2015 Employee 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.

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CONTACT INFORMATION

Contact Information

Vendors	Phone Number	Website
United Healthcare *(Medical)* Group Number: 755633	Call the number on the back of your ID card.	www.myuhc.com.com
MetLife *(Dental)* Group Number: 687779	(800) ASK-4-MET	www.metlife.com/mybenefits
VBA *(Vision)* Group Number: 3212	(800) 432-4966	www.visionbenefits.com
Mutual of Omaha *(Life/AD&D)* Group Number: G000AJUI	(800) 439-3809	www.mutualofomaha.com
Mutual of Omaha *(Voluntary Life/AD&D)* Group Number: G000AJUI	(800) 439-3809	www.mutualofomaha.com
Mutual of Omaha *(Voluntary STD)* Group Number: G000AJUI	(800) 439-3809	www.mutualofomaha.com
Mutual of Omaha *(LTD)* Group Number: G000AJUI	(800) 439-3809	www.mutualofomaha.com
UNUM *(Voluntary Accident/CI)* Group Number: 1039307	(800) 635-5597	www.unum.com/employees

Benefits Team	Phone	Email
HDIS Human Resources Karen Czachowski	(314) 997-8771 ext. 5386	karen.czachowski@hdis.com
Consultant Rusty Besancenez Asha Kuhn	(314) 692-2249 (800) 844-4510	rbesancenez@CBIZ.com akuhn@cbiz.com

ELIGIBILITY

JOINING THE PLAN:

If you are a new HDIS employee, you are eligible for coverage on the first day of the month following 60 days of full time employment. You may submit your enrollment forms/applications and complete your 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:

- Legal Spouse
- Natural and Adopted Children up to age 26
- Your Stepchildren
- Children placed in your custody for adoption
- Children under your legal guardianship
- Children under a qualified medical child support order
- Disabled children 26 years of age or older

Ineligible:

- Divorced or legally separated spouse
- Common law spouse
- Same or Opposite Sex Domestic Partners
- 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 open 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 31 days of the qualifying event or you will have to wait until the next annual open enrollment period. Premiums and enrollment eligibility may change; contact Karen Czachowski x5386 in your Human Resources department for details.

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

YOUR HEALTH PLAN OPTIONS

HDIS knows your employee benefit package is extremely important to you. HDIS understands benefits should meet you and your family's needs, as well as be affordable. In order to meet the needs of all HDIS employees, we offer you the choice between three medical plan options. Two of the medical plans are traditional PPO plans offering a copayment schedule for doctor visits and prescriptions. The Buy Up Plan offers a lower deductible and out-of-pocket cost as well as well as lower copayments. The Base Plan offers higher out-of-pocket expenses, however, the premium is lower. There is also an option to enroll in a Qualified High Deductible Health Plan (QHDHP). This plan does not have a copayment schedule for doctor visits and prescriptions. The services you receive under this plan go towards your annual deductible and out-of-pocket maximum. This option allows you the opportunity to establish a tax favored Health Savings Account (H.S.A.). Please pay close attention to the details and costs associated with each plan in order to determine which plan best fits you and your family's needs.

PRE-TAX PREMIUM CONTRIBUTIONS

It is important to remember that all contributions for medical, dental, and vision premiums are paid on a pre-tax basis according to Section 125 of the IRS code. This results in a tax savings for you and allows you to maximize your take home pay!

Advocate4ME

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

RALLY

Rally is a user-friendly digital experience on www.myuhc.com that will engage you in a new way by using technology, gaming and social media to help you understand, learn and support you on your health journey. With the online Rally Health Survey, personalized missions, rewards and connections to wearables like Fitbit, Jawbone and more, it is easier for you to get motived to be healthier.

HOW TO FIND A PROVIDER

It's simple to look for a medical providers in your area.

1. Go to myuhc.com
2. Click on Find Physician, Laboratory or Facility on the right hand side of the page.
3. Select United Healthcare Choice Plan as the plan name.
4. On the next screen you can personalize your search by zip code and physician type.

YOUR HEALTH BENEFITS

Get the Most from Your Benefits

HDIS 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

MEDICAL INSURANCE

Benefit Plan—BASE PLAN	In-Network	Out-of-Network
	Deductible (calendar year)	
Single	$3,500	$6,000
Family	$7,000	$12,000
	Coinsurance (plan pays/you pay)	
	80% / 20%	60% / 40%
	Out-of-Pocket Limit (including the deductible + coinsurance + copayments)	
Single	$6,000	$10,000
Family	$12,000	$20,000
	Copayments	
Primary Physician Visit	$25 co-pay	Deductible, then you pay 40%
Specialist Physician Visit	$50 co-pay	Deductible, then you pay 40%
Preventive Care*	Plan pays 100%	Deductible, then you pay 40%
Emergency Room Visit	$250 co-pay	$250 co-pay
Urgent Care Center Visit	$75 co-pay	Deductible, then you pay 40%
	Prescription Drug Coverage	
Retail Pharmacy	$10/35/60	$10/35/60**
Mail Order Pharmacy	$25/87.50/150	$25/87.50/150**

*Coverage for Preventive Care is mandated by Health Care Reform guidelines. Please refer to www.healthcare.gov for a list of preventive care services covered under this provision.

**If you purchase a Prescription Drug Product form a Non-Network Pharmacy, you are responsible for any difference between what the Non-Network Pharmacy charges and the amount UHC would have paid for the same Prescription Drug Product dispensed by a Network Pharmacy.

2015—2016 Employee Base Plan Medical Contributions

Employee Deduction (per pay Period)	
Employee	$39.91
Employee & Spouse	$320.92
Employee & Child(ren)	$247.76
Employee & Family	$540.39

MEDICAL INSURANCE

Benefit Plan—BUY UP PLAN	In-Network	Out-of-Network
Deductible (calendar year)		
Single	$750	$1,000
Family	$1,500	$2,000
Coinsurance (plan pays/you pay)		
	80% / 20%	60% / 40%
Out-of-Pocket Limit (including the deductible + coinsurance + copayments)		
Single	$3,500	$5,000
Family	$7,000	$10,000
Copayments		
Primary Physician Visit	$20 co-pay	Deductible, then you pay 40%
Specialist Physician Visit	$40 co-pay	Deductible, then you pay 40%
Preventive Care*	Plan pays 100%	Deductible, then you pay 40%
Emergency Room Visit	$200 co-pay	$200 co-pay
Urgent Care Center Visit	$75 co-pay	Deductible, then you pay 40%
Prescription Drug Coverage		
Retail Pharmacy	$10/35/60	$10/35/60**
Mail Order Pharmacy	$25/87.50/150	$25/87.50/150**

*Coverage for Preventive Care is mandated by Health Care Reform guidelines. Please refer to www.healthcare.gov for a list of preventive care services covered under this provision.

**If you purchase a Prescription Drug Product form a Non-Network Pharmacy, you are responsible for any difference between what the Non-Network Pharmacy charges and the amount UHC would have paid for the same Prescription Drug Product dispensed by a Network Pharmacy.

2015—2016 Employee Buy Up Plan Medical Contributions

Employee Deduction (per pay Period)	
Employee	$95.84
Employee & Spouse	$432.78
Employee & Child(ren)	$345.64
Employee & Family	$694.20

MEDICAL INSURANCE

Benefit Plan—QHDHP PLAN	In-Network	Out-of-Network
Deductible (calendar year/embedded)		
Single	$2,600	$7,500
Family	$5,200	$15,000
Coinsurance (plan pays/you pay)		
	80% / 20%	60% / 40%
Out-of-Pocket Limit (including the deductible + coinsurance + copayments)		
Single	$4,000	$8,500
Family	$8,000	$17,000
Copayments		
Primary Physician Visit	Deductible, then you pay 20%	Deductible, then you pay 40%
Specialist Physician Visit	Deductible, then you pay 20%	Deductible, then you pay 40%
Preventive Care*	Plan pays 100%	Deductible, then you pay 40%
Emergency Room Visit	Deductible, then you pay 20%	Deductible, then you pay 20%
Urgent Care Center Visit	Deductible, then you pay 20%	Deductible, then you pay 40%
Prescription Drug Coverage		
Retail Pharmacy	Deductible and Coinsurance, then $10/30/50	Deductible and Coinsurance, then $10/30/50**
Mail Order Pharmacy	Deductible and Coinsurance, then $25/75/125	Deductible and Coinsurance, then $25/87.50/150**

*Coverage for Preventive Care is mandated by Health Care Reform guidelines. Please refer to www.healthcare.gov for a list of preventive care services covered under this provision.

**If you purchase a Prescription Drug Product form a Non-Network Pharmacy, you are responsible for any difference between what the Non-Network Pharmacy charges and the amount UHC would have paid for the same Prescription Drug Product dispensed by a Network Pharmacy.

2015—2016 Employee QHDHP Plan Medical Contributions

Employee Deduction (per pay Period)	
Employee	$31.43
Employee & Spouse	$303.96
Employee & Child(ren)	$232.92
Employee & Family	$517.01

HEALTH SAVINGS ACCOUNT (HSA)

With the Election of the UnitedHealthcare Qualified High Deductible Health Plan (QHDHP) 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 *Qualified 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 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 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?

- **The contribution limits for 2016 are $3,350 for Single and $6,750 for Family.** You cannot put more than this amount in the account in a calendar year; 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.
- HDIS has established accounts at Central Bank of Missouri so you can take advantage of payroll deductions on a pre-tax basis. An enrollment form is available if you are interested in establishing a Health Savings Account through Central Bank.
- Per IRS guidelines, the QHDHP minimum in network embedded deductible for 2015 is $2,600 for single.

- An **embedded** deductible means your plan contains two components, an individual deductible and a family deductible. Having two components to the deductible allows for each member of your family the opportunity to have the insurance policy cover their medical bills prior to the entire dollar amount of the family deductible being met. The individual deductible is embedded in the family deductible.

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 HSA.

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

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

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

- Doctor's office visits
- Dental services
- Eye exams, eyeglasses, contact lenses and solution, and laser surgery
- Hearing aids
- Orthodontia, dental cleanings, and fillings
- Prescription drugs
- 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 www.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.

When to Use Primary Care, Convenience Care, Urgent Care, Lab Services, or Emergency Care

PRIMARY CARE

For routine, primary/preventive care, or non-urgent treatment, it is recommended 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. It is, however, recommended that you seek routine medical care from your primary care physician whenever possible.

To find an in-network Convenience Care Center near you, visit UnitedHealthcare's website at www.myuhc.com.

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

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.

It is, however, recommended that you seek routine medical care from a UnitedHealthcare 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 UnitedHealthCare's website at www.myuhc.com.

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.

LAB SERVICES

If you require lab work, consider having these services performed at **LabCorp.** If you choose to use Quest, 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

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.

EMERGENCY ROOM

Some examples of emergency conditions may include the following:

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

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.

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.

PRESCRIPTION BENEFITS

Most prescriptions are filled right away when you take them to the pharmacy. However, some drugs need to be reviewed by UnitedHealthcare 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 HDIS and potentially lower future renewal increases. Some prescription drugs are covered only if the physician obtains prior authorization from UnitedHealthcare. 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 www.healthcare.gov.

WOMEN'S PREVENTIVE CARE COVERAGE

Your health plan will provide first dollar coverage for certain women's preventive coverage without any cost sharing requirements (copayment, coinsurance or deductible), when delivered by in-network providers. This includes 100% coverage for FDA-approved tier 1 contraceptive methods for women when filled at an in-network pharmacy.

DENTAL INSURANCE

MetLife Dental

Benefit/Service (Base Plan)	In-Network	Out-of-Network Benefit
Preventive	100%	100%
Basic*	80%	80%
Major	50%	25%
Ortho	Not covered	Not covered
Deductibles & Maximums		
Deductible Individual **	$50	$50
Deductible Family	$150	$150
Annual Maximum Per Person	$1,000	

*includes endodontics and periodontics ** Does not apply to preventive services

Benefit/Service (Buy Up Plan)	In-Network	Out-of-Network Benefit
Preventive	100%	100%
Basic*	80%	80%
Major	50%	50%
Ortho (child only up to age 26)	50%	50%
Deductibles & Maximums		
Deductible Individual **	$50	$50
Deductible Family	$150	$150
Annual Maximum Per Person	$1,500	
Lifetime Orthodontia Maximum	$1,500	

*includes endodontics and periodontics ** Does not apply to preventive services

2015—2016 Employee Dental Contributions

Employee Deduction (per pay Period)	Base	Buy Up
Employee	$8.44	$10.32
Employee & Spouse	$28.59	$36.56
Employee & Child(ren)	$28.59	$36.56
Employee & Family	$28.59	$36.56

Our dental plan is provided by MetLife. You will have coverage both in-network and out-of-network. It is to your advantage to utilize a network dentist to take advantage of contracted fees. You will experience the deepest discounts when seeing an in-network dentist. If you go out -of-network, you will be responsible for any amount exceeding MetLife's negotiated rates plus any deductible and co-insurance associated with your procedure.

The Buy Up Plan offers a larger annual out-of-pocket maximum as well as orthodontia services for children. The Base Plan offers lower payroll deductions and does not include orthodontia.

To find a participating dentist in your elected plan, visit www.metlife.com/mybenefits.

Please note if you are not currently enrolled or if you chose not to enroll during your initial eligibility period, you will be subject to a 6 month waiting period on basic restorative services, a 12 month waiting period on all other basic services and a 24 month waiting period on major and orthodontia services if you choose to enroll at this time.

VISION INSURANCE

Vision Benefits of American (VBA) Vision

Benefit/Service	In-Network	Out-of-Network Benefit
Examination	$20 Co-pay	$40 reimbursement
Frequency of Service:		
Exam	Every 12 months	
Lenses	Every 12 months	
Frames	Every 24 months	
Lenses:	$25 Co-pay then:	Reimbursement:
Single	100%*	$40
Bifocal	100%*	$60
Trifocal	100%*	$80
Lenticular	100%*	$120
Frames	Covered 100% up to $125-150 Retail	$65
Contacts:		Reimbursement
Necessary	UCR	$320
Cosmetic	$160 Allowance	$160

*covered within allowance

Our Vision benefit is provided by VBA. 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. You can review a full list of providers at www.visionbenefits.com.

2015—2016 Employee Vision Contributions

Employee Deduction (per pay Period)	
Employee	$1.74
Employee & Spouse	$3.81
Employee & Child(ren)	$3.92
Family	$6.14

BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

All eligible employees receive Basic Life and Accidental Death & Dismemberment coverage. This coverage is provided by HDIS at **no cost** to you. This coverage is administered through Mutual of Omaha. This benefit provides $30,000 of Life Insurance. This benefit amount also carries an equal benefit of accidental death and dismemberment coverage. Benefit reductions apply upon attaining certain age levels.

This plan also offers Travel Assistance which is an added benefit that provides assistance for your travels over 100 miles away from home or outside of the country.

VOLUNTARY LIFE INSURANCE

Your Voluntary Life/AD&D is administered through Mutual of Omaha. You must purchase voluntary life on yourself in order to purchase coverage for your spouse and dependent children. Benefit reductions apply upon attaining certain age levels.

Employees can purchase up to 5 times their annual salary, with a minimum of $10,000 in $10,000 increments up to a maximum of $250,000 of coverage. The Guarantee Issue amount for newly eligible employees is $100,000.

Spousal coverage is available in $5,000 increments not to exceed 50% of the employee amount, with a minimum of $5,000 to a maximum of $100,000. The Guarantee Issue amount for newly eligible spouses is $30,000. Coverage is available for children age 6 months up to age 21 or age 26 if a full time student. Dependent children coverage can be purchased in $1,000 increments up to $10,000.

Please note: If you did not enroll during your initial enrollment period in the Voluntary Life/AD&D you will be required to complete an Evidence of Insurability (EOI) form and be approved by Mutual of Omaha before you are able to obtain coverage.

Please refer to the Certificate of Coverage for plan and rate specifics or contact Human Resources.

LONG TERM DISABILITY

Long Term Disability is intended to protect your income for a long duration. HDIS provides this benefit to you at **no cost.**

After the 180th day of an illness or injury, you may be eligible for long term disability benefits through Mutual of Omaha. The disability benefit is a monthly benefit and covers 66.67% of your monthly salary to a maximum of $6,000 (this monthly income benefit is subject to a 3/12 pre-existing condition limitation). This benefit may be paid to Social Security retirement age 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 an illness or injury. After 24 months, benefits continue if you cannot perform any gainful occupation for which you would be reasonably fitted considering education, training, and experience.

FLEXIBLE SPENING ACCOUNT (FSA)

A Flexible Spending Account allows an employee to set aside a portion of earnings to pay for qualified expenses as established in the cafeteria plan, most commonly for medical expenses but often for dependent care or other expenses. Money deducted from an employee's pay into an FSA is not subject to payroll taxes, resulting in substantial payroll tax savings. Open enrollment allows you the opportunity to enroll in and/or increase your election amounts for your Flexible Spending Account. Therefore, now is the time to gauge how much you utilize your benefits and how much money you spend in deductibles and copayments each year so that you can properly enroll in the FSA.

Medical Reimbursement Account (**$1,500 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. **Please note that you can not participate in this plan if you have established a Health Savings Account.**

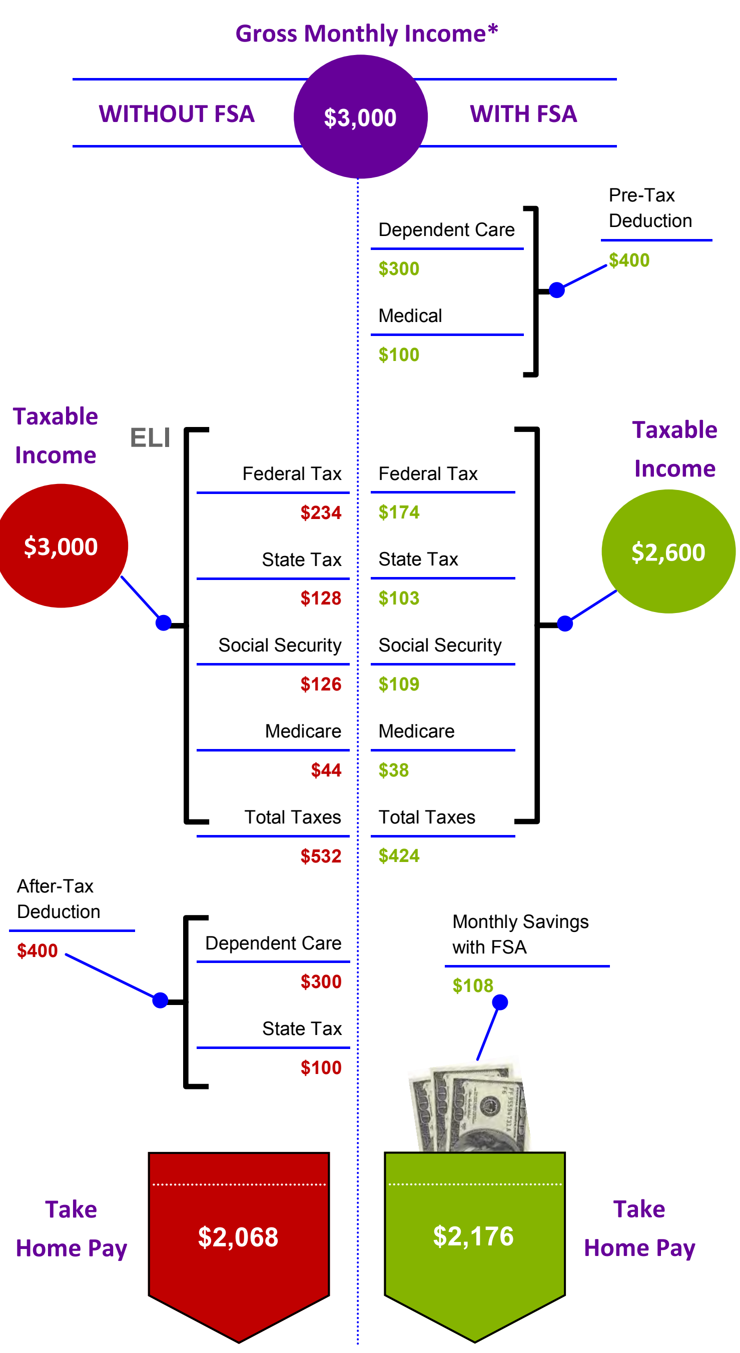
Dependent Care Reimbursement Account (**$5,000 Maximum**) - This account allows employees the opportunity to pay for qualified child/dependent care expenses with pre-tax dollars. In most cases, there is substantially more tax savings with this plan than there is with the "tax credit" that you get when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

You have 90 days past the plan year to turn expenses in for reimbursement. Any excess amount remaining for a particular benefit at plan year-end will be retained by the plan. This program is administered by CBIZ. **You will have the opportunity to enroll in the Flexible Spending Account effective January 1, 2016 later this year. You must enroll/ re-enroll in the plan to participate for the plan year January 1, 2016 – December 31, 2016. Health Reimbursement Account Expenses are limited to $1,500 per plan year; Dependent Care Reimbursement Account expenses are limited to $5,000 per family per plan year.**

How the Medical Reimbursement FSA Works:

- Estimate health care expenses that are not covered by your health plan at all or a portion you have to pay when using your benefits (i.e. Co-pays, deductibles, coinsurance).
- Decide the amount you will spend and enroll in the Plan.
- The annual amount you elect will be deducted from your **Bi-Weekly** pay on a pre-tax basis.
- The annual amount you select is available for reimbursement for qualified expenses.
- **Beginning January 1, 2016,** use your **debit card** to pay for qualified expenses or send a reimbursement form and your receipts or statements to CBIZ, and a reimbursement check will be sent to you for the qualified expenses.

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.

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

Home Delivery Incontinent Supply Co.

ENROLLMENT WORKSHEET

Medical	Base	Buy Up	QHDHP	My Per Pay Cost
Employee	$95.84	$39.91	$31.43	
Employee & Spouse	$432.78	$320.92	$303.96	
Employee & Child(ren)	$345.64	$247.76	$232.92	
Family	$694.20	$540.39	$517.01	

Dental	Base	Buy Up		My Per Pay Cost
Employee	$8.44	$10.32		
Employee & Spouse	$28.59	$36.56		
Employee & Child(ren)	$28.59	$36.56		
Family	$28.59	$36.56		

Vision				My Per Pay Cost
Employee	$1.74			
Employee & Spouse	$3.81			
Employee & Child(ren)	$3.92			
Family	$6.14			

Health Savings Account				My Per Pay Cost

Voluntary Life **My Monthly Cost**

Employee

$________ ÷ 1,000 X $_______ = $_______

Amount of Coverage | Unit Cost from Rate Table | Employee Monthly Cost

Spouse

$________ ÷ 1,000 X $__________ = $___________

Amount of Coverage | Unit Cost from Rate Table | Spouse Monthly Cost

Voluntary Life **My Monthly Cost**

Child(ren)

$__________ ÷ 1,000 X $__________ = $__________

Amount of Coverage | Unit Cost from Rate Table | Child(ren) Monthly Cost

VOLUNTARY LIFE/AD&D—PLEASE CONTACT KAREN CZACHOWSKI x5386 FOR PLAN AND RATE SPEFIFICS

Spouse rates are based on the employee's age

ENROLLMENT WORKSHEET

DEPENDENT PARTICIPATION DETAIL

Legal Name	SS#	Relationship	Gender	DOB	Medical Yes or No	Dental Yes or No	Vision Yes or No

BENEFICIARY INFORMATION

Basic Life Primary Beneficiary - Total Must Equal 100%			
Name	SS#	Relationship	%
Name	SS#	Relationship	%
Basic Life Contingent Beneficiary - Total Must Equal 100%			
Name	SS#	Relationship	%
Name	SS#	Relationship	%
Voluntary Life Primary Beneficiary - Total Must Equal 100%			
Name	SS#	Relationship	%
Name	SS#	Relationship	%
Voluntary Life Contingent Beneficiary - Total Must Equal 100%			
Name	SS#	Relationship	%
Name	SS#	Relationship	%

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 31 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 31 days of the event. To request special enrollment or obtain more information, contact Karen Czachowski.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

As a requirement of the Women's Health and Cancer Rights Act of 1998, you 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 co-pays, deductibles, and co-insurance. You may contact our health carrier at the phone number on the back of your ID card for additional benefit information.

NOTICE OF MATERIAL CHANGE (also Material Reduction in benefits)

Home Delivery Incontinent Supply Co. has amended the HDIS 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.

NOTICE OF PRIVACY PRACTICES

HDIS 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.

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 HDIS.

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 in October through February 15.

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 www.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 eligible for our health coverage 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 www.healthcare.gov.

If you believe 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 go to www.insurekidsnow.gov website 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, you will be allowed to enroll in our medical 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 www.askebsa.dol.gov or call 1-866-444-3272.

Link to the latest form: **http://www.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
www.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
www.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 HDIS' 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 plan provide at least a standard level of coverage set by Medicare. More coverage may be offered at a higher premium.

United Healthcare has determined that the prescription drug coverage offered by the HDIS Base, Buy UP and QHDHP plans are 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 may not 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 www.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 www.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 – Your 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. The plan pays 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 service 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 – This 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 co-pays 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.

Preferred 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.

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 a 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.