

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.**
- **The Plan Year is from July 1, 2010 to June 30, 2011.**

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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, 2010 - June 30, 2011.
- Payroll deductions for this year's enrollment will start:

	Pay Period	Deduction Date
Health & Dental	5/29/10 - 6/11/10	6/18/10
Short Term Disability	6/12/10 - 6/25/10	7/2/10
Flexible Spending Account	6/26/10 - 7/9/10	7/16/10

- This year, Forsyth County Government has added the debit card to the Medical and Dependent Care Flexible Spending Accounts. Our new FSA vendor is Flexible Benefit Administrators. You can use the debit card for both the medical and dependent care spending accounts.
- 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 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.
- 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.
- 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.flex-admin.com, 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..

BCBS PPO - Summary of Benefits

Effective Date: July 1, 2010

	<u>In-Network</u>	<u>Out-Of-Network¹</u>
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PHYSICIAN OFFICE SERVICES

(See "Outpatient Clinic Services" for "outpatient clinic" or "hospital-based" services.)

Office Visit

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".

Primary Care Provider	\$25 copayment	70% after deductible
Specialist	\$50 copayment	70% after deductible

Preventive Care

Routine Examinations, Well-Child Care, Immunizations, Pap Smears, Mammograms, Prostate Specific Antigen Tests (PSAs)

Primary Care Provider	\$0 copayment	Not Available*
Specialist	\$0 copayment	Not Available*

*Pap Smears, Mammograms, and PSAs are covered Out-of-network.

Therapies

Short-term Rehabilitative Therapies (Maximums apply to Home, Office and Outpatient Settings):

Physical/Occupational: 30 visits per Benefit Period

Speech Therapy: 30 visits per Benefit Period

Primary Care	\$25 copayment	70% after deductible
Specialist	\$50 copayment	70% after deductible

URGENT CARE CENTERS AND EMERGENCY ROOM

Urgent Care Centers	\$50 copayment	\$50 copayment
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Emergency Room Visit

<i>(Inpatient Hospital benefits apply if admitted. If held for observation, outpatient benefits apply. See "Inpatient and Outpatient Hospital Services".)</i>	\$150 copayment	\$150 copayment
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AMBULATORY SURGICAL CENTER	80% after deductible	70% after deductible
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INPATIENT AND OUTPATIENT HOSPITAL SERVICES

Hospital and Hospital Based Services	80% after deductible	70% after deductible
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Outpatient Clinic Services	80% after deductible	70% after deductible
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Professional Services	80% after deductible	70% after deductible
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Hospital and Professional

Outpatient Labs and Mammograms with surgery or other services.	80% after deductible	70% after deductible
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Outpatient Labs and Mammograms without surgery or other services.	100% no deductible	70% after deductible
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Outpatients X-rays, ultrasounds & other diagnostic tests such as EEG's & EKG's	80% after deductible	70% after deductible
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CT Scans, MRI's, MRA's, & PET scans in any location, including physician's office	80% after deductible	70% after deductible
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	<u>In-Network</u>	<u>Out-of-Network¹</u>
OTHER SERVICES		
Skilled Nursing Facility <i>(60 days per Benefit Period)</i>	80% after deductible	70% after deductible
Home Health Care, Ambulance, Durable Medical Equipment & Hospice	80% after deductible	70% after deductible
Maternity <i>Maternity Delivery includes Prenatal and Post-delivery care</i>		
Hospital Services <i>(Delivery)</i>	80% after deductible	70% after deductible
Professional Services <i>(Delivery)</i>	80% after deductible	70% after deductible
Transplants		
Hospital Services	80% after deductible	70% after deductible
Professional Services	80% after deductible	70% after deductible
Infertility and Sexual Dysfunction Services <i>Up to \$5,000 per Lifetime</i>		
Primary Care Provider	\$25 copayment	70% after deductible
Specialist	\$50 copayment	70% after deductible
Hospital Services Inpatient and Outpatient	80% after deductible	70% after deductible
Professional Services	80% after deductible	70% after deductible
Vision Care		
Comprehensive Eye Exam	\$0 copayment	Benefits not available
LIFETIME MAXIMUM, DEDUCTIBLES & COINSURANCE MAXIMUMS		
Lifetime Benefit Maximum	None	None
Deductibles		
Individual <i>(per Benefit Period)</i>	\$750	\$1,500
Family <i>(per Benefit Period)</i>	\$2,250	\$4,500
Coinsurance Maximum		
Individual <i>(per Benefit Period)</i>	\$1,000	\$2,000
Family <i>(per Benefit Period)</i>	\$3,000	\$6,000
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES		
	<u>Certified*</u>	<u>Not-Certified¹</u>
<i>*Inpatient/Outpatient Certification is required. Call Magellan Behavioral Health at 1-800-359-2422.</i>		
Mental Health Services		
Office Visit/Outpatient	100% no deductible	70% after deductible
Inpatient	80% after deductible	70% after deductible
Substance Abuse Services		
Office Visit/Outpatient	100% no deductible	70% after deductible
Inpatient	80% after deductible	70% after deductible

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>)	\$5 copayment	Copayment + charge over in-network allowed amount
Tier 2 (<i>Preferred Brand</i>)	\$35 copayment	Copayment + charge over in-network allowed amount
Tier 3 (<i>Brand</i>)	\$50 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.

¹ 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. 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**



BCBS HEALTH PLAN BI-WEEKLY RATES

Individual	\$29.84
Employee + One	\$84.55
Family	\$223.06

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

Flexible Benefit Administrators Medical Spending Account

Plan Year: July 1, 2010 - June 30, 2011

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

Medical Reimbursement Plan Minimum: \$260.00 or \$10.00 per paycheck

Run-out Period: 90-days

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

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

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

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

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

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

After you read this material, if you have any questions please feel free to contact **Flexible Benefit Administrators, Inc. at (757)340.4567 or 800.437.3539.**

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

HEALTH CARE REIMBURSEMENT ACCOUNT

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

EXAMPLES OF ELIGIBLE HEALTH CARE EXPENSES: FEES/CO-PAYS/DEDUCTIBLES:

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

OTHER ELIGIBLE EXPENSES:

- Prescription drugs
- Artificial limbs & breasts (only if reconstructive)
- Birth control pills, patches (e.g. Norplant)
- Orthopedic shoes/inserts
- Incontinence supplies
- Carpal tunnel wrist supports
- Vaccinations & Immunizations
- Elastic hose (medically prescribed)
- Contact lens supplies
- Therapeutic care for drug and alcohol addiction
- At home pregnancy test kits
- Smoking cessation programs and prescribed drugs designed to alleviate nicotine withdrawal
- Mileage, parking and tolls (you may be reimbursed \$.24* 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)
- Diabetic supplies
- Routine Physicals
- Condoms
- Dentures
- Oxygen
- Physical Therapy
- Fertility Treatments
- Hearing aids and batteries
- Reading glasses
- Medical equipment
- Pedialyte for dehydration
- Nicotine gum/patches
- Take-home screening kits (HIV, colon cancer)

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

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

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

OVER-THE-COUNTER DRUGS

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

ELIGIBLE OVER-THE-COUNTER EXPENSES

• Examples of eligible medications and drugs purchased in reasonable quantities without a prescription:

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

OVER-THE-COUNTER EXPENSES THAT ARE NOT ELIGIBLE

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

- Multi/Daily Vitamins
- Weight loss products/foods
- Face cream/moisteners
- Mouthwash/toothpaste
- Feminine hygiene products
- Deodorant
- Chapstick
- Suntan lotion
- Herbal/natural supplements
- Acne creams/face cleanser
- Medicated shampoo/soaps
- Toothbrushes (even if dentist recommends a special one)
- Eye/facial makeup/preparations
- 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)
- Prenatal vitamins
- Nasal sprays for snoring
- Pills for lactose intolerance
- Fiber supplements (to treat a medical condition for a limited time)
- OTC Hormone therapy (to treat menopausal symptoms)
- Glucosamine/Chondroitin (for arthritis)
- St. John’s Wort (for depression)

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

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

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

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

OTHER EXPENSES THAT ARE NOT ELIGIBLE FOR REIMBURSEMENT THROUGH THE HEALTH CARE ACCOUNT

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

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

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

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's website (See sample Claim Form on page 15). You must attach a receipt or bill from the service provider which includes all the pertinent information regarding the expense:

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

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

OBTAINING A REIMBURSEMENT FOR OVER-THE-COUNTER ITEMS

For the purchase of over-the-counter medications and items exclusively, 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. 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.

THE BENEFITS CARD

The Benefits Card system allows you to pay for eligible pre-tax account expenses electronically at approved service providers and merchants. The Benefits Card provides you with instant access to your pre-funded Health Care Reimbursement Account for many common regular eligible expenses. You may also enjoy the convenience of paying for 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, select the credit option, not the debit option (there is no PIN).

- Your card will be mailed to your home address via first class mail. Please allow up to two weeks for delivery of your card. If you do not receive your card two weeks after the start of your Plan Year, contact Flexible Benefit Administrators, Inc. so that a replacement card may be ordered. Any eligible expense incurred during that time may be reimbursed by mailing, 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.
- Flexible Benefit Administrators, Inc. will notify you by mail or e-mail if you incur an expense with the card that is or appears to be ineligible. Upon this notice you must send Flexible Benefit Administrators, Inc. a Transaction Substantiation Form with the corresponding itemized documentation within 40 days of the transaction; you may download and print a Transaction Substantiation Form from our website. If you do not send in those required items, your card will be deactivated until the documentation is received.
- Your transaction will be denied for any amount greater than your health care reimbursement account annual election or your dependent care reimbursement account posted balance at the time of the "swipe".
- You should notify Flexible Benefit Administrators, Inc. immediately if your card is lost or stolen to deactivate the card. If your employment is terminated, your card will be permanently deactivated.
- You may monitor your account balance, transaction history or print a statement at any time, night or day on the Benefits Card website: www.benefitspaymentsystem.com.
- Additional information regarding the Benefits Card is available on our website: www.flex-admin.com. You may also download the Transaction Substantiation Form from our website under Participants; FBA Benefits Card; Forms.

Attention: Benefits Card Participant

Subject: Benefits Card Use

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

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

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

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

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

PLEASE NOTE: Eligible items purchased at participating Inventory Information Approval System (IIAS) merchants will be automatically approved! When purchasing prescriptions and/or over-the-counter FSA-eligible items, the merchant's IIAS will verify the items and automatically approve the transaction with no follow-up request. Effective July 1, 2009, the Benefits Card will no longer be 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.

RULES AND REGULATIONS

CLAIM FILING DATES

All claims received in the office of Flexible Benefit Administrators, Inc. will be processed within one week.

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) 437.3539**, from 8:30 a.m. to 5:00 p.m., Monday through Friday.

REIMBURSING THE PROVIDER OF SERVICE

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

ELIGIBLE DEPENDENTS

An individual is considered to be a dependent if he or she is a qualifying child or qualifying relative of the taxpayer. The following qualifying criteria now apply to be a "dependent child": the individual has a specific family type relationship to the taxpayer, the individual does not provide more than half of his or her own support, the individual has the same place of abode as the taxpayer for more than half of the year, and the individual does not turn age 19, (24 if full-time student), by the end of the Plan Year.

In addition, the following qualifying criteria apply to be a "dependent relative": the individual has a specific family type relationship to the taxpayer, the individual is not a qualifying child of any other taxpayer, the individual receives more than half of his or her support from the taxpayer, and the individual's annual gross income is less than the Section 151 limit (\$3,200 for 2005; this criteria does not apply to health plans).

RUNOFF PERIOD FOR FILING CLAIMS

You have the entire Plan Year plus 90 days to file all claims that were incurred during the Plan Year. All claims must be received in the office of Flexible Benefit Administrators, Inc. by 5:00 p.m. on the 90th day, following the end of your Plan Year. Therefore, for the Plan Year 07/01/10 - 6/30/11, all claims must be in our office by 5:00 p.m. on September 28, 2011. If claims are not received during this time frame for expenses incurred during the Plan Year, your remaining funds will be forfeited. (Remember "90 days" does not mean 3 months and "received in the office" does not mean the day it was postmarked). Please, do not delay; complete your claims early.

FORFEITING FUNDS

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

CHANGES IN YOUR ELECTION

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 cover a age due to change in age, student status, or any similar circumstance;

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.

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.

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 **1.757.340.4567** or **1.800.437.3539** from 8:30 a.m. to 5:00 p.m., Monday through Friday, to check your account balance. You may also access your personal account information at your convenience via our **secure website: www.flex-admin.com**. Each reimbursement check stub will show your contributions, request for reimbursements, and disbursements. It will also show your annual election and the balance to request by the end of the Plan Year. A reminder letter will be sent **two months** prior to the end of the Plan Year if you have funds left in your account.

ESTIMATING YOUR QUALIFYING HEALTH CARE EXPENSES

This worksheet will help you determine your annual expenses for your Health Care account. Good planning and careful estimating is the best way to take full advantage of your Flexible Benefit Plan. Keep in mind, your maximum annual election cannot exceed \$2,600.

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	_____


FBA ANNOUNCES ITS ONLINE PHARMACY!!

Busy day and don't have time to stop by the drugstore?

Do you have unspent money in your FSA?

Looking for savings from the comfort of your couch?

Here's how!

- Visit www.flex-admin.com
- Click on "More" at the top header announcing the online pharmacy – it's free to use!
- Shop and purchase items online at discounted pricing!
- You may use your FBA Benefits Card for eligible FSA items (marked  FSA approved)* and not have to submit receipts!



√ Purchase non-eligible FSA items using your own personal payment method.

√ All items are shipped directly to you!

√ Free shipping on purchases over \$25.00!

Visit our website now to start making your life a little easier!

* Please note if you do not have a FBA Benefits Card, you may purchase FSA Approved items out of pocket and submit to FBA for reimbursement.

Flexible Benefit Administrators Dependent Care Spending Account

Plan Year: July 1, 2010 to June 30, 2011

- ***Dependent Care Flexible Spending Account Maximum: \$4,999.80***
- ***Dependent Care Flexible Spending Account Minimum: \$0***
- ***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
- 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 pre-school 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:

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

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

USING THE DEPENDENT CARE REIMBURSEMENT ACCOUNT VERSUS FILING FOR A TAX CREDIT ON YOUR TAXES

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

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

If the amount you have placed through the reimbursement account does not meet the maximum allowed by the IRS, you can claim the difference between your Dependent Care deductions and the IRS maximum allowable expenses for the tax credit. You can claim a tax credit for any additional dependent care expenses incurred over the \$5,000 maximum FSA limit up to the \$6,000 child care tax credit

limit on your taxes. You cannot claim the tax credit for any dependent care expenses paid from the Dependent Care Reimbursement Account. It is your responsibility to report the Dependent Care amount on your tax form 2441. The amount is listed on your W-2 under Dependent Care Benefit for the tax year. If you are not sure about the eligibility of an expense, phone Flexible Benefits Administrators at 1.757.340.4567 or 1.800.437.FLEX or refer to IRS Publication 503: "Dependent Care Expenses". This publication can be ordered by calling the IRS at 1.800.829.3676.

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.

ESTIMATING YOUR EXPENSES

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

ESTIMATING YOUR DEPENDENT CARE EXPENSES

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

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

SAMPLE CLIENT FLEXIBLE BENEFIT PLAN – CLAIM FORM

Employee's name _____ SS# _____

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

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

Date of Treatment	Person treated and Relationship	Type of eligible Expense	Amount of Expense
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____

TOTAL \$ _____

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

Care Provided By	Date Care Provided	Person Care for and Relationship	Amount of Expense
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____

TOTAL \$ _____

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

EMPLOYEE'S SIGNATURE _____ DATE _____

Mail This Claim Form To: Flexible Benefit Administrators, Inc. P.O. Box 8188, Virginia Beach, VA, 23450	Fax Claim Form To: Please Include Cover Sheet Flexible Benefit Administrators, Inc. Fax Number: 757.431.1155
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Claims can also be scanned and emailed to FlexDivision@flex-admin.com
 View your account on our website @ www.flex-admin.com or call FBA at 757.340.4567.

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

ACCESSING YOUR FLEX ACCOUNT ONLINE

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

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

Step 1. Log-on to our website at www.flex-admin.com

Step 2. Select **Participants**

Step 3. Select **ACCOUNT LOG IN** under the appropriate account type that you participate in. Please note that if you participate in more than one type of account, you do not have to set up a separate account for each one. You will be able to see all your account information under the one User ID and Password you create

Step 4. Select **Participant Login**

Step 5. Select **Create Account**

Step 6. You will be prompted to enter your Name and Employee ID number

Step 7. You must then enter your Benefits Card Number or, if you do not have a Benefits Card, you may enter your Employer ID, which is: **FBAFOR**

Step 8. Create your User ID, Password, Security Word and Birth City and your email address. Please note that your User ID will need to be between 4-10 characters. Your password needs to be between 7-10 characters and must include at least one letter and number.

Step 9. You are now ready to access your individual account!

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

Problems Logging into your Account?



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

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

ADMINISTERED BY

**FLEXIBLE BENEFIT ADMINISTRATORS, INC.
509 VIKING DRIVE, SUITE F
P.O. BOX 8188
VIRGINIA BEACH, VA 23450**

**757.340.4567 or 800.437.FLEX
FAX: 757.431.1155**

**FlexDivision@flex-admin.com
www.flex-admin.com**



Ameritas Dental Plan

Effective Date: July 1, 2010

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, Partialals
- 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

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.

**U&C - Usual and Customary*

Humana Specialty Benefits Short Term Disability

Effective Date; July 1, 2010

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

Monthly Benefit						
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

Monthly Benefit						
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. If you have any questions regarding your policy, Please call (877)378-1505



45017/01 NC

Lincoln Financial Term Life Plan

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 CONNECTSM 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. 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

Continuation of Benefits Options If You Leave Employment

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 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.

Important Phone Numbers

Blue Cross / Blue Shield / 877-258-3334
Flexible Benefit Administrators / 800-437-3539
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