

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 Account	Page 4
Gilsbar Debit Card Instructions	Page 12
Gilsbar Dependent Care Reimbursement Account	Page 14
Cancer Fact Sheet	Page 19
Assurity Cancer Plan	Page 20
Superior Vision Plan 1	Page 28
Superior Vision Plan 2	Page 32
Ameritas Dental Plan.....	Page 36

AFTER-TAX BENEFITS

Disability Fact Sheet	Page 39
Standard Life Short Term Disability Plan	Page 40
Boston Mutual Whole Life Plan	Page 42
Continuing Your Benefits When You Leave the District	Page 46

Gilsbar Flexible Spending Accounts

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

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. At the end of this summary, please see the Gilsbar "Welcome Letter" for more details on how to register on mygilsbar.com.

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

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

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

What is eligible for reimbursement under the Health Care FSA?

Eligible health care expenses may include deductibles, co-payments and amounts over the maximum your plan pays, expenses for routine physicals and other expenses not covered by your health care plan. For more complete listing please refer to the "Qualified Medical Expenses Eligible for Reimbursement" 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		Vitamins (if prescribed)
Therapy equipment	Ultra-violet ray treatment	Weight loss programs* (not food)
Transplants (organ)	Vaccines	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		
Dietary supplements	Insurance premiums	Vitamins

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, Chlora Trimaton, 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-Synephrine-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

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)



Gilsbar Welcome Letter

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

Your Gilsbar group number is S2553.

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

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

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

It's easy to get started:

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

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

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

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

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

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

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

SUBMIT YOUR CLAIMS	CONTACT US
<p>For Fastest Processing, FAX Claims and Receipts to: 1-866-635-1329</p> <p>Mail Claims and Receipts to: Claims Processing Center PO Box 26046 Tampa, FL 33623</p> <p>(Please keep your originals)</p>	<p>Customer Contact Center</p> <p>7:00 AM – 7:00 PM Central Time</p> <p>Phone: 1-800-445-7227 ext. 883 Email: flex@gilsbar.com</p> <p>(Please do not email claims/receipts)</p>

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

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

Effective: 09/01/09

BASIC BENEFITS

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

RATE STRUCTURE

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

PRE-EXISTING CONDITIONS

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

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

ISSUE AGE

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

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

HOSPITAL INDEMNITY

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

PRESCRIPTION DRUGS AND MEDICINES

Assurity will play the actual charges, up to 25% of the Daily Hospital Confinement benefit shown on the policy schedule per day for the hospital charges for the prescribed drugs and medicines taken during hospital confinement for an insured person. This benefit is limited to the first 75 days for each period of confinement.

A535-0709

SURGICAL BENEFIT

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

ANESTHESIA

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

ADDITIONAL SURGICAL OPINIONS

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

ARTIFICIAL LIMB AND PROSTHESIS

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

ATTENDING PHYSICIAN

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

PRIVATE DUTY NURSE

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

RADIATION, RADIO-ACTIVE ISOTOPES THERAPY, CHEMOTHERAPY OR IMMUNOTHERAPY

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

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

EXPERIMENTAL TREATMENT

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

PHYSICAL AND SPEECH THERAPY

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

EXTENDED CARE FACILITY

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

BONE MARROW TRANSPLANT FOR CANCER

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

TRANSPORTATION AND LODGING FOR BONE MARROW DONORS

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

TRANSPORTATION FOR NON-LOCAL TREATMENT WHICH REQUIRES HOSPITAL CONFINEMENT

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

TRANSPORTATION AND LODGING FOR NON-LOCAL TREATMENT WHICH DOES NOT REQUIRE HOSPITAL CONFINEMENT

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

- the actual charges for round trip coach fare on a common carrier to the facility that provides the prescribed treatment or 50 cents per mile for personal automobile expenses in excess of 50 miles one way, not to exceed 700 miles round trip up to a maximum of \$1,500 per calendar year. Mileage will be measured from the insured person's residence to the nearest facility where the treatment is administered; and
- the actual charges up to \$50 per day for lodging and meal expenses incurred by an insured person when staying at a hotel, motel or other accommodations acceptable to Assurity. Benefits will be paid up to the number of days covered treatment is received.

ADULT COMPANION TRANSPORTATION AND LODGING

The policy pays the following expenses for one adult companion to be in near the insured when the insured is confined in a non-local hospital for specialized covered treatment (a) up to a maximum of \$1,500 per calendar year for actual charges for non-local round trip

coach fare by a common carrier to the nearest hospital that provides the prescribed treatment or 50 cents per mile for personal automobile expenses in excess of 50 miles one-way, up to 700 miles round trip and (b) pays actual charges up to \$50 per day for lodging and meal expenses when staying at a hotel, motel or other accommodation acceptable to Assurity, limited to the number of days of each confinement.

OUTPATIENT POSITIVE DIAGNOSTIC TEST

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

OUTPATIENT SURGERY BENEFIT

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

SKIN CANCER

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

AMBULANCE

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

HOSPICE CARE

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

GOVERNMENT OR CHARITY HOSPITAL

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

BLOOD AND BLOOD PLASMA

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

BREAST CANCER/BREAST RECONSTRUCTION/BREAST PROSTHESIS

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

HAIRPIECE BENEFIT

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

CANCER (WELLNESS) SCREENING TEST

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

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

WELLNESS CLAIMS

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

HOME HEALTH CARE SERVICES

When services are provided by a licensed Home Health Agency, when prescribed by a physician, policy pays (a) up to \$60 per day for services provided at home, not to exceed 180 days per calendar year., (b) up to \$100 per day for Private Duty Nursing, not to exceed 15 days per calendar year, and (c) pays actual charges for a physician's visit up to \$40 per day not to exceed 15 days a calendar year. Care cannot be provided by a relative. This benefit is in lieu of all other benefits.

RENTAL OR PURCHASE OF DURABLE MEDICAL EQUIPMENT

The policy pays the actual charges up to \$1,500 per calendar year for purchases or rental of (a) a respirator or similar medical device, (b) brace, (c) crutches, (d) hospital bed, or (e) wheel chair.

PROFESSIONAL MENTAL HEALTH CONSULTATION

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

EXTENDED BENEFITS

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

WAIVER OF PREMIUM

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

SPECIFIED DISEASE BENEFITS

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

Addison's Diseases	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
Legionnaire's Disease	Tay-Sachs Disease
Lou Gehrig's Disease	Tetanus
Lupus Erythematosus	Trichinosis
Malaria	Toxic Shock Syndrome
Meningitis	Tuberculosis
Multiple Sclerosis	Typhoid Fever
Muscular Dystrophy	Whooping Cough

CANCER OR OTHER SPECIFIED DISEASE CLAIMS

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

OPTIONAL RIDERS

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

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

LIMITATIONS AND EXCLUSIONS

30-Day Waiting Period

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

Exclusions

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

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

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

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

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

Policy Form No. AAW-C120

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

Cancer and Specified Dread Disease Benefit with Radiation/Chemotherapy

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, 2009

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

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

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

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

Items or Services Not Covered

While Superior Vision offers a variety of vision benefits, there are a few materials, services and treatments that are generally not covered, or have limitations to their coverage. We do offer discounts on many of these items, as outlined in our discount plan coverage information. Your specific Superior Vision Plan may differ, so confirm the details of your employer's plan prior to seeking services.

Items or Services Not Covered or Have Limited Coverage

- non-prescription (plano) lenses of any kind, sunglasses, or contact lenses
- any coating applied to lenses such as anti-reflective, scratch, UV, lamination, tints (except pink tint #1 and #2), and sunglass coloring
- any lens materials other than standard plastic or glass such as polycarbonate, hi-index, poloroid and photochromic

- any special lens feature or treatment such as prisms, slab off, faceted, oversize lens, greater than 61mm, polished bevel, groove, drill mount, notch, roll and polish, and blended bifocal
- progressive lenses (Though progressive lenses are not a covered benefit, the provider will apply the retail charge for standard trifocal lenses against the retail charge for the progressive lenses you selected. You are responsible for paying the provider the difference)
- replacement of broken, lost or damaged frames and/or lenses
- orthoptics, vision training, and developmental vision procedures
- experimental or non-conventional treatment or device
- medical or surgical treatment of the eyes
- post cataract lenses (intra-ocular)
- subnormal or low vision aids
- safety eyewear
- eye examination or corrective eyewear required by an employer as a condition of employment
- services or materials when covered under workers' compensation or similar third party coverage
- 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 services or procedures outside of a routine eye exam and contact lens fitting
- services or materials rendered after the date a member ceases to be covered by the benefits plan except when vision materials ordered before coverage ended are delivered AND the corresponding services are provided to the member within 31 days of the initial order

Regardless of optical necessity, benefits are not available more frequently than that which is specified in the Outline of Benefits.

* Plans vary, so please refer to your own employer's specific coverage.

How to Use the Plan

Welcome to Superior Vision's vision plan. Superior Vision provides primary vision care benefits including eye examinations, prescription eyewear, and contact lenses through a broad-based provider network consisting of ophthalmologist, optometrists, and opticians. The plan also contract with a large number of national and regional optometric chain locations.

Your first step should be to choose an eye care provider, or ensure that your current provider is part of the Superior Vision network. Go to www.superiorvision.com and click on "Locate a Provider" for an updated list. You will learn about "in-network" and "out-of-network" providers - it is an important distinction when receiving benefits. You will also learn more about how to use your benefits, as well as the discounts that are available to you.

Remember that a routine eye exam is important not only for correcting vision problems, but for maintaining healthy eyes and overall health wellness. Superior Vision eye care providers are trained to test for and diagnose a variety of health

issues - not just eye problems. Take the time to get to know your vision plan, and start experiencing healthy eyes and healthy living.

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 Phoochromic | \$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 a nationwide network of refractive surgeons. These providers offer Superior Vision Plan members a discounted rate off the usual and customary prices for LASIK surgery. These discounts may vary depending on the provider but are the best possible discounts available to Superior Vision.

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
(916) 852-2277 fax

Authorization numbers (out-of-network)
Explanation of benefits
Provider locator; provider information
Claim inquiries
Grievance issues

Customer Service/Corporate Office

11101 White Rock Rd., Ste. 150
Rancho Cordova, CA 95670

Claim Administration

P.O. Box 967
Rancho Cordova, CA 95741

Disclaimer: All final determinations of benefits, administrative duties, and definitions are governed by the Certificate of Insurance Coverage for you vision plan. Please check with your Benefits Administrator or Human Resources department if you have any questions.



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



Superior Vision Plan 2 - Materials Only Plan

Effective Date: September 1, 2009

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

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

Customer Service

(800) 507-3800
(916) 852-2277 Fax

Authorization numbers (out-of-network)
Explanation of benefits
Provider locator, provider nominations
Claims Inquires
Grievance issues

Web Site: www.superiorvision.com

Customer Service/Coporate Office

11101 White Rock Road, Suite 150
Rancho Cordova, CA 95670

Claims administration:

P.O. Box 967
Rancho Cordova, CA 95741

Disclaimer: All final determinations of benefits, administrative duties and definitions are governed by the Certificate of Insurance Coverage for your plan. Please check with your Benefits Adiministrator or Human Resources department if you have any questions.



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



Ameritas Dental Plan

Effective Date: September 1, 2009

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, Partial
- 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, 2009, pending underwriting approval

- Payable in addition to sick leave
- Benefits payable regardless of other insurance
- Weekends and holidays are covered
- Benefits are paid directly to you
- Benefits are tax free
- Disability 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, 2009 (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**.