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Plan Arranged By:



* * * * * **NOTICE** * * * * *

The products described in this booklet are part of a Cafeteria Benefits Plan arranged by Mark III Brokerage for eligible City of Dalton employees. The Cafeteria Benefits Plan allows you to pay for certain insurance premiums before taxes are taken out of your paycheck. Paying for benefits in this method reduces your taxes and increases your take home pay.

The plan year is January 1, 2010 through December 31, 2010.

All products described in this booklet are pre-taxed **EXCEPT:**

- **AIG Critical Illness Plan**
- **Standard Life Short Term Disability**
- **MetLife Group Term Life Insurance**
- **Texas Life Universal Life Insurance**

If you wish to add or make changes to your insurance coverage(s), please consult a Benefits Representative during your scheduled enrollment period. ***You will not be able to make any changes once the enrollment period is over*** unless you experience a qualified event (i.e., marriage, divorce, birth of a child, etc.)

All information in this booklet is a brief description of your coverage and is not a contract. Refer to your policy or certificate for each product for the exact terms and conditions.

Ameriflex FSA Plan

*Flexible Spending Account
With Debit Card*

Plan Information

- Maximum Annual Election:
 - \$5,000
- Minimum Annual Election:
 - \$50
- Waiting Period:
 - 30 days

.....
: *Ameriflex Flexible Spending Account allows you to* :
: *use pre-taxed dollars towards health care expenses* :
: *such as prescription and over-the-counter medica-* :
: *tion, certain medical procedures, copays, and more.* :
:
.....



Plan Year: January 1, 2010 to December 31, 2010

Medical Reimbursement Plan Maximum: \$5,000

Medical Reimbursement Plan Minimum: \$50

Run Off Period: 90 days following the end of the plan year to file for services rendered during the plan year.

Waiting Period: Coverage for new hires will be effective the first of the month following 30 days of continuous employment.

How the AmeriFlex Plan Works

If you participate, you will elect to have a specific amount of pre-taxed money deducted from your paycheck each pay period. These dollars are subtracted from your gross earnings before taxes and put into a Flexible Spending Account to cover eligible out-of-pocket cost. Once you submit a claim for a qualified expense, you will be reimbursed from this account.

- Lower your taxable income, pay less tax, increase your take-home pay.
- Participation is the equivalent to getting a raise.

| The following table illustrates how you save by participating in a FSA | | | |
|--|----------|-----------------------------------|----------|
| Without This Plan | | With This Plan | |
| Gross pay (annual) | \$30,000 | Gross pay (annual) | \$30,000 |
| Tax deductions (@25%) | \$ 7,500 | •Eligible expenses | \$ 1,000 |
| Take-home pay | \$22,500 | Taxable income | \$29,000 |
| •Eligible expenses | \$ 1,000 | Tax deductions (@25%) | \$ 7,250 |
| New take-home pay | \$21,500 | New take-home pay | \$21,750 |
| | | •Result (increased take-home pay) | \$ 250 |

Eligible Expenses

Medical Spending Account Eligible Expenses

A medical FSA is used to pay for healthcare expense not covered under your medical or other insurance plan. The IRS determines eligible expenses. IRS-qualified expenses may include:

- Co-pays, deductibles, and other payments you are responsible for under your medical plan
- Charges that may not be covered by your medical plan such as:
 - Routine exams
 - Dental care
 - Orthodontia
 - Eyecare; Lasik, glasses, contact lenses
 - Hearing aids
 - Well-baby care

- Miscellaneous expenses such as:
 - Many over-the-counter drugs; e.g., pain relief, sleep aids, allergy treatments
 - Transportation, tolls, and parking to receive medical care
 - Individual psychiatric or psychological counseling
 - Diabetic equipment and supplies
 - Durable medical equipment
 - Qualified medical products or services prescribed by a doctor

Some examples of ineligible expenses include insurance premiums, teeth whitening, prescription drugs for male pattern baldness, and most cosmetic procedures. A more comprehensive list of eligible medical and over-the-counter expenses is available on the AmeriFlex website. You can also refer to IRS Publication 502 for the complete list of medical expenses for reimbursement.

Dependent Day Care Spending Account Eligible Expenses

With a Dependent Day Care Account, you can set aside pre-tax payroll deductions to reimburse the expenses associated with day care for your qualified dependents. Eligible expenses must meet the following qualifications:

- The care of the dependent must enable you and your spouse to be employed
- The amount to be reimbursed must not be greater than your spouse's income or your income, whichever is less
- The child must be under 13 years old and must be your dependent under federal tax rules
- The services may be provided in your home or another location, but not by someone who is your minor child or dependent for income tax purposes (e.g., an older child)
- If the services are provided by a day care facility that cares for six or more children simultaneously, the facility must comply with state and local day care regulations
- Services must be for the physical care of the child, not for education, meals, etc.

Qualified dependent care expenses also include cost for the care of a spouse or dependent who is incapable of self-care, regularly spends at least eight hours per day in your home, has gross income below the exemption amount in IRS Code 151, is dependent on you for over half of their support, and is not anyone else's qualifying child (e.g., an invalid parent). The same rules that apply for child care apply to the care of other dependents, except the dependents need not be under age 13.

For more details on dependents day care eligible expenses, reference IRS Publication 503 - Child and Dependent Care Expenses, available on the AmeriFlex website.

Commuter Reimbursement Account Eligible Expenses

Commuter Reimbursement Accounts allow for the pre-taxing of qualified parking, transit, and commuter highway vehicle expense related to your transportation to and from work.

- Parking expenses are expenses incurred to park your vehicle on or near the business premises of the employer or expenses incurred to park your car at a location from which you commute to work by (a) mass transit facilities, (b) a commuter highway vehicle or (c) car-pool.

- Transit expenses are those incurred for a pass, token, fare card, voucher, or similar item (a pass) for transportation (a) on mass transit facilities, whether or not publicly owned or (b) provided a by a person in the business of transporting persons for compensation or hire if such transportation is provided in a vehicle with a seating capacity of at least six adults (excluding the driver).
- Commuter highway vehicle (van-pool) expenses are those incurred for transportation in a commuter highway vehicle when traveling between your residence and place of employment. A commuter highway vehicle is any highway vehicle with a seating capacity of at least six adults (not including the driver) and for which at least 80% of the mileage is for purposes of transporting employees between their residences and their places of employment, and where the number of employees is, on average, at least half of the adult seating capacity of the vehicle (not including the driver).

Funding Your Account

The maximum amount you can contribute to your FSA depends on the type of account you select. Your employer determines the maximum annual election for your Medical Flexible Spending Account while the government sets the maximum amount for your Dependent Day Care Spending Account and Commuter Reimbursement Account.

Determining Account Contributions

- Medical: Your employer determines the maximum allowable contribution for your Medical Flexible Spending Account. Within that maximum, you determine your contribution for yourself and your eligible dependents based on expenses you expect to incur in the upcoming plan year. Your annual contribution is then divided by your number of pay periods, and that amount will be deducted pre-tax each pay period.
- Dependent Day Care: The IRS has set the maximum allowable contribution per calendar year for a Dependent Day Care Spending Account as follows:
 - \$5,000 for a married couple filing jointly
 - \$5,000 for a single parent
 - \$2,500 for a married person filing separately
- Commuter: The maximum amount you may contribute to a Commuter Reimbursement Account is determined by the IRS. These amounts may change annually, so ask your employer for current maximums for parking expenses, transit passes and commuter highway vehicle expenses.

The Use-It-or-Lose-It Rule

If you contribute dollars to a reimbursement account and do not use all the money you deposit, you will lose any remaining balance in the account at the end of the eligible claims period. A very important thing to remember is that the rule exist because the IRS has established strict guidelines for plans with tax advantages.

Claims Process

To be reimbursed for any expense, you must first file a claim. You can file a claim in two ways, either manually or electronically. To file a claim manually, simply complete a claim form and mail or fax it to AmeriFlex along with substantiation of

the claim. Acceptable forms of substantiation include itemized receipts and the Explanation of Benefits (EOB) from your insurance carrier. Information required on all claim request include: the date of service, the product or service description drug names and numbers, the total dollar amount being requested, the service providers name, and, in the case of dependent day care request, the provider's signature and tax ID or Social Security number. When you submit a claim by fax or mail, your reimbursement will either be mailed or direct-deposited into your bank account, whichever you prefer. To eliminate the hassle of paper, faxing, and the time delays of mailing, simply use your AmeriFlex Convenience Card.

The AmeriFlex Convenience Card

The AmeriFlex Convenience Card is a MasterCard debit card providing electronic access to your FSA funds. The card provides the convenience of a single debit card with access to all your accounts.

Your AmeriFlex Convenience Card gives you easy access to the funds in your Flexible Spending Account(s). It works just like any other debit card, but with three important differences:

- First, its use is limited to specific merchants* and to expenses deemed eligible by your plan
- Second, you cannot use it at an ATM or to obtain "cash back" when making a purchase
- Third, you are not given a PIN with this. Should a merchant or provider ask you for a PIN, simply explain that this card does not require one. If given the option between debit and credit at the terminal, choose credit

*Every merchant that accepts MasterCard is assigned an MCC Code based on their type of business. Only a limited number of these codes apply to merchants providing products or services eligible for FSAs. Use of the AmeriFlex Convenience Card is limited to the day care providers; medical care providers such as hospitals, doctor's offices, optometrist, dentists, orthodontist, pharmacies, or other merchants providing prescription and over-the-counter eligible products; and CRA merchants such as parking garages or metro-card machines. In other words, your card cannot be used at non-qualified businesses such as gas stations, retailers, convenience stores, etc. For example: aspirin is an eligible expense in your Medical Flexible Spending account; however, you cannot purchase aspirin at your local convenience store because that type of business does not have an eligible MCC code. You would need to purchase your aspirin at your local pharmacy or other qualifying business to use the card. However, under new regulations, if the merchant has an IRS approved inventory management system that provides SKU level data on the item, it can automatically determine if an expense is eligible, eliminating the MCC code restriction. Check with your local retailer to find out if they already have or may be adding this system.

Your Card Account Balances and Transaction Receipts

- What if there's not enough money in my account?

If you charge more than the available balance in your account, the transaction will be declined. You can find your balance online at www.flex125.com or by calling the AmeriFlex Interactive Voice Response System, which is available 24/7. Review your account balance to avoid declined charges.

- Do I need the receipts?

Possibly, so please save all of your itemized receipts for certain expenses, AmeriFlex may need additional information, including receipts, to verify eligibility of the expenses and to comply with IRS rules. That's why it's important for you to save all your receipts, then fax or mail them promptly if requested. Failure to comply could jeopardize the tax-exempt status of your account and cause the card to be deactivated

FSA Election Changes

What if I want to make a change to my FSA Election?

The latest set of cafeteria plan regulations develops a process for determining if a participant is allowed to make a change in election during the plan year. A change in status must have occurred and that event must fall into one of the following categories:

- Changes in provider (Dependent Day Care only)
- Changes in cost of day care (Dependent Day Care only)
- Changes in legal marital status
- Changes in number of dependents
- Changes in employment status
- Changes in work schedule (increase or decrease in hours)
- Dependent satisfies (or ceases to satisfy) requirements for eligibility

The election change must be consistent with the status-change event. A change is consistent with the event for Medical Flexible Spending accounts if the following occurs:

- The employee, spouse, or dependent is gaining or losing eligibility for health coverage
- The election change corresponds with that gain or loss of coverage

For Commuter Reimbursement Accounts, elections can be made for a period as short as one month. Check with your human resources department to see how often you can change your CRA election.

Employee Termination/Claims Procedures

AmeriFlex will deactivate the terminated employee's AmeriFlex Convenience Card on the Date of Termination listed above. Claims may be incurred up to the Date of Termination. However, the IRS defines "participation" as "making pre-tax contributions to the plan," therefore if the employee's last payroll deduction occurs after their Date of Termination, they may continue to incur claim through the date of their last payroll deduction. Those claims must be submitted for processing on a Manual Claim Form and can be submitted for a period of 90 days from the date of last payroll deduction or through the end of the eligible claims period (as defined in the Summary Plan Description), whichever occurs first.

Tax Implications

Will pre-taxing have an Impact on Social Security benefits?

Reductions in your taxable pay may lead to a reduction in Social Security benefits; however, for most employees, the reduction in Social Security benefits is insignificant when compared to the value of paying lower taxes now.

Dependent Day Care

On your tax return you must report the correct name, address, and taxpayer identification number (TIN) of your dependent care provider. If your dependent care provider is exempt from federal income taxation, you are not required to report the TIN; however, you must report the correct name and address of the exempt provider and write "tax exempt" in the space provided for the TIN.

Tax Credits vs. Dependent Care Spending Accounts

If you participate in a Dependent Care Spending Account, you cannot claim credits on your income tax return for the same expenses. Also, any amount reimbursed under this plan will reduce the amount of other dependent care expenses that you can claim for purposes of tax credits. Before you enroll in a Dependent Day Care Account, evaluate whether the federal income tax credit or the Dependent Care Spending Account is best for you. Refer to the following federal tax forms and publications for more information (available at www.irs.gov):

- Form 2441 (Child and Dependent Care Expense);
- Form 1040 Schedule EIC and IRS Publication 596 (Earned Income Credit);
- Form 8812 and IRS Publication 972 (Child Tax Credit)
- Frequently Asked Questions

List of Eligible Expenses

1. **Abortion/Yes:** Fees paid to obtain a legal abortion are medical expenses;
2. **Acupuncture/Yes:** Fees paid for acupuncture are eligible medical expenses;
3. **Adoption/Maybe:** You can include medical expenses you paid for your child before adoption, if the child qualified as your dependent when the services were rendered. Fees for medical expenses or any fees relating to the adoption process incurred prior to the beginning of adoption negotiations are not eligible. Medical expenses associated with an adopted baby's birth incurred by the birth mother are also not eligible;
4. **Air Conditioning, Air Purifier, Humidifier/Maybe:** The cost of an air conditioner recommended by a physician as treatment for a specific medical condition is an eligible expense. If the value of the home increases then these amounts are not reimbursable;
5. **Alcoholism Treatment/Yes:** Payments to a treatment center for alcohol or drug addiction are eligible medical expenses. This includes meals and lodging provided by the center during medical treatment. You may include transportation cost incurred to attend Alcoholic Anonymous (AA) meeting recommended by the attending physician, when submitted with supporting documentation;
6. **Ambulance/Yes:** Fees submitted for ambulance service are covered;
7. **Anesthesiology/Yes:** Fees for anesthesiology are covered;
8. **Arch Support/Maybe:** Qualifies as a medical expense only if prescribed by a physician as a treatment and when submitted with documentation supporting a specific medical condition;
9. **Artificial Insemination/Yes:** See fertility
10. **Artificial Limb/Yes:** Expenses for the purchase of an artificial limb qualify as medical expenses;
11. **Artificial Teeth/Yes:** You can include in medical expenses the amount you pay for artificial teeth;
12. **Asthma Equipment/Yes:** Nebulizers or peak flow meters prescribed for treatment of asthma are eligible expenses;
13. **Birth Control/Yes:** Expenses associated with the purchase of birth control purchased over the counter or prescribed by a doctor are eligible expenses (e.g., IUD, diaphragm, Norplant, condoms);
14. **Birthing Coach/No:** Expenses associated with a birthing assistant/coach for women in labor are not considered eligible medical expenses;
15. **Bleaching of Teeth/No:** Bleaching of teeth is not an eligible medical expense;

16. **Blood donation/Yes:** Expenses associated with blood donation qualify as medical expenses;
17. **Braille Books/Magazines/Yes:** The cost of braille books and magazines for use by visually impaired persons qualifies as a medical expense. Eligible expense include only the amounts over the cost of the products in its standard form;
18. **Breast Augmentation/No:** Expenses related to breast augmentation (such as implants or injections) are not reimbursable because the procedure is considered cosmetic in nature;
19. **Breast Implant Removal/Maybe:** The removal of breast implant that are defective or are causing a medical problem are reimbursable;
20. **Breast Pump (purchase or rental)/Maybe:** The cost of a breast pump is considered a medical expense if the pump needs to be used to treat a medical condition;
21. **Breast Reduction/Maybe:** Medical expenses related to breast reduction surgery are reimbursable only if the physician substantiates that the procedure is medically necessary. i.e., to prevent or treat an illness or disease;
22. **Capital Expenses/Maybe:** Amounts paid for special equipment to be installed in you home for improvement qualify as medical expenses if there is documentation from a physician that the equipment is mainly needed for or as a result of a specific medical condition. If the capital expenditure increases the value of the property, excess value is not reimbursable. Improvements made to accommodate a residence for a person's disability do not usually increase the value of the residence, and the full cost is usually reimbursable. Only reasonable cost to accommodate a personal residence for a disabled condition are considered medical care. Additional cost for personal motives, such as for architectural or aesthetic reasons, are not reimbursable;
23. **Car Modification/Maybe:** Special hand controls and other special equipment installed in a car for use by a disabled person qualify as medical expenses;
24. **Childbirth Classes (lamaze)/Maybe:** Some of the expenses may qualify; Expenses for instructions relating to the birth of the child are eligible for the mother to be. Fees for instructions in topics such as newborn care are not eligible. Expenses for the coach or significant other do not qualify;
25. **Chiropody/Yes:** Fees paid to a chiropodist (chiropractic foot doctor) for medical care are eligible expenses;
26. **Chiropractors/Yes:** Fees paid to chiropractor are eligible;
27. **Christian Science Practitioner/Maybe:** Fees paid to a Christian Science Practitioner are eligible expenses when treatment is rendered for a specific medical condition;
28. **Circumcision/Yes:** Circumcision is a covered medical expense. This procedure is also covered if performed in the member's home by a rabbi;
29. **COBRA Premiums/No:** Premiums paid for COBRA benefits are not a covered expense;
30. **Collagen Injections/Maybe:** Collagen injections are considered to be cosmetic, however, may be covered if medically necessary (e.g., for treatment of severe acne);
31. **Contact Lenses, Solutions, Supplies, and Warranties/Yes:** Expenses,

- including shipping and handling incurred for the purchase of contact lenses, qualify if the contact lenses are need for medical reasons. Amounts paid for contact lens solutions and supplies qualify as medical expenses. Fees paid for eye exams are also eligible;
32. **Copays/Coinsurance/Yes:** A copay or coinsurance fee qualifies as a medical expense;
 33. **Cosmetic Treatment/Maybe:** Generally, medical expenses paid for unnecessary, i.e., elective, cosmetic treatment are not covered. (This applies to any procedure that is directed at improving the patient appearance and that does not meaningfully promote the proper function of the body or prevent or treat an illness or disease.) Examples if non-covered cosmetic surgery procedures include breast augmentation, chemical electrolysis, face lift, hair transplant, liposuction, and tattoo removal. Expenses incurred for cosmetic surgery necessary to improve a deformity arising from or directly related to a congenital abnormality, a personal injury or a disfiguring disease qualifies as eligible medical expenses;
 34. **Counseling/Maybe:** Amounts paid for counseling which is medically necessary to treat a specific medical or mental illness is covered. Marriage counseling and Family counseling are not covered expenses;
 35. **CPR Classes/No:** CPR classes are not considered “medically necessary”; therefore, the expense is not reimbursable under FSA;
 36. **Dancing Lessons/Maybe:** Amounts paid for dancing lessons do not normally qualify as medical expense. But the expense may qualify if recommended to treat a specific medical condition (such as part of a rehabilitation program after surgery);
 37. **Deductible/Yes:** Deductible qualify as medical expenses;
 38. **Dental Treatment/Yes:** Amounts paid for dental treatments qualify as medical expenses. This includes fees paid to dentist for X-rays, fillings, braces, extractions, dentures, caps, crowns, fluoride treatments, implants, etc. In addition, the installation and monthly rental charges for fluoride treatments to home water qualify as medical expenses when prescribed by a physician or dentist. However, the amount should be limited to the cost allocable to the current plan year;
 39. **Denturist/Yes:** Fees paid to a denturist qualify as health care expenses when services are for the treatment of a specific medical condition;
 40. **Dermatology/Yes:** Fees paid to a dermatologist for medical care qualify as medical expenses;
 41. **Diabetic Equipment and Supplies/Yes:** Medical expenses may include amounts paid for the following equipment and supplies for treatment of diabetes; glucose monitor, urine/blood test strips, insulin, and syringes and alcohol swabs.
 42. **Diagnostic Services/Yes:** Fees paid for diagnostic services, as prescribed by a physician, are eligible medical expenses.
 43. **Diapers - Diaper services/Maybe:** Amounts paid for adult diapers or a diaper service, qualify as a medical expense if prescribed by a physician to relieve the effects of a specific medical condition. Diaper expenses for handicapped individuals beyond infancy are also covered.
 44. **Dietitian/Maybe:** Fees paid to a dietitian are eligible when referred by a physician for treatment of a specific medical condition.
 45. **DNA Testing/No:** DNA testing for paternal responsibility is not considered an eligible expense.

- 46. Domestic Partners/Maybe:** Medical expense incurred by domestic partners are usually not eligible for reimbursement from an FSA. Members should consult with their plan sponsors on domestic partner coverage.
- 47. Drug Addiction -** See Alcoholism
- 48. Durable Medical Equipment (DME)/Yes:** The cost associated with the purchase or rental of durable medical equipment that is prescribed by a medical practitioner to alleviate or treat a specific medical condition qualifies as an eligible expense. Cost can include: bed wetting alarm, blood pressure kit, chair*, crutches, hearing aids, medical alert equipment, and oral hygiene equipment.
*Reimbursement is only for the amount that exceeds the cost of a similar or regular product. Letter of medical necessity only needed for items that have a dual purpose (e.g. chair, sheets, oral hygiene equipment).
- 49. Ear Piercing/No:** Expenses associated with ear or body piercing are not eligible medical expenses.
- 50. Educational Classes/No:** Educational classes are not eligible medical expenses (care for a newborn, breast feed, cope with diabetes, etc.).
- 51. Electrolysis/No:** See Cosmetic Treatment
- 52. Eyeglasses/Supplies (e.g. storage case, replacement cost), Warranties/ Yes:** Amounts paid for prescription vision/sports eyewear, supplies (i.e. eyeglasses, goggles, sunglasses) for a medical condition qualify as a medical expense. Fee paid for eye exams are also eligible. Tinting of prescription eyewear qualifies as an eligible medical expense.
- 53. Exercise Equipment/Maybe:** Exercise equipment may be covered when prescribed by a physician as treatment for a specific medical condition. Exercise equipment used for improvement of general health is not covered.
- 54. Fertility/Yes:** Medical expenses associated with the treatment of infertility, including shots, in vitro fertilization and artificial insemination incurred by the member, are reimbursable. Semen and embryo storage associated with an active attempt to conceive are also eligible for reimbursement. Note: donor expenses incurred by the member (egg donation, sperm donation) are eligible during active treatment only, if expenses are not covered by a medical plan. The cost of an ovulation kit qualifies as an eligible medical expense.
- 55. Flu Shot/Yes:** Flu shots are eligible medical expenses.
- 56. Guide Dog or Animal/Yes:** The cost of a guide dog or other animal to be used by the visually impaired or hearing impaired qualifies as a medical expenses. The cost of a dog or other animal trained to assist persons with other disabilities can also be covered. Amounts paid for the care of these specially trained animals are also available.
- 57. Gynecologist/Yes:** Fees paid to a gynecologist for medical care are eligible medical expenses.
- 58. Health Club/Maybe:** Dues paid to a health club, YMCA, YWCA or spas are allowable when the member submits documentation from the attending physician stating that the membership expenses are for treatment of a specific medical condition. Reimbursement should be only for the individual membership and for the component that is related to a single year. Any dues that carry over to a subsequent year would violate this IRS rule of constructive receipt. Health club dues, YMCA/YWCA dues or amounts paid for steam baths for your general health or to relieve physical or mental

- discomfort not related to a particular medical condition are not eligible medical expenses.
59. **Health Screenings/Yes:** See Diagnostic Services
 60. **Holistic-Homeopathy Practitioner/Maybe:** Fees paid to a holistic or homeopathy doctor are eligible when treatment is provided for a specific medical condition.
 61. **Hospital Services/Yes:** Amounts paid for hospital services that are not covered under a medical plan qualify as medical expenses (e.g., upgrade from semi-private to private room, fees charged for parents to stay with a child, etc.). (also see Lodging/Trips)
 62. **Human Guide/Yes:** Expenses for a human guide - to take a blind child to school for example - are reimbursable.
 63. **Hypnosis/Maybe:** Hypnosis is considered a medical expense when it is prescribed by a physician as treatment for a specific medical or mental condition.
 64. **Insurance Premiums/No:** Amounts paid as premiums to purchase health care coverage are not eligible medical expenses. This includes COBRA, Medicare A&B premiums.
 65. **Laboratory Fees/Yes:** Amounts paid for laboratory fees that are part of your medical care are eligible expenses.
 66. **LASIK Eye Surgery/Yes:** Expenses associated with LASIK/PRK or radical keratotomy surgery to correct impaired vision are eligible.
 67. **Late Fees Payments/No:** Late fees associated with payment of medical expenses are not eligible.
 68. **Lead Paint/Asbestos Removal/Maybe:** Cost of removing lead-based paints/asbestos from surfaces in a home to prevent a child who has (or has had) lead poisoning from eating the paint are eligible expenses. The cost of repainting is not reimbursable.
 69. **Learning Disability** - See Schools, Special
 70. **Legal Fees/Maybe:** Legal fees may qualify as medical care if they bear a direct or proximate relationship to the provision of medical care to you, your spouse or your dependent.
 71. **Lifetime Care Advance Payments/No:** Prepayments of life care fees or founders fees paid monthly or as lump sum under an agreement with a retirement home are not eligible expenses. These payments are considered premiums.
 72. **Lodging - Trips/Maybe:** The cost of meals and lodging at a hospital or similar institution qualify as medical expenses if the main reason for being there is to receive medical care. Expenses incurred for transportation to another city are eligible health care expenses if the trip is primarily for and essential to receiving medical services. You may also be able to include up to \$50 (refer to IRS Publication 502) per person, per night for lodging. You cannot include in medical expenses amounts you pay for a trip or vacation taken for a change in environment, improvement of morale or general improvement of health, even if a doctor recommends the trip.
 73. **Marijuana/No:** Expenses associated with marijuana when purchased or used under state laws for treatment of a medical condition are not eligible for reimbursement. This drug remains illegal under federal law and does not qualify as a Sect. 13 medical expense.
 74. **Massage Therapy/Maybe:** Massage therapy is covered if the member

- submits documentation from a physician confirming that massage therapy is prescribed as treatment of a specific medical condition. The physical should also include the frequency and duration of the therapy. Massage therapy for general health does not qualify as a medical expense.
75. **Maternity Charges/Yes:** Amounts paid to physicians for delivery charges qualify as eligible expenses.
 76. **Maternity Clothes/No:** The cost of maternity clothing is not an eligible expense.
 77. **Mattresses/Maybe:** Amounts paid for a mattress or special bedding for a person with documentation supporting a medical condition is a medical expense, but only for the amount that exceeds the cost of similar regular bedding. Proof of the cost of regular bedding is necessary to pay the expense.
 78. **Meals/Maybe:** Meals associated with inpatient medical care are eligible expenses.
 79. **Medical Plan Information/Yes:** Payments for services to keep your medical information so that it can be retrieved from a computer data bank are an eligible medical expense. Fee associated with copying medical records are also eligible.
 80. **Medical Services/Yes:** Eligible medical expenses for treatment of specific medical conditions include fees paid to Doctors, Surgeons, Specialist, or other medical practitioners.
 81. **Medicines/Yes:** Eligible medical expenses include amounts paid for prescribed medicines and drugs. A prescribed drug is one that requires a written order by a medical practitioner and is dispensed through a pharmacy for its use by an individual. You may include expenses you pay for delivery charges, postage and handling of mail-order prescribed drugs. Also see Over-the Counter Drugs section.
 82. **Mentally Retarded (Special Home For)/Maybe:** Expenses associated with keeping a mentally retarded in a special home (not the home of a relative) on the recommendation of a psychiatrist to help the person adjust to life in a mental hospital to community living is an eligible expense.
 83. **Mouth Guards/Yes:** Occlusal guards prescribed by a dentist to prevent a person from grinding his/her teeth at night are eligible expenses.
 84. **Neurologist Fees/Yes:** Fees paid to a neurologist for treatment of a specific condition qualify as medical care and are eligible for reimbursement.
 85. **Nursing Home/Maybe:** Medical expense associated with the cost of medical care provided in a nursing home or home for the aged for an employee, spouse or dependent are eligible for reimbursement (i.e., with a bill from a provider or facility for medical services). This includes the cost of meals and lodging in the home of the main reason for being there is to receive medical care. Non-medical expenses are not eligible.
 86. **Nursing Services/Yes:** Wages and other amounts paid for nursing services are eligible medical expenses. This includes services connected with caring for the patient's condition, such as dispensing medications changing dressings, bathing and grooming the patient. Only the amount spent for nursing services is a medical expense. If the attendant also provides personal and household services, these amounts must be divided up between the times spent performing household and personal services and the time spent for nursing services. However certain expenses for household

- services or for the care of a qualifying individual incurred to allow an employee to work may qualify for the child and dependent care credit. See Publication 503, Child and Dependent Care Expense.
87. **Nutritional Supplements/Maybe:** Special foods or nutritional supplements are only covered if there is supporting documentation from a physician that they were prescribed as treatment for a specific medical condition.
 88. **Optometrist/Yes:** See Contact Lenses & Eye Glasses
 89. **Organ Donor/Yes:** Donor's expenses that are paid by the FSA enrollee are eligible for reimbursement.
 90. **Orthodontia/Yes:** Out-of-Pocket orthodontia expenses are eligible for reimbursement. AmeriFlex's policy is to reimburse only the prepaid amount corresponding to the member's current enrolled plan year. Prepaid expenses are subject to proof of payment (i.e., cancelled check, bill from provider indicating payments or credit card receipts). You will also be required to initially submit a copy of the orthodontia treatment contract.
 91. **Orthopedic Shoes/Yes:** Amounts paid for special shoes are eligible medical expenses, but for the amount that exceeds the cost of regular footwear.
 92. **Over-the-Counter Medication/Yes:** See Over-the-Counter section
 93. **Oxygen/Yes:** Amounts paid for oxygen or oxygen equipment to relieve breathing problems caused by a medical condition is eligible.
 94. **Parking** - See transportation
 95. **Personal Trainers/Maybe:** Fees paid to personal trainers are eligible for reimbursement if recommended by a medical practitioner to treat a specific medical condition. The use of personal trainers for improvement of general health is not covered.
 96. **Personal Use Items/Maybe:** Personal use items used primarily to prevent or alleviate physical or mental defect or illness are an eligible medical expense when accompanied with documentation supporting a specific medical condition. For example, the full cost of a wig purchased upon advice of a physician for the mental health of a patient who has lost all of his/her hair from disease, can be included as medical expenses.
 97. **Physical Exam for Caregiver/No:** Expenses for a physical exam for a potential caregiver are not expenses for the care of a qualifying individual, nor do they fit into the definition of a household expense.
 98. **Physical Therapy/Yes:** Physical therapy is covered only if the member submits documentation from a physician confirming that physical therapy is prescribed as treatment for a specific medical condition. The physician should also include the frequency and duration of the therapy.
 99. **Prescription Drugs/Yes:** See Medicines
 100. **Prosthesis/Yes:** See Artificial Limb
 101. **Psychiatric /Yes:** Amounts paid for psychiatric care are eligible for reimbursement. This includes fees associated with the care of a qualifying individual in a specially equipped medical center where the dependent receives medical care when prescribed by a physician.
 102. **Psychoanalysis/Yes:** Amounts paid for psychoanalysis qualify as medical expenses.
 103. **Psychologist/Yes:** Fees paid to a psychologist for medical care are eligible medical expenses when submitted with documentation supporting a specific medical condition.

- 104. Reasonable & Customary/Yes:** Amounts that exceed Reasonable & Customary fees qualify as medical expenses.
- 105. Schools, Special/Maybe:** Payments to a special school for a mentally impaired or physically disabled person qualify as eligible health care expenses if the main reason for using the school is relieving the disability. Cost can include: teaching Braille to a visually impaired child, teaching lip reading to a hearing impaired child, giving remedial language training to correct a condition caused by a birth defect. The cost of meals, lodging and ordinary education supplied by a special school can be covered medical expenses only if the main reason for the child being there is the resources the has for relieving the mental or physical disability.
- 106. Smoking Cessation Program/Yes:** Expenses associated with the cost of a stop-smoking program are eligible health care expenses and do not require letter of medical necessity.
- 107. Speech Therapy/Yes:** Expenses associated with speech therapy are eligible when prescribed as treatment for medical condition (e.g., autism or dyslexia).
- 108. Sperm Storage/Maybe:** Fees paid for storage of sperm for treatment of infertility are eligible health care expenses. Storage fees paid for non-medical reason are ineligible.
- 109. Stem Cell Storage/Maybe:** This expense is reimbursable if used in treatment of a specific medical condition. The cost to collect, freeze and store stem cells would also be eligible as long as a specific medical condition is present. The amount that is not covered under regular medical coverage would be a reimbursable expense.
- 110. Sterilization/Yes:** The cost of obtaining a legal sterilization or to reverse sterilization is an eligible health care expense.
- 111. Substance Abuse - See Alcoholism**
- 112. Sunglasses/Maybe:** The cost of prescription sunglasses are allowable.
- 113. Surrogate Mother/Maybe:** Flexible Spending Account members who fulfill the role of surrogate mother may submit for reimbursement for qualified medical expenses incurred that is not covered by insurance. Medical expenses incurred by a third party, i.e., a surrogate mother, are not considered eligible expenses. Fees paid to an agency to search for a surrogate mother are not considered eligible for reimbursement.
- 114. Swim Therapy/Maybe:** Expenses associated with swim therapy or a swim club membership when prescribed by a medical practitioner as treatment for a specific medical condition (e.g., rheumatoid arthritis) are eligible health care expenses. Swim lessons to learn fundamentals of swimming are not eligible health care expenses.
- 115. Taxes/Yes:** Taxes incurred for medical services or products qualify as eligible health care expenses (e.g., sales tax and state hospital bill surcharges).
- 116. Telephone/Maybe:** Expenses associated with enhancing a telephone to accommodate a deaf person or person with disabilities are eligible health care expenses.
- 117. Telephone Consultation (Physician's Fees)/Yes:** Fees charged by physicians for telephone consultation are eligible health care expenses. The phone charge is also an eligible expense.
- 118. Television/Maybe:** Expenses associated with the cost of modifying a

television to assist a handicapped person are eligible health care expenses. Cost may include an adapter that attaches to a regular television. It may also include the cost of a specifically equipped television. Eligible reimbursement is the cost associated with the specialization over the cost of a similar standard model.

119. Transplants/Yes: See Organ Donor

120. Transportation/Maybe: Amounts paid for transportation primarily for, and essential to, medical care qualifies as medical expenses when submitted with documentation supporting a specific medical condition. Included are: ambulance services, buses, car rentals, parking fees, plane fare, taxis, tolls, and personal care - (.20 a mile) effective calendar year 1/1/07. Transportation expenses can be covered for a nurse who provides medical services to the patient who is traveling to get medical care and is unable to travel alone. Transportation expenses to see a mentally ill dependent are covered, if the visits are recommended as part of the treatment. Commuting expenses for a physically disabled person are not covered. IRS Publication 502 indicates that transportation expenses to travel to another city will not qualify as an eligible expense when a member elects the destination.

121. Tuition/Maybe: Expenses charged for medical care included in the tuition of a college or private school are eligible health care if the charges are separately stated in the bill provided by the school. Medical coverage premiums attached to a college tuition or private school bill do not qualify as an eligible expense.

122. Tutoring/Maybe: Tutoring fees paid on a doctor's recommendation for a child's tutoring by a specialized teacher qualify as medical expenses with documentation supporting a specific medical condition.

123. Umbilical Cord Blood/Maybe: Expense is reimbursable if used in treatment of a medical condition. The amount not covered under regular medical coverage would be a reimbursable expense. The cost to collect, freeze and store umbilical cord blood would be eligible as long as a medical condition is present.

124. UVR Treatments/Yes: UVR treatments are eligible expenses when recommended by a physician for a medical condition. (e.g., chronic psoriasis)

125. Vaccinations/Yes: Amounts paid for vaccinations or immunizations against disease are eligible medical expenses.

126. Vasectomy/Yes: Medical expenses paid for a legal vasectomy are covered.

127. Varicose Vein Surgery/Maybe: Expenses associated with the removal of varicose veins prescribed by a doctor for the treatment of a specific medical condition are eligible health care expenses. Removal for cosmetic purposes is not an eligible expense.

128. Weight Loss Drugs/Maybe: Weight loss drugs prescribed by a physician to treat a medical condition (e.g., morbid obesity, hypertension) are eligible for reimbursement. Weight loss drugs associated with general weight loss are not eligible for reimbursement.

129. Weight Loss Programs/Maybe: Medical expenses paid for a weight loss program prescribed by a doctor for treatment of a specific medical condition (e.g., high blood pressure, heart disease) are covered. Reimbursement should be only for the component that is related to a single calendar year. The member should submit documentation from the attending physician

prescribing the weight loss program confirming that it was medically necessary for a specific medical condition and not for general health enhancement.

130.X-rays/Yes: X-ray fees associated with medical care qualify as eligible health care expenses.

Over-The-Counter Medications

Allergy Prevention & Treatment - Benadryl, Sudafed, Actifed, Claritn, ChlorTrimeton, and Nasalcrom.

Anesthetics - Sucrets and other throat lozenges; Bactine and its equivalent, Aspercreme, and other topical anesthetics.

Antifungal - Femstat, Gyne-Lotrimin, Micatin, Monistat, etc., and their generic equivalents. Antimicrobial EZ scrub and similar disinfectants used on the body only. Antibacterial soap not included.

Anti-itch - Caldecort, Cort-aid, Lanacort, etc., and their generic equivalents. Hydrocortisone.

Antihistamine - Benadryl, Claritn, Allerest, Chlor-Trimeton, Dimetane, Sudafed Plus, Tavist, Triaminic, Drixoral, Actifed, and their generic equivalents. Ivy Block for poison ivy. Nasalcrom and similar antihistamine nasal sprays.

Contraceptives (over-the-counter) - Yes. IRS officials have informally said that the cost of over-the-counter contraceptives, such as condoms and spermicides are reimbursable if they aren't a drug or biological.

Decongestant - Afrin, Chlor-Trimeton, Duration, Dristan, Neo-Synephrine, Orrivin, Sudafed, Triaminic, etc., and their generic equivalents.

Diagnostic tests - Home-based kits for pregnancy, blood glucose for diabetes, and similar test kits.

Family planning - Contraceptives of any kind, pregnancy testing and ovulation testing kits.

Head lice treatment - RID and similar head lice treatments.

Hemorrhoid - Preparation H, Plazo, and similar treatments.

Pain relief - Actron, Advil, Aleve, Motrin, Nuprin, Orudis, Tylenol etc., and their generic equivalents.

Parasite treatments - Pin-X, EZ Scrub, and other such items for intestinal worms, ringworm etc.

Sleep aides - Unisom, Sominex, Excedrin PM, Nyquil, etc., and their generic equivalents.

Smoking cessation - Nicotine gum, lozenges and patches.

Sprain/strain - Bandages, Ben-Gay, and similar medication, and other items used to treat sprains and strains.

Stomach and digestive ailments - Medications used to treat heartburn, upset stomach, constipation, diarrhea, etc. AXID, Imodium, Pepcid, Pepto-Bismol, Prilosec, Tagamet, etc. and their generic equivalents. Enemas, Ex-Lax, and other laxatives.

Sunburn care - Solarcaine, and equivalent generics.

Swimmer's ear - Swim-ear and equivalent generics.

Vision care items - Contact lens solution, reading glasses glass eye, eye drops such as Visine and Ocuclear.

Wart removal - Compound W and similar medication

Wound care/First Aid - Antibiotic cream, Bactine, band-aids, and other 'first-aid' wound care treatments

Eligible with Doctor's Note:

Acne treatments - Clearasil, Stridex, sodium sulfocetamide, benzoyl peroxide products and similar treatments. Facials, aesthetician treatments, etc., and skin care treatments, if accompanied by a doctor's note indicating they are for treatment of acne.

Iron supplements - If accompanied by a doctor's note indicating they are for treatment of active anemia.

Calcium supplements - If accompanied by a doctor's note indicating they are for treatment of osteoporosis.

Over-the Counter Medications (partial list of OTC-eligible items by brand name)

| | | | |
|---------------|---------------|------------------|-----------------|
| Abreva | Correctol | Lotrimin | Phillips |
| Actidil | CQ | Maalox | Pin-X |
| Acitifed | Delsym | Maltsupex | Premysym PMS |
| Actron | Destin | Marizine | Preparation H |
| Advil | DexAlone | Metamucil | Prilosec |
| Afrin | Di-Gel | Micatin | Primatene |
| Afrinol | Diabe-Tuss DM | Midol | Privine |
| Aleve | Diametane | Mitrolan | Prodiem |
| Alka-Mints | Dimetapp | Monistat | Propagest |
| Alka-Seltzer | Doan's | Motrin | Pseudo 60's |
| Allerest | Donnagel | Mycelex-7 | Rheaban |
| AternaGel | Doxidan | Mylanta | Robitussin |
| Amphojel | Dramanine | Naphcon A | Rolaids |
| Arco-Lase | Dristan | Nasal crom | Safe Tussin 30 |
| Ascriptin | Drixoral | Natur-vent | Senokot |
| Aspirin | Dulcolax | Nature's Remedy | Sinarest |
| Axid AR | Duration | Neo-Synephrine | Sine-Off |
| Backache Caps | Ecotrin | Nicoderm | Singlet |
| Bactine | Efidac | Nicorette | Sinulin |
| Balmax | Emetrol | Nicotine Patches | Sinutab |
| Bassaljel | Ex-Lax | Nicotrol | St. Joseph |
| Bayer | Excedrin | Nix | Sucrets |
| BC Powder | Femstat 3 | Nolahist | Sudafed |
| Benadryl | FiberCon | Nostrills | Surfak |
| Benamist | Fleet Sof-Lax | Novahistine | Surpass Antacid |
| Benylin | Gas Aid | Nuprin | Tagament HB |
| Benzedrex | Gas-X | Nyquil | Tavist |
| Bonine | Gaviscon | Nytol | TheraFlu |

| | | | |
|-----------------|----------------|-----------------|------------|
| Bufferin | Goody's | OcuHist | Titralac |
| Caladryl | Gyne-Lotrimin | Orajel | Triaminic |
| Calamine Lotion | Halfprin | Orrvin | Tronolane |
| Caldecort | Halls | Orudis KT | Tums |
| Cepacol | Hemroids | Otrivin | Tylenol |
| Chloraseptic | Hydrocortisone | Pamprin | Unifiber |
| Chlor-Trimeton | Imodium | Pediacare | Unisom |
| Citrucel | Ivy Block | Pediatric Vicks | Vagistat-1 |
| Claritin | Kaopectate | Pepsid | Vanquish |
| Colace | Kondremul | Pepto-Bismol | Vasocon-A |
| Cortaid | Konsyl | Percogesic | Vicks |
| Commit | Lactaid | Perdiem | Zantac |
| Comtrex | Lamisil | Peri-Colance | |
| Contac | Lanacort | Pertussin | |
| Coricidin | Legatrin | Phazyme | |



- **24/7 Interactive Voice Response (IVR):** 888.868.3539 (option 2, option 2 for automated account balances and claims status)
- **Toll-Free Phone:** 888.868.3539 (option 2, option 3, 8:30 a.m. to 5:30 p.m. EST)
- **Web:** www.flex125.com (select Employees from the flex menu, then view your account activity)
- **Email:** service@flex125.com
- **Fax:** 856.631.1020
- **Mail:** 700 East Gate Drive, Suite 510, Mount Laurel, NJ 08054

Ameritas Dental Plan

Plan Highlights

- Coverage for Preventive Dental Services
- Coverage for Basic and Major Dental Services
- Coverage for Orthodontics

A frown is worthless . . .

But a smile is priceless!



Combined Calendar Year Deductible

\$50.00 per individual for Type 2 - Basic Procedures and Type 3 - Major Procedures (3 times family limit). After the date that 3 covered family members have each satisfied their individual deductible the entire deductible or any remaining portion of the deductible for any family member will be waived for the rest of that calendar year.

Type 1 - Preventive and Diagnostic

- Type 1 benefits are payable at 100% U&C*. **No deductible applies.**

- Evaluations (Two per calendar year)
- Cleanings (Two per calendar year)
- Fluoride for Children (Once a year)
(Under age 19)
- Space Maintainers
- Radiographs (X-rays)
- Bitewings x-rays
(Two per calendar year)

Type 2 - Basic Procedures

- Type 2 benefits are payable at 80% U&C* \$50.00 deductible applies.

- Sealants (under 17)
- Anesthesia
- Denture Repair
- Periodontics (Gum Disease)
- Oral Surgery
- Restorative Amalgam & Resin
- Endodontics (Root Canal)

Type 3 -Major Procedures

- Type 3 benefits are payable at 50% U & C* \$50.00 deductible applies.

- Restorative - Crowns
- Prosthodontics - Fixed Pontics
or Abutment
- Recement/Repair- Crowns
- Prosthodontics-
(Removable Dentures, Partials)
- Crown Repair

Orthodontia - Adult & Children

• Paid at 50% U & C* with a \$1,000 lifetime maximum per person. **No deductible applies.**

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

*Percentage Paid based on Usual and Customary Charges

Annual Maximum Benefit

- Type I, 2, and 3 Procedures - \$1,000 per calendar year per person.
- Orthodontia Procedures - \$1,000 Lifetime per person (carryover does not apply)

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

1. Visit a dentist between January 1 and December 31 of the plan year.
2. Submit a claim for payment prior to March 1 of the following year.
3. Total benefits paid for the Calendar Year must be less than \$500.

If you meet all 3 requirements you will have an additional \$250 available in the Annual Dental Maximum for the next plan year. In future years if you have benefits paid of less than \$500, additional amounts of \$250 will be added to the carryover. However, the most you can accumulate in the maximum carryover is \$1,000. Therefore, the maximum annual benefit may never exceed \$2,000 in any one year.

Eligible Employees

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

Eligible Dependents

Provides Coverage On:

- Your Spouse
- Children up to age 19 and unmarried (Up to age 25 if wholly dependent upon you for maintenance and support and if enrolled as a full-time student in an accredited school or college.)

Dental Exclusions (Deferment Period)

During the first 36 months following your or your dependent's Dental Coverage Effective Date, the initial placement of dentures, partial dentures, or bridges, if it includes the replacement of teeth all of which are missing prior to the effective date. (For currently covered insureds, Ameritas will use the employees Date of Hire to determine the 36 month period.) This exclusion will not apply if the prosthesis replaces a sound natural tooth which is extracted while the patient is insured under this Dental Coverage and which is replaced within 12 months of the extraction. During the first 36 months of coverage, the replacement of bridges, partial dentures, dentures, inlays or crowns is excluded.

Exceptions to this exclusion will be made if the replacement is made necessary by:

- a) accidental bodily injury to sound natural teeth (chewing injuries are not considered accidental bodily injuries), or
- b) the extraction of a sound natural tooth provided the replacement is completed within 12 months of the date of the injury or extraction.

Pre-Determination of Benefits

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

Coordination of Benefits

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

Late Entrant Provision

There is a 12 month waiting period on all procedures (except cleanings, exams, and fluoride treatments) for employees who do not enroll within 31 days of becoming eligible for coverage. This provision is waived for employees who enrolled during the initial enrollment period.

Certificate of Insurance

This is a summary of coverage and is not a binding contract. A certificate of coverage will be made available to you shortly which describes the benefits in greater detail. Should there be differences between this summary and the contract, the contract will govern.

Section 125

This policy is provided as part of the Policyholder's Section 125 Plan. Each member has the option under the Section 125 Plan of participating or not participating in this policy.

Orthodontia Limitations (not a complete list)

No benefit is payable for expenses incurred:

- In connection with a Treatment Program which was begun before the individual became insured for orthodontic benefits.
- During any quarter of a Treatment Program if the individual was not continuously insured for orthodontic benefits for the entire quarter.
- After the individual's insurance for orthodontic benefits terminates.

Limitations/Exclusions (not a complete list)

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

A member may change their election only during an annual election period, except for a change in family status. Examples of such events would be marriage, divorce, birth of a child, death of a spouse or child or termination of employment. Please see your plan administrator for details.

This information is not a guarantee of eligibility or benefits. The benefits shown are subject to policy provisions and the patient's eligibility at the time services are rendered.

MONTHLY RATES

| | |
|-----------------------------|-----------------|
| Employee Only | \$30.84 |
| Employee + 1 | \$62.46 |
| Employee + 2 or more | \$107.74 |

This insurance is underwritten by Ameritas Life Insurance Corp.



Customer Service

1-800-487-5553

Web Address

www.ameritasgroup.com

Superior Vision Plan

Plan Highlights

- Coverage for Exams
- Coverage for Frames and Lenses
- Discounts on Additional Purchases and Upgrades

This Plan provides primary vision care benefits including eye examinations, prescription eyewear and contact lenses offered through a broad-based provider network consisting of ophthalmologists, optometrists and opticians.



Effective Date: 01/01/2010

Outline of Benefits - Gold Preferred Plan with Materials Discount

Vision Plan - Preferred Provider (PPO / Indemnity)

Copayment : \$10.00 Comprehensive Eye Exam

\$25.00 Materials

\$35.00 Contact Lens Fitting Fee

| Benefits | Frequency | In-network | Non-Network |
|--|------------------|-------------------|--------------------|
| • Comprehensive Exam (by an Ophthalmologist) | 12 Months | Covered in Full | Up to \$42.00 |
| • Comprehensive Exam (by an Optometrist) | 12 Months | Covered in Full | Up to \$37.00 |
| • Lenses (Standard) per Pair | | | |
| • Single Vision | 12 Months | Covered in Full | Up to \$32.00 |
| • Bifocal | 12 Months | Covered in Full | Up to \$46.00 |
| • Trifocal | 12 Months | Covered in Full | Up to \$61.00 |
| • Lenticular | 12 Months | Covered in Full | Up to \$84.00 |
| • Contact Lenses (Per Pair)* | | | |
| • Medically Necessary | 12 Months | Covered in Full | Up to \$210.00 |
| • Cosmetic (Elective)** | 12 Months | Up to \$120.00 | Up to \$100.00 |
| • Contact Lens Fitting Fee*** | | | |
| • Standard | 12 Months | Covered in Full | Not Covered |
| • Specialty | 12 Months | Up to \$50.00 | Not Covered |
| • Frames (Standard)** | 24 Months | Up to \$100.00 | Up to \$48.00 |

*Contact lenses are in lieu of eyeglass lenses and frames benefit.

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

***Standard contact lens fitting fee applies to an existing contact lens user who wears disposable, daily wear, or extended wear lenses only. The specialty contact lens fitting fee applies to new contact lens wearers and/or a member who wears toric, gas permeable, or multifocal lenses. For the specialty fit, the member is responsible for any charges over \$50.

Items or Services Not Covered

While Superior Vision offers a variety of vision benefits, there are a few materials, services and treatments that are generally not covered, or have limitations to their coverage. We do offer discounts on many items, as outlined in our discount plan coverage information. **YOUR specific Superior Vision Plan may differ, so confirm the details of your employer's plan prior to seeking services.**

Items or Services Not Covered or Have Limited Coverage*

- non-prescription (plano) lenses of any kind, sunglasses, or contact lenses
- any coating applied to lenses such as anti-reflective, scratch, UV, lamination, tints (except pink tint #1 and #2), and sunglass coloring
- any lens materials other than standard plastic or glass such as polycarbonate, hi-index, polaroid, and photochromic
- any special lens feature or treatment such as prisms, slab off, faceted, over-size lens greater than 61mm, polished bevel, groove, drill mount, notch, roll and polish, and blended bifocal
- progressive lenses (Though progressive lenses are not a covered benefit, the provider will apply the retail charge for standard trifocal lenses against the retail charge for the progressive lenses you selected. You are responsible for paying the provider the difference)
- replacement of broken, lost, or damaged frames and/or lenses
- orthoptics, vision training, and developmental vision procedures
- experimental or non-conventional treatment or device
- medical or surgical treatment of the eyes
- post-cataract lenses (intra-ocular)
- subnormal or low vision aids
- safety eyewear
- eye examination or corrective eyewear required by an employer as a condition of employment
- services or materials rendered by a provider other than an ophthalmologist, optometrist, or optician acting within the scope of his or her license
- any additional services or procedures outside of a routine eye exam and contact lens fitting
- services or materials rendered after the date a member ceases to be covered by the benefits plan except when vision materials ordered before coverage ended are delivered AND the corresponding services are provided to the member within 31 days of the initial order

Regardless of the optical necessity, benefits are not available more frequently than that which is specified in the Outline of Benefits.

*Plans vary so please refer to your own employer's specific coverage.

How to Use the Plan

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

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

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

Discount Features

Materials Discounts on Additional Purchases

| | |
|---|-----------------------|
| Prescription eyeglass lenses | 30% off retail prices |
| Eyeglass frames | 30% off retail prices |
| Add-on charges to basic lenses | 20% off retail prices |
| Everyday "frame and lens package pricing" | 20% off retail prices |
| Contact lenses, standard hard or soft | 20% off retail prices |
| Disposable contact lenses | 10% off retail prices |
| All other prescription materials | 20% off retail prices |

Materials Discount SVP8-20

Frames - 20% off the difference between the covered frame allowance and the retail price of the selected frame.

Note: Discounts do not apply when prohibited by the manufacturer.

Add ons to the covered pair of lenses:

| | |
|-------------------------------------|---|
| Lens Options and Upgrades* | Member pays 20% off retail, up to: |
| Factory scratch coat | \$13 (single vision & standard lined multifocal lenses) |
| Ultraviolet coat | \$15 (single vision & standard lined multifocal lenses) |
| Standard anti-reflective coat | \$50 (single vision & standard lined multifocal lenses) |
| High index 1.6 | \$55 (single vision lenses only) |
| Polycarbonate | \$40 (single vision lenses only) |
| Standard Photochromic | \$80 (single vision lenses only) |
| Glass coloring | \$35 (any type lenses) |
| Plastic, tints, solid, or gradients | \$25 (any type lenses) |

| | |
|---|---|
| Lens Options and Upgrades | Member pays |
| Power over 4.00D Sphere, 2.00D Cylinder & 5.00 Prism | 20% discount of retail prices (any type lenses) |
| Cosmetic finishing, beveling, edging and mounting | 20% discount of retail prices (any type lenses) |
| Miscellaneous options | 20% discount of retail prices (any type lenses) |

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

Refractive Surgery Discounts

Superior Vision Services has a nationwide network of refractive surgeons. These providers offer Superior Vision Plan members a discounted rate off the usual and customary prices for LASIK surgery. These discounts vary depending on the provider but are the best possible discounts available to Superior Vision.

Monthly Cost

| | |
|------------------------|---------|
| Employee Only | \$9.78 |
| Employee + 1 Dependent | \$18.98 |
| Employee + Family | \$27.88 |

Customer Service

800-507-3800

916-852-2277 fax

Authorization numbers (out-of-network)

Explanation of benefits

Provider locator; provider nomination

Claims inquires

Grievance issues

Customer Service/Corporate Office

11101 White Rock Rd., Ste. 150

Rancho Cordova, CA 95670

Claims Administration

P.O. Box 967

Rancho Cordova, CA 95741

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



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



Superior Vision[®]
Our Members. Our Mission.

Cancer and Specified Disease Insurance Policy

Some Plan Benefits

- Hospital Confinement
- Experimental Treatment
- Radiation and Chemotherapy
- Immunotherapy
- Cancer Screening
- Wellness
- Plus . . . much more

.....
: *Assurity's Cancer & Specified Disease Plan is* :
: *designed to create a source of extra cash that can* :
: *help you and your family cope during the battle* :
: *against cancer or a specified disease.* :
.....



Policy availability, rates and provisions may vary by state. This policy contains limitations and exclusions. For more detailed and complete information, please contact Assurity Life Insurance Company and ask to review the policy contract.

Effective: 01/01/2010

BASIC BENEFITS

Provides benefits caused by cancer and certain other specified diseases for the employee, spouse and covered children with continuous benefits and premium policy for life. The Family Rider allows for the addition of family members to the employee's policy.

RATE STRUCTURE

Unisex Rates; Employee Issue Ages: 18-69, Family: Up to Age 69 on spouse and 25 on children if a full-time student in a accredited school. Issue age is age of last birthday on the day the policy is issued.

PRE-EXISTING CONDITIONS

Assurity will not pay any benefits for loss caused by a pre-existing condition during the first two years (one year in NC and SC) following the Issue Date. Loss due to such conditions will be payable unless specifically excluded from coverage after this two year (or one in NC and SC) period.

A pre-existing condition is defined as cancer or a specified disease which first manifest itself within five years (two years in NC) prior to the issue date for each insured. Conditions which are fully disclosed to Assurity on the application and are not excluded or limited by Assurity are not considered pre-existing conditions. In GA, the policy does not contain a definition for pre-existing conditions. In NC, pre-existing conditions for insureds age 65 and older shall include only conditions specifically excluded by rider.

ISSUE AGE

The Assurity cancer policy is available for persons ages 18-69, including spouses. This issue age of children is 15 days through 18 years of age. The coverage is continued up to age 25 if the child is a full-time student in an accredited school.

Policy will pay the following specified benefits based on policy provisions:

Hospital Indemnity

Assurity will pay you benefits for each day while the insured is confined in the hospital for cancer or certain other specified diseases for the first 75 days of each period of confinement. There are three options for the daily benefit amount: \$150, \$250, and \$350.

Prescription Drugs and Medicines

Assurity will play the actual charges, up to 25% of the Daily Hospital Confinement benefit shown on the policy schedule per day for the hospital charges for the prescribed drugs and medicines taken during hospital confinement for an insured person. This benefit is limited to the first 75 days for each period of confinement.

Surgical Benefit

Assurity will pay up to \$7,500 for the actual charges made by a surgeon for a surgery in or out of a hospital up to the maximum amount shown in the Surgical Benefits Schedule. For operations not listed, a comparable reasonable benefit will be paid. Surgical procedures performed through the same incision or in the same body opening will be considered one operation.

Anesthesia

Assurity will pay up to 25% of the amount payable under the Surgical Benefit for the administration of an anesthetic for an insured person. This amount does not apply to skin cancer operations. Assurity will pay the actual charges up to \$50 per skin cancer operation.

Additional Surgical Opinions

Assurity will pay up to \$150 for a second opinion. If the second opinion differs from the first, pays up to \$150 for a third opinion.

Artificial Limb and Prosthesis

The policy pays actual charges for artificial limb or reconstructive procedure to affix or implant in up to a \$2,000 life time maximum per Insured.

Attending Physician

The policy pays actual charges up to \$35 dollars per day for in-hospital physician's visits, other than surgeon's charges.

Private Duty Nurse

The policy pays actual charges up to \$150 per day while confined in the hospital when authorized by a physician when a Private Nurse is required.

Radiation, Radio-Active Isotopes Therapy, Chemotherapy or Immunotherapy

Assurity will pay 50% of the actual charges up to the monthly maximum and lifetime maximum shown in the Policy Schedule for the following techniques, provided they are used for the purpose of modification or destruction of cancerous tissue. Benefits will also be provided for immunotherapy when used for treatment of covered specified diseases.

- teleradio therapy using either natural or artificial propagated radiation. This includes actual charges for radiation treatment delivery only. It does not include charges for clinical treatment planning, clinical treatment management, medical radiation physics, dosimetry, treatment devices or special services;
- interstitial or intracavity application of radium or radioisotopes in sealed or non-sealed sources;
- chemical substances and their administration including hormonal therapy. This includes the actual charges for only those chemical substances which modify or destroy cancerous tissue, and does not include other drugs or medicines given in conjunction with this treatment;
- antigenic preparations of immunosuppressive techniques.

Experimental Treatment

Assurity pays the actual charges incurred up to \$25,000 per calendar year for experimental treatment, except for experimental bone marrow transplants for an insured person. This benefit is in lieu of all other benefits under this policy for the same treatment.

Physical and Speech Therapy

The policy pays the actual charges up to \$25 per therapy session up to a lifetime maximum of \$1,000.

Extended Care Facility

The policy pay up to \$60 per day for confinement in an extended care facility. Confinement must be recommended by a physician and begin within 14 days following a covered hospital stay. Benefits are limited to the number of days of the prior hospital confinement.

Bone Marrow Transplant for Cancer

The policy pays actual charges up to a lifetime maximum of \$25,000 for bone marrow transplants or other forms of stem cell rescue and all related services or supplies. This benefit is payable in lieu of any other benefits payable under this policy, except Transportation and Lodging for Bone Marrow Donors.

Transportation and Lodging for Bone Marrow Donors

The policy pays (a) actual charges up to \$2,500 for medical expenses for a donor when directly related to such a transplant, (b) pays actual charges for a round trip coach fare on a common carrier or a personal automobile allowance of 50 cents per mile in excess of 50 mile one-way to the city where the transplant is performed, up to 700 miles round trip, and (c) pays actual charges up to \$50 per day for lodging and meal expenses when donor stays in a hotel, motel or other accommodations acceptable to Assurity when the donor is asked to remain near the hospital. This payment is in lieu of any other benefit payable under this policy when the donor is a person insured under this policy.

Transportation for Non-local Treatment Which Requires Hospital Confinement

For covered treatment, the policy pays (a) actual charges for non-local round trip charge by common carrier to the nearest hospital that provides the prescribed treatment or (b) 50 cents per mile for personal automobile expenses in excess of 50 miles one way, up to 700 miles round trip. Transportation benefits will not be paid for periodic checkups or when receiving non-covered treatments.

Transportation and Lodging for Non-local Treatment Which Does Not Require Hospital Confinement

For non-local covered treatment prescribed by the attending physician as medically necessary which is not available locally, Assurity will pay for an insured person:

- the actual charges for round trip coach fare on a common carrier to the facility that provides the prescribed treatment or 50 cents per mile for personal automobile expenses in excess of 50 miles one way, to to exceed 700 miles round trip up to a maximum of \$1,500 per calendar year. Mileage will be measured from the insured person's residence to the nearest facility where the treatment is administered; and
- the actual charges up to \$50 per day for lodging and meal expenses incurred by an insured person when staying at a hotel, motel or other accommodations acceptable to Assurity. Benefits will be paid up to the number of days covered treatment is received.

Adult Companion Transportation and Lodging

The policy pays the following expenses for one adult companion to be in near the insured when the insured is confined in a non-local hospital for specialized covered treatment (a) up to a maximum of \$1,500 per calendar year for actual charges for non-local round trip

coach fare by a common carrier to the nearest hospital that provides the prescribed treatment or 50 cents per mile for personal automobile expenses in excess of 50 miles one-way, up to 700 miles round trip and (b) pays actual charges up to \$50 per day for lodging and meal expenses when staying at a hotel, motel or other accommodation acceptable to Assurity, limited to the number of days of each treatment.

Outpatient Positive Diagnostic Test

Assurity will pay up to \$250 for actual charges incurred for the diagnostic test that leads to a positive diagnosis within 90 days of such test for an insured person. This benefit is not payable if the same cancer or specified disease recurs.

Outpatient Surgery Benefit

Assurity will pay a benefit equal to the Daily Hospital Confinement benefit shown on the policy schedule for outpatient surgery in a hospital or ambulatory surgical center for an insured person. This benefit is not payable for surgery in a physician's office or clinic, and is not available for skin cancer or specified diseases.

Skin Cancer

The policy pays up to \$150 for actual charges for the removal of skin cancer when diagnosis is made by a physician, other than a legally qualified pathologist.

Ambulance

The policy pays charges up to \$75 per trip to transfer an insured person to the hospital for confinement as an inpatient.

Hospice Care

Assurity will pay the actual charges up to \$100 per day for care provided by a Hospice if the insured person has been diagnosed as terminally ill. This benefit is payable for confinement in a Hospice care center, including centers that are in designated areas of a Hospital, or in the insured person's home, limited to a policy maximum of \$7,500.

Government or Charity Hospital

The policy pays \$200 per day for conditions in a government or charity hospital. Payment of this benefit is in lieu of all other policy benefits.

Blood and Blood Plasma

The policy pays the actual charges for blood, blood plasma, and platelets. Policy does not pay for blood that is donated or replaced.

Breast Cancer/Breast Reconstruction/Breast Prosthesis

The policy pays a benefit equal to the daily hospital confinement benefit for a minimum of 48 hours of inpatient care following a mastectomy and a minimum of 24 hours following a lymph node dissection for the treatment of breast cancer. Lifetime maximum of \$2,500 per breast. Assurity will pay the actual charges incurred for an external breast prosthesis, or an internal breast prosthesis and the surgeon's fee for implantation for an insured person. For natural tissue breast reconstruction surgery, Assurity will pay the actual charges incurred with a lifetime maximum of \$2,500 per breast. Assurity will pay the actual charges for reconstructive surgery and any adjustments made to the non-diseased breast if performed within 24 months (five years in TN) of reconstruction of the diseased breast for an insured person.

Hairpiece Benefit

The policy pays one-time benefit of up to \$150 for a hairpiece when hair loss is a result of cancer treatment.

Cancer (Wellness) Screening Test

The policy pays the amount charged up to \$100 per calendar year for cancer screening test. Test covered are:

- Mammography Screening
- Pap Smear (test only)
- CA125 (blood test for ovarian cancer)
- PSA (blood tests for prostate cancer)
- Hemocult Stool Specimen
- Flexible Sigmoidoscopy
- CEA (blood test for colon cancer)
- Colonoscopy
- Chest X-ray
- Thermography
- Serum Protein Electrophoresis

Wellness Claims

An employee can file a wellness claim by fax, call-in, or mail. Employees can call As-surity to get a wellness claim form or download one from www.markiiiibrokerage.com/cityofdaltonga. Employees can also call in their wellness claim at (888)-358-8808 ext. 23. The call in service requires all the information on the wellness claim form. The wellness claim form must include the name and phone number of your physician. All claims are subject to verification.

Home Health Care Services

When services are provided by a licensed Home Health Agency, when prescribed by a physician, policy pays (a) up to \$60 per day for services provided at home, not to exceed 180 days per calendar year., (b) up to \$100 per day for Private Duty Nursing, not to exceed 15 days per calendar year, and (c) pays actual charges for a physician's visit up to \$40 per day not to exceed 15 days a calendar year. Care cannot be provided by a relative. This benefit is in lieu of all other benefits.

Rental or Purchase of Durable Medical Equipment

The policy pays the actual charges up to \$1,500 per calendar year for purchases or rental of (a) a respirator or similar medical device, (b) brace, (c) crutches, (d) hospital bed, or (e) wheel chair.

Professional Mental Health Consultation

The policy pays actual charges up to \$50 per session not to exceed a lifetime maximum of \$250, when receiving treatment for cancer or specified disease for which benefits are payable.

Extended Benefits

If a covered hospital confinement last more than 75 consecutive days, policy pays usual and customary charges for hospital room and board, medicine, lab test and other medically necessary hospital charges, up to \$1,000 per day beginning on the 76th day. Payable after the 75th day in lieu of all other policy benefits for the same time period.

Waiver of Premium

If while this policy is in force and before an insured person turns 65, he or she becomes disabled due to cancer or a specified disease (as indicated on the Policy Schedule), and is receiving treatment for such cancer or specified disease for which benefits are payable under this policy and remains disabled for 90 consecutive days, Assurity will waive premiums for as long as the insured person remains disabled. Premiums waived will be in accordance with the mode of payment in effect when treatment began.

Specified Disease Benefits

The benefits of the policy will be extended to pay for the loss that results from the following specified diseases:

| | |
|-----------------------|------------------------------|
| Addison's Diseases | Myasthenia Gravis |
| Botulism | Osteomyelitis |
| Brucellosis | Polio |
| Budd-Chiari Syndrome | Q Fever |
| Cystic Fibrosis | Reye's Syndrome |
| Diphtheria | Rheumatic Fever |
| Encephalitis | Rocky Mountain Spotted Fever |
| Histoplasmosis | Sickle Cell Anemia |
| Legionnaire's Disease | Tay-Sachs Disease |
| Lou Gehrig's Disease | Tetanus |
| Lupus Erythematosus | Trichinosis |
| Malaria | Toxic Shock Syndrome |
| Meningitis | Tuberculosis |
| Multiple Sclerosis | Typhoid Fever |
| Muscular Dystrophy | Whooping Cough |

Cancer or Other Specified Disease Claims

You may file a claim for cancer or specified diseases by completing an Assurity Claim Form. Please make sure to include all pertinent information as stated on the form. You can obtain a claim form by contacting Assurity, or by downloading on from www.markiiibrokerage.com/cityofdaltonga. Should you have any question on how to file or submit a claim or regarding the Assurity Cancer Plan, please call (888) 358-8808 ext. 23.

Optional Riders

Intensive Care Rider - pays a \$300 or \$600 daily benefit if an insured person is confined to a Hospital's Intensive Care Unit, up to a maximum of 20 days per period of confinement.

LIMITATIONS AND EXCLUSIONS

30-Day Waiting Period

There is a 30-day waiting period during which no benefits will be paid during the first 30 days. Covered losses which manifest after the issue date will be payable starting on the 31st day.

Exclusions

Assurity will not pay any Benefits for loss caused by or resulting from:

1. Injuries;
2. Sickness, illness or bodily infirmity resulting from anything other than Cancer or Specified Disease;
3. Any Sickness, illness, bodily infirmity or incapacity that has been caused, or complicated, worsened or affected by cancer or a specified disease or as a result of cancer or specified disease treatment (not applicable in SC);
4. Hospital confinement or expense that are incurred prior to the Issue Date regardless of the date of positive diagnosis;
5. Experimental treatment, except as specifically provided in the experimental treatment benefit or bone marrow transplant benefit (Benefits for experimental treatment are limited to \$25,000 per calendar year. Benefits for bone marrow transplants are limited to a policy lifetime maximum of \$25,000. No other benefits are payable for such treatment.) In TN, benefits for experimental treatment will not be denied based solely on the fact that the insured was a participant in a clinical trial;
6. Care and/or treatment received outside the U.S. or its territories; or
7. Care, confinement and/or treatment in a government or charity hospital except as specifically provided in the government or charity hospital benefit.

*Assurity Life Insurance Company
PO Box 82533, Lincoln, NE, 68501-2533
Assurity Customer Service: (866) 289-7337
Website: www.assurity.com*

**To Call in a Wellness Claim: (888) 358-8808 Ext. 23
To Fax in a Claim/Toll Free: (800) 869-0368**

Policy Form No. AAW-C120

Rider Form Nos. AAW-CR261, AAW-CR262, AAW-CR263, AAW-CR264

A605-1009



Cancer & Specified Disease Plan Monthly Rates

| Assurity Life Cancer & Specified Disease Plan | | | | |
|---|---------------|----------------------------|----------------------------|----------------------------|
| | | \$150 Daily Benefit | \$250 Daily Benefit | \$350 Daily Benefit |
| Base Policy (\$10,000 per month/\$50,000 lifetime maximum) (radiation/chemotherapy) | Individual | \$20.77 | \$23.07 | \$25.37 |
| | EE & Spouse | \$31.82 | \$35.40 | \$38.97 |
| | EE & Children | \$25.78 | \$28.39 | \$31.00 |
| | Family | \$36.83 | \$40.72 | \$44.60 |
| Base Policy with Intensive Care Rider (\$300 daily benefit) | Individual | \$22.87 | \$25.17 | \$27.47 |
| | EE & Spouse | \$36.02 | \$39.60 | \$43.17 |
| | EE & Children | \$29.08 | \$31.69 | \$34.30 |
| | Family | \$42.23 | \$46.12 | \$50.00 |
| Base Policy with Intensive Care Rider (\$600 daily benefit) | Individual | \$24.97 | \$27.27 | \$29.57 |
| | EE & Spouse | \$40.22 | \$43.80 | \$47.37 |
| | EE & Children | \$32.38 | \$34.99 | \$37.60 |
| | Family | \$47.63 | \$51.52 | \$55.40 |

AAW-C120RAB (7/04)

Personal Accident Indemnity Plan

Accident-Only Insurance – Level 2
Policy A-34200-GA

Plan Benefits

- Emergency Treatment
- Follow-Up Treatment
- Initial Hospitalization
- Hospital Confinement
- Physical Therapy
- Accidental-Death
- Wellness
- Plus ... much more

.....
: Benefits are payable for a covered person's :
: death, dismemberment, or injury caused by a :
: covered accident that occurs on or off the job. :
.....



American Family Life Assurance Company of Columbus (Aflac)

Effective Date: 1/1/2010

Aflac insurance policies are subject to health underwriting.

Accident Emergency Treatment Benefit

Aflac will pay \$120 for the insured and the spouse, and \$70 for children if a covered person receives treatment for injuries sustained in a covered accident. This benefit is payable for X-rays, treatment by a physician, or treatment received in a hospital emergency room. Treatment must be received within 72 hours of the accident for benefits to be payable. This benefit is payable once per 24-hour period and only once per covered accident, per covered person.

Accident Follow-Up Treatment Benefit

Aflac will pay \$35 for one treatment per day for up to a maximum of six treatments per covered accident, per covered person for follow-up treatment received for injuries sustained in a covered accident. Treatment must begin within 30 days of the covered accident or discharge from the hospital. Treatments must be furnished by a physician in a physician's office or in a hospital on an outpatient basis. This benefit is not payable for the same visit that the Physical Therapy Benefit is paid.

Initial Accident Hospitalization Benefit

*Aflac will pay \$1,000 when a covered person is confined to a hospital for at least 24 hours for injuries sustained in a covered accident. If the covered person is admitted directly to an intensive care unit, *Aflac will pay \$2,000*. This benefit is payable only once per hospital confinement* or intensive care unit confinement and is payable only once per calendar year, per covered person.*

Accident Hospital Confinement Benefit

Aflac will pay \$250 per day for which a covered person is charged for a room for hospital confinement of at least 18 hours for treatment of injuries sustained in a covered accident. This benefit is payable up to 365 days per covered accident, per covered person. The Accident Hospital Confinement Benefit and the Rehabilitation Unit Benefit will not be paid on the same day; only the highest eligible benefit will be paid.*

Intensive Care Unit Confinement Benefit

Aflac will pay an additional \$400 per day for each day a covered person is receiving the Accident Hospital Confinement Benefit and is confined to and charged for a room in an intensive care unit. This benefit is payable up to 15 days per covered accident, per covered person. Confinements must start within 30 days of the accident.

**Hospital confinement is defined as a covered person's confinement to a bed in a hospital for which a room charge is made. The confinement must be on the advice of a physician and medically necessary. Benefits are also payable for confinement in hospitals operated by or for the United States government. Confinement must start within 30 days of the accident.*

Accident Specific-Sum Injuries Benefit

Aflac will pay \$35–\$12,500 for:

| | | |
|--------------|---------------------|-------------------|
| Dislocations | Burns | Skin Grafts |
| Eye Injuries | Lacerations | Fractures |
| Broken Teeth | Comas | Brain Concussions |
| Paralysis | Surgical Procedures | |

Treatment must be performed on a covered person for injuries sustained in a covered accident. We will pay for no more than two dislocations per covered accident, per covered person. Dislocations must be diagnosed by a physician within 72 hours after the covered accident. Benefits are payable for only the first dislocation of a joint. If a physician reduces a dislocation with local or no anesthesia, we will pay 25 percent of the amount shown for the closed reduction dislocation. A physician must treat burns within 72 hours after a covered accident. A total of 50 percent of the burn benefit will be paid for one or more skin grafts. Lacerations requiring sutures must be repaired under the attendance of a physician within 72 hours after the covered accident. Fractures must be diagnosed by a physician by X-ray within 14 days after a covered accident. For chip fractures and other fractures not reduced by open or closed reduction, we will pay 25 percent of the benefit amount shown for the closed reduction. We will pay for no more than two fractures per covered accident, per covered person. We will pay no more than one benefit for broken teeth per covered accident, per covered person. Coma duration must be at least seven days and must require intubation for respiratory assistance. Paralysis must result from spinal cord injuries that are received in a covered accident and that result in complete and total loss of use of two or more limbs for a period of at least 30 days, and the loss must be confirmed by a physician. Surgical procedures must be performed within one year of a covered accident. Two or more surgical procedures performed through the same incision will be considered one operation, and benefits will be paid based upon the most expensive procedure. Only one miscellaneous surgery benefit is payable per 24-hour period even though more than one procedure may be performed.

Major Diagnostic Exams

Aflac will pay \$200 if a covered person requires one of the following exams for injuries sustained in a covered accident: CT (computerized tomography) scan, MRI (magnetic resonance imaging), or EEG (electroencephalogram). The exam must be performed in a hospital, a physician's office, or an ambulatory surgical center, and a charge must be incurred. This benefit is limited to one payment per calendar year, per covered person. No lifetime maximum.

Physical Therapy Benefit

Aflac will pay \$35 for one treatment per day up to a maximum of ten treatments per covered accident, per covered person if a physician advises the person to seek treatment from a physical therapist. Physical therapy must be for injuries sustained in a covered accident and must start within 30 days of the covered accident or discharge from the hospital. Treatment must take place within six months after the accident. This benefit is not payable for the same visit that the Accident Follow-Up Treatment Benefit is paid.

Rehabilitation Unit Benefit

Aflac will pay \$150 per day when a covered person is charged for confinement in a hospital and transferred to a bed in a rehabilitation unit of a hospital for a covered injury. This benefit is limited to 30 days for each covered person per period of hospital confinement and is limited to a calendar year maximum of 60 days. The Accident Hospital Confinement Benefit and the Rehabilitation Unit Benefit will not be paid on the same day; only the highest eligible benefit will be paid. No lifetime maximum.

A period of hospital confinement is a time period of confinement that starts while the policy is in force. If the confinement follows a previously covered confinement, it will be deemed a continuation of the first unless it is the result of an entirely unrelated injury or the confinements are separated by 30 days or more.

Appliances Benefit

Aflac will pay \$125 if a covered person requires, as advised by a physician, the use of a medical appliance as an aid in personal locomotion resulting from injuries sustained in a covered accident. This benefit is payable for crutches, wheelchairs, leg braces, back braces, and walkers, and is payable once per covered accident, per covered person.

Prosthesis Benefit

Aflac will pay \$750 if a covered person requires a prosthetic device as a result of injuries sustained in a covered accident. This benefit is payable once per covered accident, per covered person and is not payable for hearing aids, wigs, or dental aids, to include false teeth.

Blood/Plasma/Platelets Benefit

Aflac will pay \$200 if a covered person requires blood, plasma, or platelets for the treatment of injuries sustained in a covered accident. This benefit is not payable for immunoglobulins and is payable only once per covered accident, per covered person.

Ambulance Benefit

Aflac will pay \$200 for ground ambulance transportation or \$1,500 for air ambulance transportation if a covered person requires ambulance transportation to a hospital or emergency center for injuries sustained in a covered accident. A licensed professional ambulance company must provide the transportation within 72 hours of the covered accident.

Transportation Benefit

Aflac will pay \$600 per round trip to a hospital if a covered person requires special treatment and hospital confinement* for injuries sustained in a covered accident. The hospital must be more than 100 miles from the covered person's residence or site of the accident. This benefit will be paid for only the covered person for whom the treatment is prescribed, or if the treatment is for a dependent child and commercial travel is necessary, one of the dependent child's parents or legal guardians who travels with the child will also receive this benefit. The local

attending physician must prescribe the treatment, and the treatment must not be available locally. This benefit is payable for up to three round trips per calendar year, per covered person. This benefit is not payable for transportation by ambulance or air ambulance to the hospital.

Family Lodging Benefit

Aflac will pay \$125 per night for one motel/hotel room for a member of the immediate family to accompany the covered person if treatment of injuries sustained in a covered accident requires hospital confinement. The hospital and motel/hotel must be more than 100 miles from the covered person's residence. This benefit is payable up to 30 days per covered accident and only during the time the covered person is confined in the hospital.*

Accidental-Death and -Dismemberment Benefits

Aflac will pay the following benefit for death if it is the result of injuries sustained in a covered accident:

| | Insured/Spouse | Child |
|---------------------------------|-----------------------|--------------|
| Common-Carrier Accidents | \$150,000 | \$25,000 |

A covered person must be a passenger at the time of the common-carrier accident, and a proper authority must have licensed the vehicle to transport passengers for a fee. Common-carrier vehicles are limited to airplanes, trains, buses, trolleys, and boats that operate on a regularly scheduled basis between predetermined points or cities. Taxis are not included.

| | Insured/Spouse | Child |
|------------------------|-----------------------|--------------|
| Other Accidents | \$40,000 | \$12,500 |

(Other Accidents are accidents that are not classified as common-carrier accidents and that are not specifically excluded in the limitations and exclusions of the policy.)

Aflac will pay the following benefit for dismemberment resulting from injuries sustained in a covered accident:

| | Insured/Spouse | Child |
|--|-----------------------|--------------|
| Both arms and both legs | \$40,000 | \$12,500 |
| Two eyes, feet, hands, arms, or legs | \$40,000 | \$12,500 |
| One eye, foot, hand, arm, or leg | \$10,000 | \$ 3,750 |
| One or more fingers and/or one or more toes | \$ 2,000 | \$ 625 |

Death or dismemberment must be independent of disease, bodily infirmity, or any other cause other than a covered accident and must occur within 90 days of the accident. Only the highest single benefit per covered person will be paid for accidental dismemberment. Benefits will be paid only once for any covered accident. If death and dismemberment result from the same accident, only the

Accidental-Death Benefit will be paid. Loss of use does not constitute dismemberment, except for eye injuries resulting in permanent loss of vision such that central visual acuity cannot be corrected to better than 20/200.

Wellness Benefit

After the policy has been in force for 12 months, Aflac will pay \$60 if you or any one family member undergoes routine examinations or other preventive testing during the following policy year. Eligible family members are your spouse and the dependent children of you or your spouse. Services covered are: annual physical examinations, dental exams, mammograms, Pap smears, eye examinations, immunizations, flexible sigmoidoscopies, prostate-specific antigen tests (PSAs), ultrasounds, and blood screenings. This benefit will become available following each anniversary of the policy's effective date for service received during the following policy year and is payable only once per policy each 12-month period following the policy anniversary date. Service must be under the supervision of or recommended by a physician and received while your policy is in force, and a charge must be incurred.

Continuation of Coverage Benefit

Aflac will waive all monthly premiums due for the policy for up to two months if you meet all of the following conditions: (1) Your policy has been in force for at least six months; (2) We have received premiums for at least six consecutive months; (3) Your premiums have been paid through payroll deduction and you leave your employer for any reason; (4) You or your employer notifies us in writing within 30 days of the date your premium payments cease because of your leaving employment; and (5) You re-establish premium payments, either through your new employer's payroll deduction process or direct payment to Aflac. You will again become eligible for this benefit after you re-establish your premium payments through payroll deduction for a period of at least six months, and we receive premiums for at least six consecutive months. (*Payroll deduction* means your premium is remitted to Aflac for you by your employer through a payroll deduction process.)

Guaranteed-Renewable

The policy is guaranteed-renewable for your lifetime, subject to Aflac's right to change premiums by class upon any renewal date.

Effective Date

The effective date of the policy is the date shown in the Policy Schedule, not the date the application is signed. The policy is available through age 64. The payroll rate may be retained after one month's premium payment on payroll deduction.

Refer to the policy for complete details, limitations, and exclusions.

This information is for illustration purposes only.

What Is Not Covered

We will not pay benefits for services rendered by a member of the immediate family of a covered person or for an accident that occurs while coverage is not in force.

We will not pay benefits for an accident or sickness that is caused by or occurs as a result of a covered person's:

- Participating in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a physician and taken according to the physician's instructions) or while intoxicated (*intoxicated* means that condition as defined by the law of the jurisdiction in which the accident occurred);
- Driving any taxi for wage, compensation, or profit;
- Mountaineering using ropes and/or other equipment, parachuting, or hang gliding;
- Participating in, or attempting to participate in, an illegal activity that is defined as a felony, whether charged or not (*felony* is as defined by the law of the jurisdiction in which the activity takes place), or being incarcerated in any type penal institution;
- Intentionally self-inflicting bodily injury or attempting suicide, while sane or insane;
- Having cosmetic surgery or other elective procedures that are not medically necessary, or having dental treatment except as a result of injury;
- Being exposed to war or any act of war, declared or undeclared;
- Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Army Reserve;
- Participating in any form of flight aviation other than as a fare-paying passenger in a fully licensed, passenger-carrying aircraft;
- Participating in any sport or sporting activity for wage, compensation, or profit, including officiating or coaching, or racing any type vehicle in an organized event.

Hospital does not include any institution or part thereof used as a rehabilitation unit; a hospice unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial or educational care, care or treatment for persons suffering from mental disease or disorders, care for the aged, or care for persons addicted to drugs or alcohol.

Family Coverage

Family coverage includes the insured; spouse; and dependent, unmarried children to age 19 (25 if full-time students). Newborn children are automatically insured from the moment of birth. One-parent family coverage includes the insured and all unmarried, dependent children to age 19 (25 if full-time students). A dependent child must be under the age of 19 at the time of application to be eligible for coverage.

Accidents Happen

- Unintentional injuries are the fifth leading cause of death overall and first among persons in age groups from 1 to 44.
- On the average, there are 14 unintentional-injury deaths and about 2,990 disabling injuries every hour during the year.
- A disabling injury occurs in the home every three seconds.
- In 2005 about 36% of all hospital emergency department visits in the United States were injury-related.

Injury Facts, 2008 Edition, National Safety Council.

Personal Accident Indemnity Plan Accident-Only Insurance – Level 2

Monthly Premium Rates

| | |
|---------------------------|---------|
| Individual | \$24.10 |
| Named Insured/Spouse Only | \$32.30 |
| One-Parent Family | \$35.10 |
| Two-Parent Family | \$43.30 |

The rates do not imply coverage.

Refer to the policy for complete details, limitations, and exclusions.

American Family Life Assurance Company of Columbus (Aflac)

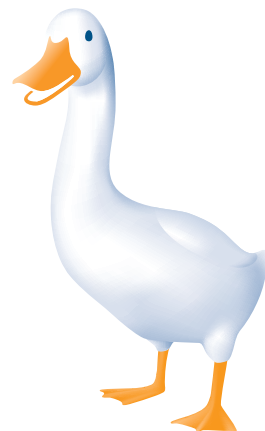
Worldwide Headquarters
1932 Wynnton Road
Columbus, Georgia 31999

1.800.99.AFLAC (1.800.992.3522)

En español:

1.800.SI.AFLAC (1.800.742.3522)

Visit our Web site at aflac.com.



Group Critical Illness Plan

Plan Benefits

- Additional Occurrence Benefit
- Re-occurrence Benefit
- Dependent Child/No cost
- Spouse coverage available
- Health Screening

.....
: *AGAC's Group Critical Illness plan provides a lump* :
: *sum benefit upon the diagnosis of not only one* :
: *covered illness, but for each covered illness.* :
.....

American General
Life Companies

Group Critical Illness Benefits

| Critical Illnesses* | |
|----------------------------------|---------------------------|
| Illnesses Covered Under Plan | Percentage of Face Amount |
| Heart Attack | 100% |
| Stroke | 100% |
| Major Organ Transplant | 100% |
| Renal Failure (End Stage) | 100% |
| Coronary Artery Bypass Surgery** | 25% |

* At age 70, benefits are reduced by 50%.

** A partial benefit (25%) is payable for coronary artery bypass surgery. Payment of the partial benefit for coronary artery bypass surgery will reduce the benefit for a heart attack.

We will pay benefits, after any applicable waiting period and while the insured's certificate is in force, if the insured:

1. is diagnosed with a specified critical illness
2. is confined to a hospital as a result of the specified critical illness and charged for room, board and other applicable charges.
3. it is not excluded by name or specific description in the certificate

Additional Occurrence Benefit

If an insured collects full benefits for a Specified Critical Illness under the plan and later has one of the remaining covered illnesses, then we will pay the full benefit amount for any additional illness. Occurrences must be separated by at least 6 months.

Re-occurrence Benefit

If an insured receives full benefit for a covered condition and is later diagnosed with the same condition, we will pay the full benefit again. The two dates of diagnosis must be separated by at least 12 months.

Health Screening Benefits

After the Waiting Period, An insured may receive a maximum of \$50 for any one covered screening test per calendar year. We will pay this benefit regardless of the results of the test. Payment of this benefit will not reduce the amount payable for the diagnosis of a specified critical illness. There is no limit to the number of years the insured can receive the health screening benefit; it will be paid as long as the policy remains inforce. This benefit is payable for the covered employee and spouse. This benefit is not paid for dependent children. The covered health

screening tests include:

- ◆ Stress test on a bicycle or treadmill
- ◆ Fasting blood glucose test, blood test for triglycerides or serum cholesterol test to determine level of HDL and LDL
- ◆ Bone marrow testing
- ◆ Breast ultrasound
- ◆ CA 15-3 (blood test for breast cancer)
- ◆ CA 125 (blood test for ovarian cancer)
- ◆ CEA (blood test for colon cancer)
- ◆ Chest x-ray
- ◆ Colonoscopy
- ◆ Flexible sigmoidoscopy
- ◆ Hemocult stool analysis
- ◆ Mammography
- ◆ Pap smear
- ◆ PSA (blood test for prostate cancer)
- ◆ Serum protein electrophoresis (blood test for myeloma)
- ◆ Thermography

Individual Eligibility

All full-time employees, working at least 30 hours or more weekly, with at least 90 days of continuous employment by the date of the enrollment are eligible. If an employee is eligible, their spouse is eligible for coverage and all children of the insured who are unmarried and are younger than age 19 or younger than age 25 if they are full time students. Issue age is between 18-69. Seasonal and temporary workers are not eligible to participate.

Spouse Coverage Available

The employee may elect to purchase spouse coverage. In order to apply for spouse coverage, the employee must also apply. The spouse amount may not exceed 50% of the employee amount, subject to the minimum face amount of \$5,000. If the employee does not meet the underwriting requirements necessary to participate in the plan, the spouse can still obtain coverage. The spouse would then become the primary insured and is limited to face amounts between \$5,000 and \$25,000.

Dependent Children Coverage at No Additional Charge

Each eligible dependent child is covered at 10 percent of the primary insured amount at no additional charge. We will not pay 10% of the primary insured amount more than once for the same covered specified critical illness. The payment of benefits for a dependent child does not reduce the face amount of the primary insured. Children-only coverage is not available.

Portability

- Continuously insured for at least six months prior to terminating employment
- Same rates
- Remains in force until the earlier of the date the employee fails to pay or the group master policy is terminated.

Underwriting Guidelines

All applicants are required to answer underwriting questions. Spouse coverage is always underwritten using the Modified Guarantee Issue questions.

Modified Guaranteed Issue

For employee amounts of \$50,000 or less, and spouse amounts of \$25,000 or less:

1. Is any person to be insured now being treated for or has any person ever been treated for: a) cancer or any malignancy, which includes carcinoma, sarcoma, Hodgkin's Disease, leukemia, lymphoma, or malignant tumor. Cancer does not include basal cell or squamous cell carcinoma of the skin; b) a stroke, a heart attack, a heart condition, heart trouble, or any abnormality of the heart (including artery disease), diabetes or any liver disorder; c) kidney (renal) failure or end stage kidney (renal) disease; d) organ transplant; e) emphysema; or f) now taking three or more medications for high blood pressure?

2. Is any person to be insured now being treated or has ever been treated or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or "AIDS" related Complex (ARC), or ever been tested positive for antigens or antibodies to an "AIDS" virus?

3. Is any person to be insured now hospitalized or unable to perform their normal duties and activities?

These questions are knockout questions. Any "yes" response results in a declination.

Participation Requirements

A minimum of 25 approved employee payees are needed to establish group billing.

Limitations and Exclusions

This policy contains a 30-day “waiting period.” This means that no benefits are payable for any insured who has been diagnosed and confined to a hospital before coverage has been in force 30 days from the effective date of coverage. If a insured is first diagnosed during the “waiting period,” benefits for treatment of that Critical Illness or specified procedure or the employee may elect to void the certificate from the beginning and receive a full refund of premium*.

The date of diagnosis of a Critical Illness must be separated from the date of diagnosis of a subsequent different Critical Illness by at least 6 months.

The applicable benefit amount will be paid if: the date of diagnosis is after the waiting period; the date of diagnosis occurs while the policy is in force; you are confined to a hospital as a result of a specified critical illness and are charged for a room, board, and other applicable charges and the cause of the illness is not excluded by name or specific description.

Benefits will not be paid for loss due to:

1. Intentionally self-inflicted injury or action;
2. Suicide or attempted suicide while sane or insane;
3. Illegal activities or participation in an illegal occupation;
4. War, whether declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence;
5. Substance abuse; or
6. Pre-existing conditions.

Pre-existing Condition Limitation**

“Pre-existing condition” means a sickness or physical condition which, within 12 month period prior to the effective date of the certificate, either: 1. resulted in the insured receiving medical advice or treatment, or; 2. caused symptoms for which an ordinarily prudent person would seek medical advice or treatment.”

We will not pay benefits for any condition or illness starting within 12 months of the effective date which is caused by, contributed to, or resulting from a pre-existing condition.

A claim for benefits for loss starting after 12 months from the effective date will not be reduced or denied on the grounds that it is caused by a pre-existing condition. A condition will no longer be considered pre-existing at the end of 12 consecutive months starting and ending after the effective date of coverage.

“Treatment” means consultation, care or services provided by a physician including diagnostic measures and taking prescribed drugs and medicines.

Critical Illness Plan Monthly Rates

(Spouse coverage can not exceed 50% of the employee coverage)

| | \$5,000 | \$10,000 | \$15,000 | \$20,000 | \$25,000 |
|--------------|----------|----------|----------|----------|----------|
| 18-29 | \$2.86 | \$3.94 | \$5.07 | \$6.15 | \$7.24 |
| 30-39 | \$4.03 | \$6.37 | \$8.67 | \$10.96 | \$13.26 |
| 40-49 | \$6.46 | \$11.14 | \$15.86 | \$20.54 | \$25.26 |
| 50-59 | \$10.27 | \$18.76 | \$27.26 | \$35.75 | \$44.24 |
| 60-69 | \$15.30 | \$28.86 | \$42.38 | \$55.94 | \$69.51 |
| | | | | | |
| | \$30,000 | \$35,000 | \$40,000 | \$45,000 | \$50,000 |
| 18-29 | \$8.36 | \$9.45 | \$10.53 | \$11.66 | \$12.74 |
| 30-39 | \$15.56 | \$17.85 | \$20.15 | \$22.45 | \$24.74 |
| 40-49 | \$29.94 | \$34.67 | \$39.35 | \$44.07 | \$48.75 |
| 50-59 | \$52.74 | \$61.23 | \$69.77 | \$78.26 | \$86.75 |
| 60-69 | \$83.07 | \$96.59 | \$110.15 | \$123.72 | \$137.24 |

* Rates include benefits for the Additional Occurrence, Re-occurrence, and Wellness Screening

Policy underwritten by:

American General Assurance Company

1000 East Woodfield Road

Schaumburg, IL 60173

Member of American International Group, Inc.

American General
Life Companies

Short-Term Disability Plan

Plan Highlights

- Selection of:
 - monthly benefit amount
 - benefit period
- Benefits paid regardless of any other insurance

.....
: *Standard Life & Casualty's Short-Term Disability* :
: *plan benefits provide a source of income while* :
: *you concentrate on getting better.* :
.....



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

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

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

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

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

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

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

You have life insurance, home insurance, and automobile insurance.

But is your income insured?

1 National Safety Council, Injury Facts, 2003 Edition

2 American Cancer Society, Cancer Facts & Figures 2004

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

4 American Lung Association, Lung Disease Data 2003

5 National Underwriter, May 2002

Why Income Protection?

If you are suddenly unable to work because of a disability, how will you continue to meet your financial obligations without a paycheck?

Counting on Social Security to provide disability benefits?

Social Security's definition of disability requires that the impairment must be expected to result in death or to last at least 12 months, or must have lasted at least 12 months. Also, Social Security disability benefits usually have a five-month waiting period.

Covered by workers' compensation?

Workers' compensation provides benefits only for occupational-related injuries or illnesses. About two-thirds of the disabling injuries suffered by American workers in 2002 occurred off the job.*

Think your savings will get you through a disability?

Experts recommend a minimum savings of three months' salary to prepare for a sudden loss of income. However, most people simply aren't saving enough money to last more than a few weeks without a regular income. For some, the financial impact of even one missed paycheck can be devastating.

Will you have to turn to family or friends to help support you?

Chances are, if you are not saving enough, your loved ones are not either.

Plan Features

- Payable in addition to sick leave
- Benefits payable regardless of other insurance
- Weekends and holidays are covered
- Benefits are paid directly to you
- Benefits are tax free
- Disability resulting from pregnancy is covered as any other sickness
- No change in premium due to age
- You may continue coverage if you leave your Employer, provided you maintain continuous employment.

**Injury Facts, 2003 Edition, National Safety Council*

Accident & Sickness protection

On or off the job, 24 hour a day coverage. Income is provided when you are disabled due to a sickness or as a result of an accident. Benefits begin on the first day if you are disabled due to an accident. Benefits begin on the eighth day if you are disabled due to sickness.

You can choose to insure up to 70% of your gross monthly income, up to a maximum of \$2,000.00 per month. Income will be provided for the benefit period you choose up to 365 days.

Eligibility

These benefit plans are optional and all full-time employees under 65 years of age may apply. The disability benefit is for employees only. Applications for new participants will be underwritten.

POLICY FEATURES

Pre-existing Conditions

If you received medical advice for treatment of a health condition within twelve months prior to the effective date of insurance, there will be no coverage for that condition until twelve consecutive months beyond the effective date.

Disability Due to Pregnancy

Benefits are covered provided conception occurs after the effective date of the policy.

Portability

When an employee leaves the employment of Johnson City Schools, they may continue the short-term disability coverage, subject to the renewability provision, provided they maintain continuous employment.

Limits and Exclusions

Benefits will not be paid for any total disability which:

- 1) Occurs while the policy is not in force;
- 2) Does not require the regular care of a physician;
- 3) Is due to the use of intoxicants or narcotics, except on the advice of a physician;
- 4) Is on account of intentional self-inflicted injury;
- 5) Is a result of mental or nervous disorders;
- 6) Results from armed conflicts;
- 7) Arises out of aviation, except scheduled passengers on commercial airlines;
- 8) Results from traveling more than forty miles outside the US;
- 9) Results from the participation in a felony or working at an illegal job.
- 10) Results from a pre-existing condition, as defined in the policy.

Standard Life Short-Term Disability

Monthly Rates

| Benefit Duration: 90 Days | | Benefit Duration: 180 Days | | Benefit Duration: 365 Days | |
|--------------------------------------|----------------------------|---------------------------------------|----------------------------|---------------------------------------|----------------------------|
| Monthly Benefit | Monthly Premium | Monthly Benefit | Monthly Premium | Monthly Benefit | Monthly Premium |
| \$500 | \$11.25 | \$500 | \$17.50 | \$500 | \$22.50 |
| \$600 | \$13.50 | \$600 | \$21.00 | \$600 | \$27.00 |
| \$700 | \$15.75 | \$700 | \$24.50 | \$700 | \$31.50 |
| \$800 | \$18.00 | \$800 | \$28.00 | \$800 | \$36.00 |
| \$900 | \$20.25 | \$900 | \$31.50 | \$900 | \$40.50 |
| \$1,000 | \$22.50 | \$1,000 | \$35.00 | \$1,000 | \$45.00 |
| \$1,100 | \$24.75 | \$1,100 | \$38.50 | \$1,100 | \$49.50 |
| \$1,200 | \$27.00 | \$1,200 | \$42.00 | \$1,200 | \$54.00 |
| \$1,300 | \$29.25 | \$1,300 | \$45.50 | \$1,300 | \$58.50 |
| \$1,400 | \$31.50 | \$1,400 | \$49.00 | \$1,400 | \$63.00 |
| \$1,500 | \$33.75 | \$1,500 | \$52.50 | \$1,500 | \$67.50 |
| \$1,600 | \$36.00 | \$1,600 | \$56.00 | \$1,600 | \$72.00 |
| \$1,700 | \$38.25 | \$1,700 | \$59.50 | \$1,700 | \$76.50 |
| \$1,800 | \$40.50 | \$1,800 | \$63.00 | \$1,800 | \$81.00 |
| \$1,900 | \$42.75 | \$1,900 | \$66.50 | \$1,900 | \$85.50 |
| \$2,000 | \$45.00 | \$2,000 | \$70.00 | \$2,000 | \$90.00 |

This is a brief description of the important features of your policy. This is not an insurance contract; therefore, it is important that you read your policy carefully.

Standard Life and Casualty
Claims Toll-Free Number (800)227-0251
Customer Service (800) 327-0695



Group Term Life Plan

Plan Benefits

- Coverage available for yourself up to \$100,000
- Coverage available on your spouse up to \$10,000
- Coverage available on your children for \$5,000

This insurance is underwritten by:

MetLife[®]

Optional Employee Life Insurance

You have the opportunity to elect additional group life insurance through payroll deduction.

Optional Dependent Life Insurance

Provides coverage on:

- Your Spouse
- Child(ren) from 15 days of age to age 19 (to age 25 if wholly dependent upon you for maintenance and support if enrolled as a full-time student in an accredited school or college). Handicapped children can continue to be covered with no age limit, as long as the child is covered prior to age 19 or to age 25 if a full-time student.

It is your responsibility to notify payroll in writing when a dependent is ineligible for coverage. Examples of ineligible dependent status are divorce or a child graduates from college.

Eligibility

You will be eligible for this program if you are a full-time employee working 30 hours or more per week.

Enrollment

Enrollment is simple - just fill out the election card provided by your employer. You have 31 days to enroll yourself and dependents without evidence of insurability.

Statement of Health

Increases in coverage, Optional Dependent Spouse coverage over \$10,000, a re-entry in the plan and participants who enroll 31 days beyond the eligibility period will be required to provide evidence of insurability satisfactory to MetLife.

Beneficiary

You have the right to designate the beneficiary of your choice. The beneficiary elected on your life enrollment form designates your beneficiary for optional coverage. You are automatically the beneficiary under Dependent Life. It is the responsibility of the insured to update one's beneficiary designation as necessary.

When Your Insurance Starts

Your Optional Employee Life Insurance becomes effective on the date of your eligibility if you are then actively at work; otherwise, on the day you return to active work. In addition, in order for your Optional Employee Life Insurance and Optional Dependent Life Insurance to become effective, it is necessary for you to certify that neither you nor any of your eligible dependents have been "hospitalized" in the last three months prior to your enrollment date. The term "hospitalized" includes inpatient hospital care, hospice care, care in an intermediate or long-term care facility and/or receipt of chemotherapy, radiation therapy or dialysis treatment. However, a confinement which is strictly due to pregnancy or childbirth will not be included in the term "hospitalized".

In addition, coverage will not become effective for you or any dependent who is hospitalized as defined above or who is not performing normal daily activities on the date coverage would otherwise become effective. Normal daily activities means that the individual is not confined at home under the care of a doctor for a sickness or injury or is not entitled to receive any disability income from any source.

If you meet the eligibility requirements described above for date of enrollment and for effective date of coverage, your Optional Employee Life Insurance, if you have enrolled for that coverage, will become effective on the date of your eligibility provided you are then actively at work; otherwise, on the day you return to active work. If you enroll for Optional Dependent Life Insurance, that coverage will become effective on the date your Optional Employee Life Insurance becomes effective, for any dependents who meet the eligibility requirements described above.

If you or any dependents do not satisfy the eligibility requirements described above for date of enrollment and for effective date of coverage, that person will not become insured for Optional Life Insurance until such person has furnished medical evidence of insurability satisfactory to Metropolitan Life.

Termination of Coverage

All insurance under this plan will terminate upon the earlier of the date you retire or the date your employment terminates. Spouse coverage terminates at age 70. Nevertheless, if you or a covered dependent should die within 31 days thereafter, the life insurance will still be paid to the beneficiary.

Disability - Continued Protection

Prior to Age 60 - If an insured becomes totally disabled prior to age 60, the amount of life insurance will be continued without payment of premium provided evidence of disability is submitted annually. The waiver of premium provision terminates at death or at age 65, whichever is earlier.

Conversion

If your employment terminates while you are covered under the plan, you may purchase without medical evidence of insurability, any individual insurance, except a term policy, issued by MetLife. If you wish to continue with a term policy, please refer to the section below on Portability. The amount of the individual contract may not be more than the amount of your life coverage in effect on your date of termination. You must apply for this policy within 31 days after the date your employment terminates. This privilege applies to Optional Employee Life Insurance, Dependent Spouse Life Insurance, and Dependent Child Life Insurance.

Portability

Portability allows employees whose coverage ends due to certain qualifying events to continue their current (or a lesser) amount of insurance. Portability applies to Employee Optional Life Insurance only.

Qualifying Events Include:

- Termination of Employment
- Retirement
- Change in EE class resulting in termination of Optional Life Benefits.

The minimum face amount which an employee may elect portability is \$20,000. Portable coverage reduces to 50% on January 1st of the year the insured attains age 70 and terminates on January 1st of the year the insured attains age 80. When portable coverage ends, insured individuals have the right to convert to an individual policy.

Accelerated Death Benefit

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

Suicide Exclusion

No Optional Employee Life Benefits are payable if you commit suicide within two years from the effective date of the coverage. Likewise, no Optional Dependent Life Benefits are payable if the insured dependent commits suicide within two years from the effective date of this coverage.

Claims Procedure

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

SCHEDULE OF BENEFITS

Optional Employee Life Insurance

Your choice of the following amounts:

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

- Guaranteed Issue coverage up to \$100,000 if elected when first eligible.

Optional Dependent Life Insurance

Your choice of either Spouse only coverage, Child(ren) only coverage, or family coverage in the amount of:

- \$10,000 for your Spouse
- \$5,000 on each of your eligible children (\$100 benefit from 15 days to 6 months)
- Family coverage - both \$10,000 on your Spouse and \$5,000 on each of your eligible children (\$100 benefit from 15 days to 6 months).

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

This insurance is underwritten by Metropolitan Life Insurance Company, New York, New York 10010.

MetLife[®]

L0007BCZ5(exp0803)(xFL,NY,UT)-LD

| Employee Optional Life Insurance - Monthly Rates | | | | | | | | | | | |
|---|-----------------|------------------|------------------|------------------|------------------|------------------|------------------|------------------|------------------|------------------|----------------|
| Amount of Coverage | Under 25 | Age 25-29 | Age 30-34 | Age 35-39 | Age 40-44 | Age 45-49 | Age 50-54 | Age 55-59 | Age 60-64 | Age 65-69 | Age 70+ |
| \$10,000 | \$0.70 | \$0.70 | \$1.00 | \$1.30 | \$1.60 | \$2.40 | \$4.00 | \$7.40 | \$9.30 | \$16.80 | \$27.20 |
| \$20,000 | \$1.40 | \$1.40 | \$2.00 | \$2.60 | \$3.20 | \$4.80 | \$8.00 | \$14.80 | \$18.60 | \$33.60 | \$54.40 |
| \$30,000 | \$2.10 | \$2.10 | \$3.00 | \$3.90 | \$4.80 | \$7.20 | \$12.00 | \$22.20 | \$27.90 | \$50.40 | \$81.60 |
| \$40,000 | \$2.80 | \$2.80 | \$4.00 | \$5.20 | \$6.40 | \$9.60 | \$16.00 | \$29.60 | \$37.20 | \$67.20 | \$108.80 |
| \$50,000 | \$3.50 | \$3.50 | \$5.00 | \$6.50 | \$8.00 | \$12.00 | \$20.00 | \$37.00 | \$46.50 | \$84.00 | \$136.00 |
| \$60,000 | \$4.20 | \$4.20 | \$6.00 | \$7.80 | \$9.60 | \$14.40 | \$24.00 | \$44.40 | \$55.80 | \$100.80 | \$163.20 |
| \$70,000 | \$4.90 | \$4.90 | \$7.00 | \$9.10 | \$11.20 | \$16.80 | \$28.00 | \$51.80 | \$65.10 | \$117.60 | \$190.40 |
| \$80,000 | \$5.60 | \$5.60 | \$8.00 | \$10.40 | \$12.80 | \$19.20 | \$32.00 | \$59.20 | \$74.40 | \$134.40 | \$217.60 |
| \$90,000 | \$6.30 | \$6.30 | \$9.00 | \$11.70 | \$14.40 | \$21.60 | \$36.00 | \$66.60 | \$83.70 | \$151.20 | \$244.80 |
| \$100,000 | \$7.00 | \$7.00 | \$10.00 | \$13.00 | \$16.00 | \$24.00 | \$40.00 | \$74.00 | \$93.00 | \$168.00 | \$272.00 |

| Dependent Life Insurance - Spouse Monthly Rates | | | | | | | | | | |
|--|------------------|------------------|------------------|------------------|------------------|------------------|------------------|------------------|------------------|------------------|
| Amount of Coverage | Age 20-24 | Age 25-29 | Age 30-34 | Age 35-39 | Age 40-44 | Age 45-49 | Age 50-54 | Age 55-59 | Age 60-64 | Age 65-69 |
| \$10,000 | \$0.60 | \$0.80 | \$1.00 | \$1.20 | \$1.50 | \$2.20 | \$4.00 | \$6.50 | \$11.80 | \$19.60 |

| Dependent Life Insurance - Child(ren) Monthly Rates | |
|--|---|
| Amount of Coverage | Monthly Rate for any number of eligible children |
| \$5,000 | \$0.54 |

Whole Life Policy

VPL Plus

Effective Date: February 1, 2010

*Pending underwriting approval

Plan Highlights

- No physical required for coverage amounts under \$100,000
 - Acceptance will be based upon answers to questions on your application
- Cash Value Accumulation
- Accelerated Death Benefit

.....
: Whole Life Insurance can give you the insurance :
: protection you need on yourself, your spouse, :
: children and/or grandchildren. :
:
:

TEXASLIFE INSURANCE
COMPANY

Since 1901 | 900 WASHINGTON | POST OFFICE BOX 830 | WACO, TEXAS 76703-0830

Underwritten by Texas Life Insurance Company

Form #08M070-C 1030 (Exp 05/31/10)

Common Issue Date:
February 1, 2009 pending underwriting approval

This Voluntary Permanent Life Program will allow you to purchase permanent life insurance for you and your eligible dependents.

VPL- plus is an individual permanent life insurance product specifically designed for employees and their families. It provides a guaranteed level premium and death benefit for the life of the policy, and you can keep the life insurance even after you retire.

As an employee, you are eligible to apply if you have satisfied your employer's eligibility period. You may also apply for coverage on your spouse, children and grandchildren.

Why Voluntary Coverage

- Most employees are dependent on group term
- Only 50% of U.S. Households have individually owned life insurance¹
- 72% of life insurance policies are paid to beneficiaries of individually owned life plans¹
- Most term policies expire before paying a death claim
- When do you want a life insurance policy in force?
 - Answer: When you die
- Term is for IF you die; permanent is for WHEN you die
- Everybody dies

The New Product: Texas Life's VPL-plus

- Portable, permanent life insurance through the convenience of payroll Deduction
- Whole life chassis
- Strong guarantees
- Popular features
- Coverage available for spouse, children and grandchildren

VPL-plus: Portable and Permanent

- Employee can keep policy, at same premium, if he/she retires or changes jobs
- Employee may apply for spouse, children and grandchildren at the worksite
- Permanent coverage: policy guaranteed to remain in force as long as necessary premiums are paid

VPL-plus: The Guarantees Employees Want

- Guaranteed level premium
- Guaranteed level death benefit
- Guaranteed reduced paid-up insurance at retirement
- Guaranteed paid-up for face amount at age 70 (or after 20 years for insureds between ages 51 and 70)

VPL-plus: CGI (Express Issue) Underwriting

Employee, spouse coverage require 3 health and employment related questions:

- During the last six months, has the proposed insured been actively at work on a full-time basis, performing usual duties?
- During the last six months, has the proposed insured been absent from work due to illness or medical treatment for a period of more than five consecutive working days?
- During the last six months, has the proposed insured been disabled or received tests, treatment or care of any kind in a hospital or nursing home or received chemotherapy, hormonal therapy for cancer, radiation therapy, dialysis treatment or treatment for alcohol or drug abuse?

Child coverage (ages 6 months -18 years old):

- During the last six months, has the proposed insured been disabled or received tests, treatment or care of any kind in a hospital or nursing home or received chemotherapy, hormonal therapy for cancer, radiation therapy, dialysis treatment or treatment for alcohol or drug abuse?

Express Issue Maximums

- Employee
 - ages 17-49, \$100,000
 - ages 50-65, \$50,000
 - ages 66-70, \$10,000
- Spouse (if employee applies)
 - ages 17-49, \$50,000
 - ages 50-65, \$25,000
 - ages 66-70, \$10,000
- Spouse (if employee does not apply)
 - ages 17-24 \$25,000
 - ages 25-29 \$20,000
 - ages 30-39 \$15,000
 - ages 40-44 \$10,000
 - ages 45-49 \$7,500
 - ages 50-70 \$5,000
- Children - ages 6 months -18 \$25,000
- Grandchildren - ages 6 months -16 \$25,000

Simplified Issue

- Use if proposed insured wants amounts over Express Issue maximums
- Coverage is dependent on answers to health-related and other questions contained in the application
- Answer all underwriting questions
- Blood required for amounts in excess of \$100,000
- Rates are unisex
- Rates are unismoke

Accelerated Death Rider

- Included on all policies (Employee, Spouse, Children, Grandchildren)
- Pays 92% of death benefit, less \$150 processing fee, upon physician-certified diagnosis of condition expected to result in death within 12 months (conditions and limitations apply)
- Percentage lower in New York and Massachusetts
- No extra charge for rider
- Policy terminates when rider is exercised

Waiver of Premium

- Available for issue ages 17-55
- Benefit payable to insured through age 60
- Cost is included in premium

VPL-plus: Review

- Permanent and portable
- Non-participating Whole Life chassis (no dividends)
- Guaranteed level death benefit
- Guaranteed level premium
- Guaranteed reduced paid-up insurance at retirement
- Premiums cease at age 70 (or after 20 years, ages 51-70)
- Accelerated Death Benefit Rider included on all policies
- Waiver of Premium available issue ages 17-55
- Express Issue underwriting
- Unisex rates
- Unismoke rates
- Blood required for amounts over \$100,000
- Simplified issue for health reasons or for amounts over Express Issue maximums

This brochure has been prepared to give you the highlights of coverage now being offered through your employer to meet your insurance needs. The details will be provided during your individual meeting with a qualified Texas Life Enrollment Representative. Those employees who wish to participate will be provided a personal policy that spells out all policy provisions.

*If you have any questions regarding your Texas Life policy, please call
(800) 283-9233 prompt #3.*



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Continuing Your Benefits

Upon Termination of Employment

To Continue Your Vision, and/or FSA Plan

*Under the group vision plan and your Flexible Spending Accounts, you and your covered dependents are eligible to continue coverage through COBRA. Upon termination, you will receive notification from your COBRA administrator with premium and continuation options. Should you have any questions, you may contact your Benefits Department at **706-281-1267**.*

To Convert Your Term Life Insurance

When you leave your employment, you may convert the existing group term coverage you have through your employer to a guaranteed issue individual whole life policy. You also have the option of porting your existing coverage as well. It is the responsibility of the employee to convert or port coverage. You must apply for conversion or portability within 31 days from the date your employer terminates your term life coverage. For more information and a quote, please contact 1-877-275-6387. If you do not convert or port your group term life insurance, coverage will terminate when you leave your employer.

To Continue Your Other Policies

You may continue your Assurity Cancer, Aflac Accident, AIG Critical Illness, Standard Life Short-Term Disability, Transamerica Accident or Texas Life Universal Life policies by having the premiums currently deducted from your paycheck drafted from your bank account or billed to your home. For more information, contact

*Assurity at **866-289-7337**,*

*Aflac at **800-992-3522***

*AIG at **800-308-6457***

*Standard Life at **800-227-0251**,
(bank draft not offered)*

*Transamerica at **800-763-7474***

*Texas Life at **800-283-9233 prompt #3***

Contact Information for Questions and Claims

Ameriflex

24/7 Interactive Voice Response (IVR):

888-686-3539

Toll Free Phone: 888-868-3539

Web: www.flex125.com

Email: service@flex125.com

Fax: 856-361-1020

*Mail: 700 East Gate Drive, Suite 510,
Mount Laurel, NJ 08054*

Ameritas

Customer Service

1-800-487-5553

Web Address

www.ameritasgroup.com

Superior Vision Services

11101 White Rock Rd, Suite 150

Rancho Cordova, CA 95670

1-800-507-3800

www.superiorvision.com

Non-Network Claims Submission:

PO Box 967

Rancho Cordova, CA 95741

Assurity Life Insurance

PO Box 80926
Lincoln, NE 68501
1-866-289-7337

Wellness Claims:
1-888-358-8808 x23

**American Family Life Assurance Company
of Columbus (Aflac)**

Worldwide Headquarters
1932 Wynnton Road
Columbus, GA 31999
1-800-99-AFLAC (1-800-992-3522)
En español:
1-800-SI-AFLAC (1-800-742-3522)
aflac.com

**American General Assurance Company
(AGAC)**

1000 East Woodfield Road
Schaumburg, IL 60173
1-800-308-6457

Standard Life & Casualty

Claims Toll-Free Number
1-800-227-0251
Customer Service
1-800-327-0695

Texas Life Insurance Company

900 Washington PO Box 803

Waco, TX 76703

800-283-9233 prompt #3

Mark III Brokerage

114 E. Unaka Ave.

Johnson City, TN 37604

423-929-2051

www.markiiibrokerage.com/cityofdaltonga