2016 Employee Benefits Guide

client SERVICES INCORPORATED

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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Client Services, Inc.

Contact Information

HOW TO USE THIS

Lauren Bohanan
636-947-2321 Ext. 3168

YOUR CONSULTANT

CBIZ Benefits & Insurance Services
Eric File, Senior Account Executive
Asha Kuhn, Senior Account Manager
314-692-2249 or 800-844-4510

MEDICAL/PHARMACY

UnitedHealthcare
Policy #715412
Member Services Phone Number:
See Number on Back of ID Card
Provider Web Address:
www.myuhc.com

FLEXIBLE SPENDING ACCOUNT

UnitedHealthcare
Policy #715413
Member Services Phone Number:
See Number on Back of ID Card
Provider Web Address:
myuhc.com

VISION

UnitedHealthcare Vision
Policy #715412
Member Services Phone Number:
800-638-3120
Provider Web Address:
myuhcvision.com

DENTAL, LIFE/AD&D, LONG TERM DISABILITY & VOL. LIFE/AD&D

MetLife
Policy #5913672
Member Services Phone Number:
1-800-ASK-4MET
Provider Web Address:
metlife.com/mybenefits

EMPLOYEE ASSISTANCE PROGRAM

Personal Assistance Services (PAS)
Member Services Phone Number:
314-842-6223 or 800-356-0845
Provider Web Address:
paseap.com

Reasons to Call:

Claim Questions—Contact UHC / CBIZ

I.D. Cards / Numbers—Contact UHC / CBIZ

Pre-Certification—UHC

Provider Directories—www.myuhc.com

Payroll Issues / Status Changes/ Miscellaneous Issues—Contact Client Services Human Resources

How to use this claims resolutions:

1. First contact Member Services
2. If issue still unresolved, contact Account Manger at CBIZ Benefits & Insurance Services, Inc. for assistance.

Enrolling in the Plans

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

- Read your materials and make sure you understand all of the options available.
- Locate your Enrollment/Change/Annual Election Form.
- Fill out any necessary personal information.
- Make your benefit choices on the form.
- Sign and date the form.
- Submit the form to the Human Resources Department.
- For help with completing the form, or if you have any questions regarding the benefits offered, please contact the Human Resources Department.

IMPORTANT NOTE:

It is very important that you complete your enrollment within the required timeframe. If you do not complete your enrollment by the deadline, you will, by default, waive your rights to the company sponsored group benefits.

Eligibility

Joining the Plan:

If you are a Client Services full-time, new hire working at least 30 hours per week, you will become eligible for coverage the first day following 90 days of employment. This will be the date on which your coverage becomes effective.

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

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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
- Children placed in your physical custody for adoption

Ineligible:

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

Frequently Asked Questions

ARE CHANGES TO MY PLAN ALLOWED DURING THE YEAR?

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

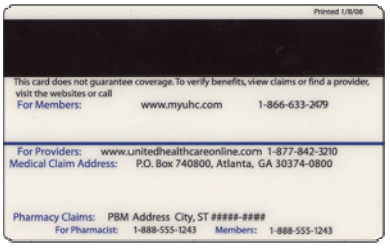
Pre-Notification Information

UnitedHealthcare will require notification before you receive certain covered health services. In general, Network providers are responsible for notifying UnitedHealthcare before they provide these services to you. There are some Network Benefits, however, for which you are responsible for notifying UnitedHealthcare and as a rule UnitedHealthcare 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.

UNITEDHEALTHCARE CUSTOMER CARE

Call the number on the back of your ID card for Customer Care.

SAMPLE CARD



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 $23,850–$95,400 for a family of four or $11,670–$46,680 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. 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.

Rally

Rally is a user-friendly digital experience on 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 motived 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 the toll-free number on the back of your 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.

Full Spectrum of Health Care Support

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
- Stomach Ache

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, the cost of the visit will apply towards your deductible/coinsurance.

Medical Insurance

UnitedHealthcare QHDHP with the option to open an HSA

Benefit Plan	QHDHP In-Network	QHDHP Out-of-Network
Deductible (calendar year)		
Single	$3,000	$6,000
Family	$6,000	$12,000
Coinsurance (plan pays/you pay)		
	80% / 20%	60% / 40%
Out-of-Pocket Limit (including the deductible + coinsurance)		
Single	$6,000	$12,000
Family	$12,000	$24,000
Copayments		
Primary Physician Visit	Deductible, then plan pays 80%	Deductible, then plan pays 60%
Specialist Physician Visit	Deductible, then plan pays 80%	Deductible, then plan pays 60%
Preventive Care	Plan pays 100%	Not Covered
Emergency Room Visit	Deductible, then plan pays 80%	Deductible, then plan pays 80%
Urgent Care Center Visit	Deductible, then plan pays 80%	Deductible, then plan pays 60%
Prescription Drug Coverage		
Retail Pharmacy	Deductible, then plan pays 80%	Deductible, then plan pays 60%
Mail Order Pharmacy	Deductible, then plan pays 80%	Not Covered

2016 Employee Medical Plan Contributions

Employee Monthly Cost	
Employee	$165
Employee & Spouse	$352
Employee & Child(ren)	$302
Employee & Family	$419

To the left are the monthly premiums associated with the medical plan option being offered in 2016. Please note that your premiums will be withheld from you paycheck on a pre-tax basis for medical, dental and vision insurance. This can save you considerable money as the savings are based upon your individual tax bracket.

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, reduced claims expense for CSI, 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 or coinsurance when these services are provided by a **network provider**. The types of preventive services covered are defined by federal law and can vary based on your age, gender, and health status. There may be services you had in the past that will now be covered as preventive at no cost to you. The preventive services included in this provision are described at healthcare.gov.

Women's Preventive Care Coverage

Your health plan will provide first dollar coverage for certain women's preventive coverage without any cost sharing requirements (co-payment, 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.

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, Wal-mart and Target, and offer services without the need to schedule an appointment. Services at a Convenience Care Center may be provided at a lower out-of-pocket cost than an urgent care center visit and are subject to the deductible/coinsurance.

Services at a Convenience Care Center are generally available to patients 18 months of age or older. Services

that are available may vary per center. We do, however, recommend that you seek routine medical care from your primary care physician whenever possible.

Convenience Care Center

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

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

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

To find an in-network Convenience Care Center near you, visit our website at 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, 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 myuhc.com.

LAB SERVICES

If you require lab work, please check to be sure the provider you are going to is in-network. Example, Lab Corp is a network provider and Quest is not. Utilizing Quest will cause your benefits to be paid at the non-network level.

URGENT CARE

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

- Sprains
- Strains
- Mild asthma attacks
- Minor infections
- Vaccinations
- Small cuts
- Sore throats
- Rashes
- Preventive screenings
- Back pain or strains

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

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.

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

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.

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.

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.

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 a 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 fund your deductible.
- 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 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 a 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 a 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 a HSA.
- You cannot establish a HSA if you also have a medical *flexible* spending account (FSA).
- You cannot set up a 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. The employee contribution levels for 2016 are $3,350 for single coverage and $6,750 for family coverage. If you're age 55 or older, you are allowed to make an extra $1,000 catch-up contribution each year. The employee cannot put more than this amount in the account; but 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 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 Optum Bank, so you can take advantage of payroll deductions on a pre-tax basis.
- 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 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.

Please Note: if you elect to enroll in the QHDHP and you establish a HSA, you will not be eligible to participate in the medical FSA.

Dental Insurance

MetLife Dental

Benefit/Service	In-Network	Out-of-Network Benefit
Preventive	**100%**	**100%**
Basic	**90%**	**80%**
Major	**60%**	**50%**
Ortho	**50%**	**50%**
Deductibles & Maximums		
Deductible Individual *	$50	
Deductible Family	$150	
Annual Maximum Per Person	$2,000	
Lifetime Orthodontia Maximum **	$2,000	

* Does not apply to preventive services.

** Orthodontic services are available for children up to age 19 and the annual deductible does NOT apply.

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.

Out-of-Network Services

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

2016 Employee Dental

Dental Employee Cost	Monthly
Employee	$19.40
Employee & Spouse	$37.51
Employee & Child(ren)	$40.11
Employee & Family	$69.85

VISION INSURANCE

UnitedHealthcare Vision

Benefit/Service	In-Network	Out-of-Network Benefit
Examination	$10 Co-pay	$40 reimbursement
Frequency of Service:		
Exam	Every 12 months	
Lenses	Every 12 months	
Frames	Every 12 months	
Lenses:	$25 Co-pay then:	Reimbursement:
Single	100%	$40
Bifocal	100%	$60
Trifocal	100%	$80
Frames	*Covered 100% up to $50 Wholesale/ $130 Retail	$45
Contacts:		Reimbursement
Necessary	Covered at 100%	$210
Cosmetic	Reimbursed up to $125	$125

* With UnitedHealthcare Vision's frame benefits, all frames with a $50 wholesale cost or less are covered in full at private practice providers. For any frame over $50 at private practice providers, the member pays the difference between the wholesale cost of the frame and the $50 allowance. Plan participants receive $130 retail frame allowance for frames purchased at a retail chain and for any frame above the $130 retail, the member will pay the difference.

UnitedHealthcare Vision has been trusted for more than 40 years to deliver affordable, innovative vision care solutions to the nation's leading employers through experienced, customer-focused people and the nation's most accessible, diversified vision care network. There are no ID cards or claim forms needed for this benefit.

If you are considering Lasik Surgery, there is a discount available. To find a participating surgeon, go to myuhcvision.com.

2016 Employee Vision

Vision Employee Cost	Monthly
Employee	$5
Employee & Spouse	$9
Employee & Child(ren)	$9
Employee & Family	$13

Basic Life and Accidental Death & Dismemberment Insurance

This benefit is paid by CSI and administered through MetLife. In the event of your death, your beneficiary will receive the amount of your annual earnings (prior year W-2) in group life insurance benefit (maximum $50,000). For those employees who have not completed a full calendar year of employment, the group life insurance benefit will be $20,000. This coverage is provided by the company to all eligible employees, working at least 30 hours per week, at no additional cost. The Accidental Death and Dismemberment (AD&D) benefit is equal to your basic group life insurance benefit.

Voluntary Life and Accidental Death & Dismemberment Insurance

Your Voluntary Life/AD&D is administered through MetLife. Employees can purchase up to $500,000 of coverage in $10,000 increments or five times your annual earnings. The Guarantee Issue amount for employees is $100,000. Spousal coverage is available in $5,000 increments not to exceed 50% of the employee amount up to a maximum of $100,000. The Guarantee Issue amount for spouses is $25,000. Coverage is available for children 15 days to 6 months in the amount of $1,000. Children age 6 months up to age 25 have the following options: $1,000, $2,000, $4,000, $5,000 or $10,000, not to exceed the spouse's benefit amount.

VOLUNTARY LIFE/AD&D EMPLOYEE CONTRIBUTION (Rates are per month)	
Age Band	**Employee/Spouse Rate per $1,000***
Under 30	$.048
30-34	$.056
35-39	$.071
40-44	$.100
45-49	$.150
50-54	$.230
55-59	$.402
60-64	$.572
65-69	$.918
70+	$1.735
AD&D	$0.017
Child Life	$0.240
Child AD&D	$0.510

***Spouse rates are based on the employees age**

Please note: You will be able to increase your Voluntary Life/AD&D coverage election annually by up to $10,000 up to the guarantee issue maximum election without submitting an Evidence of Insurability form. Spouses are able to increase their Voluntary Life coverage election annually by up to $5,000 up to the guarantee issue maximum election without submitting an Evidence of Insurability form. Your voluntary life benefits with MetLife will **NOT** reduce based on your age.

If you and/or your dependents chose not to enroll in the Voluntary Life/AD&D plan during your initial enrollment period you and/or your dependents will be required to complete an Evidence of Insurability form and be approved by MetLife before you are able to obtain coverage in the future. Newly hired employees who are currently in their initial eligibility period can obtain up to $100,000 without completing an Evidence of Insurability form for themselves and $25,000 for their spouse.

MetLife offers a complementary will preparation service for those who are enrolled in the voluntary life plan. This service provides you with a face-to-face meeting with an attorney in your area to prepare a will, living will and power of attorney. This is over a $1,500 value!

Long Term Disability Insurance

Disability Insurance, provided through MetLife, replaces a portion of your income if you are unable to work due to a disability resulting from an accident or illness. This coverage is provided by the company to all eligible employees at no additional cost.

Coverage begins after 90 days of disability (elimination period) and pays you a monthly benefit equal to 60 percent of your monthly earnings (prior year W2), to a maximum of $5,000 per month. This benefit may be paid to age 65 (see the benefit payment schedule below) or until you no longer meet the definition of disability. You are considered disabled if you have a loss of duties in regards to your regular occupation due to injury or illness. After 24 months, benefits continue if you cannot perform any gainful occupation for which you would be reasonably fitted considering education, training, and experience. You must be under the care of a doctor.

LTD BENEFIT PAYMENT SCHEDULE	
Age at Disability	Maximum Period of Payment
Less than age 60	To age 65, but not less than 5 years
Age 60	60 months
Age 61	48 months
Age 62	42 months
Age 63	36 months
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

Employee Assistance Program (EAP)

Through our EAP contract with our service provider, Personal Assistance Services (PAS), you and your eligible dependents can receive confidential assistance with personal and work/life concerns.

Our EAP benefit offers confidential, short-term counseling for personal and family issues at no cost to you. The EAP provides short-term, confidential counseling in dealing with family and relationship issues, substance abuse, stress and anxiety, communication issues, and emotional concerns. The EAP also provides the following services to help you balance work and home life:

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

The EAP is administered by Personal Assistance Services (PAS), an independent firm that specializes in providing professional counseling services through highly qualified, licensed behavioral health practitioners. PAS professionals answer calls 24 hours a day, seven days a week. PAS' telephone number is 314-842-6223 or 1-800-356-0845. When you call the EAP, a PAS representative will answer any questions you have and set up an appointment for you. Please visit the PAS website for additional information at paseap.com,

Flexible Spending Accounts (FSAs)

TYPES OF ACCOUNTS

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

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

Maximum Contributions	
Section 125 Medical Account*	$2,550 max
Dependent Care Expense Account	$5,000 max

* Note: The minimum you can contribute is $20

ACCOUNT STATEMENTS

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

HOW THE ACCOUNT WORKS

When you have eligible expenses not covered under the health insurance plan, such as co-payments and deductibles, a flexible spending claim is automatically generated and a reimbursement payment from your Section 125 Medical Account is issued. For expenses not directly related to a health plan claim, you may submit a FSA claim form with your receipt and a reimbursement payment is issued to you directly or you may use your Consumer Accounts Card to pay for out-of-pocket expenses at qualified vendors.

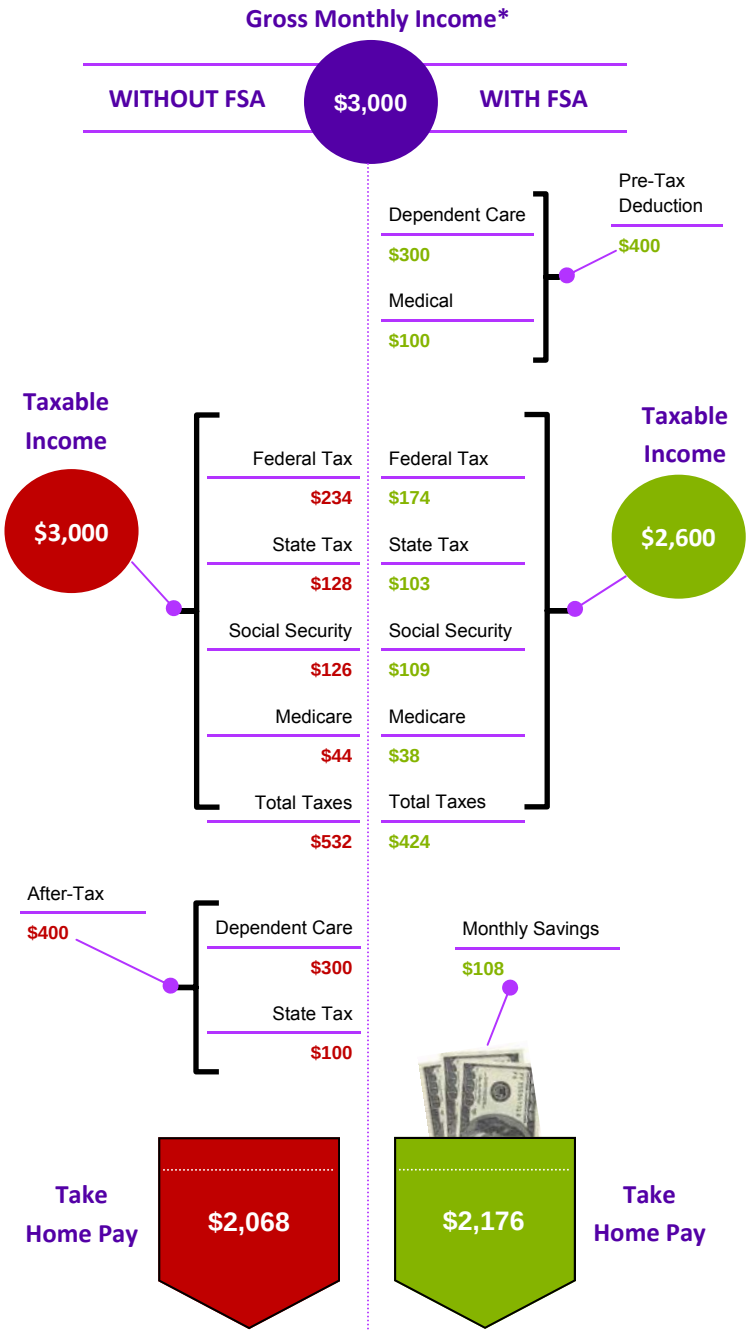
When you have dependent care expenses, you may complete a dependent care claim form and submit it to UnitedHealthcare with a receipt from your child care provider. A reimbursement payment is issued to you directly. Please note, the receipt for your child care provider must include the name, address,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

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

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

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

How will a flexible spending arrangement save you money?



* This is an example and for illustration purposes only. Taxes are not exact and will vary.

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 Department.

Women's Health and Cancer Rights Act of 1998

As a requirement of the Women's Health and Cancer Rights Act of 1998, your plan provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. The benefits must be provided and are subject to the health plan's regular copays, deductibles, and co-insurance. You may contact our health carrier at the phone number on the back of your ID card for additional benefit information.

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 2015. If you were eligible for coverage under our group plan you will receive a personalized 1095-C form in January 2016. 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.

You'll need a 1095 form to complete your annual Federal tax return.

Notice of Privacy Practices

CSI 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 your Human Resources Department

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 CSI.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance which meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit which lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace

begins November 1st through January 31st.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium. Savings depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer which offers minimum essential coverage and meets affordability standards, you will not be eligible for a tax credit through the Marketplace. If you purchase health coverage through the Marketplace, you may lose any employer contribution offered for the employer-offered coverage. Employer and employee contributions for employer-offered coverage are often excluded from Federal income tax. Payment for Marketplace coverage is made on an after-tax basis.

More Information

New employees will receive a notice of Marketplace Coverage Options advising the standards of offered coverage. Please visit HealthCare.gov for more Marketplace information.

Medicaid CHIP Notice

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're also eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed on the DOL website provided below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

Following is a link to the latest form and states where you may be eligible for assistance paying your employer health premiums: dol.gov/ebsa/pdf/chipmodelnotice.pdf

For more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
dol.gov/ebsa
1-866-444-3272
Menu Option 4, Ext 61565

U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
cms.hhs.gov
1-877-267-2323

Medicare Part D Creditable Coverage

This notice has information about your current prescription drug coverage and about your options under Medicare's prescription drug coverage. If you are eligible for Medicare, the following information can help you decide whether or not you want to join a Medicare drug plan. You should consider comparing your current coverage through our medical plan with the costs of plans offering Medicare prescription drug coverage in your area. Two important things you need to know about your current coverage and Medicare prescription drug coverage:

Medicare prescription drug coverage is available if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan. All Medicare drug plans provide at least a standard level of coverage set by Medicare. More coverage may be offered at a higher premium.

UnitedHealthcare has determined that the prescription drug coverage offered by CSI is on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because this coverage is Creditable Coverage, you can keep it and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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

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

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

This information is provided for the Medicare open enrollment period which begins on October 15. If you want more information about Medicare plans that offer prescription drug coverage, you will find it in the Medicare & You handbook or you can visit medicare.gov or call 1-800-MEDICARE (1-800-633-4227)

TTY users: 1-800-486-2048. If you have limited income and resources, visit Social Security on their website at socialsecurity.gov, or call them at 1-800-772-1213. TTY users: 1-800-325-0778.

Keep all Creditable Coverage notices. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of the notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Glossary of Terms

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

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

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

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

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

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

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

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

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

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

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

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

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

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. Client Services, Inc. also specifically reserves the right to revise, modify or terminate the Plans at any time.

To obtain a copy of the official Medical Plan documents, simply log onto CSI Net/Reference/Employee Benefit Websites/www.MYUHC.com/member login/"Plan Document." To obtain a copy of the Medicare Part D notice, please log onto CSI Net/CSI News/"Prescription Drug Coverage and Medicare Notice." You can then either view the appropriate Plan Document and/or notice or print a copy for your records. To obtain a written copy of the Medical Plan documents and/or Medicare Part D notice, you can also call the Human Resource Department to request a copy. To obtain a copy of the official Dental, Vision, Life/AD&D, Voluntary Life/AD&D and Long Term Disability Plan documents and Notice of Privacy Practices, please contact the Human Resource Department and a copy will be provided to you.

I understand that some information, forms and/or policies relating to the benefits package can be sent electronically."

Signature _____ Date_____