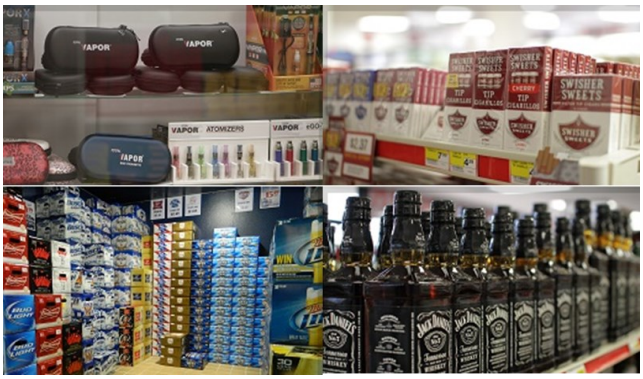
2017 Employee Benefits Guide

wallis companies



The purpose of this booklet is to describe the highlights of your benefit program. Your specific rights to benefits under the Plans are governed solely, and in every respect, by the official Plan documents and insurance contracts, not by this booklet. If there is any discrepancy between the description of the Plans as described in this material and official Plan documents, the language of the Plan documents shall govern.

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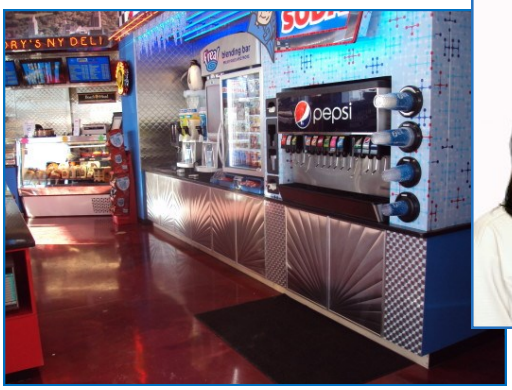
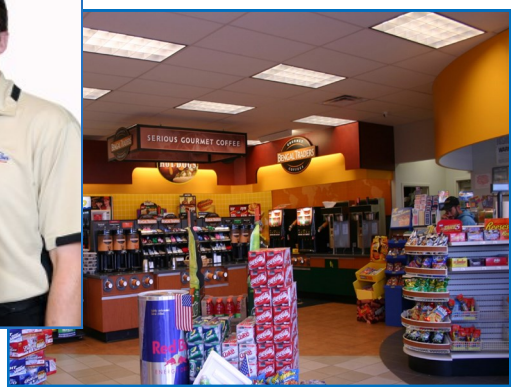


Contact Information

Wallis Companies, in partnership with the following carriers, strives to meet your benefit needs. If you have any questions regarding your benefits, please contact the corresponding carrier listed below or the Human Resources Department at Wallis Companies.

Contact Information

Vendors	Phone Number	Website
UnitedHealthcare *(Medical)* Group Number: 741961 Rx Bin: 610279 PCN: 9999 Rx Group: UHEALTH	800-235-6271	www.myuhc.com
Sun Life Dental (Assurant Dental Plan) Group Number: 5483847	800-442-7742	www.sunlife.com/oaregister
Sun Life Vision (VSP Network) Group Number: 5483847	800-877-7195	www.vsp.com
Unum *(Accident and Critical Illness)*	866-679-3054	www.unum.com
UnitedHealthcare *(Flexible Spending)*	800-331-0480	www.myuhc.com
Personal Assistance Services-PAS *(EAP)*	800-356-0845	www.paseap.com

Benefits Team	Phone	Email
WALLIS COMPANIES Myra Modglin Dawn Houser	 636-549-1574 636-549-1575	 mmodglin@mail.wallisco.com dawn.houser@wallisco.com
CBIZ Sara Miller Rusty Besancenez	 (314) 692-2249 Toll Free (800) 844-4510	 samiller@cbiz.com rbesancenez@cbiz.com

Enrolling in the Plans

As part of our company's mission to Make It Convenient, benefit enrollment for new hires will be completed via phone with trained benefit counselors. Please note that enrollment will need to be completed by all newly eligible individuals, even if an individual decides not to participate. The enrollment process is easy. Approximately 2 weeks after your hire, but no later than the 21st of the month prior to your benefit effective date, call 888-205-3036 to reach an enrollment counselor. Lines are open 8am to 5pm Monday—Friday. It will take about 20-30 minutes to complete the process. You are encouraged to have computer/ Internet access at the time of your call so that you can view enrollment with the counselor. Counselors will instruct you to go to www.gotomeeting.com and select "join a meeting." Other eligible employees who need to make changes or enroll should do so through the online enrollment portal at www.benselect.com/Enroll.

✓ What you will need for enrollment:

	Personal information (date of birth, social security number, address, email, phone, etc.)
	Names, social security numbers, and dates of birth of anyone you may cover as a dependent
	Names, Distribution Percentages, and Relationship for all Primary and Contingent Life Insurance beneficiaries. If possible, have address, phone, SSN, and email.
	Review plan options in advance so that you have an idea about the types of coverage you wish to elect and who you want to cover
	Proper documentation to verify dependent eligibility must be provided to HR prior to eligibility. If you will cover a spouse, a copy of your marriage certificate and your most recent tax return must be provided (white out any wage information or social security numbers). If you will cover a dependent child, a copy of a birth certificate, adoption decree, or proof of legal guardianship must be provided for each dependent. Additional information may be required for step children to document relationship.
	Information regarding any other plans you will have in effect at the same time as Wallis benefits should be provided to HR.

Eligibility

All regular, full-time employees will be eligible for Health, Dental, Vision, Company-Paid Life/AD&D, Supplemental Life/AD&D, Short Term Disability (STD), Accident Insurance, Critical Illness Insurance, and Flexible Spending benefits on the first of the month following 60 days of employment. To maintain full-time status, employees must work at least 30 hours per week.

Frequently Asked Questions

Can I make changes to my elections any time?

Generally, you may only enroll in the plan or make changes to your benefits when you are first hired, when you move from part time to full time, or during the re-enrollment period each year in early Feb (effective March 1). However, you can make changes/ enroll in Health, Dental, Vision, and/or Flexible Spending during the plan year, if you experience a qualifying event. Limited changes can be made to Supplemental Life/AD&D, if you experience a qualifying event, but no changes are allowed in STD coverage mid year, regardless of any qualifying events.

What do I do if I have a qualifying event?

Employees should contact Human Resources regarding plan changes BEFORE the qualifying event occurs in order to ensure the change can be made. You must have paperwork related to any changes turned in to HR within 30 days of the qualifying event or you will have to wait until the next annual open enrollment period.

What is a qualifying event?

Qualifying events are changes in family, work, or other status which would allow changes to be made to benefit elections mid-plan year. Some common qualifying events are listed below. This is not an exhaustive list. Restrictions may apply. Contact HR regarding your specific situation.

- You get married, divorced, or legally separated
- You have a baby, adopt a child, or have a child placed for adoption
- You, your spouse, or another dependent dies
- You become eligible for or lose Medicaid or Medicare
- Change in dependent eligibility for coverage
- Change in employment status of employee, spouse, or dependent (start or end employment, part time/full time change, leave of absence, etc..)
- Loss of other coverage

Can I cancel my coverage during the plan year?

You must also experience a qualifying event in order to drop Health, Dental, Vision, and/or Flexible Spending. You can cancel Supplemental Life/AD&D and STD any time.

When do I need to enroll?

You must complete the enrollment process by the 21st of the month before your eligibility date in order to ensure coverage.

What is the dependent age limit?

Health, Dental, Vision, and Supplemental Life/AD&D coverage is available for dependents up to age 26 without regard to student, employment, marriage, or other coverage status. You may also receive reimbursement under the Health Care Flexible Spending Plan based on the same eligibility.

Do I have to do anything if I don't want any coverage?

Even if you choose not to participate in some or any plans, all full time employees newly eligible for benefits must complete the enrollment process, waiving coverage as necessary and completing beneficiary information for the Company-Paid Life Insurance.

What if I miss the deadline or want coverage after I waive it?

You will not have an opportunity to enroll in Health, Dental, Vision, and Flexible Spending until the next annual open enrollment period in early Feb (effective March 1), unless you experience a qualifying event. You will not have an opportunity to enroll in Supplemental Life/AD&D or STD until the annual open enrollment period, regardless of qualifying events.

Do I have to enroll myself and/or my dependents in all lines of coverage?

Employees can enroll in Health only, Dental only, Vision only, Supplemental Life/A&D only, STD only, Flexible Spending only, or any combination of plans. You may also choose to enroll dependents on any combination of plans. The employee must be enrolled in any program in order to enroll dependents.

When are the deductions for insurance taken out of my pay?

Deductions for coverage are included on the first two checks of each month. Two to three times each year, there are 3 payrolls in one month, and deductions are not included on the third payroll of any month.

Please read all materials in the packet. It covers the details of Health, Dental, Vision, Company-Paid Life, Supplemental Life/AD&D, Short-Term Disability, Accident Insurance, and Critical Illness Insurance coverage, as well as Flexible Spending Accounts.

PLEASE READ ALL INFORMATION BELOW CAREFULLY, EVEN IF YOU ARE NOT INTERESTED IN INSURANCE COVERAGE.

Health Insurance

Wallis Companies offers two self-insured health plans (Plan A & Plan B) that utilize UnitedHealthcare's Choice Plus Network. The primary differences between the plans are the deductibles ($100 individual/$200 family for Plan A and $2600 individual/$5200 family for Plan B) and copayments for emergency room and office visits (Primary and Specialty Office Visits, as well as Urgent Care visits fall under deductible/coinsurance on Plan B). See plan descriptions for details. In order to maximize benefits from either plan, you must go to a doctor in the UnitedHealthcare (UHC) Choice Plus Network. Wallis Companies shares the cost of the insurance by paying the difference in the total cost and your cost.

Participants also have access to a 24 hour nurseline, pregnancy/parenting resources, partner discounts, and other diagnosis specific resources through UHC. In addition, www.myuhc.com has information on costs of services, prescriptions alternatives, and a host of other resources. Check out www.myuhc.com for more information and watch for HR updates and reminders about programs.

Wellness Initiatives

At Wallis Companies, we have aligned employee contributions for health insurance coverage with wellness initiatives. Employees who participate in an annual health screening and/or meet the wellness goal established after the prior year's screening will be eligible for lower health insurance contribution rates than those employees who don't participate in the health screening and/or do not meet the established wellness goal. More details about the health screening will be provided as the screening schedule is developed each year.

Note that new participants will be eligible for the lowest rate, until the health screening is offered. If an employee chooses not to participate in the health screening when offered, or if in subsequent years, the wellness goal is not met, higher rates will apply.

Monthly Employee Cost

(Rates Effective 3/1/17-2/28/18)

Plan A	Employee Cost (Highest Discount)	Employee Cost (Basic Discount)	Employee Cost (No Discount)	Total Cost (Combined EE & Co)
Employee Only	$100.00	$150.00	$225.00	$647.00
Employee & Spouse	$405.00	$505.00	$655.00	$1,248.00
Employee & Child(ren)	$291.00	$341.00	$416.00	$1,029.00
Family	$612.00	$712.00	$862.00	$1,729.00

Plan B	Employee Cost (Highest Discount)	Employee Cost (Basic Discount)	Employee Cost (No Discount)	Total Cost (Combined EE & Co)
Employee Only	$25.00	$75.00	$150.00	$573.00
Employee & Spouse	$327.00	$427.00	$577.00	$1,106.00
Employee & Child(ren)	$225.00	$275.00	$350.00	$912.00
Family	$517.00	$617.00	$767.00	$1,548.00

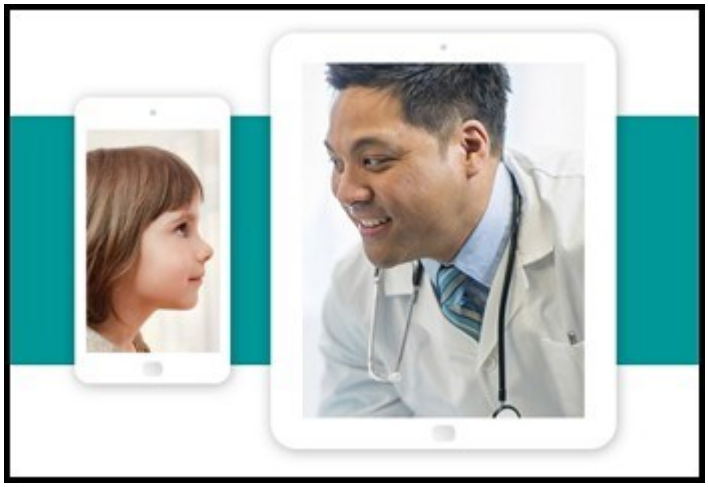
UnitedHealthcare Plan A Summary

Plan Highlights	In-Network	Out-of-Network	What it Means to You
Deductible *(per year)* Individual Family	$100 $200	$1,000 $2,000	The total amount you pay before the Plan pays for covered medical expenses. If you cover your spouse or any dependent children, each individual is subject to the individual deductible. The family deductible is the maximum combined deductible for all covered individuals.
Member copayments do not accumulate towards the deductible.			
Out-of-Pocket Maximum* *(per year)* Individual Family	$7,150 $14,300	$14,300 $28,600	You pay coinsurance until you reach the out-of-pocket maximum. Then the Plan pays 100% for covered medical and prescription drug expenses for the remainder of the plan year. If you cover your spouse or any dependent children, the individual out-of-pocket maximum will apply to each individual. The family maximum out-of-pocket includes combined out-of-pocket for all covered individuals.
The out-of-pocket maximum includes the annual deductible, copayments and coinsurance. Member copayments do not accumulate towards deductible, but do accumulate towards the out-of-pocket maximum.			
Coinsurance *(the amount the plan pays)*	80% after deductible has been met	50% after deductible has been met	Once you meet the annual deductible, you and the Plan share the cost of services by paying a percentage (called coinsurance) for covered services. Once you reach the out-of-pocket maximum, the Plan pays 100% for covered services.
Other Coverage Preventive Care	100%, no copay/deductible	Deductible, then 50%	A copayment is a fixed amount you pay for a covered health care service, paid when you receive the covered service.
Primary Physician Visit	$20 copay, then 100%	Deductible, then 50%	
Specialist Physician Visit	$45 copay, then 100%	Deductible, then 50%	
Urgent Care	$45 copay, then 100%	Deductible, then 50%	
Emergency Room	$250 copay, then deductible & coinsurance*	$250 copay, then in-network deductible & coinsurance*	
Hospital - Inpatient Stay	$300 copay, then deductible & coinsurance	$300 copay, then deductible & coinsurance	
Outpatient Surgery	$150 copay, then deductible & coinsurance	$150 copay, then deductible & coinsurance	
***If you are admitted as an inpatient to a Network Hospital directly from the emergency room, you will not have to pay this copayment. The benefits for an Inpatient Stay in a Hospital will apply instead**.*			
Prescription Drug Coverage Tier 1 Tier 2 Tier 3 Specialty Drugs	$15 copay on 30 day retail/$45 on 90-day retail 20% with $50 max. on 30-day retail/ $150 on 90-day retail 30% with $100 max. on 30-day retail/ $300 on 90-day retail 30% with $200 max. per Rx		Your cost is determined by the tier to which the prescription drug list management committee has assigned the prescription drug. All prescription drugs on the prescription drug list are assigned to Tier-1, Tier-2, Tier-3, or Specialty Drugs. To check your prescription drug tier status, log on to www.myuhc.com or call the number on the back of your card.
Mail Order Tier 1 Tier 2 Tier 3	$30 copay on 90-day 20% with $100 max. on 90-day 30% with $200 max. on 90-day		

UnitedHealthcare Plan B Summary

Plan Highlights	In-Network	Out-of-Network	What it Means to You
Deductible *(per year)* Individual Family	$2,600 $5,200	$5,000 $10,000	The total amount you pay before the Plan pays for covered medical expenses. If you cover your spouse or any dependent children, each individual is subject to the individual deductible. The family deductible is the maximum combined deductible for all covered individuals.
Member copayments do not accumulate towards the deductible.			
Out-of-Pocket Maximum* *(per year)* Individual Family	$6,350 $12,700	$12,700 $25,400	You pay coinsurance until you reach the out-of-pocket maximum. Then the Plan pays 100% for covered medical and prescription drug expenses for the remainder of the plan year. If you cover your spouse or any dependent children, the individual out-of-pocket maximum will apply to each individual. The family maximum out-of-pocket includes combined out-of-pocket for all covered individuals.
****The out-of-pocket maximum includes the annual deductible, copayments and coinsurance.*** ***Member copayments do not accumulate towards deductible, but do accumulate towards the out-of-pocket maximum.***			
Coinsurance *(the amount the plan pays)*	80% after deductible has been met	50% after deductible has been met	Once you meet the annual deductible, you and the Plan share the cost of services by paying a percentage (called coinsurance) for covered services. Once you reach the out-of-pocket maximum, the Plan pays 100% for covered services.
Other Coverage			
Preventive Care	100%, no deductible	Deductible, then 50%	
Primary Physician Visit	Deductible, then 80%	Deductible, then 50%	
Specialist Physician Visit	Deductible, then 80%	Deductible, then 50%	
Urgent Care	Deductible, then 80%	Deductible, then 50%	
Emergency Room	Deductible, then 80%	In-network deductible & co-insurance	
Hospital - Inpatient Stay	Deductible, then 80%	Deductible, then 50%	
Outpatient Surgery	Deductible, then 80%	Deductible, then 50%	
Prescription Drug Coverage Tier 1 Tier 2 Tier 3 Specialty Drugs	$15 copay on 30 day retail/$45 on 90-day retail 20% with $50 max. on 30-day retail/ $150 on 90-day retail 30% with $100 max. on 30-day retail/ $300 on 90-day retail 30% with $200 max. per Rx		Your cost is determined by the tier to which the prescription drug list management committee has assigned the prescription drug. All prescription drugs on the prescription drug list are assigned to Tier-1, Tier-2, Tier-3, or Specialty Drugs. To check your prescription drug tier status, log on to www.myuhc.com or call the number on the back of your card.
Mail Order Tier 1 Tier 2 Tier 3	$30 copay on 90-day 20% with $100 max. on 90-day 30% with $200 max. on 90-day		

Virtual Visits



A virtual visit lets you see and talk to a doctor from your mobile device or computer without an appointment. Most visits take about 10-15 minutes, and doctors can write a prescription, if needed, that you can pick up at your local pharmacy.

CONDITIONS COMMONLY TREATED THORUGH A VIRTUAL VISIT

- Bladder infection/Urinary Tract Infection
- Bronchitis
- Cold/Flu
- Diarrhea
- Fever
- Migraine/Headaches
- Pink Eye
- Rash
- Sinus Problems
- Sore Throat

ACCESS TO VIRTUAL VISITS

Log in to myuhc.com and choose from provider sites where you can register for a virtual visit. After registering and requesting a visit, you will pay the primary care visit copay of $20 under Plan A and the applicable deductible/coinsurance under Plan B.

Advocate4ME

Advocate4Me is a consumer engagement program that provides UnitedHealthcare's members with a single point of contact to address your various health needs. By calling a single toll-free number, or using your preferred communication channel, members are connected with an Advocate who provides them with end-to-end support, "owning" their request until it's resolved. This service is offered at no charge to UnitedHealthcare members.

Rally

Rally is a user-friendly digital experience on myuhc.com that uses technology, gaming, and social media to help support you on your journey toward health and wellness. Rally can help you understand and learn more about healthy choices and enhance your success in meeting wellness goals. With the online Rally Health Survey, personalized missions, rewards, and connections to wearables like Fitbit, Jawbone, and more, motivation and support on your wellness journey is at your fingertips.

Dental Insurance

Sun Life Voluntary Dental Plan Summary

PPO Benefits	In-Network	Out-of-Network
Deductible Individual Family (Waived for Preventative Services)	 $0 $0	 $25 $75
Coinsurance Diagnostic/Preventive Basic Restorative Care Major Restorative Services Orthodontia	 100% 90% 60% Not Covered	 100% 80% 50% Not Covered
Annual Maximum	$1,300	

Coverage Type	Services Covered
Class 1 — Preventive & Diagnostic Care	• Oral Exams *(2 per calendar year)* • Routine Cleanings *(2 per calendar year)* • Fluoride Treatment (1 per calendar year for those under age 19) • X-Rays *(Bitewing: 2 per calendar year; Full-mouth and Panorex 1 every 36 months)* • Sealants *(limited to posterior tooth. 1 treatment per tooth every three years up to age 14)* • Space Maintainers • Dental Prophylaxis • Genetic Testing
Class II — Basic Restorative Care	• Fillings • Root Canal Therapy/Endodontics • Osseous Surgery • Periodontal Scaling and Root Planing • Denture Adjustments and Repairs • Oral Surgery-Simple Extractions • Oral Surgery-all except simple extractions • Anesthetics • Surgical Extractions of Impacted Teeth • Repairs to Crowns and Inlays
Class III — Major Restorative Services	• Crowns • Dentures • Bridges • Inlays/Onlay

Monthly Employee Cost

(Rates Effective 3/1/17-2/28/18)

Type of Coverage	Employee Cost Per Month
Employee Only	$25.74
Employee & Spouse	$50.44
Employee & Child(ren)	$49.57
Family	$67.95

Network Information

The Sun Life dental plan uses the Assurant Dental PPO network. It is to your advantage to utilize a network dentist to get the greatest benefit and the lowest cost through contracted fees. To find a network provider, participants should register on www.sunlife.com/oaregister by entering your name and email address. You will receive an email thereafter to finalize your registration. You can also search for a provider at www.assurantemployeebenefits.com by selecting Find a Dentist on the left side of the page.

If you choose not to see a network provider, you will be responsible for any amounts exceeding 95% of usual and customary allowances when using out-of-network providers.

This Plan Includes Lifetime of Smiles

- **Preventive Max Waiver®** allows families and individuals to get routine dental care without tapping into their annual maximums.
- **Brush biopsies** to help with early detection of oral cancer.
- **Genetic testing** to help identify individuals who are at genetic risk for gum disease.
- **Periochips** to help control bacteria and reduce the size of periodontal pockets.
- **Online Dental Health Center** a trusted resource that offers members the most up-to-date information available on preventive dental care.

Vision Insurance

Sun Life Voluntary Vision Plan Summary

Benefit/Service	In-Network	Out-of-Network
Exam Allowances (One per calendar year)	$10 Copay 100% (after copay)	Up to $52
Materials Copay (Eyeglass Lenses, Frames, and/or Contacts)	$10	NA
Eyeglass Lenses Allowances (One pair per calendar year) Single Bifocal Trifocal Lenticular	 100% (after copay) 100% (after copay) 100% (after copay) 100% (after copay)	 Up to $55 Up to$75 Up to $95 Up to $125
Frame Retail Allowance (One every calendar year)	Up to $130	Up to $57
Contact Lenses Allowances (One pair or single purchase each calendar year) Elective Therapeutic	 Up to $130 Covered 100%	 Up to $105 Up to $105

Employee Monthly Cost

(Rates Effective 3/1/17-2/28/18)

Type of Coverage	Employee Cost Per Month
Employee Only	$4.93
Employee & Spouse	$9.84
Employee & Child(ren)	$9.94
Family	$15.66

Network Information

The plan uses the VSP Vision Network that includes both providers in private practice and retail chains. To find a network provider, participants should register on www.vsp.com and go to the provider search. To check before you are enrolled, go to www.vsp.com, enter the zip code under Find a VSP Doctor, and click on Search. A directory of participating vision providers will be displayed. You can also call 800-877-7195 for assistance finding a participating provider near you.

Coverage Includes

- One vision and eye health evaluation including but not limited to eye health exam, dilation, refraction, and prescription for glasses
- One pair of prescription plastic or glass lenses, all ranges of prescriptions (powers and prisms). Polycarbonate lenses for those under 18, oversize lenses, Rose #1 and #2 solid tints.
- 20% savings on non-covered lens options
- Progressive lenses covered up to bifocal lens amount with 20% savings on the difference
- One frame for prescription lenses—frame choice up to allowance with 20% savings on amount that exceeds frame allowance
- One pair or contact lenses or a single purchase of a supply of contact lenses—in lieu of lenses and frame benefit (may not receive contact lenses and frames in the same benefit year). Allowance applied toward cost of supplemental contact lens professional services (including fitting and evaluation) and contact lens materials.

Additional Network Savings

When you use a Vision Service Plan (VSP) Network Eye Care Professional, you can save 20% (or more) on additional frames and/or lenses, including lens options, with a valid prescription. Savings does not apply to contact lens materials. See your network professional for details.

Additional Information

Participants must file paper claim forms with itemized receipts when using out-of-network providers.

Section 125 Premium Savings Plan

Your contributions to Health, Dental, and Vision premiums can be payroll deducted on a pre-tax basis through a Section 125 Premium Savings Plan. The option allows you to reduce your taxable income (you don't have to pay taxes on the part of your income used to pay for medical and dental premiums) and save money on your insurance premiums. Your decision to participate cannot be changed until the next annual open enrollment period, unless you experience a qualifying event (see FAQs pg 2-3).

Company-Paid Life and Accidental Death & Dismemberment Insurance

Wallis Companies provides FREE life and accidental death and dismemberment (AD&D) coverage through Cigna to eligible employees based on years of service as outlined below. All eligible, full-time employees will be automatically enrolled in the plan, but those employees should provide beneficiary information during enrollment, even if other coverage is waived. Note that both coverage amounts are reduced when employees reach age 65 and again at age 70.

Years of Service	Life Insurance Coverage	AD&D Coverage
Up to 5	$20,000	$20,000
6 - 9	$35,000	$35,000
10 - 19	$50,000	$50,000
20+	$100,000	$100,000

Supplemental Life and Accidental Death & Dismemberment Insurance

Supplemental Life Insurance

Employees may purchase life insurance in addition to the life insurance provided free by Wallis Companies. Low group rates make the supplemental insurance an exceptional value. Employees may get insurance for themselves, spouses, or dependents.

Coverage

Employees are eligible to request up to $500,000 of life insurance in $10,000 increments. Spouses can request coverage up to 50% of employee life amount in increments of $5,000. Coverage for children is available in $1,000 increments up to 10% of the employee life amount, with a maximum amount of $10,000. Note that any coverage amounts over the guaranteed issue amounts indicated below are subject to underwriting approval.

Evidence of Insurability

Newly eligible participants will be eligible for up to $150,000 of coverage guaranteed without answering medical questions, and spouses newly eligible for coverage have a guaranteed issue amount of $50,000. All coverage for children is guaranteed and does not require underwriting approval or a medical questionnaire.

Accidental Death & Dismemberment (AD&D)

AD&D coverage, which is paid over and above the life insurance amount, should a covered individual lose his/her life in an accident, is also available. You can elect coverage in $10,000 increments up to $500,000. AD&D coverage amounts do not need to match life insurance amounts. Coverage level for spouse/dependents is based on the employee coverage amount. Spouses have 60% of employee coverage, if no other dependents are on the plan. Dependents each have 20% of employee coverage with a $10,000 maximum, if there is no spouse on the plan. If both a spouse and dependents are covered, spouse coverage is 40% of employee and dependent coverage is 10% of the employee's ($10,000 max). Evidence of insurability is not required for AD&D.

Other Important Plan Information

- Life insurance and AD&D coverage is portable. That is, you can continue to pay for the coverage at group rates, even if you are no longer eligible through Wallis Companies.
- Spousal life insurance rates are based on the employee's age.

- Employees may elect life insurance without AD&D, AD&D without life insurance, or both coverage options.
- When an employee reaches 65 years of age, the coverage in force must be reduced to 65% of the original amount for both the employee and spouse. Once an employee reaches 70 years of age, the employee coverage in force must be reduced to 50% of the original amount, and spousal coverage must be dropped.
- Rates will change based on age. If an employee reaches a new rate level, the premium change will take effect on March 1 following the birthday on which the employee reached the new age bracket.

Plan Changes and Deductions

- Employees who waive coverage or miss the enrollment deadline will not be eligible to enroll later without evidence of insurability, unless only the employee wants coverage of no more than $10,000. Evidence of insurability will be required for enrollment after the initial enrollment period, unless strict coverage limitations are met.
- Employees who want to enroll after initial eligibility or increase coverage may do so at open enrollment or in the case of a qualifying event. Employees will be required to provide evidence of insurability to qualify for any amount of life coverage, unless the employee is requesting no more than $10,000 or increasing the life amount by no more than $10,000 and the total remains at or below $150,000. Though no evidence of insurability is required for children, spouses must complete evidence of insurability for life insurance enrollment after initially eligible or for life coverage increases.
- Employees with new dependents must add coverage for those dependents prior to the first of the month after the dependent is acquired to take advantage of guarantee issue. Employees must contact Human Resources BEFORE a new dependent is acquired to ensure coverage and complete enrollment.
- All premiums are deducted on a post-tax basis.

Employee and Spouse Monthly Supplemental Life Rates

Age	Employee/Spouse Rate per $1,000*
<25	$0.08
25-29	$0.08
30-34	$0.10
35-39	$0.13
40-44	$0.20
45-49	$0.33
50-54	$0.56
55-59	$0.91
60-64	$1.14
65-69	$1.98
70-74	$3.21
75+	$4.94

*Spouse rate is determined by employee age.

Child Monthly Supplemental Life Rates

Child Life Amount	Monthly Cost
$1,000	$0.20
$2,000	$0.40
$3,000	$0.60
$4,000	$0.80
$5,000	$1.00
$6,000	$1.20
$7,000	$1.40
$8,000	$1.60
$9,000	$1.80
$10,000	$2.00

Children 6 months to 26 years are eligible for coverage. Contact HR for rates on children 14 days to 6 months.

Monthly AD&D Rates

If employee only coverage is elected, the rate is $0.03 per $1,000. If any dependent coverage is elected, the rate is $0.06 per $1,000 of the employee amount.

The Enrollment System will calculate Monthly Life Insurance Costs based on elections. A sample supplemental life calculator follows on page 12.

Supplemental Life Cost Calculator

Employee				
$_____	÷ 1,000	X	$_____	= $_____
Amount of Coverage			Unit Cost from Rate Table	Employee Monthly Cost
Spouse				
$_____	÷ 1,000	X	$_____	= $_____
Amount of Coverage			Unit Cost from Rate Table	Spouse Monthly Cost
Child(ren)				
$_____	÷ 1,000	X	$_____	= $_____
Amount of Coverage			Unit Cost from Rate Table	Child(ren) Monthly Cost

Short Term Disability

Short-term disability benefits help replace lost income if you become disabled. If you are unable to work due to a disability (including pregnancy or complications of pregnancy), you are eligible to receive payments to replace your income. There is a two week waiting period before benefits will be paid. Benefits are paid for up to 13 weeks. STD coverage is guaranteed. You do not have to complete a health questionnaire.

Partial Disability Benefit

A partial disability benefit is included with the plan. A partial disability benefit provides an opportunity for employees who are not able to work at full capacity to receive supplemental income. Employees can receive up to 100% of their pre-disability income through a combination of earnings and disability payments. Employees enrolled in STD benefits are eligible for partial disability benefits, if the partial disability follows a period of total disability which has continued for at least 30 days. You must be earning less than 80% of your pre-disability income at the time the partial disability employment begins to be eligible for partial disability benefits.

Pre-Existing Conditions

New enrollments and increases in benefit amounts are subject to a pre-existing condition limitation. Any disability contributed to or caused by a pre-existing condition within the first 12 months of your effective date will not be covered. A pre-existing condition is a sickness or injury for which you have received treatment within the 12 months prior to the effective date of your coverage. Should you file a claim in the first 12 months of your coverage, benefits may be delayed while information is researched regarding the possibility of a pre-existing condition.

Weekly Benefit Amount

Employees can choose weekly benefit amounts from $100 to $750 in $50 increments. The weekly benefit cannot exceed 70% of your basic weekly income. Basic weekly income includes the weekly compensation you earn from your normal occupation with Wallis Companies. It does not include overtime, bonuses, or any other extra pay. To determine your maximum weekly benefit, multiply your weekly wage by 0.7 (weekly hours * hourly rate * 0.7). Employees may choose a benefit amount less than the maximum, but benefits cannot exceed the maximum. If your maximum weekly benefit falls between two benefit increments, your maximum is the lower of the two. See Other Important Plan Information for information regarding taxability of benefits.

*The Wallis family of companies...a **great place** with **great people**!*

Make It Convenient!

Monthly STD Rates

The cost for STD coverage is based on your age and the weekly benefit amount you choose based on the schedule below.

Weekly Benefit	Under 40	40-49	50-59	60+
$100	$8.67	$7.82	$10.46	$14.88
Each $50 over $100	$4.34	$3.91	$5.23	$7.44

For example, $150 weekly benefit for 44 year old employee would cost $11.73 per month ($7.82 + $3.91). $250 weekly benefit for a 57 year old employee would cost $26.15 per month ($10.46 + ($5.23 * 3)).

Other Important Plan Information

- Benefits paid while disabled are non-taxable. Since the premiums are paid on an after tax basis, benefits are not taxed.
- If you are eligible for state-mandated temporary disability benefits, you may enroll in the STD program, but the combination of this plan's benefit and your other income may not exceed 70% of your basic weekly income.
- STD benefits are not payable for injury or sickness that is the result of employment.
- Disability caused by self inflicted injuries or injuries sustained as a result of your commission (or attempt to commit) an assault or felony is not a covered disability.
- To receive disability benefits, an employee must be treated regularly by a physician during the disability period.
- STD coverage is not portable. That is, you cannot continue coverage if you are no longer employed by the company.
- Rates will change based on age. If an employee reaches a new rate level, the premium change will take effect on January 1 following the birthday on which the employee reached the new age bracket.

Worksite Benefit Program

The worksite benefit plans through UNUM have been designed to provide dollars to offset new expenses and out of pocket costs associated with accidents and/or illnesses that can happen to anyone at any age. You can use the benefit however you want – to help pay medical bills or those everyday living expenses such as housing, car payments, utility bills, child-care, groceries, and credit card bills and even lost time from work.

The costs associated with the two available worksite benefits are illustrated in the online enrollment portal or can be accessed by calling (888) 205-3036.

Accident Expense Benefit

Accident insurance is designed to help meet the out of pocket expenses and extra bills that can follow an accidental injury, whether minor or catastrophic. This plan covers a wide range of off the job accidental injuries. Indemnity lump sum benefits are paid directly to you based on the benefit amount listed in the schedule of benefits. The accident plan is guaranteed issue, so no health questions are required. This plan includes coverage for scholastic sports. This coverage also pays $50 cash each year for any insured that has 1 of 26 covered health screenings. More details to follow on page 14.

Critical Illness Insurance

Critical Illness insurance is designed to help offset the final effects of a catastrophic illness with a lump sum benefit if an insured is diagnosed with a covered critical illness. This benefit is based on the amount of coverage in effect on the date of diagnosis of a critical illness or the date treatment is received according to the terms and provisions of the policy. There are no pre-existing condition limitations for you, your spouse and children. This coverage also pays $50 cash each year for any insured that has 1 of 26 covered health screenings. More details to follow on page 15.

As a new hire, you have a one-time opportunity to enroll for $10,000 for yourself and $5,000 for your spouse without needing to answer any medical questions! If you do not enroll when first eligible, all amounts of coverage will require the completion of medical questions.

If you have an accident, will it hurt your bank account too?

Unum's accident insurance gives you something to fall back on.

Benefits that pay for covered accidents while you are on the road to recovery….

Unum's coverage provides a lump sum benefit based on the type of injury (or covered incident) you sustain or the type of treatment you need.

Examples of covered injuries include:

- Broken bones
- Burns
- Torn ligaments
- Cuts repaired by stitches
- Coma due to a covered injury
- Eye injuries
- Ruptured discs
- Concussion

Some covered expenses include:

- Emergency room treatment
- Outpatient surgery facility
- Doctor office visit
- Hospitalization
- Occupational therapy
- Speech therapy
- Chiropractic visit
- Physical therapy

See the schedule of benefits for a full list of covered injuries and expenses.

Get the coverage you need.

Choose the coverage that's right for you. Your accident insurance plan can provide benefits for covered accidents that occur ***off the job***. Accident insurance is offered to all eligible employees who are actively at work. You decide if it's right for you and your family.

The following benefits are automatically included in your plan:

Wellness Benefit

Based on the plan selected by your employer, this benefit can pay $50 per calendar year per insured individual* if a covered health screening test is performed, including:

- Blood tests
- Stress tests
- Colonoscopies
- Chest X-rays
- Mammograms

There is an additional charge for this feature. A full list of covered tests will be provided in your certificate.

Catastrophic Benefit

This pays an additional sum if a covered individual has a serious injury—such as loss of sight, hearing or a limb.

An illustrative example of how accident coverage can help you with your expenses*

40-year-old claimant

Accident: Fall at Home

Injury: Broken toe and ACL tear (knee ligament Injury)

Out-of-pocket expenses incurred:

$100 emergency room copay

$500 deductible

$875 coinsurance for surgery ($3,500 x 25%)

$90 copay for six physical therapy visits

Total out-of-pocket expenses: $1,565

Benefits paid:

$150 emergency room visit

$100 appliance (knee brace)

$150 fractured toe

$800 surgical ligament tear repair

$75 follow-up appointment

$150 for six physical therapy sessions

Total benefit paid under policy: $1,425

*Costs of treatment and benefit amounts may vary. Example is based on the level 2 schedule of benefits.

Available family coverage—Who can have it?	
Spouse Coverage	Ages 17 to 64
Child Coverage	Dependent children newborn until their 26th birthday, regardless of marital or student status.

Four reasons to buy this coverage at work:

1. No health questions to answer. If you apply, you automatically receive this base plan.
2. This plan is portable. You may take the coverage with you if you leave the company or retire without having to answer new health questions. Unum will bill you directly.
3. Coverages becomes effective on the first day of the month in which payroll deductions begin.
4. Premiums are conveniently deducted from your paycheck.

Could your bank account survive a serious illness?

Get protected with group critical illness insurance from Unum.

Key advantage….

You can use this coverage more than once. If you receive a full benefit payout for a covered illness, your coverage can be continued for the remaining covered conditions. The diagnosis of a new covered illness must occur at least 90 days after the most recent diagnosis and be medically unrelated. Each condition is payable once per lifetime.

How can critical illness insurance help?

Critical illness insurance can pay a lump sum benefit at the diagnosis of a critical illness. You can choose the level of coverage from $5,000 to $50,000—and you can use the money any way you see fit.

Covered Conditions	
Heart attack	Blindness
Major organ failure	End-stage renal (kidney) failure
Occupational HIV	Coronary artery bypass surgery; pays 25% of lump sum benefit
Benign brain tumor	
Covered Conditions With Time Limitations	
Stroke	Evidence of persistent neurological deficits confirmed by a neurologist at least 30 days after the event
Coma	Coma resulting from severe traumatic brain injury lasting for a period of 14 or more consecutive days
Permanent Paralysis	Complete and permanent loss of the use of two or more limbs for continuous 90 days as a result of a covered accident
Cancer Conditions	
Cancer	Carcinoma in situ;[1] pays 25% of lump sum benefit

The following benefit is automatically included in your plan:

Wellness Benefit

Based on the plan selected by your employer, this benefit can pay $50 per calendar year per insured individual* if a covered health screening test is performed, including:

- Blood tests
- Chest X-rays
- Stress tests
- Mammograms
- Colonoscopies

There is an additional charge for this feature. A full list of covered tests will be provided in your certificate.

Available family coverage

Who can have it?	Benefit
Employees who are actively at work	$5,000 to $50,000 in $1,000 increments
Dependent Children newborn until their 26th birthday, regardless of marital or student status **All eligible children are automatically covered at 25% of the employee benefit amount (no additional cost)**	Eligible children are covered for the same conditions as employee and the following specific childhood conditions: cerebral palsy, cleft lip or palate, cystic fibrosis, Down syndrome and spina bifida. Diagnosis must occur after the child's coverage effective date.
Spouse ages 17 through 64 with purchase of employee coverage	From $5,000 to $30,000 in $1,000 increments

Three reasons to buy this coverage at work:

1. You get affordable rates when you buy this coverage through your employer, and the premiums are conveniently deducted from your paycheck.
2. Coverage is portable. You may take the coverage with you if you leave the company or retire without having to answer new health questions. Unum will bill you directly.
3. Coverage becomes effective on the first day of the month in which payroll deductions begin.

[1] Carcinoma in situ is defined as cancer that involves only cells in the tissue in which it began and that has not spread to nearby tissues.

* If you have purchased both enhanced group critical illness and group accident coverage with $50 wellness benefits, Unum will pay wellness benefits for both policies (maximum benefit: $100). This does not apply to policies with $75 or $100 wellness benefit amounts.

Flexible Spending Accounts (FSA)

This plan, administered by UHC, allows employees to set aside pre-tax money to pay for certain health care or dependent care expenses. No federal or state income taxes are paid, and no Social Security & Medicare taxes are paid on amounts set aside in the accounts. Employees on the plan elect to have a specific amount of money deducted from their pay pre-tax to be allocated to their spending account. Employees then submit claims to the plan administrator to get reimbursed for qualified expenses. Therefore, employees are able to pay for expenses with pre-tax money. Since the expenses are typically expenses that an employee is going to have to pay for in some manner, employees benefit from this plan by being able to pay for the expenses with pre-tax money. The plan can create a savings of up to 27% for employees in lower tax brackets. For employees in higher tax brackets, savings could reach up to 40%. There is no cost to employees for the plan.

Forfeitures

Funds deposited during the plan year (March 1 to February 28) may only be used for expenses incurred during that period. Any money left in accounts on February 28 may be collected by submitting receipts for expenses incurred during the plan year, but all claims must be received by May 31. Any money left in the account at year-end, which is not claimed by May 31, will be forfeited. Federal tax law requires the forfeiture as a provision of the plan. Plan your election carefully to avoid forfeiting money.

Health Care Spending Plan

The Health Care Spending Plan can be used to pay for qualified out of pocket health care expenses. The minimum annual election is $120, and the maximum election is $1500. Employees can elect to set aside any amount within that range. The following are examples of some of the items that are available for reimbursement:

- Health, Dental, Vision and prescription deductible, co-pays, and coinsurance
- Prescriptions (retail and mail)
- Dental cleanings, fillings, x-rays, etc...
- Braces and Orthodontia
- Dentures
- Hearing aids and batteries
- Eye exams, eyeglasses, frames, and contact lenses
- Contact Lens Supplies & Solutions
- Lasik Eye Surgery
- Acupuncture
- Infertility Treatments
- Orthopedic Shoes (restrictions may apply)
- Crutches and wheelchairs
- Chiropractor visits, doctor visits, x-rays, and lab work
- Over the counter medicines (must be prescribed)
- Service Animals
- Blood Sugar Test Kits
- Breast pumps/lactation supplies
- Sunscreen (SPF 30 or higher with prescription)
- Surgery, excluding cosmetic surgery

Health Care Spending Plan Special Rules

- Charges must be incurred during the plan year (Mar 1 – Feb 28). To be eligible for reimbursement, charges must also be incurred after you are eligible and participating in the plan.
- If your employment with Wallis Companies ends, only charges incurred during your employment with Wallis Companies may be reimbursed, unless you elect COBRA continuation. You are eligible to continue the health spending account under COBRA after your employment ceases, but you must continue contributions on an after-tax basis.
- Any amounts reimbursed by the spending plan are not eligible to be claimed as an itemized medical deduction on your income tax return.

Dependent Care Spending Plan

The dependent care spending plan allows you to pay for daycare expenses on a pre-tax basis. Dependent care services must be rendered for the sole purpose of allowing both spouses to work or to seek an education. Eligible dependent care must be provided for children under age 13, elderly dependents, or disabled dependents. You are limited to contributing no more than $5,000 per year by the IRS. However, if one spouse is a full-time student, you are entitled to contribute only $250 per month ($500 per month if you have two or more dependents). All dependent care services must be provided by a licensed day care center or a babysitter over the age of 19.

Dependent Care Spending Plan Special Rules

- Though you will not be reimbursed for expenses incurred prior to enrollment, you may be reimbursed for expenses incurred after employment with the company ends as long as expenses are incurred during the plan year of your termination.
- You are not allowed to claim the childcare credit on your tax return for any amounts contributed to this plan. Any amount contributed to the spending account will offset dollar for dollar the maximum amount available for the credit.
- If you participate in the dependent care spending plan, you are required to file form 2441 with your income tax return. You will be required to report the name, address, and taxpayer identification number (SSN) of your care provider.

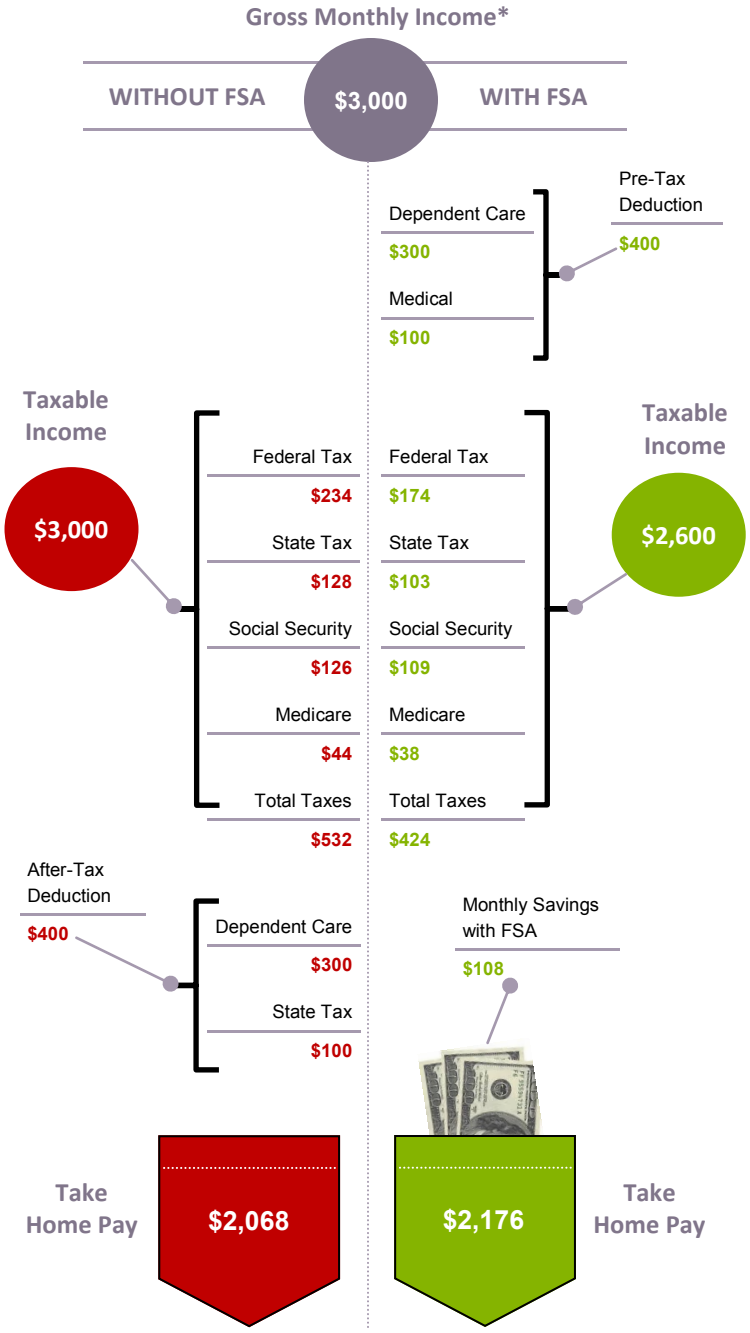
Other Important Plan Information

- You may elect to create a medical spending account, a dependent care spending account, or both.
- You may choose to enroll when you are first eligible or at the beginning of a plan year. The plan year starts March 1 of each year. Enrollment information is available for eligible employees to enroll during the open enrollment period in February.
- Employees that create flexible spending accounts must "re-enroll" each year. That is, employees must complete a new election each year to continue the plan.
- The election that you make is irrevocable. That is, you will not be allowed to enroll, change, or terminate contributions during the plan year, unless you experience a qualifying event.

Plan Administration and Claims

- All dependent care and health care spending account claims are filed with the plan administrator.
- Claim forms are available from myuhc.com, Human Resources, and The Pipeline.
- There is a $25 minimum reimbursement for direct deposit / checks.
- To obtain reimbursement for medical claims, you will be required to submit receipts, Explanations of Benefits, or other invoices documenting an eligible item and cost. Cancelled checks and credit card statements won't be accepted.
- To obtain reimbursement for dependent care, you will be required to submit receipts or invoices which include the provider's name, address, and tax ID number.

How will a flexible spending arrangement save you money?



* This is an example and for illustration purposes only. Taxes are not exact and will vary.

Employee Assistance Program (EAP)

Wallis Companies offers an Employee Assistance Program (EAP) that is FREE to employees and their dependents. Counseling, financial planning, legal consultation, child/elder care management/referral, college planning, and wellness services are provided. EAP services are 100% confidential and available 24 hours a day.

Tuition Reimbursement

The company offers a variety of training and development opportunities at no cost to employees. The tuition reimbursement program outlined below is available to full-time and part time employees seeking to further their education through college credit courses.

Employees with at least 6 months of service can get up to 50% of tuition paid. Employees with at least 1 year of service can get up to 80% of tuition paid. Full-time employees are limited to $2500 per calendar year, and part time employees are limited to $1500 per calendar year. Additional limitations and exclusions may apply. See Tuition Reimbursement policy for further clarification.

Paid Time Off

Full-time and part-time employees receive paid time off based on hours worked to allow time away from work for rest, recreation, and important personal matters.

After 1 year	2 weeks
After 5 years	3 weeks
After 10 years	4 weeks

Special Pay on Holidays and/or Paid Holidays may also be available based on division/position. See Holiday Pay policy for details. Pay for Bereavement and Jury Duty may also be available, as well as Leaves of Absence. See the Policy Manual for details.

Traditional 401(k) and Roth

The 401(k) is offered to all employees who have been with the company at least one year that are at least 18 years old. Activation begins on January 1, April 1, July 1, and October 1 after meeting both eligibility criteria. The company matches 100% of the first 2% employees put into the program and 50% of the next 5% employees put into the program. That's a total company match of 4.5% when employees contribute 7%! Employees are 100% vested after 3 years of service.

Referral Bonus

The Company believes that its employees are the best recruiters. A finder's fee is offered to employees for each new team member they recruit. Employees could potentially receive 90,000 Be a Star pointes equivalent to a $300.00 value. See Referral Bonus policy for further clarification.

Discount Programs

- Discounted tickets for Six Flags & Hurricane Harbor; and a discount code available for Silver Dollar City & Whitewater
- Enterprise Rent-A-Car and National Car Rental
- Jos. A Bank Clothiers
- AT&T Cellular Service
- Discounted tickets to select events at Scottrade Center and Peabody Opera House and select St. Louis Blues events
- Various employee discounts for drinks, food, and car washes are available based on work location. Restrictions apply. Please see the policy for additional information.

Important Notices

Special Enrollment Notice

During the open enrollment period, eligible employees are given the opportunity to enroll themselves and dependents into our group health plans. If you elect to decline coverage because you are covered under an individual health plan or a group health plan through your parent's or spouse's employer, you may be able to enroll yourself and your dependents in this plan if you and/or your dependents lose eligibility for that other coverage. If coverage is lost, you must request enrollment within 30 days after the other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll any new dependent within 30 days of the event. To request special enrollment or obtain more information, contact Human Resources.

Women's Health and Cancer Rights Act of 1998

As a requirement of the Women's Health and Cancer Rights Act of 1998, your plan provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. The benefits must be provided and are subject to the health plan's regular copays, deductibles, and co-insurance. You may contact our health carrier at the phone number on the back of your ID card for additional benefit information.

Notice of Material Change (also Material Reduction in Benefits)

Wallis Companies has amended the Medical benefit plans. This benefit guide contains a summary of the modifications that were made. It should be read in conjunction with the Summary Plan Description or Certificate of Coverage, which is available to you once it has been updated by the carriers. If you need a copy, please submit your request to Human Resources.

Notice of Privacy Practices

Wallis Companies is subject to the HIPAA privacy rules. In compliance with these rules, it maintains a Notice of Privacy Practices. You have the right to request a copy of the Notice of Privacy Practices by contacting Human Resources.

Important Information Regarding 1095 Forms

As an employer with 50 or more eligible employees we are required to provide 1095-C forms to all employees who were eligible for coverage under our group health plan in 2016. If you were eligible for coverage under our group plan you will receive a personalized 1095-C form before March 2, 2017. We are also required to send a copy of your 1095-C form to the IRS.

The information reported on Form 1095-C is used in determining whether an employer owes a payment under the employer shared responsibility provisions under section 4980H. Form 1095-C is also used by the IRS and the employee in determining the eligibility of the employee for the premium tax credit. You'll need a 1095 form to complete your annual Federal tax return.

Marketplace Options

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

General Information

When key parts of the health care law took effect in 2014, there was a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by Wallis Companies.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance which meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit which lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins November 1st through January 31st.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium. Savings depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer which offers minimum essential coverage and meets affordability standards, you will not be eligible for a tax credit through the Marketplace. If you purchase health coverage through the Marketplace, you may lose any employer contribution offered for the employer-offered coverage. Employer and employee contributions for employer-offered coverage are often excluded from Federal income tax. Payment for Marketplace coverage is made on an after-tax basis.

More Information

New employees will receive a notice of Marketplace Coverage Options advising the standards of offered coverage. Please visit HealthCare.gov for more Marketplace information.

Medicaid CHIP Notice

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're also eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed on the DOL website provided below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

Following is a link to the latest form and states where you may be eligible for assistance paying your employer health premiums: **dol.gov/ebsa/pdf/chipmodelnotice.pdf**

For more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
dol.gov/ebsa
1-866-444-3272
Menu Option 4, Ext 61565

U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
cms.hhs.gov
1-877-267-2323

Notice Regarding Wellness Program

The Wallis Wellness Initiative with Interactive Health is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood pressure screening and a comprehensive blood test that evaluates your risk for cardiovascular disease, diabetes, liver and kidney disease, anemia, and other chronic conditions. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive as outlined in 2017 Employee Benefits Guide. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the discounted health premium.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Dawn Houser at (314) 549-1575.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Wallis Companies may use aggregate information it collects to design a program based on identified health risks in the workplace, Interactive Health will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of

your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is the health coach contracted through Interactive Health, in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Dawn Houser at (636) 549-1575.

Medicare Part D Creditable Coverage

This notice has information about your current prescription drug coverage and about your options under Medicare's prescription drug coverage. If you are eligible for Medicare, the following information can help you decide whether or not you want to join a Medicare drug plan. You should consider comparing your current coverage through our medical plan with the costs of plans offering Medicare prescription drug coverage in your area. Two important things you need to know about your current coverage and Medicare prescription drug coverage:

Medicare prescription drug coverage is available if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan. All Medicare drug plans provide at least a standard level of coverage set by Medicare. More coverage may be offered at a higher premium.

UnitedHealthcare has determined that the prescription drug coverage offered by Wallis Companies is on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because this coverage is Creditable Coverage, you can keep it and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

If you lose your current creditable prescription drug coverage through no fault of your own, you will be eligible for a two-month Special Enrollment Period to join a Medicare drug plan.

If you decide to join a Medicare drug plan, your current coverage will not be affected. This plan will coordinate with Part D coverage. If you drop your current coverage, be aware that you and your dependents will be able to get this coverage back.

If you drop or lose your current coverage and don't join a Medicare drug plan within 63 continuous days after your coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

This information is provided for the Medicare open enrollment period which begins on October 15. If you want more information about Medicare plans that offer prescription drug coverage, you will find it in the Medicare & You handbook or you can visit medicare.gov or call 1-800-MEDICARE (1-800-633-4227).

TTY users: 1-800-486-2048. If you have limited income and resources, visit Social Security on their website at socialsecurity.gov, or call them at 1-800-772-1213. TTY users: 1-800-325-0778.

Keep all Creditable Coverage notices. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of the notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).