2016-2017 Employee Benefits Guide

Helping You Become A Better You.

The purpose of this booklet is to describe the highlights of your benefit program. Your specific rights to benefits under the Plans are governed solely, and in every respect, by the official Plan documents and insurance contracts, and not by this booklet. If there is any discrepancy between the description of the Plans as described in this material and official Plan documents, the language of the documents shall govern.

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Contact Information

[COMPANY NAME] in partnership with the following carriers, strives to meet your benefit needs. If you have any questions regarding your benefits, please contact the corresponding carrier listed below or your [COMPANY NAME] human resources representative.

Contact Information		
Vendors	**Phone Number**	**Website**
Medical: ***UnitedHealthcare*** Group Number:	877.844.4999	myuhc.com
Dental: ***MetLife*** Group Number:	800.438.6388	metlife.com
Vision: ***EyeMed*** Group Number:	866.939.3633	eyemed.com
Basic Life & AD&D, Voluntary Life & AD&D, Dependent Life, Short-Term Disability and Long-Term Disability: ***Mutual of Omaha*** Group Number:	800-369-3809	mutualofomaha.com
Virtual Benefits: ***Call-A-Doctor Plus***	800-835-2362	teladoc.com
Flexible Spending Accounts: ***CBIZ***	800-815-3023	myplans.cbiz.com
Benefits Team	**Phone**	**Email**
CBIZ Benefits & Insurance Services: ***Asha Kuhn, Senior Account Manager*** ***Eric File, Senior Account Executive***	800.844.4510 314.692.5846 314.692.5848	akuhn@cbiz.com efile@cbiz.com

Medical Insurance

Understanding Your Health Plan Options

As an employee of [COMPANY NAME] you have the choice between two medical plan options. Regardless of the plan you choose to elect, the deductible will run on a calendar year basis (January 1—December 31). These options are re-evaluated every year and are effective each February 1st. You have the choice of a Traditional PPO and an HSA Qualified High Deductible Health Plan.

While each plan gives you the option of using out-of-network providers, it is to your advantage to use in-network providers because UnitedHealthcare has negotiated significant discounts with in-network providers. If you choose to go out-of-network, you will be responsible for the difference between the actual charge and UnitedHealthcare's UCR (Usual, Customary and Reasonable) charge for the service or procedure plus any deductible and coinsurance associated with your service or procedure.

The major advantage the Qualified High Deductible Health Plan has over the Traditional PPO Plan is the Qualified High Deductible Health Plan offers you significantly lower premiums than the PPO Plan. You can establish a Health Savings Account (HSA) banking arrangement with a bank of your choice and contribute all or part of the premium savings into the HSA. The HSA can be used to cover medical expenses including deductibles. These funds are yours forever even if you leave [COMPANY NAME]. They are not forfeited at the end of the year.

The HSA Qualified Plan offers several benefits:

- Lower premium contributions and potential maximum out of pocket expenses.
- Routine preventive exams are covered at 100%.
- Catastrophic coverage.
- The HSA banking arrangement is owned by the employee.
- This type of arrangement offers you more control over your health care dollars.

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

✓ Frequently Asked Questions

How many hours per week must I work to be eligible for the insurance benefits?

✓ You must be a full-time employee working a minimum of 30 hours per week on a regular basis.

Will I receive a Medical ID card?

✓ You will receive an ID card in the mail if you are electing medical coverage.

Does the deductible run on a calendar year or policy year basis?

✓ The deductible runs on a calendar year basis.

When will my benefits become effective?

✓ Your medical benefits insurance will begin on the first of the month following thirty (30) days of employment for regular full-time employees.

How long can I cover my dependent children?

✓ Dependent children are eligible until the end of the month in which they turn age 26.

The traditional plan may be for you if:

- You are not interested in establishing a Health Savings Account.
- You would rather pay more in monthly premiums and less on medical expenses when they occur.
- You expect to incur medical expenses at the beginning of the year and don't have the resources to pay for them.

Understanding Health Savings Accounts (HSA)

What is an HSA?

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

What rules must I follow?

- You must be covered under a Q*ualified High Deductible Health Plan (QHDHP)* in order to establish an HSA.
- You cannot establish an HSA if you or your spouse also have a medical *flexible* spending account (FSA), 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 enrolled to Medicare or Tricare due to age or disability.
- You cannot be claimed as a dependent under someone else's tax return.

What else do I need to know?

- Contributions are based on a calendar year. The contribution limits for 2016 are $3,350 for Single and $6,750 for Family coverage. You cannot put more than this amount in the account; you can put less.
- The contributions 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 medications 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).
- There is no penalty for distributions following death, disability (as defined in IRC 72), or attainment of Medicare eligibility age, but taxes would apply for non-qualified distributions.

Another advantage is that your account can grow over time.

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

The HSA is also an investment opportunity.

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

Generally, you can put enough in your HSA to cover 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 cannot be more than the IRS annual contribution limit. If you're age 55 or older, you are allowed to make extra contributions each year.

You can spend only the money that is actually in your HSA.

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

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

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

- Doctor's office visits
- Dental services
- Eye exams, eyeglasses, contact lenses and solution, and laser surgery
- Hearing aids
- Orthodontia, dental cleanings, and fillings
- Prescription drugs and some over-the-counter medications, with a physician's prescription
- Physical therapy, speech therapy, and chiropractic expenses

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

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

The HSA is your personal account and contains your personal funds. It can be considered an asset by a creditor and garnished as applicable.

As an HSA account holder, you will be required to file a Form 8889 with the IRS each year. This form identifies any contributions, distributions, or earned interest associated with the account.

This may be the plan option for you if:

- You do not incur a lot of medical and prescription medication expenses.
- You would like money in a savings account to pay for Qualified Expenses permitted under Federal Law.
- You would like the opportunity to contribute pre-tax to a Health Savings Account.

✓ Frequently Asked Questions

What will I pay at the pharmacy with the HSA qualified plan options?

✓ You will pay the actual discounted cost of the drug until you satisfy your calendar year deductible in full, then your pharmacy copays will apply.

What will I pay at the physician's office with the HSA qualified plan option?

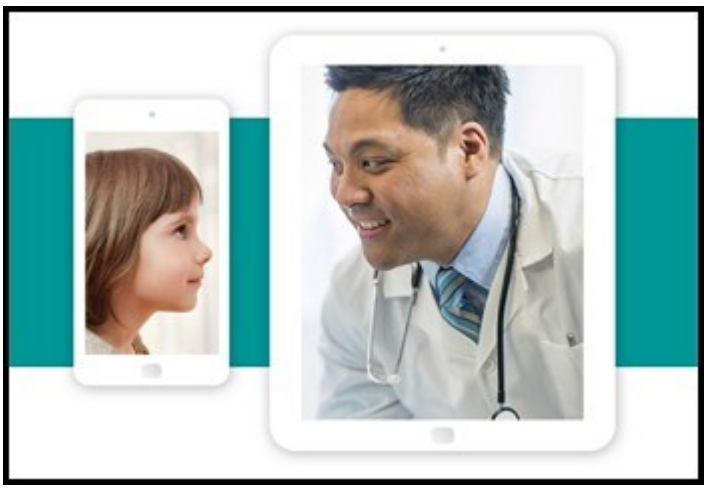
✓ You will provide your ID card at the time of the visit. The office will submit the claim to UnitedHealthcare. UnitedHealthcare will discount the charges based upon the physician's contract with UnitedHealthcare. You will receive an Explanation of Benefits (EOB) from UnitedHealthcare that illustrates your responsibility. You will receive a bill from the physician's office. You will pay them the discounted cost from the EOB.

Where can I obtain a copy of an EOB?

✓ You can access all of your EOB information, and even print a copy, by registering on myuhc.com.

Virtual Visits

A virtual visit lets you see and talk to a doctor from your mobile device or computer without an appointment. Most visits take about 10-15 minutes and doctors can write a prescription, if needed, that you can pick up at your local pharmacy.



CONDITIONS COMMONLY TREATED THROUGH A VIRTUAL VISIT

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

ACCESS TO VIRTUAL VISITS

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

Advocate4ME

Advocate4Me is a consumer engagement program that provides UnitedHealthcare's members with a single point of contact to address your various health needs. By calling a single toll-free number, or using your preferred communication channel, members are connected with an Advocate who provides them with end-to-end support, "owning" their request until it's resolved. This service is offered at no charge to UnitedHealthcare members.

Rally

Rally is a user-friendly digital experience on myuhc.com that will engage you in a new way by using technology, gaming and social media to help you understand, learn and support you on your health journey. With the online Rally Health Survey, personalized missions, rewards and connections to wearables like Fitbit, Jawbone and more, it is easier for you to get motivated to be healthier.

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, Wal-mart and Target, and offer services without the need to schedule an appointment. Services at a Convenience Care Center may be provided at a lower out of pocket cost than an urgent care center visit and are subject to primary care physician office visit copays and/or deductible/coinsurance.

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

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

Urgent Care

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

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 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.

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.

Urgent Care

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

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

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

Emergency Room

Some examples of emergency conditions may include the following:

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

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.

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

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 an emergency, no matter where you are, call 911 or go to the nearest emergency room for treatment. In an emergency, all facilities are considered in-network.*

*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.

Lab Services

If you require lab work consider having these services performed at LabCorp. If you choose to use LabCorp, services associated with the cost of your lab work will not apply to the deductible and coinsurance and will be covered 100% in most cases.

Your Medical Insurance Plan Options and Costs

UnitedHealthcare - Plan Designs

Features	Traditional PPO Plan		Qualified High Deductible Health Plan (QHDHP) with HSA Option	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible (Individual / Family)	$1,000 / $2,000	$3,000 / $6,000	$2,600 / $5,200	$7,500 / $15,000
Coinsurance	80%	50%	100%	70%
Out-of-Pocket Maximum (Individual / Family) *Includes Deductible, Coinsurance & Co-Pay*	$4,000 / $8,000	$8,000 / $16,000	$6,250 / $12,500	$12,500/ $25,000
Office Visit (Primary Care physician / Specialist)	$30 / $60 Co-Pay	50% after Deductible	$35 / $70 Co-Pay After Deductible	70% after deductible
Preventive Care	100%	50% after Deductible	100%	70% after deductible
Diagnostics: Lab and X-Ray Major Diagnostics (MRI, CT, PET…)	 100% 80% after Deductible	 50% after Deductible 50% after Deductible	 100% after Deductible 100% after Deductible	 70% after deductible 70% after deductible
Urgent Care	$100 Co-Pay	50% after Deductible	$100 Co-Pay After Deductible	70% after deductible
Emergency Room	$300 Co-Pay		$300 Co-Pay after In-Network Deductible	
Outpatient Surgery	80% after Deductible	50% after Deductible	100% after Deductible	70% after deductible
Inpatient Hospital Services	80% after Deductible	50% after Deductible	100% after Deductible	70% after deductible
Prescription Drug *Retail (at Participating Pharmacies)* *Mail Order (90-Day Supply)*	 $10/$35/$60 $25/$87.50/$150		 Deductible, then $10/$35/$60 Co-Pay Deductible, then $25/$87.50/$150 Co-Pay	

Below are the per paycheck costs associated with each of the two medical plan options being offered for 2016/ 2017 plan year. Please note that your premiums will be withheld from your paycheck on a pre-tax basis for medical, dental and vision insurance. This can save you considerable money as the savings are based upon your individual tax bracket. Your election can only be changed mid plan year if you experience a qualifying life status change. You must notify Human Resources within 30 days of the event.

NOTE: If you purchase a Prescription Drug Product from a Non-Network Pharmacy, you are responsible for any difference between what the Non-Network Pharmacy charges and the amount UnitedHealthCare would have paid for the same Prescription Drug Product dispensed by a Network Pharmacy.

Per Paycheck Employee Cost

Type of Coverage	Traditional PPO Plan	QHDHP with HSA Option
Employee	$109.58	$40.03
Employee & Spouse	$339.11	$200.00
Employee & Child(ren)	$281.73	$160.01
Employee & Family	$511.25	$319.99

Both plans are included in UnitedHealthcare's 2016 Certificate of Coverage (COC). This is a brief summary only. For exact terms and conditions, please refer to your summary plan description.

Voluntary Dental Insurance

MetLife is the dental carrier for 2016/2017. The dental plan offers coverage in a PPO network and out-of-network. It is to your advantage to utilize a network dentist to take advantage of contracted fees. If you go out-of-network, you will be responsible for any amount exceeding MetLife's negotiated fees plus any deductible and coinsurance associated with your procedure. Dependent children are eligible until the end of the month in which they turn age 26. The following is a brief summary of your MetLife benefits:

MetLife - Plan Design

Features		PPO In-Network	Out-of-Network
Deductible (Individual/Family)	■ Aggregate	$50 / $150	$50 / $150
Annual Maximum	■ Applied to Type A, B & C Services	$1,500	$1,500
Type A - Preventive Services	■ Oral Examinations ■ Bitewing X-rays ■ Fluoride Treatments ■ Sealants ■ Prophylaxis: Cleanings	100% (No Deductible)	80% (No Deductible)
Type B - Basic Services	■ Space Maintainers ■ Full Mouth, Periapical & Other X-Rays ■ Fillings ■ Occlusal Guards / Bruxism Appliances ■ Oral Surgery - Simple Extractions ■ Labs & Other Tests ■ Emergency Palliative Treatment	80%	60%
Type C - Major Services	■ Endodontics ■ Periodontics ■ Fixed Bridges ■ Inlays/Onlays/Crowns ■ Implants ■ Dentures ■ Occlusal Adjustments ■ General Anesthesia ■ Oral Surgery: Surgical Extractions & Other Surgery	50%	50%
Orthodontia Child(ren)	■ Diagnostics and Treatment	50% up to $1,000 Lifetime maximum	50% up to $1,000 Lifetime maximum

In-Network Providers: agree to be reimbursed from a fee schedule and no balance billing.

Out-of-Network Providers: benefit payments are made up to the 90th percentile of Reasonable and Customary; and balance billing is possible.

Per Paycheck Employee Cost

Type of Coverage	Cost
Employee	$13.87
Employee & Spouse	$27.43
Employee & Child(ren)	$32.35
Employee & Family	$49.34

FIND A DENTIST

To find a MetLife provider in your area, visit the website at metlife.com.

- **Click on "Find a Dentist"**
- **Enter your Zip Code**
- **Select the PDP Plus network**
- **Click "Submit"**

A comprehensive directory of dentists will appear.

Voluntary Vision Insurance

EyeMed is the vision carrier for 2016/2017. The vision plan offers coverage both in-network and out-of-network. It is to your advantage to utilize a network provider to take advantage of the established contract rates and benefits. If you go out-of-network, your benefit is based on a reimbursement schedule. Also, if you are considering Lasik Surgery, there is a discount available with particular providers. To find a participating provider, go to eyemed.com. The following is a brief summary of your EyeMed vision benefits:

EyeMed - Plan Design

Features	In-Network	Out-of-Network
Examination Co-pay	$10 Co-Pay	$40 Reimbursement
Frequency of Service:		
Exam	Every 12 Months	
Lenses	Every 12 Months	
Frames	Every 24 Months	
Lenses		Reimbursement
Single	$15 Co-Pay	$30
Bifocal	$15 Co-Pay	$50
Trifocal	$15 Co-Pay	$70
Lenticular	$15 Co-Pay	$70
Standard Progressive Lenses	$80 Co-Pay	$50
Frames	$0 Co-Pay; $160 allowance, 20% off balance over $160	Reimbursement $112
Contacts *(Contact lens allowance includes materials only)*		Reimbursement
Conventional	$0 Co-Pay; $160 allowance, 15% off balance over $160	$160
Disposable	$0 Co-Pay;/ $160 allowance, plus balance over $160	$160
Medically Necessary	$0 Co-Pay, Paid-in-Full	$210

Out-of-Network Services: You can choose to receive care outside of the EyeMed network. You simply get an allowance toward services and you pay the rest. (In-Network benefits and discounts will not apply.) Just pay in full at the time of service and then file a claim for reimbursement.

Per Paycheck Employee Cost

Type of Coverage	Cost
Employee	$3.85
Employee & Spouse	$7.32
Employee & Child(ren)	$7.71
Employee & Family	$11.33

FIND A PROVIDER

To find a EyeMed vision provider in your area, visit the website at eyemed.com.

- **On the right side of the webpage you can quickly find a provider by clicking on "Find a Provider"**
- **Enter your zip code and hit the Search button**
- **The search will generate a report of the Search Results, listing the providers closest to your zip code first**
- **Clicking on the "More Info" button next to the provider will display products, services, doctors, etc. for that location**
- **OR, you can call 866.939.3633 to speak with a Customer Service representative**

Basic Life and AD&D

[COMPANY NAME] provides two and a half times your annual earnings to a maximum of $50,000 in Basic Life and Accidental Death and Dismemberment insurance. This coverage is offered through Mutual of Omaha and is at no cost to you. Coverage for your spouse and children is also available for a monthly cost of $1.44. Spouses are eligible for $5,000 in coverage and $2,500 is available for your dependent children. Additional Life and AD&D coverage is available under the Voluntary Life and AD&D coverage described below.

Employees are eligible the first of the month after thirty (30) days of employment for regular full-time employees.

Voluntary Life and AD&D and Dependent Life

Rates per $1,000 of coverage			
	Age	**Employee**	**Spouse***
Voluntary Life	<24	$0.060	$0.060
	25-29	$0.060	$0.060
	30-34	$0.070	$0.070
	35-39	$0.080	$0.080
	40-44	$0.130	$0.130
	45-49	$0.210	$0.210
	50-54	$0.350	$0.350
	55-59	$0.550	$0.550
	60-64	$0.860	$0.860
	65-69	$1.55	$1.55
	70-74	$2.77	
	75-79	$4.57	
	80+	$9.25	
	Child(ren)	$0.130/month for $1,000 coverage	
Voluntary AD&D	$.020 $.040 for Child(ren)		

*Spouse rate is based on the employee's age.

- Voluntary Employee Life & AD&D, minimum $10,000 to a maximum of 5 times annual salary or $250,000 in $10,000 increments. The guarantee issue amount for the employee is up to $100,000.
- Optional Dependent Life & AD&D, for spouse, minimum $10,000 up to 50% of the employee amount to $100,000 maximum in $10,000 increments. The guarantee issue amount for the spouse is up to $50,000
- Optional Dependent Life & AD&D, for children, minimum $1,000 up to $10,000 maximum. The guarantee issue amount for children is $10,000.
- If you do not enroll during your initial enrollment period in the Voluntary Life and AD&D plan, you will be required to complete an Evidence of Insurability form and be approved by Mutual of Omaha before you are able to obtain coverage in the future.

Please note: If you elect Voluntary Life for yourself and/or your dependents, Voluntary AD&D is an automatic election based on the voluntary life insurance amount.

Disability Insurance

Short-Term Disability

Short-Term Disability insurance is offered through Mutual of Omaha. [COMPANY NAME] contributes 80% of the premium cost. The plan benefit is 60% of basic weekly earnings up to a maximum of $1,500 per week. Basic earnings is the average of your gross weekly income for the year immediately prior to the onset of disability and includes commissions, bonuses, overtime pay, shift differential pay or any other earnings. There is a waiting period of 30 days for an accident and 30 days for sickness and continues for 9 weeks.

Long-Term Disability

Long-Term Disability insurance is offered through Mutual of Omaha and [COMPANY NAME] contributes 80% of the premium for this benefit. The plan benefit is 60% of basic monthly earnings up to a maximum of $7,500 per month. Basic earnings is the average of your gross monthly income for the year immediately prior to the onset of disability and includes commissions, bonuses, overtime pay, shift differential pay or any other earnings. The benefits begin after a 90 day waiting period.

Long-Term Care

Long-term care is defined as the type of care received either at home or in a facility when someone needs assistance with activities of daily living, or suffers severe cognitive impairment due to an accident, an illness or advancing age. Health insurance won't cover the cost for nursing home stays, and government programs like Medicare and Medicaid often fall short as well. That is why [COMPANY NAME] offers employees and their extended families the opportunity to purchase long-term care insurance at a group rate through Unum. Employees' spouses, their parents and grandparents and their spouses' parents and grandparents and siblings, and children 18 or older are also eligible to purchase coverage.

Employee pays the full premium for a basic level of long-term care coverage for all benefit eligible employees. In addition to the base level, employees can purchase amounts up to and including a $6,000 monthly benefit and a facility benefit duration of 3 or 6 years on a guarantee issue basis. All newly hired employees will have 30 days to sign up for the guarantee issue coverage. Completion of a benefit election form is required for enrollment. If you choose an amount or a duration beyond the guarantee issue, a medical questionnaire will also be required. All family members must complete the benefit election form as well as a medical questionnaire. Plan options are listed below. Please contact Human Resources to obtain the forms.

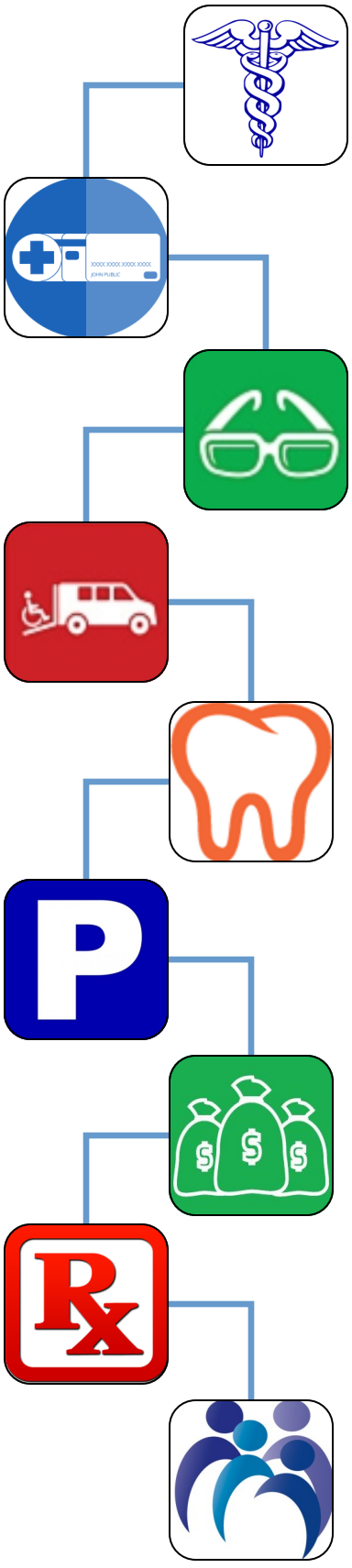
Benefit Duration	3 Years	6 Years	Unlimited Duration
Facility Benefit Amount per	$2,000 to $8,000	$2,000 to $8,000	$2,000 to $8,000
Residential Care Facility II	60%	60%	60%
Lifetime Maximum Per	$36,000	$72,000	Unlimited
Professional Home Care	50%	50%	50%
Total Home Care—Option	50%	50%	50%

Flexible Spending Accounts (FSAs)

Types of Accounts

SECTION 125 MEDICAL ACCOUNT: This account enables you to pay with pre-tax dollars any medical, dental, vision, and prescription drug expenses that are not covered under your insurance program or that of your spouse. You may also cover dependent health care expenses through the account even if you choose single coverage. The total amount of your annual pledge is available to you up front thus reducing the risk of a large out-of-pocket expense at any one time during the plan year. Be aware that with the Section 125 Medical Account, any unused portion of the account at the end of the plan year is forfeited.

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



How the Accounts Works

When you have eligible expenses not covered under the health insurance plan, such as copayments and deductibles, you can either use your flexible spending account debit card to pay for out-of-pocket expenses at qualified vendors or submit a FSA claim form with your receipt to CBIZ. Reimbursement is issued to you through direct deposit into your bank account, or if you do not wish to have direct deposit, a manual check may be issued to you.

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

Contact Information

You may request a full statement of your accounts at any time by calling CBIZ at 1-800-815-3023 (option #4) or log on to myplans.cbiz.com to review your Flexible Spending Account balance. The address to mail claims to is CBIZ Flex, 2797 Frontage Rd NW, Suite 2000, Roanoke, VA 24017.

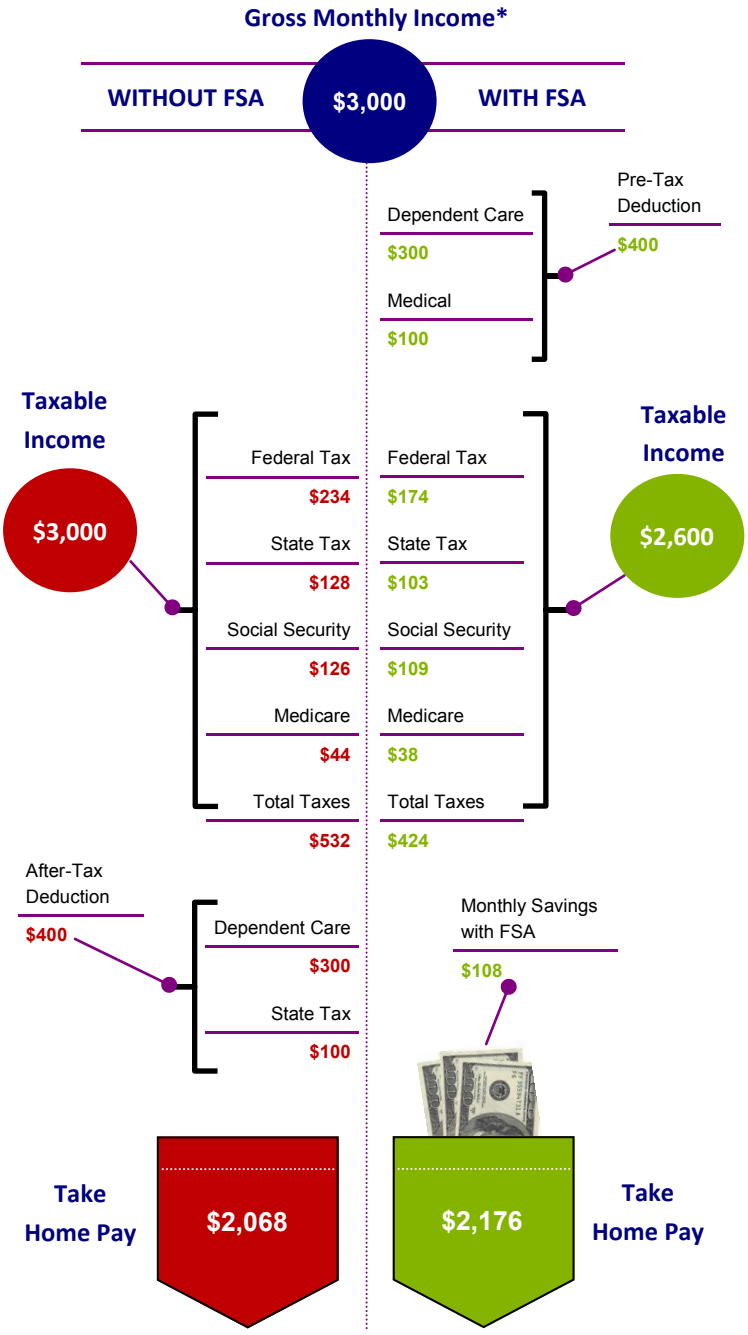
From the website you can:

- View account information and activity
- File claims
- Manage your profile
- View notifications
- Access forms

Below is a partial list of eligible expenses that can be reimbursed from a Section 125 Medical Account. Other

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

How will a flexible spending arrangement save you money?



* This is an example and for illustration purposes only. Taxes are not exact and will vary.

Call-A-Doctor Plus

Call-A-Doctor Plus is the new age of healthcare. [COMPANY NAME] provides this service at no cost to you and your family members. This program provides a complete package of virtual benefits, which give you unlimited access to doctors, counselors, support from patient healthcare advisors and a wellness platform. There is no cost for you to use this plan.

Teladoc - "Concierge Doctor" services 24/7. The physicians can consult, diagnose and provide treatment plans - including prescription medications. This is available by Phone – (800) 835-2362; Online – teladoc.com; Mobile App – Search for 'Teladoc' in the Apple and Android stores

Health Advocate - Counseling services for emotional and personal challenges 24/7. The counselors help with problem resolution in relationships, work-life, stress, alcoholism, legal concerns, financial concerns and more. Plus, their Medical Bill Saver program and comprehensive Advocacy Services will help you with medical bills, care coordination, fee negotiation and so much more.

WellCard Dicount Card - This is a discount health card that provides you with savings on a wide range of health care products and services, including prescription drugs, lab tests, vision care, and dental care.

401(k) Retirement Plan

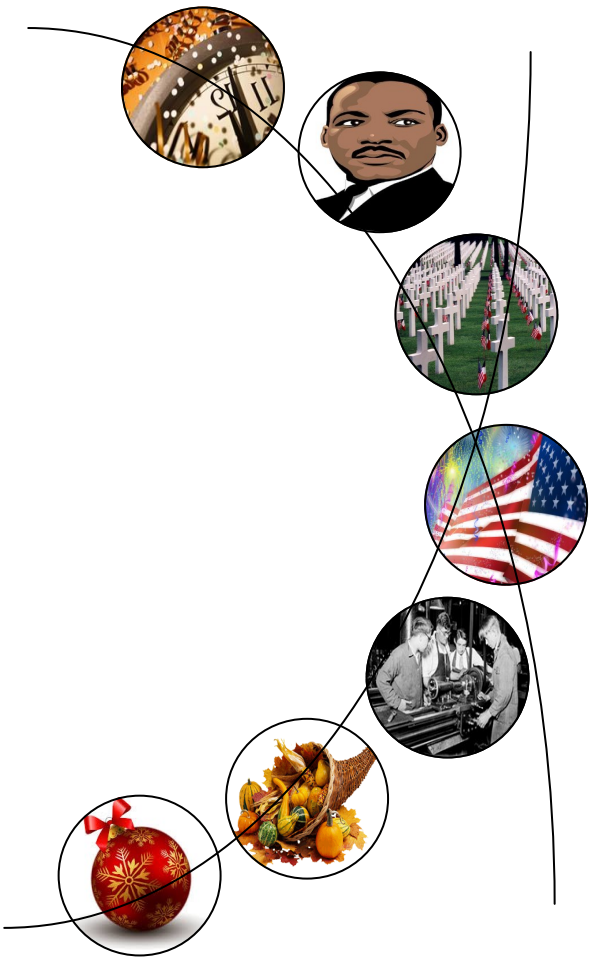
The 401(k) plan is managed by Pentegra. The contributions to the 401(k) plan are deducted pre-tax and pre FICA from your paycheck. Employees are eligible to participate in the 401(k) plan the first of the month after competing a 90 day waiting period or after completing 480 hours of service.

An employee may contribute from 1% up to 60% of their eligible pay in the Plan up to the annual IRS dollar limit. In addition, [COMPANY NAME] will make a competitive matching contribution (100% of the first 4% of the amount you save) as defined by the Retirement Savings Plan.

Holidays

[COMPANY NAME] provides all full-time employees with paid holidays. In order to qualify for holiday pay, you must work the scheduled workday immediately before and after the holiday. Only excused absences will be considered exceptions to this policy. For holidays falling on Saturday the [COMPANY] will be open the preceding Friday. For holidays falling on Sunday, the [COMPANY] will be closed the following Monday. We observe the following holidays:

New Year's Day	**Labor Day**
Dr. Martin Luther King Jr. Day	**Columbus Day**
President's Day	**Veteran's Day**
Memorial Day	**Thanksgiving Day**
Fourth of July	**Christmas Day**



Paid Time Off Policy

[COMPANY NAME] believes that employees should have opportunities to enjoy time away from work to help balance their lives. The [COMPANY] recognized that employees have diverse needs for time off from work and, therefore, has established this paid time off (PTO) policy to meet those needs. The benefits of PTO are that it promotes a flexible approach to time off. Employees are accountable and responsible for managing their own PTO hours to allow for adequate reserves if there is a need to cover vacation, illness, disability, appointments, emergencies, or other situations that require time off from work. PTO is accrued upon hire or transfer into a benefits-eligible position. Employees working less than 20 hours per week on a regular basis and temporary employees are not eligible to accrue PTO. Part-time employees working 20 or more hours per week accrue PTO on a prorated basis. Part-time employees will accrue 3.08 hours of paid time off per pay period.

Full-Time Employees	Officers and Director Level and Above Positions	Accrual Rate Per Pay Period
0-6 years of service	0-4 years of service	5.33 Hours
7-14 years of service	5-11 years of service	7 Hours
15+ years of service	12+ years of service	8.66 Hours

The amount of PTO you accrue each year is based on your length of service and accrues according to the schedule for full-time employees as indicated in the chart above. PTO is accrued as you work. You will not accrue PTO time while you are on leave of absence or suspension by the [COMPANY].

Employees are required to use available PTO when taking time off from work with the exception of a company required absence due to low workload or absences occasioned by the company. The minimum amount of PTO you can use at one time depends on whether you are an exempt or a non-exempt status employee. If you are non-exempt, you may not take less than one hour off at a time. If you are exempt status employees you must take PTO in increments of not less than one half day (four hours). Whenever possible, PTO must be scheduled in advance. PTO is subject to supervisory approval, department staffing needs and established departmental procedures. The supervisor may request that the employee provide a statement from a health care provider concerning the justification for absences due the illness longer than three days. PTO is paid at the employee's straight time rate and is not part of any overtime calculation.

If an employee who is hired or promoted to a position with officer status is subsequently demoted or transferred to a non-officer position and vice versa, an employee will accrue paid time off at the rate provided for in this policy for the new position.

Although you may carry over unused PTO time from year to year, there is a cap on the amount of PTO time you can accumulate. You can have maximum of 125% of the eligible PTO you would accrue for that year. If you are an employee with two years of service, the maximum amount of PTO you may have at any given time would equal 160 hours. This encourages you to use your PTO and allows the [COMPANY] to manage its financial obligations responsibly. Once you reach your cap, you will not accumulate any more PTO until you use some of the time in your account and drop below the cap. After your balance goes below the cap, you will begin accruing PTO again; however, you will not receive retroactive credit for time worked while you were at the cap limit.

You must request and record all PTO time used. The amount of PTO accrued, used and available will appear on your paycheck stub.

All employees terminating employment will be paid for accrued but unused PTO unless they are terminated for a cause. Employee terminating employment voluntarily must provide two weeks' notice to be eligible for payout. Employees whose positions are eliminated through a reduction in force or reorganization or whose hours drop below 20 hours per week are paid PTO on the effective date of the termination. Part-time employees will not be paid for accrued PTO upon termination.

Most employees will start the new PTO system with an account balance consisting of old banked and unused sick time. This time will be in a frozen account and used first for your absences as they are related to illness, disability, doctor's appointments and medical family emergencies. This time will not be paid out upon termination of employment. You will have two years to use the time off from this account. All balances will be cleared on January 1, 2017.

Bereavement (Funeral) Leave

Employees are allowed up to three (3) days per year with pay for funerals/bereavement of members of their immediate family. Immediate family/stepfamily members include: spouse, children, parents, brothers, and sisters. A two (2) day absence with pay is allowed for parents-in-law, children-in-law, grandparents and grandchildren. The period of time that an employee is on bereavement leave is not considered time worked for purposes of determining eligibility for overtime calculation.

An employee seeking paid bereavement leave must notify his or her supervisor or manager or Human Resources of the death before taking leave.

Jury Duty

All regular full-time and regular part-time employees shall be allowed to attend jury duty service in accordance with their legal obligations to do so.

An employee who receives a jury duty summons shall present the summons to his or her supervisor immediately. Employees on jury duty must report to work on days or parts of days when they are not required to serve. Employee will be reimbursed for the difference between the jury pay and regular pay for the absence up to 30 days. A part-time employee called for jury duty on a regularly scheduled work day, will be reimbursed for any difference between jury pay and pay for the hours scheduled to work that day. Time spent on jury duty is not considered as time worked in computing overtime.

Service Awards

The [COMPANY] appreciates the effort you put into your work and your service. When you have been with the [COMPANY] for five years and every five years of completed service, thereafter, you will receive a Service Award. The Award will be a gift to you and a token of sincere appreciation for years of service.

Voting

[COMPANY NAME] encourages employees to fulfill their civic responsibilities by participating in elections. Generally, employees are expected to find time to vote either before or after their regular work schedule. Polls are generally open from 7 am to 7 pm and allow all [COMPANY] employees to vote either prior to their shift or after the shift, as generally [COMPANY] hours are from 8 am to 5 pm. However, if employees are unable to vote in an election during their non-working hours, [COMPANY NAME] will grant up to 3 hours of unpaid time off to vote.

Worker’s Compensation Insurance

[COMPANY NAME] provides a workers' compensation insurance program. This program covers any injury or illness sustained in the course of employment that requires medical, surgical, or hospital treatment. Subject to applicable legal requirements, workers' compensation insurance provides benefits after a short waiting period.

Employees who sustain work-related injuries or illnesses should inform their supervisor immediately. No matter how minor an on-the-job injury may appear, it is important that it be reported immediately. This will enable an eligible employee to qualify for coverage as quickly as possible. The accident report must be completed and forwarded to Human Resources for timely reporting to the insurance carrier.

Military Service Leave of Absence

A military Leave of Absence will be granted to employees who are absent from work because of service in the U.S. uniformed services in accordance with the Uniformed Services Employment and Reemployment Rights Act (USERRA). Advance notice of military service is required, unless military necessity prevents such notice or it is otherwise impossible or unreasonable.

Employees will receive partial pay for two-week training assignments and shorter absences. Upon presentation of satisfactory military pay verification data, employees will be paid the difference between their normal base compensation and the pay (excluding expense pay) received while on military duty.

Continuation of health insurance benefits is available as required by USERRA based on the length of the leave and subject to the terms, conditions and limitations of the applicable plans for which the employee is otherwise eligible.

Employees on military leave for up to 30 days are required to return to work for the first regularly scheduled shift after the end of service, allowing reasonable travel time. Employees on longer military leave must apply for reinstatement in accordance with USERRA and all applicable state laws.

Employees returning from military leave will be placed in the position they would have attained had they remained continuously employed or a comparable one depending on the length of military service in accordance with USERRA. They will be treated as though they were continuously employed for purposes of determining benefits based on length of service.

Business Travel Expenses

[COMPANY NAME] will reimburse employees for reasonable business travel expenses incurred while on assignments away from their normal work location. All business travel must be approved in advance by the employee's supervisor or manager.

When approved, the actual costs of travel, meals, lodging, and other expenses directly related to accomplishing business travel objectives will be reimbursed by [COMPANY NAME]. Employees are expected to limit expenses to reasonable amounts.

Expenses that generally will be reimbursed include the following:

- Airfare or train fare for travel in coach or economy class or the lowest available fare.
- Car rental fees, only for compact or mid-sized cars.
- Fares for shuttle or airport bus service, where available; costs of public transportation for other ground travel.
- Taxi fares, only when there is no less expensive alternative.
- Cost of standard accommodations in low to mid-priced hotels, motels, or similar lodgings.
- Cost of meals, no more lavish than would be eaten at the employee's own expense.
- Tips not exceeding 15% of the total cost of a meal or 10% of a taxi fare.
- Charges for telephone calls, fax, and similar services required for business purposes.

When travel is completed, employees should submit completed expense reports. Reports should be accompanied by receipts for all individual expenses.

Employees should contact their supervisor for guidance and assistance on procedures related to travel arrangements, expense reports, reimbursement for specific expenses, or any other business travel issues.

Abuse of this business travel expenses policy, including falsifying expense reports to reflect costs not incurred by the employee, can be grounds for disciplinary action, up to and including termination of employment.

Important Notices

Special Enrollment Notice

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

Women's Health and Cancer Rights Act of 1998

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

Notice of Material Change (also Material Reduction in Benefits)

[COMPANY NAME] has amended the Medical, Dental and Vision benefit plans. This benefit guide contains a summary of the modifications that were made. It should be read in conjunction with the Summary Plan Description or Certificate of Coverage, which is available to you once it has been updated by the carriers. If you need a copy, please submit your request to Human Resources.

Notice of Privacy Practices

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

Important Information Regarding 1095 Forms

As an employer with 50 or more eligible employees we are required to provide 1095-C forms to all employees who were eligible for coverage under our group health plan in 2015. If you were eligible for coverage under our group plan you will receive a personalized 1095-C form before March 31, 2016. We are also required to send a copy of your 1095-C form to the IRS.

The information reported on Form 1095-C is used in determining whether an employer owes a payment under the employer shared responsibility provisions under section 4980H. Form 1095-C is also used by the IRS and the employee in determining the eligibility of the employee for the premium tax credit.

You'll need a 1095 form to complete your annual Federal tax return.

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 [COMPANY NAME].

What is the Health Insurance Marketplace?

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

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

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

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

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

More Information

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

Medicaid CHIP Notice

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

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

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

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

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

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

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

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

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

Medicare Part D Creditable Coverage

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

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

UnitedHealthcare has determined that the prescription drug coverage offered by [COMPANY NAME] is on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because this coverage is Creditable Coverage, you can keep it and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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

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

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

This information is provided for the Medicare open enrollment period which begins on October 15. If you want more information about Medicare plans that offer prescription drug coverage, you will find it in the Medicare & You handbook or you can visit **medicare.gov** or call 1-800-MEDICARE (1-800-633-4227).

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

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

Glossary of Terms

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

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

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

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

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

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

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

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

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

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

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

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

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