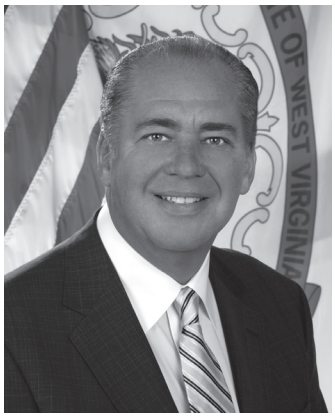
2014

PUBLIC EMPLOYEES INSURANCE AGENCY

MOUNTAINEER FLEXIBLE BENEFITS PLAN

REFERENCE GUIDE

STATE OF WEST VIRGINIA
OFFICE OF THE GOVERNOR
1900 KANAWHA BOULEVARD, EAST
CHARLESTON, WV 25305
(304) 558-2000



EARL RAY TOMBLIN
GOVERNOR

Dear Public Employee:

The yearly window to enroll in the Mountaineer Flexible Benefits Plan will open April 1, 2013. The benefits available include flexible spending accounts, dental insurance, vision insurance, hearing aids, short and long term disability insurance, and legal insurance. These programs are provided to you by the Public Employees Insurance Agency (PEIA). This enrollment window affects your benefits beginning July 1, 2013 and continues through June 30, 2014. I'm pleased to announce, for the eleventh consecutive year, there have been no premium increases to the Mountaineer Flexible Benefits Plans.

To help our employees better understand the programs available and to provide assistance with the enrollment process, we have organized PEIA Benefit Fairs around the state April 8-18, 2013. I encourage you to attend a fair in your area so you can learn more about the benefits available to you. Enrollment counselors will be available to answer any questions you may have. A schedule has been provided in the back of this booklet for your convenience.

Please take a few minutes to learn more about the valuable programs offered through the Mountaineer Flexible Benefits Plans.

Sincerely,

Earl Ray Tomblin
Governor

Benefits Directory

Delta Dental of West Virginia
(Dental) Plan #01058
Customer Service
Mon - Fri, 8 a.m. - 8 p.m. ET
1-800-932-0783
www.deltadentalins.com

EPIC Hearing Service Plan
(Hearing Benefits)
Mon - Fri, 9 a.m. - 9 p.m. ET
1-866-956-5400
www.epichearing.com

FBMC Benefits Management, Inc.
(Contract Administrator)
Mon - Fri, 7 a.m. - 8 p.m. ET
1-855-5MYFBMC (1-855-569-3262)
www.fbmc.com

WageWorks
(Flexible Spending Accounts)
Customer Service
Mon - Fri, 8 a.m. - 8 p.m. ET
1-855-426-0446

Toll-Free Claims Fax
1-855-291-0625

Activation Line
24 hours a day
1-866-363-4128

Hyatt Legal Plans, Inc.
(Legal)
Client Service Center
Mon - Fri, 8 a.m. - 7 p.m. ET
1-800-821-6400
info.legalplans.com

Standard Insurance Company
(STD) Policy #611506-B
(LTD) Policy #611506-A
STD/LTD Claims
Mon - Fri, 10 a.m. - 9 p.m. ET
1-800-368-2859
www.standard.com

Important Dates to Remember
Your Open Enrollment dates are:
April 1, 2013, through April 30, 2013.

Your Period of Coverage dates are:
July 1, 2013, through June 30, 2014.

Trustmark Insurance Company*
(LifeEvents®)
Customer Service
Mon - Fri, 8 a.m. - 7 p.m. ET
1-800-918-8877
www.trustmarkinsurance.com

Vision Service Plan
Customer Service
Mon - Fri, 8 a.m. - 10 p.m. ET
Sat, 9 a.m. - 8 p.m. ET
1-800-877-7195
www.vsp.com

Synovus
Health Savings Account (HSA)
Customer Service Line
1-877-367-4472 (1-877-367-4HSA)
Mon. - Fri., 8:30 a.m. - 5:30 p.m. ET
www.bankNBSC.com

*Trustmark no longer offers new LifeEvents® policies. Employees who currently have LifeEvents® may continue coverage.

Mountaineer Flexible Benefits Plan

Table of Contents

5 Enrollment at a Glance

6 Accessing Your Benefits

7 How to Enroll

8 Eligibility Requirements

9 Hearing Benefits

11 Health Savings Accounts (HSAs)

13 Limited-Use Medical FSA

14 Flexible Spending Accounts (FSAs)

15 Medical FSA

15 Dependent Care FSA

16 Appeal Process

17 WageWorks® Health Care Card

18 FSA Worksheets

19 Delta Dental – Dental Care Plans

22 Vision Service Plan

24 Long-term Disability Income Plans

26 Short-term Disability Income Plan

27 Group Legal Plan (Post-tax)

29 Changing Your Coverage

30 COBRA

31 Beyond Your Benefits

Back 2013 Benefit Fair Schedule

What's New?

- Short-term Disability Rate is decreasing. See Page 26 for details.
- Starting July 1, 2013, administration of the Mountaineer Flexible Benefits sponsored Flexible Spending Account (FSA) Plan will move to a new system supported by WageWorks, Inc ("WageWorks"). Learn more on Pages 14-18.
- Your HSA per pay period rate has decreased by $1.00.

Enrollment at a Glance

Important Enrollment Information

- Open Enrollment is April 1, 2013, through, April 30, 2013.
- For an easy enrollment, please visit **www.myFBMC.com** and enroll online or return your completed enrollment form to your Benefit Coordinator by April 30, 2013, to make changes to your current benefits.
- This is a changes-only enrollment. Therefore, all benefit selections will continue for the new plan year as currently enrolled. Complete an enrollment form if you would like to add, change or cancel coverage.
- Your 2014 Plan Year is July 1, 2013, through June 30, 2014.
- For more information, go to **www.myFBMC.com**, or call 1-855-5MYFBMC (1-855-569-3262), 7 a.m. - 8 p.m., Monday through Friday.

Making your benefits work for you — it's easy!

- FBMC Benefits Management, Inc., your employee benefits manager, along with your employer, offer you a wide selection of benefits to choose from during your open enrollment. FBMC specializes in enrollment management, partner relations and brokerage, communication and education, and administration and compliance.
- FBMC provides you with convenient ways to track your benefit transactions, including online review, telephone tracking and statements.

About your FSA

- Before you sign up for an FSA, review the FSA guidelines and become familiar with how the program works. See how to save yourself and your family a significant amount of taxes. For more information, refer to the Flexible Spending Accounts section beginning on Page 14 of this reference guide.
- Submit your supporting documentation and completed WageWorks Pay Me Back claim form (for paper claims) to WageWorks, for reimbursement processing. Once the plan year ends, you have a 120-day, run-out period to submit your supporting documentation.
- You may visit FBMC's website at **www.myFBMC.com** for more information. You may also contact Customer Care at 1-855-5MYFBMC (1-855-569-3262).

Benefit Fairs

Benefit Fairs will take place from April 8, 2013, through, April 18, 2013. Benefit Fairs allow you access to specific information on each of your benefits. You're invited to ask questions, share your concerns and gain more knowledge about the coverages you select.

Mountaineer Flexible Benefits Representatives will be available at the Benefit Fairs to:

- Provide you with detailed benefit information
- Answer any benefit questions, and
- Help you complete your enrollment form.

Bring your dependents' Social Security numbers and dates of birth with you to complete the dependent section of the enrollment form.

Remember, a Mountaineer Flexible Benefits Representative's incentive and objective is your satisfaction!

See the schedule of Benefit Fairs on the back of this reference guide for times and locations.

Enrollment Forms

- **Enrolling for the first time?** You must complete an enrollment form and make your benefit selections by checking the "Add Coverage" box.
- **Changing your benefits?** You must complete an enrollment form and change your selections by checking the "Change Coverage" box. Complete the line with the new coverage information.
- **Adding a new benefit?** You must complete an enrollment form and make your selections by checking the "Add Coverage" box. Complete the line with the new coverage information.
- **Keeping all of your current benefits?** All benefits will continue as currently enrolled.
- **Canceling current benefits?** You must complete an enrollment form and check the "Cancel Coverage" box for the benefit you want to cancel; otherwise it will automatically continue for the 2013-14 Plan Year.
- **Transferring to a new agency?** If you transfer from one agency to another, your benefits will remain the same. You must complete an enrollment form, mark box "Transfer" and turn the form in to your Benefits Coordinator.

Enrollment Deadline: Sign and date your enrollment form. Remember to keep the bottom, goldenrod copy for your records. Submit the top three copies to your Benefit Coordinator **no later than April 30, 2013.**

Accessing Your Benefits

Customer Care offers you a variety of resources to make inquiries on your benefits and Flexible Spending Accounts (FSAs), including information from the FBMC website or Customer Care.

On the Web

Go to myFBMC.com to begin. Your first step is to register, using your name, mailing zip code, e-mail address and one of the following: FBMC ID or Social Security number (current users will continue to use your existing login credentials.)

Fill out the registration form, enter the random image string into the text box, read the user acceptance agreement and then click the "I agree. Complete my registration" button. You will receive an e-mail shortly to finalize the registration. Follow the instructions within the e-mail.

If you previously registered an e-mail address and password on FBMC's website, you may continue using this information. If you haven't registered, log in to the site as a first-time user. Follow the link on the login page and register through the FBMC Premier Login.

Managing Your Account

You can manage and check your account online. The "Claims and Activity" page online details all your account activity and will even alert you if any card transactions are in need of verification.

For the latest information, visit www.myFBMC.com and link to your account information 24/7. In addition to reviewing your most recent FSA activity, you can:

- Update your account preferences and personal information.
- View your transactions and account history for current and past plan years.
- Download applicable forms.
- Schedule payments to health care and dependent care providers.
- Check the complete list of eligible expenses for FSA program.
- Order additional WageWorks® Health Care cards for your family.
- Manage your account while on the go via the mobile website.
- Download the EZ Receipts® app so that you are able to file claims and take care of card use paperwork from your smartphone.

Personal Identification Number (PIN)

The last four digits of your SSN will be your first PIN. After your initial login, you will be asked to register and select your own confidential PIN to access this system in the future. Your new PIN cannot be the last four digits of your SSN, cannot be longer than eight digits and must be greater than zero.

Record your PIN here.
Remember, this will be your PIN.

If you forget your PIN, call Customer Care at **1-855-5MYFBMC (1-855-569-3262)**.

Note: Please be sure to keep this reference guide in a safe, convenient place and refer to it for benefit information.

How to Enroll

Who needs to complete a form?

- New participants who want to enroll for the first time
- Employees who want to add, change or cancel coverage for the new plan year and who don't want to use the online system
- Employees who need to update dependent information

If you are not making any changes to your benefits, you do not need to complete an enrollment form.

Enrollment Form Section 1

Complete all of your personal information.

Enrollment Form Section 3

For each benefit you are adding, changing or canceling, you must check the appropriate box next to the corresponding benefit. For the benefit selections you are not altering, check the "Keep Coverage" box. If you complete an enrollment form, but do not indicate your desire to cancel or change an existing benefit, that benefit will continue regardless of other benefits which may or may not be indicated on the enrollment form.

Remember to complete all requested information for your benefits.

Dental Care: Select a Delta Dental plan.

- All employees are eligible to enroll in any Delta Dental plan.
- Check the type of coverage you are choosing and enter the cost per-pay-period amount in the box on the right.
- If you are selecting 'Employee & Children,' 'Employee & Spouse' or 'Employee & Family' coverage, you must complete the dependent information in Section 4.

Vision Care: You may choose either the Full Service plan or the Exam Plus plan, but not both. Check the type of coverage you are choosing, and enter the cost per-pay-period in the box on the right. If you select 'Employee & Family' coverage, you must complete the dependent information in Section 4.

Long-term Disability Income Plans: This benefit is for employees only. You must select a plan with a coverage level of either 70 percent or 50 percent of your salary. See Page 25 for help in calculating your per-paycheck deduction amount, then enter this cost per-pay-period on your enrollment form.

Short-term Disability Income Plan: This benefit is for employees only. See Page 26 for help in calculating your per-paycheck deduction amount, then enter this cost per-pay-period on your enrollment form.

Health Care Flexible Spending Account: Enter your per-pay-period contribution in the space to the right. Refer to the FSA worksheets on Page 18 for help in computing your amount.

Dependent Care Flexible Spending Account: Enter your per-pay-period contribution in the space to the right. Refer to the FSA worksheets on Page 18 for help in computing your amount.

Health Savings Account: If you are enrolled in PEIA Plan C, you may also enroll in a Health Savings Account (HSA). If enrolling in the HSA, you may also enroll in a Limited-Use Medical FSA to increase your tax savings.

Limited-Use Medical FSA (for HSA participants only): Enter your per-pay-period contribution in the space to the right. Refer to the FSA worksheets on Page 18 for help in computing your amount.

Hyatt Legal Plan: Enter the cost per-pay-period. Remember, this premium is paid on a post-tax basis.

Cost Per Pay Period: Your cost per period is based on your number of payrolls per plan year. All West Virginia state agencies are paid on a 24-pay, rate. Please check with your Benefit Coordinator if you have questions.

Enrollment Form Section 4

If you selected dependent coverage (child, spouse, family) for dental, vision or legal benefits, you must complete this section. This includes the dependents' names, relationship to you, birth dates and Social Security numbers.

Sign and date the form at the bottom. Please keep the goldenrod copy for your records. Return the top three copies of your completed form to your Benefit Coordinator no later than April 30, 2013.

Web Enrollment is an easy option!

Employees may choose to enroll at **www.myFBMC.com**. You must be registered to access the web enrollment. If you have not already, you will need to register following the first time user link provided. Once registered, you may access the web enrollment instructions at the "Resources" tab.

If you:

- Are a new hire after 3/1/13
- Currently do not participate and work for a non-state agency or a County Board of Education, you may not enroll on our website, but must use an enrollment form.

Note: This is a "changes only" enrollment. If you have no changes, you do not have to do anything and your benefits will remain the same.

Accessing the online enrollment website:

- Log in to **www.myFBMC.com.**
- Follow the instructions to set up your own username and password.
- Click the "Web Enrollment" link.
- Verify your demographic information.
- Add or update any dependent or beneficiary information.
- Begin the enrollment process.
- For each benefit, choose your coverage level or election amounts and then go to the next benefit.
- Continue until enrollment is complete.
- Print out your confirmation statement containing all your benefit elections for you and your family.

Eligibility Requirements

Who is Eligible?

All active benefit-eligible employees of state agencies, colleges and universities and participating County Boards of Education are eligible to participate in this program. This program is also offered to some non-state agencies. Please check with your benefits department to see if you are eligible.

Upon certain qualifying events, spouses, children and employees may be eligible for group health plan coverage under COBRA law. Please contact FBMC Customer Care at 1-855-5MYFBMC (1-855-569-3262) for more information.

A provision in the Patient Protection and Affordable Care Act (PPACA) allows for an employee's adult child to be covered under the employee's healthcare plan through end of the month in which they turn age 26. Coverage applies whether the adult child is/ is not married or is/ is not a student and is already in effect. For more information please read the FAQs at **www.myFBMC.com**.

Period of Coverage

Your period of coverage begins on July 1, 2013, and continues until June 30, 2014, unless you:

- Terminate employment
- Go on an unpaid leave of absence or
- Change your benefit elections in limited circumstances as further discussed under "Changing Your Coverage."

COBRA Coverage

If you terminate employment, retire or go on unapproved leave, you can continue certain benefits by calling FBMC Customer Care at 1-855-5MYFBMC (1-855-569-3262). According to federal and state law, you can continue your own and your dependents' coverage if you terminate employment or have certain other qualifying events under COBRA. You will be notified of your rights and any continuable benefits you may have after you have notified FBMC that you have a qualifying event. Call FBMC at 1-855-5MYFBMC (1-855-569-3262) for details.

If you participated in a Medical FSA and a triggering event occurred during the plan year, making you eligible to continue your Medical FSA under COBRA until that plan year ended, your Medical FSA coverage will be cancelled at the end of the plan year in which the triggering event occurred, unless otherwise required by law.

Retiree Coverage

During the 90 days prior to your anticipated retirement date, contact FBMC for your retiree enrollment packet to continue your dental and/ or vision plan.

HIPAA-Special Enrollment Rights Pertaining to Group Health Plans

If you are declining enrollment for yourself or your dependent(s) (including your spouse) because of other health insurance coverage, you may, in the future, be able to enroll yourself or your dependents in this plan – provided that you request enrollment within 30 days after the other coverage ends.

Employees on Leave

Approved Medical Leave: If you go on medical leave because of your own disability (which includes pregnancy and disabilities resulting from pregnancy complications), your premium deductions will continue through the Mountaineer Flexible Benefits Plan as long as you receive a salary. The Family and Medical Leave Act may affect your rights concerning the continuation of your health benefits while on unpaid leave. Call FBMC at 1-855-5MYFBMC (1-855-569-3262) for further information.

Approved Unpaid Leave: You can continue to receive coverage for certain benefits for the duration of your leave if you pay your premium to FBMC on an after-tax basis.

If you have not maintained a current premium status while on leave, you will be required to re-satisfy eligibility requirements when you return to active status, except as otherwise provided by law. Call FBMC Customer Care at 1-855-5MYFBMC (1-855-569-3262) for further information on billing if you go on approved, unpaid leave.

Hearing Health Care

Why have a Hearing Plan?

Hearing is one of the five natural senses that allow us to enjoy life and the world around us. Music, radio, television, movies, theater – all become less accessible and enjoyable without the benefit of hearing. And the loss of sounds like sirens and alarms can actually endanger your life.

Hearing is a valued life asset that can be protected, treated and assisted through a program for hearing healthcare. The EPIC Hearing Service Plan provides easy access to hearing health professionals – primarily physicians and audiologists who can help you achieve your maximum hearing potential throughout your life.

EPIC's Five-Step Plan

The EPIC Hearing Service Plan starts with an evaluation of your ears and hearing. Diagnostic tests and measures will determine the course of treatment most likely to help you hear better. The EPIC Hearing Plan's 5 Basic Steps to Good Hearing include:

1. **Pure Tone Hearing Test** - to determine if a hearing problem exists
2. **Functional Assessment** - to define the magnitude of the problem and the technology best suited to treat it
3. **Hearing Aid Evaluation** - to determine your ability to wear a hearing aid and select the best model and make
4. **Fitting and Programming** your hearing aid
5. **Therapy and Training** - to fine tune your device and maximize the benefits you receive.

How the EPIC Plan Works

1. Call EPIC at 866-956-5400.
2. A hearing counselor will register you and assist in determining your healthcare needs.
3. You will receive a Hearing Service Plan booklet outlining all plan benefits, services and pricing.
4. A hearing counselor will coordinate a referral to a provider location near your home or work.
5. Contact the provider; follow through with an appointment, examination and treatment.
6. EPIC will coordinate and manage all payments.
7. EPIC will assist you in coordinating any insurance benefits or coverages when applicable.
8. Contact EPIC at any time for assistance, advice or additional information at 866-956-5400.

When to call EPIC

If you or a family member experience any of the following, you may have a hearing problem that could be helped by a hearing health professional:

- Difficulty understanding voices and words (especially those of women and children)
- Occasional ringing in one or both ears
- Itching in the ear canals
- Difficulty understanding in noisy situations
- Turning up the television volume to understand the dialogue

In addition, some more serious symptoms merit immediate attention by a physician.

- A sudden hearing loss
- Spinning and dizziness with vomiting
- Persistent ringing in one ear
- Blood or fluid draining from one or both ears
- Persistent pain in one or both ears

Underwritten by Fidelity Security Life Insurance Company, Kansas City, MO Policy Form #M-9091.

The per pay period rates are as follows:

	10 pay	12 pay	18 pay	20 pay	21 pay	22 pay	24 pay	26 pay
Employee Only:	**$2.10**	**$1.75**	**$1.17**	**$1.05**	**$1.00**	**$0.95**	**$0.88**	**$0.81**
Employee + Spouse:	**$4.27**	**$3.56**	**$2.37**	**$2.14**	**$2.03**	**$1.94**	**$1.78**	**$1.64**
Employee + Children:	**$3.12**	**$2.60**	**$1.73**	**$1.56**	**$1.49**	**$1.42**	**$1.30**	**$1.20**
Employee + Family:	**$5.28**	**$4.40**	**$2.93**	**$2.64**	**$2.51**	**$2.40**	**$2.20**	**$2.03**

Hearing Health Care

Feature	Benefit Amount	Frequency
Examination • Adults • Children	$50	Adults: Once every 2 years Children: Once every year
Hearing Aid Device • Adults • Children	$300 per ear device benefit	Adults: Once every 5 years Children: Once every two year

Summary of Additional Hearing Products at Discounted Prices*

- Hearing Device Batteries - Discount battery program provides savings up to 40% off MSRP on name brand batteries. Orders are shipped direct with no shipping fees. EPIC will provide a one-year supply of batteries for any hearing aid(s) purchased in-network at the completion of the trial period.
- Custom Ear Protection
- Custom Swim Plugs
- Custom Musician Plugs
- Hearing Aid Cleaning Supplies
- Telephone Amplification
- Wireless TV Amplification
- Hearing Aid Compatible Cell Phones
- Assistive/Alerting Devices
- Product Warranties - EPIC provides an extended 3-year warranty on all hearing aid purchases at no additional cost to you.

Call EPIC to order or for more information, 1-866-956-5400.

* These are discounted items and are not insured benefits.

Health Savings Account

What is a Health Savings Account?

Providing economical health care in the face of rising costs is a major issue facing the nation. To deal with this issue and help you plan for future health expenses, you will have the choice of enrolling in a Health Savings Account (HSA). This option allows you and your family to take greater responsibility for your medical care to reduce your insurance premiums and save money for future health expenses.

A Health Savings Account (HSA) is a tax-free account that can be used to pay health care expenses. Unlike money in a Flexible Spending Account, the funds do not have to be spent in the plan year they are deposited. Money in the account, including interest or investment earnings, accumulates tax-free, so the funds can be used to pay qualified medical expenses in the future[1]. An important advantage of an HSA is that it is owned by the employee. If you leave your job, you can take the account with you and continue to use it for qualified medical expenses.

Who is eligible to contribute to an HSA?

- Employees must be covered by an eligible, high deductible health plan (PEIA Plan C).
- Employees cannot be covered by any other health plan that is not a qualified high deductible health plan, including Medicare. However, they may be covered for specific injuries, accidents, disability, dental care, vision care and long-term care.
- Participants cannot be claimed as a dependent on another person's tax return.

How much may I contribute to my HSA?

If you enroll in an HSA and elect to make contributions, your contributions are deducted on a pre-tax basis. An individual with single coverage may contribute up to $3,250 a year to an HSA. Those covering more than one family member may contribute up to $6,450 a year. These limits, established by the federal government and subject to change, are tied to the rate of inflation. An individual age 55[2] and older may make "catch-up" contributions of up to $1,000 above the limits shown above in 2013.

You may also make after-tax contributions, which apply toward the maximum annual limit(s). You will receive additional information when you enroll.

Can I transfer funds from my IRA to my HSA?

A one-time irrevocable trustee-to-trustee transfer of IRA funds to an HSA will be allowed as long as the transferred amount does not exceed the annual HSA contribution limits[3]. Any transfer from an IRA to an HSA will reduce the maximum amount that may be contributed to an HSA during a calendar year.

[1] Please consult your tax advisor or IRS Publication 502 with questions regarding these expenses, qualified health plans, and tax information.

[2] The "catch-up" contribution rule applies to employees who are or become age 55 prior to 12/31 of the election year.

[3] Please consult a tax advisor. Certain restrictions apply.

How do I get funds out of my HSA?

After enrolling in the HSA and completing an HSA application, your contributions will be sent to the custodian, Synovus®. The HSA custodian will establish an individual account for you and mail you up to two VISA® debit cards to your home address at no charge. You may order additional cards or a small supply of checks by contacting the HSA Customer Service Line at **1-877-367-4HSA**. You may use the debit card or checks to get funds out of your HSA. Remember, as long as you are taking funds out for qualified medical expenses incurred on or after the date the HSA was established, there are no taxable consequences to you. However, if you withdraw funds for ineligible expenses, you may have to pay taxes and penalties on those funds, unless you reimburse your HSA for the ineligible amount. You may only use the funds that have accumulated to date.

Will I be charged any banking or custodian fees?

In addition to the per pay period administrative fee below, the custodian will charge you $2 per month for your HSA. This fee includes the VISA® debit card, all transaction fees associated with the card, monthly statements and other banking services. The debit card should be used for your purchases. In the rare situation where you may need to write a check, there is a nominal $.50 charge per check. The custodian will deduct these fees automatically from your HSA. Other fees may apply, including fees for insufficient funds. Refer to the Synovus Fees and Charges for more information.

The per pay period rates are as follows:

10 pay	12 pay	18 pay	20 pay	21 pay	22 pay	24 pay	26 pay
$1.80	**$1.50**	**$1.00**	**$.90**	**$.86**	**$.82**	**$.75**	**$.69**

Pre-tax Benefits Savings Example*

(With HSA)		*(Without HSA)*
$31,000	Annual Gross Income	$31,000
- 5,000	HSA Deposit for Recurring Expenses	- 0
$26,000	Taxable Gross Income	$31,000
- 5,369	Federal, Social Security Taxes	-6,401
$20,631	Annual Net Income	$24,599
- 0	Cost of Recurring Expenses	-5,000
$20,631	Spendable Income	$19,599

By using an HSA to pay for anticipated recurring expenses, you convert the money you save in taxes to additional spendable income. That's a potential annual savings of

$1,032!

* Based upon a 20.65% tax rate (15% federal and 5.65% Social Security) calculated on a calendar year.

Health Savings Account

Are my HSA funds invested?

Your funds will be held initially in an interest-bearing checking account at Synovus. To check the current rate on this account, call the HSA Customer Service Line at **1-877-367-4HSA**.

Once your HSA balance reaches $3,500, you may invest a portion of your account balance in Fidelity Investments® Class "T" mutual funds[1] offered through Synovus Securities, Inc.[2], the bank's brokerage provider. Your minimum initial investment in each fund must equal $2,500; after this initial investment, you may make periodic investments in increments of $100 or more. Additional information will be sent once your account balance reaches $3,500. There is an annual investment fee of $25. The mutual funds available under your HSA are:

- Fidelity Advisor Diversified International Fund
- Fidelity Advisor Small Cap Fund
- Fidelity Advisor Mid Cap II Fund
- Fidelity Advisor Dividend Growth Fund
- Fidelity Advisor Balanced Fund
- Fidelity Investment Grade Bond Fund
- Fidelity Advisor New Insights Fund
- Fidelity Advisor Money Market Fund
- Fidelity Advisor Strategic Income Fund

Are there any special tax forms or tax reporting that I must complete when filing my income taxes?

The bank will send your tax filing information, after the end of the taxable year, for your use in reporting contributions to your HSA and to report any withdrawals or distributions from your HSA. It is important that you save receipts, invoices and any explanations of benefits received from your health insurance carrier as documentation, in case you are ever asked to show proof of qualified medical expenses to the IRS.

What if I exceed the annual contribution limits established by the IRS?

The custodian will send a courtesy notice around October reminding you to check your account balance and ensure that you are not exceeding the allowable annual contribution limits. You may decrease or stop your contributions accordingly, but the best way to ensure that you do not exceed the annual contribution limit is to elect a per-pay-period contribution that ensures you will not exceed the annual limit. Of course, you can add the "catch-up" contribution amount to these annual limits if you are age 55 or older. The catch-up contribution for 2013 is $1,000.

Regarding the HSA Section (on your enrollment form), you must agree to the following:

- I understand when starting an HSA and electing my initial HSA contribution amount, **I am required to complete additional forms that will be provided by e-mail to your Benefit Coordinator from FBMC giving instructions on how to download an application and access the link**. I also understand my HSA will not be created until this documentation is properly completed and received by the HSA Custodian.
- If I have enrolled in an HSA, I certify that I am covered by the State Health Plan Savings Plan (High-Deductible Health Plan), and I am not covered by a health plan other than an HDHP that provides any of the same benefits as an HDHP. I have reviewed and agree to the terms and conditions found in the Health Savings Custodial Account, Disclosure Statement and Funds Availability Disclosure Statement amendments thereto. (Contact your benefits administrator for a copy of this statement.) I assume sole responsibility for all consequences relating to my actions concerning this HSA. I understand that I may revoke this HSA on or before seven (7) days after the date of establishment as outlined in the Funds Availability Disclosure Statement. (Contact Customer Care at 1-855-5MYFBMC (1-855-569-3262).) I have not received any tax or legal advice from the custodian, and I will seek the advice of my own tax or legal professional to ensure my compliance with related laws. I release and agree to hold the HSA custodian harmless against any and all claims or losses arising from my actions. I also understand: 1) the HSA maximum contributions, established by the federal government and subject to change, are tied to the rate of inflation; 2) the maximum monthly contribution is calculated based on the annual allowable amount and number of months remaining in the contribution year; and 3) a subscriber age 55 and older may make "catch-up" contributions to an HSA.-In 2013, that subscriber can contribute up to $1,000 above the limit.
- I understand I can change my HSA contribution once a month. The change is effective at the beginning of the first month after the change is requested. Re-enrollment is not required each plan year.

May I have an HSA and Medical FSA?

Yes, individuals may enroll in a Limited-Use Medical FSA to pay certain eligible expenses. The Limited-Use Medical FSA may be used to pay expenses not covered by your HSA or a high deductible health plan, including dental, vision and preventive care expenses not covered by PEIA Plan C. Dependent Care Spending Account eligibility is not affected by your HSA participation. You can save money and pay less tax too by enrolling in an Limited Use Medical FSA, HSA or both. These are Pre-tax benefits that you can take advantage of either independently of each other or together.

Remember, Limited-Use Medical FSAs are available to HSA participants. Dependent Care Spending Account eligibility is not affected by your HSA participation.

[1] Mutual fund investing involves risk, including loss of principal. Please carefully consider the fund's investment objective, risks, charges and expenses applicable to a continued investment in the fund before investing. For more information, please thoroughly read the prospectus prior to investing.

[2] **The registered broker-dealer offering brokerage products for Synovus is Synovus Securities, Inc., member NASD/SIPC.** Investment products and services **are not FDIC insured, are not deposits of or obligations of any Synovus® (SFC) bank, are not guaranteed** by any SFC bank and involve investment risk, **including possible loss of principal amount invested.** Your Synovus® -owned bank and Synovus Securities, Inc. are part of the Synovus® family of companies.

Limited-Use Medical FSA

For HSA Participants Only

Minimum Annual Deposit: $150
Maximum Annual Deposit: $2,500

What is a Limited-Use Medical Reimbursement Account?

A Limited-Use Medical FSA is designed specifically for employees who wish to take advantage of a Health Savings Account (HSA), while continuing to enjoy the tax savings expected from an FSA. Much like a Medical FSA, funds are set aside from your salary before taxes are deducted, allowing you to pay your eligible expenses tax free. **However, the funds in a Limited-Use Medical FSA can only be used for dental, vision and preventive care expenses not covered by your high deductible health plan**. Your HSA is designed to be used for all other medical-related expenses. A partial list of eligible Limited-Use Medical FSA expenses can be found on this page.

Aside from these minor differences, a Limited-Use Medical FSA follows the same procedures for reimbursement as a Medical FSA.

Whose expenses are eligible?

Your Health Care Flexible Spending Account may be used to reimburse eligible expenses incurred by yourself, your spouse, your qualifying child or your qualifying relative. You may use your Dependent Care Flexible Spending Account to receive reimbursement for eligible dependent care expenses for qualifying individuals. Please see the Flexible Spending Account FAQs at **www.myFBMC.com**.

Note: There is no age requirement for a qualifying child if they are physically and/or mentally incapable of self-care. An eligible child of divorced parents is treated as a dependent of both, so either or both parents can establish a Medical FSA. Only the custodial parent of divorced or legally-separated parents can be reimbursed using the Dependent Care FSA.

Also note that no card will be issued for use with the Limited-Use Medical FSA.

Partial List of Medically Necessary Eligible Expenses*

Birth control pills and devices for dependent children
Contact lenses (corrective)
Dental fees
Eyeglasses
Guide dogs
LASIK
Optometrist fees
Orthodontic treatment

Note: Budget conservatively. No reimbursement or refund of a Limited Medical FSA funds is available for services that do not occur within your plan year.

* IRS-qualified expenses are subject to federal regulatory change at any time during a tax year.

When are my funds available?

Once you sign up for a Limited-Use Medical FSA and decide how much to contribute, the maximum annual amount of reimbursement for eligible expenses will be available throughout your period of coverage.

Since you don't have to wait for the cash to accumulate in your account, you can use it to pay for your eligible expenses at the start of your plan year, which is July 1, 2013.

There is no administrative charge for a Limited-Use Medical FSA.

Flexible Spending Accounts

Medical FSA

A Medical FSA is used to pay for eligible medical expenses which aren't covered by your insurance or other plan. These expenses can be incurred by you, your spouse, a qualifying child or relative. Your full annual contribution amount is available at the beginning of the plan year, so you don't have to wait for the money to accumulate.

Dependent Care FSA

The Dependent Care FSA is a great way to pay for eligible dependent care expenses such as after school care, baby-sitting fees, elder care services, nursery and preschool. Eligible dependents include your qualifying child, spouse and/or relative.

You can request reimbursement from your Dependent Care FSA as often as you like. However, your approved expense will not be reimbursed until the last date of service for which you are requesting reimbursement has passed. Also, remember that for timely processing of your reimbursement, your payroll contributions must be current.

Annual Contribution Limits

For Medical Expense FSA:

Minimum Annual Deposit: $150
Maximum Annual Deposit: $2,500

For Dependent Care FSA:

Minimum Annual Deposit: $150
The maximum contribution depends on your tax filing status.

- If you are married and filing separately, your maximum annual deposit is $2,500.
- If you are single and head of household, your maximum annual deposit is $5,000.
- If you are married and filing jointly, your maximum annual deposit is $5,000.
- If either you or your spouse earn less than $5,000 a year, your maximum annual deposit is equal to the lower of the two incomes.
- If your spouse is a full-time student or incapable of self-care, your maximum annual deposit is $3,000 a year for one dependent and $5,000 a year for two or more dependents.

Typical FSA-Eligible Expenses

Use your FSA to save on hundreds of products and services for you and your family. Eligible expenses are defined by the IRS and your employer. For details and more eligible expenses, visit: **www.myfbmc.com.**

Eligible medical expenses
Typically, your Medical FSA covers:

Acupuncture
Ambulance service
Birth control pills and devices
Breast pumps
Chiropractic care
Contact lenses (corrective)
Dental fees
Diagnostic tests/health screening
Doctor fees
Drug addiction/alcoholism treatment
Drugs
Experimental medical treatment
Eyeglasses
Guide dogs
Hearing aids and exams
In vitro fertilization
Injections and vaccinations
Nursing services
Optometrist fees
Orthodontic treatment
Over-the-counter items (some require prescription)
Prescription drugs to alleviate nicotine withdrawal symptoms
Smoking cessation programs/treatments
Surgery
Transportation for medical care
Weight-loss programs/meetings
Wheelchairs
X-rays

Eligible dependent care expenses
Your Dependent Care FSA typically covers expenses, such as:

After school care
Baby-sitting fees
Day care services
In-home care/au pair services
Nursery and preschool
Summer day camps

Typical Ineligible Expenses

For Medical FSA:

- insurance premiums
- vision warranties and service contracts
- cosmetic surgery not deemed medically necessary to alleviate, mitigate or prevent a medical condition and
- over-the-counter items requiring a prescription.

For Dependent Care FSA:

- books and supplies
- child support payments or child care if you are a non-custodial parent
- health care or educational tuition costs and
- services provided by your dependent, your spouse's dependent or your child who is under age 19.

Flexible Spending Accounts

FSA Savings Example*

	(With FSA)	(Without FSA)
Annual Gross Income	$31,000.00	$31,000.00
FSA Deposit for Eligible Expenses	- 2,500.00	- 0.00
Taxable Gross Income	$28,500.00	$31,000.00
Federal, Social Security Taxes	- 6,455.25	- 7,021.50
Annual Net Income	$22,044.75	$23,978.50
Cost of Eligible Expenses	- 0.00	- 2,500.00
Spendable Income	$22,044.75	$21,478.50

By using an FSA to pay for anticipated recurring expenses, you convert the money you save in taxes to additional spendable income. That's a potential annual savings of **$566.25!**

Notes: The "payroll tax holiday" expired on December 31, 2012, resulting in an increase in the employee portion of Social Security taxes from 4.2% to 6.2% as of January 1, 2013. The reduction in Social Security tax has now expired and employees will see the additional 2% taken out of their paychecks, up to the Social Security wage base for 2013, $113,700. More information can be found in IRS Notice 1036.

Using Your FSA Dollars

When you pay for an eligible health care or dependent care expense, you want to put your account to work right away. WageWorks gives you several convenient reimbursement options.

Filing a claim

You can file a claim online to request reimbursement for your eligible expenses. To submit a paper claim by fax or mail, log into your account, download a Pay Me Back claim form and follow the instructions for submission. You may also contact Customer Service at 1-855-428-0446 to obtain a claim form.

- Go to www.myfbmc.com, log into your account and click the Health Care or Dependent Care tab.
- Select the online claim form.
- Fill in all the information requested on the form and submit.
- Scan or take a photo of your receipts, EOBs and other supporting documentation.
- Attach supporting documentation to your claim by using the upload utility.
- Make sure your documentation includes the five following pieces of information required by the IRS:
  - ✓ Date of service or purchase
  - ✓ Detailed description
  - ✓ Provider or merchant name
  - ✓ Patient name
  - ✓ Patient portion (or amount owed)

Most claims are processed within one to two business days after they are received, and payments are sent shortly thereafter.

- If you use your Card at an eye doctor's or dentist's office, you will most likely be asked to submit an Explanation of Benefits (EOB) or other documentation for verification. Failure to do so will result in your Card being suspended.
- If you lose your Card, please call WageWorks immediately and order a new one. You will be responsible for any charges until you report the lost Card.

Examples of how to use your FSA

Medical FSA Example:
Paying an office visit

After paying for your care at a service provider's office, obtain an Explanation of Benefits (EOB) or detailed receipt of the completed services. Submit these documents, along with a claim form to WageWorks. Within five business days, WageWorks will process your request and mail your reimbursement check to you or direct deposit your funds into the account of your choice. Or, you may have the ability to use your WageWorks Health Care Card, and have instant access to your medical reimbursement funds (see Page 17 for more information on the WageWorks Health Care Card).

Dependent Care FSA Example:
Paying for dependent care services

Once you have paid for (and received) dependent care service, send a completed claim form to WageWorks, along with documentation showing the following:

- Provider Name – Facility name or person who provided the service.
- Dates of Service – Start and end dates for services provided.
- Service Description – Detailed description for services provided.
- Amount – The amount incurred for the services.
- Dependent Name – Person who received the service.

Your request will be processed within five business days and either mailed to you or deposited into the account you have chosen.

Appeals

To Appeal a Denied Medical FSA or Dependent Care FSA Claim

If you feel your claim was denied in error, you have the right to file an appeal by writing a letter that explains why you believe the claim should be approved.

Your appeal may be submitted in writing and mailed to:

WageWorks Claims Appeal Board
P.O. Box 991
Mequon, WI 53092-0991

Otherwise, your appeal may be submitted in writing and faxed to:

Fax Number: 1-877-220-3248

- Your appeal must be received within 180 days of the date you receive notice that your claim was denied.
- You will be notified of the decision regarding your appeal in writing by WageWorks within 30 days of receipt of your written appeal.
- You can request copies of all documents and information related to your denied claim. These will be provided at no charge.
- For Medical FSAs: You are welcome to submit additional information related to your claim along with your appeal, such as: written comments, documents, records, a letter from your health practitioner indicating medical necessity of the denied product or service, and any other information you feel will support your claim.

Appeal Review Process for FSA Claims

- Your appeal will be reviewed by a person who was not involved with the initial claim denial and who is not a subordinate of any person who was.
- The review will be a fresh look at your claim and appeal without deference to the initial denial and will take into account all information submitted with your claim and/or appeal.
- You will be notified of the decision regarding your appeal in writing by WageWorks within 30 days of receipt of your written appeal.
- The appeal decision on review is the Third Party Administrator's (WageWorks) final decision. If you choose to appeal this claim again, your employer has the final coverage decision.

What happens if I have money left in my account at the end of the plan year?

These funds will be used first until exhausted — through September 15, 2014, which is the grace period allowed by the IRS. Then, subsequent claims will be debited from your new plan year account balance.

Important FSA Notes:

- You may, however, continue using your Medical Expense FSA during the **grace period** (September 15, 2014), which is two months and 15 days after the end of your plan year. Be sure to submit your grace period claims before the end of your 120-day run-out period. **During the grace period, you may incur expenses and submit claims for those expenses. The grace period does not apply to Dependent Care FSAs.**
- You have a **120-day run-out period** (ending October 31, 2014) after your plan year ends to submit reimbursement requests for all eligible FSA expenses (for both Medical Expense or Dependent Care FSAs) incurred DURING your plan year.

Send all FSA Pay Me Back forms to:

Fax Toll-Free : 1-855-291-0625
Mail to: Claims Administrator
P.O. Box 14326
Lexington, KY 40512

WageWorks Health Care Card

About Your Card

While your WageWorks Health Care Card and account offer a great deal of convenience, both are regulated by IRS rules that all participants are required to follow. In most instances, you will be able to use your Card with little or no inconvenience. There are, however, situations where the Card will be declined or you will be required to submit receipts and/or other documentation to verify that the item or service purchased was eligible.

How To...

Use your Card

You can use your Card in these ways:

1) For eligible goods and services at health care providers and select pharmacies
2) For eligible over-the-counter (OTC) non-drug items at general merchandise stores (including most drugstores) that have an industry standard (IIAS) inventory and checkout system
3) For prescribed OTC drugs at the pharmacy counter, as long as the drug is dispensed as a valid prescription. In most instances, your Card transaction will be verified at checkout, which means you will not have to submit a receipt to WageWorks after the transaction. You are, however, required to keep each receipt for tax purposes, and in the event it is needed for verification.

Before shopping for prescriptions and over-the-counter items, always visit www.sigis.com for a list of merchants that have an IIAS system in place.

Use your Card at the doctor or other health care provider

If you use the Card at a health care provider or at a pharmacy that does not have an IIAS system, WageWorks will likely require that you submit a receipt or your health insurance explanation of benefits (EOB) to verify that the transaction was for an eligible health care expense or service.

Verify a Card transaction after the purchase

If WageWorks is unable to determine that your Card was used to pay for eligible health care products and services, you will need to take the following action to verify the transaction:

- Log into your account at **www.myfbmc.com**
- Click on the "Submit Receipts for Health Care Card Use" link on the right-hand side of the Welcome page
- Select the unverified transaction
- Scan and upload the corresponding receipt and/or documentation

If you have lost or misplaced the receipt, you can submit a substitute receipt of equivalent value or repay your account.

- To mail or fax your documentation:
  Fax Toll-Free: 1-855-291-0625
  Mail to: **Claims Administrator**
  P.O. Box 14326
  Lexington, KY 40512

Make sure your receipts meet the requirements for verification

In order for the receipt (or any documentation) to be valid, it must include the five specific pieces of information required by the IRS:

- The patient name
- Provider name
- Date of service
- Type of service
- The amount you were charged or your cost (e.g. your deductible or co-pay amount or the portion not covered by your insurance)
- For OTC prescriptions drugs, the receipt must also include the prescription number. If not included, a copy of the prescription must accompany the receipt.

Quick Tips

Log into your account at **www.myfbmc.com** regularly to see if you have any Card transactions in need of verification.

If you have a Card transaction that requires verification, you will be notified immediately on the Welcome page upon login and via email. Remember to also monitor the Statement of Activity page for pending transactions, as it can take up to three weeks to verify a purchase. If a pending transaction cannot be verified, the Status will update to "Receipt Needed."

Avoid problems: Act quickly to resolve all unverified transactions.

You have 60 days from the date of the transaction to take care of any outstanding unverified purchases. If you do not take action within 60 days:

1. The amount of any outstanding unverified Card transactions may be deducted from your next Pay Me Back claim submission.
2. Your Card will be suspended.

If your Card is suspended, it will be reactivated within 24 – 48 hours after receipts or repayment have been processed for all unverified Card transactions.

Know when a Card transaction needs to be verified

WageWorks will notify you of any Card transactions that require attention by email and when you log into your account.

FSA Worksheets

Use the worksheets below to determine how much to deposit in your FSA. Calculate the amount you expect to pay during the plan year for eligible, uninsured out-of-pocket medical and/or dependent care expenses. This calculated amount (including the administrative fees) cannot exceed established IRS and plan limits. (Refer to the individual FSA descriptions in this Reference Guide for limits.)

Be conservative in your estimates, since any money remaining in your accounts cannot be returned to you or carried forward to the next plan year.

Medical FSA Worksheet

Estimate your eligible, uninsured out-of-pocket medical expenses for the plan year.

UNINSURED MEDICAL EXPENSES

Health insurance deductibles	$ _____
Coinsurance or co-payments	$ _____
Vision care	$ _____
Dental care	$ _____
Prescription drugs	$ _____
Travel costs for medical care	$ _____
Other eligible expenses	$ _____
TOTAL (cannot exceed $2,500)	$ _____
DIVIDE by the number of paychecks you will receive during the plan year.*	÷ _____
This is your pay period contribution.	$ _____

* If you are a new employee enrolling after the plan year begins, divide by the number of pay periods remaining in the plan year.

Dependent Care FSA Worksheet

Estimate your eligible dependent care expenses for the plan year. Remember that your calculated amount cannot exceed the calendar year limits established by the IRS.

CHILD CARE EXPENSES

Day care services	$ _____
In-home care/au pair services	$ _____
Nursery and preschool	$ _____
After school care	$ _____
Summer day camps	$ _____

ELDER CARE SERVICES

Day care center	$ _____
In-home care	$ _____
TOTAL Remember, your total contribution cannot exceed IRS limits.	$ _____
DIVIDE by the number of paychecks you will receive during the plan year.*	÷ _____
This is your pay period contribution.	$ _____

* If you are a new employee enrolling after the plan year begins, divide by the number of pay periods remaining in the plan year.

Direct Deposit delivers your money to you faster, and unlike with a check, the funds are in your account automatically – no waiting in bank or ATM lines, no waiting for it to clear.
You will have the opportunity to elect Direct Deposit reimbursements when setting up your profile.

Please note the bank information entered will be sent to the bank to confirm the account number. Any reimbursements issued during this prenote process will be issued as a check until this process has been completed. If you do not want your reimbursements sent via direct deposit, you may have your reimbursements sent via a check to your home address.

There is no administrative charge for a Flexible Spending Account.

Delta Dental – Dental Care Plans

Strong, healthy teeth create beautiful smiles. To give your smile the care and attention it deserves, Delta Dental offers you the Dental Assistance, Basic and Enhanced Indemnity dental care plans.

With Delta Dental, you have complete freedom of choice in selecting a dentist. You can choose a dentist from the Delta Dental Premier® or Delta Dental PPO℠ networks, or a dentist who does not participate in either network. Your choice of dentist can determine your cost savings.

There are 861 Delta Dental Premier access points and 614 Delta Dental PPO access points in West Virginia.

Delta Dental PPO dentists will accept the Delta Dental PPO Maximum Plan Allowance (MPA)* or the dentist's fee – whichever is less (the PPO Allowed Amount) – as payment in full for covered services. Copayments and deductibles may also apply.

Delta Dental Premier dentists will accept the Delta Dental Premier MPA (a slightly higher MPA) or the dentist's total charge – whichever is less (Premier Allowed Amount) – as payment in full for covered services. Copayments and deductibles may also apply.

Non-participating dentists do not contract with Delta Dental to limit their costs. For services received from non-participating dentists, you may be responsible for these dentists' total charges without limit by Delta Dental, including applicable copayments and deductibles. Delta Dental will reimburse you for its portion of the PPO Allowed Amount.

Your total out-of-pocket payment is least if you go to a PPO dentist, is more if you go to a Premier dentist, and likely will be highest if you go to a non-participating dentist. Please call Delta Dental to find a participating dentist in your area at **1-800-932-0783**, or visit **www.deltadentalins.com**.

Employees who visit a dentist under the Delta Dental PPO network or the Delta Dental Premier network, will receive the benefit of increased plan year maximums.

This year, you may enroll in any of the following three dental programs:

Dental Assistance Plan

The Dental Assistance plan is a discounted open network, managed-cost dental plan that allows employees the freedom to choose any dentist for treatment, but they receive the greatest benefits when they visit a Delta Dental participating dentist.

Basic Plan

The Basic plan is a low-cost plan designed to cover preventive and basic services only. Please look carefully at the plan descriptions in the chart before making your choice.

Enhanced Plan

The Enhanced plan is the most comprehensive coverage offered with this program and covers preventive, basic and major restorative, orthodontic and TMJ services.

Further Information

You may cover your spouse and any children, stepchildren or foster children, up to age 26.

See the chart on page 21 for a partial list of covered services. For more information concerning your benefits or to request a claim form, call the Interactive Benefits Information Line at 1-800-865-FBMC (3262).

There are no I.D. cards distributed with these plans. Submit claim forms to:

Delta Dental of West Virginia Plan #01058
P.O. Box 2105
Mechanicsburg, PA 17055-2105

Customer Service: 1-800-932-0783 TTY/TDD: 1-888-373-3582.

How to Print your ID Card

1. Go to **www.deltadentalins.com**
2. Log in to Online Services with your username and password. (If you don't already have a username or password, click "Register Today" link to complete the quick registration process.)
3. Once you've logged in, click the "Eligibility & Benefits" tab.
4. Select "Print ID Card" on the left-hand side of the page. (If you do not see this option, in some instances you may also need to click on the "Eligibility & Benefits" link on the left-hand side of the page before you have the option to select "Print an ID Card.")
5. Click "Print."

Note: The card is not required to obtain services.

Plan #01058

Delta Dental – Dental Care Plans

Your Tax-Free Rates

Dental Assistance	10 pay	12 pay	18 pay	20 pay	21 pay	22 pay	24 pay	26 pay
Employee Only	$12.55	$10.46	$6.97	$6.28	$5.98	$5.71	$5.23	$4.83
Employee & Children	$25.16	$20.97	$13.98	$12.58	$11.98	$11.44	$10.49	$9.68
Employee & Spouse	$28.07	$23.39	$15.59	$14.03	$13.37	$12.76	$11.70	$10.80
Employee & Family	$40.74	$33.95	$22.63	$20.37	$19.40	$18.52	$16.98	$15.67
Basic	**10 pay**	**12 pay**	**18 pay**	**20 pay**	**21 pay**	**22 pay**	**24 pay**	**26 pay**
Employee Only	$21.54	$17.95	$11.97	$10.77	$10.26	$9.79	$8.98	$8.28
Employee & Children	$43.14	$35.95	$23.97	$21.57	$20.54	$19.61	$17.98	$16.59
Employee & Spouse	$48.07	$40.06	$26.71	$24.04	$22.89	$21.85	$20.03	$18.49
Employee & Family	$69.72	$58.10	$38.73	$34.86	$33.20	$31.69	$29.05	$26.82
Enhanced	**10 pay**	**12 pay**	**18 pay**	**20 pay**	**21 pay**	**22 pay**	**24 pay**	**26 pay**
Employee Only	$35.82	$29.85	$19.90	$17.91	$17.06	$16.28	$14.93	$13.78
Employee & Children	$71.65	$59.71	$39.81	$35.83	$34.12	$32.57	$29.86	$27.56
Employee & Spouse	$83.20	$69.33	$46.22	$41.60	$39.62	$37.82	$34.67	$32.00
Employee & Family	$118.85	$99.04	$66.03	$59.42	$56.59	$54.02	$49.52	$45.71

Delta Dental – Dental Care Plans

Partial List of Covered Services	DENTAL ASSISTANCE PLAN	BASIC PLAN	ENHANCED PLAN
DEDUCTIBLE (per person per plan year)	You pay $25 (applies to all services)†	You pay $25 (applies to all services)†	You pay $50 (diagnostic, preventive and ortho are exempt)
Maximum total family deductible	$75	$75	$150
Plan year max (per person)			
Delta Dental network dentist	$750	$750	$1,250
Non-participating dentist	$500	$500	$1,000
OTHER MAXIMUMS			
Ortho Lifetime Max.	N/A	N/A	$1,000
TMJ Disorder	N/A	N/A	$500
BENEFIT	**PLAN PAYS**	**PLAN PAYS**	**PLAN PAYS**
Diagnostic/Preventive Services* ** Visits/Exams (twice in a plan year) - Routine cleaning (twice in a plan year) - Fluoride treatments (to age 19, twice in a plan year) - Bitewing X-rays (twice in a plan year) - Space maintainers (to age 14) - Sealants (to age 14, once in any 36-month period on unfilled permanent first and second molars)	**100%***	**80%***	**100%***
Basic Restorative Amalgam ("silver") and composite ("white" non-molar) fillings	**25%***	**80%***	**80%***
Oral Surgery - Extractions - Oral surgery procedures - General Anesthesia and IV sedation are benefitted with all covered oral surgery procedures and with select endodontic and periodontic surgeries.	**25%***	**80%***	**80%***
Endodontics - Pulpal therapy - Root canal therapy	**25%***	**80%***	**80%***
Periodontics* ** Treatment for gums and supporting structures	**25%***	**80%***	**80%***
Major Restorative** Inlays, onlays, crowns	**NOT COVERED**	**NOT COVERED**	**50%***
Prosthodontic - Bridges - Full and partial dentures - Denture adjustments/relining	**NOT COVERED**	**NOT COVERED**	**50%***
Orthodontia** (For eligible employees, spouses, and dependent children to age 26)	**NOT COVERED**	**NOT COVERED**	**50%***
TMJ	**NOT COVERED**	**NOT COVERED**	**50%***

† Deductible waived for diagnostic/preventive procedures at Delta Dental PPO Provider. Deductible applies to all services rendered by Delta Dental Premier and non-participating dentists.

* Percentage is based on Delta Dental's applicable Maximum Plan Allowance or the dentist's fee, whichever is less (the Allowed Amount). The Delta Dental payment under the program, plus the patient payment, equals the Allowed Amount, which is accepted by Delta Dental participating dentists as full payment. Participating dentists are paid directly by Delta Dental, and by agreement cannot bill you more than the applicable copayment, deductible or charges where maximums have been exceeded for covered services. By selecting a participating dentist, you always limit your out-of-pocket costs. For services performed by non-participating dentists, Delta Dental sends the benefit payment directly to you. You are responsible for paying the non-participating dentist's total fee, which may include amounts in addition to your share of Delta Dental's Allowed Amount. Out-of-pocket costs may also include applicable copayments, deductibles, charges where maximums have been exceeded, and services not covered by the Group Dental Service Contract. *Maximum Plan Allowance is an amount, determined by Delta Dental, from claim charges submitted on a regional basis for a given service by dentists of similar training within the same geographical area. These charges are blended by Delta Dental with dentist fee information from a number of other sources, using various factors, subject to regulatory limitations and adjustment for extraordinary circumstances, such as extreme difficulty or unusual circumstances.

** Major Restorative, Prostodontics, and Orthodontics require 6 month plan participation.

*** Enhanced benefits for pregnancy, which include an additional oral evaluation and a choice of an additional periodontal scaling, root planing or prophylaris, or additional periodontal maintenance procedure are covered.

Vision Service Plan

Vision Service Plan (VSP) offers you the Full Service or Exam Plus vision coverage plans to help pay for your eyecare needs.

Full Service Plan

The Full Service Plan covers you and your family for all routine eye care including eye exams, eyeglass lenses and frames, or contact lenses. When it's time for an eye exam and/or eyeglasses, you can see any VSP doctor you want, or use a non-member doctor.

The deductible for materials is $20. A member may receive an examination and contact lenses or spectacle lenses once every plan year. Contact lenses are in lieu of lenses and frames. In other words, if a member chooses to use the contact lens benefit, this utilizes the lenses and frame benefit. The member would then be eligible for the frame benefit on July 1st.

Full Service Plan (Plan Year runs July 1 through June 30)

	VSP MEMBER DOCTOR	NON-MEMBER DOCTOR
Co-payments†		
Exam	**$20**	**$20**
Prescription Glasses	**$20**	**$20**
	Plan Pays	**Plan Pays**
Vision Examination** (every plan year)	Covered in full	$35
Lenses (every plan year)***		
Single Vision Lenses**	Covered in full	$25
Bifocal Lenses (including progressive lenses)**	Covered in full	$40
Trifocal Lenses (including progressive lenses)**	Covered in full	$55
Lenticular Lenses**	Covered in full	$80
Frames (every other plan year)*** (up to $150 allowance)	Covered in full*	$45
Contacts Lenses** (in place of lenses and frames)		
Necessary	Covered in full***	Exam & $210
Elective	$150 allowance	Exam & $105
Fitting and evaluation	services are covered in full once every plan year, after a maximum $60.00 co-payment****	$0

Participants receive a 20 percent discount on additional pairs of prescription glasses or non-prescription glasses, including sunglasses from a VSP Member Doctor. You can also receive a 15 percent discount on the participating doctor's professional fees when you purchase prescription contact lenses. This benefit is available in conjunction with your VSP contact lens allowance, or you can use it to purchase contacts in addition to glasses.

These discounts may be used for 12 months following the date of the covered eye examination and are available from any participating VSP Member Doctor.

VSP's Laser Vision Care Program now provides discounts for LASIK and PRK surgeries from network laser surgery centers. Contact your VSP doctor for more information.

You may choose to cover your family by selecting the "Employee & Family" rates. You may cover your spouse and any children, stepchildren or foster children up to age 26.

Value-Added Benefits

Diabetic Eyecare Program - Provides additional coverage through medical diagnosis and procedure codes specifically targeted toward members with Type 1 diabetes.

Thirty percent off additional glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your WellVision Exam. Or get 20% off from any VSP doctor within 12 months of your last WellVision Exam.

† Co-payments apply in-network (VSP Member Doctor) at the time of service. Co-payments apply out-of-network and will be deducted from the doctor's charge.

* Within Plan Limitations. If you select a frame that costs more than your plan allowance, there will be an additional charge you will pay out of pocket. When you visit the VSP member doctor, ask him/her which frames are covered in full. The allowance is very competitive and ensures a good choice with little or no out-of-pocket cost.

There will be an extra cost if you select materials or services that are elective or cosmetic in nature, such as tints and scratch coatings. (These charges are audited by VSP to ensure that you are not paying more than necessary.)

** Exam and contact lenses are also covered once every plan year, if necessary, provided you have not received spectacle lenses in the same plan year. You may receive eyeglass frames every other plan year. You may receive either spectacle lenses or contact lenses in the plan year, but not both.

*** There is a single materials co-payment of $20 on lenses and frames or medically necessary contact lenses.

NOTE: Some brands of spectacle frames, such as Apsex, may be unavailable for purchase as plan benefits, or may be subject to additional limitations. Covered persons may obtain details regarding frame brand availability from their VSP member doctor or by calling VSP's Customer Care Division at (800) 877-3195.

**** Fifteen percent discount applies to Member Doctor's usual and customary professional fees for contact lens evaluation and fitting.

Your Tax-free Rates

Full Service plan	**10 pay**	**12 pay**	**18 pay**	**20 pay**	**21 pay**	**22 pay**	**24 pay**	**26 pay**
Employee Only	$12.11	$10.09	$6.73	$6.05	$5.77	$5.50	$5.05	$4.66
Employee & Family	$29.44	$24.53	$16.35	$14.72	$14.02	$13.38	$12.27	$11.32

Vision Service Plan

Exam Plus Vision Plan

(Vision Plan Year Runs July 1 through June 30)

Exam Plus is an alternative to the Full Service plan. When it's time for an eye exam, you can see any VSP doctor you want or use a non-member doctor. Benefits include an eye exam once every plan year and discounts on materials and professional services through VSP member doctors. Your co-payment is $10 for your eye exam.

For glasses, a 20 percent discount will be applied to a VSP doctor's usual and customary fee for prescription glasses and spectacle lens options, such as scratch coating and anti-reflective coating.

For contact lenses, a 15 percent discount will be applied on VSP member doctor's professional services associated with all prescription contact lenses, which includes the contact lens exam (fitting and evaluation).

These discounts may be used for 12 months following the date of the covered eye examination and are available from any participating VSP Member Doctor.

VSP's Laser Vision Care Program now provides discounts for LASIK and PRK surgeries from network laser surgery centers. Contact your VSP doctor for more information.

You may choose to cover your family by selecting the 'Employee & Family' rates. You may cover your spouse and any children, stepchildren or foster children up to age 26.

Your Tax-free Rates

Exam Plus plan	**10 pay**	**12 pay**	**18 pay**	**20 pay**	**21 pay**	**22 pay**	**24 pay**	**26 pay**
Employee Only	$2.03	$1.69	$1.13	$1.01	$0.97	$0.92	$0.85	$0.78
Employee & Family	$4.61	$3.84	$2.56	$2.30	$2.19	$2.09	$1.92	$1.77

How To Use These Plans

To obtain vision care benefits, call a VSP member doctor, identify yourself as a VSP patient and make an appointment. The doctor's office will verify the patient's eligibility and plan coverage and obtain authorization from VSP. **There are no I.D. cards distributed with these plans.**

The doctor will explain any additional charges. After you pay your co-payment, the doctor will take care of all the paperwork.

If you prefer, you can visit a non-member doctor and pay the doctor's normal charges. Save your itemized receipt and mail it within six months of service date to:

Vision Service Plan
P.O. Box 997105
Sacramento, CA 95899-7105

For more information, contact VSP's Customer Service Line at 1-800-877-7195.

For a current list of available VSP doctors, go to **www.vsp.com, and select "VSP Signature" network**.

How To Print Your Vision ID Card

A Member Vision Card will be available to VSP Members on VSP.com.

- Members will need to sign into VSP.com to access the card.
- If the member does not have active coverage, a Member Vision Card will not be available.
- After logging on the employee will see "Member Vision Card" on the left under the category Benefit Resources.
- Member should click on the link, and the card will create.

** The **Card** is not required to obtain services.

Long-term Disability Income Plans

Employee Only, Pre-tax Benefit

Long-term Disability (LTD) insurance can help safeguard your family's lifestyle and provide some peace of mind in the event you become disabled and are unable to work.

Because the State of West Virginia's retirement plan may not provide you adequate protection in the event you become disabled, you should consider enrolling in one of the two Long-term Disability insurance plans offered by Standard Insurance Company.

When am I considered disabled?

During the benefit waiting period and the next 24 months you are considered disabled if, due to injury, physical disease, pregnancy or mental disorder, you are unable to perform with reasonable continuity the material duties of your own occupation, or you are unable to earn more than 80 percent of your pre-disability earnings while working in your own occupation.

Thereafter, you are considered disabled if, due to an injury, physical disease, pregnancy or mental disorder, you are unable to perform with reasonable continuity the material duties of any gainful occupation for which you are reasonably fitted by education, training and experience, or you are unable to earn more than 60 percent of your pre-disability earnings while working in your own or any other occupation.

What is the LTD benefit?

The monthly LTD benefit is based on your earnings from your public employer. The group insurance policy refers to these earnings as pre-disability earnings. The group policy has an actively-at-work requirement you must meet before your insurance will become effective.

You may apply for coverage under either Plan 1 or Plan 2. The monthly benefit under each plan is determined as follows:

Plan 1: 50 percent of the first $6,000 of your monthly pre-disability earnings, reduced by deductible income. The maximum monthly benefit is $3,000.

Plan 2: 70 percent of the first $8,571 of your monthly pre-disability earnings, reduced by deductible income. The maximum monthly benefit is $6,000.

Both Plans have a minimum monthly LTD benefit of $100.

What is deductible income?

Deductible Income is income you receive or are eligible to receive from other sources. It includes, but is not limited to: sick pay or other salary continuation, workers' compensation benefits, Social Security benefits, disability benefits from any other group insurance, 50 percent of earnings from work activity while you are disabled (after the first 12 months of your disability), and disability or retirement benefits you receive or are eligible to receive because of your disability under any state disability benefit law or similar law or your retirement plan.

When do LTD benefits become payable?

If your LTD claim is approved by Standard Insurance Company, LTD benefits become payable at the end of the 180-day benefit waiting period. Refer to the Beyond Your Benefits section for information on taxes you may have to pay on insurance payments you receive.

How long can LTD benefits continue?

If you become continuously disabled before age 62, LTD benefits can continue during disability until age 65, or three years and six months if longer. If you become continuously disabled at age 62 or older, LTD benefits can continue during disability for a limited time. See the chart on Page 25.

What are the exclusions and limitations?

You are not covered for a disability caused or contributed to by: 1) a pre-existing condition (except as provided in your Certificate), 2) an intentionally self-inflicted injury or 3) war or any act of war. Benefits are not payable for more than 24 months for each period of disability caused or contributed to by a mental disorder, or for any period when you are not under the ongoing care of a physician.

What is the definition of a pre-existing condition?

If your disability results, directly or indirectly, from a pre-existing sickness or injury for which you received medical treatment or services, took prescribed drugs or medicines, or consulted a Physician within three (3) months before the most recent effective date of your insurance, you will receive no monthly benefit for that condition. However, this exclusion does not apply to a period of Disability that begins after you have been insured under the plan for 12 consecutive months.

The Pre-existing Condition Exclusion will apply to any added benefits or increases in benefits.

What are some of the features of this coverage?

- Coverage for disabilities occurring 24 hours a day both on or off the job.
- Insurance continues without premium payments while LTD benefits are payable.
- A survivors' benefit may be applicable if you die while LTD benefits are payable.

Assisted Living Benefit:

This benefit is available when LTD benefits are payable. It provides additional income replacement if you become disabled and cannot perform two of six activities of Daily Living or suffer a Severe Cognitive Impairment, and the condition is expected to last 90 days or more. It increases the income replacement to 80% of your pre-disability earnings. The additional benefits paid under the Assisted Living Benefit are not reduced by deductible income. The maximum benefit amount for the Assisted Living Benefit cannot exceed $1,800 for Plan 1 or $857 for Plan 2. This benefit is available on both Plan 1 and Plan 2.

Lifetime Security Benefit:

This benefit provides a lifetime income to severely disabled employees, extending LTD benefits indefinitely by continuing to pay benefits, beyond the regular Maximum Benefit Period of age 65,until death at the original 70% level. Severely disabled means you cannot perform two of six activities of Daily Living or suffer a Severe Cognitive Impairment, and the condition is expected to last 90 days or more. Benefits paid under the Lifetime Security Benefit are reduced by deductible income. This benefit is available on Plan 2.

Long-term Disability Income Plans

How long are benefits payable?

Your benefits are payable according to the following schedule:

Age	Maximum Benefit Period
age 61 or younger	to age 65 (or 3 years, 6 months, if longer)
age 62	3 years, 6 months
age 63	3 years
age 64	2 years, 6 months
age 65	2 years
age 66	1 year, 9 months
age 67	1 year, 6 months
age 68	1 year, 3 months
age 69 +	1 year

Benefits are limited to 24 months for each period of continuous disability caused or contributed by a mental disorder. This limitation will not apply if you are continuously confined in a hospital at the end of the 24 months.

This description is designed to answer some common questions about the Long-term Disability coverage. It is not intended to provide a detailed description of the plans. If you become insured, a more detailed description will be available in group insurance certificates provided to you. The controlling provisions are in the master group insurance policies. This description and the certificates do not modify the group policies or the insurance in any way.

For rules governing the taxes on the insurance payments you may receive, please read the Beyond Your Benefits section in the back of this Reference Guide.

PRE-TAX RATES FOR PLAN 1 (50% Coverage Level)

Age*	Monthly Premium Rate per $100 of Salary
to 29	$.175
30-34	.20
35-39	.255
40-44	.36
45-49	.52
50-54	.765
55-59	1.07
60-64	1.21
65-69	1.54
70 and over	1.98

* Age as of July 1, 2013. Disability Income Plan premiums are adjusted on an annual basis according to the employee's age and salary.

DISABILITY INCOME PROTECTION FORMULA

1. Enter your monthly salary (maximum $6,000) _____
2. Divide by 100 _____
3. Find your age on the chart above and enter the figure from the "Rate" column _____
4. Multiply the amount in Line 2 by the amount in Line 3 to get your monthly premium (based on 12 months). _____ Monthly Premium

If you are paid more than 12 times a year, you can calculate the amount to be deducted from your paycheck by completing the following chart.

5. Enter the monthly premium amount from Line 4 _____
6. Multiply by 12 _____
7. This is your annual premium _____
8. Divide by the number of regular paychecks you receive annually. _____ Per Paycheck Deduction

PRE-TAX RATES FOR PLAN 2 (70% Coverage Level)

Age*	Monthly Premium Rate per $100 of Salary
to 29	$.30
30-34	.36
35-39	.46
40-44	.64
45-49	.95
50-54	1.40
55-59	1.84
60-64	1.96
65-69	2.20
70 and over	2.35

* Age as of July 1, 2013. Disability Income Plan premiums are adjusted on an annual basis according to the employee's age and salary.

DISABILITY INCOME PROTECTION FORMULA

1. Enter your monthly salary (maximum $8,571) _____
2. Divide by 100 _____
3. Find your age on the chart above and enter the figure from the "Rate" column _____
4. Multiply the amount in Line 2 by the amount in Line 3 to get your monthly premium (based on 12 months). _____ Monthly Premium

If you are paid more than 12 times a year, you can calculate the amount to be deducted from your paycheck by completing the following chart.

5. Enter the monthly premium amount from Line 4 _____
6. Multiply by 12 _____
7. This is your annual premium _____
8. Divide by the number of regular paychecks you receive annually. _____ Per Paycheck Deduction

Policy #611506-A

Standard Insurance Company
Mon - Fri, 10 a.m. - 9 p.m. ET
1-800-368-2859

Policy Provider

Standard Insurance Company underwrites this plan. The A.M. Best Company, an organization that rates the financial strength and performance of insurance companies rates Standard Insurance Company "A" Excellent.

Short-term Disability Income Plan

Employee Only, Pre-tax Benefit

When am I considered disabled?

You are considered disabled if, due to sickness, injury or pregnancy, you are unable to perform with reasonable continuity the material duties of your own occupation or you are unable to earn more than 60 percent of your pre-disability earnings while working in your own occupation.

What is the STD benefit?

The weekly Short-term Disability (STD) benefit is based on your earnings from your public employer. The group insurance policy refers to these earnings as pre-disability earnings.

The weekly benefit is 70 percent of your pre-disability earnings, reduced by deductible income. The maximum weekly benefit is $750. The minimum weekly benefit is $15.

What is deductible income?

Deductible income includes 50 percent of earnings from work activity while you are disabled, and disability benefits you receive or are eligible to receive because of your disability under any state disability benefit law or similar law.

When do STD benefits become payable?

If your STD claim is approved by Standard Insurance Company, STD benefits become payable at the end of the 30-day benefit waiting period. During this 30-day period, no STD benefits are payable. The Group Policy has an actively-at-work requirement you must meet before your insurance will become effective.

How long can STD benefits continue?

STD benefits can continue during disability until no longer disabled, but no longer than the 180th day of disability.

What are the exclusions and limitations?

You are not covered for a disability caused or contributed to by: 1) a work-related injury, 2) an intentionally self-inflicted injury or 3) war or any act of war. Benefits are not payable for any period when you 1) receive or are eligible to receive sick leave, 2) are working for any employer other than the State of West Virginia or your public employer, 3) are eligible for any benefits under a workers' compensation act or similar law or 4) are not under the ongoing care of a physician.

This description is designed to answer some common questions about the Short-term Disability coverage. It is not intended to provide a detailed description of the plan. If you become insured, a more detailed description will be available in group insurance certificates provided to you. The controlling provisions are in the master group insurance policies. This description and the certificates do not modify the group policies or the insurance in any way.

For rules governing the taxes on the insurance payments you may receive, please read the Beyond Your Benefits section in the back of this Reference Guide.

Policy Provider

Standard Insurance Company underwrites this plan. The A.M. Best Company, an organization that rates the financial strength and performance of insurance companies rates Standard Insurance Company "A" Excellent.

YOUR PRE-TAX RATES

Example:

If your weekly salary is $350, your monthly premium would be calculated: $350 x $0.045 = $15.75 per month.

Worksheet

1. Your weekly salary (maximum $1071.00) _____
   X $0.045
2. This is your monthly premium _____

If you are paid more than 12 times a year, you can calculate the amount to be deducted from your paycheck by completing the following chart.

3. Enter the monthly premium amount from Line 2 _____
4. Multiply by 12 _____
5. This is your annual premium _____
6. Divide by the number of regular paychecks you receive annually. _____

Per Paycheck Deduction

Policy #611506-B

Standard Insurance Company
Mon - Fri, 10 a.m. - 9 p.m. ET
1-800-368-2859

Group Legal Plan

A Payroll Deductible, Post-tax Benefit

Here's an affordable solution to help with your legal needs.

Finding an affordably-priced lawyer to represent you when you buy or sell your home or even prepare your will can be a challenge. Did you ever wish you could pick up the phone and call a lawyer for some quick advice? For just pennies a day, the Legal Plan gives you your own "attorney on retainer." The Legal Plan also covers full representation for many important personal legal services.

How do I use the plan?

When you face a situation that you think may have legal implications, simply pick up the phone and call 1-800-821-6400 Monday-Friday, 8 a.m. to 7 p.m. (Eastern Time). A knowledgeable client service representative will be available to assist you in locating a Plan Attorney near your home or workplace. Plan Attorneys are generally available to meet with you on weekdays, evenings and even Saturdays. Or, visit **info.legalplans.com**. If you're enrolled, click the"Members Click Here" tab on the left. If you have questions as you decide to enroll, use WVA (all capital letters) as your password.

In or Out-of-Network?

Hyatt has more than 4,000 law firms in its nationwide network. When you use a Plan Attorney, covered legal services are provided at no additional attorney fees. Of course, you also have the flexibility to use a non-Plan Attorney and get reimbursed for covered services according to a set fee schedule. You will be responsible to pay the difference between the plan's payment and the Attorney's fees. It's completely your choice.

What's covered?

- Living Wills
- Security Deposit Assistance
- Tax Audits
- Personal Injury Discounts
- Probate Discounts
- In-office Consultation & Telephone Advice with an attorney on virtually any personal legal matter
- Divorce & Separation
- Wills and Codicils* (see note)
- Identity Theft Defense
- Sale, Purchase of your Home
- Eviction Defense & Tenant Negotiations
- Juvenile Court Defense
- Traffic Ticket Defense (except DUI)
- Restoration of Driver's License
- Criminal Misdemeanor Defense
- Consumer Protection Matters
- Debt Collection Defense
- Uncontested Adoption
- Powers of Attorney
- Uncontested Guardianship
- Preparation of Deeds, Mortgages, Notes and Demand Letters

* Preparing for the future may be the most important thing you'll ever do for your family. Estate planning can be complex, and may require tax planning. You may need assistance from an accountant or financial planner. If you do require tax planning, whether it's done by an accountant, a financial planner or your Plan Attorney, you are responsible for paying the portion of the fees charged for tax planning. The Legal Plan does not cover the tax planning necessary to decide what documents you need.

Your Rates for the Hyatt Legal Plan

	10 pay	12 pay	18 pay	20 pay	21 pay	22 pay	24 pay	26 pay
Employee & Family	$19.80	$16.50	$11.00	$9.90	$9.43	$9.00	$8.25	$7.62

This is a brief summary of the Legal Plan. For definitions of covered services, visit Hyatt at **info.legalplans.com** or call 1-800-821-6400 and request a Fact Sheet.

What's excluded?

- Legal services for matters involving the State of West Virginia and any employment related matter
- Any business-related matters (including owned rental property)
- Appeals, class action suits and any matter where a spouse or dependent's interest might conflict with yours
- Payments made to a third party (someone other than the lawyer), such as court costs, witness fees or fines, filing fees, transcripts, recording fees or judgements

Group Legal Plan offered by Hyatt Legal Plans, Inc., Cleveland, OH. In certain states, provided through insurance coverage underwritten by Metropolitan Property and Casualty Company and Affiliates, Warwick, Rhode Island.

More Covered Benefits

Small Claims Assistance
This service covers counseling on prosecuting a small claims action; helping the Participant prepare documents; advising the Participant on evidence, documentation and witnesses; and preparing the Participant for trial. The service does not include the Plan Attorney's attendance or representation at the small claims trial, collection activities after a judgment or any services relating to post-judgment actions.

Affidavits
This service covers preparation of any affidavit in which the Participant is the person making the statement.

Document review
This service covers the review of any personal legal document of the Participant, such as letters, leases or purchase agreements.

Elder Law matters
This service covers counseling the Participant over the phone or in the office on any personal issues relating to the Participant's parents as they affect the Participant. The service includes reviewing documents of the parents to advise the Participant on the effect on the Participant. The documents include Medicare or Medicaid materials, prescription plans, leases, nursing homes agreements, powers of attorney, living wills and wills. The service also includes preparing deeds involving the parents when the Participant is either the grantor or grantee; and preparing promissory notes involving the parents when the Participant is the payor or payee.

Prenuptial agreement
This service covers the preparation of an agreement by a Plan Member and his or her fiancé/partner prior to their marriage or legal union (where allowed by law), outlining how property is to be divided in the event of separation, divorce or death of a spouse. Representation is provided only to the Plan Member. The fiancé/partner must have separate counsel or must waive representation.

Immigration assistance
This service covers advice and consultation, preparation of affidavits and powers of attorney, review of any immigration documents and helping the Participant prepare for hearings.

What's not covered?

If your legal matter is not listed as covered or excluded, your initial advice and consultation are free. If you need representation on a non-covered matter, your Plan Attorney will give you a written fee agreement in advance. This means that you will know, up front, what these services will cost.

Changing Your Coverage

Changing your benefits during the Plan Year

Within **60 days** of a qualifying event, you must submit an election form and supporting documentation to your Benefits Coordinator. Upon the approval of your election change request, your existing benefit elections will be stopped or modified (as appropriate). However, if your benefit election change request is denied, you will have **60 days**, from the date you receive the denial, to file an appeal with your employer. For more information, contact FBMC Service Center or your Benefits Coordinator. Visit **www.myFBMC.com** for information on rules governing periods of coverage and IRS Special Consistency Rules.

Changes in Status:	
Marital Status	A change in marital status includes marriage, death of a spouse, divorce or annulment (legal separation is not recognized in all states).
Change in Number of Tax Dependents	A change in number of dependents includes the following: birth, death, adoption and placement for adoption. You can add existing dependents not previously enrolled whenever a dependent gains eligibility as a result of a valid Change In Status (CIS) event.
Change in Status of Employment Affecting Coverage Eligibility	Change in employment status of the employee, or a spouse or dependent of the employee, that affects the individual's eligibility under an employer's plan includes commencement or termination of employment.
Gain or Loss of Dependents' Eligibility Status	An event that causes an employee's dependent to satisfy or cease to satisfy coverage requirements under an employer's plan may include change in age, student, marital, employment or tax dependent status.
Change in Residence*	A change in the place of residence of the employee, spouse or dependent that affects eligibility to be covered under an employer's plan includes moving out of an HMO service area.
Some Other Permitted Changes:	
Coverage and Cost Changes*	Your employer's plans may permit election changes due to cost or coverage changes. You may make a corresponding election change to your Dependent Care FSA benefit whenever you actually switch dependent care providers. However, if a relative (who is related by blood or marriage) provides custodial care for your eligible dependent, you cannot change your salary reduction amount solely on a desire to increase or decrease the amount being paid to that relative.
Open Enrollment Under Other Employer's Plan*	You may make an election change when your spouse or dependent makes an Open Enrollment Change in coverage under their employer's plan if they participate in their employer's plan and: • The other employer's plan has a different period of coverage (usually a plan year) or • The other employer's plan permits mid-plan year election changes under this event.
Judgment/Decree/Order†	If a judgment, decree or order from a divorce, legal separation (if recognized by state law), annulment or change in legal custody requires that you provide accident or health coverage for your dependent child (including a foster child who is your dependent), you may change your election to provide coverage for the dependent child. If the order requires that another individual (including your spouse and former spouse) covers the dependent child and provides coverage under that individual's plan, you may change your election to revoke coverage only for that dependent child and only if the other individual actually provides the coverage.
Medicare/Medicaid†	Gain or loss of Medicare/Medicaid coverage may trigger a permitted election change.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	If your employer's group health plan(s) are subject to HIPAA's special enrollment provision, the IRS regulations regarding HIPAA's special enrollment rights provide that an IRC § 125 cafeteria plan may permit you to change a salary reduction election to pay for the extra cost for group health coverage, on a pre-tax basis, effective retroactive to the date of the CIS event, if you enroll your new dependent within 30 days of one of the following CIS events: birth, adoption or placement for adoption. Note that a Medical FSA is not subject to HIPAA's special enrollment provisions if it is funded solely by employee contributions.
Family and Medical Leave Act (FMLA) Leave of Absence	Election changes may be made under the special rules relating to changes in elections by employees taking FMLA leave. Contact your employer for additional information.

* Does not apply to a Medical FSA plan.
† Does not apply to a Dependent Care FSA plan.

COBRA

What is continuation coverage?

Federal law requires that most group health plans, including Medical Flexible Spending Accounts (Medical FSAs), give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan.

How long will continuation coverage last?

For Medical FSAs:

If you fund your Medical FSA entirely, you may continue your Medical FSA (on a post-tax basis) only for the remainder of the plan year in which your qualifying event occurs, **if** you have not already received, as reimbursement, the maximum benefit available under the Medical FSA for the year. For example, if you elected a Medical FSA benefit of $1,000 for the plan year and have received only $200 in reimbursement, you may continue your Medical FSA for the remainder of the plan year or until such time that you receive the maximum Medical FSA benefit of $1,000.

If your employer funds all or any portion of your Medical FSA, you may be eligible to continue your Medical FSA beyond the plan year in which your qualifying event occurs and you may have open enrollment rights at the next open enrollment period. There are special continuation rules for employer-funded Medical FSAs. If you have questions about your employer-funded Medical FSA, you should call FBMC Customer Care Center at 1-855-5MYFBMC (1-855-569-3262).

For More Information

This COBRA section does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available from your employer. You can get a copy of your summary plan description from the Public Employees Insurance Agency (PEIA).

For more information about your COBRA rights, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at **www.dol.gov/ebsa**.

Keep Your Address Updated

In order to protect your family's rights, you should keep your employer and WageWorks, informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to your employer and WageWorks.

Beyond Your Benefits

Deferred Compensation (457 Plan)

Participating in the Flexible Benefits Plan may affect your maximum annual contribution to the 457 plan. That is, Flexible Benefits Plan contributions reduce includible compensation* from which the maximum deferrable amount is computed. You should contact the Deferred Compensation vendor or the Tax Deferred Annuity (TDA) provider about the specific effect of the Flexible Benefits Plan.

* Includible compensation is the gross income shown on your W-2 form.

Taxable Benefits and the IRS

Certain benefits may be taxed if you become disabled, depending on how the premiums were paid during the year of the disabling event. Payments, such as disability, from coverages purchased with pre-tax premiums and/or nontaxable employer credits, will be subject to federal income and employment (FICA) tax. If premiums were paid with a combination of pre-tax and after-tax dollars, then any payments received under the plan will be taxed on a pro rata basis. If premiums were paid on a post-tax basis, you will not be taxed on the money you receive from the plan. You can elect to have federal income tax withheld by the provider just as it is withheld from your wages. Consult your personal tax adviser for additional information.

In addition, FICA and Medicare taxes will be withheld from any disability payments paid through six calendar months following the last calendar month in which you worked prior to becoming disabled. Thereafter no FICA or Medicare tax will be withheld.

You will be required by the IRS to pay FICA, Medicare, and federal income taxes on certain other benefit payments, such as those from Hospital Indemnity Insurance, Personal Cancer Expense Insurance and Hospital Intensive Care Insurance, that exceed the actual medical expenses you incur, if these premiums were paid with pre-tax dollars and/or nontaxable employer credits. If you have questions, consult your personal tax adviser.

According to IRS regulations, you can pay life insurance premiums tax free on your first $50,000 of life insurance. You must pay tax on premiums for coverage exceeding $50,000.

Notice of Administrator's Capacity

This notice advises insured persons of the identity and relationship among the contract administrator, the policyholder and the insurer:

1. FBMC has been authorized by your employer to provide administrative services for your employer's insurance plans offered herein. In some instances, FBMC may also be authorized by one or more of the insurance companies underwriting the benefits offered herein to provide certain services, including (but not limited to) marketing, underwriting, billing and collection of premiums, processing claims payments, and other services. FBMC is not the insurance company or the policyholder.
2. The policyholder is the entity to whom the insurance policy has been issued. The policyholder is identified on either the face page or schedule page of the policy or certificate.
3. The insurance companies noted herein have been selected by your employer, and are liable for the funds to pay your insurance claims.

If FBMC is authorized to process claims for the insurance company, we will do so promptly. In the event there are delays in claims processing, you will have no greater rights to interest or other remedies against FBMC than would otherwise be afforded to you by law. FBMC is not an insurance company.

Social Security

Social Security consists of two tax components: the FICA or OASDI component (the tax for old-age, survivors' and disability insurance) and the Medicare component. A separate maximum wage to which the tax is assessed applies to both tax components. There is no maximum taxable annual wage for Medicare. The maximum taxable annual wage for FICA is subject to federal regulatory change. If your annual salary after salary reduction is below the maximum wage cap for FICA, you are reducing the amount of taxes you pay and your Social Security benefits may be reduced at retirement time.

However, the tax savings realized through the Flexible Benefits Plan generally outweigh the Social Security reduction. Call FBMC Customer Care Center at 1-855-5MYFBMC (1-855-569-3262) for an approximation.

Disclaimer - Health Insurance Benefits Provided Under Health Insurance Plan(s)

Health Insurance benefits will be provided not by your Employer's Flexible Benefits Plan, but by the Health Insurance Plan(s). The types and amounts of health insurance benefits available under the Health Insurance Plan(s), the requirements for participating in the Health Insurance Plan(s) and the other terms and conditions of coverage and benefits of the Health Insurance Plan(s) are set forth from time to time in the Health Insurance Plan(s). All claims to receive benefits under the Health Insurance Plan(s) shall be subject to and governed by the terms and conditions of the Health Insurance Plan(s) and the rules, regulations, policies and procedures from time to time adopted.

FBMC Privacy Statement

As a provider of products and services that involve compiling personal—and sometimes, sensitive—information, protecting the confidentiality of that information has been, and will continue to be, a top priority of FBMC. We collect only the customer information necessary to consistently deliver responsive services. FBMC collects information that helps serve your needs, provide high standards of customer service and fulfill legal and regulatory requirements. The sources and types of information collected generally varies depending on the products or services you request and may include:

- Information provided on enrollment and related forms - for example, name, age, address, Social Security number, e-mail address, annual income, health history, marital status and spousal and beneficiary information.
- Responses from you and others such as information relating to your employment and insurance coverage.
- Information about your relationships with us, such as products and services purchased, transaction history, claims history and premiums.
- Information from hospitals, doctors, laboratories and other companies about your health condition, used to process claims and prevent fraud.

We maintain safeguards to ensure information security and are committed to preventing unauthorized access to personal information.

We limit how, and with whom, we share customer information. We do not sell lists of our customers, and under no circumstances do we share personal health information for marketing purposes. With the following exceptions, we will not disclose your personal information without your written authorization. We may share your personal information with insurance companies with whom you are applying for coverage, or to whom you are submitting a claim. We also may disclose personal information as permitted or required by law or regulation. For example, we may disclose information to comply with an inquiry by a government agency or regulator, in response to a subpoena or to prevent fraud.

Note this Privacy Statement is not meant to be a Privacy Notice as defined by the Health Insurance Portability and Accountability Act (HIPPA). You may receive a Privacy Notice from your employer or from the providers of various health plans in which you enroll. You should read these statements carefully to assure you understand your rights under HIPPA.

2013 Benefit Fair Schedule

Date	Location	Time
Monday, **April 8**	Martinsburg Holiday Inn 300 Foxcroft Ave.	3 p.m. - 7 p.m.
Tuesday, **April 9**	Comfort Suites Parkersburg South 167 Elizabeth Pike, Mineral Wells	3 p.m. - 7 p.m
Wednesday, **April 10**	Charleston Civic Center Parlor A, 200 Civic Center Drive	3 p.m. - 6 p.m.
Thursday, **April 11**	Morgantown Ramada Inn Interstate-68 Exit 1, U.S. 119 North	3 p.m. - 7 p.m
Monday, **April 15**	Northern Community College Market Street, Wheeling	3 p.m. - 7 p.m
Tuesday, **April 16**	Tamarack Conference Center, Board Room One Tamarack Park, Beckley	3 p.m. - 7 p.m
Thursday, **April 18**	Big Sandy Superstore Arena One Civic Center Plaza, Huntington	3 p.m. - 7 p.m

FBMC
BENEFITS MANAGEMENT

Contract Administrator
FBMC Benefits Management, Inc.
P.O. Box 1878 • Tallahassee, Florida 32302-1878
Customer Care 1-855-5MYFBMC (1-855-569-3262) • 1-800-955-8771 (TDD)
www.myFBMC.com

Information contained herein does not constitute an insurance certificate or policy. Certificates will be provided to participants following the start of the plan year, if applicable.

FBMC/WV/0313