



2009 Benefits at a Glance

These charts highlight the Medical, Dental, Vision, Life Insurance and Short Term Disability Plans available to Ajilon Associates who work a minimum of 110 hours in a prior payroll month to become eligible for benefits. A payroll month includes all payroll checks dated in that month and is different than a calendar month. More information about these benefits is available on your benefits Web site, www.ajilonccbeneftscenter.com.

UnitedHealthcare Medical Plan

	CHOICE Plus 25%		CHOICE Plus 15%	
	In-Network	Out-of-Network ^{1,2}	In-Network	Out-of-Network ^{1,2}
Choice of Doctors	You may see any network provider and self-refer to any specialist	You may see any licensed provider	You may see any network provider and self-refer to any specialist	You may see any licensed provider
Calendar Year Deductible (You Pay)	<ul style="list-style-type: none"> \$400 Individual \$1,200 Family 	<ul style="list-style-type: none"> \$800 Individual \$2,400 Family 	<ul style="list-style-type: none"> \$300 Individual \$900 Family 	<ul style="list-style-type: none"> \$600 Individual \$1,800 Family
Coinsurance (Plan Pays)	75%	55%	85%	65%
Annual Out-of-Pocket Limit	<ul style="list-style-type: none"> \$2,000 Individual \$6,000 Family 	<ul style="list-style-type: none"> \$5,000 Individual \$15,000 Family 	<ul style="list-style-type: none"> \$1,500 Individual \$4,500 Family 	<ul style="list-style-type: none"> \$4,000 Individual \$12,000 Family
Lifetime Maximum	Unlimited	\$1,000,000	Unlimited	\$1,000,000
Claims Forms	Usually submitted by physician	You must submit claim for reimbursement	Usually submitted by physician	You must submit claim for reimbursement
Precertification by You	No	Yes	No	Yes
Preexisting Condition Limitation	None	None	None	None
PREVENTIVE CARE SERVICES (The deductible applies to all services unless otherwise noted)				
Child (Includes Office Visit, Immunizations, Lab/X-Ray in Office)	100% of eligible expenses (no deductible/no copayment)	55%	100% of eligible expenses (no deductible/no copayment)	65%
Man (Includes Office Visit, PSA Testing, Lab/X-Ray in Office)	100% of eligible expenses (no deductible/no copayment)	55%	100% of eligible expenses (no deductible/no copayment)	65%
	One visit per calendar year			
Woman (Includes Office Visit, Lab/X-Ray, OB/GYN Visit and Pap Smear, Mammogram)	100% of eligible expenses (no deductible/no copayment)	55%	100% of eligible expenses (no deductible/no copayment)	65%
	One visit per calendar year			
NON-PREVENTIVE CARE DOCTOR VISITS (The deductible applies to all services unless otherwise noted)				
OBGYN (Office Visits)	\$20 copayment ³ (no deductible)	55%	85% (no deductible)	65%
Regular (Non-Preventive) Primary Care Physician Office Visits (Sick Visits)	\$20 copayment ³ (no deductible)	55%	85% (no deductible)	65%
Specialist (Non-Primary Care) Office Visits	75%	55%	85%	65%
MEDICAL SERVICES (The deductible applies to all services unless otherwise noted)				
Hospital Services (Semi-Private Room and Board and Related Charges)	\$50 copayment ³ per day to a maximum of 5 days/ Then 75% after deductible	\$50 copayment ³ per day to a maximum of 5 days/ Then 55% after deductible	\$50 copayment ³ per day to a maximum of 5 days/ Then 85% after deductible	\$50 copayment ³ per day to a maximum of 5 days/ Then 65% after deductible
Other Hospital Services and Supplies	75%	55%	85%	65%
Physician Hospital Visits	75%	55%	85%	65%
Surgery Anesthetologist, Assistant	75%	55%	85%	65%
Surgeon	75%	55%	85%	65%
Second Opinion	75%	55%	85%	65%
Preadmission Testing	75%	55%	85%	65%

¹ Unless otherwise indicated, all covered expenses are subject to the deductible before the Plan pays benefits.

² Covered out-of-network expenses are subject to the "reasonable and customary" charge as determined by UnitedHealthcare.

³ Copayment does not count towards deductible or the out-of-pocket maximum.

UnitedHealthcare Medical Plan (continued)

	CHOICE Plus 25%		CHOICE Plus 15%	
	In-Network	Out-of-Network ^{1,2}	In-Network	Out-of-Network ^{1,2}
Emergency Care	\$100 copayment (waived if admitted) ^{t3}			
Skilled Nursing Facility (SNF) /Rehabilitation Facility	75%	55%	85%	65%
	Subject to duration limitations; maximum is determined by diagnosis as well as days per calendar year			
Outpatient Surgery-Physician's Office or Facility	75%	55%	85%	65%
Outpatient Lab and X-Ray	75%	55%	85%	65%
	Covered at 100% for services included in preventive care visits			
Home Health Care	75%	55%	85%	65%
	100-visit limit per calendar year (in- and out-of-network combined)		100-visit limit per calendar year (in- and out-of-network combined)	
Outpatient Rehabilitation Services	<ul style="list-style-type: none"> • 75% Office • 75% O/P Hospital 	<ul style="list-style-type: none"> • 55% Office • 55% O/P Hospital 	<ul style="list-style-type: none"> • 85% Office • 85% O/P Hospital 	<ul style="list-style-type: none"> • 65% Office • 65% O/P Hospital
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES (The deductible applies to all services unless otherwise noted)				
Inpatient	75% for up to 60 days/year	55% for up to 60 days/year	85% for up to 60 days/year	65% for up to 60 days/year
	Mental Health and Substance Abuse benefits combined in-and out- of-network		Mental Health and Substance Abuse benefits combined in-and out- of-network	
Outpatient	75% for up to 60 visits/year	55% for up to 60 visits/year	85% for up to 60 visits/year	65% for up to 60 visits/year
	Mental Health and Substance Abuse benefits combined in- and out- of-network		Mental Health and Substance Abuse benefits combined in- and out- of-network	
PRESCRIPTION DRUGS (No deductible applies)				
Retail Pharmacy	Up to a 31-day supply. You pay 20% of the cost subject to a minimum or maximum copayment			
Tier 1	\$10 minimum copayment \$30 maximum copayment		\$10 minimum copayment \$30 maximum copayment	
Tier 2	\$20 minimum copayment \$50 maximum copayment		\$20 minimum copayment \$50 maximum copayment	
Tier 3	\$35 minimum copayment \$65 maximum copayment		\$35 minimum copayment \$65 maximum copayment	
Home Delivery	Up to a 90-day supply. You pay 20% of the cost subject to a minimum or maximum copayment			
Tier 1	\$20 minimum copayment \$60 maximum copayment		\$20 minimum copayment \$60 maximum copayment	
Tier 2	\$40 minimum copayment \$100 maximum copayment		\$40 minimum copayment \$100 maximum copayment	
Tier 3	\$70 minimum copayment \$130 maximum copayment		\$70 minimum copayment \$130 maximum copayment	
	IMPORTANT NOTE: You must use Home Delivery for maintenance medications. Maintenance medications purchased at a retail pharmacy after the second refill will not be covered by the Plan and you will have to pay the full cost.			

¹ Unless otherwise indicated, all covered expenses are subject to the deductible before the Plan pays benefits.

² Covered out-of-network expenses are subject to the "reasonable and customary" charge as determined by UnitedHealthcare.

³ Copayment does not count towards deductible or the out-of-pocket maximum.

2009 UnitedHealth Basics Limited Medical Plan Options

	UHB Limited Medical Option 1 (\$30K Max, Low RX)	UHB Limited Medical Option 2 (\$30K Max, High RX)	UHB Limited Medical Option 3 (\$60K Max, High RX)
Calendar Year Deductible	\$200 individual \$400 individual + 1 \$600 Family (3 or more)	\$200 individual \$400 individual + 1 \$600 Family (3 or more)	\$200 individual \$400 individual + 1 \$600 Family (3 or more)
In-Network Coinsurance	80%	80%	80%
Out-of-Network Coinsurance	50%	50%	50%
Annual Maximum Limit (includes Inpatient, Outpatient, In-network and Out-of-Network)	\$30,000	\$30,000	\$60,000
PREVENTIVE OR NON-PREVENTIVE DOCTOR OFFICE VISIT Deductible does not apply			
In-Network	\$15 copayment per visit	\$15 copayment per visit	\$15 copayment per visit
Out-of-Network	50%	50%	50%
Annual Maximum (Combined In-and Out-of-Network)	Up to \$200	Up to \$200	Up to \$200
OUTPATIENT BENEFITS (Unless otherwise noted, all expenses apply to the deductible)			
Outpatient Surgery (at Hospital or Non-Hospital Facility)	Plan pays up to \$1,500 per person per year	Plan pays up to \$1,500 per person per year	Plan pays up to \$5,000 per person per year
Diagnostic Services (X-Rays, Blood Tests, Mammography, etc.)	Plan pays up to \$100 per person per year	Plan pays up to \$100 per person per year	Plan pays up to \$100 per person per year
INPATIENT HOSPITAL CARE (In- and Out-of-Network) Unless otherwise noted, all expenses apply to deductible			
Maximum Daily Benefit, Per Diem	Plan pays up to \$1,000 per day	Plan pays up to \$1,000 per day	Plan pays up to \$1,000 per day
Annual Maximum (Combined In-and Out-of-Network)	Up to 30 days per year or until \$30,000 annual maximum is reached	Up to 30 days per year or until \$30,000 annual maximum is reached	Up to 60 days per year or until \$60,000 annual maximum is reached
OTHER BENEFITS (Unless otherwise noted, all expenses apply to deductible)			
Maternity Care	Same as for any other expenses up to the benefit maximum		
Emergency Care	Covered under outpatient benefits for trauma-related injuries		
Discounts for Services Not Covered with UnitedHealth Allies Discount Card	Allergy Injections, Ambulance, Alternative Medicine, Durable Medical Equipment & Prosthetics, Hearing, Home Health Care, Hospice Services, Infertility Treatment, Long-Term Care, Mental Health/Substance Abuse, Outpatient Rehabilitation: Physical Therapy, Occupational Therapy, Speech Therapy, Transplants, Vision, Skilled Nursing Facility, Inpatient Rehabilitation		
PRESCRIPTION DRUG BENEFITS (In- and out-of-network)			
Annual Deductible	\$50 per covered person	\$50 per covered person	\$50 per covered person
Annual Maximum Benefit	\$500	\$1,000	\$1,000
Retail (For Up to a 31-Day Supply)	Tier 1: \$10 copayment Tier 2: \$25 copayment Tier 3: \$40 copayment	Tier 1: \$10 copayment Tier 2: \$25 copayment Tier 3: \$40 copayment	Tier 1: \$10 copayment Tier 2: \$25 copayment Tier 3: \$40 copayment
Mail Order (For Up to a 90-Day Supply)	Tier 1: \$25 copayment Tier 2: \$62.50 copayment Tier 3: \$100 copayment	Tier 1: \$25 copayment Tier 2: \$62.50 copayment Tier 3: \$100 copayment	Tier 1: \$25 copayment Tier 2: \$62.50 copayment Tier 3: \$100 copayment
Discount Card for Prescriptions	Up to 20% discount on prescriptions at most retail drug stores	Up to 20% discount on prescriptions at most retail drug stores	Up to 20% discount on prescriptions at most retail drug stores

Additional Medical Benefits

UnitedHealth Allies Enhanced Discount Program offers you access to quality health care, and the tools, discounts, and resources you need to stay healthy, while controlling your costs for coverage. Features include:

- Over 300,000 participating physicians and other health care professionals nationwide.
- Savings of 10%-50% on dental, vision, medical, prescription drug, and wellness services not covered by your other health plans.
- Discounts on adult and pediatric behavioral health care.
- Simple, point-of-service payment, with no required referrals and no claim forms to file.
- A 24-hour NurseLine for answers to your health questions.
- 24-hour online access to consumer tools that help guide your benefit decisions.
- Access to the UnitedHealth Allies Customer Care Center and consumer support services at 1-800-548-8947.

CIGNA Dental PPO Plan and NEW CIGNA Out-of-Area Plan

As of January 1, 2009, if you live in a zip code where there is very limited access to network dentists (as determined by CIGNA), you will be eligible to enroll in the NEW Out-of-Area Dental Plan. When enrolling online, you will see this option if you are determined to be eligible; if you do not see this option, you may elect dental coverage through the CIGNA Dental PPO Plan only.

	In-Network ¹	Out-of-Network ²
Choice of Dentists	You must choose a PPO dentist	You may choose any licensed dentist
Calendar-year Deductible	None	\$100 individual deductible applies to Basic and Major care and TMJ services
What Plan Pays for Services		
Preventive Care	100%	80%, no deductible
Basic Care	80%	60%, after deductible
Major Care	50%	50%, after deductible
Orthodontic Care	50%	50%, subject to separate \$100 annual deductible
TMJ (Non-Surgical Treatment Only)	50%	50%, after deductible
Calendar-year Maximum	\$1,500 for Preventive, Basic and Major care (combined for in- and out-of-network)	
Lifetime Maximum (Combined for In- and Out-of-Network)	\$2,000 for orthodontia \$850 for non-surgical TMJ	\$1,000 for orthodontia \$750 for non-surgical TMJ
CIGNA Dental Out-of-Area Plan	If you are eligible for the CIGNA Out-of-Area Plan , you may visit any licensed dentist and receive in-network benefits. Out-of-network benefits do not apply.	

1 Because PPO network dentists agree to charge reduced fees, the actual dollar amount you pay in coinsurance is lower.

2 Out-of-network charges are subject to reasonable and customary limitations; therefore it is advisable to request a predetermination of benefits

UnitedHealth Basics Limited Dental Plan

Type of Service	UnitedHealth Basics Limited Dental Plan Benefit	Waiting Period
Annual Deductible	\$50 per covered individual/\$150 family	
Annual Maximum Benefit	\$500 per covered person	
Preventive Services: Routine exams, X-Rays, Cleanings	Covered at 80% after deductible	No waiting period
Basic Services: Fillings, Oral Surgery, General Anesthesia	Covered at 60% after deductible	3 months of continuous enrollment
Major Services: Inlays and Onlays, Crowns, Bridges, Dentures	Covered at 50% after deductible	12 months of continuous enrollment
Orthodontia	Not Covered	

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This information contains highlights of Ajilon Associates' Benefits Program. Full details are contained in the official plan documents. If there is any difference between information stated here and the official plan documents, the plan documents will govern. Ajilon reserves the right to change or terminate any benefit at any time. This Web site does not create a contract between you and Ajilon.

UnitedHealth Basics Limited Vision Plan

By using the Vision Plan you will receive the following benefits:

- For each eye examination, you pay only a \$10 copayment when you visit a network provider. If you use an out-of-network provider, you must pay the full cost of the service and submit a claim for the \$25 out-of-network reimbursement. You pay the cost for other services and supplies.
- The benefit period is 12 consecutive months beginning on the later of your effective date of coverage or the date of your last eye examination under this plan.
- The Plan's nationwide network of vision care providers offers you and your family glasses, contact lenses, non-prescription sunglasses, contact lens solutions and other eye care accessories at a discounted price. Plus, you can receive up to a 15% discount on LASIK eye surgery.
- Eye exam benefits and discount eyewear purchases apply to each covered person.

UnitedHealth Basics Limited Short-Term Disability Insurance

Under the Short-Term Disability Insurance Plan, you can receive weekly benefits for up to 6 months while you are disabled.

- You can choose STD benefits that are calculated at 50% of your base pay received from the employer that sponsors this program up to your choice of a maximum weekly benefit of \$75 or \$125; or
- You can choose STD benefits that are calculated at 60% of your base pay received from the employer that sponsors this program up to your choice of a maximum weekly benefit of \$400 or \$600.
- The definition of base pay does not include overtime.
- STD benefits begin on the fifteenth day that you are unable to work; however, if you are hospitalized, the Plan begins paying immediately.

Note:

- If you work in California, Hawaii, New Jersey, New York, Puerto Rico or Rhode Island, this Insurance is not available to you.
- You cannot enroll dependents in the STD Insurance; only you can be covered under STD.

UnitedHealth Basics Limited Term Life and AD&D Insurance

Term Life Insurance Plan with Accidental Death Benefit

You can enroll in term life insurance with an accidental death benefit. This plan offers \$20,000 of term life coverage for yourself and a matching accidental death benefit of \$20,000. If you sign up for term life yourself, you can enroll your eligible dependents for:

- \$2,500 in term life (only) for dependents age 7 years or older.
- \$500 for children up to 7 years of age.

Note: Your benefits are reduced by 50% at age 70.

Your Beneficiary

Benefits will be paid to your named beneficiary. If no designated beneficiary should survive you, your benefits will be paid to the first survivor in the following order:

- Your spouse
- Your children
- Your parents
- Your brothers and sisters or
- If none of the above survives you, your estate

You are the beneficiary for your covered dependents.

Retirement Savings Plans (Wells Fargo)

Please refer to www.ajilonbenefitscenter.com for additional information regarding the Wells Fargo Retirement Plan.

Effective Dates of Coverage

The effective date for benefits elected during the enrollment period varies based upon the plan option elected:

- Coverage under the **Comprehensive Benefit Options** is effective on the 1st day of the month following the date you enroll for benefits,
- Coverage under any of the **UHB Limited Benefit Options** is effective on the Monday following the issue date of the paycheck that deductions came out for your elected benefits.

Your Costs

Your 2009 contribution costs for benefits available for Annual Enrollment are shown in the following tables – your Personalized Benefits Enrollment Worksheet will have rates specific to your family situation. Your benefits contributions are deducted from each paycheck as follows:

Pre-tax:	After-tax:
<ul style="list-style-type: none"> • Comprehensive Medical • Comprehensive Dental 	<ul style="list-style-type: none"> • Limited Medical • Limited Dental • Limited Vision • Limited Life Insurance • Limited STD

Your Contributions for 2009 Benefits (weekly contribution rates)

Your 2009 contribution costs for benefits available for Annual Enrollment are shown in the following tables. Your Personalized Benefits Enrollment Worksheet will have rates specific to your family situation. Your contributions are deducted from each paycheck.

Medical Plans

Medical	UHC CHOICE Plus 25%	UHC CHOICE Plus 15%	UHB Limited Medical Option 1 (\$30K Max, Low RX)	UHB Limited Medical Option 2 (\$30K Max, High RX)	UHB Limited Medical Option 3 (\$60K Max, High RX)
Employee Only	\$111.48	\$153.59	\$25.59	\$32.82	\$40.76
Employee + 1	\$233.73	\$322.09	\$50.92	\$65.32	\$81.12
Employee + Family	\$300.41	\$414.01	\$84.45	\$108.31	\$134.52

Dental Plans

	CIGNA Dental PPO Plan	Out-of-Area Dental Plan	UHB Limited Dental Plan
Employee Only	\$8.31	\$10.38	\$4.56
Employee + 1	\$17.74	\$21.81	\$8.95
Employee + Family	\$22.44	\$28.04	\$14.92

UnitedHealth Basics Limited Vision Plan

	UHB Limited Vision Plan
Employee Only	\$0.23
Employee + 1	\$0.41
Employee + Family	\$0.66

UnitedHealth Basics Limited Life/AD&D Insurance

	UHB Limited Life and AD&D Insurance
Employee Only	\$2.23
Employee + 1	\$2.70
Employee + Family	\$2.70

UnitedHealth Basics Limited Short-Term Disability Insurance

Medical	UHB Limited STD 50%/\$75	UHB Limited STD 50%/\$125	UHB Limited STD 60%/\$400	UHB Limited STD 60%/\$600
Employee Only	\$2.26	\$3.78	\$6.04	\$7.15