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Plan Arranged By:



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

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

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

- **Standard Life Short Term Disability**
- **The Standard Long Term Disability**
- **Unum Universal Life Insurance**

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

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

Ameriflex FSA Plan

*Flexible Spending Account
With Debit Card*

Plan Information

- Maximum Annual Election:
 - \$5,000
- Minimum Annual Election:
 - \$300

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

AMERIFLEX

Plan Year: January 1, 2009 to December 31, 2009

Medical Reimbursement Plan Maximum: \$5,000

Medical Reimbursement Plan Minimum: \$300

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

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

How the AmeriFlex Plan Works

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

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

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

Eligible Expenses

Medical Spending Account Eligible Expenses

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

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

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

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

Dependent Day Care Spending Account Eligible Expenses

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

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

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

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

Commuter Reimbursement Account Eligible Expenses

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

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

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

Funding Your Account

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

Determining Account Contributions

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

The Use-It-or-Lose-It Rule

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

Claims Process

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

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

The AmeriFlex Convenience Card

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

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

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

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

Your Card Account Balances and Transaction Receipts

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

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

- Do I need the receipts?

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

FSA Election Changes

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

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

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

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

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

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

Employee Termination/Claims Procedures

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

Tax Implications

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

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

Dependent Day Care

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

Tax Credits vs. Dependent Care Spending Accounts

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

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

List of Eligible Expenses

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

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

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

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

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

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

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

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

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

119. Transplants/Yes: See Organ Donor

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

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

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

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

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

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

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

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

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

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

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

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

Over-The-Counter Medications

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

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

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

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

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

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

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

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

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

Head lice treatment - RID and similar head lice treatments.

Hemorrhoid - Preparation H, Plazo, and similar treatments.

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

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

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

Smoking cessation - Nicotine gum, lozenges and patches.

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

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

Sunburn care - Solarcaine, and equivalent generics.

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

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

Wart removal - Compound W and similar medication

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

Eligible with Doctor's Note:

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

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

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

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

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

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



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

Superior Vision Plan

Plan Highlights

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

.....
: *This Plan provides primary vision care benefits includ-* :
: *ing prescription eyewear and contact lenses offered* :
: *through a broad-based provider network consisting* :
: *of ophthalmologists, optometrists and opticians.* :
.....



Copayment Amount

- \$15.00 Materials
- \$35.00 Contact Lens Fitting

Benefits	Frequency	In-network	Non-Network
• Lenses (Standard) per Pair			
• Single Vision	12 Months	Covered in Full	Up to \$32.00
• Bifocal	12 Months	Covered in Full	Up to \$46.00
• Trifocal	12 Months	Covered in Full	Up to \$57.00
• Lenticular	12 Months	Covered in Full	Up to \$90.00
• Contact Lenses (Per Pair)*			
• Medically Necessary	12 Months	Covered in Full	Up to \$210.00
• Cosmetic (Elective)**	12 Months	Up to \$120.00	Up to \$100.00
• Contact Lens Fitting Fee***			
• Standard	12 Months	Covered in Full	Not Covered
• Specialty	12 Months	Up to \$50.00	Not Covered
• Frames (Standard)**	24 Months	Up to \$100.00	Up to \$47.00

*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 multifocal lenses. For the specialty fit, the member is responsible for any charges over \$50.

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 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).
- Anisometriopia 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.

Contact Lens Examining Fee:

Most providers charge a fee for the fitting of contact lenses. This fee is separate from the eye examination and will vary depending on the provider's fee structure policies. It will also vary due to circumstances or complexities involving the physiological condition of the eyes, the lens prescription, and the type of lenses used. The contact lens exam/fitting fee may be included in the contact lens allowance.

Exclusions

- 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 lamination 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 charge for the Professional Service or Materials
- Experimental or non-conventional treatment or device
- Safety eyewear
- Spectacle lens styles, materials, treatments of “add-ons” not shown in the Benefits Summary
- 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

Discount Programs

Discounts on Additional Purchases

- | | |
|--|---------|
| • Eyeframes | 30% off |
| • Lenses (uncoated std glass or plastic) | 30% off |
| • Add-on features | 20% off |
| • Everyday “Frames & Lenses” package pricing | 20% off |
| • Contact Lenses | 20% off |
| • Disposable Contacts | 10% off |
| • Other Items | 20% off |

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.

Note: The discount benefit is available only from Superior Vision Plan in-network providers who are identified in the provider directory with a “DP.”

Discount SVP8-20

These discounts apply to upgrades on the covered frame and lenses only. For discounts on additional pairs, please refer to the Discounts on Additional Purchases.

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

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

Add-ons to the covered pair of lenses

Lens Options and Upgrades

Member pays 20% off retail up to

- Scratch Coat (Factory) \$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)
- Plastic Tints solid or gradient \$25(Any Type Lenses)
- Glass coloring \$35(Any Type Lenses)

Member pays

- Power over 4.00 Sphere, 2.00D Cylinder & 5.00D Prism 20% discount off retail
- Cosmetic Finishing, Beveling, Edging & Mounting 20% discount off retail
- All other Lens Options/Upgrades 20% discount off retail

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

Progressive Power Lens Benefit (no-line): The member pays the difference between the provider's price for Standard Trifocal lenses and the price of the progressive power lenses selected, less 20%.

How to use your benefit

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

1. 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.

2. 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 copayments and charges above the covered benefits. The in-network provider handles all claims and paperwork.

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

1. 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.

2. After receiving services and paying in-full for the examination and/or materials (you do not pay a copayment 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.

3. You will be reimbursed according to the schedule of allowances for non-network providers, less any required copayments.

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.

Superior Vision Plan Tenthly (10 Pay) Rates

Employee Only	\$7.80
Employee/One Dependent	\$15.10
Employee/Family	\$22.20

Member Services, Provider Listings and Claims Services:

1-800-507-3800

916-852-2277 (FAX)

Provider Nominations:

Lee Sims @ 800-923-6766 X254

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. National Guardian Life Insurance Company is not affiliated with The Guardian Life Insurance Company of America, a/k/a The Guardian or Guardian Life.

Cancer and Specified Disease Plan

Plan Benefits

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

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



Basic Benefits

Provides medical expense benefits caused by cancer and certain other specified diseases by rider for the employee, spouse and covered children with continuous benefit and premium period 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.

Underwriting

Pre-existing conditions are not covered during the first 2 years the policy is in force. Persons with previous history of cancer will be excluded unless added by rider for those with simple skin cancers. Additional question regarding diagnostic tests that have been completed within last 30 days or are scheduled to be performed is also asked. No benefits will be paid during a 30-day waiting period. Conditions that manifest after the policy date will be payable beginning on the 31st day.

Definition of manifested: "Symptoms or visible indications that would put an ordinary prudent person on notice that diagnosis, care or treatment by a medical professional should be sought."

Policy will pay the following specified benefits for each unit for a covered injury:

Hospital Indemnity

Pays benefits each day while confined in the hospital for cancer or certain other specified disease 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

Pays actual charges up to 25% of daily hospital confinement benefit for the first 75 days of hospital confinement.

Surgical Benefit

Pays up to \$7,500 for actual charges made by surgeon as shown in Surgical Table in policy.

Anesthesia

Pays up to 25% of the amount payable under the Surgical Benefit. Limit of \$50 per skin cancer operation.

Additional Surgical Opinions

Pays up to \$150 for a second opinion. If the second opinion differs from the first, up to \$150 for a third opinion.

Artificial Limb and Prosthesis

Pays actual charges for prosthesis and reconstructive procedure to affix or implant it up to \$2,000 lifetime maximum.

Attending Physician

Pays actual charges up to \$35 per day for in-hospital physician's visits.

Private Duty Nurse

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, Chemotherapy or Immunotherapy

Pays 50% of actual charges for treatments up to \$10,000 per month with a lifetime maximum of \$100,000.

Experimental Treatment

Pays the actual charges up to \$25,000 per calendar year for such treatment received in the United States or its territories, except for experimental bone marrow transplants.

Physical and Speech Therapy

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

Extended Care Facility

Pays up to \$60 per day for confinement in such a 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

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. 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

Pays (a) actual charges up to \$2,500 for medical expenses 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 has 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

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 for Non-local Treatment Which Does Not Require Hospital Confinement

Pays (a) 50 cents per mile for personal automobile expenses in excess of 50 miles one way, up to 700 miles round trip with a maximum of \$1,500 per calendar year, (b) pays actual charges for 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.

Adult Companion Transportation and Lodging

Pays the following expenses for one adult companion to be near insured when insured is confined in a non-local hospital (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 limited to the number of days of each confinement.

Outpatient Positive Diagnostic Testing

Pays actual charges up to \$250 for the diagnostic test that leads to a positive diagnosis within 90 days of the test.

Outpatient Surgery

Pays a benefit equal to the daily hospital confinement benefit for outpatient surgery in a hospital or ambulatory surgical center.

Skin Cancer

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

Pays actual charges up to \$75 per trip to transfer an insured person to the hospital for confinement as an inpatient.

Hospice

Pays actual charges up to \$100 per day up to a lifetime maximum of \$7,500.

Government or Charity Hospital

Pays actual charges up to \$200 per day for confinement in a government or charity hospital. Payment is in lieu of all other policy benefits.

Blood and Blood Plasma

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

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 following a lymph node dissection for the treatment of breast cancer. Lifetime maximum of \$2,500 per breast.

Cancer (Wellness) Screening Tests

Pays a scheduled amount up to \$100 per 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

Home Health Care Services

When services are provided by a Home Health Care Agency, policy pays (a) up to \$60 per day for services provided at home, not to exceed 180 days per calendar year, (b) up to \$100 per day for Private Duty Nursing, not to exceed 15 days per calendar year, and (c) pays actual charges for a physician's visit up to \$40 per day not to exceed 15 days per calendar year. Benefits herein are not payable under provisions of this policy.

Hairpiece Benefit

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

Rental or Purchase of Durable Medical Equipment

Pays the actual charges up to \$1,000 per calendar year for (a) a respirator or similar medical device, (b) brace, (c) crutches, (d) hospital bed or (e) wheel chair.

Professional Mental Health Consultation

Pays actual charges up to \$50 per session not to exceed a lifetime maximum of \$250.

Extended Benefits

If a covered hospital confinement lasts for more than 75 days in a row, policy pays usual and customary charges for hospital room and board, medicines, lab test and other normal charges, up to \$1,000 per day beginning on the 76th day. Payable after the 75th day in lieu of all other policy benefits.

Waiver of Premium

Premiums of the insured person will be waived while that person is receiving treatment for cancer or specified disease for which benefits are payable.

Issue Age

The Assurity cancer plan 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.

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

Intensive Care Rider

Provides a Daily Benefit (you choose \$300 or \$600) 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.

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 the website: www.markiibrokerage.com/johnsoncityschoolstn. If a bill is not included with the claim form, a scheduled amount will be paid. (Scheduled amounts are listed on the claim form). Employees can also call in their wellness claim at **(888) 358-8808 x23**.

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 seeing someone in your Payroll Department. Should you have any questions on how to file or submit a claim, or regarding the Assurity Cancer Plan, please call **(888) 358-8808 x23**.

Pre-Existing Conditions

Assurity will not pay any Benefits for loss caused by a Pre-Existing Condition during the first year following the Issue Date; however, loss due to such conditions will be payable unless specifically excluded from coverage after such 2 year period.

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.

**Assurity Life Insurance Company
PO Box 80926
Lincoln, NE 68501-0926**

Website: www.assurityatwork.com



**Assurity Customer Service: (866) 289-7337
To Call in a Wellness Claim: (888) 358-8808 x23
To Fax in a Wellness Claim (Toll Free): (800) 869-0368**

Cancer & Specified Disease Plan Tenthly Rates

Assurity Life Cancer & Specified Disease Plan				
		\$150 Daily Benefit	\$250 Daily Benefit	\$350 Daily Benefit
Base Policy (\$10,000 per month/\$100,000 lifetime maximum) (radiation/chemotherapy)	Individual	\$25.10	\$27.86	\$30.62
	EE & Spouse	\$38.45	\$42.74	\$47.03
	EE & Children	\$31.19	\$34.32	\$37.45
	Family	\$44.53	\$49.20	\$53.86
Base Policy with Intensive Care Rider (\$300 daily benefit)	Individual	\$27.62	\$30.38	\$33.14
	EE & Spouse	\$43.49	\$47.78	\$52.07
	EE & Children	\$35.15	\$38.28	\$41.41
	Family	\$51.01	\$55.68	\$60.34
Base Policy with Intensive Care Rider (\$600 daily benefit)	Individual	\$30.14	\$32.90	\$35.66
	EE & Spouse	\$48.53	\$52.82	\$57.11
	EE & Children	\$39.11	\$42.24	\$45.37
	Family	\$57.49	\$62.16	\$66.82
Base Policy with First Occurrence Benefit Rider (\$2,500 benefit)	Individual	\$28.50	\$31.26	\$34.02
	EE & Spouse	\$43.52	\$47.82	\$52.10
	EE & Children	\$35.29	\$38.42	\$41.56
	Family	\$50.32	\$54.98	\$59.64
Base Policy with First Occurrence Benefit Rider (\$2,500 benefit) and Intensive Care Rider (\$300 daily benefit)	Individual	\$31.02	\$33.78	\$36.54
	EE & Spouse	\$48.56	\$52.86	\$57.14
	EE & Children	\$39.25	\$42.38	\$45.52
	Family	\$56.80	\$61.46	\$66.12
Base Policy with First Occurrence Benefit Rider (\$2,500 benefit) and Intensive Care Rider (\$600 daily benefit)	Individual	\$33.54	\$36.30	\$39.06
	EE & Spouse	\$53.60	\$57.90	\$62.18
	EE & Children	\$43.21	\$46.34	\$49.48
	Family	\$63.28	\$67.94	\$72.60
Base Policy with First Occurrence Benefit Rider (\$5,000 benefit)	Individual	\$31.90	\$34.66	\$37.42
	EE & Spouse	\$48.60	\$52.90	\$57.18
	EE & Children	\$39.40	\$42.53	\$45.66
	Family	\$56.10	\$60.77	\$65.42
Base Policy with First Occurrence Benefit Rider (\$5,000 benefit) and Intensive Care Rider (\$300 daily benefit)	Individual	\$34.42	\$37.18	\$39.94
	EE & Spouse	\$53.64	\$57.94	\$62.22
	EE & Children	\$43.36	\$46.49	\$49.62
	Family	\$62.58	\$67.25	\$71.90
Base Policy with First Occurrence Benefit Rider (\$5,000 benefit) and Intensive Care Rider (\$600 daily benefit)	Individual	\$36.94	\$39.70	\$42.46
	EE & Spouse	\$58.68	\$62.98	\$67.26
	EE & Children	\$47.32	\$50.45	\$53.58
	Family	\$69.06	\$73.73	\$78.38

AAW-C120RAB (7/04)

Short-Term Disability Plan

Plan Highlights

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

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



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

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

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

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

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

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

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

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

But is your income insured?

1 National Safety Council, Injury Facts, 2003 Edition

2 American Cancer Society, Cancer Facts & Figures 2004

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

4 American Lung Association, Lung Disease Data 2003

5 National Underwriter, May 2002

Why Income Protection?

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

Counting on Social Security to provide disability benefits?

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

Covered by workers' compensation?

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

Think your savings will get you through a disability?

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

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

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

Plan Features

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

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

Accident & Sickness protection

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

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

Eligibility

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

POLICY FEATURES

Pre-existing Conditions

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

Disability Due to Pregnancy

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

Portability

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

Limits and Exclusions

Benefits will not be paid for any total disability which:

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

Standard Life Short-Term Disability Tenthly Rates

Benefit Duration: 90 Days		Benefit Duration: 180 Days		Benefit Duration: 365 Days	
Monthly Benefit	10 Pay Premium	Monthly Benefit	10 Pay Premium	Monthly Benefit	10 Pay Premium
\$500	\$13.50	\$500	\$21.00	\$500	\$27.00
\$600	\$16.20	\$600	\$25.20	\$600	\$32.40
\$700	\$18.90	\$700	\$29.40	\$700	\$37.80
\$800	\$21.60	\$800	\$33.60	\$800	\$43.20
\$900	\$24.30	\$900	\$37.80	\$900	\$48.60
\$1,000	\$27.00	\$1,000	\$42.00	\$1,000	\$54.00
\$1,100	\$29.70	\$1,100	\$46.20	\$1,100	\$59.40
\$1,200	\$32.40	\$1,200	\$50.40	\$1,200	\$64.80
\$1,300	\$35.10	\$1,300	\$54.60	\$1,300	\$70.20
\$1,400	\$37.80	\$1,400	\$58.80	\$1,400	\$75.60
\$1,500	\$40.50	\$1,500	\$63.00	\$1,500	\$81.00
\$1,600	\$43.20	\$1,600	\$67.20	\$1,600	\$86.40
\$1,700	\$45.90	\$1,700	\$71.40	\$1,700	\$91.80
\$1,800	\$48.60	\$1,800	\$75.60	\$1,800	\$97.20
\$1,900	\$51.30	\$1,900	\$79.80	\$1,900	\$102.60
\$2,000	\$54.00	\$2,000	\$84.00	\$2,000	\$108.00

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

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



Long-Term Disability Plan

Plan Highlights

- LTD Income Benefit - 50%
- Maximum Benefit - \$3,000
- Elimination Period - 90 days
- Maximum Benefit Period - to age 65
- Employee Paid - Tax-Free Benefit

The Standard's Long-Term Disability plan benefits provide a source of income while you concentrate on getting better.



TheStandard™

Voluntary Long Term Disability, underwritten by The Standard Insurance Company, offers disability income protection to employees unable to perform all of the material duties of their occupation on a full-time basis due to sickness or injury.

Long Term Disability coverage is needed by employees as a replacement for lost income should they become sick or injured. Under the Standard Long Term Disability Plan, a monthly benefit is paid directly to an employee to help with ongoing personal expenses.

Elimination Period

Elimination Period is the number of continuous days (90 days) you must be totally disabled before benefit payments start. The Elimination Period is waived on Recurrent Disabilities. You can return to your regular occupation for up to six months without having to satisfy a new Elimination Period if there is a recurrence of the prior disability.

Maximum Benefit Period

To age 65 - the longest period of time that benefits will continue to be paid to the disabled employee as long as he/she remains disabled in accordance with the contract. **The benefit period starts reducing depending on the age at the onset of the disability.**

Maximum Monthly Benefit

50% of salary - is the highest monthly benefit the disabled employee can receive up to a maximum of \$3,000.00.

Monthly Rate

The following Voluntary Long Term Disability rate is for full-time employees who are working a minimum of 30 hours per week and who are not qualified to receive disability benefits under the North Carolina Local Governmental Employee's Retirement System: **rates are per \$100.00 of covered monthly salary, excluding bonuses and overtime pay. Please see chart at the end of this section for rates corresponding to your age bracket.**

Pre-Existing Condition Exclusion

A **3/12 pre-existing condition limitation** applies to all insurance amounts. Pre-existing condition means any sickness or injury for which an employee has received medical treatment, consultation, care or services (including diagnostic measures or the taking of prescribed drugs or medicines) **during the 90 days prior to the insured employee's coverage effective date.** A disability arising from any such sickness or injury will be covered only if it begins after an employee **has performed his/her regular occupation on a full-time basis for 12 months following the coverage effective date.**

Partial Disability Benefit

Benefits are payable when an insured is unable to perform one or more of his/her main duties at his/her own or any other occupation, or is unable to perform those duties on a full-time basis.

To qualify for the benefit, an insured must be earning less than 80% of his/her pre-disability income. An 85% earnings test will be applied after the first two years of partial disability, unless total earnings reaches 100% of pre-disability income.

Benefit payments are reduced by partial employment earnings and other income sources and end on the earliest of:

- the date the insured ceases to be partially disabled;
- the date the insured's current earnings exceed 85% of his/her pre-disability income; or
- the date the maximum benefit period ends.

Survivors Benefit

Pays a lump sum benefit equal to 3 times the insured's last gross monthly LTD benefit to the surviving spouse or children of the insured. The insured must have been disabled for a minimum of 180 days and have been receiving benefits under the policy when death occurs.

Waiver of Premium

Premiums due during an insured's total or partial disability period are waived after benefits become payable and as long as the payments continue.

Recurrent Disability Provision

An insured can return to his/her regular occupation for up to six months without having to satisfy a new elimination period if there is a recurrence of the prior disability. However, if an insured returns to his/her regular occupation on a full-time basis for six months or more, a recurrent disability will be treated as a new period of disability, and the insured employee must complete another elimination period.

Pregnancy

Pregnancy is treated as an illness. The definition of disability must be satisfied and the elimination period completed before benefits would begin.

Mental Disorders and Substance Abuse

Disability resulting from a mental disorder or substance abuse (such as alcoholism or drug addiction) will be covered up to 24 months of benefit payments unless the employee is hospitalized at the end of 24 months. In that case, benefits will continue for as long as the employee is confined to a hospital up to the specified maximum benefit duration.

Benefit Integration*

Voluntary Long Term Disability benefits are reduced by any other income the insured is eligible for under:

- Primary and Family Social Security Disability or Retirement or any similar plan or act;
- Worker's Compensation Law, occupational disease law or any similar law;
- State Disability Plans or any compulsory benefit act or law;
- Other group disability plans;
- Disability or retirement benefits through the employer; and
- Any form of employment (full or part-time).

****The minimum benefit payable will never be less than \$100.00.***

Exclusions

The Standard Insurance Company does not pay Long Term Disability benefits for any period of disability:

- Which is the result of self-inflicted injury or attempted suicide;
- Due to a pre-existing condition (see *Pre-Existing Condition Exclusions*);
- Due to violent or criminal conduct;
- Due to war, declared or undeclared, or any act of armed aggression

When a disability is due to mental illness, Standard's contract considers benefits payable for up to a maximum period of 24 months. However, if the insured employee is confined to a hospital at the end of the 24-month period, benefits will continue up to the specified maximum benefit duration.

Long term disability coverage is needed by employees as a replacement for lost income should they become sick or injured. A monthly benefit is paid directly to them to help with ongoing personal expenses.

This plan is insured by The Standard Insurance Company. This is not a contract. This brochure briefly summarizes the insurance coverages described. Controlling provisions are in the related policies, which are not modified by this brochure. State requirements may necessitate variances.

**If you have any questions, please call The Standard
at 800-368-1135.**

Your monthly premium is calculated as follows:

Enter your annual earnings.	\$	
Divide by 10.	/	10
Enter your result. (Tenthly Income)	\$	
Divide by 100.	/	100
Enter your result.	\$	
Enter premium rate based on your age and multiply.	x	
Enter your result. (Tenthly Premium)	\$	

Age	Rate per Hundred
<29	0.150
30-34	0.159
35-39	0.181
40-44	0.251
45-49	0.359
50-54	0.525
55-59	0.679
60-64	0.711
65-69	0.749
70-74	0.856
75+	1.119

Universal Life Insurance Plan

Plan Highlights

- Living Benefit Option
- No Physical Required
- Cash Value Accumulation
- Long Term Care Rider

Unum's universal life insurance can give you the insurance protection you need, while also giving you the financial flexibility you want.



Better benefits at work.

Affordable Insurance Protection

Unum's voluntary individual universal life insurance can give you the insurance protection you need, while also giving you the financial flexibility you want. This policy is designed to provide a death benefit to your beneficiaries if you pass away in addition to the life insurance coverage your employer may already be providing for you. For an affordable premium, you can help provide more financial protection for your family — now and into the future.

Living Benefit Option Included

This feature is automatically included for all eligible employees and spouses between the ages of 15 and 80 and children/grandchildren ages 14 days through 24 years for no additional premium. It provides the option of requesting up to 100% of the policy's death benefit, to a maximum of \$150,000, if the insured is diagnosed with a medical condition limiting life expectancy to 12 months or less. If you have to face a terminal illness, this option can provide additional financial assistance during a difficult time. Any payout of this benefit would reduce the death benefit.

Convenient Payroll Deduction

Your premiums are automatically deducted from your paycheck, so you don't have to worry about writing checks or mailing payments.

No Physicals Required

If you are actively at work¹, you may apply for coverage by completing an application and no physical exams are required! Your coverage becomes effective on the date you sign the application. You may be asked health-related questions which may affect issuance of coverage. This means that you will receive the plan and coverage amount you applied for on the application unless it is determined to be unacceptable under Unum's rules, limits or standards. In such event, the plan and coverage amount may be modified or declined.

Individually Owned

If you leave your company, you can take your policy with you and still pay the same premium. Instead of paying your premiums through payroll deduction, Unum will bill you directly at home.

Cash Value Accumulation Feature

Voluntary individual universal life insurance can potentially build cash value that earns interest. The interest rate your policy is credited with will never be less than the guaranteed minimum rate of 3.0%. It is important for you to remember, as with all universal life policies, that the projected cash value of your policy may change over time. Such changes can result from fluctuations in interest rates, scheduled changes in the cost of insurance, or non-payment of premiums, policy loans and loan interest. We encourage you to maintain consistent premium payments and repay any outstanding loans in a timely fashion to avoid an early lapse in coverage or termination of your policy.

Additional Features

Accidental Death Benefit Rider

- Available to employees and spouse between the ages of 15 - 65 for an additional premium.
- Provides an additional death benefit equal to the face amount, up to a maximum of \$150,000, if the insured dies as a result of an accident before age 70.
- Under certain conditions, the benefit will double if death occurs from injuries sustained while the insured is a fare-paying passenger via commercial transportation.
- Benefits increase by 25% if death occurs from accidental bodily injury sustained while wearing a seatbelt.

Waiver of Monthly Deduction

- All eligible employees between the ages of 15 and 55 will receive the waiver of monthly deduction, which credits your policy's monthly planned periodic premium if you become disabled before age 65 and remain disabled beyond a six-month period. The rider terminates at age 65, however benefits will not cease for total disability which began before age 65.

Family Coverage

Spouse Coverage

Voluntary individual universal life coverage is available for your spouse based on a qualifying health question. However, no physical exams are required and coverage is available even if you don't apply for coverage yourself. A few additional health questions may be asked based on the level of coverage being applied for.

Children's Standalone Coverage

A standalone insurance policy is available to children, stepchildren, legally adopted children and grandchildren between the ages of 14 days and 24 years.

Life is unpredictable. But you can take steps to help protect your family now and into the future with Unum's voluntary individual universal life insurance. Ask your benefits representative for more information and apply today!

FREQUENTLY ASKED QUESTIONS

Am I required to participate in this coverage?

No. Your coverage is voluntary, and you decide if it is right for you and your family's needs. It's your choice.

Who becomes the owner of the policy?

Unum's voluntary individual universal life insurance policy is just that - voluntary and individual. This means that electing coverage is optional, and if you decide coverage is right for you, then you become the owner of your policy.

Does this policy automatically replace any of my existing group insurance coverage?

No. Voluntary individual universal life insurance is a supplemental insurance policy and can enhance your group coverage.

May I increase my coverage in the future?

Yes, your coverage can be increased to meet your changing needs. Once you have owned your policy for one year, you may apply for additional coverage up to the maximum amount available for your age.

May I insure my spouse and/or my children even if I don't participate in this plan?

Yes, coverage is available for your spouse and children even if you choose not to purchase coverage for yourself. Certain minimal underwriting requirements may apply. Ask your benefits representative for more details during enrollment.

May I take a loan on my policy?

Yes, you may borrow part of your cash value from the policy at an annual interest rate of 8.0% per year. Any loan taken will have an effect on the cash value of the policy.

How will I be kept informed of my cash value?

Each year, Unum will mail you a policy statement outlining what you have paid, how much cash value you have, plus the status of any loans, interest credited and applicable administrative charges. These statements are designed to provide you with a valuable record of your policy activity.

Does my policy have a surrender charge?

If you surrender your policy during the first 14 years of coverage, a surrender charge will apply. Beyond the 14th year, there is no surrender charge. A unique 14-year period applies to each increase in coverage.

Who can I contact if I have questions about my policy after enrolling?

During enrollment, a benefits representative will be available one-on-one to answer any questions you may have about voluntary individual universal life insurance.

If you have questions about your policy after enrolling, simply pick up the phone and call Unum at 1-800-635-5597.

The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. See the actual policy or your Unum representative for specific provision and details of availability.

¹ Being “actively at work” means that on the day you apply for coverage, you are working at one of your company’s business locations, or you are working at a location where you are required to represent your company. If you are applying for coverage on a day that is not one of your scheduled workdays, then you will be considered actively at work if you meet this definition as of your last scheduled workday. You are not considered actively at work if your normal duties are limited or altered due to your health, or if you are on a leave of absence.

Underwritten by the following subsidiary of Unum Group:
Provident Life and Accident Insurance Company
1 Fountain Square, Chattanooga, TN 37402
www.unum.com

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CU-2944 (9-08)

Long Term Care Rider

If you're like most people, you've heard how important it is to prepare for your future and that of your family. You may have acquired a home, built a savings nest egg, begun contributing to retirement funds, and even made plans and preparations for your children's education. But is that enough? Are you financially prepared to cover the expenses of long term care should you or your spouse become ill or disabled, or need special medical treatment as you get older?

Unum's long term care rider complements your voluntary life insurance helping to give you the additional financial protection you may need. In the event you or your covered spouse need long term care, this rider can help provide benefits to cover those costs.

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www.unum.com
1-800-635-5597

CU-2944 (9-08)

Continuing Your Benefits

Upon Termination of Employment

To Continue Your Dental, Vision, and/or FSA Plan

*Under the group dental and vision plan and your Flexible Spending Accounts, you and your covered dependents are eligible to continue coverage through COBRA. Upon termination, your employer will notify IMS and IMS will send you information regarding COBRA. Should you have any questions, you may contact IMS at **800-426-8739**.*

To Continue Other Policies

You may continue your Assurity Cancer, Standard Life Short-Term Disability, and UnumProvident Universal Life policies by having the premiums currently deducted from your paycheck drafted from your bank account or billed to your home. For more information, contact

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

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

*Unum at **800-635-1049***

Contact Information for Questions and Claims

Ameriflex

*24/7 Interactive Voice Response: 888-868-3539
(option 2, option 2)*

*Toll Free Phone: 888-868-3539
(option 2, option 3, 8:30 am to 5:30 pm EST)*

www.flex125.com

Email: service@flex125.com

Fax 856-631-1020

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

Assurity Life Insurance

PO Box 80926

Lincoln, NE 68501

1-866-289-7337

*Wellness Claims:
1-888-358-8808 x23*

Superior Vision Services

11101 White Rock Rd, Suite 150

Rancho Cordova, CA 95670

1-800-507-3800

www.superiorvision.com

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