



BENEFITS (2008 - 2009)
These policies are effective 9/1/2008

HEALTHCARE

After completion of six (6) months of employment with us (six months from the start date), as well as completion of 500 hours of work during this six (6) months period of time, The Execu | Search Group temporary employees are eligible for medical, dental and vision benefits*. If you decide to receive benefits, you must elect to do so within 30 days of eligibility.

The Execu | Search Group offers you the choice of Oxford (Medical) and/or Guardian (Dental and/or Vision). Below is a brief summary of the plan designs.

MEDICAL, DENTAL AND/OR VISION CARE

An employee may choose from the following plans; a summary of which follows:

Oxford Health Plans - This program includes major medical, hospitalization, prescription benefits, mail order prescription program, gym reimbursement, mental health care, chiropractic care and more. You may choose to participate in the POS (Freedom), EPO (Freedom) or the EPO (Liberty) Plan.

POS (Freedom Network)

The POS program is a health plan that provides members the option of receiving their care on both an In-Network or, for some services, Out-of-Network basis. By choosing In-Network providers, members may receive their care from any of the providers within the plan's network while keeping their out-of-pocket costs low (a minimal co-payment is required for most services). For some services (described in additional plan materials), members may seek care from Out-of-Network providers. However, by doing so, members will be required to share a greater responsibility of the expenses, through deductibles and co-insurance.

In-Network Providers

Co-payment: \$25 PCP / \$40 Specialist
Emergency Room: \$50 Co-payment
Hospital: \$500 Co-payment

(No co-payment for preventive care and immunization for children who are 19 years of age or younger - In-network; Birth - 1 Year (7 visits/year); 1 - 2 Years (3 visits/year); 2 - 19 Years (1 visit/year))

Out-of-Network Providers

Deductible: \$1,000 (Single) / \$2,000 (Family)
Coinsurance: 30% of Eligible Expenses
Out-of-Pocket Max: \$3,000 single / \$6,000 family (excluding deductible)

Prescription \$10 Generic / \$25 Preferred Brand / \$50 Non-Preferred Brand

EPO (Freedom Network)

The EPO (Freedom Network) program is a health plan that provides members the option of receiving their care on an In-Network only. By choosing In-Network providers, members may receive their care from any of the providers within the plan's network while keeping their out-of-pocket costs low (a minimal co-payment is required for most services).

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In-Network Providers

Co-payment: \$15 PCP / \$30 Specialist
Emergency Room: \$75 Co-payment
Hospital: \$500 Co-payment
(No co-payment for preventive care and immunization for children who are 19 years of age or younger - In-network; Birth - 1 Year (7 visits/year); 1 - 2 Years (3 visits/year); 2 - 19 Years (1 visit/year))

Prescription \$10 Generic
\$50 Deductible (Preferred/Non-Preferred Brand)
\$25 Preferred Brand, \$50 Non-Preferred Brand

EPO (Liberty Network)

The EPO (Liberty Network) program is a health plan that provides members the option of receiving their care on an In-Network only. By choosing In-Network providers, members may receive their care from any of the providers within the plan's network while keeping their out-of-pocket costs low (a minimal co-payment is required for most services).

In-Network Providers

Co-payment: \$15 PCP / \$30 Specialist
Emergency Room: \$75 Co-payment
Hospital: \$500 Co-payment
(No co-payment for preventive care and immunization for children who are 19 years of age or younger - In-network; Birth - 1 Year (7 visits/year); 1 - 2 Years (3 visits/year); 2 - 19 Years (1 visit/year))

Prescription \$10 Generic
\$50 Deductible (Preferred/Non-Preferred Brand)
\$25 Preferred Brand, \$50 Non-Preferred Brand

* Rates are available upon request. The employee is responsible for 100% of the cost of this plan.

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Guardian Dental - There are two plans from which to choose dental coverage:

(1) Guardian's Managed DentalGuard Pre-Paid Dental Plan

To have your dental services covered, you must go to the dental office that you choose when you enroll. You can find a conveniently located dentist in the Managed DentalGuard Directory of Participating General dentists or locate a dentist on the Internet using their on-line listing at www.GuardianLife.com. Each family member could go to a different network or non-network dentist or specialist, every time they need care. All of your dental care will be provided by, or arranged by, your selected dental office.

You can change dental offices just by call Guardian at (888) 618-2016. The change will be effective on the first day of the next month, as long as you call before the 20th day of the month. There is no limit on the number of times you can change dental offices. Any services started at one dental office must be completed by that office, and your account with the first office must be paid in full before a transfer can be processed.

The Managed DentalGuard network includes oral surgeons, periodontists, endodontists, orthodontists and pediatric dental specialists. If you need dental services that only a specialist can provide, your dental office will request authorization from Guardian for you to see a participating specialist. You will be responsible for the patient charge shown in your booklet for any covered services performed by a specialist dentist.

With the Managed DentalGuard PPD plan, most diagnostic and preventive services are covered at no cost to you. However, for basic, major and some preventive services, you will pay a certain amount – which is referred to as a patient charge – for each covered service you receive. The patient charges for your PPD plan can be found in this booklet, so you'll always know what you'll have to pay for services you need. Better yet, with the Managed DentalGuard plan there are no deductibles, annual maximums or co-insurance – plus no pre-treatment reviews are required for services provided by your participating general dentist.

Under the PPD plan, any necessary paperwork for services from participating dentists is handled by your selected dental office. Just show your Managed DentalGuard ID card.

(2) DentalGuard Maximum Rollover Preferred Provider Organization (PPO) Program

If you go to a DentalGuard Preferred Network Provider, the benefits described on the Benefit Illustration will be paid based on a reduced fee schedule (this will mean less out-of-pocket). The network provider cannot balance bill charges in excess of the fee schedule and you get more services with your yearly maximum. If you go to a non-contracted dentist, the benefits will be based on usual, customary and reasonable rates for a given area. A deductible is the dollar amount of covered dental expenses you must pay during the year before benefits are paid by The Guardian. An annual maximum is the maximum amount your dental plan will pay in benefits during the year. Both are generally based on the calendar year. Deductibles and annual maximums apply to each covered person.

With Maximum Rollover, Guardian will roll over a portion of your unused annual maximum into your personal Maximum Rollover Account (MRA). The MRA can be used in future years, if you reach the plan's annual maximum. If you use the services of Preferred Providers exclusively during the benefit year, Guardian will increase the amount credited to your MRA. To qualify, you must submit a claim and not exceed the paid claims threshold during the benefit year. You and your dependents maintain separate MRA's based on your own claim activity. Your MRA may not exceed the MRA limit. Maximum Rollover Plans based on a calendar year benefit period with a plan effective date in October, November, or December; the plan features will be effective as of the first full benefit year. (Example: If a plan starts in November of 2007, claim activity in 2008 will be used and applied to MRAs for use in 2009).

For some service categories, you may share in the cost of your dental expenses. This is represented as a percentage of the usual, customary, and reasonable level (if a non-network dentist is used) or a percentage of the negotiated fee for covered services (if a network dentist is used). The percentage of co-insurance usually depends on the type of service received: Preventive, Basic, Major. Network services are typically reimbursed at a higher co-insurance percentage. A negotiated fee-for-service refers to the set maximum fees for services that have been negotiated with Guardian's contracted network dentists and specialists. These average 30% less than the fees they usually charge.

For all courses of treatment expected to exceed \$300, your dentist should submit a report to The Guardian describing the proposed treatment and itemizing expected charges. Guardian will review the report and send the dentist an estimate of benefits they will pay. This will help ensure that you receive the best and most appropriate treatment necessary. Emergency treatment, oral examinations, cleaning and x-rays may be performed before the review is prepared.

Network dentists have contracted with The Guardian to submit claim forms and accept benefits directly from The Guardian. Some non-network dentists may submit claims directly to The Guardian. More often, however, non-network dentists will require that you pay for services at the time they are rendered. Afterwards, complete a simple claim form and forward it to us along with a copy of your payment receipt. You may either refer to your

DentalGuard Preferred provider directory or locate a dentist on the Internet using our on-line listing at www.GuardianLife.com. Each family member could go to a different network or non-network dentist or specialist, every time they need care.

Usual, customary, and reasonable (UCR) charges for covered services are determined by using the usual level of charges made by the majority of dentists in the same geographic area for the same service. If your dentist's fee is lower than the UCR charge, the plan will pay benefits based on the actual fee. If the fee is higher, the plan will pay benefits based on the UCR charge, and you are responsible for any amount above the UCR limit.

	<u>Managed</u>	<u>DentalGuard Preferred (PPO)</u>	
	<u>DentalGuard</u> <u>In-Network (ONLY)</u>	<u>In-Network</u>	<u>Out-of-Network</u>
Deductible	No ded., \$5 office copay	\$0 - Ind. / \$0 - Fam.	\$50 - Ind. / \$150 - Fam.
Preventive	Subject to Fixed Copay See Prepaid Dental Plan	100%	100%
Basic	Subject to Fixed Copay See Prepaid Dental Plan	80%	80%
Major	Subject to Fixed Copay See Prepaid Dental Plan	50%	50%
Annual Max	N/A		\$2,000
Orthodontic			
Coverage	Child \$1,925 Copay		50%
Ortho Max	Adult \$2,425 Copay		\$2,000

* Rates are available upon request. The employee is responsible for 100% of the cost of this plan.

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Guardian Vision

With Guardian's VisionGuard, you and your covered family members can visit a provider from the extensive Vision Service Plan (VSP) network or any doctor. This includes any licensed optometrist or ophthalmologist. But remember, if you see a VSP network provider, you'll usually save money.

When you seek network care:

1. Find a VSP doctor by calling the VSP customer service line **(1-800-VSP-7195)** or accessing the VSP provider directory on the Internet at <http://www.vsp.com>. Once you are in the VSP website, click onto the "Find a Doctor" page. To view and obtain a listing of doctors near you who participate in your plan, enter your member ID #, your last name and either your home address or work address and click on "submit".
2. Call the VSP doctor *in advance* to schedule an appointment. When you telephone, always identify yourself as a VSP/Guardian member and be prepared to give your Social Security number and your company's name.
3. Before your visit, the VSP doctor will contact VSP to verify your eligibility and plan coverage. The VSP doctor will also obtain treatment authorization and information about your group's specific benefits so he or she can offer you the most appropriate services. If you're currently *not* eligible, the VSP provider will promptly notify you. You can view the plan benefits you or a covered family member are eligible for on-line. Simply access VSP using the same Internet instructions previously outlined. Under "Members Sign-On", enter your member ID# and last name and click on "sign-on". You will see what benefits are available under "Benefits at a Glance". If you wish to view more details about the available benefits, click on "More About My Benefits/Dependent Coverage".
4. At the time of your examination, the VSP doctor will determine if eyewear is necessary or if your current prescription needs to be changed. The VSP doctor will discuss the most effective, cost-efficient eyewear options and coordinate your prescription.
5. The VSP doctor will handle all paperwork; no claim forms are necessary. Exams and most eyewear are covered in full. Typically, your only out-of-pocket costs are co-pays, specialty frames (that may not be fully covered by your plan) or cosmetic extras. Pay these to the provider at the time services are rendered.
6. Your plan satisfaction is important to us. One of our methods of monitoring satisfaction is to randomly send out questionnaires to patients. If you receive one, please complete it and return it to VSP.

If you choose non-network care:

1. Pay the doctor in full at the time services are rendered.
2. No claim form is necessary, just submit your payment receipt to VSP at: *Vision Service Plan, P.O. Box 997105, Sacramento, CA 95899-7105*. Be sure to note your name and address, employee's Social Security Number, date-of-birth, relationship to the insured (employee or dependent), plan number and employer/group name.
3. The amount of reimbursement is based on your plan's Schedule of Benefit Allowances. Note that you are responsible for any costs above the scheduled amount, as well as any applicable co-pay(s).

	<u>In-Network</u>	<u>Out-of-Network</u>
COPAYMENT		
Exam	\$10.00	
Materials	\$20.00	
EYE EXAMS		
	Covered in Full after	\$46.00 Max after copay
	Copay	
Frequency:	Every 12 months	
LENSES		
Single Vision	Covered in Full after	\$46.00 Max after copay
	Copay	
Bifocal	Covered in Full after	\$66.00 Max after copay
	Copay	
Trifocal	Covered in Full after	\$85.00 Max after copay
	Copay	
Lenticular	Covered in Full after	\$125.00 Max after copay
	Copay	
Frequency:	Every 12 months	
CONTACT LENSES		
Medical Necessary	Covered in Full after	\$21.00 Max after copay
	Copay	
Elective	\$120.00 Maximum (Copay Does Not Apply)	
FRAMES		
	\$120.00 Retail Allowance	\$47.00 Max after copay
Frequency:	Every 24 months	

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401(k) PLAN

Effective at the completion of 12 months of continuous employment, the employee has a choice of a diverse group of mutual funds to invest in, and can contribute up to the maximum dollar amount set each year by the IRS, which is \$15,500 in 2008. There are four (4) open enrollment periods, January 1, April 1, July 1 and October 1 of every year.

This communication is not intended to be the Summary Plan Description required by the Employee Retirement Income Security Act (ERISA). If there is a conflict between this communication, the Summary Plan Description and the legal Plan documents, the Plan documents will govern.

SECTION 125 - CAFETERIA PLAN (FLEX PLAN)

The following describes our "Flex Plan" employee benefit program. This program allows you to set aside pre-tax dollars for any of the following:

- Out-of-pocket health care expenses (e.g., eyeglasses, contacts, eye exams, dental care, deductibles or co-pays) for you and your family up to \$3,000 per year
- Eligible child or dependent day care up to \$5,000 per year
- Qualified mass transit to or from your residence and workplace up to \$115.00 per month
- Allowed parking expenses near your workplace up to \$220.00 per month

Your participation in this plan will not change any other benefits we provide. As an employee working at least 500 hours during a consecutive 6 months period, you are eligible, even if you are not using any of the insurance plans we provide. These are optional benefits that can save you money by using pre-tax dollars for health care not paid by any insurance or for child/dependent day care. Pre-tax dollars can mean savings of 20% - 40% (Federal, State, Local and FICA taxes) on moneys which you and your family will be spending anyway. These tax savings work with any insurance plan.

We will be using BeneFlex, Inc. to assist us with the enrollment and the administration. Their representatives will be available by phone to answer your questions and explain: key IRS rules, how pre-tax contributions impact your paycheck, examples of allowed deductions, and how to enroll. Please call 888-423-6359 or visit their website at www.flexaccount.com.

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Please note: These policies supersede any previously released benefit policies.

Working Advantage Program

The Execu|Search Group has a valuable membership with Working Advantage and our employees now have access to exclusive discounts for movie theatres, movie rentals, theme parks, ski tickets, Broadway theatre, special family events, online shopping and much more.

Registering is easy. Simply go to the Working Advantage website at <http://www.workingadvantage.com> and click on "Register". Using our Member ID (962265677), you may complete your one-time registration for free and create your own personal account with a password of your choice. Once you have registered, you can order either online or by phone at 1-800-565-3712 Monday through Friday 8:00 a.m. to 6:30 p.m. and Saturday 9:00 a.m. to 5:00 p.m. ET.

We hope you will take advantage of their discount offers so you can save up to 40% on popular attractions such as Universal Studios, Sea World, Regal Cinemas, AMC Theatres, BLOCKBUSTER®, sporting events and some of the hottest shows on Broadway! If you have any questions about any discounts, please call Working Advantage at 1-800-565-3712.