




COMMUNITY ACTION PARTNERSHIP OF ORANGE COUNTY

2009 / 2010 B E N E F I T S P R O G R A M



This Benefits Enrollment Guide highlights the provisions of our employee benefits program. More detail can be found in the summary plan descriptions and plan documents. In the case of a discrepancy between the plan documents and this Guide, the plan documents will prevail.

Community Action Partnership of Orange County intends to continue the benefit plan indefinitely. However, Community Action Partnership of Orange County reserves the right to amend, suspend or discontinue any of the plans at any time.




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Customer Service Information

Carrier	Group Number	Customer Service	Website
Anthem Blue Cross Medical Select HMO Classic HMO Lumenos HIA Plus	#154278 Select HMO - H007 Classic HMO - H001 HIA Plus - M004	HMO's: (800) 227-3560 HIA: (800) 866-207-9878	www.anthem.com/ca
Kaiser Medical HMO	#226458	(800) 464-4000	www.kp.org
Guardian Dental DMO – M80 PPO – Dental Guard	#385321	Dental Services: DMO: 800- 273-3330 PPO: 800-541-7846	www.glic.com
Anthem Blue Cross Life Insurance Basic Life and AD&D Optional Life	#154278 Basic Life – 0001 Basic AD&D – 0002 Optional Life - 0003	(800) 552-2137	www.anthem.com/ca

Eligible Employees

You may enroll in the Community Action Partnership of Orange County's Benefit Plan if you are an active, regular employee working a minimum of 32 hours per week. Your coverage will begin the first of the month following 30 days of employment with the Community Action Partnership of Orange County.

Eligible Dependents

As you become eligible for these benefits, so do your eligible dependents. In general, eligible dependents include your spouse, Domestic Partner and children under age 19. If your child is mentally or physically disabled, coverage may continue beyond age 19 once proof of the ongoing disability is provided. If your child is a full-time student, coverage may continue to age 24. Children may include natural, adopted, or stepchildren.

Plan Year

Each Plan Year runs from August 1, to July 31.

Changes in Benefit Elections

Your elections are in effect from August 1, 2009 through July 31, 2010. Each year, during open enrollment, you will have the opportunity to change your elections for the following plan year.

Only during open enrollment will you have the opportunity to:

- ◆ Add or delete lines of coverage.
- ◆ Add or delete dependents from coverage.
- ◆ Increase or decrease your optional life coverage.

You can make some limited changes during the year due to a Qualified Status change. However, you must notify Human Resources within 31 days.

Qualified Status Changes Include:

- Change in employee's legal marital status.
- Change in number of dependents.
- Change in employment.
- Dependent satisfies (or ceases to satisfy) dependent eligibility requirements.
- Change in residence.
- Commencement or termination of adoption proceedings.

(For an election change to be permitted, the election change must also be "consistent" with the qualifying event.)

How to Build Your Program

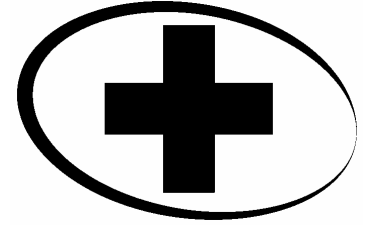
We know that our employees have very different needs. That is why our benefits program now allows you to choose from four options for your medical coverage.

Each benefit has a price tag. In general, the more coverage provided the higher the cost. The employee monthly price tags are shown below. Community Action Partnership of Orange County will continue to pay the total monthly cost for employee only coverage. Employees are responsible for the cost for dependent participation.

Carrier	Coverage	Category	Monthly Price Tag
KAISER	HMO	Employee Only	\$0.00
		Employee + Spouse	\$467.56
		Employee + Child(ren)	\$279.83
		Employee + Family	\$655.29
ANTHEM BLUE CROSS	SELECT HMO	Employee Only	\$0.00
		Employee + Spouse	\$522.06
		Employee + Child(ren)	\$348.04
		Employee + Family	\$913.60
ANTHEM BLUE CROSS	CLASSIC HMO	Employee Only	\$103.55
		Employee + Spouse	\$749.87
		Employee + Child(ren)	\$534.42
		Employee + Family	\$1,234.60
ANTHEM BLUE CROSS	Lumenos HIA PLUS	Employee Only	\$245.96
		Employee + Spouse	\$1,063.15
		Employee + Child(ren)	\$790.76
		Employee + Family	\$1,676.04
GUARDIAN	Plan M80 DMO	Employee Only	\$0.00
		Employee + Spouse	\$16.94
		Employee + Child(ren)	\$11.62
		Employee + Family	\$30.73
GUARDIAN	Dental Guard DPO	Employee Only	\$43.95
		Employee + Spouse	\$102.57
		Employee + Child(ren)	\$134.06
		Employee + Family	\$192.66
ANTHEM BLUE CROSS	Life Insurance / AD&D	Employee Only	Employer-Paid
ANTHEM BLUE CROSS	Optional Life Insurance	Employee + Family	Age Rated
COLONIAL LIFE & ACCIDENT	Voluntary Products	Employee only	Varies by election choice

You have four options of medical programs to choose from:

Anthem Blue Cross Classic HMO: HMO's are pre-paid health plans that provide care through a network of participating physicians, medical groups and hospitals. The primary objective of an HMO is to have one physician coordinate a patient's care.



- ◆ You and each family member must each choose a Primary Care Physician (PCP). This PCP can be changed once a month by calling member services.
- ◆ Keep in mind that your PCP will admit you only to hospitals where he or she has admitting privileges. Therefore, you may wish to confirm that your PCP has admitting privileges to your preferred hospital.
- ◆ Your care is coordinated through your PCP for a co-payment.
- ◆ Your PCP office visit co-pay is \$20. Your co-pay for a specialist visit is \$20.
- ◆ Your PCP must refer you to specialty care and hospitalization.
- ◆ You must live or work within 30 miles of your PCP.
- ◆ You and your family members do not have to select the same PCP.
- ◆ There are no claim forms to complete nor is there a deductible to meet.
- ◆ Women may go to an OB/GYN within their PCP's medical group for their annual well-woman exam without a referral or authorization from their PCP.

Anthem Blue Cross Select HMO: The Select HMO functions very similar to the Classic HMO. Health care is coordinated through a Primary Care Physician (PCP) of your choice but from a smaller network of participating physicians than the Classic HMO. There are also some plan differences, such as those listed below:

- ◆ Your PCP office visit co-pay is \$20. Your co-pay for a specialist visit is \$30.
- ◆ Hospitalization is \$100 per day.
- ◆ There is a \$100 deductible per member/year for brand name formulary and non-formulary prescriptions (waived when no generic is available).

Kaiser Permanente HMO: You have the option to enroll for HMO based coverage through a benefit plan from Kaiser Permanente. The Kaiser plan offers participants access to services from Kaiser facilities located throughout the Southern California area. You will have the availability of physicians and specialists who work out of Kaiser facilities, and you must receive care only at Kaiser facilities.

- ◆ There are no claims forms to file, few deductibles to meet and no hidden, out-of-pocket costs. Please review Kaiser Benefit Summary info complete plan details.
- ◆ You have a co-pay of \$20 for physician's office visits, and the plan pays 100% for most other services.
- ◆ This plan makes preventive care accessible and affordable so you can take care of small health concerns before they become big ones.
- ◆ You must call Kaiser within 24 hours after you are admitted to a non-Plan hospital for emergency services.
- ◆ Your prescription drugs are distributed directly at the Kaiser facility with a generic or brand-name drug

Medical Plan Types *(continued)*

Lumenos Health Incentive Account (HIA) Plan: This Lumenos plan includes a health incentive account in which the health plan places money for the insured persons to use on routine medical care. The plan also includes traditional health coverage that protects the insured person against large medical expenses.

Covered expenses are paid for by the HIA Plus account with no copays or deductibles to satisfy. If covered expenses exceed the insured person's available HIA Plus dollars, the traditional health coverage is available after a "bridge" or limited out-of-pocket amount is paid by insured person. Insured persons are responsible for all costs over the plan maximums. Plan maximums and other important information appear in italics. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Explanation of Covered Expense

Plan payments are based on covered expense, which is the lesser of the charges billed by the provider or the following:

- Participating Providers— Negotiated rates. Insured persons are not responsible for the difference between the provider's usual charges & the negotiated amount.
- Non-Participating Providers & Other Health Care Providers (includes those not represented in the PPO provider network) — The customary & reasonable charge for professional services or the reasonable charge for institutional services.
- Participating Pharmacies & Mail Service Program—Prescription drug negotiated rates. Insured persons are not responsible for any amount in excess of the prescription drug negotiated rate.
- Non-Participating Pharmacies—Drug limited fee schedule amount. Insured persons are responsible for any expense not covered under this plan & any amount in excess of drug limited fee schedule amount.

HIA Plus Allocation

Covers 100% of covered expense incurred; applied toward calendar year deductible or out-of-pocket maximums; unused HIA Plus dollars roll over year to year.

- \$1,500 per individual insured person
- \$3,000 per insured family

Note: The HIA Plus Allocation may be prorated based on the month the insured person joins the plan (1/12th for each month in the plan).

Healthy Rewards

If insured person completes the following programs, the insured person will earn HIA Plus credits to reduce out-of-pocket expense; unused HIA Plus dollars roll over year-to-year.

- Complete Health Assessment Online
\$50 per one insured adult person in a family per calendar year
- Enroll in Health Coach Program
\$100 per insured person per calendar year
- Graduate from Health Coach Program
\$200 per insured person per calendar year
- Complete Smoking Cessation Program
\$50 per insured person per lifetime
- Complete Weight Management Program
\$50 per insured person per lifetime

Bridge Amount

Out of pocket expense insured person pays until the calendar year deductible is met.

- \$3,000 per insured person
- \$6,000 per family

Medical Plan Comparison

Type of Plan	Anthem Blue Cross Classic HMO	Anthem Blue Cross Select HMO	Kaiser HMO
Calendar Year Deductible	N/A	N/A	N/A
Inpatient Hospital Co-pay	\$250/day (3 day max)	\$100/day	\$500 per admission
Outpatient Surgery Co-pay	No co-pay	No co-pay	\$20 / Procedure
Physician Office Visit Co-pay	\$20 co-pay	\$20 co-pay	\$20 co-pay
Specialist Office Visit Co-pay	\$20 co-pay	\$30 co-pay	\$20 co-pay
Emergency Room Co-pay (deductible waived if admitted)	\$100 co-pay	\$100 co-pay	\$100 co-pay
Wellness Co-pay	\$20 co-pay	\$20 co-pay	\$20 co-pay
Routine GYN Exam	\$20 co-pay	\$20 co-pay	\$20 co-pay
Physical Therapy	No co-pay	No co-pay	\$20 co-pay
Substance Abuse Inpatient Detoxification Only	\$250/day (3 day max)	\$100/day	\$500 per admission
Mental Health Inpatient	\$100/day (30 days/yr. max)	\$100/day (30 days/yr. max)	\$500 per admission (30 days/yr. max)
Mental Health / Outpatient	\$20 visits 20 days/year	\$30 visits 20 days/year	\$20/visit (20 visits/yr.)
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Out-of-Pocket Maximum	\$1,500/person \$3,000/family	\$1,500/person \$3,000/family	\$1,500/person \$3,000/family
Rx Retail: 30-day supply	\$10 generic \$25 formulary brand \$40 non-formulary (30 day supply)	Generic - 50% up to \$10 *Brand name Formulary – 45% up to \$25 (after \$100 ded.) Brand name non-formulary – 45% up to \$40 (after \$100 ded.)	\$10 generic co-pay \$20 brand name co-pay at Kaiser pharmacies (up to 100 day supply)
Mail Order	2 co-pays/90 days supply	2 co-pays/90 days supply	\$40 for up to 100- day supply

* When no generic equivalent available; deductible waived.

This information is provided for Summary purposes only. Please refer to the Summary Plan Description for specific plan information. In the event of a discrepancy, the official plan document prevails.

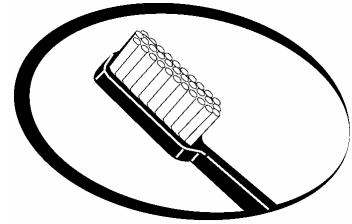
Medical Plan Comparison *(continued)*

Type of Plan	Anthem Blue Cross Lumenos HIA Plus	
	In-Network	Out-of-Network
Calendar Year Deductible	\$3,000/Individual \$6,000/Family	
Inpatient Hospital Per Confinement Copay	No co-pay	30%
Outpatient Surgery	No co-pay	30%
Physician Office Visit	No co-pay	30%
Skilled Nursing Facility	No co-pay	30%
Emergency Room	No co-pay	No co-pay
Wellness Co-pay Routine GYN Exam	No co-pay (deductible waived)	30%
Substance Abuse Inpatient (limited to \$175/day & 30 days/yr.)	No co-pay	30%
Substance Abuse Outpatient (limited to \$25/visit & 50 days/yr.)	No co-pay	30%
Mental Health Inpatient (limited to \$175/day)	No co-pay	30%
Mental Health / Outpatient (limited to \$25/visit)	No co-pay	30%
Lifetime Maximum	\$5,000,000/Individual	
Out-of-Pocket Maximum	\$1,500/Individual \$3,000/Family	
Rx Retail: 30-day supply	No co-pay	30%
Mail Order: 31-90-day supply	No co-pay	

This information is provided for Summary purposes only. Please refer to the Summary Plan Description for specific plan information. In the event of a discrepancy, the official plan document prevails.

You have the option to enroll for the Guardian Dental DMO or DPO option for you and your dependents.

Dental DMO: You must select a network provider at enrollment and you must receive services from, or coordinated through, the selected network provider. There is no coverage available when using a non-network dentist. Of course you may change your dentist on a monthly basis by calling member services.



Dental DPO: The DPO allows you the flexibility of seeing a network dentist and receiving benefits at a negotiated rate, or seeing a non-network dentist and paying the difference between the usual, customary, and reasonable (UCR) charges and what your dentist bills. There is no need to select a dentist at enrollment.

	Managed Dental Guard Plan M80	Dental DPO	
		Network	Non-Network
Annual Deductible	None	\$50 individual / \$150 family	
Annual Maximum Benefit	Unlimited	\$1,500	
Preventive Services (Cleanings, x-rays)	\$5 office visit copay	100% of covered exp Deductible waived	80% of covered exp. after deductible
Basic Services (Fillings, root canals, etc.)	Per co-pay schedule	80% of covered fee	80% of covered fee
Major Services (Crowns, bridges, etc.)	Per co-pay schedule	50% of covered fee	50% of covered fee
Orthodontia Services Child Adult	\$1,975 co-pay \$2,175 co-pay	50% to \$1500 Lifetime maximum	

This information is provided for Summary purposes only. Please refer to the Summary Plan Description for specific plan information. In the event of a discrepancy, the official plan document prevails.

Community Action Partnership of Orange County provides employees who enroll in the Anthem Blue Cross medical plans a discount vision plan through Healthy Extensions at no additional cost. Healthy Extensions Program works with your HMO eye exam benefit and provides you with a discount on all eye-care needs including frames, lenses, contact lenses, LASIK, and prescription sunglasses.

The vision discount program is honored at thousands of providers nationwide. Choose from private practitioners or leading optical retailers such as LensCrafters, Target Optical, and most Sears Optical and Pearle Vision locations. Present your Anthem Blue Cross ID card at the time of the visit, the provider verifies your eligibility and discounted Healthy Extensions prices are automatically calculated. There are no claims to file, and there is no waiting for reimbursement. You and your family can use the program as often as you like.

	TYPICAL SAVINGS
EyeMed – Vision Care	
Prescription eyeglasses	Up to 30% savings
Prescription sunglasses	Up to 30% savings
Lens options	Up to 30% savings
Accessories	Up to 30% savings
TruVision – Laser Vision Correction	
Traditional LASIK and PRK	\$895 per eye
Custom LASIK	\$1,295 per eye
Bladeless LASIK (where available)	\$1,895 per eye
TruVision – Contact Lens Discounts	
Contact Lenses with free home delivery	Up to 50% savings

TO FIND A PROVIDER CALL...

EyeMed Vision Care – (866) 680-1180

TruVision Laser Vision Correction – (877) 766-2020

TruVision Contact Lens – (877) 330-2020

Employee Life/AD&D Insurance

Because we are concerned about not only your well-being, but also the well-being of your family, we have purchased Life/AD&D insurance on your behalf. The policy will pay a benefit equal of \$15,000 in the event of your death. This amount reduces to 35% at age 65 and 50% at age 70. Benefits terminate at retirement.

The Accidental Death & Dismemberment (AD&D) coverage pays a benefit of an additional \$15,000 should you experience a loss of limb or life.

Life/AD&D Examples:

Should you lose your life as the result of an accident, the Accidental Death & Dismemberment insurance would pay an additional benefit of \$15,000. Therefore, your beneficiary would receive up to a maximum benefit of \$30,000.

Optional Life Insurance

We realize that the life insurance benefit that we have purchased on your behalf may not be enough to maintain your family's standard of living. Therefore, you have the option to purchase additional Life insurance for not only yourself, but also your dependents.

You must buy coverage for yourself in order for your dependents to be eligible.

You are eligible to purchase the following amounts:

- ◆ **Employee:** 1 times - 5 times annual salary to a max of \$250,000.
- ◆ **Spouse:** 50% of Employees Optional Life amount to a max of \$50,000
- ◆ **Children:** 8 days to 6 months: \$500
Six months or older: 50% of Employee Optional Life amount to a max of \$10,000

Guarantee Issue: Employee \$50,000, Spouse \$25,000 and Child \$10,000. (For newly eligible employees only)

*This benefit will be funded with after-tax dollars to generate a non-taxable benefit.

Optional Life Insurance Advantages

Convertibility Feature: This means that if you leave Community Action Partnership of Orange County for any reason other than sickness or injury, you can continue your coverage on an individual basis to age 70 and make payments directly to the insurance carrier.

Living Care: If a doctor certifies that an insured individual is terminally ill and not expected to live more than 12 months, the insured may request up to 50% of his/her life insurance amount while still living.

Waiver of Premium: If you become disabled prior to age 60 and are no longer able to work, your premium payments – as well as premiums for your spouse and dependents – will be waived during the period of disability, until you return to work or terminate.

Section 125 Plan

The Section 125 Premium Only Plan offers you a great way to save money in taxes on a regular basis. By allowing you to have medical and dental premiums deducted from each paycheck, you save money in the taxes paid each pay period.

Advantages of the Premium Only Plan:

- ◆ **More Take-Home Pay.** Premium deductions are taken out of your paycheck before taxes are computed.
- ◆ **Reduced annual taxes.** For tax purposes, your reportable income is reduced by the amount of premiums paid each month. This means you pay less income tax and you increase your take-home pay.

All employees who are enrolled for medical and dental are included in this plan. Those employees electing to participate in the voluntary products outlined below have the option to have those premiums deducted on a pre-tax basis as well (with the exception of Universal Life and Pre-paid Legal).

Voluntary Products

In addition to the benefits detailed on previous pages, your benefits program through the Community Action Partnership also provides you the opportunity to purchase additional voluntary products on an individual basis through Benefit Communications and Colonial Life. The benefits offered are:

- **Universal Life Insurance** - Universal Life combines permanent life insurance protection with cash value accumulation. The cash value accumulation is available to you at a later date through loan or policy surrender. This plan provides insurance protection in addition to the plans provided through the COMMUNITY ACTION PARTNERSHIP group benefits.
- **Cancer Wellness** - This coverage provides benefits paid directly to the insured for cancer related expenses, such as screenings, mammograms and pap tests, radiation and chemotherapy, bone marrow transplants, surgery, prosthesis, etc.
- **Short-Term Disability** – provides disability benefits to you if you are disabled and unable to perform your normal occupation for a specified period of time.
- **Accident Expense** – provides separate benefits if you incur expenses as a result of an accident.
- **Pre-Paid Legal** – This benefit provides legal counseling and referral services for issues that require additional professional assistance.

Premiums for these plans will be payroll deducted and, with the exception of Universal Life and Pre-paid Legal, can be deducted on either a pre-tax or after-tax basis. Some benefits when paid out can be affected by your payroll decision, so please discuss the tax implications in detail with your enrollment specialist. A representative from Benefit Communications is available to discuss the plan in more complete detail and will assist you in the enrollment process. All communication following enrollment will be handled directly with the carrier on an individual basis.

Medicare Part D

Important Notice from Community Action Partnership of Orange County (CAPOC) About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with CAPOC and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. CAPOC has determined that the prescription drug coverage offered by the Anthem Blue Cross and Kaiser is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current CAPOC coverage will not be affected. See pages 7-9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at <http://www.cms.hhs.gov/CreditableCoverage/>), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current CAPOC coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with CAPOC and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through CAPOC changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	August 1, 2009
Name of Entity/Sender:	CAPOC
Contact--Position/Office:	Ron Mondragon
Address:	12640 Knott St., Garden Grove, CA 92641
Phone Number:	714-897-6670

Women's Health and Cancer Rights Act

In accordance with the Women's Health and Cancer Rights Act of 1998, your coverage under the ProNet Solutions medical plan provides benefits for mastectomy-related services, including reconstruction and surgery to improve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). The ProNet Solutions medical plans will not restrict benefits if:

You or your dependent received benefits for a mastectomy, and;

- You or your dependent elected breast reconstruction in connection with the mastectomy. Benefits will not be restricted provided that the breast reconstruction is performed in a manner determined in consultation with you or your dependent's physician and may include: Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas

Benefits for breast reconstruction may be subject to appropriate annual deductibles and coinsurance provisions that are consistent with those established for other benefits under the applicable plan. For more information, call Aetna member services phone number on your ID card.

Continuation of Benefits COBRA

If a qualifying event occurs that causes you, your spouse, or your dependent child(ren) to lose coverage under our group health care plan, you have a legal right under COBRA to purchase a temporary extension of group health coverage. Qualifying events include reduction in work hours, termination of employment (except for gross misconduct), death of the associate, legal separation or divorce, or loss of eligibility for dependent coverage.

The purchase price of continuing coverage is the full cost of the premium for similarly situated active s', plus two percent to help pay for administration costs. The period for which the coverage can be continued depends on the nature of the qualifying event.

This policy statement is a brief description of the health care continuation plan and does not fully explain employees' rights under COBRA. Employees should read the COBRA notice they received when they first enrolled in the group health plan or the summary plan description for a detailed explanation of their COBRA rights. Copies of the COBRA notice and summary plan description can be obtained from the Human Resources Department at (714) 897-6670.

Enrollment Steps

Enrollment Steps:

Newly eligible employees, or employees enrolling for the first time

During Open Enrollment you must complete a 2009-2010 Benefits Election Form and all appropriate carrier enrollment forms.

Medical, Basic Life, and Voluntary Life Enrollment Forms:

- Kaiser enrollment form
- Anthem Blue Cross enrollment form
- Anthem Blue Cross EOI form (if enrolling for amounts over the Guarantee Issue)

Dental Enrollment Forms:

- Guardian enrollment form

All employees currently enrolled in our benefits program

During Open Enrollment you will receive a Benefit Confirmation Statement showing your current benefit elections and new payroll deductions for the 2009 – 2010 plan year.

- ◆ Review and confirm your current election information.
- ◆ Complete the bottom portion of the confirmation statement to choose any new benefit elections for the 2009 – 2010 plan year.
- ◆ If you wish to make changes to your current elections you will need to complete the appropriate insurance carrier enrollment / change forms.

Medical Change Forms:

- Anthem Blue Cross form or,
- Kaiser form

Dental Change Form:

- Guardian form

Voluntary Life/AD&D – changing current elections

You must complete the Enrollment & Evidence of Insurability Form if you are changing your current enrollment amount or if you are a current employee enrolling for the first time.

Voluntary Life/AD&D Forms:

- Anthem Blue Cross form
- Anthem Blue Cross Evidence of Insurability form

Colonial Voluntary Products

If you wish to enroll in any of the Colonial plans please notify Analisa Aguilar in Human Resources to schedule a meeting with a representative.

SIGN AND RETURN ALL FORMS

Return all forms to Analisa Aguilar in the Human Resources Department **no later than Wednesday, July 15, 2009**. (If you are a new hire and become eligible for benefits after 08/01/09, please return your election forms to the Human Resources Department two weeks prior to your eligibility date.)

If you have questions during enrollment you can contact Analisa Aguilar or Ron Mondragon in Human Resources, or our Precept Benefit Analyst, Patty Nichols by phone (800) 344-1430, extension 1203, or via email @ pnichols@preceptgroup.com .

Contributors: The Precept Group
CAPOC
Human Resources Dept.

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