



Forsyth County Government offers all **full-time employees** a comprehensive Cafeteria Benefits program. The Cafeteria Benefits program is being arranged by Mark III Brokerage, an employee benefits firm that has worked with the public sector since 1973. The Cafeteria Benefits program allows you to pay for certain insurance premiums, work-related child care, and unreimbursed medical expenses before taxes are taken out of your paycheck. Paying for these benefits by this method reduces your income & FICA taxes and increases your take home pay. The Cafeteria Benefits program includes pre-tax and after-tax products listed below.

- **Annual enrollment is the only time you may enroll in the Flexible Spending Plan, Ameritas Dental Plan or in the Humana Specialty Benefits Short Term Disability Plan.**
- **All employees who would like to enroll in or make a change to the Humana Specialty Benefits Short Term Disability Plan must be seen by a Mark III Representative during open enrollment.**
- **Mark III representatives will be available May 14th, 15th and 16th.**
- **The Plan Year is from July 1, 2009 to June 30, 2010.**

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*(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, 2009 - June 30, 2010.
  - Payroll deductions for this year's enrollment will start:
    - Health and Dental - June 19, 2009
    - Short Term Disability - July 3, 2009
    - Flexible Spending Accounts - July 17, 2009
  - Please remember that 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 FSA 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.
  - You must re-elect your Tucker Administrators Medical Spending and Dependent Care Accounts each year. These accounts do not automatically carry-over to the next year.
  - Medical Reimbursement and Dependent Care expenses 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 Tucker Administrators Medical Reimbursement or Dependent Care Account can be directed to [www.tuckeradministrators.com](http://www.tuckeradministrators.com), or you can call Customer Contact Center at 1-800-347-1232.
  - Any questions regarding all other benefits can be directed to Staci Kelso at 336-703-2407..
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## ***Important Phone Numbers***

Blue Cross / Blue Shield / 877-258-3334  
Tucker Administrators / 800-347-1232  
Ameritas Dental / 800-776-9446  
Humana Short Term Disability / 877-378-1505  
Lincoln Financial Term Life / 800-423.2765  
Interactive Medical Systems (IMS) COBRA / 800-426-8739 ext. 5342

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## BCBS PPO - Summary of Benefits

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**Effective Date:** July 1, 2009

	<u>In-Network</u>	<u>Out-Of-Network<sup>1</sup></u>
<b>PHYSICIAN OFFICE SERVICES</b>		
<i>(See "Outpatient Clinic Services" for "outpatient clinic" or "hospital-based" services.)</i>		
<b>Office Visit</b>		
<i>Includes Office Surgery, Consultation, X-rays and Lab, and a benefit period maximum of 4 office visits for the assessment of obesity in and out of network. See "Inpatient and Outpatient Services".</i>		
Primary Care Provider	\$20 copayment	80% after deductible
Specialist	\$40 copayment	80% after deductible
<b>Preventive Care</b>		
<i>Routine Examinations, Well-Child Care, Immunizations, Pap Smears, Mammograms, Prostate Specific Antigen Tests (PSAs)</i>		
Primary Care Provider	\$20 copayment	Not Available*
Specialist	\$40 copayment	Not Available*
*Pap Smears, Mammograms, and PSAs are covered Out-of-network.		
<b>Therapies</b>		
<i>Short-term Rehabilitative Therapies (Maximums apply to Home, Office and Outpatient Settings):</i>		
<i>Physical/Occupational: 30 visits per Benefit Period</i>		
<i>Speech Therapy: 30 visits per Benefit Period</i>		
Primary Care	\$20 copayment	80% after deductible
Specialist	\$40 copayment	80% after deductible
<b>URGENT CARE CENTERS AND EMERGENCY ROOM</b>		
Urgent Care Centers	\$40 copayment	\$40 copayment
Emergency Room Visit		
<i>(Inpatient Hospital benefits apply if admitted. \$150 copayment</i>		\$150 copayment
<i>If held for observation, outpatient benefits apply. See "Inpatient and Outpatient Hospital Services".)</i>		
<b>AMBULATORY SURGICAL CENTER</b>	100% after deductible	80% after deductible
<b>INPATIENT AND OUTPATIENT HOSPITAL SERVICES</b>		
Hospital and Hospital Based Services	100% after deductible	80% after deductible
Outpatient Clinic Services	100% after deductible	80% after deductible
Professional Services	100% after deductible	80% after deductible
Hospital and Professional		
Outpatient Labs and Mammograms with surgery or other services.	100% after deductible	80% after deductible
Outpatient Labs and Mammograms without surgery or other services.	100%	80% after deductible
Outpatients X-rays, ultrasounds & other diagnostic tests such as EEG's & EKG's	100% after deductible	80% after deductible
CT Scans, MRI's, MRA's, & PET scans in any location, including physician's office	100% after deductible	80% after deductible

	<u>In-Network</u>	<u>Out-of-Network<sup>1</sup></u>
<b>OTHER SERVICES</b>		
<b>Skilled Nursing Facility</b> <i>(60 days per Benefit Period)</i>	100% after deductible	80% after deductible
<b>Home Health Care, Ambulance, Durable Medical Equipment &amp; Hospice</b>	100% after deductible	80% after deductible
<b>Maternity</b> <i>Maternity Delivery includes Prenatal and Post-delivery care</i>		
Hospital Services <i>(Delivery)</i>	100% after deductible	80% after deductible
Professional Services <i>(Delivery)</i>	100% after deductible	80% after deductible
<b>Transplants</b>		
Hospital Services	100% after deductible	80% after deductible
Professional Services	100% after deductible	80% after deductible
<b>Infertility and Sexual Dysfunction Services</b> <i>Up to \$5,000 per Lifetime</i>		
Primary Care Provider	\$20 copayment	80% after deductible
Specialist	\$40 copayment	80% after deductible
Hospital Services	100% after deductible	80% after deductible
Inpatient and Outpatient		
Professional Services	100% after deductible	80% after deductible
<b>Vision Care</b>		
Comprehensive Eye Exam	\$20 copayment	Benefits not available

**LIFETIME MAXIMUM, DEDUCTIBLES & COINSURANCE MAXIMUMS**

<b>Lifetime Benefit Maximum</b>	\$5,000,000	\$5,000,000
<b>Deductibles</b>		
Individual <i>(per Benefit Period)</i>	\$750	\$1,500
Family <i>(per Benefit Period)</i>	\$2,250	\$4,500
<b>Coinsurance Maximum</b>		
Individual <i>(per Benefit Period)</i>	\$0	\$1,250
Family <i>(per Benefit Period)</i>	\$0	\$3,750

**MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES**      Certified\*      Not-Certified<sup>1</sup>

*\*Inpatient/Outpatient Certification is required. Call Magellan Behavioral Health at 1-800-359-2422.*

<b>Mental Health Services</b>		
Office <i>(30 visits per Benefit Period)</i>	\$40 copayment	80%
Inpatient/Outpatient <i>(30 Days per Benefit Period)</i>	100%	80% after deductible
<b>Substance Abuse Services</b>		
Office Visit	\$40 copayment	80%
Inpatient/Outpatient	100%	80% after deductible
Benefit Period Maximum		\$8,000
Lifetime Maximum		\$16,000

**PRESCRIPTION DRUGS**

*Up to 30 day supply. 31-60 day supply is two copayments and 61-90 day supply is three copayments. Infertility Drugs up to \$5,000 Lifetime Maximum. MAC B Pricing, Brand Penalty*

Tier 1 ( <i>Generic</i> )	\$10 copayment	Copayment + charge over in-network allowed amount
Tier 2 ( <i>Preferred Brand</i> )	\$25 copayment	Copayment + charge over in-network allowed amount
Tier 3 ( <i>Brand</i> )	\$40 copayment	Copayment + charge over in-network allowed amount
Tier 4 ( <i>Specialty Brand</i> )	75% coinsurance	Coinsurance + charge over in-network allowed amount

There is a \$50 per Drug Minimum and a \$100 per Drug Maximum for each 30-day supply of Tier 4 Specialty Brand drugs.

<sup>1</sup> NOTICE: Your actual expenses for covered services may exceed the stated coinsurance percentage or co-payment amount because actual provider charges may not be used to determine the payment obligations for BCBSNC and its members.

**ADDITIONAL INFORMATION ABOUT BLUE OPTIONS FROM BCBSNC**

**BENEFIT PERIOD**

The period of time, usually 12 months as stated in the group contract, during which charges for covered services provided to a member must be incurred in order to be eligible for payment by BCBSNC. A charge shall be considered incurred on the date the service or supply was provided to a member.

**ALLOWED AMOUNT**

The charge that BCBSNC determines using a methodology which is applied to comparable providers for similar services under a similar health benefit plan.

**COINSURANCE MAXIMUM**

The dollar amount of coinsurance a member must pay prior to BCBSNC paying 100% for certain services.

NOTE: In some plans, there is no coinsurance maximum; members are responsible for coinsurance once the deductible has been met.

**DAY AND VISIT MAXIMUMS**

All day and visit maximums are on a combined In- and Out-of Network basis.

**UTILIZATION MANAGEMENT**

To make sure you have access to high quality, cost-effective health care, we manage utilization through a variety of programs including certification, transplant management, concurrent and retrospective review.

If you have a concern regarding the final determination of your care, you have the right to appeal the decision. If you would like a copy of a benefit booklet providing more information about our Utilization Management programs, call the toll free number listed in your information packet.

### **CERTIFICATION**

Certification is a program designed to make sure that your care is given in a cost effective setting and efficient manner.

If you need to be hospitalized, you must obtain certification. Non-emergency and non-maternity hospital admissions must be certified prior to the hospitalization. If the admission is not certified, a penalty will be applied.

For maternity admissions, your provider is not required to obtain certification from BCBSNC for prescribing a length of stay up to 48 hours for a normal vaginal delivery, or up to 96 hours for delivery by cesarean section. You or your provider must request certification for coverage for additional days, which will be given by BCBSNC, if medically necessary.

All inpatient and outpatient Mental Health and Substance Abuse services must be certified in advance by Magellan Behavioral Health.

In-network providers are responsible for obtaining certifications. The member will bear no financial penalties if the in-network provider fails to obtain the appropriate authorization. The member is responsible for obtaining certification for services rendered by an out-of-network provider. Obtaining certification for Mental Health and Substance Abuse services is the member's responsibility. Failure to obtain certification for Mental Health and Substance Abuse services will result in these services being paid at the out-of-network benefit level.

### **HEALTH AND WELLNESS PROGRAM**

Because we want to help you stay healthy, we offer a variety of wellness benefits and services. You can take advantage of HealthLine Blue, our 24-hour health information service, a health topics library, asthma and diabetes management and a prenatal program. You will also receive Active Blue, our quarterly health magazine, and have access to online health and wellness information at [www.bcbsnc.com](http://www.bcbsnc.com). With our program you can get health advice anytime you need it, so you can learn how to take charge of your health.

### **WHAT IS NOT COVERED?**

The following are summaries of some of the coverage restrictions. A full explanation and listing of restrictions will be found in your benefit booklet.

Your health benefit plan does not cover services, supplies, drugs or charges that are:

- Not medically necessary
- For injury or illness resulting from an act of war
- For personal hygiene and convenience items
- For inpatient admissions that are primarily for diagnostic studies
- For palliative or cosmetic foot care

- For investigative or experimental purposes
- For hearing aids or tinnitus maskers
- For cosmetic services or cosmetic surgery
- For custodial care, domiciliary care or rest cures
- For treatment of obesity, except for surgical treatment of morbid obesity, or as specifically covered by your health benefit plan
- For reversal of sterilization
- For treatment of sexual dysfunction not related to organic disease
- For conception by artificial means
- For self-injectable drugs in the provider's office

A waiting period for coverage of pre-existing conditions may apply to your coverage. BCBSNC defines pre-existing conditions as those conditions for which medical advice, diagnosis, care or treatment was received or recommended within 6 months of the date that your [BCBSNC] coverage begins. You may receive credit toward the 12-month waiting period if your enrollment date is within 63 days of the termination of your previous health coverage.

The benefit highlights is a summary of Blue Options benefits. This is meant only to be a summary. Final interpretation and a complete listing of benefits and what is not covered are in and governed by the group contract and benefit booklet. You may preview the benefit booklet by requesting a copy of the Blue Options benefit booklet from BCBSNC Customer Services.

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



**BCBS HEALTH PLAN BI-WEEKLY RATES**

Individual	\$28.42
Employee + One	\$80.52
Family	\$212.44

**FOR CLAIMS / CUSTOMER SERVICE  
PLEASE CALL: 1-877-258-3334  
website address: [www.bcbsnc.com](http://www.bcbsnc.com)**

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## **Tucker Administrators Flexible Spending Accounts (General Overview)**

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Tucker Administrators Flexible Spending Accounts allow you to use pre-taxed dollars towards health care expenses such as prescription and over-the-counter medication, certain medical procedures, copays, and more. With Flexible Spending Accounts (FSA), you can save a significant amount of money on your health and day care expenses using a Health Care and/or Dependent Care Flexible Spending Account (FSA). The frequently asked FSA questions below will help you understand how to make the most of this program and your paycheck.

### **General questions regarding Health Care and Dependent Care Accounts:**

#### **What is an FSA?**

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

#### **Will I pay taxes on the money I set aside?**

No. FSA contributions and reimbursements are exempt from Federal Income taxes, Social Security (FICA) taxes, and in most cases, state income taxes.

#### **What kind of savings can I realize by participating in this program?**

Actual savings depend on your tax bracket, but most people will save about 30% on their eligible health care and dependent care expenses.

#### **Can I submit expenses I incurred before the beginning of the plan year?**

No. Only expenses incurred during the plan year and while you are a participant are eligible for reimbursement.

#### **How long do I have to file a claim with Tucker Administrators after the plan year ends?**

You have a grace period (90 days) after the end of the plan year to submit expenses that were incurred during the plan year.

#### **Is there any risk to an employee by participating in a medical spending account or a dependent care account?**

Changes in elections for dependent care expenses may be made if there is a status change during the plan year (example: birth of a new baby). However, you may not change your elections for a Medical Spending Account during the plan year. 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.

#### **Can I change the amount of my election(s) in the FSA program during the plan year? (i.e. my glasses cost more than I anticipated, I miscalculated my daycare expenses for the year)**

Generally, you may not change your FSA elections during the Plan Year. However, you may change during the annual enrollment period for the coming Plan Year.

There is an exception to this rule: you may change or revoke your deferral rate in the FSA if you have a Change in Family Status.

Examples of a qualifying status change may include:

- Marriage, divorce, or legal separation
- Birth, adoption or placement for adoption of a child
- Death of a dependent or spouse
- Change in employment status of yourself or your spouse
- A significant change caused by a third party in the cost of your dependent care coverage

**If I terminate employment, or participation in the FSA, what happens to the money left in my account(s)?**

You will be reimbursed only for expenses incurred prior to your termination date, and submitted within the termination grace period. Any money remaining in your account(s) after the grace period will be forfeited.

**Can I view my FSA balances online?**

Yes. Visit [tuckeradministrators.com](http://tuckeradministrators.com) and login to access claims information and FSA balances online. Once you are logged in, you may view your account balances. If you are new to Tucker Administrators, when you log into the website, you will be asked to create your own user ID and password.

**What if I have a question?**

If you have any questions regarding your account balance, claim reimbursement or eligible expenses, you can access your account information at [tuckeradministrators.com](http://tuckeradministrators.com) or you can call Customer Service at **1-800-347-1232**.

**How does participating in an FSA save me money?**

The following example illustrates how a FSA saves you money. This example shows the per period savings for an employee on a bi-weekly payroll, with a tax status of "single" with one exemption:

	<u>With FSA</u>	<u>Without FSA</u>
<b>Salary</b>	\$1000	\$1000
<b>Less Pre-Taxed Dollars:</b>		
Health Care Reimbursement	\$100	0
Dependent Day Care Reimbursement	\$150	0
Taxable Income	\$750	\$1000
<b>Less:</b>		
Federal Income Tax	\$82	\$121
State Income Tax	\$17.58	\$23.44
Social Security	\$57.37	\$76.50
<b>Net Take Home Pay</b>	<b>\$593.05</b>	<b>\$779.06</b>
<b>Less Health Care &amp; Dependent Care Expenses</b>	<b>\$0</b>	<b>\$250</b>
<b>Net After Expenses</b>	<b>\$593.05</b>	<b>\$529.06</b>

Tax Savings This Pay Period: \$63.99

Annual Tax Savings: \$63.99 X 26 pay periods = \$1,663.74

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## **Tucker Administrators Medical Spending Account**

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**Plan Year: July 1, 2009 - June 30, 2010**

**Medical Reimbursement Plan Maximum: \$2,600.00 or \$100 per paycheck**

**Medical Reimbursement Plan Minimum: \$10.00 per paycheck**

**Run-out Period: 90-days**

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

### **How does the Health Care FSA Work?**

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

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

Once you decide how much you want to contribute each paycheck, the money is automatically deposited into your account. As you incur eligible expenses, fax or mail your completed claim form and receipts to Tucker Administrators for reimbursement. Claim forms can be downloaded at [tuckeradministrators.com](http://tuckeradministrators.com).

### **What is eligible for reimbursement under the Health Care FSA?**

Eligible health care expenses may include deductibles, co-payments and amounts over the maximum your plan pays, expenses for routine physicals and other expenses not covered by your health care plan. For more complete listing please refer to the "Qualified Medical Expenses Eligible for Reimbursement" on page 6.

### **How do I get reimbursed?**

For reimbursement of expenses covered under a health care plan:

- Ensure your expenses are submitted to your health carrier
- If you also have coverage through a spousal plan, you must submit your expenses to both carriers before you submit your expenses for FSA reimbursement

- Once processed by your health carrier(s), complete the Health Care Expense Claim form and attach a copy of the “Explanation of Benefits” showing the unpaid expenses.

For reimbursement of expenses not covered under a health care plan: ex.: over-the-counter medicines

- Complete the Health Care Expenses claim form and attach itemized bills for the expense

**Fax claims and proof of expense to 704-525-9534 for processing.**

**How much will be reimbursed?**

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

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

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

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

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

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

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

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

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

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

If you have any questions, you can access your account information at [tuckeradministrators.com](http://tuckeradministrators.com), or you can call Tucker Administrators at 1-800-347-1232.

Qualified medical expenses are those expenses paid for medical care as described in Section 213(d) of the Internal Revenue Code. Insurance premiums are considered qualified medical expenses when they are for payment for a health plan as stated in Section 220(d) (2) of the code. IRS Publication 502, titled "Medical and Dental Expenses", provides more detailed information on eligible expenses. The following is a brief summary of information and is intended to serve as a quick reference to help determine whether or not an expense may be eligible for reimbursement. This list is not all-inclusive. This information is not tax advice. Tax advice should be obtained from a professional tax advisor. IRS Publication 502 can be ordered from the IRS 1-800-TAX-FORM (1-800-829-3676).

**Qualified Medical Expenses Eligible For Reimbursement:**

Alcoholism Treatment	FICA and FUTA tax for the handicapped	Organ transplant (including donor's expenses)
Ambulance	Guide dog	Orthodontist
Anesthetists	Gynecologist	Orthopedic shoes
Artificial limbs	Healing service	Orthopedist
Birth control pills (by prescription)	Hearing aid and batteries	Osteopath
Blood tests	Hospital bills	Oxygen
Braces	Hydrotherapy	Paid-for medical care service
Cardiographs	Insulin treatments	Pediatrician
Chiropractor	Lab tests	Physician
Christian Science Practitioner	Lead paint removal	Physiotherapist
Contact lenses	Legal fees (to authorize treatment for a mental illness)	Postnatal treatments
Contraceptive devices	Lodging away from home for outpatient care	Practical nurse
Convalescent home (for medical treatment only)	Medical services	Prenatal care
Crutches	Medical Testing	Prescription medicines
Dental treatment	Metabolism tests	Psychiatrist
Dental x-rays	Neurologist	Psychoanalyst
Dentures	Nursing (including board and meals)	Psychologist
Dermatologist	Obstetrician	Psychotherapy
Diagnostic fees	Operating room costs	Radium Therapy
Drug addiction therapy costs	Ophthalmologist	Registered nurse
Drugs (prescription)	Optician	Special School
Equipment (medical)	Oral surgery	Spinal fluid tests
Eyeglasses		

Splints	Therapy equipment	Vaccines
Sterilization	Transportation expenses relative to health care (Mileage is eligible for the miles driven to and from the doctor's office.	Vasectomy
Stop smoking programs	The amount that can be reimbursed is nineteen (19) cents per mile.)	Vitamins (if prescribed)
Surgeon	Ultra-violet ray treatment	Weight loss programs (Physician prescribed)
Telephone or TV equipment to assist the hearing impaired		Wheelchair
		X-rays

### Expenses Not Eligible For Reimbursement

Automobile Insurance	Funeral, cremation, or burial expenses	Scientology counseling
Athletic Club Membership	Expenses for sending a problem child to a special school	Social activities
Automobile Insurance	Health programs offered by resorts	Special foods or beverages
Boarding school fees	Hotels, health clubs, and gyms	Specially designed car for handicapped other than autoette or special equipment
Bottled water	Illegal operations and treatments	Swimming pool
Commuting expenses of a disabled person	Maternity clothes	Travel for general health improvement
Cosmetics, hygiene products, and similar items	Medical coverage	Tuition and travel
Cosmetic surgery and procedures	Premiums for life insurance, income protection, disability, loss of limbs, sight, or similar benefits.	
Diaper service		
Domestic help		

## Over-the-Counter Drug/Medicine List

### Over-the-Counter Drugs Used Primarily for Medical Care.

The Drugs/ Medicines listed below are approved with a receipt from the Provider/ Store. A recommendation from a health care provider is not needed.

The following is a brief summary of information and is intended to serve as a quick reference to help determine whether or not an expense may be eligible for reimbursement. **This list is not all-inclusive.** This information is not tax advice. Tax advice should be obtained from a professional tax advisor. IRS Publication 502 can be ordered from the IRS: 1-800-TAX-FORM (1-800-829-3676).

Drug / Medicine	Examples
Allergy Prevention & Treatment	Benadryl, Sudafed, Actifed, Claritin, Chloro Trimaton, and Nasalcrom
Antacids and Acid Reducers	Gas-X, Maalox, Mylanta, Tums, AXID AR, Pepcid AC, Prilosec OTC, Tagament HB, Zantac 75
Anticandial	Femstat 3, Gyne-Lotrimin, Mycelrx-7, Monistat 3, 7, and Vagistat-1
Antihistamines	Actidil Syrup and Capsule, Actifed, Allerest, Benadryl, Claritin, Chlor-Trimeton, Contac, Dimetane, Drixoral, Nyquil, Sudafed, Tavist-1, and Triaminic
Antidiarrheal and Laxatives	Ex-Lax, Pepto-Bismol, Immodium A.D. and Kaopectate
Anti-fungal	Lamisil AT, Lotramin AF, and Micatin
Anti-itch Lotions and Creams	Bactine, Caldecort, Cortaid, Hydrocortisone, and Lanacort, Calamine Lotion, Benadryl Cream, Caladryl, Lamisil AT, Lotramin AF and Micatin
Asthma	Primatene Mist
Cold Sore / Fever Blister	Abreva Cream, Carmex
Condoms and other contraceptive Devices	Trojans, Magnums, VGF Films, and Delfen Contraceptive Foam

<b>Drug / Medicine</b>	<b>Example</b>
Contact Lenses Solutions	Baush & Lomb, Renu, Aosept, Allergan, Boston and Opti-Free
Cough Suppressants	Robitussin, Vicks 44, Chloraseptic
Decongestant / Nasal Decongestant and Cold Remedies	Advil Cold and Sinus, Afrin, Afrinol, Aleve Cold and Synus, Children's Advil Cold, Duration, Dristan Long Lasting, Neo-Synephrine-12 Hour, Orrivin, Sudafed, Tavist-D, Tylenol Cold and Flu, Thera-ful, Alka Seltzer Cold and Flu, Nyquil, Actidil Syrup and Capsules, Actifed, Allerest, Benadryl, Claritin, Chlor-Trimeton, Contac, Dimetane, Drixoral, Sudafed, Tavist-1, and Triaminic
Diaper Rash Ointments	Balmax and Destin
Eye Drops for Allergy / Cold Relief	Ocu Hist
First Aid Supplies	Ace Bandages, Band-Aids, Bandage Tapes, Thermometers, Medical Gloves, Gauze, Neosporin, Rubbing Alcohol, and Visine
Hemorrhoid Treatments	Preparation H, Hemroid, and Tronolane
Internal Analgesics / Antipyretic	Advil, Aleve, Children Motrin, Nuprin, Excedrin, Tylenol, and Bayer
Incontinence Supplies	Depends
Liniments	BenGay, Tiger Balm, and Flexall
Medical Monitoring	Services and Bracelets specifically for medical information
Medical Products and Devices	Blood Pressure Monitor, Glucose Tester, HIV Test, Cholesterol Test, Diabetic Supplies, Crutches, Ovulation Monitor and Pregnancy Testing Kit
Menstrual Cycle Medications	Midol, Pamprin, and Premysyn PMS

<b>Drug / Medicine</b>	<b>Examples</b>
Migraine	Advil Migraine Liqui-gels, Excedrin Migraine, Motrin Migraine Pain
Motion Sickness Medication	Dramamine and Marizine
Nicotine Gum or Patches and Smoking Cessation Aids	Nicorette, Nicotrol and Nicodin
Pediculicide ( head lice)	Nix
Poison Ivy Protection	Ivy Block
Smoking Cessation	Commit, Nicoderm CQ, Nicorette, Nicotrol
Toothache and Teething Pain Relievers	Orajel
Wart Removal and Medications	Tinamed

#### **Dual Purpose OTC Drugs.**

**The items listed below require a third-party receipt and a note from the health care provider listing the diagnosis of the medical condition or illness and the recommendation of the OTC drug/ medicine. This list is not all inclusive** and is intended to give examples of the most common brand names of OTC drugs.

- Anti-baldness/hair loss/hair replacement, such as Rogaine, but only if to replace hair loss due to a medical condition (e.g. cancer treatment) and not for balding due to age.
- Fiber supplements such as Benefiber and Metamucil
- Glucosamine/Chondroitin for arthritis or other medical conditions (not reimbursable if taken for overall joint health)
- Herbal supplements used to treat a specific disease such as St. John's wort for depression
- Hormone therapy drugs
- Medicated shampoos used to treat a specific medical condition like psoriasis and only the amount in excess of the cost of normal shampoo
- No Doz (and other sleep prevention drugs)
- Nose strips for proper breathing or other medical conditions
- Pedialyte for a child's dehydration
- Retin-A and other acne medicines (not reimbursable if used for cosmetic purposes such as wrinkle reduction)
- Sleep Aids
- Snoring cessation aids and medications such as Breath Right Spray, Snorezz
- Sunscreen and Sunblock



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## ***Tucker Administrators***

### ***Dependent Care Spending Account***

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**Plan Year: July 1, 2009 - June 30, 2010**

**Dependent Care Plan Maximum: \$5,000**

**Dependent Care Plan Minimum: None**

**Run-out Period: 90-Days**

The Dependent Care FSA helps you pay for child care services which make it possible for you and your spouse (if applicable) to work. It also may be used to help pay for the care of a disabled spouse or dependent.

The Dependent Care FSA creates tax savings on up to \$5,000 of daycare expenses. That can mean \$1,500 in tax savings enough to pay for weeks of eligible child or adult daycare!

#### **How Does a Dependent Care FSA work?**

A Dependent Care FSA is a reimbursement account that allows you to set aside a certain amount of each paycheck on a pre-tax basis to pay for your eligible dependent day care expenses. The amount you elect at the beginning of each plan year, is deducted from your gross earnings before federal and state taxes are calculated. By using your FSA to pay for qualified expenses you save on income tax...which means you have more money in your pocket!

To estimate your dependent care expenses, consider your expenses from last year. An expense worksheet is provided at the end of this section to help you determine the amount of money to allocate for your Dependent Care FSA. Remember, the IRS requires that all money in your account be used during the plan year. You can access balance information online via **tuckeradministrators.com**.

#### **Am I eligible to use the Dependent Care FSA?**

To be eligible, you must be at work during the time your eligible dependent receives care. You must also meet one of the following eligibility guidelines:

- You and your spouse are both employed;
- You are a single parent;
- Your spouse is a full-time student at least five months during the year while you are working;
- Your spouse is physically or mentally unable to provide his/her own care; or
- You are divorced or legally separated and have custody of your child most of the time even though your former spouse may claim the child for income tax purposes.

#### **Who is an eligible dependent?**

An eligible dependent is defined as any person who can be claimed as a dependent for federal tax purposes and who:

- Is a child under 13 years of age;
- Is a child over the age of 13 who is physically or mentally incapable of caring for himself or herself;
- Is your spouse who is physically or mentally incapable of caring for himself or herself,
- An elderly parent who resides with you and is physically or mentally incapable of caring for himself or herself.

### **What expenses are covered?**

Eligible dependent care expenses are those which allow you and your spouse, if you are married, to work or attended school full- time. Below are some examples of eligible dependent care expenses:

- Day care facility fees
- Before/after school care
- Summer day camp (not overnight)
- Nursery school or preschool, if child is too young for kindergarten
- In home babysitting fees, if not provided by another dependent and claimed as income by the care provider
- Private school tuition, K4 and above is not eligible for reimbursement

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

You are required to provide the name, address and taxpayer identification (or Social Security number) of the dependent care provider on your income tax return. If you are unable to provide this information, both the tax credit and the exclusion for the spending account reimbursement may be denied by the IRS. Verify that this information is available before you elect to participate in the Dependent Care FSA.

Expenses reimbursed from this FSA cannot be used to claim a Federal Income Tax credit; therefore, you will have to determine which approach is best for you. You may even be able to combine the expense account and tax credits to reduce your overall dependent care expenses. However, the maximum expense you can claim when using both the tax credit and FSA is the tax credit limit (\$3,000 for one dependent or \$6,000 for two or more dependents), minus the amount reimbursed under the Dependent Care FSA. You may wish to consult your tax advisor to see if the Flexible Spending Account or the tax credit will be more advantageous to your family.

### **How do I get reimbursed?**

As you incur eligible expenses you must submit a completed Dependent Care claim form to Tucker Administrators with proof of payment from your day care provider or from the individual who provides the care. Dependent Care FSA claims must include the federal tax identification number or Social Security number, name and address of the provider, dates of service, type of service rendered and name of dependent. The individual who provides the care cannot be your spouse or a dependent under the age of 19.

With a Dependent Care FSA, you will be reimbursed as you set funds aside. If you submit a claim for more than what has been set aside for that account, the unreimbursed claim portion will be placed in "pending" status until funds are received through payroll deduction at which time you will receive reimbursement.

**Can I pay my in-home daycare provider through the Dependent Care FSA?**

Yes. You can be reimbursed from your Dependent Care FSA for any qualified daycare expenses, whether performed in your home, the provider’s home or a “daycare center”. Receipts for the expenses and the caregiver’s Tax ID number or Social Security number must be provided.

**I’m divorced; my ex-spouse claims our child as a deduction for tax purposes. I pay for child care. Can I use the Dependent Care FSA?**

If your child resides with you most of the year, you can use the dependent care account to pay for child care services. However, you might want to call your tax advisor to discuss your particular circumstances before you elect to participate in the account.

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

If you have any questions, you can call Tucker Administrators Customer Service at **1-800-347-1232**.

**Dependent Care FSA Expense Worksheet**

Dependent care expenses you paid last year could include:

Costs of Child or Adult Care Facilities\*

Day Care Center / Nursery School \$ \_\_\_\_\_

Family Day Care / Adult Day Care Centers\*\* \$ \_\_\_\_\_

Wages paid to a nanny or in home care provider\*\*\* \$ \_\_\_\_\_

\* The facility must follow all local and state laws.

\*\* These costs are eligible only if the adult dependent spends at least eight hours per day at home.

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

Other dependent care expenses considered eligible by the IRS \$ \_\_\_\_\_

TOTAL ESTIMATED DEPENDENT CARE EXPENSES \$ \_\_\_\_\_

Compare last year’s typical expenses to those eligible under your Dependent Care FSA and budget accordingly for the upcoming year.

(PLEASE KEEP YOUR ORIGINALS)

**Tucker Administrators, Inc.**  
**3800 Arco Corporate Dr., Suite 450**  
**Charlotte, NC 28273**  
**Telephone: (800) 347-1232**  
**Fax: (704) 525-9534**  
**www.tuckeradministrators.com**



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## **Ameritas Dental Plan**

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**Effective Date: July 1, 2009**

**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, Partial
- 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.

**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 - \$1,200 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.

**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.***

**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 19 and unmarried. (Up to age 26 if wholly dependent upon you for maintenance and support and if enrolled as a full-time student in an accredited school or college).

**BI-WEEKLY RATES**

<b>Employee (paid by the County)</b>	<b>Paid by County</b>
<b>Employee + 1 Dependent</b>	<b>\$7.44</b>
<b>Employee + 2 or more Dependents</b>	<b>\$17.82</b>

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



This insurance is underwritten by Ameritas Life Insurance Corp.

*\*U&C - Usual and Customary*

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## **Humana Specialty Benefits Short Term Disability**

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**Effective Date; July 1, 2009**

**INCOME PROTECTOR** is a disability income insurance policy designed to help provide you with a monthly income when you are totally disabled as a result of an accidental injury or sickness and cannot work.

### **6 MONTH POLICY**

- Covers off-the-job injuries after 0 days of total disability
- Covers off-the-job sicknesses after 7 days of total disability
- Benefits are paid for a maximum of 6 months per disability
- You can protect up to 60% of your pay

### **MONTHLY DEDUCTIONS - 6 Months**

<b>Monthly Benefit</b>						
Ages	\$400	\$600	\$800	\$1,000	\$1,500	\$2,000
18-50	12.00	18.00	24.00	30.00	45.00	60.00
51-69	16.80	25.20	33.60	42.00	63.00	84.00

### **3 MONTH POLICY**

- Covers off-the-job injuries after 0 days of total disability
- Covers off-the-job sicknesses after 7 days of total disability
- Benefits are paid for a maximum of 3 months per disability
- You can protect up to 60% of your pay

### **MONTHLY DEDUCTIONS - 3 Months**

<b>Monthly Benefit</b>						
Ages	\$400	\$600	\$800	\$1,000	\$1,500	\$2,000
18-50	10.40	15.60	20.80	26.00	39.00	52.00
51-69	12.40	18.60	24.80	31.00	46.50	62.00

### **PLAN FEATURES**

- Policy is guaranteed renewable to age 70
- Pre-existing conditions covered after 12 months
- Includes coverage for pregnancy as long as conception occurs after the date the application is signed
- Non-occupational coverage
- Unisex Rates
- Only two rate bands: ages 18-50 and 51-69
- Portability: Premiums do not increase if you change employment
- No billing fee
- Waiver of premium included after 90 days of total disability
- Guarantee Issue is available for up to a benefit of \$2000 per month for new employees only
- Ease of payroll deductions
- Benefits are paid directly to the insured
- Can cancel policy at any time

Form 80260 8/99 NC

**Guaranteed Renewable to Age 70.** The policy is guaranteed renewable until the anniversary date of the policy nearest your age 70 as long as you pay the premiums when they are due. KMG America can change your premium if the premiums for all the policies in the same class are changed. You will be given at least 45 days notice before your premium is changed. Any increase or decrease in premium will begin the next premium due date after the 45-day notice is given.

A **Pre-existing Condition** is a condition for which medical advice or treatment was received or recommended or that could be medically documented within the 12-month period immediately preceding the Date of Policy.

A normal pregnancy which began before the date of policy is considered to be a pre-existing condition whether or not it was fully disclosed in the application.

**Total Disability** is the complete inability to perform the material and substantial duties of your regular occupation as certified by your attending physician. Regular occupation is that which you were performing immediately before total disability began. The total disability must be the result of an injury or sickness. You must be under the regular care of a physician and not, in fact, engaged in any employment or occupation for wages or profit.

A **Benefit Period** is the period of time for which monthly income benefits are payable for disability due to the same cause after the elimination period ends.

An **Elimination Period** is the number of continuous days, beginning with the first day of total disability, before any monthly benefit amount is payable. There is a separate elimination period for injury and sickness.

**Exclusions, Exceptions and Limitations.** Benefits otherwise payable under the policy will not be paid if your injury or sickness was caused by or contributed to by:

- Intentionally self-inflicted injury;
- War or act of war, whether declared or undeclared;
- The insured's employment;
- Sickness or injury which has been paid or is payable under North Carolina's Workers' Compensation law;
- Pre-existing conditions, subject to the time limit on certain defenses provision;
- The insured committing or attempting to commit an assault or felonious act or while engaged in an illegal occupation; or
- The insured being intoxicated or under the influence of any controlled substance (as defined by The Controlled Substances Act of 1970 as amended) unless administered as prescribed on the advice of a physician.

*Underwritten by Kanawha Insurance Company*

*This brochure is presented as a matter of general information for illustrative sales purposes only. See the policy and any applicable riders for complete details.*

*Visit our website: [www.kmgamerica.com](http://www.kmgamerica.com). If you have any questions regarding your policy, Please call (877)378-1505*



45017/01 NC

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## ***Lincoln Financial Term Life Plan***

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**Effective Date:** When approved by carrier.

### **BASIC LIFE INSURANCE**

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

### **SUPPLEMENTAL LIFE INSURANCE**

Your employer-sponsored basic life coverage provides important protection for you, but you may need to add to that protection. Now you can...at low group rates and through convenient payroll deductions.

To help meet this need, you have the opportunity to elect additional group life insurance under the supplemental portion of your program to go along with any personal insurance coverage you may have.

### **SUPPLEMENTAL DEPENDENT LIFE INSURANCE**

Provides coverage on:

- Your Spouse
- Unmarried child(ren) from birth up to age 19 years (up to age 26 if wholly dependent upon you for maintenance and support and if enrolled as a full-time student in an accredited school or college). Handicapped children can continue to be covered with no age limit.

***It is your responsibility to notify Human Resources when a spouse or dependent child is no longer eligible for coverage. (ie. divorce, child no longer full-time college student, etc.)***

### **FLEXIBILITY**

Simply choose the amount of coverage that suits your needs from the selection provided, as outlined on the back of this folder.

### **FEATURES**

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

### **LOW COST**

Your cost is lower than for comparable insurance on an individual basis due to the "wholesale" economies inherent in group insurance. Additionally, the County absorbs the cost of administering the program which is underwritten by Lincoln Financial.

### **ELIGIBILITY**

You will be eligible for this program if you are a full-time active employee.

### **ENROLLMENT**

Enrollment is simple. Just fill out the election card provided by your employer. Make sure you supply all the required information and return the form where you work. That's all. You will be notified as to when coverage starts.

**BENEFICIARY**

You have the right to designate the beneficiary of your choice under employee coverage. You are automatically the beneficiary under Dependent Life.

**WHEN YOUR INSURANCE STARTS**

If you enroll on or before the day you become eligible, your employer provided insurance becomes effective on the date of your eligibility if you are then actively at work; otherwise, on the day you return to active work.

If you have elected Supplemental Employee or Dependent Life Insurance, you will be notified as to when that coverage begins. Anyone electing not to enroll when first eligible or within three months thereafter can enroll later only if evidence of insurability satisfactory to the Insurance Company is provided.

**TERMINATION OF COVERAGE**

All insurance under the plan will terminate upon the earlier of retirement, termination of employment, when the plan ceases or when you withdraw from the plan. Nevertheless, if you should die within 31 days thereafter, and you are eligible for conversion or portability, your life insurance will still be paid to your beneficiary. If any of your covered dependents should die within such 31 day period, the amount of Life Insurance on account will be paid to you.

**REDUCTIONS AT AGES 70 & OVER (EMPLOYEE &/OR SPOUSE)**

If you remain in active service beyond age 70 your amount of Basic Employee Life Insurance will be as follows:

<u>Attained Age</u>	<u>Percent of Original Amount</u>
70	65%
75	45%
80	30%

**FAMILY STATUS CHANGE**

This provision allows you to increase your coverage by the next increment without evidence of insurability within 31 days of the following:

- *Marriage or divorce*
- *Death of a spouse or dependent child*
- *Birth or adoption of a dependent child*
- *Change in employment status for you or your spouse*

**DISABILITY**

Your Basic & Supplemental Life Insurance may be continued during your disability provided that premiums are remitted on your behalf. However, your insurance will be subject to reduction as shown under the "Reductions at ages 70 & Over."

**CONVERSION**

The conversion privilege gives an Insured the right, under certain conditions, to continue life insurance protection under a non-term permanent insurance policy\*. We require no medical examination or other evidence of insurability -- regardless of age or state of health -- as long as application is made and the first premium is paid within 31 days of termination of insurance coverage.

### **PORTABILITY**

If you terminate your employment, the portability provision allows you to take your optional life or dependent life coverage with you, subject to the following provisions.

- You must apply for coverage within 31 days from the date your life coverage terminates.
- You must be actively at work prior to employment termination.
- Dependents are only eligible for portable coverage if the employee is also porting coverage.
- You may only port up to your current coverage amount. You cannot increase coverage or add new dependents.
- The minimum face amount which an employee or dependent may elect portability is \$20,000. Portable coverage reduces to 50% on January 1st of the year the insured attains age 70 and terminates on January 1st of the year the insured attains age 80. When portable coverage ends, insured individuals have the right to convert to an individual policy.”

### **ACCELERATED BENEFITS RIDER**

Lincoln Financial has included an Accelerated Benefit Option (ABR) as part of your group life benefits. Under this option, if you are diagnosed as having a terminal illness, you may be eligible to receive a portion of your group life benefits at such a difficult time. Please refer to your Group Certificate for details.

### **GROUP POLICY AND CERTIFICATE**

The insurance briefly described in this folder is subject to the terms and conditions of the Group Policy issued by Lincoln Financial. If you become insured, you will receive a certificate outlining your benefits under the policy. Unless otherwise stated, we follow all applicable state & federal laws.

### **BENEFICIARY CONNECT<sup>SM</sup> SERVICES**

Assistance through a difficult time. Please accept our sympathy at your time of sorrow. If needed, Lincoln Financial offers free beneficiary assistance to help you cope with this difficult and emotional period.

#### ***Services Include:***

- Unlimited phone contact with grief counselors and legal advisors.
- Up to six sessions or equivalent professional time for grief and/or legal consultation.
- Memorial planning assistance.
- Child and elder care referrals.

Other support services including financial counseling and moving/relocation services. To utilize BeneficiaryConnect services, please contact BDA at (800) 580-0576.

**TravelConnectSM - Travel Assistance Services**

Introducing TravelConnectSM services. A no-cost benefit providing you valuable services while traveling.

***Traveling just got easier***

As part of your employee benefits package, your Lincoln Financial Group life insurance coverage now includes our TravelConnect program, an employee benefit that includes travel, medical, and safety-related services while traveling. Lincoln Financial has partnered with MEDEX Assistance Corporation, a worldwide leader in travel assistance, to make this valuable benefit available to you and your immediate family members.

***Business or leisure travel – it's covered***

The TravelConnect benefit is provided at no cost to you and includes a wealth of services when traveling just 100 miles or more from home. These services are provided regardless if you're traveling for business or leisure. Whether you simply want the weather forecast for your travel destination or you need emergency medical assistance halfway around the world, MEDEX has the professional staff and resources to provide support, 24 hours a day, seven days a week.

***Comprehensive coverage***

Just a sampling of the services includes:

- Destination info – weather, currency, etc.
- Emergency travel arrangements and funds transfer.
- Lost or stolen travel documents assistance.
- Language translation services.
- Emergency medical evacuation and transportation.
- Dependent child transportation if left unattended.
- Medical and dental referrals.
- Assistance with corrective lenses or medical device replacement.
- Treatment monitoring of a medical situation.
- Arrange delivery of medications, vaccines, or blood.
- Updates to family, employer, and/or home physician.
- Repatriation of a deceased traveler.
- Security and political evacuation assistance.

Travel assistance services are subject to specific terms, conditions and limitations. A program description is available at [www.jpfc.com](http://www.jpfc.com). To use TravelConnect services, call MEDEX at (800) 527-0218 or (410) 453-6330 and provide them with ID number 322541.

**Customer Service Center: (800) 423.2765**

**Press "Option One" for claims.**

**Press "Option Two" for administration and other questions.**

## SCHEDULE OF BENEFITS

### **BASIC LIFE INSURANCE (No Cost To You)**

An amount equal to one and one half times your Basic Annual Earnings, rounded to the next higher multiple of \$1,000 if not an even multiple of \$1,000. Maximum \$150,000.

### **SUPPLEMENTAL LIFE INSURANCE**

You choose either:

One, two or three times your Basic Annual Earnings\* to a maximum of \$350,000.

\*Rounded to the next higher \$1,000 if not an even multiple.

### **YOUR MONTHLY COST SUPPLEMENTAL LIFE INSURANCE**

<u>YOUR AGE</u>	<u>RATE PER \$1,000</u>
Less than 40	\$ .076
40-44	.162
45-49	.228
50-54	.304
55-59	.475
60-64	.523
65-69	1.026
70-74	1.663
75+	2.024

### **SUPPLEMENTAL DEPENDENT LIFE INSURANCE**

\$10,000 or \$20,000 on your spouse

\$ 5,000 on each of your eligible children

You may obtain coverage on your spouse &/or dependents even if you are not insured for optional coverage. (Children can only be covered by one parent).

### **Your Monthly Cost Supplemental Dependent Life Insurance**

Family Coverage w/ \$10,000 Spouse	\$3.39 Monthly
Spouse Only \$10,000	\$2.74 Monthly
Child(ren) Only Coverage	\$ .66 Monthly
Spouse Only \$20,000	\$8.86 Monthly
Family w/ \$20,000 Spouse	\$9.51 Monthly

### **PLAN SPONSOR**

Forsyth County Government  
Government Center  
201 N Chestnut St., Winston-Salem, NC 27101

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## ***Continuation of Benefits Options If You Leave Employment***

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### **TUCKER 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 **Tucker Administrators at 800-347-1232**

### **COBRA HEALTH AND DENTAL**

Under the dental and health plan, 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.

### **HUMANA SPECIALTY BENEFITS SHORT TERM DISABILITY PLAN**

When you leave employment you may continue your disability coverage as long as continuous employment is maintained. Please contact **Humana Specialty Benefits at: (877)378-1505** to set up a direct bill.

### **LINCOLN FINANCIAL 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.