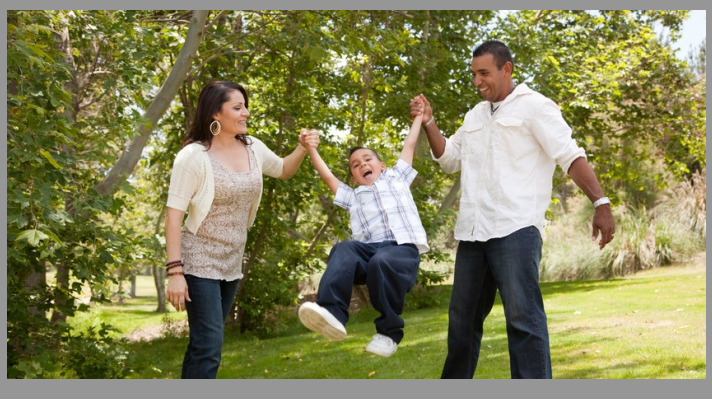
CODE CONSULTANTS, INC.

2015 - 2016
Benefits Guide



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.

TABLE OF CONTENT

CONTACT INFORMATION

Contact Information		
Vendors	**Member Services**	**Website / Email**
Medical: *Anthem* Policy Number: 127653	800.490.6145	anthem.com
Dental: *Anthem* Policy Number: 725103	855.769.1465	anthem.com
Vision: *Vision Benefits of America (VBA)* Policy Number: 1971	800.432.4966	visionbenefits.com
Life/AD&D, Vol. LTD, STD: *UNUM* Policy Number: 363787	866.679.3054	unum.com
Vol. Life: *Unum* Policy Number: 580504	866.679.3054	unum.com
Accident and Critical Illness Insurance: *Allstate Benefits* Policy Number: V8366	800.521.3535	allstatebenefits.com
Benefits Team	**Phone**	**Email**
Code Consultants, Inc. *Vicki Schafale*	314.991.2633	vickis@codeconsultants.com
CBIZ Benefits & Insurance Services: *Rusty Besancenez - Sr. Account Executive* *Sara Miller - Director of Client Services*	314.692.2249 or 800.844.4510	rbesancenez@cbiz.com samiller@cbiz.com

Reasons to Call and Who to Call:

Claim Questions—Contact Carrier / CBIZ
I.D. Cards / Numbers—Contact Carrier / CBIZ
Provider Search—Carrier Websites
If Drug Prescription is Denied—Contact Carrier / Doctor

WELCOME TO CODE CONSULTANTS, INC.

As a benefit eligible employee, you are offered a benefit package which includes medical, dental, vision, short-term disability, life and accidental death and dismemberment insurance. Additionally, you have the ability to purchase voluntary benefits where you can add long-term disability, additional life and accidental death and dismemberment insurance for yourself, spouse, and/or children, critical illness and accident insurance.

Code Consultants offers you the choice between two medical plans. The Qualified High Deductible Health Plan (QHDHP) is one option. This option affords you the opportunity to contribute to a Health Savings Account (HSA) to save pre-tax money for medical expenses. There are no copayments for services or prescription drugs in this option. The other medical plan option is a traditional PPO plan. This option includes copayments for services such as office visits and prescription drugs, but you would NOT be able to contribute to an H.S.A Consider how you and your family utilize medical care to determine which plan is best for you.

Voluntary life and voluntary long-term disability are elections you should consider during your initial enrollment period. If you do not elect this coverage now, you will be required to provide evidence of insurability if you want to enroll at a later date.

Code Consultants also provides the opportunity for employees to purchase additional worksite benefits. These benefits include accident and critical illness insurance and are explained in more detail in the following pages.

Open enrollment is the time to determine if you would like to participate in any or all of the four types of Flexible Spending Accounts (FSA) that Code Consultants offers and how many pre-tax dollars you want to contribute. The available accounts are: Medical Reimbursement Account, Limited Purpose Reimbursement Account, Dependent Care Reimbursement Account and Transit and Parking Account.

During your initial enrollment period you have the opportunity to participate in each of the benefit plans. 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.

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
- Gain or loss of Medicaid entitlement
- You become eligible for Medicare

Please review all the benefit information. If you have any questions, contact Vicki Schafale in Human Resources.

WHAT'S INSIDE

This brochure provides a summary of your benefit options and is designed to help you make your choices and enroll for your coverage. If you have any questions after enrolling, please call the benefit plan providers directly or log on to their websites for more details.

MEDICAL INSURANCE OPTIONS

Anthem - PPO Plan

Benefit Plan	In-Network	Out-of-Network	Plan Features
Deductible (individual / family)	$1,000 / $3,000	$2,000 / $6,000	All prescription drug copayments apply to the out-of-pocket maximums, along with the deductible, your share of the coinsurance, and the medical plan copays (Office visits, urgent care, and emergency room). Both the deductible and out-of-pocket maximums are based on a calendar year, so these benefits will start over at $0 each January 1st.
Coinsurance	80%	50%	
Out-of-Pocket Max. (individual / family)	$5,000 / $10,000	$10,000 / $20,000	
Office Visit Copay	Primary—$20 Specialist—$40	Deductible / Coinsurance	
Preventive Services	100%	Deductible / Coinsurance	
Hospitalizations	Deductible / Coinsurance	Deductible / Coinsurance	
Urgent Care Center	$75	Deductible / Coinsurance	
Emergency Room	$200, then 20%	$200, then 20%	
Prescription *Retail* *Mail Order*	 $10/$35/$60/25% $10/$90/$180/25%	 See Contract Not Covered	

Anthem - QHDHP

Benefit Plan	In-Network	Out-of-Network	Plan Features
Deductible (individual / family)	$1,500 / $3,000	$1,500 / $3,000	All medical services, with the exception of Preventive Care, apply to the deductible until it is completely satisfied. Prescription Drug coverage requires you to meet the deductible. Once the deductible is satisfied, your prescriptions will be covered at 100%. The plan deductible does not apply to the Preventive Care Services.
Coinsurance	100%	70%	
Out-of-Pocket Max. (individual / family)	$1,500 / $3,000	$3,000 / $6,000	
Office Visit Co-pay	Deductible / Coinsurance	Deductible / Coinsurance	
Preventive Services	100%	Deductible / Coinsurance	
Hospitalizations	Deductible / Coinsurance	Deductible / Coinsurance	
Urgent Care Center	Deductible / Coinsurance	Deductible / Coinsurance	
Emergency Room	Deductible / Coinsurance	Deductible / Coinsurance	
Prescription *Retail* *Mail Order*	 Deductible / Coinsurance Deductible / Coinsurance	 See Contract Not Covered	

MEDICAL INSURANCE COST SHARING

Anthem PPO Plan	
Type of Coverage	**Per Paycheck Cost**
Employee Only	$60
Employee & Spouse	$146
Employee & Child(ren)	$128
Employee & Family	$230

Anthem QHDHP	
Type of Coverage	**Per Paycheck Cost**
Employee Only	$65
Employee & Spouse	$156
Employee & Child(ren)	$136
Employee & Family	$243

YOUR HEALTH BENEFITS

Get the Most from Your Benefits

Code Consultants offers you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

To get the most from your benefits during the year, try these tips:

- Ask your doctor for the generic equivalent of the brand-name drug prescribed
- Visit in-network providers for your care

LiveHealth Online

Talk to a doctor anytime—365 days a year from the comfort of your own computer or mobile device.

With LiveHealth Online, you don't have to schedule an appointment, drive to the doctor's office, and then wait for your appointment. In fact, you don't even have to leave your home or office. Doctors can answer questions, make a diagnosis, and even prescribe basic medications when needed *(as legally permitted in certain states)*.

With LiveHealth Online, you get:

- Immediate doctor visits through live video.
- Your choice of U.S. board-certified doctors.
- Private, secure and convenient online visits.

How much does it cost?

The cost for an online doctor visit is just $49 if you don't have a health plan, if your plan doesn't cover online visits or if you haven't met your plan's deductible. If your health plan covers these visits, you may only owe the copay or coinsurance amount. Either way, you will always see what you owe before you begin a visit.

When to use LiveHealth Online?

As always, you should call 911 with any emergency; otherwise, you can use LiveHealth Online whenever you have a health concern and don't want to wait. Some of the most common uses include:

- Cold and flu symptoms such as a cough, fever and headaches
- Allergies
- Sinus infections
- Family health questions

To get started, enroll for free at livehealthonline.com or on the app, and you're ready to see a doctor.

Three Convenient Ways to Manage Your Health Care

1. Download Anthem's free app - just search for Anthem Blue Cross and Blue Shield at the app store on your mobile device. Find doctors and urgent care centers, and get driving directions from wherever you are. You can also log in and view, email or fax an electronic version of your ID card.
2. Get to Anthem's mobile site by going to anthem.com on your smartphone - and you'll get many of the same features of their app.
3. Get the full anthem.com experience on the go - by using your tablet computer. Check your claims and benefits, use your health and wellness tools, get discounts on contact lenses and glasses. Coupons for health foods and much more.

To log in on your smartphone, you must be registered on Anthem's secure member site and have a username and password. If you are an Anthem member but haven't registered, go to anthem.com from your computer and click *Register Now*.

Your Care Options and When to Use Them

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, Walmart 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.

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.

To find an in-network Convenience Care Center near you, visit anthem.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.

URGENT CARE

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

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

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

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 anthem.com.

LAB SERVICES

If you require lab work consider having these services performed at Quest . When coded as preventive, the cost will be covered 100%. If you choose to use LabCorp, services associated with the cost of your lab work will apply to the out-of-network deductible and coinsurance.

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.

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

EMERGENCY ROOM

Some examples of emergency conditions may include the following:

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

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.

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.

Please Note: you may incur out-of-network expenses if you receive services from an out-of-network Emergency Room physician, pathologist, radiologist or anesthesiologist, even if the hospital is in-network.

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

HEALTH SAVINGS ACCOUNT (HSA)

If you elect the Qualified High Deductible Health Plan for your insurance coverage, then 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), 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.
- 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 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. 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.
- If you are age 55 or older, you are allowed to make an extra $1,000 contribution each year.
- 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 based on the IRS Publication 502, (medical, dental, vision and over -the-counter medically necessary items 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).
- Once you turn 65, become disabled, or upon account holder's death, the account can be used for other purposes without paying the 20% penalty.
- The savings account can be established, 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, 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 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, unless you can make a catch up contribution.

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 qualified expenses incurred by 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 an accompanying physician 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.

DENTAL INSURANCE

Anthem Dental

Benefit			PPO In-Network	Out-of-Network Providers
Calendar Year Deductible	♦	Applied to Basic and Major services	$50 individual $150 family	$50 individual $150 family
Annual Maximum	♦	Applied to Preventive, Basic and Major services	$1,000	$1,000
Preventive Services	♦ ♦ ♦ ♦ ♦	Oral examinations Bitewing and Intraoral x-rays Full mouth x-rays Topical fluoride treatments Sealants	100%	80%
Basic Services	♦ ♦ ♦ ♦	Fillings Simple Extractions Endodontics Periodontics	80%	60%
Major Services	♦ ♦ ♦ ♦	Dentures Crowns Inlays Onlays	50%	50%
Orthodontia	♦	Covers child orthodontia to age 19	50% up to $1,000 Lifetime maximum (No deductible)	50% up to $1,000 Lifetime maximum (No deductible)

Anthem Dental Employee Cost

Type of Coverage	Per Paycheck Cost
Employee Only	$4
Employee & Spouse	$8
Employee & Child(ren)	$10
Employee & Family	$15

Anthem Website

You can access an online directory by going to anthem.com
■ Click on “Find a Doctor” on the right side of the page
■ You may search as a Guest or by logging in as a Member
■ Indicate the state in which you are searching for a provider
■ Choose Dental as the type of care you are looking for
■ Choose Dental Complete as the plan name
■ You can narrow down your list of providers by specifying a specialty and the zip code
■ Hit the Search button to display your results

VISION INSURANCE

Vision Benefits of America (VBA)

Benefit	In-Network	Out-of-Network
Examination Copay	$0 Copay	$40 Reimbursement
Frequency of Service:		
Exams	Every 12 Months	
Lenses	Every 12 Months	
Frames	Every 24 Months	
Basic Lenses:	$0 Copay, then	Reimbursement
Single Vision	100%	up to $40
Bifocal	100%	up to $50
Trifocal	100%	up to $75
Frames	$150 Allowance	up to $50
Contacts		
Necessary	UCR	$300
Cosmetic	$150 Allowance	$150

VBA Vision Employee Cost

Type of Coverage	Per Paycheck Cost
Employee Only	$0
Employee & Family	$5.25

If you utilize an out-of-network provider, your benefit is based on a reimbursement schedule. Also, if you are considering Lasik Surgery, there is a discount available. To find a participating provider go to visionbenefits.com.

Short-Term Disability

Short-Term Disability is provided for you by Code Consultants through UNUM at ***no cost***. It protects your income up to 13 weeks if you become sick or temporarily disabled. Following are some key components of the plan:

- Coverage begins the first day for an accident and after 7 days for an illness
- 66.67% Salary Reimbursement to **$2,000** per Week Maximum
- Maternity is treated like any other illness

Voluntary Long-Term Disability

Code Consultants will continue to offer this benefit to all eligible employees on a voluntary basis! Disability Insurance replaces a portion of your income if you are unable to work due to a disability resulting from an accident or illness. This coverage will continue to be provided through UNUM.

Coverage begins after 90 days of disability (elimination period) and pays you a monthly benefit equal to 60 percent of your monthly earnings, to a maximum of $7,500 per month. This benefit may be paid to age 65 or until you no longer meet the definition of disability. You are considered disabled if you have a loss of duties in regards to your regular occupation due to injury or illness.

Employee Cost of Coverage	$0.29 per $100 of your salary

VOLUNTARY TERM LIFE / AD&D INSURANCE

During your initial enrollment period you have the opportunity to purchase additional life insurance with UNUM for yourself, your spouse, and/or dependent children. You cannot cover your spouse or dependent children unless you elect coverage for yourself. You may elect coverage up to the guaranteed issue amount without providing evidence of insurability (EOI), which is a statement of health. Coverage above the guaranteed issue and coverage for those who did not make an election when initially eligible, must complete an EOI and be approved by UNUM before it goes into effect.

As long as you purchase the minimum amount of coverage, you will retain the ability to increase coverage up to the Guarantee Issue amount without EOI at each annual enrollment period.

EMPLOYEE COVERAGE

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

SPOUSE COVERAGE

Spousal coverage is available in $10,000 increments not to exceed 100% of the employee amount up to a maximum of $500,000. The Guarantee Issue amount for spouses is $50,000.

CHILDREN

Coverage is available in $2,500 increments to a maximum of $10,000. The monthly cost is $0.30 per $2,500 of coverage.

Voluntary life and voluntary AD&D are separate elections.

UNUM VOL. LIFE	
Age Band	**Monthly Employee/Spouse Rate Per $1,000**
Under 30	$.091
30-34	$.093
35-39	$.128
40-44	$.183
45-49	$.288
50-54	$.460
55-59	$.716
60-64	$1.057
65-69	$1.807
70-74	$3.194
75+	$6.205

UNUM VOL. AD&D	
Type of Coverage	**Monthly Employee/Spouse Rate Per $1,000**
Employee	$.0333
Spouse	$.0175
Children	$.07/$2,500

Financial protection for what matters most.

BASIC LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT

Code Consultants will continue to provide this benefit at ***no cost*** to you through UNUM. This protection will provide a benefit of 1 times your annual salary of life insurance to a maximum of $50,000. This benefit also carries an equal amount of accidental death and dismemberment coverage.

ACCIDENT INSURANCE

Accident insurance is offered to you on a voluntary basis through Allstate Benefits. This plan pays lump-sum benefits for off-the-job accidents, in addition to existing medical coverage.

This coverage provides 24-hour accident benefits for dislocations, fractures, loss of limbs and death as a result of an accident. Hospital, intensive care and other medical expenses are covered in the Accident plan. The plan also provides an Outpatient Physician's Benefit as well.

Contact your Human Resources department for rates and more details.

CRITICAL ILLNESS INSURANCE

This coverage pays lump-sum benefits directly to the insured at the time a covered illness is diagnosed and is offered to you on a voluntary basis through Allstate Benefits.

Critical Illness pays benefits directly to the insured at the time of diagnosis for heart attack, stroke, heart transplant and other threatening conditions as defined in the certificate.

Contact your Human Resources department for rates and more details.

FLEXIBLE SPENDING ACCOUNTS (FSA)

These accounts are on a calendar year starting on January 1st and ending on December 31st. Therefore, now is the time to gauge how much you would utilize your benefits and estimate how much money you might spend in deductibles and copayments each year so that you can appropriately enroll in the FSA.

All eligible employees must complete an FSA enrollment form, even if you do not want to participate. This is an IRS requirement.

This year there will be FOUR types of flexible spending accounts available for members:

Medical Reimbursement Account

($2,550 Maximum) - This account allows employees the opportunity to pay for medical expenses not covered by insurance with pre-tax dollars. This means the amount you elect for the year comes out of your paycheck in equal deductions **before** the federal government takes their taxes out. Many employees use this account for deductible amounts, copayments, eyeglasses, etc.

Limited Purpose Reimbursement Account

($2,550 Maximum) - This account is only available to those members and their families who choose to contribute in a Health Savings Account. It works similarly to the Medical Reimbursement Account except this account can ONLY be used for dental and vision expenses. Medical services and prescription drugs CANNOT be reimbursed through this account unless they are specifically used for a dental or vision purpose.

Dependent Care Reimbursement Account

($5,000 Maximum) - This account allows employees the opportunity to pay for qualified child/ dependent care expenses with pre-tax dollars. In most cases, there is substantially more tax savings with this plan than there is with the "tax credit" that you get when doing your tax return. It is best to discuss your options with your tax advisor if you have any concerns.

Transit and Parking Account - This account allows employees the opportunity to pay for transit and parking expenses with pre-tax dollars. The maximum amounts for 2016 are $130 per month for transit and $250 per month for parking as they are not combined.

REMINDER!! If you have money left in your Medical FSA or Limited Purpose FSA account on December 31st, you will be able to carry forward up to $500 into the new plan year. Any carry forward will not prevent you from being able to elect the $2,550 maximum in the following year. Please note, however, that if you are currently enrolled in the Medical FSA and want to contribute to an H.S.A., you MUST have a zero balance in your Medical FSA account on December 31 in order to start contributing on January 1, 2016. (Participation in a Limited Purpose FSA does not have an impact on your eligibility to contribute to an H.S.A.)

Getting reimbursed is easy! You just utilize your Debit Card at the time of service OR you submit copies of your receipts to CBIZ along with a claim form and receive a reimbursement. The receipts are necessary because the IRS requires your FSA Vendor to substantiate expenses that do not match your copayments exactly or cannot be auto substantiated at the time of the debit card swipe.

You can access your Flexible Spending Account information by going to myplans.cbiz.com. The website allows you to:

- Verify your election
- View your account balance
- On-line claim form available for completion and faxing

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 your Human Resource Department.

Notice of Material Change (also Material Reduction in Benefits)

Code Consultants has amended the Code Consultants Health Benefits Plan. 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.

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

Code Consultants is subject to the HIPAA privacy rules. In compliance with these rules, Anthem maintains a Notice of Privacy Practices. You have the right to request a copy of the Notice of Privacy Practices by contacting the member service number on the back of your identification card.

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 Code Consultants.

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, **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 Credible 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.

Anthem has determined that the prescription drug coverage offered by Code Consultants is on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pay 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 during annual enrollment so long as you continue to meet the eligibility requirements.

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, but they will be credited to your out-of-pocket maximums. 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.

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

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.

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.

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