Brinker Capital

2018 Benefits Guide

Helping investors fund current and future goals has directed our focus for the past 30 years.

INSIDE THIS GUIDE

REFERENCE

Coverage	Vendor	Website / Phone
Employee Call Center	CBIZ	eMail pabenefits@cbiz.com (800) 820-5090
Medical & Prescription	Independence Administrators and FutureScripts	To register, use: https://myibxtpabenefits.com (844) 864-4352
Independence Administrators Wellness Reimbursement	Independence Administrators	(888) 356-7899
Dental	Unum/United Concordia	www.unumdental.com (888) 222-2685
Vision	Superior Vision	www.superiorvision.com (800) 507-3800
Life, AD&D, Disability	Cigna	Disability - (800) 362-4462
Travel & Accident	The Hartford	Travel Assistance & ID Theft Protection (800) 243-6108 Travel Assistance ID #: GLD-09012
Health Savings Account (HSA)	HealthEquity	www.healthequity.com/hsalearn (866) 346-5800
Flexible Spending Account (FSA)	The Harrison Group, Inc.	eMail service@theharrisongrouponline.com (610) 853-9075
Employee Life Assistance Program	Cigna	www.cignabehavioral.com/cgi (800) 538-3543

This benefits summary describes the highlights of our benefits in non-technical language. Your specific rights to benefits under the plan are governed solely, and in every respect, by the official documents and not the information in this summary. If there is any discrepancy between the descriptions of the programs as contained in this brochure and the official plan documents, the language of the official plan document shall prevail as accurate. Please refer to the plan-specific documents for detailed plan information. Any plan benefits may be modified in the future to meet Internal Revenue Service rules or otherwise as decided by Brinker Capital.

WELCOME

Brinker Capital takes pride in offering a comprehensive and competitive benefits package to its employees that allows choice and flexibility. Through this program you can choose the benefits that are best for you and your family.

Please take the time to review all of the plan options available to you prior to making your selections. Consider each benefit and the associated cost carefully and choose the benefits package that will best meet you and your family's needs throughout the year.

New Hires: All regular full-time employees working 30+ hours are eligible to enroll in the group benefit plans on the first of the month following 30 days of employment.

Options selected during open enrollment then remain in place until December 31, 2018.

If you do not enroll during your initial eligibility period, you waive your right to group benefit coverage through the end of the 2018 plan year, unless you have a Qualified Change in Family Status (explained below).

Qualified Change in Family Status

If you wish to make changes, you must contact the CBIZ Employee Services Center (ESC) within 31 days of the qualifying event.

Qualifying events include:

- Marriage
- Birth, adoption of a child, placement for adoption or death of dependent
- Divorce, legal separation or annulment
- Change in employment status on the part of the employee, employee's spouse or dependent
- A dependent fails to satisfy eligibility requirements of eligibility under the employee benefit plans

Dependents eligible for benefits coverage include your:

- Legal spouse
- Domestic Partner & domestic partner's dependent children
- Dependent child up to age 26 under the medical, dental and vision plan (no student verification required)

EMPLOYEE CALL CENTER

Of course, once you have enrolled in the company group benefit plans and voluntary benefit plans, making use of the benefits can sometimes be a challenge. You may have questions and that is why CBIZ makes the Employee Call Center available to you and your dependents.

Phone: 1-800-820-5090
Email: pabenefits@cbiz.com

The Call Center offers the following services:

- A dedicated Customer Service Representative who can answer employee benefit questions;
- Provide information about your group insurance plans (i.e., eligibility and enrollment and insurance information, including when you are eligible for coverage and specific plan details such as benefit summaries and assistance locating participating providers);
- Assistance in satisfactorily resolving your claims issues (acting as a liaison between you, the insurance carrier and provider).

Employees and their dependents are invited to call to speak with a person familiar with Brinker Capital's benefit plans to help answer any questions.

You may be required to provide an authorization form to release medical information to CBIZ depending on your inquiry.

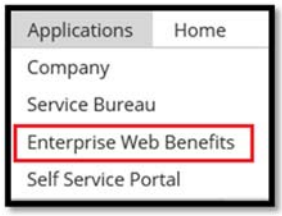
Whether online or via a telephone call, the CBIZ Employee Service Call Center is dedicated to providing our employees with prompt and accurate answers to your benefit plan questions.

The CBIZ Employee Service Call Center is available to assist:
Monday through Friday, 8:30 a.m. - 5:00 p.m. EST

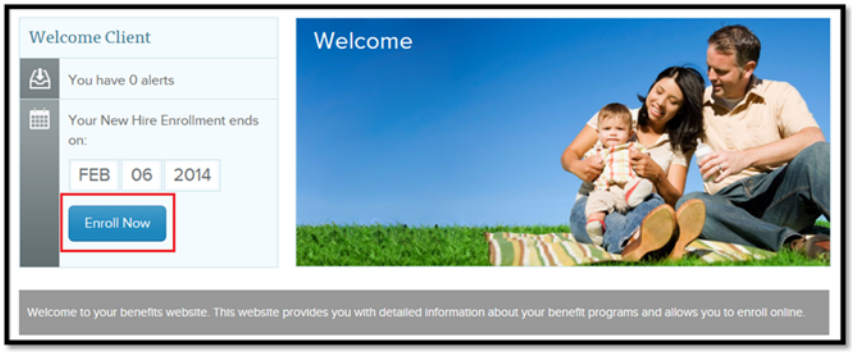
Customer Service Representatives are the quickest and most efficient resources available to assist you as questions arise or as you need guidance through claim intricacies with the benefit plan carriers!
Don't hesitate to call!

How Do I Enroll:: Paylocity / WebPay Online Enrollment Instructions

To access the system, log into WebPay as you would to view your payroll information. On the top left corner, click on the Applications bar and then Web Benefits, this will take you to your Web Benefits home page.



From the Home Page, click on **ENROLL NOW.**



MEDICAL BENEFITS

Among the most important decisions you will make about the benefit plan options available through Brinker is the type of medical insurance coverage that is best for you and your family. Medical insurance represents a major part of our benefit program. This important coverage helps to protect you and your family from the financial loss or hardship that could result from illness. With the rising cost of health care, few of us could afford to pay medical expenses out of our own pockets. You may choose coverage through one of the three available insurance plans or you may choose not to participate.

Brinker offers three medical plans through Independence Administrators (IA): two qualified high deductible plans (HDHP) (the $4,000 and the $2,500 HDHP) and the PPO Copay Plan. All plans are PPO plans that do not require any Referrals and they cover the same types of procedures. What is different about each plan is the out-of-pocket cost to you. No matter which plan you choose, you may select between five levels of coverage: Employee Only, Employee & Child, Employee & Children, Employee & Spouse or Employee & Family coverage. You also have the option to waive medical coverage.

	$4,000 HDHP	$2,500 HDHP	PPO Copay Plan
In-Network	Calendar Year	Calendar Year	Calendar Year
Deductible (Individual/Family)	$4,000/$8,000	$2,500/$5,000	None
Coinsurance	100% After Deductible	100% After Deductible	100%
Out-of-Pocket Maximum	$6,650/$13,300	$6,650/$13,300	$6,600/$13,200
Primary Care Office Visit	Covered 100% after Ded.	Covered 100% after Ded.	$10 Copay
Specialty Office Visit	Covered 100% after Ded.	Covered 100% after Ded.	$20 Copay
Lab/Pathology	Covered 100% after Ded.	Covered 100% after Ded.	Covered 100%
Routine Radiology	Covered 100% after Ded.	Covered 100% after Ded.	$20 Copay
MRI/MRA, CT & PET Scans	Covered 100% after Ded.	Covered 100% after Ded.	$20 Copay
Emergency Room	Covered 100% after Ded.	Covered 100% after Ded.	$40 Copay
Inpatient Hospitalization	Covered 100% after Ded.	Covered 100% after Ded.	$75 per day to $375 Max
Outpatient Surgery	Covered 100% after Ded.	Covered 100% after Ded.	$75 Copay
Vision Reimbursement	Not Covered	Not Covered	Not Covered
Prescription Drug - Retail **Generic** **Brand Formulary** **Brand Non-Formulary** **Specialty** **Prescription Drug - Mail Order**	 $5 after Ded. $30 after Ded. $55 after Ded. $150 after Ded. 2 copays/90 Day Supply after Ded	 $5 after Ded. $30 after Ded. $55 after Ded. $150 after Ded. 2 copays/90 Day Supply after Ded	 $10 $20 $35 $150 2 copays/90 Day Supply
Out-of-Network			
Deductible (Individual/Family)	$5,000/$10,000	$5,000/$10,000	$5,000/$10,000
Coinsurance	50%	50%	50%
Out-of-Pocket Maximum	$10,000/$20,000	$10,000/$20,000	$10,000/$20,000

Should there be any discrepancies between the above summary and the actual plan contract(s), the Plan contract(s) supersedes this summary.

Embedded Deductible

The two High Deductible Health Plans have an embedded deductible. An embedded deductible is applicable when you are covering any dependents. Once an individual family member pays the individual deductible, insurance begins to pay for medical expense associated with the individual's services even if the family deductible has not been met.

QUALIFIED HIGH DEDUCTIBLE PLANS

Two of the medical plan options Brinker offers to you are Qualified High Deductible Plans (HDHP). Qualified High Deductible Plans are often referred to as consumer-centric plans. This means the consumer is financially motivated to take personal responsibility for maintaining good health and working to improve one's health. The first health expense(s) you incur will be out-of-pocket as you pay through the high deductible. When the first dollars are yours to spend for your care, studies show you will begin to look at your health care service needs like other consumer products and services; looking for the best providers, at a cost you understand and making lifestyle changes that maximize your personal health and minimize unnecessary use of the health care system.

HIGHLIGHTS OF QHDPs:

- Annual preventive/wellness exams are not subject to the deductible and are covered at 100% if services are received from a Personal Choice or Blue Cross and Blue Shield participating providers. Diagnostic office visits and hospital services will apply to your deductible.
- Prescription drugs are subject to the deductible. Once the deductible has been satisfied, prescriptions will be covered with the listed copays until the Out-of-Pocket maximum is met for the calendar year.
- If you remain in-network, you will benefit from Personal Choice's or Blue Cross and BlueShield contracts with their network providers. Only the discounted "allowable" charges will apply to your deductible, not the full bill.
- When selecting coverage under either of these HDHPs, you may be eligible to open a health savings account (HSA). (Please see Page 8 for HSA details).

MEDICAL INSURANCE PLAN

The following scenarios illustrate the amount of out-of-pocket expenses an individual would pay according to each medical plan option. For simplicity, each scenario assumes the member is enrolled in Employee Only coverage, and is using in-network providers; however, does not take into account any proscription drug expenses.

SCENARIO #1

Sally has a very active life. She usually goes to her primary care physician (PCP) once a year for her routine physical and recommended screenings. In January, her PCP recommended she have some moles removed from her back. She had an outpatient service at her PCP's office in February. Following is an estimate of Sally's out-of-pocket costs:

	$4,000 HDHP	$2,500 HDHP	PPO Copay Plan
1. PCP Office Visit			
a. Total Cost	$100	$100	$100
b. Sally's Cost*	$0	$0	$0
c. IA Paid	$100	$100	$100
2. Outpatient Surgery			
a. Total Cost	$700	$700	$700
b. Deductible/Copay Paid by Sally	$700	$700	$75
c. Coinsurance Paid by Sally	0	0	0
d. Coinsurance Paid by IA	0	0	100%
3. Total Paid by IA (1c+2d)	$100	$100	$626
4. Summary of Sally's Costs			
a. Medical Expenses (1b+2b+2c)	$700	$700	$75
b. Annual Premium	$1,023**	$1,301**	$3,329
c. Annual Brinker HSA Contribution	-$500	-$500	$0
5. Sally's Total Annual Cost (4a+4b+4c)	**$1,223**	**$1,501**	**$3,404**

**Routine preventive care is covered at 100% with no copayment.*

***Based on a monthly premium only - does not include contributions you might make to an HSA..*

MEDICAL INSURANCE PLANS

SCENARIO #2

Judy considers herself to be relatively healthy. This year she got a very bad cold that progressed to pneumonia. She saw her PCP two times while ill and had blood tests and a chest x-ray upon diagnosis and then additional blood tests and a chest x-ray once she was feeling better. Following is an estimate of Judy's out-of-pocket costs:

	$4,000 HDHP	$2,500 HDHP	PPO Copay Plan
1. PCP Office Visits (2)			
a. Total Cost	$400	$400	$400
b. Judy's Cost	$400	$400	$20*
c. IA Paid	0	0	$380
2. Lab & X-Ray (2)			
a. Total Cost	$1,200	$1,200	$1,200
b. Deductible/Copay Paid by Judy	$1,200	$1,200	$40
c. Coinsurance Paid by Judy	0	0	0
d. Coinsurance Paid by IA	0	0	$1,160
3. Total Paid by IA (1c+2d)	0	0	$1,160
4. Summary of Judy's Costs			
a. Medical Expenses (1b+2b+2c)	$1,600	$1,600	$60
b. Annual Premium	$1,012**	$1,301**	$3,329
c. Annual Brinker HSA Contribution	-$500	-$500	$0
5. Judy's Total Annual Cost (4a+4b+4c)	**$2,112**	**$2,401**	**$3,389**

**Based on two office visits at a $10 copayment per visit.*

***Based on a monthly premium only - does not include contributions you might make to an HSA..*

SCENARIO #3

Robert experienced sudden stomach pains and went to see his PCP. He was later hospitalized for three days with appendicitis that required surgery, additional services from a surgeon and an anesthesiologist. Following is an estimate of Robert's out-of-pocket costs:

	$4,000 HDHP	$2,500 HDHP	PPO Copay Plan
1. PCP Office Visit			
a. Total Cost	$150	$150	$150
b. Robert's Cost	$150	$150	$10
c. IA Paid	0	0	$140
2. Inpatient Hospitalization			
a. Inpatient Hospital Charges	$10,000	$10,000	$10,000
b. Inpatient Physician Services	$2,500	$2,500	$2,500
c. Anesthesiology	$1,000	$1,000	$1,000
d. Deductible Copay Paid by Robert	$4,000	$2,500	$225
e. Coinsurance Paid by Robert	0	0	0
f. Coinsurance Paid by IA	$9,500	$11,000	$13,275
3. Total Paid by IA (1c+2f)	$9,500	$11,000	$13,275
4. Summary of Robert's Costs			
a. Medical Expenses (1b+2d+2e)	$4,000	$2,500	$235
b. Annual Premium	$1,012*	$1,301*	$3,329
c. Annual Brinker HSA Contribution	-$500	-$500	
5. Robert's Total Annual Cost (4a+4b+4c)	**$4,512**	**$3,301**	**$3,564**

**Based on a monthly premium only - does not include contributions you might make to an HSA..*

HEALTH SAVINGS ACCOUNT (HSA)

An **HSA** is a tax-favored account used in conjunction with a **Qualified High Deductible Health Plan (QHDHP)** that allows you to contribute funds on a pre-tax or tax deducible basis. These funds may be used to pay for current and future eligible medical expenses. This means medical expenses during your deductible period, RX copays after your deductible, or any eligible dental or vision expenses not covered under those programs. Available HSA funds are based upon the HSA account balance.

What are the eligibility requirements to enroll in the HSA?

1. Must be enrolled in a Qualified High Deductible plan.
2. Cannot be covered by any other traditional health plan (spouse's FSA or Spouse's non-HDHP will make you ineligible for HSA).
3. Cannot be enrolled in Medicare, Medicaid, Tricare or VA benefits
4. Traditional Flexible Spending Accounts (FSAs) and Health Reimbursement Arrangements (HRAs) will make you ineligible for an HSA.

The money in your HSA is always yours - there is no "use it or lose it" rule. All amounts in your HSA are fully vested, and unspent balances in accounts remain in your account until spent. Your HSA account is portable too, meaning your money stays put even if you change jobs, change medical coverage, or move to another state.

In addition, HSA funds can be invested for greater earning potential, and they can be used to pay for qualified medical expenses in your retirement, and after age 65 for non-qualified expenses (subject to income tax). With an HSA, you are in charge. You decide how much you will contribute to your account, when you want to use your savings to pay for or reimburse yourself for qualified medical expenses, and whether or not to invest some of your savings for greater potential long-term growth.

The 2018 IRS contribution limits to an HSA are $3,450 for single plan coverage and $6,900 for family coverage. If you are 55 or older, you can make "catch-up" contributions, meaning you can deposit an additional $1,000 in the 2018 tax year.

HealthEquity

When you elect either of the two HDHPs with Brinker, you also have the option to enroll in a Health Savings Account (HSA) that will be administered by HealthEquity. Brinker will make an annual $500 deposit for the 2018 plan year.

Being as an HSA is a personal banking account, members may be subject to fees for items including paper statements, checks, non-sufficient funds, and to replace lost or stolen debit cards.

Use your HSA for Qualified Medical Expenses

HSA funds can be used for a variety of qualified medical, dental and vision expenses including:

- Acupuncture
- Chiropractor
- Contact lenses
- Dental treatment
- Prescription eyeglasses
- Fertility enhancement
- Hearing aids
- Lab work
- Medical supplies
- Prescriptions
- Orthodontia
- Radiology
- Stop-smoking programs
- Surgery (non-cosmetic)
- Therapy
- And more……

For an expanded list of qualified medical expenses, visit: HealthEquity.com/qme

MEDICAL PLAN CONTRIBUTIONS

If you choose to enroll in either of the two HDHP Options then Brinker Capital will contribute $500 a year to your HSA to help offset deductible medical expenses for 2018 only. If you choose not to enroll in Brinker's Medical plans, you will be eligible to receive the $1,000 Opt out contribution from Brinker.

	$4,000 HDHP	$2,500 HDHP	PPO Copay Plan
	Employee's Bi-Weekly Contribution	Employee's Bi-Weekly Contribution	Employee's Bi-Weekly Contribution
Employee	$38.93	$50.05	$128.03
Employee & Child	$57.90	$74.45	$198.47
Employee & Child(ren)	$83.22	$106.99	$285.23
Employee & Spouse	$89.58	$115.17	$294.58
Employee & Family	$114.42	$147.12	$374.45

BRINKER TOBACCO USE SURCHARGE

- Brinker is implementing a tobacco surcharge to focus on the significant impact of tobacco on employees' health and wellness.
- Benefits-eligible employees who use tobacco products will pay a $50/month or $23.07 per pay surcharge effective January 1, 2018.
- Tobacco products: cigarettes, cigars, chewing tobacco, pipe tobacco, snuff, dip, e-cigarettes or any similar tobacco-related product.
- During your 2018 open enrollment, you will be asked to certify whether or not you have used tobacco in the last three months. Employees certifying that they currently are and have been tobacco free for the previous three months will remain at the current discounted rates.
- Each employee is responsible for completing enrollment accurately.
- Any misrepresentation, intentional omission, misleading statements, or falsification of records is a violation of Brinker's Employment Practices and could result in collection of the applicable tobacco surcharge by the medical plan, and/or disciplinary action up to and including termination of employment.
- If you complete a program by April 30, 2018 and receive a reimbursement form Independence Administrators, please provide HR with the form and the fee will be waived for the 2018 plan year.

FLEXIBLE SPENDING ACCOUNTS (FSA)

Brinker Capital allows you to defer a portion of your pay though payroll deduction into Flexible Spending Accounts. The money that goes into an FSA is deducted on a pre-tax basis, which means it is taken from your pay before federal and social security taxes are calculated. Because you do not pay income taxes on money that goes into your FSA, you decrease your taxable income.

It is important that you estimate carefully. If you do not use all of the money in your accounts by the end of the plan year, Federal law requires you to forfeit any unused balances. You have up to 3 months after the plan year ends to submit qualified expenses for reimbursement incurred during the prior year.

Medical FSA: You may deposit up to **$2,650** per plan year into your Medical FSA to cover you and your dependents during the plan year. Eligible expenses include, but are not limited to, deductibles, co-payments and co-insurance payments, routine physicals, uninsured dental expenses, vision care expenses and hearing expenses.

Limited Flexible Spending Account (Limited FSA) Available to those employees enrolled in either of the HDHPs: The rules governing the Limited FSA are similar to the Medical FSA, with a few exceptions. The Limited FSA allows you to save a pre-determined amount each year on a tax-free basis, primarily for expense relating to your dental and vision services. You may also set aside funds in the Limited FSA for qualified medical expenses, in that you only need to reach the regulatory

deductibles first (rather than the medical plan deductibles). This way, you may spend Limited Flexible Spending savings for medical expense rather than using Health Savings Account dollars. The regulatory deductibles may change. For 2018, the individual/family regulatory deductibles are $1,350/ $2,700.

Many members enrolled in a HDHP won't require the use of a Limited FSA because the Health Savings Account may be used for medical, dental, and vision expenses. The Limited FSA is typically for families who will exhaust their HSA balances on medical expenses and expect additional dental and vision expenses in the same plan year.

Dependent Care FSA: You may deposit up to **$5,000** per plan year into Dependent Care FSA.

Establishing a Dependent Care FSA is a major advantage for families with day care expenses. Whether for your children (under age 13 or disabled and dependent on you for care) or elders in your care, paying these routine bills with pre-tax savings only makes sense. Eligible expenses for this plan are the cost of care for a dependent so you're able to work, search for work or attend school full time.

Examples of eligible expenses include nursery or day care, before and after school care, preschool tuition, day care camps and facilities (if not primarily for educational purposes), whether in or outside the home.

Although the "Use It or Lose It" rules do apply, there is a major difference in this plan compared to the medical flex spending accounts. This plan is not pre-funded. Expenses are only reimbursed up to the amount of savings accumulated in your account.

DENTAL BENEFITS

Good dental health is important to your overall well being. At the same time, we all need different levels of dental treatment. The Unum PPO dental plan provides affordable coverage based on the type of services obtained – **Preventive, Basic or Major** – whether or not you obtain services from a network or non-network provider.

Under this plan, you may obtain covered services from any dentist. However, if an out-of-network is used, reimbursement is based on the 90th percentile of charge. Employees who use dentists or dental specialists that are part of UCCI's Advantage Plus 2.0 Network *(participating Dental Provider)* will see reduced or eliminated out-of-pocket expenses.

Annual Maximum rollover:

Each year, you and the dependents on your policy can roll over up to $300 of unused benefit dollars to the next plan year - as long as each insured individual gets at least one dental exam during the plan year, and uses less than 50% of the annual maximum in coverage. You can accumulate as much as $1,200 in rollover dollars.

To find a provider, go to www.unumdental.com and click on "Find Providers" and select Advantage Plus 2.0 Network.

Dental Benefits Description	Unum/United Concordia Advantage Plus 2.0	
	In-Network	*Out-of-Network*
Calendar Year Deductible *(waived for preventive care)* Individual Family	 $50 $150	 $50 $150
Preventive Services Exams, Sealants, Fluoride Treatments, Teeth Cleaning	100%	100%
Basic Services Fillings, Extractions, General Anesthesia	80%	80%
Major Services Inlays & Onlays, Crowns, Dentures, Bridges & Periodontal	50%	50%
Orthodontia Services (dep children to age 19 only)	50%	50%
Annual Maximum per member	$2,500 *Per Year*	$2,500 *Per Year*
Lifetime Orthodontia Maximum	$1,000	$1,000

Employee Contributions	**Employee Bi-Weekly Per Pay Contribution**
Employee	$3.02
Employee + Child(ren)	$6.12
Employee + Spouse	$5.96
Family	$9.08

VISION BENEFITS

At Brinker, we are concerned with your overall health. That is why Brinker is offering a more robust freestanding vision plan not included in the medical plan.

Through this vision plan, you have coverage for routine eye exams, materials (including eyeglasses and contact lenses) and laser vision correction. You are free to see any provider, however, you will receive a higher level of benefit coverage should you receive your care from a participating provider. To obtain a list of in-network providers you can call (800) 507-3800 or go to www.superiorvision.com. Double click on the "Locate a Provider" tab - choose the "National" network.

Refractive Surgery

Superior Vision has a nationwide network of refractive surgeons and leading LASIK networks who offer members a discount. These discounts range from 15% - 50%, and are the best possible discounts available to Superior Vision.

The plan discount features are not insurance.

All allowances are retail; the member is responsible for paying the provider directly for all non-covered items and/or any amount over the allowances, minus available discounts. These are not covered by the plan.

Discounts are subject to change without notice.

Disclaimer: Al final determinations of benefits, administrative duties, and definitions are governed by the Certificate of Insurance for your vision plan. Please check with your Human Resources department if you have any questions.

Pennsylvania residents: Please contact our customer service department if you need assistance finding a provider within a reasonable distance (30 miles) of your residence. Adjustments to your benefits may be available.

Vision Benefits Description	Superior Vision	
	In-Network Member cost	*Out-of-Network Reimbursement*
Service Frequency Comprehensive Exam Spectacle Lenses Frames Contact Lenses in Lieu of Eye Glasses	Once every 12 months Once every 12 months Once every 24 months Once every 12 months	
Eye Exam	$10 copay	Up to $44 (Optometrist)
Materials (Lenses & Frames Only)	$25 copay	See Schedule
Contact Lens Fitting	$30 copay	Not Covered
Frames	$130 retail allowance	Up to $61
Contact Lenses (in lieu of eyeglasses & frame) Elective - All Other	$130 retail allowance	Up to $100

Employee Contributions	**Employee Bi-Weekly Per Pay Contribution**
Employee	$0.78
Employee + Child(ren)	$1.77
Employee + Spouse	$1.56
Family	$2.74

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Brinker Capital provides all employees regularly working 30 hours or more per week with Life and Accidental Death & Dismemberment (AD&D) Insurance at no cost to you.

Life and AD&D	
Purpose of Insurance	**Life Insurance** benefits paid to a beneficiary(ies) you designate in the event of your death. **AD&D** benefits paid to your beneficiary(ies) upon your accidental death or to you for a covered loss (use of a limb, eyesight or hearing).
Benefit Amount	**Class 1:** Employees earning over $100,000 = 1x Annual Salary to $250,000 plus Additional $10,000 Maximum **Class 2:** Employees earning less than $100,000 = 2x Annual Salary $250,000 plus Additional $10,000 Maximum
Reduction Schedule	Benefits reduce 75% at age 65, 50% at age 70. Please see SPD for exclusions and limitations.

VOLUNTARY LIFE INSURANCE

Active full-time employees regularly working at least 30 hours per week also have the option to purchase supplemental life coverage for yourself, as well as your dependents. Life insurance benefits are paid to a beneficiary(ies) you designate in the event of your death. You must be enrolled to cover dependents.

Employee: May purchase increments of $10,000 to maximum of $300,000
Spouse: May elect 50% of employee amount to maximum of $150,000
Child: You have the option of purchasing in units of $1,000 to $10,000.

Employee Guarantee Issue: $150,000*
Spouse Guarantee Issue: $10,000*
Child Guarantee Issue: All Guarantee Issue

* New for 2018 ONLY: Employees can elect up to the Guarantee issue with no Evidence of Insurability being required. After this open enrollment; If you do not enroll when you first become eligible for coverage, you will be considered a Late Entrant and will be required to complete an Evidence of Insurability Form and Cigna will then approve or deny your request.

DISABILITY

Your disability benefits provide you with a source of income in the event that you are not able to work due to an accident, illness or injury. Brinker Capital provides short- and long-term disability benefits to all eligible employees at no cost to the employee. Exclusions and limitations may apply. Please see the SPD for details.

Short-Term Disability *(STD)*: Your STD benefit equals 60% of your salary to a maximum of $1,000 per week. STD begins after a 7-day elimination period and will provide coverage up to 13 weeks.

Long-Term Disability *(LTD):* Your LTD benefit equals 60% of your monthly base earnings to a maximum benefit of $10,000 per month. This benefit begins on the 91st day of disability. The benefit duration while disabled is to Social Security Normal Retirement Age.

EMPLOYEE LIFE ASSISTANCE PROGRAM

Your Confidential Employee Assistance Program - Helping find balance between work and home life.

Brinker Capital is providing the Employee Assistance Program (EAP) to covered employees in connection with your group insurance to offer support, guidance and resources to help you and your family find the right balance between your work and home life.

Life Assistance Program

Call us anytime, any day.
We're just a phone call away whenever you need us, at no extra cost to you. An advocate can help you assess your needs and develop a solution. He or she can also direct you to community resources and online tools.

Visit a specialist.
You have three face-to-face sessions with a behavioral counselor available to you - and your household members. Call us to request a referral.

Reward yourself.
Access your Health Rewards discount program. You can get discounts on health and wellness products and services.

Achieve work/life balance.
If you'd like help handling life's demands, call us for extra support. We can refer you to a service in your community. Or provide guidance on topics such as:

- **Legal consultation.**
  Receive a free 30-minute consultation. And up to a 25% discount on select fees.
- **Parenting.**
  Get guidance on child development, sibling rivalry, separation anxiety and much more.
- **Senior care.**
  Learn how to solve the challenges of caring for an aging loved one.
- **Child care.**
  Whether you need care all day or just after school, find a place that's right for your family.
- **Pet care.**
  From grooming to boarding to veterinary services, find what you need to care for your pet.
- **Financial Services & Referral.**
  Receive a free 30-minute consultation and 25% discount on select fees with network providers.

Life Assistance Program - 24/7 support
800.538.3543
www.cignabehavioral.com/cgi

TRAVEL & ACCIDENT INSURANCE

Some employees of CBIZ are occasionally asked to travel on business away from their home office location. The company provides Travel & Accident Insurance to full-time employees with a Principal Sum of $500,000 with The Hartford.

You are covered for injuries sustained while on a business trip made on behalf of the company, excluding travel to and from work. Accidental Death & Dismemberment Insurance accompanies this benefit.

The business trip begins when you leave your residence or regular place of employment, whichever occurs last, for the purpose of going on a business trip. The trip ends when you return to your residence or regular place of employment. The term "on a business trip made on behalf of the company" means travel and sojourn authorized by or at the direction of the company.

No action is required on your part to enroll in this benefit. The beneficiary, in the case of a claim, is the same beneficiary you name for the group life insurance policy (in effect on the date of the accident).

TRAVEL ASSISTANCE AND ID THEFT PROTECTION SERVICES

Even the best planned trips can be full of surprises. The best laid travel plans can go awry, leaving you vulnerable and, possibly, unable to communicate your needs. When the unexpected happens far from home, it's important to know whom to call for assistance.

You and your family have access to Travel Assistance Services provided by Europ Assistance USA. With a local presence in 200 countries and territories around the world, and numerous 24/7 assistance centers, they are available to help you anytime, anywhere.

Good to go: Multilingual assistance 24/7. Whether you're traveling for business or pleasure, Travel Assistance services are available when you're more than 100 miles from home for 90 days or less. As long as you contact Europ Assistance USA at the time of need, you could be approved for up to $1 million in covered services.

Services from here to there. Travel Assistance begins even before you embark, with pre-trip information, and continues throughout your trip. See the list of services in the below chart.

Identity theft assistance, too. Identity theft America's fast growing crime, victimizes almost 10 million American consumers each year. Europ Assistance USA helps protect you and your family from its consequences 24/7, at home and when you travel.

TRAVEL ASSISTANCE AND ID THEFT PROTECTION SERVICES

Emergency Medical Assistance[6]	Pre-trip Information	Emergency Personal Services[7]	Identity Theft Assistance
• Medical referrals • Medical monitoring • Medical evacuation • Repatriation • Traveling companion assistance • Dependent children assistance • Visit by a family member or friend • Emergency medical payments • Return of mortal remains	• Visa and passport requirements • Inoculation and immunization requirements • Foreign exchange rates • Embassy and consular referrals	• Medication and eyeglass prescription assistance • Emergency travel arrangements • Emergency cash • Locating lost items • Bail advancement	• Prevention Services - Education - Identity Theft Resolution Kit • Detection Services - Fraud alert to three credit bureaus • Resolution Guidance and Assistance - Credit information review - ID Theft Affidavit Assistance - Card replacement • Personal Services - Translation - Emergency cash advance*

Have a serious medical emergency? Please obtain emergency medical services first (contact the local "911"), and then contact Europ Assistance USA to alert them to your situation.
Call: **1-800-243-6108** Collect from other locations: **202-331-1528** Fax: **202-331-1528**
Travel Assistance Identification Number: **GLD-09012**

COMPLIANCE NOTICES

Medicare Part D Notice

Important Notice from Brinker Capital About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Brinker Capital and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Brinker Capital has determined that the prescription drug coverage offered by **FutureScripts** 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 your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current **Brinker Capital** coverage may be affected. You may keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. See pages 7-9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/) which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current **Brinker Capital** coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with **Brinker Capital** and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

Medicare Part D Notice

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through **Brinker Capital** changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this 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).

Date:	**January 1, 2018**
Name of Entity/Sender:	**Brinker Capital**
Contact--Position/Office:	**Sharon Horvath**
Address:	**1055 Westlakes Drive, Suite 250, Berwyn, PA 19312**
Phone Number:	**(610) 640-6818**

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 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)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of August 10, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**KANSAS – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512
ALASKA – Medicaid	**KENTUCKY – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570
ARKANSAS – Medicaid	**LOUISIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**MAINE – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711
FLORIDA – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268	Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840
GEORGIA – Medicaid	**MINNESOTA – Medicaid**
Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507	Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739
INDIANA – Medicaid	**MISSOURI – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
IOWA – Medicaid	**MONTANA – Medicaid**
Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084

NEBRASKA – Medicaid	SOUTH CAROLINA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 1-402-473-7000 Omaha: 1-402-595-1178	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEVADA – Medicaid	**SOUTH DAKOTA - Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW HAMPSHIRE – Medicaid	**TEXAS – Medicaid**
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW JERSEY – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NEW YORK – Medicaid	**VERMONT– Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
NORTH DAKOTA – Medicaid	**WASHINGTON – Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
OKLAHOMA – Medicaid and CHIP	**WEST VIRGINIA – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://mywvhipp.com/ Phone: 1-855-MyWVHIPP (1-855-699-8447)
OREGON – Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
PENNSYLVANIA – Medicaid	**WYOMING – Medicaid**
Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
RHODE ISLAND – Medicaid	
Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347	

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/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, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020**)**

PART A: General Information

When key parts of the health care law take effect in 2014, there will be 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 new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that 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 that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for 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 that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Sharon Horvath at (610) 640-6818 or shorvath@brinkercapital.com.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Brinker Capital		4. Employer Identification Number (EIN) 22-2799756
5. Employer address 1055 Westlakes Drive, Suite 250		6. Employer phone number (610) 640-6818
7. City Berwyn	8. State PA	9. ZIP code 19312
10. Who can we contact about employee health coverage at this job? Sharon Horvath		
11. Phone number (if different from above)	12. Email address shorvath@brinkercapital.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☒ Some employees. Eligible employees are:

    All active full-time employees working 30 plus hours per week
- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:

    Legal spouse, domestic partner, and dependent child up to age 26
  - ☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

Brinker Capital

Notes: