PLANNING / RENEWAL MEETING

July 8, 2015

VERSA-TAGS™

QUALITY ▪ SERVICE ▪ DEPENDABILITY

CBIZ Benefits & Insurance Services has been and will continue to be committed to acting in our client's best interest by providing services and products that meet our client's needs as communicated to CBIZ. From time to time, CBIZ may participate in agreements with one or more insurance companies or third party vendors, in connection with the insurance related transactions, to received additional compensation or consideration. These compensation arrangements are provided to CBIZ as a result of the performance and expertise by which products and services are provided to the client and may result in enhancing CBIZ's ability to access certain markets and services on behalf o CBIZ clients. More information regarding these agreements and the consideration received pursuant to these agreements is available upon written request.

VERSA-TAGS, INC.
HEALTH INSURANCE ANALYSIS
Effective Date: October 1, 2015

Current & Renewal

FEATURES:	UNITED HEALTHCARE					
	Base Plan - E9J, 2V		Buy Up - E9C, 2V		Enriched - E94, 2V	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Individual Deductible	$1,500	$4,500	$500	$1,500	$1,000	$3,000
Family Deductible	$3,000	$9,000	$1,000	$3,000	$2,000	$6,000
Co-Insurance	80%	50%	80%	50%	100%	70%
Out of Pocket Maximum: (Deductible, Coinsurance & Copayment)						
Individual:	$6,250	$12,500	$6,250	$12,500	$4,000	$8,000
Family:	$12,500	$25,000	$12,500	$25,000	$8,000	$16,000
Lifetime Maximum Benefit:	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Office Visits (PCP/SCP):	$35/70 Co-Pay	50% after Deductible	$25/70 Co-Pay	50% after Deductible	$25/50 Co-Pay	70% after Deductible
Preventative Care Services:	100%	50% after Deductible	100%	50% after Deductible	100%	70% after Deductible
Lab & X-Ray:	80% after Deductible	50% after Deductible	100%	50% after Deductible	100%	70% after Deductible
Major Diagnostics:	$400 Co-Pay	50% after Deductible	80% after Deductible	50% after Deductible	100% after Deductible	70% after Deductible
Emergency Services:						
Urgent Care	$100 Co-Pay	50% after Deductible	$100 Co-Pay	50% after Deductible	$100 Co-Pay	70% after Deductible
Emergency Room:	$300 Co-Pay then 80%		$300 Co-Pay		$300 Co-Pay	
Hospital Inpatient Stay:	80% after Deductible	50% after Deductible	80% after Deductible	50% after Deductible	100% after Deductible	70% after Deductible
Outpatient Surgery:	80% after Deductible	50% after Deductible	80% after Deductible	50% after Deductible	100% after Deductible	70% after Deductible
Prescription Drug Coverage:	*at Participating In Network Pharmacies*		*at Participating In Network Pharmacies*		*at Participating In Network Pharmacies*	
Tier One	$10 Co-Pay		$10 Co-Pay		$10 Co-Pay	
Tier Two	$35 Co-Pay		$35 Co-Pay		$35 Co-Pay	
Tier Three	$60 Co-Pay		$60 Co-Pay		$60 Co-Pay	
Tier Four	N/A		N/A		N/A	
Mail Order Drug Coverage: for a 90 Day Supply:	$25/87.50/150 Co-Pay		$25/87.50/150 Co-Pay		$25/87.50/150 Co-Pay	

RATES:	E9J	E9C	E94	Current	Renewal	Current	Renewal	Current	Renewal
Employee Only	17	7	2	$428.65	$462.51	$473.68	$511.10	$523.53	$564.89
Employee + Spouse	7	1	2	$857.30	$925.02	$947.36	$1,022.20	$1,047.06	$1,129.78
Employee + Child(ren)	8	1	0	$750.14	$809.40	$828.94	$894.43	$916.18	$988.56
Employee + Family	14	1	2	$1,178.75	$1,271.86	$1,302.58	$1,405.48	$1,439.66	$1,553.40
Total:	46	10	6	$35,791.77	$38,619.05	$6,394.64	$6,899.81	$6,020.50	$6,496.14
					7.9%		7.9%		7.9%
Employee Only Total:				$19,717.90	$21,275.46	$4,736.80	$5,111.00	$3,141.18	$3,389.34
Dependent Only Total:				$16,073.87	$17,343.59	$1,657.84	$1,788.81	$2,879.32	$3,106.80
Monthly Total:				$35,791.77	$38,619.05	$6,394.64	$6,899.81	$6,020.50	$6,496.14

Total Current Premium	**Total Renewal Premium**
$48,206.91	$52,015.00
Percentage Difference:	**7.9%**

The above outline is for illustration purposes only. It is not intended to provide specific definitions of the plan's coverage or to determine if specific claims are eligible for payment.

UNITED HEALTHCARE
CLAIMS UTILIZATION FOR VERSA-TAGS, INC.

CUSTOMER NUMBER 000008P9047

MEMBERSHIP OVERVIEW

EMPLOYEES	= 62	RENEWAL DATE	= 10/01/2015
MEMBERS	= 150	MEDICAL PRODUCT	= POS-SIGNATURE POS

PERCENTAGE OF MEMBERS UTILIZING THE PLAN = 79%

MEMBER AGE DISTRIBUTION
- AGES 0-19 = 48
- AGES 20-34 = 33
- AGES 35-49 = 39
- AGES 50-64 = 29
- AGES 65+ = 1

*NETWORK PAID CLAIMS	= 100%	ELECTRONIC SUBMISSIONS	= 99%
*OUT OF NETWORK PAID CLAIMS	= 0%	PAPER SUBMISSIONS	= 1%

OFFICE VISITS		INPATIENT TREND	
# OF CLAIMS	= 746	# OF CLAIMS	= 8
URGENT CARE VISITS		OUTPATIENT TREND	
# OF CLAIMS	= 1	# OF CLAIMS	= 216
EMERGENCY ROOM VISITS		PHARMACY TREND	
# OF CLAIMS	= 6	# OF CLAIMS	= 609

CATASTROPHIC CLAIMS >=$50K = 0

GROUPS = 0008P8027 0008P8462 0008S8074

Versa-Tags, Inc.

United Healthcare

Group Information -- Missouri Mandate

Service Dates		Members	Paid Claims	Claim Count	Paid per Claim
10/1/2014	4/30/2015	149	$263,716	1,546	$170.58
10/1/2013	9/30/2014	151	$281,701	2,469	$114.10
Annualized					
10/1/2014	4/30/2015	149	$452,085	2,650	$170.58
10/1/2013	9/30/2014	151	$281,701	2,469	$114.10
Increase					
10/1/2014	4/30/2015		60.5%	7.3%	49.5%
10/1/2013	9/30/2014				

UnitedHealthcare

Medical Proposed Rates with Alternate Plan Designs

Customer Name: VERSA-TAGS, INC.
Medical Policy: 008P9047
Renewal Date: October 1, 2015

• The numbers below are on an illustrative basis. Rates are subject to Underwriting approval.

	Option 1: Current E9J (MCP1-Copay) Rx Plan: 2V	Option 2: Current E94 (MCP1-Copay) Rx Plan: 2V	Option 3: Current E9C (MCP1-Copay) Rx Plan: 2V
Plan Name			
Product	Choice + Insurance *	Choice + Insurance *	Choice + Insurance *
Option	008P8027	008P8462	008S8074
Plan Offering	Multiple Option	Multiple Option	Multiple Option
Multiple Option with:	Option(s) <enter #(s)>	Option(s) <enter #(s)>	Option(s) <enter #(s)>
HRA or HSA	No	No	No
Benefits*	**Network Single/Family**	**Network Single/Family**	**Network Single/Family**
Office Copay (PCP/SPC)	PCP $35, SPC $70	PCP $25, SPC $50	PCP $25, SPC $70
Hospital Copays	OP N/A, IP N/A	OP N/A, IP N/A	OP N/A, IP N/A
UC/ER/Major Diag Copay	C $100, ER $300+Copay, Maj Diag $4(	UC $100, ER $300, Maj Diag N/A	UC $100, ER $300, Maj Diag N/A
Other	ENRP	ENRP	ENRP
Deductible	$1500/$3000 (Emb)	$1000/$2000 (Emb)	$500/$1000 (Emb)
Coinsurance	80%	100%	80%
Out-of-Pocket	$6250/$12500	$4000/$8000	$6250/$12500
Pharmacy	2V - $10/35/60; 2.5x for M.O.	2V - $10/35/60; 2.5x for M.O.	2V - $10/35/60; 2.5x for M.O.
	Out of Network Single/Family	**Out of Network Single/Family**	**Out of Network Single/Family**
Deductible	$4500/$9000 (Emb)	$3000/$6000 (Emb)	$1500/$3000 (Emb)
Coinsurance	50%	70%	50%
Out of Pocket	$12500/$25000	$8000/$16000	$12500/$25000
Enrollment			
Employee	17	2	7
Employee + Spouse	7	2	1
Employee + Child(ren)	8	0	1
Employee + Family	14	2	1
Total	46	6	10

	Rates (Billed)		Rates (Billed)		Rates (Billed)	
Rates	Current	Proposed	Current	Proposed	Current	Proposed
Employee	$428.65	**$462.51**	$523.53	**$564.89**	$473.68	**$511.10**
Employee + Spouse	$857.30	**$925.02**	$1,047.06	**$1,129.78**	$947.36	**$1,022.20**
Employee + Child(ren)	$750.14	**$809.40**	$916.18	**$988.56**	$828.94	**$894.43**
Employee + Family	$1,178.75	**$1,271.86**	$1,439.66	**$1,553.40**	$1,302.58	**$1,405.48**
Monthly Cost	$35,792	**$38,619**	$6,021	**$6,496**	$6,395	**$6,900**
Annual Cost	$429,501	**$463,429**	$72,246	**$77,954**	$76,736	**$82,798**
Change from Current	**7.9%**		**7.9%**		**7.9%**	

**High level benefit summary. Please see your plan summary for more detailed benefit description.*

The numbers above are on an illustrative basis. Rates are subject to Underwriting approval.

For markets moving to service fees, current rates (applicable for renewals only) include commission expenses. Proposed rates, for your convenience, include any applicable producer service fees. Producer service fees are not a contingency of obtaining insurance coverage but are fees agreed to between you (client) and your producer/service provider for service rendered on behalf of client.

For markets continuing to pay commissions, both the current (applicable for renewals only) and proposed rates include commissions.

UnitedHealthcare

Medical Quote Assumptions

Customer Name: VERSA-TAGS, INC.
Medical Policy: 008P9047
Renewal Date: October 1, 2015

The rates quoted here are based on the following assumptions. Changes to these assumptions may result in an adjustment to rates.

Medical Quote Assumptions

- Rates are guaranteed for the contract period of 10/1/15 through 9/30/16.
- Rates are based on your submitted census. UnitedHealthcare reserves the right to adjust the rates from audit date back to effective date if any of the following changes:
  - Enrollment +/- 10%
  - Average Contract Size +/- 10%
  - Area Factor +/- 7.5%
  - Age/Sex Factor +/- 10%
  - Any Material Changes
  - Cobra enrollees are more than 10% of enrollment
- Employer contributes a minimum of 75% toward the employee only rates and 75% toward the dependent rates.
- Requires a minimum participation level of 75%.
- Unless otherwise stated, this offer replaces and renders all previous offers null and void.
- Rates Assume: No OOA; No Retirees nor Part-time Employees; Standard Riders Only; Calendar Year Deductible and OOP.
- Multichoice is a pre-packaged product of plan designs. Only plan designs within a package can be offered to an employer and their employees.
- If quoting UHC Marketplace (UHCM), a $2.50 per eligible employee charge, not reflected in the quoted rates, will be applied to the premium.
- Renewal includes ENRP. ENRP affects non-emergency services provided by an out of network physician or other healthcare professional at a network hospital, facility or ambulatory surgery center. ENRP also affects emergency services provided by an out of network provider at any hospital, facility or freestanding emergency room. For emergencies, the affected services could include all types of providers: physicians, other health care professionals, and facilities.

UnitedHealthcare reserves the right to adjust the rates and/or fees (i) in the event of any changes in federal, state or other applicable legislation or regulation; (ii) in the event of any changes in Plan design required by the applicable regulatory authority (i.e. mandated benefits) or by the Plan Sponsor; and (iii) as otherwise permitted in our policy.

This premium includes state and federal taxes and fees, including the Insurer Fee (about 3% of premium) and the Reinsurance Fee (about $3 per member per month) under the Affordable Care Act. These estimates will vary based on renewal date and state reinsurance fees.

Premium rates and/or product forms included herein are subject to approval by regulators. If rates or product forms offered herein are subsequently modified by regulators we will immediately advise you of the change in plan design and retroactively adjust premium in subsequent billings.

Plan design and corresponding premium rates offered herein represent a coverage option that is consistent with your current group size (based on most recent census or survey information) and closely matches your current coverage. Additional coverage options may be available to you.

At your request, a service fee to be paid to your producer/service agent of 3.00% has been added as an expense item in sites where service fees apply.

Agents may receive commissions and other compensation from us and these costs may be reflected in your premium or fee. Separately, you may have contracted with producers to provide services directly for your group and have agreed to pay them a 'service fee'. Since 'service fees' are not a contingency of the purchase of health insurance such fees are not part of your premium but may be included in your bill under total amount due.

Health Plan Product Offering

UnitedHealthcare Multi-Choice® allows you to purchase one health plan package with multiple benefit design options (can choose up to 5 plans) to meet a variety of health care and financial needs. Your employees can choose the option that meets their individual needs, whether it's saving money on essential coverage or paying additional dollars for more comprehensive coverage. And you can keep or change your benefit design package year after year, ensuring that your health plan will evolve with the changing needs of your business and your employees.

Missouri
51-99 Eligible Employees
Effective 01/01/2015

Standard Choice Plus Plans

Plan Code	Plan Type	Co-insurance		Deductible				Out-of-Pocket Maximum				Co-pay/Per Occurrence				Deductible Type[5]
		Network	Out of Network	Network		Out of Network		Network		Out of Network		PCP[1]	Spec	Urgent Care	ER[4]	
				Single	Family	Single	Family	Single	Family	Single	Family					
E9-2	Standard	100%	70%	$500	$1,000	$1,500	$3,000	$4,000	$8,000	$8,000	$16,000	$20	$40	$100	$250	Emb
E9-3	Standard	100%	70%	$500	$1,000	$1,500	$3,000	$6,250	$12,500	$12,500	$25,000	$25	$70	$100	$300	Emb
E9-4	Standard	100%	70%	$1,000	$2,000	$3,000	$6,000	$4,000	$8,000	$8,000	$16,000	$25	$50	$100	$300	Emb
E9-5	Standard	100%	70%	$1,500	$3,000	$4,500	$9,000	$4,000	$8,000	$8,000	$16,000	$25	$50	$100	$300	Emb
E9-6	Standard	100%	70%	$2,000	$4,000	$6,000	$12,000	$4,000	$8,000	$8,000	$16,000	$25	$50	$100	$300	Emb
E9-7	Standard	100%	70%	$2,500	$5,000	$7,500	$15,000	$4,000	$8,000	$8,000	$16,000	$25	$50	$100	$300	Emb
E9-8	Standard	100%	70%	$3,000	$6,000	$9,000	$18,000	$6,250	$12,500	$12,500	$25,000	$25	$70	$100	$300	Emb
E9-A	Standard	100%	70%	$5,000	$10,000	$10,000	$20,000	$6,250	$12,500	$12,500	$25,000	$25	$70	$100	$300	Emb
E9-D	Standard	80%	50%	$500	$1,000	$1,500	$3,000	$4,000	$8,000	$8,000	$16,000	$30	$60	$100	$300	Emb
E9-C	Standard	80%	50%	$500	$1,000	$1,500	$3,000	$6,250	$12,500	$12,500	$25,000	$25	$70	$100	$300	Emb
E9-F	Standard	80%	50%	$1,000	$2,000	$3,000	$6,000	$4,000	$8,000	$8,000	$16,000	$30	$60	$100	$300	Emb
E9-E	Standard	80%	50%	$1,000	$2,000	$3,000	$6,000	$6,250	$12,500	$12,500	$25,000	$25	$70	$100	$300	Emb
E9-I	Standard	80%	50%	$1,000	$2,000	$3,000	$6,000	$6,250	$12,500	$12,500	$25,000	$40	$80	$100	$300+80%	Emb
E9-J	Standard	80%	50%	$1,500	$3,000	$4,500	$9,000	$6,250	$12,500	$12,500	$25,000	$35	$70	$100	$300+80%	Emb
E9-K	Standard	80%	50%	$2,000	$4,000	$6,000	$12,000	$6,250	$12,500	$12,500	$25,000	$35	$70	$100	$300+80%	Emb
E9-L	Standard	80%	50%	$2,500	$5,000	$7,500	$15,000	$6,250	$12,500	$12,500	$25,000	$35	$70	$100	$300+80%	Emb
E9-M	Standard	80%	50%	$3,000	$6,000	$9,000	$18,000	$6,250	$12,500	$12,500	$25,000	$35	$70	$100	$300+80%	Emb
E9-G	80/50/50[16]	80%	50%	$500	$1,000	$1,500	$3,000	$5,000	$10,000	$10,000	$20,000	$25	$50	$100	$300	Emb
E9-H	80/50/50[16]	80%	50%	$1,000	$2,000	$3,000	$6,000	$6,250	$12,500	$12,500	$25,000	$25	$70	$100	$300	Emb
E9-N	FlexPoint[6]	80%	50%	$1,500	$3,000	$4,500	$9,000	$6,250	$12,500	$12,500	$25,000	$35	$70	$100	80%	Emb
E9-O	FlexPoint[6]	80%	50%	$2,000	$4,000	$6,000	$12,000	$6,250	$12,500	$12,500	$25,000	$35	$70	$100	80%	Emb
E9-P	FlexPoint[6]	80%	50%	$2,500	$5,000	$7,500	$15,000	$6,250	$12,500	$12,500	$25,000	$35	$70	$100	80%	Emb
E9-Q	FlexPoint[6]	80%	50%	$3,000	$6,000	$9,000	$18,000	$6,250	$12,500	$12,500	$25,000	$35	$70	$100	80%	Emb
E9-R	FlexPoint[6]	80%	50%	$5,000	$10,000	$10,000	$20,000	$6,250	$12,500	$12,500	$25,000	$35	$70	$100	80%	Emb
E9-T	Consumer	80%	50%	$2,000	$4,000	$6,000	$12,000	$6,250	$12,500	$12,500	$25,000	80%	80%	80%	80%	Emb
E9-S	Consumer	80%	50%	$2,500	$5,000	$7,500	$15,000	$6,250	$12,500	$12,500	$25,000	80%	80%	80%	80%	Emb
E9-U	Consumer	80%	50%	$5,000	$10,000	$10,000	$20,000	$6,250	$12,500	$12,500	$25,000	80%	80%	80%	80%	Emb

UnitedHealthcare®

Plan Code	Plan Type	Co-insurance		Deductible				Out-of-Pocket Maximum				Co-pay/Per Occurrence						Deductible Type[5]
		Network	Out of Network	Network		Out of Network		Network		Out of Network		PCP[1]	Spec	Urgent Care	ER[4]	Inpatient Hospital[10]	Outpatient Surgery[10]	
				Single	Family	Single	Family	Single	Family	Single	Family							
AA-9X	Standard	100%	70%	$0	$0	$1,500	$3,000	$2,500	$5,000	$5,000	$10,000	$20	$40	$100	$200	$500	$250	Emb
E9-1	Standard	100%	70%	N/A	N/A	$2,500	$5,000	$6,250	$12,500	$12,500	$25,000	$25	$70	$100	$300	$500	$250	Emb
AA-9Y	Standard	100%	70%	$2,500	$5,000	$5,000	$10,000	$3,500	$7,000	$7,000	$14,000	$20	$40	$100	$250	$500	$250	Emb
E9-9	Standard	100%	70%	$3,000	$6,000	$9,000	$18,000	$6,250	$12,500	$12,500	$25,000	$35	$70	$100	$500	$500	$250	Emb
E9-B	Standard	100%	70%	$5,000	$10,000	$10,000	$20,000	$6,250	$12,500	$12,500	$25,000	$35	$70	$100	$500	$500	$250	Emb

HSA Plans

Plan Code	Plan Type	Co-insurance		Deductible				Out-of-Pocket Maximum				Co-pay/Per Occurrence[9]				Deductible Type[5]
		Network	Out of Network	Network		Out of Network		Network		Out of Network		PCP[1]	Spec	Urgent Care	ER	
				Single	Family	Single	Family	Single	Family	Single	Family					
E9-V	HSA	100%	70%	$1,500	$3,000	$4,500	$9,000	$6,250	$12,500	$12,500	$25,000	$35	$70	$100	$300	NonEmb
E9-W	HSA	100%	70%	$2,000	$4,000	$6,000	$12,000	$6,250	$12,500	$12,500	$25,000	$35	$70	$100	$300	NonEmb
AB-BJ	HSA	100%	70%	$2,600	$5,200	$7,500	$15,000	$6,250	$12,500	$12,500	$25,000	$35	$70	$100	$300	Emb
E9-Y	HSA	100%	70%	$3,000	$6,000	$9,000	$18,000	$6,250	$12,500	$12,500	$25,000	$35	$70	$100	$300	Emb
E9-Z	HSA	100%	70%	$5,000	$10,000	$10,000	$20,000	$6,250	$12,500	$12,500	$25,000	$35	$70	$100	$300	Emb

UnitedHealthcare Navigate® Plans

Plan Code	Plan Type[8, 11]	Coinsurance							Deductible			Out-of-Pocket Maximum			Copay/Per Occurrence					Deductible Type[5]
		Network	Network w/o Referral	Inpatient	Inpatient w/o Referral	Outpatient	Outpatient w/o Referral	Out-of-Network	Network		Out of Network	Network		Out of Network	PCP[1]	Spec	Spec w/o Referral	Urgent Care	ER[4]	
									Single	Family		Single	Family							
48-S	Navigate	100%	Not covered	100%	Not covered	100%	Not covered	Not covered	$1,000	$2,000	Not covered	$4,000	$8,000	Not covered	$30	$60	Not covered	$75	$250	Emb
48-T	Navigate	100%	Not covered	100%	Not covered	100&	Not covered	Not covered	$2,000	$4,000	Not covered	$4,000	$8,000	Not covered	$35	$70	Not covered	$100	$300	Emb
48-P	Navigate	80%	Not covered	80%	Not covered	80%	Not covered	Not covered	$500	$1,000	Not covered	$4,500	$9,000	Not covered	$30	$60	Not covered	$75	$250	Emb
48-Q	Navigate	80%	Not covered	80%	Not covered	80%	Not covered	Not covered	$2,000	$4,000	Not covered	$6,250	$12,500	Not covered	$35	$70	Not covered	$100	$300+80%	Emb
48-R	Navigate	80%	Not covered	80%	Not covered	80%	Not covered	Not covered	$3,000	$6,000	Not covered	$6,250	$12,500	Not covered	$35	$70	Not covered	$100	$300+80%	Emb

Pharmacy

Rx Plan Code	Deductible Type	Co-pays			Mail-Order Ratio
		Tier 1	Tier 2	Tier 3	
K4	Sep	$10	$25	$40	2.5
K5	Sep	$10	$25	$50	2.5
H9	Sep	$10	$30	$50	2.5
2V	Sep	$10	$35	$60	2.5
IU	Sep	$15	$40	$75	2.5
KU	Sep	$20	$45	$80	2.5
KC	Sep	$20	$50	$80	2.5
5X[15]	Sep	$10	$25	$40	2.5
VO[15]	Sep	$10	$35	$60	2.5
50[15]	Sep	$15	$45	$75	2.5
17[15]	Sep	$20	$50	$80	2.5

HSA Pharmacy

Rx Plan Code	Deductible Type	Co-pays[9]			Mail-Order Ratio
		Tier 1	Tier 2	Tier 3	
H9	Comb	$10	$30	$50	2.5
2V	Comb	$10	$35	$60	2.5
VO[15]	Comb	$10	$35	$60	2.5

1 Primary Care Physicians include General Practice, Family Practice, Internal medicine, Obstetrics-gynecology, and pediatrics.

4 Plan deductible is waived for Emergency Room visits on plans where a co-payment or co-payment plus co-insurance are listed.

5 "Embedded" deductible means once an individual meets his or her portion of the deductible, services are paid for that person without the entire family deductible being met. "Non-Embedded" deductible means no covered family member will satisfy an individual deductible until the entire family deductible is met.

6 "Flexpoint" plans feature a copay for Physician Office and Urgent Care visits one through four during the calendar year or policy year, depending on plan type selected. Physician Office and Urgent Care visits five and over will be subject to plan deductible/coinsurance. This is a separate limit for both Physician Office and Urgent Care visits. Plans feature one Preventive Care visit per service year, which does not count against the Office Visit copay limit. These visits on Flexpoint plans are counted on either a calendar or policy year basis. The visits accrued under an existing UHC plan will apply to the Flexpoint visit maximum until the next calendar or policy year, at that point the count will reset.

8 "Navigate" plans (Navigate, Balanced, Plus) require referrals for certain services. Failure to obtain a referral may result in either nonpayment of claims or in a reduction of benefits.

9 Co-payments on HSA plans will be required after the deductible has been met and will continue to be required until the annual out-of-pocket maximum is met.

10 Co-payments for Inpatient Hospital admissions and Outpatient Surgery services are prior to and in addition to any required deductible and co-insurance.

11 EPO plans exclude coverage for services provided by Out-of-Network Providers with the exception of (1) Services performed in a Network Facility by hospital-based providers; and (2) Services performed under the Emergency Care benefit.

15 These pharmacy plans feature co-pays of $150 (Tier 2) and $300 (Tier 3) for specialty medications. This is in lieu of the listed co-payments. Refer to plan documents for more information.

16 80/50/50 plans cover inpatient and outpatient facilities at 50% and physician services at 80%.

Premium rates and/or product forms included herein are subject to approval by regulators. If rates or product forms offered herein are subsequently modified by regulators, we will immediately advise you of the change in plan design and retroactively adjust premium in subsequent billings.

Please note: The information in this grid is provided for informational purposes only and is not intended for use as a contract. For a complete listing of coverage and exclusions, please refer to the Certificate of Coverage or talk to your UnitedHealthcare representative for additional details that could impact the benefits. Different UnitedHealthcare plans may have varying approaches to whether pharmacy costs are included or excluded from the medical deductible.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates. Health Plan coverage provided by or through UnitedHealthcare of Missouri, Inc.

Versa Tags, Inc.
Policy Number: 8P8027,8P8462,8S8074
Renewal Date: October 1, 2015

REQUIRED UNIFORM MODIFICATION NOTICE FOR LARGE GROUP EMPLOYERS

Important: Legal Notice Regarding Changes to Your Group Health Coverage to Take Effect at Your Next Renewal in 2015

Your group health insurance coverage is coming up for renewal. Below are changes we'll be making to your coverage at renewal.

Coverage changes via Uniform Modification (applicable to Choice, Choice Plus and Options PPO):

The mandatory benefit changes include:

- For members with out-of-network benefits:
    - Laboratory Services – If a member receives services from an out-of-network provider the out-of-pocket costs will be higher. The claim will be processed using 50 percent of the published rate allowed by the Centers for Medicare & Medicaid Services (CMS). The rate is based on the same or similar service.
    - Durable Medical Equipment – If a member receives durable medical equipment from an out-of-network provider the out-of-pocket costs will be higher. The claim will be processed using 45 percent of the published rate allowed by CMS. The rate is based on the same or similar equipment.
    - Prior Authorization – A member must receive prior authorization or approval before services are received. The following services need prior authorization:
        - Outpatient surgery for cardiac catheterization, pacemaker insertion and implantable cardioverter defibrillators;
        - Rehabilitation services – physical, occupational and speech therapy;
        - Prosthetic devices that cost more than $1,000;
        - Lab, X-ray and major diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – outpatient; and
        - Sleep studies
- Any cost-sharing changes are described in your renewal package.

Other coverage changes (applicable to Choice, Choice Plus and Options PPO):

- There is a difference in how certain claims are processed when a member receives services from out-of-network providers. If a member receives non-emergency services in a network facility from an out-of-network provider, they are responsible for the difference between the amount charged by the provider and the eligible expense. The eligible expense is the amount the plan determines can be paid for a health care service. If emergency services are received from any out-of-network providers the member is responsible for the difference between the amount charged by the provider and the eligible expense, which is based on the median network rate or a higher rate required by law. For emergency and non-emergency services, the member is also responsible for the deductible, co-insurance or co-pay. This amount is determined by using the network cost share level.

Refer to the benefit documents for specific coverage details. Rates and/or benefits may be subject to regulatory approval. If the rates or products offered are changed as a result of the regulatory review process, we will advise you as soon as possible.

If you have any questions or would like to discuss, please contact me.

We're looking forward to another year of serving you and your employees.

MO LG
4/1/15

What happens when I use out-of-network doctors?

Using doctors and facilities outside of the UnitedHealthcare network could cost you a lot more money. Using network providers whenever possible could help lower your health care costs. Out-of-network providers may charge more for their services. Plus, they may bill you for what your health plan didn't pay for (called balance billing).

What is an out-of-network provider?

An out-of-network provider is a doctor, health care professional or facility (like a hospital or ambulatory surgery center) that isn't part of your health plan's network.

What happens when I use an out-of-network hospital or provider?

Your out-of-pocket costs (like co-payments, co-insurance and deductibles) are usually higher. The reason is that out-of-network providers do not have a contract with UnitedHealthcare to provide services at lower rates.

If I go to a network hospital, will all of the providers there be in the network?

Not always. For example, if you go to a network hospital to get an X-ray, the doctor reading the X-ray may not be in the network. That doctor may charge more for the X-ray than a network provider.

What if I have an emergency?

In a true emergency, you should visit the nearest emergency room. If you receive emergency services from an out-of-network doctor or hospital, the charge for services may be greater than from a network provider. And, you may be billed for the difference in costs.

What is an eligible expense?

An **eligible expense** (sometimes called the allowable charge or allowed amount) is a health care service that your health plan covers. The plan may pay for or reimburse you for the full cost or only part of it.

What is balance billing?

Balance billing is when a provider bills you for the difference between their charge and what your health plan will pay. For example, let's say an out-of-network doctor charges $100 to review your X-ray. But your plan will only pay for $70. The doctor may bill you for the remaining $30. **Note:** Any balance bill you may pay for will not apply to your out-of-pocket limit.

Find definitions for these useful terms on the last page

- Balance billing
- Co-insurance
- Co-payment
- Deductible
- Out-of-Pocket Limit

UnitedHealthcare®

What can I do to help keep my costs down?

Use network doctors and facilities.

If you don't have a network doctor, you can use myuhc.com® to find network doctors near you. The UnitedHealthcare national network has more than 768,000 doctors and health care professionals and more than 5,600 hospitals across the country. This means there's a good chance that a network doctor is near you.

Facilities in the UnitedHealthcare network may have out-of-network physicians or health professionals providing services at the facility. You can visit the "Find Physicians & Facilities" section of the **myuhc.com** member website to determine whether the network facility you are considering has network anesthesiologists, emergency room physicians, pathologists, and radiologists providing services at the facility.

Talk to your doctor.

Before you have a health care procedure, be sure to talk to your doctor. Ask your doctor about the facility and other specialists who may be involved so that you can make sure they participate in the network. If you are balance billed by an out-of-network doctor, you can also contact that doctor directly to ask if they will lower the charges or if you can set up a payment plan.

Understand your benefits.

You should review your health plan documents to fully understand your coverage and benefits. Most members can find their coverage details online at myuhc.com. Click on the "Benefits & Coverage" menu, and then click on "Coverage Documents." If you cannot find your coverage details online, you can get a free, printed copy by calling the Customer Care phone number on your health plan ID card.

UnitedHealthcare®

100-15357 10/14

Useful Terms

- **Balance billing** When a provider bills you for the difference between the provider's charge and the allowed amount (allowed amount may also be referred to as eligible expense). A network provider may not balance bill you for covered services.
- **Co-insurance** The amount you pay (calculated as a percentage of eligible expenses) each time you receive certain covered health services.
- **Co-payment** A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.
- **Deductible** The amount you owe for covered services before your health plan begins to pay. For example, if your deductible is $1,000, your plan won't pay anything until you've met your $1,000 deductible for covered services. The deductible may not apply to all services.
- **Out-of-Pocket Limit** The most you pay during a policy period (usually a year) before your health plan begins to pay 100%. This limit never includes your premium, health care services your plan doesn't cover, or any balance bills you pay to out-of-network providers.

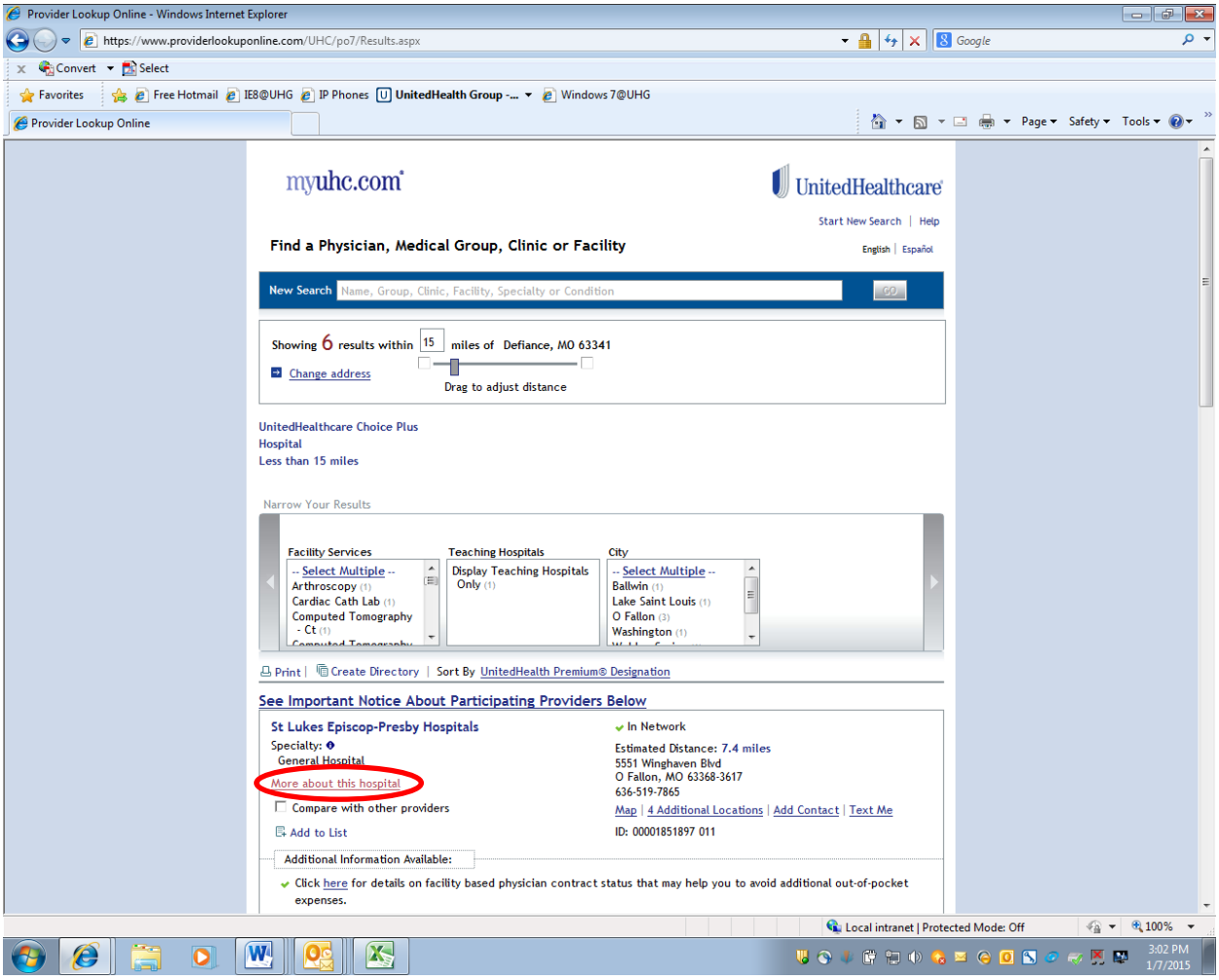
We know that health care and health insurance terms can be difficult for anyone. For help with any terms used in this document, please visit **JustPlainClear.com**.

Always refer to your health plan documents to view the details of your specific coverage and learn how your plan works.

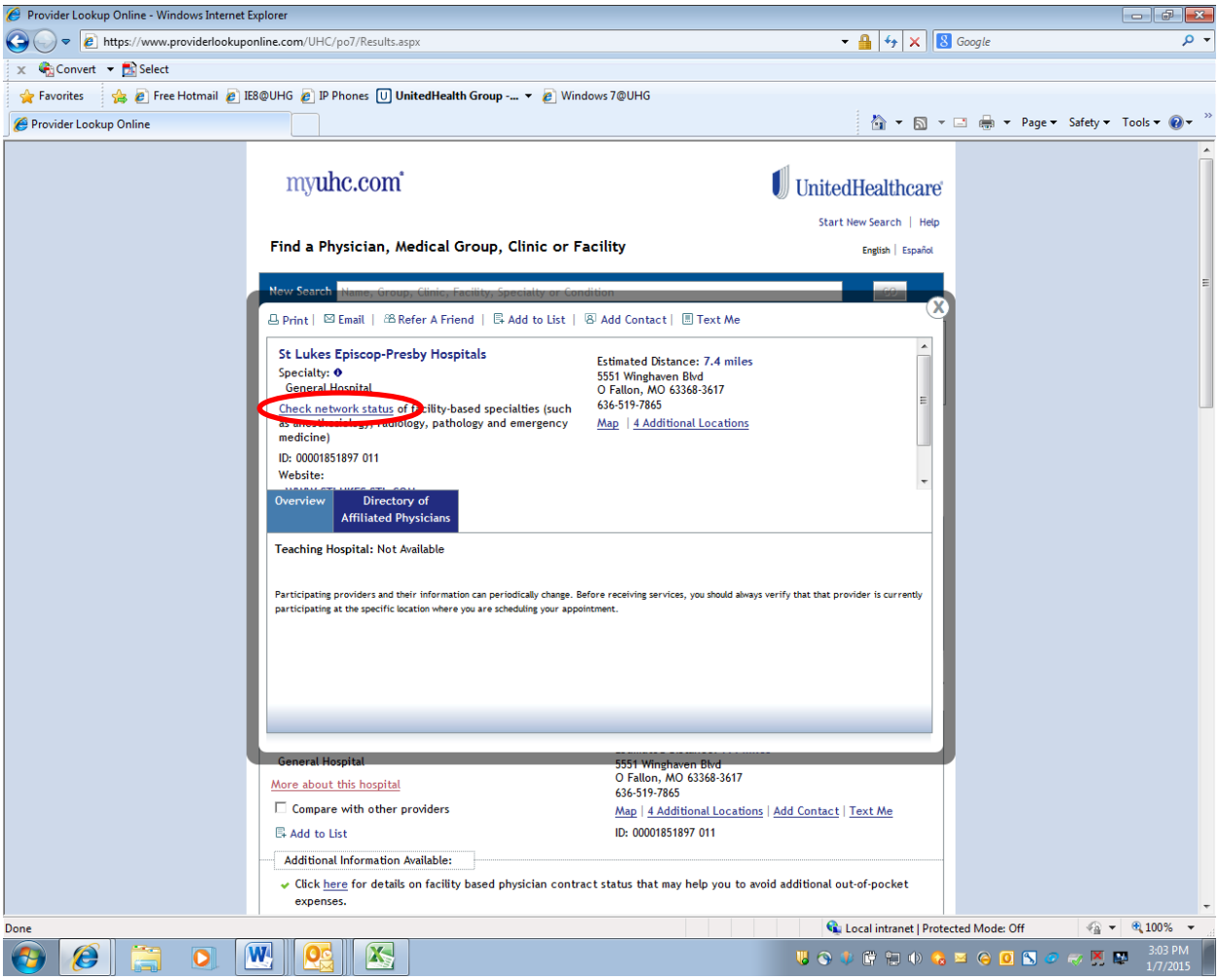
How to search for Network status of Facility-Based Specialists

Go to www.myuhc.com and on the right column, click on “Find Physician, Lab, or Facility”.

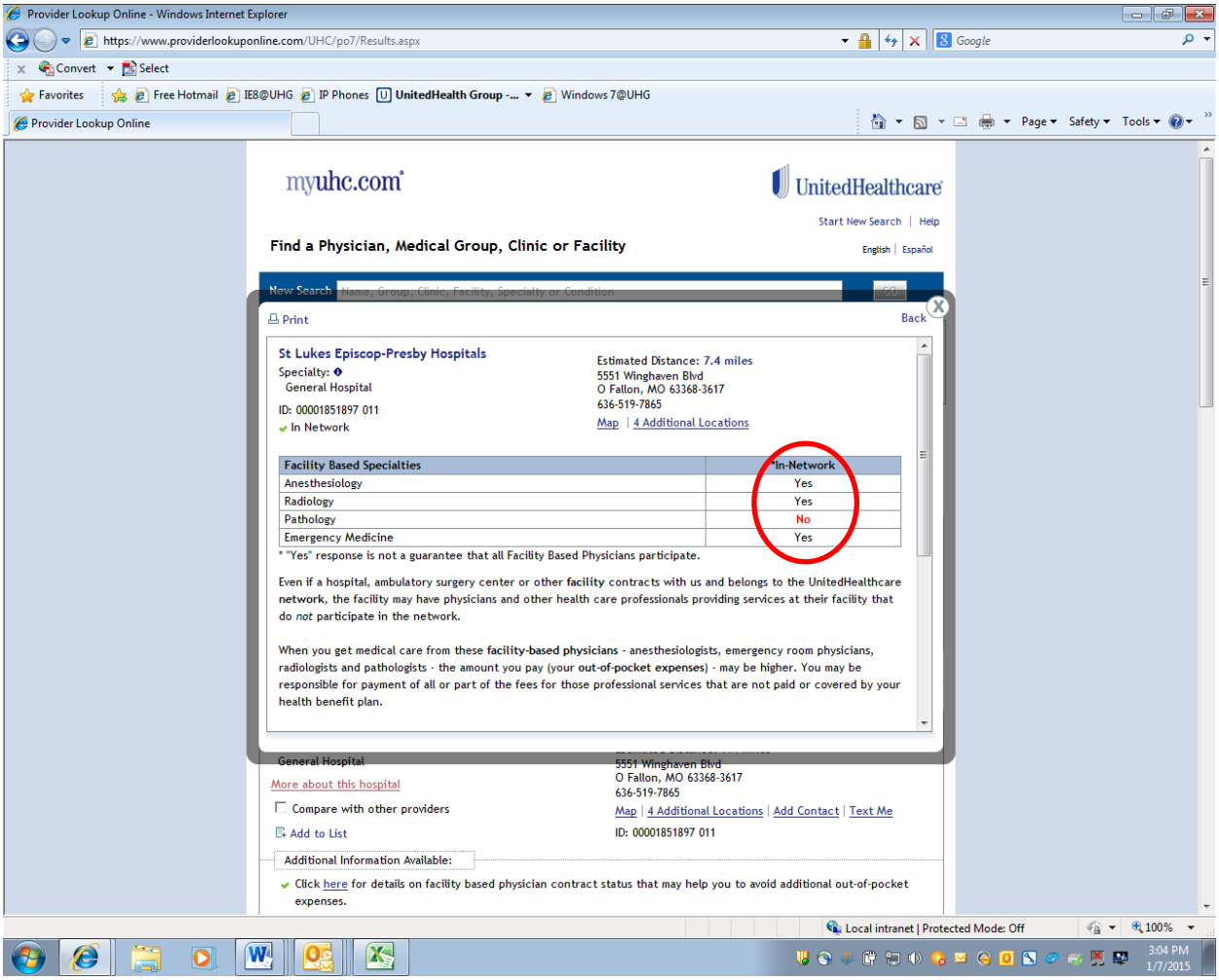
For this example, I did a search for Network Hospitals within 15 miles of my home:



I then clicked on “More about this hospital” in red, under St. Lukes…

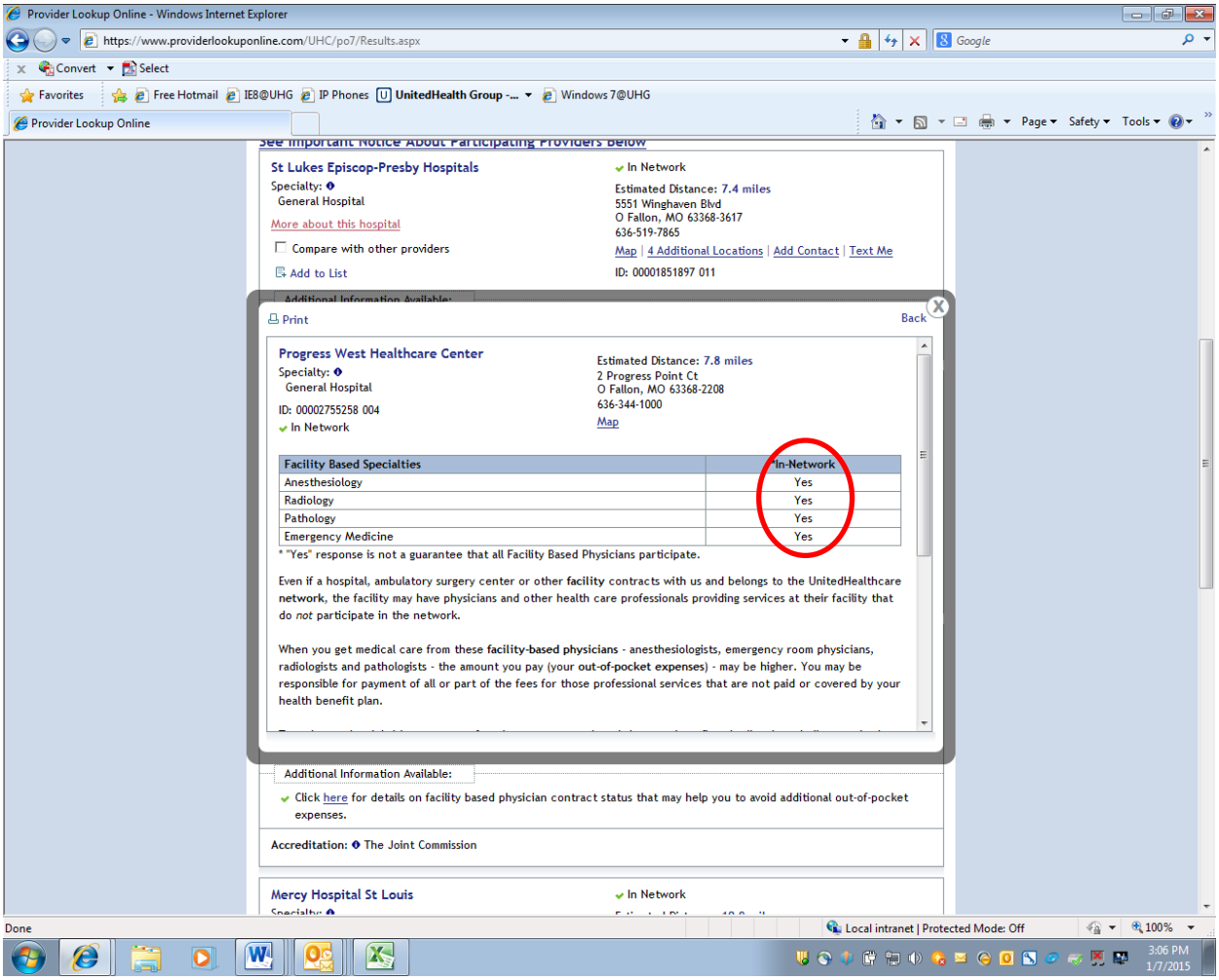


Then I clicked on "Check network status of facility-based specialties.."



Here, I see that Pathology specialists are **NOT In-Network**.

Here is the same result for Progress West…



Note that ALL Facility Based Specialties are In-Network.

FACILITY BASED SPECIALTIES - MISSOURI HOSPITALS 50 Miles from Zip Code 65453

Facility Based Specialties	*In-Network SSM Cardinal Glennon Childrens Hospital	*In-Network Barnes Jewish (St. Louis)	*In-Network St Louis Childrens Hospital	*In-Network Barnes Jewish (St. Peters)	*In-Network Barnes Jewish (West County)	*In-Network Chistian Hospital NE/NW	*In-Network St Louis University Hospital	*In-Network Mercy Hospital - St Louis	*In-Network SSM St Marys Health Center	*In-Network SSM DePaul Health Center	*In-Network St Lukes Episcop-Presby Hospitals
Anesthesiology	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Radiology	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Pathology	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Emergency Medicine	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes

Facility Based Specialties	*In-Network St Anthonys Medical Center	*In-Network Missouri Baptist Medical Center	*In-Network Des Peres Hospital	*In-Network Heart Care Institute	*In-Network SSM St Clare Health Center	*In-Network SSM St Joseph Health Center (St. Charles)	*In-Network SSM St Joseph Health Center (West)	*In-Network Mercy Hospital-Washington	*In-Network Progress West Healthcare Center	*In-Network Phelps County Regional	*In-Network Mercy Hospital Lebanon (Rolla)	*In-Network Salem Memorial District Hosp
Anesthesiology	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Radiology	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Pathology	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
Emergency Medicine	Yes	Yes	Yes	Yes	No	No	No	Yes	Yes	No	Yes	Yes

Facility Based Specialties	*In-Network Washington County Memorial Hospital	*In-Network Hermann Area District Hospital	*In-Network Mercy Hospital Washington	*In-Network Lake Regional (Iberia, MO)
Anesthesiology	Yes	Yes	Yes	Yes
Radiology	Yes	Yes	Yes	Yes
Pathology	Yes	Yes	Yes	Yes
Emergency Medicine	Yes	Yes	Yes	No

*** "Yes" response is not a guarantee that all Facility Based Physicians participate.**

Even if a hospital, ambulatory surgery center or other **facility** contracts with us and belongs to the UnitedHealthcare **network**, the facility may have physicians and other health care professionals providing services at their facility that do *not* participate in the network.

When you get medical care from these **facility-based physicians** - anesthesiologists, emergency room physicians, radiologists and pathologists - the amount you pay (your **out-of-pocket expenses**) - may be higher. You may be responsible for payment of all or part of the fees for those professional services that are not paid or covered by your health benefit plan.

To assist you in minimizing your out-of-pocket expenses and maximize your benefits, the list above indicates whether the facilities you are considering have facility-based physicians and non-physician providers on their staffs in the below specialties that are contracted by UnitedHealthcare.

Some things you should keep in mind:

- The information is subject to change and is provided for informational purposes only.

- Some facilities have more than one group of facility-based physicians and non-physician providers providing these services and, therefore, not all physicians within a particular specialty may participate in UnitedHealthcare's network.

- This list is not a guarantee that the physician providing services to you is in-network with UnitedHealthcare. You should always confirm the participation status of the particular physician or non-physician provider before receiving services.

- The list below does not indicate whether services provided to you are covered services. Refer to your benefit plan documents to determine whether the services are covered under your benefit plan. **Your benefit plan may not include coverage of non-contracted health care professionals at the in-network level.**

Physicians and other professionals who practice exclusively within a facility like a hospital or surgical center, and see you only as a result of your seeking care at the facility, are credentialed by the facility in which they practice. Only those individual physicians listed in our provider directory are separately credentialed by UnitedHealthcare.

VERSA-TAGS, INC.
VOLUNTARY DENTAL INSURANCE ANALYSIS
Renewal Date: January 1, 2016

FEATURES:		DELTA DENTAL Current & Renewal		
		PPO	**Premier**	**Out-of-Network**
Individual Deductible:		$50	$50	$50
Family Deductible:		$150	$150	$150
Type I - Preventive Care: (Exams, Cleanings)		100% (No Ded)	100% (No Ded)	100% (No Ded)
Type II - Basic Procedures: (Fillings, Extractions)		100%	80%	80%
Type III - Major Procedures: (Caps, Crowns)		60%	50%	50%
Endodontics:		100%	80%	80%
Periodontics:		100%	80%	80%
Type IV - Orthodontia: Dependent Children Only		50% to $1,000 Lifetime Max	50% to $1,000 Lifetime Max	50% to $1,000 Lifetime Max
Maximum Benefit/Year:		$1,000	$1,000	$1,000
UCR Percentile:				MAC
Monthly Rates:			**Current**	
Employee	14		$32.06	
Employee & Spouse	8		$62.31	
Employee & Children	11		$65.19	
Employee & Family	11		$98.11	
Total	44		$2,744	
Employee Only Premium:			$1,411	
Dependent Only Premium:			$1,333	
Total Monthly Premium:			$2,744	

The above outline is for illustration purposes only. It is not intended to provide specific definitions of the plan's coverage or to determine if specific claims are eligible for payment

VERSA-TAGS, INC.
LIFE INSURANCE ANALYSIS
Renewal Date: January 1, 2016

FEATURES	PRINCIPAL
BENEFIT:	
Class One: **12+ Months of Service**	Flat $100,000
Class Two: **6-12 Months of Service**	Flat $50,000
Class Three: **3-6 Months of Service**	Flat $20,000
Conversion Privilege:	Included
Waiver of Premium:	Included
Accelerated Death:	Included
Rate Guarantee	2 Years
Monthly Volume:	$6,110,000
Life Rate per $1000:	$0.09
Total Monthly Premium:	$550

VERSA-TAGS, INC
VOLUNTARY LIFE INSURANCE ANALYSIS
Renewal Date: January 1, 2016

FEATURES	PRINCIPAL	
COVERAGES:		
Employee	$10,000 Increments $500,000 Max.	
Spouse	50% of EE Amount not to exceed $250,000	
Children	10% of EE Amount not to exceed $10,000	
Guarantee Issue Amount:	EE under age 65 - $120,000 SP under age 65 - $50,000 CH - $10,000	
Reduction Schedule:	35% at age 65 25% at age 70 15% at age 75 10% at age 80	
Portability:	Included	
Waiver of Premium:	Included	
Rate Guarantee:	2 Years	
Minimum Participation:	10 Lives or 35%	
Age Bands	**EE**	**SP**
20-24	$0.080	$0.080
25-29	$0.080	$0.080
30-34	$0.100	$0.100
35-39	$0.130	$0.160
40-44	$0.210	$0.230
45-49	$0.310	$0.360
50-54	$0.570	$0.680
55-59	$1.120	$1.250
60-64	$1.640	$1.870
65-69	$2.760	$3.070
70-74	$4.970	$5.670
75+	$17.810	$19.340
Child	$0.170	
AD&D	$0.045	
	Sp rate based on age of Ee	

VERSA-TAGS INC.
VOLUNTARY VISION ANALYSIS
Renewal Date: January 1, 2016

FEATURES:		DELTA VISOIN	
		In Network	**Out of Network***
EXAMINATION CO-PAY:		$10	$40 Max
FREQUENCY OF SERVICE:			
Exams		12 Months	
Lenses		12 Months	
Frames		24 Months	
BASIC LENSES:		After $25 Copay	
Single Vision		100%	$30
Bifocal		100%	$50
Trifocal		100%	$65
FRAMES:		After $25 Copay: $125 Allowance	$40 Max
CONTACTS:		After $25 Copay:	
Necessary		$250 Allowance	$250 Max
Cosmetic:		$25 Allowance	$60 Max
EMPLOYER CONTRIBTUION:		0%	
Participation Requirement:		10 enrolled	
Rate Guarantee:		24 Months	
Monthly Premium			
Employee	14	$7.04	
Employee & Spouse	6	$14.08	
Employee & Children	7	$13.38	
Family	5	$23.00	
Total Monthly Premium:	32	$392	
Employee Only Premium:		$225	
Dependent Only Premium:		$166	
Total Monthly Premium:		$392	

The above outline is for illustration purposes only. It is not intended to provide specific definitions of the plan's coverage or to determine if specific claims are eligible for payment.