



Community BlueSM PPO – Plan 1 Benefits-at-a-Glance for The Romine Group

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In-network

Out-of-network

Deductible, copays and dollar maximums

Note: Services from a provider for which there is no PPO network and services from a non-network provider in a geographic area of Michigan deemed a “low access area” by BCBSM for that particular provider specialty are covered at the in-network benefit level. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider’s charge.

Deductible	None	\$250 for one member, \$500 for the family each calendar year
Copays • Fixed dollar copays • Percent copays	\$30 for office visits and \$150 for emergency room visits	\$150 for emergency room visits
	50% for mental health care, substance abuse treatment and private duty nursing	20% for general services and 50% for mental health care, substance abuse treatment and private duty nursing
Copay dollar maximums • Fixed dollar copays • Percent copays – excludes mental health care, substance abuse treatment and private duty nursing copays	None	None
	Not applicable	\$2,000 for one member, \$4,000 for two or more members each calendar year
Dollar maximums	\$1 million lifetime per covered specified human organ transplant type and a separate \$5 million lifetime per member for all other covered services and as noted for individual services	

Preventive care services – *Payment for preventive services is limited to a combined maximum of \$1000 per member per calendar year

Health maintenance exam – includes chest x-ray, EKG and select lab procedures	Covered – 100%*, one per calendar year	Not covered
Gynecological exam	Covered – 100%*, one per calendar year	Not covered
Pap smear screening – laboratory and pathology services	Covered – 100%*, one per calendar year	Not covered
Well-baby and child care	Covered – 100%* • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 2 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • 1 visit per birth year, 48 months through age 15	Not covered
Childhood immunizations as recommended by the Advisory Committee on Immunizations Practices and the American Academy of Pediatrics	Covered – 100%*	Not covered
Fecal occult blood screening	Covered – 100%*, one per calendar year	Not covered
Flexible sigmoidoscopy exam	Covered – 100%*, one per calendar year	Not covered
Prostate specific antigen (PSA) screening	Covered – 100%*, one per calendar year	Not covered

Mammography

Mammography screening	Covered – 100%	Covered – 80% after deductible
One per calendar year, no age restrictions		

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In-network

Out-of-network

Physician office services

Office visits	Covered – \$30 copay	Covered – 80% after deductible, must be medically necessary
Outpatient and home medical care visits	Covered – 100%	Covered – 80% after deductible, must be medically necessary
Office consultations	Covered – \$30 copay	Covered – 80% after deductible, must be medically necessary
Urgent care visits	Covered – \$30 copay	Covered – 80% after deductible, must be medically necessary

Emergency medical care

Hospital emergency room	Covered – \$150 copay, waived if admitted or for an accidental injury	Covered – \$150 copay, waived if admitted or for an accidental injury
Ambulance services – must be medically necessary	Covered – 100%	Covered – 100%

Diagnostic services

Laboratory and pathology services	Covered – 100%	Covered – 80% after deductible
Diagnostic tests and x-rays	Covered – 100%	Covered – 80% after deductible
Therapeutic radiology	Covered – 100%	Covered – 80% after deductible

Maternity services provided by a physician

Prenatal and postnatal care	Covered – 100%	Covered – 80% after deductible
	Includes care provided by a certified nurse midwife	
Delivery and nursery care	Covered – 100%	Covered – 80% after deductible
	Includes delivery provided by a certified nurse midwife	

Hospital care

Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies Note: Nonemergency services must be rendered in a participating hospital.	Covered – 100%	Covered – 80% after deductible
	Unlimited days	
Inpatient consultations	Covered – 100%	Covered – 80% after deductible
Chemotherapy	Covered – 100%	Covered – 80% after deductible

Alternatives to hospital care

Skilled nursing care	Covered – 100%	Covered – 100%
	Up to 120 days per calendar year	
Hospice care	Covered – 100%	Covered – 100%
	Limited to dollar maximum that is reviewed and adjusted periodically	
Home health care – must be medically necessary	Covered – 100%	Covered – 100%
Home infusion therapy – must be medically necessary	Covered – 100%	Covered – 100%

Surgical services

Surgery – includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	Covered – 100%	Covered – 80% after deductible
Presurgical consultations	Covered – 100%	Covered – 80% after deductible
Colonoscopy	Covered – 100%	Covered – 80% after deductible
Voluntary sterilization	Covered – 100%	Covered – 80% after deductible



In-network

Out-of-network

Human organ transplants

Specified human organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 100%	Covered – in designated facilities only
	Limited to \$1 million lifetime maximum per member per transplant type for transplant procedure(s) and related professional, hospital and pharmacy services	
Bone marrow – when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 100%	Covered – 80% after deductible
Specified oncology clinical trials	Covered – 100%	Covered – 80% after deductible
Kidney, cornea and skin	Covered – 100%	Covered – 80% after deductible

Mental health care and substance abuse treatment

Inpatient mental health care	Covered – 50%	Covered – 50% after deductible
	Unlimited days	
Inpatient substance abuse treatment	Covered – 50%	Covered – 50% after deductible
	Unlimited days, up to \$15,000 annual, \$30,000 lifetime maximum	
Outpatient mental health care • Facility and clinic • Physician's office	Covered – 50%	Covered – 50%
	Covered – 50%	Covered – 50% after deductible
Outpatient substance abuse treatment – in approved facilities	Covered – 50%	Covered – 50%
	Up to the state-dollar amount that is adjusted annually	

Other covered services

Outpatient Diabetes Management Program (ODMP)	Covered – 100%	Covered – 80% after deductible
Allergy testing and therapy	Covered – 100%	Covered – 80% after deductible
Chiropractic spinal manipulation	Covered – \$30 copay per office visit	Covered – 80% after deductible
	Up to 24 visits per calendar year	
Outpatient physical, speech and occupational therapy	Covered – 100%	Covered – 80% after deductible
	Limited to a combined maximum of 60 visits per member per calendar year	
Durable medical equipment	Covered – 100%	Covered – 100%
Prosthetic and orthotic appliances	Covered – 100%	Covered – 100%
Private duty nursing	Covered – 50%	Covered – 50%
Prescription drugs	Not covered	Not covered

Optional riders

Rider CB-CSR , cost sharing requirements	Changes the member's cost sharing requirements for out-of-state services. Note: This rider is available only to groups in the Upper Peninsula.
Rider CBC-MT , copay requirement for manipulative treatment	Imposes the same fixed dollar copay requirement for chiropractic and osteopathic manipulative treatment by a network provider as is required for all network physician office visits.
Rider CB-OV\$20 , office visit copay requirement	Increases fixed dollar copay amount from \$10 to \$20.
Rider CB-OV\$30 , office visit copay requirement	Increases fixed dollar copay amount from \$10 to \$30.
Rider CB-RM 100 , routine mammograms	Removes deductible and copay requirements from screening mammography services provided by PPO network providers.
Rider CI , contraceptive injections Rider PCD , prescription contraceptive devices Rider PD-CM , prescription contraceptive medications	Adds coverage for contraceptive injections, physician-prescribed contraceptive devices such as diaphragms and IUDs, and "Rx only" oral or injectable contraceptive medications. Note: These riders are only available as part of a prescription drug package. Riders CI and PCD are part of your medical-surgical coverage, subject to the same deductible and copay, if any, you pay for medical-surgical services. (Rider PCD waives the copay for services provided by a network provider.) Rider PD-CM is part of your prescription drug coverage, subject to the same copay you pay for prescription drugs.
Rider XVA , excludes voluntary abortions	Excludes benefits for voluntary abortions.

Blue VisionSM

Benefits-at-a-Glance for The Romine Group



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Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blue members. To find a VSP doctor, call **800-877-7195** or log onto the VSP Web site at **vsp.com**.

Note: Members may choose between prescription glasses (lenses and frame) or contact lenses, but not both.

	VSP network doctor	Non-VSP provider
Copays		
• Eye exam	\$5 copay	\$5 copay applies to charge
• Prescription glasses (lenses and/or frames)	A combined \$10 copay	Member responsible for difference between approved amount and provider's charge, less a \$10 copay
• Medically necessary contact lenses	\$10 copay	Member responsible for difference between approved amount and provider's charge, less a \$10 copay
Eye exam		
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	Covered – \$5 copay	Reimbursement up to \$35, less a \$5 copay (member responsible for any difference)
	One eye exam in any period of 12 consecutive months	
Lenses and frames		
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary. Note: Discounts on additional prescription glasses and savings on lens extras when obtained from a VSP doctor.	Covered – \$10 copay (one copay applies to both lenses and frames)	Reimbursement up to predetermined amount based on lense type after copay (member responsible for any difference)
	One pair of lenses, with or without frames, in any period of 12 consecutive months	
Standard frames Note: All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.	Covered – \$10 copay (one copay applies to both lenses and frames)	Reimbursement up to \$45, less a \$10 copay (member responsible for any difference)
	One frame in any period of 12 consecutive months	
Contact lenses		
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	Covered – \$10 copay	Reimbursement up to \$210 after a \$10 copay (member responsible for any difference)
	One pair of contact lenses in any period of 12 consecutive months	
Elective contact lenses that improve vision (prescribed, but do not meet criteria of medically necessary)	Covered – \$120 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	Covered – \$105 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	One pair of contact lenses in any period of 12 consecutive months	



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Community Dental Coverage Plan 3 Benefits-at-a-Glance for The Romine Group

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	In-network	Out-of-network
Copays and dollar maximums		
Copays		
• Class I services	0%	50%
• Class II services	25%	50%
• Class III services	50%	50%
• Class IV services	50%	60%
Dollar maximums		
• Annual maximum (for Class I, II and III services)	\$1,000 per member	
• Lifetime maximum (for Class IV services)	\$1,000 per member	

Class I services

Oral exams	Covered – 100%	Covered – 50%
	Twice per calendar year	
A set (up to 4) of bitewing x-rays	Covered – 100%	Covered – 50%
	Twice per calendar year	
Full-mouth and panoramic x-rays	Covered – 100%	Covered – 50%
	Once every 60 months	
Prophylaxis (teeth cleaning)	Covered – 100%	Covered – 50%
	Twice per calendar year	
Pit and fissure sealants – for members age 19 or under	Covered – 100%	Covered – 50%
	Once per tooth every 36 months when applied to the first and second permanent molars	
Palliative (emergency) treatment	Covered – 100%	Covered – 50%
Fluoride treatment	Covered – 100%	Covered – 50%
	Two per calendar year	
Space maintainers – missing posterior (back) primary teeth	Covered – 100%	Covered – 50%
	Once per quadrant per lifetime, for members under age 19	

Class II services

Fillings – permanent teeth	Covered – 75%	Covered – 50%
	Replacement fillings covered after 24 months or more after initial filling	
Fillings – primary teeth	Covered – 75%	Covered – 50%
	Replacement fillings covered after 12 months or more after initial filling	
Onlays, crowns and veneer fillings – permanent teeth	Covered – 75%	Covered – 50%
	Once every 60 months per tooth, payable for members age 12 or older	
Recementing of crowns, veneers, inlays, onlays and bridges	Covered – 75%	Covered – 50%
	Three times per tooth per calendar year after six months from original restoration	
Oral surgery including extractions	Covered – 75%	Covered – 50%
Root canal treatment – permanent tooth	Covered – 75%	Covered – 50%
	Once every 12 months for tooth with one or more canals	
Scaling and root planing	Covered – 75%	Covered – 50%
	Once every 24 months per quadrant	

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In-network

Out-of-network

Class II services, continued

Occlusal adjustments	Covered – 75%	Covered – 50%
	Limited occlusal adjustments covered up to five times in a 60-month period	
Occlusal biteguards	Covered – 75%	Covered – 50%
	Once every 12 months	
General anesthesia or IV sedation	Covered – 75%	Covered – 50%
	When medically necessary and performed with oral or dental surgery	
Adjustment of dentures	Covered – 75%	Covered – 50%
	Six months or more after it is delivered	
Relining or rebasing of partials or complete dentures	Covered – 75%	Covered – 50%
	Once every 36 months per arch	
Tissue conditioning	Covered – 75%	Covered – 50%
	Once every 36 months per arch	
Repair and adjustments of partial or complete dentures	Covered – 75%	Covered – 50%

Class III services

Removable dentures (complete and partial)	Covered – 50%	Covered – 50%
Bridges (fixed partial dentures) – for members age 16 or older	Covered – 50%	Covered – 50%
	Once every 60 months after original was delivered	
Endosteal implants – for members age 16 or older who are covered at the time of the actual implant replacement	Covered – 50%	Covered – 50%
	Once per tooth in a member lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31	

Class IV services – Orthodontic services for dependents under age 19

Minor treatment for tooth guidance appliances	Covered – 50%	Covered – 40%
Minor treatment to control harmful habits	Covered – 50%	Covered – 40%
Interceptive and comprehensive orthodontic treatment	Covered – 50%	Covered – 40%
Post-treatment stabilization	Covered – 50%	Covered – 40%
Cephalometric film (skull) and diagnostic photos	Covered – 50%	Covered – 40%

Note: For non-urgent, complex or expensive dental treatment such as crowns, bridges or dentures, members should encourage their dentist to submit the claim to Blue Cross for predetermination **before** treatment begins. If you receive care from a nonparticipating dentist, you may be billed for the difference between our approved amount and the dentist's charge.



Blue Preferred® Rx Prescription Drug Coverage with \$10 Generic / \$40 Formulary Brand / \$80 Nonformulary Brand Triple-Tier Copay Open Formulary Benefits-at-a-Glance for The Romine Group

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Note: Effective October 1, 2006, the mail order pharmacy for **specialty drugs** changed to Option Care, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis. These drugs require special handling, administration or monitoring. Option Care will handle mail order prescriptions only for specialty drugs while many retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Medco. (Medco is an independent company providing pharmacy benefit services for Blue members.) A list of specialty drugs is available on our Web site at bcbsm.com. Log in under "I am a Member." If you have any questions, please call Option Care customer service at 866-515-1355.

If you are enrolled in one of our integrated medical-surgical prescription drug products, your prescription drug benefits, including mail order drugs, are subject to the same deductible and lifetime dollar maximum required under your medical-surgical coverage. Benefits are not payable until after you have met the annual deductible. After you have satisfied the deductible you are required to pay the copays listed below, which may be limited to an annual out-of-pocket maximum.

		90-day retail network pharmacy	Network mail order provider	Network pharmacy (not part of the 90-day retail network)	Non-network pharmacy
Member's responsibility (copays)					
Tier 1 – Generic or prescribed over-the-counter drugs	1 to 34 day period	\$10 copay	\$10 copay	\$10 copay	\$10 copay <i>plus</i> 25% of the BCBSM approved amount for the drug
	35 to 83 day period	No coverage	\$20 copay	No coverage	No coverage
	84 to 90 day period	\$20 copay	\$20 copay	No coverage	No coverage
Tier 2 – Formulary brand-name drugs	1 to 34 day period	\$40 copay	\$40 copay	\$40 copay	\$40 copay <i>plus</i> 25% of the BCBSM approved amount for the drug
	35 to 83 day period	No coverage	\$80 copay	No coverage	No coverage
	84 to 90 day period	\$80 copay	\$80 copay	No coverage	No coverage
Tier 3 – Nonformulary brand-name drugs	1 to 34 day period	\$80 copay	\$80 copay	\$80 copay	\$80 copay <i>plus</i> 25% of the BCBSM approved amount for the drug
	35 to 83 day period	No coverage	\$160 copay	No coverage	No coverage
	84 to 90 day period	\$160 copay	\$160 copay	No coverage	No coverage

Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law.

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Preferred Rx – TTC \$10/\$40/\$80-RXCM (Open Formulary), FEB 09



	*90-day retail network pharmacy	**Network mail order provider	Network pharmacy (not part of the 90-day retail network)	Non-network pharmacy
Covered services				
“Rx only” drugs	Covered – 100% less plan copay	Covered – 100% less plan copay	Covered – 100% less plan copay	Covered – 75% less plan copay
Prescribed over-the-counter drugs – when covered by BCBSM	Covered – 100% less plan copay	Covered – 100% less plan copay	Covered – 100% less plan copay	Covered – 75% less plan copay
State-controlled drugs	Covered – 100% less plan copay	Covered – 100% less plan copay	Covered – 100% less plan copay	Covered – 75% less plan copay
Disposable needles and syringes – when dispensed with insulin or other covered injectable legend drugs Note: Needles and syringes have no copay.	Covered – 100% less plan copay for the insulin or other covered injectable legend drug	Covered – 100% less plan copay for the insulin or other covered injectable legend drug	Covered – 100% less plan copay for the insulin or other covered injectable legend drug	Covered – 75% less plan copay for the insulin or other covered injectable legend drug

* **Note:** The member must have been on the medication, under BCBSM coverage, for at least 60 days out of the previous 120 days before being eligible for the 90-day supply.

** **Note:** We will not pay for drugs obtained from non-network mail order providers, including Internet providers.

Features of your plan	
BCBSM custom formulary	<p>A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the formulary is to provide members with the greatest therapeutic value at the lowest possible cost.</p> <ul style="list-style-type: none"> ▪ Tier 1 (generic) – Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay, making them the most cost-effective option for the treatment. ▪ Tier 2 (formulary brand) – Tier 2 includes brand-name drugs from the Custom Formulary. Formulary options are also safe and effective, but require a higher copay. ▪ Tier 3 (nonformulary brand) – Tier 3 contains brand-name drugs not included in the Custom Formulary. Members pay the highest copay for these drugs.
Mandatory preauthorization	<p>A process that requires a physician to obtain approval from BCBSM before select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. Step Therapy, an initial step in the “Prior Authorization” process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Only claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at bcbsm.com. Log in under “I am a Member” and click on “Prescription Drugs.”</p>
Mandatory maximum allowable cost (MAC) drugs	<p>If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a generic equivalent drug, you pay only the copay. If you obtain a formulary brand name drug when a generic equivalent drug is available, you MUST pay the difference in cost between the formulary brand name drug dispensed and the maximum allowable cost for the generic drug plus your copay regardless of whether you or your doctor requests the formulary brand name drug. If you obtain a nonformulary brand-name drug when a generic equivalent is available, the nonformulary brand-name drug is not a covered benefit. Exception: If your physician requests and receives authorization for a nonformulary brand-name drug with a generic equivalent from BCBSM and writes “Dispense as Written” or “DAW” on the prescription order, you pay only your applicable copay.</p>
Physician-administered injectable drugs	<p>Injectable drugs administered by a health care professional (not self-administered) are not covered under the pharmacy benefit, but may be covered under your medical benefit.</p>
Drug interchange and generic copay waiver	<p>Certain drugs may not be covered for future prescriptions if a suitable alternate drug is identified by BCBSM, unless the prescribing physician demonstrates that the drug is medically necessary. A list of drugs that may require authorization is available at bcbsm.com.</p> <p>If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay. If your physician rewrites your prescription for the recommended brand-</p>



	name alternate drug, you will have to pay a brand-name copay. In select cases BCBSM may waive the initial copay after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
Quantity limits	Select drugs may have limitations related to quantity and doses allowed per prescription unless the prescribing physician obtains preauthorization from BCBSM. A list of these drugs is available at bcbsm.com .

Optional riders selected	
None	

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Eligibility: Each full-time, non-union employee working 30 hours or more per week

Basic Life Benefits	
Employee Coverage	
Basic Term Life:	One times Basic Annual Earnings to a maximum of \$125,000
Basic AD&D:	Same as Life
AD&D Coverage	Provides up to 100% of the AD&D benefit for loss of life or limb due to an accident.
Age Reduction Schedule	Benefits will reduce by 35% at age 65 and an additional 23% at age 70. Benefits will terminate at retirement.
Disability Waiver of Premium	To age 65 or for 12 months, whichever is longer
Accelerated Death Benefit	If a covered employee becomes terminally ill, he or she may elect to receive 50% of the Basic Life amount to a maximum of \$100,000
Seat Belt Benefit	Provides the lesser of \$25,000 or AD&D Principal Sum if a covered employee or dependent dies as a result of a passenger auto accident while wearing a seat belt
Short Term Disability Income Benefits	
Weekly Benefit	60% of Basic Weekly Earnings
Maximum Benefit	\$1250 per week
Benefits Begin	1st day of disability due to injury 8th day of disability due to sickness
Maximum Benefit Duration	26 weeks
First Day Hospital Coverage	Not Included
Occupational (24 hour) Coverage	Not included (work related conditions are not covered). Not intended to replace Workers' Compensation coverage.
Maternity	Included
Other Income	Benefits are reduced by income received from the employer's salary continuance or accumulated sick leave plan, Social Security and any state cash sickness plan.

Long Term Disability Income Benefits	
Definition of Disability	Employee must be unable to perform the material duties of his/her regular occupation during and beyond the elimination period. Allows for partial disability during the elimination period
Monthly Benefit	60% of Basic Monthly Earnings to a maximum benefit of \$ 5000 per month
Elimination Period	Employee must be disabled for a period of 180 days before benefits begin
Maximum Benefit Duration	To the greater of age 65 or employee's normal Social Security retirement age
Basic Monthly Earnings	Gross monthly earnings from the employer, including employee contributions to a deferred compensation plan. Excludes overtime, commissions and bonuses.
Other Income	Benefits are reduced by income received from the employer's salary continuance or accumulated sick leave plan, Social Security disability or retirement benefits, Workers' Compensation, any state cash sickness plan and any employer-sponsored group disability plan.
Pre-Existing Conditions	Benefits are excluded for a disability that begins within 12 months following the employee's effective date if treatment was received for the disabling condition during the 3 month period preceding the effective date. Prior service credit for coverage under the employer's prior plan.
Mental Illness	Benefits limited to 2 years per disability
Substance Abuse	Benefits limited to 2 years lifetime

Life Claims:

Mailing Address
 Genworth Financial - EBG
 101 Munson Street
 P.O. Box 810
 Greenfield, MA 01302-0810

Disability Claims:

Mailing Address
 Genworth Financial-EBG
 Group Disability Claims
 175 Addison Road
 P. O. Box 725
 Windsor, CT 06095-0725

Our Website

www.gefinancialbenefits.com

Customer Service:

800-451-2513

This is a summary of the benefits provided under a group insurance plan underwritten by GE Group Life Assurance Company. The summary is an outline only and is not a contract. This plan contains certain exclusions and limitations as well as terms under which coverage may be continued or discontinued. Please refer to the Certificate of Insurance for a complete description of actual plan benefits and terms of coverage.

THE ROMINE GROUP 401(k) PLAN SUMMARY

EMPLOYEE CONTRIBUTIONS: An employee may defer from 1% to 25% of compensation on a pre-tax basis up to a maximum of \$16,500 in 2010 (indexed annually). An additional \$5,500 contribution can be made by participant who attained at least age 50 during each calendar year.

DEFERRAL CHANGE DATES: You may increase or decrease the amount you are contributing on January 1, April 1, July 1 and October 1. You may stop making contributions at any time.

ELIGIBILITY All full time employees who are at least age 21 are eligible to participate beginning on the first day of the month following their date of hire.

EMPLOYER CONTRIBUTIONS Your employer has elected to match at a rate of 100% on the first 4% of your compensation that you defer as a participant in the plan. A discretionary employer contribution equal to 4% of your salary will also be contributed to the plan.

VESTING: Employee Deferrals are always 100% vested. Employer Contributions are subject to the following vesting schedule:

<u>YEARS OF SERVICE</u>	<u>% VESTED</u>
1	20%
2	40%
3	60%
4	80%
5	100%

WITHDRAWALS: Your account may be withdrawn only in the event of retirement, disability, death, termination of employment or financial hardship. Hardship withdrawals must be approved by the Employer. Distributions made prior to age 59 1/2 may be subject to a 10% excise tax if not rolled into a new plan or rollover IRA. In the event of death your beneficiary will receive 100% of your investment account balance.

LOANS: Loans are not available.

INVESTMENT OPTIONS: Over one hundred individual investment options, including Lifestyle Funds and Lifecycle Funds.

JOHN HANCOCK: You may transfer money between investment accounts, change future contributions between accounts, receive daily unit values and get up-to-date account balances over the internet www.jhpensions.com or over the telephone using John Hancocks automated voice response service at (800) 395-1113.

BENEFIT STATEMENTS: Individual statements will be furnished quarterly to each participant detailing the status of accounts.

Prepared By:

BARCLAY PLANNING GROUP, LLC

