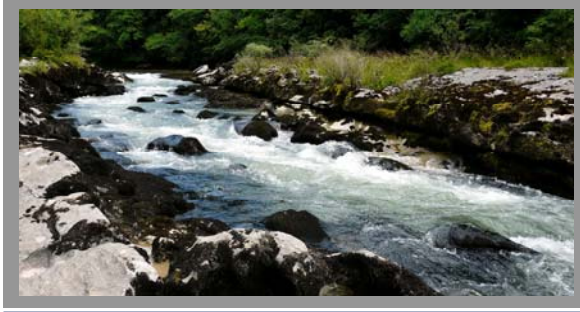
SCI Engineering, Inc.

2016 Employee Benefits Guide



Helping You Become a Better You.

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.

Table of Contents

SCI Engineering, Inc.

Contact Information

Contacts		
Vendors	**Member Services**	**Website**
Medical: *UnitedHealthcare* Group Number Traditional Plan: 2G1175 Group Number QHDHP: 2G1245	866.527.9597	myuhc.com
Dental: *MetLife* Group Number: 5933062	800.438.6388	metlife.com
Vision: *Vision Benefits of America* Group Number: 1756	800.432.4966	visionbenefits.com
Basic Life: *MetLife* Group Number: 5933062	800.438.6388	metlife.com
Voluntary Life: *MetLife* Group Number: 5933062	800.438.6388	metlife.com
Short-Term Disability: *MetLife* Group Number: 5933062	800.438.6388	metlife.com
Long-Term Disability: *MetLife* Group Number: 5933062	800.438.6388	metlife.com
Flexible Spending Account (FSA): *ASI Flex*	800.422.4661	asiflex.com
Benefits Team	**Phone**	**Email**
SCI Engineering, Inc.: *Julie Lynch - Human Resources*	636.757.1050	jlynch@sciengineering.com
CBIZ Benefits & Insurance Services: *Donna Clifton - Sr. Account Manager* *Eric File - Sr. Account Executive*	314.692.2249 314.692.5812 314.692.5848	dclifton@cbiz.com efile@cbiz.com

Reasons to Call	Who to Call
Claims Questions	Carrier / CBIZ
Identification Cards / Numbers	Carrier / CBIZ
Pre-Certification	Carrier
Provider Directories	Carrier Websites
If Drug Prescription is Denied	Provider / Doctor
Payroll Issues / Status Changes / Miscellaneous Issues	SCI Engineering

How to use this resource sheet for questions regarding a medical claim:

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

Understanding Your Plan Options

Employees of SCI Engineering, Inc. (SCI) who meet eligibility requirements are offered an employee benefit package which includes Medical, Dental, Vision, Basic Life / Accidental Death & Dismemberment (AD&D), Voluntary Life / AD&D, Short-Term Disability, Long-Term Disability, Flexible Spending Accounts and Identity Theft Protection.

SCI offers two medical plans administered by UnitedHealthcare. The Traditional PPO Plan is a benefits rich plan with lower deductibles for a higher premium. The Qualified High Deductible Health Plan (QHDHP) has a higher deductible for lower premiums. This plan gives you the option to open a Health Savings Account (HSA) to save funds to cover the medical expenses you may incur with the higher deductible.

The dental insurance offered through MetLife includes orthodontia benefits for children up to age 19. This benefit is provided to SCI employees at no cost.

As an employee of SCI, your vision benefits through Vision Benefits of America (VBA) are offered to employees at no cost.

Basic Life / AD&D, short-term and long-term disability benefits are offered by MetLife and are benefits that SCI pays for their employees. Employees may purchase additional life through MetLife for themselves, spouse, and child(ren).

Identity Theft Protection from Legal Shield is a voluntary benefit offered to employees. Using identity theft protection is a way to protect your personal information from being misused.

This Benefit Guide provides a brief summary of all SCI's benefit plans along with the rates based upon the coverage you select. You will also find notices and other important information in this guide.

WHAT CAN I DO TO KEEP MY MEDICAL COSTS DOWN?

Use Network doctors and facilities

- Check myuhc.com to find network providers near you.
- Ask your provider if they participate in the UnitedHealthcare Choice Plus network
- Before you have any procedure, be sure to talk to your doctor or the facility to which you are referred to be sure they are in-network.
- If you are balance-billed by an out-of-network provider, contact them and ask if they will lower the charge if you set up a payment plan.

Understand your benefits

- Always review your health plan documents to fully understand your benefits. If you are not sure, contact UnitedHealthcare customer service at the phone number on the back of your ID card.

Ask the provider about their fees before you receive services

- You can ask about fees before you receive services or pharmacy benefits. Contracted fees are not the same for all providers. You have the right to ask before you receive services so you are aware of what your expenses will be. This may not always be possible, however, when it is...ask.
- To estimate and compare costs, you can also go online at myuhc.com and look for "Estimate Health Plan Costs".

Get the most out of your insurance by using in-network providers.

Eligibility

WHO CAN YOU ADD TO YOUR PLAN:

Eligible:

- Your legal spouse
- Your or your spouse's child who is under age 26
- Legally adopted child or a child placed for adoption
- Child for which you or your spouse is the legal guardian
- A disabled child who is unmarried and over age 26
- A child for whom health care coverage is required through a Qualified Medical Child Support Order or other court order.

Ineligible:

- A common law spouse
- Divorced or legally separated spouse
- Foster children
- Sisters, brothers, parents, or in-laws, grandchildren, etc.

Frequently Asked Questions

ARE CHANGES TO MY PLAN ALLOWED DURING THE YEAR?

Generally, you may only enroll in the plan, or make changes to your benefits during the re-enrollment period or when you are first hired. However, you can make changes/enroll during the plan year if you experience a qualifying event. As with a new enrollee, you must have your paperwork turned in within 31 days of the qualifying event or you will have to wait until the next annual open enrollment period. Premiums and enrollment eligibility may change; see your Human Resources department for details.

EXAMPLES OF QUALIFYING EVENTS?

- Your dependents or you lose health coverage because of loss of eligibility or loss of employer contributions
- You get married, divorced, or legally separated (with court order)
- You have a baby or adopt a child
- You or your spouse take an unpaid leave of absence
- Death of an insured member
- Gain or loss of Medicaid entitlement
- You become eligible for Medicare

HOW ARE NEWBORNS COVERED?

SCI's medical plan covers newborns for up to the first 4 days. Coverage is based upon the Federal law, The Mother's and Newborns' Health Protection Act. This law requires coverage for a 48-hour inpatient hospital stay for natural birth or 96-hour inpatient stay for cesarean section. If coverage beyond the 48 or 96 hours is wanted, the newborn must be enrolled within the first 30 days. If the medical coverage for a newborn is elected under a spouse's plan, coordination of benefits will take place which will determine if the SCI's or a spouse's plan will be the primary payer.

WHAT IF I USE AN OUT-OF-NETWORK PROVIDER?

It is important to ask if your medical provider is a participant of the UnitedHealthcare Choice Plus Network. If your provider is not a participating provider, your claim may be processed based upon what Medicare allows. Non-network claims may be based upon 175% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service. Non-network benefits are then applied to the eligible charges. This means you may be balance-billed for non-eligible charges.

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 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 his 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.

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 THORUGH A VIRTUAL VISIT

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

ACCESS TO VIRTUAL VISITS

Log in to **myuhc.com** and choose from provider sites where you can register for a virtual visit. After registering and requesting a visit, you will pay the primary care visit copay for the UnitedHealthcare Traditional PPO Plan and the deductible for the QHDHP.

Medical Insurance

UnitedHealthcare - Plan Designs

Features	Traditional PPO Plan		Qualified High Deductible Health Plan (QHDHP) HSA Eligible*	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible (Individual / Family)	$500 / $1,000	$1,000 / $2,000	$2,600 / $5,200	$5,000 / $10,000
Coinsurance	80%	60%	100%	80%
Out-of-Pocket Maximum (Individual / Family)	$4,500 / $9,000	$10,000 / $20,000	$5,000 / $10,000	$10,000/ $20,000
Office Visit Co-Pay (Primary Care physician / Specialist)	$30 / $50	60% After the Deductible	$30 / $60 After the Deductible	80% After the Deductible
Preventive Care	100% Deductible Does Not Apply	60% After the Deductible	100% Deductible Does Not Apply	80% After the Deductible
Inpatient Hospital Outpatient Surgery	80% After the Deductible	60% After the Deductible	100% After the Deductible	80% After the Deductible
Lab, X-Ray (Outpatient)	100% Deductible Does Not Apply	60% After the Deductible	100% After the Deductible	80% After the Deductible
Major Diagnostics (CT, PET, MRI, MRA, & Nuclear Medicine)	80% After the Deductible	60% After the Deductible	100% After the Deductible	80% After the Deductible
Emergency Room	$150 Co-Pay	$150 Co-Pay	$300 Co-Pay After the Deductible	80% After the Deductible
Urgent Care	$75 Co-Pay	60% After the Deductible	$75 Co-Pay After the Deductible	80% After the Deductible
Prescription Drug *Retail* *Mail Order (90-Day Supply)*	Tier 1/Tier 2/Tier 3 $10/$30/$50 $25/$75/$125	Tier 1/Tier 2/Tier 3 $10/$30/$50 Not Covered	Tier 1/Tier 2/Tier 3 $10/$30/$50 $25/$75/$125	Tier 1/Tier 2/Tier 3 $10/$30/$50 Not Covered

* If you elect the QHDHP, you may also participate in the Health Savings Account (HSA). SCI will contribute $1,000 for individual and $2,000 for family coverage to your HSA on an annual basis. The SCI contribution is divided and paid on a per pay period basis.

Per Paycheck Employee Cost

Type of Coverage	Traditional PPO Plan	QHDHP
Employee	$61.34	$30.41
Employee & Spouse	$208.14	$130.76
Employee & Child(ren)	$175.24	$112.51
Employee & Family	$339.96	$203.73

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. For 2016, **SCI will contribute $1,000 for individual and $2,000 for family coverage to your HSA on an annual basis.** The employee contribution levels for 2016 are $2,350 for single coverage and $4,750 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.

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

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

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

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 as an alternative.

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 primary care physician office visit copays and/or deductible/coinsurance.

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.

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.

To find an in-network Convenience Care Center near you, visit 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.

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.

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 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.

EMERGENCY ROOM

If you think you or your loved one may be experiencing an emergency medical condition, you should go to the nearest emergency room or call 911. Emergency services are always considered at the in-network benefit level.

An emergency medical condition is any condition (including severe pain) which you believe that without immediate medical care may result in:

- Serious jeopardy to your or your loved one's health, including the health of a pregnant woman or her unborn child
- Serious impairment to your or your loved one's bodily functions
- Serious dysfunction of any of your or your loved one's bodily organ or part

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 obtain care at an emergency room, you will likely pay more out-of-pocket than if you were treated at your doctor's office, a Convenience Care Center or Urgent Care facility.

*If you receive treatment for an emergency in a non-network facility, you may be transferred to an in- network facility once the condition has been stabilized.

PRESCRIPTION DRUG 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 SCI, 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.

PREVENTIVE CARE

Certain preventive services will be covered without charging a deductible, copayment, or coinsurance when these services are provided by a **network provider**. The types of preventive services covered are defined by federal law and can vary based on your age, gender, and health status. There may be services you had in the past that will now be covered as preventive at no cost to you. The preventive services included in this provision are described at healthcare.gov. Another important website to review preventive care information is cdc.gov/vaccines.

Dental Insurance

MetLife Plan Design

Coverage Type	In-Network	Out-of-Network
Individual Deductible:	$50	$50
Family Deductible:	$150	$150
Type A - Preventive Exams X-Rays Cleanings (2 in 12 months) Fluoride (To Age 19)	100%	100%
Type B - Basic Procedures Sealants (To Age 19) Fillings Root Canal Periodontal Oral Surgery (Extractions)	90%	80%
Type C - Major Services Crowns/Inlays/Onlays Repairs Bridges Dentures Implants	60%	50%
Type D - Orthodontia (Child Only to Age 19)	50% to $1,500 Lifetime Max.	50% to $1,500 Lifetime Max.
Maximum Benefit/Year	$1,500	$1,500

Dental Per Pay Period Employee Cost

Coverage	Cost
Employee Only	$0.00
Family	$32.64

Vision Insurance

Vision Benefits of America Plan Design

Coverage Type	In-Network	Out-of-Network
Examination Co-Pay	$5	Reimbursed up to: $35
Lenses: Single Bifocal Trifocal Lenticular	$25 Co-Pay 100% 100% 100% 100% (add'l copay's may apply)	Reimbursed up to: $30 $40 $60 $80 (less applicable co-pay)
Frames	$25 Co-Pay $125 Allowance	Reimbursed up to: $40 (less applicable co-pay)
Contacts: Necessary Cosmetic	$25 Co-Pay UCR $140	Reimbursed up to: $300 $140 (less applicable co-pay)

Frequency of Service:	
Exam	Every 12 Months
Lenses	Every 12 Months
Frames	Every 24 Months

Vision Per Pay Period Employee Cost

Coverage	Cost
Employee Only	$0.00
Employee + 1	$2.38
Family	$4.34

Basic Life and AD&D

SCI provides Basic Life and Accidental Death & Dismemberment coverage at no cost to you through MetLife. Your benefit is one times your annual salary to a maximum of $50,000.

Coverage for your spouse and dependent child(ren) is also provided in the amount of $2,500 for your spouse and $1,000 for each child.

Voluntary Life / AD&D

During your initial enrollment period you have the opportunity to purchase additional life insurance for yourself, your spouse, and/or dependent child(ren) through MetLife. You cannot cover your spouse or dependent child (ren) unless you elect coverage for yourself. You may elect coverage up to the guaranteed issue amount without providing evidence of insurability, which is a statement of health. Guaranteed issue does not apply if you are over the age of 70 for initial coverage. Evidence of insurability is required for any amount of coverage, if you are over the age of 70. Coverage above the guaranteed issue must be approved by MetLife before it goes into effect.

EMPLOYEE COVERAGE

Employees may elect coverage in increments of $10,000 subject to a maximum of the lesser of 5 times your salary or $500,000. Coverage maximum if you are age 70 or older is $50,000. Guaranteed Issue: $100,000 if you are under age 70.

MONTHLY EMPLOYEE COST	
Age Band	**Employee & Spouse Rate per $1,000**
Under 30	$.067
30-34	$.077
35-39	$.097
40-44	$.147
45-49	$.227
50-54	$.417
55-59	$.677
60-64	$.797
65-69	$1.41
70+	$3.50
Child	$.248 Per $1,000

SPOUSE COVERAGE

Spousal coverage is available in $5,000 increments not to exceed 50% of the employee amount up to a maximum of $100,000. Spouse rates are based upon the employee's age. Guaranteed Issue: $30,000 if you are under age 70; Spouse coverage terminates when you reach age 70.

CHILDREN

Coverage is available for your child(ren) up to age 19 or 25 if they are a full-time student. Coverage options are $1,000, $2,000, $4,000, $5,000 or $10,000 not to exceed spouse benefit amount. The amount you select is for each child you cover. The cost is based upon the family unit and not each child. Guarantee issue does not apply to child coverage. Coverage for a child age 14 days to 6 months is $250.

HOW TO CALCULATE VOLUNTARY PREMIUM

$\frac{\$50{,}000}{\text{Elected Coverage}} \div 1{,}000 = \frac{50}{\text{Units}} \times \frac{\$0.227}{\text{Rate}} = \frac{\$11.35}{\text{Per Month Cost}}$

* See Note

*The premium calculation is based upon the life rate for an employee age 45.

REMEMBER: You must use the employee's age to calculate the spouse's premium.

Short-Term Disability

In the event you are unable to work because you have suffered an illness or injury, SCI provides, at no cost to all active, full-time employees, a short-term disability plan. This plan, through MetLife, covers 66 2/3% of your weekly income up to a maximum benefit of $1,000 per week.

Coverage will begin on the 8th day due to a sickness, or as a direct result of an accidental injury. You must be receiving appropriate care and treatment determined by your physician as necessary to treat the sickness or injury and comply with the requirements of such treatment.

Long-Term Disability

SCI provides, at no cost to all active, full-time employees, a long-term disability plan. This benefit through MetLife provides you with a percentage of your earnings while you are deemed disabled and unable to earn a living.

After being deemed totally disabled by the treating physician for 180 days, you are eligible to receive up to 60% of your monthly salary to a monthly maximum of $5,000. An additional benefit of 10% is available if you participate in an approved rehabilitation program. Benefits are payable for up to two years if you are disabled from your own occupation. If you are disabled and unable to perform any occupation, you are eligible to receive benefits up to age 65, or Social Security Normal Retirement Age (SSNRA). If you are disabled due to a nervous and mental condition, benefits are limited to two years.

If you received medical treatment (including prescription drugs), consultation or medical care during the three months prior to becoming eligible for the long-term disability benefits and then become disabled, you are subject to the pre-existing condition limitation of the contract. You may not be eligible for benefits under this plan until you satisfy the conditions of the contract. Please refer to the MetLife benefit information for more details.

This plan allows a one-time lump sum payment of three months of benefit in the event you pass away while receiving benefits under the plan. This survivor benefit is payable to the beneficiary on file.

Flexible Spending Accounts (FSAs)

A Flexible Spending Account allows an employee to set aside a portion of earnings to pay for qualified expenses as established in the cafeteria plan, most commonly for medical expenses but often for dependent care or other expenses. Money deducted from an employee's pay into an FSA is not subject to payroll taxes, resulting in substantial payroll tax savings.

TYPES OF ACCOUNTS

MEDICAL REIMBURSEMENT 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 contribute to a Health Savings Account (HSA).

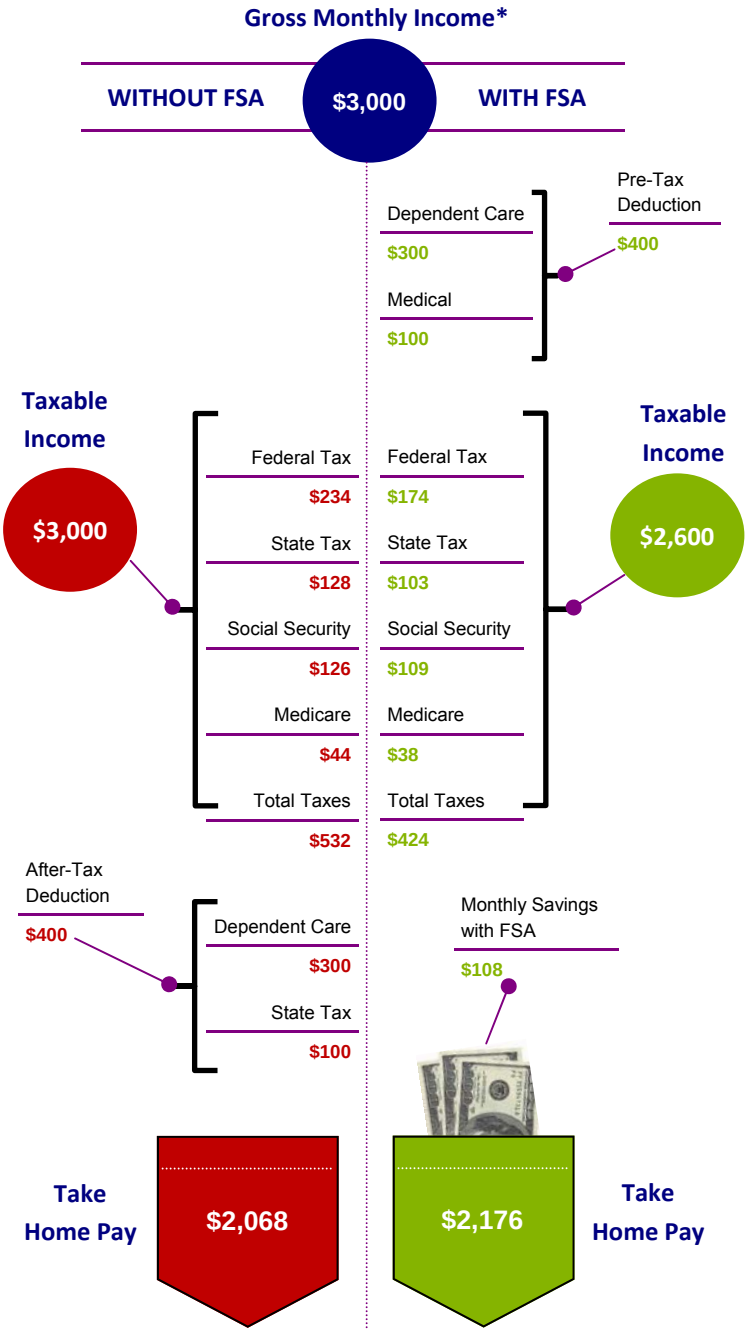
IRS rules do not allow you to contribute to a health savings account (HSA) if you are covered by any non-qualifying health plan, including a general-purpose health FSA

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 Supplements (medically necessary)
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	

DEPENDENT CARE REIMBURSEMENT 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.

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.

HOW THE ACCOUNT WORKS

If you decide to participate in the FSA you should carefully consider the amount you elect to deduct from your paycheck.

You will be able to enroll on-line for the Flexible Spending Account (FSA) plan. Instructions will be sent to all employees via email.

Online Access: asiflex.com

Go Mobile: Participants can access account information 24/7 with the ASIflex mobile app. Available at asiflex.com, Google Play or the App Store.

Identity Theft Protection

It can be very challenging when your identity has been stolen, leaving you helpless as you deal with the aftermath of the theft. SCI offers identity theft protection through Legal Shield. This is a voluntary benefit and will be paid through payroll deduction.

The cost to enroll in the Identity Theft Protection Plan for employee and spouse is $5.98 per pay period. For an additional $1.00 per month, you can cover your child(ren) up to the age of 26.

The Legal Shield Identity Theft Shield Plan includes: Credit Report, Continuous Monitoring, Consultation and Restoration Services.

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.

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.

Notice of Privacy Practices

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

Marketplace Options

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

General Information

When key parts of the health care law took effect in 2014, there was a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate

options for you and your family, this notice provides some basic information about the Marketplace and employment -based health coverage offered by SCI.

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 SCI 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)

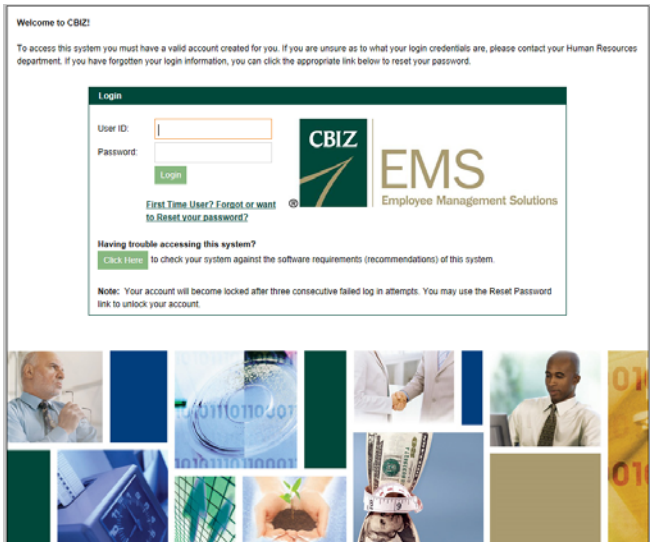
TTY users: 1-800-486-2048. If you have limited income and resources, visit Social Security on their website at socialsecurity.gov, or call them at 1-800-772-1213. TTY users: 1-800-325-0778.

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).

How to Enroll

Enrolling on the web is a fast and easy way to get the benefits you want. This means you can enroll in and review your benefit information from work, home, the library, or anywhere you can access the internet 24 hours a day, seven days a week. **All employees and new hires MUST enroll whether or not you are electing benefits.** Any choices made during this enrollment will override any previous elections.

TO GET STARTED



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

ONCE YOU ARE IN THE SYSTEM

- When you start the enrollment process, you will be asked to review your demographic information and report any changes.
- You will then be asked to provide the Name, Home Address, Social Security Number and Date of Birth for **ALL** of your dependents.
- Then, you will be directed through several screens that will provide information on all of your benefit plan options.
- **You will be required to provide your beneficiary information for the Employer Provided Life and AD&D and any elected Voluntary Life coverage, this includes the SSN of your beneficiaries.**

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

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.