Table of Contents

Pre-Tax Benefits

FBA Flexible Spending Accounts 5

Ameritas Dental High Plan 21

Ameritas Dental Low Plan 27

Superior Vision High Plans 32

Assurity Accident Expense + Plan 35

Allstate Cancer and Specified Disease Plan 44

After-Tax Benefits

Humana Short-Term Disability Plan 55

Group Term Life Plan 60

Texas Life Whole Life Policy 65

For Your Reference

Continuing Your Benefits 68

Contact Information for Questions and Claims 69

Plan Arranged By:

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

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

The Plan Year is September 1, 2012 through August 31, 2013.

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

- **Humana Short-Term Disability**
- **MetLife Group Term Life**
- **Texas Life Whole Life**

If you wish to add or make changes to your insurance coverage(s), please consult a Benefits Representative during your scheduled enrollment period. ***You will not be able to make any changes once the enrollment period is over*** unless you experience a qualified event outlined by the IRS (i.e., marriage, divorce, birth of a child, etc.) If you should experience a qualified event, you have 30 days from the date of the event to make any changes.

Enrollment Period: April 23, 2012 - May 3, 2012

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.

Frequently Asked Questions

What is a Flexible Benefits Plan?

A Flexible Benefits Plan allows employees to select various employee benefits to match their specific needs. Under IRS Code Section "125", certain insurance premiums can be payroll deducted on a pre-tax basis.

How does a Flexible Benefits Plan help employees save money?

By electing to pay for qualified insurance premiums on a pre-tax basis, dollars are deducted for these elections and taxable payroll is reduced before state, federal and FICA withholding are taken out. In the example below, the employee is saving $120 per month, or $1,440 per year.

	With Plan	Without Plan
Salary (monthly)	$3000	$3000
Less Pre-Taxed Dollars:		
Flexible Spending Account (FSA)	$250	0
Qualified Insurance Premiums	$150	0
Taxable Income	$2600	$3000
Less:		
Taxes (30%)	$780	$900
Net Take Home Pay	$1820	$2100
Less FSA & Insurance Premiums	0	$400
Net After Expenses	$1820	$1700

Who can participate in the Flexible Benefits Plan?

All employees of Rowan-Salisbury Schools who work 30 hours or more and who meet policy eligibility requirements will be able to participate in the Plan. Rehired retirees are not eligible to participate in the plan.

Newly hired employees are immediately eligible for group benefits. Group benefits include dental, vision, and term life. If benefits are elected, coverage will begin the first of the month following date of hire.

How do I enroll in the Flexible Benefits Plan?

Enrollment is held on an annual basis in the spring (April 23 - May 3, 2012). During enrollment, employees can meet with a Benefits Representative to review current benefit elections and make changes to their benefits for the upcoming plan year. Any changes made during the enrollment period will become effective September 1st of the upcoming year.

Can I make changes to my benefits during the Plan Year?

Generally you cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections. You are permitted to change elections if you have a "change in status" and you make an election change that is consistent with the "change in status." If you need to make a change to your benefits due to a "change in status," you have 30 days from the date of status change to make appropriate changes.

Currently, Federal law considers the following events to be "changes in status":

- Marriage, divorce, death of a spouse, legal separation or annulment;
- Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent
- Any of the following events for you, your spouse or dependent: Termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in work site, or any other change in employment status that affects eligibility for benefits;
- One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance;
- A change in place of residence of you, your spouse, or your dependent. This applies ONLY to Dependent Care and ONLY if that change in residence results in a change of dependent care service provider and its cost.

For additional details, please see "Changes in Your Election" on page 16.

Are there waiting periods on any of the benefits?

Yes. There are waiting periods for new enrollees on the dental, cancer, and disability plans.

- **Dental** - There is a 12 month waiting period on all procedures (except cleanings, exams, and fluoride treatments) for employees who do not enroll within 31 days of becoming eligible for coverage.
- **Cancer** - Charges incurred during the first 30 days of coverage are not eligible for payment.
- **Disability** - Humana will not cover pre-existing conditions for one year after coverage becomes effective. Pre-existing conditions mean:

(1) the existence of symptoms first manifested during the one year period before the Effective Date of your coverage; or

(2) any Sickness, disease, or physical condition for which medical advice or treatment was recommended by or received from a Physician during the one year period preceding the Effective Date of your Coverage.

Flexible Benefit Administrators
Flexible Spending Accounts

Plan Year: September 1, 2012 - August 31, 2013
Health Care Flexible Spending Account Maximum: $2,500.00
Health Care Flexible Spending Account Minimum: $200.00
Waiting Period: None
Runoff Period: 90 days

FLEXIBLE BENEFIT PLAN: THE BETTER YOU PLAN, THE MORE YOU SAVE!

It's more than a slogan. The Flexible Benefit Plan is a real solution to issues facing all of us. Simply stated, by taking advantage of tax laws, the Flexible Benefit Plan works with your benefits to save you money.

Your insurance programs are designed to help you and your family become financially secure as well as to protect you against the high cost of medical care including catastrophic events. However, almost everyone has a number of necessary, predictable expenses that are not covered by your insurance programs. The Flexible Benefit Plan will help you pay for these predictable expenses.

The Flexible Benefit Plan offers a unique way to help pay for some of your health care expenses.

The key to the Flexible Benefit Plan is that your eligible expenses are paid for with Tax Free Dollars. You will not pay any federal, state or social security taxes on funds placed in the Plan. You will save between, approximately, $27.65 and $37.65 on every $100 you place in the Plan. The amount of your savings will depend on your federal tax bracket.

Using the Flexible Benefit Plan can save you a significant amount of money each year, however, it is important that you understand how the Plan works and how you can make the most of the advantages the Flexible Benefit Plan offers.

This chapter will help you understand the Flexible Benefit Plan. The chapter covers how the Plan works, describes the categories of the Plan, explains the rules governing the Plan, the reimbursement process and how you can elect to participate in the Flexible Benefit Plan. Prior to electing to participate in the Flexible Benefit Plan, it is important that you read and understand the Rules and Regulations section of this handbook.

After you read this material, if you have any questions please feel free to contact **Flexible Benefit Administrators, Inc. at (757) 340-4567 or (800) 437-FLEX.**

FLEX NOTE: FLEX is authorized by Section 125 of the Internal Revenue Code

Health Care Reimbursement Account

The Health Care Reimbursement Account allows you to pay for your uninsured medical expenses with pre-tax dollars. With this account, you can pay for your out of pocket medical expenses for yourself, your spouse and all of your dependents for medical services that are incurred during your Plan Year. The maximum you may place in this account for the Plan Year is $2,500.

Examples of Eligible Health Care Expenses:
Fees/Copays/Deductibles

- Acupuncture
- Ambulance hire
- Anesthetist
- Chiropractor
- Dental Fees
- Diagnostic
- Eye Exams
- Prescription Eye glasses/ Contact lenses
- Psychiatrist
- Hospital
- Laboratory
- Nursing
- Obstetrician
- Laser Eye Surgery
- Physician
- Psychologist
- Erectile dysfunction medication
- Sterilization Fee
- Surgery
- X-Rays
- Wheel Chair

Other Eligible Expenses:

- Prescription drugs
- Artificial limbs & breasts (only if reconstructive)
- Birth control pills, patches (e.g. Norplant)
- Orthopedic shoes/inserts
- Incontinence supplies
- Carpal tunnel wrist supports
- Vaccinations & Immunizations
- Elastic hose (medically prescribed)
- Contact lens supplies
- Therapeutic care for drug and alcohol addiction
- Diabetic supplies
- Routine Physicals
- Condoms
- Dentures
- Oxygen
- Physical Therapy
- Fertility Treatments
- Hearing aids and batteries
- Reading glasses
- Medical equipment
- Pedialyte for dehydration
- Nicotine gum/patches
- Take-home screening kits (HIV, colon cancer)
- At home pregnancy test kits
- Smoking cessation programs and prescribed drugs designed to alleviate nicotine withdrawal
- Mileage, parking and tolls (you may be reimbursed $.19* a mile plus parking and tolls when medical reasons make it necessary to travel)
- Tuition fees for medical care (if the college furnishes a breakdown of medical charges)
- Orthodontic expenses (not for cosmetic purposes)

NOTE: ORTHODONTIC TREATMENT IS REIMBURSED ACCORDING TO YOUR PAYMENT PLAN WITH THE ORTHODONTIST. FOR EXAMPLE: If your payment plan is set up to pay $100 a month for the orthodontic treatment, you can be reimbursed $100 a month for the payments that become due during the Plan Year.

This above list is compiled from IRS publication 502. If you are unsure that your expected medical expense will be eligible under tax code regulations, please call Flexible Benefit Administrators at (757) 340-4567 or (800) 437-FLEX before making your election for the Plan Year. IRS publication 502 can be ordered by calling the IRS at (800) 829-3676.

**Mileage reimbursement rate is based on IRS regulation and subject to change.*

Over-the-Counter Drugs

Please be advised that recent Senate legislation has stated that effective January 1, 2011, participants are required to have a prescription for Over-the-Counter ("OTC") products to be eligible under their FSA plan. Therefore a prescription or letter of medical necessity would be required after January 1, 2011 for OTC items.

Over-the-Counter Expenses

Examples of medications and drugs that may be purchased in reasonable quantities with a prescription:

- Antacids
- Pain relievers/aspirin
- Ointments & creams for joint pain
- First aid creams
- Bug-bite medication
- Allergy & sinus medication
- Cough & cold medications
- Laxatives
- Anti-diarrhea medicine

Over-the-Counter Expenses that ARE NOT Eligible

The following examples are OTC items that are not eligible and will not be reimbursed under any circumstances because the items are considered dietary supplements, toiletries, cosmetic or personal use items:

- Multi/Daily Vitamins
- Weight loss products/foods
- Face cream/moisteners
- Mouthwash/toothpaste
- Feminine hygiene products
- Deodorant
- Chapstick
- Suntan lotion
- Herbal/natural supplements
- Acne creams/face cleanser
- Medicated shampoo/soaps
- Toothbrushes (even if dentist recommends a special one)
- Eye/facial makeup/preparations

DUAL PURPOSE DRUGS & ITEMS - Expenses that need documentation from your physician to be eligible through the Health Care Account

The following items are examples of products that are considered as having both a medical purpose and a general health, personal/cosmetic purpose and require a medical practitioner's note stating the name of the patient, the specific medical condition for which the OTC is recommended, the time frame of the treatment and that the treatment is not cosmetic:

- Weight-loss drugs (to treat obesity)
- Prenatal vitamins
- Nasal sprays for snoring
- Pills for lactose intolerance
- Fiber supplements (to treat a medical condition for a limited time)
- OTC Hormone therapy (to treat menopausal symptoms)
- Glucosamine/Chondroitin (for arthritis)
- St. John's Wort (for depression)

Please be advised that recent Senate legislation has stated that effective January 1, 2011, participants are required to have a prescription for Over-the-Counter ("OTC") products to be eligible under their FSA plan. Therefore a prescription or letter of medical necessity would be required after January 1, 2011 for OTC items.

EXPENSES FOR IMPROVEMENT OF GENERAL HEALTH are not eligible for reimbursement even if a doctor prescribes the program. However, if the program is prescribed for a specific medical condition (e.g. Obesity, Emphysema), then the expense would be eligible. We must have a letter from your doctor on file for each Plan Year stating specifically what illness or disease is being treated or prevented and the length of time you will be required to use this treatment in order to reimburse for any of these types of expenses.

- Health Club Dues
- Weight Loss Programs
- Exercise equipment
- Exercise classes
- Wigs

NOTE: *For Weight Loss Programs, only the cost of the program is an eligible expense. Any cost for food or food supplements is not an eligible expense.*

COSMETIC expenses, prescriptions and treatments are not eligible. This applies to any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat an illness or disease. If cosmetic treatment is necessary to correct a deformity or abnormality, a personal injury or a disfiguring disease, it must meet IRS eligibility guidelines outlined in IRS publication 502 and will require a physician's letter of medical necessity.

Other Expenses that ARE NOT Eligible for Reimbursement Through the Health Care Account:

ESTIMATES for medical expenses that have not been rendered cannot be reimbursed. Medical services do not have to be paid for, however, the services must have been rendered during the Plan Year, to be eligible for reimbursement.

PREMIUM EXPENSES for any insurance policies are not eligible for reimbursement through the Health Care Account. This includes contact lens insurance.

EXPENSES PAID BY AN INSURANCE COMPANY are not eligible for reimbursement through the Health Care Account. Only the portion you have to pay out of your pocket for your medical expenses is eligible for reimbursement.

THE BENEFITS CARD

The Benefits Card system allows you to pay for eligible pre-tax account expenses electronically at approved service providers and merchants. The Benefits Card provides you with instant access to your pre-funded Health Care Reimbursement Account for many common regular eligible expenses. You may also enjoy the convenience of paying for you childcare expenses (up to your account balance at the time of “swipe”) with the Benefits Card.

In order for you to get the most benefit from your Plan, we want to remind you of a few things concerning the Benefits Card:

- The Benefits Card works just like a debit card, only your “bank account” consists of the funds you elected to set aside in your pre-tax account(s). The card is not eligible for use at ATM’s or other unqualified merchant locations. The card will be denied at the point of sale when used at an ineligible location is attempted. If an eligible provider does not accept MasterCard®, you must file a paper claim. *When using the card at a self-service merchant terminal, select the credit option, not the debit option (there is no PIN #).
- Your card will be mailed to your home address via first class mail. Please allow up to two weeks for delivery of your card. If you do not receive your card two weeks after the start of your Plan Year, contact Flexible Benefit Administrators, Inc. so that a replacement card may be ordered. Any eligible expense incurred during that time may be reimbursed by mailing or faxing a claim form, and receipts to Flexible Benefit Administrators, Inc., following the customary claims filing procedure and cutoff times.
- When you receive your card, sign the back of the card prior to using it. Your card is activated upon the first swipe of your card.
- Continue to save all receipts. Flexible Benefit Administrators, Inc. may request them to verify expense eligibility.
- Flexible Benefit Administrators, Inc. will notify you by mail or e-mail if you incur an expense with the card that is or appears to be ineligible. Upon this notice you must send Flexible Benefit Administrators, Inc. a Transaction Substantiation Form with the corresponding itemized documentation within 40 days of the transaction; you may download and print a Transaction Substantiation Form from our website. If you do not send in those required items, your card will be deactivated until the documentation is received.
- Your transaction will be denied for any amount greater than your health care reimbursement account annual election or your dependent care reimbursement account posted balance at the time of the “swipe”.
- You should notify Flexible Benefit Administrators, Inc. immediately if your card is lost or stolen to deactivate the card. If your employment is terminated, your card will be permanently deactivated.
- You may monitor your account balance, transaction history or print a statement at any time, night or day on the Benefits Card website: **www.benefitspaymentsystem.com**.
- Additional information regarding the Benefits Card is available on our website:

www.flex-admin.com. You may also download the Transaction Substantiation Form from our website under Participant Forms; FBA Benefits Card; Forms.

Attention: *Benefits Card Participant*
Subject: *Benefits Card Use*

In light of IRS Rulings on Benefits Card use, it is important that you make yourself familiar with the cardholder agreement that accompanies your Benefits Card. Flexible Benefit Administrators, Inc. strongly suggests reviewing this document and making yourself and any dependent cardholders in your household aware of the terms.

Please be aware that upon receipt and signing of your Benefits Card, you as the cardholder and employee participant of the Plan are ultimately responsible for using the card for eligible expenses. This also applies to any dependent that has use of the Benefits Card. By signing the back of the card, the employee/dependent is agreeing to the terms and conditions of this agreement.

As in the past, your responsibility as a participant in a tax-free plan is to use the card for eligible expenses ONLY (such as prescriptions, eyeglasses and medical co-pays, etc.) As with paper claim submission, cosmetic prescriptions and procedures are not eligible for reimbursement. Please remember that each time you use your card you are certifying that the expense is eligible. If you have any doubt as to whether an expense is eligible, you should refer to your employee handbook, IRS Publication 502 or call our office to speak with one of our administrators. It is also your responsibility to acquire all documentation such as receipts, EOBs, etc. for the Plan Year's expenses and to retain the documentation for the entire Plan Year. If you are aware that you have paid for an expense with the card that is ineligible it is your responsibility to notify Flexible Benefit Administrators, Inc. immediately. You will need to submit a Transaction Substantiation Form along with repayment for the amount of the ineligible expense.

Flexible Benefit Administrators, Inc. may request documentation to substantiate your Benefits Card transactions to determine eligibility of the expense. In the event that your documentation shows ineligible expenses were paid with your Benefits Card, Flexible Benefit Administrators, Inc. will request that you re-pay the amount of the ineligible expense. If the payment is not received in the allotted time frame your card will be deactivated. Also, Flexible Benefit Administrators, Inc. may offset future claims and notify your employer. IRS rulings allow your employer to withhold this amount from your wages if necessary.

The Benefits Card is NOT PAPERLESS, just less paper and is a great convenience for the participants in the Plan, if used properly.

PLEASE NOTE: *Eligible items purchased at participating Inventory Information Approval System (IIAS) merchants will be automatically approved! When purchasing prescriptions and/or over-the-counter FSA-eligible items, the merchant's IIAS will verify the items and automatically approve the transaction with no follow-up request. The Benefits Card is not accepted at merchants who have not implemented IIAS. Please visit* ***www.sig-is.com*** *and select "IIAS Merchants List" for the most recent list of IIAS merchants.*

Obtaining a Reimbursement from your Health Care Account

To obtain a reimbursement from your Health Care Account, you must complete a Claim Form. This form is available from your benefits website. You must attach a receipt or bill from the service provider which includes all the pertinent information regarding the expense:

- Date of service
- Patient's name
- Amount charged
- Provider's name
- Nature of the expense
- Amount covered by insurance (if applicable)

Cash register receipts, credit card receipts and canceled checks alone are not eligible forms of documentation for medical expenses. These items are not considered third party receipts because they only reflect that payment has been made and do not provide the required information listed above. Prescription documentation must include the name of the prescribed medication.

Obtaining a Reimbursement for Over-the-Counter Items

For the purchase of over-the-counter medications, with a prescription or a letter of medical necessity, cash register receipts will be accepted as documentation if the receipt is detailed and indicates the name of the service provider, the date of the purchase, the amount of the purchase and the name of the product purchased. You must also send in a copy of the Rx or letter of Medical necessity signed by a Physician, along with your claim form. If the receipt does not specifically reflect the name of the product we cannot accept the claim for reimbursement of that item. The name of the patient does not have to be on the receipt, however, the name of the patient must be listed on the claim form.

NOTE: In order to be eligible for reimbursement through the Health Care Account, the medical expense must be incurred during the Plan Year. IRS defines *"incurred"* as when the medical care is provided (or date of service), not when you are formally billed, charged for, or pay for the care. FOR EXAMPLE: If you go to the doctor on June 26th and your Plan Year begins on July 1st, this expense is not eligible in the new Plan Year. Even if you pay for this expense after July 1st, the "date of service" was before the Plan Year began and therefore is not eligible.

The Health Care Account is a Pre-Funded Account

This means that you can submit a claim for medical expenses in excess of your account balance. You will be reimbursed your total eligible expense up to your annual election. The funds that you are pre-funded will be recovered as deductions continue to be deposited into your account throughout the Plan Year.

Dependent Care Reimbursement Account

The Dependent Care Reimbursement Account allows you to pay for day care expenses for your dependents with tax-free dollars.

Eligible Dependent

- A child under 13 who qualifies as a dependent on your Federal Income Taxes
- Any other dependents, including a disabled spouse, disabled children over age 13 and elderly parents, who depend on you for financial support, qualify as dependents for tax purposes, and are incapable of self care
- Please refer to Page 15 for the latest definition of a dependent, as revised under Section 152 of the Code by the Working Families Tax Relief Act of 2005 (WFTRA)

Eligible Dependent Care Expenses

For dependent care expenses to be eligible for reimbursement, you must be working during the time your eligible dependents are receiving care. If you are married, your spouse must be:

- Working at the time the day care services are provided;
- A full-time student for at least five months during the year; or
- Mentally or physically disabled and unable to provide care for him or herself

EXPENSES FOR KINDERGARTEN are not eligible for reimbursement since they are generally for education, and not for custodial care. In order for an expense to be eligible for reimbursement from the Dependent Care Reimbursement Account, the primary purpose for the care of the qualifying individual must be to assure the individual's well-being and protection. Dependent care must still be primarily for custodial care, not education, in order to qualify as an eligible employment-related expense from the Dependent Care Reimbursement Account.

Examples of Dependent Care Expenses

- Baby-sitters or Nannies that claim the child care as income on their taxes
- Licensed day care centers
- Private Preschool
- Before and after school care
- Day care for an elderly or disabled dependent

Expenses that WOULD NOT be Eligible Through the Dependent Care Account

- Kindergarten (kindergarten & above is considered an educational expense)
- Days you or your spouse are not working, including sick leave, vacation days, and maternity leave
- Transportation, books, clothing, or entertainment (Note: These expenses will be covered if provided by the nursery school or day care center as part of its preschool care services. If these types of expenses are billed separately, they are not an eligible expense.)
- Care provider may not be a child of yours under the age of 19 or anyone you claim as a dependent for federal income tax purposes

- Baby-sitting for social events
- Overnight camp is not an eligible expense, only DAY CAMPS are eligible.

Remember that this account is set-up so that you and your spouse are able to go to work and Overnight camp is 24-hour care.

Annual Maximum for the Dependent Care Reimbursement Account
Must Not Exceed The Lesser Of:

- $5,000 for one or more children ($2,500 if you are a married individual filing a separate tax return);
- Your wages or salary for the Plan Year; or
- The wages or salary of your spouse

If your spouse is either a full time student or is incapable of taking care of himself or herself then he or she is deemed to have monthly earnings of $250 if there is one (1) child or dependent, and $500 if there are two (2) or more children or dependents.

Using the Dependent Care Reimbursement Account Versus Filing for a Tax Credit on Your Taxes
Under current IRS regulations, you may be eligible to receive a tax credit for dependent care costs. You may claim a credit for dependent care, up to $3,000 for one child and $6,000 for two or more children, on your income taxes through the child care tax credit. However, through the Dependent Care Reimbursement Account you may set aside up to $5,000 per year, for one or more children, if you are married and filing a joint tax return or if you are a single parent. If you are married and filing separate tax returns, you may set aside only $2,500.

Typically, more money is saved by paying for dependent care through the FSA Dependent Care Reimbursement Account than by taking the dependent care credit on your tax return. This is because the total for federal, state, and FICA savings usually exceeds the dependent care credit. At taxable incomes greater than $14,000, participants will probably benefit more from taking reimbursement from the Flexible Benefit Plan. These assumptions are based on the inclusion of your state income tax.

You can also file for the tax credit while participating in the Dependent Reimbursement Care Account. If the amount you have placed through the reimbursement account does not meet the maximum allowed by the IRS, you can claim the difference between your Dependent Care deductions and the IRS maximum allowable expenses for the tax credit. You can claim a tax credit for any additional dependent care expenses incurred over the $5,000 maximum FSA limit up to the $6,000 child care tax credit limit on your taxes. You cannot claim the tax credit for any dependent care expenses paid from the Dependent Care Reimbursement Account. It is your responsibility to report the Dependent Care amount on your tax form 2441. The amount is listed on your W-2 under Dependent Care Benefit for the tax year.

If you are not sure about the eligibility of an expense, phone **Flexible Benefits Administrators at (757) 340-4567 or (800) 437-FLEX** or refer to IRS Publication 503: "Dependent Care Expenses". This publication can be ordered by calling the IRS at (800) 829-3676.

Obtaining a Reimbursement from Your Dependent Care Reimbursement Account

To obtain a reimbursement from your Dependent Care Reimbursement Account you must complete a Claim Form. This claim form is available from your benefits website. You must attach a receipt from the service provider which includes all of the following:

- Name of dependent receiving care
- Date(s) care was provided (must match Claim Form)
- Name of service provider
- Social Security or Tax I.D. number of the provider
- Amount of the charge

NOTE: Dependent care expenses can only be reimbursed after the care is provided. This means that advance payments of dependent care expenses cannot be made. FOR EXAMPLE: If you pay for a summer day camp for your child in May but the camp is the first week in July, we cannot reimburse you for this expense until July when the service is provided.

The Dependent Care Reimbursement Account IS NOT a Pre-Funded Account

This means that you will only be reimbursed up to your account balance at the time you submit your claim. If your claim is for more than your account balance, the unreimbursed portion of your claim will be tracked by Flexible Benefit Administrators. You will be automatically reimbursed as additional deductions are taken and deposited into your account, until your entire claim is paid out.

Claim Filing Dates

All claims received in the office of Flexible Benefit Administrators, Inc. will be processed within one week via check or direct deposit.

Common Errors to Avoid When Filing Claims

- The claim form is not signed
- Canceled checks, cash register receipts or credit card receipts are sent in place of receipts or bills from the provider of service
- Cash register receipts for OTC item(s) do not indicate the specific name of the product(s) purchased
- Claim form has not been completed
- Insufficient postage on envelope
- "Previous balance" statements or "payment on account" receipts submitted in place of actual date of service itemized bills or receipts

Your claim form may be returned to you or delayed in processing for improper or insufficient documentation. If you have questions about your claims, you may contact Flexible Benefit Administrators, Inc. at (757) 340-4567 or (800) 437-FLEX, from 8:30 a.m. to 5:00 p.m., Monday through Friday.

Reimbursing the Provider of Service

All reimbursements will be sent to you directly. After receiving payment from your account, you are responsible for paying your providers.

Eligible Dependents

An individual is considered to be a dependent if he or she is a qualifying child or qualifying relative of the taxpayer. The following qualifying criteria now apply to be a "dependent child": the individual is a child to the participant and the individual doesn't turn 27, regardless of any other status by the end of the taxable year. In addition, the following qualifying criteria apply to be a "dependent relative": the individual has a specific family type relationship to the taxpayer, the individual is not a qualifying child of any other taxpayer, the individual receives more than half of his or her support from the taxpayer, and the individual's annual gross income is less than the Section 151 limit ($3,200 for 2005; this criteria does not apply to health plans).

Runoff Period for Filing Claims

You have the entire Plan Year plus 90 days to file all claims that were incurred during the Plan Year. All claims must be received in the office of Flexible Benefit Administrators, Inc. by 5:00 p.m. on the 90th day, following the end of your Plan Year. Therefore, for the Plan Year 09/01/11 - 08/31/12, all claims must be in our office by 5:00 p.m. on November 29, 2013. If claims are not received during this time frame for expenses incurred during the Plan Year, your remaining funds will be forfeited. **(Remember "90 days" does not mean 3 months and "received in the office" does not mean the day it was postmarked).** Please, do not delay; complete your claims early.

Forfeiting Funds

Any money you do not use from a reimbursement account for expenses incurred during a Plan Year will be forfeited. The forfeited funds will be returned to your employer to offset the cost of the program. If you plan carefully, you can avoid being affected by this IRS restriction.

Changes in Your Election

Generally you cannot change the elections you have made after the beginning of the PLAN YEAR. However, there are certain limited situations when you can change your elections. You are permitted to change elections if you have "change in status" and you make an election change that is consistent with the "change in status." Currently, Federal law considers the following events to be "changes in status":

- Marriage, divorce, death of a spouse, legal separation or annulment;
- Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent
- Any of the following events for you, your spouse or dependent: Termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in work site, or any other change in employment status that affects eligibility for benefits;
- One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance;
- A change in place of residence of you, your spouse, or your dependent. This applies ONLY to Dependent Care and ONLY if that change in residence results in a change of dependent care service provider and its cost.

In addition, if you are participating in the Dependent Care Reimbursement Account, then there is a "change in status" if your dependent no longer meets the qualifications to be eligible for dependent care.

These rules on change due to cost or coverage do not apply to the Health Care Reimbursement Plan, and you may not change your election to the Health Care Reimbursement Plan if you make a change due to cost or coverage for insurance. You may not change your election under the Dependent Care Reimbursement Account if the cost change is imposed by a dependent care provider who is your relative.

To make a change in your elections, a STATUS CHANGE FORM must be completed within 30 days of the event. Flexible Benefit Administrators, Inc. or your benefits contact person will determine if your requests for an election change meets IRS Regulations.

Transferring Funds Between Accounts

IRS regulations do not allow money to be transferred between reimbursement accounts. If you elect funds to be placed in your Health Care Account, you must submit eligible medical expenses to be reimbursed from these funds. This IRS regulation also applies to the Dependent Care Reimbursement Account.

Termination of Employment

If you have funds in your Health Care Account and you submit receipts for expenses incurred prior to your termination, you can be reimbursed for funds remaining in your account up to your annual election. However, if you have money left in your Health Care Account and do not have receipts for expenses incurred prior to your termination, you cannot be reimbursed for the money remaining in your account unless you elect to participate in the federal program, COBRA. If you elect to participate in COBRA, you will need to continue to set aside dollars on an after tax basis to be deposited into your Health Care account. You can receive information concerning this program from the contact person in your company.

Your Dependent Care Reimbursement Account functions differently. If you have funds remaining in these accounts, this money will be reimbursed to you if appropriate receipts are submitted. You can receive reimbursement for expenses incurred during the Plan Year if receipts are submitted within the Plan Year and before the end of the 90-day grace period following the Plan Year end.

Effect on Social Security Benefits

As you are not paying social security tax on the portion of your income that has been placed in the Plan, your social security benefits may be slightly reduced. We suggest putting part of your tax savings into your Employer’s Retirement Program or some other savings vehicle.

Account Balances

You may call Flexible Benefit Administrators, Inc. at (**757) 340-4567** or **(800) 437-FLEX** from 8:30 a.m. to 5:00 p.m., Monday through Friday, to check your account balance. You may also access your personal account information at your convenience via our secure website: www.flex-admin.com. Each reimbursement check stub will show your contributions, request for reimbursements, and disbursements. It will also show your annual election and the balance to request by the end of the Plan Year. A reminder letter will be sent two months prior to the end of the Plan Year if you have funds left in your account.

Estimating Your Expenses

These worksheets will help you determine your annual expenses for your Health Care and Dependent Care accounts. Good planning and careful estimating is the best way to take full advantage of your Flexible Benefit Plan. Keep in mind, your maximum annual election cannot exceed $5,000 for health care and $5,000 for dependent care.

ESTIMATING YOUR HEALTH CARE EXPENSES

Medical deductibles	________________
Medical co-payments	________________
Prescription drugs	________________
Vision Exams, Glasses, Contacts	________________
Dental/Orthodontia	________________
Routine exams and physicals	________________
Over-the-counter expenses	________________

TOTAL ESTIMATED MEDICAL
EXPENSES FOR THE PLAN YEAR (Max. $2,500) ________________

ESTIMATING YOUR DEPENDENT CARE EXPENSES

Child day care expenses	________________
Pre-School expenses	________________
Summer Day Camp expenses	________________
Adult day care expenses	________________
Other eligible expenses	________________

TOTAL ESTIMATED DEPENDENT CARE
EXPENSES FOR THE PLAN YEAR (Max. $5,000) ________________

SAMPLE CLIENT FLEXIBLE BENEFIT PLAN – CLAIM FORM

Employee's name ______________________________________ SS# _______________________

HEALTH CARE EXPENSES I, the participant, hereby file claim for the medical expense(s) noted below and certify that each expense was incurred on the date and for the person and reason noted. The expense(s) listed below was incurred for medical care not general health purposes and exclude cosmetic and/or toiletries expense(s). I, the participant, certify that I have not been reimbursed for the expense(s) noted below and that I will not seek reimbursement under any other plan covering health benefits. **(Benefits Card participants:** I, the participant, further certify that the expense(s) below have not been previously paid for by use of my Benefits Card). A**ttached are receipts or bills as evidence of my expenses incurred during the Plan Year.**

**** Please note: A doctor's note must be attached if considered a "dual purpose" drug**

Date of Treatment	Person treated and Relationship	Type of eligible Expense	Amount of Expense

DEPENDENT CARE EXPENSES **I, the participant, hereby file claim for the child or dependent care expense(s) noted below and certify that each expense was incurred on the dates and for the persons noted. I, the participant, certify that I have not been reimbursed for the expense(s) noted below and that I will not seek reimbursement under any other plan. (Benefits Card participants: I, the participant, further certify that the expense(s) below have not been previously paid for by use of my Benefits Card). Attached are receipts or bills as evidence of my expenses incurred during the Plan Year. Please note that receipts must come from the day care provider and have the dates of service, a description of the expense, the amount charged and the provider's SS# or Tax ID#.**

Care Provided By	Date Care Provided	Person Care for and Relationship	Amount of Expense

I authorize the service provider to release any information requested by the Plan Administrator in connection with this request for reimbursement.

____ _____________________________________

EMPLOYEE'S SIGNATURE DATE

Mail This Claim Form To: Flexible Benefit Administrators, Inc. P.O. Box 8188, Virginia Beach, VA, 23450	Fax Claim Form To: Please Include Cover Sheet Flexible Benefit Administrators, Inc. Fax Number: 757-431-1155

Claims can also be scanned and emailed to FlexDivision@flex-admin.com
View your account on our website @ www.flex-admin.com or call FBA at (757) 340-4567.

PLEASE:
- DO NOT mail your claim form if you fax it.
- KEEP a copy of all claim forms and receipts for your records
- NOTIFY Flexible Benefits Administrators, Inc. if you have a change in address

© Copyright 2003 - Flexible Benefit Administrators, Inc.

Accessing Your Flex Account Online

Our secure Online Inquiry System allows you to have 24/7 access to your account information, payment information and your available balance.

Completing your online account set-up is just a few clicks away!

Step 1. Log-on to our website at www.flex-admin.com
Step 2. Select FLEX Participants
Step 3. Select LOG-IN TO MY FLEX ACCOUNT
Step 4. Select Continue to Login Screen
Step 5. Select Create Account
Step 6. You will be prompted to enter your Name and Employee ID
Step 7. You must then enter your Benefits Card Number or, if you do not have a Benefits Card, you may enter your Employer ID, which is: **FBARSS**
Step 8. Create your user ID, Password, Security Word and Birth City and your e-mail address.
Step 9. You are now ready to access your individual account!

Once you have completed these steps, you will have 24/7 access to current information regarding your Flexible Spending Account. It's that easy!

Problems Logging into your Account?
E-mail to: flexdivision@flex-admin.com
Include your Full Name, SS# or Employee ID#, Company Name, & Contact phone number

Telephone:
Local **757-340-4567 or Toll Free 800-437-3539** (Monday-Friday 8:30a-5:00p EST)

ADMINISTERED BY

FLEXIBLE BENEFIT ADMINISTRATORS, INC.
509 VIKING DRIVE, SUITE F
P.O. BOX 8188
VIRGINIA BEACH, VA 23450
(757) 340-4567 or (800) 437-FLEX
FAX: (757) 431-1155
FlexDivision@flex-admin.com
www.flex-admin.com

Ameritas Dental High Plan

Effective Date: September 1, 2012

Combined Calendar Year Deductible

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

Type 1 - Preventive and Diagnostic

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

- Evaluations (Two per calendar year)
- Cleanings (Two per calendar year)
- Fluoride for Children (Once a year) (Under age 19)
- Space Maintainers
- Sealants (under age 17)
- Bite wings x-rays (Two per calendar year)

Type 2 - Basic Procedures

- Type 2 benefits are payable at 80% U&C*
- $50.00 deductible applies. *Waived when a PPO provider is used.*

- Fillings
- Simple Extractions
- Periodontics (Non-Surgical)
- Panoramic X-rays (1 in 3 years)
- Restorative Amalgam

Type 3 -Major Procedures

- Type 3 benefits are payable at 50% U&C* $50.00 deductible applies.
- $50.00 deductible applies. *Waived when a PPO provider is used.*

- Crowns
- Prosthodontics (Surgical) (Removable Dentures, Partials)
- Crown & Denture Repair
- Periodontics (Gum Disease)
- Complex Extractions
- Endodontics (Root Canal)
- Anesthesia

Orthodontia - Children Only

• Paid at 50% U&C* with a $1,500 lifetime maximum per person. **No deductible applies.**

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

Annual Maximum Benefit

• Type I, 2, and 3 Procedures - $1,500 per calendar year per person.

• Orthodontia Procedures - $1,500 Lifetime per person (carryover does not apply)*This plan includes a **maximum carryover** for dental. Each insured (employee and/or dependent) will qualify for a dental maximum carryover if they:

*Percentage Paid based on Usual and Customary Charges

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 $750.

If you meet all 3 requirements you will have an additional $250 available in the Annual Dental Maximum for the next plan year. In future years if you have benefits paid of less than $750, additional amounts of $250 will be added to the carryover. However, the most you can accumulate in the maximum carryover is $1,000. Therefore, the maximum annual benefit may never exceed $2,500 in any one year.

Eligible Employees

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

Eligible Dependents

Provides Coverage On:

- Your Spouse
- Children up to age 26 and unmarried.

Dental Exclusions (Deferment Period)

During the first 36 months following your or your dependent's Dental Coverage Effective Date, the initial placement of dentures, partial dentures, or bridges, if it includes the replacement of teeth all of which are missing prior to the effective date. (For currently covered insureds, Ameritas will use the employees Date of Hire to determine the 36 month period.) This exclusion will not apply if the prosthesis replaces a sound natural tooth which is extracted while the patient is insured under this Dental Coverage and which is replaced within 12 months of the extraction. During the first 36 months of coverage, the replacement of bridges, partial dentures, dentures, inlays or crowns is excluded.

Exceptions to this exclusion will be made if the replacement is made necessary by:

a) accidental bodily injury to sound natural teeth (chewing injuries are not considered accidental bodily injuries), or

b) the extraction of a sound natural tooth provided the replacement is completed within 12 months of the date of the injury or extraction.

Pre-Determination of Benefits

A treatment plan MAY be filed if a proposed course of treatment will exceed $300.00. With this information, Ameritas can determine the benefits payable under this policy prior to the work actually being done. It will give the insured the amount payable, along with an idea of the out of pocket expense.

Coordination of Benefits

If you or any of your dependents incur charges which are covered by any other group plan, the benefits of this plan will be coordinated with the benefits of the other plan so that the total benefits received are not greater than the charges incurred.

<u>Late Entrant Provision</u>
There is a 12 month waiting period on all procedures (except cleanings, exams, and fluoride treatments) for employees and/or dependents who do not enroll within 31 days of becoming eligible for coverage. This provision is waived for employees who enrolled during the initial enrollment period. The initial enrollment period includes when the plan was first offered through Mark III (enrollment period of Spring 2008), employee's date of hire, and qualifying events (see page 4). The initial enrollment period DOES NOT INCLUDE each annual enrollment period.

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

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

Orthodontia Limitations (not a complete list)
No benefit is payable for expenses incurred:

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

Limitations/Exclusions (not a complete list)

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

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

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

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 credentials and quality assurance evaluation requirements.

Passive PPO with Deductible Reduction

In Passive PPO, the coinsurance and Annual Maximum are the same for both in-network and out-of-network. While there is an incentive for the member to see an in-network provider, there is no penalty for seeing an out-of-network dentist. Deductible Reduction is a significant difference in utilizing a network provider versus a non-network provider. With the Deductible Reduction, any applicable deductible is waived when visiting a network provider. As with all Ameritas PPO plans, 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 provider.

Commonly Asked PPO Questions

RSS is proud to provide our employees with a dental program administered by Ameritas Group. The plan provides excellent coverage for you and your eligible dependents. Please refer to the plan highlight for more details. As an added bonus, our 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 at a specific fee. Any insured member who chooses to go to a PPO provider will receive this discounted fee for procedures performed by that provider.
- As part of their contractual agreement with Ameritas, the PPO provider cannot "back-bill" the patient for the difference between the dentists' normal charges and the discounted fees that the dentist agreed to charge as an Ameritas PPO provider.
- PPO providers are required to file the claim for the patient.
- PPO providers are required to wait for reimbursement from Ameritas before billing the patient for any balances owed for deductibles, coinsurance, any amounts exceeding the annual maximum benefits, etc.

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

What happens if I don’t use an Ameritas PPO provider?
For members that do not want to utilize an Ameritas PPO provider, or if a PPO provider is not available in your area:
Rowan-Salisbury Schools wants employees to have options regarding their choice of providers. In addition, we want to ensure that employees that utilize non-panel providers receive exceptional benefits that reimburse claims for non-panel providers in the most optimal way. Non-panel providers can charge their standard fees for any service. ***However, the amount Ameritas allows for each procedure for non-panel provider utilizes 90th percentile of U&C – which is considered to be one of the highest reimbursement levels in the industry. This means that 9 out of 10 dentist’s charges will fall within the amount that Ameritas allows for each procedure.*** In doing so, employees can feel comfortable that very little back billing will occur due to the amounts allowed by the plan.

Non-panel providers have no specific requirements regarding filing of claims. However, we have found that many dentists will assist the patient with the paperwork needed to file the claim. If a dentist is not willing to file the claim on the patient’s behalf, the patient can simply attach the dentist’s bill to a claim form that includes the patient’s name and identification number, and fax or mail the claim to Ameritas for processing. Ameritas will process the claim, typically within 7-10 working days. Claim payment can be made to the patient or directly to the dentist if noted on the claim form. The patient can use Ameritas’ claim forms which are available in the Benefit’s Department or on Ameritas web site (this will be available via our Intranet in the near future), OR the patient can use any generic claim forms that the dental office may have available. Filing claims is fast and easy with Ameritas!

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

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

Ameritas Dental High Plan

TENTHLY (10-PAY) RATES

Employee Only	**$46.50**
Employee + 1 Dependent	**$88.49**
Employee + 2 or more Dependents	**$133.49**

This insurance is underwritten by Ameritas Life Insurance Corp.

Customer Service
1-800-487-5553

Web Address
www.ameritasgroup.com

Ameritas Dental Low Plan

Effective Date: September 1, 2012

Combined Calendar Year Deductible

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

Type 1 - Preventive and Diagnostic

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

- Evaluations (Two per calendar year)
- Cleanings (Two per calendar year)
- Fluoride for Children (Once a year) (Under age 19)
- Space Maintainers
- Sealants (under age 17)
- Bite wings x-rays (Two per calendar year)

Type 2 - Basic Procedures

- Type 2 benefits are payable at 80% U&C*
- $50.00 deductible applies. Waived when a PPO provider is used.

- Fillings
- Simple Extractions
- Panoramic X-rays (1 in 3 years)
- Periodontics (non-surgical)
- Restorative Amalgam

Annual Maximum Benefit

- Type I and 2 Procedures - $1,500 per calendar year per person.

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

1. Visit a dentist between January 1 and December 31 of the plan year.
2. Submit a claim for payment prior to March 1 of the following year.
3. Total benefits paid for the Calendar Year must be less than $750.

If you meet all 3 requirements you will have an additional $250 available in the Annual Dental Maximum for the next plan year. In future years if you have benefits paid of less than $750, additional amounts of $250 will be added to the carryover. However, the most you can accumulate in the maximum carryover is $1,000. Therefore, the maximum annual benefit may never exceed $2,500 in any one year.

Eligible Employees

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

*Percentage Paid based on Usual and Customary Charges

Eligible Dependents
Provides Coverage On:
- Your Spouse
- Children up to age 26 and unmarried

Pre-Determination of Benefits
A treatment plan MAY be filed if a proposed course of treatment will exceed $300.00. With this information, Ameritas can determine the benefits payable under this policy prior to the work actually being done. It will give the insured the amount payable, along with an idea of the out of pocket expense.

Coordination of Benefits
If you or any of your dependents incur charges which are covered by any other group plan, the benefits of this plan will be coordinated with the benefits of the other plan so that the total benefits received are not greater than the charges incurred.

Late Entrant Provision
There is a 12 month waiting period on all procedures (except cleanings, exams, and fluoride treatments) for employees and/or dependents who do not enroll within 31 days of becoming eligible for coverage. This provision is waived for employees who enrolled during the initial enrollment period. The initial enrollment period includes when the plan was first offered through Mark III (enrollment period of Spring 2008), employee's date of hire, and qualifying events (see page 4). The initial enrollment period DOES NOT INCLUDE each annual enrollment period.

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

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

Limitations/Exclusions (not a complete list)
- For any treatment which is for cosmetic purposes. Facings on crowns or pontics behind the 2nd bicuspid are considered cosmetic.
- Charges incurred prior to the date the individual became insured under this plan, or following the date of termination of coverage.
- Orthodontic treatments
- 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.

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

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

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 credentials and quality assurance evaluation requirements.

Passive PPO with Deductible Reduction

In Passive PPO, the coinsurance and Annual Maximum are the same for both in-network and out-of-network. While there is an incentive for the member to see an in-network provider, there is no penalty for seeing an out-of-network dentist. Deductible Reduction is a significant difference in utilizing a network provider versus a non-network provider. With the Deductible Reduction, any applicable deductible is waived when visiting a network provider. As with all Ameritas PPO plans, 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 provider.

Commonly Asked PPO Questions

RSS is proud to provide our employees with a dental program administered by Ameritas Group. The plan provides excellent coverage for you and your eligible dependents. Please refer to the plan highlight for more details. As an added bonus, our 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 at a specific fee. Any insured member who chooses to go to a PPO provider will receive this discounted fee for procedures performed by that provider.
- As part of their contractual agreement with Ameritas, the PPO provider cannot "back-bill" the patient for the difference between the dentists' normal charges and the discounted fees that the dentist agreed to charge as an Ameritas PPO provider.
- PPO providers are required to file the claim for the patient.
- PPO providers are required to wait for reimbursement from Ameritas before billing the patient for any balances owed for deductibles, coinsurance, any amounts exceeding the annual maximum benefits, etc.

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

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

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

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

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

Ameritas Dental Low Plan

TENTHLY (10-PAY) RATES

Employee Only	**$28.63**
Employee + 1 Dependent	**$54.97**
Employee + 2 or more Dependents	**$81.39**

This insurance is underwritten by Ameritas Life Insurance Corp.

Customer Service
1-800-487-5553

Web Address
www.ameritasgroup.com

Superior Vision Plan

Effective Date: September 1, 2012
Outline of Benefits - Gold Preferred Plan with Materials Discount
Vision Plan - Preferred Provider (PPO / Indemnity)
Copayment Amount: ***$0 Exam***
$10 Materials
$25 Contact Lens Fitting

HOW TO USE THE PLAN

Welcome to Superior Vision's vision plan. Superior Vision provides primary vision care benefits including eye examinations, prescription eyewear, and contact lenses through a broad-based provider network consisting of ophthalmologists, optometrists, and opticians. The plan also contracts with a large number of national and regional optometric chain locations.

Your first step should be to choose an eye care provider, or ensure that your current provider is part of the Superior Vision network. Go to **www.superiorvision.com** and click on "Locate a Provider" for an updated list. You will learn about "in-network" and "out-of-network" providers – it is an important distinction when receiving your benefits. You will also learn more about how to use your benefits, as well as the discounts that are available to you.

Remember that a routine eye exam is important not only for correcting vision problems, but for maintaining healthy eyes and overall health wellness. Superior Vision eye care providers are trained to test for and diagnosis a variety of health issues – not just eye problems. Take the time to get to know your vision plan, and start experiencing healthy eyes and healthy living.

BENEFITS	FREQUENCY	IN-NETWORK*	NON-NETWORK*
Comprehensive Exam (by an Ophthalmologist)	12 Months	Covered in Full	Up to $44.00
Comprehensive Exam (by an Optometrist)	12 Months	Covered in Full	Up to $39.00
Standard Lenses (per Pair)			
Single Vision	12 Months	Covered in Full	Up to $34.00
Bifocal	12 Months	Covered in Full	Up to $48.00
Trifocal	12 Months	Covered in Full	Up to $64.00
Lenticular	12 Months	Covered in Full	Up to $88.00
Contact Lenses (Per Pair)**			
Medically Necessary	12 Months	Covered in Full	Up to $210.00
Cosmetic (Elective)***	12 Months	Up to $120.00	Up to $100.00
Contact Lens Fitting Fee******			
Standard	12 Months	Covered in Full	Not Covered
Specialty	12 Months	Up to $50.00	Not Covered
Frames (Standard)***	24 Months	Up to $175.00	Up to $89.00

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

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

Discounts on Covered Materials

Frames:	20% off amount over allowance
Lens:	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

Discount 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 Services has a nationwide network of refractive surgeons and partners 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.

*Discounts & 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.**

10-MONTH RATES

Employee Only	$ 11.54
Employee + One	$ 16.74
Employee + Family	$ 30.01

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

Accident Expense + Plan

24 Hour Accident Plan
Effective Date: September 1, 2012
*Subject to simplified underwriting requirements

Can you remember the last time you planned to get hurt? Many believe "it won't happen" to them, but statistics tell a different story. What is your plan if you get hurt?

Accidents happen…
Not just to people in cars or on slippery sidewalks — but to cooks in the kitchen, weekend athletes, do-it-yourselfers on ladders, and kids with footballs and bikes. Some injuries can be handled with a bandage and an ice pack, but one out of 9 people sought medical attention for an injury in 2008.†

You're careful…
Seat belts, air bags, car seats, bike helmets and shin guards provide a level of protection for you and your family. You follow safety procedures at work. But, unfortunately, accidents can still result in injuries and unexpected expenses regardless of your precautions.

Disabling Injuries †
On-the-job....... 1 every 9 seconds
Off-the-job....... 1 every 3 seconds
At home........... 1 every 2 seconds

Costs are crippling…
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 separate financial crisis. And, remember, while you're laid-up — your monthly bills and expenses don't stop!

The Accident Expense+ Policy solution...
Assurity at Work, through Assurity Life Insurance Company, offers you the opportunity to protect your family and yourself from the cost of accidental injuries with the Accident Expense+ Policy. This plan pays you a fixed cash benefit for medical treatments associated with a covered accident. The benefits are paid regardless of any other insurance coverage. Here's the great news — you can extend this affordable protection to cover your spouse and children. This policy's cash benefits will be handy for your child's next trip to the emergency room for a playground or sports related injury.

Accident Expense+ Benefit Highlights…
- Accidental Death
- Accidental Death on – Common Carrier (plane, bus, train, etc.)
- Hospital Admission
- Hospital Confinement
- Hospital Intensive Care Unit
- Major Diagnostic Exams
- Physician's Office and Urgent Care

† National Safety Council Injury Facts 2011

Also included: Benefits for ambulance, emergency room, burns, dislocations, fractures, dismemberment, skin grafts, unintentional gunshot wounds, emergency dental work, eye injuries, prosthetic devices, medical appliances, blood products, ruptured disc surgery, rotator cuff surgery, abdominal or thoracic surgery, exploratory surgery, lodging and transportation.

Benefit Options
- 24-hour coverage (Form W A200)
- Off-the-job only coverage (Form W A205)

Benefit Amount
One-unit and two-unit plans are available.

Rate Structure
- Employee, Employee/Spouse, Employee/Child, Family
- One age band
- Unisex, Unismoke

Issue Age
- 18 through 64 (using Age Last Birthday as of policy issue date)
- Up to 21 for dependent children.
- Automatic coverage will be afforded any newborn or adopted dependent child if Assurity receives written notification within 30 days and only if a premium is paid for the dependent child within 30 days of birth, adoption, or placement for adoption.

Eligibility
Coverage is available for the employee, spouse and dependent children. Eligible employees must be actively at work, performing all duties of their primary occupation for the last 90 days to apply for coverage and be employed at their current employer for at least 30 days. Some industries require a longer period.

New hires must be actively at work, working 30 hours or more per week for the last 30 days, unless the waiting period is longer for that industry.

Renewability
Policy is guaranteed renewable (GR) for life. (Disability rider is GR to age 65.)

EXCLUSIONS (varies by state)
We will not pay benefits for losses caused by or as 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, parakiting or any similar activities;
- 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 contests for which any type of compensation or remuneration is received;

- who has any sickness or condition caused by 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 any injury;
- being exposed to war or any act of war, declared or undeclared;
- actively serving in any of the armed forces, or auxiliary units, including the National Guard or Army Reserve;
- 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;
- receiving injuries caused directly or indirectly while under the influence of a controlled substance or by intoxication as defined by the laws and jurisdiction of the geographical area for which the loss or cause of loss was incurred;
- having cosmetic surgery or other elective procedures that are not medically necessary;
- who is a dependent child and receives injuries during birth;
- having dental treatment except as the result of an injury;
- having a hernia;
- participating in or attempting to commit a felony;
- being incarcerated in a penal institution or government detention facility;
- driving any taxi for wages, compensation or profit;
- engaging in an illegal activity or occupation;
- self-inflicting an injury intentionally;
- 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.

For NC residents: “READ YOUR POLICY CAREFULLY. THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Care Insurance for People with Medicare, which is available from Assurity.”

Benefits – paid once per accident

Benefit	Terms/Conditions/Limits	One-Unit Plan	Two-Unit Plan
Accidental death	Within 90 days of accident	$25,000 employee $10,000 spouse $ 5,000 child	$50,000 employee $20,000 spouse $10,000 child
Accidental death on common carrier (commercial airplane, bus, train, etc.)	Within 90 days of accident not paid in addition to death benefit	$50,000 employee $20,000 spouse $10,000 child	$100,000 employee $40,000 spouse $20,000 child
Ambulance			
Air	To or from hospital or between medical facilities within 48 hours of accident	$500 any insured	$500 any insured
Ground	To or from hospital or between medical facilities within 90 days of accident	$100 any insured	$100 any insured
Appliances	As an aid in personal locomotion or mobility prescribed within 90 days of accident	$100 any insured	$100 any insured
Blood/Plasma/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
Burns	Within 72 hrs of accident		
2nd degree burns on at least 36% of body		$375 employee $150 spouse/child	$750 employee $300 spouse/child
3rd degree burns on 1-19% of body		$750 employee $300 spouse/child	$1,500 employee $600 spouse/child
3rd degree burns on at least 20% of body		$5,000 employee $2,000 spouse/child	$10,000 employee $4,000 spouse/child
Skin graft for a burn		25% of the applicable burn benefit	25% of the applicable burn benefit

Benefits – paid once per accident (continued)

Benefit	Terms/Conditions/Limits	One-Unit Plan		Two-Unit Plan	
Dislocations	Requiring correction with anesthesia diagnosed by a physician within 90 days of accident	Any insured		Any insured	
		Closed Reduction	Open Reduction	Closed Reduction	Open Reduction
Hip		$1,000	$2,000	$2,000	$4,000
Knee (except patella)	Reduction without anesthesia paid at 25%	$500	$1,000	$1,000	$2,000
Ankle or, bones of the foot (other than toes	Incomplete dislocations paid at 25%	$400	$800	$800	$1,600
Collarbone (Sternoclavicular)		$250	$500	$500	$1,000
Collarbone (Acromioclavicular), one toe or finger		$50	$100	$100	$200
Lower jaw, shoulder, elbow, wrist, bones of hand (other than fingers)		$150	$300	$300	$600
Dismemberment	Within 90 days of accident				
Both hands, both feet, sight in both eyes, or any combination of two or more hands, feet and/or eyes		$15,000 employee $10,000 spouse/child		$30,000 employee $20,000 spouse/child	
		$7,500 employee $5,000 spouse/child		$15,000 employee $10,000 spouse/child	
One hand, one foot or sight of one eye		$1,500 employee $1,000 spouse/child		$3,000 employee $2,000 spouse/child	
Two or more fingers or toes		$750 employee $500 spouse/child		$1,500 employee $1,000 spouse/child	
One finger or toe					
Emergency dental work	Paid once per accident, regardless of the number of teeth involved				
Any and all broken teeth repaired with crown		$150 any insured		$300 any insured	
		$50 any insured		$100 any insured	
Any and all broken teeth resulting in extractions					
Emergency room	Treatment within 72 hours of accident	$200 any insured		$200 any insured	
Eye injury	Requiring surgery or removal of a foreign object within 90 days of accident	$200 any insured		$200 any insured	

Benefits – paid once per accident (continued)

Benefit	Terms/Conditions/Limits	One-Unit Plan		Two-Unit Plan	
Fractures	Requiring surgical or non-surgical realignment by a physician within 90 days of the accident	Any insured		Any insured	
		Closed Reduction	Open Reduction	Closed Reduction	Open Reduction
Skull (depressed)		$1,250	$2,500	$2,500	$5,000
Skull (non-depressed)		$500	$1,000	$1,000	$2,000
Hip, thigh		$750	$1,500	$1,500	$3,000
Vertebrae (excluding vertebral process), pelvis, leg (tibia and/or fibula)		$400	$800	$800	$1,600
Vertebral process		$150	$300	$300	$600
Bones of face or nose, upper jaw (maxilla), upper arm (humerus)		$175	$350	$350	$700
Lower jaw (mandible), shoulder blade (scapula), collar bone (clavicle, sternum), forearm (radius and/or ulna), hand, wrist (except fingers), kneecap (patella), foot (except toes), ankle		$150	$300	$300	$600
Rib		$125	$250	$250	$500
Coccyx		$100	$200	$200	$400
Finger, toe		$25	$50	$50	$100
Gunshot wound (unintentional)	Requiring hospital confinement within 24 hours and surgery within 72 hours for one or more wounds	$500 any insured		$1,000 any insured	
Hospital admission	Within 180 days of accident - not included: treatment in emergency room, outpatient facility or observation unit for less than 20 hours	$500 any insured		$1,000 any insured	

Benefits – paid once per accident (continued)

Benefit	Terms/Conditions/Limits	One-Unit Plan	Two-Unit Plan
Hospital confinement (including sub-acute ICU)	Within 180 days of accident - not paid concurrent with benefits for: intensive care, emergency room, out-patient facility or observation unit for less than 20 hours	$100 per day for up to 90 days, any insured	$200 per day for up to 180 days, any insured
Hospital ICU confinement	Within 30 days of accident - if patient is in ICU for more than 15 days, the hospital confinement benefit begins on the 16th day	$200 per day for up to 15 days, any insured	$400 per day for up to 15 days, any insured
Knee cartilage – torn	Treatment within 60 days and surgery, if required, within 180 days of accident		
Arthroscopic surgery without repair or with debridement		$100 any insured	$200 any insured
Surgical repair		$500 any insured	$1,000 any insured
Laceration	Repaired within 72 hours of accident with stitches, staples or glue		
Total of all lacerations less than 3 inches (7.6 cm)		$50 any insured	$100 any insured
Total of all lacerations 3-5 inches (7.6 to 12.5 cm)		$200 any insured	$400 any insured
Total of all lacerations 5+ inches (12.5 cm)		$400 any insured	$800 any insured
Lodging	For companion to accompany insured to hospital 100 miles or more from home - 30-day max	$100 per day, any insured	$100 per day, any insured
Major diagnostic exams	Angiogram, CT Scan, CTA Scan, MRI, MRA, EEG	$100 per year, any insured	$200 per year, any insured
Physician's office or urgent care	Within 60 days of accident - initial treatment in physician's office or urgent care facility	$50 any insured	$50 any insured

Benefits – paid once per accident (continued)

Benefit	Terms/Conditions/Limits	One-Unit Plan	Two-Unit Plan
Prosthetic device/Artificial limb	Does not include hearing aids, dental aids including false teeth, eye glasses, cosmetic prosthesis such as wigs, joint replacement such as an artificial hip or knee		
One prosthetic device or artificial limb		$500 any insured	$500 any insured
More than one prosthetic device or artificial limb		$1,000 any insured	$1,000 any insured
Ruptured disc	Treatment within 60 days and surgery within one year of accident	$400 any insured	$400 any insured
Surgery	Within 72 hours of accident - does not cover hernia repair		
Open abdominal/thoracic surgery to repair injuries		$1,000 any insured	$1,000 any insured
Open abdominal/thoracic exploratory surgery without repair		$100 any insured	$100 any insured
Exploratory or other surgery without repair		$100 any insured	$100 any insured
Tendon/Ligament/Rotator cuff	Surgical repair of any and all torn, ruptured or severed tendons, ligaments or rotator cuffs within 90 days of accident		
Repair of tendon, ligament or rotator cuff		$500 any insured	$500 any insured
Exploratory surgery without repair		$100 any insured	$100 any insured
Transportation	Transportation for insured if traveling 100 miles or more round trip from home for medical treatment – maximum three trips per accident	$300 any insured	$300 any insured

Tenthly (10-Pay) Rates

	One Unit Plan	Two Unit Plan
Employee	$16.84	$20.77
Employee & Spouse	$29.81	$37.12
Employee & Child	$25.85	$32.36
Family	$40.42	$50.84

Accident Claims: You may file a claim for accidents by completing an Assurity Accident Claim Form. Please make sure to include all pertinent information as stated on the form. You can obtain a claim form by contacting Assurity, or by downloading one from **www.markiiibrokerage.com/rowansalisburyschoolsnc.** Should you have any questions on how to file or submit a claim, or regarding the Assurity Accident Plan, please call **(888) 358-8808, ext. 23.**

Assurity Life Insurance Company
PO Box 82533
Lincoln, NE, 68501-0926

Assurity Customer Service: (866) 289-7337
To Fax in a Claim/ Toll Free: (800) 869-0368

This policy is underwritten by Assurity Life Insurance Company. For specific details, please review the policy or contact your insurance representative or Assurity Life Insurance Company. This policy's availability — along with its rates, benefits and provisions — may vary by state and are subject to state approval.

Policy Form #'s WA200 and WA205

A431-0412

Allstate Benefits
Group Cancer Plan

***In the United States, about 1,529,560 new cancer cases were expected to be diagnosed in 2009.* [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 member 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 †
- 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 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 help pay for treatment, hospital stays, transportation, and much more!
- Easy enrollment without required evidence of insurability †

A cancer diagnosis can mean unforeseen expenses that may be difficult to pay, especially if you are not 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 disease on page 45***
[1] *Cancer Facts & Figures, American Cancer Society, 2010*
†*Enrolling after your initial enrollment period requires evidence of insurability.*

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.[1]

Your Benefit Coverage

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

Specified Diseases

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

Continuous Hospital Confinement

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

Government or Charity Hospital

A $100 benefit will be paid for each day a covered person is confined to:
(1) a hospital operated by or for the U.S. Government (including the Veteran's Administration);
(2) a hospital that does not charge for the services it provides (charity).

This benefit is paid in lieu of all other benefits in the policy (except Waiver of Premium Benefit).

Surgery

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

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

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

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

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

Ambulatory Surgical Center
A $500 benefit will be paid for the use of an Ambulatory Surgical Center, up to the amount shown each day for a surgical procedure covered under the surgery benefit that is performed at an ambulatory surgical center.
Radiation/Chemotherapy for Cancer

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

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

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

Hematological Drugs
Up to a $200 (Low) 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) 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) 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
$100 benefit will be paid per continuous hospital confinement for transportation by a licensed ambulance service or a hospital-owned ambulance to or from a hospital in which the covered person is confined.

Hospice Care
A $100 benefit will be paid for one of the following when a covered person has been diagnosed by a physician as terminally ill as a result of cancer or specified disease, is expected to live 6 months or less and the attending physician has approved services:
(1) Freestanding Hospice Care Center – A benefit will be paid per day for confinement in a licensed freestanding hospice care center. Benefits payable for hospice centers that are designated areas of hospitals will be paid the same as inpatient hospital confinement; or
(2) Hospice Care Team – A benefit will be paid per visit, limited to 1 visit per day, for home care services by a hospice care team. Home care services are hospice services provided in the patient's home. Benefit is payable only if: (a) the covered person has been diagnosed as terminally ill; and (b) the attending physician has approved such services. Does not pay for: food services or meals other than dietary counseling, services related to well-baby care, services provided by volunteers, or support for the family after the death of the covered person.

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

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

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

Family Member Lodging and Transportation
Up to a $50 benefit per day will be paid for lodging and $0.40 per mile or the actual cost of round trip coach fare on a common carrier will be paid for one adult member of the covered person's family to be near the covered person, when a covered person is confined in a non-local hospital for specialized treatment.
(1) Lodging - This benefit is for a single room in a motel, hotel, or other accommodations acceptable to AB. Benefit is limited to 60 days for each period of continuous hospital confinement.
(2) Transportation - Benefit is limited to 700 miles per continuous hospital confinement if traveling in personal vehicle. Mileage is measured from the visiting family member's home to the hospital where the covered person is confined. Does not pay the Family Member Transportation Benefit if the personal vehicle transportation benefit is paid under the Non-Local Transportation Benefit, when the family member lives in the same city or town as the covered person.

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

*Bone Marrow or Stem Cell Transplant**
A 1. $1,000*, 2. $2,500*, 3. $5,000* benefit will be paid for the following types of bone marrow or stem cell transplants performed on a covered person.
(1) A transplant which is other than non-autologous.
(2) A transplant which is non-autologous for the treatment of cancer or specified disease, other than Leukemia.
(3) A transplant which is non-autologous for the treatment of Leukemia.

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

ADDITIONAL BENEFITS

Wellness

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

OPTIONAL BENEFITS

Cancer Initial Diagnosis (First Occurrence)

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

Intensive Care

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

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

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

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

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

Issue Ages: 18 and older while actively at work.

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

Low Option without Cancer Initial Diagnosis and Intensive Care	
Insureds	Tenthly Rates
Employee	***$24.09***
Employee + Child(ren)	***$33.26***
Employee + Spouse	***$37.16***
Family	***$46.29***

Low Option with Cancer Initial Diagnosis and Intensive Care	
Insureds	Tenthly Rates
Employee	***$31.28***
Employee + Child(ren)	***$44.18***
Employee + Spouse	***$49.80***
Family	***$62.68***

High Option without Cancer Initial Diagnosis and Intensive Care	
Insureds	Tenthly Rates
Employee	***$37.31***
Employee + Child(ren)	***$52.38***
Employee + Spouse	***$57.02***
Family	***$72.05***

High Option with Cancer Initial Diagnosis and Intensive Care	
Insureds	Tenthly Rates
Employee	***$44.50***
Employee + Child(ren)	***$63.30***
Employee + Spouse	***$69.66***
Family	***$88.44***

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

Portability Privilege -AWD will provide portability coverage, subject to these provisions. Such coverage will not be available for you, unless: coverage under the policy terminates under the General Provision entitled “Termination of Coverage,”

we receive a written request and payment of the first premiums for the portability coverage not later than 63 days after such termination and the request is made for that purpose. No portability coverage will be provided to you if your insurance under the policy terminated due to your failure to make required premium payments.

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

We 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 child is a covered person, the child's coverage ends on the certificate anniversary next following the date the child is no longer eligible. This is the earlier of: (a) when the child marries; (b) reaches age 22 (26 if dependent on you for support, or dependent on you and a full time-time student attending an educational institution of higher learning beyond high school); (c) otherwise does not meet the requirements of an eligible dependent.

Coverage does not terminate on an incapacitated dependent child who: (1) is incapable of self-sustaining employment by reason of mental or physical incapacity; (2) became so incapacitated prior to the attainment of the limiting age of eligibility under the coverage; (3) is chiefly dependent upon you for support and maintenance.

Coverage for an incapacitated dependent child continues as long as the coverage remains in force and the child remains in such condition. Proof of the incapacity and dependency of the child must be furnished in writing when the child reaches 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 we accept a premium for coverage extending beyond the date, age or event specified for termination as to a covered person, such premium will be refunded, coverage will be refunded, coverage will terminate and claims will not be paid.

Limits, Exclusions, and Exceptions - We do not pay for any benefit due to, or caused by, a pre-existing condition, as defined, during the 12-month period beginning on the date that person became a covered person. 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. A pre-existing condition can exist even though a diagnosis has not yet been made. We do not pay for any loss except for losses due directly from cancer or specified disease. We do not pay for any other conditions or diseases caused or aggravated by cancer or a specified disease. Diagnosis must be submitted to support each claim. For the Surgery, New or Experimental Treatment and Prosthesis Benefits, if specific charges are not obtainable as proof of loss, AWD will pay 50% of the applicable

maximum for the benefits payable. Treatment must be received in the United States or its territories.

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

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

The coverage is provided by a limited benefit supplemental insurance policy. This is not a Medicare Supplement Policy. If eligible for Medicare, review Medicare Supplement Buyer's Guide available from American Heritage Life Insurance Company. Subject to COBRA continuation of coverage. **The coverage is provided by a limited benefit supplemental insurance policy.** This material is valid as long as information remains current, but in no event later than November 1, 2013. Group Cancer and Specified Disease benefits are provided by policy GVCP3, or state variations thereof. The policy and rider are 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, call
1-800-521-3535. This is a brief overview of the benefits available under the Group Voluntary Policy underwritten by American Heritage Life Insurance Company. Details of the insurance, including exclusions, restrictions and other provisions are included in the certificate issued.

Allstate Benefits is the marketing name used by
American Heritage Life Insurance Company
(Home Office, Jacksonville, FL), 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
allstateatwork.com.

Humana Short-Term Disability Plan

Effective Date: September 1, 2012

Why Income Protection?

If you are suddenly unable to work because of a disability, how will you continue to meet your financial obligations without a paycheck?

Counting on Social Security to provide disability benefits?

Social Security's definition of disability requires that the impairment must be expected to result in death or to last at least 12 months, or must have lasted at least 12 months. Also, Social Security disability benefits usually have a five-month waiting period.

Covered by workers' compensation?

Workers' compensation provides benefits only for occupational-related injuries or illnesses. About two-thirds of the disabling injuries suffered by American workers in 2002 occurred off the job.*

Think your savings will get you through a disability?

Experts recommend a minimum savings of three months' salary to prepare for a sudden loss of income. However, most people simply aren't saving enough money to last more than a few weeks without a regular income. For some, the financial impact of even one missed paycheck can be devastating.

Will you have to turn to family or friends to help support you?

Chances are, if you are not saving enough, your loved ones are not either.

Plan Features

- 24 hour coverage
- Payable in addition to sick leave
- Does not offset for other sources of income
- Benefits are paid directly to you and are tax free
- No change in premium due to age
- Guarantee Issue for new participants
- Portable before age 70 at the same rate.
- Pre-existing Conditions Benefits (covered 12 months after policy effective date)
- Waiver of Premium after the completion of the Elimination Period or 90 days of Disability.

**Injury Facts, 2003 Edition, National Safety Council*

Accident & Sickness protection

On or off the job, 24 hour a day coverage. Income is provided when you are disabled due to a sickness or as a result of an accident. Benefits begin on the first day if you are disabled due to an accident. Benefits begin on the eighth day if you are disabled due to sickness.

You can choose to insure up to 70% of your gross monthly income, up to a maximum of $2,000.00 per month. Income will be provided for the benefit period you choose up to 12 months.

Eligibility

These benefit plans are optional and all full-time employees between age 18 and 70 may apply. The disability benefit is for employees only. Guarantee Issue coverage is available for new participants.

Pre-existing Conditions

Humana will not cover pre-existing conditions for one year after coverage becomes effective. Pre-existing conditions mean:

(1) an Injury or Sickness which a Physician has treated or for which a Physician has advised treatment within 12 months prior to the Certificate Date.

(2) a normal pregnancy, where conception occurs prior to the Effective Date, whether or not it was disclosed on the Enrollment Form.

Disability Due to Pregnancy

Benefits for disability related to pregnancy are covered provided conception occurs after the effective date of the policy, not the date the application was signed.

Portability

Employees leaving the employment of Rowan Salisbury Schools can maintain coverage provided they are under age 70 and have been insured under the plan for at least six continuous months.

Survivor Benefit

A Survivor Benefit will be paid to a Covered Employee's Eligible Survivor if:

1. Proof of Death is received for a Covered Employee
2. The Employee was receiving, or was eligible to receive a Monthly Benefit due to a Covered Disability for at least one month immediately prior to his/her death.

The Survivor Benefit will not be paid if there are no Eligible Survivors.

Amount Payable to An Eligible Survivor

If the above conditions are met, an Eligible Survivor will receive a lump sum in an amount equal to three times the Monthly Benefit amount payable in the month immediately preceding the death of the Covered Employee.

Only one lump sum will be paid regardless of the number of Eligible Survivors. If there is more than on Eligible Survivor, the lump sum will be paid in equal shares to such persons.

Accidental Death Benefit

If you sustain an Injury that results in your death within 90 days of a covered accident, we will pay the Accidental Death and Dismemberment Benefit Amount of $5,000. The sum will be paid to your Eligible Survivor. If there are no Eligible Survivors then such sum will be paid in accordance with the Facility of Payment Provision.

Accidental Dismemberment and Loss of Sight Benefit

We will pay you the Accidental Death and Dismemberment Benefit if while you are insured under this policy, you sustain an Injury that results in one of the losses listed below:

1. loss of the sight of both eyes entirely, irrecoverably, and uncorrectable; or
2. permanent loss of both hands by severance at or above the wrist joint, or both feet at or above the ankle joint; or
3. permanent loss of one hand by severance at or above the wrist joint and permanent loss of one foot by severance at or above the ankle joint.

We will pay one-half of the Accidental Death and Dismemberment Benefit Amount shown in the INSURANCE SCHEDULE if you sustain an Injury which, within 90 days results in the:

1. loss of the sight of one eye entirely, irrecoverably and uncorrectable; or
2. severance of one hand at or above the wrists joint or one foot at or above the ankle joint.

Limits on Payments of Benefits

No combination of losses other than the ones shown above can be used to increase the total amount We will pay for all losses. If you sustain more than one of the above losses as the result of one Injury, the total amount We will pay will not exceed the Accidental Death and Dismemberment Benefit Amount.

Limits and Exclusions

This Benefit is not payable if a loss results from:

- suicide, attempted suicide or intentionally self-inflicted injury, whether sane or insane;
- injury intentionally inflicted by any person (This does not apply when the Covered Person is an innocent bystander not part of an altercation.);
- substance abuse (This does not exclude a loss brought about by the use of drugs prescribed by and used as ordered by a Doctor.);
- war or act of war, whether declared or undeclared;
- service in the armed forces of any country or organization or in units auxiliary thereto;
- bacterial infection, unless the infection is caused by an Accident;
- committing or attempting to commit an assault or felony;
- resisting or fleeing from arrest;
- active participation in a riot or civil disorder;
- parachute jumping or sky diving;

- travel in or on any kind of aircraft, unless as a fare paying passenger on a commercial airline, passenger on a private airline charter or as a passenger on a privately owned and operated airplane that seats more than 10 passengers;
- intoxication; or
- racing a self-propelled vehicle on a racetrack, on a public road or at any other place

This is a brief description of the important features of your policy. This is not an insurance contract; therefore, it is important that you read your policy carefully.

Product underwritten by
Kanawha Insurance Company
PO Box 7777
Lancaster, SC 29721-7777

For questions or concerns regarding your Humana Short Term Disability Plan, please call Customer Service at (877)378-1505.

Fax Claims to:
1-803-283-5634

Humana

Short-Term Disability

	Tenthly Rates		
Monthly Benefit	3-Month Benefit Duration	6-Month Benefit Duration	12-Month Benefit Duration
$300	$9.60	$13.20	$16.80
$400	$12.60	$17.40	$22.20
$500	$15.60	$21.60	$27.60
$600	$18.60	$25.80	$33.00
$700	$21.60	$30.00	$38.40
$800	$24.60	$34.20	$43.80
$900	$27.60	$38.40	$49.20
$1,000	$30.60	$42.60	$54.60
$1,100	$33.60	$46.80	$60.00
$1,200	$36.60	$51.00	$65.40
$1,300	$39.60	$55.20	$70.80
$1,400	$42.60	$59.40	$76.20
$1,500	$45.60	$63.60	$81.60
$1,600	$48.60	$67.80	$87.00
$1,700	$51.60	$72.00	$92.40
$1,800	$54.60	$76.20	$97.80
$1,900	$57.60	$80.40	$103.20
$2,000	$60.60	$84.60	$108.60

Group Term Life Plan

Effective Date: September 1, 2012, pending underwriting approval

Explore the coverage that makes it easy to give yourself and your loved ones more security today…and in the future.

Basic Term Life

Your employer provides you with $10,000 of Basic Term Life at no cost to you.

Your Supplemental (Optional) Term Life Insurance Coverage Options

For You	$10,000 increments to $150,000, then increments of $50,000 to a maximum of $300,000
For Your Spouse	$10,000, $20,000, $30,000, $40,000, $50,000 to maximum of $50,000 or 100% of your combined Basic and Optional, whichever is less.
For Your Dependent Children*	$5,000 or $10,000

*Child(ren)'s Eligibility: Dependent children ages from live birth days to 19 years old, or 26 years old if a child is a full-time student, are eligible for coverage.

Monthly Costs for Supplemental (Optional) Term Life Insurance

You have the option to purchase Supplemental (Optional) Term Life Insurance. Listed below are your monthly rates as well as those for your spouse (based on your age and the amount of coverage you want). Rates to cover your child(ren) are also shown.

Your Age	Your/Spouse Monthly Cost Per $1,000 of Coverage (Tenthly)
Under 30	$0.0624
30 – 34	$0.0936
35 – 39	$0.1068
40 – 44	$0.1164
45 – 49	$0.1788
50 – 54	$0.2748
55 – 59	$0.51
60 – 64	$0.78
65 – 69	$1.38
70 +	$2.46

Cost for your Child(ren)†	$0.06

† Covers all eligible children

Use the table below to calculate your premium based on the amount of life insurance you will need.

Example: $100,000 Supplemental (Optional) Life Coverage

1. Enter the rate from the table (example age 36)	$.1068	$ ___________
2. Enter the amount of insurance in thousands of dollars (Example: for $100,000 of coverage enter $100)	100	___________
3. Monthly premium (1) x (2)	$10.68	$ ___________

Repeat the three easy steps above to determine the cost for each coverage selected.

Features

This insurance offering from your employer and MetLife comes with a variety of added features that can provide assistance to you and your family members today and during a difficult time.

Accelerated Benefits Option

For access to funds during a difficult time

You can receive up to 80% of your Supplemental (Optional) Term Life insurance proceeds to a maximum of $500,000 per coverage in the event that you become terminally ill and are diagnosed with less than 12 months to live. To qualify, you must have a minimum of $20,000 of coverage. This can go a long way toward helping your family meet medical and other related expenses at this difficult time. The Accelerated Benefit Option is also available to spouses insured under Dependent Life insurance plans. This option is not available for dependent child coverage.

Conversion

For those who wish to have more permanent coverage

You can convert your Group Term Life insurance benefits to an **Individual Whole Life** insurance policy if your coverage terminates in whole or in part due to your retirement, termination of employment, or, a change in your employee class. Conversion is available on all Group Life insurance coverages. If you experience an event that makes you eligible to convert your coverage, please call a MetLife representative, within 30 days of your coverage termination date, by calling: 1-877-275-6387. Please contact your plan administrator/employer for more information.

Portability

So you can keep your coverage even if you leave your current employer

Should you leave Rowan Salisbury Schools for any reason, and your Supplemental (Optional) Term Life insurance under this plan terminates, you will have an opportunity to continue group term coverage (“portability”) under a different policy, subject to plan design and state availability. Competitive rates apply, but will likely be higher than your current rates. MetLife will bill you directly. To take advantage of this feature, you must have coverage of at least $20,000 up to a maximum of $2,000,000.

Portability is also available on coverage you've selected for your spouse and dependent child(ren). The maximum amount of coverage for spouses is $250,000; the maximum amount of dependent child coverage is $25,000. Increases, decreases and maximums are subject to state availability.

Generally, there is no minimum time for you to be covered by the plan before you can take advantage of the portability feature. Please see your plan administrator or certificate for specific details.

Please note that if you experience an event that makes you eligible for portable coverage, please call a MetLife representative within 30 days of your coverage termination date, at 1-866-492-6983 or contact your plan administrator/employer for more information.

***Will Preparation Service*†**
To ensure your decisions are carried out
Like life insurance, a carefully prepared Will is important. With a Will, you can define your most important decisions such as who will care for your children or inherit your property. By enrolling for Supplemental (Optional) Term Life coverage, you will have access to Hyatt Legal Plans' network of 11,000+ participating attorneys. When you enroll in this plan, you may take advantage of this benefit at no additional cost to you by calling Hyatt Legal Plan at (800)-821-6400 and providing Rowan-Salisbury Schools' group access number, 95257.

† Will Preparation and Estate Resolution Services are offered by Hyatt Legal Plans, Inc., Cleveland, Ohio. In certain states, Will Preparation and Estate Resolution Services are provided through insurance coverage underwritten by Metropolitan Property and Casualty Insurance Company and Affiliates, Warwick, Rhode Island. Will Preparation and Estate Resolution Services are not currently available in all states. The Will Preparation Service does not include tax planning.

MetLife Advice**
Assistance identifying solutions for your financial situations
MetLife Advice is a service designed to help provide assistance in making financial decisions based on the major events in your life such as marriage, the birth of a child, purchase of a home, death of a spouse or retirement. Contact your employer or plan administrator for more information.

***MetLife Advice Specialists are Financial Services Representatives of MetLife or New England Financial, a MetLife company.*

MetLife Advice for Beneficiaries—Delivering The Promise®
For support and guidance when beneficiaries need it most
MetLife Advice for Beneficiaries—Delivering The Promise® is a service designed to provide beneficiaries with the support and assistance they need during an especially difficult time. Services include assistance filing life insurance claims and consultation to help with the details.

Total Control Account®
For immediate access to death proceeds

The Total Control Account® settlement option provides your loved ones with a safe and convenient way to manage the proceeds of a life policy for claim payments of $5,000 or more, backed by the financial strength and claims paying ability of Metropolitan Life Insurance Company. They'll have the convenience of immediate access to any or all of their proceeds, through an interest bearing account with unlimited check-writing privileges. The Total Control Account gives beneficiaries time to decide what to do with their proceeds, which can be very helpful to them during a difficult time.

What's Not Covered?

Like most insurance plans, this plan has exclusions. For instance, Supplemental (Optional) and Dependent Life Insurance do not provide payment of benefits for death caused by suicide within the first two years (one year in North Dakota) of the effective date of the certificate, or payment of increased benefits for death caused by suicide within two years (one year in North Dakota or Colorado) of an increase in coverage.

Please note that a reduction schedule may apply. Please see your plan administrator or certificate for specific details.

Additional Coverage Information

*How To Apply****

Complete your enrollment form and return it today! Be sure to indicate your Beneficiary.

*** Coverage will either be approved by MetLife based upon its underwriting rules and your answers or you will be asked to submit a Statement of Health to complete your application for coverage.

For Employee Coverage

Enrollment in this Supplemental (Optional) Term Life insurance plan is available without providing a Statement of Health form as long as:

- Your enrollment takes place within 31 days from the date you become eligible for benefits, and
- You are enrolling for coverage equal to/less than $150,000.

If you do not meet all of the conditions stated above, you will need to provide additional medical information by completing a Statement of Health form.

For Dependent Coverage

Your spouse and dependent children also do not need to provide a Statement of Health form as long as they are not home or hospital confined and not receiving disability payments, and:

- The enrollment takes place within 31 days from the date you become eligible for benefits, and

• Your spouse is enrolling for coverage equal to/less than $20,000 and your child(ren) is/are enrolling for coverage equal to/less than $10,000.

Who Can Be A Designated Beneficiary?

You can select any beneficiary(ies) other than your employer, and you may change your beneficiary(ies) at any time. You may designate multiple primary and secondary beneficiaries and you have the option of selecting different beneficiaries by coverage.

About Your Coverage Effective Date

You must be "Actively at Work" on the date your coverage becomes effective, and your spouse and eligible child(ren) must be performing their Normal Activities when coverage becomes effective.

- Your **Basic Life** coverage will become effective on your date of hire.
- Your **Supplemental (Optional)** and your **Dependent Insurance** will become effective the first of the second calendar month following your hire date for all requests that do not require additional medical information. Requests for amounts that require additional medical information and are not approved by the date listed above will not be effective until the first of the month following approval from MetLife or the date that Actively at Work and Normal Activities requirements are met.

This summary provides an overview of your plan's benefits. These benefits are subject to the terms and conditions of the contract between MetLife and Rowan Salisbury Schools and are subject to each state's laws and availability. Specific details regarding these provisions can be found in the booklet certificate.

Life coverage[s] are provided under a group insurance policy (Policy Form GPNP99/G2130-S) issued to your employer by MetLife. Life coverage[s] under your employer's plan terminates when your employment ceases when your Life contributions cease, or upon termination of the group contract. Dependent Life coverage will terminate when a dependent no longer qualifies as a dependent or when the employee's coverage terminates. Should your life insurance coverage terminate for reasons other than non-payment of premium, you may convert it to a MetLife individual permanent policy without providing medical evidence of insurability.

L07084888(exp0809)(All States)(DC,GU,MP,PR,VI)
Metropolitan Life Insurance Company, New York, NY

This insurance is underwritten by:

Texas Life Whole Life Plan

<u>*Common Issue Date*</u>*:* October 1, 2012 (pending underwriting approval where applicable)

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

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

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 (if employee applies)
  — ages 17-49, $50,000
  — ages 50-65, $25,000
  — ages 66-70, $10,000
- spouse (if employee does not apply)
  — ages 17-24 $25,000
  — ages 25-29 $20,000
  — ages 30-39 $15,000
  — ages 40-44 $10,000
  — ages 45-49 $7,500
  — ages 50-70 $5,000
- children - ages 6 months -26 years $25,000[2]
- grandchildren - ages 6 months -16 $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 processing fee, upon physician certified diagnosis of condition expected to result in death within 12 months (24 months in IL) (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 financially 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

Continuing Your Benefits

Upon Termination of Employment

To Continue Your Dental and/or Vision Plan

Under the group dental and vision plans, you and your covered dependents are eligible to continue coverage through COBRA. Upon termination, you will receive notification from Interactive Medical Systems (IMS), your COBRA administrator, with premium and continuation options. Should you have any questions, you may contact your IMS at ***800-426-8739.***

To Convert Your Term Life Insurance

When you leave your employment, you may convert the existing group term coverage you have through your employer to a guaranteed issue individual whole life policy. You also have the option of porting your existing coverage as well. It is the responsibility of the employee to convert or port coverage. You must apply for conversion or portability within 31 days from the date your employer terminates your term life coverage. For more information and a quote for conversion, please contact MetLife at ***1-877-275-6387****. For more information and a quote for portability, please contact MetLife at* ***1-866-492-6983****. If you do not convert or port your group term life insurance, coverage will terminate when you leave your employer.*

To Continue Other Policies

You may continue your Allstate Cancer, Assurity Cancer and/or Accident, Humana Short-Term Disability, and Texas Life Whole Life policies by having the premiums currently deducted from your paycheck drafted from you bank account or billed to your home. For more information, contact

Allstate at ***800-521-3535,***
(See "Portability" on page 51)

Assurity at ***866-289-7337****,*

Humana at ***877-378-1505****,*
(See "Portability" on page 56)

Texas Life at ***800-283-9233***

Contact Information for Questions and Claims

Flexible Benefits Administrators

509 Viking Drive, Suite F
PO Box 8188
Virginia Beach, VA 23450
1-800-437-FLEX (1800-437-3539)
Fax: (757) 431-1155
FlexDivision@flex-admin.com
www.flex-admin.com

Ameritas Dental

Customer Service
1-800-487-5553
www.ameritasgroup.com

Superior Vision

11101 White Rock Rd, Suite 150
Rancho Cordova, CA 95670
1-800-507-3800
www.superiorvision.com

Non-Network Claims Submission:
PO Box 967
Rancho Cordova, CA 95741

Assurity Life Insurance

PO Box 82533
Lincoln, NE 68501
1-866-289-7337

Wellness Claims:
1-888-358-8808 x23

Allstate Benefits (AB)

1776 American Heritage Life Drive
Jacksonville, Florida 32224
For questions concerning your policy please call:
1-800-521-3535
For questions concerning your claim please call:
1-800-348-4489
or e-mail claimsresearch@allstate.com

Kanawha Insurance Company

(Underwriter for Humana Short-Term Disability)

PO Box 7777
Lancaster, SC 29721-7777

Customer Service
1-877-378-1505

Fax Claims to:
1-803-283-5634

MetLife Insurance Company

Benefits Line:
1-866-492-6983

Conversion:
1-877-275-6387

Group Universal Life:
1-800-GET MET-8
(1-800-438-6388)

Texas Life Insurance Company

PO Box 830
Waco, TX 76703-0830
1-800-283-9233

Mark III Brokerage
211 Greenwich Rd
Charlotte, NC 28211
1-800-532-1044
www.markiiibrokerage.com/rowansalisburyschoolsnc