

Annual Limit Waiver Notice

Please read the special notice below that explains the annual limits for coverage options

The Affordable Care Act prohibits health plans from applying dollar limits below a specific amount on coverage for certain benefits. This year, if a plan applies a dollar limit on the coverage it provides for certain benefits in a year, that limit must be at least \$1.25 million.

Your health coverage, offered by Connecticut General Life Insurance Company, does not meet the minimum standards required by the Affordable Care Act described above.

Your coverage has an annual limit of:

Covered Services	Level 1	Level 2
Outpatient Care	up to \$1,000 per coverage year	up to \$1,500 per coverage year
Daily In-Hospital Care	\$100 per day up to 100 days (maximum of \$10,000) per coverage year	\$250 per day up to 100 days (maximum of \$25,000) per coverage year
Additional In-Hospital Surgery		up to \$1,500 per surgery
Additional Maternity-Related In-Hospital Services		up to \$1,500 per occurrence
Prescription Coverage	NA - Discount Program only	up to \$300 per coverage year, included in Outpatient limit
Accident Medical Coverage	up to \$2,500 per accident 2 accidents per coverage year	up to \$5,000 per accident 2 accidents per coverage year

This means that your health coverage might not pay for all of the health care expenses you incur.

For example, a stay in the hospital costs around \$1,853 per day. At this cost, your insurance would only pay for:	Level 1	Level 2
	\$100 per day	\$250 per day
Note: If you seek care at a network hospital, additional time may be covered because the network discount may result in a lower cost per day. If you are hospitalized for surgery or maternity care, your coverage may also pay for additional hospital services as described in your benefit booklet.		

Your health plan has requested that the U.S. Department of Health and Human Services waive the requirement to provide coverage for certain key benefits of at least \$1.25 million this year. Your health plan has stated that meeting this minimum dollar limit this year would result in a significant increase in your premiums or a significant decrease in your access to benefits. Based on this representation, the U.S. Department of Health and Human Services has waived the requirement for your plan until December 31, 2012.

If you are concerned about your plans lower dollar limits on key benefits, you and your family may have other options for health care coverage. For more information, go to: www.HealthCare.gov.

If you have any questions or concerns about this notice, contact CIGNA at 1-800-420-6308. In addition, you can contact your state's Consumer Assistance Program.

State	Primary #	State	Primary #	State	Primary #	State	Primary #
AL	(334) 241-4141	IL	(877) 527-9431	MT	(800) 322-6148	RI	(401) 462-9520
AK	(800) 467-8725	IN	(800) 622-4461	NE	(877) 564-7323	SC	(800) 768-3467
AZ	(800) 325-2548	IA	(877) 955-1212	NV	(888) 333-1597	SD	(605) 773-3563
AR	(855) 332-2227	KS	(800) 432-2484	NH	(800) 852-3416	TN	(615) 741-4737
CA	(800) 927-4357	KY	(877) 587-7222	NJ	(800) 446-7467	TX	(855) 839-2427
CO	(800) 930-3745	LA	(800) 259-5301	NM	(888) 427-5772	UT	(801) 528-3077
CT	(866) 466-4446	ME	(800) 965-7476	NY	(888) 614-5400	VT	(800) 917-7787
DE	(800) 282-8611	MD	(877) 261-8807	NC	(800) 546-5664	VI	(340) 773-6459
DC	(877) 685-6391	MA	(800) 272-4232	ND	(800) 247-0560	VA	(877) 310-6560
FL	(877) 693-5236	MI	(877) 999-6442	OH	(800) 686-1526	WA	(800) 562-6900
GA	(800) 656-2298	MN	(800) 657-3602	OK	(800) 522-0071	WV	(888) 879-9842
HI	(808) 586-2799	MS	(877) 314-3843	OR	(855) 999-3210	WI	(800) 236-8517
ID	(800) 721-3272	MO	(800) 726-7390	PA	(877) 881-6388	WY	(800) 438-5768

Health coverage is within your reach.



Plan Highlights:

- Doctor visits as low as \$10
- In-Hospital Benefit
- Up to \$10,000 Accident Coverage
- Prescription Drug Programs
- CIGNA 24-Hour Employee Assistance ProgramSM

Plans starting at only

\$11.⁶⁴ a week

Also Available:

- Dental/Vision** Plan

**The vision discount program is not insurance.

Hurry! Your opportunity to enroll ends soon.
Ofrecemos seguro médico. Favor de marcar el 1-877-552-5015.

Notice of Grandfathered Plan Status

This plan is being treated as a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your coverage may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the program administrator at 1-800-511-2902, or an explanation can be found on CIGNA's website at http://www.cigna.com/sites/healthcare_reform/customer.html.

If your plan is subject to ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

If your plan is a nonfederal government plan or a church plan, you may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.



STEP 1: Choose the plan that's right for you.

Please refer to the medical chart at the back of this brochure for more detailed information.

Starbridge is a sickness & accident plan that covers everyday medical expenses. It is not a major medical plan and is not designed to cover major health problems like heart disease or cancer.

Because these are limited-benefit plans, it's best to choose the highest level of coverage that you can afford. If you're having trouble matching your budget with your health plan needs, you may find the following guidelines useful, or you can contact a Starbridge Benefits Specialist for help at 1-877-552-5015.

Level 1 Plan



Weekly Rates

Myself only	\$11.64
Myself and 1 dependent	\$28.48
Family	\$43.09

*Stay healthy and active.
Plan for the unexpected.*

If you're healthy and active and have a limited budget, this plan is your best option.

"Even after I reach my benefit maximum, I still pay less at the doctor because CIGNA negotiates great discounts for me."

Level 2 Plan



Weekly Rates

Myself only	\$21.25
Myself and 1 dependent	\$52.56
Family	\$79.69

*Discover the security that comes with
health coverage. Feel better about life.*

If you're fairly healthy but looking for more than basic coverage, Starbridge Level 2 Plan is a reasonable option.

"Starbridge helps me with everyday medical expenses like prescriptions and doctor visits—plus it helps me budget for them."

STEP 2: Choose an additional plan option.



Dental/Vision Plan Weekly Rates*

Myself only	\$.425
Myself and 1 dependent . . .	\$.820
Family	\$.12.15

*The vision discount program is not insurance.

Dental/Vision Plan

Dental

It's more than just a pretty face: good health starts with your teeth and gums. If you think going to the dentist isn't really important, think again. Your dental health impacts the rest of your body in serious ways. Research shows that gum disease, an infection of your gums, puts you at risk for conditions such as heart disease, stroke, diabetes and pregnancy complications. And because gum disease is usually painless in the early stages, you may not even know that you have it. That's why going to the dentist is just as important as getting a check-up at the doctor's office.

Big savings on visits to the dentist...all for just a few dollars a week.

Starbridge offers a Dental Plan that is available to you as an additional plan option. You'll save on annual cleanings, fillings and even major procedures such as root canals. Don't wait—your health may depend on it!

Example of How the Dental Plan Works

For illustrative purposes only. Actual fee schedules vary by location.

Periodic Oral Exam	Average Cost	\$36
	CIGNA Network Discount*	-\$12
	Dental Plan reimburses you	-\$17 (see chart below)
	You Pay	\$7

* For a complete list of participating network dentists visit www.starbridge.com

This is how much you'll be reimbursed for each procedure:

Dental Plan Reimbursement Chart \$25 per person annual deductible		
Maximum Covered Charge	Maximum Covered Charge	Maximum Covered Charge
Oral Examination	X-Ray and Pathology	Prophylaxis and Fluoride
D0120 Periodic Oral Exam* \$17	D0210 Entire Dental Series (Intraoral) Including Bitewings** \$40	D1110 Prophylaxis for age 14 and over* \$30
D0140 Limited Oral Exam/Problem Focused \$27	D0220 Single Film - Initial \$7	D1120 Prophylaxis for age under 14* \$20
D0150 Comprehensive Oral Exam † \$27	D0230 Single Film - Each Additional \$7	D1203 Topical Application of Fluoride, Child* \$12
D9110 Emergency - Palliative Treatment \$38	D0240 Intra-Oral Occlusal Film** \$10	D1204 Topical Application of Fluoride, Adult* \$12
Amalgam Restoration for Primary/Permanent Teeth	D0250 Extraoral - First Film \$11	D1351 Sealant, Per Tooth \$16
D2140 Amalgam Filling - 1 Surface \$35	D0260 Extraoral - Each Additional \$9	Periodontics
D2150 Amalgam Filling - 2 Surfaces \$45	D0270 Bitewing Film, One* \$8	D4341 Scaling and Root Planing, Per Quadrant \$72
D2160 Amalgam Filling - 3 Surfaces \$56	D0272 Bitewing Films, Two* \$12	D4355 Full Mouth Debridement to Enable Comprehensive Periodontal Evaluation \$50
D2161 Amalgam Filling - 4 or more Surfaces \$64	D0274 Bitewing Films, Four* \$17	D4910 Periodontal Maintenance \$53
Synthetic Restorations	Extractions	Endodontics (excluding final restoration)
D2330 Composite Resin - 1 Surface \$42	D7140 Extraction-Erupted tooth or exposed root \$39	D3220 Therapeutic Pulpotomy \$20
D2331 Composite Resin - 2 Surfaces \$55	D7220 Removal Impacted Tooth - Soft Tissue \$45	D3310 Root Canal - Anterior \$125
D2332 Composite Resin - 3 Surfaces \$67	D7230 Removal Impacted Tooth - Partially Bony \$70	D3320 Root Canal - Bicuspid \$135
D2335 Composite Resin - 4 or more Surfaces \$69	D7240 Removal Impacted Tooth - Completely Bony \$85	D3330 Root Canal - Molar \$140
D2390 Composite Resin Crown, Anterior \$77	D7241 Removal Impacted Tooth - Completely Bony w/Unusual Surgical Complications \$85	
D2391 Composite Resin - 1 Surface Posterior \$50	D7250 Removal Residual Tooth Roots \$30	
D2392 Composite Resin - 2 Surfaces Posterior \$68	D7510 Incision & Drainage of Abscess \$45	
D2393 Composite Resin - 3 Surfaces Posterior \$85	D9220 General Anesthesia \$52	
		FOOTNOTES
		* Limited to once every 6 months
		† Limited to once every 12 months
		** Limited to once every 3 years

Vision Discount Program*

You and your covered family members receive a membership in the CIGNA Vision Network Savings Program.

- Save up to 40% on frames
- Save \$5 off routine exams and \$10 off contact lens exams

*The vision discount program is not insurance.

Questions? Call a Starbridge Benefits Specialist: 1-877-552-5015 • www.starbridge.com

Medical Benefits Chart (applies to each covered individual)

Starbridge is not a major medical plan.

Level 1 (Plan 128)

Level 2 (Plan 148)

Illness		
Outpatient Care deductible plan pays / you pay maximum amount paid by plan	\$50/year 80% - 20% \$1,000/year	\$100/year 80% - 20% \$1,500/year
Doctor Office Visits ¹ copay plan pays	\$15 100%	\$10 100%
Daily In-Hospital Benefit deductible plan pays maximum amount paid by plan	\$100/day up to 100 days \$0 100% \$10,000/year	\$250/day up to 100 days \$0 100% \$25,000/year
In-Hospital Surgery deductible plan pays number of occurrences maximum amount paid by plan	included in Daily In-Hospital Benefit	\$0 100% no maximum \$1,500 per occurrence
Maternity Benefit deductible plan pays maximum amount paid by plan	included in Daily In-Hospital Benefit	\$0 100% \$1,500 per occurrence
Preventive Care		
Preventive Care ^{1 †} paid at number of occurrences	80% 1/year per procedure	80% 1/year per procedure
Pharmacy		
Prescription Benefit ^{1 †} deductible - Generic deductible - Brand maximum amount paid by plan	discount program included ²	discount program included ² \$15/prescription \$25/prescription \$300/year
Injury		
Accident Coverage deductible plan pays / you pay number of occurrences maximum per occurrence maximum amount paid by plan	\$50/occurrence 80% / 20% 2/year \$2,500 \$5,000/year	\$100/occurrence 80% / 20% 2/year \$5,000 \$10,000/year
Accidental Death Benefit Starbridge pays	\$10,000	\$15,000

PLEASE NOTE: If visiting the ER for a true emergency, your benefits may come out of Outpatient, Inpatient, and/or Accident Coverage. If you receive *non-emergency treatment in the Emergency Room*¹ (care you could receive in a doctor's office), your coverage is reduced to: \$100 deductible per occurrence, the plan pays 50% of total bill with a \$500 maximum per year. You will be responsible for the remaining balance.

More valuable services that are included in your plan:

Online Tools

CIGNA provides a variety of online tools available only to our members. You'll be able to locate network doctors or pharmacies that provide discounts to our members. You can also track the status of claims that have been submitted.

CIGNA 24-Hour EAP

The CIGNA 24-Hour Employee Assistance ProgramSM is available day or night for helpful information on a range of health topics. The EAP Program includes access to: a 24-hour nurse line, mental health assistance (includes 3 in-person consultations per year per condition), and a health information library.

¹ The total amount Starbridge pays will count toward your Outpatient Care Maximum and is subject to the Outpatient Deductible unless otherwise mandated. ² The prescription discount program is not insurance. [†] Coverage for Cervical Cancer Screening, Prostate Cancer Screening, and Mammogram. This benefit amount may be higher if required by law. ¹ This benefit reimburses 100% of the prescription charge after deductible has been met. The benefits above are provided by policy form SBCII-GMP-02.

Questions? Call a Starbridge Benefits Specialist: 1-877-552-5015 • www.starbridge.com

SPECIAL ENROLLMENT

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, placement for adoption, or Qualified Medical Child Support Order you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Loss of coverage (non-COBRA) that can qualify for Special Enrollment includes, but is not limited to:

Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage when a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

To request special enrollment or obtain more information, contact a Customer Service representative at 1-877-552-5015. Representatives are available Monday through Friday, 5 AM to 6 PM, Mountain Standard time.

LIMITATION FOR PRE-EXISTING CONDITION¹ – The Pre-Existing Condition Limitation provision described below does not apply to anyone who is under 19 years of age.

Pre-Existing Condition means a condition for which a Covered Person has been medically diagnosed, treated by, or sought advice from, or consulted with, a Doctor during the 6 months before his effective date of coverage (or waiting period start date) under this Policy. Benefits for this coverage shall not be payable for a Pre-Existing Condition as defined herein. This provision will cease to apply to any expenses incurred in connection with a Pre-Existing Condition after 12 months of continuous coverage (or 12 months from your waiting period start date).

The Pre-Existing Condition Limitation above does not apply to newborn or adopted children, or to any pregnancy. Pregnancy, and genetic information with no related treatment, will not be considered Pre-Existing Conditions. Any Pre-Existing Condition limitation can be reduced by that period of time the Covered Person was previously covered for the condition causing claim; provided, such Covered Person:

1. Was validly covered under his prior plan with Creditable Coverage, within 63 days prior to becoming insured under this policy; and
2. Became insured under this policy within 63 days after termination of his prior coverage exclusive of any waiting period.

BENEFIT LIMITATIONS¹ – Coverage is not provided for services, supplies or equipment when a charge is not usually made in the absence of insurance.

No coverage is provided for loss caused by or resulting from:

1. Injury or sickness arising out of or in the course of employment;
2. War or act of war
3. Expenses which are not ordered by a Physician;
4. Cosmetic surgery. This does not apply to reconstructive surgery due to:
 - a. trauma, infection, or other disease; or
 - b. congenital disease or anomaly of a covered dependent newborn or adopted infant; or
 - c. surgery on a non-diseased breast to restore and achieve symmetry between two breasts following a mastectomy.
5. Hearing examinations or hearing aids;
6. Vision services and supplies other than for a disease process, radial keratotomy, keratomileusis or excimer laser photo refractive keratectomy or similar type procedures or services;
7. Charges made by a health care provider who is a member of your family or who is living with you;
8. Custodial Care confinement in a Hospital or Skilled Nursing Facility;
9. Home Health Care Services, unless provided in place of a Hospital confinement.
10. Commission of a felony;
11. Manipulations of the musculoskeletal system;
12. The treatment of mental or nervous disorders, alcoholism, or any form of substance abuse, except as specifically provided;²
13. Intentionally self-inflicted injury or suicide attempt;
14. Dental care and treatment, except that required by injury and rendered within 6 months of the injury;
15. Treatment which is experimental or investigational;
16. Any expense incurred after the date the policy terminates.

DEFINITION OF DEPENDENT¹ – Your Dependent is:

1. Your spouse,
2. Your children up to age 26.

ACCIDENTAL DEATH – No coverage is provided by death caused by:

1. War or act of war
2. Suicide within 2 years of your effective date,
3. Medical or surgical treatment of sickness of disease, or
4. Flight except as a passenger in a commercial airline.

DENTAL EXCLUSIONS

Benefits will not be paid for dental expenses arising from or in connection with:

1. Services or supplies for which a charge is not customarily made in the absence of insurance.
2. Injury arising out of or in the course of employment; or which is compensable (in South Dakota, which is paid) under any Workers' Compensation or Occupational Disease Act or Law.
3. Declared or undeclared war, or act of war.
4. A service furnished to a Covered Person for:
 - a. Cosmetic purposes, unless needed as a result of Injury. Facing on crowns, or pontics, posterior to the second bicuspid shall always be considered cosmetic;
 - b. Dental care of a congenital or developmental malformation (unless benefits for orthodontic services are specifically provided in the Schedule of Benefits).
5. Replacement of lost or stolen appliances.
6. Appliances, restorations, or procedures for the purpose of altering vertical dimension, restoring or maintaining occlusion, splinting, or replacing tooth structure lost as a result of abrasion or attrition, or treatment of disturbances of the temporomandibular joint. In Arkansas, treatment for the temporomandibular joint is not excluded.
7. A service not furnished by a Dentist, except:
 - a. That performed by a Dental Hygienist under the supervision of a Dentist;
 - b. X-rays ordered by a Dentist.
8. Intentionally self-inflicted injury or suicide attempt.

TERMINATION

A Covered Person's coverage will terminate at 12:01 a.m. Standard Time at Your home on the earliest of the following:

1. The date the Policy terminates;
2. The date this Certificate terminates;
3. The date coverage is terminated by Us for all certificate holders in Your state;
4. The date we receive a written request to terminate coverage,
5. The end of the period for which premium is paid, subject to the Grace Period.
6. The date a Covered Person enters the armed forces of any country. Membership in the reserves or in the National Guard is not deemed entry into the armed forces. Active duty service in the reserves or National Guard for a period of 31 consecutive days or more will be deemed entry into the armed forces.
7. With respect to a Dependent spouse, the date the spouse no longer qualifies as a Dependent, unless coverage is continued as stated in the Continuation of Coverage provision.
8. With respect to a Dependent child, the date that child no longer qualifies as a Dependent, unless coverage is continued as stated in the Continuation of Coverage provision.

At least 60 days prior written notice will be given to You if We terminate Your coverage for any reason, except for nonpayment premium.

FOOTNOTES

- ¹ Provisions, Limitations & Exclusions may vary where required by state law.
- ² Where treatment of mental or nervous disorders, alcoholism, or substance abuse coverage is mandated by state law, program complies with the federal mental health and substance abuse parity requirements

Frequently-Asked Questions

Q. What is Open Enrollment?

A. A defined period of time when you can enroll for, or make changes to, your employee health coverage.

Q. What is a “provider” (as in “Provider Directory”)?

A. A general term for any licensed health care facility, program, agency, physician or health professional that delivers health care services. A medical doctor is a type of provider.

Q. Is this a PPO plan? Do I get network discounts?

A. Starbridge is not a Preferred Provider Organization plan (PPO). However, we do offer you a “network discount” if you receive care from Beech Street healthcare providers – this means you can save when you visit any Beech Street network provider.

Q: What is a limited-benefit health plan?

A: Starbridge limited-benefit health plans are designed to provide health insurance to hard-working people like you. Starbridge is not a major medical plan. It provides coverage for routine medical expenses and can help you plan for unexpected expenses due to illnesses and accidents. It is not designed to cover the cost of treatment for health problems like heart disease or cancer.

Q. What is a deductible?

A. The amount you pay for medical services before your plan begins to pay. You pay all charges for your medical treatment until you reach that amount. Then, the plan begins paying a percentage of your medical costs (co-insurance). Deductibles start over every plan year.

Q. What is co-insurance?

A. Percentages that your plan pays for covered medical services after you’ve satisfied your deductible. For example, if your plan document shows 80% coinsurance, your plan pays 80% of the cost of your covered treatment. You pay the remaining 20%. So, if you receive medical treatment for covered services that cost \$100, and you’ve already satisfied your deductible, your plan will pay 80%, or \$80. You pay the remaining 20%, or \$20.

Q. What are copays?

A. Fixed amounts for covered procedures when you visit doctors in our network. Many plans have copays in place for services such as doctor’s visits, prescription drugs, hospital stays, etc. If your plan lists a copay for a covered service, you pay that amount directly to the doctor’s office at the time you receive treatment. Network doctors cannot charge you more than the copay for covered services. Your copay coverage continues until your plan’s maximum is reached.

Q. What is a maximum?

A. The most your plan will pay for your own and your covered dependents’ medical claims during a specific timeframe such as a plan year or a lifetime. Once you reach that maximum, your plan no longer pays a percentage of your costs. Annual maximums start over on your individual anniversary date (even if it’s different from your plan sponsor’s anniversary date).

Q: What is inpatient care?

A: Services that require being admitted to the hospital and an overnight hospital stay. Examples of inpatient services can include maternity and surgery.

Q: What is outpatient care?

A: Refers to services that do not require an overnight stay in a hospital or other health care facility. Examples of outpatient services include: doctor office visits, preventive care, lab work, x-rays, and urgent care.

Q. What are out-of-pocket costs?

A. Medical expenses your plan does not pay. You may have out-of-pocket costs such as copays, deductibles, co-insurance or other fees that you are required to pay directly to the healthcare provider.

Q. What are annual limits? Does this plan meet the requirements of health care reform?

A. An “annual limit” is the maximum amount of dollars your plan will pay for a category of covered services (such as “outpatient services”) in a specific time period (such as “a year”). Please see the special annual limits notice attached to your brochure that explains that the Starbridge plan received a waiver from the annual limits provisions of the health care reform legislation.

Starbridge Select Effective January 1, 2012

Starbridge Select is a voluntary health insurance plan offered to eligible employees working at Innovative Employee Solutions. It is often referred to as a limited benefits or “mini med” plan. Employees participating in this voluntary health plan are responsible for 100% of the premium which will be taken through post-tax payroll deductions.

Eligibility

To be eligible, employees must consistently work at least 20 hours a week on a minimum 3 month assignment.

Coverage Effective Date

Coverage will be effective the first of the month **FOLLOWING** 30 days of employment. You will receive a Summary Plan Description Booklet containing your ID cards and claims forms mailed directly from Cigna Starbridge Select.

Enrollment

Employees must submit enrollment forms for Starbridge Select to IES HR within the first 30 days of employment. Outside of the initial 30 days of employment, employees may only enroll during open enrollment or within 30 days of a qualifying life event.

Termination

Employees may now terminate coverage mid-year. Terminations must be submitted to IES Human Resources, in writing, via FAX 858-715-5110 or email to jmaynard@innovative-es.com at least 30 days prior to the desired termination effective date. If an employee cancels coverage mid-year, he/she will not be eligible to enroll again until open enrollment or due to a qualifying life event, whichever transpires first.

For employment terminations, Starbridge Select coverage will terminate at midnight on last day worked.

Open Enrollment

Open enrollment is in mid-November through mid-December for January 1st coverage.

Employee Premiums

Employee premiums are taken through a post-tax deduction. Rates are effective from 1/1/12 to 12/31/12.

Exclusions/Limitations

Starbridge Select is NOT available to residents in the following states: North Dakota, Washington, Montana, New Hampshire, and Vermont.

Medical premiums for employees living in New Jersey will be reduced by \$1/week due to NJ state legislation.

Starbridge Select Contact Information

You can learn more about the Starbridge Select network providers through the links below or by calling Starbridge Select at 877-552-5015.

Medical Providers:

<http://www.beechstreet.com/beechnet/IPLU/Control?hJSPName=splash.jsp&hButtonMode=Search>

Dental Providers:

http://cigna.benefitnation.net/cignadol/dns_hrg.asp

Questions

Please contact Innovative Employee Solutions HR Team at 858-715-5100 x100.



Employee Name: _____

INSTRUCTIONS & INFORMATION

This is the authorization to enroll yourself and your qualified dependents in Starbridge Select, our voluntary limited benefits health plan. Employees must submit enrollment forms to IES HR within the first 30 days of hire or during open enrollment or within 30 days of a qualifying event. Employees must work at least 20 hours per week on a minimum 3 month assignment. This insurance plan is not available to residents in the following states: ND, WA, MT, NH, VT.

*Coverage will be effective the **first of the month following 30 days of employment** (i.e. if you were hired January 10, your coverage would be effective Mar 1). Coverage level must be the same if you are enrolling dependents on medical or dental.*

- Check appropriate box(es) to indicate selection
- Sign and date and return with the Starbridge Select Enrollment Form to IES Human Resources FAX **858-715-5110**

Plan Selection	Coverage	Weekly Premium
Level 1 - Medical	<input type="checkbox"/> Employee Only	\$11.64
	<input type="checkbox"/> Employee + One	\$28.48
	<input type="checkbox"/> Employee + Family	\$43.09
Level 2 - Medical	<input type="checkbox"/> Employee Only	\$21.25
	<input type="checkbox"/> Employee + One	\$52.56
	<input type="checkbox"/> Employee + Family	\$79.69
Dental Reimbursement with Vision Discount **	<input type="checkbox"/> Employee Only	\$4.25
	<input type="checkbox"/> Employee + One	\$8.20
	<input type="checkbox"/> Employee + Family	\$12.15
** Vision discount is not insurance		

I understand that my premiums for Starbridge Select coverage will be taken through post-tax payroll deductions. I have the right to cancel my selected coverage(s) at any time throughout the year. I understand that if I choose to terminate my coverage mid-year, I must notify IES HR, in writing, at least 30 days prior to my desired termination effective date. Additionally, I understand that if I cancel coverage for myself or my dependents mid-year, I will only be able to re-enroll during open enrollment or within 30 days of a qualifying life event, whichever transpires first. My coverage will terminate at midnight on my date of employment termination with IES.

EMPLOYEE'S SIGNATURE

DATE

These benefits and rates are only a brief summary. Rates above are effective January 1, 2012 to December 31, 2012. This document is not intended to fully describe the benefits or plan limitations. Rates are shown for selection of coverage and authorization of payroll deductions. The actual plan documents will govern final benefits and rates.

Starbridge Select Enrollment Form

Innovative Employee Solutions
Group Number: **2078**

Limited Benefits Health Plan
Starbridge is not a major medical plan

Enrollment: This insurance plan is **NOT** available to residents in the following states: **ND, WA, MT, NH, VT**
Complete this form and fax with the IES Benefits Selection Form to IES HR at **858-715-5110** or email to jmaynard@innovative-es.com

Enrollment Form: Underwritten by Connecticut General Life Insurance Company PO Box 55270 Phoenix, AZ 85078

First Name _____ Last Name _____ Initial _____
Hire Date _____ Date of Birth** _____ Gender M / F ** Soc. Sec. # _____
Address _____ City _____ State _____ Zip _____

Select Your Plan(s) & Coverage Level

Check your desired plan(s). Prices reflect cost per pay period as shown on the Benefits Selection Form. Changing to another plan level may only be done during open enrollment. You can choose to enroll in medical and/or dental but your coverage level must be the same if you are enrolling dependents.

Medical (choose one medical coverage level)

- Medical Level 1
 Medical Level 2

Coverage

- I want to cover myself only
 I want to cover myself and one dependent
 I want to cover my family

Dental (choose dental with medical or dental only)

- Dental Reimbursement Plan with Vision Discount

* Vision Discount Program is not insurance

Dependents Information List only if you are enrolling dependents - If additional space is needed, please attach separate sheet

Spouse's Full Name	Social Security Number	Date of Birth	
_____	_____	_____	
Child's Full Name	Son/Daughter	Social Security Number	Date of Birth
_____	_____	_____	_____
Child's Full Name	Son/Daughter	Social Security Number	Date of Birth
_____	_____	_____	_____
Child's Full Name	Son/Daughter	Social Security Number	Date of Birth
_____	_____	_____	_____

Beneficiary: Person who will receive benefits in the event of your death.

Full Name	Relationship To You		
_____	_____		
Street Address	City	State	Zip
_____	_____	_____	_____

** This information is being collected for administrative purposes only, and not for medical underwriting.

For Oregon residents only. Have you had prior coverage (less than 63 day gap)? Please forward us the Certificate of Creditable Coverage from your prior carrier. **For Florida residents only.** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. **For all other states' residents.** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime, may be violating state law, and may be subject to fines and confinement of prison. **Authorization:** By signing below, I indicate my desire to enroll in Starbridge; confirm that I have named my beneficiary and authorize my employer to deduct or reduce my pay for any contributions required by the plan. Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a crime and may be subject to fines and confinement in prison.

Sign to Enroll: **X**

Date _____

Declination Notice: No, I do not wish to enroll in the coverage offered above. **WAIVER OF COVERAGE:** Failure to elect coverage (for yourself and/or any of your dependents) during the Enrollment period may result in no coverage until the next Open Enrollment period. It may not be necessary to wait for the next Open Enrollment Period if you qualify as a Special Enrollee. Please fill out and sign and date.
Sign here if you do not want to enroll **X**