2015-2016 Benefits Guide

UST®
U.S. TAPE & LABEL

Your Label and Labeling Specialists

WELCOME TO US TAPE & LABEL'S -

EMPLOYEE BENEFITS

U.S. Tape & Label (USTL) is preparing for the annual enrollment of our employee benefits. We have received our renewals and are pleased to announce that, effective September 1, 2014, we are remaining with Anthem for our medical coverage. We have decided to replace the "Non BJC" plan with a Qualified High Deductible Health Plan with the option of establishing a Health Savings Account. We will remain with Lincoln Financial for short term disability and long term disability and will remain with Anthem for the Life/AD&D and Supplemental Life. Delta Dental will continue to be the carrier for our dental benefits, however, please note some benefit changes in the following pages. Lastly, Vision Benefits of America (VBA) will now be our vision provider.

We received a significant increase from Anthem between the three plans. This was caused by a combination of medical trend and Health Care Reform fees the insurance company is required to include in our rates. Although we approached the market for competitive bids to ensure our rates are competitive, were not able to receive a better rates/plans with any other carrier.

Our enrollment needs to be completed no later than August 26th. During this open enrollment time you will be allowed to add or delete dependent coverage or make changes to your current elected benefit plans. Remember, any elections you make during this annual enrollment period cannot be changed until our next enrollment period unless you experience a life changing event, such as, marriage, divorce or birth/adoption of a child.

Please review the benefit information on the following pages. They provide a brief summary of the benefit plans and associated costs offered by USTL. If you have any questions, please feel free to call Nicol Schmidt at CBIZ at (314) 692-5847.

Thank you.

ANTHEM - MEDICAL PLAN SUMMARIES

Base Medical Plan—Blue Access Choice 17AK

Benefit/Service	In-Network	Out-of- Network
Deductible	$5,000 / Individual $10,000 / Family	$10,000 / Individual $20,000 / Family
Coinsurance	80%	50%
Out-of-Pocket Max.	$6,600 / Individual $13,200 / Family	$13,200/ Individual $26,400 / Family
Inpatient Hospital Outpatient Hospital	80% After Deductible	50% After Deductible
Office Visit Copay (PCP / Specialist)	$30/50 Co-Pay	50% After Deductible
Urgent Care	$75 Co-Pay	50% After Deductible
Emergency Room	$250 Co-Pay; 20%	$250 Co-Pay; 20%
Preventive Care	100%	50% After Deductible
Prescription Retail Mail Order	$10/ $25/$45/25% up to $200; $2,500 maximum $10/$65/$135/25% up to $200; $2,500 maximum	50% After Deductible Not Covered

The Base Plan is offered for those who want lower premiums with the potential of higher out of pocket expenses in the case of emergencies. The deductible and co-pays for this plan are higher than that of the enriched plan.

In-Network Plan Highlights

- The Deductible does not have to be satisfied for office visits, emergency room, urgent care or prescription drugs.
- Co-Pays apply towards the out-of-pocket maximum. This includes prescription drug co-pays.

Enriched Medical Plan—Blue Access Choice 11AK

Benefit/Service	In-Network	Out-of- Network
Deductible	$2,500 / Individual $7,500 / Family	$5,000 / Individual $15,000 / Family
Coinsurance	80%	50%
Out-of-Pocket Max.	$6,000 / Individual $12,000 / Family	$12,000 / Individual $24,000 / Family
Inpatient Hospital Outpatient Hospital	80% After Deductible	50% After Deductible
Office Visit Copay (PCP / Specialist)	$20/$40 Co-Pay	50% After Deductible
Urgent Care	$75 Co-Pay	50% After Deductible
Emergency Room	$200 Co-Pay; 20%	$200 Co-Pay; 20%
Preventive Care	100%	50% After Deductible
Prescription Retail Mail Order	$10/ $25/$45/25% up to $200; $2,500 maximum $10/$65/$135/25% up to $200; $2,500 maximum	50% After Deductible Not Covered

The Enriched plan is offered for those who are looking for higher benefits. This plan has lower deductibles and co-pays as well as lower out-of-pocket expenses, however it will cost more in monthly premium than the Base Plan.

ANTHEM- MEDICAL PLAN SUMMARIES - (cont.)

Qualified High Deductible Health Plan with a Health Savings Account - E202

In-Network Plan Highlights

- The Deductible must be satisfied before any benefit is paid by this plan.
- Co-Pays apply towards the out-of-pocket maximum. This includes prescription drug co-pays.
- You are eligible to set up a Health Savings Account if enrolled in this plan.
- You or your spouse cannot participate in a Health Flexible Spending Account if enrolled in the Health Savings Account.
- No one in the family is covered 100% until the family deductible has been met.

The Qualified High Deductible Health Plan offers a higher deductible to offset premiums. All eligible medical claims are applied to the deductible. Co-Pays apply after the deductible has been met. You are eligible to open a Health Savings Account with this plan.

Benefit/Service	In Network	Non- Network
Deductible (individual / family)	$3,000/ $6,000	$6,000 / $12,000
Coinsurance	100%	70%
Out-of-Pocket Max. (individual / family)	$4,500 / $9,000	$12,000 / $24,000
Office Visit Co-Pay (Primary Care / Specialist)	$25 / $50 After the Deductible	70% After the Deductible
Preventive Care	100% Covered Deductible does not apply	70% After the Deductible
Inpatient Hospital Outpatient Surgery	100% After the Deductible	70% After the Deductible
Lab, X-Ray - Outpatient	100% After the Deductible	70% After the Deductible
Major Diagnostics (CT, PET, MRI, MRA, & Nuclear Medicine)	100% After the Deductible	70% After the Deductible
Emergency Room	$250 Co-Pay After the Deductible	$250 Co-Pay After In Network Ded
Urgent Care	$75 Co-Pay After the Deductible	70% After the Deductible
Prescription Retail Mail Order	 $10/ $25/$45/25% to $200 $10/$90/$180/25% to $200	 50% After Deductible Not Covered

Health Savings Account (H.S.A)

USTL's plan is considered a Qualified High Deductible Health Plan. When a Health Savings Account is opened in connection to the QHDHP, this allows participants to save money on a pre-tax basis to pay for all health care related expenses. As detailed in the plan summary the individual deductible is $3,000 per year; the family deductible is $6,000 per year.

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.

Health Savings Account (H.S.A) ...cont...

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 also have a medical *flexible* spending account (FSA), unless it is a Limited Purpose FSA.
- You cannot set up an 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 eligible for Medicare.
- You cannot be claimed as a dependent under someone else's tax return.

What is a Qualified High Deductible Health 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, inpatient and outpatient hospitalization. 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. The contribution limits for 2015 are $3,350 for Single and $6,650 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 based on the IRS Publication 502, (medical, dental, vision and over-the-counter medically necessary items with a physician's prescription).
- 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.
- The savings account can be established, so you can take advantage of payroll deductions on a pre-tax basis.

Generally, you can put enough in your HSA to cover your entire 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 – from both you and your employer – can't be more than the IRS annual contribution limit. If you're age 55 or older, you could be allowed to make an extra $1,000 contribution each year.

DELTA DENTAL PLAN SUMMARY

Benefits/Service	PPO Network	Premier	Non Network
Calendar Year Deductible			
Individual	$50	$50	$50
Family	$150	$150	$150
Coinsurance			
Diagnostic/Preventive	100% Deductible Is Waived	100% Deductible Is Waived	100% Deductible Is Waived
• Cleanings			
• X-Rays			
• Fluoride			
Basic Services	80%	60%	60%
• Fillings			
• Simple Oral Surgery			
Major Services	50%	40%	40%
• Complex Oral Surgery			
• Bridges, Dentures & Crowns			
• Endodontic & Periodontics			
Orthodontia– Child only	50% Deductible Waived	50% Deductible Waived	50% Deductible Waived
	Fee Schedule Applies	Max Plan Allowance	Max Plan Allowance
Annual Maximum	$1,000 / person		
Ortho Lifetime Maximum	$1,000 / child		

Plan Highlights

- Selecting a PPO Network or Premier dentist offers you the most cost effective coverage.
- If you select a non-participating dentist, you could be balance billed or receive a bill for any non-covered expenses.
- If the cost estimate is more than $200 for non-emergency care, ask your dentist to submit a treatment plan to Delta Dental for a pre-determination of benefits. This will enable you to know in advance how much of the cost will be paid by your dental coverage.
- Benefit Changes are indicated in red.

DELTA DENTAL

To find helpful benefit information:
Log on to www.deltadentalmo.com

- Find a Dentist
- Check Claim Status
- Order New ID Card
- View Benefits

VISION BENEFITS OF AMERICA (VBA) - VISION PLAN SUMMARY

VISION BENEFITS OF AMERICA

Log on to **www.visionbenefits.com**

- Search for an In Network Provider
- Claim forms
- View benefits
- Inquire about Laser Discounts

If you elect vision coverage you will need to commit for 2 years

Benefit/Service	In Network	Non- Network
Frequency of Service: Exam Lenses Frames	Every 12 months Every 12 months Every 24 months	
Examination Co-pay	$10 Co-pay	Reimbursed up to $40
Lenses Single Bifocal Trifocal	$10 Co-Pay 100% 100% 100%	Reimbursed up to: $40 $60 $80
Frames	$10 Co-Pay $125-$150 Allowance	Reimbursed up to: $50
Contacts Necessary Cosmetic	UCR $160 Allowance	Reimbursed up to: $320 $160

ANTHEM - BASIC LIFE / AD&D

All benefit eligible employees of USTL are provided Basic Life Insurance and Accidental Death & Dismemberment through Anthem at no cost! Coverage for Life Insurance and AD&D is 1 X your annual salary + $10,000 subject to a maximum. Now is the time to update your beneficiary information. Please see Cyrus Beckham for the appropriate form to complete.

ANTHEM- VOLUNTARY LIFE / AD&D

The Voluntary Life/AD&D benefit will continue to be offered through Anthem. Any increase in benefit will require the completion of an Evidence of Insurability form (EOI) and Anthem's approval. Keep in mind that you, the employee, must purchase voluntary life in order to purchase for your spouse and/or dependent children.

New employees must enroll within the first 31 days of becoming eligible for benefits to take advantage of the guaranteed issue (GI) amounts listed below. Anything over the GI amount will also require the completion of an Evidence of Insurability form (EOI) and approval by Anthem before it takes effect.

When calculating premium for spouse coverage use the employee's age.

If you wish to increase your Supplemental Term Life amount, paperwork must be submitted to Cyrus Beckham no later than Friday, August 28th.

MONTHLY	
Age Band	**Monthly Rate/ $1,000**
Under 30	$0.08
30-34	$0.10
35-39	$0.13
40-44	$0.20
45-49	$0.32
50-54	$0.55
55-59	$0.89
60-64	$1.17
65-69	$1.70
70-74	$3.54
Over 74	$6.72

Child(ren)	Mo. Rate
*$1,000	*$0.20

*Includes all dependent children

EMPLOYEE COVERAGE

Employees may elect coverage in increments of $10,000 up to a maximum of $300,000 or 5 X your annual earnings, whichever is less. The Guaranteed issue limit is $100,000 for employees if enrolling within 31 days of becoming eligible for supplemental life insurance.

SPOUSE COVERAGE

Spousal coverage is available in increments of $5,000 not to exceed 50% of the employee amount up to a maximum of $50,000. Guaranteed issue is $25,000 if enrolling within 31 days of becoming eligible for supplemental life. Spouse rates are based on the employee's age.

CHILDREN

Child coverage is $10,000 for children 15 days old up to age 26. The elected coverage is for each child in your family.

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

HOW TO CALCULATE VOLUNTARY PREMIUM

$50,000 Elected Coverage ÷ 1,000 = 50 Units X $0.32 Rate * See Note = $16.00 Monthly Cost

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

LINCOLN NATIONAL - SHORT TERM DISABILITY

All benefit eligible employees of USTL are provided Short Term Disability through Lincoln Financial at no cost! This will protect your income up to 13 weeks if you become sick or temporarily disabled. Coverage will begin on the 1st day for an accident; the 8th day for an illness and will provide you with a salary reimbursement of 70% per week to a monthly maximum.

LINCOLN NATIONAL - LONG TERM DISABILITY

All benefit eligible employees of USTL are provided Long Term Disability through Lincoln National at no cost! This will protect your income up to your Social Security Normal Retirement Age if you become totally disabled. There is a 90 day elimination period before benefits begin and you will receive 60% of your monthly salary to a maximum of $6,000.

HEALTH CARE REFORM REMINDER

Under the Affordable Care Act, the individual mandate is a provision of the Federal Health Law that requires you, your child(ren), and anyone you claim as a dependent on your taxes, to have health insurance in 2015 or pay a tax. That coverage can be supplied through your employer, public programs such as Medicare or Medicaid, or an individual policy you purchase through the Health Insurance Marketplace.

SUMMARY OF MATERIAL MODIFICATION

USTL has amended the Employee Medical Benefit Plan. This contains a summary of the modifications that were made. It should be read in conjunction with the Summary Plan Description or Certificate of Coverage that is available to you. If you need a copy of your Summary Plan Description or Certificate of Coverage, please go to www.anthem.com or contact Cyrus Beckham.

FACTS ABOUT FLEXIBLE SPENDING ACCOUNTS (FSA)

ADVANTAGE OF A FSA

- You can put pre-tax dollars from your paycheck into an account to pay for eligible medical expenses or dependent care.

DISADVANTAGE OF A FSA

- You should estimate carefully what you expect to spend. If you do not use the funds, they are forfeited at the end of the year.

MEDICAL FSA

- You may elect up to $2,500 for 2015, to pay for eligible medical expenses.
- You or your spouse cannot be enrolled in a HSA.
- The amount you elect is available to you immediately at the beginning of the plan year as payroll deductions are taken throughout the year.

DEPENDENT CARE

- You may elect up to $5,000 for eligible dependent care.
- You must have the funds in this account prior to being reimbursed for dependent care expenses.
- Discuss with your tax advisor if this option or the tax credit on your tax return is best for you.

BI-WEEKLY EMPLOYEE COST

Medical	Base Plan 17AK	Enriched Plan 11AK	HSA Plan E202
Employee	$39.63	$70.93	$17.74
Employee & Spouse	$238.95	$301.56	$195.16
Employee & Child(ren)	$189.12	$243.90	$150.81
Family	$388.43	$474.52	$328.23

Vision	Cost Per Pay Period
Employee	$2.47
Employee & Spouse	$4.69
Employee & Child(ren)	$4.82
Family	$6.42

Dental	Cost Per Pay Period
Employee	$12.97
Employee & Spouse	$26.52
Employee & Child(ren)	$28.12
Family	$44.54

VOLUNTARY LIFE ENROLLMENT WORKSHEET

Employee

$_____ ÷ 1,000 X $_____ = $_____

Amount of Coverage | Unit Cost from Rate Table | Employee Monthly Cost

Spouse

$_____ ÷ 1,000 X $_____ = $_____

Amount of Coverage | Unit Cost from Rate Table | Spouse Monthly Cost

Child(ren)

$_____ ÷ 1,000 X $_____ = $_____

Amount of Coverage | Unit Cost from Rate Table | Child(ren) Monthly Cost

ENROLLMENT WORKSHEET

DEPENDENT PARTICIPATION DETAIL

Legal Name	SS#	Relationship	Gender	DOB	Medical Yes or No	Dental Yes or No	Vision Yes or No

BENEFICIARY INFORMATION

Basic Life Primary Beneficiary(s) - Total Must Equal 100%			
Name	SS#	Relationship	%
Name	SS#	Relationship	%
Basic Life Contingent Beneficiary(s) - Total Must Equal 100%			
Name	SS#	Relationship	%
Name	SS#	Relationship	%
Voluntary Life Primary Beneficiary(s) - Total Must Equal 100%			
Name	SS#	Relationship	%
Name	SS#	Relationship	%
Voluntary Life Contingent Beneficiary(s) - Total Must Equal 100%			
Name	SS#	Relationship	%
Name	SS#	Relationship	%

WHAT DO I NEED TO DO?

Review all benefit information. Ask questions if you do not understand any benefit provision. Complete enrollment forms and return them to Cyrus Beckham.

HELPFUL INFORMATION

Deductibles - The deductible is the amount of money you pay before services are covered under your medical or dental plan. Normally, it is paid for in-patient and out-patient services under your medical plan. Your deductible is accumulated during each calendar year (January 1 through December 31). It does not apply to any preventive services as required under Health Care Reform.

Coinsurance - After the deductible is satisfied, claims costs are shared with the insurance carrier until the out-of -pocket maximum is reached.

Out-of-Pocket Maximums - This is the maximum amount of money you are required to pay in a calendar year. The deductible, co-pays, and your share of the coinsurance under your chosen plan will equal the most you will pay. Once the out-of-pocket maximum is reached, claims are eligible at 100% of covered services.

Office Visit Copayments - When you visit your primary care physician or a specialist, you are required to pay a copayment for that visit. The office visit co-pay will satisfy part of the out-of-pocket limit associated with the plan. There should be no copayments for services coded as preventive by your physician.

Urgent Care - If you visit an urgent care facility you will be required to pay a copayment for this service. It is higher than a regular office visit and lower than an emergency room copayment. In addition to the co-pay, the deductible and coinsurance may apply when these services are performed: CT, PET, MRI, Nuclear Medicine, Pharmaceutical Products, Scopic Procedures, Surgery, Therapeutic Treatments. Note: Take Care Clinic with Walgreens is considered at the primary care office visit co-pay.

Emergency Room - If you visit a hospital emergency room, you will be required to pay a copayment for this service (unless you are enrolled in the HSA). This is a much higher copayment than a regular office visit or urgent care facility. If you are admitted to the hospital the copayment is waived and the deductible / coinsurance applies.

Preventive Services - All services coded as Preventive are covered 100% and the deductible and copayments will not apply. Situations may arise where the "Preventive" service could be coded as "Diagnostic". In these situations the deductible and copayments could apply. Also, if you receive a preventive service in conjunction with a sick visit, you could still be charged the applicable office visit co-pay, deductible, and/or coinsurance. Communication with your provider of care is important.

Lifetime Benefit Maximum - All plan design options have an unlimited lifetime maximum.

Prescription Drugs - All plan design options will cover Tier 1 drugs after a $10 Co-Pay; Tier 2 drugs require a $25 Co-Pay; and Tier 3 drugs are covered after a $45 Co-Pay for up to a 31-day supply. Mail Order prescription will provide up to a 90-day supply of medication (Tier 1- $10, Tier 2 -$65, Tier 3 -$135).
Please visit www.anthem.com to access your prescription drug list as well as the list of prescription drug products that are available through mail order.

Review your Certificate of Coverage. It is a complete summary of your health insurance benefits. You can view the certificate online at www.anthem.com.

Ask your physician or healthcare provider if they participate in the United Healthcare network. Do not ask if they accept Anthem. The providers usually, but not always, accept payments from insurance companies or anyone who wants to give them money; however, not all providers want to accept the contractual discounts required by participation in the network. You can also check the website at www.myuhc.com for the most up-to-date list of participating providers or call customer service at the phone number on the back of your ID card for assistance.

HELPFUL INFORMATION (cont'd…)

This is Important– Understand that all eligible claims for out-of-network providers begins at 110% of what Medicare allows for the procedure. Medicare allowances are extremely low. Claim amounts, which are not eligible, become your responsibility. You could have huge out-of-pocket expenses if you utilize a provider not contracted with United Healthcare.

If you go out-of-network, know that it is your responsibility to pre-certify all procedures. Contact customer service at the phone number on the back of your ID card. There are penalties and more out-of-pocket expenses if you do not pre-certify.

If you travel and need medical services, other than emergency services, check online at www.myuhc.com for a participating provider at a location near you.

This is just a summary of benefits and is intended as a highlight only. If this description conflicts in any way with the Certificate of Coverage or Outpatient Prescription Drug Rider, the Certificate of Coverage and Outpatient Prescription Drug Rider shall prevail.

WHERE SHOULD I RECEIVE CARE?

Primary Care - For routine, primary/preventive care, or non-urgent treatment, it is recommended you go to your doctor's office for medical care. Your doctor knows you and your health history, and has access to your medical records. You will also pay the least out of pocket amount 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 which can be an alternative to seeing your doctor.

Convenience Care Centers are conveniently located in some Walgreens and offer services without the need to schedule an appointment. Services are subject to the primary care physician office visit co-pays.

It is recommended that you seek routine medical care from your primary care physician whenever possible.

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. It is recommended, however, that you seek routine medical care from your primary care physician whenever possible.

Services available for Urgent Care may vary per center. If you choose to use an Urgent Care Center, please make sure it is in-network by calling the toll-free number on the back of your medical ID card or visiting the website at www.myuhc.com.

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.

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.

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

Offer free or Low-Cost Health Coverage to Children and Families

Medicaid and the Children's Health Insurance Program (CHIP)
Offer Free Or Low-Cost Health Coverage To Children And Families

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

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

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

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

Please contact Human Resources for the list of states offering assistance.
You can also contact the following:
U.S. Department of Labor U.S. Department of Health and Human Services

Employee Benefits Security Administration Centers for Medicare & Medicaid Services

www.dol.gov/ebsa **www.cms.hhs.gov**

1-866-444-EBSA (3272) 1-877-267-2323, Ext. 61565

ENROLLMENT

The annual enrollment period for USTL will start August 19, 2015, and end August 28, 2015. During the annual enrollment period, you may enroll your eligible family members, terminate coverage, or make a change to any of your benefit elections. If you wish to enroll, add or make changes to your current coverage, add or terminate dependents on any plan, you must complete an enrollment change form and submit it to Human Resources.

If you are a new employee, you must complete your benefit elections and submit the enrollment forms to Human Resources within 30 days of your eligibility date.

Remember, the elections you make cannot be changed during the benefit year (September 1, 2015-August 31, 2015) unless you experience a life change event such as marriage, divorce, death of a family member, or the birth/adoption of a child.

Employee Benefits - Key Contact Sheet

US Tape & Label Cyrus Beckham	**CBIZ BENEFITS & INSURANCE SERVICES** Nicol Schmidt 314-692-5847
Anthem Blue Cross	**MEDICAL, LIFE & VOLUNTARY LIFE** Member Services: Please use the phone number on the back of your card) www.anthem.com
Lincoln Financial Group®	**SHORT TERM DISABILITY, LONG TERM DISABILITY** Claims Information: 1-800-423-2765 www.lfg.com
DELTA DENTAL®	**DENTAL:** Customer Service: 1-800-335-8266 service@deltadentalmo.com
Vision Benefits of America	**VISION:** Member Services: 1-800-432-4966 www.visionbenefits.com
FLEXIBLE SPENDING ACCOUNT CBIZ FLEX	Send Claims to: CBIZ Flex, 2797 Frontage Rd. Suite 2000, Roanoke, VA, 24017 Fax Claims to: 1-800-584-4185 Submit Claims Online: www.myplans.cbiz.com

REASONS TO CALL	WHO TO CALL
Claims Questions	Carrier / CBIZ
Identification Cards / Numbers	Carrier
Pre-Certification	Carrier
Provider Directory	Carrier Websites
Payroll Issues /Status Changes/ Miscellaneous Issues	US Tape & Label
How to use this resource for claims resolution:	First contact Member Services If issue is still unresolved, contact CBIZ.