

Mitchell County Schools is offering all 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 and unreimbursed medical as well as dependent day care expenses before taxes are taken out of your paycheck. Paying for these benefits using this method reduces your taxes and increases your take home pay.

- The Plan Year is from September 1 through August 31
- A Mark III representative will be available to meet with employees that are eligible to participate in the Cafeteria Benefits program at the annual enrollment period.

Table of Contents

PRE-TAX BENEFITS

Gilsbar Flexible Spending Accounts (General Overview)Page 2

Gilsbar Medical Reimbursement AccountPage 4

Gilsbar Debit Card InstructionsPage 12

Gilsbar Dependent Care Reimbursement AccountPage 14

Cancer Fact SheetPage 18

Assurity Cancer PlanPage 19

Superior Vision Plan 1Page 25

Superior Vision Plan 2Page 30

Ameritas Dental Plan..... Plan 34

AFTER-TAX BENEFITS

Disability Fact SheetPage 37

Standard Life Short Term Disability PlanPage 38

Boston Mutual Whole Life PlanPage 40

Continuing Your Benefits When You Leave the DistrictPage 44

Gilsbar Flexible Spending Accounts

Plan Year: September 1, 2008 - August 31, 2009
Health Care Flexible Spending Account Maximum: \$2,000.00
Health Care Spending Account Minimum: None
Dependent Care Account Maximum: \$5000.00

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

What if I have a question?

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

How does participating in an FSA save me money?

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

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

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

HEALTH CARE 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, precriptions, office visit, and over-the-counter medications and planned medical expenses, i.e. braces or LASIK eye surgery. An expense worksheet has been provided at the end of this section to help you determine the amount of money to allocate to your Health Care FSA.

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

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

What is eligible for reimbursement under the Health Care FSA?

Eligible health care expenses may include deductibles, co-payments and amounts over the maximum your plan pays, expenses for routine physicals and other expenses not covered by your health care plan. For more complete listing please refer to the "Qualified Medical Expenses Eligible for Reimbursement" on page 6.

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**, or you can call Gilsbar's Customer Contact Center at 1-800-445-7227 ext. 883.

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

Qualified Medical Expenses Eligible For Reimbursement:

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

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

* May require additional substantiation (documents of medical necessity)

Expenses Not Eligible For Reimbursement

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

OVER-THE-COUNTER DRUG/MEDICINE LIST

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

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

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

| Drug / Medicine | Examples |
|---|--|
| Allergy Prevention & Treatment | Benadryl, Sudafed, Actifed, Claritin, Chloral Trimeton, and Nasalcrom |
| Antacids and Acid Reducers | Gas-X, Maalox, Mylanta, Tums, AXID AR, Pepcid AC, Prilosec OTC, Tagamet HB, Zantac 75 |
| Anticandial | Femstat 3, Gyne-Lotrimin, Mycelrx-7, Monistat 3, 7, and Vagistat-1 |
| Antihistamines | Actidil Syrup and Capsule, Actifed, Allerest, Benadryl, Claritin, Chlor-Trimeton, Contac, Dimetane, Drixoral, Nyquil, Sudafed, Tavist-1, and Triaminic |
| 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 |

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

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

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

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

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

Health Care FSA Expense Worksheet

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

HEALTH CARE EXPENSES YOU PAID LAST YEAR COULD INCLUDE:

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

My out-of-pocket health care
 (expenses last year) \$ _____

HEALTH CARE FLEX DEBIT CARDS

As an added benefit, your employer has decided to offer you a debit card for your Health Care Flexible Spending Account (FSA). Please read this carefully to find out how the debit card can give you faster access to your Health Care FSA funds.

What is a Health Care FSA Debit Card?

The FSA debit card is like your bank debit card except that the FSA debit card is linked to your Health Care FSA. You can use the card to pay health care providers directly out of your FSA at the time of purchase.

How does the Flex Debit Card work?

Shortly after the start of the plan year, you will receive your FSA Debit Card to use to pay for your eligible medical expenses. When you incur an eligible health care expense, you simply swipe your debit card at the point of purchase, select the "CREDIT" option on the card reader, and the amount of the purchase is deducted directly from your Health Care FSA account balance. You do not have to pay cash, write a check or provide another means of payment. Your health care provider is paid automatically from your Health Care FSA.

What kinds of services can I purchase with the debit card?

The debit card can be used to purchase health care services from many medical providers, including physician offices, pharmacies, dental providers, vision providers, hospitals and online service providers or retailers.

Where can I use my FSA Debit Card?

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

Do I have to apply for the FSA Debit Card?

No. If you participate in the Health Care FSA, you will receive a debit card by U.S. mail at your home address. If you do not want to use the card for your eligible health care expenses, simply destroy the card upon receipt.

Do I have to use the FSA debit card for all my health care expenses?

No, the FSA debit card is provided to you as a convenience. You make the choice every time you purchase health care products or services if you would like to use the debit card. If you do not use your debit card, you can submit any health care expenses manually by fax for reimbursement to Gilsbar at 866-635-1329 along with a completed claim form and receipts.

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

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 supermarket to only use the card for FSA eligible items. That means 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.

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 be declined.

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 free-standing pharmacy, or simply continue to turn in your paper receipts for reimbursement as you have previously.

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

1. Bring prescriptions and vision products, OTC's 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 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.

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.

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

(PLEASE KEEP YOUR ORIGINALS)

**Questions? Call Gilsbar's Customer Contact Center at
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)

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. Select the "Reimbursement Account Center" link on the left side of the screen to view your balances.

Am I eligible to use the Dependent Care FSA?

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

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

Who is an eligible dependent?

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

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

What expenses are covered?

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

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

Is there anything I should 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 deduction for tax purposes. I pay for child care. Can I use the Dependent Care FSA?

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

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** 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 at
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 Plan

Effective Date: September 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 \$10,000 per month 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.

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

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

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

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

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

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

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

Waiver of Premium – premiums of the insured person will be waived while that person is receiving treatment for cancer or specified disease for which benefits are payable if that person meets all of the following requirements: (a) the insured person becomes disabled due to cancer or specified disease, (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.

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 - If purchased, provides a Daily Benefit of either \$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 - If purchased, pays your choice of either \$2,500 or \$5,000 the first time an insured is diagnosed as having internal cancer.

Wellness Claims - Wellness claims can be filed by fax, call-in, or mail. Employees can call Assurity to get a wellness claim form or download one from www.markiibrokerage.com/mitchellcountyschoolsnc. 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**.

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.

Pre-Existing Conditions

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

30-Day Waiting Period

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

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 82533

Lincoln, NE 68501



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

MONTHLY RATES

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

AAW-C120RAB (7/04)

Superior Vision Plan 1 - Full Services Plan

Effective Date: September 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**

| BENEFITS | FREQUENCY | IN-NETWORK | NON-NETWORK |
|---|------------------|-------------------|--------------------|
| Comprehensive Exam <i>(by an Ophthalmologist)</i> | 12 Months | Covered in Full | Up to \$44.00 |
| Comprehensive Exam <i>(by an Optometrist)</i> | 12 Months | Covered in Full | Up to \$39.00 |
| Lenses (Standard) per Pair | | | |
| Single Vision | 12 Months | Covered in Full | Up to \$34.00 |
| Bifocal | 12 Months | Covered in Full | Up to \$48.00 |
| Trifocal | 12 Months | Covered in Full | Up to \$64.00 |
| Lenticular | 12 Months | Covered in Full | Up to \$88.00 |
| Contact Lenses (Per Pair)* | | | |
| Medically Necessary | 12 Months | Covered in Full | Up to \$210.00 |
| Cosmetic (Elective)** | 12 Months | Up to \$120.00 | Up to \$100.00 |
| Frames (Standard)** | 24 Months | Up to \$100.00 | Up to \$50.00 |

**Contact lenses are in lieu of eyeglass lenses and frames 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 following reason or reasons. 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 eye frame 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).
- Anisometropia 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

Member pays 20% off retail up to:

- 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:

- 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)

* 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.

MONTHLY COST - FULL SERVICES PLAN

| | |
|------------------------|----------|
| Employee Only | \$ 9.90 |
| Employee + 1 Dependent | \$ 19.22 |
| Employee + Family | \$ 28.24 |

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

Member Services Fax:
(916) 852-2277

Provider Nominations:
(800) 923-6766, ext. 254 or
(800)507-3800

Web Site:
www.superiorvision.com

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

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



*The Superior Vision Plan is underwritten by National Guardian Life Insurance Company. P.O. Box 1191, Madison WI 53701-1191
National Guardian Life Insurance Company is not affiliated with The Guardian Life Insurance Company of America, a/k/a The Guardian or Guardian Life*



Superior Vision Plan 2 - Materials Only Plan

Effective Date: September 1, 2008

**Outline of Benefits - Materials Only
Vision Plan - Preferred Provider (PPO / Indemnity)**

**Copayment: \$15.00 - Materials
\$25.00 - Contact Lens Fitting Fee**

| BENEFITS | FREQUENCY | IN-NETWORK | NON-NETWORK |
|-----------------------------------|------------------|-------------------|--------------------|
| Eye Exams | No Benefit | No Benefit | No Benefit |
| Lenses (Standard) per Pair | | | |
| Single Vision | 12 Months | Covered in Full | Up to \$34.00 |
| Bifocal | 12 Months | Covered in Full | Up to \$48.00 |
| Trifocal | 12 Months | Covered in Full | Up to \$64.00 |
| Lenticular | 12 Months | Covered in Full | Up to \$88.00 |
| Contact Lenses (Per Pair)* | | | |
| Medically Necessary | 12 Months | Covered in Full | Up to \$210.00 |
| Cosmetic (Elective)** | 12 Months | Up to \$120.00 | Up to \$100.00 |
| Standard Contact | | | |
| Lens Fitting Fee*** | 12 Month | \$25.00 Copay | Not Covered |
| Specialty Contact | | | |
| Lens Fitting Fee*** | 12 Months | \$25.00 Copay | Not Covered |
| Frames (Standard) | 24 Months | Up to \$100.00 | Up to \$50.00 |

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

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

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

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 below. 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.

MATERIALS SVP8-20 DISCOUNT SCHEDULE

Featured are 20% discounts on the provider’s charges for upgrades to the 1st pair of covered eyeglass lenses. This includes tints, coatings, special materials and special lens designs.

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

FRAMES 30% Off Retail
No restrictions apply

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

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

EVERYDAY “Frame & Lens Package Pricing” 20% Off Retail

CONTACT LENSES 20% Off Retail

DISPOSABLE CONTACT LENSES 10% Off Retail

ALL OTHER MATERIALS 20% Off Retail

Refractive Surgery Discounts & Cosmetic Eyelid Surgery Discounts are available: Superior Vision Services has a nationwide network of refractive surgeons who specialize in the popular elective procedures of radial keratotomy (RK), photo-refractive keratotomy (PRK) and LASIK. These providers offer Superior Vision Plan members a 20% discount off their usual and customary surgical fees for these procedures. Ophthalmic plastic surgeons are also contracted to provide the procedure of blephoroplasty (cosmetic eyelid surgery) to Superior Vision Plan members on the same discount basis.

EXCLUSIONS (products & services not covered):

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 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
- 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 than that which is specified in the Benefits Summary

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

MONTHLY COST - MATERIALS ONLY PLAN

| | |
|-------------------|----------|
| Employee Only | \$ 6.78 |
| Employee + One | \$ 13.18 |
| Employee + Family | \$ 19.32 |

Member Services, Provider Listings and Claims Services:

(800) 507-3800

Member Services Fax:

(916) 852-2277

Provider Nominations:

(800) 923-6766, ext 254 or

(800) 507-3800

Web Site: www.superiorvision.com

Address:

Superior Vision Services, Inc
11101 White Rock Road, Suite 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. P.O. Box 1191, Madison WI 53701-1191

National Guardian Life Insurance Company is not affiliated with The Guardian Life Insurance Company of America, a/k/a The Guardian or Guardian Life



Ameritas Dental Plan

Effective Date: September 1, 2008

COMBINED CALENDAR YEAR DEDUCTIBLE

\$50.00 per individual for Type 2 (Basic) and Type 3 (Major) Procedures (3 times family limit). After the date that 3 members of a family have each satisfied their individual deductible, the entire deductible or any remaining portion of the deductible for any family member will be waived for the rest of that calendar year.

TYPE 1 - PREVENTIVE AND DIAGNOSTIC

Type 1 benefits are payable at 100% U&C**. No deductible applies.

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

TYPE 2 - BASIC PROCEDURES - Type 2 benefits are payable at 80% U&C**. \$50.00 deductible applies.

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

TYPE 3 - MAJOR PROCEDURES - Type 3 Benefits are payable at 50% U&C** \$50.00 deductible applies.

- Endodontics (Root Canal)
- Periodontics (Gum Disease)
- Prosthodontics - Removable Dentures, Partials
- Restorative - Crowns
- Prosthodontics - Fixed Pontics or Abutments
- Crown Repair

ORTHODONTIA - ADULT AND CHILD(REN)

Paid at 50% U&C** with a \$1,000 lifetime maximum. No deductible applies.

LATE ENTRANT: There is a 12 month waiting period on all services except for cleanings, exams and fluoride applications for employees who do not enroll when first eligible for coverage. The waiting period will be waived for employees who enroll when first eligible.

ANNUAL MAXIMUM BENEFIT

- Type 1, Type 2, and Type 3 Procedures - \$1,000* per calendar year per person.
- Orthodontia Procedures - \$1,000 Lifetime per person (carryover doesn't apply)

***Usual and Customary Charge*

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

1. Visit a dentist between January 1 and December 31 of each year.
2. Submit a claim for a covered procedure prior to March 1 of the following year.
3. Total dental benefits paid for the calendar year must be less than \$500.

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

DENTAL EXCLUSIONS (DEFERMENT PERIOD)

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

ELIGIBLE EMPLOYEES

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

ELIGIBLE DEPENDENTS

Provides Coverage On:

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

PREDETERMINATION OF BENEFITS

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

COORDINATION OF BENEFITS

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

CERTIFICATE OF INSURANCE

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

SECTION 125

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

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

ORTHODONTIA LIMITATIONS (This is not a complete list)

No benefit is payable for expenses incurred:

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

LIMITATIONS / EXCLUSIONS (This is not a complete List)

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

This insurance is underwritten by Ameritas Life Insurance Corporation.

**FOR CLAIMS / CUSTOMER SERVICE QUESTIONS CALL AMERITAS AT:
(800) 487-5553**

MONTHLY DENTAL RATES

| | |
|---------------------|----------|
| Employee Only | \$33.76 |
| Employee/Spouse | \$65.78 |
| Employee/Child(ren) | \$66.48 |
| Employee/Family | \$110.52 |



Why do you need Disability Insurance? Consider this . .

Statistics show you are much more likely to be injured in an accident than to die from one.

- A fatal injury occurs every 5 minutes, and a disabling injury occurs every 1.5 seconds.¹
- There is a death caused by a motor vehicle crash every 12 minutes; there is a disabling injury every 14 seconds.¹
- In the home, there is a fatal injury every 16 minutes and a disabling injury every 4 seconds.¹

While many people survive accidental injuries, many others live with serious illnesses.

- In the United States, men have a little less than a 1-in-2 lifetime risk of developing cancer; for women the risk is a little more than 1-in-3. The five year relative survival rate for all cancers combined is 63%.²
- One in five males and females has some form of cardiovascular disease. High blood pressure is the most common form of cardiovascular disease.³
- More than 35 million Americans are now living with chronic lung diseases, such as asthma, emphysema, and chronic bronchitis.⁴

Advances in medicine are allowing us to live longer. However, recovery from a serious illness or injury often requires time away from work.

- In the last 20 years, deaths due to the big three (cancer, heart attack, and stroke) have gone down significantly. But disabilities due to those same three diseases are up dramatically. Things that used to kill, now disable.⁵

**You have life insurance, home insurance
and automobile insurance.
But is your income insured?**

1 National Safety Council, Injury Facts, 2003 Edition

2 American Cancer Society, Cancer Facts & Figures 2004

3 American Heart Association, Heart Disease and Stroke Statistics – 2004 Update

4 American Lung Association, Lung Disease Data 2003

5 National Underwriter, May 2002

Standard Life Short Term Disability Plan

Policy Effective Date: September 1, 2008, pending underwriting approval

- Payable in addition to sick leave
- Benefits payable regardless of other insurance
- Weekends and holidays are covered
- Benefits are paid directly to you
- Benefits are tax free
- Disability 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. Continued coverage is subject to income and occupational guidelines.

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 employees under 65 years of age may apply. The disability benefit is for **employees** only. All applications are underwritten.

POLICY FEATURES

Pre-existing Conditions: If you received medical advice for a 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 for disability due to pregnancy 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 Mitchell County Schools, 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.

MONTHLY RATES

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

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**



Boston Mutual Life Insurance Company
Employee Life Option (ELO) Life Plus

Common Issue Date: October 1, 2008 (pending underwriting approval)

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 \$1,000.

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 accumulated 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.

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 an 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 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, Ext. 222

Website: www.bostonmutual.com

BOSTON MUTUAL
LIFE INSURANCE COMPANY SINCE 1891

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

Continuing Your Benefits If You Leave Mitchell County Schools

GILSBAR MEDICAL 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.

If you want to remain in the Plan, you can do so by electing to continue on COBRA through your employer. You will receive notification from IMS of your continuation options. If you prefer to terminate your participation and contribution to the Plan, any balance in your account on the date of termination will be forfeited if expenses were not incurred prior to the date of termination. For more detailed information, please call **Interactive Medical Systems (IMS) at: (800) 426-8739**.

ASSURITY LIFE CANCER PLAN

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. To make arrangements to continue your coverage. You may call **Assurity Life at (888) 358-8808, Ext. 23**.

SUPERIOR VISION PLAN:

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. **Interactive Medical Systems** is the COBRA Administrator. For further information, call **IMS at (800) 426-8739**.

AMERITAS DENTAL PLAN

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

If you and your dependents are enrolled in the dental plan, you will be eligible to continue coverage through COBRA after you leave your employment for a specified period. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents may be eligible to continue dental coverage through COBRA. Also, while you are covered under the plan, your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA. Examples of an ineligible dependent would be when your child graduates from college, or turns 24 years old. You will receive notification from Interactive Medical Systems with premium and continuation options shortly following your termination of employment. Should you have any questions you can contact **Interactive Medical Systems (IMS) at (800) 426-8739**.

STANDARD LIFE AND CASUALTY SHORT TERM DISABILITY PLAN

If you leave the School System, you may continue your short term 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. To set up a direct bill to your home address or to make arrangements to have the premium drafted from your bank account, please call **Standard Life at (800) 327-0695**.

BOSTON MUTUAL WHOLE LIFE

When you leave employment you may continue your Boston Mutual Whole Life coverage by having the premiums that are currently deducted from your paycheck drafted from your bank account. You may do that by contacting **Boston Mutual at 800-669-2668, Extension 222**.