Mark III
Employee Benefits

RABUN COUNTY
STATE OF GEORGIA

Employee
Benefits

Plan Year: July 1, 2016 - June 30, 2017

Arranged and Enrolled by Mark III Brokerage, Inc.

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For Your Reference

If you wish to add or make changes to your insurance coverage(s), please consult a Benefits Representative during your scheduled enrollment period. ***You will not be able to make any changes once the enrollment period is over*** unless you experience a qualified event outlined by the IRS (i.e., marriage, divorce, birth of a child, etc.) If you should experience a qualified event, you have 31 days from the date of the event to make any changes.

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

Mark III Employee Benefits

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.cigna.com/sp/ or by calling 1-866-494-2111

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For in-network providers **$1,000** person / **$3,000** family; For out-of-network providers **$2,000** person / **$6,000** family. Does not apply to in-network preventive care, office visits, emergency room visits, in-network urgent care facility visits. Co-payments don't count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. For in-network providers **$2,000** person / **$6,000** family; For out-of-network providers **$4,000** person / **$12,000** family. For in-network prescription drugs - **$1,000** person / **$2,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of the covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, penalties for no pre-authorization, prescription drug co-payments , and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of participating providers, see www.myCigna.com **or call 1-866-494-2111.**	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.

Important Questions	Answers	Why this Matters:
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charge is $1,500 for an overnight stay and **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 co-pay/visit	30% co-insurance	----------none----------
	Specialist visit	$50 co-pay/visit	30% co-insurance	----------none----------
	Other practitioner office visit	$50 co-pay/visit for chiropractor	30% co-insurance for chiropractor	----------none----------
	Preventive care/screening/ immunization	No charge	30% co-insurance (office visit & all other services)	----------none----------
If you have a test	Diagnostic test (x-ray, blood work)	No charge after initial co-pay for office visit, No charge at an outpatient facility	30% co-insurance	----------none----------
	Imaging (CT/PET scans, MRIs)	No charge during an office visit or at an outpatient facility	30% co-insurance	$250 penalty for no precertification.

Common Medical Event	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is at www.myCigna.com	Generic drugs	$10 co-pay/prescription (retail), $25 co-pay/prescription (home delivery); $10 co-pay/specialty prescription (retail & home delivery)		Coverage is limited up to a 90-day supply (retail and home delivery) at 3X copay (retail); up to a 30-day supply (retail and home delivery) for Specialty drugs
	Preferred brand drugs	$35 co-pay/prescription (retail), $88 co-pay/prescription (home delivery); $35 co-pay/specialty prescription (retail & home delivery)		Coverage is limited up to a 90-day supply (retail and home delivery) at 3X copay (retail); up to a 30-day supply (retail and home delivery) for Specialty drugs
	Non-preferred brand drugs	$60 co-pay/prescription (retail), $150 co-pay/prescription (home delivery); $60 co-pay/specialty prescription (retail & home delivery)		Coverage is limited up to a 90-day supply (retail and home delivery) at 3X copay (retail); up to a 30-day supply (retail and home delivery) for Specialty drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% co-insurance	$250 penalty for no precertification.
	Physician/surgeon fees	No charge	30% co-insurance	$250 penalty for no precertification.
If you need immediate medical attention	Emergency room services	$200 co-pay/visit	$200 co-pay/visit	----------none----------
	Emergency medical transportation	No charge	No charge	----------none----------
	Urgent care	$100 co-pay/visit	30% co-insurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% co-insurance	$250 penalty for no precertification.
	Physician/surgeon fee	No charge	30% co-insurance	$250 penalty for no precertification.

Common Medical Event	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$50 co-pay/office visit No charge/all other services	30% co-insurance/office visit 30% co-insurance/all other services	$250 penalty if no precert of non-routine services (i.e., partial hospitalization, IOP, etc.).
	Mental/Behavioral health inpatient services	No charge	30% co-insurance	$250 penalty for no precertification.
	Substance use disorder outpatient services	$50 co-pay/office visit No charge/all other services	30% co-insurance/office visit 30% co-insurance/all other services	$250 penalty if no precert of non-routine services (i.e., partial hospitalization, IOP, etc.).
	Substance use disorder inpatient services	No charge	30% co-insurance	$250 penalty for no precertification.
If you are pregnant	Prenatal and postnatal care	No charge	30% co-insurance	----------none----------
	Delivery and all inpatient services	No charge	30% co-insurance	$250 penalty for no precertification.
If you have a recovery or other special health need	Home health care	No charge	30% co-insurance	$250 penalty for no precertification. Coverage is limited to 60 visits annual max.
	Rehabilitation services	$50 co-pay/visit for Physical and Speech, Hearing & Occupational Therapy	30% co-insurance for Physical and Speech, Hearing & Occupational Therapy	$250 penalty for failure to precertify speech therapy services. Coverage is limited to an annual max of 20 visits for Physical Therapy and 20 visits for Speech, Hearing, & Occupational Therapy
	Habilitation services	Not Covered	Not Covered	----------none----------
	Skilled nursing care	No charge	30% co-insurance	$250 penalty for no precertification. Coverage is limited to 100 days annual max.
	Durable medical equipment	No charge	30% co-insurance	$250 penalty for no precertification.
	Hospice services	No charge	30% co-insurance	$250 penalty for no precertification.
If your child needs dental or eye care	Eye exam	Not Covered		----------none----------
	Glasses	Not Covered		----------none----------
	Dental check-up	Not Covered	Not Covered	----------none----------

Excluded Services & Other Covered Services

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture • Bariatric surgery • Cosmetic surgery • Dental care (Adult) • Dental care (Children)	• Habilitation services • Hearing aids • Infertility treatment • Long-term care • Non-emergency care when traveling outside of the U.S.	• Private-duty nursing • Routine eye care (Adult) • Routine eye care (Children) • Routine foot care • Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Chiropractic care		

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-494-2111. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Cigna Customer service at 1-866-494-2111. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform .

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage [does/does not] meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-494-2111.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-494-2111.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-494-2111.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-494-2111.

----------To see examples of how this plan might cover costs for a sample medical situation, see the next page.----------

Coverage Examples

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These numbers assume enrollment in individual-only coverage.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $6,430
- **Patient pays:** $1,110

Sample care costs:

Hospital charges (mother)	$2,700
Routine Obstetric Care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductible	$1,000
Co-pays	$80
Co-insurance	$0
Limits or exclusions	$30
Total	**$1,110**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,250
- **Patient pays:** $1,150

Sample care costs:

Prescriptions	$2,900
Medical equipment and supplies	$1,300
Office visits & procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductible	$0
Co-pays	$870
Co-insurance	$0
Limits or exclusions	$280
Total	**$1,150**

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Plan ID: 5493787 **BenefitVersion:** 6
Plan Name: 2016 Benefit Summary OAP for Rabun County BOC

CIGNA Health Plan Rates

Base Plan Rates
(26 pays)

Employee Only	**$20.77**
Employee & Family	**$507.86**

CIGNA HealthCare
1000 Great-West Drive
Kennett, MO 63857
1-866-494-2111 (available 24/7)

Gilsbar Flexible Spending Accounts

Plan Year: July 1, 2016 - June 30, 2017
Health Care FSA Maximum: $2,550 / Minimum $250
Dependent Care Account Maximum: $5,000 / Minimum: $500

Run-out Period: 60 days following end of the Grace Period for all Active Employees; 90 days following the termination date for Terminated Employees

Thank you for choosing to participate in the Health Care or Dependent Care FSA or HRA. Your plans are administered by Gilsbar, LLC. **Rabun County's group number is S2699.**

MANAGE YOUR ACCOUNT ONLINE 24/7 AT WWW.MYGILSBAR.COM!

- View plan year balance
- Set up or edit ACH/Bank Draft Information
- Check claim status
- View claim/receipt images within 24 hours of submission
- Obtain claim forms
- Set up email messaging
- View processed payments and payment dates
- Files appeals to denied claims

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, and you will need a valid email address and your group number, S2699.

STEP 2: Once logged in, choose the FSAs and HRAs link 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 each time:

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

STEP 3: Click the Accounts tab at the top to confirm that your address and annual election(s) are accurate. If there are any discrepancies in your account information, please contact us at (800) 445-7227 ext. 1883.

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

SUBMIT YOUR CLAIMS:	CONTACT US:
For fastest processing, fax claims and receipts to: (866) 635-1329 Mail claims and receipts to: Claims Processing Center P.O. Box 965 Covington, LA 70434 *(Please keep the original documents for your records.)*	**Customer Contact Center** **Phone: (800) 445-7227 ext. 1883** **Email: flex@gilsbar.com** **7:00 a.m. - 7:00 p.m. CST** *(Please do not email claims/receipts.)*

Your Healthcare FSA

WHAT IS A HEALTHCARE FSA?

Provided by your employer, a Healthcare FSA is a reimbursement account that allows you to set aside a certain amount of money each paycheck, pre-tax, to help pay for out-of-pocket medical expenses for you and your family. 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 can save an additional 20-30% on healthcare expenses**.

Any employee who has eligible out-of-pocket expenses beyond what their health plan covers should enroll in the Healthcare FSA. Eligible out-of-pocket expenses are determined by the IRS and include deductibles, co-insurance, co-payments, and other non-covered expenses in excess of the maximum amounts allowed under your plan.

HOW DOES THE HEALTHCARE FSA WORK?

With an FSA, you must decide on your contribution amount at the beginning of the plan year. The amount you designate will be equally divided among 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 visits, and planned medical expenses, i.e. braces or LASIK eye surgery. An expense worksheet is provided to help you determine the amount of money to allocate to your Healthcare FSA.

The IRS requires that all money in the account be used during the plan year. Money cannot be returned to you or carried over to the following year. For this reason, it is better to underestimate your expenses at the beginning of the plan year when you decide your election amount. To help avoid this situation, you will receive a notice of your balance prior to the end of the plan year, so you can use that balance on qualified expenses prior to the last day of the current plan year.

Once you decide how much you want to contribute each paycheck, the money is automatically deposited into your account. As you incur expenses, you may fax a claim form and receipts to Gilsbar for reimbursement.

HOW DOES THE HEALTHCARE FSA SAVE ME MONEY?

The following example illustrates the per pay period savings for an employee on a bi-weekly payroll with a tax status of "single" with one exemption:

	With FSA	Without FSA
Salary:	$1000.00	$1000.00
Less Pre-Taxed Dollars:		
Healthcare Reimbursement	-$100.00	$0.00
Taxable Income	$900.00	$1000.00
Less:		
Federal Income Tax (15%*)	-$135.00	-$150.00
State Income Tax (5%*)	-$45.00	-$50.00
Social Security (7.65%*)	-$68.85	-$76.50
Net Take Home Pay:	$651.15	$723.50
Less Healthcare Expenses	-$0.00	-$100.00
Net After Expenses:	**$651.15**	**$623.50**

*Your income tax rates may vary based on your income and the state in which you reside.

HOW EASY IS IT TO USE MY HEALTHCARE FSA?

Very easy! Visit www.myGilsbar.com and log in 24/7 to access claims information and FSA balances online. Once you are logged in, select the *Reimbursement Account Center* link to view your personalized FSA dashboard. If you are new to myGilsbar, complete the brief site registration to log in. You will need your group number (found on your ID card), Social Security number, and a valid e-mail address to complete this section. As a registered user, you can:

- Access balance information.
- View images of receipts and claim forms online within 24 hours of receipt.
- Receive an email when the claim is received and is viewable online, and again when it is processed and posted for payment.
- View account elections, account deposits, reimbursement payments, claim status details, receipt images, and denials.
- File online appeals to denied claims.
- Receive end-of-year reminders about available account. balances, and much more!

CAN I CHANGE MY CONTRIBUTION AMOUNT?

Generally, you may not change your FSA election during the plan year. However, you may make changes during the annual enrollment period for the coming plan year. There is one exception to this rule: you may change your contribution amount during the plan year if you have a qualifying status change. Examples include:

- Change in legal marital status
- Change in number of tax dependents
- Termination or commencement of employment
- Dependent satisfies or ceases to satisfy dependent eligibility requirements, judgment decree, or order

MOST COMMON ELIGIBLE EXPENSES

- Dental Services
- Orthodontia/Braces
- Co-pay Amounts
- Deductibles
- Hospital Services
- Physical Therapy
- Well Baby Care
- Contact Lenses
- Lab Exams/Tests
- Insulin
- Nicotine Gum or Patches
- Prescription Drugs
- Contact Lens Solution
- Eye Examinations
- Eyeglasses
- Laser Eye Surgeries

HEALTHCARE FSA EXPENSE WORKSHEET

The below worksheet has been prepared to help you determine the amount of money you wish to allocate to your Healthcare 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. Using this information and the worksheet, you can estimate the amount you wish to allocate, on a pre-tax basis, to your Healthcare FSA (keeping in mind to only budget for those expenses specifically eligible under your Healthcare FSA).

HOW WILL HEALTHCARE REFORM AFFECT MY FSA?

Healthcare reform imposes stricter reimbursement rules for qualified medical expenses. The definition of qualified medical expense, for purposes of reimbursement from an FSA, has been modified to include amounts paid for medicine or a drug only if the medicine or drug is insulin or prescribed by a physician. **AS A RESULT OF THIS CHANGE, EFFECTIVE JANUARY 1, 2011, OVER-THE-COUNTER (OTC) MEDICINES (EXCEPT THOSE PRESCRIBED BY A DOCTOR) ARE NO LONGER ELIGIBLE FOR REIMBURSEMENT BY AN FSA ACCOUNT.**

HEALTHCARE 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	$ _____
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 healthcare expenses last year	TOTAL $ _____
Compare last year's typical expenses to those eligible under your Healthcare FSA and budget accordingly for the upcoming year.	

FAX FSA claims & proof of expense to:

(866) 635-1329

myGilsbar.com • (800) 445-7227 ext. 883 • flex@gilsbar.com

FSA Debit Card

what you need to know

HOW DOES THE FSA DEBIT CARD WORK?

Shortly after enrolling in a Healthcare Flexible Spending Account (FSA), 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 pocket.

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 transactions can be verified using one of the IRS's approved electronic methods; however, not all transactions can be verified this way. 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 of transactions 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.

HOW CAN I PROVIDE SUPPORTING DOCUMENTATION?

If you receive a substantiation request letter, please go to www.myGilsbar.com to electronically upload any required receipts. For each claim requiring a receipt, click "Upload Receipt" on the far right of the Accounts Page under your Home Page and follow the instructions. (Your receipt must be in .doc, PDF, BMP, or GIF format.) Upon successful upload, the Receipt Uploaded confirmation appears: "Your receipt has been uploaded. You may upload additional receipts if needed until the claim is approved." After uploading, you may also click "View Confirmation" and print the form for your records. NOTE: If you see a "Receipts Needed" link in the Action Required section of your Home Page, click on it. A listing of any Claims Requiring Receipts will appear.

WHERE CAN I USE MY FSA DEBIT CARD?

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

WHAT DO I NEED TO KNOW ABOUT PAYING FOR PRESCRIPTIONS?

Effective January 1, 2011, OTC medications and drugs (other than insulin) will no longer be reimbursed by an FSA unless they are accompanied by a doctor's prescription. Medications or drugs must meet one of the following criteria to be eligible for reimbursement:

1) The medicine or drug requires a prescription.
2) The medicine or drug is available without a prescription and the individual obtains a prescription.
3) The medicine or drug is insulin.

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 who 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.

Your Dependent Care FSA

WHAT IS A DEPENDENT CARE FSA?

A Dependent Care FSA is a reimbursement account that allows you to set aside a certain amount of money 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 20-30% on dependent care expenses.

HOW DOES THE DEPENDENT CARE FSA WORK?

With a Dependent Care FSA, you must decide on your contribution amount at the beginning of the plan year. The amount you designate will be equally deducted from you each pay period. To estimate your dependent care expenses, consider your expenses from last year. An expense worksheet is provided for you to help you determine the amount of money to allocate to your Dependent Care FSA.

The IRS requires that all money in your account be used during the plan year. 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
- A child over the age of 13 who is physically or mentally incapable of self-care
- Your spouse and is physically or mentally incapable of self-care
- An elderly parent who resides with you and is physically or mentally incapable of self-care

HOW CAN A DEPENDENT CARE FSA SAVE ME MONEY?

The following example illustrates the per pay period savings for an employee on a bi-weekly payroll with a tax status of "single" with one exemption:

	With FSA	Without FSA
Salary	$1000.00	$1000.00
Less Pre-Taxed Dollars		
Dependent Day Care Reimbursement	-$192.00	$0.00
Taxable Income	$808.00	$1000.00
Less:		
Federal Income Tax (15%*)	-$121.20	-$150.00
State Income Tax (5%*)	-$40.40	-$50.00
Social Security (7.65%*)	-$61.81	-$76.50
Net Take Home Pay	$584.59	$723.50
Less Dependent Care Expenses	-$0.00	-$192
Net After Expenses	**$584.59**	**$531.50**

*Your income tax rates may vary based on your income and the state in which you reside.

HOW EASY IS IT TO USE THE DEPENDENT CARE FSA?

Very easy! Visit www.myGilsbar.com and log in 24/7 to access claims information and FSA balances online. Once you are logged in, select the FSA and HRA link to view your personalized FSA Home Page. If you are new to myGilsbar, complete the brief site registration to log in. You will need your group number, Social Security number, and a valid email address to complete this section. As a registered user, you can:

- Review Action Alerts that enable you to keep current on your accounts.
- File a claim online and upload receipts and other documentation
- View account balances and history
- View payments and next payment dates
- Report lost or stolen debit cards
- Review instructions to download Gilsbar's FSA Mobile App

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. Private school tuition (K4 and above) is not eligible for reimbursement. 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

HOW DO I GET REIMBURSED?

As you incur eligible expenses, you must complete a Dependent Care FSA claim form and attach proof of payment from your day care provider or from the individual who provides the care. The claim form and documentation of expense can be submitted online at www.myGilsbar.com or my using the Gilsabr FSA Mobile App. 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.

CAN I CHANGE MY ELECTION DURING THE PLAN YEAR?

Generally, you may not change your FSA elections during the plan year unless you have a change in family status that change the benefit eligibility during the plan year. Otherwise, you may change during the annual enrollment period for the coming plan year. 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 your or your spouse's employment status
- A significant change caused by a third party in the cost of your dependent care coverage

DEPENDENT CARE FSA EXPENSE WORKSHEET

The worksheet below has been prepared to help you determine the amount of money you wish to allocate to your Dependent Care FSA. You may want to review your checkbook register or credit card statements from last year to identify expenses you paid out of your own pocket. Using this information and the worksheet, you can estimate the amount you wish to allocate, on a pre-tax basis, to your Dependent Care FSA (keeping in mind to only budget for those expenses specifically eligible for your Dependent Care FSA).

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***	$ _____
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.	

* 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 your home.

*** Please note these expenses are not eligible if the care services are provided by someone that you claim as a dependent.

FAX FSA claims & proof of expense to:
(866) 635-1329

FSA Substantiation

Proof of Eligible Debit Card Purchases

IRS REGULATIONS ON FSA DEBIT CARDS

The IRS sets regulations regarding how debit cards operate in conjunction with a Flexible Spending Account (FSA). According to these rules, there are five basic requirements that must be met for you to use an FSA debit card.

Participants must provide certification each year that they will only use the debit card for FSA eligible items. This is done during the enrollment process.

- The participant must retain all receipts for all transactions.
- 100% of debit card transactions must be reviewed by a third party to ensure that the items purchased are FSA eligible.
- Sampling or employee "self-certification" is not allowed.
- Debit cards can only be used at locations that are medical service providers or provide point of purchase review.

Fortunately, the IRS defines several Auto-Substantiation (electronic substantiation) methods that we can use 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.

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 A SUBSTANTIATION REQUEST?

You may receive requests for Manual Substantiation in the event that the charges do not qualify for Auto-Substantiation. If you receive a substantiation request, please go to www.myGilsbar.com to electronically upload any required receipts.

For each claim that requires a receipt, click "Upload Receipt" on the far right of the Accounts Page under your Home Page, and follow the instructions. (Your receipt must be in .doc, pdf, bmp, or gif format.) Upon successful upload, the Receipt Uploaded confirmation appears: "Your receipt has been uploaded. You may upload additional receipts if needed until the claim is approved." After uploading, you may also click "View Confirmation" and print the form for your records.

NOTE: If you see a "Receipts Needed" link in the Action Required section of your Home Page, click on it. A listing of any Claims Requiring Receipts will appear.

WHAT ARE ACCEPTABLE FORMS OF SUBSTANTIATION?

Acceptable forms of substantiation include: Explanation of Benefits (EOBs) and register/provider receipts showing the name and address of the merchant or provider, date of service, items purchased, and dollar amount charged. Credit card receipts are not an acceptable form because they are not itemized; Gilsbar cannot verify that the expense was an FSA eligible item.

ARE PROVIDERS, PHARMACIES, HOSPITALS, ETC. REQUIRED TO 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.

SHOULD I KEEP COPIES OF MY RECEIPTS?

Yes, 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 them to Gilsbar.

FSA/HRA Employee Portal

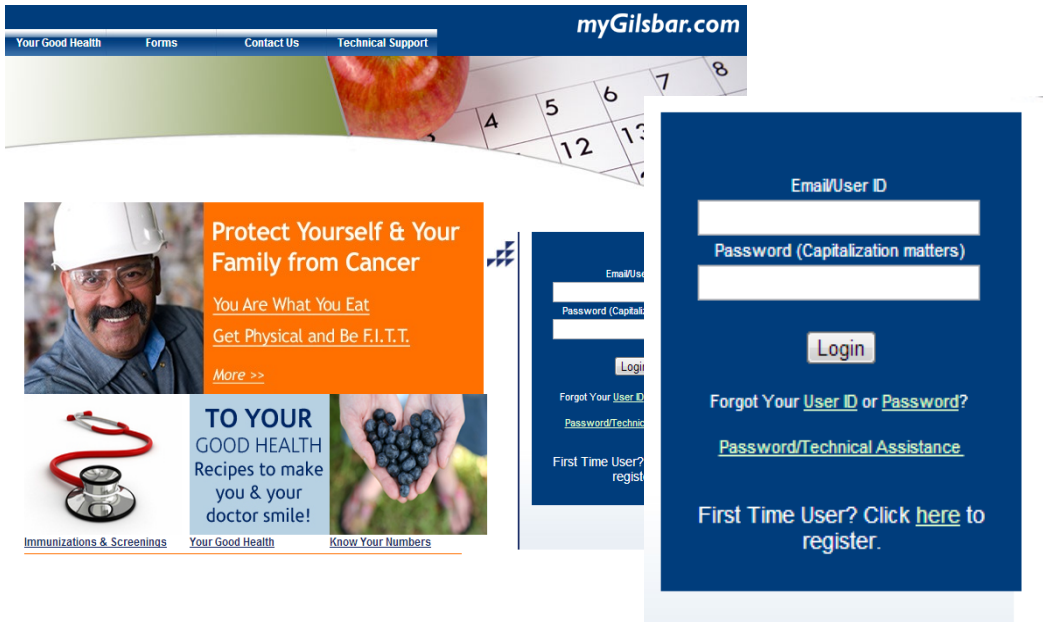
Quickstart Guide

Welcome to your Gilsbar Benefit Accounts Employee Portal. This one-stop portal gives you 24/7 access to view your information and manage your Flexible Spending Account (FSA) and Health Reimbursement Arrangement (HRA). If applicable, it enables you to:

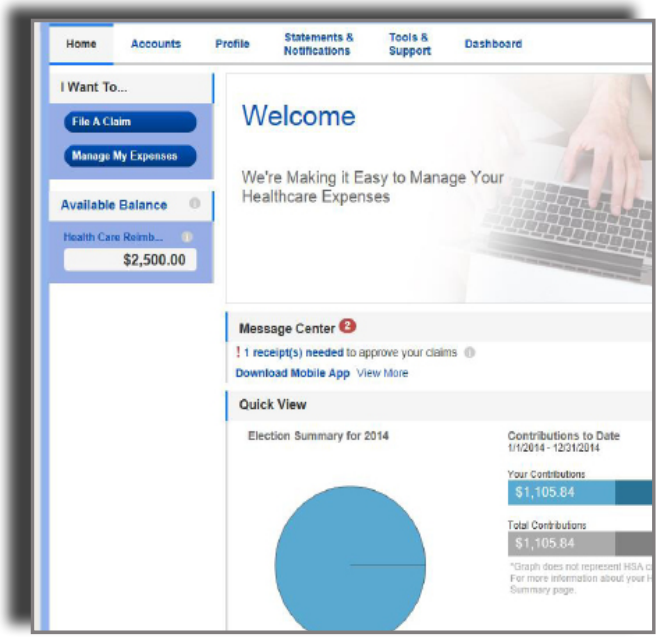
- File a claim online
- Upload receipts and track expenses
- View up-to-the-minute account balances
- View your account activity, claims and payment (reimbursement) details
- Report a lost/stolen card and request a new one
- Download forms and notifications
- Access your wellness center

ACCESSING YOUR PORTAL

1. Visit www.myGilsbar.com.
2. If you have an existing myGilsbar account, log in with your user ID and password.
3. If you are new to myGilsbar, complete the brief registration to log in. You will need your Gilsbar group number, Social Security number, and a valid email address to complete this section.
4. Once logged in, click the "FSAs and HRAs" link on the left navigation panel to access your information.



NAVIGATING THE HOME PAGE



The top section of the home page has a drop-down menu with useful links for managing your accounts.

Just below the Welcome, there are links to file a claim and to manage your expenses. Your Available Balance for each of your accounts will display towards the left side of the page. Click Available Balance to view a detailed account summary.

Your account information can also be accessed through the Accounts tab. Click on each account name to view that account's details (you may need to set your browser to allow pop-ups from the site).

The Message Center displays helpful information, alerts, and relevant links. If you see a Receipts Needed link in your Message Center, click on it. A listing of any claims requiring receipts will appear.

In the Quick View section, you will see a helpful graphical summary of paid claims, elections for the current plan year, and your contributions to date.

HOW TO FILE A CLAIM AND UPLOAD A RECEIPT

1. On the Home Page under the Accounts tab, click File Claims on the drop-down menu.
2. Enter your claim information and upload the receipt. You may also enter your mileage reimbursement information at this time. Once you have completed the form, click Add Claim.
3. You will be directed to your Claims Basket. You may choose to Add Another Claim or submit the claim(s) listed.
4. When all of your claims are added to the Claims Basket, check the box to confirm that you have read and agree to the Terms and Conditions.
5. Click Submit to send your claims for processing. The Claim Confirmation page will display. You may print the Claim Confirmation Form as a record of your submission.

FSA/HRA Mobile App

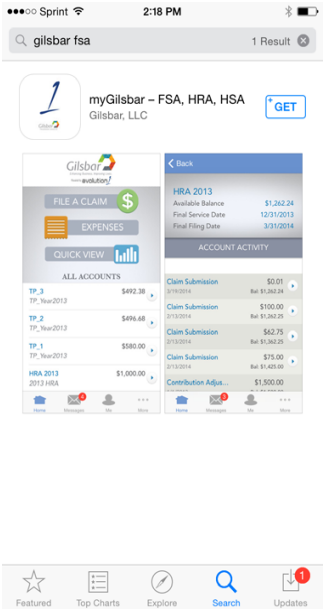
manage your accounts on the go

Gilsbar is pleased to announce the release of our FSA & HRA mobile app for your iPhone, Android, and tablet devices.

With the mobile app, you can:

- Check your FSA and HRA account balances
- View account activity and receive alerts via text message
- File new claims with receipt images
- Enter a new expense and review expense information
- Upload receipts using your mobile device's camera
- Manage expense receipts
- Report a lost or stolen ID card

DOWNLOADING THE APP

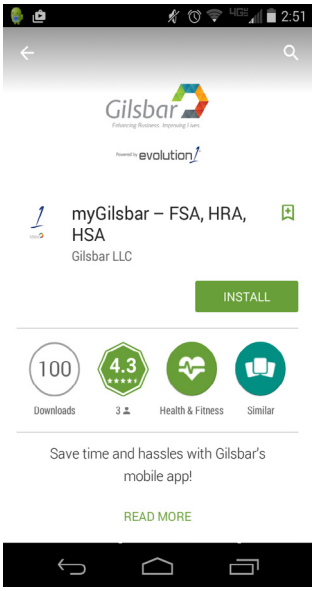


For Apple Devices:

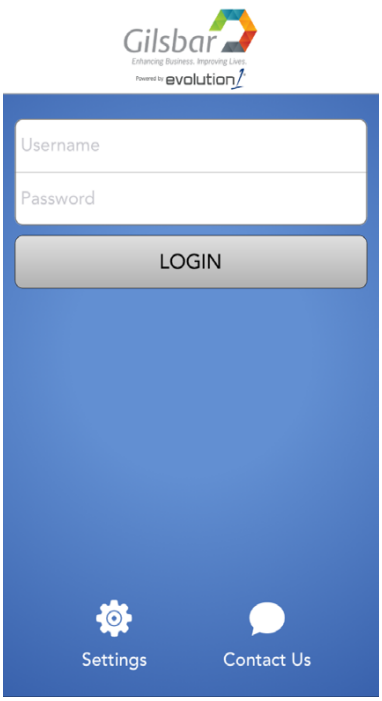
- Open the App Store and search for "Gilsbar FSA HRA."
- Tap "Get" and then "Install." You will be prompted for your Apple ID log in information. Once entered, select "OK."
- Once the app is downloaded, tap its icon to open it on your device.

For Android Devices:

- Open the Google Play Store or Market and search for "Gilsbar FSA HRA."
- Tap the Gilsbar app icon.
- Tap "Install" and then "OK."
- Once the app is downloaded, tap its icon in your app list to open it on your device.

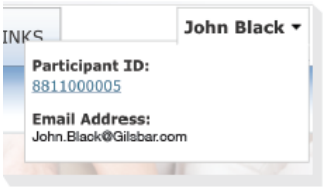


LOGGING IN TO THE MOBILE APP



- Before you log in for the first time, you will need your participant ID number.

  Your participant ID can be found in the FSA/HRA section of myGilsbar.com by clicking the arrow to the right of your name.



- Tap the Gilsbar icon to launch the app. You will be prompted to enter your username (participant ID) and password (Welcome1).
- After you enter the password, you will be prompted to set and confirm a 4-digit PIN. Each subsequent log in will require only your PIN.

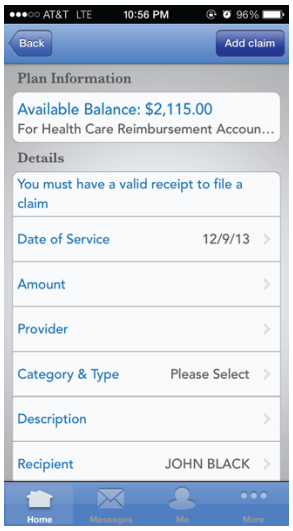
If you would like assistance installing
or logging in to the mobile app,
please contact our Customer Contact Center!
1-800-445-7227, ext 1883 • flex@gilsbar.com

INSIDE THE MOBILE APP

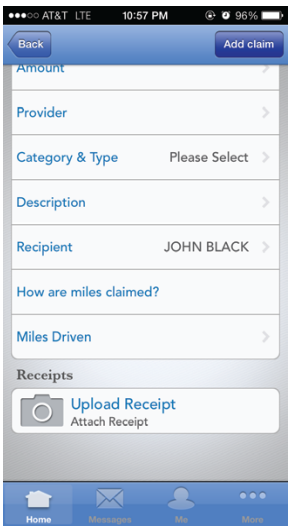
Once logged in to the app, you are seconds away from managing your FSA & HRA accounts from your phone.

view account balances & activity

file new claims



upload & manage receipts



Aetna Resources for Living EAP

Aetna Resources for Living Employee Assistance Program (EAP) provides the Rabun County employees with professional guidance in resolving issues that impact their personal and professional lives.

Counseling services are available from licensed network professionals to address such issues as: helping you balance work and home life, stress, marital/relationship, difficulty, parenting/child needs, family difficulty, alcohol and drug abuse, depression, grief, and more. The Program covers the employee, any member of the employee's household and adult children up to age 26 who don't reside in the household. Eligible members are entitled to receive up to three counseling sessions at no cost face to face, by phone or televideo.

Legal and financial counseling services are also available through the EAP. Access to an attorney in the employee's local area is available to address such needs as: estate planning, writing a last will and testament, child custody, divorce, and civil suits. A 30 minute free consultation with a participating attorney for each new legal topic, after which the employee will receive a 25% discount off the fees for service beyond the initial consultation (excluding flat legal fees, contingency fees and plan mediator services). Financial counseling is available by telephone to address financial planning, retirement planning, debt reduction/consolidation, budgeting, and home purchasing needs. A 30 minute free telephonic consultation for each new financial topic with a 25% discount off tax preparation services. Identity Theft Services include one hour fraud resolution phone consultations or coaching about ID theft prevention and credit restoration. Services include a free emergency kit for victims.

Aetna recognizes the importance of offering a high quality, proactive program that fosters good mental health and prevents disruptive and unhealthy situations. Depression, domestic violence, and marital discord are but a few examples of issues that can affect an employee's workplace performance. Our EAP focuses on providing consultation, information, success planning, and referral to resources for a variety of concerns, including, but not limited to the following:

- Depression
- Daily living issues
- Wellness
- Relationship issues
- Child care
- Personal achievement
- Elder care
- Family
- Financial
- Emotional well-being
- Legal
- Substance abuse/chemical dependency
- Stress and anxiety
- Life improvement issues

Member Services

Our EAP services are designed to meet the needs of all members. We offer a comprehensive array of Employee Assistance and WorkLife Program services that have proven to be effective in satisfying various levels of care for our members. Aetna EAP Member Services include the following:

24-Hour Member Advocate Line—Support for members that provides connection to specialists for WorkLife, legal, financial, and clinical issues

Goal and Success Planning consultation—Focuses on providing consultation and resource services to assist employees and families in achieving personal success and well-being

Personalized Resource Materials—Reinforcement for each consultation by providing members with informative materials, including educational literature that address the special needs of the employee as identified through the phone consultation

Assessment and Counseling—Up to allocated number of short-term, in-person counseling sessions for employees and family members for assessment, problem solving, and referrals to resources

National Network—Provider network coverage from anywhere in the United States (With more than 23,000 providers in our network, even employees with multi-state residences and college students away at school are covered by our services.)

MyLifevalues Online—An innovative Web site that houses all of EAP Employee Assistance services under one virtual roof, offering content, interactive tools, and educational guides for employees and managers

Legal Consultation Services—Guidance for members with legal issues such as will preparation, divorce, automobile accidents, and many other issues

Financial Consultation Services—Assistance in managing inheritance or estate taxes, retirement fund rollovers or transfers, and general tax or investment questions

Identity Theft Services—Fraud Resolution or Coaching about ID theft prevention and credit restoration.

Telephonic and Online WorkLife Services—Telephonic and online assistance with childcare, elder care, adoption, and other life events

Telephonic Follow Up—Personal follow-up contact with each member to ensure the services provided are meeting members' needs

To access these Aetna services, call: (800) 955-6422

Ameritas Dental Plan

Dental Plan Summary

Coinsurance	
Type 1	100%
Type 2	60%
Type 3	50%
Deductible	$50/Calendar Year Type 2 & 3
	Waived Type 1
	3 Family Maximum
Maximum (per person)	$1,000 per calendar year
Allowance	90th U&C
Waiting Period	None
Annual Eye Exam	None

Sample Procedure Listing
(Current Dental Terminology © American Dental Association)

Type 1	***Type 2***	***Type 3***
Routine Exam (2 per benefit period)	Restorative Amalgams	Onlays
Bitewing X-rays (2 per benefit period)	Restorative Composites	Crowns (1 in 5 years per tooth)
Full Mouth/Panoramic X-rays (1 in 3 years)	Denture Repair	Crown Repair
Periapical X-rays	Single Extractions	Endodontics (nonsurgical)
Cleaning (2 per benefit period)	Complex Extractions	Endodontics (surgical)
Fluoride for Children 18 & under (1 per benefit period)	Anesthesia	Periodontics (nonsurgical)
Sealants (age 16 & under)		Periodontics (surgical)
Space Maintainers		Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 5 years)

Ameritas Information
We're Here to Help! This plan was designed specifically for the associates of **RABUN COUNTY BOARD OF COMMISSIONERS**. At Ameritas Group, we do more than provide coverage - we make sure there's always a friendly voice to explain your benefits, listen to your concerns, and answer your questions. Our customer relations associates will be pleased to assist you 7 a.m. to midnight (Central Time) Monday through Thursday, and 7 a.m. to 6:30 p.m. on Friday. You can speak to them by calling toll-free: 800-487-5553. For plan information any time, access our automated voice response system or go online to ameritas.com/member.

Annual Maximum Carryover
Each insured (employee and/or dependent) will qualify for a dental maximum carryover if they:
1. Visit a dentist between January 1 and December 31 of the plan year.
2. Submit a claim for payment prior to March 1 of the following year.
3. Total benefits paid for the Calendar Year must be less than $500.

If you meet all 3 requirements, you will be eligible for the Annual Maximum Carryover benefits. This benefit will provide you with an additional $250 towards your annual dental maximum for the following year. In future years, if you continue to meet these requirements, you will continue to see an added "banked" amount of $250 until you have reached a maximum carry over of $1,000. This benefit can allow you to accumulate up to $1,000 in addition to your $1,000 annual maximum. Also, if you have services rendered through a network dentist, you can accumulate an additional $100 each year, allowing you to reach this $1,000 carry over amount more quickly!

PPO Information
This plan does not require a member to utilize a network provider giving you the option to visit any licensed dental provider. Although, you will likely experience some out of pocket savings by utilizing a network provider. To find a provider, visit ameritasgroup.com and select FIND A PROVIDER, then DENTAL. Enter your criteria to search by location or for a specific dentist or practice. California Residents: When prompted to select your network, choose PPO Dental Network.

Pretreatment
While we don't require a pretreatment authorization form for any procedure, we recommend them for any dental work you consider expensive. As a smart consumer, it's best for you to know your share of the cost up front. Simply ask your dentist to submit the information for a pretreatment estimate to our customer relations department. We'll inform both you and your dentist of the exact amount your insurance will cover and the amount that you will be responsible for. That way, there won't be any surprises once the work has been completed.

Late Entrant Provision
We strongly encourage you to sign up for coverage when you are initially eligible. If you choose not to sign up during this initial enrollment period, you will become a late entrant. Late entrants will be eligible for only exams, cleanings, and fluoride applications for the first 12 months they are covered.

This document is a highlight of plan benefits provided by Ameritas Life Insurance Corp. as selected by your employer. It is not a certificate of insurance and does not include exclusions and limitations. For exclusions and limitations, or a complete list of covered procedures, contact your benefits administrator.

Bi-Weekly Rates

Employee Only	$11.11
EE + Family	$31.88

AMERITAS
LIFE INSURANCE CORP.

Superior Vision Plan

Outline of Benefits – Gold Preferred Plan with Materials Discount
Vision Plan – Preferred Provider (PPO / Indemnity)
Copayment: $10.00 Exam
$15.00 Materials[1]
$35.00 Contact Lens Fitting Fee

How to Use the Plan
Welcome to Superior Visions vision plan. Superior Vision provides primary vision care benefits including eye examinations, prescription eyewear, and contact lenses through a broad-based provider network consisting of ophthalmologist, optometrist, 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 an diagnosis of 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 health living.

BENEFITS	**FREQUENCY**	**IN-NETWORK[1]**	**NON-NETWORK[1]**
Comprehensive Exam *(by an Ophthalmologist)*	12 Months	Covered in Full	Up to $42.00
Comprehensive Exam *(by an Optometrist)*	12 Months	Covered in Full	Up to $37.00
Lenses (Standard) per Pair			
Single Vision	12 Months	Covered in Full	Up to $32.00
Bifocal	12 Months	Covered in Full	Up to $46.00
Trifocal	12 Months	Covered in Full	Up to $61.00
Lenticular	12 Months	Covered in Full	Up to $84.00
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
Contact Lens Fitting[4]			
Standard	12 Months	Covered in Full	Not Covered
Specialty	12 Months	Up to $50.00	Not Covered
Frames (Standard)[3]	24 Months	Up to $100.00	Up to $48.00

1 All in-network and out-of-network allowances are at the retail value.
2 Contact lenses are in lieu of eyeglass lenses and frames benefits.
3 The insured is responsible for paying any charges in excess of this allowance.
4 Standard contact lens fitting fee applies to an existing contact lens user who wears disposable, daily wear, or extended wear lenses only. The specialty contact lens fitting fee applies to new contact lens wearers and/or a member who wears, gas permeable, or multifocal lenses.

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[5] 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 Discounts
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.

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.**

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

5 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

BI-WEEKLY COST

Employee Only	$ 4.50
Employee + 1 Dependent	$ 8.72
Employee + Family	$ 12.81

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

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

Customer Service/Corporate Office
11101 White Rock Rd., Ste. 150
Rancho Cordova, CA 95670

Claims Administration
P.O. Box 967
Rancho Cordova, CA 95741

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

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

SUPERIOR VISION
See yourself healthy.

Sun Life Financial Short Term Disability Insurance

ELIGIBILITY
- Coverage is available for all full-time employees working 37.5 hours or more per week.
- An employee is eligible for coverage on the first day of employment.
- Application for coverage must be made within 31 days of eligibility, otherwise evidence of insurability must be submitted to, and approved by Sun Life.

AMOUNT OF INSURANCE
- Weekly benefit is 60% of your weekly salary.
- Maximum benefit is $500 per week.

ELIMINATION PERIOD
- Benefits begin on the 1st day absent for accidents provided total disability occurs within 72 hours after an accident.
- Benefits begin on the on the 8th day for sickness.

MAXIMUM BENEFIT PERIOD
- Maximum benefit period is 26 weeks while you are totally or partially disabled.

TOTAL WEEKLY EARNINGS
- Your basic weekly earnings as reported by your Employer immediately before the first date your total disability begins. Total weekly earnings do not include overtime pay, bonuses, or any other extra compensation.
- If your amount of insurance increases or decreases due to a change in salary, your increase/decrease will take effect immediately upon the date of change, providing you are actively at work.

LIMITATIONS AND EXCLUSIONS

No benefits are payable for any total or partial disability during any of the following periods:
- Any period you are not under the regular and continuing care of a physician
- Any period you don't submit to a medical examination requested by Sun Life
- Any period you engage in any occupation or employment for wage, other than partial disability employment with your employer
- Any disability that is due to mental illness unless you are under the continuing care of a psychiatric specialist
- Any period of disability due to drugs or alcohol unless receiving treatment from a rehabilitation center, or designated institution approved by Sun Life

No benefits are payable for any total or partial disability due to:
- intentionally self-inflicted injuries;
- active participation in a riot, rebellion, or insurrection;
- war, declared or undeclared, or any act or war;
- committing or attempting to commit an assault, felony, or other illegal act;
- injury or sickness covered by Worker's Compensation or similar law;

COST TO YOU

- The cost of Sun Life Short Term Disability is paid by the employees through payroll deduction.
- Benefits are tax-free.
- Your cost is determined by multiplying your weekly benefit by .0721.

Example: Weekly Benefit Total cost per pay period
$350 multiplied by .0721 x 12 divided by 26 = $11.65

For questions or information about your coverage, call Sun Life Group Customer Service Center at (800) 247-6875

Sun Life Financial Long Term Disability Insurance

ELIGIBILITY

- Coverage is available for all full-time employees working 37.5 hours or more per week.
- An employee is eligible for coverage on the first day of employment.
- Application for coverage must be made within 31 days of eligibility, otherwise evidence of insurability must be submitted to, and approved by Sun Life.

AMOUNT OF INSURANCE

- Monthly benefit is 50% of your monthly salary.
- Maximum benefit is $5000 per month.
- Minimum benefit is $100 per month.

ELIMINATION PERIOD

- You must be continuously totally or partially disabled for 180 days before long term disability benefits are payable.

MAXIMUM BENEFIT PERIOD

- The maximum benefit period is the period shown below, or normal retirement age whichever is longer.

Age at Disability	Maximum Disability Period
Less than age 60	To age 65 but not less than 60 months
60	60 Months
61	48 Months
62	42 Months
63	36 Months
64	30 Months
65	24 Months
66	21 Months
67	18 Months
68	15 Months
69 and over	12 Months

Year of Birth	Normal Retirement Age
Before 1938	Age 65
1938	Age 65 & 2 months
1939	Age 65 & 4 months
1940	Age 65 & 6 months
1941	Age 65 & 8 months
1942	Age 65 & 10 months
1943 through 1954	Age 66
1955	Age 66 & 2 months
1956	Age 66 & 4 months
1957	Age 66 & 6 months
1958	Age 66 & 8 months
1959	Age 66 & 10 months
After 1959	Age 67

TOTAL MONTHLY EARNINGS

- Your basic monthly earnings as reported by your Employer immediately before the first date your total or partial disability begins. Total monthly earnings do not include overtime pay, bonuses, or any other extra compensation.
- If you are paid on an hourly basis, your total monthly earnings will be based on your hourly rate of pay, but will not exceed 40 hours per week.
- If your amount of insurance increases or decreases due to a change in salary, your increase/decrease will take effect immediately upon the date of change, providing you are actively at work.

LIMITATIONS AND EXCLUSIONS

No benefits are payable for any total or partial disability during any of the following periods:

- Any period you are not under the regular and continuing care of a physician providing appropriate treatment and regular examination and testing in accordance with your disabling condition, unless you have reached your maximum point of recovery and are still totally or partially disabled.
- Any period you don't submit to a medical examination or clinical assessment requested by Sun Life.
- Any period you engage in any occupation or employment for wage, other than partial disability employment with your employer.
- Any disability that is due to mental illness unless you are under the continuing care of a psychiatric specialist. After you complete your elimination period, benefits are payable for 24 months. Benefits after the first 24 months are payable only if you are confined to a hospital or institution licensed to provide psychiatric treatment. Benefits can be continued for up to 90 days following discharge.
- Any period of disability due to drug or alcohol use, unless your are actively supervised by a physician or rehabilitation counselor and are receiving continuing treatment from a rehabilitation center or designated institution approved by Sun Life. Benefits are payable for 24 months, if during the elimination period, you become confined to a hospital or institution licensed to provide drug or alcohol treatment or begin participation in a drug or alcohol rehabilitation program acceptable to Sun Life. Benefits after 24 months are payable only if you are confined to a hospital or institution licensed to provide drug or alcohol treatment.
- Any period during which you are incarcerated.
- Any period of disability that is due to chemical or environmental illness unless you are under the continuing care of a physician providing appropriate treatment and regular examination and testing in accordance with your disabling condition. LTD benefits are payable for 24 months. Benefits after 24 months are payable only if you are confined to a hospital.
- Any period of total or partial disability that is due to chronic fatigue illness, unless you are under the continuing care of a physician providing appropriate treatment and regular examination and testing in accordance with your disabling condition. Benefits are payable for 24 months. Benefits after 24 months are payable only if you are confined to a hospital.
- Any period of total or partial disability that is due to musculoskeletal and connective tissue illness, unless you are under the continuing care of a physician providing appropriate treatment and regular examination and
- testing in accordance with your disabling condition. Benefits are payable for 24 months. Benefits after 24 months are payable only if you are confined to a hospital.

No benefits are payable for any total or partial disability due to:

- intentionally self-inflicted injuries;
- active participation in a riot, rebellion, or insurrection;
- war, declared or undeclared, or any act or war;
- committing or attempting to commit an assault, felony, or other illegal act;
- operation of any motorized vehicle while intoxicated;
- a pre-existing condition, which is a condition that during the 12 months prior to your effective date of coverage, you received medical treatment, consultation, care, or services, or took prescribed

drugs, or had symptoms that would have caused an ordinarily prudent person to consult a health care provider for diagnosis, care or treatment.

The pre-existing condition exclusion will not apply if your total or partial disability begins later than 12 months after your effective date of insurance.

COST TO YOU

- The cost of Sun Life Long Term Disability is paid by the employees through payroll deduction.
- Benefits are tax-free.
- The cost per pay period is determined by multiplying your monthly income by the rate found in the chart below (example: $3,000 X .00135 X 12 divided by 26 = $1.87 per pay period).

Your Age	Rate
Under 30	$.00135
30-34	$.00192
35-39	$.00279
40-44	$.00384
45-49	$.00702
50-54	$.00942
55-59	$.01307
60-64	$.01153
65-69	$.00702
70-74	$.00461
75-79	$.00500

For questions or information about your coverage, call Sun Life Group Customer Service Center at (800) 247-6875.

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Sun Life Financial Term Life Insurance

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

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT
Benefits under this coverage are payable as described in your booklet. All active employees have Basic Accidental Death and Dismemberment coverage.

OPTIONAL EMPLOYEE LIFE INSURANCE
Your employer-sponsored basic life coverage provides important protection for you, but you may need to add to that protection.

OPTIONAL DEPENDENT LIFE INSURANCE
Provides coverage on:
- Your spouse
- Child(ren) up to age 19 (to age 23 if wholly dependent upon you for maintenance and support if enrolled as a full-time student.)

To help meet this need, you have the opportunity to elect additional group life insurance under the optional portion of your program.

ELIGIBILITY
You will be eligible for this program if you are a full-time Employee scheduled to work at least 37.5 hours per week.

ENROLLMENT
Enrollment is simple - just fill out the election form provided by your employer.

STATEMENT OF HEALTH
Increases in coverage, a re-entry in the plan and participants who enroll 31 days beyond the eligibility period will be required to provide evidence of insurability satisfactory to the insurer.

BENEFICIARY
You have the right to designate the beneficiary of your choice. The beneficiary elected on your life enrollment form designates your beneficiary for basic and optional coverage. You are automatically the beneficiary under Dependent Life. It is the responsibility of the insured to update the beneficiary designation as necessary.

WHEN YOUR BASIC INSURANCE STARTS
Your Basic Insurance begins on the first day of the calendar month following six months of employment, but only if you are actively at work on the date such insurance is to begin. If you are not actively at work on that date, such insurance will begin on the next date that you are actively at work.

WHEN YOUR OPTIONAL INSURANCE STARTS
If you enroll for Optional Life Insurance on or before you become eligible for coverage, your insurance becomes effective on the date of your eligibility if you are actively at work. If you are not actively at work, your insurance will not be effective until you return to active full-time work.

WHEN YOUR DEPENDENT INSURANCE STARTS
Your dependents are eligible for coverage on the date you are eligible to be insured or the date you acquire an eligible dependent, unless the dependent is confined to a hospital or confined at home and unable to perform normal activities.

WAIVER OF PREMIUM
If you become totally disabled while insured, the Waiver of Premium Provision may continue your Life Insurance without any further payment of premium by you or your employers. You must become disabled prior to age 60 and prior to retirement. The amount of your insurance is subject to reductions in age. You must apply for benefits under the Waiver of Premium Provision within 12 months after you cease to be actively at work. This provision ceases when you reach age 70.

REDUCTIONS AT AGE 70 & OVER
If you remain in active service beyond age 70 your combined amount of Basic and Optional Employee Life Insurance will reduce as follows:

Attained Age	Percent of Original Amount
70	67%
75	50%

TERMINATION OF COVERAGE
All insurance under this plan will terminate upon the earlier of:
- the date you retire.
- the date your employment terminates.
- the last date for which any required premium is paid.
- the date you request in writing to terminate your insurance.
- the date you enter active duty in any armed service during time of war (declared or undeclared).
- the date you cease to be actively at work.

Your insurance can be continued if you are on temporary layoff, leave of absence, or vacation as long as your employer pays the required premium for the length of time specified below.
- Layoff - for up to 1 month
- Leave of absence - for up to 1 month
- Vacation - up to 3 months

If you are absent from work due to an injury or sickness, your employer may continue your life insurance, by paying the required premium, for up to 12 months.

GROUP ACCELERATED BENEFITS
The Accelerated Benefits provision gives terminally ill employees with a life expectancy of 12 months or less, access of up to 75% of their group life death benefit while they are alive. The minimum Accelerated Benefit available to employees is $10,000 and the maximum is $500,000.

PORTABILITY
If prior to age 65, your Optional Life insurance ceases because you terminate employment, you may apply for portable coverage, during the 31 day conversion period instead of converting to an individual policy. Portable coverage is group term life insurance and may be continued for 10 years or to age 65, whichever comes first. At the end of that time, you may convert the coverage then in force, to an individual whole life policy under the conversion privilege.

CONVERSION
If your employment terminates while you are covered under the plan, you may purchase, without evidence of insurability, a whole life policy issued by Sun Life. You must apply for this policy within 31 days after

the date your employment terminates. This privilege applies to Optional Employee Life Insurance and Optional Dependent Life Insurance as well as the Basic Employee Life Insurance.

SUICIDE EXCLUSION
No Optional Employee Life Benefits are payable if you commit suicide within 24 months from the date you became insured for Optional Life, or for any increased amount of Optional Life insurance. No Dependent Spouse Optional Life Insurance is payable if your Spouse commits suicide within 24 months from the date the dependent spouse became insured for Dependent Optional Life Insurance.

GROUP POLICY
The insurance briefly described in this material is subject to the terms and conditions of the Group Policy issued by the Insurer. These terms and conditions are described in the booklet that will be furnished to you by the Insurer. Please refer to the booklet for a full description of your insurance.

BASIC EMPLOYEE LIFE INSURANCE AND AD&D*
All Eligible Employees - $25,000
(Paid by Rabun County)

OPTIONAL EMPLOYEE LIFE INSURANCE*
You may elect 1, 2, or 3 times your Basic Annual Earnings rounded to the next higher $1,000, if not already a multiple of $1,000, to a maximum of $300,000.

Guaranteed Issue amount for Employee's optional life is:
Under age 60 - the lesser of 3 times your Basic Annual Earnings or $50,000
Ages 60 to 69 - $20,000
Ages 70 to 79 - $10,000
Age 80 and over - $1,000

OPTIONAL DEPENDENT LIFE INSURANCE
- $5,000 to $30,000 in increments of $5,000 on your spouse**
- $5,000 or $10,000 on each of your eligible children***

Child(ren) - Monthly cost per $1,000 of coverage: $0.10
Bi-Weekly cost per $1,000 of coverage: $0.05

Guaranteed Issue amount for the Dependent Spouse is:
Under age 60 - $10,000
Ages 60 to 69 - $1,000

** See "Reductions at age 70 and Over.*
*** Spouse coverage end at age 70.*
****For children age 14 days but under 1 year, the amount is $500, the amount for children under 14 days is none*

Employee Age	Cost Per $10,000		Spouse Age	Cost Per $10,000	
	Monthly	Bi-Weekly		Monthly	Bi-Weekly
Under 30	$1.45	$0.67	**Under 30**	$0.84	$0.39
30-34	$1.67	$0.77	**30-34**	$0.94	$0.43
35-39	$2.09	$0.96	**35-39**	$1.16	$0.54
40-44	$3.32	$1.53	**40-44**	$1.78	$0.82
45-49	$5.81	$2.68	**45-49**	$3.06	$1.41
50-54	$9.82	$4.53	**50-54**	$5.04	$2.33
55-59	$16.00	$7.38	**55-59**	$7.88	$3.64
60-64	$20.80	$9.60	**60-64**	$12.30	$5.68
65-69	$36.40	$16.80	**65-69**	$21.54	$9.94
70-74	$63.03	$29.09			
75+	$194.80	$89.91			

For questions or information about your coverage, call Sun Life Group Customer Service Center at (800) 247-6875

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Texas Life Whole Life Policy - Solutions 121

Common Issue Date: August 15, 2016

An ideal complement to any group term and optional term life insurance your employer might provide, Texas Life's SOLUTIONS 121 is the life insurance you keep, even when you change jobs or retire as long as you pay the premiums. It will help protect your family, both today and, more importantly, tomorrow. Even better, you won't even have to pay for it after age 65 (or 20 years if you're 46 years of age or older), because it's guaranteed to be paid up.[1]

SOLUTIONS is an individual permanent life insurance product specifically designed for employees and their families. These policies provide a guaranteed level premium and death benefit for the life of the policy, and all you have to do to qualify for basic amounts of coverage is be actively at work the day you enroll. You also may apply for coverage on your spouse, children and grandchildren with limited underwriting requirements. [2]

As an employee, you are eligible to apply once you have satisfied your employer's eligibility period.

Why Voluntary Coverage?

- Most employees typically depend 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 most 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 is for IF you die, permanent is for WHEN you die.

The SOLUTIONS Advantage

Individual Protection SOLUTIONS 121 is a permanent life insurance policy that you own; it can never be canceled, as long as you pay the guaranteed level premiums due, even if your health changes. Because you own it, you can take SOLUTIONS 121 with you when you change jobs or retire with no change in the premium.

Coverage for Your Family You may also apply for an individual SOLUTIONS 121 policy for your spouse/domestic partner, dependent children ages 15 days-26 years and grandchildren ages 15 days-18 years, even if you do not apply for coverage.[2]

Paid Up Insurance SOLUTIONS 121 has premiums that are guaranteed to remain level until your age 65, or for 20 years if you purchase the policy after age 45. At that time, the policy becomes **fully paid up; no further premiums are due**, and the death benefit does not reduce. This gives you the peace of mind that comes with life insurance that's paid for as your income changes in retirement.

Convenience of payroll deduction Thanks to your employer, SOLUTIONS 121 premiums are paid through convenient payroll deductions and sent to Texas Life by your employer.

Portable, Permanent You may continue the peace of mind SOLUTIONS 121 provides, even when you change jobs or retire. Once your policy is issued, the coverage is yours to keep. If you should change jobs or retire before the policy becomes paid up, you simply pay the monthly premium directly to Texas Life by automatic bank draft or monthly bill (for monthly bill we may add a billing fee not to exceed $2.00). Premiums are guaranteed to remain level to your age 65, or for 20 years if you purchase the policy after age 45, when the policy is fully paid-up, no further premiums are due, and your death benefit does not reduce.

Accelerated Death Benefit due to Terminal Illness For no additional premium, the policy includes an Accelerated Death Benefit Due to Terminal Illness Rider. Should you be diagnosed as terminally ill with the expectation of death within 12 months, you will have the option to receive 92.6% (92% in CA, CT, DC, DE, FL, ND & SD) of the face amount, minus a $150 ($100 in Florida) administrative fee in lieu of the insurance proceeds otherwise payable at death. This valuable living benefit gives you peace of mind knowing that, should you need it, you can take the large majority of your death benefit while still alive. (Conditions apply)

Accelerated Death Benefit for Chronic Illness Included in the policy at the option of the employer, the Accelerated Death Benefit for Chronic Illness rider covers all applicants. If an insured becomes permanently chronically ill, meaning that he/she is unable to perform two of six Activities of Daily Living (such as bathing, continence, or dressing), or is severely cognitively impaired (such as Alzheimer's), he/she may elect to claim an accelerated death benefit in lieu of the Face Amount payable at death. The single sum payment is 92% of the Face Amount less an administrative fee of $150 ($100 in FL). The Accelerated Death Benefit for Chronic Illness Rider premiums are 8% of the base policy premium. Conditions and limitations apply. See the SOLUTIONS 121 Pamphlet for details. (Policy form ULABR-CI-14 or ICC14-ULABR-CI-14.)

Waiver of Premium Rider This benefit to age 65 (issue ages 17-59) waives the premium after six months of the insured's total disability and will even refund the prior six months' premium. Benefits continue payable until the earlier of the end of the insured's total disability or age 65. Cost is an additional 10% of the basic monthly premium. Self-inflicted or war-related disability is excluded. Notice, proof and waiting period provisions apply. (Policy Form ICC07-ULCL-WP-07 and Form Series ULCL-WP-07).

Coverage begins immediately Coverage normally begins when you complete the application and the authorization for your employer to deduct premiums from your paycheck. Two year suicide and contestability provisions apply (one year in ND).

Texas Life Whole Life Insurance – SOLUTIONS 121

Sample Rates

The chart below displays examples of SOLUTIONS 121 rates at varying ages for a $50,000 policy. Rates shown below for both non-tobacco and tobacco users, and include the cost for Waiver of Premium and the Accelerated Death for Chronic Illness benefit.

Age	SOLUTIONS 121			
	Face Amount	Monthly Premium **Non-Tobacco Chronic Illness, Waiver**	Monthly Premium **Tobacco Chronic Illness, Waiver**	**Paid-up Age**
20	$50,000	$38.11	$46.96	**65**
25	$50,000	$43.42	$54.63	**65**
30	$50,000	$53.45	$67.02	**65**
35	$50,000	$68.20	$86.49	**65**
40	$50,000	$91.80	$115.40	**65**
45	$50,000	$125.43	$162.01	**65**

SOLUTIONS Review

- Permanent and yours to keep when you change jobs or retire
- Non-participating Whole Life (no dividends)
- Guaranteed death benefit [1]
- Guaranteed level premium
- Guaranteed paid-up insurance at age 65, or for 20 years if the policy is purchased after age 45
- If you're actively at work the day you enroll, you can qualify for basic amounts with no more underwriting.
- Includes Accelerated Death Benefit for Chronic Illness
- Waiver of Premium included for ages 17-59
- If you desire more coverage, you can qualify by answering just four underwriting questions.
- Coverage available for spouse, children and grandchildren[2]

[1] Guarantees are subject to product terms, exclusions and limitations and the insurers claims-paying ability and financial strength.

[2] Coverage and spouse/domestic partner eligibility may vary by state. Coverage not available for children and grandchildren in Washington. Texas Life complies with all state laws regarding marriages, domestic and civil union partnerships and legally recognized familial relationships.

[3] Facts About Life, LIMRA International (2011)

If you have any questions regarding your Texas Life policy, please call 800-283-9233, prompt #2

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

15M002-C 1001 CI & Waiver R0715 (exp0117)

See the SOLUTIONS brochure for complete details.
Policy form WLOTO-NI-11 or ICC11-WLOTO-NI-11

Continuation of Benefits

MEDICAL AND DENTAL PLANS

Under the group medical and dental 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. Also, while you are covered under the plan, your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA. For more Cobra information, call your ***Payroll Department at 706-782-5271****.*

GILSBAR FLEXIBLE SPENDING ACCOUNTS

If you have a positive balance (payroll deductions are greater than the amount you have received in reimbursement) in your Spending Accounts at the time of your termination, you may continue participation in the Plan for the remainder of the Plan year. If you want to remain in the Plan, you can do by selecting the COBRA option.

If you prefer to terminate your participation and contribution to the Plan, any balance in your account on the date of termination will be forfeited if expenses were not incurred prior to the date of termination. For more detailed information, please call your ***Payroll Department at 706-782-5271****.*

SUPERIOR VISION PLAN

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

If you and your dependents are enrolled in the vision plan, you will be eligible to continue coverage through COBRA after you leave employment for a specified period. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents maybe eligible to continue vision coverage through COBRA. Also, while you are covered under the plan, your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA. Should you have any questions you can contact ***IMS at 1-800-426-8739****. Interactive Medical Systems is the COBRA Administrator.*

AFLAC PLANS

You may continue your Aflac policies by having the premiums currently being deducted from your paycheck either drafted from your bank account or billed directly to your home. Contact ***Aflac at 1-800-433-3036*** *for more information.*

SUN LIFE FINANCIAL TERM LIFE

When you leave employment with Rabun County prior to age 65, you may apply for portable coverage during the 31 day conversion period, instead of converting to an individual policy. This coverage is group term life and may be continued for 10 years or to age 65 whichever comes first. You must provide a statement of good health in order to qualify for portable coverage.

You may also convert your life insurance to an individual policy. The application for conversion must be made within 31 days of your termination from employment. You do not have to submit Evidence of Insurability to convert to an individual policy. For details, please call ***Sun Life at 1-800-247-6875****.*

TEXAS LIFE WHOLE LIFE

When you leave employment you may continue your whole life coverage by having the premiums that are currently deducted from your paycheck billed to your home address or drafted from your bank account. You may do that by contacting ***Texas Life at 1-800-283-9233, prompt #2.***

Contact Information for Questions and Claims

CIGNA HealthCare
1000 Great-West Drive
Kennett, MO 63857
1-866-494-2111 (available 24/7)
www.mycigna.com

Gilsbar Flexible Spending Accounts
Customer Service
1- 800-445-7227 ext. 883

Aetna Resources for Living EAP
1-800-955-6422

Ameritas Dental
1-800-487-5553
www.ameritas.com

Superior Vision Services
11101 White Rock Road
Rancho Cordova, CA 95670
1-800-507-3800
www.superiorvision.com
Non-Network Claims Submission:
P.O. Box 967
Rancho Cordova, CA 95741

Sun Life Financial
Customer Service Center 1-800-247-6875
www.sunlife-usa.com

Texas Life Insurance Company
PO Box 830
Waco, TX 76703-0830
1-800-283-9233

Mark III Employee Benefits
114 E. Unaka Ave.
Johnson City, TN 37601
1-800-532-1044 x207
www.markiiibrokerage.com/rabuncountyga

View Benefit Information & Download Forms at:

www.markiiibrokerage.com/rabuncountyga

or scan:

Mark III
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