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Plan Arranged By:



* * * * * ***NOTICE*** * * * * *

The products described in this booklet are part of a Cafeteria Benefits Plan arranged by Mark III Brokerage for full-time eligible Sampson County Government employees. The Cafeteria Benefits Plan allows you to pay for certain insurance premiums before taxes are taken out of your paycheck. Paying for benefits in this method reduces your taxes and increases your take home pay.

The Plan Year is August 1, 2008 through July 31, 2009.

All products described in this booklet are deducted on a pre-tax basis **EXCEPT:**

- **Lincoln Financial Group Term Life**

If you wish to add or make changes to your insurance coverage(s), please consult a Benefits Representative during your scheduled enrollment period. ***You will not be able to make any changes once the enrollment period is over*** unless you experience a qualified event (i.e., marriage, divorce, birth of a child, etc.)

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

Health Plan - HMO

BCBSNC Blue CareSM

Plan Benefits

- \$15 Co-Pay - In Network Visits
- \$30 Co-Pay - Specialists
- Vision Exam Benefit
- Plus . . . much more



**BlueCross BlueShield
of North Carolina**

BCBSNC BLUE CARE BENEFITS SUMMARY

PHYSICIAN OFFICE SERVICES

Participating¹

Office Visit

Includes Office Surgery, Consultation, X-rays and Lab, and a benefit period maximum of 4 office visits for the assessment of obesity in and out of network.

Primary Care Provider	\$15 copayment
Specialist	\$30 copayment

Preventive Care

Routine Examinations, Well-Child Care, Immunizations, Pap Smears, Mammograms, Prostate Specific Antigen Tests (PSAs)

Primary Care Provider	\$15 copayment
Specialist	\$30 copayment

**Pap Smears, Mammograms, and PSAs are covered Out-of-Network.*

Therapies

Short-term Rehabilitative Therapies (Maximums apply to Home, Office and Outpatient Settings):

Physical/Occupational: 30 visits per Benefit Period

Speech Therapy: 30 visits per Benefit Period

Primary Care Provider	\$15 copayment
Specialist	\$30 copayment

URGENT CARE CENTERS AND EMERGENCY ROOM

Urgent Care Centers	\$30 copayment
Emergency Room Visit	\$150 copayment

AMBULATORY SURGICAL CENTER

100% after deductible

INPATIENT AND OUTPATIENT HOSPITAL SERVICES

Hospital and Hospital Based Services	100% after deductible
Outpatient Clinic Services	100% after deductible
Physicians Services	100% after deductible
Hospital and Professional	
Outpatient Labs and Mammograms with surgery or other services.	100% after deductible
Outpatient Labs and Mammograms without surgery or other services	100%
Outpatient X-rays, ultrasounds, and other diagnostic tests such as EEG's and EKG's	100% after deductible
CT scans, MRI's, MRA's and PET scans in any location, including physicians office	100% after deductible

OTHER SERVICES

Skilled Nursing Facility

100% after deductible

(60 days per benefit period)

Home Health Care, Ambulance, Durable Medical Equipment, and Hospice

100% after deductible

Maternity

(Maternity Delivery includes Prenatal and Post-Delivery care)

Hospital Services (Delivery)	100% after deductible
Professional Services (Delivery)	100% after deductible

Transplants

Hospital Services	100% after deductible
Professional Services	100% after deductible

Infertility and Sexual Dysfunction Services*Up to \$5,000 per Lifetime*

Primary Care Provider	\$15 copayment
Specialist	\$30 copayment
Hospital Services	100% after deductible
Inpatient and Outpatient Professional Services	100% after deductible

Vision Care

Comprehensive Eye Exam	\$15 copayment
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LIFETIME MAXIMUM, DEDUCTIBLES & COINSURANCE MAXIMUMS*(The following Deductibles and Coinsurance Maximums apply to the services in the previous sections:*

Lifetime Benefit Maximum	\$5,000,000
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Deductibles

Employee Coverage <i>(per Benefit Period)</i>	\$250
Family Coverage <i>(per Benefit Period)</i>	\$500

Coinsurance Maximum

Employee Coverage <i>(per Benefit Period)</i>	\$0
Family Coverage <i>(per Benefit Period)</i>	\$0

PRESCRIPTION DRUGS*Up to 30 day supply. 31-60 day supply is two copayments and 61-90 day supply is three copayments. Infertility Drugs up to \$5,000 Lifetime Maximum. MAC B Pricing, Brand Penalty*

Tier 1 <i>(Generic)</i>	\$10 copayment
Tier 2 <i>(Preferred Brand)</i>	\$20 copayment
Tier 3 <i>(Brand)</i>	\$35 copayment

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES**Inpatient/Outpatient Certification is required. Call Magellan Behavioral Health at 1-800-359-2422.***Mental Health Services**

Office <i>(30 visits per Benefit Period)</i>	\$30 copayment
Inpatient <i>(30 Days per Benefit Period)</i>	100%

Substance Abuse Services

Office Visit	\$30 copayment
Inpatient/Outpatient	100%

Benefit Period Maximum	\$8,000
Lifetime Maximum	\$16,000

¹ NOTICE: Deductible and coinsurance are calculated using the Allowed Amount. Members may be billed by out-of-network providers for the full provider's charge.

ADDITIONAL INFORMATION ABOUT THE BLUE CARE HMO PLAN FROM BCBSNC

BENEFIT PERIOD

The period of time, usually 12 months as stated in the group contract, during which charges for covered services provided to a member must be incurred in order to be eligible for payment by BCBSNC. A charge shall be considered incurred on the date the service or supply was provided to a member.

COINSURANCE MAXIMUM

The dollar amount of coinsurance a member must pay prior to BCBSNC paying 100% for certain services.

NOTE: In some plans, there is no coinsurance maximum; members are responsible for coinsurance once the deductible has been met.

UTILIZATION MANAGEMENT

To make sure you have access to high quality, cost-effective health care, we manage utilization through a variety of programs including certification, transplant management, concurrent and retrospective review.

If you have a concern regarding the final determination of your care, you have the right to appeal the decision. If you would like a copy of a benefit booklet providing more information about our Utilization Management programs, call the toll free number listed in your information packet.

CERTIFICATION

Certification is a program designed to make sure that your care is given in a cost effective setting and efficient manner.

If you need to be hospitalized, you must obtain certification. Non-emergency and non-maternity hospital admissions must be certified prior to the hospitalization. If the admission is not certified, a penalty will be applied.

For maternity admissions, your provider is not required to obtain certification from BCBSNC for prescribing a length of stay up to 48 hours for a normal vaginal delivery, or up to 96 hours for delivery by cesarean section. You or your provider must request certification for coverage for additional days, which will be given by BCBSNC, if medically necessary.

All inpatient and outpatient Mental Health and Substance Abuse services must be certified in advance by Magellan Behavioral Health.

Participating providers are responsible for obtaining certifications. The member will bear no financial penalties if the participating provider fails to obtain the appropriate authorization. The member is responsible for obtaining certification for services rendered by a non-participating provider. Obtaining certification for Mental Health and Substance Abuse services is the member's responsibility.

HEALTH AND WELLNESS PROGRAM

Because we want to help you stay healthy, we offer a variety of wellness benefits and services. You can take advantage of HealthLine Blue, our 24-hour health information service, a health topics library, asthma and diabetes management and a prenatal program. You will also receive Active Blue, our quarterly health magazine, and have access to online health and wellness information at www.bcbsnc.com. With our program you can get health advice anytime you need it, so you can learn how to take charge of your health.

WHAT IS NOT COVERED?

The following are summaries of some of the coverage restrictions. A full explanation and listing of restrictions will be found in your benefit booklet.

Your health benefit plan does not cover services, supplies, drugs or charges that are:

- Not medically necessary
- For injury or illness resulting from an act of war
- For personal hygiene and convenience items
- For inpatient admissions that are primarily for diagnostic studies
- For palliative or cosmetic foot care
- For investigative or experimental purposes
- For hearing aids or tinnitus maskers
- For cosmetic services or cosmetic surgery
- For custodial care, domiciliary care or rest cures
- For treatment of obesity, except for surgical treatment of morbid obesity, or as specifically covered by your health benefit plan
- For reversal of sterilization
- For treatment of sexual dysfunction not related to organic disease
- For conception by artificial means
- For self-injectable drugs in the provider's office (with the exception of insulin)

A waiting period for coverage of pre-existing conditions may apply to your coverage. BCBSNC defines pre-existing conditions as those conditions for which medical advice, diagnosis, care or treatment was received or recommended within 6 months of the date that your [BCBSNC] coverage begins. You may receive credit toward the 12-month waiting period if your enrollment date is within 63 days of the termination of your previous health coverage.

These benefit highlights are summaries of Blue Care benefits. This is meant only to be a summary. Final interpretation and a complete listing of benefits and what is not covered are in and governed by the group contract and benefit booklet. You may preview the benefit booklet by requesting a copy of the Blue Care benefit booklet from BCBSNC Customer Services.

HMO MONTHLY RATES

(Participating in the Wellness Program)

Employee Only	\$0
Employee + Child(ren)	\$85.00
Employee + Family	\$245.00

(NOT Participating in the Wellness Program)

Employee Only	\$30.00
Employee + Child(ren)	\$115.00
Employee + Family	\$275.00

**FOR CLAIMS OR CUSTOMER SERVICES QUESTIONS PLEASE
CALL BLUECROSS BLUESHIELD OF NORTH CAROLINA AT:**

(877) 258-3334

www.bcbsnc.com



Health Plan - PPO

BCBSNC Blue OptionsSM

Plan Benefits

- In Network - 90/10
- Out of Network - 70/30
- \$15 Co-Pay - In Network Visits
- \$30 Co-Pay - Specialists
- Vision Exam Benefit
- Plus . . . much more



**BlueCross BlueShield
of North Carolina**

BCBSNC BLUE OPTIONS BENEFITS SUMMARY

PHYSICIAN OFFICE SERVICES

In-Network

Out-of-Network¹

Office Visit

Includes Office Surgery, Consultation, X-rays and Lab, and a benefit period maximum of 4 office visits for the assessment of obesity in and out of network.

Primary Care Provider	\$15 copayment	70% after deductible
Specialist	\$30 copayment	70% after deductible

Preventive Care

Routine Examinations, Well-Child Care, Immunizations, Pap Smears, Mammograms, Prostate Specific Antigen Tests (PSAs)

Primary Care Provider	\$15 copayment	Not Available*
Specialist	\$30 copayment	Not Available*

**Pap Smears, Mammograms, and PSAs are covered Out-of-Network.*

Therapies

Short-term Rehabilitative Therapies (Maximums apply to Home, Office and Outpatient Settings):

Physical/Occupational: 30 visits per Benefit Period

Speech Therapy: 30 visits per Benefit Period

Primary Care Provider	\$15 copayment	70% after deductible
Specialist	\$30 copayment	70% after deductible

URGENT CARE CENTERS AND EMERGENCY ROOM

Urgent Care Centers	\$30 copayment	\$30 copayment
Emergency Room Visit	\$150 copayment	\$150 copayment

AMBULATORY SURGICAL CENTER 90% after deductible 70% after deductible

INPATIENT AND OUTPATIENT HOSPITAL SERVICES

Hospital and Hospital Based Services	90% after deductible	70% after deductible
Outpatient Clinic Services	90% after deductible	70% after deductible
Physicians Services	90% after deductible	70% after deductible

Hospital and Professional

Outpatient Labs and Mammograms with surgery or other services.

90% after deductible 70% after deductible

Outpatient Labs and Mammograms without surgery or other services

100% 70% after deductible

Outpatient X-rays, ultrasounds, and other diagnostic tests such as EEG's and

EKG's, and colonoscopies 90% after deductible 70% after deductible

CT scans, MRI's, MRA's and PET scans in any location, including physicians office

90% after deductible 70% after deductible

OTHER SERVICES

Skilled Nursing Facility

90% after deductible 70% after deductible

(60 days per benefit period)

	<u>In-Network</u>	<u>Out-of-Network¹</u>
Home Health Care, Ambulance, Durable Medical Equipment, and Hospice		
	90% after deductible	70% after deductible
Maternity		
<i>(Maternity Delivery includes Prenatal and Post-Delivery care)</i>		
Hospital Services (Delivery)	90% after deductible	70% after deductible
Professional Services (Delivery)	90% after deductible	70% after deductible
Transplants		
Hospital Services	90% after deductible	70% after deductible
Professional Services	90% after deductible	70% after deductible
Infertility and Sexual Dysfunction Services		
<i>Up to \$5,000 per Lifetime</i>		
Primary Care Provider	\$15 copayment	70% after deductible
Specialist	\$30 copayment	70% after deductible
Hospital Services	90% after deductible	70% after deductible
Inpatient and Outpatient Professional Services	90% after deductible	70% after deductible
Vision Care		
Comprehensive Eye Exam	\$15 copayment	Benefits not available

LIFETIME MAXIMUM, DEDUCTIBLES & COINSURANCE MAXIMUMS

(The following Deductibles and Coinsurance Maximums apply to the services in the previous sections:

Lifetime Benefit Maximum	\$5,000,000	\$5,000,000
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Deductibles

Employee Coverage <i>(per Benefit Period)</i>	\$250	\$500
Family Coverage <i>(per Benefit Period)</i>	\$750	\$1,500

Coinsurance Maximum

Employee Coverage <i>(per Benefit Period)</i>	\$2,000	\$4,000
Family Coverage <i>(per Benefit Period)</i>	\$6,000	\$12,000

PRESCRIPTION DRUGS

Up to 30 day supply. 31-60 day supply is two copayments and 61-90 day supply is three copayments. Infertility Drugs up to \$5,000 Lifetime Maximum. MAC B Pricing, Brand Penalty

Tier 1 <i>(Generic)</i>	\$10 copayment	Copayment + charge over allowed amount
Tier 2 <i>(Preferred Brand)</i>	\$20 copayment	Copayment + charge over allowed amount
Tier 3 <i>(Brand)</i>	\$35 copayment	Copayment + charge over allowed amount

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

**Inpatient/Outpatient Certification is required. Call Magellan Behavioral Health at 1-800-359-2422.*

Mental Health Services	<u>Certified*</u>	<u>Non-Certified¹</u>
Office (20 visits per Benefit Period)	\$30 copayment	70% coinsurance
Inpatient (30 Days per Benefit Period)	90% coinsurance	70% coinsurance
Substance Abuse Services		
Office Visit	\$30 copayment	70% coinsurance
Inpatient/Outpatient	90% coinsurance	70% coinsurance
Benefit Period Maximum		\$8,000
Lifetime Maximum		\$16,000

¹ NOTICE: Your actual expenses for covered services may exceed the stated coinsurance percentage or co-payment amount because actual provider charges may not be used to determine the payment obligations for BCBSNC and its members.

ADDITIONAL INFORMATION ABOUT THE BLUE OPTIONS PPO PLANS FROM BCBSNC

BENEFIT PERIOD

The period of time, usually 12 months as stated in the group contract, during which charges for covered services provided to a member must be incurred in order to be eligible for payment by BCBSNC. A charge shall be considered incurred on the date the service or supply was provided to a member.

ALLOWED AMOUNT

The charge that BCBSNC determines using a methodology which is applied to comparable providers for similar services under a similar health benefit plan.

COINSURANCE MAXIMUM

The dollar amount of coinsurance a member must pay prior to BCBSNC paying 100% for certain services.

NOTE: In some plans, there is no coinsurance maximum; members are responsible for coinsurance once the deductible has been met.

DAY AND VISIT MAXIMUMS

All day and visit maximums are on a combined In- and Out-of Network basis.

UTILIZATION MANAGEMENT

To make sure you have access to high quality, cost-effective health care, we manage utilization through a variety of programs including certification, transplant management, concurrent and retrospective review.

If you have a concern regarding the final determination of your care, you have the right to appeal the decision. If you would like a copy of a benefit booklet providing more information about our Utilization Management programs, call the toll free number listed in your information packet.

CERTIFICATION

Certification is a program designed to make sure that your care is given in a cost effective setting and efficient manner.

If you need to be hospitalized, you must obtain certification. Non-emergency and non-maternity hospital admissions must be certified prior to the hospitalization. If the admission is not certified, a penalty will be applied.

For maternity admissions, your provider is not required to obtain certification from BCBSNC for prescribing a length of stay up to 48 hours for a normal vaginal delivery, or up to 96 hours for delivery by cesarean section. You or your provider must request certification for coverage for additional days, which will be given by BCBSNC, if medically necessary.

All inpatient and outpatient Mental Health and Substance Abuse services must be certified in advance by Magellan Behavioral Health. In-network providers are responsible for obtaining certifications. The member will bear no financial penalties if the in-network provider fails to obtain the appropriate authorization. The member is responsible for obtaining certification for services rendered by an out-of-network provider. Obtaining certification for Mental Health and Substance Abuse services is the member's responsibility. Failure to obtain certification for Mental Health and Substance Abuse services will result in these services being paid at the out-of-network benefit level.

HEALTH AND WELLNESS PROGRAM

Because we want to help you stay healthy, we offer a variety of wellness benefits and services. You can take advantage of HealthLine Blue, our 24-hour health information service, a health topics library, asthma and diabetes management and a prenatal program. You will also receive Active Blue, our quarterly health magazine, and have access to online health and wellness information at www.bcbsnc.com. With our program you can get health advice anytime you need it, so you can learn how to take charge of your health.

WHAT IS NOT COVERED?

The following are summaries of some of the coverage restrictions. A full explanation and listing of restrictions will be found in your benefit booklet.

Your health benefit plan does not cover services, supplies, drugs or charges that are:

- Not medically necessary
- For injury or illness resulting from an act of war
- For personal hygiene and convenience items
- For palliative or cosmetic foot care
- For investigative or experimental purposes
- For hearing aids or tinnitus maskers

- For cosmetic services or cosmetic surgery
- For custodial care, domiciliary care or rest cures
- For treatment of obesity, except for surgical treatment of morbid obesity, or as specifically covered by your health benefit plan
- For reversal of sterilization
- For treatment of sexual dysfunction not related to organic disease
- For conception by artificial means
- For self-injectable drugs in the provider's office (with the exception of insulin)

A waiting period for coverage of pre-existing conditions may apply to your coverage. BCBSNC defines pre-existing conditions as those conditions for which medical advice, diagnosis, care or treatment was received or recommended within 6 months of the date that your [BCBSNC] coverage begins. You may receive credit toward the 12-month waiting period if your enrollment date is within 63 days of the termination of your previous health coverage.

These benefit highlights are summaries of Blue Options benefits. This is meant only to be a summary. Final interpretation and a complete listing of benefits and what is not covered are in and governed by the group contract and benefit booklet. You may preview the benefit booklet by requesting a copy of the Blue Options benefit booklet from BCBSNC Customer Services.

PPO MONTHLY RATES
(Participating in the Wellness Program)

Employee Only	\$0
Employee + Child(ren)	\$70.00
Employee + Family	\$170.00

(NOT Participating in the Wellness Program)

Employee Only	\$30.00
Employee + Child(ren)	\$100.00
Employee + Family	\$200.00

**FOR CLAIMS OR CUSTOMER SERVICES QUESTIONS PLEASE CALL
BLUECROSS BLUESHIELD OF NORTH CAROLINA AT:**

(877) 258-3334
www.bcbsnc.com



Ameritas Dental Plan

Plan Highlights

- Coverage for Preventive Dental Services
- Coverage for Basic and Major Dental Services
- Coverage for Orthodontics

*A frown is worthless . . .
But a smile is priceless!*



Combined Calendar Year Deductible

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

Type 1 - Preventive and Diagnostic

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

- Evaluations (Two per calendar year)
- Cleanings (Two per calendar year)
- Fluoride for Children (Once a year)
(Under age 19)
- Space Maintainers
- Radiographs (X-rays)
- Bitewings x-rays
(Two per calendar year)

Type 2 - Basic Procedures

- Type 2 benefits are payable at 80-90-100% U&C* \$50.00 deductible applies.

- Oral Surgery
- Restorative Amalgam & Resin
- Endodontics (Root Canal)
- Anesthesia
- Denture Repair
- Sealants (under age 17)

Type 3 -Major Procedures

- Type 3 benefits are payable at 50% U & C* \$50.00 deductible applies.

- Restorative - Crowns
- Prosthodontics-
(Removable Dentures, Partials)
- Prosthodontics - Fixed Pontics
or Abutment

Orthodontia - Adults & Children

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

Benefits will be payable when a Covered Expense is incurred. The Covered Expenses for a program are based on the estimated cost of the insured's program. They are pro-rated by quarter (three month periods) over the estimated length of the program, but not for more than eight quarters. The last quarterly payment for a program may be changed if the estimated and actual cost of the program differ.

100% Preventive, 80-90-100% Incentive

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

If you visit a dentist during each Calendar Year and have at least one covered dental procedure performed while insured under the Company's policy, your Type II (Basic) procedures will advance to the 90% level on the following January 1

*Percentage Paid based on Usual and Customary Charges

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

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

Annual Maximum Benefit

- Type I, 2, and 3 Procedures - \$1,000 per calendar year per person.
- Orthodontia Procedures - \$1,000 Lifetime per person (carryover does not apply)

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

1. Visit a dentist between January 1 and December 31 of 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.

Eligible Employees

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

Eligible Dependents

Provides Coverage On:

- Your Spouse
- Children up to age 19 and unmarried (Up to age 25 if wholly dependent upon you for maintenance and support and if enrolled as a full-time student in an accredited school or college.)

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.

Pre-Determination 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.

Late Entrant Provision

There is a 12 month waiting period on all procedures (except cleanings, exams, and fluoride treatments) for employees who do not enroll within 31 days of becoming eligible for coverage. This provision is waived for employees who enrolled during the initial enrollment period.

Certificate of Insurance

This is a summary of coverage and is not a binding contract. A certificate of coverage will be made available to you shortly which describes the benefits in greater detail. Should there be differences between this summary and the contract, the contract will govern.

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 (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 (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 of benefits under Worker's Compensation Act or similar.

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.

This information is not a guarantee of eligibility or benefits. The benefits shown are subject to policy provisions and the patient's eligibility at the time services are rendered.

MONTHLY RATES

Employee Only	\$0 (Paid by County)
1 Dependent	\$33.24
2 or more Dependents	\$49.44

This insurance is underwritten by Ameritas Life Insurance Corp.

Customer Service

1-800-487-5553

Web Address

www.ameritasgroup.com



Superior Vision Plan

Plan Highlights

- Coverage for Frames and Lenses
- Discounts on Additional Purchases
- Discounts on Upgrades

This Plan provides primary vision care benefits including prescription eyewear and contact lenses offered through a broad-based provider network consisting of ophthalmologists, optometrists and opticians.



Copayment Amount

- \$15.00 Exam
- \$35 Contact Lens Fitting

<i>Benefits</i>	<i>Frequency</i>	<i>In-network</i>	<i>Non-Network</i>
• Comprehensive Exam (by an Ophthalmologist)	12 Months	Covered in Full	Up to \$44.00
• Comprehensive Exam (by an Optometrist)	12 Months	Covered in Full	Up to \$39.00
• Lenses (Standard) per Pair			
• Single Vision	12 Months	Covered in Full	Up to \$34.00
• Bifocal	12 Months	Covered in Full	Up to \$48.00
• Trifocal	12 Months	Covered in Full	Up to \$64.00
• Lenticular	12 Months	Covered in Full	Up to \$88.00
• Contact Lenses (Per Pair)*			
• Medically Necessary	12 Months	Covered in Full	Up to \$210.00
• Cosmetic (Elective)**	12 Months	Up to \$120.00	Up to \$100.00
• Contact Lens Fitting Fee***			
• Standard	12 Months	Covered in Full	Not Covered
• Specialty	12 Months	Up to \$50.00	Not Covered
• Frames (Standard)**	24 Months	Up to \$100.00	Up to \$50.00

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

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

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

Definitions of Contact Lenses

Contact Lenses, Elective/Cosmetic

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

Contact Lenses, Medically Necessary

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

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

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

Contact Lens Examining Fee:

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

Limitations & Exclusions

Limitations (options at additional cost):

The Superior Vision Plan is designed to provide your basic eyewear needs. It does not cover items that are considered cosmetic or elective. The following options will require an additional charge over the covered benefit. Pay any additional charges directly to your provider.

Example: Standard design bifocal lenses are a covered benefit. Blended (no line) bifocal lenses will require an additional charge.

- A frame that costs more than the Plan allowance.
- Additional costs for contact lenses (elective) over the allowance.
- Blended (no-line) and/or multifocal lenses
- Beveled and/or faceted lenses.
- Coating on lenses (anti-scratch, anti-reflective, sunglass colors)
- Cosmetic lenses
- Oversize charge for lenses larger than Plan allowance
- Polycarbonate lenses
- Replacement frames and/or lenses

Exclusions (products & services not covered):

- Professional Services and/or Materials in conjunction with:
 - blended bifocals, no line, or progressive lenses
 - compensated or special multi-focal lenses
 - plain (non-prescription) lenses
 - anti-reflective, scratch, UV400 or any coating or lamination applied to lenses.
 - subnormal vision aids
 - tints other than solid
 - orthoptics, vision training and developmental vision procedures
 - polycarbonate lenses
- Medical or surgical treatment of the eyes
- Any eye examination or any corrective eyewear required by an Employer as a condition of employment
- Any injury or illness when covered under Workers' Compensation or similar law
- Plain or prescription sunglasses, no-line bifocals, blended lenses are not covered, an Insured may elect to apply the maximum allowance for standard lenses toward his or her cost of progressive lenses.
- Subnormal vision aids
- Services rendered or Materials purchased outside the U.S. or Canada, unless:
 - the Member resides in the U.S. or Canada; and
 - the charges are incurred while on a business or pleasure trip
- Charges in excess of the Usual, Customary and Reasonable charge for the Professional Service or Materials
- Experimental or non-conventional treatment or device
- Safety eyewear
- Spectacle lens styles, materials, treatments of "add-ons" not shown in the Benefits Summary
- Services or Materials rendered by a provider other than an Ophthalmologist, Optometrist or Optician acting within the scope of his or her license
- Any additional service required outside basic vision analysis for contact lenses, except fitting fees.
- Services rendered after the date an Insured ceases to be covered under this Certificate, except when vision Materials ordered before coverage ended are delivered and the services rendered to the Insured within 31 days from the date of such order.
- Services rendered or Materials ordered before the date of coverage began under this Certificate
- Regardless of Optical Necessity, benefits are not available more frequently than that which is specified in the Benefits Summary

Discount Programs

Discounts on Additional Purchases

- Eyeframes 30% off
- Lenses (uncoated std glass or plastic) 30% off
- Add-on features 20% off
- Everyday “Frames & Lenses” package pricing 20% off
- Contact Lenses 20% off
- Disposable Contacts 10% off
- Other Items 20% off

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

Note: The discount benefit is available only from Superior Vision Plan in-network providers who are identified in the provider directory with a “DP.”

Discount SVP8-20

These discounts apply to upgrades on the covered frame and lenses only. For discounts on additional pairs, please refer to the Discounts on Additional Purchases.

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

Lens Options and Upgrades

Member pays 20% off retail up to

- Scratch Coat (Factory) \$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)
- Plastic Tints solid or gradient \$25(Any Type Lenses)
- Glass coloring \$35(Any Type Lenses)

Member pays

- Power over 4.00 Sphere, 2.00D Cylinder & 5.00D Prism 20% discount off retail
- Cosmetic Finishing, Beveling, Edging & Mounting 20% discount off retail
- All other Lens Options/Upgrades 20% discount off retail

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

Progressive Power Lens Benefit (no-line): The member pays the difference between the provider's price for Standard Trifocal lenses and the price of the progressive power lenses selected, less 20%.

How to use your benefit

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

1. Identify yourself to the in-network provider as a member of the Superior Vision Plan. You can use your ID card for this purpose or simply give the provider your name, employer name, and your social security number. The provider will call SVS Member Services to verify your eligibility and obtain an authorization number. The ID card provided to you can be used for all covered family members.

2. After eligibility is established, and an authorization number is received by the provider, services will be rendered. There is nothing else that you need to do except pay the provider directly for any appropriate copayments and charges above the covered benefits. The in-network provider handles all claims and paperwork.

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

1. To receive services from a non-network provider, it is important that you first call Superior Vision Services Member Service Department at 800-507-3800 to receive your own authorization number. By doing so, you can be assured of your eligibility and reimbursement for money spent.

2. After receiving services and paying in-full for the examination and/or materials (you do not pay a copayment to the non-network provider), submit your original itemized billing received from the provider, along with your authorization number, to the SVS Claims Administration office listed on the next page.

3. You will be reimbursed according to the schedule of allowances for non-network providers, less any required copayments.

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

MONTHLY RATES

Employee Only	\$10.80
Employee/One Dependent	\$20.96
Employee/Family	\$30.80



Member Services, Provider Listings and Claims Services:

1-800-507-3800

916-852-2277 (FAX)

Provider Nominations:

Lee Sims @ 800-923-6766 x254

Web Site: www.superiorvision.com

Address:

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

Non-network Claims Submission:

Superior Vision Services, Inc.
P.O. Box 967
Rancho Cordova, CA 95741

This 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.

Group Term Life Plan

Plan Benefits

- Basic Employee Coverage
- \$10,000
- Additional Employee Coverage
- up to \$200,000
- Dependent Coverage
- Additional Coverage for
Accidental Death

This insurance is underwritten by:



Basic Employee Life Insurance

This insurance is payable for death from any cause to any person you name as beneficiary.

Voluntary Employee Life Insurance

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

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

Voluntary Dependent Life Insurance

Provides coverage on:

- Your Spouse
- Child(ren) from 15 days to age 19 (to age 25 if wholly dependent upon you for maintenance and support 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.

Accidental Death and Dismemberment

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

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 initial enrollment 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 plan which is underwritten by Lincoln Financial - a leader in the field of group coverage.

Eligibility

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

Enrollment

Enrollment is simple - just fill out the application provided by your employer. Make sure you supply all the required information and return the form. 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 Voluntary 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 Voluntary Dependent Life Insurance, that coverage will become effective on the date your Voluntary 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 Voluntary Life Insurance until such person has furnished medical evidence of insurability satisfactory to Lincoln Financial.

Termination of Coverage

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

Disability

If an insured becomes totally disabled prior to age 60, the amount of life insurance will be continued without payment of premium provided evidence of disability is submitted annually. The amount of insurance is subject to any reductions due to age and the waiver of premium provision terminates at age 70.

The Accelerated Benefit Option (ABO)

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

Reductions At Age 65 & Over

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

<u>Attained Age</u>	<u>Percent of Original Amount</u>
65	65%
70	40%
75	25%

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 Lincoln Financial 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 Voluntary Employee Life Insurance and Dependent Life Insurance as well as the Basic Employee Life Insurance.

Suicide Exclusion

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

ERISA Information

The Plan Administrator, Sponsor and Agent for Service of Legal Process is:

Sampson County Government
435 Rowan Rd
Clinton, NC 28376

For disputes arising under the plan, service of legal process may be made on the plan administrator. For disputes arising under the insurance contract, service of legal process may be made upon Lincoln Financial at one of its local offices, or upon the supervisory official of the Insurance Department in the state in which you reside.

Claims Procedure

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. 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.

Basic Employee Life Insurance and AD&D

All Eligible Employees (No cost to you) \$10,000

Voluntary Employee Life Insurance

You may purchase additional life insurance from \$10,000 to \$200,000 in increments of \$10,000. Benefit may not exceed 5 times your salary.

Voluntary Spouse Life Insurance

You may purchase life insurance on your spouse in the amounts of \$5,000 up to 2.5 times your annual salary in \$5,000 increments.

*Spouse coverage cannot exceed more than 50% of Employee's coverage.

**The Spouse amount reduces by 35% at Employee's age 65, and terminates at Employee's age 70.

Guaranteed Issue For Initial Enrollment

Employees under age 60	\$200,000
Employees ages 60-69	\$10,000
Employees ages 70+	None - any amount will be underwritten
Spouses	\$30,000.

There is no guarantee issue for Employees, age 70 and over, or the Spouse of an Employee, if the employee is age 60 and over.

After the initial eligibility period, evidence of insurability must be furnished to enroll or to request an increase.

Voluntary Dependent Child Life Insurance

You may purchase \$10,000 on each of your eligible children at a cost of \$2.00 regardless of the number of children.

This brochure has been prepared to give you the highlights of coverage now being offered by your employer 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 enrolled in the plan.

Continuing Your Benefits

Upon Termination of Employment

To Continue Your Medical, Dental, or Vision Plan

Under the group medical, dental and vision plan, you and your covered dependents are eligible to continue coverage through COBRA for a specified period. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents may be eligible to continue 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. For more information, contact Interactive Medical System at 800-426-8739.

To Convert Your Term Life Insurance

When you leave your employment, you may convert the existing group term coverage you have through your employer to a guaranteed issue individual whole life policy. You also have the option of porting your existing coverage as well. It is the responsibility of the employee to convert or port coverage. You must apply for conversion or portability within 31 days from the date your employer terminates your term life coverage. For more information and a quote, please contact Lincoln Financial at 800-423-2765. If you do not convert or port your group term life insurance, coverage will terminate when you leave your employer.

Contact Information for Questions and Claims

BlueCross BlueShield of NC

Customer Service:

1-877-258-3334

www.bcbsnc.com

Ameritas Dental

1-800-487-5553

www.ameritasgroup.com

Superior Vision

11101 White Rock Rd, Suite 150

Rancho Cordova, CA 95670

1-800-507-3800

www.superiorvision.com

Non-Network Claims Submission:

PO Box 967

Rancho Cordova, CA 95741

Mark III Brokerage

211 Greenwich Rd

Charlotte, NC 28211

1-800-532-1044

www.markiiibrokerage.com/sampsoncountync