BOYLE BRASHER LLC

A Civil Litigation Law Firm

2016 Employee Benefits Annual Enrollment

BENEFIT NEWS

Boyle Brasher LLC is pleased to partner with the following carriers beginning March 1, 2016:

**DUE: By 5:00 P.M.
Tuesday, February 23**

ALL EMPLOYEES MUST COMPLETE AND RETURN AN ELECTION FORM TO YOUR OFFICE MANAGER BY THE DATE ABOVE.

YOU WILL FIND THE ELECTION FORMS FOR MEDICAL, DENTAL AND VISION ON PAGES 12 AND 13 OF THIS NEWSLETTER.

March 1, 2016, is the annual renewal for our employee benefit plans. During this time, benefit eligible employees may join or terminate coverage from a plan; add or remove a dependent; and/or, change coverage elections. The decision you make for yourself and your dependents will remain in effect for twelve months unless you experience a qualifying event, such as marriage, divorce, birth of a child, etc.

Boyle Brasher knows your employee benefit package is extremely important to you. We understand your benefits should meet your needs, as well as be affordable. The Medical plan renewal from United HealthCare was challenging with a significant premium increase. We again worked with CBIZ, our insurance consultants, to review the marketplace and obtain the most competitive rates without sacrificing quality.

In order to maintain a strong, comprehensive benefit package and cost structure for our employees, we decided this would be a good opportunity to look at the marketplace for all of our benefit plans. After a thorough review of all the carrier information presented, we have chosen to make the following changes:

Anthem BCBS will be our new carrier for Medical benefits. We will continue to offer two plans, a Traditional PPO plan and a Qualified High Deductible H S A plan.

The Dental and Voluntary Vision benefits will be through Anthem as well. We were very excited to secure a two-year rate guarantee for these two plans. Our new Dental plan will now include coverage for implants and white resin composites.

AUL One America will be the new carrier for our Basic Life/AD&D, Voluntary Life, Voluntary Short Term Disability and Long Term Disability. AUL was able to closely match our current benefits with minimal changes and offer a three-year rate guarantee.

Employee meetings are scheduled for each office with a representative from both Anthem and One America to review all of the new benefits and answer questions. These meetings will be educational, so your attendance is important.

The following is a schedule of the meeting dates and times:

**Memphis - Tuesday, February 16th
Time: 10:00 A.M. - Conference Call/Webinar**

**Belleville - Thursday, February 18th
Time: 10:30 A.M. and 1:00 P.M.**

**St. Louis - Friday, February 19th
Time: 1:00 P.M.**

An overview of the new plans is illustrated on the next several pages. These are a brief summary only. The benefits will be reviewed in detail at the employee meetings. For exact terms and conditions, you should always refer to your summary plan description.

Medical

Understanding Your Health Plan Options

The medical coverage with Anthem BCBS will continue to offer you the choice between two plans: a Traditional PPO Plan and an H S A Qualified High Deductible Health Plan. Regardless of the plan you select, the deductibles will run on a calendar year basis (January 1st through December 31st.)

Both plans give you the choice of using out-of-network providers. It is to your advantage to utilize in-network providers, because Anthem has negotiated significant discounts with in-network providers. If you go out-of-network, you will be responsible for the difference between the actual charge and Anthem's UCR (Usual, Customary and Reasonable) charge for the service or procedure plus any deductible and coinsurance associated with your service or procedure.

The Qualified High Deductible Health Plan allows you the opportunity to establish a Health Savings Account (HSA) banking arrangement with a bank of your choice and contribute all or part of the premium savings into the HSA. The HSA can be used to cover medical expenses including deductibles. The money in the account is yours and can be taken with you even if you are no longer a Boyle Brasher employee. Also, the funds are not forfeited at the end of the year if they haven't been used, but rather can be carried over from year to year.

Get the most out of your insurance by using in-network providers.

The Traditional PPO Plan may be the plan for you if:

- You have a lot of regular medical expenses, like maintenance medi cations or frequent office visits.
- You have children who go the doctor frequently.
- You feel you cannot afford the higher deductible associated with the Qualified High Deductible Plan.
- You are not interested in establishing a Health Savings Account.
- You are 65 or on Medicare.

The Qualified High Deductible Health Plan may be the plan for if:

- You do not use a lot of medical services.
- You do not use regular prescription medication.
- You would like a tax-advantaged savings account to use for medical expenses.
- You would like money in a savings account to pay for "Qualified Expenses" permitted under Federal Law. This includes most medical care, dental and vision services.

Your Medical Insurance Plan Options

Anthem BCBS - Plan Designs

Features	Traditional PPO Plan 4 / Rx AL		Lumenos EI / Rx AH Qualified High Deductible H S A Plan	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible (Individual / Family)	$1,000 / $3,000	$3,000 / $6,000	$3,000 / $6,000	$6,000 / $12,000
Coinsurance	90%	70%	100%	70%
Out-of-Pocket Maximum (Individual / Family) *Includes Deductible, Coinsurance & Co-Pays*	$4,000 / $8,000	$8,000 / $16,000	$4,000 / $8,000	$12,000 / $24,000
Office Visit (Primary Care physician / Specialist)	$25 / $50 Co-Pay	Ded., & Coinsurance	Ded., & Coinsurance	Ded., & Coinsurance
Preventive Care	100%	Ded., & Coinsurance	100%	Ded., & Coinsurance
Major Diagnostics: (MRI, CT, PET, MRI, MRA)	Ded., & Coinsurance	Ded., & Coinsurance	100% after deducti-ble	70% after deductible
Urgent Care	$75 Co-Pay	Ded., & Coinsurance	Ded., & Coinsurance	Ded., & Coinsurance
Emergency Room	$250 Co-Pay, then 90% Coinsurance		Ded., & Coinsurance	
Outpatient Surgery	Ded., & Coinsurance	Ded., & Coinsurance	Ded., & Coinsurance	Ded., & Coinsurance
Inpatient Hospital Services	Ded., & Coinsurance	Ded., & Coinsurance	Ded., & Coinsurance	Ded., & Coinsurance
Prescription Drug			Ded., then:	Ded., then:
Retail (at Participating Pharmacies)	$10/$35/$60/25% to $200 Max.	50%, Min $60	$10/$35/$60/25% to $200 Max.	50%, Min $60
Mail Order (90-Day Supply)	$10/$90/180/25% to $200 Max.	Not Covered	$10/$90/180/25% to $200 Max.	Not Covered

TRADITIONAL PPO EMPLOYEE CONTRIBUTIONS	
Employee Only	$2.00
Employee & Spouse	$647.19
Employee & Children	$621.89
Employee & Family	$1,267.07

QUALIFIED HIGH DEDUCTIBLE EMPLOYEE CONTRIBUTIONS	
Employee Only	$2.00
Employee & Spouse	$432.74
Employee & Children	$415.86
Employee & Family	$846.59

Understanding Health Savings Accounts (HSA)

What is an HSA?

A savings account set up by either you or your company where you can choose to direct pre-tax payroll deductions or deposit money to be used by you to pay for current or future medical expenses for you and/or your dependents. Once money goes into the account, it's yours forever - the HSA is in your name, just like a personal checking or savings account.

What rules must I follow?

- You must be covered under a Q*ualified High Deductible Health Plan (QHDHP)* in order to establish an HSA.
- You cannot establish an HSA if you or your spouse also have a medical *flexible* spending account (FSA), unless it is a Limited Purpose FSA.
- You cannot set up an HSA if you have insurance coverage under another plan, for example your spouse's employer, unless that secondary coverage is also a qualified high deductible health plan.
- You cannot be enrolled in Medicare or Tricare due to age or disability.
- You cannot be claimed as a dependent under someone else's tax return.

What else do I need to know?

- Contributions are based on a calendar year. The contribution limits for 2016 are $3,350 for Single and $6,750 for Family coverage. You cannot put more than this amount in the account; you can put less.
- The contributions grow tax-free and come out tax-free as long as you utilize the funds for approved services based on the IRS Publication 502, (medical, dental, vision and over-the-counter medications with a physician's prescription).
- Your unused contributions roll over from year to year and can be taken with you if you leave your current job.
- If you use the money for non-qualified expenses, then the money becomes taxable and subject to a 20% excise tax penalty (like in an IRA account).
- There is no penalty for distributions following death, disability (as defined in IRC 72), or attainment of Medicare eligibility age, but taxes would apply for non-qualified distributions.

Another advantage is that your account can grow over time.

Since the money always belongs to you, even if you leave the company, any unused funds carry over from year to year, you never have to worry about losing your money. That means if you don't use a lot of healthcare services now, your HSA funds will be there if you need them in the future – even after retirement.

The HSA is also an investment opportunity.

With an HSA, your account can grow tax-free in an interest-bearing savings account, a money market account, a wide variety of mutual funds – or all three. Of course, your funds are always available if you need them for qualified healthcare expenses.

Generally, you can put enough in your HSA to cover your entire deductible.

The Qualified High Deductible Health Plan helps you pay for healthcare AFTER you meet the deductible. The annual contribution limit is based on IRS rules. In general, the total amount that goes in your account each year cannot be more than the IRS annual contribution limit. If you're age 55 or older, you are allowed to make extra contributions each year.

You can spend only the money that is actually in your HSA.

If your healthcare expenses are more than your HSA balance, you need to pay the remaining cost another way, such as cash or personal check. You can request reimbursement after you have accumulated more money.

You can use your HSA for your spouse and dependents – even if they are not covered by your High Deductible Health Plan.

You can use HSA funds for IRS-approved items such as…

- Doctor's office visits
- Dental services
- Eye exams, eyeglasses, contact lenses and solution, and laser surgery
- Hearing aids
- Orthodontia, dental cleanings, and fillings
- Prescription drugs and some over-the-counter medications, with a physician's prescription
- Physical therapy, speech therapy, and chiropractic expenses

More information about approved items, plus additional details about the HSA, is available on the IRS Website at irs.gov.

Every time you use your HSA, save your receipt in case the IRS asks you to prove your claim was for a qualified expense. If you use HSA funds for a non-qualified expense, you will pay tax and a penalty on the ineligible amount.

The HSA is your personal account and contains your personal funds. It can be considered an asset by a creditor and garnished as applicable.

As an HSA account holder, you will be required to file a Form 8889 with the IRS each year. This form identifies any contributions, distributions, or earned interest associated with the account.

This may be the plan option for you if:

- You do not incur a lot of medical and prescription medication expenses.
- You would like money in a savings account to pay for Qualified Expenses permitted under Federal Law.
- You would like the opportunity to contribute pre-tax to a Health Savings Account.

✓ Frequently Asked Questions

What will I pay at the pharmacy with the HSA qualified plan options?

✓ You will pay the actual discounted cost of the drug until you satisfy your calendar year deductible in full, then your pharmacy copays will apply.

What will I pay at the physician's office with the HSA qualified plan option?

✓ You will provide your ID card at the time of the visit. The office will submit the claim to Anthem, and Anthem will discount the charges based upon the physician's contract with them. You will receive an Explanation of Benefits (EOB) from Anthem BCBS that illustrates your responsibility. You will receive a bill from the physician's office. The amount shown on the EOB as your responsibility should match the amount on the bill from the physician's office and is what you would be responsible for paying.

Where can I obtain a copy of an EOB?

✓ You can access all of your EOB information, and even print a copy, by registering on www.anthem.com

Dental

Anthem BCBS will be our new dental carrier. Even though you have the option of going to an in or out-of-network provider, it is always to your advantage to utilize a network dentist to take advantage of contracted fees. If you go out-of-network, you will be responsible for any amount exceeding Anthem's negotiated fees plus any deductible and coinsurance associated with your procedure. Dependent children are eligible for coverage until the end of the month in which they turn age 26. The following is a brief summary of your benefits:

Anthem BCBS - Complete Prime (MAC)

	Features	In-Network	Out-of-Network
Deductible (Individual/Family)	■ Aggregate	$50 / $150	$50 / $150
Annual Maximum	■ Applied to Preventive, Basic and Major Services	$1,500	$1,500
Diagnostic and Preventive Services	■ Periodic Oral Evaluation ■ Bitewing X-rays (2X per 12 Months) ■ Lab & Other Diagnostic Tests ■ Fluoride Treatments ■ Sealants ■ Space Maintainers ■ Prophylaxis: Cleanings	100% (No Deductible)	100% (No Deductible)
Basic Services	■ Amalgam (silver-colored) Filling ■ Front Composite (tooth-colored) Filling ■ Back Composite Filling, Covered as Composites ■ Simple Extractions ■ Endodontics (Root Canal) ■ Periodontics (Scaling and Root Planning)	90%	80%
Major Services	■ Oral Surgery ■ Crowns ■ Dentures ■ Bridges ■ Dental Implants	60%	50%
Orthodontic Services	■ Dependent Children Only Age 8 to 18	50%	50%

EMPLOYEE CONTRIBUTIONS	
Employee Only	**$2.00**
Employee & Spouse	**$37.76**
Employee & Children	**$62.54**
Employee & Family	**$98.29**

Voluntary Vision

Boyle Brasher offers employees the opportunity to purchase a Voluntary Vision plan. Our new carrier for this coverage will be Anthem BCBS, and if you elect this plan you will be responsible for paying the total cost of the premium through payroll deductions. Vision care doctors are often the first to identify chronic health conditions during an exam. They can detect signs of a number of eye and other health conditions. This can lead to early detection of major health problems before they become more serious.

*The out-of-network column shows the maximum amount a member is reimbursed at out-of-network providers.

Anthem BCBS - Blue View Vision Option 59

Features	In-Network	Out-of-Network*
Exam Co-Pay	$10	$42
Frequency of Service: Exams Lenses Frames	12 Months 12 Months 24 Months	
Basic Lens: Single Bifocal Trifocal	A $25 Co-Pay, then: 100% 100% 100%	 $40 $60 $80
Frames:	$25 Co-Pay, then: $130 Allowance 20% off Balance over $130	$45
Contacts: Necessary Cosmetic	$25 Co-Pay, then: 100% $130 Allowance 15% off Balance over $130	 $210 $105
Laser Vision Discount	Discounts Available	Not Available

EMPLOYEE COST	
Employee Only	$8.28
Employee & Spouse	$14.49
Employee & Children	$15.73
Employee & Family	$24.01

Basic Term Life

AUL One America will be our new carrier for the lines of coverage shown on this page. Our Basic Term Life/AD&D benefit will remain a flat $20,000 of coverage. The plan has the same age reduction schedule we had with Standard, which is a benefit reduction of 65% upon attainment of age 65, 50% at age 70 and 35% at age 75.

There is a Conversion feature that allows you to convert the policy to individual coverage should your employment at Boyle Brasher terminate in the future.

Voluntary Term Life

Boyle Brasher will continue to offer you the opportunity to purchase Voluntary Term Life insurance. You must purchase coverage on yourself in order to purchase additional coverage for your dependents.

Below are the maximum coverage levels and Guarantee Issue amounts.

EMPLOYEE COVERAGE
Employees may elect coverage in increments of $10,000 up to 5 x Salary or a maximum of $500,000, The Guarantee Issue amount for employees is $100,000.

SPOUSE COVERAGE
Spousal coverage is available in $5,000 increments not to exceed 100% of the employee amount up to a maximum of $100,000. The Guarantee Issue amount for spouses is $25,000.

CHILDREN
Coverage is available for children live birth to 6 months in the amount of $1,000. Coverage in the amount of $10,000 is available for a child more than 6 months old up to age 19 (25 if full-time student).

The Voluntary Life insurance also has Portability and Conversion features, again allowing you to take the coverage with you should your employment at Boyle Brasher terminate in the future.

Disability Insurance

Voluntary Short-Term Disability

The benefits under this plan will remain the same, 66.67% of salary up to a maximum of $1,000 per week. There is a waiting period of 7 days for an accident and 7 days for sickness with a 12 week benefit period.

Long-Term Disability (STAFF ONLY)

Long Term Disability helps replace a portion of your income for an extended period of Disability.

The benefit amount will continue at 60% of salary to a $5,000 maximum.

Benefits begin to accrue on the day following the day you completed the elimination waiting period. The elimination period begins on the day you become disabled and is the length of time you must wait while being disabled before you are eligible to receive a benefit. Your elimination waiting period for Long Term Disability is 90 days.

There are exclusions for pre-existing conditions. Your plan may not cover a sickness or accidental injury that arose in the months prior to your participation in the plan.

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, please contact your Office Manager.

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 Privacy Practices

Boyle Brasher, LLC 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 2015. If you were eligible for coverage under our group plan you will receive a personalized 1095-C form before March 31, 2016. 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 Precision Practice Management.

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.

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

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.

BOYLE BRASHER LLC
2016 MEDICAL ELECTION FORM

I, ________________________________, elect the following Medical plan effective March 1, 2016.

______ I **DO** wish to make changes to my current enrollment elections.

______ I am **NOT** making any changes to my current enrollment elections.

TRADITIONAL PPO
Blue Access Choice Option 4 / Rx AL
90% Coinsurance/$1,000 Deductible

Employee Only	_________
Employee/Spouse	_________
Employee/Child(ren)	_________
Family	_________

QUALIFIED HIGH DEDUCTIBLE PLAN
Lumenos H S A Option EI / Rx AH
100% Coinsurance/$3,000 Deductible

Employee Only	_________
Employee/Spouse	_________
Employee/Child(ren)	_________
Family	_________

Waive Coverage _________

If you waived coverage for yourself and/or your dependents on your initial FormFire application, but now wish to change your election, please contact Jamie Dagenais for instructions on how to update your information.

It is important to note that if you waive coverage for yourself and/or dependents during this annual enrollment you will not be able to enroll or make changes until next year unless you experience a qualifying event.

I understand my above election will be in effect from March 1, 2016 through February 28, 2017.

Signature______________________________ Date____________________

BOYLE BRASHER LLC
2016 DENTAL AND VOLUNTARY VISION ELECTION FORM

I, ___________________________________, elect the following Anthem Dental and/or Vision plans effective March 1, 2016.

______ I **DO** wish to make changes to my current enrollment elections.

______ I am **NOT** making any changes to my current enrollment elections.

DENTAL

COMPLETE PRIME (MAC)

Employee	__________
Employee/Spouse	__________
Employee/Child(ren)	__________
Family	__________
Waive Coverage	__________

VOLUNTARY VISION

BLUE VIEW VISION OPTION 59

Employee	__________
Employee/Spouse	__________
Employee/Child(ren)	__________
Family	__________
Waive Coverage	__________

It is important to note that if you waive coverage for yourself and/or dependents during this annual enrollment you will not be able to enroll or make changes until next year unless you experience a qualifying event.

I understand my above election will be in effect from March 1, 2016 through February 28, 2017.

Signature________________________________ Date_____________________