American Home Health Corp.

[2010 Employee Benefit Package]

Benefits Included:

Medical - ***BlueCross BlueShield of Illinois***

Dental - ***Humana/CompBenefits***

Long-term Disability - ***Prudential***

Voluntary Life & AD&D - ***Prudential***

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American Home Health Corp.

Medical Program

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New Medical Program (Effective: 1/1/10 - 12/31/10)

Carrier	BlueCross BlueShield of Illinois				
Plan Type	**HMO**	**PPO (HSA)[t]**		**PPO (Copay)**	
Network Name	**Blue Advantage**	**PPO (Participating Provider Option)**		**PPO (Participating Provider Option)**	
Plan Name	**HMO Plan B164**	**PPO BlueEdge HSA BPEC3805**		**PPO Plan 93434**	
Calendar Year Deductible [CYD] (applies wherever coinsurance indicated)	**In-Network**	**In-Network**	**Non-Network**	**In-Network**	**Non-Network**
Individual	None	$2,500	$5,000	$1,500	$3,000
Family	None	$5,000 (Aggregate)*	$10,000 (Aggregate)*	3 Satisfied Individual Deductibles	
Coinsurance Level					
Per Individual	100%	80%	60%	80%	60%
Out-of-Pocket Coinsurance Limit (excludes deductibles, Rx Copays and PPO Office Visit copays)					
Individual	$1,500 (Copay Limit)	$2,500	$5,000	$2,000	$4,000
Family	$3,000 (Copay Limit)	$5,000 (Aggregate)*	$10,000 (Aggregate)*	$6,000	$12,000
Reimbursement Method					
In-Network & Non-Network Claims	Capitation Fee Schedule	Neg. Discounts	SMA	Neg. Discounts	SMA
Physician Services					
Office Visits	$30 Copay	**Ded., then 80%**	**Ded., then 60%**	$30 Copay	**Ded., then 60%**
Specialty Office Visits	$50 Copay	**Ded., then 80%**	**Ded., then 60%**	$50 Copay	**Ded., then 60%**
Routine Eye Exams	$30 Copay	*Discounts Only*	Not Covered	*Discounts Only*	Not Covered
Diag. Lab & X-Rays (Billed by NAP)	100%	**Ded., then 80%**	**Ded., then 60%**	100% *(after copay)*	**Ded., then 60%**
Well Care - Adult	$30 Copay	100% (**Ded. Waived**)	**Ded., then 60%**	$30 Copay	**Ded., then 60%**
Well Care - Children	$30 Copay	100% (**Ded. Waived**)	**Ded., then 60%**	$30 Copay	**Ded., then 60%**
Hospital Services					
In-Patient Hospital Ded./Copay	100%	**Ded., then 80%**	$300/admission	**Ded., then 80%**	$300/admission
Out-Patient Surgery Ded./Copay	100%	**Ded., then 80%**	**Ded., then 60%**	**Ded., then 80%**	**Ded., then 60%**
Out-Patient	100%	**Ded., then 80%**	**Ded., then 60%**	**Ded., then 80%**	**Ded., then 60%**
In-Patient	100%	**Ded., then 80%**	**Ded., then 60%**	**Ded., then 80%**	**Ded., then 60%**
Out-Patient Services					
*** Chiropractic/Spinal Manipulation	$50 Copay	**Ded., then 80%**	**Ded., then 60%**	**Ded., then 80%****	**Ded., then 60%****
Diagnostic Lab and X-Rays	100%	**Ded., then 80%**	**Ded., then 60%**	$30 or Ded/Coins.***	**Ded., then 60%**
*** Physical Therapy	100%	**Ded., then 80%**	**Ded., then 60%**	**Ded., then 80%****	**Ded., then 60%****
Emergency Room Facility	$150 Copay, then 100%	**Deductible, then 90%**		$150 Copay, then 100%	
Prescriptions Drugs (Participating Providers)					
Rx Deductible	**None**	**Calendar Year Deductible Applies**		**None**	
Retail (30-day Supply)	$15 Generic 35% Formulary Brand [z] 50% Non-Formulary Brand [z]	**Deductible, then 80%**		$15 Generic 35% Formulary Brand [z] 50% Non-Formulary Brand [z]	
Mail Order (90-day Supply)	$30 Generic 35% Formulary Brand [z] 50% Non-Formulary Brand [z]	**Deductible, then 80%**		$30 Generic 35% Formulary Brand [z] 50% Non-Formulary Brand [z]	
Lifetime Maximum					
Per Individual	Unlimited	$5,000,000		$5,000,000	

[t] ***An HSA may be established in conjunction with this PPO plan***

[z] ***Minimum cost per prescription is $15; maximum cost per prescription is $150 (double for Mail Order)***

****Aggregate means that 1 person in your covered family could be responsible for paying the full family Deductible/Out-of-Pocket Coinsurance Limit***

*****PPO Out-of-pocket costs incurred for these services do not apply towards Coinsurance Limit***

******If billed by Freestanding Facility: 100% after Copay (1 Copay per day maximum). If billed by Hospital: Subject to Deductible/Out-of-Pocket Coinsurance Limit***

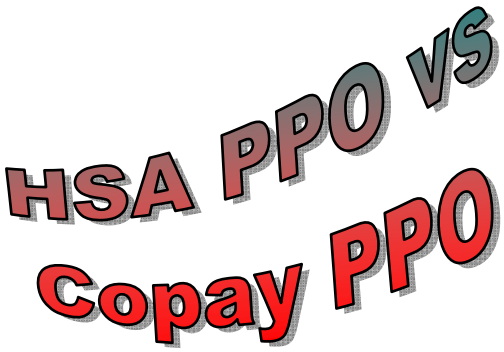
Deductions below are taken on a pre-tax basis

Payroll Deductions	HMO		PPO (HSA)		PPO (Copay)	
	Bi-monthly	Annual Cost	Bi-monthly	Annual Cost	Bi-monthly	Annual Cost
Employee Only	**$49.33**	$1,183.99	**$45.80**	$1,099.27	**$134.69**	$3,232.51
Employee + Spouse	**$387.39**	$9,297.43	**$378.81**	$9,091.39	**$594.89**	$14,277.43
Employee + Child(ren)	**$235.41**	$5,649.91	**$229.10**	$5,498.47	**$388.00**	$9,312.07
Full Family	**$573.47**	$13,763.35	**$562.11**	$13,490.59	**$848.21**	$20,356.99

This coverage has limitations and exclusions. Please refer to your benefit booklet for a complete description of your coverage and benefits. This highlight sheet provides a brief description of coverage. In the event that a discrepancy exists, the policy provisions will prevail.

IPA

Insurance Plans Agency, Inc.



What's the difference?

An "HSA PPO" is similar to your "Copay PPO" in the following ways:

- ✓ *Both PPO programs use the same network of physicians and hospitals*
- ✓ *Neither PPO program requires you to choose a Primary Care Physician (PCP)*
- ✓ *Neither PPO program requires you to obtain a Referral from your PCP in order to receive covered services from a Specialist*
- ✓ *Both PPO programs have a Deductible*
- ✓ *Both PPO programs have Coinsurance after the Deductible*
- ✓ *Both PPO programs offer you comprehensive coverage for:*
    - **Physician Office Visits** *(Specialists & Non-specialists)*
    - **Routine Physicals**
    - **Physician & Hospital Services**
    - **Lab and X-ray Services**
    - **Physical Therapy**
    - **Emergency Care**
    - **Prescriptions**

An "HSA PPO" is different than your "Copay PPO" in several ways:

- ✓ *On your "Copay PPO," certain medical services will be covered in full after you pay your specified "Copay." These same services on the "HSA PPO" will apply to your Deductible and then be covered at your coinsurance level. These services include:*
    - **Physician Office Visits** *(Specialists & Non-specialists)*
    - **Diagnostic Labs and X-rays** *(billed by your Network Attending Physician)**
    - **Emergency Care**
    - **Prescriptions**
- ✓ *The "HSA PPO" program covers your once a year routine physical exam at 100%, no Copay, no Deductible required. The "Copay PPO" program requires that you pay your "Copay."*
- ✓ *If you are enrolled in an "HSA PPO" program, you can legally establish a **Health Savings Account (HSA)** and deposit money into the HSA to pay for your Deductible and Out-of-pocket Medical and Prescription expenses. The advantage of paying your Medical bills out of an HSA is that the Federal Government allows you as the HSA account owner to **deduct from your taxes** the amount of HSA contributions you made during that tax year. Limitations apply as to how much money can be deposited into an HSA each year. Any money remaining in your HSA at the end of the year **rolls over** to the next year.*

**Major Diagnostic Labs/tests including MRI, CAT Scans, Pulmonary functioning test, Cardiac Catheterization and Swanz Ganz Catheterization will always apply to your Deductible, regardless if you are enrolled in the "HSA PPO" or "Traditional PPO" program.*

The HMOs of Blue Cross and Blue Shield of Illinois
BlueAdvantage HMO
300 East Randolph, Chicago, IL 60601 ● Member Services: (800) 892-2803 ● *www.bcbsil.com*

2010 Description of Coverage

The Managed Care Reform and Patient Rights Act of 1999 established rights for enrollees in health care plans. These rights cover the following:

- What emergency room visits will be paid for by your health care plan.
- How specialists (both in and out of network) can be accessed.
- How to file complaints and appeal health care plan decisions, including external independent reviews.
- How to obtain information about your health care plan, including general information about its financial arrangements with providers.

You are encouraged to review and familiarize yourself with these subjects and the other benefit information in the attached Description of Coverage Worksheet. SINCE THE DESCRIPTION OF COVERAGE IS NOT A LEGAL DOCUMENT, for full benefit information please refer to your contract or certificate, or contact your health care plan at **(800) 892-2803**. In the event of any inconsistency between your Description of Coverage and contract or certificate, the terms of the contract or certificate will control.

For general assistance or information, please contact the Illinois Department of Financial and Professional Regulation – Division of Insurance, Office of Consumer Health Insurance at **(877) 527-9431** or in writing to either of the following addresses:

320 West Washington Street
Springfield, IL 62767-0001

100 West Randolph Street, Suite 15-100
Chicago, IL 60601-3251

You may also contact the department online at http://www.idfpr.com.

(Please be aware that the Office of Consumer Health Insurance will not be able to provide specific plan information. For this type of information you should contact your health care plan directly.)

BlueCross BlueShield
of Illinois

Basics		Description of Coverage
Your Doctor		Choose a medical group and primary care physician (PCP) for each member of your family from our directory or Web site. Each female member may select a Woman's Principal Health Care Provider (WPHCP) in addition to her PCP. A member's PCP and WPHCP must have a referral arrangement with each other. **All care must be provided or coordinated by your PCP, WPHCP or medical group/Independent Practice Association (IPA).**
Annual Deductible		none
Out-of-Pocket Maximum (excludes drugs, vision, durable medical equipment and prosthetics)	Individual	$1,500/calendar year
	Family	$3,000/calendar year
Lifetime Maximums		none
Pre-existing Condition Limitations		none

In the Hospital	Description of Coverage	Health Care Plan Covers	You Pay
Number of Days of Inpatient Care	unlimited days	n/a	n/a
Room & Board	private or semi-private room	100%*	$0
Surgeon's Fees	covered	100%*	$0
Doctor's Visits	covered	100%*	$0
Medications	covered	100%*	$0
Other Miscellaneous Charges	see exclusions	100%*	$0
Emergency Care			
Emergency Services (medical conditions with acute symptoms of sufficient severity such that a prudent layperson could reasonably expect the absence of medical attention to result in serious jeopardy of the person's health, serious impairment to bodily functions or serious dysfunction to any bodily organ or part)	covered services performed in a hospital emergency room in or out of area. Copay, if any, waived if admitted.	100%	$150
Emergency Post-stabilization Services covered if approved by PCP	primary care physician	100%*	$30
	specialist	100%*	$50

* HMO pays 100 percent of covered charges after member's copayment, if any, is paid.

In the Doctor's Office		Description of Coverage	Health Care Plan Covers	You Pay
Doctor's Office Visit (copayment covers the visit and all covered services provided)		primary care physician	100%*	$30
		specialist	100%*	$50
Routine Physical Exams		covered	100%*	$30
Diagnostic Tests and X-rays		covered	100%*	$0
Immunizations		covered	100%*	$0
Allergy Treatment & Testing		covered	100%*	$0
Wellness Care		covered	100%*	$30
Medical Services				
Outpatient Surgery		hospital facility	100%*	$0
		physician(s)	100%*	$0
Maternity Care	Hospital Care	unlimited days	100%*	$0
	Physician Care	copay, if any, for 1st visit only	100%*	$30
Infertility Services		based on your group policy	100%* if covered	$50
Non-Serious Mental Health	Outpatient	unlimited visits	100%*	$50
	Inpatient	unlimited days	100%*	$0
Substance Abuse/ Chemical Dependency	Outpatient	unlimited visits	100%*	$50
	Inpatient	unlimited days	100%*	$0
Serious Mental Health	Outpatient	unlimited visits	100%*	$50
	Inpatient	unlimited days	100%*	$0
Outpatient Rehabilitation Services (includes, but is not limited to, physical, occupational or speech therapy)		60 visits combined/CY	100%*	$0
Outpatient Speech Therapy (for Pervasive Developmental Disorder only)		20 visits/CY	100%*	$0

* HMO pays 100 percent of covered charges after member's copayment, if any, is paid.

Other Services		Description of Coverage	Health Care Plan Covers	You Pay
Durable Medical Equipment		covered	100%*	$0
Prosthetic Devices		covered	100%*	$0
Ambulance Service		covered	100%*	$0
Hospice		covered	100%*	$0
Coordinated Home Care (excludes custodial care)		covered	100%*	$0
Prescription Drug – up to 34 day supply per script	Generic	based on your group policy	100%*	$15
	Formulary Brand	based on your group policy	100%*	35%
	Non-formulary Brand	based on your group policy	100%*	50 %
	Self-injectable	based on your group policy	100%*	$50
Prescription Drug – ▫ up to 90 day supply per script ▫ visit *www.bcbsil.com* or call Member Services for information on the 90 day pharmacy network	Generic	based on your group policy	100%*	$30
	Formulary Brand	based on your group policy	100%*	35%
	Non-formulary Brand	based on your group policy	100%*	50%
	Self-injectable	based on your group policy	100%*	$50
Dental Services		see limitations, pages 6-7	100%*	$50
Vision Care	Exams	one every 12 months	100%*	$30
	Eyewear	based on your group policy	0%	remainder after discount

*HMO pays 100 percent of covered charges after member's copayment, if any, is paid.

Service Area

The HMO Illinois and BlueAdvantage HMO service areas include the Illinois counties of Boone, Christian, Cook, DeKalb, DuPage, Fulton, Greene, Grundy, Iroquois, Kane, Kankakee, Kendall, Lake, LaSalle, Lee, Livingston, Logan, Macoupin, Mason, McHenry, Menard, Monroe, Morgan, Ogle, Peoria, Sangamon, Stark, St. Clair, Stephenson, Tazewell, Whiteside, Williamson, Will, Winnebago and Lake county in Indiana. The HMO Illinois service area also includes Kenosha county in Wisconsin. *Please note: Some employer groups may have different service areas (see your employer for details) and the service area is subject to change*.

Exclusions and Limitations

To receive benefits, all care must be provided or coordinated by the member's Primary Care Physician (PCP) or Woman's Principal Health Care Provider (WPHCP) or medical group/Independent Practice Association (IPA), except substance abuse/chemical dependency, vision care and hospital emergency care benefits, which are available at contracting providers without a PCP referral.

Below is a summary list of exclusions and limitations. Your plan may have specific exclusions and limitations not included on this list – check *Your Health Care Benefit Program Certificate*.

Exclusions

1. Services or supplies that are not specifically listed in *Your Health Care Benefit Program Certificate*.
2. Services or supplies that were not ordered by your primary care physician or Woman's Principal Health Care Provider, except as explained in the *Certificate*.
3. Services or supplies received before your coverage began or after the date your coverage ended.
4. Services or supplies for which benefits have been paid under any Workers' Compensation Law or other similar laws.
5. Services or supplies that are furnished to you by the local, state or federal government and services or supplies to the extent payments or benefits for such services are provided by or available from the local, state or federal government (for example, Medicare) whether or not those payments or benefits are received; except, however, this exclusion shall not be applicable to medical assistance benefits under Article V, VI or VII of the Illinois Public Aid Code or similar legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.
6. Services or supplies rendered to you as the result of an injury caused by another person to the extent that you have collected damages for such injury and that the Plan has provided benefits for the services or supplies rendered in connection with such injury.
7. Services or supplies that do not meet accepted standards of medical or dental practice including, but not limited to, services which are investigational in nature.
8. Custodial care services.
9. Long Term Care services.
10. Respite Care Services, except as specifically mentioned under Hospice Care Benefits.
11. Services or supplies rendered because of behavioral, social maladjustment, lack of discipline or other antisocial actions, which are not specifically the result of mental illness.
12. Special education therapy, such as music therapy or recreational therapy.
13. Cosmetic surgery and related services and supplies unless correcting congenital deformities or conditions resulting from accidental injuries, tumors or disease.
14. Services or supplies received from a dental or medical department or clinic maintained by an employer, labor union or other similar person or group.
15. Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
16. Charges for failure to keep a scheduled visit or for completion of a claim form or charges for transferring medical records.

17. Personal hygiene, comfort or convenience items commonly used for purposes that are not medical in nature, such as air conditioners, humidifiers, physical fitness equipment, televisions or telephones.
18. Special braces, splints, specialized equipment, appliances, ambulatory apparatus or battery controlled implants.
19. Prosthetic devices, special appliances or surgical implants unrelated to the treatment of disease or injury, for cosmetic purposes or for the comfort of the patient.
20. Nutritional items such as infant formula, weight-loss supplements, over-the-counter food substitutes and non-prescription vitamins and herbal supplements.
21. Blood derivatives which are not classified as drugs in the official formularies.
22. Marriage counseling.
23. Hypnotism.
24. Inpatient and Outpatient Private-Duty Nursing Service.
25. Routine foot care, except for persons diagnosed with diabetes.
26. Maintenance occupational therapy, maintenance physical therapy, and maintenance speech therapy.
27. Maintenance care.
28. Self-management training, education and medical nutrition therapy.
29. Services or supplies which are rendered for the care, treatment, filling, removal, replacement or artificial restoration of the teeth or structures directly supporting the teeth.
30. Treatment of temporomandibular joint syndrome with intraoral prosthetic devices or any other method which alters vertical dimension or treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma.
31. Services or supplies rendered for human organ or tissue transplants, except as stated in the *Certificate*.
32. Hearing aids, except as stated in the Certificate.
33. Wigs (also referred to as cranial protheses).

Limitations

In addition to the exclusions noted, the following limitations apply:

1. Benefits for oral surgery are limited to:
   - surgical removal of completely bony impacted teeth,
   - excision of tumors or cysts from the jaws, cheeks, lips, tongue, roof or floor of the mouth,
   - surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof or floor of the mouth,
   - excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses),
   - treatment of fractures of the facial bone,
   - external incision and drainage of cellulitis,
   - incision of accessory sinuses, salivary glands or ducts, and
   - reduction of, dislocation of or excision of the temporomandibular joints.
2. Benefits for treatment of dental injury due to accident are limited to treatment of sound natural teeth.
3. Benefits for outpatient rehabilitative therapy are limited to therapy which is expected to result in significant improvement within two months in the condition for which it is rendered.
4. Family planning benefits are not available for repeating or reversing sterilization.
5. Benefits for elective abortion are limited to two per lifetime and are not covered under all benefit plans.
6. Benefits for infertility, when covered, will not be provided for the following:
   - Reversal of voluntary sterilization. However, in the event a voluntary sterilization is successfully reversed, benefits will be provided if your diagnosis meets the definition of "infertility",
   - Services or supplies rendered to a surrogate, except those costs for procedures to obtain eggs, sperm or

embryos from you, will be covered if you choose to use a surrogate,

- selected termination of an embryo in cases where the mother's life is not in danger,
- cryo-preservation or storage of sperm, eggs or embryos, except for those procedures which use a cryo-preserved substance
- non-medical costs of an egg or sperm donor,
- travel costs for travel within 100 miles of the covered person's home or which is not medically necessary or which is not required by the plan,
- infertility treatments which are determined to be investigational, in writing, by the American Society for Reproductive Medicine or American College of Obstetrics and Gynecology, and
- Infertility treatment rendered to your dependents under the age of 18.

7. Benefits for ambulance service are limited to certified ground ambulance, except for human organ transplants.
8. Human organ transplants must be performed at a plan-approved center for human organ transplants and benefits do not include organ transplants and/or services or supplies rendered in connection with an organ transplant which are investigational as determined by the appropriate technological body; drugs which are investigational; storage fees; services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision; cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a hospital for transplant surgery; or travel time or related expenses incurred by a provider.
9. Hospice benefits are only available for persons having a life expectancy of one year or less.
10. Prescription drug benefits, when covered, do not include drugs used for cosmetic purposes; any devices or appliances; any charges incurred for administration of drugs; or refills if the prescription is more than one year old.
11. Vision exams are limited to one per 12 month period. Vision coverage does not include benefits for:
    - recreational sunglasses
    - orthoptics, vision training, subnormal vision aids, aniseikonic lenses or tonography
    - additional charges for tinted, photo-sensitive or anti-reflective lenses beyond the benefit allowance for regular lenses
    - replacement of lenses, frames or contact lenses, which are lost or broken unless such lenses, frames or contact lenses would otherwise be covered according to the benefit period limitations
12. Durable Medical Equipment rental is covered up to the price of purchase.
13. Mental health and chemical dependency treatment benefits may be limited – see your *Certificate*.
14. Rehabilitation therapy benefits may be limited – see your *Certificate*.
15. Maternity inpatient hospital benefits are limited to 48 hours after birth for vaginal deliveries and 96 hours after birth for cesarean deliveries, unless a longer stay is medically necessary.

Pre-certification and Utilization Review

All benefits are provided or coordinated by your PCP or WPHCP. Therefore, certification by the member is not required. Utilization review is conducted by your medical group/IPA, not by the HMO. To ensure fair and consistent decisions regarding medical care, the HMOs of Blue Cross and Blue Shield of Illinois require medical groups/IPAs to use nationally recognized utilization review criteria.

Primary Care Physician (PCP) Selection

Each member must join a contracting medical group/IPA and select a PCP affiliated with that medical group/IPA to provide and coordinate care. Each female member may also choose an OB/GYN to be her Woman's Principal Health Care Provider (WPHCP). A member's PCP and WPHCP must have a referral arrangement with each other. A member has access to her WPHCP as often as needed without a PCP referral. Members may change PCPs/WPHCPs – refer to the Member Handbook or *Certificate* for instructions and exceptions. Listings of contracting providers are available in the printed HMO directory or online at *www.bcbsil.com.*

Access to Specialty Care

If clinically appropriate, your PCP or WPHCP will refer you to a specialist, usually within the same medical group as your PCP. If the member's preferred network specialist does not have a referral arrangement with your PCP/WPCHP, you may choose a new PCP/WPCHP with whom the specialist has such an arrangement. You can ask your PCP for a standing referral for conditions that require ongoing care from a specialist physician. Standing referrals may be made for a specified number of visits or a time period up to one year. Specialist copays may differ, depending on plan design.

Out-of-Area Coverage

When you are out of state, urgent care and hospital emergency room services are available through a network of contracting Blue Cross and Blue Shield providers. When you are out of state for a minimum of 90 consecutive days, guest membership may be arranged in participating communities throughout the U.S. with the Guest Membership Coordinator.

Financial Responsibility

You are responsible for copayments at time of service, as shown in the Description of Coverage. You are also responsible for payment for care not provided or coordinated by your PCP or WPHCP, except where otherwise noted. You should contact your employer's benefit administrator to confirm the level of your contribution to the premium.

Continuity of Treatment (Transition of Care)

If a physician you are currently obtaining services from leaves the HMO network, you have the right to request transition of care benefits. To qualify for transition of care services, you must currently be undergoing a course of evaluation and/or medical treatment or be in the second or third trimester of pregnancy. The ongoing evaluation and/or medical treatment concerns a condition or disease that requires repeated health care services under a physician's treatment plan, with the potential for changes in a therapeutic regimen.

Transitional services may be authorized for up to 90 days from the date the physician terminated from the network. Authorization of services depends on the physician's agreement to comply with contractual requirements and submit a detailed treatment plan, including reimbursement from the HMO at specified rates and adherence to the HMO's quality assurance requirements, policies and procedures. All care must be transitioned to your new HMO PCP in the medical group/IPA after the transition period has ended. Coverage will be provided only for benefits outlined in your *Certificate*.

Existing members: Submit a written Transition of Care request *within 30 days* of receiving notice of the termination of the physician or medical group/IPA.

New members: Submit a written Transition of Care request *within 15 days* after your eligibility effective date. When submitting the transition of care form prior to your effective date, please include a copy of the signed application and/or confirmation of enrollment with the HMO.

Submit the request to:

Blue Cross and Blue Shield of Illinois
Customer Assistance Unit, Transition of Care
300 East Randolph Street, 23rd Floor
Chicago, IL 60601

Include the following information:

- Policyholder's name and work/home phone numbers
- Group and ID numbers

- Chosen medical group site
- Chosen PCP name, address and phone/fax numbers
- Current treating physician
- Clinical diagnosis
- Presenting clinical condition (if applicable)
- Reason for transition of care request
- Expected effective date with the HMO or new medical group/IPA (if applicable)

You will be notified within 15 business days of the outcome of your Transition of Care request.

Appeals Process

You can file an appeal by writing to the HMO or calling Member Services.

Non-urgent Clinical Appeal

After the appeal is received, the HMO Level II Appeal Committee will request any additional information needed to evaluate your appeal and make a decision about your appeal within 15 days after receiving the required information.

You will be informed in advance that you, or someone representing you, have the right to appear before the Committee either in person, via conference call or some other method. You will also receive a verbal notification of the HMO's decision. A written notification will be sent within five business days of the appeal determination. Your representative (if any), your PCP and any other health care provider involved in the matter will receive the same verbal and written notices.

Urgent Clinical Appeal

After the appeal is received, the HMO Level II Appeal Committee will request any additional information needed to evaluate your appeal and make a decision about your appeal and notify you by phone within 24 hours – or no later than three calendar days – of the initial receipt of the clinical appeal request. You will be informed in advance that you, or someone representing you, have the right to appear before the Committee either in person, via conference call or some other method. You will also receive a verbal notification of the HMO's decision. A written notification will be sent within two business days of the appeal determination. Your representative (if any), your PCP and any other health care provider involved in the matter will receive the same verbal and written notices.

Non-clinical Appeal

A non-clinical appeal concerns an adverse decision of an inquiry, complaint or action by the HMO, its employees or its independent contractors that has not been resolved to your satisfaction. A non-clinical appeal relates to administrative health care services that include (but are not limited to) membership, access, claim payment, denial of benefits, out-of-area benefits and coordination of benefits with another health carrier.

To begin a Level I appeal, notify Member Services by telephone or in writing that you want to pursue a non-clinical appeal. The HMO will send you a written confirmation within five business days of receiving your request. If your appeal can be resolved with existing information, the HMO will inform you of its decision within 30 business days.

If additional information is needed from either you or your medical group/IPA, the HMO will request that it be provided within five business days. The appeal decision will be made within 30 business days. When the decision cannot be made within 30 business days, due to circumstances beyond the HMO's control, the HMO will inform you in writing of the delay. A decision will be made on or before the 45th business day of receiving the appeal.

If the appeal is denied, you will be notified that your case is being referred to a Level II review. You or a representative has the right to appear in person, via conference call or some other method. After receiving your Level II appeal, the HMO will notify you in writing at least five business days before the Level II Appeals Committee meets. You will receive the Committee's decision in writing within five business days of the meeting and within 30 business days of beginning the Level II appeal process.

ANY ENROLLEE NOT SATISFIED WITH THE PLAN'S RESOLUTION OF ANY CLINICAL APPEAL, APPEAL OR COMPLAINT MAY APPEAL THE FINAL PLAN DECISION TO THE DIVISION OF INSURANCE, CONSUMER SERVICES SECTION, THROUGH ONE OF THE FOLLOWING LOCATIONS:

- **100 West Randolph Street, Suite 15-100 Chicago, IL 60601-3251**
- **320 West Washington Street, Springfield, IL 62767-0001**

You may also contact the Division of Insurance by phone or online at:

- **(877) 527-9431**
- **http://www.idfpr.com.**

IMPORTANT: External review determinations might not be appealable through the Division of Insurance.

Members have the right to request information on, the financial relationships between the HMO and any health care provider; the percentage of copayments, deductibles and total premiums spent on health care; and HMO administrative expenses.

For any additional information concerning this Description of Coverage, call the HMO's toll-free number at (800) 892-2803.

To receive a Description of Coverage specific to your benefits, call **(800) 892-2803** or return the enclosed pre-paid card.

In the event of any inconsistency between your Description of Coverage and contract or certificate, the terms of the contract or *Certificate* shall control.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

BlueEdge HSA 80/60

$2,500/$5,000 DEDUCTIBLE - $5,000 OPX

E2EC3805
BPEC3805

BlueCross BlueShield of Illinois

BENEFIT HIGHLIGHTS

PPO Network

This provides only highlights of the benefit plans(s). After enrollment, members will receive a Certificate that more fully describes the terms of coverage.

Program Basics	PPO (In-Network)	Non-PPO (Out-of-Network)
Lifetime Benefit Maximum		
Per individual	$5,000,000	
Individual Coverage Deductible*	$2,500	$5,000
Family Coverage Deductible*		
Entire deductible must be met.	$5,000	$10,000
Individual Coverage Out-of-Pocket Expense (OPX) Limit	$5,000	$10,000
The maximum amount of money that any individual will have to pay toward covered health care expenses during any one calendar year, **including the program deductible**. The following items will **not** be applied to the out-of-pocket expense limit: • **Reductions in benefits** due to non-compliance with utilization management program requirements • **Charges that exceed the eligible charge** or the Schedule of Maximum Allowances (SMA)		
Family Coverage Out-of-Pocket Expense (OPX) Limit	$10,000	$20,000
The family OPX limit includes the family deductible amount. Please refer to Certificate for details on how the family OPX limit works.		
Outpatient Prescription Drugs	80% after deductible	
Covered under Other Covered Services below. Please refer to the *Outpatient Prescription Drug Benefit Highlights* sheet for detailed information.		
Physician Services		
Well Adult Care (age 16 and over)	100%	60% after deductible $500 maximum per calendar year
Includes benefits for routine physical examinations, immunizations and routine diagnostic tests. • Limited to one physical exam plus one gynecological exam per calendar year.		
Well Child Care (to age 16)	100%	60% after deductible, $500 maximum per calendar year
Coverage for physical exams, immunizations and routine diagnostic tests.		
Maternity Services	80% after deductible	60% after deductible
Medical / Surgical Services	80% after deductible	60% after deductible
Hospital Services		
Hospital Admission Deductible	$0	$300
Per admission, per individual		
Inpatient Hospital Services	80% after deductible	60% after deductible
Coverage includes pre-admission testing and services received in a hospital, skilled nursing facility, coordinated home care and hospice, including mental health and substance abuse services. Room allowances based on the hospital's most common semi-private room rates.		
Outpatient Hospital Services	80% after deductible	60% after deductible
Coverage for services includes, but is not limited to outpatient or ambulatory surgical procedures, diagnostic x-rays, lab tests, chemotherapy, radiation therapy, renal dialysis, and mammograms performed in a hospital or ambulatory surgical center, including mental health and substance abuse services. For routine services such as mammograms, lab tests and x-rays performed in an outpatient hospital setting, see Well Care benefits.		
Outpatient Emergency Care (Accident or Illness)*	90% after deductible	
Each calendar year, the program deductible must be met before benefits will begin under this policy. The coinsurance applies to both in- and out-of-network emergency room visits.		

BlueEdge HSA 80/60

$2,500/$5,000 DEDUCTIBLE - $5,000 OPX

E2EC3805
BPEC3805

BlueCross BlueShield of Illinois

BENEFIT HIGHLIGHTS

PPO Network

Additional Services	PPO (In-Network)	Non-PPO (Out-of-Network)
Muscle Manipulation Services		
Coverage for spinal and muscle manipulation services provided by a physician or chiropractor. Related office visits are paid the same as other Physician Office Visits. • $1,000 maximum per calendar year.	*80% after deductible*	*60% after deductible*
Therapy Services – Speech, Occupational and Physical		
Coverage for services provided by a physician or therapist. • $5,000 maximum per therapy per calendar year	*80% after deductible*	*60% after deductible*
Temporomandibular Joint (TMJ) Dysfunction and Related Disorders		
• $2,500 lifetime maximum	*80% after deductible*	*60% after deductible*
Other Covered Services		
• Private duty nursing - $3,000 maximum per month • Naprapathic services - $1,000 maximum per calendar year • Blood and blood components • Ambulance services • Medical supplies *See paragraph below regarding Schedule of Maximum Allowances (SMA).*	*80% after deductible*	

Durable Medical Equipment (DME) is a covered benefit. Please refer to Certificate for details.

Optometrists, Orthotic, Prosthetic, Pedorthists, Registered Surgical Assistants, Registered Nurse First Assistants and Registered Surgical Technologists are covered providers. Please refer to Certificate for details.

Discounts on Eye Exams, Prescription Lenses and Eyewear
Members can present their ID cards to receive discounts on eye exams, prescription lenses and eyewear. To locate participating vision providers, log into Blue Access® for Members (BAM) at www.bcbsil.com/member and click on the **BlueExtras Discount Program** link.

Blue Care Connection (BCC)
When members receive covered inpatient hospital services, coordinated home care, skilled nursing facility or private duty nursing from a participating provider in the state of Illinois, the provider will be responsible for contacting the BCC pre-notification line. When using non-participating Illinois providers and out-of-state providers, members are required to contact the BCC pre-notification line **1 business day prior** to any elective inpatient admission or within **2 business days after** an emergency or maternity admission. Failure to pre-notify with the BCC when required will result in benefits being reduced by $1,000.

***More on Individual Coverage and Family Coverage Deductibles…**

- If a member has **individual coverage**, each calendar year he/she must satisfy an **individual coverage deductible** before receiving benefits under this policy. The amount of the individual deductible is indicated above on this benefit highlight sheet. Once a member's claims for covered services in a calendar year exceed this deductible amount, benefits will begin.
- If a member and his/her dependents have **family coverage**, each calendar year they must satisfy the **family coverage deductible** before receiving benefits under this policy. The amount of the family deductible is indicated above on this benefit highlight sheet. Once the family deductible has been satisfied it will not be necessary for anyone else in the family to meet a deductible in that calendar year. That is, for the remainder of the calendar year, no other family member will be required to meet the deductible before receiving benefits. No one is eligible for benefits under family coverage until the entire family deductible has been satisfied.
- **Please note:** The deductible amount may be adjusted based on the cost-of-living adjustments determined under the Internal Revenue Code and rounded to he nearest $50.
- **Also note:** Should the Federal Government adjust the deductible for high deductible plans as defined by the Internal Revenue Service, the deductible amount in the Certificate will be adjusted accordingly.

Schedule of Maximum Allowances (SMA)
The Schedule of Maximum Allowances (SMA) is not the same as a Usual and Customary fee (U&C). Blue Cross and Blue Shield of Illinois' SMA is the maximum allowable charge for professional services, including but not limited to those listed under Medical/Surgical and Other Covered Services above. The SMA is the amount that professional PPO providers have agreed to accept as payment in full. Providers who do not participate in the PPO network are not obligated to accept the SMA as payment in full and may bill for the balance of their actual charge above and beyond the SMA. When members use PPO providers, they avoid any balance billing other than applicable deductible, coinsurance and/or copayment.

To Locate a Participating Provider: Visit our Web site at **www.bcbsil.com/providers** and use our Provider Finder® tool.

In addition, benefits for covered individuals who live outside Illinois will meet all extraterritorial requirements of those states, if any, according to the group's funding arrangements.

BlueAdvantage Entrepreneur PPO 80/60

$1,500/$3,000 DEDUCTIBLE - $30 COPAY

BlueCross BlueShield of Illinois

Plans E2P93432, E2P93433, E2P93434, E2P93436

BENEFIT HIGHLIGHTS

PPO Network

This provides only highlights of the benefit plans(s). After enrollment, members will receive a Certificate that more fully describes the terms of coverage.

Program Basics	PPO (In-Network)	Non-PPO (Out-of-Network)
Lifetime Benefit Maximum		
Per individual	$5,000,000	
Individual Deductible		
Program deductible does **not** apply to services that have a copayment.	$1,500	$3,000
Family Deductible		
The family deductible maximum is equal to three individual deductibles.	3x individual	
Individual Out-of-Pocket Expense (OPX) Limit		
The amount of money that any individual will have to pay toward covered health care expenses during any one calendar year. The following items will **not** be applied to the out-of-pocket expense limit: • **Deductibles** • **Copayments** • **Reductions in benefits** due to non-compliance with utilization management program requirements • **Charges that exceed the eligible charge** or the Schedule of Maximum Allowances (SMA) • **Services that are asterisked below** (*)	$2,000	$4,000
Family Out-of-Pocket Expense (OPX) Limit		
	$6,000	$12,000
Prescription Drug Card (Retail and Mail Service)		
Please refer to the *Three Tier Formulary Prescription Drug Card Benefit Highlights Sheet* for the covered benefits.		
Physician Services		
Physician Office Visits		
One copayment per day when you receive services from a Family Practice, Internal Medicine, OB/GYN, or Pediatrician. Surgeries, therapies and certain diagnostic procedures performed in a physician's office may be subject to the deductible and/or coinsurance, including mental health and substance abuse services..	$30 copay, then 100%	60% after deductible
One copayment per day when you receive services from a specialist. Surgeries, therapies and certain diagnostic procedures performed in a physician's office may be subject to the deductible and/or coinsurance, including mental health and substance abuse services..	$50 copay, then 100%	60% after deductible
Well Adult Care (age 16 and over)		
Includes benefits for routine physical examinations, immunizations and routine diagnostic tests. • Limited to one physical exam plus one gynecological exam per calendar year.	$30 copay, then 100%	60% after deductible $500 maximum per calendar year
Well Child Care (to age 16)		
Coverage for physical exams, immunizations and routine diagnostic tests.	$30 copay, then 100%	60% after deductible, $500 maximum per calendar year
Maternity Services		
Copayment applies to first prenatal visit (per pregnancy). All other maternity physician covered services are paid the same as Medical / Surgical Services.	$30 copay, then 100%	60% after deductible
Medical / Surgical Services		
Coverage for surgical procedures, inpatient visits, therapies, allergy injections or treatments, and certain diagnostic procedures as well as other physician services.	80% after deductible	60% after deductible
Hospital Services		
Hospital Admission Deductible		
Per admission, per individual	$0	$300
Inpatient Hospital Services		
Coverage includes services received in a hospital, skilled nursing facility, coordinated home care and hospice. Room allowances based on the hospital's most common semi-private room rates including mental health and substance abuse services.	80% after deductible	60% after deductible
Outpatient Hospital Services		
Coverage for services includes, but is not limited to outpatient or ambulatory surgical procedures, x-ray, lab tests, chemotherapy, radiation therapy, renal dialysis, and mammograms performed in a hospital or ambulatory surgical center, including mental health and substance abuse services. Routine mammograms performed in an in-network outpatient hospital setting are payable at 100%, no deductible will apply.	80% after deductible	60% after deductible
Outpatient Emergency Care (Accident or Illness)		
The copayment applies to both in- and out-of-network emergency room visits. The copayment is waived if the member is admitted to the hospital.	$150 copay, then 100%	

BlueAdvantage Entrepreneur PPO 80/60

$1,500/$3,000 DEDUCTIBLE - $30 COPAY

Plans E2P93432, E2P93433, E2P93434, E2P93436

BlueCross BlueShield of Illinois

BENEFIT HIGHLIGHTS

Additional Services	PPO Network: PPO (In-Network)	PPO Network: Non-PPO (Out-of-Network)
Muscle Manipulation Services*		
Coverage for spinal and muscle manipulation services provided by a physician or chiropractor. Related office visits are paid the same as other Physician Office Visits. • $1,000 maximum per calendar year.	*80% after deductible*	*60% after deductible*
Therapy Services – Speech, Occupational and Physical*		
Coverage for services provided by a physician or therapist. • $5,000 maximum per therapy per calendar year	*80% after deductible*	*60% after deductible*
Temporomandibular Joint (TMJ) Dysfunction and Related Disorders*		
• $2,500 lifetime maximum	*80% after deductible*	*60% after deductible*
Other Covered Services		
• Private duty nursing* - $3,000 maximum per month • Naprapathic services* - $1,000 maximum per calendar year • Blood and blood components • Ambulance services • Medical supplies *See paragraph below regarding Schedule of Maximum Allowances (SMA).*	*80% after deductible*	

* Does not apply to any out-of-pocket limits

Durable Medical Equipment (DME) is a covered benefit. Please refer to Certificate for details.

Optometrists, Orthotic, Prosthetic, Pedorthists, Registered Surgical Assistants, Registered Nurse First Assistants and Registered Surgical Technologists are covered providers. Please refer to Certificate for details.

Discounts on Eye Exams, Prescription Lenses and Eyewear
Members can present their ID cards to receive discounts on eye exams, prescription lenses and eyewear. To locate participating vision providers, log into Blue Access® for Members (BAM) at www.bcbsil.com/member and click on the **BlueExtras Discount Program** link.

Blue Care Connection (BCC)
When members receive covered inpatient hospital services, coordinated home care, skilled nursing facility or private duty nursing from a participating provider in the state of Illinois, the provider will be responsible for contacting the BCC pre-notification line. When using non-participating Illinois providers and out-of-state providers, members are required to contact the BCC pre-notification line **1 business day prior** to any elective inpatient admission or within **2 business days after** an emergency or maternity admission. Failure to pre-notify with the BCC when required will result in benefits being reduced by $1,000.

Schedule of Maximum Allowances (SMA)
The Schedule of Maximum Allowances (SMA) is not the same as a Usual and Customary fee (U&C). Blue Cross and Blue Shield of Illinois' SMA is the maximum allowable charge for professional services, including but not limited to those listed under Medical/Surgical and Other Covered Services above. The SMA is the amount that professional PPO providers have agreed to accept as payment in full. Providers who do not participate in the PPO network are not obligated to accept the SMA as payment in full and may bill for the balance of their actual charge above and beyond the SMA. When members use PPO providers, they avoid any balance billing other than applicable deductible, coinsurance and/or copayment.

To Locate a Participating Provider: Visit our Web site at **www.bcbsil.com/providers** and use our Provider Finder® tool.

In addition, benefits for covered individuals who live outside Illinois will meet all extraterritorial requirements of those states, if any, according to the group's funding arrangements.

Three Tier Formulary Prescription Drug Card

$15/35%/50% MIXED COPAY/COINSURANCE OPTION

BlueCross BlueShield of Illinois

BENEFIT HIGHLIGHTS

Program Basics	Copayment Options (Generic / Formulary Brand / Non-Formulary Brand)
Retail	
Prescriptions are for up to a 34-day supply at a retail pharmacy. • **Contracting Pharmacy:** Minimum coinsurance out-of-pocket expense is $15 per prescription; maximum coinsurance out-of-pocket expense is $150 per prescription. • **Non-contracting Pharmacy:** Minimum coinsurance out-of-pocket expense is $15 per prescription; no maximum coinsurance out-of-pocket expense applies.*	*$15/35%/50%*
Mail Service	
Maintenance medications are available for up to a 90-day supply and are subject to the appropriate copayment/coinsurance amount. • The appropriate copayment / coinsurance amount applies per prescription. • Minimum coinsurance out-of-pocket expense is $30 per prescription; maximum coinsurance out of pocket expense is $300 per prescription.	*$30/35%/50%*
Contraceptives	
Available at retail and mail service at the appropriate payment level based on drug classification.	
Self-Injectibles	
Available at retail and mail service at the appropriate payment level based on drug classification.	

***Reimbursement for non-contracting pharmacies**
Benefits at a non-contracting pharmacy are covered at 75% of the amount that would have been paid at a contracting pharmacy minus the appropriate member share.

Prior Authorization and Step Therapy Program Requirements
Your physician may be required to obtain authorization from BCBSIL in order to receive benefits for certain drugs that have a potential for misuse. Examples of these medications include: rheumatoid arthritis, growth hormone, hepatitis C, and anabolic steroids. In the event prior authorization is not obtained, you will be responsible for the first $1,000 or 50% of the Eligible Charge, whichever is less.

If you are required to receive prior authorization for certain medications under the step therapy program, you need to first try a proven, cost effective medication before progressing to a more costly treatment, if necessary. After a member has a prescription history for a lower-cost alternative medication, coverage will automatically be provided for a more costly medication included in the step therapy program, if the physician and member determine that it is necessary for the member to try a drug included in the program. As an alternative to receiving prior authorization for a drug included in the step therapy program, or paying the entire cost of the drug out-of-pocket, a member along with his/her physician may select another drug, which is not part of the program.

Prescription drugs categories are added to the program and are subject to change periodically. To verify which drugs are included in your prescription drug benefit program, contact the Pharmacy Program customer service number, which is located on the back of your ID card. You can also visit the BCBSIL Web site at *www.bcbsil.com* and log on to **Blue Access® for Members** to find additional information.

What is the Blue Cross and Blue Shield of Illinois formulary?
The BCBSIL formulary is a regularly updated list of preferred drugs determined by our Pharmacy and Therapeutic Committee, a national panel comprised of individuals who hold a medical or pharmacy degree who evaluate U.S. Food and Drug Administration (FDA)-approved drugs based on comparative clinical standards, including efficacy, safety, uniqueness and cost-effectiveness. The formulary includes all generic drugs and select group of brand drugs. The BCBSIL formulary is "open," meaning that benefits are payable for drugs that are not on the formulary, but are subject to the highest copayment level.

How can I find out if a drug is on the formulary, and if it is a generic or a brand name drug?
As part of the enrollment literature, members may receive a list of some of the most commonly prescribed formulary drugs. If a particular drug does not appear on the list, members can:

- Refer to the pocket edition of the BCBSIL formulary.
- Visit the BCBSIL Web site at www.bcbsil.com.
- Discuss the most appropriate drug therapy with their physician or pharmacist. Using generic drugs whenever possible will help save money.

How can I find a contracting pharmacy?
Visit our Web site at www.bcbsil.com to find a contracting pharmacy.

Blue Cross and Blue Shield of Illinois
Mail Service Order Form — PrimeMail™ Pharmacy

INSTRUCTIONS: Please PRINT in CAPITAL letters using **black ink** only. Fill in the applicable ovals completely (●).

For information about your mail service benefits, to preregister or to download additional order forms or a physician fax form, visit the Blue Cross Web site at **www.bcbsil.com** or call customer service at **800.423.1973.**

Member and Dependent History Section information is required only on the first order unless there is a change in health status. Indicate all known allergies, conditions or other current medications for you, your spouse, or your dependents by filling in the corresponding oval that matches the description. Please detail * as necessary. Contact your physician if you are unsure about any of this information.

MEMBER AND DEPENDENT HISTORY SECTION

Member ID Number (on face of member ID card)

Group Number

Member Last Name

Sex: M F

Member First Name

MI

Birth Date (MM/DD/YYYY)

PCN (lower face of ID card) I L

Member Phone Number – –

Permanent Address

City

State

Zip Code

Email Address

ALLERGIES							CONDITIONS							
○ None Known	○ Aspirin	○ Codeine	○ Penicillin	○ Sulfa	○ Tetracycline	○ Other Allergy*	○ None Known	○ Diabetes	○ Epilepsy	○ Glaucoma	○ Heart Condition	○ Hypertension	○ Ulcer	○ Other Condition*

* Please detail "other allergy " or "other condition," including related medications. _____

Dependent Last Name

Sex: M F

Dependent First Name

MI

Birth Date (MM/DD/YYYY)

Email Address

ALLERGIES							CONDITIONS							
○ None Known	○ Aspirin	○ Codeine	○ Penicillin	○ Sulfa	○ Tetracycline	○ Other*	○ None Known	○ Diabetes	○ Epilepsy	○ Glaucoma	○ Heart Cond.	○ Hypertension	○ Ulcer	○ Other*

* Please detail "other allergy " or "other condition."

_____

Dependent Last Name

Sex: M F

Dependent First Name

MI

Birth Date (MM/DD/YYYY)

* Please detail "other allergy " or "other condition."_____

ALLERGIES							CONDITIONS							
○ None Known	○ Aspirin	○ Codeine	○ Penicillin	○ Sulfa	○ Tetracycline	○ Other*	○ None Known	○ Diabetes	○ Epilepsy	○ Glaucoma	○ Heart Cond.	○ Hypertension	○ Ulcer	○ Other*

Dependent Last Name

Sex: M F

Dependent First Name

MI

Birth Date (MM/DD/YYYY)

* Please detail "other allergy " or "other condition."_____

ALLERGIES							CONDITIONS							
○ None Known	○ Aspirin	○ Codeine	○ Penicillin	○ Sulfa	○ Tetracycline	○ Other*	○ None Known	○ Diabetes	○ Epilepsy	○ Glaucoma	○ Heart Cond.	○ Hypertension	○ Ulcer	○ Other*

- **Do you want the Generic?** ____ **Yes** (if available and your doctor permits) ____ **No**
- Some health plans require the patient to pay the difference between generic and brand name cost. State law allows pharmacist to substitute a less expensive generically equivalent drug for a brand drug unless you or your physician directs otherwise.

Blue Cross and Blue Shield of Illinois Mail Service Order Form — PrimeMail™

PRESCRIPTION SECTION — Please PRINT in CAPITAL letters using **black ink** only.

For **NEW** prescriptions you may use either:

- **MAIL** — Mail the original physician-signed prescriptions with this completed form to: **Blue Cross and Blue Shield of Illinois c/o PrimeMail Pharmacy, P.O. Box 650041, Dallas, TX 75265-0041**
- **FAX** — Your physician must fax both pages of this completed form, along with your prescription(s), to **877.774.6360** provided you have either previously completed and submitted this form or registered at **www.bcbsil.com**

For **REFILL** prescriptions you may use:

- **PHONE** — Call our automated refill line at 877.357.7463.
- **WEB** — Visit **www.bcbsil.com**
- **MAIL** — Mail this form with the refill information completed to: **Blue Cross and Blue Shield of Illinois c/o PrimeMail Pharmacy, P.O. Box 650041, Dallas, TX 75265-0041**

Prescription	Member	Spouse	Dependent	Patient Name	Physician Name/Phone Number/Drug Name (for new prescriptions only)	Prescription Numbers (for refills only)
1	○	○	○			
2	○	○	○			
3	○	○	○			
4	○	○	○			
5	○	○	○			
6	○	○	○			

PrimeMail Pharmacy staff may contact your physician for clarification and safety purposes, which may result in your physician prescribing a different, clinically-appropriate product. PrimeMail Pharmacy will dispense FDA-approved generic equivalents when available and appropriate.

PAYMENT SECTION — Payment is due with each order and may be made by credit card, check or money order.

Do not send cash. Orders received without payment will delay processing. Credit card is the only payment option for faxed orders. If you have questions about your payment amount, call the Prescription Drug Inquiry Unit at **800.423.1973.**

○ **Payment by check or money order** (Make payable to Prime Therapeutics LLC and write your member ID number on the memo line.)

Check Amount: ____________________ Check Number: ____________________

○ **Payment by credit card** (Provide information below) ○ MasterCard ○ Visa ○ American Express ○ Discover

○ **Use credit card on file, with the last four digits:** ☐☐☐☐

○ **Use alternate credit card number** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Expiration Date (MM/YYYY) ☐☐|☐☐☐☐

Your credit card will be charged for drug costs, expedited shipping (if requested) and any outstanding balances due.

○ **Use this card for all future orders**

Credit card holder's signature

SHIPMENT SECTION — Delivery date does not include prescription processing time. Please choose your shipping method.

○ **Regular** — no charge ○ **Second Business Day*** ○ **Next Business Day*** ***Additional costs charged to you**

If you've chosen Second Business Day or Next Business Day shipping, we are unable to ship to P.O. boxes. Shipping address must be a physical location.

○ **Ship to Permanent Address**

Alternate Shipping Address (If different than permanent address)

City | State | Zip Code | Phone Number ☐☐☐–☐☐☐–☐☐☐☐

Above address is: ○ **For this order only** ○ **For this and all future orders**

All medications in this order will be sent to the address provided on this form. If a family member's medication needs to be delivered to a separate address, please submit a separate order form.

By returning this form to PrimeMail, you consent to the use and release of your health information and that of your covered dependents (if you are their guardian or authorized representative) to your health plans and health care providers/agents for health benefits management. Prime Therapeutics' use or disclosure of individually identifiable health information, whether furnished by you or obtained from other sources such as medical providers, shall be in accordance with the federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).

"

BlueCross BlueShield "Value Adds"

Blue Extras℠

Money-Saving Discount Program

To use BlueExtras, simply show your BCBSIL ID card to a participating provider to receive your discount.

Through the BlueExtras discount program, all Blue Cross and Blue Shield of Illinois (BCBSIL) members are eligible to save money on value-added health care products and services that help support healthy lifestyles. These discounts are for health care products and services not usually covered by your health care benefit plan. There are no claims to file, no referrals or pre-authorizations, and no additional fees to participate – it's just one more benefit of being a BCBSIL member.

For additional information about the products and services offered through BlueExtras, log into Blue Access® for Members (BAM) at *www.bcbsil.com*. Click on the **My Coverage** tab, and then the **BlueExtras Discount Program** link.

Complementary Alternative Medicine

www.bcbsil.com/member
(866) 656-6069

Complementary Alternative Medicine (CAM) includes a variety of therapies that may help to improve your health, prevent illness and address existing symptoms and conditions. As a BCBSIL member, you're automatically eligible to receive up to 30 percent off standard fees through a network of more than 35,000 practitioners, spas, and wellness and fitness centers.

You're also eligible to receive discounts on vitamins, herbal supplements, and health and wellness magazines. You can access the wholehealthmd Web site by logging into BAM.

Jenny Craig

www.jennycraig.com
(800) 597-Jenny (800-597-5366)

Jenny Craig is a long-term food/body/mind solution that can help you manage your weight by teaching you how to create a healthy relationship with food, build an active lifestyle and develop a balanced approach to living. You have the option to choose the right program for your lifestyle with weekly consultations at a Jenny Craig Centre or over the phone with the Jenny At-Home program. It's up to you! To download your discount coupon, log into BAM.

BlueCross BlueShield of Illinois

BlueCross BlueShield of Illinois

Blue Extras

BlueExtras gives members and covered dependents access to discounts on a variety of health care and wellness products and services.

Curves
www.curves.com
(800) CURVES-30 (800-287-8373)
Curves offers a 30-minute workout that combines strength training and sustained cardiovascular activity through resistance equipment. Curves has made exercise available to more than four million women, many of whom are in the gym for the first time.

Davis Vision
www.davisvision.com
(877) 393-8844
Save on eyeglasses (frames and lenses), as well as contact lenses, laser vision correction services, examinations and accessories through one of the nation's leading providers of routine vision care programs. For a list of Davis Vision providers near you, search the Provider Finder® at *www.bcbsil.com*. The Davis Vision network consists of major national and regional retail locations, such as EyeMasters and Visionworks, as well as independent ophthalmologists and optometrists.

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Save on digital hearing aids through TruHearing. Get a hearing test at no additional charge by a licensed hearing specialist when performed for the purpose of fitting a hearing aid. Enjoy a 45-day money back guarantee, a two-year warranty and a selection of hearing aid styles at various price levels.

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www.bcbsil.com

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

HSA Information

HSA PPO…So how does it work?

If you enroll in a High Deductible Health Plan (HDHP) and set up a Health Savings Account (HSA) in conjunction with your HDHP, this is a general overview of how the plan will actually work for you throughout the policy year…

Doctor Visits
Step 1) Give your doctor your new ID card.

Step 2) Doctor will submit the itemized bill to your insurance company.

Note: You will not pay anything at the doctor's office because you do not have a Copay plan.

Step 3) A couple weeks after your insurance company receives your doctor's bill, they will reprice the claim for their discounts and then send you and the doctor an Explanation of Benefits (EOB) showing how much of the billed charge is allowed and what your member responsibility is. Remember, before you have coverage on your HDHP HSA PPO, you first have to pay your Deductible.

Step 4) After your doctor receives the EOB from your insurance company, they will send you a bill.

Step 5) After you receive the bill from the doctor, cross check that with the EOB from your insurance company to make sure the amount the doctor is billing you matches what your insurance company states you owe.

Step 6) After you've done Step 5 and have verified that the doctor is billing you the correct amount, pay the bill by writing your HSA debit card number on the bill they sent you.

Note: If you do not have enough money in your HSA to pay the bill, you will have to pay the bill with another source albeit a check out of your regular checking account, cash, debit or a credit card.

Tip: Talk to your provider about a payment plan if you will have money in your HSA in the near future and want to pay out of your HSA.

Emergency Room & Hospitalization Visits
Step 1) Give the medical facility your new ID card.

Step 2) Medical facility will submit the itemized bill to your insurance company.

Note: You will not pay anything to the medical facility at the time you are discharged because you do not have a Copay plan.

Step 3) After your insurance company receives your doctor's bill, they will reprice the claim for their discounts and then send you and the medical facility an Explanation of Benefits (EOB) showing how much of the billed charge is allowed and what your member responsibility is. Remember, before you have coverage on your HDHP HSA PPO, you first have to pay your Deductible.

Step 4) After the medical facility receives the EOB from your insurance company, they will send you a bill.

Step 5) After you receive the bill from the medical facility, cross check that with the EOB from your insurance company to make sure the amount they are billing you matches what your insurance company states you owe.

Step 6) After you've done Step 5 and have verified that the medical facility is billing you the correct amount, pay the bill by writing your HSA debit card number on the bill they sent you.

Note: If you do not have enough money in your HSA to pay the bill, you will have to pay the bill with another source albeit a check out of your regular checking account, cash, debit or a credit card.

Tip: Talk to your provider about a payment plan if you will have money in your HSA in the near future and want to pay out of your HSA.

Pharmacy
Step 1) Give your pharmacy your new ID card.

Step 2) The pharmacy will run your prescription(s) through their system and reprice the prescription(s) to account for your insurance company's discount.

Step 3) The pharmacy will submit the claim electronically to your insurance company, so you will get Deductible and/or Coinsurance credit applied for your prescription(s).

Note: You will be required to pay the pharmacy for your prescription(s) at the time you pick up your prescription(s).

Step 4) Pay for your prescriptions using your HSA debit card.

Note: If you do not have enough money in your HSA to pay for your prescriptions, you will have to pay for them with another source albeit a check out of your regular checking account, cash, debit or a credit card.

HSA BANK™
National Leader in Health Savings Accounts.

P.O. Box 939 • Sheboygan • Wisconsin, 53082-0939
605 N. 8th Street, Suite 320 • Sheboygan • Wisconsin, 53081-4525
Phone: 800-357-6246 • Fax: 877-851-7041
E-mail: askus@hsabank.com • Internet: www.hsabank.com

Eligible Medical Expenses

An eligible expense is defined as those expenses paid for care as described in Section 213 (d) of the Internal Revenue Code. Below are two lists which may help determine whether an expense is eligible.

These lists are to serve as a quick reference and are provided to you with the understanding that ***HSA Bank™*** is not engaged in rendering tax advice. For more detailed information, please refer to IRS Publication 502 titled, "Medical and Dental Expenses," Catalog Number 15002Q. Publications can be ordered directly from the IRS by calling 1-800-TAX FORM. If tax advice is required, you should seek the services of a professional.

Eligible Medical Expenses (for HSA Distributions)

- Abdominal supports
- Abortion
- Acupuncture
- Air conditioner *(when necessary for relief from difficulty in breathing)*
- Alcoholism treatment
- Ambulance
- Anesthetist
- Arch supports
- Artificial limbs
- Autoette *(when used for relief of sickness/disability)*
- Birth Control Pills *(by prescription)*
- Blood tests
- Blood transfusions
- Braces
- Cardiographs
- Chiropractor
- Childbirth/Delivery
- Christian Science Practitioner
- Contact Lenses
- Contraceptive devices *(by prescription)*
- Convalescent home *(for medical treatment only)*
- Crutches
- Dental Treatment
- Dental X-rays
- Dentures
- Dermatologist
- Diagnostic fees
- Drug addiction therapy
- Drugs *(prescription)*
- Elastic hosiery *(prescription)*
- Eyeglasses
- Fees paid to health institute prescribed by a doctor
- FICA and FUTA tax paid for medical care service
- Fluoridation unit
- Guide dog
- Gum treatment
- Gynecologist
- Hearing aids and batteries
- Hospital bills
- Hydrotherapy
- Insulin treatment
- Lab tests
- Lead paint removal
- Legal fees
- Lodging *(away from home for outpatient care)*
- Metabolism tests
- Neurologist
- Nursing *(including board and meals)*
- Obstetrician
- Operating room costs
- Ophthalmologist
- Optician
- Optometrist
- Oral surgery
- Organ transplant *(including donor's expenses)*
- Orthopedic shoes
- Orthopedist
- Osteopath
- Oxygen and oxygen equipment
- Pediatrician
- Physician
- Physiotherapist
- Podiatrist
- Postnatal treatments
- Practical nurse for medical services
- Prenatal care
- Prescription medicines
- Psychiatrist
- Psychoanalyst
- Psychologist
- Psychotherapy
- Radium Therapy
- Registered nurse
- Special school costs for the handicapped
- Spinal fluid test
- Splints
- Sterilization
- Surgeon
- Telephone or TV equipment to assist the hard-of-hearing
- Therapy equipment
- Transportation expenses *(relative to health care)*
- Ultra-violet ray treatment
- Vaccines
- Vasectomy
- Vitamins *(if prescribed)*
- Wheelchair
- X-rays

Over-the-Counter Drugs

- Antacids
- Allergy medications
- Pain relievers
- Cold medicine
- Anti-diarrhea medicine
- Cough drops and throat lozenges
- Sinus medications and nasal sprays
- Nicotine medications and nasa sprays
- Pedialyte
- First aid creams
- Calamine lotion
- Stop-smoking programs
- Wart removal medication
- Antibiotic ointments
- Suppositories and creams for hemorrhoids
- Sleep Aids
- Motion sickness pills

Ineligible Medical Expenses

- Advancement payment for services to be rendered next year
- Athletic Club membership
- Automobile insurance premium allocable to medical coverage
- Boarding school fees
- Bottled Water
- Commuting expenses of a disabled person
- Cosmetic surgery and procedures
- Cosmetics, hygiene products and similar items
- Funeral, cremation, or burial expenses
- Health programs offered by resort hotels, health clubs, and gyms
- Illegal operations and treatments
- Illegally procured drugs
- Maternity clothes
- Non-prescription medication
- Premiums for life insurance, income protection, disability, loss of limbs, sight or similar benefits
- Scientology counseling
- Social activities
- Special foods and beverages
- Specially designed car for the handicapped other than an autoette or special equipment
- Swimming pool
- Travel for general health improvement
- Tuition and travel expenses a problem child to a particular school
- Weight loss programs

Over-the-Counter Drugs

- Toiletries (including toothpaste)
- Acne treatments
- Lip balm (including cahpstick or carmex)
- Suntan lotion
- Medicated shampoos and soaps
- Vitamins (daily)
- Fiber supplements
- Dietary supplements
- Weight loss drugs for general well being
- Herbs

Health insurance may not be purchased with HSA Funds. There are three (3) situations which are exceptions whereby HSA funds can be used to pay for:

1) A health plan during any period of continuation coverage required under any Federal law
2) A qualified long-term care insurance contract
3) A health plan during a period in which the individual is receiving unemployment compensation under any Federal or State Law.
4) For individuals over age 65, premiums for Medicare Part A or B, a Medicare HMO and/or the employee share of premiums for employer-sponsored health insurance, including premiums for employer-sponsored retiree health insurance.

HSA Bank™ is a division of Webster Bank, N.A.

HSAEME0206

Treasury, IRS Issue 2009 Indexed Amounts for Health Savings Accounts

Washington, DC--The Treasury Department and Internal Revenue Service issued new guidance on the maximum contribution levels for Health Savings Accounts (HSAs) and out-of-pocket spending limits for High Deductible Health Plans (HDHPs) that must be used in conjunction with HSAs. These amounts have been indexed for cost-of-living adjustments for 2010 and are included in Revenue Procedure 2009-29.

The new levels are as follows:

New Annual Contribution Levels for HSAs:

- For 2010, the maximum annual HSA contribution for an eligible individual with self-only coverage is $3,050.
- For family coverage, the maximum annual HSA contribution is $6,150.
- Catch up contribution for individual who are 55 or older is $1,000 (set by statute and unchanged from 2009).
- Individuals who are eligible individuals on the first day of the last month of the taxable year (December for most taxpayers) are allowed the full annual contribution (plus catch up contribution, if 55 or older by year end), regardless of the number of months the individual was an eligible individual in the year. For individuals who are no longer eligible individuals on that date, both the HSA contribution and catch up contribution apply pro rata based on the number of months of the year a taxpayer is an eligible individual.

New Amounts for Out-of-Pocket Spending on HSA-Compatible HDHPs:

- For 2010, the maximum annual out-of-pocket amounts for HDHP self-coverage increase to $5,950 and the maximum annual out-of-pocket amount for HDHP family coverage is twice that, $11,900.

Minimum Deductible Amounts for HSA-Compatible HDHPs:

- For 2010, the minimum deductible for HDHPs increases to $1,200 for self-only coverage and $2,400 for family coverage.

In addition, a fiscal year plan that satisfies the requirements for an HDHP on the first day of the first month of its fiscal year may apply that deductible for the entire fiscal year.

Revenue Procedure 2009-29 is attached.

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REPORTS

- Revenue Procedure 2009-29

Dental Program

American Home Health Corp.

Dental Program (Effective: 1/1/10 - 12/31/10)

Carrier		Humana/CompBenefits			
Plan Type		**PPO**		**PPO**	
Network Name		**Humana/CompBenefits PPO**		**Humana/CompBenefits PPO**	
Plan Name		**PPO EP 605 ("Low Plan")**		**PPO EP 505 ("High Plan")**	
Annual Maximum		**In-Network**	**Non-Network**	**In-Network**	**Non-Network**
Per Individual		$2,000	$1,000	$1,000	
Calendar Year Deductible (applies unless otherwise indicated)					
Individual		$0	$100	$50	
Family		$0	$300	$150	
Reimbursement Method					
Limitations		Negotiated Discounts	MAC	Negotiated Discounts	80th Percentile of U&C
Preventive Services	**Code**				
Deductible		**Waived**	**Waived**	**Waived**	**Waived**
Oral Examination	0120	100%	25%	100%	80%
Prophylaxis/Cleaning	1110/20	100%	25%	100%	80%
Bitewings (2 or 4 Films)	0270/74	100%	25%	100%	80%
Sealants (per tooth)	1351	100%	25%	100%	80%
Basic Services	**Code**				
Waiting Periods		**None**		**None**	
Amalgams (1 Surface Primary)	2110	80%	25%	90%	80%
Resins (1 Surface Anterior)	2330	80%	25%	90%	80%
Extraction	7110	80%	25%	90%	80%
***Endodontics**	**Code**				
Waiting Periods		**12 Months (Credit Given)**		**12 Months (Credit Given)**	
Molar Root Canal	3330	50%	25%	60%	50%
Pulpotomy	3220	50%	25%	60%	50%
***Periodontics**	**Code**				
Waiting Periods		**12 Months (Credit Given)**		**12 Months (Credit Given)**	
Scaling and Root Planing	4341	50%	25%	60%	50%
Osseous Surgery	4260	50%	25%	60%	50%
***Major Services**	**Code**				
Waiting Periods		**12 Months (Credit Given)**		**12 Months (Credit Given)**	
Crown (Porcelain)	2740	50%	25%	60%	50%
Denture (Complete)	5110/20	50%	25%	60%	50%
Bridge (High Noble)	6210	50%	25%	60%	50%
***Orthodontics**	**Code**				
Waiting Periods		**12 Months (Credit Given)**		N/A	
Lifetime Maximum		$1,000		N/A	
Child Ortho	8080	50%		Not Covered	
Adult Ortho	8090	Not Covered		Not Covered	

***If you have been enrolled on American Home Health Corp's (AHHC's) group dental plan from 1/1/09 - 12/31/09, the 12 month waiting period is waived for you. If you have not been on AHHC's dental plan for the 12 months prior to 1/1/10, you will have to be enrolled on the new Humana/CompBenefits dental program for 12 months before getting benefits paid for these services.**

THE "LOW PLAN" PPO OPTION WAS DESIGNED FOR EMPLOYEES WHO WILL USE HUMANA's/COMPBENEFIT's NETWORK OF DENTISTS. IF YOU ARE NOT GOING TO USE THEIR NETWORK, YOU ARE ADVISED TO ENROLL IN THE "HIGH PLAN"

Deductions below are taken on a pre-tax basis

Payroll Deductions	PPO "Low Plan"		PPO "High Plan"	
	Bi-monthly	Annual Cost	Bi-monthly	Annual Cost
Employee Only	**$6.68**	$160.32	**$16.27**	$390.48
Employee + 1 Dependent (Spouse or Child)	**$13.39**	$321.36	**$31.35**	$752.40
Family (Employee + 2 or more dependents)	**$23.16**	$555.84	**$47.28**	$1,134.72

This coverage has limitations and exclusions. Please refer to your benefit booklet for a complete description of your coverage and benefits. This highlight sheet provides a brief description of coverage. In the event that a discrepancy exists, the policy provisions will prevail.

HOW TO FIND A NETWORK DENTAL PROVIDER

Humana/CompBenefits

Note: As a Humana/CompBenefits' Dental PPO member, you may choose a dentist in either Humana's PPO network or CompBenefits' PPO network. To find a dentist in either network, follow these guidelines…

Humana

1. Log on to: http://www.humanadental.com.
2. Click on the link, "Find a Dentist."
3. Enter a Zip Code in the box entitled, "Search by Coverage & Network."
4. In the drop down menu box where you can select a network name, choose, "PPO/Traditional Preferred" and hit the "Go" button.
5. Click the "I agree to the Terms of Use" box and enter your specific dentist search criteria from here.

CompBenefits

1. Log on to: http://www.compbenefits.com.
2. Under "Customers," choose on the drop down menu, "Members."
3. Click on the link, "Find Dental Providers."
4. Click on the link, "PPO Plans."
5. Enter your specific dentist search criteria from here.

American Home Health
Low Option

➢ **QUICK CLAIMS TURNAROUND**
CompBenefits' state of the art claims center provides fast reimbursement of your claims.

➢ **ACCESS TO INFORMATION**
Our toll-free customer service number at 1-(800)-342-5209 has Member Services Representatives who can provide the answers you need quickly and thoroughly.

➢ **TOTAL FREEDOM OF CHOICE**
The plan provides you with total freedom of choice by allowing you to use any licensed dentist for treatment. The plan reimburses a percentage of eligible expenses based on the plan you have chosen.

This brochure contains a brief description of the plan. A complete description of the coverage, including limitations on certain procedures, is found in the Schedule of Benefits and Certificate of Group Dental Insurance.

*Coverage based on contracted fees for the Preferred Provider Network.

**Time served on the employer's immediately preceding group dental plan may be credited towards this plan's waiting periods, subject to Underwriting approval.

***Maximum of 3 per family.

CompBenefits Family of Companies

CompBenefits Company • CompDent • CompBenefits Insurance Company
CompBenefits Dental, Inc. • American Dental Plan of North Carolina, Inc.
National Dental Plans, Inc.• OHS of Alabama, Inc.
American Dental Plan of Georgia, Inc. • Texas Dental Plans, Inc.
Ultimate Optical, Inc. • VisionCare Plan • Primary Plus

SUMMARY OF BENEFITS

Partial Listing of Covered Services*	In-Network Reimbursements	Out-of-Network Reimbursements

Type I Diagnostic & Preventive…100%……..…..25%
Oral Examination (once per six months)
Prophylaxis (cleaning, once per six months)
Topical Fluoride (children under 16, once per 12 months)
X-Rays (limitations may apply)
Sealants (once per 3 years for children under age 16, for non carious molars only)

Type II Basic Services……80%……25%
Simple Restorative (amalgam, synthetic, or composite fillings)
Space Maintainers (for children under age 16)
Non-Surgical Tooth Extractions
Non-Surgical Periodontics

Type III Major Services……50%……25%
(Prior carrier credit - 12 month waiting period**)
Major Restorative (crowns/inlays/onlays)
Bridge, Denture Repair
Prosthetics (bridges and dentures)
Emergency Palliative Treatment
Endodontics (root canals)
Surgical Tooth Extractions
Surgical Periodontics

Type IV Orthodontics (Optional)…50%……50%
Prior carrier credit - 12 month waiting period**)
Dependent children 18 years of age or younger

MAXIMUM BENEFITS

	Insured Individual and Dependents
Lifetime	
Type I, II, III	Unlimited / Unlimited
Type IV	$1,000 / $1,000
Calendar Year	
Type I, II, III	$2,000 / $1,000
Type IV	$1,000 / $1,000
Deductible* **	
Type I	None / None
Type II, III, IV	$0 / $100

Voluntary+ PPO – Ortho

MAJOR RESTORATIVE LIMITATIONS

The charges for Major Restorative services will be Covered Dental Expenses subject to the following:

1. the denture or partial denture must replace a Natural Tooth extracted while insured for Dental Benefits under this policy;

2. the fixed bridge (including a resin bonded fixed bridge) must replace a Natural Tooth extracted while insured for Dental Benefits under this policy;

3. the replacement of a partial denture, full denture, or fixed partial denture (including a resin bonded bridge), or the addition of teeth to a partial denture if: (a) replacement occurs at least five years after the initial date of insertion of the current full or partial denture or resin bonded bridge; (b) replacement occurs at least five years after the initial date of insertion of an existing implant or fixed bridge; (c) replacement prosthesis or the addition of a tooth to a partial denture is required by the necessary extraction of a Functioning Natural Tooth while insured for Dental Benefits under this policy; or (d) replacement is made necessary by a Covered Dental Injury to a partial denture, full denture, or fixed partial denture (including a resin bonded bridge) provided the replacement is completed within 12 months of the injury;

4. the replacement of crowns, cast restorations, inlays, onlays or other laboratory prepared restorations if: (a) replacement occurs at least five years after the initial date of insertion; and (b) they are not serviceable and cannot be restored to function;

5. the replacement of an existing partial denture with fixed bridgework, only if upgrading to fixed bridgework is essential to the correction of the person's dental condition; and

6. the replacement of teeth up to the normal complement of 32.

EXCLUSIONS

Benefits will not be paid for:

1. procedures which are not included in the Schedule of Benefits; which are not medically necessary; which do not have uniform professional endorsement; are experimental or investigational in nature; for which the patient has no legal obligation to pay; or for which a charge would not have been made in the absence of insurance;

2. any procedure, service, or supply which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least three years, as determined by CompBenefits Insurance Company;

3. crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth which may be restored with an amalgam or composite resin filling;

4. appliances, inlays, cast restorations or other laboratory prepared restorations used primarily for the purpose of splinting;

5. any procedure, service, supply or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension; the alteration or restoration of occlusion including occlusal adjustment, bite registration, or bite analysis;

6. pulp caps, adult fluoride treatments, athletic mouthguards; myofunctional therapy; infection control; precision or semi-precision attachments; denture duplication; oral hygiene instruction; separate charges for acid etch; broken appointments; treatment of jaw fractures; orthognathic surgery; completion of claim forms; exams required by third party; personal supplies (e.g. water pik, toothbrush, floss holder, etc.); or replacement of lost or stolen appliances;

7. charges for travel time; transportation costs; or professional advice given on the phone;

8. procedures performed by a Dentist who is a member of Your immediate family;

9. any charges, including ancillary charges, made by a hospital, ambulatory surgical center, or similar facility;

10. charges for treatment rendered: (a) in a clinic, dental or medical facility sponsored or maintained by the employer of any member of Your family; or (b) by an employee of the employer of any member of Your family;

11. any procedure, service or supply required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joints or their associated structures;

12. charges for treatment performed outside of the United States other than for emergency treatment. Benefits for emergency treatment which is performed outside of the United States are limited to a maximum of $100 (US dollars) per year;

13. the care or treatment of an injury or sickness due to war or an act of war, declared or undeclared;

14. treatment for cosmetic purposes. Facings on crowns or bridge units on molar teeth will always be considered cosmetic;

15. any services or supplies which do not meet the standards set by the American Dental Association or which are not reasonably necessary, or customarily used, for dental care;

16. procedures that are a covered expense under any other medical plan (established by the employer) which provides group hospital, surgical, or medical benefits whether or not on an insured basis;

17. a sickness for which the patient can receive benefits under a workers' compensation act or similar law;

18. an injury that arises out of or in the course of a job or employment for pay or profit;

19. charges to the extent that they are more than the Prevailing Fee. If the amount of the Prevailing Fee for a service cannot be determined due to the unusual nature of the service, CompBenefits Insurance Company will determine the amount. CompBenefits Insurance Company will take into account: (a) the complexity involved; (b) the degree of professional skill required; and (c) other pertinent factors; or

20. orthodontic plan benefits for persons 19 years of age or older.

PREDETERMINATION

If Covered Dental Expenses for a procedure are expected to be more than $200 it is recommended that you send a Dental Treatment Plan in prior to beginning treatment, send preauthorization to CompBenefits, P.O. Box 8236 Chicago, IL 60680–8236. You and/or your dentist will be notified of the benefits payable based upon the Dental Treatment Plan.

This brochure contains a brief description of the plan. A complete description of the coverage, including limitations on certain procedures is found in the Schedule of Benefits and Certificate of Group Dental Insurance.

American Home Health
High Option

➢ **QUICK CLAIMS TURNAROUND**
CompBenefits' state of the art claims center provides fast reimbursement of your claims.

➢ **ACCESS TO INFORMATION**
Our toll-free customer service number at 1-(800)-342-5209 has Member Services Representatives who can provide the answers you need quickly and thoroughly.

➢ **TOTAL FREEDOM OF CHOICE**
The plan provides you with total freedom of choice by allowing you to use any licensed dentist for treatment. The plan reimburses a percentage of eligible expenses based on the plan you have chosen.

This brochure contains a brief description of the plan. A complete description of the coverage, including limitations on certain procedures, is found in the Schedule of Benefits and Certificate of Group Dental Insurance.

*Coverage based on usual, customary and reasonable fees.

**Time served on the employer's immediately preceding group dental plan may be credited towards this plan's waiting periods, subject to Underwriting approval.

***Maximum of 3 per family.

SUMMARY OF BENEFITS

Partial Listing of Covered Services*	In-Network Reimbursements	Out-of-Network Reimbursements

Type I Diagnostic & Preventive….100%…….80%
Oral Examination (once per six months)
Prophylaxis (cleaning, once per six months)
Topical Fluoride (children under 16, once per 12 months)
X-Rays (limitations may apply)
Sealants (once per 3 years for children under age 16, for non carious molars only)

Type II Basic Services……..90%…….80%
Simple Restorative (amalgam, synthetic, or composite fillings)
Space Maintainers (for children under age 16)
Non-Surgical Tooth Extractions
Non-Surgical Periodontics

Type III Major Services…….60%…….50%
(Prior carrier credit - 12 month waiting period**)
Major Restorative (crowns/inlays/onlays)
Bridge, Denture Repair
Prosthetics (bridges and dentures)
Emergency Palliative Treatment
Endodontics (root canals)
Surgical Tooth Extractions
Surgical Periodontics

MAXIMUM BENEFITS

	Insured Individual and Dependents
Lifetime	
Type I, II, III	Unlimited……Unlimited
Calendar Year	
Type I, II, III	$1,000……$1,000
Deductible* **	
Type I	None……None
Type II, III	$50……$50

Voluntary+ PPO

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MAJOR RESTORATIVE LIMITATIONS

The charges for Major Restorative services will be Covered Dental Expenses subject to the following:

1. the denture or partial denture must replace a Natural Tooth extracted while insured for Dental Benefits under this policy;

2. the fixed bridge (including a resin bonded fixed bridge) must replace a Natural Tooth extracted while insured for Dental Benefits under this policy;

3. the replacement of a partial denture, full denture, or fixed partial denture (including a resin bonded bridge), or the addition of teeth to a partial denture if: (a) replacement occurs at least five years after the initial date of insertion of the current full or partial denture or resin bonded bridge; (b) replacement occurs at least five years after the initial date of insertion of an existing implant or fixed bridge; (c) replacement prosthesis or the addition of a tooth to a partial denture is required by the necessary extraction of a Functioning Natural Tooth while insured for Dental Benefits under this policy; or (d) replacement is made necessary by a Covered Dental Injury to a partial denture, full denture, or fixed partial denture (including a resin bonded bridge) provided the replacement is completed within 12 months of the injury;

4. the replacement of crowns, cast restorations, inlays, onlays or other laboratory prepared restorations if: (a) replacement occurs at least five years after the initial date of insertion; and (b) they are not serviceable and cannot be restored to function;

5. the replacement of an existing partial denture with fixed bridgework, only if upgrading to fixed bridgework is essential to the correction of the person's dental condition; and

6. the replacement of teeth up to the normal complement of 32.

EXCLUSIONS

Benefits will not be paid for:

1. procedures which are not included in the Schedule of Benefits; which are not medically necessary; which do not have uniform professional endorsement; are experimental or investigational in nature; for which the patient has no legal obligation to pay; or for which a charge would not have been made in the absence of insurance;

2. any procedure, service, or supply which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least three years, as determined by CompBenefits Insurance Company;

3. crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth which may be restored with an amalgam or composite resin filling;

4. appliances, inlays, cast restorations or other laboratory prepared restorations used primarily for the purpose of splinting;

5. any procedure, service, supply or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension; the alteration or restoration of occlusion including occlusal adjustment, bite registration, or bite analysis;

6. pulp caps, adult fluoride treatments, athletic mouthguards; myofunctional therapy; infection control; precision or semi-precision attachments; denture duplication; oral hygiene instruction; separate charges for acid etch; broken appointments; treatment of jaw fractures; orthognathic surgery; completion of claim forms; exams required by third party; personal supplies (e.g. water pik, toothbrush, floss holder, etc.); or replacement of lost or stolen appliances;

7. charges for travel time; transportation costs; or professional advice given on the phone;

8. procedures performed by a Dentist who is a member of Your immediate family;

9. any charges, including ancillary charges, made by a hospital, ambulatory surgical center, or similar facility;

10. charges for treatment rendered: (a) in a clinic, dental or medical facility sponsored or maintained by the employer of any member of Your family; or (b) by an employee of the employer of any member of Your family;

11. any procedure, service or supply required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joints or their associated structures;

12. charges for treatment performed outside of the United States other than for emergency treatment. Benefits for emergency treatment which is performed outside of the United States are limited to a maximum of $100 (US dollars) per year;

13. the care or treatment of an injury or sickness due to war or an act of war, declared or undeclared;

14. treatment for cosmetic purposes. Facings on crowns or bridge units on molar teeth will always be considered cosmetic;

15. any services or supplies which do not meet the standards set by the American Dental Association or which are not reasonably necessary, or customarily used, for dental care;

16. procedures that are a covered expense under any other medical plan (established by the employer) which provides group hospital, surgical, or medical benefits whether or not on an insured basis;

17. a sickness for which the patient can receive benefits under a workers' compensation act or similar law;

18. an injury that arises out of or in the course of a job or employment for pay or profit;

19. charges to the extent that they are more than the Prevailing Fee. If the amount of the Prevailing Fee for a service cannot be determined due to the unusual nature of the service, CompBenefits Insurance Company will determine the amount. CompBenefits Insurance Company will take into account: (a) the complexity involved; b) the degree of professional skill required; and (c) other pertinent factors; or

20. orthodontic plan benefits for persons 19 years of age or older.

PREDETERMINATION

If Covered Dental Expenses for a procedure are expected to be more than $200 it is recommended that you send a Dental Treatment Plan in prior to beginning treatment, send preauthorization to CompBenefits, P.O. Box 8236 Chicago, IL 60680–8236. You and/or your dentist will be notified of the benefits payable based upon the Dental Treatment Plan.

This brochure contains a brief description of the plan. A complete description of the coverage, including limitations on certain procedures is found in the Schedule of Benefits and Certificate of Group Dental Insurance.

Long-term Disability

&

Voluntary Life & AD&D

AMERICAN HOME HEALTH CORPORATION

Insurance Benefit Summary

Dear Valued Employee:

AMERICAN HOME HEALTH CORPORATION is very pleased to offer you an opportunity to purchase optional coverage from The Prudential Insurance Company of America. The pages that follow this letter describe the additional insurance that you may purchase.

Your coverage will begin on the effective date of coverage if you are actively at work. If you apply for an amount that requires evidence of good health, your coverage will be effective on the date of approval for the amount requiring evidence if you are actively at work on that date. Otherwise, your coverage will begin on the date you return to active work. See your Booklet-Certificate for details.

Peace of Mind from Prudential

Prudential's resources, financial strength, and stability allow us to honor our long-term commitments. That means that we'll be here when you and your family need us. We've been a top insurance provider for over 130 years. Plus, we have the advanced technology and caring professionals to provide your beneficiaries with the kind of customer support they want and deserve. Our Customer Service Representatives are well-trained, knowledgeable professionals who can quickly answer your family's questions. By choosing Prudential, you give yourself peace of mind, knowing you are providing for your loved ones.

For more information about Prudential's Group Insurance, visit us online at: www.prudential.com/gi

Enrolling is easy!

Simply complete the following enrollment form and return it. Don't miss out on this valuable employee benefit!

What does group life insurance offer my family?

The choices for coverage available to you include the following special features.

Accelerated Benefit Option - If terminally ill, you can get a partial payment of your group term life insurance benefit. You can use this payment as you see fit. In the event of your death, your beneficiary will receive the benefit payout which has been reduced by the amount you receive.

Prudential's Alliance Account®[1] - This settlement option is a convenient way for beneficiaries to manage their benefit payout during a stressful time. Once a claim is approved, we establish an interest-bearing Alliance Account in the beneficiary's name. Beneficiaries can leave the money in the account to earn continuous interest, withdraw the entire amount immediately, or write drafts (checks) against the balance.

Waiver of Premium - Payment of your premium can be waived if you meet certain conditions. The Waiver of Premium Benefit terminates at Age 65.This provision may vary by state.

Conversion to Individual Insurance Coverage - Upon termination of employment, you may convert your coverage to a Prudential individual life insurance policy, without having to provide evidence of good health.

Portability of Group Insurance Coverage - Upon termination of employment, you may continue a certain level of your employee and dependent coverage, without having to provide evidence of good health.

Employee Assistance Plan - The services resolve concerns before they become serious problems for individuals or employers. It addresses a wide range of issues from stress and family conflicts to major life changes.

Travel Assist - With a single phone call, Travel Assist participants have access to assistance services when faced with an emergency while travelling internationally or domestically when more than 100 miles away from home.

How much Life Insurance do I need?

The Consumer Federation of America (CFA, 1997) **recommends 6 to 8 times your income** for a married couple with children. While rules of thumb may be helpful, they do not take each individual's personal situation into consideration. Please use our needs calculator to learn more about how much you & your family need. You can find our calculator by visiting **www.prudential.com/howmuchdoIneed.**

[1]Open Solutions BIS, Inc. is the administrator of the Prudential Alliance Account Settlement Option, a contractual obligation of the Prudential Insurance Company of America, located at 751 Broad Street, Newark, NJ 07102-3777. Check clearing is provided by JPMorgan Chase Bank, N.A. and processing support is provided by Integrated Payment Systems, Inc. Alliance Account balances are not insured by the Federal Deposit Insurance Corporation (FDIC). Open Solutions BIS, Inc., JPMorgan Chase Bank, N.A. and Integrated Payment Systems, Inc. are not Prudential Financial companies.

What does disability insurance offer me?

For Long Term Disability

Zero Day Residual Provision - You can satisfy the elimination period without being totally disabled.

Partial Disability Benefit - Receive partial disability benefits while working a reduced schedule.

Return-to-Work Incentive - During the first 12 months of part-time work while disabled, you can receive full benefits as long as your combined income and disability benefits do not exceed your monthly indexed pre-disability earnings.

Worksite Modification - Remain at work or return to work with worksite modifications.

Rehabilitation Program - Receive vocational evaluation and job placement assistance.

Waiver of Premium - Disability premiums are waived while you are disabled.

Employee Assistance Plan - The services resolve concerns before they become serious problems for individuals or employers. It addresses a wide range of issues from stress and family conflicts to major life changes.

Why do I need Disability Insurance?

While nearly everyone has auto or homeowner's insurance, many people have not insured their most valuable asset - their ability to produce income. Studies show that American workers face at least a one-in-three chance of being disabled, for three months or longer, during their career. If you were sick or injured that long, how would you pay your monthly expenses? Could you afford essentials like food, utilities, and house and car payments? What about credit-card debt, college tuition, and retirement funding? Disability causes nearly 50% of all mortgage foreclosures, 2% are caused by death (Health Affairs, The Policy Journal of the Health Sphere, 2 February 2005). Please use our expense calculator to better understand how much you would need to meet your bills in the event of a disability. You can find our calculator by visiting **www.prudential.com/replacemyincome.**

Optional Employee Term Life

You may elect to purchase coverage amounts in increments of $10,000 from $10,000 to $300,000, not to exceed 5 times your covered annual earnings.

- During the initial enrollment period, if you have not been previously denied coverage, you may enroll for coverage up to $200,000. If you choose a coverage amount over $200,000, you will need to provide evidence of insurability satisfactory to Prudential.
- During annual enrollment periods, if you have not been previously denied coverage, you may select to increase your current coverage amount by up to $40,000, without providing evidence of insurability satisfactory to Prudential.
- Late entrants are required to provide evidence of insurability satisfactory to Prudential to enroll in all coverage amounts. A late entrant is someone who is enrolling more than 31 days after they were first eligible.
- Coverage will be reduced as you age by 35% at age 65 and 50% at age 70.

Optional Term Life Insurance For You

To determine the semi-monthly cost of your coverage, please see the chart below.

Age	$10,000	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000	$90,000	$100,000	$110,000	$120,000	$130,000
0-19	$0.35	$0.70	$1.05	$1.40	$1.75	$2.10	$2.45	$2.80	$3.15	$3.50	$3.85	$4.20	$4.55
20-24	$0.35	$0.70	$1.05	$1.40	$1.75	$2.10	$2.45	$2.80	$3.15	$3.50	$3.85	$4.20	$4.55
25-29	$0.35	$0.70	$1.05	$1.40	$1.75	$2.10	$2.45	$2.80	$3.15	$3.50	$3.85	$4.20	$4.55
30-34	$0.40	$0.80	$1.20	$1.60	$2.00	$2.40	$2.80	$3.20	$3.60	$4.00	$4.40	$4.80	$5.20
35-39	$0.60	$1.20	$1.80	$2.40	$3.00	$3.60	$4.20	$4.80	$5.40	$6.00	$6.60	$7.20	$7.80
40-44	$1.05	$2.10	$3.15	$4.20	$5.25	$6.30	$7.35	$8.40	$9.45	$10.50	$11.55	$12.60	$13.65
45-49	$1.40	$2.80	$4.20	$5.60	$7.00	$8.40	$9.80	$11.20	$12.60	$14.00	$15.40	$16.80	$18.20
50-54	$2.20	$4.40	$6.60	$8.80	$11.00	$13.20	$15.40	$17.60	$19.80	$22.00	$24.20	$26.40	$28.60
55-59	$3.25	$6.50	$9.75	$13.00	$16.25	$19.50	$22.75	$26.00	$29.25	$32.50	$35.75	$39.00	$42.25
60-64	$4.30	$8.60	$12.90	$17.20	$21.50	$25.80	$30.10	$34.40	$38.70	$43.00	$47.30	$51.60	$55.90
65-69	$6.35	$12.70	$19.05	$25.40	$31.75	$38.10	$44.45	$50.80	$57.15	$63.50	$69.85	$76.20	$82.55
70-74	$10.30	$20.60	$30.90	$41.20	$51.50	$61.80	$72.10	$82.40	$92.70	$103.00	$113.30	$123.60	$133.90
75-79	$19.85	$39.70	$59.55	$79.40	$99.25	$119.10	$138.95	$158.80	$178.65	$198.50	$218.35	$238.20	$258.05
80-84	$19.85	$39.70	$59.55	$79.40	$99.25	$119.10	$138.95	$158.80	$178.65	$198.50	$218.35	$238.20	$258.05
85+	$19.85	$39.70	$59.55	$79.40	$99.25	$119.10	$138.95	$158.80	$178.65	$198.50	$218.35	$238.20	$258.05

Age	$140,000	$150,000	$160,000	$170,000	$180,000	$190,000	$200,000	$220,000	$230,000	$250,000	$270,000	$280,000	$300,000
0-19	$4.90	$5.25	$5.60	$5.95	$6.30	$6.65	$7.00	$7.70	$8.05	$8.75	$9.45	$9.80	$10.50
20-24	$4.90	$5.25	$5.60	$5.95	$6.30	$6.65	$7.00	$7.70	$8.05	$8.75	$9.45	$9.80	$10.50
25-29	$4.90	$5.25	$5.60	$5.95	$6.30	$6.65	$7.00	$7.70	$8.05	$8.75	$9.45	$9.80	$10.50
30-34	$5.60	$6.00	$6.40	$6.80	$7.20	$7.60	$8.00	$8.80	$9.20	$10.00	$10.80	$11.20	$12.00
35-39	$8.40	$9.00	$9.60	$10.20	$10.80	$11.40	$12.00	$13.20	$13.80	$15.00	$16.20	$16.80	$18.00
40-44	$14.70	$15.75	$16.80	$17.85	$18.90	$19.95	$21.00	$23.10	$24.15	$26.25	$28.35	$29.40	$31.50
45-49	$19.60	$21.00	$22.40	$23.80	$25.20	$26.60	$28.00	$30.80	$32.20	$35.00	$37.80	$39.20	$42.00
50-54	$30.80	$33.00	$35.20	$37.40	$39.60	$41.80	$44.00	$48.40	$50.60	$55.00	$59.40	$61.60	$66.00
55-59	$45.50	$48.75	$52.00	$55.25	$58.50	$61.75	$65.00	$71.50	$74.75	$81.25	$87.75	$91.00	$97.50
60-64	$60.20	$64.50	$68.80	$73.10	$77.40	$81.70	$86.00	$94.60	$98.90	$107.50	$116.10	$120.40	$129.00
65-69	$88.90	$95.25	$101.60	$107.95	$114.30	$120.65	$127.00	$139.70	$146.05	$158.75	$171.45	$177.80	$190.50
70-74	$144.20	$154.50	$164.80	$175.10	$185.40	$195.70	$206.00	$226.60	$236.90	$257.50	$278.10	$288.40	$309.00
75-79	$277.90	$297.75	$317.60	$337.45	$357.30	$377.15	$397.00	$436.70	$456.55	$496.25	$535.95	$555.80	$595.50
80-84	$277.90	$297.75	$317.60	$337.45	$357.30	$377.15	$397.00	$436.70	$456.55	$496.25	$535.95	$555.80	$595.50
85+	$277.90	$297.75	$317.60	$337.45	$357.30	$377.15	$397.00	$436.70	$456.55	$496.25	$535.95	$555.80	$595.50

Optional Spouse Term Life

If you are electing Optional Life coverage, you may also elect Dependent Term Life Insurance for your spouse. Purchase coverage for your spouse in increments of $5,000 from $5,000 to $150,000, not to exceed 50% of your Optional Life coverage amount.

- During the initial enrollment period, if you have not been previously denied coverage, you may enroll for coverage up to $20,000. If you choose a coverage amount over $20,000, you will need to provide evidence of insurability satisfactory to Prudential.
- Late entrants are required to provide evidence of insurability satisfactory to Prudential to enroll in all coverage amounts. A late entrant is someone who is enrolling more than 31 days after they were first eligible.
- If your spouse or other dependent is confined for medical care or treatment at home or elsewhere, coverage will begin when confinement ends.
- Spouse coverage will be reduced as the employee ages by 35% at age 65 and 50% at age 70.

Optional Term Life For Your Spouse

To determine the semi-monthly cost of your spouse's coverage, please see the chart below.

Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000	$55,000	$60,000	$65,000
0-19	$0.18	$0.35	$0.53	$0.70	$0.88	$1.05	$1.23	$1.40	$1.58	$1.75	$1.93	$2.10	$2.28
20-24	$0.18	$0.35	$0.53	$0.70	$0.88	$1.05	$1.23	$1.40	$1.58	$1.75	$1.93	$2.10	$2.28
25-29	$0.18	$0.35	$0.53	$0.70	$0.88	$1.05	$1.23	$1.40	$1.58	$1.75	$1.93	$2.10	$2.28
30-34	$0.20	$0.40	$0.60	$0.80	$1.00	$1.20	$1.40	$1.60	$1.80	$2.00	$2.20	$2.40	$2.60
35-39	$0.30	$0.60	$0.90	$1.20	$1.50	$1.80	$2.10	$2.40	$2.70	$3.00	$3.30	$3.60	$3.90
40-44	$0.53	$1.05	$1.58	$2.10	$2.63	$3.15	$3.68	$4.20	$4.73	$5.25	$5.78	$6.30	$6.83
45-49	$0.70	$1.40	$2.10	$2.80	$3.50	$4.20	$4.90	$5.60	$6.30	$7.00	$7.70	$8.40	$9.10
50-54	$1.10	$2.20	$3.30	$4.40	$5.50	$6.60	$7.70	$8.80	$9.90	$11.00	$12.10	$13.20	$14.30
55-59	$1.63	$3.25	$4.88	$6.50	$8.13	$9.75	$11.38	$13.00	$14.63	$16.25	$17.88	$19.50	$21.13
60-64	$2.15	$4.30	$6.45	$8.60	$10.75	$12.90	$15.05	$17.20	$19.35	$21.50	$23.65	$25.80	$27.95
65-69	$3.18	$6.35	$9.53	$12.70	$15.88	$19.05	$22.23	$25.40	$28.58	$31.75	$34.93	$38.10	$41.28
70-74	$5.15	$10.30	$15.45	$20.60	$25.75	$30.90	$36.05	$41.20	$46.35	$51.50	$56.65	$61.80	$66.95
75-79	$9.93	$19.85	$29.78	$39.70	$49.63	$59.55	$69.48	$79.40	$89.33	$99.25	$109.18	$119.10	$129.03
80-84	$9.93	$19.85	$29.78	$39.70	$49.63	$59.55	$69.48	$79.40	$89.33	$99.25	$109.18	$119.10	$129.03
85+	$9.93	$19.85	$29.78	$39.70	$49.63	$59.55	$69.48	$79.40	$89.33	$99.25	$109.18	$119.10	$129.03

Age	$70,000	$75,000	$80,000	$85,000	$90,000	$95,000	$100,000	$110,000	$115,000	$125,000	$135,000	$140,000	$150,000
0-19	$2.45	$2.63	$2.80	$2.98	$3.15	$3.33	$3.50	$3.85	$4.03	$4.38	$4.73	$4.90	$5.25
20-24	$2.45	$2.63	$2.80	$2.98	$3.15	$3.33	$3.50	$3.85	$4.03	$4.38	$4.73	$4.90	$5.25
25-29	$2.45	$2.63	$2.80	$2.98	$3.15	$3.33	$3.50	$3.85	$4.03	$4.38	$4.73	$4.90	$5.25
30-34	$2.80	$3.00	$3.20	$3.40	$3.60	$3.80	$4.00	$4.40	$4.60	$5.00	$5.40	$5.60	$6.00
35-39	$4.20	$4.50	$4.80	$5.10	$5.40	$5.70	$6.00	$6.60	$6.90	$7.50	$8.10	$8.40	$9.00
40-44	$7.35	$7.88	$8.40	$8.93	$9.45	$9.98	$10.50	$11.55	$12.08	$13.13	$14.18	$14.70	$15.75
45-49	$9.80	$10.50	$11.20	$11.90	$12.60	$13.30	$14.00	$15.40	$16.10	$17.50	$18.90	$19.60	$21.00
50-54	$15.40	$16.50	$17.60	$18.70	$19.80	$20.90	$22.00	$24.20	$25.30	$27.50	$29.70	$30.80	$33.00
55-59	$22.75	$24.38	$26.00	$27.63	$29.25	$30.88	$32.50	$35.75	$37.38	$40.63	$43.88	$45.50	$48.75
60-64	$30.10	$32.25	$34.40	$36.55	$38.70	$40.85	$43.00	$47.30	$49.45	$53.75	$58.05	$60.20	$64.50
65-69	$44.45	$47.63	$50.80	$53.98	$57.15	$60.33	$63.50	$69.85	$73.03	$79.38	$85.73	$88.90	$95.25
70-74	$72.10	$77.25	$82.40	$87.55	$92.70	$97.85	$103.00	$113.30	$118.45	$128.75	$139.05	$144.20	$154.50
75-79	$138.95	$148.88	$158.80	$168.73	$178.65	$188.58	$198.50	$218.35	$228.28	$248.13	$267.98	$277.90	$297.75
80-84	$138.95	$148.88	$158.80	$168.73	$178.65	$188.58	$198.50	$218.35	$228.28	$248.13	$267.98	$277.90	$297.75
85+	$138.95	$148.88	$158.80	$168.73	$178.65	$188.58	$198.50	$218.35	$228.28	$248.13	$267.98	$277.90	$297.75

All benefit features may not be available in all states. Premiums may increase as you age. Cost of insurance for all coverages, may increase or decrease in the future based upon the claims experience of participants. All provisions that apply to this coverage are governed by the Certificate. Rates may be subject to change. Rates will not be changed on an individual basis.

Optional Child Term Life

If you are electing Optional Life coverage, you may also elect Dependent Term Life Insurance for your child(ren). Purchase coverage for your child(ren) in increments of $2,000 from $2,000 to $10,000, not to exceed 50% of your Optional Life coverage amount.

- There are no health requirements for this coverage.
- Your children include your natural children, legally adopted children, stepchildren and foster children who depend on you for support. Child Dependent Term Life coverage has one rate that covers all eligible children.
- Eligible children are unmarried from 14 days, up to age 19, or up to age 25 if a full-time student at an accredited college/university.

Optional Term Life for Your Child(ren)

To determine the semi-monthly cost of your child(ren)'s coverage, please see the chart below.

$2,000	$4,000	$6,000	$8,000	$10,000
$0.10	$0.20	$0.30	$0.40	$0.50

All benefit features may not be available in all states. Premiums may increase as you age. Cost of insurance for all coverages, may increase or decrease in the future based upon the claims experience of participants. All provisions that apply to this coverage are governed by the Certificate. Rates may be subject to change. Rates will not be changed on an individual basis.

Optional AD&D

If you are enrolled in Optional Life, you may also enroll in Optional Accidental Death and Dismemberment. The following coverage options are available to you:

- You may elect to purchase coverage amounts in increments of $10,000 from $10,000 to $300,000, not to exceed 5 times your covered annual earnings.
- You may elect to purchase coverage amounts for your spouse in increments of $5,000 from $5,000 to $150,000.
- You may elect to purchase coverage amounts for your child(ren) in increments of $2,000 from $2,000 to $10,000.
- Coverage will be reduced as you age by 35% at age 65 and 50% at age 70.
- If your spouse or other dependent is confined for medical care or treatment at home or elsewhere, coverage will begin when confinement ends.
- Your children include your natural children, legally adopted children, stepchildren and foster children who depend on you for support.
- Eligible children are unmarried from live birth, up to age 19, or up to age 25 if a full-time student at an accredited college/university.
- Spouse coverage will be reduced as the employee ages by 35% at age 65 and 50% at age 70.
- There are no health requirements for this coverage.

Optional Accidental Death and Dismemberment Insurance Costs

To determine the semi-monthly cost of your coverage, please see the chart below.

$10,000	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000	$90,000	$100,000	$110,000	$120,000	$130,000
$0.08	$0.16	$0.24	$0.32	$0.40	$0.48	$0.56	$0.64	$0.72	$0.80	$0.88	$0.96	$1.04

$140,000	$150,000	$160,000	$170,000	$180,000	$190,000	$200,000	$220,000	$230,000	$250,000	$270,000	$280,000	$300,000
$1.12	$1.20	$1.28	$1.36	$1.44	$1.52	$1.60	$1.76	$1.84	$2.00	$2.16	$2.24	$2.40

To determine the semi-monthly cost of your spouse's coverage, please see the chart below.

$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000	$55,000	$60,000	$65,000
$0.05	$0.10	$0.15	$0.20	$0.25	$0.30	$0.35	$0.40	$0.45	$0.50	$0.55	$0.60	$0.65

$70,000	$75,000	$80,000	$85,000	$90,000	$95,000	$100,000	$110,000	$115,000	$125,000	$135,000	$140,000	$150,000
$0.70	$0.75	$0.80	$0.85	$0.90	$0.95	$1.00	$1.10	$1.15	$1.25	$1.35	$1.40	$1.50

To determine the semi-monthly cost of your child(ren)'s coverage, please see the chart below.

$2,000	$4,000	$6,000	$8,000	$10,000
$0.01	$0.02	$0.03	$0.04	$0.05

All benefit features may not be available in all states. Premiums may increase as you age. Cost of insurance for all coverages, may increase or decrease in the future based upon the claims experience of participants. All provisions that apply to this coverage are governed by the Certificate. Rates may be subject to change. Rates will not be changed on an individual basis.

Optional Long Term Disability

If you elect coverage, your monthly Long Term Disability benefits will be 60% of your monthly pre-disability earnings, up to a maximum of $5,000.

- You are considered disabled when you are unable to perform the material and substantial duties of your regular occupation, you have a 20% or more earnings loss and you are under the regular care of a doctor.
- If you meet the definition of disability, your benefits will begin following the elimination period. The elimination period is 90 days.
- The maximum period of payment is up to your normal retirement age under the Social Security Act. However, if you become disabled at or after age 65, benefits are payable according to an age-based schedule.
- A disability due to a pre-existing condition that begins within the first 12 months of the effective date of coverage is excluded from coverage. A pre-existing condition is an injury or sickness for which you received medical treatment, consultation, diagnostic measures, prescribed drugs or medicines, or for which you followed treatment recommendations during the 3 months prior to your effective date of coverage.
- Late entrants are required to provide evidence of insurability satisfactory to Prudential. A late entrant is someone enrolling more than 31 days after they were first eligible.
- The benefit amount is less deductible sources of income. Deductible sources of income may include benefits from statutory plans, unemployment income, and salary continuation.
- The minimum monthly benefit is the greater of $100 or 10% of the gross monthly benefit.
- Your Long Term Disability coverage also includes the following additional benefits:
    - An Enhanced Rehabilitation Incentive benefit that provides an additional 5% of the monthly disability benefit for 6 months while you are participating in an approved rehabilitation program.
    - An Elder Care Benefit which provides an additional $500 monthly benefit to you for 6 months if you have a chronically ill or disabled spouse or certain family members to help cover the cost of care while you are participating in an approved rehabilitation program.
    - A Day Care Benefit which pays to you an additional $500 monthly benefit per eligible child for 6 months to help cover the cost of child day care while you are participating in an approved rehabilitation program.

Long Term Disability for You

If you would like to calculate the semi-monthly cost of your LTD benefits:

Step 1	**Indicate your Annual Earnings in the box to the right.**	**= $**
Step 2	**Divide your annual earnings by 12 to get your monthly earnings.**	**= $**
Step 3	**Compare your monthly earnings from step 2 with 8,333. Write the lesser of the two in the box to the right.**	**= $**
Step 4	**Multiply the result of step 3 by the 0.00522. This is your Monthly Cost.**	**= $**
Step 5	**To get the semi-monthly cost of your coverage, multiply the monthly amount from Step 4 by 12, and divide by 24.**	**= $**

Sample LTD Costs for certain salary amounts:

Annual Salary	$25,000	$50,000	$75,000	$100,000
Cost of LTD	$5.44	$10.88	$16.31	$21.75

All benefit features may not be available in all states. Premiums may increase as you age. Cost of insurance for all coverages, may increase or decrease in the future based upon the claims experience of participants. All provisions that apply to this coverage are governed by the Certificate. Rates may be subject to change. Rates will not be changed on an individual basis.

Important Information about Portability and Continuation of Coverage

MINNESOTA RESIDENTS - You may elect to continue coverage at your expense if your employment is terminated either voluntarily or involuntarily, or if you are laid-off, as long as the group policy is still in force with the employer. Coverage may be continued until you obtain coverage under another group policy or you return to work from lay-off; however, the maximum period that coverage will be continued is 18 months.

SOUTH DAKOTA RESIDENTS - Portability is not available to South Dakota residents.

VERMONT RESIDENTS - Portability is not available to Vermont residents.

Important Notes

FOR RESIDENTS OF ALL STATES EXCEPT FLORIDA, NEW JERSEY, NEW YORK, PENNSYLVANIA, UTAH, VERMONT, VIRGINIA AND WASHINGTON; WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

NEW JERSEY RESIDENTS - Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

PENNSYLVANIA AND UTAH RESIDENTS - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

VERMONT RESIDENTS - Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

VIRGINIA RESIDENTS - Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing a statement of claim for payment of a loss or benefit may have violated state law, is guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

WASHINGTON RESIDENTS - Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company commits a crime. Penalties include imprisonment, fines, and denial of insurance benefits.

Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. Please contact your personal tax advisor for further information. There is no administrative fee to accelerate death benefits. The accelerated amount is not discounted.

Group Term Life and Disability coverage(s) are issued by The Prudential Insurance Company of America, a New Jersey company, 751 Broad Street, Newark, NJ 07102. Please refer to the Booklet-Certificate, which is made a part of the Group Contract, for all plan details, including any exclusions, limitations and restrictions which may apply. If there is a discrepancy between this document and the Booklet-Certificate/Group Contract issued by Prudential, the terms of the Group Contract will govern. Contract provisions may vary by state. California COA #1179, NAIC #68241. Contract series: 83500, 31300

Important Notice: For residents of all states except Florida, New Jersey, New York, Pennsylvania, Utah, Vermont, Virginia and Washington: Warning: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive, or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is or may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto. **Florida Residents:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree. **New Jersey Residents:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. **New York Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. This notice ONLY applies to accident and disability income coverage. **Pennsylvania and Utah Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **Vermont Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law. **Virginia Residents:** Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing a statement of claim for payment of a loss or benefit may have violated state law, is guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto. **Washington Residents:** Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company commits a crime. Penalties include imprisonment, fines, and denial of insurance benefits.

Please keep a copy of this form for your records.

Group Life and Disability coverages are issued by The Prudential Insurance Company of America, a New Jersey company, 751 Broad Street, Newark, NJ 07102.

American Home Health Corp.

Enrollment Forms

Forms Included:

Section 125 Premium Only Plan Election Form (for Pre-tax Payroll Deductions)

BlueCross BlueShield of Illinois (for Medical)

Humana/CompBenefits (for Dental)

Prudential (For Long-term Disability and/or Voluntary Life & AD&D)

Salary Reduction Contributions Enrollment Form

Employee Information

Employer Name _____ Department _____

Employee Name (Last, First, Middle) _____ Social Security Number ___-__-____

Employee Street Address _____ Plan Year (from/to) __/__ **to** __/__ (mm/dd)

City _____ State _____ Zip _____ Hours regularly worked each week _____

Pre-Tax Premium Elections

Listed below are the benefits that may be available under the P.O.P. Plan. Please indicate which benefits you elect to deduct pre-tax by checking the box next to the applicable benefit.

Benefits (X)	
☐ Medical	$_____
☐ Dental	$_____
☐ Vision	$_____
☐ Group Term Life	$_____
☐ Disability	$_____
☐ Other	$_____
☐ Other	$_____
☐ Other	$_____

Authorization

I authorize the adjustment to my annual base salary based on my elections above. I understand that by signing and submitting this form I am making a binding election for the plan year as stated unless such revocation or new election is on account of and consistent with a change in status (e.g., marriage, divorce, death, and termination of employment of spouse). I further understand that this form must be signed and dated prior to my plan effective date in order to be eligible to participate in this plan year.

Signature _____ Date __/__/____

Declination

The benefits of the plan have been thoroughly explained to me and I decline to participate. I understand that I cannot re-enroll until the beginning of the next plan year or until I experience a change in status that would allow me to change my election.

Signature _____ Date __/__/____

FORT DEARBORN LIFE INSURANCE COMPANY

Employee Application

BlueCross BlueShield of Illinois

1. Enrollment Information: Employee Identification # (if known): _____
If this is your initial enrollment, leave blank

New Enrollment: ❑ Timely ❑ Special (If special, reason_____) ❑ Late
(e.g., marriage)

Open Enrollment: ❑ New Member ❑ Plan Change ❑ Add Dependents

Group and Section Number	Employee Social Security # __ __ __ /___ ___/ __ __ __ __
Effective Date ___ ___ /___ ___/ ___ ___ ___ ___	**Date of Employment** ___ ___ /___ ___/ ___ ___ ___ ___

Employer Name			
Employee Last Name	First Name	MI	E-Mail Address
Home Mailing Address - Street	Apt. #	City	State / Zip Code
Date of Birth ___ ___ /___ ___/ ___ ___ ___ ___	Business Telephone Number ( )	Home Telephone Number ( )	Gender ❑ Male ❑ Female

Previous Blue Cross and Blue Shield of Illinois Group # (if applicable):

Employment Status: ❑ Active Employee ❑ COBRA Continuation ❑ IL Continuation ❑ If Retiree, Retirement Date: ___/___/___

COBRA / Illinois Continuation Section

❑ COBRA: Start Date ___/___/___ Projected End Date: ___/___/___ | ❑ IL Continuation Privilege: Start Date ___/___/___ Projected End Date: ___/___/___

Previously covered with group as:

❑ 1. Employee (Termination of employment, Reduction in hours, other)
❑ 2. Spouse (Divorce from employee, Death of employee, other)
❑ 3. Dependent (Reached age limit, Married, No longer full-time student, other)
❑ 4. Spouse & Dependents (Divorce from employee, Death of employee, other)

2. Coverage Applied for: Check all that apply based on the plans offered by your employer.

Health Plans*

Check one: ❑ Employee ❑ Employee + Spouse ❑ Employee + Child(ren) ❑ Family

Check one:
❑ PPO ❑ PPO Value Choice ❑ Blue*Choice* Select
❑ HMO *select your PCP in section 4 and in section 5 when applicable.*
❑ BlueEdge HSA ❑ *integrated with BCBSIL vendor* ❑ *non-integrated*
❑ BlueEdge HCA
❑ BlueEdge Select HSA ❑ *integrated with BCBSIL vendor* ❑ *non-integrated*
❑ BlueEdge Select HCA
❑ CPO ❑ CPO Value Choice ❑ BlueDecision PPO

BlueCare Dental Options*

If applying for dental, please complete.

Check one: ❑ Employee ❑ Employee + Spouse ❑ Employee + Child(ren) ❑ Family

Check one: ❑ Dental PPO ❑ Dental HMO
select your dental office in section 4 and 5 when applicable
Dental HMO Group #:_____

**actual billed premiums will be dependent upon the group contract in force.*

Fort Dearborn Life (FDL) If applying for life coverage, please complete.

FDL Group #: Class:

Job Title:

Basic Salary (exclude bonuses) $

❑ Hourly ❑ Weekly ❑ Semi-Monthly ❑ Monthly ❑ Annual

Number of hours worked in a normal work week:

❑ Term Life / A D & D ❑ Voluntary Life
❑ Dependent Life Employee Amount $ _____
❑ Short Term Disability Spouse Amount $ _____

FDL Beneficiary: If more than one beneficiary is named, interest will be equal unless otherwise indicated.

1. Last Name _____ First Name_____
Relationship _____ Age_____ Percentage _____

2. Last Name _____ First Name_____
Relationship _____ Age_____ Percentage _____

3. Medicare/ESRD Coverage Information If you or your dependents are covered under your employer's health plan and covered by Medicare, please complete.

Name: HIC #

Medicare A	Medicare B	ESRD Dialysis	Disability
Start Date: __ __/__ __/__ __	Start Date: __ __/__ __/__ __	Start Date: __ __/__ __/__ __	Start Date: __ __/__ __/__ __

Name: HIC #

Medicare A	Medicare B	ESRD Dialysis	Disability
Start Date: __ __/__ __/__ __	Start Date: __ __/__ __/__ __	Start Date: __ __/__ __/__ __	Start Date: __ __/__ __/__ __

4. Employee Coverage Information — HMO — CPO — DENTAL HMO — If selected

If you have chosen HMO: Medical Group/IPA # __ __ __ __ __ __ __ __ __ __Medical Group/IPA Name: PCP # __ __ __ __ __ __ __ __ __ __ PCP Name:

WPHCP Medical Group/IPA # __ __ __ __ __ __ __ __ __ __WPHCP Medical Group/IPA Name: WPHCP# __ __ __ __ __ __ __ __ __ __ WPHCP (Physician) Name*:

*Female members may also choose a Woman's Principal Health Care Provider (WPHCP). A WPHCP may be seen for care without referrals from your PCP; however, the PCP and WPHCP must have a referral arrangement with one another.

If you have chosen CPO/CPO Value Choice: Network # CO_____**Dental HMO Office ID #**_____

Employer Name:

Employee Social Security # __ __ __-__ __-__ __ __ __

5. Family Coverage Information: Complete for your spouse and all children to be covered.

Last Name (if different) First Name MI

Spouse: Date of Birth ____/____/_______ Social Security # __ __ __ - __ __ - __ __ __ __

If you have chosen HMO: Medical Group/IPA # __ __ __ __ __ __ __ __ __ __ __Medical Group/IPA Name: PCP # __ __ __ __ __ __ __ __ __ __ __ __ PCP Name:

WPHCP Medical Group/IPA # __ __ __ __ __ __ __ __ __ __ __WPHCP Medical Group/IPA Name: WPHCP# __ __ __ __ __ __ __ __ __ __ __ __ WPHCP (Physician) Name*:

Dental HMO Office ID#______________________________

Last Name (if different) First Name MI

❑ **Son** ❑ **Daughter** Date of Birth ____/____/_______ Social Security # __ __ __ - __ __ - __ __ __ __ Full time student? ❑ Yes ❑ No

If you have chosen HMO: Medical Group/IPA # __ __ __ __ __ __ __ __ __ __ __Medical Group/IPA Name: PCP # __ __ __ __ __ __ __ __ __ __ __ __ PCP Name:

WPHCP Medical Group/IPA # __ __ __ __ __ __ __ __ __ __ __WPHCP Medical Group/IPA Name: WPHCP# __ __ __ __ __ __ __ __ __ __ __ __ WPHCP (Physician) Name*:

Dental HMO Office ID#______________________________

Last Name (if different) First Name MI

❑ **Son** ❑ **Daughter** Date of Birth ____/____/_______ Social Security # __ __ __ - __ __ - __ __ __ __ Full time student? ❑ Yes ❑ No

If you have chosen HMO: Medical Group/IPA # __ __ __ __ __ __ __ __ __ __ __Medical Group/IPA Name: PCP # __ __ __ __ __ __ __ __ __ __ __ __ PCP Name:

WPHCP Medical Group/IPA # __ __ __ __ __ __ __ __ __ __ __WPHCP Medical Group/IPA Name: WPHCP# __ __ __ __ __ __ __ __ __ __ __ __ WPHCP (Physician) Name*:

Dental HMO Office ID#______________________________

Last Name (if different) First Name MI

❑ **Son** ❑ **Daughter** Date of Birth ____/____/_______ Social Security # __ __ __ - __ __ - __ __ __ __ Full time student? ❑ Yes ❑ No

If you have chosen HMO: Medical Group/IPA # __ __ __ __ __ __ __ __ __ __ __Medical Group/IPA Name: PCP # __ __ __ __ __ __ __ __ __ __ __ __ PCP Name:

WPHCP Medical Group/IPA # __ __ __ __ __ __ __ __ __ __ __WPHCP Medical Group/IPA Name: WPHCP# __ __ __ __ __ __ __ __ __ __ __ __ WPHCP (Physician) Name*:

Dental HMO Office ID#______________________________

*Female members may also choose a Woman's Principal Health Care Provider (WPHCP). A WPHCP may be seen for care without referrals from your PCP; however, the PCP and WPHCP must have a referral arrangement with one another.

6. Other Insurance Information: Complete ONLY if you or your dependents have other group coverage.

Do you or any of your family members have OTHER GROUP COVERAGE **that will not be cancelled** when this application is approved? ❑ Yes ❑ No

If yes, complete the following section. Check all that apply. This information will be used to coordinate benefits with the other insurance company.

Health coverage for: ❑ Self ❑ Spouse ❑ Dependent Child ❑ Other Policy Number _______________ ❑ Single ❑ Family

Name of Insured: SSN: __ __ __ / __ __ /__ __ __ __ Date of Birth: ___/___/_______

Employer Name: Name and Address of Insurance Company:

City State Zip Telephone #

Dental coverage for: ❑ Self ❑ Spouse ❑ Dependent Child ❑ Other Policy Number _______________ ❑ Single ❑ Family

Name of Insured: SSN: __ __ __ / __ __ /__ __ __ __ Date of Birth: ___/___/_______

Employer Name: Name and Address of Insurance Company:

City State Zip Telephone #

7. Application for Coverage

I apply for coverage as indicated above, for which I am or may become eligible under the agreement with Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (providing hospital, medical, dental and health maintenance coverage) and/or Fort Dearborn Life Insurance Company (providing life and disability insurance) which are herein collectively called the Company. I have read the above statements and represent they are true and complete to the best of my knowledge. I authorize my employer/group to deduct from my pay and remit any required contribution for the cost of said coverage. This authorization is to remain in effect until the Company is notified by me in writing to the contrary. I understand that the benefits listed in the Certificate(s) will be available subject to the Terms and Conditions thereof effective as listed in the Certificate(s) of Coverage.

Authorization

I authorize any medical professional, hospital, other medical facility or medical provider to disclose to the Company Underwriting Department my medical records, including information concerning advice, care or treatment for any condition, except that this authorization does not include psychotherapy notes. I understand that this authorization will enable the Company to request medical information in order to consider my application for coverage. This authorization shall expire on the date that you receive notice of the Company's decision on my application. I understand that I may revoke this authorization at any time, but that such a revocation will have no effect on any actions taken by the Company prior to receipt of the revocation. I understand that information disclosed pursuant to the authorization may be redisclosed and no longer protected by the federal privacy laws. I understand that I should retain a duplicate copy of this authorization for my own records. I authorize Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company and Fort Dearborn Life Insurance Company or their designee to transmit the information contained herein electronically.

Signature of Employee to be covered: ______________________________ Date Signed:_____________

FORT DEARBORN LIFE INSURANCE COMPANY

Waiver of Coverage

BlueCross BlueShield of Illinois

Please complete this form if you are waiving any coverage. If you are not declining any coverage, please do not complete this form.

Employer Name		Employee social security #:		
Employee Last Name	First Name			M I
Street Address	Apt. #	City	State	Zip Code

If you are declining health or dental coverage for yourself, your spouse or your children because of other coverage, you may in the future be able to enroll yourself, your spouse and/or your children in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new spouse or child as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and them, provided you request enrollment within 31 days of the marriage, birth, adoption or placement for adoption. ***I acknowledge that I, along with my spouse and/or children (if any), were provided an opportunity to enroll in my employer's Group Health, Life and Dental Insurance plans.***

I DO NOT WISH TO ENROLL FOR: (check all that apply)

Health Plans

❑ I do not wish to enroll for Health coverage. I hereby elect not to enroll in the Group Health Insurance plan for the reason indicated below and understand that the opportunity to enroll at any future time will be subject to such arrangements as may be made available with the Company.

Reason:

❑ Covered under spouse's employer-based health insurance plan (Please complete "Other Insurance Information" section below)

❑ Covered under a Medicare supplement plan

❑ Other (please explain) _____

Your signature is required below for any waiver of coverage.

BlueCare Dental Options

❑ I do not wish to enroll for Dental coverage.

Your signature is required below for any waiver of coverage.

Fort Dearborn Life (FDL)

❑ I do not wish to enroll for Life coverage.

❑ I do not wish to enroll for Short Term Disability coverage.

Your signature is required below for any waiver of coverage.

If you are waiving any or all coverages offered, please remember to complete the "not enrolling" boxes for the coverage types you are waiving. Your signature is required for any waiver of coverage.

Other Insurance Information: Complete ONLY if you have other group coverage.

If you or any of your family members have other group coverage please complete the following section. Check all that apply.

Health coverage for: ❑ Self ❑ Spouse ❑ Dependent Child ❑ Other	Policy Number _____	❑ Single ❑ Family
Name of Insured:	SSN: __ __ __ / __ __ /__ __ __ __	Date of Birth: ___/___/_____
Employer Name:	Name and Address of Insurance Company:	
City	State Zip	Telephone #

Dental coverage for: ❑ Self ❑ Spouse ❑ Dependent Child ❑ Other	Policy Number _____	❑ Single ❑ Family
Name of Insured:	SSN: __ __ __ / __ __ /__ __ __ __	Date of Birth: ___/___/_____
Employer Name:	Name and Address of Insurance Company:	
City	State Zip	Telephone #

Signature of Employee: _____ Date: _____

compbenefits
VISION
DENTAL

Group Name: American Home Health

Benefits Enrollment Form

Please complete the following information:					
Social Security No.	Last Name		First	Middle	Date of Birth
Home Address			Home Phone		Gender
City	State	ZIP Code	Business Phone		Facility Number **N/A**

List All Your Eligible Dependents That Are To Be Covered			
First MI Last	Facility Number **N/A**	Sex	Birth Date
Spouse:		M☐ F☐	/ /
Child:		M☐ F☐	/ /
Child:		M☐ F☐	/ /
Child:		M☐ F☐	/ /
Child:		M☐ F☐	/ /
Child:		M☐ F☐	/ /
Child:		M☐ F☐	/ /

Effective Date:	Plan Code:	Group Number	Your E-mail Address	Agent Number **521191**

PLEASE CHECK YOUR CHOICE	☐ Dental Plan **EP605 – Low Option**	☐ Dental Plan **EP505 – High Option**	☐ **Waiving Dental Plan**
Employee Only	☐	☐	
Employee + 1 Dependent	☐	☐	
Employee + 2 or more dependents	☐	☐	

I wish to enroll in the plan indicated above as offered through my employer. I understand that this is a minimum one (1) year contract. I hereby authorize my employer to deduct all applicable contribution amounts from my salary or other compensation for the plan year, and for future renewal period(s). I understand that such contribution rate is subject to change on the anniversary date of the plan.
I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

Signature: X _____ Date: _____

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

751 Broad Street, Newark, New Jersey 07102

1. Employee Information - Please enter your information in the spaces provided below.

(For Office use only) Effective Date of Coverage: Control No: 55633		
Last Name	**First Name**	**MI**
Street Address		
City	**State**	**Zip Code**
Social Security Number:		
Date of Birth ____/____/_____ (mm/dd/yyyy)	**Date of Employment** ____/____/_____ (mm/dd/yyyy)	
Annual Earnings: $_____	**Occupation:** _____	
Daytime Phone: _____	**Sex:** ☐ Male	☐ Female
Marital Status: ☐ Single	☐ Married	☐ Divorced ☐ Widowed

Prudential

Client Name : AMERICAN HOME HEALTH CORPORATION

Control No : 55633

2. Coverage Elections - Please make your optional selections below. Check each applicable box.

Optional Employee Term Life

☐ Max without Medical Questions, the lesser of $200,000 and 5 times my annual salary	☐ $_____	☐ None

Optional Dependent Term Life - Spouse

☐ Max without Medical Questions, $20,000	☐ $_____(not to exceed 50% of your Optional Life amount)	☐ None

Optional Dependent Term Life - Child

☐ $_____(not to exceed 50% of your Optional Life amount)	☐ None

Eligible children are unmarried from 14 days, up to age 19, or up to age 25 if a full-time student at an accredited college/university.

Optional Accidental Death and Dismemberment - Employee

☐ $_____(Not to Exceed 5 times earnings)	☐ None

Optional Accidental Death and Dismemberment - Spouse

☐ Spouse Coverage $_____	☐ None

Optional Accidental Death and Dismemberment - Child

☐ Child Coverage $_____	☐ None

Long Term Disability

☐ Elect Coverage	☐ Do Not Elect Coverage

For coverage to become effective, you must be actively at work during the enrollment period and on the effective date of the plan. If you apply for an amount that requires evidence of good health, you must be actively at work on the date of approval for the amount requiring evidence of good health. In the future, if you wish to enroll for employee-paid insurance, increase coverage amounts, or add dependent coverage, you may be required to furnish evidence of insurability for yourself and/or your spouse. If your dependents are confined for medical treatment at home or elsewhere, coverage will begin when confinement ends.

Employee Name : _____

Prudential

Client Name : AMERICAN HOME HEALTH CORPORATION

Control No : 55633

3. Authorization - Please review the Important Notes that follow before completing this step. Then, indicate your acceptance or waiver of coverage below, sign and date this form, and return to your Benefits Administrator. You will receive a Booklet-Certificate with complete plan information for any coverages you have elected.

Acceptance or Waiver of Coverage

☐ I am enrolling for coverage and I authorize my employer to deduct from my earnings until further notice my contributions for insurance under a contract issued by Prudential. I understand that, if I desire to increase the amount of my insurance or my dependent insurance coverage hereafter, I may be required to furnish evidence of good health satisfactory to Prudential for myself and/or my dependent. I declare the statements above are true, accurate and complete and understand they are the basis for determining my insurability and contribution for coverage.
☐ I do not wish to enroll for coverage. I certify that I have been given the opportunity by my employer to enroll for coverage. I understand that, if I desire to enroll hereafter, I may be required to furnish evidence of good health satisfactory to Prudential for myself and/or my dependent.

NEW YORK RESIDENTS - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. This warning ONLY applies to accident and disability income coverage.

FLORIDA RESIDENTS - Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree.

I have read and understand the terms and requirements of the fraud warnings included as part of this form.

X_____ _____

Employee Signature **Date**

_____

Print Employee Name

MICHIGAN RESIDENTS ONLY: When enrolling for Spouse Dependent Term Life coverage and/or Child coverage ($10,000 or more), the spouse and children must sign below to acknowledge consent for the coverage.

X_____ **X**_____ _____

Spouse's Signature **and/or** **Children age 18 and over** **Date**

This brochure is intended to be a summary of your benefits and does not include all plan provisions, exclusions and limitations. Please refer to the Booklet-Certificate, which is made a part of the Group Contract, for all plan details, including any exclusions, limitations and restrictions which may apply. If there is a discrepancy between this document and the Booklet-Certificate/Group Contract issued by The Prudential Insurance Company of America, the Group Contract will govern. Contract provisions may vary by state. Contract Series: 83500. Group Term Life coverage is issued by The Prudential Insurance Company of America, 751 Broad Street, Newark, NJ 07102. Life Claims: 1-800-524-0542. Prudential and the Rock logo are registered service marks of The Prudential Insurance Company of America and its affiliates. **Please also read the Important Notes that follow.**

Client Name : AMERICAN HOME HEALTH CORPORATION

Control No : 55633

4. Indicate your beneficiary(ies) - Do not name a beneficiary for spouse and/or child Dependent Term Life Coverage; these benefits are paid to you if you survive them. If more than one primary beneficiary is designated, settlement will be made in equal shares to the designated beneficiaries (or beneficiary) who are then still living, unless their shares are specified. If there is no named beneficiary or no beneficiary survives the insured, settlement will be made in accordance with the terms of your Group Contract. Use a separate piece of paper for additional beneficiary designations. I understand that, unless otherwise indicated, this designation applies to all coverages offered by Prudential under my employer's group plan and I expressly revoke all prior designations. All of the fields listed below are mandatory and must be completed in full if you have elected coverage.

Employee Primary Beneficiary Designation (must equal 100%)

Full Name	Address	Social Security Number	Percentage	Relationship to Insured

Employee Contingent Beneficiary Designation (must equal 100%)

A contingent beneficiary is the person(s) or entity you choose to receive your life insurance proceeds if the primary beneficiary(ies) die (or the entity dissolves) before you die.

Full Name	Address	Social Security Number	Percentage	Relationship to Insured

Employee Name : _____

Client Name : AMERICAN HOME HEALTH CORPORATION

Control No : 55633

Prudential

GROUP INSURANCE

The Prudential Insurance Company of America

Employer/Association Name:

AMERICAN HOME HEALTH CORPORATION

Group Contract No.(s): **Branch No.:**

00 55633 **000001**

Mail the completed form to:
The Prudential Insurance Company of America
Group Medical Underwriting, P.O. Box 8796
Philadelphia, PA 19176

Or fax the completed form to:
877-605-6671

Short Form Health Statement Questionnaire (A separate form must be completed for each person requiring Evidence of Insurability)

Employee/Member Information

First Name | MI | Last Name

Number and Street | P.O. Box / Apt. Number

City | State | ZIP Code

Social Security Number | Employee/Member ID Number | Telephone

E-Mail Address

Applicant Information

Relationship to Employee/Member: ☐ Self ☐ Spouse

First Name | MI | Last Name | Social Security Number

Applicant Coverage requiring Evidence of Insurability: **Employee/Member** ☐ Life ☐ Long Term Disability ☐ Short Term Disability
Spouse ☐ Life

Gender: ☐ Female ☐ Male

Height: ft. in.

Weight: lbs.

Date of Birth: (mm-dd-yyyy)

Please answer these questions by checking "Yes" or "No."

Yes ☐ No ☐ **Do you currently** have any disorder, condition (including pregnancy), or disease or are you currently taking medication prescribed or provided by a medical or other practitioner for any disorder, condition (including pregnancy), or disease other than a cold, cough, or allergies?

Yes ☐ No ☐ **During the last five years**, have you been in a hospital or other institution for observation, rest, diagnosis, or treatment?

Yes ☐ No ☐ **During the last five years**, have you had life, disability, or health insurance declined, postponed, changed, rated-up, cancelled, or withdrawn by an insurer?

Yes ☐ No ☐ **Within the last five years,** have you been treated for or had any trouble with any of the following: heart; chest pain; high blood pressure; cancer or tumors; diabetes; lungs; kidneys; liver; alcoholism; mental, or nervous disorder or have you been diagnosed with, or treated by a member of the medical profession for, Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?

Yes ☐ No ☐ **Within the last five years**, have you been diagnosed with, or treated by a member of the medical profession for, drug addiction, chronic pain, neurological, musculoskeletal, or respiratory disorder?

Prudential reserves the right to request additional health information on the basis of the responses given to the above questions.

I have read and understand the terms and requirements of the Important Notice included as page 2 of this form. I declare that, to the best of my knowledge and belief, the statements made in this application are complete and true. I agree that the coverage applied for is subject to the terms of the plan and shall become effective on the date or dates established by the plan, provided the evidence of good health is satisfactory.

Applicant's Signature (unless a minor) | Date Signed (mm-dd-yyyy)

If applicant is a minor, Signature of Parent, Guardian or Person Liable for Support of Applicant | Relationship | Date Signed (mm-dd-yyyy)

Prudential Financial

GROUP INSURANCE

The Prudential Insurance Company of America

Mail the completed form to:

The Prudential Insurance Company of America
Group Medical Underwriting, P.O. Box 8796
Philadelphia, PA 19176

Or fax the completed form to: 877-605-6671

Employer/Association Name:

Group Contract No(s): 0 0

Short Form Health Statement Questionnaire

Employee/Member First Name | MI | Last Name

Employee/Member Social Security Number

Applicant First Name | MI | Last Name

Street | Apt.

City | State | ZIP Code

Date of Birth | Social Security Number

Sex ☐ Male ☐ Female | Height ft. in. | Weight lbs.

Please answer these questions by checking "Yes" or "No."

Yes ☐ No ☐ Do you **currently** have any disorder, condition (including pregnancy), disease, or defect or are you **currently** taking medication prescribed or provided by a medical or other practitioner for any disorder, condition (including pregnancy), disease, or defect other than a cold, cough, flu, or allergies?

Yes ☐ No ☐ **During the last five years**, have you been in a hospital, sanitarium, or other institution for observation, rest, diagnosis, or treatment?

Yes ☐ No ☐ **During the last five years**, have you had life, disability, or health insurance declined, postponed, changed, rated-up, cancelled, or withdrawn?

Yes ☐ No ☐ **Within the last five years**, have you been diagnosed with, or treated by a member of the medical profession for, Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC), or have you been treated for or had any trouble with any of the following: heart, chest pain, high blood pressure, cancer or tumors, diabetes, lungs, kidneys, liver?

Prudential reserves the right to request additional health information on the basis of the responses given to the above questions.

IMPORTANT NOTICE:

In all states except Arkansas, Colorado, Florida, Maine, Maryland, Massachusetts, Ohio, Oregon, New York, New Jersey, Tennessee, Virginia, Washington, and the District of Columbia: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

In Arkansas, Colorado, Maine, Maryland, New York, Ohio, Tennessee, and the District of Columbia: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

In addition, any person who commits such a fraudulent act:

- may be subject to fines and confinement in prison under Arkansas law.
- is subject to penalties that may include imprisonment, fines, denial of insurance, and civil damages under Colorado law. Also, any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding, or attempting to defraud, the policyholder or claimant with regard to a settlement of award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
- may be subject to penalties that may include imprisonment, fines, or a denial of insurance benefits under Maine law.
- may be found guilty of insurance fraud under Maryland law.
- is subject to civil penalties, with such penalties not exceeding $5,000 and the stated value of the claim for each such violation under New York law. This notice ONLY applies to disability income coverage in New York.
- is guilty of insurance fraud under Ohio law.
- is subject to penalties including imprisonment, fines, and denial of insurance benefits under Tennessee law.
- may be subject to imprisonment and/or fines under the law of the District of Columbia.

In Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

In New Jersey: Any person who includes false or misleading information on an application for insurance under a group contract is subject to criminal and civil penalties.

In Virginia: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company has committed a crime. Penalties include imprisonment, fines, and denial of insurance benefits.

In Massachusetts: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may subject such person to criminal and civil penalties.

In Oregon: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

In Washington: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company commits a crime. Penalties include imprisonment, fines, and denial of insurance benefits.

I declare that, to the best of my knowledge and belief, the statements made in this application are complete and true. I agree that the coverage applied for is subject to the terms of the plan and shall become effective on the date or dates established by the plan, provided the evidence of good health is satisfactory.

Applicant's Signature (unless a minor)	Date
If applicant is a minor, Signature of Parent, Guardian, or Person Liable for Support of Applicant	Relationship / Date

Group Life and Disability Income Medical Underwriting
NOTICE

Thank you for choosing The Prudential Insurance Company of America (Prudential) for your insurance needs. Before we can issue coverage we must review your application/enrollment form. To do this, we need to collect and evaluate personal information about you. This notice is being provided to inform you of certain practices Prudential engages in, and your rights, with regard to your personal information. We would like you to know that:

- Personal information may be collected from persons other than yourself or other individuals, if applicable, proposed for coverage;
- This personal information as well as other personal or privileged information subsequently collected by us may in certain circumstances be disclosed to third parties without authorization;
- You have a right of access and correction with respect to personal information we collect about you; and
- Upon request from you, we will provide you with a more detailed notice of our information practices and your rights with respect to such information. Should you wish to receive this notice, please contact:

  The Prudential Insurance Company of America
  Group Medical Underwriting
  P.O. Box 8796
  Philadelphia, PA 19176

Any information we obtain regarding a person's insurability will be treated as confidential. We may, however, make a brief report of it to the Medical Information Bureau (the Bureau), a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. When you apply for life, disability, or health insurance to any company, including Prudential, which is a member of the Bureau, or submit a claim for benefits to such a company, the Bureau will, on request, give the company the information in its files. In addition, upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If the information came from the Bureau and you question the accuracy of the information in the Bureau's files, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is: P.O. Box 105, Essex Station, Boston, MA 02112, (617) 426-3660.

Please keep this notice for your records.