

Randolph County Schools is offering all full-time employees a comprehensive Cafeteria Benefits program. The Cafeteria Benefits program is arranged by Mark III Brokerage, an employee benefits firm that has worked in the public sector since 1973. The Cafeteria Benefits program allows you to pay for certain insurance premiums, child-care, and un-reimbursed medical expenses before taxes are taken out of your paycheck. Paying for benefits by this method reduces your income & FICA taxes and increases your take home pay. The Cafeteria Benefits program includes pre-tax and after-tax products listed below.

- The Annual Enrollment Period is September 13, 2010 to September 24, 2010.
- The Plan Year is November 1, 2010 to October 31, 2011.

Pre-Tax Benefits

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*(This booklet highlights the benefits offered through your employer for the current plan year. This is **not** an Insurance Contract and only the actual policy provisions will prevail. All information in this booklet including premiums are subject to change. All policy descriptions are for informational purposes only. Please read your certificate for each product for the exact terms and conditions).*

Key Points to Remember

- The Plan Year: November 1, 2010 thru October 31, 2011.
- Payroll deduction: November 29, 2010
- **Please remember there is a late entrant provision on the dental plan: 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 enrollment is NOT considered the date of your eligibility.***
- **Please be advised that recent Senate legislation has stated that effective January 1, 2011, participants are required to have a prescription for Over-the-Counter (“OTC”) products to be eligible under their FSA plan. Therefore a prescription or letter of medical necessity would be required after January 1, 2011 for OTC items. You will not be able to use your debit card for OTC items as of January 1, 2011.**
- Please remember that elections made during annual enrollment **cannot be changed once the enrollment period ends** unless you have a qualifying event such as marriage, divorce, death of a spouse or child, birth or adoption, termination of employment or change in employment hours from full-time to part-time or vice-versa.
- If you should have a qualifying event, you will have 30-days from the date of the qualifying event to request a change to your current benefit enrollment and FSA elections. All requests must be made in writing to Debra Brower at the Randolph County Schools benefits office.
- You must **re-elect** your Gilsbar Medical Spending and Dependent Care Accounts each year. They do not automatically carry-over to the next year.
- For *current* Gilsbar participants, your existing Gilsbar account will be replenished as long as you re-elect the Medical Spending Account. Debit cards are good for 3 years from the issue date.
- For *new* Gilsbar participants, a card will be mailed to your home in a **plain white envelope** with no reference to Gilsbar. Again, this card will be good for three (3) years from issue date as long as you re-elect the Medical Spending Account each year.
- Medical Reimbursement and Dependent Care expenses must be *incurred during the plan year* to be eligible for reimbursement.
- Any questions regarding your Gilsbar Medical Reimbursement or Dependent Care Account can be directed to www.myGilsbar.com, or you can call Gilsbar’s Customer Contact Center at 1-800-445- 7227 ext. 883.
- Access your Gilsbar account online.
 1. Go to www.mygilsbar.com to register with a valid email address and your Group Number. The group number is **S2560**.
 2. Once logged in, click the Reimbursement Account Center link on the left navigation bar.
- Any questions regarding all other benefits can be directed to Debra Brower at 336-318-6142 or dbrower@randolph.k12.nc.us.

Gilsbar Flexible Spending Accounts (General Overview)

Plan Year: November 1, 2010 - October 31, 2011

Medical Reimbursement Plan Annual Maximum / Minimum: \$1,500 / \$240

Dependent Care Account Annual Maximum / Minimum: \$5,000 / \$0

Run-out Period: 90-days

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

Flexible Spending Accounts allow you to use pre-taxed dollars towards health care expenses such as prescription and over-the-counter medication (with a prescription or letter of medical necessity), 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

(You have 30 days from the date of the qualifying event to request a change to your FSA election. This must be done in writing to your benefits office).

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

What if I have a question?

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

How does participating in an FSA save me money?

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

	With FSA	Without FSA
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	\$82.00	\$121.00
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	\$0.00	\$250.00
Net After Expenses	\$593.05	\$529.06
Tax Savings This Pay Period: \$63.99		
Annual Tax Savings: \$63.99 X 26 pay periods = \$1,663.74		

MEDICAL REIMBURSEMENT ACCOUNT

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

How does the Health Care FSA Work?

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

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

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

What is eligible for reimbursement under the Health Care FSA?

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

How do I get reimbursed?

For reimbursement of expenses covered under a health care plan:

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

FAX CLAIMS AND PROOF OF EXPENSE TO 866-635-1329

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		

** Prescription or letter of medical necessity is required as of January 1, 2011.

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	Insurance premiums	Vitamins
Dietary supplements		

Over the Counter Drugs

Please be advised that recent Senate legislation has stated that effective January 1, 2011, participants are required to have a prescription for Over-the-Counter (“OTC”) products to be eligible under their FSA plan. Therefore a prescription or letter of medical necessity would be required after January 1, 2011 for OTC items. You will not be able to use your debit card for OTC items as of January 1, 2011.

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

Allergy Prevention & Treatment	First Aid Supplies
Antacids and Acid Reducers	Hemorrhoid Treatments
Anticandial	Internal Analgesics / Antipyretic
Antihistamines	Incontinence Supplies
Anti-diarrheal and Laxatives	Liniments
Anti-fungal	Medical Monitoring
Anti-itch Lotions and Creams	Medical Products and Devices
Asthma	Menstrual Cycle Medications
Cold Sore / Fever Blister	Migraine
Condoms and other contraceptive Devices	Motion Sickness Medication
Contact Lenses Solutions	Nicotine Gum or Patches and moking Cessation Aids
Cough Suppressants	Pediculicide (head lice)
Decongestant / Nasal Decongestant and Cold Remedies	Smoking Cessation
Diaper Rash Ointments	Toothache/Teething Pain Relievers
Eye Drops for Allergy / Cold Relief	Wart Removal and Medications

Health Care FSA Expense Worksheet

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

HEALTH CARE EXPENSES YOU PAID LAST YEAR COULD INCLUDE:

Deductibles

(medical and dental) \$ _____

Benefit percentage/co-insurance

(The amount NOT paid by your insurance) \$ _____

Amounts paid over plan limits

Over reasonable and customary allowance \$ _____

Over psychiatric limits \$ _____

Over private room allowance \$ _____

Expenses NOT covered by your insurance plan

Physicals \$ _____

Prescription drugs \$ _____

Over-the-counter medications \$ _____

Vision care \$ _____

Hearing expenses \$ _____

Psychiatric care \$ _____

Dental and orthodontic care \$ _____

Assistance for the handicapped \$ _____

Therapy/treatments \$ _____

Physician's fees/services \$ _____

Medical equipment \$ _____

Miscellaneous charges \$ _____

My out-of-pocket health care

(expenses last year) \$ _____

Flex Debit Cards

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

Please visit <http://www.sig-is.org/en/index.asp> and click on SIGIS Merchant List for the latest list of participating merchants.

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

1. Bring prescriptions and vision products, OTCs and other purchases to the register at checkout to let the clerk ring them up.
2. Present your Card and swipe it for payment.
3. If the Card swipe transaction is approved (e.g., there are sufficient funds in the account and at least some of the purchases are FSA eligible), the amount of the FSA-eligible purchases is deducted from the account balance and no receipt follow up is required. The clerk will then ask for another form of payment for the non-FSA-eligible items.
4. If the Card swipe transaction is declined, the clerk will ask for another form of payment for the total amount of the purchase.
5. The receipt will identify the FSA-eligible items and may also show a subtotal of the FSA-eligible purchases.

How does the FSA Debit Card work?

Shortly after the start of the plan year you will receive your FSA Debit Card to use for your eligible medical expenses. If you are a current participant, your card will reflect the new plan year contribution amount on the new effective date of the plan. As you incur expenses, use your FSA Debit Card to have the funds taken directly out of your account so you don't have to pay with cash out of your pocket.

Where can I use my FSA Debit Card?

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

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

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

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

Starting on January 1, 2008, new special IRS rules allow you to use your FSA debit card in participating discount stores and supermarkets that can identify FSA-eligible items at checkout. This means that you can use your card at participating stores for the total FSA-eligible amount and NO receipts are needed to verify the eligibility of the purchase! Important point to remember: If you use your card on or after January 1, 2008 in a discount store or supermarket that is not participating in the IRA program, even if you purchased FSA-eligible items there before, your card may decline. Effective January 1, 2011 you will not be able to purchase OTC's with your debit card.

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

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

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

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

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

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

FSA Substantiation

Documenting & Submitting Proof of FSA Eligible Purchases

FREQUENTLY ASKED QUESTIONS:

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

The IRS changed the rules regarding how debit cards need to operate for an FSA. These rules took effect on January 1, 2008, so the process Gilsbar has to follow has changed and hence, you have seen a change. According to the new rules, there are five basic requirements that must be met for you to use a debit card for your FSA. These requirements are:

- Participants must provide certification each year that they will only use the debit card for FSA eligible items. This is done during the enrollment process.
- The participant must retain all receipts for all transactions.
- 100% of debit card transaction must be reviewed by a third party to ensure that the items purchased are FSA eligible.
- Sampling or employee “self-certification” is not allowed for an FSA.
- Debit cards can only be used at locations that are medical service providers or provide point of purchase review.

Fortunately, in the new rules, the IRS defines several electronic substantiation methods that we can follow to help with the adjudication process. These methods are:

- Co-pay Match – If a transaction equals a co-pay amount or multiples of co-pay amounts under the health plan, no additional information is needed to support a card transaction.
- Recurring Expense – For transactions that were previously substantiated, recurring expenses will also be considered substantiated provided they are incurred with the same provider at the same location for exactly the same amount.
- Real-Time or Merchant Substantiation – If a transaction can be matched against real-time data at the point of purchase identifying it as a medical expense, no additional substantiation is needed.

All in all, with the new rules, about 72% of all debit card transactions fit one of the electronic substantiation categories listed above. Meaning, Gilsbar is asking for detail on about 28% of all debit cards transactions.

Why does the IRS have these rules? Isn't it my money?

Yes, the money that you put into an FSA is your money; however, in order to receive this money WITHOUT paying taxes you must follow the rules that the IRS has provided for the receipt of an FSA pre-tax reimbursement. At the present time, these rules require all administrators to verify that the money in the FSA is being used for medical care purposes.

What should I do if I receive substantiation letters?

You should sign and return these notices to Gilsbar when you submit your receipts, and keep a copy of these letters for your records. Remember, you can mail or fax your receipts and forms to Gilsbar:

Mail: Employee Reimbursement Center /P.O. Box 26046 / Tampa, FL 33623 /

Fax: 1-866-635-1329

What are acceptable forms of substantiation?

Acceptable forms of substantiation include: Explanation of Benefits (EOBs) and register and/or provider receipts showing the date, item bought and dollar amount charged. Credit card receipts are not acceptable forms because they do not provide the specific item purchased; therefore, Gilsbar cannot determine if the expense was an FSA eligible item.

Is it a requirement that providers, pharmacies, hospitals, etc. provide a receipt with service?

No, it is not a requirement that they provide a receipt, but we suggest you always ask for and collect a receipt from medical providers and facilities. If you are ever audited by the IRS, they will require these receipts for validation of purchases.

In addition to sending my receipts to Gilsbar, should I also keep copies of my receipts?

Because FSAs are federally regulated accounts, we do encourage you to practice good record-keeping habits. Just like you track other items for tax purposes each year, consider your FSA documentation just as important. It is our recommendation that you keep these receipts for your personal records in addition to sending to Gilsbar.

Here are a few organization and record-keeping suggestions:

- Designate a folder to keep copies of only your FSA eligible receipts.
- In this same folder, keep copies of any information you receive from your employer or Gilsbar regarding FSAs. This includes marketing pieces, letters, or notices you may receive.
- Register on myGilsbar.com and start utilizing the Reimbursement Account Center to stay informed and up-to-date on your account. The reimbursement account center allows you to access the following:
 - Available balance
 - Submitted claims
 - Pending claims
 - Payments received
 - Lists of eligible expenses
 - Downloadable forms
 - And much more!

I thought purchases at certain vendors were automatically substantiated and considered approved purchases?

Effective January 1, 2009, no additional substantiation will be required for debit card transactions that are approved at the point of sale by merchants (specifically pharmacies) who have adopted the Inventory Information Approval System (IIAS). The IIAS system compares the SKU on the item being purchased to a list of FSA eligible items sold at the store. When a FSA debit card is used, the pharmacy will only allow the card to pay for the FSA eligible items and any non-FSA eligible items will need to be paid for using an alternative method of payment. After January 1, 2009, if merchants have not adopted this system, FSA debit cards might not work at their places of business. Until then, providing copies of receipts, even pharmacy purchases, is still required.

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 have to keep in mind when it comes time to file my taxes?

You are required to provide the name, address and taxpayer identification (or Social Security number) of the dependent care provider on your income tax return. If you are unable to provide this information, both the tax credit and the exclusion for the spending account reimbursement may be denied by the IRS. Verify that this information is available before you elect to participate in the Dependent Care FSA.

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

How do I get reimbursed?

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

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

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

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

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

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

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

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

If you have any questions, you can access your account information 24/7 at myGilsbar.com 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.

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

(PLEASE KEEP YOUR ORIGINALS)

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

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

Claims Processing Center, P.O. Box 26046, Tampa, FL 33623

(PLEASE KEEP YOUR ORIGINALS)

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 S2560.**

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.

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

Effective Date: November 1, 2010

COMBINED CALENDAR YEAR DEDUCTIBLE

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

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

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

TYPE II - BASIC PROCEDURES - Benefits are payable at 80% U&C*. \$50.00 deductible applies.

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

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

- Endodontics (Root Canal)
- Periodontics (Gum Disease)
- Crowns
- Prosthodontics -Removable
- Dentures & Partial
- Restorative -Inlays and Crown
- Prosthodontics - Fixed Pontics or Abutments
- Crown Repair

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

LATE ENTRANT PROVISION

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.

**Usual and Customary*

ANNUAL MAXIMUM BENEFIT

- *Type I, Type II and Type III Procedures* - \$1,000 per calendar year per person.
- *Orthodontia Procedures* - \$1,000 Lifetime per person.

ANNUAL MAXIMUM CARRY OVER

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 the plan year.
2. Submit a claim for payment prior to March 1 of the following year.
3. Total benefits paid for the Calendar Year must be less than \$500.

If you meet all 3 requirements you will have an additional \$250 available in the Annual Dental Maximum for the next plan year. In future years if you have benefits paid of less than \$500, additional amounts of \$250 will be added to the carryover. However, the most you can accumulate in the maximum carryover is \$1,000. Therefore, the maximum annual benefit may never exceed \$2,000 in any one year.

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.

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.

ELIGIBLE EMPLOYEES

You are eligible for dental insurance if you are an active employee working at least 20 hours per week.

ELIGIBLE DEPENDENTS

Provides Coverage On:

- Your Spouse
- Children up to age 19 and unmarried (Up to age 26 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.

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 Corp.



Ameritas Managed Care Products

- Employers achieve a balance between cost efficiency and employee choice.
- Plan members are free to receive care from any dentist they choose. Their out-of-pocket expenses are generally lower when using PPO dentist who have agreed to provide dental care at contracted fees.
- Over 70,000 PPO provider access points are available nationwide.
- PPO network dentists must meet our credentialing and quality assurance evaluation requirements.

Passive PPO

In passive PPO, the coinsurance, deductible and maximum are the same for the member in and out-of-network. The only difference is the claim allowance. There is an incentive for the member to see an in network dentist; however, there is no penalty for seeing an out-of-network dentist. As with all Ameritas PPO Solutions, the member has the liberty to choose any dentist they wish. However, they will usually save out-of-pocket costs by seeing an in-network dentist.

Passive PPO-Deductible Reduction

Deductible Reduction continues the difference of in-network and out-of-network claim allowance and allows a reduced deductible for those who visit an in-network dentist. As with all Ameritas PPO Solutions, the member has the liberty to choose any dentist they wish. However, they will usually save out-of-pocket costs by seeing an in-network dentist.

Commonly Asked PPO Questions

Do I have to use an Ameritas PPO provider?

No, employees and their covered dependents may utilize any licensed dental provider that they choose.

Please note, there is no difference in the coinsurance, deductible, and maximums on either plan whether a PPO provider is utilized or not.

Why would I use an Ameritas PPO provider?

By using a PPO provider:

- A Participating Provider is a dentist who has entered into an agreement to provide services to insured members of Ameritas' plans for at a specific fee. Any insured member who chooses to go to a PPO provider will receive this discounted fee for procedures performed by that provider.
- As part of their contractual agreement with Ameritas, the PPO provider cannot "back-bill" the patient for the difference between the dentists' normal charges and the discounted fees that the dentist agreed to charge as an Ameritas PPO provider.
- PPO providers are required to file the claim for the patient.

- PPO providers are required to wait for reimbursement from Ameritas before billing the patient for any balances owed for deductibles, coinsurance, any amounts exceeding the annual maximum benefits, etc.

PPO providers are available in many areas; please visit the Ameritas website at www.ameritasgroup.com to search for a provider in your area.

What happens if I don't use an Ameritas PPO provider?

For members that do not want to utilize an Ameritas PPO provider, or if a PPO provider is not available in your area:

- Randolph County Schools wants employees to have options regarding their choice of providers. In addition, we want to ensure that employees that utilize non-panel providers receive exceptional benefits that reimburse claims for non-panel providers in the most optimal way. Non-panel providers can charge their standard fees for any service. ***However, the amount Ameritas allows for each procedure for non-panel provider utilizes 90th percentile of U&C – which is considered to be one of the highest reimbursement levels in the industry. This means that 9 out of 10 dentist's charges will fall within the amount that Ameritas allows for each procedure.*** In doing so, employees can feel comfortable that very little back billing will occur due to the amounts allowed by the plan.
- Non-panel providers have no specific requirements regarding filing of claims. However, we have found that many dentists will assist the patient with the paperwork needed to file the claim. If a dentist is not willing to file the claim on the patient's behalf, the patient can simply attach the dentist's bill to a claim form that includes the patient's name and identification number, and fax or mail the claim to Ameritas for processing. Ameritas will process the claim, typically within 7-10 working days. Claim payment can be made to the patient or directly to the dentist if noted on the claim form. The patient can use Ameritas' claim forms which are available in the Benefit's Department or on Ameritas web site (this will be available via our Intranet in the near future), OR the patient can use any generic claim forms that the dental office may have available. Filing claims is fast and easy with Ameritas!

If you have any questions about Claims, PPO or the plan, please call:
Ameritas Group Claims Department at 800-487-5553

Or, visit the Ameritas website at:
www.AmeritasGroup.com

DENTAL RATES

Employee:	\$29.98
Employee and Spouse:	\$65.34
Employee and Child/ren:	\$86.34
Family:	\$119.98

Cancer Can Affect Anyone

Statistics Predict:

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

Are you prepared for the cost of cancer?

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

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

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

THIS CANCER PLAN is designed to create a source of extra cash that can 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 distinctive 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.
- Provides cash to offset the costs of 30 other diseases.
- Coverage is portable. Employees can keep the coverage if they change jobs.

Selected benefits paying cash to you:

- Cancer Screening Tests
- Chemotherapy, Radiation, Immunotherapy, or Hormone therapy
- Experimental Treatment
- Adult Companion Transportation and Lodging

**Cancer Facts & Figures, American Cancer Society, 2001.*

***Report from the American Hospital Administration.*

Assurity Cancer Plan

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

BASIC BENEFITS

Provides benefits caused by cancer, and with a rider, certain other specified diseases for the employee, spouse and covered children with continuous benefit and premium policy for life.

RATE STRUCTURE

Age bands: 18-34, 35-49, 50-64. Employee Issue Ages: 18-64, Family: Up to Age 64 on spouse. Children Age 0-21 (if "dependent children" definition is met, coverage is available to Age 25). Issue Age is age of last birthday on the day policy is issued.

PRE-EXISTING CONDITIONS

Assurity will not pay benefits for any expenses incurred concerning a Pre-existing Condition unless the expenses are for services rendered after coverage has been in force for 12 months from the Issue Date.

A pre-existing condition means a sickness or physical condition for which, during the 12 months before the Issue Date, the Insured Person received medical consultation, advice or treatment from a Physician or had taken prescribed medication.

ISSUE AGE

The Assurity cancer policy is available for persons ages 18-64, including spouses. The issue age of children is 0 days through 21 years of age. The coverage is continued up to age 25 if "dependent children" definition is met.

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

HOSPITAL CONFINEMENT

Assurity will pay you benefits for each day while the Insured is confined in the hospital for cancer up to 75 consecutive days of each period of confinement. The daily benefit amount is \$150. This benefit is not payable for government or charity hospital confinements.

SURGICAL BENEFIT

For the treatment of, removal of, or destruction of Cancer, Assurity will pay the actual charges incurred up to the amount shown on the surgery schedule for surgical procedures in or out of a Hospital for an Insured Person. For operations not listed, a comparable reasonable benefit will be paid. If two or more surgical procedures are performed at the same time through the same incision or in the same body opening, Assurity will pay the greater of the surgical benefit amounts, but not both. The surgery can be performed in a Hospital, an ambulatory surgical center or a Physician's office. See policy for surgical schedule.

ANESTHESIA

Assurity will pay actual charges incurred up to 25% of the Surgical Benefit if a Surgical Benefit is paid and charges are made by a Physician for anesthesia administered in connection with such surgical procedure.

ADDITIONAL SURGICAL OPINIONS

Assurity will pay the actual charges incurred up to a maximum of \$200 for a second surgical opinion. If the second surgical opinion differs from the first, Assurity pays the actual charges incurred up to a maximum of \$200 for a third surgical opinion.

PROSTHESIS

The policy pays actual charges incurred up to \$1,000 per prosthetic device that are required to replace a body part lost due to Cancer as a direct result of surgery for Cancer treatment. This benefit has a maximum of \$2,500 per Calendar Year. This benefit does not include breast prosthesis.

ATTENDING PHYSICIAN

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

PRIVATE DUTY NURSE

The policy pays actual charges up to \$100 per day while confined in the hospital for treatment of cancer when authorized by a physician when a Private Nurse is required. Maximum of 60 days per calendar year.

RADIATION TREATMENT, CHEMOTHERAPY, HORMONE THERAPY OR IMMUNOTHERAPY

The calendar monthly and lifetime maximum benefit is \$10,000 per month, \$100,000 lifetime. Assurity will pay 50% of the actual charges incurred up to this calendar monthly and lifetime maximum for the following treatment techniques provided they are used for the purpose of modification or destruction of cancerous tissue:

- Radiation Treatment;
- Chemotherapy, Hormone Therapy and Immunotherapy drugs that are self-administered intravenously or administered directly by a Physician; or
- Chemotherapy, Hormone Therapy and Immunotherapy drugs that are self-administered or taken orally, up to a maximum of \$300 for each filled prescription or supply of drugs received from a medical provider. This benefit for self-administered or oral drugs is subject to a maximum of \$1,200 per Calendar Month.

Assurity will also pay for actual charges incurred up to maximum of \$500 per calendar year for the following services related to Radiation Treatment, Chemotherapy, Hormone Therapy and Immunotherapy:

- professional fees for administering the covered drugs;
- medical supplies, equipment and solutions;
- laboratory tests;

- x-rays, port films, MRIs, scans and ultrasounds;
- clinical treatment planning, clinical treatment management, medical radiation physics, dosimetry, treatment devices and special services;
- treatment consultation, planning and office visits; or
- Supportive and Protective Care Drugs

EXPERIMENTAL TREATMENT

Assurity pays actual charges up to \$4,000 per Calendar Year for experimental treatment that is approved by the Federal Drug Administration (FDA), National Cancer Institute (NCI) or American Cancer Society (ACS), for the purpose of modification or destruction of cancerous tissue.

BONE MARROW TRANSPLANT FOR CANCER

The policy pays the actual charges incurred up to a lifetime maximum of \$10,000 for bone marrow transplants or other forms of stem cell rescue (not to include any payments for donor expenses) and all related services and supplies. This benefit will pay for immunoglobulins, immunotherapy or colony-stimulating factors.

ADULT COMPANION TRANSPORTATION AND LODGING

The policy pays you the following expenses for one adult companion to be near the insured person when they are confined in a non-local hospital for specialized covered treatment prescribed by a physician as medically necessary: (a) the actual charges incurred up to \$40 per day for lodging incurred by the adult companion when staying at a hotel, motel or accommodation acceptable to Assurity, (b) the actual charges incurred up to \$15 per day for meals incurred by the adult companion (c) and the actual charges incurred up to \$500 per trip, for round trip coach fare on a common carrier to the nearest hospital that provides the prescribed treatment; or (d) \$.50 per mile for personal automobile expenses up to 700 miles round trip, provided that the destination is more than 50 miles one way from the city where the adult companion lives. This benefit is limited to two trips per calendar year.

This benefit is not payable for lodging occurring more than 24 hours prior to treatment nor for lodging occurring more than 24 hours following treatment. This benefit will not be paid for visits when an insured person receives non-covered treatments or periodic check-ups.

POSITIVE DIAGNOSIS TEST

Assurity will pay the actual charges incurred up to a lifetime maximum of \$500 for the diagnostic test that leads to a positive diagnosis of Cancer within 90 days of such test for an Insured Person. This benefit is not payable for non-melanoma skin Cancer.

OUTPATIENT SURGERY BENEFIT

Assurity will pay a benefit equal to the Daily Hospital Confinement benefit shown on the policy schedule for outpatient surgery due to cancer 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 non-melanoma skin Cancer treatment.

SKIN CANCER (NON-MELANOMA)

The policy pays up to \$100 for actual charges for the removal of non-melanoma skin cancer when diagnosis is made by a physician. This benefit is limited to two procedures per calendar year.

AMBULANCE

The policy pays actual charges up to \$200 per trip if a licensed professional ambulance company transports an insured person to or from a hospital or between medical facilities where the insured person is confined for cancer treatment. This benefit is limited to two trips per confinement.

HOSPICE CARE

Assurity will pay the actual charges incurred 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 a lifetime maximum of 120 days.

GOVERNMENT OR CHARITY HOSPITAL CONFINEMENT

The policy pays \$200 per day, up to 75 consecutive days, for an insured person confined for treatment of cancer in: (a) a hospital operated by or for the United States Government (including Veteran's Administration); (b) or a hospital that does not charge for the services it provides (charity). If this benefit is payable, no other benefits will be paid for the same time period and covered condition.

BLOOD AND BLOOD PLASMA

The policy pays the actual charges up to \$150 per day for an insured person requiring the transfusion, administration, cross-matching, typing and processing of blood and blood plasma due to cancer. This benefit is not payable for clerical, storage, and administration expenses associated with blood and blood plasma. This benefit does not pay for immunoglobulins, immunotherapy or colony-stimulating factors. There is a maximum of \$5,000 per calendar year for this benefit.

BREAST PROSTHESIS

Assurity will pay the actual charges incurred up to a lifetime maximum of \$2,500 per breast for an external breast prosthesis or an internal breast prosthesis due to cancer as a direct result of surgery for cancer treatment.

HAIRPIECE BENEFIT

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

CANCER SCREENING TESTS

Assurity will pay the sum of the actual charges incurred for the following tests up to a maximum of \$100 per calendar year. Benefits are not payable for tests performed within the 30-day waiting period.

- biopsy for skin Cancer;
- CA 125 (blood test for ovarian Cancer);
- CEA (blood test for colon Cancer);
- chest x-ray;
- colonoscopy;

- flexible sigmoidoscopy;
- hemocult stool specimen;
- mammography screening;
- pap smear (test only);
- PSA (blood test for prostate Cancer);
- serum protein electrophoresis; or
- thermography.

WELLNESS CLAIMS

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

Assurity will pay up to \$100 per day of actual charges for services provided at home, up to a maximum of 60 days per calendar year, when an insured person is provided services by a licensed home health care agency. Such care must be prescribed by a physician and begin within seven days of release from a covered hospital confinement. The care cannot be provided by an immediate family member. This benefit will not be payable on the same day that Hospice Care is payable.

RENTAL OR PURCHASE OF DURABLE MEDICAL EQUIPMENT

Upon a physician's recommendation, Assurity will pay the sum of the actual charges incurred for the rental or purchase of the following pieces of durable medical equipment up to \$1,000 per Calendar Year:

- brace;
- crutches;
- hospital bed;
- respirator or similar mechanical device; or
- wheel chair.

EXTENDED BENEFITS

If an insured person is continuously confined in a Hospital for treatment of cancer for more than 75 consecutive days, the policy pays the actual charges incurred up to the minimum of the usual and normal charges or \$1,000 per day, beginning on the 76th day for:

- drugs and medicines;
- Hospital room and board;
- tests; and
- other Medically Necessary Hospital charges.

Periods of Confinement separated by more than 30 days shall not be considered consecutive days.

CANCER OR OTHER SPECIFIED DISEASE CLAIMS

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

SPECIFIED DISEASE BENEFIT RIDER

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

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

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 30 days per period of confinement. The daily benefit amount reduces by 50% when that Insured Person reaches age 70. Benefits are not payable during the 30-day waiting period.

Cancer First Occurrence Rider -- pays \$2,500 or \$5,000 the first time an insured is diagnosed as having cancer. This benefit is not payable if diagnosed within the 30-day waiting period.

LIMITATIONS

Pre-existing Conditions. We will not pay benefits for any expenses incurred concerning a Pre-existing Condition unless the expenses are for services rendered after coverage has been in force for 12 months from the Issue Date.

Waiting Period. Charges incurred during the first 30 days of coverage are not eligible for payment.

EXCLUSIONS

We will not pay benefits for loss caused by or resulting from:

- Injuries;
- Noncancerous sickness;
- Any sickness, illness, bodily infirmity or incapacity that has been caused, complicated, worsened, or affected by Cancer or as a result of Cancer treatment;
- Expenses that are incurred prior to the Issue Date regardless of the date of positive diagnosis; or
- Care, and/or treatment received outside the United States.

Assurity Life Insurance Company
PO Box 82533, Lincoln, NE, 68501-2533
Assurity Customer Service: 1.866.289.7337
Website: www.assurity.com

To Call in a Wellness Claim: 1.888.358.8808 Ext. 23
To Fax in a Claim/Toll Free: 1.800.869.0368

Policy Form No. W C240
Rider Form Nos. R WC241, R WC242 & R WC243





**Cancer Policy and Specified Disease Benefit Rider
With Radiation/Chemotherapy**

Monthly Rates

Assurity Life Cancer & Specified Disease Plan With Radiation/Chemotherapy				
		Ages 18-34	Ages 35-49	Ages 50-64
Base Policy with Specified Disease Benefit Rider (\$10,000 per month/\$100,000 lifetime maximum radiation/chemotherapy, \$150 daily hospital benefit)	Individual	\$12.52	\$25.22	\$53.14
	EE & Spouse	\$22.19	\$47.06	\$105.54
	EE & Children	\$15.13	\$27.60	\$55.90
	Family	\$24.66	\$49.53	\$107.31
Base Policy with Specified Disease Benefit Rider \$150 daily hospital benefit with First Occurrence Benefit Rider (\$2500 benefit) and Intensive Care Rider (\$300 daily benefit)	Individual	\$15.73	\$29.53	\$61.40
	EE & Spouse	\$28.66	\$55.53	\$122.03
	EE & Children	\$20.72	\$34.11	\$66.01
	Family	\$33.67	\$60.51	\$125.59
Base Policy with Specified Disease Benefit Rider \$150 daily hospital benefit with First Occurrence Benefit Rider (\$5000 benefit) and Intensive Care Rider (\$600 daily benefit)	Individual	\$18.93	\$33.85	\$69.68
	EE & Spouse	\$35.13	\$64.00	\$138.51
	EE & Children	\$26.31	\$40.63	\$76.13
	Family	\$42.68	\$71.50	\$143.85

NC/SC

Superior Vision Plan 1 - Full Services

Effective Date: November 1, 2010

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

Copayment: \$20 Comprehensive Eye Exam
 \$0 Materials
 \$35 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

Standard Lenses (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, polaroid, 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 ophthalmologists, optometrists, and opticians. The plan also contracts 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 your 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 diagnosis 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.

Discount Features

Materials Discounts on Additional Purchases

Prescription eyeglass lenses	30% off retail prices
Eyeglass frames	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

Materials Discount SVP8-20

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

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

Add-ons to the covered pair of lenses:

<u>Lens Options and Upgrades*</u>	<u>Member pays 20% off retail, up to:</u>
Factory scratch coat	\$13 (single vision & standard lined multifocal lenses)
Ultraviolet coat	\$15 (single vision & standard lined multifocal lenses)
Standard anti-reflective coat	\$50 (single vision & standard lined multifocal lenses)
High Index 1.6	\$55 (single vision lenses only)
Polycarbonate	\$40 (single vision lenses only)
Standard photochromic	\$80 (single vision lenses only)
Glass coloring	\$35 (any type lenses)
Plastic, tints, solid, or gradients	\$25 (any type lenses)

<u>Lens Options and Upgrades</u>	<u>Member pays:</u>
Power over 4.00D Sphere, 2.00D Cylinder & 5.00D Prism	20% discount off retail prices (any type lenses)
Cosmetic finishing, beveling, edging, and mounting	20% discount off retail prices (any type lenses)
Miscellaneous options	20% discount off retail prices (any type lenses)

*Higher end or brand name lens upgrades are at an additional expense. These upgrades will be available at a 20% discount off retail.

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 vary depending on the provider but are the best possible discounts available to Superior Vision.

MONTHLY RATES - FULL SERVICE PLAN

Employee Only	\$7.98
Employee + Family	\$20.24

Customer Service
800-507-3800
916-852-2277 fax

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

Customer Service/Corporate Office

11101 White Rock Rd., Ste. 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 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

Effective Date: November 1, 2010

Outline of Benefits - Materials Only

Vision Plan - Preferred Provider (PPO / Indemnity)

Copayment: \$0 - Materials

\$35.00 - Contact Lens Fitting Fee

BENEFITS	FREQUENCY	IN-NETWORK	NON-NETWORK
Eye Exams	No Benefit	No Benefit	No Benefit
Standard Lenses (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, polaroid, 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 ophthalmologists, optometrists, and opticians. The plan also contracts 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 your 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 diagnosis 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.

Discount Features

Materials Discounts on Additional Purchases

Prescription eyeglass lenses	30% off retail prices
Eyeglass frames	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

Materials Discount SVP8-20

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

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

Add-ons to the covered pair of lenses:

<u>Lens Options and Upgrades*</u>	<u>Member pays 20% off retail, up to:</u>
Factory scratch coat	\$13 (single vision & standard lined multifocal lenses)
Ultraviolet coat	\$15 (single vision & standard lined multifocal lenses)
Standard anti-reflective coat	\$50 (single vision & standard lined multifocal lenses)
High Index 1.6	\$55 (single vision lenses only)
Polycarbonate	\$40 (single vision lenses only)
Standard photochromic	\$80 (single vision lenses only)
Glass coloring	\$35 (any type lenses)
Plastic, tints, solid, or gradients	\$25 (any type lenses)

<u>Lens Options and Upgrades</u>	<u>Member pays:</u>
Power over 4.00D Sphere, 2.00D Cylinder & 5.00D Prism	20% discount off retail prices (any type lenses)
Cosmetic finishing, beveling, edging, and mounting	20% discount off retail prices (any type lenses)
Miscellaneous options	20% discount off retail prices (any type lenses)

*Higher end or brand name lens upgrades are at an additional expense. These upgrades will be available at a 20% discount off retail.

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 vary depending on the provider but are the best possible discounts available to Superior Vision.

MONTHLY RATES - MATERIALS ONLY PLAN

Employee Only	\$5.64
Employee + Family	\$13.98

Customer Service
800-507-3800
916-852-2277 fax

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

Customer Service/Corporate Office

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

Claims Administration

P.O. Box 967
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Disclaimer: All final determinations of benefits, administrative duties, and definitions are governed by the Certificate of Insurance Coverage for your vision plan. Please check with your Benefits Administrator or Human Resources department if you have any questions.



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MetLife Term Life Plan

Effective Date: When approved by MetLife.

BASIC EMPLOYEE LIFE INSURANCE

This insurance is payable for death from any cause to any person you name as beneficiary. All active employees have Basic Life coverage.

OPTIONAL EMPLOYEE LIFE AND AD&D INSURANCE

Your employer-sponsored basic life coverage provides important protection for you, but you may need to add to that protection. Now you can... at low group rates and through payroll deductions.

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

OPTIONAL DEPENDENT LIFE INSURANCE

Provides coverage on:

- Your Spouse
- Child(ren) from 14 days of age up to 19 (to age 26 if wholly dependent upon you for maintenance and support and if enrolled as a full-time student in an accredited school or college). Handicapped children can continue to be covered with no age limit. It is your responsibility to notify payroll in writing when a dependent is ineligible for coverage. Examples of ineligible dependent status are divorce or a child graduates from college.

FEATURES

The plan features easy eligibility and simple enrollment procedures. AND. . . There is no need for a medical exam if you sign up during your eligibility period. Furthermore, automatic payroll deductions simplify paperwork. This means less bookkeeping for you and no worries about a lapse in coverage due to missed payments.

LOW COST

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

ELIGIBILITY

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

ENROLLMENT

Enrollment is simple - just fill out the election card provided by your employer. Make sure you supply all the required information and return the form where you work. That's all. You will be notified as to when coverage starts.

BENEFICIARY

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

WHEN YOUR INSURANCE STARTS

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

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

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

REDUCTIONS AT AGE 65 AND OVER

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

<u>Attained Age</u>	<u>Percent of Original Amount</u>
65	65%
70	45%
75	30%
80	20%

TERMINATION OF COVERAGE

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

DISABILITY

Your insurance may be continued during your disability provided the Board of Education continues premium payments on your behalf. However, your insurance will be subject to reduction as shown under "Reductions at ages 65 & Over."

CONVERSION

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

PORTABILITY

Portability allows employees whose coverage ends due to certain qualifying events to continue their current (or a lesser) amount of insurance. Portability applies to Employee Optional Life Insurance not dependent(s).

Qualifying Events Include:

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

The minimum face amount which an employee may elect portability is \$20,000. Portable coverage reduces to 50% on January 1st of the year the insured attains age 70 and terminates on January 1st of the year the insured attains age 80. When portable coverage ends, insured individuals have the right to convert to an individual policy.

THE ACCELERATED BENEFIT OPTION (ABO)

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

SUICIDE EXCLUSION

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

CLAIMS PROCEDURE

Procedures for Presenting Claims for Benefits

Claim forms needed to file for benefits under the group insurance program can be obtained from your employer who will also be ready to answer questions about the insurance benefits and to assist in filing claims. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully.

Routine Questions

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

SCHEDULE OF BENEFITS

BASIC EMPLOYEE LIFE INSURANCE

All eligible employees \$5,000*
 (No cost to you)

**See "Reductions at age 65 & Over."*

OPTIONAL EMPLOYEE LIFE AND AD&D INSURANCE

Your choice of the following amounts:

\$200,000, \$100,000, \$50,000, \$40,000, \$30,000, \$20,000 or \$10,000

(To be eligible for amount over \$100,000 you must furnish medical evidence of insurability satisfactory to MetLife).

OPTIONAL DEPENDENT LIFE INSURANCE

- \$10,000 on your spouse
- \$5,000 on each of your eligible children

You choose either:

Family coverage, Spouse only coverage or Child(ren) only coverage.

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

YOUR MONTHLY COST

<u>Optional Employee Life and AD&D Insurance</u>	<u>Monthly Payroll Deduction</u>
\$200,000	\$48.00
100,000	24.00
50,000	12.00
40,000	9.60
30,000	7.20
20,000	4.80
10,000	2.40
 <u>Optional Dependent Life Insurance</u>	
Family coverage	\$3.50
Spouse Only coverage	\$2.50
Child(ren) Only Coverage	\$1.00

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

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

AUL Short-Term Disability Plan

Effective Date: November 1, 2010

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 are up dramatically! Things that use 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

Class Description

All Full-Time Eligible Employees working a minimum of 30 hours per week, electing to participate in the Voluntary Short Term Disability Insurance

Disability

You are considered disabled if, because of injury or sickness, you cannot perform the material and substantial duties of your regular occupation.

Monthly Benefit

You can choose to ***insure up to 70% of an Employee's covered basic monthly earnings to a maximum monthly benefit of \$3,000.***

Elimination Period

This means a period of consecutive days of disability for which no benefit is payable; ***the greater of seven (7) days for a sickness and one (1) day for injury.*** This is the period of time a disabled Employee must wait before weekly disability benefits begin.

Benefit Duration

This is the period of time that benefits will be payable for disability. You can choose a maximum STD benefit duration, if continually disabled, of thirteen (13) weeks, twenty-six (26) weeks or fifty-two (52) weeks.

Basis of Coverage

24 hour coverage, on or off the job.

Maternity Coverage

Benefits will be paid the same as any other qualifying disability, subject to any applicable pre-existing condition exclusion.

Partial Disability

When selecting 52 week benefit duration, benefits will continue to be paid, even if you work partial hours for your employer. AUL will offset with monies earned from your employer for your partial hours so that your total compensation will equal 80% of your pre-disability earnings based upon a set formula administered through AUL's Home Office.

STD Pre-Existing Condition Exclusion

3/12, If a person receives medical treatment, or service or incurs expenses as a result of an Injury or Sickness within 3 months prior to the Individual Effective Date, then the Group Policy will not cover any Disability which is caused by, contributed to by, or resulting from that Injury or Sickness; and begins during the first 12 months after the Person's Individual Effective Date.

Recurrent Disability

If you resume Active Work for 30 consecutive workdays following a period of Disability for which the Weekly Benefit was paid, any recurrent Disability will be considered a new period of Disability. A new Elimination Period must be completed before the Weekly Benefit is payable.

Exclusions and Limitations

This plan will not cover any disability resulting from war, declared or undeclared or any act of war; active participation in a riot; intentionally self-inflicted injuries; commission of an assault or felony; or a pre-existing condition for a specified time period.

This information is provided as a summary of the product. It is not a part of the insurance contract and does not change or extend AUL's liability under the group policy. If there are any discrepancies between this information and the group policy, the group policy will prevail.

Customer Service

1.800-553-5318

Disability Claims

1.866-258-8744

Fax: 207-591-3048

Disability Claims Email: claims@disabilityrms.com

Website: www.employeebenefits.aul.com



AMERICAN UNITED LIFE
INSURANCE COMPANY®
a ONEAMERICA® company

AUL Life Short-Term Disability Monthly Rates

Benefit Duration: 13-Weeks

Monthly Benefit	Monthly Premium
\$500	\$10.37
\$600	\$12.44
\$700	\$14.50
\$800	\$16.57
\$900	\$18.65
\$1,000	\$20.72
\$1,100	\$22.79
\$1,200	\$24.87
\$1,300	\$26.94
\$1,400	\$29.00
\$1,500	\$31.07
\$1,600	\$33.15
\$1,700	\$35.22
\$1,800	\$37.29
\$1,900	\$39.37
\$2,000	\$41.44
\$2,100	\$43.50
\$2,200	\$45.57
\$2,300	\$47.65
\$2,400	\$49.72
\$2,500	\$51.79
\$2,600	\$53.87
\$2,700	\$55.94
\$2,800	\$58.00
\$2,900	\$60.07
\$3,000	\$62.15

Benefit Duration: 26-Weeks

Monthly Benefit	Monthly Premium
\$500	\$15.02
\$600	\$18.02
\$700	\$21.00
\$800	\$24.00
\$900	\$27.01
\$1,000	\$30.01
\$1,100	\$33.01
\$1,200	\$36.02
\$1,300	\$39.02
\$1,400	\$42.00
\$1,500	\$45.00
\$1,600	\$48.01
\$1,700	\$51.01
\$1,800	\$54.01
\$1,900	\$57.02
\$2,000	\$60.02
\$2,100	\$63.00
\$2,200	\$66.00
\$2,300	\$69.01
\$2,400	\$72.01
\$2,500	\$75.01
\$2,600	\$78.02
\$2,700	\$81.02
\$2,800	\$84.00
\$2,900	\$87.00
\$3,000	\$90.01

Benefit Duration: 52-Weeks

Monthly Benefit	Monthly Premium
\$500	\$19.73
\$600	\$23.68
\$700	\$27.60
\$800	\$31.55
\$900	\$35.49
\$1,000	\$39.44
\$1,100	\$43.39
\$1,200	\$47.33
\$1,300	\$51.28
\$1,400	\$55.20
\$1,500	\$59.15
\$1,600	\$63.09
\$1,700	\$67.04
\$1,800	\$70.99
\$1,900	\$74.93
\$2,000	\$78.88
\$2,100	\$82.80
\$2,200	\$86.75
\$2,300	\$90.69
\$2,400	\$94.64
\$2,500	\$98.59
\$2,600	\$102.53
\$2,700	\$106.48
\$2,800	\$110.40
\$2,900	\$114.35
\$3,000	\$118.29

Texas Life Whole Life Insurance Plan

Common Issue Date: January 1, 2011 pending underwriting approval

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

VPL- plus is an individual permanent life insurance product specifically designed for employees and their families. It provides a guaranteed level premium and death benefit for the life of the policy, and you can keep the life insurance even after you retire.

As an employee, you are eligible to apply if you have satisfied your employer's eligibility period. You may also apply for coverage on your spouse, children and grandchildren.

WHY VOLUNTARY COVERAGE

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

THE NEW PRODUCT: TEXAS LIFE'S VPL-plus

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

VPL-plus: PORTABLE AND PERMANENT

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

VPL-plus: THE GUARANTEES EMPLOYEES WANT

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

¹Trends in Life Insurance Ownership,
09M022-C 1003 (Expires 013111) Rev 08/09

LIMRA International (2006)

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

*Guarantees are backed by the claims paying ability and financial strength of the issuing company.

VPL-plus: CGI (EXPRESS ISSUE) UNDERWRITING

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

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

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

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

Express Issue Maximums

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

Simplified Issue

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

Accelerated Death Rider

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

Waiver of Premium

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

VPL-plus: Review

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

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

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

TEXASLIFE INSURANCE
COMPANY
Since 1901 | 900 WASHINGTON | POST OFFICE BOX 830 | WACO, TEXAS 76703-0830

MetLife Auto & Home Plan

PROGRAM DESCRIPTION

MetLife Auto & Home is a voluntary group auto and home* benefit program that provides you with access to insurance coverage for your personal insurance needs. Policies available include: auto, landlord's rental dwelling, condo, mobile/motor home, renters, recreational vehicle, boat, and personal excess liability ("umbrella") policies.

BENEFITS

The program gives you access to **special group rates*** and **policy discounts***. You could also benefit from these program features:

- One easy-to-remember, toll-free number for all your insurance needs, such as receiving free insurance quotes, making changes to your policy or just asking questions
- 24-hour claim reporting
- Extended customer service hours, including weekday evenings and Saturdays
- Coverage you can take with you should you retire or leave the company for another reason
- Enhanced product coverages that are built into every auto policy†

CONVENIENT PAYMENT OPTIONS

You can choose to have your premiums automatically deducted from your paychecks or checking account. With these options, insurance premiums are spread throughout the policy term with no down payments, interest charges or service fees (a down payment is required in some instances). Other payment options are available including mortgagee billing for home insurance.

FREE PREMIUM QUOTES AND APPLICATION PROCESSING

Since everyone's insurance policies renew at different times during the year, you can apply for group auto and home insurance at any time by calling a toll-free number when the program begins.

An Insurance Consultant will provide you with free, no-obligation premium quotes. If you choose to switch, a consultant can help you apply for insurance while you're on the phone. Please have your current insurance policies with you when you call. Retirees remain eligible for the group rate.

*Available in most states to those who qualify.

†Subject to state availability. See your policy for exact details.

Coverage, underwritten by MetLife Auto & Home, is available in most states to those who qualify. In Texas, real property policies are provided by Metropolitan Lloyds Insurance Company of Texas, Irving, TX. In Texas, auto policies are written by either Metropolitan Direct Property and Casualty Insurance Company, Metropolitan Property and Casualty Insurance Company, Metropolitan Casualty Insurance Company, Metropolitan General Insurance Company, all of Warwick, RI, or Liberty County Mutual Insurance Company, Irving, TX, through an arrangement with Metropolitan Property and Casualty Insurance Company. In some instances, special arrangements for coverage have been made with other carriers. MetLife Auto & Home is a brand of Metropolitan Property and Casualty Insurance Company and its Affiliates, Warwick, RI. L0309CNFJ(exp0907)MPC-LD



Call
1 800 GET-MET 8
(1-800-438-6388)

Continuation of Benefits

GILSBAR MEDICAL SPENDING ACCOUNTS:

Under the Cafeteria Plan, you and your covered dependents are eligible to continue your medical spending or dependent care coverage through COBRA according to the following “qualifying events”.

If you and your dependents are enrolled in the plan, you will be eligible to continue coverage through COBRA after you leave employment for a specified period. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents maybe eligible to continue coverage through COBRA. 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 at: (800) 426-8739.**

AMERITAS DENTAL:

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 employment for a specified period. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents maybe eligible to continue 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 26 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 at: (800) 426-8739.**

PHILADELPHIA AMERICAN (FORMERLY CSO) & ASSURITY CANCER:

When you leave your employment, you may continue your Philadelphia America Cancer coverage or Assurity Cancer coverage by having the premiums that are currently deducted from your paycheck billed directly to your home address or drafted from your bank account. For billing options, please call Philadelphia America at **(800)541-2363** or Assurity at **(866)289-7337.**

SUPERIOR VISION:

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

If you and your dependents are enrolled in the vision plan, you will be eligible to continue coverage through COBRA after you leave employment for a specified

period. 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 at: (800) 426-8739.**

METLIFE TERM LIFE:

Conversion: If your employment terminates while you are covered under the plan or when you are approved for long-term disability, you may purchase without medical evidence of insurability, any individual insurance policy, except a term policy. You must apply for conversion within 31 days after the date your coverage terminates. This applies to Optional Life and Dependent Life as well as the basic coverage. To get information and rates for converting coverage, please contact MetLife direct at 877-275-6387

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

- You must apply for coverage with 31 days from the date your life coverage terminates.
- You must be **ACTIVELY** at work prior to employment termination.
- You may only port up to your current coverage amount. You cannot increase or add dependents.

To get information and rates for coverage, please contact MetLife direct at 866-492-6983.

AUL SHORT TERM DISABILITY

Once an employee is on the AUL disability plan for 12 months, you can port the coverage for one year at the same cost without evidence of insurability. You have 30 days from your date of termination to contact AUL to Port your coverage by calling 800-553-5318.

METLIFE WHOLE LIFE:

When you leave employment you may continue your Met Whole Life coverage by having the premiums that are currently deducted from your paycheck billed to your home address or drafted from your bank account. You may call **MetLife at: (800) 634-5007.**

TEXAS LIFE WHOLE LIFE:

When you leave employment you may continue your Texas Life Whole Life coverage by having the premiums that are currently deducted from your paycheck billed to your home address or drafted from your bank account. You may call **Texas Life at: (800) 283-9233 prompt #3.**

Important Phone Numbers:

American United Life (AUL) STD - (800) 553-5318
Ameritas Dental Plan - (800) 487-5553
Assurity Cancer Plan - (888) 358-8808, ext. 36
Continental American (800) 433-3036
Gilsbar Medical and Dependent Care - (800) 445-7227 ext. 883
Mark III Brokerage, Inc. - (800) 532-1044, ext. 210
MetLife Auto & Home Plan - (800) 438-6388
MetLife Term Life Plan - (800) 638-6420
MetLife Whole Life Plan - (800) 634-5007
Philadelphia American Cancer Plan (Formerly CSO) - (800) 554-0092
Texas Life Whole Life Plan - (800) 283-9233, prompt #3