Forsyth County Government offers a comprehensive benefits package specifically designed to protect your income and assets. The benefit plans are arranged and enrolled by Mark III Brokerage, an employee benefits firm that has worked in the public sector since 1973. During annual enrollment, you may purchase coverage through pre-tax and after-tax payroll deductions.

To learn more about your benefits package, please plan to meet with a Mark III Benefits Representative during this year's annual enrollment period.

- The Plan Year is from July 1st to June 30th.
- Coverage effective date is July 1, 2016.
- A Mark III representative will be conducting individual meetings at all scheduled locations.

Table of Contents

This booklet highlights the benefits offered through your employer for the current plan year. This is not an Insurance Contract and only the actual policy provisions will prevail. All information in this booklet including premiums are subject to change. All policy descriptions are for informational purposes only.

Key Points to Remember

- The Plan Year for Forsyth County Government is July 1, 2016 - June 30, 2017.
- Effective Dates: July 1, 2016
- Web Enrollment Dates: April 12 thru May 12, 2016.
- Enroller Support: May 9 thru May 12, 2016.
- Payroll deductions for this year's enrollment will start:

	Pay Period	Deduction Date
Health, Dental, Vision and Life	5/21/16 - 6/3/16	6/10/16
STD and LTD	5/21/16 - 6/3/16	6/10/16
Flexible Spending Account	6/18/16 - 7/1/16	7/08/16

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

- **Please remember to keep your existing FBA debit card.** Your card is good for 3 years from issue date. Your account will be replenished if you re-elect a Flexible Spending Account for the new plan year. Again, you must re-elect your Medical and Dependent Care Flexible Spending Accounts each year. These accounts do not automatically carry-over to the next year.

- Pre-taxed elections made during annual enrollment **cannot be changed once the enrollment period ends** unless you have a qualifying event such as marriage, divorce, death of a spouse or child, birth or adoption, termination of employment or change in employment hours from full-time to part-time or vice-versa.

- If you should have a qualifying event, you will have 30-days from the date of the qualifying event to request a change to your current benefit and medical and dependent care flexible spending account elections. The participant's election change must be consistent with the qualifying event. All requests must be made in writing to Staci Kelso in the Forsyth County Government's benefits office.

- Expenses for the Medical and Dependent Care Flexible Spending Accounts must be incurred during the plan year to be eligible for reimbursement. You have a 90-day run-out period to remit receipts.

- Contributions are treated on a ***"use it or lose it" basis.*** If you do not incur expenses during the plan year for reimbursement, you will lose it. Therefore, the key to participation is to be conservative.

- Any questions regarding your Medical or Dependent Care Flexible Spending Account can be directed to www.mywealthcareonline.com/fba or you can call Customer Contact Center at 800-437-FLEX.

- Any questions regarding all other benefits can be directed to Staci Kelso at 336-703-2407.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbsnc.com or by calling **1-877-275-9787**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,250** person/**$3,750** family for in-network; **$1,750** person/**$5,250** family for out-of-network. Doesn't apply to In-Network preventive care. Coinsurance and copayments do not apply to the deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	**Yes. $2,250** person/**$6,750** family for in-network; **$3,750** person/**$11,250** family for out-of-network	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain pre-authorizations for services, Premiums, balance-billed charges, and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the **out–of–pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of In-Network providers, see www.bcbsnc.com/content/	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term

	providersearch/index.htm or please call 1-877-275-9787	in-network, **preferred**, or participating for **providers** in their **network.** See the chart starting on page 2 for how this plan pays different kinds of **providers.**
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on a later page. See your policy or plan document for additional information about **excluded services.**

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

Common Medical Event	Services You May Need	Your cost* if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30/visit	30% Coinsurance	---none---
	Specialist visit	$60/visit	30% Coinsurance	---none---

Questions: Call 1-877-275-9787 or visit us at www.bcbsnc.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html or call 1-877-275-9787 to request a copy.

Common Medical Event	Services You May Need	Your cost* if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have a test	Other practitioner office visit	$60/Chiropractic Visit	30% Coinsurance/ Chiropractic Visit	-- Coverage is limited to 30 visits for Chiropractic care.
	Preventive care/screening/immunization	No Charge	Not Covered	-- Limits may apply
	Diagnostic test (x-ray, blood work)	20% Coinsurance	30% Coinsurance	-- No coverage for tests not ordered by a doctor.
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	30% Coinsurance	---none---
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.bcbsnc.com/content/services/formulary/presdrugben.htm	Generic drugs	$5/prescription; $12.50/ prescription mail order	$5/prescription	-- No coverage for drugs in excess of quantity limits, or therapeutically equivalent to an over the counter drug.
	Preferred brand drugs	$45/prescription; $112.50/ prescription mail order	$45/prescription	-- Same as above
	Non-preferred brand drugs	$60/prescription; $150/prescription mail order	$60/prescription	-- Same as above
	Specialty drugs	25% Coinsurance	25% Coinsurance	-- Coverage is limited to a 30 day supply -- Minimum of $50 in coinsurance but no more than $100
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	30% Coinsurance	---none---
	Physician/surgeon fees	20% Coinsurance	30% Coinsurance	---none---

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Common Medical Event	Services You May Need	Your cost* if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need immediate medical attention	Emergency room services	$250/visit	$250/visit	---none---
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	---none---
	Urgent care	$60/visit	$60/visit	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	30% Coinsurance	-Precertification may be required
	Physician/surgeon fee	20% Coinsurance	30% Coinsurance	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$60 / visit; 20% Coinsurance	30% Coinsurance	Prior Authorization may be required
	Mental/Behavioral health inpatient services	20% Coinsurance	30% Coinsurance	Precertification required
	Substance use disorder outpatient services	$60 / visit; 20% Coinsurance	30% Coinsurance	Prior Authorization may be required
	Substance use disorder inpatient services	20% Coinsurance	30% Coinsurance	Precertification required
If you are pregnant	Prenatal and postnatal care	20% Coinsurance	30% Coinsurance	-- No coverage for maternity for dependent children.
	Delivery and all inpatient services	20% Coinsurance	30% Coinsurance	Precertification may be required
	Home health care	20% Coinsurance	30% Coinsurance	-- Prior authorization required or services will not be covered
If you need help recovering or have other special health needs	Rehabilitation services	20% Coinsurance	30% Coinsurance	-- Coverage is limited to 30 visits per benefit period for Rehabilitation and Habilitation services combined, for OT/PT/ Chiropractic, and 30 visits per benefit period for Speech Therapy

Questions: Call 1-877-275-9787 or visit us at www.bcbsnc.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html or call 1-877-275-9787 to request a copy.

Common Medical Event	Services You May Need	Your cost* if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If your child needs dental or eye care	Habilitation services	20% Coinsurance	30% Coinsurance	-- Coverage is limited to 30 visits per benefit period for Rehabilitation and Habilitation services combined, for OT/PT/ Chiropractic, and 30 visits per benefit period for Speech Therapy
	Skilled nursing care	20% Coinsurance	30% Coinsurance	-- Coverage is limited to 60 days per benefit period.-- Precertification required
	Durable medical equipment	20% Coinsurance	30% Coinsurance	-- Prior authorization may be required for benefits to be provided-- Limits may apply
	Hospice services	20% Coinsurance	30% Coinsurance	-- Precertification may be required
	Eye exam	No Charge	Not Covered	-Limits may apply
	Glasses	Not Covered	Not Covered	Excluded Service
	Dental check-up	Not Covered	Not Covered	Excluded Service

*HSA/HRA funds, if available, may be used to cover eligible medical expenses

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Hearing aids
- Termination of Pregnancy
- Cosmetic surgery and services
- Long-term care, respite care, rest cures
- Weight loss programs
- Dental care (Adult)
- Routine Foot Care

*HSA/HRA funds, if available, may be used to cover eligible medical expenses
**Self-funded groups may cover this service; check your benefit booklet for details

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

- Bariatric surgery
- Non-emergency care when traveling outside the U.S. (PPO). Coverage provided outside the United States. See www.bcbsnc.com
- Chiropractic care
- Private duty nursing
- Infertility treatment
- Routine eye care (Adult)

***Self-funded groups may not cover this service; check your benefit booklet for details

Questions: Call 1-877-275-9787 or visit us at www.bcbsnc.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html or call 1-877-275-9787 to request a copy.

Your Rights to Continue Coverage:

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

For more information on your rights to continue coverage, contact BCBSNC at 1-877-275-9787. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or **www.cciio.cms.gov**.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: BCBSNC at 1-877-275-9787 or **mybcbsnc.com**. You may also receive assistance from the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or **www.dol.gov/ebsa/healthreform**, if applicable.

Does This Coverage Provide Minimum Essential Coverage?

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

Does This Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of health plan. **The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.**

*Please note that although amounts contributed by an employer to an employee's HSA or integrated HRA should be taken into account for this calculation, the amount of that contribution, if unknown, has not been considered.

Questions: Call 1-877-275-9787 or visit us at www.bcbsnc.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html or call 1-877-275-9787 to request a copy.

Language Access Services:

Spanish (Español): Para obtener asistencia en español, llame al número que aparece al respaldo de su tarjeta del seguro.
Tagalog (Tagalog): Para matulungan sa Tagalog, tawagan ang numerong nasa likuran ng insurance card.
Chinese (中文):如需國語或廣東話協助，請致電您保險卡背面的電話號碼。
Navajo (Dine):Diné bizaad bee shíká'adoowoł nínzingo kwojį' hólne', naaltsoos áłts'ísí nantinígíí bine'dęę' binámboo bikáá'.

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

Questions: Call 1-877-275-9787 or visit us at www.bcbsnc.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html or call 1-877-275-9787 to request a copy.

About these Coverage Examples:

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

This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,300
- **You pay** $2,200

Sample care costs:

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

Patient pays:

Deductibles	$1,000
Copays	$40
Coinsurance	$1,000
Limits or exclusions	$200
Total	**$2,200**

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

- **Amount owed to providers:** $5,100
- **Plan pays** $3,800
- **You pay** $1,300

Sample care costs:

Prescriptions	$2,700
Medical Equipment and Supplies	$1,200
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,100**

Patient pays:

Deductibles	$600
Copays	$400
Coinsurance	$200
Limits or exclusions	$50
Total	**$1,300**

Questions: Call 1-877-275-9787 or visit us at www.bcbsnc.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html or call 1-877-275-9787 to request a copy.

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

Questions: Call 1-877-275-9787 or visit us at www.bcbsnc.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html or call 1-877-275-9787 to request a copy.

BCBS HEALTH PLAN BI-WEEKLY RATES

Individual	$50.44
Employee + One	$142.50
Family	$288.04

FOR CLAIMS OR CUSTOMER SERVICES QUESTIONS PLEASE CALL BLUECROSS BLUESHIELD OF NORTH CAROLINA AT:
(877) 258-3334
www.bcbsnc.com

FBA Medical Spending Account

Medical Reimbursement Plan Maximum: $2,549.82
Medical Reimbursement Plan Minimum: $260
Run-out Period: 90-days

Forsyth County Government offers all full-time employees a comprehensive Cafeteria Benefits program.

New IRS rules also allow same-sex spouses to participate in the Flexible Spending Accounts, if they were legally married in a state where the employee entered into a legally-recognized marriage.

Therefore, employees who were married in states that recognize same-sex marriages and have proper documentation, can pay for qualified unreimbursed medical expenses for their spouse thru the flexible spending account.

All other rules regarding the flexible spending account remain in place.

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 minimum you may place in this account for the Plan Year is $260. The maximum you may place in this account for the Plan Year is **$2,549.82.**

EXAMPLES OF ELIGIBLE HEALTH CARE EXPENSES

FEES/CO-PAYS/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
- Carpal tunnel wrist supports
- Incontinence supplies
- Vaccinations & Immunizations
- Elastic hose (medically prescribed)
- Contact lens supplies
- Therapeutic care for drug and alcohol addiction
- Take-home screening kits (HIV, colon cancer)
- At home pregnancy test kits
- Diabetic supplies
- Routine Physicals
- Condoms
- Dentures
- Oxygen
- Physical Therapy
- Fertility Treatments
- Hearing aids and batteries
- Reading glasses
- Medical equipment
- Pedialyte for dehydration

- 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.

FLEX NOTE:

You can save between 28% and 38% in taxes on every $100 you place in the Plan.

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.

FLEX NOTE:

You can save between 28% and 38% in taxes on every $100 you place in the Plan

OVER-THE-COUNTER DRUGS

Please be advised that 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 or letter of medical necessity:

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

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	Herbal/natural supplements
Weight loss products/foods	Acne creams/face cleanser
Face cream/moisteners	Medicated shampoo/soaps

Mouthwash/toothpaste	Toothbrushes (even if dentist recommends a special one)
Feminine hygiene products	Deodorant
Eye/facial makeup/preparations	Chapstick
Suntan lotion	Rogaine

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)	Nasal sprays for snoring
Fiber supplements (to treat a medical condition for a limited time)	Pills for lactose intolerance
OTC Hormone therapy (to treat menopausal symptoms)	
St. John's Wort (for depression)	

• 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	Exercise classes
Weight Loss Programs	Wigs
Exercise equipment	

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.***CLAIMS SUBMISSION***

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 employer (See sample Claim Form in back of handbook). You must attach a receipt or bill from the service provider which includes all the pertinent information regarding the expense:

- ***Date of service***
- ***Provider's name***
- ***Patient's name***
- ***Nature of the expense***
- ***Amount charged***
- ***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 prescription 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.

FBA Dependent Care Spending Account

• Dependent Care Flexible Spending Account Maximum: $4,999.80
• Debit card CAN be used with the Dependent Care 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 Rules and Regulations: Eligible Dependents, 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

- Babysitters 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
- Babysitting for social events
- **OVERNIGHT CAMP**: 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:

- $4,999.80 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 childdren, on your income taxes through the child care tax credit. However, through the Dependent Care Reimbursement Account you may set aside up to $4,999.80 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 $4,999.80 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 employer (See sample Claim Form in back of handbook). 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.

FLEX NOTE:

FLEX can help you cope with the high cost of quality day care.

FBA 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 your childcare expenses (up to your account balance at the time of the "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 ATMs or other unqualified merchant locations. The card will be denied at the point of sale when a transaction 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, you may select the credit or debit option (with your PIN).

- How To Receive Your PIN:
  The most cost effective way to provide a cardholder their PIN is to use the e-PIN delivery functionality. e-PIN delivery provides a simple and secure way for participants to view their PIN on the FBA WealthCare Portal. The FBA WealthCare Portal "Debit Card" page provides a "View PIN" button next to each card number. Upon clicking "View PIN", FBA WealthCare Portal pops-up a new window containing the card's four digit PIN.

- Detailed information will also be available on our website at www.mywealthcareonline.com/fba.

- 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, faxing or emailing a claim form and proper documentation 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.

- You may also elect to have an additional Benefits Card for your dependent(s) over the age of 18.

- 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.mywealthcareonline.com/fba

- 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 Participants; 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 as well as over the counter medications and products 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 paper claim form with substantiating documentation 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.org and select "IIAS Merchants List" for the most recent list of IIAS merchants.

FBA Rules and Regulations

CLAIM FILING DATES

All claims received in the office of Flexible Benefit Administrators, Inc. will be processed within one week via 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 8:30a.m. to 5:00p.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 ($4,050 for 2016; this criteria does not apply to health plans).

GRACE 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. 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.

This worksheet will help you determine your annual expenses for each reimbursement account. Good planning and careful estimating is the best way to take full advantage of your Flexible Benefit Plan.

ESTIMATING YOUR QUALIFYING 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 (Min. $260) _____

(Max. $2,549.82)

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. $4,999.80) _____

CHANGES IN YOUR ELECTION

No, 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." 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 worksite, 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; and
- 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.

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 Account.

FLEX NOTE:

You must enroll in the reimbursement accounts each year before the Plan effective date to participate during the Plan Year or when you become benefit eligible.

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 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 8:30am to 5:00pm, Monday through Friday, to check your account balances. You may also access your personal account information at your convenience via our secure website: www.mywealthcareonline.com/fba. Each reimbursement check stub will show your contributions, request for reimbursements, and disbursements for each account. It will also show your annual election and the balance to request by the end of the Plan Year for each account. A reminder letter will be sent two months prior to the end of the Plan Year if you have funds left in your accounts.

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.mywealthcareonline.com/fba

Ameritas Dental Plan

TYPE I (PREVENTIVE & DIAGNOSTIC) AND TYPE II (BASIC) - Pays at 70-80-90-100% U&C*. $50.00 lifetime (per person) deductible applies.

- Evaluations (Two per calendar year)
- Cleanings (Two per calendar year)
- Fluoride for Children (Under age 19)
- Sealants (Under age 17)
- Restorative Amalgam & Resin (Excluding Inlays & Crowns)
- Oral Surgery - Simple Extractions
- Oral Surgery - Complex Extractions
- Space Maintainers
- Radiographs (X-rays)
- Bitewings (Two per calendar year)
- Limited exams
- Anesthesia
- Denture Repair
- Endodontics (Root Canal)
- Periodontics (Gum Disease)

TYPE III (MAJOR) - Payable at 50% U&C*. $50.00 calendar year deductible (per person) applies. The Incentive Mechanism does not apply to Type III (Major)

- Crown Repair
- Prosthodontics - Fixed Pontics or Abutments
- Prosthodontics - Removeable Dentures, Partials
- Restorative Crowns
- TMJ

ORTHODONTIA - Pays at 50% U&C with a $1,200 lifetime maximum. No deductible applies. The Incentive Mechanism does not apply to Orthodontia.

INCENTIVE MECHANISM 70-80-90-100%

All employees insured on the effective date of the Company policy will:
a) begin at the 70% level of the Incentive Mechanism for Type I and Type II procedures if they have been hired during the calendar year in which the Company policy becomes effective;
b) begin at the 80% level if they were hired in the calendar year preceding the effective date of the Company policy;
c) begin at the 90% level if they were hired two calendar years before the effective date of the Company policy; and
d) begin at the 100% level if they were hired three or more calendar years before the effective date of the Company policy.

Dependents will enter the Incentive Mechanism at the same level as employees. All Initial Insureds will remain at the appropriate level until the next January 1. At that time, their Type 1 and Type 2 coinsurance will increase by 10% if the initial insured has visited the dentist and had one Dental procedure performed. Initial Insureds will remain at that level during the next calendar year if they fail to visit the dentist to have one dental procedure performed. After the first January 1 has passed, should an initial insured fail to visit the dentist in any calendar year, or should he or she fail to have at least one dental procedure performed within the given year, the coinsurance percentage will reduce one level (i.e. from 100% to 90%). Standard incentive coinsurance advancement requirements will always apply to people insured after the effective date of the Company policy.

**U&C - Usual and Customary*

All new hires or re-hires that enroll after the effective date will begin at the 70% coinsurance for the Preventive and Basic procedures. These employees will advance through the Incentive plan at the 80, 90 and 100% levels as outlined above.

ANNUAL MAXIMUM BENEFIT

- Type I, II and III Procedures - $1,500 per calendar year per person.
- Orthodontia Procedures - $1,200 lifetime per person.

LATE ENTRANT PROVISION

There is a 12 month waiting period on all services except **cleanings, exams, and fluoride applications** for employees who do not enroll when first eligible for coverage. This provision is waived for employees who enrolled during the initial enrollment period.

PRE-DETERMINATION OF BENEFITS

A treatment plan MAY be filed if a proposed course of treatment will exceed $200.00. With this information, Ameritas can determine the benefits payable under this policy prior to the work actually being done. It will give the insured the amount payable, along with an idea of the out of pocket expense.

COORDINATION OF BENEFITS

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

CERTIFICATE OF INSURANCE

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

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

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 laws.
- Services for Major and Orthodontic procedures. Endodontics (root canals) and Periodontics (gum disease) which are normally in the Major category are included in the Basic procedural category for this plan.

SECTION 125

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

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

BI-WEEKLY RATES

Employee (paid by the County)	**Paid by County**
Employee + 1 Dependent	**$7.44**
Employee + 2 or more Dependents	**$17.82**

For Claims/Customer Service call:
Ameritas: (800) 776-9446
Website: www.ameritasgroup.com

This insurance is underwritten by Ameritas Life Insurance Corp.

AMERITAS
LIFE INSURANCE CORP.

Superior Vision Plan - Materials Only Plan

Outline of Benefits	Superior Vision Plan	
Copays:	Materials	$15
	Contact Lens Fitting	$15

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
Standard Lenses (per Pair):			
Single Vision	12 Months	Covered in Full	Up to $26.00
Bifocal	12 Months	Covered in Full	Up to $34.00
Trifocal	12 Months	Covered in Full	Up to $50.00
Lenticular	12 Months	Covered in Full	Up to $76.00
Progressive	12 Months	Covered to providers retail trifocal price	Up to $50.00
Contact Lenses (Per Pair)[2]			
Medically Necessary	12 Months	Covered in Full	Up to $210.00
Cosmetic (Elective)[3]	12 Months	Up to $150.00	Up to $100.00
Contact Lens Fitting[4]			
Standard	12 Months	Covered in Full	Not Covered
Specialty	12 Months	Up to $50.00	Not Covered
Frames -Standard[3]	24 Months	Up to $150.00	Up to $60.00

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

Discount Features[5]
Look for providers in the Provider Directory who accept discounts; please verify their discounts prior to service.

Discounts on Covered Materials

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

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

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

Discounts on Non-Covered Exam and Materials[5]
Superior Vision offers discounts on an unlimited number of materials after the member has exhausted their covered benefit.

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

Refractive Surgery[5]
Superior Vision has a nationwide network of refractive surgeons and partnerships with leading LASIK networks (QualSight, TruVision, and LasikPlus) who offer members a discount. These discounts range from 20%-50%, and are the best possible discounts available to Superior Vision.

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.

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

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

Rates

	Bi-Weekly Rates
Employee Only	**$3.02**
Employee + 1	**$5.84**
Employee + Family	**$10.02**

Superior Vision Contacts

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

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

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

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

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

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

SUPERIOR VISION
See yourself healthy.

Superior Vision - Full Services Plan

Outline of Benefits Superior Vision Plan

Co-pays:

Comprehensive Eye Exam	$0
Materials	$15
Contact Lens Fitting	$15

How to Use the Plan

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

Your first step should be to choose an eye care provider, or ensure that your current provider is part of the Superior Vision network. Go to www.superiorvision.com and click on "Locate a Provider" for an updated list. You will learn about "in-network" and "out-of-network" providers – it is an important distinction when receiving your benefits. You will also learn more about how to use your benefits, as well as the discounts that are available to you. Remember that a routine eye exam is important not only for correcting vision problems, but for maintaining healthy eyes and overall health wellness. Superior Vision eye care providers are trained to test for and diagnosis a variety of health issues – not just eye problems. Take the time to get to know your vision plan, and start experiencing healthy eyes and healthy living.

Benefits

	FREQUENCY	IN-NETWORK	NON-NETWORK
Comprehensive Exam			
Ophthalmologist	12 Months	Covered in Full	Up to $44.00
Optometrist	12 Months	Covered in Full	Up to $39.00
Standard Lenses (per Pair):			
Single Vision	12 Months	Covered in Full	Up to $26.00
Bifocal	12 Months	Covered in Full	Up to $34.00
Trifocal	12 Months	Covered in Full	Up to $50.00
Lenticular	12 Months	Covered in Full	Up to $76.00
Progressive	12 Months	Covered to providers retail trifocal price	Up to $50.00
Contact Lenses (Per Pair)[2]			
Medically Necessary	12 Months	Covered in Full	Up to $210.00
Cosmetic (Elective)[3]	12 Months	Up to $150.00	Up to $100.00
Contact Lens Fitting[4]			
Standard	12 Months	Covered in Full	Not Covered
Specialty	12 Months	Up to $50.00	Not Covered
Frames -Standard[3]	24 Months	Up to $150.00	Up to $60.00

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

Discount Features[5]
Look for providers in the Provider Directory who accept discounts; please verify their discounts prior to service.

Discounts on Covered Materials

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

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

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

Discounts on Non-Covered Exam and Materials[5]
Superior Vision offers discounts on an unlimited number of materials after the member has exhausted their covered benefit.

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

Refractive Surgery[5]
Superior Vision has a nationwide network of refractive surgeons and partnerships with leading LASIK networks (QualSight, TruVision, and LasikPlus) who offer members a discount. These discounts range from 20%-50%, and are the best possible discounts available to Superior Vision.

Items or Services Not Covered
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*Higher end or brand name lens upgrades are at an additional expense. These upgrades will be available at a 20% discount off retail.

Rates

	Bi-Weekly Rates
Employee Only	**$4.57**
Employee + 1	**$8.87**
Employee + Family	**$15.44**

Superior Vision Contacts

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

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SUPERIOR VISION
See yourself healthy.

AUL / One America Short-Term Disability Plan

Why do you need Disability Insurance? Consider this . . .

Statistics show you are much more likely to be injured in an accident than to die from one.

- A fatal injury occurs every 5 minutes, and a disabling injury occurs every 1.5 seconds.[1]
- There is a death caused by a motor vehicle crash every 12 minutes; there is a disabling injury every 14 seconds.[1]
- In the home, there is a fatal injury every 16 minutes and a disabling injury every 4 seconds.[1]

While many people survive accidental injuries, many others live with serious illnesses.

- In the United States, men have a little less than a 1-in-2 lifetime risk of developing cancer; for women the risk is a little more than 1-in-3. The five-year relative survival rate for all cancers combined is 63%.[2]
- One in five males and females has some form of cardiovascular disease. High blood pressure is the most common form of cardiovascular disease.[3]
- More than 35 million Americans are now living with chronic lung diseases, such as asthma, emphysema, and chronic bronchitis.[4]

Advances in medicine are allowing us to live longer. However, recovery from a serious illness or injury often requires time away from work.

- In the last 20 years, deaths due to the big three (cancer, heart attack, and stroke) have gone down significantly. But disabilities due to those same three are up dramatically! Things that use to kill now disable.[5]

You have life insurance, home insurance, and automobile insurance. But is your income insured?

1 National Safety Council, Injury Facts, 2003 Edition

2 American Cancer Society, Cancer Facts & Figures 2004

3 American Heart Association, Heart Disease and Stroke Statistics – 2004 Update

4 American Lung Association, Lung Disease Data 2003

5 National Underwriter, May 2002

Class Description
All Full-Time Eligible Employees working a minimum of 30 hours per week, electing to participate in the Voluntary Short Term Disability Insurance

Disability
You are considered disabled if, because of injury or sickness, you cannot perform the material and substantial duties of your regular occupation. You are not working in any occupation and are under the regular attendance of a Physician for that injury or sickness

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

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

Benefit Duration
This is the period of time that benefits will be payable for disability. The benefit duration is thirteen (13) weeks.

Basis of Coverage
Off the job coverage only.

Maternity Coverage
Benefits will be paid the same as any other qualifying disability, subject to any applicable pre-existing condition exclusion.

STD Pre-Existing Condition Exclusion
3/12, If a person receives medical treatment, or service or incurs expenses as a result of an Injury or Sickness within 3 months prior to the Individual Effective Date, then the Group Policy will not cover any Disability which is caused by, contributed to by, or resulting from that Injury or Sickness; and begins during the first 12 months after the Person's Individual Effective Date. This Pre-Existing Condition limitation will be waived for all Persons who were included as part of the final premium billing statement received by AUL/OneAmerica from the prior carrier and will be Actively at work on the effective date.

Recurrent Disability
If you resume Active Work for 30 consecutive workdays following a period of Disability for which the Weekly Benefit was paid, any recurrent Disability will be considered a new period of Disability. A new Elimination Period must be completed before the Weekly Benefit is payable.

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

Portability
Once an employee is on the AUL disability plan for 3 consecutive months, you may be eligible to port your coverage for one year at the same rate without evidence of insurability. You have 31 days from your date of termination to submit an application to AUL in order to port your coverage. The Application to port coverage is located on the Mark III website.

The Portability Privilege is not available to any Person that retires (when the Person receives payment from any Employer's Retirement Plan as recognition of past services or has concluded his/her working career). Please refer to the Mark III web-site for a copy of your certificate, a claim form or application to port form.

Exclusions and Limitations

This plan will not cover any disability resulting from war, declared or undeclared or any act of war; active participation in a riot; intentionally self-inflicted injuries; commission of an assault or felony; or a pre-existing condition for a specified time period.

This information is provided as a summary of the product. It is not a part of the insurance contract and does not change or extend AUL's liability under the group policy. If there are any discrepancies between this information and the group policy, the group policy will prevail.

AUL Short-Term Disability (Based on 24 deductions)

Benefit Duration*: 13 Weeks*

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

Customer Service
1.800-553-5318

Disability Claims
1.866-258-8744
Fax: 207-591-3048

Disability Claims Email: claims@disabilityrms.com

Website: www.employeebenefits.aul.com

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

AUL Long Term Disability

Class Description:

All Full-Time Eligible Employees working a minimum of 30 hours per week, electing to participate in Voluntary Long Term Disability Insurance

Monthly Benefit:

60% of an Employee's covered base monthly earnings to a maximum of $10,000; reduced by Other Income Benefits as outlined in the contract.

Elimination Period:

This means a period of time a disabled Employee must be out of work and totally disabled before weekly benefits begin; 90 consecutive days for a sickness or injury.

Maximum Benefit Duration:

This is the length of time that an insured Employee may be entitled to benefits if continuously disabled as outlined in the contract.

Up to the greater of the Employee's Social Security Full Retirement Age (SSFRA) or age 65, if disabled prior to age 60. If disabled after age 60, on the scale as outlined below from the contract:

Age When Total Disability Begins	Maximum Duration
Less Than Age 60	Greater of: SSFRA or To Age 65
60	5 Years
61	4 Years
62	3.5 Years
63	3 Years
64	2.5 Years
65	2 Years
66	21 Months
67	18 Months
68	15 Months
Age 69 and over	12 Months

Minimum Monthly Benefit: $100.

Accumulation of Elimination Period:

If disability ends during the elimination period and reoccurs, the time while the Insured is Disabled will be treated as continuous and a new elimination period will not be required, if Total Disability ceases for not more than thirty days during the elimination period.

Mental & Nervous / Drug & Alcohol:

Benefit payments will be limited to benefit duration or 24 months, whichever is less, cumulative for each of these limitations for treatment received on an outpatient basis. Benefit payments may be extended if the treatment for the disability is received while hospitalized or institutionalized in a facility licensed to provide care and treatment for the disability.

Enrollment
Coverage is 60% of an Employee's base monthly earnings to a maximum of $10,000. There are no offsets with the NC State Disability Plan. However all other offsets will apply. Anyone that did not elect the LTD coverage when first eligible must go thru medical underwriting.

Total Disability Definition:

An Insured is considered Totally Disabled, if, because of an injury or sickness, he cannot perform the material and substantial duties of his Regular Occupation, is not working in any occupation and is under the regular care of physician. After benefit have been paid for 24 months, the definition of disability changes to mean the Insured cannot perform the material and substantial duties of any Gainful Occupation for which he is reasonably fitted for by training, education or experience.

Partial Disability:

A partial benefit may be paid when an Insured is unable to perform every material and substantial duty of his regular occupation on a full-time basis due to injury or sickness. However, he must be performing at least one of the material and substantial duties of his regular occupation, or another occupation, on a full or part-time basis, and earning less than 80% of his indexed pre-disability earnings due to the same injury or sickness.

Residual Benefit:

The Residual Benefit allows the Elimination Period to be met whether the Insured is totally disabled, partially disabled or a combination of both.

Return to Work Benefit:

If it is determined the Insured can return to work on a part-time basis, a Monthly Benefit will be paid to supplement earnings for 12 months. During the twelve month period there will be no offset against the Monthly Benefit from part-time earnings unless the Current Monthly Income combined with incomes from all other sources, including the Monthly Benefit, exceeds 100% of the pre-disability earnings.

Pre-Existing Condition Exclusion:
The pre-existing period is 3/12. Benefits will not be paid if the Person's Disability begins in the first 12 months of coverage; and the Disability is caused by, contributed to, or the result of a condition, whether or not that condition is diagnosed at all or is misdiagnosed, for which the Person received medical treatment, consultation, care or services, including diagnostic measures, or was prescribed medicines in the 3 months just prior to the Individual's effective date of insurance.

Maternity Coverage:
Benefits will be paid the same as any other qualifying disability, subject to any applicable pre-existing condition exclusion; also excluding elective caesarian section delivery.

Recurrent Disability Provision: A recurrent disability is the direct result of the injury or sickness that caused a prior disability. This benefit allows payments to resume without satisfying a new elimination period if an Employee returns to active full-time work and has a recurrent disability within 6 months of return to active work.

Survivor Benefit: Benefits may be paid to the Eligible Survivor when a disabled Insured dies while receiving a Monthly Benefit and the disability had continued 180 days. The lump sum benefit is equal to 3 times the Insured's last Gross Monthly Benefit.

Employee Contributions: 100% contributory

There are no offsets with the NC State LTD Plan. All other offsets apply.

Additional Enhancements in this Contract:

Portability
Once an employee is on the AUL disability plan for 12 consecutive months, you may be eligible to port your coverage for one year at the same rate without evidence of insurability. You have 31 days from your date of termination to submit an application to AUL in order to port your coverage. The Application to port coverage is located on the Mark III website.

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

Please refer to the Mark III web-site for a copy of your certificate, a claim form or application to port form.

Waiver of Premium Provision
AUL will waive the premium payments for your coverage while you are disabled.

Exclusions and Limitations:
This plan will not cover any disability resulting from war, declared or undeclared or any act of war; active participation in a riot; intentionally self-inflicted injuries; commission of an assault or felony.

Rates (Age Banded)

Age Category	*LTD Monthly Premium Rate per $100 of Covered Monthly Earnings*
29 and Under	*$0.170*
30 - 34	*$0.350*
35 - 39	*$0.470*
40 - 44	*$0.720*
45 - 49	*$1.020*
50 - 54	*$1.390*
55 - 59	*$1.750*
60+	*$1.980*

*The LTD is age banded so the premium is based on salary and the rate for the employee's age band. The calculation is: monthly salary/100*rate = monthly premium*

Example:
For an employee, age 33, making $3,000 monthly, the calculation is:
$3,000/100 * $0.35 = $10.50 a month.

Customer Service
1.800-553-5318

Disability Claims
1.866-258-8744
Fax: 207-591-3048

Disability Claims Email: claims@disabilityrms.com

Website: www.employeebenefits.aul.com

This information is provided as a Benefit Outline. It is not part of the insurance policy and does not change or extend American United Life Insurance Company's liability under the group Policy. Employers may receive either a group Policy or a Certificate of Insurance containing a detailed description of the insurance coverages under the group Policy. If there are any discrepancies between this information and the group Policy, the Policy will prevail.

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Forysth County Government (#737350) – Full-Time

Your Summary of Group Life Benefits

Basic and Supplemental Term Life

Benefit Election Period: **04/12/2016 to 05/12/2016**

Coverage Effective Date: **07/01/2016**

Your Group Life Insurance Benefits

Protecting your greatest asset - your family

Am I eligible for coverage?

You qualify if **you are an active, full-time AAFT employee working at least 40 hours per week.**

When does my coverage begin?

When does coverage become effective?*	The **"Guaranteed Issue Amount"** is the most coverage you can get without having to submit Evidence of Insurability (EOI). Coverage up to the Guaranteed Issue Amounts will begin on **07/01/2016**. *You must be actively-at-work for your coverage to begin. Other rules may apply. Please review your policy documents for more information.
Do I have to provide **proof of good health (EOI)** to enroll?	An EOI Form (medical questionnaire) **is required** to enroll in the **Supplemental** Life insurance if you are a late applicant during this enrollment period. If you are currently covered, you may be able to increase coverage without EOI. Newly hired/newly eligible employees can enroll themselves and their dependents up to the Guaranteed Issue maximums during the 31 day period after they become eligible for benefits
When will coverage that **requires proof of good health (EOI)** begin?	Coverage will begin after Aetna reviews and approves your EOI. If EOI is not approved, coverage will be limited to any "Guaranteed Issue Amounts" that apply.

How much coverage does my Employer provide?

Employer Paid - Term Life Your employer pays for a benefit in the amount of: • **You:** 1.5 times your basic annual earnings rounded to the next higher $1,000 to a maximum of $150,000	Life insurance provides your loved ones with financial protection if you die. It can help pay your final expenses like funeral and burial; everyday living expenses like mortgage or rent, car payments and groceries; future expenses like college tuition payments.

Can I buy coverage and how much will it cost?

You can buy coverage called Supplemental Life insurance for yourself and your spouse and children.

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Forysth County Government(#737350) – Full-Time

Your Summary of Group Life Benefits

Supplemental Life Coverage

	Available Coverage Amounts
You	**1, 2 or 3X** Basic Annual Earnings up to a maximum of **$350,000**
Dependents	**Option 1:** Spouse: $**10,000 /** Child(ren) **$5,000; Option 2:** Spouse: **$20,000 /** Child(ren) **$5,000; Option 3:** Spouse only coverage: **$10,000**; **Option 4:** Spouse only coverage: **$20,000** **Option 5:** Child(ren) only coverage: **$5,000**

	Guaranteed Issue Amounts	
	New Hire/Newly Eligible*	**Annual Enrollment 04/12/2016-05/12/2016***
You	**3X** Basic Annual Earnings or **$350,000**, whichever is less	**2X** Basic Annual Earnings or **$350,000**, whichever is less
Your Spouse	**$20,000**	**$20,000**
Child(ren)	**$5,000**	**$5,000**

*Available during initial 31-day eligibility period. See your policy documents for more information.

***During Annual Enrollment an employee may increase their coverage from 1X to 2X basic annual earnings without EOI. If an employee has 1X or 2X they must submit an EOI form to increase to 3X their basic annual earnings. If you are a dependent spouse who is covered at $10,000 you can increase to $20,000 during Annual Enrollment without EOI; other election or increase would require submitting an EOI Form.**

Child(ren) Eligibility: From live birth up to 20 years. Unmarried, full-time students up to the ae of 26 are also eligible if dependent on the employee for support.

Monthly Rates for Term Life Insurance (rate per $1,000)

Age bands	<20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Employee	0.067	0.067	0.067	0.067	0.067	0.142	0.200	0.266	0.416	0.458	0.898	1.455	1.771

Dependent Coverage (monthly premium per Option elected): Option 1: **$3.39;** Option 2: **$9.51;** Option 3: **$2.74;** Option 4: **$8.86;** Option 5: **$0.66**

Reductions that apply to Life Insurance	**Your coverage will reduce as follows:**
Your coverage will reduce as you age.	At age 70 your coverage will reduce by 35% of the original amount. At age 75 your coverage will reduce by 55% of the original amount. At age 80 your coverage will reduce by 75% of the original amount.

What additional features should I know about?

Accelerated Death Benefit Provision	You may be eligible to receive up to **75%** of your (combined basic and supplemental) life insurance coverage if diagnosed with a terminal or serious medical condition.
AD&D Ultra® Features A benefit is paid to your surviving spouse/domestic partner or dependent children if you die in an accident.	**Seatbelt/airbag benefits:** If you or your dependent die from a motor vehicle accident while wearing a seatbelt, a benefit is paid. An added benefit is paid if an airbag inflated. **Educational benefit:** For your spouse and each eligible dependent child under 23. **Childcare Benefit:** For each dependent child under 13 to help pay for childcare. **Repatriation of Mortal Remains:** If you or your dependent die in an accident 200 miles or more from home, a benefit will be paid to transport the body to your hometown funeral home.

Life, AD&D Ultra, STD and LTD policies have limitations and exclusions. The purpose of this Benefit Summary and any additional enrollment materials or brochures is to give a general overview of the policies. Complete coverage information can be found in the policy documents issued by Aetna to your employer. Please review the policy documents to familiarize yourself with the terms of coverage. If there is a discrepancy between the policy documents and these materials, the terms of the policy documents will apply.

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Forysth County Government(#737350) – Full-Time

Your Summary of Group Life Benefits

Conversion If your coverage ends or is reduced, you can convert your term life policy to a Whole Life Policy.	You may convert your basic and/or supplemental coverage into a Whole Life Policy with rates based on your age at that time by paying premiums directly to Aetna. Whole life insurance is generally more expensive than term insurance so a change in your premium may apply. You will have **31** days to convert your coverage without answering any medical questions.
Portability If you leave your employer, you can take your term life plan with you.	You have an additional option to conversion. You can continue your basic and/or supplemental life insurance as a term policy by paying premiums directly to Aetna. Term insurance is generally less expensive than Whole Life insurance but your rates will increase as you reach higher age bands. You will have **31** days to convert or port your coverage without answering any medical questions.
Aetna Life Essentials® Aetna Life Essentials web address: **www.aetna.com/aetnalifeessentials/**	**Legal:** Create a will, living will, health care directive or a durable/financial power of attorney. **Financial:** Financial planning to help your beneficiaries maximize their life/AD&D Ultra payment. **Emotional:** Master-level social workers provide emotional support in the event of an advanced illness or disabling condition. **Physical:** Save on gym memberships, fitness equipment, eyeglasses, contact lenses and hearing aids.
Funeral Planning and Concierge Services	Advisory Assistance to help you and your family make decisions on all funeral-related issues. Planning advice and cost-comparison tools available **24/7** by phone and online. Call **1-800-913-8318** or visit **www.everestfuneral.com/aetna** (Ask your Human Resources department for your company code.)

Peace of mind when you need it most

Funeral planning services

Offered through Aetna Life insurance

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

EVEREST
The First Nationwide Funeral Planning and Concierge Service

Who is Everest?

Everest gives you the information you need to make the best choices about funeral issues. They offer both **pre-planning** and **at-need** services at or near the time of need. Their online planning tools help you prepare for the future. At-need services include family support and pricing information. And Everest advisors are available by phone 24/7.

You're never locked into a decision because Everest's funeral advisory services can be used at any funeral home across North America. Everest works for you, not a funeral home. Everest does not sell funeral goods or services, nor do they receive money in return from funeral homes or other funeral service providers.

Everest advisors talk with the funeral home about your personal plan and costs, so that you and your family can help feel assured that you made the best choices during a stressful time.

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Getting started

To use Everest's online planning tools, visit **www.everestfuneral.com/aetna** and follow these steps:

- Click "Log On" to create a New User account.
- Enter your e-mail address and the Enrollment Identification Code: **AETNA0100**
- Your employer will provide details regarding eligible family members
- Complete your online profile
- Access "Planning Tools" at **www.everestfuneral.com/aetna** using your unique user name and password
- If you do not have access to a computer, advisors are available 24/7 by calling **1-800-913-8318**

Pre-planning services

24/7 advisor assistance

- To discuss funeral planning issues

PriceFinder℠ custom reports

- The only nationwide database of funeral home prices
- Compare prices for funeral homes within your ZIP code or area that you select

Online planning tools and guides

- **My Personal History** — Record your information for when your family needs it most
- **10 Key Decisions** — A form to help you make the best choices
- **My Wishes** — List your personal wishes for your funeral plans

At-need services

Family support

- Everest advisors are available 24/7 throughout the funeral process
- Advisors will talk with the funeral home about your Personal Funeral Plan on your behalf

Pricing assistance

- Pricing information is given to the family in an easy-to-read format
- Advisors will help the family compare prices of all funeral-related services and talk with local funeral homes to agree on pricing

Protection for personal data

You'll have access to Tenzing™, an online data storage system for protecting, storing, updating and accessing your personal information.

- Store financial records, user names and passwords, estate plans, memberships, photos and other important personal documents
- Online access to your most valuable information while protecting against unauthorized access to personal data

While you can't predict life's outcome, you can help prepare for it.

We provide our life insurance members access to programs and services that provide support throughout various stages of their lives.

Life insurance plans are offered and/or underwritten by Aetna Life Insurance Company (Aetna).
Aetna has provided its policyholders with access to Everest Funeral Planning and Concierge Services ("Services") which are independently administered by Everest Funeral Package, LLC ("Everest"). Access to these Services is not insurance, may be discontinued at any time without notice, and is void where prohibited. Everest is solely responsible for furnishing these Services and Aetna makes no guarantee or representations as to their quality or suitability. In no event will Aetna be responsible or liable for any acts or omissions by Everest and its agents, employees or representatives in connection with the Services provided. Life insurance plans contain exclusions and limitations. This material is for information only and is not an offer or invitation to contract. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to **www.aetna.com**.
Policy forms issued in Oklahoma include: GR-9/GR-9N and/or GR-29/GR-29N.

www.aetna.com

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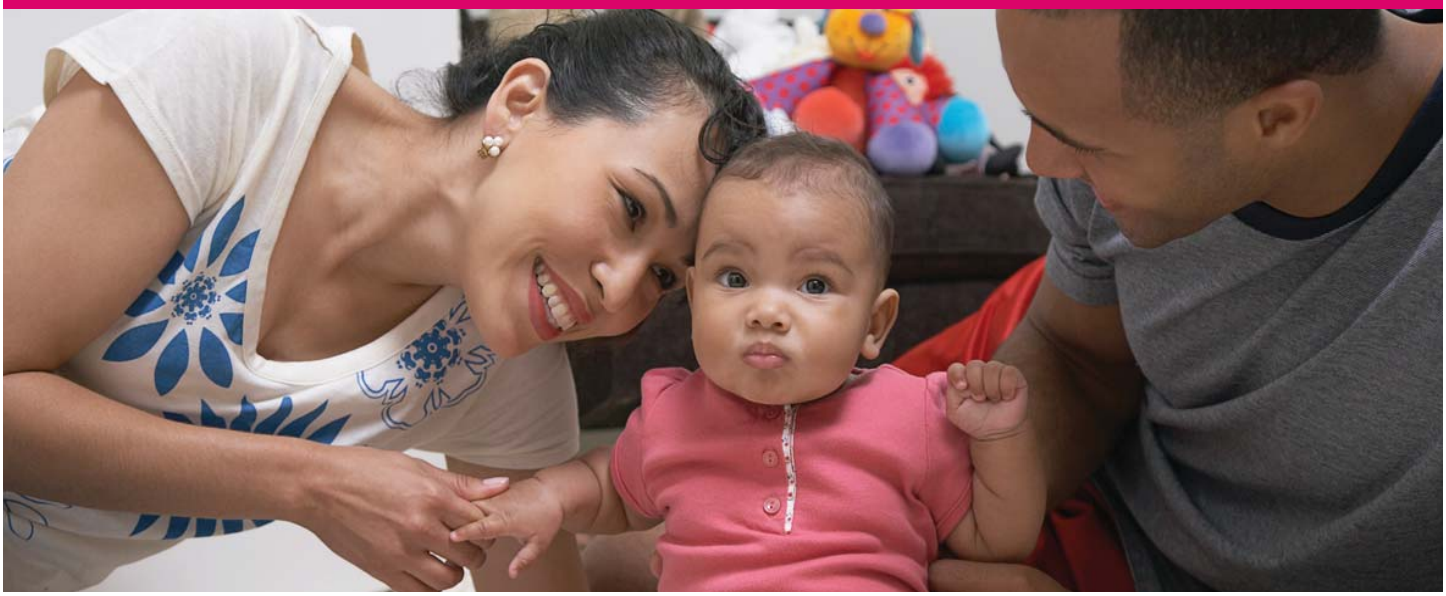
Quality health plans & benefits
Healthier living
Financial well-being
Intelligent solutions

aetna[SM]



Services for every stage of your life

Aetna Life Essentials[SM]

With Aetna Life Insurance coverage, you not only get financial protection for your loved ones. You also get tools and services to use **today** for a healthy, fulfilling life. This is what Aetna Life Essentials is all about.

Financial services

You can receive JPMorgan Chase Financial Counseling and Level I Financial Planning. It's available to you whether you're an active employee, retired, terminated employee having ported coverage, or a beneficiary of a deceased life member.

To learn more, call **1-866-222-8008**.

Accelerated Death Benefit

If you are terminally ill, the Accelerated Death Benefit lets you have up to 75 percent of your life insurance before your death.

There are no limits on how you can use this money. You can use it for medical expenses or daily living costs. You can even use it to take a vacation!

Unlike using a settlement company that pays pennies to the dollar, our Accelerated Death Benefit (ADB) provides the **full** remaining balance to be paid to your beneficiary after your death, as long as the policy remains active.

Master's-level social workers in our Care Advocacy Unit will walk you through every step of the process.

There is no cost to the program, no application fee, no processing fee.

Let us help you take control of your life situation.

Contact your human resources department for more information.*

*Before you request the ADB, you should discuss the impact of receiving an early payout with your own legal counsel. State variations do exist. The listing of medical conditions that may qualify you, your spouse or domestic partner may also vary based on state insurance laws.

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Legal Reference™ Program

If you have an approved accelerated death benefit claim, you are entitled to **free** legal services in an attorney's office. These include:

- Wills
- Health care directives
- Durable financial power of attorney
- Uncontested guardianship documentation
- Tax planning

Physical services

An important part of living longer is staying healthy. You'll have access to Aetna's wellness programs such as:

- Aetna Vision℠ discount program
- Aetna Hearing℠ discount program
- Aetna Fitness℠ discount program
- Waterpik® discount program

Care Advocacy Program

This is a telephone social work service. It's available to those who:

- Are permanently and totally disabled
- Are terminally ill and are applying for an accelerated death benefit, or have been approved for one
- Have an injury that has resulted in a loss covered by the Accidental Death and Personal Loss coverage benefit

Master's-level social workers offer:

- Education about coverage
- Referrals to local and national programs that can provide housing, food, insurance, prescription and financial assistance, emotional support and referrals to behavioral health services

To learn more, call **1-800-276-5120**.

End-of-life support

You can use the Compassionate Care website to be better prepared during this challenging time. You can find:

- Advice on how to start talking about end-of-life issues
- End-of-life care information
- Printable checklists of important papers and contacts

Whenever you need access, visit **www.aetnacompassionatecare.com**.

Grief counseling

We're here when you need to talk. You and your family members can speak with an Aetna Behavioral Health representative. You have up to three telephone bereavement or grief counseling sessions.

To speak with someone, call **1-800-806-8891**.

Legal services

With the Legal Reference™ Program, you and your spouse can get free, online access to estate planning services. These include:

- Living wills
- Health care directives
- Durable financial power of attorney

Plus — you get two will-preparation sessions a year. One for you and one for your spouse or domestic partner.

To learn more, call **1-888-257-2934**. Or visit us at **www.ichooselegal.com**.

More than life insurance. It's your essentials for every stage of life. To learn more, visit **www.aetnalifeessentials.com**

The Legal Reference™ Program

Estate Planning Documents offered FREE for you and your spouse.

What is estate planning?
Estate planning is the process of setting up legally valid instructions to carry out your wishes if you become disabled or you die.

Estate planning is no longer just for the wealthy.
In today's world, you should consider an estate plan if:

- You are the parent of minor children
- You own property
- You want to have a say in your healthcare treatment

Brought to you by ARAG®
a leading legal services provider

Estate planning just got easier and less expensive for you.
We're offering you an important program – The Legal Reference™ Program – that allows you to easily and affordably complete several essential estate planning documents:

Simpy visit www.iChooseLegal.com for these FREE documents

- **Simple Will** - Make basic decisions about how you want to distribute your assets.
- **Living Will** - Ease the burden on your family by creating a living will that states the kind of care you wish.
- **Healthcare Power of Attorney** - Grant someone permission to make medical decisions on your behalf if you're unable.
- **Financial Power of Attorney** - Grant someone permission to make financial decisions on your behalf if you're unable.

Plus, you'll find FREE Information at iChooseLegal.com

- Educational information on Estate Planning
- Legal research tools
- Information on Identity Theft and a downloadable Victim Action Kit

Protects Your Family, Finances and Future

www.iChooseLegal.com

The Legal Reference™ Program

Estate Planning Q & A

Why is a Will Important?
Without a valid Will you cannot control who will inherit your property upon your death. Should you die intestate (without a Will), your property will be distributed according to state law, which may be inconsistent with your personal wishes. Moreover, a part of your estate may go to the state instead of to family or other loved ones.

With a Will you can determine precisely who will inherit your property. Equally important, you can designate who will administer your estate and who will act as guardian for your minor children should they be without a surviving parent.

Who should make a Will?
Every adult should have an up-to-date last Will and testament.

What is a Living Will?
A Living Will is a written document that contains a person's wishes regarding the use of extraordinary life-support or other life-sustaining medical treatment when the person's condition is medically without hope of recovery or death is imminent.

Why should I create a Living Will?
A Living Will can ease the burden on family members by letting them know your wishes regarding life support in the event you cannot speak for yourself. Creating a document that states the type of care you desire may help eliminate undue stress, even legal action, between loved ones who may be faced with decisions regarding your care.

What is a Healthcare Power of Attorney?
A Healthcare Power of Attorney is a legal document you can create to grant someone permission to make medical decisions for you if you are unable to make those decisions yourself. The person you name to represent you may be called an agent, attorney-in-fact, healthcare proxy, patient advocate, or something similar, depending on where you live.

Why should I create a Healthcare Power of Attorney?
A Healthcare Power of Attorney allows you to determine who will make the important decisions in your life in the event you are unable mentally or physically to make them for yourself.

What is a Financial Power of Attorney?
A Financial Power of Attorney is a legal document you can create to grant someone permission to make financial decisions for you if you are unable to make those decisions yourself.

www.iChooseLegal.com
Toll-free Customer Care: 888-257-2934
7:00 a.m. – 7:00 p.m. Central time

Quality health plans & benefits
Healthier living
Financial well-being
Intelligent solutions

aetna®

A life insurance plan that offers conversion or portability **It's your choice**

This guide will help you make the right choice for yourself and your family.

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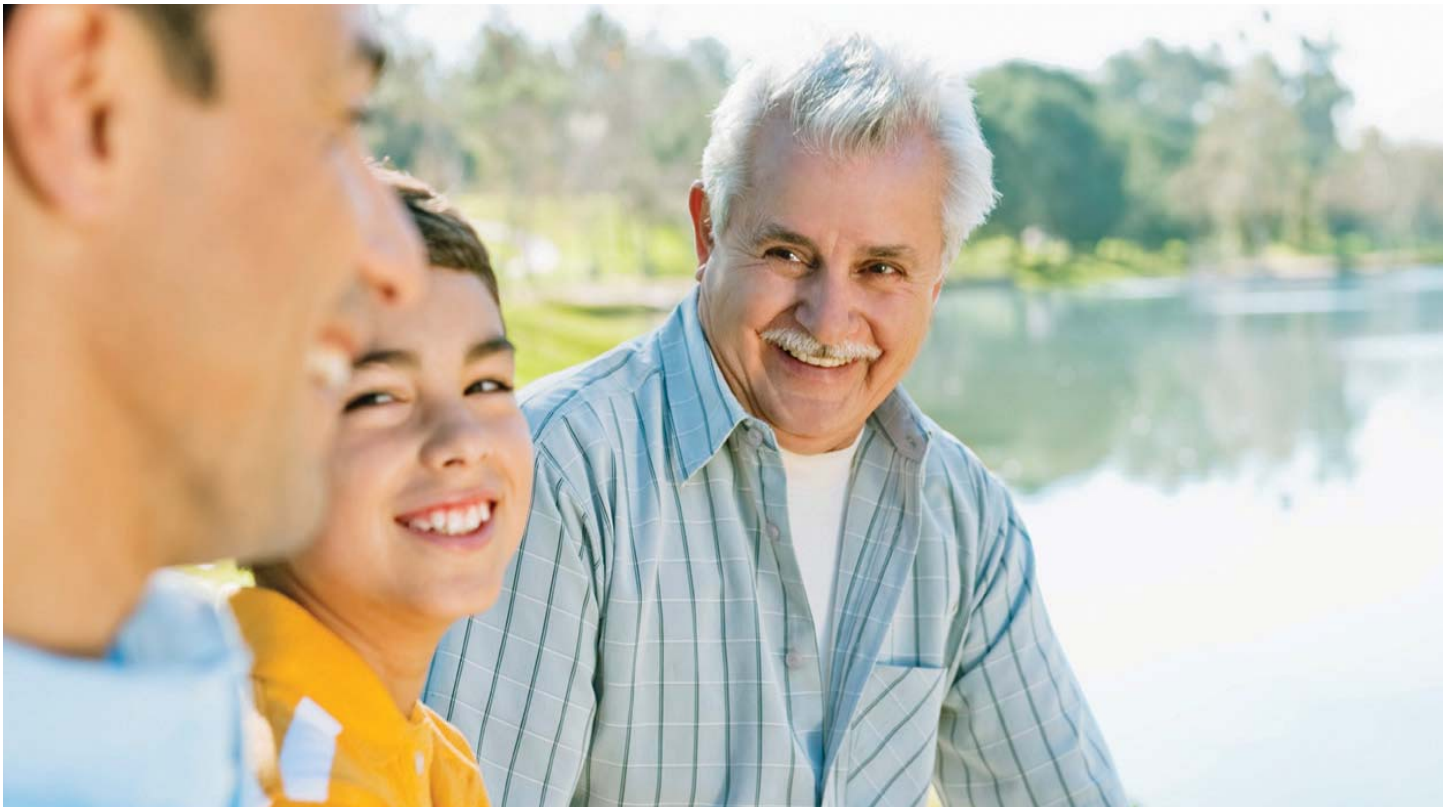

Your group life insurance coverage helps provide important financial protection, but ...

If that help ends, can you continue your coverage? Yes. Here's how:
You can convert your coverage to an individual policy. Or you can take it with you as another group life term policy. When you understand these options, you can make an informed decision.

Conversion*

Current coverage **converts** to an Aetna Individual Whole Life policy.

- Your new policy remains in effect as long as you live if you continue to pay your premiums.
- You will not have to answer any medical questions.
- Your premium, based on your age when your policy is issued, will never change.

When your whole life policy begins to mature and earn a **cash value**:

- You can borrow against this cash value if you need a loan
- You can cancel your coverage by surrendering your policy without a claim (you'll receive a sum that's equivalent to what the policy is worth at that time**)

Portability***

You can **continue** (or port) your current group term coverage, but on an individual basis.

- Pay premiums directly to Aetna instead of having them deducted from your payroll.
- Your premium amount (determined by your age at the time you elect to port your coverage) will change as you age.
- You can't borrow against this coverage, and there is no cash surrender value if you cancel your coverage.

*Important note for residents of New York and West Virginia: If you choose conversion, you may elect to defer your whole life option for up to one year and purchase term insurance. After one year, this term life insurance will automatically convert to a whole life policy.

**You may wish to consult with a tax adviser as to the proper tax treatment.

***Important note for people who are covered under a Minnesota group policy: The state of Minnesota does not allow portability. However, your coverage may be continued for up to 18 months as required by Minnesota law. Ask your employer for details.

Now let's take a more detailed look at your options

Question	Conversion	Portability
Will I receive a new policy from Aetna?	If you convert your coverage, we'll mail your whole life policy to the address you provided. Please keep this policy in a safe place in case you need to make a claim.	If you port your coverage, your existing Certificate of Coverage will remain in effect. Please keep this certificate in a safe place in case you need to make a claim. If you don't have a copy of this certificate, please ask your employer to give you one.
How much life insurance can I convert or port?	• If your employment ends, you can convert the full amount of coverage you had on the date your employment ended. • If your coverage is reduced due to age or retirement, you can convert the amount of coverage you are losing. • If your policy is cancelled, you can convert a maximum of $10,000 per person, minus any amount of group insurance you become eligible for within 31 days of your coverage end date.	If your employment ends, you can port the amount of coverage you had on the date your employment ended, up to the following limits: • Employee — $500,000† • Spouse — $100,000† • Child — $5,000†
Who can I cover?	You can continue to cover yourself and any family members who are listed as dependents when your coverage ends.	You can continue to cover yourself and any family members who are listed as dependents when your coverage ends.
Can I convert or port just my dependent coverage?	Yes.	No. If you want to port your dependent's life insurance coverage, you must also port your own coverage.
Can I convert or port my coverage if I get divorced or my marriage is annulled?	Yes. If your life insurance coverage ends because of divorce or annulment, you or your former spouse will be eligible to convert the coverage that is ending.	No. You cannot port your former spouse's coverage if it ends due to divorce or annulment.
If I was away from active work due to an illness or injury when my coverage ended, can I convert or port my coverage?	Yes.	No.
Is there a minimum amount that I must convert or port?	Yes: $1,000	Yes: • Employee — $5,000 • Spouse — $1,000 • Child — $1,000
Will the coverage ever reduce?	No.	Yes: • At age 65, coverage will reduce by 35%. • At age 70, it will reduce by 60%. • At age 75, it will reduce by 75%, but not to an amount less than $5,000.
When will coverage end?	As long as premiums are paid, your coverage will have no end date and will not expire.	Coverage will end on the first anniversary of your port date after you or your spouse reaches age 99. For any covered children, coverage will end on the first anniversary of your port date after they reach the child-limiting age that is shown on your Certificate of Coverage.

†Amounts of life insurance in excess of these limits are eligible for conversion.

Question	Conversion	Portability
Will I need to answer any medical questions?	No.	No.
Does the policy contain any exclusions?	Yes. There is a two-year exclusion for suicide. However, you will receive credit toward the two-year period for the period of time that you were covered under your original group policy.	If your Certificate of Coverage includes a two-year suicide exclusion, it will only apply in a ported situation for the period of time that remains once ported coverage has been elected.
Does the life insurance benefit contain an accelerated death provision?	No.	Although the Certificate of Coverage may contain an accelerated death benefit provision, it does not apply after you have ported your coverage.
Does the life insurance benefit contain a disability provision?	No.	Maybe. If your Certificate of Coverage includes a premium waiver provision, you can apply for a premium waiver extension. If you meet all of the qualifying conditions, your coverage will continue while you are disabled, with no payments required. If your Certificate of Coverage does not include a premium waiver provision, you must continue to pay for your coverage if you become disabled.
Does the coverage include protection for losses that result from an accident?	Maybe. If you had accidental death and personal loss coverage on the day before you became eligible to convert your coverage, you can purchase an accidental death and dismemberment (AD&D) rider (in an amount equal to the life insurance you're converting) that pays additional benefits if you suffer a covered loss that results from an accident.	Maybe. If you had accidental death and personal loss coverage on the day before you became eligible to port your coverage, you can purchase an accidental death (AD) rider (in an amount equal to the life insurance you're porting) that pays additional benefits if you suffer a covered loss that results from an accident.
If I purchase the AD&D rider or the AD rider, will it end at a specific age?	No. The AD&D coverage will remain in effect until your date of death, provided the premium for the AD&D rider is paid.	Yes. The AD rider will terminate when you or your covered spouse reaches age 70.
When should I make my decision to convert or port my coverage?	Now. This decision is simply too important to put off and you have only 31 days to decide from the date you become eligible for conversion.	Now. This decision is simply too important to put off and you have only 31 days to decide from the date you become eligible for portability.

Conversion or portability?

It's your choice. Make it an informed decision ... for your sake and your family's.
To learn more, call toll-free **1-877-503-3448**, Monday – Friday from 9 a.m. – 7 p.m. ET.

Life insurance policies are offered, underwritten and/or administered by Aetna Life Insurance Company (Aetna).

This material is for information only. Life insurance plans/policies contain exclusions and limitations. Specific features of life insurance plans vary, depending on employers and states. Exclusions and limitations apply. See policy or plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to **www.aetna.com**.

www.aetna.com

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Continuation of Benefits Options

FLEXIBLE BENEFITS ADMINISTRATORS MEDICAL & DEPENDENT CARE REIMBURSEMENT ACCOUNTS

If you have a positive balance (payroll deductions are greater than the amount you have received in reimbursement) in your Medical Reimbursement Account at the time of your termination, you may continue participation in the Plan for the remainder of the Plan year through COBRA. If you prefer to terminate your participation and contribution to the Plan, any balance in your account on the date of termination will be forfeited if claims were not incurred prior to the date of termination. To obtain your balance, please call **Flexible Benefit Administrators (FBA) at** 800-437-FLEX.

COBRA HEALTH, DENTAL AND VISION

Under the health, dental and vision plans, you and your covered dependents are eligible to continue coverage through COBRA according to the following “qualifying events”.

Continuation 18 months for:

- Resignation
- Reduction in Hours
- Layoff
- Retired
- Involuntary Termination

Continuation for 36 months for:

- Divorce/Legal Separation
- Loss of “Dependent Child” Status
- Employee Enrolled in Medicare
- Death of Employee

You will receive notification with premium and continuation options shortly following your termination of employment or you may call **IMS at 800-426-8739 ext: 5342.**

AUL SHORT-TERM AND LONG-TERM DISABILITY PLAN

Once an employee is on the AUL disability plan for 3 months for STD or 12 months for LTD, you can port the coverage for one year at the same cost without evidence of insurability. You have 30 days from your date of termination to contact AUL to Port your coverage by calling 800-553-5318.

AETNA TERM LIFE

When you leave your employment, you may convert the existing group term coverage you have through your employer to a guaranteed issue, individual whole life policy. You also have the option of porting your existing coverage as well. It is the responsibility of the employee to convert or port coverage. You must apply for conversion or portability within 31 days from the date your employer terminates your term life coverage. If you would like to convert or port your term life coverage, please contact your employer for the appropriate forms. If you do not convert or port your group term life insurance, coverage will terminate when you leave your employer.

Important Phone Numbers

- Aetna (Conversion and Portability) / 877.503.3448
- Ameritas Dental / 800.776.9446
- AUL Short Term and Long Term Disability / 800.553.5318
- Blue Cross / Blue Shield / 877.258.3334
- Flexible Benefit Administrators / 800.437.3539
- Interactive Medical Systems (IMS) COBRA / 800.426.8739 ext. 5342
- Superior Vision / 800.507.3800