

Jackson County is offering all regular full-time employees a comprehensive Cafeteria Benefits program. The Cafeteria Benefits program is being arranged by Mark III Brokerage, an employee benefits firm that has worked with the public sector for many years. The Cafeteria Benefits program allows you to pay for certain insurance premiums before taxes are taken out of your paycheck. Paying for these benefits in this method reduces your taxes and increases your take home pay. The Cafeteria Benefits program includes all coverages listed below in the Table of Contents. The Plan Year is from July 1 to June 30. All eligible employees will have an opportunity to meet with a Mark III representative to review their benefits, and either accept or decline participation in the Cafeteria Benefits Plan. Employees who work 80% of the regularly scheduled hours are eligible for the Gilsbar Health Care and Dependent Care Flexible Spending Accounts, Jackson County Medical & Dental, Sun Life Short Term Disability and Sun Life Group Term Life and all voluntary benefits. Employees who work 53% of the regularly scheduled hours or more are eligible for the Gilsbar Health Care and Dependent Care Flexible Spending Accounts and all voluntary benefits.

## ***Table of Contents***

### Pre-Tax Benefits

GILSBAR Flexible Spending Account .....	Page 2
Cancer Fact Sheet.....	Page 18
Assurity Cancer Plan.....	Page 19
Transamerica Accident Plan .....	Page 25
Superior Vision Plan.....	Page 31

### Employer Paid Benefits

Jackson County Medical & Dental.....	Page 36
Lincoln Financial Short Term Disability.....	Page 52
Lincoln Financial Group Term Life .....	Page 53
(employee and dependent premium paid by Jackson County)	

### After-Tax Benefits

Disability Fact Sheet.....	Page 56
Standard Life Short Term Disability.....	Page 57
MetLife Optional Term Life.....	Page 59
Boston Mutual Life.....	Page 63
Liberty Mutual Auto & Homeowners Insurance Plan .....	Page 67
Continuation of Benefits.....	Page 69

---

---

## *GILSBAR Health Care Flexible Spending Account*

---

---

**PLAN YEAR: JULY 1, 2008 - JUNE 30, 2009**

**HEALTH CARE CHOICE FSA MAXIMUM: \$3,900**

**HEALTH CARE CHOICE FSA MINIMUM: \$130**

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

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

### **General questions regarding Health Care and Dependent Care Accounts:**

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

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

By using your FSA to pay for qualified expenses you save on income tax...which means your take home pay increases!

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

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

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

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

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

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

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

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

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

Generally, you may not change your FSA elections during the Plan Year. However, you may change during the annual enrollment period for the coming Plan Year.

There is an exception to this rule: you may change or revoke your deferral rate in the FSA if you have a Change in Dependent Status. Examples of a qualifying status change may include:

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

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

## **What if I have a question?**

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

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

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

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

Tax Savings This Pay Period: \$63.99

Annual Tax Savings: \$63.99 X 26 pay periods = \$1,663.74

## **MEDICAL REIMBURSEMENT ACCOUNT**

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

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

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

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

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

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

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

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

For reimbursement of expenses covered under a health care plan:

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

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

## **How much will be reimbursed?**

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

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

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

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

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

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

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

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

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

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

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

---

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

### **Qualified Medical Expenses Eligible For Reimbursement:**

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

care service	Psychotherapy	Therapy equipment to assist the hearing impaired
Pediatrician	Radium therapy	
Physician	Registered nurse	Transportation expenses (relative to health care)
Physiotherapist	Special school costs	Ultra-violet treatment
Postnatal treatments	Spinal fluid test	Vaccines
Practical nurse	Splints	Vasectomy
Prenatal care	Sterilization	Vitamins (if prescribed)
Prescription medicines	Stop Smoking Programs	Wheelchair
Psychiatrist	Surgeon	X-rays
Psychoanalyst	Telephone or TV equipment	
Psychologist		

## **Expenses Not Eligible For Reimbursement**

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

# OVER-THE-COUNTER DRUG/MEDICINE LIST

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

THE DRUGS/ MEDICINES LISTED BELOW ARE APPROVED WITH A RECEIPT FROM THE PROVIDER / STORE. A RECOMMENDATION FROM A HEALTH CARE PROVIDER IS NOT NEEDED.

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

### Drug / Medicine Examples:

Allergy Prevention & Treatment	Benadryl, Sudafed, Actifed, Claritin, Chlor Trimeton, and Nasalcrom
Antacids and Acid Reducers	Gas-X, Maalox, Mylanta, Tums, AXID AR, Pepcid AC, Prilosec OTC, Tagament HB, Zantac 75
Anticandial	Femstat 3, Gyne-Lotrimin, Mycelrx-7, Monistat 3, 7, and Vagistat-1
Antihistamines	Acyrup and Capsule, Actifed, Allerest, Benadyrl, Claritin, Chlor-Trimeton, Contac, Dimetane, Drixoral, Nyquil, Sudafed, Tavist-1, and Triaminic
Antidiarrheal and Laxatives	Ex-Lax, Pepto-Bismol, Immodium A.D. and Kaopectate
Anti-fungal	Lamisil AT, Lotramin AF, and Micatin
Anti-itch Lotions and Creams	Bactine, Caldecort, Cortaid, Hydrocortisone, and Lanacort, Calamine Lotion, Benadryl Cream, Caladryl, Lamisil AT, Lotramin AF and Micatin
Asthma	Primatene Mist
Cold Sore / Fever Blister	Abreva Cream, Carmex
Condoms and other contraceptive Devices	Trojans, Magnums, VGF Films, and Delfen Contraceptive Foam
Contact Lenses Solutions	Baush & Lomb, Renu, Aosept, Allergan, Boston and Opti-Free
Cough Suppressants	Robitussin, Vicks 44, Chloraseptic

Decongestant / Nasal Decongestant and Cold Remedies	Advil Cold and Sinus, Afrin, Afrinol, Aleve Cold and Synus, Children's Advil Cold, Duration, Dristan Long Lasting, Neo-Syneophrine-12 Hour, Orrivin, Sudafed, Tavist-D, Tylenol Cold and Flu, Thera-ful, Alka Seltzer Cold and Flu, Nyquil, Actidil Syrup and Capsules, Actifed, Allerest, Benadryl, Claritin, Chlor-Trimeton, Contac, Dimetane, Drixoral, Sudafed, Tavist-1, and Triaminic
Diaper Rash Ointments	Balmax and Destin
Eye Drops for Allergy / Cold Relief	Ocu Hist
First Aid Supplies	Ace Bandages, Band-Aids, Bandage Tapes, Thermometers, Medical Gloves, Gauze, Neosporin, Rubbing Alcohol, and Visine
Hemorrhoid Treatments	Preparation H, Hemroid, and Tronolane
Internal Analgesics / Antipyretic	Advil, Aleve, Children Motrin, Naprin, Excedrin, Tylenol, and Bayer
Incontinence Supplies	Depends
Liniments	BenGay, Tiger Balm, and Flexall
Medical Monitoring	Services and Bracelets specifically for medical information
Medical Products and Devices	Blood Pressure Monitor, Glucose Tester, HIV Test, Cholesterol Test, Diabetic Supplies, Crutches, Ovulation Monitor and Pregnancy Testing Kit
Menstrual Cycle Medications	Midol, Pamprin, and Premysyn PMS
Migraine	Advil Migraine Liqui-gels, Excedrin Migraine, Motrin Migraine Pain
Motion Sickness Medication	Dramamine and Marizine
Nicotine Gum or Patches and Smoking Cessation Aids	Nicorette, Nicotrol and Nicodin
Toothache and Teething Pain Relievers	Orajel
Wart Removal and Medications	Tinamed

## Dual Purpose OTC Drugs.

THE ITEMS LISTED BELOW REQUIRE A THIRD-PARTY RECEIPT AND A NOTE FROM THE HEALTH CARE PROVIDER LISTING THE DIAGNOSIS OF THE MEDICAL CONDITION OR ILLNESS AND THE RECOMMENDATION OF THE OTC DRUG / MEDICINE.

This list is not all inclusive and is intended to give examples of the most common brand names of OTC drugs.

- **Anti-baldness/hair loss/hair replacement**, such as Rogaine, but only if to replace hair loss due to a medical condition (e.g. cancer treatment) and not for balding due to age.
- **Fiber supplements** such as Benefiber and Metamucil
- **Glucosamine/Chondrotin** for arthritis or other medical conditions (not reimbursable if taken for overall joint health)
- **Herbal supplements** used to treat a specific disease such as St. John's wort for depression
- **Hormone therapy drugs**
- **Medicated shampoos** used to treat a specific medical condition like psoriasis and only the amount in excess of the cost of normal shampoo
- **No Doz** (and other sleep prevention drugs)
- **Nose strips** for proper breathing or other medical conditions
- **Pedialyte** for a child's dehydration
- **Retin-A** and other **acne medicines** (not reimbursable if used for cosmetic purposes such as wrinkle reduction)
- **Sleep Aids**
- **Snoring cessation aids and medications** such as Breath Right Spray, Snorezz
- **Sunscreen and Sunblock**
- **Vitamins** are not an eligible expense, unless prescribed by a physician to treat a specific medical condition (i.e. Iron to treat, not prevent anemia, Calcium Supplements to treat, not prevent Osteoporosis). A doctor's note detailing the specific medical condition will be required for reimbursement.
- **Weight loss/dietary supplements** must be for a specific medical condition such as obesity.

## Health Care FSA Expense Worksheet

This worksheet has been prepared to help you determine the amount of money you wish to allocate to your Health Care FSA. You may want to review your 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 Cards**

Beginning January 1, 2008, new IRS rules have simplified the use of Flex Debit Cards. These rules now require drug stores and supermarkets to identify FSA-eligible items at checkout and require the drug store or super market to only use the card for FSA eligible items. This means that you can use your Card at participating stores that offer this feature for the total FSA-eligible amount and NO receipts are needed to verify the eligibility of the purchase! And of course, you can continue to use your Card at pharmacies and other health care providers.

Please visit <http://www.sig-is.org/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 transaction can be verified using one of the IRS' approved electronic methods: however, **not all transactions can be verified electronically**. For any expense that cannot be verified electronically, **you must provide supporting documentation** upon request in the form of an itemized bill or receipt to Gilsbar. Verification should include the patient name, date of service, description of services rendered, cost and patient liability. If Gilsbar does not receive verification within 30 days of the date requested you will be asked to return the un-verified amounts to your employer, or they may be counted as taxable income to you.

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

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

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

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

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

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

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

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

## **DEPENDENT CARE REIMBURSEMENT ACCOUNT**

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

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

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

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

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

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

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

- You and your spouse are both employed;
- You are a single parent;
- Your spouse is a full-time student at least five months during the year while you are working;

- Your spouse is physically or mentally unable to provide his/her own care; or
- You are divorced or legally separated and have custody of your child most of the time even though your former spouse may claim the child for income tax purposes.

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

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

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

## **What expenses are covered?**

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

- Day care facility fees
- Before/after school care
- Summer day camp (not overnight)
- Nursery school or preschool, if child is too young for kindergarten
- In home baby sitting fees, if not provided by another dependent and claimed as income by the care provider
- Private school tuition, K-4 and above is not eligible for reimbursement

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## Dependent Care FSA Expense Worksheet

Dependent care expenses you paid last year could include:

Costs of Child or Adult Care Facilities\*

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

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

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

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

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

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

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

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

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

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

(PLEASE KEEP YOUR ORIGINALS)

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

If you prefer to submit your form by mail, please send claim form and receipts to:  
Claims Processing Center, P.O. Box 26046, Tampa, FL 33623 (PLEASE KEEP YOUR ORIGINALS)

## Cancer Can Affect Anyone

### **Statistics Predict:**

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

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

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

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

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

**Assurity's Cancer Plan is designed to create a source of extra cash that will help you and your family cope during the battle against cancer or a specified disease.**

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

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

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

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

### **Selected benefits paying cash to you:**

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

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

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

---

---

## *Assurity Cancer & Specified Disease Expense Plan*

---

---

**Effective Date: July 1, 2008, pending underwriting approval**

### **BASIC BENEFITS**

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

### **RATE STRUCTURE**

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

### **UNDERWRITING**

Pre-existing conditions are not covered during the first year the policy is in force. Persons with previous history of cancer will be excluded unless added by rider for those with simple skin cancers. Additional question regarding diagnostic tests that have been completed within last 30 days or are scheduled to be performed is also asked. No benefits will be paid during a 30-day waiting period. Conditions that manifest after the policy date will be payable beginning on the 31st day. Definition of manifested: "Symptoms or visible indications that would put an ordinary prudent person on notice that diagnosis, care or treatment by a medical professional should be sought."

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

**Hospital Indemnity** – pays benefits each day while confined in the hospital for cancer or certain other specified disease for the first 75 days of each period of confinement. There are three options for the daily benefit amount: **\$150, \$250, and \$350.**

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

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

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

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

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

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

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

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

There are four options for monthly benefit:

- **\$5,000 with a lifetime maximum of \$25,000**
- **\$5,000 with a lifetime maximum of \$50,000**
- **\$10,000 with a lifetime maximum of \$50,000**
- **\$10,000 with a lifetime maximum of \$100,000**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Wellness Claims** - An employee can file a wellness claim by fax, call-in or mail. Employees can call Assurity to get a wellness claim form or download one from your employer's website. 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.

**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.

**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 if that person meets all of the following requirements: (a) the insured person becomes disabled due to cancer or a specified disease and is receiving treatment for such cancer or specified disease for which benefits are payable under this policy, (b) remains disabled for a period of 90 consecutive days, and (c) the insured person is less than 65 years of age at the time he/she becomes disabled. Premiums will be waived beginning with the first premium payment after the 90 day period of disability and continue to be waived for as long as the insured person remains disabled.

### **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 31<sup>st</sup> day.

**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

**Intensive Care Rider** - Provides a Daily Benefit of \$300 or \$600 if an Insured Person is confined to a Hospital's Intensive Care Unit, up to a maximum of 20 days per period of confinement.

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

#### **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 1st year period.

Cancer or other Specified Disease Claims: You may file a claim for cancer or specified diseases by completing an Assurity Claim Form. Please make sure to include all pertinent information as stated on the form. You can obtain a claim form by contacting Assurity, downloading from your employer's website or from your benefits department. Should you have any questions on how to file or submit a claim, please contact Assurity customer service at the number listed below.

**For Claims or Customer Service relating to your Assurity Cancer Plan:**

**Please call (866) 289-7337**

**For Wellness Claims by phone:**

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

**Wellness Claims by facsimile at (800) 869-0368**

**or mail claims to:**

**Assurity Life Insurance Company**

**PO Box 80926**

**Lincoln, NE 68501-0926**

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

### Bi-Weekly Rates

Per Month	\$5,000	\$5,000	\$10,000	\$10,000
Lifetime Maximum	\$25,000	\$50,000	\$50,000	\$100,000
<b>\$150/day Hospital Confinement Benefit Amount</b>				
Individual	\$9.01	\$9.11	\$9.59	\$9.66
Employee and Spouse	\$13.82	\$13.97	\$14.69	\$14.79
Employee and Children	\$11.11	\$11.25	\$11.90	\$12.00
Employee and Family	\$15.92	\$16.11	\$17.00	\$17.13
<b>\$250/day Hospital Confinement Benefit Amount</b>				
Individual	\$10.07	\$10.17	\$10.65	\$10.72
Employee and Spouse	\$15.47	\$15.62	\$16.34	\$16.44
Employee and Children	\$12.32	\$12.46	\$13.10	\$13.20
Employee and Family	\$17.72	\$17.91	\$18.79	\$18.92
<b>\$350/day Hospital Confinement Benefit Amount</b>				
Individual	\$11.13	\$11.23	\$11.71	\$11.78
Employee and Spouse	\$17.12	\$17.27	\$17.99	\$18.09
Employee and Children	\$13.52	\$13.66	\$14.31	\$14.40
Employee and Family	\$19.51	\$19.70	\$20.58	\$20.71
	<b>Intensive Care Rider</b>		<b>First Occurrence Rider</b>	
	\$300	\$600	\$2,500	\$5,000
Individual	\$0.97	\$1.94	\$1.31	\$2.61
Employee and Spouse	\$1.94	\$3.88	\$1.95	\$3.90
Employee and Children	\$1.52	\$3.05	\$1.58	\$3.16
Employee and Family	\$2.49	\$4.98	\$2.22	\$4.45



---

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

---

**Effective Date: July 1, 2008**

**ACCIDENTSELECT<sup>®</sup>**

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

AccidentSelect<sup>®</sup> provides Insureds with several benefits to assist with injuries associated with certain accidents. More importantly, it gives Insureds peace of mind in the event of a Covered Accident.

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

**SCHEDULE OF BENEFITS** (continued)**PLAN I****PLAN II**

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

**SCHEDULE OF BENEFITS** (continued)**PLAN I****PLAN II**

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

**SCHEDULE OF BENEFITS (continued)****PLAN I****PLAN II**

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

**IMPORTANT INFORMATION****RENEWABILITY**

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

**EFFECTIVE DATE**

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

## **ISSUE AGES**

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

## **FAMILY COVERAGE**

Spouse and dependent children coverage is available. Family Coverage includes the Insured, his or her spouse, and all dependent, unmarried children under age 24. Newborn children are automatically covered under the terms of the policy from the moment of birth. Single-Parent Coverage includes the Insured and all of his or her dependent children who are unmarried and under 25.

## **PRE-EXISTING CONDITIONS**

Disability and hospitalization caused by a pre-existing condition will not be covered unless it begins more than 12 months after the Effective Date of coverage. A pre-existing condition is a sickness, disease, or physical condition not disclosed on the application or excluded from coverage by name or specific description; it is one for which medical advice, consultation, or treatment was recommended or received, or symptoms existed that would cause an ordinarily prudent person to seek diagnosis, care or treatment within the 12-month period before the Effective Date.

## **TIME LIMIT ON CERTAIN DEFENSES**

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

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

## **FRAUDULENT MISSTATEMENT**

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

## **ADDITIONAL LIMITATIONS AND EXCLUSIONS**

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

- a) Driving any taxi or intrastate or interstate long-distance vehicle for wage, compensation or profit.
- b) Mountaineering, parachuting or hang gliding.
- c) Poison, gas or fumes voluntarily taken, administered, absorbed or inhaled;
- d) Alcoholism or drug addiction.
- e) Participating in any sport or activity for wage, compensation or profit; or racing any type vehicle in an organized event.
- f) Travel in, or descent from any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a commercial airline (other than a chartered airline) on a regularly scheduled passenger trip.

- g) War, or any act of war, whether declared or undeclared.
- h) Participating in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a physician or taken according to the physician's instructions), or committing an illegal act while intoxicated (intoxicated means that condition as defined by the law of the jurisdiction in which the accident occurred).
- i) Participating in, or an attempt to participate in, an illegal activity that is defined as a felony, whether charged or not. (A felony is defined by the law of the jurisdiction in which the activity takes place.)
- j) Intentionally self-inflicted bodily injury or attempting suicide, while sane or insane.
- k) Any loss incurred while on active duty status in the armed forces. (If the Insurer is notified of such active duty, a refund will be provided for any premiums paid for any period for which no coverage is provided as a result of the exception.)

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

*This brochure provides information about AccidentSelect I and II (Policy Form Series TPA0100, or CP500100, with Riders Form Series TRA0100, TRA0200, TRA0300, TRA0400, TRA0500, TRA0700, TRW0100, and TRIH0200, CR500100, CR500200, CR500800, CR500400, CR500500, CR500700, CR501000, and CR501100), underwritten by Transamerica Assurance Company. Form and number may vary and coverage may not be available in all jurisdictions.*

**IF YOU HAVE ANY QUESTIONS ABOUT THE PLAN, PLEASE CALL  
CUSTOMER SERVICE AT: 1-888-763-7474.**

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



<b>Bi-Weekly Premium Rates - Plan I</b>				
<b>Industry Class</b>	<b>Individual</b>	<b>Single Parent Family</b>	<b>Two Adults</b>	<b>Family</b>
Class B	5.57	8.24	8.02	10.69

<b>Bi-Weekly Premium Rates - Plan II</b>				
<b>Industry Class</b>	<b>Individual</b>	<b>Single Parent Family</b>	<b>Two Adults</b>	<b>Family</b>
Class B	9.39	14.56	14.06	19.24

---



---

## *Superior Vision Plan*

---



---

**Effective Date: July 1, 2008**

**Outline of Benefits – Gold Preferred Plan with Materials Discount  
Vision Plan – Preferred Provider (PPO / Indemnity)**

**Copayment:     \$10.00 Exam  
                      \$15.00 Materials  
                      \$35.00 Contact Lens Fitting Fee**

<b>BENEFITS</b>	<b>FREQUENCY</b>	<b>IN-NETWORK</b>	<b>NON-NETWORK</b>
<b>Comprehensive Exam</b> <i>(by an Ophthalmologist)</i>	12 Months	Covered in Full	Up to \$44.00
<b>Comprehensive Exam</b> <i>(by an Optometrist)</i>	12 Months	Covered in Full	Up to \$39.00
<b>Lenses (Standard) per Pair</b>			
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
<b>Contact Lenses (Per Pair)*</b>			
Medically Necessary	12 Months	Covered in Full	Up to \$210.00
Cosmetic (Elective)**	12 Months	Up to \$120.00	Up to \$100.00
Standard Contact Lens Fitting Fee***	12 Months	Covered in Full	Not Covered
Specialty Contact Lens Fitting Fee***	12 Months	Up to \$50.00	Not Covered
Frames (Standard)**	24 Months	Up to \$100.00	Up to \$50.00

*\*Contact lenses are in lieu of eyeglass lenses and frames benefits.*

*\*\*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 multifocal lenses. For the specialty fit, the member is responsible for any charges over \$50.*

### **DEFINITIONS OF CONTACT LENSES**

**Contact Lenses, Elective/Cosmetic**

Elective/Cosmetic contact lenses are those that are worn solely for cosmetic or convenience reasons. They are chosen because they are preferred over the wearing of conventional eyeglasses. Contact lenses covered by the Plan must contain a prescription for correcting a vision deficiency. Charges over the benefit allowance are paid directly to the provider.

**Contact Lenses, Medically Necessary**

These lenses must be specifically prescribed by the eye doctor to be used for the reason or reasons described on the following page. Reimbursement for these lenses will be considered as payment-in-full when utilizing an in-network provider.

- Aphakia (after cataract surgery without implant lens)  
A pair of prescription single vision or multifocal eye glass lenses and an eyeframe can be provided along with contact lenses prescribed for this reason.
- When visual acuity cannot be corrected to 20/70 in the better eye except through the use of contact lenses (must be 20/60 or better).
- Anisometriopia of 4.0 diopters or more, provided visual acuity improves to 20/60 or better in the weak eye.
- Kerataconus

Note: The narrowing of visual fields due to high minus or high plus corrections is not considered a reason for medically necessary contact lenses.

**Contact Lens Examining Fee:**

Most providers charge a fee for the fitting of contact lenses. This fee is separate from the eye examination and will vary depending on the provider’s fee structure policies. It will also vary due to circumstances or complexities involving the physiological condition of the eyes, the lens prescription, and the type of lenses used. The contact lens exam/fitting fee may be included in the contact lens allowance.

**EXCLUSIONS (products & services not covered):**

There is no benefit coverage for the following products and services.

- Professional Services and/or Materials in conjunction with:
  - blended bifocals, no line, or progressive lenses
  - compensated or special multi-focal lenses
  - plain (non-prescription) lenses
  - anti-reflective, scratch, UV400, or any coating or laminate applied to lenses
  - subnormal vision aids
  - tints, other than solid
  - orthoptics, vision training and developmental vision procedures
  - polycarbonate lenses
  - Medical or surgical treatment of the eyes
- Any eye examination or any corrective eyewear required by an Employer as a condition of employment
- Any injury or illness when covered under Workers Compensation or similar law
- 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
- Subnormal vision aids
- Services rendered or Materials purchased outside the U.S. or Canada unless the member resides in the U.S. or Canada; and the charges are incurred while on a business or pleasure trip
- Charges in excess of the Usual, Customary and Reasonable charges for the Professional Service or Materials
- Experimental or non-conventional treatment or device
- Safety eyewear
- Spectacle lens styles, materials, treatments, or “add-ons” not shown in the Benefits Summary

- Services or Materials rendered by a provider other than an Ophthalmologist, Optometrist or Optician acting within the scope of his, or her license
- Any additional service required outside basic vision analysis for contact lenses except fitting fees
- 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
- Services rendered or Materials ordered before the date of coverage began under this Certificate
- Regardless of Optical Necessity, benefits are not available more frequently delivered, and the services rendered to the Insured within 31 days from the than that which is specified in the Benefits Summary

## **HOW TO USE YOUR BENEFIT**

### **Procedure when using a Superior Vision Plan in-network provider:**

- Identify yourself to the in-network provider as a member of the Superior Vision Plan. You can use your ID card for this purpose or simply give the provider your name, employer name, and your social security number. The provider will call SVS Member Services to verify your eligibility and obtain an authorization number. The ID card provided to you can be used for all covered family members.
- After eligibility is established, and an authorization number is received by the provider, services will be rendered. There is nothing else that you need to do except pay the provider directly for any appropriate copayments and charges above the covered benefits. The in-network provider handles all claims and paperwork.

### **Procedure when using a Superior Vision Plan non-network provider:**

- To receive services from a non-network provider, it is important that you first call Superior Vision Services Member Service Department at 800-507-3800 to receive your own authorization number. By doing so, you can be assured of your eligibility and reimbursement for money spent.
- After receiving services and paying in-full for the examination and/or materials (you do not pay a copayment to the non-network provider), submit your original itemized billing received from the provider, along with your authorization number, to the SVS Claims Administration office listed on the next page.
- You will be reimbursed according to the schedule of allowances for non-network providers, less any required copayments.

## DISCOUNTS ON ADDITIONAL PURCHASES

- |                                             |                       |
|---------------------------------------------|-----------------------|
| • Prescription eyeglass lenses              | 30% off retail prices |
| • Eyeframes                                 | 30% off retail prices |
| • Add-on charges to basic lenses            | 20% off retail prices |
| • Everyday “frame and lens package” pricing | 20% off retail prices |
| • Contact lenses, standard hard or soft     | 20% off retail prices |
| • Disposable contact lenses                 | 10% off retail prices |
| • All other prescription materials          | 20% off retail prices |

## DISCOUNT SVP8-20

- Frames - 20% off the difference between the covered frame Allowance and the retail price of the selected frame

### Add-on charges to covered pair of lenses

- |                                   |                                                   |
|-----------------------------------|---------------------------------------------------|
| • Factory Scratch Coat            | \$13 (Single Vision & Standard Multifocal lenses) |
| • Ultraviolet Coat                | \$15 (Single Vision & Standard Multifocal lenses) |
| • Standard Anti-Reflective coat*  | \$50 (Single Vision & Standard 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)                            |

### Member pays 20% off retail up to:

- |                                                       |                                         |
|-------------------------------------------------------|-----------------------------------------|
| • Power over 4.00 Sphere, 2.00D Cylinder & 5.00 Prism | 20% off retail prices (any type lenses) |
| • Cosmetic finishing, Beveling, Edging, and Mounting  | 20% off retail prices (any type lenses) |
| • Miscellaneous Options                               | 20% off retail prices (any type lenses) |

### Member pays:

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

## REFRACTIVE SURGERY DISCOUNTS

Superior Vision Services has contracted a network of over 500 refractive surgeons nationwide 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 blepharoplasty (cosmetic eyelid surgery) to Superior Vision Plan members on the same discount basis.

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

**BI-WEEKLY (26 DEDUCTION) COST**

Employee Only	\$ 4.57
Employee + 1 Dependent	\$ 8.87
Employee + Family	\$13.03

**Member Services, Provider Listings and Claims Services:**

(800) 507-3800

**Member Services Fax:**

(916) 852-2277

**Provider Nominations:**

(800) 923-6766

**Web Site:**

[www.superiorvision.com](http://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*



---

---

## *Jackson County Self Funded Medical and Dental Plan*

---

---

**Effective Date: July 1, 2008**

### **ABOUT THE PLAN**

Your Health Care Plan is provided by Jackson County. Claims-paying services and other administrative services for the Plan are performed on behalf of Jackson County by Wells Fargo Third Party Administrators, Inc. The Plan provides Medical, Prescription Drug, Vision and Dental Benefits.

### **YOUR RIGHTS AS A PARTICIPANT**

As a Plan Participant, you are protected by a federal law called the Employee Retirement Income Security Act of 1974 (ERISA). Your rights under the law are described in the Statement of ERISA Rights in your Medical and Dental handbook provided by Wells Fargo Third Party Administrators, Inc.

### **YOUR SUMMARY PLAN DESCRIPTION**

ERISA requires that all Plan Participants be given a Summary Plan Description, a brief summary of their Plan Benefits. This booklet is intended to fulfill that requirement. If your booklet is misplaced, you may get a replacement from your employer.

Your Summary Plan Description booklet is not a contract of insurance or a formal Plan Description. Complete information about the Plan is contained in the written Plan Description maintained by Jackson County.

This Summary Plan Description replaces and supersedes any and all previous benefit booklets or Summary Plan Descriptions. In the event of an inadvertent discrepancy between the information in this booklet and the actual provisions of the Plan, the terms of the written Plan Description will rule.

## SUMMARY OF BENEFITS

### PLAN FOR EMPLOYEES WHO ARE NON-USERS OF TOBACCO PRODUCTS

MEDICAL BENEFITS	In-Network	Out-of-Network
<b>Calendar Year Deductible (when applicable)</b> <ul style="list-style-type: none"> <li>• Individual</li> <li>• Family (2 Individuals)</li> </ul>	\$500 Two times Individual	Two times In-Network Two times In-Network
<b>Per Confinement Copayment</b>	None	\$250
<b>Out-of-Pocket Maximum***</b> <ul style="list-style-type: none"> <li>• Individual</li> <li>• Family</li> <li>• Payment rate after Out-of-Pocket is satisfied</li> </ul>	\$2,500 Two times Individual 100%	Two time In-Network Two times In-Network 100% R&C
<b>Hospital Services</b> <ul style="list-style-type: none"> <li>• Inpatient</li> <li>• Outpatient</li> <li>• Emergency Room (non-Emergency Services)</li> <li>• Emergency Room (Emergency Services)</li> </ul> <i>Copayment waived if followed by Admission</i>	90% * 90% * 90% * 90% - \$75 Copay	80% * (**) 80% * 80% * 90% - \$75 Copay
<b>Physicians Services</b> <ul style="list-style-type: none"> <li>• Primary Care Office Visits</li> <li>• Urgent Care Centers</li> <li>• Specialist Office Visits</li> <li>• Allergy Injections</li> <li>• Independent Laboratory Services</li> <li>• Other Services - Surgeons Fees, etc.</li> </ul>	100% - \$15 Copay 100% - \$25 Copay 100% - \$25 Copay 100% - \$5 Copay 100% 90% *	100% R&C - \$25 Copay 100% R&C - \$25 Copay 80% R&C* 80% R&C* 80% R&C* 80% R&C*
<b>Wellness and Preventive Care Services</b> <i>(Maximum Calendar Year Benefit: Form birth to age 1 is \$500, age 1 to age 2 is \$500, and age 2 through adult is \$500)</i> <ul style="list-style-type: none"> <li>• Pap Smears, Mammograms, PSA Screenings, Well Baby Care and Immunizations</li> <li>• Primary Care Office Visits</li> <li>• Specialist Care Office Visits</li> </ul>	100% - \$15 Copay**** 100% - \$15 Copay****	100% R&C - \$25 Copay 80% R&C*
<b>Ambulatory Surgical Facility Services</b>	90% *	80% R&C*
<b>Maternity Services</b> <ul style="list-style-type: none"> <li>• OB/GYN Services (<i>Copay maximum \$250 for Prenatal and Postpartum Visits</i>)</li> <li>• Hospital Services</li> </ul>	100% - \$25 Copay 90% *	80% R&C* 80% R&C*
<b>Ambulance Services</b> ( <i>Maximum Benefit of \$2000 per Participant per trip</i> )	80% R&C*	

\* Calendar Year Deductible Applies

\*\* Per Confinement Copayment Applies

\*\*\* Certain expenses do not apply towards satisfaction of the Out-of-Pocket Maximum. See the MEDICAL BENEFITS Section for details.

\*\*\*\* Copayment is waived for mammograms received within 3 months before or after wellness examination.

<b>Psychiatric Services</b> • Inpatient • Outpatient	80% R&C* 50% R&C*
<b>Substance Abuse Treatment Services</b> • Inpatient • Outpatient	80% R&C* 50% R&C*
<b>Outpatient Prescription Drugs</b> (PRx drug card program) NOTE: • Inpatient Prescription Drugs are covered under Ancillary Services and Supplies • Prilosec OTC is available with a prescription at the Generic Drug Copay level • Smoking Cessation over-the-counter drugs are available at the Generic Drug Copay level	\$10 Copay - Generic Drug \$35 - Brand Name Drugs, if no Generic available \$50 - Brand Name Drugs, if Generic available
<b>All Other Covered Services</b>	80% R&C*

\* Calender Year Deductible Applies

**PLAN FOR EMPLOYEES WHO ARE USERS OF TOBACCO PRODUCTS  
EMPLOYEES HIRED ON OR AFTER JULY 1, 2006**

<b>MEDICAL BENEFITS</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Calender Year Deductible</b> <i>(when applicable)</i> • Individual • Family (2 Individuals)	\$750 Two times Individual	Two times In-Network Two times In-Network
<b>Per Confinement Copayment</b>	\$250	\$250
<b>Out-of-Pocket Maximum</b> *** • Individual • Family • Payment rate after Out-of-Pocket is satisfied	\$5,000 Two time Individual 100%	Two times In-Network Two times In-Network 100% R&C
<b>Hospital Services</b> • Inpatient • Outpatient • Emergency Room (non-Emergency Services) • Emergency Room (Emergency Services) <i>Copayment waived if followed by Admission</i>	80%* (**) 80%* 80%* 90% - \$75 Copay	70%* (**) 70%* 70%* 90% - \$75 Copay

\* Calender Year Deductible Applies

\*\* Per Confinement Copayment Applies

\*\*\* Certain expenses do not apply toward satisfaction of the Out-of-Pocket Maximum. See the MEDICAL BENEFITS Section for details.

<b>Physicians Services</b> <ul style="list-style-type: none"> <li>• Primary Care Office Visits</li> <li>• Urgent Care Centers</li> <li>• Specialist Office Visits</li> <li>• Allergy Injections</li> <li>• Independent Laboratory Services</li> <li>• Other Services - Surgeon Fees, etc</li> </ul>	100% - \$25 Copay 100% - \$25 Copay 80% * 80% * 80% * 80% *	100% R&C - \$25 Copay 100% R&C - \$25 Copay 70% R&C* 70% R&C* 70% R&C* 70% R&C
<b>Wellness and Preventative Care Services</b> ( <i>Maximum Calendar Year Benefit: From birth to age 1 is \$5 00, age 1 to age 2 is \$500 and age 2 through adult is \$500</i> ) <ul style="list-style-type: none"> <li>• Pap Smears, Mammograms, PSA Screenings, Well Baby Care and Immunizations <ul style="list-style-type: none"> <li>• Primary Care Office Visits</li> <li>• Specialist Care Office Visits</li> </ul> </li> </ul>	100% - \$25 Copay 80% *	100% R&C - \$25 Copay 70% R&C
<b>Ambulatory Surgical Facility Services</b>	80% *	70% R&C*
<b>Maternity Services</b> <ul style="list-style-type: none"> <li>• OB/GYN Services</li> <li>• Hospital Services</li> </ul>	80% * 80% *	70% R&C* 70% R&C*
<b>Ambulance Services</b> ( <i>Maximum Benefit of \$2,000 per Participant per trip</i> )	80% R&C*	
<b>Psychiatric Services</b> <ul style="list-style-type: none"> <li>• Inpatient</li> <li>• Outpatient</li> </ul>	80% R&C* 50% R&C*	
<b>Substance Abuse Treatment Services</b> <ul style="list-style-type: none"> <li>• Inpatient</li> <li>• Outpatient</li> </ul>	80% R&C* 50% R&C*	
<b>Outpatient Prescription Drugs</b> (PRx drug card program) NOTE: <ul style="list-style-type: none"> <li>• Inpatient Prescription Drugs are covered under Ancillary Services &amp; Supplies</li> <li>• Prilosec OTC is available with a prescription at the Generic Drug Copay level</li> <li>• Smoking cessation over-the-counter drugs are available at the Generic Drugs Copay level</li> </ul>	\$10 Copay - Generic Drugs \$35 Copay - Brand Name Drugs, if no Generic available \$50 Copay - Brand Name Drugs, if Generic available	
<b>All Other Covered Services</b>	80% R&C*	

\* Calendar Year Deductible Applies

<b>MAXIMUM BENEFITS</b>	
Applicable to both of the above plans	
<b>Maximum Medical Benefit</b>	\$1,000,000
<b>Chiropractic Services</b>	\$500 Calendar Year Maximum
<b>Physical Therapy Services</b>	\$5,000 Calendar Year Maximum
<b>Home Health Care</b>	\$5,000 Calendar Year Maximum
<b>Psychiatric Services</b> • Inpatient • Outpatient	Limited to 10 days per Calendar Year Limited to 20 Visits per Calendar Year
<b>Substance Abuse Services</b> <i>Inpatient and Outpatient combined</i>	\$8,000 Calendar Year Maximum \$16,000 Plan Maximum

### VISION BENEFITS SUMMARY

<b>Calendar Year Maximum Benefit</b>	\$100 per Participant
<b>Plan Payment Rate</b>	100% Less \$25 Copay
<b>Covered Charges</b>	<ul style="list-style-type: none"> <li>• Eye examinations, including refractions</li> <li>• eyeglass lenses</li> <li>• eyeglass frames</li> <li>• contact lenses</li> </ul>

### DENTAL BENEFITS SUMMARY

<b>Covered Charges for:</b>	<b>Plan Payment Rate</b>
<b>Diagnostic and Preventative Services</b>	80% of Allowable Covered Charges
<b>Basic Services</b>	80% of Allowable Covered Charges
<b>Major Services</b>	50% of Allowable Covered Charges
<b>Orthodontic Services</b>	50% of Allowable Covered Charges
<b>Maximum Calendar Year Benefit</b> (not applicable to Orthodontia Services)	\$1,000 per Participant
<b>Maximum Orthodontic Benefit</b>	\$1,000 per Participant
<b>Calendar Year Deductible</b>	None

**DOCTORS DIRECT HEALTHCARE**

Telephone 1-877-503-0388 or (910) 485-0510

Fax 1-866-252-8232 or (910) 485-8662

**PRECERTIFICATION REQUIREMENTS  
for JACKSON COUNTY MEDICAL PLAN**

<b>BENEFITS &amp; SERVICES UTILIZATION REVIEW REQUIREMENTS</b>	<b>Precertification Requirement and Penalty for Noncertification</b>
<b>Inpatient Admissions</b> (Non-emergency) *Includes Medical, Mental Health, Chemical Dependency and Rehabilitation	<b>Precertification Required.</b> (If not obtained, benefits will be reduced by \$500 pending medical necessity approval)
<b>Inpatient Admissions</b> (Emergency) *Includes Medical, Mental Health and Chemical Dependency	<b>Notification Required within 2 business days of admission.</b> (If not obtained, benefits will be reduced by \$500 pending medical necessity approval)
<b>Surgery -- Outpatient</b>	<b>Precertification Required.</b> (If not obtained, benefits will be reduced by 50% pending medi- cal necessity approval)
<b>Skilled Nursing Facility Care</b>	<b>Precertification Required.</b> (If not obtained, benefits will be reduced by 50% pending medi- cal necessity approval)
<b>Private Duty Nursing</b>	<b>Precertification Required.</b> (If not obtained, benefits will be reduced by 50% pending medi- cal necessity approval)
<b>Transplants</b>	<b>Precertification Required.</b> (If not obtained, benefits will be reduced by 50% pending medi- cal necessity approval)
<b>Other Services:</b> Ambulance (non-emergency) Home Health, Hospice Home Infusion Therapy Physical Therapy (after initial evaluation) Occupational Therapy (after initial evaluation) Speech Therapy (after initial evaluation) Cardiac Rehab (after initial evaluation) Pulmonary Rehab (after initial evaluation) Adult MRI's (17 y.o. and older) Nuclear Medicine Study Sleep Study Sonorex/OssaTron Therapy Reconstructive/Plastic Surgery Oral Surgery/Medical Dental TMJ (surgery, splints, MRI, PT) Durable Medical Equipment Orthotics & Prosthetics	<b>Precertification Required.</b> (If not obtained, benefits will be reduced by 50% pending medi- cal necessity approval)  (DME/Medical Supplies /Orthotics & Prosthet- ics: Pre-Certification is required for all rentals. Purchases greater than \$500 will also require Pre-Certification.) **Please note - Nebulizers and Diabetic Sup- plies do not require precertification with excep- tion of Insulin Pumps.

\*Please contact the Medical Management Office at 1-877-503-0388 for questions regarding authori-  
zations or precertification requirements.

## MEDICAL EXCLUSIONS

*The following charges are not covered under the Plan:*

- Charges Incurred:
  - Before the Participant's effective date of coverage under the Plan; or
  - After the date the Participant's coverage under the Plan has ended.
- Charges applied to a Participant's Calendar Year Deductible.
- The portion of charges a Participant is required to pay due to application of the Plan Payment Rate.
- The first \$500 of charges for Inpatient Hospital Services when Pre-Admission certification is not obtained.
- Charges for which claims are filed more than 90 days after the date they were Incurred.
- Charges processed by Well Fargo Third Party Administrators, Inc after any applicable Maximum Benefit has been exhausted.
- Charges in excess of Allowable Covered Charges.
- Charges for Experimental/Investigative services or supplies, or which are required to treat routine complications of an Experimental/Investigative service.
- Charges for services or supplies that are not: (a) ordered or performed by a Doctor; or (b) Medically Necessary, unless specifically listed in the Covered Medical Charges provision of the Summary Plan Description.
- Charges for Hospital Room and Board: (a) in connection with Hospital Admissions for which Pre-Admission Review was requested but not granted; or (b) for Inpatient Hospital Services rendered on days in excess of the number of days certified by the Medical Management Program.
- Charges Incurred due to a Pre-existing Condition, unless:
  - The charges are Incurred after the date the Participant has been a Participant for 12 successive months; or
  - The Participant has evidence of prior Creditable Coverage to reduce the exclusion period for Pre-existing Conditions. In such case, Preexisting Conditions are excluded for the length of the Preexisting Condition Exclusion Period that is not reduced by prior Creditable Coverage.
- Charges for marital counseling, family counseling, educational therapy, behavior therapy, vocational therapy, coma-stimulation therapy, activities therapy, or recreational therapy. Recreational therapy includes, but is not limited to, play, sleep, dance, art, crafts, aquatic, hydro, gambling, and nature therapy.

## MEDICAL EXCLUSIONS (Continued)

- Separate charges for: (a) pre- and post-operative services in connection with Surgical Services; (b) anesthesia administered by the surgeon or assistant at Surgery; or (c) local infiltration anesthesia.
- Charges for Skilled Nursing Facility Services when the total covered expense for each day in the Skilled Nursing Facility exceeds half the semi-private room rate of the last Hospital where the patient was discharged for the same or a related condition; and Skilled Nursing Facility Services charges when the Confinement is chiefly for Custodial Care.
- Charges for Home Health Care Services which are not Incurred: (a) when the Participant is confined at home; and (b) immediately following a Hospital Confinement for the same Sickness or Injury.
- Charges submitted as charges for Home Health Care Services if the charges are for: (a) homemaker services; (b) maintenance therapy; (c) Dialysis Treatment; (d) purchase or rental of dialysis equipment; or (e) food or home-delivered meals.
- Charges for more than one Surgery performed during the same operation in excess of: (a) the amount payable for the primary procedure; plus (b) 50% of the amount that would have been payable for each of the next three procedures had they been performed alone. No Benefits are payable for procedures in excess of four.
- Charges for Surgical Services in excess of one surgeon's Allowable Covered Charges, if the Surgery was performed by two or more surgeons but could have been performed by one surgeon.
- Charges for x-rays or other examinations for an Inpatient which are not related to the diagnosis of the condition requiring the Inpatient Admission. These include chest x-rays and other examinations which a Hospital requires as part of its routine Admission procedure.
- Charges for Dental Services related to an Injury which occurred before the Participant's Effective Date of coverage under the Plan.
- Charges for treatment of any Sickness or Injury related in any way to the Participant's job when:
  - The Participant receives payment from his or her Employer on account of the Sickness or Injury;
  - The Participant's Employer is required by federal, state, or local laws or regulations to provide benefits to the Participant; or
  - The Participant could have received benefits for the Injury or Sickness if he or she had complied with the laws and regulations.

*This exclusion applies whether or not the Participant claims the benefits or compensation and whether or not the Participant recovers losses from a third party.*

## MEDICAL EXCLUSIONS (Continued)

- Charges for Outpatient Prescription Drugs.
- Charges to the extent any payment was provided or available:
  - Under a U.S. government program or a program for which a governmental entity pays all or part of the cost;
  - Under the Medicare program or under any similar program authorized by state or local laws or regulations or any future amendments to them, whether or not the Participant waives his or her rights under these laws, amendments, programs, or terms of employment.
- Charges for which a Participant would have no legal obligation to pay in the absence of the Plan or similar coverage.
- Charges for services or supplies received from a dental or medical department maintained by or on behalf of an employer, a mutual association, a labor union, a trust, or a similar person or group.
- Charges for Cosmetic Surgery or related services, including services for complications of Cosmetic Surgery. In determining whether Surgical Services are cosmetic or not, the Plan will not take into account the Participant's mental state.
- Charges for services rendered by a Doctor who is the Participant's Employer, coworker, spouse, child, sibling, or parent.
- Charges for personal hygiene and convenience items, including, but not limited to: (a) humidifiers; (b) air conditioners; or (c) physical fitness equipment.
- Charges for: (a) telephone Consultations; (b) failure to keep a scheduled appointment; or (c) completion of a claim form.
- Charges for rest cures, Residential Care, or Custodial Care.
- Charges for travel, even if prescribed by a Doctor.
- Charges Incurred during Inpatient Admissions primarily for observation or diagnostic studies, unless:
  - The Participant's medical condition requires that medical supervision by the attending Doctor be constantly available;
  - The Participant's medical condition requires that the skills of a licensed medical professional be constantly available; or
  - The Diagnostic Services and equipment required are available only on an Inpatient basis.
- Charges for services rendered to an Inpatient which might have been safely and adequately rendered in the Participant's home, the Doctor's office, or at any lesser level of institutional care.

## MEDICAL EXCLUSIONS (Continued)

- Charges for: (a) routine or periodic physical examinations; (b) school entry, work permit, insurance, or employment examinations; (c) screening examinations (including x-ray examinations made without film); (d) immunizations; and (e) other care not related to a specific Sickness or Injury which is known or reasonably suspected; except as provided by the Wellness and Preventive Services Benefit.
- Charges for dentistry or dental processes other than:
  - Dental Services, including pre- and post-operative care; and
  - Inpatient Hospital Services for a medical condition which might become life-threatening if the Participant were not hospitalized for a dental procedure. For example, if a Participant with hemophilia (a medical condition) needed to have an unimpacted tooth extracted, the Plan would cover Hospital Services needed to safeguard the patient against the bleeding that might occur as a result of the Participant's medical condition; however, charges for the extraction itself would not be covered.
- Charges Incurred during Hospital Admissions which are primarily for Physical Therapy that could have been rendered on an Outpatient basis.
- Charges for Physical Therapy to maintain motor functions, except when the Plan determines that there is a reasonable chance that the patient's motor functions will improve as a result of the therapy.
- Charges Incurred during a Hospital Admission for environmental change.
- Charges made separately for care by interns, residents, house Physicians, or other health care professionals who are employed by the Hospital which makes their services available.
- Charges for treatment of obesity or in connection with weight reduction or dietary control, whether or not an obesity-related medical condition exists, except for surgical treatment of morbid obesity when weight exceeds by at least 100 pounds or is at least twice the ideal weight specified for frame, age, height, and sex in the most recent Metropolitan Life Insurance tables.
- Charges for Surgery to correct nearsightedness.
- Charges made by a Hospital Incurred during a temporary absence from the Hospital.
- Charges for nutritional counseling and related services, except when provided as part of Home Health Care Services.
- Charges for educational or teachers' services.

## **MEDICAL EXCLUSIONS (Continued)**

- Charges for Organ Transplant Services, except as defined.
- Charges for Maternity Services rendered to a Dependent child.
- Charges for common first aid supplies or over-the-counter Medical Supplies.
- Charges Incurred due to: (a) autistic disease of childhood; (b) learning disabilities; (c) behavioral problems; (d) mental retardation; or (e) conduct and oppositional disorders.
- Charges for acupuncture.
- Charges for occupational or rehabilitative therapy if the primary purpose is to train the Participant for a new job.
- Charges for treatment of: (a) anti-social personality; (b) inadequate personality; (c) sexual deviation; (d) social maladjustment without apparent psychiatric disorder; or (e) group delinquent reaction of childhood.
- Charges for services or supplies, including Prescription Drugs, related to smoking cessation.
- Charges for hearing aids or their fitting, or for hearing exams.
- Charges for infertility treatment or infertility drugs.
- Charges for: (1) artificial insemination or in vitro fertilization; (2) treatment of sexual dysfunction not related to organic disease; or (3) surgical sex transformation and follow-up care.
- Charges for palliative or cosmetic foot care, including: (a) care for flat foot conditions; (b) supportive devices, including shoes inserts; (c) treatment of subluxation; (d) care of corns, calluses, toe nails, fallen arches, weak feet, or chronic foot strain; and (e) care for bunions, except capsular or bone Surgery.
- Charges for dorsal rhizotomy to treat spasticity.
- Charges for treatment of any Sickness or Injury resulting from: (a) any act of war (declared or undeclared); or (b) voluntary participation in civil disobedience.
- Charges for surgical trays (if charged separately).
- Charges for Doctors' after-hours services.

### **MEDICAL EXCLUSIONS (Continued)**

- Charges for abortion, except therapeutic.
- Charges for a provider not charging for services.
- Charges for: (1) vision training; (2) vision therapy; or (3) orthoptics.
- Charges for an Injury or Sickness resulting from commission of a felony or active participation in a riot.
- Charges for services or supplies not shown in the COVERED MEDICAL CHARGES Section.

## **DENTAL EXCLUSIONS**

*The following types of Dental Charges are not covered under the Dental Benefits section of the Plan:*

- Facility charges.
- Charge for Dental Services with respect to congenital or developmental malformation or primarily for cosmetic or aesthetic purposes except those described in the Plan.
- Charges for patient training in plaque control or other personal dental care instructions.
- Charges for Dental Services for which the Participant usually Incurs no charge.
- Charges for Dental Services received from a dental or medical department maintained by, or on behalf of, an employer, a mutual benefit association, a labor union, a trustee or similar person or group.
- Charges for routine examinations, prophylaxes and topical application of fluoride provided more than twice in a Calendar Year.
- Charges for complete mouth x-rays provided more frequently than once in a three-year period, unless special need is shown in a treatment plan submitted by the Dentist and approved in writing by the Plan.
- Charges for supplemental bitewing x-rays provided more than twice in a Calendar Year.
- Charges for care or treatment rendered or furnished after termination of coverage, except for procedures, as determined by the Plan, which are performed in states, such as root canals, crowns and bridges, when the procedure was in actual process prior to termination.
- Charges for dental implants.
- Charges for Sargenti procedure-paste fill root canal.
- Charges for occlusion analysis.
- Charges for local anesthesia, nitrous oxide, or intravenous sedative when billed separately from Dental Service (allowance for Dental Services include Benefits for local anesthesia, nitrous oxide or intravenous sedation).
- Charges for replacement of any full or partial, immediate (temporary) denture by another immediate denture.
- Charges for replacement of Prosthetic Appliances more often than once every five (5) Calendar Years.

## DENTAL EXCLUSIONS (Continued)

- Charges for replacement of fixed or removable bridgework, crowns or splints, or the replacement of any full or partial permanent denture by another permanent denture, if the cost of the original such appliance or restoration was paid, in full or in part, by the Plan unless a period of five (5) years has elapsed from the installation of such bridgework, denture, crowns or splints. However, Benefits will be paid for revision of an existing denture or bridge necessitated by extractions of one or more teeth supporting such appliance when the extraction occurs after the existing denture or bridge was installed.
- Charges for Dental Services when procedures are in actual process prior to commencement of coverage, except for monthly orthodontic fees Incurred after the effective date of dental coverage.
- Charges for Orthodontic Services Incurred by a Participant other than a covered child under 19 years of age.
- Charges not listed as Covered Dental Charges.
- Charges for which claims were filed more than 90 days after the date the charges were Incurred, unless evidence is provided to the Claims Administrator that: (a) it was not reasonably possible to submit the claim within that 90-day period; or (b) the Participant was unable to submit the claim within the 90-day period because he or she was legally incompetent.
- Charges processed by Wells Fargo Third Party Administrators, Inc after the Maximum Calendar Year Dental Benefit has been exhausted.
- Charges for the portion of the charges a Participant is required to pay due to the application of the Plan Payment Rate.
- Charges for space maintainers Incurred by Participants over age 19.
- Charges for application of fluoride Incurred by Participants over age 19.
- Charges for Orthodontic Services when the Course of Treatment covers a period of more than 36 months, unless the services are rendered during a new Course of Treatment which begins at least 5 years after the prior Course of Treatment.
- Charges for permanent crowns for Participants under age 16, unless approved in advance by the Plan.
- Charges for care by more than one Dentist if a Participant transfers from the care of one Dentist to another Dentist during the Course of Treatment.
- Charges for care by more than one Dentist if more than one Dentist renders services for one dental procedure.

## DENTAL EXCLUSIONS (Continued)

- Charges in excess of Allowable Covered Charges.
- Charges in excess of charges for the least costly services or supplies which meet sound professional standards and correct the dental Injury or oral disease being treated.
- Charges for services to correct or treat congenital or developmental malformation.
- Charge for services rendered for cosmetic purposes, except if required due to an accidental Injury sustained while the Participant is covered under the Dental Benefits section of the Plan.
- Charges for gold foil restorations.
- Charges for appliances or restoration necessary to increase vertical dimensions or restore or correct the occlusion.
- Charges for an appliance or a modification to an appliance, if an impression for it was made before the Participant became covered under the Dental Benefits section of the Plan.
- Charges for root canal therapy, if the pulp chamber for it was opened before the Participant became covered under the Dental Benefits section of the Plan.
- Charges for a crown, bridge, or gold restoration, if a tooth was prepared for it before the Participant became covered under the Dental Benefits section of the Plan.
- Charges for replacing lost or stolen appliances.
- Charges for services or supplies not provided by a Dentist.
- Charges for services or supplies that are Experimental/Investigative in nature.
- Charges for treatment of any Sickness or Injury resulting from: (a) any act of war (declared or undeclared); or (b) voluntary participation in civil disobedience.
- Charges for services rendered by a Dentist who is the Participant's: Employer; coworker; spouse; child; sibling; or parent.
- Charges covered under the Medical Benefits section of the Plan.
- Charges for: (a) telephone Consultations; (b) failure to keep a scheduled appointment; or (c) completion of a claim form.

## DENTAL EXCLUSIONS (Continued)

- Charges for treatment of any Sickness or Injury related in any way to the Participant's job when:
  - The Participant receives payment from his or her Employer on account of the Sickness or Injury;
  - The Participant's Employer is required by federal, state, or local laws or regulations to provide benefits to the Participant; or
  - The Participant could have received benefits for the Injury or Sickness if he or she had complied with the laws and regulations.

*This exclusion applies whether or not the Participant claims the benefits or compensation and whether or not the Participant recovers losses from a third party.*

- Charges to the extent any payment was provided or available:
  - Under a U.S. government program or a program for which a governmental entity pays all or part of the cost;
  - Under the Medicare program or under any similar program authorized by state or local laws or regulations or any future amendments to them, whether or not the Participant waives his or her rights under these laws, amendments, programs, or terms of employment.
- Charges Incurred: (a) before the Participant's Effective Date of coverage; or (b) during an Inpatient Admission that began before the Participant's Effective Date of coverage.
- Charges Incurred after the date a Participant's coverage ends.

MEDICAL RATES 07/01/2007 thru 06/30/2008	NEW MONTHLY RATES	EMPLOYEE BI-WEEKLY RATE
Individual	\$652.18	No Cost to You
Employee/ Child	\$850.91	\$91.72
Employee/ Children	\$947.92	\$136.50
Employee/ Spouse	\$947.92	\$136.50
Family	\$1,063.24	\$189.72

DENTAL RATES 07/01/2007 thru 06/30/2008	NEW MONTHLY RATES	EMPLOYEE BI-WEEKLY RATE
Individual	\$11.82	No Cost to You
Employee/ Child	\$20.31	\$3.92
Employee/ Children	\$24.43	\$5.82
Employee/ Spouse	\$24.43	\$5.82
Family	\$29.39	\$8.11

---

---

## *Lincoln Financial* *Short Term Disability Insurance*

---

---

### **GROUP SHORT TERM DISABILITY BENEFITS FOR EMPLOYEES OF JACKSON COUNTY GOVERNMENT**

#### **BENEFITS**

- Coverage for all full-time employees working 32 hours or more per week and elected County Commissioner.
- Coverage for accidents and sicknesses for up to 26 weeks. .
- Weekly benefit is 50% of your weekly salary. Maximum benefit is \$300 per week.
- Benefits begin on the 15th day absent for accidents and on the 15th day for sickness.
- Pregnancy is covered as any other disability.

#### **NO COST TO YOU**

- **Jackson County Government pays your Group STD premium.**

#### **ABOUT THE PLAN**

- These highlights are intended to provide an overview of the benefits available from your employer and are ***not*** a complete description of plan provisions. In the event that a discrepancy exists, the policy provisions will prevail.
- When you become eligible for benefits, Jackson County Government will provide you with a Lincoln Financial Group STD booklet containing complete plan details.
- This coverage has limitations and exclusions. For complete details, please contact your benefits representative or refer to your benefit booklet.
- Lincoln Financial is one of the largest, strongest and most highly rated financial companies in the world. We've been providing Disability coverage in the U.S. for decades.

---

---

## *Lincoln Financial Group Term Life Insurance*

---

---

### **BASIC EMPLOYEE LIFE INSURANCE**

This insurance (1 times base salary rounded to the next \$1,000, maximum of \$70,000) is payable for death from any cause to any person you name as beneficiary.

### **BASIC ACCIDENTAL DEATH AND DISMEMBERMENT**

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

### **DEPENDENT LIFE INSURANCE**

Your employer provides coverage on:

- Your legal spouse
- Child(ren) up to age 19 (to age 26 if wholly dependent upon you for maintenance and support if enrolled as a full-time student.)

### **ELIGIBILITY**

You will be eligible for this program if you are a full-time Employee scheduled to work at least 40 hours per week.

### **BENEFICIARY**

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

### **WHEN YOUR BASIC INSURANCE STARTS**

Your Basic Insurance begins on the first day of the calendar month which occurs on or follows the date you are first eligible, but only if you are actively at work on the date such insurance is to begin. If you are not actively at work on that date, such insurance will begin on the next date that you are actively at work.

### **WHEN YOUR DEPENDENT INSURANCE STARTS**

Your dependents are eligible for coverage on the date you are eligible to be insured or the date you acquire an eligible dependent, unless the dependent is confined to a hospital or confined at home and unable to perform normal activities.

**APPROVED LEAVE OF ABSENCE**

If you are on leave (off the payroll) you may continue your group term life insurance for the length of the leave by paying the cost of your Basic Employee Life Insurance plus the cost of your Optional Life Insurance. Group Life coverage may be continued on a premium-paying basis for the following:

Leave of Absence or layoff .....	1 month
Vacation.....	3 months
Family & Medical Leave .....	12 weeks
Injury or Sickness .....	12 months

**REDUCTIONS AT AGE 65 & OVER**

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

<b>Attained Age</b>	<b>Percent of Original Amount</b>
65	65%
70	50%

**TERMINATION OF COVERAGE**

All insurance under this plan will terminate upon the earlier of the date you retire, or the date your employment terminates. Nevertheless, if you or a covered dependent should die within 31 days thereafter, the life insurance will still be paid to the beneficiary.

**DISABILITY**

**Prior to Age 60** - If you become totally disabled prior to age 60, your amount of life insurance will be continued without payment of premium provided proof of your continued total disability is provided annually. The amount of insurance is subject to reduction due to age and terminates at age 70 or retirement, whichever is earlier.

**One Year Continuance Between 60 and 70** - If you become totally disabled at age 60, but before age 70, your amount of life insurance will be continued without payment of premium for up to one year. Under this provision, your Life Insurance will be reduced according to the "Reductions at age 65 and Over" schedule, as though you were an active employee.

**CONVERSION**

If your employment terminates while you are covered under the plan, you may purchase without medical evidence of insurability, a whole life policy issued by the Insurer. You must apply for this policy within 31 days after the date your employment terminates.

## **GROUP POLICY**

The insurance briefly described in this folder is subject to the terms and conditions of the Group Policy issued by the Insurer. These terms and conditions are described in the booklet that will be furnished to you by the Insurer. Please refer to the booklet for a full description of your insurance.

**This coverage has limitations and exclusions. For complete details, please contact your benefits representative or refer to your benefits booklet. In the event that a discrepancy exists, the policy provisions will prevail.**

## **GROUP ACCELERATED BENEFITS**

The Accelerated Benefits provision gives terminally ill employees with a life expectancy of 12 months or less, access of up to 75% of their group life death benefit while they are alive. The minimum Accelerated Benefit available to employees is 10% or \$1,000, whichever is greater, and the maximum is 75% to \$250,000, whichever is less.

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

### **(Paid by your employer)**

All Eligible Employees 1 times base salary (rounded to the next \$1,000) up to \$70,000\*.

## **DEPENDENT LIFE INSURANCE (Paid by your employer)**

- \$2,000 on your spouse
- \$2,000 on each of your eligible children

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

## **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 dies
  - 1 in 88 homes catches fire
  - 1 in 70 cars is involved in a serious accident
  - 1 in 8 people is disabled

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

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

---

---

## *Standard Life Short Term Disability Plan*

---

---

**Effective Date: July 1, 2008, pending underwriting approval**

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

### **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.

### **ELIGIBILITY**

These benefit plans are optional, and all full-time, benefit-eligible employees, under 65 years of age, who are scheduled for 30 hour or more per week may apply. The disability benefit is for **employees** only. All applications will be underwritten.

### **POLICY FEATURES**

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

**Pregnancy:** Benefits are covered provided conception occurs **after** the effective date of the policy, not the date the application was signed.

**Portability:** When an employee leaves the employment of Jackson County Government, they may continue the short term disability coverage, subject to the renewability provision, provided they maintain continuous employment. Your new occupation must be within the Company's underwriting guidelines.

**This coverage expires on the policy anniversary date following your 65th birthday.**

## BI-WEEKLY RATES

<i>Benefit Duration: 90 Days</i>		<i>Benefit Duration: 180 Days</i>		<i>Benefit Duration: 365 Days</i>	
Monthly Benefit	Bi-Weekly Premium	Monthly Benefit	Bi-Weekly Premium	Monthly Benefit	Bi-Weekly Premium
\$500	\$5.19	\$500	\$8.08	\$500	\$10.38
\$600	\$6.23	\$600	\$9.69	\$600	\$12.46
\$700	\$7.27	\$700	\$11.31	\$700	\$14.54
\$800	\$8.31	\$800	\$12.92	\$800	\$16.62
\$900	\$9.35	\$900	\$14.54	\$900	\$18.69
\$1,000	\$10.38	\$1,000	\$16.15	\$1,000	\$20.77
\$1,100	\$11.42	\$1,100	\$17.77	\$1,100	\$22.85
\$1,200	\$12.46	\$1,200	\$19.38	\$1,200	\$24.92
\$1,300	\$13.50	\$1,300	\$21.00	\$1,300	\$27.00
\$1,400	\$14.54	\$1,400	\$22.62	\$1,400	\$29.08
\$1,500	\$15.58	\$1,500	\$24.23	\$1,500	\$31.15
\$1,600	\$16.62	\$1,600	\$25.85	\$1,600	\$33.23
\$1,700	\$17.65	\$1,700	\$27.46	\$1,700	\$35.31
\$1,800	\$18.69	\$1,800	\$29.08	\$1,800	\$37.38
\$1,900	\$19.73	\$1,900	\$30.69	\$1,900	\$39.46
\$2,000	\$20.77	\$2,000	\$32.31	\$2,000	\$41.54

**Limits and Exclusions:**

Benefits will not be paid for any total disability which:

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

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

**For questions about your policy, call  
Standard Life and Casualty at (800) 327-0695  
For Claims call (800) 227-0251**



---

---

## *MetLife Optional Term Life Insurance*

---

---

### **OPTIONAL EMPLOYEE LIFE INSURANCE**

You now have the opportunity to elect group term life insurance coverage at low group rates and through payroll deductions.

### **OPTIONAL DEPENDENT LIFE INSURANCE**

Provides coverage on:

- ◆ Your Spouse
- ◆ Child(ren) from 15 days of age up to 19 (to age 25 if wholly dependent upon you for maintenance and support, and if enrolled as a full-time student in an accredited school or college). Handicapped children can continue to be covered with no age limit. It is your responsibility to notify payroll in writing when a dependent is ineligible for coverage. Examples of ineligible dependent status are divorce, or a child graduates from college.

### **FEATURES**

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

### **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 - a leader in the field of group coverage.

### **ELIGIBILITY**

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

### **WHEN YOUR INSURANCE STARTS**

Your Optional 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. In addition, coverage will not become effective for you or any dependent who is not performing normal daily activities on the date coverage would otherwise become effective. Normal daily activities means that the individual is not confined at home under the care of a doctor for a sickness or injury, or is not entitled to receive any disability income from any source.

If you meet the eligibility requirements described above for date of enrollment and for effective date of coverage, your Optional Employee Life Insurance, if you have enrolled for that coverage, will become effective on the date of your eligibility, provided you are then actively at work; otherwise, on the day you return to active work. If you enroll for Optional Dependent Life Insurance, that coverage will become effective on the date your Optional Employee Life Insurance becomes effective, for any dependents who meet the eligibility requirements described above.

If you, or any dependents do not satisfy the eligibility requirements as described for date of enrollment and for effective date of coverage, that person will not become insured for Optional Life Insurance until such person has furnished medical evidence of insurability satisfactory to MetLife.

### **TERMINATION OF COVERAGE**

All insurance under this plan will terminate with the earliest of the following events: termination upon retirement, termination of employment, plan cessation or withdrawal from the plan. Nevertheless, if you should die within 31 days thereafter, your life insurance will still be paid to the beneficiary. If any of your covered dependents should die within such 31 day period, the amount of Life Insurance on account of such dependent will be paid to you.

### **WAIVER OF PREMIUM**

The waiver benefit applies to disabilities beginning before age 60. MetLife must be notified of the disability within 12 months of the date the insured's disability begins. After inception of disability, there is a 9 month waiting period before benefits begin. During the waiting period, normal monthly deductions are taken, which are not refundable. This means that employees who become disabled on, or after the effective date of coverage, and before age 60, and whose application for disability is approved have continuing coverage without premium payment until death, or recovery, or age 65, whichever is earliest. If the employee remains on disability at age 65, the death benefit will reduce to zero. You must be insured for 12 months prior to the date of disability in order for Waiver of Premium to apply.

### **CONVERSION**

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

### **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, not dependents.

#### **Qualifying Events Include:**

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

The minimum face amount which an employee may elect portability is \$20,000. 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.

## **THE ACCELERATED BENEFIT OPTION (ABO)**

Metropolitan Life Insurance Company has included an Accelerated Benefit Option (ABO) as part of your group life benefits. Under this option, if you are diagnosed as having a terminal illness, you may be eligible to receive a portion of your group life

## **SUICIDE EXCLUSION**

No Optional Employee Life Benefits are payable if you commit suicide within two years from the effective date of the coverage. This exclusion also applies to Optional Dependent Life.

## **CLAIMS PROCEDURE**

Procedures for Presenting Claims for Benefits - Claim forms needed to file for benefits under the group insurance program can be obtained from your employer who will also be ready to answer questions about the insurance benefits and to assist in filing claims.

The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully.

Routine Questions - If there is any question about a claim payment, an explanation can be requested from MetLife, who is usually able to provide the necessary information.

## **SCHEDULE OF BENEFITS**

### **OPTIONAL EMPLOYEE LIFE INSURANCE**

Your choice of the following amounts:

Coverage of \$10,000 to \$200,000 in \$10,000 increments, \$200,000 to \$500,000 in \$50,000 increments not to exceed 5 times your base annual salary. Amounts over \$250,000 will require medical evidence of insurability.

### **OPTIONAL DEPENDENT LIFE INSURANCE**

Spouse - Increments of \$10,000 up to a maximum of \$100,000. Amounts over \$20,000 will require medical evidence of insurability. Spouse coverage cannot exceed employee coverage.

Child - Guaranteed issue in increments of \$2,000 to a maximum of \$10,000 per child.

**Optional Dependent Life Insurance is available only to those eligible employees who are insured for Optional Employee Life Insurance. If both husband and wife are employees of Jackson County, only one can cover the dependent children.**

<b>Optional Employee and Spouse Term Life Biweekly Cost</b>											
<i>Spouse Cost is determined by the employees age</i>											
	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
\$10,000	\$0.32	\$0.42	\$0.55	\$0.69	\$0.88	\$1.29	\$2.17	\$3.92	\$4.85	\$8.54	\$13.62
\$20,000	\$0.65	\$0.83	\$1.11	\$1.38	\$1.75	\$2.58	\$4.34	\$7.85	\$9.69	\$17.08	\$27.23
\$30,000	\$0.97	\$1.25	\$1.66	\$2.08	\$2.63	\$3.88	\$6.51	\$11.77	\$14.54	\$25.62	\$40.85
\$40,000	\$1.29	\$1.66	\$2.22	\$2.77	\$3.51	\$5.17	\$8.68	\$15.69	\$19.38	\$34.15	\$54.46
\$50,000	\$1.62	\$2.08	\$2.77	\$3.46	\$4.38	\$6.46	\$10.85	\$19.62	\$24.23	\$42.69	\$68.08
\$60,000	\$1.94	\$2.49	\$3.32	\$4.15	\$5.26	\$7.75	\$13.02	\$23.54	\$29.08	\$51.23	\$81.69
\$70,000	\$2.26	\$2.91	\$3.88	\$4.85	\$6.14	\$9.05	\$15.18	\$27.46	\$33.92	\$59.77	\$95.31
\$80,000	\$2.58	\$3.32	\$4.43	\$5.54	\$7.02	\$10.34	\$17.35	\$31.38	\$38.77	\$68.31	\$108.92
\$90,000	\$2.91	\$3.74	\$4.98	\$6.23	\$7.89	\$11.63	\$19.52	\$35.31	\$43.62	\$76.85	\$122.54
\$100,000	\$3.23	\$4.15	\$5.54	\$6.92	\$8.77	\$12.92	\$21.69	\$39.23	\$48.46	\$85.38	\$136.15
\$110,000	\$3.55	\$4.57	\$6.09	\$7.62	\$9.65	\$14.22	\$23.86	\$43.15	\$53.31	\$93.92	\$149.77
\$120,000	\$3.88	\$4.98	\$6.65	\$8.31	\$10.52	\$15.51	\$26.03	\$47.08	\$58.15	\$102.46	\$163.38
\$130,000	\$4.20	\$5.40	\$7.20	\$9.00	\$11.40	\$16.80	\$28.20	\$51.00	\$63.00	\$111.00	\$177.00
\$140,000	\$4.52	\$5.82	\$7.75	\$9.69	\$12.28	\$18.09	\$30.37	\$54.92	\$67.85	\$119.54	\$190.62
\$150,000	\$4.85	\$6.23	\$8.31	\$10.38	\$13.15	\$19.38	\$32.54	\$58.85	\$72.69	\$128.08	\$204.23
\$160,000	\$5.17	\$6.65	\$8.86	\$11.08	\$14.03	\$20.68	\$34.71	\$62.77	\$77.54	\$136.62	\$217.85
\$170,000	\$5.49	\$7.06	\$9.42	\$11.77	\$14.91	\$21.97	\$36.88	\$66.69	\$82.38	\$145.15	\$231.46
\$180,000	\$5.82	\$7.48	\$9.97	\$12.46	\$15.78	\$23.26	\$39.05	\$70.62	\$87.23	\$153.69	\$245.08
\$190,000	\$6.14	\$7.89	\$10.52	\$13.15	\$16.66	\$24.55	\$41.22	\$74.54	\$92.08	\$162.23	\$258.69
\$200,000	\$6.46	\$8.31	\$11.08	\$13.85	\$17.54	\$25.85	\$43.38	\$78.46	\$96.92	\$170.77	\$272.31
\$250,000	\$8.08	\$10.38	\$13.85	\$17.31	\$21.92	\$32.31	\$54.23	\$98.08	\$121.15	\$213.46	\$340.38
\$300,000	\$9.69	\$12.46	\$16.62	\$20.77	\$26.31	\$38.77	\$65.08	\$117.69	\$145.38	\$256.15	\$408.46
\$350,000	\$11.31	\$14.54	\$19.38	\$24.23	\$30.69	\$45.23	\$75.92	\$137.31	\$169.62	\$298.85	\$476.54
\$400,000	\$12.92	\$16.62	\$22.15	\$27.69	\$35.08	\$51.69	\$86.77	\$156.92	\$193.85	\$341.54	\$544.62
\$450,000	\$14.54	\$18.69	\$24.92	\$31.15	\$39.46	\$58.15	\$97.62	\$176.54	\$218.08	\$384.23	\$612.69
\$500,000	\$16.15	\$20.77	\$27.69	\$34.62	\$43.85	\$64.62	\$108.46	\$196.15	\$242.31	\$426.92	\$680.77

Child(ren) Rates	Biweekly
\$2,000	\$0.06
\$4,000	\$0.13
\$6,000	\$0.19
\$8,000	\$0.52
\$10,000	\$0.65

To determine the cost for **Employee and Dependent** Optional Life, correspond the elected coverage to the correct age category for YOU (the employee). Spouse rates are based on the age of the employee, not the age of the spouse.

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

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



---

---

## *Boston Mutual Life Insurance* *Employee Life Option (ELO) Life Plus*

---

---

### **GUARANTEED BENEFITS, LEVEL PREMIUMS AND GREATER POLICY VALUES**

The Employee Life Option is more than just life insurance at an affordable price. It combines the guaranteed premiums, coverage and values that have always been so attractive in life insurance with the advantages of cash accumulation at current interest rates. This policy is an endowment at 95 with coverage to age 95.

### **BASIC PLAN**

Traditional whole life insurance provides cash value accumulation based on a low fixed interest rate. The ELO Basic Plan provides *current interest rates* on your policy's value. This means that along with guaranteed premiums and guaranteed coverage, you may also benefit from competitive interest rates. ELO is affordable and is available through the convenience of payroll deduction. The Basic Plan is offered to eligible employees, their spouses, children and grandchildren.

### **PAYOR WAIVER OF PREMIUM**

This benefit pays all the premiums on your policy, your spouse's or dependent's policy or policies in the event the payor (employee) becomes totally disabled before age 60. The disability must last at least six consecutive months and meet the definitions set forth in your policy.

This benefit is available for issue on policies owned by employees up to and including issue age 55 at a cost of 10% of the basic premium for each policy. This benefit terminates on the policy anniversary on or following the Payor's 60th birthday, as long as the Payor is not disabled at that time.

### **ACCIDENTAL DEATH BENEFIT (ADB)**

This option could *double or even triple* your ELO death benefit. This benefit pays an additional amount equal to the basic coverage to the beneficiary if the insured is killed accidentally. If accidental death occurs while the insured is a passenger on a bus, plane, train or any other common carrier, this benefit pays the accidental death benefit as above but will also pay an additional benefit of the basic coverage (up to \$100,000). This extra protection is available at affordable rates. Any Basic Plan participant age 5 years through age 60 is eligible for this benefit.

### **CHILDREN'S TERM BENEFIT (CTB)**

For pennies a week, you can provide level term coverage for all your unmarried, dependent children, age 15 days up to and including age 24. Future children will be automatically covered upon the attainment of 15 days with no increase in the premium. This benefit may be added to any policy issued to any employee or spouse age 18-55. Coverages range from \$1,000-\$10,000 in unit increments of \$1000.

The weekly cost is 11¢ per unit. One premium covers all children. As many as 10 units of CTB are allowed regardless of the parents' ELO Basic Plan contribution. Any number of CTB units may be split between an Employee's and Spouse's policies, not to exceed the 10 units. If the insured parent dies, coverage on the children will continue without further premium payments until each insured child's 25th birthday.

Additionally, any insured child between the ages of 21-25 may purchase without evidence of insurability a permanent policy up to the lesser of 5 times the children's benefit or \$25,000.

### **AFFORDABLE, FLEXIBLE PROTECTION**

You choose the amount of insurance or the amount of premium that best suits your needs and budget. All eligible employees and their spouses through age 70 may purchase coverage under the Basic Plan. Weekly deductions range from \$2.00-\$15.00 per week.

Insurance is also available for your spouse, unmarried dependent children and grandchildren, even if you choose not to buy coverage on yourself.

### **POLICY VALUES\***

As long as premiums are paid, your ELO Basic Plan offers a guaranteed cash value that can grow over the years. The cash value can be used to supplement retirement income, for emergency cash, as an education fund or to provide a paid-up insurance benefit. While this value can never be less than the guaranteed amount, ELO gives you the advantage of potential cash values in excess of the guaranteed amount. The current interest rate in effect when your policy is issued is guaranteed for the first year. On each policy anniversary date, you will receive an annual statement outlining your policy's fund value and changes in the interest rate, if any.

*\* The actual cash value may be decreased by loans or withdrawals.*

### **CONSTANT COVERAGE**

ELO participants are protected worldwide, 24 hours a day. Your policy is owned by you and supplements any other insurance you may have.

### **BENEFITS YOU CAN KEEP**

Once purchased, your ELO plan remains in force as long as premiums continue to be paid; and your premiums cannot be increased. If you change jobs or retire, as long as you continue to pay premiums, your insurance will remain in force without interruption. Boston Mutual will bill you at home and you may choose from several payment options — annual, semi-annual, quarterly, monthly coupon book or monthly automatic check plan.

### **ACCELERATED DEATH BENEFIT\*\***

This very important feature allows a portion of the policy's death benefit to be paid before the death of the insured. This benefit is a part of your life insurance policy and is made available at no extra cost. With certification from a licensed physician that the insured, because of any illness, has a life expectancy of no more than 12 months, the policy owner may request the early distribution of a portion of the policy's face amount.

Distribution of the requested face amount (minimum \$10,000, maximum \$50,000) will be paid in a lump sum or in six equal installments. The proceeds will be discounted at the current interest rate. Accelerated benefit payments may be taxable. Consult your tax advisor for specific advice.

## **QUESTIONS AND ANSWERS**

### **CAN I BUY THIS PLAN ON MY OWN?**

No! This plan is available only to employees of companies that provide the convenience of payroll deduction for the ELO plan. Because your employer has chosen to offer ELO, you receive the advantages of more liberal underwriting and the convenience of payroll deduction.

### **DOES THIS POLICY REPLACE MY PRESENT GROUP INSURANCE?**

No! ELO coverage is independent of and supplements your present group insurance program.

### **IF I LEAVE MY EMPLOYER WHAT HAPPENS TO MY ELO PLAN?**

You can take the ELO plan with you when you leave with no change in cost or benefits. We will bill you at home.

### **WHAT HAPPENS IF I CAN'T PAY MY PREMIUM AS A RESULT OF A LEAVE OF ABSENCE OR TERMINATION FROM MY EMPLOYER?**

Your policy includes the "Automatic Premium Loan" provision which will be used to pay your premium at the end of your grace period, provided you have accumulated cash value.

### **WHAT OPTIONS DOES MY ELO POLICY PROVIDE AT RETIREMENT?**

Depending on how long your policy has been in force, you have the following options: (1) continue your premium payments and accumulated value; (2) choose a paid-up policy; (3) decide to turn your policy in for its accumulated cash value.

### **CAN I INCREASE MY COVERAGE IN THE FUTURE?**

You may apply for additional coverage in the future subject to the ELO underwriting guidelines.

### **CAN I TAKE A LOAN ON MY POLICY?**

Yes. You may borrow all or part of your fund value at just 8% fixed interest.

### **DOES THE ELO COVERAGE HAVE A SURRENDER CHARGE?**

If you discontinue your plan before the 21st policy year, there will be a surrender charge. The amount of this charge decreases every year. No charge is made if you decide to terminate your coverage after it has been in force for at least 20 years.

### **WILL ELO BENEFITS BE PAID FOR SUICIDE?**

If suicide occurs during the first 2 years your policy is in effect, benefits will not be paid, but any premiums paid will be refunded. After 2 years, benefits will be paid if death is caused by suicide.

## **CONSIDER...**

### **IF YOU HAVE A FAMILY**

The ELO plan enables you to build a cash reserve for yourself, your spouse and your children for less than 1 hour's pay per week. It is a sound way to protect your family without exceeding your present budget.

### **IF YOU'RE SINGLE WITH NO DEPENDENTS**

For a single working person insurance is the foundation for future financial planning. The longer you wait to buy insurance the more expensive it will be. The flexibility of the ELO plan enables you to expand your coverage to meet any future responsibilities.

### **IF YOU ARE OLDER AND NEARING RETIREMENT**

A lot of obligations and responsibilities have probably come and gone in the past few years. Now you can think about your future. Your ELO plan can be continued after retirement.

**No matter where you are in your life and career, you will benefit from ELO – Life Insurance that Works for Life.**

**For questions concerning this policy please contact:**

**BOSTON MUTUAL LIFE INSURANCE COMPANY  
120 Royall Street • Canton, MA 02021**

**(800) 669-2668 • (781) 828-7000  
Extension 222 - Customer Service**

**Web site: [www.bostonmutual.com](http://www.bostonmutual.com)**

***BOSTON MUTUAL***  
**LIFE INSURANCE COMPANY SINCE 1891**

*Policy Series END 95(ESO) (9/00)*

---

---

## *Liberty Mutual Auto & Homeowners Insurance Plan*

---

---

Employee benefits now include savings on auto and home insurance! Swain County Government has teamed up with Liberty Mutual to offer employees Group Savings Plus<sup>®</sup>. This unique program allows you to purchase high-quality auto, home, and renters insurance at low group rates through the convenience of bank draft.

### **Liberty Guard Auto Insurance**

Liberty Guard Auto Insurance provides coverage from collision to theft, and includes extra benefits to help make insurance easier for you. Here is a brief list of some of the coverages that come with a Liberty Guard Auto Insurance Policy.

#### **Liability coverage**

- If you cause an accident, your policy will pay the damages up to your policy limits.
- We will pay the legal expenses if a suit is brought against you.

#### **Medical payments coverage**

- In some states, Medical Payments Coverage is required, and is included in your policy. In other states, you may choose to purchase Medical Payments Coverage at an additional cost. This coverage covers anyone injured in your vehicle for reasonable medical and funeral expenses for up to three years after the accident.

#### **Uninsured motorist coverage**

- In some states, Uninsured Motorist Coverage is required, and is included in your policy. In other states, you may choose to purchase Uninsured Motorist Coverage at an additional cost. If you are in an accident with someone who does not have enough, or any, insurance, this coverage will protect you up to your policy limits.

#### **You can purchase coverage for damage to your auto that best fits your needs—**

- Collision coverage provides protection if your car rolls over, is hit by another car, or hits another car or object
- Other Than Collision coverage protects your car when it is damaged by other perils, such as birds, animals, fire, theft, vandalism, windstorm, earthquake, and hail.
- Towing and Labor coverage provides for towing each time you need it.

### **LibertyGuard<sup>®</sup> Deluxe Homeowners Insurance**

Your home is not only one of the largest investments you'll ever make, it is also one of the most important assets you and your family have. You need to feel secure about your home and its contents, and that starts with the right insurance coverage.

A Liberty Mutual LibertyGuard® Deluxe Homeowners Insurance policy protects your home and other structures on your premises against direct physical loss on your premises. We'll protect your belongings if they are damaged or stolen, and we'll even protect your pets against claims for accidental bodily injury or property damage.

Think you need to live near water to need flood insurance? Think again. Floods can be caused by storms, hurricanes and even melting snow. Don't get caught in rising water – protect your home with flood insurance.

**Flood insurance** is provided by Liberty Mutual authorized by the Federal Emergency Management Agency for over 18,000 participating communities. Flood coverage must be purchased as a separate policy as flood damage is not covered under homeowner policies.

### **LibertyGuard® Tenants Insurance**

Insurance is not just for homeowners. If you rent your home, you should consider protecting your possessions with a LibertyGuard® Tenants Insurance policy. It covers you for items such as computer equipment, jewelry, stereo equipment, furniture, and clothing if these belongings are stolen or damaged, whether they are at home or anywhere in the world. You will also have protection against claims for accidental bodily injury or property damage, at or away from your home.

**Watercraft Insurance** can be added to your Tenants policy as well as many other endorsements for an additional cost.

### **LibertyGuard® Condominium Insurance**

Your condominium is more than a place to live; it is a home—filled with memories and your valuable possessions. Should you ever suffer a loss due to fire, robbery, or other circumstances, you want to be sure your belongings are protected. Liberty Mutual's LibertyGuard® Condominium Insurance will provide you with the coverage you need. The LibertyGuard® Condominium policy also provides coverage for the alterations, appliances, fixtures and improvements which are part of your unit.

See for yourself how much money you could save with Liberty Mutual compared to your current insurance provider. **For a free, no-obligation quote, please call 1-800-835-0894.**

*\*Group discounts, other discounts, and credits are available where state laws and regulations allow, and may vary by state. Certain discounts apply to specific coverages only. To the extent permitted by law, applicants are individually underwritten; not all applicants may qualify.*

*Coverage provided and underwritten by Liberty Mutual Insurance Company and its affiliates, 175 Berkeley Street, Boston, MA.*



---

---

## *Continuation of Benefits*

---

---

### **HEALTH CARE FLEXIBLE SPENDING ACCOUNT**

If you have a positive balance (payroll deductions are greater than the amount you have received in reimbursement) in your Medical Reimbursement Account at the time of your termination, you may continue participation in the Plan for the remainder of the Plan year through COBRA. If you prefer to terminate your participation and contribution to the Plan, any balance in your account on the date of termination will be forfeited if claims were not incurred prior to the date of termination. To continue your medical spending account, you may contact **Interactive Medical Systems (IMS) at: (800) 426-8736.**

### **GROUP MEDICAL & DENTAL**

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

If you and your dependents are enrolled in the plan, you will be eligible to continue coverage through COBRA after you leave employment for a specified period. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents maybe eligible to continue coverage through COBRA. Also, while you are covered under the plan, your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA. Examples of an ineligible dependent would be when your child graduates from college, or turns 24 years old. You will receive notification from **Wells Fargo Third Party Administrators, Inc** with premium and continuation options shortly following your termination of employment. You may also contact **Wells Fargo Third Party Administrators at (800) 337-6288.**

### **LINCOLN FINANCIAL BASIC 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. You must apply for conversion within 31 days after the date your coverage terminates. To get information and rates for converting coverage, please contact **Lincoln Financial at (800) 423-2765.**

### **ASSURITY CANCER**

When you leave employment you may continue your Assurity Cancer coverage by having the premiums that are currently deducted from your paycheck billed to your home address or drafted from your bank account. Assurity will send you a letter explaining your options or you may arrange that by contacting **Assurity at: (888) 358-8808, Extension 23.**

### **TRANSAMERICA ACCIDENT**

When you leave employment you may continue your Transamerica Accident coverage by having the premiums that are currently deducted from your paycheck billed to your home address or drafted from your bank account. You may do that by contacting **Transamerica at: (800) 400-3042.**

### **STANDARD LIFE SHORT TERM DISABILITY**

If you leave your employment with the County, you may continue your disability coverage as long as continuous employment is maintained and proof of employment is furnished to Standard Life. Coverage expires on the policy anniversary date following your 65th birthday. Please contact **Standard Life at: (800) 327-0695** to set up a direct bill to your home.

### **SUPERIOR VISION**

Under the Superior Vision plan, you and your covered dependents are eligible to continue vision coverage through COBRA according to the following “qualifying events”.

If you and your dependents are enrolled in the vision plan, you will be eligible to continue coverage through COBRA after you leave 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 vision coverage through COBRA. Also, while you are covered under the plan, your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA. Examples of an ineligible dependent would be when your child graduates from college, or turns 24 years old. You will receive notification from **Interactive Medical Systems (IMS)** with premium and continuation options shortly following your termination of employment or you may call them at **(800) 426-8736.**

### **BOSTON MUTUAL UNIVERSAL LIFE**

When you leave employment you may continue your universal life coverage by having the premiums that are currently deducted from your paycheck billed to your home address or drafted from your bank account. You may do that by contacting **Boston Mutual: at (800) 669-2668.**

### **LIBERTY MUTUAL AUTO & HOMEOWNERS**

When you leave employment, you may continue the coverage that you have with Liberty Mutual. The coverage will continue to be drafted from your bank account. If you have questions you may contact **Liberty Mutual at 800-835-0894.**

## **METLIFE OPTIONAL EMPLOYEE & DEPENDENT 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. You must apply for conversion within 31 days after the date your coverage terminates. This applies to Optional Life and Dependent Life.

**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.

Your employer will advise MetLife of your termination and MetLife will in turn, contact you directly to assist with the conversion/portability process, and advise you of your options.

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