



Hourly Team Member Associates

Summary Plan Description

Details about your 2017 Compass Group Benefits Program



summary plan description

Team Member Associate

Compass Group provides you with a comprehensive benefits package designed to help you meet the health and insurance needs of you and your eligible family members.

To help you make the most of these benefits, this 2017 Summary Plan Description (SPD) defines the major provisions of the Compass Group Benefits Program and explains how you can use your benefits effectively.

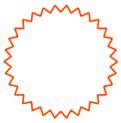
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Verify your address

Be sure to keep your most current address on file so that Compass Group can provide you with your benefit payments and benefit plan information.

If you have any questions about this document, contact the Benefits Department at 877-311-4747.



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summary plan description

Compass Group Benefits Program

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

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

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

Nothing in this document says or implies that participation in the benefit plans is a guarantee of continued employment with Compass Group. Nor is anything in this document intended to guarantee that benefit levels will remain unchanged in future years. If you have any questions about this document, contact the Benefits Department at 877-311-4747.

At a Glance

- You are eligible to participate in the benefit program if you are a non-union team member associate working an average of 30 hours or more per week.
- Your benefit selections made during your enrollment period remain in effect for the rest of the plan year (January 1 – December 31) and cannot be changed, unless you have a qualifying life event.
- Depending on eligibility, your benefits can continue while on qualified leaves.

How the program works

The Compass Group Benefits Program allows you to design the benefits program that best meets your personal needs.

What benefits could I be eligible for?

- Medical
- Dental
- Vision
- Basic Life
- Supplemental Life
- Spouse Life
- Child Life
- Short Term Disability (STD)
- Long Term Disability (LTD)
- Accidental Death and Dismemberment (AD&D)
- Flexible Spending Accounts (FSAs)
- Commuter Benefits
- Voluntary Benefits

Important things to note ...

- Benefits are not payable for expenses or events that occur before your coverage begins or after your coverage ends.
- For some benefit plans, you (or your beneficiary) must apply for benefits or file a claim. Benefits generally cannot be paid until you apply or make a claim for payment.
- If you (or your surviving spouse) are unable to care for your own financial affairs, any payments due may be paid to someone who is legally authorized to conduct your financial affairs.
- Benefits may not be payable for pre-existing conditions under Long Term Disability (LTD).

The cost of your benefits

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

The following benefits are paid for on a pre-tax basis:

- Medical
- Dental
- Vision
- Supplemental Life
- Accidental Death and Dismemberment (AD&D)
- Flexible Spending Accounts (FSAs)
- Commuter Benefits (up to the federal limits)

The following benefits are paid for on a post-tax basis:

- Spouse Life
- Child Life
- Long Term Disability (LTD)
- Commuter Benefits (amounts above federal limits)
- Voluntary Benefits

Benefit deductions and surcharges

The last day of the pay period in which you are paid determines whether or not a benefit deduction and applicable surcharge will be taken. If coverage is active on the last day of the pay period, a full deduction and applicable surcharge will be taken. If coverage is not active on the last day of the pay period, a deduction and applicable surcharge will not be taken at all. Benefit deductions and surcharges are not prorated.

What happens if I miss a benefits deduction or surcharge?

Your benefit and applicable surcharge records are set to take as much of a missed deduction as possible – up to a maximum 1½ times your normal deduction. This means if you miss a pay cycle or have a retroactive benefits change, your deduction and applicable surcharge will increase by half until the amount you missed – or owe – has been repaid. This does not apply to 401(k) contributions or loans, Health Care or Dependent Daycare Spending Accounts.

Let's look at an example

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

Paying for benefits with pre-tax dollars

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

Although the use of pre-tax dollars reduces your taxable pay, benefits that are based on your pay (for example, supplemental life insurance and/or your AD&D insurance) aren't reduced.

Because the IRS allows this pre-tax deduction advantage, there are certain restrictions regarding changes throughout the plan year. See *Qualifying Life Events* on page 84 or go to <http://www.irs.gov>.

Benefit deductions and surcharges for the Puerto Rico plans are taken on a post-tax basis.

Spouse surcharge

If you would like to cover your spouse under a Compass Group medical plan and he or she works for an employer who offers medical coverage, you will pay an additional spousal surcharge for medical coverage. If your spouse does not have access to medical coverage through their employer, or they work for Compass Group, the surcharge will not apply.

Tobacco surcharge

All associates who enroll in a Compass Group medical plan will have to identify annually whether or not they are a tobacco user during their enrollment. Associates who

identify that they are a tobacco user will pay an additional tobacco surcharge for medical coverage. The tobacco surcharge does not apply to dependents or premiums for dental and vision coverage.

Eligibility

Full-time team member associates are eligible for benefits on the first day of the month following two months of service, after the completion of the company's one month orientation period.

Full-time team member associates that work at locations covered by the Service Contract Act and full time team member associates working in Hawaii, are eligible for benefits on the first day of the month following one month of service.

Full-time GSC Antarctica team member associates are eligible for benefits on the first day of service.

Full-time Google team member associates are eligible for benefits on the first day of the month following their date of hire date.

Union associates eligible for the standard union plans through their Collective Bargaining Agreement are eligible for benefits on the first day of the month following two months of service. All other union associates should refer to their Collective Bargaining Agreement for benefits and plan eligibility.

Associates that work at least 20 hours a week at the San Francisco Airport, excluding union associates, are eligible for benefits on the first day of the month following one month of service.

Measurement Process

You are eligible to participate in the Compass Group benefits program if you are a full-time non-union team member associate working an average of 30 hours or more per week.

Compass Group uses measurement periods to assess an associate's benefit eligibility. A measurement period is a look-back period (12 months) used to determine whether an associate is working an average 30 hours or more per week. If an associate is determined to be benefits eligible, they are eligible during a subsequent 12-month coverage period, called a stability period.

Hours that count toward a measurement period and eligibility for benefits include:

- The hours for which you are paid to work, and
- The hours for which you are paid for: vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or a paid leave of absence.

Once an associate has completed a full measurement period, they are considered an ongoing associate. Employment status and benefits eligibility are recalculated for ongoing associates annually (Annual Measurement Period), based on the average of actual hours paid in the previous 12 months.

See the *Glossary of Eligibility Terms* on page 129 for eligibility definitions.

Who can I cover?

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

- Yourself only
- Yourself and your spouse
- Yourself and child(ren)
- Yourself and your family

Eligible dependents include:

- Your lawful spouse (regardless of gender) who is not living separate and apart from you
- Your common law spouse if you reside in the following states and you meet the following requirements:
 - Alabama
 - Colorado
 - District of Columbia
 - Georgia (if created before 1/1/97)
 - Idaho (if created before 1/1/96)
 - Iowa
 - Kansas
 - Montana
 - New Hampshire (for inheritance purposes only)
 - New Mexico
 - Ohio (if created before 10/10/91)
 - Oklahoma
 - Pennsylvania (if created before 1/1/05)
 - Rhode Island
 - South Carolina
 - Texas
 - Utah

- Your children (including stepchildren up to age 26*
 - “Children” means your natural children. It also includes your legally adopted children, children placed for adoption (to the extent required by federal and/or state law), stepchildren, and foster children. Note: Foster children are not eligible for life insurance coverage.
- Your unmarried children age 26 or older who are mentally or physically unable to care for themselves, but only if the disability arose at a time when the child could have been covered as a dependent under Compass Group’s benefits

Contact the Benefits Department if you have questions about your specific situation.

* Some state mandates may apply.

Important: Compass Group requires associates to submit documentation proving the relationship of all dependent(s) covered under a Compass Group medical, dental and/or vision plan to ADP — Dependent Verification Services. Documentation must be submitted by a required time frame in order for dependents to remain on coverage. Dependents who are dropped due to a failed audit are not eligible for COBRA.

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

Ineligibility

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

Grandchildren, nieces and/or nephews, and sisters and/or brothers are not eligible dependents, unless you have legal guardianship and the dependent meets the age requirements. In addition, spouses that are legally married to you but who no longer share a common address, and live separate and apart from you for a continuous period longer than 6 months, are not eligible.

If your dependent(s) lose eligibility under the plan

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

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

Enrolling for benefits

How do I enroll?

To enroll for benefits, you must enroll through the benefits enrollment website by your eligibility date. Then, each Annual Enrollment period, you have the opportunity to make new benefit elections for the upcoming year. If you do not have access to the web, contact the Benefits Department at 877-311-4747, to elect your benefits over the phone.

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

What if I don't enroll by the deadline?

All newly eligible associates must complete their enrollment by the deadline or the following "default" coverage will be assigned:

- Basic Life Insurance of \$10,000

You will not have Medical, Dental, Vision, Supplemental Life, Spouse Life, Child Life, Accidental Death and Dismemberment (AD&D), Flexible Spending Accounts (FSAs), or Voluntary Benefits if you miss the deadline.

When coverage begins

Your coverage will begin on the first day of the month following two months of service, after the completion of the company's one month orientation period. For example, if your first day of work is March 15, you become eligible for coverage on July 1. You must enroll on or prior to July 1, and your coverage will begin on July 1.

If you do not enroll by July 1, you will have default coverage only for that year. Your next opportunity to enroll for coverage will be the next Annual Enrollment period, or if you have a qualifying life event.

Making changes during the year

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

It is important to consider your benefit needs and choose benefits that will meet those needs. However, if your family or employment status changes, you may be allowed to add, drop or change some benefits by the appropriate deadline. See the *Qualifying Life Events* section on page 84 for more information.

When coverage ends

Coverage for you

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

- When you terminate employment. However, if you were hired prior to January 1, 1993, by Canteen Corporation, you may be eligible for continued medical coverage if you retire from Compass Group at age 55 or older and have completed 15 years of credited service.
- If after your Initial Measurement Period it is determined you were not paid an average of 30 hours or more per week
- If after your Initial Stability Period you were not paid an average of 30 hours or more per week during your first Standard Measurement Period
- At the end of your On-going Stability Period if you were not paid an average of 30 hours per week during an On-going Standard Measurement Period
- The last day of the period for which you have made a required contribution, if you fail to make the next required contribution
- The date the plan is amended to terminate coverage for a class of associates of which you are a member
- The date you choose to stop coverage due to a family/employment status change
- During the Annual Enrollment period, you do not elect to continue coverage for the next year. In this case, coverage will end on the last day of the current calendar year.

If your medical, dental, and/or vision coverage ends, you may be eligible to continue coverage. See *Continuing Your Coverage Under COBRA* on page 98.

Coverage for your dependents

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

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

If the plan is terminated

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

Reinstatement of coverage after termination

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

Your coverage under the certificate may be reinstated automatically, or a waiting period. The amount of insurance will be that which applies to the classification to which you belonged prior to the termination of employment unless Compass Group, in its sole discretion, determines that your termination was bona fide and not a pretext to modify the level of coverage in the absence of a legitimate change of status. If the policyholder's plan of insurance provides for contributory insurance under the certificate, your amount of contributory insurance will be limited to that for which you were insured immediately prior to the loss of coverage.

Medical Coverage

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

At a Glance

- Compass Group offers you the opportunity to enroll in medical coverage for you and your eligible dependent(s) that provides protection in the event of illness or injury. You may choose from several medical options or you may waive coverage completely if you have other coverage.
- The available medical plans: Bronze Plus, Silver Plus, Gold Plus, Out-of-Area – Bronze Plus, Silver Plus and Gold Plus, Kaiser Permanente HMO (if available in your area), Aetna Global (available only in Antarctica), Triple S (available only in Puerto Rico), CommunityCare (available only in Oklahoma) and HMSA (available only in Hawaii).
- The Bronze Plus, Silver Plus, Gold Plus and Out-of-Area Plans are administered by Aetna, BlueCross BlueShield of North Carolina and UnitedHealthcare.
- CVS Caremark™ provides prescription drug coverage for the Bronze Plus, Silver Plus, Gold Plus, and Out-of-Area – Bronze Plus, Silver Plus and Gold Plus Plans. The Kaiser Permanente HMOs, Aetna Global (Antarctica), Triple S (Puerto Rico), CommunityCare (Oklahoma) and HMSA (Hawaii) Plans administer their own prescription drug coverage.
- The Compass Group Wellness Program offers a variety of resources to associates and eligible dependents enrolled in a Compass Group medical plan through our wellness partners INTERVENT, your medical vendor, and HealthAdvocate.

Medical plan options

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

- Bronze Plus Plan
- Silver Plus Plan
- Gold Plus Plan
- Out-of-Area – Bronze Plus, Silver Plus and Gold Plus Plans
- Kaiser Permanente HMO (if available in your area)
- Aetna Global Plan (available only in Antarctica)
- Triple S Plan (available only in Puerto Rico)
- CommunityCare (available only in Oklahoma)
- HMSA (available only in Hawaii)

Some medical plan options are not offered in all locations.

You may choose from the following coverage levels:

- Yourself
- Yourself and your spouse
- Yourself and child(ren)
- Yourself and your family

This section describes benefits provided through the Bronze Plus, Silver Plus, Gold Plus, Out-of-Area – Bronze Plus, Silver Plus and Gold Plus Plans. Details on the Kaiser Permanente HMO, Aetna Global, Triple S, CommunityCare and HMSA Plans are provided by the carriers through Certificates of Coverage and are not included in this document.

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

- Cover preventive care at 100%
- Cover hospital charges, doctors' bills, surgery, prescription drugs, and other supplies, and services described in this medical plan section

- Pay benefits within plan limits up to a negotiated amount or the Reasonable and Customary (R&C) charges — sometimes referred to as Maximum Reimbursable Charges (MRC) or Allowed Amount
- Require that all inpatient hospital admissions be pre-certified by your medical plan carrier or the plan will reduce or deny benefits

You have the right to designate any primary care physician (PCP) who participates in the plan's network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care physician.

For information on how to select a primary care physician, and for a list of the participating primary care physicians, contact the plan's carrier listed on the back of your medical plan ID card or in the *Administrative Information* section on page 107.

You do not need prior authorization from the plan or from any other person (including a primary care physician) in order to obtain access to a specialist in the plan's network. The specialist, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating specialists, contact the plan's carrier listed on the back of your medical plan ID card or in the *Administrative Information* section on page 107.

Teladoc

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

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

Beginning July 1, 2017-December 31, 2017, the copay for Teladoc service is waived.

To set up an account, go to www.teladoc.com, and click *Set up account*, then provide the required information. Teladoc consultations are available on-demand or scheduled by phone or video 24 hours a day, seven days a week.

It's important to note:

- Teladoc does not replace your PCP, but it can help in after-hours situations, when you can't get in to your PCP and is less expensive than an Urgent Care Center.
- Teladoc does not guarantee that a prescription will be written.
- Teladoc operates subject to state regulations and is not available in Puerto Rico and Arkansas. Teladoc video consults are not available in Texas and phone consults are not available in Idaho.
- Teladoc does not prescribe DEA controlled substances, non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse.
- Teladoc physicians reserve the right to deny care for potential misuse of services.

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

If you are enrolled in the Kaiser Permanente HMO Plan, you also have after-hours access to an Advice Nurse at no cost. Call the Member Services number on the back of your Kaiser Permanente Medical Record card and ask to be connected to the Advice Nurse. Additionally, BlueCross BlueShield of NC, UnitedHealthcare and Aetna provide a Nurseline service. Call the member Services on the back of your ID card for more information.

Medical Plans At a Glance

Below are comparisons of the Bronze Plus, Silver Plus and Gold Plus Plans. The specific plans offered are based on your home ZIP code. Depending on geographic location, most associates are offered more than one national carrier.

In most areas, at least one carrier is offered as “Best in Market.” Best in Market carriers provide you with access to the largest provider network in your state and the deepest network discounts – to help save you money.

	BRONZE PLUS PLAN	SILVER PLUS PLAN	GOLD PLUS PLAN
Carrier	Aetna BlueCross BlueShield of North Carolina (BCBSNC) UnitedHealthcare (UHC)	Aetna BlueCross BlueShield of North Carolina (BCBSNC) UnitedHealthcare (UHC)	Aetna BlueCross BlueShield of North Carolina (BCBSNC) UnitedHealthcare (UHC)
In-network vs. out-of-network coverage	In-and out-of-network coverage	In-and out-of-network coverage	In-and out-of-network coverage
Other considerations	This plan meets the federal definition of affordability, but has a higher deductible that must be satisfied before benefits are paid. On average, the plan will pay 60% of covered charges and you will pay 40% when you use in-network healthcare services.	This is our mid-level plan and requires a modest payroll deduction. In this plan you must meet your deductible before most benefits are paid, except for in-network office visit services which are covered by paying a copay. On average, the plan will pay 70% of covered charges and you will pay 30% when you use in-network healthcare services.	This plan provides access to in-network physician services by paying a minimal copay that is not subject to the plan deductible. On average, the plan will pay 80% of covered charges and you will pay 20% when you use in-network healthcare services.
Preventive care	Covered at no cost using in-network providers	Covered at no cost using in-network providers	Covered at no cost using in-network providers
Payroll deductions	Lowest	Modest	Highest

Am I considered a tobacco user?

Tobacco products are defined as any product made with or derived from tobacco that is intended for human consumption, including any component, part or accessory of a tobacco product. This includes, but is not limited to cigarettes, e-cigarettes, cigars, pipes, chewing tobacco, snuff, hookahs and other tobacco products. You are considered a tobacco user if you use any of these tobacco products regularly (four or more times per week, excluding religious or ceremonial uses) within six months of enrollment into a Compass Group medical plan.

Tobacco products do not include tobacco cessation aids approved by the FDA, such as:

- Over-the-counter nicotine replacement products (gum, patches, lozenges),
- All over-the-counter tobacco cessation products for adults ages 18 and older,
- Prescription nicotine replacement products (inhaler, nasal spray), and
- Non-nicotine replacement therapy prescription medications (Zyban, Chantix, etc.).

Tobacco use does not include the religious or ceremonial use of tobacco. Visit www.altogethergreat.com/rewards to learn more.

Medical Benefit Options Comparison

The tables in this section provide a summary of features under the Bronze Plus, Silver Plus and Gold Plus Plans. Benefits are available for eligible expenses that are medically necessary. Medical necessity is determined by the plan carrier. Reimbursement for in-network services are based on network-contracted rates while out-of-network services must be within the reasonable and customary fee limits.

Each table shows the amount or percentage you pay for eligible expenses. You also must satisfy your selected medical carrier's calendar year deductible amount before benefits are payable for medical services subject to coinsurance. There are certain covered expenses that do not require satisfaction of the deductible and these are referenced in the following chart.

As you review the benefit comparison tables, keep the following in mind:

Deductibles, office visit copays and coinsurance apply to the annual out-of-pocket maximum. The out-of-pocket maximum does not include prescription copays, amounts not covered, or amounts exceeding the reasonable and customary fee limits.

IMPORTANT FACTS FOR YOU TO KNOW ABOUT THE MEDICAL PLAN COMPARISON CHART...

Allowed Amount (BCBS only)	The maximum amount that BCBSNC determines is reasonable for covered services provided to a member. The allowed amount includes any BCBSNC payment to the provider, plus any deductible, coinsurance or copayment. For providers that have entered into an agreement with BCBSNC, the allowed amount is the negotiated amount that the provider has agreed to accept as payment in full. Except as otherwise specified in "Emergency Care," for providers that have not entered into an agreement with BCBSNC, the allowed amount will be the lesser of the provider's billed charge or an amount based on an out-of-network fee schedule established by BCBSNC that is applied to comparable providers for similar services under a similar health benefit plan. Where BCBSNC has not established an out-of-network fee schedule amount for the billed service, the allowed amount will be the lesser of the provider's billed charge or a charge established by BCBSNC using a methodology that is applied to comparable providers who may have entered into an agreement with BCBSNC for similar services under a similar health benefit plan. Calculation of the allowed amount is based on several factors including BCBSNC's medical, payment and administrative guidelines. Under the guidelines, some procedures charged separately by the provider may be combined into one procedure for reimbursement purposes.
Coinsurance	This is the percentage of covered expense that you're required to pay. When you see a percentage referenced in the medical plan comparison chart, it is the coinsurance that is the Plan's financial responsibility. You will be responsible for the remaining amount.
Copay	This is the flat dollar amount of covered expense that you're required to pay. When you see a flat dollar amount in the medical plan comparison chart, it is the copay that is your financial responsibility.
Deductible	For most covered expenses, you must meet your elected medical plan's (calendar year) deductible amount before you start receiving benefits. Certain covered expenses, however, may be payable even if you haven't yet met your deductible for the calendar year. The medical plan comparison chart references those particular expenses that are payable whether or not you've met your deductible. Unless the covered expenses in the chart specifically state that benefits are payable even if you haven't met your deductible for the calendar year, you should know that you have to meet your deductible before benefits can be paid. Only covered expenses can be used to meet your deductible amount. Out-of-network deductible and out-of-pocket amounts will cross apply but not vice versa.
Medical Necessity	All of the medical services and supplies described in the medical plan comparison chart must be covered by the Plan and be medically necessary in order to be determined to be covered expenses. Your medical Plan will help you and your physician determine the best course of treatment based on your diagnosis and acceptable medical practice. Your Plan will determine whether certain covered services and supplies are medically necessary solely for the purposes of determining what the medical plans will reimburse. No benefits are payable unless your Plan determines that the covered services and supplies are medically necessary. The Plan Administrator may delegate the discretionary authority to determine medical necessity under the Plan.

IMPORTANT FACTS FOR YOU TO KNOW ABOUT THE MEDICAL PLAN COMPARISON CHART...

Out-Of-Pocket Maximum	This is the portion of covered expenses (that you have to pay) that must accumulate until it reaches the dollar limit where the Plan begins paying 100% of any further covered expenses for the remainder of the calendar year. Out-of-pocket maximum never includes expenses that are excluded from coverage, and expenses that exceed the usual and prevailing allowances.
Preventive care	<p>Preventive care is covered at no cost to you — with no annual dollar maximum – when a contracted provider is used. This includes services like annual checkups/ physicals, mammograms, certain cancer screenings, etc. To ensure preventive care is covered at 100%, your physician visit must be coded with a preventive care diagnosis.</p> <p>To be covered as a preventive care service, the care must meet nationally recognized guidelines for preventive care — like minimum age and frequency rules. Contact your medical plan carrier for more information.</p>

IMPORTANT FACTS FOR YOU TO KNOW ABOUT THE MEDICAL PLAN COMPARISON CHART...

Reasonable and Customary (R&C) charges (Aetna and UnitedHealthcare)	<p>Reasonable and customary (R&C) charges are the typical range of fees charged by out-of-network medical providers in your geographic area for similar services. In other words, it is the “going rate” for a certain service in your area. The plan will not pay for charges above the reasonable and customary (R&C) rate — you are responsible for paying the additional amount. R&C is also called the Maximum Reimbursable Charge (MRC) or Allowed Amount. Maximum Reimbursable Charges are the typical range of fees charged by providers in your geographical area for similar services. The Allowed Amount will be the lesser of the provider’s billed charge or an amount based on an out-of-network fee schedule that is applied to comparable providers for similar services under a similar health benefit plan.</p> <p><i>How do I know if my provider’s proposed fees are within R&C limits?</i></p> <p>Call your medical plan carrier to discuss your physician’s/surgeon’s fees.</p> <p>Provide the following information:</p> <ul style="list-style-type: none">• Your provider’s name and address (including ZIP code)• The five-digit procedure code• The provider’s proposed fee <p>In addition, your provider may send a pre-determination of benefits request to your medical plan carrier. Your medical plan carrier will let you and your provider know, in writing, which benefits are available under the plan. This helps you determine your out-of-pocket costs for that procedure.</p>
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A Summary of Benefits Coverage (SBC) is available at www.altogethergreat.com/rewards under *Resources*.

Bronze Plus Plan

PLAN DESIGN	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible		
• Individual	\$3,000	\$6,000
• Family	\$6,000	\$12,000
Medical Annual Out-of-Pocket Maximum¹		
• Individual	\$6,000	\$12,000
• Family	\$12,000	\$24,000
Coinsurance		
• Plan pays after the deductible	60%	40%
• Associate pays after the deductible	40%	60%
TYPE OF SERVICE		
Physician Services		
Preventive Care Services²: Annual checkups/physicals, mammograms, certain cancer screenings, etc.	100%	40%, no deductible
Phone or Online Consultation — provided by Teladoc¹	100% after \$10 copay	N/A
Primary Care Physician (PCP) Office Visit	60% coinsurance after deductible	40% coinsurance after deductible
Specialist Office Visit	60% coinsurance after deductible	40% coinsurance after deductible
Surgery (Physician's Office)	60% coinsurance after deductible	40% coinsurance after deductible
Surgery (Inpatient or Outpatient Hospital)	60% coinsurance after deductible	40% coinsurance after deductible
Chiropractor	60% coinsurance after deductible	40% coinsurance after deductible
Allergy Injections	60% coinsurance after deductible	40% coinsurance after deductible
Hospital Services		
Inpatient Hospital Care	60% coinsurance after deductible	40% coinsurance after deductible
Outpatient Hospital Care³ (e.g. minor surgery, lab charges)	60% coinsurance after deductible	40% coinsurance after deductible
Emergency Care		
Emergency Room	60% coinsurance after deductible	60% coinsurance after deductible
Urgent Care Clinic	60% coinsurance after deductible	40% coinsurance after deductible
Maternity Care		
Physician's Office	60% coinsurance after deductible	40% coinsurance after deductible
Physician Services (Pre- and postnatal visits, delivery)	60% coinsurance after deductible (no copay)	40% coinsurance after deductible
Delivery and Newborn Charges — Hospital	60% coinsurance after deductible	40% coinsurance after deductible
Mental Health Services		
Specialist Office Visit	60% coinsurance after deductible	40% coinsurance after deductible
Outpatient Services	60% coinsurance after deductible	40% coinsurance after deductible
Inpatient Services	60% coinsurance after deductible	40% coinsurance after deductible
Substance Abuse Services		
Detoxification/Rehabilitation	60% coinsurance after deductible	40% coinsurance after deductible
Outpatient	60% coinsurance after deductible	40% coinsurance after deductible
Inpatient	60% coinsurance after deductible	40% coinsurance after deductible

See footnotes on page 16

Silver Plus Plan

PLAN DESIGN	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible		
• Individual	\$1,000	\$2,000
• Family	\$2,000	\$4,000
Medical Annual Out-of-Pocket Maximum¹		
• Individual	\$5,500	\$11,000
• Family	\$11,000	\$22,000
Coinsurance		
• Plan pays after the deductible	70%	50%
• Associate pays after the deductible	30%	50%
TYPE OF SERVICE		
Physician Services		
Preventive Care Services²: Annual checkups/physicals, mammograms, certain cancer screenings, etc.	100%	50%, no deductible
Phone or Online Consultation — provided by Teladoc¹	100% after \$10 copay	N/A
Primary Care Physician (PCP) Office Visit	100% after \$35 copay	50% coinsurance after deductible
Specialist Office Visit	100% after \$65 copay	50% coinsurance after deductible
Surgery (Physician's Office)	100% after applicable office visit copay	50% coinsurance after deductible
Surgery (Inpatient or Outpatient Hospital)	70% coinsurance after deductible	50% coinsurance after deductible
Chiropractor	100% after \$35 copay	50% coinsurance after deductible
Allergy Injections	70% coinsurance after deductible	50% coinsurance after deductible
Hospital Services		
Inpatient Hospital Care	70% coinsurance after deductible	50% coinsurance after deductible
Outpatient Hospital Care³ (e.g. minor surgery, lab charges)	70% coinsurance after deductible	50% coinsurance after deductible
Emergency Care		
Emergency Room	\$150 copay, plus 70% coinsurance after deductible	\$150 copay, plus 70% coinsurance after deductible
Urgent Care Clinic	100% after \$65 copay	50% coinsurance after deductible
Maternity Care		
Physician's Office (Initial visit)	100% after \$30 copay	50% coinsurance after deductible
Physician Services (Pre- and postnatal visits, delivery)	70% coinsurance after deductible (no copay)	50% coinsurance after deductible
Delivery and Newborn Charges — Hospital	70% coinsurance after deductible	50% coinsurance after deductible
Mental Health Services		
Specialist Office Visit	100% after \$65 copay	50% coinsurance after deductible
Outpatient Services	70% coinsurance after deductible	50% coinsurance after deductible
Inpatient Services	70% coinsurance after deductible	50% coinsurance after deductible
Substance Abuse Services		
Detoxification/Rehabilitation	100% after \$65 copay	50% coinsurance after deductible
Outpatient	70% coinsurance after deductible	50% coinsurance after deductible
Inpatient	70% coinsurance after deductible	50% coinsurance after deductible

See footnotes on page 16

Gold Plus Plan

PLAN DESIGN	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible		
• Individual	\$500	\$1,000
• Family	\$1,000	\$2,000
Medical Annual Out-of-Pocket Maximum¹		
• Individual	\$3,500	\$7,000
• Family	\$7,000	\$14,000
Coinsurance		
• Plan pays after the deductible	80%	60%
• Associate pays after the deductible	20%	40%
TYPE OF SERVICE		
Physician Services		
Preventive Care Services²: Annual checkups/physicals, mammograms, certain cancer screenings, etc.	100%	60%, no deductible
Phone or Online Consultation — provided by Teladoc⁴	100% after \$10 copay	N/A
Primary Care Physician (PCP) Office Visit	100% after \$25 copay	60% coinsurance after deductible
Specialist Office Visit	100% after \$50 copay	60% coinsurance after deductible
Surgery (Physician's Office)	100% after applicable office visit copay	60% coinsurance after deductible
Surgery (Inpatient or Outpatient Hospital)	80% coinsurance after deductible	60% coinsurance after deductible
Chiropractor	100% after \$25 copay	60% coinsurance after deductible
Allergy Injections	80% coinsurance after deductible	60% coinsurance after deductible
Hospital Services		
Inpatient Hospital Care	80% coinsurance after deductible	60% coinsurance after deductible
Outpatient Hospital Care³ (e.g. minor surgery, lab charges)	80% coinsurance after deductible	60% coinsurance after deductible
Emergency Care		
Emergency Room	\$150 copay, plus 80% coinsurance after deductible	\$150 copay, plus 80% coinsurance after deductible
Urgent Care Clinic	100% after \$50 copay	60% coinsurance after deductible
Maternity Care		
Physician's Office (Initial visit)	100% after \$25 copay	60% coinsurance after deductible
Physician Services (Pre- and postnatal visits, delivery)	80% coinsurance after deductible (no copay)	60% coinsurance after deductible
Delivery and Newborn Charges — Hospital	80% coinsurance after deductible	60% coinsurance after deductible
Mental Health Services		
Specialist Office Visit	100% after \$50 copay	60% coinsurance after deductible
Outpatient Services	80% coinsurance after deductible	60% coinsurance after deductible
Inpatient Services	80% coinsurance after deductible	60% coinsurance after deductible
Substance Abuse Services		
Detoxification/Rehabilitation	100% after \$50 copay	60% coinsurance after deductible
Outpatient	80% coinsurance after deductible	60% coinsurance after deductible
Inpatient	80% coinsurance after deductible	60% coinsurance after deductible

See footnotes on page 16

Out-of-Area Plans

Out-of-Area – Bronze Plus, Silver Plus and Gold Plus Plans are offered in areas where no networks are provided. These plans are administered by BCBSNC. A Summary of Benefits Coverage (SBC) is available at www.togethergreat.com/rewards under *Resources*.

How the plan works

Compass Group provides the Out-of-Area Plans, administered by BlueCross BlueShield of NC (BCBSNC), to associates who do not have provider networks available in their area (based on home ZIP code).

With the Out-of-Area Plans, you see the provider of your choice, obtain itemized receipts and submit a claim form for reimbursement. Or, your provider can submit a claim directly to BCBSNC.

How the plan pays benefits

Before the Out-of-Area Plans pay for most covered services for you or a covered dependent, you must first meet your annual deductible for most expenses for the period of January 1 through December 31. When you have met your calendar year deductible, the plan begins to pay for covered expenses.

What the plan covers

PLAN DESIGN	BRONZE PLUS OUT-OF-AREA PLAN	SILVER PLUS OUT-OF-AREA PLAN	GOLD PLUS OUT-OF-AREA PLAN
Calendar Year Deductible	\$3,000 / \$6,000	\$1,000 / \$2,000	\$500 / \$1,000
Medical Annual Out-of-Pocket Maximum¹	\$6,000 / \$12,000	\$5,500 / \$11,000	\$3,500 / \$7,000
Coinsurance	60% / 40%	70% / 30%	80% / 20%
TYPE OF SERVICE			
Physician Services			
Preventive Care Services²: Annual checkups/ physicals, mammograms, certain cancer screenings, etc.	100%	100%	100%
Phone or Online Consultation — provided by Teladoc¹	100% after \$10 copay	100% after \$10 copay	100% after \$10 copay
Primary Care Physician (PCP) Office Visit	60% coinsurance after deductible	70% coinsurance after deductible	80% coinsurance after deductible
Specialist Office Visit	60% coinsurance after deductible	70% coinsurance after deductible	80% coinsurance after deductible
Surgery (Physician's Office)	60% coinsurance after deductible	70% coinsurance after deductible	80% coinsurance after deductible
Surgery (Inpatient or Outpatient Hospital)	60% coinsurance after deductible	70% coinsurance after deductible	80% coinsurance after deductible
Chiropractor	60% coinsurance after deductible	70% coinsurance after deductible	80% coinsurance after deductible
Allergy Injections	60% coinsurance after deductible	70% coinsurance after deductible	80% coinsurance after deductible

See footnotes on page 16

PLAN DESIGN	BRONZE PLUS OUT-OF-AREA PLAN	SILVER PLUS OUT-OF-AREA PLAN	GOLD PLUS OUT-OF-AREA PLAN
TYPE OF SERVICE			
Hospital Services			
Inpatient Hospital Care	60% coinsurance after deductible	70% coinsurance after deductible	80% coinsurance after deductible
Outpatient Hospital Care³ (e.g. minor surgery, lab charges)	60% coinsurance after deductible	70% coinsurance after deductible	80% coinsurance after deductible
Emergency Care			
Emergency Room	60% coinsurance after deductible	70% coinsurance after deductible	80% coinsurance after deductible
Urgent Care Clinic	60% coinsurance after deductible	70% coinsurance after deductible	80% coinsurance after deductible
Maternity Care			
Physician's Office	60% coinsurance after deductible	70% coinsurance after deductible	80% coinsurance after deductible
Physician Services (Pre- and postnatal visits, delivery)	60% coinsurance after deductible	70% coinsurance after deductible	80% coinsurance after deductible
Delivery and Newborn Charges — Hospital	60% coinsurance after deductible	70% coinsurance after deductible	80% coinsurance after deductible
Mental Health Services			
Specialist Office Visit	60% coinsurance after deductible	70% coinsurance after deductible	80% coinsurance after deductible
Outpatient Services	60% coinsurance after deductible	70% coinsurance after deductible	80% coinsurance after deductible
Inpatient Services	60% coinsurance after deductible	70% coinsurance after deductible	80% coinsurance after deductible
Substance Abuse Services			
Detoxification/Rehabilitation	60% coinsurance after deductible	70% coinsurance after deductible	80% coinsurance after deductible
Outpatient	60% coinsurance after deductible	70% coinsurance after deductible	80% coinsurance after deductible
Inpatient	60% coinsurance after deductible	70% coinsurance after deductible	80% coinsurance after deductible

1 Out-of-pocket maximum does not include Teladoc and prescription drugs. Prescription drug Out-of-Pocket Maximum is separate.

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

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

Services covered by coinsurance require deductible to be satisfied first. Services covered by a copay do not require the deductible to be satisfied. The Regional HMO benefits may vary. Please review the SBCs for the Regional HMOs before you make your election. They are available at www.altogethergreat.com.

About the Kaiser Permanente HMO Plan

In some locations, Kaiser Permanente HMOs may be available and coverage under these Regional HMOs may vary. The Kaiser Permanente Plan is only offered in certain ZIP codes.

Nationwide, over nine million people turn to Kaiser Permanente as their trusted partner in health. With a mission to help members thrive, the health plan offers high-quality, affordable care from a team of top doctors who are connected through one of the most advanced and secure electronic health record systems in existence. When they receive care at Kaiser Permanente facilities, members can choose their own personal physician after browsing online doctor profiles, and they have access to a full suite of online tools that lets them email their doctor's office, refill most prescriptions, schedule routine appointments, and more. Members can also often take care of multiple health needs in a single visit. Many Kaiser Permanente locations offer pharmacy, lab, and X-ray services under one roof, so there's no need to make extra trips. A Summary of Benefits Coverage (SBC) is available at www.altogethergreat.com/rewards under *Resources*.

About the Aetna Global Plan (Antarctica)

Aetna Global Benefits (AGB) is the international business segment of Aetna. AGB's expatriate business is one of the industry's largest and most prominent U.S.-based international health benefits providers, supporting more than 400,000 members worldwide. The Aetna Global Plan is offered to the associates in the Antarctica Support Contract. A Summary of Benefits Coverage (SBC) is available at www.altogethergreat.com/rewards under *Resources*.

About the Triple S Plan (Puerto Rico)

Triple-S is a leader in health insurance and the largest health insurance company in Puerto Rico with over 1.2 million members. For over forty years, Triple S has focused on quality care. Triple-S is an independent licensee of the Blue Cross and Blue Shield Association, serving residents and businesses in Puerto Rico. A Summary of Benefits Coverage (SBC) is available at www.altogethergreat.com/rewards under *Resources*.

About the CommunityCare Plan

CommunityCare is owned by St. John Health System and Saint Francis Health System, employs over 450 employees and is headquartered in downtown Tulsa. They are the largest locally owned health plan in the state of Oklahoma. They are committed to offering network providers who deliver high quality care and services. The CommunityCare Member Services department is available Monday through Friday to help serve its members. A Summary of Benefits Coverage (SBC) is available at www.altogethergreat.com/rewards under *Resources*.

About the HMSA Plan (Hawaii)

HMSA is the most experienced health plan in the state, covering more than half of Hawaii's population. As a recognized leader, HMSA embraces responsibility to strengthen the health and well-being of the community. Headquartered on Oahu with centers statewide to serve plan members, HMSA is an independent licensee of the Blue Cross and Blue Shield Association. Their mission is to provide the people of Hawaii access to a sustainable, quality healthcare system that improves the overall health and well-being of the state. A Summary of Benefits Coverage (SBC) is available at www.altogethergreat.com/rewards under *Resources*.

About the Group Health Plan

Group Health Cooperative is a member-governed, nonprofit health care system that coordinates care and coverage.

The plan network gives you access to a broad choice of in-network doctors, medical facilities, hospitals and pharmacies anywhere in the country. You can access care from preferred providers with Group Health Medical Centers and other medical groups they contract with directly. A Summary of Benefits Coverage (SBC) is available at www.altogethergreat.com/rewards under *Resources*.

For all medical plan options

When to call your medical plan carrier

Call your medical plan carrier's member services department first. Compass Group's Benefits Department cannot answer specific medical plan questions. The medical plan carrier must provide you or your dependents/beneficiary details on:

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

Special Healthcare Provisions

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

Inpatient hospital stays

You must pre-certify all in-network and out-of-network inpatient hospital stays before you or your covered dependent is admitted. To have your hospital stay pre-certified, you or your provider must call your medical plan carrier's customer service department prior to admission. If certified, your hospital stay will be approved for a certain number of days. If you're admitted to the hospital due to an emergency, your medical plan carrier must be called by the end of the next business day (Monday – Friday) after you're admitted or as soon as reasonably possible to certify your stay. If you or your provider don't have an inpatient hospital stay pre-certified, your benefits may be reduced or denied. It is the member's responsibility to recertify all out-of-network inpatient hospital stays, or be subject to a \$500 penalty. See *If You Have a Medical Emergency* below for examples of medical emergencies. If your hospital requires you to stay additional days, it will contact your medical plan carrier to approve the additional days.

If you have a medical emergency

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

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

- Placing your health in serious jeopardy,
- Serious impairment to a bodily function(s),
- Serious dysfunction to a body part(s) or organ(s) or
- In the case of a pregnant woman, serious jeopardy to the health of the unborn child.

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

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

Compass Group medical plans cover emergency room treatment for conditions that reasonably appear to constitute an emergency based on your presenting symptoms. In an emergency situation, care may be received from an in-network or out-of-network provider at the in-network rate. For all services that have provisions or limitations pertaining to ER visits, your medical plan follows the prudent layperson ER policy in the Balanced Budget Act of 1997.

The symptoms related to the medical emergency usually occur suddenly and are severe in nature. When the emergency care is given in the ER of a facility, your plan will cover the care received, provided that the situation meets the criteria as described above.

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

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

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

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

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

What the medical plans cover

All the medical plans pay the reasonable and customary, allowed amount or negotiated charges for covered medical care and treatment of injury or illness certified as necessary by a physician after you meet your deductible.

This section describes which expenses are covered, but you may check with your carrier to review the terms of the medical policy related to your condition. Only expenses incurred for the services and supplies shown in this section are covered. Limitations and exclusions apply. See the medical plan comparison charts beginning on page 12 for details on copays, deductibles, coinsurance and out-of-pocket maximums.

Physician services

Preventive care services

Covered expenses include routine physical examinations and cancer screenings provided in a doctor's office.

Physical exams

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

- Radiological services, X-rays, lab and other tests given in connection with the exam
- Immunizations for infectious diseases and the materials for administration of immunizations as recommended by the Advisory Committee on Immunization Practices of the Department of Health and Human Services, Center for Disease Control
- Testing for Tuberculosis

Covered expenses for children from birth through age 18 also include an initial hospital checkup and well child visits in accordance with the prevailing clinical standards.

Cancer screenings

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

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

Physician or specialist

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

Covered expenses also include:

- Immunizations for infectious disease, but not if solely for your employment or travel
- Allergy testing and allergy injections
- Charges made by the physician for supplies, radiological services, X-rays, and tests provided by the physician

Surgery

Covered expenses include charges made by a physician for:

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

Prescription drug coverage

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

For more information about how you can save money on prescription drugs through the participating pharmacy network and the mail-order program, see page 32.

Hospital expenses

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

- Room and board at the hospital's current rate for a semi-private room. Private rooms are paid up to the cost of a semi-private room. Benefits for maternity care must be available for a minimum of 48 hours following a normal vaginal delivery and 96 hours following a cesarean section. See *Maternity Care* on page 23 for further information.
- Intensive care room and board at the hospital's current rates.
- Other charges for necessary inpatient hospital services and supplies.
- Ambulatory surgical center services in connection with surgery. An ambulatory surgical center is a public or private facility performing surgical procedures on an outpatient basis. The facility must be staffed by physicians, nurses and anesthesiologists and does not provide accommodations for patients to stay overnight.
- Outpatient hospital services and supplies.

You or your provider must call your medical plan carrier for pre-certification/notification of overnight stays at in-network and out-of-network hospitals or benefits may be reduced or denied. It is the member's responsibility to recertify all out-of-network inpatient hospital stays, or be subject to a \$500 penalty.

Alternatives to hospital stays

Extended care facility coverage

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

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

You must meet the following conditions:

- You are currently receiving inpatient hospital care, or inpatient sub-acute care, and
- The skilled nursing facility admission will take the place of an admission to, or continued stay in, a hospital or sub-acute facility; or it will take the place of three or more skilled nursing care visits per week at home; and
- There is a reasonable expectation that your condition will improve sufficiently to permit discharge to your home within a reasonable amount of time; and
- The illness or injury is severe enough to require constant or frequent skilled nursing care on a 24-hour basis.
- Your stay in a skilled nursing facility:
 - Follows a hospital stay of at least three days in a row
 - Begins within 14 days after your discharge from the hospital
 - Is necessary to recover from the illness or injury that caused the hospital stay
- Pre-certification may be required.

Home healthcare coverage

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

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

The medical plans provide benefits for:

- Part time or intermittent nursing care by or under the supervision of a registered nurse
- Part time or intermittent services of a home healthcare aide (certain limitations may apply)
- Physical, occupational, or speech therapy
- Medical supplies, drugs and medicines prescribed by a doctor and laboratory services, if these charges would have been covered had the patient been confined in a hospital

The medical plans cover 100 home healthcare visits — or days — in a calendar year for all of the plans. “One visit” means each visit by a home healthcare agency associate. Pre-certification may be required.

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

Hospice care coverage

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

Limitations

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

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

Refer to the *Employee Assistance Program (EAP)* section on page 40 for information regarding bereavement, financial and legal counseling.

Outpatient Rehabilitation Coverage

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

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

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

Maternity care

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

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

Newborn baby coverage

Routine room and board charges for a newborn infant are covered while the child is enrolled in the medical plan. For newborn coverage to apply, you must enroll newborns in the medical plan within two months of their birth. Any claims submitted after the two month period will be denied unless the child has already been added as a dependent. See *Qualifying Life Events* on page 84.

Charges for the newborn infant may be subject to the deductible and coinsurance. Please contact your administrator for additional information.

Mental health coverage

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

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

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

Inpatient care

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

Coverage includes:

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

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

Remember, you or your provider must call your medical plan carrier for pre-certification/notification of overnight stays at in-network and out-of-network hospitals or benefits may be reduced or denied. It is the member's responsibility to recertify all out-of-network inpatient hospital stays, or be subject to a \$500 penalty. Compass Group's medical plans comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

Substance abuse services

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

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

Outpatient care

Covered expenses include charges for treatment received while not confined as a full time inpatient in a hospital or residential treatment facility. Certain outpatient services may require prior authorization. Please contact your carrier for additional information.

Other covered services

The plan also will pay benefits up to reasonable and customary, allowed amount or negotiated charges for the following medically necessary supplies and services:

- Physician's charges for diagnosis, treatment and surgery
- Cosmetic surgery needed to:
 - Improve a significant functional impairment of a body part
 - Correct the result of an accidental injury, including subsequent related or staged surgery, provided that the surgery occurs no more than 24 months after the original injury. For a covered child, the time period for coverage may be extended through age 18. BCBSNC does not require the surgery to occur 24 months or less after the original injury
 - Correct the result of an injury that occurred during a covered surgical procedure provided that the reconstructive surgery occurs no more than 24 months after the original injury. BCBSNC does not require the surgery to occur 24 months or less after the original injury
 - Anatomical defects present at birth or appearing after birth (but not the result of an illness or injury)
 - Surgical benefits include diagnostic surgery, such as biopsies, and reconstructive surgery performed to correct congenital defects that result in functional impairment of newborn children. These benefits may be subject to medical necessity standards. Please contact your carrier for additional information.
- Breast reductions that are medically necessary (not for cosmetic purposes)
- Birthing center charges for services and supplies related to the mother's care for prenatal care, delivery and postpartum care within 48 hours after a vaginal delivery and 96 hours after a Cesarean delivery
 - One breast pump provided per delivery through in-network DME providers. (Supplies for breast pumps are provided at no cost)
- Charges for the following when ordered in writing by the attending physician:
 - Blood and plasma not donated or replaced
 - Oxygen and rental of equipment to administer oxygen
 - Ostomy supplies (limited to pouches, face plates and belts, irrigation sleeves, bags and catheters and skin barriers)
- Internal and external prosthetic devices and special appliances that replace a limb or body part, or help an impaired limb or body part work. Examples include, but are not limited to:
 - Artificial limbs
 - Artificial eyes
 - Breast prosthesis following mastectomy as required by the Women's Health and Cancer Rights Act of 1998, including mastectomy bras and lymphedema stockings for the arm
 - Benefits are provided for medically necessary replacements of a prosthetic device when ordered by the attending physician
- Rental or purchase (as determined by the medical plan carrier) of a wheelchair, hospital bed or other durable medical equipment (DME) used exclusively for treatment of injury or illness. Pre-certification may be required.
 - Charges are covered for:
 - The initial purchase of DME if long term care is planned and the equipment cannot be rented or is likely to cost less to purchase than to rent
 - Repair of purchased equipment
 - Replacement of broken purchased equipment when determined by a physician to be medically necessary and if the replacement is likely to cost less to replace the item than to repair the existing item or rent a similar item
 - Replacement of purchased equipment if the replacement is needed because of a change in your physical condition
- Casts, splints, dressings, trusses, braces and crutches
- Orthotic devices of the foot are covered when medically necessary and prescribed by a qualified physician for:
 - Treatment of or to prevent complications of a severe systemic disease, such as diabetes
 - When the foot orthotic is an integral part of a leg brace and is necessary for the proper functioning of the leg brace
- Vision hardware coverage of two pair of contact lenses and fittings per year for the treatment of keratoconus.
- Anesthesia and its administration. Aetna also covers acupuncture in lieu of anesthesia.
- X-ray and laboratory services for diagnosis and treatment
- X-ray, radium and radioactive isotope treatment

- Chemotherapy
- Tubal ligation or vasectomy for you or your covered spouse
- Professional ambulance service to or from the nearest hospital that is equipped to provide necessary treatment
- Organ transplant services including charges made by a transplant team, hospital or outpatient facility for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program. The in-network benefits are paid only for a treatment received at a facility designated by the plan as a Center of Excellence for the type of transplant being performed. Each Centers of Excellence facility has been selected to perform only certain types of transplants. Services obtained from a facility that is not designated as a Center of Excellence for the transplant being performed will not be covered. Services obtained from a facility that is not designated as a Center of Excellence will not be covered unless you live more than 100 miles from one. The Out-of-Area Plan does not require you to use an in-network provider.
- Charges in connection with temporomandibular joint (TMJ) syndrome — diagnostic services and surgery only, other services covered under dental
- Nutritional counseling by a registered dietician for chronic diseases in which a dietary adjustment has a therapeutic role. Limited to three individual sessions per lifetime per condition. BCBSNC does not limit the number of sessions.
- Diaphragm and intrauterine devices purchased and fitted in a physician's office
- Routine hearing exam as part of preventive care, subject to your medical plan's standard guidelines for frequency
- Hearing aids, including the replacement of hearing aids once every five calendar years
- Orthoptic therapy
- Congenital Heart Disease services
- Bariatric surgery for morbid obesity — subject to your medical plan's standard guidelines for medical necessity and step therapy treatment. If approved for surgery, you must use a Center of Excellence for treatment, where you're more likely to get better care and be treated by experienced, knowledgeable providers
- Diagnosis, treatment and correction of any underlying causes of infertility and/or sexual dysfunction
- Elective abortions

Clinical trials

Benefits are available for routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted;
- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below;
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below; and
- Other diseases or disorders which are not life threatening for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the covered person is clinically eligible for participation in the qualifying clinical trial as defined by the researcher.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Services for which benefits are typically provided absent a clinical trial;
- Covered Health Services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Covered Health Services needed for reasonable and necessary care arising from the provision of an investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service or item. The only exceptions to this are:
 - Devices approved by the FDA for clinical trials the plan is required to cover under federal regulation
 - Certain promising interventions for patients with terminal illnesses; and
 - Other items and services that meet specified criteria in accordance with our medical and drug policies;

- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine and hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*);
 - *Centers for Disease Control and Prevention (CDC)*;
 - *Agency for Healthcare Research and Quality (AHRQ)*;
 - *Centers for Medicare and Medicaid Services (CMS)*;
 - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA)*;
 - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants; or

- The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
 - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*; and
 - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*;
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application;
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial; or
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Services Received Outside of North Carolina (BCBSNC)

BCBSNC has a variety of relationships with other Blue Cross and/or Blue Shield licensees, generally referred to as “Inter-Plan Programs.” As a member of the plan, you have access to providers outside the state of North Carolina. Your ID card tells providers that you are a member of the plan. While the plan maintains its contractual obligation to provide benefits to members for covered services, the Blue Cross and/or Blue Shield licensee in the state where you receive services (“Host Blue”) is responsible for contracting with and generally handling all interactions with its participating providers.

	IN-NETWORK	OUT-OF-NETWORK
Care Outside of North Carolina	Your ID card gives you access to participating providers outside the state of North Carolina through the BlueCard Program, and benefits are provided at the in-network benefit level.	If you are in an area that has participating providers and you choose a provider outside the network, you will receive the lower out-of-network benefit. Also see “Out-Of-Network Benefit Exceptions.”

Whenever you obtain healthcare services outside the area in which the BCBSNC network operates, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include Negotiated National Account Arrangements available between BCBSNC and other Blue Cross and/or Blue Shield licensees.

Under the BlueCard Program, the amount you pay toward such covered services, such as deductibles, copayments or coinsurance, is usually based on the lesser of:

- The billed charges for your covered services, or
- The negotiated price that the “Host Blue” passes on to BCBSNC.

This “negotiated price” can be:

- A simple discount that reflects the actual price paid by the Host Blue to your provider
- An estimated price that factors in special arrangements with your provider or with a group of providers that may include types of settlements, incentive payments, and/or other credits or charges
- An average price, based on a discount that reflects the expected average savings for similar types of healthcare providers after taking into account the same types of special arrangements as with an estimated price

The estimated or average price may be adjusted in the future to correct for over- or underestimation of past prices. However, such adjustments will not affect the price that BCBSNC uses for your claim because they will not be applied retroactively to claims already paid.

Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

As an alternative to the BlueCard Program and depending on your geographic location, your claim may be processed through a Negotiated National Account Arrangement with a Host Blue. In these situations, the amount you pay for covered services will be calculated based on the negotiated price made available to BCBSNC by the Host Blue.

If you receive covered services from a nonparticipating provider outside the state of North Carolina, the amount you pay will generally be based on either the Host Blue’s nonparticipating provider local payment or the pricing arrangements required by applicable state law. However, in certain situations, the plan may use other payment bases, such as billed charges, to determine the amount the plan will pay for covered services from a nonparticipating provider. In any of these situations, you may be liable for the difference between the nonparticipating provider’s billed amount and any payment the plan would make for the covered services.

What the medical plans do not cover

Please note this list may not be all inclusive – please check with your carrier. While the plans pay for most medical expenses, the following are not covered:

- Food of any kind. Foods that are not covered include:
 - Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk even if they are the only source of nutrition and even if they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU); infant formula available over-the-counter is always excluded
 - Foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes
 - Oral vitamins and minerals
 - Meals you can order from a menu, for an additional charge, during an inpatient stay
 - Other dietary and electrolyte supplements
- Health services provided in a foreign country
- Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) when the services are dental in nature
- Treatment of benign gynecomastia (abnormal breast enlargement in males)
- Acupuncture, acupressure and acupuncture therapy, except as provided in your medical plan
- Any services provided by a covered provider who is a member of your or your spouse's immediate family
- Charges above reasonable and customary or allowed amount guidelines
- Charges for any service provided without charge or that would have been provided without charge if this plan weren't in effect
- Charges for blood plasma that is replaced on behalf of you or your covered dependent
- Charges for experimental and/or investigational/unproven drugs or substances not approved by the Food and Drug Administration (FDA), or for drugs labeled "Caution: Limited by Federal law to investigational use"
- Charges for eyeglasses or contact lenses and exams for their prescription or fitting (see *Vision Coverage* on page 49)
- Charges for non-covered health services
- Charges for services and supplies that are not medically necessary
- Charges for services or supplies provided before your effective date of coverage under this plan, or after your coverage is terminated under this plan
- Charges for which no legal liability would exist had coverage under the plan existed — or charges prohibited by law in your jurisdiction at the time you incur the expense
- Cochlear implants if guidelines are not met
- Cosmetic procedures, such as plastic surgery, dermabrasion, chemosurgery and other skin abrasion procedures associated with the removal or revision of scars, tattoos, actinic changes, and/or which are provided to treat acne
- Counseling services and treatment for marriage, religious, family, career, social adjustment, pastoral, or financial counselor (see *Employee Assistance Program (EAP)* on page 40)
- Custodial care, including institutions such as homes for the aged, rest homes and schools for the mentally disabled
- Cranial banding — unless medically necessary and not for cosmetic reasons
- Dental care or treatment, except for care covered by the medical plan
- Experimental, investigational or unproven services
- Illness or injury received at the time or when attempting an assault or felony — or injuries received while involved in an illegal occupation, except illness or injuries you have because of a medical condition or resulting from domestic violence
- Infertility treatment with drugs or surgery, such as artificial insemination, in-vitro fertilization, reverse sterilization, GIFT, ZIFT or any combination
- Luxury services and supplies such as mineral baths, massages, telephones, radio and television
- Nutritional supplements or vitamins, even if a written prescription is provided
- Private duty nursing

- Routine foot care, including treatment of corns or calluses, care of toenails (except surgery for ingrown nails) or other foot tissue or mycotic toenails when no indication of metabolic disease is present; treatment of foot weakness or strain, such as fallen arches, flat feet, weak feet, chronic foot strain. Also excluded:
 - Orthopedic and therapeutic shoes, shoe additions, modifications or other devices to support the feet, unless it meets the criteria as outlined in the covered services section
 - Orthotics for sports related activities
 - Spring loaded orthotics
 - Prefabricated foot orthoses
- Service or supplies for sex reassignment surgery or hormonal treatments
- Services for weight control, including: medical treatments (except bariatric surgery); weight control/loss programs; dietary regimens and supplements; appetite suppressants and other medications; food or food supplements; exercise programs; exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions
- Services or supplies provided by the Veterans Administration or by any hospital or institution owned, operated or maintained by the U.S. Government for a service-related illness or injury
- Services or supplies provided to you or your covered dependents after coverage has terminated, unless your coverage is extended as explained on page 101
- Services outside the scope of a physician or other provider's license
- Speech therapy for treatment of delays in speech development, except as specifically provided by the medical plan. For example, the plan does not cover therapy when it is used to improve speech skills that have not fully developed
- Certain transplant-related coverage including:
 - Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence
 - Services and supplies furnished to a donor when recipient is not a covered person
 - Harvesting and/or storage of organs, without the expectation of immediate transplantation for an existing illness
 - Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing illness
 - Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise precertified
 - Health services for transplants involving non-FDA approved mechanical or animal organs
 - Services and supplies not obtained from a Centers of Excellence facility or health plan approved Organ Procurement Organization, including the harvesting of organs, bone marrow, tissue or stem cells for storage purposes
 - Organ transplant services including charges made by a transplant team, hospital or outpatient facility for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program
 - Any solid organ transplant that is performed as a treatment for cancer, unless specifically approved as medically necessary and non-experimental by the health plan
- Treatment not provided by a licensed doctor or other provider
- Under Aetna and UnitedHealthcare, charges made by an assistant surgeon in excess of 25% of the surgeon's allowable charge; or for charges made by a co-surgeon in excess of the surgeon's allowable charge plus 25%. Under BCBSNC, charges made by an assistant surgeon in excess of 20% of the surgeon's allowable charge; or for charges made by a co-surgeon in excess of the surgeon's allowable charge plus 20%.
- Under Aetna, BCBSNC and UnitedHealthcare when two or more surgical procedures are performed together, the maximum amount allowable will be the sum of the amount otherwise allowable for the most expensive procedure plus 50% of the allowable amount for the secondary procedure and 25% of the allowable amount for all other surgical procedures combined.

Medical claims

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

For the in-network portion of the Bronze Plus, Silver Plus and Gold Plus, your medical provider will submit your claims directly to your medical plan carrier. If you use out-of-network providers or you are a participant in the Out-of-Area – Bronze Plus, Silver Plus and Gold Plus Plans, you will need to submit claims directly to your medical plan carrier.

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

The Medical Claim form contains a section for you to complete and sign and a section for your doctor or other provider to complete. All claim forms must be signed by you (the associate) and the patient, if the patient is not a minor. As an alternative to having your doctor complete the claim form, you may attach the itemized bill to the claim form. The bill must include:

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

Refer to the *Claims and appeal process* section on page 116 for additional information on the timing of claims processing and appeals of claim denials.

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

Aetna

P.O. Box 981106
El Paso, TX 79998-1106
866-238-1128

www.aetna.com/docfind/custom/compassgroup

BlueCross BlueShield of NC

P.O. Box 35
Durham, NC 27702
877-275-9787

www.bcbsnc.com/members/compassgroup

United Healthcare

P.O. Box 740800
Atlanta, GA 30374-0800
877-571-9862

<http://welcometouhc.com/compassgroup>

Regional HMO claim office

<p>CALIFORNIA - Northern Kaiser Foundation Health Plan, Inc. Attn: Claims Department P.O. 12923 Oakland, CA 94604-2923 800-464-4000 www.kp.org</p>	<p>CALIFORNIA - Southern Kaiser Foundation Health Plan, Inc. Attn: Claims Department P.O. Box 7004 Downey, CA 90242 800-464-4000 www.kp.org</p>	<p>COLORADO - Colorado Springs Kaiser Permanente Attn: Claims Department P.O. Box 372910 Denver, CO 80237-6910 888-681-7878 www.kp.org</p>
<p>COLORADO - Denver Kaiser Permanente Attn: Claims Department P.O. Box 373150 Denver, CO 80237-6970 303-338-3600 www.kp.org</p>	<p>MARYLAND- Mid-Atlantic Kaiser Permanente P.O. Box 6233 Rockville, MD 20849-6217 301-468-6000 or 800-777-7902 www.kp.org</p>	<p>OKLAHOMA CommunityCare P.O. Box 3249 Tulsa, OK 74101-3249 918-594-5242 or 800-777-4890 www.ccok.com</p>
<p>WASHINGTON Group Health Cooperative of Puget Sound Attn: Claims Administration P.O. Box 34585 Seattle, WA 98124-1585 888-901-4636- West 800-497-2210- East www.ghc.org</p>	<p>PUERTO RICO (HMO Plan) Triple-S Salud PO Box 363628 San Juan, Puerto Rico 00936-3628 787-774-6060 Out-of-Area: 800-810-2583 www.ssspr.com</p>	<p>ANTARTICA - Aetna Global Aetna International/Aetna PO Box 981543 El Paso, TX 79998-1543 www.aetnainternational.com</p>
<p>HAWAII Kaiser Permanente Hawaii Claims Administration PO Box 378021 Denver, CO 80237 www.kp.org</p>	<p>HAWAII HMSA - Claims Administration 8/CA P.O. Box 860 Honolulu, HI 96808-0860 Oahu: 808-948-607 Neighbor Islands: 800-776-4672 www.hmsa.com</p>	

The Prescription Drug Program

Compass Group has contracted with CVS Caremark™ to be the Pharmacy Benefit Manager (PBM) for the Bronze Plus, Silver Plus, Gold Plus and Out-of-Area – Bronze Plus, Silver Plus and Gold Plus Plans. The Regional HMOs that may be available to you administer their own prescription drug coverage.

At a Glance

- CVS Caremark™ offers you several advantages including significant cost savings on prescriptions, customer service representatives who are available 24 hours a day/seven days a week to answer your questions, and the convenience of access to thousands of pharmacies nationwide, including most major chains.
- You can receive 30-day supplies of medications at a retail pharmacy or 90-day supplies through the Mail-Order or Maintenance Choice® programs.
- For certain conditions such as ulcers, acid reflux disease and some types of pain or inflammation, Compass Group’s Step Therapy program requires that lower cost options be explored before higher cost options are covered under the plan.

Your prescription drug coverage

By using CVS Caremark’s™ pharmacy networks, you’ll get discounted prices for your prescriptions. You will receive a pharmacy prescription drug card from CVS Caremark™ that you will need to use when you have a short term prescription of 30-days or less filled at a local participating pharmacy. You don’t need to file claim forms.

Due to Health Care Reform regulations, there is a separate out-of-pocket maximum for prescription drugs which limits the amount you pay for eligible prescription drug expenses in the plan, saving you money. The out-of-pocket maximum is \$1,000 individual/\$2,000 family for the Bronze Plus plan and \$1,500 individual/\$3,000 family for the Gold and Silver Plus plans. Once the maximum is reached, the cost for prescription drugs will be paid at 100% for the remainder of the calendar year.

RETAIL PHARMACY (UP TO 30-DAY SUPPLY)	BRONZE PLUS & OUT-OF-AREA – BRONZE PLUS PLANS	SILVER PLUS & OUT-OF-AREA – SILVER PLUS PLANS	GOLD PLUS & OUT-OF-AREA – GOLD PLUS PLANS
Generic	100% after \$12.50 copay	100% after \$12.50 copay	100% after \$12.50 copay
Preferred	50% coinsurance, associate pays min \$50/max \$100	70% coinsurance, associate pays min \$30/max \$50	70% coinsurance, associate pays min \$30/max \$50
Non-preferred	50% coinsurance, associate pays min \$75/max \$150	70% coinsurance, associate pays min \$50/max \$100	70% coinsurance, associate pays min \$50/max \$100
Specialty Brand	50% coinsurance, associate pays min \$100/max \$200	70% coinsurance, associate pays min \$75/max \$125	70% coinsurance, associate pays min \$75/max \$125

Using out-of-network pharmacies

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

Which pharmacies participate in the network?

You have access to thousands of pharmacies nationwide, including most major chains — like Walmart, Target, Walgreens, Rite Aid and CVS. To find an in-network pharmacy in your area, check out CVS Caremark’s™ website at www.caremark.com.

The Mail-Order Program

If you take long term medications, you can take advantage of each plan's mail-order prescription program. By using the mail-order program, you receive up to a three-month (90-day) supply of your prescription at a lower cost than if the same prescription was purchased at your local pharmacy on a month-to-month basis. Simply mail your prescription and payment in the pre-addressed envelope provided by CVS Caremark™.

If coinsurance is required, call CVS Caremark™ to determine your coinsurance cost. Your prescription will be delivered to your home, postage paid, along with another pre-addressed envelope for your next prescription order.

If you have any questions about the mail-order program, or if you need a mail-order package containing pre-addressed envelopes, call CVS Caremark™ at 855-656-0360.

PHARMACY MAIL-ORDER (90-DAY SUPPLY)	BRONZE PLUS & OUT-OF-AREA – BRONZE PLUS PLANS	SILVER PLUS & OUT-OF-AREA – SILVER PLUS PLANS	GOLD PLUS & OUT-OF-AREA – GOLD PLUS PLANS
Generic	100% after \$25 copay	100% after \$25 copay	100% after \$25 copay
Preferred	50% coinsurance, associate pays min \$100/max \$200	70% coinsurance, associate pays min \$75/max \$125	70% coinsurance, associate pays min \$75/max \$125
Non-preferred	50% coinsurance, associate pays min \$150/max \$300	70% coinsurance, associate pays min \$125/max \$250	70% coinsurance, associate pays min \$125/max \$250

Getting started with home delivery

To get started

Go online to www.caremark.com or call 855-656-0360. CVS Caremark™ will contact your physician to request a 90-day prescription.

To manage refills

Set up your profile with CVS Caremark™, and you'll receive telephone calls or emails when your refill is due — or when your order is shipped.

To ship to a different address

If you don't want your prescriptions shipped to your home, CVS Caremark™ can ship to a different address.

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

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

You are required to fill a 90-day supply of your maintenance medications with Maintenance Choice®. You can choose to fill a 90-day supply of your prescriptions through Maintenance Choice in two ways:

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

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

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

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

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

Due to Health Care Reform regulations, all medical plans offer 100% coverage for in-network women's preventive services, including FDA approved contraception methods and sterilization procedures.

Tobacco cessation medication

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

Specialty medications

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

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

Specialty medications may:

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

Caremark Specialty for specialty medications

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

SPECIALTY MEDICATIONS (30-DAY SUPPLY)	BRONZE PLUS & OUT-OF-AREA – BRONZE PLUS PLANS	SILVER PLUS & OUT-OF-AREA – SILVER PLUS PLANS	GOLD PLUS & OUT-OF-AREA – GOLD PLUS PLANS
Generic	100% after \$12.50 copay	100% after \$12.50 copay	100% after \$12.50 copay
Brand	50% coinsurance, associate pays min \$100/max \$200	70% coinsurance, associate pays min \$75/max \$125	70% coinsurance, associate pays min \$75/max \$125

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

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

For Bronze Plus, Silver Plus, Gold Plus and Out-of-Area – Bronze Plus, Silver Plus and Gold Plus Plans, Compass Group only covers specialty medications through Caremark Specialty. To receive coverage, be sure to order your specialty medications through the Caremark Specialty Program. Your physician will need to complete a Patient Enrollment Form. This form can be obtained by calling the CVS Caremark Customer Service Department at 855-656-0360.

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

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

Drugs that are not covered

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

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

Lifestyle medications

Lifestyle medications are prescriptions that are not medically necessary but are FDA-approved to treat conditions such as hair loss, wrinkle reduction and certain allergies. While these drugs are not covered under the Prescription Drug Program, with Compass Group's purchasing power, you'll be able to purchase these medications at the group discounted rates. In these instances, you pay 100% of the discounted cost.

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

Reduce your costs with generic drugs

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

Generic Preferred Program

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

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

- If you choose a generic drug, your copay will be \$10 for a 30-day supply (\$20 for a 90-day supply)
- If you choose a brand-name drug, you'll pay your coinsurance plus the difference in cost between the generic and the brand-name drug

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

What is a preferred drug?

Certain medical conditions, such as asthma, may be treated using any number of brand-name prescription options. CVS Caremark™ designates which brand-name prescriptions are included on its preferred drug lists, for a wide range of medical conditions. The medications on the preferred drug lists are known to be safe, effective, FDA-approved and more cost effective than other brand-name drugs. Preferred drugs have a lower out-of-pocket cost to you than non-preferred drugs. The lists are available at www.caremark.com.

Step Therapy Program

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

Your doctor is involved, and approves the substitution of the lower cost drug covered by our plan. Your pharmacy provider starts the process for specific drug categories.

How does Step Therapy work?

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

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

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

Prior authorization

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

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

If your medication requires prior authorization:

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

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

Quantity Limits

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

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

If you go to the pharmacy for a refill:

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

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

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

Mail order and prescription claims

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

CVS Caremark (for mail order)

Mail Pharmacy Service
P.O. Box 94467
Palatine, IL 60094-4467
855-656-0360

CVS Caremark Claims Department (for paper claims)

P.O. Box 52136
Phoenix, AZ 85072-2136
855-656-0360

Wellness Program

Compass Group provides a Wellness Program for associates and eligible dependents. While the Wellness Program is available to everyone, some programs are only available to associates and dependents enrolled in a Compass Group medical plan. The programs available through our wellness partners — INTERVENT and HealthAdvocate include:

- INTERVENT:
 - A free, confidential online or telephonic Health Risk Assessment (HRA)
 - Online health improvement programs
 - Lifestyle health coaching by phone
 - Maternity Management Program
 - Tobacco Cessation Program
- HealthAdvocate:
 - Employee Assistance Program (for eligible associates and their spouse, dependent children, parents and parents-in-law) — to help you deal confidentially with personal issues that affect your health, family and work life
 - Healthcare Help team — to help you and your family members navigate the complex healthcare system

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

INTERVENT programs

INTERVENT is our partner to offer the HRA, online health improvement programs, lifestyle health coaching, maternity management and tobacco cessation programs.

Health Risk Assessment (HRA)

As a Compass Group associate, you and your adult dependents can complete a free HRA, available online and via telephone interview in both English and Spanish. All Compass Group associates and eligible dependents can take the HRA – you do not have to be enrolled in a Compass Group medical plan.

You'll receive individualized reports that include:

- Brief score cards and comprehensive risk factor goals
- The ability to conduct “what if” reviews – such as what if my blood pressure and/or cholesterol are improved or if I quit smoking
- Personal recommendations and action plans including meal and exercise plans
- Summary reports to take to your personal doctor
- Educational kits on select topics

The HRA takes about 15 minutes to complete.

By completing the HRA, you can learn more about getting healthy and staying healthy by answering a few simple questions. Take the HRA and you can earn a \$3 per week wellness credit toward your medical deductions. You can also earn a \$3 per week wellness credit if your spouse takes the HRA, too.

To get the credit, associates and spouses must:

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

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

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

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

Ready to take the HRA?

- Height and weight are required. Blood pressure numbers and fasting cholesterol, triglyceride and blood glucose levels aren't required, but you get a more accurate assessment if you have them.
- Then, go to www.myintervent.com/compassgroup.

From **INTERVENT's** landing page:

- Click START My New Health Risk Assessment and then follow the prompts to enter your personal information and complete your HRA.
 - You'll need to provide your eight-digit Compass Group personnel ID number. Your spouse will also use your ID number. If you and your spouse are both employed by Compass Group, use the ID number of the associate who is the primary member on the medical plan.
- If you provide an email address, your password will be emailed to you. **You must have this password to return to the site.**
- If you don't provide an email address, you will receive a sign-on ID and password in a pop-up box that you must use to return to the site.

No access to the web? Call 866-334-2137 and an INTERVENT representative will help you complete the HRA.

INTERVENT *Incentive Program*

You may earn points that make you eligible for quarterly, semi-annual and annual drawings for valuable gift cards from INTERVENT. The more points you earn the more chances you have to win. You'll earn 50 points by completing your HRA.

You'll also have access to a variety of new resources and tools from INTERVENT, CardioSmart@Work and the American College of Cardiology, including access to challenges and a vibrant, active online community. You may request health-oriented messaging, including text messaging, to keep you motivated to live healthfully.

Online Health Improvement Programs

Once you complete the HRA, you can access a variety of online self-directed lifestyle coaching tools. These online tools include programs and information on physical activity, weight loss/weight management, healthy eating, and stress management. You do not need to be enrolled in a Compass Group medical plan to participate in the Online Health Improvement Programs.

Lifestyle Health Coaching Program

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

You'll have phone calls with your own professional health coach to talk about changes in your lifestyle that are important to you. Whether you want to lose weight, improve your fitness, manage stress, give up tobacco and/or decrease the likelihood of developing certain chronic conditions and their complications, a health coach can help you get healthier and stay healthier. After the initial telephonic 30-minute coaching session, additional coaching sessions are approximately 15 minutes.

The program is designed to help you make and adhere to meaningful lifestyle changes (including regular exercise, proper nutrition, weight management, tobacco cessation, and stress management). The program also helps you learn about preventive screenings, other exams and important self-care strategies. You may be referred to your doctor or healthcare provider to discuss medications to help manage common chronic conditions such as high blood pressure or abnormal cholesterol. For people who are overweight and serious about losing weight, INTERVENT provides a booster phase that allows participants to begin losing weight right away and increases self-discipline, motivation and confidence.

As part of the coaching process, INTERVENT offers over 80 different educational/behavior modification kits/modules with audios. Free online food and exercise diaries with mobile applications for your smart phone are provided. You and your dedicated coach use your personal goals and action plan to work together from session to session to identify the specific topics that are appropriate for you. Follow-up evaluations and progress reports are provided to participants after 12 weeks and one year.

For more information

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

Maternity Management Program

Expectant mothers enrolled in a Compass Group medical plan will have access to INTERVENT's enhanced lifestyle management and health coaching program for pregnant women. Those who participate in the program will receive pregnancy related healthcare information and support throughout the pregnancy. Once the program is completed, INTERVENT will send you a gift card with a maternity incentive amount.

- \$250 gift card when enrolled in the first trimester (pregnancy weeks 1 to 13)
- \$125 gift card when enrolled in the second trimester (pregnancy weeks 14 to 26)

Eligible dependents can also participate in the program if they are enrolled in a Compass Group medical plan.

Tobacco Cessation Program

Compass Group and INTERVENT offer associates enrolled in a Compass Group medical plan access to the Tobacco Cessation Program, at no cost to you.

- You'll receive one-on-one support over the telephone from an INTERVENT coach, who can help you to identify your triggers, create methods of dealing with the cravings, and help keep you on track towards quitting tobacco.
- Plus, you have access to self-directed online coaching.
- Non-prescription nicotine replacement therapy is also provided at no cost to you when you enroll in the Tobacco Cessation Program.
- Prescription tobacco cessation medication is covered under the CVS Caremark™ prescription drug plan.

For more information

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

HealthAdvocate programs

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

Employee Assistance Program

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

Through the EAP, you can get help with:

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

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

Generally, the EAP is available to team member associates enrolled in a Compass Group medical plan.

Your Personal Health Advocate

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

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

HealthAdvocate does not replace your current health insurance coverage nor does it provide medical care or recommend treatment. To learn more about the EAP and Healthcare Help Team, visit www.healthadvocate.com/compass-group or call 866-799-2728, 24 hours a day, seven days a week.

Condition Management Program

Compass Group partners with the medical carriers to offer condition management. You must be enrolled in a Compass Group medical plan to participate in these programs.

Each medical plan offers a condition management program that includes support for adults and children with conditions including:

- Heart and Blood Vessel Conditions
- Diabetes
- Lung Conditions
- Kidney Conditions
- Cancer
- Bone and Joint Conditions

Please contact your medical carrier to get additional information about the programs that are offered. If you participate in one of the condition management programs, you'll have a chance to work one-on-one with a nurse, other clinical professionals and your doctors to set goals to help improve your overall health and quality of life. Not only will you learn more about your health condition and improve your health, your team can help you to control your out-of-pocket costs.

For more information

Call the number on your medical ID card.

Livongo Diabetes Management Program

Livongo provides a cellular enabled smart glucometer to diabetic members enrolled in a Compass Group medical PPO plan. The technology allows remote diabetes experts to passively monitor patient blood glucose levels and check in when abnormal or risky test results are detected. When you participate in the program, you will receive direct messaging sent to the device or via telephone. The diabetic member also has the option to designate additional contacts (e.g. a doctor or family member) to receive out of range notifications.

Once enrolled, Livongo sends the diabetic member a starter kit, ready for the member to use right out of the box. It's so easy for you — you continue to test your blood glucose as you did with your previous meter but now that data is captured for you through the cellular enabled Livongo meter. Testing supplies are sent to the member at no cost. It's so convenient, when your testing supplies are running low, Livongo will send your refills.

You will have access to 24/7/365 on-call coaching from Livongo Certified Diabetes Educators. Find more information at welcome.livongo.com/Compass.

Dental Coverage

Dental benefits help you and your covered dependents take care of your dental needs. Coverage is provided for routine dental care and treatment for disease, defect and injury.

This section describes benefits provided through the Cigna Basic and Comprehensive Plans. Details on the Delta Dental Plan, available only in Puerto Rico, are provided by the carrier through a Certificate of Coverage and is not included in this document.

At a Glance

- Eligible associates and their eligible dependents can enroll in dental coverage, even if they do not elect medical coverage.
- Cigna administers the dental plans.
- You must enroll yourself in a dental plan if you would like to cover any dependents under a dental plan.
- Covered expenses include preventive, basic and major services. The Comprehensive Plan provides orthodontia coverage.
- You can choose from these dental plan options — Cigna Basic Dental Plan and Cigna Comprehensive Dental Plan – or you may waive your dental coverage.

The Cigna Dental Plans (Total Cigna DPPO Network)

How the plans work

The dental plans allow you to use any dentist you choose, but also gives you access to the Total Cigna DPPO network of preferred provider dentists. If you use a Cigna preferred provider, you'll receive a higher level of benefits because preferred provider dentists provide services at discounted rates and your preventive care is covered at 100%. This may result in lower out-of-pocket expenses by:

- Paying less for covered services because in-network dentists have agreed to offer services at lower negotiated rates.

- Saving on out-of-pocket costs for many services not covered under your plan since in-network dentists have agreed to offer our customers discounted fees for all procedures on their fee schedules. (Not available in all states.)

If you need more information about the Total Cigna DPPO preferred providers in your area, you can contact Cigna at 800-Cigna24 (800-244-6224) or log on to www.mycigna.com.

By choosing a DPPO preferred dentist, you may receive higher in-network benefit coverage than you would with a DPPO dentist.

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

Basic and Comprehensive Plan highlights

- A self-insured plan available to all associates throughout the country
- You can use any dentist you choose and receive traditional benefits from the plan
- If you use a Total Cigna DPPO network dentist, you receive a higher level of benefits due to discounted rates and preventive care is covered at 100%
- There is no deductible for preventive care or orthodontia
- There is a deductible for basic and major treatment
- You can receive toll-free help from experienced dental representatives
- These plans use a dental ID card. Your ID card will be sent to you from Cigna within 31 days of your election
- You may have to file a claim form. Forms are online at www.altogethergreat.com/rewards or at www.mycigna.com

SERVICES COVERED	BASIC DENTAL PLAN	COMPREHENSIVE DENTAL PLAN
Annual Benefit Preventive, basic and major treatments	\$750 per year, per person for all levels combined	\$1,500 per year, per person for all levels combined
Preventive Treatment Checkups, cleanings, fluoride treatment, bitewing X-rays	100% when you use a Cigna network dentist or 80% when you use a non-network dentist	100% when you use a Cigna network dentist or 80% when you use a non-network dentist
Basic Treatment Fillings, simple extraction	50% of reasonable and customary charges ¹ after \$50 deductible ²	80% of reasonable and customary charges ¹ after \$50 deductible ²
Major Treatment Crowns, bridges, dentures (including over implants)	50% of reasonable and customary charges ¹ after \$50 deductible ²	50% of reasonable and customary charges ¹ after \$50 deductible ²
Orthodontia Braces and related treatment	Not covered	50% up to lifetime maximum benefit of \$2,500 per person, no deductible

¹ Services provided by a Cigna preferred provider dentist are at a discounted rate. Therefore, your out-of-pocket expenses are lower.

² \$50 deductible per person or \$150 per family annually.

What are reasonable and customary charges?

Reasonable and customary charges are the normal range of fees charged by dentists in your geographic area for similar services. In other words, it is the “going rate” for a certain service in your area. The dental plans will not pay for charges above the reasonable and customary charge — you are responsible for paying the additional amount.

If you use a Total Cigna DPPO network provider, the charges are within the reasonable and customary charge range.

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

If you are enrolled in the Basic or Comprehensive dental plan, you can use any dentist you wish and receive the benefits outlined in the dental plan. However, if you use a Total Cigna DPPO network dentist, you’ll pay less money and maximize the plan’s benefits. That’s because Total Cigna DPPO network dentists charge discounted fees. For a Total Cigna DPPO network provider listing in your area, go to www.mycigna.com or call Cigna at 800-Cigna24 (800-244-6224).

How dental expenses are paid

Benefits for reasonable and customary charges and negotiated charges covered under the Basic and Comprehensive dental plans are paid like this:

1. You pay a \$50 annual deductible for most covered expenses. If you chose family coverage, then the annual family deductible is \$150.
2. The annual deductible does not apply to preventive care. If you use a Total Cigna DPPO network dentist, preventive care is paid at 100%. If you use a non-network dentist, preventive care is paid at 80%.
3. After you’ve met your deductible, the plan pays a percentage of covered charges and you pay the rest. The percentage paid by the plan depends on the type of service you receive.
4. The plans continue to pay a percentage of your covered services until the \$750 or \$1,500 maximum annual benefit has been paid. Then the plans stop paying benefits for the rest of the plan year (January 1 – December 31). Remember, if you use a Total Cigna DPPO network dentist, you’ll be paying discounted fees, so you’ll have more dental services before you reach the plan’s \$750 or \$1,500 maximum annual benefit.
5. You or your dentist complete and submit a dental claim form, or your dentist may file your claim electronically.

Your deductible amount

The deductible is the amount of covered charges you pay each year before the plan begins paying benefits. You pay *no* deductible for preventive care provided by a Total Cigna DPPO network dentist. You pay no deductible for orthodontic services if provided by a Total Cigna DPPO network dentist in the Comprehensive Plan. You pay a \$50 deductible each year for all other covered services combined. This deductible is subtracted from the eligible dental expenses that you or your dentist submits on the dental claim form, available at www.mycigna.com or www.altogethergreat.com/rewards.

If you have selected dependent coverage, no one person has to meet the individual deductible as long as the \$150 family deductible is met.

Meeting the deductible

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

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

Percentage of covered charges paid by the Basic and Comprehensive Dental Plans

After you have met your deductible, the dental plans pay a percentage of your covered dental expenses. The percentage paid depends on the type of service you receive and whether you use a Total Cigna DPPO network dentist. For example, the Comprehensive Plan pays 100% of preventive* treatment with an in-network dentist, 80% of basic treatment and 50% of major treatment and orthodontia. The plan continues paying a percentage of covered charges until the maximum annual benefit of \$1,500 is paid. Orthodontia is subject to a separate \$2,500 lifetime maximum.

* Preventive treatment is payable at 80% (no deductible) when you use a non-network dentist.

Maximum annual benefits

- Annual maximum for all types of treatment combined (except orthodontia) — \$750 of paid claims for the Basic Plan and \$1,500 of paid claims for the Comprehensive Plan
- Orthodontia lifetime maximum — \$2,500 of paid claims (Comprehensive Plan only)

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

When you use a Total Cigna DPPO network dentist

Visit 1: Preventive (no deductible)

$$\begin{array}{r} \$75 \text{ covered charges} \\ \times 100\% \\ \hline \$75 \text{ plan pays} \end{array}$$

Visit 2: Basic (deductible)

$$\begin{array}{r} \$1,025 \text{ covered charges} \\ - \$50 \text{ deductible} \\ \hline \$975 \\ \times 80\% \\ \hline \$780 \text{ plan pays} \end{array}$$

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

Visit 3: Basic

$$\begin{array}{r} \$875 \text{ covered charges} \\ \times 80\% \\ \hline \$700 \end{array}$$

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

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

Avoid costly surprises with predetermination of benefits

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

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

To do this, submit a predetermination of benefits request to:

Cigna Service Center
P.O. Box 188037
Chattanooga, TN 37422-8037

Alternate treatment plans

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

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

What the Basic and Comprehensive Dental Plans cover

The dental plans pay the reasonable and customary charges for covered dental care that is necessary. However, not all expenses are covered (see *What the Basic and Comprehensive Dental Plans do not cover* on page 46).

Dental benefits are paid for these services:

- Preventive and diagnostic treatment
- Basic treatment
- Major treatment
- Orthodontia (Comprehensive Plan only)

Preventive and diagnostic treatment

The Basic and Comprehensive plans pay 100% (Total Cigna DPPO network dentist) of these expenses (up to the maximum annual benefit) with no deductible:

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

Basic treatment

The Basic Plan pays 50% (at any dentist) of covered charges (up to the maximum annual benefit) after you have met your deductible; the Comprehensive Plan pays 80%. Basic treatments include:

- Fillings
- Amalgam restorations (if at least one calendar year has passed since the existing amalgam was placed)
- Silicate restorations (if at least one calendar year has passed since the existing filling was placed)
- Composite resin restorations (if at least one calendar year has passed since the existing filling was placed)
- Root canal therapy
- Osseous surgery
- Periodontal scaling and root planning
- Adjustments to dentures during the initial installment but not during the six-month period following installation
- Denture adjustments
 - Relining dentures and rebasing dentures – if more than six months after the initial insertion, and then not more than once every three calendar years

- Tissue conditioning (maxillary or mandibular) – if more than one calendar year after the insertion of a full or partial denture, and then only once in every three calendar years
- Bridge repairs (recement bridge)
- Simple and surgical extractions (local anesthetic, analgesic and routine postoperative care for extractions and other oral surgery are part of the allowance for each dental service)
- General anesthesia or IV sedation, for covered services, when medically necessary
- Crown repairs

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

Call Cigna at 800-Cigna24 (800-244-6224). Customer service representatives are available 24 hours a day, seven days a week, including holidays.

Major treatment

The Basic and Comprehensive dental plans pay 50% (at any dentist) of covered charges for these expenses (up to the maximum annual benefit) after you have met the deductible:

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

Orthodontia (Comprehensive Plan only)

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

- Orthodontic appliances
- X-rays
- Care and treatment

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

What the Basic and Comprehensive Dental Plans do not cover

The dental plans do not cover:

- Services performed solely for cosmetic reasons
- Charges over and above reasonable and customary charge limits
- Charges for services and supplies that are not necessary
- Dental services that do not meet common dental standards
- Charges for services and supplies that are for experimental treatment or are investigative and not proven safe and effective
- Any services provided by a covered provider who is a member of your or your spouse's immediate family
- Replacement of a lost or stolen appliance
- Replacement of a bridge, crown or denture within five years after the date it was originally installed unless:
 - Such replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth, or
 - The bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is covered for these benefits.
- Any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards unless:
 - Such replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth, or
 - The bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is covered for these benefits.

- Procedures, appliances or restorations (except full dentures) whose main purpose is to:
 - Change vertical dimension to restore occlusion — the attempt to correct a TMJ problem by placing single crowns on the teeth
 - Stabilize periodontically involved teeth by splinting — or, cementing wire to teeth
- Porcelain or acrylic veneers of crowns or pontics on or replacing the upper and lower first, second and third molars
- Bite registrations — precision or semi-precision attachments, or splinting
- Instructions of plaque control, oral hygiene and diet
- Surgery to correct temporomandibular joint (TMJ)

Oral Health Integration Program

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

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

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

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

Oral health maternity program

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

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

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

Dental Plan Claims

For a dental claim form, go to www.mycigna.com or contact Cigna at 800-Cigna24 (800-244 6224). Send dental claim forms to the dental plan carrier:

Cigna Service Center
P.O. Box 188037
Chattanooga, TN 37422-8037

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

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

The dental claim form contains a section for you to complete and sign as well as a section for your dentist to complete. All claim forms must be signed by you (the associate) and the patient, if the patient is not a minor. As an alternative to having your dentist complete the claim form, you may attach an itemized bill. The bill must include:

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

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

If your claim is denied, refer to the *Claims and appeal process* section beginning on page 116.

Vision Coverage

Vision benefits help you and your covered dependents take care of your vision needs. Coverage is provided for routine eye exams, eyeglass frames and lenses or contact lenses.

At a Glance

- Eligible associates and their dependents can enroll in the vision coverage.
- You can choose from two vision plan options — the Basic Plan and the Comprehensive Plan or you may waive vision coverage.
- Vision Service Plan (VSP) administers the vision plans.
- Both plans are fully-insured by VSP and offer different levels of coverage.
- VSP Diabetic Eyecare Plus ProgramSM provides coverage of additional eye care services for members with type 1 or type 2 diabetes. Eligible members can receive both routine and follow-up medical eye care from their VSP Preferred Provider.

In-network providers lower your costs

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

If you choose a VSP in-network provider, your charges may be covered in full, covered in full after a copay, or you may receive an allowance and/or discount, based on the type of service and the plan selected. If you choose a non-VSP provider, you will pay the provider in full and submit a claim to VSP for reimbursement up to the amount shown on the out-of-network reimbursement schedule on page 54.

Which providers participate in the vision service plan network?

To find out which providers participate in the VSP network, call 800-877-7195. You also can check www.vsp.com.

Note: This plan does not issue ID cards.

What the Basic and Comprehensive Vision Plans Cover

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

Under The Basic Plan

Each covered person is eligible to receive:

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

Under The Comprehensive Plan

Each covered person is eligible to receive benefits for:

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

You have the option of in-network or out-of-network coverage. You have a copay if you use an in-network provider. If you use an out-of-network provider, a reimbursement rate applies. Copays do not apply to out-of-network benefits.

Vision Plan Highlights

THE BASIC PLAN			
Exam	Once every calendar year	Covered in full	Up to \$35
Lenses and Frames	N/A	20% discount	Not covered
Contact Lenses	N/A	15% discount off contact lens exam (fitting and evaluation) No allowance for contact lenses	Not covered
THE COMPREHENSIVE PLAN			
SERVICE	FREQUENCY	PREFERRED PROVIDER (IN-NETWORK)	OPEN ACCESS (OUT-OF-NETWORK)
Exam	Once every calendar year	Covered in full	Up to \$45
Lenses			
Single	Once every calendar year	Covered in full, after \$20 copay	Up to \$45
Bifocal		Covered in full, after \$20 copay	Up to \$65
Trifocal		Covered in full, after \$20 copay	Up to \$85
Lenticular		Covered in full, after \$20 copay	Up to \$125
Scratch coating		Covered in full, after \$20 copay	Not covered
Frames	Once every other calendar year	Up to \$160 allowance (20% discounts on amounts over \$160)	Up to \$70
Contact lenses			
Exam	Once every calendar year	15% discount (fitting and evaluation), \$60 maximum copay	Not covered
Lenses	Once every calendar year	Up to \$160 for materials	Up to \$105

VSP Diabetic Eyecare Plus ProgramSM

This program provides coverage of additional eye care services for members with type 1 or type 2 diabetes. Eligible members can receive both routine and follow-up medical eye care from their VSP Preferred Provider. This program ensures that members with diabetes get the follow-up medical eye care they need from their VSP Preferred Provider – the provider who already knows their eyes best.

Laser vision correction

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

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

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

Additional discount — VSP in-network providers offer discounts on reasonable and customary charges for the following covered services:

- Contact lenses
- Lens options (treatments) such as scratch resistant and anti-reflective coatings and progressives
- A 30% discount off of additional glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your WellVision Exam, or get 20% off from any VSP preferred provider within 12 months of your last WellVision Exam

Discounts are applied to the VSP in-network providers' reasonable and customary charges for such services and are available within 12 months of the covered eye examination from the VSP in-network provider who provided the covered eye examination.

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

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

How vision plan expenses are paid

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

If you use an in-network provider

When you use a VSP in-network provider, both plans will pay the full cost of covered eye examinations. If you choose a VSP in-network provider under the Basic Plan:

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

If you choose a VSP in-network provider under the Comprehensive Plan:

- Lenses are covered in full, after a \$20 copay.
- Frames and contact lenses are covered up to a flat dollar amount, and/or you receive a discount off of the covered services.

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

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

If you use a non-VSP provider

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

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

What the Basic and Comprehensive Vision Plans Do Not Cover

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

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

Flexible Spending Accounts (FSAs)

Compass Group offers two Flexible Spending Accounts (FSAs) through ADP Spending Accounts that let you pay yourself back — on a tax-free basis — for certain healthcare and dependent care expenses. You do not have to be enrolled in any other plans to participate in an FSA.

The Flexible Spending Account rules are subject to changes based on IRS regulations, revenue ruling and case law.

At a Glance

- The Health Care Spending Account and the Dependent Daycare Spending Account allow you to set aside money on a pre-tax basis to pay for eligible healthcare or daycare expenses. Paying for these expenses pre-tax helps reduce your taxes.
- The Health Care Spending Account rules referenced here are subject to change based on IRS regulations, revenue rulings and case law.
- IRS rules specify the types of expenses eligible for reimbursement from your Health Care or Dependent Daycare Spending Account.
- You can contribute through payroll deduction up to \$2,550 a year in your Health Care Spending Account.
- A single associate or an associate who files a joint income tax return with his or her spouse and both earn over \$5,000 for the year, may contribute up to \$5,000 per calendar year in your Dependent Daycare Spending Account. A lower limit applies to associates who file separate returns and special rules apply if your spouse does not work.
- You can incur Dependent Daycare FSA claims until the last calendar date of the plan year or termination date and submit incurred claims for reimbursement 90 days after that date.
- You are allowed to rollover up to \$500 of unused funds remaining at the end of a plan year in a Health Care FSA to be paid or reimbursed for qualified medical expenses incurred during the following plan year. Rollover funds in the Health Care FSA are available beginning in May of the following plan year.

About FSAs

FSA options

Compass Group recognizes that the costs of health and dependent care can be overwhelming expenses. To help you meet these expenses cost-effectively, Compass Group offers two programs for you to use your own pre-tax dollars to pay for certain health and dependent care expenses. With both spending accounts you make automatic, voluntary contributions from your paycheck pre-tax. Reimbursements are then paid to you from these accounts to cover the cost of your qualifying health and dependent care expenses while you work.

You can choose to contribute to either of these pre-tax accounts:

Health Care Spending Account reimburse yourself, tax-free, for eligible health-related expenses (including medical, dental and vision) that are not reimbursable through any insurance plans for yourself or your eligible dependents. The program permits eligible associates to contribute up to \$2,550 (minimum of \$100) a year to reimburse most healthcare-related expenses.

Dependent Daycare Spending Account reimburse yourself, tax-free, for most dependent daycare expenses for your qualifying dependents. The program permits eligible associates to contribute up to \$5,000 (minimum of \$100) a year to reimburse most dependent daycare expenses (\$2,500, if you're married and file separate tax returns).

Your contributions to the FSAs, as well as the reimbursements that you receive from them, are not subject to federal income tax or Social Security taxes or, in most cases, state income tax.

Why Enroll in FSAs?

The main reason to enroll in FSAs is to save money on expenses that you already pay anyway. Here are more reasons to enroll:

- **It's covered!**
 - Your Health Care Spending Account covers your copays, deductibles, dental care, vision care and prescriptions.
 - Your Dependent Daycare Spending Account covers babysitting, daycare and pre-school programs, and eldercare services while you work.
- **Easy as a debit card.** Your FSA is built for maximum convenience, from on-the-spot access with the Health Care FSA Debit Card, to easy online tracking.
- **Flexible for your needs.** It's your account — you decide how to use it. You can elect just a Health Care Spending Account, just the Dependent Daycare Spending Account, or both — and choose how much to set aside in each.
- **Check your account balance.** You can get up-to-the-minute account information at any time through myspendingaccount.adp.com. You'll also receive a monthly online statement.

Health Care Spending Account

With a Health Care Spending Account, you set aside part of your pre-tax pay to an account set up for you. If you (or your eligible dependents) incur qualifying expenses that are not covered, or are only partially covered, by insurance or any other source, you can be reimbursed through the spending account for these expenses. Because your contributions to the spending account are not subject to federal tax, using the spending account allows you to pay for qualifying health expenses while at the same time paying less in taxes.

WHO CAN BE REIMBURSED

You can be reimbursed for expenses for your:

- Self
- Spouse
- Dependent children

KEY FEATURES

- Contribute up to \$2,550 a year
- Pre-tax contributions
- Eligible dependents do not have to be covered under your medical, dental or vision plan to be eligible for reimbursement
- Can rollover up to \$500 of unused funds to the next plan year

The following examples show how much money you could save in taxes by participating in the Health Care Spending Account. These examples are based on federal income tax withholding and Social Security rates. Keep in mind, the example estimates state taxes and does not include any local taxes.

MARRIED FILING JOINTLY*	WITH A HEALTH CARE FSA	WITHOUT A HEALTH CARE FSA
Gross Family Income	\$30,000	\$30,000
Pre-Tax Contribution to Health Care FSA	-\$500	\$0
Taxable Family Income	\$29,500	\$30,000
Estimated Taxes		
• Social Security and Medicare	– \$2,257	– \$2,295
• Federal	– \$715	– \$765
• State (6% assumption)**	– \$1,770	– \$1,800
Post-Tax Healthcare Expenses	\$0	– \$500
Associate's Net Pay	\$24,758	\$24,640
Savings through the Health Care FSA	\$118	N/A

MARRIED FILING JOINTLY*	WITH A HEALTH CARE FSA	WITHOUT A HEALTH CARE FSA
Gross Family Income	\$30,000	\$30,000
Pre-Tax Contribution to Health Care FSA	-\$3,500	\$0
Taxable Family Income	\$26,500	\$30,000
Estimated Taxes		
• Social Security and Medicare	– \$2,027	– \$2,295
• Federal	– \$415	– \$765
• State (6% assumption)**	– \$1,590	– \$1,800
Post-Tax Healthcare Expenses	\$0	– \$3,500
Associate's Net Pay	\$22,468	\$21,640
Savings through the Health Care FSA	\$828	N/A

* Assumes a married couple filing jointly with three exemptions and taking the standard deduction. Based on 2011 tax rates.

** State taxes will vary depending on the state.

Therefore, a married couple with a total family income of \$30,000 can save \$118 in income taxes by putting \$500 in the Health Care Spending Account, and they can save \$828 if they contribute \$2,500.

ADP

ADP administers the Health Care Spending Account and provides you with two reimbursement options: Health Care FSA Debit Card or Claims Submission. See *Account Information for Flexible Spending Accounts* on page 65 for additional information on these options.

Health Care FSA Debit Card — Works like a pre-paid debit card that you use to make purchases for eligible healthcare expenses at healthcare providers and compliant non-medical merchants who accept VISA. You do not need to enter a PIN.

Claims Submission — You submit a claim and ADP reimburses you directly through direct deposit or you'll receive a paper check.

Eligible expenses

Only eligible expenses can be reimbursed through the Health Care Spending Account. Eligible expenses are medical, dental and vision care expenses incurred by you or an eligible dependent in the diagnosis, treatment or prevention of disease, or the diagnosis or treatment of an injury, including prescription drug expenses, over-the-counter (OTC) medications prescribed by a doctor and transportation or lodging expenses incurred in receiving treatment. Certain other medical expenses not covered by your medical insurance are also eligible expenses, such as in vitro fertilization. Any deductibles or copays you have paid under any type of healthcare plan, including HMOs and dental or vision plans, are also eligible expenses.

Remember though, that the expenses you submit for reimbursement must not be covered by any other insurance or any other source, including a plan sponsored by your spouse's employer, Medicare, Workers' Compensation, automobile insurance or any recovery or settlement from a lawsuit.

The list below is a broader, but not exhaustive, list of healthcare expenses eligible for reimbursement from your spending account.

- Acupuncture
- Adult diapers
- Alcoholism treatment
- Ambulance charges
- Analysis or psychotherapy
- Artificial insemination
- Birth control
- Braille books/magazines

- Specialized car equipment for disabled persons
- Chiropractic costs
- Childbirth classes
- Christian Science Practitioners
- Coinsurance/Deductibles
- Contact lenses
- Cosmetic surgery:
 - To treat illness/disease
 - To improve a congenital abnormality
 - To treat injury from accident/trauma
 - To improve a disfiguring deformity
- Crutches
- Dental treatment
- Drug addiction treatment
- Excess of reasonable and customary (R&C) charges
- Eyecare
- Eyeglasses (prescription only)
- Guide dogs
- Hearing aides
- Insulin, syringes and related testing supplies
- In vitro fertilization
- Laboratory fees
- Laser eye surgery
- Nursing home costs
- Orthodontia (non-cosmetic only)
- Over-the-counter medication prescribed by a doctor
- Oxygen
- Prescription vitamins
- Smoking cessation program (prescription)
- Speech therapy
- Sterilization
- Transplants (except hair)
- Vaccinations and immunizations
- Well baby care
- Wheelchairs
- X-ray fees

Go to www.irs.gov/pub/irs-pdf/p502.pdf for more information on what expenses are FSA eligible.

Ineligible expenses

Any healthcare expense that is not an eligible expense cannot be reimbursed by the Compass Group Flexible Spending Account. Below is a broad, but not exhaustive, list of expenses that are not eligible for reimbursement.

- Bleaching/Bonding of teeth
- Contact lens insurance
- Cosmetic surgery, unless necessary to correct a deformity that is congenital or that resulted from a disfiguring disease or an injury resulting from an accident or trauma
- Dancing lessons
- Diaper services for children
- Electrolysis
- Expenses for general health purposes, such as fitness, exercise, weight loss or health club dues
- Expenses for over-the-counter medications (like aspirin and Tylenol) without a doctor's prescription
- Expenses in excess of the amount you have elected to contribute to the Health Care Spending Account
- Expenses of someone who is not an eligible dependent
- Funeral expenses
- Hair transplants
- Health club dues
- Household help
- Insurance premiums (including COBRA premiums)
- Liposuction
- Maternity clothes
- Retin A
- Rogaine
- School tuition
- Smoking cessation (non-prescription)
- Swimming lessons
- Transportation costs of a disabled person to and from work
- Vacation or travel costs to improve health
- Vitamins (non-prescription)

Annual Health Care Spending Account contribution amount

Your contributions will be deducted from your pay check in equal amounts throughout the plan year. If your spouse also maintains a Health Care Spending Account, whether through Compass Group or another employer, this will not affect the maximum amount of your contribution. You may each contribute the maximum amount under the two programs. Please note there is a different rule that applies to contributions to the Dependent Daycare Spending Account. See page 64 for more information.

How the Compass Group Health Care Spending Account works

As an example, assume that you are enrolled in the Compass Group's Gold Plus medical plan option for Associate Only coverage. There is a \$500 deductible, so you contribute that amount to your Health Care Spending Account in equal installments through payroll deductions.

As you satisfy some or all of the deductible under the Compass Group's medical plan, you pay the deductible amount at point of service using your Health Care FSA Debit Card. You will receive an email from the FSA Administrator to submit a copy of the receipt or bill for verification. See *Claims Submission requests* on page 66.

How to determine your annual contribution amount

The amount that you decide to contribute to the Health Care Spending Account will depend on the amount of qualifying healthcare expenses you expect to have during the year.

One way of estimating your future expenses is to look at past annual healthcare expenses. You might look over prescription drug costs, doctors' bills, Explanation of Benefits (EOB) statements from your medical, dental and vision plans and canceled checks. From these items you might anticipate which of the expenses will be repeated in the coming year.

Remember to plan your contribution carefully, because you will be required to forfeit any unused amounts, and you are not permitted to either change or stop your contributions during the plan year unless you have a qualifying life event.

Reimbursement funds availability

The amount available to you for reimbursement for qualifying expenses from January 1 of the plan year is the annual amount you have elected to contribute to the spending account, even if the full amount has not yet been deducted from your pay. For example, if you elect to contribute \$1,200 to the spending account, the entire \$1,200 will be available to you for reimbursement of your eligible expenses beginning January 1. Please note that there is a different rule for reimbursements from the Dependent Daycare Spending Account. See page 64 for more information.

If you are terminated, you can send claims incurred up to your termination date. However, these claims must be submitted within 90 days of the termination date. If there is a balance left in your Health Care Spending Account, you can elect COBRA. For more information on COBRA, see page 101.

Using your Health Care FSA Debit Card

Your Health Care FSA Debit Card can be used to purchase eligible healthcare services from healthcare providers such as doctors, dentists, hospitals, pharmacies as well as eligible merchandise at discount chain stores, supermarket pharmacies and wholesale clubs. Your Health Care FSA Debit Card has an expiration date. Do not dispose of your card prior to receiving a new card, unless you discontinue enrollment in the FSA. If you are enrolled, a new card will be sent to you before the expiration date.

Before using your Health Care FSA Debit Card for the first time, you must activate the card. Once activated, you can use the card to purchase eligible healthcare services and items from all compliant institutions that accept VISA. At the time of payment, give the card to the service provider or swipe it yourself. If you are using a terminal, choose the credit option and then sign for your purchase. Remember to save your itemized receipts and the credit card-like receipt. ADP may require you to submit your itemized receipts to show that you used the card for eligible healthcare expenses. If you are required to submit a receipt, ADP will contact you.

IRS rules

Due to IRS rules, you are limited to where you can use your Health Care FSA Debit Card. The IRS requires “non-medical” merchants (like retail and grocery stores) to agree to certain guidelines in order to accept FSA debit cards, like the Health Care FSA Debit Card. You only can use your card at merchants who have agreed to these guidelines.

To use your Health Care FSA Debit Card at a retail store, grocery store or pharmacy, check to see if they accept the card. You can use your card at your doctor’s office, the hospital and all medical providers.

You may not be able to use your debit card for certain over-the-counter medications — even if they are prescribed by a doctor. You will need to pay out of pocket for the expense and file a claim to get reimbursed. When filing a claim for a prescribed over-the-counter medication, you need to submit either an itemized cash register receipt that includes the date, amount, provider name, over-the-counter item and prescription number or the itemized receipt and a copy of the prescription.

Check myspendingaccount.adp.com under the E-Learning Center regularly for the most up-to-date list of compliant non-medical merchants and pharmacies.

Always save your FSA receipts for ALL items and services, such as visits to your doctor or dentist. You may need to submit receipts to ADP for these purchases. Due to stricter federal regulations, ADP may suspend your Health Care FSA Debit Card if you don’t submit receipts within 90 days from the date of the purchase and if you’ve used over half of your contribution amount.

Health Care FSA Debit Card expiration

Health Care FSA Debit Cards are issued with a three-year expiration date. This means that participants can use their card if they re-enroll for subsequent plan years. The participant will not be issued a new Card for the next plan year unless their card expires. The following are examples for the three-year card expiration.

Example one

If the participant’s account is depleted before the plan year is over, do not destroy the card as the card will be replenished with the next plan year’s election at the beginning of the next plan year.

Example two

If the participant’s account still has funds at the end of the plan year they may rollover up to \$500 of unused amounts in their Health Care FSA to the next plan year. New elected funds will be placed on the Health Care FSA Debit Card at the beginning of the new plan year and will include up to \$500 of unused funds from the previous year. Rollover funds in the Health Care FSA are available beginning in May of the following plan year.

Unused account balance

The IRS requires that any amounts remaining in your spending account after the deadline for submitting claims for the plan year must be forfeited. However, you may rollover up to \$500 of unused amounts in your Health Care FSA to the next plan year, but you may not transfer unused amounts from the Health Care Spending Account to another Compass Group program or account, for example, the Dependent Daycare Spending Account. The rollover provision does not apply to the Dependent Daycare Spending Account. Therefore, you should carefully plan the amount of money you will contribute to your account. Rollover funds in the Health Care FSA are available beginning in May of the following plan year, and will end on December 31 of that plan year.

Unused account balances for military reservists

If you are a Qualified Reservist called to active duty for at least six months, you may request for all or a part of your Health Care Spending Account balance to be reimbursed to you. The amount available to you will be the contributions in your account as of the date of your request minus any reimbursements you have received as of the request date. Any amounts you request will be included in your gross income and wages, reportable on your W-2 and subject to employment taxes. See *Claim Submission Deadline* on page 67 for more information.

Mid-year contribution changes

You may not change your contribution amount during the year unless you experience one of the following qualifying life events:

- A marriage or divorce
- The birth or adoption of a child
- The death of your spouse or a dependent
- The loss of coverage under your spouse's employer-sponsored FSA

Health Care Spending Account and medical insurance

The Health Care Spending Account does not replace your medical insurance. The spending account is a separate program that reimburses you for qualifying expenses that are not covered, or only partially covered, by your medical, dental or vision plan or by any other source.

Dependent Daycare Spending Account

The Dependent Daycare Spending Account allows you to contribute money on a pre-tax basis to an account set up for you to use that money to pay for qualifying dependent care expenses. The amount contributed to the Dependent Daycare Spending Account can be used to reimburse you for most daycare expenses you might incur for your qualifying dependents. Because contributions to the spending account are not federally taxed, more of your paycheck will be available to you while you work.

REIMBURSEMENT	KEY FEATURES
<p>You can be reimbursed for:</p> <ul style="list-style-type: none">• Licensed child and adult daycare centers• Private kindergarten• Babysitters• Au pairs	<ul style="list-style-type: none">• Contribute up to \$5,000 a year• Pre-tax contributions• Have until 12/31 of the benefit year to incur expenses• Have until 3/31 to file claims for previous year's eligible expenses• You cannot use your funds until they are deposited in your account

ADP

ADP administers the Dependent Daycare Spending Account and provides you with the Claims Submission reimbursement option. You submit a claim and ADP reimburses you directly through direct deposit or you'll receive a paper check.

Qualified dependents

Expenses for care of the following individuals may be paid through the Dependent Daycare Spending Account:

- Children under age 13 for whom you are able to take a tax exemption
- Any dependent or non-dependent spouse who is physically or mentally incapable of independent care*
- A parent incapable of independent care who lives with you and whom you claim as a dependent on your tax return*

* If you provide over half the support of an individual with a specified relationship (such as parents, stepparents, etc.), he or she will not qualify as a dependent for spending account reimbursement if he or she has gross income of \$3,200 or more during the year.

Eligible expenses

Eligible expenses include dependent care expenses that enable you and your spouse to work or your spouse to attend school full time while you work. Such expenses include:

- A qualified child or adult daycare center that receives payment for the care of more than six individuals who do not reside there
- Expenses of a babysitter, whether in your home or elsewhere, during the time that you are working
- A housekeeper whose duties include dependent care
- A relative who cares for your dependents, but is neither your dependent nor your child under age 19
- Someone who cares for an elderly or disabled dependent in your home
- Day camp expenses, provided that the camp is NOT for a specific educational purpose, such as learning tennis or computer skills and the care is necessary in order for you or your spouse to work (or for your spouse to attend school full time while you work)
- Nursery school expenses, provided that the school is a state-licensed facility

Remember, the care must be necessary so that you and, if you are married, your spouse can work. If your spouse does not work, dependent care expenses are not eligible, unless you work and your spouse is a full time student or physically or mentally unable to care for himself or herself.

You can use your Dependent Daycare Spending Account to pay for eligible dependent care services provided for a qualifying child or relative during your coverage period — as long as the services are provided on days the dependent is a qualifying child or relative.

Example:

- Compass Group's plan year runs January 1 to December 31, and you will be covered for the entire plan year.
- Your daughter is a qualifying child until her 13th birthday on March 1, but is not a qualifying child or relative as of March 1.
- The dependent care services provided for your daughter between January 1 to February 28 are eligible to be paid from your account.
- The dependent care services provided for your daughter on March 1 and later are not eligible because she was not a qualifying child or relative at the time the services were provided.

The same example applies for a qualifying relative who becomes capable of self-care on March 1. Since Compass Group's plan only allows legally permitted status changes, both events (your daughter's 13th birthday and a person ceasing to be a dependent) are qualified status change events that will allow you to decrease your election or cancel your enrollment in the Dependent Daycare Account.

Ineligible expenses

Private school tuition is not reimbursable. Transportation costs to and from the location where the care or program is provided are also not reimbursable, unless the transportation cost is included in and cannot be separated from the cost of the program. Other expenses ineligible for reimbursement are as follows:

- Expenses for food, clothing, education or entertainment you incur for the normal care of an eligible dependent, unless these expenses are included in and cannot be separated from the cost of care
- 24-hour nursing home expenses
- Cost for child care that enables your spouse to do volunteer work
- Educational expenses for children in the first grade or higher
- Overnight camp expenses
- Payments for babysitters when you are not working, such as in the evening or on weekends

This list is intended to give you a general description of expenses not eligible for reimbursement through the Dependent Daycare Spending Account. There may be other expenses in addition to those listed above which are not eligible. Go to www.irs.gov/pub/irs-pdf/p503.pdf for more information.

Annual Dependent Daycare Spending Account contribution

Generally, you may elect to contribute up to a maximum of \$5,000 per year, regardless of the actual number of qualifying dependents you have, or \$2,500 per year if you are married but file a separate tax return. If your spouse also maintains a Dependent Daycare Spending Account, whether through Compass Group or another employer and you file a joint tax return, the \$5,000 limit will apply to the total contributions both of you make to your respective accounts. For example, if your spouse contributes \$4,000 to his or her account, you may contribute only \$1,000 to your Dependent Daycare Spending Account.

Special rules

In addition, your Dependent Daycare Spending Account contribution is subject to an earned wages limitation. Your contribution can never be more than your earned wages or, if you are married, your spouse's earned wages, whichever is less.

If you are married and your spouse is either a full time student, or physically or mentally incapable of caring for himself or herself, when you apply the earned wages limitation, the earned wages of your spouse will be deemed to be \$250 per month (\$3,000 per year) if you have one dependent and \$500 per month (\$6,000 per year) if you have two or more dependents. A full time student is an individual who maintains status as a full time student at a college or university during at least five months of the year.

The Internal Revenue Code places limits on how much higher-paid associates, as a group, can deposit in Dependent Daycare Spending Accounts in a year. If this limit is reached and it affects you, you will be advised of any required changes in your elected amount.

How to determine your annual contribution amount

The amount you elect to contribute will depend upon the amount you anticipate you will need to cover your dependent care expenses up to the \$5,000 limit. You should compare the tax benefit that you will receive with the Dependent Daycare Spending Account to the benefit that you would receive with the federal child and dependent care tax credit and then choose between them. The federal credit allows you to subtract a percentage of your qualifying dependent care expenses from your taxes on your federal tax return.

The tax credit ranges from 20% to 35% of qualifying expenses, depending on your earned income. You may not claim the federal credit for an expense reimbursed through the spending account. For additional details about the federal tax credit, see IRS Publication 503 (Child and Dependent Daycare Expenses) which you may obtain from your local IRS office or at www.irs.gov/pub/irs-pdf/p503.pdf.

Keep in mind, however, that you may initially experience a period of increased expenses because you will have to pay your dependent care provider and have payroll deductions before you receive reimbursements from your account.

Remember to plan your contribution carefully, since you will forfeit any unused amounts as required by IRS rules. In

addition, you are not permitted to either change or stop your contributions during the year unless you have an eligible change in family or employment status. See *Mid-Year Contribution Changes* on page 65.

Expenses greater than account balance

You will make contributions to the Dependent Daycare Spending Account through payroll deductions. You can receive reimbursements from your spending account only up to the balance of such contributions in the spending account at the time you submit the claim for reimbursement.

For example, you know that your children's daycare will cost \$2,400 during the year, so you elect to deposit \$2,400 into your Dependent Daycare Spending Account. Every pay period \$92.31 is deducted from your bi-weekly pay, pre-tax. When the first daycare bill is due, you pay the bill and submit a reimbursement claim along with a copy of the bill. You will then be reimbursed from your account, assuming that you have an adequate balance in your account. If not, your claim will be held in a pending account until such time as the balance in your Dependent Daycare Spending Account is sufficient to cover the bill.

Your claim will be applied against your Dependent Daycare Spending Account contributions and a reimbursement check will be mailed to you from ADP, usually within 10 days. See *Claims Submission requests* on page 66.

Unused account balance

At the end of each calendar year, the IRS requires that you forfeit any money left in your Dependent Daycare Spending Account. You may not carry forward unused amounts to the next plan year, nor may you transfer unused amounts from your Dependent Daycare Spending Account to another Compass Group program or account, for example, the Health Care Spending Account. For this reason, it is important that you carefully plan your deposit amounts. You have 90 days after your coverage ends to submit a claim.

Partial payments

At the end of each calendar year or within 90 days after your coverage ends, a partial payment amount can be applied to a daycare bill. For example, you have \$20 remaining in your account and your daycare bill is \$120. ADP will apply the remaining \$20 toward the daycare bill and you will be responsible for the remaining balance of \$100. Therefore, you will not forfeit the remaining \$20 balance.

Mid-year contribution changes

You may not change the amount of your deposit, or stop making deposits, unless you terminate employment with Compass Group, have a change in employment status or experience a qualifying life event during the plan year and that event directly affects your participation in the account. A qualifying life event is any one of the following:

- A marriage or divorce
- The birth or adoption of a child
- The death of your spouse or a dependent
- The termination of employment of your spouse
- A loss of group coverage
- Changing caregivers
- Your child reaches age 13
- Guardianship termination

You should consider the possibility of these events when you plan your annual deposits.

Timing of your deposit

Your deduction will be accessible in your Dependent Daycare Spending Account by the end of the week following your pay date. If you have questions about the timing of your deposit, contact ADP at 866-363-7150.

COBRA and the Dependent Daycare Spending Account

If you terminate employment with Compass Group, COBRA will NOT apply to your Dependent Daycare Spending Account. This means that you will not be entitled to make any contributions to your spending account after your termination date.

Account information for Flexible Spending Accounts (FSAs)

Obtaining up-to-date information on claim status, account activity and account balance is a simple process. Online access to your account information is available to you 24 hours a day, seven days a week through myspendingaccount.adp.com. First time users will need to set up an account using the code COMPASSGRP-COMP. You also can obtain your account information by calling ADP at 866-363-7150.

When calling ADP, you can take advantage of its automated voice system to check your account or you may speak with an ADP Customer Service Representative.

Paperless FSA statements*

If you have an email address in your ADP online profile, you will only receive online FSA statements. **ADP will not send you an additional paper statement.** Using ADP online statements is an easy way to help control administrative costs, protect the environment, eliminate waste and help promote corporate and social responsibility through Compass Group 360°.

If you haven't established an ADP profile or selected to receive online statements, do it today. Email is the best way for ADP to communicate with you — particularly when it comes to information like your claims notification and account updates — and an easy way to go green.

* Only associates without an email address on file with ADP — or who have selected to receive their statements by mail — will receive paper statements.

Setting up your ADP online account

Before you can access your Spending Account information online, you need to register to use the ADP site.

- Go to myspendingaccount.adp.com
- On the bottom left side of your screen click “New Users – Register Here”
- You will be asked to enter your name, date of birth and social security number
- You will now set up a user name and password

Once you have access to myspendingaccount.adp.com, you can download claim forms by accessing the Print Forms and Health Care tabs.

Using the Claims Submission Option

The *Claims Submission* option allows you to pay for your eligible expenses first and then obtain reimbursement by submitting a claim form directly to ADP with your itemized receipts, bills and Explanation of Benefits (EOB) statements.

For over-the-counter medications, you will also need to include a copy of the prescription unless the receipt includes the date, amount, provider name, over-the-counter item and prescription number. You can choose to be reimbursed through direct deposit or receive a paper check.

Claims Submission requests

ADP offers you the convenience and option to complete your Claims Submission form online when you log on to your ADP account. Once the form is complete, you have two options:

- Print the form and mail or fax it to ADP with the appropriate documentation, or
- Submit the claim online and upload the corresponding receipts to the ADP system for faster processing.

You can mail or fax a *Claims Submission* form, along with an itemized bill or a receipt showing proof of payment, to:

ADP Spending Accounts
P.O. Box 34700
Louisville, KY 40232

OR

Fax: 1-866-643-2219

Health Care or Dependent Daycare Claim forms are online at myspendingaccount.adp.com or www.altogethergreat.com/rewards.

Normally, you can expect to receive your reimbursement check by mail within 10 days or within 48 hours for direct deposit after your claim is processed.

Any itemized bills that you submit should contain, at a minimum, the following items:

- The name of the patient and the associate.
- The date(s) the services were provided.
- A description of the service or item provided.
- The name and address of the provider.
- The cost of the service or item.

Claim submission deadline

Qualifying expenses incurred between January 1, and December 31 of the plan year, are eligible for reimbursement from your Flexible Spending Account(s). You may submit reimbursement requests at any time during this period. If your plan ends mid-year due to employment termination or qualified status change — you will have 90 days from the termination date to submit receipts for reimbursement.

All reimbursement requests for expenses incurred in the current plan year must be received no later than March 31 of the next year, or 90 days after your coverage ends, whichever comes first.

Account balance

You will receive a monthly statement detailing the status of your account. If you provided your email address to ADP, this statement will be sent directly to your email account.

Remember, the expense must be for services provided while you participated in the Health Care Spending Account. Expenses for services provided before you enrolled in the FSA are not eligible.

An expense is considered incurred on the date that the services were provided, regardless of when you are billed or pay for the services.

Life Insurance Coverage

As an eligible Compass Group associate, you automatically receive \$10,000 of basic life insurance at no cost to you.

At a Glance

- Life Insurance pays a benefit in the event of your death, but has no cash value and remains in effect only during the time premiums are being paid.
- Compass Group provides all eligible associates with Basic Life Insurance at no cost to you. You are auto-enrolled in this benefit and may not waive this benefit.
- Compass Group offers supplemental life insurance coverage for yourself and/or coverage for your spouse and/or children.

Coverage for you and your family

Associate basic life insurance

Compass Group pays the entire cost of basic life insurance coverage for you (the associate) of \$10,000. This is called your basic coverage. You also have access to LifeSuite support and resources (see page 73 for more information).

Associate supplemental life insurance

You also have the option to purchase additional life insurance coverage up to \$250,000.

Your options are an additional:

- \$10,000
- \$25,000
- \$50,000
- \$100,000
- \$150,000
- \$200,000
- \$250,000

Or you may choose no additional coverage.

You may “move up” only one level of coverage each enrollment period after your initial enrollment up to the guarantee issue amount of \$250,000. The cost for supplemental life depends on your age.

Actively at Work Provision

To be eligible to become insured or to receive an increase in the amount of insurance, you must be actively at work, fully performing your customary duties for your regularly scheduled number of hours at the employer’s normal place of business, or at other places the employer’s business requires you to travel.

If you are not working due to illness or injury, you do not meet the actively at work requirement. If you are receiving sick pay, short-term disability benefits or long-term disability benefits, you do not meet the actively at work requirement.

If you are not actively at work on the date coverage would otherwise begin, or on the date an increase in your amount of insurance would otherwise be effective, you will not be eligible for the coverage or increase until you return to active work. However, if the absence is on a non-work day, coverage will not be delayed provided you were actively at work on the work day immediately preceding the non-work day.

Any insurance or increase in insurance which is elected or put in force while you are not actively at work will not be eligible for claim payment. You will receive a refund of premium for any contributory insurance for which you were not eligible.

Spouse life insurance

Compass Group offers five levels of life insurance coverage for your lawful spouse:

- \$10,000
- \$20,000
- \$30,000
- \$40,000
- \$50,000

Or, you may choose no spouse life insurance coverage. As with your supplemental life insurance, your spouse can choose any level of coverage during initial enrollment, but may “move up” only one level of coverage each enrollment period. For example, if you selected \$10,000 of coverage for your spouse, the most you can select for him or her the next enrollment period is \$20,000 of coverage.

Children’s life insurance

You also may cover the lives of your children, stepchildren, or legally adopted children from live birth to age 26 and certified disabled dependents for the following coverage amounts:

- \$5,000 for each child
- \$10,000 for each child

Or, you may choose no life insurance for your children. An automatic \$2,500 benefit is available to you for your first eligible child for 31 days from the child’s live birth. To continue coverage, you must elect child coverage within the appropriate timeframe otherwise the coverage shall terminate at the end of the 31 day period.

The maximum benefit paid for a child before the age of six months is \$2,500 (rather than \$5,000 or \$10,000). As with the other life insurance programs, you may “move-up” only one level of coverage each enrollment period.

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

When you reach age 65

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

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

For example, if you have \$48,000 of coverage and reach age 65, it will be reduced to \$31,200. Coverage at age 70 will be reduced to \$24,000. Your coverage amount is not rounded when an age reduction is applied.

Paying for life insurance coverage

You pay for the cost of supplemental life insurance for yourself (the associate) with pre-tax dollars. You pay for spouse and child life insurance with post-tax dollars.

Your life insurance coverage during disability

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

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

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

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

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

If disabled before age 60

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

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

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

If you die while disabled

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

When extended coverage ends

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

- When you are no longer totally disabled
- If you do not submit to a physical exam when required by the plan carrier
- If you fail to provide proof of continuous total disability
- When you reach age 65
- The date you retire, unless you are eligible for a retiree benefit as outlined under the policy

Accelerated benefits

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

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

Payment of an accelerated benefit

Benefits may be paid if:

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

Minimum and maximum benefits

The full amount of coverage in force is eligible to be accelerated. Benefits paid under the plan would be a minimum of \$10,000 basic life insurance up to \$250,000 supplemental life insurance. The maximum benefit is \$260,000. You (or your covered dependents) may choose to receive the full or partial amount of the benefit.

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

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

How to file a life insurance claim

The initial notification of death should be made to Compass Group's Benefits Department at 877-311-4747. The plan carrier will pay benefits within 60 days of receiving proof of death while insured, such as a certified death certificate and a fully completed claim form.

For information on benefit determination and the process for reviewing denied claims, please see *All Other Self-Insured and Non-Insured Benefits* beginning on page 126.

Naming a beneficiary

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

If you name more than one beneficiary, each will receive an equal share, unless you have requested another method in writing. To receive benefits, a beneficiary must be living on the date of your death. If the beneficiary is not living on the date of your death, the beneficiary's portion of the benefit will be equally distributed to the remaining surviving beneficiaries. In the event of the simultaneous deaths of you and a beneficiary, the benefit will be paid as if you survived the beneficiary.

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

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

- Your lawful spouse, if living
- Your natural or legally adopted child or children in equal shares, if living
- Your parents in equal shares, if living
- Your natural or legally adopted siblings in equal shares, if living
- The personal representative of your estate

To verify your beneficiary designation, go to the benefits enrollment website. To make changes, call the Benefits Department at 877-311-4747. You may change your beneficiary designation at any time. Because family situations change, you should review your beneficiary designation at least yearly.

When basic and supplemental life insurance coverage ends

Your basic and supplemental life insurance coverage will end:

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

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

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

If you stop working for Compass Group because of injury or sickness, supplemental life coverage will continue while you remain totally and continuously disabled. See page 70 for details. If your situation is not addressed in this section, your insurance coverage will end on the date Compass Group stops paying for your coverage or cancels your insurance.

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

Basic and Supplemental Life Portability

You can take your basic and supplemental life insurance coverage with you (also known as "porting" your coverage) if your Compass Group employment ends for any reason other than illness or injury. You can port up to your in-force coverage at date of termination within 60 days of the date your Compass Group coverage ends. If you are age 65 or older when you port, you may take a maximum of

\$260,000 for you and \$195,000 for your spouse. When you port your coverage, you may also port your dependent coverage. You cannot port coverage if you are age 70 or older.

When your ported coverage ends, you may convert the amount of your coverage to an individual conversion policy. Ported coverage terminates at age 70.

Converting to an individual policy

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

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

Provided you meet these requirements within the 60-day time period, the individual policy becomes effective 60 days after your Compass Group coverage ends.

Limited conversion right

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

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

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

To convert your group coverage to an individual policy:

- Request an application from Compass Group's Benefits Department at 877-311-4747.
- Return the written application.
- Pay the first premium to the plan carrier within 60 days after your group coverage ends.

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

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

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

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

Reinstatement of coverage after termination

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

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

LifeSuite support and resources

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

BENEFIT	DESCRIPTION
Beneficiary Financial Counseling Provided by PricewaterhouseCoopers LLP www.pwc.com or call 800-435-7554	<ul style="list-style-type: none"> • Designed to support sound financial decisions at a difficult time • Independent financial counseling resources for beneficiaries • Resources include: Financial Fitness Assessment, beneficiary reference guide, bi-monthly newsletter, personalized financial analysis
Legacy Planning Services Provided by Minnesota Life Insurance Company	<ul style="list-style-type: none"> • End-of-life planning information and resources for everyone • Easy to access website • Express Assignment for expedited funeral home assignments • Support for insured's anywhere in the world
Legal Services Provided by Ceridian www.lifeworks.com (enter username "will" and password "preparation") or call 877-849-6034	<ul style="list-style-type: none"> • Comprehensive legal services and resources • Will preparation, estate planning and all legal issues from A to Z • Unlimited telephonic general legal information • 30-minute consultation with a local attorney for each unique legal issue • Discount for retention of an attorney
Travel Assistance Services Provided by Global Rescue LLC http://www.lifebenefits.com/travelassistance or call 877-708-6992	<ul style="list-style-type: none"> • Emergency assistance and medical evacuation services • Security evacuation services • Online pre-trip planning resources • Available 24/7/365 for business or personal travel when 100+ miles from home
Identity Theft Assistance Program Provided by Europ Assistance USA www.lifebenefits.com	<ul style="list-style-type: none"> • ID Theft Resolution Kit • Support to address identity theft occurrence • Education to avoid further occurrence

For more information contact Minnesota Life or visit www.lifebenefits.com.

Disability Income Protection Plans

Short and Long Term Disability (STD and LTD) coverage provides income in the event you are unable to work due to an approved disability resulting from an illness or injury. For STD coverage, work related injuries are excluded. You have the option to enroll in STD and/or LTD coverage at various levels. You pay the cost of coverage on a post-tax basis.

You must be actively at work for your benefits to take effect when you are first eligible and enroll. You will be considered to be active at work, actively at work or performing active work on any of your employer's scheduled work days if, on that day, you are performing the regular duties of your job on a full time basis for the number of hours you are normally scheduled to work. In addition, you will be considered to be actively at work on the following days:

- Any day which is not one of your employer's scheduled work days if you were actively at work on the preceding scheduled work day; or
- A normal vacation day.

Short Term Disability (STD)

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

Compass Group does not offer STD coverage to associates who work in California, Hawaii, New Jersey, New York, Rhode Island and Puerto Rico, as these locations provide mandated disability benefits under state law. If you have any questions about your disability benefits in these locations, contact your respective state's or U.S. territory's disability agency for more details. If you work in New York, contact the Compass Group Leave of Absence Department at 877-311-4747, for more information.

How the STD income protection plan works

Your coverage options

You can choose from four levels of STD coverage:

- Option 1: \$150 per week
- Option 2: \$200 per week

- Option 3: \$250 per week
- Option 4: \$300 per week

Or, you may choose no coverage. Union associates eligible for the standard union plans are eligible for the \$250 per week or \$300 per week coverage options only, subject to the terms in the Collective Bargaining Agreement.

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

When coverage is effective

Coverage becomes effective on the first day of the month following three months of service unless you are absent from work that day due to injury or sickness. In that case, coverage will begin on the date you are actively at work for one full work day.

When benefits begin

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

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

Benefits are payable on the first or eighth day if:

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

You must be continuously disabled through the elimination period.

How benefits are paid

Benefits are paid weekly, tax-free as long as you remain disabled, as approved by the STD insurance carrier and you are unable to work for up to 26 weeks. If your weekly benefit is payable for less than a week, you'll receive 1/7 of the weekly benefit (\$150, \$200, \$250 or \$300) for each day you are disabled. For example, if you enroll for the \$150 per week option, and you are disabled for three days, your benefit would be: $\$150/7 \times 3 \text{ days} = \64.29 .

Applying for STD benefits

To start your leave of absence/FMLA process, notify the Leave of Absence Department of your leave as soon as possible. You must notify the STD insurance carrier within 31 days after the date of your disability. If, through no fault of your own, you are not able to meet the deadline for filing a claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims will not be covered if they are filed more than one year after the deadline. You cannot receive more than 26 weeks of STD benefits within any period of 52 consecutive weeks.

What is disability?

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

- You are unable to perform the material and substantial duties of your regular occupation.
- You are unable to work for pay or profit, due to illness or injury.

The STD insurance carrier may require you to be examined by a physician, other medical practitioner or vocational expert of their choice. You will not be charged for this examination. The STD insurance carrier also may require you to be examined as often as it is reasonable to do so, or require you to be interviewed by an authorized disability representative. The loss of a professional or occupational license or certification that is required by your own occupation does not mean you meet the test of disability. You must meet this Plan's test of disability to be considered disabled.

Coordinating with other disability benefits

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

When STD benefits end

STD benefits will end on the earliest of:

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

When STD coverage ends

STD coverage ends on the earliest of:

- The date you are no longer in a STD eligible group.
- The last day of the period you made any required contributions.
- The date the policy ends.
- The date coverage under this program ends for you or your class of associates.
- The date you retire or terminate your employment (your last day of active service).
- You become covered under another plan offered by your employer.

If you return to work and become disabled again

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

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

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

What's not covered by the STD plan

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

- The loss of a professional or occupational license or certification.
- A work-related sickness or injury.
- Sickness or injury resulting from declared or undeclared war or any action of war or aggression.
- Sickness or injury resulting from active participation in a riot.
- Suicide attempt, while sane or insane or other intentionally self-inflicted injury.
- Commission of a crime for which you have been convicted under state or federal law.
- Any period of disability during which you are incarcerated.
- Operating motor vehicle while under the influence of alcohol, intoxicants or illegal drugs
- Prescription drugs in excess of physician prescribed amounts
- Over-the-counter medications taken in excess of dosage instructions

Long Term Disability (LTD)

The Long Term Disability (LTD) Plan pays a monthly benefit based for up to five years, depending on your age at the time of disability. See *How benefits continue* for a chart showing how long benefits last at various ages. Your LTD coverage begins after your STD benefits end or after the 180 day elimination period if you are not enrolled in STD coverage.

How the LTD income protection plan works

Your coverage options

You can choose from five levels of LTD coverage:

- Option 1: \$500 per month
- Option 2: \$750 per month
- Option 3: \$1,000 per month
- Option 4: \$1,250 per month
- Option 5: \$1,500 per month

Or, you may choose no coverage.

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

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

You may change your coverage amount each year. However, you may only increase your coverage by one level. For example, if you have coverage under the \$500 per month option, you may select the \$700 per month option. You cannot increase your coverage from \$500 per month to \$1,000 per month. You may decrease your coverage any number of levels.

When benefits begin

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

LTD benefits

LTD benefits are paid if you're totally disabled while covered and you remain disabled during and after the 180-day elimination period. The plan provides that you receive \$500, \$750, \$1,000, \$1,250 or \$1,500 monthly, depending on the level of coverage you elect.

If you don't elect coverage when you are first eligible, you can do so during Annual Enrollment at the first level of coverage, \$500 per month. However, you will be subject to the pre-existing condition exclusion. See *Pre-existing conditions* on page 77 for more information.

Applying for LTD benefits

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

The deadline for filing a long term disability claim is 90 days after the end of the elimination period, if any. If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims will not be covered if they are filed more than one year after the deadline. Please call the Leave of Absence Department for information on how to apply.

How benefits continue

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

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

Limitations which apply to LTD coverage

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

1. Continued confinement to a hospital or treatment facility beyond the end of the 24-month period. If you are still disabled when you are ultimately discharged, the LTD insurance carrier will continue your benefits for a recovery period of up to 90 days. If you are re-confined at any time during the 90-day recovery period and remain confined for at least 14 consecutive days, you will be eligible for benefits during the additional confinement and for one additional recovery period up to 90 more days.
2. In addition to item one, if you remain disabled beyond the 24-month period and subsequently become confined to a hospital or institution for at least 14 consecutive days, you will receive payments during the length of the re-confinement.
3. You will not be paid beyond the limited pay period as indicated in the first condition above, or the maximum period of payment, whichever occurs first.

You will no longer be considered as disabled and eligible for long term monthly benefits after benefits have been

payable for 24 months if it is determined that your disability is primarily caused by:

- A mental health or psychiatric condition, including physical manifestations of these conditions, but excluding conditions with demonstrable, structural brain damage; or
- Alcohol and/or drug abuse.

There are 2 exceptions to the above limitations if you are confined as an inpatient in a hospital or treatment facility for treatment of that condition at the end of such 24 months.

- If the inpatient confinement lasts less than 30 days, the disability will cease when you are no longer confined.
- If the inpatient confinement lasts 30 days or more, the disability may continue until 90 days after the date you have not been so continuously confined.

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

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

What is total disability?

From the date that you first became disabled and until monthly benefits are payable for 24 months you meet the test of disability on any day that:

- You cannot perform the material duties of your own occupation solely because of an illness, injury or disabling pregnancy-related condition; and
- Your earnings are 80% or less of your adjusted pre-disability earnings.
- During the 180-day elimination period, you are unable to perform any of the material and substantial duties of your regular occupation.

After the first 24 months of your disability that monthly benefits are payable, you meet the plan's test of disability on any day you are unable to work at any reasonable occupation solely because of an illness, injury or disabling pregnancy-related condition.

After 24 months of benefits, you are considered "disabled" if it is determined that due to the same sickness or injury,

you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience. The loss of a professional or occupational license or certification does not, in itself, constitute disability.

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

Pre-existing conditions

If you are a new LTD plan participant, you will not receive disability benefits relating to a pre-existing condition.

A “pre-existing condition” is a condition for which:

- You received medical treatment, consultation, care or services for the condition including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage, and
- A disability related to the condition begins within the first 12 months after your effective date of coverage.

In addition, an increase in LTD coverage elected during Annual Enrollment will not be recognized for any disability related to a pre-existing condition that arises within 12 months of the increased coverage.

In no event will:

- A benefit be payable as to a disability caused by a pre-existing condition, if the disability is excluded by any other terms of this LTD plan.
- A condition will be considered to be a pre-existing condition under this LTD plan if it was not a pre-existing condition under the prior coverage.

Coordinating with other sources of income

Compass Group LTD benefits are coordinated with deductible sources of income you may receive so that your benefit doesn't exceed \$500, \$750, \$1,000, \$1,250 or \$1,500 monthly, as applicable.

If, for instance, you become disabled and receive Social Security disability benefits of \$400 and enrolled in the \$750 level, the LTD benefit you receive from your Compass Group coverage will equal \$350 monthly.

Deductible sources of income include:

- Social Security retirement or disability benefits payable to you and your dependents.
- Workers' Compensation, occupational disease benefits or other disability legislation.
- Any state disability benefits law.
- Disability pay from any group insurance plan.
- Pay from sick leave plans.
- Half of any pay you earn through rehabilitative employment.
- Occupational accident coverage provided by Compass Group.
- Any statutory disability benefits law.
- Proceeds from the Railroad Retirement Act.
- Proceeds from the Canada Pension Plan, Quebec Pension Plan, or any other similar disability or pension plan or act.
- Proceeds from any public employee retirement system plan, or any state teacher's retirement system plan, or any plan provided as an alternative to any of the above acts or plans. Your plan benefit will not be affected by:
 - Cost-of-living increases you may receive for any other source of disability benefits.
 - Benefits you receive from a private disability policy you purchased on your own.

Regardless of the age at which you become disabled, if you remain continuously disabled for a period of 12 months or longer, you will receive at least 12 monthly payments.

The LTD plan will only subtract deductible sources of income which are payable as a result of the same disability. The LTD plan will not reduce your payment by your Social Security retirement income if your disability begins after age 65 and you were already receiving Social Security retirement payments.

Information about Social Security benefits

- All primary and dependent old age and disability insurance benefits under the Social Security Act reduce your LTD benefit.
- Once your Social Security benefit amount is determined, any cost-of-living changes won't change your LTD benefit amount.
- If you receive a retroactive lump-sum Social Security benefit that applies to a period during which you received LTD benefits, the portion of the lump-sum benefit attributable to that waiting period is payable to the plan carrier and must be reimbursed by you.

How much will I be paid if I continue to be disabled but am able to return to work on a partial basis?

Your long term disability monthly benefit may be reduced if, while monthly benefits are payable, you receive income from:

- Your employer or any other employer, employment or self-employment; or
- Any occupation for compensation or profit; which is more than 20% of your adjusted pre-disability earnings. The monthly benefit adjustment is calculated as follows:
 - During the first 12 months that you have such income, the benefit will be reduced only to the extent the sum of the amount of that income and the monthly benefit payable, without any reduction for other income benefits, exceeds 100% of your adjusted pre-disability earnings.

Thereafter, the adjusted monthly benefit will be calculated by using the following formula:

- (A divided by B), times C, where:
 - A = Your adjusted pre-disability earnings, minus the income you receive while disabled
 - B = Your adjusted pre-disability earnings
 - C = The monthly benefit payable.

Income means income you earn, while disabled and working, from your employer or any other employer. However, any income earned by working for another employer will be considered income only if you:

- Become employed after the date your disability started; or
- Increase the number of hours you work, or the number or type of duties you perform for another employer after the date of your disability started. In that event, only the amount of the income increase will be taken into the consideration for the benefit adjustment.

This is the amount of your benefit.

During the first 24 months of disability payments, if your monthly disability earnings exceed 80% of your indexed monthly earnings, LTD benefits will end. After 24 months of disability payments, if your monthly disability earnings exceed the gross disability payment, LTD benefits will end. You may be required to send proof of your monthly disability earnings at least quarterly. Your benefit will be adjusted based on your quarterly disability earnings.

As part of your proof of disability earnings, you may be required to provide appropriate financial records which may be necessary to substantiate your income. After the elimination period, if you are disabled for less than one month, you will be eligible to receive 1/30th of your benefit for each day of disability.

When LTD benefits end

Long Term Disability benefits will end on the earliest of:

- The date you are no longer disabled
- The date you reach the maximum benefit period in the benefit schedule
- The date you fail to provide required proof of total disability or fail to take a required medical exam

When LTD coverage ends

LTD coverage ends on the earliest of:

- During the first 24 months of payments, when you are able to work in your regular occupation on a part-time basis but you do not.
- After 24 months of payments, when you are able to work in any gainful occupation on a part-time basis but you do not.
- If you are working and your monthly disability earnings exceed 80% of your indexed monthly earnings, the date your earnings exceed 80%.
- The end of the maximum period of payment.
- The date you are no longer disabled under the terms of the plan, unless you are eligible to receive benefits under Aetna's Rehabilitation and Return to Work Assistance program.
- The date you fail to submit proof of continuing disability.
- After 12 months of payments if you are considered to reside outside the United States or Canada. You will be considered to reside outside these countries when you have been outside the United States or Canada for a total period of six months or more during any 12 consecutive months of benefits.
- The date you die.

If you return to work and become disabled again

If you received LTD benefits, recover and return to work — but are disabled again for the same or a related cause less than six months after your return to work, you are considered to be in the same period of disability. Benefits will be paid according to the plan in effect at the time the initial disability period began.

If your disability recurs more than six months after you return to work, a new 180-day waiting period will apply and benefits will be paid based on the plan in effect on the day the disability re-occurred.

What's not covered by the LTD plan

Your plan does not cover any disabilities caused by, contributed to by, or resulting from your:

- Intentionally self-inflicted injuries.
- Active participation in a riot.
- Loss of a professional license, occupational license or certification.
- Commission of a crime for which you have been convicted.
- Pre-existing condition.
- Prescription drugs in excess of physician prescribed amounts
- Over-the-counter medications taken in excess of dosage instructions

Your plan will not cover a disability due to war, declared or undeclared, or any act of war.

The LTD plan will not pay a benefit for any period of disability during which you are incarcerated.

Accidental Death and Dismemberment Coverage

Compass Group offers you and your eligible dependents coverage under the Accidental Death and Dismemberment (AD&D) plan.

At a Glance

- AD&D coverages pay a benefit if you (or a covered dependent) have a loss within 180 days of an accidental injury that results directly and independently of all other causes, from an accidental injury which is unintended, unexpected and unforeseen. If you experience more than one loss from the same accident, the coverages pay the largest amount applicable to one loss.
- A covered loss includes death, paralysis or loss of limb, sight, speech or hearing.

AD&D coverage

This plan provides coverage:

- 24 hours a day, 365 days a year
- For any type of accident, including accidents occurring:
 - On or off the job
 - In or away from the home
 - In a train, airplane, or automobile, or private conveyance (except those noted in the Exclusions section of the Insurance Policy)

Benefits also are payable if you or a covered family member becomes comatose as a result of an accident.

If you choose to cover your family, the AD&D plan also features:

- An education benefit if you (the associate) or your spouse dies
- A daycare benefit if you or your spouse dies and you have dependent children under age thirteen
- An additional benefit for dependent children who suffer physical losses in an accident
- A survivor's benefit if you and/or your spouse die in an accident

Amount of AD&D coverage

There are six AD&D coverage levels, ranging from \$25,000 to \$500,000. Or you may choose to not elect AD&D coverage. You can choose Associate Only or Associate Plus Family. AD&D pays a benefit if you die or suffer dismemberment or loss of sight or hearing or paralysis as the result of an accident.

Death benefits from this plan are paid in addition to your benefits from the Life Insurance Plan. If you choose to cover your family, benefits payable for the death or physical loss of a dependent will be a portion of the amount of your coverage.

This chart shows the AD&D options you can elect:

YOUR COVERAGE	DEPENDENT COVERAGE				
	AMOUNT	SPOUSE'S COVERAGE		CHILDREN'S COVERAGE	
		With Children	Without Children	With Spouse	Without Spouse
\$25,000	\$10,000	\$12,500	\$2,500	\$3,750	
\$50,000	\$20,000	\$25,000	\$5,000	\$7,500	
\$100,000	\$40,000	\$50,000	\$10,000	\$15,000	
\$150,000	\$60,000	\$75,000	\$15,000	\$22,500	
\$250,000	\$100,000	\$125,000	\$25,000	\$37,500	
\$500,000	\$200,000	\$250,000	\$50,000	\$50,000	

As shown in the chart, your coverage is the same whether you elect single or family coverage. If you decide to cover your family, the coverage provided to dependents depends on your family make-up, as follows:

- Your spouse's coverage will be 40% of your coverage if you have dependent child(ren),
- Your spouse's coverage will be 50% of your coverage if you don't have dependent child(ren), or
- Your child(ren)'s coverage will be 10% of your coverage if you have a spouse, or
- Your child(ren)'s coverage will be 15% of your coverage (up to \$50,000) if you don't have a spouse.

Benefit amount

If bodily injuries result in an associate's dismemberment or paralysis within 180 days of the date of the injury, the plan will pay the following benefits.

LOSS	BENEFIT
Loss of life	Full benefit amount
Loss of two or more members*	Full benefit amount
Quadriplegia	Full benefit amount
Speech and hearing	Full benefit amount
Paraplegia	75% of benefit amount
Hemiplegia	50% of benefit amount
Loss of one member*	50% of benefit amount
Speech or hearing	50% of benefit amount
Loss of all four fingers of one hand	50% of benefit amount
Thumb and index finger of one hand	25% of benefit amount

* Member is defined as a hand, foot or sight of one eye.

If I choose family coverage, are all of my family members covered?

No. Only the family members you enroll who are eligible dependents are covered under the plan. Benefits paid for the death or covered loss of a dependent are a portion of your coverage amount as shown in the previous chart.

When you reach age 65

The amount of your AD&D coverage will be reduced as of January 1 on or following the year you reach age 65 and age 70:

AGE ON JANUARY 1	NEW BENEFIT LEVEL
65	65% of original benefit
70 and older	50% of original benefit

For example, if you choose the \$150,000 option, your coverage amount would be reduced to \$97,500 (65% of \$150,000) on January 1 following the year you reach age 65 and to \$75,000 on January 1 following the year you reach age 70. If your birthday is January 1, coverage will change that day.

Actively at Work

You must be actively at work for your benefits to take effect when you are first eligible and enroll. You will be considered to be active at work, actively at work or performing active work on any of your employer's scheduled work days if, on that day, you are performing the regular duties of your job on a full time basis for the number of hours you are normally scheduled to work. In addition, you will be considered to be actively at work on the following days:

- Any day which is not one of your employer's scheduled work days if you were actively at work on the preceding scheduled work day; or
- A normal vacation day.

Filing an AD&D claim

The plan carrier will pay benefits within 60 days of receiving proof of death while insured, such as a certified death certificate, or proof of your or a covered dependent's loss such as a physician's statement, and a fully completed claim form. A claim form can be obtained from Compass Group's Benefits Department. For information on benefit determination and the process for reviewing denied claims, please see *All Other Self-Insured and Non-Insured Benefits* beginning on page 126.

Naming a beneficiary

It is important to name a beneficiary to receive benefits from the plan if you die. To verify your beneficiary designation, go to the benefits enrollment website at www.altogethergreat.com/rewards. To make changes, call the Benefits Department at 877-311-4747. You may change your beneficiary at any time. Because family situations change, you should review your beneficiary designation at least yearly.

You automatically will be the beneficiary for:

- Any benefits payable for the covered loss of a dependent if the dependent is enrolled in coverage.
- Benefits payable for your own covered dismemberment loss.

When benefits are not paid

In no event will the accidental death or dismemberment benefits be paid if the insured's death or dismemberment results from or is caused directly or indirectly by any of the following:

- Suicide or attempted suicide, whether sane or insane
- Intentionally self-inflicted injury or any attempt at self-inflicted injury, whether sane or insane

- The insured's participation in or attempt to commit a crime, assault or felony
- The insured's active participation in a riot
- Bodily or mental infirmity, illness or disease
- Intoxication or influence of any narcotic unless administered on the advice of a physician
- The insured operating a motor vehicle under the influence of alcohol as evidenced by a blood alcohol level in excess of the legal intoxication limit in the state in which the accident occurred
- Bacterial infection, other than infection occurring simultaneously with, and as a result of, the accidental injury
- Travel or flight in or on, or descent from or with, any type of military aircraft
- War or any act of war, whether declared or undeclared

When coverage ends

Your insurance ends on the earliest of the following:

- The date the group policy ends
- The date you no longer meet the eligibility requirements
- The date the group policy is amended so you are no longer eligible
- 60 days (grace period) after the due date of any unpaid premium if the premium remains unpaid at that time
- The last day for which premium contributions have been paid following your written request to cease participation under the certificate
- When the total amount of insurance paid under the certificate due to your accidental injuries, including any amount paid according to the terms of the Additional Benefits section of the certificate, equal one and one-half times the full amount of your insurance. If no additional benefits are payable under the Additional Benefits section of the certificate, the maximum amount payable will equal the full amount of your insurance

If your insurance under the certificate terminates due to non-payment of premiums, your coverage may be reinstated if all premiums due are paid and received with 60 days of the date of termination and during your lifetime.

For more detail information — see the AD&D Policy, which is available on the benefits enrollment website at www.altogethergreat.com/rewards.

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

Commuter Benefits Program

Compass Group offers the Commuter Benefits Program to eligible full time associates. You pay no fees for the program. The costs to administer the program and delivering your passes are covered by Compass Group as part of your benefits. You may enroll in commuter benefits at any time during the year.

At a Glance

- The Commuter Benefits Program, administered by ADP, allows you to save money on your commute by letting you pay for eligible parking and transportation expenses with pre-tax money through a Commuter Spending Account.
- Your deductions for the program are withheld from your paycheck, up to the federal limit, on a pre-tax basis. Amounts above the federal limit are withheld post-tax.
- You can enroll or make changes whenever you choose — there is no open enrollment period.
- 2017 commuter pre-tax maximum benefit permitted for transportation is \$130.00 per month; \$250.00 per month for parking

How the program works

Our Commuter Benefits Program, administered by ADP, allows you to save money on your commute by letting you pay for eligible parking and transportation expenses with pre-tax money through a Commuter Spending Account (CSA).

There are two types of CSAs:

- The Transportation Spending Account is used to pay for eligible mass transit or vanpool expenses associated with travel to and from work, including bus, train or subway.
- The Parking Spending Account is used to pay for eligible parking expenses either at your place of employment or at a location where you use mass transit.

A CSA is beneficial for just about everyone who commutes to work. You will save money on what you would normally spend on transit and parking, up to the maximum pre-tax benefit. ADP offers public transit coverage in all 50 states and in more than 350 metropolitan areas. You can enroll throughout the year or make changes whenever you choose.

Commuter benefits payment options

OPTION	USE IT TO...	HOW IT WORKS...
Public Transit or Vanpool		
Commuter Card	Pay at transit agency ticket machines and windows — where credit and debit cards are accepted	Funds are added to your card each pay date — the card is reusable
Transit Agency SmartCards	Buy a SmartCard at your local transit agency	Funds are added to your transit agency card
Transit Account — Buy My Pass	Buy transit or vanpool passes/tickets	Funds are added to your account monthly; buy your passes/tickets and have them mailed to your home
Parking Account		
Direct Pay Parking	Pay for parking at a parking garage	ADP can send a check directly to your parking provider
Claims Submission	Pay for parking at a parking garage	Pay to park, and then get reimbursed by direct deposit or check

Enrollment

You can enroll at any time throughout the year. There are three steps to enroll:

1. Decide how much you'd like to contribute from your paycheck and which payment option(s) are best for you.
2. Log into myspendingaccount.adp.com to complete your Commuter Spending Account enrollment by clicking on the Commuter Enrollment link in the left-hand menu, or call 866-363-7150. First time users will need to set up an account using the code COMPASSGRP-COMP.

- Place your order. You will need to provide information about your transit, vanpool or parking provider for passes/tickets and direct parking payments. You must place your order by the 10th of the following month for these options. If you live in the greater New York metropolitan area and ride the Long Island Rail Road or Metro-North Railroad, the deadline is the 4th rather than the 10th.

ADP

To register to use the ADP site:

- Visit myspendingaccount.adp.com and click on New User
- Enter the Compass Group registration code, COMPASSGRP-COMP.
- Follow the registration prompts and create a user profile

If you are already signed up with ADP for FSAs, use your current login information.

Changing or canceling your order

You can change or cancel your commuter order for any month. The change or cancellation must be done by the 10th of the month prior to the commuting month. Log into your account at myspendingaccount.adp.com to change or cancel your order. To stop your deductions, go online and click the “Stop Deduction” button to stop your monthly election amount.

Important Rules

Since each payment option works a little differently, here are some general guidelines for enrolling and placing an order. Note: you will only have access to funds that have been posted to your account.

- Commuter Card** — Enroll by the 15th of the month, and your card will arrive by the first of the following month. Payroll deductions will begin the following month, and the funds will be deposited to your account based on your pay date. You can then begin to use the card.
- SmartCards, transit/vanpool passes or tickets** — Enroll by the 15th of the month, and place your order by the 10th of the following month. You’ll receive your card, passes or tickets before the first month after you place your order. For more information about the different types of SmartCards and passes, call 866-363-7150.
- Parking Accounts** — For the “Direct Pay Parking” option, enroll by the 15th of the month, and place your order by the 10th of the following month. ADP will send payments to your parking provider beginning the first month after you place your order.

When commuter benefits end

Benefits end when the first of the following events occur:

- The date you terminate employment
- The date you no longer meet the eligibility requirements
- The date of your death
- The date the program is terminated
- The date you discontinue participation

Commuter benefits are not tied to a benefit year, so the funds will remain in your account until exhausted. If your employment ends, any money remaining in your account will be forfeited. However, funds on your Commuter Card will remain on your card for 90 days before being forfeited.

If you are using your ADP card for parking, you will not have any days to spend the remaining money in your account. The benefit ends on your date of termination. However, for the parking benefit, post-tax money will be returned to you via check.

- Never received or lost commuter passes and tickets** — If you have not received your commuter passes and tickets by the 1st of the month or you need to report lost or stolen commuter passes and tickets, you must report it as quickly as possible by logging on to myspendingaccount.adp.com, selecting “Commuter Enrollment” and navigating to the Claims tab. You may also call 866-363-7150 for immediate assistance.

Note: Your claim submission must be received before 11:59 pm EST on the 10th day of the benefit month.

Ineligible Expenses

Commuting expenses you cannot claim under the Commuter Benefits Program include, but are not limited to:

- Commuting or parking expenses that are partially or fully subsidized or reimbursed by Compass Group
- Expenses incurred for parking at your spouse’s workplace
- Fuel
- Mileage or other costs you incur in operating a vehicle
- Parking at a mall or similar location where you stop on your drive to or from work
- Parking on or near property where you live
- Payments to fellow participants in a carpool or to a friend who drives you to work
- Taxis
- Tolls
- Traffic tickets

For more information

Go to myspendingaccount.adp.com, or call 866-363-7150 for more information.

Voluntary Benefits

Voluntary Benefits provide expanded coverage in case of serious illness, injury from an accident or death. Other offerings include fully-insured legal/ID theft and auto or homeowners' insurance.

At a Glance

- You are eligible to participate in these benefits 90 days from your hire date if you are an associate working 20 hours or more per week.
- You pay special group premiums or rates, or you can receive money-saving discounts as an eligible Compass Group associate.
- Your Voluntary Benefit coverage is portable – you can take your coverage with you if you leave Compass Group.

Group Critical Illness Coverage

What is Critical Illness Insurance?

Critical Illness Insurance pays a lump-sum benefit if you are diagnosed with a covered illness or condition. You have the option to elect Critical Illness Insurance to meet your needs. Critical Illness Insurance is a limited benefit policy. It is not health insurance and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

Features of Critical Illness Insurance include:

- **Guaranteed Issue:** No medical questions or tests required for coverage.
- **Flexible:** You can use the benefit money for any purpose you like.
- **Payroll deductions:** Premiums are paid through convenient payroll deductions.
- **Portable:** Should you leave your current employer or retire, you can take your coverage with you.

How can Critical Illness Insurance help?

Below are a few examples of how your Critical Illness Insurance benefit could be used (coverage amounts may vary):

- Medical expenses, such as deductibles and copays
- Child care
- Home healthcare costs
- Mortgage payment/rent and home maintenance

Who is eligible for Critical Illness Insurance?

- **You** – all active employees working 20+ hours per week. Temporary and seasonal workers are excluded from coverage.
- **Your spouse*** – under age 70. Coverage is available only if employee coverage is elected.
- **Your child(ren)** – to age 26. Coverage is available only if employee coverage is elected.

*The use of "spouse" in this document means a person insured as a spouse as described in the certificate of insurance or rider. Please contact your employer for more information.

Accident Coverage — ReliaStar Life Insurance Company, a member of the Voya® family of companies

What is Accident Insurance?

Accident Insurance pays you benefits for specific injuries and events resulting from a covered accident while off-job. The amount paid depends on the type of injury and care received. You have the option to elect Accident Insurance to meet your needs. Accident Insurance is a limited benefit policy. It is not health insurance and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

Other features of Accident Insurance include:

- **Guaranteed Issue:** No medical questions or tests required for coverage.
- **Flexible:** You can use the benefit money for any purpose you like.
- **Payroll deductions:** Premiums are paid through convenient payroll deductions.
- **Portable:** Should you leave your current employer or retire, you can take your coverage with you.

How can Accident Insurance help?

Below are a few examples of how your Accident Insurance benefits could be used:

- Medical expenses, such as deductibles and copays
- Home healthcare costs

- Lost income due to lost time at work
- Everyday expenses like utilities and groceries

Who is eligible for Accident Insurance?

- **You** – all active employees working 20+ hours per week. Temporary and seasonal workers are excluded from coverage.
- **Your spouse*** – under age 70. Coverage is available only if employee coverage is elected.
- **Your child(ren)** – to age 26. Coverage is available only if employee coverage is elected.

* The use of “spouse” in this document means a person insured as a spouse as described in the certificate of insurance or rider. Please contact your employer for more information.

Whole Life Insurance Coverage

Aflac Group Whole Life insurance can give your family a financial cushion when they need it.

- You may apply for benefit amounts by answering only a few medical questions.
- Once your Whole Life insurance application has been approved and payroll deductions have started, the coverage is yours to keep as long as you continue to pay premiums.
- Aflac Group Whole Life builds cash value that you can access for life’s challenges and life’s opportunities.
- Employee and spouse may choose a \$10,000, \$20,000 or \$30,000 benefit amount.
- Children may be covered with the Child Term Rider for dependent children ages 15 days through 24 years and the rider will cover all of your dependent children with a \$10,000 benefit.
- Waiver of Premium Benefit Rider (employee only)
- Accidental Death Benefit Rider (employee and spouse only)
- Accelerated Benefit Rider (employee and spouse only)

Evidence of Insurability

Associate and child life options are available for up to certain amounts during Annual Enrollment without underwriting questions or providing EOI. Spouse coverage requires the answer to one qualifying question.

Auto and Homeowners Coverage

Auto and Homeowners insurance through MetLife, Liberty Mutual and Travelers allows you to keep your personal auto or home protected if you experience accidental damage or loss. Speak with a licensed representative to review your options, enroll and compare your coverages and premiums at 1-866-486-1947. Coverage is effective immediately.

These policies are not offered in some states.

Legal Coverage

With the Hyatt Legal Plan, you can enroll in a fully-insured legal plan that pays for attorney fees for many types of legal matters including:

- Immigration
- Estate planning/Will preparation
- Divorce
- Power of attorney
- Bankruptcy
- Adoption/Guardianship
- Tax audits

To use your Legal Plan, visit www.members.legalplans.com or call Hyatt Legal Plans’ Client Service Center at 1-800-821-6400.

Purchasing Power

Purchasing Power is a purchase program that provides you with an affordable way to buy today and pay over time, right from your paycheck.

Sign up for free to shop over 45,000 brand-name products, such as computers, appliances and vacation packages. Receive your item immediately and pay over 6 or 12 months through automatic payroll payments – with no credit checks, hidden fees, or interest.

You must be an active associate and have been employed for at least 12 months and make at least \$16,000 a year.

Identity Theft Coverage

ID Watchdog provides financial, personal, and social identity protection. Our identity theft protection plan includes credit monitoring and advanced tools to help you manage your identity.

The ID Watchdog identity theft plan also consists of payday loan monitoring, social network and financial threshold alerts.

The plan includes up to \$1 million Identity Theft Insurance** and helps pay certain out-of-pocket expenses in the event you are a victim of identity theft.

** Identity theft insurance underwritten by subsidiaries or affiliates of American International Group Inc. The description herein is a summary and intended for informational purposes only and does not include all terms, conditions and exclusions of the policies described. Please refer to the actual policies for terms, conditions and exclusions of coverage. Coverage may not be available in all jurisdictions.

Enrolling in Voluntary Benefits Coverage

You can choose to enroll in Critical Illness, Accident or Whole Life Coverage when you are first eligible or during Annual Enrollment. If you don't enroll within 90 days from your date of hire, you must wait until the next enrollment period, and you may be required to provide EOI.

You can choose to enroll in Auto and Homeowners after 90 days of service.

When you are ready to enroll, visit:
compassgroupvoluntarybenefits.com.

To enroll, simply follow the enrollment instructions found on compassgroupvoluntarybenefits.com.

You will be asked to enter your name, eight-digit associate ID and/or your date of birth. Some Voluntary Benefits may require a telephonic enrollment.

Paying for Voluntary Benefits Coverage

Payments for coverage you elect (or an item you purchase) will be based on the number of paychecks for the year. If you miss a deduction, your per deduction amount may be recalculated.

For more information

You can get more information at
compassgroupvoluntarybenefits.com.

Qualifying Life Events

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

The following pages provide a summary of the most common qualifying life events that legally permit benefit election changes outside of the regular Annual Enrollment period, and outline the corresponding changes that may be made to your Compass Group Benefits Program if one of these events occurs.

Remember that you may change your beneficiary information at any time by calling the Benefits Department at 877-311-4747.

At a Glance

- If you wish to make changes to your benefit elections, contact the Benefits Department at 877-311-4747 within the required timeframe.

Remember, your election change must be because of and consistent with the qualifying life event. For example, if your qualifying life event is a dependent child ceasing to be eligible under the plan, an election change that would be consistent is one that would remove the dependent from your coverage. However, this status change would not permit you to remove your spouse from coverage.

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA) regulates how a group health plan may permit special enrollment periods and prohibits discrimination based on health status.

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

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

HIPAA Special Enrollment events

- Marriage
- Birth, legal adoption of child, placement for adoption, permanent guardianship
- Loss of group insurance coverage (associate, spouse, and/or dependent children lose coverage through another employer, the public healthcare exchange or Medicare)
- Gain or loss of Medicaid or Children's Health Insurance Program (CHIP) coverage
- Eligible dependent entering the USA

For HIPAA Special Enrollment events, you may enroll yourself and eligible dependents **within two months of the event date**. In addition, HIPAA events may allow you to change plans. However, your election change must be because of and consistent with the event. These rules do not apply to Commuter Benefits.

If you lose other group health plan coverage, you qualify under HIPAA Special Enrollment events if each of the following conditions is met:

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

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

Compass Group also will allow a HIPAA special enrollment opportunity within two months of the event date if you or your eligible dependents either:

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

Qualifying life events

- Gain of coverage (associate, spouse, and/or dependent children gain coverage through another employer, the public healthcare exchange, Medicaid, Medicare, etc.)
- Dependent loses eligibility (divorce/legal separation/guardianship termination)/dependent leaving the USA
- Death of a dependent
- Dependent Daycare change
- Move from full-time to part-time during the stability period
- Permanent employment change resulting in 20% or more reduction of hours or pay
- Incarceration of a dependent

For qualifying life events, you may drop coverage for yourself and/or your dependent(s) within one month of the event date. You may also be able to make changes to your Dependent Daycare Spending Account.. However, your election change must be because of and consistent with the qualifying life event. These rules do not apply to commuter benefits.

The following describes qualifying life events in more detail.

Dissolution of marriage or common law marriage –

An event that changes your legal marital status, such as the death of your spouse, divorce, legal separation, and annulment.

Employment status –

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

Reduction in hours or rate of pay –

If you experience an employment change resulting in a reduction of your hours or your rate of pay by 20% or more while remaining benefit eligible, you will be allowed to drop all benefits coverage — 20% or more is considered “significant.” The reduction in hours or rate of pay must be “permanent” in order to qualify as a status change.

Moving from full-time to part-time during the stability period –

If your position changes and you become a part-time associate during the stability period, you have the right to maintain that coverage during the 12-month stability period, assuming you can continue to pay the premiums. If your hours as a part-time associate are such that you cannot afford to pay the premiums, you may elect to drop certain coverage.

Residence –

A change in the place of your residence that affects eligibility for coverage under the plan.

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

Change in dependent daycare provider costs or enrollment status – Changing your Dependent Daycare Spending Account election amount during the plan year is not permitted unless there is a change in dependent day care provider costs or enrollment status. This includes changes as a result of marriage, divorce, death of a spouse or dependent, birth or adoption of a child.

Other qualifying events

Federal law currently recognizes several other events that will permit you to make election changes during the plan year. Please note these events do not apply to life insurance changes. The events include:

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

Judgments, decrees or orders – You may make a change that corresponds to any valid judgment, decree or order (including a court-approved settlement agreement) that requires medical, dental and/or vision coverage through Compass Group for your child or qualifying dependent.

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

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

If you are not enrolled in a Compass Group medical, dental or vision plan at the time the court order is received, you will be enrolled in order to add the court ordered dependent. You will be enrolled in the most appropriate and affordable plan that is available to you and is consistent with the court order. If your coverage level increases to Associate Plus Child(ren) or Associate Plus Family when your child is added, your cost for coverage will also increase.

Once the QMCSO is in place, coverage will remain active until the dependent loses eligibility or a court issued termination of medical support order is received by the Benefits Department. See *Continuing Your Coverage Under COBRA*, beginning on page 98, for details on coverage if dependents are no longer eligible for coverage.

Significant cost or coverage changes –

- If the cost of the option increases or decreases significantly during the plan year as a result of action taken by you or Compass Group, you may:
 - Increase or decrease your election
 - Revoke your election if you elect similar coverage under another option that provides similar coverage on a prospective basis
 - Drop coverage if another benefit package providing similar coverage is available
- If coverage under an option is either significantly curtailed without a loss of coverage (for example, there is a significant increase in the deductible, copay or out-of-pocket cost-sharing limit under an accident or health plan) or ceases during a plan year, you may revoke your election if you elect similar coverage under another option that provides similar coverage on a prospective basis. Coverage under any option providing accident and health benefits will be deemed to be significantly curtailed only if there is an overall reduction in benefits that constitutes reduced coverage to participants generally.
- If coverage under an option ceases (for example, the elimination of your option or HMO ceases to be available in the area where you reside or a substantial decrease in the medical care providers available under your option), you may either revoke your election and elect coverage under another option that provides similar coverage on a prospective basis, or you may drop coverage if no similar coverage is available.

- If a new option is added (or an existing option is significantly improved) during a plan year, you may select the new or improved option on a prospective basis and make corresponding election changes with respect to other options that provide similar coverage.
- You may make a prospective election change that corresponds with a change made under a benefit plan sponsored by the employer of your spouse, former spouse, or dependent, provided the plan permits its participants to make similar election changes or maintains a different plan year than the Compass Group benefits plan.

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

You must declare your HIPAA Special Enrollment or qualifying life event within the appropriate timeframe. You will also be required to submit documentation supporting your event. If you fail to provide the required documentation within the appropriate timeframe, your requested changes will be denied and you will have to wait until the next Annual Enrollment to make changes to your benefits. Please contact the Benefits Department 877-311-4747 if you have questions.

More about Medicaid and Medicare coverage

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

Qualifying Life Event Summary Chart

EVENT	MEDICAL/ DENTAL/VISION	SUPPLEMENTAL LIFE INSURANCE	SPOUSE AND CHILD LIFE INSURANCE	SHORT AND LONG TERM DISABILITY INSURANCE	ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)	HEALTH CARE SPENDING ACCOUNT	DEPENDENT DAYCARE SPENDING ACCOUNT
HIPAA Special Enrollment – Two Months							
Marriage/ Spouse entering the USA (Newly eligible dependents can enroll in life insurance and AD&D benefits at any coverage level)	<ul style="list-style-type: none"> Enroll associate, along with spouse and/or dependent children Add spouse & dependent children to current plan Choose new option 	<ul style="list-style-type: none"> Enroll in coverage at the \$10,000 level of coverage Increase current coverage by one level Decrease current coverage to any level Drop coverage 	Spouse <ul style="list-style-type: none"> Enroll in coverage at any level Child <ul style="list-style-type: none"> Enroll in coverage at any level Increase current coverage by one level Decrease current coverage to any level Drop coverage 	<ul style="list-style-type: none"> No change 	<ul style="list-style-type: none"> Enroll in coverage at any level Add dependent to current coverage Increase current coverage by one level Decrease current coverage to any level Drop coverage 	<ul style="list-style-type: none"> Enroll Increase 	<ul style="list-style-type: none"> Enroll Increase
Birth/adoption/ placement for adoption/ guardianship/ eligible dependent child entering the USA (Newly eligible dependents can enroll in life insurance and AD&D benefits at any coverage level)	<ul style="list-style-type: none"> Enroll associate, along with spouse and/or dependent children Add spouse and dependent child to current plan Choose new option 	<ul style="list-style-type: none"> Enroll in coverage at the \$10,000 level of coverage Increase current coverage by one level 	Spouse <ul style="list-style-type: none"> Enroll in coverage at the 1st level Child <ul style="list-style-type: none"> Enroll in coverage at any level Increase current coverage by one level 	<ul style="list-style-type: none"> No change 	<ul style="list-style-type: none"> Enroll in coverage at any level Add dependent to current coverage Increase current coverage by one level Decrease current coverage to any level Drop coverage 	<ul style="list-style-type: none"> Enroll Increase 	<ul style="list-style-type: none"> Enroll Increase
Loss of group coverage (Associate, spouse and/or dependent children lose coverage through another employer, Medicaid / CHIP, the public healthcare exchange, Medicare, etc.)	<ul style="list-style-type: none"> Enroll associate, along with spouse and/or dependent children Add spouse & dependent children to current plan Choose new option 	<ul style="list-style-type: none"> Enroll in coverage at the \$10,000 level of coverage Increase current coverage by one level Decrease current coverage to any level Drop coverage 	<ul style="list-style-type: none"> Enroll in coverage at the 1st level Increase current coverage by one level Decrease current coverage to any level Drop coverage 	<ul style="list-style-type: none"> No change 	<ul style="list-style-type: none"> Enroll in coverage at the 1st level Add dependent to current coverage Increase current coverage by one level Decrease current coverage to any level Drop coverage 	<ul style="list-style-type: none"> Enroll Increase 	<ul style="list-style-type: none"> Enroll Increase

EVENT	MEDICAL/ DENTAL/VISION	SUPPLEMENTAL LIFE INSURANCE	SPOUSE AND CHILD LIFE INSURANCE	SHORT AND LONG TERM DISABILITY INSURANCE	ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)	HEALTH CARE SPENDING ACCOUNT	DEPENDENT DAYCARE SPENDING ACCOUNT
Gain of Medicaid / CHIP coverage	<ul style="list-style-type: none"> Drop associate, spouse and/or dependent children 	<ul style="list-style-type: none"> No change 	<ul style="list-style-type: none"> No change 	<ul style="list-style-type: none"> No change 	<ul style="list-style-type: none"> Enroll in coverage at the 1st level Increase current coverage by one level Decrease current coverage to any level Drop coverage 	<ul style="list-style-type: none"> Decrease up to amount used or deducted – whichever is greater 	<ul style="list-style-type: none"> No change

Qualifying Life Event – One Month

Gain of group coverage (Associate, spouse and/or dependent children gain coverage through another employer, the public healthcare exchange, Medicare, etc./ a dependent's incarceration)	<ul style="list-style-type: none"> Drop associate, spouse and/or dependent children 	<ul style="list-style-type: none"> Enroll in coverage at the \$10,000 level of coverage Increase current coverage by one level Decrease current coverage to any level Drop coverage 	<ul style="list-style-type: none"> Enroll in coverage at the 1st level Increase current coverage by one level Decrease current coverage to any level Drop coverage 	<ul style="list-style-type: none"> No change 	<ul style="list-style-type: none"> Enroll in coverage at the 1st level Increase current coverage by one level Decrease current coverage to any level Drop coverage 	<ul style="list-style-type: none"> Decrease up to amount used or deducted – whichever is greater 	<ul style="list-style-type: none"> No change
Permanent employment change resulting in a 20% or more reduction of hours or pay	<ul style="list-style-type: none"> Drop coverage 	<ul style="list-style-type: none"> Drop coverage 	<ul style="list-style-type: none"> Drop coverage 	<ul style="list-style-type: none"> Drop coverage 	<ul style="list-style-type: none"> Drop coverage 	<ul style="list-style-type: none"> Decrease up to amount used or deducted – whichever is greater 	<ul style="list-style-type: none"> No change
Move from full-time to part-time during the stability period	<ul style="list-style-type: none"> Drop associate, spouse and/or dependent children 	<ul style="list-style-type: none"> No change 	<ul style="list-style-type: none"> No change 	<ul style="list-style-type: none"> No change 	<ul style="list-style-type: none"> No change 	<ul style="list-style-type: none"> Decrease up to amount used or deducted – whichever is greater 	<ul style="list-style-type: none"> No change

EVENT	MEDICAL/ DENTAL/VISION	SUPPLEMENTAL LIFE INSURANCE	SPOUSE AND CHILD LIFE INSURANCE	SHORT AND LONG TERM DISABILITY INSURANCE	ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)	HEALTH CARE SPENDING ACCOUNT	DEPENDENT DAYCARE SPENDING ACCOUNT
Dependent loses eligibility (Divorce/legal separation/guardianship termination/dependent leaving the USA)	<ul style="list-style-type: none"> Drop ineligible dependent 	<ul style="list-style-type: none"> Enroll in coverage at the \$10,000 level of coverage Increase current coverage by one level Decrease current coverage to any level Drop coverage 	<ul style="list-style-type: none"> Drop ineligible dependent 	<ul style="list-style-type: none"> No change 	<ul style="list-style-type: none"> Drop ineligible dependent Decrease current coverage to any level Drop coverage 	<ul style="list-style-type: none"> Decrease up to amount used or deducted – whichever is greater 	<ul style="list-style-type: none"> Decrease up to amount deducted
Dependent daycare change	<ul style="list-style-type: none"> No change 	<ul style="list-style-type: none"> No change 	<ul style="list-style-type: none"> No change 	<ul style="list-style-type: none"> No change 	<ul style="list-style-type: none"> No change 	<ul style="list-style-type: none"> No change 	<ul style="list-style-type: none"> Enroll Increase Decrease up to the amount deducted

Other Events

Commencement of an approved leave of absence * Processed by the LOA Department	<ul style="list-style-type: none"> Drop coverage during LOA 	<ul style="list-style-type: none"> Drop coverage during LOA 	<ul style="list-style-type: none"> Drop coverage during LOA 	<ul style="list-style-type: none"> No change 	<ul style="list-style-type: none"> Drop coverage during LOA 	<ul style="list-style-type: none"> Decrease during LOA up to amount used or deducted – whichever is greater 	<ul style="list-style-type: none"> Decrease during LOA up to amount deducted
Return from an approved leave of absence	<ul style="list-style-type: none"> All coverage in force on the last active day of work will be reinstated 	<ul style="list-style-type: none"> All coverage in force on the last active day of work will be reinstated 	<ul style="list-style-type: none"> All coverage in force on the last active day of work will be reinstated 	<ul style="list-style-type: none"> No change 	<ul style="list-style-type: none"> All coverage in force on the last active day of work will be reinstated 	<ul style="list-style-type: none"> All coverage in force on the last active day of work will be reinstated 	<ul style="list-style-type: none"> All coverage in force on the last active day of work will be reinstated
Death of a dependent	<ul style="list-style-type: none"> Drop deceased dependent 	<ul style="list-style-type: none"> Enroll in coverage at the \$10,000 level of coverage Increase current coverage by one level Decrease current coverage to any level Drop coverage 	<ul style="list-style-type: none"> Benefit amount paid Enroll surviving dependents at the 1st level Increase current coverage by one level Drop coverage 	<ul style="list-style-type: none"> No change 	<ul style="list-style-type: none"> Drop deceased dependent Benefit amount paid, if applicable Enroll in coverage at the 1st level Increase current coverage by one level Decrease current coverage to any level Drop coverage 	<ul style="list-style-type: none"> Decrease up to amount used or deducted – whichever is greater 	<ul style="list-style-type: none"> Enroll Increase Decrease up to amount deducted

EVENT	MEDICAL/ DENTAL/VISION	SUPPLEMENTAL LIFE INSURANCE	SPOUSE AND CHILD LIFE INSURANCE	SHORT AND LONG TERM DISABILITY INSURANCE	ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)	HEALTH CARE SPENDING ACCOUNT	DEPENDENT DAYCARE SPENDING ACCOUNT
Death of an associate	<ul style="list-style-type: none"> Coverage ends at 11:59 pm as of the date on the death certificate 	<ul style="list-style-type: none"> Coverage ends at 11:59 pm as of the date on the death certificate 	<ul style="list-style-type: none"> Coverage ends at 11:59 pm as of the date on the death certificate 	<ul style="list-style-type: none"> Coverage ends at 11:59 pm as of the date on the death certificate 	<ul style="list-style-type: none"> Coverage ends at 11:59 pm as of the date on the death certificate 	<ul style="list-style-type: none"> Coverage ends at 11:59 pm as of the date on the death certificate 	<ul style="list-style-type: none"> Coverage ends at 11:59 pm as of the date on the death certificate

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

Making changes

If you wish to make changes to your benefit elections, you must declare your event within the appropriate timeframe via the enrollment website.

Once you declare your event, a letter will be mailed to your home requesting documentation supporting your event and dependent verification documentation, if applicable. If you fail to provide the required documentation within the

appropriate timeframe, your requested changes will be denied and you will have to wait until the next Annual Enrollment to make changes to your benefits.

Please see the Qualifying Life Event Summary chart on pages 88-91 to review the specific changes that can be made to your benefits according your qualifying life event. If you have further questions, contact the Benefits Department 877-311-4747.

Below are some examples of acceptable forms of documentation required as proof of your event. In order for your changes to be processed, you must submit the required documentation to the Compass Group Benefits Department by the appropriate deadline.

ACCEPTABLE FORMS OF DOCUMENTATION

Marriage	<ul style="list-style-type: none"> A copy of the marriage certificate/common law affidavit
Birth/adoption/placement for adoption/guardianship	<ul style="list-style-type: none"> Proof of birth, or a copy of the birth certificate Adoption/permanent guardianship papers or proof that the child has been placed in your home
Loss of group coverage	<ul style="list-style-type: none"> A letter from employer, Medicaid/CHIP, the public healthcare exchange, Medicare, etc., indicating type of coverage lost, dependents who were covered, and date coverage ended
Gain of Medicaid/CHIP coverage	<ul style="list-style-type: none"> A letter from Medicaid/CHIP indicating the type of coverage gained, dependent(s) covered, and the date coverage began
Gain of group coverage	<ul style="list-style-type: none"> A letter from employer, the public healthcare exchange, Medicare, etc., indicating the type of coverage gained, dependent(s) covered, and the date coverage began
Dependent loses eligibility	<ul style="list-style-type: none"> A copy of the court order granting a divorce or legal separation or a copy of the court order terminating guardianship
Death of a dependent or associate	<ul style="list-style-type: none"> A certified death certificate
Reduction in hours or rate of pay	<ul style="list-style-type: none"> Notification from the associate or manager and verification of payroll
Move from full-time to part-time during the stability period	<ul style="list-style-type: none"> A statement from the associate or manager advising when the associate went part time
Dependent daycare change	<ul style="list-style-type: none"> Letter/invoice from daycare provider stating details of the daycare change
Eligible dependent entering the USA	<ul style="list-style-type: none"> Passport with the date stamp of when dependent entered the USA
Dependent leaves the USA	<ul style="list-style-type: none"> Copy of passport with date stamp of when dependent left the USA

When do the changes take effect?

The coverage change and payroll deductions and/or applicable surcharges are effective as follows:

QUALIFYING LIFE EVENT EFFECTIVE DATE	
Marriage	<ul style="list-style-type: none">• The date of your marriage
Birth/adoption/placement for adoption/guardianship	<ul style="list-style-type: none">• The date of your child's birth• The date your adopted child is placed with you for adoption• The date of court-appointed permanent guardianship
Loss of group coverage	<ul style="list-style-type: none">• The day after previous coverage ends
Gain of Medicaid/CHIP coverage	<ul style="list-style-type: none">• The day the new coverage begins
Gain of group coverage	<ul style="list-style-type: none">• The day the new coverage begins
Dependent loses eligibility	<ul style="list-style-type: none">• The date of your child's loss of eligibility• The date of divorce/legal separation• The date of guardianship termination
Death of a dependent or associate	<ul style="list-style-type: none">• The day after the date of death
Your termination of employment	<ul style="list-style-type: none">• At midnight on the last day of work
Reduction in hours or rate of pay	<ul style="list-style-type: none">• The day the reduction in hours or pay becomes effective
Status change from full-time to part-time	<ul style="list-style-type: none">• The day the reduction of hours becomes effective
Dependent daycare change	<ul style="list-style-type: none">• The effective date of the daycare change stated on the letter/invoice
Eligible dependent enters the USA	<ul style="list-style-type: none">• The date stamp on the passport indicating when dependent entered the USA
Dependent leaves the USA	<ul style="list-style-type: none">• The date stamp on the passport indicating when dependent left the USA

Please note for life insurance changes, any election or increase in coverage due to a life event is effective the date of the election.

If your life event affects...

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

Coordinating benefits between two plans

Primary and Secondary Plans

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

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

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

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

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

Guidelines are used to determine which plan pays first:

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

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

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

Does it pay to have coverage under two medical plans?

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

Your Compass Group Gold Plus Plan: 80% covered charges paid

Your spouse's plan: 70% covered charges paid

Spouse's plan pays:

	\$3,000	covered expense
x	70%	
	<u>\$2,100</u>	primary benefit

Compass Group Gold Plus Plan pays of the difference, if any:

	\$3,000	covered expense
x	80%	
	<u>\$2,400</u>	

so

	\$2,400	covered expense
-	\$2,100	primary benefit
	<u>\$300</u>	

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

Subrogation

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

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

See page 112 for more about subrogation in the *Administrative Information* section.

Family and Medical Leave (FMLA)

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

You are eligible for family medical leave if you have been with Compass Group for one year and have completed 1,250 hours of service in the previous 12 months. Eligibility requirements may vary in some states. Call the Leave of Absence Department at 877-311-4747 for more information about what applies to you.

Note that this section highlights some of the FMLA rules. For a complete set of Compass Group policies or to address your particular situation, contact the Leave of Absence Department at 877-311-4747.

The following reasons qualify for family medical leave:

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

Military leave

If you take a military leave, whether for active duty or for training, you are entitled to extend your medical coverage for the length of the leave or 24 months, whichever is shorter, as long as you give Compass Group advance notice of the leave (with certain exceptions).

If Compass Group does not receive notice to extend your coverage, benefits will cease on the 30th day of military leave. Your total leave, when added to any prior periods of military leave from Compass Group, cannot exceed five years (with certain exceptions).

If the entire length of the leave is 30 days or less, you will pay for coverage on a monthly basis, prorated as appropriate. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the full coverage amount as required under COBRA.

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

Going on leave

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

Leave request forms are available from the Leave of Absence Department. To provide notice of leave contact the Leave of Absence Department and/or, complete a leave request form and return it to the Leave of Absence Department. Compass Group will require a doctor's written certification as proof of a serious health condition. If requested, you must provide a medical certification form completed by your doctor within 15 days of Compass Group's request. Compass Group also may require you to get a second or third medical opinion. Any expenses you incur for obtaining the additional medical opinions will be paid by Compass Group.

While on leave

If you are on leave because of a family member's or your own health condition, you will be asked to provide medical proof of that condition. If you are covered by a Compass Group plan before going out on leave, your coverage will continue for a period of time as long as you make all required contributions. Coverage may continue for:

- Up to six months, for your medical condition
- Up to twelve weeks, for a family member's medical condition

For more information, refer to the Family and Medical Leave policy in your HR Handbook.

When you return to work

When you return from leave, if your leave was designated as FMLA, you will be restored to your original or an equivalent position, with equivalent pay, benefits, and other employment terms as if you had not taken the leave.

However, certain associates who are considered “key” associates may not be restored if their reinstatement would cause substantial economic harm to Compass Group. The Leave of Absence Department may require a medical release from your doctor before you can return to work. You can send the release to the Leave of Absence Department before you return.

If you do not return to work

If you do not come back to work when your leave ends, you will be eligible to continue healthcare coverage through COBRA. The date you should have returned to work will be the date your coverage is considered to end for determining COBRA coverage. See *Continuing Your Coverage Under COBRA*, beginning on page 98, for details.

More information

For a complete set of Compass Group policies or to address your particular situation, contact the Leave of Absence Department at 877-311-4747. For more information on the Family and Medical Leave Act (FMLA), you may contact the Leave of Absence Department or the Wage and Hour Division of the U.S. Department of Labor.

Continuing your coverage under COBRA

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

COBRA coverage is available to you and your covered eligible dependents in certain instances where coverage would otherwise end (called “qualifying events”). For example, COBRA coverage is available to you and your covered eligible dependents if you are terminated, or if your hours are reduced to the extent that you no longer qualify for Compass Group coverage.

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

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

Compass Group Benefits Department
Attention: COBRA
2400 Yorkmont Road
Charlotte, NC 28217
877-311-4747

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

You don’t have to show that you’re insurable to choose COBRA coverage. However, COBRA coverage is provided subject to your eligibility for coverage as described on the following page. Compass Group reserves the right to terminate your and/or your dependents’ coverage retroactively if it’s determined that you and/or your dependents are ineligible for COBRA coverage under the terms of the Compass Group plan. COBRA can continue for up to 18, 29 or 36 months, depending on the reason you or your dependent becomes eligible. Unlike active coverage, COBRA coverage can be canceled at any time. However once your COBRA coverage is canceled, you cannot re-enroll.

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

Through COBRA, you may continue the same healthcare coverage you had before the event that qualified you for COBRA. That means you may be eligible to extend your medical, dental and vision benefits, and in some instances Flexible Spending Accounts, by electing COBRA continuation coverage. If coverage for non-COBRA beneficiaries is modified, coverage made available to you through COBRA will be similarly modified.

COBRA At a Glance

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

WHO IS AFFECTED?	QUALIFYING EVENT	WHO IS ELIGIBLE FOR COBRA COVERAGE	DURATION OF COBRA COVERAGE*
You	Terminate employment	You and your covered dependents	Up to 18 months
You	Have a reduction in hours below the level required for benefit eligibility	You and your covered dependents	Up to 18 months
You	Are disabled at the time you become eligible for COBRA or you are determined to be disabled within the first 60 days of COBRA continuation coverage	You and your covered dependents	Up to 29 months***
Your Spouse or Dependent Child(ren)**	You die	Your covered dependents	Up to 36 months
Your Spouse or Dependent Child(ren)	You and your enrolled spouse become divorced, or legally separated	Your former spouse and your other covered dependents, if coverage is lost because of a divorce	Up to 36 months
Your Spouse or Dependent Child(ren)	The original COBRA event was termination of employment or reduction in hours and your spouse and/or dependent child is disabled at the time he or she becomes eligible for COBRA — or becomes disabled within the first 60 days of COBRA continuation coverage	You and your covered dependents	29 months***
Your Dependent Child(ren)****	Your dependent child is no longer an eligible dependent (for example, due to reaching a plan's age limit)	Your covered dependent child(ren)	36 months

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

**Compass Group provides a subsidy for the COBRA medical and dental coverage your dependents were enrolled in prior to your death, up to 90 days.

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

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

Who is eligible

As an associate

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

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

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

As a covered spouse

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

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

As an eligible dependent child

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

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

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

Electing COBRA

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

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

You must submit your COBRA election form within 60 days of the date of the COBRA notice.

Simply fill out the COBRA election form and return it to the Compass Group Benefits Department. The first premium payment is due 45 days after the date on which you make your COBRA coverage election. Payment must be received before your coverage will be effective. Your initial payment will be applied retroactively from the termination of your Compass Group benefits.

All subsequent premium payments are due on the 10th of each month. Your payment must be received by Compass Group and be postmarked on or before the 10th of the month. Premium payments are due one month in advance.

COBRA coverage will be canceled and you will lose your COBRA rights if full payment is not received within 10 days of the print date of the past due statement. Failure to pay premiums on a timely basis will result in permanent termination of COBRA coverage.

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

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

How to apply for COBRA

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

If you have questions about COBRA, contact the Compass Group Benefits Department at 877-311-4747.

Coverage options

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

"Similarly situated" refers to a current associate not covered by a collective bargaining agreement or dependent who has not had a qualifying event.

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

Separate elections

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

Cost of COBRA coverage

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

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

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

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

COBRA premium payment deadlines

The first premium payment is due 45 days after the date on which you make your COBRA coverage election. Payment must be received before your coverage will be effective. Your initial payment will be applied retroactively from the termination of your Compass Group benefits. All subsequent premium payments are due on the 10th of each month. Your payment must be received by Compass Group and be postmarked on or before the 10th of the month. Premium payments are due one month in advance. Claims are covered only through the last day you paid for COBRA coverage.

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

For example, a qualified beneficiary owes \$345.00 for COBRA coverage but only pays \$280.00. The shortfall of \$65.00 is considered significant because it is greater than 10% (\$34.50) or over \$50. Therefore, your payment could be returned to you without being processed.

If you fail to make a payment by the due date, you will receive a past due statement. COBRA coverage will be canceled and you will lose your COBRA rights if full payment is not received within 10 days of the print date of the past due statement.

Adding a newly acquired dependent due to a qualifying life event

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

Compass Group also will ask you to provide documentation supporting the birth, adoption or placement for adoption or permanent legal guardianship of the new child.

If you are a former associate and get married while you are covered under COBRA, your spouse can also receive COBRA coverage for the duration of your COBRA continuation coverage. You must notify the Compass Group Benefits Department in writing within two months of the date of your marriage in order for your spouse to be covered as of the date of marriage. In this case, your spouse will have the same rights as any other dependent covered immediately prior your COBRA eligibility. Compass Group also will ask you to provide documentation supporting your marriage.

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

If a qualifying life event occurs while on COBRA

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

If you or the dependents fails to notify the Compass Group Benefits Department in accordance with these procedures, COBRA rights will be forfeited.

Documentation required

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

- **Birth** — proof of birth or a copy of the birth certificate
- **Adoption/Permanent Legal/Guardianship** — adoption/permanent legal/guardianship papers or proof that the child has been placed in your home
- **Marriage** — a copy of the marriage certificate
- **Divorce** — a copy of the divorce decree
- **Legal separation** — a copy of the separation agreement filed with the courts
- **Child no longer qualifying as a dependent** — a copy of a driver's license or birth certificate showing the child's age or physician's statement that dependent child is no longer disabled
- **Gain of group coverage/Medicaid/CHIP coverage** — a letter from employer, Medicare, Medicaid/CHIP, etc., indicating the type of coverage gained, dependent(s) covered, and the date coverage began
- **Death of a dependent or associate** — a certified death certificate
- **Dependent entering and leaving the USA** — a copy of the picture page and arrival stamp from the dependent's passport.

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

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

What Compass Group does

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

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

Rules governing COBRA

This chart highlights federal rules governing COBRA and the actions you and/or your covered dependents, who are qualified beneficiaries, will need to take if you have a COBRA qualifying event and become eligible for COBRA coverage. “Your responsibility” applies to you and your covered dependents who are qualified beneficiaries. See *Who is Eligible* on page 100 for more information.

FEDERAL RULES	YOUR RESPONSIBILITY	COMPASS GROUP'S RESPONSIBILITY	WHAT YOU CAN EXPECT
Compass Group has up to 44 days from your termination date of coverage to mail COBRA enrollment materials.	Make sure that your mailing address is current.	Process the termination event in the payroll system.	COBRA enrollment materials mailed to you within 44 days.
You have 60 days from the print date of the COBRA enrollment notice to elect COBRA.	Send your COBRA enrollment selections to Compass Group within 60 days of the print date of the COBRA enrollment notice.	Process your enrollment and send you an initial COBRA statement of the payments due.	COBRA enrollment process begins. Your coverage is not active until Compass Group receives your payment.
The first premium payment is due 45 days after the date on which you make your COBRA coverage election.	Send the first payment to the Compass Group Benefits Department.	Process your payment and apply coverage retroactive to your benefits termination date.	COBRA coverage from the benefits termination date through the end of the period that the payment covers. Retroactive claims can be filed for dates of service included in the paid coverage period.
Shortfall Rule: If you underpay your COBRA premium and the amount you owe is the greater than \$50 or 10% of the required payment, you are required to pay the “shortfall.”	Send payment to cover the shortfall and bring your account current.	Process your payment or return the payment if there is a significant underpayment.	The shortfall must be paid within the same calendar month, or your coverage will be terminated.
Coverage is provided up to 18 months — or longer in some cases (See <i>COBRA At a Glance</i> chart on page 102).	Continue to send payments or submit written notification to the Compass Group Benefits Department if you want to end COBRA coverage early.	Continue to process COBRA premium payments until the end of COBRA eligibility.	Coverage continues up to the end of COBRA coverage.

Duration of COBRA coverage

If elected, COBRA coverage begins on the day following the date active coverage is lost. For dependents who no longer satisfy the requirements for dependent coverage, COBRA coverage begins on the date their dependent coverage ends. For newly acquired dependents, COBRA coverage begins the date of birth, adoption or placement for adoption, permanent legal guardianship or the date of your marriage.

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

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

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

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

If an additional qualifying event occurs within the first 18 months of coverage, you must notify the Compass Group Benefits Department within 60 days of the second qualifying event to include divorce, legal separation, loss of dependent status and eligibility for Social Security Disability extension in accordance with the procedures described in *Electing COBRA* on page 104 or your coverage cannot be extended.

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

Extension of COBRA coverage for disability

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

This 11-month extension is available to all dependent's who have elected COBRA coverage due to the termination

of employment or reduction in hours. This applies even to dependents who aren't disabled. During this 11-month period, the COBRA premium cost increases to 150%.

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

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

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

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

If a dependent is receiving COBRA coverage under a disability extension and another qualifying life event occurs within the 29-month continuation period, then the qualified dependent's COBRA coverage period may be extended to 36 months from the initial termination of employment or reduction in hours. The dependent must provide the appropriate notice to the Compass Group Benefits Department as described under *Electing COBRA* on page 104.

Social Security Administration determination of disability

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

Early termination of COBRA coverage

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

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

Continuing coverage in special cases

COBRA and FMLA

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

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

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

COBRA and USERRA

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

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

Trade Act of 2002

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

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

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

Converting coverage

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

COBRA questions

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

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

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

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

Compass Group Benefits Department
Attention: COBRA
2400 Yorkmont Road
Charlotte, NC 28217
877-311-4747

Administrative Information

When you choose coverage under the Employee Benefit Plan of the Compass Group USA, Inc. (“Benefit Plan”), you may receive benefits within the provisions described in this summary. You also have other rights as a plan participant, some of which are listed in this section. If you have any general questions that cannot be answered by the plan carriers listed on page 109, contact the Benefits Department at 877-311-4747.

At a Glance

The information in this section tells you:

- How to contact the plan administrator
- How to contact the plan carriers that administer each plan
- What to do if a claim for benefits is denied
- Rules and regulations for continuing coverage during military leave and subrogation
- Your rights under ERISA

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

Compass Group reserves the right to terminate your plan benefits prospectively without notice for cause (as determined by Compass Group), or if you are otherwise determined ineligible. In addition, if you commit fraud, or intentional misrepresentation of a material fact with respect to enrolling in the plan, or in a claim or appeal for benefits, or in response to any request for information in connection with your plan benefits, your coverage may be terminated retroactively with 30 days’ notice to you. Knowingly providing false information to obtain coverage for an ineligible dependent is an example of fraud. To the extent permitted by applicable law and regulations, coverage may also be terminated retroactively and without notice (unless required by law or applicable regulation), if Compass Group determines that you or your dependent is ineligible for coverage.

Federal Discrimination Notice

IMPORTANT INFORMATION REGARDING THE PLAN:

In accordance with applicable federal law, the plan will not discriminate against any healthcare provider acting within the scope of their license or certification, or against any person who has applicable federal law. Further, the plan shall not impose eligibility rules or variations in premiums based on any specified health status-related factors unless specifically permitted by law.

Basic administrative information

PLAN NAME	Employee Benefit Plan of the Compass Group USA, Inc.
PLAN ADMINISTRATOR	Compass Group is the plan administrator (as defined under ERISA) for most of the benefits described in this summary. However, some of the benefits are provided by insurance companies or HMO providers, and in those instances the companies (not Compass Group) are the plan administrators and have the legal responsibility to make decisions under those plans.
PLAN SPONSOR CONTACT INFORMATION	Compass Group Benefits Department 2400 Yorkmont Road Charlotte, NC 28217 877-311-4747
EMPLOYER IDENTIFICATION NUMBER	56-1874931
PLAN NUMBER	510
TYPE OF PLAN	Medical and prescription drug, wellness, dental, vision, flexible spending accounts, life insurance, accidental death and dismemberment insurance and disability benefits
PLAN YEAR	January 1 – December 31
PLAN FUNDING/SOURCE OF FUNDING	The plans are unfunded arrangements. Benefits are paid either out of general assets of your employer or under an insurance contract. All of your benefits are provided through contributions made by Compass Group and/or by you as specified in the specific benefit description.
AGENT FOR SERVICE OF LEGAL PROCESS	Legal process for all of the benefit plans described in this summary should be directed to: Compass Group USA, Inc. General Counsel 2400 Yorkmont Road Charlotte, NC 28217 704-328-4000 Legal process may be made upon the plan administrator.
RIGHTS TO EMPLOYMENT	This summary is for your information only; it is not a binding contract, nor does it impose any legal obligation upon Compass Group. No information in this summary says or implies that participation in the benefit plan is a guarantee of continued employment with the Company.
RIGHT TO AMEND OR TERMINATE PLANS	Compass Group, in its sole discretion, reserves the right to amend, modify, suspend or terminate the benefit plan, in whole or in part, subject to applicable legal and contractual agreements, at any time and for any reason. A decision to terminate, amend or replace the benefit plan may be due to changes in federal law or state laws governing benefits, the requirements of the Internal Revenue Service or ERISA, or for any other reason. This may include the elimination of or decreases in benefits, changes in plan networks, and increases in your required contributions for coverage.

Plan carriers

Claims under the plans for the benefits provided therein are administered by the following plan carriers:

PLAN	PLAN CARRIER	CONTACT INFORMATION
Non-HMO Medical Plans Self-Insured	Aetna	P.O. Box 981106 El Paso, TX 79998-1106 866-238-1128 www.aetna.com/docfind/custom/compassgroup
	BlueCross BlueShield of NC	P.O. Box 35 Durham, NC 27702 877-224-3305 www.bcbsnc.com/members/compassgroup For appeals: Appeals Department P.O. Box 30055 Durham, NC 27702 For mental health/substance abuse (first level appeals only): Magellan Behavioral Health Appeals Department PO Box 1619 Alpharetta, GA 30009
	UnitedHealthcare	P.O. Box 740800 Atlanta, GA 30374-0800 877-571-9862 http://welcometouhc.com/compassgroup
Prescription Drug Plan Self-Insured	CVS Caremark™	Attn: Claims Department P.O. Box 52136 Phoenix, AZ 85072-2136 855-656-0360 www.caremark.com Mail Order: P.O. Box 94467 Palatine, IL 60094-4467 855-656-0360
Telemedicine	Teladoc	4100 Spring Valley, Suite 515 Dallas, TX 75244 800-835-2362 www.teladoc.com
Regional HMO Medical Plans	Refer to the appropriate HMO booklets for addresses and telephone numbers. The HMO must provide you or your beneficiary upon request, written materials concerning (1) the nature of services provided to members, (2) conditions pertaining to eligibility to receive such services (other than general conditions pertaining to eligibility for participation in the plan) and circumstances under which services may be denied and (3) the procedures to be followed in obtaining such services, and the procedures available for the review of claims for services which are denied in whole or in part.	
Wellness Program	INTERVENT	340 Eisenhower Dr. Building 1400, Suite 17 Savannah, GA 31406 866-334-2137 www.interventint.com/compassgroup
	HealthAdvocate	3043 Walton Rd., Suite 150 Plymouth Meeting, PA 19462 866-799-2728 www.healthadvocate.com/compass-group

PLAN	PLAN CARRIER	CONTACT INFORMATION
Dental Plan Self-Insured	Cigna	Cigna P.O. Box 188037 Chattanooga, TN 37422-8037 800-244-6224 www.cigna.com
Dental Plan Fully-Insured	Delta Dental of Puerto Rico	Refer to the appropriate booklet for addresses and telephone numbers. The carrier must provide you or your beneficiary upon request, written materials concerning (1) the nature of services provided to members, (2) conditions pertaining to eligibility to receive such services (other than general conditions pertaining to eligibility for participation in the plan) and circumstances under which services may be denied and (3) the procedures to be followed in obtaining such services, and the procedures available for the review of claims for services which are denied in whole or in part. Metro Office Park 14 Street 2 Suite 200 Guaynabo, PR 00968 866-622-6120 www.deltadentalpr.com
Vision Plan Fully-Insured	Vision Service Plan (VSP)	P.O. Box 997105 Sacramento, CA 95899-7105 800-877-7195 www.vsp.com
Associate (Basic and Supplemental), Spouse and Child Life Insurance	Securian Life Insurance Company	400 Robert Street St. Paul, MN 55101 888-658-0193
Short Term Disability (STD)	Aetna	P.O. Box 14560 Lexington, KY 40512-4560 866-825-0185
Long Term Disability (LTD) Plan	Aetna	P.O. Box 14560 Lexington, KY 40512-4560 866-825-0185
Accidental Death and Dismemberment (AD&D) Insurance	Securian Life Insurance Company	400 Robert Street St. Paul, MN 55101 888-658-0193

PLAN	PLAN CARRIER	CONTACT INFORMATION
Flexible Spending Accounts (Health Care/Dependent Daycare)	ADP	ADP Spending Accounts P.O. Box 34700 Louisville, KY 40232 866-363-7150 www.spendingaccounts.info myspendingaccount.adp.com – if you already have an ADP account
Commuter Benefits Program	ADP	ADP Spending Accounts P.O. Box 34700 Louisville, KY 40232 866-363-7150 www.spendingaccounts.info myspendingaccount.adp.com – if you already have an ADP account

Claims and appeal process

Filing a claim

The claims filing procedures are set forth in the specific benefit section, for example “Medical Coverage” or “Dental Coverage,” or call your insurance carrier. In general, any participant or beneficiary under the Plan (or his or her authorized representative) may file a written claim for benefits using the proper form and procedure. A claimant can obtain the necessary claim forms from the Claims Administrators. When the Claims Administrator receives your claim, it will be responsible for reviewing the claim and determining how to pay it on behalf of the Plan.

Claims Administrators – Fully Insured

Compass Group provides the following benefits under the Plan through contracts with the insurance companies listed below. The Medical, Dental, Vision, Life, Basic, Supplemental & Dependent Life, Accidental Death and Dismemberment and Long Term Disability benefits of the Plan are guaranteed under contracts of insurance with the insurance companies listed below. The insurance companies administer claims for those benefits and are solely responsible for providing benefits.

Medical	<ul style="list-style-type: none"> • Kaiser Permanente • Group Health Cooperative of Puget Sound • Aetna Global (Antarctica) • Triple S Salud (Puerto Rico) • CommunityCare (Oklahoma) • HMSA (Hawaii)
Dental	<ul style="list-style-type: none"> • Delta Dental of Puerto Rico • Cigna Managed Care Dental
Vision	<ul style="list-style-type: none"> • Vision Service Plan (VSP)
Basic, Supplemental & Dependent Life, Accidental Death and Dismemberment (AD&D)	<ul style="list-style-type: none"> • Securian Life Insurance Company
Short Term Disability (STD)	<ul style="list-style-type: none"> • Aetna
Long Term Disability (LTD) Insurance	<ul style="list-style-type: none"> • Aetna

Claims Administrators – Self-Insured

Non-HMO Medical Plans, Prescription Drug, Dental, the Health Care Flexible Spending Account and Dependent Daycare Flexible Spending Account are self-insured. Compass Group has the fiduciary responsibility for determining whether you are entitled to benefits and authorizing payment under the Non-HMO Medical Plans, Prescription Drug, Dental, the Health Care Flexible Spending Account and Dependent Daycare Flexible Spending Account. Benefits are paid out of the general assets of the Company and are not guaranteed under a contract or policy of insurance.

Medical	<ul style="list-style-type: none"> • Aetna • BlueCross BlueShield of NC • UnitedHealthcare
Prescription Drug	<ul style="list-style-type: none"> • CVS Caremark™
Dental	<ul style="list-style-type: none"> • Cigna PPO Plan
Flexible Spending Accounts (Health Care/Dependent Daycare)	<ul style="list-style-type: none"> • ADP

This section provides general information about the claims and appeals procedure applicable to the Plan under ERISA. Note that state insurance laws may provide additional protection to claimants under insured arrangements and if so, those rules will apply. See the Benefit Booklets for more information.

For Medical benefits, the Plan will comply with additional claim and appeal rules required under Health Care Reform. You will be notified if any of these new rules impact your claim. These rules will not apply to Dental or Vision claims or Health Care Flexible Spending Account claims.

Claim-related definitions

Claim

Any request for plan benefits made in accordance with the plan's claims-filing procedures, including any request for a service that must be pre-approved.

The Plan recognizes four categories of health benefit claims:

Urgent Care Claims

"Urgent care claims" are claims (other than post-service claims) for which the application of non-urgent care time frames could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function or, in the judgment of a physician, would subject the patient to severe pain that could not be adequately managed otherwise.

Pre-service Claims

"Pre-service claims" are claims for approval of a benefit if the approval is required to be obtained before a patient receives healthcare (for example, claims involving preauthorization or referral requirements).

Post-Service Claims

"Post-service claims" are claims involving the payment or reimbursement of costs for healthcare that has already been provided.

Concurrent Care Claims

"Concurrent care claims" are claims for which the Plan previously has approved a course of treatment over a period of time or for a specific number of treatments, and the Plan later reduces or terminates coverage for those treatments. A concurrent care claim may be treated as an "urgent care claim," "pre-service claim," or "post-service claim," depending on when during the course of your care you file the claim. However, the Plan must give you sufficient advance notice of the initial claims determination so that you may appeal the claim before a concurrent care claims determination takes effect.

Adverse Benefit Determination

If the Plan does not fully agree with your claim, you will receive an "adverse benefit determination" — a denial, reduction, or termination of a benefit, or failure to provide or pay for (in whole or in part) a benefit. An adverse benefit determination includes a decision to deny benefits based on:

- An individual being ineligible to participate in the Plan;
- Utilization review;
- A service being characterized as experimental or investigational or not medically necessary or appropriate; and
- A concurrent care decision; and
- Certain retroactive terminations of coverage, whether or not there is an adverse effect on any particular benefit at that time.

Initial claim determination

For each of the Plan options, the Plan has a specific amount of time, by law, to evaluate and respond to claims for benefits covered by the Employee Retirement Income Security Act of 1974 (ERISA). The period of time the Plan has to evaluate and respond to a claim begins on the date the Plan receives the claim. If you have any questions regarding how to file or appeal a claim, contact the Claims Administrator for the benefit at issue. The timeframes on the following pages apply to the various types of claims that you may make under the Plan, depending on the benefit at issue.

In the event of an adverse benefit determination, the claimant will receive notice of the determination. The notice will include:

- The specific reasons for the adverse determination;
- The specific plan provisions on which the determination is based;
- A request for any additional information needed to reconsider the claim and the reason this information is needed;
- A description of the plan's review procedures and the time limits applicable to such procedures;
- A statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;

- If any internal rules, guidelines, protocols or similar criteria was used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request;
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request; and
- For adverse determinations involving urgent care, a description of the expedited review process for such claims. This notice can be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than 3 days after the oral notice.

For Medical claims, the notice will include information sufficient to identify the claim involved. This includes:

- the date of service;
- the healthcare provider;
- the claim amount (if applicable); and
- the denial code.

For Medical claims, the notice will also include:

- a statement that diagnosis and treatment codes (and their meanings) will be provided upon request;
- a description of the Plan's standard used in denying the claim. For example, a description of the "medical necessity" standard will be included;
- in addition to the description of the Plan's internal appeal procedures, a description of the external review processes; and
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes.

Time Frames for Initial Claims Decisions

Time frames generally start when the Plan receives a claim. (See the special rule for “concurrent care” decisions to limit previously-approved treatments.) Notices of benefit determinations generally may be provided through in-hand delivery, mail, or electronic delivery, before the period expires, though oral notices may be permitted in limited cases. A reference to “days” means calendar days. Health Care FSA claims are considered non-urgent “post-service” claims.

MEDICAL, DENTAL, VISION, EAP & HEALTH CARE FSA PLANS				
	URGENT CARE CLAIMS	NON-URGENT “PRE-SERVICE” CLAIMS	NON-URGENT “POST-SERVICE” CLAIMS	“CONCURRENT CARE” DECISION TO REDUCE BENEFITS
Time frame for Providing Notice	<p>Notice of determination (<i>whether adverse or not</i>) must be provided by the Plan as soon as possible considering medical exigencies, but no later than 72 hours.</p> <p>If you request in advance to extend concurrent care, the Plan shall provide notice as soon as possible taking into account medical exigencies, but no later than 24 hours of receipt of the claim, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.</p>	<p>Notice of determination (<i>whether adverse or not</i>) must be provided by the Plan within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days.</p>	<p>Notice of adverse determination must be provided within a reasonable period of time, but no later than 30 days.</p>	<p>Notice of adverse determination must be provided by the Plan enough in advance to give you an opportunity to appeal and obtain decision before the benefit at issue is reduced or terminated.</p>
Extensions	<p>If your claim is missing information, the Plan has up to 48 hours (subject to decision being made as soon as possible) from the earlier of the Plan’s receipt of the missing information, or the end of the period afforded to you to provide the missing information, to provide notice of determination.</p>	<p>The Plan has up to 15 days, if necessary due to matters beyond the Plan’s control, and must provide extension notice before initial 15-day period ends.*</p>	<p>The Plan has up to 15 days, if necessary due to matters beyond the Plan’s control, and must provide extension notice before the initial 30-day period ends.*</p>	N/A
Period for Claimant to Complete Claim	<p>You have a reasonable period of time to provide missing information (no less than 48 hours from when you are notified by the Plan that your claim is missing information).</p>	<p>You have at least 45 days (90 days for BCBSNC) to provide any missing information.</p>	<p>You have at least 45 days (90 days for BCBSNC) to provide any missing information.</p>	N/A
Other Related Notices	<p>Notice that your claim is improperly filed or that information is missing must be provided by the Plan as soon as possible (no later than 24 hours after receipt of the claim by the Plan).</p>	<p>Notice that your claim is improperly filed must be provided by the Plan as soon as possible (no later than 5 days after receipt of the claim by the Plan).</p>	N/A	N/A

Appealing a claim

The following section generally describes the Plan's internal claim appeals process. The appeals processes of fully insured health plans may vary somewhat. Please see your Benefit Booklets for more information on fully insured health benefits.

If you receive notice of an adverse benefit determination and disagree with the decision, you are entitled to apply for a full and fair review of the claim and the adverse benefit determination. You (or an appointed representative) can appeal and request a claim review in accordance with the time frames described in the chart below. The request must be made in writing, except for urgent care claims which you may file orally or in writing, and should be filed with the appropriate Claims Administrator as listed on pages 112-114. If you don't appeal on time, you lose your right to later object to the decision.

Medical coverage for you and your dependents will continue pending the outcome of an internal appeal. This means that the Plan will not terminate or reduce any ongoing course of treatment without providing advance notice and the opportunity for review.

The Claims Administrator will forward the appeal request to the appropriate named fiduciary for review. The review will be conducted by the Claims Administrator (if serving as the reviewer for appeals) or other appropriate named fiduciary of the Plan. In either case, the reviewer will not be the same individual who made the initial adverse benefit determination that is the subject of the review, nor the subordinate of such individual (including any physicians involved in making the decision on appeal if medical judgment is involved). Where the adverse determination is based in whole or in part on a medical judgment, the reviewer will consult with an appropriate healthcare professional. No deference will be afforded to the initial adverse benefit determination.

You will have the opportunity to submit written comments, documents, records, and other information relating to the claim; and you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. Whether a document, record, or other information is relevant to the claim will be determined in accordance with the applicable Department of Labor (DOL) regulations. You also are entitled to the identification of medical or vocational experts whose advice was obtained on behalf

of the Plan in connection with your adverse benefit determination. The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim without regard to whether such information was submitted or considered in the initial benefit determination.

If the Plan fails to strictly adhere to all the requirements of the internal claims and appeals process with respect to your medical claim, you are deemed to have exhausted the internal claims and appeals process. In this case, you may seek an external review or pursue legal remedies (as discussed below) without waiting for further Plan action. However, this will not apply if the error was de minimus, if the error does not cause harm to the claimant, if the error was due to good cause or to matters beyond the Plan's control, if it occurs in context of good faith exchange of information, or if the error does not reflect a pattern or practice of noncompliance. In that case, you may resubmit your claim for internal review and you may ask the Plan to explain why the error is minor and why it meets this exception.

Additionally, if your claim is an Urgent Care Claim or a claim requiring an ongoing course of treatment, you may begin an expedited external review before the Plan's internal appeals process has been completed.

The Claims Administrator will provide you with written notification of the Plan's determination on review, within the time frames described on page 119. For urgent care, all necessary information, including the benefit determination on review, will be transmitted between the Plan and the claimant by telephone, fax, or other available similarly expeditious method. In the case of an adverse benefit determination, such notice will indicate:

- The specific reason for the adverse determination on review;
- Reference to the specific provisions of the Plan on which the determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- A description of your right to bring a civil action under ERISA following an adverse determination on review;

- If any internal rules, guidelines, protocols or similar criteria were used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request; (for health and disability claims)
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request; (for health and disability claims) and
- A description of the voluntary appeals procedure under the Plan, if any, and your right to obtain additional information upon request about such procedures.

For Medical claim adverse benefit determinations, the notice will include information sufficient to identify the claim involved. This includes:

- The date of service;
- The healthcare provider;
- The claim amount (if applicable); and
- The denial code.

Time Frames for Appeals Process

The claims appeals procedures for a specific benefit are set forth in the Benefit Booklets for that benefit. Please consult the Benefit Booklet for the specific benefit involved. Where not otherwise covered by the Benefit Booklets, the following procedures will apply. The time frame for filing an appeal starts when you receive written notice of adverse benefit determination. The time frame for providing a notice of the appeal decision (a “notice of benefit determination on review”) starts when the appeal is filed in accordance with the Plan’s procedures. The notice of appeals decision may be provided through in-hand delivery, mail, or electronic delivery before the period expires. Urgent care decisions may have to be delivered by telephone, facsimile, or other available expeditious method. References to “days” mean calendar days. The Plan can require two levels of mandatory appeal review.

For Medical claims, the notice will also include:

- A statement that diagnosis and treatment codes (and their meanings) will be provided upon request;
- A description of the Plan’s standard used in denying the claim. For example, a description of the “medical necessity” standard will be included;
- In addition to the description of the Plan’s internal appeal procedures, a description of the external review processes; and
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes.

The time periods for providing notice of the benefit determination on review depends on the type of claim, as provided in the following chart.

All decisions are final and binding unless determined to be arbitrary and capricious by a court of competent jurisdiction.

MEDICAL, DENTAL, VISION, EAP & HEALTH CARE FSA PLANS			
	URGENT CARE CLAIMS	NON-URGENT “PRE-SERVICE” CLAIMS	NON-URGENT “POST-SERVICE” CLAIMS
Period for Filing Initial Appeal	You have at least 180 days.	You have at least 180 days.	You have at least 180 days.
Time frame for Providing Notice of Benefit Determination on Review	As soon as possible taking into account medical exigencies, but not later than 72 hours after receipt of request for review.	The Plan has up to 30 days, if necessary due to matters beyond the Plan’s control, and must provide extension notice before initial 30-day period ends.*	The Plan has up to 30 days, if necessary due to matters beyond the Plan’s control, and must provide extension notice before the initial 30-day period ends.*
Extensions	None.	None.	None.

Second level appeals

If you are not satisfied with the determination of the plan carrier on your first level appeal, you can submit a second level appeal to the plan administrator. All second level appeals except those involving urgent care should be submitted in writing within 180 days (60 days for UnitedHealthcare and Aetna) after you receive the notice of determination on your first level appeal. Note: Second level appeals are not allowed for benefits or services that are clearly excluded by this booklet, or for quality of care complaints.

Like first level appeals, the review of a second level appeal will not be based on prior determinations and will be conducted by someone other than individuals involved in the prior determinations or subordinates of such individuals. Also, if the first level appeal was denied based on a medical judgment, the plan administrator will consult a health professional other than the professional consulted for the first level appeal.

The plan administrator will provide you written or electronic notification of the determination, as follows:

- For appeals of pre-service claims, not later than 15 days after receipt of your request for a second level appeal (45 days for BCBSNC).
- For second level appeals of post-service medical or dental claims, not later than 30 days after receipt of your request for a second level appeal (45 days for BCBSNC).

If more time or information is needed to make the determination, the plan administrator will notify you in writing to request an extension of up to 15 days and to specify any additional information needed to complete the review.

You will be notified in writing of a decision within five business days after the determination is made, and within the review timeframes above if the requested coverage is denied.

Denial notifications of second level appeals will include the information listed above for first level appeal denials.

You may also receive assistance from the Employee Benefits Security Administration at 866-444-3272.

External review

If you choose, you may obtain an external review of a denied claim under the medical plan options provided:

- You have exhausted the appeal process for denied claims, as outlined above and you have received a final denial;
- The final denial was based upon a lack of medical necessity, or the experimental or investigational nature of the proposed service or treatment; and
- The cost of the service or treatment at issue exceeds \$500.

An external review is a review by an independent physician with appropriate expertise in the area at issue. The review is of claim denials based upon lack of medical necessity, or the experimental or investigational nature of a proposed service or treatment. The external review process is completely voluntary; you need not complete an external review process before pursuing other remedies allowed by law.

If you meet the eligibility requirements, you receive written notice of your right to request an external review when the final decision on your internal appeal is rendered. Either you or an individual acting on your behalf must submit an *External Review Request Form* to the plan carrier. You also must submit a copy of your coverage denial letter and any other information you wish to be reviewed in support of your request. Your written request for an external review must be submitted to the plan carrier within 60 calendar days after you receive the final decision on your internal appeal (four months for BlueCross BlueShield of NC).

The plan carrier contacts the external review organization that will conduct your external review. The organization then will select an independent physician with appropriate expertise in the area at issue to perform the external review. In rendering a decision, the external reviewer may consider any appropriate credible information submitted by you with the *External Review Request Form*, and must follow Compass Group's benefit plan contractual documents and plan criteria governing the benefits.

In general, the external review organization notifies you of the decision within 30 calendar days of the plan carrier's receipt of a properly completed *External Review Request Form* (45 days for BCBSNC). The notice states whether the prior determination was upheld or reversed, and briefly explain the basis for the determination. The decision of the external reviewer is binding on the plan, except where the

plan carrier or the plan can show reviewer conflict of interest, bias or fraud. In such cases, you are notified, and the matter is promptly resubmitted for consideration by a different reviewer.

You are responsible for the cost of compiling and sending information that you wish to be reviewed by the external review organization to the plan carrier. The plan carrier pays the cost for sending this information to the external review organization. The plan carrier also pays the professional fee for the external review.

For an individual to act on your behalf in connection with an external review, you need to specifically consent to the representation by signing the appropriate line on the *External Review Request Form*.

To obtain more information about the external review process, call your plan carrier's member service number on the back of your ID card.

Expedited external review

An expedited review is available when your treating physician certifies on a separate *Request for Expedited External Review Form* (or by telephone with prompt written follow-up) the clinical urgency of the situation. "Clinical urgency" means that a delay (waiting the full 30 calendar day period, or 45 calendar day period for BCBSNC) in receiving the service or treatment would jeopardize your health. Expedited reviews are decided within five calendar days of receipt of the request. In the case of expedited reviews, you are initially notified of the determination by telephone, followed immediately by a written notice delivered by expedited mail or fax.

Self-insured and non-insured disability benefits

For a description on applying for disability benefits, see page 70 for STD and page 72 for LTD.

Benefit determination for STD claims

Aetna Life for STD claims ("STD insurance carrier") will notify you in writing regarding its determination after it receives your disability claim. The STD program will be governed in accordance with the Compass Group Short Term Disability Policy contained in the HR Policy and Procedure Manual.

Benefit determination for LTD claims

Aetna Life for LTD claims ("LTD insurance carrier") will notify you in writing regarding its initial determination within a reasonable time — not to exceed 45 days from the date that it receives your disability claim.

Before the expiration of the 45-day time period, the LTD insurance carrier will, among other things:

- Assign the claim to a disability claims professional
- Verify whether the associate is covered under the plan
- Assess whether the associate meets the plan's eligibility requirements
- Investigate and gather facts regarding the disability claim
- Evaluate medical and vocational reports
- Make a determination regarding the claim for disability benefits

The LTD insurance carrier may request in writing two written 30-day extensions if it determines that they are necessary due to matters beyond its control. For example, the LTD insurance carrier may request an extension if you, your employer or your physician fails to submit requested information or documents necessary to process your claim.

You will receive a 30-day extension notice prior to the expiration of the initial 45-day period. This extension stops or suspends the initial 45-day time period and explains in writing what the unresolved issues are that prevent a determination regarding your claim for disability benefits. In addition, this notice may request that you provide specified information or documents to resolve those issues so that the LTD insurance carrier can make a determination regarding your claim for disability benefits.

ERISA affords you 45 days to provide the specified information or documentation necessary to resolve the issues raised in the 30-day extension notice.

The 30-day extension notice will inform you that the LTD insurance carrier expects to notify you of a determination within 30 days from the date it receives the specified information, documentation or the expiration of the 45-day time period to submit the specified information or documentation.

If you do not provide the required information or documents within the 30-day extension period, the LTD insurance carrier may make a determination regarding the claim

without the requested information or documentation. You will receive a determination within the time remaining in the initial 45-day period starting from the date the claims process was tolled (stopped, suspended).

During the claims process, you must be under the continuous care of a licensed physician who may be required periodically to certify that you continue to be disabled. The LTD insurance carrier also reserves the right to request that you undergo an examination by an independent physician, selected by the LTD insurance carrier, to verify your disability.

The LTD insurance carrier will contact you if it determines that you are entitled to disability benefits.

If the LTD insurance carrier makes an adverse determination, denying, reducing or terminating disability benefits, you will be notified in writing.

The written notification will contain the following:

- The specific reason(s) for the denial or adverse determination.
- Reference to the specific plan provision(s) on which the adverse determination is based.
- A description of any additional information or material needed from you to complete the claim and an explanation of why such additional information or material is necessary.
- Identification of the medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse determination, without regard to whether the advice was relied upon in the making of the adverse determination.
- A description of the plan's review or appeal procedure, including time limits, plus a statement of the claimant's rights to bring a civil action under ERISA with respect to any adverse determination after an appeal.
- A statement and a copy of the internal rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination.
- A statement if the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit. The statement will explain how your medical circumstances, the scientific or clinical judgment applied to the terms of the plan resulted in an adverse determination.

Appeal or review of adverse determination

Once the appeal is received, the LTD insurance carrier will conduct a full and fair review of your claim.

The LTD insurance carrier's Disability Claim Appeals Committee will review your claim. The Committee does not consist of claims professionals that either decided or participated in the initial adverse determination.

There is no fee to file a written request for an appeal.

You must submit your written appeal request within 180 days from the date you receive the adverse determination. The written adverse determination notification will specify to whom and where to mail your written appeal request.

Written appeals must include the reasons why the adverse determination was wrong and include any documents or comments that support reversal of the initial adverse determination.

Once an appeal is received, the Committee will review and make a determination regarding the merits of the appeal within a reasonable time — not to exceed 45 days.

The Committee may request in writing one 45-day extension if it determines that it is necessary to extend the time to make a determination due to matters beyond its control. For example, the Committee may seek to verify any written comments, documents or other information you submitted that were not considered during the initial claims process.

You will receive a 45-day extension notice prior to the expiration of the initial appeal period. This extension stops or suspends the initial period and will explain in writing the special circumstances requiring the extension. In addition, the 45-day extension notice will specify what is required in order for the Committee to make a determination.

The Committee will notify you in writing of its determination prior to the expiration of the 45-day extension period.

During the appeal period, you may request access to and copies of information relevant to the claim without charge. Information relevant to the claim includes documents submitted, considered, generated and relied upon in the course of making an adverse determination. For example, you may request access to or copies of your claim form, employer's statement, attending physician statement, independent medical or vocational examination reports.

Prior to the date the Committee convenes to review your appeal, you have the opportunity to submit written comments, documents and other information related to the claim. The Committee will consider the written comments, documents or other information you submit regardless of whether or not it was considered during the initial determination.

You will receive written notification if the Committee upholds the adverse determination. The written notification will include the following:

- The specific reason(s) for the adverse determination.
- Reference to the specific plan provision(s) on which the benefit determination is based.
- A statement and a copy of the internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination.
- Identification of the medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse determination, without regard to whether the advice was relied upon in making the benefit determination.
- A statement of the claimant's rights to bring a federal suit under ERISA with respect to any adverse determination after an appeal; and
- A statement if the adverse determination is based on a medical necessity, experimental treatment or similar exclusion or limit. The statement will explain how your medical circumstances, the scientific or clinical judgment and the terms of the plan resulted in an adverse determination. This statement will be provided free of charge upon request if the adverse determination was based on medical necessity, experimental treatment or similar exclusion or treatment.

Judicial review of adverse determinations

All interpretations, determinations and decisions of the insurance carrier with respect to any claim will be its sole decision based upon plan documents and will be deemed final and conclusive. If you disagree with the decision upholding an adverse determination, you may file a civil suit in federal district court where the plan is administered or where you live.

Other important claims information

ERISA requires the LTD insurance carrier to follow all of its rules, procedures, guidelines and protocols while it processes your disability claim. You may file a civil suit in federal district court where the plan is administered or where you live if the LTD insurance carrier fails to follow all of its rules, procedures, guidelines and protocols while it processes your disability claim.

The LTD insurance carrier has the right to utilize any reasonable method, such as a debt collection agency, or file a civil action to recover any amount overpaid. An overpayment may occur by fraud or any error the LTD insurance carrier makes in processing a claim.

An overpayment may also occur if you receive a deductible source of income while receiving disability benefits. A deductible source of income would be the following:

- The amount that you would receive under:
 - A Workers' Compensation law.
 - An occupational disease law.
 - Any other acts or laws with similar intent.
- The amount that you receive or are entitled to receive as disability income payments under any:
 - State compulsory benefit act or law.
 - Other group insurance plan.
 - Automobile liability insurance policy.
 - Governmental retirement system as a result of your job with your employer.
 - Union contract or collective bargaining agreement authorized under the Labor Management Relations Act.
- The amount that you, your spouse and children receive or are entitled to receive as disability payments or retirement payments under:
 - The United States Social Security Act.
 - The Canada Pension Plan.
 - The Quebec Pension Plan.
 - Any similar pension plan or act.

- The amount that you:
 - Received as disability payments under your employer’s retirement plan.
 - Voluntarily elect to receive as retirement payments under your employer’s retirement plan.
 - Are eligible to receive as retirement payments when you reach the later of age 62 or normal retirement, as defined in your employer’s retirement plan.
- The amount you receive as a result of any action under the Jones Act.
- The amount you receive under the mandatory portion of any “no fault” motor vehicle plan.

Any inconsistency between the claims procedure outlined herein and the Aetna Life Certificate of Coverage will be governed by the Certificate of Coverage. You may obtain a copy of the Certificate of Coverage by contacting the Compass Group Benefits Department.

All other self-insured and non-insured benefits

Claims for benefits

Claims for self-insured and non-insured benefits that are not health or disability benefits under the Benefit Plan must be submitted on the appropriate forms, available from the Benefits Department, to the representatives designated on the forms and hereinafter referred to as the “plan carrier.” Note that the forms will specify any additional information that must be provided with a claim for benefits.

The plan carrier will process the claim within 90 days (45 days for disability claims) after the claim is filed. If an extension of time for processing is required due to special circumstances, written notice will be given to you before the end of the initial 90-day period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the plan carrier expects to render its final decision. In no event can the extension period exceed a period of 90 days (30 days for disability claims) from the end of the initial 90-day period.

If additional information is requested of you, you will be given 45 days from the notice date to provide the specific information. During this time, the 90-day time limit for issuing a decision is suspended until the earlier of the date you provide that information to the plan carrier, or the expiration of the 45-day period within which you are required to furnish that information. If you do not furnish the requested

information by the end of the 45-day period, the plan carrier will proceed with its determination based on the documentation provided up to that date.

If a claim is wholly or partially denied, the plan carrier will notify you within 90 days following receipt of the claim, or 180 days in the case of an extension for special circumstances. The denial notification will:

- State the specific reason or reasons for the denial.
- Specifically refer to the pertinent plan provisions on which the denial is based.
- Describe any additional material or information necessary to support the claim.
- Explain why the additional information or material is necessary.
- Describe the plan’s appeal procedures, including its time limits.

If notice of the denial of a claim is not furnished within the 90/180-day period, the claim is considered denied and you will be permitted to proceed to the appeals stage.

Appeals procedure

You or your authorized representative have 60 days (180 days for any disability claims) after receipt of a claim denial to appeal the denial to the plan carrier and to receive a full and fair review of the claim. As part of the review, you are allowed to review all plan documents and other papers that affect the claim and are allowed to submit issues and comments and argue against the denial in writing.

The plan carrier will conduct the review and decide the appeal within 60 days (45 days for disability claims) after the request for review is made. The plan carrier may ask you or Compass Group to submit such additional facts, documents, or other evidence as it deems necessary or advisable in making its review. During the review of your denied claim by the plan carrier, you may, upon written request, be permitted to review documents or materials that pertain to your claim. You also may submit written issues and comments that pertain to your claim.

If special circumstances require an extension of time for processing such as the need to hold a hearing if the plan procedure provides for such a hearing, written notice will be given to you before the end of the initial 60-day period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the

plan carrier expects to render its final decision. In no event can the extension period exceed a period of 60 days (45 days for disability claims) from the end of the 60-day period.

The decision will be written in clear and understandable language and will include specific reasons for the decision as well as specific references to the pertinent plan provisions on which the decision is based. If the decision is not made within the time limits specified above, the appeal will be considered denied. All interpretations, determinations and decisions of the reviewing entity with respect to any claim will be its sole decision based upon the plan documents and will be deemed final and conclusive. If your appeal is denied, whole or in part, you have the right to file suit in a state or federal court.

Compliance with regulations

It is intended that the claims procedures of all plans under the Benefit Plan be administered in accordance with the claims procedure regulations of the Department of Labor.

Other important claims information

If you fail to file a request for review in accordance with the claims procedures as set forth above, you will have no right to review or to bring an action in any court. The denial of your claim will become final and binding on all persons for all purposes except as otherwise provided by ERISA.

Your rights under ERISA

As a participant in the plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants in the plans are entitled to the following:

Receive information about your plans and benefits

You may examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plans, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the plans with the U.S. Department of Labor (DOL) and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

Upon written request to the plan administrator, you may obtain copies of documents governing the operation of the plans, including insurance contracts and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The plan administrator may make a reasonable charge for the copies.

In addition, you will receive a summary of the plan's annual financial reports. The plan administrator is required by law to furnish each participant with a copy of the summary annual reports.

Continue group health plan coverage

If there is a loss of coverage under the group health plans as a result of a qualifying event, you may continue certain healthcare coverage for yourself, spouse or dependents under COBRA. You or your dependents may have to pay for such coverage. Review this summary and the documents governing the plans on the rules governing your COBRA continuation coverage rights. See *Continuing Your Coverage Under COBRA* on page 98, for more information on COBRA.

Prudent actions by plan fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefits plan. The people who operate your plans, called "fiduciaries" of the plans, have a duty to do so prudently and in the interest of you and other participants and beneficiaries in the plans. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce your rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plans and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in federal court. In addition, if you disagree with the plans' decisions or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plans' money, or if you are discriminated

against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court. The court will decide who should pay court costs and legal fees.

If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with your questions

If you have any questions about your plans, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor (DOL), listed in your telephone directory or the Division of Technical Assistance and Inquiries, EBSA, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the EBSA publications hotline at 866-444-EBSA (3272).

Other rules and regulations

Uniformed Services Employment and Re-Employment Rights Act Of 1994 (USERRA)

The Benefit Plan is intended to comply at all times with the regulations of the Uniformed Services Employment and Reemployment Rights Act of 1994, (USERRA), for associates going into or returning from military service. Associates and dependents that lose healthcare coverage due to the associate's military leave of absence under USERRA may elect to continue coverage for up to 24 months. Any individual who elects to continue such coverage will be required to make the same premium payments as a COBRA participant.

For additional information concerning the USERRA, including your rights and responsibilities under USERRA, contact the Benefits Department at 877-311-4747.

No assignment

Except as may otherwise be specifically provided in plan documents, benefit arrangements, insurance contracts or applicable law, a participant's rights, interests or benefits

under the plans or the benefit arrangements shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, prior to being received by the persons entitled thereto under the terms of the plans or benefit arrangements and any such attempt shall be void.

Subrogation and reimbursement

Expenses for which a third party may be responsible

This plan does not cover:

1. Expenses incurred by you or your dependent (hereinafter individually and collectively referred to as a "participant,") for which another party may be responsible as a result of having caused or contributed to an injury or sickness.
2. Expenses incurred by a participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.

Subrogation/right of reimbursement

If a participant incurs a covered expense for which, in the opinion of the plan or its claim administrator, another party may be responsible or for which the participant may receive payment as described above:

1. **Subrogation:** The plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a participant may have against such party and shall automatically have a lien upon the proceeds of any recovery by a participant from such party to the extent of any benefits paid under the plan. A participant or his/her representative shall execute such documents as may be required to secure the plan's subrogation rights.
2. **Right of Reimbursement:** The plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the plan.

Lien of the plan

By accepting benefits under this plan, a participant:

- Grants a lien and assigns to the plan an amount equal to the benefits paid under the plan against any recovery made by or on behalf of the participant which is binding on any attorney or other party who represents the participant whether or not an agent of the participant or of any insurance company or other financially responsible party against whom a participant may have a claim provided said attorney, insurance carrier or other party has been notified by the plan or its agents;
- Agrees that this lien shall constitute a charge against the proceeds of any recovery and the plan shall be entitled to assert a security interest thereon;
- Agrees to hold the proceeds of any recovery in trust for the benefit of the plan to the extent of any payment made by the plan.

Additional terms

- No adult participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor dependent of said adult participant without the prior express written consent of the plan. The plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan's right of recovery shall be a prior lien against any proceeds recovered by the participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine," "Rimes Doctrine," or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.

- No participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan's recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called "Fund Doctrine," "Common Fund Doctrine," or "Attorney's Fund Doctrine."
- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any participant, whether under comparative negligence or otherwise.
- In the event that a participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

Misstatement of Fact

In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

Choice of medical provider

If your plan generally requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in the plan carrier's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Employer or, if you are a current member, your plan carrier contact number on the back of your ID card.

If your plan allows for the designation of a primary care provider for a child, you may designate a pediatrician as the primary care provider.

If your plan provides coverage for obstetric or gynecological care and requires the designation of a primary care provider then you do not need prior authorization from your plan carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in our network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating healthcare professionals who specialize in obstetrics or gynecology, contact your Employer or, if you are a current member, your plan carrier contact number on the back of your ID card.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour or 96-hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other healthcare provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain pre-certification for any days of confinement that exceed 48 hours or 96 hours. For information on pre-certification, contact your plan carrier.

Notice regarding Women's Health and Cancer Rights Act

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

1. All stages of reconstruction of the breast on which a mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.

For more information, you can visit this U.S. Department of Health and Human Services website, <http://www.cms.gov/home/regsguidance.asp>, and this U.S. Department of Labor website, http://www.dol.gov/ebsa/consumer_info_health.html.

Genetic Information

Title II of the Genetic Information Nondiscrimination Act of 2008 protects applicants and employees from discrimination based on genetic information in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment. GINA also restricts employers' acquisition of genetic information and strictly limits disclosure of genetic information. Genetic information includes information about genetic tests of applicants, employees, or their family members; the manifestation of diseases or disorders in family members (family medical history); and requests for or receipt of genetic services by applicants, employees, or their family members.

It is the intention of the Employee Benefit Plan of the Compass Group USA, Inc., to comply with Title II of GINA. If you have any questions with regard to GINA, please contact the Benefits Department at 877-311-4747.

Important Notice for Compass Group Associates and Dependents Age 65 or Older About Your Prescription Drug Coverage and Medicare

This notice has information about your current prescription drug coverage with Compass Group 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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. Compass Group has determined that the prescription drug coverage offered by the Compass Group Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Creditable Coverage.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. 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.

If you decide to join a Medicare drug plan, your Compass Group coverage will be affected. You cannot drop your Compass Group prescription drug coverage and retain your Compass Group medical coverage; you would only be able to drop your Compass Group prescription drug coverage by dropping your entire medical plan.

If you do decide to join a Medicare drug plan and drop your Compass Group medical/prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

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

For more information about this notice or your current prescription drug coverage, contact:

Compass Group Benefits Department
2400 Yorkmont Road
Charlotte, NC 28217
877-311-4747

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).

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 whether or not you are required to pay a higher premium (a penalty).

Notice Regarding Wellness Program

The Compass Group wellness program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You are not required to complete the HRA.

However, employees who choose to participate in the wellness program will receive an incentive of \$3 per week toward their medical deductions for completion of the INTERVENT HRA. Although you are not required to complete the HRA, only employees who do so will receive the \$3 per week toward their medical deductions.

The information from your HRA will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as INTERVENT's lifestyle health coaching, or the Livongo for Diabetes program. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Compass Group may use aggregate information it collects to design a program based on identified health risks in the workplace, the Compass Group wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) an INTERVENT health coach or a Livongo Certified Diabetes Educator in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the Compass Group Benefits Department at 877-311-4747.

Glossary

Eligibility Terms

Orientation Period – An orientation period is the time when Compass Group and a new associate evaluate whether the employment situation is satisfactory for each party, and standard orientation and training processes begin. The one-month period begins on the associate's start date and ends on the day before the corresponding date in the next calendar month.

Example: Ann starts working for Compass Group on May 18. Ann's Orientation Period will end on June 17.

Waiting Period – A waiting period is the time between the end of your orientation period and the date an associate is first eligible for full-time benefits. Full-time team member associates are eligible for full-time benefits on the first day of the month following two months of service after the end of your orientation period.

Example: Ann's Waiting Period begins on June 18 and she will be eligible for benefits on September 1.

Initial Measurement Period – The initial measurement period for Compass Group associates is a 12-month period that's used to measure your hours worked to determine your eligibility for full-time benefits. It starts on the first of the month following your hire date or on the first of the month if you were hired on the first day of a month, and continues for 12 months. In the 13th month Compass Group will measure the hours you worked in the previous 12 months. If you average 30 or more hours per week during the 12-month period, you will be eligible for full-time benefits for one year, beginning the month following the measurement.

Example: Ann starts working for Compass Group on May 18. Her initial measurement period will start on June 1 and end on May 31 of the following year. During the month of June in the following year, Compass Group will measure the hours Ann worked during the prior 12-month period. If she worked an average of 30 or more hours per week, Ann will be eligible for full-time benefits for a 12 month stability period.

Annual Measurement Period – Compass Group uses measurement periods to assess an associate's benefit eligibility. A measurement period is a look-back period (12 months) used to determine whether an associate is working an average 30 hours or more per week. If an associate is determined to be benefits eligible, they are eligible during a subsequent 12-month coverage period, called a stability period.

Hours that count toward a measurement period and eligibility for benefits include:

- The hours for which you are paid to work, and
- The hours for which you are paid for: vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or a paid leave of absence.

Once an associate has completed a full measurement period, they are considered an ongoing associate. Employment status and benefits eligibility are recalculated for ongoing associates annually (Annual Measurement Period), based on the average of actual hours paid in the previous 12 months.

Administrative Period – After the initial measurement period, the administrative period is the one-month period following the initial measurement period. After the standard measurement period, the administrative period is the 90 days in October, November and December when Compass Group measures hours worked, notifies associates about eligibility for benefits and associates make their benefit elections.

Stability Period – This is a 12-month period following an initial measurement period (initial stability) or annual measurement period (on-going stability) that determines your eligibility for benefits. If during either measurement period an employee worked 30 or more hours a week, the associate will be eligible for full-time benefits for the ensuing 12-month stability period.

Example: Ann is a new team member associate that starts work on May 18, 2017 and she is hired as a full-time associate. In June of 2017, Compass Group will measure the hours Ann worked in the previous 12 months. If she averages 30 hours a week, she is guaranteed an option to continue those full-time benefits through June of 2018.

Benefit Terms

Actively at work – To be eligible for life and disability insurance, an associate must be actively at work performing his/her customary duties for Compass Group. If the associate is not actively at work on the date the insurance begins, or on the effective date of an increase in his/her amount of insurance, he/she will not be eligible for the coverage until he/she returns to active work.

Beneficiary – A beneficiary is a person, organization or trust designated to receive the life insurance payment in the event of the associate's death.

“Best in Market” – The “Best in Market” medical carrier provides the deepest network discounts and broadest network access at a preferred price.

Coinsurance – The percentage of charges you pay for covered services, in addition to any applicable deductible.

Copayment/Copay – The amount you pay, generally a flat dollar amount, out-of-pocket before certain network services are covered in full by a managed healthcare option (e.g., office visit or prescription drugs).

Deductible – The amount you pay out-of-pocket each year before the plan begins to pay benefits.

Evidence of Insurability – A statement of medical history, which the insurance company uses to determine whether an applicant will be approved for life insurance coverage. Evidence of Insurability is required for any amount of life insurance greater than the guaranteed amount.

Fully-Insured Plan – A plan where an employer contracts with a carrier to assume financial responsibility for the enrollees' claims and for all administrative costs.

Generic Drugs – Generic drugs are drugs for which the patent has expired, allowing other manufacturers to produce and distribute the product under a generic name. Generics are essentially a chemical copy of their brand name equivalents. The color or shape may be different, but the active ingredients must be the same for both.

Guaranteed issue – The amount of life insurance an associate can receive without evidence of insurability when first eligible under the plan, provided enrollment is made within the enrollment period.

In-network – An in-network provider is under contract to a health plan to provide services. In-network providers can include doctors, hospitals, optometrists, dentists, orthodontists, pharmacies, and/or other designated service providers. Generally, your out-of-pocket expenses are less when using in-network providers.

Lifetime maximum – The total pool of money payable for covered medical services received while you are insured.

Non-preferred Drugs – The most expensive of all prescription drugs. These drugs tend to be the latest, most heavily-marketed drugs.

Out-of-network – Healthcare providers who are not contracted with a carrier to provide services. Generally, your out-of-pocket expenses are more when using out-of-network providers.

Out-of-pocket maximum – The limit you pay for your share of covered expenses in a plan year. Once you reach the annual out-of-pocket maximum, the plan pays 100% of any other covered expenses for the rest of the plan year, up to the lifetime maximum. Note: The Compass Group Gold, Silver and Bronze plans have a separate medical vs. prescription drug out-of-pocket maximum.

Preferred Drugs – A list of approved drugs covered under the Prescription Drug Plan, which cost you less than the non-formulary/non-preferred drugs.

Secondary beneficiary – A secondary beneficiary is a person, organization or trust designated to receive the life insurance payment in the event of the death of your primary beneficiary(ies).

Self-Insured Plan – An employer contracts with a third party to deliver administrative services to the plan such as claims processing and billing. The client pays a fixed monthly administrative fee to the third party and takes full responsibility for funding claims. These claims costs vary from month to month based on health care use by covered persons (example: employees and dependents).

Spouse surcharge – An additional charge (surcharge) incurred if you elect to enroll your spouse into a Compass Group medical plan, and they have access to medical coverage through their employer. This surcharge will be deducted from your paycheck.

If your spouse does not have access to medical coverage through their employer or they work for Compass Group, the surcharge will NOT be deducted from your paycheck.

Tobacco products – Any product made with or derived from tobacco that is intended for human consumption, including any component, part, or accessory of a tobacco product. This includes, but is not limited to cigarettes, e-cigarettes, cigars, pipes, chewing tobacco, snuff, hookahs and other tobacco products.

Tobacco products do not include tobacco cessation aids approved by the FDA, such as:

- Over-the-counter nicotine replacement products (gum, patches, lozenges),
- All over-the-counter tobacco cessation products for adults ages 18 and older,
- Prescription nicotine replacement products (inhaler, nasal spray), and
- Non-nicotine replacement therapy prescription medications (Zyban, Chantix, etc.)

Tobacco surcharge – An additional charge (surcharge) incurred if you have used any tobacco product within two weeks of attesting to your tobacco use. The tobacco surcharge will be deducted from your paycheck.

Tobacco use – Any use of tobacco products four or more times per week within six months of attesting to your tobacco use. This attestation is completed at the time you enroll into a Compass Group medical plan. Tobacco use does not include the religious or ceremonial use of tobacco.