

Johnson County Schools is offering all full-time employees a comprehensive Cafeteria Benefits program. The Cafeteria Benefits program is being arranged by Mark III Brokerage, an employee benefits firm that has worked in the public sector for many years. The Cafeteria Benefits program allows you to pay for certain insurance premiums, child-care, and unreimbursed medical expenses before taxes are taken out of your paycheck. Paying for these benefits in this method may reduce your taxes and may increase your take home pay. The Cafeteria Benefits program includes Flexible Spending Accounts, Ameritas Dental, Assurity Cancer Plan, Superior Vision Plan, Standard Life Short Term Disability & MetLife Term Life Plan. The Plan Year runs from January 1, 2009 through December 31, 2009.

Table of Contents

PRE-TAX BENEFITS

Tucker Administrators Medical Spending AccountPage 2

Tucker Administrators Dependent Care AccountPage 17

Ameritas Dental Plan.....Page 24

Cancer Fact Sheet.....Page 27

Assurity Cancer PlanPage 28

Superior Vision Plan..... Page 34

BlueCross BlueShield of TennesseePage 39

AFTER-TAX BENEFITS

Disability Fact SheetPage 49

Standard Life - Short Term Disability Plan.....Page 50

MetLife Term Life PlanPage 52

Boston Mutual Whole Life PlanPage 57

Horace Mann Retirement PlanningPage 61

Horace Mann Auto InsurancePage 62

Continuation of BenefitsPage 63

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

Tucker Administrators *Medical Spending Account*

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

Medical Reimbursement Plan Maximum: \$2,500

Medical Reimbursement Plan Minimum: \$200

The Medical Spending Account offers a real advantage for your pocketbook. Many people find this a cost effective way to pay for such items as medical and dental plan deductibles/co-payments, eyeglasses, contact lenses, orthodontics and other health-related expenses that may not be covered by insurance. Even taxpayers who do not itemize can take advantage of this tax break by using the Medical Spending Account.

WHO SHOULD ENROLL?

The Medical Spending Account is beneficial for anyone who has eligible out-of-pocket medical, dental, vision, or hearing expenses beyond what their insurance plan covers.

IS THIS A GOOD PROGRAM FOR ME?

It's easy to determine if the Medical Spending Account can save you money. Before the plan year begins, you will need to determine your annual election. It's a good idea to estimate the expenses that you will incur during the plan year.

You are allowed to include eligible out-of-pocket expenses for you, your spouse, and anyone claimed as a dependent for tax purposes. Review your health care expenses from the previous year. If you find you had \$150 or more in recurring or predictable expenses, this account can help you stretch your income.

A worksheet is provided in this booklet to help you calculate your estimated eligible expenses.

HOW DOES IT WORK?

After you determine your annual expenses, identify an annual Medical Spending Account election that you are comfortable with. This amount will be deducted in even amounts from each of your paychecks. **You will need to plan carefully as the IRS requires that any unused money left in your account at the end of the plan year will be forfeited.**

HOW IS A CLAIM FILED?

a. Please attach all back up documentation to your claim form. Make sure that the original date of service appears on your documentation. Balance due statements and paid on account receipts usually do not contain the original date of service, therefore you may need to include additional documentation to show when the service was incurred. Remember that you must incur the service within each applicable plan year. **The important date is when the service was incurred - not when it was paid.**

b. Make sure the claim form is signed when submitting a request for reimbursement. Claim forms are available from the website listed on the front cover of this booklet.

c. Some of the acceptable documentation for medical spending accounts would include the following:

- Explanations of Benefits from health plans
- Walk out statements from health providers
- Bills from medical providers and suppliers
- Copies of prescription receipts

Note: Itemized cash register receipts would be acceptable documentation for contact lens solutions and other allowable Over The Counter items.

d. Reimbursement Account checks are mailed out each week. Please have your requests to Tucker Administrators by Wednesday, the week before the check run to make sure your claim is processed and your check can be mailed to you the following week.

e. Remember, you may submit claims for yourself and any dependent family members. You may submit claims for deductibles, coinsurance and doctor's office copays for your spouse's health insurance as long as those expenses have not been reimbursed by another pre-tax medical spending account.

You may send all requests for reimbursement directly to Tucker Administrators at the following address:

**Tucker Administrators, Inc.
3800 Arco Corporate Dr., Suite 450
Charlotte, NC 28273
Telephone: (800) 347-1232
Fax: (704) 525-9534
www.tuckeradministrators.com**

CAN I CHANGE MY ELECTION?

In line with Internal Revenue Service guidelines, you can change your election if you have a **qualifying status change** during the plan year. This includes change in legal marital status, change in number of tax dependents, termination or commencement of employment, dependent satisfies or ceases to satisfy dependent eligibility requirements, or a judgment, decree or order. However, the adjustment in your election must be relevant to the change in status and the requested election change has to be in line and consistent with the event. All requests must be submitted to Johnson County Schools for approval.

WHAT ARE THE ADVANTAGES OF THE MEDICAL SPENDING ACCOUNT?

Most important, the net cost of your required out-of-pocket health care expenses is reduced and made more affordable. The amount you contribute to your Medical Spending Account and the amount you are reimbursed from your Medical Spending Account are income tax-free. The amount you contribute to your Medical Spending Account is not subjected to Federal, State, or FICA taxes. Generally, this will mean a tax savings of 15% to 40% depending on your tax bracket. As a direct result of your personal tax savings, you will actually reduce the cost of required expenses and thus, increase your spendable income.

HOW THE MEDICAL SPENDING ACCOUNT SAVES YOU MONEY...

Let's look at an example. As shown below, Ben E. Fits makes \$26,000 a year, and elects to contribute \$500 to his Medical Spending Account. He then files eligible claims for the \$500 in his account. As the example shows, Ben E. Fits will save \$139 in taxes.

	Without a Medical Spending Account	With a Medical Spending Account	Tax Savings with a Medical Spending Account
Annual Pay	\$26,000	\$26,000	
Subtract Out-of-Pocket Medical Expense (Pretaxed)	\$0	-\$500.00	
Federal Taxes 15%	\$3,900	\$3,825	\$75
State Taxes (Based on 5.3%)*	\$1,378	\$1,352	\$26
FICA Taxes (Based on 7.65%)	\$1,989	\$1,951	\$38
Out-of-Pocket Medical Expense (After-Tax)	-\$500	-\$0	
Annual Tax Savings			\$139
<i>The above figures assume taxes for an employee who is single, using the standard deduction, no dependents and only includes wage income.</i>			
<i>*State taxes where applicable.</i>			

WHAT ARE THE DISADVANTAGES OF THE MEDICAL SPENDING ACCOUNT?

Generally speaking, there are none with a bit of careful planning. However, we do want you to know that when you reduce your FICA taxes, you will be reducing your Social Security contribution. Research studies on this matter indicate that your tax savings generally outweigh any Social Security benefit reduction.

Based on group participation, key employees' participation may be restricted. You will be notified if this applies to you.

As required by law, any money in your Medical Spending Account not used by the end of the plan year will be forfeited. Therefore, it is in your best interest to be conservative when estimating your contribution. But keep in mind that your tax savings may more than make up for any extra dollars you leave in your account at the end of the year.

If you are in doubt about an expense, please contact Tucker Administrators for assistance. You will want to have your annual election as much in line with your medical out-of-pocket costs as possible.

Medical Spending Account Tax-Free Worksheet Illustration

This worksheet will help you estimate your annual uninsured medical expenses for the upcoming plan year, and your estimated tax savings realized through your participation in your Medical Spending Account. Remember to estimate conservatively, considering only those expenses you are confident will be incurred during the plan year, and that will not be covered by any insurance plan.

	Projected Plan Year Expenses (not covered by insurance)
1. Medical and Dental Deductible	\$ _____
Medical insurance co-payments and co-insurance	\$ _____
Dental insurance co-payments and co-insurance	\$ _____
Immunizations, injections and vaccinations	\$ _____
Routine examinations	\$ _____
Dental and orthodontic expenses not covered by insurance	\$ _____
Prescription drugs or co-payments	\$ _____
Eye examinations, glasses and contacts not covered by insurance	\$ _____
Hearing examinations	\$ _____
Transportation to and from medical provider	\$ _____
Medically necessary elective surgery	\$ _____
Other expenses	\$ _____
2. Total estimated, uninsured medical expenses for the plan year	\$ _____
	Estimated Contribution and Tax Savings
3. Write down your desired MSA plan year contribution.	\$ _____
4. You will have equal amounts taken out of each regular paycheck and deposited into your Medical Spending Account.	\$ _____
5. Multiply your per pay contribution by your total tax bracket (the sum of Federal, State, FICA tax rates). See the previous page for an example.	
Your Tax Rate: _____	\$ _____

FLEXIBLE SPENDING ACCOUNT PLAN ELIGIBLE EXPENSES

Medical care expenses are defined by the Internal Revenue Service (IRS) as amounts paid for the diagnosis, cure, mitigation or treatment of a disease, and for treatments affecting any part or function of the body. The expenses must be primarily to alleviate a physical or mental defect or illness.

With that in mind, we have listed below many of the medical expenses eligible for payment under the Medical Spending Account, to the extent such expenses are not covered by your medical or dental insurance. This list is not meant to be all-inclusive. Other expenses not specifically mentioned may also qualify. For additional information, please refer to IRS Publication 502 Medical and Dental Expenses. However, the two exceptions to be aware of are: 1) Insurance premiums are not reimbursable under a Medical Spending Account, and 2) The reimbursement under a Medical Spending Account is based only upon when the expense was incurred; i.e., date of service, not the date paid. To be eligible, the service has to be provided in your plan year.

HEALTH CARE/MEDICAL

MEDICATIONS

Aspirin, if plan allows
Insulin
Nicotine Gum or Patches, if plan allows
OTC Medicines, if plan allows
Prescribed Birth Control
Prescribed Vitamins
(to treat specific disease)
Prescription Drugs

OBSTETRIC SERVICES

Mid-Wife Expenses
OB/GYN Exams
OB/GYN Prepaid Maternity Fees
(reimbursable after date of birth)
Post-Natal/Pre-Natal Treatment
Pre-Natal Vitamins

PRACTITIONERS

Allergist
Chiropractor
Christian Science
Dermatologist
Homeopath
Naturopath
Osteopath
Physician
Psychiatrist
Psychologist

DENTAL SERVICES

Crowns/Bridges
Dental X-Rays
Dentures
Exams/Teeth Cleaning
Extractions
Fillings
Gum Treatment
Oral Surgery
Orthodontia/Braces

INSURANCE-RELATED ITEMS

Copay Amounts
Deductibles
Pre-existing Condition Expenses
(medical)
Private Hospital Room Differential

LAB EXAMS/TESTS

Blood Tests
Cardiographs
Diagnostic
Laboratory Fees
Metabolism Tests
Spinal Fluid Tests
Urine/Stool Analyses
X-Rays

OTHER MEDICAL TREATMENTS/PROCEDURES

Acupuncture
Alcoholism (inpatient treatment)
Cosmetic Surgery (if medically necessary)
Drug Addiction
Hearing Exams
Hospital Services
Infertility
In-vitro Fertilization
Norplant Insertion or Removal
Patterning Exercises
Physical Examination
(not employment related)
Physical Therapy
Pregnancy Tests
Rolfing
Smoking Cessation Programs
Speech Therapy
Sterilization
Transplants (includes organ donor)
Treatment for Handicapped
Vaccinations/Immunizations
Vasectomy
Well Baby Care

Syringes
Transportation Expenses (essential to medical care)
Tuition Fee at Special School for Disabled Child
Wheelchair
Wigs (hair loss due to disease)

VISION SERVICES

Artificial Eyes
Contact Lenses
Contact Lens Solution
Eye Examinations
Eyeglasses
Laser Eye Surgeries
Ophthalmologist
Optometrist
Prescription Sunglasses
Radial Keratotomy

OTHER MEDICAL EQUIPMENT, SUPPLIES and SERVICES

Abdominal/Back Supports
Ambulance Services
Arches/Orthopedic Shoes
Contraceptives
Counseling
Crutches
Guide Dog (for visually/hearing impaired person)
Hearing Aids & Batteries
Hospital Bed
Learning Disability (special school/ teacher)
Medic Alert Bracelet or Necklace
Oxygen Equipment
Prescribed Medical and Exercise Equipment
Prosthesis
Splints/Casts
Support Hose (if medically necessary)

INELIGIBLE EXPENSES

The IRS does not allow the following expenses to be reimbursed under the Medical Spending Account. Expenses to promote general health are not eligible expenses. This is not an inclusive listing.

Babysitting & Child Care	Lamaze Class***
Breast Pumps*	Marriage Counseling
Calcium Supplements	Massage Therapy**
Canceled Appointment Fees	Maternity Clothes
Contact Lens Insurance	Personal Trainer
Cosmetic Surgery/Procedures	Prescription Drug Discount
Custom Fit overs (clip-ons)	Program Premiums
Dancing Lessons	Retin-A*
Diaper Service	Rogaine*
Discounted Fees/Write-offs	Special Foods* (cost difference of common product)
Electrolysis	Student Health Fee
Exercise Equipment*	Swimming Lessons
Eyeglass Insurance	Tattoo Removal
Fitness Programs*	Teeth Whitening/Bleaching
Hair Loss Medication	Toiletries, Toothpaste, etc.
Hair Transplant	Varicose Vein Treatment*
Health Club Dues	Vision Discount Program
Treatment Program (at a Health Club)*	Premiums
Herbs & Herbal Medicines	Vitamins*
Homeopathic Drugs	Weight Loss Programs &/or Drugs*
Illegal Operation or Treatment	Prescription drugs purchased outside the United States
Insurance Premium Interest Charge	
Insurance Premiums	

**Eligible only with Doctor's certification identifying the medical condition and length of treatment program.*

***Eligible only with Doctor's certification identifying the physical nature of the medical condition and length of treatment program. Massage therapy for the sole purpose of tension/stress relief or depression (even with a Doctor's statement) does not qualify as an eligible expense.*

****Eligible expenses are limited to the mother's instruction related to birth.*

Please be aware that the Internal Revenue Service looks to the reasonableness of the cost of the treatment.

Over the Counter Drug Ruling Questions & Answers

Q. Can I be reimbursed for all over-the-counter (OTC) drugs?

A. No, only drugs for use by the participant, or the participant's spouse or dependents, to alleviate or treat personal injuries or sickness are eligible for reimbursement. Therefore, dietary supplements such as vitamins for general well-being are not eligible. Cosmetic purchases continue to be an ineligible expense.

Q. Why did the IRS make this change?

A. The IRS realizes that many drugs that were available only by prescription have become available over-the-counter, and that this is likely to continue. Over-the-counter drugs could actually cost the participant more than the copay for the prescription. Therefore, allowing these types of expenses to be reimbursed on a pre-tax basis should help people manage their health care costs.

Q. If I don't have a headache and I buy a bottle of aspirin to put in my medicine cabinet (to have some on hand for my next headache), is the cost of the aspirin a reimbursable expense? Or must the participant, spouse, or dependent have a headache at the time the aspirin is purchased?

A. Although the OTC Drug Ruling does not answer these questions, the Employee Benefits Institute of America states that the OTC Drug Ruling realizes that some sort of advance purchase of medicines and drugs for use in the near future is reasonable—that the advance purchase of medicines and drugs is permitted to treat a medical condition that has a strong likelihood of occurring.

Q. Can a reimbursement account reimburse a participant for the cost of 48 bottles of aspirin purchased at the end of the plan year?

A. Again, the OTC Drug Ruling does not answer this question. However, IRS officials have informally indicated that participants may be reimbursed for a reasonable quantity of OTC drugs to have on hand for use during the plan year, if the OTC drugs qualify as an eligible medical expense. In fact, even year-end purchases should be permissible in small quantities.

Q. What are the substantiation requirements for eligible OTC drugs?

A. It is permissible to reimburse with an adequate receipt and a participant's statement. The receipt must state the name of the medicine or drug, the date and the amount paid. The patient's name is not required on the receipt. But the participant statement needs to include the name of the employee, spouse or dependent.

Q. Is there a list of eligible and ineligible over-the-counter drugs that I can refer to?

A. The IRS has not developed such a list. However, the list on the following pages should serve as a guide to the type of expenses that are ineligible, eligible, and those that may be eligible with a doctor's letter of medical necessity.

The IRS has recently ruled that certain over-the-counter drugs can now be reimbursed through your Medical Spending Account. Following is a list of eligible and ineligible expenses:

Over-the-Counter Drugs Eligible Expenses

Eligible over-the-counter drugs include, but are not limited to the following:

- Allergy medicines
- Antacids
- Anti-diarrhea medicines
- Bactine
- BenGay, Tiger Balm and similar products for muscle or joint pain
- Bug bite medications
- Calamine lotion
- Cold medicines
- Cough drops, throat lozenges
- First aid creams
- Laxatives
- Menstrual cycle products for pain and cramp relief
- Motion sickness pills
- Nasal sinus sprays
- Nicotine gum or patches for stop-smoking purposes
- Pain relievers
- Pedialyte for ill child's dehydration
- Sinus medications
- Special diaper rash ointments
- Special ointments or creams for sunburn (not just regular skin moisturizers)
- Suppositories and creams for hemorrhoids
- Visine and other such eye products
- Wart remover treatments

Over-the-Counter Drugs - Dual Purpose Expenses Requiring a Letter of Medical Necessity

Dual purpose over-the-counter drugs include, but are not limited to the following:

- Acne treatments
- Dietary supplements or herbal medicines to treat a specific medical condition
- Fiber supplements to treat a specific medical condition for a limited time
- Glucosamine/Chondroitin for arthritis or other medical condition
- Lactose intolerance pills
- Menopause treatments for hot flashes, night sweats
- Nasal sprays for snoring
- OTC hormone therapy
- Prenatal vitamins
- Sleeping aids
- Sunscreens
- St. John's Wort for depression
- Weight-loss drugs to treat obesity

Over-the-Counter Drugs Ineligible Expenses

Ineligible over-the-counter expenses include, but are not limited to the following:

- Chapstick
- Deodorants
- Eye and facial makeup preparations
- Face creams
- Feminine hygiene products
- Fingernail polishes
- Hair colors
- Hand lotions
- Lipsticks
- Medicated shampoos
- Medicated soaps
- Perfumes
- Permanent waves
- Shaving creams
- Shaving lotions
- Skin moisturizers
- Suntan lotions
- Toothpaste
- Vitamins

MEDICAL SPENDING ACCOUNT MOST QUESTIONED EXPENSES

IRS regulations periodically change, affecting the eligibility of certain expenses in Flexible Spending Account Plans. The following will assist you in making your elections for the plan year based on the **most current rulings** regarding some of the **most questioned expenses**. As a third party administrator, Tucker Administrators follows Internal Revenue Service Guidelines as provided in IRS Publication 502 Medical and Dental Expenses. There are two exceptions: 1) Insurance premiums are not reimbursable under a Medical Spending Account; and 2) The tax credit as outlined in IRS Publication 502 allows the tax credit in the year the expense is paid; **the reimbursement under a Medical Spending Account is based only upon when the expense was incurred; i.e., date of service, not the date paid.**

Canceled Appointments	Fees for missed appointments are not eligible .
Cosmetic Treatments	Only qualify if they are medically necessary. Electrolysis is not an eligible expense. Cosmetic surgery simply to enhance bodily features is not eligible . Cosmetic surgery which is necessary due to an accident, disease, illness or congenital abnormality is eligible .
Custom Fitovers (Clip-Ons)	Are not eligible as they do not correct vision.
Counseling	Family counseling is only eligible for the family member who is the patient with a specific medical condition. Marriage counseling is not eligible .
Dentistry	Monthly orthodontic expenses are eligible, but only for those months within the plan year. Only expenses for orthodontic services incurred in the plan year are eligible; the months before or after the plan year are not eligible. Reimbursement is available by providing a treatment plan. Teeth Bleaching/Whitening is not eligible .
Diabetic Supplies	Insulin, syringes, test tapes, and needle boxes are eligible .
Dietary Needs/Special Foods	Special foods are eligible if prescribed to treat a specific illness to the extent the cost exceeds cost of commonly available versions of the same product. Special foods to promote general health are not eligible .
Discount Fees/Write Offs	Are not eligible .
Drugs	Over-the-counter drugs such as aspirin, antacids, allergy medicines, pain relievers or cold medicines are eligible, if allowed by your plan . Dietary supplements without a medical condition are not eligible . Non-prescription drugs for general well being like vitamins, herbal supplements or cosmetic purchases are not eligible . Date ordered is the date of service . Drugs that are legal at state or local level, but illegal at federal level are not medical expenses and are not eligible .
Health Club Membership Dues	Are not eligible , even when prescribed by a physician. Treatment programs at a health club, exercise equipment, and exercise programs are only eligible if the doctor prescribes them to treat a disease or illness.

Insurance Estimates	Services must be incurred before reimbursement through the spending account. Pre-certification and estimates are not eligible for reimbursement under the HCRA.
Insurance Premiums	Your portion of a company sponsored and/or individual insurance premium is not eligible for reimbursement under a health care spending account. Your portion of premiums for employer sponsored insurance is pre-taxed through the Premium Expense Account, not the HCRA. Student health fees are similar to insurance premiums and are not eligible for reimbursement under the HCRA.
Interest Charges	Are not eligible .
Lamaze Classes	Only expenses for instruction related to the birth are eligible. Child rearing instruction is not eligible . The fee will have to be apportioned to exclude instruction in topics such as newborn care. Also, amounts for the coach or significant other are not eligible .
Maternity Fees—Prepaid	In line with insurance companies, the date of child's birth is considered date of service.
Massage Therapy	Is eligible with a doctor's statement of medical necessity. It is not eligible if therapy is solely for the purpose of tension/stress.
Mileage	Mileage is eligible for the miles driven to and from the doctor's office. The amount that can be reimbursed is twelve (12) cents per mile.
Rogaine	Is not eligible , unless accompanied by a letter of medical necessity.
Vision	Contact lens solution and sales tax are eligible expenses. Contact lens insurance is not eligible . The date the glasses or contacts are ordered, not picked up , is considered the date of service. Radial Keratotomy, LASIK and other laser eye surgeries are eligible. Vision Discount Program Fees are not eligible .
Vitamins	Dietary supplements (for example, vitamins) to maintain general health are not eligible . Dietary supplements or herbal medicines to treat a specific medical condition are eligible with a doctor's letter stating medical necessity .
Weight Loss	Physician prescribed weight loss programs necessary to treat physician diagnosed obesity is an eligible expense. Health clubs and spas are not viable treatment options. Weight loss programs attended to improve general health or appearance are not eligible . Special diet food that is a substitute for the food normally consumed is not eligible . If the same results can be obtained from a program that costs less, such as walking, the IRS may look to the reasonable cost of the prescribed exercise program.

MID-YEAR ELECTION CHANGES MEDICAL SPENDING ACCOUNT

You are allowed to change your annual election for a Medical Spending Account ONLY if you have a qualifying status change such as the following:

- Change in employee's legal marital status
 - Marriage
 - Divorce
 - Death of a Spouse
 - Legal Separation or Annulment of Marriage
- Change in number of dependents (Note: gaining or losing an individual who is not a tax dependent does not allow an election change; this is in line with the tax definition of dependent under Section 152.)
- Change in employment status
 - Termination or Commencement of Employment by the Employee, Spouse or Dependent
 - Change in Work Schedule (reduction or increase in hours by employee, spouse or dependent, including a change between part-time and full-time, a strike or lockout, or commencement or return from unpaid Leave of absence)
- Dependent satisfies (or ceases to satisfy) dependent eligibility requirements
 - Attainment of limiting age, change in student status, or marriage
- Commencement or termination of adoption proceedings
- FMLA leave for you or your spouse
- Judgment, Decree or Order resulting from a divorce, legal separation, annulment or change in legal custody {includes a Qualified Medical Child Support Order (QMCSO)}
- Entitlement of Medicare or Medicaid

PLEASE NOTE THAT SIGNIFICANT COST OR COVERAGE CHANGES DO NOT APPLY TO HEALTH FSAs!!

The following are **NOT** qualifying events that trigger a mid-year change to a health FSA election:

- Over or under-estimated expenses for the year
- Services planned for the year are no longer needed
- A significant change in your insurance coverage
- Financial hardship

Two important facts must be considered when allowing a status change mid-year:

1. Participants may make changes to their elections “on account of, and corresponding with, a change in status that affects eligibility for coverage.” In other words, a change in status must have occurred.
2. The change in election must be “consistent with the reason that such change was permitted.” Example, increasing coverage due to a marriage, or decreasing coverage due to a death.

ORTHODONTIA GUIDELINES - FLEXIBLE SPENDING ACCOUNT

Please read this notice before making your annual election

Orthodontia expenses are reimbursed over the period of time the appliances are worn. The treatment plan and/or contract from the Orthodontist will state the length of time the appliances/braces will be worn by the patient. The IRS recognizes that orthodontia services are continuous from the installation to the removal of the appliances, therefore you may have services spanning 1-3 plan years. In line with those guidelines, your orthodontic reimbursements need to be in accordance with the length of time you will have services. The total fee owed to the Orthodontist will be pro-rated by the number of months the appliances will be worn. If you make a lump sum payment to receive a discount, the above still applies; therefore, you will not be reimbursed a lump sum payment. **You can be reimbursed monthly based on the expected length of treatment.**

Example 1: Plan year begins January, 2009. Orthodontia begins in January with treatment lasting 36 months. Total fee is \$4600.00. Down payment of \$1000.00 is due in January. \$3600.00 will be divided by 36 months. First payment is due February, 2009. The amount that can be reimbursed in the 2009 plan year is the \$1000.00 down payment plus eleven (11) monthly reimbursements of \$100.00 totaling \$1100.00.

Example 2: Orthodontist offers a 10% discount if you pay in one lump sum payment. Total fee is \$4140.00. There is no down payment. \$4140.00 will be divided by 36 months. The amount that can be reimbursed in the 2009 plan year is twelve (12) monthly reimbursements of \$115.00 totaling \$1380.00.

****Note** Above example uses appliances placed in January. Appliances placed in a different month would need to be pro-rated using remaining months in the plan year. Example: For appliances placed in September, the amount that can be requested is the down payment and three months of Orthodontia payments. Reimbursements cannot be paid out prior to the services rendered, even if you paid up front.**

VISION EXPENSE GUIDELINES - FLEXIBLE SPENDING ACCOUNT

Please read this notice before making your annual election

Vision bills/expenses must include the name of the patient and provider, the type of service, the date the service was incurred/provided, and your out-of-pocket expense. **Balance due statements, charge card receipts, and canceled checks are not acceptable documentation for reimbursement.** The date the glasses or contacts are ordered is considered the date of service, **not the pick up date.**

Tucker Administrators *Dependent Care Account*

Plan Year: January 1, 2009 - December 31, 2009
Dependent Care Reimbursement Plan Maximum: \$5,000.00

Extend your income by using the Dependent Care Account to pay for work-related dependent care expenses with income tax-free dollars. You may save a significant amount of money by participating in this account.

If you are paying for day care expenses now, you are paying in taxable dollars and probably taking the Federal Tax Credit at the end of the year. If you use the Dependent Care Reimbursement Account, you will pay these expenses in pre-tax dollars throughout the year, eliminating the need to use the tax credit at the end of the year.

WHO SHOULD ENROLL?

The Dependent Care Reimbursement Account is generally beneficial to any eligible employee who has a qualified dependent and eligible day care expenses.

WHO IS A QUALIFIED DEPENDENT?

Dependents are defined as children under 13 years of age, or children 13 or over who are physically or mentally unable to care for themselves. A spouse or an elderly parent residing in your home, who is physically, or mentally unable to care for himself or herself, also qualifies.

WHAT EXPENSES ARE ELIGIBLE?

Expenses incurred which allow you (and your spouse, if married) to work, look for work or attend school as a full-time student are eligible. Below are expenses which qualify.

- Day care facility fees (excluding transportation, lunches, educational services)
- Before-school and after-school care
- Local day camp
- In-home babysitting fees (income must be claimed by your care provider)
- Nursery school and preschool (preschool expenses are eligible if the amount you pay for schooling cannot be separated from the cost of care)

WHO IS AN ELIGIBLE PROVIDER?

You may use any care provider you choose, except a dependent child who is claimed as a dependent and is under the age of 19. The care provider must meet the requirements of your state. The services may be as informal as care provided by your neighbor, as long as the provider claims the money received for services as income when determining their taxes at the end of the year. **You will need to obtain the provider's federal identification/social security number for inclusion on your tax filing.**

HOW DOES IT WORK?

The program is simple. Decide how much money you want to place in your account based on your estimate of work-related dependent care expenses for the coming plan year. Keep in mind the time in which your dependent is not receiving care, such as vacation or sick time. The amount to be deducted from your pay cannot be greater than your income or that of your spouse, whichever is lower. The maximum contribution allowed by the IRS is \$5,000 (\$2,500 each for married individuals filing separate returns). **You will need to plan carefully as the IRS requires that any unused money left in your account at the end of the plan year will be forfeited.** Identify an annual election that you are comfortable with. This amount will be deducted on a pre-tax basis each pay period and contributed to your Dependent Care Reimbursement Account.

When you have expenses to be reimbursed, simply complete a claim form indicating that the expense has been **incurred during the plan year**, along with a bill or **itemized** receipt from the provider. Copies of the bill or an itemized receipt are good examples of proof of your dependent care expenses. If none of these are available, you may have the care provider acknowledge receipt by signing directly on the claim form. That's it! Mail or fax your claim and your claim will be processed on your next reimbursement date. Advance reimbursement of future or projected dependent care expenses is not permitted. **Accordingly, you will receive Dependent Care Reimbursement up to the amount that has been deducted from your payroll earnings and contributed to your Dependent Care Reimbursement Account.**

CAN I CHANGE MY ELECTION?

In line with Internal Revenue Service guidelines, you can change your election if you have a **qualifying change in status** during the plan year. This includes marriage, divorce, death, change in coverage, change in cost (except when the provider is a relative), dependent enrolled in school, birth/adoption or a change in employment. However, the adjustment in your election must be relevant to the change in status and the requested election change has to be in line and consistent with the event. All requests must be submitted to Johnson County Schools for approval.

WHAT ARE THE ADVANTAGES OF THE DEPENDENT CARE REIMBURSEMENT ACCOUNT?

Most important, your personal taxes will be reduced. The amount you contribute to your Dependent Care Account is not subject to Federal, State, or FICA taxes. Generally, this will mean a tax savings of 15% to 40% depending on your tax bracket. As a direct result of the personal tax savings, you can actually increase your spendable income by changing the payment of those expenses from an after-tax to a pre-tax basis.

Participation in Dependent Care Account will reduce or in some cases, may eliminate the ability to use the Federal Tax Credit for Dependent Care. However, as you can determine from the comparison worksheets shown later in this booklet, for most taxpayers the Dependent Care Account results in a greater tax savings. **If you participate in a Dependent Care Reimbursement Account, IRS Form 2441 must be completed as part of your tax return.**

WHAT ARE THE DISADVANTAGES OF THE DEPENDENT CARE REIMBURSEMENT ACCOUNT?

By not paying FICA taxes, you will be reducing your Social Security contribution. Studies on this matter have determined that your tax savings generally outweigh your Social Security benefit reduction.

Any money in your Dependent Care Account that is not used by the end of the plan year will be **forfeited**. Therefore, it is in your best interest to be conservative when estimating your contribution.

Based on group participation, highly compensated and/or key employees' participation may be restricted. You will be notified if this applies to you.

DEPENDENT CARE WORKSHEETS

ESTIMATE YOUR SAVINGS

The following worksheets allow you the opportunity to compare the potential tax savings available through the Dependent Care Account vs. Federal Income Tax Credit. The general rule of thumb is that if your adjusted gross family income exceeds approximately \$39,000 to \$41,000, you will receive a greater tax savings through the Dependent Care Account. The tax credit applies to federal taxes while the Dependent Care Account saves you federal income taxes, state and local income taxes, and Social Security (FICA) taxes. You are encouraged to discuss the Dependent Care Account with a tax expert to determine the method which best serves your needs. The better "value" must also consider number of dependents, amount of dependent care expenses, your Adjusted Gross Income, and the effect of state and local tax laws.

Federal Income Tax Credit Worksheet			
1. The amount of expenses for work related dependent care (cannot exceed your income or that of your spouse, whichever is less)		\$ _____	
2. Maximum expenses eligible for tax credit (\$3,000 for one dependent; \$6,000 for more than one dependent)		\$ _____	
3. Estimated Adjusted Gross Income for you (and spouse if applicable)		\$ _____	
4. Percentage from table below based on Adjusted Gross Income		_____ %	
5. Estimated tax credit (multiply line 4 by the smaller of line 1 or line 2)		\$ _____	
Adjusted Gross Income	Percentage	Adjusted Gross Income	Percentage
Up to \$15,000	35%	\$29,001 - \$31,000	27%
\$15,001 - \$17,000	34%	\$31,001 - \$33,000	26%
\$17,001 - \$19,000	33%	\$33,001 - \$35,000	25%
\$19,001 - \$21,000	32%	\$35,001 - \$37,000	24%
\$21,001 - \$23,000	31%	\$37,001 - \$39,000	23%
\$23,001 - \$25,000	30%	\$39,001 - \$41,000	22%
\$25,001 - \$27,000	29%	\$41,001 - \$43,000	21%
\$27,001 - \$29,000	28%	\$43,001 and Over	20%

This is for illustration purposes only.

Dependent Care Reimbursement Worksheet

1. The amount of deposit to your Dependent Care Reimbursement Account (must not exceed your income, your spouse's income, or \$5,000 or \$2,500, if married and filing a separate return) \$ _____

2. Your Federal Tax Rate from the table below (using combined income for you and your spouse) _____%

3. Social Security tax rate:
 - Enter 7.65% for earnings up to \$84,900* (2002 limit) _____%
 - Enter 1.45% for earnings over \$84,900* (2002 limit) _____%

4. State and City tax rate** _____%

5. Total tax rate savings (line 2 + line 3 + line 4) _____%

6. Estimated tax savings (multiply line 5 by line 1) \$ _____

The table amounts are based on Adjusted Gross Income (after exemptions and deductions). Do not confuse Adjusted Gross Income with gross income. NOTE – Based on 2002 Federal Income Tax Rates

Federal Tax Rate	Single	Married Filing Jointly
15%	Up to \$27,950	Up to \$46,700
27%	\$27,951 - \$67,700	\$46,701 - \$112,850
30%	\$67,701 - \$141,250	\$112,851 - \$171,950

**This amount is adjusted annually by the Federal Government.*

***Deposits to your Dependent Care Reimbursement Account are generally exempt from state and city taxes. This exemption is dependent, however, on the state and city in which you reside.*

If line 6 on the Dependent Care Reimbursement Account Worksheet is larger than line 5 on the Federal Income Tax Credit Worksheet, then the Dependent Care Reimbursement Account can be expected to provide you a greater tax savings than the tax credit.

If your contributions to your Dependent Care Reimbursement Account are less than the amount of your actual dependent care expenses, you may, based on income, be able to use the Federal Income Tax Credit for the balance, however, the total amount of your expenses reimbursed under the plan and those claimed on the Tax Credit cannot exceed the limits set forth in the Tax Credit (\$3,000/\$6,000). Consult your tax adviser for further clarification.

You Have a Choice to Make!

DEPENDENT CARE REIMBURSEMENT ACCOUNT OR DEPENDENT CARE TAX CREDIT

The increased dependent care tax credit, as provided under the Economic Growth and Tax Relief Reconciliation Act (EGTRRA), became effective January 1, 2003.

What are the changes to the dependent care tax credit?

The maximum amount of dependent care expenses eligible for credit increased from \$2,400 to \$3,000 for one dependent and \$4,800 to \$6,000 for two or more dependents.

How do I take advantage of this tax credit?

The dependent care tax credit applies ONLY to federal taxes, so you calculate the tax credit with your income tax filings after year end.

Good News! You may still choose the Dependent Care Account to provide a way to pay for work-related dependent care expenses with income tax-free dollars. The maximum annual benefit remains at \$5,000 for one or more dependents.

How do I take advantage of the DCRA benefit?

Decide how much money you would like placed in your dependent care account based upon your estimated work-related dependent care expenses for the coming year. Simply make this election on your enrollment form, and it will be deducted on a pre-tax basis for each pay period and contributed to your dependent care account.

Like the tax credit, will the Dependent Care Account save me from federal taxes?

Yes, and it will do more than that! The Dependent Care Account may save you federal, state and local income taxes, and Social Security (FICA) taxes. In addition, you receive the pre-tax advantage immediately, lowering taxable income and providing timely reimbursements.

How do I decide which benefit is right for me?

The general rule is that if your adjusted gross income exceeds approximately \$39,000 you will receive a greater tax savings through the Dependent Care Account. However, since many other factors should also be considered, you are encouraged to seek the advice of a tax expert to determine which method is best for you.

MOST QUESTIONED EXPENSES DEPENDENT CARE ACCOUNT

Dependent Care expenses are not considered incurred until the child care is actually provided. Reimbursement may not exceed year-to-date deductions. Divorced parents should be aware that the Dependent Care Reimbursement Account is only **available to the custodial parent**, as it can only be used to allow the parent to be gainfully employed.

Fees for the following are **not eligible**:

- Diaper Changing Fees
- Discounts
- Entertainment
- Expenses paid to child of participant – ineligible unless child is age 19 or older and cannot be claimed as a dependent of the participant or participant's spouse
- Fees for Lessons (i.e., dance, piano or swim, etc.)
- Field Trips
- Household Services (housekeeper, maid, cook) – generally ineligible, except where incidental to child care
- Kindergarten (IRS views Kindergarten as educational)
- Late Fees
- Lunches/Food
- Maternity Leave – If you, or your spouse, are on maternity leave and you place your other children in day care, those day care expenses are not eligible. Only day care expenses incurred while at work/school are eligible.
- Overnight Camp Expenses – The cost of sending your child to an overnight camp is not eligible. This is not considered a work-related expense.
- Transportation for day care

MID-YEAR ELECTION CHANGES DEPENDENT CARE ACCOUNT

You are allowed to change your annual election for a Dependent Care Reimbursement Account **ONLY** if you have a qualifying status change such as the following:

Change in Status – changes generally restricted to events related to a gain or loss of coverage eligibility.

- Change in employee's legal marital status
- Change in number of dependents
- Change in employment status
- Dependent satisfies (or ceases to satisfy) dependent eligibility requirements
- Commencement or termination of adoption proceedings
- FMLA leave for you or your spouse

Cost or Coverage Changes – changes generally allowed whenever scope of care or care provider changes. Please Note: Rate changes due to changing providers are eligible.

- Significant change in cost, except when a relative provides the service
- Curtailment or improvement of coverage
- Open enrollment under other employer plan

Two important facts must be considered when allowing a status change mid-year.

1. Participants may make changes to their elections “on account of, and corresponding with, a change in status that affects eligibility for coverage.” In other words, a change in status must have occurred.

2. The change in election must be “consistent with the reason that such change was permitted.” Example, increasing coverage due to a marriage, or decreasing coverage due to a death.

Reminders: Canceled checks are not an acceptable receipt, as they do not satisfy the requirement that a statement be submitted from a third party provider.

Dependent care claims will not be processed based solely upon quarterly statements submitted by participants, unless documentation clearly indicates that the services have already been incurred. According to cafeteria plan regulations, an expense is “incurred” when the services have been performed, not when the bill or charge for such service is paid.

Tucker Administrators, Inc.
3800 Arco Corporate Dr., Suite 450
Charlotte, NC 28273
Telephone: (800) 347-1232
Fax: (704) 525-9534
www.tuckeradministrators.com



If you have any questions concerning your Plan, please feel free to contact Tucker Administrators at (800) 347-1232.

Ameritas Dental Plan

Effective Date: January 1, 2009

COMBINED CALENDAR YEAR DEDUCTIBLE

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

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

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

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

- Sealants (Under age 17)
- Limited Exams
- Fillings
- Oral Surgery - Simple Extractions
- Denture Repair

TYPE 3 - MAJOR PROCEDURES - Type 3 Benefits are payable at 50% U&C* \$50.00 deductible applies.

- Endodontics (Root Canal)
- Periodontics (Gum Disease)
- Crowns
- Prosthodontics-Removable (Dentures & Partial)
- Inlays and Onlays
- Bridges/Pontics
- Crown Repair

ORTHODONTIA (Adults & Children) - Paid at 50% U&C* with a \$1,000 lifetime maximum per person insured.

- No deductible applies.
- There is no waiting period for Orthodontics

ANNUAL MAXIMUM BENEFIT

- Type 1, Type 2, and Type 3 Procedures - \$1,000 per calendar year per person insured.

**U&C (Usual and Customary charge)*

ANNUAL MAXIMUM CARRYOVER

1. Visit a dentist between January 1 and December 31 of each year.
2. Submit a claim for a covered procedure prior to **March 1** of the following year.
3. Total dental benefits paid for the calendar year must be less than \$500.

If you meet all 3 requirements then you will be eligible for the Annual Maximum Carryover benefit. This benefit will provide you with an additional \$250 towards your annual dental maximum for the following year. In future years, if you continue to meet these requirements you will continue to see an increase in your annual maximum by \$250 until you have reached an annual maximum carryover limit of \$1000. This benefit allows you to accumulate up to a \$2,000 maximum annual benefit.

LATE ENTRANT CLAUSE

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

DENTAL EXCLUSIONS (DEFERMENT PERIOD)

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

ELIGIBLE EMPLOYEES

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

ELIGIBLE DEPENDENTS

Provides Coverage On:

- Your Spouse
- Children, up to age 24 regardless of student status.

PREDETERMINATION OF BENEFITS

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

COORDINATION OF BENEFITS

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

CERTIFICATE OF INSURANCE

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

SECTION 125

This policy is provided as part of the Policyholder's Section 125 Plan. Each member has the option under the Section 125 Plan of participating or not participating in this policy. A member may change their election only during an annual election period, except for a change in family status. Examples of such events would be marriage, divorce, birth of a child, death of a spouse or child or termination of employment. Please see your plan administrator for details.

ORTHODONTIA LIMITATIONS

(This is not a complete list)

No benefit is payable for expenses incurred:

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

LIMITATIONS/EXCLUSIONS

(This is not a complete List)

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

Rates (based on 10 pay periods)

Employee	\$35.01
Employee & One	\$66.29
Employee + Two or More	\$114.16

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

This insurance is underwritten by
Ameritas Life Insurance Corp.



Cancer Can Affect Anyone

Statistics Predict:

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

Are you prepared for the cost of cancer?

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

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

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

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

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

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

Plus, you get these unique features:

- Guaranteed renewable for life. You can't lose your coverage, as long as you continue to pay your premiums.
- Cash benefits paid to you regardless of any other medical insurance plan you may have.

Selected benefits paying cash to you:

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

**Cancer Facts & Figures, American Cancer Society*

***Report from the American Hospital Administration.*

Assurity Cancer Plan

Effective Date: January 1, 2009 pending underwriting approval

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 two 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 illness:

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 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

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 your employer's website at www.markiiibrokerage.com/johnsoncountyschoolstn . 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 to (888) 358-8808, ext. 23. The call in service requires all of the information on the wellness claim form. The wellness claim form must include the name and phone number of your physician. All claims are subject to verification.

Home Health Care Services – when services are provided by a 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.

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.

Intensive Care Rider - If purchased, provides a Daily Benefit of either \$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 - If purchased, pays your choice of either \$2,500 or \$5,000 the first time an insured is diagnosed as having internal cancer.

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

Pre-Existing Conditions

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

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 Benefits Department. Should you have any questions on how to file or submit a claim, please contact Assurity customer service at the number listed below.

For Claims or Customer Service relating to your Assurity Cancer Plan

Please call (866) 289-7337

For Wellness Claims by phone:

Please call (888) 358-8808, Ext. 23

Wellness Claims by facsimile at (800) 869-0368

Or Mail claims to:

PO Box 82533

Lincoln, NE 68501



Rates (based on 10 pay periods)

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)

Superior Vision Plan

Effective Date: January 1, 2009

Outline of Benefits - Gold Preferred Plan With Materials Discount

Vision Plan - Preferred Provider (PPO / Indemnity)

Exam Copayment Amount - \$15.00

Materials Copayment - None

Contact Lens Fitting Copay - \$35.00

BENEFITS	FREQUENCY	IN-NETWORK	NON-NETWORK
Comprehensive Exam <i>(by an Ophthalmologist)</i>	12 Months	Covered in Full	Up to \$34.00
Comprehensive Exam <i>(by an Optometrist)</i>	12 Months	Covered in Full	Up to \$26.00
Lenses (Standard) per Pair:			
Single Vision	12 Months	Covered in Full	Up to \$32.00
Bifocal	12 Months	Covered in Full	Up to \$46.00
Trifocal	12 Months	Covered in Full	Up to \$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
Standard Contact Lens Fitting Fee***	12 Months	Covered in Full	Not Covered
Specialty Contact Lens Fitting Fee***	12 Months	Up to \$50.00	Not Covered
Frames (Standard)**	24 Months	Up to \$100.00	Up to \$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 following reason or reasons. 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 eye frame 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 (products & services not covered):

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

- Professional Services and/or Materials in conjunction with:
 - blended bifocals, no line, or progressive lenses
 - compensated or special multi-focal lenses
 - plain (non-prescription) lenses
 - anti-reflective, scratch, UV400, or any coating or laminate applied to lenses
 - subnormal vision aids
 - tints, other than solid
 - orthoptics, vision training and developmental vision procedures
 - polycarbonate lenses
 - Medical or surgical treatment of the eyes
- Any eye examination or any corrective eye wear required by an Employer as a condition of employment
- Any injury or illness when covered under Workers Compensation or similar law
- Plain or prescription sunglasses, no-line bifocals, blended lenses are not covered; an Insured may elect to apply the maximum allowance for standard lenses toward his, or her cost of progressive lenses
- Subnormal vision aids
- Services rendered or Materials purchased outside the U.S. or Canada unless the member resides in the U.S. or Canada; and the charges are incurred while on a business or pleasure trip
- Charges in excess of the Usual, Customary and Reasonable charges for the Professional Service or Materials
- Experimental or non-conventional treatment or device
- Safety eye wear
- Spectacle lens styles, materials, treatments, or "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 delivered, and the services rendered to the Insured within 31 days from the than that which is specified in the Benefits Summary

HOW TO USE YOUR BENEFIT

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

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

- To receive services from a non-network provider, it is important that you first call Superior Vision Services Member Service Department at 800-507-3800 to receive your own authorization number. By doing so, you can be assured of your eligibility and reimbursement for money spent.
- After receiving services and paying in-full for the examination and/or materials (you do not pay a 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 page 38.
- You will be reimbursed according to the schedule of allowances for non-network providers, less any required copayments.

DISCOUNTS ON ADDITIONAL PURCHASES

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

DISCOUNT SVP8-20

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

Add-on charges to the covered pair of lenses

Member pays 20% off retail up to:

- Factory Scratch Coat \$13 (Single Vision & Standard Multifocal lenses)
- Ultraviolet Coat \$15 (Single Vision & Standard Multifocal lenses)
- Standard Anti-Reflective coat* \$50 (Single Vision & Standard Multifocal lenses)
- High Index 1.6* \$55 (Single Vision lenses only)
- Polycarbonate \$40 (Single Vision lenses only)
- Standard Photochromic \$80 (Single Vision lenses only)
- Glass coloring \$35 (Any Type lenses)
- Plastic Tints solid or gradient \$25 (Any Type lenses)

Member pays:

- Power over 4.00 Sphere, 2.00D Cylinder & 5.00 Prism 20% off retail prices (any type lenses)
- Cosmetic finishing, Beveling, Edging, and Mounting 20% off retail prices (any type lenses)
- Miscellaneous Options 20% off retail prices (any type lenses)

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

REFRACTIVE SURGERY DISCOUNTS

Superior Vision Services has contracted a network of over 500 refractive surgeons nationwide 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 blepharoplasty (cosmetic eyelid surgery) to Superior Vision Plan members on the same discount basis.

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.

RATES (BASED ON 10 PAY PERIODS)

Employee Only	\$12.34
Employee + 1	\$23.90
Employee + 2 or more	\$35.11

Member Services, Provider Listings and Claims Services:

(800) 507-3800

Member Services Fax:

(916) 852-2277

Provider Nominations:

(800) 923-6766

Web Site:

www.superiorvision.com

Address:

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

Non-network Claims Submission:

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

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



BlueCross BlueShield of TN - PPO Plan

Benefit Features	Network Provider	Out-of-Network Providers
Annual Deductible		
Individual	\$750	\$1,500
Family	\$1,500	\$3,000
Annual Out-of-Pocket Max		
Individual	\$2,000	\$6,000
Family	\$4,000	\$12,000
Dependent Age Limit		To age 24
Lifetime Maximum Benefit		\$5,000,000
Pre-Existing Conditions	12 Month Waiting Period	
Benefit for Covered Services	Network Benefits	Out-of-Network Benefits
Practitioner Office Services		
Office Visits	\$20 Copay	60% after Deductible
Routine Diagnostic Lab, X-ray, & Injections	No Additional Copay	60% after Deductible
Non-Routine Diagnostic Services	80% after Deductible	60% after Deductible
Provider-Administered Specialty Pharmacy Products	\$50 Copay	60% after Deductible
Preventive Health Care		
Well Child Care (to age 6)	\$20 Copay	60% after Deductible
Annual Well Women Exam	\$20 Copay	60% after Deductible
Annual Mammography Exam	No Additional Copay	60% after Deductible
Annual Cervical Cancer Screening	No Additional Copay	60% after Deductible
Prostate Cancer Screening	No Additional Copay	60% after Deductible
Immunizations (to age 6)	No Additional Copay	60% after Deductible
Services Received at a Facility (includes professional and facility charges)		
Inpatient Services	80% after Deductible	60% after Deductible
Outpatient Services	80% after Deductible	60% after Deductible
Routine Diagnostic Services Outpatient	100% (no deductible)	60% after Deductible
Non-routine Diagnostic Services Outpatient	80% after Deductible	60% after Deductible

Provider-Administered Specialty Pharmacy Products	80% after Deductible	60% after Deductible
Other Outpatient Services	80% after Deductible	60% after Deductible
Emergency Care Services	80% after Deductible	80% after Deductible
Emergency Care Non-Routine Diagnostics	80% after Deductible	80% after Deductible
<hr/>		
Medical Equipment		
Durable Medical Equipment, Prosthetic, & Orthotic Appliances	80% after Deductible	60% after Deductible
<hr/>		
Therapeutic Services		
Therapy	80% after Deductible	60% after Deductible
<hr/>		
Skilled Nursing Facility & Rehabilitation Facility Services		
Limited to 60 days combined	80% after deductible	60% after Deductible
<hr/>		
Home Health Services		
Limited to 60 visits per year	80% after Deductible	60% after Deductible
<hr/>		
Hospice Service	100%	60% after Deductible
<hr/>		
Ambulance Services	80% after Deductible	60% after Deductible

Notes (see benefit summary on prior page):

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

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

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

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

Call Customer Service to determine which procedures require prior approval.

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

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

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

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

9. Requires prior approval.

10. Well Care Rider services are limited to \$300 per year.

BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association

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PPO Benefit Exclusions:

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

- modalities that do not require the attendance or supervision of a licensed therapist, including activities which are primarily social or recreational in nature, simple exercise programs, hot and cold packs applied in the absence of associated therapy modalities, repetitive exercises or tasks which can be performed by the member without a therapist, in a home setting, routine dressing changes.
- behavioral therapy, play therapy, communication therapy and therapy for self-correcting language dysfunctions
- complementary and alternative therapeutic services whose value has not yet been determined to be medically necessary, including massage therapy, acupuncture, aquatic therapy, craniosacral therapy, neuromuscular reeducation, vision exercise therapy, and cognitive therapy
- charges exceeding the maximum allowable charge for the total cost of purchase of durable medical equipment
- unnecessary repair, adjustment or replacement or duplicates of any durable medical equipment
- supplies and accessories that are not necessary for the effective functioning of the covered medical equipment
- items to replace those which were lost, damaged, stolen or prescribed as a result of new technology
- motorized scooters, "deluxe" or "enhanced" equipment
- contacts after the initial pair following cataract surgery
- hearing aids
- surgery or services as a result of an injury to the jaw, natural teeth, mouth, or face not completed within 12 months of the date of the accident
- treatment for routine dental care and related services including but not limited to replacement of teeth, bone grafts, treatment of teeth roots, treatment of injuries due to biting and chewing, crowns, plates, x-rays, fillings, removal of non-impacted teeth
- treatment for correction of underbite, overbite, and misalignment of the teeth, including orthognathic surgery and braces for dental indications
- behavioral health services except as listed in a separate rider
- services and supplies to detect or correct refractive errors of the eyes, except as listed in a separate rider
- eyeglasses, contact lenses and examinations for the fitting of eyeglasses and contact lenses, except as listed in a separate rider
- eye exercises and/or therapy
- visual training
- pharmaceuticals which may be purchased without a prescription
- pharmaceuticals purchased with a prescription except those dispensed at a participating facility, unless listed in a separate rider
- services or supplies not listed as a covered service in the Evidence of Coverage
- services or supplies that are determined to be not medically necessary or determined to be experimental or investigational in nature
- illness or injury resulting from war and covered by veteran's benefit or other coverage for which the member is legally entitled and which occurred before the member's coverage began under this contract.

- self treatment or training
- staff consultations required by hospital or other facility rules
- services which are free
- services or supplies related to any treatment or services resulting from the member's participation in a felony, riot, or insurrection
- treatment of work related illness or injury, regardless of the presence or absence of worker's compensation coverage, unless resulting from self-employment by a sole proprietor or partner of the insured group who had elected not be covered by the worker's compensation law
- personal and convenience items and services such as barber and beauty services, television, air conditioners, humidifiers, air filters, heaters, physical fitness equipment, saunas, whirlpools, water purifiers, swimming pools, tanning beds and other recreational equipment, weight loss programs, physical fitness programs or self-help devices which are not primarily medical in nature, even if ordered by a practitioner
- wellcare or other preventive services at age 6 or over, unless as listed in a wellcare rider, including but not limited to well-child care, periodic health assessments, immunizations, eye and ear examinations to determine the need for vision and hearing correction
- telephone or e-mail consultations, or charges for failure to keep a scheduled appointment, or handling fees
- services for providing requested medical information or completing forms
- court-ordered examinations and treatment
- room, board and general nursing care rendered on the date of discharge, unless admission and discharge occur on the same day
- any service stated in the Evidence of Coverage as a Non-Covered Service or Limitation
- charges in excess of the Maximum Allowable Charge for Covered Services or any charges which exceed the Lifetime Maximum or any other limitations listed under the Evidence of Coverage or its attachments
- services or supplies received in a dental or medical department maintained by or on behalf of the employer, mutual benefit association, labor union or similar group
- benefits for Pre-existing Conditions (until any pre-existing waiting periods have been met)
- organ transplants when prior approval through transplant case management is not obtained
- transplant related charges above the Transplant Maximum Allowable Charge removal of an organ from a member for purposes of transplantation into another person, except as covered by the donor organ procurement provision
- services performed by a family member
- nicotine replacement therapy and aids to smoking cessation including patches
- human growth hormones except for specific conditions shown in Evidence of Coverage
- safety items or items to affect performance primarily in sports related activities

- services and supplies related to obesity, including surgical or other treatment of morbid obesity
- cosmetic services including surgical or other services, drugs, or devices, including removal of tattoos, removal of moles, face-lifts, blepharoplasty, keloid removal, dermabrasion, chemical peels, rhinoplasty, breast augmentation and breast reduction
- services and charges related to the care of the biological mother of an adopted child, if the biological mother is not a member, surrogate parenting, sperm preservation
- treatment of sexual dysfunction, including erectile dysfunction (e.g. Viagra), delayed ejaculation, anorgasmia and decreased libido **\$10/\$30/\$45**

Prescription Drug Plan

Generic Drugs	\$10 Copay per prescription, up to 30 day supply
Preferred Brand Name Drugs	\$35 Copay per prescription, up to 30 day supply
Non-preferred Brand Name Drugs	\$50 Copay per prescription, up to 30 day supply

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

Generic Drugs- your copay is \$10

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

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

Preferred Brand Drugs- your copay is \$35

You'll always save money when using generics. In fact, all you pay is the generic copay. But if your doctor prescribes a Preferred Brand drug, your copay is \$35. You may purchase a Preferred Brand drug even when a generic equivalent is available. However, if a generic equivalent is available and your doctor allows for substitutions, you will pay the generic copay plus the cost difference between the brand and generic drug. If your doctor does not allow substitutions, then you will pay the \$35 copay.

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

When your doctor prescribes a brand drug that is not on the Preferred Drug list, you pay the highest copay of \$50. You may purchase a Non-Preferred Brand drug even when a generic equivalent is available. However, if a generic equivalent is available and your doctor allows for substitutions, you will pay the generic copay plus the cost difference between the brand and generic drug. If your doctor does not allow for substitutions, then you will pay the \$50 copay.

Pricing at Participating Pharmacies

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

Limitations

These limitations apply to each prescription order.

Benefits will be provided for

- up to a 30-calendar-day supply of prescription drugs (copay) and/or a 90-calendar-day supply of prescription drugs (2 times copay)
- up to a 90-calendar-day supply of maintenance prescription drugs listed on the BlueCross BlueShield of Tennessee maintenance drug list (2 times copay)
- up to a 90-calendar-day supply of prescription drugs obtained through home delivery (2 times copay)

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

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

Prescription Home Delivery

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

Specialty Pharmacy Program

Certain injectable medications for chronic illnesses can be ordered quickly and conveniently through the Specialty Pharmacy Program. Caremark Specialty Rx, CuraScript Pharmacy, and Priority Healthcare are experienced in managing high-cost drugs for conditions such as Hepatitis C, Multiple Sclerosis, Arthritis and Hemophilia.

Caremark Specialty

Pharmacy Services

1-866-295-2779 (phone)

1-866-295-2778 (fax)

CuraScript Pharmacy

1-888-773-7376 (phone)

1-888-773-7386 (fax)

Priority Healthcare

1-866-225-5670 (phone)

1-866-225-5671 (fax)

Out-of-Network Pharmacies

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

A Broad Network

BlueCross BlueShield of Tennessee members access the Caremark network for retail pharmacy benefits. This network provides tremendous accessibility with over 56,000 pharmacies nationally and over 1,800 in Tennessee, including every national chain and many independent pharmacies. A directory of participating pharmacies is available online at www.bcbstn.com.

BENEFITS WILL NOT BE PROVIDED FOR THE FOLLOWING:

- Drugs for the treatment of onychomycosis (e.g. nail fungus), except for: 1) diabetics or 2) immunocompromised patients
- Growth hormones, except for:
1) treatment of absolute growth hormone deficiency in children whose epiphyses have not closed; 2) patients with "Turner" syndrome; and 3) patients with Prader-Willi syndrome confirmed by appropriate genetic testing;
- Prescription and non-prescription medical supplies, devices and appliances, except for syringes used in conjunction with injectable medications or other supplies used in the treatment of diabetes and/or asthma;
- Immunizations or immunological agents, including but not limited to: 1) biological sera, 2) blood, 3) blood plasma; or 4) other blood products are not Covered, except for blood products required by hemophiliacs.
- Injectable drugs, unless: 1) intended for self-administration; or 2) defined by the Plan.
- Drugs which are prescribed, dispensed or intended for use while You are confined in a hospital, skilled nursing facility or similar facility, except as otherwise Covered in the EOC;
- Any drugs, medications, Prescription devices or vitamins, available over-the-counter that do not require a Prescription by Federal or State law; except as otherwise Covered in the EOC;
- Any quantity of Prescription Drugs which exceeds that specified by the Plan's P & T Committee;
- Any Prescription Drug purchased outside the United States, except those authorized by Us;
- Any Prescription dispensed by or through a non-retail internet Pharmacy;
- Contraceptives which require administration or insertion by a Provider (e.g., non-drug devices, implantable products such as Norplant, except injectables), except as otherwise Covered in the EOC;
- Medications intended to terminate a pregnancy (e.g., RU-486);
- Non-medical supplies or substances, including support garments, regardless of their intended use;
- Artificial appliances;
- Allergen extracts;
- Any drugs or medicines dispensed more than one year following the date of the Prescription;
- Prescription Drugs You are entitled to receive without charge in accordance with any worker's compensation laws or any municipal, state, or federal program;

BENEFITS WILL NOT BE PROVIDED FOR: (con't)

- Replacement Prescriptions resulting from lost, spilled, stolen, or misplaced medications (except as required by applicable law);
- Administration or injection of any drugs;
- Prescription Drugs used for the treatment of infertility;
- Prescription Drugs not on the Drug Formulary;
- Anorectics (any drug or medicine for the purpose of weight loss and appetite suppression);
- Nicotine replacement therapy and aids to smoking cessation including, but not limited to, patches;
- All newly FDA approved drugs prior to review by the Plan's P & T Committee;
- Any Prescription Drugs or medications used for the treatment of sexual dysfunction, including but not limited to erectile dysfunction (e.g. Viagra), delayed ejaculation, anorgasmia and decreased libido;
- Prescription Drugs used for cosmetic purposes including, but not limited to: 1) drugs used to reduce wrinkles (e.g. Renova); 2) drugs to promote hair-growth; 3) drugs used to control perspiration; 4) drugs to remove hair (e.g. Vaniqa); and 5) fade cream products;
- FDA approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia;
- Drugs dispensed by a Provider other than a Pharmacy;
- Compound drugs filled or refilled at an Out-of-Network Pharmacy;
- Drugs used to enhance athletic performance;
- Experimental and/or investigational Drugs; and
- Provider-administered Specialty Pharmacy Products, as indicated on Our Specialty Pharmacy Products list.
- Prescription Drugs or refills dispensed:
 1. in quantities in excess of amounts specified in the BENEFIT PAYMENT section;
 2. without Our Prior Authorization when required; or
 3. which exceed any applicable Annual Maximum Benefit, or any other maximum benefit amounts stated in this Rider or the EOC.

Extended Well Care

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

You and each eligible dependent over the age of 6 may receive preventative health services, not to exceed \$300 per calendar year.* All services must be medically necessary and appropriate and recommended by the U.S. Preventative Health Task Force, or in conjunction with the plan's preventative health care guidelines

All well care benefits listed are subject to the terms, conditions, limitations, and exclusions contained in the Group Master contract and the Evidence of Coverage.

All services covered by the Wellcare rider are subject to normal contract benefits, which are determined by type of service and place of service.*

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

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

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

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



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 diseases are up dramatically. Things that used 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

Standard Life Short Term Disability Plan

Effective Date: January 1, 2009 pending underwriting approval

- ◆ Payable in addition to sick leave
- ◆ Benefits payable regardless of other insurance
- ◆ Weekends and holidays are covered
- ◆ Benefits are paid directly to you
- ◆ Benefits are tax free
- ◆ Disability due to 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. Continued coverage is subject to income and occupational guidelines.

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. All applications 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 month beyond the effective date

Pregnancy: Benefits for disability related to pregnancy are covered provided conception occurs **after** the effective date of the policy, not the date the application was signed.

Portability: When an employee leaves the employment of Johnson County Schools, they may continue the short term disability coverage, subject to the renewability provision, as long as continuous employment is maintained. Your new occupation must be within the Company's underwriting guidelines.

This coverage expires on the policy anniversary date following your 65th birthday.

RATES BASED ON 10 PAY PERIODS

Benefit Duration: 90 Days		Benefit Duration: 180 Days		Benefit Duration: 365 Days	
Monthly Benefit	Tenthy Premium	Monthly Benefit	Tenthy Premium	Monthly Benefit	Tenthy 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

Limits and Exclusions:

Benefits will not be paid for any total disability which:

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

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

**For questions about your policy, call
Standard Life and Casualty
at (800) 327-0695
For Claims call (800) 227-0251**



MetLife Term Life Plan

- **Basic Employee Life & AD&D Insurance**
- **Optional Employee Life & AD&D Insurance**
- **Optional Dependent Life Insurance (Spouse Life & AD&D Insurance)**

BASIC EMPLOYEE LIFE & AD&D INSURANCE

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

ACCIDENTAL DEATH & DISMEMBERMENT

Benefits under this coverage are payable as described in your certificate.

OPTIONAL EMPLOYEE LIFE INSURANCE

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

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

OPTIONAL DEPENDENT LIFE INSURANCE

Provides coverage on:

- Your Spouse
- Child(ren) from **14 days of age to age 19** (to age 25 if wholly dependent upon you for maintenance and support and if enrolled as a full-time student in an accredited school or college). Handicapped children can be covered with no age limit, as long as the child is covered prior to age 19 or to age 25 if a full-time student.

FEATURES

The plan features easy eligibility and simple enrollment procedures. And as an employee there is no need for proof of medical insurability unless you take a coverage amount over \$50,000. Furthermore, automatic payroll deductions simplify paperwork. This means less bookkeeping for you and no worries about a lapse in coverage due to missed payments.

LOW COST

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

ELIGIBILITY

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

ENROLLMENT

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

BENEFICIARY

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

WHEN YOUR INSURANCE STARTS

Your Basic Employee Life Insurance becomes effective on the date of your eligibility if you are then actively at work; otherwise, on the day you return to active work.

If you have elected Optional Employee Life Insurance or Optional Dependent Life insurance you will be notified as to when that coverage begins. Anyone electing not to enroll when first eligible or within 30 days thereafter can enroll later only if evidence of insurability satisfactory to MetLife Insurance Company is provided.

STATEMENT OF HEALTH

Increases in coverage, a re-entry in the plan, amounts over the guaranteed issue limits, and participants who enroll 31 days beyond the eligibility period will be required to provide evidence of insurability satisfactory to MetLife.

REDUCTIONS AT AGE 70 & OVER

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

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

TERMINATION OF COVERAGE

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

DISABILITY

The waiver benefit applies to disabilities beginning before age 60. MetLife must be notified of the disability within 12 months of the date the insured's disability begins. After inception of disability, there is a 9 month waiting period before benefits begin. During the waiting period, normal monthly deductions are taken, which are not refundable. This means that employees who become disabled on or after the effective date of coverage and before age 60 and whose application for disability is approved has continuing coverage without premium payment until death, or recovery or age 65, whichever is earliest. If the employee remains on disability at age 65, the death benefit will reduce to zero.

ACCELERATED BENEFIT OPTION

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

CONVERSION

If your employment terminates while you are covered under the plan, you may purchase without medical evidence of insurability, any individual insurance, except a term policy, issued by Metropolitan Life. The amount of the individual contract may not be more than the amount of your life coverage in effect on your date of termination. You must apply for this policy within 31 days after the date your employment terminates. This privilege applies to Optional Employee Life Insurance and Dependent Life Insurance as well as the Basic Employee Life Insurance. This privilege is the employees responsibility. It is not automatic.

PORTABILITY

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

The minimum face amount which an employee may elect portability is **\$20,000**. When portable coverage ends, insured individuals have the right to convert to an individual policy.

Qualifying Events Include:

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

SUICIDE EXCLUSION

No Optional Employee Life Benefits are payable if you commit suicide within two years from the effective date of the coverage. This exclusion also applies to Optional Dependent Life Benefits.

CLAIMS PROCEDURE

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

BASIC EMPLOYEE LIFE & AD&D INSURANCE

All Eligible Employees (No cost to you) \$10,000*

OPTIONAL EMPLOYEE LIFE & AD&D INSURANCE

Your choice of the following amounts:*

Increments of \$10,000 to \$100,000

Increments of \$50,000 from \$100,000 to \$250,000

To be eligible for over \$50,000 of coverage you must furnish medical evidence of insurability satisfactory to Metropolitan Life.

OPTIONAL DEPENDENT LIFE INSURANCE

Spouse Life & AD&D Insurance:

Increments of \$10,000 to \$50,000*

To be eligible for \$20,000 coverage and above your spouse must furnish medical evidence of insurability and you must elect a minimum of \$20,000 and above of Employee Optional Life Insurance.

Child(ren):

Increments of \$5,000 to \$25,000

To be eligible for coverage above \$5,000 you must furnish medical evidence of insurability for your dependent children.

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

*See "Reductions at age 70 & Over

Rates (based on 10 pay periods)

Optional Employee Life & AD&D	Deduction	Optional Spouse Life & AD&D	Deduction	Optional Child Coverage	Deduction
\$10,000	\$2.52	\$10,000	\$7.08	\$5,000	\$1.20
\$20,000	\$5.04	\$20,000	\$14.16	\$10,000	\$2.40
\$30,000	\$7.56	\$30,000	\$21.24	\$15,000	\$3.60
\$40,000	\$10.08	\$40,000	\$28.32	\$20,000	\$4.80
\$50,000	\$12.60	\$50,000	\$35.40	\$25,000	\$6.00
\$60,000	\$15.12				
\$70,000	\$17.64				
\$80,000	\$20.16				
\$90,000	\$22.68				
\$100,000	\$25.20				
\$150,000	\$37.80				
\$200,000	\$50.40				
\$250,000	\$63.00				

GROUP POLICY AND CERTIFICATE

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

This information has been prepared to give you the highlights of coverage now being offered by your School Board to meet your insurance needs. For details please ask your Payroll Department below for assistance.

PLAN ADMINISTRATOR

Johnson County Schools
211 N. Church Street
Mountain City, TN 37683
423-727-2640

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

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

MetLife[®]

Boston Mutual Life Insurance Company *Employee Life Option (ELO) Life Plus*

Common Issue Date: February 1, 2009 (pending underwriting approval)

GUARANTEED BENEFITS, LEVEL PREMIUMS, AND GREATER POLICY VALUES

The Employee Life Option is more than just life insurance at an affordable price. It combines the guaranteed premiums, coverage and values that have always been so attractive in life insurance with the advantages of cash accumulation at current interest rates. This policy is an endowment at 95 with coverage to age 95.

BASIC PLAN

Traditional whole life insurance provides cash value accumulation based on a low fixed interest rate. The ELO Basic Plan provides current interest rates on your policy's value. This means that along with guaranteed premiums and guaranteed coverage, you may also benefit from competitive interest rates. ELO is affordable and is available through the convenience of payroll deduction. The Basic Plan is offered to eligible employees, their spouses, children and grandchildren.

PAYOR WAIVER OF PREMIUM

This benefit pays all the premiums on your policy, your spouse's or dependent's policy or policies in the event the payor (employee) becomes totally disabled before age 60. The disability must last at least six consecutive months and meet the definitions set forth in your policy.

This benefit is available for issue on policies owned by employees up to and including issue age 55 at a cost of 10% of the basic premium for each policy. This benefit terminates on the policy anniversary on or following the Payor's 60th birthday, as long as the Payor is not disabled at that time.

ACCIDENTAL DEATH BENEFIT (ADB)

This option could double or even triple your ELO death benefit. This benefit pays an additional amount equal to the basic coverage to the beneficiary if the insured is killed accidentally. If accidental death occurs while the insured is a passenger on a bus, plane, train or any other common carrier, this benefit pays the accidental death benefit as above but will also pay an additional benefit of the basic coverage (up to \$100,000). This extra protection is available at affordable rates. Any Basic Plan participant age 5 years through age 60 is eligible for this benefit.

CHILDREN'S TERM BENEFIT (CTB)

For pennies a week, you can provide level term coverage for all your unmarried, dependent children, age 15 days up to and including age 24. Future children will be automatically covered upon the attainment of 15 days with no increase in the premium. This benefit may be added to any policy issued to any employee or spouse age 18-55. Coverages range from \$1,000-\$10,000 in unit increments of \$1,000.

The weekly cost is 11¢ per unit. One premium covers all children. As many as 10 units of CTB are allowed regardless of the parents' ELO Basic Plan contribution. Any number of CTB units may be split between an Employee's and Spouse's policies, not to exceed the 10 units. If the insured parent dies, coverage on the children will continue without further premium payments until each insured child's 25th birthday.

Additionally, any insured child between the ages of 21-25 may purchase without evidence of insurability a permanent policy up to the lesser of 5 times the children's benefit or \$25,000.

AFFORDABLE, FLEXIBLE PROTECTION

You choose the amount of insurance or the amount of premium that best suits your needs and budget. All eligible employees and their spouses through age 70 may purchase coverage under the Basic Plan. Weekly deductions range from \$2.00-\$15.00 per week.

Insurance is also available for your spouse, unmarried dependent children and grandchildren, even if you choose not to buy coverage on yourself.

POLICY VALUES*

As long as premiums are paid, your ELO Basic Plan offers a guaranteed cash value that can grow over the years. The cash value can be used to supplement retirement income, for emergency cash, as an education fund or to provide a paid-up insurance benefit. While this value can never be less than the guaranteed amount, ELO gives you the advantage of potential cash values in excess of the guaranteed amount. The current interest rate in effect when your policy is issued is guaranteed for the first year. On each policy anniversary date, you will receive an annual statement outlining your policy's accumulated value and changes in the interest rate, if any.

*** The actual cash value may be decreased by loans or withdrawals.**

CONSTANT COVERAGE

ELO participants are protected worldwide, 24 hours a day. Your policy is owned by you and supplements any other insurance you may have.

BENEFITS YOU CAN KEEP

Once purchased, your ELO plan remains in force as long as premiums continue to be paid; and your premiums cannot be increased. If you change jobs or retire, as long as you continue to pay premiums, your insurance will remain in force without interruption. Boston Mutual will bill you at home and you may choose from several payment options — annual, semi-annual, quarterly, monthly coupon book or monthly automatic check plan.

ACCELERATED DEATH BENEFIT

This very important feature allows a portion of the policy's death benefit to be paid before the death of the insured. This benefit is a part of your life insurance policy and is made available at no extra cost. With certification from a licensed physician that the insured because of any illness has a life expectancy of no more than 12 months, the policyowner may request the early distribution of a portion of the policy's face amount.

Distribution of the requested face amount (minimum \$10,000, maximum \$50,000) will be paid in a lump sum or in six equal installments. The proceeds will be discounted at the current interest rate. Accelerated benefit payments may be taxable. Consult your tax advisor for specific advice.

QUESTIONS AND ANSWERS

CAN I BUY THIS PLAN ON MY OWN?

No! This plan is available only to employees of companies that provide the convenience of payroll deduction for the ELO plan. Because your employer has chosen to offer ELO, you receive the advantages of more liberal underwriting and the convenience of payroll deduction.

DOES THIS POLICY REPLACE MY PRESENT GROUP INSURANCE?

No! ELO coverage is independent of and supplements your present group insurance program.

IF I LEAVE MY EMPLOYER WHAT HAPPENS TO MY ELO PLAN?

You can take the ELO plan with you when you leave with no change in cost or benefits. We will bill you at home.

WHAT HAPPENS IF I CAN'T PAY MY PREMIUM AS A RESULT OF A LEAVE OF ABSENCE OR TERMINATION FROM MY EMPLOYER?

Your policy includes the "Automatic Premium Loan" provision which will be used to pay your premium at the end of your grace period, provided you have accumulated cash value.

WHAT OPTIONS DOES MY ELO POLICY PROVIDE AT RETIREMENT?

Depending on how long your policy has been in force, you have the following options: (1) continue your premium payments and accumulated value (2) choose a paid-up policy; (3) decide to turn your policy in for its accumulated cash value.

CAN I INCREASE MY COVERAGE IN THE FUTURE?

You may apply for additional coverage in the future subject to the ELO underwriting guidelines.

CAN I TAKE A LOAN ON MY POLICY?

Yes. You may borrow all or part of your fund value at an 8% fixed interest.

DOES THE ELO COVERAGE HAVE A SURRENDER CHARGE?

If you discontinue your plan before the 21st policy year there will be a surrender charge. The amount of this charge decreases every year. No charge is made if you decide to terminate your coverage after it has been in force for at least 20 years.

WILL ELO BENEFITS BE PAID FOR SUICIDE?

If suicide occurs during the first 2 years your policy is in effect, benefits will not be paid, but any premiums paid will be refunded. After 2 years, benefits will be paid if death is caused by suicide.

CONSIDER....

IF YOU HAVE A FAMILY

The ELO plan enables you to build a cash reserve for yourself, your spouse and your children for less than 1 hour's pay per week. It is a sound way to protect your family without exceeding your present budget.

IF YOU'RE SINGLE WITH NO DEPENDENTS

For a single working person insurance is the foundation for future financial planning. The longer you wait to buy insurance the more expensive it will be. The flexibility of the ELO plan enables you to expand your coverage to meet future responsibilities.

IF YOU ARE OLDER AND NEARING RETIREMENT

A lot of obligations and responsibilities have probably come and gone in the past few years. Now you can think about your future. Your ELO plan can be continued after retirement.

No matter where you are in your life and career, you will benefit from ELO — Life Insurance that Works for Life.

For questions concerning this policy please contact:

BOSTON MUTUAL LIFE INSURANCE COMPANY

120 Royall Street • Canton, MA 02021

800- 669-2668

781- 828-7000, Ext. 222

Website: www.bostonmutual.com

BOSTON MUTUAL
LIFE INSURANCE COMPANY SINCE 1891

Policy Series END 95 (ESO) (9/00)

Horace Mann Retirement Planning

Educators, don't miss your match!

Johnson County Schools employees, remember to sign up!

If you're planning to get a jump-start on your retirement planning, consider a 403(b) annuity from Horace Mann Life Insurance Company. Johnson County Schools wants to help make reaching your retirement goals easier with its matching funds program up to \$100, but you can't take advantage if you don't participate!

For more information, please call:

**Rick Walters, LUTCF, FSS
(423) 543-0059**

Horace Mann Life Insurance Company underwrites Horace Mann Annuities.



Horace Mann Auto Insurance

Addition by deduction!

Put our math to work for you!

Add value to your auto insurance with payroll deduction.

Johnson County School Employees:

- Save 10 percent on auto insurance with payroll deduction.
- Save even more when you have auto insurance with us and additional lines.

Ask your Horace Mann Agent how.

**Rick Walters, LUTCF, FSS
(423) 543-0059**

This auto insurance is underwritten by Horace Mann Insurance Company and its affiliates.



Continuation of Benefits If You Leave Employment With Johnson County Schools

TUCKER ADMINISTRATORS MEDICAL SPENDING ACCOUNT

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

If you prefer to terminate your participation and contribution to the Plan, any balance in your account on the date of termination will be forfeited if expenses were not incurred prior to the date of termination. For more detailed information, please call **Interactive Medical Systems (IMS) at (800) 426-8739.**

SUPERIOR VISION PLAN

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

If you and your dependents are enrolled in the vision plan, you will be eligible to continue coverage through COBRA after you leave your employment with Rhea County for a specified period. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents maybe eligible to continue vision coverage through COBRA. Also, while you are covered under the plan, your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA. Examples of an ineligible dependent would be when your child graduates from college, or turns 24 years old. For further information, call **Interactive Medical Systems (IMS) at (800) 426-8739.**

AMERITAS DENTAL PLAN

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

If you and your dependents are enrolled in the dental plan, you will be eligible to continue coverage through COBRA after you leave your employment for a specified period. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents may be eligible to continue dental coverage through COBRA. Also while you are covered under the plan, your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA. Examples of an ineligible dependent would be when your child graduates from college or turns 24 years old. You will receive notification from Interactive Medical Systems with premium and continuation options shortly following your termination of employment. For further information, call **Interactive Medical Systems (IMS) at (800) 426-8739.**

ASSURITY CANCER PLAN

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

STANDARD LIFE DISABILITY PLAN

When you leave the employment of Johnson County Schools, you may continue your disability coverage as long as continuous employment is maintained. Coverage expires on the policy anniversary date following your 65th birthday. Please contact **Standard Life at (800) 327-0695** to set up direct bill to your home address.

METLIFE TERM LIFE:

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

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

- You must apply for coverage with 31 days from the date your life coverage terminates.
- You must be **ACTIVELY** at work prior to employment termination.
- You may only port up to your current coverage amount. You cannot increase or add dependents. Employees are eligible up to age 74, spouses up to age 64, and children up to age 18 (24 if a full-time student).

Your employer will advise MetLife of your termination and MetLife will in turn, contact you directly to assist with the conversion/portability process, and advise you of your options. You may also call **MetLife at (877) 275-6387**.

If you do not convert or port your group term life insurance, coverage will terminate.

BOSTON MUTUAL WHOLE LIFE INSURANCE

When you leave employment you may continue your Boston Mutual Whole Life coverage by having the premiums that are currently deducted from your paycheck drafted from your bank account. You may do that by contacting **Boston Mutual at 800-669-2668, Extension 222**.

Important Phone Numbers:

Mark III Brokerage, Inc. - (423) 929-2051
Tucker Administrators Medical and Dependent Care - (800) 347-1232
Ameritas Dental Plan - (800) 487-5553
Assurity Cancer Plan - (888) 358-8808, ext. 23
Superior Vision Plan - (800) 507-3800
BlueCross BlueShield of Tennessee Customer Service - (800) 565-9140
Standard Life STD Plan - (800) 327-0695 or (800) 227-0251
MetLife Term Life Plan - (800) 638-6420 (ext. 2 for claims) or
(877) 275-6387 to convert coverage
Boston Mutual Life - (800) 669-2668, ext. 222
Horace Mann Life Insurance Company - (423) 543-0059