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Summary Plan Description

Details about your 2012 Compass Group Benefits Program

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summary plan description

Hourly Associate

Table of contents

great rewards

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Compass Group Benefits Program

At Compass Group, benefits are an important part of your total compensation package. Our goal is to provide a comprehensive, balanced and competitive benefits package that has a great deal of flexibility. We understand that the benefits important to your coworker may not be as meaningful to you and your family. That's why we offer a variety of benefits from which you can choose.

This document covers how the program works, eligibility, enrolling, family/employment status changes and life events, when coverage ends, and continuing your coverage under COBRA.

As you read this document, keep in mind that Compass Group, the plan administrator, has the authority to interpret the plan provisions and to exercise discretion where necessary or appropriate in the interpretation and administration of the plans. This document does not replace the legal plan documents governing the plans. If there are any differences between this information and the legal plan documents, the plan documents govern. Compass Group, at its sole discretion, reserves the right to amend, suspend, or terminate, in whole or in part, any or all of the plans at any time. These modifications or terminations may be made for any reason Compass Group considers appropriate.

Nothing in this document says or implies that participation in the benefit plans is a guarantee of continued employment with Compass Group. Nor is anything in this document intended to guarantee that benefit levels will remain unchanged in future years.

If you have any questions about this document, contact the Benefits Answerline at 800-341-7763, option 1, or email us at benefits.department@compass-usa.com.

In this section

How the program works

The Compass Group Benefits Program allows you to design the benefits program that best meets your personal needs. The benefits listed below are part of the program.

- Medical
- Dental
- Vision
- Basic Life
- Supplemental Life
- Dependent Life
- Disability Income Protection (DIP)
- Long Term Disability (LTD)
- Accidental Death and Dismemberment (AD&D)
- Flexible Spending Accounts (FSAs)
- Commuter Benefits
- Voluntary Benefits

Situations that can affect your benefits

Compass Group's benefits are intended to provide you with certain levels of financial security. However, the following situations could affect your benefits under these plans:

- Benefits are not payable for expenses or events that occur before your coverage begins or after your coverage ends.
- For some benefit plans, you (or your beneficiary) must apply for benefits or file a claim. Benefits generally cannot be paid until you apply or make a claim for payment.
- Be sure to keep your most current address on file so that Compass Group can locate you (or your beneficiaries) and provide you with your benefit payments and any related benefit plan information.
- If you (or your surviving spouse/domestic partner) are unable to care for your own financial affairs, any payments due may be paid to someone who is legally authorized to conduct your financial affairs. This may be a relative or court-appointed guardian.
- Benefits may not be payable for pre-existing conditions under Long Term Disability (LTD).

Your cost for benefits

Each benefit choice has a price. Generally, the more coverage a choice provides, the greater the price. Also, if you cover more dependents, the price is higher. For some benefits, like life insurance, the prices are based on your age and pay. Deductions are taken on a pre-tax or post-tax basis — depending on the benefit. The following benefits are paid for on a pre-tax basis:

- Medical
- Dental
- Vision
- Supplemental Life
- Accidental Death and Dismemberment (AD&D)
- Flexible Spending Accounts (FSAs)
- Commuter Benefits (post-tax is also available)

Other benefits are paid for on a post-tax basis:

- Long Term Disability (LTD)
- Dependent Life
- Medical, Dental, Vision and AD&D coverage for a domestic partner and/or child(ren) of a domestic partner, who are not eligible for tax-free benefits
- Commuter Benefits (amounts above federal limits)
- Voluntary Benefits

Missed benefits deductions

Your benefit records are set to take as much of a missed deduction as possible — up to a maximum of 1½ times your normal deduction.* This means if you miss a pay cycle, your deduction will increase by half until the amount you missed — or owe — has been repaid.

* This does not apply to 401(k) Plan deferrals or loan re-payments, nor to Health Care or Dependent Care Spending Accounts.

Example

Your medical deduction is $37. If you miss a pay cycle, your deduction will increase to $55.50 ($37 + $18.50 — or half of $37) until the missed deductions are paid.

Paying for benefits with pre-tax dollars

Pre-tax benefit deductions are withheld from your pay before federal income taxes, Social Security taxes and (in most states) state income taxes are deducted. This provides you with a tax advantage — that is, when your taxable pay is less, so are your overall taxes.

Paying for benefits with pre-tax dollars means your future Social Security benefits will be slightly reduced. Generally, the tax advantages of using these pre-tax plans will outweigh the reduced Social Security benefits later, but if you have any questions or concerns, you should consult your tax advisor.

Because the IRS allows this pre-tax deduction advantage, there are certain restrictions regarding changes throughout the plan year. See *Family/Employment Status Changes* on page 6 or go to http://www.irs.gov/.

Paying for domestic partner benefits

If your domestic partner is not eligible for tax-free benefits, deductions for his/her coverage and/or child(ren) of a domestic partner are taken on a post-tax basis.

Deductions for your individual coverage are still taken on a pre-tax basis.

In addition, unless a domestic partner and/or child(ren) of a domestic partner are eligible for tax-free benefits under the IRS rules and regulations, Compass Group's contributions toward the cost of domestic partner and/or child(ren) of a domestic partner coverage is considered taxable income for the associate. This is called *Imputed Income* and will be reflected on your pay stub for each pay period throughout the calendar year and on the year-end W-2 form.

If your domestic partner is eligible for tax-free benefits, you will need to complete and return a *Domestic Partnership Tax Certification* form to the Benefits Department. The form is available at www.altogethergreat.com.

If you have any questions about the tax status of your domestic partner and/or child(ren) of a domestic partner, you should consult your tax advisor.

Eligibility and enrollment

For you

You are eligible to participate in the benefit program if you are listed as a full time, non-union hourly associate in the payroll system and are normally scheduled to work at least 30 hours each week. You are eligible for most benefits on the first day of the month following three months of service at Compass Group.

For your dependents*

You have three levels of coverage for each of the medical, dental and vision options. You can cover:

- Yourself only.
- Yourself and one dependent.
- Yourself and two or more dependents.

Your eligible dependents include:

- Your lawful spouse.
- Your certified domestic partner who has been living with you for at least six months.
- Your children (including stepchildren and children of your domestic partner) up to age 26.**
- Your unmarried children age 26 or older who are mentally or physically unable to care for themselves, but only if the disability arose at a time when the child could have been covered as a dependent under Compass Group's benefits.

* Compass Group audits dependents periodically to verify dependent eligibility status. It is your responsibility to notify the Benefits Department when a dependent becomes ineligible for coverage.

** Some state mandates may apply.

Due to federal requirements, you will need to provide Social Security Numbers for spouses and domestic partners when you enroll for coverage.

"Children" means your natural children. It also includes your legally adopted children, children placed for adoption (to the extent required by federal and/or state law), stepchildren and foster children. In addition, the definition of "children" also includes the dependent children of your qualified domestic partner. (Note: Foster children are not eligible for life insurance coverage.)

Parents and grandparents **are not** eligible dependents and cannot be covered under the Compass Group benefit plans, even if fully supported by you or in your custody.

Grandchildren, nieces and/or nephews and sisters and/or brothers **are not** eligible dependents, **unless you have legal guardianship and the dependent meets the age restrictions.**

Dependent coverage continues as long as the dependent relationship continues. When that relationship ends, dependent coverage normally stops. For example, dependent coverage for a child ends when the child reaches the age limit.

Coverage for a dependent child ends the day before the dependent child reaches age 26, unless the dependent child meets the requirements for a child who is age 26 or older and is mentally or physically unable to care for themselves and the disability has occurred prior to age 26.

To qualify for domestic partner status and to add a child of your domestic partner, the associate and domestic partner must meet all of the following criteria:

- Declare they are each other's sole domestic partner and have a committed relationship that is at least six months in duration and is intended to be of indefinite duration.
- They must not be legally married to anyone else.
- They must be at least eighteen years old.
- They must not be related by blood to a degree of closeness that would prohibit legal marriage in the state in which they reside.
- They must reside together in the same residence and intend to do so indefinitely.
- They must be jointly responsible for each other's common welfare and share financial obligations.

When you add a domestic partner to your Compass Group coverage, complete and return the *Domestic Partnership* affidavit to the Benefits Department. The affidavit is available at www.altogethergreat.com. In addition, if your domestic partner is eligible for tax-free benefits, you will need to complete and return a *Domestic Partnership Tax Certification* form to the Benefits Department. The form is available at www.altogethergreat.com.

In addition to coverage for yourself, you also can choose to cover your spouse or domestic partner and/or children under the Life Insurance and Accidental Death and Dismemberment (AD&D) Insurance Plans.

Enrolling

To enroll for benefits, you must enroll at www.altogethergreat.com within one month of your eligibility date. Then, each Annual Enrollment period, you have the opportunity to make new benefit elections for the upcoming year. If you do not have access to the web, contact the Benefits Answerline at 800-341-7763, option 1, to elect your benefits over the phone. All newly eligible associates must complete their enrollment by the deadline or the following "default" coverage will be assigned: Basic Life Insurance of $5,000.

Assigned coverage does not include Medical, Dental, Vision, Supplemental Life, Dependent Life, Accidental Death and Dismemberment (AD&D), Flexible Spending Accounts (FSAs), Commuter Benefits or Voluntary Benefits.

When coverage begins

Your coverage can begin as early as the first day of the fourth month after you start work. For example, if your first day of work is March 15, you become eligible for coverage on July 1 (the first of the month following three full months of service). If you:

- Enroll on or prior to July 1, your coverage will begin on July 1.
- Enroll between July 2 and August 1, your coverage will begin on August 1.
- Do not enroll by August 1, you will have default coverage only for that year. Your next opportunity to enroll for the coverage of your choice is the next Annual Enrollment period or when you have a qualified family/employment status change.

Family/employment status changes

Generally, once your benefit selections are made, they remain in effect for the rest of the plan year (January 1 – December 31) and cannot be changed — unless you have a qualified status change event or qualify for a Health Insurance Portability and Accountability Act (HIPAA) special enrollment.

It is important to consider your benefit needs and choose benefits that will meet those needs. However, if your family or employment status changes, you may be allowed to add, drop or change some benefits **by the appropriate deadline** for the following status change events. **Your election change must be because of and consistent with the status change event.**

HIPAA Special Enrollment events **(two-month deadline)** include:

- Marriage or qualified domestic partnership.
- Birth, legal adoption of child, placement for adoption, guardianship.
- Loss of group insurance coverage (associate, spouse/domestic partner and/or dependent children lose coverage through another employer or Medicare).
- Gain or loss of Medicaid or Children's Health Insurance Program (CHIP) coverage.

Qualified status change events **(one-month deadline)** include:

- Gain of group coverage (associate, spouse/domestic partner and/or dependent children gain coverage through another employer or Medicare).
- Dependent loses eligibility (divorce/legal separation/ termination of domestic partnership/guardianship termination).
- Death of a dependent.
- Child care change.

If you have one of these events and notify Compass Group by the appropriate deadline, you may be able to change your coverage election to:

- Add a new spouse or dependent.
- Initially enroll for coverage.
- Drop coverage.

In addition, HIPAA events may allow you to change plans.

More about HIPAA special enrollment events

If you lose other group health plan coverage, you qualify if each of the following conditions is met:

- You are otherwise eligible for coverage under the Plan, and
- You were covered under another health benefit plan at the time this coverage was previously offered and declined enrollment due to the other coverage, and
- You lose coverage under another health benefit plan due to i) the exhaustion of the COBRA continuation period, or ii) the loss of eligibility for that coverage for reasons including, but not limited to, legal separation, divorce, loss of dependent status, death of the associate, termination of employment, or reduction in the number of hours of employment, or iii) the termination of the other plan's coverage, or iv) the offered health benefit plan not providing benefits in your service area and no other health benefit plans are available, or v) the termination of employer contributions toward the cost of the other plan's coverage, or vi) meeting or exceeding the lifetime benefit maximum, or vii) the discontinuance of the health benefit plan to similarly situated individuals.

You also qualify if your dependent loses other group health plan coverage and meets all these conditions.

Compass Group also will allow a HIPAA special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for your state's premium assistance program under Medicaid or Children's Health Insurance Program (CHIP).

More about qualified status change events

You also can make changes to your pre-tax benefit elections during the calendar year if you have a qualified status change event. However, your election change must be because of and consistent with the status change event. These rules do not apply to commuter benefits.

The following describes qualified status change events in more detail.

Dissolution of marriage/domestic partnership. An event that changes your legal marital status/domestic partnership, such as the death of your spouse/domestic partner, divorce, legal separation, annulment, and dissolution of a domestic partnership.

Employment status. An event that changes the employment status of you, your spouse/domestic partner or your dependent, other than a HIPAA special enrollment event. This may include a termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence (such as FMLA) or a change in the state where you work. Status changes also include change in your employment status, or that of your spouse/domestic partner or dependent that results in the individual(s) becoming eligible to participate in a plan sponsored by the employer of your spouse/domestic partner or dependent.

Reduction in hours or rate of pay. An employment change resulting in a reduction of your hours or your rate of pay by 20% or more, you will be allowed to drop coverage — 20% or more is considered "significant." The reduction in hours or rate of pay must be "permanent" in order to qualify as a status change.

Residence. A change in the place of your residence or the residence of your spouse/domestic partner or dependent that affects eligibility for coverage under the plan.

Dependent satisfies or ceases to satisfy eligibility requirements. Events that cause your dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, or any similar circumstance.

Any election change must be consistent with your status change. For example, if your status change is a dependent child ceasing to be eligible under the plan, an election change that would be consistent is one that would remove the dependent from your coverage. However, this status change would not permit you to remove your spouse/domestic partner from coverage.

Other qualifying events

Federal law currently recognizes several other events that will permit you to make election changes during the plan year. They include:

Family Medical Leave Act (FMLA) leave. FMLA leave is a leave of absence under the Family and Medical Leave Act. When you go on FMLA leave, you may be able to drop coverage. Upon return, your coverage will be reinstated. Certain limitations may apply.

Judgments, decrees or orders. You may make a change that corresponds to any valid judgment, decree or order (including a court-approved settlement agreement) that requires medical coverage through Compass Group for your child or qualifying dependent. In the case of a child whom you're required to cover because of a Qualified Medical Child Support Order (QMCSO), coverage will begin on the date specified in the order, or if none is specified, the date of the order.

You may decrease your coverage for that child if the court order requires the child's other parent to provide coverage and your current or former spouse's/domestic partner's plan actually provides that coverage.

Qualified Medical Child Support Order (QMCSO). The plan will comply with any medical child support order (as defined under Section 609(a) of ERISA) that is a QMCSO. When Compass Group receives a court order, it will be reviewed to determine if it is a QMCSO. If the order is deemed qualified, the child must be added to your medical coverage consistent with the court order and you will be notified by Compass Group.

If you are not enrolled in a Compass Group medical, dental or vision plan at the time the court order is received, you will be enrolled in order to add the court ordered dependent. You will be enrolled in the most appropriate and affordable plan that is available to you and is consistent with the court order.

If your coverage level increases to Associate Plus One or Associate Plus Two or More Dependents when your child is added, your cost for coverage will also increase.

Once the QMCSO is in place, coverage will remain active until the dependent loses eligibility or a court issued termination of medical support order is received by the Benefits Department. See *Continuing Your Coverage Under COBRA*, beginning on page 19, for details on coverage if dependents are no longer eligible for coverage.

Significant cost or coverage changes.

These do not apply to changes in your Flexible Spending Accounts (FSAs).

- If the cost of the option increases or decreases significantly during the plan year as a result of action taken by you or Compass Group, you may:
  1) Elect a corresponding increase or decrease in your contributions.
  2) You may revoke your election if you elect similar coverage under another option that provides similar coverage on a prospective basis.
  3) Drop coverage if another benefit package providing similar coverage is available.
- If coverage under an option is either significantly curtailed without a loss of coverage (for example, there is a significant increase in the deductible, copay or out-of-pocket cost-sharing limit under an accident or health

plan) or ceases during a plan year, you may revoke your election if you elect similar coverage under another option that provides similar coverage on a prospective basis. Coverage under any option providing accident and health benefits will be deemed to be significantly curtailed only if there is an overall reduction in benefits that constitutes reduced coverage to participants generally.

- If coverage under an option ceases (for example, the elimination of your option or HMO ceases to be available in the area where you reside or a substantial decrease in the medical care providers available under your option), you may either revoke your election and elect coverage under another option that provides similar coverage on a prospective basis, or you may drop coverage if no similar coverage is available.
- If a new option is added (or an existing option is significantly improved) during a plan year, you may select the new or improved option on a prospective basis and make corresponding election changes with respect to other options that provide similar coverage.
- You may make a prospective election change that corresponds with a change made under a benefit plan sponsored by the employer of your spouse/domestic partner, former spouse/domestic partner, or dependent, provided the plan permits its participants to make similar election changes or maintains a different plan year than the Compass Group benefits plan.

The Benefits Department must receive your written request to change your benefit election within the appropriate timeframe of a change in family/employment status, otherwise you must wait until the next Annual Enrollment period.

A status change form to request a benefit change can be obtained by calling the Benefits Answerline at 800-341-7763, option 1, or at www.altogethergreat.com. You must submit written evidence of the event on which you base a request for a benefit change, such as proof of birth, a marriage certificate, a death certificate, coverage verification regarding the loss or gain of insurance, or court order granting a divorce, legal separation, or custodial change.

More about Medicaid and Medicare coverage

If you, your spouse/domestic partner or your dependent who is enrolled in a Compass Group medical, dental and/or vision plan becomes enrolled in coverage under Medicaid or Medicare Part A or Part B, you may make an election change request to cancel or reduce coverage for that individual under the Compass Group Benefits Program. Similarly, if you, your spouse/domestic partner or your dependent who has been entitled to coverage under Medicaid and Medicare lose eligibility for such coverage, you may make an election change request to enroll in the Compass Group plans to commence or increase coverage for that individual under the Compass Group's benefits program.

When can I make a change?

You must make the change within the appropriate timeframe (one month or two months) of the occurrence of the family or employment status change event. You will be required to submit the appropriate supporting documentation. (Also, life insurance increases may require evidence of insurability or EOI). If the change is not requested within the appropriate timeframe of the status change event date, you must wait until the next Annual Enrollment period to make the benefit change.

If you already are enrolled in a Compass Group medical, dental or vision plan when you have a qualified family status change, you may change your coverage level (for example, from Associate Only to Associate Plus One Dependent).

You may be able to change your medical plan option if you have a HIPAA special enrollment event — or if such a change is because of and consistent with the status change. For example, if you move out of a plan's service area, you could then change plans. But, if you divorce your spouse, you must stay in the same plan and drop the ex-spouse from coverage.

You may change your coverage by one level with respect to the life insurance programs (Associate and Dependent), if you have certain family or employment changes during the year. For example, if you now select $5,000 for supplemental life insurance coverage, you may be able to increase your coverage to $10,000 if you have an eligible family or employment status change.

Remember, it is your responsibility — not your manager's — to complete and send in the necessary forms.

Situations affecting coverage

Family and Medical Leave

The Family and Medical Leave Act (FMLA) allows eligible associates to take up to 12 weeks of unpaid, job- and benefits-protected leave during a 12-month period for specific medical and/or family reasons. In addition, associates may be eligible for up to 26 weeks of unpaid leave in a 12-month period to care for a family member wounded in military service.

You are eligible for family medical leave if you have been with Compass Group for one year and have completed 1,250 hours of service in the previous 12 months.

Note that this section highlights some of the FMLA rules. For a complete set of Compass Group policies or to address your particular situation, contact the Leave of Absence Team at 800-341-7763, option 2.

The following reasons qualify for family medical leave:

- Birth of your child, or the placement of a child for adoption or foster care in your home.
- Care for an immediate family member — your spouse/domestic partner, child or parent — with a serious health condition.
- Your inability to work because of a serious health condition.
- Qualifying exigencies arising from a family member's call to active military service.
- Care for a family member wounded in active military service.

Going on leave

You must give 30 days advance notice to Compass Group if your leave is foreseeable. If you cannot give 30 days notice, you should provide as much notice as possible.

Leave request forms are available from the Leave of Absence Team. To provide notice of leave, complete a leave request form and return it to the Leave of Absence Team. Compass Group will require a doctor's written certification as proof of a serious health condition. If requested, you must provide a medical certification form completed by your doctor within 21 days of Compass Group's request. Compass Group also may require you to get a second or third medical opinion. Any expenses you incur for obtaining the additional medical opinions will be paid by Compass Group.

While on leave

If you are on leave because of a family member's or your own health condition, you may be asked to provide medical proof of that condition periodically, and that proof must be provided within 21 days of Compass Group's request.

If you are covered by a Compass Group plan before going out on leave, your coverage will continue as long as you make any required contributions. For more information, refer to the Family and Medical Leave policy in your HR Handbook.

When you return to work

When you return from leave, you will be restored to your original or an equivalent position, with equivalent pay, benefits and other employment terms as if you had not taken the leave if your leave was designated as FMLA. However, certain associates who are considered "key" associates may not be restored if their reinstatement would cause substantial economic harm to Compass Group.

Compass Group will require a medical release from your doctor before you can return to work. You can send the release to the Leave of Absence Team before you return.

Otherwise, you must present it to your supervisor on the day you return and also fax a copy to the Leave of Absence Team.

If you do not return to work

If you do not come back to work when your leave ends, you will be eligible to continue healthcare coverage through COBRA. The date you should have returned to work will be the date your coverage is considered to end for determining COBRA coverage. See *Continuing Your Coverage Under COBRA*, beginning on page 19, for details.

More information

For more information on family medical leave, contact the Leave of Absence Team.

For more information on the Family and Medical Leave Act (FMLA), you may contact the Leave of Absence Team or the Wage and Hour Division of the U.S. Department of Labor.

Military leave

If you take a military leave, whether for active duty or for training, you are entitled to extend your medical coverage for the length of the leave or 24 months, whichever is shorter, as long as you give Compass Group advance notice of the leave (with certain exceptions). If Compass Group does not receive notice to extend your coverage, benefits will cease on the 30th day of military leave. Your total leave, when added to any prior periods of military leave from Compass Group, cannot exceed five years (with certain exceptions).

If the entire length of the leave is 30 days or less, you will not be required to pay any more for coverage than the amount you paid before the leave. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the full coverage amount as required under COBRA.

If you take a military leave, but your coverage under the plan is terminated (for instance, because you do not elect the extended coverage), you will be treated as if you had not taken a military leave upon re-employment when determining whether exclusions or waiting periods apply.

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA) regulates how a group health plan may:

- Apply pre-existing condition exclusions.
- Require plans to provide documentation of coverage for former associates and dependents to use when they apply for other group coverage.
- Permit special enrollment periods and prohibits discrimination based on health status.

HIPAA also requires the plan to maintain the privacy of your health information and to provide you with a notice of the plan's legal duties and privacy practices with respect to your health information.

The notice will describe how the plan may use or disclose your health information, and under what circumstances it may share your health information without your authorization (generally, to carry out treatment, payment or healthcare operations). In addition, the notice will describe your rights with respect to your health information. Please refer to the plan's privacy notice for details. You can obtain a copy of this notice on the Online Benefits Center at www.altogethergreat.com.

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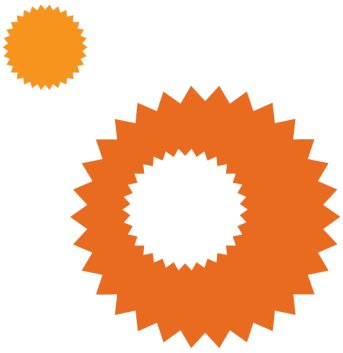
Life Events



The only sure thing about life is that it changes. You may get married, have children, take a leave of absence, or change jobs. These events not only change your life, they could affect your benefits. That's one of the many advantages of Compass Group Benefits Program — your coverage may be adjusted to meet your new needs each time your life changes.

The following two pages provide a summary chart of the most common status change events that legally permit benefit election changes outside of the regular annual enrollment period, and outline the corresponding changes that may be made to your Compass Group Benefits Program if one of these events occurs. The chart assumes that dependent children meet the plan's eligibility requirements.

Remember that you may change your beneficiary information at any time by calling the Benefits Answerline at 800-341-7763, option 1.

In this section

Life event summary chart

EVENT	MEDICAL/DENTAL/ VISION	SUPPLEMENTAL LIFE INSURANCE	DEPENDENT LIFE INSURANCE	DISABILITY INCOME PROTECTION (DIP) AND LONG TERM DISABILITY INSURANCE (LTD)	ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)	HEALTH CARE SPENDING ACCOUNT	DEPENDENT CARE SPENDING ACCOUNT
HIPAA Special Enrollment – Two Months to make changes							
Marriage/qualified domestic partnership (New dependents can enroll in life insurance and AD&D benefits at any coverage level)	• Enroll associate, along with spouse/domestic partner or dependent children • Add spouse/domestic partner and dependent children to current plan • Choose new option ***Domestic partner to spouse – no changes allowed**	• Enroll in $5,000 coverage level • Increase current coverage by one level ***Domestic partner to spouse – no changes allowed**	• Enroll in coverage at any level • Add dependent to current coverage • Increase current coverage by one level • Decrease current coverage to any level • Drop current coverage ***Domestic partner to spouse – no changes allowed**	• No change	• Enroll in coverage at any level • Add dependent to current coverage • Increase current coverage by one level • Decrease current coverage to any level • Drop coverage ***Domestic partner to spouse – no changes allowed**	• Enroll • Increase ***Domestic partner to spouse – no changes allowed**	• Enroll • Increase ***Domestic partner to spouse – no changes allowed**
Birth/adoption/ placement for adoption/ guardianship (New dependents can enroll in life insurance and AD&D benefits at any coverage level)	• Enroll associate, along with spouse/domestic partner or dependent children • Add dependent child to current plan • Choose new option	• Enroll in $5,000 coverage level • Increase current coverage by one level	• Enroll in coverage at any level • Add dependent to current coverage • Increase current coverage by one level	• No change	• Enroll in coverage at any level • Add dependent to current coverage • Increase current coverage by one level • Decrease current coverage to any level • Drop coverage	• Enroll • Increase	• Enroll • Increase
Loss of group coverage (Associate, spouse/domestic partner and/or dependent children lose coverage through another employer, Medicaid/CHIP, Medicare, etc.)	• Enroll associate, along with spouse/domestic partner or dependent children • Add spouse/domestic partner and dependent children to current plan • Choose new option	• Enroll in $5,000 coverage level • Increase current coverage by one level • Decrease current coverage to any level • Drop coverage	• Enroll in coverage at the 1st level • Increase current coverage by one level • Decrease current coverage to any level • Drop coverage	• No change	• Enroll in coverage at the 1st level • Add dependent to current coverage or increase by one level • Decrease current coverage to any level • Drop coverage	• Enroll • Increase	• Enroll • Increase
Gain of Medicaid/ CHIP coverage	• Drop associate, spouse/domestic partner or dependent children	• No change	• No change	• No change	• Enroll in coverage at the 1st level • Add dependent to current coverage or increase by one level • Decrease current coverage to any level • Drop coverage	• Decrease up to amount used or deducted – whichever is greater	• No change

Please note: Coverage can only be dropped if you and/or your dependents are covered under another group plan. Similarly, you only can enroll in coverage for yourself and/or your dependents if coverage is lost from another group plan. Where applicable, references to child(ren) include: Your natural child(ren), stepchild(ren), legally adopted child(ren), and qualifying dependent child(ren) of a domestic partner.

Life event summary chart

EVENT	MEDICAL/DENTAL/ VISION	SUPPLEMENTAL LIFE INSURANCE	DEPENDENT LIFE INSURANCE	DISABILITY INCOME PROTECTION (DIP) AND LONG TERM DISABILITY INSURANCE (LTD)	ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)	HEALTH CARE SPENDING ACCOUNT	DEPENDENT CARE SPENDING ACCOUNT
Qualified Status Change Event – One Month to make changes							
Gain of group coverage (Associate, spouse/domestic partner and/or dependent children gain coverage through another employer, Medicare, etc.)	• Drop associate, spouse/domestic partner or dependent children	• Enroll in $5,000 coverage level • Increase current coverage by one level Decrease current coverage to any level • Drop coverage	• Enroll in coverage at the 1st level • Increase current coverage by one level • Decrease current coverage to any level • Drop coverage	• No change	• Enroll in coverage at the 1st level • Increase current coverage by one level Decrease current coverage to any level • Drop coverage	• Decrease up to amount used or deducted – whichever is greater	• None
Dependent loses eligibility (Divorce/legal separation/ termination of domestic partnership/ guardianship termination)	• Drop dependent	• Enroll in $5,000 coverage level • Increase current coverage by one level Decrease current coverage to any level • Drop coverage	• Drop dependent	• No change	• Drop dependent • Decrease current coverage to any level • Drop coverage	• Decrease up to amount used or deducted – whichever is greater	• Decrease up to amount deducted • Discontinue election
Child care change	• No change	• No change	• No change	• No change	• No change	• No change	• Enroll • Increase • Decrease • Drop
Other Events							
Commencement of an approved leave of absence	• Drop coverage during LOA	• Drop coverage during LOA	• Drop coverage during LOA	• No change	• Drop coverage during LOA	• Decrease during LOA up to amount used or deducted – whichever is greater	• Decrease during LOA up to amount deducted
Return from an approved leave of absence	• All coverage enforced on your last active day of work will be reinstated	• All coverage enforced on your last active day of work will be reinstated	• All coverage enforced on your last active day of work will be reinstated	• No change	• All coverage enforced on your last active day of work will be reinstated	• All coverage enforced on your last active day of work will be reinstated	• All coverage enforced on your last active day of work will be reinstated
Death of a dependent	• Drop deceased dependent	• Enroll in $5,000 coverage level • Increase current coverage by one level Decrease current coverage to any level • Drop coverage	• Benefit amount paid • Enroll surviving dependents at the 1st level • Increase current coverage by one level • Drop coverage	• No change	• Enroll in coverage at the 1st level • Increase current coverage by one level • Decrease current coverage to any level • Drop coverage	• Decrease up to amount used or deducted – whichever is greater	• Enroll • Increase • Decrease up to amount deducted
Death of an associate	• All coverage ends at 11:59 pm as of the date on the death certificate						

Please note: Coverage can only be dropped if you and/or your dependents are covered under another group plan. Similarly, you only can enroll in coverage for yourself and/or your dependents if coverage is lost from another group plan. Where applicable, references to child(ren) include: Your natural child(ren), stepchild(ren), legally adopted child(ren), and qualifying dependent child(ren) of a domestic partner.

Making changes

If you wish to make changes to your benefit elections, complete and return a Status Change form along with any required documentation within the required timeframe (within one month of your qualified status change event or within two months of your HIPAA special enrollment event).

How do I get a Status Change form?

You can obtain a Status Change form at www.altogethergreat.com or by calling the Benefits Answerline at 800-341-7763, option 1. **In order for your changes to be processed, you must send a Status Change form and the required documentation to the Compass Group Benefits Department by the appropriate deadline. Fax the form and documentation to 704-328-4124.**

Acceptable forms of documentation

Marriage/qualified domestic partnership	• A copy of the marriage certificate/domestic partnership affidavit.
Birth/adoption/ placement for adoption/guardianship	• Proof of birth, or a copy of the birth certificate. • Adoption/guardianship papers or proof that the child has been placed in your home.
Loss of group coverage	• A letter from employer, Medicaid/CHIP, Medicare, etc., indicating type of coverage lost, dependents who were covered and date coverage ended.
Gain of Medicaid/CHIP coverage	• A letter from Medicaid/CHIP indicating the type of coverage gained, dependent(s) covered and the date coverage began.
Gain of group coverage	• A letter from employer, Medicare, etc., indicating the type of coverage gained, dependent(s) covered and the date coverage began.
Dependent loses eligibility	• A letter stating that your dependent is no longer eligible, or • A copy of the court order granting a divorce or legal separation/domestic partnership termination certification and proof of lost group coverage.
Death of a dependent or associate	• A certified death certificate.

When do the changes take effect?

If the Benefits Department receives your Status Change form and documentation by the appropriate deadline of your life event date, the coverage change and payroll deductions are effective as follows.

Status change event effective date

Marriage/qualified domestic partnership	• The date of your marriage. • Six months from the beginning of the domestic partnership.
Birth/adoption/placement for adoption/ guardianship	• The date of your child's birth. • The date your adopted child is placed with you for adoption. • The date of court-appointed guardianship.
Loss of group coverage	• The day after previous coverage ends.
Gain of Medicaid/CHIP coverage	• The day before new coverage begins.
Gain of group coverage	• The day before new coverage begins.
Dependent loses eligibility	• The date of your child's loss of eligibility. The date of divorce/legal separation. • The date the domestic partnership ends.
Death of a dependent or associate	• The day after the date of death.
Your termination of employment	• At midnight on the day of your termination.

If the Benefits Department does not receive your Status Change form by the appropriate deadline of the life event date, you must wait until the next Annual Enrollment period to make changes to your coverage. If the event causes a dependent to become ineligible and you miss the deadline — call the Benefits Answerline at 800-341-7763, option 1, for assistance.

If Your Life Event Affects…

- **Your name:** Contact your supervisor to have your name changed in Compass Group records.
- **Your address:** If you move, contact your supervisor immediately to have your address changed in Compass Group records.
- **Your W-4 withholding status:** Submit a revised W-4 to Payroll Services. Contact your supervisor or Payroll Services to get a W-4 form.

Coordinating benefits between two plans

Primary and Secondary Plans

Primary Plan — The primary plan pays full benefits as if there were no other plan.

Secondary Plan — The secondary plan pays any excess costs according to the coordination rules of the secondary plan. If the Compass Group plan is secondary, it will pay the difference, if any, between the amount that would have been paid if the Compass Group plan was primary and the amount the primary plan pays. The benefits that would be payable under this Plan in the absence of Coordination of Benefits will be reduced by the benefits payable under all other plans for the expense covered under this Plan. Coverage under this Plan plus another plan will not guarantee 100% total reimbursement.

If you or your dependents are covered under a Compass Group plan AND another group plan (like your spouse/domestic partner's plan), benefits will coordinate between the plans to provide payment. If the Compass Group plan is secondary, it will pay the difference, if any, between the amount that would have been paid if the Compass Group plan was primary and the amount the primary plan pays. An allowable expense is any expense covered in full or part under any one of your plans. If an expense is not a covered expense in either of the plans, the plan will not pay benefits.

Other medical, dental and vision plans may include benefits or services provided by any of the following:

- Other group insurance.
- Any type of union-negotiated plan.
- Any governmental program or coverage required by law.
- No-fault automobile insurance.
- Medicare and TRICARE (to the extent permitted by law).

Guidelines are used to determine which plan pays first:

- A plan that doesn't contain a coordination of benefits provision pays first.
- The plan covering the patient as the associate is primary and pays first.
- For a dependent child, if both parents have group medical plans, the parent whose birth date (excluding the year of birth) comes first during the calendar year will pay first. For example, if the father was born on May 15 and the mother on July 20, the father's plan would be primary. On the other hand, if the father was born on August 21 and the mother on February 2, the mother's plan would be primary. If both parents have the same birth date, the plan that covered one parent for a longer period would be primary. This is known as the "birthday rule".
- A plan that doesn't have the "birthday rule" as stated above will determine which plan is primary.
- There are additional Guidelines concerning dependents. In the case of a divorce or separation, the plan of the parent with custody of a dependent child usually pays benefits for the child first. If the person with custody remarries, the stepparent's plan pays second and the plan of the natural parent without custody pays third. However, if a court decree places financial responsibility for the dependent child's healthcare on one parent, that parent's plan pays first.
- If none of these situations fit, the plan covering the person the longer time pays first, except when both plans provide that the plan covering a person as the associate always pays before a plan covering that person as a former associate or retiree. In this case, the plan covering the active associate pays first. If the other plan does not have a provision regarding retired or former associates, this exception will not apply to that plan.

In order to properly apply these benefit coordination rules, the claims administrator has the right to:

- Provide or receive information needed to determine benefits. The plan may provide or request any information without notifying you. If the requested information is not furnished, the plan has the right to deny benefit payments.
- Recover money paid in excess of that allowed under the coordination of benefits rules.

Does it pay to have coverage under two medical plans?

Here is an example of a claim payment if your spouse/domestic partner and/or children are covered under a Compass Group medical plan and another group medical plan (your spouse/domestic partner's, for example). This example assumes that the Compass Group plan is secondary and your spouse/domestic partner's plan is primary. It also assumes the annual deductible for both plans has been met.

Your Compass Group plan: 80% covered charges paid

Your spouse/domestic partner's plan: 70% covered charges paid

Spouse/domestic partner's plan pays:

	$3,000	covered expense
x	70%	
	$2,100	primary benefit

Compass Group plan pays of the difference, if any:

	$3,000	covered expense
x	80%	
	$2,400	
so		
	$2,400	covered expense
-	$2,100	primary benefit
	$300	

In this example, the Compass Group plan (as the secondary plan) would pay a $300 benefit.

Subrogation

Benefits may not be payable under this plan when a member experiences an injury or illness legally attributable to an act or omission of another person or on a work-related injury unless prohibited by state law. (For example, you are injured in an automobile accident that is wholly or partially someone else's fault.) However, payment for expenses for an injury or illness which a third person has caused may be advanced by the plan administrator. The plan administrator specifically reserves and maintains the right to recover these payments for members injured due to the negligence or wrongful acts of another person or a work-related injury. This is known as "subrogation."

If you request advance payment for medical expenses incurred due to the act or omission of another person, you may be required to sign a reimbursement agreement. This agreement provides that if the plan has advanced payment for your medical expenses, and you receive compensation for the same expenses from a third party, including but not limited to an individual or the individual's insurer, you will reimburse the plan administrator for benefit payments related to that injury/illness. By accepting or applying for the advanced payments, the covered individual is conclusively presumed to have agreed to such reimbursement. The plan administrator will make no further payments for services related to the injury until this reimbursement agreement is signed; however, failure by the plan administrator to secure a signed reimbursement agreement from the covered individual prior to the advancing of payments for services due to the acts or omissions of others will not constitute a waiver of the plan administrator's right to receive reimbursement for such advanced payments.

See page 139 for more about subrogation in the *Administrative Information* section.

When coverage ends

Coverage for you

Your medical, dental and vision plan coverage will end when the first of these events occurs:

- The date you are no longer an eligible full time associate.
- The last day of the period for which you have made a required contribution, if you fail to make the next required contribution.
- The day your employment with Compass Group ends for any reason, including retirement. However, if you were hired prior to January 1, 1993, by Canteen Corporation, you may be eligible for continued medical coverage if you retire from Compass Group at age 55 or older and have completed 15 years of credited service.
- The date the plan is amended to terminate coverage for a class of associates of which you are a member.
- The date you choose to stop coverage due to a family/employment status change.
- The date your covered expenses reach the annual maximum level set by the plan. (This depends on the medical option you choose.)
- During the Annual Enrollment period, you do not elect to continue coverage for the next year. In this case, coverage will end on the last day of the current calendar year.

If your medical, dental and/or vision coverage ends, you may be eligible to continue coverage. See *Continuing Your Coverage Under COBRA* on page 19.

Coverage for your dependents

Coverage for your dependents ends when the first of these events occurs:

- The date your coverage ends.
- The date a dependent ceases to be an eligible dependent (for example, he or she reaches the age limit).
- The last day of the period for which any required contribution is made, if the next required contribution is not made.
- The date the plan is amended to end dependent coverage.
- The date you choose to stop coverage due to a family/employment status change.
-

If the plan is terminated

If the medical, dental and/or vision plan is terminated, all associate and dependent coverage will stop as of the termination date.

Reinstatement of coverage after termination

If your coverage terminates because you are no longer eligible, and you become eligible again within 30 days after the date your coverage is terminated, coverage under the certificate, including all benefits previously terminated, may be reinstated. That is, provided you are not then covered by an individual policy issued under the terms of the conversion right section of the certificate.

Your coverage under the certificate may be reinstated automatically, without EOI or a waiting period. The amount of insurance will be that which applies to the classification to which you belonged prior to the termination of employment unless Compass Group, in its sole discretion, determines that your termination was bona fide and not a pretext to modify the level of coverage in the absence of a legitimate change of status. If the policyholder's plan of insurance provides for contributory insurance under the certificate, your amount of contributory insurance will be limited to that for which you were insured immediately prior to the loss of coverage.

Certificates of Coverage

If you or your dependent loses health coverage under the plan, you automatically will receive a certificate showing your creditable coverage under the plan. See *Health Insurance Portability and Accountability Act (HIPAA)* on page 11.

If you become eligible for other medical coverage that excludes or delays coverage for certain pre-existing conditions, you can use this certificate to receive credit — to help reduce the new plan's pre-existing condition limit — for the time you were covered by the Compass Group plan.

In addition to the certificate of creditable coverage you receive when you lose coverage, you also may request a certificate from Compass Group within 24 months after coverage ends.

Continuing your coverage under COBRA

The federal law is called the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA. It requires that employers like Compass Group allow covered associates and their covered dependents (called “qualified beneficiaries”) to temporarily extend Compass Group group health plan coverage (called “COBRA coverage”) at group rates. That means you may be eligible to extend your medical, dental and vision benefits, and in some instances FSA by electing COBRA continuation coverage.

COBRA coverage is available to you and your covered eligible dependents in certain instances where coverage would otherwise end (called “qualifying events”). For example, COBRA coverage is available to you and your covered eligible dependents if you are terminated, or if your hours are reduced to the extent that you no longer qualify for Compass Group coverage. However, in certain circumstances involving termination for gross misconduct, COBRA coverage may not be available.

The following information is intended to generally inform you of your rights and obligations under the continuation coverage provisions of COBRA. Keep in mind that the coverage described below may change as permitted or required by changes in any applicable law. In some states, state law provisions may also apply to the insurers offering benefits under the Compass Group plan.

For more information and to notify the plan of an event that qualifies for COBRA (such as divorce or a child who reaches age 26), contact Compass Group Benefits Department at:

Compass Group Benefits Department
Attention: COBRA
2400 Yorkmont Road
Charlotte, NC 28217
800-341-7763, option 2

You must notify Compass Group of a qualifying COBRA event in writing within 60 days.

You don’t have to show that you’re insurable to choose COBRA coverage. However, COBRA coverage is provided subject to your eligibility for coverage as described below. Compass Group reserves the right to terminate your and/or your dependents’ coverage retroactively if it’s determined that you and/or your dependents are ineligible for COBRA coverage under the terms of the Compass Group plan.

COBRA can continue for up to 18, 29 or 36 months, depending on the reason you or your dependent become eligible. Unlike active coverage, COBRA coverage can be canceled at any time.

Individuals who elect continued coverage under COBRA generally have to pay the entire cost of that coverage for themselves and their covered dependents. You will be responsible for paying 102% of the premium cost. The 102% cost is based on you paying 100% of the plan cost (including the additional cost Compass Group paid while you were employed) in addition to a 2% administration fee.

Through COBRA, you may continue the same healthcare coverage you had before the event that qualified you for COBRA. If coverage for non-COBRA beneficiaries is modified, coverage made available to you through COBRA will be similarly modified.

COBRA at-a-glance

The following table provides an overview of available COBRA coverage that can be continued if you lose coverage on a qualifying event.

WHO IS AFFECTED	QUALIFYING EVENT	WHO IS ELIGIBLE FOR COBRA COVERAGE	DURATION OF COBRA COVERAGE*
You	• Terminate employment	• You and your covered dependents	• Up to 18 months
	• Have a reduction in hours below the level required for benefit eligibility	• You and your covered dependents	• Up to 18 months
	• Are disabled at the time you become eligible for COBRA or you are determined to be disabled within the first 60 days of COBRA continuation coverage	• You and your covered dependents	• Up to 29 months**
Your Spouse or Dependent Child(ren)	• You die	• Your covered dependents	• Up to 36 months
	• You and your enrolled spouse become divorced or legally separated	• Your former spouse and your other covered dependents, if coverage is lost because of the divorce	• Up to 36 months
	• The original COBRA event was termination of employment or reduction in hours and your spouse and/or dependent child is disabled at the time he or she becomes eligible for COBRA — or becomes disabled within the first 60 days of COBRA continuation coverage.	• You and your covered dependents	• 29 months**
Your Dependent Child(ren)* **	• Your dependent child is no longer an eligible dependent (for example, due to reaching a plan's age limit).	• Your covered dependent child(ren)	• 36 months
Your Domestic Partner or Child(ren) of Your Domestic Partner Effective June 1, 2012 – a domestic partner and child(ren) of a domestic partner will have the same COBRA rights as a spouse and dependent child(ren).	• If you elected to cover your domestic partner and/or eligible children of your domestic partner while active and have terminated employment, your domestic partner and/or eligible child(ren) of your domestic partner may be covered under COBRA. • You also may add them to your COBRA coverage while you are on COBRA. • Your domestic partner and/or eligible child(ren) of your domestic partner are not qualified beneficiaries in their own right.	• Your domestic partner and/or child(ren) of your domestic partner, if you elect to cover them. They cannot make elections of their own because they are not qualified beneficiaries.	• For as long as you (the associate/qualified beneficiary) elect to cover your domestic partner and/or eligible child(ren) of your domestic partner.

* Duration of COBRA coverage is measured from the last day of active benefits.

** You're required to provide proof of eligibility for Social Security disability benefits within 60 days of receiving the disability determination and before the end of the first 18 months of COBRA continuation coverage in order to be eligible for the additional 11 months of COBRA coverage. You must notify Compass Group of the Social Security Administration's determination of disability as instructed in "Duration of COBRA Coverage."

*** You are required to notify the Compass Group Benefits Department when your dependent is no longer eligible for coverage and to request a COBRA election package.

Who is eligible

As an associate

If you're covered by the Compass Group health plan on the day before a qualifying event, you have the right to elect COBRA coverage:

- If you lose coverage because your hours are reduced to the extent that you no longer qualify for Compass Group coverage, or
- Because your employment terminates.

Note: In some cases, you may have options to continue coverage directly under the Compass Group plan (e.g., leave of absence or illness).

As a covered spouse

If you're the legal spouse of an associate and you're covered by the Compass Group health plan on the day before the qualifying event, you're considered a "qualified beneficiary." That means you have the right to choose COBRA coverage for yourself if you lose group health coverage under the plan for any of the following reasons:

- The associate dies.
- The associate's employment is terminated.
- The associate's hours of employment are reduced.
- Divorce or legal separation from the associate.

As a domestic partner and/or child(ren) of a domestic partner

In certain circumstances, a domestic partner and/or child(ren) of a domestic partner will not be considered as a qualified beneficiary. Effective June 1, 2012 – a domestic partner and child(ren) of a domestic partner will have the same COBRA rights as a spouse and dependent child(ren).

As an eligible dependent child

If you're a dependent child of an associate and you're covered under the Compass Group health plan on the day before the qualifying event, you're also considered a qualified beneficiary.

This means you have the right to COBRA coverage if your coverage under the plan is lost for any of the following reasons:

- The associate dies.
- The associate's employment is terminated.
- The associate's hours of employment are reduced.
- Divorce or legal separation that causes the step child to lose coverage.
- The child ceases to be a dependent under the terms of the plan.

As a newly acquired dependent

If you are a former associate and a qualified beneficiary, and you have a newborn or adopted child, while you are covered under COBRA, that child can also receive COBRA coverage for the duration of your COBRA continuation coverage. You must notify Compass Group in writing within one month of the birth, adoption or placement for adoption for the child in order for the child to be covered as of the date of the birth, adoption or placement for adoption. In this case, the child will have the same rights as any dependent covered immediately prior to your COBRA eligibility. (A child is generally considered "placed for adoption" with you when you have assumed and retained a legal obligation for total or partial support of the child in anticipation of adoption.)

Written notice about a new dependent must include information about the qualified beneficiary receiving COBRA coverage as well as the new child who will be receiving COBRA coverage. Compass Group also will ask you to provide documentation supporting the birth, adoption or placement for adoption of the new child.

Note: All newly acquired dependents (such as a new spouse) won't be considered qualified beneficiaries but may be added to your COBRA coverage as dependents, in accordance with plan rules that apply to active associates.

If a qualifying event occurs while on COBRA

What you need to do

Under COBRA, you, your spouse or your other eligible dependents have the responsibility to inform the Compass Group Benefits Department of a divorce, legal separation or child's loss of dependent status under the Compass Group plan. Written notice must be provided within 60 days from the date of the divorce, legal separation or loss of dependent status.

You also must provide information about the associate or qualified beneficiary requesting COBRA coverage and any required documentation about the qualifying event that gave rise to the individual's right to COBRA coverage.

If you or the qualified beneficiary fails to notify the Compass Group Benefits Department in accordance with these procedures or to provide supporting documentation within one month, COBRA rights will be forfeited.

Documentation required

When you provide notice of the qualifying event, you or the qualified beneficiary must also submit documentation supporting the occurrence of the qualifying event. Acceptable documentation includes the documents listed below and any other supporting documentation approved by the plan administrator:

- **Divorce** — a copy of the divorce decree.
- **Legal Separation** — a copy of the separation agreement.
- **Child no longer qualifying as a dependent** — a copy of a driver's license or birth certificate showing the child's age or physician's statement that dependent child is no longer disabled.

When you inform the Compass Group Benefits Department that one of these events has happened (and the required documentation has been received), you will be notified as to whether or not you have the right to elect COBRA coverage.

Notification about qualifying events and COBRA coverage should be directed to the Compass Group Benefits Department.

What Compass Group does

Qualified dependents will be notified of the right to elect COBRA coverage automatically (without any action required by you or a family member) if any of the following events that will result in a loss of coverage occurs:

- In the event of your death.
- Your employment is terminated.
- Your hours of employment are reduced.

Electing COBRA

Generally, when you become eligible for continuation of coverage and have been notified of the right to elect COBRA — or if applicable, you have notified the Compass Group Benefits Department about a qualifying event in a timely manner — Compass Group will provide you with the appropriate election forms and more information about COBRA within 44 days from your termination date.

Note: Remember, in the case of divorce, legal separation or ineligibility of a dependent child, you are responsible for notifying the Compass Group Benefits Department in accordance with plan procedures within one month. If you do not provide notice and all required documentation, you may lose your right to elect COBRA coverage.

You must elect COBRA coverage within 60 days of the loss of coverage caused by the qualifying event, or if later, within 60 days of the date the COBRA notice is sent.

Simply fill out the COBRA election form and return it to Compass Group. You will have an additional 45-day period from the date you send your election form to pay the premium necessary (retroactive to the date benefits terminated) to avoid any gap in coverage. After that, you must pay the premium by a certain date each month. Compass Group can provide this date on request.

Failure to pay premiums on a timely basis will result in permanent termination of COBRA coverage.

If you don't make an election within the 60-day time period

An associate or family member who doesn't choose COBRA coverage within the time period described above will lose the right to elect COBRA coverage. You and your eligible family members also will be required to reimburse the Compass Group plan for any claims mistakenly paid after the date coverage would normally have otherwise been lost.

How to apply for COBRA

If you want to apply for COBRA, contact the Compass Group Benefits Department. You should be ready to provide information about the associate or qualified beneficiary requesting COBRA coverage and the qualifying event that may entitle you to COBRA continuation of coverage. Once the Compass Group Benefits Department has received all required information and documentation, you will be informed whether or not you have the right to choose COBRA coverage and will receive instructions and additional information about COBRA.

If you have questions about COBRA coverage once you've received the election forms or you've elected COBRA, contact the Compass Group Benefits Department at:

Compass Group Benefits Department
Attention: COBRA
2400 Yorkmont Road
Charlotte, NC 28217
800-341-7763, option 2

Coverage options

If you choose COBRA coverage, Compass Group is required to give you coverage that, as of the time coverage is elected, is the same coverage you and your eligible dependent(s) had on the day before the qualifying event. After your initial election, you'll have the same opportunity to change coverage as active associates have. This also means that if the coverage for "similarly situated" associates or family members is modified, your coverage will be modified in the same way.

"Similarly situated" refers to a current associate or dependent who has not had a qualifying event.

Your COBRA rights are provided as required by law. If the law changes, your rights will change accordingly.

Separate elections

Each qualified beneficiary has a separate right to elect COBRA coverage. This means that a spouse or dependent child is entitled to elect COBRA coverage even if you don't make an election. However, you or your spouse may elect COBRA coverage on behalf of other qualified beneficiaries, and a parent or legal guardian may elect COBRA coverage on behalf of a minor child.

How will COBRA work for Consumer Choice PPO plan participants?

The Consumer Choice PPO Plan will follow standard COBRA regulations. If a plan participant elects COBRA, he or she will receive the amount that was in the HRA, if any, the day before becoming a COBRA participant to use for eligible healthcare expenses.

If the COBRA beneficiary(s) decreases his or her coverage level (e.g., family to associate only), there may be a change to the HRA dollar amount for the remainder of the plan year.

When a new plan year begins, COBRA beneficiaries who elect to remain in the Consumer Choice PPO Plan will receive a new annual HRA amount in addition to any carryover amounts from the previous year, and will be subject to a new annual deductible.

If your covered family members have a qualifying event

Keep in mind that you and your qualified family members may make separate and independent COBRA elections. That means if your covered spouse or covered dependent chooses the same coverage level as you have as an associate, he or she begins COBRA with health plan components exactly as he or she stood the day before the qualifying event. That is, he or she will have the exact same deductible amount and out-of-pocket maximum amount as you had on the day before the qualifying event. If the COBRA beneficiary chooses to remain in the Consumer Choice PPO Plan when a new plan year begins, he or she will receive a new annual HRA amount and be subject to a new annual deductible and out-of-pocket maximum — along with all other annual limits based on the coverage level chosen.

If your covered spouse or covered dependent chooses to decrease the coverage level, then he or she begins COBRA with the HRA amount you had on the day before the qualifying event — but the deductible will change. The COBRA beneficiary will be subject to the new deductible and out-of-pocket maximum with any eligible claims incurred before the qualifying event credited toward the new deductible. At the beginning of a new plan year, the COBRA beneficiary will receive a new HRA, deductible, and out-of-pocket maximum based on the coverage level chosen for that year.

Cost of COBRA coverage

Under the law, you may be required to pay up to 102% of the cost of active coverage for yourself and your dependents. You will generally pay for your COBRA coverage on an after-tax basis.

If your coverage is extended from 18 months to 29 months because of a qualifying disability, you may be required to pay up to 150% of the cost of active coverage beginning with the 19th month of coverage.

The cost of group health coverage periodically changes. If you elect COBRA coverage, Compass Group will notify you of any changes in the cost. Premiums are established for a 12-month determination period and may increase during that period if any of the following occur:

- If the Compass Group plan has been charging less than the maximum permissible amount,
- If the qualified beneficiary increases his or her coverage level, or
- In the case of a disability extension.

COBRA premium payment deadlines

The initial payment for COBRA coverage is due 45 days from the date of your election. Thereafter, you must pay for coverage on a monthly basis. You have a grace period of at least 30 days for the payment of the regularly scheduled premium.

You are responsible for ensuring that the amount of your payment is correct. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to continuation of coverage under the plan.

After your initial payment, if you don't remit the full amount due, your payment may be returned to you without being processed — if the underpayment is considered significant. The underpayment is considered significant for a period of coverage if it is greater than: $50, or 10% of the required payment.

For example, a qualified beneficiary owes $345.00 for COBRA coverage but only pays $280.00. The shortfall of $65.00 is considered significant because it is greater than 10% ($34.50) or over $50.

Rules governing COBRA

This chart highlights federal rules governing COBRA and the actions you and/or your covered dependents, who are qualified beneficiaries, will need to take if you have a COBRA qualifying event and become eligible for COBRA coverage. "Your responsibility" applies to you and your covered dependents who are qualified beneficiaries. See *Who is Eligible* on page 21 for more information.

FEDERAL RULES	YOUR RESPONSIBILITY	COMPASS GROUP'S RESPONSIBILITY	WHAT YOU CAN EXPECT
Compass Group has up to 44 days from your termination date to mail COBRA enrollment materials.	Make sure that your mailing address is current.	Process the termination event in the payroll system.	COBRA enrollment materials mailed to you within 44 days.
You have 60 days from the print date of the COBRA enrollment notice to elect COBRA.	Send your COBRA enrollment selections to Compass Group within 60 days of the print date of the COBRA enrollment notice.	Process your enrollment and send you a payments due notice.	COBRA enrollment process begins. Your coverage is not active until Compass Group receives your payment.
You have 45 days from your date of COBRA coverage election to make your first payment.	Send the first payment to Compass Group.	Process your payment and apply to coverage retroactive to your benefits termination date.	COBRA coverage from the benefits termination date through the end of the period that the payment covers. Retroactive claims can be filed for dates of service included in the paid coverage period.
Shortfall Rule: If you underpay your COBRA premium and the amount you owe is the greater than $50 or 10% of the required payment, you are required to pay the "shortfall."	Send payment to cover the shortfall and bring your account current.	Process your payment or return the payment if there is a significant underpayment.	The shortfall must be paid within the same calendar month, or your coverage will be terminated.
Coverage is provided up to 18 months — or longer in some cases (See *COBRA at-a-glance* chart on page 20).	Continue to send payments and submit written notification to Compass Group if you want to end COBRA coverage early.	Continue to process COBRA premium payments until the end of COBRA eligibility.	Coverage continues up to the end of COBRA coverage.

Duration of COBRA coverage

If elected, COBRA coverage begins on the day following the date active coverage is lost. For dependents who no longer satisfy the requirements for dependent coverage, COBRA coverage begins on the date their dependent coverage ends.

However, coverage won't take effect unless COBRA coverage is elected as described above and the required premium is received. The maximum duration of COBRA coverage depends on the reason you or your covered dependents are eligible for COBRA coverage.

If you lose group health coverage because of a termination of employment or reduction in hours, COBRA coverage may continue for you and your covered dependents for up to 18 months.

COBRA coverage for your covered dependents may continue for up to 36 months if coverage would otherwise end because:

- You die.
- You divorce or legally separate.
- Your dependent child loses eligibility for coverage.

If an additional qualifying event occurs within the first 18 months of coverage, you must notify the Compass Group Benefits Department within 60 days of the second qualifying event to include divorce, legal separation, loss of dependent status and eligibility for Social Security Disability extension in accordance with the procedures described in "Electing COBRA" or your coverage cannot be extended.

If termination of employment or reduction of hours follows Medicare enrollment, the COBRA coverage period for your spouse and dependent children is 36 months from the Medicare enrollment date or 18 months from the subsequent termination or reduction of hours, whichever is longer.

Extension of COBRA coverage for disability

The 18 months of COBRA coverage may be extended to 29 months if you or your covered family member is determined to be disabled by the Social Security Administration at any time during the first 60 days of an 18-month COBRA coverage period.

This 11-month extension is available to all family members who have elected COBRA coverage due to the termination of employment or reduction in hours. This applies even to family members who aren't disabled.

To qualify for the extension, the qualified beneficiary must send, and Compass Group must receive, a copy of the Social Security Administration's determination of disability before the end of the initial 18-month COBRA continuation coverage period — and within 60 days after the latest of:

- The date the disabled qualified beneficiary receives his or her determination of disability.
- The date your employment ends.
- The date your hours are reduced.

If a child is born to you or is placed for adoption with you while you're continuing coverage and the child is determined to be disabled within the first 60 days of COBRA coverage, the child and all family members with COBRA coverage arising from the same qualifying event may be eligible for a total of up to 29 months of COBRA coverage.

If, during COBRA coverage, the Social Security Administration determines that the qualified dependent is no longer disabled, the individual must inform Compass Group of this re-determination within one month of the date it is made and continuation of coverage will end.

If a qualified beneficiary is receiving COBRA coverage under a disability extension and another qualifying event occurs within the 29-month continuation period, then the qualified beneficiary's COBRA coverage period may be extended to 36 months from the initial termination of employment or reduction in hours. The qualified beneficiary must provide the appropriate notice to Compass Group as described under "Electing COBRA."

Social Security Administration determination of disability

Notice by the Social Security Administration of a determination of disability or a determination that an associate or covered family member is no longer disabled must be provided to Compass Group in writing within one month. The notice must include a copy of the Social Security Administration Award Determination Notice and information about the associate or covered family member requesting a disability COBRA coverage extension or notifying Compass Group that he or she is no longer disabled.

How pre-existing conditions may affect your COBRA coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations.

If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated early because of your participation in that other plan.

Early termination of COBRA coverage

The law provides that your COBRA coverage may be terminated before the expiration of the 18, 29 or 36-month period for any of the following reasons:

- Compass Group no longer provides group health coverage to any of its associates,
- The full premium for COBRA coverage isn't paid on time (within the applicable grace period),
- The qualified beneficiary becomes covered — after COBRA coverage is elected — under another group health plan that doesn't contain any applicable exclusion or limitation for the individual's pre-existing condition(s), if any,
- You first become entitled to Medicare after the date COBRA coverage is elected or
- Coverage has been extended for up to 29 months due to disability, and the Social Security Administration has made a final determination that the individual is no longer disabled.

Coverage certificates

When your COBRA coverage ends, you can request a certificate of coverage from Compass Group, up to 24 months after coverage ends that:

- Confirms that you had medical coverage and
- States how long you were covered.

If you become eligible for other medical coverage that excludes or delays coverage for certain pre-existing conditions, you can use this certificate to receive credit — to help reduce the new plan's pre-existing condition limit — for the time you were covered by the Compass Group plan.

Continuing coverage in special cases

COBRA and FMLA

- Taking an approved leave under the Family and Medical Leave Act (FMLA) isn't considered a qualifying event that would make you eligible for COBRA coverage. However, a COBRA qualifying event occurs if you don't return to employment at the end of the FMLA leave or you terminate employment during your leave.

Your COBRA coverage may begin on the earlier of the following:

- When you inform Compass Group that you're not returning to work or
- The end of the FMLA leave, if you don't return to work.

COBRA and USERRA

If you take a leave of absence that qualifies as a leave under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA, also referred to as a "military leave"), and COBRA continuation of coverage rights are available to you, an election for continuation of coverage will be an election to take concurrent COBRA/USERRA medical coverage. You can continue coverage under USERRA for up to 24 months.

For additional information on military leaves, such as how to request a leave and other rights and obligations, as well as their impact on benefits, please contact the Compass Group Benefits Department — COBRA.

Trade Act of 2002

The Trade Act of 2002 created a tax credit for workers displaced by the impact of foreign trade who, as determined by the U.S. Secretary of Labor, are eligible for a "trade readjustment allowance" or "alternative trade adjustment assistance" ("eligible TAA individuals").

Under this tax credit, if you're an eligible TAA individual, you're eligible for a health insurance tax credit for qualified health insurance premiums, including COBRA coverage. If you're in this situation, you'll be notified.

If you have questions about this tax credit or other TAA benefits, call the Health Coverage Tax Credit Customer Contact Center toll-free at 866-628-4282. More information about the Trade Act of 2002 is also available by logging on to www.doleta.gov/tradeact.

Converting coverage

Your medical, prescription drug, dental and vision coverages cannot be converted to individual health insurance policies when your COBRA coverage ends. If you have continuation of coverage under an HMO, you will be notified of your right to convert coverage, if any, by the HMO.

COBRA questions

If you have any questions about COBRA coverage, contact Compass Group. You also may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website at www.dol.gov/ebsa.

Also, you must notify Compass Group in writing immediately if:

- Your marital status has changed.
- You, your spouse/domestic partner or a dependent has a change in address.
- A dependent loses eligibility for dependent coverage under the terms of the Compass Group plan.

All questions about the Plan and COBRA should be directed to:

Compass Group Benefits Department
Attention: COBRA
2400 Yorkmont Road
Charlotte, NC 28217
800-341-7763, option 2

great rewards

summary plan description

Medical Coverage

Joining the plan

Compass Group offers you and your eligible dependents medical coverage on the first day of the month after you complete three months of service. After that, you may enroll or modify medical coverage each year during Annual Enrollment or if you have a qualified status change. Your payments for medical coverage are deducted from your paycheck on a pre-tax basis. For more information on pre-tax dollars, see page 3.

About Compass Group's medical program

The goal of Compass Group's medical program is to consistently deliver quality medical care that is flexible, affordable and responsive to the varying needs of our associates. Except for Regional HMOs, Compass Group's medical plan options are self-funded, which means that Compass Group assumes the risk for providing medical coverage to you. Compass Group contracts with medical plan carriers to process claims using funds from the company's general assets. This approach makes you and Compass Group partners in the effort to control rising healthcare costs and encourages everyone to be wise healthcare consumers.

In this section

Medical plan options

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 several medical plan options:

- Value Choice Plan
- Consumer Choice PPO Plan
- Network Choice Plan
- Out-of-Area Indemnity Plan (available only where Network Choice is not)
- Regional HMO (if available in your area)
- U.S. Virgin Islands PPO Plan (available only in the U.S. Virgin Islands)

This section describes benefits provided through the Value Choice, the Consumer Choice PPO, the Network Choice, the Out-of-Area Indemnity and the U.S. Virgin Islands PPO Plans. Details on the HMO plans are provided by the HMOs through Certificates of Coverage and are not included in this document.

The chart on page 32 shows that the Consumer Choice PPO, Network Choice and Value Choice Plans have different deductibles and out-of-pocket maximums.

The three medical plan options differ in several ways, but all:

- Cover preventive care at 100% (except Consumer Choice PPO Plan out-of-network coverage).
- Require that all inpatient hospital admissions be pre-certified by your medical plan carrier or the plan will reduce or deny benefits. See *Inpatient Hospital Stays* on page 52.
- 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 — sometimes referred to as Maximum Reimbursable Charges (MRC).

You have the right to designate any primary care physician (PCP) who participates in the plan's network and who is available to accept you or your family members. For information on how to select a primary care physician, and for a list of the participating primary care physicians, contact the plan's carrier listed on the back of your medical plan ID card or in the Administrative Information section on page 127.

For children, you may designate a pediatrician as the primary care physician.

You do not need prior authorization from the plan or from any other person (including a primary care physician) in order to obtain access to a specialist in the plan's network. The specialist, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating specialists, contact the plan's carrier listed on the back of your medical plan ID card or in the *Administrative Information* section on page 127.

Teladoc

If you are enrolled in Compass Group medical coverage, you have access to Teladoc, a service that helps you resolve non-emergency medical issues — like sinus infections, cold and flu symptoms, urinary tract infections, allergies or bronchitis — at any time from wherever you happen to be.

Teladoc provides access to a national network of U.S. board-certified doctors and pediatricians who are available at any time to diagnose, treat and prescribe medication (when necessary) for many medical issues via phone or online video consultations. For covered Compass Group associates and their spouses and dependent children, the service is available for a $10 copay per consultation.

To set up an account, go to www.teladoc.com, and click *Set up account,* then provide the required information. Teladoc phone consultations are available 24 hours a day, seven days a week while video consultations are available during the hours of 7:00 a.m. to 9:00 p.m. in your local time zone, seven days a week.

It's important to note:

- Teladoc does not replace your PCP, but it can help in after-hours situations, when you can't get in to the Urgent Care Center or your PCP.
- Teladoc does not guarantee that a prescription will be written.
- Teladoc operates subject to state regulations and is not available in Oklahoma, Puerto Rico and the U.S. Virgin Islands. Teladoc video consults are not available in Idaho, Iowa, Louisiana, Missouri, Ohio, and Texas.

- Teladoc does not prescribe DEA controlled substances, non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse.
- Teladoc physicians reserve the right to deny care for potential misuse of services.

For more information, including what's excluded from Teladoc coverage, go to www.teladoc.com or call 800-Teladoc (835-2362).

Overview of the Value Choice, Consumer Choice PPO, Network Choice and Out-of-Area Indemnity Plans

Value Choice Plan

The Value Choice Plan has the lowest payroll deductions but requires you to pay the highest coinsurance when you need care. It also has no out-of-pocket maximum.

The Value Choice Plan is intended for associates who might otherwise waive coverage because of high deductions or who have access to other coverage, like Medicare. With the Value Choice Plan, you have coverage when you use any doctor or facility. If you use network providers, however, it will generally help you save money. The Value Choice Plan is currently administered by Blue Cross Blue Shield of NC.

Note: Blue Cross Blue Shield of NC is a national carrier and is available to eligible associates residing in other states outside of North Carolina.

Consumer Choice PPO Plan

The Consumer Choice PPO Plan offers the most flexible coverage as it allows you to seek care either in-network or out-of-network. This option is unique as it combines extensive coverage with high deductibles and has a Health Reimbursement Account (HRA) to help offset your medical and prescription expenses. This plan works best for associates who are wise healthcare consumers. If you elect this plan, Compass Group allocates a Health Reimbursement Account (HRA) in your name at the start of your coverage. This plan is currently administered through Aetna HealthFund®.

Consumer Choice PPO Plan Annual HRA Allocation

Compass Group allocates an amount to your HRA each year as long as you are enrolled in the Consumer Choice PPO Plan:

- $500 if you elect coverage for yourself only,
- $1,000 if you elect coverage for yourself and one dependent,
- $1,500 if you elect coverage for yourself and two or more dependents.

What is an HRA?

- When you participate in the Consumer Choice PPO Plan, Compass Group allocates an amount to you to help pay for your medical and prescription expenses throughout the plan year. These funds can only be used for this purpose, and can't otherwise be distributed.
- The money is put in a Health Reimbursement Account (HRA) to help you pay for out-of-pocket expenses.
- If you don't use all the money in your HRA for the current year, it rolls over into an account for the following year, as long as you remain in the Consumer Choice PPO Plan as an active Compass Group associate. The amount you can roll over will be limited to no more than three times the annual amount. If you leave the Consumer Choice PPO Plan, the HRA balance is forfeited.
- If you leave the company and do not elect COBRA, you lose your HRA balance.

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 Aetna, Blue Cross Blue Shield of NC, Cigna and UnitedHealthcare. The plans and networks offered to you are based on your home ZIP code; therefore, all plans are not available in all areas.

Out-of-Area Indemnity Plan

This plan is available to associates who do not have provider networks available in their area (based on ZIP code). With this plan, you are covered at any doctor or medical facility you choose.

Highlights of the Value Choice, Consumer Choice PPO, Network Choice and Out-of-Area Indemnity Plans

	VALUE CHOICE PLAN	CONSUMER CHOICE PPO PLAN		NETWORK CHOICE PLAN (NETWORK ONLY)	OUT-OF-AREA INDEMNITY
		IN-NETWORK	OUT-OF-NETWORK		
Considerations	• Low deductible • Lowest deductions for coverage • Highest coinsurance for you to pay • No out-of-pocket maximum	• Highest deductible • Higher out-of-pocket when you go out of network • Lower deductions for coverage than Network Choice • Health Reimbursement Account (HRA): $500 Associate/$1,000 Associate + one dependent/$1,500 Associate + two or more dependents		• No deductible • Lowest out-of-pocket costs • Highest deductions for coverage	• Low deductible • Access to any provider
Annual Deductible	$250/Individual	$1,500/Individual $3,000/Family	$3,000/Individual $6,000/Family	None	$300/Individual $900/Family
Annual Out-of-Pocket Maximum	None – you pay all charges above plan maximum benefits	$4,500/Individual $9,000/Family[1]	$9,000/Individual $18,000/Family[1]	$3,000/Individual $6,000/Family[1]	$3,000/Individual $9,000/Family[1]
Plan Maximums	$1,250,000 annual maximum for essential health services as defined by Health Care Reform and unlimited lifetime maximum[2]	$3,000,000 annual maximum and unlimited lifetime maximum[2]		$3,000,000 annual maximum and unlimited lifetime maximum[2]	$3,000,000 annual maximum and unlimited lifetime maximum[2]
Preventive Care Annual checkups/physicals, mammograms, certain cancer screenings, etc.[3]	100%	100%	60%, after deductible	100%	100%
Phone or Online Consultation (Teladoc) [4]	100% after $10 copay	100% after $10 copay	N/A	100% after $10 copay	100% after $10 copay
Most Other Covered Services	70%, after deductible	80%, after deductible	60%, after deductible	80% or 100%, after copay (copays may not apply to some other covered services)	80%, after deductible
Prescription Drugs (administered by CVS Caremark except for the Consumer Choice PPO, which is administered by Aetna)					
Pharmacy 30-day supply					
Generic	100% after $5 copay	70% coinsurance: associate pays max $60	Not covered	100% after $5 copay	100% after $5 copay
Formulary Brand	70% coinsurance: associate pays min $20, max $50	70% coinsurance: associate pays max $60	Not covered	70% coinsurance: associate pays min $20, max $50	70% coinsurance: associate pays min $20, max $50
Non-Formulary Brand	70% coinsurance: associate pays min $40, max $80	70% coinsurance: associate pays max $60	Not covered	70% coinsurance: associate pays min $40, max $80	70% coinsurance: associate pays min $40, max $80

	VALUE CHOICE PLAN	CONSUMER CHOICE PPO PLAN		NETWORK CHOICE PLAN (NETWORK ONLY)	OUT-OF-AREA INDEMNITY
		IN-NETWORK	OUT-OF-NETWORK		
Prescription Drugs					
Mail order 90-day supply					
Generic	100% after $12 copay	70% coinsurance: associate pays max $150	Not covered	100% after $12 copay	100% after $12 copay
Formulary Brand	70% coinsurance: associate pays min $50, max $125	70% coinsurance: associate pays max $150	Not covered	70% coinsurance: associate pays min $50, max $125	70% coinsurance: associate pays min $50, max $125
Non-Formulary Brand	70% coinsurance: min $100, associate pays max $200	70% coinsurance: associate pays max $150	Not covered	70% coinsurance: min $100, associate pays max $200	70% coinsurance: min $100, associate pays max $200
Specialty (up to a 30-day supply)					
Annual Out-of-Pocket Maximum	$2,000 Individual	None	Not covered	$2,000 Individual	$2,000 Individual
Generic	100% after $5 copay	70% coinsurance: associate pays $60 max	Not covered	100% after $5 copay	100% after $5 copay
Brand	70% coinsurance: associate pays min $60, max $100	70% coinsurance: associate pays $60 max	Not covered	70% coinsurance: associate pays min $60, max $100	70% coinsurance: associate pays min $60, max $100

1 Out-of-pocket maximum does not include prescription drugs. Specialty out-of-pocket maximum is separate.

2 For all essential health services as defined by Health Care Reform.

3 To be covered as a preventive care service, the care must meet nationally recognized guidelines — like minimum age and frequency rules. Contact your carrier for more information.

4 Oklahoma, Puerto Rico and the U.S. Virgin Islands are excluded from the service area. Teladoc video consults are not available in Idaho, Iowa, Louisiana, Missouri, Oklahoma, Ohio or Texas.

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 Value Choice Plan has the lowest payroll deduction compared to the Consumer Choice PPO and Network Choice Plans, but generally requires you to pay a higher percentage of coinsurance. In other words, your out-of-pocket costs may be more if you require care (other than preventive care) during the year. There is no annual out-of-pocket maximum. Blue Cross Blue Shield of NC provides a nationwide provider network and administers claims for this self-insured plan.

What is an Indemnity Plan?

An indemnity plan covers you at any doctor or medical facility — there are no networks required.

How the plan pays benefits

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. The plan also pays 70% of inpatient and outpatient mental health and substance abuse treatments. Refer to the chart on pages 42 – 43 for a list of covered services.

What the plan covers

Annual Deductible	$250/Individual
Annual Out-of-Pocket Maximum	None — you pay all charges above plan maximum benefits
Plan Maximums	$1,250,000 annual maximum for essential health services as defined by Health Care Reform; no lifetime maximum
Preventive Care	Plan pays 100%
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 $250 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 limit on your share of covered expenses

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.

If you become ill or injured while traveling outside a network area

If you become ill or injured while traveling outside your network area, the plan will pay for covered charges after any applicable deductible or coinsurance has been met. If you need medical attention while traveling away from home, call Blue Cross Blue Shield of NC at 877-224-3305 and you will be directed to a representative who can give you the names of participating providers where you are traveling.

How do I know if my provider’s proposed fees are within R&C limits?

Call Blue Cross Blue Shield of NC at 877-224-3305 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 Blue Cross Blue Shield of NC. Blue Cross Blue Shield of NC 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.

Maximum plan benefits

The Value Choice Plan features a total annual maximum of $1,250,000 for essential health services as defined by Health Care Reform. Preventive care benefits and prescription drug benefits are also covered and are not subject to this annual maximum.

Some services and treatments have specific lifetime and/or calendar year limits. See *Covered Services* chart on pages 42 – 43 for details on special limits for specific covered services.

Preventive care

Preventive care is covered at no cost to you — with no annual dollar maximum. This includes services — like annual checkups/physicals, mammograms, certain cancer screenings, etc.

To be covered as a preventive care service, the care must meet nationally recognized guidelines for preventive care — like minimum age and frequency rules. Contact your health carrier for more information.

Hospital admissions

All inpatient hospital admissions — emergency or planned — must be pre-certified by Blue Cross Blue Shield of NC. To have your hospital stay pre-certified, you or your provider must call Blue Cross Blue Shield of NC at 877-224-3305 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, Blue Cross Blue Shield of NC 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 page 52 for examples of medical emergencies. If your hospital requires you to stay additional days, it will contact Blue Cross Blue Shield of NC to approve the additional days.

Prescription drug coverage

Value Choice Plan participants receive a CVS Caremark prescription drug card. You can use the card to purchase prescription drugs through the mail or at one of the many CVS Caremark 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. You have no claim forms to file for each prescription up to a 30-day supply.

A 90-day supply is required 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.

Specialty medications used to treat chronic (long-term), life-threatening or rare conditions such as multiple sclerosis, rheumatoid arthritis and hemophilia are covered under your prescription drug coverage. For a 30-day supply of a generic drug, you only pay $5. The plan pays 70% coinsurance, and you pay a $60 minimum up to a $100 maximum for brand drugs. The maximum out-of-pocket costs for any covered individual for specialty medications are $2,000 each year.

Mandatory Generics Program

Compass Group uses a mandatory generics program to help keep the cost of your prescription drugs more affordable. When you fill a prescription for a brand-name drug, your pharmacist will automatically see if a generic drug is available.

Refer to *The Prescription Drug Program* section on pages 61 – 67 for more details on your prescription coverage through CVS Caremark.

For information on:

- Coordinating benefits between medical plans — see page 16.
- When medical plan coverage ends — see page 18.
- Continuing your medical plan coverage when you leave Compass Group — see page 19.

Consumer Choice PPO Plan

How the plan works

The Consumer Choice Preferred Provider Organization (PPO) Plan is a Consumer-Directed Plan that gives you, the consumer, greater control of how your healthcare dollars are spent. Aetna provides a nationwide PPO provider network and administers claims for this self-insured plan.

You have the freedom to choose your physicians and hospitals from a network of participating providers, as well as the ability to seek out-of-network care at a higher out-of-pocket cost. This plan carries high deductibles for individual as well as family coverage. This plan also provides a Health Reimbursement Account (HRA), which provides company money to help offset some of your out-of-pocket costs.

The Consumer Choice PPO Plan payroll deductions are higher than the Value Choice Plan, but lower than the Network Choice Plan.

How the plan pays benefits

Before the Consumer Choice PPO 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. You may see any doctor, specialist, or healthcare facility. The plan pays a greater percentage of covered expenses when in-network providers are used. Coverage for care you receive in-network is 80% for most services after you meet your deductible.

What the plan covers

	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	$1,500/Individual $3,000/Family	$3,000/Individual $6,000/Family
Annual Out-of-Pocket Maximum	$4,500/Individual $9,000/Family	$9,000/Individual $18,000/Family
Plan Maximums	$3,000,000 annual maximum and unlimited lifetime maximum	
Preventive Care	Plan pays 100%	Plan pays 60%, after deductible
Most Other Covered Services	Plan pays 80%, after deductible	Plan pays 60%, after deductible

Annual deductible

A deductible is the amount you must pay before the plan starts paying a percentage of your healthcare costs. Under the Consumer Choice Plan, your deductible is determined by your coverage level (individual or family).

You pay a deductible for each person up to the family maximum of two times the amount of the individual deductible. The maximum family deductible can be met by combining portions of individual deductibles. However, one person can't contribute more than the individual deductible to the family deductible.

After you meet the deductible, you will be responsible for the coinsurance, which will depend on whether you choose an in- or out-of-network provider.

Meeting the family deductible — an example

A family of four enrolled in the Consumer Choice PPO Plan has an individual deductible of $1,500 and a family deductible of $3,000. This example assumes that network providers are used.

Suppose your covered charges equal $875, your spouse's equal $750, your son's equal $775 and your daughter's equal $600, for a total of $3,000. Although no one has met the $1,500 individual deductible, your family has met the $3,000 family deductible. Once the family deductible is met, the plan begins paying a percentage of covered charges for all covered members.

Your deductible and the Aetna Healthcare Reimbursement Account (HRA)

The calendar year deductible for the Consumer Choice Plan works in a different way than most other medical plans.

Here's how it works:

- Each year Compass Group contributes benefit dollars into an HRA set up in your name.
- The HRA generally covers a portion of your deductible.
- When your HRA is empty, you become responsible for the balance of your deductible.
- Once you have satisfied your deductible, the health coverage part of the plan begins.

Your estimated deductible if you use the HRA

	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	$1,500/Individual $3,000/Family	$3,000/Individual $6,000/Family
Compass Group's Annual Contribution to the HRA	$500 Associate $1,000 Associate plus one dependent $1,500 Associate plus two or more dependents	
Your Estimated Deductible (Once Your HRA is Exhausted)	$1,000/Associate only $2,000/Associate plus one $1,500/Associate plus two or more	$2,500/Associate only $5,000/Associate plus one $4,500/Associate plus two or more

Sometimes, money from your HRA is used for expenses that will not apply to your deductible, such as prescription drugs. In this case, the amount of money taken from your HRA that does not apply to the deductible is counted toward your out-of-pocket costs.

You use the dollars in your HRA to pay regular healthcare expenses, such as prescription drugs and doctor visits. The amount Compass Group contributes to your HRA is determined by your coverage level (associate only, associate plus one dependent or associate plus two or more dependents).

Aetna administers the HRA. When you go to the doctor or pharmacy, or use the mail-order prescription drug program, your Aetna ID information will automatically begin the process of deducting the cost from your HRA. As long as dollars are available, your HRA provides 100% coverage for covered medical and pharmacy expenses, with no copay or coinsurance from you.

Rolling over your HRA

If you don't use all the money in your account for the current year, it rolls over into an account for the following year, as long as you stay in the Consumer Choice PPO Plan as an active Compass Group associate. The amount you can roll over will be limited to no more than three times the annual amount.

Your out-of-pocket costs

In most cases, your expenses are paid through your HRA first. If you use all of the dollars in your HRA, then you are responsible for additional healthcare expenses, up to your deductible. A rollover from your prior year HRA decreases your responsibility.

The amount you pay will generally be the difference between the amount of your HRA and your calendar year deductible. When your HRA is empty, you pay 100% of your healthcare expenses until your plan year deductible is met. During this stage of the plan, you will receive a bill from your provider for medical services. For prescriptions, you will need to pay 30% of the total cost of the prescription up to a maximum of $60 for retail and $150 for mail order.

Annual limit on your share of covered expenses

The out-of-pocket maximum is the most you pay in a calendar year for your and your dependents' covered medical expenses. It includes the deductible (if applicable).

The family maximum is two times the individual out-of-pocket maximum. If you use out-of-network providers, your individual out-of-pocket maximum is $9,000 and the family maximum is $18,000. After you reach your out-of-pocket maximum, the plan pays 100% of covered charges for the rest of the calendar year.

These expenses do not apply toward your out-of-pocket maximum:

- Your portion of the prescription drug coinsurance.
- Charges above the reasonable and customary (R&C) limits.
- Charges for services not covered under this plan.
- The benefit reduction percentage amount for using out-of-network providers if a PPO network is available in your area.
- The penalty for failure to have inpatient hospital admissions, high-tech diagnostic imaging procedures (i.e., CT, PET, MRI) or services requiring authorization pre-certified by Aetna.

Network providers lower your cost

The PPO network is a group of participating providers who have agreed to deliver your healthcare for negotiated fees. If you live in an area served by Aetna, you will reduce your cost for medical services if you use in-network providers.

You decide whether to use an in-network or an out-of-network provider. If you use in-network providers, your deductible and out-of-pocket maximum will be less than the deductible and out-of-pocket maximum for out-of-network providers (see the chart on pages 42 – 43). The provider networks include doctors and hospitals. You may access your personalized information at the Online Benefits Center at www.altogethergreat.com to determine if an Aetna provider network is available in your area (based on your home ZIP code).

If you use an in-network provider, the medical plan will pay 80% (100% for some services) of covered charges after you meet the deductible. If an in-network provider is available to you, but you choose an out-of-network provider, the plan will pay only 60% of covered charges after the deductible has been satisfied and your deductible and out-of-pocket maximum will more than double.

Reasonable and customary (R&C) charges

Reasonable and customary (R&C) charges are the typical range of fees charged by medical providers in your geographic area for similar services. In other words, it is the "going rate" for a certain service in your area. Out-of-network provider fees may or may not be within the plan's R&C limits. The plan will not pay for charges above the 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 out-of-network provider's proposed fees are within R&C limits?

Call Aetna at 866-238-1128 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 Aetna. Aetna 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.

If you have a life-threatening medical emergency

If you have a life-threatening medical emergency, the plan will pay for covered charges after any applicable deductible or coinsurance has been met regardless of whether you use an in-network or out-of-network provider. See definition of life-threatening emergency on page 52.

If you become ill or injured while traveling outside a network area

If you become ill or injured while traveling outside your network area, the plan will pay for covered charges after any applicable deductible or coinsurance has been met. If you need medical attention while traveling away from home, call Aetna at 866-238-1128, and you will be directed to a representative who can give you the names of participating providers where you are traveling.

If your network does not include the type of specialist you need

If your medical condition requires you to see a doctor with a particular specialty and that type of specialist is not included in your provider network, or if an in-network hospital cannot provide the care that you require, contact Aetna directly to determine if an out-of-network specialist or an out-of-network hospital can be approved.

Maximum plan benefits

The Consumer Choice PPO Plan features a total annual maximum benefit that pays up to $3,000,000 toward the covered expenses of each enrolled person in any one calendar year. The plan has an unlimited lifetime maximum.

Some services and treatments have specific lifetime and/or calendar year limits. See *Covered Services* chart on pages 42 – 43 for details on special limits for specific covered services.

Preventive care

In-network preventive care is covered at no cost to you — with no annual dollar maximum. This includes:

- Services — like annual checkups/physicals, mammograms, certain cancer screenings, etc.

To be covered as a preventive care service, the care must meet nationally recognized guidelines for preventive care — like minimum age and frequency rules. Contact Aetna for more information.

Hospital admissions

All inpatient hospital admissions — emergency or planned — must be pre-certified by Aetna. To have your hospital stay pre-certified, you or your provider must call Aetna 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, Aetna 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 page 52 for examples of medical emergencies. If your hospital requires you to stay additional days, it will contact Aetna to approve the additional days.

Prescription drug coverage

Participants in the Consumer Choice PPO Plan receive a combined medical and prescription drug card through Aetna. When the card is used to purchase prescription drugs at one of the many Aetna network pharmacies, the plan pays 70% coinsurance, and you pay up to a $60 maximum for generic, formulary brand and non-formulary brand drugs (with no claim forms to file) for each retail prescription up to a 30-day supply.

The plan pays 70% coinsurance, and you pay up to a $150 maximum for each mail order prescription for up to a 90-day supply. The out-of-pocket cost could be paid by your HRA as long as money is available. Prescription coverage outside of the network is not covered.

For information on:

- Coordinating benefits between medical plans — see page 16.
- When medical plan coverage ends — see page 18.
- Continuing your medical plan coverage when you leave Compass Group — see page 19.

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 available under Compass Group's Benefits Program, 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 Aetna, Blue Cross Blue Shield of NC, Cigna, and UnitedHealthcare 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.

The options and the provider network(s) that are available in your area (based on your home ZIP code) are listed at the Online Benefits Center at www.altogethergreat.com. 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 benefits

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.

What the plan covers

Annual Deductible	None
Annual Coinsurance Maximum	$3,000 Individual/$6,000 Family
Plan Maximums	$3,000,000 annual maximum and unlimited lifetime maximum
Preventive Care	Plan pays 100%
Most Other Covered Services	Plan pays 80% or 100% after applicable copays

Annual deductible

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

Annual limit on your share of covered expenses

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 do not apply toward your out-of-pocket maximum:

- Copays, including prescription drugs.
- Charges above the reasonable and customary (R&C) limits or Maximum Reimbursable Charges (MRC).
- Charges for services not covered under this plan.
- The penalty for failure to have inpatient hospital admissions, high-tech diagnostic imaging procedures (i.e., CT, PET, MRI) or services requiring authorization pre-certified by your medical plan carrier.

If you have a life-threatening medical emergency

If you have a life-threatening medical emergency, the plan will pay for covered charges after your copay or coinsurance regardless of whether you use an in-network or out-of-network provider. See definition of life-threatening emergency on page 52.

If you become ill or injured while traveling outside a network area

If you become ill or injured while traveling outside your network area, the plan will pay for covered charges after applicable copay or coinsurance. If you need medical attention while traveling away from home, call your carrier at the number listed on your ID card, and you will be directed to a representative who can give you the names of participating providers where you are traveling.

If your network does not include the type of specialist you need

If your medical condition requires you to see a doctor with a particular specialty and that type of specialist is not included in your provider network, or if an in-network hospital cannot provide the care that you require, contact your carrier directly to determine if an out-of-network specialist or an out-of-network hospital can be approved.

Maximum plan benefits

The Network Choice Plan features a total annual maximum that pays up to $3,000,000 toward the covered expenses of each enrolled person. Some services and treatments have specific lifetime and/or calendar year limits. See *Covered Services* chart on pages 42 – 43 for details on special limits for specific covered services.

Preventive care

Preventive care is covered at no cost to you — with no annual dollar maximum. This includes services like annual checkups/physicals, mammograms and certain cancer screenings, etc.

To be covered as a preventive care service, the care must meet nationally recognized guidelines for preventive care — like minimum age and frequency rules. Contact your health carrier for more information.

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. See page 52 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.

Prescription drug coverage

Network Choice Plan participants receive a CVS Caremark prescription drug card. You can use the card to purchase prescription drugs through the mail or at one of the many CVS Caremark 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. You have no claim forms to file for each prescription up to a 30-day supply.

A 90-day supply is required 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.

Specialty medications used to treat chronic (long-term), life-threatening or rare conditions such as multiple sclerosis, rheumatoid arthritis and hemophilia are covered under your prescription drug coverage. For a 30-day supply of a generic drug, you only pay $5. The plan pays 70% coinsurance, and you pay a $60 minimum up to a $100 maximum for brand drugs.

The maximum out-of-pocket costs for any covered individual for specialty medications are $2,000 each year.

Mandatory Generics Program

Compass Group uses a mandatory generics program to help keep the cost of your prescription drugs more affordable. When you fill a prescription for a brand-name drug, your pharmacist will automatically see if a generic drug is available.

Refer to *The Prescription Drug Program* section on pages 61 – 67 for more details on your prescription coverage through CVS Caremark.

Remember

You choose your doctors, specialists and hospitals 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.

For information on:

- Coordinating benefits between medical plans — see page 16.
- When medical plan coverage ends — see page 18.
- Continuing your medical plan coverage when you leave Compass Group — see page 19.

Covered services

		VALUE CHOICE PLAN	CONSUMER CHOICE PPO PLAN		NETWORK CHOICE PLAN (NETWORK ONLY)
			IN-NETWORK	OUT-OF-NETWORK	
PLAN FEATURE					
Calendar Year Deductible		$250/Individual	$1,500/Individual $3,000/Family	$3,000/Individual $6,000/Family	None
Annual Out-of-Pocket Maximum		None — you pay all charges above plan maximum benefits	$4,500/Individual $9,000/Family[1]	$9,000/Individual $18,000/Family[1]	$3,000/Individual $6,000/Family[1]
Plan Maximums		$1,250,000 annual maximum for essential health services as defined by Health Care Reform and unlimited lifetime maximum[2]	$3,000,000 annual maximum and unlimited lifetime maximum[2]		$3,000,000 annual maximum and unlimited lifetime maximum[2]
Health Reimbursement Account (HRA)		N/A	$500/Associate $1,000/Associate Plus One Dependent $1,500/Associate Plus Two or More Dependents		N/A
TYPE OF SERVICE		**Plan Pays**	**Plan Pays**	**Plan Pays**	**Plan Pays**
Physician Services					
Preventive Care Services: Annual checkups/physicals, mammograms, certain cancer screenings, etc. [3]		100%	100%	60%, after deductible	100%
Phone or Online Consultation — provided by Teladoc[4]		100% after $10 copay	100% after $10 copay	N/A	100% after $10 copay
Primary Care Physician (PCP) Office Visit		70%, after deductible	80%, after deductible	60%, after deductible	100%, after $20 copay
Specialist Office Visit		70%, after deductible	80%, after deductible	60%, after deductible	100%, after $45 copay
Surgery (Physician's Office)		70%, after deductible	80%, after deductible	60%, after deductible	100%, after applicable office visit copay
Surgery (Inpatient or Outpatient Hospital)		70%, after deductible	80%, after deductible	60%, after deductible	80%
Chiropractor		70%, after deductible	80%, after deductible	60%, after deductible	100%, after $20 copay
Allergy Injections, with or without office visit copay		70%, after deductible	80%, after deductible	60%, after deductible	80%
Prescription Drugs					
Pharmacy (30-day supply)	• Generic	100%, after $5 copay	70% coinsurance; associate pays max $60	Not covered	100%, after $5 copay
	• Formulary Brand	70% coinsurance: associate pays min $20, max $50	70% coinsurance; associate pays max $60	Not covered	70% coinsurance: associate pays min $20, max $50
	• Non-formulary Brand	70% coinsurance: associate pays min $40, max $80	70% coinsurance; associate pays max $60	Not covered	70% coinsurance: associate pays min $40, max $80
Mail-Order (90-day supply)	• Generic	100%, after $12 copay	70% coinsurance; associate pays max $150	Not covered	100%, after $12 copay
	• Formulary Brand	70% coinsurance: associate pays min $50, max $125	70% coinsurance; associate pays max $150	Not covered	70% coinsurance: associate pays min $50, max $125
	• Non-formulary Brand	70% coinsurance: associate pays min $100, max $200	70% coinsurance; associate pays max $150	Not covered	70% coinsurance: associate pays min $100, max $200
Specialty (up to a 30-day supply)	• Annual Out-of-Pocket Maximum	$2,000/Individual	None	Not covered	$2,000/Individual
	• Generic	100%, after $5 copay	70% coinsurance: associate pays max $60	Not covered	100%, after $5 copay
	• Brand	70% coinsurance: associate pays min $60, max $100	70% coinsurance: associate pays max $60	Not covered	70% coinsurance: associate pays min $60, max $100

PLAN FEATURE	VALUE CHOICE PLAN	CONSUMER CHOICE PPO PLAN		NETWORK CHOICE PLAN (NETWORK ONLY)
		IN-NETWORK	OUT-OF-NETWORK	
Hospital Services				
Inpatient Hospital Care	70%, after deductible	80%, after deductible	60%, after deductible	80%, after $250 copay/admit
Outpatient Hospital Care (e.g. minor surgery, lab charges)[5]	70%, after deductible	80%, after deductible	60%, after deductible	80%
Emergency Care				
Emergency Room	70%, after deductible	80%, after deductible	60%, after deductible	100%, after $250 copay (waived if admitted)
Urgent Care Clinic	70%, after deductible	80%, after deductible	60%, after deductible	100%, after $45 copay
Maternity Care				
Physicians Office — Initial visit	70%, after deductible	80%, after deductible	60%, after deductible	100%, after $45 copay
Physician Services (Pre- and post-natal visits, delivery)	70%, after deductible	80%, after deductible	60%, after deductible	80%
Delivery and Newborn Charges — Hospital	70%, after deductible	80%, after deductible	60%, after deductible	80%, after $250 copay/admit
Mental Health Services				
Outpatient Services	70%, after deductible	80%, after deductible	60%, after deductible	100%, after $45 copay in a physician's office; 80% at outpatient facility
Inpatient Services	70%, after deductible	80%, after deductible	60%, after deductible	80% at inpatient hospital after $250 copay/admit
Substance Abuse Services				
Detoxification/Rehabilitation				
Outpatient	70%, after deductible	80%, after deductible	60%, after deductible	100%, after $45 copay in a physician's office; 80% at outpatient facility
Inpatient	70%, after deductible	80%, after deductible	60%, after deductible	80% at inpatient hospital after $250 copay/admit

1 Out-of-pocket maximum does not include prescription drugs. Specialty out-of-pocket maximum is separate.

2 For all essential health services as defined by Health Care Reform.

3 To be covered as a preventive care service, the care must meet nationally recognized guidelines — like minimum age and frequency rules. Contact your carrier for more information.

4 Oklahoma, Puerto Rico and the U.S. Virgin Islands are excluded from the service area. Teladoc video consults are not available in Idaho, Iowa, Louisiana, Missouri, Oklahoma, Ohio or Texas.

5 Outpatient diagnostic imaging services, including CT/CTA scans, MRI/MRA scans, PET scans and nuclear cardiology studies require prior authorization. Contact your carrier for more information.

Note: The summaries above refer to Compass Group's self-funded plans. Information on the Regional HMOs is available at www.altogethergreat.com. For details of the Out-of-Area Indemnity Plan, see pages 44 – 47. For details of the U.S. Virgin Islands PPO Plan, see pages 48 – 51.

Out-of-Area Indemnity Plan

How the plan works

Compass Group provides the Out-of-Area Indemnity Plan, administered by Blue Cross Blue Shield of NC, to associates who do not have provider networks available in their area (based on home ZIP code).

With the Out-of-Area Indemnity Plan, you see the provider of your choice, obtain itemized receipts and submit a claim form for reimbursement. Or, your provider can submit a claim directly to Blue Cross Blue Shield of NC.

What is an Indemnity Plan?

An indemnity plan covers you at any doctor or medical facility — there are no networks required.

How the plan pays benefits

Before the Out-of-Area Indemnity 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. Coverage for care you receive is 80% of charges for covered medical care and treatment of injury or illness certified as necessary by a physician. The plan also pays 80% of inpatient and outpatient mental health and substance abuse treatments. In addition, not all expenses are covered. (See *What the Medical Plans Do Not Cover* on pages 59 – 60.)

What the plan covers

Annual Deductible	$300 Individual/$900 Family
Annual Coinsurance Maximum	$3,000 Individual/$9,000 Family
Plan Maximums	$3,000,000 annual maximum and unlimited lifetime maximum
Preventive Care in a physician's office	100%
Most Other Covered Services	Plan pays 80%, after deductible

Annual Deductible

A deductible is the amount you must pay before the plan starts paying a percentage of your healthcare costs. Under the Out-of-Area Indemnity Plan, your deductible is determined by your coverage level.

You pay a deductible for each person up to the family maximum of three times the amount of the individual deductible. The maximum family deductible can be met by combining portions of individual deductibles. However, one person can't contribute more than the individual deductible to the family deductible.

After you meet the deductible, you will be responsible for the coinsurance, which will be 20% when the plan pays 80%.

Meeting the family deductible — an example

A family of four enrolled has an individual deductible of $300 and a family deductible of $900.

Suppose your covered charges equal $225, your spouse's equal $150, your son's equal $250 and your daughter's equal $275, for a total of $900. Although no one has met the $300 individual deductible, your family has met the $900 family deductible. Once the family deductible is met, the plan begins paying a percentage of covered charges for all covered members.

Annual limit on your share of covered expenses

The out-of-pocket maximum is the most you pay in a calendar year for your and your dependents' covered medical expenses. The family maximum is three times the individual out-of-pocket maximum. Your individual out-of-pocket maximum is $3,000 and the family maximum is $9,000. After you reach your out-of-pocket maximum, the plan pays 100% of covered charges for the rest of the calendar year.

Reasonable and Customary (R&C) charges

Reasonable and customary (R&C) charges are the typical range of fees charged by medical providers in your geographic area for similar services. In other words, it is the "going rate" for a certain service in your area. Out-of-network provider fees may or may not be within the plan's R&C limits. The plan will not pay for charges above the 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 fees are within R&C limits?

Call Blue Cross Blue Shield of NC at 877-224-3305 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.

Maximum plan benefits

The Out-of-Area Indemnity Plan features an annual maximum of $3,000,000 toward covered expenses and an unlimited lifetime maximum.

Preventive care

Preventive care is covered at no cost to you — with no annual dollar maximum. This includes services like annual checkups/physicals, mammograms, certain cancer screenings, etc.

To be covered as a preventive care service, the care must meet nationally recognized guidelines for preventive care — like minimum age and frequency rules. Contact Blue Cross Blue Shield of NC for more information.

Hospital admissions

All inpatient hospital admissions — emergency or planned — must be pre-certified by Blue Cross Blue Shield of NC. To have your hospital stay pre-certified, you or your provider must call Blue Cross Blue Shield of NC 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, Blue Cross Blue Shield of NC 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 page 52 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.

Prescription drug coverage

Out-of-Area Indemnity Plan participants receive a CVS Caremark prescription drug card. You can use the card to purchase prescription drugs through the mail or at one of the many CVS Caremark 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. You have no claim forms to file for each prescription up to a 30-day supply.

A 90-day supply is required 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.

Specialty medications used to treat chronic (long-term), life-threatening or rare conditions such as multiple sclerosis, rheumatoid arthritis and hemophilia are covered under your prescription drug coverage. For a 30-day supply of a generic drug, you only pay $5. The plan pays 70% coinsurance, and you pay a $60 minimum up to a $100 maximum for brand drugs. The maximum out-of-pocket costs for any covered individual for specialty medications are $2,000 each year.

Mandatory generics program

Compass Group uses a mandatory generics program to help keep the cost of your prescription drugs more affordable. When you fill a prescription for a brand-name drug, your pharmacist will automatically see if a generic drug is available.

Refer to *The Prescription Drug Program* section on pages 61 – 67 for more details on your prescription coverage through CVS Caremark.

For information on:

- Coordinating benefits between medical plans — see page 16.
- When medical plan coverage ends — see page 18.
- Continuing your medical plan coverage when you leave Compass Group — see page 19.

Highlights of the Out-of-Area Indemnity Plan

PLAN FEATURES	
Calendar Year Deductible	$300/Individual $900/Family
Annual Maximum (Out-of-Pocket)	$3,000/Individual $9,000/Family[1]
Plan Maximums	$3,000,000 annual maximum and unlimited lifetime maximum[2]
Health Reimbursement Account	N/A
TYPE OF SERVICE	**PLAN PAYS**
Physician Services	
Preventive Care Services[3]	100%
Primary Care Physician (PCP) Office Visit Specialist Office Visit Surgery (Doctor's Office, Inpatient or Outpatient Hospital) Chiropractor Allergy Injections, without office visit copay	80%, after deductible
Phone or Online Consultation (Teladoc)[4]	100%, after $10 copay
Prescription Drugs	
Pharmacy (30-day supply) • Generic • Formulary Brand • Non-formulary Brand	 100%, after $5 copay 70% coinsurance: associate pays min $20, max $50 70% coinsurance: associate pays min $40, max $80
Mail-Order (90-day supply) • Generic • Formulary Brand • Non-formulary Brand	 100%, after $12 copay 70% coinsurance: associate pays min $50, max $125 70% coinsurance: associate pays min $100, max $200
Specialty (up to a 30-day supply) • Annual Out-of-Pocket Maximum • Generic • Brand	 $2,000/Individual 100%, after $5 copay 70% coinsurance: associate pays min $60, max $100
Hospital Services	
Inpatient Hospital Care Outpatient Hospital Care[5]	80%, after deductible 80%, after deductible
Emergency Care	
Emergency Room Urgent Care	80%, after deductible 80%, after deductible
Maternity Care	
Physicians office — Initial visit Physician services (Pre- and post-natal visits, delivery) Delivery and Newborn charges — Hospital	80%, after deductible 80%, after deductible 80%, after deductible
Mental Health Services	
Outpatient Services Inpatient Services	80%, after deductible 80%, after deductible
Substance Abuse Services	
Detoxification/Rehabilitation • Outpatient • Inpatient	 80%, after deductible 80%, after deductible

1 Out-of-pocket maximum does not include prescription drugs. Specialty out-of-pocket maximum is separate.

2 For all essential health services as defined by Health Care Reform.

3 To be covered as a preventive care service, the care must meet nationally recognized guidelines — like minimum age and frequency rules. Contact your carrier for more information.

4 Oklahoma, Puerto Rico and the U.S. Virgin Islands are excluded from the service area. Teladoc video consults are not available in Idaho, Iowa, Louisiana, Missouri, Oklahoma, Ohio or Texas.

5 Outpatient diagnostic imaging services, including CT/CTA scans, MRI/MRA scans, PET scans and nuclear cardiology studies require prior authorization. Contact your carrier for more information.

U.S. Virgin Islands PPO Plan

How the plan works

The U.S. Virgin Islands Preferred Provider Organization (PPO) Plan provides coverage for associates in the U.S. Virgin Islands. Cigna provides the PPO provider network and administers claims for this self-insured plan.

You have the freedom to choose your physicians and hospitals from a network of participating providers, as well as the ability to seek out-of-network care at a higher out-of-pocket cost.

How the plan pays benefits

In the U.S. Virgin Islands PPO Plan, you may see any doctor, specialist or healthcare facility. The plan pays a greater percentage of covered expenses when in-network providers are used. Coverage for care you receive in-network is 80% for most services. Before the plan pays for most out-of-network covered services for you or a covered dependent, you must first meet your annual out-of-network deductible for most expenses for the period of January 1 through December 31.

What the plan covers

	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	None	$750/Individual $2,250/Family
Annual Out-of-Pocket Maximum	$3,000/Individual $9,000/Family	$7,500/Individual $22,500/Family
Plan Maximums	$3,000,000 annual maximum and unlimited lifetime maximum	
Preventive Care	Plan pays 100%	Plan pays 60%, after deductible
Most Other Covered Services	Plan pays 80%	Plan pays 60%, after deductible

Annual deductible

A deductible is the amount you must pay before the plan starts paying a percentage of your healthcare costs. Under the U.S. Virgin Islands PPO Plan, you have no deductible if you use network providers. For out-of-network providers, your deductible is determined by your coverage level (individual or family).

You pay a deductible for each person up to the family maximum of three times the amount of the individual deductible.

You will be responsible for the coinsurance, which will depend on whether you choose an in- or out-of-network provider.

Annual limit on your share of covered expenses

The out-of-pocket maximum is the most you pay in a calendar year for your and your dependents' covered medical expenses. It includes the deductible (if applicable).

The family maximum is three times the individual out-of-pocket maximum. If you use out-of-network providers, your individual out-of-pocket maximum is $7,500 and the family maximum is $22,500. After you reach your out-of-pocket maximum, the plan pays 100% of covered charges for the rest of the calendar year.

These expenses do not apply toward your out-of-pocket maximum:

- Your portion of the prescription drug coinsurance.
- Charges above the reasonable and customary (R&C) limits.
- Charges for services not covered under this plan.
- The benefit reduction percentage amount for using out-of-network providers if a PPO network is available in your area.
- The penalty for failure to have inpatient hospital admissions, high-tech diagnostic imaging procedures (i.e., CT, PET, MRI) or services requiring authorization pre-certified by Cigna.

Network providers lower your cost

The PPO network is a group of participating providers who have agreed to deliver your healthcare for negotiated fees. You will reduce your cost for medical services if you use in-network providers.

You decide whether to use an in-network or an out-of-network provider. If you use in-network providers, you have no deductible and your out-of-pocket maximum will be less than the out-of-pocket maximum for out-of-network providers (see the chart on page 51). The provider networks include doctors and hospitals.

If you use an in-network provider, the medical plan will pay 80% (100% for some services) of covered charges after you meet the deductible. If an in-network provider is available to you, but you choose an out-of-network provider, the plan will pay only 60% of covered charges after the deductible has been satisfied and your deductible and out-of-pocket maximum will more than double.

Reasonable and Customary (R&C) charges

Reasonable and customary (R&C) charges are the typical range of fees charged by medical providers in your geographic area for similar services. In other words, it is the "going rate" for a certain service in your area. Out-of-network provider fees may or may not be within the plan's R&C limits. The plan will not pay for charges above the 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 out-of-network provider's proposed fees are within R&C limits?

Call Cigna at 800-Cigna24 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 Cigna. Cigna 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.

If you have a life-threatening medical emergency

If you have a life-threatening medical emergency, the plan will pay for covered charges after any applicable deductible or coinsurance has been met regardless of whether you use an in-network or out-of-network provider. See definition of life-threatening emergency on page 52.

If you become ill or injured while traveling outside a network area

If you become ill or injured while traveling outside your network area, the plan will pay for covered charges after any applicable deductible or coinsurance has been met. If you need medical attention while traveling away from home, call Cigna at 800-244-6224, and you will be directed to a representative who can give you the names of participating providers where you are traveling.

If your network does not include the type of specialist you need

If your medical condition requires you to see a doctor with a particular specialty and that type of specialist is not included in your provider network, or if an in-network hospital cannot provide the care that you require, contact Cigna directly to determine if an out-of-network specialist or an out-of-network hospital can be approved.

Maximum plan benefits

The U.S. Virgin Islands PPO Plan features a total calendar year maximum benefit that pays up to $3,000,000 toward the covered expenses of each enrolled person in any one calendar year. The plan has an unlimited lifetime maximum.

Some services and treatments have specific lifetime and/or calendar year limits. See *Covered Services* chart on page 51 for details on special limits for specific covered services.

Preventive care

In-network preventive care is covered at no cost to you — with no annual dollar maximum. This includes:

- Services — like annual checkups/physicals, mammograms, certain cancer screenings, etc.

To be covered as a preventive care service, the care must meet nationally recognized guidelines for preventive care — like minimum age and frequency rules. Contact Cigna for more information.

Hospital admissions

All inpatient hospital admissions — emergency or planned — must be pre-certified by Cigna. To have your hospital stay pre-certified, you or your provider must call Cigna 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, Cigna 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 page 52 for examples of medical emergencies. If your hospital requires you to stay additional days, it will contact Cigna to approve the additional days.

Prescription drug coverage

Participants in the U.S. Virgin Islands PPO Plan receive a combined medical and prescription drug card through Cigna. When the card is used to purchase prescription drugs at one of the many network pharmacies, the plan pays 100% after a copay for each retail prescription up to a 30-day supply and each mail order prescription for up to a 90-day supply. The amount of the copay depends on if the drug is a generic or brand-name drug.

For information on:

- Coordinating benefits between medical plans — see page 16.
- When medical plan coverage ends — see page 18.
- Continuing your medical plan coverage when you leave Compass Group — see page 19.

Highlights of the U.S. Virgin Islands PPO Plan

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible	None	$750 Individual/$2,250 Family
Annual Out-of-Pocket Maximum[1] (includes deductible)	$3,000 Individual/$9,000 Family	$7,500 Individual/$22,500 Family
Plan Maximums[2]	$3,000,000 Annual, Unlimited Lifetime	
Health Reimbursement Account	N/A	
TYPE OF SERVICE	**PLAN PAYS**	**PLAN PAYS**
Physician Services		
Preventive Care Services[3]: Annual checkups/physicals, mammograms, certain cancer screenings, etc.	100%	60%, after deductible
Primary Care Physician (PCP) Office Visit Specialist Office Visit Surgery (Doctor's Office, Inpatient or Outpatient Hospital) Chiropractor Allergy Injections, without office visit copay	100%, after $25 copay 100%, after $35 copay 80% 100%, after $25 copay 80%	60%, after deductible
Vision Benefits	Flat dollar reimbursement schedule, depending on service rendered; eye exams and lenses available every 12 months and frames every 24 months	
Prescription Drugs		
Pharmacy (30-day supply) • Generic • Brand	 100%, after $10 copay 100%, after $20 copay	 100%, after $10 copay 100%, after $20 copay
Mail-Order (90-day supply) • Generic • Brand	 100%, after $20 copay 100%, after $40 copay	 Not covered Not covered
Hospital Services		
Inpatient Hospital Care	80%	60%, after deductible
Outpatient Hospital Care	80%	60%, after deductible
Emergency Care		
Accident: Emergency Room Urgent Care Clinic	 100%	 100%
Illness: Emergency Room Urgent Care Clinic	 80% 100%, after $35 copay	 80% 100%, after $35 copay
Maternity Care		
Physicians office — Initial visit	100%, after $25 copay for PCP, or $35 copay for specialist	60%, after deductible
Physician services (Pre- and post-natal visits, delivery)	100%	60%, after deductible
Delivery and Newborn charges — Hospital	80%	60%, after deductible
Mental Health Services and Substance Abuse Services		
Specialist Office Visit	100%, after $35 copay; group therapy $25 copay	60%, after deductible
Outpatient Services	80%	60%, after deductible
Inpatient Services	80%	60%, after deductible

1. Out-of-pocket maximum does not include copays or prescription drugs.

2. For all essential health services as defined by Health Care Reform

3. To be covered as a preventive care service, the care must meet nationally recognized guidelines like minimum age and frequency rules. Contact your carrier for more information.

For all medical plan options

When to call your medical plan carrier

Call your medical plan carrier's member services department first. Compass Group's Benefits Department cannot answer specific medical plan questions. 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.

Special Healthcare Provisions

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.

Inpatient hospital stays

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.

If you have a medical emergency

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 described above.

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

If you become ill or injured while traveling outside a network area

If you become ill or injured while traveling outside your network area, call your medical plan carrier's customer service department at the number listed on your ID card.

If you become ill or injured while traveling outside of the United States

If you become ill or injured while traveling outside of the United States, you will have to cover the costs of your treatment and submit the bills to your medical plan carrier for reimbursement when you return to the United States.

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 Consumer Choice PPO, the Value Choice, the Out-of-Area Indemnity and U.S. Virgin Islands PPO Plans. 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 on pages 42 – 43, 47 and 51 for details on copays, deductibles, coinsurance and out-of-pocket maximums.

Physician services

Preventive care services: routine physical examinations and cancer screenings provided in a doctor's office

To be covered as a preventive care service, the care must meet nationally recognized guidelines for preventive care — like minimum age and frequency rules. Contact your medical carrier for more information.

Physical exams

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.

Cancer 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: primary care physician, specialist and surgery in a physician's office, inpatient or outpatient hospital

Physician or specialist

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.

Surgery

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 drug coverage

Generally, prescription drugs and medicines that have been ordered in writing by your doctor (including birth control pills) are covered by the prescription drug plan. Some drugs are excluded. For more information about how you can save money on prescription drugs through the participating pharmacy network and the mail-order program, see page 61.

Hospital expenses

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* on page 56 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.

Alternatives to hospital stays

Extended care facility coverage

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 subacute care, and
- The skilled nursing facility admission will take the place of an admission to, or continued stay in, a hospital or subacute 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 healthcare benefits

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 healthcare 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. Cigna uses 100 days, instead of visits and one day equals four hours. "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 coverage

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.

Limitations

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

- Daily room and board charges over the semi-private room rate.
- Bereavement counseling. (Aetna and Blue Cross Blue Shield of NC plans only).
- 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.
- Refer to the *Employee Assistance Program (EAP)* section on page 72 for information regarding bereavement, financial and legal counseling.

Rehabilitation services outpatient therapy

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

- Physical therapy
- Occupational therapy
- Speech therapy
- Pulmonary rehabilitation
- Cardiac rehabilitation
- Cognitive therapy (Cigna plan only)

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

Maternity care

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 baby benefits

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 two months of their birth. See *Life Events* on page 12.

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:

Outpatient care

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 care

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 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. 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.

Substance abuse services

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 care

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.

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.

Compass Group's medical plans comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

Outpatient care

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

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).
- Breast reductions that are medically necessary (not for cosmetic purposes).
- 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 medically necessary replacements of a prosthetic device when ordered by the attending physician.

- 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 broken purchased equipment when determined by a physician to be medically necessary and if the replacement is likely to cost less to replace the item than to repair the existing item or rent a similar item.
    - Replacement of purchased equipment if the replacement is needed because of a change in your physical condition.
- 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. Cigna covers first pair of eyeglasses, lenses and frames following cataract surgery.
- 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 and U.S. Virgin Islands PPO Plans. If you are enrolled in the Value Choice Plan, services obtained from a facility that is not designated as a Blue Distinction Center will not be covered unless you live more than 100 miles from one. Services will be covered as out-of-network for the Consumer Choice PPO Plan. The Out-of-Area Indemnity Plan does not require you to use a network provider.
- Charges in connection with temporomandibular joint (TMJ) syndrome — diagnostic services and surgery only, other services covered under dental.
- Except for Blue Cross Blue Shield of NC, 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.
- Hearing aids, including the replacement of hearing aids once every five calendar years.
- 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. If approved for surgery, you must use a Center of Excellence for treatment, where you're more likely to get better care and be treated by experienced, knowledgeable providers.
- Diagnosis, treatment and correction of any underlying causes of infertility and/or sexual dysfunction.
- Elective abortions.

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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 service 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 (see Vision Coverage on pages 86 – 90).
- 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 if guidelines are not met.
- 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. (See *Employee Assistance Program (EAP)* on page 72.)
- 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.
- 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.
- Prescription drugs listed as not covered are on page 66.
- 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 comorbid 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 as explained on pages 19 – 27.
- 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.
- Under Aetna and UnitedHealthcare, 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 of NC, charges made by an assistant surgeon in excess of 20% of the surgeon's allowable charge; or for charges made by a co-surgeon in excess of the surgeon's allowable charge plus 20%. For Cigna assistant surgeon's fees in excess of 20% of the surgeon's allowable charge; or for charges made by a co-surgeon in excess of 62.5% of the surgeon's allowable charge.
- Under Aetna, Blue Cross Blue Shield of NC and UnitedHealthcare 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. For Cigna, 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 all other surgical procedures combined.

The Prescription Drug Program

Compass Group has contracted with CVS Caremark™ to be the Pharmacy Benefit Manager (PBM) for the Value Choice, the Network Choice and the Out-of-Area Indemnity Plans. Aetna provides the prescription drug coverage under the Consumer Choice PPO Plan. In addition, the Regional HMOs that may be available to you administer their own prescription drug coverage.

CVS Caremark and Aetna both 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.

The program at-a-glance

	CVS Caremark™	AETNA
Plan option	Value Choice, Network Choice and Out-of-Area Plans	Consumer Choice PPO Plan
Pharmacy program — for short-term prescription drugs of 30 days or less filled at a local retail pharmacy	You'll receive a pharmacy ID card from CVS Caremark™	You'll receive a combined medical and prescription ID card from Aetna
Mail order program — optional, for any long-term medications	• Get up to a three-month (90-day) supply of your prescription drugs mailed directly to your home, postage-paid. (If you have coverage with CVS Caremark, you may also obtain a 90-day supply at a CVS pharmacy.) • Save money as compared to getting the same prescription drug on a monthly basis.	
Specialty medications — for chronic, life-threatening or rare conditions	Specialty medications are covered for conditions such as multiple sclerosis, rheumatoid arthritis and hemophilia. These medications may: • Be given by injection or taken by mouth. • Cost more than traditional medications — greater than $500 for a 30-day supply. • Have special storage and handling requirements. • Need to be taken on a very strict schedule.	
Lifestyle medications — for conditions such as hair loss or wrinkle reduction	Lifestyle medications are prescriptions that are not medically necessary but are FDA-approved. Although you pay 100 percent of the cost of these medications, they are provided at a group discount.	

Your prescription drug coverage

By using either CVS Caremark's or Aetna's 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.

PHARMACY (RETAIL) 30-DAY SUPPLY	VALUE CHOICE PLAN (CVS Caremark)	CONSUMER CHOICE PPO PLAN (AETNA)		NETWORK CHOICE PLAN (CVS Caremark)	OUT-OF-AREA INDEMNITY PLAN (CVS Caremark)
		IN-NETWORK	OUT-OF-NETWORK		
Generic	100%, after $5 copay	70% coinsurance: associate pays max $60	Not covered	100%, after $5 copay	100%, after $5 copay
Formulary Brand	70%, coinsurance: associate pays min $20, max $50	70% coinsurance: associate pays max $60	Not covered	70% coinsurance: associate pays min $20, max $50	70% coinsurance: associate pays min $20, max $50
Non-formulary Brand	70%, coinsurance: associate pays min $40, max $80	70% coinsurance: associate pays max $60	Not covered	70%, coinsurance: associate pays min $40, max $80	70%, coinsurance: associate pays min $40, max $80

Using out-of-network pharmacies

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.

Which pharmacies participate in the network?

To find a network pharmacy in your area, check out CVS Caremark's website at www.caremark.com or Aetna's website at www.aetna.com/docfind/custom/compassgroup .

The Mail-Order Program

If you take long-term medications, 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. Simply mail your prescription and payment in the pre-addressed envelope provided by CVS Caremark or Aetna.

If coinsurance is required, call CVS Caremark or Aetna to determine your 30% coinsurance cost. 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 CVS Caremark or Aetna at the number on your ID card.

PHARMACY (MAIL ORDER) 90-DAY SUPPLY	VALUE CHOICE PLAN (CVS Caremark)	CONSUMER CHOICE PPO PLAN (AETNA)		NETWORK CHOICE PLAN (CVS Caremark)	OUT-OF-AREA INDEMNITY PLAN (CVS Caremark)
		IN-NETWORK	OUT-OF-NETWORK		
Generic	100%, after $12 copay	70% coinsurance: associate pays max $150	Not covered	100%, after $12 copay	100%, after $12 copay
Formulary Brand	70% coinsurance: associate pays min $50, max $125	70% coinsurance: associate pays max $150	Not covered	70% coinsurance: associate pays min $50, max $125	70% coinsurance: associate pays min $50, max $125
Non-formulary Brand	70% coinsurance: associate pays min $100, max $200	70% coinsurance: associate pays max $150	Not covered	70% coinsurance: associate pays min $100, max $200	70% coinsurance: associate pays min $100, max $200

Getting started with home delivery

To get started	• For CVS Caremark, go online to www.caremark.com or call 855-656-0360. • For Aetna, go online to www.aetna.com or call 866-612-3862. • CVS Caremark or Aetna will contact your physician to request a 90-day prescription.
To manage refills (CVS Caremark only)	• Set up your profile with CVS Caremark, and you'll receive telephone calls or emails when your refill is due — or when your order is shipped. • Enroll in the CVS Caremark Auto Refill Program and have your prescriptions automatically shipped 25 days before you run out.
To ship to a different address	• If you don't want your prescriptions shipped to your home, CVS Caremark or Aetna can ship to a different address.

It takes up to three weeks to receive a new prescription and about 10 days to receive a refill.

CVS Caremark's Maintenance Choice® – required for maintenance prescriptions

If you are enrolled in the Value Choice, Network Choice or Out-Of-Area Plan, you are required to fill a 90-day supply of your maintenance medications with Maintenance Choice®.

You can choose to fill a 90-day supply of your prescriptions through Maintenance Choice in two ways:

- FastStart mail service program – filling through home delivery not only offers the highest prescription drug savings for your maintenance medications, but also is convenient.
- Any CVS pharmacy – you can get up to a 90-day supply for the same cost. By going to CVS pharmacy, you will get your prescription drugs the same day and be able to talk face-to-face with a pharmacist.

Note that Maintenance Choice does not apply to Consumer Choice PPO or Regional HMO plan participants.

How do I know if my prescription requires that I use the Maintenance Choice Program?

The Maintenance Choice Program pertains to maintenance medications, or prescription drugs for ongoing conditions such as diabetes or high blood pressure. A list of commonly used maintenance drugs is posted at www.caremark.com. You also can call CVS Caremark at 855-656-0360 to confirm if your medication requires use of the Maintenance Choice Program. To learn more about and enroll in the Maintenance Choice Program, call CVS Caremark at 855-656-0360.

Maintenance medications are drugs that are taken over an extended period of time and used to treat chronic health conditions, like diabetes or high blood pressure.

Important note

CVS Caremark will notify you by mail if you are using a retail pharmacy to obtain maintenance medications that are covered under the Maintenance Choice Program.

Tobacco cessation

Prescription tobacco cessation medication is covered under CVS Caremark or Aetna, like any other drug.

Specialty medications

Specialty medications are covered under the prescription drug plan. Specialty medications are often prescribed to treat chronic (long-term), life-threatening or rare conditions such as:

- Blood modifiers
- Growth hormone disorders
- Hemophilia and related bleeding disorders
- Hepatitis C
- Immune deficiencies
- Infertility
- Multiple Sclerosis
- Rheumatoid Arthritis

Specialty medications may:

- Be given by injection or taken by mouth.
- Cost more than traditional medications — greater than $500 for a 30-day supply.
- Have special storage and handling requirements.
- Need to be taken on a very strict schedule.

The maximum out-of-pocket cost for any covered individual is $2,000 each year.

Caremark Specialty for specialty medications*

Compass Group's specialty medication coverage policy allows up to one 30-day supply of a specialty medication to be filled at a CVS Caremark participating retail network provider. If you need more refills, you are required to use the Caremark Specialty program.

* Caremark Specialty is not available to Consumer Choice PPO or Regional HMO Plan participants.

SPECIALTY (UP TO A 30-DAY SUPPLY)	VALUE CHOICE PLAN (CVS Caremark)	CONSUMER CHOICE PPO PLAN (AETNA)		NETWORK CHOICE PLAN (CVS Caremark)	OUT-OF-AREA INDEMNITY PLAN (CVS Caremark)
		IN-NETWORK	OUT-OF-NETWORK		
Annual Out-of-Pocket Maximum	$2,000 Individual	None	Not covered	$2,000 Individual	$2,000 Individual
Generic	100%, after $5 copay	70% coinsurance: associate pays max $60	Not covered	100%, after $5 copay	100%, after $5 copay
Brand	70% coinsurance: associate pays min $60, max $100	70% coinsurance: associate pays max $60	Not covered	70% coinsurance: associate pays min $60, max $100	70% coinsurance: associate pays min $60, max $100

Dependable services — and more

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 Caremark Specialty, including:

- Up to a 30-day supply of specialty medications subject to the specialty drug copay.
- Direct pharmacist and nurse access to ensure you receive prompt, personalized care.
- Educational materials, support and home instruction information.
- Comprehensive coordination of care including refill 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.

Important

For the Value Choice, the Network Choice and the Out-of-Area Indemnity Plans, Compass Group only covers specialty medications through Caremark Specialty.

To receive coverage, be sure to order your specialty medications through the Caremark Specialty Program. CVS Caremark will notify you if you are currently taking specialty medications that are required for use under the Caremark Specialty Program. Your physician will need to complete a Patient Enrollment Form. This form can be obtained by calling the CVS Caremark Customer Service Department at 855-656-0360.

When I use Maintenance Choice or the Caremark specialty programs, how will I know how much my prescriptions will cost?

You can check www.caremark.com or call Caremark Specialty at 800-237-2767 to speak with a Patient Care Advocate about cost information for your prescriptions. For cost information on prescriptions filled through the Caremark Specialty Program, call 800-237-2767.

Drugs that are not covered

- Over-the-counter (OTC) medications.
- Experimental drugs.
- Medically unnecessary medications.

This is not a complete list. For more information on drugs not covered, call CVS Caremark or Aetna.

While not all drugs are 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.

Lifestyle medications

Lifestyle medications are available under the Value Choice, Consumer Choice PPO, Network Choice and Out-of-Area Plans. Lifestyle medications are prescriptions that are not medically necessary but are FDA-approved to treat conditions such as hair loss, wrinkle reduction and certain allergies. While you pay 100% of the cost for these medications, they are provided at a group discount:

- Obesity drugs
- Prescription vitamins
- Hair growth stimulants
- Hair removal agents
- Depigmenting agents
- Anti-wrinkle agents
- Erectile dysfunction
- Fertility drugs
- Non-sedating antihistamines (e.g. allergy medications)

Reduce your costs with generic drugs

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.

Generic Preferred Program

CVS Caremark has a mandatory generics program to help keep the cost of your prescription drugs more affordable. When you fill a prescription for a brand-name drug, your pharmacist will automatically see if a generic drug is available.

At your first trip to the pharmacy, keep in mind:

- If you choose a generic drug, your copayment will be $5 for a 30-day supply ($12 for a 90-day supply).
- If you choose a brand-name drug, you'll pay your coinsurance plus the difference in cost between the generic and the brand-name drug.

The choice between brand-name and generic drugs is up to you. However, choosing the generic drug will save you money and help Compass Group control the rising cost of health care.

What is a formulary drug?

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.

The lists are available at www.altogethergreat.com.

Compass Group's step therapy program

For certain conditions such as ulcers, acid reflux disease, and some types of pain or inflammation, Compass Group's Step Therapy program requires lower cost options be explored before higher cost options are covered under the plan.

Your doctor is involved, and approves the substitution of the lower cost drug covered by our plan. Your pharmacy provider starts the process for specific drug categories. Step Therapy may not be available in Regional HMO Plans.

How Does Step Therapy Work

Generic drugs are usually in the first step — allowing you to begin or continue treatment with prescription drugs that have the lowest copays. When you submit a prescription for a medication that is not a "first-step" drug, it may be rejected. Ask your pharmacist about lower-cost alternatives. You can ask the pharmacist to contact your physician about switching the medication to a "first-step" drug that will save you money. Only your doctor can approve and change your prescription to a "first-step" drug.

The pharmacist can give you examples of safe, effective generic drugs to discuss with your doctor. More expensive brand name drugs are covered in a later step — after a first-step generic has been tried or your doctor decides you need a different drug for medical reasons. Be sure to advise your doctor that your plan uses Step Therapy. Wise healthcare consumers explore the most affordable medications that meet their needs. In the end, both you and Compass Group save money.

For more information on Step Therapy, call CVS Caremark at 855-656-0360.

Prior authorization

Before certain medications are covered under your medical plan, CVS Caremark 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 CVS Caremark to see if your plan will cover the medication.
- If your medication is covered, CVS Caremark 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.

For more information on drugs requiring Prior Authorization, call CVS Caremark or log on to www.caremark.com.

Quantity Limits

To help you get the medications you need safely and affordably, CVS Caremark 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 CVS Caremark to request a prior authorization which may allow you to get a larger quantity.

Mail order and prescription claims

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

CVS Caremark (for mail order)
Mail Pharmacy Service
P.O Box 94467
Palatine, IL 60094-4467
855-656-0360

CVS Caremark Claims Department (for paper claims)
P.O. Box 52136
Phoenix, AZ 85072-2136
855-656-0360

Aetna Rx Home Delivery (for mail order)
PO Box 417019
Kansas City, MO 64179-7019
866-612-3862

Aetna Prescription Management (for paper claims)
PO Box 14024
Lexington, KY 40512-4024
Attn: Claims Department
866-238-1128

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 and the in-network portion of the Consumer Choice PPO Plan, your medical provider will submit your claims directly to your medical plan carrier. If you use out-of-network providers under the Consumer Choice PPO Plan or you are a participant in the Value Choice or Out-of-Area Indemnity Plan, 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.

Refer to the *Appeals of Denied Claims* section on page 129 for additional information on the timing of claims processing and appeals of claim denials.

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

Aetna
151 Farmington Avenue
Hartford, CT 06156
866-238-1128

Blue Cross Blue Shield of NC
P.O. Box 35
Durham, NC 27702
877-275-9787

Cigna HealthCare
P.O. Box 182223
Chattanooga, TN 37422-7223
800-Cigna-24 (800-244-6224)

United Healthcare
P.O. Box 740800
Atlanta, GA 30374
877-571-9862

Regional HMO claim office

CALIFORNIA - Northern	CALIFORNIA - Southern	COLORADO - Colorado Springs
Kaiser Foundation Health Plan, Inc. Attn: Claims Department P.O. 12923 Oakland, CA 94604-2923 800-464-4000 www.kaiserpermanente.org	Kaiser Foundation Health Plan, Inc. Attn: Claims Department P.O. Box 7004 Downey, CA 90242 800-464-4000 www.kaiserpermanente.org	Kaiser Permanente Attn: Claims Department P.O. Box 372910 Denver, CO 80237-6910 888-681-7878 www.kaiserpermanente.org
COLORADO - Denver	**MARYLAND- Mid-Atlantic**	**PENNSYLVANIA**
Kaiser Permanente Attn: Claims Department P.O. Box 373150 Denver, CO 80237-6970 303-338-3600 www.kaiserpermanente.org	Kaiser Permanente P.O. Box 6233 Rockville, MD 20849-6217 301-468-6000 or 800-777-7902 www.kaiserpermanente.org	Geisinger Health Plan P.O. Box 8200 Danville, PA 18721-3029 800-447-4000 www.thehealthplan.com
WASHINGTON	**PUERTO RICO (PPO Plan)**	**PUERTO RICO**
Kaiser Group Health Cooperative of Puget Sound Attn: Claims Administration P.O. Box 34585 Seattle, WA 98124-1585 888-901-4636- West 800-497-2210- East www.ghc.org	COSVIMED P.O. Box 363428 San Juan, PR 00936-3428 787-751-5656 www.cosvi.com	MCS Plaza 255 Ave. Ponce de León San Juan, PR 00902-3547 888-758-1616

U.S. Virgin Islands PPO Plan claim office

Cigna P.O. Box 182223 Chattanooga, TN 37422-7223 800-Cigna-24 (800-244-6224)		

Wellness Program

Compass Group provides a Wellness Program for associates and eligible dependents enrolled in a Compass Group medical plan. The programs available through our wellness partners — INTERVENT, ActiveHealth Management and HealthAdvocate include:

- INTERVENT:
  - A free, confidential online Health Assessment.
  - Online health improvement programs.
  - Lifestyle health coaching by phone.
- ActiveHealth Management:
  - Condition management.
  - Prenatal support.
  - Tobacco cessation program.
- HealthAdvocate::
  - Employee Assistance Program (for eligible associates and their spouse/domestic partner, dependent children, parents and parents-in-law) — to help you deal confidentially with personal issues that affect your health, family and work life.
  - Healthcare Help team — to help you and your family members navigate the complex healthcare system.

Here are brief descriptions of the programs with contact information for our wellness partners.

INTERVENT programs

INTERVENT is our partner to offer the Health Assessment, online health improvement programs, and lifestyle health coaching.

Health Assessment

As a Compass Group associate, you and your adult dependents can complete a free Health Assessment, available online and via telephone interview in both English and Spanish. You'll receive individualized reports that include:

- Brief score cards and comprehensive risk factor goals.
- Recommendations and action plans including meal and exercise plans.
- Summary reports to take to your personal doctor.
- Educational kits on select topics.

The Health Assessment takes about 15 minutes to complete.

By completing the Health Assessment, you can learn more about getting healthy and staying healthy by answering a few simple questions. In addition, you can earn a $156 wellness credit toward your medical deductions ($3 a week). To get the credit, you must:

- Be enrolled in a Compass Group medical plan.
- Take the Health Assessment and complete all the required questions.

New associates should take the Health Assessment before enrolling for benefits. Only associates enrolled in a Compass Group medical plan are eligible to earn the wellness credit.

Your Health Assessment answers and report are totally confidential and will never be shared with Compass Group. Compass Group only will receive non-personalized, general data.

Once you complete the Health Assessment, you will receive a report showing your health status that you can share with your medical provider.

When you're ready to complete the Health Assessment

- Gather some key information, including height and weight (required), blood pressure numbers and cholesterol levels.
- Go to www.interventint.com/compassgroup.
- On the INTERVENT landing page, click *To Start a New Health Assessment* and then follow the prompts to enter your personal information and complete your Health Assessment.
- If you provide an email address, your password will be emailed to you. You must have this password to return to the site. Note: The email address you provide also will be used for future communications from INTERVENT.
- If you don't provide an email address, you will be assigned a Sign-on ID and password in a pop-up box that you must use to return to the site.

If you don't have Internet access, call 866-334-2137, and an INTERVENT representative will help you complete the Health Assessment.

Online Health Improvement Programs

Once you complete the Health Assessment, you can access a variety of online self-directed lifestyle coaching tools. These online tools include programs and information on physical activity, weight management, healthy eating, quitting tobacco and stress management.

Lifestyle Health Coaching Program

If you are enrolled in the Compass Group medical plan and you complete the confidential Health Assessment, you may be invited to participate in a Lifestyle Health Coaching Program at no cost to you.

You'll have phone calls with your own professional health coach to talk about changes in your lifestyle that are important to you. Whether you want to lose weight, improve your fitness, manage stress or give up tobacco, a health coach can help you get healthy and stay healthy.

After the initial telephonic 30-minute coaching session, additional coaching sessions are approximately 15 minutes. The program is designed to help you make and adhere to meaningful lifestyle changes (including regular exercise, proper nutrition, weight management, tobacco cessation and stress management).

The program also helps you learn about preventive screenings and other important self-care strategies. You may be referred to your doctor or healthcare provider to discuss medications to help manage common chronic conditions such as high blood pressure or abnormal cholesterol.

As part of the coaching process, INTERVENT offers over 80 different educational/behavior modification kits/modules with audios. You and your dedicated coach work together from session to session to identify the specific topics that are appropriate for you. Spanish-speaking coaches are available. Follow-up evaluations and progress reports are provided to participants after 12 weeks and one year.

For more information

Go to www.interventint.com/compassgroup or call 866-334-2137.

ActiveHealth Management Programs

ActiveHealth Management is our partner to offer condition management, pre-natal support and tobacco cessation.

Condition management

ActiveHealth Management offers a condition management program, called Active Disease Management℠, that includes support for adults and children with the following conditions:

- Heart and Blood Vessel Conditions
  - Blood clots
  - Disease of leg arteries/PAD
  - Heart attack and angina
  - Heart failure
  - High blood pressure
  - High cholesterol
  - Stroke
- Diabetes
- Lung Conditions
  - Asthma
  - COPD
- Stomach and Intestine Conditions
  - Chronic hepatitis B or C
  - Crohn's disease
  - GERD/gastric reflux disease
  - Stomach ulcers
  - Ulcerative colitis
- Kidney Conditions
  - Chronic kidney disease
  - Kidney failure
- Cancer
  - Breast
  - Colon
  - Leukemia
  - Lung
  - Lymphoma
  - Prostate
- Bone and Joint Conditions
  - Arthritis
  - Chronic back pain
  - Chronic neck pain
  - Osteoporosis
- Neurologic Conditions
  - Migraines
  - Parkinson's disease
  - Seizures
- Healthy Aging — 65+
- Weight Management
  - Overweight/obesity
- Other
  - Cystic fibrosis
  - HIV
  - Lupus
  - Sickle cell anemia

- Programs are available for children and teens with the following conditions:
  - Asthma
  - Diabetes
  - Cystic fibrosis
  - High blood pressure
  - Sickle cell anemia
  - Weight management/obesity

You can work one-on-one with a nurse, other clinical professionals and your doctors to set goals to help improve your overall health and quality of life.

Join the program, and you'll work one-on-one with a nurse health coach who can help you:

- Learn more about your health condition.
- Work more effectively with your doctors.
- Improve your health.
- Help control your out-of-pocket cost.

Active Maternity Management

Expectant mothers enrolled in a Compass Group medical plan will have a nurse coach who will provide pregnancy-related healthcare information and support throughout the pregnancy. Once the program is completed, Compass Group will credit a Health Care Flexible Spending Account (FSA) with an incentive amount. The amount of the incentive is determined by the trimester the expectant mother enrolls in the program.

Here's what you can earn:

TRIMESTER	PREGNANCY WEEKS	INCENTIVE AMOUNT
First trimester	One to 13 Weeks	$250
Second trimester	14 to 26 Weeks	$125
Third trimester	27 to 40 Weeks	$0

Keep in mind the overall annual FSA maximum of $3,500 cannot be exceeded if you are already contributing $3,500. Your FSA election will be reduced when the Company-funded FSA maternity incentive is processed.

Tobacco Cessation Program

If you enroll in a Compass Group medical plan:

- Prescription tobacco cessation medication is covered under the CVS Caremark™ or Aetna prescription drug plan.
- You'll receive one-on-one telephone support from an ActiveHealth coach to help you quit tobacco use.
- Plus, you have access to self-directed online coaching.
- Non prescription nicotine replacement therapy is also provided at no cost to you when you enroll in the Tobacco Cessation Program.

For more information

Go to www.myactivehealth.com/compassgroup or call 877-489-0940.

HealthAdvocate programs

HealthAdvocate is our partner for the Employee Assistance Program (EAP) and the Healthcare Help Team.

Employee Assistance Program

HealthAdvocate is our EAP provider for all eligible associates and their spouse/domestic partner, dependent children, parents and parents-in-law. The program will help you deal with personal issues that affect your health, family life, work life or job performance — confidentially.

Through the EAP, you can get help with:

- Stress, depression, anxiety
- Marital relationships, family/parenting issues
- Work conflicts
- Anger, grief and loss
- Drug and alcohol abuse

You have direct access to qualified professionals who can provide guidance or direct you to specialized resources. When you call the EAP, a counselor will listen to your concerns and obtain a referral for you to talk to an expert counselor located in your area. Your first three visits to a referred counselor are free.

Generally, the EAP is available to all salaried associates.

Healthcare Help Team

In addition, HealthAdvocate offers a Healthcare Help Team of medical, benefits and claims experts — or Personal Health Advocates — to help you navigate the healthcare system and insurance-related issues. When you call, your Personal Health Advocate can help you:

- Find qualified doctors, dentists, hospitals and other healthcare providers anywhere in the country.
- Expedite appointments including hard-to-reach specialists and arrange for specialized treatments and tests.
- Help resolve insurance claims and negotiate billing/payment arrangements.
- Assist with eldercare such as finding adult daycare, assisted living and other related issues facing your parents and parents-in-law.
- Obtain unbiased health information about complex medical conditions to help you make informed decisions.
- Secure second opinions.
- Work with insurance companies to obtain appropriate approvals for needed services.
- Answer general questions about test results, treatments and medications prescribed by your doctor.

HealthAdvocate does not replace your current health insurance coverage nor does it provide medical care or recommend treatment.

For more information

Go to www.healthadvocate.com or call 866-799-2728, 24 hours a day, seven days a week.

great rewards

summary plan description

Dental Coverage

Joining the plan

Compass Group offers you and your eligible dependents dental coverage on the first of the month after you complete three months of service. After that, you may enroll for dental coverage each year during Annual Enrollment or if you have a qualified status change. Your payments for dental coverage are deducted from your paycheck pre-tax. For more information on pre-tax dollars, see page 3.

Dental plan options

Compass Group offers two dental plan options, or you may waive your dental coverage:

- **Cigna PPO Dental Plan (Dental CORE Network)** — a self-insured plan available to all associates. You can use a network dentist (and receive care at discounted rates) or any dentist you wish and receive traditional benefits from the plan. The PPO Dental Plan is available throughout the country.
- **Cigna Managed Care Dental Plan (a Dental Maintenance Organization)** — a fully insured plan available to those living within the Managed Care Dental Plan network area. Primary care dentists must participate in the Managed Care Dental network. The Managed Care Dental Plan is not available in all areas of the country. Availability is based on your home ZIP code.

In this section

Cigna PPO Dental Plan (Dental CORE Network)

How the PPO Plan works

The plan allows you to use any dentist you choose, but also gives you access to Cigna's network of preferred provider dentists. If you use a Cigna preferred provider, you'll receive a higher level of benefits because preferred provider dentists provide services at discounted rates and your preventive care is covered at 100%. If you need more information about preferred providers in your area, you can contact Cigna at 800-Cigna24 (800-244-6224) or log on to www.cigna.com.

The plan provides four levels of dental coverage — preventive treatment, basic restorative treatment, major restorative treatment and orthodontia coverage. An individual annual $50 deductible applies as a combined deductible for basic and major treatment. The annual family deductible is $150. No one person has to meet the individual deductible as long as the $150 family deductible is met. Preventive treatment is not subject to the $50 deductible.

PPO Plan highlights

- You can use any dentist you choose.
- If you use a PPO dentist, you receive a higher level of benefits due to discounted rates and preventive care is covered at 100%.
- There is no deductible for preventive care.
- There is a deductible for basic and major treatment.
- You can receive toll-free help from experienced dental representatives.
- This plan uses a dental ID card. Your ID card will be sent to you from Cigna within 31 days of your election.
- You may have to file a claim form. Forms are online at www.altogethergreat.com or at www.mycigna.com.

SERVICES COVERED	BENEFITS
Annual Benefit for Preventive, Basic and Major Treatment	$1,500/year per person for Preventive, Basic and Major Treatment combined (Excludes Orthodontia)
Preventive Treatment (Check-ups, cleanings, fluoride treatment, bitewing X-rays)	100% when you use a Cigna network dentist or 80% when you use a non-network dentist, no deductible
Basic Treatment (Fillings, root canal treatment, simple tooth extractions)	80% after $50 deductible*
Major Treatment (Crowns, bridges, dentures, implants, crowns/bridges over implants)	50% after $50 deductible*
Orthodontia (Braces and related treatment)	50% up to lifetime maximum benefit of $2,500, no deductible

* Services provided by a PPO dentist will be based on negotiated fees which are at a discounted rate. You will not be billed the balance. Services provided by a non-PPO dentist will be based on MRC. See below.

What are Maximum Reimbursable Charges (MRC)**?

Maximum Reimbursable Charges (MRC) are the normal range of fees charged by dentists 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 maximum reimbursable charge — you are responsible for paying the additional amount.

If you use a PPO network provider, the charges are within the maximum reimbursable charge range.

** Note: MRC is another term for reasonable and customary (R&C).

Can I use any dentist, or must I use network dentists to receive maximum dental plan benefits?

If you are enrolled in the PPO plan, you can use any dentist you wish and receive the benefits outlined in the dental plan.

However, if you use a PPO network dentist, you'll pay less money and maximize the plan's benefits. That's because PPO network dentists charge discounted fees.

For a preferred provider listing in your area, go to www.cigna.com or call Cigna at 800-Cigna24 (800-244-6224).

How dental expenses are paid

Benefits for Maximum Reimbursable Charges (MRC) and negotiated charges covered under the PPO plan are paid like this:

1. You pay a $50 annual deductible for most covered expenses. If you chose family coverage, then the annual family deductible is $150.
2. The annual deductible does not apply to preventive care. If you use a network dentist, preventive care is paid at 100%. If you use a non-network dentist, preventive care is paid at 80%.
3. After you've met your deductible, the plan pays a percentage of covered charges and you pay the rest. The percentage paid by the plan depends on the type of service you receive.
4. The plan continues to pay a percentage of your covered services until the $1,500 maximum annual benefit has been paid. Then the plan stops paying benefits for the rest of the plan year (January 1 – December 31). Remember, if you use PPO network dentists, you'll be paying discounted fees, so you'll have more dental services before you reach the plan's $1,500 maximum annual benefit.
5. You or your dentist complete and submit a dental claim form, or your dentist may file your claim electronically.

Your deductible amount

The deductible is the amount of covered charges you pay each year before the plan begins paying benefits. You pay NO deductible for preventive care provided by a network dentist and orthodontic services. You pay a $50 deductible each year for all other covered services combined. This deductible is subtracted from the eligible dental expenses that you or your dentist submits on the dental claim form, available at www.altogethergreat.com.

If you have selected "Associate + 2 or more dependents" coverage, a maximum of three family members must meet the individual annual deductible. No one person has to meet the individual deductible as long as the $150 family deductible is met.

Meeting the deductible

The annual deductible applies to all types of dental services combined — you don't have to meet a separate deductible for each type of service you receive.

For example, if you satisfy the deductible after paying for $50 of basic treatment, like a filling, no deductible would be required if you need major treatment, such as a crown, later in the year.

Percentage of covered charges paid by the PPO Plan

After you have met your deductible, the PPO plan pays a percentage of your covered dental expenses. The percentage paid depends on the type of service you receive and whether you use an in-network dentist. For example, the plan pays 100% of preventive* treatment with a network dentist, 80% of basic treatment and 50% of major treatment and orthodontia. The plan continues paying a percentage of covered charges until the maximum annual benefit of $1,500 is paid.

* Preventive treatment is payable at 80% (no deductible) when you use an out-of-network dentist.

Maximum annual benefits

- Annual maximum for all types of treatment combined (except orthodontia) — $1,500 of paid claims.
- Orthodontia lifetime maximum — $2,500 of paid claims.

After you have reached the annual maximum benefit limit for your option, the plan stops paying benefits for the rest of the plan year (January 1 – December 31).

Dental claims payment example (using a network dentist)

Visit 1: Preventive (no deductible)

	$75	covered charges
x	100%	
	$75	plan pays

Visit 2: Basic (deductible)

	$1,025	covered charges
-	$50	deductible
	$975	
x	80%	
	$780	plan pays

After visits 1 and 2, the participant has had $1,100 of covered charges and received $855 ($75 + $780) in benefits.

Visit 3: Basic

	$875	covered charges
x	80%	
	$700	

$855 of benefits has been paid for visits 1 and 2. Because the annual maximum benefit is $1,500, only $645 in benefits can be paid for visit 3.

This participant had $1,975 of covered charges and received $1,500 in benefits.

Avoid costly surprises with predetermination of benefits

If you expect charges for planned dental work to be $200 or more, you should find out in advance how much the plan will pay for the work. This is called predetermination of benefits.

Ask your dentist to complete a dental claim form describing the proposed treatment and related charges and send it to the plan's dental carrier. After the dental carrier has reviewed the plan and considered alternative treatments, your dentist will receive an estimate of the benefits the plan will pay.

To do this, submit a predetermination of benefits request to: Cigna HealthCare Service Center, P.O. Box 188037, Chattanooga, TN 37422-8037.

Alternate treatment plans

Many dental problems can be treated in more than one way. If this is the case with your planned treatment, Cigna will determine which treatment plan will be covered under the PPO plan. Your benefit will be based on the treatment Cigna recommends.

For example, if you have a cavity and have the tooth crowned for appearance's sake instead of simply having the cavity filled, your benefit payable under the plan will be based on the filling. However, you can use this benefit to pay for the treatment of your choice. You are responsible for the cost that exceeds the covered expenses. For example, if the plan pays a $70 benefit to have the cavity filled, you can apply the $70 toward the cost of a crown.

What the PPO Plan covers

The PPO plan pays the Maximum Reimbursable Charges (MRC) for covered dental care that is necessary. However, not all expenses are covered. (See *What the PPO Plan Does Not Cover* on page 79.)

Dental benefits are paid for these services:

- Preventive and diagnostic treatment
- Basic treatment
- Major treatment
- Orthodontia

Preventive and diagnostic treatment

The PPO plan pays 100% (network dentist) or 80% (non-network dentist) of these expenses (up to the maximum annual benefit) with no deductible:

- Oral examinations, up to twice each calendar year.
- Dental X-rays:
  - Full mouth X-rays, but not more than one set in a three-year period.
  - Bitewing X-rays, but not more than twice each calendar year.
  - Panoramic X-rays, but not more than once in a three-year period.
- Topical fluoride for a covered dependent child under age 19, but not more than one treatment each calendar year.
- Dental sealants on a posterior tooth, but only one treatment per tooth in a three-year period.
- Prophylaxis (cleanings), up to twice each calendar year.
- Space maintainers.
- Emergency treatment to relieve dental pain.

Basic treatment

The PPO plan pays 80% (at any dentist) of covered charges (up to the maximum annual benefit) after you have met your deductible:

- Fillings.
- Amalgam restorations (if at least one calendar year has passed since the existing amalgam was placed).
- Silicate restorations (if at least one calendar year has passed since the existing filling was placed).
- Composite resin restorations (if at least one calendar year has passed since the existing filling was placed).
- Root canal therapy.
- Osseous surgery.
- Periodontal scaling and root planing.
- Adjustments to dentures during the initial installment but not during the six-month period following installation:
- Denture adjustments.
  - Relining dentures and rebasing dentures – if more than six months after the initial insertion, and then not more than once every 36 months.
  - Tissue conditioning (maxillary or mandibular) – if more than one calendar year after the insertion of a full or partial denture, and then only once in every three calendar years.
- Bridge repairs (recement bridge).
- Simple and surgical extractions (local anesthetic, analgesic and routine postoperative care for extractions and other oral surgery are part of the allowance for each dental service).
- General anesthesia or IV sedation, for covered services, when medically necessary.
- Crown repairs.

Question about what's covered and what's not?

Call Cigna HealthCare, the dental plan carrier for the PPO Plan, at 800-Cigna24 (800-244-6224). Customer service representatives are available 24 hours a day, seven days a week, including holidays.

Major treatment

The PPO plan pays 50% (at any dentist) of covered charges for these expenses (up to the maximum annual benefit) after you have met the deductible:

- Crowns
- Inlay restoration
- Dentures
- Partial dentures
- Bridgework
- Gold or crown restorations (covered only as a result of extensive caries or fracture and cannot be replaced with amalgam, silicate, acrylic or plastic restoration)
- Surgical implants and prosthesis
- Non-surgical treatment of temporomandibular joint (TMJ)

Orthodontia

The PPO plan covers 50% (at any dentist) of covered charges for these expenses with no deductible:

- Orthodontic appliances
- X-rays
- Care and treatment

This benefit is administered in monthly payments. Payments are released quarterly and are prorated over the full course of treatment. Orthodontia treatment has a lifetime maximum benefit of $2,500 — per person.

What the PPO Plan does not cover

The PPO plan does not cover:

- Services performed solely for cosmetic reasons.
- Charges over and above Maximum Reimbursable Charges (MRC) limits.
- Charges for services and supplies that are not necessary.
- Dental services that do not meet common dental standards.
- Charges for services and supplies that are for experimental treatment or are investigative and not proven safe and effective.
- Any services provided by a covered provider who is a member of your or your spouse's immediate family.
- 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:
  - Such replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth, or
  - 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 covered for these benefits.
- Any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards unless:
  - Such replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth, or
  - 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 covered for these benefits.
- Procedures, appliances or restorations (except full dentures) whose main purpose is to:
  - Change vertical dimension to restore occlusion — the attempt to correct a TMJ problem by placing single crowns on the teeth.
  - Stabilize periodontically involved teeth by splinting — or, cementing wire to teeth.
- Porcelain or acrylic veneers of crowns or pontics on or replacing the upper and lower first, second and third molars.
- Bite registrations — precision or semi-precision attachments, or splinting.
- Instructions of plaque control, oral hygiene and diet.
- Surgery to correct temporomandibular joint (TMJ).

Dental PPO Plan Claims

For a dental claim form, go to www.mycigna.com or contact Cigna at 800-Cigna24 (800-244-6224).

Send dental claim forms to the dental plan carrier:
Cigna HealthCare Service Center
P.O. Box 188037
Chattanooga, TN 37422-8037

To receive benefits from the plan for covered dental expenses, it is your responsibility to file a claim form with the dental plan carrier, Cigna HealthCare. Separate claim forms must be submitted for each person filing a claim.

Benefits are generally payable to you. However, you may authorize Cigna HealthCare to pay benefits directly to the dentist providing the covered service. You make this authorization in a special section on the claim form.

The dental claim form contains a section for you to complete and sign as well as a section for your dentist 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 dentist complete the claim form, you may attach an itemized bill. The bill must include:

- Your name, your 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.

Your dentist also may file your claim electronically on your behalf.

If your claim is denied, refer to the *Appeals of Denied Claims* section beginning on page 129.

Cigna Managed Care Dental Plan

How the Managed Care Dental Plan works

When you enroll in the Managed Care Dental Plan, you receive many dental services at no cost when you use your primary care dentist. You may elect a different primary care dentist for each family member. The advantages of using your primary care dentist are:

- There is no deductible.
- There are no annual benefit maximum limits — even for orthodontic services.
- Preventive care services, including cleanings, check-ups and X-rays are provided at no cost to you.
- Other types of care are covered at reduced rates.
- You file no claim forms.
- The plan uses ID cards.

To make dental care more affordable, the Managed Care Dental Plan provides a network of dentists under contract with the Managed Care Dental Plan to provide their services at lower costs. To make the Managed Care Dental Plan work for you, make sure that you:

- Elect your primary care dentist by calling Cigna at 800-Cigna24 (800-244-6224) or log on to www.cigna.com. Choose a network dentist that is convenient to you. Be sure to call the network dentist you chose to confirm that he or she is accepting new Managed Care Dental Plan patients.
- If you don't, a primary care dentist will be automatically assigned to you.
- Use your primary care dentist for dental services to ensure payment of claims. Your care is covered for dental services rendered only by your primary care dentist.
- This plan is not available in all areas of the country. Availability is based on your home ZIP code.

Your network dentist

To take advantage of the lower fees negotiated by the Managed Care Dental Plan, you must use a network dentist under contract with the Managed Dental Care program. They are in the list of providers available by calling Member Services at the number on your ID card or contact Cigna at 800-Cigna24 (800-244-6224) or log on to www.cigna.com.

- You may select a different network dentist for each covered family member.
- You can change network dentists at any time online or by calling Member Services.
- If your network dentist leaves the network, you must select a new network dentist. Except during Annual Enrollment or a qualified status change, you cannot switch coverage out of the Managed Care Dental Plan just because your network dentist is no longer available.

Your network dentist handles all of your dental care unless a specialist is needed. Your network dentist will refer you to any required specialist in the Managed Care Dental Plan network.

You may select a network pediatric dentist as the network general dentist for your dependent child under age seven. Call Member Services at 800-Cigna24 (800-244-6224) for a list of network pediatric dentists in your service area. Or, if your network general dentist sends your child under age seven to a network pediatric dentist, the network pediatric dentist's office will have primary responsibility of your child's care.

Your network general dentist will provide care for children seven years and older. If your child continues to visit the pediatric dentist after his/her seventh birthday, you will be fully responsible for the pediatric dentist's usual fees. Exceptions for medical reasons may be considered on a case-by-case basis.

For a complete list of Cigna Managed Care Dental Plan providers or questions about what's covered and what's not, contact Cigna at 800-Cigna24 (800-244-6224) or log on to www.cigna.com.

What you pay for services under the Managed Care Dental Plan

Managed Care Dental Plan network dentists have agreed to provide services to Managed Care Dental Plan participants at a reduced rate. Remember, you pay no deductible, there is no annual benefit maximum and preventive care is provided at no charge when you use your primary care dentist. However, when you need a service for which there is a charge, you pay the reduced network rate.

Cost example: PPO Plan versus Managed Care Dental Plan

Here are examples of how the cost of a routine cleaning (preventive service) compares under the PPO plan and Managed Care Dental Plan.

Example A — Network Dentist

PPO Plan (Network Dentist)	Managed Dental Care
$80 charge x 100% * $80 plan pays	$80 charge x 100% * $80 plan pays
You pay nothing for this service.	You pay nothing for this service.

* Percentage covered by plan.

Example B — Non-Network Dentist

PPO Plan (Non-Network Dentist)	Managed Dental Care
$80 charge x 80% * $64 plan pays	$80 charge x 0% * $0 plan pays
You pay $16 for this service.	You pay $80 for this service.

* Percentage covered by plan.

In Example A — as you can see, both plans pay for 100% of the cost of the routine cleaning when you use a network dentist.

In Example B — when you use a non-network dentist, the PPO plan pays 80% of the cost of the routine cleaning. However, the Managed Care Dental Plan does not pay any of the cost if you use a non-network dentist.

See a partial list of common services on the Managed Care Dental Plan patient charges and covered services chart to the right. For a complete listing of Managed Care Dental Plan patient charges, refer to the Managed Care Dental Plan Patient Charge Schedule. This schedule is available at www.cigna.com or by calling Cigna Dental at 800-Cigna24 (800-244-6224).

Partial list of Managed Care Dental Plan patient charges and covered services

SERVICE	MANAGED CARE DENTAL PATIENT CHARGE
Diagnostic/Preventive	
• Oral Examination (periodic)	$0
• X-rays (bitewing)	$0
• Prophylaxis (routine cleaning with no active periodontal disease) — limit two per calendar year	$0
• Topical application of fluoride — limit two per calendar year up to 19th birthday	$0
Restorative (primary or permanent fillings)	
Amalgam — one surface	$6
Crown and Bridge (including temporaries)	
• Crown — Porcelain/Ceramic Substrate	$460
• Crown — Porcelain fused to predominantly base metal	$370
• Core Buildup, including any pins	$95
• Prefabricated post and core in addition to crown	$120
Periodontics (treatment of supporting gum and bone)	
• Periodontal evaluation and treatment plan	$43
• Periodontal maintenance (limit two per calendar year – only covered after active therapy)	$73
• Periodontal scaling and root planing, four or more teeth or bound teeth spaces per quadrant (limit four quadrants per consecutive 12 months)	$110
Prosthetics (example — dentures)	
• Complete upper or lower denture (includes characterization)	$535
• Partial denture resin base (including clasps, rests and teeth) — upper or lower	$400
Oral Surgery	
• Extraction (single tooth)	$12
• Partial bony impaction	$135
Orthodontics (example — braces) As part of contract, full orthodontic case, 24 months including initial evaluation, treatment plan and records, banding, 24 months of treatment and retention	
• Children (up to 19th birthday) — 24-month treatment fee	$2,270*
• Adults — 24-month treatment fee	$3.000*

* These amounts do not include the patient charge for the initial evaluation, treatment plan and records, banding and retention listed in the patient charge schedule.

Emergency treatment

An emergency is a dental condition of recent onset and severity which would lead a prudent layperson possessing an average knowledge of dentistry to believe the condition needs immediate dental procedures necessary to control excessive bleeding, relieve severe pain, or eliminate acute infection.

If you have an emergency in your service area — contact your network dentist.

Your network dentist is obligated to provide service within 24 hours.

If you have an emergency while you are out of your service area:

- You may receive emergency care for services that are covered under the plan from any general dentist:
  - If the need for treatment occurs at least 50 miles from your home address, or
  - If you are unable to contact your designated Participating Dental Facility; and your emergency treatment is performed during regular office hours.
- You will be responsible for the patient charges listed on your Patient Charge Schedule.
- Cigna Dental will reimburse you the difference, if any, between the dentist's MRC for emergency covered services and your patient charge, up to a total of $50 per incident.

Routine restorative procedures or definitive treatment (e.g. root canal) are not considered emergency care. You should return to your network dentist for these procedures. What is considered an emergency may vary in your state.

Other covered services

- Up to a total of four clinical evaluations (periodic oral evaluations, and/or comprehensive oral evaluations, and/or comprehensive periodontal evaluations, and/or oral evaluations for patients under three years of age are covered during a 12 consecutive month period.
- Localized delivery of antimicrobial agents for up to eight teeth (or eight sites, if applicable) per 12 consecutive months.
- General anesthesia, IV sedation and nitrous oxide when medically necessary and provided in conjunction with covered services performed by an oral surgeon or periodontist. General anesthesia and IV sedation when used for anxiety control or patient management do not meet the criteria of medical necessity.
- Bone grafting and/or guided tissue regeneration when performed for the treatment of periodontal disease at a tooth site other than the site of an extraction, apicoectomy or periradicular surgery.
- Root canal treatment in the presence of injury to, or disease of, the pulp (nerve tissue) of a tooth.
- Services performed for the treatment of pathology or disease not related to congenital conditions.
- The replacement of an occlusal guard (night guard) once every 24 months.
- Bleaching (tooth whitening) specific to the use of take-home bleaching gel with trays.

What the Managed Care Plan does not cover

- Services not listed on the Patient Charge Schedule.
- Services provided by an out-of-network dentist without Cigna's prior approval (except in emergencies).
- Services related to an injury or illness paid under worker's compensation, occupational disease or similar laws.
- Services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
- Services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.
- Services performed solely for cosmetic reasons.
- Injury arising out of, or in the course of, any employment for wage or profit.
- Charges made by a hospital owned or operated by the United States government unless there is a legal obligation to pay such charges whether or not there is insurance or, such charges are directly related to a military service connected sickness or injury.
- Injuries which are intentionally self-inflicted.
- Prescription drugs.
- Replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
- Surgical placement of a dental implant; repair, maintenance or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant.
- Procedures or appliances for minor tooth guidance or to control harmful habits.
- Hospitalization, including any associated incremental charges for dental services performed in a hospital (Benefits are available for network dentist charges for covered services performed at a hospital. Other associated charges are not covered and should be submitted to the medical carrier for benefit determination).
- The completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of your Cigna dental coverage.
- Crowns and bridges used solely for splinting.
- Resin bonded retainers and associated pontics.
- When charges would not have made if the person had no insurance.
- Charges for services and supplies that are not necessary.
- Experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.
- All clinical lab services, pharmacy services, X-rays or imaging services, if referred by a practitioner who has a financial relationship (or whose immediate family member has a financial relationship) with the provider of those services.

If any law requires coverage for a particular service noted above, the exclusion or limitation for the service will not apply.

For information on:

- Coordinating benefits between dental plans — see page 16.
- When dental plan coverage ends — see page 18.
- Continuing your dental plan coverage when you leave Compass Group — see page 19.

Oral Health Integration Program

Cigna offers a Cigna Dental Oral Health Integration Program for eligible participants. The program includes the following conditions:

- Pregnancy
- Cardiovascular (heart) disease
- Cerebrovascular (stroke) disease
- Diabetes
- Chronic kidney disease
- Organ transplants
- Head and neck cancer radiation

If you are eligible, Cigna reimburses your out-of-pocket expenses (coinsurance and copays) for certain services in the chart below, depending on the condition. Just visit your regular dentist for the necessary services and pay your applicable coinsurance or copay. Then submit a completed reimbursement form to apply for reimbursement.

The form has a section where you can request information on a prescription and non-prescription drug dental program discount. If you have questions or need a reimbursement form, go online to www.mycigna.com or call Cigna at 800-Cigna24 (800-244-6224).

Oral health maternity program

One part of the Oral Health Integration Program is the Oral Health Maternity Program. Research shows that women with periodontal (gum) disease may be at increased risk for premature births. Because of this, Compass Group offers these enhanced benefits for pregnant women who are covered by Cigna Dental coverage and have not exceeded their annual dental maximum:

- Periodontal scaling and root planing will be covered at 100% during pregnancy.
- For pregnant women not requiring scaling and root planing, an additional cleaning will be covered at 100% during pregnancy.
- Treatment for inflamed gums around wisdom teeth will be covered at 100% during pregnancy.

Participants who qualify for the Oral Health Maternity Program will need to pay for the service at the time of treatment, and then submit a claim to Cigna for reimbursement.

Covered dental services by medical condition

	CARDIO	STROKE	DIABETES	MATERNITY	CHRONIC KIDNEY DISEASE	ORGAN TRANSPLANTS	HEAD & NECK CANCER RADIATION
Periodontal Treatment & Maintenance Four times per year	✓	✓	✓	✓	✓	✓	✓
Periodontal Evaluation				✓			
Oral Evaluation One additional evaluation				✓			
Cleaning One additional cleaning				✓			
Emergency Palliative Treatment No limitations				✓			
Fluoride – topical application & varnish Age limits removed, all other limitations apply					✓	✓	✓
Sealants Age limits removed, all other limitations apply					✓	✓	✓

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summary plan description

Vision Coverage

Joining the plan

Compass Group offers you and your eligible dependents vision coverage on the first day of the month after you complete three months of service. After that, you may enroll for or modify your vision coverage each year during Annual Enrollment or if you have a qualified status change. Your payments for vision coverage are deducted from your paycheck on a pre-tax basis. For more information on pre-tax dollars, see page 3.

Vision plan options

Compass Group offers two options for vision coverage — The Comprehensive Plan and The Exam Plus Plan, or you may waive vision coverage. Both plans are self-insured, administered by Vision Service Plan (VSP) and offer different levels of coverage.

Network providers lower your costs

As a vision plan participant, you choose whether to use a VSP network provider or a non-VSP provider. Dollar for dollar, you get the best value from your VSP benefit when you visit a VSP network provider.

If you choose a VSP network provider, your charges may be covered in full, covered in full after a copay, or you may receive an allowance and/or discount, based on the type of service and the plan selected. If you choose a non-VSP provider, you will pay the provider in full and submit a claim to VSP for reimbursement up to the amount shown on the out-of-network reimbursement schedule on page 87.

Which providers participate in the vision service plan network?

To find out which providers participate in the VSP network, call **800-877-7195**.
You also can check www.vsp.com.
Note: This plan does not issue ID cards.

In this section

What the vision plan covers

Each covered person is eligible to receive benefits for one eye examination every calendar year. In addition:

Under The Comprehensive Plan, each covered person is eligible to receive benefits for:

- One pair of lenses every calendar year.
- One pair of frames every other calendar year.
- Contact lenses (in lieu of a complete pair of prescription glasses).

Under The Exam Plus Plan, each covered person is eligible to receive:

- Discounts for lenses, frames and contact lenses (evaluation and fitting) from a VSP network provider.

THE COMPREHENSIVE PLAN			
SERVICE	**FREQUENCY**	**PREFERRED PROVIDER (IN-NETWORK)**	**OPEN ACCESS (OUT-OF-NETWORK)**
Eye Examination	Once every calendar year	Covered in full	Up to $35
Lenses			
Single Vision Lenses	Once every calendar year	Covered in full, after $15 copay (applied to lenses and frames)	Up to $25
Lined Bifocal Lenses	Once every calendar year	Covered in full, after $15 copay (applied to lenses and frames)	Up to $40
Lined Trifocal Lenses	Once every calendar year	Covered in full, after $15 copay (applied to lenses and frames)	Up to $55
Frames	Once every other calendar year	Up to $140 allowance, 20% discount on amounts over $140	Up to $45
Contact Lenses*			
Exams	Once every calendar year	15% discount (fitting and evaluation)	Not covered
Lenses	Once every calendar year	Up to $140	Up to $140

THE EXAM PLUS PLAN			
SERVICE	**FREQUENCY**	**PREFERRED PROVIDER (IN-NETWORK)**	**OPEN ACCESS (OUT-OF-NETWORK)**
Eye Examination	Once every calendar year	Covered in full	Up to $35
Lenses and Frames	N/A	20% discount	Not covered
Contact Lens	N/A	15% discount off contact lenses exam (evaluation and fitting) No allowance for contact lenses	Not covered

* If you purchase contacts with this benefit, it counts as a complete set of glasses/frames.

Laser vision correction

VSP has arranged for members to receive laser vision correction surgery at a discounted fee, which could add up to hundreds of dollars in savings. Discounts will vary by location, but an average of 15% off of the laser center's reasonable and customary (R&C) price.

In addition, if the laser center is offering a temporary price reduction, VSP members will receive 5% off of the advertised price if it is less than the usual discounted price. VSP network providers can be located through www.vsp.com or by calling VSP at 888-354-4434.

You pay up to $1,500 per eye for PRK, $1,800 per eye for LASIK or $2,300 per eye for Custom LASIK. You pay the facility either the maximum amount or the discounted rate, whichever is less.

Additional discount — VSP network providers offer discounts on reasonable and customary (R&C) fees for the following covered services:

- Contact lenses.
- Lens options (treatments) such as scratch resistant and anti-reflective coatings and progressives.
- A 30% discount off of 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 preferred provider within 12 months of your last WellVision Exam.

Discounts are applied to the VSP network providers' R&C fees for such services and are available within 12 months of the covered eye examination from the VSP network provider who provided the covered eye examination.

The following cosmetic eyewear are also covered at a discounted rate as part of the covered expense for the basic eyewear:

- Blended lenses — oversized lenses.
- Photochromic or tinted lenses, other than Pink 1 or 2.
- Polycarbonate lenses, except for children.
- Progressive multifocal lenses.
- The coating of the lens or lenses.
- The laminating of the lens or lenses.
- Frames exceeding the cost agreed to by the VSP network provider and VSP.
- Contact lenses exceeding the cost agreed to by the VSP network provider and VSP.
- Certain limitations on low vision care.
- Cosmetic lenses — optional cosmetic processes.
- UV (ultraviolet) protected lenses.

How vision plan expenses are paid

The amount of your benefit depends on whether you use a VSP network provider or non-VSP provider.

If you use a network provider

When you use a VSP network provider, both plans will pay the full cost of covered eye examinations.

If you choose a VSP network provider under The Comprehensive Plan:

- Lenses are covered in full, after a $15 copay.
- Frames and contact lenses are covered up to a flat dollar amount, and/or you receive a discount off of the covered services.

If you choose a VSP network provider under The Exam Plus Plan:

- You receive a discount off of the covered services for lenses, frames and contact lenses.

When you call your VSP network provider for an appointment, let him or her know that you are a VSP member. You will be asked to give the last four digits of the member's identification number (same as the last four digits of the member's Social Security Number), member's date of birth and member's first and last name.

Your provider will then contact VSP to verify your eligibility and get authorization for services and eyewear. If you are not eligible, your provider will notify you.

If you use a non-VSP provider

You'll receive a lesser benefit and typically pay more out-of-pocket. After you pay the provider in full at the time of your appointment, the plan will pay for covered services you receive from a non-VSP provider up to the amount shown on the out-of-network reimbursement schedule.

When you have a non-VSP provider claim, send your itemized provider's bill along with a claim form. You can get a claim form at www.vsp.com. Login and select "Benefits with Other Providers" and follow the instructions. You can also get a claim form at www.altogethergreat.com.

What the vision plan does not cover

No benefits are payable under The Comprehensive Plan and The Exam Plus Plan for the expenses listed below. However, plan discounts may apply to some services:

- Plano lenses (i.e., when patient's refractive error is less than a +/- 0.50 diopter power), except for sunglasses after LASIK.
- Two pairs of glasses instead of bifocals.
- Orthoptics or vision training and any associated supplemental visual field and single meridian testing.
- Replacement of lenses and frames furnished under this program, except at the normal intervals when services are available.
- Corrective vision treatment of an experimental nature.
- Vision examinations more than once in any plan year.
- Medical or surgical treatment of the eyes.
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.
- Lenses more than once in any plan year and then only if replacement is deemed necessary by the provider.
- Frames more than once every other plan year.
- Replacement of lost or damaged contact lenses, except at the normal intervals when services are available.
- Expenses above the contact lens reimbursement limit for contact lenses purchased for any reason other than the following:
  - Following cataract surgery.
  - To correct extreme visual problems that cannot be corrected with spectacle lenses.
  - Certain conditions of anisometropia.
  - Certain conditions of keratoconus.
- Contact lens insurance policies or service agreements.
- Contact lens refitting after the initial (90-day) fitting period.
- Additional office visits associated with contact lens pathology.
- Contact lens modification, polishing or cleaning.
- Contact lenses to reshape the lens for vision correction.
- Cosmetic eyewear over and above the covered expense for the basic eyewear.
- Dilation, other than drops.
- Services for which a claim is filed more than six months after completion of the service.
- Non-VSP provider services that are not listed in the out-of-network provider reimbursement schedule.
- Retinal photography, fundus photography, optomap and corneal topography.

For information on:

- Coordinating benefits between vision plans — see page 16.
- When vision coverage ends — see page 18.
- Continuing your vision plan coverage after you leave Compass Group — see page 19.

Life Insurance Coverage

Joining the plan

As an eligible Compass Group associate, you automatically receive $5,000 of basic life insurance at no cost to you. This coverage begins on the first of the month after you complete three months of service.

Compass Group offers supplemental life insurance coverage for yourself and/or coverage for your spouse/domestic partner and/or children, on the first of the month after you complete three months of service. You pay for the cost of supplemental life insurance for yourself (the associate) with pre-tax dollars. For more information on pre-tax dollars, see page 3. You pay for dependent life insurance with post-tax dollars.

You may be required to provide evidence of insurability, or EOI, for certain coverage. EOI is evidence satisfactory to the underwriter of your good health and any other underwriting information required.

In this section

Coverage for you and your family

Associate basic life insurance

Compass Group pays the entire cost of basic life insurance coverage for you (the associate) for $5,000 of coverage. This is called your basic coverage. You also have access to LifeSuite support and resources (see page 96 for more information).

Associate supplemental life insurance

You also have the option to purchase additional life insurance coverage. Your options are an additional:

- $5,000 of coverage.
- $10,000 of coverage.
- $15,000 of coverage.

Or you may choose no additional coverage.

If you select an additional $10,000 of supplemental life insurance, you are insured for $15,000 — $5,000 of basic life insurance plus $10,000 of supplemental life insurance coverage.

The cost for supplemental life depends on your age.

You may "move up" only one level of coverage each enrollment period after your initial enrollment.

You may change your coverage amount each year, or within the appropriate timeframe if you experience a qualified family status change event. However, you may increase your coverage by only one level each event. For example, if you select an additional $5,000 of coverage one year, you may choose an additional $10,000 the next enrollment event — you cannot increase your supplemental coverage from $5,000 to $15,000. See the life event summary chart on pages 13-14 for more information.

Dependent life insurance

You can choose life insurance for your eligible dependents:

- Your lawful spouse/domestic partner.
- Children, stepchildren, legally adopted children or children of your domestic partner up to age 26.
- Certified disabled dependents.

You can elect coverage for the following amounts:

- $5,000 for each dependent ($2,500 for children less than six months old) or
- $10,000 for each dependent ($2,500 for children less than six months old).

Or, you may choose no dependent coverage.

As with your supplemental life insurance, **you may elect or increase your dependent coverage to the next level of coverage each enrollment event.** For example, if you selected $5,000 of coverage for your dependent one year, you can select the $10,000 option of coverage at the next enrollment event.

When you choose coverage, you automatically cover all of your eligible dependents. The number of dependents does not affect your coverage cost. In the event of a dependent's death, the benefit amount is paid to you.

How the plans work

When you reach age 65

The amount of your life insurance (basic and supplemental) coverage will be reduced as of January 1st on or following your birthday according to the following schedule:

AT AGE	NEW BENEFIT LEVEL
65	65% of original benefit
70 and older	50% of original benefit

For example, if you have $15,000 of combined coverage and reach age 65, it will be reduced to $9,750. Combined coverage at age 70 will be reduced to $7,500.

Limit on associate supplement life benefits

Associate supplemental life insurance is subject to a suicide exclusion, which limits the amount of your benefit if you commit suicide (whether sane or insane). If death due to suicide occurs within two years of the effective date of your coverage, your benefit will be an amount equal to the premiums paid.

Your life insurance coverage during disability

If you stop working at Compass Group because you are totally disabled, you may be eligible to receive extended supplemental life insurance coverage during your period of disability.

You are considered totally disabled when you are completely unable to perform any occupation for wage or profit because of injury or sickness as determined by the plan carrier.

The plan carrier has the right to require proof of your continuing total disability and have a designated physician examine you at any time while your coverage is being extended at no cost to you.

However, your coverage will not be continued if your disability results from:

- An intentional, self-inflicted injury.
- Participation in or any attempt to commit a felony.
- War or any act of war, whether declared or undeclared.

If disabled before age 60

If you stop working for Compass Group before age 60 because you are totally disabled, your basic life insurance will end. However, your supplemental life insurance will continue — if approved by the plan carrier — at no cost to you as long as you have been totally disabled for at least six months and have provided acceptable proof of your disability.

Such proof must be submitted no later than one year after you stop working due to the disability. Coverage will be extended as long as you remain totally disabled (or as stated in *When Extended Coverage Ends*) and submit proof of the continuation of your total disability when requested.

If you are not eligible for benefits under the group policy after your disability ends, you may convert your coverage to an individual policy.

If you die while disabled

If you die during the period of extended coverage, written notice of your death must be provided to the plan carrier within one year of your death or no benefits will be paid. The benefit will be the amount of coverage you had as of the day you stopped working due to your disability — or your last day of active service at Compass Group.

When extended coverage ends

Extension of your supplemental life insurance coverage resulting from a disability will end:

- When you are no longer totally disabled.
- If you do not submit to a physical exam when required by the plan carrier.
- If you fail to provide proof of continuous total disability.
- When you reach age 65.

Accelerated benefits

You or your covered dependents who are insured under the plan can apply to receive accelerated benefits, if either you or your covered dependents have a terminal condition.

A terminal condition is a condition caused by sickness or accident, which directly results in a life expectancy of twelve months or less.

Payment of an accelerated benefit

Benefits may be paid if:

- Coverage is in effect and all premiums are fully paid.
- You or your dependents apply in writing and in a form that is satisfactory to the plan carrier.
- You or your dependent is the sole owner of the certificate.
- The insurance coverage does not have an irrevocable beneficiary.

Minimum and maximum benefits

Benefits paid under the plan must be at least $10,000, or if less, the total amount of the insured life insurance. The maximum benefit is $20,000.

You (or your covered dependents) may choose to receive the full or partial amount of the benefit.

- If you choose to receive a partial amount, your remaining coverage will stay in effect and premiums will be reduced. The remaining benefit will be the full amount of the benefit minus the accelerated benefit amount. The remaining benefit must be at least $5,000. You may reapply for payment of the remaining amount of insurance at any time. However, the plan carrier may ask for additional evidence that you meet all requirements for the benefit.
- If you choose to receive the full amount, coverage and all other benefits under the certificate and any certificate supplements will end. If benefits end, and your covered spouse or dependent children loses coverage as a result, each of them will be allowed to convert the policy to individual life insurance.

Accelerated benefits are generally paid to you in one lump sum. If you die before all payments are made, the remainder will be paid to your beneficiary.

How to file a life insurance claim

The initial notification of death should be made to Compass Group's Benefits Department at 800-341-7763. The plan carrier will pay benefits within 60 days of receiving proof of death while insured, such as a certified death certificate and a fully completed claim form.

Benefits are generally paid in a lump sum. Interest will be paid on the benefit from the date of death until the date of the payment. Interest will be at an annual rate determined by the plan carrier, but never less than 4% per year compounded annually, or the minimum required by state law, whichever is greater.

For information on benefit determination and the process for reviewing denied claims, please see *All Other Self-Insured and Non-Insured Benefits* beginning on page 136.

Naming a beneficiary

It is important to name a beneficiary who will receive benefits from the plan in the event of your death. You are automatically the beneficiary of any dependent life insurance. You may also name an irrevocable beneficiary that you cannot change without his/her consent.

If you name more than one beneficiary, each will receive an equal share, unless you have requested another method in writing.

To receive benefits, a beneficiary must be living on the date of your death. If the beneficiary is not living on the date of your death, the beneficiary's portion of the benefit will be equally distributed to the remaining surviving beneficiaries. In the event of the simultaneous deaths of you and a beneficiary, the benefit will be paid as if you survived the beneficiary.

The plan carrier does not pay benefits to beneficiaries under age 18 (in most states). The beneficiary's guardian must submit a certified copy of court issued Letters of Guardianship (or conservatorship) for benefits to be paid. Some states may allow the plan carrier to pay small amounts to a minor's custodian using the Uniform Transfers to Minors Act, which does not require a court appointed guardian. For more information, contact the plan carrier.

If there is no eligible beneficiary, or if you do not name one, the plan carrier will pay the death benefit to:

- Your lawful spouse, if living (A domestic partner does not qualify as a spouse for this purpose. A domestic partner must be a named beneficiary in order to receive the benefit).
- Your natural or legally adopted child or children in equal shares, if living.
- Your parents in equal shares, if living.
- Your brothers and sisters in equal shares if living.
- The personal representative of your estate.

To verify your beneficiary designation, go to the Online Benefits Center at www.altogethergreat.com. To make changes, call the Benefits Department at 800-341-7763. You may change your beneficiary designation at any time. Because family situations change, you should review your beneficiary designation at least yearly.

When basic and supplemental life insurance coverage ends

Your basic and supplemental life insurance coverage will end:

- The day you leave employment with Compass Group for any reason, including retirement.
- The date you no longer meet the eligibility rules.
- The date the group plan ends.
- When you stop making the required contribution for supplemental life insurance coverage. If your coverage ends due to non-payment of premiums, your coverage may be reinstated if all premiums due are paid and received within 60 days of the date your coverage ended and during your lifetime.

In addition, dependent coverage will end in any of the following situations:

- Spouse/domestic partner coverage will end on the date:
  - Your basic coverage ends.
  - Your spouse/domestic partner is no longer eligible for coverage.
- Dependent child coverage will end on the date:
  - Your basic coverage ends.
  - Your child is no longer an eligible dependent; for example, because she/he reaches the eligibility age limit.

If you stop working for Compass Group because of injury or sickness, supplemental life coverage will continue while you remain totally and continuously disabled. See page 93 for details. If your situation is not addressed in this section, your insurance coverage will end on the date Compass Group stops paying for your coverage or cancels your insurance.

When your or your dependent's coverage ends, you may be eligible to convert this coverage to an individual policy.

Porting basic and supplemental life insurance coverage

You can take your basic and supplemental life insurance coverage with you (also known as "porting" your coverage) if your Compass Group employment ends for any reason other than illness or injury. You can port up to $20,000 (the maximum) within 60 days of the date your Compass Group coverage ends. If you are age 65 or older when you port, you may take a maximum of $13,000. In either case, you do not need to provide Evidence of Insurability (EOI). When you port your coverage, you may also port your dependent coverage. You cannot port coverage if you are age 70 or older.

When your ported coverage ends, you may convert the amount of your coverage to an individual conversion policy.

Converting to an individual policy

You have the option to convert the full amount of your basic and supplemental life insurance, as well as your dependent life insurance, to individual policies if your or your dependents' Compass Group coverage ends because you move from one existing eligible class to another or you are no longer in an eligible class.

You must submit a written application to the plan carrier and pay the first premium within 60 days of the date your coverage under the group policy ends.

Provided you meet these requirements within the 60-day time period, the individual policy becomes effective 60 days after your Compass Group coverage ends. When you apply for individual coverage, you will not need to provide EOI.

Limited conversion right

You also may convert a limited amount of life insurance coverage if Compass Group's group policy terminates or is changed to reduce or terminate your coverage. However, in order to do so, you need to have been covered for at least five years under Compass Group's group policy prior to one of those events occurring.

If you qualify for a limited conversion, you may convert the amount of your group life insurance, up to a maximum amount of either:

- $10,000, or
- The amount of your coverage under the terminated Compass Group plan minus the total amount of any other group life insurance for which you become eligible under any group policy issued or reinstated by the plan carrier or any other insurer within 60 days of the date your coverage under Compass Group's policy ended, whichever is less.

To convert your group coverage to an individual policy:

- Request an application from Compass Group's Benefits Department at 800-341-7763.
- Return the written application.
- Pay the first premium to the plan carrier within 60 days after your group coverage ends.

If you or your dependent dies during the 60-day conversion period

Your beneficiary, or you in case your spouse/domestic partner or child dies, will receive the amount of insurance coverage that the beneficiary would have received under the group policy, whether or not you applied for an individual policy or paid the first premium before your or your dependent's death.

Remember, it's your responsibility to apply for coverage. You will not receive a conversion application from Compass Group unless you request it.

In the event of a conflict between the terms of this summary and the plan administrator's policies and/or certificates, the plan administrator policies and/or certificates will govern.

LifeSuite support and resources

LifeSuite provides support and resources for life's everyday and extraordinary needs. Here's a summary.

BENEFIT	DESCRIPTION
Beneficiary Financial Counseling From PricewaterhouseCoopers LLP	• Designed to support sound financial decisions at a difficult time. • Independent financial counseling resources for beneficiaries. • Resources include: Financial Fitness Assessment, beneficiary reference guide, bi-monthly newsletter, personalized financial analysis.
Legacy Planning Services From Minnesota Life Insurance Company	• End-of-life planning information and resources for everyone. • Easy to access website. • Express Assignment™ for expedited funeral home assignments. • Support for insureds anywhere in the world.
Legal Services From Ceridian	• Comprehensive legal services and resources. • Will preparation, estate planning and all legal issues from A to Z. • Unlimited telephonic general legal information. • 30-minute consultation with a local attorney for each unique legal issue. • Discount for retention of an attorney.
Travel Assistance Services From Global Rescue LLC	• Emergency assistance and medical evacuation services. • Security evacuation services. • Online pre-trip planning resources. • Available 24/7/365 for business or personal travel when 100+ miles from home.
Identity Theft Assistance Program From Europ Assistance USA	• ID Theft Resolution Kit. • Support to address identity theft occurrence. • Education to avoid further occurrence.

For more information, contact Minnesota Life or visit www.LifeBenefits.com.

Disability Income Protection Plans

Joining the plan

Disability Income Protection (DIP) and Long Term Disability (LTD) coverage provides income in the event you are unable to work due to an approved disability resulting from a sickness, including pregnancy or a non work related injury.

You are eligible to elect DIP and/or LTD coverage on the first of the month after you complete three months of service.

You have the option to enroll in DIP and/or LTD coverage at various levels. You pay the cost of coverage on a post-tax basis.

Disability Income Protection (DIP) Plan

The Disability Income Protection (DIP) Plan pays a weekly benefit for up to 26 weeks within a period of 52 consecutive weeks from the date of the disability or during any one period of disability. The cost is based on your age as of January 1 of the plan year.

Compass Group does not offer the DIP option to associates who work in California, Hawaii, New Jersey, New York, Rhode Island and Puerto Rico, as these locations provide mandated disability benefits under state law. If you have any questions about your disability benefits in these locations, contact your respective state's or U.S. territory's disability agency for more details. If you work in New York, contact the Compass Group Benefits Department Leave of Absence Team at 800-341-7763, select Option 2, for more information.

Long Term Disability (LTD) Plan

The Long-Term Disability (LTD) Plan pays a monthly benefit based for up to five years, depending on your age at the time of disability. See page 100 for a chart showing how long benefits last at various ages.

Your LTD coverage begins after your DIP Plan benefits end, or after the 180 day elimination period if you are not enrolled in DIP coverage. See page 100 for details.

In this section

How the Disability Income Protection (DIP) plan works

Your coverage options

You can choose from three levels of DIP coverage:

- Option 1: $150 per week
- Option 2: $200 per week
- Option 3: $250 per week

Or, you may choose no coverage.

You may change your coverage amount each year. However, you may only increase your coverage by one level. For example, if you have coverage under the $150 per week option, you may select the $200 per week option. You cannot increase your coverage from $150 per week to $250 per week. You may decrease your coverage any number of levels.

When coverage is effective

Coverage becomes effective on the first day of the month following three months of service unless you are absent from work that day due to injury or sickness.

In that case, coverage will begin on the date you are actively at work for one full work day.

When benefits begin

The DIP Plan begins paying benefits if you become disabled, the DIP insurance carrier approves your claim and you are unable to perform the essential functions of your job:

- On the first calendar day of the disability resulting from a non-work related injury, or
- On the eighth calendar day of the disability resulting from a sickness, including pregnancy.

Benefits are payable on the first or eighth day if:

- You are unable to work as a result of the injury or sickness.
- The injury or sickness is not work-related.
- You are being treated by a doctor for the injury or sickness and the doctor is not a member of your immediate family (spouse, father, mother, sister, brother, daughter or son).

You must be continuously disabled through the elimination period.

How benefits are paid

Benefits are paid weekly, tax-free as long as you remain disabled, as approved by the DIP insurance carrier and you are unable to work for up to 26 weeks.

If your weekly benefit is payable for less than a week, you'll receive 1/7 of the weekly benefit ($150, $200 or $250) for each day you are disabled. For example, if you enroll for the $150 per week option, and you are disabled for three days, your benefit would be: $150/7 x 3 days = $64.29.

Applying for DIP benefits

To start your leave of absence/FMLA process, notify the Benefits Department Leave of Absence Team of your leave as soon as possible. You must notify the DIP insurance carrier within 30 days after the date of your disability. However, you must provide written proof of your DIP claim no later than 180 days (six months) after your elimination period. If it is not possible to provide proof within 180 days, it must be provided no later than one year after the time proof is otherwise required, except in the absence of legal capacity. You cannot receive more than 26 weeks of DIP benefits within any period of 52 consecutive weeks.

What is disability?

You are disabled if due to sickness, including pregnancy or a non work related injury:

- You are unable to perform the material and substantial duties of your regular occupation.
- You are not working in another occupation.

The DIP insurance carrier may require you to be examined by a physician, other medical practitioner or vocational expert of their choice. You will not be charged for this examination. The DIP insurance carrier also may require you to be examined as often as it is reasonable to do so, or require you to be interviewed by an authorized disability representative.

Coordinating with other disability benefits

DIP insurance coverage is for "off-the-job" disabilities. Workers' Compensation covers "on-the-job" disabilities. DIP coverage does not replace or affect the requirements for coverage by any Workers' Compensation or state disability insurance benefits.

When DIP benefits end

DIP benefits will end on the earliest of:

- The date you are no longer disabled as determined by the DIP insurance carrier.
- The date you reach the maximum benefit period in the benefit schedule.
- The date you fail to provide required proof of continuing disability or fail to take a required medical exam.
- The date of your death.

When DIP coverage ends

DIP coverage ends on the earliest of:

- The date you are no longer in a DIP eligible group.
- The last day of the period you made any required contributions.
- The date the policy ends.
- The date coverage under this program ends for you or your class of associates.
- The date you retire or terminate your employment (your last day of active service).

If you return to work and become disabled again

If you received DIP benefits, recover and return to work at Compass Group, but are disabled again for the same or a related cause 14 days or less after your return to work, you are considered to be in the same period of disability and will not have to meet a new elimination period.

Benefits will continue according to the plan in effect at the time the initial disability period began.

If your disability for the same or a related cause occurs 15 days or more after you return to work, a new elimination period will apply and benefits will be paid based on the plan in effect on the day the disability re-occurred.

If your disability is unrelated to or due to a different cause as your prior disability for which the DIP insurance carrier made a payment, and you are performing any work for Compass Group on a full time basis for less than one full day, the DIP insurance carrier will treat your disability as part of your prior claim.

What's not covered by the DIP plan

DIP benefits will not be paid if you are disabled because of:

- The loss of a professional or occupational license or certification.
- A work-related sickness or injury.
- Sickness or injury resulting from declared or undeclared war or any action of war or aggression.
- Sickness or injury resulting from active participation in a riot.
- Suicide attempt, while sane or insane or other intentionally self-inflicted injury.
- Commission of a crime for which you have been convicted under state or federal law.
- Any period of disability during which you are incarcerated.

How the Long Term Disability (LTD) plan works

Your coverage options

You can choose from three levels of LTD coverage:

- Option 1: $500 per month
- Option 2: $750 per month
- Option 3: $1,000 per month

Or, you may choose no coverage.

You can only choose coverage up to 60% your monthly earnings. For example, you cannot choose the $1,000 per month level if your monthly earnings are not $1,700 or more.

"Monthly earnings" is defined as your gross monthly income from Compass Group in effect on the December 31st just prior to your date of disability. If you did not have earnings as of December 31st prior to your date of disability, "monthly earnings" will mean your gross monthly income for the period of your employment with Compass Group. It includes your total income before taxes and any pre-tax deductions for benefits. It includes income actually received from commissions, but does not include bonuses, overtime pay, any other extra compensation, or income received from sources other than Compass Group.

You may change your coverage amount each year. However, you may only increase your coverage by one level. For example, if you have coverage under the $500 per month option, you may select the $750 per month option. You cannot increase your coverage from $500 per month to $1,000 per month. You may decrease your coverage any number of levels.

When benefits begin

The LTD plan begins paying benefits after you have been totally disabled through your elimination period of 180 days. Generally, benefits are payable for up to five years if you are age 65 or younger. You will not have to make contributions toward this coverage in the months you receive LTD benefits.

LTD benefits

LTD benefits are paid if you're totally disabled while covered and you remain disabled during and after the 180-day elimination period. The plan provides that you receive $500, $750 or $1,000 monthly, depending on the level of coverage you elect.

If you don't elect coverage when you are first eligible, you can do so during Annual Enrollment at the first level of coverage, $500 per month. However, you will be subject to the pre-existing condition exclusion. See *Pre-Existing Conditions* on page 101 for more information.

Applying for LTD benefits

You should notify the Benefits Department Leave of Absence Team of your claim as soon as possible, so that necessary information can be communicated to the LTD insurance carrier and a claim decision can be made in a timely manner. You must provide written proof of your LTD claim no later than 180 days (six months) after your DIP benefits, if any, begin.

If it is not possible to provide proof within 180 days, it must be provided no later than one year after the time proof is otherwise required, except in the absence of legal capacity. The claim form is available from the Benefits Department Leave of Absence Team.

How long benefits continue

Generally, your LTD benefit is payable for up to five years. However, if you become totally disabled on or after age 65, your benefit is paid according to the schedule listed below.

MAXIMUM TIME BENEFITS ARE PAYABLE	
AGE WHEN YOU BECAME TOTALLY DISABLED …	**BENEFITS ARE PAYABLE FOR …**
Less than age 65	Up to 5 years
65 to 68	Until age 70 (but not less than one year)
69 or older	1 year

For disabilities caused by mental and emotional illness

Disabilities, due to sickness or non work related injuries, which are primarily based on self-reported symptoms, or disabilities due to mental illness have a limited benefit period up to 24 months. You will continue to receive payments beyond the 24-month period if you meet one or both of these conditions:

1. Continued confinement to a hospital or treatment facility beyond the end of the 24-month period. If you are still disabled when you are ultimately discharged, the LTD insurance carrier will continue your benefits for a recovery period of up to 90 days. If you are re-

confined at any time during the 90-day recovery period and remain confined for at least 14 consecutive days, you will be eligible for benefits during the additional confinement and for one additional recovery period up to 90 more days.

2. In addition to item one, if you remain disabled beyond the 24-month period and subsequently become confined to a hospital or institution for at least 14 consecutive days, you will receive payments during the length of the re-confinement.
3. You will not be paid beyond the limited pay period as indicated in the first condition above, or the maximum period of payment, whichever occurs first.

The mental illness limitation relating to dementia will not apply if it is a result of:

- Stroke
- Trauma
- Viral infection
- Alzheimer's disease or
- Other conditions not listed which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment.

What is total disability?

You are totally disabled if:

- You are limited from performing the material and substantial duties of your regular occupation due to sickness or injury.
- You have a 20% or more loss in your indexed monthly earnings due to the same sickness or injury.
- During the 180-day elimination period, you are unable to perform any of the material and substantial duties of your regular occupation.

After 24 months of benefits, you are considered “disabled” if it is determined that due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience. The loss of a professional or occupational license or certification does not, in itself, constitute disability.

The LTD insurance carrier may require you to be examined by a physician, other medical practitioner or vocational expert of their choice. You will not be charged for this examination. The LTD insurance carrier may also require you to be examined as often as it is reasonable to do so. In addition, they also may require you to be interviewed by an authorized disability representative.

Pre-existing conditions

You have a pre-existing condition if:

- You received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the three months just prior to your effective date of coverage; and
- The disability begins in the first 12 months after your effective date of coverage.

In addition, this plan will not cover an increase in your coverage made during an Annual Enrollment period if you have a pre-existing condition.

However, if during an Annual Enrollment period you increase your monthly benefit to the maximum amount for which you are then eligible, and if your monthly benefit in effect just prior to this Annual Enrollment period was the maximum amount for which you were eligible on the date you last enrolled under the LTD plan, then the above pre-existing condition provision will not apply to the increase in your monthly benefit.

Coordinating with other sources of income

Compass Group LTD benefits are coordinated with deductible sources of income you may receive so that your benefit doesn’t exceed $500, $750 or $1,000 monthly, as applicable.

If, for instance, you become disabled and receive Social Security disability benefits of $400 and enrolled in the $700 level, the LTD benefit you receive from your Compass Group coverage will equal $350 monthly.

Deductible sources of income include:

- Social Security retirement or disability benefits payable to you and your dependents.
- Workers’ Compensation, occupational disease benefits or other disability legislation.
- Any state disability benefits law.
- Disability pay from any group insurance plan.
- Pay from sick leave plans.
- Half of any pay you earn through rehabilitative employment.
- Occupational accident coverage provided by Compass Group.
- Any statutory disability benefits law.
- Proceeds from the Railroad Retirement Act.
- Proceeds from the Canada Pension Plan, Quebec Pension Plan, or any other similar disability or pension plan or act.

- Proceeds from any public employee retirement system plan, or any state teacher's retirement system plan, or any plan provided as an alternative to any of the above acts or plans. Your plan benefit will not be affected by:
  - Cost-of-living increases you may receive for any other source of disability benefits.
  - Benefits you receive from a private disability policy you purchased on your own.

Regardless of the age at which you become disabled, if you remain continuously disabled for a period of 12 months or longer, you will receive at least 12 monthly payments.

The LTD plan will only subtract deductible sources of income which are payable as a result of the same disability. The LTD plan will not reduce your payment by your Social Security retirement income if your disability begins after age 65 and you were already receiving Social Security retirement payments.

Information about Social Security benefits

- All primary and dependent old age and disability insurance benefits under the Social Security Act reduce your LTD benefit.
- Once your Social Security benefit amount is determined, any cost-of-living changes won't change your LTD benefit amount.
- If you receive a retroactive lump-sum Social Security benefit that applies to a period during which you received LTD benefits, the portion of the lump-sum benefit attributable to that waiting period is payable to the plan carrier and must be reimbursed by you.

How much you will be paid if you are disabled and continue working

The LTD insurance carrier will send you a monthly payment if you are disabled and your monthly disability earnings, if any, are less than 20% of your indexed monthly earnings, due to the same sickness or injury.

If you are disabled and your monthly disability earnings are 20% or more of your indexed monthly earnings, due to the same sickness or injury, the carrier will calculate your benefit as follows:

During the first 12 months of payments, while working, your monthly payment will not be reduced as long as disability earnings plus the gross disability payment does not exceed 100% of indexed monthly earnings.

1. Add your monthly disability earnings to your gross disability payment.
2. Compare the answer from number one to your indexed monthly earnings.

If the answer from number one is less than or equal to 100% of your indexed monthly earnings, your monthly payment will not be reduced.

If the answer from number one is more than 100% of your indexed monthly earnings, the amount over 100% will be subtracted from your monthly payment.

After 12 months of payments, while working, you will receive payments based on the percentage of income you are losing due to your disability.

1. Subtract your disability earnings from your indexed monthly earnings.
2. Divide the answer from number one by your indexed monthly earnings. This is your percentage of lost earnings.
3. Multiply your monthly payment by the answer from number two.

This is the amount of your benefit.

During the first 24 months of disability payments, if your monthly disability earnings exceed 80% of your indexed monthly earnings, LTD benefits will end. After 24 months of disability payments, if your monthly disability earnings exceed the gross disability payment, LTD benefits will end. You may be required to send proof of your monthly disability earnings at least quarterly. Your benefit will be adjusted based on your quarterly disability earnings.

As part of your proof of disability earnings, you may be required to provide appropriate financial records which may be necessary to substantiate your income. After the elimination period, if you are disabled for less than one month, you will be eligible to receive 1/30th of your benefit for each day of disability.

When LTD benefits end

Long Term Disability benefits will end on the earliest of:

- During the first 24 months of payments, when you are able to work in your regular occupation on a part-time basis but you do not.
- After 24 months of payments, when you are able to work in any gainful occupation on a part-time basis but you do not.
- If you are working and your monthly disability earnings exceed 80% of your indexed monthly earnings, the date your earnings exceed 80%.
- The end of the maximum period of payment.

- The date you are no longer disabled under the terms of the plan, unless you are eligible to receive benefits under Unum's Rehabilitation and Return to Work Assistance program.
- The date you fail to submit proof of continuing disability.
- After 12 months of payments if you are considered to reside outside the United States or Canada. You will be considered to reside outside these countries when you have been outside the United States or Canada for a total period of six months or more during any 12 consecutive months of benefits.
- The date you die.

If you return to work and become disabled again

If you received LTD benefits, recover and return to work — but are disabled again for the same or a related cause less than six months after your return to work, you are considered to be in the same period of disability. Benefits will be paid according to the plan in effect at the time the initial disability period began.

If your disability recurs more than six months after you return to work, a new 180-day waiting period will apply and benefits will be paid based on the plan in effect on the day the disability re-occurred.

What's not covered by the LTD plan

Your plan does not cover any disabilities caused by, contributed to by, or resulting from your:

- Intentionally self-inflicted injuries.
- Active participation in a riot.
- Loss of a professional license, occupational license or certification.
- Commission of a crime for which you have been convicted.
- Pre-existing condition.

Your plan will not cover a disability due to war, declared or undeclared, or any act of war.

The LTD plan will not pay a benefit for any period of disability during which you are incarcerated.

Accidental Death and Dismemberment (AD&D) Coverage

Joining the plan

Compass Group offers you and your eligible dependents coverage under the Accidental Death and Dismemberment (AD&D) plan on the first of the month after you complete three months of service. After that, you may enroll for AD&D coverage each year during Annual Enrollment or if you have a qualified status change. Your payments for AD&D coverage are deducted from your paycheck pre-tax.

AD&D coverage

AD&D coverage pays benefits upon death or for specified physical losses caused by an accident (such as the loss of hands, feet, sight, speech, or hearing and for paralysis). Benefits also are payable if you or a covered family member becomes comatose as a result of an accident. This plan provides coverage:

- 24 hours a day, 365 days a year.
- For any type of accident, including accidents occurring:
  - On or off the job.
  - In or away from the home.
  - In a train, airplane, or automobile, or private conveyance (except those noted in the Exclusions section of the Insurance Policy).

If you choose to cover your family, the AD&D plan also features:

- An education benefit if you (the associate) or your spouse/domestic partner dies.
- A daycare benefit if you or your spouse/domestic partner dies and you have dependent children under age thirteen.
- An additional benefit for dependent children who suffer physical losses in an accident.
- A survivor's benefit if you and/or your spouse/domestic partner die in an accident.

Amount of AD&D coverage

There are six AD&D coverage levels, ranging from $25,000 to $500,000. Or you may choose no AD&D coverage. You can choose Associate only or Associate Plus Family. AD&D pays a benefit if you die or suffer dismemberment or loss of sight or hearing as the result of an accident.

Death benefits from this plan are paid in addition to your benefits from the Life Insurance Plan. If you choose to cover your family, benefits payable for the death or physical loss of a dependent will be a portion of the amount of your coverage.

This chart shows the AD&D options you can elect:

YOUR COVERAGE	DEPENDENT COVERAGE			
Amount	Spouse/Domestic Partner's Coverage		Children's Coverage	
	With Children	Without Children	With Spouse/Domestic Partner	Without Spouse/Domestic Partner
$25,000	$10,000	$12,500	$2,500	$3,750
$50,000	$20,000	$25,000	$5,000	$7,500
$100,000	$40,000	$50,000	$10,000	$15,000
$150,000	$60,000	$75,000	$15,000	$22,500
$250,000	$100,000	$125,000	$25,000	$37,500
$500,000	$200,000	$250,000	$50,000	$75,000

As shown in the chart, your coverage is the same whether you elect single or family coverage. If you decide to cover your family, the coverage provided to dependents depends on your family make-up, as follows:

- Your spouse/domestic partner's coverage will be 40% of your coverage if you have dependent child(ren) covered,
- Your spouse/domestic partner's coverage will be 50% of your coverage if you don't have dependent child(ren) covered, or
- Your child(ren)'s coverage will be 10% of your coverage if you have a spouse/domestic partner covered, or
- Your child(ren)'s coverage will be 15% of your coverage if you don't have a spouse/domestic partner covered.

You may "move up" only one level of coverage each enrollment period.

Benefit amount

If bodily injuries result in an associate's dismemberment or paralysis within 180 days of the date of the injury, the plan will pay the following benefits.

LOSS	BENEFIT
Loss of life	Full benefit amount
Loss of two or more members*	Full benefit amount
Loss of speech **and** hearing	Full benefit amount
Quadriplegia	Full benefit amount
Paraplegia	75% of benefit amount
Hemiplegia	50% of benefit amount
Loss of speech **or** hearing	50% of benefit amount
Loss of one member*	50% of benefit amount
Thumb and index finger of one hand	25% of benefit amount

*Member is defined as a hand, foot or sight of one eye.

If I choose family coverage, are all of my family members covered?

No. Only the family members you enroll who are eligible dependents are covered under the plan. Benefits paid for the death or covered loss of a dependent are a portion of your coverage amount as shown in the previous chart.

When you reach age 65

The amount of your AD&D coverage will be reduced as of January 1 on or following the year you reach age 65 and age 70:

AGE ON JANUARY 1	NEW BENEFIT LEVEL
65	65% of original benefit
70 and older	50% of original benefit

For example, if you choose the $150,000 option, your coverage amount would be reduced to $97,500 (65% of $150,000) on January 1 following the year you reach age 65 and to $75,000 on January 1 following the year you reach age 70. If your birthday is January 1, coverage will change that day.

Filing an AD&D claim

The plan carrier will pay benefits within 60 days of receiving proof of death while insured, such as a certified death certificate, or proof of your or a covered dependent's loss such as a physician's statement, and a fully completed claim form. A claim form can be obtained from Compass Group's Benefits Department. For information on benefit determination and the process for reviewing denied claims, please see *All Other Self-Insured and Non-Insured Benefits* beginning on page 136.

Naming a beneficiary

It is important to name a beneficiary to receive benefits from the plan if you die. To verify your beneficiary designation, go to the Online Benefits Center at www.altogethergreat.com. To make changes, call the Benefits Department at 800-341-7763. You may change your beneficiary at any time. Because family situations change, you should review your beneficiary designation at least yearly.

You automatically will be the beneficiary for:

- Any benefits payable for the covered loss of a dependent if you have chosen family coverage.
- Benefits payable for your own covered dismemberment loss.

When benefits are not paid

In no event will the accidental death or dismemberment benefits be paid if the insured's death or dismemberment results from or is caused directly or indirectly by any of the following:

- Suicide or attempted suicide, whether sane or insane.
- Intentionally self-inflicted injury or any attempt at self-inflicted injury, whether sane or insane.
- The insured's participation in or attempt to commit a crime, assault or felony.
- The insured's active participation in a riot.
- Bodily or mental infirmity, illness or disease.
- Intoxication or influence of any narcotic unless administered on the advice of a physician.
- The insured operating a motor vehicle under the influence of alcohol as evidenced by a blood alcohol level in excess of the legal intoxication limit in the state in which the accident occurred.
- Bacterial infection, other than infection occurring simultaneously with, and as a result of, the accidental injury.
- Travel or flight in or on, or descent from or with, any type of military aircraft.
- War or any act of war, whether declared or undeclared.

When coverage ends

Your insurance ends on the earliest of the following:

- The date the group policy ends.
- The date you no longer meet the eligibility requirements.
- The date the group policy is amended so you are no longer eligible.
- 60 days (grace period) after the due date of any unpaid premium if the premium remains unpaid at that time.
- The last day for which premium contributions have been paid following your written request to cease participation under the certificate.
- When the total amount of insurance paid under the certificate due to your accidental injuries, including any amount paid according to the terms of the Additional Benefits section of the certificate, equal one and one-half times the full amount of your insurance. If no additional benefits are payable under the Additional Benefits section of the certificate, the maximum amount payable will equal the full amount of your insurance.

If your insurance under the certificate terminates due to non-payment of premiums, your coverage may be reinstated if all premiums due are paid and received with 60 days of the date of termination and during your lifetime.

For more detail information — see the AD&D Policy, which is available on the Online Benefits Center at www.altogethergreat.com.

In the event of a conflict between the terms of this summary and the insurance carrier's policies and/or certificates, the insurance carrier's policies and/or certificates will govern.

great rewards

summary plan description

Flexible Spending Accounts (FSAs)

Joining the plan

Compass Group offers you and your eligible dependents coverage under the Flexible Spending Accounts (FSAs) on the first of the month after you complete three months of service. After that, you may enroll in the FSAs each year during Annual Enrollment or if you have a qualified status change. The IRS requires re-enrollment each Annual Enrollment period — the contribution amount does not rollover each year. Your payments for FSAs are deducted from your paycheck pre-tax. For more information on pre-tax dollars, see page 3.

In this section

About Flexible Spending Accounts (FSAs)

FSA options

Compass Group recognizes that the costs of health and dependent care can be challenging. To help you meet these expenses cost-effectively, Compass Group offers two programs for you to use your own pre-tax dollars to pay for certain health and dependent care expenses. With both spending accounts you make automatic, voluntary contributions from your paycheck pre-tax. Reimbursements are then paid to you from these accounts to cover the cost of your qualifying health and dependent care expenses while you work.

You can choose to contribute to either of these pre-tax accounts:

Health Care Spending Account reimburses you, tax-free, for eligible health-related expenses (including medical, dental and vision) that are not reimbursable through any insurance plans for yourself or your eligible dependents. The program permits eligible associates to contribute up to $3,500 (minimum of $100) a year to reimburse most healthcare-related expenses.

Dependent Care Spending Account reimburses you, tax-free, for most dependent daycare expenses for your qualifying dependents. The program permits eligible associates to contribute up to $5,000 (minimum of $100) a year to reimburse most dependent daycare expenses ($2,500, if you're married and file separate tax returns).

Your contributions to the FSAs, as well as the reimbursements that you receive from them, are not subject to federal income tax or Social Security taxes or, in most cases, state income tax.

Why Enroll in FSAs?

The main reason to enroll in FSAs is to save money on expenses that you already pay anyway. Here are more reasons to enroll:

- It's covered!
  - Besides your copays, deductibles, dental care, vision care and prescriptions, your Health Care Spending Account is also good for over-the-counter medications prescribed by a doctor, insulin and other healthcare items that are not medications, such as ACE bandages and non-medicated Band-Aids.
  - Your Dependent Care Spending Account covers babysitting, daycare and pre-school programs, and eldercare services while you work.
- **Easy as a debit card.** Your FSA is built for maximum convenience, from on-the-spot access with the WageWorks Health Care Card, to great time-saving features like direct payments to providers and easy online tracking.
- **Flexible for your needs.** It's your account — you decide how to use it. You can elect just a Health Care Spending Account, just the Dependent Care Spending Account, or both — and choose how much to set aside in each.
- **Check your account balance.** You can get up-to-the-minute account information at any time through www.wageworks.com, or by calling 877-WageWorks (877-924-3967). You'll also receive a monthly online statement.

Domestic Partners

Expenses for a domestic partner/domestic partner's children are not eligible for reimbursement by a Flexible Spending Account, unless the domestic partner or child/children of the domestic partner qualifies as your tax code dependent based on IRS rules.

Health Care Spending Account

With a Health Care Spending Account, you set aside part of your pre-tax pay to an account set up for you. If you (or your eligible dependents) incur qualifying expenses that are not covered, or are only partially covered, by insurance or any other source, you can be reimbursed through the spending account for these expenses. Because your contributions to the spending account are not subject to federal tax, using the spending account allows you to pay for qualifying health expenses while at the same time paying less in taxes.

The following examples show how much money you could save in taxes by participating in the Health Care Spending Account. These examples are based on federal income tax withholding and Social Security rates. Keep in mind, the example estimates state taxes and does not include any local taxes.

MARRIED FILING JOINTLY*	WITH A HEALTH CARE FSA	WITHOUT A HEALTH CARE FSA
Gross Family Income	$30,000	$30,000
Pre-Tax Contribution to Health Care FSA	-$500	$0
Taxable Family Income	$29,500	$30,000
Estimated Taxes		
• Social Security and Medicare	- $2,257	- $2,295
• Federal	- $715	- $765
• State (6% assumption)**	- $1,770	- $1,800
Post-Tax Health Care Expenses	$0	- $500
Associate's Net Pay	$24,758	$24,640
Savings through the Health Care FSA	**$118**	**N/A**

MARRIED FILING JOINTLY*	WITH A HEALTH CARE FSA	WITHOUT A HEALTH CARE FSA
Gross Family Income	$30,000	$30,000
Pre-Tax Contribution to Health Care FSA	- $3,500	$0
Taxable Family Income	$26,500	$30,000
Estimated Taxes		
• Social Security and Medicare	- $2,027	- $2,295
• Federal	- $415	- $765
• State (6% assumption)**	- $1,590	- $1,800
Post-Tax Health Care Expenses	$0	- $3,500
Associate's Net Pay	$22,468	$21,640
Savings through the Health Care FSA	**$828**	**N/A**

* Assumes a married couple filing jointly with three exemptions and taking the standard deduction. Based on 2011 tax rates.

** State taxes will vary depending on the state.

Therefore, a married couple with a total family income of $30,000 can save $118 in income taxes by putting $500 in the Health Care Spending Account, and they can save $828 if they contribute $3,500.

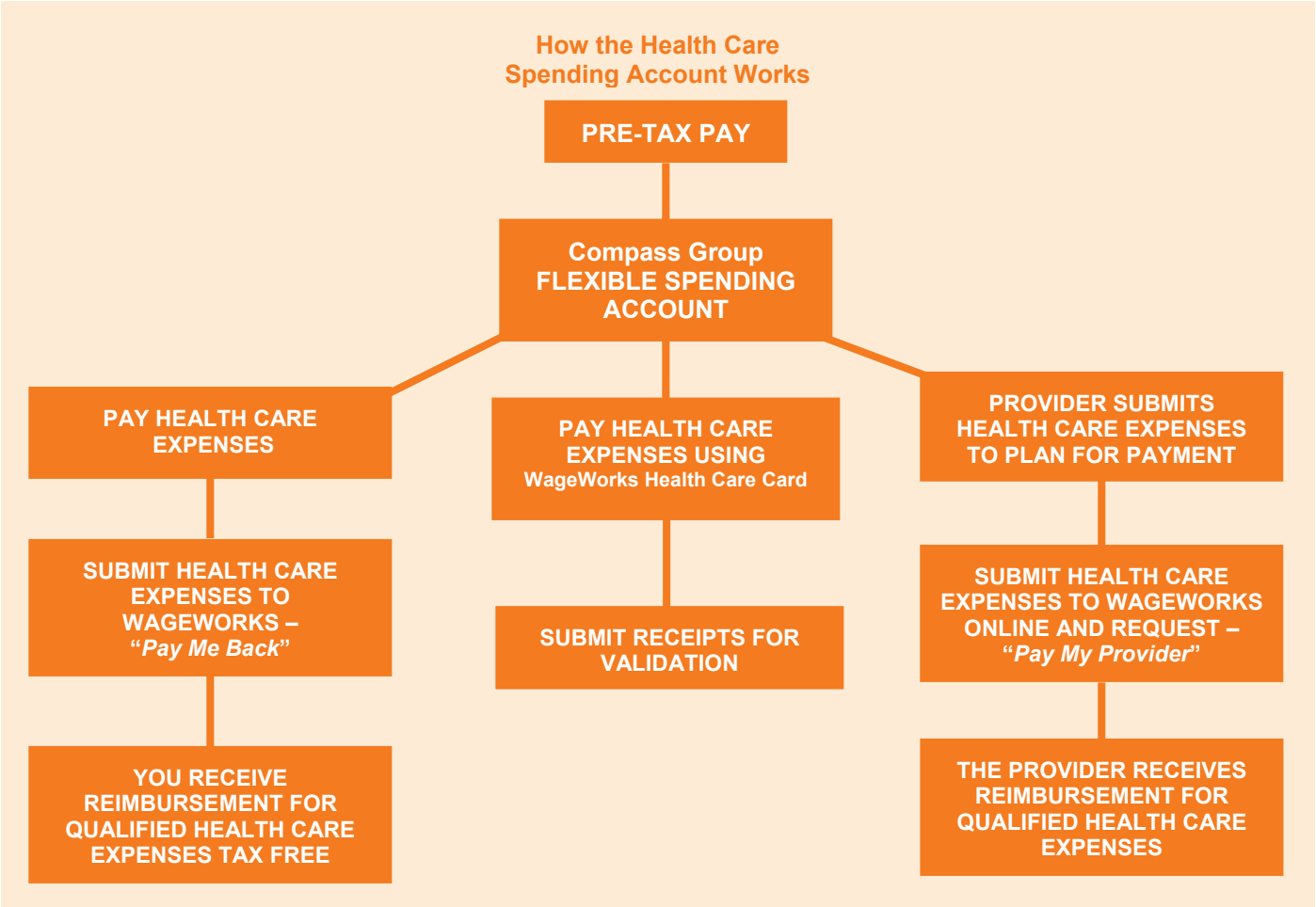
WageWorks

WageWorks administers the Health Care Spending Account and provides you with three reimbursement options: WageWorks Health Care Card, *Pay My Provider*, or *Pay Me Back*. See *WageWorks and Your Health Care Spending Account* on pages 114 – 116 for additional information on these options.

WageWorks Health Care Card — Works like a pre-paid debit card that you use to make purchases for eligible healthcare expenses at healthcare providers and compliant non-medical merchants who accept MasterCard. You do not need to enter a PIN.

Pay My Provider — Allows WageWorks to reimburse your provider directly from the Health Care Spending Account for certain regularly scheduled payments, balance due billings and invoices.

Pay Me Back — You submit a claim and WageWorks reimburses you directly through direct deposit or you'll receive a paper check.



Eligible expenses

Only eligible expenses can be reimbursed through the Health Care Spending Account. Eligible expenses are medical, dental and vision care expenses incurred by you or an eligible dependent in the diagnosis, treatment or prevention of disease, or the diagnosis or treatment of an injury, including prescription drug expenses, over-the-counter (OTC) medications prescribed by a doctor and transportation or lodging expenses incurred in receiving treatment. Certain other medical expenses not covered by your medical insurance are also eligible expenses, such as in vitro fertilization. Any deductibles or copayments you have paid under any type of healthcare plan, including HMOs and dental or vision plans, are also eligible expenses.

Your account can be used for prescribed medications or insulin. For over-the-counter medications with a doctor's prescription, the medication does not need to be dispensed by a pharmacist, but you will need to substantiate the expense with a copy of the doctor's prescription and a receipt.

You also can use your account for other healthcare items that are not medications, like ACE bandages and non-medicated Band-Aids. However, expenses which are considered merely beneficial, such as over-the-counter vitamins, are not eligible under the Health Care Spending Account.

Remember though, that the expenses you submit for reimbursement must not be covered by any other insurance or any other source, including a plan sponsored by your spouse's employer, Medicare, Workers' Compensation, automobile insurance or any recovery or settlement from a lawsuit.

The box to the right is a broader, but not exhaustive, list of healthcare expenses eligible for reimbursement from your spending account.

- Acupuncture
- Adult diapers
- Alcoholism treatment
- Ambulance charges
- Analysis or psychotherapy
- Artificial insemination
- Birth control
- Braille books/magazines
- Specialized car equipment for disabled persons
- Chiropractic costs
- Childbirth classes
- Christian Science Practitioners
- Coinsurance/Deductibles
- Contact lenses
- Cosmetic surgery:
  - To treat illness/disease
  - To improve a congenital abnormality
  - To treat injury from accident/trauma
  - To improve a disfiguring deformity
- Crutches
- Dental treatment
- Drug addiction treatment
- Excess of:
  - Reasonable and customary (R&C) charges
  - Scheduled, annual or lifetime maximums
- Eyecare
- Eyeglasses (prescription only)
- First-aid supplies
- Guide dogs
- Hearing aides
- Insulin, syringes and related testing supplies
- In vitro fertilization
- Laboratory fees
- Laser eye surgery
- Nursing home costs
- Orthodontia (non-cosmetic only)
- Over-the-counter medication prescribed by a doctor
- Oxygen
- Prescription vitamins
- Smoking cessation program (prescription)
- Speech therapy
- Sterilization
- Transplants (except hair)
- Vaccinations and immunizations
- Well baby care
- Wheelchairs
- X-ray fees

Go to www.irs.gov/pub/irs-pdf/p502.pdf or www.wageworks.com for more information on what expenses are FSA eligible.

Ineligible expenses

Any healthcare expense that is not an eligible expense cannot be reimbursed by the Compass Group Flexible Spending Account. Expenses that cannot be reimbursed include:

- Expenses for over-the-counter medications (like aspirin and Tylenol) without a doctor's prescription.
- Expenses of someone who is not an eligible dependent.
- Insurance premiums (including COBRA premiums).
- Expenses in excess of the amount you have elected to contribute to the Health Care Spending Account.
- Expenses for general health purposes, such as fitness, exercise, weight loss or health club dues.
- Vacation or travel costs to improve health.
- Vitamins (non-prescription).
- Cosmetic surgery, unless necessary to correct a deformity that is congenital or that resulted from a disfiguring disease or an injury resulting from an accident or trauma.

Below is a broader, but not exhaustive, list of expenses that are NOT eligible for reimbursement.

- Bleaching/Bonding of teeth
- Contact lens insurance
- Dancing lessons
- Diaper services for children
- Electrolysis
- Funeral expenses
- Hair transplants
- Health club dues
- Household help
- Liposuction
- Maternity clothes
- Over-the-counter medications without a prescription
- Retin A
- Rogaine
- School tuition
- Smoking cessation (non-prescription)
- Swimming lessons
- Transportation costs of a disabled person to and from work
- Vitamins (non-prescription)
- YMCA/YWCA memberships

Annual Health Care Spending Account contribution amount

You may elect to contribute up to $3,500 (minimum of $100) per year to the Health Care Spending Account. Your contributions will be deducted from your pay check in equal amounts throughout the plan year.

If your spouse also maintains a Health Care Spending Account, whether through Compass Group or another employer, this will not affect the maximum amount of your contribution. You may each contribute the maximum amount under the two programs. Please note there is a different rule that applies to contributions to the Dependent Care Spending Account. See page 118 for more information.

How the Compass Group Health Care Spending Account works

As an example, assume that you are enrolled in the Compass Group's Value Choice medical plan option for Associate Only coverage. You know that you will have a $250 deductible, so you contribute that amount to your Health Care Spending Account in equal installments through payroll deduction.

As you satisfy some or all of the deductible under the Compass Group's medical plan, you pay the deductible amount and submit a copy of the receipt and Explanation of Benefits to the FSA Administrator. Your claim will be applied against your Health Care Spending Account contributions (for the full year) and a reimbursement check will be mailed to you, usually within 10 days. See *Pay Me Back Requests* on page 116.

How to determine your annual contribution amount

The amount that you decide to contribute to the Health Care Spending Account will depend on the amount of qualifying medical expenses you expect to have during the year.

One way of estimating your future expenses is to look at past annual medical expenses. You might look over prescription drug costs, doctors' bills, Explanation of Benefits (EOB) statements from your medical, dental and vision plans and canceled checks. From these items you might anticipate which of the expenses will be repeated in the coming year. Use the FSA Savings Calculator to estimate your expenses and determine how much to contribute.

Remember to plan your contribution carefully, because you will be required to forfeit any unused amounts, and you are not permitted to either change or stop your contributions during the plan year unless you have a family status change.

Reimbursement funds availability

The amount available to you for reimbursement for qualifying expenses from January 1 of the plan year is the annual amount you have elected to contribute to the spending account, even if the full amount has not yet been deducted from your pay. For example, if you elect to contribute $1,200 to the spending account, the entire $1,200 will be available to you for reimbursement of your eligible expenses beginning January 1. Please note that there is a different rule for reimbursements from the Dependent Care Spending Account. See page 119 for more information.

If you are terminated, you can send claims incurred up to your termination date. However, these claims must be submitted within 90 days of the termination date. If there is a balance left in your Health Care Spending Account, you can elect COBRA. For more information on COBRA, see pages 19 – 27.

Unused account balance

The IRS requires that any amounts remaining in your spending account after the deadline for submitting claims for the plan year must be forfeited. You may not carry forward unused amounts to the next plan year and you may not transfer unused amounts from the Health Care Spending Account to another Compass Group program or account, for example, the Dependent Care Spending Account. Therefore, you should carefully plan the amount of money you will contribute to your account.

Unused account balances for military reservists

If you are a Qualified Reservist called to active duty for at least six months, you may request for all or a part of your Health Care Spending Account balance to be reimbursed to you. The amount available to you will be the contributions in your account as of the date of your request minus any reimbursements you have received as of the request date. Any amounts you request will be included in your gross income and wages, reportable on your W-2 and subject to employment taxes. See *Claim Submission Deadline* on page 116 for more information.

Mid-year contribution changes

You may not change your contribution amount during the year unless you experience one of the following qualified family status change events:

- A marriage or divorce.
- The birth or adoption of a child.
- The death of your spouse or a dependent.
- The loss of coverage under your spouse's employer-sponsored FSA.

Health Care Spending Account and medical insurance

The Health Care Spending Account does not replace your medical insurance. The spending account is a separate program that reimburses you for qualifying expenses that are not covered, or only partially covered, by your medical, dental or vision plan or by any other source.

WageWorks and your Health Care Spending Account

WageWorks provides you with easy access to your Health Care Spending Account funds and account information.

Account information

Obtaining up-to-date information on claim status, account activity and account balance is a simple process. Online access to your account information is available to you 24 hours a day, seven days a week through www.wageworks.com. You also can obtain your account information by calling WageWorks at 877-924-396**7**.

When calling WageWorks, you can take advantage of its automated voice system to check your account or you may speak with a WageWorks Customer Service Representative.

Paperless FSA statements*

If you have an email address in your WageWorks online profile, you will only receive online FSA statements. **WageWorks will not send you an additional paper statement.** Using WageWorks online statements is an easy way to help control administrative costs, protect the environment, eliminate waste and help promote corporate and social responsibility through Compass Group 360°.

If you haven't established a WageWorks profile or selected to receive online statements, do it today. Email is the best way for WageWorks to communicate with you — particularly when it comes to information like your claims notification and account updates — and an easy way to go green.

* Only associates without an email address on file with WageWorks — or who have selected to receive their statements by mail — will receive paper statements.

Setting up your WageWorks online account

Before you can access your Spending Account information online, you need to register to use the WageWorks site.

- Go to www.wageworks.com and click *First Time User? Register Now*.
- Enter the information requested.
- Confirm the contact information in your *Profile*. (This is where you confirm your email address to receive monthly emailed account statements.)
- Review the *User Agreement* and confirm your acceptance.

Once you have access to www.wageworks.com, you can download claim forms and schedule payments to your healthcare providers by accessing the *Print Forms* and *Health Care* tabs.

Using your WageWorks Health Care Card

Your WageWorks Health Care Card can be used to purchase eligible healthcare services from healthcare providers such as doctors, dentists, hospitals, pharmacies as well as eligible merchandise at discount chain stores, supermarket pharmacies and wholesale clubs. **Your WageWorks Health Care Card has an expiration date.** Do not dispose of your card prior to receiving a new card, unless you discontinue enrollment in the FSA. If you are enrolled, a new card will be sent to you before the expiration date.

Before using your WageWorks Health Care Card for the first time, you must activate the card. Once activated, you can use the card to purchase eligible healthcare services and items from all compliant institutions that accept MasterCard. At the time of payment, give the card to the service provider or swipe it yourself. If you are using a terminal, choose the credit option and then sign for your purchase. Remember to save your itemized receipts and the credit card-like receipt. WageWorks may require you to submit your itemized receipts to show that you used the card for eligible healthcare expenses. Your monthly statements will contain additional information on this requirement.

IRS rules

Due to IRS rules, you are limited to where you can use your WageWorks Health Care Card. The IRS is requiring "non-medical" merchants (like retail and grocery stores) to agree to certain guidelines in order to accept FSA debit cards, like the WageWorks Health Care Card. You only can use your card at merchants who have agreed to these guidelines.

To use your WageWorks Health Care Card at a retail store, grocery store or pharmacy, check to see if they accept the card. You can continue to use your card at your doctor's office, the hospital and all medical providers.

You may not be able to use your WageWorks debit card for certain over-the-counter medications — even if they are prescribed by a doctor. You will need to pay out of pocket for the expense and file a claim to get reimbursed. When filing a claim for a prescribed over-the-counter medication, you need to submit either an itemized cash register receipt that includes the date, amount, provider name, over-the-counter item and prescription number or the itemized receipt and a copy of the prescription.

Check www.wageworks.com regularly for the most up-to-date list of compliant non-medical merchants and pharmacies.

Always save your FSA receipts for ALL items and services, such as visits to your doctor or dentist. You may need to submit receipts to WageWorks for these purchases. Due to stricter federal regulations, WageWorks may suspend your Health Care Card if you don't submit receipts within 90 days from the date of the purchase and if you've used over half of your contribution amount.

Using the *Pay My Provider* option

The *Pay My Provider* option allows you to authorize WageWorks to pay your provider directly from your Health Care Spending Account for:

- Eligible regularly scheduled payments (such as orthodontic care or physical therapy).
- Balance billings where your service provider bills the medical, dental or vision plan for eligible expenses and then bills you for any remaining balance.
- Invoices you receive after the date of service for eligible expenses that require only basic proof of service (such as doctor's receipts and pharmacy forms).

To take advantage of this option, simply log onto your account at www.wageworks.com, click the *Health Care* tab, then click *Request Pay My Provider*. Once you complete all of the required information, WageWorks will make the requested payments from your Health Care Spending Account and mail it to your service provider.

Using the *Pay Me Back* Option

The *Pay Me Back* option allows you to pay for your eligible expenses first and then obtain reimbursement by submitting a claim form directly to WageWorks with your itemized receipts, bills and Explanation of Benefits (EOB) statements.

For over-the-counter medications, you will also need to include a copy of the prescription unless the receipt includes the date, amount, provider name, over-the-counter item and prescription number. You can choose to be reimbursed through direct deposit or receive a paper check.

Pay Me Back requests

WageWorks offers you the convenience and option to complete your Pay Me Back claim form online when you log on to your WageWorks account. Once the form is complete, you have two options:

- **Print the form and mail or fax it to WageWorks with the receipts, or**
- **Scan and upload the corresponding receipts to the WageWorks' system for faster processing.**

You can mail or fax a Health Care *Pay Me Back* form, along with an itemized bill or a receipt showing proof of payment, to:

WageWorks
P.O. Box 14053
Lexington, KY 40512

Fax Number: 877-353-9236
Health Care *Pay Me Back* forms are online at:
www.wageworks.com
(use the Print Forms tab)
or www.altogethergreat.com

Normally, you can expect to receive your reimbursement check by mail within 10 days or within 48 hours for direct deposit.

Any itemized bills that you submit should contain, at a minimum, the following items:

- The name of the patient and the associate.
- The date(s) the services were provided.
- A description of the service or item provided.
- The name and address of the provider.
- The cost of the service or item.

Claim submission deadline

Qualifying expenses incurred between January 1, and December 31 of the plan year, are eligible for reimbursement from your Health Care Spending Account. You may submit reimbursement requests at any time during this period. If your plan ends mid-year due to employment termination or qualified status change — you will have 90 days from the termination date to submit receipts for reimbursement.

All reimbursement requests for expenses incurred in the current plan year must be received no later than March 31 of the next year, or 90 days after your coverage ends, whichever comes first.

Health Care Card expiration

Health Care Cards are issued with a three-year expiration date. This means that participants can use their card if they re-enroll for subsequent plan years. The participant will not be issued a new Card for the next plan year unless their card expires. The following are examples for the three-year card expiration.

Example one

If the participant's account is depleted before the plan year is over, do not destroy the card as the card will be replenished with the next plan year's election at the beginning of the next plan year.

Example two

If the participant's account still has funds at the end of the plan year they will need to use another payment feature to be reimbursed. The Health Care Card cannot be used for the prior-year's expenses. The funds will be depleted from the Card at the end of the plan year. New elected funds will be placed on the Card at the beginning of the new plan year.

Account balance

You will receive a monthly statement detailing the status of your account. If you provided your email address to WageWorks, this statement will be sent directly to your email account.

Remember, the expense must be for services provided while you participated in the Health Care Spending Account. Expenses for services provided before you enrolled in the spending account are not eligible.

An expense is considered incurred on the date that the services were provided, regardless of when you are billed or pay for the services.

Dependent Care Spending Account

The Dependent Care Spending Account allows you to contribute money on a pre-tax basis to an account set up for you to use that money to pay for qualifying dependent care expenses. The amount contributed to the Dependent Care Spending Account can be used to reimburse you for most daycare expenses you might incur for your qualifying dependents. Because contributions to the spending account are not federally taxed, more of your paycheck will be available to you while you work.

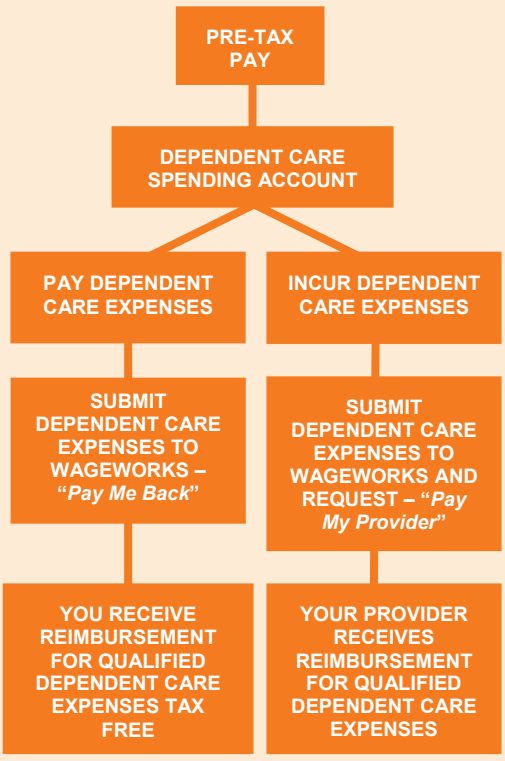
WageWorks

WageWorks administers the Dependent Care Spending Account and provides you with two reimbursement options — *Pay My Provider* or *Pay Me Back*. See *WageWorks and Your Dependent Care Spending Account* on page 120 for additional information on these options.

Pay My Provider — Allows WageWorks to reimburse your daycare provider directly from your Dependent Care Spending Account for regularly scheduled daycare expenses.

Pay Me Back — You submit a claim and WageWorks reimburses you directly through direct deposit or you'll receive a paper check.

Dependent Care reimbursement options



Qualified dependents

Expenses for care of the following individuals may be paid through the Dependent Care Spending Account:

- Children under age 13 for whom you are able to take a tax exemption.
- Any dependent or non-dependent spouse who is physically or mentally incapable of independent care.*
- A parent incapable of independent care who lives with you and whom you claim as a dependent on your tax return.*

* If you provide over half the support of an individual with a specified relationship (such as parents, siblings, stepparents, etc.), he or she will not qualify as a dependent for spending account reimbursement if he or she has gross income of $3,200 or more during the year.

Eligible expenses

Eligible expenses include dependent care expenses that enable you and your spouse to work or your spouse to attend school full time while you work. Such expenses include:

- A qualified child or adult daycare center that receives payment for the care of more than six individuals who do not reside there.
- Expenses of a babysitter, whether in your home or elsewhere, during the time that you are working.
- A housekeeper whose duties include dependent care.
- A relative who cares for your dependents, but is neither your dependent nor your child under age 19.
- Someone who cares for an elderly or disabled dependent in your home.
- Day camp expenses, provided that the camp is NOT for a specific educational purpose, such as learning tennis or computer skills and the care is necessary in order for you or your spouse to work (or for your spouse to attend school full time while you work).
- Nursery school expenses, provided that the school is a state-licensed facility.

Remember, the care must be necessary so that you and, if you are married, your spouse can work. If your spouse does not work, dependent care expenses are not eligible, unless you work and your spouse is a full time student or physically or mentally unable to care for himself or herself.

You can use your Dependent Care Spending Account to pay for eligible dependent care services provided for a qualifying child or relative during your coverage period — as long as the services are provided on days the dependent is a qualifying child or relative.

Example:

- Compass Group's plan year runs January 1 to December 31, and you will be covered for the entire plan year.
- Your daughter is a qualifying child until her birthday on March 1, but is not a qualifying child or relative as of March 1.
- The dependent care services provided for your daughter between January 1 to February 28 **are eligible** to be paid from your account.
- The dependent care services provided for your daughter on March 1 and later **are not eligible** because she was not a qualifying child or relative at the time the services were provided.

The same example applies for a qualifying relative who becomes capable of self-care on March 1.

Since Compass Group's plan only allows legally permitted status changes, both events (your daughter's birthday and a person ceasing to be a dependent) are qualified status change events that will allow you to decrease your election or cancel your enrollment in the Dependent Care Account.

Ineligible expenses

Private school tuition is not reimbursable. Transportation costs to and from the location where the care or program is provided are also not reimbursable, unless the transportation cost is included in **and** cannot be separated from the cost of the program. Other expenses ineligible for reimbursement are as follows:

- Expenses for food, clothing, education or entertainment you incur for the normal care of an eligible dependent, unless these expenses are included in **and** cannot be separated from the cost of care.
- 24-hour nursing home expenses.
- Cost for child care that enables your spouse to do volunteer work.
- Educational expenses for children in the first grade or higher.
- Overnight camp expenses.
- Payments for babysitters when you are not working, such as in the evening or on weekends.

This list is intended to give you a general description of expenses not eligible for reimbursement through the Dependent Care Spending Account. There may be other expenses in addition to those listed above which are not eligible. Go to www.irs.gov/pub/irs-pdf/p503.pdf or www.wageworks.com for more information.

Annual Dependent Care Spending Account contribution

Generally, you may elect to contribute up to a maximum of $5,000 per year, regardless of the actual number of qualifying dependents you have, or $2,500 per year if you are married but file a separate tax return. If your spouse also maintains a Dependent Care Spending Account, whether through Compass Group or another employer and you file a joint tax return, the $5,000 limit will apply to the total contributions both of you make to your respective accounts. For example, if your spouse contributes $4,000 to his or her account, you may contribute only $1,000 to the Compass Group Dependent Care Spending Account.

Special rules. In addition, your Dependent Care Spending Account contribution is subject to an earned wages limitation. Your contribution can never be more than your earned wages or, if you are married, your spouse's earned wages, whichever is less.

If you are married and your spouse is either a full time student, or physically or mentally incapable of caring for himself or herself, when you apply the earned wages limitation, the earned wages of your spouse will be deemed to be $250 per month ($3,000 per year) if you have one dependent and $500 per month ($6,000 per year) if you have two or more dependents. A full time student is an individual who maintains status as a full time student at a college or university during at least five months of the year.

The Internal Revenue Code places limits on how much higher-paid associates, as a group, can deposit in Dependent Care Spending Accounts in a year. If this limit is reached and it affects you, you will be advised of any required changes in your elected amount.

How to determine your annual contribution amount

The amount you elect to contribute will depend upon the amount you anticipate you will need to cover your dependent care expenses up to the $5,000 limit. You should compare the tax benefit that you will receive with the Dependent Care Spending Account to the benefit that you would receive with the federal child and dependent care tax credit and then choose between them. The federal credit allows you to subtract a percentage of your qualifying dependent care expenses from your taxes on your federal tax return.

The tax credit ranges from 20% to 35% of qualifying expenses, depending on your earned income. You may not claim the federal credit for an expense reimbursed through the spending account. For additional details about the federal tax credit, see IRS Publication 503 (*Child and Dependent Care Expenses*) which you may obtain from your local IRS office or at www.irs.gov/pub/irs-pdf/p503.pdf or www.wageworks.com.

Keep in mind, however, that you may initially experience a period of increased expenses because you will have to pay your dependent care provider and have payroll deductions before you receive reimbursements from your account.

Remember to plan your contribution carefully, since you will forfeit any unused amounts as required by IRS rules. In addition, you are not permitted to either change or stop your contributions during the year unless you have an eligible change in family or employment status. See *Mid-Year Contribution Changes* on this page.

Expenses greater than account balance

You will make contributions to the Dependent Care Spending Account through payroll deductions. You can receive reimbursements from your spending account only up to the balance of such contributions in the spending account at the time you submit the claim for reimbursement.

For example, you know that your children's daycare will cost $2,400 during the year, so you elect to deposit $2,400 into your Dependent Care Spending Account. Every pay period $92.31 is deducted from your bi-weekly pay, pre-tax. When the first daycare bill is due, you pay the bill and submit a reimbursement claim along with a copy of the bill. You will then be reimbursed from your account, **assuming that you have an adequate balance in your account**. If not, your claim will be held in a pending account until such time as the balance in your Dependent Care Spending Account is sufficient to cover the bill.

Your claim will be applied against your Dependent Care Spending Account contributions and a reimbursement check will be mailed to you from WageWorks, usually within 10 days. See *Pay Me Back Requests* on page 121.

Unused account balance

At the end of each calendar year, the IRS requires that you forfeit any money left in your Dependent Care Spending Account. You may not carry forward unused amounts to the next plan year, nor may you transfer unused amounts from your Dependent Care Spending Account to another Compass Group program or account, for example, the Health Care Spending Account. For this reason, it is important that you carefully plan your deposit amounts. You have 90 days after your coverage ends to submit a claim.

Partial payments

At the end of each calendar year or within 90 days after your coverage ends, a partial payment amount can be applied to a daycare bill. For example, you have $20 remaining in your account and your daycare bill is $120. WageWorks will apply the remaining $20 toward the daycare bill and you will be responsible for the remaining balance of $100. Therefore, you will not forfeit the remaining $20 balance.

Mid-year contribution changes

You may not change the amount of your deposit, or stop making deposits, unless you terminate employment with Compass Group, have a change in employment status or experience a qualified change in family status during the plan year and that event directly affects your participation in the account. A qualified family status change is any one of the following:

- A marriage or divorce.
- The birth or adoption of a child.
- The death of your spouse or a dependent.
- The termination of employment of your spouse.
- Changing caregivers.
- Your child reaches age 13.

You should consider the possibility of these events when you plan your annual deposits.

Timing of your deposit

Your deduction will be accessible in your Dependent Care Spending Account by the end of the week following your pay date. If you have questions about the timing of your deposit, contact the Benefits Department at 800-341-7763 or by email at benefits.department@compass-usa.com.

COBRA and the Dependent Care Spending Account

If you terminate employment with Compass Group, COBRA will NOT apply to your Dependent Care Spending Account. This means that you will not be entitled to make any contributions to your spending account after your termination date.

WageWorks and your Dependent Care Spending Account

WageWorks provides you with easy access to your Dependent Care Spending Account funds and account information.

Account information

Obtaining up-to-date information on claim status, account activity and account balance is available in several ways. Online access to your account information is available to you 24 hours a day, seven days a week through www.wageworks.com. You also can review your account information by calling WageWorks at 877-924-3967. When calling WageWorks, you can take advantage of its automated voice system to check your account or you may speak with a WageWorks Customer Service Representative.

Paperless FSA statements*

If you have an email address in your WageWorks online profile, you will only receive online FSA statements. WageWorks will not send you an additional paper statement. Using WageWorks online statements is an easy way to help control administrative costs, protect the environment, eliminate waste and help promote corporate and social responsibility through Compass Group 360°.

If you haven't established a WageWorks profile or selected to receive online statements, do it today. Email is the best way for WageWorks to communicate with you — particularly when it comes to information like your claims notification and account updates — and an easy way to go green.

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- Go to www.wageworks.com and click *First Time User? Register Now*.
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- Confirm the contact information in your *Profile*. (This is where you confirm your email address to receive monthly emailed account statements.)
- Review the *User Agreement* and confirm your acceptance.

Once you have access to www.wageworks.com, you can download claim forms and schedule payments to your daycare providers by accessing the *Print Forms* and *Dependent Care* tabs.

Using the *Pay My Provider* option

The *Pay My Provider* option allows you to authorize WageWorks to pay your provider directly from your Dependent Care Spending Account.

To take advantage of this option, log on to your account at www.wageworks.com, click *Dependent Care*, then click *Request Pay My Provider*. Once you have completed all of the required information, WageWorks will make the requested payments from your Dependent Care Spending Account and mail it to your service provider.

Using the *Pay Me Back* option

The *Pay Me Back* option allows you to pay for your eligible expenses first and then get reimbursed by submitting a claim form directly to WageWorks with your itemized receipts/bills. You can choose to be reimbursed through direct deposit or receive a paper check.

Pay Me Back Requests

You should mail or fax a Dependent Care Pay Me Back form, along with an itemized bill or a receipt showing proof of payment to:

WageWorks
P.O. Box 14053
Lexington, KY 40512

Fax Number: 877-353-9236
Dependent Care *Pay Me Back* forms are online at:
www.wageworks.com
(use the Print Forms tab)
or www. altogethergreat.com

Normally, you can expect to receive your reimbursement check via mail within 10 days or within 48 hours for direct deposit if you have an adequate balance in your account.

Any itemized bills that you submit should contain, at a minimum, the following items:

- **The dependent's name and age.**
- **The nature of the care provided.**
- **The date(s) the care was provided.**
- **The amount paid for the care.**
- **The dependent's relationship to you and**
- **The name and taxpayer identification number (or Social Security Number) of the care provider.**

Claim submission deadline

Qualifying expenses incurred between January 1, and December 31, are eligible for reimbursement from your Dependent Care Spending Account. You may submit reimbursement requests at any time during this period. **All reimbursement requests for expenses incurred in the current year must be received no later than March 31 of the next year, or 90 days after your coverage ends, whichever comes first.**

Remember, the expense must be for care provided while you participated in the spending account. Expenses for care provided before you enrolled in the spending account are not eligible. An expense is considered incurred on the date that the care is provided, regardless of when you are billed or pay for the services.

Account Balance

You will receive a monthly statement detailing the status of your account. If you provided your email address to WageWorks, this statement will be sent directly to your email account — otherwise it will be mailed to your home address.

great rewards

summary plan description

Commuter Benefits Program

Joining the plan

Compass Group offers the Commuter Benefits Program to eligible full time associates.

You can enroll or make changes whenever you choose — there is no open enrollment period.

Your deductions for the program are withheld from your paycheck, up to the federal limit, on a pre-tax basis. Amounts above the federal limit are withheld post-tax. For more information on pre-tax dollars, see page 3.

In this section

About the Commuter Benefits Program

Compass Group offers a Commuter Benefits Program that helps you save on the cost of commuting when you use public transportation or parking to get to work. Through our partnership with WageWorks, you can have dollars deducted from your paycheck to use to pay for specific types of transportation expenses, including:

- Public transit, for example, traveling by bus, regional rail, streetcar, trolley, subway or ferry.
- Vanpools.
- Parking at or near work, or at or near public transportation lots if you park and ride.

WageWorks offers public transit coverage in all 50 states and in more than 350 metropolitan areas.

How the program works

When you enroll, you can set aside up to $125 a month pre-tax for transit and vanpool expenses, and up to $240 a month pre-tax for parking.

Amounts above these limits will be deducted post-tax. You select the monthly transit and/or parking amount.

You can enroll or make changes throughout the year — there is no open enrollment period.

You pay no fees for the program. The costs to administer the program and delivering your passes are covered by Compass Group as part of your benefits.

Commuter benefits payment options

OPTION	USE IT TO…	HOW IT WORKS…
Public Transit or Vanpool		
WageWorks Commuter Card	Pay at transit agency ticket machines and windows — where credit and debit cards are accepted	Funds are added to your card each pay date — the card is reusable
Transit Agency SmartCards	Buy a SmartCard at your local transit agency	Funds are added to your transit agency card
WageWorks Transit Account — Buy My Pass	Buy transit or vanpool passes/tickets	Funds are added to your account monthly; buy your passes/tickets and have them mailed to your home
WageWorks Parking Account		
Pay My Parking	Pay for parking at a parking garage	WageWorks can send a check directly to your parking provider
Pay Me Back	Pay for parking at a parking garage	Pay to park, and then get reimbursed by direct deposit or check

Enrollment

You can enroll at any time. There is no open enrollment period. There are three steps to enroll:

1. Decide how much you'd like to contribute from your paycheck and which payment option(s) are best for you.
2. Go to www.wageworks.com, or call 877-WageWorks (877-924-3967) and enroll by the 15th of the month.
3. Place your order. You will need to provide information about your transit, vanpool or parking provider for passes/tickets and direct parking payments. You must place your order by the 10th of the following month for these options. If you live in the greater New York metropolitan area and ride the Long Island Rail Road or Metro-North Railroad, the deadline is the 4th rather than the 10th.

WageWorks

To register to use the WageWorks site.

- Go to www.wageworks.com and click Register with WageWorks now!
- Answer a few simple questions about your employment status.
- Confirm your contact information.
- Create a username and password.

If you are already signed up with WageWorks for Flexible Spending Accounts (FSAs), use your current login information.

Important Rules

Since each payment option works a little differently, here are some general guidelines for enrolling and placing an order. Note: You will only have access to funds that have been posted to your account.

WageWorks Commuter Card — Enroll by the 15th of the month, and your card will arrive by the first of the following month. Payroll deductions will begin the following month, and the funds will be deposited to your account based on your pay date. You can then begin to use the card.

SmartCards, transit/vanpool passes or tickets — Enroll by the 15th of the month, and place your order by the 10th of the following month. You'll receive your card, passes or tickets before the first month after you place your order. For more information about the different types of SmartCards and passes, go to www.wageworks.com.

Parking Accounts — For the "Pay My Parking" option, enroll by the 15th of the month, and place your order by the 10th of the following month. WageWorks will send payments to your parking provider beginning the first month after you place your order.

When commuter benefits end

Benefits end when the first of the following events occur:

- The date you terminate employment.
- The date you no longer meet the eligibility requirements.
- The date of your death.
- The date the program is terminated.
- The date you discontinue participation.

Commuter benefits are not tied to a benefit year, so the funds will remain in your account until exhausted. If your employment ends, any money remaining in your account will be forfeited. However, funds on your WageWorks Commuter Card will remain on your card for 90 days before being forfeited.

If you are using your WageWorks card for parking, you will not have any days to spend the remaining money in your account. The benefit ends on your date of termination. However, for the parking benefit, post-tax money will be returned to you via check.

Changing or canceling your order — You can change or cancel your commuter order for any month. The change or cancellation must be done by the 10th of the month prior to the commuting month. Log into your account at www.wageworks.com to change or cancel your order.

Stopping your deductions — Go online and click the "Stop Deduction" button to stop your monthly election amount.

Ineligible Expenses

Commuting expenses you cannot claim under the Commuter Benefits Program include, but are not limited to:

- Commuting or parking expenses that are partially or fully subsidized or reimbursed by Compass Group.
- Expenses incurred for parking at your spouse's workplace.
- Fuel.
- Mileage or other costs you incur in operating a vehicle.
- Parking at a mall or similar location where you stop on your drive to or from work.
- Parking on or near property where you live.
- Payments to fellow participants in a carpool or to a friend who drives you to work.
- Taxis.
- Tolls.
- Traffic tickets.

For more information

Go to www.wageworks.com, or call 877-WageWorks (877-924-3967) Monday through Friday, 8:00 a.m. to 8:00 p.m. EST for more information. You also can contact the Benefits Answerline at 800-341-7763 or by email at benefits.department@compass-usa.com.

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summary plan description

Administrative Information

When you choose coverage under the Employee Benefit Plan of the Compass Group USA, Inc. (“Benefit Plan”), you may receive benefits within the provisions described in this summary. You also have other rights as a plan participant, some of which are listed in this section. If you have any general questions that cannot be answered by the plan carriers listed on pages 127 – 128, contact the Benefits Answerline at 800-341-7763, option 1. The information in this section tells you:

- How to contact the plan administrator.
- How to contact the plan carriers that administer each plan.
- What to do if a claim for benefits is denied.
- Rules and regulations for continuing coverage during military leave and subrogation.
- Your rights under ERISA.

Note: Compass Group reserves the right to terminate your plan benefits prospectively without notice for cause (as determined by Compass Group), or if you are otherwise determined ineligible. In addition, if you commit fraud, or intentional misrepresentation of a material fact with respect to enrolling in the plan, or in a claim or appeal for benefits, or in response to any request for information in connection with your plan benefits, your coverage may be terminated retroactively with 30 days notice to you. Knowingly providing false information to obtain coverage for an ineligible dependent is an example of fraud. To the extent permitted by applicable law and regulations, coverage may also be terminated retroactively and without notice (unless required by law or applicable regulation), if Compass Group determines that you or your dependent is ineligible for coverage.

In this section

Basic administrative information

PLAN NAME	Employee Benefit Plan of the Compass Group USA, Inc.
PLAN ADMINISTRATOR	Compass Group is the plan administrator (as defined under ERISA) for most of the benefits described in this summary. However, some of the benefits are provided by insurance companies or HMO providers, and in those instances the companies (not Compass Group) are the plan administrators and have the legal responsibility to make decisions under those plans.
PLAN SPONSOR CONTACT INFORMATION	Benefits Department Compass Group 2400 Yorkmont Road Charlotte, NC 28217 800-341-7763
EMPLOYER IDENTIFICATION NUMBER	56-1874931
PLAN NUMBER	510
TYPE OF PLAN	Medical and prescription drug, wellness, dental, vision, flexible spending accounts, life insurance, accidental death & dismemberment insurance and disability benefits
PLAN YEAR	January 1 – December 31
PLAN FUNDING/SOURCE OF FUNDING	The plans are unfunded arrangements. Benefits are paid either out of general assets of your employer or under an insurance contract. All of your benefits are provided through contributions made by Compass Group and/or by you as specified in the specific benefit description.
AGENT FOR SERVICE OF LEGAL PROCESS	Legal process for all of the benefit plans described in this summary should be directed to: General Counsel Compass Group USA, Inc. 2400 Yorkmont Road Charlotte, NC 28217 704-328-4000 Legal process may be made upon the plan administrator.
RIGHTS TO EMPLOYMENT	This summary is for your information only; it is not a binding contract, nor does it impose any legal obligation upon Compass Group. No information in this summary says or implies that participation in the benefit plan is a guarantee of continued employment with the Company.
RIGHT TO AMEND OR TERMINATE PLANS	Compass Group, in its sole discretion, reserves the right to amend, modify, suspend or terminate the benefit plan, in whole or in part, subject to applicable legal and contractual agreements, at any time and for any reason. A decision to terminate, amend or replace the benefit plan may be due to changes in federal law or state laws governing benefits, the requirements of the Internal Revenue Service or ERISA, or for any other reason. This may include the elimination of or decreases in benefits, changes in plan networks, and increases in your required contributions for coverage.

Plan carriers

Claims under the plans for the benefits provided therein are administered by the following plan carriers:

PLAN	PLAN CARRIER	CONTACT INFORMATION
Non-HMO Medical Plans ***Self-Insured***	Aetna	P.O. Box 14079 Lexington, KY 40512-4079 866-238-1128
	Blue Cross Blue Shield of NC	P.O. Box 35 Durham, NC 27702 877-275-9787 For appeals: Appeals Department P.O. Box 30055 Durham, NC 27702 For mental health/substance abuse (first level appeals only): Magellan Behavior Health Appeals Department P.O. Box 1691 Alpharetta, GA 30009
	Cigna HealthCare	P.O. Box 182223 Chattanooga, TN 37422-7223 800-244-6224
	UnitedHealthcare	P.O. Box 740800 Atlanta, GA 30374 877-571-9862
	Cigna U.S. Virgin Islands PPO Plan	P.O. Box 182223 Chattanooga, TN 37422-7223 800-244-6224
Health Fund Reimbursement Account	Aetna Health Fund Consumer Choice Plan	P.O. Box 14089 Lexington, KY 40512-4089 877-204-0431
Prescription Drug Plan ***Self-Insured***	CVS Caremark™ (Value Choice, Network Choice, Out-of-Area Plans)	Attn: Claims Department P.O. Box 52136 Phoenix, AZ 85072-2136 855-656-0360 Mail Order: P.O. Box 94467 Palatine, IL 60094-4467 855-656-0360
	Aetna Pharmacy Management (Consumer Choice PPO Plan)	Box 36185 Minneapolis, MN 55435-6185 800-238-6279 Mail Order: P.O. Box 417019 Kansas City, MO 64179-9892 866-612-3862
Physician Services – Phone or Online Consultation	Teladoc	4100 Spring Valley, Suite 515 Dallas, TX 75244 800-835-2362

PLAN	PLAN CARRIER	CONTACT INFORMATION
HMO Medical Plans	Refer to the appropriate HMO booklets for addresses and telephone numbers. The HMO must provide you or your beneficiary upon request, written materials concerning (1) the nature of services provided to members, (2) conditions pertaining to eligibility to receive such services (other than general conditions pertaining to eligibility for participation in the plan) and circumstances under which services may be denied and (3) the procedures to be followed in obtaining such services, and the procedures available for the review of claims for services which are denied in whole or in part.	
Wellness Program	INTERVENT ActiveHealth Management HealthAdvocate	340 Eisenhower Dr. Building 1400, Suite 17 Savannah, GA 31406 866-334-2137 1333 Broadway, 4th Floor New York, NY 10018 877-489-0940 3043 Walton Rd., Suite 150 Plymouth Meeting, PA 19462 866-799-2728
Dental Plan ***Self-Insured***	Cigna CORE Network PPO Plan	Cigna HealthCare P.O. Box 188037 Chattanooga, TN 37422-8037 800-244-6224
Dental Plan ***Fully-Insured***	Cigna Managed Care Dental	Cigna Managed Care Dental P.O. Box 188045 Chattanooga, TN 37422-8045 800-244-6224
Vision Plan ***Self-Insured***	Vision Service Plan	P.O. Box 997105 Sacramento, CA 95899-7105 800-877-7195
Associate (Basic and Supplemental) and Dependent Life Insurance	Minnesota Life Insurance Company	400 Robert Street St. Paul, MN 55101 888-658-0193
Disability Income Protection (DIP Plan and Long-Term Disability (LTD) Plan	UNUM Life Insurance Company of America, Inc.	Attn: LTD Chattanooga Customer Care Center P.O. Box 12030 Chattanooga, TN 37401-3030 800-633-7479
Accidental Death and Dismemberment (AD&D) Insurance	Minnesota Life Insurance Company	400 Robert Street St. Paul, MN 55101 888-658-0193
Flexible Spending Accounts (Health Care/Dependent Care)	WageWorks	1100 Park Place, 4th Floor San Mateo, CA 94403 877-924-3967
Commuter Benefits Program	WageWorks	1100 Park Place, 4th Floor San Mateo, CA 94403 877-924-3967

Appeals of denied claims

Filing claims

For information on filing claims, see the specific benefit section, for example “Medical Coverage” or “Dental Coverage,” or call the Benefits Department at 800-341-7763, option 1.

Denied claims

Insured benefits

The insurers through whom certain benefits are provided shall make all determinations as to the right of any claimant to an insured benefit under the Benefit Plan, in accordance with their procedures and applicable law. Refer to the insurers benefit booklets and/or insurance contracts for additional information.

Self-insured and non-insured benefits

The plan administrator, or any third party administrator to whom the plan administrator has delegated authority, shall make all determinations as to the right of any claimant to a non-insured benefit or self-insured benefit in accordance with one of the following three procedures: benefits provided under a group health plan, benefits provided under a disability plan and all other benefits.

Self-insured and non-insured health benefits

Claims for health benefits

Claims for self-insured and non-insured health benefits under the Benefit Plan must be submitted on the appropriate forms, available from the Benefits Department, to the representatives designated on the forms and hereinafter referred to as the plan carrier. Please note that the forms will specify any additional information that must be provided with a claim for benefits.

Claims for health benefits are categorized as either emergency care or non-emergency care. The claims procedures for determining eligibility for health benefits differ for each.

Emergency care health benefit claims

An emergency care claim is any claim for medical care or treatment which, if not addressed expeditiously, (i) could seriously jeopardize your life or health or your ability to regain maximum function, or (ii) in the opinion of your treating physician, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

In the case of a claim involving emergency care, the plan carrier will respond within 72 hours of receipt of the claim. If the claim data is insufficient, the plan carrier will notify you within 24 hours and request the specific information necessary to complete the processing of the claim. You will then have at least 48 hours to provide this required information. Once any additional information is provided, the plan carrier will make its determination within 48 hours. If the information is not provided, the plan carrier will make its determination within 48 hours after the end of the period that you had to submit the information.

If you fail to follow a plan’s procedures for filing an emergency care claim, you will be notified within 24 hours. This notice may be oral unless written notification is requested.

If a claim is wholly or partially denied, the plan carrier will notify you, in writing, of its determination. This notification may be oral, but written notification will subsequently be provided within three days.

The denial notification will:

- State the specific reason or reasons for the denial.
- Refer to the pertinent plan provisions and include any internal rule, guideline, protocol or other similar criterion, upon which the denial is based.
- Describe any additional information needed to support the claim and explain why the additional information is necessary.
- Describe the plan’s expedited appeal procedures, including its time limits.

When the plan intends to terminate or reduce an ongoing course of treatment or care, the plan carrier will provide you with notice of this determination in time for you to appeal and to receive a determination on the appeal before the termination or reduction takes effect. Also, if you seek to extend a course of treatment beyond what has been previously approved in a case involving emergency care, the plan carrier will resolve the claim and notify you of its determination within 24 hours.

Appeals of emergency care health benefit claim denials

You or your authorized representative have 180 days after receipt of a claim denial to appeal the denial to the plan carrier. The plan carrier will review the claim, with no deference given to the initial determination.

You are allowed to review all plan documents and other papers that affect the claim and are allowed to submit issues and comments and argue against the denial in writing. All communications between the plan carrier and you must use an expeditious method, such as telephone or fax.

The plan carrier will make a determination on an emergency care appeal within 72 hours after receiving the appeal. If the plan carrier requires additional information from you to make its determination, the plan carrier will notify you within 24 hours and request the specific information necessary to complete the review of the appeal.

You will then have at least 48 hours to provide this required information. Once any additional information is provided, the plan carrier will make its determination within 48 hours. If the information is not provided, the plan carrier will make its determination within 48 hours after the end of the period that you had to submit the information.

The decision on appeal will be written in clear and understandable language and will:

- State the specific reason or reasons for the denial and
- Refer to the pertinent plan provisions and include any internal rule, guideline, protocol or other similar criterion, upon which the denial is based.

All interpretations, determinations and decisions of the reviewing entity with respect to any claim will be based upon the plan documents and will be deemed final and conclusive. If the appeal is denied, in whole or in part, you have a right to file suit in federal court.

Non-emergency care health benefit claims

A non-emergency care claim is any claim that is not an emergency care claim. A non-emergency care claim is either a pre-service claim (any claim for medical care or treatment for which you must obtain approval in advance of obtaining the medical care or treatment sought) or a post-service claim (any claim for medical care or treatment that is not a pre-service claim) and the claims process differs for each.

Pre-service claims

In the case of pre-service claims, the plan carrier will notify you of its determination within 15 days after receiving your claim. If an extension of time for processing is required due to matters beyond the control of the plan carrier, written notice will be given to you before the end of this 15-day period. The extension notice will indicate the reason for the extension of time and the date by which the plan carrier expects to render its final decision. In no event can the extension period exceed a period of 15 days from the end of the initial 15-day period.

If additional information is requested of you, you will be given 45 days from the notice date to provide the specific information. During this time, the 15-day time limit for issuing a decision is suspended until the earlier of the date you provide that information to the plan carrier, or the expiration of the 45-day period within which you are required to furnish the information. If you do not furnish the requested information by the end of the 45-day period, the plan carrier will proceed with its determination based on the documentation provided up to that date.

If you fail to follow a plan's procedures for filing a pre-service claim, you will be notified within five days after the failure. This notice may be oral unless written notification is requested.

If a claim is wholly or partially denied, the plan carrier will notify you, in writing, of its determination. The denial will:

- State the specific reasons(s) for the denial.
- Refer to the pertinent plan provision on which the denial is based.
- Describe any additional information needed to support the claim.
- Explain why the additional information is necessary.
- Describe the plan's appeal procedures, including its time limits.
- Include the following statement: "You may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office.

Where a plan intends to terminate or reduce an ongoing course of treatment or care, the plan carrier will provide you with notice of this determination in time for you to appeal and to receive a determination on the appeal before the termination or reduction takes effect.

Extended care decisions (concurrent reviews)

If the medical, dental or vision plan has approved an ongoing course of treatment to be provided over a period of time or a number of treatments, any request to extend the course of treatment, if for urgent care, will be decided as soon as possible. If the request is made at least 24 hours before the end of the prescribed course of treatment, the plan carrier will notify you within 24 hours after your request (or within 48 hours for Blue Cross Blue Shield of NC due to relevant North Carolina law). If your request does not involve urgent care, your claim will be treated as a regular pre-service claim.

Any reduction or termination by the plan of a course of treatment will be treated as an adverse benefit determination. If a claim concerning an extended care decision is denied, you have up to 180 days to file an appeal.

Post-service claims

For post-service claims, the plan carrier will provide you with notice of its determination within 30 days after receiving your claim. If an extension of time for processing is required due to matters beyond the control of the plan carrier, written notice will be given to you before the end of this 30-day period. The extension notice will indicate the reason for the extension of time and the date by which the plan carrier expects to render its final decision. In no event can the extension period exceed a period of 15 days from the end of the initial 30-day period.

If additional information is requested, you will be given 45 days from the notice date to provide the specific information (90 days for Blue Cross Blue Shield of NC). During this time, the 30-day time limit for issuing a decision is suspended until the earlier of the date you provide that information to the plan carrier, or the expiration of the time period within which you are required to furnish that information.

If you do not furnish the requested information by the end of the time period, the plan carrier will proceed with its determination based on the documentation provided up to that date.

If a claim is wholly or partially denied, the plan carrier will notify you, in writing, of its determination. The denial notification will:

- State the specific reason(s) for the denial.
- Refer to the pertinent plan provisions on which the denial is based.
- Describe any additional information needed to support the claim.
- Explain why the additional information is necessary.
- Describe the plan's appeal procedures, including its time limits.
- Include the following statement: "You may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office.

Where a plan intends to terminate or reduce an ongoing course of treatment or care, the plan carrier will provide you with notice of determination in time for you to appeal and to receive a determination on the appeal before the termination or reduction takes effect.

Appeals of non-emergency care health benefit claim denials

First level appeals

The plan carrier is responsible for reviewing first level appeals. You or your authorized representative have 180 days after receipt of a claim denial to appeal the denial to the plan carrier. Although you are not allowed to attend a first level appeal, you may provide and/or present written evidence and testimony.

The review of the first level appeal will not be based on the initial benefit determination. Someone other than an individual involved in the initial benefit determination or a subordinate of such individual will be appointed to decide the first level appeal.

If your claim was denied based on a medical judgment (such as whether a service or supply is experimental or medically necessary), the plan carrier will consult with a health professional with appropriate training and experience. The healthcare professional consulted for the first level appeal will not be the professional (if any) consulted during the prior determination or a subordinate of such professional. The plan carrier also will identify medical or vocational experts whose advice was obtained on behalf of the plan in connection with the adverse benefit determination being appealed, even if the advice was not relied upon in making the benefit determination.

You may receive, in advance, any new information that the plan carrier may use in making a decision or any new or additional rationale so that you have an opportunity to respond prior to the notice of benefit determination.

The plan carrier will provide you written or electronic notification of the determination, as follows:

- For first level appeals of pre-service claims, not later than 15 days after receipt of your request for a first level appeal (30 days for Blue Cross Blue Shield of NC).
- For first level appeals of post-service claims, not later than 30 days after receipt of your request for a first level appeal. The plan carrier may extend that review process by 60 days if it is unable to complete the review in the first 60 days because of extenuating circumstances. You will be notified of any delay before the end of the first 60-day review period.

If your first level appeal is denied, the notification from the plan carrier will include:

- The specific reasons for the denial.
- Reference to the specific plan provisions on which the determination is based.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to or copies of all documents, records, or other information relevant to the claim.
- A description of any voluntary appeal procedures offered by the plan and statement of your right to bring a civil action under Section 502(a) of ERISA.
- A statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse determination, or a statement that such information will be provided free of charge upon request.
- If the denial on appeal is based on a medical necessity, experimental treatment, or similar exclusion, an explanation of the scientific or clinical judgment for the adverse benefit determination, or a statement that such explanation will be provided free of charge upon request.
- Instructions on how to request an external, independent review from an independent review organization upon completion of this review if you are not satisfied with the decision (available for noncertifications only).

The first level of appeal is the only level you must complete before you can pursue your appeal in an action in federal court.

Second level appeals

If you are not satisfied with the determination of the plan carrier on your first level appeal, you can submit a second level appeal to the plan administrator. All second level appeals except those involving urgent care should be submitted in writing within 180 days after you receive the notice of determination on your first level appeal.

(Note: Second level appeals are not allowed for benefits or services that are clearly excluded by this booklet, or for quality of care complaints.)

Like first level appeals, the review of a second level appeal will not be based on prior determinations and will be conducted by someone other than individuals involved in the prior determinations or subordinates of such individuals. Also, if the first level appeal was denied based on a medical judgment, the plan administrator will consult a health professional other than the professional consulted for the first level appeal.

The plan administrator will provide you written or electronic notification of the determination, as follows:

- For appeals of pre-service claims, not later than 15 days after receipt of your request for a second level appeal (45 days for Blue Cross Blue Shield of NC).
- For second level appeals of post-service medical or dental claims, not later than 30 days after receipt of your request for a second level appeal (45 days for Blue Cross Blue Shield of NC).

If more time or information is needed to make the determination, the plan administrator will notify you in writing to request an extension of up to 15 days and to specify any additional information needed to complete the review.

You will be notified in writing of a decision within five business days after the determination is made, and within the review timeframes above if the requested coverage is denied.

Denial notifications of second level appeals will include the information listed above for first level appeal denials.

You may also receive assistance from the Employee Benefits Security Administration at 866-444-3272.

External review

If you choose, you may obtain an external review of a denied claim under the medical plan options provided:

- You have exhausted the appeal process for denied claims, as outlined above and you have received a final denial;
- The final denial was based upon a lack of medical necessity, or the experimental or investigational nature of the proposed service or treatment; and
- The cost of the service or treatment at issue exceeds $500.

An external review is a review by an independent physician with appropriate expertise in the area at issue. The review is of claim denials based upon lack of medical necessity, or the experimental or investigational nature of a proposed service or treatment. The external review process is completely voluntary; you need not complete an external review process before pursuing other remedies allowed by law.

If you meet the eligibility requirements, you receive written notice of your right to request an external review when the final decision on your internal appeal is rendered. Either you or an individual acting on your behalf must submit an *External Review Request Form* to the plan carrier. You also must submit a copy of your coverage denial letter and any other information you wish to be reviewed in support of your request. Your written request for an external review must be submitted to the plan carrier within 60 calendar days after you receive the final decision on your internal appeal (four months for Blue Cross Blue Shield of NC).

The plan carrier contacts the external review organization that will conduct your external review. The organization then will select an independent physician with appropriate expertise in the area at issue to perform the external review. In rendering a decision, the external reviewer may consider any appropriate credible information submitted by you with the *External Review Request Form*, and must follow Compass Group's benefit plan contractual documents and plan criteria governing the benefits.

In general, the external review organization notifies you of the decision within 30 calendar days of the plan carrier's receipt of a properly completed *External Review Request Form* (45 days for Blue Cross Blue Shield of NC). The notice states whether the prior determination was upheld or reversed, and briefly explain the basis for the determination. The decision of the external reviewer is binding on the plan, except where the plan carrier or the plan can show reviewer conflict of interest, bias or fraud. In such cases, you are notified, and the matter is promptly resubmitted for consideration by a different reviewer.

You are responsible for the cost of compiling and sending information that you wish to be reviewed by the external review organization to the plan carrier. The plan carrier pays the cost for sending this information to the external review organization. The plan carrier also pays the professional fee for the external review.

For an individual to act on your behalf in connection with an external review, you need to specifically consent to the representation by signing the appropriate line on the *External Review Request Form*.

To obtain more information about the external review process, call your plan carrier's member service number on the back of your ID card.

Expedited external review

An expedited review is available when your treating physician certifies on a separate *Request for Expedited External Review Form* (or by telephone with prompt written follow-up) the clinical urgency of the situation. "Clinical urgency" means that a delay (waiting the full 30 calendar day period, or 45 calendar day period for Blue Cross Blue Shield of NC) in receiving the service or treatment would jeopardize your health. Expedited reviews are decided within five calendar days of receipt of the request. In the case of expedited reviews, you are initially notified of the determination by telephone, followed immediately by a written notice delivered by expedited mail or fax.

Non-insured disability benefits

For a description on applying for disability benefits, see page 98 for DIP and page 100 for LTD.

Benefit determination for DIP and LTD claims

Unum Life for DIP and LTD claims ("DIP and LTD insurance carrier") will notify you in writing regarding its initial determination within a reasonable time — not to exceed 45 days from the date that it receives your disability claim.

Before the expiration of the 45-day time period, the DIP and LTD insurance carrier will, among other things:

- Assign the claim to a disability claims professional.
- Verify whether the associate is covered under the plan.
- Assess whether the associate meets the plan's eligibility requirements.
- Investigate and gather facts regarding the disability claim.
- Evaluate medical and vocational reports.
- Make a determination regarding the claim for disability benefits.

The DIP and LTD insurance carrier may request in writing two written 30-day extensions if it determines that they are necessary due to matters beyond its control. For example, the DIP and LTD insurance carrier may request an extension if you, your employer or your physician fails to submit requested information or documents necessary to process your claim.

You will receive a 30-day extension notice prior to the expiration of the initial 45-day period. This extension stops

or suspends the initial 45-day time period and explains in writing what the unresolved issues are that prevent a determination regarding your claim for disability benefits. In addition, this notice may request that you provide specified information or documents to resolve those issues so that the DIP and LTD insurance carrier can make a determination regarding your claim for disability benefits.

ERISA affords you 45 days to provide the specified information or documentation necessary to resolve the issues raised in the 30-day extension notice.

The 30-day extension notice will inform you that the DIP and LTD insurance carrier expects to notify you of a determination within 30 days from the date it receives the specified information, documentation or the expiration of the 45-day time period to submit the specified information or documentation.

If you do not provide the required information or documents within the 30-day extension period, the DIP and LTD insurance carrier may make a determination regarding the claim without the requested information or documentation. You will receive a determination within the time remaining in the initial 45-day period starting from the date the claims process was tolled (stopped, suspended).

During the claims process, you must be under the continuous care of a licensed physician who may be required periodically to certify that you continue to be disabled. The DIP and LTD insurance carrier also reserves the right to request that you undergo an examination by an independent physician, selected by the DIP and LTD insurance carrier, to verify your disability.

The DIP and LTD insurance carrier will contact you if it determines that you are entitled to disability benefits.

If the DIP and LTD insurance carrier makes an adverse determination, denying, reducing or terminating disability benefits, you will be notified in writing.

The written notification will contain the following:

- The specific reason(s) for the denial or adverse determination.
- Reference to the specific plan provision(s) on which the adverse determination is based.
- A description of any additional information or material needed from you to complete the claim and an explanation of why such additional information or material is necessary.
- Identification of the medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse determination, without regard to whether the advice was relied upon in the making of the adverse determination.
- A description of the plan's review or appeal procedure, including time limits, plus a statement of the claimant's rights to bring a civil action under ERISA with respect to any adverse determination after an appeal.
- A statement and a copy of the internal rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination.
- A statement if the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit. The statement will explain how your medical circumstances, the scientific or clinical judgment applied to the terms of the plan resulted in an adverse determination.

Appeal or review of adverse determination

Once the appeal is received, the DIP and LTD insurance carrier will conduct a full and fair review of your claim.

The DIP and LTD insurance carrier's Disability Claim Appeals Committee will review your claim. The Committee does not consist of claims professionals that either decided or participated in the initial adverse determination.

There is no fee to file a written request for an appeal.

You must submit your written appeal request within 180 days from the date you receive the adverse determination. The written adverse determination notification will specify to whom and where to mail your written appeal request.

Written appeals must include the reasons why the adverse determination was wrong and include any documents or comments that support reversal of the initial adverse determination.

Once an appeal is received, the Committee will review and make a determination regarding the merits of the appeal within a reasonable time — not to exceed 45 days.

The Committee may request in writing one 45-day extension if it determines that it is necessary to extend the time to make a determination due to matters beyond its control. For example, the Committee may seek to verify any written comments, documents or other information you submitted that were not considered during the initial claims process.

You will receive a 45-day extension notice prior to the expiration of the initial appeal period. This extension stops or suspends the initial period and will explain in writing the special circumstances requiring the extension. In addition,

the 45-day extension notice will specify what is required in order for the Committee to make a determination.

The Committee will notify you in writing of its determination prior to the expiration of the 45-day extension period.

During the appeal period, you may request access to and copies of information relevant to the claim without charge. Information relevant to the claim includes documents submitted, considered, generated and relied upon in the course of making an adverse determination. For example, you may request access to or copies of your claim form, employer's statement, attending physician statement, independent medical or vocational examination reports.

Prior to the date the Committee convenes to review your appeal, you have the opportunity to submit written comments, documents and other information related to the claim. The Committee will consider the written comments, documents or other information you submit regardless of whether or not it was considered during the initial determination.

You will receive written notification if the Committee upholds the adverse determination. The written notification will include the following:

- The specific reason(s) for the adverse determination.
- Reference to the specific plan provision(s) on which the benefit determination is based.
- A statement and a copy of the internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination.
- Identification of the medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse determination, without regard to whether the advice was relied upon in making the benefit determination.
- A statement of the claimant's rights to bring a federal suit under ERISA with respect to any adverse determination after an appeal; and
- A statement if the adverse determination is based on a medical necessity, experimental treatment or similar exclusion or limit. The statement will explain how your medical circumstances, the scientific or clinical judgment and the terms of the plan resulted in an adverse determination. This statement will be provided free of charge upon request if the adverse determination was based on medical necessity, experimental treatment or similar exclusion or treatment.

Judicial review of adverse determinations

All interpretations, determinations and decisions of the insurance carrier with respect to any claim will be its sole decision based upon plan documents and will be deemed final and conclusive. If you disagree with the decision upholding an adverse determination, you may file a civil suit in federal district court where the plan is administered or where you live.

Other important claims information

ERISA requires the DIP and LTD insurance carrier to follow all of its rules, procedures, guidelines and protocols while it processes your disability claim. You may file a civil suit in federal district court where the plan is administered or where you live if the DIP and LTD insurance carrier fails to follow all of its rules, procedures, guidelines and protocols while it processes your disability claim.

The DIP and LTD insurance carrier has the right to utilize any reasonable method, such as a debt collection agency, or file a civil action to recover any amount overpaid. An overpayment may occur by fraud or any error the DIP and LTD insurance carrier makes in processing a claim.

An overpayment may also occur if you receive a deductible source of income while receiving disability benefits. A deductible source of income would be the following:

- The amount that you would receive under:
  - A Workers' Compensation law.
  - An occupational disease law.
  - Any other acts or laws with similar intent.
- The amount that you receive or are entitled to receive as disability income payments under any:
  - State compulsory benefit act or law.
  - Other group insurance plan.
  - Individual disability insurance contract sponsored by your employer, the Policyholder or an associated company.
  - Automobile liability insurance policy.
  - Governmental retirement system as a result of your job with your employer.
  - Union contract or collective bargaining agreement authorized under the Labor Management Relations Act.
- The amount that you, your spouse and children receive or are entitled to receive as disability payments or retirement payments under:
  - The United States Social Security Act.
  - The Canada Pension Plan.
  - The Quebec Pension Plan.
  - Any similar pension plan or act.

- The amount that you:
  - Received as disability payments under your employer's retirement plan.
  - Voluntarily elect to receive as retirement payments under your employer's retirement plan.
  - Are eligible to receive as retirement payments when you reach the later of age 62 or normal retirement, as defined in your employer's retirement plan.
- The amount you receive as a result of any action under the Jones Act.
- The amount you receive under the mandatory portion of any "no fault" motor vehicle plan.

Any inconsistency between the claims procedure outlined herein and the Unum Life Certificate of Coverage will be governed by the Certificate of Coverage. You may obtain a copy of the Certificate of Coverage by contacting the Compass Group Benefits Department.

All other self-insured and non-insured benefits

Claims for benefits

Claims for self-insured and non-insured benefits that are not health or disability benefits under the Benefit Plan must be submitted on the appropriate forms, available from the Benefits Department, to the representatives designated on the forms and hereinafter referred to as the "plan carrier." Note that the forms will specify any additional information that must be provided with a claim for benefits.

The plan carrier will process the claim within 90 days after the claim is filed. If an extension of time for processing is required due to special circumstances, written notice will be given to you before the end of the initial 90-day period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the plan carrier expects to render its final decision. In no event can the extension period exceed a period of 90 days from the end of the initial 90-day period.

If additional information is requested of you, you will be given 45 days from the notice date to provide the specific information. During this time, the 90-day time limit for issuing a decision is suspended until the earlier of the date you provide that information to the plan carrier, or the expiration of the 45-day period within which you are required to furnish that information. If you do not furnish the requested information by the end of the 45-day period, the plan carrier will proceed with its determination based on the documentation provided up to that date.

If a claim is wholly or partially denied, the plan carrier will notify you within 90 days following receipt of the claim, or 180 days in the case of an extension for special circumstances. The denial notification will:

- State the specific reason or reasons for the denial.
- Specifically refer to the pertinent plan provisions on which the denial is based.
- Describe any additional material or information necessary to support the claim.
- Explain why the additional information or material is necessary.
- Describe the plan's appeal procedures, including its time limits.

If notice of the denial of a claim is not furnished within the 90/180-day period, the claim is considered denied and you will be permitted to proceed to the appeals stage.

Appeals procedure

You or your authorized representative have 60 days (180 days for any disability claims) after receipt of a claim denial to appeal the denial to the plan carrier and to receive a full and fair review of the claim. As part of the review, you are allowed to review all plan documents and other papers that affect the claim and are allowed to submit issues and comments and argue against the denial in writing.

The plan carrier will conduct the review and decide the appeal within 60 days after the request for review is made. The plan carrier may ask you or Compass Group to submit such additional facts, documents, or other evidence as it deems necessary or advisable in making its review. During the review of your denied claim by the plan carrier, you may, upon written request, be permitted to review documents or materials that pertain to your claim. You also may submit written issues and comments that pertain to your claim.

If special circumstances require an extension of time for processing such as the need to hold a hearing if the plan procedure provides for such a hearing, written notice will be given to you before the end of the initial 60-day period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the plan carrier expects to render its final decision. In no event can the extension period exceed a period of 60 days from the end of the 60-day period.

The decision will be written in clear and understandable language and will include specific reasons for the decision as well as specific references to the pertinent plan provisions on which the decision is based. If the decision is not made within the time limits specified above, the appeal will be considered denied. All interpretations, determinations and decisions of the reviewing entity with respect to any claim will be its sole decision based upon the plan documents and will be deemed final and conclusive. If your appeal is denied, whole or in part, you have the right to file suit in a state or federal court.

Compliance with regulations. It is intended that the claims procedures of all plans under the Benefit Plan be administered in accordance with the claims procedure regulations of the Department of Labor.

Other important claims information. If you fail to file a request for review in accordance with the claims procedures as set forth above, you will have no right to review or to bring an action in any court. The denial of your claim will become final and binding on all persons for all purposes except as otherwise provided by ERISA.

Your rights under ERISA

As a participant in the plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants in the plans are entitled to the following:

Receive information about your plans and benefits

You may examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plans, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the plans with the U.S. Department of Labor (DOL) and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

Upon written request to the plan administrator, you may obtain copies of documents governing the operation of the plans, including insurance contracts and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The plan administrator may make a reasonable charge for the copies.

In addition, you will receive a summary of the plan's annual financial reports. The plan administrator is required by law to furnish each participant with a copy of the summary annual reports.

Continue group health plan coverage

If there is a loss of coverage under the group health plans as a result of a qualifying event, you may continue certain healthcare coverage for yourself, spouse or dependents under COBRA. You or your dependents may have to pay for such coverage. Review this summary and the documents governing the plans on the rules governing your COBRA continuation coverage rights. See *Continuing Your Coverage Under COBRA* on page 19, for more information on COBRA.

Prudent actions by plan fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefits plan. The people who operate your plans, called "fiduciaries" of the plans, have a duty to do so prudently and in the interest of you and other participants and beneficiaries in the plans. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce your rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plans and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in federal court. In addition, if you disagree with the plans' decisions or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plans' money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court. The court will decide who should pay court costs and legal fees.

If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with your questions

If you have any questions about your plans, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor (DOL), listed in your telephone directory or the Division of Technical Assistance and Inquiries, EBSA, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the EBSA publications hotline at 866-444-EBSA (3272).

Other rules and regulations

Uniformed Services Employment and Re-Employment Rights Act Of 1994 (USERRA)

The Benefit Plan is intended to comply at all times with the regulations of the Uniformed Services Employment and Re-employment Rights Act of 1994, (USERRA), for associates going into or returning from military service. Associates and dependents that lose healthcare coverage due to the associate's military leave of absence under USERRA may elect to continue coverage for up to 24 months. Any individual who elects to continue such coverage will be required to make the same premium payments as a COBRA participant.

For additional information concerning the USERRA, including your rights and responsibilities under USERRA, contact the Benefits Department at 800-341-7763.

No assignment

Except as may otherwise be specifically provided in plan documents, benefit arrangements, insurance contracts or applicable law, a participant's rights, interests or benefits under the plans or the benefit arrangements shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, prior to being received by the persons entitled thereto under the terms of the plans or benefit arrangements and any such attempt shall be void.

Subrogation and reimbursement

Expenses for which a third party may be responsible

This plan does not cover:

1. Expenses incurred by you or your dependent (hereinafter individually and collectively referred to as a "participant,") for which another party may be responsible as a result of having caused or contributed to an injury or sickness.
2. Expenses incurred by a participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.

Subrogation/right of reimbursement

If a participant incurs a covered expense for which, in the opinion of the plan or its claim administrator, another party may be responsible or for which the participant may receive payment as described above:

1. **Subrogation:** The plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a participant may have against such party and shall automatically have a lien upon the proceeds of any recovery by a participant from such party to the extent of any benefits paid under the plan. A participant or his/her representative shall execute such documents as may be required to secure the plan's subrogation rights.
2. **Right of Reimbursement:** The plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the plan.

Lien of the plan

By accepting benefits under this plan, a participant:

- Grants a lien and assigns to the plan an amount equal to the benefits paid under the plan against any recovery made by or on behalf of the participant which is binding on any attorney or other party who represents the participant whether or not an agent of the participant or of any insurance company or other financially responsible party against whom a participant may have a claim provided said attorney, insurance carrier or other party has been notified by the plan or its agents;
- Agrees that this lien shall constitute a charge against the proceeds of any recovery and the plan shall be entitled to assert a security interest thereon;
- Agrees to hold the proceeds of any recovery in trust for the benefit of the plan to the extent of any payment made by the plan.

Additional terms

- No adult participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor dependent of said adult participant without the prior express written consent of the plan. The plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan's right of recovery shall be a prior lien against any proceeds recovered by the participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine," "Rimes Doctrine," or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan's recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called "Fund Doctrine," "Common Fund Doctrine," or "Attorney's Fund Doctrine."
- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any participant, whether under comparative negligence or otherwise.
- In the event that a participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

Choice of medical provider

If your plan generally requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in the plan carrier's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Employer or, if you are a current member, your plan carrier contact number on the back of your ID card.

If your plan allows for the designation of a primary care provider for a child, you may designate a pediatrician as the primary care provider.

If your plan provides coverage for obstetric or gynecological care and requires the designation of a primary care provider then you do not need prior authorization from your plan carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Employer or, if you are a current member, your plan carrier contact number on the back of your ID card.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact your plan carrier.

Notice regarding Women's Health and Cancer Rights Act

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

1. All stages of reconstruction of the breast on which a mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.

For more information, you can visit this U.S. Department of Health and Human Services website, http://www.cms.gov/home/regsguidance.asp, and this U.S. Department of Labor website, http://www.dol.gov/ebsa/consumer_info_health.html.

Genetic Information

Title II of the Genetic Information Nondiscrimination Act of 2008 protects applicants and employees from discrimination based on genetic information in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment. GINA also restricts employers' acquisition of genetic information and strictly limits disclosure of genetic information. Genetic information includes information about genetic tests of applicants, employees, or their family members; the manifestation of diseases or disorders in family members (family medical history); and requests for or receipt of genetic services by applicants, employees, or their family members.

It is the intention of the Employee Benefit Plan of the Compass Group USA, Inc., to comply with Title II of GINA. If you have any questions with regard to GINA, please contact the Benefits Department at 800-341-7763.