

General Information

Open Enrollment for 2012

Open Enrollment begins Monday, Sept. 12 and continues through Friday, Sept. 30, at 5 p.m. This year, the company is having an "active enrollment," which means employees must make an election to ensure that they are enrolled in coverage of their choice for 2012. Elections made during this Open Enrollment will be effective Jan. 1, 2012, through Dec. 31, 2012. There is no second opportunity to enroll for coverage in 2012 if you miss the Sept. 30 deadline.

Mandatory Open Enrollment

For everyone who wants to:

- Continue medical coverage for 2012
- Continue dental coverage for 2012
- Change medical or dental options
- Change coverage tiers
- Add or disenroll dependents
- Enroll in the Health Care Reimbursement Account
- Enroll in the Dependent Care Reimbursement Account

What happens if I don't re-enroll during Open Enrollment?

If you do not re-enroll during the Open Enrollment period, your 2012 coverage will be defaulted from your current coverage level to:

- PPO Standard option if enrolled in medical for 2011
- Basic dental option if enrolled in dental for 2011
- Waive if you waived coverage in 2011
- Waive employee contributions to the health care reimbursement account
- Waive employee contributions to the dependent care reimbursement account

Online enrollment only

All employees will be required to submit their enrollment elections **entirely online**. No paper forms will be used.

You have two online ways to submit your enrollment elections:

1. MyHR from the **intranet home page**
2. MyHR from the corporate website on the **Internet**

The site to enter your elections will be live on Sept. 12 and will stay open until Sept. 30.

Job aids are available for the very simple online enrollment process. At the click of a mouse, your elections are submitted to the Benefits Department, and you will receive an e-mail reply to your work e-mail address that confirms your elections were successfully submitted online.

For more information

During the Open Enrollment period, closely examine your health care coverage to make sure that your medical and dental plans have the services you and your dependents need, and that the health care providers you want are available. To support our corporate "green" initiative, Open Enrollment information is published on the Open Enrollment website instead of being printed and mailed. The Benefits website is available to you 24 hours a day, seven days a week. For questions about specific plan benefits, contact the plan administrator. For open enrollment questions, please send an email to open.enrollment@lge-ku.com.

Open Enrollment

12

Sept. 12 - 30, 2011

Online only — 100% paperless enrollment 

Everyone required to make an election

Special Open Enrollment notes

- **If you are adding dependents** to any of your benefit plans during Open Enrollment, you will need to provide documentation to the Benefits Dept., such as a birth certificate or marriage certificate.
- **If you are a COBRA participant**, you can change your medical or dental elections during the annual Open Enrollment if you currently participate, but you and your dependents cannot enroll for medical or dental if you are not currently participating. You are not eligible to participate in the flexible spending accounts.
- **If you are a disabled (LTD) participant**, and you are eligible for Medicare, you must enroll in Medicare Part A and B to have medical coverage with the company. You can change your medical or dental elections during the annual Open Enrollment if you currently participate or if you waived coverage. You are not eligible to participate in the flexible spending accounts.
- **When both spouses work for the company**, you and your spouse may each elect a medical and dental plan. Only one employee may elect to cover the children on the plan.

Changing coverage during the year

Outside of Open Enrollment, you can change your coverage levels (e.g., single to family) during the year only when you experience a Change in Family status. Examples include:

- marriage or divorce;
- birth or adoption;
- loss of coverage (e.g., if your spouse loses his or her job);
- dependent child no longer meets the definition of dependent; or
- death of a covered dependent.

Any changes you make to your coverage must be made within 30 days of the event, must be consistent with the qualifying event and must be documented. For example, if you have a baby on June 14, you have until July 14 to add the new baby to your plan, and you'll need to provide a birth certificate which includes the names of the parents and the date of birth.

It is your responsibility to submit a new application form and required documentation to the Benefits Dept. indicating the changes within 30 days. If you fail to return the application form within 30 days after the qualifying event and the required documentation within 60 days, the company will conclude you elected not to change your coverage due to the event.

Dependent Coverage

Open Enrollment

Sept. 12 – 30, 2011

Online only — 100% paperless enrollment 

Everyone required to make an election

Eligible dependents

An eligible dependent is defined as an employee's spouse and/or child(ren). The definition of "child(ren)" is different for the medical/vision plan and the dental plan. The chart below lists the required documentation that an employee must provide in order to enroll an eligible dependent for coverage.

Eligible Dependents		
	Medical/Vision	Dental
Eligible Dependent	An eligible dependent is defined as a Subscriber's spouse and/or child(ren).	Same as Medical/vision
Spouse	The Subscriber's legal spouse in the Subscriber's state of primary residence.	Same as Medical/vision
Child(ren)	The Subscriber's child may include: <ul style="list-style-type: none"> • natural children. • legally adopted children (The event date for an adopted child is the earlier of the date of adoption or date of placement for adoption. Placement for adoption means the assumption and retention of legal obligation for total and partial support for a child in anticipation of adoption of such child.) • children under your legal guardianship (temporary custody not eligible). • stepchildren. 	The Subscriber's unmarried child who relies on the Subscriber for over 50 percent of his/her financial support. Children may include: <ul style="list-style-type: none"> • natural children (who live in or outside your home). • legally adopted children. (The event date for an adopted child is the earlier of the date of adoption or date of placement for adoption. Placement for adoption means the assumption and retention of legal obligation for total and partial support for a child in anticipation of adoption of such child.) • children under your legal guardianship (temporary custody not eligible). • stepchildren who reside with you as the primary caregiver in a normal parent-child relationship.
Age Limits for Children	End of the month Child attains age 26.	End of the month child attains age 19; or to end of the month Child attains age 25 if a full-time student. Vacation Period for Full-Time Students — a Child continues to be a Full-time Student during periods of regular vacation established by the institution. If the Child does not continue as a Full-time Student immediately following the period of vacation, the Full-time Student designation will end on the last day of the calendar month preceding the month in which such period of vacation ended. For example: Spring semester ends May 10 and students are on vacation for the calendar months of June and July. Fall semester starts August 25 and if students do not return to school, Full-time Student designation will end July 31.
Dependent Children with Disabilities	Eligibility will be continued past the end of the month the Child attains the Age Limits for Children only for those already enrolled unmarried Children who cannot work to support themselves due to mental retardation or physical or mental handicap. These children must be allowed as a federal tax exemption by the Subscriber or Subscriber's Spouse. The Child's disability must start before the end of the period they would become ineligible for benefits. The Plan must certify the Child's eligibility.	Same as Medical/Vision
Foster Child	Any foster child who is eligible for any governmental program or law will not be eligible for benefits under the Plan unless required by the laws of the Subscriber's state of residence.	Same as Medical/Vision

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Supporting documentation required for dependent coverage

The company needs to ensure that only eligible employees and their dependents, are receiving health care coverage under the LG&E and KU medical/vision and dental plans. If you add dependents to your coverage, their eligibility must be verified by providing documentation to the Benefits Department.

The Company may require you to submit proof of continued

eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's benefits under the Plan.

The chart below lists the required documentation that an employee must provide in order to enroll an eligible dependent for coverage.

Verifying Dependent Eligibility — Required Documentation When Adding Dependents		
	Medical/Vision	Dental
Spouse	A copy of your marriage certificate and one form of documentation establishing current marital status such as a joint household bill, joint bank/credit account, or the front page of your most recently filed federal tax return (with all financial information concealed).	Same as Medical/vision
Natural Child(ren)	A copy of the child's birth certificate which includes the names of the parents.	A copy of the child's birth certificate which includes the names of the parents and a copy of the front page of your most recently filed federal tax return confirming this child as a dependent (with all financial information concealed) and if between age 19 and 25, a copy of the current school schedule or enrollment verification statement that confirms the dependent's status as a full-time student.
Legally adopted Children or Children under your legal guardianship (temporary custody not eligible)	A copy of the child's birth certificate which includes the appropriate court order/adoption decree naming you or your spouse as the child's legal guardian.	A copy of the child's birth certificate which includes the appropriate court order/adoption decree naming you or your spouse as the child's legal guardian and a copy of the front page of your most recently filed federal tax return confirming this child as a dependent (with all financial information concealed) and if between age 19 and 25, a copy of the current school schedule or enrollment verification statement that confirms the dependent's status as a full-time student.
Step Children	A copy of the child's birth certificate and employee's marriage certificate and joint bill/account listing employee and spouse or last year's federal tax return showing a joint filing.	A copy of the child's birth certificate and proof of residency documenting the child resides with you as the primary caregiver in a normal parent-child relationship and a copy of the front page of your most recently filed federal tax return confirming this child as a dependent (with all financial information concealed). and if between age 19 and 25, a copy of the current school schedule or enrollment verification statement that confirms the dependent's status as a full-time student.
Dependent Children with Disabilities	A copy of the child's birth certificate which includes the names of the parents or appropriate court order/adoption decree naming you or your spouse as the child's legal guardian and an affidavit will need to be completed to prove disability through the insurance carrier.	Same as Medical/Vision

How and when to submit documentation for new dependents

Documentation is required when new dependents are added to an employee's medical and/or dental plan. Outside of Open Enrollment, participants have 30 days to add a dependent from the Change in Family Status date and 60 days to submit the required documentation. Failure to submit required documentation within 60 days will result in the dependent being retro-actively removed from coverage. Failure to add your dependent within 30 days will result in waiting until next year's open enrollment.

Documentation can be sent via mail (regular U.S. mail or inter-office) or faxed to the Benefits Dept.

- **Regular U.S. Mail:** LG&E Center, Attn: Benefits Department, P.O. Box 32030, Louisville, KY 40232
- **Inter-office mail:** LG&E Center — 16th Floor
- **Benefits fax#:** 502-217-2412

If you add a dependent during this year's Open Enrollment, you must submit the required documentation by Oct. 31, 2011.

Medical Highlights

Open Enrollment

Sept. 12 – 30, 2011

Online only — 100% paperless enrollment 

Everyone required to make an election

Understanding your options

As an eligible employee, four medical options are available to you and your eligible dependents for 2012. You may choose among the four options administered by Anthem.

- EPO
- PPO Low Deductible
- PPO Standard
- PPO High Deductible

Review the options carefully before selecting an option that best meets your needs. We feel that each of these options will offer important advantages to different employees.

How the options work

All four medical options provide high-quality health care and cover a wide range of services, including:

- in-patient hospital services;
- doctors' and surgeons' fees;
- X-rays and lab tests;
- medical supplies;
- out-patient services;
- medications; and
- vision services.



All four options offer the same coverage for medications and vision benefits. The options differ in premium costs, co-payments, deductibles, co-insurance, out-of-pocket maximums and network coverage.

How the EPO option works

This option provides 100 percent benefit coverage at in-network providers after you pay applicable co-payments, such as \$20 physician visits, \$30 specialist visits, \$300 in-patient hospital stay and \$100 out-patient surgeries. See "Highlights of 2012 Medical Options" chart for more information.

The Anthem Blue Preferred EPO option allows you to obtain benefits from in-network providers only. Out-of-network providers are covered only in cases of emergencies. Availability is limited to certain parts of Indiana and Kentucky. To determine availability in your area, contact Anthem at 1-877-750-6062 or check its website at www.anthem.com.

How the PPO Low Deductible option works

The PPO Low Deductible option has co-pays for certain in-network services — \$20 physician visits, \$30 specialist visits, \$30 urgent care centers. For other covered medical expenses at an in-network provider, you must first pay an annual \$200 deductible per person, limited to \$400 for a family. Once the deductible is paid, the plan pays 90% of covered medical services, and you pay 10%, until your out-of-pocket costs (including your deductible, 10% co-insurance, \$20 physician co-pays, \$30 specialist co-pays, \$30 urgent care centers), reach \$2,500 for any person or \$5,000 for a family, in-network. Then, the plan pays 100% of covered medical services at in-network providers.

The Anthem PPO Low Deductible option allows you to receive benefits from in-network and out-of-network providers and provides access on a statewide and national basis across the United States. To receive the highest level of benefit coverage and to avoid balance billing, you should use an in-network provider. If you use an out-of-network provider, the reimbursement will be lower, and you will be subject to balance billing from your provider. See "Highlights of 2012 Medical Options" chart for more information.

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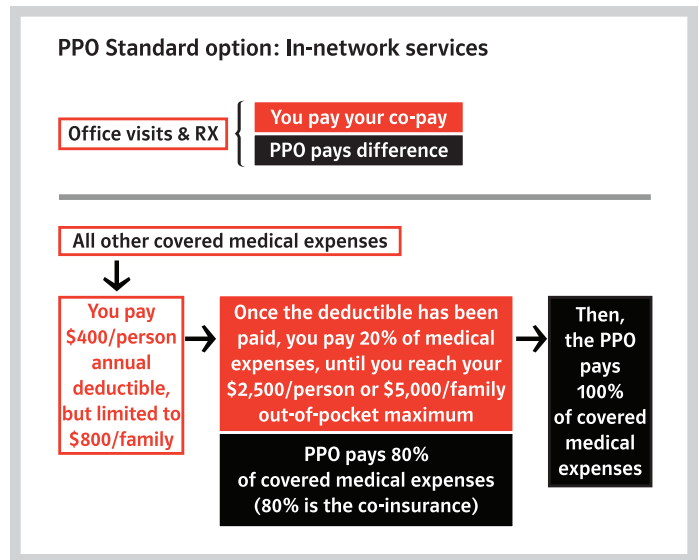
How the PPO Standard option works

The PPO Standard option has co-pays for certain in-network services — \$20 physician visits, \$30 specialist visits, \$30 urgent care centers. For other covered medical expenses at an in-network provider, you must first pay an annual \$400 deductible per person, limited to \$800 for a family, in-network. Once the deductible is paid, the plan pays 80% of covered medical services, and you pay 20%, until your out-of-pocket costs (including your deductible, 20% co-insurance, \$20 physician co-pays, \$30 specialist co-pays, \$30 urgent care centers), reach \$2,500 for any person or \$5,000 for a family. Then, the plan pays 100% of covered medical services at in-network providers.

The Anthem Standard option is like the PPO Low Deductible option that provides benefits from in-network and out-of-network providers, and provides access on a statewide and national basis across the United States. See "Highlights of 2012 Medical Options" chart for more information.

How the PPO High Deductible Works

In return for low monthly premiums, you must satisfy a high deductible that applies to all health care expenses except preventive care and prescription drug coverage. You pay 20 percent co-insurance after you have paid the deductible until you reach your out-of-pocket maximum. If you cover dependents — coverage levels of employee + spouse, employee + child(ren) or family — you must meet the **entire** family deductible before benefits are payable for any family member, and you must reach the **entire** family out-of-pocket maximum before the plan pays 100% for any family member.



The Anthem PPO High Deductible option is like the PPO Standard option that provides benefits from in-network and out-of-network providers and provides access on a statewide and national basis across the United States. See "Highlights of 2012 Medical Plan Options" chart for more information.

For more information

The Benefits website is available to you 24 hours a day, seven days a week. You can contact Anthem at 1-877-750-6062 for questions about specific plan benefits or search for in-network providers online at www.anthem.com. Anthem's Coverage Advisor online tool can help you compare the four options. Go to www.anthem.com/preenrollment/ and use the login name **LKE**.

Additional Information			
	Customer Service	Web Access	Searching for In-Network Providers
Anthem Blue Preferred EPO Contract #003329600 Prefix: LGH	1-877-750-6062	www.anthem.com	Access Web address. Click on Find a Doctor ; select Kentucky ; click Next . From the Select a Plan drop-down box, select Blue Preferred HMO . From Select a Provider Type , make your selection; from Select a Specialty Category , make your selection; click Next . Follow screen instructions to continue your search.
Anthem National PPO: — PPO Low Deductible — PPO Standard — PPO High Deductible Contract #003329600 Prefix: LGE	1-877-750-6062	www.anthem.com	Access Web address. Click on Find a Doctor ; select Search National BlueCard Directory ; click Next . Under Members , enter LGE . Click Next . Select Search Type (Search by Location or Look up by Name) . Follow screen instructions for continue your search.

See **Highlights of 2012 Medical Options** charts on the following pages.

New for 2012: Employed Spouse Premium

Beginning Jan. 1, 2012, the company will implement a monthly \$200 employed-spouse premium (ESP). The ESP is an additional \$200 per month added to your monthly medical premium if certain conditions apply to you — see details below.

Employed-spouse premium — To whom does it apply?

The employed-spouse premium is an additional \$200 per month added to your 2012 monthly medical premium if you meet **all** of the following conditions:

1. Your spouse is employed full-time (as defined by your spouse's employer) or your spouse works on average 30 hours or more per week;
- and**
2. Your spouse's employer provides your spouse with access to employer-sponsored medical insurance;
- and**
3. Your spouse does not enroll in medical insurance with his or her own employer for 2012 and chooses instead to enroll in the LG&E and KU medical plan for 2012.

If you meet all of the conditions above, the ESP applies to you and you will pay an additional \$200 per month for your 2012 medical coverage. Please refer to the 2012 Health Care options rate sheet that shows the monthly medical premium amounts.

Employed-spouse premium — To whom does it **not** apply?

The employed-spouse premium (ESP) does **not** apply to you and \$200 will not be added to your 2012 monthly medical premium if **any** of the following circumstances apply to you:

1. Your spouse is **not** employed;
- or**
2. Your spouse is not employed full-time (as defined by your spouse's employer) or your spouse works on average fewer than 30 hours per week;
- or**
3. Your spouse's employer does **not** provide your spouse with access to employer-sponsored medical insurance;
- or**
4. Your spouse does not enroll in the LG&E and KU medical plan for 2012;
- or**
5. Your employed spouse enrolls in his or her own employer's medical insurance for 2012 and also chooses to enroll in the LG&E and KU medical plan for 2012;
- or**
6. You are a part-time LG&E and KU employee.

Do the math

Will the ESP apply to you? If the ESP applies to you, you're encouraged to "do the math" during this year's open enrollment. You can compare your monthly LG&E and KU medical premium rates (with the \$200 Employed Spouse Premium) to your spouse's employer's medical premium rates. Comparing the rates will help you decide which option is more economical for your family.

Will it be more reasonable for you to pay the \$200 monthly ESP and enroll your spouse into the LG&E and KU medical plan? Or, will it be more cost-effective for your spouse to enroll in his or her own employer's medical plan? If your spouse enrolls in his or her own employer's medical plan, you could change your coverage level to the less expensive "Employee Only" or "Employee plus Children" coverage on the LG&E and KU medical plan.

In addition to looking at your spouse's monthly medical premium costs, you'll also want to look at your spouse's medical plan provisions such as covered benefits, out of pocket expenses, co-pays and deductibles to help you make your decision. "Doing the math" can assist you in deciding which option is best for your family.



Online Open Enrollment

When you complete your online Open Enrollment this year, the Open Enrollment screens will ask you a series of questions to determine if the ESP applies to you. If the ESP applies to you, the \$200 ESP will automatically be added to your monthly medical premium. If the ESP does not apply to you, the additional \$200 will not be added to your monthly premium. After you complete your online Open Enrollment, you will receive an email confirmation showing your 2012 medical premium rate.

Audit of Spousal Health Care Coverage

After Open Enrollment ends, all employees that have a spouse enrolled in the LG&E and KU medical plan for 2012 will be sent a "Verification of Spousal Health Care Coverage" form. You will be required to complete the verification form and return it to the third party auditor by the due date. Your signed verification form will confirm whether or not the employed-spouse premium applies to you. If you fail to return the signed verification form to the third party auditor by the audit due date, your spouse will be dropped from coverage from the LG&E and KU medical plan for 2012.

For more information, please see the *Employed-Spouse Premium Frequently Asked Questions* exhibit.

Highlights of 2012 Medical Options

		EPO (In-Network Services Only)	PPO Low Deductible		PPO Standard		PPO High Deductible	
			In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible ^{1,2}	Employee-Only Coverage	None	\$200/person	\$400/person	\$400/person	\$800/person	\$1,200/person	\$2,400/person
	Employee + Spouse Coverage	None	\$200/person; \$400/family	\$400/person; \$800/family	\$400/person; \$800/family	\$800/person; \$1,600/family	\$2,400/family	\$4,800/family
	Employee + Child(ren) Coverage	None	\$200/person; \$400/family	\$400/person; \$800/family	\$400/person; \$800/family	\$800/person; \$1,600/family	\$2,400/family	\$4,800/family
	Family Coverage	None	\$200/person; \$400/family	\$400/person; \$800/family	\$400/person; \$800/family	\$800/person; \$1,600/family	\$2,400/family	\$4,800/family
Annual Maximum Out-of-Pocket Limit ^{1,3}	Employee-Only Coverage	\$2,500/person	\$2,500/person	\$5,000/person	\$2,500/person	\$5,000/person	\$2,400/person	\$4,800/person
	Employee + Spouse Coverage	\$2,500/person; \$5,000/family	\$2,500/person; \$5,000/family	\$5,000/person; \$10,000/family	\$2,500/person; \$5,000/family	\$5,000/person; \$10,000/family	\$4,800/family	\$9,600/family
	Employee + Child(ren) Coverage	\$2,500/person; \$5,000/family	\$2,500/person; \$5,000/family	\$5,000/person; \$10,000/family	\$2,500/person; \$5,000/family	\$5,000/person; \$10,000/family	\$4,800/family	\$9,600/family
	Family Coverage	\$2,500/person; \$5,000/family	\$2,500/person; \$5,000/family	\$5,000/person; \$10,000/family	\$2,500/person; \$5,000/family	\$5,000/person; \$10,000/family	\$4,800/family	\$9,600/family
Lifetime Maximum Amount		Unlimited	Unlimited		Unlimited		Unlimited	
Choice of Providers		Must use participating providers	Must use participating providers	Can use any providers	Must use participating providers	Can use any providers	Must use participating providers	Can use any providers
Monthly Premium for Full-Time Employee	Employee-Only Coverage	Employee pays \$122	Employee pays \$87		Employee pays \$65		Employee pays \$29	
	Employee + Spouse Coverage	Employee pays \$290	Employee pays \$220		Employee pays \$174		Employee pays \$102	
	Employee + Spouse Coverage with Employed Spouse Premium	Employee pays \$490	Employee pays \$420		Employee pays \$374		Employee pays \$302	
	Employee + Child(ren) Coverage	Employee pays \$259	Employee pays \$194		Employee pays \$151		Employee pays \$88	
	Family Coverage	Employee pays \$427	Employee pays \$329		Employee pays \$260		Employee pays \$157	
	Family Coverage with Employed Spouse Premium	Employee pays \$627	Employee pays \$529		Employee pays \$460		Employee pays \$357	

1) There are different Maximum Out-of-Pocket Limits and Deductible amounts for In-Network and Out-of-Network services; however, the In-Network and Out-of-Network Maximum Out-of-Pocket Limit and Deductibles are cross-applied — which means they will accumulate toward each other.

2) The Annual Deductible is the annual amount you're responsible for paying for covered medical services before the plan begins to pay. Your annual premium cost or co-pays for prescriptions, vision, dental, physician office services or urgent care centers don't count toward your deductible.

3) The Annual Maximum Out-of-Pocket Limit is the limit on the dollar amount you're responsible for paying out of pocket in a calendar year for covered medical services. This includes your deductible, co-pays and co-insurance. Once you reach your out-of-pocket limit, the plan will pay 100% of the allowable amount for eligible medical expenses up to the plan's lifetime maximum benefit amount. Because your expenses for your monthly premium amount, prescriptions, vision, dental and non-precertification penalties do not count toward your out-of-pocket limit, however, you would have to continue paying for those expenses even after you have reached your out-of-pocket limit.

This summary is intended to provide a brief description of the medical options and is not a comprehensive disclosure of all plan terms. Detailed information can be found in the Summary Plan Description and in the plan document. If statements in this summary are inconsistent with the formal provisions of the plan document, the formal provisions of the plan document apply and control. A copy of the plan document is available on the company's intranet or, upon request, from your Human Resources representative.

Highlights of 2012 Medical Options

		EPO (In-Network Services Only)	PPO Low Deductible		PPO Standard		PPO High Deductible	
			In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Covered Services	Inpatient Services	Plan pays 100% after \$300 co-pay for each in-patient confinement	Plan pays 90% after deductible	Plan pays 70% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
	Emergency Room	Plan pays 100% after \$100 co-pay (waived if admitted)	Plan pays 90% after deductible	Plan pays 90% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible
	Urgent Care Facility	Plan pays 100% after \$30 co-pay	Plan pays 100% after \$30 co-pay	Plan pays 100% after \$30 co-pay	Plan pays 100% after \$30 co-pay	Plan pays 100% after \$30 co-pay	Plan pays 80% after deductible	Plan pays 80% after deductible
	Outpatient Surgery, MRI/MRA, PET Scans, CAT Scans	Plan pays 100% after \$100 co-pay	Plan pays 90% after deductible	Plan pays 70% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Physician Office Services	Primary Care Physician	Plan pays 100% after \$20 co-pay	Plan pays 100% after \$20 co-pay	Plan pays 70% after deductible	Plan pays 100% after \$20 co-pay	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
	Specialist	Plan pays 100% after \$30 co-pay	Plan pays 100% after \$30 co-pay	Plan pays 70% after deductible	Plan pays 100% after \$30 co-pay	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
	Chiropractic Care (maximum 20 visits/year)	Plan pays 100% after \$20 co-pay	Plan pays 100% after \$20 co-pay	Plan pays 70% after deductible	Plan pays 100% after \$20 co-pay	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
	Allergy Injection	Plan pays 100% after \$5 co-pay	Plan pays 100% after \$5 co-pay	Plan pays 70% after deductible	Plan pays 100% after \$5 co-pay	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
	Preventive Health Care Services	Covered in Full	Covered in Full	Not Covered	Covered in Full	Not Covered	Covered in Full	Not Covered
	Maternity Services	\$20 co-pay first visit only; all other care — plan pays 100% of allowable amount	\$20 co-pay first visit only; all other care — plan pays 90% of allowable amount	Plan pays 70% after deductible	\$20 co-pay first visit only; all other care — plan pays 80% of allowable amount	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
	In-patient (unlimited visits)	Plan pays 100% after \$300 co-pay for each in-patient confinement	Plan pays 90% after deductible	Plan pays 70% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Mental Health and Substance Abuse	Out-patient (unlimited visits)	Individual Therapy: Plan pays 100% after \$20 co-pay; Group Therapy: Plan pays 100% after \$20 co-pay	Individual Therapy: Plan pays 100% after \$20 co-pay; Group Therapy: Plan pays 100% after \$20 co-pay	Plan pays 70% after deductible	Individual Therapy: Plan pays 100% after \$20 co-pay; Group Therapy: Plan pays 100% after \$20 co-pay	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
	Limitations	Advance approval required	Advance approval required		Advance approval required		Advance approval required	

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Highlights of 2012 Medical Options

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			In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Other Coverage	Cardiac Rehabilitation (maximum 30 visits/year)	Plan pays 100% after \$30 co-pay	Plan pays 90% after deductible	Plan pays 70% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
	Occupational, Physical and Speech Therapy (maximum 20 visits/year)	Plan pays 100% after \$30 co-pay	Plan pays 90% after deductible	Plan pays 70% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
	Skilled Nursing Facility (maximum 60 days/year)	Plan pays 100% after \$300 co-pay for each inpatient confinement	Plan pays 90% after deductible	Plan pays 70% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
	Ambulance Services	Covered in Full	Plan pays 90% after deductible	Plan pays 90% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible
	Home Care Services (limited to 60 visits/year)	Covered in Full	Plan pays 90% after deductible	Plan pays 70% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
	Human Organ and Tissue Transplant Services	Covered in Full	Plan pays 90% after deductible	Plan pays 70% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
	Hospice Services	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full
	Durable Medical Equipment	Covered in Full	Plan pays 90% after deductible	Plan pays 90% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible
Prescription Drugs Covered Thru Medco Health Solutions	Generic formulary (retail pharmacy)	Plan pays 100% after \$7 co-pay	Plan pays 100% after \$7 co-pay	Not Covered	Plan pays 100% after \$7 co-pay	Not Covered	Plan pays 100% after \$7 co-pay	Not Covered
	Brand name formulary (retail pharmacy)	Plan pays 100% after \$25 co-pay	Plan pays 100% after \$25 co-pay	Not Covered	Plan pays 100% after \$25 co-pay	Not Covered	Plan pays 100% after \$25 co-pay	Not Covered
	Non-formulary (retail pharmacy)	Plan pays 100% after \$40 co-pay	Plan pays 100% after \$40 co-pay	Not Covered	Plan pays 100% after \$40 co-pay	Not Covered	Plan pays 100% after \$40 copay	Not Covered
	Medco Mail Order Pharmacy — Members are required to use Medco's Mail Order Pharmacy for refilling Maintenance prescriptions (required after three refills at retail pharmacy for the same maintenance medication) ⁴	Plan pays 100% after two co-pays for 90 day supply	Plan pays 100% after two co-pays for 90-day supply	Not Covered	Plan pays 100% after two co-pays for 90-day supply	Not Covered	Plan pays 100% after two co-pays for 90-day supply	Not Covered
	Medco's Accredo Health Pharmacy — Mail order is required for Specialty prescriptions ⁵	Plan pays 100% after one co-pay for 30 day supply	Plan pays 100% after one co-pay for 30-day supply	Not Covered	Plan pays 100% after one co-pay for 30-day supply	Not Covered	Plan pays 100% after one co-pay for 30-day supply	Not Covered
Vision Services Covered Thru Vision Service Plan (VSP)	Exam (one/12 months)	Plan pays 100% after \$15 co-pay	Plan pays 100% after \$15 co-pay	Not Covered	Plan pays 100% after \$15 co-pay	Not Covered	Plan pays 100% after \$15 co-pay	Not Covered
	Lenses, Frames and Contacts (VSP) (one/24 months)	Plan pays based on plan allowance	Plan pays based on plan allowance	Not Covered	Plan pays based on plan allowance	Not Covered	Plan pays based on plan allowance	Not Covered

4) Maintenance prescriptions include medications taken regularly to maintain certain medical conditions (e.g., diabetes, hypertension, cholesterol). Members are allowed to refill the same maintenance medication at a retail pharmacy three times. After the third refill at retail for the same maintenance medication, members are required to use Medco's Pharmacy. Call Medco to set up your mail order refills.

5) Specialty prescriptions include medications for conditions such as multiple sclerosis, psoriasis, rheumatoid arthritis, transplants, etc. If your prescription is a specialty medication, Medco's Accredo Pharmacy will contact you to get you set up on the mail order program.

This summary is intended to provide a brief description of the medical options and is not a comprehensive disclosure of all plan terms. Detailed information can be found in the Summary Plan Description and in the plan document. If statements in this summary are inconsistent with the formal provisions of the plan document, the formal provisions of the plan document apply and control. A copy of the plan document is available on the company's intranet or, upon request, from your Human Resources representative.

Pharmacy Highlights

Medco's prescription drug card program allows you to purchase prescriptions simply by paying your applicable co-pay.

Medco's prescription drug program	
Prescription drugs	Plan pays 100% after you pay:
Generic	a \$7 co-pay for a 30-day supply
Brand name formulary	a \$25 co-pay for a 30-day supply
Non-formulary	a \$40 co-pay for a 30-day supply
Mail order — Medco	two co-pays for a 90-day supply
Mail order — Accredo	one co-pay for a 30-day supply

Medco Health Solutions (Medco) will continue to be our prescription drug vendor for 2012. Medco is one of the top pharmacy benefits management companies. You'll be able to fill your eligible prescriptions through a network of approximately 60,000 local and chain pharmacies or a mail order pharmacy. The Medco call center — 1-866-677-8928 — is open 24/7. And you can register at the Medco secure, personalized website — www.medco.com.

Required mail order for maintenance drugs

The mail order feature is required if you have a maintenance medication that is prescribed for an ongoing medical condition.

Mail order gives members a 90-day supply for the price of two co-pays. Members are allowed to refill the same maintenance prescription three times at a retail pharmacy; on the fourth refill, the drug must be filled through Medco's mail order in order for the costs to be covered.

If you have any questions or would like to find out if your prescription is a maintenance medication, please call Medco's pharmacy at 1-866-677-8928.

Two ways to submit a new prescription to Medco for mail order:

1. **By mail** — Get a new prescription from your doctor and mail it, along with a Medco mail order form, to Medco. Ask your doctor for a 90-day supply with refills up to one year.
2. **By fax** — Your doctor's office can call Medco to obtain instructions on faxing in your prescription. The number for the doctor to call is (888) EASY-RX1 [(888) 327-9791].

Three easy ways to refill a mail order prescription:

You should have your Medco member ID number on hand when you begin, along with a prescription number from a current mail-order label or refill slip. Please request your refill when you have a two-week supply of medication remaining.

1. **By phone** — You can refill your existing prescription by phone. Just call (800) 4-REFILL [(800) 473-3455] and use the automated refill service. Have your prescription number, which can be located on your prescription label or refill slip, and your credit card available. Use Medco's automated phone system to request your prescription refill. If you need help, you will be transferred to a Member Services representative.

Open Enrollment

Sept. 12 – 30, 2011

Online only — 100% paperless enrollment 

Everyone required to make an election

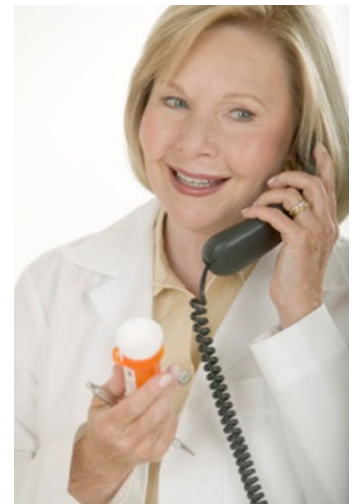
2. **By Internet** — You can reach the Medco Pharmacy by visiting www.medco.com. Activate your account by registering with your Medco member ID number and a recent prescription number. Follow the instructions for refilling your prescriptions.
3. **By mail** — Fill out the information on the Medco mail order form. Attach your most recent refill slip(s) in the space indicated. Mail Medco the completed form and your mail-order co-payment.

"Worry-Free Refills" for mail order

Another feature of the Medco Mail Order Pharmacy is the "Worry-Free Refill Program" which allows your eligible maintenance prescriptions to be refilled automatically. When you enroll in the program, Medco will automatically send your next refill as you near the end of your current supply. To enroll in the program, visit www.medco.com, or call Member Services at 1-866-677-8928. For safety and other reasons, prescriptions for some medications are never allowed to be automatically filled, including specialty medications and controlled substances.

Changing dosage amounts on maintenance drugs

Members often have to change the dosage amounts on their prescriptions when first being prescribed maintenance medication for conditions such as high blood pressure or cholesterol. If a member's doctor changes the dosage on the maintenance drug, the new dosage will be the first retail fill, not the second or third — depending on how many previous dosages were prescribed. For example, suppose you try a 30-day supply of Lipitor 10 mg and need to increase your dosage to 15 mg. When the prescription is filled at the retail pharmacy for 15 mg, this is your first fill of your maintenance medication, and you have two more fills for the Lipitor 15 mg at retail



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before paying the full cost of the drug.

Accredo Health Group for specialty drugs

Members taking specialty drugs (e.g., for multiple sclerosis, growth hormone, psoriasis, rheumatoid arthritis and transplants) will be required to obtain their prescription through Medco's dedicated specialty pharmacy, Accredo. They will have access to personal care coordinators, registered nurses, pharmacists and clinical care coordinators.

Unlike mail order for maintenance drugs, a co-pay is paid every time a specialty drug is refilled, and specialty drug refills are limited to a 30-day supply at each refill.

Members taking infusible chemotherapy medication will continue to receive these drugs as they do today at their doctor's office. Accredo mail order will be used for oral chemotherapy medication.

Formulary or preferred drug list

A formulary or preferred drug list is a list of medications designed to help reduce the amount you pay for your prescriptions. It also ensures that you receive medications that have been reviewed and selected for their effectiveness and quality by practicing physicians and clinical pharmacists. If you purchase a prescription drug that is not on the preferred drug list, you will pay a \$40 co-pay at a

retail pharmacy for a 30-day supply, or an \$80 co-pay by mail order for a 90-day supply. Preferred drug lists are subject to change throughout the year.

Generics

Generic drugs are cost-effective alternatives to brand medications. If you purchase a generic drug, you will pay a \$7 co-pay. You can save money on your co-pay by asking your physician if a generic substitution can be prescribed.

A generic is a drug which is produced and distributed without patent protection. A generic must contain the same active ingredients as the original formulation. In most cases, generic products are available once the patent protections afforded to the original developer have expired. When generic products become available, the market competition often leads to substantially lower prices for both the original brand name product and the generic forms.

For more information

The Benefits website is available to you 24 hours a day, seven days a week. For questions about specific plan benefits, contact Medco at 1-866-677-8928.

Additional Information		
Customer Service	Web Access	Searching for drug lists and online access to mail order pharmacy
Medco	1-866-677-8928 www.medco.com	Access Web address. Click Register Now to register. Follow screen instructions to refill a prescription, track an order, view claims history, price a drug or search the national drug list.
	www.medco.com/choices	To view lower-cost options for medications you take on an ongoing basis.

Vision Highlights



Open Enrollment

Sept. 12 – 30, 2011

Online only — 100% paperless enrollment 

Everyone required to make an election

Periodic eye exams and appropriate corrective lenses are important for maintaining good vision. If you enroll in one of the Anthem medical options, you are automatically enrolled in the vision option administered by Vision Service Plan (VSP). The plan covers the cost of eye exams, lenses and frames. There are no ID cards required. Just tell your VSP doctor that you are a VSP member, and the doctor will handle the rest.

VSP Choice Network

The plan uses the VSP "Choice" network. To receive the most value from your vision benefits, you should use a participating VSP "Choice" network doctor. Register at www.vsp.com to view your benefits, doctor visit savings, and other helpful information about how to keep your eyes healthy.

Highlights of vision benefits

Covered services	Your co-payment/co-insurance/limitations	
	VSP "Choice" provider	Non-network provider
Eye examination (once every 12 months)	\$15 co-payment	Covered up to \$43 after \$15 co-payment
Single-vision	Covered in full	Covered up to \$26
Lenses (once every 24 months)	Bifocal	Covered up to \$43
Trifocal	Covered in full	Covered up to \$60
Frames (once every 24 months)	Covered up to \$120 plan allowance (and 20% off the amount over the allowance)	Covered up to \$40
Elective contact lenses (once every 24 months; in lieu of all other lens and frame benefits)	Covered up to \$105 plan allowance (contacts, fitting and evaluation); pre-certification required	Covered up to \$100; pre-certification required

For more information

The Benefits website is available to you 24 hours a day, seven days a week. For questions about specific plan benefits, contact VSP's Customer Service.

Additional Information

	Customer Service	Web Access	Searching for In-Network Providers
Vision Service Plan	1-800-877-7195	www.vsp.com	VSP "Choice" — Access the Web address. Follow screen instructions to continue your search

Dental Highlights

Open Enrollment

Sept. 12 – 30, 2011

Online only — 100% paperless enrollment 

Everyone required to make an election

Understanding your options

As an eligible employee, two dental options, administered by Delta Dental, are available to you and your eligible dependents:

- High Option; or
- Basic Option.

How the options work

Both dental options provide coverage for:

- Diagnostic and Preventive services (oral exams, x-rays, teeth cleaning);
- Minor services (fillings, oral surgery/extractions);
- Major services (dentures, crowns, periodontics, dental implants); and
- Orthodontia.

The High and Basic options emphasize preventive and diagnostic care by paying 100% of the allowable amount. Oral exams and teeth cleaning are limited to two exams per calendar year. For Minor and Major services, you pay a co-insurance after meeting a \$25 per person annual deductible. The co-insurance amounts differ by option, with the High option paying a higher percentage of the allowable amount for covered services than the Basic option. Dental benefits are limited to annual maximum benefit amounts, which differ by option.

Delta Dental Networks

The High and Basic options allow you to receive benefits from any licensed dentist. If you use a participating Delta Dental "Premier" network dentist, however, you will not be billed for charges that exceed the plan's allowable amount for covered services. Delta Dental offers a "PPO" network to help maximize your dental benefits. By selecting a participating "PPO" dentist or specialist, you increase your savings, allowing your dental benefits dollars to go further.

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Highlights of dental plan options

		Delta Dental — High Option	Delta Dental — Basic Option	
Choice of providers		Any licensed dentist	Any licensed dentist	
Annual maximum benefit		\$1,750 per person	\$1,000 per person	
Annual deductible (applies to Basic and Major services)		\$25 per person	\$25 per person	
Covered services	Diagnostic and preventive (oral exams, x-rays, teeth cleaning)	Plan pays 100%; not subject to the deductible	Plan pays 100%; not subject to the deductible	
	Minor services (fillings, oral surgery/ extractions)	Plan pays 80% after the deductible	Plan pays 30% after the deductible	
	Major services (all services subject to the deductible)	Dentures/bridgework	Plan pays 50%	Plan pays 30%
		Crowns	Plan pays 50%	Plan pays 30%
		Periodontics	Plan pays 50%	Plan pays 30%
		Dental implants	Plan pays 50%	Plan pays 30%
	Orthodontia (for dependent child)	Plan pays 50%; \$1,500 lifetime maximum per person	Plan pays 50%; \$750 lifetime maximum per person	
<i>Healthy Mouth, Healthy Body Program</i>	Members who are pregnant or who have diabetes can receive three cleanings in a year after submitting a one-time application to Delta Dental.	Members who are pregnant or who have diabetes can receive three cleanings in a year after submitting a one-time application to Delta Dental.		
Monthly premium for full-time employee	Employee-only coverage	\$7	\$0	
	Employee + spouse coverage	\$17	\$0	
	Employee + child(ren) coverage	\$17	\$0	
	Family coverage	\$27	\$0	

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Healthy Mouth, Healthy Body Program

Recent research indicates growing evidence that connects oral health to overall general health. Our dental options offer a program to assist in better oral health for diabetic members and expectant mothers by offering an additional cleaning during the calendar year. To enroll, obtain a *Healthy Mouth, Healthy Body* enrollment form from the Benefits intranet site or by calling Delta Dental, and return

the completed form to Delta Dental. Once enrolled, you can talk to your dentist about scheduling a third appointment.

For more information

The Benefits website is available to you 24 hours a day, seven days a week. For questions about specific plan benefits, contact Delta Dental.

Additional Information			
	Customer Service	Web Access	Searching for In-Network Providers
Delta Dental (High or Basic) <i>Contract #008450 plus</i>	1-800-955-2030	www.deltadentalky.com	Delta Dental Premier or Delta Dental PPO — Access Web address. Click on Dentist Search . Select Delta Dental Premier or Delta Dental Premier PPO under Product Selection and click on Select Product . Follow screen instructions to continue your search.

Health Care Reimbursement Account (HCRA)

Open Enrollment

12

Sept. 12 – 30, 2011

Online only — 100% paperless enrollment 

Everyone required to make an election

Flexible Spending Accounts

Flexible Spending Accounts (FSA) offer you the opportunity to reduce your taxable income. You can set up an account with pre-tax dollars to pay for eligible health care expenses and qualifying dependent care expenses. By using pre-tax dollars, money that is set aside in an FSA is not included in your earnings for tax purposes. The amount of federal, state and Social Security taxes you pay is reduced.

While the tax savings advantage of a flexible spending account is very valuable to you, it is important to carefully plan your contributions. Internal Revenue Service (IRS) regulations do not allow you to receive any unused money left in your account at the end of the calendar year. This means any money deposited during the calendar year that is not used for eligible expenses incurred that year is forfeited.

For 2012

- The company will provide \$200 of coverage in the HCRA for all full-time and regular part-time employees actively employed as of Dec. 31, 2011.
- You will continue to use your same debit card you previously received. Your current debit card will automatically be loaded on Jan. 1, 2012 with your 2012 annual HCRA amount.
- Over-the-counter drugs (other than insulin) must be prescribed by a physician to be eligible for reimbursement under the HCRA.

Health Care Reimbursement Account (HCRA)

The Health Care Reimbursement Account is a flexible spending account. If you participate, you can reimburse yourself for eligible health care expenses for you and your eligible dependents with pre-tax money. Eligible expenses include co-payments, deductibles, co-insurance and other IRS-approved health expenses, including eligible over-the-counter items.

If you decide to participate, you may contribute from \$120 to \$7,500 annually to your HCRA in addition to any company coverage for which you are eligible. Your annual contribution will be converted to a per-pay-period amount and deducted from your first and second paycheck each month.

The HCRA, combined with the company's medical and dental plans, offers you flexibility to design a health care program that best meets your needs. For example, you could choose a lower cost medical plan during Open Enrollment and use your premium savings to contribute more to your HCRA.

Health Care Account Debit Card

Your ADP Health Care Account Debit Card (Card) is a convenient way to pay for eligible expenses directly from your HCRA. If you are paying for prescription drug co-pays or physician co-pays, you do not need to file substantiation for your eligible purchases. For all other eligible expenses where you use the Card, however, you need to substantiate your purchases (this means faxing your itemized receipts for Health Care Account Card purchases along with a claim form to prove the HCRA eligibility of the items or services purchased). If you've not submitted required substantiation within 59 days from date of purchase, your Card will be deactivated until substantiation is submitted.

Eligible expenses

As you consider participation in the company's medical and dental plans, keep in mind that the HCRA provides this tax-savings advantage on any health care expenses considered tax-deductible by the IRS and not reimbursed under any medical, dental, vision or hearing program. ADP's website offers a listing of eligible expenses. You may not be reimbursed for any eligible expenses arising before your participation became effective or after you cease participation. Eligible expenses must be incurred during the calendar year.

Examples of eligible expenses:

- your share of medical and dental costs — deductibles, co-payments, co-insurance;
- all over-the-counter medicines and drugs (other than insulin) must be prescribed by a physician;
- eye examinations, eyeglasses, contact lenses, eye surgery;
- hearing aids and batteries; and
- smoking-cessation programs and prescribed drugs to alleviate nicotine withdrawal.

For more information

The Benefits website is available to you 24 hours a day, seven days a week. For questions about specific plan benefits, contact ADP.

Additional Information

Customer Service

Web Access

Health Care Reimbursement Account (HCRA)

1-800-654-6695

www.flexdirect.adp.com

ADP Services — Access Web address for tax-savings worksheet, listing of eligible expenses, view your claims history, arrange for direct deposit of your reimbursement checks.

HCRA Frequently Asked Questions

Open Enrollment

2012

Sept. 12 – 30, 2011

Online only — 100% paperless enrollment 

Everyone required to make an election

The following Q&A will give you a better understanding of this flexible spending account, which is used by a growing number of employees to pay non-covered health care expenses.

Q. Do I need to enroll in the HCRA during Open Enrollment in order to receive my \$200 of company-provided coverage?

A. No action is required on your part to receive your \$200 in company-provided coverage. Beginning Jan. 1, 2012, your HCRA account, which is administered by ADP Benefits Services, will automatically reflect your company coverage of \$200. While an employee contribution is not required, you may want to consider contributing your own money into the HCRA so that you can use pre-tax money to reimburse yourself for uninsured health care expenses.

Q. I want to contribute my own money to my HCRA in addition to the \$200 company-provided coverage. What do I need to do?

A. You will need to make an election during Open Enrollment if you want to put your own money — above the \$200 company-provided coverage — into your HCRA for 2012. The minimum annual employee contribution level for 2012 is \$120, which means you can enroll for just \$10 per month.

Q. Will my current ADP debit card work in 2012?

A. Yes — please keep your current ADP debit card that you previously received. Your current debit card will automatically be loaded with your 2012 annual goal amount on January 1, 2012.

Q. How much can I contribute to my HCRA account?

A. For 2012, You can contribute any amount between the minimum of \$120 and the maximum of \$7,500. Please note that beginning Jan. 1, 2013, health care reform will allow you to contribute only up to a maximum amount of \$2,500 for 2013.

Q. What types of expenses can be reimbursed using my HCRA?

A. Your HCRA enables you use pre-tax money to pay for a wide variety of expenses that are eligible for reimbursement. These include co-payments and deductibles, plus various health-related products and services — from chiropractic care to dental care to laser eye surgery — and much more. ADP's website offers a listing of eligible HCRA expenses.

Q. Can I carry over my unused 2011 HCRA account to 2012?

A. No. The plan does not allow you to receive any unused money left in your account at the end of 2011. This means any of your money and any of the \$200 of company provided coverage that is not used for eligible expenses incurred in 2011 is forfeited.

Q. How will I receive my HCRA reimbursements?

A. ADP offers reimbursement through direct deposit, or a paper check can be mailed to your home address.

Q. How do I get direct deposit for my HCRA?

A. To get direct deposit, visit the ADP website. First-time users should click the registration link under **Participant Login**. Enter your Social Security number and ZIP code, then follow the

prompts to establish your permanent user ID and password.

After entering your user ID and password, click **Participant Profile** from the landing page, then select **Yes** to the direct deposit option. Enter the necessary information, such as your EFT checking account number and the EFT routing number that appear on your checks.

When finished, select **Update Information**. Direct deposit will be in effect in approximately 10 business days. If you have any questions, call ADP at 1-800-654-6695.

Q. How do I monitor my personal HCRA account with ADP?

A. After Jan. 1, 2012, you can log onto ADP's Website at <http://www.flexdirect.adp.com> to view your 2012 account and to track the status of your reimbursements.

Q. Will we have auto-claims rollover?

A. Effective Jan. 1, 2011, you no longer had the Anthem auto-claims rollover feature. This means you'll either need to use your Health Care Account Debit Card or submit paper claims for your eligible HCRA expenses.

Q. What is the Health Care Account Debit Card (Card)?

A. It's a convenient way to pay for eligible expenses directly from your HCRA, without the need to pay out of pocket and wait for reimbursement. The IRS has regulations regarding appropriate use of the Card, as far as **where the Card can be used, and when follow-up documentation is required. Use of the Card DOES NOT eliminate all of the paperwork.**

Q. Where can the Card be used?

A. Per IRS regulations, the Card can only be used at health care providers — hospital, doctor, dentist, optometrist, pharmacy, etc.

Q. What do I do if I go to a pharmacy/doctor's office, and my debit Card is denied?

A. You will need to pay with your personal funds and then submit a claim form to ADP.

Q. I used the Card. When do I have to turn in substantiation (paperwork)?

A. Certain situations will allow the Card transactions to be electronically substantiated, meaning that no follow-up documentation will be required. If you are enrolled in the company medical plan and are paying for prescription drug co-pays or physician co-pays, you do not need to file substantiation for your eligible purchases.

For all other eligible expenses where you use the Card and for anyone not enrolled in the company medical plan, you need to

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substantiate your purchases — this means faxing your itemized receipts for Card purchases along with a claim form to prove the HCRA eligibility of the items or services purchased. If you've not submitted substantiation within 59 days from the date of purchase, your Card will be deactivated for all future purchases until substantiation is submitted.

Q. How do I file a claim or submit substantiation (paperwork)?

A. To file a claim for an expense that you did not purchase using your Card or to respond to a receipt request for a Card purchase, please visit the ADP website "Flex Forms" tab and use the Online Claim Form Completion tool. Each online form contains step-by-step instructions. Online forms are the most secure and preferred method of submitting claims. If you prefer to use a paper-based form, however, hard-copy claim forms can be printed and completed by hand from the "Tools & Forms" tab.

Q. Will ADP let me know if I need to send substantiation (paperwork)?

A. Yes. ADP will send an e-mail asking for substantiation to either your company or personal e-mail address depending on the following situations.

- If you are registered with a Health FSA account, ADP has your preferred e-mail address.
- If you are not registered, ADP will use your work e-mail to send substantiation.

Q. If I need copies of Explanation of Benefits to substantiate claims, can I get copies from Anthem?

A. Yes. Log onto Anthem's website (www.anthem.com) and click "Check Claim Status" in the right hand column to search for paid claims.

Q. How many Cards will I be issued?

A. You will receive one Card in your name, which is ADP's standard practice. The debit card is good for three years.

Q. May I order additional Cards for other family members? If not, what are my options for paying medical expenses if I don't have the Card with me?

A. ADP will only issue one Card to an employee. You could pay for the claims or services with your personal funds and submit a claim form to ADP. You could ask the health care provider if they would be willing to take the Card number over the phone and process without the swiping the Card.

Q. What if I don't want the Card?

A. The Card will not work until you activate it. If you don't want to use the Card, do not activate the Card.

Q. Can I use the Card when purchasing medications and supplies that qualify under HCRA online?

A. If the vendor will accept the Card, yes. If the vendor will not accept the Card, you will need to purchase the item using your personal funds and submit a claim form to ADP.

Q. What if I lose my Card?

A. Because the Card has the full amount of your annual health FSA contributions, you'll want to keep it in a secure place. If you lose your Card, contact ADP — **1-800-654-6695** — immediately so that your Card can be deactivated and cancelled.

Q. Do I have to register on ADP's website?

A. We encourage you to register your e-mail address on ADP's website so that ADP can inform you of any issues — such as when you need to send in substantiation after using the Card. It's quick and easy to register. You can monitor your account, view payroll contributions and check on a paper claim status.

Q. How can I learn more about the Card?

A. The Card is a great benefit, but it is important that you understand how it works. Visit the ADP website (address on back of Card or www.flexdirect.adp.com) to learn about using your Card, view frequently asked questions and monitor your account.

Q. Who is ADP?

A. ADP Benefit Services is the claims administrator for the HCRA.

Q. Is our HCRA plan the same as a health Flexible Spending Account?

A. Yes. The two terms are one and the same.

Dependent Care Reimbursement Account (DCRA)

Open Enrollment

2012

Sept. 12 – 30, 2011

Online only — 100% paperless enrollment 

Everyone required to make an election

Flexible Spending Accounts

Flexible Spending Accounts (FSA) offer you the opportunity to reduce your taxable income. You can set up an account with pre-tax dollars to pay for eligible, not-reimbursed health care expenses and qualifying dependent care expenses. By using pre-tax dollars, money that is set aside in an FSA is not included in your earnings for tax purposes. The amount of federal, state and Social Security taxes you pay is reduced.

While the tax savings advantage of a flexible spending account is very valuable to you, it is important to carefully plan your contributions. Internal Revenue Service (IRS) regulations do not allow you to receive any unused money left in your account at the end of the calendar year. This means any money deposited during the calendar year that is not used for eligible expenses incurred that year is forfeited.

Dependent Care Reimbursement Account (DCRA)

The Dependent Care Reimbursement Account is a flexible spending account. If you participate, you can reimburse yourself for child care expenses for dependents under age 13. You also may use this account to pay for the care of dependents of any age who are mentally or physically handicapped, live with you and are claimed as dependents on your federal income tax return.

Dependent care may be provided in the home or in a facility outside the home. The care may be provided by a baby-sitter, licensed facility or by a relative who is not your dependent.

If you decide to participate, you may contribute from \$120 to \$5,000 annually to your DCRA in addition to any company contribution for which you are eligible. Your annual contribution will be converted to a per-pay-period amount and deducted from your first and second paycheck each month. If you are single or are married and filing income taxes jointly, you may contribute up to \$5,000 of pre-tax income for eligible dependent care expenses each year. If you are married and filing income taxes separately, you may contribute up to \$2,500 annually.

How the DCRA works

You estimate your eligible dependent care expenses for 2012, and during Open Enrollment, you specify the amount of your paycheck

you want to allocate to your DCRA account. The money you set aside is automatically deducted from your salary on a pre-tax basis and deposited into your DCRA account before federal, state and Social Security taxes are withheld.

ADP Benefit Services (ADP) is the claims administrator. After you incur eligible child care expenses, you submit a paper claim for reimbursement to ADP. After ADP processes the claim, you are reimbursed by check or direct deposit.

For more information

The Benefits website is available to you 24 hours a day, seven days a week. For questions about specific plan benefits, contact ADP.



Additional Information

	Customer Service	Web Access
Dependent Care Reimbursement Account (DCRA)	1-800-654-6695	www.flexdirect.adp.com

ADP Services — Access Web address for tax savings worksheet, listing of eligible expenses, view your claims history, arrange for direct deposit of your reimbursement checks.

Additional Information

Open Enrollment

Sept. 12 – 30, 2011

Online only — 100% paperless enrollment 

Everyone required to make an election

If you have questions, please call the Customer Service toll-free telephone numbers or visit the websites of the administrators listed below. When you call the Customer Service for the medical and dental plans, for security purposes, you need to provide information from your ID card and may need to answer certain security questions.

Additional Information		Customer Service	Web Access
Anthem Blue Preferred EPO Contract #003329600 Prefix: LGH	1-877-750-6062	www.anthem.com	Access Web address. Click on Find a Doctor ; select Kentucky ; click Next . From the Select a Plan drop-down box, select Blue Preferred HMO . From Select Provider Type drop-down box, make your selection and click Next . Follow screen instructions to continue your search.
Anthem National PPO: — PPO Low Deductible — PPO Standard — PPO High Deductible Contract #003329600 Prefix: LGE	1-877-750-6062	www.anthem.com	Access Web address. Click on Find a Doctor ; select Search National BlueCard Directory ; click Next . Under Members , enter LGE . Click Next . Select Search Type (Search by Location or Look up by Name) . Follow screen instructions for continue your search.
Medco (pharmacy)	1-866-677-8928	www.medco.com	Access Web address. Click Register Now to register. Follow screen instructions to refill a prescription, track an order, view claims history, price a drug or search the drug list.
Delta Dental (High or Basic) Contract #008450 plus	1-800-955-2030	www.deltadentalky.com	Delta Dental Premier or Delta Dental PPO — Access Web address. Click on Dentist Search . Select Delta Dental Premier or Delta Dental Premier PPO under Product Selection and click on Select Product . Follow screen instructions for continue your search.
Vision Service Plan	1-800-877-7195	www.vsp.com	VSP "Choice" — Access the Web address. Follow screen instructions for continue your search.
Flexible Spending Accounts Health Care Reimbursement Account (HCRA) and Dependent Care Reimbursement Account (DCRA)	1-800-654-6695	www.flexdirect.adp.com	ADP Services — Access Web address. First-time users should click the registration link under Participant Login . Register by entering your Social Security number and ZIP code. Then, follow the prompts to establish your permanent user ID and password. Access Web address for tax savings worksheet, listing of eligible expenses, to view your claims history or to arrange for direct deposit of your reimbursement checks.

Please note: This is a general summary of your benefits. For specific details, you may refer to the summary plan description that can be found on the Benefits website. Every effort has been made to ensure that this summary accurately represents the benefits. If, however, there are any discrepancies between the terms of this summary and the terms of the plan document, the plan document will prevail.

2012 Health Care Plans *(based on full-time employment)*

Employee-Only Coverage — Monthly Premiums			
	Plans	2011	2012
Current Options	EPO	\$114	\$122
	PPO Standard	\$61	\$65
	PPO Low Deductible	\$85	\$87
	PPO High Deductible	\$23	\$29

Employee + Spouse Coverage — Monthly Premiums			
	Plans	2011	2012
Current Options	EPO	\$278	\$290
	PPO Standard	\$167	\$174
	PPO Low Deductible	\$220	\$220
	PPO High Deductible	\$90	\$102

Employee + Spouse Coverage <i>with Employed Spouse Premium</i> — Monthly Premiums			
	Plans	2011	2012
Current Options	EPO	N/A	\$490
	PPO Standard	N/A	\$374
	PPO Low Deductible	N/A	\$420
	PPO High Deductible	N/A	\$302

Employee + Child(ren) Coverage — Monthly Premiums			
	Plans	2011	2012
Current Options	EPO	\$247	\$259
	PPO Standard	\$151	\$151
	PPO Low Deductible	\$194	\$194
	PPO High Deductible	\$79	\$88

Family Coverage — Monthly Premiums			
	Plans	2011	2012
Current Options	EPO	\$411	\$427
	PPO Standard	\$257	\$260
	PPO Low Deductible	\$329	\$329
	PPO High Deductible	\$146	\$157

Family Coverage <i>with Employed Spouse Premium</i> — Monthly Premiums			
	Plans	2011	2012
Current Options	EPO	N/A	\$627
	PPO Standard	N/A	\$460
	PPO Low Deductible	N/A	\$529
	PPO High Deductible	N/A	\$357

2012 Dental Care Plans — *No premium increase*

Open Enrollment for 2012 Plan Year

General Comparison of 2012 Medical Plan Options for In-Network Services		EPO	PPO Low Deductible	PPO Standard	PPO High Deductible
Annual full-time employee premium cost — annual total payment to participate in medical plan.	Employee-Only Coverage	\$1,464	\$1,044	\$780	\$348
	Employee + Spouse Coverage	\$3,480	\$2,640	\$2,088	\$1,224
	Employee + Spouse Coverage with Employed Spouse Premium	\$5,880	\$5,040	\$4,488	\$3,624
	Employee + Child(ren) Coverage	\$3,108	\$2,328	\$1,812	\$1,056
	Family Coverage	\$5,124	\$3,948	\$3,120	\$1,884
	Family Coverage with Employed Spouse Premium	\$7,524	\$6,348	\$5,520	\$4,284
Co-payment ¹ — Additional fee (or flat \$ amount) you pay the doctor or hospital at the time you receive in-network services.	\$20 PCP/\$30 specialists; ⁵ \$300 per hospital stay; \$100 outpatient services. ²	\$20 PCP/\$30 specialists ⁵	\$20 PCP/\$30 specialists ⁵	100% for well baby/child care; 100% for preventive office visits; other office visits covered under co-insurance after the deductible.	
Deductible ^{3,4} — An amount you must pay for services before the plan begins to pay its co-insurance percentage of in-network services.	\$0	\$200 per person, but limited to \$400 for a family.	\$400 per person, but limited to \$800 for a family.	\$1,200 (EE-only coverage); \$2,400 (EE plus 1 or more).	
Co-insurance ¹ — After deductible is met, percentage of allowable charge the plan pays and you pay for covered in-network services.	Plan pays 100%	Plan pays 90%; participant pays 10%.	Plan pays 80%; participant pays 20%.	Plan pays 80%; participant pays 20%.	
Maximum out-of-pocket limit (OPL) ^{3,4} — Limit on the dollar amount you are responsible for paying out of your pocket for covered medical services. Once you reach your out-of-pocket maximum, the plan pays 100% of the allowable amount for covered in-network services.	\$2,500 per person, but limited to \$5,000 for a family.	\$2,500 per person, but limited to \$5,000 for a family.	\$2,500 per person, but limited to \$5,000 for a family.	\$2,400 (EE-only coverage); \$4,800 (EE plus 1 or more).	
Network restrictions	Must use network providers; no coverage when services are received out-of-network.	Both in-network (90/10) and out-of-network (70/30) coverage.	Both in-network (80/20) and out-of-network (60/40) coverage.	Both in-network (80/20) and out-of-network (60/40) coverage.	
Prescription drugs — same for all plans	Generic formulary: \$7 retail co-pay Brand name formulary: \$25 retail co-pay Non-formulary: \$40 retail co-pay Mail-order required for maintenance medications after 3 fills at a retail pharmacy — Medco mail order: 1-866-677-8928 Accredo mail order for certain specialty medications (transplants, MS, growth hormone, etc.)				

1) Co-payments, deductibles, co-insurance and out-of-pocket limits above assume in-network services. Actual plan document will control plan provisions.
 2) Outpatient Surgery, MRA/MRI, PET Scans and CAT Scans.
 3) Does **not** include annual premium cost or co-pays for prescription, vision, dental, physician office services and urgent care center.
 4) Does **not** include annual premium cost or co-pays for prescription, vision and dental. Includes the deductible, office visit co-pays, urgent care co-pays and your co-insurance.
 5) There is no cost sharing for certain preventive exams and procedures based on health care reform guidelines.



PPL companies