

The **City of McMinnville** is offering all full-time employees a comprehensive Cafeteria Benefits program. The Cafeteria Benefits program is being arranged by Mark III Brokerage, an employee benefits firm that has worked in the public sector for more than 33 years. The Cafeteria Benefits program allows you to pay for certain insurance premiums before taxes are taken out of your paycheck. (Paying for these benefits in this method may reduce your taxes and may increase your take home pay.) The Cafeteria Benefits program includes pre-tax and after tax products.

- The Plan Year is from January 1 to December 31.
- A Mark III representative will be conducting enrollment meetings.

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(All information in this booklet is a brief description of your coverage and is not a contract. Read your certificate for each product for the exact terms and conditions).

Ameriflex Flexible Spending Accounts

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

Medical Reimbursement Plan Maximum: \$2,000

Medical Reimbursement Plan Minimum: \$0

Waiting Period: 0 days

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 costs. 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 you 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, ChlorTrimaton, 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	Roloids
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

BlueCross BlueShield of TN - PPO Plan (Network P)

Effective Date - January 1, 2010

Benefit Features	Network Providers	Out-of-Network Providers[2]
Annual Deductible		
Individual	\$1,000	\$2,000
Family	\$2,000	\$4,000
Annual Out-of-Pocket Maximum Amount		
Individual	\$1,500	\$4,500
Family	\$3,000	\$9,000
Dependent Age Limit	To age 24	To age 24
Lifetime Maximum Benefit		\$5,000,000
Pre-Existing Waiting Period [1]	12 months	12 months
Benefits for Covered Services	Network Benefits	Out-of-Network Benefits [2]
Practitioner Office Services		
Office Visits	90% after Deductible	70% after Deductible
Routine Diagnostic Lab, X-Ray, & Injections	90% after Deductible	70% after Deductible
Non-routine Diagnostic Services [5]	90% after Deductible	70% after Deductible
Provider Admin Specialty Pharmacy Products	\$90 Copay	70% after Deductible
Preventive Health Care Services		
Well Child Care (to age 6)	\$10 Copay	70% after Deductible
Annual Well Woman Exam	\$10 Copay	70% after Deductible
Annual Mammography Screening	No Additional Copay	70% after Deductible
Annual Cervical Cancer Screening	No Additional Copay	70% after Deductible
Prostate Cancer Screening	No Additional Copay	70% after Deductible
Immunizations (to age 6)	No Additional Copay	70% after Deductible
Well Care Rider Services (ages 6 and up) (Exams, Screenings & Immunizations) [10]	\$10 Copay	70% after Deductible
Services Received at a Facility (includes professional and facility charges)		
Inpatient Services [3]	90% after Deductible	70% after Deductible
Outpatient Surgery [4]	90% after Deductible	70% after Deductible
Routine Diagnostic Services-Outpatient	90% after Deductible	70% after Deductible
Non-routine Diagnostic Services-Outpatient [5]	90% after Deductible	70% after Deductible
Other Outpatient Services [6]	90% after Deductible	70% after Deductible
Emergency Care Services [7]	90% after Deductible	90% after Deductible
Emergency Care Non-Routine Diagnostics [5]	90% after Deductible	90% after Deductible
Medical Equipment		
Durable Medical Equipment, Prosthetic & Orthotic Appliances	90% after Deductible	70% after Deductible
Therapeutic Services [8]		
Therapy (Limited to 30-36 visits per year per therapy type)	90% after Deductible	70% after Deductible
Skilled Nursing Facility & Rehabilitation Facility Services [3]		
Limited to 60 days combined	90% after Deductible	70% after Deductible
Home Health Services [9]		
Limited to 60 visits per year	90% after Deductible	70% after Deductible
Hospice Services [9]	100%	70% after Deductible
Ambulance Service	90% after Deductible	90% after Deductible

Notes (see benefit summary on prior page):

1. HIPAA regulations apply. A Group enrollee's pre-existing condition waiting period can be reduced by the enrollee's applicable 'creditable coverage'.

2. Out-of-network benefit payment based on BlueCross BlueShield of Tennessee maximum allowable charge. You are responsible for paying any amount exceeding the maximum allowable charge.

3. Services require prior approval. Benefits will be reduced to 50% for services received from network providers outside Tennessee and all out-of-network providers when prior approval is not obtained.

4. Certain surgical procedures require prior approval. Benefits will be reduced to 50% for services received from network providers outside Tennessee and all out-of-network providers when prior approval is not obtained.

Call Customer Service to determine which procedures require prior approval.

5. CAT scans, MRIs, nuclear medicine and other similar technologies.

6. Includes services such as chemotherapy, radiation therapy, infusions, and renal dialysis.

7. ER services include all services in conjunction with ER visit except non-routine diagnostic services.

8. Physical, speech, manipulative, and occupational therapies are limited to 30 visits per therapy type per year. Cardiac and pulmonary rehabilitative therapies are limited to 36 visits per therapy type per year.

9. Requires prior approval.

10. Well Care Rider services are limited to \$750 per year.

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PPO Benefit Exclusions:

- routine transportation, supportive environmental equipment, maintenance or custodial care, social casework, or meal delivery
- homemaker or housekeeping services, meals, funeral or financial counseling
- office visits and physical exams for school, camp, employment, travel insurance, marriage or legal proceedings and related immunizations and tests
- second surgical opinions given by a practitioner in the same medical group as the practitioner who initially recommended the surgery
- routine foot care for the treatment of flat feet, corns, bunion, calluses, toenails, fallen arches, weak feet or chronic foot strain
- foot orthotics, shoe inserts and custom made shoes except for diabetic patients or as part of a leg brace
- custodial, domiciliary or private duty nursing services
- inpatient hospital stays primarily for therapy
- private duty nursing
- service which could be provided in a less intensive setting
- transportation for the sole convenience of the member
- transportation that is not essential to reduce the probability of harm to the patient
- ambulance services when the member is not transported to a facility
- services or supplies that are designed to medically enhance a member's level of fertility in the absence of a disease
- assisted reproductive technology (ART), such as *GIFT*, *ZIFT*, invitro-fertilization and fertility drugs
- services or supplies for the reversals of sterilizations
- elective abortions
- services, supplies or prosthetics primarily to improve appearance, including wigs or other hair prostheses or transplants
- surgeries in order to correct or repair the results of a prior surgical procedure, the primary purpose of which was to improve appearance
- surgeries and related services to change gender
- treatment beyond what can reasonably be expected to significantly improve health, including therapeutic treatments for ongoing maintenance or palliative care and duplicative therapies
- enhancement therapy which is designed to improve the member's

physical status beyond their pre-injury or pre-illness state

- modalities that do not require the attendance or supervision of a licensed therapist, including activities which are primarily social or recreational in nature, simple exercise programs, hot and cold packs applied in the absence of associated therapy modalities, repetitive exercises or tasks which can be performed by the member without a therapist, in a home setting, routine dressing changes.
- behavioral therapy, play therapy, communication therapy and therapy for self-correcting language dysfunctions
- complementary and alternative therapeutic services whose value has not yet been determined to be medically necessary, including massage therapy, acupuncture, aquatic therapy, craniosacral therapy, neuromuscular reeducation, vision exercise therapy, and cognitive therapy
- charges exceeding the maximum allowable charge for the total cost of purchase of durable medical equipment
- unnecessary repair, adjustment or replacement or duplicates of any durable medical equipment
- supplies and accessories that are not necessary for the effective functioning of the covered medical equipment
- items to replace those which were lost, damaged, stolen or prescribed as a result of new technology
- motorized scooters, "deluxe" or "enhanced" equipment
- contacts after the initial pair following cataract surgery
- hearing aids
- surgery or services as a result of an injury to the jaw, natural teeth, mouth, or face not completed within 12 months of the date of the accident
- treatment for routine dental care and related services including but not limited to replacement of teeth, bone grafts, treatment of teeth roots, treatment of injuries due to biting and chewing, crowns, plates, x-rays, fillings, removal of non-impacted teeth
- treatment for correction of underbite, overbite, and misalignment of the teeth, including orthognathic surgery and braces for dental indications
- behavioral health services except as listed in a separate rider
- services and supplies to detect or correct refractive errors of the eyes, except as listed in a separate rider
- eyeglasses, contact lenses and examinations for the fitting of eyeglasses and contact lenses, except as listed in a separate rider
- eye exercises and/or therapy
- visual training
- pharmaceuticals which may be purchased without a prescription
- pharmaceuticals purchased with a prescription except those dispensed at a participating facility, unless listed in a separate rider
- services or supplies not listed as a covered service in the Evidence of Coverage
- services or supplies that are determined to be not medically necessary or determined to be experimental or investigational in nature
- illness or injury resulting from war and covered by veteran's benefit or other coverage for which the member is legally entitled and which occurred before the member's coverage began under this contract.
- self treatment or training
- staff consultations required by hospital or other facility rules
- services which are free
- services or supplies related to any treatment or services resulting from the member's participation in a felony, riot, or insurrection
- treatment of work related illness or injury, regardless of the presence or absence of worker's compensation coverage, unless resulting from self-employment by a sole proprietor or partner of the insured group who had elected not to be covered by the worker's compensation law
- personal and convenience items and services such as barber and beauty services, television, air conditioners, humidifiers, air filters, heaters, physical fitness equipment, saunas, whirlpools, water purifiers, swimming pools, tanning beds and other recreational equipment, weight loss programs, physical fitness programs or self-help devices which are not primarily medical in nature, even if ordered by a practitioner
- wellness or other preventive services at age 6 or over, unless as listed in a well-care rider, including but not limited to well-child care, periodic health assessments, immunizations, eye and ear examinations to determine the need for vision and hearing correction
- telephone or e-mail consultations, or charges for failure to keep a scheduled appointment, or handling fees
- services for providing requested medical information or completing forms
- court-ordered examinations and treatment
- room, board and general nursing care rendered on the date of discharge, unless admission and discharge occur on the same day
- any service stated in the Evidence of Coverage as a Non-Covered Service or Limitation
- charges in excess of the Maximum Allowable Charge for Covered Services or any charges which exceed the Lifetime Maximum or any other limitations listed under the Evidence of Coverage or its attachments
- services or supplies received in a dental or medical department maintained by or on behalf of the employer, mutual benefit association, labor union or similar group
- benefits for Pre-existing Conditions (until any pre-existing waiting periods have been met)
- organ transplants when prior approval through transplant case management is not obtained
- transplant related charges above the Transplant Maximum Allowable Charge
- removal of an organ from a member for purposes of transplantation into another person, except as covered by the donor organ procurement provision
- services performed by a family member
- nicotine replacement therapy and aids to smoking cessation including patches
- human growth hormones except for specific conditions shown in Evidence of Coverage
- safety items or items to affect performance primarily in sports related activities
- services and supplies related to obesity, including surgical or other treatment of morbid obesity
- cosmetic services including surgical or other services, drugs, or devices, including removal of tattoos, removal of moles, facelifts, blepharoplasty, keloid removal, dermabrasion, chemical peels, rhinoplasty, breast augmentation and breast reduction
- services and charges related to the care of the biological mother of an adopted child, if the biological mother is not a member, surrogate parenting, sperm preservation
- treatment of sexual dysfunction, including erectile dysfunction (e.g. Viagra), delayed ejaculation, anorgasmia and decreased libido

Please Note: This benefit summary is only a brief description of PPO benefits. All benefit determinations are governed by the Master Contract on file with the employer.

\$5/\$30/\$45 Prescription Drug Plan
\$10/\$60/\$90 Specialty Drug Plan

Generic Drugs	\$ 5 Copay per prescription, up to 30 day supply
Preferred Brand Name Drugs	\$30 Copay per prescription, up to 30 day supply
Non-preferred Brand Name Drugs	\$45 Copay per prescription, up to 30 day supply

The copayment is the amount you pay to a network pharmacy for each prescription you have filled. Your copayment is dependent upon which brand level of drug you choose.

Generic Drugs- your copay is \$5

Generic drugs offer the best value. A generic drug is a safe and effective alternative to a brand name drug. You pay the lowest copay when you choose a generic drug. When your doctor writes your prescription, ask about using a generic drug.

Generic drugs are made with the same active ingredients and produce the same effects in the body as their brand-name equivalents. The difference? Just the name and price -- and generics cost less. BlueCross BlueShield of Tennessee encourages the use of generic drugs by offering lower copayments when choosing generics.

Preferred Brand Drugs- your copay is \$30

The Preferred Drug List is a list of therapeutically sound, cost-effective drugs, and is provided to encourage the use of certain drugs within a therapeutic class. When your doctor prescribes a preferred brand drug, your copay is \$20.

Non-Preferred Brand Drugs- your copay is \$45

When your doctor prescribes a brand drug that is not on the Preferred Drug list, you pay the highest copay of \$35.

Pricing at Participating Pharmacies

When a member receives a prescription at a pharmacy, he or she typically pays the appropriate copayment (either generic or brand under a two-tier plan; or generic, preferred brand or non-preferred brand under a three-tier plan). Members pay less than the copayment if the pharmacy's usual price for the drug is less than the copayment.

Choosing a Brand when a Generic Equivalent is Available

You'll always save money when using generics. In fact, all you pay is the generic copay. But if you or your physician request a brand-name drug when a generic equivalent is available, you must pay the generic copay plus the cost difference between the brand-name drug and generic drug.

Limitations

These limitations apply to each prescription order.

Benefits will be provided for

- up to a 30-calendar-day supply of prescription drugs, and/OR
- up to a 90-calendar-day supply of prescription drugs obtained through Prescription Home Delivery or the Home Delivery Retail Network.

Refills

Refills must be dispensed pursuant to a Prescription. If the number of refills is not specified in the Prescription, benefits for refills will not be provided beyond one year from the date of the original prescription.

The Plan has time limits on how soon a Prescription can be refilled. If you request a refill too soon, the Network Pharmacy will advise you when your Prescription benefit will cover the refill.

Prescription Home Delivery

Enjoy the convenience of prescription home delivery by calling 1-877-683-6837, or completing a Caremark.com mail order form. Simply mail the completed form along with the written prescription and payment in the Caremark.com envelope. For more information, visit the pharmacy section at www.bcbst.com.

Home Delivery Retail Network

Another convenient way to obtain up to a 90-calendar-day supply of drugs is through the Home Delivery Retail network. The Home Delivery Retail Network is a network of retail pharmacies that are permitted to dispense prescription drugs to BlueCross BlueShield of Tennessee members on the same terms as pharmacies in the Home Delivery Network. A directory of the participating Home Delivery Retail Network is available online at www.bcbst.com.

Out-of-Network Pharmacies

If a prescription is filled at an out-of-network pharmacy, you must pay all costs. A claim can then be submitted to BlueCross BlueShield of Tennessee. Reimbursement is based on the BlueCross BlueShield of Tennessee allowed charge, less any applicable copay, deductible or coinsurance amount.

A Broad Network of Retail Pharmacies

BlueCross BlueShield of Tennessee members access the Caremark network for retail pharmacy benefits. The RX04 pharmacy network provides tremendous accessibility with over 60,000 pharmacies nationally and over 1,500 in Tennessee, including every national chain and many independent pharmacies. A directory of participating pharmacies is available online at www.bcbst.com.

Self-Administered Specialty Pharmacy Network and Coverage

You have a separate network for Specialty Pharmacy Products: the specialty pharmacy network. You receive the highest level of benefits when you use a specialty pharmacy network provider for your self-administered Specialty Pharmacy Products. Accredo Health Group, Caremark Specialty Pharmacy Services, and CuraScript Pharmacy/Priority Healthcare are experienced in managing high-cost drugs and providing patient support for complex conditions such as Hepatitis C, Multiple Sclerosis, Arthritis and Hemophilia.

Accredo Health Group 1-888-239-0725 (phone) 1-866-387-1003 (fax)	Caremark Specialty Pharmacy Services 1-866-295-2779 (phone) 1-866-295-2778 (fax)	CuraScript Pharmacy/ Priority Healthcare 1-888-773-7376 (phone) 1-888-773-7386 (fax)
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You may purchase self-administered specialty pharmacy products from a retail pharmacy, but your copay will be higher. When purchasing self-administered Specialty Pharmacy Products from an Out-of-Network Pharmacy, you must pay all expenses and file a claim for reimbursement with us. You will be reimbursed based on the Maximum Allowable Charge, less any applicable Drug Copayment amount.

Please refer to the Specialty Pharmacy Products List to see which drugs are covered as self-administered specialty pharmacy products. Go to www.bcbst.com/Pharmacy.

Specialty Pharmacy Products are limited to a **30-day supply** per Prescription.

	Specialty Pharmacy Network	Other Network Pharmacies	Out-of-Network Pharmacies
A Self-Administered Specialty Pharmacy Product, as indicated on Our Specialty Pharmacy Products list.	\$35 Drug Copayment per Prescription	\$70 Drug Copayment per Prescription	You pay all costs, then file a claim for reimbursement. You will be reimbursed based on the Maximum Allowable Charge, less any applicable Drug Copayment amount.
If a drug that is on Our Specialty Pharmacy Products list is also a Generic Drug or a Preferred Brand Drug, then Your Copayment will be:			
If a drug that is on Our Specialty Pharmacy Products list is also a Generic Drug or a Preferred Brand Drug, then Your Copayment will be: A Generic Drug that is also a Self-Administered Specialty Pharmacy Product, as indicated on Our Specialty Pharmacy Products list.	\$10 Drug Copayment per Prescription	\$20 Drug Copayment per Prescription	You pay all costs, then file a claim for reimbursement. You will be reimbursed based on the Maximum Allowable Charge, less any applicable Drug Copayment amount.
A Preferred Brand Drug that is also a Self-Administered Specialty Pharmacy Product, as indicated on Our Specialty Pharmacy Products list.	\$20 Drug Copayment per Prescription	\$40 Drug Copayment per Prescription	You pay all costs, then file a claim for reimbursement. You will be reimbursed based on the Maximum Allowable Charge, less any applicable Drug Copayment amount.
(Please refer to Your EOC for information on benefits for provider-administered Specialty Pharmacy Products, which are covered as a Medical benefit.) Need More Information? For more information on prescription drug coverage or our pharmacy programs call 1-800-565-9140. You can also visit the pharmacy section at www.bcbst.com .			
RX04-MACA 10-20-35		Updated 10/17/06	

Benefits will not be provided for:

- drugs for the treatment of onychomycosis (e.g., nail fungus), except for: 1) diabetics; or 2) immuno-compromised patients.
- growth hormones, except for: 1) treatment of absolute growth hormone deficiency in children whose epiphyses have not closed; 2) patients with “Turner” syndrome; and 3) patients with Prader-Willi syndrome confirmed by appropriate genetic testing;
- prescription and non-prescription medical supplies, devices and appliances, except for syringes used in conjunction with injectable medications or other supplies used in the treatment of diabetes and/or asthma;
- immunizations or immunological agents, including but not limited to: 1) biological sera, 2) blood, 3) blood plasma; or 4) other blood products are not Covered, except for blood products required by hemophiliacs.
- injectable drugs, unless: 1) intended for self-administration; or 2) defined by the Plan.
- drugs which are prescribed, dispensed or intended for use while You are confined in a hospital, skilled nursing facility or similar facility, except as otherwise Covered in the EOC;
- any drugs, medications, Prescription devices or vitamins, available over-the-counter that do not require a Prescription by Federal or State law; except as otherwise Covered in the EOC;
- any quantity of Prescription Drugs which exceeds that specified by the Plan’s P & T Committee;
- any Prescription Drug purchased outside the United States, except those authorized by Us;
- any Prescription dispensed by or through a non-retail internet Pharmacy;
- contraceptives which require administration or insertion by a Provider (e.g., non-drug devices, implantable products such as Norplant, except injectables), except as otherwise Covered in the EOC;
- medications intended to terminate a pregnancy (e.g., RU-486);
- non-medical supplies or substances, including support garments, regardless of their intended use;
- artificial appliances;
- allergen extracts;
- any drugs or medicines dispensed more than one year following the date of the Prescription;
- Prescription Drugs You are entitled to receive without charge in accordance with any worker’s compensation laws or any municipal, state, or federal program;
- replacement Prescriptions resulting from lost, spilled, stolen, or misplaced medications (except as required by applicable law);
- drugs dispensed by a Provider other than a Pharmacy;
- administration or injection of any drugs;
- Prescription Drugs used for the treatment of infertility;
- Prescription Drugs not on the Drug Formulary;
- anorectics (any drug or medicine for the purpose of weight loss and appetite suppression);
- nicotine replacement therapy and aids to smoking cessation including, but not limited to, patches;
- all newly FDA approved drugs prior to review by the Plan’s P & T Committee;
- any Prescription Drugs or medications used for the treatment of sexual dysfunction, including but not limited to erectile dysfunction (e.g. Viagra), delayed ejaculation, anorgasmia and decreased libido;

- Prescription Drugs used for cosmetic purposes including, but not limited to: 1) drugs used to reduce wrinkles (e.g. Renova); 2) drugs to promote hair-growth; 3) drugs used to control perspiration; 4) drugs to remove hair (e.g. Vaniqa); and 5) fade cream products;
- FDA approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia;
- Compound drugs filled or refilled at an Out-of-Network Pharmacy;
- drugs used to enhance athletic performance;
- Experimental and/or Investigational Drugs; and

- Provider-administered Specialty Pharmacy Products, as indicated on Our Specialty Pharmacy Products list.
- Prescription Drugs or refills dispensed:
 - in quantities in excess of amounts specified in the BENEFIT PAYMENT section;
 - without Our Prior Authorization when required; or
 - which exceed any applicable Annual Maximum Benefit, or any other maximum benefit amounts stated in this Rider or the EOC

RX04-MACA 10-20-35

Updated 10/17/06

These exclusions only apply to this Rider. Items that are excluded under the Rider may be Covered as medical supplies under the EOC. Please review your EOC carefully

Employee Premium Semi-Monthly Rates

(24 payroll deductions per year)

Employee	\$75.00
Employee + One	\$140.00
Employee + Family	\$159.00

Insurance Incentives for 2010

- Proof of employee annual physical in 2009 = a \$50.00 monthly / \$600 annual health insurance deduction credit.
- Signing a Waiver that the employee is tobacco free for 30 consecutive days as of 12:00 December 31,2009 = \$50.00 monthly / \$600 annual health insurance deduction credit. Tobacco free discount incentives for those who sign Waivers in 2010. Please see Fredia Black for more information.

Customer Service

1-800-451-9097

Extended Well Care

To maintain your health throughout your life, you should receive the proper tests and immunizations at the appropriate time and frequency. Many factors, including your age, gender, family history, and other special needs, determine when particular services are beneficial. Therefore, you should discuss with your physician what is right for you.

You and each eligible dependent age 6 and older may receive preventive health services, not to exceed \$750, per calendar year*. All services must be medically necessary and appropriate and recommended by the U.S. Preventive Health Task Force, or in conjunction with the plan's preventive health care guidelines.

All well care benefits listed are subject to the terms, conditions, limitations, and exclusions contained in the Group Master Contract and the Evidence of Coverage. All services covered by the Wellcare Rider are subject to normal contract benefits, which are determined by type of service and place of service. *

The following is a list of items that are covered as a part of the annual preventive health exam for persons age 6 and older:

- Annual Health Assessment
- Childhood immunizations
- Blood pressure screening
- Periodic cholesterol screening
- Periodic colorectal cancer screening, not subject to the \$300 calendar year limit*
- Flu shot
- Tetanus-diphtheria (Td) booster
- Pneumococcal immunization
- Other recommended adult immunizations and immunizations not completed in childhood
- Immunizations for travel to foreign countries
- Other prescribed x-ray and lab screenings associated with preventive care
- Vision and hearing screenings performed by the physician during the preventive health exam

Most of these services are not needed every year, or may be appropriate only for people of particular age groups, genders, or those who meet other specific health criteria.

*Important Note Regarding Colonoscopy and Sigmoidoscopy Benefits:

All services covered by the Wellcare Rider are subject to normal contract benefits, which are determined by type of service and place of service. When Wellcare Rider services are provided in a physician's office, as the majority are, the office visit benefit applies. However, colonoscopy and sigmoidoscopy are invasive diagnostic surgical procedures, so surgery benefits apply to these services. Sigmoidoscopies and colonoscopies performed in the physician's office are subject to the office surgery benefit (copay or deductible/coinsurance, depending on the benefit plan). Sigmoidoscopies and colonoscopies performed in an outpatient facility are subject to the outpatient surgery benefit (usually deductible/coinsurance).

BlueCross BlueShield of TN - HSA Plan (Network P)

Effective Date - January 1, 2010

Benefit Highlights	In-Network Benefits	Out-of-Network Benefits
Annual Deductible		
Individual	\$2,000	\$4,000
Family	\$4,000	\$8,000
If more than one person is covered under the group health plan, the full family deductible must be satisfied before benefits will be paid for the employee or any covered family members.		
Annual Out-of-Pocket Maximum		
Individual	\$2,000	\$6,000
Family	\$4,000	\$12,000
Dependent Age Limit	To age 24	
Lifetime Maximum	\$5,000,000	
Preexisting Conditions Waiting Period	12 months	
Office Visits		
Office Visits	100% After Deductible	80% After Deductible
Routine Diagnostic Lab, X-ray & Injections	100% After Deductible	80% After Deductible
Advanced Radiological Imaging	100% After Deductible	80% After Deductible
Preventive Health Care Services		
Well Child Care (to age 6)	100% After \$20 Copay	80% After Deductible
Annual Well Women Exam	100% After \$20 Copay	80% After Deductible
Annual Mammography Screening	100%	80% After Deductible
Prostate Cancer Screening	100%	80% After Deductible
Immunizations	100%	80% After Deductible
Well Care Rider Services (ages 6 and up) - See Well Care Rider for more information	100% After \$20 Copay	80% After Deductible
Services Received at a Facility (includes professional and facility charges)		
Inpatient Services	100% After Deductible	80% After Deductible
Outpatient Services	100% After Deductible	80% After Deductible
Routine Diagnostic Services - Outpatient	100% After Deductible	80% After Deductible
Advanced Radiological Services - Outpatient	100% After Deductible	80% After Deductible
Other Outpatient Services	100% After Deductible	80% After Deductible
Emergency Care Services	100% After Deductible	80% After Deductible
Medical Equipment		
Durable Medical Equipment - \$2,500 annual limit	100% After Deductible	80% After Deductible
Prosthetics - \$20,000 annual limit	100% After Deductible	80% After Deductible
Orthotic Appliances	100% After Deductible	80% After Deductible

Behavioral Health		
Inpatient: Unlimited days per calendar year	100% After Deductible	80% After Deductible
Outpatient: Unlimited days per calendar year	100% After Deductible	80% After Deductible
Therapeutic Services		
Therapy (limited to 20-36 visits per year per therapy type)	100% After Deductible	80% After Deductible
Skilled Nursing Facility & Rehabilitation Facility Services		
Limited to 60 days combined	100% After Deductible	80% After Deductible
Home Health Services		
Limited to 60 visits per year	100% After Deductible	80% After Deductible
Hospice Services	100% After Deductible	80% After Deductible
Ambulance Services	100% After Deductible	100% After Deductible
Pharmacy - Prescription Drugs	100% After Deductible	80% After Deductible

High Deductible Health Plans Prescription Drug Coverage with the Preventive Drug List

Benefits are available for prescription drugs when filled by a BlueCross BlueShield of Tennessee participating pharmacy, subject to you deductible and coinsurance.

In-network Pharmacy

Benefits are subject to your In-network and coinsurance

Out-of-Network Pharmacy

Benefits are subject to your out-of-network deductible and coinsurance

When you get your prescription filled, you are only responsible for paying your deductible and coinsurance. Once your deductible is met, you only need to pay the applicable coinsurance at point of sale. The pharmacy will electronically file your claim with BlueCross BlueShield of Tennessee. For the best benefits, get your prescription filled at a participating pharmacy.

Benefits are available for brand name drugs and generic drugs. Generic drugs offer the best value. A generic drug is a safe and effective alternative to a name brand drug. When your doctor writes your prescription, ask about using a generic drug.

Limitations - These limitations apply to each prescription order.

Benefits will be provided for

- up to a 100-calendar-day supply of prescription drugs obtained at retail pharmacies or
- up to a 102-calendar-day supply of prescription drug obtained through home delivery.

Some drugs require prior authorizations, step therapy or have quantity limitations. Please refer to the special drugs list on the pharmacy page on www.bcbst.com for more details.

Step Therapy

Step Therapy is a form of Prior Authorization. When Step Therapy is required, You must initially try a drug that has been proven effective for most people with your condition. This initial drug will be a Covered Generic Drug (if available) or a Preferred Brand Drug.

However, if You have already tried an alternate, less expensive drug and it did not work, or if Your doctor believes that You must take the more expensive drug because of Your medical condition, Your doctor contact the Plan to request an exception. If the request is approved, the Plan will cover the requested drug.

Preventive Drug List - \$5/\$25/\$50 Copayment

For prescription drugs on the Preventive Drug List you pay copayment amounts instead of hte deductible and coinsurance. This allows you to obtain your medication for preventive indications without first meeting the deductible. Copayment amounts do apply to your annual out-of-pocket maximum.

Generic Drugs	\$5 Copay per prescription, each 34 day supply
Preferred Brand Name Drugs	\$25 Copay per prescription, each 34 day supply
Non-preferred Brand Name Drugs	\$50 Copay per prescription, each 34 day supply

The copayment is the amount you pay to a network pharmacy for each preventive prescription you have filled. Your copayment is dependent upon which brand level drug you choose.

Generic Drugs - your copay is \$5

Generic drugs are made with the same active ingredients and produce the same effects in the body as their brand-name equivalents. The difference? Just the name and price -- and generics cost less. BlueCross BlueShield of Tennessee encourages the use of generic drugs by offering lower copayments when choosing generics.

Preferred Brand Drugs - your copay is \$25

The Preferred Drug List is a list of therapeutically sound, cost-effective drugs, and is provided to encourage the use of certain drugs with a therapeutic class. When your doctor prescribes a preferred brand drug on the preventive drug list, your copay is \$25. But if you receive a brand-name drug when a generic equivalent is available, you must pay the generic copay plus the cost difference between the brand-name drug and generic drug.

Non-Preferred Brand Drugs - your copay is \$50

When your doctor prescribes a brand drug on the preventive drug list that is not a Preferred Drug you pay the highest copay of \$50. But if you receive a brand name drug when a generic equivalent is available, you must pay the generic copay plus the cost difference between the brand name and generic drug.

Some drugs require prior authorization or have quantity limitations. Please refer to the special drug lists on the pharmacy page on www.bcbsnc.com for more information.

Refills

Refills must be dispensed pursuant to a Prescription. If the number of refills is not specified in the Prescription, benefits for refills will not be provided beyond one year from the date of the original prescription.

The Plan has time limits on how soon a Prescription can be refilled. If you request a refill too soon, the Network Pharmacy will advise you when your Prescription benefit will cover the refill.

Prescription Home Delivery

Enjoy the convenience of prescription home delivery. Simply mail a completed form along with the written prescription and payment in one of the envelopes provided or visit the pharmacy section at www.bcbst.com for other helpful ways to have your prescriptions delivered to your home or another preferred address.

Out-of-Network Pharmacies

If a prescription is filled at an out-of-network pharmacy, you must pay all cost. A claim can then be submitted to BlueCross BlueShield of Tennessee. Reimbursement is based on the BlueCross BlueShield of Tennessee allowed charge, less any applicable copay, deductible or coinsurance amount.

A Broad Network of Retail Pharmacies

BlueCross BlueShield of Tennessee members access the Caremark network for retail pharmacy benefits. Your pharmacy network provides tremendous accessibility in Tennessee as well nationally. A directory of participating pharmacies is available online at www.bcbst.com. Click on Find a Pharmacy, and enter the pharmacy network code that appears in the bottom center of your BlueCross BlueShield of Tennessee ID card. This code will start with RX (RX03, for example).

Self-Administered Specialty Pharmacy Network and Coverage

You have a separate network for Specialty Drugs: the Specialty Pharmacy Network. You receive the highest level of benefits when you use a Specialty Pharmacy Provider for your self-administered Specialty Drugs. Accredo Health Group, Caremark Specialty Pharmacy Services, and CuraScript Pharmacy are experienced in managing high-cost drugs and providing patient support for complex conditions such as Hepatitis C, Multiple Sclerosis, Arthritis and Hemophilia.

Accredo Health Group	Caremark Specialty Pharmacy Services	CuraScript Pharmacy
1-888-239-0725	1-800-237-2767	1-888-773-7376
1-888-387-1004 (fax)	1-800-323-2445 (fax)	1-888-773-7386 (fax)

You may purchase self-administered Specialty Drugs from a retail pharmacy, but your cost may be higher. When purchasing self-administered Specialty Drugs from an Out-of-Network Pharmacy, you must pay all expenses and file a claim for reimbursement with us. You will be reimbursed based on the Maximum Allowable Charge, less any applicable Deductible and Coinsurance amount.

Please refer to the Specialty Drug list to see which drugs are covered as self-administered

Specialty Drugs. Go to www.bcbst.com/pharmacy.
 Specialty Drugs are limited to a 30-day supply per Prescription.

	Specialty Pharmacy Network	Other Network Pharmacies	Out-of-Network Pharmacies
A Self-Administered Specialty Drug, as indicated on Our Specialty Drug List	Benefits are subject to your in-network deductible and coinsurance	Benefits are subject to your in-network deductible and coinsurance	Benefits are subject to your out-of-network deductible and coinsurance

(Please refer to Your EOC for information on benefits for provider-administered Specialty Drugs, which are covered as a Medical benefit.)

Need More Information?

For more information on prescription drug coverage or our pharmacy programs call 1-800-565-9140. You can also visit the pharmacy section at www.bcbst.com.

Employee Premium Semi-Monthly Rates
 (24 payroll deductions per year)

Employee	\$65.00
Employee + One	\$120.00
Employee + Family	\$127.50

Insurance Incentives for 2010

- Proof of employee annual physical in 2009 = a \$50.00 monthly / \$600 annual health insurance deduction credit.
- Signing a Waiver that the employee is tobacco free for 30 consecutive days as of 12:00 December 31, 2009 = \$50.00 monthly / \$600 annual health insurance deduction credit. Tobacco free discount incentives for those who sign Waivers in 2010. Please see Fredia Black for more information.

Customer Service
1-800-451-9097

Horizon Behavioral Services Employee Assistance Plan

Horizon Behavioral Services' Employee Assistance Program (EAP) provides the City of McMinnville's employees with professional guidance in resolving issues that impact their personal and professional lives.

Counseling services are available from licensed professionals to address such issues as: stress, marital/relationship difficulty, parenting/child needs, family difficulty, alcohol and drug abuse, depression, grief, and more. Employees and their dependents are entitled to receive ***up to six visits with a counselor per issue per year.***

Legal and financial counseling services are also available through the EAP. Access to an attorney in the employee's local area is available to address such needs as: estate planning, writing a last will and testament, child custody, divorce, and civil suits. The first 30 minutes of each consult with an attorney is free of charge, after which the employee will receive a 25% discount off each billable hour. Financial counseling is available by telephone to address financial planning, retirement planning, debt reduction/consolidation, budgeting, and home purchasing needs.

HBS recognizes the importance of offering a high quality, proactive program that fosters good mental health and prevents disruptive and unhealthy situations. Depression, domestic violence, and marital discord are but a few examples of issues that can affect an employee's workplace performance. Our EAP focuses on providing consultation, information, success planning, and referral to resources for a variety of concerns, including, but not limited to the following:

- Depression
- Daily living issues
- Wellness
- Relationship issues
- Child care
- Personal achievement
- Elder care
- Family
- Financial
- Emotional well-being
- Legal
- Substance abuse/chemical dependency
- Stress and anxiety
- Life improvement issues

MEMBER SERVICES

Our EAP services are designed to meet the needs of *all* members. We offer a comprehensive array of Employee Assistance and WorkLife Program services that have proven to be effective in satisfying various levels of care for our members. HBS' Member Services include the following.

24-Hour Member Advocate Line—Support for members that provides connection to specialists for WorkLife, legal, financial, and clinical issues

Goal and Success Planning Consultation—Focuses on providing consultation and resource services to assist employees and families in achieving personal success and well-being

Personalized Resource Materials—Reinforcement for each consultation by providing members with informative materials, including educational literature that address the special needs of the employee as identified through the phone consultation

Assessment and Counseling—Up to allocated number of short-term, in-person counseling sessions for employees and family members for assessment, problem solving, and referrals to resources

National Network—Provider network coverage from anywhere in the United States (With more than 23,000 providers in our network, even employees with multistate residences and college students away at school are covered by our services.)

HorizonCareLink™ Online—An innovative Web site that houses all of HBS' Employee Assistance services under one virtual roof, offering content, interactive tools, and educational guides for employees and managers

Legal Consultation Services—Guidance for members with legal issues such as will preparation, divorce, automobile accidents, and many other issues

Financial Consultation Services—Assistance in managing inheritance or estate taxes, retirement fund rollovers or transfers, and general tax or investment questions

Telephonic and Online WorkLife Services—Telephonic and online assistance with childcare, elder care, adoption, and other life events

Telephonic Follow Up—Personal follow-up contact with each member to ensure the services provided are meeting members' needs

To access these Horizon services, call: (800) 955-6422



Ameritas Dental Plan (Block B)

Effective Date: January 1, 2010

COMBINED CALENDAR YEAR DEDUCTIBLE

\$50.00 per individual for Type II (Basic) and Type III (Major) Procedures (3 times family limit). After the date that 3 members of a family 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 I - PREVENTIVE AND DIAGNOSTIC* - Type I benefits are payable at 100% U&C. No deductible applies.

- Evaluations (Two per benefit period)
- Cleanings (Two per benefit period)
- Fluoride for Children (Under age 19)
- Space Maintainers
- Radiographs (X-rays)
- Bitewings (Two per benefit period)

TYPE II - BASIC PROCEDURES* - Type II benefits are payable at 80% U&C.. \$50.00 deductible applies.

- Sealants (Under 17)
- Limited Exams
- Anesthesia
- Restorative Amalgam & Resin (excluding inlays & crowns)
- Oral Surgery - Complex and Simple Extractions
- Denture Repair

TYPE III - MAJOR PROCEDURES* - Type III Benefits are payable at 50% U&C. \$50.00 deductible applies.

- Endodontics (Root Canal)
- Periodontics (Gum Disease)
- Crowns
- Prosthodontics-Removable Dentures, Partials
- Prosthodontics -Fixed Pontics or Abutments
- Crown Repair

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

LATE ENTRANT PROVISION

*There is a 12 month waiting period on all services except for cleanings, exams and fluoride applications for employees who do not enroll when first eligible for coverage. The waiting period will be waived for employees who enroll when first eligible.

SEMI-MONTHLY RATES

Employee Only	\$12.77
Family	\$37.49

ANNUAL MAXIMUM BENEFIT

- Type I, II and III Procedures - \$1,000 per calendar year per person.
- Orthodontia Procedures - \$1,000 Lifetime per person.

*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.

DENTAL EXCLUSIONS (DEFERMENT PERIOD)

During the first 36 months following you 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.

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 24 and unmarried

PREDETERMINATION 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.

CERTIFICATE OF INSURANCE

The Certificate of Insurance issued to you describes in detail the benefits and limitations of this plan. This brochure is for general information only.

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.

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.

ORTHODONTIA LIMITATIONS (This is 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 (This is 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 laws.

FOR CLAIMS/CUSTOMER SERVICE QUESTIONS CONTACT AMERITAS AT:

(800) 487-5553 or www.ameritasgroup.com

This insurance is underwritten by Ameritas Life Insurance Corp.



Cancer Can Affect Anyone

Statistics Predict:

- Cancer will strike one in every two men and one in every three women in the U.S.*
- One out of eight women will develop breast cancer in her lifetime*.
- One out of every six men will develop prostate cancer*.
- The number of people with cancer will double in this decade**.

Are you prepared for the cost of cancer?

Your medical insurance covers most of the direct charges such as hospital and physicians' bills, but may not cover these indirect costs:

- Loss of wages while caring for a family member
- Loss of wages while you receive treatment
- Everyday living expenses and bills
- Childcare
- Home health care expenses
- Transportation for non-local or specialized treatment centers
- Experimental treatment
- Meals eaten out, fast food for family at home
- Lodging during non-local treatment

In fact, non-medical costs account for 67 percent of all costs associated with cancer*. Many Americans find themselves financially strapped as the result of the battle against cancer or a specified disease, even with medical insurance.

THIS CANCER PLAN is designed to create a source of extra cash that will help you and your family cope during the battle against cancer or a specified disease.

Extra cash when you need it. Here's how it works:

- We provide cash benefits to you.
- You use the money to meet your needs - loss of income, house and car payments, transportation for treatment, other bills, etc. These non-medical expenses of cancer may not be covered by your major medical insurance.

Plus, you get these unique features:

- Guaranteed renewable for life. You can't lose your coverage, as long as you continue to pay your premiums.
- Cash benefits paid to you regardless of any other medical insurance plan you may have.
- No lifetime maximum limits for most cash benefits.
- Provides cash to offset the costs of 30 other diseases, at no extra premium cost.
- Coverage is portable. Employees can keep the coverage if they change jobs.

Selected benefits paying cash to you:

- Cancer Screening Tests
- Chemotherapy, Radiation, Immunotherapy, or Radioactive Isotopes Therapy
- Experimental Treatment
- Individual/Family Transportation and Lodging

**Cancer Facts & Figures, American Cancer Society, 2001.*

***Report from the American Hospital Administration.*

Assurity Cancer & Specified Disease Plan

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 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.

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 pay 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 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 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 Assurance to get a wellness claim form or download one from www.markiiiibrokerage.com/cityofmcminnville. 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.markiiiibrokerage.com/cityofmcminnvilletn. 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.

Internal Cancer First Occurrence Rider - pays \$2,500 or \$5,000 the first time an insured is diagnosed as having internal cancer.

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

A608-1009



Cancer and Specified Dread Disease Benefit with Radiation/Chemotherapy

SEMI-MONTHLY RATES

Assurity Life Cancer & Specified Disease Plan				
		\$150 Daily Benefit	\$250 Daily Benefit	\$350 Daily Benefit
Base Policy (\$10,000 per month/\$100,000 lifetime maximum) (radiation/chemotherapy)	Individual	\$10.46	\$11.61	\$12.76
	EE & Spouse	\$16.02	\$17.81	\$19.60
	EE & Children	\$13.00	\$14.30	\$15.61
	Family	\$18.56	\$20.50	\$22.44
Base Policy with Intensive Care Rider (\$300 daily benefit)	Individual	\$11.51	\$12.66	\$13.81
	EE & Spouse	\$18.12	\$19.91	\$21.70
	EE & Children	\$14.65	\$15.95	\$17.26
	Family	\$21.26	\$23.20	\$25.14
Base Policy with Intensive Care Rider (\$600 daily benefit)	Individual	\$12.56	\$13.71	\$14.86
	EE & Spouse	\$20.22	\$22.01	\$23.80
	EE & Children	\$16.30	\$17.60	\$18.91
	Family	\$23.96	\$25.90	\$27.84
Base Policy with First Occurrence Benefit Rider (\$2,500 benefit)	Individual	\$11.88	\$13.03	\$14.18
	EE & Spouse	\$18.14	\$19.93	\$21.71
	EE & Children	\$14.71	\$16.01	\$17.32
	Family	\$20.97	\$22.91	\$24.85
Base Policy with First Occurrence Benefit Rider (\$2,500 benefit) and Intensive Care Rider (\$300 daily benefit)	Individual	\$12.93	\$14.08	\$15.23
	EE & Spouse	\$20.24	\$22.03	\$23.81
	EE & Children	\$16.36	\$17.66	\$18.97
	Family	\$23.67	\$25.61	\$27.55
Base Policy with First Occurrence Benefit Rider (\$2,500 benefit) and Intensive Care Rider (\$600 daily benefit)	Individual	\$13.98	\$15.13	\$16.28
	EE & Spouse	\$22.34	\$24.13	\$25.91
	EE & Children	\$18.01	\$19.31	\$20.62
	Family	\$26.37	\$28.31	\$30.25
Base Policy with First Occurrence Benefit Rider (\$5,000 benefit)	Individual	\$13.29	\$14.44	\$15.59
	EE & Spouse	\$20.25	\$22.04	\$23.83
	EE & Children	\$16.42	\$17.72	\$19.03
	Family	\$23.38	\$25.32	\$27.26
Base Policy with First Occurrence Benefit Rider (\$5,000 benefit) and Intensive Care Rider (\$300 daily benefit)	Individual	\$14.34	\$15.49	\$16.64
	EE & Spouse	\$22.35	\$24.14	\$25.93
	EE & Children	\$18.07	\$19.37	\$20.68
	Family	\$26.08	\$28.02	\$29.96
Base Policy with First Occurrence Benefit Rider (\$5,000 benefit) and Intensive Care Rider (\$600 daily benefit)	Individual	\$15.39	\$16.54	\$17.69
	EE & Spouse	\$24.45	\$26.24	\$28.03
	EE & Children	\$19.72	\$21.02	\$22.33
	Family	\$28.78	\$30.72	\$32.66

AAW-C120RAB (7/04)

Superior Vision Plan

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.

Semi-Monthly Cost

Employee Only	\$4.70
Employee + Family	\$11.80

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.

Lincoln Financial Long Term Disability Plan

ELIGIBILITY

All full-time employees working in the United States of America who are Actively at Work for the Employer and who have completed the waiting period required by the Employer.

A “full-time” employee is one who regularly works a minimum of 30 hours per week for the Employer. Part-time, seasonal and temporary employees are not eligible.

WAITING PERIOD

For employees in an eligible group - 30 Days of continuous active, full-time employment.

ELIMINATION PERIOD

- 180 Days

MONTHLY BENEFIT

60% of Monthly Earnings to a maximum benefit of \$6,000 per month subject to reduction by deductible sources of income or Disability Earnings.

SOCIAL SECURITY OFFSET METHOD - Family Social Security

EMPLOYER CONTRIBUTION - 100% of premium

MAXIMUM BENEFIT DURATION - 2 years

PRE-EXISTING CONDITION LIMITATION - 3/12

OTHER FEATURES

- Waiver of Premium
- Work Incentive Benefit
- Enhanced Work Incentive Benefit
- Minimum Benefit - \$100
- Recurrent Disability - 3 months
- Survivor Benefit
- Worksite Modification Benefit
- Vocational Rehabilitation Service
- Social Security Assistance
- 24 Month Own Occupation

Lincoln Financial Employee Basic Life and AD&D - Employee Optional Life and AD&D

Effective Date: 1/1/10

BASIC EMPLOYEE LIFE INSURANCE

This insurance is payable for death from any cause to any person you name as beneficiary.

OPTIONAL EMPLOYEE LIFE INSURANCE

Your employer-sponsored basic life coverage provides important protection for you, but you may need to add to that protection. Now you can...at low group rates and through convenient payroll deductions.

To help meet this need, you have the opportunity to elect additional group life insurance under the optional portion of your program to go along with any personal insurance coverage you may have.

OPTIONAL DEPENDENT LIFE INSURANCE

Provides coverage on:

- Your Spouse
- Unmarried child(ren) from live birth to 14 days \$0, 14 days to 6 months \$250, 6 months to age 19 \$5,000 or to age 25 if full time student. Handicapped children can continue to be covered with no age limit.

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

ACCIDENTAL DEATH AND DISMEMBERMENT

Benefits under this coverage are payable as described in your certificate. All active employees have Basic Accidental Death and Dismemberment coverage. Matching Optional Accidental Death and Dismemberment amounts apply to employees electing Optional Life coverage.

ELIGIBILITY

You will be eligible for this program if you are a permanent employee who works a minimum of 30 hours per week.

ENROLLMENT

Enrollment is simple - employees need to complete an enrollment card and may need an Evidence of Insurability for Additional Life. Forms are provided by your Employer.

BENEFICIARY

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

WHEN YOUR BASIC INSURANCE STARTS

If you enroll on or before the day you become eligible your 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.

WHEN YOUR OPTIONAL INSURANCE STARTS

If you enroll for Optional and/or Dependent Life Insurance on or before you become eligible for coverage, your insurance becomes effective on the date of your eligibility if you are actively at work. If you or a covered dependent are confined in a hospital, not actively at work, or not performing normal daily activities, your insurance will not be effective. You and/or your dependents will become covered when you return to active full-time work, are no longer confined in a hospital, and can perform normal daily activities. Normal daily activities means not confined at home under the care of a doctor for sickness or injury and not entitled to receive any disability income from any source.

Eligible employees and dependents who do not apply for coverage within 31 days of becoming eligible under the plan must submit proof of good health and The Lincoln Financial Insurance Company must approve it.

REDUCTIONS AT AGE 65 & OVER

If you remain in active service beyond age 65 your combined amount of Basic Life and Supplemental Employee Life Insurance will reduce as follows:

Employee Attained <u>Age</u>	Percent of Original <u>Amount</u>	Spouse <u>Amount</u>
65	65%	65%
70	50%	Terminates

TERMINATION OF COVERAGE

All insurance under this plan will terminate upon the earlier of retirement, termination of employment, when the plan ceases or when you withdraw from the plan. Nevertheless, if you should die within 31 days thereafter, your life insurance will still be paid to the beneficiary. If any of your covered dependents should die within such 31 day period, the amount of Life Insurance on the life of such dependent will be paid to you.

DISABILITY

If you become totally disabled for a consecutive 180 days and are under age 60 the amount of life insurance will be continued without payment of premium provided you give Lincoln Financial Proof of Loss. The amount of insurance is subject to any age reductions. Waiver of premium terminates at age 65, date you cease to become totally disabled or the date you convert your insurance to an individual plan.

CONVERSION

If your employment terminates while you are covered under the plan, you may purchase without medical evidence of insurability, any individual insurance policy, except a term policy, then issued by The Lincoln Financial Insurance Company in any amount up to the amount of your 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 and Optional Dependent Life Insurance

as well as the Basic Employee 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 and can perform with reasonable continuity the material duties of at least one gainful occupation.
- Retirement
- Under age 65
- Change in employee class which results in the termination of optional life benefits.
- Insured under the group policy for 12 months
- Apply within 31 days of qualifying event.

The minimum face amount which an employee may elect portability is \$10,000. 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

The Lincoln Financial Insurance Company 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 additional employee life benefits are payable if you commit suicide within 2 years from effective date of coverage. AD&D benefits are not payable.

GROUP POLICY AND CERTIFICATE

The insurance briefly described in this folder is subject to the terms and conditions of the Group Policy issued by The Lincoln Financial Insurance Company. If you become insured, you will receive a certificate outlining your benefits under this policy.

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

BASIC EMPLOYEE LIFE INSURANCE AND AD&D

All Eligible Employees (No cost to you)

\$50,000*

OPTIONAL EMPLOYEE LIFE INSURANCE AND AD&D

Your choice of the following amounts:* \$10,000 to \$250,000 in increments of \$10,000 not to exceed 5X annual salary.

Employees 70+ - \$50,000 max

Guaranteed Issue amount for optional life is \$150,000 for employees under 70 years old and \$20,000 for employees 60-69.

No Guaranteed Issue for employees above 70.

OPTIONAL DEPENDENT LIFE INSURANCE

\$10,000 on Spouse / \$5,000 on Child(ren)

Dependent Life may only be purchased with Employee Optional Life

\$.93 Unit / Semi-Monthly Rate

Semi-Monthly Rates (24 payroll deductions per year)

Monthly Rate	Under Age 30	Ages 30-34	Ages 35-39	Ages 40-44	Ages 45-49	Ages 50-54	Ages 55-59	Ages 60-64	Ages 65-69	Age 70+
10,000	\$0.60	\$0.70	\$0.85	\$1.35	\$2.15	\$3.40	\$5.20	\$8.00	\$14.20	\$25.30
20,000	\$1.20	\$1.40	\$1.70	\$2.70	\$4.30	\$6.80	\$10.40	\$16.00	\$28.40	\$50.60
30,000	\$1.80	\$2.10	\$2.55	\$4.05	\$6.45	\$10.20	\$15.60	\$24.00	\$42.60	\$75.90
40,000	\$2.40	\$2.80	\$3.40	\$5.40	\$8.60	\$13.60	\$20.80	\$32.00	\$56.80	\$101.20
50,000	\$3.00	\$3.50	\$4.25	\$6.75	\$10.75	\$17.00	\$26.00	\$40.00	\$71.00	\$126.50
60,000	\$3.60	\$4.20	\$5.10	\$8.10	\$12.90	\$20.40	\$31.20	\$48.00	\$85.20	\$151.80
70,000	\$4.20	\$4.90	\$5.95	\$9.45	\$15.05	\$23.80	\$36.40	\$56.00	\$99.40	\$177.10
80,000	\$4.80	\$5.60	\$6.80	\$10.80	\$17.20	\$27.20	\$41.60	\$64.00	\$113.60	\$202.40
90,000	\$5.40	\$6.30	\$7.65	\$12.15	\$19.35	\$30.60	\$46.80	\$72.00	\$127.80	\$227.70
100,000	\$6.00	\$7.00	\$8.50	\$13.50	\$21.50	\$34.00	\$52.00	\$80.00	\$142.00	\$253.00
110,000	\$6.60	\$7.70	\$9.35	\$14.85	\$23.65	\$37.40	\$57.20	\$88.00	\$156.20	\$278.30
120,000	\$7.20	\$8.40	\$10.20	\$16.20	\$25.80	\$40.80	\$62.40	\$96.00	\$170.40	\$303.60
130,000	\$7.80	\$9.10	\$11.05	\$17.55	\$27.95	\$44.20	\$67.60	\$104.00	\$184.60	\$328.90
140,000	\$8.40	\$9.80	\$11.90	\$18.90	\$30.10	\$47.60	\$72.80	\$112.00	\$198.80	\$354.20
150,000	\$9.00	\$10.50	\$12.75	\$20.25	\$32.25	\$51.00	\$78.00	\$120.00	\$213.00	\$379.50
160,000	\$9.60	\$11.20	\$13.60	\$21.60	\$34.40	\$54.40	\$83.20	\$128.00	\$227.20	\$404.80
170,000	\$10.20	\$11.90	\$14.45	\$22.95	\$36.55	\$57.80	\$88.40	\$136.00	\$241.40	\$430.10
180,000	\$10.80	\$12.60	\$15.30	\$24.30	\$38.70	\$61.20	\$93.60	\$144.00	\$255.60	\$455.40
190,000	\$11.40	\$13.30	\$16.15	\$25.65	\$40.85	\$64.60	\$98.80	\$152.00	\$269.80	\$480.70
200,000	\$12.00	\$14.00	\$17.00	\$27.00	\$43.00	\$68.00	\$104.00	\$160.00	\$284.00	\$506.00
210,000	\$12.60	\$14.70	\$17.85	\$28.35	\$45.15	\$71.40	\$109.20	\$168.00	\$298.20	\$531.30
220,000	\$13.20	\$15.40	\$18.70	\$29.70	\$47.30	\$74.80	\$114.40	\$176.00	\$312.40	\$556.60
230,000	\$13.80	\$16.10	\$19.55	\$31.05	\$49.45	\$78.20	\$119.60	\$184.00	\$326.60	\$581.90
240,000	\$14.40	\$16.80	\$20.40	\$32.40	\$51.60	\$81.60	\$124.80	\$192.00	\$340.80	\$607.20
250,000	\$15.00	\$17.50	\$21.25	\$33.75	\$53.75	\$85.00	\$130.00	\$200.00	\$355.00	\$632.50

This is a summary of benefits. The actual policy will govern the contractual provisions and benefits. Please refer to the certificate of plan summary given to you by your employer for detailed information.

Disability Is A Fact of Life

- ◆ 27,000,000 Americans are currently on disability.
- ◆ 6.85 out of 10 people between the ages of 20 and 35 will suffer a disability that lasts 3 months or longer.
- ◆ If a disability lasts longer than 3 months, its average duration is 2.9 years at age 30, 3.9 years at age 40 and 4.5 years at age 50.
- ◆ 48% of all home foreclosures done in this country today are a result of disabilities, only 3% are due to premature death.
- ◆ Death rates are down; disability rates are up.
- ◆ At ages 35 - 40, your chances of being disabled are twice as great as those of dying.
- ◆ Worker's Compensation rates recently rose again. Analysts attribute this in part to the inclusion of stress on the job as a possible claim.
- ◆ Each year, the statistics average as follows:
 - ▶ 1 in 106 people die
 - ▶ 1 in 88 homes catch fire
 - ▶ 1 in 70 cars is involved in a serious accident
 - ▶ 1 in 8 people are disabled

Source: Commissioners Disability Trade, US Gov't Housing/Finance, Society of Actuaries

Could You Live Off Of Savings?

Standard Life Short Term Disability

Effective Date: January 1, 2010 (pending underwriting approval)

- 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 from pregnancy 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.

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

Disability resulting from Pregnancy: Benefits are covered provided conception occurs after the effective date of the policy.

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.

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.

Semi-Monthly Rates (24 payroll deductions per year)

Benefit Duration: 90 Days		Benefit Duration: 180 Days		Benefit Duration: 365 Days	
Monthly Benefit	Semi-Monthly Premium	Monthly Benefit	Semi-Monthly Premium	Monthly Benefit	Semi-Monthly Premium
\$500	\$5.63	\$500	\$8.75	\$500	\$11.25
\$600	\$6.75	\$600	\$10.50	\$600	\$13.50
\$700	\$7.88	\$700	\$12.25	\$700	\$15.75
\$800	\$9.00	\$800	\$14.00	\$800	\$18.00
\$900	\$10.13	\$900	\$15.75	\$900	\$20.25
\$1,000	\$11.25	\$1,000	\$17.50	\$1,000	\$22.50
\$1,100	\$12.38	\$1,100	\$19.25	\$1,100	\$24.75
\$1,200	\$13.50	\$1,200	\$21.00	\$1,200	\$27.00
\$1,300	\$14.63	\$1,300	\$22.75	\$1,300	\$29.25
\$1,400	\$15.75	\$1,400	\$24.50	\$1,400	\$31.50
\$1,500	\$16.88	\$1,500	\$26.25	\$1,500	\$33.75
\$1,600	\$18.00	\$1,600	\$28.00	\$1,600	\$36.00
\$1,700	\$19.13	\$1,700	\$29.75	\$1,700	\$38.25
\$1,800	\$20.25	\$1,800	\$31.50	\$1,800	\$40.50
\$1,900	\$21.38	\$1,900	\$33.25	\$1,900	\$42.75
\$2,000	\$22.50	\$2,000	\$35.00	\$2,000	\$45.00

**STANDARD LIFE AND CASUALTY CLAIMS
TOLL-FREE NUMBER IS: 1-800-227-0251**



AGAC Critical Illness Plan

Effective Date: January 1, 2010 (pending underwriting approval)

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.
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 in-force. 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 pay-

ment 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.

City of McMinnville Critical Illness

Semi-Monthly Rates

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

EMPLOYEE NON-TOBACCO										
AGES	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
18-29	\$1.80	\$2.73	\$3.65	\$4.58	\$5.50	\$6.43	\$7.35	\$8.28	\$9.20	\$10.13
30-39	\$2.58	\$4.28	\$5.98	\$7.68	\$9.38	\$11.08	\$12.78	\$14.48	\$16.18	\$17.88
40-49	\$4.33	\$7.78	\$11.23	\$14.68	\$18.13	\$21.57	\$25.03	\$28.48	\$31.93	\$35.38
50-59	\$7.11	\$13.34	\$19.57	\$25.81	\$32.04	\$38.27	\$44.51	\$50.74	\$56.98	\$63.21
60-69	\$10.88	\$20.88	\$30.88	\$40.88	\$50.88	\$60.88	\$70.88	\$80.88	\$90.88	\$100.88
EMPLOYEE TOBACCO										
AGES	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
18-29	\$2.43	\$3.98	\$5.53	\$7.08	\$8.63	\$10.18	\$11.73	\$13.28	\$14.83	\$16.38
30-39	\$3.80	\$6.73	\$9.65	\$12.58	\$15.50	\$18.43	\$21.35	\$24.28	\$27.20	\$30.13
40-49	\$8.13	\$15.38	\$22.63	\$29.88	\$37.13	\$44.38	\$51.63	\$58.88	\$66.13	\$73.38
50-59	\$13.38	\$25.88	\$38.38	\$50.88	\$63.38	\$75.88	\$88.38	\$100.88	\$113.38	\$125.88
60-69	\$20.88	\$40.88	\$60.88	\$80.88	\$100.88	\$120.88	\$140.88	\$160.88	\$180.88	\$200.88
SPOUSE NON-TOBACCO										
AGES	\$5,000	\$7,500	\$10,000	\$12,500	\$15,000	\$17,500	\$20,000	\$22,500	\$25,000	
18-29	\$1.80	\$2.25	\$2.73	\$3.19	\$3.64	\$4.12	\$4.57	\$5.05	\$5.50	
30-39	\$2.58	\$3.42	\$4.27	\$5.14	\$5.98	\$6.83	\$7.67	\$8.52	\$9.38	
40-49	\$4.33	\$6.05	\$7.78	\$9.49	\$11.22	\$12.96	\$14.67	\$16.40	\$18.14	
50-59	\$7.11	\$10.23	\$13.35	\$16.47	\$19.57	\$22.68	\$25.81	\$28.93	\$32.05	
60-69	\$10.88	\$15.88	\$20.87	\$25.87	\$30.88	\$35.88	\$40.88	\$45.87	\$50.87	
SPOUSE TOBACCO										
AGES	\$5,000	\$7,500	\$10,000	\$12,500	\$15,000	\$17,500	\$20,000	\$22,500	\$25,000	
18-29	\$2.43	\$3.21	\$3.97	\$4.75	\$5.53	\$6.31	\$7.09	\$7.84	\$8.62	
30-39	\$3.79	\$5.27	\$6.72	\$8.19	\$9.64	\$11.12	\$12.57	\$14.04	\$15.49	
40-49	\$8.13	\$11.74	\$15.38	\$19.00	\$22.62	\$26.26	\$29.88	\$33.50	\$37.12	
50-59	\$13.37	\$19.63	\$25.87	\$32.13	\$38.37	\$44.63	\$50.87	\$57.13	\$63.38	
60-69	\$20.87	\$30.88	\$40.88	\$50.87	\$60.88	\$70.87	\$80.88	\$90.87	\$100.88	

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

AMERICAN GENERAL ASSURANCE COMPANY
1000 East Woodfield Road / Schaumburg, Illinois 60173
Customer Service: 800-308-6457



Texas Life Whole Life Insurance Plan

Common Issue Date: February 1, 2010 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.*



Since 1901 900 Washington Post Office Box 830 Waco, Texas 76703-0830

Continuation of Benefits

AMERIFLEX MEDICAL & DEPENDENT CARE REIMBURSEMENT ACCOUNT

If you have a positive balance (payroll deductions are greater than the amount you have received in reimbursement) in your Medical Reimbursement Account at the time of your termination, you may continue participation in the Plan for the remainder of the Plan year. If you want to remain in the Plan, you can do by selecting the COBRA option.

If you prefer to terminate your participation and contribution to the Plan, any balance in your account on the date of termination will be forfeited if expenses were not incurred prior to the date of termination. For more detailed information, please call Ameriflex at 888-868-3539.

BLUE CROSS BLUE SHIELD OF TN PPO/HSA PLAN

Under the medical plan, you and your covered dependents are eligible to continue medical coverage through COBRA according to the following “qualifying events”. If you and your dependents are enrolled in the medical plan, you will be eligible to continue coverage through COBRA for a specified period after you leave your employment.. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents maybe eligible to continue medical coverage through COBRA. Also, while you are covered under the plan, your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA. Examples of an ineligible dependent would be when your child graduates from college or turns 24 years old. To continue coverage thru COBRA, your employer will notify IMS of your termination and IMS will then send you a letter regarding COBRA. Should you have any questions you can contact Interactive Medical Systems (IMS) at (800) 426-8739 ext. 3130.

ASSURITY CANCER PLAN

When you leave your employment, you may continue your Assurity Cancer coverage by having the premiums that are currently deducted from your paycheck billed directly to your home address or drafted from your bank account. For billing options, please call Assurity at (866) 289-7337.

AMERITAS DENTAL PLAN

Under the Ameritas dental plan, you and your covered dependents are eligible to continue dental coverage through COBRA according to the following “qualifying events”.

If you and your dependents are enrolled in the dental plan, you will be eligible to continue coverage through COBRA for a specified period after you leave your employment. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered

dependents maybe eligible to continue dental coverage through COBRA. Also, while you are covered under the plan, your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA. Examples of an ineligible dependent would be when your child graduates from college, or turns 24 years old. To continue coverage thru COBRA, your employer will notify IMS of your termination and IMS will then send you a letter regarding COBRA. Should you have any questions you can contact Interactive Medical Systems (IMS) at (800)426-8739.

STANDARD LIFE SHORT TERM DISABILITY PLAN

When you leave your employment, you may continue your short term disability coverage as long as continuous employment is maintained. Coverage expires at age 65. Please contact Standard Life at (800)327-0695 to set up direct bill to your home address.

SUPERIOR VISION PLAN

Under the Superior Vision plan, you and your covered dependents are eligible to continue vision coverage through COBRA according to the following “qualifying events”.

If you and your dependents are enrolled in the vision plan, you will be eligible to continue coverage through COBRA after you leave your employment for a specified period. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents maybe eligible to continue vision coverage through COBRA. Also, while you are covered under the plan, your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA. Examples of an ineligible dependent would be when your child graduates from college, or turns 24 years old. To continue coverage thru COBRA, your employer will notify IMS of your termination and IMS will then send you a letter regarding COBRA. Should you have any questions you can contact Interactive Medical Systems (IMS) at (800)426-8739.

LINCOLN FINANCIAL TERM LIFE PLAN

Conversion/ Portability:

If your employment terminates while you are covered under the plan, you may convert or port your term life coverage within 31 days from the date your coverage terminates.

To get information and rates for coverage, please contact your benefits department.

UNUM UNIVERSAL LIFE

When you leave your employment, you may continue your Unum universal life insurance coverage by having the premiums that are currently deducted from your paycheck billed to your home address or drafted from your bank account. Unum will send you a letter explaining your options or you may make arrangements by contacting **Unum at 1-800-635-1049.**

AIG CRITICAL ILLNESS

When you leave employment coverage may be continued as long as you have been continuously insured for at least six months prior to terminating employment. You may continue the coverage that was in force on the date employment ended, including any dependent coverage that was in effect. Please contact **AIG at 800- 308-6457.**

TEXAS LIFE WHOLE LIFE

When you leave the employment of City of McMinnville you may continue your Texas Life Whole Life coverage by having the premiums that are currently deducted from your paycheck billed to your home address or drafted from your bank account. **You may do that by contacting Texas Life Insurance Company at (800) 283-9233 prompt #3.**

Important Phone Numbers:

City of McMinnville Benefits Department- 931-473-1209

Mark III Brokerage, Inc.- 423-929-2051

Ameriflex Medical and Dependent Care - 888-868-3539

BlueCross/Blue Shield Medical Plan - 800-451-9097

Horizon Behavioral Services (EAP) - (800) 955-6422

Assurity Cancer Plan - 888-358-8808, ext. 23

Ameritas Dental Plan - 800-776-9446

Superior Vision Plan - 800-507-3800

Standard Life STD Plan - 800-327-0695 or 800-227-0251

AIG Critical Illness Plan- 800-308-6457

Lincoln Financial Life Plan - (call benefits department) - 931-473-1209

Texas Life Insurance Company - 800-283-9233 prompt #3