



Big Meadows

Comprehensive Benefit Package

Information subject to change.

Health Insurance — Full-time employees may be eligible for group health insurance benefits after 90 days of employment through our mini-medical plan from “Employer’s Choice” through the American Sentinel Insurance Company. Big Meadows’ contribution towards the group mini-medical coverage is 75% of the employee’s standard monthly premium up to \$150. If employees have alternative coverage or do not wish to participate in the program, they are not obligated to do so. *

Employers Choice Month Premiums/Deduction Per Pay Period:

Employee:	\$195.07 / \$ 24.38
Employee + 1 dependent:	\$382.60 / \$118.15
Employee + 2 or more	\$570.37 / \$212.04

Dental Insurance – Full-time employees are eligible for dental insurance after 90 days of employment. The employee pays a nominal fee per month for coverage and Big Meadows pays the remainder of the employee’s monthly premium (\$10.00/month). Coverage is also available for family members at the employee’s expense.*

*The Standard Dental Insurance Monthly Premiums/Deduction Per Pay Period
Orthodontia care for coverage that includes children.

Employee:	\$25.32 / \$ 7.66
Employee & Spouse:	\$49.76 / \$19.88
Employee & Children:	\$49.80 / \$19.90
Employee & Family:	\$74.08 / \$32.04

*Effective 02/01/2011

Voluntary Vision Insurance Program — After 90 days of service, full-time employees and their dependents are eligible to participate in the Vision Service Plan (VSP) at the employee’s expense. *

VSP Vision Monthly Premiums/Deduction Per Pay Period:

Employee:	\$ 7.15 / \$ 3.58
Employee & Spouse:	\$11.44 / \$ 5.72
Employee & Children:	\$11.68 / \$ 5.84
Employee & Family:	\$18.83 / \$ 9.42

*Effect 1/1/2011

**Under the “125 Cafeteria” Flex Plan, employee contributions to health, dental and vision plans are made pre-tax, which allows each employee to save money on income and social security taxes.*

Life Insurance – Group life and accidental death and dismemberment insurance is provided at no cost to full-time employees after 90 days of employment. The benefit is one and one-half times your annual base salary.

Voluntary Life Insurance – After 90 days of service, full-time employees are eligible to participate in our Voluntary Life Insurance Program at the employee's expense. Employees and their dependents have the opportunity to choose a level of low cost group term protection that best suits them and their family members. Cost is based on the level of coverage chosen and the insured's age.

Retirement - Employees with at least one year of employment are eligible to participate in the Simple IRA retirement program. The program allows each employee to contribute to a tax deferred retirement account. Big Meadows in turn may contribute a matching amount up to 3% per month.

Educational Assistance - is available up to a maximum of \$250 per semester up to a maximum of \$750 per year, which may be applied toward tuition, books, lab fees, and special fees. The courses, which are subject to administrative approval, must be job related, must be taken from an accredited teaching institution, and must be passed with a minimum of a "C" grade, or Big Meadows must be repaid in full. The employee is required to work one full year for Big Meadows after completion of the classes (this does not include approved leaves of absence / maternity leave), or they will be required to pay back the assistance on a pro-rata basis. Tuition bills must be submitted to the business office at least two weeks prior to their due date to ensure timely remittance.

Professional Licenses and Membership Dues – Big Meadows employees whose positions require that a professional license be maintained will be eligible for reimbursement of such a license up to \$250. Also, if an employee belongs to an organization representing your profession, and your membership is beneficial to Big Meadows, the cost of your membership, up to \$250 annually, will be paid on your behalf. Other fees associated with boards or licensure/certification examinations may be reimbursed contingent on administrative approval.

Credit Union - Big Meadows, Inc. employees are eligible to join the Blackhawk Area Credit Union or the RIA Credit Union in Savanna. You may start a savings plan with the credit union as soon as you start working for us. Employees also have the added benefit of payroll deduction, so loan payments and savings deposits can be taken directly from your paychecks.

Vacations - During your first year of service, you may earn up to a maximum of one week (40 hours) paid vacation. Starting in your third year of continuous service, you begin earning vacation towards a maximum of two weeks (80 hours) annually. Beginning with your fifth year of continuous service, your vacation accrues at a rate that will yield three weeks (120 hours) of annual paid vacation. Your vacation accrues on actual regular hours worked and vacation taken (including personal days, perfect attendance days and holidays). Any absences or approved leaves of absence will affect the vacation time accrued.

Personal Days - Big Meadows, Inc. awards full-time employees, with at least one year of service or more, personal days. Personal days are a real advantage over fixed holidays or other set benefits because they allow employees to be flexible to use them in a way that benefits them individually. You may use these as vacation days, to celebrate your birthday, or for doctor appointments or errands, or for family illness. Personal days are awarded on the following basis:

- 1 personal day per year after one or two years of service
- 2 personal days after three or more years of service

Paid Holidays - We observe the following holidays each year: New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day.

Other Benefits - Perfect Attendance Incentives, Call-In Bonus.

Insurance premiums are prepaid by Big Meadows, therefore final payroll deductions may need to be adjusted accordingly.

APPLICANT INFORMATION					
Your Name (Last, First, Middle)		Date of Birth: _____		<input type="checkbox"/> Married	
		Date of Hire: _____		<input type="checkbox"/> Single	
		SSN: _____		<input type="checkbox"/> Divorced	
Your Address		City/State/Zip		Job Title / Occupation	
				<input type="checkbox"/> Male	
				<input type="checkbox"/> Female	
COVERAGE SECTION - Provided at no cost to employee.					
Life with AD&D <input checked="" type="checkbox"/> Company Paid					
BENEFICIARY Person you designate to be the payee for your life Insurance benefit.					
Primary - Full Name		Address		% of Benefit	SSN
Relationship					
Primary - Full Name		Address		% of Benefit	SSN
Relationship					
Contingent - Full Name		Address		% of Benefit	SSN
Relationship					
Contingent - Full Name		Address		% of Benefit	SSN
Relationship					
CHANGE Use this section only when you wish to make a change after insurance becomes effective.					
<input type="checkbox"/> Add Dependent		<input type="checkbox"/> Delete Dependent		<input type="checkbox"/> Name Change	
Date of add/delete _____		Former name _____		<input type="checkbox"/> Beneficiary Change	
				<input type="checkbox"/> Other _____	
SIGNATURE I wish to make the choices indicated on this form. I understand that these are my company paid benefits.					
Employee Signature (required)				Date (mo/Day/Yr)	
FOR COMPANY USE:					
Division ID 0300		Date of Hire		<input type="checkbox"/> Per Hr	Group Number:
		Earnings \$ _____		<input type="checkbox"/> Per Wk	147170
Billing Cat. Big Meadows		Date of Rehire		<input type="checkbox"/> Per Mo	Group Name:
		Hours Worked Per Week		<input type="checkbox"/> Per Yr	American Health Enterprises

APPLICANT INFORMATION			
Your Name (Last, First, Middle)		Date of Birth: _____	<input type="checkbox"/> Married
		Date of Hire: _____	<input type="checkbox"/> Single
		SSN: _____	<input type="checkbox"/> Divorced
Your Address	City/State/Zip	Job Title / Occupation	<input type="checkbox"/> Male
			<input type="checkbox"/> Female

COVERAGE SECTION - Employee must elect coverage for self in order to elect dependent coverage.			
Employee Voluntary Life Ins. (Choose one)	Spouse (Choose one)	Spouse Name: _____	Spouse DOB: _____
<input type="checkbox"/> \$25,000	<input type="checkbox"/> \$10,000		
<input type="checkbox"/> \$50,000	<input type="checkbox"/> Waive coverage		
<input type="checkbox"/> \$75,000			
<input type="checkbox"/> \$100,000			
<input type="checkbox"/> Waive coverage	Child (Choose one)		
	<input type="checkbox"/> \$2,500		
	<input type="checkbox"/> Waive coverage		

BENEFICIARY Person you designate to be the payee for your life Insurance benefit.				
Primary - Full Name	Address	% of Benefit	SSN	Relationship
Contingent - Full Name	Address	% of Benefit	SSN	Relationship

DENTAL - Must either elect coverage or waive coverage.	
Spouse Name (only if electing) _____	<input type="checkbox"/> You only
Child 1 (only if electing) _____	<input type="checkbox"/> You and your spouse
Child 2 (only if electing) _____	<input type="checkbox"/> You and your children
Child 3 (only if electing) _____	<input type="checkbox"/> You and your spouse & children
	<input type="checkbox"/> I decline dental insurance for myself
	<input type="checkbox"/> I decline dental insurance for my dependents

CHANGE Use this section only when you wish to make a change after insurance becomes effective.			
<input type="checkbox"/> Add Dependent	<input type="checkbox"/> Delete Dependent	<input type="checkbox"/> Name Change	<input type="checkbox"/> Beneficiary Change
Date of add/delete _____	Former name _____	<input type="checkbox"/> Other _____	

SIGNATURE	
I wish to make the choices indicated on this form. If electing coverage I authorize deductions from my wages to cover my contribution, if required, towards the cost on insurance. I understand my deductions will change if my coverage or cost change.	
Employee Signature (required)	Date (mo/Day/Yr)

FOR COMPANY USE:					
Division ID 0300	Date of Hire	Earnings \$ _____	<input type="checkbox"/> Per Hr	Group Number: 147170	
Billing Cat. Big Meadows	Date of Rehire	Hours Worked Per Week	<input type="checkbox"/> Per Wk	Group Name: American Health Enterprises	
			<input type="checkbox"/> Per Mo		
			<input type="checkbox"/> Per Yr		

VSP - vision
NEW ENROLLMENT

EMPLOYEE NAME	
PLACE OF EMPLOYMENT	
S.S #	
D.O.B.	
GENDER	
DATE OF HIRE	
COVERAGE CODE (circle one)	A = FULL FAMILY
	B = EMP. SPOUSE
	C = EMPL ONLY
	D = EMPL CHILDREN

ENROLLMENT FORM

Please Print or Type All Answers

Applicant's Full Name: Last First MI				<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Legally Separated		<input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Applicant's Home Address		Street		City		County		State Zip Code	
Social Security Number				Date of Birth		Home Phone Number Area Code ()			
Employer				Date of Hire _____ Effective Date _____		Daytime Phone Number Area Code ()			
Address						Group Number			
City		County		State		Zip Code			
Beneficiary						Relationship to you			

IF DEPENDENT COVERAGE IS REQUESTED, LIST ALL ELIGIBLE DEPENDENTS

Full name (last, first, middle initial)	Date of Birth (MM/DD/YY)	Age	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number	If a dependent child is 19 but less than 25 years of age, is he or she a full-time college student or disabled?
Spouse (full name)			<input type="checkbox"/> Male <input type="checkbox"/> Female		
Child (full name)			<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Full-time Student <input type="checkbox"/> Disabled
Child (full name)			<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Full-time Student <input type="checkbox"/> Disabled
Child (full name)			<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Full-time Student <input type="checkbox"/> Disabled

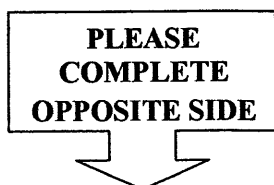
The coverage for which you are applying includes a Pre-existing limitation which states: We will not pay for a condition for which you, your spouse or covered dependent has received medical treatment, care or advice within 6 months before being covered under this policy. This Pre-existing limitation does not apply if:

- a) you, your spouse or covered dependent has received no such treatments, care or advice for that condition for 6 straight months after being covered; or
- b) coverage has been in effect for 12 months; or
- c) the condition is a pregnancy.

This Pre-existing limitation can be reduced by the period of time you, your spouse or dependents were previously insured under a prior plan, if coverage under this plan is effective within 63 days of termination of your prior plan.

I hereby apply for coverage indicated. I understand this application is subject to approval by American Sentinel Insurance Company and/or its reinsurers, and any coverage provided is also subject to the terms of agreement and/or contracts issued to me. Any persons or organizations, or any government agency having provided health care services to me, or any person named on this application or attachments to this application, either prior to or during the period of the contract, is authorized to furnish to American Sentinel Insurance Company, any information or records related to any claims submitted. "Any person knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which is a crime and subject to criminal and civil penalties." I verify that statements made in this application are true and correct.

Date Signed _____ Signature _____



Were you or any of your dependents ever treated or advised that you have any of the following conditions:

- Myocardial Infarction (Heart Attack) Congestive Heart Failure or Chronic Obstructive Pulmonary Disease
- Cerebral Vascular Accident (Stroke) or any conditions of the circulatory system
- Asthma, Emphysema, or any conditions of the respiratory system
- Allergies
- Diabetes
- High Blood Pressure
- Hepatitis
- Acquired Immune Deficiency Syndrome
- Migraine Headaches
- Any conditions for which you or your dependents were treated within the last six months.

Name of person and condition _____

Answers to these questions will not be used to deny coverage for you or any of your dependents.

**PLEASE RETURN
APPLICATION TO
YOUR GROUP
ADMINISTRATOR**