

Enrollment Dates: May 18, 2009 - August 12, 2009

Davidson County Schools offers all full-time employees a comprehensive Cafeteria Benefits program. The Cafeteria Benefits program is arranged by Mark III Brokerage, an employee benefits firm that has worked in the public sector since 1973. The Cafeteria Benefits program allows you to pay for certain insurance premiums, child-care, and non-reimbursed medical expenses before taxes are taken out of your paycheck. Paying for these benefits by this method reduces your applicable FICA and income tax withholding resulting in increases to your take home pay. The Cafeteria Benefits program includes pre-tax and after-tax products.

- The Plan Year is from September 1, 2009 to August 31, 2010.
- Internet Enrollment Dates: May 18, 2009 thru August 12, 2009.
- Changes during Enrollment Period must be made by August 12, 2009.

PRE-TAX BENEFITS

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(This booklet highlights the benefits offered through your employer for the current plan year. This is not an Insurance Contract and only the actual policy provisions will prevail. All information in this booklet including premiums are subject to change. All policy descriptions are for informational purposes only).

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WeCare Internet Enrollment Instructions

Logon to the following website: www.davidson.k12.nc.us and click on Internet Enrollment (LOCATED ON THE DAVIDSON COUNTY SCHOOLS HOME PAGE)

To enter the Enrollment internet site:

- Enter Case ID: 912
- Enter the Online ID which is: last 5 digits of your SSN, first initial of first name and first initial of last name
»Example: John Smith #123-45-6789 would be 56789js
- Enter your password which is: enroll09
- Enter Security Code (will see on screen)
- Click Sign In

1. "On-line Service Agreement." – Please read the agreement.

- Click Agree and then click Next.
- Clicking "Agree" will allow you to enter the site. Once you click "Agree" you will go to the "Welcome Page."
- Click "Enter" to continue.
- Clicking "Disagree" will prevent you from viewing the rest of the internet site.

2. "Start Page"

- Initially you will view the Start Page which contains important information relative to the site. Take a moment to read the information provided.
- Click "Next" to continue.
- Employee Data (you can update and correct info on this screen by clicking, Edit
- Click Next to proceed to the following screen(s)

3. "Election Summary"

- From the "Election Summary" screen you can review your benefit selection(s) and print a copy for your records.
- To print the Election Summary, click on the "Print Confirmation Statement Tab" at the bottom of the page.
- You will then need to click "Print" at the top of the "Benefit Election Form" page. Once you have printed the form, click "Close Window". Retain this print-out as proof of the benefits you have selected for the 2009-2010 plan year.

4. "Logout"

- Click "Logout" at the top of the Election Summary screen. Please close your browser when you are finished

You may enter and exit the website and update your elections as often as you like from May 18, 2009 through August 12, 2009. The site will recall the last change made each time you log on. For any changes you make, please print the benefit election summary confirmation statement for you records.

Contacts:

Shelly Hodges / 336-242-5531 or email at shodges@davidson.k12.nc.us
Cindy Horton / 800-532-1044 ext. 210 or email at cindy@markiifinancial.com.

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Key Points to Remember

- The Plan Year for Davidson County Schools is:
 - September 1, 2009 thru August 31, 2010.
- Payroll deductions for this year's enrollment:
 - End of month pay will be 08/31/09.
 - Middle of month pay will be 09/15/09.
- Please remember that elections made during annual enrollment **cannot be changed once the enrollment period ends** unless you have a qualifying event such as marriage, divorce, death of a spouse or child, birth or adoption, termination of employment or change in employment hours from full-time to part-time or vice-versa.
- If you should have a qualifying event, you will have 30-days from the date of the qualifying event to request a change to your current benefit enrollment and FSA elections. All requests must be made in writing to Shelly Hodges at the Davidson County Schools benefits office.
- You must **re-elect** your Gilsbar Medical Spending and Dependent Care Accounts each year. They do not automatically carry-over to the next year.
- For *current* Gilsbar participants, your existing Gilsbar account will be replenished as long as you re-elect the Medical Spending Account. You will **NOT** receive a new card as your existing card is good for 3 years from the issue date.
- For *new* Gilsbar participants, a card will be mailed to your home in a **plain white envelope** with no reference to Gilsbar. Again, this card will be good for three (3) years from issue date as long as you re-elect the Medical Spending Account each year.
- Medical Reimbursement and Dependent Care expenses must be *incurred during the plan year* to be eligible for reimbursement.
- Any questions regarding your Gilsbar Medical Reimbursement or Dependent Care Account can be directed to www.myGilsbar.com, or you can call Gilsbar's Customer Contact Center at 1-800-445- 7227 ext. 883.
- Access your Gilsbar account online.
 1. Go to www.mygilsbar.com to register with a valid email address and your Group Number. The group number is **S2551**
 2. Once logged in, click the Reimbursement Account Center link on the left navigation bar.
- Any questions regarding all other benefits can be directed to Shelly Hodges at 336-242-5531.

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Gilsbar Flexible Spending Accounts (General Overview)

Plan Year: September 1, 2009 - August 31, 2010

Medical Reimbursement Plan Maximum / Minimum: \$3,600 / \$240

Dependent Care Account Maximum / Minimum: \$5,000 / \$0

Waiting Period: None

Run Out Period: 90-Days

REMINDER: The Internal Revenue Service (IRS) requires review of all receipts for eligible expenses in an FSA, including debit card transactions and over the counter drugs. As a reminder, participants should keep all of their receipts for the entire plan year in the event that Gilsbar ask for documentation or the IRS requests a copy of a receipt.

Flexible Spending Accounts allow you to use pre-taxed dollars towards health care expenses such as prescription and over-the-counter medication, certain medical procedures, copays, and more. With Flexible Spending Accounts (FSA), you can save a significant amount of money on your health and day care expenses using a Health Care and/or Dependent Care Flexible Spending Account (FSA). The frequently asked FSA questions below will help you understand how to make the most of this program and your paycheck.

General questions regarding Health Care and Dependent Care Accounts:

What is an FSA?

Offered by your employer, an FSA is a reimbursement account that allows you to set aside a certain amount of each paycheck, pre-tax, to help pay for your out-of-pocket medical expenses and/or dependent day care expenses. The amount you elect is deducted from gross earnings before federal and state taxes are calculated. By using your FSA to pay for qualified expenses you save on income tax... which means your take home pay increases!

Will I pay taxes on the money I set aside?

No. FSA contributions and reimbursements are exempt from Federal Income taxes, Social Security (FICA) taxes, and in most cases, state income taxes.

What kind of savings can I realize by participating in this program?

Actual savings depend on your tax bracket, but most people will save about 30% on their eligible health care and dependent care expenses.

Can I submit expenses I incurred before the beginning of the plan year?

No. Only expenses incurred during the plan year and while you are a participant are eligible for reimbursement.

How long do I have to file a claim with Gilsbar after the plan year ends?

You have a grace period (90 days) after the end of the plan year to submit expenses incurred during the plan year.

Can I change the amount of my election(s) in the FSA program during the plan year? (i.e. my glasses cost more than I anticipated, I miscalculated my daycare expenses for the year)

Generally, you may not change your FSA elections during the Plan Year.

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However, you may change during the annual enrollment period for the coming Plan Year. There is an exception to this rule: you may change or revoke your deferral rate in the FSA if you have a Change in Dependent Status. Examples of a qualifying status change may include:

- Marriage, divorce, or legal separation
- Birth, adoption or placement for adoption of a child
- Death of a dependent or spouse
- Change in employment status for yourself or your spouse
- A significant change caused by a third party in the cost of your dependent care coverage

(You have 30 days from the date of the qualifying event to request a change to your FSA election. The change must be consistent with the qualifying event. This must be done in writing to your benefits office).

If I terminate employment, or participation in the FSA, what happens to the money left in my account(s)?

You will be reimbursed only for expenses incurred prior to your termination date, and submitted within the termination grace period. Any money remaining in your account(s) after the grace period will be forfeited.

Can I view my FSA balances online?

Yes! Visit myGilsbar.com and login to access claims information and FSA balances online. Once you are logged in, select the "Reimbursement Account Center" link on the left side of the screen to view your account balances. If you are new to myGilsbar, complete the brief site registration to login. You will need your group number, social security number, and a valid email address to complete this section.

What if I have a question?

If you have any questions regarding your account balance, claim reimbursement or eligible expenses, you can access your account information at myGilsbar.com or you can call our Customer Contact Center at 1-800-445-7227 ext. 883.

How does participating in an FSA save me money?

The following example illustrates how a FSA saves you money. This example shows the per period savings for an employee on a bi-weekly payroll, with a tax status of "single" with one exemption:

	With FSA	Without FSA
Salary	\$1000	\$1000
Less Pre-Taxed Dollars:		
Health Care Reimbursement	\$100	0
Dependent Day Care Reimbursement	\$150	0
Taxable Income	\$750	\$1000
Less:		
Federal Income Tax	\$82.00	\$121.00
State Income Tax	\$17.58	\$23.44
Social Security	\$57.37	\$76.50
Net Take Home Pay	\$593.05	\$779.06
Less Health Care & Dependent Care Expenses	\$0.00	\$250.00
Net After Expenses	\$593.05	\$529.06
Tax Savings This Pay Period: \$63.99		
Annual Tax Savings: \$63.99 X 26 pay periods = \$1,663.74		

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MEDICAL REIMBURSEMENT ACCOUNT

The Health Care FSA is simple! Provided by your employer, a Health Care FSA is a reimbursement account that allows you to set aside a certain amount of each paycheck, pre-tax, to help you pay for your out-of-pocket medical expenses. The amount you elect is deducted from gross earnings before federal and state taxes are calculated. By using your FSA to pay for qualified medical expenses you save on income tax... which means your take home pay increases.

How does the Health Care FSA Work?

With a Health Care FSA, you must decide on your contribution amount at the beginning of the plan year. The amount you designate will be equally divided between pay periods. To estimate the out-of-pocket expenses that you, your spouse, and your dependents may incur, consider any standard co-pays, prescriptions, office visit, and over-the-counter medications and planned medical expenses, i.e. braces or LASIK eye surgery. An expense worksheet has been provided at the end of this section to help you determine the amount of money to allocate to your Health Care FSA.

The IRS requires you to forfeit any money that is left in the FSA at the end of the year. Generally, it is better to underestimate the expenses and pay a little extra tax than to overestimate expenses and forfeit money. To help avoid forfeitures, you will receive a notice of your balance prior to the end of each year.

You can access balance information online 24/7 via myGILSBAR.com. Select the "Reimbursement Account Center" link on the left side of the screen to view your balances. Once you decide how much you want to contribute each paycheck, the money is automatically deposited into your account. As you incur eligible expenses, fax your completed claim form and receipts to Gilsbar for reimbursement.

What is eligible for reimbursement under the Health Care FSA?

Eligible health care expenses may include deductibles, co-payments and amounts over the maximum your plan pays, expenses for routine physicals and other expenses not covered by your health care plan. For more complete listing please refer to the "Qualified Medical Expenses Eligible for Reimbursement" list below.

How do I get reimbursed?

For reimbursement of expenses covered under a health care plan:

- Ensure your expenses are submitted to your health carrier
- If you also have coverage through a spousal plan, you must submit your expenses to both carriers before you submit your expenses for FSA reimbursement
- Once processed by your health carrier(s), complete the Health Care Expense Claim form and attach a copy of the "Explanation of Benefits" showing the unpaid expenses
- For reimbursement of expenses not covered under a health care plan: (ex.: over-the-counter medicines) Complete the Health Care Expenses claim form and attach itemized bills for the expense.

FAX CLAIMS AND PROOF OF EXPENSE TO 866-635-1329

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How much will be reimbursed?

When you submit a health care expense, you will be reimbursed for eligible expenses claim up to the maximum amount you elected for the plan year, minus any previous reimbursements.

Can I use my Health Care FSA for my family's expenses?

Eligible health care expenses incurred by you, your spouse, or any dependent that you claim as a dependent on your income tax returns are allowable for reimbursement.

If I don't have any medical insurance through my company, can I still participate in the Health Care FSA?

Yes. Out-of-pocket expenses for you and your dependents are eligible for reimbursement whether or not you are insured through your company. Health related expenses are reimbursable for your dependents, if you claim them as a dependent on your income tax returns (this definition of a dependent may be different than that used for your health insurance plan).

Is there anything I have to keep in mind when it comes time to file my taxes?

Expenses payable through your benefits program (or your spouse's, if applicable) are not eligible for reimbursement under the Health Care FSA. In addition, expenses reimbursed through your Health Care FSA cannot be claimed as a deduction on your income tax returns.

I am covered under both my health insurance plan and my spouse's. Do I have to submit medical expenses to both plans before I can file for reimbursement from my Health Care FSA?

Yes. IRS regulations do not permit reimbursement of expenses through the FSA that would otherwise be covered under your health insurance plan. Expenses should first be submitted to your health insurance plan(s), then send any remaining unpaid claims to Gilsbar for reimbursement.

If I have a question about my account, what should I do?

If you have any questions, you can access your account information 24/7 at myGilsbar.com, or you can call Gilsbar's Customer Contact Center at 1-800-445-7227 ext. 883.

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The following is a brief summary of information and is intended to serve as a quick reference to help determine whether or not an expense may be eligible for reimbursement. This list is not all-inclusive. This information is not tax advice. Tax advice should be obtained from a professional tax advisor.

Qualified Medical Expenses Eligible For Reimbursement:

Acupuncture	Guide dog	Orthopedist
Alcoholism Treatment	Gynecologist	Osteopath
Ambulance	Healing service	Over-the-counter medications *
Anesthetists	Hearing aid and batteries	Oxygen
Artificial limbs	Hospital bills	Paid-for medical care service
Birth control pills (by prescription)	Hydrotherapy	Pediatrician
Blood tests	Immunizations	Physician
Braces	Insulin treatments	Physiotherapist
Braille books and magazines	Lab tests	Postnatal treatments
Cardiographs	Lead paint removal	Practical nurse
Chiropractor	Legal fees (to authorize treatment for a mental illness)	Prenatal care
Christian Science Practitioner	Lodging away from home for outpatient care	Prescription medicines
Contact lenses	Medical services	Psychiatrist
Contraceptive devices	Medical Testing	Psychoanalyst
Convalescent home (for medical treatment only)	Metabolism tests	Psychologist
Crutches	Neurologist	Psychotherapy
Dental treatment	Nursing (including board and meals)	Radium Therapy
Dental x-rays	Obstetrician	Registered nurse
Dentures	Operating room costs	Special School
Dermatologist	Ophthalmologist	Spinal fluid tests
Diagnostic fees	Optician	Splints
Drug addiction therapy costs	Oral surgery	Sterilization
Drugs (prescription)	Organ transplant (including donor's expenses)	Stop smoking programs
Equipment (medical)	Orthodontist	Surgeon
Eye exams and eyeglasses	Orthopedic shoes	
FICA and FUTA tax for the handicapped		

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Telephone equipment to assist the hearing impaired	Transportation expenses relative to health care (Mileage is eligible for the miles driven to and from the doctor's office. The amount that can be reimbursed is nineteen (19) cents per mile.)	Vasectomy
Television equipment for the hearing impaired		Vitamins (if prescribed)
Therapy equipment	Ultra-violet ray treatment	Weight loss programs* (not food)
Transplants (organ)	Vaccines	Wheelchair
		X-rays

* May require additional substantiation (documents of medical necessity)

Expenses Not Eligible For Reimbursement

Any expense not considered "medically necessary" by the IRS	Electrolysis	Laetrile
	Face lifts	Liposuction
Any expense for your general health, even if your doctor prescribes the program	Food	Marijuana used medically
	Funeral, cremation, or burial expenses	Maternity clothes
Babysitting and childcare	Hair transplants	Personal use items
Bleaching teeth (cosmetic)	Health club membership dues	Prescription drugs considered cosmetic
Cosmetic surgery	Household help	Rogaine
Dancing lessons	Illegal operations and treatments	Swimming lessons
Diaper service		Vitamins
Dietary supplements	Insurance premiums	

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OVER-THE-COUNTER DRUG/MEDICINE LIST

**Over-the-Counter Drugs Used Primarily for Medical Care.
THE DRUGS/ MEDICINES LISTED BELOW ARE APPROVED WITH A RECEIPT FROM THE PROVIDER/ STORE. A RECOMMENDATION FROM A HEALTH CARE PROVIDER IS NOT NEEDED.**

The following is a brief summary of information and is intended to serve as a quick reference to help determine whether or not an expense may be eligible for reimbursement. This list is not all-inclusive. This information is not tax advice. Tax advice should be obtained from a professional tax advisor. IRS Publication 502 can be ordered from the IRS 1-800-TAX-FORM (1-800-829-3676).

Drug / Medicine	Examples
Allergy Prevention & Treatment	Benadryl, Sudafed, Actifed, Claritin, Chloral Trimeton, and Nasalcrom
Antacids and Acid Reducers	Gas-X, Maalox, Mylanta, Tums, AXID AR, Pepcid AC, Prilosec OTC, Tagamet HB, Zantac 75
Anticandial	Femstat 3, Gyne-Lotrimin, Mycelrx-7, Monistat 3, 7, and Vagistat-1
Antihistamines	Actidil Syrup and Capsule, Actifed, Allerest, Benadryl, Claritin, Chlor-Trimeton, Contac, Dimetane, Drixoral, Nyquil, Sudafed, Tavist-1, and Triaminic
Anti-diarrheal and Laxatives	Ex-Lax, Pepto-Bismol, Immodium A.D. and Kaopectate
Anti-fungal	Lamisil AT, Lotramin AF, and Micatin
Anti-itch Lotions and Creams	Bactine, Caldecort, Cortaid, Hydrocortisone, and Lanacort, Calamine Lotion, Benadryl Cream, Caladryl, Lamisil AT, Lotramin AF and Micatin
Asthma	Primatene Mist
Cold Sore / Fever Blister	Abreva Cream, Carmex
Condoms and other contraceptive Devices	Trojans, Magnums, VGF Films, and Delfen Contraceptive Foam

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Drug / Medicine	Example
Contact Lenses Solutions	Baush & Lomb, Renu, Aosept, Allergan, Boston and Opti-Free
Cough Suppressants	Robitussin, Vicks 44, Chloraseptic
Decongestant / Nasal Decongestant and Cold Remedies	Advil Cold and Sinus, Afrin, Afrinol, Aleve Cold and Synus, Children's Advil Cold, Duration, Dristan Long Lasting, Neo-Synephrine-12 Hour, Orrivin, Sudafed, Tavist-D, Tylenol Cold and Flu, Thera-ful, Alka Seltzer Cold and Flu, Nyquil, Actidil Syrup and Capsules, Actifed, Allerest, Benadryl, Claritin, Chlor-Trimeton, Contac, Dimetane, Drixoral, Sudafed, Tavist-1, and Triaminic
Diaper Rash Ointments	Balmax and Destin
Eye Drops for Allergy / Cold Relief	Ocu Hist
First Aid Supplies	Ace Bandages, Band-Aids, Bandage Tapes, Thermometers, Medical Gloves, Gauze, Neosporin, Rubbing Alcohol, and Visine
Hemorrhoid Treatments	Preparation H, Hemroid, and Tronolane
Internal Analgesics / Antipyretic	Advil, Aleve, Children Motrin, Nuprin, Excedrin, Tylenol, and Bayer
Incontinence Supplies	Depends
Liniments	BenGay, Tiger Balm, and Flexall
Medical Monitoring	Services and Bracelets specifically for medical information
Medical Products and Devices	Blood Pressure Monitor, Glucose Tester, HIV Test, Cholesterol Test, Diabetic Supplies, Crutches, Ovulation Monitor and Pregnancy Testing Kit
Menstrual Cycle Medications	Midol, Pamprin, and Premysyn PMS

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Drug / Medicine	Examples
Migraine	Advil Migraine Liqui-gels, Excedrin Migraine, Motrin Migraine Pain
Motion Sickness Medication	Dramamine and Marizine
Nicotine Gum or Patches and Smoking Cessation Aids	Nicorette, Nicotrol and Nicodin
Pediculicide (head lice)	Nix
Poison Ivy Protection	Ivy Block
Smoking Cessation	Commit, Nicoderm CQ, Nicorette, Nicotrol
Toothache and Teething Pain Relievers	Orajel
Wart Removal and Medications	Tinamed

Dual Purpose OTC Drugs. THE ITEMS LISTED BELOW REQUIRE A THIRD-PARTY RECEIPT AND A NOTE FROM THE HEALTH CARE PROVIDER LISTING THE DIAGNOSIS OF THE MEDICAL CONDITION OR ILLNESS AND THE RECOMMENDATION OF THE OTC DRUG / MEDICINE. This list is not all inclusive and is intended to give examples of the most common brand names of OTC drugs.

- Anti-baldness/hair loss/hair replacement, such as Rogaine, but only if to replace hair loss due to a medical condition (e.g. cancer treatment) and not for balding due to age.
- Fiber supplements such as Benefiber and Metamucil
- Glucosamine/Chondroitin for arthritis or other medical conditions (not reimbursable if taken for overall joint health)
- Herbal supplements used to treat a specific disease such as St. John's wort for depression
- Hormone therapy drugs
- Medicated shampoos used to treat a specific medical condition like psoriasis and only the amount in excess of the cost of normal shampoo
- No Doz (and other sleep prevention drugs)
- Nose strips for proper breathing or other medical conditions
- Pedialyte for a child's dehydration
- Retin-A and other acne medicines (not reimbursable if used for cosmetic purposes such as wrinkle reduction)
- Sleep Aids
- Snoring cessation aids and medications such as Breath Right Spray, Snorezz
- Sunscreen and Sunblock

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- Vitamins are not an eligible expense, unless prescribed by a physician to treat a specific medical condition (i.e. Iron to treat, not prevent anemia, Calcium Supplements to treat, not prevent Osteoporosis). A doctor's note detailing the specific medical condition will be required for reimbursement.
- Weight loss/dietary supplements must be for a specific medical condition such as obesity.

Health Care FSA Expense Worksheet

This worksheet has been prepared to help you determine the amount of money you wish to allocate to your Health Care FSA. You may want to review your checkbook register or credit card statements from last year to identify medical expenses you paid out of your own pocket. Compare last year's typical expenses to those eligible under your Health Care FSA and budget accordingly for the upcoming year, keep in mind to only budget for those expenses specifically eligible under your Health Care FSA.

HEALTH CARE EXPENSES YOU PAID LAST YEAR COULD INCLUDE:

Deductibles	
(medical and dental)	\$ _____
Benefit percentage/co-insurance	
(The amount NOT paid by your insurance)	\$ _____
Amounts paid over plan limits	
Over reasonable and customary allowance	\$ _____
Over psychiatric limits	\$ _____
Over private room allowance	\$ _____
Expenses NOT covered by your insurance plan	
Physicals	\$ _____
Prescription drugs	\$ _____
Over-the-counter medications	\$ _____
Vision care	\$ _____
Hearing expenses	\$ _____
Psychiatric care	\$ _____
Dental and orthodontic care	\$ _____
Assistance for the handicapped	\$ _____
Therapy/treatments	\$ _____
Physician's fees/services	\$ _____
Medical equipment	\$ _____
Miscellaneous charges	\$ _____
 My out-of-pocket health care	
(expenses last year)	\$ _____

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FLEX DEBIT CARDS

New IRS rules have simplified the use of Flex Debit Cards. These rules now require drug stores and supermarkets to identify FSA-eligible items at checkout and require the drug store or super market to only use the card for FSA eligible items. This means that you can use your Card at participating stores that offer this feature for the total FSA-eligible amount and NO receipts are needed to verify the eligibility of the purchase! And of course, you can continue to use your Card at pharmacies and other health care providers.

Please visit <http://www.sig-is.org/en/index.asp> and click on **SIGIS Merchant List** for the latest list of participating merchants.

Here's an example:

You have been purchasing prescriptions at a pharmacy in a local supermarket using your Card during 2007. On January 5, 2008, you go to the store to pick up a prescription. If the store has not made the change required by the IRS to identify FSA-eligible items, your Card may be declined at the point of purchase. In this case, you can transfer your prescriptions to a pharmacy in a participating discount store or supermarket, or to a freestanding pharmacy, or simply continue to turn in your paper receipts for reimbursement as you have previously.

Important point to remember:

If you use your Card in a discount store or supermarket that is not participating — even if you purchased FSA-eligible items in the store, your Card may decline.

Here's how your Flex Card works at participating stores:

1. Bring prescriptions and vision products, OTCs and other purchases to the register at checkout to let the clerk ring them up.
2. Present your Card and swipe it for payment.
3. If the Card swipe transaction is approved (e.g., there are sufficient funds in the account and at least some of the purchases are FSA eligible), the amount of the FSA-eligible purchases is deducted from the account balance and no receipt follow up is required. The clerk will then ask for another form of payment for the non-FSA-eligible items.
4. If the Card swipe transaction is declined, the clerk will ask for another form of payment for the total amount of the purchase.
5. The receipt will identify the FSA-eligible items and may also show a subtotal of the FSA-eligible purchases.

IMPORTANT INFORMATION REGARDING YOUR FLEX DEBIT CARD!!!

Debit cards are mailed to each new participants home address in a plain white envelope with reference to ACCLARIS. There will be no reference to Gilsbar. Please check thoroughly before throwing mail away. If you already have a FSA debit card, you will not receive a new one. Debit cards are good for three (3) years from the issue date and your account will be replenished *only* if you re-elect the Medical FSA each year. If you do not receive your flex debit card prior to your plan year, manual claims can be filed until your card arrives.

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How does the FSA Debit Card work?

Shortly after the start of the plan year you will receive your FSA Debit Card to use for your eligible medical expenses. If you are a current participant, your card will reflect the new plan year contribution amount on the new effective date of the plan. As you incur expenses, use your FSA Debit Card to have the funds taken directly out of your account so you don't have to pay with cash out of your pocket.

Where can I use my FSA Debit Card?

Your FSA Debit Card will only be accepted at authorized vendors that have the appropriate merchant codes, such as medical clinics, hospitals, dental offices, vision care centers and pharmacies.

If I use my FSA Debit Card, is verification of claims still required?

Per IRS requirements, verification of claims is required for all debit card transactions. A large portion of debit card transaction can be verified using one of the IRS' approved electronic methods; however, not all transactions can be verified electronically. For any expense that cannot be verified electronically, you must provide supporting documentation upon request in the form of an itemized bill or receipt to Gilsbar. Verification should include the patient name, date of service, description of services rendered, cost and patient liability. If Gilsbar does not receive verification within 30 days of the date requested you will be asked to return the un-verified amounts to your employer, or they may be counted as taxable income to you.

Are there special rules that related to prescriptions, over-the-counter (OTC) products, and vision expenses incurred at retail merchants?

Yes, as of January 1, 2008, new special IRS rules allow you to use your FSA debit card in participating discount stores and supermarkets that can identify FSA-eligible items at checkout. This means that you can use your card at participating stores for the total FSA-eligible amount and NO receipts are needed to verify the eligibility of the purchase! Important point to remember: If you use your card on or after January 1, 2008 in a discount store or supermarket that is not participating in the IRA program, even if you purchased FSA-eligible items there before, your card may decline.

Can I use my FSA Debit Card for eligible Dependent Care expenses?

No. Your FSA Debit Card may not be used to pay for eligible Dependent Care expenses. Your card will only be accepted at authorized vendors that have the appropriate merchant codes, such as medical clinics, hospitals, dental offices, vision care centers and pharmacies.

What happens if the FSA Debit Card is used for an ineligible expense?

Gilsbar will review all charges and determine if the card was used for an ineligible expense, according to IRS guidelines. If it was, we will notify you for repayment of the invalid amount. Failure to repay within 30 days of the request can result in the loss of your debit card privileges.

What should I do to pay for an expense that is more than my account balance?

You should tell the merchant to swipe your card for the amount equal to what is left in your account, then use another payment method to pay the remaining balance.

Enrollment Dates: May 18, 2009 - August 12, 2009

FSA Substantiation

Documenting & Submitting Proof of FSA Eligible Purchases

FREQUENTLY ASKED QUESTIONS:

Previously, I never received notices asking for debit card receipts. Why am I now getting these notices?

Last August, the IRS changed the rules regarding how debit cards need to operate for an FSA. These rules took effect on January 1, 2008, so after January 1, 2008, the process Gilsbar has to follow has changed and hence, you have seen a change. According to the new rules, there are five basic requirements that must be met for you to use a debit card for your FSA. These requirements are:

- Participants must provide certification each year that they will only use the debit card for FSA eligible items. This is done during the enrollment process.
- The participant must retain all receipts for all transactions.
- 100% of debit card transaction must be reviewed by a third party to ensure that the items purchased are FSA eligible.
- Sampling or employee "self-certification" is not allowed for an FSA.
- Debit cards can only be used at locations that are medical service providers or provide point of purchase review.

Fortunately, in the new rules, the IRS defines several electronic substantiation methods that we can follow to help with the adjudication process. These methods are:

- Co-pay Match – If a transaction equals a co-pay amount or multiples of co-pay amounts under the health plan, no additional information is needed to support a card transaction.
- Recurring Expense – For transactions that were previously substantiated, recurring expenses will also be considered substantiated provided they are incurred with the same provider at the same location for exactly the same amount.
- Real-Time or Merchant Substantiation – If a transaction can be matched against real-time data at the point of purchase identifying it as a medical expense, no additional substantiation is needed.

All in all, with the new rules, about 72% of all debit card transactions fit one of the electronic substantiation categories listed above. Meaning, Gilsbar is asking for detail on about 28% of all debit cards transactions.

Why does the IRS have these rules? Isn't it my money?

Yes, the money that you put into an FSA is your money; however, in order to receive this money WITHOUT paying taxes you must follow the rules that the IRS has provided for the receipt of an FSA pre-tax reimbursement. At the present time, these rules require all administrators to verify that the money in the FSA is being used for medical care purposes.

What should I do if I receive substantiation letters?

You should sign and return these notices to Gilsbar when you submit your receipts, and keep a copy of these letters for your records. Remember, you can mail or fax your receipts and forms to Gilsbar:

*Mail: Employee Reimbursement Center /P.O. Box 26046 / Tampa, FL 33623 /
Fax: 1-866-635-1329*

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What are acceptable forms of substantiation?

Acceptable forms of substantiation include: Explanation of Benefits (EOBs) and register and/or provider receipts showing the date, item bought and dollar amount charged. Credit card receipts are not acceptable forms because they do not provide the specific item purchased; therefore, Gilsbar cannot determine if the expense was an FSA eligible item.

Is it a requirement that providers, pharmacies, hospitals, etc. provide a receipt with service?

No, it is not a requirement that they provide a receipt, but we suggest you always ask for and collect a receipt from medical providers and facilities. If you are ever audited by the IRS, they will require these receipts for validation of purchases.

In addition to sending my receipts to Gilsbar, should I also keep copies of my receipts?

Because FSAs are federally regulated accounts, we do encourage you to practice good record-keeping habits. Just like you track other items for tax purposes each year, consider your FSA documentation just as important. It is our recommendation that you keep these receipts for your personal records in addition to sending to Gilsbar.

Here are a few organization and record-keeping suggestions:

- Designate a folder to keep copies of only your FSA eligible receipts.
- In this same folder, keep copies of any information you receive from your employer or Gilsbar regarding FSAs. This includes marketing pieces, letters, or notices you may receive.
- Register on myGilsbar.com and start utilizing the Reimbursement Account Center to stay informed and up-to-date on your account. The reimbursement account center allows you to access the following:
 - Available balance
 - Submitted claims
 - Pending claims
 - Payments received
 - Lists of eligible expenses
 - Downloadable forms
 - And much more!

I thought purchases at certain vendors were automatically substantiated and considered approved purchases?

Effective January 1, 2009, no additional substantiation will be required for debit card transactions that are approved at the point of sale by merchants (specifically pharmacies) who have adopted the Inventory Information Approval System (IIAS). The IIAS system compares the SKU on the item being purchased to a list of FSA eligible items sold at the store. When a FSA debit card is used, the pharmacy will only allow the card to pay for the FSA eligible items and any non-FSA eligible items will need to be paid for using an alternative method of payment. After January 1, 2009, if merchants have not adopted this system, FSA debit cards might not work at their places of business. Until then, providing copies of receipts, even pharmacy purchases, is still required.

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DEPENDENT CARE REIMBURSEMENT ACCOUNT

The Dependent Care FSA helps you pay for child care services which make it possible for you and your spouse (if applicable) to work. It also may be used to help pay for the care of a disabled spouse or dependent.

The Dependent Care FSA creates tax savings on up to \$5,000 of daycare expenses. That can mean \$1,500 in tax savings enough to pay for weeks of eligible child or adult daycare!

How Does a Dependent Care FSA work?

A Dependent Care FSA is a reimbursement account that allows you to set aside a certain amount of each paycheck on a pre-tax basis to pay for your eligible dependent day care expenses. The amount you elect at the beginning of each plan year, is deducted from your gross earnings before federal and state taxes are calculated. By using your FSA to pay for qualified expenses you save on income tax...which means you have more money in your pocket!

To estimate your dependent care expenses, consider your expenses from last year. An expense worksheet is provided at the end of this section to help you determine the amount of money to allocate for your Dependent Care FSA. Remember, the IRS requires that all money in your account be used during the plan year. You can access balance information 24/7 online via myGilsbar.com. Select the "Reimbursement Account Center" link on the left side of the screen to view your balances.

Am I eligible to use the Dependent Care FSA?

To be eligible, you must be at work during the time your eligible dependent receives care. You must also meet one of the following eligibility guidelines:

- You and your spouse are both employed;
- You are a single parent;
- Your spouse is a full-time student at least five months during the year while you are working;
- Your spouse is physically or mentally unable to provide his/her own care; or
- You are divorced or legally separated and have custody of your child most of the time even though your former spouse may claim the child for income tax purposes.

Who is an eligible dependent?

An eligible dependent is defined as any person who can be claimed as a dependent for federal tax purposes and who:

- Is a child under 13 years of age;
- Is a child over the age of 13 who is physically or mentally incapable of caring for himself or herself;
- Is your spouse who is physically or mentally incapable of caring for himself or herself,
- An elderly parent who resides with you and is physically or mentally incapable of caring for himself or herself.

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What expenses are covered?

Eligible dependent care expenses are those which allow you and your spouse, if you are married, to work or attended school full- time. Below are some examples of eligible dependent care expenses:

- Day care facility fees
- Before/after school care
- Summer day camp (not overnight)
- Nursery school or preschool, if child is too young for kindergarten
- In home babysitting fees, if not provided by another dependent and claimed as income by the care provider
- Private school tuition, K4 and above is not eligible for reimbursement

Is there anything I have to keep in mind when it comes time to file my taxes?

You are required to provide the name, address and taxpayer identification (or Social Security number) of the dependent care provider on your income tax return.

If you are unable to provide this information, both the tax credit and the exclusion for the spending account reimbursement may be denied by the IRS. Verify that this information is available before you elect to participate in the Dependent Care FSA.

Expenses reimbursed from this FSA cannot be used to claim a Federal Income Tax credit; therefore, you will have to determine which approach is best for you. You may even be able to combine the expense account and tax credits to reduce your overall dependent care expenses. However, the maximum expense you can claim when using both the tax credit and FSA is the tax credit limit (\$2,400 for one dependent or \$4,800 for two or more dependents), minus the amount reimbursed under the Dependent Care FSA.

How do I get reimbursed?

As you incur eligible expenses you must submit a completed Dependent Care FSA claim form to Gilsbar with proof of payment from your day care provider or from the individual who provides the care. Dependent Care FSA claims must include the federal tax identification number or Social Security number, name and address of the provider, dates of service, type of service rendered and name of dependent. The individual who provides the care cannot be your spouse or a dependent under the age of 19.

With a Dependent Care FSA, you will be reimbursed as you set funds aside. If you submit a claim for more than what has been set aside for that account, the unreimbursed claim portion will be placed in "pending" status until funds are received through payroll deduction at which time you will receive reimbursement.

**FAX CLAIMS AND PROOF OF EXPENSE TO 866-635-1329
FOR PROCESSING.**

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Can I pay my in-home daycare provider through the Dependent Care FSA?

Yes. You can be reimbursed from your Dependent Care FSA for any qualified daycare expenses, whether performed in your home, the provider's home or a "daycare center". Receipts for the expenses and the caregiver's Tax ID number or Social Security number must be provided.

I'm divorced; my ex-spouse claims our child as a dependent for tax purposes. I pay for child care. Can I use the Dependent Care FSA?

If your child resides with you most of the year, you can use the dependent care account to pay for child care services. However, you might want to call your tax advisor to discuss your particular circumstances before you elect to participate in the account.

If I have a question about my account, what should I do?

If you have any questions, you can access your account information 24/7 at myGilsbar.com or you can call Gilsbar's Customer Contact Center at 1-800-445-7227 ext. 883.

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Dependent Care FSA Expense Worksheet

Dependent care expenses you paid last year could include:

Costs of Child or Adult Care Facilities*

Day Care Center / Nursery School \$ _____

Family Day Care / Adult Day Care Centers** \$ _____

Wages paid to a nanny or in home care provider*** \$ _____

* The facility must follow all local and state laws.

** These costs are eligible only if the adult dependent spends at least eight hours per day at home.

*** Please note these expenses are not eligible if the care services are provided by someone that you claim as a dependent.

Other dependent care expenses considered eligible by the IRS \$ _____

TOTAL ESTIMATED DEPENDENT CARE EXPENSES \$ _____

Compare last year's typical expenses to those eligible under your Dependent Care FSA and budget accordingly for the upcoming year.

PLEASE FAX CLAIMS AND PROOF OF EXPENSE TO 866-635-1329
FOR PROCESSING.

(PLEASE KEEP YOUR ORIGINALS)

**Questions? Call Gilsbar's Customer Contact Center;
1-800-445-7227, ext. 883**

If you prefer to submit your form by mail, please send claim form and receipts to:

Claims Processing Center, P.O. Box 26046, Tampa, FL 33623

(PLEASE KEEP YOUR ORIGINALS)

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Ameritas Dental Plan

Policy Effective Date: September 1, 2009

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. (If PPO provider is used, calendar year deductible is waived).

TYPE I - PREVENTIVE AND DIAGNOSTIC

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

- Evaluations (Two per calendar year)
- Cleanings (Two per calendar year)
- Fluoride for Children (Under age 19 / One per calendar year)
- Space Maintainers
- Bitewings (Two per calendar year)

TYPE II - BASIC PROCEDURES

Type II benefits are payable at 80-90-100% U&C*. \$50.00 deductible applies.

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

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, Partial)
- Prosthodontics (Fixed Pontics or Abutments)
- Restorative - Crown
- Crown Repair

ORTHODONTIA

Paid at 50% U&C* with a \$1,000 lifetime maximum per person. No deductible applies. (Includes Children and Adults)

**Usual & Customary*

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.

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

ELIGIBLE EMPLOYEES

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

ELIGIBLE DEPENDENTS

Provides Coverage On:

- Your Spouse
- Children up to age 19 and unmarried (Up to age 24 if wholly dependent upon you for maintenance and support and if enrolled as a full-time student in an accredited school or college.). A child must be added within thirty-one (31) days of turning age 2 not to be considered a late entrant.

100% PREVENTIVE, 80-90-100% INCENTIVE

Everyone insured on the effective date of the Company's policy begins with 100% coinsurance for Type 1 (Preventive) and 80% coinsurance level for Type II (Basic) procedures and will remain at that level until the next January 1.

If you visit a dentist during each Calendar Year and have at least one covered dental procedure performed while insured under the Company's policy, your Type II (Basic) procedures will advance to the 90% level on the following January 1 and to 100% on the next January 1. Your Type II (Basic) procedures will remain at 100% each year as long as you visit a dentist during each subsequent calendar year and have at least one covered dental procedure performed while insured under the Company's policy.

If you do not have at least one covered dental procedure performed during any calendar year while insured under the Company's policy, you will revert back to 80% coinsurance level during the next calendar year and must begin to progressively advance to the next levels as described above.

DENTAL EXCLUSIONS (DEFERMENT PERIOD)

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

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PRE-DETERMINATION OF BENEFITS

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

LATE ENTRANT

If you do not elect to participate in the dental program when first eligible, you will be considered a **Late Entrant** and you must wait 12 months for most benefits. If an employee or dependent does not elect to participate when initially eligible, and elects to participate at the policyholders next annual election period, they will become a **Late Entrant**. For a **Late Entrant**, benefits will be limited to exams, cleanings and fluoride applications for the first 12 months. The late entrant provision is waived if the employee comes on the plan as a result of a qualifying event.

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.

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 re-quired 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.

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Ameritas Managed Care Products

- Employers achieve a balance between cost efficiency and employee choice.
- Plan members are free to receive care from any dentist they choose. Their out-of-pocket expenses are generally lower when using PPO dentist who have agreed to provide dental care at contracted fees.
- Over 70,000 PPO provider access points are available nationwide.
- PPO network dentists must meet our credentialing and quality assurance evaluation requirements.

Passive PPO

In passive PPO, the coinsurance, deductible and maximum are the same for the member in and out-of-network. The only difference is the claim allowance. There is an incentive for the member to see an in network dentist; however, there is no penalty for seeing an out-of-network dentist. As with all Ameritas PPO Solutions, the member has the liberty to choose any dentist they wish. However, they will usually save out-of-pocket costs by seeing an in-network dentist.

Passive PPO-Deductible Reduction

Deductible Reduction continues the difference of in-network and out-of-network claim allowance by waiving the deductible for those who visit an in-network dentist. As with all Ameritas PPO Solutions, the member has the liberty to choose any dentist they wish. However, they will usually save out-of-pocket costs by seeing an in-network dentist.

Commonly Asked PPO Questions

Davidson County Schools is proud to provide our employees with a dental program administered by Ameritas Group. The plan offers excellent coverage for you and your eligible dependents. Please refer to the plan highlight for more details. As an added bonus, our plan includes access to Ameritas' Participating Provider Organization (PPO). The plan provides excellent coverage for you and your eligible dependents. Please refer to the plan highlight for more details. As an added bonus, our plan includes access to Ameritas' Participating Provider Organization (PPO).

Do I have to use an Ameritas PPO provider?

No, employees and their covered dependents may utilize any licensed dental provider that they choose.

Please note, there is no difference in the coinsurance or plan maximums on either plan whether a PPO provider is utilized or not.

Why would I use an Ameritas PPO provider?

By using a PPO provider:

- A Participating Provider is a dentist who has entered into an agreement to provide services to insured members of Ameritas' plans for at a specific fee. Any insured member who chooses to go to a PPO provider will receive this discounted fee for procedures performed by that provider.
- As part of their contractual agreement with Ameritas, the PPO provider cannot "back-bill" the patient for the difference between the dentists' normal charges and the discounted fees that the dentist agreed to charge as an Ameritas PPO provider.

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- PPO providers are required to wait for reimbursement from Ameritas before billing the patient for any balances owed for deductibles, coinsurance, any amounts exceeding the annual maximum benefits, etc.

PPO panels are available in many areas; please visit the Ameritas website at www.ameritasgroup.com to search for a provider in your area.

What happens if I don't use an Ameritas PPO provider?

For members that do not want to utilize an Ameritas PPO provider, or if a PPO provider is not available in your area:

- Davidson County Schools wants employees to have options regarding their choice of providers. In addition, we want to ensure that employees that utilize non-panel providers receive exceptional benefits that reimburse claims for non-panel providers in the most optimal way. Non-panel providers can charge their standard fees for any service. ***However, the amount Ameritas allows for each procedure for non-panel provider utilizes 90th percentile of U&C – which is considered to be one of the highest reimbursement levels in the industry. This means that 9 out of 10 dentist's charges will fall within the amount that Ameritas allows for each procedure.*** In doing so, employees can feel comfortable that very little back billing will occur due to the amounts allowed by the plan.
- Non-panel providers have no specific requirements regarding filing of claims. However, we have found that many dentists will assist the patient with the paperwork needed to file the claim. If a dentist is not willing to file the claim on the patient's behalf, the patient can simply attach the dentist's bill to a claim form that includes the patient's name and identification number, and fax or mail the claim to Ameritas for processing. Ameritas will process the claim, typically within 7-10 working days. Claim payment can be made to the patient or directly to the dentist if noted on the claim form. The patient can use Ameritas' claim forms which are available in the Benefit's Department or on Ameritas web site (this will be available via our Intranet in the near future), OR the patient can use any generic claim forms that the dental office may have available. Filing claims is fast and easy with Ameritas!

If you have any questions about PPO or the plan, please call:
Ameritas Group Claims Department at 800-487-5553

Or, visit the Ameritas website at:
www.AmeritasGroup.com

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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.

MONTHLY DENTAL RATES

(DENTAL RATES BELOW WILL BECOME EFFECTIVE OCTOBER 1, 2009)

Employee Only	\$0.00 <i>(paid by Davidson County)</i>
Employee & Spouse	\$52.82
Employee & Child(ren)	\$56.16
Employee & Family	\$108.98

For Claims/Customer Service Questions call Ameritas: 1-800-487-5553.



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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.

A 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.
- 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.●

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Assurity Cancer Plan

Effective Date: September 1, 2009

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.

BASIC BENEFITS

Provides benefits caused by cancer and certain other specified diseases for the employee, spouse and covered children with continuous benefit 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 an accredited school. Issue Age is age of last birthday on the day 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 (one year in NC and SC) period.

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

ISSUE AGE

The Assurity cancer policy is available for persons ages 18-69, including spouses. The 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

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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 it up to a \$2,000 lifetime maximum per Insured.

Attending Physician

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

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- 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 pays 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 miles 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 at 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 charges 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 expense in excess of 50 miles one way, not to exceed 700 miles round trip up to

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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 near the insured when the insured is confined in a nonlocal hospital for specialized covered treatment (a) up to a maximum of \$1,500 per calendar year for actual charges for non-local round trip coach fare by a common carrier to the nearest hospital that provides the prescribed treatment or 50 cents per mile for personal automobile expenses in excess of 50 miles one-way, up to 700 miles round trip and (b) pays actual charges up to \$50 per day for lodging and meal expenses when staying at a hotel, motel or other accommodation acceptable to Assurity, limited to the number of days of each confinement.

Outpatient Positive Diagnostic Test

Assurity will pay up to \$250 for the 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 treatment.

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 actual 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 confinement in a government or charity hospital. Payment of this benefit is in lieu of all other policy benefits.

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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 for a minimum of 24 hours of inpatient care 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 a one-time benefit of up to \$150 for a hairpiece when hair loss is a result of cancer treatment.

Cancer (Wellness) Screening Tests

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

- Mammography Screening
- Pap Smear (test only)
- CA125 (blood test for ovarian cancer)
- PSA (blood test 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 Assurity to get a wellness claim form or download one from www.markiibrokerage.com/davidsoncountyschoolsnc. 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 Care 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

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charges for a physician's visit up to \$40 per day not to exceed 15 days per 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 \$1,000 per calendar year for purchase 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 a specified disease for which benefits are payable.

Extended Benefits

If a covered hospital confinement lasts for more than 75 consecutive days, policy pays usual and customary charges for hospital room and board, medicines, lab tests 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 age 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 starting with the first renewal premium following the 90-day period of disability. 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 Disease | 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 |
| Legionnaires' 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 |

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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 one from www.markiiibrokerage.com/davidsoncountyschoolsnc. Should you have any questions 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, 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 expenses 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

Enrollment Dates: May 18, 2009 - August 12, 2009

**Cancer and Specified Dread Disease Benefit
with Radiation/Chemotherapy**

Assurity Life Cancer & Specified Disease Plan - Monthly Rates		\$150 Daily Benefit	\$250 Daily Benefit	\$350 Daily Benefit
Base Policy (\$10,000 per month/\$100,000 lifetime maximum) (radiation/chemotherapy)	Individual	\$20.92	\$23.22	\$25.52
	EE & Spouse	\$32.04	\$35.62	\$39.19
	EE & Children	\$25.99	\$28.60	\$31.21
	Family	\$37.11	\$41.00	\$44.88
Base Policy with Intensive Care Rider (\$300 daily benefit)	Individual	\$23.02	\$25.32	\$27.62
	EE & Spouse	\$36.24	\$39.82	\$43.39
	EE & Children	\$29.29	\$31.90	\$34.51
	Family	\$42.51	\$46.40	\$50.28
Base Policy with Intensive Care Rider (\$600 daily benefit)	Individual	\$25.12	\$27.42	\$29.72
	EE & Spouse	\$40.44	\$44.02	\$47.59
	EE & Children	\$32.59	\$35.20	\$37.81
	Family	\$47.91	\$51.80	\$55.68
Base Policy with First Occurrence Benefit Rider (\$2,500 benefit)	Individual	\$23.75	\$26.05	\$28.35
	EE & Spouse	\$36.27	\$39.85	\$43.42
	EE & Children	\$29.41	\$32.02	\$34.63
	Family	\$41.93	\$45.82	\$49.70
Base Policy with First Occurrence Benefit Rider (\$2,500 benefit) and Intensive Care Rider (\$300 daily benefit)	Individual	\$25.85	\$28.15	\$30.45
	EE & Spouse	\$40.47	\$44.05	\$47.62
	EE & Children	\$32.71	\$35.32	\$37.93
	Family	\$47.33	\$51.22	\$55.10
Base Policy with First Occurrence Benefit Rider (\$2,500 benefit) and Intensive Care Rider (\$600 daily benefit)	Individual	\$27.95	\$30.25	\$32.55
	EE & Spouse	\$44.67	\$48.25	\$51.82
	EE & Children	\$36.01	\$38.62	\$41.23
	Family	\$52.73	\$56.62	\$60.50
Base Policy with First Occurrence Benefit Rider (\$5,000 benefit)	Individual	\$26.58	\$28.88	\$31.18
	EE & Spouse	\$40.50	\$44.08	\$47.65
	EE & Children	\$32.83	\$35.44	\$38.05
	Family	\$46.75	\$50.64	\$54.52
Base Policy with First Occurrence Benefit Rider (\$5,000 benefit) and Intensive Care Rider (\$300 daily benefit)	Individual	\$28.68	\$30.98	\$33.28
	EE & Spouse	\$44.70	\$48.28	\$51.85
	EE & Children	\$36.13	\$38.74	\$41.35
	Family	\$52.15	\$56.04	\$59.92
Base Policy with First Occurrence Benefit Rider (\$5,000 benefit) and Intensive Care Rider (\$600 daily benefit)	Individual	\$30.78	\$33.08	\$35.38
	EE & Spouse	\$48.90	\$52.48	\$56.05
	EE & Children	\$39.43	\$42.04	\$44.65
	Family	\$57.55	\$61.44	\$65.32

AAW-C120RAB (7/04)



Assurity Cancer Claims/Customer Service: (866)289-7337
Assurity Wellness Claims/Customer Service: (888)358-8808, ext 23
Wellness Claims / Fax: (800) 869-0368
Cancer Claims/ Fax: (402)437-4592
Claims can also be mailed to:
Assurity / PO Box 80926 / Lincoln, NE 68501

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Superior Vision Plan 1 - Full Services

Effective Date: September 1, 2009

**Outline of Benefits – Gold Preferred Plan with Materials Discount
Vision Plan – Preferred Provider (PPO / Indemnity)**

**Copayment: \$20.00 Exam
\$35.00 Contact Lens Fitting Fee
No Copayment for Materials**

BENEFITS	FREQUENCY	IN-NETWORK	NON-NETWORK
Comprehensive Exam <i>(by an Ophthalmologist)</i>	12 Months	Covered in Full	Up to \$44.00
Comprehensive Exam <i>(by an Optometrist)</i>	12 Months	Covered in Full	Up to \$39.00
Lenses (Standard) per Pair			
Single Vision	12 Months	Covered in Full	Up to \$34.00
Bifocal	12 Months	Covered in Full	Up to \$48.00
Trifocal	12 Months	Covered in Full	Up to \$64.00
Lenticular	12 Months	Covered in Full	Up to \$88.00
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
Standard Contact Lens Fitting Fee***	12 Months	Covered in Full	Not Covered
Specialty Contact Lens Fitting Fee***	12 Months	Up to \$50.00	Not Covered
Frames (Standard)**	24 Months	Up to \$100.00	Up to \$50.00

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

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

HOW TO USE YOUR BENEFIT

Procedure when using a Superior Vision Plan *in-network* provider:

- Identify yourself to the in-network provider as a member of the Superior Vision Plan. You can use your ID card for this purpose or simply give the provider your name, employer name, and your social security number. The provider will call SVS Member Services to verify your eligibility and obtain an authorization number. The ID card provided to you can be used for all covered family members.
- After eligibility is established, and an authorization number is received by the provider, services will be rendered. There is nothing else that you need to do except pay the provider directly for any appropriate co-payments and charges above the covered benefits. The in-network provider handles all claims and paperwork.

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Procedure when using a Superior Vision Plan non-network provider:

- To receive services from a non-network provider, it is important that you first call Superior Vision Services Member Service Department at 800-507-3800 to receive your own authorization number. By doing so, you can be assured of your eligibility and reimbursement for money spent.
- After receiving services and paying in-full for the examination and/or materials (you do not pay a co-payment to the non-network provider), submit your original itemized billing received from the provider, along with your authorization number, to the SVS Claims Administration office listed on the next page.
- You will be reimbursed according to the schedule of allowances for non-network providers, less any required co-payments.

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-on charges to the covered pair of lenses

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 gradient	\$25 (Any Type Lenses)
•Power over 4.00D Sphere, 2.00D Cylinder & 5.00D Prism Lenses)	20% discount off retail prices (Any Type Lenses)
•Cosmetic Finishing, Beveling, Edging & Mounting Lenses)	20% discount off retail prices (Any Type Lenses)
•Miscellaneous Options Lenses)	20% discount off retail prices (Any Type Lenses)

*Higher end or brand name lens upgrades are at an additional expense to the member. Apply maximum out of pocket expense toward the upgraded lens retail cost and the member is responsible for the difference less 20%.

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Discounts on Additional Purchases

•Prescription eyeglass lenses	30% discount off retail prices
•Eyeframes	30% discount off retail prices
•Add-on charges to basic lenses	20% discount off retail prices
•Contact lenses, standard hard or soft	20% discount off retail prices
•Disposable contact lenses	10% discount off retail prices
•All other prescription materials	20% discount off retail prices

Discounts are available for additional purchases of eyewear and contact lenses. Discounts are provided by Superior Vision Services contracted providers identified in the Provider Directory with a "DP". Discounts do not apply to the insured benefit underwritten by National Guardian Life Insurance Company.

Refractive Surgery Discounts & Cosmetic Eyelid Surgery Discounts are available: Superior Vision Services has a nationwide network of refractive surgeons who specialize in the popular elective procedures of radial keratotomy (RK), photo-refractive keratotomy (PRK) and LASIK. These providers offer Superior Vision Plan members a 20% discount off their usual and customary surgical fees for these procedures. Ophthalmic plastic surgeons are also contracted to provide the procedure of blephoroplasty (cosmetic eyelid surgery) to Superior Vision Plan members on the same discount basis.

EXCLUSIONS (products & services not covered):

There is no benefit coverage for the following products and services.

- Professional Services and/or Materials in conjunction with:
 - blended bifocals, no line, or progressive lenses
 - compensated or special multi-focal lenses
 - plain (non-prescription) lenses
 - anti-reflective, scratch, UV400, or any coating or laminate applied to lenses
 - subnormal vision aids
 - tints, other than solid
 - orthoptics, vision training and developmental vision procedures
 - polycarbonate lenses
- Medical or surgical treatment of the eyes
- Any eye examination or any corrective eyewear required by an Employer as a condition of employment
- Any injury or illness when covered under Workers' Compensation or similar law
- Plain or prescription sunglasses, no-line bifocals, blended lenses are not covered; an Insured may elect to apply the maximum allowance for standard lenses toward his, or her cost of progressive lenses
- Subnormal vision aids
- Services rendered or Materials purchased outside the U.S. or Canada unless
 - the member resides in the U.S. or Canada; and
 - the charges are incurred while on a business or pleasure trip
- Charges in excess of the Usual, Customary and Reasonable charges for the Professional Service or Materials
- Experimental or non-conventional treatment or device
- Safety eyewear
- Spectacle lens styles, materials, treatments, or "add-ons" not shown in the Benefits Summary

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- 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 service required outside basic vision analysis for contact lenses, except fitting fees
- Services rendered after the date an Insured ceases to be covered under this Certificate, except when vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured within 31 days from the date of such order
- Services rendered or Materials ordered before the date of coverage began under this Certificate
- Regardless of Optical Necessity, benefits are not available more frequently than that which is specified in the Benefits Summary

MONTHLY COST - FULL SERVICE PLAN

Employee Only	\$ 9.30
Employee + One	\$18.05
Employee + Family	\$26.50

Member Services, Provider Listings and Claims Services:

(800) 507-3800

Member Services Fax:

(916) 852-2277

Provider Nominations:

(800) 923-6766

Web Site:

www.superiorvision.com

Address:

Superior Vision Services, Inc
11101 White Rock Road, Ste. 150
Rancho Cordova, CA 95670

Non-network Claims Submission:

Superior Vision Services, Inc.
P.O. Box 967
Rancho Cordova, CA 95741

*This plan is underwritten by National Guardian Life Insurance Company
P.O. Box 1191 Madison, WI 53701-1191*



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Superior Vision Plan 2 - Materials Only

Effective Date: September 1, 2009

Outline of Benefits - Materials Only

Vision Plan - Preferred Provider (PPO / Indemnity)

Copayment: \$15.00 - Materials
\$25.00 - Contact Lens Fitting Fee

BENEFITS	FREQUENCY	IN-NETWORK	NON-NETWORK
Eye Exams	No Benefit	No Benefit	No Benefit
Lenses (Standard) per Pair			
Single Vision	12 Months	Covered in Full	Up to \$34.00
Bifocal	12 Months	Covered in Full	Up to \$48.00
Trifocal	12 Months	Covered in Full	Up to \$64.00
Lenticular	12 Months	Covered in Full	Up to \$88.00
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
Standard Contact Lens Fitting Fee***	12 Month	Covered in Full	Not Covered
Specialty Contact Lens Fitting Fee***	12 Months	Up to \$50.00	Not Covered
Frames (Standard)	24 Months	Up to \$100.00	Up to \$50.00

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

**The insured is responsible for paying any charges in excess of this 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 multi-focal lenses. For the specialty fit, the member is responsible for any charges over \$50.

In-network co-payment is paid directly to the provider.

Out-of-network co-payment will be deducted from the out-of-network reimbursement.

DEFINITIONS OF CONTACT LENSES

Contact Lenses, Elective/Cosmetic

Elective/Cosmetic contact lenses are those that are worn solely for cosmetic or convenience reasons. They are chosen because they are preferred over the wearing of conventional eyeglasses. Contact lenses covered by the Plan must contain a prescription for correcting a vision deficiency. Charges over the benefit allowance are paid directly to the provider.

Contact Lenses, Medically Necessary

These lenses must be specifically prescribed by the eye doctor to be used for the reason or reasons described below. Reimbursement for these lenses will be considered as payment-in-full when utilizing an in-network provider.

- Aphakia (after cataract surgery without implant lens) - A pair of prescription single vision or multifocal eye glass lenses and an eyeframe can be provided along

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with contact lenses prescribed for this reason.

- When visual acuity cannot be corrected to 20/70 in the better eye except through the use of contact lenses (must be 20/60 or better).
- Anisometropia of 4.0 diopters or more, provided visual acuity improves to 20/60 or better in the weak eye.
- Kerataconus

Note: The narrowing of visual fields due to high minus or high plus corrections is not considered a reason for medically necessary contact lenses.

MATERIALS SVP 8-20 DISCOUNT SCHEDULE

Featured are 20% discounts on the provider's charges for upgrades to the 1st pair of covered eyeglass lenses. This includes tints, coatings, special materials and special lens designs.

Also included are discounts on the purchases or additional pairs of eyeglasses and contact lenses. See the schedule below. These materials discounts are available from in-network providers who are identified in the directory with a "DP" (discount plan) associated with their listing as a service they provide at the location.

FRAMES 30% OFF RETAIL
No restrictions apply

LENSES (Uncoated Plastic-CR39, or Glass) 30% OFF RETAIL
Single Vision
Bifocal (FT 25-35 & Executive)
Trifocal (FT 7X25, 7X28, 8X35 & Executive)
Progressives
Zyl and Metal Mounting

ADD-ON TO BASE LENSES 20% OFF RETAIL
Tints, Coatings, Colored Lenses
Power over 4.00D Sphere, 2.00D Cylinder & 5.00D Prism
Polycarbonate, High Index, Photochromatics
Cosmetic Finishing, Beveling, Edging & Mounting

EVERYDAY "Frame & Lens Package Pricing" 20% OFF RETAIL

CONTACT LENSES 20% OFF RETAIL

DISPOSABLE CONTACT LENSES 10% OFF RETAIL

ALL OTHER MATERIALS 20% OFF RETAIL

Refractive Surgery Discounts & Cosmetic Eyelid Surgery Discounts are available: Superior Vision Services has a nationwide network of refractive surgeons who specialize in the popular elective procedures of radial keratotomy (RK), photo-refractive keratotomy (PRK) and LASIK. These providers offer Superior Vision Plan members a 20% discount off their usual and customary surgical fees for these procedures. Ophthalmic plastic surgeons are also contracted to provide the procedure of blephoroplasty (cosmetic eyelid surgery) to Superior Vision Plan members on the same discount basis.

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EXCLUSIONS (products & services not covered)

1. Professional Services and/or Materials in conjunction with:
 - a. **blended bifocals, no line, or progressive lenses**
 - b. **compensated or special multi-focal lenses**
 - c. **plain (non-prescription) lenses**
 - d. **anti-reflective, scratch, UV400 or any coating or lamination applied to lenses.**
 - e. **subnormal vision aids**
 - f. **tints other than solid**
 - g. **orthoptics, vision training and developmental vision procedures**
 - h. **polycarbonate lenses**
2. Medical or surgical treatment of the eyes
3. Any eye examination or any corrective eyewear required by an Employer as a condition of employment
4. Any injury or illness when covered under Workers' Compensation or similar law
5. Plain or prescription sunglasses, no-line bifocals, blended lenses are not covered, an Insured may elect to apply the maximum allowance for standard lenses toward his or her cost of progressive lenses.
6. Subnormal vision aids
7. Services rendered or Materials purchased outside the U.S. or Canada, unless:
 - a. **the Member resides in the U.S. or Canada; and**
 - b. **the charges are incurred while on a business or pleasure trip**
8. Charges in excess of the Usual, Customary and Reasonable charge for the Professional Service or Materials
9. Experimental or non-conventional treatment or device
10. Safety eyewear
11. Spectacle lens styles, materials, treatments or "add-ons" not shown in the Benefits Summary
12. Services or Materials rendered by a provider other than an Ophthalmologist, Optometrist or Optician acting within the scope of his or her license
13. Any additional service required outside basic vision analysis for contact lenses, except fitting fees.
14. Services rendered after the date an Insured ceases to be covered under this Certificate, except when vision Materials ordered before coverage ended are delivered and the services rendered to the Insured within 31 days from the date of such order.
15. Services rendered or Materials ordered before the date of coverage began under this Certificate
16. Regardless of Optical Necessity, benefits are not available more frequently than which is specified in the Benefits Summary

Note: This is only a summary of the benefit plan. You may review and/or obtain a copy of the Master Policy and Certificate of Coverage by contacting your Human Resources/Employee Benefits Office.

Enrollment Dates: May 18, 2009 - August 12, 2009

MONTHLY COST - MATERIALS ONLY PLAN

Employee Only	\$ 6.78
Employee + One	\$ 13.18
Employee + Family	\$ 19.32

Member Services, Provider Listings, and Claims Services:
800-507-3800

To order contact lens via the internet go to this site: www.SVContacts.com

Member Services FAX:
916-852-2277

Provider Nominations:
Lee Sims @ 800-923-6766 X.254

Web Site: www.superiorvision.com

Address:
Superior Vision Services, Inc.
11101 White Rock Road, Ste. 150
Rancho Cordova, CA 95670

Non-network Claims Submission:
Superior Vision Services, Inc.
P.O. Box 967
Rancho Cordova, CA 95741

"The Superior Vision Plan is underwritten by 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."

Enrollment Dates: May 18, 2009 - August 12, 2009

Disability Is A Fact of Life

- ◆ 17.2 million people, or 9.9 percent of the working age U.S. population in 1998 (16-64 years old), had a disability that prevented or limited work. ¹
- ◆ Wage losses, medical expenses, property damage, employer costs, fire losses and other expenses related to unintentional injuries and fatalities cost Americans an estimated \$512.4 billion in 2000. That's equal to about \$5,000 per household. ²
- ◆ A disability injury occurs every 1.5 seconds. ²
- ◆ 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:

¹ Stoddard, S., Janus, L., Ripple, J. and Kraus, L. (1998) Chartbook on Work and Disability in the United States, 1998. An InfoUse Report. Washington, D.C.: U.S. National Institute on Disability and Rehabilitation Research.

² Report on Injuries in America, 2001, National Safety Council

Commissioners Disability Trade, Us Gov't Housing/Finance,
Society of Actuaries.

Could You Live Off Of Your Savings??

Enrollment Dates: May 18, 2009 - August 12, 2009

MetLife Short Term Disability Plan

Effective Date: September 1, 2009

Existing Employees - Underwriting approval required

Newly Hired Employees - Guarantee Issue up to \$3,000.

This insurance provides for payment of a monthly disability benefit to replace up to 60% of earnings lost by employees who are totally disabled because of an injury or sickness and are unable to work. Benefit payments begin the first day following an accident and on the eighth day due to a sickness. The maximum monthly benefit is \$3,000.

ELIGIBILITY

All active full-time employees (30 hours or more per week) are eligible to apply for this plan.

FEATURES

- **Group Premium Rates** - Special low group rates are available to all employees. Premiums cannot be individually increased due to change in health.
- **Guarantee Issue** - Newly eligible employees will be guaranteed the coverage for which he or she qualifies up to \$3,000 subject to the 3/12 pre-existing condition clause.*
- **Unisex Rates** - Equitable rates for all.
- **Payroll Deduction** - Premiums are paid by convenient payroll deduction.
- **Elimination Period** - 0 days accident, 7 days sickness.
- **Duration of Benefits** - 3 months, 6 months or 12 months.
- **Covers Pregnancy** - Pregnancy paid same as sickness if conception is after the coverage effective date.
- **Effective Date of Insurance** - An employee's insurance will be made effective on the first day of the calendar month following the date his or her application is approved, provided the employee is "actively at work."
- **Benefits Payable Regardless of Other Insurance**
- **Summer Months, Weekends and Holidays are Covered**
- **Partial Disability Benefits Available**
- **Benefits Paid Directly to You**

*See following page for definition of pre-existing condition.

(Please note that the salary used at time of enrollment is based on the 2008-2009 salary information received from Davidson County Schools).

Enrollment Dates: May 18, 2009 - August 12, 2009

BENEFITS PROVIDED

Definition of Disability

"Disabled" or "Disability" means that, due to sickness, pregnancy or accidental injury, you:

1. are receiving Appropriate Care and Treatment from a Doctor on a continuing basis; and
2. are unable to earn more than 80% of your Pre-disability Earnings at your Own Occupation for any employer in your Local Economy.

Your loss of earnings must be a direct result of your sickness, pregnancy or accidental injury. Economic factors such as, but not limited to, recession, job obsolescence, pay cuts and job-sharing will not be considered in determining whether you meet the loss of earnings test.

Work Incentive

While you are Disabled, you are encouraged to work or participate in a rehabilitation program during your Elimination Period or while Weekly Benefits are being paid to you. Reimbursement for Eligible Family Care Expenses may also be available when you work or participate in an approved Rehabilitation Program while Disabled.

When you work while Disabled, you will receive the sum of the following amounts:

1. your Weekly Benefit (including your Rehabilitation Incentive when applicable);
2. the amount of your earnings for working while Disabled.

(Please note that the sum of the above 2 may not exceed 100% of your Pre-Disability earnings).

LIMITATIONS AND EXCLUSIONS

Benefits will not be paid for disability due to:

- any act of war, declared or undeclared, or participation in an insurrection, rebellion or riot;
- an intentionally self-inflicted injury;
- a commission of, or attempt to commit an assault, battery, or felony, or engagement in any illegal occupation.

PRE-EXISTING CONDITION LIMITATION*

A Pre-Existing Condition is an injury, sickness, or pregnancy for which the employee in the past 3 months before the effective date: received medical treatment, consultation, care, services, took prescription medications or had medications prescribed; No benefits would be payable under the plan in connection with a disability that is due to a pre-existing condition unless the employee's elimination period started after they were employed under the plan for 12 consecutive months.

If you have any questions regarding your MetLife Short Term Disability Plan, please call (800) 300-4296.

(This is a brief description of your coverage and is not a contract. Read your certificate for exact terms and conditions.)

Enrollment Dates: May 18, 2009 - August 12, 2009

METLIFE SHORT TERM DISABILITY MONTHLY RATES

*Rates for Class I Employees**

Benefit Duration: 90 Days		Benefit Duration: 180 Days		Benefit Duration: 365 Days	
Monthly Benefit	Monthly Premium	Monthly Benefit	Monthly Premium	Monthly Benefit	Monthly Premium
\$500	\$12.30	\$500	\$14.00	\$500	\$17.90
\$600	\$14.76	\$600	\$16.80	\$600	\$21.48
\$700	\$17.22	\$700	\$19.60	\$700	\$25.06
\$800	\$19.68	\$800	\$22.40	\$800	\$28.64
\$900	\$22.14	\$900	\$25.20	\$900	\$32.22
\$1,000	\$24.60	\$1,000	\$28.00	\$1,000	\$35.80
\$1,100	\$27.06	\$1,100	\$30.80	\$1,100	\$39.38
\$1,200	\$29.52	\$1,200	\$33.60	\$1,200	\$42.96
\$1,300	\$31.98	\$1,300	\$36.40	\$1,300	\$46.54
\$1,400	\$34.44	\$1,400	\$39.20	\$1,400	\$50.12
\$1,500	\$36.90	\$1,500	\$42.00	\$1,500	\$53.70
\$1,600	\$39.36	\$1,600	\$44.80	\$1,600	\$57.28
\$1,700	\$41.82	\$1,700	\$47.60	\$1,700	\$60.86
\$1,800	\$44.28	\$1,800	\$50.40	\$1,800	\$64.44
\$1,900	\$46.74	\$1,900	\$53.20	\$1,900	\$68.02
\$2,000	\$49.20	\$2,000	\$56.00	\$2,000	\$71.60
\$2,100	\$51.66	\$2,100	\$58.80	\$2,100	\$75.18
\$2,200	\$54.12	\$2,200	\$61.60	\$2,200	\$78.76
\$2,300	\$56.58	\$2,300	\$64.40	\$2,300	\$82.34
\$2,400	\$59.04	\$2,400	\$67.20	\$2,400	\$85.92
\$2,500	\$61.50	\$2,500	\$70.00	\$2,500	\$89.50
\$2,600	\$63.96	\$2,600	\$72.80	\$2,600	\$93.08
\$2,700	\$66.42	\$2,700	\$75.60	\$2,700	\$96.66
\$2,800	\$68.88	\$2,800	\$78.40	\$2,800	\$100.24
\$2,900	\$71.34	\$2,900	\$81.20	\$2,900	\$103.82
\$3,000	\$73.80	\$3,000	\$84.00	\$3,000	\$107.40

**Teacher, Teacher Aides and Administration
All benefits will be paid out on a weekly basis.*

Enrollment Dates: May 18, 2009 - August 12, 2009

METLIFE SHORT TERM DISABILITY MONTHLY RATES

*Rates for Class II Employees***

Benefit Duration: 90 Days		Benefit Duration: 180 Days		Benefit Duration: 365 Days	
Monthly Benefit	Monthly Premium	Monthly Benefit	Monthly Premium	Monthly Benefit	Monthly Premium
\$500	\$21.55	\$500	\$24.55	\$500	\$31.35
\$600	\$25.86	\$600	\$29.46	\$600	\$37.62
\$700	\$30.17	\$700	\$34.37	\$700	\$43.89
\$800	\$34.48	\$800	\$39.28	\$800	\$50.16
\$900	\$38.79	\$900	\$44.19	\$900	\$56.43
\$1,000	\$43.10	\$1,000	\$49.10	\$1,000	\$62.70
\$1,100	\$47.41	\$1,100	\$54.01	\$1,100	\$68.97
\$1,200	\$51.72	\$1,200	\$58.92	\$1,200	\$75.24
\$1,300	\$56.03	\$1,300	\$63.83	\$1,300	\$81.51
\$1,400	\$60.34	\$1,400	\$68.74	\$1,400	\$87.78
\$1,500	\$64.65	\$1,500	\$73.65	\$1,500	\$94.05
\$1,600	\$68.96	\$1,600	\$78.56	\$1,600	\$100.32
\$1,700	\$73.27	\$1,700	\$83.47	\$1,700	\$106.59
\$1,800	\$77.58	\$1,800	\$88.38	\$1,800	\$112.86
\$1,900	\$81.89	\$1,900	\$93.29	\$1,900	\$119.13
\$2,000	\$86.20	\$2,000	\$98.20	\$2,000	\$125.40
\$2,100	\$90.51	\$2,100	\$103.11	\$2,100	\$131.67
\$2,200	\$94.82	\$2,200	\$108.02	\$2,200	\$137.94
\$2,300	\$99.13	\$2,300	\$112.93	\$2,300	\$144.21
\$2,400	\$103.44	\$2,400	\$117.84	\$2,400	\$150.48
\$2,500	\$107.75	\$2,500	\$122.75	\$2,500	\$156.75
\$2,600	\$112.06	\$2,600	\$127.66	\$2,600	\$163.02
\$2,700	\$116.37	\$2,700	\$132.57	\$2,700	\$169.29
\$2,800	\$120.68	\$2,800	\$137.48	\$2,800	\$175.56
\$2,900	\$124.99	\$2,900	\$142.39	\$2,900	\$181.83
\$3,000	\$129.30	\$3,000	\$147.30	\$3,000	\$188.10

****Cafeteria Workers, Maintenance and Bus Drivers**
All benefits will be paid out on a weekly basis.

Enrollment Dates: May 18, 2009 - August 12, 2009

MetLife Term Life Plan

Effective Date: When approved by carrier

Existing Employees - Electing coverage for the first time or any increases to existing coverage is not effective until approved by Metropolitan Life.

Newly Hired Employees - Coverage is effective the first day of either the first or the second month following employment, provided eligibility requirements are met in "When Your Insurance Starts".

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 payroll deductions.

To help meet this need, you now 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
- Child(ren) from 15 days of age up to 19 (to age 25 if wholly dependent upon you for maintenance and support and if enrolled as a full-time student in an accredited school or college). 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 are divorce or a child graduates from college.

FEATURES

The plan features easy eligibility and simple enrollment procedures. AND. . . There is no need for a medical exam if you sign up during the enrollment period. Furthermore, automatic payroll deductions simplify paperwork. This means less bookkeeping for you and no worries about a lapse in coverage due to missed payments.

LOW COST

Your cost is lower than for comparable insurance on an individual basis due to the "wholesale" economies inherent in group insurance. Additionally, the system absorbs the cost of administering the program which is underwritten by MetLife - a leader in the field of group coverage.

ELIGIBILITY

You will be eligible for this program if you are a full-time active employee.

Enrollment Dates: May 18, 2009 - August 12, 2009

ENROLLMENT

Enrollment is simple - just fill out the election card provided by your employer. Make sure you supply all the required information and return the form where you work. That's all. You will be notified as to when coverage starts.

BENEFICIARY

You have the right to designate the beneficiary of your choice under employee coverage. You are automatically the beneficiary under Dependent Life.

WHEN YOUR INSURANCE STARTS

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

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

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

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

REDUCTIONS AT AGE 70 AND OVER

If you remain in active service beyond age 70 your combined amount of Basic and Optional Employee Life Insurance will be as follows:

<u>Attained Age</u>	<u>Percent of Original Amount</u>
70	65%
75	45%
80	30%

Enrollment Dates: May 18, 2009 - August 12, 2009

TERMINATION OF COVERAGE

All insurance under this plan will terminate with the earliest of the following events. The events include: termination upon retirement, termination of employment, plan cessation or withdrawal 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 account of such dependent will be paid to you.

DISABILITY

Your insurance may be continued during your disability provided the Board of Education continues premium payments on your behalf. However, your insurance will be subject to reduction as shown under "Reductions at ages 70 & Over."

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, issued by Metropolitan Life 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 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 not dependent(s).

Qualifying Events Include:

- Termination of Employment
- Retirement
- Change in employee class which results in the termination of Optional Life Benefits.

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

THE ACCELERATED BENEFIT OPTION (ABO)

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

SUICIDE EXCLUSION

No Optional Employee Life Benefits are payable if you commit suicide within two years from the effective date of the coverage.

Enrollment Dates: May 18, 2009 - August 12, 2009

CLAIMS PROCEDURE

Procedures for Presenting Claims for Benefits

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.

Routine Questions

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

All eligible employees\$5,000*
(No cost to you)

*See "Reductions at age 70 & Over."

OPTIONAL EMPLOYEE LIFE INSURANCE

Your choice of the following amounts:

\$350,000, \$300,000, 250,000, \$200,000, \$150,000, \$100,000, \$50,000, \$40,000, \$30,000, \$20,000 or \$10,000

To be eligible for amounts above \$50,000, you must furnish medical evidence of insurability satisfactory to MetLife. (If you elect amounts of \$300,000 or \$350,000 they may not exceed 5 times your base annual salary).

OPTIONAL DEPENDENT LIFE INSURANCE

Spouse - \$10,000, \$20,000, \$30,000, \$40,000, \$50,000, \$60,000, \$70,000, \$80,000, \$90,000, \$100,000
Child(ren) - \$5,000, \$15,000, \$25,000

You choose either:

Family coverage, Spouse only coverage or Child(ren) only coverage.

Optional Dependent Life Insurance is available only to those eligible employees who are insured for Employee Optional Life Insurance. Spouse or Child coverage cannot exceed the amount of employee's optional life coverage. If both husband and wife are employees of Davidson County Schools, only one can cover the dependent children.

Enrollment Dates: May 18, 2009 - August 12, 2009

YOUR MONTHLY COST

<u>Optional Employee Life Insurance</u>	<u>Monthly Payroll Deduction</u>
\$350,000	\$38.50
300,000	33.00
250,000	27.50
200,000	22.00
150,000	16.50
100,000	11.00
*50,000	5.50
40,000	4.40
30,000	3.30
20,000	2.20
10,000	1.10

<u>Optional Spouse Life Insurance</u>	<u>Monthly Payroll Deduction</u>
\$100,000	\$40.30
90,000	36.27
80,000	32.24
70,000	28.21
60,000	24.18
50,000	20.15
40,000	16.12
30,000	12.09
20,000	8.06
*10,000	4.03

<u>Optional Child Life Insurance</u>	<u>Monthly Payroll Deduction</u>
\$25,000	3.60
15,000	2.16
*5,000	0.72

**Amounts above these require evidence of insurability if not applied for when first eligible.*

This information has been prepared to give you the highlights of additional coverage now being offered by your School Board to meet your insurance needs. For details please ask your personnel office or refer to the certificate of insurance that you will receive after you have signed up for protection.

If you have any questions regarding your statement of health or life insurance claim, please call (800)638-6420.

Enrollment Dates: May 18, 2009 - August 12, 2009

Hyatt Legal Plan

Effective Dates:

Existing Employees - September 1, 2009

Newly Hired Employees - Coverage is effective the first day of either the first or second month following employment.

If you are like most people, you encounter at least four to six legal questions a year*, but don't consult an attorney. Many people avoid consulting an attorney because they are afraid of high fees or do not know how to select one. Or maybe they are not sure a matter has legal implications at all.

The Hyatt Premier Legal Plan Provides you with easy access to professional, confidential, and personal legal services at a price you can afford. As a participant in Hyatt's group legal plan, you won't think twice about picking up the phone to consult an attorney about the common, and not so common, legal matters that most people deal with in their lives.

PROFESSIONAL LEGAL SERVICES AT A PRICE YOU CAN AFFORD

For a low monthly payroll deduction, The Hyatt Premier Legal Plan gives you, your spouse, and your dependents unlimited access to Plan Attorneys for assistance with a wide range of legal matters. For covered legal services, this assistance includes consultations on the telephone or in person, document preparation, and representation in many frequently needed legal matters.

Hyatt Legal Plans provides legal services through our network of more than 10,000 attorneys nationwide. Our Plan Attorneys are carefully selected, have met stringent selection criteria, and have an average of over 22 years of legal experience.

EASY ACCESS WITHOUT THINKING TWICE...

When you face a situation that you think may have legal implications, you can call a Plan Attorney to discuss it. You access a Plan Attorney by calling Hyatt Legal Plans at 1-800-821-6400 Monday thru Friday between 8:00 a.m. and 7:00 p.m. Eastern time. Our Client Service Representatives will give you an authorization number for the particular matter and assist you in selecting a Plan Attorney in your area. Once you have an authorization number, you can call the attorney to schedule an appointment at your convenience. There are no waiting periods, no deductibles or copayments, and no claim forms. And to make it even easier for you, the low monthly fee is paid through convenient payroll deduction.

WIDE RANGE OF LEGAL SERVICES

WILL & ESTATE PLANNING

- Simple and Complex Wills
- Powers of Attorney
- Living Wills
- Living Trusts
- Codicils
- Revocable & Irrevocable Trusts

REAL ESTATE MATTERS

- Sale/Purchase of Primary Residence
- Refinancing Primary Residence
- Tenant Negotiations (as tenant)
- Eviction Defense (as tenant)
- Home Equity Loans of Primary Residence

Enrollment Dates: May 18, 2009 - August 12, 2009

DOCUMENT REVIEW/ DEBT COLLECTION DEFENSE DEFENSE OF CIVIL LAWSUITS	FAMILY MATTERS	DOCUMENT PREP.
<ul style="list-style-type: none">• Civil Litigation Defense• Administrative Hearings• Incompetency Defense• School Hearings• Pet Liabilities	<ul style="list-style-type: none">• Uncontested Adoption• Uncontested Guardianship• Name Change	<ul style="list-style-type: none">• Deeds• Mortgages• Promissory Notes• Demand Letters• Affidavits

LEGAL ADVICE ABOUT NON-COVERED SERVICES

The Hyatt Premier Legal Plan provides telephone and office consultations about virtually any personal legal matter. (This does not apply to services which are excluded.) During the consultation, the Plan Attorney will explain your rights and options and recommend a course of action. If you choose to retain a Plan Attorney to represent you on matters which are not covered for representation, the Plan Attorney will provide a written statement of fees prior to providing any service.

REIMBURSEMENT FOR COVERED SERVICES OF AN OUT-OF-NETWORK ATTORNEY

The Hyatt Premier Legal Plan also gives you the flexibility to use an out-of-network attorney for services which are covered under the Plan. If you choose to do so, you will be reimbursed according to a published fee schedule. Call our client service center for a copy of the reimbursement fee schedule.

EXCLUSIONS

The Plan offers an extensive array of legal services. Certain legal matters and services are excluded. Some of these include: Any employment or business related matters; pre-existing legal matters where an attorney has been retained prior to receiving a case number; and any third party costs. If you have a question regarding excluded matters, please call our client service center for further information.

HYATT LEGAL PLANS, INC. - THE LEADER IN GROUP LEGAL SERVICES

Hyatt Legal Plans, Inc., a MetLife company, has been administering group legal plans since 1981. Since then, we have focused on offering our members easy access to affordable legal services. Hyatt is the nation's leading provider of group legal plans.** We serve over five million plan participants at more than 1,000 major U.S. corporations and have a network of over 10,000 attorneys nationwide with over 22 years of experience.

Monthly Rates through payroll deduction are \$19.50 (Includes coverage for employee, spouse and dependents)

If you would like more information about The Hyatt Premier Legal Plan, please call us at 1-800-821-6400 between 8:00am and 7:00pm EST Monday through Friday. A knowledgeable Client Service Representative will be available to assist you. You may also access additional information on Hyatt's website: www.legalplans.com. The password is 572513 or 570005.

**Source: National Resource Center for Consumers of Legal Services Legal Plan Letter, September 1996.*

*** Based on covered lives. Source: National Resource Center for Consumers of Legal Services Plan Letter, September 1996.*

Enrollment Dates: May 18, 2009 - August 12, 2009

ANNOUNCING NEW COVERAGE AT NO ADDITIONAL COST!

Hyatt Legal Plans, Inc. is pleased to announce three new changes in coverage to the Premier Legal Plan at no additional cost to plan participants. Besides covering issues like estate planning, buying and selling your home and debt matters. The Premier Legal Plan coverage has been expanded to include.

- Identity Theft Defense
- Immigration Assistance
- Traffic Ticket Only (No DUI)

IMMIGRATION ASSISTANCE

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

IDENTITY THEFT DEFENSE

This benefit provides Participants with consultations with an attorney regarding potential creditor actions resulting from identity theft, and attorney services as needed to contact creditors, credit bureaus and financial institutions. It also provides defense services for specific creditor actions over disputed accounts as set forth in the Debt Collection Defense coverage. In addition it provides Participants with online help and information about Identity Theft and prevention.

TRAFFIC TICKET ONLY (NO DUI)

This service covers representation of the Participant in defense of any traffic ticket except driving under influence or vehicular homicide, including court hearings, negotiation with the prosecutor and trial.

**If you have any questions regarding your Hyatt Legal Plan, please call
1-800-821-6400.**

Enrollment Dates: May 18, 2009 - August 12, 2009

Continuation of Benefits

Gilsbar Medical and Dependent Care Accounts:

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 through COBRA. 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 claims were not incurred prior to the date of termination. To continue your medical spending account, you may contact **IMS (Interactive Medical Systems) at 800-426-8739**.

Ameritas Dental:

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 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 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. You will receive notification from IMS with premium and continuation options shortly following your termination of employment. Should you have any questions, please call **IMS (Interactive Medical Systems) at 800-426-8739**.

Philadelphia American (Formerly CSO) / Assurity Cancer:

When you leave your employment, you may continue your Central States of Omaha Cancer coverage or Assurity Cancer coverage by having the premiums that are currently deducted from your paycheck billed to your home address or drafted from your bank account. For billing options, please call Philadelphia American (formerly CSO) **800-541-2363** or Assurity **866-289-7337**.

Superior Vision:

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 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 may be 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.

Enrollment Dates: May 18, 2009 - August 12, 2009

Examples of an ineligible dependent would be when your child graduates from college, or turns 24 years old. You will receive notification from IMS with premium and continuation options shortly following your termination of employment. If you have any questions, please call **IMS (Interactive Medical Systems) at 800-426-8739**.

MetLife Short Term Disability:

This coverage is not portable. Coverage terminates upon termination of your employment.

MetLife Term Life:

Conversion: If your employment terminates while you are covered under the plan or when you are approved for long-term disability, you may purchase without medical evidence of insurability, any individual insurance policy, except a term policy. You must apply for conversion within 31 days after the date your coverage terminates. This applies to Optional Life and Dependent Life as well as the basic coverage.

To get information and rates for converting coverage, please contact MetLife direct at **877-275-6387**.

Portability: If you terminate employment, the portability provision allows you to take your optional life coverage with you, subject to the following provisions:

- You must apply for coverage with 31 days from the date your life coverage terminates.
- You must be **ACTIVELY** at work prior to employment termination.
- You may only port up to your current coverage amount. You cannot increase or add dependents.

To get information and rates for porting coverage, please contact MetLife direct at: **866-492-6983**.

MetLife Whole Life:

When you leave your employment, you may continue your Met 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. Please call **MetLife 800-634-5007**.

Hyatt Legal Plan:

When you leave your employment, you may continue your Hyatt Legal plan by having the premiums that are currently deducted from your paycheck billed to your home address or drafted from your bank account. Please call **Hyatt Legal 800-821-6400**.

Enrollment Dates: May 18, 2009 - August 12, 2009

Contact Information:

Mark III Brokerage, Inc. - (800) 532-1044, ext. 210
Gilsbar Medical and Dependent Care - (800) 445-7227 ext. 883
Ameritas Dental Plan - (800) 487-5553
Assurity Cancer Claims/Customer Service - (866) 289-7337
Assurity Wellness Claims/Customer Service - (888) 358-8808, ext 23
Philadelphia American Cancer Plan (Formerly CSO) - (800) 554-0092
Superior Vision Plan - (800) 507-3800
MetLife Term Life Plan - (800) 638-6420 (ext. 2 for claims)
MetLife Conversions - (877) 275-6387
MetLife Portability - (866) 492-6983
MetLife Short Term Disability Plan - (800) 300-4296
MetLife Whole Life Plan - (800) 634-5007
Hyatt Legal Plan - (800) 821-6400