FROST

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# 2016 Employee Benefits Guide



LED EVOLUTION

FROST GREEN CHOICE

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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 plan documents shall govern.

# 2016 Benefits Guide

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# CONTACT INFORMATION

| Contact Information | | |
|---|---|---|
| **Vendors** | **Phone Number** | **Website** |
| Aetna *(Medical)*<br>Group Number: | Call the toll-free number on the back of your ID card. | www.aetna.com |
| Aetna (Dental)<br>Group Number: | Call the toll-free number on the back of your ID card. | www.aetna.com |
| VBA (Vision)<br>Group Number: 3612 | Toll Free (800) 432-4966 | www.visionbenefits.com |
| Aetna *(Life/AD&D)*<br>Group Number: | Toll Free (800) 523-5065 | www.aetna.com |
| Aetna *(Voluntary Life/AD&D)*<br>Group Number: | Toll Free (800) 523-5065 | www.aetna.com |
| Lincoln *(STD)*<br>Group Number: 10190988 | Toll Free (800) 423-2765 | www.lfg.com |
| Lincoln *(LTD)*<br>Group Number: 10190987 | Toll Free (800) 423-2765 | www.lfg.com |
| H&H Health Associates *(EAP)* | (314) 845-8302<br>Toll Free (800) 832-8302 | www.hhhealthassociates.com |
| Aflac | Toll Free (800) 99-Aflac | www.aflac.com |
| CBIZ *(HRA, HSA & FSA)* | Toll Free (800) 815-3023, press 4 | myplans.cbiz.com |
| CBIZ *(COBRA Services)* | Toll Free (800) 815-3023, press 6 | enroll.cbiz.com |

| **Benefits Team** | **Phone** | **Email** |
|---|---|---|
| Frost HR Service Team | (314) 995-5517<br>Toll Free (877) 634-6235<br>Fax (866) 399-0412 | FrostHR@cbiz.com |
| Consultant<br>Sara R. Miller<br>Karen Grasso | (314) 692-2249<br>Toll Free (800) 844-4510 | samiller@cbiz.com<br>kgrasso@cbiz.com |

# ENROLLING IN THE PLANS

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

- Read your materials and make sure you understand all of the options available.
- Log in to **cbizems.com** using your *UserID* and *Password* by the date provided by Frost HR.
- Under the *Change Events* section, click *Begin Event*.
- Follow the onscreen instructions to complete enrollment. Use the *Save & Continue* button to move to the next screen.
- Review and confirm your elections and information. If accurate, click *Save & Confirm Elections*. If you need to make a change, select the screen you wish to return to in the *Steps* list.
- Print your confirmation statement for your records.

For help with completing the form, or if you have any questions regarding the benefits offered, please contact the Frost Human Resources Department.

**IMPORTANT NOTE:**

It is very important that you complete your enrollment by the due date provided by Frost HR. If you do not complete your enrollment by that date, you will, by default, waive your rights to the company sponsored group benefits.

# ELIGIBILITY

**Joining the Plan:**

If you are a Frost new hire, please contact Frost HR to review the waiting period requirements for each benefit. You will be provided the date on which your coverage becomes effective.

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

**WHO CAN YOU ADD TO YOUR PLAN:**

**Eligible:**

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

**Ineligible:**

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

# FREQUENTLY ASKED QUESTIONS

### ARE CHANGES TO MY PLAN ALLOWED DURING THE YEAR?

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

### EXAMPLES OF QUALIFYING EVENTS?

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

### HOW OFTEN ARE BENEFIT DEDUCTIONS TAKEN FROM MY PAYCHECK?

Payroll deductions will be based on 24 pay periods. The months in which you have a 3rd paycheck, the 3rd payroll will not have deductions for benefits except for 401(k) contributions, Holiday Savings Plan, or United Way.

# PRE-NOTIFICATION INFORMATION

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

# AETNA PROVIDERS

With Aetna's Find a Doctor online tool, it's simple to look for medical providers in your area.

1. Go to aetna.com
2. At the top of the page, select Find a Doctor.
3. Click on "A plan offered by my employer…"
4. Select the type of provider you want to search for.
5. Input your zip code or city and state.
6. Select the Aetna Choice POS II (Open Access) plan.

Remember, regardless of the medical plan option you choose, the provider network is the same.

# MEDICAL PLAN IMPORTANT FEATURES

- You have the opportunity to choose the in network deductible that best fits your family needs.
- All other plan features in the Base and H.R.A Plans remain the same regardless of the deductible you choose. In the QHDHP Option, all services apply to the deductible first; and there are no copays in this plan.
- The deductible and out of pocket maximums are based on a Plan Year. This means these benefit features start over at $0 every June 1st.
- All medical plan co-pays, coinsurance, deductibles, and prescription drug co-pays accumulate towards the out of pocket maximums.

Remember, you have a choice on where to go for care.

- Doctor's Office—Manage your overall health
- Convenience Care Clinic—non-urgent visits when your doctor is not available
- Urgent Care Center—non-emergency visits when your doctor is not available
- Emergency Room—serious or critical visits

# MEDICAL INSURANCE—QHDHP Option ($3,000 Ded)

| Benefit Plan | QHDHP Option In-Network | QHDHP Option Out-of-Network |
|---|---|---|
| **Deductible** (plan year) | | |
| Single | $3,000 | $6,000 |
| Family | $6,000 | $12,000 |
| **Coinsurance** (plan pays/you pay) | | |
| | 100% / 0% | 80% / 20% |
| **Out-of-Pocket Limit** (including the deductible + coinsurance) | | |
| Single | $3,000 | $12,000 |
| Family | $6,000 | $24,000 |
| **Copayments** | | |
| Primary Physician Visit | Deductible, then you pay 0% | Deductible, then you pay 20% |
| Specialist Physician Visit | Deductible, then you pay 0% | Deductible, then you pay 20% |
| Preventive Care | Plan pays 100% | Deductible, then you pay 20% |
| Major Diagnostic Lab | Deductible, then you pay 0% | Deductible, then you pay 20% |
| Emergency Room Visit | Deductible, then you pay 0% | In Network Ded., then you pay 0% |
| Urgent Care Center Visit | Deductible, then you pay 0% | Deductible, then you pay 20% |
| **Prescription Drug Coverage** | | |
| Retail Pharmacy | Deductible, then you pay 0% | Deductible, then you pay 20% |
| Mail Order Pharmacy | Deductible, then you pay 0% | Not Covered |

## 2016 Employee QHDHP Option Medical Contributions

| Employee Semi-Monthly Cost | Previous 2015 Cost | New 2016 Cost |
|---|---|---|
| Employee | $46.15 | $45.89 |
| Employee & Spouse | $216.41 | $243.16 |
| Employee & Child(ren) | $199.66 | $203.49 |
| Employee & Family | $294.04 | $300.62 |

# HEALTH SAVINGS ACCOUNT (HSA)

### WITH THE ELECTION OF THE AETNA QHDHP OPTION FOR YOUR INSURANCE COVERAGE, YOU MAY ALSO OPEN AN HSA

**What is an HSA?**

A savings account set up by either you or your company where you can either direct pre-tax payroll deductions or deposit money to be used by you to pay for current or future medical expenses for you and/or your dependents. Once money goes into the account, it's yours forever - the HSA is in your name, just like a personal checking or savings account.

**Why would I want an HSA?**

Because you fund the HSA with pre-tax money, you are using tax-free funds for healthcare expenses you would normally pay for out-of-pocket using after-tax dollars. Your HSA contributions do NOT count toward your taxable income for federal taxes.

### WHAT RULES MUST I FOLLOW?

- You must be covered under a Q*ualified High Deductible Health Plan (QHDHP)* in order to establish an HSA.
- You cannot establish an HSA if you or your spouse also have a medical *flexible* spending account (FSA).
- You cannot set up an HSA if you have insurance coverage under another plan, for example your spouses employer, unless that secondary coverage is also a qualified high deductible health plan.
- You cannot be enrolled in Medicare.
- You cannot be claimed as a dependent under someone else's tax return.

### WHAT IS THE DIFFERENCE BETWEEN A 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 and coinsurance first. This would include office visits that are not preventive, emergency room visits, and prescription drugs. You will, however, still have the opportunity to benefit from the discounts associated with using a network physician or facility.

### WHAT ELSE DO I NEED TO KNOW?

- Contributions are based on a calendar year. For 2016, the contribution limits are $3,350 for Single and $6,750 for Family coverage. You cannot put more than this amount in the account; you can put less.
- The contributions from your paycheck are tax-free, grow tax-free, and come out tax-free as long as you utilize the funds for approved services. (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 subject to a 20% excise tax penalty (like in an IRA account).
- Once you turn 65, become disabled and/or qualify for Medicare, you can use the account for other purposes without paying the 20% penalty but you will pay income taxes.
- The savings account can be established with Anthem, so you can take advantage of payroll deductions on a pre-tax basis.

*(A welcome kit will be mailed to your attention from a bank when you express an interest in opening and contributing to an H.S.A.)*

**Another advantage is that your account can grow over time.**

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

**The HSA is also an investment opportunity.**

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

**Generally, you can put enough in your HSA to cover most of your deductible**.

The Qualified High Deductible Health Plan helps you pay for healthcare AFTER you meet the deductible. The annual contribution limit is based on IRS rules. In general, the total amount that goes in your account each year can't be more than the IRS annual contribution limit. If you're age 55 or older, you are allowed to make an extra $1,000 catch-up contribution each year.

**You can spend only the money that is actually in your Health Savings Account.**

If your healthcare expenses are more than your HSA balance, you need to pay the remaining cost another way, such as cash or personal check. You can request reimbursement after you have accumulated more money.

**You can use your HSA for your spouse and dependents – even if they are not covered by your High Deductible Health Plan.**

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

- Doctor's office visits
- Dental services
- Eye exams, eyeglasses, contact lenses and solution, and laser surgery
- Hearing aids
- Orthodontia, dental cleanings, and fillings
- Prescription drugs
- Physical therapy, speech therapy, and chiropractic expenses

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

Every time you use your HSA, save your receipt in case the IRS asks you to prove your claim was for a qualified expense. If you use HSA funds for a non-qualified expense, you will pay tax and a penalty on the ineligible amount.

# MEDICAL INSURANCE—Base Plan ($3,000 Ded)

| Benefit Plan | Base Plan In-Network | Base Plan Out-of-Network |
|---|---|---|
| **Deductible** (plan year) | | |
| Single | $3,000 | $6,000 |
| Family | $6,000 | $12,000 |
| **Coinsurance** (plan pays/you pay) | | |
| | 80% / 20% | 50% / 50% |
| **Out-of-Pocket Limit** (including the deductible + coinsurance + copayments) | | |
| Single | $6,350 | $12,500 |
| Family | $12,700 | $25,000 |
| **Copayments** | | |
| Primary Physician Visit | $30 co-pay | Deductible, then you pay 50% |
| Specialist Physician Visit | $60 co-pay | Deductible, then you pay 50% |
| Preventive Care | Plan pays 100% | Deductible, then you pay 50% |
| Major Diagnostic Lab | Deductible, then you pay 20% | Deductible, then you pay 50% |
| Emergency Room Visit | $300 co-pay | $300 co-pay |
| Urgent Care Center Visit | $100 co-pay | Deductible, then you pay 50% |
| **Prescription Drug Coverage** | | |
| Retail Pharmacy | $12/40/65 | Deductible, then you pay 50% |
| Mail Order Pharmacy | $30/100/162.50 | Not Covered |

## 2016 Employee Base Plan Medical Contributions

| Employee Semi-Monthly Cost | Previous 2015 Cost | New 2016 Cost |
|---|---|---|
| Employee | $46.15 | $46.36 |
| Employee & Spouse | $216.41 | $246.10 |
| Employee & Child(ren) | $199.66 | $205.51 |
| Employee & Family | $294.04 | $303.68 |

## MEDICAL INSURANCE—H.R.A Plan ($2,000 Ded)

| Benefit Plan | H.R.A Plan In-Network | H.R.A Plan Out-of-Network |
|---|---|---|
| **Deductible** (plan year) | | |
| Single | $2,000 | $6,000 |
| Family | $4,000 | $12,000 |
| **Coinsurance** (plan pays/you pay) | | |
| | 80% / 20% | 50% / 50% |
| **Out-of-Pocket Limit** (including the deductible + coinsurance + copayments) | | |
| Single | $6,350 | $12,500 |
| Family | $12,700 | $25,000 |
| **Copayments** | | |
| Primary Physician Visit | $30 co-pay | Deductible, then you pay 50% |
| Specialist Physician Visit | $60 co-pay | Deductible, then you pay 50% |
| Preventive Care | Plan pays 100% | Deductible, then you pay 50% |
| Major Diagnostic Lab | Deductible, then you pay 20% | Deductible, then you pay 50% |
| Emergency Room Visit | $300 co-pay | $300 co-pay |
| Urgent Care Center Visit | $100 co-pay | Deductible, then you pay 50% |
| **Prescription Drug Coverage** | | |
| Retail Pharmacy | $12/40/65 | Deductible, then you pay 50% |
| Mail Order Pharmacy | $30/100/162.50 | Not Covered |

## 2016 Employee H.R.A Plan Medical Contributions

| Employee Semi-Monthly Cost | Previous 2014 Cost | New 2015 Cost |
|---|---|---|
| Employee | $92.94 | $88.03 |
| Employee & Spouse | $303.66 | $287.76 |
| Employee & Child(ren) | $287.16 | $247.18 |
| Employee & Family | $381.23 | $345.34 |

# HEALTH REIMBURSEMENT ACCOUNT (HRA)

Remember, this process only applies to you if you elect to participate in the **H.R.A Plan** with the $2,000 deductible option for yourself and the $4,000 deductible option for your dependents.

### Step 1

Present your Medical ID card to your Aetna provider at the time of service.

### Step 2

The provider sends the claim detail to Aetna where the network discount is deducted from the total charges. The benefits are applied to the remaining amount and an Explanation of Benefits (EOB) is generated and sent to both the provider and the patient.

### Step 3

When the in network deductible is applied to a claim, fax a copy of the EOB along with a completed CBIZ reimbursement form to (877) 634-6236.

Once the elected deductible amount is completely satisfied, CBIZ will begin reimbursing you until the maximum in network deductible ($3,000/$6,000) has been satisfied.

# HRA CONTACT INFORMATION

Phone Number: (800) 815-3023 (press 4 for Flex Dept)

Hours of Operation: 8:00 a.m. to 8:00 p.m. ET (Monday thru Friday)

Web Access: www.myplans.cbiz.com (provides 24 hour access to your account information)

Claims Address: CBIZ Flex, 310 First Street, Ste. 600, Roanoke, VA 24011

Claims Fax Number: (877) 634-6236 (All claims received by Wednesday at 5:00 p.m. ET will be processed by Friday of the same week.)

# PRESCRIPTION BENEFITS

Most prescriptions are filled right away when you take them to the pharmacy. However, some drugs need to be reviewed by Aetna 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 and reduced claims expense for Frost and potentially lower future renewal increases.

Some prescription drugs are covered only if the physician obtains prior authorization from Aetna. In addition, coverage for some drugs is provided in limited quantities and duration.

This is only a brief summary of benefits. The Certificate, issued when coverage is approved for the group, contains program details, and will, in all cases, have control over any information in this summary. The certificate is available upon request.

# PREVENTIVE CARE

Certain preventive services will be covered without charging a deductible, 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 www.healthcare.gov.

# WOMEN'S PREVENTIVE CARE COVERAGE

Your health plan will provide first dollar coverage for certain women's preventive coverage without any cost sharing requirements (co-payment, coinsurance or deductible), when delivered by in network providers. This includes 100% coverage for FDA-approved tier 1 contraceptive methods for women when filled at an in network pharmacy.

# SUMMARY OF MATERIAL MODIFICATION

Frost has amended the Frost Electric Supply, Inc. Medical Plan. This benefit guide contains a summary of the modifications that were made. It should be read in conjunction with the Summary Plan Description or Certificate of Coverage, which is available to you once it has been updated by the carriers. If you need a copy, please submit your request to the Frost HR Team.

# DENTAL INSURANCE

## Aetna Voluntary Dental

| Benefit/Service | DMO In-Network | PPO In-Network | PPO Out-of-Network |
|---|---|---|---|
| Preventive | See | 100% | 80% |
| Basic | Aetna | 80% | 80% |
| Major | Copayment | 50% | 50% |
| Ortho | Schedule | 50% | 50% |
| **Deductibles & Maximums** | | | |
| Office Visit Copayment | $15 | N/A | N/A |
| Deductible Individual * | N/A | $50 | $75 |
| Deductible Family * | N/A | $150 | $225 |
| Annual Maximum Per Person | Unlimited | $1,000 | |
| Lifetime Orthodontia Maximum ** | $2,400 Copay (Adult & Child) | $1,000 (Child Only) | |

* The deductible applies to: Basic & Major services only.

## 2016 Employee Dental Contributions

| Semi-Monthly Employee Cost | DMO/PPO |
|---|---|
| Employee | $11.27 |
| Employee Plus One | $22.03 |
| Employee Plus Family | $40.87 |

**This is your one time opportunity to enroll without waiting periods! If you decline to participate in the dental coverage when first eligible and want to join at a later date, you will be subject to waiting periods for most services!**

***Freedom of Choice***—In addition to the PPO plan option you are used to using, you also now have a DMO option to choose from. The DMO option works just like the old medical HMO. You are required to select a Primary Care Dentist (PCD) when you enroll. The PCD will give you a referral to any specialist with the exception of an orthodontist.

Benefits of the DMO include:

⇒ No deductible

⇒ No annual maximum—unlimited benefits!

⇒ Adult and child orthodontia

*Because the contribution is the same for both plans, members can move between the DMO and PPO as often as Monthly! Simply call customer service before the 15th of the month for the change to be effective the next month.*

### How do I find a dentist in my area?

Finding a dentist is easy!

Click on this link: http://www.aetna.com/docfind/home.do?site_id=docfind&langpref=en&tabKey=tab5&fromDse=fromDse to access the online directory.

DMO Network = DMO/DNO
PPO Network = Dental PPO/PDN with PPO II

*The PCD office number you need to enroll in the DMO Plan is located above the provider's name.*

**Out-of-Network Services**

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

# VISION INSURANCE

## VBA Voluntary Vision

| Benefit/Service | In-Network | Out-of-Network Benefit |
|---|---|---|
| Examination | $0 Co-pay | $40 reimbursement |
| Frequency of Service: | | |
| Exam | Every 12 months | |
| Lenses | Every 12 months | |
| Frames | Every 24 months | |
| Lenses: | $0 Co-pay then: | Reimbursement: |
| Single | 100% | $40 |
| Bifocal | 100% | $60 |
| Trifocal | 100% | $80 |
| Frames | Covered 100% up to $50 Wholesale ($125—$150 Retail) | $50 |
| Contacts: | | Reimbursement |
| Necessary | Covered at 100% | $320 |
| Cosmetic | $160 Allowance | $160 |

Vision Benefits of America (VBA) maintains a network of more than 16,000 participating Optometrists, Ophthalmologists and Retail Locations nationwide to provide professional vision care for persons covered under this plan.

Select a VBA Participating Provider in your area. When scheduling an appointment, please notify the VBA provider that your vision coverage is administered by VBA. The provider will contact VBA to verify eligibility via on-line system and will process services received electronically.

To access a list of participating providers and to verify your benefit eligibility prior to visiting your eye care provider, please visit www.visionbenefits.com or call (800) 432-4966.

Discounts on LASIK services are also available.

## 2016 Employee Vision Contributions

| Vision Employee Cost | Semi-Monthly |
|---|---|
| Employee | $3.00 |
| Employee Plus One | $5.70 |
| Employee Plus Two or More | $7.80 |

# BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

This benefit is paid by Frost for all benefit eligible employees. It is administered through Aetna. In the event of your death, your beneficiary will receive $15,000. The Accidental Death and Dismemberment (AD&D) benefit is equal to your basic group life insurance benefit. Benefit reductions apply upon attaining certain age levels.

# VOLUNTARY LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Your Voluntary Life/AD&D is administered through Aetna as well. An equal amount of AD&D coverage may also be purchased when you elect voluntary life. You must purchase voluntary life on yourself in order to purchase coverage for your spouse and dependent children.

| VOLUNTARY LIFE/AD&D EMPLOYEE CONTRIBUTION (Rates are per month) | |
|---|---|
| **Age Band** | **Employee/Spouse Rate per $1,000*** |
| Under 30 | $0.09 |
| 30-34 | $0.11 |
| 35-39 | $0.15 |
| 40-44 | $0.23 |
| 45-49 | $0.36 |
| 50-54 | $0.60 |
| 55-59 | $0.97 |
| 60-64 | $1.27 |
| 65-69 | $1.99 |
| 70+ | $3.49 |
| **Vol. AD&D** | |
| Employee Only | $0.021/$1,000 |
| Employee & Family | $0.027/$1,000 |
| **Child Life** | $0.082/$1,000 |

***Spouse rates are based on the employee's age**

Employees can purchase the lesser of 5 x Salary or $500,000 of coverage in $10,000 increments. The Guarantee Issue amount for newly eligible employees is $150,000.

Spousal coverage is available in $5,000 increments not to exceed 100% of the employee amount up to a maximum of $500,000. The Guarantee Issue amount for newly eligible spouses is $30,000. Children up to age 19, or 25 if a full-time student, can purchase coverage in $1,000 increments up to a $10,000 maximum.

**Please note:** You or your spouse may increase existing amounts of life insurance coverage up to 1 increment on a guaranteed acceptance basis during each subsequent annual open enrollment period, provided the additional amount does not exceed the Guarantee Issue amount. If you did not elect voluntary life coverage when first eligible, you will be required to complete an Evidence of Insurability form and be approved by Aetna before you will be able to purchase coverage.

Benefit reductions apply upon attaining certain age levels.

You also have the ability to purchase voluntary Accidental Death & Dismemberment (AD&D) coverage for yourself and your dependents. The voluntary AD&D coverage must match the amount of voluntary life purchased for the employee. If family voluntary AD&D is purchased, the spouse benefit amount is 50% of the EEs amount (40% if Child is included); and the child benefit amount is 15% of EEs amount (10% if Spouse is included).

## VOLUNTARY SHORT TERM DISABILITY

Short term disability is intended to protect your income for a short duration in case you become ill or injured.

Beginning on the 15th day of an illness or injury, you are eligible to receive 60% of your weekly income to a maximum of $1,500 through Lincoln Financial. The maximum benefit period is 11 weeks. (The weekly income benefit is subject to a 3/12/12 pre-existing condition limitation.)

| VOL. SHORT TERM DISABIILTY MONTHLY RATES | |
|---|---|
| **Age Band** | **Employee Monthly Rate per $10** |
| Under 25 | $0.20 |
| 25-29 | $0.21 |
| 30-34 | $0.20 |
| 35-39 | $0.21 |
| 40-44 | $0.24 |
| 45-49 | $0.27 |
| 50-54 | $0.31 |
| 55-59 | $0.39 |
| 60-64 | $0.48 |
| 65-69 | $0.54 |
| 70+ | $0.54 |

## VOLUNTARY LONG TERM DISABILITY

Long term disability is intended to protect your income for a long duration after you have depleted short term disability or any sick leave your company may offer.

After the 90th day of an illness or injury, you may be eligible for long term disability benefits through Lincoln Financial. The disability benefit changes to a monthly benefit and covers 60% of your monthly salary to a maximum of $5,000. The duration of this benefit is based upon the extent of your disability and contact maximums. (This monthly income benefit is subject to a 3/12/12 pre-existing condition limitation.)

The monthly rate for this benefit is $0.43 per $100 of monthly covered payroll.

## VOLUNTARY WORKSITE BENEFITS

Aflac offers voluntary products that are used to compliment your medical benefits by helping you cover your expenses until your deductible is satisfied. These products are eligible for pre-tax payroll deductions.

**Accident Indemnity**—This plan helps you cover your out of pocket expenses associated with an accident. Cash benefits are paid directly to you based on a schedule.

**Critical Care & Recovery**—Specific Health Event Policy includes, but is not limited to: Coma, Paralysis, Stroke, Heart Attack, Intensive Care, Transplants, etc.

**Cancer Indemnity**—While major medial insurance can help with the costs of cancer treatment, you may still have out of pocket expenses that are not covered by your major medical insurance, including travel, food, lodging, child care and household help. Includes coverage for surgical and non-surgical treatment for cancer, including Hospice Care.

These Aflac plans have pre-existing condition waivers and terms. For Aflac coverage(s) employees must meet with an Aflac representative to complete your application. These plans are portable. Please contact Frost HR if you have any questions.

# EMPLOYEE ASSISTANCE PROGRAM (EAP)

Through our EAP contract with our service provider, H&H Health Associates (H&H), you and your eligible dependents can receive confidential assistance with personal and work/life concerns.

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

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

H&H is an independent firm that specializes in providing professional counseling services through highly qualified, licensed behavioral health practitioners. H&H professionals answer calls 24 hours a day, seven days a week. H&H's telephone number is 314-845-8302 or 1-800-832-8302. When you call the EAP, an H&H representative will answer any questions you have and set up an appointment for you. Please visit the H&H website for additional information at www.hhhealthassociates.com.

## MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) OFFER FREE OR LOW-COST HEALTH COVERAGE TO CHILDREN AND FAMILIES

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

For a listing of the states that offer assistance please contact Frost HR. You can also contact:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

# FLEXIBLE SPENDING ACCOUNTS (FSAs)

The FSAs have a plan year of January 1st to December 31st.

### TYPES OF ACCOUNTS

**SECTION 125 MEDICAL SPENDING ACCOUNT:** This account enables you to pay with pre-tax dollars any medical, dental, vision, and prescription and non-prescription (used to treat personal injuries or sickness only) 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).

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

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

### ACCOUNT STATEMENTS

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

### HOW THE ACCOUNT WORKS

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

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

# FLEXIBLE SPENDING ACCOUNTS (FSAs) - con't

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

## ELIGIBLE EXPENSES

Below is a partial list of eligible expenses that can be reimbursed from a Section 125 Medical Account. Other out-of-pocket expenses may qualify.

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