2018 Employee Benefits Guide

SUGAR CREEK CAPITAL

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.

Sugar Creek Capital

Carrier Contact Information	
	**Medical, Dental & Vision Insurance:** Member Services: 1-800-357-0978 www.myuhc.com
	**Base Life/AD&D & Voluntary Life/AD&D:** Life Claims: www.unum.com 1-866-679-3054

For questions regarding your benefits please contact our benefit consultants at CBIZ Benefits & Insurance Services, Inc:

Tina Borge *Account Executive*
314-692-2249 Ext. 145
tborge@cbiz.com
Amanda Acebal *Account Manager*
314-692-2249 Ext. 140

ENROLLING IN THE PLANS

It is time once again for the annual review of the Sugar Creek Realty employee benefits. Sugar Creek will continue to offer 4 medical plans, including a Health Savings Account (see additional information in this guide). The current United Healthcare plans Sugar Creek offers will remain the same.

OPEN ENROLLMENT

During this open enrollment period, anyone not currently on the plan can now take the coverage offered. This is also the time when you can make additions/deletions, or terminate your coverage. If you do not take the opportunity now, you will not be able to make any changes until the next open enrollment period at this time next year, unless you experience a qualifying event (marriage, divorce, birth of a child, etc). **Note: Your deductible runs on a calendar year (Jan.-Dec.)**

ENROLLING IN THE PLANS IS FAST AND EASY - HERE'S HOW:

Human Resources will provide a form with your current coverage. You will need to complete the form indicating which plans you are electing for the upcoming year.

ELIGIBILITY

WHO CAN YOU ADD TO YOUR PLAN:

Eligible: Employees working more than 30 hours per week for medical coverage and 40 hours per week for dental, life and vision coverage.

Ineligible: Employees working under 30 hours per week and considered part time.

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

Please review the information on the next two pages to determine which medical plan is best for you.

Sugar Creek Capital

UHC Balanced (E9F, 2V) PLAN 1

Benefit	In Network	Out of Network
Calendar Year Deductible: Individual	$1,000 $2,000	$3,000 $6,000
Per Occur. Ded Inpatient Outpatient	N/A	N/A
Coinsurance	80%	50%
Out-of-Pocket Max Individual Family	$4,000 $8,000	$8,000 $16,000
Preventive Care	100%	Deductible & Coinsurance
Office Visits: PCP/Specialist	$30/$60	Deductible & Coinsurance
Virtual Visits	$20 Co-Pay	Deductible & Coinsurance
Inpatient/ Outpatient Hospital	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Lab & X-Ray	100%	Deductible & Coinsurance
Major Diagnostics	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Room	$300 Co-Pay	$300 Co-Pay
Urgent Care	$100 Co-Pay	Deductible & Coinsurance
Prescription *Tier 1* *Tier 2* *Tier 3*	Participating Pharmacies: $10 $35 $60	Mail Order: $25 $87.50 $150

Previous Rate	New Rate
$68.65	**$86.78**

UHC Balanced (E9J, 2V) PLAN 2

Benefit	In Network	Out of Network
Calendar Year Deductible: Individual	$1,500 $3,000	$4,500 $9,000
Per Occur. Ded Inpatient Outpatient	N/A	N/A
Coinsurance	80%	50%
Out-of-Pocket Max Individual Family	$6,250 $12,500	$12,500 $25,000
Preventive Care	100%	Deductible & Coinsurance
Office Visits: PCP/Specialist	$35/$70	Deductible & Coinsurance
Virtual Visits	$20 Co-Pay	Deductible & Coinsurance
Inpatient/ Outpatient Hospital	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Lab & X-Ray	Deductible & Coinsurance	Deductible & Coinsurance
Major Diagnostics	$400 Co-Pay	Deductible & Coinsurance
Emergency Room	$300 Co-Pay, then 20%	$300 Co-Pay, then 20%
Urgent Care	$100 Co-Pay	Deductible & Coinsurance
Prescription *Tier 1* *Tier 2* *Tier 3*	Participating Pharmacies: $10 $35 $60	Mail Order: $25 $87.50 $150

Previous Rate	New Rate
$39.95	**$55.79**

These rates are for employee only, per pay period. See page 13 for a full list of premiums.

UHC Balanced (E9B, 2V) PLAN 3

Benefit/Service	In Network	Out of Network
Calendar Year Deductible: Individual	$5,000 $10,000	$10,000 $20,000
Per Occur. Ded. Inpatient Outpatient	$500 $250 *Ded/Coins applies	$500 $250 *Ded/Coins applies
Coinsurance	100%	70%
Out-of-Pocket Max Individual Family	$6,250 $12,500	$12,500 $25,000
Preventive Care	100%	Deductible & Coinsurance
Office Visit Primary Care Specialist	$35 Co-Pay $70 Co-Pay	Deductible & Coinsurance
Virtual Visits	$20 Co-Pay	Deductible & Coinsurance
Inpatient/ Outpatient Hospital	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Lab & X-Ray	Deductible & Coinsurance	Deductible & Coinsurance
Major Diagnostics	$400 Co-Pay	Deductible & Coinsurance
Emergency Room	$500 Co-Pay	$500 Co-Pay
Urgent Care	$100 Co-Pay	Deductible & Coinsurance
Prescription *Tier 1* *Tier 2* *Tier 3*	Participating Pharmacies: $10 $35 $60	Mail Order: $25 $87.50 $150

Previous Rate	New Rate
$25.35	**$40.02**

UHC Balanced (HSA-E9Y, 2V) PLAN 4

Benefit/Service	In Network	Out of Network
Calendar Year Deductible: Individual	$3,000 $6,000	$9,000 $18,000
Per Occur. Ded Inpatient Outpatient	N/A	N/A
Coinsurance	100%	70%
Out-of-Pocket Max Individual Family	$6,250 $12,500	$12,500 $25,000
Preventive Care	100%	Deductible & Coinsurance
Office Visits Primary Care Specialist	DEDUCTIBLE THEN: $35 Co-Pay $70 Co-Pay	Deductible & Coinsurance
Virtual Visits	Deductible & Coinsurance	Deductible & Coinsurance
Inpatient/ Outpatient Hospital	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Lab & X-Ray	Deductible & Coinsurance	Deductible & Coinsurance
Major Diagnostics	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Room	$300 Co-Pay After Ded	$300 Co-Pay After Deductible
Urgent Care	$100 Co-Pay After Ded	Deductible & Coinsurance
Prescription *Tier 1* *Tier 2* *Tier 3*	Participating Pharmacies: AFTER DEDUCTIBLE: $10 $35	Mail Order: $25 $87.50 $150

Previous Rate	New Rate
$12.45	**$26.06**

These rates are for employee only, per pay period. See page 13 for a full list of premiums.

PRE-NOTIFICATION INFORMATION

This is 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. Be sure that this process is completed before any tests, or inpatient/outpatient services are received. If the insurance carrier does not given authorization for certain services, they will not be covered.

VIRTUAL VISITS

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

Conditions Commonly Treated Through a Virtual Visit

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

Access to Virtual Visits

Log in to **myuhc.com** and choose from provider sites where you can register for a virtual visit. After registering and requesting a visit, you will pay the primary care visit copay for the United Healthcare Base Plan and High Plans and the deductible for the QHDHP (Health Savings Account).

Rally

Rally is a user-friendly digital experience on www.myuhc.com that will enhance 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 motivated to be healthier.

ADVOCATE4ME

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

Full Spectrum of Health Care

Three Convenient Ways to Manage Your Health Care

1. Download the Health4Me app - just search for United Healthcare 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 UHC's mobile site by going to myuhc.com on your smartphone - and you'll get many of the same features of their app.
3. Get the full myuhc.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 UHC's secure member site and have a username and password. If you are a UHC member but haven't registered, go to myuhc.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.

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 www.myuhc.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,

URGENT CARE

Typical conditions that may be treated at an 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.

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 www.myuhc.com.

LAB SERVICES

If you require lab work consider having these services performed at LabCorp . When coded as preventive, the cost will be covered 100%. 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.

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 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

Mail Order Drugs—CVS Caremark

OptumRx® and CVS Pharmacy® make it easy for you to get your maintenance medications, while helping you save money.[1] The OptumRx Preferred90 and Mail Service Member Select program allows you to get a three-month supply of your medication(s) at nearly 9,700 CVS Pharmacy locations, through OptumRx home delivery, or you can continue filling 30-day supplies at your current retail pharmacy – the choice is yours.

Here is what this means for you:

Cost savings
You may pay less for your medication(s) with a three-month supply.

Convenience
Your pharmacist is happy to answer your questions either at the pharmacy or by phone.

Choice
Choose between OptumRx home delivery or nearly 9,700 CVS Pharmacy locations.

Whether you decide to get your maintenance medication(s) from a CVS Pharmacy location or through OptumRx home delivery, it's easy to get your medication(s).

If you choose a CVS Pharmacy location:	
In store	Bring in your prescription(s) or empty prescription bottles.
Online	Visit **CVS.com/transfer** and follow a few simple steps.
Phone	Call your local CVS Pharmacy and a pharmacy staff member will help you.

If you choose OptumRx home delivery:	
ePrescribe	Ask your doctor to send an electronic prescription.
Online	Go to **myuhc.com®** and register.
Phone	Call the member phone number on your health plan ID card.

If you choose to continue filling 30-day supplies at your current pharmacy:
You must disenroll from Mail Service Member Select. Contact OptumRx by calling the phone number on your health plan ID card or visit **myuhc.com.** There is no penalty for this option and you will continue to pay your same plan cost share after you disenroll.

CVS pharmacy®

UnitedHealthcare®

HEALTH SAVINGS ACCOUNT (HSA)

A Health Savings Account (HSA) is type of health care plan that involves a tax advantaged savings plan paired with a qualified high deductible health plan. There are two components to an HSA plan: the *qualified high deductible health plan* (required) and the *health savings account* (optional but encouraged).

The *qualified high deductible health plan (QHDHP)* will be designed within the specific regulations established by the IRS. It will consist of the underlying insurance benefits and will include deductibles, co-insurance amounts and costs for various benefits including how prescription drugs are covered. It is important to note that the deductible must be completely satisfied before the plan pays any benefits.

The *health savings account (HSA)* is optional but is recommended that participants fund this account. Individuals who place money in this account will enjoy the following tax advantages:

- Funds that go into the HSA are payroll deducted before taxes are taken so the employee's taxable income is reduced. Generally, you can deposit enough money each year to help fund your deductible. Individuals who are age 55 or older are also allowed to contribute extra money into their account.
- Any earnings or investment income in the HSA is not taxed. This bank account can grow tax free.
- Any funds used for qualified health care expenses are not taxed. Additionally, once an individual becomes Medicare eligible, those funds can be used for other items without being taxed.

The HSA is established in your name. It is your bank account and can be taken with you if you change employers. Any money deposited into the account is your money. HSA accounts do not include the "use it or lose it" provision you would see with a flex spending account. Keep in mind that you can only spend money that is actually in your account. If your health care expenses are more than your HSA balance, you will have to pay the remaining cost in another manner such as cash, personal check, credit card, etc. Later, once you have accumulated the funds in your account, you can request reimbursement of what you've spent.

You can use your HSA funds for your spouse and dependents – even if they are not covered by your Qualified High Deductible Health Plan. You can use HSA funds to pay for qualified expenses of your spouse and tax eligible dependents.

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

- Doctor's office visits
- Hospitalization, urgent care, emergency room, etc.
- 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
- Physical therapy, speech therapy, and chiropractic expenses

Facts about the 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 banking 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 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 or Tricare.
- You cannot be claimed as a dependent under someone else's tax return.

What is the difference between 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 benefit from the discounts associated with using an in-network physician or facility.

What else do I need to know?

- Contributions are based on a calendar year. For 2018, contribution limits are $3,450 for Single and $6,900 for Family coverage. You cannot put more than this amount in the account; you can put less. Individuals who are age 55 or older can also contribute an additional $1,000 in catch up contributions per 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 (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 is 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 with a variety of banking institutions, so you can take advantage of payroll deductions on a pre-tax basis.

This type of health plan may be right for you if…...

- You do not use a lot of medical services.
- You do not have a lot of prescription medications.
- You would like money in a savings account to pay for "Qualified Expenses" permitted under Federal Law. This includes most medical care, dental and vision services.
- You'd like a tax-advantaged savings account.
- You would like more control over your healthcare dollars.
- You would rather pay less in payroll deductions and you can afford the higher deductible.
- Please note: the deductible applies to all services with the exception of wellness.

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

HSA ELIGIBLE EXPENSES

Below is a **partial** list of eligible expenses that can be reimbursed from a Health Savings Account. Other out-of-pocket expenses may qualify.

Alcoholism treatment	Ambulance	Artificial limbs
Braces	Chiropractors	Coinsurance and co-payments
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	

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.

Health Care Coverage Options: COBRA and Its Alternatives

Selecting the right health care coverage option is important when facing an employment transition. We know how complex healthcare coverage can be, especially with the recent introduction of the Affordable Care Act.

The Affordable Care Act did not eliminate COBRA or change the COBRA rules. COBRA beneficiaries generally are eligible for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction of hours of work.

The question then becomes whether or not taking COBRA is a better choice than purchasing a new policy through an insurance exchange and applying for a federal subsidy if eligible.

- **COBRA coverage may be more expensive than a new individual policy through the health insurance exchanges.**

  This is because if a COBRA policy is continued, the employee has to pay both their share of the premium and the employer's contribution. If the policy is rich with benefits and the employer has been paying a significant portion of the premium, chances are the full premium will be higher than other health insurance coverage options through the health exchanges.

- **Rather than take COBRA, the Affordable Care Act provisions allow low-income individuals to get coverage at a lower cost because of their potential eligibility for federal subsidies.**

  These subsidies are designed for people who earn between 100 percent and 400 percent of the Federal Poverty Line, or about $24,600–$98,400 for a family of four or $12,060–$48,240 for an individual. If an employee's income is under these limits, it will probably be more cost effective to purchase a new policy and receive the subsidies to help pay the premium.

WHY IS CBIZ SELECTQUOTE BEING OFFERED?

SelectQuote Benefit Solutions, through its partner CBIZ, will help you understand your choices and guide you through the options related to healthcare coverage to help you find a plan that best suits your needs should you leave Sugar Creek and need an individual policy. This service available to anyone seeking additional health care options and there is no additional cost associated with this service.

KEEPING YOUR HEALTH CARE AFFORDABLE

As the healthcare marketplace evolves, we are committed to providing you access to affordable, high quality healthcare options. Get started today to make the most of this benefit for you and your family.

GETTING STARTED

Review your options at cbiz.selectquotebenefits.com or call at 1-855-801-5742.

Dental Insurance to Make You Smile

Effective March 1st, we will remain with United Healthcare for our dental insurance. For those who did not previously have dental coverage, you may enroll at this time. Please request an enrollment form from the Payroll Department. In order to find a provider, go to www.myuhcdental.com and click on "Find a Dentist." You will need to select the National Options PPO 20 network.

You will continue to have coverage both in network and out of network in the PPO options. It is to your advantage to utilize a network dentist to take advantage of contracted fees. If you go out of network, you will be responsible for any amount exceeding United Healthcare's negotiated rates plus any deductible and co-insurance associated with your procedure.

Benefit Plan	In Network	Out of Network
Deductible		
Individual	$50	$50
Family	$150	$150
Coinsurance		
Diagnostic/Preventive	100%	100%
Basic Services	80%	80%
Endodontics	80%	80%
Periodontics	80%	80%
Major Services	50%	50%
Orthodontia	Not Covered	Not Covered
Annual Maximum	$1,000/person	

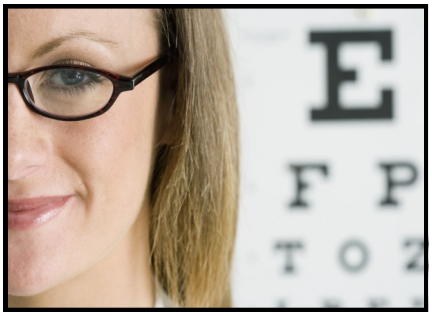
See Clearly with Vision Insurance

United Healthcare will remain our vision carrier. The United Healthcare vision network is national and includes over 35,000 private practice and retail chain providers. To find a participating provider go to www.myuhcvision.com. In addition to the benefits outlined in the table below, discounts for non-covered options, mail order contacts and laser vision correction procedures are also available.

Coverage both in network and out of network is included in this plan. It is to your advantage to utilize a network provider to take advantage of contracted fees. If you go out of network, you will be responsible for paying the provider directly and seeking reimbursement from UHC for the amounts listed in the out of network column below.

Benefit/Service	In Network	Out of Network
Examination Co-pay	$10 Co-pay	$40 reimbursement
Frequency of Service: Exam Lenses Frames	 Every 12 months Every 12 months Every 24 months	
Lenses Single Bifocal Trifocal	$25 Co-pay then: 100% 100% 100%	Reimbursement $40 $60 $80
Frames	$25 Co-Pay then: *Covered 100% up to $130 retail	$45
Contacts Necessary Cosmetic	 $25 Co-Pay then: 100% Up to $105	Reimbursement $210 $105

With United Healthcare Vision's frame benefit, you will receive a retail frame allowance toward the purchase of any frame at a network provider. For frames that exceed your allowance, you may receive an additional 30% discount on the coverage (available only at participating providers and may exclude certain frame manufacturers).



EMPLOYEE COST PER PAY PERIOD

Medical	E9F $1,000 Ded	E9J $1,500 Ded	E9B $5,000 Ded	E9Y (HSA) $3,000 Ded
Employee	$86.78	$55.79	$40.02	$26.06
Employee & Spouse	$355.86	$290.78	$257.65	$228.34
Employee & Child(ren)	$306.93	$248.05	$218.09	$191.57
Family	$551.55	$461.68	$415.99	$375.46

Dental	P5430			
Employee	$12.97			
Employee & Spouse	$25.93			
Employee & Child(ren)	$26.18			
Family	$40.34			

Vision	V1008			
Employee	$3.30			
Employee & Spouse	$6.27			
Employee & Child(ren)	$7.33			
Family	$10.33			

Health Savings Account (HSA)				
If participating, what is your monthly contribution? *(Yearly Maximums: Individual $3,400; Family $6,750 and if you are 55 or older, you can make "catch-up" contributions of an additional $1,000 per year.) Contact Human Resources to obtain the H.S.A. contribution form.*				

Life and Accidental Death & Dismemberment

Effective March 1, 2018, Unum will continue to be our provider for life and accidental death and dismemberment coverage. ***The company provided benefit from is $50,000 of life insurance for each full time employee***. Each benefit amount also carries an equal benefit of accidental death and dismemberment coverage. Now is a great time to ensure that Sugar Creek has the most up to date beneficiary information on file for you.

Voluntary Life and AD&D

Unum's group voluntary term life and AD&D insurance can provide benefits for those who depend on you, if you die during your working years. This coverage can help your loved ones deal with expenses such as: a mortgage, ongoing living expenses, or funeral arrangements (Average Cost in Midwest is between $8,000 & $12,000)

You may purchase voluntary life in $10,000 increments to a maximum benefit amount of 5x your annual earnings or $500,000, whichever is less. You can purchase life amounts in $5,000 increments (not to exceed your elected amount) on your spouse with a guaranteed benefit of $25,000. For your children ages 6 months to 19 years (26 years if full time student) you may choose to purchase this benefit in increments of $2,000 with a maximum of $10,000.

The cost is based on your age and whether you use tobacco products. Use the table below to determine the cost of additional life insurance according to your age, amount and whether you are a smoker or non smoker. Keep in mind your benefit reduces by 35% at age 65 and 50% at age 70.

	Employee Monthly Rate/$10,000		*Spouse Monthly Rate/ $5,000
	Non-Tobacco User	**Tobacco User**	
Under 29	$0.690	$1.280	$.350
30-34	$0.770	$1.280	$.390
35-39	$1.150	$2.080	$.580
40-44	$1.860	$3.370	$.930
45-49	$2.870	$5.190	$1.440
50-54	$4.670	$8.460	$2.340
55-59	$7.340	$13.290	$3.670
60-64	$10.190	$18.450	$5.100
65-69	$18.800	$34.060	$9.400
70-74	$31.540	$54.210	$15.77

**The spouse rate is based off the employee's age*

Voluntary AD&D Rates	
Employee AD&D per $10,000	$0.31
Spouse AD&D per $5,000	$0.15
Child(ren) AD&D per $2,000	$0.40

Voluntary Child(ren) Life	
Child(ren) Rate per $2,000	$.082

VOLUNTARY LIFE ENROLLMENT WORKSHEET

	Employee Monthly Rate/$10,000		*Spouse Monthly Rate/ $5,000
	Non-Tobacco User	**Tobacco User**	
Under 29	$0.690	$1.280	$.350
30-34	$0.770	$1.280	$.390
35-39	$1.150	$2.080	$.580
40-44	$1.860	$3.370	$.930
45-49	$2.870	$5.190	$1.440
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55-59	$7.340	$13.290	$3.670
60-64	$10.190	$18.450	$5.100
65-69	$18.800	$34.060	$9.400
70-74	$31.540	$54.210	$15.77

Employee

$_____	÷ 1,000	X	($_____	(AD&D + .031)	=	$_____
Amount of Coverage			Unit Cost from Rate Table			Employee Monthly Cost

Spouse

$_____	÷ 1,000	X	($_____	(AD&D + .030)	=	$_____
Amount of Coverage			Unit Cost from Rate Table			Spouse Monthly Cost

Child(ren)

$_____	÷ 1,000	X	$_____	(AD&D + .041)	=	$_____
Amount of Coverage			Unit Cost from Rate Table			Child(ren) Monthly Cost

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 at* 314-561-6830.

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 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)

Sugar Creek Capital has amended the *United Healthcare* benefit 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

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

Important Information Regarding 1095 Forms

As an employer with 50 or more eligible employees we are required to provide 1095-C forms to all employees who were eligible for coverage under our group health plan in 2016. If you were eligible for coverage under our group plan you will receive a personalized 1095-C form before March 2, 2018. We are also required to send a copy of your 1095-C form to the IRS.

The information reported on Form 1095-C is used in determining whether an employer owes a payment under the employer shared responsibility provisions under section 4980H. Form 1095-C is also used by the IRS and the employee in determining the eligibility of the employee for the premium tax credit.

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 *Sugar Creek Capital*.

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.

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 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 *Sugar Creek Capital* 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 not be able to get this coverage back until open enrollment or you experience a qualifying event.

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.

A notice will be provided to you prior to the October 15 Medicare open enrollment period. 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).

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 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 **www.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 www.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 **www.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: 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

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 – 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 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.

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.