Cumberland County Government offers 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, work-related childcare, and unreimbursed medical expenses before taxes are taken out of your paycheck. Paying for these benefits in this method reduces your taxes and increases your take home pay. The Cafeteria Benefits program includes both pre-taxed and after-taxed benefits.

- The Plan Year is from July 1st to June 30th.
- A Mark III representative will be conducting individual meetings at all scheduled locations.

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PRE-TAX BENEFITS

AFTER-TAX BENEFITS

(This booklet highlights the benefits offered through your employer for the current plan year. **This is <u>not</u> 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

- Plan Year: July 1, 2012 thru June 30, 2013.

- Payroll deductions for this year's enrollment will start on July 6, 2012.

- **Cumberland County Government has elected Allstate as the new cancer carrier. Alltstate is offering guaranteed issue coverage.** For employees that are currently enrolled in the Assurity Cancer Plan, ***you will be required*** to see a Mark III representative to **re-elect** your cancer coverage with the new carrier. Your existing coverage ***WILL NOT*** rollover automatically for this product. If you do not see a Mark III representative, you ***WILL LOSE*** your cancer coverage thru payroll deduction and will need to contact Assurity to set up on direct bill..

- **Cumberland County Government has elected AUL/One America as the new short-term disability carrier**. **AUL is offering guaranteed issue coverage.** For employees that are currently enrolled in the Standard Life Short-Term Disability Plan, your coverage ***WILL*** automatically rollover to the new carrier to the benefit you currently have. If you would like to make changes, you must see a Mark III Representative.

- **NEW Ameritas PPO Dental Plan**

There will be a second option available for the Dental Plan effective July 1, 2012. The PPO Plan mirrors the current Plan with the following differences:

- You may only use an In-Network provider.
- In-Network providers have a lower negotiated rate for procedures. You can obtain a PPO Provider List online or from a Mark III Representatiave.
- Lower Premiums than current Plan.

To promote the new PPO Plan, Ameritas has granted an open enrollment. This means that employees and dependents that enroll in the PPO Plan during this year's Annual Enrollment Period (April 2nd – May 1st, 2012) will not be subject to the normal waiting periods. ***Please note: The open enrollment applies to the PPO Dental Plan ONLY.***

- A **Funeral Planning Service** has been added to the current Aetna Term Life Plan with no additional cost. Please see booklet for more details regarding this benefit.

- Participants are required to have a prescription for Over-the-Counter ("OTC") drugs/medicines to be eligible under their FSA plan.

- 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 enrollments and FSA elections. All requests must be done in writing to Julie Crawford in the Cumberland County 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. The debit card card is 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.

• Questions regarding all other benefits can be directed to Julie Crawford at 910-223-3327.

BCBS Medical Plan - Summary of Benefits

Effective Date: July 1, 2012

	In-network	Out-of-network[1]
Physician Office Services		
(See Outpatient Services for "outpatient clinic" or "hospital-based" services).		
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. See "Inpatient & Outpatient Services".		
Primary Care Provider	$30 copayment	70% after ded
Specialist	$60 copayment	70% after ded
Preventive Care		
Routine Examinations, Well-Child Care, Immunizations, Pap Smears, Mammograms, Prostate Specific Antigen Test (PSAs)		
Primary Care Provider	100%	Not Available*
Specialist	100%	Not Available*
*Pap Smears, Mammograms and PSAs are covered Out-of-Network		
Therapies		
Short-term Rehabilitative Therapies (Maximums apply to Home, Office & Outpatient Settings)		
Physical/Occupational: 30 visits per Benefit Period		
Speech Therapy: 30 visits per Benefit Period		
Primary Care	$30 copayment	70% after ded
Specialist	$60 copayment	70% after ded
Urgent Care Centers and Emergency Room		
Urgent Care Centers	$60 copayment	$60 copayment
Emergency Room Visit	80% after ded	80% after ded
If held for observation, outpatient benefits apply. See "Inpatient & Outpatient Hospital Services".		
Ambulatory Surgical Center	80% after ded	70% after ded
Inpatient and Outpatient Hospital Services		
Hospital & Hospital-Based Services	80% after ded	70% after ded
Outpatient Clinic Services	80% after ded	70% after ded
Professional Services	80% after ded	70% after ded
Hospital & Professional		
Outpatient Labs & Mammograms with surgery or other services	80% after ded	70% after ded
Outpatient Labs & Mammograms without surgery or other services	100%	70% after ded
Outpatient X-rays, ultrasounds, and other diagnostic tests such as EEGs & EKGs	80% after ded	70% after ded
CT scans, MRI's, MRA's, and PET scans in any location, including physician's office	80% after ded	70% after ded

	In-network	Out-of-network[1]
Other Services		
Skilled Nursing Facility (60 days per benefit period)	80% after ded	70% after ded
Home Health Care, Ambulance, Durable Medical Equipment & Hospice	80% after ded	70% after ded
Maternity		
Maternity Delivery includes Prenatal & Post-delivery care		
Hospital Services *(Delivery)*	80% after ded	70% after ded
Professional Services *(Delivery)*	80% after ded	70% after ded
Transplants		
Hospital Services	80% after ded	70% after ded
Professional Services	80% after ded	70% after ded
Infertility Services		
Up to $5,000 per Lifetime		
Primary Care Provider	$30 copayment	70% after ded
Specialist	$60 copayment	70% after ded
Hospital Services	80% after ded	70% after ded
Inpatient & Outpatient Professional Services	80% after ded	70% after ded
Vision Care		
Comprehensive Eye Exam	$30 copayment	Not Available

Lifetime Maximum, Deductibles, and Coinsurance Maximums

The following Deductibles and Coinsurance Maximums only apply to the services above & on the previous page and Mental Health and Substance Abuse services below:

Lifetime Benefit Maximum	Unlimited	Unlimited
Deductibles		
Individual (per benefit period)	$1,000	$2,000
Family (per benefit period)	$3,000	$6,000
Coinsurance Maximum		
Individual (per benefit period)	$2,000	$4,000
Family (per benefit period)	$6,000	$12,000

Mental Health & Substance Abuse Services	**Certified***	**Not-Certified[1]**
*Inpatient/Outpatient Certification is required. Call Magellan Behavioral Health at 1-800-359-2422.		
Mental Health Services		
Office/Outpatient	$60 copayment	70% after ded
Inpatient/Outpatient	80% after ded	70% after ded
Substance Abuse Services		
Office Visit/Outpatient	$60 copayment	70% after ded
Inpatient	80% after ded	70% after ded

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 Pricing, Brand Penalty

Tier 1 (Generic)	$10 copayment	Copayment + charge over In-network allowed amount
Tier 2 (Preferred Brand)	$45 copayment	Copayment + charge over In-network allowed amount

	In-network	Out-of-network[1]
Tier 3 (Brand)	$60 copayment	Copayment + charge over In-network allowed amount
Tier 4 (Specialty Brand)	75% coinsurance	Copayment + charge over In-network allowed amount

There is a $50 per Drug Minimum for each 30-day supply of Tier 4 Specialty Brand drugs.

There is a $100 per Drug Maximum for each 30-day supply of Tier 4 Specialty Brand drugs.

ADDITIONAL INFORMATION ABOUT BLUE OPTIONS 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 that 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 and care management.

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. Office visits do not require certification. 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 Healtand 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 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
- For reversal of sterilization
- For treatment of sexual dysfunction not related to organic disease
- For conception by artificial means

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.

The benefit highlights is a summary 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 found 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.

The benefit highlights is a summary of BCBSNC 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 BCBSNC benefit booklet from BCBSNC Customer Services.

	MONTHLY RATES	**PER PAY PERIOD RATES**
Employee Only	$51.00	$25.50
Employee + Child	$157.00	$78.50
Employee + Children	$254.00	$127.00
Employee + Spouse	$241.00	$120.50
Employee + Family	$326.00	$163.00

DISCOUNTED RATES WITH WELLNESS FAIR PARTICIPATION

	MONTHLY RATES	**PER PAY PERIOD RATES**
Employee Only	$21.00	$10.50
Employee + Child	$127.00	$ 63.50
Employee + Children	$224.00	$112.00
Employee + Spouse	$211.00	$105.50
Employee + Family	$296.00	$148.00

FOR CLAIMS/CUSTOMER SERVICE
PLEASE CALL: 1-877-258-3334
website address: www.bcbsnc.com

FSAs and Healthcare Reform
What The New Legislation Means To You

WILL HEALTHCARE REFORM LAWS AFFECT MY FLEXIBLE SPENDING ACCOUNT (FSA)?
Yes. The new healthcare reform legislation will significantly change the landscape of cafeteria plans, including FSAs.

CAN I STILL USE MY FSA FUNDS FOR OVER-THE-COUNTER (OTC) MEDICATIONS?
Medications and drugs (other than insulin) are longer reimbursed by an FSA unless they are accompanied by a doctor's prescription. Medication or drugs must meet one of the following criteria to be eligible for reimbursement.

1. The medicine or drug requires a prescription.

2. The medicine or drug is available without a prescription and the individual obtains a prescription.

3. The medicine or drug is insulin.

Not all OTC expenses are excluded from reimbursement. Items such as adult diapers, bandages, first aid kits, diabetes monitors, and test strips may still be purchased on a pre-tax basis, with reimbursable funds, without a doctor's prescription. A final list of approved OTC items has not been released by the U.S. Department of Health and Human Services.

AM I STILL ABLE TO USE MY FSA DEBIT CARD FOR ELIGIBLE EXPENSES?
Most retailers cannot distinguish which OTC medications and drugs are prescribed. Therefore, individuals may not use an FSA debit card to purchase OTC medications or drugs. Additionally, even though certain OTC expenses are still eligible for reimbursement with FSA funds, you may not use your FSA debit card for these eligible purchases. Individuals must submit an online claim for reimbursement of these items.

OTC medications must be substantiated by submitting the prescription (or a copy of the prescription or other documentation that a prescription has been issued) when the claim is filed with Gilsbar.

HOW CAN I SUBMIT AN ONLINE CLAIM?

1. Login to **www.myGilsbar.com**.
2. Select FSAs and HRAs.
3. Click *New Reimbursement Request* found in the center box labeled Recent Reimbursement Requests.
4. Click *Request Reimbursement* for the appropriate account.
5. Select the Claim Category from the drop down menu and click *Next*.
6. Fill in the Claim Type, Amount, Provider, and Service From Date(s) fields. Click *Next.*
7. Review the data entered. If you need to make an edit, click *Modify*. If everything is correct, click *Finish*.
8. Repeat Steps 4 – 6 if you need to enter multiple claims. When finished, click *Submit all Entered Claims for Processing*.
9. Select the box next to the statement "I hereby certify that all items..." and click *Confirm*.
10. Print a copy of the confirmation page with transaction number for your records.
11. Download the Fax Coversheet by selecting the link labeled *Click Here*.
12. Fax a copy of the Fax Coversheet and your receipt(s) to (866) 635-1329*.

* It is necessary to submit a faxed copy of your receipt(s) including a description of services in order to fully process the claim(s). Please attach a copy of your doctor's prescription or documentation that a prescription was issued when you submit your claim.

Because the majority of OTC medications and drugs are no longer eligible for reimbursement, this may affect how much you choose to contribute to your FSA. Remember, as a general rule, the IRS requires that all money in the account be used during the plan year.

Money cannot be returned to you or carried over to the following year. For this reason, it is better to underestimate your expenses at the beginning of the plan year when you decide your contribution amount.

Gilsbar Flexible Spending Accounts (General Overview)

Plan Year: July 1, 2012 - June 30, 2013
Medical Reimbursement Plan Maximum: $2,400
Dependent Care Account Maximum: $5,000
Run-out Period: 90-days following end of plan year

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 FSA and HRA links 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 “FSAs and HRAs” 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, 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

Alcoholism Treatment

Ambulance

Anesthetists

Artificial limbs

Birth control pills (by prescription)

Blood tests

Braces

Braille books and magazines

Cardiographs

Chiropractor

Christian Science Practitioner

Contact lenses

Contraceptive devices

Convalescent home (for medical treatment only)

Crutches

Dental treatment

Dental x-rays

Dentures

Dermatologist

Diagnostic fees

Drug addiction therapy costs

Drugs (prescription)

Equipment (medical)

Eye exams and eyeglasses

FICA and FUTA tax for the handicapped

Guide dog

Gynecologist

Healing service

Hearing aid and batteries

Hospital bills

Hydrotherapy

Immunizations

Insulin treatments

Lab tests

Lead paint removal

Legal fees (to authorize treatment for a mental illness

Lodging away from home for outpatient care

Medical services

Medical Testing

Metabolism tests

Neurologist

Nursing (including board and meals)

Obstetrician

Operating room costs

Ophthalmologist

Optician

Oral surgery

Organ transplant (including donor's expenses)

Orthodontist

Orthopedic shoes

Orthopedist

Osteopath

Over-the-counter medications **

Oxygen

Paid-for medical care service

Pediatrician

Physician

Physiotherapist

Postnatal treatments

Practical nurse

Prenatal care

Prescription medicines

Psychiatrist

Psychoanalyst

Psychologist

Psychotherapy

Radium Therapy

Registered nurse

Special School

Spinal fluid tests

Splints

Sterilization

Stop smoking programs

Surgeon

Telephone equipment to assist the hearing impaired

Television equipment for the hearing impaired

Therapy equipment

Transplants (organ)

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 (.23) cents per mile.)

Ultra-violet ray treatment

Vaccines

Vasectomy

Vitamins (if prescribed)

Weight loss programs* (not food)

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

Any expense for your general health, even if your doctor prescribes the program

Babysitting and childcare

Bleaching teeth (cosmetic)

Cosmetic surgery

Dancing lessons

Diaper service

Dietary supplements

Electrolysis

Face lifts

Food

Funeral, cremation, or burial expenses

Hair transplants

Health club membership dues

Household help

Illegal operations and treatments

Insurance premiums

Laetrile

Liposuction

Marijuana used medically

Maternity clothes

Personal use items

Prescription drugs considered cosmetic

Rogaine

Swimming lessons

Vitamins

Over the Counter Drugs

Please be advised that participants are required to have a prescription for Over-the-Counter ("OTC") drugs/medicines to be eligible under their FSA plan.

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
Antacuds 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 smoking 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 Card

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, 2011, Over the Counter (OTC) are only eligible with a prescription. You must submit the prescription with the receipt for reimbursement.

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?
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 25123 /Lehigh Valley, PA 18002-5123 / 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 25123 / Lehigh Valley, PA 18002-5123*
(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 S2544.**
Access the MyGilsbar.com Website to Manage your Account 24/7!

- ☒ View plan year balance
- ☒ Set up or edit ACH/Bank Draft information*
- ☒ Check claim status
- ☒ View claim/ receipt images within 24 hours
- ☒ Obtain claim forms
- ☒ Set up email messaging
- ☒ View payments and payment dates
- ☒ 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 *FSA and HRA* sections 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. A claim is received
b. The claim/receipt images are ready to view online
c. 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.

For Fastest Processing, FAX Claims and Receipts to: 1-866-635-1329 Mail Claims and Receipts to: Claims Processing Center PO Box 25123 Lehigh Valley, PA 18002-5123 ***(Please keep your originals)***	**Customer Contact Center** **7:00 AM – 7:00 PM Central Time** **Phone: 1-800-445-7227 ext. 883 Email: flex@gilsbar.com** (Please do not email claims/receipts)

Ameritas Dental Plan - Standard

Effective Date: July 1, 2012

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

- Evaluations (Two per calendar year)
- Cleanings (Two per calendar year)
- Fluoride for Children (Under age 19)
- Space Maintainers
- Radiographs (Xrays)
- Bitewings (Two per calendar year)

TYPE II - BASIC PROCEDURES - Type II benefits are payable at **80-90-100%** U&C*. $50.00 deductible applies.

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

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

- Endodontics (Root Canal)
- Periodontics (Gum Disease)
- Crowns - Stainless Steel
- Restorative
- Prosthodontics - Removable Dentures, Partials
- Prosthodontics - Fixed Pontics or Abutment

ORTHODONTIA (INCLUDES CHILDREN & ADULTS) - Benefits are payable at 50% U&C with a lifetime maximum of $1,000.00. 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.

**Usual and Customary Charge*

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 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, II, and III Procedures - $1,000* per calendar year per person.
- Orthodontia Procedures - $1,000 Lifetime per person (carry over 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 26 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.

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.

LATE ENTRANT

If you do not elect to participate in the dental program when first eligible, you will be considered a **Late Entrant** and you must wait 12 months for most benefits. If an employee or dependent does not elect to participate when initially eligible, and elects to participate at the policyholders next annual election period, they will become a **Late Entrant.** For a **Late Entrant**, benefits will be limited to exams, cleanings and fluoride applications for the first 12 months. The late entrant provision is waived if the employee comes on the plan as a result of a qualifying event.

SECTION 125

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

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

ORTHODONTIA LIMITATIONS

(This is not a complete list)

No benefit is payable for expenses incurred:

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

LIMITATIONS/EXCLUSIONS

(This is not a complete List)

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

	Monthly Rates	**Bi-Weekly Rates**
Employee Only	**$32.83**	**$16.42**
Employee plus 1	**$66.29**	**$33.15**
Employee plus 2 or more	**$98.18**	**$49.09**

This insurance is underwritten by Ameritas Life Insurance Corp.

AMERITAS LIFE INSURANCE CORP.

For Claims/Customer Service call Ameritas: 1-800-487-5553

www.ameritasgroup.com

Ameritas Dental Plan - PPO

Effective Date: July 1, 2012

To access the full value of the PPO Plan, you are strongly encouraged to utilize In-Network providers. If you are not planning to utilize an In-Network Provider, do not enroll in the PPO Plan or your Out-of-Network benefits will be significantly reduced. Out-of-Network benefits will be paid based on the maximum allowable charge.

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 AND DIAGNOSTIC - Type I benefits are payable at 100% MAC*. No deductible applies.

- Evaluations (Two per calendar year)
- Cleanings (Two per calendar year)
- Fluoride for Children (Under age 19)
- Space Maintainers
- Radiographs (Xrays)
- Bitewings (Two per calendar year)

TYPE II - BASIC PROCEDURES - Type II benefits are payable at **80-90-100%** MAC*. $50.00 deductible applies.

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

TYPE III - MAJOR PROCEDURES - Type III Benefits are payable at 50% MAC*. $50.00 deductible applies.

- Endodontics (Root Canal)
- Periodontics (Gum Disease)
- Crowns - Stainless Steel
- Restorative
- Prosthodontics - Removable Dentures, Partials
- Prosthodontics - Fixed Pontics or Abutment

ORTHODONTIA (INCLUDES CHILDREN & ADULTS) - Benefits are payable at 50% MAC with a lifetime maximum of $1,000.00. 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.

**Maximum Allowable Charge*

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 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, II, and III Procedures - $1,000* per calendar year per person.
- Orthodontia Procedures - $1,000 Lifetime per person (carry over 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 26 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.

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.

LATE ENTRANT

If you do not elect to participate in the dental program when first eligible, you will be considered a **Late Entrant** and you must wait 12 months for most benefits. If an employee or dependent does not elect to participate when initially eligible, and elects to participate at the policyholders next annual election period, they will become a **Late Entrant.** For a **Late Entrant**, benefits will be limited to exams, cleanings and fluoride applications for the first 12 months. The late entrant provision is waived if the employee comes on the plan as a result of a qualifying event.

SECTION 125

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

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

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.

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.

	Monthly Rates	**Bi-Weekly Rates**
Employee Only	**$29.98**	**$14.99**
Employee plus 1	**$60.54**	**$30.27**
Employee plus 2 or more	**$89.66**	**$44.83**

This insurance is underwritten by Ameritas Life Insurance Corp.

AMERITAS LIFE INSURANCE CORP.

For Claims/Customer Service call Ameritas: 1-800-487-5553

www.ameritasgroup.com

Ameritas PPO Dental Plan

PLAN HIGHLIGHTS

Beginning July 1, 2012, Cumberland County Government will offer a second option under the Ameritas Dental Plan. The PPO Plan will mirror the current Standard Plan with a few differences:

LOWER PREMIUMS

• Compared to the Standard Plan, the PPO Plan can save you $34.20 - $102.24 per year depending on your level of coverage.

	MONTHLY		ANNUAL SAVINGS
	Standard Plan	PPO Plan	
Employee	$32.83	$29.98	$34.20
Employee + 1	$66.29	$60.54	$69.00
Employee + 2 or more	$98.18	$89.66	$102.24

LOWER PROCEDURE COSTS

• To access the full value of the PPO Plan, you are strongly encouraged to utilize In-Network providers. If you are not planning to utilize an In-Network Provider, do not sign up for the PPO Plan or your Out-of-Network benefits will be significantly reduced.

• All In-Network Providers have a lower negotiated rate for procedures. This not only saves you money out-of-pocket, but also allows you to get more out of your Annual Maximum Allowance.

• Please see below for examples of cost savings.

Procedure (Code)	% covered under plan[1]	Out-of-Network Cost[2]	Your Cost	In-Network Cost[3]	Your Cost	Savings[4]
Exam (D120)	100%	$49	**$0**	$35	**$0**	**$0**
Cleaning (D1110)	100%	$88	**$0**	$64	**$0**	**$0**
Filling (D2330)	80%	$166	**$33.20**	$108	**$21.60**	**$11.60**
Simple Extraction (D7140)	80%	$173	**$34.60**	$102	**$20.40**	**$14.20**
Crown (D6750)	50%	$1,100	**$550**	$766	**$383**	**$167**
Pontic (Bridge) (D6240)	50%	$1,100	**$550**	$750	**$375**	**$175**

1 - $50 deductible per covered individual per calendar year applies for Type 2 (Basic) and Type 3 (Major) Procedures.

2 - Cost represents Usual & Customary Charges in the Fayetteville area

3 - Cost represents the Maximum Allowable Benefit for In-Network Providers

4 - Savings is your total out-of-pocket savings. You are also saving on dollars applied toward your Annual Maximum Allowance.

Ameritas PPO Dental FAQ

Commonly Asked PPO Questions

Cumberland County Government wants employees to have options regarding their dental benefits. You have a choice of enrolling in the PPO plan or the Non-PPO plan. Both plans are administered by Ameritas and the benefits in each plan are very similar. The key difference in the PPO and Non-PPO option is the decision of utilizing one of the many participating network providers or choosing to use a non-network provider when seeking dental services. Utilizing a network provider will allow greater cost savings opportunities in terms of your premium dollars as well as out of pocket costs.

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 panels 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?

As noted above, you have a choice of enrolling in the PPO plan or the Non-PPO plan.

If you elect to enroll in the PPO option, it is strongly advised that you and your covered dependents utilize one of the many available network providers when seeking dental services. Members enrolling in the PPO plan should absolutely utilize a participating provider for all procedures and services in order to benefit from the plan and the Maximum Allowable Charge (MAC) reimbursement tied to the PPO option.

For members enrolling in the Non-PPO option, you can choose to visit any provider. Non-panel providers will charge their standard fees and Ameritas will reimburse based on the 90th U&C. The 90th U&C reimbursement means that 9 out of 10 dentists in an area are within our reimbursement allowance. The 90th U&C is the highest in the industry and does provide a strong reimbursement.. That said, unlike the Ameritas PPO providers, non-panel providers have no specific

• 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 PPO or the plan, please call:
Ameritas Group Claims Department at 800-487-5553

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

This insurance is underwritten by Ameritas Life Insurance Corp.

Customer Service

1-800-487-5553

Web Address

www.ameritasgroup.com

AMERITAS
LIFE INSURANCE CORP.

Superior Vision Plan

Effective Date: July 1, 2012

Outline of Benefits Platinum Preferred Plan with Materials Discount

Co-pays:

Comprehensive Eye Exam	$10
Materials	$10
Contact Lens Fitting	$25

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.

Benefits

	FREQUENCY	IN-NETWORK	NON-NETWORK
Comprehensive Exam			
Ophthalmologist	12 Months	Covered in Full	Up to $44.00
Optometrist	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
Progressive	12 Months	Covered to providers retail trifocal price	Up to $64.00
Contact Lenses (Per Pair)[2]			
Medically Necessary	12 Months	Covered in Full	Up to $210.00
Cosmetic (Elective)[3]	12 Months	Up to $150.00	Up to $100.00
Contact Lens Fitting[4]			
Standard	12 Months	Covered in Full	Not Covered
Specialty	12 Months	Up to $50.00	Not Covered
Frames -Standard[3]	24 Months	Up to $150.00	Up to $77.00

1 All in-network and out-of-network allowances are at the retail value.
2 Contact lenses are in lieu of eyeglass lenses and frames benefits.
3 The insured is responsible for paying any charges in excess of this allowance.
4 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.

Discount Features[5]

Look for providers in the Provider Directory who accept discounts; please verify their discounts prior to service.

Discounts on Covered Materials

Frames:	20% off amount over allowance
Lens options:	20% off retail
Progressives:	20% off amount over retail lined trifocal lens, including lens options

The following options have out-of-pocket maximums on standard plastic single vision lenses, and select options are available on standard bifocal and trifocal lenses. Out-of-pocket maximums are not available on premium options or progressives.

	Maximum Member Out-of-Pocket	
	Single Vision	Bifocal & Trifocal
Scratch coat	$13	$13
Ultraviolet coat	$15	$15
Tints, solid or gradients	$25	$25
Anti-reflective coat	$50	$50
Polycarbonate	$40	20% off retail
High-index 1.6	$55	20% off retail
Photochromic	$80	20% off retail

Discounts on Non-Covered Exam and Materials[5]

Superior Vision offers discounts on an unlimited number of materials after the member has exhausted their covered benefit.

Exams, frames, and prescription lenses:	30% off retail
Lens options, contacts, other prescription materials:	20% off retail
Disposable contact lenses:	10% off retail

Refractive Surgery[5]

Superior Vision has a nationwide network of refractive surgeons and partnerships with leading LASIK networks (QualSight, TruVision, and LasikPlus) who offer members a discount. These discounts range from 20%-50%, and are the best possible discounts available to Superior Vision.

[5]Discounts and maximums may vary by lens type. Please check with your provider. The discount features are not insurance. The plan does not make payments directly to the providers of discounted health care services; the plan beneficiary pays for the discounted health care services.

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

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. For a list of these, please see your benefits administrator. Please confirm the details of your employer's plan prior to seeking services.

	Monthly Rates	Bi-Weekly Rates
Employee Only	**$9.70**	**$4.85**
Employee + 1	**$18.80**	**$9.40**
Employee + Family	**$27.60**	**$13.80**

Superior Vision Contacts

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

Explanation of benefits
Provider locator; provider nomination
Claims inquiries
Authorization numbers (out-of-network)
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®
Our Members. Our Mission.

Allstate Benefits (AB) Group Cancer Plan

In the United States, about 1,529,560 new cancer cases were expected to be diagnosed in 2010. [1]

Group Voluntary Cancer

If you suddenly become diagnosed with cancer, it can be difficult on your family's financial and emotional stability. Having the right coverage to help when you are sick and undergoing treatment or when you cannot work is important. Our cancer insurance can help provide security when you need it most.

Meeting Your Needs:

Our cancer coverage can help offer you and your family members financial support during a period of unexpected illness.

- Benefits will be paid directly to you unless otherwise assigned
- Coverage can be purchased for you and your entire family
- No evidence of insurability required at initial enrollment for new hires
- Waiver of premium after 90 days of disability due to cancer for as long as your disability lasts*
- Includes coverage for 29 other specified diseases**
- Convertible coverage

Benefit Coverage Highlights

Group Voluntary Cancer Insurance offers you coverage should you be diagnosed with cancer or 29 specified diseases. It helps protect you and your family 24 hours a day, seven days a week.

Each pre-packaged plan doesn't just cover you; if you choose, it also covers your dependents (which can include spouse, domestic partner and children). Our valuable coverage can help supplement your traditional medical insurance which may only cover a small portion of the non-medical expenses that can be incurred with such a diagnosis as cancer.

You and each covered family member can be sure they will receive:

- Benefits that can be used to help pay for treatment, hospital stays, transportation, and more!
- Easy enrollment without required evidence of insurability for qualified employees
- Benefit coverage that includes 29 other specified diseases

A cancer diagnosis can mean unforeseen expenses that may be difficult to pay. Hospital stays, medical or surgical treatments, and transportation by air or ground ambulance can add up quickly and be very costly. Our Group Voluntary Cancer Supplemental Insurance helps offset some of the expenses your health insurance may not cover, so you can focus on getting well.

**Primary insured only*

List of covered disease on page 42

[1] ***Cancer Facts & Figures, American Cancer Society, 2010***

In the U.S., men have slightly less than a 1 in 2 lifetime risk of developing cancer, for women, the risk is a little more than 1 in 3.[2]

Your Benefit Coverage

Benefits are paid for cancer and specified diseases and can help cover the costs of specific treatments and expenses as they happen. Terms and conditions for each benefit will vary.

Specified Diseases

Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease), Muscular Dystrophy, Poliomyelitis, Multiple Sclerosis, Encephalitis, Rabies, Tetanus, Tuberculosis, Osteomyelitis, Diphtheria, Scarlet Fever, Cerebrospinal Meningitis (bacterial), Brucellosis, Sickle Cell Anemia, Thallasemia, Rocky Mountain Spotted Fever, Legionnaire's Disease (confirmation by culture or sputum), Addison's Disease, Hansen's Disease, Tularemia, Hepatitis (Chronic B or Chronic C with liver failure or Hepatoma), Typhoid Fever, Myasthenia Gravis, Reye's Syndrome, Primary Sclerosing Cholangitis (Walter Payton's Liver Disease), Lyme Disease, Systemic Lupus Erythematosus, Cystic Fibrosis and Primary Biliary Cirrhosis.

Continuous Hospital Confinement

A $100 benefit will be paid for each day of continuous hospital confinement for the treatment of cancer or specified diseases.

Government or Charity Hospital

A $100 benefit will be paid for each day a covered person is confined to:

(1) a hospital operated by or for the U.S. Government (including the Veteran's Administration);

(2) a hospital that does not charge for the services it provides (charity). This benefit is paid in lieu of all other benefits in the policy (except Waiver of Premium Benefit).

Surgery

Up to a $3,000 benefit will be paid** when a covered surgery (**amount per surgery depends on surgery) is performed on a covered person. This benefit pays the actual charges, up to the amount listed in the Schedule of Surgical Procedures for the specific procedure. Two or more procedures performed at the same time through one incision or entry point are considered one operation; AB pays the amount for the procedure with the greatest benefit. AB pays for a covered surgery performed on an outpatient basis at 150% of the scheduled benefit. This benefit does not pay for surgeries covered by other benefits in the Schedule of Benefits.

2 Cancer Facts & Figures, American Cancer Society, 2010.

Second Opinion

A $400 benefit will be paid for a second opinion, if physician recommends surgery or treatment for covered condition. This second opinion must be rendered prior to surgery or treatment being performed, and obtained from a physician not in practice with the physician rendering the original recommendation.

Physical or Speech Therapy

A $50 benefit will be paid per day for physical or speech therapy for restoration of normal body function.

Anesthesia

25% of the surgery benefit will be paid for anesthesia received by an anesthetist.

Ambulatory Surgical Center

A $500 benefit will be paid for the use of an Ambulatory Surgical Center each day for a surgical procedure covered under the surgery benefit that is performed at an ambulatory surgical center.

Radiation/Chemotherapy for Cancer

Up to a $10,000 (Low and Mid) or $20,000 (High) benefit will be paid per 12-month period for radiation therapy and chemotherapy received by a covered person. This benefit pays the actual cost and is limited to the amount shown per 12-month period beginning with the first day of benefit under this provision. Administration of radiation therapy or chemotherapy other than by medical personnel in a physician's office or hospital, including medications dispensed by a pump, will be limited to the costs of the drugs only, subject to the maximum amount payable per 12-month period.

Anti-Nausea Benefit

Up to a $200 benefit will be paid per calendar year for the actual cost of anti-nausea medication prescribed for a covered person by a physician. This benefit does not pay for medication administered while the covered person is an inpatient.

Inpatient Drugs and Medicine

A $25 benefit will be paid per day for drugs and medicine while continuously hospital confined. This benefit does not pay for drugs and/or medicine covered under the Radiation/Chemotherapy Benefit or the Anti-Nausea Benefit.

Hematological Drugs

Up to a $200 (Low and Mid) or $400 (High) benefit will be paid per year for the actual cost of drugs intended to boost cell lines such as white blood cell counts, red blood cell counts and platelets. This benefit is paid only when the Radiation/ Chemotherapy for Cancer benefit is paid.

Medical Imaging

Actual cost up to a $500 (Low and Mid) or $1,000 (High) benefit will be paid per calendar year if a covered person receives an initial diagnosis or follow-up evaluation based upon one of the following medical imaging exams: CT scan, Magnetic Resonance Imaging (MRI) scan, bone scan, thyroid scan, Multiple Gated Acquisition (MUGA) scan, Positron Emission Tomography (PET) scan, transrectal ultrasound, or abdominal ultrasound. This benefit is limited to 1 payment per calendar year per covered person.

Private Duty Nursing Services

A $100 benefit will be paid per day while hospital confined, if a covered person requires the full-time services of a private nurse. Full-time means at least 8 hours of attendance during a 24-hour period. These services must be required and authorized by a physician and must be provided by a nurse.

New or Experimental Treatment

Actual charges up to a $5,000 benefit will be paid per 12-month period, for new or experimental treatment. New or experimental treatment is covered for cancer and specified disease when: the treatment is judged necessary by the attending physician and no other generally accepted treatment produces superior results in the opinion of the attending physician. This benefit is limited to the maximum shown per 12-month period beginning with the first day of treatment under this provision. This benefit does not pay if benefits are payable for treatment covered under any other benefit in the Schedule of Benefits.

Blood, Plasma, and Platelets

Up to a $10,000 (Low and Mid) or $20,000 (High) benefit will be paid per 12-month period for the actual cost of blood, plasma and platelets (including transfusions and administration charges), processing and procurement costs and cross-matching. Does not pay for blood replaced by donors or immunoglobulins.

Physician's Attendance

A $50 benefit will be paid for a visit by a physician during hospital confinement. Benefit is limited to one visit by one physician per day of hospital confinement. Admission to the hospital as an inpatient is required.

At Home Nursing

A $100 benefit will be paid per day for private nursing care and attendance by a nurse at home. At-home nursing services must be required and authorized by the attending physician. Benefit is limited to the number of days of the previous continuous hospital confinement.

Prosthesis

Up to a $2,000 benefit will be paid per amputation, per covered person for the actual charges for prosthetic devices which are prescribed as a direct result of surgery and which require surgical implantation.

Hair Prosthesis

A $25 benefit will be paid every 2 years for a wig or hairpiece if the covered person experiences hair loss.

Nonsurgical External Breast Prosthesis

Up to a $50 benefit will be paid for the actual cost of the initial, nonsurgical breast prosthesis following a covered mastectomy or partial mastectomy that is paid for under the policy.

Ambulance

A $100 benefit will be paid per continuous hospital confinement for transportation by a licensed ambulance service or a hospital-owned ambulance to or from a hospital in which the covered person is confined.

Hospice Care

A $100 benefit will be paid for one of the following when a covered person has been diagnosed by a physician as terminally ill as a result of cancer or specified disease, is expected to live 6 months or less and the attending physician has approved services:

(1) Freestanding Hospice Care Center – A benefit will be paid per day for confinement in a licensed freestanding hospice care center. Benefits payable for hospice centers that are designated areas of hospitals will be paid the same as inpatient hospital confinement; or

(2) Hospice Care Team – A benefit will be paid per visit, limited to 1 visit per day, for home care services by a hospice care team. Home care services are hospice services provided in the patient's home. Benefit is payable only if: (a) the covered person has been diagnosed as terminally ill; and (b) the attending physician has approved such services. Does not pay for: food services or meals other than dietary counseling, services related to well-baby care, services provided by volunteers, or support for the family after the death of the covered person.

Extended Care Facility

A $100 benefit will be paid for each day a covered person is confined in an extended care facility for the treatment of cancer or specified disease. Confinement must be at the direction of the attending physician and must begin within 14 days after a covered hospital confinement. Benefit is limited to the number of days of the previous continuous hospital confinement.

Outpatient Lodging

A $50 benefit will be paid for lodging per day when a covered person receives radiation or chemotherapy treatment on an outpatient basis, provided the specific treatment is authorized by the attending physician and cannot be obtained locally. Benefit is for a single room in a motel, hotel, or other accommodations acceptable to AB during treatment, **up to the maximum $2,000** per 12 months beginning with the first day of benefit under this provision. Outpatient treatment must be received at a treatment facility more than 100 miles from the covered person's home.

Non-Local Transportation

$0.40 per mile or actual cost of round trip coach fare on a common carrier benefit will be paid for treatment at a hospital (inpatient or outpatient), radiation therapy center, chemotherapy or oncology clinic, or any other specialized freestanding treatment center nearest to the covered person's home, provided the same or similar treatment cannot be obtained locally. Benefit pays up to 700 miles for round trip in personal vehicle. "Non-Local" means a round trip of more than 70 miles from the covered person's home to the nearest treatment facility. Mileage is measured from the covered person's home to the nearest treatment facility as described above. Does not cover transportation for someone to accompany or visit the person receiving treatment, visits to a physician's office or clinic, or for services other than actual treatment.

Family Member Lodging and Transportation

Up to a $50 benefit per day will be paid for lodging and $0.40 per mile or the actual cost of round trip coach fare on a common carrier will be paid for one adult member of the covered person's family to be near the covered person, when a covered person is confined in a non-local hospital for specialized treatment.

(1) Lodging - This benefit is for a single room in a motel, hotel, or other accommodations acceptable to AB. Benefit is limited to 60 days for each period of continuous hospital confinement.

(2) Transportation - Benefit is limited to 700 miles per continuous hospital confinement if traveling in personal vehicle. Mileage is measured from the visiting family member's home to the hospital where the covered person is confined. Does not pay the Family Member Transportation Benefit if the personal vehicle transportation benefit is paid under the Non-Local Transportation Benefit, when the family member lives in the same city or town as the covered person.

Waiver of Premium (primary insured only)

If while coverage is in force the insured employee becomes disabled due to cancer first diagnosed after the effective date of coverage and remains disabled for 90 days, AB pays premiums due after such 90 days for as long as the insured employee remains disabled.

*Bone Marrow or Stem Cell Transplant**

A 1. $1,000*, 2. $2,500*, 3. $5,000* benefit will be paid for the following types of bone marrow or stem cell transplants performed on a covered person.

(1) A transplant which is other than non-autologous.

(2) A transplant which is non-autologous for the treatment of cancer or specified disease, other than Leukemia.

(3) A transplant which is non-autologous for the treatment of Leukemia.

***This benefit is payable only once per covered person per calendar year.**

ADDITIONAL BENEFITS

Wellness

A $100 benefit will be paid per calendar year per covered person for one of the following wellness tests: Biopsy for skin cancer; Blood test for triglycerides; Bone Marrow Testing; CA15-3 (cancer antigen 15 - 3 - blood test for breast cancer); CA125 (cancer antigen 125 – blood test for ovarian cancer); CEA (carcinoembryonic antigen – blood test for colon cancer); Chest X-ray; Colonoscopy; Doppler screening for carotids; Doppler screening for peripheral vascular disease; Echocardiogram; EKG (Electrocardiogram); Flexible sigmoidoscopy; Hemocult stool analysis; HPV (Human Papillomavirus) Vaccination; Lipid panel (total cholesterol count); Mammography, including Breast Ultrasound; Cervical Cancer Screening; PSA (prostate specific antigen – blood test for prostate cancer); Serum Protein Electrophoresis (test for myeloma); Stress test on bike or treadmill; Thermography; and Ultrasound screening of the abdominal aorta for abdominal aortic aneurysms. This benefit is paid regardless of the result of the test.

OPTIONAL BENEFITS

Cancer Initial Diagnosis (First Occurrence)

A one time benefit of $3,000 (Low and High) or $10,000 (Mid) benefit will be paid when a covered person is diagnosed for the first time in their life as having cancer other than skin cancer. The first diagnosis must occur after the effective date of coverage for that covered person. Benefit is payable only once per covered person.

Intensive Care (Low and High Plans Only)

A benefit will be paid for each day for the following types of intensive care confinement:

(1) **Hospital Intensive Care Unit Confinement $600*** - This benefit is for hospital intensive care unit confinement for any illness or accident.

(2) **Step-Down Hospital Intensive Care Unit Confinement $300*** - This benefit is for step-down hospital intensive care unit confinement for any illness or accident.

(3) **Ambulance - AB pays the actual charges for transportation of a covered person** by licensed air or surface ambulance service to a hospital for admission to an intensive care unit for a covered confinement. This benefit is not paid if an ambulance benefit is paid under the Ambulance benefit in the policy.

This benefit is limited to 45 days for each period of such confinement. A day is a 24-hour period. If confinement is for only a portion of a day, then a pro-rata share of the daily benefit is paid.

Issue Ages: 18 and older while actively at work.

Certificates - Certificates under this plan are issued on a guaranteed basis only at the time of the initial enrollment. A completed Evidence of Insurability form is required for late entrants into the group plan.

Eligibility - Family members eligible for coverage include: you, your legal spouse or domestic partner; and your unmarried children including adopted children or foster children from the moment of placement in the residence, stepchildren, children of a domestic partner, or legal ward who are under 26 years old, unless he or she continues to meet the definition of a dependent. Your children must be dependent on you for support or reside with you and be named on the enrollment or Evidence of Insurability Form.

Portability Privilege -AB will provide portability coverage, subject to these provisions. Such coverage will not be available for you, unless: coverage under the policy terminates under the General Provision entitled “Termination of Coverage,” we receive a written request and payment of the first premiums for the portability coverage not later than 63 days after such termination and the request is made for that purpose. No portability coverage will be provided to you, if your insurance under the policy terminated due to your failure to make required premium payments.

Termination of Coverage - As long as you are insured, your coverage under the policy ends on the earliest of: the date the policy is canceled, the last day of the period for which you made any required premium payments, the last day you are in active employment except as provided under the “Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence” provision, the date you are no longer in an eligible class, or the date your class is no longer eligible.

AB will provide coverage for a payable claim incurred while you are covered under the policy. If your spouse is a covered person, the spouse’s coverage ends upon valid decree of divorce or your death. If your domestic partner is a covered person, the domestic partner’s coverage ends upon termination of the domestic partnership or your death. If your child is a covered person, the child’s coverage ends when the child reaches age 26, unless he or she continues to meet the requirements of an eligible dependent.

Coverage does not terminate on a child who: (1) is incapable of self-sustaining employment by reason of mental or physical incapacity; and (2) became so incapacitated prior to the attainment of the limiting age of eligibility under the coverage; and (3) is chiefly dependent upon you for support and maintenance. • Dependent coverage continues as long as the coverage remains in force and the dependent remains in such condition. Proof of the incapacity and dependency of the child must be furnished within 60 days of the child’s attainment of the limiting age of eligibility. Thereafter, such proof must be furnished as frequently as may be required, but no more frequently than annually after the child’s attainment of the limiting age for eligibility. If AB accepts a premium for coverage extending beyond the date, age or event specified for termination as to a covered person, such premium will be refunded, coverage will be refunded, coverage will terminate and claims will not be paid.

Low Option without Optional Benefits

Insureds	Monthly Rates
Employee	*$20.07*
Employee + Child(ren)	*$27.71*
Employee + Spouse	*$30.96*
Family	*$38.57*

Low Option with Optional Benefits

Insureds	Monthly Rates
Employee	*$26.06*
Employee + Child(ren)	*$36.81*
Employee + Spouse	*$41.50*
Family	*$52.23*

Mid Option with $10,000 Initial Diagnosis Benefit

Insureds	Monthly Rates
Employee	*$29.75*
Employee + Child(ren)	*$42.16*
Employee + Spouse	*$47.02*
Family	*$59.39*

High Option without Optional Benefits

Insureds	Monthly Rates
Employee	*$31.09*
Employee + Child(ren)	*$43.65*
Employee + Spouse	*$47.51*
Family	*$60.04*

High Option with Optional Benefits

Insureds	Monthly Rates
Employee	*$37.08*
Employee + Child(ren)	*$52.75*
Employee + Spouse	*$58.05*
Family	*$73.70*

Pre-Existing Condition, Exclusions and Limitations - We do not pay for any benefit due to, or caused by, a pre-existing condition, as defined, during the 12-month period beginning on the date that person became a covered person. This exclusion will not apply to your newborn child, adopted child or foster child under the age of 18 if AB is notified within 31 days of the child's birth or date of placement. A Pre-Existing Condition is a disease or physical condition for which medical advice or treatment was recommended or received from a member of the medical profession within the 12-month period prior to the effective date of coverage. AB does not pay for any loss except for losses due directly from cancer or specified disease. We do not pay for any other conditions or diseases caused or aggravated by cancer or a specified disease. Diagnosis must be submitted to support each claim. For the Surgery, New or Experimental Treatment and Prosthesis Benefits, if specific charges are not obtainable as proof of loss, AB will pay 50% of the applicable maximum for the benefits payable. Treatment must be received in the United States or its territories.

Intensive Care Exclusions and Limitations - The Hospital Intensive Care Unit Confinement benefit does not pay for intensive care if a covered person is admitted because of an attempted suicide, intentional self-inflicted injury, intoxication or being under the influence of drugs not prescribed or recommended by a physician, or alcoholism or drug addiction. AB does not pay for confinements in any care unit that does not qualify as a hospital intensive care unit. Progressive care units, sub-acute intensive care units, intermediate care units, and private rooms with monitoring, step-down units and any other lesser care treatment units do not qualify as hospital intensive care units. We do not pay for step-down hospital intensive care unit confinement if a covered person is admitted and confined in the following type of units: telemetry or surgical recovery rooms, post-anesthesia care units, progressive care units, intermediate care units, private monitored rooms, observation units located in emergency rooms or outpatient surgery units, beds, wards, or private or semi-private rooms with or without telemetry monitoring equipment, an emergency room, labor or delivery rooms, or other facilities that do not meet the standards for a step-down hospital intensive care unit. We do not pay this benefit for continuous hospital intensive care unit confinements or continuous step-down hospital intensive care unit confinements that occur during a hospitalization that begins before the effective date of coverage.

Coverage Subject to the Policy - The coverage described in the certificate of insurance is subject in every way to the terms of the policy that is issued to the policyholder (your employer). It alone makes up the agreement by which the insurance is provided. The group policy may at any time be amended or discontinued by agreement between AB and the policyholder. Your consent is not required for this. AB is not required to give you prior notice.

The policy is Limited Benefit Cancer and Specified Disease Insurance. This is not a Medicare Supplement Policy. If eligible for Medicare, review Medicare Supplement Buyer's Guide available from American Heritage Life Insurance Company. Subject to COBRA continuation of coverage.

The coverage is provided by a limited benefit supplemental insurance policy.

This material is valid as long as information remains current, but in no event later than August 1, 2014. Group Cancer and Specified Disease benefits are provided by policy GVCP3, or state variations thereof. This brochure highlights some features of the policy but is not the insurance contract. Only the actual policy provisions control. The policy sets forth in detail, the rights and obligations of both the policyholder (employer) and the insurance company. For complete details, call 1-800-521-3535. This is a brief overview of the benefits available under the Group Voluntary Policy underwritten by American Heritage Life Insurance Company. Details of the insurance, including exclusions, restrictions and other provisions are included in the certificate issued.

Allstate Benefits is the marketing name used by American Heritage Life Insurance Company
(Home Office, Jacksonville, FL), a subsidiary of The Allstate Corporation.

Allstate Benefits, ***The Workplace Marketer ©***
1776 American Heritage Life Drive, Jacksonville, Florida 32224

Customer Care Center: 1.800.521.3535
www.allstate.com or allstateatwork.com

AUL/One America Short-Term Disability

Effective July 1, 2012

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. You are not working in any occupation and are under the regular attendance of a Physician for that injury or sickness

Monthly Benefit
You can choose to ***insure up to 70% of an Employee's covered basic monthly earnings to a maximum monthly benefit of $2,000.***

Elimination Period
This means a period of time a disabled Employee must be out of work and totally disabled before weekly benefits begin; seven (7) consecutive days for a sickness and zero (0) days for injury

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.

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. This Pre-Existing Condition limitation will be waived for all Persons who were included as part of the final premium billing statement received by AUL/ OneAmerica from the prior carrier and will be Actively at work on the 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.

Annual Enrollment

Enrollees that did not elect coverage during their initial enrollment are eligible to sign up for $500 to $1000 monthly benefit without medical questions. Current participants may increase their coverage up to $500 monthly benefit without medical questions. The maximum benefit cannot exceed 70% of basic monthly earnings and must be in $100 increments.

Portability

Once an employee is on the AUL disability plan for 12 months, you may be eligible to port your coverage for one year at the same rate without evidence of insurability. You have 31 days from your date of termination to contact AUL and make application to port your coverage by calling 1.800.553.3522.

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

ONEAMERICA®

AMERICAN UNITED LIFE INSURANCE COMPANY®
a ONEAMERICA® *company*

AUL Life Short-Term Disability
Monthly Rates

Benefit Duration:
13 Weeks

Monthly Benefit	Monthly Premium
$500	$10.36
$600	$12.43
$700	$14.50
$800	$16.57
$900	$18.64
$1,000	$20.71
$1,100	$22.78
$1,200	$24.85
$1,300	$26.92
$1,400	$28.99
$1,500	$31.07
$1,600	$33.14
$1,700	$35.21
$1,800	$37.28
$1,900	$39.35
$2,000	$41.42

Benefit Duration:
26 Weeks

Monthly Benefit	Monthly Premium
$500	$15.00
$600	$18.00
$700	$21.00
$800	$24.00
$900	$27.00
$1,000	$30.00
$1,100	$33.00
$1,200	$36.00
$1,300	$39.00
$1,400	$42.00
$1,500	$45.00
$1,600	$48.00
$1,700	$51.00
$1,800	$54.00
$1,900	$57.00
$2,000	$60.00

Benefit Duration:
52 Weeks

Monthly Benefit	Monthly Premium
$500	$19.72
$600	$23.66
$700	$27.60
$800	$31.54
$900	$35.49
$1,000	$39.43
$1,100	$43.37
$1,200	$47.32
$1,300	$51.26
$1,400	$55.20
$1,500	$59.15
$1,600	$63.09
$1,700	$67.03
$1,800	$70.97
$1,900	$74.92
$2,000	$78.86

Aetna Term Life and AD&D Insurance Plan

Policy Effective Date: When approved by Aetna Life Insurance Company

BASIC EMPLOYEE LIFE AND AD&D INSURANCE
This plan will pay as a Life Insurance benefit the amount of Life Insurance in force for you if you die while insured. You name your beneficiary.

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.

OPTIONAL 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 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 to age 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, as long as the child is covered prior to age 19 or to age 26 if a full-time student.

(It is your responsibility to notify the benefits office in writing when a dependent is ineligible for coverage. Examples of ineligible dependent status are divorce or a child graduates from college).

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

ELIGIBILITY
You will be eligible for this program if you are an active employee that works 20 hours or more per week.

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. The beneficiary elected on your life enrollment form designates your beneficiary for basic and optional coverage. You are automatically the beneficiary under Dependent Life. It is your responsibility to update the beneficiary designation as needed.

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. Your Optional Employee Life Insurance will become 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 enroll in Optional Dependent Life Insurance, that coverage will become effective on the date your Optional Employee Life Insurance becomes effective, provided the dependent is performing the usual and customary duties or activities of an individual in good health and of the same age and sex. If you or any dependents do not apply for Optional Employee Life Insurance and/or Optional Dependent Life Insurance within 31 days from date of hire, that person will not become insured until such person has furnished medical evidence of insurability satisfactory to Aetna Life Insurance Company.

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
Your insurance may be continued during your disability provided the premium payments continue, and the policy remains in force. However, your insurance will be subject to reduction as shown under “Reductions at ages 65 & Over” below.

REDUCTIONS AT AGE 65 AND OVER
If you remain in active service beyond age 65 your combined amount of Basic Life, Optional Employee Life, and Spouse Insurance will reduce as follows:

Attained Age	Percent of Original Amount
65	65%
70	40%
75	30%
80	25%

CONVERSION
If your employment terminates while you are covered under the plan, you may purchase without medical evidence of insurability, an individual insurance policy, except a term policy, issued by Aetna Life Insurance Company 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 coverage terminates.

This privilege applies to Supplemental Employee Life Insurance and Dependent Life Insurance as well as the Basic Employee Life Insurance.

PORTABILITY

If you terminate your employment, the portability provision allows you and your dependent spouse & children to take the optional life coverage with you, subject to the following provisions:

- You must apply for coverage within 31 days from the date your life coverage terminates.
- You must be actively at work prior to employment termination. Retirees & disabled employees are not eligible.
- Dependents are eligible for portable coverage if the employee participates.
- You may only port up to your current coverage amount.
- You cannot increase coverage or add new dependents.
- Employees are eligible up to age 98, spouses up to age 64 and children up to age 18, 22 if a full-time student.
- The minimum and maximum amounts to port are as follows:

  Employee -$5,000 / $100,000

  Spouse - $1,000 / $10,000

  Children - $1,000 / $5,000

SUICIDE EXCLUSION

No optional employee life benefits are payable if you commit suicide within two years from the effective date of the coverage.

ACCELERATED DEATH BENEFIT (ADB)

Aetna Life Insurance Company has included an Accelerated Death Benefit (ADB) 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.

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.

GROUP POLICY AND CERTIFICATE

The insurance briefly described in this folder is subject to the terms and conditions of the Group Policy issued by Aetna Life Insurance Company. If you become insured, you will receive a certificate outlining your benefits under this policy.

PLAN SPONSOR

Cumberland County Government
117 Dick Street
Fayetteville, NC 28302-1829
(910) 678-7700

This brochure has been prepared to give you the highlights of coverage now being offered by Cumberland County Government to meet your insurance needs. For details, please refer to the certificate of insurance that you will receive after you have signed up for protection.

SCHEDULE OF BENEFITS

BASIC EMPLOYEE LIFE INSURANCE AND AD&D

All eligible employees. . . . . .$5,000* (No cost to you)
**See "Reductions at age 65 & Over."*

OPTIONAL LIFE INSURANCE

Your choice of the following amounts:
$100,000, $90,000, $80,000, $70,000, $60,000, **$50,000, $40,000, $30,000, $20,000 or $10,000

**See "Reductions at age 65 & Over."*
***To be eligible for more than $50,000 of coverage you must furnish medical evidence of insurability satisfactory to Aetna Life Insurance Company.*

OPTIONAL DEPENDENT LIFE INSURANCE

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

YOUR MONTHLY COST

Optional Employee Life Insurance	Monthly Payroll Deduction
$100,000	$25.00
$90,000	$22.50
$80,000	$20.00
$70,000	$17.50
$60,000	$15.00
$50,000	$12.50
$40,000	$10.00
$30,000	$7.50
$20,000	$5.00
$10,000	$2.50

Optional Dependent Life Insurance*	
Family Coverage	$3.20
Spouse Only Coverage	$2.30
Child(ren) Only Coverage	$ .90

**Optional Dependent Life Insurance is available only to those eligible employees who are insured for Optional Employee Life Insurance.*

Customer Service/Conversion: 800-523-5065
Portability: 800-826-7448
Evidence of Insurability Inquiries: 800-660-9913

This insurance is underwritten by Aetna Life Insurance Company.

Funeral Planning Services

Brought to you by Aetna

We are pleased to provide a unique, value-added service for our life insurance members — funeral planning and concierge services from Everest.

Who is Everest?

Everest is an independent consumer advocate who works on your behalf. Everest's sole purpose is to provide the information you need to make the most informed decisions about all funeral related issues, and then put those wishes into action. You're never locked into a decision because Everest's funeral advisory services can be used at any funeral home across North America. Everest is an impartial consumer advocate, not a funeral home. Everest does not sell funeral goods or services, nor do they receive any commissions from funeral homes or other service providers in the funeral industry. With Everest, you are removed from a sales-focused environment allowing you and your family to make well-informed and confident decisions during a stressful time.

Everest offers both pre-planning and at-need services at or near the time of need. Everest's online planning tools help you prepare for the future. At-need services include family support and negotiation assistance. And, Everest advisors are available by phone 24/7.

Getting started

Create an online profile and use Everest's planning tools:

■ Visit www.everestfuneral.com/aetna

■ Enter your e-mail address and the Enrollment Identifi cation Code: AETNA0102

■ Your employer will provide details regarding eligible family members

■ Complete your online profile

■ Access "Planning Tools" at www.everestfuneral.com/aetna using your unique user name and password

■ If you do not have access to a computer, Advisors are available 24/7 by calling 1-800-913-8318

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies (Aetna).

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Everest's Services Includes:

Pre-planning services

24/7 Advisor assistance

- To discuss funeral planning issues

Pricefinder research reports

- The only nationwide database of funeral home prices
- Detailed, local funeral home price comparisons

Online planning tools

- Personal Profile
- 10 Key Decisions Planner
- "My Wishes" Planning Guide
- Reference Guide
- Secure data warehouse to store and maintain information

At-need services

At-need family support

- Family assistance and plan implementation
  - > Communicate the Personal Funeral Plan to the funeral home; removing the family from a sales-focused environment
  - > Provide 24-hour assistance throughout the funeral process
- Negotiation assistance
  - > Gather pricing information and present it to the family in an easy-to-read format
  - > Negotiate funeral service pricing with local funeral homes
  - > Help the family compare prices of caskets and other products

Aetna provides our life insurance members access to programs and services that provide support throughout all the stages of their lives.

Aetna has provided its policyholders with access to Everest Funeral Planning and Concierge Services ("Services") which are independently administered by Everest Funeral Package, LLC ("Everest"). Access to these Services is not insurance, may be discontinued at any time without notice, and is void where prohibited. Everest is solely responsible for furnishing these Services and Aetna makes no guarantee or representations as to their quality or suitability. In no event will Aetna be responsible or liable for any acts or omissions by Everest and its agents, employees or representatives in connection with the Services provided. Life policies are underwritten by Aetna Life Insurance Company and contain exclusions and restrictions. This material is for information only and is not an offer or invitation to contract. Information is believed to be accurate as of the production date; however, it is subject to change.

Unum Interest-Sensitive Whole Life Insurance

AFFORDABLE INSURANCE PROTECTION

Unum's Voluntary Interest Sensitive Whole Life Insurance can help provide the insurance protection you need, while also giving you the financial flexibility you want. This policy is designed to provide a death benefit to your beneficiaries if you pass away in addition to the life insurance coverage your employer may already be providing for you. This coverage is available to all eligible employees, ages 15-80 who are actively at work. For an affordable premium, you can help provide more financial protection for your family — now and into the future.

LIVING BENEFIT OPTION INCLUDED

This feature is automatically included in all policies. It provides the option of requesting up to 100% of the policy's death benefit, to a maximum of $150,000, if the insured is diagnosed with a medical condition limiting life expectancy to 12 months or less. If you have to face a terminal illness, this option can provide financial assistance during a difficult time. Any payout of this benefit would reduce the death benefit.

CONVENIENT PAYROLL DEDUCTION

Your premiums are automatically deducted from your paycheck, so you don't have to worry about writing checks or mailing payments.

NO PHYSICALS REQUIRED

If you are actively at work[1], you may apply for coverage by completing an application and no physical exams are required! Your coverage becomes effective on the first day of the month in which payroll deductions begin. This means that you will receive the plan and coverage amount you applied for on the application unless it is determined to be unacceptable under Unum's rules, limits or standards. In such event, the plan and coverage amount may be modified or declined.

INDIVIDUALLY OWNED

If you leave your company, you can take your policy with you and still pay the same premium. Instead of paying your premiums through payroll deduction, Unum will bill you directly at home.

CASH VALUE ACCUMULATION FEATURE

Voluntary Interest Sensitive Whole Life Insurance can build cash value that earns interest. The interest rate your policy is credited with will never be less than the guaranteed minimum rate of 4.0%. It is important for you to remember, as with all whole life policies, that the projected cash value of your policy may change over time. Such changes can result from fluctuations in interest rates, scheduled changes in the cost of insurance, or non-payment of premiums, policy loans and loan interest. We encourage you to maintain consistent premium payments and repay any outstanding loans in a timely fashion to avoid an early lapse in coverage or termination of your policy.

ADDITIONAL FEATURES

ACCIDENTAL DEATH BENEFIT RIDER

- Available at initial enrollment to employees and spouses ages 15-65.
- Provides an additional death benefit equal to the face amount, up to a maximum of $150,000, if the insured dies as a result of a covered accident before age 70.
- Under certain conditions, the benefit will double if death occurs from accidental bodily injuries sustained while the insured is a fare-paying passenger via commercial transportation.
- Benefits increase by 25% if death occurs from accidental bodily injury while insured is driving or riding in a non-commercial automobile while wearing a seat belt.

FAMILY COVERAGE

- Spouse Coverage

Interest Sensitive Whole Life coverage is available for your spouse (ages 15-80) based on a qualifying health question. However, no physical exams are required and coverage is available even if you don't apply for coverage yourself. A few additional health questions may be asked based on the level of coverage being applied for.

- Children's Standalone Coverage

A standalone insurance policy is available to children, stepchildren, legally adopted children and grandchildren between the ages of 14 days and 24 years who reside in the United States. Coverage is available even if you decide not to purchase coverage for yourself.

LONG TERM CARE RIDER

If you're like most people, you've heard how important it is to prepare for your future and that of your family. You may have acquired a home, built a savings nest egg, begun contributing to retirement funds, and even made plans and preparations for your children's education. But is that enough? Are you financially prepared to cover the expenses of long term care should you or your spouse become ill or disabled, or need special medical treatment as you get older?

Your employer is offering you Long Term Care coverage to complement your voluntary life insurance plan. For a nominal cost, you may add additional Long Term Care coverage to extend this benefit. Please see your Unum representative for more information.

Life is unpredictable. But you can take steps to help protect your family now and into the future with Unum's Interest Sensitive Whole Life insurance. Ask your benefits representative for more information and apply today!

FREQUENTLY ASKED QUESTIONS

Am I required to participate in this coverage?
No. Your coverage is voluntary, and you decide if it is right for you and your family's needs. It's your choice.

Who becomes the owner of the policy?
Unum's Interest Sensitive Whole Life Insurance policy is just that - voluntary and individual. This means that electing coverage is optional, and if you decide coverage is right for you, then you become the owner of your policy.

Does this policy automatically replace any of my existing group insurance coverage?
No. Interest Sensitive Whole Life Insurance is a supplemental insurance policy and can enhance your group coverage.

May I increase my coverage in the future?
Yes, your coverage can be increased to meet your changing needs. Once you have owned your policy for one year, you may apply for additional coverage up to the maximum amount available for your age. A new policy will be issued for the amount of the increase at your attained age.

May I insure my spouse and/or my children even if I don't participate in this plan?
Yes, coverage is available for your spouse and children even if you choose not to purchase coverage for yourself. Certain minimal underwriting requirements may apply. Ask your benefits representative for more details during enrollment.

May I take a loan on my policy?
Yes, you may borrow part of your cash value from the policy at an annual interest rate of 8.0% per year. Any loan taken will affect the cash value on the policy.

How will I be kept informed of my cash value?
Each year, Unum will mail you a policy statement outlining what you have paid, how much cash value you have, plus the status of any loans, interest credited and applicable administrative charges. These statements are designed to provide you with a valuable record of your policy activity.

Does my policy have a surrender charge?
If you surrender your policy during the first 14 years of coverage, a surrender charge will apply. Beyond the 14th year, there is no surrender charge. A unique 14- year period applies to each increase in coverage.[2]

Who can I contact if I have questions about my policy after enrolling?
During enrollment, a benefits representative will be available one-on-one to answer any questions you may have about Interest Sensitive Whole Life Insurance. If you have questions about your policy after enrolling, simply pick up the phone and call Unum at 1-800-635-5597.

Being “actively at work” means on the day the employee applies for coverage, the individual must be working at one of his/her company’s business locations; or the individual must be working at a location where he/she is required to represent the company. If applying for coverage on a day that is not a scheduled workday, the employee will be considered actively at work as of his/her last scheduled workday. Employees are not considered actively at work if they are on a leave of absence.

[2] Surrender charges may vary by state.

Any person currently covered by Medicaid, except residents of Kentucky, will be excluded from eligibility.

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form L-21794 of contact your Unum representative.

Underwritten by
Provident Life and Accident Insurance Company
1 Fountain Square, Chattanooga, TN 37402

unum.com
1-800-635-5597

CE-12499

Continuation of Benefits

GILSBAR MEDICAL & DEPENDENT CARE REIMBURSEMENT ACCOUNTS
If you have a positive balance (payroll deductions are greater than the amount you have received in reimbursement) in your Medical Reimbursement Account at the time of your termination, you may continue participation in the Plan for the remainder of the Plan year through COBRA by contacting **Interactive Medical Systems (IMS) at (800) 426-8739 ext: 3130.**

If you prefer to terminate your participation and contribution to the Plan, any balance in your account on the date of termination will be forfeited if claims were not incurred prior to the date of termination. To obtain your balance, please call **Gilsbar at 800-445-7227, ext. 883.**

AMERITAS DENTAL PLAN
Under the dental plan, you and your covered dependents are eligible to continue dental coverage through COBRA according to the following "qualifying events". If you and your dependents are enrolled in the dental plan, you will be eligible to continue coverage through COBRA after you leave your employment for a specified period. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents 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. To continue coverage thru COBRA, your employer would notify IMS of your termination and IMS will then send you a letter regarding COBRA. Should you have any questions you can contact **Interactive Medical Systems (IMS) at (800) 426-8739 ext: 3130.**

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

If you and your dependents are enrolled in the vision plan, you will be eligible to continue coverage through COBRA after you leave employment for a specified period. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents may be eligible to continue vision coverage through COBRA. Also, while you are covered under the plan, your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA. Examples of an ineligible dependent would be when your child graduates from college, or turns 26 years old. You will receive notification from **Interactive Medical Systems (IMS)** with premium and continuation options shortly following your termination of employment.

ALLSTATE CANCER PLAN
When you leave the employment, you may continue your Allstate Cancer coverage by having the premiums that are currently deducted from your paycheck billed to your home address or drafted from your bank account. For billing options, please call Allstate at (800) 521-3535.

AUL SHORT TERM DISABILITY PLAN
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.

UNUM WHOLE LIFE
When you leave your employment, you may continue your Unum Whole Life Insurance coverage by having the premiums that are currently deducted from your paycheck billed to your home address or drafted from your bank account. For billing options, please call Unum at 1-800-635-1049.

AETNA TERM LIFE
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 Aetna direct at: 1-800-523-5065 for Conversion or 1-800-826-7448 for Portability.

If you do not convert or port your Aetna term life insurance, coverage will terminate when you leave your employer.

Important Phone Numbers:

- Aetna Term Life Plan - 800.660.9913 or 800.523.5065
- Alltate Cancer Plan - 800.521.3535
- American United Life (AUL) STD - 800.553.5318
- Ameritas Dental Plan - 800.487.5553
- BCBS Health Plan - 877.258.3334
- Cumberland County Government - 910.223.3327
- Gilsbar Flexible Spending Accounts - 800.445.7227, ext. 883
- Mark III Brokerage, Inc. - 800.532.1044, ext. 21
- Superior Vision Plan - 800.507.3800
- Unum Universal and Whole Life Plan - 800.635.5597

View Benefits Online and Download Forms:
www.markiiibrokerage.com/cumberlandcountync