State of West Virginia
Public Employees Insurance Agency

REQUEST FOR PROPOSAL
FOR
FRINGE BENEFITS MANAGEMENT
AND
ADMINISTRATIVE SERVICES

PEI10001

July 15, 2009

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WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE AGENCY

REQUEST FOR PROPOSAL
FOR
FRINGE BENEFITS MANAGEMENT AND ADMINISTRATIVE SERVICES

1. GENERAL INFORMATION

1.1. Purpose

The West Virginia Public Employees Insurance Agency (Agency) is soliciting proposals to provide administrative services for its IRS Section 125-qualified cafeteria plan known as Mountaineer Flexible Benefits.

1.2. Overview

The Agency provides optional additional benefits to certain employees through the Mountaineer Flexible Benefits plan, an IRS Section 125 cafeteria plan. The optional benefits currently include three dental benefit options; two vision benefit options; long-term and short-term disability insurance; a legal services plan; and medical and dependent day care flexible spending accounts. The legal services plan is a post tax benefit. Contracts for these products are between PEIA and the individual product vendors.

The Agency is seeking a vendor to administer the plan. The Vendor will be responsible for all aspects of the plan, including producing and distributing all communication materials associated with the plan; conducting annual open enrollments; assisting with the procurement of benefits available under this contract; processing all payroll information; collecting and distributing premiums and eligibility information to the benefit vendors, providing periodic reports on plan status; recommending changes to the plan; updating and filing the plan document; and preparing all paperwork required by the IRS.

All costs of this plan are borne by participating employees in the form of premiums and administrative fees. By State statute, no State dollars may be expended in the administration of this program.

1.3. General

These and other professional service contract awards are not subject to the provisions or rules of the Purchasing Division of the West Virginia Department of Administration. (Refer to W. Va. Code 5-16-9(e))

Agreements and contracts entered into under this RFP are not subject to the provisions or rules of the Purchasing Division of the State of West Virginia.

1.4. RFP Format

This RFP has five sections. "Section 1" contains general procurement information and procedures; "Section 2" describes the background and work environment; "Section 3" describes the work to be performed and establishes the contractual terms and conditions; "Section 4" describes information required from bidders; and "Section 5" contains the evaluation methodology.

1.5. Inquiries

Requests for additional information regarding specifications of this RFP must be submitted in writing to the Deputy Director of Operations of PEIA with the exception of questions regarding proposal submission which may be oral. The deadline for written inquiries is identified in the Schedule of Events, Section 1.19. Requests must be addressed to:

J. Michael Adkins, Deputy Director of Operations
West Virginia Public Employees Insurance Agency
601 – 57th Street, SE, Suite 2
Charleston WV 25304
Fax: (866) 792-3574
Telephone: (304) 957-2630
Email: michael.adkins@wv.gov

Absolutely NO contact shall be made by the Vendor with any member of the evaluation committee. Violation may result in rejection of the bid. The individual named above is the sole contact for any and all inquiries after this RFP has been released.

1.6. Vendor Registration

Vendors participating in this process should complete and file a ***Vendor Registration and Disclosure Statement*** (Form WV-1) and remit the registration fee to the West Virginia Purchasing Division. Vendor is not required to be a registered vendor in order to submit a proposal, but the successful bidder must register and pay the fee prior to the award of the contract.

The Vendor Registration and Disclosure Statement (Form WV-1), and fee requirement can be located on West Virginia Purchasing Divisions website at www.state.wv.us/admin/purchase under "Vendor Resource Center".

1.7. Oral Statements and Commitments

Vendor must clearly understand that any verbal representations made or assumed to be made during any oral discussions held between Vendor's representatives and any State personnel are not binding. Only the information issued in writing and added to the Request for Proposal by an official written addendum is binding.

1.8. Economy of Preparation

Proposals should be prepared simply and economically, providing a straightforward, concise description of Vendor's abilities to satisfy the requirements of the RFP. Emphasis should be placed on completeness and clarity of content.

1.9. Mandatory Requirements to Bid

In order to submit bids for this RFP to serve as the Mountaineer Flexible Benefits administrator for the Agency, the organization must currently have one client with a total active employee count in excess of 25,000 with an actual enrollment in the Section 125 cafeteria plan in excess of 2,500.

1.10. Labeling of RFP Sections

The sections within this RFP contain instructions governing how the Vendor's proposal is to be arranged and submitted, and to identify the material to be included therein.

1.10.1. Mandatory Requirements

The mandatory segments included in Sections 3 and 4 require a response, and they describe the minimum requirements requested in this RFP. Any specification or statement containing the word "must", "shall, or "will" is mandatory. The vendor is required to meet the intent of the mandatory specifications to be eligible for consideration and to continue in the evaluation process. A simple "yes" or "no" response to these sections is not adequate. Failure to meet mandatory items shall result in disqualification of the Vendor's proposal and termination of the evaluation process for that Vendor. Decisions regarding compliance with the intent of any mandatory specification shall be at the sole discretion of the State.

1.10.2. Contract Terms and Conditions

Section 3 details the terms and conditions under which the State of West Virginia will enter into a contract.

1.10.3. Informational Sections

All information specifications do not require a response from the Vendor. They are intended to aid the Vendor in structuring an effective proposal capable of meeting the needs of the issuing agency.

1.11. Proposal Format and Submission

1.11.1. Vendors must complete a response to all mandatory specifications in order to be considered. Each proposal must be formatted according to the outline in Section 4 of this RFP. No other arrangement or distribution of the proposal information may be made by the bidder. Failure to respond to specific requirements detailed in the RFP may be basis for disqualification of the proposal. The State reserves the right to waive any informality in the proposal format and minor irregularities.

1.11.2. Submission of Technical and Cost Proposals

Technical and cost proposals must be submitted in separate and clearly marked envelopes or packages (see 1.11.3. and 1.12.1. below). Failure to do so will result in disqualification. Submit separate originals of the technical and cost proposals to:

J. Michael Adkins, Deputy Director of Operations
West Virginia Public Employees Insurance Agency
601 – 57th Street, SE, Suite 2
Charleston WV 25304
Fax: (866)-792-3574
Telephone: (304) 957-2630
Email: michael.adkins@wv.gov

In addition to the original, please submit in hard copy six (6) Agency convenience copies of each proposal along with a complete copy in electronic form. All copies must be submitted **prior** to the date and time stipulated in the RFP as the proposal due date (Friday, September 4, 2009). All bids will be date and time stamped to verify official time and date of receipt.

Vendors mailing proposals should allow sufficient time for mail delivery to ensure timely arrival. PEIA cannot waive or excuse late receipt of proposals that are delayed or late for any reason. Any proposals received after 4:00 PM EST on

the proposal due (Friday, September 4, 2009) date will be immediately disqualified.

1.11.3. The outside of the envelopes or packages should be clearly marked **"Mountaineer Flexible Benefits Proposal - Technical"** and **"Mountaineer Flexible Benefits Proposal - Cost"**.

1.12. Best Value Purchasing Standard Format

1.12.1. Proposal Format and Content: Proposals shall be received in two distinct parts: technical and cost. The cost portion shall be sealed in a separate envelope and will not be opened initially. The proposal submitted in electronic form shall be received on two (2) distinct discs: Technical Proposal on one and Cost Proposal on the second.

1.12.2. Technical Bid Opening: PEIA will open only the technical proposals on the date and time specified in the Request for Proposal.

1.12.3. Technical Evaluation: An evaluation committee will review the technical proposals, assign appropriate points and make a final written consensus recommendation to the PEIA Director.

1.12.4. Cost Bid Opening: Upon approval of the technical evaluation, the PEIA Director or his designee shall open cost proposals.

1.12.5. Cost Evaluation: The evaluation committee or other designee of the PEIA Director will review the cost proposals, assign appropriate points and make final consensus recommendation to the PEIA Director. The PEIA Director will provide guidance on the determination of the Resident Vendor Preference, if applicable.

1.12.6. Contract Approval and Award: After the cost proposals have been opened, the evaluation committee performs its review and makes its recommendation to the PEIA Director based on the highest scoring vendor. The PEIA Director will review the scoring, justification, and recommendation of the committee. If it is the opinion of the PEIA Director that the analysis of the committee has been performed correctly and he or she is confident that the correct procedures have been followed, the PEIA Director will make the award to the

apparent successful vendor. The PEIA Director will ensure that all vendors who submitted proposals are informed of the award to the apparent successful vendor.

The PEIA Director will negotiate the contract directly with the Vendor as set forth in W.Va. Code 5-16-9. Upon approvals, the contract may be signed.

1.13. Rejection of Proposals

The State shall select the best value solution according to the evaluation criteria. However, the State reserves the right to accept or reject any or all proposals, in whole or in part at its discretion. The State reserves the right to withdraw this RFP at any time and for any reason. Submission of, or receipt by the State of proposals confers no rights upon the bidder nor does it obligate the State in any manner.

A contract based on this RFP and the Vendor's proposal, may or may not be awarded. Any contract resulting in an award from this RFP is not valid until properly executed by the Agency.

1.14. Incurring Costs

The State and any of its employees or officers shall not be held liable for any expenses incurred by any bidder responding to this RFP for expenses to prepare or deliver the proposal, or to attend any mandatory pre-bid meeting or oral presentations.

1.15. Addenda

If it becomes necessary to revise any part of this RFP, an official written addendum will be issued by the State to all bidders of record.

1.16. Independent Price Determination

A proposal will not be considered for award if the price in the proposal was not arrived at independently without collusion, consultation, communication, or agreement as to any matter relating to prices with any competitor unless the proposal is submitted as a joint venture.

1.17. Price Quotations

The price(s) quoted in the bidder's proposal will not be subject to any increase and will be considered firm for the life of the contract unless specific provisions have been provided for adjustment in the original contract as negotiated by the PEIA Director.

1.18. Public Record

1.18.1. Submissions are Public Record. All documents submitted which are related to purchase orders or contracts are

considered public records. All bids, proposals, or offers submitted by bidders shall become public information and are available for inspection during normal official business hours in the PEIA offices.

1.18.2. Written Release of Information. All public information may be released with or without a Freedom of Information Act request; however, only a written request will be acted upon with duplication fees paid in advance. Duplication fees shall apply to all requests for copies of any document. Currently the fees are $1.00/page, or a minimum of $10.00 per request, whichever is greater.

1.18.3. Risk of Disclosure. The only exemptions from disclosure of information are listed in West Virginia Code §29B-1-4. Primarily, trade secrets as submitted by a bidder are the only exemption from public disclosure. The submission of any information to the State by a vendor puts the risk of disclosure on the vendor. The State will make a reasonable effort not to disclose information that is legitimately within the guidelines of §29B-1-4 and is properly and in good faith labeled "proprietary information not for public disclosure." The State does not guarantee non-disclosure of any information to the public. Designation of an entire proposal or excessive portions of the proposal as "proprietary" is not considered to be in good faith and will be disregarded.

1.19. Schedule of Events

The following is the tentative schedule of events for this procurement. Adjustments may be made if they become necessary.

Release of the RFP	Wednesday, July 15, 2009
Mandatory Pre-bid Conference	Friday, July 31, 2009
Vendor's Written Questions Submission Deadline	Friday, August 7, 2009
Response to Questions	Friday, August 14, 2009
Proposals Due (By 4:00 PM EST)	Friday, September 4, 2009
Oral Presentation (If necessary)	Wednesday, September 23, 2009
Contract Award (Anticipated)	Friday, October 16, 2009
Open Enrollment Commences	Thursday, April 1, 2010
Open Enrollment Ends	Friday, April 30, 2010
New Plan Year Begins	Thursday, July 1, 2010

1.20. Mandatory Pre-bid Conference

A mandatory pre-bid conference shall be conducted on Friday, July 31, 2009, at 1:00 p.m. Said conference will be held in the PEIA Conference Room 1058, 601 57th Street, SE, Suite 2, Charleston, West Virginia. **All interested bidders are required to be present at this meeting. Failure to attend the mandatory pre-bid conference shall automatically result in disqualification. No person can represent more than one vendor at this conference.**

1.21. Bond Requirement

Vendors will be required to submit a litigation bond. (The litigation bond may be waived by submission of waiver. See Section 3). The bond requirement is described in detail in Section 3 of this RFP.

1.22. No Debt Affidavit

West Virginia State Code §5A-3-10a(3)(d) requires that all proposers submit an affidavit of debt which certifies that there are no outstanding obligations or debts owed the State of West Virginia. The Debt Affidavit is attached to this RFP as an attachment and **MUST** be completed, signed and returned with your proposal.

1.23. Letter of Good Standing

The Agency requires a Letter of Good Standing from the State Tax Department also be submitted with proposals. This letter can be acquired by submitting a written request to:

State of West Virginia Tax Department
Attention: Darlena Lilly
Administrative Support Unit
1001 Lee Street East
Charleston, WV 25301
Fax: (304) 558-8643

2. OPERATING ENVIRONMENT

2.1. Location

The Agency is located at 601 – 57th Street, SE, Suite 2, Charleston WV 25304.

2.2. Background

PEIA is the agency of the State of West Virginia that is charged with providing health and life insurance to approximately 118,000 active and retired employees of State agencies, colleges, universities, county boards of education and those local government agencies that choose to participate in the plan. However, not all county boards of education, and very few of the local governments, currently

participate in the Mountaineer Flexible Benefits plan. Current enrollment in the Mountaineer Flexible Benefit plan is approximately 19,970 active employees and 6,329 retired employees.

PEIA implemented the Mountaineer Flexible Benefits plan in March 1992 to provide optional additional benefits to eligible employees. All benefits available under the plan are 100% employee-paid. Participation in the program has grown steadily throughout its 17 year history. The enrollment history for 1998 through 2008 is included as Exhibit A. Also included in Exhibit A are the enrollment statistics for Plan Year 2010 effective July 1, 2009.

The plan currently offers three indemnity dental benefits from Delta Dental, two vision benefit options from VSP, long and short term disability insurance from Standard Insurance Company, and the group legal services plan from Hyatt Legal Plans. Existing contracts are between these companies and the Agency, and will not be re-bid until an administrator is chosen through this RFP. They will continue through Plan Year 2010 (June 30, 2010). Current enrollment information is included as Exhibit A of this RFP.

The Agency desires to continue the growth of the program and to expand the availability of the program to include local government agencies, which, until recently, had been excluded from participation. The local government agencies range in size from public libraries with one or two employees to cities and counties with hundreds of employees.

Each participating agency has an employee designated as the benefit coordinator. This person is responsible for all enrollments and changes for employees of his/her agency. Although their work involves PEIA, they are not employed by or responsible to the PEIA. Levels of benefit coordinator training and cooperation vary widely.

Payroll for employees of State agencies and colleges and universities are handled through the State of West Virginia Auditor's EPICs payroll system. However, payroll for county boards of education, other colleges and universities and local government agencies are handled through various means, depending on the size of the agency. Some agencies have sophisticated payroll systems, while others are still handling payroll manually. The Vendor will be required to interface with all of these systems.

3. PROCUREMENT SPECIFICATIONS

3.1. General Requirements

The Vendor will be responsible, at a minimum, for the following:

a. Receipt of policyholder funds from participating agencies, including the State of West Virginia, county boards of education and local government agencies.
b. Maintenance of all funds in accounts that are open to inspection at all times by the Agency. These funds will be deposited into a bank account which is acceptable to the Agency.
c. Disbursement and payment of funds to insurance providers, third party providers, or participants.
d. Implementation, including a written Master Plan.
e. Plan Design, in subsequent years.
f. Marketing, education, and enrollment which will include a toll-free telephone number available to all covered participants within the State of West Virginia.
g. Administration and plan account management.
h. Customer service.
i. Review and evaluation of the plan and its attendant benefits.
j. Financial recordkeeping and reporting.
k. Statutory and regulatory compliance.
l. Solicitation and review of benefit proposals for the benefits available under this plan. The Vendor will make recommendations to the Agency regarding best proposal and final benefit vendor selection. The solicitation document, prospective benefit vendor list and all other aspects of benefit procurement will require the Agency's approval.
m. Administer COBRA services for the dental and vision plans.

3.2. Scope of Work

The successful vendor shall perform the following functions:

3.2.1. Eligibility and Enrollment

a. Successful vendor must offer on-line enrollment in addition to hard copy form enrollment.
b. Construct appropriate master files for each individual participant by means of enrollment information generated by the vendor from enrollment forms from computer files supplied by the incumbent vendor.
c. After enrollment, provide participants with notice of their benefit elections as part of the enrollment confirmation letter.
d. Transmit eligibility data to the benefit vendors on a weekly basis in a format agreeable to both the administrator and the benefit vendor.

e. Reconcile eligibility errors with the benefit vendors on a timely basis to assure smooth operation of the plan for participants.

3.2.2. Customer Service

a. Provide a toll-free telephone number and an interactive website for participants' use to obtain general information about their FSAs and other benefits under this plan. Available information must include specific details of account balances and transactions related to FSAs. If the telephone system is automated, participants should have the option to speak to a dedicated customer service representative.

b. Telephone service shall be available, at a minimum, from 8:00 a.m. to 7:00 p.m. ET, Monday through Friday, and from 8:00 a.m. to noon ET, Saturday.

c. Adequate personnel shall be available to respond to incoming calls within 60 seconds or less at all times.

d. A dedicated telephone number and e-mail address of a contact person who has expertise in the Mountaineer Flexible Benefits plan and can respond to questions from PEIA staff and the various agency benefit coordinators shall be provided. This line should be open from 8:00 a.m. to 7:00 p.m. ET, Monday through Friday, and from 8:00 a.m. to noon ET, Saturday. A 24-hour response time shall be deemed acceptable for providing answers to questions.

e. Assistance shall be provided to eligible participants during the annual open enrollment period by means of the telephone, at a minimum, from 8:00 a.m. to 7:00 p.m. ET, Monday through Friday, and from 8:00 a.m. to noon ET, Saturday. Personal and confidential telephone counseling should be provided to help individuals understand the benefits available to them, including the insurance coverages, the concept of salary reduction arrangements and reimbursement accounts, as well as the completion of the enrollment application.

f. Operate an automatic call distribution system which allows for the measurement of the number of abandoned calls, call waiting times, etc. All calls shall be documented, which shall include the time and date of the call, the wait time, the name of the telephone counselor, the nature of the call, and the disposition of the call.

g. Advise PEIA's representative immediately whenever there are problems in the claims system which may create

public inquiries, such as system breakdowns, missed payment cycles, or egregious errors.

h. Receive, evaluate, and respond to participants' questions by telephone, mail, fax, or electronically (e-mail) in an accurate, polite, timely, and confidential manner.

i. Provide referral service to employees inquiring about benefits provided by the benefit vendors.

3.2.3. Educational Materials and Training

a. Provide and pay for educational materials (sample copies of the current enrollment packet are included as (Exhibit B) for prospective and current participants for each open enrollment during the life of the contract. No additional costs shall be billed outside of the contract.

- PEIA will have final approval of all copy to be included in the materials; the Vendor will be responsible for all printing, overprinting, and distribution costs.
- PEIA will pay postage for mailing enrollment materials to home addresses of eligible active employees and retirees. These funds will be derived from forfeitures from the flexible spending accounts.
- A plain text (non-graphic) copy must be provided to PEIA for printing of alternate formats no later than 30 days prior to open enrollment.

b. Prepare a Mountaineer Flexible Benefits group-specific administrative plan manual, with provision for updates, for use by the Vendor's claims processors and customer service representatives to include, but not be limited to, reporting requirements, standards, and processing procedures and policies for the administration of the fringe benefits plan. Provide a draft of this manual to the Agency for approval at least 30 days prior to start of the plan year.

c. Prepare a Mountaineer Flexible Benefits group-specific reference manual, with provision for updates, for use by agency benefit coordinators to include, but not be limited to, eligibility and enrollment information, instructions for processing enrollments, instructions for processing refunds and overpayments, information on member appeal rights and general information about the enrollment and de-enrollment rules required by Section 125.

d. Participate in all PEIA-sponsored benefit fairs during Open Enrollment (approximately 12-15 per year).

Providing members with details of benefits available and instructions for completing enrollment forms.

e. Pursue opportunities to meet with employees at their work locations during open enrollment either on a one-to-one basis or in group benefit presentations.

f. Have a visible presence in the field throughout the open enrollment period.

g. Participate in PEIA's regional benefit coordinator training sessions (approximately 10 per year) prior to open enrollment.

3.2.4. Flexible Spending Account Requirements

The selected Vendor shall provide a responsive, efficient, auditory, service-oriented system for the administration of the State of West Virginia's existing health care and dependent care reimbursement accounts, to include the following:

a. Account Creation and Maintenance

- Successful vendor must offer on-line account access.
- Establish separate health care and dependent care reimbursement accounts for eligible employees.
- Record and update changes in participants' contribution information as they are received from each agency's benefit coordinator. Allow corrections to a participant's account(s) in the event that erroneous transactions are posted to it. Payrolls are processed twice per month and updates to participants' accounts by the Vendor are expected in the same time frame. If a scheduled contribution is not received for an individual account, suspend that account's activity, as appropriate, and request clarification from the benefit coordinator.

b. Flexible Benefit Reimbursement Processing

- Successful vendor must offer on-line claim submissions.
- Accept claims from participants by means of mail or facsimile.
- Confirm eligibility of claimants and the availability of funds.
- Verify claims documentation and determine compliance of the claims, in accordance with the State

of West Virginia's flexible benefits plan document (Exhibit C).

- Determine that the claim is valid with respect to the item of expense, the date of service, and the eligibility of the claimant, pursuant to Prop. Treas. Reg. § 1.125-2.
- Record and code claims in sufficient detail to permit required reporting and to avoid duplicate payments.
- Screen claims prior to payment to uncover potential duplicate claims. Checking for duplicate claims must be an automated feature of the payment system. Investigate and resolve potential duplicate filings.
- Approve reimbursement payment requests. Determine amounts available for reimbursement payments. Generate payment checks and remittance statements for participants. Ensure that remittance statements clearly explain the basis for denial, if applicable, and advise the claimant of how the claim may be perfected or to whom the denial may be appealed. Reissue payment checks when necessary, at no charge.
- Provide reimbursement forms and the payment check stock.
- Develop a claims payment schedule that conforms to, or exceeds, a seven (7) business day cycle.
- Produce demand letters for collecting any amounts due from participants and process refunds for participants, as required.
- Within 30 days of the close of each calendar quarter, mail to each participant a statement disclosing the status of his/her accounts as of the end of the quarter.
- Mail to participants on or before 60 days prior to the end of each plan year, a statement of balances, alerting participants to possible forfeitures (including information on the two months and 15 day grace period and 120 day run-out).
- Send a statement of balances alerting participants who terminate within the plan year, to possible forfeitures within 14 days of notice of termination.
- Process claims incurred during the plan year and grace period that are received on or before October 31 of the next plan year. Except during the first year of the contract, process claims simultaneously for more than one (1) plan year (that is, claims for the current plan year and claims for the 75-day grace period of the

previous plan year). Monitor and report claims payments by plan year.

- During the 75-day grace period, mail a statement of account to participants whose accounts have a positive balance. This notice to be mailed as soon as possible, but no later than 15 days after the close of the first month of the grace period. These provisions shall apply equally in the event of the cancellation or termination of the contract resulting from this RFP for any of reason to the extent that the Vendor shall be responsible for processing eligible claims submitted by participants for a 75-day run-out period subsequent to the effective date of cancellation or termination of the contract.
- The choice of alternative methods of reimbursement must be available to offer to participants, i.e., direct electronic deposit, debit card, etc. at no cost to the participant.

3.2.5. Banking Arrangements

a. The Vendor shall establish appropriate bank accounts at a financial institution designated by PEIA, which account shall be used solely for the operations of the plans covered by this RFP. Ownership of all funds shall reside with the State of West Virginia. The Vendor, however, shall have authority to disburse funds under its own signature.

b. Write checks from the special bank account to pay premiums to the providers of benefits under this plan and to reimburse participants for flexible spending account claims.

c. Process deposits and other monies, as received, into the special bank account and post all individual sub-accounts. The Vendor must post actual amounts withheld to the appropriate individual accounts.

d. Reconcile the special bank account on a monthly basis within 45 days of the monthly closing date of the account.

e. Provide the Agency with an audited reconciliation of the fund within 45 days of the end of the 120-run out period following each plan year, providing balances and listing all outstanding checks.

f. Safeguard check stock and control signature authority according to best GAAP procedures or equivalent

business practices. Account for all wasted, voided, and manual checks.

g. Secure appropriate errors and omissions insurance so as to indemnify the State of West Virginia in case of fraud or embezzlement.

h. All stale dated checks must be turned over to the West Virginia Treasurer's Office – Unclaimed Property Division in the proper time frame.

3.2.6. Auditing

a. Have an audit conducted of the plan year's activity by an outside auditing firm following the end of the run-out period, and provide the Agency with the results.

b. The entity must provide copies of its independently audited financial statements and accompanying independent auditors' report annually.

c. Produce and maintain payment registers and associated documents that provide a clear and complete audit trail of the entire administrative process.

d. Provide a SAS 70, Type II audit report performed by an independent firm encompassing at least 6 months of the Agency's fiscal/plan year, annually.

3.2.7. Management Reports

a. Provide, at a minimum, the management reports listed in Exhibit D at no additional cost to the Agency. The reports must be submitted as specified in Exhibit D by the 15th day of the month following the reporting date.

3.2.8. Administrative Duties

a. Prepare and distribute the required certificates of prior creditable coverage pursuant to the Health Insurance Portability and Accountability Act (HIPAA) to individuals terminating participation under any applicable benefit.

b. Prepare and file the appropriate Form 5500 annual reports with the Internal Revenue Service.

c. Perform the applicable nondiscrimination tests for cafeteria plans in accordance with Section 125 of the Code.

d. General contract administration of benefit vendors offering under this plan.

3.2.9. Account Management

a. An on-site account manager must be housed at the PEIA offices to provide customer service, work with benefit coordinators, plan open enrollment in cooperation with PEIA staff, and maintain contact with benefit vendors.

b. Interface with benefit vendors to resolve customer service problems and clarify benefit issues.

c. Negotiate annual renewals and premiums with benefit vendors.

d. Have the financial stability and capability to handle the additional volume that the State of West Virginia's program will generate with the appropriate start-up costs, etc., as indicated by its most recent annual report and audited financial statement.

3.3. Special Terms and Conditions

3.3.1. Insurance Requirements: The vendor must possess and maintain Professional Liability Insurance in a form acceptable to the Agency, which shall cover the Vendor, its officers, employees, and agents for any actual or alleged breach of duty, neglect, error, misstatement, misleading statement, or omission committed by the Vendor in the performance of its duties and responsibilities as the administrator under this contract, including any hold harmless and/or indemnification agreement. The Professional Liability Insurance shall be maintained from the inception of the Vendor's service under the contract until at least three (3) years after completion of all services required under the contract. The required Professional Liability Insurance shall have a limit of liability of at least $1,000,000 for each occurrence.

3.3.2. License Requirements: The vendor must employ an account manager who is a licensed health and life insurance agent in the State of West Virginia.

3.3.3. Litigation Bond: Each bidder responding to this request for proposal **is required** to submit a litigation bond in the amount of $20,000, made payable to the West Virginia Public Employees Insurance Agency. This bond must be

issued by a surety company licensed to do business in the State of West Virginia with the West Virginia Insurance Commission, on a form acceptable to the State, and countersigned by a West Virginia Resident Agent. The only acceptable alternate forms of the bond are (1) a company certified check (not an individual) or (2) a cashier's check.

The purpose of the litigation bond is to discourage unwarranted or frivolous law suits pertaining to the award of a contract from this RFP. Secondly, the bond provides a mechanism for the State of West Virginia, the Agency, it's officers, employees, or agents thereof to recover damages, including, but not limited to, attorney fees, loss of revenue, loss of grants or portions thereof, penalties imposed by the federal government and travel expenses which may result from any such litigation. A claim against the bond will be made if the Vendor contests the award in a court of competent jurisdiction and the grounds are found to be unwarranted or frivolous based on the facts of the award or applicable law as determined by the court.

The bond or alternate form must remain in effect for two years from the proposal submission date. After six (6) months, each vendor may request, and the State anticipates granting, a release of the litigation bond. However, the Vendor will be required to provide a release, signed and notarized in a form that is acceptable to the State, prior to release of the bond that states that the Vendor will not sue.

The Agency **will** waive the litigation bond if the bidder submits in writing on a form acceptable to the Agency a complete waiver of any rights to challenge this RFP/award in any jurisdiction or venue. The only acceptable alternative to the litigation bond is the submission of this signed "Bidder's Total Waiver of Legal Challenge" form included with the vendor's bid. (See Exhibit E.)

Failure to submit an appropriate bond, alternate bond, or signed waiver form with the proposal at the time of bid opening will result in automatic disqualification of the vendor's proposal and the proposal will be considered non-responsive.

3.3.4. No Debt Affidavit: It is required that all vendors submit an affidavit of debt which certifies that there are no outstanding obligations or debts owing the State of West Virginia. The

Debt Affidavit is attached to this RFP and **must** be completed, signed and returned ***with*** the vendor's proposal. If bidding a joint proposal, a Debt Affidavit must be completed for both vendors.

3.3.5. Letter of Good Standing: The Agency requires that a Letter of Good Standing from the State Tax Department also be submitted with proposals. This letter can be acquired by submitting a written request to:

State of West Virginia Tax Department
Attention: Darlena Lilly
Administrative Support Unit
1001 Lee Street East
Charleston, WV 25301
Fax (304) 558-8643

3.4. General Terms and Conditions

By signing and submitting their proposal, the successful Vendor agrees to be bound by all the terms contained in Section 3 of this RFP.

3.4.1. Conflict of Interest. Vendor affirms that it, its officers or members or employees currently have no interest and shall not acquire any interest, direct or indirect which would conflict or compromise in any manner or degree with the performance or its services hereunder. The Vendor further covenants that in the performance of the contract, the Vendor shall periodically inquire of its officers, members and employees concerning such interests. Any such interests discovered shall be promptly presented in detail to the Agency.

3.4.2. Prohibition Against Gratuities. Vendor warrants that it has not employed any company or person other than a bona fide employee working solely for the Vendor or a company regularly employed as its marketing agent to solicit or secure the contract and that it has not paid or agreed to pay any company or person any fee, commission, percentage, brokerage fee, gifts or any other consideration directly contingent upon, or directly resulting from, the award of the contract.

For breach or violation of this warranty, the State shall have the right to annul this contract without liability at its

discretion, and/or to pursue any other remedies available under this contract or by law.

3.4.3. Certifications Related to Lobbying. Vendor certifies that no federal appropriated funds have been paid or will be paid by, or on behalf of, the company or an employee thereof, to any person for purposes of influencing or attempting to influence an officer or employee of any federal entity, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement.

If any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee or any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this federal contract, grant, loan, or cooperative agreement, the Vendor shall complete and submit a disclosure form to report the lobbying.

Vendor agrees that this language of certification shall be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly. This certification is a material representation of fact upon which reliance was placed when this contract was made and entered into.

3.4.4. Vendor Relationship. The relationship of the Vendor to the State shall be that of an independent contractor and no principal-agent relationship or employer-employee relationship is contemplated or created by the parties to this contract. The Vendor, as an independent contractor, is solely liable for the acts and omissions of its employees and agents.

Vendor shall be responsible for selecting, supervising and compensating any and all individuals employed pursuant to the terms of this RFP and resulting contract. Neither the Vendor nor any employees or contractors of the Vendor shall

be deemed to be employees of the State for any purposes whatsoever.

Vendor shall be exclusively responsible for payment of employees and contractors for all wages and salaries, taxes, withholding payments, penalties, fees, fringe benefits, professional liability insurance premiums, contributions to insurance and pension or other deferred compensation plans, including but not limited to Workers' Compensation and Social Security obligations, and licensing fees, etc. and the filing of all necessary documents, forms and returns pertinent to all of the foregoing.

Vendor shall hold harmless the State, and shall provide the State and the Agency with a defense against any and all claims including, but not limited to, the foregoing payments, withholdings, contributions, taxes, social security taxes and employer income tax returns.

The Vendor shall not assign, convey, transfer or delegate any of its responsibilities and obligations under this contract to any person, corporation, partnership, association or entity without expressed written consent of the Agency.

3.4.5. Indemnification. The Vendor agrees to indemnify, defend and hold harmless the State and the Agency, their officers, and employees from and against any and all claims relating to the failure to perform or the performance of its services, including but not limited to: (1) any claims or losses for services rendered by any subcontractor, person or firm performing or supplying services, materials or supplies in connection with the performance of the contract; (2) any claims or losses resulting from any person or entity injured or damaged by the Vendor, its officers, employees, or subcontractors by the publication, translation, reproduction, delivery, performance, use or disposition of any data used under the contract in a manner not authorized by the contract, or by federal or state statutes or regulations; and (3) any failure of the Vendor, its officers, employees or subcontractors to observe state and federal laws including, but not limited to, labor and wage laws.

The PEIA and or the State of West Virginia will not indemnify the Vendor.

3.4.6. Contract Provisions. After the successful Vendor is selected, a formal contract document will be executed between the State and the Vendor. In addition, the RFP and the Vendor's response will be included as part of the contract by reference. The order of precedence is the contract, the RFP, and the Vendor's proposal in response to the RFP.

3.4.7. Governing Law. This contract shall be governed by the laws of the State of West Virginia. The Vendor further agrees to comply with the Civil Rights Act of 1964 and all other applicable laws (federal, state or municipal) and regulations.

3.4.8. Compliance with Laws and Regulations. The Vendor shall procure all necessary permits and licenses to comply with all applicable laws (federal, state or municipal), along with all regulations, and ordinances of any regulating body.

The Vendor shall pay any applicable sales, use, or personal property taxes arising out of this contract and the transactions contemplated thereby. Any other taxes levied upon this contract, the transaction, or the equipment, or services delivered pursuant hereto shall be borne by the Vendor. It is clearly understood that the State of West Virginia is exempt from any taxes regarding performance of the scope of work of this contract.

3.4.9. Subcontracts/Joint Ventures. The Vendor is solely responsible for all work performed under the contract and shall assume prime contractor responsibility for all services offered and products to be delivered under the terms of this contract. The State will consider the Vendor to be the sole point of contact with regard to all contractual matters. The Vendor may, with the prior written consent of the State, enter into written subcontracts for performance of work under this contract; however, the Vendor is totally responsible for payment of all subcontractors. Subcontractors shall have no standing to challenge a contract award under the RFP.

3.4.10. Term of Contract and Renewals. This contract will be effective July 1, 2010, and shall extend for the period of one (1) year, at which time the contract may, upon mutual consent, be renewed. Such renewals are for a period of up to one (1) year. Notice by the Vendor of intent to terminate will not relieve the Vendor of the obligation to continue to provide services pursuant to the terms of the contract.

Any change in federal or state law, or court actions which constitute binding precedent in West Virginia, and which significantly alters the Vendor's required activities or any change in the availability of funds, shall be viewed as binding and shall warrant good faith renegotiation of the compensation paid to the Vendor by the Agency and of such other provisions of the contract that are affected. If such renegotiation proves unsuccessful, the contract may be terminated by the State upon written notice to the Vendor at least thirty (30) days prior to termination of this contract.

3.4.11. Non-Appropriation of Funds. If the Agency is not allotted funds in any succeeding fiscal year for the continued use of the service covered by this contract by the West Virginia Legislature, the Agency may terminate the contract at the end of the affected current fiscal period without further charge or penalty. The Agency shall give the Vendor written notice of such non-allocation of funds as soon as possible after the Agency receives notice. No penalty shall accrue to the Agency in the event this provision is exercised.

3.4.12. Contract Termination. The State may terminate any contract resulting from this RFP immediately at any time the Vendor fails to carry out its responsibilities or to make substantial progress under the terms of this RFP and resulting contract. The State shall provide the Vendor with advance notice of performance conditions which are endangering the contract's continuation. If, after such notice, the Vendor fails to remedy the conditions contained in the notice within the time period also contained in the notice, the State shall issue the Vendor an order to cease and desist any and all work immediately. The State shall be obligated only for services rendered and accepted prior to the date of the notice of termination.

The contract may also be terminated without cause by the Agency with thirty (30) days prior notice.

3.4.13. Changes. If changes to the original contract become necessary, a formal contract change order will be negotiated by the Agency and the Vendor, to address changes to the terms and conditions, costs of work included under the contract. Any contract change order must be approved by the PEIA Director prior to the effective date of such amendment. An approved contract change order is required

whenever the change affects the payment provision and/or the scope of the work. Such changes may be necessitated by new and amended federal and state regulations and requirements. (No changes are to be implemented except as described above and shall be limited to 10% of the original contract award amount.)

As soon as possible after receipt of a written change request from the Agency, but in no event more than thirty (30) days thereafter, the Vendor shall determine if there is an impact on price with the change requested and provide the Agency a written statement identifying any price impact on the contract or stating that there is no impact. In the event that price will be affected by the change, the Vendor shall provide a description of the price increase or decrease involved in implementing the requested change.

NO CHANGE SHALL BE IMPLEMENTED BY THE VENDOR UNTIL SUCH TIME AS THE VENDOR RECEIVES AN APPROVED WRITTEN CHANGE ORDER. To proceed on verbal approval only is to do so at the VENDOR'S own risk.

3.4.14. Liquidated Damages. The Agency may impose liquidated damages on the vendor for failure to perform. To avoid liquidated damages, the vendor must:

a. Adhere to the Standards of Performance, with the liquidated damages set forth below applied for failure to satisfy the standards, as follows:

- Strict adherence to any applicable sections of the West Virginia Code and the requirements of the plan document of the Mountaineer Flexible Benefit plan is required.
- Strict adherence to the Vendor's payment schedule, as agreed to by the Agency, is required.
- Mailing of the year-end notice on or before 60 days prior to the end of the plan year is required.
- 100% of clean claims for the flexible spending account reimbursements shall be processed, paid or denied, and mailed within a maximum of ten (10) business days of receipt.
- Correspondence involving incomplete claims for flexible spending account reimbursements shall be

made to claimants within five (5) business days of receipt of claim.

- 100% of incomplete claims for flexible spending account reimbursements shall be paid, pended, or processed within five (5) business days of receipt of the additional/corrected information.
- Vendor shall maintain a claims payment accuracy exceeding 99% for financial accuracy and 95% for non-financial processing accuracy of all claims for flexible spending account reimbursements processed in each measured period of the contract.
- Correspondence, other than claims, from participants shall be date stamped on the day it is received and responded to within ten (10) calendar days. Telephone inquiries shall be logged and dated on the date received and return calls made within 24 hours.
- The abandonment rate for telephone calls shall not exceed 5% in any given month.
- Vendor shall provide the required reports and strictly adhere to the agreed upon reporting time frames.
- Vendor shall strictly adhere to the agreed upon implementation schedule.

b. Reporting Standards of Performance/Liquidated Damages

Vendor must agree that liquidated damages shall be imposed at the rates described in the chart below. This clause shall in no way be considered exclusive and shall not limit the State's or the Agency's right to pursue any other additional remedy to which the State or Agency may have legal cause for action including further damages against the Vendor. Failure to meet the above Standards of Performance shall be assessed on a quarterly basis, as follows:

Performance Category	***Performance Criteria***	***How Measured***	***Penalty if Standard Not Met***

Performance Category	***Performance Criteria***	***How Measured***	***Penalty if Standard Not Met***
Claims	Claims Processing: 100% of complete claims for flexible spending account reimburse-ments should be processed & mailed within ten (10) business days of receipt	Self-reported monthly	$0.25 per participant
	Claims Processing: 100 % of incomplete claims for flexible spending account reimburse-ments should be processed within five (5) business days of receipt of the additional/ corrected information	Self-reported monthly	$0.25 per participant
	Claims Accuracy: 99% Financial	Self-reported monthly	$0.25 per participant
	Claims Accuracy: 95% Claims payment	Self-reported monthly	$.025 per participant
Correspon-dence	Written response mailed within ten (10) days of receipt	Self-reported monthly	$0.10 per participant

Performance Category	*Performance Criteria*	*How Measured*	*Penalty if Standard Not Met*
	Mailing of year end notices on or before 60 days prior to end of year	Self-reported 30 days after notice is mailed	$0.15 per participant
Telephone Standards	Telephone inquiries not answered within 24 hours	Self-reported monthly	$0.10 per participant
	Telephone abandonment rate >5%	Self-reported monthly	$0.10 per participant
Reports	Reports should be delivered within five (5) business days of designated time frames	Self-reported last day of month following close of quarter	$0.25 per participant

3.4.15. Record Retention (Access & Confidentiality). Vendor shall comply with all applicable federal and state rules and regulations, and requirements governing the maintenance of documentation to verify any cost of services or commodities rendered under this contract by Vendor. The Vendor shall maintain such records a minimum of six (6) years and make available all records to Agency personnel at Vendor's location during normal business hours upon written request by the Agency within 10 days after receipt of the request.

Vendor shall have access to private and confidential data maintained by the Agency to the extent required for the Vendor to carry out the duties and responsibilities defined in this contract. Vendor agrees to maintain confidentiality and security of the data made available, shall comply with all applicable confidentiality laws or regulations, including HIPAA, and shall indemnify and hold harmless the State and the Agency against any and all claims brought by any party attributed to actions of breach of confidentiality by the Vendor, subcontractors, or individuals permitted access by the Vendor.

Vendor agrees to the terms of the West Virginia State Government Covered Entity HIPAA Business Associate Addendum (Attached as Exhibit F), and can be found at http://www.state.wv.us/admin/purchase/vrc/hipaa.htm.

3.4.16. Acceptance of Terms and Conditions
By submitting a proposal in response to this RFP, Vendor agrees to the terms and conditions set forth therein.

4. PROPOSAL FORMAT

4.1. Vendor's Proposal Format
The proposal must be formatted in the same order, providing the information listed below:

4.1.1. Title Page
Title page should state the RFP subject and number (PEI10001), the name of the Vendor, Vendor's business address, telephone number, name of authorized contact person to speak on behalf of the Vendor, dated and signed.

4.1.2. Table of Contents
Clearly identify the material by section and page number.

4.1.3. Section I - Bidder Understanding
A thorough understanding of the Agency's desire to provide an efficient Section 125 cafeteria plan with perpetually growing enrollment and quality benefit choices will be critical. All bidders must provide this in narrative form along with a brief explanation as to why their organization is the right one to serve the Agency as its Section 125 cafeteria plan administrator.

4.1.4. Section II – Vendor Capability Administering Section 125 cafeteria plans
The bidder must demonstrate that they are experienced in administering plans similar in size and nature to the Agency. The evaluation committee reserves the right to determine whether the bidder has met this requirement based on information submitted. However, consideration will be given to bidders who establish they have extensive experience with:

a. State government entities.

b. Clients with an eligibility pool in excess of 30,000 employees and 6,000 enrolled cafeteria plan participants.
c. Industry experience in excess of 7 years.
d. Experienced, qualified staff assigned to the Agency's account.

In order for the bidder to lend credence to their assertions, the following must be provided:

a. Willing, unconditional references of all entities listed with applicable contact data.
b. Documentation of corporate charter or other documentation that substantiates the organization's creation and mission.
c. Resumes detailing professional biographies of proposed PEIA account representatives who will be involved in the development, implementation, and administration of the plan.

4.1.5. Section III – Financial Stability

The bidder must demonstrate that their organization is financially stable. The bidder is required to provide audited financial statements encompassing 4 consecutive fiscal periods with the latest period ending within a minimum of 16 months previous to the proposal's submission date. Any additional independent financial measures pertinent to determining the organizations financial condition will be accepted.

4.1.6. Section IV – Implementation Methodology and Timeline, Ongoing Plan Administration Methodology

All bidders must provide a detailed explanation of their implementation methodology. The explanation should allow the evaluation team to develop a thorough understanding of the organizations implementation plan from beginning to end. All bidders should include a detailed time line that coincides with the implementation plan.

Additionally, an explanation of the bidder's methodology for ongoing administration of the plan subsequent to implementation will also be required. This explanation should address how the bidder plans to perform the scope of work outlined in this RFP and any other significant issues known to the bidder not addressed in the RFP.

The explanation should provide information regarding any expectations of PEIA staff or participating employers within the plan.

4.1.7. Cost

The bidder must provide full transparency and disclosure in the cost proposal regarding the pricing of each product.

To this end, we request the costs that will be charged our members and the disclosure of other revenues your company will earn. The information must be provided in the following two formats:

Format 1 – Member Costs:

Premium To Members	Member Administration Costs

Fees must be inclusive of all costs.

Format 2 – Other Revenue Disclosure:

Commissions	Brokerage Fees	Other

Respective other revenues will be earnings in addition to the fees paid by the Public Employees Insurance Agency (PEIA) membership.

If applicable, sign and submit the attached Resident Vendor Preference Certificate with the proposal.

5. Evaluation Process

Proposals will be evaluated by a committee of three (3) or more individuals in accordance with the criteria stated. The Vendor who meets all of the mandatory specifications, attains the final highest point score of all vendors (possible one-hundred 100 points maximum) shall be awarded the contract.

The selection of the successful vendor will be made by a consensus of the evaluation committee. The criteria and the assigned weight factors are as follows:

5.1. Evaluation Criteria

The following are the factors and point values:

Bidder Understanding – *5 Points Possible*

Vendor Capability Administering Section 125 Cafeteria Plans – *30 Points Possible*

Financial Stability – *20 Points Possible*

Implementation Methodology and Timeline, Ongoing Plan Administration Methodology – *15 Points Possible*

Cost – *30 Points Possible*

Total – *100 Points Possible*

Each cost proposal cost will be evaluated by use of the following formula:

Lowest price of all proposals

---------- *x 30 = Price Score*

Price of Proposal being evaluated

5.2. Minimum Acceptable Score

Vendors must score a minimum of 70% of the total technical points possible. The minimum qualifying score would be 70% of 70 points or a technical score of 49 points or greater to be eligible for further consideration and to continue in the evaluation process. All vendors not attaining the minimum acceptable score (MAS) shall be disqualified and removed from further consideration.

The State will select the successful vendor's proposal based on best value purchasing which is not necessarily the low bidder. Cost is considered, but is not the sole determining factor, for award. The State does reserve the right to accept or reject any or all of the proposals, in whole or in part, without prejudice if to do so is felt to be in the best interests of the State.

Vendor's failure to provide complete and accurate information may be considered grounds for disqualification. The State reserves the right if necessary to ask vendors for additional information to clarify their proposals. Nothing may be added to alter the written solution or method contained in the original proposal after the bid opening.

5.3. Protest of Award

Protest based on the contract award must be submitted in writing to the PEIA Director within five (5) working days from the date of the award announcement. Protest should be sent to:

Director
West Virginia Public Employees Insurance Agency
601 57th Street SE, Suite 2
Charleston, WV 25304

Protest may be submitted by FAX at: (866) 792-3574

5.3.1. Protest Contents

All protests shall contain:

a. The name and address of the protesting Bidder.
b. A statement of the grounds of the protest.
c. Supporting documentation (if available).
d. The resolution or relief sought.

Failure to submit this information shall be grounds for rejection of the protest by the PEIA Director.

The Agency may refuse to review any protests when the matter involved is the subject of litigation before a court of competent jurisdiction; if the merits have previously been decided by a court of competent jurisdiction; or if it has been decided in a previous protest by the PEIA Director. Subcontractors under a vendor's proposal do not have standing to file a protest.

The PEIA Director will respond to the protest within five (5) days of receipt of the written notice at the offices of PEIA.

Bidders in disagreement with the response of the PEIA Director may ask for further review of the protest by the Cabinet Secretary of the West Virginia Department of Administration within five (5) days of the PEIA Director's response. The request for further review should be sent to:

Cabinet Secretary
West Virginia Department of Administration
State Capitol Complex
Building 1, Room E-119
1900 Kanawha Boulevard, East

Charleston, WV 25305

Appeals may be submitted by FAX at (304) 558-2999.

If the protesting company believes that, due to the nature of the contract award, an expedited determination is required, a requests that the matter be directed immediately to the Department of Administration Cabinet Secretary should be in the in the original protest submitted to the PEIA Director. If the PEIA Director is in agreement with the reasons for the expedited request, the PEIA Director will forward the protest to the Department of Administration Cabinet Secretary and inform the requesting vendor of his/her actions.

Decisions by the Department of Administration Cabinet Secretary shall be considered to be the final level of administrative relief. Any further appeal of the administrative decision of the Department of Administration Cabinet Secretary must be directed to the Circuit Court of Kanawha County, Charleston, West Virginia.

EXHIBIT A

ENROLLMENT STATISTICS SUMMARY 1998-2008

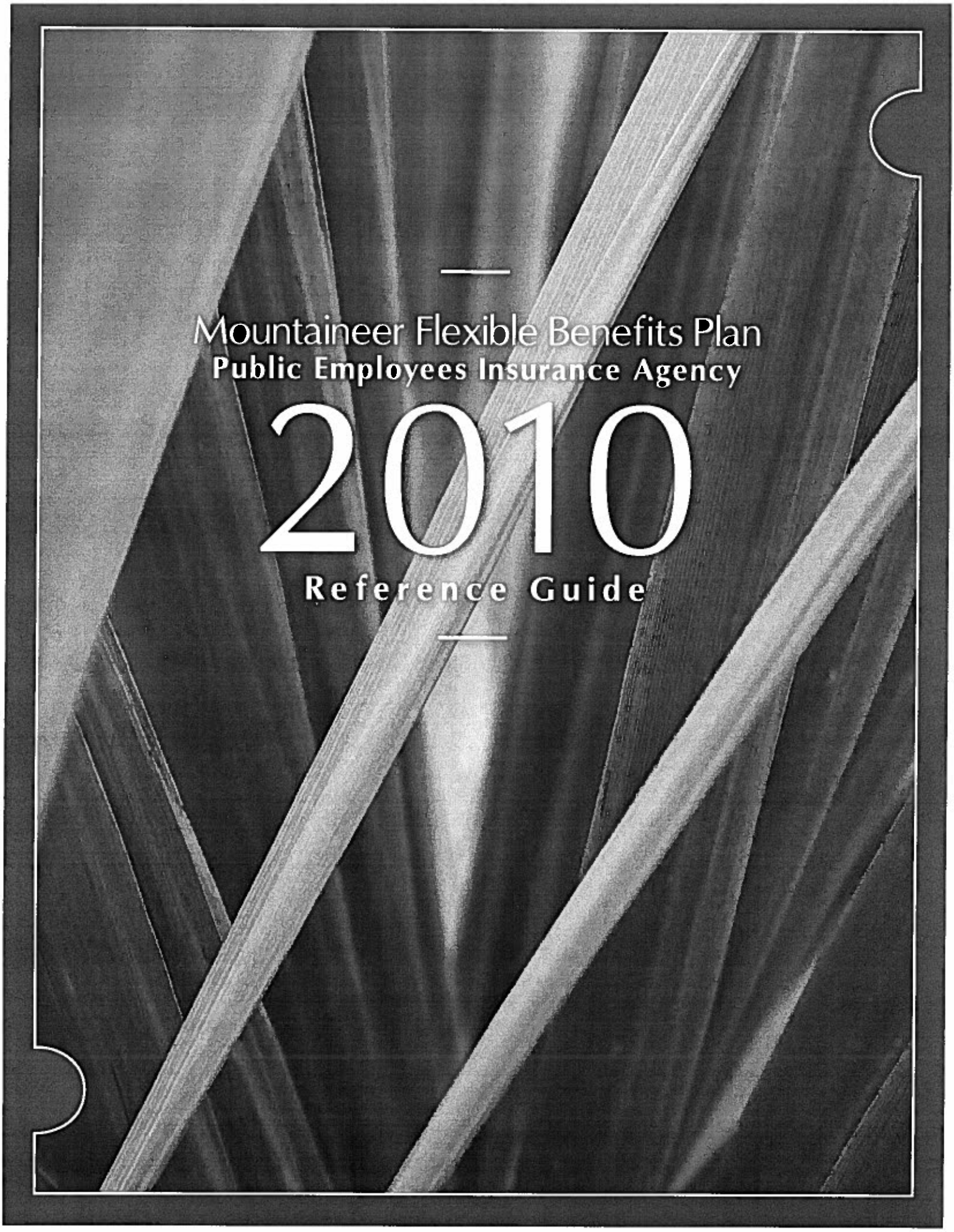
Product	1998	1999	1999/2000	2001	2002	2003	2004	2005	2006	2007	2008
Prepaid Dental	2565	2807	2706	2801	2893	2838	2789	n/a	n/a	n/a	n/a
Indemnity Dental	1654	2121	2549	3033	3670	4665	5675	7928	11326	12853	15029
Vision – Full Service	3564	3919	4033	4080	4588	4865	5688	6413	9219	10441	12464
Vision – Exam Plus	210	406	503	572	644	747	873	911	1137	1333	1519
LTD - 40%	37	107	110	164	203	219	252	302	349	355	396
LTD - 60%	1037	1066	1139	1102	1181	1271	1364	1375	1467	1454	1561
STD	240	180	207	254	328	394	491	561	627	662	730
Flexible Spending Accounts	1247	1264	1371	1666	2044	2623	2786	3232	3637	3871	3980
Legal	N/A	N/A	171	251	309	344	382	426	506	510	549

West Virginia
Public Employees Insurance Agency

Mountaineer Flexible Benefit Plan
Plan Year 2010
Enrollment Statistics

- Dental
  - Active Employee 15,141
  - Retiree 4,813
- Vision
  - Active EMPLOYEE 13,313
  - Retiree 4,695
- Long-Term Disability 2,353
- Short-Term Disability 945
- Medical Flexible Spending Accounts 4,190
- Dependent Flexible Spending Accounts 310
- Legal = 705

EXHIBIT B


Mountaineer Flexible Benefits Plan
Public Employees Insurance Agency
2010
Reference Guide

Office of the Governor
State Capitol
1900 Kanawha Boulevard, E.
Charleston, WV 25305

State of West Virginia
Joe Manchin III
Governor

Dear Public Employee:

It is time again to enroll in the Mountaineer Flexible Benefits Plan. This program is provided to you by the Public Employees Insurance Agency (PEIA).

The program features Flexible Spending Accounts, dental, vision and short-term and long-term disability insurances. We are pleased to announce there will be no premium increases in this flexible benefits program this year and we have again enhanced the program benefits. These benefits will become effective on July 1, 2009 and continue through June 30, 2010.

I encourage you to attend one of the PEIA Benefit Fairs in your area to learn more about your benefits. The Benefits Fairs run from April 6 through April 22 and a schedule is provided for you on page 25 of this booklet.

The State of West Virginia continually recognizes the need to provide quality benefits to its employees. We want to make sure that you and your family have the protection you need. I urge you to look closely at the benefits offered through this program.

With warmest regards,

Joe Manchin III
Governor

Benefits Directory

Delta Dental of West Virginia
(Dental) Plan #1058
Customer Service
Mon - Fri, 8 a.m. - 8 p.m. ET
1-800-932-0783
www.deltadentalins.com

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

Fringe Benefits Management Company
(Flexible Spending Accounts)
FBMC Customer Care Center
Mon - Fri, 7 a.m. - 10 p.m. ET
1-800-342-8017

FBMC Toll-Free Claims Fax
1-866-440-7145

FBMC Automated Services
24 hours a day
1-800-86S-FBMC (3262)
www.myFBMC.com

myFBMC Card℠ Visa® Card
Lost or Stolen Card
24 hours a day
1-888-462-1909

Dispute Line
FBMC Customer Care Center
Mon - Fri, 7 a.m. - 10 p.m. ET
1-800-342-8017

Activation Line
24 hours a day
1-888-514-6845

Hyatt Legal Plans, Inc.
(Legal)
Client Service Center
Mon - Fri, 8 a.m. - 7 p.m. ET
Fri, 8 a.m. - 6 p.m. ET
1-800-821-6400
www.legalplans.com

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

Important Dates to Remember
Your Open Enrollment dates are:
April 1, 2009, through April 30, 2009.

Your Period of Coverage dates are:
July 1, 2009, through June 30, 2010.

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

Mountaineer Flexible Benefits Plan

Table of Contents

What's New
The myFBMC Visa® Card is now being offered at no additional charge, but you must select it to receive it.

Enrollment at a Glance

Important Enrollment Information

- Open Enrollment is April 1, 2009, through April 30, 2009.
- For easier enrollment, please visit **www.myFBMC.com** and enroll online or return your completed Enrollment Form to your Benefit Coordinator by April 30, 2009, 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 2010 Plan Year is July 1, 2009, through June 30, 2010.
- You may choose to receive the myFBMC℠ Card by checking the appropriate box on your Enrollment Form. See Page 12 for more details.
- For more information, visit Fringe Benefits Management Company (FBMC) Web site at **www.myFBMC.com**, or call 1-800-342-8017, 7 a.m. - 10 p.m., Monday through Friday.

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

- FBMC, your employee benefits administrator, along with your employer, offer you a wide selection of benefits to choose from during your Open Enrollment. FBMC specializes in tax-saving benefits administration, including Flexible Spending Accounts (FSAs), which may save you a significant amount of your annual income.
- FBMC provides you with convenient ways to track your benefit transactions, including online review, telephone tracking and statements.
- 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 9 of this Reference Guide.
- Remember to submit your supporting documentation, billing statements or invoices along with your myFBMC Card℠ Claim form when using your myFBMC Card℠.
- Submit your supporting documentation and completed reimbursement request form (for paper claims) to FBMC 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 Web site at **www.myFBMC.com** for more information. You may also contact FBMC Customer Care Center at 1-800-342-8017.

Benefit Fairs

Benefit Fairs will take place April 6, 2009, through April 22, 2009. 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.

Enrollment Counselors 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, an Enrollment Counselor's incentive and objective is your satisfaction!

See the schedule of Benefit Fairs on page 25 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?** You do not have to do anything. 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 2010 Plan Year.

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, 2009.**

Accessing Your Benefits

FBMC Customer Care Center offers you a variety of resources to make inquiries on your benefits and Flexible Spending Accounts (FSAs), including information from the FBMC Web site, Interactive Voice Response system or Customer Care.

On the Web

Type "**www.myFBMC.com**" into your Internet browser to access FBMC's home page. Use the navigational tabs along the top of the Web page to get answers to many of your benefits questions.

If you previously registered an e-mail address and password on FBMC's Web site, you may continue using this information. If you haven't registered, or if you registered prior to January 19, 2008, log in to the site as a first time user. Follow the link on the login page and register through the FBMC Premier Login.

Benefits

You can check your benefit status, read benefit descriptions, use our tax calculator and much more.

Claims

Check the status of your claim, download forms, get more information about mailing and faxing your claim to FBMC or see transactions that need documentation.

Accounts

View your account balance and contributions or review monthly statements and your transaction history.

myFBMC Card℠ Visa® Card

Download a card fact sheet or claim form, read detailed instructions on proper use and review our IIAS Store List to maximize card convenience. Please visit **www.myFBMC.com** to activate your myFBMC Card℠ Visa® Card.

Profile

Change the e-mail address we have on file, complete your online registration or select a new PIN.

Resources

Browse through our extensive resource library, including: benefit materials, eligible expenses, required documentation, Over-the-Counter drug listings and benefit tips.

Forms

Download applicable forms for reimbursement and Direct Deposit.

Over the Phone

FBMC's 24-hour automated phone system, Interactive Voice Response (IVR), can be reached by calling 1-800-865-FBMC (3262). Allowing you to access your benefits any time, follow the voice prompts to find out information about your benefits such as:

- Current Account Balance(s)
- Claim Status
- Mailing Address Verification
- Obtain FSA Reimbursement Request Claim Forms
- Change Your PIN

Personal Identification Number (PIN)

To access Interactive Voice Response (IVR) system, all you need is your Social Security number (SSN). 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 PIN here.
Remember, this will be your PIN for IVR access.

If you forget your PIN, call Customer Care at **1-800-342-8017**.

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

Completing Your Enrollment Form

Who needs to complete an Enrollment 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
- 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. However, if you do not currently have an myFBMC Card℠ Visa® Card and wish to participate in the program, you must complete an Enrollment Form. Likewise, if you currently have an myFBMC Card℠ and do not wish to participate in the program any longer, you must also complete an Enrollment Form.

Web Enrollment

Employees may choose to enroll on our Web site 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 3/1/09
- currently do not participate and work for a non-state agency or a County Board of Education

You may not enroll on our Web site 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.

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 60 percent or 40 percent of your salary. See Page 19 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 20 for help in calculating your per-paycheck deduction amount, then enter this cost per-pay-period on your Enrollment Form.

Medical Expense Flexible Spending Account: Enter your per-pay-period contribution in the space to the right. Refer to the FSA worksheets on Page 13 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 13 for help in computing your amount.

Add your total per-pay-period administrative fees from the bottom of Page 13 ($1.96/month for one or both FSAs) to your per-pay-period benefit costs. This is your total tax-free salary deduction amount per pay period.

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, 2009.

Your Benefit Coordinator will process your application and send it to FBMC postmarked by May 7, 2009.

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 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 Center at 1-800-342-8017 for more information.

Period of Coverage

Your period of coverage begins on July 1, 2009, and continues until June 30, 2010, 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 your employment, retire or go on unapproved leave, you can continue certain benefits by calling FBMC Customer Care Center at 1-800-342-8017. 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 1-800-342-8017 for details.

If you participated in a Medical Expense FSA and a triggering event occurred during the plan year making you eligible to continue your Medical Expense FSA under COBRA until that plan year ended, your Medical Expense 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 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 1-800-342-8017 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 Customer Care at 1-800-342-8017 for further information on billing if you go on approved, unpaid leave.

Flexible Spending Accounts

A Flexible Spending Account (FSA) is an account you set up to pre-fund your anticipated, eligible medical services, medical supplies and dependent care expenses that are normally not covered by your insurance. You can choose from two accounts: Medical Expense FSA and Dependent Care FSA.

Not only are your Medical Expense FSA funds available to you in one lump sum at the beginning of your plan year, but your FSA funds are deducted before federal and state taxes are calculated on your paycheck.

With either FSA, you benefit from having less ***taxable*** income in each of your paychecks, which means more ***spendable*** income to use toward your eligible medical and dependent care expenses.

Once you decide how much to contribute to your Medical Expense and/or Dependent Care FSA, the amount is deducted in small, equal amounts from your paychecks during the plan year.

Examples of how to use your FSA:

Example 1: Paying a co-payment and doctor/dental fees
After paying your co-payment and doctor/dental fees 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 Reimbursement Request Form to FBMC. Within five business days, FBMC will process your request and mail your reimbursement check to you or direct deposit your funds into the account of your choice.

Example 2: Paying for daycare services
Once you have paid for your child's daycare service, send a completed Reimbursement Request Form to FBMC, along with documentation showing the following:

- Name, age and grade of the dependent receiving the service
- Cost of the service
- Name and address of the service provider
- Beginning and ending dates of the service.

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

FSA Eligibility

Your Medical Expense 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 Expense FSA. Only the custodial parent of divorced or legally-separated parents can be reimbursed using the Dependent Care FSA.

FSA Savings Example*

(With FSA)		*(Without FSA)*
$31,000	Annual Gross Income	$31,000
- 5,000	FSA Deposit for Recurring Expenses	- 0
$26,000	Taxable Gross Income	$31,000
- 5,889	Federal, Social Security Taxes	-7,021
$20,111	Annual Net Income	$23,979
- 0	Cost of Recurring Expenses	-5,000
$20,111	Spendable Income	$18,979

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

$1,132!

* Based upon a 22.65% tax rate (15% federal and 7.65% Social Security) calculated on a calendar year.

Annual Contribution Limits

For Medical Expense FSA:
Minimum Annual Deposit*: $150
Maximum Annual Deposit*: $5,000

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.

* including administrative fee

Written Certification

When enrolling in either or both FSAs, written notice of agreement with the following will be required:

- I will only use my FSA to pay for IRS-qualified expenses and only for my IRS-eligible dependents
- I will exhaust all other sources of reimbursement, including those provided under my employer's plan(s) before seeking reimbursement from my FSA
- I will not seek reimbursement through any additional source and
- I will collect and maintain sufficient documentation to validate the foregoing.

Flexible Spending Accounts

Medical Expense FSA

A Medical Expense 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 yourself, 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.

Partial List of Medically Necessary Eligible Expenses*

Acupuncture
Ambulance service
Birth control pills and devices
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
LASIK
Nursing services
Optometrist fees
Orthodontic treatment
Over-the-Counter items
Prescription drugs to alleviate nicotine withdrawal symptoms
Smoking cessation programs/treatments
Surgery
Transportation for medical care
Weight-loss programs/meetings
Wheelchairs
X-rays

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

* IRS-qualified expenses are subject to federal regulatory change at any time during a tax year. Certain other substantiation requirements and restrictions may apply, and will be supplied to you following enrollment.

Visit www.myFBMC.com for a list of frequently asked questions.

You must keep your documentation for a minimum of one year and submit to FBMC upon request.

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, daycare services, nursery and preschool. Eligible dependents include your qualifying child, spouse and/or relative.

Partial List of Eligible Dependent Care Expenses*

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

Note: Budget conservatively. No reimbursement or refund of Dependent Care 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. Certain other substantiation requirements and restrictions may apply, and will be supplied to you following enrollment.

FSA Fund Availability

For Medical Expense FSA:

Once you sign up for a Medical Expense FSA and decide how much to contribute, the maximum annual amount of reimbursement for eligible health care 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 health care expenses at the start of your deductions.

For Dependent Care FSA:

Once you sign up for a Dependent Care FSA and decide how much to contribute, the funds available to you depend on the actual funds in your account. Unlike a Medical Expense FSA, the entire maximum annual amount is not available during the plan year, but rather after your payroll deductions are received.

Ineligible Expenses

For Medical Expense FSA:

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

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

A properly completed request will help speed along the process of your reimbursement, allowing you to receive your check or Direct Deposit promptly.

Requesting Reimbursement

For a Medical Expense FSA:

You can use your Medical Expense FSA to reimburse eligible expenses after you have sought (and exhausted) all means of reimbursement provided by your employer and any other appropriate resource. Keep in mind that some eligible expenses are reimbursable on the date available, not the date ordered.

To request reimbursement, simply fax or mail a correctly completed FSA claim form along with the following:

- an invoice or bill from your health care provider listing the date you received the service, the cost of the service, the specific type of service and the person for whom the service was provided or
- an Explanation of Benefits (EOB)* from your health insurance provider that shows the specific type of service you received, the date and cost of the service and any uninsured portion of the cost and
- a written statement from your health care provider indicating the service was medically necessary if those services could be deemed cosmetic in nature, accompanied by the invoice or bill for the service.

* EOBs are not required if your coverage is through a HMO.

For a Dependent Care FSA:

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. Remember that for timely processing of your reimbursement, your payroll contributions must be current.

Requesting reimbursement from your Dependent Care FSA is easy. Simply fax or mail a correctly completed FSA claim form along with documentation showing the following:

- the name, age and grade of the dependent receiving the service
- the cost of the service
- the name and address of the provider and
- the beginning and ending dates of the service.

Be certain you obtain and submit the above information when requesting reimbursement from your Dependent Care FSA. This information is required with each request for reimbursement.

Note: Cancelled checks or credit card receipts (or copies) listing the cost of eligible expenses are **not** valid documentation for either Medical Expense or Dependent Care FSA reimbursement.

Send all FSA reimbursement claims to:

Fax Toll-Free: 1-866-440-7145

Mail to: Contract Administrator
Fringe Benefits Management Company
P.O. Box 1800
Tallahassee, FL 32302-1800

Note: If you elect to participate in the Dependent Care FSA, or if you file for the Dependent Care Tax Credit, you must attach IRS Form 2441, reflecting the information above, to your 1040 income tax return. Failure to do this may result in the IRS denying your pre-tax exclusion.

Important FSA Notes:

- You may, however, continue using only your Medical Expense FSA during the **grace period** (September 15, 2010), 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.**
- You have a **120-day run-out period** (ending October 31, 2010) after your plan year ends to submit reimbursement requests for all eligible FSA expenses incurred DURING your plan year.

Appeal Process

If you have a request for a mid-plan year election change, FSA reimbursement claim or other similar request denied, in full or in part, you have the right to appeal the decision by sending a written request within 30 days of the denial for review to FBMC (Attn: Appeals Process, P. O. Box 1878, Tallahassee, FL, 32302-1878).

Your appeal must include:

- the name of your employer
- the date of the services for which your request was denied
- a copy of the denied request
- the denial letter you received
- why you think your request should not have been denied and
- any additional documents, information or comments you think may have a bearing on your appeal.

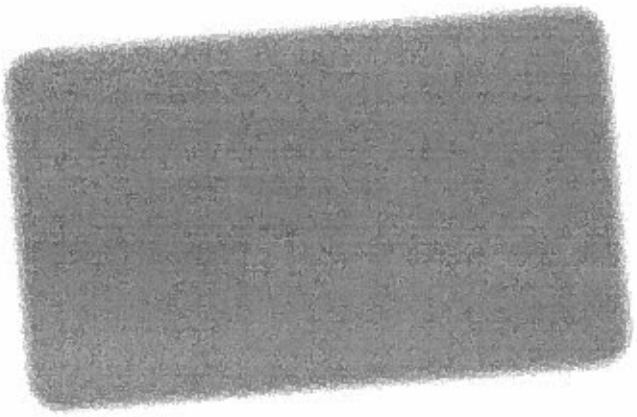
Your appeal and supporting documentation will be reviewed upon receipt. You will be notified of the results of this review within 30 business days from receipt of your appeal. In unusual cases, such as when appeals require additional documentation, the review may take longer than 30 business days. If your appeal is approved, additional processing time is required to modify your benefit elections.

Note: Appeals are approved only if the extenuating circumstances and supporting documentation are within your employer's, insurance provider's and the IRS' regulations governing the plan.

Be certain you obtain and submit all required information with each FSA reimbursement request.

myFBMC Card℠ Visa® Card

The myFBMC Card℠ Visa® Card is issued by First Horizon.



The myFBMC Card℠ is a convenient reimbursement option that allows FBMC to electronically reimburse eligible expenses under your employer's plan and IRS guidelines. Because it is a payment card, when you use the myFBMC Card℠ to pay for eligible expenses, funds are electronically deducted from your account.

myFBMC Card℠ advantages

You can use the myFBMC Card℠ for your eligible Over-the-Counter (OTC) expenses at drugstores. Other advantages include:

- **instant reimbursements** for health care
- **instant approval** of all eligible OTC and prescription expenses, as well as some medical, vision and dental (others require documentation)
- **no out-of-pocket expense** and
- **easy access** to your account funds.

Note: You **cannot** use the myFBMC Card℠ for cosmetic dental expenses or eye glass warranties.

Using the myFBMC Card℠

For eligible expenses, simply swipe the myFBMC Card℠ like you would with any other credit card. Whether at your health care provider or at your drugstore, the amount of your eligible expenses will be automatically deducted from your Medical Expense account. Effective July 1, 2009, for Over-the-Counter and prescription purchases the card will only be accepted at IIAS merchants. For all other qualified expenses, such as medical and dental co-payments, the myFBMC Card℠ will be used normally. To find out if a pharmacy or drugstore near you accepts the card, please refer to the **IIAS Store List** at **www.myFBMC.com**.

Two cards will be sent to you in the mail; one for you and one for your spouse or eligible dependent. You should keep your cards to use each plan year until their expiration date.

Remember, you can go to **www.myFBMC.com** to activate your card, see your account information and check for any outstanding Card transactions.

When do I send in documentation for a myFBMC Card℠ expense?

You must send in documentation for certain myFBMC Card℠ transactions, such as those that are **not** a known office visit or prescription co-payment (as outlined in your health plan's Schedule of Benefits). When requested, you must send in documentation for these transactions. Documentation for a card expense is a statement or bill showing:

- name of the patient
- name of the service provider
- date of service
- type of service (including prescription name) and
- total amount of service.

Note: This documentation must be sent with a **myFBMC Card℠ *Claim Form*** and cannot be processed without it. Like all other FSA documentation, you must keep your myFBMC Card℠ expense documentation for a minimum of one year, and submit it to FBMC when requested.

If you fail to send in the requested documentation for an myFBMC Card℠ expense, you will be subject to:

- withholding of payment for an eligible paper claim to offset any outstanding myFBMC Card℠ transaction
- suspension of your myFBMC Card℠ privileges
- payback through payroll
- the reporting of any outstanding myFBMC Card℠ transaction amounts as income on your W-2 at the end of the tax year.

What agreement am I making when I use the myFBMC Card℠?

For more information about the myFBMC Card℠, see the Cardholder Agreement that accompanies it.

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 Expense 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 $5,000)	$ _____
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

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

ELDER CARE SERVICES

Daycare center	$ _____
In-home care	$ _____
TOTAL Remember, your total contribution cannot exceed IRS limits for the plan year and calendar year (including administrative fee).	$ _____
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 - No one likes waiting for their money, why are you?
With Direct Deposit there are no fees for the service and your FSA reimbursement checks are deposited into the checking or savings account of your choice within 48 hours of claim approval.

Please remember to include all applicable fees to your Medical Expense FSA contribution if you plan to use your myFBMC Card℠ Visa® Card as a form of payment.

**** You will be assessed a per-pay-period FSA Administrative Fee (whether you select one or both plans).**
The per-pay-period fees are as follows:

10 pay	12 pay	18 pay	20 pay	21 pay	22 pay	24 pay	26 pay
$2.35	$1.96	$1.31	$1.18	$1.12	$1.07	$0.98	$0.90

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 576 Delta Dental Premier access points and 330 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 Premier 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 fee-for-service, 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 25.

See the chart on the following page 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
One Delta Drive
Mechanicsburg, PA 17055-6999

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

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	$22.20	$18.50	$12.33	$11.10	$10.57	$10.09	$9.25	$8.54
Employee & Children	$44.47	$37.06	$24.71	$22.24	$21.18	$20.21	$18.53	$17.10
Employee & Spouse	$49.56	$41.30	$27.53	$24.78	$23.60	$22.53	$20.65	$19.06
Employee & Family	$71.88	$59.90	$39.93	$35.94	$34.23	$32.67	$29.95	$27.65
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

* 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.

Plan #1058

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 12-month period) - Routine cleaning (twice in a 12-month period) - Fluoride treatments (to age 19, twice in a 12-month period) - Bitewing X-rays (twice in a 12-month period) - 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 w/ oral surgery procedures with one or more simple extractions and/or with surgical extractions for patients under age 19; and with three or more simple extractions and/or surgical extractions for patients age 19 and over.	**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 19)	**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.

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

*** Enhanced benefit 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)		
Medically Necessary	Covered in full***	Exam & $210
Elective	Exam & $150	Exam & $105

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 19 or to age 25, if they are unmarried, full-time students.

Value-Added Benefits Effective 7/1/09

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

Additional 30% Discount applies to glasses purchased the same day as the member's eye exam from the same VSP doctor who provided the exam. Members will also receive 20% off unlimited additional pairs of glasses valid through any VSP doctor within 12 months of the last covered eye 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.

When you choose elective contacts instead of glasses, your $150 allowance applies to the cost of your lenses and the fitting/evaluation exam. This exam is in addition to your vision exam to ensure proper fit of contacts.

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

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. Under this plan, you must obtain services through a VSP 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.

For contact lenses, a 15 percent discount will be applied on VSP member doctor's professional services associated with all prescription contact lenses.

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 25, if they are unmarried and depend on you for support.

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 nonmember 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 99710S
Sacramento, CA 95899-7105

For more information, contact VSP's Customer Service Line at 1-800-877-719S.

For a current list of available VSP doctors, go to **www.vsp.com**.

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: 40 percent of the first $5,000 of your monthly pre-disability earnings, reduced by deductible income. The maximum monthly benefit is $2,000.

Plan 2: 60 percent of the first $4,167 of your monthly pre-disability earnings, reduced by deductible income. The maximum monthly benefit is $2,500.

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, 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 61, LTD benefits can continue during disability until age 65. 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 19.

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 limitation does not apply to a period of Disability that begins more than twelve (12) months after the most recent effective date of your insurance.

The Pre-existing Condition Limitation 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.

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.

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 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 (40% 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, 2007. 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 $5,000) _____
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 (60% Coverage Level)

Age*	Monthly Premium Rate per $100 of Salary
to 29	$.33
30-34	.405
35-39	.51
40-44	.71
45-49	1.05
50-54	1.56
55-59	2.04
60-64	2.18
65-69	2.44
70 and over	2.61

* Age as of July 1, 2007. 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 $4,167) _____
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

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 60 percent of your pre-disability earnings, reduced by deductible income. The maximum weekly benefit is $500. 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 $0.092 = $32.20 per month.

Worksheet

1. Your weekly salary (maximum $833.00) _____

X $0.092

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

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 **www.legalplans.com**. If you're enrolled, click "Members Log In." If you have questions as you decide to enroll, click "Thinking about Enrolling?" and 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.

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

What's covered?

- 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.

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.

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.

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

Changing Your Coverage

Changing your FSA during the Plan Year

Within **60 days** of a qualifying event, you must submit a Change in Status (CIS)/Election Form and supporting documentation to your employer. Upon the approval of your election change request, your existing FSA(s) elections will be stopped or modified (as appropriate). However, if your FSA 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, refer to the "Appeal Process" section on Page 11. 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 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 Expense 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 Expense 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 Expense 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 Expense FSAs:

If you fund your Medical Expense FSA entirely, you may continue your Medical Expense 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 Expense FSA for the year. For example, if you elected a Medical Expense FSA benefit of $1,000 for the plan year and have received only $200 in reimbursement, you may continue your Medical Expense FSA for the remainder of the plan year or until such time that you receive the maximum Medical Expense FSA benefit of $1,000.

If your employer funds all or any portion of your Medical Expense FSA, you may be eligible to continue your Medical Expense 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 Expense FSAs. If you have questions about your employer-funded Medical Expense FSA, you should call Fringe Benefits Management Company (FBMC) at 1-800-342-8017.

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 Web site at **www.dol.gov/ebsa**.

Keep Your Address Updated

In order to protect your family's rights, you should keep your employer and FBMC 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 FBMC.

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 1-800-342-8017 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 Notice 4/14/03

This notice applies to products administered by Fringe Benefits Management Company and its wholly-owned subsidiaries (collectively "FBMC"). FBMC takes your privacy very seriously. 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. This notice explains how FBMC handles and protects the personal information we collect. Please note that the information we collect and the extent to which we use it will vary depending on the product or service involved. In many cases, we may not collect all of the types of information noted below. FBMC's privacy policy is as follows:

I. 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.

II. Under HIPAA, you have certain rights with respect to your protected health information. You have rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan in care of FBMC's Privacy Officer or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

Additional information that describes how medical information about you may be used and disclosed and how you can get access to this information is provided electronically on our Web site: **www.myFBMC.com**. You have a right to a paper copy at any time. Contact FBMC Customer Care Center at 1-800-342-8017.

III. We maintain safeguards to ensure information security. We are committed to preventing unauthorized access to personal information. We maintain physical, electronic and procedural safeguards for protecting personal information. We restrict access to personal information to those employees, insurance companies and service providers who need to know that information to provide products or services to you. Any employee who violates our Privacy Policy is subject to disciplinary action.

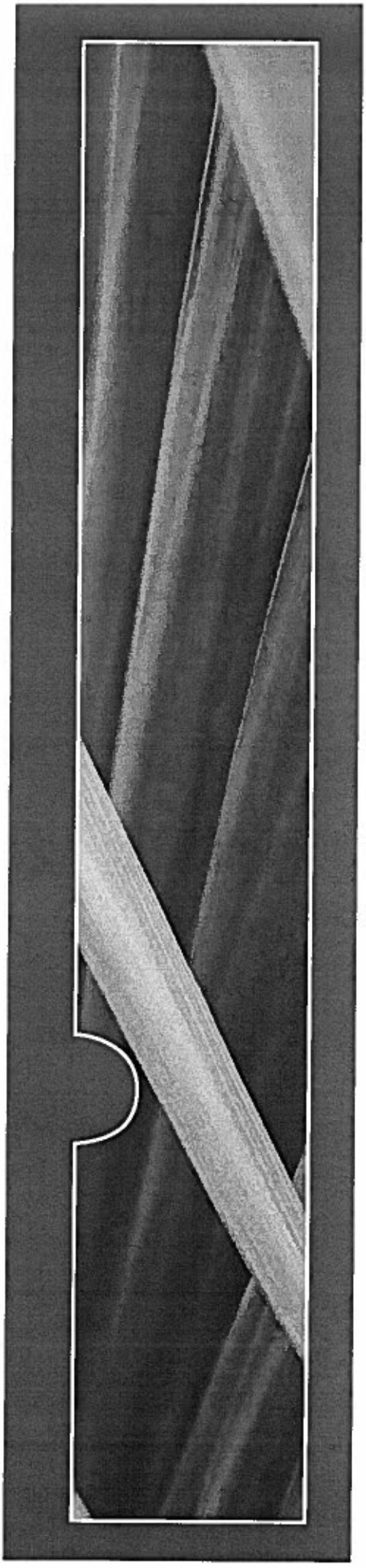
IV. We limit how, and with whom, we share customer information. We do not sell lists of our customers, and under no circumstances do we share personal health information for marketing purposes. With the following exceptions, we will not disclose your personal information without your written authorization. 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.

We will provide our Privacy Notice to current customers annually and whenever it changes. If you no longer have a customer relationship with us, we will still treat your information under our Privacy Policy, but we will no longer send notices to you. In this notice of our Privacy Policy, the words "you" and "customer" are used to mean any individual who obtains or has obtained an insurance, financial product or service from FBMC that is to be used primarily for personal or family purposes.

2009 Benefit Fair Schedule

Date	Location	Time
Monday, **April 6**	Charleston State Capitol Complex	9:00 a.m. - 2:00 p.m.
Monday, **April 6**	Charleston Charleston Civic Center	3:00 – 7:00 p.m.
Tuesday, **April 7**	Weirton Holiday Inn 350 Springs Drive	3:00- 7:00 p.m.
Wednesday, **April 8**	Wheeling Northern Comm. College	1:00 – 7:00 p.m.
Thursday, **April 9**	Morgantown WVU Alumni Center	10:00 a.m. – 1:30 p.m.
Thursday, **April 9**	Morgantown Ramada Inn	3:00 – 7:00 p.m.
Monday, **April 13**	Parkersburg Comfort Suites	3:00 – 7:00 p.m.
Tuesday, **April 14**	Martinsburg Holiday Inn Foxcroft Avenue	3:00 – 7:00 p.m.
Wednesday, **April 15**	Fairmont State College	9:00 a.m. – 2:00 p.m.
Wednesday, **April 15**	Romney South Branch Inn	3:00 – 7:00 p.m.
Thursday, **April 16**	Beckley Tamarack Conf. Ctr. Ballroom A	3:00 – 7:00 p.m.
Monday, **April 20**	Huntington Big Sandy Superstore Arena	3:00 – 7:00 p.m.
Wednesday, **April 22**	Flatwoods Days Inn	3:00 – 7:00 p.m.

Notes



FBMC

Premier Benefits Solutions

Contract Administrator
Fringe Benefits Management Company
P.O. Box 1878 • Tallahassee, Florida 32302-1878
Customer Care Center 1-800-342-8017 • 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/0309

FBMC
Premier Benefits Solutions
P.O. Box 1878, Tallahassee, FL 32302-1878

ENROLLMENT FORM
Plan Year 2010
July 1, 2009-June 30, 2010

STATE OF WEST VIRGINIA
Mountaineer Flexible Benefits

PLEASE PRINT USING A BALLPOINT PEN. PRESS FIRMLY; THE LAST COPY IS YOURS.

1

SOCIAL SECURITY #	E-MAIL	TYPE OF FORM ☐ OPEN ENROLLMENT ☐ NEW HIRE ☐ TRANSFER	
LAST NAME	FIRST NAME		MI
HOME ADDRESS (STREET)	CITY	STATE / ZIP	HOME PHONE
BIRTH DATE / / ☐ MALE ☐ FEMALE ☐ MARRIED ☐ SINGLE	DATE EMPLOYED / /	BENEFIT START DATE	OFFICE PHONE

INSTRUCTIONS

2

WHO NEEDS TO COMPLETE AN ENROLLMENT FORM?
- New participants who want to enroll for the first time
- Employees who want to add, change or cancel coverage of other benefits
- Employees who wish to participate in the myFBMC Card℠ Visa® Card program for the first time or current participants who wish to cancel.
- **EXISTING BENEFITS NOT INDICATED ON THIS FORM WILL CONTINUE AS CURRENTLY ENROLLED.**

HOW TO ENROLL IN THE MOUNTAINEER FLEXIBLE BENEFITS PLAN:
- IMPORTANT: If you want to add, change or cancel coverage, **you must check the box beside the appropriate benefit** in Section 3. Indicate coverage levels and any other pertinent information.
- If you select family coverage for any benefit, you must provide dependent information in Section 4.

RETURN COMPLETED FORM TO YOUR BENEFITS COORDINATOR NO LATER THAN APRIL 30, 2009.

Mountaineer Flexible Benefits
Tax-Free Benefits Paid by Employees

3

KEEP COVERAGE	ADD COVERAGE	CHANGE COVERAGE	CANCEL COVERAGE	BENEFITS		COST PER PAY PERIOD
☐	☐	☐	☐	**DELTA DENTAL** ☐ Dental Assistance ☐ Basic ☐ Enhanced	☐ Employee Only ☐ Employee & Spouse* ☐ Employee & Children* ☐ Employee & Family*	
☐	☐	☐	☐	**VISION** CHOOSE ONE VISION OPTION: ☐ Full Service ☐ Exam Plus	☐ Employee Only ☐ Employee & Family*	
☐	☐	☐	☐	**LONG-TERM DISABILITY INCOME PLAN** Employee Only (If you enroll in this benefit, please be sure to provide your birthdate and salary in the space provided above in Section 1.)	☐ 60% of salary coverage ☐ 40% of salary coverage	
☐	☐	☐	☐	**SHORT-TERM DISABILITY INCOME PLAN** Employee Only (If you enroll in this benefit, please be sure to provide your birthdate and salary in the space provided above in Section 1.)		
☐	☐	☐	☐	**MEDICAL EXPENSE FLEXIBLE SPENDING ACCOUNT** Use cost per-pay-period from your Worksheet. ALL CLAIMS MUST BE SUBMITTED BY October 31, 2010.	☐ I elect to receive the myFBMC Card℠ Visa® Card.	
☐	☐	☐	☐	**DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT** ☐ Married, filing separately ☐ Married, filing jointly ☐ Single, head of household	Use cost per-pay-period from your Worksheet. ALL CLAIMS MUST BE SUBMITTED BY October 31, 2010.	
☐	☐		☐	**LEGAL (Post-tax)**		
				TOTAL PER-PAY-PERIOD FSA ADMINISTRATIVE FEE		
				TOTAL SALARY DEDUCTION AMOUNT PER PAY PERIOD		

*IF YOU SELECT DEPENDENT COVERAGE FOR DENTAL, VISION OR LEGAL, YOU MUST COMPLETE THE INFORMATION BELOW.

4

DEPENDENT INFORMATION

DEPENDENT NAME	RELATIONSHIP	BIRTH DATE	SOCIAL SECURITY #	CHECK COVERAGE SELECTED		
				DENTAL	VISION	LEGAL
	SPOUSE					Automatic
						Automatic
						Automatic
						Automatic
						Automatic

I hereby authorize my Employer to reduce my gross salary (before federal and state income and Social Security taxes are calculated) by the total per pay period cost of my Flexible Benefits. I understand that I CANNOT CHANGE THE AMOUNT OF THE REDUCTION OR REVOKE THIS AGREEMENT DURING THE PLAN YEAR UNLESS THERE IS A CHANGE IN STATUS AS DEFINED BY IRS RULES. I further understand that any amount remaining in my Flexible Spending Accounts that is not used during this plan yearand grace period CANNOT BE ACCUMULATED AND CARRIED FORWARD TO THE NEXT PLAN YEAR BUT WILL REVERT TO THE PLAN.

The Premium Deduction "total salary deduction" amount specified above will continue in effect until I discontinue or modify my Agreement for a subsequent plan year, terminate employment, or take an unpaid leave of absence from employment. I UNDERSTAND AND AGREE THAT PEIA AND FRINGE BENEFITS MANAGEMENT COMPANY, THE CONTRACT ADMINISTRATOR, WILL BE HELD HARMLESS FROM ANY LIABILITY RESULTING FROM EITHER MY PARTICIPATION IN MOUNTAINEER FLEXIBLE BENEFITS OR MY FAILURE TO SIGN OR ACCURATELY COMPLETE THIS ENROLLMENT FORM. I hereby appoint my Plan Sponsor to serve as Agent to receive dividends, premiums, refunds, rate reductions or any other funds that might be returned from the benefit plans, and to use these funds in the best interest of the employees for the purpose of reducing future premiums and improving benefits on behalf of employees, defraying administrative costs, or for such other purpose as permitted under applicable state and federal law.

YOUR COMPLETED FORM INTO YOUR BENEFITS COORDINATOR NO LATER THAN APRIL 30, 2009.

FOR BENEFITS COORDINATOR USE ONLY (COMPLETE IN FULL)

FEIN# _____
AGENCY# & NAME _____
EFFECTIVE DATE _____
NO. PAY DEDUCTIONS _____
GROSS ANNUAL SALARY _____
BENEFIT COORDINATOR SIGNATURE _____
BENEFIT COORDINATOR PHONE# ( ) _____
BENEFIT COORDINATOR FAX# ( ) _____

LOCATION TYPE ☐ WVU ☐ STATE AGENCIES, COLLEGES & UNIV SCHOOLS ☐ COUNTY BOARDS OF EDUCATION/ SCHOOLS ☐ OTHER

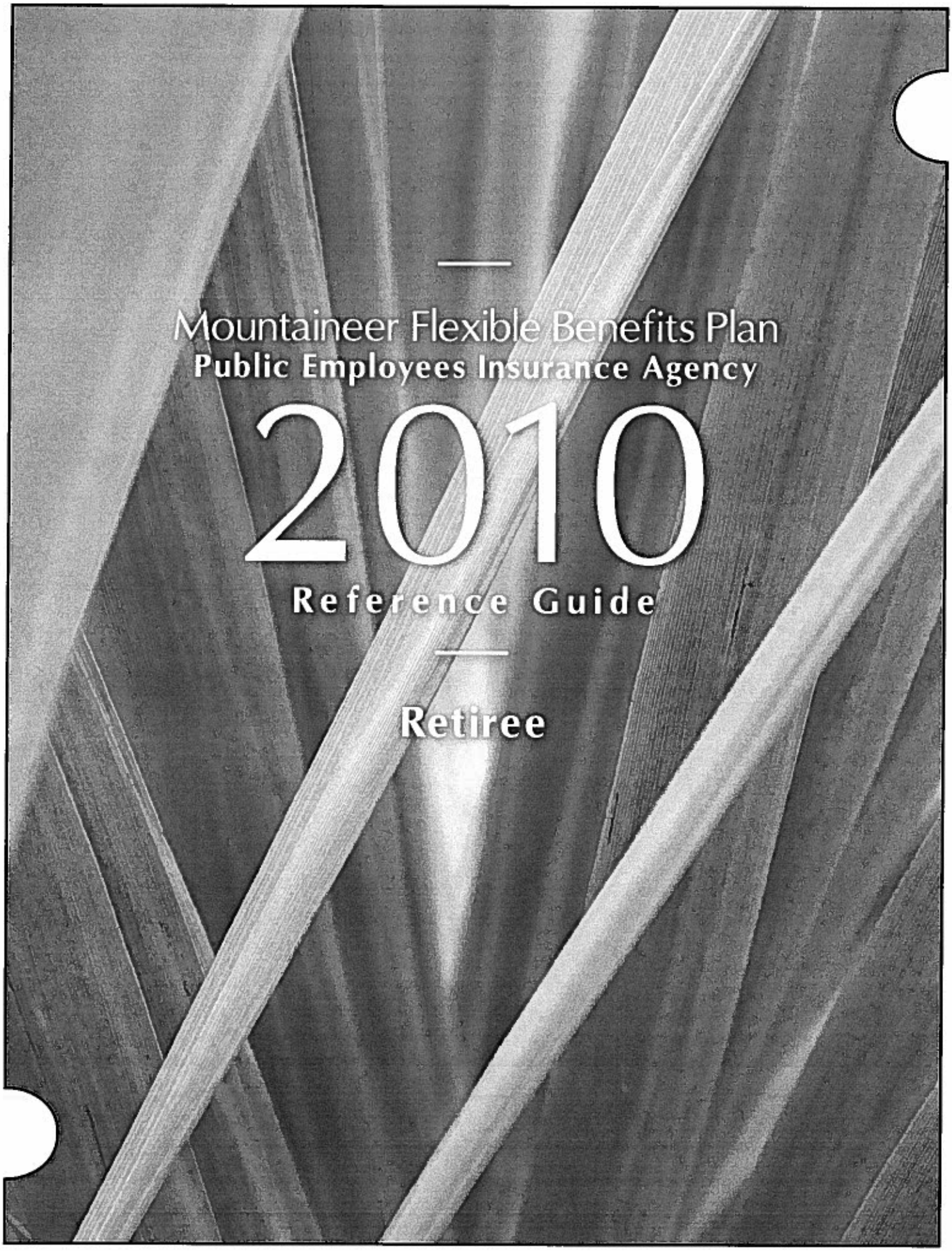
APPLICATIONS SHOULD BE MAILED TO FBMC TWICE EACH WEEK DURING OPEN ENROLLMENT. MUST BE POSTMARKED BY MAY 1, 2009.

EMPLOYEE SIGNATURE	DATE SIGNED	TIME SIGNED

FBMC USE ONLY

DATA ENTRY	VERIFICATION	SCANNED	INDEXED	SPECIAL NOTES

FBMC/WV/0309 WHITE COPY-EMPLOYER YELLOW COPY-FBMC PINK COPY-PAYROLL OFFICER GOLDENROD COPY-EMPLOYEE



Mountaineer Flexible Benefits Plan

Public Employees Insurance Agency

2010

Reference Guide

Retiree

Office of the Governor
State Capitol
1900 Kanawha Boulevard, E.
Charleston, WV 25305

State of West Virginia
Joe Manchin III
Governor

Dear Retired State Employee:

It is once again time for the annual open enrollment for Dental and Vision Insurance. This program is sponsored by the Public Employees Insurance Agency (PEIA) through the Mountaineer Flexible Benefits Plan.

You may select to enroll in dental and/or vision benefits with various coverage levels. We are pleased to announce there will be no increase in premiums for dental and vision in this flexible benefits program. These benefits begin on July 1, 2009 and continue through June 30, 2010.

I encourage you to attend one of the PEIA Benefit Fairs in your area to learn more about your benefits. Enrollment counselors will be available to answer all your questions. The Benefit Fairs run from April 6 through April 22 and a schedule is provided for you on page 13 of this booklet.

The State of West Virginia continually recognizes the need to provide quality benefits to its retirees. We want the best for our retirees and their families and I urge you to look closely at the benefits offered through this program.

With warmest regards,

Joe Manchin III
Governor

Retiree Mountaineer Flexible Benefits Plan

Table of Contents

Benefits Directory

Delta Dental of West Virginia
(Dental) **Plan #1058**
Customer Service
Mon - Fri, 8 a.m. - 8 p.m. ET
1-800-932-0783
www.deltadentalins.com

Vision Service Plan
(Vision)
Customer Service
Mon - Fri, 8 a.m. - 7 p.m. ET
1-800-877-7195
www.vsp.com

Fringe Benefits Management Company
FBMC Customer Care Center
Mon - Fri, 7 a.m. - 10 p.m. ET
1-800-342-8017

Welcome to your Retiree Mountaineer Flexible Benefits Plan! Fringe Benefits Management Company (FBMC) is the Contract Administrator of this plan, giving you the opportunity to purchase dental and vision coverage. In addition to this Reference Guide, you will find a Retiree Enrollment Form and a return envelope in this packet. **Please keep this Reference Guide for use during the plan year.**

If you wish to participate in coverage as a Retiree, complete and return the enclosed Retiree Enrollment Form. All return envelopes must be postmarked by **April 30, 2009**, which is the last day of open enrollment. (Late forms will not be accepted.)

For more information, contact FBMC Customer Care Center at 1-800-342-8017.

Completing Your Enrollment Form

If you wish to add coverage, increase coverage or decrease coverage to your retiree dental and/or vision benefits, you must complete the enclosed Retiree Enrollment Form.

You do not need to complete a Retiree Enrollment Form if you wish to continue your current benefits without changes.

Enrollment Form Section 1

Complete all of your personal information.

Enrollment Form Section 3

For each benefit you are selecting, you must check the appropriate box next to the corresponding benefit. Remember to complete all requested information for your benefits.

Dental Care: You may select any of the three Delta Dental plans: Delta Assistance Plan, Basic Plan or Enhanced Plan.

- Check the type of coverage you are choosing.
- If you are selecting 'Retiree & Children,' 'Retiree & Spouse,' or 'Retiree & 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. If you select 'Retiree & Family' coverage, you must complete the dependent information in Section 4.

Important Dates to Remember

Plan Year: July 1, 2009 – June 30, 2010
Open Enrollment for Current Retirees:
April 1, 2009 – April 30, 2009

Enrollment Form Section 4

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

If your retirement date is after July 1, 2009, your Enrollment Form must be returned within 60 days of your retirement date. Your coverage will be effective the first day of the month following your retirement and you will be billed accordingly.

Until deductions begin, payment by personal check or money order is required. FBMC will send coupons for your use until deductions begin from your retirement check.

Eligibility Requirements

Who is Eligible?

An eligible retiree is a former employee, or the surviving spouse of a former employee, of the State of West Virginia, County Board of Education or any non-state agency who currently receives income under the WV Consolidated Public Retirement Board (CPRB) or is a participant in a TIAA-CREF retirement plan.

How to Enroll?

Current Retirees

If you wish to enroll in vision and/or dental coverage, you will need to complete, sign and return the enclosed Retiree Enrollment Form to FBMC, using the enclosed envelope. Your return envelope must be postmarked by April 30, 2009. Late forms will not be accepted. For more information, contact FBMC's Customer Care Center at 1-800-342-8017.

New Retirees

You may enroll in any of the three Delta Dental plans.

If you wish to enroll in vision and/or dental coverage, you will need to complete, sign and return the enclosed Retiree Enrollment Form to FBMC, using the enclosed envelope, within 60 days of retiring. Your coverage will be effective the first day of the month following your retirement and you will be billed accordingly. If you do not enroll during this time, you must wait until the next open enrollment period to participate.

For more information, please contact FBMC Customer Care Center at 1-800-342-8017.

Benefits you choose will remain in effect for one plan year, without exception.

You may only change your coverage if you experience a qualifying Change in Status (CIS) event.

Making Payments

- **State of West Virginia Retirement System Retirees**
  Payment for vision and dental benefits will be deducted from your West Virginia CPRB retirement check, unless premium costs are greater than the total amount of your check. In this instance, payment can be made directly to FBMC by the use of coupons.

  Until deductions begin, payment by personal check or money order is required. Full premium payment(s) must be paid by the due date specified. FBMC will send coupons for your use until deductions begin from your retirement check.

- **TIAA-CREF Retirees**
  Payment by personal check or money order should be sent with the monthly coupons supplied to you by FBMC and must be paid by the due date specified.

Changes to Coverage

Any changes to your Retiree benefits will require your written authorization. Premium changes due to your written authorization will be promptly initiated after FBMC receives your written request.

If you experience a qualifying Change In Status (CIS) event during your coverage as a retiree, coverage levels can be increased or decreased based on the type of CIS event.

If you are having premium payments deducted from your retirement check, any required refunds will be completed as soon as verification is received that your deduction has changed.

Be sure to carefully consider your benefit elections. Coverage you select will stay in effect the entire plan year and **coverage you cancel cannot be reinstated until the next annual open enrollment period.**

Please send your written requests for changes to:

Fringe Benefits Management Company
P.O. Box 730561
Ormond Beach, Florida 32173-0561

Changing Your Coverage

How do I make a change?

Within **60 days** of an event that is consistent with one of the events below, you must contact FBMC with your change information.

What are the IRS Special Consistency Rules governing Changes in Status?

1. **Loss of Dependent Eligibility**– If a change in your marital status involves a decrease or cessation of your spouse's or dependent's eligibility for coverage due to: your divorce, or annulment from your spouse, your spouse's or dependent's death or a dependent ceasing to satisfy eligibility requirements, you may decrease or cancel coverage only for the individual involved. You cannot decrease or cancel any other individual's coverage under these circumstances.
2. **Gain of Coverage Eligibility Under Another Employer's Plan**– If you, your spouse or your dependent gains eligibility for coverage under another employer's plan as a result of a change in marital or employment status, you may cease or decrease that individual's coverage.

Delta Dental 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 576 Delta Dental Premier access points and 330 access points 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 are 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 Premier 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 fee-for-service, 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.

Your Monthly Retiree Rates

Dental Assistance	
Retiree Only	$10.46
Retiree & Children	$20.97
Retiree & Spouse	$23.39
Retiree & Family	$33.95
Basic	
Retiree Only	$18.50
Retiree & Children	$37.06
Retiree & Spouse	$41.30
Retiree & Family	$59.90
Enhanced	
Retiree Only	$29.85
Retiree & Children	$59.71
Retiree & Spouse	$69.33
Retiree & Family	$99.04

Plan #1058

* 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.

Delta Dental Care - Dental Plans

Further Information

You may cover your spouse and any children, stepchildren or foster children, up to age 25.

See the chart on the following page 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. All you need to tell your dentist is that you have Delta Dental and plan #1058. Submit claim forms to:

Delta Dental of West Virginia
One Delta Drive
Mechanicsburg, PA 17055-6999

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

Delta Dental Care - Dental 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 12-month period) - Routine cleaning (twice in a 12-month period) - Fluoride treatments (to age 19, twice in a 12-month period) - Bitewing X-rays (twice in a 12-month period) - 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 w/ oral surgery procedures with one or more simple extractions and/or with surgical extractions for patients under age 19; and with three or more simple extractions and/or surgical extractions for patients age 19 and over.	**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 19)	**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.

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

*** Enhanced benefit for pregnancy, which includes an additional oral evaluation and a choice of an additional periodontal scaling, root planing or prophylaxis, 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.

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 19 or to age 25, if they are unmarried, full-time students.

Your Monthly Retiree Rates

Full Service plan

Retiree Only	$10.09
Retiree & Family	$24.53

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)		
Medically Necessary	Covered in full***	Exam & $210
Elective	Exam & $150	Exam & $105

† 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.

When you choose elective contacts instead of glasses, your $150 allowance applies to the cost of your lenses and the fitting/evaluation exam. This exam is in addition to your vision exam to ensure proper fit of contacts.

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

Vision Service Plan

Value-Added Benefits Effective 7/1/09

Diabetic Eyecare Program - Provides additional coverage through medical diagnosis and procedure codes specifically targeted toward members with Type 1 diabetes **Additional 30% Discount** applies to glasses purchased the same day as the member's eye exam from the same VSP doctor who provided the exam. Members will also receive 20% off unlimited additional pairs of glasses valid through any VSP doctor within 12 months of the last covered eye exam.

Exam Plus Vision Plan

(Plan Year runs July 1 through June 30)

Exam Plus is an alternative to the Full Service plan. Under this plan, you must obtain services through a VSP 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.

For contact lenses, a 15 percent discount will be applied on VSP member doctor's professional services associated with all prescription contact lenses.

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 19 or to age 25, if they are unmarried, full-time students.

Your Monthly Retiree Rates

Exam Plus plan

Retiree Only	$1.69
Retiree & Family	$3.84

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 nonmember 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**.

FBMC Privacy Notice 4/14/03

This notice applies to products administered by Fringe Benefits Management Company and its wholly-owned subsidiaries (collectively "FBMC"). FBMC takes your privacy very seriously. 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. This notice explains how FBMC handles and protects the personal information we collect. Please note that the information we collect and the extent to which we use it will vary depending on the product or service involved. In many cases, we may not collect all of the types of information noted below. FBMC's privacy policy is as follows:

I. 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.

II. Under HIPAA, you have certain rights with respect to your protected health information. You have rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan in care of FBMC's Privacy Officer or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

Additional information that describes how medical information about you may be used and disclosed and how you can get access to this information is provided electronically on our Web site: **www.myFBMC.com.** You have a right to a paper copy at any time. Contact FBMC Customer Care Center at 1-800-342-8017.

III. We maintain safeguards to ensure information security. We are committed to preventing unauthorized access to personal information. We maintain physical, electronic, and procedural safeguards for protecting personal information. We restrict access to personal information to those employees, insurance companies, and service providers who need to know that information to provide products or services to you. Any employee who violates our Privacy Policy is subject to disciplinary action.

IV. 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.

We will provide our Privacy Notice to current customers annually and whenever it changes. If you no longer have a customer relationship with us, we will still treat your information under our Privacy Policy, but we will no longer send notices to you. In this notice of our Privacy Policy, the words "you" and "customer" are used to mean any individual who obtains or has obtained an insurance, financial product or service from FBMC that is to be used primarily for personal or family purposes.

Notice of Administrator's Capacity

PLEASE READ: 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.

2009 Benefit Fair Schedule

Date	Location	Time
Monday, **April 6**	Charleston State Capitol Complex	9:00 a.m. - 2:00 p.m.
Monday, **April 6**	Charleston Charleston Civic Center	3:00 – 7:00 p.m.
Tuesday, **April 7**	Weirton Holiday Inn 350 Springs Drive	3:00- 7:00 p.m.
Wednesday, **April 8**	Wheeling Northern Comm. College	1:00 – 7:00 p.m.
Thursday, **April 9**	Morgantown WVU Alumni Center	10:00 a.m. – 1:30 p.m.
Thursday, **April 9**	Morgantown Ramada Inn	3:00 – 7:00 p.m.
Monday, **April 13**	Parkersburg Comfort Suites	3:00 – 7:00 p.m.
Tuesday, **April 14**	Martinsburg Holiday Inn Foxcroft Avenue	3:00 – 7:00 p.m.
Wednesday, **April 15**	Fairmont State College	9:00 a.m. – 2:00 p.m.
Wednesday, **April 15**	Romney South Branch Inn	3:00 – 7:00 p.m.
Thursday, **April 16**	Beckley Tamarack Conf. Ctr. Ballroom A	3:00 – 7:00 p.m.
Monday, **April 20**	Huntington Big Sandy Superstore Arena	3:00 – 7:00 p.m.
Wednesday, **April 22**	Flatwoods Days Inn	3:00 – 7:00 p.m.

Notes

FBMC

Premier Benefits Solutions

Contract Administrator
Fringe Benefits Management Company
P.O. Box 730561 Ormond Beach, FL 32173-0561
Customer Care Center 1-800-342-8017 • 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/WVRET/0309

FBMC
Premier Benefits Solutions
P.O.Box730561,OrmondBeach,FL32173-0561

RETIREE ENROLLMENT FORM
Plan Year 2010
July 1, 2009-June 30, 2010

STATE OF WEST VIRGINIA
Mountaineer Retiree Benefits

PLEASE PRINT USING A BALLPOINT PEN.

1

SOCIAL SECURITY #			Choose one: ☐ Pay by check (includes TIAA-CREF) ☐ Deduct from CPRB Retirement check
LAST NAME (RETIREE OR SURVIVING SPOUSE)	FIRST NAME (RETIREE OR SURVIVING SPOUSE)		MI
MAILING ADDRESS 1 (STREET)	CITY	STATE	ZIP
MAILING ADDRESS 2 (STREET)	BIRTH DATE	☐ MALE ☐ FEMALE	BENEFIT START DATE
HOME PHONE	☐ MARRIED ☐ SINGLE ☐ WIDOW/WIDOWER	E-MAIL	

2 ## INSTRUCTIONS

All retirees or surviving spouse must complete this application to enroll for coverage. Please complete the dependent information section if you select coverage that includes dependents. Complete and return this entire application to FBMC in the envelope provided.

3 ## MOUNTAINEER RETIREE BENEFITS

Indicate all benefits selections by entering the necessary information below. Dependent eligibility is limited to the same benefit categories and amounts selected by the Retiree. If you elect dependent coverage for any benefit, you must provide dependent information in Section 4 below.

KEEP COVERAGE	CANCEL COVERAGE	ADD COVERAGE	BENEFITS		
☐	☐	☐	**DELTA DENTAL**	**CHOOSE ONE DENTAL OPTION:** ☐ Dental Assistance ☐ Basic ☐ Enhanced	**CHOOSE YOUR COVERAGE LEVEL:** ☐ Retiree Only ☐ Retiree & Spouse* ☐ Retiree & Children* ☐ Retiree & Family*

MONTHLY RETIREE DELTA DENTAL RATES	Dental Assistance	Basic	Enhanced
Retiree Only	$10.46	$18.50	$29.85
Retiree & Children	$20.97	$37.06	$59.71
Retiree & Spouse	$23.39	$41.30	$69.33
Retiree & Family	$33.95	$59.90	$99.04

KEEP COVERAGE	CANCEL COVERAGE	ADD COVERAGE			
☐	☐	☐	**VISION**	**CHOOSE ONE VISION OPTION:** ☐ Full Service ☐ Exam Plus	**CHOOSE YOUR COVERAGE LEVEL:** ☐ Retiree Only ☐ Retiree & Family*

MONTHLY RETIREE VISION SERVICE PLAN RATES	Full Service plan	Exam Plus plan
Retiree Only	$10.09	$1.69
Retiree & Family	$24.53	$3.84

*IF YOU SELECT DEPENDENT COVERAGE FOR ANY OF THE BENEFITS ABOVE, YOU MUST COMPLETE THE INFORMATION BELOW.

4 ## DEPENDENT INFORMATION

DEPENDENT NAME	RELATIONSHIP	BIRTH DATE	SOCIAL SECURITY #	CHECK COVERAGE SELECTED	
				DENTAL	VISION
	SPOUSE				

I hereby authorize the WV Consolidated Public Retirement Board to deduct my insurance premiums from my monthly benefit check and make any subsequent premium changes as directed by FBMC. **Participants in the TIAA-CREF retirement plan:** I certify the preceeding benefit elections are correct and agree to remit payment to FBMC.

RETIREE SIGNATURE	DATE SIGNED

FBMC USE ONLY

EFFECTIVE DATE	CPRB	DIVISION

DATA ENTRY	VERIFICATION	SCANNED	INDEXED

EXHIBIT C

IV: SECTION 125 PLAN

ARTICLE I - INTRODUCTION

1.1 Purpose of Plan. The purpose of this Plan is to permit Participants to choose between cash and certain nontaxable health and welfare benefits provided by the Employer. In accordance with this purpose, the Plan provides Premium Conversion Benefits, which are non-taxable benefits provided automatically to Participants through payroll deductions upon the satisfaction of eligibility requirements (unless such benefits are declined for cash), and provides Mountaineer Flexible Benefits, which are non-taxable benefits provided to Participants only upon their election and agreement to payroll deductions.

1.2 Authorization. West Virginia Code Section 5-16-14 authorizes Director of the State of West Virginia Public Employees Insurance Agency to develop and implement deductible and employee premium programs which qualify for favorable income tax treatment under Section 125 of the Internal Revenue Code of 1986, as amended.

1.3 Cafeteria Plan Status. The Plan is intended to qualify as a "cafeteria plan" under Section 125 of the Code, and is to be interpreted in a manner consistent with the requirements of Section 125.

1.4 Effective Date. The Plan is amended and restated effective January 1, 1996.

ARTICLE II – DEFINITIONS

For all purposes herein, the following definitions and terms shall apply:

2.1 "Administrator" means PEIA and such other TPA as may be appointed from time to time by PEIA to supervise the administration of the Plan.

2.2 "Basic and Optional Life Insurance Program" means the group term life insurance plan offered by PEIA through a contractual arrangement with an insurance carrier of term life insurance under which benefits are excluded from the Employee's gross income pursuant to Section 79 of the Code.

2.3 "Benefit Election Form" means the form promulgated by the Administrator by which an eligible Employee makes his benefit election(s) as described in Section 4.1 of the Plan and in accordance with Article IV.

2.4 "Code" means the Internal Revenue Code of 1986, as amended from time to time. Reference to any Section or Subsection of the Code includes reference to any comparable or succeeding provision of any legislation, which amends, supplements or replaces such Section or Subsection.

2.5 "Compensation" means the total compensation for services paid or made available by the Employer to an Employee including elective contributions or deferrals which would be included in the Employee's compensation except for the operation of Code Sections 125, 403(b), or 457.

2.6 "Contributions" means Employee contributions as described in Article IV used to purchase Premium Conversion Benefits and Mountaineer Flexible Benefits.

2.7 "Dental Benefit Plan" means the dental care plan, or plans, offered by PEIA under which benefits are excluded from the Employee's gross income pursuant to Section 105 of the Code.

2.8 "Dependent" means any person, which falls within the definition of dependent provided in Section 125 of the Code.

2.9 "Dependent Care Expenses" has the meaning specified in Article II of the Dependent Care Reimbursement Plan.

2.10 "Dependent Care Reimbursement Plan" means the State of West Virginia Public Employees Insurance Agency Dependent Care Reimbursement Plan.

2.11 "Director" means the Director of PEIA.

2.12 "Effective Date" means, with respect to this amendment and restatement, January 1, 1996.

2.13 "Eligible Employee" means any Employee who is eligible to participate in the Medical Benefit Plan.

2.14 "Employee" means any common law employee of the Employer.

2.15 "Employer" means the State of West Virginia, its boards, agencies, commissions, departments, institutions or spending units, or a county board of education, or eligible municipality or other eligible local entity which elects to participate in the Plan.

2.16 "Health Care Expenses" has the meaning specified in Article II of the Medical Reimbursement Plan.

2.17 "Highly Compensated Individual" means a Participant which is (a) an officer, (b) a shareholder owning more than 5 percent of the voting power or value of all classes of stock of the Employer, (c) highly compensated, or (d) a spouse or dependent (within the meaning of Section 152 of the Code) of an individual described in (a), (b), (c) above.

2.18 "Key Employee" means any person who is a key employee as defined in Section 416(i)(1) of the Code.

2.19 "Long-Term Disability Plan" means the long-term disability plan offered by PEIA under which benefits are excluded from the Employee's gross income pursuant to Section 106 of the Code.

2.20 "Medical Benefit Plan" means the Employer's respective medical insurance plan(s) and any contract or contracts with health maintenance organizations or group plans in effect from time to time which provide for health care benefits.

2.21 "Medical Reimbursement Plan" means the State of West Virginia Public Employees Insurance Agency Medical Reimbursement Plan.

2.22 "Mountaineer Flexible Benefits" means, collectively, the Vision Benefit Plan, Dental Benefit Plan, Long-Term and Short-Term Disability Plan and the Dependent Care Reimbursement and Medical Reimbursement Plan, and related plans.

2.23 "Open Enrollment" means the period of time prior to or during a Plan Year which PEIA has designated and communicated to Eligible Employees as the period within which they may make elections to allocate Contributions under the Section 125 Plan. The Open Enrollment period may be changed from year to year by PEIA.

2.24 "Participant" means each Eligible Employee who elects to participate in the Plan in accordance with Article III.

2.25 "PEIA" means the State of West Virginia Public Employees Insurance Agency and any successor thereto.

2.26 "Period of Coverage" for the Premium Conversion Benefits means the period of time during the Plan Year in which a Participant is eligible to participate in the Plan under the terms of the Plan and pursuant to the laws of the State of West Virginia. In no event shall the Period of Coverage commence prior to, nor terminate after, the commencement and ending dates of the Plan Year.

For the Mountaineer Flexible Benefits, the Period of Coverage shall be the PEIA Plan year. The Period of Coverage, shall generally be twelve (12) months, except for Plan Years during which an Employee is a Participant for less than the entire Plan Year. A Period of Coverage shall not be for a duration which would enable a Participant to defer the receipt of Compensation or to obtain coverage under the Plan only for periods during which a Participant expects to incur Health Care Expenses or Dependent Care Expenses or require medical insurance coverage.

2.27 "Plan" means the Sate of West Virginia Public Employee Insurance Agency Section 125 Plan as set forth herein, together with any and all amendments and supplements hereto.

2.28 "Plan Year" means the twelve-month benefit period.

2.29 "Premium Conversion Benefits" means the Medical Benefit Plan and Basic and Optional Life Insurance Program.

2.30 "Spouse" means an Employee's legally married husband or wife.

2.31 "TPA" means the third-party administrator retained by PEIA to administer the Plan.

2.32 "Vision Benefit Plan" means the vision plan offered by PEIA under which benefits are excluded from the Employee's gross income pursuant to Section 105 of the Code.

The masculine gender, whenever used herein, shall include the feminine, and the Singular shall include the plural and vice versa, unless the context clearly indicates otherwise.

ARTICLE III – PARTICIPATION

3.1 Commencement of Participation. All Eligible Employees may participate in and enter the Plan.

(a) With respect to Premium Conversion Benefits, each Eligible Employee shall automatically become a Participant in this Plan for a Period of Coverage on the first day of the first month following enrollment in the Medical Benefits Plan, unless the employee properly files with the Administrator a Benefit Election Form to decline participating in the Plan in accordance with Section 4.5.

(b) With respect to the Mountaineer Flexible Benefits, participation begins when the Eligible Employee elects, pursuant to Section 4.5, to allocate the Contributions available under this Plan to pay for such benefits during an Open Enrollment period. An Eligible Employee is hired after Open Enrollment is not eligible to participate in the Plan until the next Open Enrollment.

(c) The effect of participation, in this Plan is that the Participant's Compensation will be reduced, pursuant to this Plan, by an amount equal to the amounts required as employee contributions for the benefits elected by the Participant.

(d) Except as provided in Sections 3.2 and 4.8, an election to participate in the Plan with respect to a particular Plan Year shall remain in effect for the remainder of that Plan Year.

3.2 Cessation of Participation. Except as provided in Article VIII, a Participant shall cease to be Participant as of the earlier of (a) the date on which the Plan terminates, (b) the date on which the employee ceases to be an Eligible Employee, or (c) the date on which he/she has elected to cancel the applicable benefit coverage(s) under Article IV.

3.3 Reinstatement of Former Participant. A Former Participant who is rehired shall become a Participant again in accordance with Section 3.1. However, in the case of a Participant who separates from service with the Employer during a Period of Coverage and elects to revoke existing benefit elections and terminates the receipt of benefits for the remaining portion of the Period of Coverage, upon return to service, such a Former Participant shall be prohibited from making new benefit elections for the remaining portion of the Period of Coverage.

3.4 Relation to Other Eligibility Requirements. Each of the optional benefits incorporated in this Plan, such as the Mountaineer Flexible Benefits and Premium Conversion Benefits, may have its own eligibility requirements for participation, which may differ from those set forth in this Plan. The eligibility requirements set forth in this Plan relate only to participation in this Plan and

shall have no effect on such other eligibility requirements.

ARTICLE IV – BENEFIT OPTIONS

4.1 Benefit Elections. A Participant may elect under this Plan to receive full Compensation for any Period of Coverage in cash or have a portion of his/her Compensation contributed to the Plan by the Employer toward the cost of one or more of the following optional benefits:

(1) Benefits available to the Participant as Premium Conversion Benefits, including, but not limited to, benefits available under the Medical Benefit Plan and Basic and Optional Life Insurance Program;

(2) Benefits available to the Participant as Mountaineer Flexible Benefits, including, but not limited to, the Vision Benefit Plan, Dental Benefit Plan and Long-Term Disability Plan, but excluding the Dependent Care Reimbursement and the Medical Reimbursement Plans;

(3) Benefits available to the Participant under the Dependent Care Reimbursement and the Medical Reimbursement Plans.

4.2 Salary Reduction. By participating in the Plan, each Participant agrees to have his/her annual Compensation reduced by the cost of the benefit(s) selected by him or her under the Plan.

4.3 Description of Benefits Other Than Cash. While the election to receive one or more of the optional benefits described in Section 4.1 may be made under this Plan, the benefit will be provided not by this Plan but by the Employer's Dependent Care Reimbursement Plan, the Medical Reimbursement Plan, any Premium Conversion Benefit plans, and Mountaineer Flexible Benefit plans. The types and amounts of benefits available under each option, and the other terms and conditions of coverage and benefits under such options shall be established and set forth in each of the above plans described in Section 4.1 as provided in their respective Plan Documents, and in the group insurance contracts and prepaid health plan contracts that constitute (or are incorporated by reference) those plans. The benefit descriptions in such plans and contracts, as in effect from time to time, are hereby incorporated by reference into this Plan.

4.4 Election of Optional Benefits in Lieu of Cash. A Participant may elect under this Plan to receive one or more of the optional benefits described in Section 4.1 in accordance with the procedure described in Section 4.5. If a Participant elects any such benefit described in Sections 4.1(1) or 4.1(2), the Participant's Compensation will be reduced by the amount of the Participant's share of the cost of the selected benefit as determined by the Employer, and an amount equal to the reduction will be contributed by the Employer under the respective plans described in Sections 4.1(1) and 4.1(2) to cover the Participant's share of the cost of such optional benefit. Such amount shall be adjusted automatically in the event of a change in such cost. The balance of the cost of such benefit, if any,

shall be paid by the Employer with non-elective Employer contributions. If a Participant's net pay is not sufficient to fully fund the salary reduction for benefits offered under Sections 4.1(1) and 4.1(2), the contribution can be made up in the future when the Participant has earned salary sufficient to fund such benefit election.

If a Participant elects an optional benefit described in Section 4.1(3), the Participant's case Compensation will be reduced, and an amount equal to the reduction will be credited by the Employer to a reimbursement account in accordance with the Dependent Care Reimbursement Plan and/or the Medical Reimbursement Plan, as the case may be. If a Participant's net pay is not sufficient to fund the salary reduction for benefits offered under Section 4.1(3) for any payroll period, the Participant's ability to contribute for such payroll period shall be determined in accordance with the Dependent Care Reimbursement Plan and/or Medical Reimbursement Plan, as the case may be.

4.5 Election Procedure. With respect to the cash benefit described in Section 4.1, the Participant must file a Benefit Election Form with the Administrator to receive this taxable cash benefit, and thereby refuse to receive the qualified tax free benefits known as the Premium Conversion Benefits.

Each Participant who desires optional benefit coverage(s) under Sections 4.1(2) or (3), shall so specify on the appropriate Benefit Election Form, as provided by the Employer, and shall agree to a corresponding reduction in Compensation. The amount of the reduction in the Participant's Compensation for the Period of Coverage for each optional benefit described in Sections 4.1(2) and (3), shall be the amount elected by the Participant, subject to the limitations set forth in the separate Plan Documents governing such benefits.

Each Benefit Election Form described in this Section 4.5 must be completed and returned to the Administrator on or before such date as the Administrator shall specify, which date shall be no later than the beginning of the Period of Coverage.

4.6 New Participants. An Employee who is hired after the Effective Date and who becomes a Participant in accordance with Section 3.1 or 3.3 hereof shall be provided a Benefit Election Form, as soon as practicable after his date of hire.

An Employee may elect or decline participation in the optional benefit coverage(s) in accordance with Section 4.5 hereof. If a Benefit Election Form must be completed and returned to the Administrator, such form must be returned on or before such date as the Administrator shall specify, which date shall be no later than the beginning of the first pay period for which the Participant's compensation reduction agreements will apply.

4.7 Failure to Elect. Except as otherwise provided under Section 4.5, a Participant who has elected to be a Participant in the Premium Conversion Benefit described in Section 4.1(1) shall automatically and simultaneously become a Participant in this Plan for such Period of Coverage, without having to complete and return a Benefit Election Form. The Participant shall also be deemed to have agreed to a reduction in Compensation for such Period of Coverage equal to the Participant's share of the cost from time to time during such Period of Coverage of each such optional benefit the Participant is deemed to have elected for such Period of Coverage. If a Participant fails to return a completed Benefit Election Form to the Administrator on or before the specified due date for any subsequent Period of Coverage, the Participant shall be deemed to have elected to continue the same Premium Conversion Benefit elections as in the prior Period of Coverage.

With regard to the Mountaineer Flexible Benefits, the Dependent Care Reimbursement benefits and the Medical Reimbursement benefits described in Sections 4.1(2) or (3) respectively, a Participant failing to return a completed Benefit Election Form to the Administrator on or before the specified due date for any Period of Coverage shall be deemed to have elected cash compensation in lieu of such optional benefits, regardless of the election in effect during any preceding Period of Coverage.

4.8 Changes by Administrator. If the Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy for such Plan Year the non-discrimination requirement imposed by the Code or any limitation on benefits provided to Key Employees, Highly Compensated Individuals, principal shareholders, or owners with or without the consent of such individuals, it may be necessary for the Administrator to change the Plan.

4.9 Irrevocability of Election by the Participant During the Period of Coverage. Elections made under the Plan (or deemed to be made) with respect to the Optional Benefits described in Section 4.1 shall be irrevocable by the Participant during the Period of Coverage, subject to a change in family status. A Participant may revoke a benefit election for the balance of a Period of Coverage and file a new election only if both the revocation and the new election are on account of and consistent with a change in family status as defined below.

A change in family status for this purpose includes marriage or divorce of the Employee, death of the Employee's Spouse or dependent, birth or adoption of a child of the Employee, termination or commencement of employment of a Spouse, the switching from part-time to full-time employment status or from full-time to part-time status by the Employee or the Employee's Spouse and the taking of an unpaid leave of absence by the Employee or the Employee's Spouse and such other events that the Administrator determines will permit a change or revocation of an election during a Period of Coverage under regulations and rulings of the Internal Revenue Service. A Participant may also revoke a benefit election and in lieu thereof receive, on a prospective basis, coverage under

another benefit plan with similar coverage if coverage is significantly curtailed or ceases during a Period of Coverage or if the premium amount of a benefit plan significantly increases. Election changes are also permitted where there has been a significant change in health coverage of the Employee or Spouse attributable to the Spouse's employment. Any new election under this Section 4.9 must be filed by the participant with the Administrator within 62 days of the qualifying event, and shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after an election form is completed and returned to the Administrator.

4.10 Automatic Termination of Election. Elections made under this Plan (or deemed to be made) shall automatically terminate on the date on which the Participant ceases to be a Participant in the Plan, although coverage or benefits under the respective plans described in Section 4.1 may continue if and to the extent provided by such plans.

4.11 Maximum Employer Contributions. The maximum amount of Employer contributions under the Plan for any Participant shall be the sum of (a) the maximum amounts which the Participant may receive in the form of dependent care reimbursement under the Dependent Care Reimbursement Plan and as health care reimbursements under the Medical Reimbursement Plan, as set forth in such plans, and (b) the costs from time to time of the most expensive Premium Conversion Benefits and Mountaineer Flexible Benefits available to the Participant (including the portion of such costs payable with non-elective Employer Contributions).

4.12 Effective Periods for Elections. Only Compensation earned after an Employee elects participation in the Plan may be used to purchase optional benefits described in Section 4.1 for a Participant. Participants may not carry over any overused contributions or benefits from one Period of Coverage to a subsequent Period of Coverage.

4.13 Nondiscrimination. Notwithstanding any provisions of insurance coverage provided for under this Plan and any other provisions of this Plan, this Plan shall not discriminate as to eligibility to participate, contributions or benefits in favor of Highly Compensated Individuals or Key Employees.

ARTICLE V – ADMINISTRATION OF PLAN

5.1 Plan Administrator. The Administrator shall have the sole responsibility for the administration of this Plan which responsibility is specifically described in this Plan. The Administrator shall have the authority to appoint such other person or committee from time to time to supervise the administration of the Plan. The designated representatives of the Administrator shall have only those specific powers, duties, responsibilities and obligations as are specifically given them under this Plan.

The Employer shall have the sole responsibility for making the contributions provided for under Article IV hereof. PEIA shall have the sole authority to amend or terminate, in whole or in part, this Plan at any time with the approval of PEIA's Director.

The Administrator warrants that any directions given, information furnished, or action taken by it shall be in accordance with the provisions of the Plan authorizing or providing for such direction, information or action. Furthermore, the Administrator may rely upon any such direction, information or action of another Employee of the Employer as being proper under this Plan, and is not required under this Plan to inquire into the propriety of any such direction, information or action. It is intended under this Plan that the Administrator shall be responsible for the proper exercise of its own powers, duties, responsibilities and obligations under this Plan and shall not be responsible for any act or failure to act of another Employee of the Employer. Neither the Administrator nor the Employer makes any guarantee to any Participant in any manner for any loss or other event because of the Participant's participation in this Plan.

All usual and reasonable expenses of the Administrator that are not properly chargeable to or payable by the Plan (including payment out of forfeitures pursuant to Section 5.4) shall be paid by the Employer, and any expenses not paid by the Employer shall not be the responsibility of the Administrator personally. The Administrator or any other designated representative of the Employer who is an Employee of the Employer shall not receive any compensation with respect to services hereunder except as such person may be entitled to benefits under this Plan.

5.2 Records and Reports. The Administrator shall exercise such authority and responsibility as it deems appropriate in order to comply with the terms of the Plan relating to the records of the Participant and the balances, if any, which are maintained under this Plan. The Administrator shall be responsible for complying with all reporting, filing and disclosure requirements established by the Internal Revenue Service for Code Section 125 plans.

5.3 Other Powers and Duties of the Administrator. The Administrator shall have such duties and powers as may be necessary to discharge its duties hereunder, including, but not limited to, the following:

(a) To prescribe such procedures as the Administrator deems necessary or proper to be followed by Participants in the filing of applications for benefits;

(b) To construe and interpret the Plan, its construction and interpretation thereof in good faith to be final and conclusive on all persons claiming benefits under the Plan;

(c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan;

(d) To prepare and distribute, in such manner as the Administrator determines to be appropriate, information explaining the Plan;

(e) To receive from the Employer and from Participants such information as shall be necessary for the proper administration of the Plan;

– To furnish the Employer, upon request, such annual reports with respect to the administration of the Plan as are reasonable and appropriate;

(g) To receive, review and keep on file (as it deems convenient and proper) reports of benefit payments by the Employer and reports of disbursements for expenses directed by the Administrator;

(h) To appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan; and,

(i) To allocate and delegate its responsibilities under the Plan and to designate other persons to carry our any of it responsibilities under the Plan, any such allocations, delegation, or designation to be in writing.

The TPA shall have no power to add to, subtract from, or modify any of the terms of Plan, or to change or add to any benefits provided by the Plan, or to waive or fail to apply any requirements of eligibility for a benefit under the Plan.

Notwithstanding anything herein to the contrary, any claim which arises under the plans described in Section 4.1 shall not be subject to review under this Plan, and the Administrator's authority under this Section 5.4 shall not extend to any matter the determination of which an Administrator under the respective plan is empowered to make.

5.4 Examination of Records. The Administrator shall make available to each Participant for examination (at reasonable times during normal business hours) such of the records under the Plan as pertain to such Participant. The Administrator shall be responsible for complying with all notice, reporting, filing and disclosure requirements established by the Internal Revenue Service for Code Section 125 Plans.

5.5 Reliance on Tables, etc. In administering the Plan, the Administrator shall be entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by, or in accordance with the instructions of the administrators of the plans described in Section 4.1 or by accountants, counsel (legal or otherwise), or other experts employed or engaged by the Administrator.

5.6 Rules and Decisions. The Administrator may adopt such rules as it deems necessary, desirable or appropriate. All rules and decisions of the Administrator, whether discretionary or otherwise, shall be exercised in a uniform and consistent manner so that all persons similarly situated will receive substantially the same treatment. When making a determination or calculation, the Administrator shall be entitled to rely upon information by a Participant, the Employer, or the legal counsel of the Employer.

5.7 Procedures. The Administrator may act at a meeting or in writing without a meeting. The Administrator may adopt such bylaws and regulations as it deems necessary for the conduct of its affairs.

5.8 Authorization of Benefit Payments. The Administrator shall issue directions to the Employer concerning all benefits which are to be paid from the Employer's general assets pursuant to the provisions of the Plan, and warrants that all such directions are in accordance with the Plan.

5.9 Application and Forms for Benefits. The Administrator may require a Participant to complete and file with the Administrator an application for a benefit and all other forms approved by the Administrator, and to furnish all pertinent information requested by the Administrator. The Administrator may rely upon all such information so furnished it, including the Participant's current mailing address.

5.10 Facility of Payment. Whenever, in the Administrator's opinion, a person entitled to receive any payment of a benefit or installment thereof hereunder is under a legal disability or is incapacitated in any way so as to be unable to manage the person's financial affairs, the Administrator may direct the Employer to make payments to such person or to the person's legal representative or to a relative of such person for such person's benefit, or the Administrator may direct the Employer to apply the payment for the benefit of such person in such manner as the Administrator considers advisable. Any payment of a benefit or installment thereof in accordance with the provisions of this Section 5.11 shall be a complete

discharge of any liability for the making of such payment under the provisions of the Plan.

5.11 Indemnification of Administrator. The Employer agrees to indemnify and to defend to the fullest extent permitted by law, any individual serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who formerly served as Administrator or as a member of such committee) against any and all liabilities, damages, costs and expenses (including reasonable attorney's fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or failure to act in connection with the Plan, if such act or failure to act is made in good faith pursuant to the provisions of the Plan.

5.12 Claims Procedure.

(a) A claim for benefits under the Plan shall first be filed with the TPA. Notice of the decision shall be furnished to the claimant by the TPA within a reasonable period of time after receipt of the claim by the TPA. IF a Participant does not receive notice of denial of a claim for benefits under the Plan within 90 days of the filing of such claim, then the claim shall be deemed denied.

(b) A claimant may review all pertinent documents and may request a review by the TPA of any claim. Any such request must be filed in writing with the TPA within 90 days after the earlier of (i) receipt by the claimant of written notice of the decision on the claim or (ii) 90 days after the initial filing of such claim. Such written request for review shall contain all additional information which the claimant wishes the TPA to consider. Notice of the decision on review shall be furnished in writing to the claimant within 90 days (unless special circumstances require an extension of up to 90 additional days) following the receipt of the request for review. The TPA's written decision shall include specific reasons for the decision and shall refer to the pertinent provisions of the Plan or of the Plan Documents on which the decision is based.

(c) If such claim is denied by the TPA, a claimant may appeal in writing to PEIA. Such appeal must be filed with PEIA within 30 days of receipt of the TPA's decision denying such claim. All information relating to the denial, including a copy of the denial letter from the TPA, must be supplied to PEIA by the claimant. PEIA shall, after reviewing the facts, make a final determination and notify the claimant of its decision. Such decision shall be final and binding.

5.13 Claims and Review Procedure for Insured Benefits. To the extent that benefits hereunder are provided by an insurance company, the provisions of Section 5.12 shall not apply to claims for such benefits, and claims shall be filed with and

subject to review by such insurance company.

ARTICLE VI – AMENDMENT AND TERMINATION OF PLAN

6.1 Amendment and Termination. PEIA hopes and expects to continue this Plan indefinitely and every effort has been made to arrange its provisions so that it will meet future conditions insofar as they can be foreseen. However, in order to protect against unforeseen circumstances, PEIA reserves the right to make any amendment it deems necessary or desirable, or to terminate this Plan at any time by an instrument in writing executed by the Director of PEIA.

However, no such amendment or termination of the Plan shall adversely affect the rights of any Participant hereunder (a) with respect to any balance remaining in his Dependent Care Reimbursement Plan or Medical Reimbursement Plan at the time of such amendment or termination; or (b) with respect to any claims incurred prior to such amendment or termination for the optional benefits described in Section 4.1 hereof.

ARTICLE VII – MISCELLANEOUS PROVISIONS

7.1 Information to be Furnished. Participants shall provide the Employer and Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.

7.2 Limitation of Rights. Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits, will be construed as giving to any Participant or other person any legal or equitable right against the Employer or Administrator, except as provided herein. No Employer or Employee upon termination of employment or otherwise shall have additional rights or benefits under the Plan, except as provided from time to time under this Plan, and then only the extent of benefits payable under the Plan to such Employee or beneficiary. All payments of benefits as provided for in this Plan shall be made solely out of the assets of the Employer and the Administrator shall not be liable therefore in any manner.

7.3 Governing Law. This Plan shall be construed, administered and enforced according to the laws of the State of West Virginia.

7.4 Selection of Beneficiaries. In the case of any insurance policy which permits or requires the naming of a beneficiary, it shall be the responsibility of the Employee to see to it that this is done. The Employer shall not be liable for any loss or cost which may result from such failure. The Employer's responsibility shall be limited to joining in the execution of any documents as requested by an Employee or insurance carrier in order to carry out the purpose of this Plan.

7.5 Non-alienation of Benefits. Benefits payable under this Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge garnishment, execution, or levy of any kind, either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a Spouse or former Spouse, or for any other relative of the Employee, prior to actually being received by the person entitled to the benefit under the terms of the Plan; and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge, or otherwise dispose of any right to benefits payable hereunder, shall be void. The Employer shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements, or torts of any person entitled to benefits hereunder.

7.6 Divestment of Benefits. Subject only to the specific provisions of this Plan, nothing shall be deemed to divest a Participant of a right to the benefit to which the Participant becomes entitled in accordance with the provisions of this Plan.

7.7 Discontinuance of Contributions. In the event of a permanent discontinuance of contributions to the Plan, all Participants shall receive any and all benefits to

which they were entitled as of the date the discontinuance of contributions occurred.

7.8 Non-guarantee of Employment. Neither the establishment or continuance of the Plan, nor any modification thereof, nor the establishment or continuance of any Medical Benefit Plan or any trust, nor the payment of any benefits, shall give any participating Employee, or other person whomsoever the right to be retained in the service of any Employer or PEIA, and all Participants and other Employees shall remain subject to discharge to the same extent as if the Plan had never been adopted.

7.9 Binding Effect. Subject to the other provisions of this Article VII, this Plan shall be binding upon PEIA and each Employer, their successors and assigns, and upon anyone participating in, or claiming benefits under, the Plan, including each Participant and each of the beneficiaries, heirs, executors, administrators, personal representatives, successors and assigns.

7.10 Severability. If any provision of this Plan shall be held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof shall continue to be fully effective, unless such action would then render the Plan inoperable relative to its original intent.

7.11 Construction of the Plan. The Director may construe any ambiguous provisions of the Plan, correct any defect, supply any omission, or reconcile any inconsistency, in such manner and to such extent as the Director in his discretion may determine; any such action of the Director shall be binding and conclusive upon all Participants.

7.12 Benefits Solely From Assets. The benefits provided hereunder will be paid solely from the assets of the Employer. The benefits provided by the Plan are given in exchange for the Participant's salary reduction agreement. Nothing herein will be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset for the Employer from which any payment under the Plan may be made.

ARTICLE VIII – CONTINUATION COVERAGE

8.1 Right to Elect Continuation Coverage. To the extent required by COBRA, a Participant, the Participant's Spouse, ex-spouse, and the Participant's dependent child can elect continuation coverage of such optional benefits available under the Employer's Medical Benefit Plan and Medical Reimbursement Plan, Dental Benefit Plan, and Vision Plan.

EXHIBIT D

Management Reports

Availability Requirements:

All reports shall be available electronically via internet or other acceptable medium. Hard copy reports shall be provided upon request.

Quarterly Reporting:

1. List of negative flexible spending or dependent care account (FSA's) balances.

2. Policyholder appeal statistics detailed by nature of appeal, status of appeal process and ultimate result.

3. Statistics detailing necessary payroll refunds by payroll location and the reason for the refund.

4. Total quarter ending balance of FSA's with individual account balance detail available.

5. Total enrollment and enrollment changes (additions/terminations) per all participating employers and a list of non-participating employers.

Annual Reporting:

1. Annual Statement of Forfeiture, Interest Earnings and Net Available Surplus.

2. Loss Ratio Reports for Insurance Products.

3. Premium Stabilization Fund Reporting for all insured products.

EXHIBIT E

BIDDER'S TOTAL WAIVER OF LEGAL CHALLENGE

(Legal Name of Bidder) _____, hereinafter "Bidder," wishes to submit a Proposal in response to the Request For Proposal For providing administrative services for its IRS Section 125-qualified cafeteria plan known as Mountaineer Flexible Benefits (the RFP) issued _____ by the State of West Virginia Public Employees Insurance Agency (PEIA). The Bidder acknowledges that a mandatory requirement of the RFP is that the Bidder submit a litigation bond with its proposal.

In consideration of the waiver of said litigation bond requirement by the PEIA, and in lieu of such bond, the Bidder agrees:

That the Bidder completely waives and foregoes any and all legal right or ability it may now have, or in the future acquire, to initiate any sort of challenge to or against the selection of a Bidder and/or the ultimate award of a contract or contracts pursuant to the RFP. This Waiver is entered voluntarily by a representative authorized to legally bind the Bidder and shall be binding on the Bidder, its successors, assigns, heirs and any others claiming under the legal rights of the Bidder. This Waiver shall apply to any and all types of action, in challenge to or seeking to attack, in any way, the RFP selection process, or the subsequent award of contract(s) to the successful Bidder, including but not limited to, administrative, judicial, or collateral actions.

_____
(Legal Name of Bidder)

By: _____
(Authorized Signature)

Title: _____
(Title of Authorized Representative)

Approved:

The West Virginia Public Employees Insurance Agency

By: _____
(Authorized Representative)

EXHIBIT F

WV STATE GOVERNMENT

HIPAA BUSINESS ASSOCIATE ADDENDUM

This Health Insurance Portability and Accountability Act of 1996 (hereafter, HIPAA) Business Associate Addendum ("Addendum") is made a part of the Agreement ("Agreement") by and between the State of West Virginia ("Agency"), and Business Associate ("Associate"), and is effective on the date of execution of a binding agreement with the Agency.

Whereas it is desirable, in order to further the continued efficient operations of Agency to disclose to its Associate certain information which may contain confidential individually identifiable health information (hereafter, Protected Health Information or PHI); and

Whereas, it is the desire of both parties that the confidentiality of the PHI disclosed hereunder be maintained and treated in accordance with all applicable laws relating to confidentiality, including the Privacy and Security Rules, and the parties do agree to at all times treat the PHI and interpret this Addendum consistent with that desire.

NOW THEREFORE; the parties agree that in consideration of the mutual promises herein, in the Agreement; and of the exchange of PHI hereunder that:

1. Definitions.

a. Terms used, but not otherwise defined, in this Addendum shall have the same meaning as those terms in the Privacy and Security Rules.

b. Privacy Rule. Privacy Rule means the Standards for Privacy of Individually Identifiable Health Information found at 45 CFR Parts 160 and Part 164, Subparts A and E, as amended.

c. Security Rule. Security Rule means the Standards for the security of electronic protected health information found at 45 CFR Part 164, Subpart C, as amended.

d. Security Incident. Any known successful or unsuccessful attempt by an authorized or unauthorized individual to inappropriately use, disclose, modify, access, or destroy any information.

2. PHI Disclosed; Permitted Uses.

a. PHI Described. PHI disclosed by the Agency to the Associate, PHI created by the Associate on behalf of the Agency, and PHI received by the Associate from a third party on behalf of the Agency are disclosable under this Addendum. The disclosable PHI is limited to the minimum necessary to complete the tasks, or to provide the services, associated with the terms of the original agreement.

b. Purposes. Except as otherwise limited in this Addendum, Associate may use or disclose the PHI on behalf of, or to provide services to, Agency for the purposes necessary to complete the tasks, or provide the services, associated with, and required by the terms of the original agreement, if such use or disclosure of the PHI would not violate the Privacy or Security Rules or applicable state law if done by Agency or violate the minimum necessary policies and procedures of the Agency.

3. Obligations of Associate.

a. Stated Purposes Only. The PHI may not be used by the Associate for any purpose other than stated in this Addendum or as required or permitted by law.

b. Limited Disclosure. The PHI is confidential and will not be disclosed by the associate other than as stated in this Addendum or as required or permitted by law.

c. Safeguards. The Associate will use appropriate safeguards to prevent use or disclosure of the PHI except as provided for in this Addendum. This shall include, but not be limited to:

(i) Limitation of the groups of its employees or agents to whom the PHI is disclosed to those reasonably required to accomplish the purposes stated in this Addendum, and the use and disclosure of the minimum PHI necessary;

(ii) Appropriate notification and training of its employees or agents to whom the PHI will be disclosed in order to protect the PHI from unauthorized disclosure;

(iii) Maintenance of a comprehensive written PHI privacy and security program that includes administrative, technical and physical safeguards appropriate to the size, nature, scope and complexity of the Associate's operations.

d. Compliance With Law. The Associate will not use or disclose the PHI in a manner in violation of existing law and specifically not in violation of laws relating to confidentiality of PHI, including but not limited to, the Privacy and Security Rules.

e. Mitigation. Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Associate of a use or disclosure of the PHI by Associate in violation of the requirements of this Addendum.

f. Documentation. Associate agrees to document disclosures of the PHI and information related to such disclosures as would be required for Agency to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR §§ 164.528 and 164.316. This should include a process that allows for an accounting to be collected and maintained by Associate and its agents or subcontractors for at least six (6) years from the date of disclosure, or longer if required by state law. At a minimum, such documentation shall include:

(i) the date of disclosure;
(ii) the name of the entity or person who received the PHI, and if known, the address of the entity or person;
(iii) a brief description of the PHI disclosed; and
(iv) a brief statement of purposes of the disclosure that reasonably informs the Individual of the basis for the disclosure, or a copy of the Individual's authorization, or a copy of the written request for disclosure.

g. Accounting Rights. Within ten (10) days of notice of a request for an accounting of disclosures of the PHI, Associate and its agents or subcontractors shall make available to Agency the documentation required to provide an accounting of disclosures to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR §164.528.

h. **Access to PHI.** Associate shall make the PHI maintained by Associate or its agents or subcontractors in Designated Record Sets available to Agency for inspection and copying within ten (10) days of a request by Agency to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.524.

i. Amendment of PHI. Within ten (10) days of receipt of a request from Agency for an amendment of the PHI or a record about an individual contained in a Designated Record Set, Associate or its agents or subcontractors shall make such PHI available to Agency for amendment and incorporate any such amendment to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.526.

j. Retention of PHI. Notwithstanding section 4.a. of this Addendum, Associate and its subcontractors or agents shall retain all PHI pursuant to state and federal law and shall continue to maintain the PHI required under Section 3.f. of this Addendum for a period of six (6) years after termination of the Agreement, or longer if required under state law.

k. Agents, Subcontractors Compliance. The Associate will ensure that any of its agents, including any subcontractors, to whom it provides any of the PHI it receives hereunder, or to whom it provides any PHI which the Associate creates or receives on behalf of the Agency, agree to the restrictions and conditions which apply to the Associate hereunder.

l. Amendments. The Associate shall make available to the specific Individual to whom it applies any PHI; make such PHI available for amendment; and make available the PHI required to provide an accounting of disclosures, all to the extent required by 45 CFR §§ 164.524, 164.526, and 164.528 respectively.

m. Federal Access. The Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by the Associate on behalf of the Agency available to the U.S. Secretary of Health and Human Services consistent with 45 CFR § 164.504.

n. Security. The Associate shall take all steps necessary to ensure the continuous security of all PHI and data systems containing PHI, and provide data security procedures for the use of the Agency at the end of the contract period. These steps shall include, at a minimum, the requirements contained in the West Virginia Office of Technology Policy No. WVOT-PO1001 (1-18-07) which may be found at:
http://www.state.wv.us/ot/PDF/Document_center/SecurityPol0107.pdf

o. Notification of Breach. During the term of this Agreement:

i. The Associate shall notify the Agency immediately by telephone call plus e-mail or fax upon the discovery of breach of security of PHI, where the use or disclosure is not provided for by this addendum of which it becomes aware, if the PHI was, or is reasonably believed to have been, acquired by an unauthorized person; or within 24 hours by e-mail or fax of any suspected security incident, intrusion or unauthorized use or disclosure of PHI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. Notification shall be provided to the Agency contract manager (see www.state.wv.us/admin/purchase/vrc/agencyli.htm) and the Office of Technology Help Desk at (304) 558.9966; (877) 558.9966 (Toll Free); or servicedesk@wv.gov.

ii. The Associate shall immediately investigate such security incident, breach, or unauthorized use or disclosure of PHI or confidential data. Within 72 hours of the discovery, the Associate shall notify the Agency contract manager, and the Office of Technology Help Desk of: (a) What data elements were involved and the extent of the data involved in the

breach; (b) A description of the unauthorized persons known or reasonably believed to have improperly used or disclosed PHI or confidential data; (c) A description of where the PHI or confidential data is believed to have been improperly transmitted, sent, or utilized; (d) A description of the probable causes of the improper use or disclosure; and (e) Whether any federal or state laws requiring individual notifications of breaches are triggered.

iii. All associated costs shall be borne by the Associate. This may include, but not be limited to costs' associated with notifying affected individuals.

p. Assistance in Litigation or Administrative Proceedings. The Associate shall make itself and any subcontractors, employees or agents assisting Associate in the performance of its obligations under this Agreement, available to the Agency at no cost to the Agency to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against the Agency, its officers or employees based upon claimed violations of HIPAA, the HIPAA regulations or other laws relating to security and privacy, which involves inactions or actions by the Associate, except where Associate or its subcontractor, employee or agent is a named adverse party.

4. Termination.

a. Duties at Termination. Upon any termination of the underlying agreement, if feasible, the Associate shall return or destroy all PHI received from, or created or received by the Associate on behalf of the Agency that the Associate still maintains in any form and retain no copies of such PHI or, if such return or destruction is not feasible, the Associate shall extend the protections of this Addendum to the PHI and limit further uses and disclosures to the purposes that make the return or destruction of the PHI infeasible. This shall also apply to all agents and subcontractors of Associate. The duty of the Associate and its agents and subcontractors to assist the Agency with any HIPAA required accounting of disclosures survives the termination of the underlying agreement.

b. Termination For Cause. Agency may terminate the underlying agreement if at any time it determines that the Associate has violated a material term of the agreement or this Addendum. Agency may, at its sole discretion, allow Associate a reasonable period of time to cure the material breach before termination.

c. Judicial or Administrative Proceedings. The Agency may terminate this Agreement if the Associate is found guilty of a criminal violation of HIPAA. The Agency may terminate this Agreement if a finding or stipulation that the Associate has violated any standard or requirement of HIPAA, or other security or privacy laws is made in any administrative or civil proceeding in which the Associate is a party or has been joined.

d. Survival. The respective rights and obligations of Associate under Section 3.j. and 3.o. of this Addendum shall survive the termination of the underlying agreement.

5. General Provisions/Ownership of PHI.

a. Retention of Ownership. Ownership of the PHI resides with the Agency and is to be returned on demand.

b. Secondary PHI. Any data or PHI generated from the PHI disclosed hereunder which would permit identification of an Individual must be held confidential and is also the property of Agency.

c. Electronic Transmission. Except as permitted by law or this Addendum, the PHI or any data generated from the PHI which would permit identification of an Individual must not be transmitted to another party by electronic or other means for additional uses not authorized by this Addendum or to another contractor, or allied agency, or affiliate without prior written approval of Agency.

d. No Sales. Reports or data containing the PHI may not be sold without Agency's or the affected Individual's written consent.

e. No Third-Party Beneficiaries. Nothing express or implied in this Addendum is intended to confer, nor shall anything herein confer, upon any person other than Agency, Associate and their respective successors or assigns, any rights remedies, obligations or liabilities whatsoever.

f. Interpretation. The provisions of this Addendum shall prevail over any provisions in the Agreement that may conflict or appear inconsistent with any provisions in this Addendum. The interpretation of this Addendum shall be made under the laws of the state of West Virginia.

g. Amendment. The parties agree that to the extent necessary to comply with applicable law they will agree to further amend this Addendum.

h. Additional Terms and Conditions. Additional discretionary terms may be included in the release order or change order process.

APPROVED AS TO FORM THIS 20th
DAY OF December, 2007
DARRELL V. McGRAW, JR.
ATTORNEY GENERAL
BY. Janice E Warfield
DEPUTY ATTORNEY GENERAL

ATTACHMENTS

Rev. 11/01

STATE OF WEST VIRGINIA
VENDOR PREFERENCE CERTIFICATE

Certification and application* is hereby made for Preference in accordance with West Virginia Code, §5A-3-37. (Does not apply to construction contracts).

West Virginia Code, §5A-3-37, provides an opportunity for qualifying vendors to request (at the time of bid) preference for their residency status. Such preference is an evaluation method only and will be applied only to the cost bid in accordance with the ***West Virginia Code***. This certificate for application is to be used to request such preference. The Purchasing Division will make the determination of the Resident Vendor Preference, if applicable.

A. Application is made for 2.5% preference for the reason checked:

☐ Bidder is an individual resident vendor and has resided continuously in West Virginia for four (4) years immediately preceding the date of this certification;

or

☐ Bidder is a partnership, association or corporation resident vendor and has maintained its headquarters or principal place of business continuously in West Virginia for four (4) years immediately preceding the date of this certification; or 80% of the ownership interest of Bidder is held by another individual, partnership, association or corporation resident vendor who has maintained its headquarters or principal place of business continuously in West Virginia for four (4) years immediately preceding the date of this certification;

or

☐ Bidder is a nonresident vendor which has an affiliate or subsidiary which employs a minimum of one hundred state residents and which has maintained its headquarters or principal place of business within West Virginia continuously for the four (4) years immediately preceding the date of this certification.

B. Application is made for 2.5% preference for the reason checked:

☐ Bidder is a resident vendor who certifies that, during the life of the contract, on average at least 75% of the employees working on the project being bid are residents of West Virginia who have resided in the state continuously for the two years immediately preceding submission of this bid;

or

☐ Bidder is a nonresident vendor employing a minimum of one hundred state residents or is a nonresident vendor with an affiliate or subsidiary which maintains its headquarters or principal place of business within West Virginia employing a minimum of one hundred state residents who certifies that, during the life of the contract, on average at least 75% of the employees or Bidder's affiliate's or subsidiary's employees are residents of West Virginia who have resided in the state continuously for the two years immediately preceding submission of this bid.

Bidder understands if the Secretary of Tax & Revenue determines that a Bidder receiving preference has failed to continue to meet the requirements for such preference, the Secretary may order the Director of Purchasing to: (a) rescind the contract or purchase order issued; or (b) assess a penalty against such Bidder in an amount not to exceed 5% of the bid amount and that such penalty will be paid to the contracting agency or deducted from any unpaid balance on the contract or purchase order.

By submission of this certificate, Bidder agrees to disclose any reasonably requested information to the Purchasing Division and authorizes the Department of Tax & Revenue to disclose to the Director of Purchasing appropriate information verifying that Bidder has paid the required business taxes, provided that such information does not contain the amounts of taxes paid nor any other information deemed by the Tax Commissioner to be confidential.

Under penalty of law for false swearing (West Virginia Code, §61-5-3), Bidder hereby certifies that this certificate is true and accurate in all respects; and that if a contract is issued to Bidder and if anything contained within this certificate changes during the term of the contract, Bidder will notify the Purchasing Division in writing immediately.

Bidder: _____ **Signed:** _____

Date: _____ **Title:** _____

*Check any combination of preference consideration(s) in either "A" or "B", or both "A" and "B" which you are entitled to receive. You may request up to the maximum of 5% preference for both "A" and "B".

RFQ No. _____

AFFIDAVIT

West Virginia Code §5A-3-10a states:

No contract or renewal of any contract may be awarded under this article to any vendor or prospective vendor when the vendor or prospective vendor or a related party to the vendor or prospective vendor is a debtor as defined in this section and the debt owed is an amount greater than five thousand dollars in the aggregate.

Definitions:

"Debt" means any assessment, penalty, fine, tax or other amount of money owed to the state because of a judgement, fine, permit violation, license assessment, penalty or other assessment presently due and required to be paid to the state or any of its political subdivisions, including any interest or additional penalties accrued thereon;

"Debtor" means any individual, corporation, partnership, association, limited liability company or any other form or business association owing a debt to the state or any of its political subdivisions;

"Related party" means a party, whether an individual, corporation, partnership, association, limited liability company or any other form or business association or other entity whatsoever related to any vendor by blood, marriage, ownership or contract through which the party has a relationship of ownership or other interest with the vendor, so that the party will actually or by effect receive or control a portion of the benefit, profit or other consideration from performance of a vendor contract with the party receiving an amount that meets or exceeds five percent of the total contract amount.

Exception:

The prohibition does not apply where a vendor has contested any tax administered pursuant to chapter eleven of the West Virginia Code, worker's compensation premium, permit fee or environmental fee or assessment, and the matter has not become final, or where the vendor has entered into a payment plan or agreement and the vendor is not in default of any of the provisions of such plan or agreement.

Under penalty of law for false swearing (West Virginia Code §61-5-3), it is hereby certified that the bidder and all related parties do not owe any debts or, if a debt is owed, that the provisions of the exception clause (above) apply.

Vendor's Name: _____

Authorized Signature: _____ Date: _____