2015 Employee Benefits Guide

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 plan documents shall govern.

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Company Name

CONTACT INFORMATION

Contact Information		
Vendors	**Phone Number**	**Website**
Anthem *(Medical)* Group Number:	Call the toll-free number on the back of your ID card.	www.anthem.com
Anthem (Dental) Group Number:	Call the toll-free number on the back of your ID card.	www.anthem.com
Anthem (Vision) Group Number:	Call the toll-free number on the back of your ID card.	www.anthem.com
Reliance Standard *(Life /AD&D)* Group Number: xxxxxxx	Toll Free (800) 351-7500	www.reliancestandard.com
Reliance Standard *(Voluntary Life/AD&D)* Group Number: xxxxxxxx	Toll Free (800) 351-7500	www.reliancestandard.com
H&H Health Associates *(EAP)*	(314) 845-8302 Toll Free (800) 832-8302	www.hhhealthassociates.com
CBIZ *(Flexible Spending Accounts)*	Toll Free (800) 815-3023, press 4	myplans.cbiz.com
CBIZ *(COBRA Services)*	Toll Free (800) 815-3023, press 6	enroll.cbiz.com
Benefits Team	**Phone**	**Email**
HR Service Team	(314) 995-5538 Toll Free (888) 689-8922 Fax (866) 399-0412	HR@cbiz.com
Consultant Eric File Asha Kuhn	(314) 692-2249 Toll Free (800) 844-4510	efile@cbiz.com akuhn@cbiz.com

ENROLLING IN THE PLANS

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

- Read your materials and make sure you understand all of the options available.
- Log in to **cbizems.com** using your *UserID* and *Password* **by March 19th**.
- Under the *Change Events* section, click *Begin Event*.
- Follow the onscreen instructions to complete enrollment. Use the *Save & Continue* button to move to the next screen.
- Review and confirm your elections and information. If accurate, click *Save & Confirm Elections*. If you need to make a change, select the screen you wish to return to in the *Steps* list.
- Print your confirmation statement for your records.

For help with completing the form, or if you have any questions regarding the benefits offered, please contact the Human Resources Department.

IMPORTANT NOTE:

It is very important that you complete your enrollment by the due date provided by HR. If you do not complete your enrollment **by March 19th**, you will, by default, waive your rights to the company sponsored group benefits.

ELIGIBILITY

Joining the Plan:

If you are a COMPANY NAME new hire, you will become eligible for coverage the first day following 90 days of employment. This will be the date on which your coverage becomes effective.

You may submit your enrollment forms/applications and complete enrollment anytime before this date, but you must turn these forms in within 30 days of the effective date. If you do not submit your enrollment forms within 30 days after your effective date you will need to wait until the next annual open enrollment to make your benefit elections.

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 30 days of the qualifying event or you will have to wait until the next annual open enrollment period.

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

PRE-NOTIFICATION INFORMATION

Anthem will require notification before you receive certain covered health services. In general, Network providers are responsible for notifying Anthem before they provide these services to you. There are some Network Benefits, however, for which you are responsible for notifying Anthem and as a rule Anthem 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 which is located in your enrollment packet.

ANTHEM PROVIDERS

With Anthem's Find a Doctor online tool, it's simple to look for medical, dental, and vision providers in your area.

1. Go to anthem.com
2. Under Useful Tools on the right, select Find a Doctor.
3. Under Search by selecting a plan/network, go to Select a state and select your state from the drop-down list.
4. Under Select a plan/network, select the name of your plan/network from the drop-down list. Then choose Select and Continue.
5. Select what type of doctor and the location you're looking for, then select Search.

Remember, choose the network carefully. Blue Preferred network does **NOT** have any BJC facilities or affiliated physicians including, but not limited to:

- Alton Memorial Hospital
- Washington University Hospital
- All Barnes-Jewish Hospitals
- Boone Hospital Center
- Christian Hospital
- All Missouri Baptist Hospitals
- Northwest HealthCare
- Parkland Health Center
- Progress West Hospital
- St. Louis Children's Hospital
- The Rehabilitation Institute of St. Louis

If you choose to participate in one of the Blue Preferred Network medical plans (Base and Buy-Up Plans) and utilize a BJC hospital or physician, the cost for those services will be paid at the out-of-network benefit level associated with your plan.

Blue Access Choice PPO is the full network including BJC. It is only available in conjunction with the Enhanced Medical Plan option being offered effective April 1, 2015.

MEDICAL INSURANCE—Base Plan (QHDHP) Option

Blue Preferred Network—No BJC providers or facilities.

Participating in this option allows you to contribute to an H.S.A.

Benefit Plan	Base Plan (QHDHP) In-Network	Base Plan (QHDHP) Out-of-Network
Deductible (calendar year)		
Single	$5,000	$10,000
Family	$10,000	$20,000
Coinsurance (plan pays/you pay)		
	100% / 0%	70% / 30%
Out-of-Pocket Limit (including the deductible + coinsurance + copayments)		
Single	$6,050	$20,000
Family	$12,100	$40,000
Copayments		
Primary Physician Visit	Deductible, then $25 co-pay	Deductible, then you pay 30%
Specialist Physician Visit	Deductible, then $50 co-pay	Deductible, then you pay 30%
Preventive Care	Plan pays 100%	Not Covered
Emergency Room Visit	Deductible, then $250 co-pay	Deductible, then $250 co-pay
Urgent Care Center Visit	Deductible, then $75 co-pay	Deductible, then you pay 30%
Prescription Drug Coverage		
Retail Pharmacy	Deductible, then $15/45/75/25% to $400	Deductible, then you pay 50%
Mail Order Pharmacy	Deductible, then $15/112/225/25% to $400	Not Covered

2015 Employee Base Plan Medical Contributions

Employee Bi-Weekly Cost	Old 2014 Tobacco	New 2015 Tobacco
Employee	$66.87	$48.70
Employee & Spouse	$139.59	$144.46
Employee & Child(ren)	$145.70	$140.74
Employee & Family	$204.80	$209.22

Employee Bi-Weekly Cost	Old 2014 Tobacco User	New 2015 Tobacco User
Employee	$71.87	$53.70
Employee & Spouse	$144.59	$149.46
Employee & Child(ren)	$150.70	$145.74
Employee & Family	$209.80	$214.22

Remember, in order to qualify for the tobacco free discount, you must sign an affidavit indicating that you are "tobacco free" and you will remain "tobacco free" during the next plan year. If you enrolled in a tobacco-cessation course and can provide proof of completion, you will qualify for the discount.

MEDICAL INSURANCE—Buy-Up Plan Option

Blue Preferred Network—No BJC providers or facilities.

Benefit Plan	Buy-Up Plan In-Network	Buy-Up Plan Out-of-Network
Deductible (calendar year)		
Single	$5,000	$6,000
Family	$10,000	$12,000
Coinsurance (plan pays/you pay)		
	100% / 0%	70% / 30%
Out-of-Pocket Limit (including the deductible + coinsurance + copayments)		
Single	$6,000	$8,000
Family	$12,000	$16,000
Copayments		
Primary Physician Visit	$30 co-pay	Deductible, then you pay 30%
Specialist Physician Visit	$60 co-pay	Deductible, then you pay 30%
Preventive Care	Plan pays 100%	Not Covered
Emergency Room Visit	$250 co-pay	$250 co-pay
Urgent Care Center Visit	$75 co-pay	Deductible, then you pay 30%
Prescription Drug Coverage		
Retail Pharmacy	$15/45/75	Deductible, then you pay 50%
Mail Order Pharmacy	$20/90/150	Not Covered

2015 Employee Buy-Up Plan Medical Contributions

Employee Bi-Weekly Cost	Old 2014 Tobacco Free	New 2015 Tobacco Free
Employee	$66.87	$67.24
Employee & Spouse	$139.59	$184.67
Employee & Child(ren)	$145.70	$177.44
Employee & Family	$204.80	$267.05

Employee Bi-Weekly Cost	Old 2014 Tobacco User	New 2015 Tobacco User
Employee	$71.87	$72.24
Employee & Spouse	$144.59	$189.67
Employee & Child(ren)	$150.70	$182.44
Employee & Family	$209.80	$272.05

Remember, in order to qualify for the tobacco free discount, you must sign an affidavit indicating that you are "tobacco free" and you will remain "tobacco free" during the next plan year. If you enrolled in a tobacco-cessation course and can provide proof of completion, you will qualify for the discount.

MEDICAL INSURANCE—Enhanced Plan Option

Blue Access Choice Network—Includes BJC in the network.

Benefit Plan	Enhanced Plan In-Network	Enhanced Plan Out-of-Network
Deductible (calendar year)		
Single	$3,000	$6,000
Family	$6,000	$12,000
Coinsurance (plan pays/you pay)		
	80% / 20%	60% / 40%
Out-of-Pocket Limit (including the deductible + coinsurance + copayments)		
Single	$6,000	$8,000
Family	$12,000	$16,000
Copayments		
Primary Physician Visit	$30 co-pay	Deductible, then you pay 40%
Specialist Physician Visit	$60 co-pay	Deductible, then you pay 40%
Preventive Care	Plan pays 100%	Not Covered
Emergency Room Visit	$250 co-pay	$250 co-pay
Urgent Care Center Visit	$75 co-pay	Deductible, then you pay 40%
Prescription Drug Coverage		
Retail Pharmacy	$15/45/75	Deductible, then you pay 50%
Mail Order Pharmacy	$20/90/150	Not Covered

2015 Employee Enhanced Plan Medical Contributions

Employee Bi-Weekly Cost	Old 2014 Tobacco	New 2015 Tobacco
Employee	$66.87	$84.58
Employee & Spouse	$139.59	$222.30
Employee & Child(ren)	$145.70	$211.77
Employee & Family	$204.80	$321.16

Employee Bi-Weekly Cost	Old 2014 Tobacco User	New 2015 Tobacco User
Employee	$71.87	$89.58
Employee & Spouse	$144.59	$227.30
Employee & Child(ren)	$150.70	$216.77
Employee & Family	$209.80	$326.16

Remember, in order to qualify for the tobacco free discount, you must sign an affidavit indicating that you are "tobacco free" and you will remain "tobacco free" during the next plan year. If you enrolled in a tobacco-cessation course and can provide proof of completion, you will qualify for the discount.

PRESCRIPTION BENEFITS

Most prescriptions are filled right away when you take them to the pharmacy. However, some drugs need to be reviewed by Anthem and approved before they're covered. This process, called ***prior authorization***, helps ensure drugs are used as recommended by The FDA. Prior authorization focuses mainly on drugs that may have:

- Risk of serious side effects or dangerous drug interactions
- High potential for incorrect use or abuse
- **Better alternatives that may cost you less**
- Restrictions for use with very specific conditions

Prior authorization may require you to take an additional step when you are prescribed certain medications, but the long-term gain is lower out-of-pocket prescription costs for you and reduced claims expense for CSI and potentially lower future renewal increases.

Some prescription drugs are covered only if the physician obtains prior authorization from Anthem. In addition, coverage for some drugs is provided in limited quantities and duration.

This is only a brief summary of benefits. The Certificate, issued when coverage is approved for the group, contains program details, and will, in all cases, have control over any information in this summary. The certificate is available upon request.

PREVENTIVE CARE

Certain preventive services will be covered without charging a deductible, copayment, or coinsurance when these services are provided by a **network provider**. The types of preventive services covered are defined by federal law and can vary based on your age, gender, and health status. There may be services you had in the past that will now be covered as preventive at no cost to you. The preventive services included in this provision are described at www.healthcare.gov.

WOMEN'S PREVENTIVE CARE COVERAGE

Your health plan will provide first dollar coverage for certain women's preventive coverage without any cost sharing requirements (co-payment, coinsurance or deductible), when delivered by in network providers. This includes 100% coverage for FDA-approved tier 1 contraceptive methods for women when filled at an in network pharmacy.

HEALTH SAVINGS ACCOUNT (HSA)

WITH THE ELECTION OF THE ANTHEM BASE PLAN (QHDHP) FOR YOUR INSURANCE COVERAGE, YOU MAY ALSO OPEN AN 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.

Why would I want an HSA?

Because you fund the HSA with pre-tax money, you are using tax-free funds for healthcare expenses you would normally pay for out-of-pocket using after-tax dollars. Your HSA contributions do NOT count toward your taxable income for federal taxes.

WHAT RULES MUST I FOLLOW?

- You must be covered under a *Qualified High Deductible Health Plan (QHDHP)* in order to establish an HSA.
- You cannot establish an HSA if you also have a medical *flexible* spending account (FSA).
- You cannot set up an HSA if you have insurance coverage under another plan, for example your spouses employer, unless that secondary coverage is also a qualified high deductible health plan.
- You cannot be enrolled in Medicare.
- You cannot be claimed as a dependent under someone else's tax return.

WHAT IS THE DIFFERENCE BETWEEN A QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN AND A TRADITIONAL PPO PLAN?

In a QHDHP, all services received, with the exception of preventive office visits, are applied to the deductible and coinsurance first. This would include office visits that are not preventive, emergency room visits, and prescription drugs. You will, however, still have the opportunity to benefit from the discounts associated with using a network physician or facility.

WHAT ELSE DO I NEED TO KNOW?

- Contributions are based on a calendar year. For 2015, the contribution limits are $3,350 for Single and $6,650 for Family coverage. You cannot put more than this amount in the account; you can put less.
- The contributions from your paycheck are tax-free, grow tax-free, and come out tax-free as long as you utilize the funds for approved services. (medical, dental, vision and over-the-counter medically necessary items)
- Your unused contributions roll over from year to year and can be taken with you if you leave your current job.
- If you use the money for non-qualified expenses, then the money becomes taxable and subject to a 20% excise tax penalty (like in an IRA account).
- Once you turn 65, become disabled and/or qualify for Medicare, you can use the account for other purposes without paying the 20% penalty but you will pay income taxes.
- The savings account can be established with Anthem, so you can take advantage of payroll deductions on a pre-tax basis.

(A welcome kit will be mailed to your attention from Anthem when you express an interest in opening and contributing to an H.S.A.)

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, so 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 most of your 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 can't be more than the IRS annual contribution limit. If you're age 55 or older, you are allowed to make an extra $1,000 catch-up contribution 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
- 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 www.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.

DENTAL INSURANCE

Anthem Voluntary Dental

Benefit/Service	In-Network	Out-of-Network Benefit
Preventive	**100%**	**100%**
Basic	**80%**	**80%**
Major	**50%**	**50%**
Ortho	**50%**	**50%**
Deductibles & Maximums		
Deductible Individual *	$50	
Deductible Family	$150	
Annual Maximum Per Person	$1,000	
Lifetime Orthodontia Maximum **	$1,000	

* Does not apply to preventive services.

** Orthodontic services are available for children up to age 19 and the annual deductible does NOT apply.

You will have coverage both in-network and out-of-network. It is to your advantage to utilize a network dentist to take advantage of contracted fees. You will experience the deepest discounts when seeing an in-network dentist. If you go out-of-network, you will be responsible for any amount exceeding Anthem's negotiated rates plus any deductible and co-insurance associated with your procedure.

Out-of-Network Services

All out-of-network claims are paid at the 80th Percentile of UCR. The provider will bill the insured for any charges that exceed the 80th Percentile of UCR. (Usual and Customary Reimbursement)

2015 Employee Dental Contributions

Dental Employee Cost	Bi-Weekly
Employee	$12.13
Employee & Spouse	$24.67
Employee & Child(ren)	$29.22
Employee & Family	$41.28

VISION INSURANCE

Anthem Voluntary Vision

Benefit/Service	In-Network	Out-of-Network Benefit
Examination	$10 Co-pay	$42 reimbursement
Frequency of Service:		
Exam	Every 12 months	
Lenses	Every 12 months	
Frames	Every 24 months	
Lenses:	$25 Co-pay then:	Reimbursement:
Single	100%	$40
Bifocal	100%	$60
Trifocal	100%	$80
Frames	Covered 100% up to $130 Retail, then 20%	$45
Contacts:		Reimbursement
Necessary	Covered at 100%	$210
Cosmetic	$130 Allowance	$105

Anthem Blue Cross and Blue Shield vision members have access to one of the nation's largest vision networks. As a Blue View Vision member, you can use your in-network benefits at 1-800-CONTACTS, visit a private practice eye doctor, or go in store to LensCrafters®, Sears Opticalsm, Target Optical®, JCPenney® Optical and most Pearle Vision® locations.

If you are considering Lasik Surgery, there is a discount available. To find a participating surgeon, go to www.anthem.com.

2015 Employee Vision Contributions

Vision Employee Cost	Bi-Weekly
Employee	$3.70
Employee Plus One	$6.47
Employee Plus Two or More	$10.35

BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

This benefit is paid by COMPANY NAME for all employees who participate in the medical plan. It is administered through Reliance Standard. In the event of your death, your beneficiary will receive $10,000. The Accidental Death and Dismemberment (AD&D) benefit is equal to your basic group life insurance benefit.

VOLUNTARY LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Your Voluntary Life/AD&D is administered through Reliance Standard. An equal amount of AD&D coverage is provided when you elect voluntary life. You must purchase voluntary life on yourself in order to purchase coverage for your spouse and dependent children.

VOLUNTARY LIFE/AD&D EMPLOYEE CONTRIBUTION (Rates are per month)	
Age Band	**Employee/Spouse Rate per $1,000***
Under 30	$.105
30-34	$.155
35-39	$.195
40-44	$.225
45-49	$.335
50-54	$.575
55-59	$.945
60-64	$1.415
65-69	$2.045
70+	$3.595
Child Life	$0.65/$2,500

***Spouse rates are based on the employees age**

Employees can purchase up to $500,000 of coverage in $10,000 increments or five times your annual earnings. The Guarantee Issue amount for employees is $100,000 or five times your annual earnings, whichever is less.

Spousal coverage is available in $5,000 increments not to exceed 50% of the employee amount up to a maximum of $250,000. The Guarantee Issue amount for spouses is $50,000. Coverage is available for children 14 days to 6 months in the amount of $1,000. Children age 6 months up to age 20, or 26 if a student, have the following options: $2,500, $5,000, $7,500 or $10,000.

Please note: If you and/or your dependents chose not to enroll in the Voluntary Life plan during your initial enrollment period you and/or your dependents will be required to complete an Evidence of Insurability form and be approved by Anthem before you are able to obtain coverage in the future. Newly hired employees who are currently in their initial eligibility period can obtain up to $100,000 without completing an Evidence of Insurability form for themselves, $50,000 for their spouse and $10,000 for their eligible dependent children.

Reliance Standard offers a complementary bereavement counseling service as well as a travel assistance service for those who are enrolled in the voluntary life plan.

This is meant to be a summary of benefits only. Please review to your certificate of coverage for information pertaining to the policies benefits and limitations.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Through our EAP contract with our service provider, H&H Health Associates (H&H), you and your eligible dependents can receive confidential assistance with personal and work/life concerns.

Our EAP benefit offers confidential, short-term counseling for personal and family issues at no cost to you. The EAP provides short-term, confidential counseling in dealing with family and relationship issues, substance abuse, stress and anxiety, communication issues, and emotional concerns. The EAP also provides the following services to help you balance work and home life:

- Managing stress and change
- Family and relationship concerns
- Parenting issues
- Legal concerns
- Budgeting and debt management
- Substance abuse
- Care management for aging parents
- Locating child and elder care resources
- Identifying school/college resources
- Emotional and personal conflicts
- Depression and grief
- Lifestyle weight management
- Work performance issues
- Retirement issues
- Health and wellness issues
- Financial planning

H&H is an independent firm that specializes in providing professional counseling services through highly qualified, licensed behavioral health practitioners. H&H professionals answer calls 24 hours a day, seven days a week. H&H's telephone number is 314-845-8302 or 1-800-832-8302. When you call the EAP, an H&H representative will answer any questions you have and set up an appointment for you. Please visit the H&H website for additional information at www.hhhealthassociates.com.

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) OFFER FREE OR LOW-COST HEALTH COVERAGE TO CHILDREN AND FAMILIES

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

For a listing of the states that offer assistance please contact HR. You can also contact:

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

FLEXIBLE SPENDING ACCOUNTS (FSAs)

Participation in the FSAs is only available to employees who have work for COMPANY NAME at least **three** years.

TYPES OF ACCOUNTS

SECTION 125 MEDICAL SPENDING ACCOUNT: This account enables you to pay with pre-tax dollars any medical, dental, vision, and prescription and non-prescription (used to treat personal injuries or sickness only) 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. You cannot establish the FSA if you also contribute to a Health Savings Account (HSA).

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.

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

* Note: The minimum you can contribute is $20

ACCOUNT STATEMENTS

You may request a full statement of your accounts at any time by calling or sending a written request to CBIZ. You can also manage your account by logging onto myplans.cbiz.com to view account balances, view the expenses that have been paid, and see any other account information.

HOW THE ACCOUNT WORKS

When you have eligible expenses not covered under the health insurance plan, such as co-payments and deductibles, you can utilize your CBIZ FSA Debit Card for payment from your Section 125 Medical Account. For expenses not directly related to a health plan claim, you may submit a FSA claim form with your receipt and a reimbursement payment is issued to you directly or you may use your CBIZ FSA Debit Card to pay for out-of-pocket expenses at qualified vendors.

When you have dependent care expenses, you may complete a dependent care claim form and submit it to CBIZ with a receipt from your child care provider. A reimbursement payment is issued to you directly. Please note, the receipt for your child care provider must include the name, address, and federal tax identification number or social security number of the provider.

ELIGIBLE EXPENSES

Below is a partial list of eligible expenses that can be reimbursed from a Section 125 Medical Account. Other out-of-pocket expenses may qualify.

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

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, 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.

SUMMARY OF MATERIAL MODIFICATION

COMPANY NAME has amended COMPANY NAME Benefit Plan. 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 the HR Team.

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.

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 in October through February 15.

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 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.gov 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
1-866-444-3272
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

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.

> Coventry has determined that the prescription drug coverage offered by COMPANY NAME Base and High plans 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.

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 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 – This 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.

Preferred 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.

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 a 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.