Lee County Government is offering all benefit eligible employees a comprehensive Cafeteria Benefits plan. The Cafeteria Benefits plan is being arranged by Mark III Brokerage, an employee benefits firm that has worked in the public sector since 1973. The Cafeteria Benefits plan allows you to pay for certain insurance premiums, child-care, and unreimbursed medical expenses before taxes are taken out of your paycheck. Paying for these benefits in this method may reduce your taxes and may increase your take home pay.

• The Plan Year is from August 1, 2013 to July 31, 2014

Table of Contents

Pre-Tax Benefits

After-Tax Benefits

This booklet highlights the benefits offered through your Employer for the current plan year. This is neither an Insurance Contract nor a Summary Plan Description 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.

Gilsbar Welcome Letter (Example)

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 S2548 *(actual group # for Lee County)*
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 Reimbursement Account Center section in the left navigation bar.
If you are a first time user, you will be prompted to enter your email address to sign up for our Reimbursement Account Center email service. This is an important step to ensure you will receive email updates when:

a. 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)

Gilsbar Health Care Flexible Spending Account

Plan Year: August 1, 2013 - July 31, 2014

•Health Care Spending Account Maximum: $2,500.00
•Health Care Spending Account Minimum: $120
•Run Off Period: 90 days following the end of the plan year to file for services rendered during the plan year
• Waiting Period: Employees can apply during the Annual Enrollment

REMINDER: The Internal Revenue Service (IRS) requires review of all receipts for eligible expenses in a 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 the Human Resources Department).

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

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

How does the Health Care FSA Work?

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

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

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

What is eligible for reimbursement under the Health Care FSA?

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

How do I get reimbursed?

For reimbursement of expenses covered under a health care plan:

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

FAX CLAIMS AND PROOF OF EXPENSE TO 866.635.1329

How much will be reimbursed?

When you submit a health care expense, you will be reimbursed for eligible expenses claim up to the maximum amount you elected for the plan year, minus any previous reimbursements.

Can I use my Health Care FSA for my family's expenses?

Eligible health care expenses incurred by you, your spouse, or any dependent that you claim as a dependent on your income tax returns are allowable for reimbursement.

If I don't have any medical insurance through my company, can I still participate in the Health Care FSA?

Yes. Out-of-pocket expenses for you and your dependents are eligible for reimbursement whether or not you are insured through your company. Health related expenses are reimbursable for your dependents, if you claim them as a dependent on your income tax returns (this definition of a dependent may be different than that used for your health insurance plan).

Is there anything I have to keep in mind when it comes time to file my taxes?

Expenses payable through your benefits program (or your spouse's, if applicable) are not eligible for reimbursement under the Health Care FSA. In addition, expenses reimbursed through your Health Care FSA cannot be claimed as a deduction on your income tax returns.

I am covered under both my health insurance plan and my spouse's. Do I have to submit medical expenses to both plans before I can file for reimbursement from my Health Care FSA?

Yes. IRS regulations do not permit reimbursement of expenses through the FSA that would otherwise be covered under your health insurance plan. Expenses should first be submitted to your health insurance plan(s), then send any remaining unpaid claims to Gilsbar for reimbursement.

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

If you have any questions, you can access your account information 24/7 at myGilsbar.com, or you can call Gilsbar's Customer Contact Center at 1.800.445.7227 ext. 883.

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

Qualified Medical Expenses Eligible For Reimbursement:

- Acupuncture
- 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

** Prescription required as of January 1, 2011.

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 twenty three (.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

Participants are required to have a prescription for Over-the-Counter ("OTC") products to be eligible under the 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
Antacids and Acid Reducers	Hemorrhoid Treatments
Anticandial	Internal Analgesics / Antipyretic
Antihistamines	Incontinence Supplies
Anti-diarrheal and Laxatives	Liniments
Anti-fungal	Medical Monitoring
Anti-itch Lotions and Creams	Medical Products and Devices
Asthma	Menstrual Cycle Medications
Cold Sore / Fever Blister	Migraine
Condoms and other contraceptive Devices	Motion Sickness Medication
Contact Lenses Solutions	Nicotine Gum or Patches and 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 Cards

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?

Since 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?
The IRS changed the rules regarding how debit cards need to operate for an FSA. These rules took effect on January 1, 2008. 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 the 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?
Since January 1, 2009, no additional substantiation is 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. 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.

Gilsbar Dependent Care Flexible Spending Account

Plan Year: August 1, 2013 - July 31, 2014
• Dependent Care Flexible Spending Account Maximum: $5,000
• Waiting Period: Employees can apply during the Annual Enrollment
• Reminder: Debit card cannot be used with the Dependent Care 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)

REMINDERS:

• You 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.

• Remember that you will have **90 days** following the end of the plan year to file for services rendered during the plan year. You may send all requests for reimbursement directly to Gilsbar.

IMPORTANT!

Debit cards are mailed to each new participants home address in a plain white envelope with reference to Reimbursement Account Center. There will be no reference to Gilsbar. Please check thoroughly before throwing mail away. Debit cards are good for three (3) years from the issue date and your account will be replenished only if you **re-elect t**he Healthcare FSA each year.

If you have any questions concerning your Plan, please feel free to contact:

Gilsbar's Customer Contact Center at 1.800.445.7227 ext. 883.

Fax Claims and Proof of expense to: **1.866.635.1329 for processing**

(PLEASE KEEP YOUR ORIGINALS)

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)

WEBSITE: www.myGilsbar.com

GILSBAR *Our Ingenuity. Your Opportunity.*

Ameritas Dental Plan

Effective Date: August 1, 2013

COMBINED CALENDAR YEAR DEDUCTIBLE*
• $50.00 per individual for:
TYPE II (Basic Procedures) and
TYPE III (Major Procedures)

***If you visit a PPO provider, the deductible is waived**

• **3 times family limit).** After the date that 3 covered family members have each satisfied their individual deductible the entire deductible or any remaining portion of the deductible for any family member will be waived for the rest of that calendar year.

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

- Exams (Two per benefit period)
- Cleanings (Two per benefit period)
- Fluoride for Children (Under age 19)
- Sealants
- Space Maintainers
- Other X-rays
- Bitewings X-rays (Two per benefit period)

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

- Non Surgical Extractions
- General Anesthesia
- Amalgams & Fillings
- Non Surgical Periodontics

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

- Endodontics (Root Canal)
- Crown Repair
- Denture Repair
- Dentures
- Crown- Precious Metal
- Surgical Periodontics
- Oral Surgery
- Bridges
- Crown- Porcelain

ORTHODONTIA - ADULT & CHILDREN (UP TO AGE 19) - Paid at 50% U& C* with a $1,000 lifetime maximum. **No deductible applies.**

***U&C- Usual & Customary**

ANNUAL MAXIMUM BENEFIT
• Type I , II, and III Procedures - $1,000 per calendar year per person.

Ameritas Managed Care Products

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

Passive PPO & Passive PPO-Deductible Reduction

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

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

Commonly Asked PPO Questions

The plan provides excellent coverage for you and your eligible dependents. Please refer to the plan highlight for more details. As an added bonus, the plan includes access to Ameritas' Participating Provider Organization (PPO).

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

• Lee County Government wants employees to have options regarding their choice of providers. In addition, we want to ensure that employees that utilize non-panel providers receive exceptional benefits that reimburse claims for non-panel providers in the most optimal way. Non-panel providers can charge their standard fees for any service. ***However, the amount Ameritas allows for each procedure for non-panel provider utilizes 90th percentile of U&C (Usual & Customary) which is considered to be one of the highest reimbursement levels in the industry. This means that 9 out of 10 dentist's charges will fall within the amount that Ameritas allows for each procedure.*** In doing so, employees can feel comfortable that very little back billing will occur due to the amounts allowed by the plan.

• Non-panel providers have no specific requirements regarding filing of claims. However, we have found that many dentists will assist the patient with the paperwork needed to file the claim. If a dentist is not willing to file the claim on the patient's behalf, the patient can simply attach the dentist's bill to a claim form that includes the patient's name and identification number, and fax or mail the claim to Ameritas for processing. Ameritas will process the claim, typically within 7-10 working days. Claim payment can be made to the patient or directly to the dentist if noted on the claim form. The patient can use Ameritas' claim forms which are available in the Benefit's Department or on the Ameritas website (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 the PPO or the plan, please call:
Ameritas Group Claims Department at 1.800.487.5553

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

ELIGIBLE EMPLOYEES
Any active, full-time employee is eligible for this coverage.

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.)

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.

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.

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

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

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

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.

LATE ENTRANT

If an employee or dependent(s) come on the plan after the initial opportunity to apply for dental coverage, Basic procedures will not be covered until 6 months after the effective date and Major procedures will not be covered until 12 months after the effective date. The late entrant provision is waived if the employee and or dependent(s) come on the plan as a result of a qualifying event.

Rates (based on 24 pay periods)

Employee	$16.37
Employee/Spouse	$33.51
Employee/Children	$39.78
Employee/Family	$56.92

These highlights are a summary of your dental plan. For complete details, please refer to the Ameritas Certificate Booklet.

For Claims/Customer Service call Ameritas: 1.800.487.5553
Website: www.ameritasgroup.com

AMERITAS
LIFE INSURANCE CORP.

Superior Vision Plan

Effective Date: August 1, 2013

Outline of Benefits - Gold Preferred Plan With Materials Discount
Vision Plan - Preferred Provider (PPO / Indemnity)

COPAYMENT: **$10.00- Comprehensive Eye Exam**
$15.00- Materials

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 [1]	Out-of-Network[1]
Comprehensive Eye 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
Contact Lenses (Per Pair)[2]			
Medically Necessary	12 Months	Covered in Full	Up to $210.00
Cosmetic (Elective)[3]	12 Months	Up to $120.00	Up to $100.00
Frames-Standard[3]	24 Months	Up to $100.00	Up to $50.00

[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.

Discount Features

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

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
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.

[4]Discounts and maximums may vary by lens type. Please check with your provider.

*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.

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

Rates (based on 24 pay periods)

Employee Only	$4.65
Employee + One	$9.05
Employee + Family	$13.27

Allstate (AB) Benefits Group Cancer Plan

Effective Date: August 1, 2013

In the United States, about 1,596,670 new cancer cases were expected to be diagnosed in 2011.[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**
- •Portable coverage

Benefit Coverage Highlights

Group Voluntary Cancer Insurance offers you coverage should you be diagnosed with cancer or 29 specified diseases. It protects 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 dependent 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

A cancer diagnosis can mean unforeseen expenses that may be difficult to pay, especially if you aren't working. 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 diseases on the following page**

[1] ***Cancer Facts & Figures, American Cancer Society, 2011***

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 disease 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); or 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; Allstate Benefits 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, 2011.

Second Opinion

A $400 benefit will be paid for a second surgical opinion, if physician recommends surgery 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.

Ambulatory Surgical Center

A $500 benefit will be paid 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 in conjunction with cancer of specified disease treatment. 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) 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; or services related to well-baby care; or 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 the actual cost of 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); or radiation therapy center; or 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 BENEFIT

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) 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 & High only)**

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

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

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

C. **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.**

****This benefit is not disease-specific and pays a benefit for a covered confinement in a hospital intensive-care unit for any covered illness or accident from the first day of coverage.**

Allstate Benefits Cancer Rates

Low Option without Cancer Initial Diagnosis and Intensive Care

Insureds	24-Pay Rates
Employee	$10.04
Employee + Child(ren)	$13.86
Employee + Spouse	$15.48
Family	$19.29

Low Option with Cancer Initial Diagnosis and Intensive Care

Insureds	24-Pay Rates
Employee	$13.03
Employee + Child(ren)	$18.41
Employee + Spouse	$20.75
Family	$26.12

Mid Option with Cancer Initial Diagnosis

Insureds	24-Pay Rates
Employee	$14.88
Employee + Child(ren)	$21.08
Employee + Spouse	$23.51
Family	$29.70

High Option without Cancer Initial Diagnosis and Intensive Care

Insureds	24-Pay Rates
Employee	$15.55
Employee + Child(ren)	$21.83
Employee + Spouse	$23.76
Family	$30.02

High Option with Cancer Initial Diagnosis and Intensive Care

Insureds	24-Pay Rates
Employee	$18.54
Employee + Child(ren)	$26.38
Employee + Spouse	$29.03
Family	$36.85

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 children.

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”; and AB receives 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 terminates 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; or the last day of the period for which you made any required premium payments; or 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; or 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 terminate and claims will not be paid.

Pre-Existing Condition - AB does 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.

Exclusions and Limitations - AB does not pay for any loss except for losses due directly from cancer or specified disease. AB does 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; or intentional self-inflicted injury; or 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. We do not pay for ambulance if paid under the cancer and specified-disease ambulance benefit.

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. The policy 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 provided by policy GVCP3, or state variations thereof. The policy is underwritten by American Heritage Life Insurance Company. 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, contact your Insurance Agent, or 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.

This information is for use in enrollments which are sitused in North Carolina.

Allstate®
Benefits

Allstate Benefits is the marketing name used by American Heritage Life Insurance Company (Home Office, Jacksonville, FL), the underwriting company and 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
Customer Claims : 1.800.348.4489
www.allstate.com or
AllstateBenefits.com

Assurity Accident Expense PRO Plan

24-hour Accident Plan

Effective Date: August 1, 2013

Accidents happen to even the most cautious people
Recovering from an injury is tough enough, but out-of-pocket expenses for the emergency room, ambulance, hospital stay and doctors' bills can cause a financial crisis – while regular monthly bills and expenses continue to accumulate.

The solution – an Accident Expense PRO® Insurance policy
Assurity at Work®, a division of Assurity Life Insurance Company, offers employees the opportunity to protect themselves and their families from the cost of accidental injuries with an Accident Expense PRO Insurance policy/certificate. This plan pays a fixed cash benefit for medical treatments associated with a covered accident. Better still, the benefits are paid regardless of any other insurance coverage. This affordable protection may be extended to cover an employee's spouse and children, and is also portable – it may be kept in force after leaving the current employer if premiums continue to be paid.

Assurity at Work's Accident Expense PRO Benefits
The employee may choose basic coverage with a one-unit plan, or higher benefits with a two-unit plan. Our Accident Expense PRO rate structure has the same premium regardless of age or gender.

Benefit	Conditions	One-Unit Plan	Two Unit Plan
Accident emergency treatment	Within 72 hours after the accident by physician, urgent care facility or emergency room	**$125**	**$150**
Follow-up treatment	First treatment within 30 days after receiving Accident Emergency Treatment; eligible for last treatment within one year	**$25** up to three treatments	**$35** up to three treatments
Diagnostic exams	Requiring angiogram, CT Scan, CTA Scan, MRI, MRA or EEG within 180 days after the accident	**$100 per year**	**$200 per year**

Hospital Admission	Within 180 days after the accident if confined for at least 20 hours	**$500**	**$1,000**
Hospital confinement (including Sub-Acute ICU)	Within 180 days after the accident if confined for at least 20 hours; not paid concurrent with ICU benefit	**$100 per day** up to 90 days	**$200 per day** up to 180 days
Hospital ICU confinement	Within 180 days after the accident if confined for at least 20 hours; not paid concurrent with hospital confinement benefit	**$200 per day** up to 15 days	**$400 per day** up to 15 days
Ambulance	To or from hospital within 48 hours of accident for air or 90 days for ground	**$500 air / $100 ground**	**$500 air / $100 ground**
Physical therapy treatment	First treatment within 30 days after the accident; eligible for last treatment within one year	**$25** up to six treatments	**$35** up to six treatments
Appliances	Prescribed within 90 days after the accident as an aid in mobility; includes crutches, wheelchairs, etc.	**$100 any insured**	**$100 any insured**
Specific injury and treatment benefits: **• Fractures** **• Lacerations** **• Dislocations** **• Burns** **• Unintentional gunshot wounds** **• Eye injuries** **• Ruptured disc surgery** **• Tendon, ligament or rotator cuff surgery** **• Knee cartilage surgery** **• Abdominal or thoracic surgery**		**$25 - $5,000** (according to schedule)	**$50 - $10,000** (according to schedule)
Emergency dental work	Within 90 days after the accident	**$50-$150** (according to schedule)	**$100-$300** (according to schedule)

Prosthetic device/ artificial limb	Prescribed within one year after the accident	**$500 for one device/ limb; $1,000 for more than one device/ limb**	**$500 for one device/limb; $1,000 for more than one device/ limb**
Transportation	For an insured person's non-local treatment including hospital confinement within 180 days after the accident	**$300 per round trip** up to three round trips	**$300 per round trip** up to three round trips
Lodging	For a companion accompanying an insured person for non-local treatment including hospital confinement within 180 days after the accident	**$100 per night** up to 30 nights	**$100 per night** up to 30 nights
Dismemberment (loss of toes, fingers, hands, feet, eyesight)	Within 90 days of accident	**$500-$15,000** (according to schedule)	**$1,000-$30,000** (according to schedule)
Blood, plasma or platelets	For transfusion, administration, cross matching, typing and processing within 90 days of the accident	**$300** employee **$200** spouse/ child	**$300** employee **$200** spouse/ child
Accidental death	Within 90 days after the accident; not paid if common carrier benefit paid	**$25,000** employee **$10,000** spouse **$5,000** child	**$50,000** employee **$20,000** spouse **$10,000** child
Accidental death - common carrier (commercial plane, bus, train, etc.)	Within 90 days after the accident	**$50,000** employee **$20,000** spouse **$10,000** child	**$100,000** employee **$40,000** spouse **$20,000** child

Wellness Benefit Rider

The Wellness Benefit Rider pays a benefit when a charge is incurred for a specific test or procedure from each of the two groups.

Group 1:$50 per calendar year for each insured category (once for employee and spouse individually, once for children collectively) when a charge is incurred for one and only one of the following after the waiting period of 30 days following the issue date or 10 days following any reinstatement date.

- *Annual physical*
- *Blood test for triglycerides*
- *CA 19-9 (blood test for pancreatic cancer)*
- *Fast blood glucose test*
- *Hemocult stool analysis*
- *PSA (blood test for prostate cancer)*
- *Pap smear*
- *Vision/hearing exams*
- *Vaccinations (flu shot, pneumonia shot, tetanus shot, MMR, polio vaccine, chicken pox, diphtheria)*

Group 2: $100 per calendar year for each insured category (once for employee and spouse individually, once for children collectively) when a charge is incurred for one and only one of the following after the waiting period of 30 days following the issue date or 10 days following any reinstatement date.

- *Biopsy for skin cancer*
- *Bone marrow biopsy and aspiration*
- *Breast ultrasound*
- *CA 15-3 (blood test for breast cancer)*
- *CA 125 (blood test for ovarian cancer)*
- *CEA (blood test for colon and cervical cancer)*
- *Chest X-ray*
- *Colonoscopy*
- *Flexible sigmoidoscopy*
- *Mammography*
- *Serum cholesterol test to determine level of HDL and LDL*
- *Serum protein electrophoresis (blood test for myeloma)*
- *Stress test (bicycle or treadmill)*
- *Thermography*

Eligible Persons

Available to employee, spouse and dependent children (same as policy/certificate).

Issue Ages

Employee and spouse 18+; children 15 days to 25 years (age last birthday as of issue date; same as policy/certificate).

Limitations, Conditions and Exclusions

Accident Expense PRO provides limited benefit coverage.

Actively Employed

The employee must be actively employed to be eligible for coverage.

Right to Cancel

The contract contains a 30-day free look period.

Renewal
Accident Expense PRO is guaranteed renewable to age 70.

Termination
Coverage will terminate the earliest of the following: the date policy terminates for any reason; the date employee is no longer an employee; when premiums are not paid by the end of the grace period; the date Assurity receives written notice to terminate; when the employee establishes residence in a foreign country; or upon the employee's death.

Elimination Period
The benefit payable under the Accident-Only Disability Income Rider has an elimination period. Assurity will not pay benefits during the elimination period.

Waiting Period
The benefit payable under the Wellness Benefit Rider has a waiting period. Assurity will not pay benefits during the waiting period.

Exclusions
Assurity will not pay benefits for losses that are caused by or are the result of any insured person(s): operating, learning to operate or serving as a crew member of any aircraft; engaging in hang-gliding, hot air ballooning, bungee jumping, parachuting, scuba diving, sail gliding, parasailing or parakiting; riding in or driving any motor-driven vehicle in a race, stunt show or speed test; officiating, coaching, practicing for or participating in any semi-professional or professional competitive athletic contest for which any type of compensation or remuneration is received; having a sickness independent of the covered accident, including physical or mental infirmity (sickness means any illness, infection, disease or any other abnormal physical condition which is not caused by an Injury); being exposed to war or any act of war, declared or undeclared; actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Army Reserve, except during active duty training of less than 60 days; suffering from mental or nervous disorders; being addicted to drugs or suffering from alcoholism; being under the influence of an excitant, depressant, hallucinogen, narcotic, or any other drug or intoxicant, including those prescribed by a physician that are misused; being intoxicated (as determined by the laws governing the operation of motor vehicles in the jurisdiction where loss occurs) or under the influence of an illegal substance or a narcotic (except for narcotics used as prescribed to the insured person by a physician); who is a dependent child incurring injuries during birth; having cosmetic surgery or other elective procedures that are not medically necessary; having dental treatment; having a hernia; committing or attempting to commit a felony; being incarcerated in a penal institution or government detention facility; driving any taxi for wage, compensation or profit; engaging in an illegal activity or occupation; intentionally self inflicting an injury; committing or attempting to commit suicide, while sane or insane; or traveling outside the U.S., except for those injuries that require emergency care in a hospital.

Semi-Monthly Rates (based on 24 pay periods)		
Coverage	**One Unit**	**Two Unit**
Employee	**$9.08**	**$11.03**
Employee and Spouse	**$16.32**	**$19.96**
Employee and Children	**$14.32**	**$17.62**
Family	**$22.49**	**$27.75**

Policy/certificate and rider availability, features and rates may vary by state. This description of benefits is intended only to highlight your benefits and should not be relied upon to fully determine coverage.

There may be other reductions of benefits, limitations and exclusions. If this description conflicts in any way with the terms of the policy, the terms of the policy prevail. For costs and complete details of the coverage, please contact your agent, Assurity Life Insurance Company or ask to review the policy/certificate for more information.

All guarantees are based on the claims-paying abilities of Assurity Life Insurance Company.

This policy and riders are underwritten by Assurity Life Insurance Company, Lincoln, Neb.

Policy form Nos. *Individual:* WH1101 (24 hour) and WH1102 (Off the job);
Rider form Nos. *Individual:* Wellness Benefit Rider RW1110;
Individual: Accident-Only Disabililty Income Rider RW1111 (24 hour) and RW1112 (Off the job)

A106-0413

Assurity® Life Insurance Company

AUL Short-Term Disability Plan

Effective Date: August 1, 2013

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 40 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 your covered basic monthly earnings to a maximum monthly benefit of $2,000. The minimum benefit is $500.***

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.

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.

Portability

Once an employee is on the AUL disability plan for 3 consecutive 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.

The Portability Privilege is not available to any Person that retires (when the Person receives payment from any Employer's Retirement Plan as recognition of past services or has concluded his/her working career).

Annual Enrollment

Employees who did not elect coverage during their initial enrollment period are eligible to sign up for $500 to $1000 monthly benefit without medical questions, subject to pre-existing exclusion. Employees 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.

Employees that elect to increase their Benefit Duration may do so only during the annual enrollment period subject to the pre-existing exclusion. The pre-existing exclusion will apply to the increased benefit duration.

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: 1.207.591.3048

Disability Claims Email: claims@disabilityrms.com

Website: www.employeebenefits.aul.com

AUL Life Short-Term Disability
Semi-Monthly Rates

Benefit Duration:
13 Weeks

Monthly Benefit	Semi Monthly Premium
$500	$5.18
$600	$6.21
$700	$7.25
$800	$8.28
$900	$9.32
$1,000	$10.36
$1,100	$11.39
$1,200	$12.43
$1,300	$13.46
$1,400	$14.50
$1,500	$15.53
$1,600	$16.57
$1,700	$17.60
$1,800	$18.64
$1,900	$19.67
$2,000	$20.71

Benefit Duration:
26 Weeks

Monthly Benefit	Semi Monthly Premium
$500	$7.50
$600	$9.00
$700	$10.50
$800	$12.00
$900	$13.50
$1,000	$15.00
$1,100	$16.50
$1,200	$18.00
$1,300	$19.50
$1,400	$21.00
$1,500	$22.50
$1,600	$24.00
$1,700	$25.50
$1,800	$27.00
$1,900	$28.50
$2,000	$30.00

Benefit Duration:
52 Weeks

Monthly Benefit	Semi Monthly Premium
$500	$9.86
$600	$11.83
$700	$13.80
$800	$15.77
$900	$17.74
$1,000	$19.72
$1,100	$21.69
$1,200	$23.66
$1,300	$25.63
$1,400	$27.60
$1,500	$29.57
$1,600	$31.54
$1,700	$33.52
$1,800	$35.49
$1,900	$37.46
$2,000	$39.43

Lincoln Financial Insurance Company
Basic & Voluntary Term Life Plan

Effective Date: (pending underwriting approval, if applicable)

• This information is a brief description of your coverage and is not a contract. Read your certificate for the exact terms and conditions.

PLAN BASICS

- **Basic Term Life Coverage** is provided to all full-time employees of Lee County Government.
- The amount of **Basic Term Life Coverage** is $50,000.
- In addition to the Basic Life Insurance that Lee County Government is providing to employees, eligible employees can purchase coverage by enrolling in a **Voluntary Term Life Insurance Plan.**
- **The Basic Employee Life is convertible.**
- **The Dependent /Voluntary Life** coverages are portable and convertible. Please refer to your certificate for eligibility.
- Coverage terminates when the respective employee is no longer employed by Lee County Government.

VOLUNTARY COVERAGE AVAILABLE

Employee:

Apply for Voluntary Life coverage in amounts of $10,000 to a maximum of $300,000 (in $10,000 increments to $100,000 and $50,000 increments afterwards).

- **For amounts in excess of $100,000, proof of good health satisfactory to the carrier must be provided.**
- If enrolled within 31 days from date of eligibility, new hires are guaranteed coverage up to $100,000.
- Employees who elect coverage outside their initial 31- day period or are increasing their coverage, must provide proof of good health satisfactory to the carrier.**

Spouse & Child(ren)*:

You may also cover your dependents with the following amounts:

• Option 1- **Spouse -** $5,000 & **Children -** $5,000
• Option 2- **Spouse**- $20,000 & **Children**- $10,000
Children - (covered from live birth through age 20 or through age 24 if a full-time student)

***It is your responsibility to notify the Human Resources Department in writing when a dependent is ineligible for coverage. Examples of ineligible dependent status are divorce, death, or a child graduates from college.**

PLAN FEATURES

Accelerated Life Benefit

Allows employees to receive a portion of their life insurance if he or she is diagnosed with a terminal illness or physical condition which is reasonably expected to result in death within 12 months. The Accelerated Life Benefit can be up to 75% of your life insurance.

Waiver of Premium Benefit*
Lincoln Financial may continue your Life Insurance without premium payments if you:
- become totally disabled while insured under the group policy
- are under the age of 60
- continuously disabled for 180 consecutive days
- give us satisfactory proof of loss

This benefit ends at age 70.*

BENEFIT REDUCTION SCHEDULE : Benefits will begin reducing as follows:

Age when reduction occurs:	65	70
Reduces to:	65%	50%

COVERED MEMBERS
An active employee of Lee County Government working 40 hours per week.

PORTABILITY
If you are under age 65 and your insurance ends because your employment terminates, you may be eligible to buy portable group insurance coverage. Please see your Human Resources representative for additional information. This is subject to state variations.

CONVERSION
If your coverage terminates while you are covered under the plan, you may purchase without medical evidence of insurability, any individual insurance policy, except a term or universal policy, This also includes a policy with disability, accidental death, or other additional benefits or a policy in an amount we issue for the form of life insurance you select. You must apply for this policy within 31 days after the date your coverage terminates. This privilege applies to insurance continued under Waiver of Premium, but excluding AD&D insurance.

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.

EXCLUSIONS
AD&D Insurance Benefits are not payable for death or dismemberment caused or contributed to by:
- war or act of war, declared or undeclared, whether civil or international, and any substantial armed conflict between organized forces of a military nature
- suicide or other intentionally self-inflicted injury
- committing or attempting to commit an assault or felony, or actively participating in a violent disorder or riot
- voluntary use or consumption of any poison, chemical compound, alcohol or drug, unless used or consumed according to the directions of a physician
- sickness or pregnancy existing at the time of the accident
- heart attack or stroke
- medical or surgical treatment for any of the above

SCHEDULE OF BENEFITS

• **Basic Employee** Life & AD&D - **$50,000** (at no cost to you, paid by Lee County Government)

Voluntary **Employee** Life Coverage

Face Amount	Rates (based on 24 pay periods)
$10,000	$1.20
$20,000	$2.40
$30,000	$3.60
$40,000	$4.80
$50,000	$6.00
$60,000	$7.20
$70,000	$8.40
$80,000	$9.60
$90,000	$10.80
$100,000	$12.00
$150,000	$18.00
$200,000	$24.00
$250,000	$30.00
$300,000	$36.00

- **Amounts over $100,000 will require you to complete a health statement.**

• Voluntary **Dependent** Life Coverage

Option 1- $5,000 on Spouse & $5,000 on Child(ren) = $.92 (per pay period)

Option 2 - $20,000 on Spouse & $10,000 on Child(ren) = $2.95 (per pay period)

- **Children means as many children as you may have**

PLAN SPONSOR
Lee County Government
106 Hillcrest Drive
Sanford NC 27330
919.718.4615

This is neither an Insurance Contract nor a Summary Plan Description 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.

Texas Life Whole Life Plan

Common Issue Date: September 1, 2013 (pending underwriting approval)

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

VPL-plus plus is an individual permanent life insurance product specifically designed for employees and their families. It provides a guaranteed level premium and death benefit for the life of the policy, and you can keep the life insurance even after you retire.[1]

As an employee, you are eligible to apply if you have satisfied your employer's eligibility period. You may also apply for coverage on your spouse, children and grandchildren. [2]

WHY VOLUNTARY COVERAGE

- Most employees are typically dependent on group term life insurance
- Today more adults than ever have only group life insurance obtained through their employers, but they carry the lowest average amounts of coverage [3]
- On the other hand, adults with both individual life and group life policies have the highest life insurance protection[3]
- Most term policies generally expire before paying a death claim
- When do you want a life insurance policy in force? --Answer: When you die
- Term if for IF you die, permanent is for WHEN you die

TEXAS LIFE'S VPL-plus

- Portable, permanent life insurance through the convenience of payroll deduction
- Whole life chassis
- Strong guarantees[1]
- Popular features
- Coverage available for spouse, minor children and grandchildren [2]

VPL-plus: PORTABLE AND PERMANENT

- Employee can keep policy, at same premium, if he/she retires or changes jobs
- Employee may apply for spouse, children and grandchildren at the worksite [2]
- Permanent coverage: policy guaranteed to remain in force as long as necessary premiums are paid.

VPL-plus: THE GUARANTEES EMPLOYEES WANT

- Guaranteed level premium
- Guaranteed level death benefit [1]
- Guaranteed reduced paid-up insurance at retirement
- Guaranteed paid-up for face amount at age 70 (or after 20 years for insureds between ages 51 and 70)

12M203-C NonEdu 2005 (exp0914) See the VPL-plus brochure for complete details. Policy PWLESV-NI-05

VPL-plus: CGI (EXPRESS ISSUE) UNDERWRITING

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

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

Child coverage (ages 6 months -26 years old)[2]:

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

Express Issue Maximums

- Employee
  - — ages 17-49, $100,000
  - — ages 50-65, $50,000
  - — ages 66-70, $10,000
- Spouse
  - — ages 17-49, $50,000
  - — ages 50-60, $25,000
- Children - ages 6 months -26 years $25,000[2]
- Grandchildren - ages 6 months -16 years $25,000[2]

Simplified Issue[4]

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

Accelerated Death Rider

- Included on all policies (Employee, Spouse, Minor Children, Grandchildren) [2]
- Pays 92% of death benefit, (84% for Illinois) less $150 ($100 in Florida) processing fee, upon physician certified diagnosis of condition expected to result in death within 12 months (24 months in Illnois) (conditions and limitations apply)
- No extra charge for rider
- Policy terminates when rider is exercised

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

VPL-plus: Review
- Permanent and portable when you change jobs or retire
- Non-participating Whole Life chassis (no dividends)
- Guaranteed level death benefit [1]
- Guaranteed level premium
- Guaranteed reduced paid-up insurance at retirement
- Premiums cease at age 70 (or after 20 years, ages 51-70)
- Accelerated Death Benefit Rider included on all policies
- Waiver of Premium available issue ages 17-55
- Express Issue underwriting
- Unisex rates
- Unismoke rates
- Blood required for amounts over $100,000
- Simplified issue for health reasons or for amounts over Express Issue maximums

[1]Guarantees are backed by the claims paying ability and financial strength of the issuing company.
[2]Policies not available on children & grandchildren in WA.
[3]Generations at Risk LIMRA International (2008)
[4] We retain the right to require a medical exam.

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

If you have any questions regarding your Texas Life policy, please call 800.283.9233 prompt #3.

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

Continuation of Benefits

ALLSTATE CANCER PLAN
When you leave employment you may continue your cancer coverage by having the premium that is currently deducted from your paycheck drafted from your bank account. You may contact **Allstate Benefits at 1.800.521.3535.**

ASSURITY ACCIDENT EXPENSE PRO PLAN
When you leave employment, you may continue your Assurity Accident coverage by having the premium that is currently deducted from your paycheck drafted from your bank account. You may call **Assurity Life at 866.289.7337.**

AUL SHORT TERM DISABILITY
When you leave employment, you will be able to have the premium billed directly to your home. Should you have any questons you may contact **AUL at 1.800.553.5318.**

GILSBAR FLEXIBLE SPENDING ACCOUNT
Under the Gilsbar Healthcare Spending Account plan, you and your covered dependents may be eligible to continue participation through COBRA. If you are eligible to continue participation, you will be notified by **IMS**, **I**nteractive **M**edical **S**ystems who is the COBRA Administrator. Unlike COBRA continuation for insurance benefits, you may only continue participation in the Health Care Spending Account until the end of the plan year in which your termination occurs. For more Cobra information, you may call your **Human Resources Department at 919.718.4615 ext. 5562.**

LEE COUNTY GOVERNMENT BCBS HEALTH, DENTAL AND VISION PLANS
Under the health, dental and vision plans, you and your covered dependents are eligible to continue medical coverage through COBRA if you experience certain “qualifying events”.

If you and your dependents are enrolled in these plans, you will be eligible to continue coverage through COBRA after you leave your employment for a specified period. In addition, while covered under the plans, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents may be eligible to continue coverage through COBRA. For more Cobra information, call your **Human Resources Department at 919.718.4615 ext. 5562.**

LINCOLN FINANCIAL TERM LIFE
Conversion: If your employment terminates while you are covered under the plan or when you are approved for long-term disability, you may purchase without medical evidence of insurability, any individual insurance policy, except a term policy. You must apply for conversion within **31 days after the date your coverage terminates**. This applies to Voluntary Life as well as the Basic coverage.

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

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

To get information and rates for porting and or converting coverage, please contact **your Human Resources Department at 919.718.4615 ext. 5562.**

TEXAS LIFE WHOLE LIFE

When you leave employment, you may continue your Texas Life Whole Life coverage by having the premiums that are currently deducted from your paycheck drafted from your bank account. You may do that by contacting **Texas Life at 1.800.283.9233 prompt #3.**

Phone Directory

- Allstate Benefits - 1.800.521.3535
- Ameritas Dental - 1.800.487.5553
- Assurity Cancer & Assurity Accident - 1.866.289.7337
- AUL/OneAmerica Short Term Disability - 1.800.553.5318
- Blue Cross Blue Shield Health - 1.877.258.3334
- Gilsbar Health and Dependent Care - 1.800.445.7227 x.883
- IMS (Interactive Medical Systems) 1.800.426.8739
- Lee County Government Human Resources Department- 919.718.4615
- Lincoln Financial Life Insurance- 1.800.423.2765 or 919.718.4615 x.5562
- Mark III Brokerage, Inc.- 1.800.532.1044
- Superior Vision - 1.800.507.3800
- Texas Life - 1.800.283.9233 prompt #3

NOTE: The website www.markiiibrokerage.com/leecountygovernmentnc will allow you to view the benefits booklet online and download claim forms for certain benefits.