CITY OF PINE BLUFF

DEPARTMENT OF HUMAN RESOURCES
200 East 8th Avenue, Suite 104
Pine Bluff, Arkansas 71601
(870) 730-2038 Fax (870) 730-2157

City of Pine Bluff
2020 Employee Benefits Summary

Health Benefits

Medical Insurance

QualChoice is the health insurance provider for the City of Pine Bluff. New employees become eligible for benefits the first day of the month following 30 days of employment. If the employee does not elect coverage at this time, the employee will have to wait until open enrollment, which is at the end of each year.
The co-pay is $20.00.

Coverage	Deductible	Amount per Pay Period
Single	$2000	$43.03
Family	$4000	$219.83

Dental Insurance

Delta Dental is the dental insurance provider for the City of Pine Bluff. New employees become eligible for benefits the first day of the month following 30 days of employment. If the employee does not elect coverage at this time, the employee will have to wait until open enrollment, which is at the end of each year.
The co-pay is $10.00.

Coverage	Amount per Month
Single	$0
Family	$39.36

Vision Insurance

The City of Pine Bluff has two options for vision coverage. Please make sure that your doctor is in-network for your selection.

Superior Vision (Delta Dental)

Coverage	Amount per Month
Single	$6.26
Family	$14.40

VSP Vision Care

Coverage	Amount per Month
Single	$11.90
Employee +1	$17.70
Family	$29.90

Additional Benefits

The City also offers short term and long term disability insurance contracted through Lincoln Financial. If the employee does not enroll within the first 30 days of hire, then the employee is subject to approval in which coverage can be denied.
See enrollment form for rates.

Supplemental insurance plans are available through Allstate that cover benefits for critical illness; accidents; cancer; universal life; or term life.
Contact Allstate directly to enroll.

The City of Pine Bluff provides free life insurance coverage to all employees. All non-uniformed employees will receive $10,000 Group Life and AD&D. Uniformed employees and department heads will receive $20,000 Group Life and AD&D. Employees may elect to add dependent coverage or increase his/her coverage by doubling the amount. Additional life insurance policies are also available for certain job positions.

Wellness Center

All City employees receive a discount with the JRMC Wellness Center if they choose to enroll. The monthly charge is deducted from each of the employee's payroll checks.
See enrollment form for rates and instructions on how to join.

**Please note the following information is for non-uniformed employees only. Leave and retirement benefits will differ for Police and Fire.*

Leave Benefits

All employees accrue 1 day of sick leave per month, equal to 12 days per year, regardless of years of service. An employee may not carryover more than 90 days of sick leave per calendar year.

Annual leave, however, is calculated based on the years of service. Employees are not allowed to carryover more than 45 days per calendar year. Vacation leave shall be earned according to the following table:

Years of Service	Time Accrued
Up to 1 year	½ day per month (6 each year)
1—10 years	1 day per month (12 each year)
10—15 years	1½ day per month (18 each year)
15+ years	2 days per month (24 each year)

Retirement

The City has a mandatory retirement plan. The employee's contribution is 3% and the city's is 7%. These percentages cannot be modified under any circumstance.
Employees are vested in 10 years. Employees may retire at age 65 with 10 years; age 55 with 20 years; and any age with 28 years.

QualChoice®
HEALTH INSURANCE

PreferredChoice Benefit Summary
Large Non-Grandfathered Benefit Custom Plan P2000
Sample

This benefit summary is part of the Evidence of Coverage (EOC), Form QCA POS LG NGF EOC (1-2017) and subject to all benefit terms and conditions, limitations and exclusions included in the Evidence of Coverage. This benefit summary is intended only to highlight your benefits and should not be relied upon solely to determine coverage. Please refer to the Evidence of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. In the event the language in the Evidence of Coverage is different than this benefit summary, the Evidence of Coverage prevails.

For both In-Network and Out-of-Network Benefits, some services may require pre-authorization by QualChoice. For details and to access the most current listing of services requiring pre-authorization, visit our website at www.qualchoice.com. Before seeking service, you should refer to QualChoice Medical Policies, also on our website at www.qualchoice.com

All benefit payments are based on the QualChoice Maximum Allowable Charge. Use of an Out-of-Network Provider may result in you being balance billed and higher out-of-pocket costs. Amounts in excess of the QualChoice Maximum Allowable Charge do not count toward Deductible or Out-of-Pocket Limits. See the "Member Financial Responsibility Comparison" section in the Evidence of Coverage.

Medical Benefits and Covered Services	In-Network (You Pay)	Out-of-Network (You Pay)
Deductible • Copayments are not included in the Deductible • In-Network and Out-of-Network Deductibles apply separately • Family Deductible is not considered satisfied until at least 2 separate family members have satisfied their individual Deductibles • Deductible amounts applied in the last quarter of a Calendar Year will carry over to the next Calendar Year • The Deductible is calculated on a Calendar Year basis	Individual: $2,000 Family: $4,000	Individual: $4,000 Family: $8,000
Annual Out-of-Pocket Limit • Annual Out-of-Pocket Limit includes Deductible • Applicable Coinsurance will apply until 2 separate family members meet their individual Annual Out-of-Pocket Limits satisfying the family Annual Out-of-Pocket limit • Benefits will be paid at 100% of the Maximum Allowable Charge once the Annual Out-of-Pocket Limit is satisfied • Annual Out-of-Pocket Limits apply separately to In-Network and Out-of-Network Benefits • Copayments apply toward your Annual Out-of-Pocket • Annual Out-of-Pocket Limit is calculated on a Calendar Year basis	Individual: $4,000 Family: $8,000	Individual: $8,000 Family: $16,000
Maximum Out-of-Pocket Limit • The Maximum Out-of-Pocket Limit is the most that you could pay for covered benefits in a Calendar Year • Maximum Out-of-Pocket Limit includes Deductible, Coinsurance and Copayments	Individual: $4,000 Family: $8,000	Not applicable
Coinsurance	20% after Deductible	40% after Deductible
Preventive Care Services (Performed in the Office): QualChoice preventive health benefits are intended for the early detection of diseases by screening for their presence in an individual who has neither symptoms nor findings suggestive of those diseases. Some tests are not covered as part of the preventive health screening benefit because they are not recommended by the United States Preventive Services Task Force (USPSTF) or approved QualChoice medical polices. Those services that will be considered to be a preventive health service are subject to change at any time in order to align with and be consistent with the USPSTF guidelines and QualChoice medical policies.		
Immunizations, including flu and pneumonia vaccines Child Immunizations (age 0-18) Adult Immunizations (age 18+) *Refer to QualChoice Medical Policies for complete list and access rules for immunizations.* *Immunizations for travel, school, work or recreation are not covered*	No Cost to You	Not Covered
Routine vision exam (limit 1 every 24 months)	$20 Copayment	Not Covered
Well child care, birth through age 18	No Cost to You	Not Covered
Other preventive services • Annual physical • Pap smear • Screening mammogram (including breast exam) age 40 and over • Prostate screenings for men age 40 and over	No Cost to You	Not Covered
Other preventive services, continued • Bone density screening tests, preventive for women age 65+ Colon Cancer screening, age 50 and older (diagnostic testing at any age, see Outpatient Care for cost sharing)	No Cost to You	Not Covered

Preventive Care Services, continued	In-Network (You Pay)	Out-of-Network (You Pay)
Family Planning • Tubal ligation and associated services (reversal of sterilization is not a covered benefit) • Insertion or implantation of birth control pellets, capsules or IUDs • Fitting and insertion of diaphragms, rings or caps • Injection of long acting contraceptives *NOTE:This benefit is administered in accordance with the "Family Planning Services Rider"*	No Cost to You	Not Covered
Smoking cessation • Kick the Nic: smoking cessation; 12 week program *Note: Contact QCARE 1-888-795-6810*	No Cost to You	Not Covered
Professional Services NOTE: Refer to QualChoice Medical Policies at www.qualchoice.com for a list of routine and complex procedures.		
Primary Care Physician (PCP) Office Visit • Consultation/evaluation only • Routine care • Complex Care • Advanced Care	 $20 Copayment No cost to you 20% 20% after Deductible	40% after Deductible
Specialist Office Visit • Consultation/evaluation only • Routine care • Complex care • Advanced Care	 $35 Copayment No cost to you 20% 20% after Deductible	40% after Deductible
Inpatient Care - Room and Board • Services and procedures provided by a physician in a facility • Inpatient care - room and board (semi-private only) • Skilled Nursing Facility and Inpatient Rehabilitation Services (combined 30 day limit per Calendar Year)	20% after Deductible	40% after Deductible
Outpatient Care and Ambulatory Care Centers • Services and procedures provided by a physician in a facility • Outpatient Care and Ambulatory Care Centers • Observation Services, whether in an emergency department or hospital • Diagnostic Services - Advanced Imaging, Lab & X-Ray • Hospice services (limited to a lifetime maximum of 180 days) • Home HealthCare (40 visits per Calendar Year) • Outpatient Surgical Services	20% after Deductible 20% after Deductible	40% after Deductible
Emergency Services • Emergency Room or ER Observation Services • Urgent Care	$250 Copayment + 20% $35 Copayment	$250 Copayment + 20% 40% after Deductible
Transportation Services • Ambulance - Ground - $1,000 Benefit Maximum per trip • Ambulance - Air $5,000 Benefit Maximum per trip *Note: Ambulance is only covered if it is deemed Medically Necessary by QualChoice, and only to the closest appropriate facility. Travel by air ambulance will only be covered if such travel will result in quicker arrival at the closest appropriate facility and if the difference in travel time is likely to improve patient outcome.* *Facility to facility ambulance transfer requires pre-authorization.*	20% 20%	20% 20%
Rehabilitation Services • Physical Therapy • Occupational Therapy • Speech Therapy and Audiology Testing • Chiropractic Care • Cardiac Rehabilitation (36 visits per Calendar Year) *Therapy and chiropractic services are limited to a combined maximum of 30 visits per Calendar year. This does not include Cardiac Rehabilitation.* *Therapy services provided and billed by a licensed Physical, Occupational or Speech Therapist - PCP cost sharing*	In-Network (You Pay) $35 Copayment	Out-of-Network (You Pay) 40% after Deductible
Maternity Services *Out-of-Network Newborn coverage limited to $2,000 Benefit Maximum per covered person for all services (first 90 days after birth)* Physician Services • Initial Office Visit • All other services Facility Services	 $20 Copayment 20% after Deductible	 40% after Deductible
Infertility Diagnostic Services Only *Note: Treatment of infertility is not covered.*	20% after Deductible 20% after Deductible	40% after Deductible Not Covered

Mental Health and Substance Use Disorder Services		
• Inpatient Hospital Services • Professional Services (Office/Outpatient Visits) • Professional Services (Inpatient/Outpatient Facility)	20% after Deductible $35 Copayment 20% after Deductible	40% after Deductible
Allergy Services		
• Office Visit and Allergy Testing • Allergy Shots • Serum	$35 Copayment No Cost to You 20% after Deductible	40% after Deductible
Other Treatment, Services and Supplies		
Durable Medical Equipment (DME)	20% after Deductible	Not Covered
Medical Supplies • Provided in physician's office; if it is in conjunction with an office surgery it is not paid separately. • Provided in connection with home infusion therapy • Provided in connection with Durable Medical Equipment	20% after Deductible 20% after Deductible 20% after Deductible	40% after Deductible 40% after Deductible Not Covered
Prosthetic and Orthotic Services and Devices • Prosthetic Services and Prosthetic Devices • Orthotic Services and Orthotic Devices *Note: QualChoice does not cover replacement or associated services more frequently than (1) time every three years unless Medically Necessary.* *Refer to QualChoice Medical Policies for more information: qualchoice.com*	20% after Deductible	40% after Deductible
Reconstructive Surgery • Breast reconstruction following mastectomy • Restoration due to acute trauma, infection or cancer *Note: These benefits are for physician/professional charges. For benefits related to these services for Inpatient or Outpatient charges, see Inpatient or Outpatient sections on page 2.*	20% after Deductible	40% after Deductible
Transplantation Services • Physician/Professional charges • Inpatient and Outpatient Charges *Note: Lifetime maximum of two transplants*	20% after Deductible 20% after Deductible	Not Covered
Diabetes Management Services • Insulin Pumps ($5,500 Benefit Maximum per pump) • Supplies and equipment • Diabetic Education (1 training per lifetime)	20% after Deductible 20% after Deductible $35 Copayment	Not Covered 40% after Deductible
Dental Care • Accidental injury to sound and natural teeth $2,000 Benefit Maximum per accident	20% after Deductible	40% after Deductible
Genetic Counseling and Testing *Note: Genetic testing is only covered in specific situations where such testing affects choice of treatment or outcome of treatment. When covered, these tests are subject to Deductible and Coinsurance. It requires pre-authorization, if genetic testing is done and there is no pre-authorization, you will be responsible for the charges. See medical policies at www.qualchoice.com for more information.*	20% after Deductible	40% after Deductible

QualChoice®
HEALTH INSURANCE

Prescription Benefits Summary
Enhanced Formulary

QCRX- Custom Rx Plan

This benefit summary is part of the Evidence of Coverage, Form QCA POS LG NGF EOC (1-2017) and is subject to all benefit terms and conditions, limitations and exclusions included in the Evidence of Coverage. This benefit summary is intended only to highlight your benefits for Covered Prescription Drugs and should not be relied upon solely to determine coverage. Please refer to your Evidence of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. In the event the language in the Evidence of Coverage is different than this benefit summary, the Evidence of Coverage prevails.

Some medications may require pre-authorization by QualChoice. For details and to access the most current listing of specific medications, including those requiring pre-authorization, visit our website at www.qualchoice.com.

Payment Procedures		
Network Pharmacy • You must pay the applicable cost sharing amount to the network pharmacy at the time the prescription is filled. Out-of-Network Pharmacy • No benefits		
Prescription Benefits In-Network	**Retail (You Pay)**	**90 Day Supply (You Pay)**
• Tier 1	$15 Copayment	$45 Copayment
• Tier 2	$50 Copayment	$150 Copayment
• Tier 3	$75 Copayment	$225 Copayment
• Tier 5*	$100 Copayment	Not Applicable
**NOTE: If dispensed in your physician office or at a facility - see medical benefits*		
Deductible	Not Applicable	
Maximum Out-of-Pocket Limit (shared with Medical expenses)	Refer to the Medical Benefit Summary	

Contraceptive Coverage
• All oral contraceptives in either formulary Tiers 1 or 2 (all formulary options) - No Cost to You. (No Out-of-Network Coverage) • Oral contraceptives in Tier 3 - Normal cost sharing, see Tier 3 above • Ortho Evra patch, Nuvaring, Caps and Diaphragms - No Cost to You (No Out-of-Network Coverage) • Emergency contraceptives, e.g. Plan B, Ella - no cost sharing with a prescription, otherwise, not a covered benefit • Over-the-counter birth control methods, e.g. gels, creams, condoms, etc. - not a covered benefit • Abortion or abortifacient drugs - not a covered benefit
Limitations
• Retail pharmacy - One monthly cost sharing amount per 30 day supply • Mail order pharmacy - 3 monthly cost sharing amounts per 90-day supply *Note:* • *Non-maintenance medications are limited to a 30 day supply. Maintenance medications, retail or mail order, available up to a 90 day supply.* • *Insulin and syringes will be covered with one monthly cost sharing amount for each 30 day supply, if filled at the same time.* • *Test strips and lancets will be covered with one monthly cost sharing amount for each 30 day supply, if filled at the same time.* • *Contact a Health Coach at 1-888-795-6810, if you need assistance obtaining a new glucometer.*
Step Therapy
Certain medications may be required to be used before another medication is covered. Step therapy is the process of beginning drug therapy for a medical condition with the most cost-effective and safest drug therapy and progressing to other and more costly therapy if the first line medication fails. Contact Customer Service at 1-501-228-7111 or 1-800-235-7111 for more details.
Exclusions
Examples of drugs that we will not pay for are listed below. • Experimental or investigational drugs or research drugs; • Over-the-counter drugs, unless listed on the Formulary; • Cosmetic agents, including, but not limited to, Retin-A for enrollees over age 25; • Drugs for which there is a therapeutically equivalent over-the-counter drug; • Oral or topical medication for hair loss; • Smoking cessation medications, except for persons enrolled in the QualChoice "Kick the Nic" program; • Smoking cessation devices; • Weight loss medication; appetite suppressants; anti-obesity drugs; anorexiants; • General vitamins;

DELTA DENTAL

Delta Dental PPO Plus Premier

Schedule of Benefits for CITY OF PINE BLUFF

a) Original Effective Date: 12:01 a.m. Central Standard Time, 01/01/2008

b) Group Number: 000002610

c) Deductible: $50 for benefits received in

- Coverage B
- Coverage C
- Child Orthodontic Rider

with a maximum of $150 per family, per benefit period. There is no deductible on Coverage A.

d) Annual Maximum Payment: $1,500 per person per benefit period.

e) Benefit Period: A benefit period for each eligible participant shall mean a calendar year, the period from January 1st to December 31st of each year.

Covered Services:

Coverages and Maximum Plan Allowances (MPA)

Coverage A – Diagnostic and Preventative Services	In-Network 100% MPA
• Routine periodic examinations not more than two (2) in any benefit period, inclusive of an initial oral examination.	
• Bitewing and periapical x-rays as required.	
• Full-mouth x-rays one (1) in any sixty (60) consecutive month period.	
• Prophylaxis (cleaning) not more than two (2) in any benefit period. * Please see information on Evidence Based Dentistry.	
• Topical application of fluoride one (1) per benefit period for dependent children to age nineteen (19).	
• Sealants one (1) per tooth on permanent maxillary and mandibular first and second molars with no caries (decay) on the occlusal surface, for dependent children to age sixteen (16).	

Coverage B – Basic Restorative Services	In-Network 80% MPA
• Minor emergency treatment for the relief of pain as needed by the participant.	
• Amalgam (silver) and composite/resin (white) fillings (composites are not a covered benefit on molars).	
• Simple extractions.	
• Space maintainers for prematurely lost teeth of eligible dependent children to age fourteen (14) .	
• Endodontics, including pulpal therapy and root canal filling.	
• Oral surgery, including pre- and post-operative care and surgical extractions, except TMJ surgery.	

- Stainless steel crowns used as a restoration to natural teeth for dependent children to age sixteen (16) when the teeth cannot be restored with a filling material.
- Non-surgical periodontics.
- Periodontal maintenance; two (2) per benefit period following active periodontal treatment.
  * Please see information on Evidence Based Dentistry .

Coverage C – Major Restorative Services — In-Network
12 Months Wait for Late Entrants — 50% MPA

- Crowns, inlays, onlays, and veneers are benefits for the treatment of visible decay and fractures of tooth structure when teeth are so badly damaged they cannot be restored with amalgam or composite restorations.
- Prosthodontics, including procedures for construction of fixed bridges, partial or complete dentures, and repair of fixed bridges.
- Complete or partial denture reline, including chair side or laboratory procedures to improve the fit of the appliance to the tissue.
- Complete or partial denture rebase, including laboratory replacement of the acrylic base of the appliance.
- Surgical periodontics.
- Coverage for an endosteal implant to support a crown.

Rider(s) — In-Network
12 Month Wait for Late Entrants

Child Orthodontic Rider – Orthodontic services for dependent children to age nineteen (19). — 50% MPA
Lifetime Maximum Payment – $1,000

Carry Over Benefit Rider
Carry over benefit: $375
Claims threshold: $749
Carry over benefit maximum: $1,500

The benefit allowance for services of an out-of-network dentist will be reduced by 10% for eligible services as determined by Delta Dental after applying the applicable deductibles, co-payments and maximums. This means your out-of-pocket expense may be greater if you choose an out-of-network dentist.

(*)Evidence Based Dentistry: DDAR covers additional routine cleanings or periodontal maintenance procedures (up to four per year) for covered members with diabetes, heart disease, who are pregnant or have a history of periodontal disease. The additional benefits may not be combined by those with more than one of the above conditions.

Questions? Contact Delta Dental's Customer Service Department at (800) 462-5410.

Delta Dental's network of participating providers may be found on our website at www.deltadentalar.com.

SUPERIOR VISION

Below is a summary of your DeltaVision 976 benefits.

BENEFIT FREQUENCY	
Eye Exam	Every 12 months
Lenses	Every 12 months
Frames	Every 24 months
Contact Lenses	Every 12 months

IN-NETWORK COPAYMENTS	
Eye Exam	$10
Frames and/or Lenses[1] (no copay for contacts)	$25

	IN-NETWORK BENEFITS	OUT-OF-NETWORK REIMBURSEMENTS
Eye Exam (subject to copay)	Covered in full	$35
Standard Lenses (per pair - subject to copay)		
Single Vision	Covered in full	$25
Bifocal	Covered in full	$40
Trifocal	Covered in full	$50
Lenticular	Covered in full	$80
Progressive Lens Upgrade (subject to copay)	See description[2]	$40
Frames (subject to copay)	$110 retail allowance	$45
Contact Lenses[3]		
Elective (Conventional or Disposable)	$110 retail allowance	$110
Medically Necessary[4]	Covered in full	$250

DISCOUNTS[5]	
Insured Materials	
Frames	20% off amount over allowance
Lens Options (scratch coat, UV coat, tint, etc.)	20% off retail (premium options) or out-of-pocket maximums[6] (standard options)
Progressives	20% off amount over retail lined trifocal lenses[7]
Additional Services	
Exams, Frames & Prescription Lenses	30% off retail
Lens Options & Contacts	20% off retail
Disposable Contacts	10% off retail
Refractive Surgery (LASIK)	15% — 50% off retail

More Eye Care Providers

More than 60,000 eye care providers nationwide. To find an eye care provider in the Superior National Network, visit deltadentalar.com.

Customer Service

Starting January 1, 2017, when you have questions about your DeltaVision benefits, please contact Superior Vision Services at (800) 507-3800, Monday - Friday, 7 a.m. to 8 p.m. Central Time.

In-network national retailers include:

Walmart Vision Center

Sam's Club Optical

JCPenney | optical

Plus online in-network options:

contactsdirect

DITTO

A The state of the optometric profession: 2013, page 9. https://www.aoa.org/Documents/news/state_of_optometry.pdf

1 Copay applies one time to eyeglass frame and/or lenses.

2 Covered to provider's in-office standard retail lined trifocal amount; member pays difference between progressive and standard retail lined trifocal, plus applicable copay, less any applicable discounts.

3 Contact lenses are in lieu of eyeglass frame and lenses benefit.

4 Medically necessary contact lenses are those prescribed for extreme visual acuity or other functional problems not treatable by eyeglass lenses. Prior authorization required.

5 The Plan discount features are not insurance. All allowances are retail; the member is responsible for paying the provider directly for all non-covered items and/or any amount over the allowances, minus available discounts. Discounts are subject to change without notice and do not apply if prohibited by the manufacturer. Discounts may vary by provider and location. Members should confirm a provider participates in offering discounts before receiving services, as not all providers offer discounts.

6 Out-of-pocket maximums apply to certain standard options on standard plastic single vision lenses and standard bifocal and trifocal lenses.

7 Discount over retail lined trifocal lens, including lens options.

DELTA DENTAL

Requested quote for:

City Of Pine Bluff, AR

VSP Voluntary Vision Plan

Effective: January 1, 2008

(Quote valid 60 days from effective date)

Provided by:

Jones & Associates Insurance

Quote # 2540

MONTHLY RATES

Employee Only	**$11.90**
Employee & One	**17.70**
Employee & Family	**29.90**

A $10 administration fee will be added to each group billing statement. Minimum of 3 enrollees required.

••$15 co-pay on examinations

Exam co-payment once every 12 months

••$25 co-pay on materials

Material co-payment for spectacles - once every 12 months.
Material co-payment for frames - once every 24 months.
No co-payment is required for contact lenses.

NETWORK DOCTOR: VSP will pay the cost of a comprehensive eye examination and prescribed materials purchased (frames, lenses, or contacts), up to the plan allowance, less any co-payments.

Benefit	**VSP Doctor**
Exam	Covered in full
Single Vision	Covered in full
Bifocal Lenses	Covered in full
Trifocal Lenses	Covered in full
Frames Covered	up to $100.00

Up to a 20% savings on lens extras such as scratch resistant and anti-reflective tints, blended and progressive lenses. A 20% discount is applied to the amount over the $100 frame allowance. There is a 20% discount off additional pairs of prescription glasses and sunglasses. Polycarbonate lenses are included for dependent children up to age 25.

***Contact Lenses, Evaluation and Fitting**	
Medically Necessary	Covered in full
Elective (instead of glasses)	Up to $105.00

Laser Vision Surgery: Discounts vary by location, but will average 15% off the contracted laser center's usual and customary charges.Additionally, if the laser center is offering a temporary price reduction, VSP members will receive 5% off the promotional price.

NON-NETWORK DOCTOR: VSP will pay the cost of an eye examination and prescribed materials purchased (frames, lenses, or contacts) based upon a schedule of benefits. Although over 90% of VSP patients typically receive services from member doctors, services may be secured from any licensed optometrist, ophthalmologist, and/or dispensing optician. Bills for services from non-member doctors may be submitted to VSP for reimbursement. Services obtained through non-member doctors are subject to the same co-pays and limitations as services through VSP member doctors.

*Current soft contact lens wearers may qualify for a special contact lens program that includes a contact lens evaluation and initial supply of replacement lenses. Learn more from your doctor or

HOW TO ACCESS THE BENEFITS

If you need to locate a VSP participating doctor, call Vision Service Plan at (800) 877-7195 or visit VSP's web site at

AVAILABLE THROUGH BROKERS NATIONAL, 1-800-798-1125

12/10/2007

Lincoln Financial Group®

You're In Charge®

Group Short-Term Disability Insurance
Specialty Worksite

SUMMARY OF BENEFITS

Sponsored by: City of Pine Bluff

Short-term disability is intended to protect your income for a short duration in case you become ill or injured.

STD Benefit

Weekly Benefit	Elimination Period	Maximum Duration
60% of weekly salary up to $500 per week	Benefits begin on: Accident: 15th day Illness:15th day	11 weeks

Pre-Existing Condition

You may not be eligible for benefits if you have received treatment for a condition within 3 months prior to your effective date under this policy until you have been covered under the policy for 6 months.

Waiver of Premium

You will not be required to pay premium during any time of approved total or partial disability.

Additional Benefits

Portability
Rehab Assistance - 5%
Survivor Income - 3 Weeks
C-Section Benefit - 8 weeks
See your Schedule of Benefits on your Certificate for more information

Enrolling for Coverage

Eligibility:

All employees in an eligible class.
You are able to take advantage of this coverage now without a health examination. You may not be offered this opportunity again until your annual open enrollment.

Monthly Premium Calculation**

		EXAMPLE Age 35
List your weekly earnings (Maximum covered payroll is $833 weekly)	$ _____	$610
Multiply by the premium factor	_____	0.02754
Your Estimated Monthly Premium	$ _____	$16.80

*This is an estimate of premium cost.
Actual deductions may vary slightly due to rounding and payroll frequency.

Attained Age	Premium Factor
0 - 24	0.02862
25 - 29	0.03132
30 - 34	0.02808
35 - 39	0.02754
40 - 44	0.02970
45 - 49	0.03132
50 - 54	0.03732
55 - 59	0.04704
60 - 64	0.05730
65 - 69	0.06378
70 +	0.06378

Lincoln Financial Group®

You're In Charge®

Group Long-Term Disability Insurance
Specialty Worksite

SUMMARY OF BENEFITS

Sponsored by: City of Pine Bluff

Long-term disability is intended to protect your income for a long duration after you have depleted short-term disability or any sick leave your company may offer.

LTD Benefit

	Monthly Benefit	Maximum Benefit Duration	Own Occupation Period	Elimination Period
Employee Paid Plan	60% of monthly salary up to $5,000 per month	Later of Age 65 or Social Security Normal Retirement Age	24 Months	90 Days

Pre-Existing Condition You may not be eligible for benefits if you have received treatment for a condition within 3 months prior to your effective date under this policy until you have been covered under the policy for 12 months.

Waiver of Premium You will not be required to pay premium during any time of approved total or partial disability.

Benefit Limitations
Mental Illness: 24 Months
Substance Abuse: 24 Months
Specified Illness: 24 Months

Enrolling for Coverage

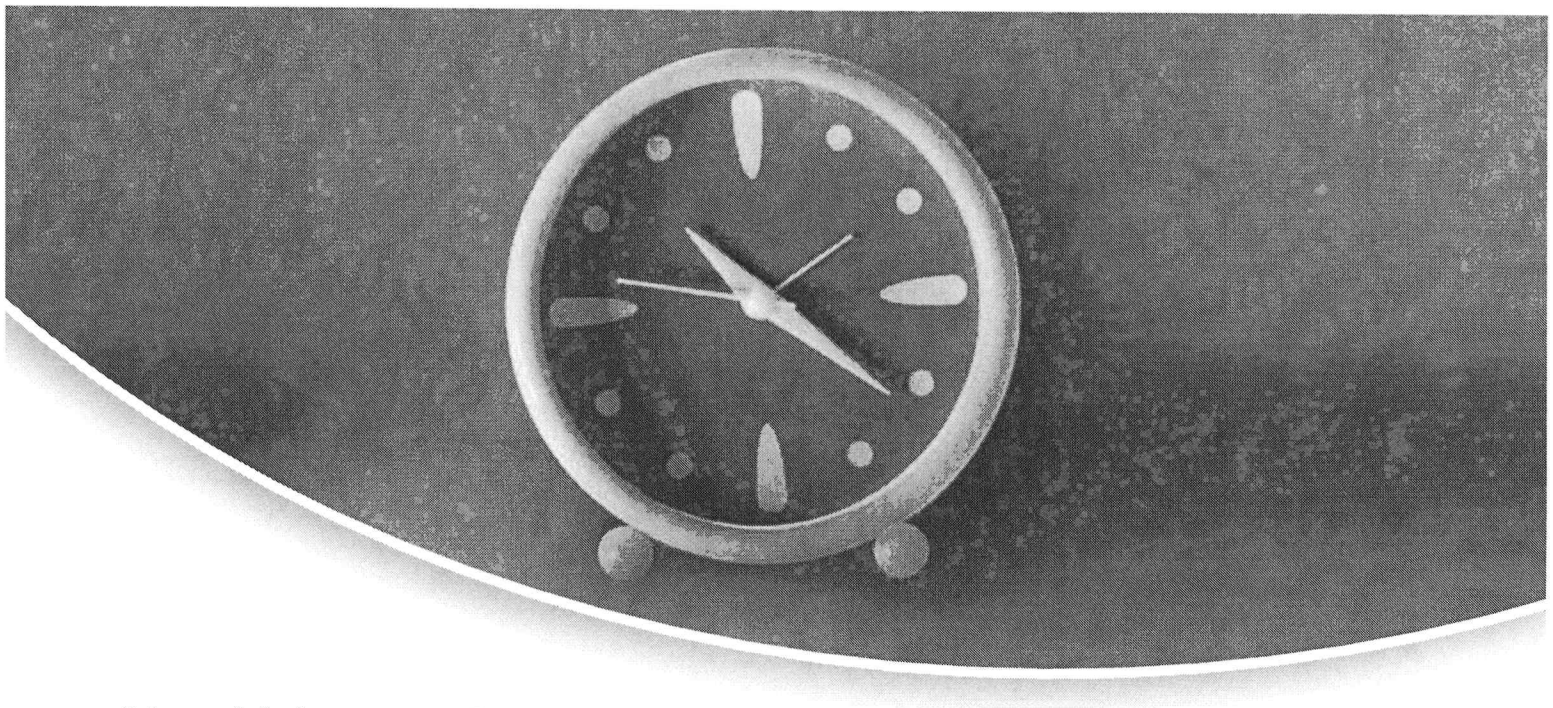
Eligibility: All employees in an eligible class.
You are able to take advantage of this coverage now without a health examination. You may not be offered this opportunity again until your annual open enrollment.

Monthly Premium Calculation**

		EXAMPLE Age 35
List your monthly earnings (*Maximum covered payroll is $8,333 Monthly)	$_____	$2,643
Multiply by your premium factor	_____	0.00675
Your Estimated Monthly Premium**	$_____	$17.84

**This is an estimate of premium cost.
Actual deductions may vary slightly due to rounding and payroll frequency.

Attained Age	Premium Factor
0 - 29	0.00261
30 - 34	0.00477
35 - 39	0.00675
40 - 44	0.00864
45 - 49	0.01188
50 - 54	0.01584
55 - 59	0.02007
60 - 64	0.02043
65 - 69	0.02655
70 - 74	0.03421
75 - 99	0.03421



New Voluntary Benefits Program from Allstate Benefits

Meeting your needs

Life can be unpredictable and full of surprises. Sometimes your circumstances change and you need coverage that can help meet your needs. With access to a wide range of products from Allstate Benefits, you can rest easy knowing your future is a little more secure.

Budget friendly

Sometimes, receiving proper health care can be difficult if money is tight. Our supplemental benefits can provide valuable coverage at an affordable price. Supplemental health insurance can help alleviate worry and help keep your finances strong. All you have to do is focus on getting well.

Putting you first

The quality of your health shouldn't be undermined by unaffordable care. The products on the back of this sheet are designed to supplement any insurance you may already have and can help offset medical expenses not paid by other coverage you may have. Take action now to help protect yourself and your family from future uncertainty; apply for your coverage today!

Advantages to you*:

- Different coverage options available
- Benefits paid directly to you unless assigned
- Benefits paid in addition to any other coverage
- Individual or family coverage
- Affordable premium rates

*Varies by product, state and group size.

Benefit options

The reverse side of this sheet highlights the coverage that is available. This coverage can help cover expenses if the unexpected happens. It is never too early to prepare for the future.

You must contact Santa Cruz Insurance Group at 228-463-0033 to discuss your available plan information and rates.

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THE POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED. *(TX only)*

GROUP ACCIDENT, CRITICAL ILLNESS, CANCER AND LIFE INSURANCE

Best in Benefits Series℠

ABJ34344X

your benefit coverage

Benefits can help offset the costs of an accident, sudden illness, cancer diagnosis, or loss of life. They can also cover some non-medical expenses that your current insurance might not.

Group Voluntary Accident

Accident insurance provides cash benefits for out-of-pocket expenses associated with an accidental injury and can help protect hard-earned savings should an on- or off-the-job accidental injury occur. No one plans to have an accident, but it can happen at any moment throughout the day. Accident coverage from Allstate Benefits can help pick up where other insurance leaves off.

- 24-hour coverage for yourself or your entire family
- Coverage can be continued at the same benefit level and premium amount, as long as premiums are paid to Allstate Benefits
- Benefits that correspond with treatment for on- or off-the-job accidental injuries, including hospitalization, emergency treatment, and intensive care, plus more
- Pays benefits for open and closed fractures
- Additional riders may be available to enhance coverage

Group Voluntary Critical Illness

Critical Illness insurance from Allstate Benefits pays benefits that can be used for non-medical expenses that your health insurance might not cover. The Group Voluntary Critical Illness benefit is in the form of a lump-sum payment, which is paid to you at diagnosis.

- Benefits paid directly to you, unless you assign benefits to someone else
- Available for you or your entire family
- Supplements your present coverage
- Additional riders may be available to enhance coverage
- Coverage can be continued

† Employee only

Group Voluntary Cancer

Cancer insurance provides cash benefits for cancer and 29 specified diseases, and can help cover the costs of specific cancer and specified disease treatments and expenses as they happen.

- Benefits paid directly to you unless otherwise assigned
- Coverage for you or your entire family
- Waiver of premium after 90 days of disability due to cancer for as long as your disability lasts†
- Coverage can be continued

Group Universal Life

Life insurance is for the living; those left behind must deal with final expenses, bills, mortgage, and expenses associated with day-to-day life. It can also help provide financial security during life-changing events that occur as you age and your needs change.

- Up to the maximum amount being offered by your employer
- Family coverage*
- Affordable premiums
- Tax benefits**
- Withdrawals and loans**

It is possible that coverage will expire when either no premiums are paid following the initial premium or subsequent premiums are insufficient to continue coverage.

*Coverage for spouse and child(ren) is limited to a percentage of the insured's face amount and is subject to state limits on dependent life coverage.

**Partial withdrawals, surrenders, non-qualified additional benefit rider charges and loans from life insurance policies may be subject to ordinary income taxes and possibly an additional 10% federal tax penalty. Outstanding loan balances and withdrawals generally reduce the death benefit and cash value. With proper planning, the death benefit can pass to your beneficiaries free from state or federal estate taxes. Please consult with your tax advisor for specific information.

Allstate BENEFITS

For use in enrollments situsued in: AL, AR, GA, LA, MS, PR, TX, VI

This material is valid as long as information remains current, but in no event later than April 15, 2021. Benefits provided by the following forms, or state variations thereof: GVAP1, GVCIP2, GVCP3, and GUL22. **The accident, critical illness and cancer coverage is provided by limited benefit supplemental insurance.** The policies have exclusions and limitations, may have reductions of benefits at specific ages, and may not be available for sale in all states. This is a brief overview of the coverage underwritten by American Heritage Life Insurance Company. For costs and complete details, contact your Allstate Benefits Agent. Allstate Benefits is the marketing name used by American Heritage Life Insurance Company (Home Office, Jacksonville, FL), a subsidiary of The Allstate Corporation. www.allstate.com or allstatebenefits.com

Lincoln Financial Group®

The Lincoln National Life Insurance Company
P.O. Box 2616, Omaha, NE 68103-2616
Phone: (800) 423-2765 Fax: (877) 573-6177

SCHEDULE OF INSURANCES

BASIC INSURANCE:

- LIFE and AD&D

** Insured Persons are not required to make contributions for Basic Personal Life Insurance and AD&D Insurance. This coverage is provided by the City for all Employees.

	Amount of Personal Life Insurance	AD&D Insurance Principal Sum
Class 1	$20,000	$20,000
Class 2	$10,000	$10,000

CLASSIFICATION

Class 1	Elected Officials, All Full-Time Department Heads, Uniformed Police and Fire Employees
Class 2	All Other Full-Time Employees

Personal Life and AD&D Insurance will be reduced as follows:
-- At age 65, benefits will reduce by 35% of the original amount;
-- At age 70, benefits will reduce by an additional 25% of the original amount;
-- At age 75, benefits will reduce by an additional 15% of the original amount;
Benefits will terminate when the Insured Person retires.

If the Insured Person first enrolls for Personal Life and AD&D Insurance at age 65 or older, the above reductions will apply to:
-- Any Guarantee Issue Amount available without evidence of insurability; and
-- The maximum amount of insurance for which he or she is eligible.

AD&D BENEFIT. If an Insured Person sustains an accidental bodily injury, and the injury directly causes one of the following losses within 90 days of the date of that injury; then he/she will receive the following benefit:

LOSS	BENEFIT
One hand by severance at or above the wrist	½ of the Principal Sum
One foot by severance at or above the ankle	½ of the Principal Sum
Irrecoverable loss of sight in one eye	½ of the Principal Sum
Any combination of 2 or more of the losses listed above	Principal Sum
Loss of Life	Principal Sum

DEPENDENT INSURANCE:

Type of Dependent	Amount of Life Insurance
Spouse	$5,000
Dependent Child (age 14 days to 6 months)	$250
Dependent Child (age 6 months to 19 years, 23 years if student)	$2,500

- Spouse Life Insurance will terminate when the Spouse attains age 70.
- Dependent's Life Insurance is subject to a maximum of 50% of the Insured Employee's Life Insurance Benefit.

** Insured Persons are required to make contributions for Basic Dependent Life Insurance at a rate of $1.00 per month.

OPTIONAL INSURANCE:

Insured Persons may elect Optional Personal Life Insurance, provided such Insured Persons are also enrolled in the Basic Insurance Program.

Amount of Optional Personal Life Insurance

Class 1	$20,000
Class 2	$10,000

Optional coverage is not available for dependents.

** Insured Persons are required to make contributions for Optional Personal Life Insurance based on the following rate schedule:

Insured Employee's Attained Age	Monthly Rate per $1,000 of insurance
15—29 years	$0.12
30—39 years	$0.17
40—49 years	$0.45
50—59 years	$1.18
60 years & over	$2.17