

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

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

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

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*Paying for benefits by this method reduces your applicable FICA and income tax withholding resulting in increases to your take home pay.*

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*This overview of benefits is only intended to offer an outline of options. All details and contract obligations of plans are stated in the actual benefit booklets provided by the insurance companies represented. Contact your Benefit Administrator for additional information.*

## Important Points to Remember

- Plan Year: July 1, 2016 thru June 30, 2017.
- Effective date of coverage is July 1, 2016
- Rates for based on 24 deductions for certain products.
- **Allstate Benefits** - Allstate Benefits requires anyone who would like to sign up for the low, mid or high cancer plan to complete an evidence of insurability form. If interested, please make an appointment to meet with a Mark III representative.
- **AUL Short-Term Disability** - Enrollees that did not elect coverage during their initial enrollment are eligible to sign up for \$500 to \$1000 monthly benefit without medical questions. Current participants may increase their coverage up to \$500 monthly benefit without medical questions. The maximum benefit cannot exceed 70% of basic monthly earnings and must be in \$100 increments.
- **Funeral Planning Service** is part of your Aetna Term Life Plan at no additional cost. Please see booklet for more details regarding this benefit.
- Pre-taxed elections made during annual enrollment cannot be changed once the enrollment period ends unless you have a qualifying event such as marriage, divorce, death of a spouse or child, birth or adoption, termination of employment or change in employment hours from full-time to part-time or vice-versa.
- If you should have a qualifying event, you will have 30-days from the date of the qualifying event to request a change to your current benefit enrollments and FSA elections. All requests must be done in writing to Julie Crawford in the Cumberland County benefits office.
- **You must re-elect your Gilsbar Medical Spending and Dependent Care Accounts each year. They do not automatically carry-over to the next year.**
- Your existing Gilsbar account will be replenished as long as you re-elect the Medical Spending Account. Your debit card is good for 3 years from the issue date.
- Medical Reimbursement and Dependent Care expenses must be incurred during the plan year to be eligible for reimbursement.
- Any questions regarding your Gilsbar Medical Reimbursement or Dependent Care Account can be directed to [www.myGilsbar.com](http://www.myGilsbar.com), or you can call Gilsbar's Customer Contact Center at 1-800-445- 7227 ext. 883.
- Questions regarding all other benefits can be directed to Julie Crawford at 910-223-3327.

# Cumberland County: PPO Plan

Coverage Period: 07/01/2016 - 06/30/2017

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage for:** Individual/Family **Plan Type:** PPO



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

Important Questions	Answers	Why this Matters:
<b>What is the overall deductible?</b>	In-Network- <b>\$2,000</b> Individual/ <b>\$6,000</b> Family Total. Out-of-Network- <b>\$3,000</b> Individual/ <b>\$9,000</b> Family Total. Doesn't apply to In-Network preventive care. Coinsurance and copayments do not apply to the deductible.	You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <b>deductible</b> .
<b>Are there other deductibles for specific services?</b>	Yes. \$150 for prescription drugs. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific <b>deductible</b> amount before this plan begins to pay for these services.
<b>Is there an out-of-pocket limit on my expenses?</b>	Yes. In-Network- <b>\$5,000</b> Individual/ <b>\$12,000</b> Family Total. Out-of-Network- <b>\$6,000</b> Individual/ <b>\$21,000</b> Family Total.	The <b>out-of-pocket limit</b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
<b>What is not included in the out-of-pocket limit?</b>	Premiums, balance-billed charges, health care this plan doesn't cover and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
<b>Is there an overall annual limit on what the plan pays?</b>	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
<b>Does this plan use a network of providers?</b>	Yes. For a list of In-Network providers, see <a href="http://www.bcbsnc.com/">www.bcbsnc.com/</a>	If you use an in-network doctor or other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans

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

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



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost* if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
<b>If you visit a health care <b>provider's</b> office or clinic</b>	Primary care visit to treat an injury or illness	\$30/visit	30% Coinsurance	---none---
	Specialist visit	20% Coinsurance	30% Coinsurance	---none---

**Questions:** Call 1-877-275-9787 or visit us at [www.bcbsnc.com](http://www.bcbsnc.com). If you aren't clear about any of the underlined

Common Medical Event	Services You May Need	Your cost* if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
	Other practitioner office visit	\$30/Chiropractic Visit	30% Coinsurance/ Chiropractic Visit	-Coverage is limited to 30 visits for Chiropractic care.
	Preventive care/screening/immunization	No Charge	Not Covered	-Limits may apply
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	20% Coinsurance	30% Coinsurance	-No coverage for tests not ordered by a doctor.
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	30% Coinsurance	---none---
<b>If you need drugs to treat your illness or condition</b>  More information about <b>prescription drug coverage</b> is available at <a href="http://www.bcbsnc.com/content/services/formulary/presdrugben.htm">http://www.bcbsnc.com/content/services/formulary/presdrugben.htm</a>	Tier 1 Drugs	\$10/prescription	\$10/prescription	-No coverage for drugs in excess of quantity limits, or therapeutically equivalent to an over the counter drug. -For Infertility dosage limits apply -Coverage is limited to a 30 day supply -Minimum of \$50 in coinsurance but no more than \$100 for Tier 4 drugs
	Tier 2 Drugs	\$55/prescription	\$55/prescription	
	Tier 3 Drugs	\$70/prescription	\$70/prescription	
	Tier 4 Drugs	25% Coinsurance with min/max copay	25% Coinsurance with min/max copay	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	30% Coinsurance	---none---
	Physician/surgeon fees	20% Coinsurance	30% Coinsurance	---none---
<b>If you need immediate medical attention</b>	Emergency room services	20% Coinsurance	20% Coinsurance	---none---
	Emergency medical transportation	20% Coinsurance	30% Coinsurance	---none---
	Urgent care	20% Coinsurance	20% Coinsurance	---none---

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Common Medical Event	Services You May Need	Your cost* if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% Coinsurance	30% Coinsurance	-Precertification may be required
	Physician/surgeon fee	20% Coinsurance	30% Coinsurance	---none---
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	20% Coinsurance/ outpatient	30% Coinsurance/ outpatient	-Prior Authorization may be required
	Mental/Behavioral health inpatient services	20% Coinsurance	30% Coinsurance	-Precertification required
	Substance use disorder outpatient services	20% Coinsurance/ outpatient	30% Coinsurance/ outpatient	-Prior Authorization may be required
	Substance use disorder inpatient services	20% Coinsurance	30% Coinsurance	-Precertification required
<b>If you are pregnant</b>	Prenatal and postnatal care	20% Coinsurance	30% Coinsurance	-No coverage for maternity for dependent children.
	Delivery and all inpatient services	20% Coinsurance	30% Coinsurance	-Precertification may be required
<b>If you need help recovering or have other special health needs</b>	Home health care	20% Coinsurance	30% Coinsurance	-Prior authorization may be required for benefits to be provided
	Rehabilitation services	20% Coinsurance	30% Coinsurance	-Coverage is limited to 30 visits per benefit period for Rehabilitation and Habilitation services combined, for Occupational Therapy/Physical Therapy/Chiropractic and 30 visits per benefit period for Speech Therapy

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Common Medical Event	Services You May Need	Your cost* if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
	Habilitation services	20% Coinsurance	30% Coinsurance	-Coverage is limited to 30 visits per benefit period for Rehabilitation and Habilitation services combined, for Occupational Therapy/Physical Therapy/Chiropractic and 30 visits per benefit period for Speech Therapy
	Skilled nursing care	20% Coinsurance	30% Coinsurance	-Coverage is limited to 60 days per benefit period.-Precertification required
	Durable medical equipment	20% Coinsurance	30% Coinsurance	-Prior authorization may be required for benefits to be provided-Limits may apply
	Hospice services	20% Coinsurance	30% Coinsurance	-Precertification may be required
<b>If your child needs dental or eye care</b>	Eye exam	\$30/visit	Not Covered	-Limits may apply
	Glasses	Not Covered	Not Covered	Excluded Service
	Dental check-up	Not Covered	Not Covered	Excluded Service

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

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## Excluded Services & Other Covered Services:

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

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

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

\*\*Self-funded groups may cover this service; check your benefit booklet for details

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

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

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

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

## Your Rights to Continue Coverage:

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

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

## Your Grievance and Appeals Rights:

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

## Does This Coverage Provide Minimum Essential Coverage?

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

## Does This Coverage Meet the Minimum Value Standard?

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

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

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## Language Access Services:

Spanish (Español): Para obtener asistencia en español, llame al número que aparece al respaldo de su tarjeta del seguro.

Tagalog (Tagalog): Para matulungan sa Tagalog, tawagan ang numerong nasa likuran ng insurance card.

Chinese (中文): 如需國語或廣東話協助，請致電您保險卡背面的電話號碼。

Navajo (Dine): Diné bizaad bee shiká'adoowoł nínzingo kwoji' hólne', naaltsoos áłts'ísí nantinígíí bine'déé' binámboo bikáá'.

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

**Questions:** Call 1-877-275-9787 or visit us at [www.bcbsnc.com](http://www.bcbsnc.com). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at

## About these Coverage Examples:

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



**This is not a cost estimator.**

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

See the next page for important information about these examples.

### Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays** \$4,340
- **You pay** \$3,200

#### Sample care costs:

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

#### Patient pays:

Deductibles	\$2,000
Copays	\$50
Coinsurance	\$900
Limits or exclusions	\$200
<b>Total</b>	<b>\$3,200</b>

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

- **Amount owed to providers:** \$5,400
- **Plan pays** \$3,800
- **You pay** \$1,600

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$700
Copays	\$600
Coinsurance	\$200
Limits or exclusions	\$80
<b>Total</b>	<b>\$1,600</b>

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## Questions and answers about Coverage Examples:

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### What are some of the assumptions behind the Coverage Examples?

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

---

### What does a Coverage Example show?

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

---

### Does the Coverage Example predict my own care needs?

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

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### Does the Coverage Example predict my future expenses?

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

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### Can I use Coverage Examples to compare plans?

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

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### Are there other costs I should consider when comparing plans?

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

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

	<u>MONTHLY RATES</u>	<u>PER PAY PERIOD RATES</u>
Employee Only	\$51.00	\$25.50
Employee + Child	\$157.00	\$78.50
Employee + 2 Children	\$254.00	\$127.00
Employee + Spouse	\$241.00	\$120.50
Employee + Family	\$326.00	\$163.00

**DISCOUNTED RATES WITH WELLNESS FAIR PARTICIPATION**

	<u>MONTHLY RATES</u>	<u>PER PAY PERIOD RATES</u>
Employee Only	\$21.00	\$10.50
Employee + Child	\$127.00	\$ 63.50
Employee + 2 Children	\$224.00	\$112.00
Employee + Spouse	\$211.00	\$105.50
Employee + Family	\$296.00	\$148.00

# Gilsbar Flexible Spending Accounts



## Gilsbar Flexible Spending Accounts

**Medical Reimbursement Plan Maximum: \$2,550**  
**Dependent Care Account Maximum: \$5,000**

**Claims Filing Limit:** All claims for reimbursement must be submitted within 30 days following the end of the *grace period*, or if earlier, 90 days following the date you cease to participate in the *Plan*, or the claims will be denied.

Thank you for choosing to participate in the Health Care or Dependent Care FSA or HRA. Your plans are administered by Gilsbar, LLC.  
**Your group number is S2544.**

### MANAGE YOUR ACCOUNT ONLINE 24/7 AT [WWW.MYGILSBAR.COM](http://WWW.MYGILSBAR.COM)!

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

### IT'S EASY TO GET STARTED:

**STEP 1: After your effective date, go to [www.myGilsbar.com](http://www.myGilsbar.com) and register as a new participant.** You will complete a brief registration form, and you will need a valid email address and your group number, S2544.

**STEP 2: Once logged in, choose the FSAs and HRAs link 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 each time:

- 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 address and annual election(s) are accurate.** If there are any discrepancies in your account information, please contact us at (800) 445-7227 ext. 1883.

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

SUBMIT YOUR CLAIMS:	CONTACT US:
<p><b>For fastest processing, fax claims and receipts to: (866) 635-1329</b></p> <p>Mail claims and receipts to: Claims Processing Center P.O. Box 965 Covington, LA 70434</p> <p><i>(Please keep the original documents for your records.)</i></p>	<p><b>Customer Contact Center</b></p> <p><b>Phone: (800) 445-7227 ext. 1883</b> <b>Email: <a href="mailto:flex@gilsbar.com">flex@gilsbar.com</a></b></p> <p><b>7:00 a.m.-7:00 p.m. CST</b></p> <p><i>(Please do not email claims/receipts.)</i></p>



2100 Covington Centre • Covington, LA • 70433  
800.445.7227 • [www.gilsbar.com](http://www.gilsbar.com)





# Your Healthcare FSA

## WHAT IS A HEALTHCARE FSA?

Provided by your employer, a Healthcare FSA is a reimbursement account that allows you to set aside a certain amount of money each paycheck, pre-tax, to help pay for out-of-pocket medical expenses for you and your family. 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 can save an additional 20-30% on healthcare expenses.

Any employee who has eligible out-of-pocket expenses beyond what their health plan covers should enroll in the Healthcare FSA. Eligible out-of-pocket expenses are determined by the IRS and include deductibles, co-insurance, co-payments, and other non-covered expenses in excess of the maximum amounts allowed under plan.

## HOW DOES THE HEALTHCARE FSA WORK?

With an FSA, you must decide on your contribution amount at the beginning of the plan year. The amount you designate will be equally divided among 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 visits, and planned medical expenses, i.e. braces or LASIK eye surgery. An expense worksheet is provided to help you determine the amount of money to allocate to your Healthcare FSA.

The IRS requires that all money in the account be used during the plan year. Money cannot be returned to you or carried over to the following year. For this reason, it is better to underestimate your expenses at the beginning of the plan year when you decide your election amount. To help avoid this situation, you will receive a notice of your balance prior to the end of the plan year, so you can use that balance on qualified expenses prior to the last day of the current plan year.



I just saved  
**\$27.65** in taxes  
this pay period.  
That's an annual  
tax savings of  
**\$718.90!!**

Once you decide how much you want to contribute each paycheck, the money is automatically deposited into your account. As you incur expenses, you may fax a claim form and receipts to Gilsbar for reimbursement.

## HOW DOES THE HEALTHCARE FSA SAVE ME MONEY?

The following example illustrates the per pay period savings for an employee on a bi-weekly payroll with a tax status of "single" with one exemption:

	With FSA	Without FSA
<b>Salary:</b>	\$1000.00	\$1000.00
<b>Less Pre-Taxed Dollars:</b>		
Healthcare Reimbursement	-\$100.00	\$0.00
Taxable Income	\$900.00	\$1000.00
<b>Less:</b>		
Federal Income Tax (15%*)	-\$135.00	-\$150.00
State Income Tax (5%*)	-\$45.00	-\$50.00
Social Security (7.65%*)	-\$68.85	-\$76.50
<b>Net Take Home Pay:</b>	\$651.15	\$723.50
Less Healthcare Expenses	-\$0.00	-\$100.00
<b>Net After Expenses:</b>	<b>\$651.15</b>	<b>\$623.50</b>

\*Your income tax rates may vary based on your income and the state in which you reside.

## HOW EASY IS IT TO USE MY HEALTHCARE FSA?

Very easy! Visit [www.myGilsbar.com](http://www.myGilsbar.com) and log in 24/7 to access claims information and FSA balances online. Once you are logged in, select the Reimbursement Account Center link to view your personalized FSA dashboard. If you are new to myGilsbar, complete the brief site registration to log in. You will need your group number (found on your ID card), Social Security number, and a valid e-mail address to complete this section. As a registered user, you can:

- Access balance information.
- View images of receipts and claim forms online within 24 hours of receipt.
- Receive an email when the claim is received and is viewable online, and again when it is processed and posted for payment.
- View account elections, account deposits, reimbursement payments, claim status details, receipt images, and denials.
- File online appeals to denied claims.
- Receive end-of-year reminders about available account balances, and much more!



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## CAN I CHANGE MY CONTRIBUTION AMOUNT?

Generally, you may not change your FSA election during the plan year. However, you may make changes during the annual enrollment period for the coming plan year. There is one exception to this rule: you may change your contribution amount during the plan year if you have a qualifying status change. Examples include:

- Change in legal marital status
- Change in number of tax dependents
- Termination or commencement of employment
- Dependent satisfies or ceases to satisfy dependent eligibility requirements, judgment decree, or order

## MOST COMMON ELIGIBLE EXPENSES

- Dental Services
- Orthodontia/Braces
- Co-pay Amounts
- Deductibles
- Hospital Services
- Physical Therapy
- Well Baby Care
- Contact Lenses
- Lab Exams/Tests
- Insulin
- Nicotine Gum or Patches
- Prescription Drugs
- Contact Lens Solution
- Eye Examinations
- Eyeglasses
- Laser Eye Surgeries

## HEALTHCARE FSA EXPENSE WORKSHEET

The below worksheet has been prepared to help you determine the amount of money you wish to allocate to your Healthcare 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. Using this information and the worksheet, you can estimate the amount you wish to allocate, on a pre-tax basis, to your Healthcare FSA (keeping in mind to only budget for those expenses specifically eligible under your Healthcare FSA).

## HOW WILL HEALTHCARE REFORM AFFECT MY FSA?

Healthcare reform imposes stricter reimbursement rules for qualified medical expenses. The definition of qualified medical expense, for purposes of reimbursement from an FSA, has been modified to include amounts paid for medicine or a drug only if the medicine or drug is insulin or prescribed by a physician. **AS A RESULT OF THIS CHANGE, EFFECTIVE JANUARY 1, 2011, OVER-THE-COUNTER (OTC) MEDICINES (EXCEPT THOSE PRESCRIBED BY A DOCTOR) ARE NO LONGER ELIGIBLE FOR REIMBURSEMENT BY AN FSA ACCOUNT.**

HEALTHCARE EXPENSES YOU PAID LAST YEAR COULD INCLUDE:	
<b>Deductibles</b> (medical and dental) Benefit percentage/co-insurance (The amount NOT paid by your insurance)	\$ _____ \$ _____
<b>Amounts</b> paid over plan limits Over reasonable and customary allowance Over psychiatric limits Over private room allowance	\$ _____ \$ _____ \$ _____
<b>Expenses</b> NOT covered by your insurance plan Physicals Prescription Drugs Vision Care Hearing Expenses Psychiatric Care Dental and Orthodontic Care Assistance for the Handicapped Therapy / Treatments Physician's Fees / Services Medical Equipment Miscellaneous Charges	\$ _____ \$ _____
<b>My out-of-pocket healthcare expenses last year</b>	<b>TOTAL \$</b> _____
Compare last year's typical expenses to those eligible under your Healthcare FSA and budget accordingly for the upcoming year.	



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# FSA Debit Card

## What You Need To Know

### HOW DOES THE FSA DEBIT CARD WORK?

Shortly after enrolling in a Healthcare Flexible Spending Account (FSA), 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 pocket.

### 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 transactions can be verified using one of the IRS's approved electronic methods; however, not all transactions can be verified this way. 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 of transactions 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.

### HOW CAN I PROVIDE SUPPORTING DOCUMENTATION?

If you receive a substantiation request letter, please go to [www.myGilsbar.com](http://www.myGilsbar.com) to electronically upload any required receipts. For each claim requiring a receipt, click "Upload Receipt" on the far right of the Accounts Page under your Home Page and follow the instructions. (Your receipt must be in .doc, PDF, BMP, or GIF format.) Upon successful upload, the Receipt Uploaded confirmation appears: "Your receipt has been uploaded. You may upload additional receipts if needed until the claim is approved." After uploading, you may also click "View Confirmation" and print the form for your records. NOTE: If you see a "Receipts Needed" link in the Action Required section of your Home Page, click on it. A listing of any Claims Requiring Receipts will appear.

### WHERE CAN I USE MY FSA DEBIT CARD?

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

### WHAT DO I NEED TO KNOW ABOUT PAYING FOR PRESCRIPTIONS?

Effective January 1, 2011, OTC medications and drugs (other than insulin) will no longer be reimbursed by an FSA unless they are accompanied by a doctor's prescription. Medications or drugs must meet one of the following criteria to be eligible for reimbursement:

- 1) The medicine or drug requires a prescription.
- 2) The medicine or drug is available without a prescription and the individual obtains a prescription.
- 3) The medicine or drug is insulin.

### 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 who 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.



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# Your Dependent Care FSA

## WHAT IS A DEPENDENT CARE FSA?

A Dependent Care FSA is a reimbursement account that allows you to set aside a certain amount of money 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 20-30% on dependent care expenses.

## HOW DOES THE DEPENDENT CARE FSA WORK?

With a Dependent Care FSA, you must decide on your contribution amount at the beginning of the plan year. The amount you designate will be equally deducted from you each pay period. To estimate your dependent care expenses, consider your expenses from last year. An expense worksheet is provided for you to help you determine the amount of money to allocate to your Dependent Care FSA.

The IRS requires that all money in your account be used during the plan year. 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
- A child over the age of 13 who is physically or mentally incapable of self-care
- Your spouse and is physically or mentally incapable of self-care
- An elderly parent who resides with you and is physically or mentally incapable of self-care



I just saved  
**\$53.09** in taxes  
this pay period.  
That's an annual  
tax savings of  
**\$1,380.34!!**

## HOW CAN A DEPENDENT CARE FSA SAVE ME MONEY?

The following example illustrates the per pay period savings for an employee on a bi-weekly payroll with a tax status of "single" with one exemption:

	With FSA	Without FSA
<b>Salary</b>	\$1000.00	\$1000.00
<b>Less Pre-Taxed Dollars</b>		
Dependent Day Care Reimbursement	-\$192.00	\$0.00
<b>Taxable Income</b>	\$808.00	\$1000.00
<b>Less:</b>		
Federal Income Tax (15%*)	-\$121.20	-\$150.00
State Income Tax (5%*)	-\$40.40	-\$50.00
Social Security (7.65%*)	-\$61.81	-\$76.50
<b>Net Take Home Pay</b>	\$584.59	\$723.50
Less Dependent Care Expenses	-\$0.00	-\$192.00
<b>Net After Expenses</b>	<b>\$584.59</b>	<b>\$531.50</b>

\*Your income tax rates may vary based on your income and the state in which you reside.

## HOW EASY IS IT TO USE THE DEPENDENT CARE FSA?

Very easy! Visit [www.myGilsbar.com](http://www.myGilsbar.com) and log in 24/7 to access claims information and FSA balances online. Once you are logged in, select the FSA and HRA link to view your personalized FSA Home Page. If you are new to myGilsbar, complete the brief site registration to log in. You will need your group number, Social Security number, and a valid email address to complete this section. As a registered user, you can:

- Review Action Alerts that enable you to keep current on your accounts.
- File a claim online and upload receipts and other documentation
- View account balances and history
- View payments and next payment dates
- Report lost or stolen debit cards
- Review instructions to download Gilsbar's FSA Mobile App



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**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. Private school tuition (K4 and above) is not eligible for reimbursement. 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

**HOW DO I GET REIMBURSED?**

As you incur eligible expenses, you must complete a Dependent Care FSA claim form and attach proof of payment from your day care provider or from the individual who provides the care. The claim form and documentation of expense can be submitted online at [www.myGilsbar.com](http://www.myGilsbar.com) or my using the Gilsabr FSA Mobile App. Dependent Care FSA claims must include the federal tax identification number or Social Security number, name, and address of the provider, dates of service, type of service rendered, and name of dependent. The individual who provides the care cannot be your spouse or a dependent under the age of 19. With a Dependent Care FSA, you will be reimbursed as you set funds aside. If you submit a claim for more than what has been set aside for that account, the unreimbursed claim portion will be placed in “pending” status until funds are received through payroll deduction, at which time you will receive reimbursement.

**CAN I CHANGE MY ELECTION DURING THE PLAN YEAR?**

Generally, you may not change your FSA elections during the plan year unless you have a change in family status that change the benefit eligibility during the plan year. Otherwise, you may change during the annual enrollment period for the coming plan year. 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 your or your spouse's employment status
- A significant change caused by a third party in the cost of your dependent care coverage

**DEPENDENT CARE FSA EXPENSE WORKSHEET**

The worksheet below has been prepared to help you determine the amount of money you wish to allocate to your Dependent Care FSA. You may want to review your checkbook register or credit card statements from last year to identify expenses you paid out of your own pocket. Using this information and the worksheet, you can estimate the amount you wish to allocate, on a pre-tax basis, to your Dependent Care FSA (keeping in mind to only budget for those expenses specifically eligible for your Dependent Care FSA).

<b>DEPENDENT CARE EXPENSES YOU PAID LAST YEAR COULD INCLUDE:</b>	
<b>Costs of Child or Adult Care Facilities*</b>	
Day Care Center / Nursery School	\$ _____
Family Day Care / Adult Day Care Centers**	\$ _____
<b>Wages paid to a nanny or in home care provider***</b>	\$ _____
Other dependent care expenses considered eligible by the IRS	\$ _____
<b>TOTAL ESTIMATED DEPENDENT CARE EXPENSES</b>	\$ _____
Compare last year's typical expenses to those eligible under your Dependent Care FSA and budget accordingly for the upcoming year.	
* 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 your home.	
*** Please note these expenses are not eligible if the care services are provided by someone that you claim as a dependent.	





# FSA Substantiation

## Proof of Eligible Debit Card Purchases

### IRS REGULATIONS ON FSA DEBIT CARDS

The IRS sets regulations regarding how debit cards operate in conjunction with a Flexible Spending Account (FSA). According to these rules, there are five basic requirements that must be met for you to use an FSA debit card.

Participants must provide certification each year that they will only use the debit card for FSA eligible items. This is done during the enrollment process.

- The participant must retain all receipts for all transactions.
- 100% of debit card transactions must be reviewed by a third party to ensure that the items purchased are FSA eligible.
- Sampling or employee "self-certification" is not allowed.
- Debit cards can only be used at locations that are medical service providers or provide point of purchase review.

Fortunately, the IRS defines several Auto-Substantiation (electronic substantiation) methods that we can use to help with the adjudication process.

These methods are:

- **Co-pay Match** - If a transaction equals a co-pay amount or multiples of co-pay amounts under the health plan, no additional information is needed to support a card transaction.
- **Recurring Expense** - For transactions that were previously substantiated, recurring expenses will also be considered substantiated provided they are incurred with the same provider at the same location for exactly the same amount.
- **Real-Time or Merchant Substantiation** - If a transaction can be matched against real-time data at the point of purchase identifying it as a medical expense, no additional substantiation is needed.

### WHY DOES THE IRS HAVE THESE RULES? ISN'T IT MY MONEY?

Yes, the money that you put into an FSA is your money; however, in order to receive this money WITHOUT paying taxes you must follow the rules that the IRS has provided for the receipt of an FSA pre-tax reimbursement. At the present time, these rules require all administrators to verify that the money in the FSA is being used for medical care purposes.

### WHAT SHOULD I DO IF I RECEIVE A SUBSTANTIATION REQUEST?

You may receive requests for Manual Substantiation in the event that the charges do not qualify for Auto-Substantiation. If you receive a substantiation request, please go to [www.myGilsbar.com](http://www.myGilsbar.com) to electronically upload any required receipts.

For each claim that requires a receipt, click "Upload Receipt" on the far right of the Accounts Page under your Home Page, and follow the instructions. (Your receipt must be in .doc, pdf, bmp, or gif format.) Upon successful upload, the Receipt Uploaded confirmation appears: "Your receipt has been uploaded. You may upload additional receipts if needed until the claim is approved." After uploading, you may also click "View Confirmation" and print the form for your records.

NOTE: If you see a "Receipts Needed" link in the Action Required section of your Home Page, click on it. A listing of any Claims Requiring Receipts will appear.

### WHAT ARE ACCEPTABLE FORMS OF SUBSTANTIATION?

Acceptable forms of substantiation include: Explanation of Benefits (EOBs) and register/provider receipts showing the name and address of the merchant or provider, date of service, items purchased, and dollar amount charged. Credit card receipts are not an acceptable form because they are not itemized; Gilsbar cannot verify that the expense was an FSA eligible item.

### ARE PROVIDERS, PHARMACIES, HOSPITALS, ETC. REQUIRED TO PROVIDE A RECEIPT WITH SERVICE?

No, it is not a requirement that they provide a receipt, but we suggest you always ask for and collect a receipt from medical providers and facilities. If you are ever audited by the IRS, they will require these receipts for validation of purchases.

### SHOULD I KEEP COPIES OF MY RECEIPTS?

Yes, because FSAs are federally regulated accounts, we do encourage you to practice good record-keeping habits. Just like you track other items for tax purposes each year, consider your FSA documentation just as important. It is our recommendation that you keep these receipts for your personal records in addition to sending them to Gilsbar.



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# FSA/HRA Employee Portal

## Quickstart Guide

Welcome to your Gilsbar Benefit Accounts Employee Portal. This one-stop portal gives you 24/7 access to view your information and manage your Flexible Spending Account (FSA) and Health Reimbursement Arrangement (HRA). If applicable, it enables you to:

- File a claim online
- Upload receipts and track expenses
- View up-to-the-minute account balances
- View your account activity, claims and payment (reimbursement) details
- Report a lost/stolen card and request a new one
- Download forms and notifications
- Access your wellness center

### ACCESSING YOUR PORTAL

1. Visit [www.myGilsbar.com](http://www.myGilsbar.com).
2. If you have an existing myGilsbar account, log in with your user ID and password.
3. If you are new to myGilsbar, complete the brief registration to log in. You will need your Gilsbar group number, Social Security number, and a valid email address to complete this section.
4. Once logged in, click the “FSAs and HRAs” link on the left navigation panel to access your information.



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## NAVIGATING THE HOME PAGE

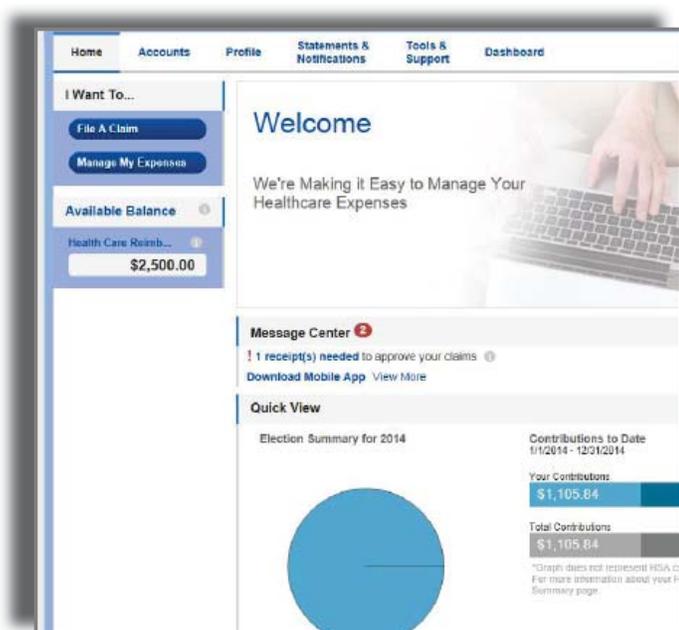
The top section of the home page has a drop-down menu with useful links for managing your accounts.

Just below the Welcome, there are links to file a claim and to manage your expenses. Your Available Balance for each of your accounts will display towards the left side of the page. Click Available Balance to view a detailed account summary.

Your account information can also be accessed through the Accounts tab. Click on each account name to view that account's details (you may need to set your browser to allow pop-ups from the site).

The Message Center displays helpful information, alerts, and relevant links. If you see a Receipts Needed link in your Message Center, click on it. A listing of any claims requiring receipts will appear.

In the Quick View section, you will see a helpful graphical summary of paid claims, elections for the current plan year, and your contributions to date.



## HOW TO FILE A CLAIM AND UPLOAD A RECEIPT

1. On the Home Page under the Accounts tab, click File Claims on the drop-down menu.
2. Enter your claim information and upload the receipt. You may also enter your mileage reimbursement information at this time. Once you have completed the form, click Add Claim.
3. You will be directed to your Claims Basket. You may choose to Add Another Claim or submit the claim(s) listed.
4. When all of your claims are added to the Claims Basket, check the box to confirm that you have read and agree to the Terms and Conditions.
5. Click Submit to send your claims for processing. The Claim Confirmation page will display. You may print the Claim Confirmation Form as a record of your submission.



# FSA/HRA Mobile App

Manage Your Accounts On-The-Go

Gilsbar is pleased to announce the release of our FSA & HRA mobile app for your iPhone, Android, and tablet devices.

With the mobile app, you can:

- Check your FSA and HRA account balances
- View account activity and receive alerts via text message
- File new claims with receipt images
- Enter a new expense and review expense information
- Upload receipts using your mobile device's camera
- Manage expense receipts
- Report a lost or stolen ID card



## DOWNLOADING THE APP

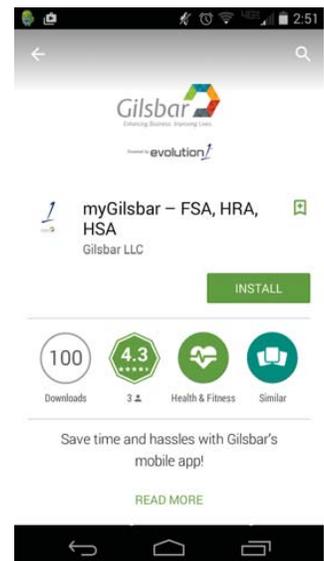


### For Apple Devices:

- Open the App Store and search for “Gilsbar FSA HRA.”
- Tap “Get” and then “Install.” You will be prompted for your Apple ID log in information. Once entered, select “OK.”
- Once the app is downloaded, tap its icon to open it on your device.

### For Android Devices:

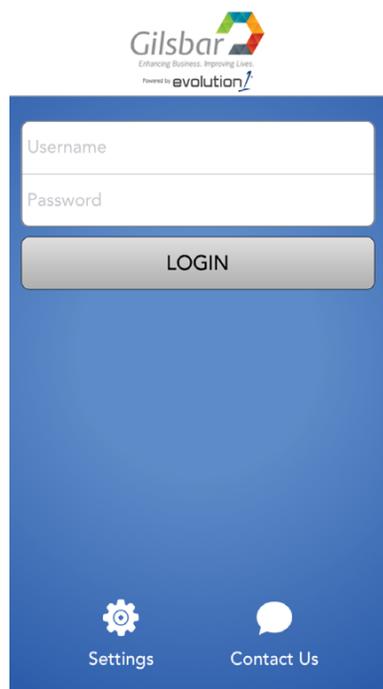
- Open the Google Play Store or Market and search for “Gilsbar FSA HRA.”
- Tap the Gilsbar app icon.
- Tap “Install” and then “OK.”
- Once the app is downloaded, tap its icon in your app list to open it on your device.



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## LOGGING INTO THE MOBILE APP



- Before you log in for the first time, you will need your participant ID number.

Your participant ID can be found in the FSA/HRA section of myGilsbar.com by clicking the arrow to the right of your name.



- Tap the Gilsbar icon to launch the app. You will be prompted to enter your username (participant ID) and password (Welcome1).
- After you enter the password, you will be prompted to set and confirm a 4-digit PIN. Each subsequent log in will require only your PIN.

If you would like assistance installing  
or logging in to the mobile app,  
please contact our Customer Contact Center!  
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## INSIDE THE MOBILE APP

Once logged in to the app, you are seconds away from managing your FSA & HRA accounts from your phone.

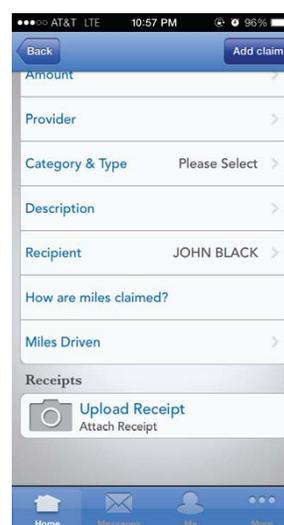
view account balances & activity



file new claims



upload & manage receipts



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# Ameritas Standard Dental Plan

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## CALENDAR 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 calendar year.

**TYPE I - PREVENTIVE AND DIAGNOSTIC** - Type I benefits are payable at 100% U&C\*. No deductible applies.

- Evaluations (Two per calendar year)
- Cleanings (Two per calendar year)
- Fluoride for Children (Under age 19)
- Space Maintainers
- Radiographs (Xrays)
- Bitewings (Two per calendar year)

**TYPE II - BASIC PROCEDURES** - Type II benefits are payable at **80-90-100%** U&C\*. \$50.00 deductible applies.

- Sealants (under 17)
- Limited Exams
- Restorative Amalgam & Resin (excluding inlays and crowns)
- Oral Surgery - Complex Extractions
- Oral Surgery - Simple Extractions
- Denture Repair
- Anesthesia

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

- Endodontics (Root Canal)
- Crowns - Stainless Steel
- Restorative
- Prosthodontics - Removable Dentures and Partial.
- Periodontics (Gum Disease)
- Prosthodontics - Fixed Pontics or Abutment

**ORTHODONTIA (INCLUDES CHILDREN & ADULTS)** - Benefits are payable at 50% U&C with a lifetime maximum of \$1,000.00. No deductible applies.

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

*\*Usual and Customary Charge*

## 100% PREVENTIVE, 80-90-100% INCENTIVE

Everyone insured on the effective date of the Company's policy begins with 100% coinsurance for Type 1 (Preventive) and 80% coinsurance level for Type II (Basic) procedures and will remain at that level until the next January 1.

If you visit a dentist during each Calendar Year and have at least one covered dental procedure performed while insured under the Company's policy, your Type II (Basic) procedures will advance to the 90% level on the following January 1 and to 100% on the next January 1. Your Type II (Basic) procedures will remain at 100% each year as long as you visit a dentist during each subsequent calendar year and have at least one covered dental procedure performed while insured under the Company's policy.

If you do not have at least one covered dental procedure performed during any calendar year while insured under the Company's policy, you will revert back to 80% coinsurance level during the next calendar year and must begin to progressively advance to the next levels as described above.

### **ANNUAL MAXIMUM BENEFIT**

- Type I, II, and III Procedures - \$1,000\* per calendar year per person.
- Orthodontia Procedures - \$1,000 Lifetime per person (carry over does not apply).

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

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 \$500.

If you meet all 3 requirements you will have an additional \$250 available in the Annual Dental Maximum for the next plan year. Plus, as a bonus, if you visit a participating network provider you will be eligible for an additional \$100 carryover. In future years if you have benefits paid of less than \$500, 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 \$2,000 in any one year.

### **ELIGIBLE EMPLOYEES**

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

### **ELIGIBLE DEPENDENTS**

Provides Coverage On:

- Your Spouse
- Children up to age 26

### **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.

### **PREDETERMINATION OF BENEFITS**

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

### **COORDINATION OF BENEFITS**

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

## CERTIFICATE OF INSURANCE

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

### 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 most 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 exams, cleanings and fluoride applications 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.

### 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.

### 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.

### LIMITATIONS/EXCLUSIONS

(This is not a complete List)

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

#### Rates (based on 24 deductions)

<b>Employee Only</b>	<b>\$16.75</b>
<b>Employee plus 1</b>	<b>\$33.81</b>
<b>Employee plus 2 or more</b>	<b>\$50.07</b>

This insurance is underwritten by Ameritas Life Insurance Corp.



**For Claims/Customer Service call Ameritas: 1-800-487-5553**  
**[www.ameritasgroup.com](http://www.ameritasgroup.com)**

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# Ameritas PPO Dental Plan

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**To access the full value of the PPO Plan, you are strongly encouraged to utilize In-Network providers. If you are not planning to utilize an In-Network Provider, do not enroll in the PPO Plan or your Out-of-Network benefits will be significantly reduced. Out-of-Network benefits will be paid based on the maximum allowable charge. If a member visits a participating provider then the deductible is waived for all procedures**

## CALENDAR 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 calendar year.

**TYPE I - PREVENTIVE AND DIAGNOSTIC** - Type I benefits are payable at 100% MAC\*. No deductible applies.

- Evaluations (Two per calendar year)
- Cleanings (Two per calendar year)
- Fluoride for Children (Under age 19)
- Space Maintainers
- Radiographs (Xrays)
- Bitewings (Two per calendar year)

**TYPE II - BASIC PROCEDURES** - Type II benefits are payable at **80-90-100%** MAC\*. \$50.00 deductible applies.

- Sealants (under 17)
- Limited Exams
- Restorative Amalgam & Resin (excluding inlays and crowns)
- Oral Surgery - Complex Extractions
- Oral Surgery - Simple Extractions
- Denture Repair
- Anesthesia

**TYPE III - MAJOR PROCEDURES** - Type III Benefits are payable at 50% MAC\*. \$50.00 deductible applies.

- Endodontics (Root Canal)
- Crowns - Stainless Steel
- Restorative
- Prosthodontics - Removable Dentures and Partial.
- Periodontics (Gum Disease)
- Prosthodontics - Fixed Pontics or Abutment

**ORTHODONTIA (INCLUDES CHILDREN & ADULTS)** - Benefits are payable at 50% MAC\* with a lifetime maximum of \$1,000.00. No deductible applies.

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

*\*Maximum Allowable Charge*

## **100% PREVENTIVE, 80-90-100% INCENTIVE**

Everyone insured on the effective date of the Company's policy begins with 100% coinsurance for Type I (Preventive) and 80% coinsurance level for Type II (Basic) procedures and will remain at that level until the next January 1.

If you visit a dentist during each Calendar Year and have at least one covered dental procedure performed while insured under the Company's policy, your Type II (Basic) procedures will advance to the 90% level on the following January 1 and to 100% on the next January 1. Your Type II (Basic) procedures will remain at 100% each year as long as you visit a dentist during each subsequent calendar year and have at least one covered dental procedure performed while insured under the Company's policy.

If you do not have at least one covered dental procedure performed during any calendar year while insured under the Company's policy, you will revert back to 80% coinsurance level during the next calendar year and must begin to progressively advance to the next levels as described above.

## **ANNUAL MAXIMUM BENEFIT**

- Type I, II, and III Procedures - \$1,000\* per calendar year per person.
- Orthodontia Procedures - \$1,000 Lifetime per person (carry over does not apply).

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

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 \$500.

If you meet all 3 requirements you will have an additional \$250 available in the Annual Dental Maximum for the next plan year. Plus, as a bonus, if you visit a participating network provider you will be eligible for an additional \$100 carryover. In future years if you have benefits paid of less than \$500, 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 \$2,000 in any one year.

## **ELIGIBLE EMPLOYEES**

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

## **ELIGIBLE DEPENDENTS**

Provides Coverage On:

- Your Spouse
- Children up to age 26

## **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 employee's 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.

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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.

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## **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.

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## **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.

## **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.

## LIMITATIONS/EXCLUSIONS

(This is not a complete List)

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

### Rates (based on 24 deductions)

Employee Only	\$14.99
Employee plus 1	\$30.27
Employee plus 2 or more	\$44.83

This insurance is underwritten by Ameritas Life Insurance Corp.



**For Claims/Customer Service call Ameritas: 1-800-487-5553**  
**[www.ameritasgroup.com](http://www.ameritasgroup.com)**



# Ameritas PPO Dental Plan

## PLAN HIGHLIGHTS

Cumberland County Government offers a second option under the Ameritas Dental Plan. The PPO Plan will mirror the current Standard Plan with a few differences:

### LOWER PREMIUMS

- Compared to the Standard Plan, the PPO Plan can save you money depending on your level of coverage.

	PER PAY		ANNUAL SAVINGS
	Standard Plan	PPO Plan	
Employee	\$16.75	\$14.99	\$42.24
Employee + 1	\$33.81	\$30.27	\$84.96
Employee + 2 or more	\$50.07	\$44.83	\$125.76

### LOWER PROCEDURE COSTS

- To access the full value of the PPO Plan, you are strongly encouraged to utilize In-Network providers. If you are not planning to utilize an In-Network Provider, do not sign up for the PPO Plan or your Out-of-Network benefits will be significantly reduced.
- All In-Network Providers have a lower negotiated rate for procedures. This not only saves you money out-of-pocket, but also allows you to get more out of your Annual Maximum Allowance.
- Please see below for examples of cost savings.

Procedure (Code)	% covered under plan <sup>1</sup>	Out-of-Network Cost <sup>2</sup>	Your Cost	In-Net-work Cost <sup>3</sup>	Your Cost	Savings <sup>4</sup>
Exam (D120)	100%	\$49	\$0	\$35	\$0	\$0
Cleaning (D1110)	100%	\$88	\$0	\$64	\$0	\$0
Filling (D2330)	80%	\$166	\$33.20	\$108	\$21.60	\$11.60
Simple Extraction (D7140)	80%	\$173	\$34.60	\$102	\$20.40	\$14.20
Crown (D6750)	50%	\$1,100	\$550	\$766	\$383	\$167
Pontic (Bridge) (D6240)	50%	\$1,100	\$550	\$750	\$375	\$175

1 - \$50 deductible per covered individual per calendar year applies for Type 2 (Basic) and Type 3 (Major) Procedures.

2 - Cost represents Usual & Customary Charges in the Fayetteville area

3 - Cost represents the Maximum Allowable Benefit for In-Network Providers

4 - Savings is your total out-of-pocket savings. You are also saving on dollars applied toward your Annual Maximum Allowance.

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# Ameritas PPO Dental FAQ

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## Commonly Asked PPO Questions

Cumberland County Government wants employees to have options regarding their dental benefits. You have a choice of enrolling in the PPO plan or the Non-PPO plan. Both plans are administered by Ameritas and the benefits in each plan are very similar. The key difference in the PPO and Non-PPO option is the decision of utilizing one of the many participating network providers or choosing to use a non-network provider when seeking dental services. Utilizing a network provider will allow greater cost savings opportunities in terms of your premium dollars as well as out of pocket costs.

### Why would I use an Ameritas PPO provider?

By using a PPO provider:

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

PPO panels are available in many areas; please visit the Ameritas website at [www.ameritasgroup.com](http://www.ameritasgroup.com) to search for a provider in your area.

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

As noted above, you have a choice of enrolling in the PPO plan or the Non-PPO plan.

If you elect to enroll in the PPO option, it is strongly advised that you and your covered dependents utilize one of the many available network providers when seeking dental services. Members enrolling in the PPO plan should absolutely utilize a participating provider for all procedures and services in order to benefit from the plan and the Maximum Allowable Charge (MAC) reimbursement tied to the PPO option.

For members enrolling in the Non-PPO option, you can choose to visit any provider. Non-panel providers will charge their standard fees and Ameritas will reimburse based on the 90th U&C. The 90th U&C reimbursement means that 9 out of 10 dentists in an area are within our reimbursement allowance. The 90th U&C is the highest in the industry and does provide a strong reimbursement.. That said, unlike the Ameritas PPO providers, non-panel providers have no specific

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

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

Or, visit the Ameritas website at:  
[www.AmeritasGroup.com](http://www.AmeritasGroup.com)

This insurance is underwritten by Ameritas Life Insurance Corp



**Customer Service**  
1-800-487-5553

**Web Address**  
[www.ameritasgroup.com](http://www.ameritasgroup.com)

# Superior Vision Plan

## Outline of Benefits Superior Vision Plan

### Co-pays:

Comprehensive Eye Exam	\$10
Materials	\$10
Contact Lens Fitting	\$25

### How to Use the Plan

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

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

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

### Benefits

	FREQUENCY	IN-NETWORK	NON-NETWORK
<b>Comprehensive Exam</b>			
Ophthalmologist	12 Months	Covered in Full	Up to \$44.00
Optometrist	12 Months	Covered in Full	Up to \$39.00
<b>Standard Lenses (per Pair):</b>			
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
Progressive	12 Months	Covered to providers retail trifocal price	Up to \$64.00
<b>Contact Lenses (Per Pair)<sup>2</sup></b>			
Medically Necessary	12 Months	Covered in Full	Up to \$210.00
Cosmetic (Elective) <sup>3</sup>	12 Months	Up to \$150.00	Up to \$100.00
<b>Contact Lens Fitting<sup>4</sup></b>			
Standard	12 Months	Covered in Full	Not Covered
Specialty	12 Months	Up to \$50.00	Not Covered
<b>Frames -Standard<sup>3</sup></b>	24 Months	Up to \$150.00	Up to \$77.00

1 All in-network and out-of-network allowances are at the retail value.

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

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

4 Standard contact lens fitting fee applies to an existing contact lens user who wears disposable, daily wear, or extended wear lenses only. The specialty contact lens fitting fee applies to new contact lens wearers and/or a member who wears toric, gas permeable, or multifocal lenses.

## Discount Features<sup>5</sup>

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

### Discounts on Covered Materials

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

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

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

## Discounts on Non-Covered Exam and Materials<sup>5</sup>

Superior Vision offers discounts on an unlimited number of materials after the member has exhausted their covered benefit.

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

## Refractive Surgery<sup>5</sup>

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

## Items or Services Not Covered

While Superior Vision offers a variety of vision benefits, there are a few materials, services, and treatments that are generally not covered, or have limitations to their coverage. We do offer discounts on many of these items, as outlined in our discount plan coverage information. For a list of these, please see your benefits administrator. Please confirm the details of your employer's plan prior to seeking services.

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

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

**Rates (based on 24 deductions)**

Employee Only	\$4.85
Employee + 1	\$9.40
Employee + Family	\$13.80

**Superior Vision Contacts**

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

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

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

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

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



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

**SUPERIOR VISION**   
See yourself healthy.

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# Allstate Benefits Group Cancer Plan

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*In the United States, about 1,596,670 new cancer cases were expected to be diagnosed in 2013. <sup>1</sup>*

## **Group Voluntary Cancer**

If you suddenly become diagnosed with cancer, it can be difficult on your family's financial and emotional stability. Having the right coverage to help when you are sick and undergoing treatment or when you cannot work is important. Our cancer insurance can help provide security when you need it most.

### **Meeting Your Needs:**

Our cancer coverage can help offer you and your family members financial support during a period of unexpected illness.

- Benefits will be paid directly to you unless otherwise assigned
- Coverage can be purchased for you and your entire family
- No evidence of insurability required at initial enrollment for new hires
- Waiver of premium after 90 days of disability due to cancer for as long as your disability lasts\*
- Includes coverage for 29 other specified diseases\*\*
- Portable coverage

### **Benefit Coverage Highlights**

Group Voluntary Cancer Insurance offers you coverage should you be diagnosed with cancer or 29 specified diseases. It helps protect you and your family 24 hours a day, seven days a week.

Each pre-packaged plan doesn't just cover you; if you choose, it also covers your dependents (which can include spouse, domestic partner and children). Our valuable coverage can help supplement your traditional medical insurance which may only cover a small portion of the non-medical expenses that can be incurred with such a diagnosis as cancer.

You and each covered family member can be sure they will receive:

- Benefits that can be used to help pay for treatment, hospital stays, transportation, and more!
- Easy enrollment without required evidence of insurability for qualified employees

A cancer diagnosis can mean unforeseen expenses that may be difficult to pay. Hospital stays, medical or surgical treatments, and transportation by air or ground ambulance can add up quickly and be very costly. Our Group Voluntary Cancer Supplemental Insurance can help offset some of the expenses your health insurance may not cover, so you can focus on getting well.

*\*Primary insured only*

*\*\*List of covered disease on the following page*

*<sup>1</sup> Cancer Facts & Figures, American Cancer Society, 2013*

**In the U.S., men have slightly less than a 1 in 2 lifetime risk of developing cancer, for women, the risk is a little more than 1 in 3.<sup>2</sup>**

### ***Your Benefit Coverage***

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

### ***Specified Diseases***

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

### ***Continuous Hospital Confinement***

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

### ***Government or Charity Hospital***

**A \$100 benefit will be paid** for each day a covered person is confined to:

- (1) a hospital operated by or for the U.S. Government (including the Veteran's Administration);
- (2) a hospital that does not charge for the services it provides (charity). This benefit is paid in lieu of all other benefits in the policy (except Waiver of Premium Benefit).

### ***Surgery***

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

### ***Second Opinion***

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

### ***Physical or Speech Therapy***

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

### ***Anesthesia***

**25% of the surgery benefit will be paid** for anesthesia.

### ***Ambulatory Surgical Center***

**A \$500 benefit will be paid** for a surgical procedure covered under the surgery benefit at an ambulatory surgical center.

### ***Radiation/Chemotherapy for Cancer***

**Up to a \$10,000 (Low and Mid) or \$20,000 (High) benefit will be paid** per 12-month period for radiation therapy and chemotherapy received by a covered person. This benefit pays the actual cost and is limited to the amount shown per 12-month period beginning with the first day of benefit under

<sup>2</sup> *Cancer Facts & Figures, American Cancer Society, 2013*

this provision. Administration of radiation therapy or chemotherapy other than by medical personnel in a physician's office or hospital, including medications dispensed by a pump, will be limited to the costs of the drugs only, subject to the maximum amount payable per 12-month period.

### ***Anti-Nausea Benefit***

**Up to a \$200 benefit will be paid** per calendar year for the actual cost of anti-nausea medication prescribed for a covered person by a physician in conjunction with cancer or specified disease treatment. This benefit does not pay for medication administered while the covered person is an inpatient.

### ***Inpatient Drugs and Medicine***

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

### ***Hematological Drugs***

**Up to a \$200 (Low and Mid) or \$400 (High) benefit will be paid** per year for the actual cost of drugs intended to boost cell lines such as white blood cell counts, red blood cell counts and platelets. This benefit is paid only when the Radiation/Chemotherapy for Cancer benefit is paid.

### ***Medical Imaging***

**Actual cost up to a \$500 (Low and Mid) or \$1,000 (High) benefit will be paid** per calendar year if a covered person receives an initial diagnosis or follow-up evaluation based upon one of the following medical imaging exams: CT scan, Magnetic Resonance Imaging (MRI) scan, bone scan, thyroid scan, Multiple Gated Acquisition (MUGA) scan, Positron Emission Tomography (PET) scan, transrectal ultrasound, or abdominal ultrasound. This benefit is limited to 1 payment per calendar year per covered person.

### ***Private Duty Nursing Services***

**A \$100 benefit will be paid** per day while hospital confined, if a covered person requires the full-time services of a private nurse. Full-time means at least 8 hours of attendance during a 24-hour period. These services must be required and authorized by a physician and must be provided by a nurse.

### ***New or Experimental Treatment***

**Actual charges up to a \$5,000 benefit will be paid** per 12-month period, for new or experimental treatment. New or experimental treatment is covered for cancer and specified disease when: the treatment is judged necessary by the attending physician and no other generally accepted treatment produces superior results in the opinion of the attending physician. This benefit is limited to the maximum shown per 12-month period beginning with the first day of treatment under this provision. This benefit does not pay if benefits are payable for treatment covered under any other benefit in the Schedule of Benefits.

### ***Blood, Plasma, and Platelets***

**Up to a \$10,000 (Low and Mid) or \$20,000 (High) benefit will be paid** per 12-month period for the actual cost of blood, plasma and platelets (including transfusions and administration charges), processing and procurement costs and cross-matching. Does not pay for blood replaced by donors or immunoglobulins.

### ***Physician's Attendance***

**A \$50 benefit will be paid** for a visit by a physician during hospital confinement. Benefit is limited to one visit by one physician per day of hospital confinement. Admission to the hospital as an inpatient is required.

### ***At Home Nursing***

**A \$100 benefit will be paid** per day for private nursing care and attendance by a nurse at home. At-home nursing services must be required and authorized by the attending physician. Benefit is limited to the number of days of the previous continuous hospital confinement.

### ***Prosthesis***

**Up to a \$2,000 benefit will be paid** per amputation, per covered person for the actual charges for prosthetic devices which are prescribed as a direct result of surgery and which require surgical implantation.

### ***Hair Prosthesis***

**A \$25 benefit will be paid** every 2 years for a wig or hairpiece if the covered person experiences hair loss.

### ***Nonsurgical External Breast Prosthesis***

**Up to a \$50 benefit will be paid** for the actual cost of the initial, nonsurgical breast prosthesis following a covered mastectomy or partial mastectomy that is paid for under the policy.

### ***Ambulance***

**A \$100 benefit will be paid** per continuous hospital confinement for transportation by a licensed ambulance service or a hospital-owned ambulance to or from a hospital in which the covered person is confined.

### ***Hospice Care***

**A \$100 benefit will be paid** for one of the following when a covered person has been diagnosed by a physician as terminally ill as a result of cancer or specified disease, is expected to live 6 months or less and the attending physician has approved services:

(1) Freestanding Hospice Care Center – A benefit will be paid per day for confinement in a licensed freestanding hospice care center. Benefits payable for hospice centers that are designated areas of hospitals will be paid the same as inpatient hospital confinement; or

(2) Hospice Care Team – A benefit will be paid per visit, limited to 1 visit per day, for home care services by a hospice care team. Home care services are hospice services provided in the patient's home. Benefit is payable only if: (a) the covered person has been diagnosed as terminally ill; and (b) the attending physician has approved such services. Does not pay for: food services or meals other than dietary counseling, services related to well-baby care, services provided by volunteers, or support for the family after the death of the covered person.

### ***Extended Care Facility***

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

### ***Outpatient Lodging***

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

### ***Non-Local Transportation***

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

accompany or visit the person receiving treatment, visits to a physician's office or clinic, or for services other than actual treatment.

### ***Family Member Lodging and Transportation***

**Up to a \$50 benefit per day will be paid for lodging and \$0.40 per mile or the actual cost of round trip coach fare on a common carrier will be paid** for one adult member of the covered person's family to be near the covered person, when a covered person is confined in a non-local hospital for specialized treatment.

(1) Lodging - This benefit is for a single room in a motel, hotel, or other accommodations acceptable to Allstate Benefits. Benefit is limited to 60 days for each period of continuous hospital confinement.

(2) Transportation - Benefit is limited to 700 miles per continuous hospital confinement if traveling in personal vehicle. Mileage is measured from the visiting family member's home to the hospital where the covered person is confined. Does not pay the Family Member Transportation Benefit if the personal vehicle transportation benefit is paid under the Non-Local Transportation Benefit, when the family member lives in the same city or town as the covered person.

### ***Waiver of Premium (primary insured only)***

If while coverage is in force the insured employee becomes disabled due to cancer first diagnosed after the effective date of coverage and remains disabled for 90 days, Allstate Benefits pays premiums due after such 90 days for as long as the insured employee remains disabled.

### ***Bone Marrow or Stem Cell Transplant\****

**A 1. \$1,000\*, 2. \$2,500\*, 3. \$5,000\* benefit will be paid** for the following types of bone marrow or stem cell transplants performed on a covered person.

(1) A transplant which is other than non-autologous.

(2) A transplant which is non-autologous for the treatment of cancer or specified disease, other than Leukemia.

(3) A transplant which is non-autologous for the treatment of Leukemia.

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

## ***ADDITIONAL BENEFITS***

### ***Wellness***

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

## ***OPTIONAL BENEFITS***

### ***Cancer Initial Diagnosis (First Occurrence)***

**A one time benefit of \$3,000 (Low and High) or \$10,000 (Mid) benefit will be paid** when a covered person is diagnosed for the first time in their life as having cancer other than skin cancer. The first diagnosis must occur after the effective date of coverage for that covered person. Benefit is payable only once per covered person.

### ***Intensive Care (Low and High Plans Only)\*\****

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

- (1) **Hospital Intensive Care Unit Confinement \$600\*** - This benefit is for hospital intensive care unit confinement for any illness or accident.
- (2) **Step-Down Hospital Intensive Care Unit Confinement \$300\*** - This benefit is for step-down hospital intensive care unit confinement for any illness or accident.
- (3) **Ambulance - Allstate Benefits pays the actual charges for transportation of a covered person** by licensed air or surface ambulance service to a hospital for admission to an intensive care unit for a covered confinement. This benefit is not paid if an ambulance benefit is paid under the Ambulance benefit in the policy.

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

**Issue Ages: 18 and older while actively at work.**

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

**Eligibility** - Family members eligible for coverage include: you, your spouse or domestic partner; and your children.

**Portability Privilege** - Allstate Benefits will provide portability coverage, subject to these provisions. Such coverage will not be available for you, unless: coverage under the policy terminates under the General Provision entitled "Termination of Coverage," we receive a written request and payment of the first premiums for the portability coverage not later than 63 days after such termination and the request is made for that purpose. No portability coverage will be provided to you, if your insurance under the policy terminated due to your failure to make required premium payments.

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

Allstate Benefits will provide coverage for a payable claim incurred while you are covered under the policy. If your spouse is a covered person, the spouse's coverage ends upon valid decree of divorce or your death. If your domestic partner is a covered person, the domestic partner's coverage ends upon termination of the domestic partnership or your death. If your child is a covered person, the child's coverage ends when the child reaches age 26, unless he or she continues to meet the requirements of an eligible dependent.

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

- Dependent coverage continues as long as the coverage remains in force and the dependent remains in such condition. Proof of the incapacity and dependency of the child must be furnished within 60 days of the child's attainment of the limiting age of eligibility. Thereafter, such proof must be furnished as frequently as may be required, but no more frequently than annually after the child's attainment of the limiting age for eligibility. If Allstate Benefits accepts a premium for coverage extending beyond the date, age or event specified for termination as to a covered person, such premium will be refunded, coverage will be refunded, coverage will terminate and claims will not be paid.

**\*\*This benefit is not disease-specific and pays a benefit for covered confinement in a hospital intensive-care unit for any covered illness or accident from the first day of coverage.**

**Low Option without Optional Benefits**

<b>Insureds</b>	<b>Rates (based on 24 deductions)</b>
<i>Employee</i>	<b>\$10.04</b>
<i>Employee + Child(ren)</i>	<b>\$13.86</b>
<i>Employee + Spouse</i>	<b>\$15.48</b>
<i>Family</i>	<b>\$19.29</b>

**Low Option with Optional Benefits**

<b>Insureds</b>	<b>Rates (based on 24 deductions)</b>
<i>Employee</i>	<b>\$13.03</b>
<i>Employee + Child(ren)</i>	<b>\$18.41</b>
<i>Employee + Spouse</i>	<b>\$20.75</b>
<i>Family</i>	<b>\$26.12</b>

**Mid Option with \$10,000 Initial Diagnosis Benefit**

<b>Insureds</b>	<b>Rates (based on 24 deductions)</b>
<i>Employee</i>	<b>\$14.88</b>
<i>Employee + Child(ren)</i>	<b>\$21.08</b>
<i>Employee + Spouse</i>	<b>\$23.51</b>
<i>Family</i>	<b>\$29.70</b>

**High Option without Optional Benefits**

<b>Insureds</b>	<b>Rates (based on 24 deductions)</b>
<i>Employee</i>	<b>\$15.55</b>
<i>Employee + Child(ren)</i>	<b>\$21.83</b>
<i>Employee + Spouse</i>	<b>\$23.76</b>
<i>Family</i>	<b>\$30.02</b>

**High Option with Optional Benefits**

<b>Insureds</b>	<b>Rates (based on 24 deductions)</b>
<i>Employee</i>	<b>\$18.54</b>
<i>Employee + Child(ren)</i>	<b>\$26.38</b>
<i>Employee + Spouse</i>	<b>\$29.03</b>
<i>Family</i>	<b>\$36.85</b>

**Pre-Existing Condition, Exclusions and Limitations** - We do not pay for any benefit due to, or caused by, a pre-existing condition, as defined, during the 12-month period beginning on the date that person became a covered person. This exclusion will not apply to your newborn child, adopted child or foster child under the age of 18 if Allstate Benefits is notified within 31 days of the child's birth or date of placement. A Pre-Existing Condition is a disease or physical condition for which medical advice or treatment was recommended or received from a member of the medical profession within the 12-month period prior to the effective date of coverage. Allstate Benefits does not pay for any loss except for losses due directly from cancer or specified disease. We do not pay for any other conditions or diseases caused or aggravated by cancer or a specified disease. Diagnosis must be submitted to support each claim. For the Surgery, New or Experimental Treatment and Prosthesis Benefits, if specific charges are not obtainable as proof of loss, Allstate Benefits will pay 50% of the applicable maximum for the benefits payable. Treatment must be received in the United States or its territories.

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

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

**The policy is Limited Benefit Cancer and Specified Disease Insurance.** This is not a Medicare Supplement Policy. If eligible for Medicare, review Medicare Supplement Buyer's Guide available from American Heritage Life Insurance Company. Subject to COBRA continuation of coverage.

This material is valid as long as information remains current, but in no event later than March 1, 2018. Group Cancer and Specified Disease benefits are provided by policy GVCP3, or state variations thereof. This brochure highlights some features of the policy but is not the insurance contract. Only the actual policy provisions control. The policy sets forth in detail, the rights and obligations of both the policyholder (employer) and the insurance company. For complete details, contact your Allstate Benefits Representative. This is a brief overview of the benefits available under the Group Voluntary Policy underwritten by American Heritage Life Insurance Company. Details of the insurance, including exclusions, restrictions and other provisions are included in the certificate issued.

*This coverage does not constitute comprehensive health insurance coverage (often referred to as "major medical coverage") and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.*

**Allstate Benefits is the marketing name used by American Heritage Life Insurance Company (Home Office, Jacksonville, FL), a subsidiary of The Allstate Corporation.**

**Allstate Benefits, The Workplace Marketer ©  
1776 American Heritage Life Drive, Jacksonville, Florida 32224**

**Customer Care Center: 1.800.521.3535  
www.allstate.com or AllstateBenefits.com**



**Allstate**  
Benefits

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# AUL / One America Short-Term Disability Plan

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

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

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

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

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

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

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

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

1 National Safety Council, Injury Facts, 2003 Edition

2 American Cancer Society, Cancer Facts & Figures 2004

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

4 American Lung Association, Lung Disease Data 2003

5 National Underwriter, May 2002

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

### ***Class Description***

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

### ***Disability***

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

### ***Monthly Benefit***

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

### ***Elimination Period***

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

### ***Benefit Duration***

This is the period of time that benefits will be payable for disability. You can choose a maximum STD benefit duration, if continually disabled, of thirteen (13) weeks, twenty-six (26) weeks or fifty-two (52) weeks.

### ***Basis of Coverage***

24 hour coverage, on or off the job.

### ***Maternity Coverage***

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

### ***STD Pre-Existing Condition Exclusion***

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

### ***Recurrent Disability***

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

### ***Annual Enrollment***

Employees who did not elect coverage during their initial enrollment period are eligible to sign up for \$500 to \$1000 monthly benefit without medical questions, subject to pre-existing exclusion. Employees may increase their coverage up to \$500 monthly benefit without medical questions. The maximum benefit cannot exceed 70% of basic monthly earnings and must be in \$100 increments. The pre-existing exclusion will apply to the increased benefit amount.

Employees that elect to increase their Benefit Duration may do so only during the annual enrollment period subject to the pre-existing exclusion. The pre-existing exclusion will apply to the increased benefit duration.

### ***Portability***

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

**Exclusions and Limitations**

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

**AUL Life Short-Term Disability Rates (based on 24 deductions)**

Benefit Duration: 13 Weeks		Benefit Duration: 26 Weeks		Benefit Duration: 52 Weeks	
Monthly Benefit	Rates	Monthly Benefit	Rates	Monthly Benefit	Rates
\$500	\$5.18	\$500	\$7.50	\$500	\$9.86
\$600	\$6.21	\$600	\$9.00	\$600	\$11.83
\$700	\$7.25	\$700	\$10.50	\$700	\$13.80
\$800	\$8.28	\$800	\$12.00	\$800	\$15.77
\$900	\$9.32	\$900	\$13.50	\$900	\$17.74
\$1,000	\$10.36	\$1,000	\$15.00	\$1,000	\$19.72
\$1,100	\$11.39	\$1,100	\$16.50	\$1,100	\$21.69
\$1,200	\$12.43	\$1,200	\$18.00	\$1,200	\$23.66
\$1,300	\$13.46	\$1,300	\$19.50	\$1,300	\$25.63
\$1,400	\$14.50	\$1,400	\$21.00	\$1,400	\$27.60
\$1,500	\$15.53	\$1,500	\$22.50	\$1,500	\$29.57
\$1,600	\$16.57	\$1,600	\$24.00	\$1,600	\$31.54
\$1,700	\$17.60	\$1,700	\$25.50	\$1,700	\$33.52
\$1,800	\$18.64	\$1,800	\$27.00	\$1,800	\$35.49
\$1,900	\$19.67	\$1,900	\$28.50	\$1,900	\$37.46
\$2,000	\$20.71	\$2,000	\$30.00	\$2,000	\$39.43

**Customer Service**  
1.800-553-5318

**Disability Claims**  
Phone: 1-855-517-6365  
Fax: 1-844-287-9499

**Disability Claims Email:** [OneAmerica.claims@customdisability.com](mailto:OneAmerica.claims@customdisability.com)

**Website:** [www.employeebenefits.aul.com](http://www.employeebenefits.aul.com)



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

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# Aetna Term Life and AD&D Insurance Plan

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**Policy Effective Date: When approved by Aetna Life Insurance Company**

## **BASIC EMPLOYEE LIFE AND AD&D INSURANCE**

This plan will pay as a Life Insurance benefit the amount of Life Insurance in force for you if you die while insured. You name your beneficiary.

## **ACCIDENTAL DEATH AND DISMEMBERMENT**

Benefits under this coverage are payable as described in your certificate. All active employees have Basic Accidental Death and Dismemberment coverage.

## **OPTIONAL EMPLOYEE LIFE INSURANCE**

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

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

## **OPTIONAL DEPENDENT LIFE INSURANCE**

Provides coverage on:

- Your Spouse
- Child(ren) from 14 days of age to age 19 (to age 26 if wholly dependent upon you for maintenance and support **and** if enrolled as a full-time student in an accredited school or college). Handicapped children can continue to be covered with no age limit, as long as the child is covered prior to age 19 or to age 26 if a full-time student.

***(It is your responsibility to notify the benefits office in writing when a dependent is ineligible for coverage. Examples of ineligible dependent status are divorce or a child graduates from college).***

## **FEATURES**

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

## **ELIGIBILITY**

You will be eligible for this program if you are an active employee that works 20 hours or more per week.

## **ENROLLMENT**

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

## **BENEFICIARY**

You have the right to designate the beneficiary of your choice under employee coverage. The beneficiary elected on your life enrollment form designates your beneficiary for basic and optional coverage. You are automatically the beneficiary under Dependent Life. It is your responsibility to update the beneficiary designation as needed.

## **WHEN YOUR INSURANCE STARTS**

Your Basic Employee Life Insurance becomes effective on the date of your eligibility if you are then actively at work; otherwise, on the day you return to active work. Your Optional Employee Life Insurance will become effective on the date of your eligibility if you are then actively at work: otherwise, on the day you return to active work.

If you enroll in Optional Dependent Life Insurance, that coverage will become effective on the date your Optional Employee Life Insurance becomes effective, provided the dependent is performing the usual and customary duties or activities of an individual in good health and of the same age and sex. If you or any dependents do not apply for Optional Employee Life Insurance and/or Optional Dependent Life Insurance within 31 days from date of hire, that person will not become insured until such person has furnished medical evidence of insurability satisfactory to Aetna Life Insurance Company.

## **TERMINATION OF COVERAGE**

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

## **DISABILITY**

Your insurance may be continued during your disability provided the premium payments continue, and the policy remains in force. However, your insurance will be subject to reduction as shown under “Reductions at ages 65 & Over” below.

## **REDUCTIONS AT AGE 65 AND OVER**

If you remain in active service beyond age 65 your combined amount of Basic Life, Optional Employee Life, and Spouse Insurance will reduce as follows:

<b><u>Attained Age</u></b>	<b><u>Percent of Original Amount</u></b>
65	65%
70	40%
75	30%
80	25%

## **CONVERSION**

If your employment terminates while you are covered under the plan, you may purchase without medical evidence of insurability, an individual insurance policy, except a term policy, issued by Aetna Life Insurance Company in any amount up to the amount of your coverage in effect on your date of termination. You must apply for this policy within 31 days after the date your coverage terminates.

This privilege applies to Supplemental Employee Life Insurance and Dependent Life Insurance as well as the Basic Employee Life Insurance.

## **PORTABILITY**

If you terminate your employment, the portability provision allows you and your dependent spouse & children to take the optional life coverage with you, subject to the following provisions:

- You must apply for coverage within 31 days from the date your life coverage terminates.
- You must be actively at work prior to employment termination. Retirees & disabled employees are not eligible.
- Dependents are eligible for portable coverage if the employee participates.
- You may only port up to your current coverage amount.
- You cannot increase coverage or add new dependents.
- Employees are eligible up to age 98, spouses up to age 64 and children up to age 18, age 22 if a full-time student.
- The minimum and maximum amounts to port are as follows:
  - Employee: \$5,000 / \$100,000
  - Spouse: \$1,000 / \$10,000
  - Children: \$1,000 / \$5,000

## **SUICIDE EXCLUSION**

No optional employee life benefits are payable if you commit suicide within two years from the effective date of the coverage.

## **ACCELERATED DEATH BENEFIT (ADB)**

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

## **CLAIMS PROCEDURE**

Claim forms needed to file for benefits under the group insurance program can be obtained from your employer who will also be ready to answer questions about the insurance benefits and to assist in filing claims. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully. If there is any question about a claim payment, an explanation can be requested from your employer, who is usually able to provide the necessary information.

## **GROUP POLICY AND CERTIFICATE**

The insurance briefly described in this folder is subject to the terms and conditions of the Group Policy issued by Aetna Life Insurance Company. If you become insured, you will receive a certificate outlining your benefits under this policy.

## **PLAN SPONSOR**

Cumberland County Government  
117 Dick Street  
Fayetteville, NC 28302-1829  
(910) 678-7700

**SCHEDULE OF BENEFITS**

**BASIC EMPLOYEE LIFE INSURANCE AND AD&D**

All eligible employees. . . . . \$5,000\* (No cost to you)

\*See "Reductions at age 65 & Over."

**OPTIONAL LIFE INSURANCE**

Your choice of the following amounts:

\$100,000, \$90,000, \$80,000, \$70,000, \$60,000, \*\*\$50,000, \$40,000, \$30,000, \$20,000 or \$10,000

\*See "Reductions at age 65 & Over."

\*\*To be eligible for more than \$50,000 of coverage you must furnish medical evidence of insurability satisfactory to Aetna Life Insurance Company.

**OPTIONAL DEPENDENT LIFE INSURANCE**

\$10,000 on your spouse

\$5,000 on each of your eligible children

**YOUR MONTHLY COST**

<u>Optional Employee Life Insurance</u>	<u>Monthly Payroll Deduction</u>
\$100,000	\$25.00
\$90,000	\$22.50
\$80,000	\$20.00
\$70,000	\$17.50
\$60,000	\$15.00
\$50,000	\$12.50
\$40,000	\$10.00
\$30,000	\$7.50
\$20,000	\$5.00
\$10,000	\$2.50
<u>Optional Dependent Life Insurance*</u>	
Family Coverage	\$3.20
Spouse Only Coverage	\$2.30
Child(ren) Only Coverage	\$ .90

\*Optional Dependent Life Insurance is available only to those eligible employees who are insured for Optional Employee Life Insurance.

**Customer Service/Conversion: 800-523-5065**

**Portability: 800-826-7448**

**Evidence of Insurability Inquiries: 800-660-9913**

**This insurance is underwritten by Aetna Life Insurance Company.**

*This brochure has been prepared to give you the highlights of coverage now being offered by Cumberland County Government to meet your insurance needs. For details, please refer to the certificate of insurance that you will receive after you have signed up for protection.*

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# Unum Whole Life Plan

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## AFFORDABLE INSURANCE PROTECTION

Unum's Voluntary Whole Life Insurance can help provide the insurance protection you need, while also giving you the financial flexibility you want. This policy is designed to provide a death benefit to your beneficiaries if you pass away in addition to the life insurance coverage your employer may already be providing for you. This coverage is available to all eligible employees, ages 15-80 who are actively at work. For an affordable premium, you can help provide more financial protection for your family — now and into the future.

You may have two premium payment options:

1. A "paid-up at age 70" option is available if you are between ages 15 and 50. You pay an adjusted premium so the policy will be paid in full by age 70. You will continue to receive coverage without having to pay any more premiums.
2. Lifetime premium option. Coverage continues as long as premiums are paid.

## LIVING BENEFIT OPTION INCLUDED

This feature is automatically included in all policies. It provides the option of requesting up to 100% of the policy's death benefit, to a maximum of \$150,000, if the insured is diagnosed with a terminal illness limiting life expectancy to 12 months or less.. If you have to face a terminal illness, this option can provide financial assistance during a difficult time. Any payout of this benefit would reduce the death benefit.

## CONVENIENT PAYROLL DEDUCTION

Your premiums are automatically deducted from your paycheck, so you don't have to worry about writing checks or mailing payments.

## NO PHYSICALS REQUIRED

If you are actively at work<sup>1</sup>, you may apply for coverage by completing an application and no physical exams are required! Your coverage becomes effective on the first day of the month in which payroll deductions begin. This means that you will receive the plan and coverage amount you applied for on the application unless it is determined to be unacceptable under Unum's rules, limits or standards. In such event, the plan and coverage amount may be modified or declined. Coverage may be subject to medical underwriting approval.

## INDIVIDUALLY OWNED

If you leave your company, you can take your policy with you and still pay the same premium. Instead of paying your premiums through payroll deduction, Unum will bill you directly at home.

## CASH VALUE ACCUMULATION FEATURE

Voluntary Whole Life Insurance accumulates cash value based on a guaranteed interest rate of 4.5%.

## ADDITIONAL FEATURES

### ACCIDENTAL DEATH BENEFIT RIDER

- Available at initial enrollment to employees and spouses ages 15-65.
- Provides an additional death benefit equal to the face amount, up to a maximum of \$150,000, if the insured dies as a result of a covered accident before age 70.

- Under certain conditions, the benefit will double if death occurs from accidental bodily injuries sustained while the insured is a fare-paying passenger via commercial transportation.
- Benefits increase by 25% if death occurs from accidental bodily injury while insured is driving or riding in a non-commercial automobile while wearing a seat belt.

## FAMILY COVERAGE

- Spouse Coverage

Whole Life coverage is available for your spouse (ages 15-80) based on a qualifying health question. However, no physical exams are required and coverage is available even if you don't apply for coverage yourself. A few additional health questions may be asked based on the level of coverage being applied for.

- Children's Standalone Coverage

A standalone insurance policy is available to eligible children, stepchildren, legally adopted children and grandchildren between the ages of 14 days and 26th birthday who reside in the United States. Coverage is available even if you decide not to purchase coverage for yourself.

## LONG TERM CARE RIDER

If you're like most people, you've heard how important it is to prepare for your future and that of your family. You may have acquired a home, built a savings nest egg, begun contributing to retirement funds, and even made plans and preparations for your children's education. But is that enough? Are you financially prepared to cover the expenses of long term care should you or your spouse become ill or disabled, or need special medical treatment as you get older?

A Long Term Care rider is available; please see your benefit representative for more information.

**Life is unpredictable. But you can take steps to help protect your family now and into the future with Unum's Whole Life insurance. Ask your benefits representative for more information and apply today!**

## FREQUENTLY ASKED QUESTIONS

### **Am I required to participate in this coverage?**

No. Your coverage is voluntary, and you decide if it is right for you and your family's needs. It's your choice.

### **Who becomes the owner of the policy?**

Unum's Whole Life Insurance policy is just that - voluntary and individual. This means that electing coverage is optional, and if you decide coverage is right for you, then you become the owner of your policy.

### **Does this policy automatically replace any of my existing group insurance coverage?**

No. Whole Life Insurance is a supplemental insurance policy and can enhance your group coverage.

### **May I increase my coverage in the future?**

Yes, your coverage can be increased to meet your changing needs. Once you have owned your policy for one year, you may apply for additional coverage up to the maximum amount available for your age. A new policy will be issued for the amount of the increase at your attained age.

**May I insure my spouse and/or my children even if I don't participate in this plan?**

Yes, coverage is available for your spouse and children even if you choose not to purchase coverage for yourself. Certain minimal underwriting requirements may apply. Ask your benefits representative for more details during enrollment.

**May I take a loan on my policy?**

Yes, you may borrow part of your cash value from the policy at an annual interest rate of 8.0% per year. Any loan taken will affect the cash value on the policy.

**Who can I contact if I have questions about my policy after enrolling?**

During enrollment, a benefits representative will be available one-on-one to answer any questions you may have about Whole Life Insurance. If you have questions about your policy after enrolling, simply pick up the phone and call Unum at 1-800-635-5597.

<sup>1</sup>Being "actively at work" means on the day the employee applies for coverage, the individual must be working at one of his/her company's business locations; or the individual must be working at a location where he/she is required to represent the company. If applying for coverage on a day that is not a scheduled workday, the employee will be considered actively at work as of his/her last scheduled workday. Employees are not considered actively at work if they are on a leave of absence.

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form L-21848 or contact your Unum representative.

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Employees must be U.S. or Canadian citizens, or have a green card, to receive coverage. Spouses and dependents must live in the U.S. to receive coverage.

Unum complies with all state civil union and domestic partner laws when applicable.

Underwritten by Provident Life and Accident Insurance Company, Chattanooga, Tennessee

Underwritten by  
Provident Life and Accident Insurance Company  
1 Fountain Square, Chattanooga, TN 37402

unum.com  
1-800-635-5597



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# Continuation of Benefits

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## **GILSBAR MEDICAL & DEPENDENT CARE REIMBURSEMENT ACCOUNTS**

If you have a positive balance (payroll deductions are greater than the amount you have received in reimbursement) in your Medical Reimbursement Account at the time of your termination, you may continue participation in the Plan for the remainder of the Plan year through COBRA by contacting **Interactive Medical Systems (IMS) at (800) 426-8739 ext: 3130.**

If you prefer to terminate your participation and contribution to the Plan, any balance in your account on the date of termination will be forfeited if claims were not incurred prior to the date of termination. To obtain your balance, please call **Gilsbar at 800-445-7227, ext. 883.**

## **BLUECROSS / BLUESHIELD HEALTH PLAN**

Under the BlueCross/BlueShield health plan, you and your covered dependents are eligible to continue coverage through COBRA according to the following “qualifying events”.

If you and your dependents are enrolled in the health 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 health 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. You will receive notification with premium and continuation options shortly following your termination of employment. Should you have any questions you can contact **Interactive Medical Systems (IMS) at (800) 426-8739 ext: 3130.**

## **AMERITAS DENTAL PLAN**

Under the dental plan, 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 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. To continue coverage thru COBRA, your employer would notify IMS of your termination and IMS will then send you a letter regarding COBRA. Should you have any questions you can contact **Interactive Medical Systems (IMS) at (800) 426-8739 ext: 3130.**

## **SUPERIOR VISION:**

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 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 may be 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.

You will receive notification from **Interactive Medical Systems (IMS)** with premium and continuation options shortly following your termination of employment.

### **ALLSTATE BENEFITS CANCER PLAN**

When you leave the employment, you may continue your Allstate Benefits Cancer coverage by having the premiums that are currently deducted from your paycheck billed to your home address or drafted from your bank account. For billing options, please call Allstate Benefits at (800) 521-3535.

### **AUL SHORT TERM DISABILITY PLAN**

Once an employee is on the AUL disability plan for 3 months, you can port the coverage for one year at the same cost without evidence of insurability. You have 31 days from your date of termination to apply for portability. Please see the Mark III website for the portability form.

### **UNUM WHOLE LIFE**

When you leave your employment, you may continue your Unum Whole Life Insurance coverage by having the premiums that are currently deducted from your paycheck billed to your home address or drafted from your bank account. For billing options, please call Unum at 1-800-635-1049.

### **AETNA TERM LIFE**

When you leave your employment, you may convert the existing group term coverage you have through your employer to a guaranteed issue, individual whole life policy. You also have the option of porting your existing coverage as well. It is the responsibility of the employee to convert or port coverage. You must apply for conversion or portability within 31 days from the date your employer terminates your term life coverage. For more information and a quote, please contact Aetna direct at: 1-800-523-5065 for Conversion or 1-800-826-7448 for Portability.

If you do not convert or port your Aetna term life insurance, coverage will terminate when you leave your employer.

### **Important Phone Numbers:**

- Aetna Term Life Plan - 800.660.9913 or 800.523.5065
- Allstate Benefits Cancer Plan - 800.521.3535
- American United Life (AUL) STD - 800.553.5318
- Ameritas Dental Plan - 800.487.5553
- BCBS Health Plan - 877.258.3334
- Cumberland County Government - 910.223.3327
- Gilsbar Flexible Spending Accounts - 800.445.7227, ext. 883
- Mark III Brokerage, Inc. - 800.532.1044, ext. 21
- Superior Vision Plan - 800.507.3800
- Unum Whole Life Plan - 800.635.5597

**View Benefits Online and Download Forms:**  
[www.markiiibrokerage.com/cumberlandcountync](http://www.markiiibrokerage.com/cumberlandcountync)