2016 Employee Benefits Guide

Family Care Health Centers

…...Your Health Care Partner for Life

Welcome to Family Care Health Centers

Annual Enrollment Period

August 1st is the anniversary of our employee benefit plans. We are pleased to announce that we are remaining with Anthem Blue Cross Blue Shield as our carrier for all coverage. With the help of CBIZ, our benefit consultants, we were able to negotiate the medical increase to a low 3%, which remains well below the market trends.

It is also time for our annual enrollment period. At this time you are able to enroll, change, or drop your current medical or dental, supplemental life or vision coverage. You may also change the enrollment status for your eligible dependents. Please note you will not be able to make changes to your coverage again until the next annual enrollment period unless you experience a qualifying event (i.e. marriage, birth of child, divorce, loss of other coverage).

During this annual enrollment you are also offered the opportunity to change from one plan to another. Please take the time to compare plans to ensure you elect the best plan for you and, if applicable, your dependents. This year we have decided to only offer two plans; one traditional co-pay plan along side the HSA plan.

Family Care Health Centers will, once again, be utilizing the CBIZ Employee Management System Portal (EMS). **All employees must go to this Portal and enter your information even if you are declining coverage!** Additional information regarding how to enroll using EMS can be found later in this newsletter.

PLEASE NOTE: This year when you meet with Unum to review the voluntary benefits (in particular, the Critical Illness, Accident, and Hospital Indemnity [Med Support] policies), everyone who is currently enrolled will need to re-sign new enrollment forms. We have updated the contracts to be HSA compliant so that they integrate with the HSA plan that is offered through Anthem. Doing this has also given the policies enhancements at no extra charge. Stay tuned for more information closer to the Unum annual enrollment period in August.

ENROLLING IN THE PLANS

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

If you are newly eligible or would like to now enroll in benefits due to the annual enrollment period, you will need to enroll through the EMS Portal. You will find instructions later in this booklet.

ELIGIBILITY

WHO CAN YOU ADD TO YOUR PLAN:

Eligible:

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

Ineligible:

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

FREQUENTLY ASKED QUESTIONS…...

ARE CHANGES TO MY PLAN ALLOWED DURING THE YEAR?

Generally, you may only enroll in the plan, or make changes to your benefits, during the re-enrollment period or when you are first hired. However, you can make changes/enroll during the plan year if you experience a qualifying event. As with a new enrollee, you must have your paperwork turned in within 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
- You become eligible for or lose Medicaid coverage
- You become eligible for Medicare

Family Care Health Centers

Medical Insurance to Keep You Healthy

Anthem Base Plan	In Network	Out of Network
Deductible: Individual Family	 $1,000 $2,000	 $2,000 $4,000
Coinsurance After Deductible	80%	60%
Out-of-Pocket Max: Individual Family	 $4,000 $8,000	 $8,000 $16,000
Office Visit Primary Care Specialist	 $20 Co-Pay $40 Co-Pay	Deductible & Coinsurance
Preventive Care	100%	Deductible & Coinsurance
Inpatient Hospital	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Surgery, Lab & X-Ray	Deductible & Coinsurance	Deductible & Coinsurance
Major Diagnostics: Lab, X-Ray, CT, PET, MRI, MRA, Nuclear Medicine	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Room	$200 Co-Pay	$200 Co-Pay
Urgent Care	$50 Co-Pay	Deductible & Coinsurance
Prescription *Retail—Tier 1* *Retail—Tier 2* *Retail—Tier 3* *Retail—Tier 4* *Mail Order* *(90 Day Supply)*	<u>At Participating Pharmacies:</u> $10 $35 $60 25% $20/$50/$75/25%	

Anthem HSA Plan	In Network	Out of Network
Deductible: Individual Family	 $3,000 $6,000	 $3,000 $6,000
Coinsurance After Deductible	100%	70%
Out-of-Pocket Max: Individual Family	 $3,000 $6,000	 $6,000 $12,000
Office Visit Primary Care Specialist	Deductible & Coinsurance	Deductible & Coinsurance
Preventive Care	100%	Deductible & Coinsurance
Inpatient Hospital	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Surgery, Lab & X-Ray	Deductible & Coinsurance	Deductible & Coinsurance
Major Diagnostics: Lab, X-Ray, CT, PET, MRI, MRA, Nuclear Medicine	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Room	Deductible & Coinsurance	Deductible & Coinsurance
Urgent Care	Deductible & Coinsurance	Deductible & Coinsurance
Prescription *Retail—Tier 1* *Retail—Tier 2* *Retail—Tier 3* *Retail—Tier 4* *Mail Order* *(90 Day Supply)*	 Deductible & Coinsurance Deductible & Coinsurance Deductible & Coinsurance Deductible & Coinsurance Deductible & Coinsurance	

Medical Insurance to Keep You Healthy

Plan Highlights:

- Coinsurance, Prescription Drug Co-Pays, and Deductibles accumulate towards the Out-of-Pocket Maximum.
- Lab, X-Ray, and other preventive tests for Preventive care are covered at 100% with no deductible.
- You can visit a Walgreens Take Care clinic for a Primary Care Office Visit Co-Pay.
- If you use a non-network pharmacy you will be responsible for any difference between what the non-network pharmacy charges and the amount Anthem would have paid for the same prescription drug product dispensed by a network pharmacy.
- You should read and review the certificate of coverage and the Summary of Benefit and Coverage to know your exact benefits. You can also contact Anthem at the phone number on the back of your ID card.

Pre Notification Information:

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

Health Savings Account Information

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 also have a medical *flexible* spending account (FSA), unless it is a Limited Purpose FSA.
- You cannot set up an HSA if you have insurance coverage under another plan, for example your spouse's employer, unless that secondary coverage is also a qualified high deductible health plan.
- You cannot be eligible for Medicare.
- 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 and urgent care visits, and prescription drugs. You will, however, still have the opportunity to benefit from the discounts associated with using a network physician or facility.

What else do I need to know?

- Contributions are based on a calendar year. The contribution limits for 2016 are $3,350 for Single and $6,750 for Family coverage. You cannot put more than this amount in the account; you can put less.
- The contributions from your paycheck are tax-free, grow tax-free, and come out tax-free as long as you utilize the funds for approved services based on the IRS Publication 502, (medical, dental, vision and over-the-counter medically necessary items with a physician's prescription).
- Your unused contributions roll over from year to year and can be taken with you if you leave your current job.
- If you use the money for non-qualified expenses, then the money becomes taxable and subject to a 20% excise tax penalty (like in an IRA account).
- Once you turn 65, become disabled, and/or qualify for Medicare, you can use the account for other purposes without paying the 20% penalty.
- The savings account can be established, so you can take advantage of payroll deductions on a pre-tax basis.

Another advantage is that your account can grow over time.

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

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

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

The 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 could be 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 and some over-the-counter medications
- 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.

Enhance Your Smile with Dental Coverage

Anthem Dental Complete		
Schedule of Benefits	**In Network**	**Out of Network**
Deductible		
Individual	$50	$50
Family	$150	$150
Coinsurance		
Diagnostic/Preventive	100%	100%
Basic Services	80%	75%
Major Services	50%	50%
Annual Maximum	$1,000/person	

See Clearly with Vision Coverage

Anthem Blue View Vision	In Network	Out of Network
Examination Co-pay	$20	$42 Reimbursement
Frequency of Service:		
Exam	Every 12 months	
Lenses	Every 12 months	
Frames	Every 24 months	
Lenses	$20 Co-pay then	Reimbursement
Single	100%	$40
Bifocal	100%	$60
Trifocal	100%	$80
Frames	$130 Allowance, 20% off remaining balance	$45
Contacts		Reimbursement
Non-Elective	100%	$210
Elective Conventional	$130 Allowance, plus 15% off remaining balance	$105
Elective Disposable	$130 Allowance	

Below is only a few (of many) vision providers in Anthem's network.

PEARLE VISION · sears optical · OPTICAL · jcp optical · LensCrafters

Find a dental or additional vision providers by going to www.anthem.com and clicking on "Find a Doctor": You will enter search criteria such as ***Blue View Vision*** and ***Dental Complete*** to find providers in Anthem's Network.

Protect Your Family with Life & Accidental Death and Dismemberment Insurance

All benefit eligible employees of Family Care Health Centers are provided Basic Life Insurance and Accidental Death & Dismemberment through Anthem at no cost! Coverage for Life Insurance and AD&D is 1 X your annual salary up to $125,000 maximum. An additional $5,000 of coverage is provided for your spouse or domestic partner and up to $5,000 in coverage for child(ren). **Now is the time to update your beneficiary information.**

Voluntary Life and Accidental Death & Dismemberment (AD&D) Insurance

You may enroll yourself and/or your eligible dependents. You, the employee, must purchase voluntary life in order to purchase for your spouse and/or dependent children. If you are enrolling as a late entrant, or want to increase your current amount, you must complete a new Enrollment Form and Evidence of Insurability Form (EOI).

New employees must enroll within the first 31 days of becoming eligible for benefits to take advantage of the guaranteed issue (GI) amounts listed below. Anything over the GI amount will also require an EOI form and approval by Anthem before it takes effect.

When calculating premium for spouse coverage use the **employee** age!

EMPLOYEE COVERAGE

Employees may elect coverage in increments of $10,000 up to a maximum of $500,000 or 5 X your salary. Guaranteed issue is $150,000 for new employees if enrolling within 31 days of becoming eligible for supplemental life.

SPOUSE COVERAGE

Spousal coverage is available in increments of $5,000 not to exceed 50% of the employee amount up to a maximum of $250,000. Guaranteed issue is $50,000 for spouses of new employees if enrolling within 31 days of becoming eligible for voluntary life.

CHILDREN

Child coverage is available in $2,000 increments up to $10,000. The elected coverage is for all children in your family. Coverage for a child 15 days to 6 months is $100. Children are eligible up to age 26.

Voluntary Life/AD&D Employee Contribution (Rates are per month)	
Age Band	**Employee/Spouse Rate per $1,000**
Under 30	$.04
30-34	$.05
35-39	$.08
40-44	$.12
45-49	$.18
50-54	$.29
55-59	$.45
60-64	$.66
65-69	$1.07
70-74	$2.50
Over 74	$6.43

Child Coverage	Monthly Rate
$.42/$2,000	

How to Calculate Your Voluntary Life Premium

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

Child(ren)

$_____ ÷ 1,000 X $_____ = $_____

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

EMPLOYEE COST PER PAY PERIOD

Medical	BASE	HSA
Employee	$140.28	$79.12
Employee & Spouse	$375.36	$268.06
Employee & Child(ren)	$316.59	$220.80
Family	$551.67	$409.88

Vision	
Employee	$3.46
Employee & Spouse	$5.54
Employee & Child(ren)	$5.65
Family	$9.12

Dental	
Employee	$5.77
Employee & Spouse	$11.62
Employee & Child(ren)	$11.15
Family	$18.94

NOTE: You have the option of paying for your portion of the premiums on a "pre-tax" or "post-tax" basis. You will be asked through the EMS portal which method you would like. Keep in mind that by electing to have your premiums taken out of your check on a "pre-tax" basis, this will lock you in for coverage until next open enrollment (or one year).

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

Helpful Information

Deductibles - The deductible is the amount of money you pay before services are covered under your medical or dental plan. Normally, it is paid for in-patient and out-patient services under your medical plan. Your deductible is accumulated during each calendar year (January 1 through December 31). It does not apply to any preventive services as required under Health Care Reform.

Coinsurance - After the deductible is satisfied, claims costs are shared with the insurance carrier until the out-of-pocket maximum is reached.

Out-of-Pocket Maximums - This is the maximum amount of money you are required to pay in a calendar year. The deductible, co-pays, and your share of the coinsurance under your chosen plan will equal the most you will pay. Once the out-of-pocket maximum is reached, claims are eligible at 100% of covered services.

Office Visit Copayments - When you visit your primary care physician or a specialist, you are required to pay a copayment for that visit. The office visit co-pay will satisfy part of the out-of-pocket limit associated with the plan. There should be no copayments for services coded as preventive by your physician. NOTE: The HSA Plan does not have co-pays. You will pay the negotiated rate that the physician has with Anthem and this amount will accumulate toward your deductible.

Urgent Care - If you visit an urgent care facility you will be required to pay a copayment for this service. It is higher than a regular office visit and lower than an emergency room copayment. In addition to the co-pay, the deductible and coinsurance may apply when these services are performed: CT, PET, MRI, Nuclear Medicine, Pharmaceutical Products, Scopic Procedures, Surgery, Therapeutic Treatments. The Take Care Clinic with Walgreens is considered at the primary care office visit co-pay.

Emergency Room - If you visit a hospital emergency room, you will be required to pay a copayment. This is a much higher cost than a regular office visit or urgent care facility. If you are admitted to the hospital the copayment/coinsurance is waived and the deductible / coinsurance applies.

NOTE: The HSA Plan does not have co-pays for urgent care or emergency room services. You will pay the negotiated rate that the physician has with Anthem and this amount will accumulate toward your deductible.

Preventive Services - All services coded as Preventive are covered 100% and the deductible and copayments will not apply. Situations may arise where the "Preventive" service could be coded as "Diagnostic". In these situations the deductible and copayments could apply. Also, if you receive a preventive service in conjunction with a sick visit, you could still be charged the applicable office visit co-pay, deductible, and/or coinsurance. Communication with your provider of care is important.

Lifetime Benefit Maximum - All plan design options have an unlimited lifetime maximum.

Prescription Drugs - You have a 4 tier co-pay structure (see benefit outline) for prescription drugs. Mail Order prescription will provide up to a 90-day supply of medication at a lesser cost than the tier co-pay. Please visit www.anthem.com to access your prescription drug list as well as the list of prescription drug products that are available through mail order.

Review your Certificate of Coverage. It is a complete summary of your health insurance benefits. You can view the certificate online at www.anthem.com.

Ask your physician or healthcare provider if they participate in the Anthem network. Do not ask if they accept Anthem. The providers usually, but not always, accept payments from insurance companies or anyone who wants to give them money; however, not all providers want to accept the contractual discounts required by participation in the network. You can also check the website at www.anthem.com for the most up-to-date list of participating providers or call customer service at the phone number on the back of your ID card for assistance.

If you go out-of-network, know that it is your responsibility to pre-certify all procedures. Contact customer service at the phone number on the back of your ID card. There are penalties and more out-of-pocket expenses if you do not pre-certify.

IMPORTANT NOTICES

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.gove 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-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

www.cms.hhs.gov

1-877-267-2323, Ext. 61565

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.

Anthem has determined that the prescription drug coverage offered by Family Care Health Center for the Traditional plan 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. Anthem has determined that the HSA plan is not, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pay and is therefore considered Non-Creditable Coverage.

If you lose your current creditable prescription drug coverage through no fault of your own, you will be eligible for a two-month Special Enrollment Period to join a Medicare drug plan.

If you decide to join a Medicare drug plan, your current coverage will not be affected. This plan will coordinate with Part D coverage. If you drop your current coverage, be aware that you and your dependents will be able to get this coverage back.

If you drop or lose your current coverage and don't join a Medicare drug plan within 63 continuous days after your coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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.

IMPORTANT NOTICES (cont.)

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.

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 *Jade Held* in Human Resources.

SUMMARY OF MATERIAL MODIFICATION

Anthem has amended the Employee Medical Benefit Plan. This contains a summary of the modifications that were made. It should be read in conjunction with the Summary Plan Description or Certificate of Coverage that is available to you. If you need a copy of your Summary Plan Description or Certificate of Coverage, please go to www.anthem.com or contact Human Resources.

EMS ON-LINE PORTAL ENROLLMENT INSTRUCTIONS

This year's annual enrollment will again be handled on-line. This means you can enroll in and review your benefit information from work, home, the library, or anywhere you can access the internet 24 hours a day, seven days a week. **All employees MUST enroll whether or not you are electing benefits.** Any choices made during this enrollment will override any previous elections. This portal will be open from June 20th-July 8th.

TO GET STARTED

- Access www.cbizems.com to log in to the Employee Portal Homepage Log In.
- Please click on *"First Time User?* The system will prompt you to enter your SSN and date of birth to verify your identity. The system will then advise you of your account credentials.
- Once you have logged in, select "Begin Event" link to commence the enrollment process. **Please note, the Open Enrollment link will only be activated during the active Open Enrollment window (2 weeks).** You will **not** have access to the Open Enrollment event outside of this two weeks window.
- Review information on each tab, beginning from "Instructions" through "Confirmation" tabs.
- Should you wish to make changes to personal information, dependent, beneficiary and/or emergency contacts, you will be allowed the opportunity to do so on each of the tabs shown above.
- Under "Benefits" tab, you may choose to elect a different plan, coverage level or waive current elections.
- Please complete the enrollment process and submit your enrollment on the "Confirmation" tab.
- You will receive a notification via email when the event is reviewed and processed by your Human Resources Department.

ONCE YOU ARE IN THE SYSTEM

- When you start the enrollment process, you will be asked to review your demographic information and report any changes.
- You will then be asked to provide the Name, Home Address, Social Security Number and Date of Birth for ALL of your dependents.
- Then, you will be directed through several screens that will provide information on all of your benefit plan options.
- **You will be required to provide your beneficiary information for the Employer Provided Life and AD&D and any elected Voluntary Life coverage, this includes the SSN of your beneficiaries.**
- Please print TWO copies of the confirmation statement. Keep one copy for your records. Please sign and date the other copy and give to Jade Held in Human Resources by **July 11, 2016.**
- **You will not be enrolled in the benefits you choose unless you hand in a signed copy of your confirmation statement by the deadline stated above.**

NOTE: Once you have printed your confirmation statements you will need to return to the home page to complete your online enrollment process.

CONTACT INFORMATION

Your Carriers	
Anthem Blue Cross	Medical, Dental, Vision Life & Voluntary Life Insurance: Member Services: Call the number on the back of your card www.anthem.com

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

Donna Clifton, Account Executive

314-692-2249 Ext. 112

dclifton@cbiz.com

Nicol Schmidt, Account Manager

314-692-2249 Ext. 147

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