.
11101 White Rock Road, Ste. 150
Rancho Cordova, CA 95670

Non-network Claims Submission:
Superior Vision Services, Inc.
P.O. Box 967
Rancho Cordova, CA 95741

Note: This is only a summary of the benefit plan. You may review and/or obtain a copy of the Master Policy and Certificate of Coverage by contacting your Human Resources Office

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



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.
- Workers' 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

Could You Live Off Of Your Savings?

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

Standard Life Short Term Disability Plan

Effective Date: August 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 is covered as any other sickness
- No change in premium due to age
- You may continue coverage if you leave your Employer, provided you maintain continuous employment.

ACCIDENT & SICKNESS PROTECTION

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

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

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

Eligibility

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

POLICY FEATURES

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

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

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

Limits and Exclusions:

Benefits will not be paid for any total disability which:

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

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

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

If you have any questions regarding the Standard Life Disability Plan,

Please call: 800-327-0695

Toll Free Claims Line: 800-227-0251



Lincoln Financial Group Long Term Disability Plan

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

Voluntary Long Term Disability, underwritten by Lincoln Financial Group offers disability income protection to employees unable to perform all of the material duties of their occupation on a full-time basis due to sickness or injury.

Long Term Disability coverage is needed by employees as a replacement for lost income should they become sick or injured. Under the Lincoln Financial Group Long Term Disability Plan, a monthly benefit is paid directly to an employee to help with ongoing personal expenses.

FEATURES AND ADVANTAGES

- Affordability
- Guaranteed Acceptance (according to underwriting guidelines)
- Coverage Options
- Partial Disability Benefits
- Pregnancy and pregnancy complications covered the same as any other sickness
- Mental and Nervous Conditions covered up to 24 months
- Alcoholism and Drug Addiction covered same as any other sickness
- Family Income Benefit
- Waiver of Premium
- Portability
- Payment through convenient payroll deduction

ELIMINATION PERIOD

Elimination Period is the number of continuous days (90 days) you must be totally disabled before benefit payments start. The Elimination Period is waived on Recurrent Disabilities. You can return to your regular occupation for up to six months without having to satisfy a new Elimination Period if there is a recurrence of the prior disability.

MAXIMUM BENEFIT PERIOD

To age 65 - the longest period of time that benefits will continue to be paid to the disabled employee as long as he/she remains disabled in accordance with the contract. **The benefit period starts reducing depending on the age at the onset of the disability.**

MAXIMUM MONTHLY BENEFIT

60% of salary - is the highest monthly benefit the disabled employee can receive up to a maximum of \$5,000.00.

MONTHLY RATE

The following Voluntary Long Term Disability rate is for full-time employees who are working a minimum of 30 hours per week and who are not qualified to receive disability benefits under the North Carolina Local Governmental Employee's Retirement System: **\$.96 per \$100.00 of covered monthly salary, excluding bonuses and overtime pay.**

PRE-EXISTING CONDITION EXCLUSION

A **12/12/24 pre-existing condition limitation** applies to all insurance amounts. Pre-existing condition means any sickness or injury for which an employee has received medical treatment, consultation, care or services (including diagnostic measures or the taking of prescribed drugs or medicines) **during the 12 months prior to the insured employee's coverage effective date**, unless no treatment was received for **12 consecutive months after the insured employee's effective date**. A disability arising from any such sickness or injury will be covered only if it begins after an employee **has performed his/her regular occupation on a full-time basis for 24 months following the coverage effective date**.

PARTIAL DISABILITY BENEFIT

Benefits are payable when an insured is unable to perform one or more of his/her main duties at his/her own or any other occupation, or is unable to perform those duties on a full-time basis.

To qualify for the benefit, an insured must be earning less than 80% of his/her pre-disability income. An 85% earnings test will be applied after the first two years of partial disability, unless total earnings reaches 100% of pre-disability income.

Benefit payments are reduced by partial employment earnings and other income sources and end on the earliest of:

- the date the insured ceases to be partially disabled;
- the date the insured's current earnings exceed 85% of his/her pre-disability income; or
- the date the maximum benefit period ends.

FAMILY INCOME BENEFIT

Pays a lump sum benefit equal to 3 times the insured's last gross monthly LTD benefit to the surviving spouse or children of the insured. The insured must have been disabled for a minimum of 180 days and have been receiving benefits under the policy when death occurs.

WAIVER OF PREMIUM

Premiums due during an insured's total or partial disability period are waived after benefits become payable and as long as the payments continue.

ACCUMULATION OF ELIMINATION PERIOD

The elimination period is satisfied when the required number of days is accumulated in a period which does not exceed 2 times the program elimination period. For example, a 90-day elimination period may be met by days of disability accumulated over a 180-day period. Only days of disability due to the same or a related sickness or injury will count towards the elimination period.

RECURRENT DISABILITY PROVISION

An insured can return to his/her regular occupation for up to six months without having to satisfy a new elimination period if there is a recurrence of the prior disability. However, if an insured returns to his/her regular occupation on a full-time basis for six months or more, a recurrent disability will be treated as a new period of disability, and the insured employee must complete another elimination period.

PREGNANCY

Pregnancy is treated as an illness. The definition of disability must be satisfied and the elimination period completed before benefits would begin.

MENTAL AND NERVOUS CONDITIONS

Disability resulting from a mental illness or nervous condition will be covered up to 24 months of benefit payments unless the employee is hospitalized at the end of 24 months. In that case, benefits will continue for as long as the employee is confined to a hospital up to the specified maximum benefit duration.

ALCOHOLISM AND/OR DRUG ADDICTION

Disability caused by alcoholism and/or drug addiction will be covered the same as any other sickness.

PORTABILITY

An insured may keep his/her coverage for up to one year after he/she leaves employment at the same rates that were in effect at the time of termination. Coverage must be in force at least 12 months prior to termination and the insured must not be disabled, on a leave of absence or retired on the date of termination of employment.

BENEFIT INTEGRATION*

Voluntary Long Term Disability benefits are reduced by any other income the insured is eligible for under:

- Primary and Family Social Security Disability or Retirement or any similar plan or act;
- Worker's Compensation Law, occupational disease law or any similar law;
- State Disability Plans or any compulsory benefit act or law;
- Other group disability plans;
- Disability or retirement benefits through the employer; and
- Any form of employment (full or part-time).

****The minimum benefit payable will never be less than \$100.00.***

EXCLUSIONS

Lincoln Financial Group does not pay Long Term Disability benefits for any period of disability:

- Which is the result of self-inflicted injury or attempted suicide;
- During which you are not under the regular care of a doctor;
- Due to active participation in a riot or in the commission of a felony;
- Due to war, declared or undeclared, or any act of armed aggression; or

When a disability is due to mental illness, Lincoln Financial Group's standard contract considers benefits payable for up to a maximum period of 24 months. However, if the insured employee is confined to a hospital at the end of the 24-month period, benefits will continue up to the specified maximum benefit duration.

Long term disability coverage is needed by employees as a replacement for lost income should they become sick or injured. A monthly benefit is paid directly to them to help with ongoing personal expenses. Your employees will appreciate the fact that you realize the value of this benefit and cares enough to offer it to them.

This plan is insured by Lincoln Financial Group headquartered in Omaha, Nebraska. This is not a contract. This brochure briefly summarizes the insurance coverages described. Controlling provisions are in the related policies, which are not modified by this brochure. State requirements may necessitate variances.

GLVP 57 (7-98)

**If you have any questions, please call
Lincoln Financial Group at 800-423-2765.**

Met Life Term Life Insurance Plan

Effective Date: *pending underwriting approval*

BASIC EMPLOYEE LIFE INSURANCE

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

OPTIONAL EMPLOYEE LIFE INSURANCE

Your employer sponsored Basic Life coverage provides important protection for you, but you may need to add to that protection. To help meet this need, you have the opportunity to elect additional group life insurance under the optional portion of your plan.

OPTIONAL DEPENDENT LIFE INSURANCE

Provides coverage on:

- Your Spouse
- Child(ren) from 14 days of age to age 19 (up to age 23 if wholly dependent upon you for maintenance and support **and** if enrolled as a full-time student in an accredited school or college). Handicapped children can continue to be covered with no age limit if handicap is diagnosed prior to age 19.

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

ACCIDENTAL DEATH AND DISMEMBERMENT

Accidental Death and Dismemberment (AD&D) Insurance provides specified benefits for a covered accidental bodily injury that directly causes dismemberment. In the event that death occurs from a covered accident, both the Life and AD&D benefit would be payable. **AD&D applies to Basic Employee coverage only.**

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

All full time active employees working 30 or more hours per week are eligible for coverage. A delayed effective date will apply if the employee is not actively at work on the date the insurance would otherwise take effect.

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.

SUICIDE EXCLUSION

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

WHEN YOUR INSURANCE STARTS

Your Basic, Optional Employee Life and Dependent 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.

If you complete an application more than 30 days after the eligibility date, your insurance will take effect on the date on which MetLife in writing, either approved evidence of your insurability or waived such requirement.

REDUCTIONS AT AGE 70 AND OVER

If you remain in active service beyond age 70, your combined amount of Basic and Optional Employee Life Insurance will reduce as follows:

<u>Attained Age</u>	<u>Percent of Original Amount</u>
70	65%
75	50%
80	30%

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.

WAIVER OF PREMIUM

If an insured becomes totally disabled prior to age 60, the amount of group life coverage will be continued without payment of premium provided evidence of disability is submitted annually. The amount of insurance is subject to any reductions due to age and the Waiver of Premium provision terminates at age 70.

CONVERSION

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

THE ACCELERATED DEATH BENEFIT (ADB)

A Living Benefit (also called an Accelerated Death Benefit) is available to employees who have satisfied the Active Work rule and have been covered under this policy for at least 30 days. When such employees are diagnosed as terminally ill (having 12 months or less to live), they may withdraw up to 75% of their life insurance coverage to a maximum of \$75,000. The death benefit will be reduced by the amount taken as a Living Benefit.

CONTINUATION OF COVERAGE

This option gives you the opportunity to continue your Term Life Insurance policy for up to 36 months, without submitting Evidence of Insurability, if employment or policy terminates due to anything other than retirement or disability. Coverage must be in force for at least 12 months in a row to be eligible.

CLAIMS PROCEDURE

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

SCHEDULE OF BENEFITS

• BASIC EMPLOYEE LIFE INSURANCE AND AD&D

All eligible employees \$20,000* (No cost to you)

*See "Reductions at age 70 & Over."

• OPTIONAL EMPLOYEE LIFE INSURANCE*

An amount equal to 100% of your basic annual earnings (rounded to the next higher \$1,000 of benefit) to a maximum of \$100,000.

EXAMPLE: OPTIONAL LIFE PREMIUM CALCULATION

An employee age 37 with an annual salary of \$20,000 would calculate their monthly premium as follows: $\$20,000 \times .08 / \$1000 = \$1.60$ monthly premium

Optional Employee Life Insurance	
Age	Rate per \$1,000 of Life Insurance
<30	\$0.06
30-34	\$0.06
35-39	\$0.08
40-44	\$0.14
45-49	\$0.24
50-54	\$0.38
55-59	\$0.57
60-64	\$0.85
65-69	\$1.33
70-74	\$2.15
75-79	\$2.15

****NOTE: If you do not elect Optional Employee or Dependent coverage when first hired, you will be required to submit a Statement of Health to MetLife. This applies to your dependents as well.***

• OPTIONAL DEPENDENT LIFE INSURANCE & MONTHLY COST*

\$2,500 on your Spouse

If your spouse is age 70 or older on the Spouse's effective date of insurance, Life Insurance is not available. If your Spouse is under age 70 on the effective date of Insurance, the Spouse's Life insurance will end on the date on which the Spouse attains age 70.

\$2,500 on each of your eligible Children

- Regardless of the number of children
- Age 14 days to 19 years; 23 years if a full time student

- **Cost is: \$.50 (per pay period) for Spouse & Child(ren)**
-no matter how many children
- **To elect Dependent coverage, you must elect Optional Employee coverage.**

This material has been prepared to give you the highlights of coverage now being offered by your employer to meet your insurance needs. For details please ask your Benefits office or refer to the certificate of insurance that you will receive after you have signed up for protection.

**For Questions regarding the status of your statement of health or life claim,
please call 800-638-6420.**

MetLife®

Texas Life Whole Life Plan

Common Issue Date: September 1, 2009 (pending underwriting approval)

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

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

WHY VOLUNTARY COVERAGE

- Most employees are dependent on group term
- Only 50% of U.S. Households have individually owned life insurance¹
- 72% of life insurance policies are paid to beneficiaries of individually owned life plans¹
- Most term policies expire before paying a death claim
- When do you want a life insurance policy in force?
 - Answer: When you die
- Term is for IF you die; permanent is for WHEN you die
- Everybody dies

THE NEW PRODUCT: TEXAS LIFE'S VPL-plus

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

VPL-plus: PORTABLE AND PERMANENT

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

VPL-plus: THE GUARANTEES EMPLOYEES WANT

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

¹LIMRA International, 2005
07M014-C (Expires 022809)

See the VPL-plus brochure for complete details- Form PWLSEV-NI-05

VPL-plus: CGI (EXPRESS ISSUE) UNDERWRITING

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

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

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

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

Express Issue Maximums

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

Simplified Issue

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

Accelerated Death Rider

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

Waiver of Premium

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

VPL-plus: Review

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

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

**If you have any questions regarding your Texas Life policy, please call
(800) 283-9233, press prompt #3.**

Texas Life Insurance Company®
A MetLife Company

Since 1901 900 Washington Post Office Box 830 Waco, Texas 76703-0830

Continuation of Benefits

GILSBAR HEALTH CARE FLEXIBLE SPENDING ACCOUNT

If you prefer to terminate your participation and contribution to the Plan, any balance in your account on the date of termination will be forfeited if expenses were not incurred prior to the date of termination. For more detailed information, please call **Gilsbar at 800.445.7227 x.883.**

CIGNA MEDICAL, DENTAL & SUPERIOR VISION

Under the Cigna Medical, Dental, and Superior Vision plan, you and your covered dependents are eligible to continue coverage through COBRA according to the "qualifying events".

If you and your dependents are enrolled in these plans, you will be eligible to continue coverage through COBRA after you leave your employment for a specified period. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents may be eligible to continue dental coverage through COBRA. Also, while you are covered under the plan, your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA. Examples of an ineligible dependent would be when your child graduates from college, or reaches the age of not being eligible for dependent coverage. You will receive notification with premium and continuation options shortly following your termination of employment. Should you have any questions you may contact your **Benefits Department at 252.641.7832.**

CSO/ PHILADELPHIA AMERICAN CANCER

When you leave employment you may continue your CSO Cancer coverage by having the premiums that are currently deducted from your paycheck drafted from your bank account. **You may contact CSO/Philadelphia American at 800.554.0092.**

ASSURITY CANCER

When you leave employment, you may continue your Assurity Cancer coverage by having the premiums that are currently deducted from your paycheck drafted from your bank account. Please call **Assurity at 866.289.7337.**

ACCIDENT ONLY INSURANCE

When you leave employment you may continue your AccidentSelect Insurance coverage by having the premiums that are currently deducted from your paycheck drafted from your bank account. Please contact Transamerica Life Insurance Company at **800.400.3042.**

STANDARD LIFE SHORT TERM DISABILITY PLAN

When you leave you may continue your disability coverage provided you send Standard Life proof of continuous employment. Coverage is subject to occupational and income underwriting rules. Coverage expires at age 65. You can have the

premium that is currently deducted from your paycheck drafted from your bank account. Please contact **Standard Life at 800.327.0695.**

LINCOLN FINANCIAL GROUP LONG TERM DISABILITY PLAN

An insured may keep coverage for up to one year after employment has been terminated at the same rates that were in effect at the time of termination. Coverage must be in force at least 12 months prior to termination and the insured must not be disabled, on a leave of absence, or retired on the date of termination. **Please contact Lincoln Financial Group at 800.423.2765.**

METLIFE TERM LIFE PLAN

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

To get information for converting coverage, please contact MetLife at 877.275.6387.

METLIFE WHOLE LIFE

When you leave employment you may continue your MetLife Whole Life coverage by having the premium that is currently deducted from your paycheck drafted from your bank account. Please contact **MetLife at 800.634.5007.**

TEXAS LIFE WHOLE LIFE

When you leave employment, you may continue your Texas Life Whole Life coverage by having the premiums that are currently deducted from your paycheck drafted from your bank account. You may do that by contacting **Texas Life at 800.283.9233 prompt #3.**

Important Phone Numbers

- Assurity Cancer - 888.358.8808, ext. 23
- County (Cigna) Health & Dental- 866.622.2288
- Edgecombe County Government Benefits Department- 252.641.7832
- Gilsbar Health and Dependent Care - 800.445.7227 ext. 883
- Lincoln Financial Group Long Term Disability- 800.423.2765
- Mark III Brokerage, Inc.- 800.532.1044
- MetLife Term Life Insurance- conversion: 877.275.6387
- MetLife Whole Life- 800.634.500
- Standard Life Short Term Disability - 800.327.0695
- Transamerica Accident- 888.763.7474
- Texas Life Whole Life- 800.283.9233 prompt #3.

