

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

◆ The Plan Year begins September 1, 2008 and ends August 31, 2009

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

Gilsbar Health Care Flexible Spending Account

Plan Year: September 1, 2008 - August 31, 2009

Healthcare Choice Flexible Spending Account Maximum: \$2,500.00

Healthcare Choice Flexible Spending Account Minimum: \$240.00

Run Off Period: 90 days following the end of the plan year to file for services rendered during the plan year.

Waiting Period: Coverage for new hires will be effective the first of the month following 30 days of continuous employment.

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. The Welcome Page Letter at the end of this summary will give you instructions on how to login.

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, ex-

penses 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/imwp/download.asp?ContentID=12418> 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 Dependent Care Flexible Spending Account

Plan Year: September 1, 2008 to August 31, 2009

- **Dependent Care Flexible Spending Account Maximum: \$5,000**
- **Dependent Care Flexible Spending Account is the same as dependent spending account or one of the reimbursement accounts.**
- **Reminder: Debit card cannot be used with 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 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.
- Remember that 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: www.mygilsbar.com



Example of the Gilsbar Welcome Letter

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 S2554

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>For Fastest Processing, 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>Customer Contact Center</p> <p>7:00 AM – 7:00 PM Central Time</p> <p>Phone: 1-800-445-7227 ext. 883 Email: flex@gilsbar.com</p> <p>(Please do not email claims/receipts)</p>
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Ameritas Dental Plan

Effective Date: September 1, 2008

COMBINED CALENDAR YEAR DEDUCTIBLE

- **\$25.00 per individual for Type II (Basic) and Type III (Major) Procedures**

3 times family limit. After the date that 3 members of a family have each satisfied their individual deductible, the entire deductible or any remaining portion of the deductible for any family member will be waived for the rest of that calendar year.

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

- Evaluations (Two per benefit period)
- Cleanings (Two per benefit period)
- Fluoride for Children (Under age 19)
- Space Maintainers
- Radiographs (X-rays)
- Bitewings (Two per benefit period)

TYPE II - BASIC PROCEDURES - Type II benefits are payable at **80-90-100%** \$25.00 deductible applies.

- Sealants (to age 16)
- Limited Exams
- Restorative Amalgam & Resin
- Simple Extractions
- Oral Surgery
- Anesthesia
- Denture Repair

80-90-100% INCENTIVE PLAN

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

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

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

TYPE III -MAJOR PROCEDURES - Type III benefits are payable at 50% U & C*. \$25.00 deductible applies.

- Endodontics (Root Canal)
- Periodontics (Non-Surgical)
- Prosthodontics - Fixed Pontics or Abutment
- Dentures, Partial
- Restorative - Crowns
- Periodontics (Surgical)
- Prosthodontics - Removable
- Bridges / Pontics
- TMJ- \$500 Lifetime Maximum

ORTHODONTIA (CHILDREN AND ADULTS)

- Paid at 50% U & C*.
- No deductible applies.
- \$1,000 Lifetime maximum per person.

ANNUAL MAXIMUM BENEFIT

- Applies to Type I, Type II, and Type III Procedures
- \$1,500 per calendar year per person

****Usual & Customary charges***

DENTAL EXCLUSIONS (DEFERMENT PERIOD)

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

EXCEPTIONS to this exclusion will be made if the replacement is made necessary by: a) accidental bodily injury to sound natural teeth (chewing injuries are not considered accidental bodily injuries), or b) the extraction of a sound natural tooth provided the replacement is completed within 12 months of the date of the injury or extraction.

ANNUAL MAXIMUM CARRYOVER

1. Visit a dentist between January 1 and December 31 of each year.
2. Submit a claim for a covered procedure prior to **March 1** of the following year.
3. Total dental benefits paid for the calendar year must be less than \$750.

If you meet all 3 requirements then you will be eligible for the Annual Maximum Carryover benefit. This benefit will provide you with an additional \$250 towards your annual dental maximum for the following year. In future years, if you continue to meet these requirements you will continue to see an increase in your annual maximum by \$250 until you have reached an annual maximum carryover limit of \$1,000. This benefit allows you to accumulate up to a \$2,500 annual dental maximum.

ELIGIBLE EMPLOYEES

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

ELIGIBLE DEPENDENTS

Provides Coverage On:

- Your Spouse
- Children up to age 19 and unmarried (Up to age 24 if wholly dependent upon you for maintenance and support and if enrolled as a full-time student in an accredited school or college.)

PREDETERMINATION OF BENEFITS

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

COORDINATION OF BENEFITS

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

CERTIFICATE OF INSURANCE

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

SECTION 125

This policy is provided as part of the Policyholder's Section 125 Plan. Each member has the option under the Section 125 Plan of participating or not participating in this policy. A member may change their election only during an annual election period, except for a change in family status. Examples of such events would be marriage, divorce, birth of a child, death of a spouse or child or termination of employment. Please see your plan administrator for details.

ORTHODONTIA LIMITATIONS

(This is not a complete list)

No benefit is payable for expenses incurred:

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

LATE ENTRANT

If you or your dependents do not elect to participate in the dental plan when first eligible, you will be considered a **Late Entrant** and you must wait 12 months for most procedures. For a **Late Entrant**, benefits will be limited to **exams, cleanings, and fluoride treatments**. The late entrant provision is waived if the employee comes on the plan as a result of a qualifying event.

LIMITATIONS/EXCLUSIONS

(This is not a complete List)

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

Monthly Rates

Employee Only	\$22.12
Employee and Child(ren)	\$61.76
Employee and Spouse	\$47.86
Employee and Family	\$83.98

For Claims/Customer Service call Ameritas: 800-776-9446

Website: www.ameritasgroup.com

This insurance is underwritten by Ameritas Life Insurance Corp.



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, or Radioactive Isotopes Therapy
- Experimental Treatment
- Individual/Family Transportation and Lodging

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

Assurity Cancer & Specified Disease Plan

Effective Date: September 1, 2008

BASIC BENEFITS

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

RATE STRUCTURE

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

UNDERWRITING

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

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

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

Hospital Indemnity – pays benefits each day while confined in the hospital for cancer or certain other specified disease for the first 75 days of each period of confinement. There are three options for the daily benefit amount: \$150, \$250, and \$350. (NOTE: The \$150 benefit amount is not available in Utah.)

Prescription Drugs and Medicines – pays actual charges up to 25% of daily hospital confinement benefit for the first 75 days of hospital confinement.

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

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

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

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

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

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

Radiation, Chemotherapy or Immunotherapy – pays 50% of actual charges for treatments up to the maximum amount purchased.

The monthly option for this benefit is:

- **\$10,000 with a lifetime maximum of \$100,000**

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

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

Extended Care Facility – pays up to \$60 per day for confinement in such a facility. Confinement must be recommended by a physician and begin within 14 days following a covered hospital stay. Benefits are limited to the number of days of the prior hospital confinement.

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

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

Transportation for Non-local Treatment Which Requires Hospital Confinement – pays (a) actual charges for non-local round trip charges by common carrier to the nearest hospital that provides the prescribed treatment or (b) 50 cents per mile for personal automobile expenses in excess of 50 miles one way, up to 700 miles round trip.

Transportation for Non-local Treatment Which Does Not Require Hospital Confinement – pays (a) 50 cents per mile for personal automobile expenses in excess of 50 miles one way, up to 700 miles round trip with a maximum of \$1,500 per calendar year, (b) pays actual charges for round trip coach fare on a common carrier or a personal automobile allowance of 50 cents per mile in excess of 50 miles one-way to the city where the transplant is preformed, up to 700 miles round trip and (c) pays actual charges up to \$50 per day for lodging and meal expenses.

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

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

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

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

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

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

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

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

Breast Cancer / Breast Reconstruction / Breast Prosthesis – pays a benefit equal to the daily hospital confinement benefit for a minimum of 48 hours of inpatient care following a mastectomy and for a minimum of 24 hours following a lymph node dissection for the treatment of breast cancer. Lifetime maximum of \$2,500 per breast.

Cancer (Wellness) Screening Tests – pays up to \$100 per year for cancer screening test. Tests covered are:

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

Wellness Claims: An employee can file a wellness claim by fax, call-in or mail. Employees can call Assurity to get a wellness claim form or download one from www.markiibrokerage.com/elizabethcitypasquotankpublicschoolsnc.

If a bill is not included with the claim form, a scheduled amount will be paid. (Scheduled amounts are listed on the claim form). Employees can also call in their wellness claim at **888-358-8808 ext. 23**. The call in service requires all the information on the wellness claim form. The wellness claim form must include the name and phone number of your physician. All claims are subject to verification.

Home Health Care Services – when services are provided by a Home Health Care Agency, policy pays (a) up to \$60 per day for services provided at home, not to exceed 180 days per calendar year, (b) up to \$100 per day for Private Duty Nursing, not to exceed 15 days per calendar year, and (c) pays actual charges for a physician's visit up to \$40 per day not to exceed 15 days per calendar year. Benefits herein are not payable under provisions of this policy.

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

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

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

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

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

30-Day Waiting Period

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

Pre-Existing Conditions

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

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

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

Cancer or other Specified Disease Claims: You may file a claim for cancer or specified diseases by completing an Assurity Claim Form. Please make sure to include all pertinent information as stated on the form. You can obtain a claim form by contacting Assurity, or by downloading from www.markiiibrokerage.com/elizabethcitypasquotankpublicschoolsnc. Should you have any questions on how to file or submit a claim, please contact Assurity at **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.

**Assurity Life Insurance Company
PO Box 82533
Lincoln, NE, 68501-0926
Assurity Customer Service: (866) 289-7337**

**Fax: (402) 437-4592
Website: www.assurityatwork.com**

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

Assurity Life Cancer & Specified Disease Plan- Monthly Rates

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



Assurity Critical Illness+ Plan

Effective Date: September 1, 2008

- Pays a benefit to you when you're struck with a covered illness.
- "You need critical illness insurance — not because you're going to die — but because you are going to survive." — Dr. Marius Barnard, Father of critical illness insurance

Could it happen to you?

Life can change in a heartbeat — an unanticipated critical illness could dramatically change your life. No one has immunity from life's risks.

Fortunately — if a critical illness like a heart attack, stroke or other serious illness strikes, you'll probably survive thanks to recent medical advances. But, recovery comes at a price. If you had to take an extended leave from your work or if you couldn't return to your job because of physical limitations, your bills would pile up while your income decreased.

Financial Impact...

Nearly half (48 percent) of all U.S. bankruptcies are caused by soaring medical bills. According to a recent Harvard study, the average person who filed bankruptcy earned a middle-income salary and had health insurance but was financially crippled with out-of-pocket expenses for co-payments, deductibles and noncovered medical services.*

The Critical Illness+ Solution

Assurity at Work's Critical Illness+ Insurance can reduce the financial stress of a major illness by putting money directly into your pocket when you need it most. With the diagnosis of a covered illness, you receive a check for the benefit amount. The benefit is paid whether or not you're able to work — independent of any other health coverage. You choose how to spend the money, but many recipients pay down their home mortgage, clear up debt or supplement family income so that a care-giving spouse can be by their side.

Covered Illnesses

- Heart Attack
- Stroke
- Heart Transplant (or combination transplant including heart)
- Coronary Bypass Surgery
- Angioplasty
- Advanced Alzheimer's Disease
- Kidney (Renal) Failure
- Paralysis (other than from stroke)
- Severe Burns
- Loss of Independent Living
- Coma
- Occupational HIV
- Major Organ Transplant (other than heart)
- Cancer (optional rider)

Critical Illness+ highlights...

- Lump-sum benefits available from \$5,000 to \$50,000!
- Multiple benefits — up to double the maximum benefit — are paid if you suffer an illness from the “heart/stroke” category and from the “other illnesses” category.
- Loss of Independent Living Benefit is paid (25 percent of policy benefit) when you’re unable to perform two “activities of daily living” if you satisfy the waiting and elimination periods. This benefit terminates at age 75.
- If you leave your current employer, you may keep the policy in force by continuing to pay premiums.
- You may expand your policy to include coverage for your spouse and children. All of your eligible children are covered for one rate!

Critical Illness+ Features

• Issue Ages-

Adults- 18 -69 years of age

Children- 0-18 years of age

- **Renewability-** Guaranteed renewable for life, except for Loss of Independent Living Benefit which terminates at age 75.
- **Benefit Paid-** Lump-sum payment to you at diagnosis of covered illness or procedure.
- **Benefit Options-**
Employee \$5,000 to \$50,000
Spouse \$5,000 to \$50,000
Child \$10,000
- **Return of Premium Upon Death-** Returns 100% of primary insured premiums when you die of any cause (minus any benefits received).
- **Waiting Period -** None for any illness except for Loss of Independent Living Benefit, Cancer Rider and Wellness Rider each with a 30-day waiting period.
- **Pre-existing Condition-** Benefits are payable for a specified critical illness resulting from a pre-existing condition if the illness begins more than 12 months after the policy issue date.
- **Portable-** If you leave your current employer, you may keep the policy in force by continuing to pay premiums.

Wellness Benefit Rider (30-day waiting period from date of policy issue)

You and any insured person in your family are eligible for a \$50 benefit once per calendar year for health screening tests. Tests covered are:

- Biopsy for skin cancer
- Blood test for triglycerides
- Bone Marrow biopsy and aspiration
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 19-9 (blood test for pancreatic cancer)
- CA125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer and cervical cancer screening)
- Chest X-ray
- Colonoscopy
- Fast blood glucose test
- Flexible sigmoidoscopy
- Hemocult stool analysis
- Mammography
- Pap Smear
- PSA (blood test for prostate cancer)
- Serum cholesterol- HDL & LDL
- Serum Protein Electrophoresis
- Thermography
- Stress Test (bicycle or treadmill)

Critical Illnesses, Conditions, and Procedures Covered

Multiple Benefits — All of the illnesses in both categories are covered by your critical illness policy and pay the benefit indicated. You can only receive 100 percent of your benefit from within either category. But, beyond that, if you collect the benefit for an illness or procedure in the “heart/stroke” category and then are diagnosed with a condition in the “other illnesses” category (or vice versa), this policy will pay the full benefit indicated to you again. There must be 180 days separating the date of diagnosis of the two critical illnesses.

Heart/Stroke Category

Critical Illness	Percentage of Benefit Payable for each illness	Maximum Benefit for “Heart/Stroke” Category
Heart Attack	100%	
Stroke	100%	
Heart Transplant (or combination transplant including heart)	100%	100%
Coronary Bypass Surgery	25% (payable once per lifetime)	
Angioplasty	10% (payable once per lifetime)	

Other Illnesses Category

Critical Illness	Percentage of Benefit Payable for each illness	Maximum Benefit for "Other Illness" Category
Advanced Alzheimer's Disease	100%	
Kidney (Renal) Failure	100%	
Paralysis (Other than from a stroke)	100%	
Severe Burns	100%	100%
Coma	100%	
Occupational HIV (Documented accidental injury)	100%	
Major Organ Transplant (Other than heart)	100%	
Loss of Independent Living ¹	25% (payable once per lifetime)	

Employee- Non-Tobacco Monthly Rates with Wellness Rider								
Employee (ages)	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$40,000	\$50,000
18-29	\$2.27	\$3.45	\$4.64	\$5.83	\$7.02	\$8.20	\$10.58	\$12.95
30-39	\$3.16	\$4.89	\$6.63	\$8.37	\$10.11	\$11.84	\$15.32	\$18.79
40-49	\$5.23	\$8.44	\$11.66	\$14.88	\$18.09	\$21.31	\$27.74	\$34.18
50-59	\$9.25	\$15.74	\$22.23	\$28.73	\$35.22	\$41.71	\$54.69	\$67.67
60-64	\$16.68	\$30.24	\$43.81	\$57.37	\$70.93	\$84.49	\$111.62	\$138.74
65-69	\$23.60	\$43.87	\$64.14	\$84.41	\$104.68	\$124.95	\$165.49	\$206.03

Employee- Tobacco Monthly Rates with Wellness Rider								
Employee (ages)	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$40,000	\$50,000
18-29	\$2.75	\$4.42	\$6.09	\$7.76	\$9.43	\$11.10	\$14.45	\$17.79
30-39	\$4.37	\$7.33	\$10.28	\$13.24	\$16.19	\$19.14	\$25.05	\$30.96
40-49	\$8.15	\$14.29	\$20.43	\$26.58	\$32.72	\$38.86	\$51.14	\$63.42
50-59	\$15.98	\$29.20	\$42.42	\$55.64	\$68.86	\$82.08	\$108.52	\$134.96
60-64	\$30.76	\$58.41	\$86.05	\$113.70	\$141.34	\$168.99	\$224.28	\$279.57
65-69	\$43.69	\$84.04	\$124.40	\$164.76	\$205.11	\$245.47	\$326.18	\$406.90

Spouse- Non-Tobacco Monthly Rates with Wellness Rider								
Spouse (ages)	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$40,000	\$50,000
18-29	\$1.90	\$2.45	\$3.00	\$3.55	\$4.10	\$4.65	\$5.75	\$6.85
30-39	\$2.74	\$3.78	\$4.83	\$5.87	\$6.92	\$7.96	\$10.06	\$12.15
40-49	\$4.58	\$6.94	\$9.31	\$11.67	\$14.03	\$16.39	\$21.12	\$25.84
50-59	\$8.23	\$13.59	\$18.94	\$24.30	\$29.65	\$35.00	\$45.71	\$56.42
60-64	\$15.10	\$27.09	\$39.07	\$51.05	\$63.03	\$75.02	\$98.98	\$122.95
65-69	\$21.77	\$40.21	\$58.65	\$77.09	\$95.53	\$113.98	\$150.86	\$187.74

Spouse- Tobacco Monthly Rates with Wellness Rider								
Spouse (ages)	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$40,000	\$50,000
18-29	\$2.34	\$3.32	\$4.31	\$5.30	\$6.29	\$7.27	\$9.25	\$11.22
30-39	\$3.82	\$5.96	\$8.09	\$10.22	\$12.36	\$14.49	\$18.76	\$23.02
40-49	\$7.18	\$12.14	\$17.09	\$22.05	\$27.01	\$31.97	\$41.89	\$51.80
50-59	\$14.30	\$25.73	\$37.15	\$48.58	\$60.00	\$71.43	\$94.28	\$117.13
60-64	\$28.02	\$52.93	\$77.83	\$102.73	\$127.64	\$152.54	\$202.35	\$252.15
65-69	\$40.52	\$77.70	\$114.89	\$152.07	\$189.26	\$226.45	\$300.82	\$375.19

Child Coverage with Wellness Rider	
Issue Age Range	Benefit Amount
0-18	\$10,000
0-18	\$0.69

Assurity Life Insurance Company
PO Box 82533
Lincoln, NE, 68501-0926

Assurity Customer Service: (866) 289-7337
Fax: (402) 437-4592

Website: www.assurityatwork.com



Superior Vision Plan I- Full Services

Effective Date: September 1, 2008

Outline of Benefits - Gold Preferred Plan With Materials Discount
 Vision Plan - Preferred Provider (PPO / Indemnity)

COPAYMENT AMOUNT:

\$20.00 - Exam Copayment
 \$20.00- Materials Copayment
 \$35.00- Contact Lens Fitting Fee

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
Standard Contact Lens Fitting Exam Fee***			
Fitting Exam Fee***	12 Months	Covered in Full	Not Covered
Specialty Contact Lens Fitting Exam Fee***			
Fitting Exam Fee***	12 Months	Up to \$50	Not Covered
Frames (Standard)**	24 Months	Up to \$100.00	Up to \$50.00

***Contact lenses are in lieu of eyeglass lenses and frames benefit.**
****The insured is responsible for paying any charges in excess of this allowance.**
*****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 multi-focal lenses. For the specialty fit, the member is responsible for any charges over \$50.**

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 paperwork is required from you.
- Pay the provider directly for the \$20 co-pay for exam or materials 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 co-pay if applicable.

DISCOUNT SVP8-20

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

Note: Discounts do no 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

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 Employee Benefits Department.

Plan I Monthly Rates- (Full Services Plan)

Employee Only	\$ 8.38
Employee + Spouse	\$17.82
Employee + Child(ren)	\$13.56
Employee + Family	\$24.72

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

"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."



Superior Vision Plan II- Materials Only

Effective Date: September 1, 2008

Outline of Benefits - Gold Preferred Materials Only Plan With Materials Discount
Vision Plan - Preferred Provider (PPO / Indemnity)

COPAYMENT AMOUNT:	\$25.00 (Materials)		
BENEFITS:	IN-NETWORK	NON-NETWORK	
Lenses (Standard) per Pair:			
Single Vision	Covered in Full	Up to \$34.00	
Bifocal	Covered in Full	Up to \$48.00	
Trifocal	Covered in Full	Up to \$64.00	
Lenticular	Covered in Full	Up to \$88.00	
Contact Lenses (Per Pair):			
Medically Necessary	Covered in Full	Up to \$210.00	
Cosmetic (Elective)**	Up to \$120.00	Up to \$100.00	
Frames (Standard)**	24 Months	Up to \$100.00	Up to \$50.00

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

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

Materials copayment only applies to lenses and frames, not contact lenses. Copayments apply to in network benefit and are deducted from non network reimbursements.

SERVICES/FREQUENCY:

Lenses- 12 months

Frames- 24 months

Contact Lenses- 12 months

Materials SVP 8-20 Discount Schedule

Featured are 20% discounts on the provider's charges for upgrades to the 1st pair of covered eyeglass lenses. This includes tints, coatings, special materials and special lens designs. Members may also receive a 20% discount on the difference between the retail price of the frame they have selected, and their allowance, as shown on the benefit outline above.

Out of Pocket Maximums for Lens Add-Ons - Single Vision Lenses

Scratch Coat (Factory)	\$13
UV Coat	\$15
Standard Anti-Reflective Coat	\$50
High Index 1.6	\$55

Plastic Tints Solid or Gradient	\$25
Standard transitions(& other standard photochromic lenses)	\$80
Polycarbonate	\$40
Glass Coloring	\$35

Out of Pocket Maximums for Lens Add-Ons-Std Lined Bi & Tri-focal Lenses

Scratch Coat (Factory)	\$13
UV Coat	\$15
Standard Anti-Reflective Coat	\$50

Also included are discounts on the purchases of additional pairs of eyeglasses and contact lenses. (See the schedule below). These materials discounts are available from in-network providers who are identified in the directory with a "DP" (discount plan) associated with their listing as a service they provide at the location.

FRAMES 30% OFF RETAIL
No restrictions apply

LENSES (Uncoated Plastic-CR39, or Glass) 30% OFF RETAIL
Single Vision
Bifocal (FT 25-35 & Executive)
Trifocal (FT 7X25, 7X28, 8X35 & Executive)
Progressives
Zyl and Metal Mounting

ADD-ON TO BASE LENSES 20% OFF RETAIL
Tints, Coatings, Colored Lenses
Power over 4.00D Sphere, 2.00D Cylinder & 5.00D Prism
Polycarbonate, High Index, Photochromatics
Cosmetic Finishing, Beveling, Edging & Mounting

EVERYDAY "Frame & Lens Package Pricing" 20% OFF RETAIL

CONTACT LENSES 20% OFF RETAIL

DISPOSABLE CONTACT LENSES 10% OFF RETAIL

ALL OTHER MATERIALS 20% OFF RETAIL

REFRACTIVE SURGERY DISCOUNT PLAN

Superior Vision Services has contracted with Ophthalmologists who specialize in the highly publicized elective procedures of Radial Keratotomy (RK), Photo Refractive Keratotomy (PRK), and LASIK. These participating providers provide their services for the aforementioned procedures at a 20% discount off their usual and customary surgical fees (non-insured benefit) for Superior Vision Plan members. The Materials Discount also includes Blepharoplasty (upper and lower eyelid surgery).

Plan II Monthly Rates- (Materials Only Plan)

Employee Only	\$6.16
Employee & Spouse	\$12.20
Employee & Children	\$11.96
Employee & Family	\$18.18

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

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Disability Is A Fact of Life!

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

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

Could You Live Off Of Savings??

Standard Life Short Term Disability Plan

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

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

ACCIDENT & SICKNESS PROTECTION

On or off the job, 24 hour a day coverage. Income is provided when you are disabled due to a sickness or as a result of an accident. Benefits begin on the **first day** if you are disabled due to an accident. Benefits begin on the **eighth day** if you are disabled due to sickness. You can choose to insure up to **70% of your gross monthly income**, up to a maximum of \$2,000.00 per month. Income will be provided for the benefit period you choose up to 365 days.

Benefit Duration: 90 Days

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

Benefit Duration: 180 Days

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

Benefit Duration: 365 Days

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

Eligibility

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

POLICY FEATURES

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

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

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

Limits and Exclusions:

Benefits will not be paid for any total disability which:

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

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

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

If you have any questions regarding the Standard Life Disability Plan, **please call: 800-327-0695**
Toll Free Claims Line: 800-227-0251



MetLife Group 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. Now you can...at low group rates and through convenient payroll deductions.

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

OPTIONAL DEPENDENT LIFE INSURANCE

Provides coverage on:

- Your Spouse
- Child(ren) from 14 days of age to age 19 (to age 25 if wholly dependent upon you for maintenance and support and if enrolled as a full-time student in an accredited school or college). Handicapped children can be covered with no age limit, as long as the child is covered prior to age 19 or to age 25 if a full-time student.

FEATURES

The plan features easy eligibility and simple enrollment procedures. And as an employee there is no need for proof of medical insurability unless you take a coverage amount over \$50,000.

Furthermore, automatic payroll deductions simplify paperwork. This means less bookkeeping for you and no worries about a lapse in coverage due to missed payments.

LOW COST

Your cost is lower than for comparable insurance on an individual basis due to the "wholesale" economies inherent in group insurance. Additionally, the System absorbs the cost of administering the program which is underwritten by MetLife Insurance Company - a leader in the field of group coverage.

ELIGIBILITY

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

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.

You will be notified as to when coverage starts. Employees currently participating in the life plan will not have to fill out a new enrollment card unless there is an increase or decrease of coverage(s).

BENEFICIARY

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

WHEN YOUR INSURANCE STARTS

Your Basic Employee Life Insurance becomes effective on the date of your eligibility if you are then actively at work; otherwise, on the day you return to active work.

If you have elected Optional Employee Life Insurance or Optional Dependent Life insurance you will be notified as to when that coverage begins.

Anyone electing not to enroll when first eligible or within 31 days of their hire date can enroll later only if evidence of insurability satisfactory to MetLife is provided.

REDUCTIONS AT AGE 70 & 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	45%
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.

DISABILITY

Your insurance may be continued during your disability provided the Board of Education continues premium payments on your behalf. However, your insurance will be subject to reduction as shown under "Reductions at ages 70 & Over" above.

ACCELERATED BENEFIT OPTION

MetLife Insurance Company has included an Accelerated Benefit Option (ABO) as part of your group life benefits. Under this option, if you are diagnosed as having a terminal illness, you may be eligible to receive a portion of your group life benefits at such a difficult time. Please refer to your Group Certificate for details.

CONVERSION

If your employment terminates while you are covered under the plan, you may purchase without medical evidence of insurability, any individual insurance, except a term policy, issued by MetLife. The amount of the individual contract may not be more than the amount of your life coverage in effect on your date of termination. You must apply for this policy within 31 days after the date your employment terminates. This privilege applies to Optional Employee Life Insurance and Dependent Life Insurance as well as the Basic Employee Life Insurance. This privilege is the employees responsibility. It is not automatic.

PORTABILITY

Portability allows employees whose coverage ends due to certain qualifying events to continue their current (or a lesser) amount of insurance. Portability applies to Employee Optional Life Insurance only.

The minimum face amount which an employee may elect portability is \$10,000. Portable coverage reduces to 50% on January 1st of the year the insured attains age 70 and terminates on January 1st of the year the insured attains age 80. When portable coverage ends, insured individuals have the right to convert to an individual policy.

Qualifying Events Include:

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

SUICIDE EXCLUSION

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

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 assist in filing claims. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully. If there is any question about a claim payment, an explanation can be requested from your employer, who is usually able to provide the necessary information.

GROUP POLICY AND CERTIFICATE

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

This information has been prepared to give you the highlights of coverage now being offered by your School Board to meet your insurance needs.

Schedule of Benefits

BASIC EMPLOYEE LIFE INSURANCE

All Eligible Employees \$1,000 (No cost to you)

OPTIONAL EMPLOYEE LIFE INSURANCE

Your choice of the following amounts:

\$10,000, \$20,000, \$30,000, \$40,000, \$50,000, \$60,000, \$70,000, \$80,000
\$90,000, \$100,000, \$150,000, \$200,000, \$250,000

*To be eligible for coverage amounts over \$50,000 of coverage you **must** furnish medical evidence of insurability satisfactory to MetLife.

OPTIONAL DEPENDENT LIFE INSURANCE

• **Spouse-** choice of the following amounts:

\$10,000, \$20,000, \$30,000, \$40,000, or \$50,000

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

For coverage over \$10,000, your spouse **must** furnish medical evidence of insurability and you must elect a minimum of \$20,000 and above of Employee Optional Life Insurance.

• **Child(ren)-** choice of the following amounts:

\$5,000, \$10,000, \$15,000, \$20,000, \$25,000

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

To be eligible for coverage over \$5,000, you **must** furnish medical evidence of insurability for your dependent children.

NOTES:

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.

If you elect to increase your current coverage amount of Term Life insurance, you **will be required** to submit a Statement of Health to MetLife. This applies to your dependents as well.

<u>Optional Employee Coverage</u>	<u>Monthly Payroll Deduction</u>	<u>Optional Spouse Coverage</u>	<u>Monthly Payroll Deduction</u>	<u>Optional Child(ren) Coverage</u>	<u>Monthly Payroll Deduction</u>
\$10,000	\$1.80	\$10,000	\$5.60	\$5,000	\$1.00
\$20,000	\$3.60	\$20,000	\$11.20	\$10,000	\$2.00
\$30,000	\$5.40	\$30,000	\$16.80	\$15,000	\$3.00
\$40,000	\$7.20	\$40,000	\$22.40	\$20,000	\$4.00
\$50,000	\$9.00	\$50,000	\$28.00	\$25,000	\$5.00
\$60,000	\$10.80				
\$70,000	\$12.60				
\$80,000	\$14.40				
\$90,000	\$16.20				
\$100,000	\$18.00				
\$150,000	\$27.00				
\$200,000	\$36.00				
\$250,000	\$45.00				

PLAN ADMINISTRATOR

Elizabeth City-Pasquotank Board of Education
1200 S. Halstead Blvd.
Elizabeth City, NC
252-335-2981

If you have any questions regarding your statement of health or life insurance claim, please call MetLife at: 800-638-6420.



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

Texas Life Whole Life Insurance Plan

Common Issue Date: October 1, 2008 (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.**

TEXASLIFE | **INSURANCE COMPANY**
A MetLife® Company
Since 1901 | 900 WASHINGTON | POST OFFICE BOX 830 | WACO, TEXAS 76703-0830

Continuation of Benefits

GILSBAR FLEXIBLE SPENDING ACCOUNT

If you have a positive balance (payroll deductions are greater than the amount you have received in reimbursement) in your Health Care Spending Account at the time of your termination, you may continue participation in the Plan for the remainder of the Plan year. If you want to remain in the Plan, you can do by selecting one of the COBRA options.

If you prefer to terminate your participation and contribution to the Plan, any balance in your account on the date of termination will be forfeited if expenses were not incurred prior to the date of termination. For more detailed information, please call **your Benefits Department at 252- 335-2981**.

AMERITAS DENTAL & SUPERIOR VISION PLANS

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

If you and your dependents are enrolled in the dental or vision plan, you will be eligible to continue coverage through COBRA after you leave your employment for a specified period. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents 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- 335-2981**.

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 Philadelphia American/CSO at 800-554-0092.**

STANDARD LIFE DISABILITY

When you leave employment you may continue your short term disability coverage as long as continuous employment is maintained and proof of employment has been sent to Standard Life. Coverage expires at age 65. You may continue coverage by having the premium that is currently deducted from your paycheck drafted from your bank account. Please contact **Standard Life at 800-327-0695**.

ASSURITY CANCER & ASSURITY CRITICAL ILLNESS+

When you leave employment you may continue your Assurity Cancer & Assurity Critical Illness+ coverage by having the premium that is currently deducted from your paycheck drafted from your bank account. You may contact **Assurity at 866-289-7337**.

METLIFE TERM LIFE

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

Portability: If you terminate employment, the portability provision allows you to take your optional life coverage with you, subject to the following provisions:

- You must apply for coverage within 31 days from the date your life coverage terminates.
- You must be ACTIVELY at work prior to employment termination.
- You may only port up to your current coverage amount. You cannot increase or add dependents. Employees are eligible to age 74, spouses to age 64 and children up to age 18, 24 if a full-time student.

To get information for **converting** coverage, please contact **MetLife at (877)-275-6387**.

To get information for **porting** coverage, please contact **MetLife at (866) 492-6983**.

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. You may 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

Elizabeth City Schools Benefits Department- 252-335-2981

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

Giltsbar Health & Dependent Care Flexible Accounts-800-445-7227,ext.883

Assurity Cancer & Assurity Critical Illness- 888-358-8808, ext. 23

Ameritas Dental Plan - 800-776-9446

Superior Vision Plan - 800-507-3800

Standard Life STD Plan - 800-327-0695 or 800- 227-0251

MetLife Whole Life Plan- 800-634-5007

MetLife Term Life- **Conversion:** 877-275-6387

MetLife Term Life- **Portability:** 866-492-6983

Texas Life Whole Life- 800 283-9233 prompt #3.

CSO/Philadelphia American Cancer Plan- 800-554-0092