



November 1, 2009

Dear Associate:

We are happy to inform you that our open enrollment period begins November 1, 2009 and ends on November 30th, 2009. PLEASE PAY CLOSE ATTENTION TO THIS LETTER AS ESS GULF OF MEXICO WILL BE SWITCHING MEDICAL INSURANCE COVERAGE. ESS's medical insurance will now be provided by Blue Cross Blue Shield (BCBS) of North Carolina, which is a more popular plan accepted by a larger number of providers in our area than our current Cigna plan. The switch in this benefit will also affect our Prescription Coverage Plan which will now be administered by Express Scripts. You will still have the option of two plans, a Value Choice Plan (similar to the \$150 Limited Coverage Plan from 2009) and the Network Choice Plan (similar to the \$400 deductible plan from 2009).

The national average price of employee health care coverage is estimated to increase over 10% for 2010; however, by switching plans to Blue Cross Blue Shield, ESS is able to limit this increase to 7%. In order to keep rates unchanged for our valuable employees for 2010, ESS will cover the \$70,000 increase in our health insurance premiums for 2010.

Dental Insurance will continue to be provided by CIGNA Healthcare and vision insurance will continue to be available through Vision Service Plans. ESS's vision plan will have a slight increase in cost of the monthly premium.

Everyone wishing to re-enroll or enroll for the first time **MUST** fill out the attached forms for health, dental, and vision as well as the "2010 Enrollment Form" and the "Cafeteria Plan Salary Reduction Agreement".

IF YOU DO NOT RETURN THESE FORMS AND YOU ARE CURRENTLY ENROLLED IN ANY OF THESE BENEFITS, YOUR COVERAGE WILL BE CANCELLED EFFECTIVE JANUARY 1, 2010.

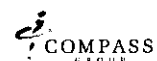
Follow these instructions to Re-Enroll AND Enroll for the first time:

1. Included in your packets are outlines of both health insurance options - the BCBS Value Choice Plan and the BCBS Network Choice Plan as well as brief outline of the Express Scripts prescription drug plan, Cigna Dental Plan, and the VSP vision plan.
2. For any specific questions regarding the BCBS health plan beyond what is contained in your packet, please contact BCBS Pre-Enrollment Hotline at: 1-877-224-3305.
3. If you want to re-enroll, enroll for the first time, or make any changes for health, dental, and/or vision insurance for 2010, please complete the 2010 BCBS Enrollment Form, Cigna Dental Enrollment Form, and/or the vision (VSP) enrollment form. If you are enrolling for ANY of these plans, you **MUST** fill out the Cafeteria Plan Salary Reduction Agreement form as well.

great people
great service
great results

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Telephone (337) 233-9153 Facsimile (337) 233-9156

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A member of Compass Group PLC



4. Forms can be faxed into the office at 337.233.9156 to the attention of HR, dropped off at the office, or mailed in. If you are mailing them, they must be received by the office no later than November 27th, 2009.

We will continue to offer the Voluntary Insurances through Fort Dearborne Life. Please study the enclosed information regarding Voluntary Life Insurance, Short-term Disability, Long-term Disability, and Accidental Death and Dismemberment. Please complete the Fort Dearborne Life Enrollment Form to enroll, change, or cancel your insurance. The Cancer Protection Insurance will still be offered through Colonial. Please see the enclosed information and contact an enroller with Colonial Life Insurance at (225) 231-1441.

The open enrollment period ends on November 30, 2009. All forms **must** be received by NOVEMBER 27th to be effective for January 1, 2010.

****Be advised, if you do not enroll now, you will not be able to enroll again until next year's open enrollment period for January 1, 2011.**

If you need assistance or have questions, please call the Human Resources Department at 337-233-9153 or 877-387-3781.

Sincerely,

Human Resources
ESS Support Services, GoM

Medical Plan Options for ESS GOM

Choosing a medical plan option is really a matter of balance between coverage and cost. Choice is one of the key components of the Compass Group Benefits Program. As part of Compass Group's commitment to providing choice, you have two medical plan options:

- Value Choice Plan
- Network Choice Plan

The Network Choice Plan option provides comprehensive coverage, while the Value Choice Plan provides limited benefits at a lower cost.

The medical plan options differ in several ways, but both:

- Require that all inpatient hospital admissions be pre-certified by your medical plan carrier or the plan will reduce or deny benefits.
- Cover hospital charges, doctors' bills, surgery, prescription drugs and other supplies and services described in this medical plan section.
- Pay benefits within plan limits up to a negotiated amount or the reasonable and customary (R&C) charges.

VALUE CHOICE PLAN

The Value Choice Plan offers basic coverage for typical healthcare expenses like office visits and prescription drug coverage. While it also covers items like hospitalization and surgical procedures, its coverage for major expenses is limited. In exchange, this plan provides the lowest payroll deduction of the three options. This option is designed to offer our associates a basic medical plan that is very affordable — or a good value. The Value Choice Plan is currently administered by Blue Cross Blue Shield of North Carolina.

NETWORK CHOICE PLAN

This option functions as a Network Only Plan, which means that you agree to seek care only within a network of physicians, specialists, facilities and hospitals. In exchange for only using in-network providers, this plan offers the most extensive levels of benefits and coverage. However, since this plan provides higher levels of coverage, it comes with the highest payroll deduction of the three medical plan options. The Network Choice Plan currently uses networks with Blue Cross Blue Shield of North Carolina.

HIGHLIGHTS OF THE VALUE CHOICE, AND NETWORK CHOICE PLANS

	Value Choice Plan	Network Choice Plan
Considerations	<ul style="list-style-type: none"> Low deductible Limited benefits Lowest deductions for coverage 	<ul style="list-style-type: none"> No deductible Lowest out-of-pocket costs Highest deductions for coverage
Annual Deductible	\$200/Individual	None
Annual Out-of-Pocket Maximum	None – you pay all charges above plan maximum benefits	\$3,000/Individual \$6,000/Family
Plan Maximums	\$15,000 hospital services/\$1,500 non-hospital services each year	\$3,000,000 Lifetime
Preventive Care	100% up to \$500	100%, no copay
PCP Visits	70%, after deductible	\$20 copay
Specialist Visits	70%, after deductible	\$45 copay
Most Other Covered Services	70%, after deductible	80% or 100%, after copay (copays may not apply to some other covered services)
Prescription Drugs (provided by Express Scripts)	<p>Pharmacy 30-day supply – plan pays 100% after \$5 copay generic; 70% coinsurance: associate pays min \$20, max \$50 formulary brand; 70% coinsurance: associate pays min \$40, max \$80 non-formulary brand; 70% coinsurance: associate pays min \$100, max \$200 specialty drugs</p> <p>Mail-Order 90-day supply – plan pays \$12 copay generic; 70% coinsurance: associate pays min \$50, max \$125 formulary brand; 70% coinsurance: min \$100, associate pays max \$200 non-formulary brand</p>	<p>Pharmacy 30-day supply – plan pays 100% after \$5 copay generic; 70% coinsurance: associate pays min \$20, max \$50 formulary brand; 70% coinsurance: associate pays min \$40, max \$80 non-formulary brand; 70% coinsurance: associate pays min \$100, max \$200 specialty drugs</p> <p>Mail-Order 90-day supply – plan pays \$12 copay generic; 70% coinsurance: associate pays min \$50, max \$125 formulary brand; 70% coinsurance: associate pays min \$100, max \$200 non-formulary brand</p>

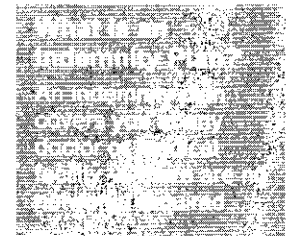
Value Choice Plan

HOW THE PLAN WORKS

The Value Choice Plan is an indemnity plan, which means you have coverage when you use almost any doctor and facility. The plan provides very basic and limited medical coverage. The Value Choice Plan requires the lower payroll deduction compared to the Network Choice Plan. It provides limited coverage at a relatively low cost and is intended for associates who might otherwise waive coverage because of high premiums or who have access to other coverage, such as Medicare. For Massachusetts associates, the Value Choice Plan does not meet the minimum requirements for creditable health coverage defined by the Massachusetts Health Care Reform of 2006.

HOW THE PLAN PAYS FOR SERVICES

Before the Value Choice Plan pays for most covered services for you or a covered dependent, you must first meet your annual deductible for most expenses for the period of January 1 through December 31. When you have met your calendar year deductible, the plan begins to pay for covered expenses. The plan pays 70% for most services after you meet your deductible.



WHAT THE PLAN COVERS

Annual Deductible	\$200/Individual
Annual Out-of-Pocket Maximum	None — you pay all charges above plan maximum benefits
Plan Maximums	\$15,000 hospital services/\$1,500 non-hospital services
Preventive Care	Plan pays 100% up to \$500, per person, per year
Most Other Covered Services	Plan pays 70%, after deductible

ANNUAL DEDUCTIBLE

A deductible is the amount you must pay before the plan starts paying a percentage of your healthcare costs. There is a minimal annual deductible of \$200 with the Value Choice Plan — after you meet the deductible, you will be responsible for the 30% coinsurance. There is no family maximum deductible under the Value Choice Plan.

ANNUAL OUT-OF-POCKET MAXIMUM FOR COVERED FAMILY MEMBER

An out-of-pocket maximum is the most you pay in many plans in a calendar year for covered medical expenses. However, the Value Choice Plan has no annual out-of-pocket maximum.

REASONABLE AND CUSTOMARY (R&C) CHARGES

Reasonable and customary (R&C) charges are the typical range of fees charged by out-of-network medical providers in your geographic area for similar services. In other words, it is the “going rate” for a certain service in your area. The plan will not pay for charges above the reasonable and customary (R&C) rate — you are responsible for paying the additional amount. R&C is also called the Maximum Reimbursable Charge (MRC). Maximum

Reimbursable Charges are the typical range of fees charged by providers in your geographically area for similar services.

HOW DO I KNOW IF MY PROVIDER'S PROPOSED FEE IS WITHIN RAC LIMITS?

Call the number listed on your medical plan ID card to discuss your physician's/surgeon's fees. Provide the following information:

- Your provider's name and address (including ZIP code).
- The five-digit procedure code.
- The provider's proposed fee.

In addition, your provider may send a pre-determination of benefits request to your medical plan carrier. Your medical plan carrier will let you and your provider know, in writing, which benefits are available under the plan. This helps you determine your out-of-pocket costs for that procedure.

ANNUAL MAXIMUMS

The Value Choice Plan features a total annual maximum that pays up to \$15,000 for hospital benefits and \$1,500 for all other healthcare expenses. Preventive care benefits and prescription drug benefits are also covered and are not subject to these annual maximums.

PREVENTIVE CARE

Preventive care services (such as routine physical exams, well-child care visits and immunizations) are covered at 100% up to \$500, per person, per year.

INPATIENT HOSPITAL STAY

All inpatient hospital admissions — emergency or planned — must be pre-certified by your medical plan carrier. To have your hospital stay pre-certified, you or your provider must call your medical plan carrier's customer service department prior to admission. If certified, your hospital stay will be approved for a certain number of days. If you're admitted to the hospital due to an emergency, your medical plan carrier must be called by the end of the next business day (Monday – Friday) after you're admitted or as soon as reasonably possible to certify your stay. If you or your provider don't have an inpatient hospital stay pre-certified, your benefits may be reduced or denied. If your hospital requires you to stay additional days, it will contact your medical plan carrier to approve the additional days.

HOW MANY TIMES CAN I USE MY INDIVIDUAL DEDUCTIBLE IN AN ACCIDENT?

If two or more covered family members are injured in the same accident, you pay only one individual deductible for any of their combined medical expenses caused by the accident.

CHILD BIRTH

If you acquire two or more dependents as a result of a multiple birth, only one individual deductible will apply.

Value Choice Plan participants receive an Express Scripts prescription drug card. You can use the card to purchase prescription drugs through the mail or at one of the many Express Scripts network pharmacies, including independent drug stores.

For a 30-day supply of a generic drug, you only pay \$5. The plan pays 70% coinsurance, and you pay a \$20 minimum up to a \$50 maximum for formulary brand drugs. The plan pays 70% coinsurance, and you pay a \$40 minimum up to an \$80 maximum for non-formulary brand drugs. The plan pays 70% coinsurance, and you pay a \$100 minimum up to a \$200 maximum for specialty drugs. You have no claim forms to file for each prescription up to a 30-day supply.

A mail-order prescription drug program is also available for long term maintenance drugs. A 90-day supply costs only \$12 for generic drugs. The plan pays 70% coinsurance, and you pay a \$50 minimum up to a \$125 maximum for formulary brand drugs. The plan pays 70% coinsurance, and you pay a \$100 minimum up to a \$200 maximum for non-formulary brand drugs. Refer to *The Prescription Drug Program* section for more details on your prescription coverage through Express Scripts.

Network Choice Plan

HOW THE PLAN WORKS

The Network Choice Plan provides the most comprehensive coverage and benefit levels. While this plan provides the richest benefits, it also requires a more substantial payroll deduction. When you enroll in the Network Choice Plan, you must use participating network providers. Compass Group uses Blue Cross Blue Shield of NC to supply provider networks and administer claims.

The Network Choice Plan is very similar to an HMO, but it is self-funded by Compass Group instead of fully insured by an insurance carrier. The Network Choice Plan networks do not require a primary care physician referral for specialty care.

If you do not use participating network doctors and hospitals, care you receive will not be covered (except in a medical emergency, as defined by the plan).

HOW THE PLAN PAYS

Before the Network Choice Plan pays for covered services for you or a covered dependent, you must first pay the applicable copay or coinsurance for most expenses for the period of January 1 through December 31. Coverage for care you receive is generally 80% or 100%, depending on the service, after you pay a copay.

PLAN BENEFIT COVERAGE

Annual Deductible	None
Annual Coinsurance Maximum	\$3,000 Individual/\$6,000 Family
Plan Maximums	\$3,000,000 Lifetime
Preventive Care	Plan pays 100%, no copay
PCP Visits	\$20 copay
Specialist Visits	\$45 copay
Most Other Covered Services	Plan pays 80% or 100% after applicable copays

ANNUAL CALENDAR YEAR

Under the Network Choice Plan, there is no calendar year deductible before the plan begins to pay for covered expenses.

ANNUAL LIMIT OF COVERAGE OF OUT-OF-POCKET CHARGES

The out-of-pocket maximum is the most you pay in a calendar year for you and your dependents' covered medical expenses. The family maximum is two times the individual out-of-pocket maximum. Your individual out-of-pocket maximum is \$3,000 and the family maximum is \$6,000. After you reach your out-of-pocket maximum, the plan pays 100% of covered charges for the rest of the calendar year.

THESE EXPENSES COUNT TOWARD YOUR ANNUAL DEDUCTIBLE MAXIMUM:

- Copays, including prescription drugs.
- Charges above the reasonable and customary (R&C) limits or Maximum Reimbursable Charges (MRC).
- Charges not covered under this plan.
- The penalty for failure to have inpatient hospital admissions pre-certified by your medical plan carrier.

NETWORK CHOICE PLAN

The Network Choice Plan features a total lifetime maximum that pays up to \$3,000,000 toward the covered expenses of each enrolled person for the length of time the member is covered by the Compass Group plan. Some services and treatments have specific lifetime and/or calendar year limits.

PREVENTIVE CARE

There are no copays for preventive care services in the Network Choice Plan. This means if you are in the Network Choice Plan, you will not be responsible for a copay for preventive care visits — like annual checkups and physicals, mammograms, certain cancer screenings, etc. The plan pays 100% for preventive care.

HOSPITAL ADMISSIONS

All inpatient hospital admissions — emergency or planned — must be pre-certified by your medical plan carrier. To have your hospital stay pre-certified, you or your provider must call your medical plan carrier's customer service department prior to admission. If certified, your hospital stay will be approved for a certain number of days. If you're admitted to the hospital due to an emergency, your medical plan carrier must be called by the end of the next business day (Monday – Friday) after you're admitted or as soon as reasonably possible to certify your stay. If you or your provider don't have an inpatient hospital stay pre-certified, your benefits may be reduced or denied. If your hospital requires you to stay additional days, it will contact your medical plan carrier to approve the additional days.

PHARMACY SERVICES

Network Choice Plan participants receive an Express Scripts prescription drug card. You can use the card to purchase prescription drugs through the mail or at one of the many Express Scripts network pharmacies, including independent drug stores.

For a 30-day supply of a generic drug, you only pay \$5. The plan pays 70% coinsurance, and you pay a \$20 minimum up to a \$50 maximum for formulary brand drugs. The plan pays 70% coinsurance, and you pay a \$40 minimum up to an \$80 maximum for non-formulary brand drugs. The plan pays 70% coinsurance, and you pay a \$100 minimum up to a \$200 maximum for specialty drugs. You have no claim forms to file for each prescription up to a 30-day supply.

A mail-order prescription drug program is also available for long term maintenance drugs. A 90-day supply costs only \$12 for generic drugs. The plan pays 70% coinsurance, and you pay a \$50 minimum up to a \$125 maximum for formulary brand drugs. The plan pays 70% coinsurance, and you pay a \$100 minimum up to a \$200 maximum for non-formulary brand drugs. Refer to *The Prescription Drug Program* section for more details on your prescription coverage through Express Scripts.

REMEMBER

You choose your doctors, specialists, hospitals and laboratories from the network whenever or wherever you need care. You must make sure you are receiving care from network providers in order for your expenses to be covered. Except for an emergency, always confirm with your provider and your medical plan carrier that the provider belongs to the network before you obtain care.

Covered Services

PLAN FEATURE

Calendar Year Deductible	\$200/Individual	None
Annual Out-of-Pocket Maximum	None – you pay all charges above plan maximum benefits	\$3,000/Individual \$6,000/Family
Plan Maximums	\$15,000 hospital services/\$1,500 non-hospital services a year	\$3,000,000 Lifetime
Health Reimbursement Account (HRA)	N/A	N/A
TYPE OF SERVICE	Benefits Schedule	Benefits Schedule
Physician Services		
Preventive Care Services	100% up to \$500 per person, per year	100%, no copay
Primary Care Physician (PCP) Office Visit	70%, after deductible	100%, after \$20 copay
Specialist Office Visit	70%, after deductible	100%, after \$45 copay
Surgery (Physician's Office)	70%, after deductible	100%, after applicable office visit copay
Surgery (Inpatient or Outpatient Hospital)	70%, after deductible	80%
Chiropractor	70%, after deductible	100%, after \$15 copay
Prescription Drugs		
Pharmacy (30-day supply)	Generic	100%, after \$5 copay
	Formulary brand	70% coinsurance: associate pays min \$20, max \$50
	Non-formulary brand	70% coinsurance: associate pays min \$40, max \$80
	Specialty Drugs	70% coinsurance; associate pays min \$100, max \$200
Mail-Order (90-day supply)	Generic	100%, after \$12 copay
	Formulary brand	70% coinsurance: associate pays min \$50, max \$125
	Non-formulary brand	70% coinsurance: associate pays min \$100, max \$200
Allergy Injections	70%, after deductible	85%
Hospital Services		
Inpatient Hospital Care	70%, after deductible	80%, after \$250 copay/admit
Outpatient Hospital Care (e.g. minor surgery, lab charges)	70% after deductible	80%
Emergency Care		
Emergency Room	70%, after deductible	100%, after \$150 copay (waived if admitted)
Urgent Care Clinic	70%, after deductible	100%, after \$45 copay

PLAN FEATURE

Maternity Care

Physicians Office – Initial visit	70%, after deductible	100%, after \$20 copay
Physician Services (Pre- and post-natal visits, delivery)	70%, after deductible	80%
Delivery and Newborn Charges – Hospital	70%, after deductible	80%, after \$250 copay/admit

Mental Health Services/ Substance Abuse Services

Outpatient Services	70%, after deductible	100%, after \$45 copay
Inpatient Services	70%, after deductible	80%, after \$250 copay/admit

PLEASE NOTE: The Value Choice Plan limits its benefit payments to \$1,500 per person annually for all non-hospital medical expenses. Therefore, all non-hospital services/medical expenses you incur combine to meet the \$1,500 per person annual plan maximum. The Value Choice Plan includes preventive care benefits and prescription drug benefits which are not subject to these annual maximums. For Massachusetts associates, the Value Choice Plan does not meet the minimum requirements for creditable health coverage defined by the Massachusetts Health Care Reform of 2006.

All references to lifetime maximums combine both in-network and out-of-network benefits. Your lifetime maximum benefit is the combined total amount of benefit payments you receive from the Compass Group Medical Plan regardless of the plan in which you have been enrolled.

This means that if you change your medical plan election from one self-insured option to another, the benefits you received when covered under both the first option and the second option (and any successive options) are taken into account to determine when you have reached the lifetime maximum.

For A Medical Plan Election

CALL YOUR MEDICAL PLAN CARRIER

Call your medical plan carrier's member services department first. The medical plan carrier must provide you or your beneficiary details on:

- Claims questions or problems.
- ID cards.
- Covered services and circumstances under which services may be denied.
- Review of a claim that is denied in whole or in part.

PRE-CERTIFY YOUR HOSPITAL STAY

In some circumstances, certain steps may be taken before and after you receive medical treatment in order to receive the highest level of insurance coverage. The following steps may be needed in order to receive coverage under your medical plan election.

PRE-CERTIFY HOSPITAL STAY

You must pre-certify all inpatient hospital stays before you or your covered dependent is admitted. To have your hospital stay pre-certified, you or your provider must call your medical plan carrier's customer service department prior to admission. If certified, your hospital stay will be approved for a certain number of days. If you're admitted to the hospital due to an emergency, your medical plan carrier must be called by the end of the next business day (Monday – Friday) after you're admitted or as soon as reasonably possible to certify your stay. If you or your provider don't have an inpatient hospital stay pre-certified, your benefits may be reduced or denied. See *If You Have a Medical Emergency* for examples of medical emergencies. If your hospital requires you to stay additional days, it will contact your medical plan carrier to approve the additional days.

HOW TO AVOID EMERGENCY CARE

In order to avoid problems, it is essential that you understand your coverage for emergency care. Most participating Primary Care Physicians (PCPs) provide emergency, on-call coverage 24 hours a day, including weekends and holidays. Chronic or less severe problems should be handled during routine office hours, but your PCP provides around-the-clock coverage to advise you in the case of an emergency.

An emergency medical condition is a recent and severe condition, sickness, or injury, including (but not limited to) severe pain, which would lead a prudent layperson (including the parent or guardian of a minor child or the guardian of a disabled individual) possessing an average knowledge of medicine and health, to believe that failure to get immediate medical care could result in:

- Placing your health in serious jeopardy,
- Serious impairment to a bodily function(s),
- Serious dysfunction to a body part(s) or organ(s) or

In the case of a pregnant woman, serious jeopardy to the health of the unborn child.

When emergency care is necessary, please follow the guidelines below:

- Seek the nearest emergency room, or dial 911 or your local emergency response service for medical and ambulatory assistance. If possible, call your physician provided a delay would not be detrimental to your health.
- After assessing and stabilizing your condition, the emergency room should contact your physician to obtain your medical history to assist the emergency physician in your treatment.
- If you are admitted to an inpatient facility, notify your regular physician as soon as reasonably possible.

Compass Group medical plans cover emergency room treatment for conditions that reasonably appear to constitute an emergency based on your presenting symptoms. For all services that have provisions or limitations pertaining to ER visits, your medical plan follows the prudent layperson ER policy in the Balanced Budget Act of 1997. The symptoms related to the medical emergency usually occur suddenly and are severe in nature. When the emergency care is given in the ER of a facility, your plan will cover the care received, provided that the situation meets the criteria as defined.

For minor non-emergencies, call your family physician or go to an urgent care center.

What the Medical Plans Cover

All the medical plans pay the reasonable and customary (R&C) or negotiated charges for covered medical care and treatment of injury or illness certified as necessary by a physician after you meet your deductible under the Value Choice Plan. There is no deductible under the Network Choice Plan.

This section describes which expenses are covered. Only expenses incurred for the services and supplies shown in this section are covered. Limitations and exclusions apply.

See the medical plan charts for details on copays, deductibles, coinsurance and out-of-pocket maximums.

PHYSICIAN SERVICES

Preventive Care, Routine Physical Examinations and Cancer Screenings

Value Choice Plan

Covered expenses include charges made by your physician for routine physical exams. A routine exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury, and also includes:

- Radiological services, X-rays, lab and other tests given in connection with the exam,
- Immunizations for infectious diseases and the materials for administration of immunizations as recommended by the Advisory Committee on Immunization Practices of the Department of Health and Human Services, Center for Disease Control and
- Testing for Tuberculosis.
- Covered expenses for children from birth through age 18 also include an initial hospital check up and well child visits in accordance with the prevailing clinical standards.

Preventive Screenings

Covered expenses include charges incurred for routine cancer screenings. Your medical plan uses prevailing clinical standards to determine preventive care guidelines. Contact your medical plan carrier for the specific frequency.

Physician Services – Inpatient, Outpatient, and Telemedicine Services – Office of the Physician or Outside the Office

Physician Services

Covered medical expenses include charges made by a physician during a visit to treat an illness or injury. The visit may be at the physician's office, in your home, in a hospital or other facility during your stay or in an outpatient facility. Covered expenses also include:

- Immunizations for infectious disease, but not if solely for your employment or travel.
- Allergy testing and allergy injections.

Charges made by the physician for supplies, radiological services, X-rays, and tests provided by the physician.

or

Covered expenses include charges made by a physician for:

- Performing your surgical procedure.
- Pre-operative and post-operative visits.
- Consultation with another physician to obtain a second opinion prior to the surgery.

PRESCRIPTION DRUGS AND MEDICINES

Prescription drugs and medicines that have been ordered in writing by your doctor (including birth control pills) are covered by the prescription drug plan.

PRESCRIPTION DRUGS

The plan will pay benefits for the following services while you are confined to a hospital:

- Room and board at the hospital's current rate for a semi-private room. Private rooms are paid up to the cost of a semi-private room. Benefits for maternity care must be available for a minimum of 48 hours following a normal vaginal delivery and 96 hours following a cesarean section. See *Maternity Care* for further information.
- Intensive care room and board at the hospital's current rates.
- Other charges for necessary inpatient hospital services and supplies.
- Ambulatory surgical center services in connection with surgery. An ambulatory surgical center is a public or private facility performing surgical procedures on an outpatient basis. The facility must be staffed by physicians, nurses and anesthesiologists and does not provide accommodations for patients to stay overnight.
- Outpatient hospital services and supplies.

You or your provider must call your medical plan carrier for pre-certification/notification of overnight stays at network and out-of-network hospitals or benefits may be reduced or denied.

Extended Care Facility (ECF) Coverage

Home Care and Extended Care Facility

The plan will pay benefits for up to 120 days in an extended care facility. Covered expenses include charges made by a skilled nursing facility during your stay for the following services and supplies, up to the maximums shown in the Schedule of Benefits, including:

- Room and board, up to the semi-private room rate. The plan will cover up to the private room rate if it is needed due to an infectious illness or a weak or compromised immune system.
- Use of special treatment rooms.
- Radiological services and lab work.
- Oxygen and other gas therapy.
- Other medical services and general nursing services usually given by a skilled nursing facility (this does not include charges made for private or special nursing, or physician's services).
- Medical supplies.

You must meet the following conditions:

- You are currently receiving inpatient hospital care, or inpatient sub-acute care, and
- The skilled nursing facility admission will take the place of an admission to, or continued stay in, a hospital or sub-acute facility; or it will take the place of three or more skilled nursing care visits per week at home; and
- There is a reasonable expectation that your condition will improve sufficiently to permit discharge to your home within a reasonable amount of time; and
- The illness or injury is severe enough to require constant or frequent skilled nursing care on a 24-hour basis.

Your stay in a skilled nursing facility:

- Follows a hospital stay of at least three days in a row,
- Begins within 14 days after your discharge from the hospital and
- Is necessary to recover from the illness or injury that caused the hospital stay.

Home Health Care (HHC) Coverage

Your doctor may recommend home healthcare if you need continuing professional care, but can be treated at home. To qualify for home healthcare benefits, charges must be made by a home healthcare agency, a hospital, or a non-profit or public agency that:

- Primarily provides skilled nursing service and other therapeutic service under the supervision of a physician or a registered nurse.
- Is operated according to rules established by a group of professional persons.
- Maintains clinical records on all patients.
- Does not primarily provide custodial care or care and treatment of the mentally ill.
- Is licensed, if required and operated according to laws that pertain to agencies that provide home healthcare.
- Charges for care and treatment must be specified in the home healthcare plan. The plan must be established and approved by a physician who certified that the person would require confinement in a hospital or skilled nursing facility with the care and treatment specified in the plan.

The medical plans provide benefits for:

- Part time or intermittent nursing care by or under the supervision of a registered nurse.

- Part time or intermittent services of a home health aide.
- Physical, occupational, or speech therapy.
- Medical supplies, drugs and medicines prescribed by a doctor and laboratory services, if these charges would have been covered had the patient been confined in a hospital.

The medical plans cover 100 home healthcare visits — or days — in a calendar year for all of the plans. “One visit” means each visit by a home healthcare agency associate and each four hours of care by a home healthcare aide.

The plan does not cover charges for care or treatment not specified in the home healthcare plan that is provided by a person who is a member of the patient’s family or normally lives in the patient’s home, or is provided during a period when the patient is not under the continuing care of a physician.

Hospice Care Services (Section 1001)

Hospice care is an integrated program recommended by a physician that provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Benefits are available only when hospice care is received from a licensed hospice agency.

Exclusions

Unless specified above, not covered under this benefit are charges for:

- Daily room and board charges over the semi-private room rate.
- Bereavement counseling.
- Funeral arrangements.
- Pastoral counseling.
- Financial or legal counseling. This includes estate planning and the drafting of a will.
- Homemaker or caretaker services. These are services which are not solely related to your care. These include, but are not limited to: sitter or companion services for either you or other family members; transportation; maintenance of the house.
- Respite care. This is care furnished during a period of time when your family or usual caretaker cannot attend to your needs.

Subacute Rehabilitation Services (Section 1001)

The plan provides short-term outpatient rehabilitation services for the following types of therapy:

- Physical therapy
- Occupational therapy
- Speech therapy
- Pulmonary rehabilitation
- Cardiac rehabilitation

A licensed therapy provider under the direction of a physician must perform all rehabilitation services.

Maternity Services (Section 1001)

Federal law generally does not prohibit the mother’s or newborn’s attending physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). However,

plans and insurers may not require a provider to obtain authorization from the plan or the medical plan carrier from prescribing a length of stay not in excess of 48 hours (or 96 hours).

NEWBORN ROOM AND BOARD CHARGES

Routine room and board charges for a newborn infant are covered while the child is enrolled in the medical plan. For newborn coverage to apply, you must enroll newborns in the medical plan within one month of their birth.

MENTAL HEALTH SERVICES

Covered expenses include charges made for the treatment of other mental disorders by behavioral health providers. In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a written treatment plan prescribed and supervised by a behavioral health provider,
- The plan includes follow-up treatment and
- The plan is for a condition that can favorably be changed.

Benefits are payable for charges incurred in a hospital, psychiatric hospital, residential treatment facility or behavioral health provider's office for the treatment of mental disorders as follows:

Daily Treatment

Covered expenses include charges for treatment received while not confined as a full time inpatient in a hospital, psychiatric hospital or residential treatment facility.

Inpatient

Covered expenses include charges for room and board at the semi-private room rate, and other services and supplies provided during your stay in a hospital, psychiatric hospital or residential treatment facility. Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting.

The plan covers partial hospitalization services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment. The partial hospitalization will only be covered if you would need inpatient care if you were not admitted to this type of facility.

Remember, you or your provider must call your medical plan carrier for pre-certification/notification of overnight stays at network and out-of-network hospitals or benefits may be reduced or denied.

ALCOHOLISM AND SUBSTANCE ABUSE

Covered expenses include charges made for the treatment of alcoholism and substance abuse by behavioral health providers. In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a program of therapy prescribed and supervised by a behavioral health provider.
- The program of therapy includes either:
 - A follow up program directed by a behavioral health provider on at least a monthly basis or
 - Meetings at least twice a month with an organization devoted to the treatment of alcoholism or substance abuse.

Inpatient Treatment for Alcoholism and Substance Abuse

The plan covers room and board at the semi-private room rate and other services and supplies provided during your stay in a psychiatric hospital or residential treatment facility, appropriately licensed by the State Department of Health or its equivalent.

Coverage includes:

- Treatment in a hospital for the medical complications of alcoholism or substance abuse.
- "Medical complications" include detoxification, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.
- Treatment in a hospital, when the hospital does not have a separate treatment facility section.

Outpatient Treatment for Alcoholism and Substance Abuse

The plan covers partial hospitalization services (more than four hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of alcoholism or substance abuse. The partial hospitalization will only be covered if you would need inpatient treatment if you were not admitted to this type of facility.

Remember, you or your provider must call your medical plan carrier for pre-certification/notification of overnight stays at in-network and out-of-network hospitals or benefits may be reduced or denied.

Other Covered Services

The plan also will pay benefits up to reasonable and customary (R&C) or negotiated charges for the following medically necessary supplies and services:

- * Physician's charges for diagnosis, treatment and surgery.
- * Cosmetic surgery needed to:
 - Improve a significant functional impairment of a body part.
 - Correct the result of an accidental injury, including subsequent related or staged surgery, provided that the surgery occurs no more than 24 months after the original injury. For a covered child, the time period for coverage may be extended through age 18.
 - Correct the result of an injury that occurred during a covered surgical procedure provided that the reconstructive surgery occurs no more than 24 months after the original injury.
 - Anatomical defects present at birth or appearing after birth (but not the result of an illness or injury).
- Birthing center charges for services and supplies related to the mother's care for prenatal care, delivery and postpartum care within 48 hours after a vaginal delivery and 96 hours after a Cesarean delivery.
- * Charges for the following when ordered in writing by the attending physician:
 - Blood and plasma not donated or replaced.
 - Oxygen and rental of equipment to administer oxygen.
 - Ostomy supplies (limited to pouches, face plates and belts, irrigation sleeves, bags and catheters and skin barriers).
 - Internal and external prosthetic devices and special appliances that replace a limb or body part, or help an impaired limb or body part work. Examples include, but are not limited to:
 - Artificial limbs.
 - Artificial eyes.

Breast prosthesis following mastectomy as required by the Women's Health and Cancer Rights Act of 1998, including mastectomy bras and lymphedema stockings for the arm.

Benefits are provided for the replacement of a type of prosthetic device once every five calendar years.

- Rental or purchase (as determined by the medical plan carrier) of a wheelchair, hospital bed or other durable medical equipment (DME) used exclusively for treatment of injury or illness.
- Charges are covered for:
 - The initial purchase of DME if long-term care is planned and the equipment cannot be rented or is likely to cost less to purchase than to rent.
 - Repair of purchased equipment.
 - Replacement of purchased equipment if the replacement is needed because of a change in your physical condition and is likely to cost less to replace the item than to repair the existing item or rent a similar item.
- Casts, splints, dressings, trusses, braces and crutches.
- Orthotic devices of the foot are covered when medically necessary and prescribed by a qualified physician for:
 - Treatment of or to prevent complications of a severe systemic disease, such as diabetes.
 - When the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the leg brace.
- Vision hardware coverage of two pair of contact lenses and fittings per year for the treatment of keratoconus.
- Anesthesia and its administration or acupuncture in lieu of anesthesia.
- X-ray and laboratory services for diagnosis and treatment.
- X-ray, radium and radioactive isotope treatment.
- Chemotherapy.
- Tubal ligation or vasectomy for you or your covered spouse/domestic partner.
- Birth control pills (covered under the Prescription Drug Plan).
- Professional ambulance service to or from the nearest hospital that is equipped to provide necessary treatment.
- Organ transplant services including charges made by a transplant team, hospital or outpatient facility for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program. The in-network benefits are paid only for a treatment received at a facility designated by the plan as a Center of Excellence for the type of transplant being performed. Each Centers of Excellence facility has been selected to perform only certain types of transplants. Services obtained from a facility that is not designated as a Center of Excellence for the transplant being performed will not be covered under the Network Choice program and covered as out-of-network for the Value Choice program.
- Charges in connection with temporomandibular joint (TMJ) syndrome — surgery only, other services covered under dental.
- Nutritional counseling by a registered dietician for chronic diseases in which a dietary adjustment has a therapeutic role. Limited to three individual sessions per lifetime per condition.
- Diaphragm and intrauterine devices purchased and fitted in a physician's office.
- Routine hearing exam as part of preventive care, subject to your medical plan's standard guidelines for frequency.
- Orthoptic therapy.
- Congenital Heart Disease services.
- Bariatric surgery for morbid obesity — subject to your medical plan's standard guidelines for medical necessity and step therapy treatment.

- Diagnosis, treatment and correction of any underlying causes of infertility and/or sexual dysfunction.
- Elective abortions.

The Prescription Drug Program

Compass Group has contracted with Express Scripts to be the Pharmacy Benefit Manager (PBM) for the Value Choice, the Network Choice Plans.

Express Scripts offer you several advantages including significant cost savings on prescriptions, customer service representatives who are available 24 hours a day/seven days a week to answer your questions, and the convenience of access to thousands of pharmacies nationwide, including most major chains.

YOUR PHARMACY NETWORK

By using either Express Scripts' pharmacy networks, you'll get discounted prices for your prescriptions. You will receive a pharmacy prescription drug card from your respective plan that you will need to use when you have a short term prescription of 30 days or less filled at a local participating pharmacy. You don't need to file claim forms.

USING AN OUT-OF-NETWORK PHARMACY

If you use an out-of-network pharmacy, you will pay the full cost of your prescription. The plans do not cover prescriptions purchased at out-of-network pharmacies.

HOW TO FIND A NETWORK PHARMACY

To find a network pharmacy in your area check out Express Scripts at www.express-scripts.com.

MAINTENANCE MEDICATION

If you require maintenance medication, you can take advantage of each plan's mail-order prescription program. By using the mail-order program, you receive up to a three-month (90-day) supply of your prescription at a lower cost than if the same prescription was purchased at your local pharmacy on a month-to-month basis. The prescriptions are mailed directly to your home, postage paid.

Simply mail your prescription and payment in the pre-addressed envelope provided by Express Scripts. To determine your 30% coinsurance cost, call Express Scripts. Your prescription will be delivered to your home, postage paid, along with another pre-addressed envelope for your next prescription order. If you have any questions about the mail-order program, or if you need a mail-order package containing pre-addressed envelopes, call Express Scripts at the number on your ID card.

ORDERING SPECIALTY MEDICATIONS

If you order specialty medications through your local retail pharmacy or through the mail-order program, you can order your specialty medications exclusively through Express Scripts' specialty pharmacy program, CareLogicSM, and also receive additional care and services. Specialty medications include conditions like:

- Blood modifiers
- Growth hormone disorders

- Hemophilia and related bleeding disorders
- Hepatitis C
- Immune deficiencies
- Infertility
- Multiple Sclerosis
- Rheumatoid Arthritis

Specialty Medication Delivery

Specialty medications will be delivered to your home, your doctor’s office or any approved location. Medications and supplies will be delivered within 72 hours after receipt of a properly completed prescription requiring no additional information from your physician to process, or within 24 hours prior to the next injection date. In addition, you’ll have access to other benefits through CareLogic, including:

- Up to a 30-day supply of specialty medications subject to the retail card copayment.
- Direct pharmacist and nurse access to ensure you receive prompt, personalized care.
 - Educational materials, support and home instruction information.
- Comprehensive coordination of care including refills reminders and interaction with your physician.
 - Care management programs to help ensure you’re taking medications correctly and to provide the support you need to manage your condition.
 - A Patient Care Coordinator to provide comprehensive clinical management services.
 - Supplies for administering your medications — like syringes, needles and sharps containers.

Program Details

For the Value Choice and the Network Choice Plans, Compass Group only covers specialty medications through CareLogic. To receive coverage, be sure to order your specialty medications through the CareLogic Program. Express Scripts will notify you if you are currently taking specialty medications that are required for use under the CareLogic Program. To participate in the program, your physician will need to complete a Patient Enrollment Form. This form can be obtained by calling the CareLogic Pharmacy Customer Service Department at 866-848-9870.

Compass Group’s specialty medication coverage policy allows up to one 30-day supply of a specialty medication to be filled at an Express Scripts’ participating retail network provider other than CareLogic. Subsequent refills must be dispensed by CareLogic pharmacy.

WHEN I USE THE CARELOGIC PROGRAM, HOW WILL I KNOW HOW MUCH MY PRESCRIPTIONS WILL COST?

You can check www.express-scripts.com or call CareLogic at the number on your ID card to speak with a Patient Care Advocate about cost information for your prescriptions. For cost information on prescriptions filled through the CareLogic Program, call 866-848-9870.

Specialty Medication Exclusions

- Fertility drugs
- Obesity drugs
- Prescription vitamins

- Over-the-counter (OTC) medication
- Smoking cessation
- Hair growth stimulants
- Retin A (except for age 35+ with pre-authorization)
- Experimental drugs

This is not a complete list. For more information on drugs not covered, call Express Scripts.

While these drugs are not covered under the Prescription Drug Program, with Compass Group's purchasing power, you may be able to purchase some of these medications at discounted rates. In these instances, you pay 100% of the discounted cost.

• Pay Less for Generic Drugs Instead of Brand-Name

You will reduce your drug costs if you are able to use a therapeutically equivalent generic drug instead of a brand-name drug. The brand-name is the trade name under which the drug is advertised and sold. By law, the generic and brand-name drugs must meet the same standards for safety, purity, strength and effectiveness. Since you pay less for generic prescriptions than for brand-name medications, you should always ask your doctor to prescribe a generic drug whenever possible.

• Use Formulary Brand-Name Drugs

A formulary drug is simply a preferred brand-name drug. Certain medical conditions, such as asthma, may be treated using any number of brand-name prescription options. The pharmacy manager designates which brand-name prescriptions are included on its formulary list for a wide range of medical conditions. The medications on the formulary list are known to be safe, effective, FDA-approved and more cost effective than other brand-name drugs. Brand-name drugs included on a formulary list have a lower out-of-pocket cost to you than non-formulary drugs.

• Prior Authorization

Before certain medications are covered under your medical plan, Express Scripts will check to see if these medications meet your medical plan's conditions for coverage. This encourages appropriate and cost-effective use of medications by allowing coverage only when certain conditions are met.

Prior authorization helps your providers comply with dosage guidelines, avoid duplication of therapies and ensure that medications are used based on generally accepted medical criteria.

If your medication requires prior authorization:

- Your doctor will contact Express Scripts to see if your plan will cover the medication.
- If your medication is covered, Express Scripts will notify your doctor. You'll pay the applicable copay when you fill your prescription.
- If your medication isn't covered, and you still want to take it, you must pay the full cost for the medication.

• Quantity Limits

To help you get the medications you need safely and affordably, Express Scripts limits the amount of certain prescription drugs you can have filled at one time. This ensures that you receive the medications you need in the quantity considered safe.

Quantity limits also help you save money. For example, if your medicine is available in different strengths, you might take one dose of a higher strength instead of two or more doses of a lower strength — saving you money since you pay for fewer dosage units.

If you go to the pharmacy for a refill:

- Your pharmacist will check to see if your medication can be refilled, based on the number of days since your last refill.
- If you're asking for a refill too soon, your pharmacist will let you know when you can get your next refill.

If you need a new prescription drug filled, and your provider writes a prescription for a larger amount than your plan covers:

- You can work with your pharmacist (and provider) to get the amount of the prescription drug your plan will cover.
- Your doctor can also contact Express Scripts to request a prior authorization which may allow you to get a larger quantity.

Mail Order or Prescription Claim Form

For a Mail Order or a Prescription Claim form, contact Express Scripts or Aetna directly at the number listed below. Also, send Mail Order or Prescription Claim forms to:

Express Scripts (for mail order)

Mail Pharmacy Service
PO Box 8545
Bensalem, PA 19020-8545
888-976-3326

Express Scripts (for paper claims)

PO Box 66773
St Louis, MO 63166-6773
Attn: Claims Department
888-976-3326

What the Medical Plans Do Not Cover

While the plans pay for most medical expenses, the following are not covered:

- Acupuncture, acupressure and acupuncture therapy, except as provided in your medical plan.
Any services provided by a covered provider who is a member of your or your spouse's immediate family.
- Charges above reasonable and customary (R&C) guidelines.
- Charges for any illness or injury provided without charge or that would have been provided without charge if this plan weren't in effect.
- Charges for blood plasma that is replaced on behalf of you or your covered dependent.
Charges for experimental and/or investigational/unproven drugs or substances not approved by the Food and Drug Administration (FDA), or for drugs labeled Caution: Limited by Federal law to investigational use.
- Charges for eyeglasses or contact lenses and exams for their prescription or fitting
- Charges for non-covered health services.
Charges for services and supplies that are not medically necessary.
Charges for services or supplies provided before your effective date of coverage under this plan, or after your coverage is terminated under this plan.
Charges for which no legal liability would exist had coverage under the plan existed — or charges prohibited by law in your jurisdiction at the time you incur the expense.
- Cochlear implants.
- Cosmetic procedures, such as plastic surgery, dermabrasion, chemosurgery and other skin abrasion procedures associated with the removal or revision of scars, tattoos, actinic changes, and/or which are provided to treat acne.
- Counseling services and treatment for marriage, religious, family, career, social adjustment, pastoral, or financial counselor.
- Custodial care, including institutions such as homes for the aged, rest homes and schools for the mentally disabled.
- Cranial banding — unless medically necessary and not for cosmetic reasons.
- Dental care or treatment, except for care covered by the medical plan.
Experimental, investigational or unproven services.
- Hearing aids and non-routine exams.
- Illness or injury received at the time or when attempting an assault or felony — or injuries received while involved in an illegal occupation, except illness or injuries you have because of a medical condition or resulting from domestic violence.
- Infertility treatment with drugs or surgery, such as artificial insemination, in-vitro fertilization, reverse sterilization, GIFT, ZIFT or any combination.
Luxury services and supplies such as mineral baths, massages, telephones, radio and television.
- Non-prescription birth control drugs, medicines or devices used to prevent pregnancy.
- Nutritional supplements or vitamins, even if a written prescription is provided.

Routine foot care, including treatment of corns or calluses, care of toenails (except surgery for ingrown nails) or other foot tissue or mycotic toenails when no indication of metabolic disease is present; treatment of foot weakness or strain, such as fallen arches, flat feet, weak feet, chronic foot strain. Also excluded:

Orthopedic and therapeutic shoes, shoe additions, modifications or other devices to support the feet, unless it meets the criteria as outlined in the covered services section

Orthotics for sports related activities

Spring loaded orthotics

Prefabricated foot orthoses

Service or supplies for sex reassignment surgery or hormonal treatments.

Services for weight control, including: medical treatments (except bariatric surgery); weight control/loss programs; dietary regimens and supplements; appetite suppressants and other medications; food or food supplements; exercise programs; exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of co-morbid conditions.

Services or supplies provided by the Veterans Administration or by any hospital or institution owned, operated or maintained by the U.S. Government for a service-related illness or injury.

Services or supplies provided to you or your covered dependents after coverage has terminated, unless your coverage is extended.

Services outside the scope of a physician or other provider's license.

Speech therapy for treatment of delays in speech development, except as specifically provided by the medical plan. For example, the plan does not cover therapy when it is used to improve speech skills that have not fully developed.

Certain transplant-related coverage including:

Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence.

Services and supplies furnished to a donor when recipient is not a covered person.

Harvesting and/or storage of organs, without the expectation of immediate transplantation for an existing illness.

Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing illness.

Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise precertified.

Health services for transplants involving non-FDA approved mechanical or animal organs.

Services and supplies not obtained from a Centers of Excellence facility or health plan approved Organ Procurement Organization, including the harvesting of organs, bone marrow, tissue or stem cells for storage purposes.

Organ transplant services including charges made by a transplant team, hospital or outpatient facility for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.

Any solid organ transplant that is performed as a treatment for cancer, unless specifically approved as medically necessary and non-experimental by the health plan.

Treatment not provided by a licensed doctor or other provider.

Charges made by an assistant surgeon in excess of 25% of the surgeon's allowable charge; or for charges made by a co-surgeon in excess of the surgeon's allowable charge plus 25%.

Under Blue Cross Blue Shield when two or more surgical procedures are performed together, the maximum amount allowable will be the sum of the amount otherwise allowable for the most expensive procedure plus 50% of the allowable amount for the secondary procedure and 25% of the allowable amount for all other surgical procedures combined.

Medical Claims

For a Medical Claim form, contact your medical plan carrier directly at the number listed in this section. Send Medical Claim forms to the appropriate carrier.

For the Network Choice Plan, your medical provider will submit your claims directly to your medical plan carrier. If you use out-of-network providers in the Value Choice, you will need to submit claims directly to your medical plan carrier.

Benefits are generally payable to you. However, you may authorize the medical plan carrier to pay benefits directly to the doctor or hospital providing the covered services. You make this authorization in a special section on the claim form.

The Medical Claim form contains a section for you to complete and sign and a section for your doctor or other provider to complete. All claim forms must be signed by you (the associate) and the patient, if the patient is not a minor.

As an alternative to having your doctor complete the claim form, you may attach the itemized bill to the claim form. The bill must include:

- Your name and Social Security Number and the name of the patient.
- The provider's name, address, Social Security or Tax ID Number and telephone number.
- Codes for the diagnosis and complete description of services.
- Charges for the services received.
- The date (day, month and year) the service was received.

For a Medical Claim form, contact your medical plan carrier directly at the number listed here. Send Medical Claim forms to:

Blue Cross Blue Shield

P.O. Box 35
Durham, NC 27702
877-258-3334

CIGNA HealthCare*

P.O. Box 182223
Chattanooga, TN 37422
800-CIGNA-24



**CIGNA Dental PPO Benefit Summary for
Eurest Support Services
DNPPPO**

**CIGNA Dental PPO
Effective 01/01/2010**

<i>Benefits</i>	In-Network		Out-of-Network	
	Plan Pays	You Pay	Plan Pays	You Pay
Calendar Year Maximum <i>(Applies to Class I, II and III expenses)</i>	\$1,500		\$1,500	
Annual Deductible <i>(Applies to Class II and III expenses)</i>	\$50 per person \$150 per family		\$50 per person \$150 per family	
Lifetime Maximum <i>(Applies to Class IV expenses)</i>	\$2,500		\$2,500	
Reimbursement Levels	Based on reduced contracted fees		Based on the 90th percentile of Reasonable & Customary allowances	
<i>Class I – Preventive and diagnostic services</i> Oral Exams (Two per year) Routine Cleanings (Two per year) Full Mouth X-rays (One complete set every three years) Bitewing X-rays (Two per year) Panoramic X-ray (One every three years) Fluoride Application (One per year for persons under 19) Sealants (Limited to posterior teeth; one treatment per tooth every three years) Space Maintainers (Limited to nonorthodontic treatment) Emergency Care to Relieve Pain Simple Extractions	100%	0%	80%	20%
<i>Class II – Basic restorative services</i> Fillings Root Canal Therapy Osseous Surgery Periodontal Scaling and Root Planing Denture Adjustments and Repairs Oral Surgery Anesthetics Repairs to Crowns and Inlays Surgical Extractions of Impacted Teeth Minor Periodontics Root Canal/Therapy Oral Surgery, All Except Surgical Extraction of Impacted Teeth Anesthetics	80%	20%	80%	20%

Class III – Major restorative services Crowns Dentures Bridges Repairs to Crowns and Inlays Surgical Extractions of Impacted Teeth	50%	50%	50%	50%
Class IV – Orthodontia (Applies to employees and all dependents)	50%	50%	50%	50%
Missing Tooth Limitation	No coverage until insured for 24 months; thereafter, considered a Class III expense.			

Pretreatment review is suggested when dental work in excess of \$200 is proposed. All plan deductibles and maximums (dollar and occurrence) cross-accumulate between In-Network and Out-of-Network unless otherwise noted.

Exclusions

Covered expenses will not include, and no payment will be made for, expenses incurred for:

- Services performed solely for cosmetic reasons;
- Replacement of a lost or stolen appliance;
- Replacement of a bridge, crown or denture within five years after the date it was originally installed unless: (a) such replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or (b) the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits;
- Any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- Procedures, appliances or restorations (except full dentures) whose main purpose is to (a) change vertical dimension; (b) diagnose or treat conditions or dysfunction of the temporomandibular joint; (c) stabilize periodontally involved teeth; or (d) restore occlusion;
- Porcelain or acrylic veneers of crowns or pontics on or replacing the upper and lower first, second or third molars;
- Bite registrations; precision or semi-precision attachments; or splinting;
- Instruction for plaque control, oral hygiene and diet;
- Dental services that do not meet common dental standards;
- Services that are deemed to be medical services;
- Services and supplies received from a hospital;
- Services for which benefits are not payable according to the “General Limitations” section.

In addition, these benefits will be reduced so that the total payment will not be more than 100% of the charge made for the Dental Service if benefits are provided for that service under this plan and any medical expense plan or prepaid treatment program sponsored or made available by your Employer.

General Limitations

No payment will be made for expenses incurred for you or any one of your Dependents:

- For or in connection with an injury arising out of, or in the course of, any employment for wage or profit;
- For or in connection with a sickness which is covered under any workers’ compensation or similar law;
- For charges made by a Hospital owned or operated by or which provides care or performs services for the United States Government, if such charges are directly related to a military service connected condition;
- To the extent that payment is unlawful where the person resides when the expenses are incurred;
- For charges which the person is not legally required to pay;
- To the extent that they are more than either the applicable Contracted Fee, applicable Reasonable or Customary Charges or applicable Scheduled Amount;
- For charges for unnecessary care, treatment or surgery;
- To the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid; or
- For or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.
- No payment will be made for expenses incurred by you or any one of your Dependents to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a “no-fault”

insurance law or an uninsured motorist insurance law. Connecticut General Life Insurance Company will take into account any adjustment option chosen under such part by you or any one of your Dependents.

This Fee Overview highlights some of the benefits available under your plan. A complete description regarding the terms of coverage, exclusions and limitations, including benefits will be provided in your insurance certificate or plan description. In case of discrepancy between this Fee Overview and your plan documents, the plan documents will prevail.

CIGNA Dental refers to the following operating subsidiaries of CIGNA Corporation: Connecticut General Life Insurance Company and CIGNA Dental Health, Inc., and its operating subsidiaries. The CIGNA Dental Care plan is provided by CIGNA Dental Health Plan of Arizona, Inc.; CIGNA Dental Health of California, Inc.; CIGNA Dental Health of Colorado, Inc.; CIGNA Dental Health of Delaware, Inc.; CIGNA Dental Health of Florida, Inc., a Prepaid Limited Health Services Organization licensed under Chapter 636, Florida Statutes; CIGNA Dental Health of Kansas, Inc. (Kansas and Nebraska); CIGNA Dental Health of Kentucky, Inc.; CIGNA Dental Health of Maryland, Inc.; CIGNA Dental Health of New Jersey, Inc.; CIGNA Dental Health of New Mexico, Inc., (available only in Albuquerque and Santa Fe); CIGNA Dental Health of North Carolina, Inc.; CIGNA Dental Health of Ohio, Inc.; CIGNA Dental Health of Pennsylvania, Inc.; CIGNA Dental Health of Texas, Inc., CIGNA Dental Health of Virginia, Inc. In other states, the CIGNA Dental Care plan is underwritten by Connecticut General Life Insurance Company and administered by CIGNA Dental Health, Inc. The CIGNA Dental PPO is underwritten or administered by Connecticut General Life Insurance Company with network management services provided by CIGNA Dental Health, Inc., and certain of its operating subsidiaries. The CIGNA Traditional plan is underwritten or administered by Connecticut General Life Insurance Company.



Why enroll in a VSP® Vision Care plan? Because we'll help keep you and your eyes healthy with personalized care from a doctor you can trust.

You'll like what you see with VSP:

- **Personalized Care.** Our doctors take the time to get to know you and your eyes. They'll look for vision problems and signs of other health conditions too.
- **Doctor Network.** You'll find the VSP doctor who's right for you at vsp.com or by calling us at **800.877.7195**. Our doctors offer flexible hours, a variety of office settings, and eyewear choices you'll love.
- **Value and Savings.** You'll get great savings on your eye exam and eyewear, and discounts on laser vision correction.
- **Satisfaction Guaranteed.** You'll be 100% happy or we'll make it right.

**Enroll today.
You'll be glad you did.**

Once enrolled, simply tell your VSP doctor you're a member. We'll handle the rest.

Contact VSP vsp.com
800.877.7195



Compass Group and VSP provide you with an affordable eyecare plan. Sign up for VSP today.

Your Coverage from a VSP Doctor

WellVision Exam® focuses on your eye health and overall wellness

- No copay **every calendar year**

Prescription Glasses

- \$15 copay

Lenses..... **every calendar year**

- *Single vision, lined bifocal, and lined trifocal lenses*
- *Polycarbonate lenses for dependent children*

Frame..... **every other calendar year**

- \$140 allowance for frame of your choice
- 20% off the amount over your allowance

~OR~

Contact Lens Care

- No copay **every calendar year**

\$120 allowance for contacts and the contact lens exam (fitting and evaluation). If you choose contact lenses you will be eligible for a frame one calendar year from the date the contact lenses were obtained.

Current soft contact lens wearers may be eligible for a special program that includes an initial contact lens evaluation and initial supply of lenses.

Extra Discounts and Savings

Glasses and Sunglasses

- Average 35 - 40% savings on all non-covered lens options
- 30% off additional glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your WellVision Exam. Or get 20% off from any VSP doctor within 12 months of your last WellVision Exam

Contacts

- 15% off cost of contact lens exam (fitting and evaluation)

Laser Vision Correction

- Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities.
- After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor

VSP guarantees service from VSP doctors only. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.



For Office Use Only
EFF. DATE

2010 ENROLLMENT FORM
ESS Support Services

ASSOCIATE'S NAME: _____ SOC.SEC.# _____

HOME ADDRESS: _____

CITY: _____ STATE _____ ZIP CODE _____

HOME PHONE: _____ JOB TITLE: _____

A. INSURANCE PLAN OPTIONS

Eligible associates may pick medical, dental, both, or no coverage.

Blue Cross Blue Shield Network Choice Plan	<u> </u>	Associate only	<u> </u>	<u>Payroll Deduction</u>
	<u> </u>	Associate + 1 Dependent	<u> </u>	\$162.15 per month
	<u> </u>	Associate + Family	<u> </u>	\$327.75 per month
				\$511.75 per month

Blue Cross Blue Shield Value Choice Plan	<u> </u>	Associate only	<u> </u>	\$ 60.38 per month
	<u> </u>	Associate + 1 Dependent	<u> </u>	\$299.00 per month
	<u> </u>	Associate + Family	<u> </u>	\$450.80 per month

Cigna Dental PPO Plan	<u> </u>	Associate only	<u> </u>	\$ 28.87 per month
	<u> </u>	Associate + 1 Dependent	<u> </u>	\$ 58.45 per month
	<u> </u>	Associate + Family	<u> </u>	\$ 119.07 per month

Waive Coverage
 No Coverage

These premium co-pays remain in effect through 12/31/10 or Contract date.

The benefit levels in these plans are attached and are determined by the provider.

I have made my 2010 benefit elections on this form. I authorize the company to deduct from my pay any necessary contributions for my coverage on a pre-tax basis for so long as the IRS permits this procedure.

I understand that I cannot change my benefit elections until January 1, 2011, unless my family or employment status changes, and that my requested action must be consistent with that family or employment status change. If a family or employment status change occurs, a completed benefits change form with appropriate documentation must be received by the ESS Support Services Human Resources Department within 30 days of the event.

Associate Signature _____ Date _____



For Office Use Only
EFF. DATE

2010 Vision Enrollment Form

ASSOCIATE'S NAME: _____ SOC.SEC.# _____

HOME ADDRESS: _____

CITY: _____ STATE _____ ZIPCODE _____

HOME PHONE: _____ JOB TITLE: _____

DATE OF BIRTH: _____

Vision Service Plan (VSP)

_____ Associate only	\$7.80 per month
_____ Associate + 1 Dependent	\$11.31 per month
_____ Associate + Family	\$20.28 per month

Dependent Information

<u>Name</u>	<u>Social Security #</u>	<u>Date of Birth</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

These premium co-pays remain in effect through 12/31/10 or Contract date.

The benefit levels in these plans are attached and are determined by the provider.

I have made my 2009 benefit elections on this form. I authorize the company to deduct from my pay any necessary contributions for my coverage on a pre-tax basis for so long as the IRS permits this procedure.

I understand that I cannot change my benefit elections until January 1, 2011, unless my family or employment status changes, and that my requested action must be consistent with that family or employment status change. If a family or employment status change occurs, a completed benefits change form with appropriate documentation must be received by the ESS Support Services Human Resources Department within 30 days of the event.

Associate Signature _____ Date _____



Support Services

BCBS Health Insurance Enrollment Form



1. Employee Name	2. Social Security Number	3. Choose the desired medical plan (circle one): VALUE CHOICE or NETWORK CHOICE		For Office Use Only:
4. Reason for completing form: New Enrollment	Effective Date 01 / 01 / 2010	Date Of Hire	Benefit Office Initials	Group # _____ Eff Date: _____

7. Home Address	8. City	9. State	10. Zip Code	11. County/Parish
12. Primary Phone	13. Secondary Phone	14. Marital Status	15. Coverage Level: Employee + 1	16. Pharmacy Number
Spouse's Employer:		Do dependents have other health coverage? Yes ___ No ___		
		If Yes, Other Insurance Carrier: Group Number		

List each person to be covered including yourself and each eligible dependent.
List eligible dependents for MEDICAL coverage only.

Name	Relationship to Employee	Social Security No.	Sex	Date of Birth (MM/DD/YY)	Medicare Eligible? (yes or no) *****	Physician Center, ID Code	Current Patient Y/N	For HMO/POS Use Only
1								
2								
3								
4								
5								
6								

***** If dependant is a full time college student, insert name of college in this column.

I CERTIFY THAT ALL INFORMATION ON THIS APPLICATION FOR COVERAGE IS CORRECT. I AGREE ON BEHALF OF MYSELF AND MY COVERED DEPENDENTS TO ABIDE BY ALL TERMS AND CONDITIONS OF THE PLAN I HAVE SELECTED AS DESCRIBED IN THE GROUP MEMBERSHIP DOCUMENTS. I AUTHORIZE ANY PHYSICIAN, HOSPITAL, OR OTHER HEALTH CARE PROVIDER TO RELEASE THE MEDICAL RECORDS OF EACH PERSON COVERED BY THIS APPLICATION TO THE HMO/POS I HAVE SELECTED AT THEIR REQUEST.

FOR THOSE REGIONS THAT REQUIRE ARBITRATION: THE PARTICIPANT AGREES THAT HE OR SHE AND ALL DEPENDENTS ENROLLING IN THE PLAN SHALL ABIDE BY THE PROVISION OF THE GROUP MEDICAL AND HOSPITAL SERVICE AGREEMENT, INCLUDING THE PROVISION REQUIRING THAT ALL CLAIMS ARISING FROM ALLEGED VIOLATION OF ANY DUTY INCIDENT TO HIS OR HER AGREEMENT WITH THE HMO/POS, INCLUDING ANY CLAIM FOR MEDICAL OR HOSPITAL NEGLIGENCE, BE SUBJECT TO BINDING ARBITRATION, AS PROVIDED FOR IN THE GROUP MEDICAL AND HOSPITAL SERVICE AGREEMENT.

SIGNATURE ON FILE _____ Date: _____

Enrollment / Change Form (Consolidated)

Insured and/or Administered by
 Connecticut General Life Insurance Company
 CIGNA Healthcare



Please print and thank you for providing this information

A

OPEN ENROLL CHANGE REINSTATE
 NEW ENROLL CANCEL

EFFECTIVE DATE OF ADD/CHANGE/CANCELLATION (MM/DD/CCYY) 01-01-10
 DIVISION/BRANCH/LOCATION/CLASS NETWORK ID BRANCH CODE COH GROUP NO MEDICAL BEN. OPTION DENTAL BEN. OPTION CIGNA CHOICE FUND ANNUAL AMOUNT

EMPLOYER NAME EMPLOYER ADDRESS EMPLOYEE IDENTIFICATION NUMBER
 HOME PHONE HOME E-MAIL ADDRESS (State) ZIP Code

DATE OF HIRE (MM/DD/CCYY) NETWORK ID BRANCH CODE COH GROUP NO MEDICAL BEN. OPTION DENTAL BEN. OPTION CIGNA CHOICE FUND ANNUAL AMOUNT

TYPE OF CHANGE:
 Add Dependent(s) * Date: _____
 Cancel Employee Last Date of Coverage: _____
 Cancel Dependent(s) * Last Date of Coverage: _____

Address Change
 Transfer to COBRA
 18 mos. 29 mos. 36 mos.

Family Security Benefit/ Surviving Spouse
 Retirement
 Other

* List Names in Section B

B

EMPLOYEE NAME (Last, First, MI) SOCIAL SECURITY #

EMPLOYEE DATE OF BIRTH (MM/DD/CCYY) HOME PHONE WORK PHONE HOME E-MAIL ADDRESS EMPLOYEE IDENTIFICATION NUMBER
 ADDRESS (Street) City State ZIP Code

Last Name	First Name	M.I.	DATE OF BIRTH	DEPENDENT SOCIAL SECURITY NO.	GEN- DER	COVERAGE SELECTION	FULL TIME STUDENT?	If you choose a Managed Care Medical Option: Select your choice of Primary Care Physician (PCP) or Health Care Center (HCC) and enter the ID Numbers below. Note: PCP selection is optional for Open Access Plans.	EXISTING PATIENT?	If you choose the CIGNA Dental Care Option: Enter your 1st and 2nd choice of Dental Office Number below.	EXISTING PATIENT?	DENTAL OPTIONS:
Employee								PCP or HCC Choice				
Spouse								PCP or HCC Choice				
Dependent *								PCP or HCC Choice				
Dependent *								PCP or HCC Choice				
Dependent *								PCP or HCC Choice				

C

MANAGED CARE MEDICAL OPTIONS:
 Point-of-Service (or DPP or CHA) HMO Open Access Network Open Access Open Access Plus Network (or EPP) Point-of-Service Open Access In-Network

OTHER MEDICAL OPTIONS:
 Preferred Provider Option (PPO) In-Network PPO or EPO Preferred Provider Access (PPA) Medical Indemnity

CIGNA CHOICE FUND OPTIONS:
 HRA HSA Pharmacy HRA Dental HRA with PPO with Open Access Plus with EPO with Indemnity Decline Coverage Decline Coverage

OPTION # (if applicable): 1: 2: 3:

If you choose a Managed Care Medical Option other than Open Access Plus, print the name of the CIGNA HealthCare network. (See the cover or first page of the physician directory). Include the name of the city and state.

D

FLEXIBLE SPENDING ACCOUNT OPTIONS:
 Health Care Dependent Day Care Decline Coverage

DENTAL OPTIONS:
 CIGNA Dental Care (CDC) Dental PPO Dental EPO Decline Indemnity Decline Coverage

E

OTHER HEALTH CARE COVERAGE:
 Do you or your dependents have other health insurance under a group plan, HMO, or Medicare? Yes No

NAME OF PERSON COVERED SOCIAL SECURITY NO. EFFECTIVE DATE MEDICARE Part A Part B MEDICAID OTHER INSURANCE CARRIER

F

SIGNATURE - The information provided above is true and correct to the best of my knowledge, and I accept the provisions on the reverse side of this form which I have read and understand.
 EMPLOYEE'S SIGNATURE / DATE SPOUSE'S SIGNATURE / DATE EMPLOYER'S SIGNATURE / DATE

**ESS SUPPORT SERVICES
CAFETERIA PLAN
SALARY REDUCTION AGREEMENT**

I, _____ SS# _____, hereby make the following election regarding the benefits available to me under the ESS SUPPORT SERVICES Cafeteria Plan. I am further making an election to have my taxable compensation reduced by an amount equal to the value of the benefits specified below, such amount to be deducted in approximately equal sums from my regular pay check during the plan year beginning January 1, 2010.

Benefit(s) Effective Date: 1/1/2010

BENEFITS AVAILABLE	2010 ELECTION	
Group Health Insurance	\$ _____ Monthly	
Supplemental Insurance	\$ _____ Monthly	
Dental PPO Plan	\$ _____ Monthly	
Vision	\$ _____ Monthly	
Unreimbursed Medical Expense	\$ _____ Monthly	\$ _____ Annually
Dependent Care Assistant Plan (Day Care)	\$ _____ Monthly	\$ _____ Annually
Individually Owned Medical	\$ _____ Monthly	\$ _____ Annually

_____ **YES**, I want to participate in the Plan and receive the benefits as shown above. I have read the Summary Plan Description and the Plan Summary give to me by my employer. I understand that I cannot change or revoke this election unless I have a "Change in Status".

Signature _____ Date _____



FORT DEARBORN LIFE
Insurance Company

A Packet

Of

Voluntary Group
Insurance Benefits

For

ESS SUPPORT SYSTEMS

Presented by:

Dwight Andrus Insurance

Underwritten By:

Fort Dearborn Life Insurance Company • Downers Grove, IL



FORT DEARBORN LIFE
Insurance Company
 Chicago, Illinois

Especially Designed for the Employees of:
Eurest Support Services

The Voluntary STD plan **provides bi-weekly benefit payments** for loss of income in the event of a disability which results from a non-occupational Accident or Sickness.

- WAITING PERIODS.....** *0 Days Accident, 7 Days Sickness*
- BENEFIT PERIOD.....** *26 weeks*
- BENEFIT AMOUNTS.....** *Employee choice from \$100 to \$750 per week.
 Not to exceed 60% of income.*

- No Minimum Participation Requirements.**
- Guaranteed Issue.** No evidence of insurability required.
- 12 month waiting period** on pre-existing conditions.
- Pregnancy is covered** as any other illness.
- Plan provides a Partial Disability Benefit.**

STD Weekly Premiums

Age	\$100/wk	\$150/wk	\$200/wk	\$250/wk	\$300/wk	\$350/wk	\$400/wk
Under 40	3.72	5.57	7.43	9.29	11.15	13.00	14.86
40-49	3.35	5.02	6.69	8.37	10.04	11.71	13.38
50-59	4.48	6.72	8.95	11.19	13.43	15.67	17.91
60 & Over	6.35	9.52	12.69	15.87	19.04	22.21	25.38

Age	\$450/wk	\$500/wk	\$550/wk	\$600/wk	\$650/wk	\$700/wk	\$750/wk
Under 40	16.72	18.58	20.43	22.29	24.15	26.01	27.87
40-49	15.06	16.73	18.40	20.08	21.75	23.42	25.10
50-59	20.15	22.38	24.62	26.86	29.10	31.34	33.58
60 & Over	28.56	31.73	34.90	38.08	41.25	44.42	47.60

*3 out of 10 working individuals between the ages of 25 & 65 will become disabled for 90 days or longer.

**Accident Facts, 1992 Edition, by National Safety Council*

So, protect your most important asset, YOUR PAYCHECK!!



*Especially Designed for the Employees of:
Eurest Support Services*

The Voluntary LTD plan provides monthly benefit payments for loss of income in the event of a total disability which results from an Accident or Sickness. Details regarding benefits provisions and limitations are explained more completely on the back of this form.

- ELIMINATION PERIOD:** 180 Day Accident, 180 Day Sickness
- MAXIMUM BENEFIT PERIOD:** 5 Years for Accidents, 2 Years for Sickness, with reducing benefit duration in compliance with ADEA
- WEEKLY BENEFIT AMOUNT** Employee choice from \$100 to \$1,150 per week.
Buy Down OPTION: \$50 increments. Not to exceed 60% of income.
- WAIVER OF PREMIUM:** Premium payments are waived during any period for which benefits are payable
- 24 MONTHS COVERAGE ON:** Own occupation, Mental Illness or Substance Abuse

- Guaranteed Issue.** No evidence of insurability required.
- 12/6/24 pre-existing condition exclusion applies. (12/12 in some states--see reverse)
- Pregnancy covered as illness.
- Minimum participation required is 2 enrollees.**
- Coordinates with Social Security and other income benefits.
Minimum monthly benefit is \$100

LTD WEEKLY PREMIUM

Age	29 & Under	30-39	40-44	45-49	50-54	55-59	60 & Over
\$100/wk	0.72	1.14	1.55	2.25	3.22	4.47	7.55
\$150/wk	1.08	1.70	2.33	3.38	4.83	6.70	11.32
\$200/wk	1.44	2.27	3.10	4.50	6.43	8.93	15.09
\$250/wk	1.79	2.84	3.88	5.62	8.04	11.16	18.86
\$300/wk	2.15	3.40	4.65	6.75	9.65	13.39	22.63
\$350/wk	2.51	3.97	5.42	7.87	11.25	15.62	26.40
\$400/wk	2.87	4.53	6.20	9.00	12.86	17.85	30.17
\$450/wk	3.23	5.10	6.97	10.12	14.47	20.08	33.95
\$500/wk	3.58	5.67	7.75	11.24	16.07	22.32	37.72
\$550/wk	3.94	6.23	8.52	12.37	17.68	24.55	41.49
\$600/wk	4.30	6.80	9.30	13.49	19.29	26.78	45.26
\$650/wk	4.66	7.36	10.07	14.61	20.89	29.01	49.03
\$700/wk	5.02	7.93	10.84	15.74	22.50	31.24	52.80
\$750/wk	5.37	8.50	11.62	16.86	24.11	33.47	56.57
\$800/wk	5.73	9.06	12.39	17.99	25.71	35.70	60.34
\$850/wk	6.09	9.63	13.17	19.11	27.32	37.93	64.12
\$900/wk	6.45	10.19	13.94	20.23	28.93	40.16	67.89
\$950/wk	6.81	10.76	14.72	21.36	30.53	42.40	71.66
\$1000/wk	7.16	11.33	15.49	22.48	32.14	44.63	75.43
\$1050/wk	7.52	11.89	16.26	23.61	33.75	46.86	79.20
\$1100/wk	7.88	12.46	17.04	24.73	35.35	49.09	82.97
\$1150/wk	8.24	13.02	17.81	25.85	36.96	51.32	86.74



Voluntary Accidental Death & Dismemberment

Voluntary AD&D pays a benefit in the event of accidental death.
The plan provides 24 hour coverage, on or off the job.

Two plans are available:

The *Individual Plan* allows the employee to choose up to \$500,000 in increments of \$10,000.

The *Family Plan* allows the employee to insure his or her spouse and / or dependent children*. The spouse benefit is 50% of the employee's benefit and each child* is covered for 10% of the employee's benefit amount.

* children are covered from 15 days until age 18 (23 if full time student).

The Voluntary AD&D Plan is Guaranteed Issue up to \$500,000

The Plan is available for groups with 2 or more employees

No Minimum Participation Required

All Industries/Occupations are eligible

Weekly Premium:

	Rate per mo. per thousand	\$50,000	\$100,000	\$150,000	\$200,000	\$250,000
Employee Only	\$0.05	\$0.58	\$1.16	\$1.74	\$2.32	\$2.90
Full Family	\$0.08	\$0.94	\$1.85	\$2.79	\$3.70	\$4.63

		\$300,000	\$350,000	\$400,000	\$450,000	\$500,000
Employee Only		\$3.48	\$4.06	\$4.64	\$5.22	\$5.80
Full Family		\$5.55	\$6.49	\$7.40	\$8.37	\$9.25

Product Features:

Seat Belt Benefit: Pays an additional benefit equal to the employee benefit (up to \$25,000) if an insured employee dies as the result of a covered accident and his seat belt was in actual use. There is no additional cost for this benefit.

Repatriation Benefit: If an insured employee dies as a result of a covered accident at least 75 miles from his principal residence, up to \$5,000 will be paid for the preparation and transportation of the insured employee's body.

Education Benefit: Under the family plan if an insured employee dies as a result of a covered accident, each insured child will receive reimbursement for incurred educational expenses in a school of higher education beyond the 12th grade. The maximum education benefit is equal to the lesser of the employee benefit amount or \$12,000 and will be payable in four equal installments. A benefit of \$1,000 is payable for children in elementary or high school. (Not available in all states)

Common Disaster Benefit: Under the family plan if the employee and spouse both die within 90 days of the date of, and as a result of the same accident, the spouse's benefit will be increased to 100% of the employee's benefit.



FORT DEARBORN LIFE
Insurance Company
Chicago, Illinois

New Enrollment Change

Enrollment Form

Administrative Offices: Downers Grove, Illinois | Cleveland, Ohio | Dallas, Texas

EMPLOYER: If group is self-administered, submit enrollment form *only* if evidence of insurability is required. If group is not self administered, submit enrollment form to us.

EMPLOYEE NAME – LAST		FIRST	MIDDLE INITIAL	SEX M <input type="checkbox"/> F <input type="checkbox"/>	DATE OF BIRTH	DATE OF HIRE (FULL TIME)
SOCIAL SECURITY NO. (THIS IS YOUR CERTIFICATE NO.)		EARNINGS \$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annual		JOB TITLE		CLASS
EMPLOYER			GROUP NO./ACCOUNT NO. /		LOCATION	

COVERAGE SELECTION: Your non-medical group insurance program may not include all the benefits listed below. Ask your employer for the details about the benefits available to you, your cost, if any, and whether you will be required to complete a health questionnaire.

BASIC COVERAGE(S)				Supplemental Life	Supplemental AD&D	Other
Basic Life/AD&D <input type="checkbox"/> YES <input type="checkbox"/> NO	STD Benefit <input type="checkbox"/> YES <input type="checkbox"/> NO	LTD Benefit <input type="checkbox"/> YES <input type="checkbox"/> NO	Dependent Life <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Del. \$ _____	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Del. \$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No \$ _____

VOLUNTARY COVERAGE(S) (Evidence of Insurability may be required on employee and spouse Life and Critical Illness Insurance)	(A)dd (C)hange (D)elete	Total Amount of Coverage Applied for	If (C), my prior coverage was
Voluntary Term Life: Employee <input type="checkbox"/> YES <input type="checkbox"/> NO			
Voluntary Term Life: Spouse <input type="checkbox"/> YES <input type="checkbox"/> NO			
Voluntary Term Life: Dependent Child(ren) <input type="checkbox"/> YES <input type="checkbox"/> NO			
Voluntary AD&D: Individual Plan <input type="checkbox"/> YES <input type="checkbox"/> NO			
Voluntary AD&D: Family Plan <input type="checkbox"/> YES <input type="checkbox"/> NO			
Voluntary Short-Term Disability <input type="checkbox"/> YES <input type="checkbox"/> NO			
Voluntary Long-Term Disability <input type="checkbox"/> YES <input type="checkbox"/> NO			
Voluntary Critical Illness with Cancer Benefit <input type="checkbox"/> YES <input type="checkbox"/> NO			
Voluntary Critical Illness without Cancer Benefit <input type="checkbox"/> YES <input type="checkbox"/> NO			

SPOUSE NAME – LAST (if applicant)	FIRST	M.I.	SEX M <input type="checkbox"/> F <input type="checkbox"/>	SPOUSE DATE OF BIRTH	SPOUSE SOCIAL SECURITY #
Has Employee (if applicant) used cigarettes or other tobacco products in the last 2 years? <input type="checkbox"/> YES <input type="checkbox"/> NO			Has Spouse (if applicant) used cigarettes or other tobacco products in the last 2 years? <input type="checkbox"/> YES <input type="checkbox"/> NO		

*** Review the following guidelines which apply to voluntary coverage(s)**

- You may enroll, apply for additional coverage, or request a change to current voluntary benefits only during a scheduled enrollment period.
- Your weekly STD benefit may not exceed 60% of your basic weekly earnings (excluding bonuses, overtime and any extra compensation other than commissions).
- If you are eligible for state-mandated temporary disability benefits, or any employer sponsored income replacement benefits, the combination of your state mandated benefit or other income benefit and your STD weekly benefit may not exceed 60% of your basic weekly earnings.
- New Voluntary STD plans and benefit increases are subject to a 12/12 pre-existing condition limitation (3/12 in PA).
- Your Voluntary LTD benefit may not exceed 60% of your basic earnings (excluding bonuses, overtime and any extra compensation other than commissions).
- New Voluntary LTD plans and benefit increases are subject to a 12/6/24 pre-existing condition limitation (12/12 in CO, MS, SC, MT, CT, WI; 3/12 in PA).
- If your earnings are based in whole or in part on commissions, commissions will be averaged over the 12-month period prior to the date disability begins.

BENEFICIARY DESIGNATION (For Employee Only: Must Be Completed if you have applied for life or AD&D insurance) If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100%. (Employee is the beneficiary of proceeds from spouse or child coverage.)

FIRST NAME	LAST NAME	DATE OF BIRTH	RELATIONSHIP	SOCIAL SECURITY #	BENEFIT %
Primary					%
Primary					%
Contingent					%

I HEREBY REQUEST TO BE INSURED AND AUTHORIZE DEDUCTIONS, IF ANY, FROM MY COMPENSATION FOR MY SHARE OF THE COST OF THE BENEFITS TO WHICH I MAY BE ENTITLED UNDER THE GROUP POLICY (IES) ISSUED TO THE EMPLOYER LISTED ABOVE. I UNDERSTAND THAT IF I AM NOT ACTIVELY AT WORK AS DEFINED IN THE POLICY ON THE DATE MY COVERAGE WOULD OTHERWISE BECOME EFFECTIVE, MY INSURANCE WILL NOT BEGIN UNTIL THE DAY I MEET THE POLICY DEFINITION OF ACTIVELY AT WORK. FOR THOSE COVERAGES I HAVE DECLINED, I UNDERSTAND THAT IF I CHOOSE TO ENROLL AT A LATER DATE, MY COST MAY BE HIGHER AND A HEALTH QUESTIONNAIRE MAY BE REQUIRED.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties. (Not enforceable in OR or VA.)

EMPLOYEE SIGNATURE _____ DATE ____ / ____ / ____

FOR FDL USE ONLY



PART I: TO BE COMPLETED BY POLICYHOLDER (Please Print)

Group Number _____	FOR FDL USE ONLY	
	EMPLOYEE <input type="checkbox"/> Approved <input type="checkbox"/> Declined <input type="checkbox"/> Cancelled <input type="checkbox"/> Smoker <input type="checkbox"/> Nonsmoker	SPOUSE <input type="checkbox"/> Approved <input type="checkbox"/> Declined <input type="checkbox"/> Cancelled <input type="checkbox"/> Smoker <input type="checkbox"/> Nonsmoker
Group Name and Address _____	GI <input type="checkbox"/> No <input type="checkbox"/> Yes \$ _____	GI <input type="checkbox"/> No <input type="checkbox"/> Yes \$ _____
	AMOUNT APPROVED \$ _____ Eff. Date _____	AMOUNT APPROVED \$ _____ Eff. Date _____
Group Contact _____ (Print Name)	Reviewed by _____ Date _____	Reviewed by _____ Date _____
Group Contact _____ (Print Title)	CHILD(REN) <input type="checkbox"/> Approved <input type="checkbox"/> Declined Eff. Date: _____	State Code _____ Agency (CB)(TPA) _____
Telephone (____) _____	New Hire Waiting Period _____	<input type="checkbox"/> Self-Admin <input type="checkbox"/> Direct Bill _____

PART II: TO BE COMPLETED BY EMPLOYEE Voluntary Life Amount over Guarantee Issue Late Enrollment

Employee Name	Last	First	M.I.	Date of Birth	Age	Sex	State of Birth
				/	/	<input type="checkbox"/> M <input type="checkbox"/> F	
Home Mailing Address - Street		City	State	Zip	Work Telephone	Home Telephone	
					()	()	
Social Security #	Employee Height _____ ft. _____ in.		Weight _____ lbs.	Spouse/Dep. Height _____ ft. _____ in.		Weight _____ lbs.	
Spouse/Dep.	Last	First	M.I.	Social Security #	Date of Birth	Age	State of Birth
					/	/	

PART III: INSURABILITY QUESTIONNAIRE (Underline condition & record details in PART IV.)

	Employee	Spouse/Dep.
1. Have you used cigarettes or other tobacco products in the last 2 years?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
2. Within the past 5 years, have you been medically counselled or treated for, or been told by a medical practitioner that you had: heart murmur; high blood pressure; heart attack; any disease of the heart or blood vessels; diabetes; albumin; blood or sugar in urine; any kidney disorder; tumor; cancer; asthma; lung or respiratory disorder; any disease of the stomach, liver or intestines; back, spine or bone disease or disorder; epilepsy; any mental or nervous system disorder?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
3. Within the past 5 years have you been diagnosed by or received treatment from a member of the medical profession for AIDS or ARC (AIDS Related Complex) or any other immunological disorders?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
4. Within the past 5 years have you consulted or been attended by a doctor, psychiatrist, psychologist or medical practitioner for any health reason or condition not disclosed in the preceding questions?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
5. Are you presently receiving any treatment by a medical practitioner or taking any medication?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
6. Have you ever had or been told by a medical practitioner that you had (or still have) a problem with substance abuse?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
7. Have you ever been rated, declined, postponed or limited in any way for life, health, accident or sickness insurance?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

PART IV: Provide details of all 'YES' answers given to questions in PART III. - If additional space is required, attach a separate signed and dated sheet.

Question # & Individual	Illness/Reason for Checkup or Doctor's Treatment/Consultation	Dates From To	Full Name, Complete Address and Telephone # of Attending Physician or Other Practitioner

YOU MUST COMPLETE BOTH PAGES OF THIS APPLICATION IN ORDER TO BE CONSIDERED FOR COVERAGE.



Employee Name _____ Social Security # _____

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties. (Not enforceable in Oregon or Virginia.)

AGREEMENTS AND AUTHORIZATION: I, the undersigned applicant(s), have read and agree that the above statements are complete, true and correctly recorded to the best of my knowledge and belief. Further, I understand Fort Dearborn Life Insurance Company (FDL) shall not be liable for any claim arising prior to the date of approval of this application at FDL's Home Office.

To determine my eligibility for the coverages applied for, I authorize any medical professional, hospital, medical facility, medical provider, the MIB Group, Inc., or any Covered Entity or Health Plan as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to disclose to FDL's underwriting department or its authorized representative(s) my medical records, or that of my children, including information concerning advice, care or treatment for any condition, including but not limited to drug or alcohol use or abuse, mental illness, HIV (AIDS Virus) or other sexually transmitted diseases.

I further authorize FDL to disclose the information obtained in the consideration of my application for insurance to its reinsurers and the MIB Group, Inc. a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members.

This authorization shall expire 24 months from the date it is signed. I understand and agree that:

- I may revoke this authorization at any time, but that such a revocation will have no effect on any actions taken by FDL prior to receipt of the revocation;
- Information disclosed may be redisclosed and no longer protected by federal privacy laws;
- I should retain a duplicate copy of this authorization for my own records;
- A photocopy of this authorization shall be as valid as the original;
- I have received a Disclosure Statement; and
- Coverage will not become effective until FDL approves my application, provided that I am actively at work on that day.

I as well as any other person authorized to act on my behalf or my personal representative, acknowledge the right upon request to obtain a true copy of this authorization from FDL.

If my answers on this application are incorrect or untrue, or if I refuse to sign this authorization, FDL has the right to deny benefits or rescind my coverage or that of my dependents, if applicable.

 Signature of Employee

 Date

 Signature of Spouse (if requesting insurance)

 Date

 Signature of Dependent Child (if to be insured and of age of majority)

 Date



(Please retain with your insurance records)

Thank you for enrolling for Group Insurance with Fort Dearborn Life Insurance Company. To assist us in processing the group policy, your signature on the Agreements and Authorization section of the Evidence of Insurability form authorizes information concerning proposed insureds to be released relative to each person's insurability. You or your personal representative are entitled to receive a copy of this authorization.

Information regarding your insurability will be treated as confidential. Fort Dearborn Life Insurance Company or its designated representative(s) may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization, of life insurance companies which operates as an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such company, the Bureau, upon request, will supply each company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston MA 02112, telephone number 866-692-6901 (TTY 866-346-3642).

Fort Dearborn Life Insurance Company, its reinsurers, or designated representative(s) may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

