

Guilford County Schools offers all full-time employees a comprehensive Cafeteria Benefits program. The Cafeteria Benefits program is arranged by Mark III Brokerage, an employee benefits firm that has worked in the public sector for the last 35 years. The Cafeteria Benefits program allows you to pay for certain insurance premiums, dependent-care, and non-reimbursed medical expenses before taxes are taken out of your paycheck. Paying for benefits by this method reduces your applicable FICA and income tax withholding resulting in increases to your take home pay. The Cafeteria Benefits program includes pre-tax and after-tax products.

- Short Plan Year is from October 1, 2008 thru December 31, 2008.
- New Plan Year is from January 1, 2009 thru December 31, 2009

A Mark III representative will be conducting individual enrollment meetings at all locations.

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*(All information in this booklet is a **brief description** of your coverage and is not a contract. Read your certificate for each product for the exact terms and conditions).*

Gilsbar Flexible Spending Accounts (Overview)

Short Plan Year: October 1, 2008 - December 31, 2008

New Plan Year: January 1, 2009 - December 31, 2009

Maximum Medical FSA Short Plan Year: \$625 / New Plan Year: \$2500

Maximum Dependent FSA Short Plan Year: \$1250 / New Plan Year: \$5000

Run Out Period: 90-Days

Waiting Period: None

REMINDER: The Internal Revenue Service (IRS) requires review of all receipts for eligible expenses in an FSA, including debit card transactions and over the counter drugs. As a reminder, participants should keep all of their receipts for the entire plan year in the event that Gilsbar ask for documentation or the IRS requests a copy of a receipt.

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 Gilsbar after the plan year ends?

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

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 Dependent 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 myGilsbar.com and login to access claims information and FSA balances online. Once you are logged in, select the “Reimbursement Account Center” link on the left side of the screen to view your account balances. If you are new to myGilsbar, complete the brief site registration to login. At the end of this summary, please see the Gilsbar “Welcome Letter” for more details on how to register on mygilsbar.com.

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 myGilsbar.com or you can call our Customer Contact Center at 1-800-445-7227 ext. 883.

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:

	With FSA	Without FSA
Salary	\$1000	\$1000
Less Pre-Taxed Dollars:		
Medical Reimbursement	\$100	\$0.00
Dependent Day Care Reimbursement	\$150	\$0.00
Taxable Income	\$750	\$1000
Less:		
Federal Income Tax	\$82.00	\$121.00
State Income Tax	\$17.58	\$23.44
Social Security	\$57.37	\$76.50
Net Take Home Pay	\$593.05	\$779.06
Less Health Care & Dependent Care Expenses	\$0.00	\$250.00
Net After Expenses	\$593.05	\$529.06

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

GILSBAR Medical Reimbursement Account

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, you will receive a notice of your balance prior to the end of each year.

You can access balance information online 24/7 via myGILSBAR.com. Select the "Reimbursement Account Center" link on the left side of the screen to view your balances. 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 your completed claim form and receipts to Gilsbar for reimbursement.

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" list below.

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 866-635-1329

How much will be reimbursed?

When you submit a health care expense, you will be reimbursed for eligible expenses 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 Gilsbar 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 24/7 at myGilsbar.com, or you can call Gilsbar's Customer Contact Center at 1-800-445-7227 ext. 883.

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.

Qualified Medical Expenses Eligible For Reimbursement:

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

Telephone equipment to assist the hearing impaired	Transportation expenses relative to health care (Mileage is eligible for the miles driven to and from the doctor's office. The amount that can be reimbursed is nineteen (19) cents per mile.)	Vasectomy
Television equipment for the hearing impaired		Vitamins (if prescribed)
Therapy equipment	Ultra-violet ray treatment	Weight loss programs* (not food)
Transplants (organ)	Vaccines	Wheelchair
		X-rays

* May require additional substantiation (documents of medical necessity)

Expenses Not Eligible For Reimbursement

Any expense not considered "medically necessary" by the IRS	Electrolysis	Laetrile
	Face lifts	Liposuction
Any expense for your general health, even if your doctor prescribes the program	Food	Marijuana used medically
	Funeral, cremation, or burial expenses	Maternity clothes
Babysitting and childcare	Hair transplants	Personal use items
Bleaching teeth (cosmetic)	Health club membership dues	Prescription drugs considered cosmetic
Cosmetic surgery	Household help	Rogaine
Dancing lessons	Illegal operations and treatments	Swimming lessons
Diaper service	Insurance premiums	Vitamins
Dietary supplements		

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, Tagamet 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
Anti-diarrheal 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

Drug / Medicine	Example
Contact Lenses Solutions	Bausch & 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	Balmox 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

Drug / Medicine	Examples
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 & 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/Chondrotin 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

- Vitamins are not an eligible expense, unless prescribed by a physician to treat a specific medical condition (i.e. Iron to treat, not prevent anemia, Calcium Supplements to treat, not prevent Osteoporosis). A doctor's note detailing the specific medical condition will be required for reimbursement.
- Weight loss/dietary supplements must be for a specific medical condition such as obesity.

Health Care FSA Expense Worksheet

This worksheet has been prepared to help you determine the amount of money you wish to allocate to your Health Care FSA. You may want to review your checkbook register or credit card statements from last year to identify medical expenses you paid out of your own pocket. Compare last year's typical expenses to those eligible under your Health Care FSA and budget accordingly for the upcoming year, keep in mind to only budget for those expenses specifically eligible under your Health Care FSA.

HEALTH CARE EXPENSES YOU PAID LAST YEAR COULD INCLUDE:

Deductibles	
(medical and dental)	\$ _____
Benefit percentage/co-insurance	
(The amount NOT paid by your insurance)	\$ _____
Amounts paid over plan limits	
Over reasonable and customary allowance	\$ _____
Over psychiatric limits	\$ _____
Over private room allowance	\$ _____
Expenses NOT covered by your insurance plan	
Physicals	\$ _____
Prescription drugs	\$ _____
Over-the-counter medications	\$ _____
Vision care	\$ _____
Hearing expenses	\$ _____
Psychiatric care	\$ _____
Dental and orthodontic care	\$ _____
Assistance for the handicapped	\$ _____
Therapy/treatments	\$ _____
Physician's fees/services	\$ _____
Medical equipment	\$ _____
Miscellaneous charges	\$ _____
My out-of-pocket health care	
(expenses last year)	\$ _____

Gilsbar Flex Debit Card

Beginning January 1, 2008, new IRS rules have simplified the use of Flex Debit Cards. These rules now require drug stores and supermarkets to identify FSA-eligible items at checkout and require the drug store or super market to only use the card for FSA eligible items. This means that you can use your Card at participating stores that offer this feature for the total FSA-eligible amount and NO receipts are needed to verify the eligibility of the purchase! And of course, you can continue to use your Card at pharmacies and other health care providers.

Please visit <http://www.sig-is.org/en/index.asp> and click on **SIGIS Merchant List** for the latest list of participating merchants.

Here's an example:

You have been purchasing prescriptions at a pharmacy in a local supermarket using your Card during 2007. On January 5, 2008, you go to the store to pick up a prescription. If the store has not made the change required by the IRS to identify FSA-eligible items, your Card may be declined at the point of purchase. In this case, you can transfer your prescriptions to a pharmacy in a participating discount store or supermarket, or to a freestanding pharmacy, or simply continue to turn in your paper receipts for reimbursement as you have previously.

Important point to remember:

If you use your Card on or after January 1, 2008 in a discount store or supermarket that is not participating — even if you purchased FSA-eligible items in the store prior to January 1, 2008, your Card may decline.

Here's how your Flex Card works at participating stores:

1. Bring prescriptions and vision products, OTCs and other purchases to the register at checkout to let the clerk ring them up.
2. Present your Card and swipe it for payment.
3. If the Card swipe transaction is approved (e.g., there are sufficient funds in the account and at least some of the purchases are FSA eligible), the amount of the FSA-eligible purchases is deducted from the account balance and no receipt follow up is required. The clerk will then ask for another form of payment for the non-FSA-eligible items.
4. If the Card swipe transaction is declined, the clerk will ask for another form of payment for the total amount of the purchase.
5. The receipt will identify the FSA-eligible items and may also show a subtotal of the FSA-eligible purchases.

How does the FSA Debit Card work?

Shortly after the start of the plan year you will receive your FSA Debit Card to use for your eligible medical expenses. If you are a current participant, your card will reflect the new plan year contribution amount on the new effective date of the plan. As you incur expenses, use your FSA Debit Card to have the funds taken directly out of your account so you don't have to pay with cash out of your pocket.

Where can I use my FSA Debit Card?

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

If I use my FSA Debit Card, is verification of claims still required?

Per IRS requirements, verification of claims is required for all debit card transactions. A large portion of debit card transaction can be verified using one of the IRS' approved electronic methods; however, not all transactions can be verified electronically. For any expense that cannot be verified electronically, you must provide supporting documentation upon request in the form of an itemized bill or receipt to Gilsbar. Verification should include the patient name, date of service, description of services rendered, cost and patient liability. If Gilsbar does not receive verification within 30 days of the date requested you will be asked to return the un-verified amounts to your employer, or they may be counted as taxable income to you.

Are there special rules that related to prescriptions, over-the-counter (OTC) products, and vision expenses incurred at retail merchants?

Starting on January 1, 2008, new special IRS rules allow you to use your FSA debit card in participating discount stores and supermarkets that can identify FSA-eligible items at checkout. This means that you can use your card at participating stores for the total FSA-eligible amount and NO receipts are needed to verify the eligibility of the purchase! Important point to remember: If you use your card on or after January 1, 2008 in a discount store or supermarket that is not participating in the IRA program, even if you purchased FSA-eligible items there before, your card may decline.

Can I use my FSA Debit Card for eligible Dependent Care expenses?

No. Your FSA Debit Card may not be used to pay for eligible Dependent Care expenses. Your card will only be accepted at authorized vendors that have the appropriate merchant codes, such as medical clinics, hospitals, dental offices, vision care centers and pharmacies.

What happens if the FSA Debit Card is used for an ineligible expense?

Gilsbar will review all charges and determine if the card was used for an ineligible expense, according to IRS guidelines. If it was, we will notify you for repayment of the invalid amount. Failure to repay within 30 days of the request can result in the loss of your debit card privileges.

What should I do to pay for an expense that is more than my account balance?

You should tell the merchant to swipe your card for the amount equal to what is left in your account, then use another payment method to pay the remaining balance.

GILSBAR Dependent Care Account

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 24/7 online via myGilsbar.com. Select the "Reimbursement Account Center" link on the left side of the screen to view your balances.

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 (\$2,400 for one dependent or \$4,800 for two or more dependents), minus the amount reimbursed under the Dependent Care FSA.

How do I get reimbursed?

As you incur eligible expenses you must submit a completed Dependent Care FSA claim form to Gilsbar 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.

FAX CLAIMS AND PROOF OF EXPENSE TO 866-635-1329 FOR PROCESSING.

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 dependent 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 access your account information 24/7 at myGilsbar.com or you can call Gilsbar's Customer Contact Center at 1-800-445-7227 ext. 883.

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 FAX CLAIMS AND PROOF OF EXPENSE TO 866-635-1329
FOR PROCESSING.

**Questions? Call Gilsbar's Customer Contact Center;
1-800-445-7227, ext. 883**

If you prefer to submit your form by mail, please send claim form and receipts to:
Claims Processing Center, P.O. Box 26046, Tampa, FL 33623
(PLEASE KEEP YOUR ORIGINALS)

Gilsbar Welcome Letter

Thank you for choosing to participate in the Health Care or Dependent Care FSA. Your FSA plans are administered by Gilsbar, Inc. **Your Gilsbar group number is S2555.**

Access the MyGilsbar.com Website to Manage your Account 24/7!

- | | |
|--|-----------------------------------|
| ⇒ View plan year balance | ⇒ Obtain claim forms |
| ⇒ Set up or edit ACH/Bank Draft information* | ⇒ Set up email messaging |
| ⇒ Check claim status | ⇒ View payments and payment dates |
| ⇒ View claim/ receipt images within 24 hours | ⇒ File appeals to denied claims |

**To participate in the FSA Direct Deposit (ACH / Bank Draft) a valid email address is required.*

It's easy to get started:

Step 1: After your effective date, go to www.mygilsbar.com and register as a new participant.

You will complete a brief registration form to register with a valid email address and your group number.

Step 2: Once logged in, click on a selection under the Reimbursement Account Center section in the left navigation bar.

If you are a first time user, you will be prompted to enter your email address to sign up for our Reimbursement Account Center email service. This is an important step to ensure you will receive email updates when:

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

Step 3: Click the Accounts tab at the top to confirm that your annual election(s) and address are accurate. Contact us with any discrepancies.

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

<p>For Fastest Processing, FAX Claims and Receipts to: 1-866-635-1329</p> <p>Mail Claims and Receipts to: Claims Processing Center PO Box 26046 Tampa, FL 33623</p> <p><i>(Please keep your originals)</i></p>	<p>Customer Contact Center</p> <p>7:00 AM – 7:00 PM Central Time</p> <p>Phone: 1-800-445-7227 ext. 883 Email: flex@gilsbar.com</p> <p>(Please do not email claims/receipts)</p>
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Cancer Can Affect Anyone

Statistics Predict:

- Cancer will strike one in every two men and one in every three women in the U.S.*
- One out of eight women will develop breast cancer in her lifetime*.
- One out of every six men will develop prostate cancer*.
- The number of people with cancer will double in this decade**.

Are you prepared for the cost of cancer?

Your medical insurance covers most of the **direct** charges such as hospital and physicians' bills, but **may not cover** these **indirect** costs:

- Loss of wages while caring for a family member
- Loss of wages while you receive treatment
- Everyday living expenses and bills
- Childcare
- Home health care expenses
- Transportation for non-local or specialized treatment centers
- Experimental treatment
- Meals eaten out, fast food for family at home
- Lodging during non-local treatment

In fact, non-medical costs account for **67 percent** of all costs associated with cancer*. Many Americans find themselves financially strapped as the result of the battle against cancer or a specified disease, even with medical insurance.

Extra cash when you need it. Here's how it works:

- We provide **cash benefits** to you.
- You use the money to meet **your needs** - loss of income, house and car payments, transportation for treatment, other bills, etc. These non-medical expenses of cancer may not be covered by your major medical insurance.

**Cancer Facts & Figures, American Cancer Society, 2001.*

***Report from the American Hospital Administration.*

Plus, you get these unique features:

- Guaranteed renewable for life. You can't lose your coverage, as long as you continue to pay your premiums.
- Cash benefits paid to you regardless of any other medical insurance plan you may have.
- Provides cash to offset the costs of 30 other diseases.
- Coverage is portable. Employees can keep the coverage if they change jobs.

Selected benefits paying cash to you:

- Cancer Screening Tests
- Chemotherapy, Radiation, Immunotherapy, or Radioactive Isotopes Therapy
- Experimental Treatment
- Individual/Family Transportation and Lodging

Assurity Cancer Plan

Effective Date: October 1, 2008 pending Assurity approval

BASIC BENEFITS

Provides medical expense benefits caused by cancer and certain other specified diseases by rider for the employee, spouse and covered children with continuous benefit and premium period for life. The Family Rider allows for the addition of family members to the employee's policy.

RATE STRUCTURE

Unisex Rates; Employee Issue Ages: 18-69, Family: Up to Age 69 on spouse and 25 on children if a full-time student in an accredited school. Issue Age is age of last birthday on the day policy is issued.

UNDERWRITING

Pre-existing conditions are not covered during the first year the policy is in force. Persons with previous history of cancer will be excluded unless added by rider for those with simple skin cancers. Additional question regarding diagnostic tests that have been completed within last 30 days or are scheduled to be performed is also asked. No benefits will be paid during a 30-day waiting period. Conditions that manifest after the policy date will be payable beginning on the 31st day. Definition of manifested: "Symptoms or visible indications that would put an ordinary prudent person on notice that diagnosis, care or treatment by a medical professional should be sought."

Policy will pay the following specified benefits for each unit for a covered injury:

Hospital Indemnity – pays benefits each day while confined in the hospital for cancer or certain other specified disease for the first 75 days of each period of confinement. There are three options for the daily benefit amount: **\$150, \$250, and \$350.**

Prescription Drugs and Medicines – pays actual charges up to 25% of daily hospital confinement benefit for the first 75 days of hospital confinement.

Surgical Benefit – pays up to \$7,500 for actual charges made by surgeon as shown in Surgical Table in policy.

Anesthesia – pays up to 25% of the amount payable under the Surgical Benefit. Limit of \$50 per skin cancer operation.

Additional Surgical Opinions – pays up to \$150 for a second opinion. If the second opinion differs from the first, up to \$150 for a third opinion.

Artificial Limb and Prosthesis – pays actual charges for prosthesis and reconstructive procedure to affix or implant it up to \$2,000 lifetime maximum.

Attending Physician – pays actual charges up to \$35 per day for in-hospital physician's visits.

Private Duty Nurse – pays actual charges up to \$150 per day while confined in the hospital when authorized by a physician when a Private Nurse is required.

Radiation, Chemotherapy or Immunotherapy – pays 50% of actual charges for treatments up to \$10,000 per month with a lifetime maximum of \$100,000.

Experimental Treatment – pays the actual charges up to \$25,000 per calendar year for such treatment received in the United States or its territories, except for experimental bone marrow transplants.

Physical and Speech Therapy – pays the actual charges up to \$25 per therapy session up to a lifetime maximum of \$1,000.

Extended Care Facility – pays up to \$60 per day for confinement in such a facility. Confinement must be recommended by a physician and begin within 14 days following a covered hospital stay. Benefits are limited to the number of days of the prior hospital confinement.

Bone Marrow Transplant for Cancer – pays actual charges up to a lifetime maximum of \$25,000 for bone marrow transplants or other forms of stem cell rescue and all related services or supplies. Payable in lieu of any other benefits payable under this policy, except Transportation and Lodging for Bone Marrow Donors.

Transportation and Lodging for Bone Marrow Donors - pays (a) actual charges up to \$2,500 for medical expenses directly related to such a transplant, (b) pays actual charges for a round trip coach fare on a common carrier or a personal automobile allowance of 50 cents per mile in excess of 50 miles one-way to the city where the transplant is performed, up to 700 miles round trip, and (c) pays actual charges up to \$50 per day for lodging and meal expenses when donor has to remain near the hospital. This payment is in lieu of any other benefit payable under this policy when the donor is a person insured under this policy.

Transportation for Non-local Treatment Which Requires Hospital Confinement – pays (a) actual charges for non-local round trip charges by common carrier to the nearest hospital that provides the prescribed treatment or (b) 50 cents per mile for personal automobile expenses in excess of 50 miles one way, up to 700 miles round trip.

Transportation for Non-local Treatment Which Does Not Require Hospital Confinement – pays (a) 50 cents per mile for personal automobile expenses in excess of 50 miles one way, up to 700 miles round trip with a maximum of \$1,500 per calendar year, (b) pays actual charges for round trip coach fare on a common carrier or a personal automobile allowance of 50 cents per mile in excess of 50 miles one-way to the city where the transplant is preformed, up to 700 miles round trip and (c) pays actual charges up to \$50 per day for lodging and meal expenses.

Adult Companion Transportation and Lodging - pays the following expenses for one adult companion to be near insured when insured is confined in a non-local hospital (a) up to a maximum of \$1,500 per calendar year for actual charges for non-local round trip coach fare by a common carrier to the nearest

hospital that provides the prescribed treatment or 50 cents per mile for personal automobile expenses in excess of 50 miles one-way, up to 700 miles round trip and (b) pays actual charges up to \$50 per day for lodging and meal expenses limited to the number of days of each confinement.

Outpatient Positive Diagnostic Testing – pays actual charges up to \$250 for the diagnostic test that leads to a positive diagnosis within 90 days of the test.

Outpatient Surgery – pays a benefit equal to the daily hospital confinement benefit for outpatient surgery in a hospital or ambulatory surgical center.

Skin Cancer – pays up to \$150 for actual charges for the removal of skin cancer when diagnosis is made by a physician, other than a legally qualified pathologist.

Ambulance – pays actual charges up to \$75 per trip to transfer an insured person to the hospital for confinement as an inpatient.

Hospice – pays actual charges up to \$100 per day up to a lifetime maximum of \$7,500.

Government or Charity Hospital – pays actual charges up to \$200 per day for confinement in a government or charity hospital. Payment is in lieu of all other policy benefits.

Blood and Blood Plasma – pays the actual charges for blood, blood plasma and platelets. Policy does not pay for blood that is donated or replaced.

Breast Cancer / Breast Reconstruction / Breast Prosthesis – pays a benefit equal to the daily hospital confinement benefit for a minimum of 48 hours of inpatient care following a mastectomy and for a minimum of 24 hours following a lymph node dissection for the treatment of breast cancer. Lifetime maximum of \$2,500 per breast.

Cancer (Wellness) Screening Tests – pays a scheduled amount up to \$100 per year for cancer screening test. Tests covered are: Mammography screening, pap smear (test only), CA125 (blood test for ovarian cancer), PSA (blood test for prostate cancer), hemocult stool specimen, flexible sigmoidoscopy, CEA (blood test for colon cancer), colonoscopy, chest x-ray, thermography and serum protein electrophoresis.

Home Health Care Services – when services are provided by a Home Health Care Agency, policy pays (a) up to \$60 per day for services provided at home, not to exceed 180 days per calendar year, (b) up to \$100 per day for Private Duty Nursing, not to exceed 15 days per calendar year, and (c) pays actual charges for a physician's visit up to \$40 per day not to exceed 15 days per calendar year. Benefits herein are not payable under provisions of this policy.

Hairpiece Benefit – pays a one-time benefit of up to \$150 for a hairpiece when hair loss is a result of cancer treatment.

Rental or Purchase of Durable Medical Equipment – pays the actual charges up to \$1,000 per calendar year for (a) a respirator or similar medical device, (b) brace, (c) crutches, (d) hospital bed or (e) wheel chair.

Professional Mental Health Consultation – pays actual charges up to \$50 per session not to exceed a lifetime maximum of \$250.

Extended Benefits – If a covered hospital confinement lasts for more than 75 days in a row, policy pays usual and customary charges for hospital room and board, medicines, lab test and other normal charges, up to \$1,000 per day beginning on the 76th day. Payable after the 75th day in lieu of all other policy benefits.

Waiver of Premium – premiums of the insured person will be waived while that person is receiving treatment for cancer or specified disease for which benefits are payable.

Specified Disease Benefits - The benefits of the policy will be extended to pay for the loss that results from the following specified diseases: Addison's Disease, Botulism, Brucellosis, Budd-Chiari Syndrome, Cystic- Fibrosis, Diphtheria, Encephalitis, Histoplasmosis, Legionnaire's Disease, Lou Gehrig's Disease, Lupus Erythematosus, Malaria, Meningitis, Multiple Sclerosis, Muscular Dystrophy, Myasthenia Gravis, Osteomyelitis, Polio, Q Fever, Reye's Syndrome, Rheumatic Fever, Rocky Mountain Spotted Fever, Sickle Cell Anemia, Tay-Sachs Disease, Tetanus, Toxic Shock Syndrome, Trichinosis Tuberculosis, Typhoid Fever and Whooping Cough.

Intensive Care Rider - Provides a Daily Benefit (you choose \$300 or \$600) if an Insured Person is confined to a Hospital's Intensive Care Unit, up to a maximum of 20 days per period of confinement.

Internal Cancer First Occurrence Rider - pays \$2,500 or \$5,000 the first time an insured is diagnosed as having internal cancer.

Wellness Claims - An employee can file a wellness claim by fax, call-in or mail. Employees can get a wellness claim form from www.markiibrokerage.com/guilfordcountyschoolsnc. If a bill is not included with the claim form, a scheduled amount will be paid. (Scheduled amounts are listed on the claim form). Employees can also call in their wellness claim at **(888)-358-8808, ext. 23**. The call in service requires all the information on the wellness claim form. The wellness claim form must include the name and phone number of your physician. All claims are subject to verification.

Cancer or other Specified Disease Claims - You may file a claim for cancer or specified diseases by completing an Assurity Claim Form. Please make sure to include all pertinent information as stated on the form. You can obtain a claim form by contacting Assurity or by downloading the form from your employer's website. Should you have any questions on how to file or submit a claim, or regarding the Assurity Cancer Plan, please call (888) 358-8808, ext. 23.

Cancer Claims/ Fax: (402)437-4592
Customer Service/Wellness Claims / Call In: (888)358-8808, ext. 23
Wellness Claims / Fax: (800) 869-0368

Claims can also be mailed to:
Assurity / PO Box 80926 / Lincoln, NE 68501

**Cancer and Specified Dread Disease Benefit
with Radiation/Chemotherapy**

MONTHLY RATES

Assurity Life Cancer & Specified Disease Plan				
		\$150 Daily Benefit	\$250 Daily Benefit	\$350 Daily Benefit
Base Policy (\$10,000 per month/\$100,000 lifetime maximum) (radiation/chemotherapy)	Individual	\$20.92	\$23.22	\$25.52
	EE & Spouse	\$32.04	\$35.62	\$39.19
	EE & Children	\$25.99	\$28.60	\$31.21
	Family	\$37.11	\$41.00	\$44.88
Base Policy with Intensive Care Rider (\$300 daily benefit)	Individual	\$23.02	\$25.32	\$27.62
	EE & Spouse	\$36.24	\$39.82	\$43.39
	EE & Children	\$29.29	\$31.90	\$34.51
	Family	\$42.51	\$46.40	\$50.28
Base Policy with Intensive Care Rider (\$600 daily benefit)	Individual	\$25.12	\$27.42	\$29.72
	EE & Spouse	\$40.44	\$44.02	\$47.59
	EE & Children	\$32.59	\$35.20	\$37.81
	Family	\$47.91	\$51.80	\$55.68
Base Policy with First Occurrence Benefit Rider (\$2,500 benefit)	Individual	\$23.75	\$26.05	\$28.35
	EE & Spouse	\$36.27	\$39.85	\$43.42
	EE & Children	\$29.41	\$32.02	\$34.63
	Family	\$41.93	\$45.82	\$49.70
Base Policy with First Occurrence Benefit Rider (\$2,500 benefit) and Intensive Care Rider (\$300 daily benefit)	Individual	\$25.85	\$28.15	\$30.45
	EE & Spouse	\$40.47	\$44.05	\$47.62
	EE & Children	\$32.71	\$35.32	\$37.93
	Family	\$47.33	\$51.22	\$55.10
Base Policy with First Occurrence Benefit Rider (\$2,500 benefit) and Intensive Care Rider (\$600 daily benefit)	Individual	\$27.95	\$30.25	\$32.55
	EE & Spouse	\$44.67	\$48.25	\$51.82
	EE & Children	\$36.01	\$38.62	\$41.23
	Family	\$52.73	\$56.62	\$60.50
Base Policy with First Occurrence Benefit Rider (\$5,000 benefit)	Individual	\$26.58	\$28.88	\$31.18
	EE & Spouse	\$40.50	\$44.08	\$47.65
	EE & Children	\$32.83	\$35.44	\$38.05
	Family	\$46.75	\$50.64	\$54.52
Base Policy with First Occurrence Benefit Rider (\$5,000 benefit) and Intensive Care Rider (\$300 daily benefit)	Individual	\$28.68	\$30.98	\$33.28
	EE & Spouse	\$44.70	\$48.28	\$51.85
	EE & Children	\$36.13	\$38.74	\$41.35
	Family	\$52.15	\$56.04	\$59.92
Base Policy with First Occurrence Benefit Rider (\$5,000 benefit) and Intensive Care Rider (\$600 daily benefit)	Individual	\$30.78	\$33.08	\$35.38
	EE & Spouse	\$48.90	\$52.48	\$56.05
	EE & Children	\$39.43	\$42.04	\$44.65
	Family	\$57.55	\$61.44	\$65.32

AAW-C120RAB (7/04)



Ameritas Dental Plan

Policy Effective Date: October 1, 2008

PLAN YEAR DEDUCTIBLE

\$50.00 per individual for Type II (Basic) and Type III (Major) Procedures (3 times family limit). After the date that 3 members of a family have each satisfied their individual deductible, the entire deductible or any remaining portion of the deductible for any family member will be waived for the rest of that plan year. (If PPO provider is used, calendar year deductible is waived).

TYPE I - PREVENTIVE AND DIAGNOSTIC

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

- Routine Exams (*Two per benefit period*)
- Sealants (*Age 16 & Under*)
- Bitewing X-rays (*Two per benefit period*)
- Cleanings (*Two per benefit period*)
- Full Mouth/Panoramic X-rays (*1 in 3 years*)
- Periapical X-rays
- Fluoride for Children 18 & Under (*One per benefit period*)

TYPE II - BASIC PROCEDURES

Type II benefits are payable at 80% U&C*. \$50.00 deductible applies.

- Restorative Amalgams
- Crown Repair
- Restorative Composites
- Extractions - Simple/Complex
- Endodontics - Surgical/Nonsurgical
- Anesthesia
- Denture Repair

TYPE III - MAJOR PROCEDURES

Type III Benefits are payable at 50% U&C*. \$50.00 deductible applies.

- Onlays
- Periodontics - Nonsurgical
- Crowns
- Periodontics - Surgical
- Implants
- Prosthodontics-Fixed bridge/removable complete/partial dentures

ORTHODONTIA

Paid at 50% U&C* with a \$1,500 lifetime maximum per person. No deductible applies. (Includes Children and Adults)

**Usual & Customary*

ANNUAL MAXIMUM BENEFIT

Type I, II and III Procedures -\$1,500 per plan year per person.

Orthodontia Procedures -\$1,500 Lifetime per person.

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

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

If you meet all 3 requirements you will have an additional \$250 available in the Annual Dental Maximum for the next plan year. (Plus an additional \$150 if you visit a dentist in our panel). In future years if you have benefits paid of less than \$750, additional amounts of \$250 will be added to the carryover. However, the most you can accumulate in the maximum carryover is \$1,000. Therefore, the maximum annual benefit may never exceed \$2,500 in any one year.

ELIGIBLE EMPLOYEES

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

ELIGIBLE DEPENDENTS

Provides Coverage On:

- Your Spouse
- Children up to age 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.)

DENTAL EXCLUSIONS (DEFERMENT PERIOD)

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

PRE-DETERMINATION OF BENEFITS

A treatment plan MAY be filed if a proposed course of treatment will exceed \$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.

LATE ENTRANT

If you do not elect to participate in the dental program when first eligible, you will be considered a **Late Entrant** and you must wait 12 months for certain benefits. If an employee or dependent does not elect to participate when initially eligible, and elects to participate at the policyholders next annual election period, they will become a **Late Entrant**. For a **Late Entrant**, benefits will be limited to Preventive and Basic for the first 12 months. The late entrant provision is waived if the employee comes on the plan as a result of a qualifying event.

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.

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.

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.

EXCLUSIONS (This is not a complete List)

- *for any procedure except exams, cleaning and fluoride applications for the first 12 months when an employee or dependent becomes classified as a late entrant. If an employee or dependent does not enroll within 31 days from the date the person qualifies for the insurance or who elected to become covered again after canceling a premium contribution agreement will be classified as a late entrant.*
- *for any treatment which is for cosmetic purposes. Facings on crowns or pontics behind the second bicuspid are considered cosmetic.*
- *to replace any prosthetic appliance, crown, inlay or onlay restoration, or fixed partial denture within five years of the date of the last placement of these items. However, if a replacement is required because of an accidental bodily injury sustained while the plan member is covered under the dental expense benefit, it will be a Covered Expense.*
- *for initial placement of any dental prosthesis or prosthetic crown unless such placement is needed because of the extraction of one or more teeth while the plan member is covered under the dental expense benefit. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such dental prosthesis or prosthetic crown must include the replacement of the extracted tooth or teeth.*
- *for any procedure begun before the plan member was covered under the dental expense benefit.*
- *for any procedure begun after the member's insurance under the dental expense benefit terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the member's insurance under the dental expense benefit terminates.*
- *to replace lost or stolen appliances.*
- *for appliances, restorations, or procedures to:*
 - *alter vertical dimension;*
 - *restore or maintain occlusion;*
 - *splint or replace tooth structure lost because of abrasion or attrition*
- *for any procedure which is not shown on the Table of Dental Procedures.*
- *for orthodontic treatment. (Unless otherwise specified in this contract.)*
- *for which the plan member is entitled to benefits under any workmen's compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.*
- *for charges for which the plan member is not liable or which would not have been made had no insurance been in force.*
- *for services which are not required for necessary care and treatment or are not within the generally accepted parameters of care.*
- *because of war or any act of war, declared or not.*
- *in any quarter of a Program if the member was not covered under the orthodontic expense benefits for the entire quarter.*
- *after the member's insurance under the orthodontic expense benefits terminates.*

ORTHODONTIA LIMITATIONS (This is not a complete list)

No benefit is payable for expenses incurred:

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

Ameritas Managed Care Products

- Employers achieve a balance between cost efficiency and employee choice.
- Plan members are free to receive care from any dentist they choose. Their out-of-pocket expenses are generally lower when using PPO dentist who have agreed to provide dental care at contracted fees.
- Over 70,000 PPO provider access points are available nationwide.
- PPO network dentists must meet our credentialing and quality assurance evaluation requirements.

Passive PPO

In passive PPO, the coinsurance, deductible and maximum are the same for the member in and out-of-network. The only difference is the claim allowance. There is an incentive for the member to see an in network dentist; however, there is no penalty for seeing an out-of-network dentist. As with all Ameritas PPO Solutions, the member has the liberty to choose any dentist they wish. However, they will usually save out-of-pocket costs by seeing an in-network dentist.

Passive PPO-Deductible Reduction

Deductible Reduction continues the difference of in-network and out-of-network claim allowance and allows a reduced deductible for those who visit an in-network dentist. As with all Ameritas PPO Solutions, the member has the liberty to choose any dentist they wish. However, they will usually save out-of-pocket costs by seeing an in-network dentist.

Commonly Asked PPO Questions

Guilford County Schools is proud to provide our employees with a new dental program effective October 1, 2008, administered by Ameritas Group. The plan provides excellent coverage for you and your eligible dependents. Please refer to the plan highlight for more details. As an added bonus, our plan includes access to Ameritas' Participating Provider Organization (PPO).

Do I have to use an Ameritas PPO provider?

No, employees and their covered dependents may utilize any licensed dental provider that they choose.

Please note, there is no difference in the coinsurance, deductible, and maximums on either plan whether a PPO provider is utilized or not.

Why would I use an Ameritas PPO provider?

By using a PPO provider:

- A Participating Provider is a dentist who has entered into an agreement to provide services to insured members of Ameritas' plans for at a specific fee. Any insured member who chooses to go to a PPO provider will receive this discounted fee for procedures performed by that provider.
- As part of their contractual agreement with Ameritas, the PPO provider cannot "back-bill" the patient for the difference between the dentists' normal charges and the discounted fees that the dentist agreed to charge as an Ameritas PPO provider.
- PPO providers are required to file the claim for the patient.
- PPO providers are required to wait for reimbursement from Ameritas before billing the patient for any balances owed for deductibles, coinsurance, any amounts exceeding the annual maximum benefits, etc.

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

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

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

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

MONTHLY DENTAL RATES

Employee Only	\$20.80
Employee & Family	\$98.74
Split Rate	\$67.19

For Claims/Customer Service Questions call Ameritas: 1-800-487-5553.

This insurance is underwritten by Ameritas Life Insurance Corp.

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

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



Direct Reimbursement Dental Plan

Effective Date: October 1, 2008

The plan year deductible per insured is \$0.00. The plan year deductible per family is \$0.00. The plan year maximum per insured is \$1,000.00. Any licensed provider/dentist can be used. No pre-determination/prior authorization is required.

DIAGNOSTIC AND PREVENTIVE SERVICES - 50% coverage.

- Oral Exams & X-rays
- Fluoride Treatments (no age limit)
- Sealants (no age limit)
- Routine Teeth Cleanings (no limit)

BASIC SERVICES - 50% coverage.

- Space Maintainers
- Fillings
- Endodontics
- Recementations/Repairs
- Simple Extractions
- Consultations
- Surgical Extractions
- General Anesthesia

MAJOR SERVICES - 50% coverage.

- Periodontics
- Inlays/Onlays
- Crowns & Build-ups
- Rebases / Relines
- Dentures
- Bridges
- Implants
- Veneers

ORTHODONTIA SERVICES

50% coverage for children up age 26 & adult orthodontia. Orthodontia Lifetime Maximum is \$1,000.

MONTHLY RATES

Employee Only	\$0.00
Employee + Dependent(s)	\$27.85
****Split (both spouses work for Guilford County Schools)	\$17.10

*Payments to dentists are calculated on the 90th percentile of usual and customary charges for the providers in that area.

**No waiting period applies for employees and/or dependents that enroll when first eligible. A 12-month waiting period applies for Major and Orthodontic Services for late enrollees.

****In order to qualify for "split" rates, both spouses must be enrolled in the same dental plan. One employee carries children.

This is a brief description of your dental benefits and does not contain all limitations and exclusions under either plan. For more complete information, please consult your plan booklet(s) or your benefits administrator. For more information on the Direct Reimbursement Plan, call 336-889-2003.

Superior Vision Plan I - Full Services

Effective Date: October 1, 2008

**Outline of Benefits – Gold Preferred Plan with Materials Discount
Vision Plan – Preferred Provider (PPO / Indemnity)**

**Copayment: \$10.00 Exam
 \$15.00 Materials
 \$35.00 Contact Lens Fitting Fee**

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

**Contact lenses are in lieu of eyeglass lenses and frames benefits.*

***The insured is responsible for paying any charges in excess of this allowance.*

****Standard contact lens fitting fee applies to an existing contact lens user who wears disposable, daily wear, or extended wear lenses only. The specialty contact lens fitting fee applies to new contact lens wearers and/or a member who wears toric, gas permeable, or multifocal lenses. For the specialty fit, the member is responsible for any charges over \$50.*

HOW TO USE YOUR BENEFIT

Procedure when using a Superior Vision Plan *in-network* provider:

- Identify yourself to the in-network provider as a member of the Superior Vision Plan. You can use your ID card for this purpose or simply give the provider your name, employer name, and your social security number. The provider will call SVS Member Services to verify your eligibility and obtain an authorization number. The ID card provided to you can be used for all covered family members.
- After eligibility is established, and an authorization number is received by the provider, services will be rendered. There is nothing else that you need to do except pay the provider directly for any appropriate co-payments and charges above the covered benefits. The in-network provider handles all claims and paperwork.

Procedure when using a Superior Vision Plan non-network provider:

- To receive services from a non-network provider, it is important that you first call Superior Vision Services Member Service Department at 800-507-3800 to receive your own authorization number. By doing so, you can be assured of your eligibility and reimbursement for money spent.
- After receiving services and paying in-full for the examination and/or materials (you do not pay a co-payment to the non-network provider), submit your original itemized billing received from the provider, along with your authorization number, to the SVS Claims Administration office listed on the next page.
- You will be reimbursed according to the schedule of allowances for non-network providers, less any required co-payments.

DEFINITIONS OF CONTACT LENSES

Contact Lenses, Elective/Cosmetic

Elective/Cosmetic contact lenses are those that are worn solely for cosmetic or convenience reasons. They are chosen because they are preferred over the wearing of conventional eyeglasses. Contact lenses covered by the Plan must contain a prescription for correcting a vision deficiency. Charges over the benefit allowance are paid directly to the provider.

Contact Lenses, Medically Necessary

These lenses must be specifically prescribed by the eye doctor to be used for the reason or reasons described below. Reimbursement for these lenses will be considered as payment-in-full when utilizing an in-network provider.

- Aphakia (after cataract surgery without implant lens)
A pair of prescription single vision or multifocal eye glass lenses and an eyeframe can be provided along with contact lenses prescribed for this reason.
- When visual acuity cannot be corrected to 20/70 in the better eye except through the use of contact lenses (must be 20/60 or better).•
Anisometriopia of 4.0 diopters or more, provided visual acuity improves to 20/60 or better in the weak eye.
- Kerataconus

Note: The narrowing of visual fields due to high minus or high plus corrections is not considered a reason for medically necessary contact lenses.

Contact Lens Examining Fee:

Most providers charge a fee for the fitting of contact lenses. This fee is separate from the eye examination and will vary depending on the provider's fee structure policies. It will also vary due to circumstances or complexities involving the physiological condition of the eyes, the lens prescription, and the type of lenses used. The contact lens exam/fitting fee may be included in the contact lens allowance.

EXCLUSIONS (products & services not covered):

There is no benefit coverage for the following products and services.

- Professional Services and/or Materials in conjunction with:
 - blended bifocals, no line, or progressive lenses
 - compensated or special multi-focal lenses
 - plain (non-prescription) lenses
 - anti-reflective, scratch, UV400, or any coating or laminate applied to lenses
 - subnormal vision aids
 - tints, other than solid
 - orthoptics, vision training and developmental vision procedures
 - polycarbonate lenses
- Medical or surgical treatment of the eyes
- Any eye examination or any corrective eyewear required by an Employer as a condition of employment
- Any injury or illness when covered under Workers Compensation or similar law
- Plain or prescription sunglasses, no-line bifocals, blended lenses are not covered; an Insured may elect to apply the maximum allowance for standard lenses toward his, or her cost of progressive lenses
- Subnormal vision aids
- Services rendered or Materials purchased outside the U.S. or Canada unless the member resides in the U.S. or Canada; and the charges are incurred while on a business or pleasure trip
- Charges in excess of the Usual, Customary and Reasonable charges for the Professional Service or Materials
- Experimental or non-conventional treatment or device
- Safety eyewear
- Spectacle lens styles, materials, treatments, or “add-ons” not shown in the Benefits Summary
- Services or Materials rendered by a provider other than an Ophthalmologist, Optometrist or Optician acting within the scope of his, or her license
- Any additional service required outside basic vision analysis for contact lenses except fitting fees
- Services rendered after the date an Insured ceases to be covered under this Certificate, except when vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured within 31 days from the date of such order
- Services rendered or Materials ordered before the date of coverage began under this Certificate
- Regardless of Optical Necessity, benefits are not available more frequently delivered, and the services rendered to the Insured within 31 days from the than that which is specified in the Benefits Summary

DISCOUNTS ON ADDITIONAL PURCHASES

- | | |
|---|-----------------------|
| • Prescription eyeglass lenses | 30% off retail prices |
| • Eyeframes | 30% off retail prices |
| • Add-on charges to basic lenses | 20% off retail prices |
| • Everyday “frame and lens package” pricing | 20% off retail prices |
| • Contact lenses, standard hard or soft | 20% off retail prices |
| • Disposable contact lenses | 10% off retail prices |
| • All other prescription materials | 20% off retail prices |

DISCOUNT SVP8-20

- Frames - 20% off the difference between the covered frame Allowance and the retail price of the selected frame

Add-on charges to covered pair of lenses

Member pays 20% off retail up to:

- Factory Scratch Coat \$13 (Single Vision & Standard Multifocal lenses)
- Ultraviolet Coat \$15 (Single Vision & Standard Multifocal lenses)
- Standard Anti-Reflective coat* \$50 (Single Vision & Standard Multifocal lenses)
- High Index 1.6* \$55 (Single Vision lenses only)
- Polycarbonate \$40 (Single Vision lenses only)
- Standard Photochromic \$80 (Single Vision lenses only)
- Glass coloring \$35 (Any Type lenses)
- Plastic Tints solid or gradient \$25 (Any Type lenses)

Member pays:

- Power over 4.00 Sphere, 2.00D Cylinder & 5.00 Prism 20% off retail prices (any type lenses)
- Cosmetic finishing, Beveling, Edging, and Mounting 20% off retail prices (any type lenses)
- Miscellaneous Options 20% off retail prices (any type lenses)

* Higher end or brand name lens upgrades are at an additional expense to the member. Apply maximum out of pocket expense toward upgraded lens retail cost and member is responsible for the difference less 20%.

REFRACTIVE SURGERY DISCOUNTS

Superior Vision Services has contracted a network of over 500 refractive surgeons nationwide who specialize in the popular elective procedures of radial keratotomy (RK), photo-refractive keratotomy, (PRK), and LASIK. These providers offer Superior Vision Plan members a 20% discount off their usual and customary surgical fees for these procedures. Ophthalmic plastic surgeons are also contracted to provide the procedure of blepharoplasty (cosmetic eyelid surgery) to Superior Vision Plan members on the same discount basis.

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

MONTHLY COST

Employee Only	\$9.90
Employee + One	\$19.22
Employee + Family	\$28.24

Member Services, Provider Listings and Claims Services:
800-507-3800

Member Services FAX:
916-852-2277

Provider Nominations:
800-923-6766, ext. 254 or
800-507-3800

Web Site: www.superiorvision.com

Address:
Superior Vision Services, Inc.
11101 White Rock Road, Ste. 150
Rancho Cordova, CA 95670

Non-network Claims Submission:
Superior Vision Services, Inc.
P.O. Box 967
Rancho Cordova, CA 95741



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

Superior Vision Plan 2 - Materials Only

Effective Date: October 1, 2008

Outline of Benefits - Materials Only

Vision Plan - Preferred Provider (PPO / Indemnity)

Copayment: \$15.00 - Materials
\$25.00 - Contact Lens Fitting Fee

BENEFITS	FREQUENCY	IN-NETWORK	NON-NETWORK
Eye Exams	No Benefit	No Benefit	No Benefit
Lenses (Standard) per Pair			
Single Vision	12 Months	Covered in Full	Up to \$34.00
Bifocal	12 Months	Covered in Full	Up to \$48.00
Trifocal	12 Months	Covered in Full	Up to \$64.00
Lenticular	12 Months	Covered in Full	Up to \$88.00
Contact Lenses (Per Pair)*			
Medically Necessary	12 Months	Covered in Full	Up to \$210.00
Cosmetic (Elective)**	12 Months	Up to \$120.00	Up to \$100.00
Standard Contact Lens Fitting Fee***	12 Month	Covered in Full	Not Covered
Specialty Contact Lens Fitting Fee***	12 Months	Up to \$50.00	Not Covered
Frames (Standard)	24 Months	Up to \$100.00	Up to \$50.00

*Contact lenses are in lieu of eyeglass lenses and frames benefit.

**The insured is responsible for paying any charges in excess of this allowance.

***Standard contact lens fitting fee applies to an existing contact lens user who wears disposable, daily wear, or extended wear lenses only. The specialty contact lens fitting fee applies to new contact lens wearers and/or a member who wears toric, gas permeable, or multi-focal lenses. For the specialty fit, the member is responsible for any charges over \$50.

In-network co-payment is paid directly to the provider.

Out-of-network co-payment will be deducted from the out-of-network reimbursement.

DEFINITIONS OF CONTACT LENSES

Contact Lenses, Elective/Cosmetic

Elective/Cosmetic contact lenses are those that are worn solely for cosmetic or convenience reasons. They are chosen because they are preferred over the wearing of conventional eyeglasses. Contact lenses covered by the Plan must contain a prescription for correcting a vision deficiency. Charges over the benefit allowance are paid directly to the provider.

Contact Lenses, Medically Necessary

These lenses must be specifically prescribed by the eye doctor to be used for the reason or reasons described below. Reimbursement for these lenses will be considered as payment-in-full when utilizing an in-network provider.

- Aphakia (after cataract surgery without implant lens) - A pair of prescription single vision or multifocal eye glass lenses and an eyeframe can be provided along

with contact lenses prescribed for this reason.

- When visual acuity cannot be corrected to 20/70 in the better eye except through the use of contact lenses (must be 20/60 or better).
- Anisometropia of 4.0 diopters or more, provided visual acuity improves to 20/60 or better in the weak eye.
- Kerataconus

Note: The narrowing of visual fields due to high minus or high plus corrections is not considered a reason for medically necessary contact lenses.

MATERIALS SVP 8-20 DISCOUNT SCHEDULE

Featured are 20% discounts on the provider's charges for upgrades to the 1st pair of covered eyeglass lenses. This includes tints, coatings, special materials and special lens designs.

Also included are discounts on the purchases or additional pairs of eyeglasses and contact lenses. See the schedule below. These materials discounts are available from in-network providers who are identified in the directory with a "DP" (discount plan) associated with their listing as a service they provide at the location.

FRAMES 30% OFF RETAIL
No restrictions apply

LENSES (Uncoated Plastic-CR39, or Glass) 30% OFF RETAIL
Single Vision
Bifocal (FT 25-35 & Executive)
Trifocal (FT 7X25, 7X28, 8X35 & Executive)
Progressives
Zyl and Metal Mounting

ADD-ON TO BASE LENSES 20% OFF RETAIL
Tints, Coatings, Colored Lenses
Power over 4.00D Sphere, 2.00D Cylinder & 5.00D Prism
Polycarbonate, High Index, Photochromatics
Cosmetic Finishing, Beveling, Edging & Mounting

EVERYDAY "Frame & Lens Package Pricing" 20% OFF RETAIL

CONTACT LENSES 20% OFF RETAIL

DISPOSABLE CONTACT LENSES 10% OFF RETAIL

ALL OTHER MATERIALS 20% OFF RETAIL

Refractive Surgery Discounts & Cosmetic Eyelid Surgery Discounts are available: Superior Vision Services has a nationwide network of refractive surgeons who specialize in the popular elective procedures of radial keratotomy (RK), photo-refractive keratotomy (PRK) and LASIK. These providers offer Superior Vision Plan members a 20% discount off their usual and customary surgical fees for these procedures. Ophthalmic plastic surgeons are also contracted to provide the procedure of blephoroplasty (cosmetic eyelid surgery) to Superior Vision Plan members on the same discount basis.

EXCLUSIONS (products & services not covered)

1. Professional Services and/or Materials in conjunction with:
 - a. blended bifocals, no line, or progressive lenses**
 - b. compensated or special multi-focal lenses**
 - c. plain (non-prescription) lenses**
 - d. anti-reflective, scratch, UV400 or any coating or lamination applied to lenses.**
 - e. subnormal vision aids**
 - f. tints other than solid**
 - g. orthoptics, vision training and developmental vision procedures**
 - h. polycarbonate lenses**
2. Medical or surgical treatment of the eyes
3. Any eye examination or any corrective eyewear required by an Employer as a condition of employment
4. Any injury or illness when covered under Workers' Compensation or similar law
5. Plain or prescription sunglasses, no-line bifocals, blended lenses are not covered, an Insured may elect to apply the maximum allowance for standard lenses toward his or her cost of progressive lenses.
6. Subnormal vision aids
7. Services rendered or Materials purchased outside the U.S. or Canada, unless:
 - a. the Member resides in the U.S. or Canada; and**
 - b. the charges are incurred while on a business or pleasure trip**
8. Charges in excess of the Usual, Customary and Reasonable charge for the Professional Service or Materials
9. Experimental or non-conventional treatment or device
10. Safety eyewear
11. Spectacle lens styles, materials, treatments or "add-ons" not shown in the Benefits Summary
12. Services or Materials rendered by a provider other than an Ophthalmologist, Optometrist or Optician acting within the scope of his or her license
13. Any additional service required outside basic vision analysis for contact lenses, except fitting fees.
14. Services rendered after the date an Insured ceases to be covered under this Certificate, except when vision Materials ordered before coverage ended are delivered and the services rendered to the Insured within 31 days from the date of such order.
15. Services rendered or Materials ordered before the date of coverage began under this Certificate
16. Regardless of Optical Necessity, benefits are not available more frequently than which is specified in the Benefits Summary

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

MONTHLY COST - MATERIALS ONLY PLAN

Employee Only	\$ 6.78
Employee + One	\$ 13.18
Employee + Family	\$ 19.32

Member Services, Provider Listings, and Claims Services:
800-507-3800

To order contact lens via the internet go to this site: www.SVContacts.com

Member Services FAX:
916-852-2277

Provider Nominations:
Lee Sims @ 800-923-6766 X.254

Web Site: www.superiorvision.com

Address:
Superior Vision Services, Inc.
11101 White Rock Road, Ste. 150
Rancho Cordova, CA 95670

Non-network Claims Submission:
Superior Vision Services, Inc.
P.O. Box 967
Rancho Cordova, CA 95741

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Assurity Life Hospital Indemnity Plan

Effective Date: October 1, 2008

Hospital Indemnity...The Key to In-patient Protection

Few of us look forward to a hospital stay, but inevitably hospitalization happens in most families. Being admitted to the hospital for a scheduled surgery, a heart problem, a lingering illness, or an accident is trauma enough. No one wants to lay in a hospital bed or sit in the waiting room worrying about how the bill is going to get paid.

The Assurity at Work Hospital Indemnity Plan is protection from hospital bills that could cripple you financially.

How much will the gap in your health insurance cost you?

In the last decade, hospital costs as well as medical expenses have gone through the roof. Health insurance benefits rarely cover 100% of every hospital charge. Your out-of-pocket costs can include your plan's deductible, co-payment and policy maximums. Most people don't keep enough cash on hand to cover these expenses without feeling some financial strain.

The Assurity at Work Hospital Indemnity Plan pays over and above (except Workers Compensation) any other insurance benefits that you may have when you are hospitalized. It "fills the gaps" in your current insurance with a straightforward daily benefit payment to help cover expenses resulting from your stay.

When you need it – you'll be glad it's there.

U.S. Hospital Costs versus Money out of Your pocket¹:

- Average cost of hospital stay - \$1, 006 per day
- Average length of hospital stay - 6.2 days
- Average cost per hospitalization - \$6,225

Can you afford to pay your health insurance deductible and co-payment of 10-20% or more?

¹ 1998 *Statistical Abstract of the United States* (U.S. Department of Commerce) based on 1996 statistics.

It's smart, it's simple - it's the key to filling in the gaps in your health plan coverage. Protect yourself from out-of-pocket hospitalization expenses...it's the smart thing to do. Take the opportunity to visit with the insurance professional your employer has authorized. Plan to have Assurity at Work.

POLICY FEATURES

- Pays you a daily benefit amount of \$30.00 if you are confined to a hospital due to a covered injury or sickness, beginning with the 8th day; and continuing up to 180 days.
- Pays in addition to all other insurance (except for Workers' Compensation).
- Disclosed, pre-existing conditions are covered after twelve (12) months.
- Coverage available to spouse and children.
- One rate regardless of age or sex.
- Pays a daily benefit for hospital confinement (24 hours or more) for a covered accident or sickness – regardless of medical coverage or deductible².
- Accidents are covered from the first day.
- Coverage is portable if you leave your present employer.
- Conditionally renewable to age 70 (conditionally renewable over the age of 65 provided you continue to be employed on a full time basis working 30 hours or more per week).
- Issue Ages: 18-69.

² Does not pay in addition to Worker's Compensation Benefits.

Surgical and Anesthesia Benefits Policy Rider (AAW-DR228)

Benefit Amount: \$500.00

- Surgical - Pays actual charges up to the percentage of maximum listed on the schedule of operations for surgery performed in a Hospital (on an inpatient or outpatient basis), in an Ambulatory Surgical Center, or a Physician's office.
- Anesthesia - Pays actual charges up to 25% of the surgery benefits paid, for anesthesia administered by a physician in connection with such surgery.

First Hospital Admission Policy Rider (AAW-DR236)

Pays the Benefit Amount for an Insured's First Hospital Confinement according to the following schedule:

- One day hospital confinement - \$500
- Two days - \$1,000
- Three days - \$2,000
- Four Days - \$3,000
- Five days - \$4,000
- Six days - \$5,000

Benefits for the rider will be limited to the First Hospital Admission each Policy Year for each insured, (this includes one continuous Hospital Confinement or several Hospital Confinements for the same or a related cause which are separated by less than 90 days from date of discharge). This benefit is not a cumulative benefit and will not exceed \$5,000 for each Insured for each Policy Year.

MONTHLY RATES

Employee Only	\$18.54
Employee & Spouse	\$37.08
Employee & Children	\$28.40
Employee & Family	\$46.94

If you have any questions regarding the Assurity Life Hospital Indemnity Plan, please call 1-866-289-7337.

Assurity Life Insurance Company, PO Box 80926, Lincoln, NE, 68501-0926,
www.assurityatwork.com

Disability Is A Fact of Life

- 27,000,000 Americans are currently on disability.
- 6.85 out of 100 people between the ages of 20 and 35 will suffer a disability that lasts 3 months or longer.
- If a disability lasts longer than 3 months, its average duration is 2.9 years at age 30, 3.9 years at age 40 and 4.5 years at age 50.
- **48% of all home foreclosures done in this country today are a result of disabilities, only 3% are due to premature death.**
- Death rates are down; disability rates are up.
- At ages 35 - 40, your chances of being disabled are twice as great as those of dying.
- Workers' Compensation rates recently rose again. Analysts attribute this in part to the inclusion of stress on the job as a possible claim.
- Each year, the statistics average as follows:
 - 1 in 106 people die
 - 1 in 88 homes catch fire
 - 1 in 70 cars is involved in a serious accident
 - 1 in 8 people are disabled

Source: Commissioners Disability Trade, US Gov't Housing/Finance, Society of Actuaries

Could You Live Off Of Your Savings?

Standard Life Short Term Disability Plan

Effective Date - October 1, 2008, pending underwriting approval

- Payable in addition to sick leave
- Benefits payable regardless of other insurance
- Weekends and holidays are covered
- Benefits are paid directly to you
- Benefits are tax free
- Disability from pregnancy covered as any other sickness
- No change in premium due to age
- You may continue coverage if you leave your Employer, provided you maintain continuous employment. Coverage is subject to income and occupational underwriting guidelines.

ACCIDENT & SICKNESS PROTECTION

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

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

Benefit Duration: 90 Days		Benefit Duration: 180 Days		Benefit Duration: 365 Days	
Monthly Benefit	Monthly Premium	Monthly Benefit	Monthly Premium	Monthly Benefit	Monthly Premium
\$500	\$11.25	\$500	\$17.50	\$500	\$22.50
\$600	\$13.50	\$600	\$21.00	\$600	\$27.00
\$700	\$15.75	\$700	\$24.50	\$700	\$31.50
\$800	\$18.00	\$800	\$28.00	\$800	\$36.00
\$900	\$20.25	\$900	\$31.50	\$900	\$40.50
\$1,000	\$22.50	\$1,000	\$35.00	\$1,000	\$45.00
\$1,100	\$24.75	\$1,100	\$38.50	\$1,100	\$49.50
\$1,200	\$27.00	\$1,200	\$42.00	\$1,200	\$54.00
\$1,300	\$29.25	\$1,300	\$45.50	\$1,300	\$58.50
\$1,400	\$31.50	\$1,400	\$49.00	\$1,400	\$63.00
\$1,500	\$33.75	\$1,500	\$52.50	\$1,500	\$67.50
\$1,600	\$36.00	\$1,600	\$56.00	\$1,600	\$72.00
\$1,700	\$38.25	\$1,700	\$59.50	\$1,700	\$76.50
\$1,800	\$40.50	\$1,800	\$63.00	\$1,800	\$81.00
\$1,900	\$42.75	\$1,900	\$66.50	\$1,900	\$85.50
\$2,000	\$45.00	\$2,000	\$70.00	\$2,000	\$90.00

ELIGIBILITY

These benefit plans are optional and all full-time employees under 65 years of age may apply. The disability benefit is for **employees** only. Applications for new participants will be underwritten.

POLICY FEATURES

Disability due to pregnancy: Benefits are covered provided conception occurs after the effective date of the policy.

Limits and Exclusions:

Benefits will not be paid for any total disability which:

- 1) Occurs while the policy is not in force;
- 2) Does not require the regular care of a physician;
- 3) Is due to the use of intoxicants or narcotics, except on the advice of a physician;
- 4) Is on account of intentional self-inflicted injury;
- 5) Is a result of mental or nervous disorders;
- 6) Results from armed conflicts;
- 7) Arises out of aviation, except scheduled passengers on commercial airlines;
- 8) Results from traveling more than forty miles outside the US;
- 9) Results from the participation in a felony or working at an illegal job.
- 10) Results from a pre-existing condition, as defined in the policy.

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

If you have any questions regarding the Standard Life Disability Plan, please call 1-800-327-0695 .

For claims questions, please call 1-800-227-0251.

Texas Life Whole Life Plan

Common Issue Date: November 1, 2008 pending underwriting approval

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

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

As an employee, you are eligible to apply if you have satisfied your employer's eligibility period. You may also apply for coverage on your spouse, children and grandchildren.

WHY VOLUNTARY COVERAGE

- Most employees are dependent on group term
- Only 50% of U.S. Households have individually owned life insurance¹
- 72% of life insurance policies are paid to beneficiaries of individually owned life plans¹
- Most term policies expire before paying a death claim
- When do you want a life insurance policy in force?
— Answer: When you die
- Term is for IF you die; permanent is for WHEN you die
- Everybody dies

THE NEW PRODUCT: TEXAS LIFE'S VPL-plus

- Portable, permanent life insurance through the convenience of payroll Deduction
- Whole life chassis
- Strong guarantees
- Popular features
- Coverage available for spouse, children and grandchildren

VPL-plus: PORTABLE AND PERMANENT

- Employee can keep policy, at same premium, if he/she retires or changes jobs
- Employee may apply for spouse, children and grandchildren at the worksite
- Permanent coverage: policy guaranteed to remain in force as long as necessary premiums are paid

VPL-plus: THE GUARANTEES EMPLOYEES WANT

- Guaranteed level premium
- Guaranteed level death benefit
- Guaranteed reduced paid-up insurance at retirement
- Guaranteed paid-up for face amount at age 70 (or after 20 years for insureds between ages 51 and 70)

¹LIMRA International, 2005

07M014-C(Expires 022809)

See the VPL-plus brochure for complete details- Form PWLSEV-NI-05

VPL-plus: CGI (EXPRESS ISSUE) UNDERWRITING

Employee, spouse coverage require 3 health and employment related questions:

- During the last six months, has the proposed insured been actively at work on a full-time basis, performing usual duties?
- During the last six months, has the proposed insured been absent from work due to illness or medical treatment for a period of more than five consecutive working days?
- During the last six months, has the proposed insured been disabled or received tests, treatment or care of any kind in a hospital or nursing home or received chemotherapy, hormonal therapy for cancer, radiation therapy, dialysis treatment or treatment for alcohol or drug abuse?

Child coverage (ages 6 months -18 years old):

- During the last six months, has the proposed insured been disabled or received tests, treatment or care of any kind in a hospital or nursing home or received chemotherapy, hormonal therapy for cancer, radiation therapy, dialysis treatment or treatment for alcohol or drug abuse?

Express Issue Maximums

- employee
 - ages 17-49, \$100,000
 - ages 50-65, \$50,000
 - ages 66-70, \$10,000
- spouse (if employee applies)
 - ages 17-49, \$50,000
 - ages 50-65, \$25,000
 - ages 66-70, \$10,000
- spouse (if employee does not apply)
 - ages 17-24 \$25,000
 - ages 25-29 \$20,000
 - ages 30-39 \$15,000
 - ages 40-44 \$10,000
 - ages 45-49 \$7,500
 - ages 50-70 \$5,000
- children - ages 6 months -18 \$25,000
- grandchildren - ages 6 months -16 \$25,000

Simplified Issue

- Use if proposed insured wants amounts over Express Issue maximums
- Coverage is dependent on answers to health-related and other questions contained in the application
- Answer all underwriting questions
- Blood required for amounts in excess of \$100,000
- Rates are unisex
- Rates are unismoke

Accelerated Death Rider

- Included on all policies (Employee, Spouse, Children, Grandchildren)
- Pays 92% of death benefit, less \$150 processing fee, upon physician-certified diagnosis of condition expected to result in death within 12 months (conditions and limitations apply)
- Percentage lower in New York and Massachusetts
- No extra charge for rider
- Policy terminates when rider is exercised

Waiver of Premium

- Available for issue ages 17-55
- Benefit payable to insured through age 60
- Cost is included in premium

VPL-plus: Review

- Permanent and portable
- Non-participating Whole Life chassis (no dividends)
- Guaranteed level death benefit
- Guaranteed level premium
- Guaranteed reduced paid-up insurance at retirement
- Premiums cease at age 70 (or after 20 years, ages 51-70)
- Accelerated Death Benefit Rider included on all policies
- Waiver of Premium available issue ages 17-55
- Express Issue underwriting
- Unisex rates
- Unismoke rates
- Blood required for amounts over \$100,000
- Simplified issue for health reasons or for amounts over Express Issue maximums

This brochure has been prepared to give you the highlights of coverage now being offered through your employer to meet your insurance needs. The details will be provided during your individual meeting with a qualified Texas Life Enrollment Representative. Those employees who wish to participate will be provided a personal policy that spells out all policy provisions.

*If you have any questions regarding your Texas Life policy, please call
(800) 283-9233 prompt #3.*

Since 1901 900 Washington Post Office Box 830 Waco, Texas 76703-0830

Continuation of Benefits

GILSBAR HEALTH CARE & DEPENDENT 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.

If you want to remain in the Plan, you can do so by selecting one of the COBRA options listed on the Health Care Reimbursement Agreement Upon Termination Form. If you prefer to terminate your participation and contribution to the Plan, any balance in your account on the date of termination will be forfeited if expenses were not incurred prior to the date of termination. For more detailed information, please call IMS at 800-426-8739.

ASSURITY / PHILADELPHIA AMERICAN (CSO) CANCER PLAN

When you leave your employment, you may continue your Philadelphia American (formerly CSO) Cancer coverage or Assurity Cancer coverage by having the premiums that are currently deducted from your paycheck billed directly to your home address or drafted from your bank account. For billing options, please call Philadelphia American at (800)554-0092 or Assurity at (866)289-7337.

AMERITAS DENTAL PLAN & DIRECT REIMBURSEMENT DENTAL PLAN

Under the Ameritas & Direct Reimbursement dental plans, you and your covered dependents are eligible to continue dental coverage through COBRA according to the following "qualifying events".

If you and your dependents are enrolled in the dental plan, you will be eligible to continue coverage through COBRA after you leave your employment with Guilford County Schools for a specified period. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents maybe eligible to continue dental coverage through COBRA. Also, while you are covered under the plan, your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA. Examples of an ineligible dependent would be when your child graduates from college, or turns 26 years old. You will receive notification from Benefit Plan Services with premium and continuation options shortly following your termination of employment. Should you have any questions you can contact Allen Peters at Benefit Plan Services (336) 889-2003.

METLIFE TERM LIFE

Conversion: If your employment terminates while you and/or your dependents are covered under the plan or when your Extended Death Benefit period is over, you may purchase without medical evidence of insurability, any individual insurance policy, except a term policy. You must apply for conversion within 31 days after the date your or your dependents' coverage terminates.

To get information and rates for converting coverage, please contact MetLife direct at 877-275-6387.

Portability: If you terminate employment, the portability provision allows you to take your optional life coverage with you, subject to the following provisions:

- You must apply for coverage with 31 days from the date your life coverage terminates
- You must be ACTIVELY at work prior to employment termination
- You may only port up to your current coverage amount. You cannot increase or add dependents
- Employees are eligible to age 74, spouses to age 64 and children up to age 18, 24 if a full-time student.

To get information and rates for porting coverage, please contact MetLife direct at 866-492-6983.

SUPERIOR VISION PLAN

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

If you and your dependents are enrolled in the vision plan, you will be eligible to continue coverage through COBRA after you leave your employment for a specified period. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents maybe eligible to continue vision coverage through COBRA. Also, while you are covered under the plan, your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA. Examples of an ineligible dependent would be when your child graduates from college, or turns 24 years old. You will receive notification from Interactive Medical Systems (IMS) with premium and continuation options shortly following your termination of employment. If you should have any questions, please call (800) 426-8739.

ASSURITY HOSPITAL INDEMNITY PLAN

When you leave your employment, you may continue your Assurity Hospital Indemnity Plan by having the premiums that are currently deducted from your paycheck billed directly to your home address or drafted from your bank account. If you have any questions, please call Assurity at (866)289-7337.

STANDARD LIFE SHORT TERM DISABILITY PLAN

When an employee leaves employment, they may continue the short term disability coverage, subject to the renewability provision, provided they maintain continuous employment. Your new occupation must be within acceptable underwriting guidelines. Coverage expires at age 65. Please contact Standard Life at (800)227-0251 to set up direct bill to your home address.

TRANSAMERICA UNIVERSAL LIFE PLAN

This product is no longer being offered through payroll deduction. When you leave your employment, you may continue your Transamerica Universal Life Plan by having the premiums that are currently deducted from your paycheck billed directly to your home address or drafted from your bank account. You should receive a letter from Transamerica or you can arrange this by contacting Transamerica at (800)706-8502, ext. 802.

TEXAS LIFE WHOLE LIFE:

When you leave employment you may continue your Texas Life coverage by having the premiums that are currently deducted from your paycheck billed to your home address or drafted from your bank account. You can arrange this by contacting Texas Life at: (800) 283-9233 prompt #3.

Important Phone Numbers:

Mark III Brokerage, Inc. - (800) 532-1044, ext. 210

Gilsbar Medical and Dependent Care - (800) 445-7227 ext. 883

Assurity Cancer and Hospital Indemnity Plan - (888) 358-8808, ext. 23

Philadelphia American Cancer Plan (Formerly CSO) - (800) 554-0092

Direct Reimbursement Dental Plan - (336) 889-2003

Ameritas Dental Plan - (800) 487-5553

Superior Vision Plan - (800) 507-3800

Interactive Medical Systems (IMS) COBRA (800) 426-8739

Benefit Plan Services COBRA (Dental Only) (336)889-2003

Standard Life STD Plan - (800) 327-0695 or (800) 227-0251

Transamerica Universal Life Plan - (800) 706-8502

Texas Life Whole Life Plan - (800) 283-9233, prompt #3

MetLife Term Life Conversions - (877) 275-6387

MetLife Term Life Portability - (866) 492-6983