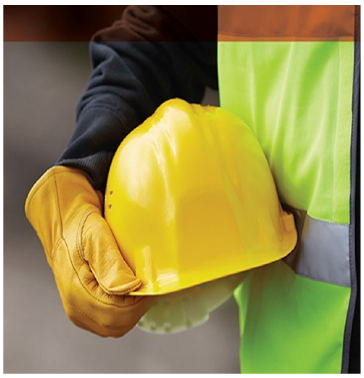
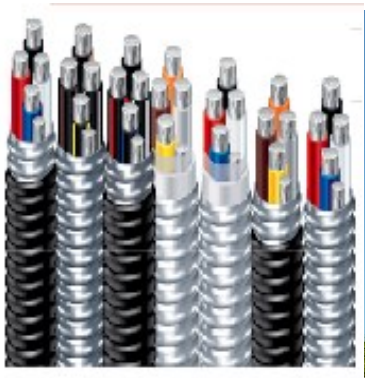
FROST
SUPPLY. SUPPORT. SERVICE.

2017 Employee Benefits Guide





Helping You Become A Better You.

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, and 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 documents shall govern.

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Contact Information

Frost, 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 a member of your Benefits Team.

Contact Information		
Vendors	**Phone Number**	**Website**
Aetna *(Medical)* Group Number: 450549	Call the toll-free number on the back of your ID card.	**aetna.com**
Aetna (Dental) Group Number: 95208684	Call the toll-free number on the back of your ID card.	**aetna.com**
VBA (Vision) Group Number: 3612	Toll Free (800) 432-4966	**visionbenefits.com**
Aetna *(Life/AD&D)* Group Number: 284883	Toll Free (800) 872-3862	**aetna.com**
Aetna *(Voluntary Life/AD&D)* Group Number: 284883	Toll Free (800) 872-3862	**aetna.com**
Aetna *(STD)* Group Number: 284883	Toll Free (800) 872-3862	**aetna.com**
Aetna *(LTD)* Group Number: 284883	Toll Free (800) 872-3862	**aetna.com**
H&H Health Associates *(EAP)*	(314) 845-8302 Toll Free (800) 832-8302	**hhhealthassociates.com**
Aflac	Toll Free (800) 99-Aflac	**aflac.com**
CBIZ *(HSA & FSA)*	Toll Free (800) 815-3023, press 4	**myplans.cbiz.com**
CBIZ *(COBRA Services)*	Toll Free (800) 815-3023, press 6	**enroll.cbiz.com**

Benefits Team	**Phone**	**Email**
Frost HR Service Team	(314) 995-5517 Toll Free (877) 634-6235 Fax (866) 399-0412	**FrostHR@cbiz.com**
Consultant Sara R. Miller Karen Grasso	(314) 692-2249 Toll Free (800) 844-4510	**samiller@cbiz.com** **kgrasso@cbiz.com**

Introduction

Eligibility

Joining the Plan:

If you are a Frost new hire, please contact Frost HR to review the waiting period requirements for each benefit. You will be provided the date on which your coverage becomes effective.

You may submit your enrollment forms/applications and complete enrollment anytime before this date, but you must complete the enrollment process within 30 days of the effective date. If you do not submit your enrollment information within 30 days after your effective date you will need to wait until the next annual open enrollment to make your benefit elections.

Who Can You Add to Your Plan:

Eligible

- Legally married spouse
- Natural or adopted children under 26 years old
- Children under your legal guardianship
- Your stepchildren
- Children under a qualified medical child support order
- Disabled children 26 years or older

Ineligible

- Divorced or legally separated spouse
- Common law spouse, even if recognized by your state
- Foster children
- Sisters, brothers, parents or in-laws, grandchildren, etc.

Frequently Asked Questions

Are Changes to My Plan Allowed During the Year?

Generally, you may only enroll in the plan, or make changes to your benefits, during the re-enrollment period or when you are first hired. However, you can make changes/enroll during the plan year if you experience a qualifying event. As with a new enrollee, you must have your paperwork turned in within 30 days of the qualifying event or you will have to wait until the next annual open enrollment period.

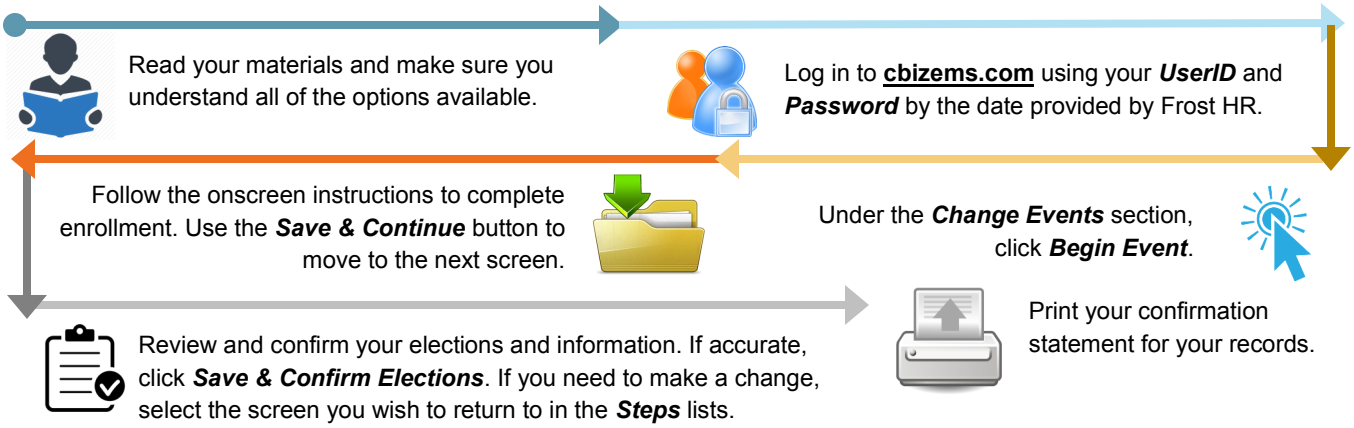
Examples of qualifying events:

- Your dependents or you lose health coverage because of loss of eligibility or loss of employer contributions
- You get married, divorced, or legally separated (with court order)
- You have a baby or adopt a child
- You or your spouse take an unpaid leave of absence
- You or your spouse dies
- You become eligible for or lose Medicaid coverage
- You become eligible for Medicare

How Often Are Benefit Deductions Taken from My Paycheck?

Payroll deductions will be based on 24 pay periods. The months in which you have a 3rd paycheck, the 3rd payroll will not have deductions for benefits except for 401(k) contributions, Holiday Savings Plan, or United Way.

Enrolling in the Plans - *it's fast and easy - here's how….*



IMPORTANT NOTE: It is very important that you complete your enrollment by the due date provided by Frost HR. If you do not complete your enrollment by that date, you will, by default, waive your rights to the company sponsored group benefits.

Medical Insurance

Pre-Notification Information

Aetna will require notification before you receive certain covered health services. In general, Network providers are responsible for notifying Aetna before they provide these services to you. There are some Network Benefits, however, for which you are responsible for notifying Aetna and as a rule Aetna should be notified of all Out-of-Network services. Services for which you must provide pre-service notification are identified in the Schedule of Benefits within each Covered Health Service Category which is located in your enrollment packet.

Aetna Providers

With Aetna's Find a Doctor online tool, it's simple to look for medical providers in your area.

1. Go to **aetna.com**
2. At the top of the page, select Find a Doctor.
3. Click on "A plan offered by my employer…"
4. Select the type of provider you want to search for.
5. Input your zip code or city and state.
6. Select the Aetna Choice POS II (Open Access) plan.

Remember, regardless of the medical plan option you choose, the provider network is the same.

Medical Plan Important Features

- You have the opportunity to choose the in network deductible that best fits your family needs.
- Some of the plan features vary between the Base and Buy-Up Plans including the deductibles. In the QHDHP Option, all services apply to the deductible first; and there are no copays in this plan.
- The deductible and out-of-pocket maximums are based on a Plan Year. This means these benefit features start over at $0 every June 1st.
- All medical plan co-pays, coinsurance, deductibles, and prescription drug co-pays accumulate towards the out-of-pocket maximums.

You Have a Choice on Where to Go for Care!

Primary Care

For routine, primary/preventive care, or non-urgent treatment, we recommend going to your doctor's office for medical care. Your doctor knows you and your health history, and has access to your medical records. You may also pay the least amount out of pocket when you receive care in your doctor's office.

Convenience Care

Sometimes, you may not be able to get to your doctor's office, and your condition is not urgent or an emergency. In these situations, you may want to consider a Convenience Care Center that can be an alternative to seeing your doctor.

Convenience Care Centers are conveniently located often in malls or some retail stores, such as CVS Caremark, Walgreens, Wal-mart and Target, and offer services without the need to schedule an appointment. Services at a Convenience Care Center may be provided at a lower out of pocket cost than an urgent care center visit and are subject to primary care physician office visit copays and/or deductible/coinsurance.

Services at a Convenience Care Center are generally available to patients 18 months of age or older. Services that are available may vary per center. We do, however, recommend that you seek routine medical care from your primary care physician whenever possible.

To find an in-network Convenience Care Center near you, visit **aetna.com**.

Urgent Care

Sometimes you may need medical care fast, but a trip to the emergency room may not be necessary. Of course, during office hours you may be able to go to your doctor for any urgently needed service; however, if you require urgent care outside your doctor's regular office hours or you are unable to be seen by your doctor immediately, you may consider going to an urgent care center. At an urgent care center, you can generally be treated for many minor medical problems faster than at an emergency room.

We do however, recommend that you seek routine medical care from your primary care physician whenever possible.

Services that are available for Urgent Care may vary per center. If you choose to use an urgent care center, please make sure it is in-network by calling the toll-free number on the back of your medical ID card or visiting the carrier's website at aetna.com.

Emergency Room

If you think you or your loved one may be experiencing an emergency medical condition, you should go to the nearest emergency room or call 911. Emergency services are always considered at the in-network benefit level.

Convenience Care Center

Typical conditions that may be treated at a Convenience Care Center include:

- Common infections (e.g.: bronchitis, bladder infections, ear infections, pink eye, strep throat)
- Minor skin conditions (e.g.: athlete's foot, cold sores; minor sunburn, poison ivy)
- Flu shots
- Pregnancy tests

This is a sample list and not all-inclusive. For a full listing of services please visit each center's Website.

Urgent Care

Typical conditions that may be treated at a Urgent Care Center include:

- Sprains
- Strains
- Mild asthma attacks
- Minor infections
- Vaccinations
- Back Pain or Strains
- Small cuts
- Sore throats
- Rashes
- Preventive Screenings

This is a sample list and not all-inclusive. For a full listing of services please visit each center's Website.

Emergency Room

Some examples of emergency conditions may include the following:

- Heavy bleeding
- Chest pain
- Sudden change in Vision
- Major burns
- Sudden weakness or trouble walking
- Large open wounds
- Spinal injuries
- Difficulty breathing
- Severe head injuries

This list only provides examples and is not intended as an exclusive list. If you believe you or your loved one is experiencing an emergency medical condition, you should go to the nearest emergency room or call 911, even if your symptoms are not described here.

An emergency medical condition is any condition (including severe pain) which you believe that without immediate medical care may result in:

- Serious jeopardy to your or your loved one's health, including the health of a pregnant woman or her unborn child
- Serious impairment to your or your loved one's bodily functions
- Serious dysfunction of any of your or your loved one's bodily organ or part

If you obtain care at an emergency room, you will likely pay more out of pocket than if you were treated at your doctor's office, a Convenience Care Center or Urgent Care facility.

*If you receive treatment for an emergency in a non-network facility, you may be transferred to an in- network facility once the condition has been stabilized.

Lab Services

If you require lab work consider having these services performed at Quest. If you choose to use Quest, services associated with the cost of your lab work will apply to the deductible and coinsurance and will only be covered 100% if the services received are coded as preventive.

Prescription Benefits

Most prescriptions are filled right away when you take them to the pharmacy. However, some drugs need to be reviewed by Aetna and approved before they're covered. This process, called ***prior authorization***, helps ensure drugs are used as recommended by the FDA. Prior authorization focuses mainly on drugs that may have:

- Risk of serious side effects or dangerous drug interactions
- High potential for incorrect use or abuse
- **Better alternatives that may cost you less**
- Restrictions for use with very specific conditions

Prior authorization may require you to take an additional step when you are prescribed certain medications, but the long-term gain is lower out-of-pocket prescription costs for you and reduced claims expense for Frost and potentially lower future renewal increases.

Some prescription drugs are covered only if the physician obtains prior authorization from Aetna. In addition, coverage for some drugs is provided in limited quantities and duration.

This is only a brief summary of benefits. The Certificate, issued when coverage is approved for the group, contains program details, and will, in all cases, have control over any information in this summary. The certificate is available upon request.

Preventive Care

Certain preventive services will be covered without charging a deductible, copayment, or coinsurance when these services are provided by a **network provider**. The types of preventive services covered are defined by federal law and can vary based on your age, gender, and health status. There may be services you had in the past that will now be covered as preventive at no cost to you. The preventive services included in this provision are described at **healthcare.gov**.

Aetna QHDHP Option ($3,000 Ded)

Benefit Plan	QHDHP Option In-Network	QHDHP Option Out-of-Network
Deductible (plan year)		
Single	$3,000	$6,000
Family	$6,000	$12,000
Coinsurance (plan pays/you pay)		
	100% / 0%	80% / 20%
Out-of-Pocket Limit (including the deductible + coinsurance)		
Single	$3,000	$12,000
Family	$6,000	$24,000
Copayments		
Primary Physician Visit	Deductible, then you pay 0%	Deductible, then you pay 20%
Specialist Physician Visit	Deductible, then you pay 0%	Deductible, then you pay 20%
Preventive Care	Plan pays 100%	Deductible, then you pay 20%
Major Diagnostic Lab	Deductible, then you pay 0%	Deductible, then you pay 20%
Emergency Room Visit	Deductible, then you pay 0%	In Network Ded., then you pay 0%
Urgent Care Center Visit	Deductible, then you pay 0%	Deductible, then you pay 20%
Prescription Drug Coverage		
Retail Pharmacy	Deductible, then you pay 0%	Deductible, then you pay 20%
Mail Order Pharmacy	Deductible, then you pay 0%	Not Covered

2017 Employee QHDHP Option Medical Contributions

Employee Semi-Monthly Cost	Previous 2016 Cost	New 2017 Cost	2017 Aetna with Wellness and Non-Tobacco Discounts
Employee	$45.89	$45.92	$38.42
Employee & Spouse	$243.16	$250.80	$243.30
Employee & Child(ren)	$203.49	$209.19	$201.69
Employee & Family	$300.62	$310.89	$303.39

Highlights of QHDPs

- Annual preventive/wellness exams are not subject to the deductible and are covered at 100% if services are received from an Aetna participating provider. Diagnostic office visits and hospital services will apply to your deductible.
- Prescription drugs are subject to the deductible. Once the deductible has been satisfied, prescriptions will be covered at 100%.
- If you remain in-network, you will benefit from Aetna's contracts with their network providers. Only the discounted "allowable" charges will apply to your deductible, not the full bill.
- When selecting coverage under the QHDHP benefit offering, you may be eligible to open a health savings account (HSA). Information about HSAs is outlined on Page 21.

Aetna Base Plan ($3,000 Ded)

Benefit Plan	Base Plan In-Network	Base Plan Out-of-Network
Deductible (plan year)		
Single	$3,000	$6,000
Family	$6,000	$12,000
Coinsurance (plan pays/you pay)		
	80% / 20%	50% / 50%
Out-of-Pocket Limit (including the deductible + coinsurance + copayments)		
Single	$6,350	$12,500
Family	$12,700	$25,000
Copayments		
Primary Physician Visit	$30 co-pay	Deductible, then you pay 50%
Specialist Physician Visit	$60 co-pay	Deductible, then you pay 50%
Preventive Care	Plan pays 100%	Deductible, then you pay 50%
Major Diagnostic Lab	Deductible, then you pay 20%	Deductible, then you pay 50%
Emergency Room Visit	$300 co-pay	$300 co-pay
Urgent Care Center Visit	$100 co-pay	Deductible, then you pay 50%
Prescription Drug Coverage		
Retail Pharmacy	$12/40/65	Deductible, then you pay 50%
Mail Order Pharmacy	$30/100/162.50	Not Covered

2017 Employee Base Plan Medical Contributions

Employee Semi-Monthly Cost	Previous 2016 Cost	New 2017 Cost	2017 Aetna with Wellness and Non-Tobacco Discounts
Employee	$46.36	$48.46	$40.96
Employee & Spouse	$246.10	$256.37	$248.87
Employee & Child(ren)	$205.51	$214.12	$206.62
Employee & Family	$303.68	$318.13	$310.63

Aetna Buy-Up Plan ($2,000 Ded)

Benefit Plan	Buy-Up Plan In-Network	Buy-Up Plan Out-of-Network
Deductible (plan year)		
Single	$2,000	$4,000
Family	$4,000	$8,000
Coinsurance (plan pays/you pay)		
	80% / 20%	50% / 50%
Out-of-Pocket Limit (including the deductible + coinsurance + copayments)		
Single	$6,350	$12,500
Family	$12,700	$25,000
Copayments		
Primary Physician Visit	$25 co-pay	Deductible, then you pay 50%
Specialist Physician Visit	$50 co-pay	Deductible, then you pay 50%
Preventive Care	Plan pays 100%	Deductible, then you pay 50%
Major Diagnostic Lab	Deductible, then you pay 20%	Deductible, then you pay 50%
Emergency Room Visit	$300 co-pay	$300 co-pay
Urgent Care Center Visit	$100 co-pay	Deductible, then you pay 50%
Prescription Drug Coverage		
Retail Pharmacy	$10/30/60	Deductible, then you pay 50%
Mail Order Pharmacy	$20/60/120	Not Covered

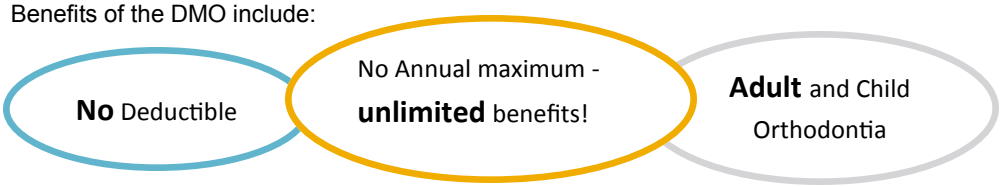
2017 Employee Buy-Up Plan Medical Contributions

Employee Semi-Monthly Cost	Previous 2016 Cost	New 2017 Cost	2017 Aetna with Wellness and Non-Tobacco Discounts
Employee	$88.03	$66.92	$59.42
Employee & Spouse	$287.76	$296.89	$289.39
Employee & Child(ren)	$247.18	$250.04	$242.54
Employee & Family	$345.34	$370.84	$363.34

Dental Insurance

Freedom of Choice—In addition to the PPO plan option you are used to using, you also now have a DMO option to choose from. The DMO option works just like the old medical HMO. You are required to select a Primary Care Dentist (PCD) when you enroll. The PCD will give you a referral to any specialist with the exception of an orthodontist.

Benefits of the DMO include:



Because the contribution is the same for both plans, members can move between the DMO and PPO as often as Monthly! Simply call customer service before the 15th of the month for the change to be effective the next month.

Aetna Voluntary Dental

Benefit/Service	DMO In-Network	PPO In-Network	PPO Out-of-Network
Preventive	See	100%	80%
Basic	Aetna	80%	80%
Major	Copayment	50%	50%
Ortho	Schedule	50%	50%
Deductibles & Maximums			
Office Visit Copayment	$15	N/A	N/A
Deductible Individual *	N/A	$50	$75
Deductible Family *	N/A	$150	$225
Annual Maximum Per Person	Unlimited		$1,000
Lifetime Orthodontia Maximum **	$2,400 Copay (Adult & Child)		$1,000 (Child Only)

* The deductible applies to: Basic & Major services only.

In-Network Providers: agree to be reimbursed from a fee schedule and no balance billing.

Out-of-Network Providers: All out-of-network claims are paid at the 90th Percentile of UCR. The provider will balance bill the insured for any charges that exceed the 90th Percentile of UCR. (Usual and Customary Reimbursement)

2017 Employee Dental Contributions

Semi-Monthly Employee Cost	DMO/PPO
Employee	$12.17
Employee Plus One	$23.79
Employee Plus Family	$44.14

FIND A DENTIST

To find a Aetna provider in your area, visit the website at aetna.com/docfind.

- **Enter "Dentist" in the "Search for" field**
- **Enter your Zip Code**
- **Click "Search"**

DMO Network = DMO/DNO
PPO Network = Dental PPO/PDN with PPO II

The PCD office number you need to enroll in the DMO Plan is located above the provider's name.

Vision Insurance

Vision Benefits of America (VBA) maintains a network of more than 16,000 participating Optometrists, Ophthalmologists and Retail Locations nationwide to provide professional vision care for persons covered under this plan.

Select a VBA Participating Provider in your area. When scheduling an appointment, please notify the VBA provider that your vision coverage is administered by VBA. The provider will contact VBA to verify eligibility via on-line system and will process services received electronically.

Discounts on LASIK services are also available.

VBA Voluntary Vision

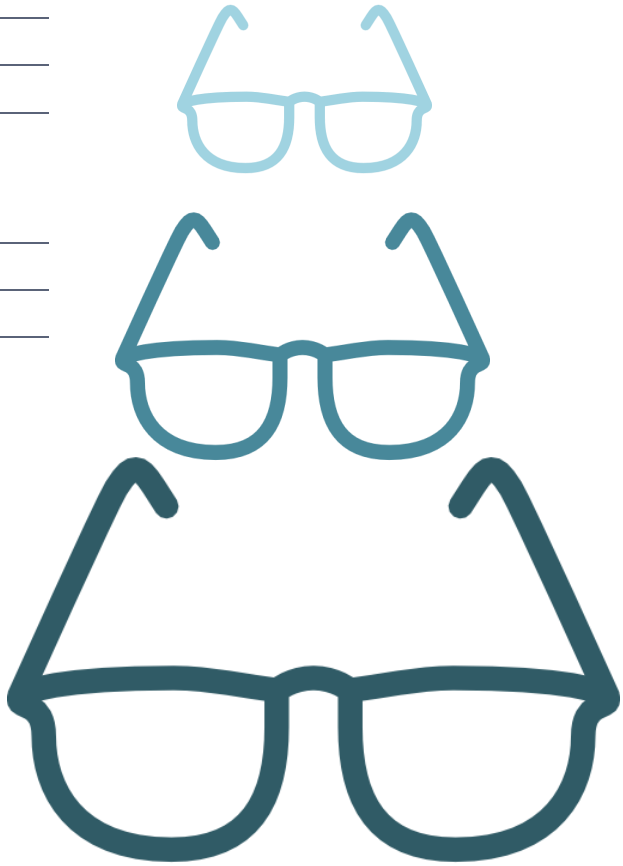
Benefit/Service	In-Network	Out-of-Network Benefit
Examination	$0 Co-pay	$40 reimbursement
Frequency of Service:		
Exam	Every 12 months	
Lenses	Every 12 months	
Frames	Every 24 months	
Lenses:	$0 Co-pay then:	Reimbursement:
Single	100%	$40
Bifocal	100%	$60
Trifocal	100%	$80
Frames	Covered 100% up to $50 Wholesale ($125—$150 Retail)	$50
Contacts:		Reimbursement
Necessary	Covered at 100%	$320
Cosmetic	$160 Allowance	$160

2017 Employee Vision Contributions

Vision Employee Cost	Semi-Monthly
Employee	$3.00
Employee Plus One	$5.70
Employee Plus Two or More	$7.80

FIND A PROVIDER

To access a list of participating providers and to verify your benefit eligibility prior to visiting your eye care provider, please visit visionbenefits.com or call (800) 432-4966.



Basic Life and AD&D Insurance

This benefit is paid by Frost for all benefit eligible employees. It is administered through Aetna. In the event of your death, your beneficiary will receive $15,000. The Accidental Death and Dismemberment (AD&D) benefit is equal to your basic group life insurance benefit. Benefit reductions apply upon attaining certain age levels.

Voluntary Life and AD&D Insurance

Your Voluntary Life/AD&D is administered through Aetna as well. An equal amount of AD&D coverage may also be purchased when you elect voluntary life. You must purchase voluntary life on yourself in order to purchase coverage for your spouse and dependent children.

Employees can purchase the lesser of 5 x Salary or $500,000 of coverage in $10,000 increments. The Guarantee Issue amount for newly eligible employees is $150,000.

Spousal coverage is available in $5,000 increments not to exceed 100% of the employee amount up to a maximum of $500,000. The Guarantee Issue amount for newly eligible spouses is $30,000. Children up to age 19, or 25 if a full-time student, can purchase coverage in $1,000 increments up to a $10,000 maximum.

Please note: You or your spouse may increase existing amounts of life insurance coverage up to 1 increment on a guaranteed acceptance basis during each subsequent annual open enrollment period, provided the additional amount does not exceed the Guarantee Issue amount. If you did not elect voluntary life coverage when first eligible, you will be required to complete an Evidence of Insurability form and be approved by Aetna before you will be able to purchase coverage.

Benefit reductions apply upon attaining certain age levels.

VOLUNTARY LIFE/AD&D EMPLOYEE CONTRIBUTION (Rates are per month)	
Age Band	**Employee/Spouse Rate per $1,000***
Under 30	$0.09
30-34	$0.11
35-39	$0.15
40-44	$0.23
45-49	$0.36
50-54	$0.60
55-59	$0.97
60-64	$1.27
65-69	$1.99
70+	$3.49
Vol. AD&D	
Employee Only	$0.021/$1,000
Employee & Family	$0.027/$1,000
Child Life	$0.082/$1,000

***Spouse rates are based on the employee's age**

You also have the ability to purchase voluntary Accidental Death & Dismemberment (AD&D) coverage for yourself and your dependents. The voluntary AD&D coverage must match the amount of voluntary life purchased for the employee. If family voluntary AD&D is purchased, the spouse benefit amount is 50% of the eligible employee's (EEs) amount (40% if Child is included); and the child benefit amount is 15% of EEs amount (10% if Spouse is included).

Disability Insurance

Voluntary Short-Term Disability

Short-term disability is intended to protect your income for a short duration in case you become ill or injured.

Beginning on the 15th day of an illness or injury, you are eligible to receive 60% of your weekly income to a maximum of $1,500 through Aetna. The maximum benefit period is 11 weeks. (The weekly income benefit is subject to a 3/12/12 pre-existing condition limitation.)

Voluntary Long-Term Disability

Long-term disability is intended to protect your income for a long duration after you have depleted short-term disability or any sick leave your company may offer.

After the 90th day of an illness or injury, you may be eligible for long term disability benefits through Aetna. The disability benefit changes to a monthly benefit and covers 60% of your monthly salary to a maximum of $5,000. The duration of this benefit is based upon the extent of your disability and contact maximums. (This monthly income benefit is subject to a 3/12/12 pre-existing condition limitation.)

The monthly rate for this benefit is $0.46 per $100 of monthly covered payroll.

VOL. SHORT-TERM DISABIILTY MONTHLY RATES	
Age Band	**Employee Monthly Rate per $10**
Under 25	$0.20
25-29	$0.21
30-34	$0.20
35-39	$0.21
40-44	$0.24
45-49	$0.27
50-54	$0.31
55-59	$0.39
60-64	$0.48
65-69	$0.54
70+	$0.54

Voluntary Worksite Benefits

Aflac offers voluntary products that are used to compliment your medical benefits by helping you cover your expenses until your deductible is satisfied. These products are eligible for pre-tax payroll deductions.

Accident Indemnity—This plan helps you cover your out of pocket expenses associated with an accident. Cash benefits are paid directly to you based on a schedule.

Critical Care & Recovery—Specific Health Event Policy includes, but is not limited to: Coma, Paralysis, Stroke, Heart Attack, Intensive Care, Transplants, etc.

Cancer Indemnity—While major medial insurance can help with the costs of cancer treatment, you may still have out of pocket expenses that are not covered by your major medical insurance, including travel, food, lodging, child care and household help. Includes coverage for surgical and non-surgical treatment for cancer, including Hospice Care.

These Aflac plans have pre-existing condition waivers and terms. For Aflac coverage(s) employees must meet with an Aflac representative to complete your application. These plans are portable. Please contact Frost HR if you have any questions.

Employee Assistance Program (EAP)

Through our EAP contract with our service provider, H&H Health Associates (H&H), you and your eligible dependents can receive confidential assistance with personal and work/life concerns.

Our EAP benefit offers confidential, short-term counseling for personal and family issues at no cost to you. They provide confidential counseling in dealing with family and relationship issues, substance abuse, stress and anxiety, communication issues, and emotional concerns.

The EAP provides the following services to help you balance work and home life...

- Managing stress and change
- Family and relationship concerns
- Parenting issues
- Legal concerns
- Budgeting and debt management
- Substance abuse
- Care management for aging parents
- Locating child and eldercare resources
- Identifying school/college resources
- Emotional and personal conflicts
- Depression and grief
- Lifestyle weight management
- Work performance issues
- Retirement issues
- Health and wellness issues
- Financial planning

H&H is an independent firm that specializes in providing professional counseling services through highly qualified, licensed behavioral health practitioners. H&H professionals answer calls 24 hours a day, seven days a week. H&H's telephone number is 314-845-8302 or 1-800-832-8302. When you call the EAP, an H&H representative will answer any questions you have and set up an appointment for you. Please visit the H&H website for additional information at **hhhealthassociates.com**.

Flexible Spending Accounts (FSAs)

Types of Accounts

SECTION 125 MEDICAL ACCOUNT: This account enables you to pay with pre-tax dollars any medical, dental, vision, and prescription drug expenses that are not covered under your insurance program or that of your spouse. You may also cover dependent health care expenses through the account even if you choose single coverage. The total amount of your annual pledge is available to you up front thus reducing the risk of a large out-of-pocket expense at any one time during the plan year. Be aware that with the Section 125 Medical Account, any unused portion of the account at the end of the plan year is forfeited.

DEPENDENT CARE EXPENSE ACCOUNT: This account gives you the opportunity to redirect a portion of your annual pay on a pre-tax basis to pay for dependent care expenses. An eligible dependent is any member of your household for whom you can claim expenses on your Federal Income Tax Form 2441, "Credit for Child and Dependent Care Expenses." Children must be under age 13. Care centers which qualify include dependent care centers, preschool educational institutions, and individuals, as long as the caregiver is not a child of yours under age 19 or anyone you can claim as a dependent for tax purposes. Before deciding to use the Dependent Care Expense Account, it would be wise to compare its tax benefit to that of claiming a child care tax credit when filing your tax return. Either may be better, depending on your personal situation. You may not use both. You may want to check with your tax advisor to determine which method is best for you and your family. Any unused portion of your account balance at the end of the plan year is forfeited.

Maximum Contributions	
Section 125 Medical Account	$2,600 max
Dependent Care Expense Account	$5,000 max

How the Accounts Work

The FSAs have a plan year of June 1st to May 31st. When you have eligible expenses not covered under the health insurance plan, such as co-payments and deductibles, you can utilize your CBIZ FSA Debit Card for payment from your Section 125 Medical Account. For expenses not directly related to a health plan claim, you may submit a FSA claim form with your receipt and a reimbursement payment is issued to you directly or you may use your CBIZ FSA Debit Card to pay for out-of-pocket expenses at qualified vendors.

When you have dependent care expenses, you may complete a dependent care claim form and submit it to CBIZ with a receipt from your child care provider. A reimbursement payment is issued to you directly. Please note, the receipt for your child care provider must include the name, address, and federal tax identification number or social security number of the provider.

Account Statements

You may request a full statement of your accounts at any time by calling or sending a written request to CBIZ. You can also manage your account by logging onto **myplans.cbiz.com** to view account balances, view the expenses that have been paid, and see any other account information.

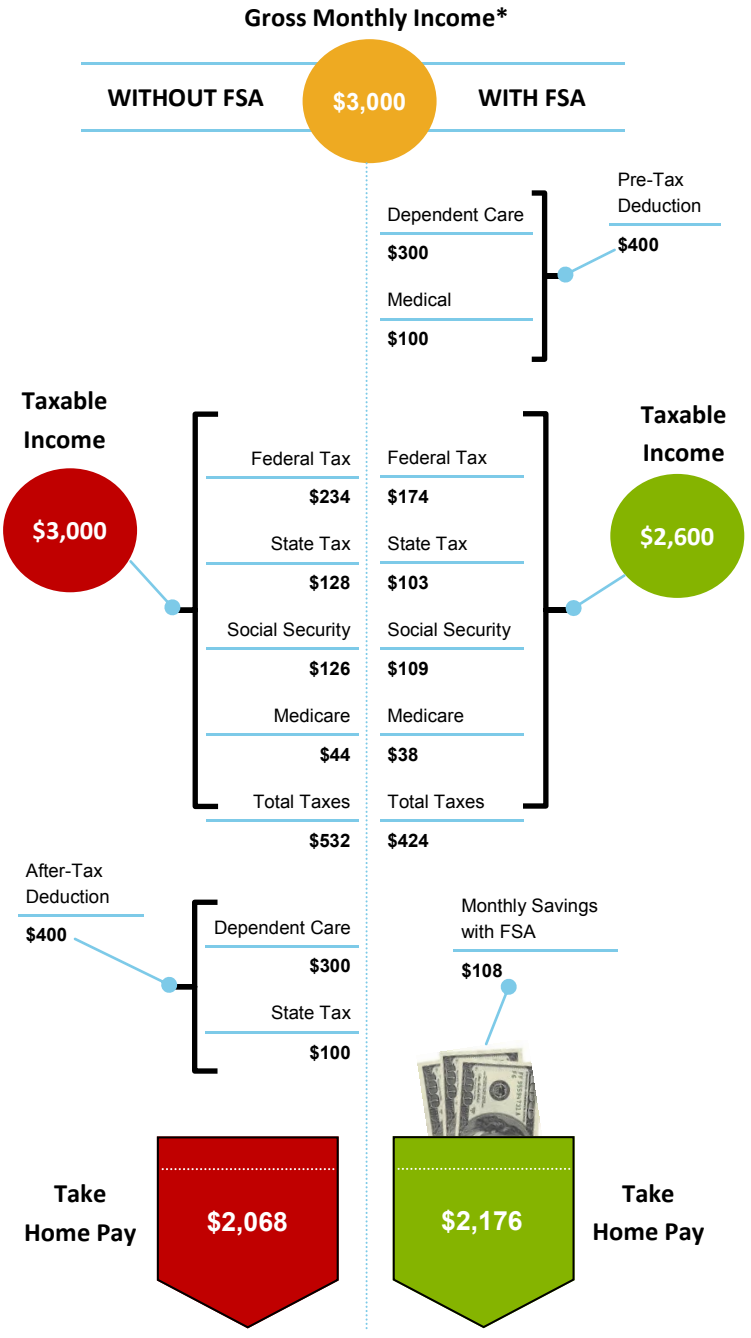
Plan Your Contribution Carefully

The IRS requires you to forfeit any unused dollars in your Section 125 Medical or Dependent Care Expense Accounts at the end of the plan year. This is called "use it or lose it". You have 90 days after the end of the plan year to be reimbursed for expenses you incurred in the previous plan year.

Below is a partial list of eligible expenses that can be reimbursed from a Section 125 Medical Account. Other out-of-pocket expenses may qualify.

Alcoholism treatment	Laboratory fees
Artificial limbs	Licensed osteopaths
Ambulance	Licensed practical nurses
Braces	Orthodontia
Chiropractors	Orthopedic shoes
Coinsurance and copayments	Obstetrical expenses
Contact lens solution	Oxygen
Contraceptives	Prescription drugs
Crutches	Podiatrists
Deductible amounts	Prescribed vitamin supplements (medically necessary)
Dental expenses	Psychiatric care
Dentures	Psychologist expenses
Dermatologists	Routine physical
Diagnostic expenses	Seeing-eye dog expenses
Eyeglasses, including exam fee	Smoking cessation programs
Handicapped care and support	Sterilization and reversals
Nutrition counseling	Substance abuse treatment
Hearing devices and batteries	Surgical expenses
Hospital bills	

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.

401(k) Retirement Savings Plan

The Frost Employees' Savings and Retirement Plan allows a participant to save for retirement on both a pre-tax and/or post-tax (Roth) basis. The savings invested will accumulate while deferring current income taxes on the saved money and earnings until withdrawal. Under certain conditions of the Roth 401(k) feature, both your deferrals and your earnings will accumulate tax free, and retirement withdrawals may be exempt from federal income tax.

How Do I Contribute to the Plan?

- Through payroll deduction, you can elect to defer from 1% to 100% of your annual pay up to the maximum allowed by law. The dollar limit is $18,000 for 2017. If you are age 50 or older, you can make an additional deferral amount of $6,000 for a total of $24,000. There may be restrictions on deferral limits by employees classified as "highly compensated."
- You can also designate your elective deferrals to a Plan account that qualifies as a Roth 401(k). In 2017 you may contribute as much as $18,000, in total, to all 401(k) accounts (Roth 401(k) and pre-tax contributions); more if you are age 50 or older. Earnings on the Roth 401(k) contribution will accumulate tax free, and retirement withdrawals may be exempt from federal income tax.
- If you have an existing qualified retirement plan (pre-tax or Roth) with a prior employer, you may transfer or rollover that account into the Plan upon becoming a participant in the Plan.
- As part of our plan's design, **you will be automatically enrolled in the plan at a 3% pre-tax deferral rate** unless you elect otherwise. In addition, every spring, your deferral rate will increase by 1% until your savings rate is 6%.

Can I Stop or Change My Contributions?

You may change or stop your contributions any time through the plan's website at **netbenefits.com** or by contacting the Fidelity Participant Service Center at (800) 835-5097 (M-F 7:30 am - 7:30 pm CST).

How Does Frost Contribute to the Plan?

- The plan provides for discretionary matching contributions on elective deferrals in an amount to be determined by Frost on an annual basis. The discretionary matching contribution will be made on both pre-tax contributions and Roth 401(k) contributions. Any match made on Roth 401(k) contributions and the earnings on that match will be subject to income tax upon withdrawal.
- While the match is discretionary and could be changed at any time, historically, the discretionary match has been 50% up to the first 10% of your salary deferrals. Participants will be eligible for employer matching when they meet their eligibility requirement of age 21 and 3 months of service. The matching contribution will be made on each payroll period that a participant elects to defer into the plan.
- Frost may also make additional elective profit sharing contributions at its discretion annually. These contributions are subject to certain restrictions which will be allocated among all eligible employees, whether or not they are deferring into the program or not.

How Do I Become "Vested" in My Plan Account?

Vesting refers to your "ownership" of a benefit from the Plan. You are always 100% vested in your Plan contributions and your rollover contributions, plus any earnings they generate. Employer contributions to the Plan, plus any earnings they generate, are vested as follows based on your hire date:

Years	% Vested
1	20%
2	40%
3	60%
4	80%
5	100%

How Are Plan Contributions Invested?

You give investment directions for your Plan account, selecting from investment choices provided under the Plan, as determined by the Plan Trustees.

- Unless you make an alternative selection, you will be automatically enrolled in the Fidelity Freedom Index Target Date Fund based on your date of birth.
- More information about your Plan's investment choices will be provided in the welcome packet mailed to you by Fidelity.

* If you are in need of individualized participant investment advice… please contact CBIZ Retirement Plan Services at **participantsupport@cbiz.com** or by calling (877) 323-3867.

When Can Money Be Withdrawn From My Plan Account?

Money may be withdrawn from your Plan account in these events:

- Normal Retirement at age 65
- Death
- Disability
- Termination of Service
- Early Retirement – Age 59 ½ and 5 years of Service
- In-Service Withdrawals *(If you have reached age 59 1/2, you may elect to withdraw all or a portion of your entire vested account while still employed.)*

To receive favorable tax treatment, distributions of Roth 401(k) contributions must be made after the participant reaches age 59 1/2, or on account of the participant's death or disability, and must be made at least 5 years after the date the first Roth 401(k) contribution was made. See your Summary Plan Description (a copy of which is on the firm intranet page) for more details about taking withdrawals from the Plan. Be sure to talk with your tax advisor before withdrawing any money from your Plan account.

May I Withdraw Money In Case Of Financial Hardship?

If you have an immediate financial need created by severe hardship and you lack other reasonably available resources to meet that need, you may be eligible to receive a hardship withdrawal from your account. A hardship, as defined by the government, can include:

- Purchase of primary residence
- Education expenses
- Medical expenses
- Prevent eviction or foreclosure on principal residence
- Burial or funeral expenses
- Damage to principal residence (IRS Section 165)

If you feel you are facing a financial hardship, contact Fidelity Participant Services at (800) 835-5097 for more details.

May I Borrow Money From My Account?

The Plan is intended to help you put aside money for your retirement. However, Frost has included a Plan feature that lets you borrow money from the Plan for any purpose.

- The amount the Plan may loan to you is limited by rules under the tax law. In general, all loans will be limited to the lesser of: one-half of your vested account balance or $50,000.
- The minimum loan amount is $1,000.
- All loans must generally be repaid within five years unless the loan is to purchase a primary residence.
- You may have 2 loans outstanding at a time.

- You pay interest back to your account.

Other requirements and limits must be met, and certain fees may apply. Refer to **netbenefits.com** for more details about this participant loan feature.

How Do I Obtain Information About My Plan Account?

- You will receive a personalized electronic account statement quarterly. The statement shows your account balance as well as any contributions and earnings credited to your account during the reporting period. You may request Fidelity to produce a printed statement by calling the Participant Service Center at (800) 835-5097.
- You will also have access to an automated voice response system and Internet site, which are designed to give you current information about your Plan account. You can get up-to-date information about your account balance, contributions, investment choices, and other Plan data by visiting **netbenefits.com**. You will receive additional information on how to use the Voice Response System and Internet site.

How Do I Enroll?

You will receive information in the mail directly from Fidelity with instructions about the auto enrollment process. Your plan entry date will be the first day of the month upon attainment of age 21 and completion of 3 months of service. If you decline to enroll, you can always enroll in the future by visiting **netbenefits.com** or by calling (800) 835-5097.

Summary Plan Description

The above highlights are only a brief overview of the Plan's features and are not a legally binding document. A more detailed Summary Plan Description is available to you. Please read it carefully and contact your Benefits Administrator if you have any further questions.

Additional Information

The Plan allows each participant to choose the amount they will contribute to the Plan and to make investment elections from the menu of funds offered. The Expense Ratio shown on each Fund fact sheet does not include fees for plan administration or investment consulting that may be paid from the Plan. Additional details about the funds and the fund prospectuses are available at **netbenefits.com**.

Vacation *(See Handbook for More Details)*

Regular full-time employees accrue:

Years of Service	Accrual Rate Per Month	Annual Equivalent
0-1	3.333 hours	5 days
2-4	6.6667 hours	10 days
10-14	10 hours	15 days
15-19	11.3333 hours	17 days
20 plus	13.3333 hours	20 days

Sick Leave *(See Handbook for More Details)*

Regular full-time employees are eligible to accrue five (5) days of sick leave equally over twelve months of continuous employment, until the maximum of five days per calendar year is accumulated.

Personal Day *(See Handbook for More Details)*

If you are a regular full-time employee, you may, in addition to the observed holidays, take a paid personal day each calendar year of continuous employment, provided that you were hired before July 1 of that calendar year.

Holiday Schedule 2017 *(See Handbook for More Details*

The following nine (9) paid holidays are generally observed by the Company.

Holiday
New Year's Day
Memorial Day
Independence Day
Labor Day
Thanksgiving Day
Day after Thanksgiving
Christmas Eve Day (Essential Crew)
Christmas Day
New Eve Year's Day (Essential Crew)

Essential Crew:

If you work on an Essential Crew day, (Christmas Eve Day and New Year's Eve Day) you may either:

1. Work the holiday, receive holiday pay and paid at their regular rate
2. **Or** paid at their regular rate and take a holiday flex day.

Union Rules Apply

Health Savings Account (HSA)

WITH THE ELECTION OF THE AETNA QHDHP OPTION FOR YOUR INSURANCE COVERAGE, YOU MAY ALSO OPEN AN HSA

What is an HSA?

A savings account set up by either you or your company where you can either 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.

Why would I want an HSA?

Because you fund the HSA with pre-tax money, you are using tax-free funds for healthcare expenses you would normally pay for out-of-pocket using after-tax dollars. Your HSA contributions do NOT count toward your taxable income for federal taxes.

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).
- You cannot set up an HSA if you have insurance coverage under another plan, for example your spouses employer, unless that secondary coverage is also a qualified high deductible health plan.
- You cannot be enrolled in Medicare.
- You cannot be claimed as a dependent under someone else's tax return.

What Is the Difference Between a Qualified High Deductible Health Plan and a Traditional PPO Plan?

In a QHDHP, all services received, with the exception of preventive office visits, are applied to the deductible and coinsurance first. This would include office visits that are not preventive, emergency room visits, and prescription drugs. You will, however, still have the opportunity to benefit from the discounts associated with using a network physician or facility.

What Else Do I Need to Know?

- Contributions are based on a calendar year. For 2017, the contribution limits are $3,400 for Single and $6,750 for Family coverage. You cannot put more than this amount in the account; you can put less.
- The contributions from your paycheck are tax-free, grow tax-free, and come out tax-free as long as you utilize the funds for approved services. (medical, dental, vision and over-the-counter medically necessary items)
- 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).
- Once you turn 65, become disabled and/or qualify for Medicare, you can use the account for other purposes without paying the 20% penalty but you will pay income taxes.
- The savings account can be established with UMB Bank, so you can take advantage of payroll deductions on a pre-tax basis.

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, so 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 most of your 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 can't be more than the IRS annual contribution limit. If you're age 55 or older, you are allowed to make an extra $1,000 catch-up contribution each year.

You can spend only the money that is actually in your Health Savings Account.

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
- Hearing aids
- Eye exams, eyeglasses, contact lenses and solution, and laser surgery
- Orthodontia, dental cleanings, and fillings
- Prescription drugs
- Physical therapy, speech therapy, and chiropractic expenses

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

HSA Online Enrollment

Enroll in your UMB HSA online at **HSA Enrollment Site** or follow the instruction below….

Click here to enroll then enter enrollment verification #: UMB0002 00130451 or enter the below online address….

https://myhsa.umb.com/HSAEnrollment

UMB | Healthcare Services

Please call the UMB Service Center with any questions Toll-Free: 866-520-4HSA (4472)

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 Privacy Practices

Frost 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.

Wellness Program Disclosure

If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program call your Human Resources Department and we will work with you to develop another way to qualify for the reward.

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 Frost.

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

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.

Aetna has determined that the prescription drug coverage offered by Frost 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).

Glossary of Terms

Coinsurance – The plan's share of the cost of covered services which is calculated as a percentage of the allowed amount. This percentage is applied after the deductible has been met. You pay any remaining percentage of the cost until the out-of-pocket maximum is met. Coinsurance percentages will be different between in-network and non-network services.

Copays – A fixed amount you pay for a covered health care service. Copays can apply to office visits, urgent care, or emergency room services. Copays will not satisfy any part of the deductible. Copays should not apply to any preventive services.

Deductible – The amount of money you pay before services are covered. Services subject to the deductible will not be covered until it has been fully met. It does not apply to any preventive services, as required under the Affordable Care Act.

Emergency Room – Services you receive from a hospital for any serious condition requiring immediate care.

Lifetime Benefit Maximum – All plans are required to have an unlimited lifetime maximum.

Medically Necessary – Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease or its symptoms, which meet accepted standards of medicine.

Network Provider - A provider who has a contract with your health insurer or plan to provide services at set fees. These contracted fees are usually lower than the provider's normal fees for services.

Out-of-Pocket Maximum – The most you will pay during a set period of time before your health insurance begins to pay 100% of the allowed amount. The deductible, coinsurance, and copays are included in the out-of-pocket maximum.

Preauthorization – A process by your health insurer or plan to determine if any service, treatment plan, prescription drug, or durable medical equipment is medically necessary. This is sometimes called prior authorization, prior approval, or precertification.

Prescription Drugs – Each plan offers its own unique prescription drug program. Specific copays apply to each tier and a medical plan can have one to five separate tiers. The retail pharmacy benefit offers a 30-day supply. Mail Order prescriptions provide up to a 90-day supply. Sometimes the deductible must be satisfied before copays are applied.

Preventive Services – All services coded as Preventive must be covered 100% without a deductible, coinsurance, or copayments.

UCR (Usual, Customary and Reasonable) – The amount paid for medical services in a geographic area based on what providers in the area usually charge for the same or similar service.

Urgent Care – Care for an illness, injury or condition serious enough that a reasonable person would seek immediate care, but not so severe to require emergency room care.