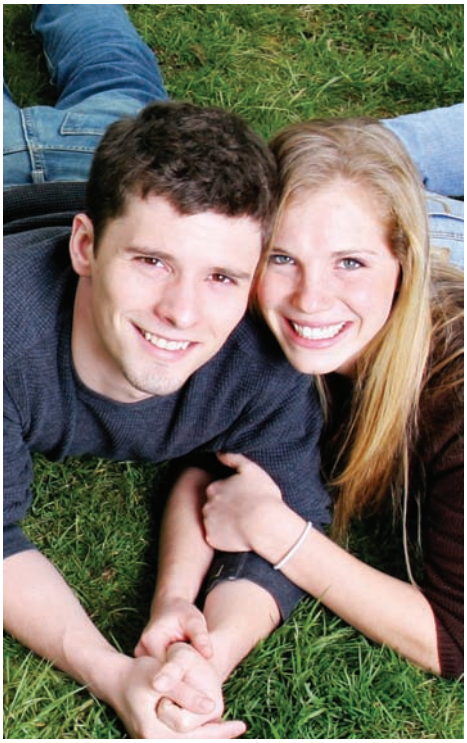

Your Full-time Benefits Program Guide

Coverage that fits

Federated
DEPARTMENT STORES, INC.

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bloomingdale's

1-800-337-2363

Coverage that fits

Your Full-time Benefits Program Guide

Contents

Read this Program Guide carefully…

Why This Program Guide?

The purpose of this Program Guide is to give eligible full-time associates detailed information about the nationwide group benefits program. Use this guide to help you select coverage that fits you and your family.

How Do I Enroll in Benefits?

Before you are eligible to enroll, Federated HR Services will mail a notice with instructions to your home. When you receive this notice, you can visit the Company's intranet site, *in-site*, to enroll in or change your benefits. Log on to *in-site* from work or by visiting the website www.employeeconnection.net after you receive your notice.

WHAT'S AVAILABLE ON *in-site*:

- Benefit Highlights - general information about the group benefit plans
- Benefit Comparison Chart booklets
- Certification of Change in Family Status Form to use when reporting a change in family status within 31 days of the change
- Links to health carriers and the Health Savings Account and Flexible Spending Accounts vendor, SHPS, Inc.
- Prescription drug coverage information, including a link to Express Scripts, Inc.
- Beneficiary Designation Forms
- And more…

FederatedHR Services

If you have questions about your benefits, call Federated HR Services at 1-800-337-2363.

Getting Started

When you first become eligible for group benefits and again each July 1, you have the opportunity to review your benefit choices and enroll or make any necessary changes. Your enrollment decisions are important because they affect your personal and financial protection. So it's important to make *informed* decisions about your benefits. This Program Guide will help you do that.

Our associates are vital to our day-to-day operations. Regular Full-time associates will be able to choose from the following plans and options:

Available after one month

- Medical Bridge. These options bridge the gap from first of the month following one month of service until the regular Medical options are available the first of the month following six months of service. Three options are available.
- Dental. At least two and as many as three options depending on home ZIP Code.
- Life Insurance. Coverage from half times pay (½ x pay) to six times pay (6 x pay). Dependent coverage also available.
- Accidental Death & Dismemberment (AD&D). Coverage from half times pay (½ x pay) to ten times pay (10 x pay). Family coverage also available.
- Executive Long Term Disability. Coverage in case of long-term disability.
- Health Care Flexible Spending Account (FSA)*. Reimbursement for eligible health care expenses and save on taxes.
- Dependent Care Flexible Spending Account (FSA). Reimbursement for eligible dependent care expenses so an associate can work and save on taxes.

Available after six months

- Medical. *Healthy Choices*: Three options – *Choice Premier*, *Choice Select* and *Choice* – provide choice of plan design, premium and more. Each option includes eye exams and access to the employee assistance program. In some parts of the country, there is an additional option available. Associates and family members enrolled in Company-sponsored medical coverage can take advantage of an employee assistance program.
- Health Savings Account (HSA). A Company-sponsored HSA that provides tax savings for those enrolled in *Choice*, a high-deductible health plan.
- Short Term Disability. Coverage in case of short-term disability. Generally available after six months of coverage. Coverage and plans vary by division. In some cases, coverage is optional.
- Long Term Disability for Hourly Associates. Coverage in case of long-term disability. Generally available after six months of employment. May not be available at all locations.

** A Limited Flexible Spending Account (LFSA) is also available for dental and vision expenses only. You can enroll in a LFSA if you participate in or will participate in a Health Savings Account through the Company or an institution such as a bank.*

Health Care

It's important to make *informed* decisions about your benefits – especially your health care coverage. After six months of employment, the Company shares in the cost of your health care coverage, but the amount **you** pay is still a big purchase for you. Like any other purchase, you should take a careful look at the overall value of your options, the pros and cons of each option, and of course, the cost. Check the details carefully before you make your decisions.

The Health Care Program allows you to elect medical and/or dental coverage as needed, to cover yourself and eligible dependents, and to cover different dependents in medical and dental coverage.

- **Spouse/Domestic Partner.** All health care options allow you to cover your spouse or your eligible same-gender domestic partner. For details, see p. 32.
- **Children.** Generally, eligible dependents include your unmarried children, your children up to age 19, and your children who are full-time students. Coverage for a full-time student ends at the end of the month of his or her 23rd birthday, although age limits for full-time students may vary in some states*. Eligible dependents also include any dependent, unmarried child who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who becomes so incapable prior to reaching age 19, and who is dependent upon the covered associate for support and maintenance. Generally you can cover dependent children of your eligible same-gender domestic partner who meet the same criteria.

* If you enroll in *Choice Premier*, *Choice Select* or *Choice*, your child who is a full-time student can be covered to the end of the month in which he or she turns age 23. Other Company-sponsored medical and/or dental options may allow you to cover dependents over age 23. This list is subject to change.

- Colorado
- Delaware
- Florida
- Georgia
- Illinois
- Iowa
- Kentucky
- Louisiana
- Maine
- Massachusetts
- Minnesota
- Nevada
- New Jersey
- New Mexico
- North Dakota
- Rhode Island
- South Dakota
- Tennessee
- Texas
- Utah
- Virginia

Call (800) 337-2363 for details.

Medical 'Bridge'

After one month of service, you can enroll in one of three medical options on an after-tax basis for the 'bridge' period. The coverage continues until the first of the month following six months of service. Following are details about the High, Mid and Basic options from Starbridge Choices, a CIGNA health insurance plan.

	Star High	Star Mid	Star Basic
Maximums	No lifetime maximum	No lifetime maximum	No lifetime maximum
Physician Services			
Doctor visit	$20 copayment	$20 copayment	$20 copayment
Outpatient Benefits			
Deductible	$100 per plan year	$100 per plan year	$100 per plan year
Maximum benefit	$2,000 per plan year	$2,000 per plan year	$1,500 per plan year
Diagnostic and Surgical	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Emergency Room	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Inpatient Benefits	No deductible; $10,000 maximum benefit; limit 1 occurrence per plan year	No deductible; $5,000 maximum benefit; limit 1 occurrence per plan year	Not included
Accident Benefits	$1,500 maximum benefit per accident; limit 3 accidents per plan year	$1,500 maximum benefit per accident; limit 2 accidents per plan year	Not included
Wellness Benefit	$20 copayment; $100 maximum benefit per plan year	$20 copayment; $100 maximum benefit per plan year	$20 copayment; $100 maximum benefit per plan year
Prescription Drugs			
	$15 copayment, generic $25 copayment, preferred brand Member has advantage of discounted prescription drug rates; $500 maximum benefit/plan year	Member has advantage of discounted prescription drug rates; Starbridge Choices contributes up to $20 toward each prescription; limit 10 prescriptions/plan year	Member has advantage of discounted prescription drug rates; Starbridge Choices contributes up to $20 toward each prescription; limit 5 prescriptions/plan year

For those enrolled in any Starbridge Choices option, a $10,000 benefit is paid in the event of accidental death.

A **24-Hour Health Information line** provides toll-free access to a registered nurse any time, seven days a week, for helpful medical information and advice. In addition, CIGNA's **Employee Assistance Program (EAP)** provides a toll-free number for participants and dependents to talk about a family matter, stress at work or a personal problem.

Online tools include the ability to locate participating physicians, compare doctors by price, research medical conditions and treatments, view plan and benefit information and check claims status and history.

Participants also can take advantage of health and wellness products and services through CIGNA's **Healthy Rewards** program. These include discounts on vision care, weight management, tobacco use cessation, fitness club memberships and magazines.

Healthy Choices Medical Options

Beginning the first of the month following six months of service, the Company offers a nationwide health care program – called *Healthy Choices*. CIGNA HealthCare and BlueCross BlueShield administer the Company's *Healthy Choices* medical options.

You can elect to have your contributions taken on a pre-tax or after-tax basis.

Three medical options provide benefits and services through a national network of participating doctors, hospitals, and other health care specialists and facilities. When you use network providers, the options pay higher benefits – and your expenses are lower.

PLEASE NOTE:

At most locations, the *Healthy Choices* medical options will be the only options available. Locations where Kaiser, Group Health, Health Assurance or HIP is offered will have an additional option. You can elect to have your contributions taken on a pre-tax or after-tax basis.

The provider network and all three medical options – *Choice Premier*, *Choice Select* and *Choice* – are administered by CIGNA HealthCare or BlueCross BlueShield, depending on your work location. In addition, the *Choice* option is designed to meet Federal guidelines to qualify as a "high-deductible health plan," or HDHP, to coordinate with a Company-sponsored or free-standing health savings account (HSA).

All three options pay for certain preventive care services at no cost to you when you use network providers. Eligible preventive care services for children and adults – including routine immunizations and wellness screenings – are subject to benefit limits.

The *Choice Premier* and *Choice Select* options have similar plan designs except *Choice Premier* has a lower deductible and lower coinsurance than *Choice Select*, but your payroll contributions for coverage in *Choice Premier* are also higher.

The *Choice* option has the highest deductibles and the lowest payroll contributions. This option is designed to coordinate with a Health Savings Account, or HSA – a type of spending account participants can establish through the Company or on their own with an outside health insurance carrier or bank to pay for qualified medical and prescription drug expenses. Any deposits you make to an HSA are tax deductible. *Choice* option participants can enroll in the Company's HSA for pre-tax payroll deductions, or make their own arrangements for an HSA directly with a bank or a health insurance carrier.

Express Scripts, Inc. administers prescription drug benefits for *Choice Premier* and *Choice Select*. Retail pharmacy purchases will be subject to coinsurance (with minimum and maximum dollar amounts) and mail order prescription drug purchases will require copayments, or copays. If you elect *Choice Premier* or *Choice Select*, you will receive a separate ID card from Express Scripts for your prescription drug coverage if you do not already have one.

Prescription drug benefits under the *Choice* option are administered by CIGNA or BlueCross BlueShield, depending on where you work, and will be subject to deductibles and coinsurance.

Health management programs are available nationwide for participants in the *Healthy Choices* options – *Nurse Advisor* and personal health report. *Nurse Advisor* will offer confidential, personal assistance from a team of licensed nurses dedicated to Company associates who may need help with any general health care issues, disease management or chronic medical conditions. Personal health report is a voluntary program available after you enroll in one of the *Healthy Choices* options. It's a confidential, online process that provides a personal health assessment to help you monitor your health and learn how to live healthy.

Contact information for CIGNA and BlueCross BlueShield is located at the end of this guide. Their customer service representatives can:

- ✓ Provide information about in-network and out-of-network benefits.
- ✓ Answer questions about network providers.
- ✓ Answer questions about claims.
- ✓ Replace lost ID cards.
- ✓ Answer questions about the prescription drug benefits under the *Choice* medical option.

On and after your coverage effective date, you can use the CIGNA and BlueCross BlueShield websites to request ID cards and check the status of claims. You also may contact Federated HR Services.

PLEASE NOTE:

Most doctors and hospitals that associates currently use are in the ***Healthy Choices*** national networks. However, transition care will be arranged by CIGNA HealthCare and BlueCross BlueShield for associates and covered dependents that enroll in one of the *Choice* medical options and were receiving treatment for certain medical conditions from non-network providers before enrolling. Treatment includes but is not limited to second or third trimester of pregnancy, chemotherapy, or scheduled surgery or planned hospital admission.

A **Transition of Care** form is available on *in-site*. You must complete this form and provide the requested information to continue certain health care services with your current providers for a limited period of time after you enroll. The appropriate carrier and *Nurse Advisor* specialists will work with you to ensure a smooth transition.

The *Healthy Choices* medical options – *Choice Premier, Choice Select* and *Choice* – provide the flexibility you need to help meet your personal and financial needs.

All three *Healthy Choices* options offer an extensive network of doctors, hospitals and other health care providers. Each time you need medical care, you decide whether or not to use network providers. Your costs are typically lower when you use network providers.

Each *Healthy Choices* option has an annual out-of-pocket maximum; generally office visit and provider copayments do not apply toward the maximum. Also, prescription copays and coinsurance under the *Choice Premier* and *Choice Select* options do not apply to your out-of-pocket maximum.

Once your share of covered expenses reaches the out-of-pocket maximum, the plan pays 100% after applicable copays. This feature helps you estimate your potential total expense under each option.

The *Choice Premier* medical option provides the highest level of coverage of the three *Healthy Choices* options. Payroll contributions are higher and the option offers the lowest deductibles and lowest out-of-pocket maximums.

The *Choice Select* medical option has higher out-of-pocket costs than the *Choice Premier* option, and your per pay-period contributions are lower.

***Choice* is a type of medical option that meets Federal guidelines to qualify as a "high-deductible health plan," or HDHP.** The *Choice* option has the highest deductibles and the lowest per pay-period contributions. This option is designed to coordinate with a Health Savings Account, or HSA – a type of spending account. The Company sponsors an HSA and associates can use payroll deduction for these contributions. Or participants can establish an HSA on their own with an outside health carrier or bank.

REASONABLE AND CUSTOMARY (R&C) CHARGES—

Fees charged by a health care provider that are within the range of fees typically charged for the same service by similar providers in the same geographic area, as determined by the health carrier. When you use out-of-network providers, you will be responsible for any fees above R&C charges in addition to deductibles and coinsurance.

The following chart compares some of the main features for each of the *Healthy Choices* medical options.

Benefit Provision	Choice Premier		Choice Select		Choice	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Annual deductible (Individual/family)	$400/person, not to exceed $1,200	$1,500/person, not to exceed $4,500	$800/person, not to exceed $2,400	$3,000/person, not to exceed $9,000	$1,500**/$3,000*** (combined in- and out-of-network)	
Coinsurance (applied after any deductible)	Plan pays 90% You pay 10%	Plan pays 70% You pay 30%	Plan pays 70% You pay 30%	Plan pays 60% You pay 40%	Plan pays 80% You pay 20%	Plan pays 60% You pay 40%
Annual out-of-pocket maximum, including deductible/coinsurance (individual/family)	$2,000/person, not to exceed $6,000	$6,000/person, not to exceed $18,000	$4,000/person, not to exceed $12,000	$12,000/person, not to exceed $36,000	$5,000**/ $10,000***	$10,000**/ $20,000***
Office visit copay (pcp/specialist)	$25/$35	You pay 30%*	$25/$35	You pay 40%*	You pay 20%*	You pay 40%*
Preventive health	No charge	Not covered	No charge	Not covered	No charge	Not covered
Lab and X-ray	You pay 10%*	You pay 30%*	You pay 30%*	You pay 40%*	You pay 20%*	You pay 40%*
Inpatient hospital	You pay 10%*	You pay 30%*	You pay 30%*	You pay 40%*	You pay 20%*	You pay 40%*
Outpatient surgery	You pay 10%*	You pay 30%*	You pay 30%*	You pay 40%*	You pay 20%*	You pay 40%*
Emergency room (visit for a true emergency)	$125	$125	You pay 30%*	You pay 30%*	You pay 20%*	You pay 20%*
Urgent care facility (visit for a true emergency)	$35	$35	You pay 30%*	You pay 30%*	You pay 20%*	You pay 20%*

* Annual medical deductible applies.
** Applies to Associate Only coverage level.
*** Applies to Associate + One and Associate + Family coverage levels. The family deductible must be satisfied before claims can be covered for an individual. The family out-of-pocket maximum must be met before an individual can have claims covered at 100%.

***Healthy Choices* options require certain out-of-pocket expenses to be paid before the option begins paying benefits, including:**

DEDUCTIBLE—An annual amount of covered expenses you pay before your medical option's benefit payments begin. The deductible is applied to the enrollment year of July 1 through June 30 and applies toward the out-of-pocket maximum.

COINSURANCE—The percentage of covered expenses you must pay for a service, up to the annual out-of-pocket maximum, after you meet the deductible. When you reach your annual out-of-pocket maximum, the medical option will begin paying benefits at 100% of reasonable and customary charges (excluding copays and, for the *Choice Premier* and *Choice Select* options, prescription drugs).

COPAYMENT OR **COPAY**—The fee you pay for a specific service or supply for in-network providers. This fee varies based on the type of service and is generally paid when services are received. Copays do not apply toward the deductible or annual out-of-pocket maximum.

PLEASE NOTE:

Certain medical procedures and services require prior authorization to be eligible for benefits. For a complete listing of covered medical services and to determine which medical services need prior authorization for any *Healthy Choices* option, please review detailed descriptions available on *in-site* at www.employeeconnection.net or call the benefits line at (800) 337-2363, or contact either CIGNA or BlueCross.

Prescription Drug Coverage

Prescription drug benefits are administered by Express Scripts for *Choice Premier* and *Choice Select*. Retail pharmacy purchases are subject to coinsurance (with minimums and maximums) and mail order prescription purchases require copays.

If you enroll in *Choice Premier* or *Choice Select*, you will receive a separate ID card from Express Scripts for prescription drug coverage unless you already have one. If you enroll in *Choice*, you use your medical ID card for prescription drug purchases.

When you use network pharmacies to fill your prescriptions, present your ID card whenever you purchase prescription drugs. A list of participating pharmacies is available on *in-site* for Express Scripts. For the *Choice* option, please contact CIGNA or BlueCross BlueShield for participating pharmacies near you.

When you use the mail order service, you can receive up to a 90-day supply of "maintenance" medications (any prescription drug you take regularly)—and it's convenient. You could save money because prescription copays for mail order service may be lower than the coinsurance you'd pay at a retail pharmacy for the same 90-day supply of medication under the *Choice Premier* and *Choice Select* options.

For the *Choice* option, please contact CIGNA or BlueCross BlueShield for information about mail order service.

Note: The prescribing physician must write the prescription for a 90-day supply with appropriate refills in order to utilize the mail order program.

There is a three-tiered payment structure for prescription drugs under *Choice Premier* and *Choice Select*.

Generic drugs are medications that contain the same active ingredients as their brand-name counterparts, but they often cost less. Generic drugs become available after the patent and market exclusivities on the brand-name drug expire. Before a generic can be sold, the U.S. Food and Drug Administration (FDA) must verify the drugs contain the same active ingredient in the same strength as the brand-name equivalent. It also must meet the same standards of quality and effectiveness.

Non-preferred brand-name drugs include medications that are typically more costly and have the highest coinsurance and copay amounts. There are frequently alternatives available in the first two categories for non-preferred brand-name medications. Ask your doctor if there is an alternative that may be clinically proven for your treatment.

Complete formularies are available on *in-site* for all three *Healthy Choices* options. You also will find other information, such as lists of covered and non-covered drug expenses, benefit limitations and more on *in-site*.

	Choice Premier		Choice Select		Choice	
Pharmacy Benefit Manager	***Express Scripts***		***Express Scripts***		***CIGNA or BlueCross BlueShield***	
Retail (up to a 30-day supply)	**In-network**	**Out-of-network**	**In-network**	**Out-of-network**	**In-network**	**Out-of-network**
Generic drug	20% ($10 minimum, $30 maximum)	+	20% ($10 minimum, $30 maximum)	+	20% *	40% * +
Preferred brand-name drug	30% ($20 minimum, $60 maximum)	+	30% ($20 minimum, $60 maximum)	+	20% *	40% * +
Non-preferred brand-name drug	50% ($35 minimum, $100 maximum)	+	50% ($35 minimum, $100 maximum)	+	20% *	40% * +
Mail Order (up to a 90-day supply)						
Generic drug	$25	Not available	$25	Not available	20% *	Not available
Preferred brand-name drug	$50	Not available	$50	Not available	20% *	Not available
Non-preferred brand-name drug	$100	Not available	$100	Not available	20% *	Not available

* Annual medical deductible applies.
+ At non-participating pharmacies, you will pay full retail cost and submit a claim for reimbursement based on plan provisions.

Health Management Programs

Your good health is important to you, your friends and family. Take advantage of the integrated health management programs available through *Healthy Choices* that can help you make smart health care decisions. Commit to a healthy lifestyle. Use the preventive services in your medical option and participate in any health screenings available. **Be a more informed consumer of health care.**

Preventive Care

Preventive care for children and adults is covered under all three *Healthy Choices* options at no cost to you when services are provided by in-network providers. These procedures include, but are not limited to:

- well-baby check-ups (birth to 2 years);
- well-child check-ups (ages 3 to 10);
- well-person check-ups (ages 11 to 18);
- periodic comprehensive physical exams;
- immunizations;
- colorectal screenings;
- prostate exams;
- pelvic exams; and
- mammography and breast exams.

Preventive care can help identify an illness or medical condition before symptoms develop. The types and the frequency of preventive care services you receive are determined between you and your physician, based on standard preventive care guidelines and individual risk factors.

Be sure to remind your doctor to indicate your visit is for preventive care when your claim is filed.

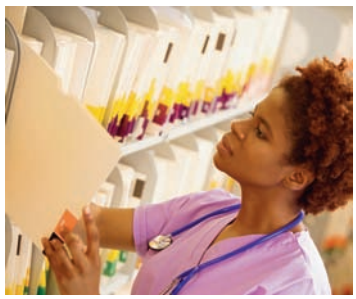
Additional information about preventive care is available on ***in-site***.

MANAGING YOUR HEALTH TAKES TIME – AND YOUR TIME IS VALUABLE.
Using the health management programs is convenient and easy to use. Many of the resources are available 24/7, by phone or online. You can participate at the level you choose, when you choose. All associates and dependents covered under the Company's *Choice Premier*, *Choice Select* and *Choice* medical options are eligible for the health management programs.

PLEASE NOTE:

Preventive care is not covered out-of-network for associates in the *Healthy Choices* options.

Nurse Advisor Program



Nurse Advisor offers confidential, personal assistance from a team of specialized nurses dedicated to associates enrolled in *Healthy Choices* and who need help with any general health care issues, disease management or certain chronic medical conditions. This dedicated team of nurses can help improve the quality of care you receive by:

- understanding the Company's specific medical options and benefits and your personal health care needs;
- coordinating care from all of your doctors and health care providers;
- helping you better understand the health care system and how to work through it in a positive way; and
- making direct contact with you, when it's appropriate, to assist with the coordination of medical, pharmacy, behavioral care and disease management needs.

When you request assistance, a dedicated nurse will be assigned to you. You decide the best way to communicate with your nurse—by phone, e-mail or mail. Your nurse will serve as your personal *health coach* who can help with a wide range of conditions—including medical treatment, prescription needs, lifestyle activities and disease management – and will continue to work with you.

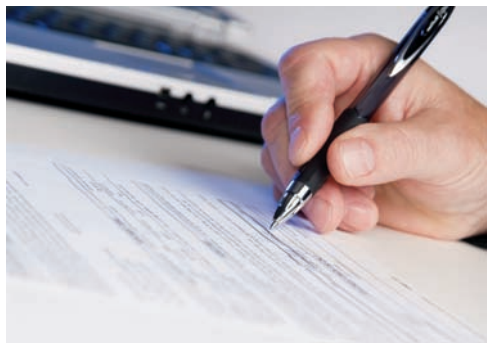
Nurse Advisor also can provide extra support and counsel for eligible associates and covered dependents facing chronic illnesses and complex medical treatments. *Nurse Advisor* will help you get answers, coordinate care, manage challenging health conditions and facilitate recovery when you or your covered dependent:

- has a chronic disease, such as asthma, coronary artery disease, congestive heart failure or diabetes;
- is hospitalized or has surgery; or
- has a condition that is considered high risk.

Nurse line service is available 24/7 beginning with your coverage effective date. You can consult with registered nurses, dieticians and educators about your health care needs.

Although there are many benefits associated with the program, it is always up to you whether you take advantage of services available through *Nurse Advisor*. *Nurse Advisor* is not a substitute for your physician or health care specialist. Participation in *Nurse Advisor* is optional and there is no cost to associates who use their services. All information shared with your personal nurse is held in strict confidence.

Personal Health Report



Personal health report is a voluntary program that will be available after you enroll in one of the *Healthy Choices* medical options. It's a confidential, personal health assessment and management tool that provides a snapshot of your state of health.

Completing a brief online questionnaire can help you:

- identify and monitor your personal health situation;
- obtain a personal analysis of many preventable and common conditions;
- review details of your contributing risk factors;
- learn how to get better control of your health and well-being; and
- access recommended steps for improvement, interactive tools and wellness information.

The assessment will cover:

- your current health conditions;
- family health history; and
- basic information about your weight, cholesterol level and blood pressure.

Completing the online questionnaire takes about 20 to 30 minutes and is a confidential process. No one at the Company will have access to individual responses or results. You will receive your personalized results immediately online. As you make health and lifestyle changes, your online health assessment can be updated to help you track your progress.

Personal health report, along with the other programs under *Healthy Choices*, supports the Company's commitment to provide you with more education, resources and communication to help you stay healthy.

It makes sense to become a more educated consumer of health care and more knowledgeable about your personal health status. Beginning on your coverage effective date, your personal health report is just a click away at the CIGNA and BlueCross BlueShield websites.

Employee Assistance Program

It seems more difficult today than ever to juggle the demands of work and family while managing a household, caring for loved ones and maintaining good health. **So the Company provides an Employee Assistance Program (EAP) to any full-time associate who is enrolled in *Choice*, *Choice Select*, *Choice Premier*, as well as in Kaiser, Group Health, Health Assurance or HIP medical options.**

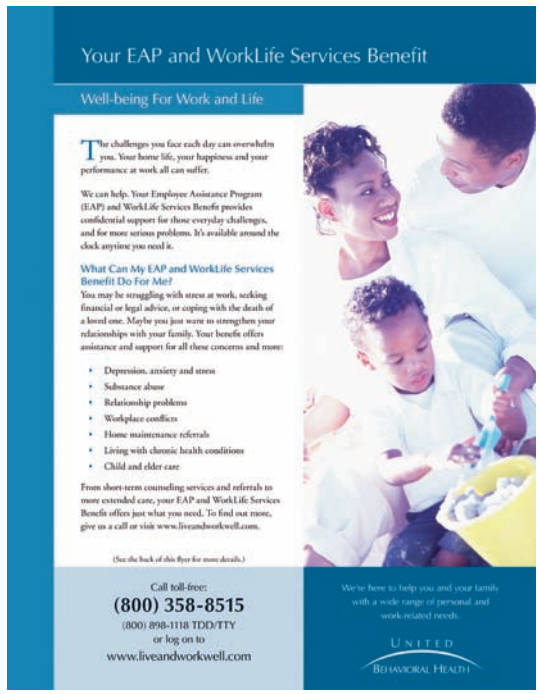
This voluntary "Employee Assistance Program (EAP) and WorkLife Solutions" program is available to all health care program participants through United Behavioral Health. The EAP is a personal consultation and resource service that can help solve life's everyday challenges – big and small.

EAP services include unlimited access to consultants, research and referral services, and various online resources at no cost to you. You also receive up to three personal counseling sessions with a licensed clinician. Discounted services for legal and financial advice are also available. You will pay for the services you decide to use as a result of a referral provided through the EAP counselors (e.g., childcare, tutoring services, etc.).

When you need help, calling the toll-free number at (800) 358-8515 gives you immediate, 24/7 access to:

- assessment and referral services;
- adult/elder support services;
- child/parenting support services;
- legal assistance;
- financial services;
- educational resources;
- chronic medical condition resources; and
- health and wellness resources.

Confidentiality is a top priority when you use EAP services. All records – including personal information, referrals and evaluations – are kept confidential in accordance with federal and state laws.



Consider the Tax Advantages

There are several ways you can save on taxes through the Company's health care program. First, you may choose to make your payroll contributions with pre-tax dollars. When you do, contributions for medical and dental coverage are deducted from your pay before Federal and state income tax is withheld.

Similar tax advantages are available if you enroll in the *Choice* high-deductible health plan and participate in the Company-sponsored Health Savings Account (HSA). If you enroll in a different option, you can participate in the Health Care Flexible Spending Account (FSA) Program. If you are enrolled in a Health Savings Account, you can participate in a similar FSA, called a Limited Flexible Spending Account (LFSA).

Contributions you make to the HSA, Health Care FSA or Limited FSA can be deducted from your taxable income, which will lower your taxes.

PRE-TAX OR AFTER-TAX?

You can elect to have health care contributions made on a pre-tax or after-tax basis. While pre-tax contributions can lower your taxable income, there are some restrictions. Here's what you need to know:

- **Pre-tax Option.** Your contribution will be made before Federal, state and FICA taxes are calculated. (FICA stands for Federal Insurance Contributions Act.) Your election must remain in effect for the entire enrollment year, which ends each June 30, unless your family status changes during the year (due to marriage, birth of a child, etc.).
- **After-tax Option.** Your contribution will be made after Federal, state and FICA taxes are calculated. You may drop dependents or cancel coverage at any time throughout the year.

Health Savings Account (HSA)

The *Choice* medical option is designed to meet Federal guidelines to qualify as a "high-deductible health plan," or HDHP, to coordinate with a Health Savings Account (HSA). The *Choice* option has the highest deductibles and out-of-pocket maximums, and the lowest per pay-period contributions compared to *Choice Premier* and *Choice Select*.

The Company offers an HSA to associates who enroll in the *Choice* option to cover most of your out-of-pocket medical expenses. Your contributions can be made before tax through payroll deductions. Withdrawals and earnings are not taxed as long as they're used for medical expenses. Any unused money stays in the account to use in the future, and if you leave the Company or retire, the account is yours so the funds are still available for you to help pay future medical costs.

An HSA requires you to take on more responsibility for health care decisions and personally direct how the account is spent on health care. It is up to you to use the Health Savings Account as intended.

SHPS, Inc. will be the administrator for the Company-sponsored Health Savings Account. Associates who enroll in the *Choice* option **and** the Company-sponsored HSA will receive a debit card to make health care purchases at retail locations and to obtain cash for these purchases at select ATMs. Associates also can request a checkbook, too, if desired.

Health Care FSA Program

The Health Care Flexible Spending Account (FSA) Program offers eligible associates a way to reduce Uncle Sam's tax bite and stretch the buying power of every dollar you deposit to this account. When you set aside part of your pre-tax pay in the Health Care FSA, you automatically get a tax break in *every* paycheck. Your contributions to the Health Care FSA will be used to reimburse eligible expenses you incur during the plan year in which you are enrolled.

If you haven't taken advantage of the tax savings offered in the Health Care FSA in the past, take another look. You do not need to enroll in a Company-sponsored medical option to participate in the Health Care FSA Program.

You may contribute from $120 to $5,000 to a Health Care FSA during an entire plan year (generally July 1 through June 30). The amount is prorated if you enroll at any other time of the plan year. If you participate, your contributions will be made each pay period through convenient payroll deductions.

EXAMPLES OF ELIGIBLE HEALTH CARE FSA EXPENSES INCLUDE:

- **medical and dental deductibles, coinsurance and copayments;**
- **prescription drug copays and coinsurance;**
- **smoking cessation program fees;**
- **orthodontia;**
- **hearing aids;**
- **prescription eye glasses and contact lenses;**
- **most other health care expenses that are eligible tax deductions (except insurance premiums and cosmetic surgery); and**
- **certain over-the-counter (OTC) items, including non-prescription antacids, allergy medication, pain relievers and cold medicines purchased to alleviate or treat personal injury or sickness. Dietary supplements and vitamins are not eligible for reimbursement.**

FSA participants enjoy the convenience of a debit card to make payments and purchases. After associates enroll, the FSA administrator, SHPS, Inc. will mail details and the debit card.

Enrollees in *Choice Premier*, *Choice Select* and *Choice* who use a FSA debit card generally will not have to submit documentation for their expenses. SHPS will obtain information from CIGNA and BlueCross BlueShield to verify the eligibility of those expenses according to IRS rules.

For those who shop for over-the-counter items at many major retailers including Walgreens, using a FSA debit card will mean instant documentation of eligible expenses.

If SHPS requires documentation for a payment or purchase made with a FSA debit card, SHPS will request an Explanation of Benefits (EOB) or receipt from the participant.

Participants can submit other claims with documentation, too. If desired, SHPS can deposit reimbursement to a participant's bank account.

Internal Revenue regulations do not permit individuals who are contributing to a Health Savings Account to be enrolled in a Health Care FSA that covers medical costs that can be paid from the HSA. However, eligible dental and vision expenses can be covered by a Flexible Spending Account. For this reason, the Company offers associates the opportunity to enroll in a Limited Flexible Spending Account (LFSA) that covers dental and vision expenses only.

So, if you are enrolled and contributing to your or your spouse's Health Savings Account, you may want to participate in the Limited FSA.

You may contribute from $120 to $5,000 to a Limited FSA during an entire plan year (generally July 1 through June 30).

An associate who is newly eligible for benefits should enroll in the LFSA if he/she participates in or will participate in a Health Savings Account through the Company or an institution such as a bank.

EXAMPLES OF ELIGIBLE LIMITED FSA EXPENSES INCLUDE:

- **orthodontia;**
- **dentures, bonding and sealants for dentures;**
- **prescription eye glasses, sunglasses, sports goggles;**
- **contact lenses and solutions;**
- **artificial eye and polish; and**
- **radial keratotomy, laser surgery or other vision correction surgery.**

An Associate Example of FSA Tax Savings

Mary is a single parent who planned her expected health care expenses carefully and plans to use her Health Care FSA to save money. Mary calculated she would spend at least $1,200 during the next twelve months on copays for her child's office visits to the doctor and for prescriptions. She will also pay toward deductibles, coinsurance and other medical, dental and vision expenses. The following example shows the tax savings Mary could realize through her Health Care FSA—leaving more take-home pay in her pocket.

Mary's Tax Savings with a Health Care FSA Account

	If she participates	If she does not participate
Annual salary before taxes	**$35,000**	**$35,000**
Minus her Health Care FSA deposit	- $ 1,200	- $ 0
Net income	**$33,800**	**$35,000**
Minus her estimated federal taxes (based on 2006 tax rates)	- $ 4,996	- $ 5,268
Net pay	**$28,804**	**$29,732**
Minus her health care expenses	- $ 0*	- $ 1,200
Net pay Mary can spend	$28,804	$28,532
Estimated tax savings	**$ 272**	**$ 0**

For illustrative purposes only.

* Mary gets reimbursed from her Health Care FSA.

Note: Using the Health Care FSA or Limited FSA may result in a slight loss of future Social Security benefits because FSA contributions are not subject to FICA tax withholding.

Using a Health Savings Account requires careful planning – like the Health Care FSA – and it gives you the opportunity to save on taxes.

Each time you incur an expense that is subject to the *Choice* option deductible, you'll make the decision *either to pay that expense out of your pocket or reimburse yourself from your Health Savings Account*. Here's a comparison of features of the HSA and FSAs:

Features and Provisions	Company-sponsored Health Savings Account (HSA)	Limited Flexible Spending Account (LFSA)	Health Care Flexible Spending Account (FSA)
Available for	Associates enrolled in the Company-sponsored *Choice* high-deductible health plan medical option.	Associates enrolled in a Health Savings Account, including the Company-sponsored HSA.	Benefits-eligible associates not enrolled in a Health Savings Account.
Examples of eligible expenses that can be paid from the account	Medical expenses including amounts payable toward the *Choice* medical option deductible and over-the-counter drugs.	Limited to dental and vision expenses.	Medical, dental and vision expenses and over-the-counter medications and supplies.
Contributions qualify for tax advantages	**Yes.** For associates who enroll in the Company-sponsored HSA, tax savings are automatic every pay period.	**Yes.** Tax savings are automatic every pay period.	**Yes.** Tax savings are automatic every pay period.
Contributions earn interest on a tax-deferred basis	**Yes.** Contributions, investment growth and withdrawals for health-related expenses are all free from taxation.	**No.**	**No.**
Contributions are subject to "use it or lose it" rule	**No.**	**Yes.**	**Yes.**
Account balances are portable if an associate changes employers	**Yes.** If an associate changes jobs, his/her HSA funds remain his/hers.	**No.**	**No.**
The account can be used to build long-term savings	**Yes.** An associate can allow an account balance to grow tax-deferred. After age 65, he/she can withdraw money without a 10% tax penalty. (Withdrawals after age 65 used for non-medical expenses are subject to regular income tax.)	**No.**	**No.**

This comparison provides only a brief summary. There are more IRS regulations that govern flexible spending accounts and health savings accounts. You should get assistance from a professional tax advisor to help you decide if the *Choice* medical option is the right fit for you.

Check out Coverage Advisor

Subimo's Coverage Advisor™ is an online tool, available through the Company's intranet site, *in-site*, that you can use to evaluate *Healthy Choices*.

When you are eligible to enroll in *Healthy Choices* options, log on to *in-site* from work or visit *in-site* from www.employeeconnection.net. Then click on the "Coverage Advisor for *Healthy Choices*" link.

Follow step-by-step instructions to create a health profile for each person you want to cover under your medical option, then describe the general health status and list any current medical conditions. Select the prescription drug categories based on current health needs.

You'll receive an estimate of the number of visits to physicians and the emergency room, inpatient and outpatient stays, prescriptions and major diagnostic services based on the information you provided. You can adjust this information based on personal experience.

You will see the medical options available to you and be able to select up to three for comparison. If another option is available in your geographic area, you can compare that option with any of the *Healthy Choices* options also.

You can see your annualized estimated health care costs before making contributions to a Health Savings Account or Health Care Flexible Spending Account. You can experiment with contributing different amounts to these accounts to evaluate the potential financial and tax aspects of the medical options available to you.

Screen shown is sample only.

Examples of Potential Costs

The following examples can help you determine the potential benefits and expenses under the *Healthy Choice* medical options. These are only examples.

The first section in each chart shows the full estimated cost of the specific health care service *before* any medical option benefits are applied. The next section itemizes the associate's actual share of out-of-pocket expenses for each covered service after benefits are applied. To estimate the total annual out-of-pocket cost under each medical option, add your expected per pay-period contributions for coverage during the 12-month plan year in the third section of each chart.

For many people, health care coverage is one of the biggest—and most important—purchases they make each year. With this in mind, it pays to take a careful look at the overall value of your medical options, including the benefit levels and of course, the costs. Check the details carefully before you make your decisions.

José enrolls for Associate Only coverage. He is relatively healthy and doesn't require much medical treatment other than routine check-ups and one prescription medication. José uses in-network providers.

José's Medical Treatment	*Choice Premier*	*Choice Select*	*Choice*
Full estimated cost of health care:			
▪ Routine annual physical/office visit	$300	$300	$300
▪ One preferred brand-name drug ($70 per month)	$840	$840	$840
Total annual health care cost	**$1,140**	**$1,140**	**$1,140**
José's out-of-pocket expenses:			
▪ Routine annual physical/office visit	$0	$0	$0
▪ One preferred brand-name drug	$252	$252	$840
José's out-of-pocket cost	**$252**	**$252**	**$840**
Add your expected annual associate contribution: Per Pay period contribution multiplied by number of pay periods in a year	$_____	$_____	$_____
Total annual out-of-pocket cost	$_____	$_____	$_____

For illustrative purposes only.

Rebeca enrolls for Single coverage. She receives medical treatment for diabetes, but has no other complications. She makes several office visits to her specialist and takes several generic and preferred brand-name medications each month. Rebeca uses in-network providers.

	Choice Premier	*Choice Select*	*Choice*
Full estimated cost of health care:			
▪ Routine preventive care office visit	$300	$300	$300
▪ Specialist doctor visits (6 visits, $150 per visit)	$900	$900	$900
▪ Four generic drugs per month ($20 average cost per medication)	$960	$960	$960
▪ Two preferred brand-name drugs per month ($70 average cost per medication)	$1,680	$1,680	$1,680
Total annual health care cost	**$3,840**	**$3,840**	**$3,840**
Rebeca's out-of-pocket expenses:			
▪ Routine preventive care office visit	$0	$0	$0
▪ Specialist doctor visits	$210	$210	$900
▪ Four generic drugs per month	$480	$480	$672
▪ Two preferred brand-name drugs per month	$504	$504	$336
Rebeca's out-of-pocket cost	**$1,194**	**$1,194**	**$1,908**
Add your expected annual associate contribution: Per Pay period contribution multiplied by number of pay periods in a year	$_____	$_____	$_____
Total annual out-of-pocket cost	$_____	$_____	$_____

For illustrative purposes only.

Lisa enrolls for Single coverage. She receives medical treatment for pregnancy and is anticipating a C-section delivery, but is otherwise healthy. She takes three preferred brand-name medications each month. Lisa uses in-network providers.

Lisa's Medical Treatment	*Choice Premier*	*Choice Select*	*Choice*
Full estimated cost of health care:			
▪ Routine preventive care office visit	$300	$300	$300
▪ Pregnancy/anticipates C-section delivery	$12,000	$12,000	$12,000
▪ Three preferred brand-name drugs per month ($70 average cost per medication)	$2,520	$2,520	$2,520
Total annual health care cost	**$14,820**	**$14,820**	**$14,820**
Lisa's out-of-pocket expenses:			
▪ Routine preventive care office visit	$0	$0	$0
▪ Pregnancy/anticipates C-section delivery:			
○ Annual deductible	$400	$800	$1,500
○ Coinsurance	$1,160	$3,200	$2,100
▪ Three preferred brand-name drugs per month	$756	$756	$504
Lisa's out-of-pocket cost	**$2,316**	**$4,756**	**$4,104**
Add your expected annual associate contribution: Per Pay period contribution multiplied by number of pay periods in a year	$_____	$_____	$_____
Total annual out-of-pocket cost	$_____	$_____	$_____

For illustrative purposes only.

George enrolls for Two-party coverage.
He receives medical treatment for a heart attack and congestive heart failure and also takes several generic and preferred brand-name medications each month. George uses in-network providers.

George's Medical Treatment	*Choice Premier*	*Choice Select*	*Choice*
Full estimated cost of health care:			
▪ Routine preventive care office visit	$300	$300	$300
▪ Cardiologist specialist visits (6 visits, $150 per visit)	$900	$900	$900
▪ One emergency room visit and hospital admission	$450	$450	$450
▪ Inpatient heart surgery	$35,000	$35,000	$35,000
▪ Cardiac rehabilitation (12 visits, $80 per visit)	$960	$960	$960
▪ Four generic drugs per month ($20 average cost per medication)	$960	$960	$960
▪ Two preferred brand-name drugs per month ($70 average cost per medication)	$1,680	$1,680	$1,680
Total annual health care cost	**$40,250**	**$40,250**	**$40,250**
George's out-of-pocket expenses:			
▪ Routine preventive care office visit	$0	$0	$0
▪ Cardiologist specialist visits	$210	$210	$900
▪ One emergency room visit and hospital admission	$125	$450	$450
▪ Inpatient heart surgery:			
○ Annual deductible	$400	$350	$1,650*
○ Coinsurance	$1,600	$3,200	$6,670
▪ Cardiac rehabilitation	No charge**	No charge**	$192
▪ Four generic drugs per month	$480	$480	$138
▪ Two preferred brand-name drugs per month	$504	$504	No charge**
George's out-of-pocket cost	**$3,319**	**$5,194**	**$10,000****
Add your expected annual associate contribution: Per Pay period contribution multiplied by number of pay periods in a year	$_____	$_____	$_____
Total annual out-of-pocket cost	$_____	$_____	$_____

For illustrative purposes only.

* George must meet the $3,000 Family deductible.
** Annual Family out-of-pocket maximum satisfied.

Dental

MetLife Dental and Aetna DMO offer dental coverage. **The options are the MetLife High Option PPO and MetLife Basic Option PPO.** You can elect to have your contributions taken on a pre-tax or after-tax basis.

"PPO" stands for Preferred Provider Organizations (PPO). Enrolled associates will be able to use in-network and out-of-network dentists and specialists as desired, but benefits generally are higher if in-network providers are used. The level of benefits is the only difference between the two options offered.

An additional option – Aetna DMO (a dental health maintenance organization) – is available based on each associate's ZIP Code. An Aetna DMO enrollee is required to name a Primary Care Dentist, or PCD, from the DMO's network of participating dentists and specialists. Except in emergencies, services must be received from dentists who have contracted with the DMO.

	MetLife Dental High	MetLife Dental Basic	Aetna DMO
Providers			
Network Providers	MetLife Dental Preferred Dentist Program (PDP)		Aetna DMO network dentist or specialist
Non-participating Providers	Benefit payments will be based on MetLife Dental's non-participating dentist fee		No coverage
Deductibles and Maximums			
Annual Deductible (per plan year; does not apply to preventive care)	Individual: $50 combined in- and out-of-network Family: $150 combined in- and out-of-network	Individual: $75 in-network and $100 out-of-network Family: $225 in-network and $300 out-of-network	None
Annual Benefit Maximum Per Plan Year	$2,000	$1,000	None
Lifetime Orthodontic Benefit Maximum (per person)	$2,000	Not covered	None
Covered Dental Services*			
Preventive Care (including routine diagnostic services such as oral exams, routine and periodontal cleaning, x-rays, etc.)	No charge	No charge	No charge
Basic Care (including fillings, extractions periodontics, etc.)	20% coinsurance	50% coinsurance	No charge
Major Restorative Care (includes crowns bridgework, dentures, etc.)	40% coinsurance	50% coinsurance	40% coinsurance
Orthodontia (dependent children under age 19)	50% coinsurance	Not available	50% coinsurance

* Frequency limitations and age restrictions apply to certain services under the program.

You can elect dental coverage if needed. You don't have to be enrolled in medical coverage to elect dental coverage.

You can cover your Spouse/Domestic Partner, your unmarried children, your children up to age 19, and your children who are full-time students (generally up to the end of the month of his or her 23rd birthday, although age limits for full-time students may vary in some states as described earlier in this booklet). Eligible dependents also may include disabled dependents. An Affidavit of Domestic Partnership may be required if you want to cover a Domestic Partner or dependent children of your eligible same-gender domestic partner who meet the criteria above.

Life Insurance

The Optional Life Insurance Program allows you to tailor your coverage to your needs:

- **Associate Life Insurance coverage.** Coverage based on the multiple of eligible annual pay[+] you select rounded to the next higher $1,000. Maximum coverage is the lesser of six times pay (6 x pay) or $2.5 million. You decide whether to have contributions deducted on a pre-tax or after-tax basis.
- **Spouse/Domestic Partner Life Insurance coverage.** $10,000 of coverage for your spouse or same-gender domestic partner.
- **Child(ren) Life Insurance coverage.** $5,000 of coverage for each eligible dependent child.

Associate Life Insurance

If you are newly eligible, you may enroll in a multiple of your eligible annual pay:

- one-half times pay (½ x pay), or
- one times pay (1 x pay) to six times pay (6 x pay) rounded to the next higher $1,000.

If newly eligible, no Statement of Health form will be required if you elect *the lesser of* three times pay (3 x pay) or the highest multiple of pay that does not exceed $500,000.

A Statement of Health form will be required if you elect:

- four times pay (4 x pay) to six times pay (6 x pay), or
- any multiple of pay that results in coverage over $500,000.

Any time you submit a Statement of Health form, Federated HR Services will enroll you in the highest multiple of pay for which you are eligible – called the guarantee issue amount. If the insurance carrier approves your Statement of Health, Federated HR Services will enroll you in your requested multiple of pay on the first of the month after the insurance carrier's notification of approval. If your Statement of Health is not approved, you will remain enrolled in the guarantee issue multiple of pay.

Increases in multiple of pay at annual enrollment or for a change in family status will require that you submit a Statement of Health form and receive the insurance carrier's approval for the increase.

[+] *Annual pay as defined in the program includes regular pay, overtime pay, cash bonuses, commissions and incentive pay received in the prior calendar year.*

For a newly eligible associate, annual pay is defined as:

- *Hourly paid associates: Multiply your hourly rate by your weekly scheduled hours, then multiply by 52.*
- *Salaried paid associates: Your annual salary.*

PRE-TAX OR AFTER-TAX?

You can elect to have Associate Life Insurance contributions made on a pre-tax or after-tax basis. While pre-tax contributions can lower your taxable income, there are some restrictions. Here's what you need to know:

- **Pre-tax Option.** Your contribution will be made before Federal, state and FICA taxes are calculated. (FICA stands for Federal Insurance Contributions Act.) Your election must remain in effect for the entire enrollment year, which ends each June 30, unless your family status changes during the year (due to marriage, birth of a child, etc.).
- **After-tax Option.** Your contribution will be made after Federal, state and FICA taxes are calculated. You may drop dependents or cancel coverage at any time throughout the year.

Rates for Associate Life Insurance coverage are based on your age.

Federal tax regulations require that the Company report your "imputed income" as taxable income to you. Imputed income is the difference between the value of your group life insurance coverage in excess of $50,000 and your after-tax contributions for coverage. Your imputed income is subject to Federal, state and FICA taxes.

Spouse/Domestic Partner Life Insurance

If you are married or have a same-gender domestic partner, you may elect Spouse/Domestic Partner Life Insurance coverage of $10,000. An Affidavit of Domestic Partnership may be required if you want to cover a Domestic Partner.

If your spouse/domestic partner was hospitalized during the previous 90 days, you will need to submit a Statement of Health for your spouse or domestic partner and receive the insurance carrier's approval. If the insurance carrier approves, the coverage will be effective on the first of the month after the insurance carrier's notification of approval. If the insurance carrier does not approve, the coverage will not be effective.

Rates for Spouse/Domestic Partner Life Insurance coverage are based on *your* age.

Child(ren) Life Insurance

If you have a dependent child or children, you may elect Child(ren) Life Insurance coverage of $5,000 for each eligible child.

Generally, eligible dependents include your unmarried children from birth to 19 years of age, or to age 25 if a full-time student, and dependent on you for support and maintenance. The unmarried children of your same-gender domestic partner who meet the same criteria and who reside in your home also are eligible. Eligible dependents also include any dependent, unmarried child who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who becomes so incapable prior to reaching age 19, and who is dependent upon you for support and maintenance. He or she will continue to be eligible for coverage under the policy regardless of age for as long as the policy is in force. An Affidavit of Domestic Partnership may be required if you want to cover dependent children of your eligible same-gender domestic partner who meet the criteria above.

The rate for Child(ren) Life Insurance is a flat amount regardless of the number of children covered.

Accidental Death & Dismemberment (AD&D)

The Optional Accidental Death & Dismemberment (AD&D) Program gives you choices:

Individual Coverage. Coverage based on the multiple of your eligible annual pay[+] you select rounded to the next higher $1,000. Maximum coverage is the lesser of ten times pay (10 x pay) or $1.5 million.

Individual + Family Coverage. Coverage for your spouse or same-gender domestic partner and eligible dependent children.

If you are newly eligible, you may enroll in a multiple of your eligible annual pay[+]:

- one-half times pay (½ x pay), or
- one times pay (1 x pay) to ten times pay (10 x pay) rounded to the next higher $1,000.

Your cost for AD&D coverage depends on the multiple of coverage you select. Contributions are deducted on an after-tax basis.

Eligible dependents for Individual + Family AD&D coverage include:

- **Spouse/Domestic Partner.** An Affidavit of Domestic Partnership may be required if you want to cover a Domestic Partner.
- **Children.** Your unmarried children from birth to 19 years of age, or to age 25 if a full-time student, and dependent on you for support and maintenance. The unmarried children of your domestic partner who meet the same criteria and who reside in your home also are eligible. Eligible dependents include any dependent, unmarried child who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who becomes so incapable prior to reaching age 19, and who is dependent upon the covered associate for support and maintenance. He or she will continue to be eligible for coverage under the policy regardless of age for as long as the policy is in force. An Affidavit of Domestic Partnership may be required if you want to cover dependent children of your eligible same-gender domestic partner who meet the criteria above.

Benefits for your dependents are a percentage of the amount of coverage you elect for yourself.

BENEFICIARIES FOR LIFE INSURANCE AND AD&D —
If you enroll in both the group life insurance and AD&D programs, the beneficiary designation you make on *in-site* will apply to both programs unless you indicate otherwise.

A **primary beneficiary** receives the proceeds from your coverage in the event of your death. A **contingent beneficiary** receives the proceeds only if your primary beneficiary predeceases you. You may name more than one beneficiary. If you name more than one beneficiary, you must identify the percentage of proceeds to be paid to each. All percentages must total 100%.

If you enroll in the Spouse/Domestic Partner Life Insurance option, Child(ren) Life Insurance option, or Individual + Family AD&D option, you, the associate, are always the beneficiary for your dependents.

[+]*Annual pay as defined in the program includes regular pay, overtime pay, cash bonuses, commissions and incentive pay received in the prior calendar year.*

For a newly eligible associate, annual pay is defined as:
- *Hourly paid associates: Multiply your hourly rate by your weekly scheduled hours, then multiply by 52.*
- *Salaried paid associates: Your annual salary*

Disability Benefits

Long-term disability insurance gives you income during the time you need to receive treatment to recover from a serious illness or manage the challenges of an extended disability that prevents you from returning to work.

Long Term Disability

The Company offers Long Term Disability (LTD) coverage to replace some of your income in case you need it.

Your cost for coverage is based on your eligible covered pay and age based rate tables or a flat rate depending on the program available to you. The maximum benefit payment is up to 60% of your covered pay (up to certain limits) and, because you contribute on an after-tax basis, benefits you receive from the Plan will be free from Federal income tax under current tax laws.

In addition, any LTD benefits you receive may be offset by other benefits for which you are eligible. These could include social security, workers' compensation, and any other salary continuation program.

Benefits are generally payable for approved disabilities after a 26-week waiting period (13 weeks at some locations). The length of time you receive LTD benefits depends on when you become disabled. For example, payments would continue to age 65 if you become disabled prior to reaching age 60. The older you are when you become disabled, the shorter the period of coverage. If you become disabled at age 69 or older, you would receive benefits for no more than 12 months.

Additional information about the LTD programs is available on *in-site* or on request. Program features may vary from this general information.

You may enroll when first eligible without a Statement of Health. If you do not enroll in LTD when first eligible, a Statement of Health may be required if you decide to enroll during an annual enrollment period or due to a life event.

A pre-existing condition limitation applies when you enroll in LTD for the first time. A pre-existing condition can be an injury or illness that occurred or began before you became a Plan member. Additional information is available on *in-site* or on request.

Short Term Disability

Your division's Short Term Disability Plan may provide you with partial income protection when an authorized health care provider certifies that you are medically disabled and unable to work as a result of an injury or illness. The coverage offered, the cost and whether you must make an election to be enrolled vary by division.

Dependent Care Flexible Spending Account (FSA)

You can establish a Dependent Care Flexible Spending Account (FSA) up to $5,000 through June 30. You contribute pre-tax dollars to this FSA, which lowers your tax withholding. Then you are reimbursed from the FSA for payments you have made for eligible dependent care expenses that are incurred so that you and your spouse can work.

You may participate in the Dependent Care FSA Program if you have:

- A dependent child or children under age 13 or
- Any other dependent (such as an adult child, spouse or grandparent) living with you on a regular basis and who is mentally or physically unable to care for himself or herself.

Eligible expenses include those required to provide household and dependent care services needed to allow you and, if applicable, your spouse, to be employed. Examples of eligible expenses include:

- Child care expenses, from babysitters to child care centers
- After-school programs and most summer day camp fees
- Elder care expenses for eligible adults

Carefully evaluate if the Dependent Care FSA Program or the federal Dependent Care Tax Credit is the best tax savings opportunity for you.

If you are married, your spouse must be a wage earner, a full-time student at least five months of the year or disabled and unable to provide for his or her own care. If you and your spouse file separate income tax returns, you are limited to a maximum contribution of $2,500 annually.

For highly compensated participants, contributions to the Dependent Care FSA Program will be limited to $1,500 and may be further reduced or recharacterized if necessary to satisfy any IRS nondiscrimination requirements. (Generally, a highly compensated employee for 2007 is someone who earned in excess of $100,000 in 2006.)

Once you make your election, your contributions will be prorated over the remaining pay periods through June 30, and set aside in your Dependent Care FSA. Your taxable income for the year will be reduced by the amount you contribute, so your income tax will be lower.

SHPS, Inc. is the FSA administrator. To be reimbursed, you will be required to submit the name, address and Taxpayer Identification Number (TIN) or social security number of the dependent care provider. For your convenience, you can request deposit to your bank account.

Carefully estimate your eligible dependent care expenses from your eligibility date through June 30. Any contributions remaining in your Dependent Care Flexible Spending Account at the end of the year and not claimed by September 30 will be forfeited. IRS guidelines do not permit them to be returned to you.

Changes during the Year

When a change in your family status occurs, you must report the change to Federated HR Services no later than 31 days after the date of the event to request to change or to cancel your benefits. You must call to report these changes whether you contribute on a pre-tax or after-tax basis.

Changes in your family or job status that could result in changes to your coverage include:

- Marriage
- Divorce
- Birth of a child
- Adoption or placement for adoption
- Death of a dependent
- Medicare entitlement
- End of a dependent's full-time student status
- Termination or commencement of your spouse's employment
- Change in your employment or your spouse's employment that affects benefits
- Loss of other group medical coverage if you have not previously elected coverage under this health care program
- Obtaining other group medical coverage while you are covered under this health care program

Any changes in coverage must be directly related to your change in family status.

If you are enrolled in any benefits on a pre-tax basis and do not notify Federated HR Services of a family status change within 31 days, your benefits (except for the exclusion of ineligible dependents) and contributions may not change until the next annual enrollment – generally July 1. These benefits could include Medical, Dental, Associate Life Insurance, Short Term Disability, Health Care Flexible Spending Account and Dependent Care Flexible Spending Account.

- Health Care FSA is subject to Internal Revenue Service (IRS) regulations, which limit changes. Changes are only permitted for qualified family status changes that result in a change in the number of covered dependents, such as the birth of a baby, marriage or divorce.
- Dependent Care FSA is subject to Internal Revenue Service (IRS) regulations, which limit changes. If your dependent care provider increases or decreases the cost of care significantly, you may be able to adjust your contribution amount. Otherwise, changes are only permitted for qualified family status changes, such as the birth of a baby, marriage or divorce, or a change in day care provider.

If you are enrolled in any benefits on an after-tax basis, you may drop a dependent or cancel coverage at any time during the year. These benefits could include Medical, Dental, Associate Life Insurance, Spouse/Domestic Partner Life Insurance, Child(ren) Life Insurance, Accidental Death & Dismemberment, Long Term Disability and Short Term Disability.

PLEASE NOTE:

Associate contributions will be required as of the effective date of any changes in coverage.

Contact Information

Contact	Telephone	Website
For "Bridge" Medical:		
Starbridge Choices, a CIGNA health insurance plan	(877) 209-7098	www.starbridgechoices.com/federated
For *Healthy Choices* Medical Coverage:		
CIGNA HealthCare	(800) 244-6224	www.mycignaplans.com Use Open Enrollment ID: FDS2007 Password: cigna (case-sensitive)
BlueCross BlueShield	(800) 363-0413	www.bluecrossca.com/fdshealthychoices
Express Scripts, Inc.*	(877) 603-8396	www.express-scripts.com
Nurse Advisor**		
CIGNA members	(800) 558-8361	
BlueCross BlueShield members	(800) 363-0413	
24-hour nurse line**		
CIGNA members	(800) 558-8361	
BlueCross BlueShield members	(800) 363-0413	
Personal health report**		
HealthQuotient™ (CIGNA)	Not applicable	www.mycigna.com
Health Risk Assessment (BCBS)	Not applicable	www.bluecrossca.com
For other Medical options in certain areas:		
Health Assurance Pittsburgh, PA	(800) 735-1022	www.healthassurance.cvty.com
Kaiser		
California	(800) 464-4000	www.kaiserpermanente.org
Washington, DC metro area	(800) 777-7902	www.kaiserpermanente.org
Atlanta, GA metro area	(888) 865-5813	www.kaiserpermanente.org
Akron and Cleveland, OH	(800) 686-7100	www.kp.org
Portland and Salem, OR	(800) 813-2000	www.kp.org
Group Health		
WA and parts of Northern ID	(888) 901-4636	www.ghc.org
Madison, WI	(800) 605-4327	www.ghc-hmo.com
HIP New York, NY	(800) 447-8255	www.hipusa.com (select "HIP Prime" when prompted)
Employee Assistance Program and WorkLife Services for enrollees in Healthy Choices options and Health Assurance, Kaiser, Group Health and HIP options	(800) 358-8515 Obtain division code from HR representative	www.liveandworkwell.com Obtain division code from HR representative
For Dental Coverage:		
MetLife Dental	(888) 262-4883	www.metdental.com
Aetna	(877) 238-6200	www.aetna.com
For Health Savings Accounts* (HSA):**		
SHPS, Inc.	(877) 777-7195	http://spendingaccount.shps.com
For Flexible Spending Accounts (FSAs):		
SHPS, Inc.	(877) 777-7195	http://spendingaccount.shps.com
Federated HR Services Representatives are available from 9 a.m. to 9 p.m. ET, Monday through Friday.	(800) 337-2363 Select option 2.	www.employeeconnection.net

* Available to participants in *Choice Premier* and *Choice Select* medical options.
** Available to participants in any *Healthy Choices* medical option. *** Available to participants in the *Choice* medical option only.

DOMESTIC PARTNERS AND DEPENDENTS OF DOMESTIC PARTNERS —
To cover a same-gender domestic partner and/or the unmarried children of your covered same-gender domestic partner who meet the same criteria as other dependents, you must complete and submit the Company's Affidavit of Domestic Partnership except in the states noted below.

Associates with same-gender domestic partners who reside in California, Connecticut, the District of Columbia, Maine, New Jersey and Vermont must follow their respective state's formal Domestic Partner Registration process. They are not required to complete the Company's Affidavit of Domestic Partnership. All other associates and domestic partners are required to complete the Company's Affidavit of Domestic Partnership. The affidavit is available on *in-site* or by calling the benefits line at (800) 337-2363.

As required by California law, associates with opposite-gender domestic partners who reside in that state may be eligible for coverage if one of the domestic partners is age 62 or over and eligible for Social Security benefits. Call the benefits line at (800) 337-2363 for additional information. They are not required to complete the Company's Affidavit of Domestic Partnership.