2016 Employee Benefits Guide

Your employer has amended the Chameleon Integrated Services Medical Plan. This contains a Summary of the Material Modifications that were made. It should be read in conjunction with the Summary of Benefits & Coverage (SBC) which will be distributed to you within the next 2-3 weeks. If you need a copy of your SBC, please contact Jane O'Malley at 314-773-7200.

Chameleon Integrated Services

CONTACT INFORMATION

Cigna	**Medical** *Call the number on the back of your ID card
MetLife®	**Dental & Vision** www.metlife.com 1-800-858-6506
Lincoln Financial Group®	**Life, Short Term & Long Term Disability:** Disability & Life: www.lfg.com Disability Email: DisabilityClaims@lfg.com Life Email: LifeClaims@lfg.com

CBIZ

If you have called the 800 number on your identification card and still need assistance regarding your benefits, please contact our benefit consultants below:

Tina Borge, Account Executive

314-692-5845 ~ tborge@cbiz.com

Nicol Schmidt, Account Manager

314-692-5847 ~ nschmidt@cbiz.com

ENROLLING IN THE PLANS

See Human Resources for forms to complete for enrollment

ELIGIBILITY

Eligible: Employees currently working 30 or more hours per week
Ineligible: Employees working under 30 hours per week

FREQUENTLY ASKED QUESTIONS

ARE CHANGES TO MY PLAN ALLOWED DURING THE YEAR?

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

EXAMPLES OF QUALIFYING EVENTS?

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

About This Bulletin

This bulletin is published for employees of Chameleon Integrated Services and is only a highlight of our benefits. Official plan and insurance documents actually govern your rights and benefits under each plan. If any discrepancy exists between this bulletin and any of the official documents, the official documents will prevail.

Chameleon Integrated Services

Three Convenient Ways to Manage Your Health Care

1. Download free Cigna app - just search for myCigna at the app store on your mobile device. Find doctors and urgent care centers, and get driving directions from wherever you are. You can also log in and view, email or fax an electronic version of your ID card.
2. Get to Cigna's mobile site by going to www.myCigna.com on your smartphone - and you'll get many of the same features of their app.
3. Get the full www.myCigna.com experience on the go by using your tablet computer. Check your claims and benefits, use your health and wellness tools, get discounts on contact lenses and glasses.

To log in on your smartphone, you must be registered on Cigna's secure member site and have a username and password. If you are an Cigna member but haven't registered, go to www.myCigna.com from your computer and click *Register Now*.

Your Care Options and When to Use Them

PRIMARY CARE

For routine, primary/preventive care, or non-urgent treatment, we recommend going to your doctor's office for medical care. Your doctor knows you and your health history, and has access to your medical records. You may also pay the least amount out-of-pocket when you receive care in your doctor's office.

CONVENIENCE CARE

Sometimes, you may not be able to get to your doctor's office, and your condition is not urgent or an emergency. In these situations, you may want to consider a Convenience Care Center that can be an alternative to seeing your doctor.

Convenience Care Centers are conveniently located often in malls or some retail stores, such as CVS Caremark, Walgreens, Walmart and Target, and offer services without the need to schedule an appointment. Services at a Convenience Care Center may be provided at a lower out-of-pocket cost than an urgent care center visit and are subject to primary care physician office visit copays and/or deductible/coinsurance.

Services at a Convenience Care Center are generally available to patients 18 months of age or older. Services that are available may vary per center. We do, however, recommend that you seek routine medical care from your primary care physician whenever possible.

Convenience Care Center

Typical conditions that may be treated at a Convenience Care Center include:

- Common infections (e.g.: bronchitis, bladder infections, ear infections, pink eye, strep throat)
- Minor skin conditions (e.g.: athlete's foot, cold sores; minor sunburn, poison ivy)
- Flu shots
- Pregnancy tests

This is a sample list and not all-inclusive. For a full listing of services please visit each center's Website.

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

URGENT CARE

Sometimes you may need medical care fast, but a trip to the emergency room may not be necessary. Of course, during office hours you may be able to go to your doctor for any urgently needed service; however, if you require urgent care outside your doctor's regular office hours or you are unable to be seen by your doctor immediately, you may consider going to an urgent care center. At an urgent care center, you can generally be treated for many minor medical problems faster than at an emergency room. We do however, recommend that you seek routine medical care from your primary care physician whenever possible.

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

URGENT CARE

Typical conditions that may be treated at an Urgent Care Center include:

- Sprains
- Strains
- Mild asthma attacks
- Minor infections
- Vaccinations
- Small cuts
- Sore throats
- Rashes
- Preventive Screenings
- Back Pain or Strains

This is a sample list and not all-inclusive. For a full listing of services please visit each center's Website.

LAB SERVICES

If you require lab work consider having these services performed at LabCorp and Quest Diagnostics. When coded as preventive, the cost will be covered 100%. If you choose to use a lab other that these, services associated with the cost of your lab work will apply to the out-of-network deductible and coinsurance.

EMERGENCY ROOM

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

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

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

EMERGENCY ROOM

Some examples of emergency conditions may include the following:

- Heavy bleeding
- Chest pain
- Major burns
- Severe head injuries
- Sudden weakness or trouble walking
- Large open wounds
- Sudden change in vision
- Spinal injuries
- Difficulty breathing

This list only provides examples and is not intended as an exclusive list. If you believe you or your loved one is experiencing an emergency medical condition, you should go to the nearest emergency room or call 911, even if your symptoms are not described here.

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

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

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

BASE PLAN

Cigna-OAP ($2500)

Benefit/Service	In-Network	Out-of-Network
Deductible (single / family)	$2,500/$5,000	$7,500/$15,000
Coinsurance	80%	50%
Out of Pocket Max. (single/family)	$6,250/$12,500	$12,500/$25,000
Lifetime Max Benefit	Unlimited	Unlimited
Inpatient Hospital	80% after Ded.	50% after Ded.
Outpatient Hospital	80% after Ded.	50% after Ded.
Preventive Care	100%	Not Covered
Office Visit Copay (PCP / Specialist)	$35/$75 Co-Pay	50% after Ded.
Outpatient Lab & X-ray	80% after Ded	50% after Ded.
Major Diagnostics (MRI, PET, CT)	$400 Co-Pay	50% after Ded.
Emergency Room	$300 Co-Pay	$300 Co-Pay
Urgent Care	$100 Co-Pay	$200 Co-Pay
Prescription	After Deductible at Participating Pharmacies:	
Retail (Tier 1, 2, 3)	$15/$40/$75	
Mail Order (Tier 1, 2, 3)	$35/$110/$215	

Type of Coverage	Employee Bi-Weekly Cost
Employee	$36.00
Employee & Spouse	$230.00
Employee & Child(ren)	$215.00
Employee & Family	$335.00

BUY UP PLAN

Cigna-OAP $1,000

Benefit/Service	In-Network	Out-of-Network
Deductible (single / family)	$1,000/$2,000	$3,000/$6,000
Coinsurance	100%	70%
Out of Pocket Max. (single/family)	$4,000/$8,000	$8,000/$16,000
Lifetime Max Benefit	Unlimited	Unlimited
Inpatient Hospital	100% after Ded.	70% after Ded.
Outpatient Hospital	100% after Ded.	70% after Ded.
Preventive Care	100%	Not Covered
Office Visit Copay (PCP or Specialist)	$25/$50 copay	70% after Ded.
Outpatient Lab & X-ray	100%	70% after Ded.
Major Diagnostics (MRI, PET, CT)	100% after Ded.	70% after Ded.
Emergency Room	$300 copay	$300 copay
Urgent Care	$100 copay	70% after ded.
Prescription	After Deductible at Participating Pharmacies:	
Retail (Tier 1, 2, 3)	$15/$40/$75	
Mail Order (Tier 1, 2, 3)	$35/$110/$215	

Type of Coverage	Employee Bi-Weekly Cost
Employee	$44.00
Employee & Spouse	$275.00
Employee & Child(ren)	$255.00
Employee & Family	$400.00

Enhance Your Smile with Metlife Dental Coverage

Benefits	PPO Network	Out of Network
Deductible		
Individual	$50	$50
Family	$150	$150
Coinsurance		
Diagnostic/ Preventive	100%	100%
- Cleanings	(no deductible)	(deductible applies)
Basic Services	80%	80%
- Periodontics	80%	80%
- Endodontics	80%	80%
Major Services	50%	50%
Annual Maximum	$1,000/person per year	

Employee Cost Per Bi-Monthly Pay Period

Type of Coverage	Cost
Employee	$13.32
Employee & Spouse	$28.19
Employee & Child(ren)	$29.70
Employee & Family	$47.60

See Clearly with Metlife Vision Coverage

Vision Benefits	In Network	Out of Network**
Frequency of Service:		
Eye Exams	12 Months	12 Months
Lenses	12 Months	12 Months
Frames	24 Months	24 Months
Eye Exam	$10	$45
Basic Lenses	$20 Co-Pay, then	
Single Vision	100%	$30
Bifocal	100%	$50
Trifocal	100%	$65
Frames	$150 Retail Allowance	$50
Contacts		
Necessary	100%	$210
Cosmetic	$150	$105

**You have in and out of network benefits providing you the flexibility to see any provider you choose. If you utilize an out of network provider you will be responsible for all charges above the allowed amount.

Lincoln Financial Life/AD&D

Chameleon Integrated Services will continue to provide Life Insurance coverage to our employees through Lincoln Financial. This protection will provide coverage in the amount of $50,000 for the employee only. This benefit amount also carries an equal benefit of Accidental Death and Dismemberment coverage. As a reminder, now is a good time to update your beneficiary information if necessary. Forms can be requested from Jane O'Malley.

Lincoln Financial Voluntary Life/AD&D

Voluntary Term Life coverage is also offered through Lincoln Financial and can be purchased for yourself and your dependents on an age-banded basis. Please see the chart for the cost based on your age. Keep in mind when calculating the cost for your spouse, be sure to base the cost on the employee age as opposed the spouse age. You will need to purchase life insurance for yourself before you can purchase it on your spouse or dependents.

Employee Term Life:

Life insurance can be purchased in the following benefit increments: $10,000, $20,000, $30,000, $50,000, $80,000 or $200,000 not to exceed 5x salary. For those age 70+, the maximum is $70,000.

Spouse Term Life:

Life insurance can be purchased in the following benefit increments: $10,000, $15,000 or $25,000. When calculating premium for spouse coverage use the employee's age.

Children 14 days to 6 months:

Life Insurance can be purchased with a benefit of $250

Children 6 months to age 26:

Life insurance can be purchased with a benefit of $10,000.

MONTHLY COST	
Age Band	Monthly Rate per $1,000
Under 30	$0.061
30-34	$0.070
35-39	$0.100
40-44	$0.150
45-49	$0.241
50-54	$0.390
55-59	$0.640
60-64	$0.850
65-69 ($6,500)*	$0.865
70-74 ($2,700)*	$0.975
75+	$1.088

* Due to reduction schedule

The **guarantee issue** amount for employees is $80,000, for spouse, $25,000 and for children $10,000. If you choose to purchase over these amounts you will need to complete an Evidence of Insurability (EOI) form and be approved by Lincoln Financial. If you previously purchased life insurance and would like to increase the benefit, you may increase by up to 2 increments without completing EOI. By example, if you currently have $80,000 in life insurance you can increase to $200,000 without Evidence of Insurability because that is the next increment.

Protect Your Income with Lincoln Financial Short Term Disability

All benefit eligible employees of Chameleon Integrated Services are provided Short Term Disability through Lincoln National at no cost! This will protect your income for up to 13 weeks if you become sick or temporarily disabled. Coverage will begin on the 8th day for an accident or illness and will provide you with a salary reimbursement of 60% per week to a maximum of $1,000.

Protect Your Future with Lincoln Financial Long Term Disability

All benefit eligible employees of Chameleon Integrated Services are provided Long Term Disability through Lincoln National at no cost! This will protect your income up to the later of age 65 or 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 $5,000.

ENROLLMENT WORKSHEET

Medical	Plan 1	Plan 2	Monthly Cost
Employee	$	$	
Employee & Spouse	$	$	
Employee & Child(ren)	$	$	
Family	$	$	

Dental			Monthly Cost
Employee	$		
Employee & Spouse	$		
Employee & Child(ren)	$		
Family	$		

DEPENDENT PARTICIPATION DETAIL

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

Basic Life Primary Beneficiary(s) - Total Must Equal 100%

BENEFICIARY INFORMATION

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	%

MARKETPLACE OPTIONS

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

General Information

When key parts of the health care law took effect in 2014, there was a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by Chameleon Integrated Services.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance which meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit which lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins November 1st through January 31st.

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

You may qualify to save money and lower your monthly premium. Savings depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer which offers minimum essential coverage and meets affordability standards, you will not be eligible for a tax credit through the Marketplace. If you purchase health coverage through the Marketplace, you may lose any employer contribution offered for the employer-offered coverage. Employer and employee contributions for employer-offered coverage are often excluded from Federal income tax. Payment for Marketplace coverage is made on an after-tax basis.

More Information

New employees will receive a notice of Marketplace Coverage Options advising the standards of offered coverage. Please visit HealthCare.gov for more Marketplace information.

MEDICAID CHIP NOTICE

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're 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 on the DOL website provided below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **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)**.

Following is a link to the latest form and states where you may be eligible for assistance paying your employer health premiums: http://www.dol.gov/ebsa/pdf/chipmodelnotice.pdf

For more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-3272
Menu Option 4, Ext 61565

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

IMPORTANT NOTICES

SPECIAL ENROLLMENT NOTICE

During the open enrollment period, eligible employees are given the opportunity to enroll themselves and dependents into our group health plans. If you elect to decline coverage because you are covered under an individual health plan or a group health plan through your parent's or spouse's employer, you may be able to enroll yourself and your dependents in this plan if you and/or your dependents lose eligibility for that other coverage. If coverage is lost, you must request enrollment within 30 days after the other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll any new dependent within 30 days of the event. To request special enrollment or obtain more information, contact *Jane O'Malley.*

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

As a requirement of the Women's Health and Cancer Rights Act of 1998, your plan provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. The benefits must be provided and are subject to the health plan's regular co-pays, deductibles, and co-insurance. You may contact our health carrier at the phone number on the back of your ID card for additional benefit information.

NOTICE OF PRIVACY PRACTICES

The Cigna Plan is subject to the HIPAA privacy rules. In compliance with these rules, it maintains a Notice of Privacy Practices. You have the right to request a copy of the Notice of Privacy Practices by contacting Jane O'Malley

MEDICARE PART D CREDITABLE COVERAGE

This notice has information about your current prescription drug coverage and about your options under Medicare's prescription drug coverage. If you are eligible for Medicare the following information can help you decide whether or not you want to join a Medicare drug plan. You should consider comparing your current coverage through our medical plan with the costs of plans offering Medicare prescription drug coverage in your area. Two important things you need to know about your current coverage and Medicare prescription drug coverage:

Medicare prescription drug coverage is available if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan. All Medicare drug plan provide at least a standard level of coverage set by Medicare. More coverage may be offered at a higher premium.

Cigna has determined that the prescription drug coverage under both plans offered by Chameleon Integrated Services are, on average, for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pay and is therefore considered Creditable Coverage. Because this coverage is Creditable Coverage, you can keep it and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

If you lose your current creditable prescription drug coverage through no fault of your own, you will be eligible for a two-month Special Enrollment Period to join a Medicare drug plan.

If you decide to join a Medicare drug plan, your current coverage will not be affected. This plan will coordinate with Part D coverage. If you drop your current coverage, be aware that you and your dependents will be able to get this coverage back.

If you drop or lose your current coverage and don't join a Medicare drug plan within 63 continuous days after your coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

A notice will be provided to you prior to the October 15 Medicare open enrollment period. If you want more information about Medicare plans that offer prescription drug coverage, you will find it in the Medicare & You handbook or you can visit www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227) TTY users: 1-800-486-2048. If you have limited income and resources, visit Social Security on their website at www.socialsecurity.gov, or call them at 1-800-772-1213. TTY users: 1-800-325-0778.

Keep all Creditable Coverage notices. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of the notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

GLOSSARY OF TERMS

Coinsurance – Your share of the cost of covered services which is calculated as a percentage of the allowed amount. This percentage is applied after the deductible has been met. The plan pays any remaining percentage of the cost until the out-of-pocket maximum is met. Coinsurance percentages will be different between in-network and non-network services.

Copays – A fixed amount you pay for a covered health care service. Copays can apply to office visits, urgent care, or emergency room services. Copays will not satisfy any part of the deductible. Copays should not apply to any preventive services.

Deductible – The amount of money you pay before service are covered. Services subject to the deductible will not be covered until it has been fully met. It does not apply to any preventive services as required under the Affordable Care Act.

Emergency Room – Services you receive from a hospital for any serious condition requiring immediate care.

Lifetime Benefit Maximum – All plans are required to have an unlimited lifetime maximum.

Medically Necessary – Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease or its symptoms, which meet accepted standards of medicine.

Network Provider - A provider who has a contract with your health insurer or plan to provide services at set fees. These contracted fees are usually lower than the provider's normal fees for services.

Out-of-Pocket Maximum – The most you will pay during a set period of time before your health insurance begins to pay 100% of the allowed amount. The deductible, coinsurance, and co-pays are included in the out-of-pocket maximum.

Preauthorization – A process by your health insurer or plan to determine if any service, treatment plan, prescription drug, or durable medical equipment is medically necessary. This is sometimes called prior authorization, prior approval, or precertification.

Prescription Drugs – Each plan offers its own unique prescription drug program. Specific copays apply to each tier and a medical plan can have one to five separate tiers. The retail pharmacy benefit offers a 30-day supply. Mail Order prescriptions provide up to a 90-day supply. Sometimes the deductible must be satisfied before copays are applied.

Preventive Services – All services coded as Preventive must be covered 100% without a deductible, coinsurance, or copayments.

UCR (Usual, Customary and Reasonable) – The amount paid for medical services in a geographic area based on what providers in the area usually charge for the same or similar service.

Urgent Care – Care for an illness, injury or condition serious enough that a reasonable person would seek immediate care, but not so severe to require emergency room care.