



Benefits Guide

Plan Year 2011

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Open Enrollment Overview

The annual Open Enrollment period allows active employees of the County of Volusia to review, enroll, and change, if necessary, benefits available. The Benefits Guide is an overview document of the benefit options available and is not a Plan Summary Description or Benefits Policy.

This Benefits Guide provides details about your 2011 plan options. Taking time to review these materials carefully will help you make informed choices about your benefits.

The Plan Summary Description and Provider Directory will not be printed and distributed. You may access these documents three ways. From the County's ENN Intranet site at <http://enn.co.volusia.fl.us/> on the left side under AMS Advantage, Select AMS Advantage Employee Self Service or from the County's Internet site at <http://www.Volusia.org/Personnel/benefits> or **From ESS under downloadable forms.**

Benefit options will not automatically roll over into the next year. All employees will be required to enroll in any benefits they want to continue in 2011 using the County's Advantage AMS Employee Self Service (ESS) system. This includes, but is not limited to, health insurance, life insurance, cancer insurance, flexible spending accounts, etc.

Employees can also make changes to their current benefits during the Open Enrollment period. These changes will become effective January 1, 2011. Changes could be an addition, deletion, or cancellation of a benefit. These changes will remain in effect throughout 2011 unless you experience a Qualifying Status Change event.

In addition to enrolling or waiving benefits using ESS, a form may be required from the benefits vendor for any policy changes,

cancellations, or additions. For example, if an employee wishes to enroll or cancel coverage with Minnesota Life, the supplemental insurance vendor, a form is required. Forms are located in your Benefits Guide or can be downloaded in ESS under the Downloadable Forms tab. **It is the employee's responsibility to obtain and complete the necessary form and submit to Personnel by November 12, 2010.** Personnel will no longer automatically send out the form.

Open Enrollment Due Dates

September 27, 2010 - Open Enrollment begins. Using AMS Advantage Employee Self Service (ESS), employees must sign up for any benefits (e.g. health insurance, dental, etc.) they want to have in 2011. Your benefits will not be automatically rolled over from 2010.

October 29, 2010 – Open Enrollment ends and all wellness forms must be turned in to Personnel. ESS will close for access into your Open Enrollment Wizard.

November 12, 2010 – Employees must submit completed policy enrollment, change, or cancellation forms **If the completed form is not received in Personnel by November 12, 2010, your benefit choice(s) will revert back to your original benefits.**

December 6, 2010 – Employees can confirm benefit changes, dependents covered, and wellness dollars by logging into ESS and viewing the Future Enrollment tab.

Personnel will no longer be distributing a benefit confirmation form. ESS will be available for you to confirm your benefits anytime during the year.

January 1, 2011 - New benefit plan elections take effect. Any changes to your elected benefits during the Plan Year must comply with IRS family status change guidelines.

Changes to your Benefits for 2011

On March 23, 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act (H.R. 3590). This comprehensive health care reform legislation will have significant implications as it is phased in over the next few years.

The County of Volusia believes the Health Partnership Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Health Partnership Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at County of Volusia, 230 N. Woodland Ave. Suite 260. Deland, FL 32720 386-736-5951: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans you may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Understanding the Affordable Care Act

Extension of Coverage to Adult Children under Age 26

Requires all group health plans to extend eligibility for dependent coverage to adult children until age 26. This applies to adult children regardless of marital status, full-time student status, level of support from employee/parent, or residence.

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in Health Partnership Plan. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective January 1, 2011. For more information contact the Personnel Division at 386-736-5951

Lifetime and Annual Limits

Effective as of January 1, 2011, no insured group health plan or self-insured plan may impose a lifetime dollar limit on “essential benefits” as defined by the Department of Health and Human Services. Essential benefits are those for ambulatory care, emergency service, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative service and devices, laboratory services, preventive and wellness services, chronic disease management and pediatric services.

Understanding the Affordable Care Act continued

The PPACA prohibits lifetime limits, and generally annual limits, on the dollar value of health benefits from being imposed by group health plans, group health insurance coverage, and individual health insurance coverage on “essential health benefits.” Lifetime limits are prohibited for all plans – both new and grandfathered – for plan years on or after September 23, 2010. Annual limits are prohibited for new plans and grandfathered group plans beginning on or after January 1, 2014. Prior to January 1, 2014, new and grandfathered group plans may impose “restricted annual limits.”

Pre-existing Condition Limitations Do Not Apply to Children under age 19

Effective as of January 1, 2011, no insured group health plan or self insured plan may impose preexisting condition exclusion against a child under the age of 19.

HIPPA defines a preexisting conditions exclusion as a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for the coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date.

The Patient Protection and Affordable Care Act (PPACA) prohibits any preexisting condition exclusion from being imposed by group health plans or group health insurance coverage and extends this protection to individual health insurance coverage. This prohibition is effective for new and grandfathered group plans beginning on or after January 1, 2014, but for enrollees who are under 19 years of age, this prohibition become effective for plan years beginning on or after September 23, 2010

No Reimbursement of Over the Counter Medications.

Effective as of January 1, 2011, non-prescription medicines, other than insulin, will no longer be eligible for reimbursement under a health flexible spending account (‘FSA’)

Limit on Health Care Flexible Spending Accounts (HCFSA) - Beginning with the 2013 plan year (for calendar-year plans), contributions to a Health Care Flexible Spending Account (HCFSA) will be capped at \$2,500 per year, indexed to the CPI.

If you have a health flexible spending account (FSA), expenses for over-the-counter drugs cannot be reimbursed after December 31, 2010, unless the drug is insulin or is prescribed by a physician.

Funds not spend in the participants medical FSA will still rollover into the new plan year, however, no over-the-counter expenses will be eligible for reimbursement after January 1, 2011.

The definition of dependent for FSA purposes can include a participant's child who is under age 27.

AMS Advantage Employee Self Service (ESS)

ESS Introduction

Welcome to Volusia County's **Employee Self Service (ESS)**. ESS is a website where employees can view their own payroll and personal information and update certain information online such as benefit enrollments during the annual Open Enrollment period. This information is intended for the sole use of the individual employee.

View your payroll and personal information such as:

1. Pay Information (Pay advices or W-2)
2. Benefits
3. Leave Balances
4. Job Title

Update personal and payroll information online:

1. Home Address
2. Contact Information
3. Emergency Contacts
4. Benefits (during Open Enrollment only)

All information entered/submitted into ESS requires additional approval by Personnel before taking effect. Please contact Personnel at (386) 736-5951 if you have additional questions. Unauthorized access of an employee's information is prohibited.

ESS User Name and Password

All employees have an ESS user name which is typically the same as their KRONOS user name (Sheriff Office employees add "SO" after user name). If you need additional assistance with your password, contact the IT Support Desk at x5222 or IT_SupportDesk@co.volusia.fl.us.

Personnel Support

If you have any questions concerning using AMS Advantage or your user name, contact Personnel at (386) 736-5951 (x5951) and ask for a HR/Payroll Representative.

An ESS User Manual is available for download on Personnel's ENN site at <http://enn/personnel> (scroll down to Training section).

Employee Self-Service (ESS) Open Enrollment Instructions

Accessing ESS

ESS can be accessed **two** ways. From the County's ENN Intranet site at <http://enn>, select the **AMS Advantage** link, then select the **AMS ADVANTAGE Employee Self Service** link or from the County's Internet site at <http://www.Volusia.org/Personnel>. Click on the **Advantage ESS** link.

Log In to ESS

1. Click in the user name field and type in your **User Name**
2. Click in the password field and type your **Password**
3. Click on **Login** (Note: The Reset button next to Login isn't operational)

Changing My Password

1. Select the **My Desktop** workspace tab on the left of screen
2. Select the **Change Password** tab at the top of screen
3. Under the Change Password section, click in the **Old Password** field and enter your old password
4. Click in the **New Password** field and enter your new password
5. Click in the **Verify New Password** field and enter your new password
6. Click on the **Change User Password** button

NOTE: If you have **never** logged into ESS before, then your initial Password is the last two digits of your of birth and last four digits of your social security number. For example, YYSSSS (671245). Your initial password is set up to automatically require you to change it upon your first log in.

Password Facts

- ✓ You can change the password to something you will remember.
- ✓ Password must be at least 6 characters long and include one number.
- ✓ User name and password are case sensitive. User name will always be lower case.
- ✓ Password will expire after 90 days and the system will prevent the reuse of the last 10 passwords.
- ✓ **NEVER** give your password to anyone. If you feel your password has been compromised, change it immediately.
- ✓ Your account will be suspended if you enter the wrong password three times in a row. Call the IT Support Desk at extension 5222 to have it reset.


Log Out of ESS

Click on the **Logout** link in the top right corner of the screen to exit the ESS system. **Do not click on the X** in the upper-right corner. Always log out to prevent unauthorized access.

Accessing Benefits Information

After successfully logging into ESS, review your current coverages by accessing My Benefits. This enables you to view details pertaining to your dependents, benefits, and deductions recorded in the system.

To Review Current Benefits and Complete Your Enrollment:

1. Click on the **My Info** tab on the left side of the screen
2. Click on the **My Benefits** tab near the top of the screen
3. Click on the **Current Enrollments** link to see your benefits for 2010
4. Click on the **PrintPage** link near the top of the screen if you want to print the page
5. Click on the **Enrollment Wizard** blue arrow  to begin the enrollment process
6. Scroll down the page and click the **Continue** button
7. Click on the **Start New or Modify Existing Enrolment** radio button (***NOTE:*** Click on the *Continue Unfinished Enrollment* button if you have already started, but not yet completed, your enrollment.)
8. Scroll down and click on the **Continue** button
9. Click on the **Open Enrollment** button
10. Scroll down the page and click on the **Continue** button
11. You will be prompted to complete your on-line enrollment through a five-step process. Read and follow the instructions on each page to complete your enrollment. Click **Continue** to advance to the next page when done:
 - a. Page 1 – The **Appointment** page lists your current job title.
 - b. Page 2 – The **Dependent** page allows you to review and modify existing dependents or add new dependents.
 - c. Page 3 – The **Benefits Enrollment** page allows you to add and/or change benefit plans and terminate coverage for yourself or one of your dependents. You must select either “Enroll” or “Waive” for each benefit plan. (***NOTE:*** Reenrollment is required each plan year for the medical and dependent care flexible spending accounts and for No Coverage benefits.
 - d. Page 4 – The **Miscellaneous Deductions** page is currently not in use.
 - e. Page 5 – The **Enrollment Summary** page is used to verify and complete your enrollment process. Click on the **PrintPage** link to print a confirmation statement for your records as Personnel is not be sending out confirmation forms.
12. Click **Finish**

***Your ESS web enrollment and wellness forms are due no later than
Friday, October 29, 2010!***

Downloading Change Forms and Policy Information

Employees must submit, when applicable, a completed policy enrollment, change, or cancellation form(s) for the applicable benefit plan.

If the completed form is not received in Personnel by November 12, 2010, your benefit choice(s) will revert back to your original benefits.

If you are unsure about which form is needed, please contact Personnel at (386) 736-5951.

To download the policy form or policy information:

1. Click on the **Home** tab near the top of the screen
2. Click on the **Downloadable Forms** tab near the top of the screen
3. Click on the **name of the form or policy needed** (e.g. MINN LIFE ENROLL) - **NOTE:** Click the **Next** button to go to the next page of forms if applicable.
4. Click on the **form document PDF file** under Form Attachments section
5. Click **Open** (or Save)
6. Click **File**
7. Click **Print**
8. Click **OK**


The screenshot shows a web application with a navigation bar at the top containing four tabs: 'Home', 'Change Password', 'Downloadable Forms' (which is selected), and 'My Work in Progress'. Below the navigation bar is a table listing various forms. The table has three columns: 'Benefit', 'ALL', and the form name. The row for 'MINN LIFE ENROL' is highlighted in yellow and has a checkmark in the 'Benefit' column. Below the table are four buttons: 'First', 'Prev', 'Next', and 'Last'. Below these buttons, the following information is displayed: 'Topic : Benefit', 'Department : ALL', 'Description : Minnesota Life Enrollment Form', and 'Additional Information Link :'. At the bottom, there is a section titled 'Form Attachments' which contains a PDF icon and the text '65388 9-08 EOI.pdf'.

Benefit	ALL	Form Name
Benefit	ALL	HPP CHANGE FORM
Benefit	ALL	HPP CO PAYS
Benefit	ALL	HPP SPD
Benefit	ALL	MINN BENEF CHG
Benefit	ALL	MINN LIFE CHG
✓ Benefit	ALL	MINN LIFE ENROL
Benefit	ALL	MINN LIFE INFO
Benefit	ALL	MINN LIFE RATES
Benefit	ALL	MINNESOTA LIFE
Benefit	ALL	PROVIDER DIRECT

First Prev Next Last

Topic : Benefit
Department : ALL
Description : Minnesota Life Enrollment Form
Additional Information Link :

Form Attachments


65388
9-08
EOI.pdf

HEALTH PARTNERSHIP CLAIMS INFORMATION

Claims Information

First Service Administrators, Inc. (FSAI)

780 W. Granda Blvd., Suite 250
Ormond Beach, FL 32174
(386) 676-5760
1-800-767-2378
Website: <https://www.myfsai.com/Members?MenHome.asp>

The On-Line Program

With FSAI On-line, you will have 24 hour access to:

- Claims History- Online check to see which claims have been paid
- Claims History- Ability to view and print Explanation of Benefits (EOB)
- Eligibility- View current coverage, verify address.

To Get Started:

If you have already registered with FBMC on-line service, your username and password remains the same.

For new users

Go to <http://www.myfsai.com/members/memhome.asp>

1. Under RESOURCES on the left select: LIN Website
2. Under MEMBER LOGIN on the left select LIN Website
3. Select REGISTER NEW USER
4. Create user name (1st initial and last name),
5. Enter e-mail address
6. What type of user are you, Select: I am the insurance subscriber.
7. Select: Next
8. Enter your Participant ID number; this is located on your ID card.
9. Enter your Last Name
10. Enter your Zip Code (If your zip code has changed and you have not notified HR or FSAI it may not let you in)
11. Enter your Date of Birth
12. Select: Next
13. Create a password and a password hint.
14. Select “submit” and you are ready to get started

Any questions or log-on issues, or to reset your password please contact FSAI (386) 676-5770 or Customer Service Dept 1-800-767-2378

Health Partnership Plan: Who to Contact

HEALTH PARTNERSHIP NETWORK INFORMATION

Claims Information

FSAI
780 West Granada Blvd., Suite 250 (800) 767-2378
Ormond Beach, FL 32174 (386) 676-5760
Website:
<https://www.mysai.com/Members/MemHome.asp>

Provider Network

For questions regarding physician providers you have several networks at your disposal. Please call any of the networks listed below.

- **24-HOUR NURSE HELP LINE**
(877) 582-7061
 - **Florida Memorial Health Network**
(386) 615-4398
(888) 839-7430
Website: <http://www.fmhn.org>
 - **Complete Health Network for Osceola, Lake, Seminole or Orange Counties Only**
(800) 741-4869
(407) 741-4869
 - **Volusia Health Network**
(386) 425-4VHN (4846)
Option 3 for Provider Relations Dept.
Website: <http://www.myvhn.com>
- Preferred Physicians Healthcare Alliance (PPHA now KePRO)**
(888) 522-7742
- Coalition of America – Client #3893**
(800) 878-7896

Pharmacy Network

Walgreen's Health Initiatives (800) 207-2568
Website: <http://www.mywhi.com>

Chiropractic Network – DPSC

Inquiry Information (386) 615-0801
Appts. & Referrals

INSURANCE-BENEFIT OFFICES

Personnel Division (386) 736-5951
Benefits Section (386) 740-5137
Website: <http://volusia.org/personnel/benefits> or
<http://enn.co.volusia.fl.us/>

UTILIZATION MANAGEMENT PRECERTIFICATION MEDICAL

Preferred Physicians Healthcare Alliance has been chosen to provide utilization management for medical services. Pre-certify the following procedures with your precertification provider before services are rendered in order to avoid a penalty.
Precertification: (888) 522-7742.

In-patient Hospital Stay – call seven (7) days prior to admission or the next working day after an emergency admission.

There are outpatient surgical and medical services which require precertification –call seven (7) days prior to service to verify benefit plan coverage.

Mental & Behavioral Health-Substance Abuse

Horizon Health (800) 272-7252
Website: <http://www.horizoncarelink.com>
Login ID: VCG
Password: VCG

The Employee Assistance Program (EAP) provider, **Horizon Health**, also manages behavioral health benefits. Pre-certify all inpatient care services being rendered by calling **(800) 272-7252** to avoid a penalty.

Dental Information

Maverest Dental Alliance, Inc.
FSAI Customer Service – Call:
(800) 767-2378 or (386) 676-5760
Website: <http://www.maverest.com> (for provider listing)

Supplemental Benefits: Who to Contact

County of Volusia-Benefit Offices

Personnel Division (386) 736-5951
Benefits Section (386) 740-5137
Website: <http://volusia.org/personnel/benefits> or
<http://enn.co.volusia.fl.us/>

American Heritage Life-Allstate

For questions regarding Cancer, Critical Illness and Heart Care.

- **Hunt Agency-Jan Hunt**
(407) 342-3728
- **American Heritage Life/Allstate**
(800) 521-3535

EBS Atlanta-Flexible Benefits Questions

EBS
2500 Northwinds Parkway Suite 400
Alpharetta, GA 30009-2256
(800) 647-3709
Fax (770) 569-0211
Website: www.ebsatlanta.com
Flex on Line Website:
<https://www.myflexonline.com/Login/Welcome.aspx>

Optional Life Insurance

Minnesota Life Insurance.
(866) 293-6047

SafeGuard-MetLife Dental

Universal II Plan (800) 880-1800
<http://www.metlife.com/individual/employee-benefits/group-dental/index.html>

Short Term Disability Insurance- The Standard

Standard Insurance Company
P.O. box 2800
Portland OR 97208
(800) 368-2859
Fax (800) 378-6053

Deferred Compensation

Nationwide Retirement Solutions
(877)-677-3678
Website:<http://www.nrsforu.com>

Health Partnership Plan (HPP) Rates

A negative dollar amount is the amount the County is providing biweekly in flex or wellness dollars for you to spend toward other insurance choices.

WELLNESS DOLLARS INCENTIVE

Annual	Biweekly Amount
\$100.00	\$-3.85
\$200.00	\$-7.69
\$300.00	\$-11.54

NO COVERAGE OPTION

Full Time Employees \$360.00 PER YEAR WITH PROOF OF OTHER INSURANCE COVERAGE	\$-13.85
Part Time Employees \$180.00 PER YEAR WITH PROOF OF OTHER INSURANCE COVERAGE	\$-6.92
Accelerated Employees \$180.00 PER YEAR WITH PROOF OF OTHER INSURANCE COVERAGE	\$-8.57

Medical and Dental coverage is included in HPP rates

FULL TIME EMPLOYEE COSTS

EMPLOYEE ONLY	\$ -2.42
PARENT COVERAGE (WITH 1 OR 2 CHILDREN)	\$104.61
COUPLE	\$104.61
FAMILY (3 OR MORE CHILDREN OR SPOUSE AND CHILDREN)	\$153.43

PART TIME EMPLOYEE COSTS

EMPLOYEE ONLY	\$ 89.51
PARENT COVERAGE (WITH 1 OR 2 CHILDREN)	\$189.12
COUPLE	\$189.12
FAMILY (3 OR MORE CHILDREN OR SPOUSE AND CHILDREN)	\$237.94

ACCELERATED PART TIME EMPLOYEE COSTS (OVER 21 PAYROLLS)

EMPLOYEE ONLY	\$110.82
PARENT COVERAGE (WITH 1 OR 2 CHILDREN)	\$234.15
COUPLE	\$234.15
FAMILY (3 OR MORE CHILDREN OR SPOUSE AND CHILDREN)	\$294.59

SPLIT PLAN (BOTH COUNTY OF VOLUSIA EMPLOYEES)

Each Employee	\$18.96
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DEPENDENT HEALTH SUBSIDY

The County of Volusia offers a subsidy to employees who elect dependent health coverage. To qualify for the subsidy each year, the employee must complete an application and submit a copy of his/her last income tax return as verification of total family income. This subsidy rates vary from \$16.00 to \$26.00 per payroll towards dependent premiums. Please contact Personnel for further information at 386-736-5951 or ex. 2214.

SCHEDULE OF BENEFITS

INDIVIDUAL MAXIMUM LIFETIME BENEFIT

NONE

FERTILITY STUDIES - MAXIMUM CALENDAR YEAR BENEFIT

\$2,000

Expenses incurred by a Non-Network provider will be paid in accordance with the Expanded Network benefits if incurred on a Medical Emergency/Life-Threatening basis. Reasonable and Customary will not apply.

If an In-Network facility is utilized, any ancillary charges incurred by an Expanded-Network or Out-of-Network provider will be paid as In-Network. Reasonable and Customary will not apply.

If an Expanded-Network facility is utilized, any ancillary charges incurred by an Expanded-Network or Out-of-Network provider will be paid in accordance with the Expanded-Network benefits

If an In-Network provider is utilized, any ancillary charges incurred by an Expanded-Network or Out-of-Network provider or facility will be paid in accordance with their respective schedule of benefits. The ancillary charges will not be paid at the In-Network level of benefits. (For example, if a member went to a network doctor and the doctor used a non-network facility to do surgery, the doctor would be paid as network and the facility would be paid as out-of-network. They would not both be paid as network.)

ANNUAL DOLLAR LIMITS ON PLAN BENEFITS

The Plan may not place lifetime dollar limits or less than "restricted" annual dollar limits on essential health benefits, effective for plan years beginning on or after 9/23/10.

	In Network	Expanded Network	Out-of- Network
CALENDAR YEAR DEDUCTIBLE			
Individual	\$250*	\$500	\$2,000
Family	\$750*	\$1,500	\$6,000
OUT-OF-POCKET MAXIMUM EXPENSE - INCLUDES CO-PAYS & CO-INSURANCE PERCENTAGES (Includes Medical and Behavioral Health Expenses Only)			
Individual Per Calendar Year	\$5,000	\$5,000	\$10,000
Family Per Calendar Year	\$10,000	\$10,000	\$20,000
PREVENTIVE CARE BENEFIT			
Annual Physical Exam	\$0	\$0	40%
Well Woman Services	\$0	\$0	40%
Well Child Care Services	\$0	\$0	40%
PHYSICIAN SERVICES			
Personal Care Physician's Office Visit (Family Practice, General Practice, Pediatrics, OB/GYN & Internal Medicine)	\$20	20%	40%
Specialist's Office Visit	\$30	20%	40%
Obstetrical Care Including Delivery (One-time charge)	\$100	20%	40%
Physician Inpatient Visit	\$0	20%	40%
Physician Inpatient Surgical Services	\$0	20%	40%
Outpatient Surgery	\$30	20%	40%
Office Surgery - (includes, but is not limited to, joint injections, fetal stress tests, nasal endoscopies)	\$30	20%	40%
Allergy Injections	\$0	\$0	\$0

SCHEDULE OF BENEFITS

	In Network	Expanded Network	Out-of- Network
Immunizations/Inoculations (Not part of Annual Physical Exam Benefit; however, when obtained from Volusia County Health Department, will be paid as In-Network)	\$25	20%	40%
WALK-IN CLINIC (Non-Emergency - Refer to Provider Directory)			
Personal Care Physician (PCP)	\$20	20%	40%
Specialist	\$30	20%	40%
URGENT CARE/WALK-IN FACILITY/CLINIC (Emergency – Refer to Provider Directory)			
Emergency Services - per visit - *Deductible will not apply	\$50	20%*	40%*
HOSPITAL SERVICES			
Inpatient Services - Per Admission (per day 3 day max.)	\$250	20%	40%
Outpatient Surgery - Per Surgery (includes 23-hour observation)	\$250	20%	40%
EMERGENCY SERVICES - PER VISIT			
Emergency Room (waived if admitted)	\$50	20%*	40%*
Ambulance Services (Volusia County EVAC Services will be paid as In-Network)	\$50	20%	40%
*Deductible will not apply			
DENTAL (In a Dentist's office) (See Teeth, Gums and Alveolar Process)			
Office Surgery	\$30	\$30	\$30
Office Visit	\$30	\$30	\$30
Impacted Teeth Surgery	\$30	\$30	\$30
SKILLED NURSING FACILITY - PER ADMISSION	\$50	20%	40%
HOSPICE	\$0	20%	40%
OUTPATIENT LAB, X-RAY & OTHER DIAGNOSTIC PROCEDURES - PER VISIT			
Diagnostic X-Rays	\$20	20%	40%
CAT	10%*	20%	40%
MRI	10%*	20%	40%
Lab Tests and Services	\$20	20%	40%
Sleep Study	\$20	20%	40%
	*Deductible Applies		
CHEMOTHERAPY/RADIATION THERAPY	\$0	20%	40%
DIALYSIS	\$0	20%	40%
OUTPATIENT THERAPIES - PER VISIT (Chiropractic, Massage, Occupational, Physical & Speech Therapy)	\$20	20%	40%
HOME HEALTH	\$0	20%	40%

SCHEDULE OF BENEFITS

	In Network	Expanded Network	Out-of- Network
DURABLE MEDICAL EQUIPMENT/ORTHOPEDIC DEVICES (Per Item) (does not include diabetic supplies, see page 28 of your SPD for definition)	\$20	20%	40%
MEDICAL SUPPLIES (for medical supplies other than diabetic supplies or DME, see page 30 of your SPD for definition)	\$10	20%	40%
Breast Prostheses	\$10	20%	40%
Wigs (Deductible does not apply)	\$10	\$10	\$10
PROSTHETIC DEVICES - PER DEVICE	\$100	20%	40%
NUTRITIONAL COUNSELING FOR DIABETES (Refer to Disease Management information in the Provider Director)	\$0	20%	40%
CARDIAC REHABILITATION - OUTPATIENT	\$0	20%	40%
BEHAVIORAL HEALTH BENEFITS			
Inpatient Services - Per Admission (per day 3 day max)	\$250	20%	40%
Outpatient	\$20	20%	40%
Rx	Retail	Mail	
Generic	\$15	\$30	50%
Preferred Brand	\$30	\$60	50%
Non Preferred Brand	\$50	\$100	50%

PRE-CERTIFICATION AND AUTHORIZATION OF MEDICAL CARE

Preferred Physicians Healthcare Alliance (PPHA now KePRO) provides utilization management of medical care for the Health Partnership Plan. Utilization management includes pre-certification of selected medical services to establish medical necessity and the appropriate level of care.

Pre-certification of the medical services listed below is mandatory, whether this Plan is providing primary or secondary coverage. It is the Employee's or Covered Person's responsibility to make certain that the compliance procedures of this program are completed. Failure to pre-certify before services are rendered will result in a possible denial of benefits or the following penalties (not to exceed Covered Charges):

**Inpatient - \$1,000 per admission
Outpatient - \$250 per occurrence**

**The medical services listed below must be pre-certified by calling:
Preferred Physicians Healthcare Alliance (PPHA now KePRO)
(888)- 522-7742**

--- All Inpatient Care; and

--- The Following Surgical and Medical Services (performed in an outpatient setting):

- Adenoidectomy
- Back Surgery
- Chemotherapy
- Radiation
- Dialysis
- Colonoscopy – under age 50
- Durable Medical Equipment – **over \$250** (Per Item – Per Treatment Plan)
- Endocrinology Services pertaining to Infertility/Reproduction
- Home Health Care
- Hyperbaric Oxygen Treatments
- Hysterectomy
- Video Endoscopy
- Interventional Pain Services
- Mammoplasty; Reduction
- Massage Therapy
- Maternal & Fetal Medicine Specialty Services
- Nasal Surgery
- Occupational Therapy
- PET Scans
- Physical Therapy (Must request precertification as of day 1 - no penalty until visit 13)
- Septoplasty
- Sleep Apnea Studies
- Speech Therapy
- TMJ/CMJ Surgery
- Tonsillectomy
- Varicose Vein Excision and Ligation

PRE-CERTIFICATION AND AUTHORIZATION OF MEDICAL CARE (Continued)

Scheduled Inpatient care should be pre-certified 7 days prior to admission. Emergency Inpatient admissions must be reported to Preferred Physicians Healthcare Alliance (PPHA now KePRO) within 24-hours or the next Working Day after an emergency admission.

Outpatient surgeries or other medical services should be pre-certified 7 days prior to delivery of medical services, or as soon as possible.

MEDICAL CASE MANAGEMENT. The primary objective of Medical Case Management is to identify and coordinate cost-effective medical care alternatives to help manage the care of patients who have catastrophic or extended care illnesses or injuries.

Medical Case Management also monitors the care of the patient, offers emotional support to the family, and coordinates communications among health care providers, patients, and others. Prior to any final determination, severity of condition and prognosis are taken into consideration.

Preferred Physicians Healthcare Alliance (PPHA now KePRO) assesses the need for alternative care and, when necessary, will refer the case for Medical Case Management.

PPHA (now KePRO) provides a 24-hour Nurse Help Line at (877)-582-7061.

The **Utilization Management Program** also includes services for the management of large or potentially large claims. On a case-by-case basis as selected by the HPP Administrator, the Utilization Management Organization will provide an initial assessment of the patient, summarize the patient's continuing medical needs, assess the quality of current treatments, coordinate alternative care when appropriate and approved by the Physician and Plan Administrator, review the progress of alternative treatment after implementation, and make appropriate recommendations to the HPP Administrator.

In conjunction with these services, the HPP Administrator reserves the right to monitor health care and modify Plan benefits to assure that high-quality medical care is provided in the most cost-effective settings.

SPECIAL NOTICES

It is the **Employee's or Covered Person's responsibility** to make certain that the compliance procedures of this program are completed. To minimize the risk of reduced benefits, an Employee must contact the review organization to make certain that the Hospital or attending Physician has initiated the necessary processes.

HPP has the absolute authority to waive the normal provisions of this plan if PPHA (now KePRO) submits a written proposed alternative which meets the accepted standards of medical practice without sacrifice of quality of patient care and is no more expensive than regular plan benefits would be.

All Precertification and Utilization Review requirements of the HPP will not apply to Surgical and treatment procedures associated with mastectomies of the Covered Employee or Covered Dependent as required pursuant to the Women's Health and Cancer Rights Act of 1998. Nor shall they apply to Hospital admissions of expectant mothers and newborns that are for periods no longer than 48 hours following a normal vaginal delivery, or 96 hours following a cesarean section delivery as required by the Newborns' and Mothers' Health Protection Act of 1996, however, recommended stays longer than these periods will require you to follow the Precertification and Utilization Review Program of the HPP.

THIS PAGE CONTAINS PENALTY PROVISIONS.

PRE-CERTIFICATION AND AUTHORIZATION OF BEHAVIORAL HEALTH BENEFITS

Inpatient behavioral health care must be pre-certified and authorized for both medical necessity and appropriate level of care before accessing your behavioral health services and benefits.

Contact *Horizon Health* at 1-800-272-7252 for pre-certification for you and your Counselor to discuss a treatment plan before any services are rendered.

Pre-certification of Behavioral Health Services is Mandatory. It is an Employee's or Covered person's responsibility to make certain that the compliance procedures of this program are completed. Failure to pre-certify, before treatment or services rendered, will result in the following penalties (not to exceed Covered Charges):

Inpatient - \$1,000 per admission;

HPP has the absolute authority to waive the normal provisions of this plan if Horizon Health submits a written proposed alternative which meets the accepted standards of medical practice without sacrifice to quality of patient care and is no more expensive than regular Plan benefits would be.

Horizon Health also provides free Employee Assistance Program (EAP) services 24-hours a day to all employees and their family members, as well as pre-certification and authorization of behavioral health benefits under This Plan.

EAP Services provide free short-term counseling for any problem which affects your well-being or ability to perform at work. Examples include stress, family or marital problems, substance abuse, financial or legal difficulties, or emotional problems. Call Horizon Health at 1-800-272-7252 for complete details.

Contact *Horizon Health* at. . .

1-800-272-7252

24-hours a day, 7 days a week.

THIS PAGE CONTAINS PENALTY PROVISIONS.

PREVENTIVE SERVICES

This Plan may cover Annual Physical Examinations for Covered Employees and Covered Spouses only. Well Woman Services are provided for Covered Employees, Covered Spouses and Covered Dependent Children.

Preventive Services are not subject to the Calendar Year Deductible.

Annual Physical Examinations

One Annual Routine Physical Exam is covered each calendar year when using a Preferred Provider Physician in one of the following specialties: Family Practice, General Practice, Internal Medicine, or Gynecology.

The Annual Routine Physical benefit includes, and is limited to, any combination of the following services:

- Physical examination and history
- EKG
- Blood tests
- Hemocult
- Urinalysis
- Chest X-Rays
- Bone Density Study – age 45 and over
- Hearing Screening
- Sigmoidoscopy
- PSA Blood Test
- Inoculations and immunizations – includes: Pneumonia, Tetanus, Flu all other immunizations/inoculations not part of routine physical exam
- Digital prostate exam

Well Woman Services

Covered benefits include a screening mammogram and an annual pelvic examination with pap smear, HPV immunizations. Screening mammograms are covered according to the following guidelines:

Ages 35-39

Baseline

Ages 40-49

Annual

Ages 50-64

Annual

Ages 65+

Every 2 Years

Well Child Care Services

The HPP covers certain Well Child Services provided by a Physician from the moment of birth through age twenty-one.

The Covered Services for each visit to the Physician include:

- Physical exam and measurements
- Vision and hearing screenings
- Oral health risk assessments
- Developmental assessments to identify any developmental problems
- Screenings for hemoglobin level, lead, tuberculin
- Counseling and guidance from your doctor about your child's health development
- Appropriate immunizations and boosters, including HPV immunizations
- Laboratory tests in keeping with prevailing medical standards

PREVENTIVE CARE BENEFIT

To receive the maximum benefit, follow the steps below:

1. Select a Personal Care Physician from the Preferred Provider Directory under Family Practice, Pediatrician, General Practice, Gynecology, or Internal Medicine.
2. Call for an appointment:
 - a. Identify yourself as a member of the Health Partnership Plan; and
 - b. Tell them the appointment is for an annual physical covered by the HPP under the preventive care benefit.
3. Arrive early for appointment.
4. Present HPP membership card to office receptionist.
5. Present list of covered examination and screenings to Physician.
6. Verify that the Physician's office codes the claim as preventive care and forwards the claim to FSAI. No Deductible or Co-Payment is applied.
7. All additional laboratory tests and screenings should be done at participating labs or Hospitals. (Check Provider Directory.)
8. Present HPP membership card at lab and verify that the coding is preventive care benefit. Send claim to FSAI, for processing. No Deductible or Co-Payment is applied.
9. Well woman screenings are covered at 100%. See Well Woman Services
10. If the Physician finds a health problem that requires additional office visits, additional tests for diagnostic purposes, or treatment, these charges may be applied to your Deductible. These charges may be subject to Precertification and appropriate Co-Payment if applicable.

PPHA 24 Hour Nurseline Information

Did you know the nation average ER wait time is 3 hours?
The benefits of using the nurse line will save you both time and money!

You now have access to trained Registered Nurses who will assist you in choosing the most appropriate care. They will take every opportunity to educate you on how to care for yourself now and in the future. The nurses are available via a toll-free number 24 hours a day, 365 days a year.

You may reach the Nurse Line at 877-582-7061.

The 24 hour nurse line en Espanol offers the only fully integrated Spanish language health information, advice and services.

The nurse line has an extensive library of topics. The Audio Library contains information on 2,200 topics – everything from Cancer and Heart Disease to Parent and Adolescent Concerns to Nutrition Tips. A list of library topics is available at www.fonemed.com/hiltopics.htm

SCHEDULE OF PHARMACEUTICAL BENEFITS

	GENERIC DRUG	PREFERRED BRAND DRUG	NON PREFERRED BRAND DRUG
	<u>YOU PAY</u>	<u>YOU PAY</u>	<u>YOU PAY</u>
CALENDAR YEAR DEDUCTIBLE PAYABLE BY COVERED MEMBER:	-0-	-0-	-0-
CO-PAYMENT PAYABLE BY COVERED MEMBER: Drugs purchased from a WHI network retail Pharmacy			
Each 30-day supply.....	\$15	\$30	\$50
CO-PAYMENT PAYABLE BY COVERED MEMBER: Drugs purchased from WHI Mail Service Pharmacy			
31- to 90 day supply	\$30	\$60	\$100
CO-INSURANCE PERCENTAGE PAYABLE: Drugs purchased from a non-network Pharmacy			
Maximum 31-day supply	50%	50%	50%

ADVANTAGE 90 (at Select Retail Pharmacies) 90-day Supply

- Through the Advantage 90 (TM) program, you can now get 90-day supplies of your maintenance medications at select retail pharmacies.

Co-payment per prescription:

Non-Preferred name drug	\$100
Preferred name drug	\$60
Generic.....	\$30

WHI PRESCRIPTION DRUG PROGRAM

Walgreens Health Initiatives (WHI) provides the Pharmacy network for the Health Partnership Plan (HPP). WHI has over 45,000 retail pharmacies in the United States as well as a Mail Service Program for maintenance medications. For a list of WHI pharmacies in Volusia County and WHI chain pharmacies throughout the United States, please refer to the Health Partnership Plan Preferred Provider Directory or access their website at www.mywhi.com.

Because WHI pharmacies transmit claim information electronically, you must show your HPP ID Card for eligibility determination when filling a Prescription.

Maintenance drugs should be purchased through the WHI Managed Prescription Mail Service Program or through the Advantage 90 (TM) Program. Maintenance drugs are covered for up to a 90-day supply.

Mail Service Order Forms are provided by WHI and are included with the "Retail and Mail Service Pharmacy Benefit" brochure which are available from your Benefits Office.

WHI PRESCRIPTION DRUG PROGRAM (Continued)

To utilize your mail order benefit, please use the order form provided in the “Retail and Mail Service Pharmacy Benefit” brochure, access forms on the web-site www.mywhi.com or mail to the following address:

Walgreens Mail Service
PO Box 628001
Orlando, FL 32862-8001

To access your personal prescription benefit information online go to www.mywhi.com. By registering with the Walgreens Health Initiatives web-site you can conveniently:

- ❖ look up medications and verify your coverage and copayments;
- ❖ verify if a drug is included in our formulary (preferred medication list);
- ❖ compare copayments between generic and brand-name drugs;
- ❖ access your prescription history;
- ❖ get drug information; and
- ❖ verify eligible family members.

Under emergency circumstances with approval, prescription drugs may be obtained from a non-network Pharmacy. You will be reimbursed by the HPP for 50% of the cost of the Prescription whether the drug was generic or brand. A maximum 31-day supply applies to non-network Pharmacy purchases. Claims must be submitted to WHI on a WHI Prescription Drug Claim Form available from your Benefits Office or WHI.

If you have questions about your Prescription drug benefit, WHI's Managed Prescription Mail Service Program, the retail Pharmacy network, or about medications, please call WHI at 800-207-2568. WHI Pharmacists are well informed about Prescription drugs and will address your questions and concerns. If you need a replacement ID Card, please call FSAI, at 386-676-5660 or 1-800-323-4890.

Automatic Generic Substitution

This plan automatically substitutes a generic drug for a brand drug when an approved generic drug is available. If you request a brand drug, or the prescribing Physician writes “Dispense As Written” because it is Medically Necessary to have the brand drug instead of the generic, the brand drug will be dispensed; however, you will be responsible for the non-preferred co-payment plus the cost difference between the brand and the generic drug.

For example if the brand name drug costs \$100 and the generic costs \$75, you will be responsible for the \$50 non-preferred co-payment plus the \$25 difference between the cost of the brand and cost of the generic drugs. Your cost will be \$75.

If the cost of the brand name drug is \$100 and the cost of the generic is \$25, the difference would be \$75 plus the non-preferred co-payment of \$50 totaling \$125. This is more than the cost of the non-preferred medication. In this example, you would only then pay the cost of the non-preferred medication which is \$100.

If no approved generic substitute is available, the HPP will dispense and cover the brand drug.

Covered Medications

Medications covered by This Plan include all generic and brand drugs prescribed by a Physician unless excluded. Compound medications are covered if at least one ingredient is a legend drug. Diabetic supplies, including insulin, syringes, needles, chemical strips and glucose monitors are covered when prescribed by a Physician.

Dispensing Limitations

This Plan covers the amount prescribed by a Physician, but not to exceed a 30-day supply for drugs purchased from the retail Pharmacy or a 90-day supply for drugs purchased from the WHI Mail Service Pharmacy.

Pre-Existing Condition

Pre-Existing Condition means a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the "Enrollment Date" (i.e., for these purposes, means the first day of coverage or, if Eligibility Waiting Period applies, the first day of the Eligibility Waiting Period). Expenses relating to a Pre-Existing Condition are not covered under this Plan until the person has been covered under the HPP for 12-months (18-months for a Late Enrollee) after the Enrollment Date.

This 12-month or 18-month period is reduced by the number of days of Creditable Coverage the individual has, provided the individual does not have more than a 63-day break in coverage. Neither a waiting period nor an HMO affiliation period is taken into account in determining if a break in coverage occurred. Creditable Coverage includes coverage under a group health plan, individual or group health insurance, Medicare, Medicaid, military coverage, and certain other medical coverage.

The HPP's Pre-Existing Condition limitation does not apply to:

1. Pregnancy;
2. A newborn child; or
3. A child adopted, or placed for adoption before attaining age 18, if such newborn child, or child adopted, or placed for adoption:
 - a. Is enrolled in a group health plan or other Creditable Coverage within 31-days after the birth, adoption, or placement, and
 - b. Does not have more than a 63-day break in coverage; or
4. Children up to the age of 19.

These pre-existing condition limitations are intended to comply with at least the minimum requirements of the Health Insurance Portability and Accountability Act of 1996 (H.R. 3103). If they are incomplete or in conflict with the Act in any way, the Act will prevail.

Schedule Of Dental Expense Benefits

LIFETIME MAXIMUM BENEFIT FOR TYPE IV ORTHODONTIC SERVICES \$1,000

CALENDAR YEAR MAXIMUM BENEFIT FOR ALL TYPE I, II, & III SERVICES \$1,000

CALENDAR YEAR DEDUCTIBLE

**You Pay at
Dentist**

- ❖ **Type I**
 - Individual None
 - Family None
- ❖ **Types II, III, and IV**
 - Individual \$ 50
 - Family \$150

CO-PAYMENT/CO-INSURANCE PERCENTAGE PAYABLE

- ❖ **Type I – Preventive Services**
 - Oral Exams and X-Rays (Adult) 20%*
 - Two (2) Cleanings per Calendar Year
including fluoride treatment for children 20%*
- ❖ **Type II – Restorative Services**
 - Fillings, Extractions, Periodontics,
Endodontics, and Root Canals 20%*
- ❖ **Type III – Replacement Services and Implant Services**
 - Crowns, Bridges, and Dentures 50%*
 - Implants 50%*
- ❖ **Type IV – Orthodontic Services**
 - Orthodontics 50%*

NOTE: Any Employee, or Dependent covered under This Plan will have free choice of his/her Dentist. The MAVEREST network of Dentists is available at www.maverest.com. Any Employee who chooses a MAVEREST Network Dentist will have a lower Out-of-Pocket expense.

Contact: FSAI: (386) 676-5760
(800) 767-2378

Depending on the Dentist, a covered member may have to pay for their services at the time of their visit and then submit a claim to be reimbursed. Some Dentists may not request payment at that time and submit the claim for the covered member

*Charges are limited to Usual, Customary, and Reasonable Charges and you are responsible for charges exceeding the UCR guidelines or percent that you pay of the reduced Maverest dentist charges

FOR DETAILS, REFER TO THE GENERAL DENTAL PROVISIONS
CONTAINED ON PAGE 41 OF YOUR SPD

Vision Coverage

Biweekly Vision Rates		
Employee	\$4.15	
Couple	\$8.31	
Single Parent	\$6.00	
Family	\$10.39	
Vision Expense Benefits	Amount of Benefits	Limitations
Eye Examinations	Up to \$50.00	Limited to one (1) examination per person per calendar year.
Frames	Up to \$100.00	Limited to one (1) pair of frames per person during any 24 consecutive months.
Lenses		
Single Vision Lenses	Up to \$25.00	Limited to (1) pair per person per calendar year.
Bifocal Vision Lenses	Up to \$25.00	Limited to (1) pair per person per calendar year.
Trifocal Vision Lenses	Up to \$32.50	Limited to (1) pair per person per calendar year.
Progressive Lenses	Up to \$32.50	Limited to (1) pair per person per calendar year.
Contact Lenses	Up to \$100.00 per calendar year.	Limited to either a pair of contacts or a pair of glasses per calendar year.
Disposable Contact Lenses	Up to \$100.00 per calendar year.	Limited to either a pair of contacts or a pair of glasses per calendar year.
Note: Any Employee or Dependent covered under this Plan will have free choice of his/her optometrist, optician or ophthalmologist, as there is no Network of Doctors.		

Vision Coverage Expense

All Vision Expense Benefits must be performed, ordered, furnished or prescribed by an Ophthalmologist, an Optometrist or Optician acting within the scope of his license. All covered charges must be based on Usual, Reasonable and Customary fees for the services and supplies listed under Vision Expense benefits. Services must be rendered, and supplies furnished, while the individual is covered under the Plan.

Payment for Covered Vision Expense benefits will be made at the Co-Payment Percentages shown in the Schedule of Vision Expense Benefits, subject to the Limitations, the Benefit Maximums, the Definitions, and all other provisions of the Plan.

Payment for any one service or supply will not exceed the lesser of the fee actually charged, or the maximum amount payable for such services as indicated in the Schedule of Vision Expense benefits.

A charge is considered to be incurred on the date the service is performed or the supply is ordered.

The Plan will pay expenses incurred for the following visual care services and supplies:

1.Examinations, including refraction, performed by a licensed ophthalmologist or optometrist. An eye examination includes your complete case history, a comprehensive analysis of your visual functions, the prescription of lenses where indicated, and the verification and fitting of such lenses if prescribed.

Vision Expense Coverage (continued)

2. Lenses, including contact lenses, prescribed by an ophthalmologist or optometrist in connection with a failure in visual acuity.

Expenses for lenses will be payable only if the lenses are prescribed as a result of an eye examination made while you are covered for these Vision Expense benefits. The date on which the lenses are ordered will be considered the date on which the charge is incurred.

3. Frames purchased in conjunction with lenses newly prescribed by an ophthalmologist or optometrist. The date on which the frame is ordered will be considered the date on which the charge is incurred.

Vision Coverage Exclusions and Limitations

IN ADDITION TO THE GENERAL PLAN EXCLUSIONS AND LIMITATIONS, THIS PLAN WILL NOT PAY FOR AND COVERED VISION EXPENSES DO NOT INCLUDE CHARGES:

1. That are not Covered Vision Expenses or for procedures, services or supplies that are not specifically included as Covered Vision Expenses.
2. For services and supplies in connection with special procedures such as, but not limited to, orthoptics, vision training, subnormal vision aides, or aniseikonia lenses, coated lenses or any other special purpose vision aids.
3. For or in connection with medical or surgical treatment of the eye, including Radial Keratotomy or other refractive Surgery, or for any prescribed drug or other medication.
4. For services or supplies which were furnished or rendered or for which charges were incurred prior to the effective date of coverage under these Vision Expense benefits, or after such Vision Expense benefits terminate.
5. For frames to be used with lenses which do not require a prescription.
6. For any procedure, service or supply which is payable under any medical expense benefit plan provided by your Employer, or provided through a medical department or clinic maintained by your Employer; and,
7. For services or supplies rendered or furnished primarily for cosmetic purposes.
8. Services or supplies received or rendered by a member of the immediate family of the Employee or the Employee's spouse.
9. **Limited to either a pair of contacts or a pair of glasses per calendar year.**

ENROLLMENT & ENROLLMENT DATES

New IAFF Employees and Dependents Enrolled in a Timely Manner

An IAFF bargaining union Employee may enroll in the HPP for Employee and Dependent coverage on, or before the 31st day following his employment date. Employee Coverage begins on the first day of the fifth (5th) pay period following the date of employment.

The County of Volusia reserves the right to waive the ten (10) week waiting period for contracted employees and elected officials.

All Other New Employees and Dependents Enrolled in a Timely Manner

An Employee may enroll in the HPP for Employee and Dependent coverage on, or before the 14th day following his employment date. Employee and Dependent Coverage begin on the first day of Employee's employment. This change does not apply to any employees represented by the IAFF bargaining union.

New Employees NOT Enrolled in a Timely Manner

If an Employee does not enroll in the HPP in a timely manner or refuses coverage at the time of enrollment, and does not provide proof of other health care coverage to the HPP Administrator, then the Employee will be automatically enrolled in single coverage by the HPP Administrator. (The premium for this coverage is paid for by the employer.)

Enrolling Newly Acquired Dependents

If an Employee does not have an Eligible Dependent when his Coverage first becomes effective and then later acquires an Eligible Dependent for the first time (other than through the birth, or adoption of a child), the Employee may apply for Dependent coverage within 31-days from the date the Eligible Dependent was first acquired. Coverage will begin on the first day of the pay period following the date the application for Coverage was made..

ELIGIBILITY

Eligible Participants

All persons in a regularly established position with the County of Volusia classified as full-time or permanent part-time, who are scheduled to work 17-1/2 or more hours per week or on an approved Leave of Absence are eligible to be covered under this Plan after 31-days of employment.

A properly qualified COBRA Beneficiary is also eligible for Coverage in accordance with COBRA continuation provisions.

All eligible Employees who retire while covered by This Plan, and are eligible to receive benefits from the Florida State Retirement System, are eligible for Coverage.

Contracted employees and elected officials as approved by the HPP Administrator are also eligible for Coverage.

An Employee or Dependent cannot be covered if he/she is maintaining a residence outside the Continental U.S.

An Employee cannot be covered as both an Employee and as a Dependent under this Plan.

Eligible Dependents

Your Eligible Dependents, as defined below are eligible for Coverage under this Plan. A newborn child of a covered Dependent child is eligible to participate from birth up to age 18-months.

Dependent means the Covered Employee's spouse and unmarried children.

The term "**spouse**" means the legally recognized marital partner, excluding the domestic partner, of a Covered Employee. The term shall exclude such spouse who has divorced the Employee, or who is legally separated from the Employee.

The term "**children**" means natural children, step-children, foster children, or children who have been placed under legal guardianship and legally adopted children from birth to age of 26 years (whether married or unmarried). This applies to any children regardless of marital status, full-time student status, level of support from employee/parent, or residence.

The Plan may choose to not extend coverage for adult children who are eligible for coverage under another employer-sponsored group health plan (other than another parent's plan), but only for plan years beginning before 1/1/14.

Note: Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in Health Partnership Plan. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective January 1, 2011. For more information contact the Personnel Division at 386-736-5951.

The term "**children**" also means pre-adopted children (i.e., children placed with a Covered Employee in anticipation of adoption.) Such children will be provided Coverage under the same terms and conditions that apply to Dependents who are a Covered Employee's natural children, irrespective of whether the adoption has become final, and with no pre-existing conditions limitations applied provided the Dependent is enrolled in a timely manner as stated within.

The term "**children**" also means a Covered Member's child who is recognized under a Qualified Medical Child Support Order (QMCSO) as having a right to Coverage under This Plan as an "alternate recipient." The HPP Administrator will communicate the procedures which have been established to determine whether a Medical Child Support Order is qualified under ERISA Sec. 609, and within a reasonable time after receiving an order will determine whether or not the order is qualified, and whether or not the child has been determined to be an "alternate recipient." The Covered Employee and each child who is the subject of the order will be notified of the determination. Such children may designate a representative to receive copies of all such notices.

A child determined to be an "**alternate recipient**" will be provided Coverage under the same terms and conditions that apply to Dependents who are a Covered Employee's natural children, with no pre-existing conditions limitations applied provided the Dependent is enrolled in a timely manner as stated within.

ELIGIBILITY (Continued)

All children are eligible for Coverage up to the age of 26. However a child will remain a Dependent until the end of the calendar year in which the child reaches the age of 30, even after leaving college and home, so long as the young adult meets the following conditions:

- Must either live in Florida or be a full-time or part-time student whose parent resides in Florida;
- Must not be married;
- Must not have a dependent of his or her own;
- Must not be covered by another health plan or policy (group or individual) or by Medicare; and
- If the child was covered under the parent's health insurance policy after the end of the calendar year in which he or she attained age 26, and that coverage was subsequently terminated, the child must have been continuously covered by other health insurance without a gap in coverage of more than 63 days in order to re-enroll in the parent's health insurance policy.

Dependent children from age 26 to 30 will incur additional cost for the coverage; see your Benefits Department for details.

If the employee fails to notify the HPP Administrator, in writing within 60 days, of a Dependent's change in eligibility status, the Dependent shall lose the right of Continuation of Coverage under COBRA. (See the COBRA section of this book for further details.)

The term ***Dependent*** also includes an Employee's unmarried child while the child is Physically, or Mentally Handicapped and is incapable of earning his own living, and who is actually dependent on either parent for a majority of his maintenance and support, and who is a Covered Member on the date immediately preceding the date his health Coverage would have terminated due to age. Proof of incapacity must be submitted to the HPP Administrator within 31-days of the date his health Coverage would have terminated due to age.

In the event both parents of an eligible Dependent child are Covered Members, then for the purposes of this Coverage, such child is considered as a Dependent of either parent, but not both parents.

No eligible person can be a Covered Employee and a Covered Dependent at the same time. No person can be covered as a Dependent of more than one Employee.

Your Eligible Dependents are eligible for Coverage on the date you become eligible for Coverage or on the date you first acquire a Dependent. There are, however, special rules that apply to newborn children and adopted children. Refer to those specific provisions for further information.

A properly qualified COBRA Beneficiary is also eligible for Coverage in accordance with COBRA continuation provisions.

No person may participate in this Plan as a Dependent of more than one Employee.

Requirements

Coverage will not become effective unless a properly completed and signed enrollment application is submitted. No Coverage will be placed in effect unless the required payroll deductions, if any, are paid to the HPP. As explained under "IRS SECTION 125 - FLEXIBLE BENEFIT PLANS," your employer will deduct your contributions before taxes are calculated and deducted from your paycheck.

You must enroll within the first 14-days of your employment date. If you desire Dependent Coverage, you must also enroll your eligible Dependents at that time. Dependents you acquire after this time must be enrolled within 31-days of the date you acquire them.

As a requirement for enrollment in the Plan, all Eligible Dependents of Covered Employees will be required to provide their social security number to the Plan Administrator. This is necessary to allow the Plan Administrator to comply with any and all reporting requirements imposed under federal CMS guidelines.

IRS Section 125 – Flexible Benefit Plans

Federal tax law, Section 125 of the Internal Revenue Code, authorizes the establishment of Flexible Benefit Plans, sometimes called FlexPlans. These FlexPlans are set up by employers to assist their Employees in saving money by allowing Employees to pay for certain expenses with pre-tax dollars. This means they are not subject to withholding for federal income tax, social security tax and the income tax of most states.

The Pre-Tax Premium Plan allows Employees to pay for their group health benefit coverage with pre-tax dollars by authorizing their employers to take payroll deductions for the cost of the coverage before taxes are calculated and deducted from the Employee's paycheck.

Participation in the FlexPlan lowers taxes by reducing the amount of taxable income. How much taxes are lowered depends on many things: total taxable income, whether or not an individual or joint return is filed, federal and state tax rates, whether or not deductions are itemized or the standard deduction is taken, the number of exemptions and so forth.

Social Security benefits may be affected for those whose earnings are below the Social Security Taxable Wage Base. Otherwise, there should be no unfavorable consequences to participating in a Flexible Benefit Plan.

Section 125 of the Internal Revenue Code which allows these special tax breaks also imposes the strict requirement that the choices an Employee makes must stay in effect for a full plan year, or through the end of the plan year in which the Employee becomes a participant.

Employees cannot add, drop, or change coverage except during the Annual Choice Period or within 31-days of a Change in Status as described below.

The County of Volusia has established a Pre-Tax Premium Plan and your premium expenses (for yourself and all enrolled eligible Dependents) for medical will be paid with pre-tax dollars.

You are not required to participate in the County of Volusia Health Partnership Plan, but if you do enroll for coverage, participation in the Pre-Tax Premium Plan is mandatory and automatic. Your premium expenses will be deducted from your paycheck before any taxes are calculated and deducted.

If you do not want to participate in the Pre-Tax Premium Plan you must sign a Refusal of Coverage, declining any coverage offered under the HPP and provide proof of other health insurance coverage.

Once you elect to participate in the Pre-Tax Premium Plan, you cannot add, drop or change your coverage until the next Annual Choice Period, which will be the month of November each year, unless there is a Change in Status as described below. In the case of a Change in Status, you have 31-days from the date of the event to make any changes.

Make your decision carefully. You will not be able to change your coverage, or stop your contributions during the year unless one of the following changes in status occurs:

1. The marriage, divorce, or legal separation (where legally recognized) of an Employee;
2. The death of the Employee's Spouse, or a Dependent;
3. The birth, or adoption of a child of the Employee;
4. The termination, or commencement of employment of Employee's Spouse;
5. The switching from part-time to full-time employment status, or from full-time to part-time status by the Employee, or the Employee's Spouse;
6. The taking of an unpaid Leave of Absence by the Employee, or Employee's Spouse;
7. A significant change occurs in the health coverage of the Employee, or Spouse attributable to the Spouse's employment; or
8. The loss of coverage related to Medicaid or SCHIP

Pre Tax Premium Plan (continued)

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Tax Advantages

Volusia County's Benefits Program allows you to choose the benefits you need while providing important tax advantages to County employees. Your share of the cost for your benefits is paid with before-tax payroll deductions. This means that employee payroll deductions for benefits are not subject to Federal taxes.

In order to maintain this favorable tax treatment, the Internal Revenue Service (IRS) has established rules that govern our Benefit program. Most important, the IRS requires that the choices you make remain in effect for 12 months unless you have a qualifying lifestyle change. The benefit premiums eligible for pretax include:

- a. Health Coverage
- b. Medical Reimbursement Account
- c. Dependent day-care Reimbursement Account
- d. Supplemental Insurances, other than Supplemental Life insurance.

Employees save money using by the plan because you're taxable earnings will be reduced.

IMPACT ON OTHER BENEFITS

When you participate in the Pretax Premium portion and/or the Reimbursement Account of the Flexible Benefits Plan, you save both federal income and social security taxes. However, participation may affect the benefits you receive from other tax-deferred or employee benefit plans:

Social Security

Since contributions to a Flexible Benefit Plan lower annual earnings against which Social Security deductions or employer contributions are made, there is a valid concern that participation in these plans would result in reduced Social Security benefits at retirement. For a person born after 1928, the Social Security benefits are calculated using a 35-year average of earnings. A reduction of \$2,000 a year or even \$5,000 a year over some portion of this 35-year span would have little effect on the average salary and, therefore, minimal impact on the Social Security benefits. The Social Security Administration has provided the U.S. Division of Pensions and Benefits with an example of an employee who retired in 1998 at age 65 whose wages had been at the maximum wages subject to Social Security deductions. Upon retirement, this individual's monthly Social Security allowance was \$1,343. If that same person had been contributing \$2,000 a year for the last 10 years to a Flexible Benefits Plan, the subsequent reduction in Social Security wages would have produced a monthly Social Security allowance of \$1,335, a difference of less than \$10 per month. In contrast, that person's \$2,000 a year contribution to a Flexible Benefits Plan would have yielded a \$63 per month tax savings."

Florida Retirement System (FRS)

Your benefits from the FRS are not affected in any way by your participation in the Flexible Benefits Plan. FRS benefits are calculated on your gross pay before pretax premiums or reimbursement account contributions are deducted.

Life Insurance and Pay Raise Calculations

Your pay raises and the value of your Group Life Insurance will continue to be based on your gross pay before pretax premiums or reimbursement account contributions are deducted. Flexible Benefits Plan participation will have no impact.

Who is Eligible

All employees paying premiums through payroll deduction for benefits are enrolled in the pretax benefit.

Enrollment

You automatically participate.

Changes to Benefit Plan Coverage's

It is your responsibility to notify the Personnel Office each time you have a change in your Family Status.

You must also notify Personnel about your dependent(s) on County benefits plans who do not meet County eligibility requirements.

Contact the County Insurance Division at (386) 74-5137 if any of the information on your benefit records change.

Split Plan Enrollment

Married couples, with children who both work for the County are provided family health coverage at a reduced rate for each employee. Contact Personnel and complete a Split Program Enrollment Form. Documentation of marriage must be submitted. If you want to include other dependents, you must also complete a Dependent Form and provide birth certificates. You and your spouse must be enrolled in the County's health coverage.

No Coverage Option

Under VOLFLEX, you can decline medical coverage with the County by choosing the "No Coverage" option.

If you have health coverage elsewhere, for instance, under your spouse's plan - you may determine that paying for double coverage is not worth the cost. If you elect the "*no coverage option*", you'll receive an allocation of flex dollars that may be applied toward the cost of another pre-tax benefit selection. **You must reapply for this benefit each year.**

To be eligible for the no coverage option, you must provide valid proof that you have this coverage elsewhere. This proof must be submitted each plan year. This may include a letter from your agent, your spouse's employer or another acceptable party verifying that coverage is in force. If you cannot show satisfactory proof of coverage, you will be placed in the County's health plan.

Wellness Dollars

Wellness Dollars are available to employees who do not use tobacco products. The Wellness form is located in the back of this book.

You are eligible for a yearly benefit of \$100 by, answering “**NO**” to question 1 on the wellness form.

To receive \$200 in wellness dollars you must pass two of the four health questions listed on the back of the wellness form.

To receive \$300 dollars you must pass all four of the health questions listed on the back of the wellness form.

You must submit your completed wellness form to Personnel no later than Friday, October 29, 2010 to be eligible for this benefit.

You do not have the option to select wellness dollars in ESS. You must submit your completed Wellness Form to Personnel no later than Friday, October 29, 2010 in order to be eligible for this benefit. You must choose how you would like your wellness spent on the wellness form.

If you submit a Wellness Form and Personnel has confirmed you qualify for the benefit, you can log in to ESS on or after December 06, 2010 to see the benefit added under the Future Enrollments section.

Your wellness dollars may be used two ways;

Example 1: You choose **EBS Medical Spending Account or EBS Dependent Care Spending Account** on your wellness form.

If you choose either EBS box, your wellness dollars will be used to help pay the amount you set up previously in ESS during open enrollment “**or**” an account will be created for you in the amount of your wellness dollars.

If you selected \$1000.00 for a yearly goal in ESS and then submitted your wellness form to Personnel to qualify for \$300.00 dollars with the **EBS Medical Spending Account** marked on your wellness form, your yearly goal will not change to \$1300. Your wellness dollars will be used to pay for part of your selected yearly goal.

Example 2: You choose **Use to lower the cost of current insurances** on your wellness form.

If you choose this box, your wellness dollars will be used to help pay your biweekly premiums of your other benefit choices, like HPP Couple or HPP Family coverage. This money may not be used to pay for your extra Life Insurances. **If you have any leftover wellness dollars after your insurance choices are paid, an EBS medical Spending Account will be set up for this amount.**

If you have couple coverage for the Health Partnership Plan with a biweekly cost of \$104.61 and you qualify for \$300.00 wellness dollars, your biweekly deductions for the plan year would decrease from \$104.61 to \$93.07.

Medical Reimbursement Accounts

ENROLLMENT IS NOT AUTOMATIC. YOU MUST ENROLL EACH PLAN YEAR BY USING ESS DURING OPEN ENROLLMENT.

What's New? HOW HEALTH CARE REFORM AFFECTS YOUR FSA.

Over The-Counter Medicines - beginning with the 2011 plan year (for calendar-year plans), the costs of over-the-counter medicines will no longer be eligible for reimbursement from a Health Care Flexible Spending Account (FSA), unless obtained with a prescription

Limit on Health Care Flexible Spending Accounts (HCFSAs) - Beginning with the 2013 plan year (for calendar-year plans), contributions to a Health Care Flexible Spending Account (HCFA) will be capped at \$2,500 per year, indexed to the CPI.

HOW REIMBURSEMENT ACCOUNTS WORK

A Medical Reimbursement Account works very much like a savings account except, instead of earning interest, you save taxes on the contributions you make. Your tax savings will be immediately reflected in your paycheck. The less taxes you pay the more money you take home!

Your Medical Reimbursement Account Is For Your Entire Family

You can use your Medical Reimbursement Account for eligible expenses incurred by you, your spouse or any dependent. There is no requirement that you have your insurance coverage through your employer to establish an Account, and you can take advantage of the Account even if you, your spouse or your dependents are covered under insurance elsewhere. This means you can set funds aside tax-free for deductibles or co-payments that your spouse or dependents may incur.

What Kind of Expenses Are Eligible

A wide range of expenses are eligible for reimbursement from your Medical Reimbursement Account. A few examples include expenses that are applied to a deductible or coinsurance, copayments, and prescription copayments. Other expenses that would qualify include physicals, prescription eyeglasses, contact lenses (including disposable contacts), dental exams, chiropractors, prescriptions, and expenses that may not be covered by insurance because of a pre-existing condition or for which you have no insurance.

Medical Reimbursement Accounts (continued)

Your Health Care Spending Account now allows you to file all of your Orthodontia expenses up front. The IRS recently changed its guidelines on how orthodontia expenses may be reimbursed. Orthodontia expenses no longer need to be prorated over the course of the treatment. You may now receive the full cost of the treatment up front as long as you have started the treatment and paid for the treatment in full. For more information on the special rules that apply toward orthodontia expenses, please call EBS/Atlanta at 1-800-647-3709.

What Kind of Expenses Are Not Eligible

While the vast majority of medical, dental and vision expenses qualify for tax-free reimbursement, there are nevertheless some expenses that do not qualify. To be eligible for reimbursement, an expense must be "medically necessary". Expenses for solely cosmetic reasons generally are not considered expenses for medical care and therefore are not reimbursable. Also, expenses that are merely beneficial to an individual's general health do not qualify for reimbursement. Examples of expenses not eligible for reimbursement include vacations, weight loss programs, over-the-counter items, or drugs that do not require a prescription to be dispensed (with the exception of insulin). Always check with EBS/Atlanta regarding whether a specific expense qualifies for reimbursement before you elect to contribute to a Medical Reimbursement Account.

How To Establish A Medical Reimbursement Account

To establish a Medical Reimbursement Account, you should first decide how much you want to contribute during the Plan Year. The amount you should consider contributing should be no greater than the amount you expect to spend for eligible medical, dental and vision expenses during the Plan Year. To determine the maximum amount you may contribute to your Medical Reimbursement Account, please refer to your Summary Plan Description, Plan Overview, or contact EBS/Atlanta. On your Election Form, you simply check the box stating you want to establish an Account and enter the amount you want to contribute. Your contributions will be set aside each pay period and credited to your Medical Reimbursement Account. All contributions are made before your federal income taxes, state income taxes, and FICA taxes are calculated.

How To Receive Reimbursement From Your Account

As you incur an eligible expense during the Plan Year, you reimburse yourself by making a withdrawal from your Medical Reimbursement Account. To receive reimbursement, you first complete a special request from that will be supplied to you and attach a copy of the Explanation of Benefits (EOB) statement that you receive from your insurance carrier. This means that you will need to submit the expense to the insurance company before you make a claim for reimbursement. For reimbursement of prescriptions, you would attach a copy of the tax receipt you receive at the time your prescription is filled which shows the cost of the drug or the prescription co-pay you paid. If you do not have insurance coverage for the medical, dental or vision expense, simply attach a copy of the itemized statement that you receive from the doctor, dentist or other provider. The important thing to remember is that the documentation must show the provider's name, address and telephone number, the date the service was provided, the nature of the service provided, for whom the service was provided, and the cost of the service. Since all reimbursements made to you are free of income and FICA taxes, it's like getting a discount on your health-related expenses so you don't have to earn as much to pay for them!

"USE IT OR LOSE IT" RULE

The Federal government has placed restrictions on reimbursement accounts. One of the rules does require that all funds must be used during the Plan Year. Set aside a amount that you feel certain that you will use during the Plan Year. Once the Plan Year ends, you may continue to submit claims for the Plan Year to EBS until March 31 of the following year. Any funds remaining for the Prior Plan Year after March 31 in accordance to IRS Regulations will be forfeited.

Dependent Care Reimbursement

How A Dependent Care Spending Account Works

A Dependent Care Spending Account is a tax-free account that you can establish with your employer. It works very much like a savings account except, instead of earning interest, you save taxes on the contributions you make.

How A Dependent Care Spending Account Saves You Money

As an example, let's assume that you expect to pay \$3,000 for work-related dependent care expenses during the year. Let's also assume that you are in a 28% tax bracket and pay 7.65% in Social Security (FICA) taxes. If you elected to contribute \$3,000 to your Dependent Care Spending Account, your tax savings would be 35.65% of \$3,000 or \$1,069.50! If you are in a higher tax bracket or reside in a state that imposes a state income tax, your savings would be even greater! (* Actual tax savings will vary by individual.)

Your Dependent Care Expenses Must Be Work-Related

To qualify for a Dependent Care Spending Account, your dependent care expenses must be work-related, meaning that the dependent care is required so that you - and your spouse, if you are married - can be gainfully employed outside the home. A special rule applies if your spouse is a full-time student or is incapable of caring for themselves.

Who Is An Eligible Dependent

An eligible dependent is defined as a person who you can claim as a dependent for federal income tax purposes and who:

Is under age 13; or

Requires full-time care because of physical or mental incapacity (such as a disabled parent); or

Is your spouse and is physically or mentally incapable of caring for himself or herself.

Who Are Eligible Dependent Care Providers

Eligible dependent care providers include:

- An individual who cares for your dependent either in your home or in their home (provided that individual is not your spouse, is not another child of yours under age 19, or is not your parent if you claim that parent as a dependent of yours);

Dependent Care Reimbursement (continued)

- A day care center or nursery (provided that center or nursery meets state and local regulations, cares for more than six nonresidents and receives a fee for such services, whether or not for profit);
- Before or after school care (provided your child is not over age 12);
- Summer day camp (but not overnight camp);
- A nursery school.
- Educational expenses for a child in kindergarten, first grade or above.

Dependent Care Provider Identification Requirements

IRS regulations require all dependent daycare claims to be verified with a third-party receipt. Starting in January 1009 your daycare provider must provide you with a receipt (hand written or itemized printout) for you to submit with your dependent daycare claim's be eligible to claim the Federal Dependent Care Tax Credit or for an expense to be eligible for reimbursement through a Dependent Care Spending Account, you must provide the caregiver's name, address and taxpayer identification number (or Social Security Number) on IRS Form 2441. You must complete a Form 2441 once each plan year and submit it to EBS/Atlanta for each dependent care provider you use.

Must I pay my dependent care provider first before I can file a claim for reimbursement?

No, you must only incur the expense during the plan year. "Incur" means that the service must actually be provided during the plan year, regardless of when you are billed or pay for the service.

What Is The Maximum Contribution?

The IRS limits the amount you may contribute to your Dependent Care Spending Account. The maximum you may contribute is \$5,000 per plan year (or \$2,500 for married individuals filing separate federal tax returns). If you and your spouse work for the same employer or if your spouse contributes to a Dependent Care Spending Account at his or her place of employment, the maximum combined contribution cannot exceed \$5,000 per household. In any case, your contributions to your Dependent Care Spending Account cannot exceed your earned income or your spouse's earned income, whichever is less. A special rule applies if your spouse is a full-time student or is incapable of self-care.

How To Establish A Dependent Care Spending Account

First, you must decide how much you want to contribute to your Dependent Care Spending Account. The amount you should consider contributing should be no greater than the amount you expect to spend for eligible dependent care expenses during the plan year. Your contributions will be deducted each pay period and credited to your Dependent Care Spending Account. All deductions will be made before federal income tax, state income tax, and Social Security taxes are calculated.

Dependent Care Reimbursement (continued)

How To Receive Reimbursement From Your Dependent Care Spending Account

When you incur an eligible dependent care expense, you will need to submit a Claim Form along with a bill or receipt, to obtain reimbursement. You can be reimbursed an amount equal to your contributions to date less any previous reimbursements. This means that if you submit a claim for expenses that exceed your contributions, you will be reimbursed for the amount you actually have available in your Dependent Care Spending Account on the date the claim is processed. You will automatically be reimbursed the balance of your claim as additional contributions are made.

If I have dependent care provided during one plan year, but I do am not billed or pay for the care until the next plan year, can I still be reimbursed?

Possibly, if you had a Dependent Care Spending Account during the plan year in which the service was provided. For example, if your employer's flexible benefits plan operates on a calendar year basis (January 1 to December 31) and you incurred the expense on December 22, 2003, but you were not billed or did not pay the expense until January 15, 2004, you could file the expense against your 2003 Medical FSA but not against your 2004 Medical FSA. Only expenses for dependent care services actually provided during the plan year may be claimed for reimbursement. Each plan year is treated separately and expenses may not be carried forward from plan year to the next.

Making Mid-Year Changes to a Dependent Care Spending Account

Generally, once you've decided to establish a Dependent Care Spending Account, you will not be able to change your contributions during the plan year unless you have a qualified change in status, such as the birth of another child, divorce or death. You may also be able to change your contribution if your day care arrangement changes (you switch providers or remove your child from daycare, the cost of day care changes during the year or your child reaches the age of 13 during the plan year). To request a mid-year change, you will need to complete a Revocation Request Form and submit it to EBS/Atlanta within 30-days of the status change or change in provider. If your change in status allows you to decrease or stop your dependent care contributions, payroll deductions for the remainder of the year will be at the lower rate. However, any contributions you've already made to your Dependent Care Spending Account must be used for reimbursements. They cannot be refunded to you as a result of your change in status.

What Happens To Your Account When You Take A Paid or Unpaid Leave of Absence?

Because dependent care expenses must be work-related, you may not be reimbursed for dependent care expenses incurred during any period of paid or unpaid leave of absence taken by you or your spouse. It is also recommended that you complete a Revocation Request Form to stop deductions during the leave of absence. You may have your deduction reinstated when you or your spouse returns to work.

What Happens To Your Account When Employment Terminates?

If your employment terminates during the plan year, no additional contributions may be made to your Dependent Care Spending Account. You may, however, continue to claim reimbursement for eligible dependent care expenses that you incurred prior to your date of termination.

Take Care Flex Spending Card



Welcome to TakeCare from EBS/Atlanta ... the fastest way to access funds from your Flexible Spending Account!

TakeCare from EBS/Atlanta makes your Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, and your Transportation Flexible Spending Account (FSA) easier to use! TakeCare from EBS/Atlanta is a special VISA card that draws on the value of your FSA election amount. Each time you incur a qualified expense at a provider that accepts VISA, you simply use your TakeCare Card. The amount of your qualified purchases will be deducted from your FSA automatically! When you use your Card for an expense that does not match your copay, the IRS will still require you to submit the itemized receipt for that transaction. When a transaction has occurred that required an itemized receipt, EBS/Atlanta will notify you by U.S. Mail or email if you prefer. Any pending items requiring receipts will also be available online by accessing your personal account at www.ebsatlanta.com.

Using your TakeCare Card is simple...

- It's Automatic! Funds are immediately deducted from your FSA at the time your card is used and the provider is paid!
- It's Fast & Easy! Simply swipe your card, press "Credit" and save your receipts!
- It Improves Your Cash Flow & Reduces Paperwork! It's not necessary to pay cash at the time of purchase and then file for reimbursement!
- It's Easy To Track! Your current balance, transactions, and items requiring receipts are all available online at www.ebsatlanta.com.
- The annual fee for this card is \$21.00 and this charge is paid from the funds into your Medical or Dependent Care Account.

When you use your TakeCare Card at a retail provider, remember to only use your card for eligible expenses. Should your card be used for an item that is ineligible, you will be required to repay your account for that expense. You can repay by check, debit or credit card.

Your TakeCare Card from EBS/Atlanta can be used for:

- Doctor and Hospital copays, deductibles, and expenses
- Prescription Drugs
- Eligible Dental and Vision expenses
- Dependent Care Providers
- Work related Mass Transit and Parking Facilities (requires a Transportation FSA)

Take Care Flex Spending Card (continued)

Simply present your TakeCare Card at any qualified provider who accepts VISA and your FSA account will automatically be debited!

With the TakeCare Card, you no longer need to pay the provider and wait for reimbursement. Nothing could be easier!

Your TakeCare Card is a special card that has been programmed to authorize payment only to providers whose merchant code meets specific criteria. The Card may only be used at Doctor's offices, Dentist offices, Chiropractors, Hospitals, Pharmacies, Child Care Providers, Parking & Transit facilities.

IMPORTANT! Be sure to check EBS/Atlanta's website for a current listing of eligible merchants where your Card may be used, or contact EBS/Atlanta by calling toll-free (800) 647-3709 or by sending an email to flex@ebsatlanta.com.

Common Questions & Answers

Q – If I use my TakeCare Card, do I need to save my itemized receipts?

A – Yes. Since FSAs are regulated by the IRS, you should save all receipts. EBS/Atlanta may contact you to submit a receipt to verify an expense. To meet IRS requirements, if you fail to submit a requested receipt within the time frame indicated in the request, your TakeCare Card will be suspended in accordance with IRS Regulations until the issue is resolved.

Q – If my prescription costs less than or more than the co-pay, can I still use my TakeCare Card?

A – Yes. Your TakeCare Card will work for all of your prescription drugs, however, those prescriptions that are not an exact co-pay match will require that an itemized receipt be submitted to EBS/Atlanta for substantiation.

Q – When receipts are required by EBS/Atlanta, what type of receipts should I submit?

A – For medical, dental and vision expenses, you will need to submit an itemized bill from the provider or an Explanation of Benefits (EOB) from your insurance company. For prescription drugs, submit the tax receipt (which includes the drug name).

Cancer Insurance

Cancer insurance from Allstate Workplace Division pays you benefits that can be used for non-medical cancer-related expenses that health insurance might not cover. The policy is guaranteed renewable for life, subject to change in premiums by class. Benefits paid directly to you unless assigned

Benefits are paid in addition to any other coverage. Individual or Family coverage

Biweekly Premiums	OPTION 1	OPTION 2
Employee	\$7.76	\$8.92
Family	\$13.63	\$15.70

First Occurrence Benefit

When a covered person is diagnosed for the first time as having cancer, other than skin cancer. Benefit is payable only once per covered person. We pay this benefit even when cancer is not diagnosed until after death	\$1,500.00	\$2,000.00
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Benefits Associated With Hospitalization for Cancer Treatment

Hospital Confinement

For each day of continuous hospital confinement up to 70 days	\$300.00 a day	\$350.00 a day
71st thru 90th day of continuous hospital confinement	\$400.00 a day	\$450.00 a day
After 90th day actual charges up to amount shown until the end of the continuous hospital confinement (in lieu of benefits which would otherwise be payable—except the waiver of premium benefit).	\$600.00 a day	\$650.00 a day

Drug and Diagnostic Testing Benefit

Actual charges made by the hospital up to amount shown per day for drugs, medicine and diagnostic testing related to cancer treatment (unless such charges are covered under the radiation/chemotherapy benefit—except the waiver of premium benefit).	\$40.00 a day	\$40.00 a day
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Attending Physician or Surgeon

Actual charges up to amount shown per day for services of an attending physician while a covered person is an inpatient receiving cancer treatment. Limit of one visit by one physician or surgeon per day.	\$35.00 a day	\$40.00 a day
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Cancer Insurance (continued)

Private Nursing

While a covered person is an inpatient receiving cancer treatment, we will pay the actual charges up to the amount indicated per day if such covered person requires the full-time services of a private nurse for at least 8 hours during a 24-hour period. Must be required and authorized by a physician for cancer treatment and must be provided by a nurse not related to the covered person.

\$125.00 a day

\$125.00 a day

Benefits Associated With Cancer Treatments, Either In Or Out Of A Hospital

Surgical Procedure

Actual charges up to amount shown and subject to a maximum that varies by procedure. Two or more procedures performed at the same time through one entry point are considered one surgery; we will pay the amount specified for the procedure with the highest benefit. This benefit does not pay for surgeries covered by other benefits in the policy

from \$37 to
\$7,500 depending
on procedure

from \$45 to
\$9,000 depending
on procedure

Anesthesia

Actual charges up to 25% of the amount paid for the surgical procedure benefit.

25%

25%

Second Surgical Opinion

Actual charges for an independent second opinion in conjunction with a surgery for cancer treatment (other than skin cancer) up to amount shown. This second opinion must be: rendered prior to surgery being performed; and obtained from a physician not in practice with or otherwise affiliated with the physician making the original recommendation.

\$225.00

\$250.00

Ambulatory Surgical Center

We will pay the actual charges up to the amount indicated per day for a surgical procedure performed in an ambulatory surgical center

\$300.00 a day

\$350.00 a day

Prosthesis and Reconstructive Breast Surgery

•Actual charges up to amount shown for a surgically implanted prosthesis, prescribed by a physician as a direct result of cancer surgery or cancer treatment.

\$2,000.00

\$3,000.00

•Actual charges up to amount shown for a non-surgically implanted prosthesis, prescribed by a physician as a direct result of cancer surgery or cancer treatment

\$300.00

\$500.00

Under this group of benefits one benefit will be paid for the procedure that will provide you the greatest benefit. We will pay the reconstructive breast surgery benefit only once per covered person for each diagnosis of cancer.

Cancer Insurance (continued)

Benefits Associated With Cancer Treatments, Either In Or Out Of A Hospital

Radiation/Chemotherapy

Option 1

Options 2

Actual charges of such treatments up to amount shown per day.

Benefit is payable for an unlimited number of days of treatment.

\$250.00 a day

\$300.00 a day

Comfort/Anti-Nausea

\$200.00 a year

\$200.00 a year

Actual charges up to amount shown per year for prescribed anti-nausea medication in conjunction with cancer treatment received as an outpatient.

Home Care Recovery

\$20.00 a day

\$25.00 a day

After discharge from a covered hospital confinement, the amount stated per day for up to a total number of days equal to the days spent in the hospital.

Blood, Plasma and Platelets

\$125.00 a day

\$150.00 a day

The actual charges for blood, plasma and platelets up to amount shown per day for each day that such items are received as part of cancer treatment. This benefit does not pay for charges incurred for the procurement or processing of blood, plasma or platelets.

Benefits Associated with Bone Marrow Transplants For Cancer Treatment

Bone Marrow Transplants

Non-autologous (donor to patient) transplant for leukemia

\$5,000.00

\$10,00.00

Non-autologous (donor to patient) transplant associated with any form of cancer, other than leukemia

\$2,500.00

\$5,000.00

Any other form of bone marrow transplant associated with any form of cancer.

\$1,000.00

\$2,000.00

Each benefit is payable only once per covered person. This benefit does not pay for stem cell transplants

Benefits Associated With Transportation and Lodging For Cancer Treatment

Ambulance

\$200.00

\$200.00

In conjunction with each continuous hospital confinement of the covered person, the cost of a licensed ambulance service up to the amount shown.

Cancer Insurance (Continued)

Transportation

\$.25 a mile

\$.30 a mile

Actual charges for the lowest unrestricted published coach class plane, train, or bus fare, or the amount shown per mile (up to 1,000 miles each way) if a covered person must travel more than 100 miles one way from home to receive covered cancer treatments, or for consultation (one time per calendar year) about his or her cancer at a Comprehensive or

Clinical/Cancer Center (as defined by the National Cancer Institute)

Family Member Transportation

\$.25 a mile

\$.30 a mile

If a covered person is an inpatient in a hospital more than 100 miles one way from home for covered cancer treatment not available within 100 miles from home, the actual charges of the lowest unrestricted published coach class plane, train, or bus fare, or the amount shown per mile for up to 1,000 miles each way if a covered person chooses to travel by car, we will pay the amount shown per mile. This benefit is limited to two one-way trips per period of continuous hospital confinement. This benefit will not be paid if a mileage benefit is paid for the covered person and the family member lives in the same city as the covered person.

Family Member Lodging

\$50.00 a day

\$60.00 a day

If a covered person is hospitalized as an inpatient more than 100 miles one-way from home for covered cancer treatment not available within 100 miles of home, we will pay the actual charges for lodging of a family member who accompanies the covered person up to the amount shown per day for up to 60 days per continuous hospital confinement

Benefits Associated With: Skilled Nursing Facility Care And Hospice Care Due To Cancer

Skilled Nursing Facility

\$125.00 a day

\$150.00 a day

If confined within 14 days of a covered hospital confinement, a benefit equal to the actual charges of the skilled nursing facility up to the amount shown per day for up to a number of days equal to the days of the immediately preceding covered hospitalization.

Hospice Care

\$100.00 a day

\$125.00 a day

When a terminally ill covered person is no longer receiving cancer treatment and expected to live 6 months or less, the amount shown per day for each of the first 60 days of hospice services at home, in a hospital, or on an outpatient or inpatient basis by a hospice.

On the 61st day and thereafter, the amount shown for every day the insured receives hospice services

\$50.00 a day

\$75.00 a day

Cancer Insurance (Continued)

Waiver Of Premium Benefit - If the primary insured becomes disabled due to cancer and remains disabled for 90 consecutive days, we will pay the premiums which become due for this policy and any riders attached to this policy after 90 days for as long as you remain disabled. **Any treatment that is covered under the benefits of the policy and is medically necessary will be covered on an outpatient basis if provided on an inpatient basis or is given as an alternative to inpatient treatment and is not covered by any other benefits of the policy.**

Eligibility/Termination - Family Plan coverage may include you, your spouse and dependent children as defined in the policy. Coverage for dependent children terminates on the policy anniversary following the date on which the child is no longer eligible, which is the earlier of when the child marries or reaches age 21 (25 if a full-time student at an educational institution of higher learning beyond high school). Coverage for the insured's spouse ends upon valid decree of divorce.

Pre-existing Condition Limitation - A pre-existing condition is cancer, as defined in the policy that first manifests itself prior to the effective date of coverage. If a covered person has a pre-existing condition, AWD does not pay benefits for such conditions under the policy or any riders attached to the policy during the 12 month period beginning on the date that person became a covered person.

Renewability - The policy is guaranteed renewable for life, subject to change in premiums by class. A notice will be mailed in advance of any change.

Exceptions and Limitations - Treatment must be received in the US or its territories. No benefits are payable for cancer treatment except those expressly stated in the Explanation of Benefits. The policy and Cancer Hospitalization Progressive Benefit Rider do not pay for: any sickness except cancer (diagnosis must be submitted to support each claim); or any disease or incapacity that has been caused, complicated, worsened or affected by cancer or as a result of cancer treatment, unless coverage is specifically covered for that disease or incapacity in Explanation of Benefits. For those benefits for which AWD pays charges up to a specified amount, if specific charges are not provided, AWD will pay 50% of the benefit maximum.

The policy is a Limited Benefit Cancer Policy. Servicing Agent: Jan Hunt 407-342-3728

Benefits are provided by Cancer/Specified Disease Insurance policy CBP2P, or state variations thereof. This flyer 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 insured and the insurance company. The policy is not a Medicare Supplement Policy. If eligible for Medicare, review Medicare Supplement Buyers Guide available from Allstate Workplace Division. The policy is underwritten by American Heritage Life Insurance Company. Allstate Workplace Division is the marketing name used by American Heritage Life Insurance Company (Home Office, Jacksonville, FL), a subsidiary of The Allstate Corporation. ©2006 Allstate Insurance Company.

Note: Federal Law, section 4354 Omnibus Budget Reconciliation Act of 1990 dictates that no person age 65 or over is allowed to enroll in any supplemental coverage which would duplicate Medicare coverage. This policy falls into this category.

Important: This plan does not provide comprehensive health coverage nor are they intended to replace your health coverage or be a substitute for health coverage!!!

Heart Care Plus

You may elect coverage for Heart Care or Critical Illness; you may not elect coverage under both plans

Biweekly Premiums

Employee	\$10.84
Family	\$21.08

Benefits are payable for treatment of a heart attack, heart disease or a stroke. Two or more surgical or invasive procedures done at the same time and through a common incision or entry point are considered one operation and benefit is paid for the one procedure with the largest total benefits

Benefit amounts listed are based on one unit of coverage.

Hospital Confinement \$400 per day for each day a covered person is admitted and confined as an inpatient in a hospital.

Physician's Attendance \$50 per day for the services of a physician during a covered hospital confinement. Payable only for the number of days the hospital confinement benefit is payable.

Inpatient Drugs and Medicine \$50 per day for drugs or medicine required during a covered hospital confinement. Payable only for the number of days the hospital confinement benefit is payable.

Pacemaker Insertion \$2,000 for the initial insertion of a permanent pacemaker

Oxygen \$400 for the use of oxygen equipment during a covered hospital confinement, subject to a maximum of 1 payment per continuous hospital confinement.

Cardiograms \$200 for an electrocardiogram, echocardiogram, phonocardiogram, or vectorcardiogram required during a covered hospital confinement, subject to a maximum of 1 payment per continuous hospital confinement.

Thromboendarterectomy \$5,000 for a thromboendarterectomy operation.

Cerebral or Carotid Angiogram \$300 for a cerebral or carotid angiogram required during a covered hospital confinement, subject to a maximum of 1 payment per continuous hospital confinement

Blood, Plasma and Platelets \$400 for the administration of blood, plasma, or platelets during a covered hospital confinement, subject to a maximum of 1 payment per continuous hospital confinement.

Coronary Angioplasty \$1,500 for a coronary angioplasty procedure, regardless of the number of blood vessels repaired during the procedure

Cardiac Catheterization \$1,000 for a cardiac catheterization procedure.

Coronary Artery Bypass Graft Operation \$5,000 for a coronary artery bypass graft operation, regardless of the number of grafts performed during the operation.

Heart Transplant \$200,000 for the implantation of a natural human heart. This benefit is only payable once per covered person

Heart Care Plus (continued)

Surgery and Anesthesia 1. Surgery*. Up to \$10,000 for a surgery performed in a hospital or ambulatory surgical center. For a surgical procedure not listed in the surgical schedule, we pay \$34 multiplied by the 1964 C.R.V.S. unit value for the procedure, subject to a maximum of \$10,000. If no 1964 C.R.V.S. unit value exists for the procedure, then the payment amount will be based upon relative difficulty and payment amounts for other procedures, up to maximum of \$10,000.

2. Anesthesia*. 25% of the amount paid for benefit described in “1” above for anesthesia received during the surgery.

3. Ambulatory Surgical Center*. \$500 when surgery benefit described in “1” above is paid for a surgery performed at an ambulatory surgical center.*These benefits do not pay for surgeries covered by other benefits in the policy.

Second Surgical Opinion \$200 for a second opinion obtained after a positive diagnosis that results in the physician recommending surgery for a covered illness.

Ambulance \$400 Non-Air Ambulance; \$800 Air Ambulance for transfer by ambulance to a hospital or emergency room for the treatment of a covered condition.

Non-Local Transportation \$400 for a covered hospital confinement which is obtained more than 100 miles from the covered person’s home because the prescribed treatment cannot be obtained locally. This is subject to a maximum of 1 payment per continuous hospital confinement

Family Member Lodging and Transportation

1. Lodging. \$100 per day when the Non-Local Transportation benefit is paid and a family member stays in a motel, hotel, or any other accommodation acceptable to us, in order to be near the covered person, subject to a maximum of 60 days per continuous hospital confinement.

2. Transportation. \$400 when the Non-Local Transportation benefit is paid and a family member travels more than 100 miles from their home to be near the covered person for a portion of their continuous hospital confinement. This is subject to a maximum of 1 payment per continuous hospital confinement.

Optional Hospital Intensive Care Rider (ICR90) This optional rider 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 very first day of confinement.

- Benefits paid in addition to other insurance coverage.
- Guaranteed renewable for life, subject to change in premiums by class.
- Pays a benefit when hospital intensive care confined to a Government or VA hospital.

Description of Benefits • Hospital Intensive Care Confinement Benefit \$500 (or \$250 at age 70 and older) per 24 hours (fractional amounts for fractions of 24 hours) of intensive care unit confinement for any covered illness or accident, subject to a maximum of 45 days per continuous hospital intensive care unit confinement.

Ambulance Benefit Actual Charges for transportation by a licensed ambulance service to the hospital for admission to an intensive care unit. This benefit is not paid if an ambulance benefit is paid under the policy

Heart Care Plus (continued)

Exclusions/Limitations We do not pay for intensive care confinement if you are admitted because of a pre-existing condition as defined in the policy. We do not pay for intensive care if admitted because of: attempted suicide or intentional self-inflicted injury; or intoxication or being under the influence of drugs not prescribed or recommended by a physician; or alcoholism or drug addiction. We do not pay for confinements in any care unit that does not qualify as a hospital intensive care unit. The following do not qualify as "Hospital Intensive Care Units:" progressive care units; or sub-acute intensive care units; or intermediate care units; or private room with monitoring; or step-down units; or any other lesser care treatment units. **Renew ability**-Your policy will remain in effect when renewal premiums are paid as they are due or during the grace period. Renewal premiums will be at the premium rates in effect on the renewal date. We can change the premium rates on premiums becoming due after the first premium. However we can only change the rate by making the rate change for all such policies in a class. After the policy has been issued, we cannot place any restrictive riders on it or cancel or refuse to renew your policy if you maintain it continuously in force. If we do change rates on all like policies in your class, we will mail you a notice of this change. Notice will be mailed at least 45 days prior to such change. It will be mailed to your address as shown on our records. No change in premiums is effective unless this notice is mailed. **Exclusions and Limitations**-This policy does not cover any other sickness or incapacity caused, complicated or otherwise affected by Heart Attack, Heart Disease or Stroke. If covered confinement is due to more than one covered condition, benefits will be payable as though the confinement were due to one condition. If a confinement due to a covered disease is also due to a condition that is not covered, benefits will be payable only for the part of confinement attributed to the covered condition. **Pre-Existing Condition Limitation**-This policy does not cover pre-existing conditions during the first 12 months. This policy is a Florida policy whose rule concerning denials of claims based upon pre-existing conditions is found in the Florida Regulations. The following is the substance of the rule as it applies to this policy: Pre existing Conditions. Coverage under the policy pertains solely to Heart Attack, Heart Disease or Stroke which first manifests subsequent to the effective date of coverage. If a covered person has a pre-existing condition as Heart Care defined, we do not pay benefits for such conditions under this policy or any riders attached to this policy during the 1 year period beginning on the date that person became a covered person. If the loss is not due to a pre-existing condition, then the pre-existing condition limitation does not apply. All losses are subject to the Incontestability provision. **Eligibility/Termination** - Family Plan coverage may include you, your spouse and dependent children as defined in the policy. Coverage for dependent children terminates on the policy anniversary following the date on which the child is no longer eligible, which is the earlier of when the child marries or reaches age 21 (25 if a full-time student at an educational institution of higher learning beyond high school). Coverage for the insured's spouse ends upon valid decree of divorce.

Servicing Agent Jan Hunt 407-342-3728 Benefits provided by policy form HSP2, or state variations thereof. Intensive Care Rider provided by rider ICR90, or state variations thereof. underwritten by American Heritage Life Insurance Company. This brochure is incomplete without a state-specific rate insert. Variations of the policy and riders may exist by state. This brochure highlights some features of the policy and riders but is not the insurance contract. Only the actual policy and rider provisions control. The policy and riders set forth, in detail, the rights and obligations of both the insured and the insurance company. The policy and optional riders are not a Medicare supplement Policy, if eligible for Medicare; review Medicare Supplement Buyer's Guide available from Allstate workplace Division. Allstate Workplace Division is the marketing name used by American Heritage Life Insurance Company (Home Office, Jacksonville, FL), a wholly owned subsidiary of The Allstate Corporation. ©2002 American Heritage Life Insurance Company. The Workplace Marketer®/Workplace Division allstate.com.

You may elect coverage for Heart Care or Critical Illness; you may not elect coverage under both plans.

Critical Illness

- Benefits payable from both Category 1 and 2
- Basic benefit amounts (\$5,000 - \$50,000) to meet your individual needs.
- Your premium is based on your age at issue, tobacco status, and basic benefit amount you select.
- Your premium does not increase with age.
- Benefits paid directly to you
- Benefits paid in addition to any other coverage
- Guaranteed renewable for life, subject to change in premiums by class
- No reduction in benefits due to age
- Individual, single parent family or family coverage available.

Category 1

Heart Attack - 100% The death of a portion of heart muscle as a result of inadequate blood supply to the relevant area. Diagnosis must be based on both new electro cardiographic changes; and elevation of cardiac enzymes or biochemical markers.

Stroke - 100% Death of a portion of the brain producing neurological sequelae including infarction of brain tissue, hemorrhage and embolization from an extra-cranial source. There must be evidence of permanent neurological deficit.

Heart Transplant -100%the process of receiving a transplant of a heart.

By-Pass Surgery - 25% Undergoing a surgical operation to correct narrowing or blockage of one or more coronary arteries with bypass grafts on the advice of a consultant cardiologist licensed in the United States. Angiographic evidence to support the necessity for bypass surgery will be required.

Angioplasty, Atherectomy, Stent Placement - 25%

The dilatation of an artery for the treatment of coronary artery disease: stenosed by atherosclerotic plaque or hyperplasia by the passage of an inflatable catheter through the vessel to the area of disease where inflation of the catheter compresses the plaque against the vessel wall. Stent placement and/or atherectomy are likewise covered in a similar manner. Confirmation by a licensed cardiologist and angiographic evidence of the underlying disease must be received. Benefits are payable for only one of the three procedures listed.

Category 2

Major Organ Transplant (other than heart) - 100% the process of receiving a transplant of a lung, liver, pancreas, or kidney.

End Stage Renal Failure - 100% End stage renal disease affecting both kidneys, due to whatever cause or causes, with the insured undergoing peritoneal dialysis or hemodialysis or resulting in renal Transplant.

Multiple Sclerosis - 25% Unequivocal diagnosis by a consultant neurologist following more than one episode of well-defined neurological symptoms and signs and confirmed by a neurological exam and M RI scan of the brain or spinal fluid analysis. Symptoms must persist continuously for 6 months to ensure that the condition is permanent.

Critical Illness (continued)

Alzheimer's Disease -25% A clinically established diagnosis of Alzheimer's disease by a psychiatrist or neurologist, resulting in the inability to perform independently 2 or more of the following activities of daily living: bathing; and dressing; and toileting; and eating; and taking medication.

Paralysis (not as a result of a stroke) - 50% (2 limbs) & 100% (4 limbs) Complete and permanent loss of use of two (2) limbs (Paraplegia) through paralysis. Complete and permanent loss of use of four (4) limbs (Quadriplegia) through paralysis. • Paralysis as a result of stroke is excluded. The additional 50% of the basic benefit amount may be payable for diagnosis of Quadriplegia subsequent to diagnosis of Paraplegia.

Wellness Benefit Rider (WBR3) Included

We pay \$75, for each covered person for each calendar year, for one of the following cancer screening tests performed: Bone Marrow Testing; CA15-3 (blood test for breast cancer); CA125 (blood test for ovarian cancer); CEA (blood test for colon cancer); chest X-ray; colonoscopy; flexible sigmoidoscopy; hemocult stool analysis; mammography, including breast ultrasound; Pap smear, including Thin Prep Pap Test; PSA (blood test for prostate cancer); Serum Protein Electrophoresis (test for myeloma); or biopsy for skin cancer. There is no limit to the number of years a covered person can receive cancer

Renewability/Termination - The policy and riders are guaranteed renewable for life, subject to change in premiums by class. All premiums may change on a class basis. A notice is mailed in advance of any change. Family coverage may include you, your spouse and eligible children as defined in the policy. Single Parent Family coverage includes you and eligible children as defined in the policy. The policy terminates at the earliest of the end of the grace period for the payment of the premium for the policy; or the next renewal date after your request to terminate the policy; or the date each covered person has received the maximum total percentage of the basic benefit amount for each illness category; or your death except that your spouse, if a covered person, becomes the new insured upon your death and assumes all the rights held by you at death. Coverage for dependent children terminates on the policy anniversary next following the date the child is no longer eligible, which is the earlier of when the child marries or reaches age 22 (26 if a full-time student at an educational institution of higher learning beyond high school). Coverage for your spouse ends upon valid decree of divorce.

Pre-Existing Condition - If a covered person has a pre-existing condition as defined, we do not pay benefits for such condition under the policy or any riders attached to the policy during the 12 month period beginning on the date that person became a covered person, unless the condition: was disclosed without material misrepresentation in answer to questions in the application; and is not excluded by name or specific description. A pre-existing condition is a condition not revealed in the application for which symptoms existed within the 12 month period before the effective date of coverage; or medical advice or treatment was recommended by or received from a medical doctor within the 12 month period before the effective date of coverage. • A pre-existing condition can exist even though a diagnosis has not yet been made. • A pre-existing condition does not include routine breast cancer follow - up care.

Limitations and Exclusions General - We do not pay benefits under the policy for an illness due to or resulting from: any act of war, whether or not declared, participation in a riot, insurrection or rebellion; or intentionally self-inflicted injuries; or injury incurred while engaging in an illegal occupation or committing or attempting to commit a felony; or attempted suicide, while sane or insane; or any injury sustained while under the influence of alcohol, narcotics or any other controlled substance or drug unless administered upon the advice of a medical doctor; or participation in any form of aeronautics except as a fare-paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports; or alcohol abuse or alcoholism, drug addiction or dependence upon any controlled substance.

Critical Illness (continued)

Claims for benefits under the policy not satisfying all the criteria for diagnosis are subject to review by our medical director or his or her designee. • The policy provides benefits only for the illnesses shown. You can only receive benefits for an illness under the policy and cancer rider once. The policy does not cover any other disease, sickness or incapacity. All covered conditions must be diagnosed by a medical doctor. Emergency situations that occur while the covered person is outside the United States will be reviewed and considered for approval by a United States medical doctor on foreign soil or when the covered person returns to the United States.

Stroke - Transient ischemic attacks (TIAs) are excluded.

By-Pass Surgery - The following procedures are not covered under the by-pass surgery benefit: balloon angioplasty; laser embolectomy; atherectomy; stent placement; or other non-surgical procedures.

Critical Illness Cancer Rider - We do not pay a benefit under the rider for any disease other than cancer as defined in the rider.

Critical Illness (CILP - The amount of coverage purchased is called the Basic Benefit Amount, which is the lifetime maximum benefit payable per category of illness for each covered person. Within the policy there are two categories of illnesses for which benefits may be payable. We pay a percentage of the basic benefit amount if you are diagnosed for the first time ever with one of the illnesses shown within this brochure if the date of diagnosis is after the policy date, and the date of diagnosis is while the policy is in force and that illness is not excluded by name or specific description in the policy.

This brochure highlights some features of the policy and riders but is not the insurance contract. Only the actual policy and rider provisions control. The policy and riders set forth, in detail, the rights and obligations of both the insured and the insurance company.

This is a Limited Benefit Critical Illness Policy with an Optional Rider. The policy and rider are not a Medicare Supplement Policy. If eligible for Medicare, review Medicare Supplement Buyer's Guide available from Allstate Workplace Division. Allstate Workplace Division is the marketing name used by American Heritage Life insurance company (Home Office, Jacksonville, FL), a wholly-owned subsidiary of The Allstate Corporation.

Servicing Agent Jan Hunt 407-342-3728

Example of How Benefits are Paid

<u>Benefit</u>	<u>Amount payable</u>
If you have	
An Angioplasty procedure	Angioplasty at 25% = \$25,000
Then	
A Stent Placement	Stent Placement at 25% = \$0.0
	(because Angioplasty benefits were paid)
By Pass Surgery	By Pass Surgery at 25% = \$12,500
Then	
A Stroke	Stroke at 100% = \$25,000
Then	(because \$25,000 was already paid under category 1)
Cancer Screening Test	CEA (blood test for colon cancer) = \$75.00
Total category 1 and wellness benefits paid = \$50,075	

Critical Illness (continued)

After 100% of the basic benefit amount of the policy has been paid within a category (Category 1 or Category 2) we do not pay any more benefit for any illness associated with that category for that covered person. Use tobacco rates for individual and single parent family coverage if the proposed insured has used any cigarette product in the last 12 months.* *Use tobacco rates for family coverage if the employee or the spouse has used any cigarette product in the last 12 months.

Critical Illness Biweekly Premium Rates

Non Tobacco Rates

Issue Ages	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
Employee										
18-29	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	4.18
30-39	n/a	n/a	n/a	n/a	4.72	5.46	6.20	6.94	7.66	8.40
40-49	n/a	4.02	5.52	7.02	8.50	10.00	11.50	13.00	14.50	15.98
50-59	n/a	5.96	8.42	10.88	13.34	15.80	18.26	20.72	23.18	25.64
60-64	4.96	8.88	12.82	16.74	20.66	24.58	28.52	32.44	36.36	40.28
Single Parent										
18-29	n/a	n/a	n/a	n/a	n/a	n/a	4.22	4.58	4.94	5.30
30-39	n/a	n/a	4.18	5.02	5.86	6.70	7.52	8.36	9.20	10.04
40-49	n/a	5.12	6.84	8.56	10.28	12.00	13.72	15.44	17.16	18.88
50-59	4.52	7.36	10.20	13.06	15.90	18.74	21.58	24.44	27.28	30.12
60-64	5.98	10.30	14.62	18.94	23.26	27.56	31.88	36.20	40.52	44.82
Family										
18-29	n/a	n/a	n/a	n/a	4.48	5.04	5.60	6.16	6.72	7.28
30-39	n/a	4.36	5.70	7.04	8.38	9.74	11.08	12.42	13.76	15.10
40-49	4.60	7.52	10.44	13.36	16.30	19.22	22.14	25.06	27.98	30.92
50-59	6.66	11.66	16.64	21.64	26.64	31.62	36.62	41.62	46.60	51.60
60-64	9.20	16.72	24.26	31.78	39.32	46.84	54.38	61.90	69.42	76.96

Critical Illness Biweekly Premium Rates

Tobacco Rates

Issue Ages	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
Employee										
18-29	n/a	n/a	n/a	n/a	4.38	5.04	5.72	6.38	7.06	7.72
30-39	n/a	4.32	5.98	7.62	9.26	10.92	12.56	14.20	15.86	17.50
40-49	4.62	8.22	11.82	15.40	19.00	22.66	26.18	29.78	33.38	36.96
50-59	7.08	13.14	19.20	25.24	31.30	37.36	43.42	49.46	55.52	61.58
60-64	9.86	18.68	27.52	36.34	45.16	54.00	62.82	71.64	80.48	89.30
Single Parent										
18-29	n/a	n/a	n/a	4.72	5.48	6.22	7.00	7.76	8.50	9.28
30-39	n/a	5.56	7.50	9.44	11.38	13.32	15.26	17.20	19.14	21.10
40-49	5.82	9.98	14.14	18.28	22.44	26.60	30.74	34.90	39.06	43.20
50-59	8.40	15.12	21.84	28.56	35.30	42.02	48.74	55.48	62.20	68.62
60-64	11.48	21.30	31.12	40.92	50.74	60.56	70.36	80.18	89.98	99.80
Family										
18-29	n/a	4.06	5.26	6.44	7.64	8.84	10.02	11.22	12.42	13.62
30-39	4.80	7.92	11.04	14.18	17.30	20.42	23.56	26.68	29.80	32.92
40-49	8.44	15.24	22.02	28.80	35.58	42.36	49.14	55.92	62.70	69.48
50-59	13.04	24.42	35.78	47.16	58.52	69.90	81.26	92.64	104.02	115.38
60-64	18.34	35.00	51.68	68.34	85.00	101.68	118.34	135.0	151.68	168.34

Safe Guard-MetLife Dental

DHMO(UNIVERSAL II PLAN)

Deductible (Waived for Preventive)	None
Annual Maximum	Unlimited
Selection of Dentist	Choice of Universal Plan network dentist
Waiting Periods	None
Office Visit Co-pay	None
Preventive Care (includes exams, cleanings, x-rays)	No Charge
Basic Care (includes fillings, simple extractions)	Scheduled Co-payment
Major Care (includes crowns, dentures)	Scheduled Co-payment
Orthodontia (at a network provider)	25% discount
Biweekly Premiums	
Employee	\$3.78
Employee plus one Dependent	\$6.16
Family	\$8.06

Visit our web-site at <http://www.metlife.com/individual/employee-benefits/group-dental/index.html>

- This is a dental plan comparison for illustrative purposes only. Please refer to the plan Schedule of Benefits and Certificate of Insurance for all rights and benefits.
- The co-payments contained in the Schedule of Benefits for the Universal II plan apply only when treatment is performed by a contracted General Dentist. If the services of a contracted specialty care provider are recommended and available, then the co-payments do not apply and the member's charge will be the specialist's usual and customary fee, less a discount of 25%.

Minnesota Life Insurance Company (Optional Life)

Employees

You may purchase Voluntary Term Life Insurance coverage for yourself in \$10,000 increments from a minimum of \$10,000 to a maximum of \$100,000.

Newly eligible employees may elect up to \$30,000 of coverage on a guaranteed issue basis – no proof of good health is required

The amount of insurance on an employee age 70 or older shall be a percentage of the amount otherwise provided by the plan of insurance applicable to such employee in accordance with the following;

Employees age 70-74 may have 65% of provided insurance, employees age 75-79 may have 45% of employees insurance, and employees 80 plus may have 30% of provided insurance Age reductions will apply the first day of the month following an insured employee's 70th, 75th, and 80th birthdays. .

Dependent Term Life Coverage

Spouse

You may purchase Term Life Insurance on your spouse in \$10,000 increments to a maximum of 50% of the Employees Voluntary Term Life coverage you have purchased for yourself.

Spouse coverage terminates at age 70.

Children

You may purchase Term Life Insurance on your eligible child(ren) in \$2,000 increments to a maximum of \$10,000 You must purchase term life for yourself.

An eligible Child is age 14 days to six months, are eligible to 19 years, or up to age 25 if a full-time student . (Children 14 days to 6 months are covered at \$500.00) Coverage may be extended for disabled children.

The cost of the excess life coverage will be payroll deducted on an after-tax basis.

If you Leave or retire you can convert your own and your family's coverage by applying for an individual policy and paying the first premium within 31 days after your group insurance terminates.

Minnesota Life Insurance (Optional Life) Rates

BIWEEKLY COST OF INSURANCE

Employee

Age	\$10,000	\$20,000	\$30,000	\$40,000	\$50,000
Under 30	\$ 0.28	\$ 0.55	\$ 0.83	\$ 1.11	\$ 1.38
30-34	\$ 0.42	\$ 0.83	\$ 1.25	\$ 1.66	\$ 2.08
35-39	\$ 0.46	\$ 0.92	\$ 1.38	\$ 1.85	\$ 2.31
40-44	\$ 0.65	\$ 1.29	\$ 1.94	\$ 2.58	\$ 3.23
45-49	\$ 1.06	\$ 2.12	\$ 3.18	\$ 4.25	\$ 5.31
50-54	\$ 1.75	\$ 3.51	\$ 5.26	\$ 7.02	\$ 8.77
55-59	\$ 2.63	\$ 5.26	\$ 7.89	\$ 10.52	\$ 13.15
60-64	\$ 3.97	\$ 7.94	\$ 11.91	\$ 15.88	\$ 19.85
65-69	\$ 5.86	\$ 11.72	\$ 17.58	\$ 23.45	\$ 29.31
70-74	\$ 9.51	\$ 19.02	\$ 28.52	\$ 38.03	\$ 47.54
75-79	\$ 12.55	\$ 25.11	\$ 37.66	\$ 50.22	\$ 62.77
Over 80	\$ 18.83	\$ 37.66	\$ 56.49	\$ 75.32	\$ 94.15

Age	\$60,000	\$70,000	\$80,000	\$90,000	\$100,000
Under 30	\$ 1.66	\$ 1.94	\$ 2.22	\$ 2.49	\$ 2.77
30 – 34	\$ 2.49	\$ 2.91	\$ 3.32	\$ 3.74	\$ 4.15
35 – 39	\$ 2.77	\$ 3.23	\$ 3.69	\$ 4.15	\$ 4.62
40 – 44	\$ 3.88	\$ 4.52	\$ 5.17	\$ 5.82	\$ 6.46
45 – 49	\$ 6.37	\$ 7.43	\$ 8.49	\$ 9.55	\$ 10.62
50 – 54	\$ 10.52	\$ 12.28	\$ 14.03	\$ 15.78	\$ 17.54
55 – 59	\$ 15.78	\$ 18.42	\$ 21.05	\$ 23.68	\$ 26.31
60 – 64	\$ 23.82	\$ 27.78	\$ 31.75	\$ 35.72	\$ 39.69
65 – 69	\$ 35.17	\$ 41.03	\$ 46.89	\$ 52.75	\$ 58.62
70 – 74	\$ 57.05	\$ 66.55	\$ 76.06	\$ 85.57	\$ 95.08
75 – 79	\$ 75.32	\$ 87.88	\$ 100.43	\$ 112.98	\$ 125.54
Over 80	\$ 112.98	\$ 131.82	\$ 150.65	\$ 169.48	\$ 188.31

Spouse

Age	\$10,000	\$20,000	\$30,000	\$40,000	\$50,000
Under 30	\$ 0.28	\$ 0.55	\$ 0.83	\$ 1.11	\$ 1.38
30 – 34	\$ 0.37	\$ 0.74	\$ 1.11	\$ 1.48	\$ 1.85
35 – 39	\$ 0.42	\$ 0.83	\$ 1.25	\$ 1.66	\$ 2.08
40 – 44	\$ 0.60	\$ 1.20	\$ 1.80	\$ 2.40	\$ 3.00
45 – 49	\$ 0.92	\$ 1.85	\$ 2.77	\$ 3.69	\$ 4.62
50 – 54	\$ 1.52	\$ 3.05	\$ 4.57	\$ 6.09	\$ 7.62
55 – 59	\$ 2.17	\$ 4.34	\$ 6.51	\$ 8.68	\$ 10.85
60 – 64	\$ 3.55	\$ 7.11	\$ 10.66	\$ 14.22	\$ 17.77
65 – 69	\$ 5.86	\$ 11.72	\$ 17.58	\$ 23.45	\$ 29.31

Child

	\$2,000	\$4,000	\$6,000	\$8,000	\$10,000
	0.12	0.24	0.36	0.48	0.60

Short Term Disability Income Insurance

This is an addition to the protection of your income. It pays 60% of your basic salary excluding overtime and any other income. Maximum Benefit is \$852.00 per week before reduction by Deductible Income. Benefits begin after all leave balances are exhausted or 15 days from first day of disability whichever is greater. Short Term Disability is payable up to the day benefits become payable under Long Term disability.

Coverage is for off-the-job sickness, injury or Pregnancy, you are unable to perform with reasonable continuity the material duties of your own occupation. You must be unable to work and under the continuous care of the physician who certifies your continued disability. **Remember - You must apply in order to obtain this valuable coverage. To request a claim form, contact Personnel at (386) 740-5137.**

You pay all of the cost of this plan. In order for you to obtain the benefits of this plan you must apply and authorize a payroll deduction (complete an enrollment form). Short Term Disability benefits are equal to 60% of your basic weekly salary.

Effective 01/01/2010 the biweekly cost is \$0.0034.

Example: Base Biweekly Pay is
 $\$600 \times .0034 = \$2.04/\text{payroll}$.
Biweekly benefit would be \$360.00

Standard Insurance administers this benefit. Premiums are paid after taxes; therefore benefits are not taxed.

You may apply for Short Term Disability at any time during the year; this is not an open enrollment benefit. You are subject to medical underwriting with a one year preexisting clause.

Long Term Disability Income Insurance

County provides long-term disability insurance at no cost to you. You are a member if you are a regular employee and actively at work at least 30 hours each week and a citizen of the United States or Canada.

Benefits begin on the 181st day of continuous disability.

Long Term Disability benefits are equal to 60% of your basic monthly salary to a maximum of \$4,000 per month (benefits will be coordinated with other salary continuation programs). Benefits are taxable.

County Provided Life Insurance

The County of Volusia provides you term life insurance with an accidental death and dismemberment-benefit administered by a third party administrator. This insurance is available to full-time and part-time employees. Retired County employees may purchase this insurance upon retirement.

Basic Life provides coverage in the amount of your annual salary, rounded up to the nearest \$1000.00 for full time active employees. All full-time employees in a status eligible for insurance and working 30 hours or more are eligible for Life Insurance coverage. All part-time employees in a status eligible the benefit is \$5,000. For employees age 70 and over, the benefit is 50%

Eligible Classes

All Active Full-Time Employees, including Elected Officials, scheduled to work at least 30 hours per week and All Permanent Part-Time Employees scheduled to work at least 17.5 hours per week

Basic Annual Earnings

Your current salary or wage from your Employer. Basic Annual Earnings does not include commissions, bonuses, overtime pay, management incentive compensation or any other extra compensation.

Designation of Beneficiary

If you die while insured, your Beneficiary will receive the amount of your Life Insurance in force when Sun Life receives written Notice and Proof of Claim.

TERMINATION OF EMPLOYEE INSURANCE

Your insurance ceases on the earliest of:

- the date the Group Policy terminates.
- the date you are no longer in an Eligible Class.
- the date your class is no longer included for insurance.
- the last day for which any required premium has been paid for your insurance.
- the date you retire, unless you are eligible for Retiree Life Insurance.
- the date you request in writing to terminate your insurance.
- the date you enter active duty in any armed service during a time of war (declared or undeclared).
- the date your employment terminates.
- the date you cease to be Actively at Work.

Are there any conditions under which my insurance can continue?

Yes, Your insurance will continue during any period the premium for your insurance is waived under the Group Policy.

If you are on temporary layoff, leave of absence or vacation, your Employer may continue your insurance by paying the required premium for the length of time specified below.

Layoff - for up to 12 months

Leave of Absence (including the Family and Medical Leave of Absence) - for up to 12 months

Vacation - for up to 3 months.

If you are absent from work due to an injury or sickness, your Employer may continue your Life insurance, by paying the required premium, for up to 12 months.

If you are "Totally Disabled" you may be eligible for a longer continuation of Life Insurance. Refer to "What is the Waiver of Premium Provision" in the Life Benefit Section. Please note you need to apply for continued benefits under the Waiver of Premium Provision within 12 months after you cease to be Actively at Work.

What is the Accelerated Benefit? If you provide satisfactory proof that you are Terminally Ill, part of your Life Insurance may be payable to you while you are still living.

However, if you terminate employment, become ineligible or retiree, you are entitled to convert some or all of your insurance to an individual policy. You may contact Personnel Division, Benefits Section for further details.

Please see your Group Life Insurance Booklet or Group Life Insurance Policy for complete details.

Deferred Compensation Plan

The Deferred Compensation Plan offered through Nationwide Retirement Solutions is a benefit available only to employees. You are eligible to invest a portion of your paycheck in a variety of investment products. You will immediately reduce your tax bill: all money invested into the Program is sheltered from Federal Income Taxes. You can invest in mutual funds, variable annuities, certificates of deposit, savings accounts or fixed annuities. Nationwide Retirement Solutions can answer your questions, and provide you with information about the Plan. Information provided will include performance information on all investment products, as well as a comparison of fees assessed by each company.

YOU CAN ENROLL IN THE PLAN AT ANY TIME DURING THE YEAR, and not just during the "open enrollment" period. Those currently in the Plan are encouraged to contact NATIONWIDE RETIREMENT SOLUTIONS, which can provide you with publications and answer any questions.

Please contact 1-877-677-3678 or see the local representative the first Wednesday of each month. You can also access them through website: <http://www.nrsretire.com>

Changes to Your Benefits

Cancer, Heart & Stroke Policy, or the Critical Illness Policy :To add or change these benefits, you must complete the form Application for Life Insurance, American Heritage Life Insurance Company.

1.Fill out the top two lines of information, go down half way down the form, and elect the appropriate coverage:

2.
 - a.Cancer - write in the Option 1 or Option 2
 - b.Heart/Stroke – check individual or family
 - c.Critical Illness – check individual, family, or single parent, and you must indicated which benefit amount you are electing, example 5,000, 10,000 etc.

3.You must complete the questions on the back of the form that pertain to the coverage for which you are applying.

- a.Cancer – answer 1, 2 6, 12 & 13
- b.Heart/Stroke – answer 1, 2, 4, 12, & 13
- c.Critical Illness – answer 1, 2, 3, 6, 7, 8, 10, 11, 12 & 13

4.Make sure you sign and date the bottom of the form where it says Signature of proposed insured, and date signed.

To Enroll in the Safeguard HMO Dental Plan

Complete the enrollment form; the Group#82834, Effective date is 1/1/2011

You must elect a Facility, and list your 1st and 2nd choices

Make sure you sign and date the bottom of the form.

To Enroll, Cancel or change the Supplemental Minnesota Supplemental Life Insurance

To enroll or increase your current coverage, you must complete all three pages of the Minnesota Life Enrollment form, answer all three health related questions, and sign and date both forms.

To cancel or decrease your current coverage, you only need to complete the first form, indicate whether you are cancelling or decreasing and to what level, sign and date the form.

Please note if you do not complete the forms needed in order to process your request, and have them to Personnel by November 12th, your benefits will revert back to the original level of coverage.

EMPLOYEE WELLNESS FORM

Name _____ Date _____
(Please Print)

Employee ID. # _____ Dept./Division _____

Return this original form to Personnel by Friday October 29th 2010. Please make a copy of this form and any documentation for your records.

1. Have you used tobacco products in the last 12 months? Yes No (Circle one)

If you answered "YES" to question #1, DO NOT SUBMIT FORM.

I certify that the information shown is correct and truthful and understand that any misrepresentation or false statement may result in the county recovering any wellness incentive and/or retroactively reducing the flex dollar allocation. I understand that all my protected health information gathered for this form will be provided to the Personnel Division for calculation of flex dollars only. This wellness form will not be part of my personnel file and will be destroyed.

Employee signature Date

Wellness dollars

For \$100 Wellness Dollars, You must answer "**NO**" to question 1.

For \$200 Wellness Dollars you must answer "**NO**" to question 1 and pass **any two (2)** wellness questions listed on the back.

For \$300 Wellness Dollars you must answer "**NO**" to question 1 and pass **ALL four (4)** wellness questions listed on the back.

NEW: In order to help stream line your open enrollment, Personnel will record your wellness dollars for you. You will be able to log on to your ESS and see your wellness dollars after November 19th.

Please check below how you would like your wellness dollars spent.

EBS Medical Spending Account []

EBS Dependent Care Spending Account []

If you choose either EBS box, your wellness dollars will be used to help pay the amount you set up previously in ESS during open enrollment or an account will be created for you in the amount of your wellness dollars.

'OR'

Use to lower the cost of current insurances []

If you choose this box, your wellness dollars will be used to help pay your biweekly premiums of your other benefit choices, like HPP Couple or HPP Family coverage. This money may not be used to pay for your extra Life Insurances. **If you have any leftover wellness dollars after your insurance choices are paid, an EBS medical Spending Account will be set up for this amount.**

Wellness Questions

These questions may be completed by your physician or you may come to the Health Fair on October 4th and 5th at the County Fairgrounds. To qualify you must list results and have a signature below or a copy of lab results attached.

All screenings must have been performed after July 1, 2010.

1. Acceptable **TOTAL** cholesterol level is 200 milligrams/deciliter or lower. Your Doctor may certify your cholesterol levels are within the acceptable ranges.

Total Cholesterol Level _____ milligrams/deciliter.

Physician or Technician Signature

Date

2. Acceptable triglyceride level is between 40-200 milligrams/deciliter

Triglyceride Level _____ milligrams/deciliter.

Physician or Technician Signature

Date

3. Acceptable blood pressure is 130/80 or Lower.

Blood pressure is _____

Physician or Technician Signature

Date

4. My BMI is within the range shown for my height, body frame and sex. Below are the acceptable ranges for BMI. Body fat testing is an alternative to BMI.

Weight is: _____ Height is: _____ BMI: _____

Physician or Technician Signature

Date

To use the table, find the appropriate height in the left-hand column labeled "Height". Move across to a given weight (in pounds). The number at the top of the column is the BMI at that height and weight.

Body Mass Index Table											
BMI	19	20	21	22	23	24	25	26	27	28	29
Height	BODY WEIGHT (lbs.)										
56	85	89	94	98	103	107	112	116	121	126	130
57	88	93	97	102	106	111	116	120	125	130	134
58	91	95	100	105	110	115	120	124	129	134	139
59	94	99	104	109	114	119	124	128	133	138	143
60	97	102	107	112	118	123	128	133	138	143	148
61	100	106	111	116	122	127	132	137	143	148	153
62	104	109	115	120	126	131	136	142	147	153	158
63	107	113	118	124	130	135	141	146	152	158	163
64	110	116	122	128	134	140	145	151	157	163	169
65	114	120	126	132	138	144	150	156	162	168	174
66	118	124	130	136	142	148	155	161	167	173	179
67	121	127	134	140	146	153	159	166	172	178	185
68	125	131	138	144	151	158	164	171	177	184	190
69	128	135	142	149	155	162	169	176	182	189	196
70	132	139	146	153	160	167	174	181	188	195	202
71	136	143	150	157	165	172	179	186	193	200	208
72	140	147	154	162	169	177	184	191	199	206	213
73	144	151	159	166	174	182	189	197	204	212	219
74	148	155	163	171	179	186	194	202	210	218	225
75	152	160	168	176	184	192	200	208	216	224	232
76	156	164	172	180	189	197	205	213	221	230	238
77	160	168	176	186	194	202	211	219	228	236	245
78	164	172	182	190	199	208	217	225	234	242	251
79	169	177	186	195	204	213	222	231	240	248	257



Benefit Cancellation Form

Instructions: Place an "X" next to the benefit plan(s) to be cancelled. More than one benefit plan may be checked.

Cancellations

I wish to cancel the following plan(s) as part of my open enrollment election (check all that apply):

- _____ Cancer Policy (American Heritage Life Insurance Company/Allstate)
- _____ Heart Care Policy (American Heritage Life Insurance Company/Allstate)
- _____ Critical Illness Policy (American Heritage Life Insurance Company/Allstate)
- _____ SafeGuard-MetLife HMO Dental (optional dental coverage)
- _____ Short Term Disability

Coverage will end on December 31, 2010.

By signing below, I acknowledge:

1. I understand these changes will be effective January 1, 2011.
2. I must select "Waive" for the coverage(s) listed above when I complete my Employee Self Service (ESS) benefit election.
3. This form must be received in Personnel no later than Friday, November 12, 2010 in order to take effect.

Otherwise, my benefit choice(s) will revert back to my original coverage(s).

Signature: _____ **Date:** _____

Name of Insured: _____ Employee ID# _____

Department/Division: _____

Contact Number: _____

If you have any questions or need assistance, please contact Personnel at (386) 736-5951.



Benefit Change Form

Instructions: Place an "X" next to the benefit plan(s) to be changed. More than one benefit plan may be checked.

Change

I wish to change the following plan(s) as part of my open enrollment election (check all that apply):

- _____ Cancer Policy (American Heritage Life Insurance Company/Allstate)
_____ Heart Care Policy (American Heritage Life Insurance Company/Allstate)
_____ Critical Illness Policy (American Heritage Life Insurance Company/Allstate)
_____ SafeGuard HMO Dental (optional dental coverage)

Change

I wish to change the following plan(s) as part of my open enrollment election (check all that apply):

- _____ Add Spouse Name _____ DOB: _____ SSN _____
_____ Add child(ren) Name _____ DOB: _____ SSN _____
_____ Terminate Spouse Name _____ DOB: _____ SSN _____
_____ Terminate Child Name _____ DOB: _____ SSN _____

Reason

_____ Marriage _____ Divorce _____ Other(explain) _____

Coverage will be effective on January 1, 2011.

By signing below, I acknowledge:

1. I understand these changes will be effective January 1, 2011.
 2. I must change the coverage(s) listed above when I complete my Employee Self Service (ESS) benefit election.
 3. This form must be received in Personnel no later than Friday, November 12, 2010 in order to take effect.
- Otherwise, my benefit choice(s) will revert back to my original coverage(s).

Signature: _____ Date: _____

Name of Insured: _____ Employee ID# _____

Department/Division: _____ Contact Number: _____

If you have any questions or need assistance, please contact Personnel at (386) 736-5951.

