2016 Employee Benefits Guide

EDM Incorporated

The Right Step toward Finishing Well

Welcome to EDM, Inc's

Annual Enrollment Period

EDM knows your employee benefits package is extremely important to you and understands that benefits should meet your and your family's needs, as well as be affordable. We are partnered with Tina Borge of CBIZ Benefits & Insurance Services, Inc. who assists us with making sure our benefits are comprehensive and meets the needs of our employees, while still managing the costs. For any claim issues, due to HIPAA privacy laws, it is necessary for you to contact the carrier directly. If your claim issue is not resolved after contacting the carrier, please call Nicol Schmidt with CBIZ Benefits & Insurance Services, Inc. at 1-314-692-5847 for further assistance.

This year we received an increase from United Healthcare. We conducted a full market research for our health benefits and were unable to get competitive rates and benefits from the other carriers. In addition to renewing with United Healthcare, we have decided to keep the current plan and add an alternative plan for the 2016/2017 policy year. More details will follow in this Employee Benefits Guide.

Note: Your annual medical deductible will start over July 1, 2016 and accumulate through June 30, 2017. EDM will reimburse the first portion of the in-network deductible, office visit, urgent care and emergency room copays ($2,000 for individual and $3,000 for family). CBIZ will be handling our HRA and all claims will need to be submitted by the employee.

The Annual Enrollment period runs from June 1 through June 30th and it is the one time of year to make changes to your current election, adding or removing dependents from your coverage for a July 1, 2016 effective date. Otherwise, the only way to change your election is due to a qualifying event (i.e. divorce, marriage, newborn). You must make these changes within 31 days of the event.

ENROLLING IN THE PLANS

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

See Human Resources for correct forms

ELIGIBILITY

WHO CAN YOU ADD TO YOUR PLAN:

Eligible:

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

Ineligible:

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

FREQUENTLY ASKED QUESTIONS…...

ARE CHANGES TO MY PLAN ALLOWED DURING THE YEAR?

Generally, you may only enroll in the plan, or make changes to your benefits, during the re-enrollment period or when you are first hired. However, you can make changes/enroll during the plan year if you experience a qualifying event. As with a new enrollee, you must have your paperwork turned in within 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
- You become eligible for or lose Medicaid coverage
- You become eligible for Medicare

Medical Insurance to Keep You Healthy

FEATURES:	UNITED HEALTHCARE QF7 / RX 2V		UNITED HEALTHCARE AHBA / RX 282	
	In Network	Out of Network	In Network	Out of Network
Individual Deductible:	$3,000	$6,000	$3,000	$5,000
Family Deductible:	$6,000	$12,000	$6,000	$10,000
Co-Insurance:	100%	80%	80%	60%
Out of Pocket Maximum: (Incl. Ded.,Copays and Coin-surance)				
Individual:	$4,500	$8,000	$6,000	$10,000
Family:	$9,000	$16,000	$12,000	$20,000
Lifetime Maximum Benefit:	Unlimited	Unlimited	Unlimited	Unlimited
Office Visits (PCP/SCP):	PCP $0 (under 19) $25 / $50 all others	80% after Deductible	PCP $0 (under 19) $30 / $60 all others	60% after Deductible
Preventive Care:	100%	80% after Deductible	100%	60% after Deductible
Diagnostic Services:				
Lab (Office, Freestanding Lab):	100%	80% after Deductible	100%	60% after Deductible
X-Ray & Major Diagnostics:	100% after Deductible	80% after Deductible	80% after Deductible	60% after Deductible
Emergency Care:				
Urgent Care	$75 Co-Pay	80% after Deductible	$75 Co-Pay	60% after Deductible
Emergency Room	$150 Co-Pay		$250 Co-Pay, then 20% Coinsurance	
Prescription Drug Coverage:	*at Participating In Network Pharmacies*		*at Participating In Network Pharmacies*	
Tier 1	$10 Co-Pay		$10 Co-Pay	
Tier 2	$35 Co-Pay		$35 Co-Pay	
Tier 3	$60 Co-Pay		$60 Co-Pay	
Tier 4	N/A		N/A	
Mail Order Drug Coverage: for a 90 Day Supply	$25 / $87.50/ $150 Co-Pay Tier 4 N/A		$25 / $87.50/ $150 Co-Pay Tier 4 N/A	

Medical Insurance to Keep You Healthy

Plan Highlights:

- Coinsurance, Prescription Drug Co-Pays, and Deductibles accumulate towards the Out-of-Pocket Maximum.
- Lab, X-Ray, and other preventive tests for Preventive care are covered at 100% with no deductible.
- You can visit a Walgreens Take Care clinic for a Primary Care Office Visit Co-Pay.
- If you use a non-network pharmacy you will be responsible for any difference between what the non-network pharmacy charges and the amount UHC would have paid for the same prescription drug product dispensed by a network pharmacy.
- You should read and review the certificate of coverage and the Summary of Benefit and Coverage to know your exact benefits. You can also contact UHC at the phone number on the back of your ID card.

Pre Notification Information:

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

Three Convenient Ways to Manage Your Health Care

1. Download the Health4Me app - just search for United Healthcare 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 UHC's mobile site by going to myuhc.com on your smartphone - and you'll get many of the same features of their app.
3. Get the full myuhc.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. Coupons for health foods and much more.

To log in on your smartphone, you must be registered on UHC's secure member site and have a username and password. If you are a UHC member but haven't registered, go to myuhc.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 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 www.myuhc.com.

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

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. 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 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.myuhc.com.

URGENT CARE

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

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

This is a sample list and not all-inclusive. For a full listing

LAB SERVICES

If you require lab work please use LabCorp. When coded as preventive, the cost will be covered 100%. If you choose to use Quest, 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 you 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

EMERGENCY ROOM

Some examples of emergency conditions may include the following:

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

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

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.

Please Note: you may incur out-of-network expenses if you receive services from an out-of-network Emergency Room physician, pathologist, radiologist or anesthesiologist, even if the hospital is in-network.

Get the most out of your

Enhance Your Smile with Dental Coverage

FEATURES:	DELTA DENTAL OF MISSOURI		
	PPO NETWORK	PREMIER NETWORK	OUT OF NETWORK
Individual Deductible:	$50	$50	$50
Family Deductible:	$150	$150	$150
Maximum Benefit/Year:	$1,000	$1,000	$1,000
Type I - Preventive Care: (Exams, Cleanings)	100% (No Ded)	100% (No Ded)	100% (No Ded)
Type II - Basic Procedures: (Fillings, Extractions)	80%	80%	80%
Type III - Major Procedures: (Inlays, Onlays, Crowns)	50%	50%	50%
Type IV - Orthodontia:	50% to $1,000 Lifetime Maximum Child Only (No Ded)	50% to $1,000 Lifetime Maximum Child Only (No Ded)	50% to $1,000 Lifetime Maximum Child Only (No Ded)
Endodontics & Periodontics:	80%	80%	80%
UCR Percentile:			MPA

See Clearly with Vision Coverage

FEATURES:	EYEMED	
	In Network	**Out of Network***
Examination Co-Pay:	$10	$40
Frequency of Service:		
Exams	12 Months	
Lenses or Contact Lenses	12 Months	
Frames	24 Months	
Basic Lenses:	$25 Copay, then:	
Single Vision	100%	$30
Bifocal	100%	$50
Trifocal	100%	$70
Lenticular	100%	$70
Frames:	$150 Allowance	$105
	20% off remaining balance	
Contacts:		
Medically Necessary	100%	$210
Conventional:	$150 Allowance	$150
	15% off remaining balance	
Laser Vision Discount:	Discounts Available	

Protect Your Family with Life & Accidental Death and Dismemberment Insurance

EDM provides this benefit at no cost to you. This protection will provide **1** times your salary to a maximum of $250,000 for the employee only. This amount also carries an equal benefit of accidental death and dismemberment coverage.

Voluntary Life and Accidental Death & Dismemberment (AD&D) Insurance

EDM will continue to offer you the opportunity to purchase additional life insurance on yourself and your dependents through Unum. We will have an open enrollment and a Unum representative will go over the benefits. 1) If you are a new hire and wish to purchase life insurance, 2) if you are a current employee and would like to purchase new coverage, or 3) if you have current coverage and want to increase the amount, you have the opportunity to get up to the guarantee issue amount with no Evidence of Insurability (EOI). Employees must purchase voluntary life in order to purchase coverage for your spouse and dependent children.

EMPLOYEE COVERAGE

Employees may elect coverage in increments of $10,000 up to a maximum of 5 x annual salary or $500,000. Guaranteed issue is $100,000.

SPOUSE COVERAGE

Spousal coverage is available in $5,000 increments not to exceed $500,000. Guaranteed Issue is $25,000 and the amount may not exceed 100% of the employees coverage. The spouse rate is based on the spouse's age.

CHILDREN

Coverage is available for your child(ren) in the amount of $5,000 or $10,000.

Monthly Cost		
Age Band	**Employee**	**Spouse**
Under 24	$.68	$.340
25-29	$.74	$.370
30-34	$.93	$.465
35-39	$1.21	$.605
40-44	$1.77	$.885
45-49	$2.89	$1.445
50-54	$4.60	$2.300
55-59	$7.45	$3.725
60-64	$9.58	$4.790
65-69	$13.63	$6.815
70-74	$25.78	$12.890
75+	$46.92	$23.460
Child	$1.00 per $5,000	

Please keep in mind that if you should leave EDM you will have 31 days to convert your voluntary life policy to an individual policy. Please speak with Susan Pfaff if you would like to enroll and/or change your voluntary life insurance amount.

Prepare for the Unexpected with Long Term Disability Insurance

EDM will continue to provide Long Term Disability coverage to you at no cost through Unum. This coverage protects your income to age 65 if you become totally disabled. Following are some key components of the plan:

- 90-Day Elimination Period Before Benefits Begin
- 66.67% Salary Reimbursement up to $5,000 Maximum per Month

How to Calculate Your Voluntary Life Premium

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

EMPLOYEE COST PER PAY PERIOD

Medical	Plan 1 QF7	Plan 2 AHBA
Employee	$0	$0
Employee & Spouse	$299.15	$273.40
Employee & Child(ren)	$244.76	$223.70
Family	$573.28	$523.94

Vision	
Employee	$0
Employee & Spouse	$2.56
Employee & Child(ren)	$2.85
Family	$5.52

Dental	
Employee	$0
Employee & Spouse	$20.69
Employee & Child(ren)	$27.68
Family	$48.37

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	%

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 policy year (July 1 through June 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 policy 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. The 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. This is a much higher cost than a regular office visit or urgent care facility. If you are admitted to the hospital the copayment/coinsurance 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 - You have a 3 tier co-pay structure (see benefit outline) for prescription drugs. Mail Order prescription will provide up to a 90-day supply of medication at a lesser cost than the tier co-pay. Please visit www.myuhc.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 United Healthcare's network. Do not ask if they "accept" United Healthcare. 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.

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.

IMPORTANT NOTICES

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 our health coverage 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 believe 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 go to www.insurekidsnow.gove website 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, you will be allowed to enroll in our medical 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 1-866-444-3272.

Link to the latest form:
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-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

www.cms.hhs.gov

1-877-267-2323, Ext. 61565

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.

UHC has determined that the prescription drug coverage offered by EDM, Inc. is, 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).

IMPORTANT NOTICES (cont.)

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

As a requirement of the Women's Health and Cancer Rights Act of 1998, you 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.

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 *Susan Pfaff* in Human Resources.

SUMMARY OF MATERIAL MODIFICATION

UHC 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.myuhc.com or contact Human Resources.

Your Carrier CONTACT INFORMATION	
	Medical Insurance: Member Services: 1-800-357-0978 www.myuhc.com
	Dental Insurance: Member Services: 1-800-323-1743 www.deltadentalmo.com
	Base Life/AD&D, Voluntary Life/AD&D, Long Term Disability Member Services: 1-877-225-2712 www.unum.com
	Vision Insurance Member Services: 1-866-939-3633 www.eyemedvisioncare.com

For questions regarding your benefits please contact our benefit consultants at CBIZ Benefits & Insurance Services, Inc:

Tina Borge, Account Executive

314-692-2249 Ext. 145

tborge@cbiz.com

Nicol Schmidt, Account Manager

314-692-2249 Ext. 147

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