



**2008 – 2009**

**Employee Benefits Package**

# Introduction

## Benefit Summary

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Tempus IT Staffing, LLC is interested in the health and well being of both you and your family. We offer a comprehensive health and life insurance program. Tempus provides group medical and dental coverage underwritten by **Blue Cross Blue Shield**. Completed Insurance Enrollment forms must be submitted within the first 14 days of employment and coverage will begin on the **first day of the month following 30 days of employment**. Please note that the POS plan is available to Georgia residents only.

The program works very simply. A benefit allowance is provided to you by Tempus and your contributions are automatically deducted from your paycheck on a pre-tax basis (see Employee Cost Sheet.)

Vision care insurance is provided, at no cost to you, through **EyeMed Vision Care**. A completed enrollment card must be submitted within the first 14 days of employment.

**GE Financial** underwrites the life insurance policy and long-term disability coverage that is provided by Tempus at no cost to you. A completed enrollment card must be submitted within the first 14 days of employment.

**CPI Qualified Plan Consultants, Inc.** administers our 401(k) plan, which is available to all consultants that have completed 90 days of service. See page 4 for additional information.

Some or all of the following benefits are provided, as defined and limited in the literature provided by our insurance companies.

- ✓ \$50,000 Group Term Life Insurance (provided at no cost to you)
- ✓ Major Medical
- ✓ Dental Care Coverage
- ✓ Dependents' Health Care Coverage
- ✓ Preferred Provider Benefits
- ✓ Drug Card
- ✓ Vision Care Coverage (provided at no cost to you)

Tempus will pay 50% of the consultant's medical insurance expenses. The consultant pays 50% of medical insurance expenses and pays all expenses for benefits for spouse and/or dependents. See *Employee Cost Sheet* for a summarization of health plan costs.

## **Special Enrollments**

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If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment ***within 30 days*** after the marriage, birth, adoption, or placement for adoption.

## **Pre-existing Condition Limitation**

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This group health plan contains a pre-existing condition exclusion that is limited to a maximum of 12 months (18 months for late enrollees). This exclusion period can be reduced by the number of days of your prior creditable coverage. When applying creditable coverage to the pre-existing limitation, the plan is not required to take into account any days of creditable coverage that precede a break in coverage of 63 days or more. To determine if any pre-existing condition limitation will apply to you, you must present your certificate of prior coverage.

Creditable coverage can include coverage under another group health plan, an individual health policy, Part A or B of Medicare, Medicaid, CHAMPUS, a medical health care program of the Indian Health Service or tribal organization, a state health plan issued under risk pool, any public health plan issued under the Peace Corps Act.

You may request a certificate of creditable coverage from a previous employer, insurance company or Health Maintenance Organization (HMO).

This pre-existing condition limitation notice is being issued to you pursuant to the Federal Health Insurance Portability and Accountability Act of 1996 and reflects the protections afforded under federal law. If the state law applicable to a fully insured Commerce Group plan is more beneficial to covered individuals as to the length of the pre-existing condition limitation and permissible break in coverage, the relevant state law provisions will apply to and be part of your Commerce Plan.

## Cobra

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In the event of your termination of employment with Tempus IT Staffing or loss of eligibility to remain covered under our group health insurance program, you and your eligible dependents may have the right to continued coverage under our health insurance program for a limited period of time at your or their own expense (this does not affect the conversion privilege as stated in the insurance policy). Qualified employees and/or dependents have the right to elect COBRA coverage if one of the following "qualifying events" occurs:

- Voluntary or involuntary termination of employment for reasons other than "gross misconduct"
- Reduction to part-time status

The types of qualifying events for spouses are:

- Termination of the covered employee's employment for any reasons other than "gross misconduct"
- Reduction to part-time status
- Covered employee's becoming entitled to Medicare
- Divorce or legal separation of the covered employee
- Death of covered employee

Qualified employees or dependent(s) have the right to elect to continue coverage that is identical to the coverage provided under our insurance plan (except life or vision insurance). In the case where the employee or their dependent(s) elect COBRA coverage, he/she will be responsible for **payment of the entire premium**. Payments are due before the **first day of every month**.

Qualified employees or dependent(s) have a 60-day period in which to elect continuation of coverage. Coverage begins on the first month following the occurrence of a qualifying event. All premiums will be retroactive to the month in which COBRA coverage begins. Cobra continued coverage ends when:

- The last day of maximum coverage is reached
- Premiums are not paid on a timely basis
- The employer ceases to maintain any group health plan
- Coverage is obtained with another employer group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary
- A beneficiary is entitled to Medicare benefits

## **401(k) Savings Plan**

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Tempus is also pleased to offer to its consultants the opportunity to enroll in our comprehensive 401(k) Savings Plan Program. Consultants may contribute up to 100% of their W-2 wages on a pre-tax basis up to \$15,500 in 2008 or \$16,000 in 2009, the maximum allowable amount determined by the IRS. Your contributions and earnings are 100% vested. Employees who are at least 21 years old and have completed 90 days of service may join the plan. Once eligible, consultants can contact Tempus to request an information packet, which will include an enrollment application. In addition, current participants may change their contribution amount or stop contributing at any time.

## **Long Term Disability**

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All full time (30 hrs. +) employees are eligible for Long Term Disability after six months of continuous employment.

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Our insurance plans offer a range of options that will aid the health and well being of you and your family. If you have any questions please feel free to call us at (404) 832-2200 or toll free at (800) 280-4144.



## **PPO 1503 SX MEDICAL PLAN OPTION**

<b>BLUE CROSS BLUE SHIELD</b>	<b>IN - NETWORK</b>	<b>OUT - OF - NETWORK</b>
<b>LIFETIME MAXIMUM</b>	\$5,000,000 Per person	\$5,000,000 Per person
<b>CALENDAR YEAR DEDUCTIBLE</b>	\$500 Ind. / \$1,500 Family	\$1,000 Ind. / \$3,000 Family
<b>OUT-OF-POCKET MAXIMUM (INCLUDES DEDUCTIBLES)</b>	\$2,000 Ind. / \$6,000 Family	\$4,000 Ind. / \$12,000 Family
<b>PHYSICIANS SERVICES</b>		
Office Visit (PCP)	\$25 Copay	60% After Deductible
Specialist	\$25 Copay	60% After Deductible
Immunizations	\$25 Copay	60% After Deductible
Routine Mammography	\$25 Copay	60% After Deductible
Routine GYN Exam	\$25 Copay	60% After Deductible
<b>OUTPATIENT SURGERY</b>	80% After Deductible	60% After Deductible
Physician Fees	80% After Deductible	60% After Deductible
<b>HOSPITALIZATION</b>	80% After Deductible	60% After Deductible
<b>EMERGENCY ROOM (COPAY WAIVED IF ADMITTED)</b>	\$100 Copay	\$100 Copay
<b>DIAGNOSTIC / X-RAY / LAB / CT SCAN / MRI'S</b>	80% After Deductible	60% After Deductible
<b>MATERNITY</b>		
First OBGYN Visit (Covers all Physician Fees)	\$100 Copay	60% After Deductible
Hospital	As any other hospitalization	
<b>CHIROPRACTIC CARE (LIMITED TO 20 VISITS PER YEAR COMBINED WITH PT/OT)</b>	80% After Deductible	60% After Deductible
<b>HOME HEALTH CARE (LIMITED TO 120 VISITS PER YEAR)</b>	\$25 Copay Per Visit	60% After Deductible
<b>SKILLED NURSING FACILITY (LIMITED TO 30 Days PER YEAR)</b>	80% After Deductible	60% After Deductible
<b>PRESCRIPTION DRUGS</b>		
Generic Preferred Drug	\$20 Copay	\$20 Copay
Brand Preferred Drug	\$35 Copay	\$35 Copay
Non - Preferred Drug	\$60 Copay	\$60 Copay
Mail Order Service (90 Day Supply) Copay	\$60 Copay	\$60 Copay
<b>MENTAL HEALTH</b>		
Inpatient (Limited to 30 Days Per Year)	80% After Deductible	60% After Deductible
Outpatient (Limited to 20 Visits Per Year)	\$25 Copay Per Visit	60% After Deductible
<b>SUBSTANCE ABUSE</b>	Included in Above Mental Health Benefits	



## **PPO 1504 SX MEDICAL PLAN OPTION**

<b>BLUE CROSS BLUE SHIELD</b>	<b>IN - NETWORK</b>	<b>OUT - OF - NETWORK</b>
<b>LIFETIME MAXIMUM</b>	\$5,000,000 Per person	\$5,000,000 Per person
<b>CALENDAR YEAR DEDUCTIBLE</b>	\$1,000 Ind. / \$3,000 Family	\$2,000 Ind. / \$6,000 Family
<b>OUT-OF-POCKET MAXIMUM (INCLUDES DEDUCTIBLES)</b>	\$2,000 Ind. / \$6,000 Family	\$4,000 Ind. / \$12,000 Family
<b>PHYSICIANS SERVICES</b>		
Office Visit (PCP)	\$40 Copay	60% After Deductible
Specialist	\$40 Copay	60% After Deductible
Immunizations	\$40 Copay	60% After Deductible
Routine Mammography	\$40 Copay	60% After Deductible
Routine GYN Exam	\$40 Copay	60% After Deductible
<b>OUTPATIENT SURGERY</b>	80% After Deductible	60% After Deductible
Physician Fees	80% After Deductible	60% After Deductible
<b>HOSPITALIZATION</b>	80% After Deductible	60% After Deductible
<b>EMERGENCY ROOM (COPAY WAIVED IF ADMITTED)</b>	\$100 Copay	\$100 Copay
<b>DIAGNOSTIC / X-RAY / LAB / CT SCAN / MRI'S</b>	80% After Deductible	60% After Deductible
<b>MATERNITY</b>		
First OBGYN Visit (Covers all Physician Fees)	\$100 Copay	60% After Deductible
Hospital	As any other hospitalization	
<b>CHIROPRACTIC CARE (LIMITED TO 20 VISITS PER YEAR COMBINED WITH PT/OT)</b>	80% After Deductible	60% After Deductible
<b>HOME HEALTH CARE (LIMITED TO 120 VISITS PER YEAR)</b>	\$40 Copay Per Visit	60% After Deductible
<b>SKILLED NURSING FACILITY (LIMITED TO 30 DAYS PER YEAR)</b>	80% After Deductible	60% After Deductible
<b>PRESCRIPTION DRUGS</b>		
Generic Preferred Drug	\$20 Copay	\$20 Copay
Brand Preferred Drug	\$35 Copay	\$35 Copay
Non - Preferred Drug	\$60 Copay	\$60 Copay
Mail Order Service (90 Day Supply) Copay	\$60 Copay	\$60 Copay
<b>MENTAL HEALTH</b>		
Inpatient (Limited to 30 Days Per Year)	80% After Deductible	60% After Deductible
Outpatient (Limited to 20 Visits Per Year)	\$40 Copay Per Visit	60% After Deductible
<b>SUBSTANCE ABUSE</b>	Included in Above Mental Health Benefits	



**POS 2010 SX MEDICAL PLAN OPTION**  
*Please note the POS Plan is available to Georgia residents only.*

<b>BLUE CROSS BLUE SHIELD</b>	<b>IN - NETWORK</b>	<b>OUT - OF - NETWORK</b>
<b>LIFETIME MAXIMUM</b>	Unlimited	\$5,000,000 Per person
<b>CALENDAR YEAR DEDUCTIBLE</b>	\$1,000 Ind. / \$3,000 Family	\$2,000 Ind. / \$6,000 Family
<b>OUT-OF-POCKET MAXIMUM (INCLUDES DEDUCTIBLES)</b>	\$1,000 Ind. / \$3,000 Family	\$4,000 Ind. / \$12,000 Family
<b>PHYSICIANS SERVICES</b>		
Office Visit (PCP)	\$25 Copay	60% After Deductible
Specialist	\$25 Copay	60% After Deductible
Immunizations	\$25 Copay	60% After Deductible
Routine Mammography	\$25 Copay	60% After Deductible
Routine GYN Exam	\$25 Copay	60% After Deductible
<b>OUTPATIENT SURGERY</b>	100% After Deductible	60% After Deductible
Physician Fees	100% After Deductible	60% After Deductible
<b>HOSPITALIZATION</b>	100% After Deductible	60% After Deductible
<b>EMERGENCY ROOM (COPAY WAIVED IF ADMITTED)</b>	\$100 Copay	\$100 Copay
<b>DIAGNOSTIC / X-RAY / LAB / CT SCAN / MRI'S</b>	100% After Deductible	60% After Deductible
<b>MATERNITY</b>		
First OBGYN Visit (Covers all Physician Fees)	\$100 Copay	60% After Deductible
Hospital	As any other hospitalization	
<b>CHIROPRACTIC CARE (LIMITED TO 20 VISITS PER Year)</b>	\$15 Copay per visit	60% After Deductible
<b>HOME HEALTH CARE (LIMITED TO 120 VISITS PER YEAR)</b>	100% After Deductible	60% After Deductible
<b>SKILLED NURSING FACILITY (LIMITED TO 30 DAYS PER YEAR)</b>	100% After Deductible	60% After Deductible
<b>PRESCRIPTION DRUGS</b>		
Generic Preferred Drug	\$15 Copay	60%
Brand Preferred Drug	\$30 Copay	60%
Non – Preferred Drug	\$60 Copay	60%
Mail Order Service (90 Day Supply) Copay	\$60 Copay	No Coverage
<b>MENTAL HEALTH</b>		
Inpatient (Limited to 30 Days Per Year)	100% After Deductible	No Coverage
Outpatient (Limited to 20 Visits Per Year)	\$25 Copay Per Visit	No Coverage
<b>SUBSTANCE ABUSE (6 DAYS PER YEAR MAX)</b>	Included in Above Mental Health Benefits	



## *DENTAL*

<u>BENEFIT</u>	<u>COVERAGE</u>
<b>DEDUCTIBLE</b> (WAIVED FOR PREVENTITIVE SERVICES)	\$50 Per Member / \$150 Per Family
<b>CALENDAR YEAR MAXIMUM</b>	\$1,000 Per Member
<b>PREVENTIVE CARE / ORAL EXAM / X-RAYS (ROUTINE) – 2 PER YEAR</b>	100%
<b>BASIC SERVICES</b>	80% After Deductible
<b>MAJOR SERVICES</b>	50% After Deductible
<b>FILLINGS / EXTRACTIONS</b>	80% After Deductible
<b>PERIODONTICS</b>	80% After Deductible
<b>ENDODONTICS</b>	50% After Deductible
<b>CROWNS / DENTURES</b>	50% After Deductible
<b>ORTHODONTIC SERVICES</b> \$1,000 Lifetime Maximum for child(ren) under age 19.	50%, Deductible does not apply



### ***BASIC LIFE AND AD&D***

<b><u>BENEFIT</u></b>	<b><u>COVERAGE</u></b>
<b>LIFE INSURANCE BENEFIT - Employee</b>	\$50,000
<b>ACCIDENTAL DEATH &amp; DISMEMBERMENT</b>	\$50,000
<b>AGE REDUCTION</b>	Reduces by 35% at age 65 Reduces by 35% at age 70 Reduces by 35% at age 75
<b>DISABILITY WAIVER OF PREMIUM</b>	If disabled prior to age 65, premiums are waived to the longer of age 65 or 12 months; If disabled on or after age 65, premiums are waived for 12 months.
<b>ACCELERATED DEATH BENEFIT</b>	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.
<b>AD&amp;D SEAT BELT BENEFIT</b>	Provides \$25,000 if a covered employee or dependent dies as a result of a passenger auto accident while wearing a seat belt.



## ***LONG TERM DISABILITY***

<b><u>BENEFIT</u></b>	<b><u>COVERAGE</u></b>
<b>ELIMINATION PERIOD</b>	90 Days
<b>PERCENTAGE OF EARNINGS</b>	60%
<b>MAXIMUM MONTHLY BENEFIT</b>	\$10,000
<b>MAXIMUM BENEFIT PERIOD</b>	To the greater of Age 65 or employee's Social Security retirement age
<b>MENTAL AND NERVOUS LIMITATIONS</b>	24 Months
<b>PRE – EXISTING CONDITIONS</b>	3 Month Look back From Effective Date / 12 Months On Plan For Condition To Be Covered
<b>GUARANTEE ISSUE</b>	\$10,000





**FREE Discount Vision Plan**

Visit [www.eyemedvisioncare.com](http://www.eyemedvisioncare.com) to find a provider near you!

<u>Benefit</u>	<u>Coverage</u>
Exam (Participating Providers)	\$5 off routine exam \$10 off contact lens exam
Standard Plastic Lens	\$50 Copay – Single Vision \$70 Copay – Bifocal \$105 Copay – Trifocal
<b>Lens Options:</b>	
Tint	\$15
UV Coating	\$15
Standard Scratch Resistance	\$15
Standard Polycarbonate	\$40
Standard Anti-Reflective	\$45
Standard Progressive	\$65
Other Add-Ons and Services	20% off retail price
Frames	35% off retail prices
Contact Lenses (allowance covers materials only)	15% off retail prices (conventional only)
Lasik Surgery	15% off retail prices or 5% off promotional prices

**TEMPUS IT STAFFING, LLC  
INSURANCE PLAN - EMPLOYEE COST  
BLUECROSS BLUESHIELD GROUP #1029343  
EFFECTIVE DATE - OCTOBER 1, 2008**

**PLAN COVERAGE COMPARISON HIGHLIGHTS**

<u>IN-NETWORK</u>	POS 2010SX Blue Cross Blue Shield	PPO 1503SX Blue Cross Blue Shield	PPO 1504SX Blue Cross Blue Shield
DEDUCTIBLE - INDIVIDUAL	1,000.00	500.00	1,000.00
DEDUCTIBLE - FAMILY	3,000.00	1,500.00	3,000.00
OFFICE VISIT CO-PAY	25.00	25.00	40.00
HOSPITAL VISITS	100%, after deductible	80%, after deductible	80%, after deductible
RX BENEFIT	15/30/60	20/35/60	20/35/60

**EMPLOYEE COST COMPARISON PER PAY PERIOD (26 PER YEAR)**

		Blue Cross Blue Shield POS 2010SX	Blue Cross Blue Shield PPO 1503SX	Blue Cross Blue Shield PPO 1504SX
<b>MEDICAL</b>				
<b>BCBS</b>	EMPLOYEE	70.48	91.39	69.86
	EMP. & SPOUSE	210.80	252.64	209.56
	EMP. & CHILD	196.77	236.52	195.60
	FAMILY	351.14	413.89	349.28
<b>DENTAL</b>				
<b>BCBS</b>	EMPLOYEE	12.11	12.11	12.11
	EMP. & SPOUSE	24.23	24.23	24.23
	EMP. & CHILD	22.41	22.41	22.41
	FAMILY	37.56	37.56	37.56
<b>VISION</b>				
	EMPLOYEE	0.00	0.00	0.00
	EMP. & SPOUSE	0.00	0.00	0.00
	EMP. & CHILD	0.00	0.00	0.00
	FAMILY	0.00	0.00	0.00
<b>TOTAL</b>				
	EMPLOYEE	82.59	103.50	81.97
	EMP. & SPOUSE	235.03	276.87	233.79
	EMP. & CHILD	219.18	258.93	218.01
	FAMILY	388.70	451.45	386.84

## PROVIDER PHONE NUMBERS AND WEBSITES

<b>Blue Cross Blue Shield of Georgia</b>	<a href="http://www.bcbsga.com">www.bcbsga.com</a>
<i>Medical</i>	1-800-441-2273
<b>Blue Cross Blue Shield of Georgia</b>	<a href="http://www.bcbsga.com">www.bcbsga.com</a>
<i>Dental</i>	1-800-441-2273
<b>Genworth Financial</b>	<a href="http://ebg.genworth.com">ebg.genworth.com</a>
<i>Life/ Long Term Disability</i>	1-880-451-2513
<b>EyeMed</b>	<a href="http://www.eyemedvisioncare.com">www.eyemedvisioncare.com</a>
<i>Free Discount Vision</i>	1-866-839-3633

*These Insurance Programs Are Available to Full – Time Employees.*

*This Booklet is a Summary of Plan Highlights. Please Consult the Carrier's Contract for Full Information on Covered Charges, Limitations, and Exclusions. This is not a Binding Contract. The Carrier's Contract Will Prevail.*

*If You Have Further Questions Please Contact the Carrier or Bryant Wharton.*

*Prepared By:*



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Insurance brokerage and consulting services