IN THE BUSINESS OF YOUR SUCCESS℠

Employee Service Center
10200 Sunset Drive
Miami, FL 33173-3033
Toll-Free Number
1-800-554-1802
www.mytotalsource.com

July 22, 2015

Dear Worksite Employee:

Congratulations! On behalf of your worksite employer and ADP TotalSource, we are pleased to provide you with important information on how to take advantage of the comprehensive worksite employee benefits available to you. You are also eligible for a variety of supplemental benefits through TotalChoice™ Voluntary Benefits program designed exclusively for ADP TotalSource by Mercer. You will soon receive more information on the various products and services that offer the advantage of group rates and convenience through payroll deductions.

If you recently participated in an onsite enrollment meeting or already received and completed the enrollment process for this plan at your worksite, no other action is required.

Please note, your eligibility date is fast approaching. To more effectively expedite the enrollment process and receive any carrier ID cards, we encourage you to enroll online today!

Important Information for the 2015 - 2016 Plan Year!

Health Care Reform Legislation

As you know, Health Care Reform legislation known as the Affordable Care Act (ACA) was passed early in 2010 with many of the legislations' requirements being phased in over time. ADP TotalSource is committed to keeping you informed. As such, we have included a Health Care Reform flyer in this enrollment kit on specific ACA provisions that are effective for the ADP TotalSource, Inc. Health and Welfare Plan and may affect your benefit election choices for you and your family. Please refer to this informative flyer for the latest information on Health Care Reform provisions.

Flexible Spending Account (FSA) Enrollment

The Health Care FSA and Dependent Care FSA let you pay for certain health care and dependent care expenses tax-free. The maximum contribution limits for the 2015 - 2016 Plan year are $2,550 for the Health Care FSA and $5,000 ($2,500, if married filing separately) for the Dependent Care FSA, however, highly compensated employees will only be permitted to contribute up to $2,000 per Plan Year to the Dependent Care FSA. Please refer to the enclosed Dependent Care FSA Summary if you have questions about who is considered a highly compensated employee for this purpose. Please be advised that if your employer does not offer group health coverage then a Health Care FSA will not be offered to you. Also note that participation by a Self-Employed Individual (SEI) in the Dependent Care FSA may be further limited by IRS guidelines. Please refer to the FSA benefit summaries in this kit for Plan details and SEI participation rules.

Please note that the claims filing deadline for FSA expenses incurred during the 2015 - 2016 Plan year is July 30, 2016.

Dependent Eligibility

The Health Care Reform Act requires group health plans and health insurance issuers to extend dependent coverage for adult children until age 26. Additionally, several states have passed legislation allowing parents to extend health coverage for their over age dependent children beyond age 26 that meet certain eligibility criteria. Please refer to the Dependent Eligibility Reference Guide in the Benefits Quick Links section located on www.mytotalsource.com for further details.

Tax Treatment of Non-Tax Dependents Benefits Coverage

If your enrolled dependent is not a tax dependent as defined by the Internal Revenue Code Section 152, you will be subject to federal and, if applicable, state income tax on the value of the coverage provided to such dependent(s). This value is considered "imputed income". TotalSource will determine the amount of imputed income periodically during the calendar year and will make adjustments to your taxable income as applicable. Please refer to the Employee Certification of Dependent Tax Status Form in this kit and the Non-Tax Dependent Imputed Income FAQ in the Benefits Quick Links section located on www.mytotalsource.com for further details.

Dependents' Social Security Numbers Required for Enrollment

The Centers for Medicare and Medicaid Studies (CMS) requires Social Security numbers (SSNs) for health plan subscribers and their dependents in order to comply with Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007. In order to ensure compliance with these reporting requirements, our health insurance carriers require worksite employees to provide SSNs for all covered dependents. **As such, we will be unable to process health plan enrollments for your identified dependents without the required SSN information.** ADP TotalSource, as well as each of our health insurance carriers, takes strict precautions to ensure the security of your personal

information, including your Social Security number. If you have questions about the security measures your health insurance carrier has in place, please call their Customer Service phone number before completing your enrollment elections.

Simply review your Enrollment Kit and make your elections. Please refer to the instruction pages that follow for more details on the process. If you do not have access to enroll online and are electing to make changes by completing the Health and Welfare Benefits Enrollment Form, please return the forms to the address or fax number indicated below.

ADP TotalSource
Attn: Benefits Center
10200 Sunset Drive
Miami, FL 33173
FAX: 1-866-616-8858

Thank you in advance for your cooperation.

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Health Care Reform Update

Health Care Reform legislation known as the Affordable Care Act (or ACA) was passed in early 2010, with many of the requirements being phased in over time. ADP TotalSource® is committed to keeping you informed of provisions that may affect your benefits or the benefit election choices for you and your family.

Educational videos are available with information about the ACA requirements that may affect you and your dependents as of January 1, 2014. To view the videos, log in to My TotalSource® at MyTotalSource.com and click Myself, then Benefit Enrollment.

Individual Mandate

Starting January 1, 2014, the individual mandate requires most individuals to either obtain a minimum level of health benefits or pay a tax penalty. You and your dependents will satisfy the individual mandate when your benefits are provided through an employer-sponsored plan, such as the ADP TotalSource, Inc. Health and Welfare Plan. Your other health coverage options could include:

- Another employer's plan, if available through your spouse/domestic partner
- An individual policy, provided it meets the required ACA minimum value level of coverage
- Coverage through the Health Insurance Marketplace
- A public program, like Medicare, Medicaid or a state Children's Health Insurance Program (CHIP)

The ADP TotalSource health plans offered to you satisfy the ACA minimum value level of coverage for the 2015−2016 Plan Year. The Summaries of Benefits and Coverage (SBCs) in your enrollment kit and on the My TotalSource website at MyTotalSource.com provide information regarding the status of the minimum value level of coverage for each respective health plan being offered to you.

For more information about the ACA individual mandate, access our educational videos by logging in to MyTotalSource.com.

Health Insurance Marketplace and Employee Notice of Coverage Options

The Health Insurance Marketplace is an additional way for individuals to secure health insurance. To assist you as you evaluate options for you and your family, we've placed an **Employee Notice of Coverage Options** on My TotalSource at MyTotalSource.com. This notice provides basic information about the Marketplace and employment-based health coverage offered to eligible employees. If your employer offers you affordable coverage (where your cost of self-only coverage is no more than 9.5% of your household income), you won't be eligible for a premium tax credit and/or cost-sharing subsidy in the Marketplace. Contact the ADP TotalSource Employee Service Center at (800) 554-1802 if you have questions or need assistance locating the Employee Notice of Coverage Options.

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Uniform Glossary of Health Coverage and Medical Terms

The **Uniform Glossary of Health Coverage and Medical Terms** provides a resource to help consumers understand some of the most common language used in health insurance documents. The Uniform Glossary of Health Coverage and Medical Terms is intended to be educational and may be different from the terms and definitions in your health insurance plan. Also, please note that some of the terms may not have exactly the same meaning when used in your health insurance policy or in the ADP TotalSource, Inc. Health and Welfare Plan, and the health insurance policy and/or the ADP TotalSource Plan Document will govern. You can obtain a copy of the Uniform Glossary of Health Coverage and Medical Terms on My TotalSource at MyTotalSource.com or by contacting the Employee Service Center at (800) 554-1802.

Increased Consumer Benefits

The Affordable Care Act law has transformed the health care delivery system and increased consumer benefits. Following are some of the ways the law has affected consumers:

- **Dependent (Adult Child) Coverage:** Adult children to age 26 are eligible for coverage. Certain states' laws may permit coverage beyond this age.
- **Pre-Existing Conditions:** Health plan insurers were required to remove all pre-existing condition exclusions from their plans.
- **Lifetime Limits:** An earlier provision of the law required that the insurers remove any lifetime limits on "essential health benefits."
- **Preventive Services:** Preventive services, such as annual exams and certain cancer screenings and tests, must be available with no out-of-pocket costs when received in the plan's network. Women's preventive care services were further expanded.
- **Annual Limits:** Annual dollar limits on essential health benefits (EHB) are prohibited. Essential health benefits have been defined by the ACA in 10 broad categories, and when such benefits are offered in a large group health plan, such as the ADP TotalSource, Inc. Health and Welfare Plan, the insurer must offer the coverage without annual limits. Some examples of benefits that may no longer have an annual dollar limit are chiropractic and durable medical equipment services, prescription drugs, mental health and substance abuse services, and more.
- **Out-of-Pocket Maximum (OOPM):** The OOPM can't be any greater than the health savings account (HSA) limits each year. Additionally, all member cost-sharing under the plan applies to the OOPM. Some health plans have received a one-year extension to integrate their pharmacy copays/coinsurance into the single OOPM of the health plan.
- **Clinical Trials:** A health plan can't deny coverage for the services related to a "qualified individual" who's participating in an "approved clinical trial." Such services are coordinated between the individual's doctor and the health plan.
- **Waiting Period for Newly Eligible Employees:** An employer can't have a health coverage waiting period greater than 90 days.

At ADP TotalSource, we're continuously evaluating our benefits program and working with our insurers and consultants to understand the ACA provisions and their impact on plan members.

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Summary of Benefits and Coverage (SBC)

ADP TotalSource will provide eligible individuals with Summary of Benefits and Coverage (SBC) documents at the time of enrollment. The SBC is intended to help consumers better understand the coverage they have and allow them to compare different coverage options. If you receive a paper enrollment kit, you can locate the SBCs in the “Reference” section of the kit. If you receive your enrollment kit electronically, you can access the SBC documents by logging in to MyTotalSource.com and selecting the health plan option displayed during the enrollment process. Any eligible individual can also contact the ADP TotalSource Employee Service Center at (800) 554-1802 to request an SBC for a specific plan option. Please note that some paper enrollment kits may initially be distributed without the SBC documents due to the timing of when ADP TotalSource receives the SBC documents from the insurance carrier. In the event that you receive a paper enrollment kit that does not contain these documents, you can log in to MyTotalSource.com or contact the Employee Service Center at (800) 554-1802 to request copies.

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Action Section

If you are making a benefit election for the 2015-2016 Plan Year, please enroll online or complete, sign and return all the forms in this section before your enrollment deadline. If you are waiving benefits, you must either enter your waiver online or complete the ADP TotalSource Health & Welfare Enrollment Form in this section.

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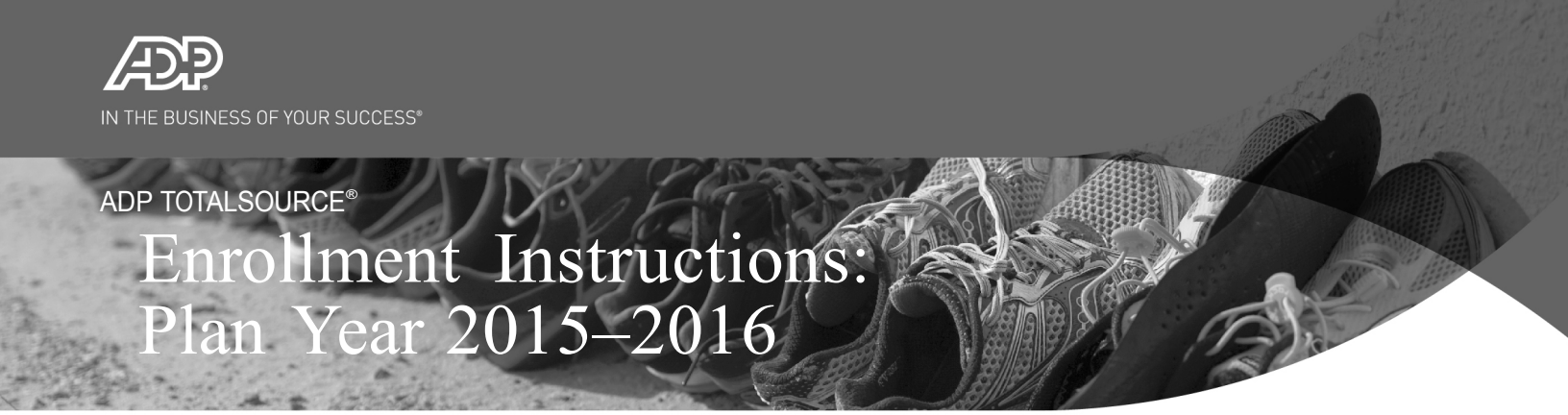

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Enrollment Instructions: Plan Year 2015–2016

These instructions will help you quickly and easily enroll in your 2015–2016 benefits. Enrolling online is the fastest way to choose your benefits. If you don't have Internet access, see the next page for instructions on completing the paper enrollment form in this kit. Please be sure to enroll before the enrollment deadline.

WHY ENROLL ONLINE?

The secure online Benefits Enrollment Wizard walks you through the process and helps you enroll quickly and correctly. It even includes a Learning Center with quick and helpful videos.

TO ENROLL ONLINE:

- **Log in to My TotalSource® (MyTotalSource.com).**

  If you're logging in to My TotalSource for the first time, follow the instructions below:

  1. Open a new browser window.
  2. Copy the following URL, paste it into the address bar of the browser and click **Go** or press the **Enter** key: https://totalsource.adp.com/ts/login.do
  3. Click on the **Register Now** link. *If you've already registered, please skip to step 9.*
  4. Enter your **registration pass code**. If you don't know your registration pass code, please contact the Employee Service Center at (800) 554-1802.
  5. Click the **Next** button.
  6. Follow the online instructions and complete the registration.
  7. Close the browser window.
  8. Open a new browser window, copy the following URL, paste it into the address bar of your browser and click **Go**: https://totalsource.adp.com/ts/login.do
  9. Click the **Employee Login** button.
  10. Enter your new user ID and password on the next screen to log in.

- **Follow the step-by-step directions on the website to enroll.**

  1. Click **Myself** and then select **Benefit Enrollment**.
  2. Click **GET STARTED** to access the Benefits Enrollment Wizard.
  3. Follow the enrollment process and make your benefit selections.
  4. After you've enrolled in or waived all coverage options, review your benefit elections carefully on the **Review and Submit Elections** page.
  5. If your elections are correct, read and accept the Acknowledgements that appear at the bottom of the **Review and Submit Elections** page and choose **Submit**.

     Congratulations – you're done!

For your records, print your benefits confirmation by clicking the **Print this Confirmation** link at the top of the **Confirmation** page. If applicable, click the temporary insurance card graphic to open and print your temporary card.

The benefits you elect will be effective through May 31, 2016 and cannot be changed until the next annual Open Enrollment period, unless you experience an IRS-qualified change in status (see the Summary Plan Description for details). After you make your election, you will receive a confirmation statement summarizing your benefit elections.

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TO ENROLL BY PAPER FORM:
Follow the instructions below to complete the two-page Health and Welfare Benefits Enrollment Form in this kit. Incomplete forms will delay the processing of your benefit elections.

To Waive/Cancel All Coverage(s):
If you are not enrolling in **any** of the benefits offered:

- Complete the **Personal Information** section or verify the preprinted information for accuracy.
- Check (√) **Waive/Cancel All Coverage(s)** above the **Medical Options** section.
- Place a check (√) beside your reason for waiving coverage in the **Waive Medical Coverage** box.
- Complete the **Beneficiary Information** section (if life insurance is offered to you).
- Sign and date the enrollment form.

To Enroll in Benefits Coverage:

- Complete the **Personal Information** section or verify the preprinted information for accuracy.
- **Medical Options** – Place a check (√) beside the plan and coverage level you want. If you don't want to enroll in a medical plan, place a check (√) beside your reason for waiving coverage in the **Waive Medical Coverage** box.
- **Dental Options** – Place a check (√) beside the plan and coverage level you want, or check (√) **Waive Coverage**.
- **Vision Options** – Place a check (√) beside the plan and coverage level you want, or check (√) **Waive Coverage**.
- **Basic Life and AD&D / Long-Term Disability / Short-Term Disability Plans** – If these benefits are offered to you, the level of coverage is indicated. You don't need to do anything.
- **FSA Options** – Write in the amount you want to contribute for the 2015–2016 Plan Year, or check (√) **Waive**.
- **Health Savings Account (HSA) Option*** – If you're currently contributing to the UMB HSA and if the HSA remains available to you, you can change the amount you contribute on the enrollment form.
- Complete the entire **General Information** section.
- **Dependent Information and PCP Designation**** – All applicable fields in this section must be completed.
  - If you're enrolling in an HMO, QPOS, POS/OA HMO or DMO plan, indicate for yourself and each covered dependent a primary care physician (PCP) or primary care dentist (PCD) by name and identification number.
  - If you want dependent coverage under any benefit plans, you must provide each dependent's name, relationship to you, Social Security number, date of birth, and gender. Indicate with an "X" if they are to be enrolled in the medical, dental and/or vision plans (and provide PCP/PCD information, if applicable).
  - ADP TotalSource® and our health insurance carriers require worksite employees to provide dependents' SSNs in order to comply with Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007.
- **Beneficiary Information** – Complete the table for each person you would like to designate as a beneficiary for basic life and AD&PL insurance, if applicable.
- **Authorization** – Sign and date the form at the bottom of page 2. If you reside in AZ, CA, ID, LA, NV, NM, TX, WA or WI, state law requires that your spouse also sign your enrollment form.

** If you are enrolling in the HSA for the first time, you must log in to My TotalSource at mytotalsource.com and click **Myself** and then **Health Savings Account**. Once on the HSA page, you will make your elections from the options presented.*

*** It is very important that you write the date of birth, Social Security number and primary care physician/dentist name and identification number for each dependent to be covered, if applicable.*

Information about PCPs: If you're enrolling in an HMO, QPOS, POS/OA HMO or DMO plan, you must identify a primary care physician (PCP) or dentist (PCD) for you and each of your covered dependents by writing the provider's name and identification number (available in the plan's provider directory or on the plan's website) in the table. If you do not provide the PCP's or PCD's name and identification number, the carrier may assign a provider to you, or your plan identification cards will be delayed.

Health and Welfare Benefits Enrollment Form (2015-2016 Plan Year)

Effective Date:

Personal Information

Name: _____
Address: _____
_____
Phone #:( )

SSN: - -
Gender: M / F
Date of Birth: / /
Date of Hire: / /

Company: Family Entertainment Group LLC
Paygroup: 14E / 627319
Region: Mid-West
HRG: Amy Mieding
Ben Rep: Denise King
~~~~~~~~~~~~~~~~
Class Code: A / All Employees
Class State: OH
Waiting Pd: 30 Days

IMPORTANT: This form has multiple pages. All pages must be completed (including your signature on the last page) and submitted, or your benefit elections may be delayed.

( ) Waive/Cancel All Coverage(s). (Medical option waiver section must be completed)

Medical Options- Elect one (1) Medical plan or Waive coverage

Plan Offering(s)	Plan Codes(s)	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
UHC-CP-3M7-1000-100-A1-OH	BAVM1	( ) $ 209.00	( ) $ 903.00	( ) $ 815.00	( ) $1,488.00
UHC-CP-3N1-1000-80-A1-OH	BAVN1	( ) $ 142.00	( ) $ 760.00	( ) $ 682.00	( ) $1,281.00
UHC-CP-3N5-2000-100-A1-OH	BAVO1	( ) $ 110.00	( ) $ 692.00	( ) $ 618.00	( ) $1,182.00
UHC-CP-3N9-3000-100-A1-OH	BAVR1	( ) $ 73.00	( ) $ 611.00	( ) $ 542.00	( ) $1,065.00

Waive Medical Coverage

( ) I certify that I am declining medical coverage at this time because I am currently covered under another health plan.

( ) I certify that I am declining medical coverage at this time and I am NOT currently covered under another health plan

Dental Options - Elect one (1) Dental plan or Waive coverage

Plan Offering(s)	Plan Codes(s)	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Guardian-Value Midwest	ACOU1	( ) $ 27.91	( ) $ 55.85	( ) $ 58.49	( ) $ 89.61

Waive Dental Coverage

( ) Waive Coverage

Vision Options - Elect or Waive Vision coverage

Plan Offering(s)	Plan Codes(s)	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
VSP- Choice Vision Plan	ASCX1	( ) $ 6.46	( ) $ 12.93	( ) $ 13.84	( ) $ 22.12

Waive Vision Coverage

( ) Waive Coverage

Life and Disability Plan Options

Plan Type	Plan Offering(s)	Plan Eligibility
Life	Basic $10,000	Life offered only to those who elect medical benefits
LTD	LTD Basic 50% $1,000/mo-180	LTD offered only to those who elect medical benefits

Flexible Spending Account (FSA) Plan Options

	Minimum Contribution	Maximum Contribution	Plan Year Election
( ) I wish to enroll in the Health Care Flexible Spending Account	$50	$2,550.00	$_____
( ) I wish to enroll in the Dependent Care Flexible Spending Account	$50	$5,000.00 ($2,500 if married filing separately)	$_____

Waive Flexible Spending Account Coverage

( ) Waive Health Care FSA Coverage
( ) Waive Dependent Care FSA Coverage

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Health and Welfare Benefits Enrollment Form (2015-2016 Plan Year)

Effective Date:

Company: Family Entertainment Group LLC **Paygroup: 14E / 627319 / Mid-West**

DEPENDENT INFORMATION AND PCP DESIGNATION

In this section, list yourself and all of your eligible dependents whom you wish to cover under a benefit plan. Provide complete information for each dependent, and identify the benefit plan(s) in which you wish to enroll each dependent by marking "X" under the appropriate benefit plan option(s).

Name	Relation	SS#	Date of Birth	Gender	----------Election Information--------- Medical PCP	Dental PCD	Vision
	Employee						

BENEFICIARY INFORMATION (List individual(s) you wish to designate as Basic Life Insurance beneficiaries)

Name	Relation	SS#	Date of Birth	Address	Amt. or %	Basic Life	Primary or Contingent

AUTHORIZATION

I have read the explanation of my Health and Welfare benefits options for the current Plan Year. I authorize the elections I have made, as well as any pre-tax payroll deductions required for these elections unless I complete an additional form requesting that benefit deductions be taken on a post-tax basis. I understand that during this or any future open enrollments if I do not make changes to my then-current health plan elections, my elections will default to either the same health plan election or a designated replacement health plan election specified in the personal statement for that enrollment period, and that such a default may result in a higher cost and increased deduction from my pay. By signing this Form, I am also authorizing any pre-tax deductions required to cover the defaulting elections.

I understand that if I am considered a Self-Employed Individual, according to the Internal Revenue Code, I am not eligible to pay for my benefits under the ADP TotalSource Health and Welfare Plan ("Plan") on a pre-tax basis, and I am not eligible to make contributions to the Health Care FSA. I may make post-tax contributions to the Dependent Care FSA if I am otherwise receiving wages that are reportable on a Form W-2.*

I acknowledge that in the event of the termination of my employment, my health, dental, vision and group life insurance coverage will continue through the end of the month in which my termination occurs. Other coverage, such as disability and participation in the FSA plan (if applicable), will end on the date of my employment termination. I agree that upon my termination, the amount needed to cover my contributions to my insurance premium(s) for that month's coverage becomes immediately due and payable and will be deducted from my final paycheck(s). I understand that this final deduction amount may be higher than the amounts deducted in previous pay periods. I understand that I cannot change my elections before the next annual enrollment period, unless a qualified change in status occurs and my requested election change is consistent with the change in status event.* I understand that if I am a newly-eligible employee waiving medical coverage because I am covered under another medical plan, I must indicate this under the medical options section by choosing the first "Waive Coverage" option. Absence of this indication may affect my eligibility for HIPAA special enrollment period should I lose this other coverage at a later date.*

I hereby certify that the above information is complete and accurate.

Worksite Employee Signature_____ **Date**_____ **Spouse's Signature**_____ **Date**_____

Required only for married residents of AZ,CA,ID,LA,NV,NM,TX,WA and WI who are designating a non-spouse beneficiary for the life insurance option.

*Please see the ADP TotalSource, Inc. Health and Welfare Plan Summary Plan Description for further details.

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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 are 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 are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can 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, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS-NOW** or visit **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the 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 permit you to enroll in your employer plan if you are not 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, you can contact the Department of Labor at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2014. You should contact your state for further eligibility information.

ALABAMA – MEDICAID	ALASKA – MEDICAID
Website: http://www.medicaid.alabama.gov **Phone:** (855) 692-5447	**Website:** http://health.hss.state.ak.us/dpa/programs/medicaid/ **Phone (Outside of Anchorage):** (888) 318-8890 **Phone (Anchorage):** (907) 269-6529
ARIZONA – CHIP	COLORADO – MEDICAID
Website: http://www.azahcccs.gov/applicants **Phone (Outside of Maricopa County):** (877) 764-5437 **Phone (Maricopa County):** (602) 417-5437	**Medicaid Website:** http://www.colorado.gov/ **Medicaid Phone (In state):** (800) 866-3513 **Medicaid Phone (Out of state):** (800) 221-3943
FLORIDA – MEDICAID	GEORGIA – MEDICAID
Website: https://www.flmedicaidtplrecovery.com/ **Phone:** (877) 357-3268	**Website:** http://dch.georgia.gov/ Click on **Programs**, then **Medicaid**, then **Health Insurance Premium Payment (HIPP)** **Phone:** (800) 869-1150
IDAHO – MEDICAID	INDIANA – MEDICAID
Medicaid Website: http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx **Medicaid Phone:** (800) 926-2588	**Website:** http://www.in.gov/fssa **Phone:** (800) 889-9949

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IOWA – MEDICAID	KANSAS – MEDICAID
Website: www.dhs.state.ia.us/hipp/ **Phone:** (888) 346-9562	**Website:** http://www.kdheks.gov/hcf/ **Phone:** (800) 792-4884
KENTUCKY – MEDICAID	LOUISIANA – MEDICAID
Website: http://chfs.ky.gov/dms/default.htm **Phone:** (800) 635-2570	**Website:** http://www.lahipp.dhh.louisiana.gov **Phone:** (888) 695-2447
MAINE – MEDICAID	MASSACHUSETTS – MEDICAID AND CHIP
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html **Phone:** (800) 977-6740 **TTY:** (800) 977-6741	**Website:** http://www.mass.gov/MassHealth **Phone:** (800) 462-1120
MINNESOTA – MEDICAID	MISSOURI – MEDICAID
Website: http://www.dhs.state.mn.us/ Click on **Health Care**, then **Medical Assistance** **Phone:** (800) 657-3629	**Website:** http://www.dss.mo.gov/mhd/participants/pages/hipp.htm **Phone:** (573) 751-2005
MONTANA – MEDICAID	NEBRASKA – MEDICAID
Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml **Phone:** (800) 694-3084	**Website:** www.ACCESSNebraska.ne.gov **Phone:** (855) 632-7633
NEVADA – MEDICAID	NEW HAMPSHIRE – MEDICAID
Medicaid Website: http://dwss.nv.gov/ **Medicaid Phone:** (800) 992-0900	**Website:** http://www.dhhs.nh.gov/oii/documents/hippapp.pdf **Phone:** (603) 271-5218
NEW JERSEY – MEDICAID AND CHIP	NEW YORK – MEDICAID
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ **Medicaid Phone:** (609) 631-2392 **CHIP Website:** http://www.njfamilycare.org/index.html **CHIP Phone:** (800) 701-0710	**Website:** http://www.nyhealth.gov/health_care/medicaid/ **Phone:** (800) 541-2831
NORTH CAROLINA – MEDICAID	NORTH DAKOTA – MEDICAID
Website: http://www.ncdhhs.gov/dma **Phone:** (919) 855-4100	**Website:** http://www.nd.gov/dhs/services/medicalserv/medicaid/ **Phone:** (800) 755-2604

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OKLAHOMA – MEDICAID AND CHIP	OREGON – MEDICAID
Website: http://www.insureoklahoma.org **Phone:** (888) 365-3742	**Website:** http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.g
PENNSYLVANIA – MEDICAID	RHODE ISLAND – MEDICAID
Website: http://www.dpw.state.pa.us/hipp **Phone:** (800) 692-7462	**Website:** www.ohhs.ri.gov **Phone:** (401) 462-5300
SOUTH CAROLINA – MEDICAID	SOUTH DAKOTA – MEDICAID
Website: http://www.scdhhs.gov **Phone:** (888) 549-0820	**Website:** http://dss.sd.gov **Phone:** (888) 828-0059
TEXAS – MEDICAID	UTAH – MEDICAID AND CHIP
Website: http://www.gethipptexas.com/ **Phone:** (800) 440-0493	**Website:** http://health.utah.gov/upp **Phone:** (866) 435-7414
VERMONT – MEDICAID	VIRGINIA – MEDICAID AND CHIP
Website: http://www.greenmountaincare.org/ **Phone:** (800) 250-8427	**Medicaid Website:** http://www.coverva.org/programs_premium_assistance.cfm **Medicaid Phone:** (800) 432-5924 **CHIP Website:** http://www.coverva.org/programs_premium_assistance.cfm **CHIP Phone:** (855) 242-8282
WASHINGTON – MEDICAID	WEST VIRGINIA – MEDICAID
Website: http://www.hca.wa.gov/medicaid/premiumpymnt/pages/index.aspx **Phone:** (800) 562-3022, Ext. 15473	**Website:** www.dhhr.wv.gov/bms/ **Phone:** (877) 598-5820, HMS Third Party Liability
WISCONSIN – MEDICAID	WYOMING – MEDICAID
Website: http://www.badgercareplus.org/pubs/p-10095.htm **Phone:** (800) 362-3002	**Website:** http://health.wyo.gov/healthcarefin/equalitycare **Phone:** (307) 777-7531

To see if any other states have added a premium assistance program since July 31, 2014, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
(866) 444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
(877) 267-2323, menu option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)

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ADP TOTALSOURCE®

Employee Certification of Dependent Tax Status

INSTRUCTIONS: Complete and return this form only if you're enrolling one or more dependents in the following categories for benefits coverage:

• Adult children who have reached age 26

• Civil union partners and their children

Certification of Tax Dependent

I understand that the following rules apply to the federal income tax treatment of benefits coverage:

If my above-mentioned dependent is not a tax dependent as defined below, I will be subject to federal and, if applicable, state income tax on the value of the coverage provided to my dependent. The taxable value of the coverage is considered imputed income, and the amount of imputed income will be determined by ADP TotalSource® periodically during the calendar year. ADP TotalSource will make this adjustment on periodic payrolls during the calendar year, and I'll be notified prior to any payroll adjustments. I understand that this adjustment may increase my federal and, if applicable, state income tax liability.

• **For an adult child who has reached age 26:**

Federal and, if applicable, state tax will apply to any coverage provided to an adult child beginning January 1 of the calendar year in which the adult child will attain age 27, unless the adult child qualifies as a tax dependent due to being permanently and totally disabled, as described in Code Section 152(c).

• **For civil union partners:**

- You provide more than half of your civil union partner's total support for the calendar year;
- You and your civil union partner have the same principal place of abode for the entire calendar year, except for temporary reasons such as vacation, military service or education;
- Your civil union partner is a member of your household for the entire calendar year (and the relationship doesn't violate local law);
- Your civil union partner isn't your (or anyone else's) "qualifying child" under Code Section 152(c); and
- Your civil union partner is a U.S. citizen, a U.S. national, or a resident of the U.S., Canada or Mexico.

• **For a civil union partner's child who isn't also your child:**

Your civil union partner's child who isn't also your child (a "covered child") may qualify as your tax dependent for health coverage purposes if they satisfy the above test or if they satisfy the "qualifying child" test found in Code Section 152(c).

Continues on next page

IN THE BUSINESS OF YOUR SUCCESS®

Employee Certification of Dependent Tax Status

Please consult with your tax advisor before certifying below whether your enrolled dependent is a tax dependent for health coverage purposes as defined by the Internal Revenue Code. Also list any dependent(s) you're enrolling from the above-listed dependent categories and indicate their tax status.

Last Name	First Name	Dependent Relationship	Dependent Tax Status	
			☐Tax Dependent	☐Not a Tax Dependent
			☐Tax Dependent	☐Not a Tax Dependent
			☐Tax Dependent	☐Not a Tax Dependent
			☐Tax Dependent	☐Not a Tax Dependent

I certify the tax status of my dependent(s) listed above as defined by the Internal Revenue Code. I understand that ADP TotalSource will rely on this certification to determine my federal and, if applicable, state income and employment taxes. I further understand that I must notify ADP TotalSource if conditions change that would cause my dependent(s) to no longer qualify as my tax dependent(s).

Employee Name _____ Last 4 Digits of SSN or Employee ID _____

Employee Signature _____ Date _____

EMAIL, FA X OR MAIL COMPLETED FORM

TO: ADP TOTALSOURCE
Attention: Benefits Center
10200 Sunset Drive
Miami, FL 33173
Fax: 1-866-616-8858
Email: TotalSourceBenefits@adp.com

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ADP TOTALSOURCE®

Reference Section

The contents of this section are for review only.
Nothing in this section needs to be returned.

SUMMARY OF MATERIAL MODIFICATIONS
TO THE SUMMARY PLAN DESCRIPTION FOR THE ADP TOTALSOURCE, INC. HEALTH AND WELFARE PLAN

Note: This document contains important information concerning your benefits. Please review this information carefully and retain with your benefit materials for future reference. Please note that eligibility varies by benefit option and your worksite employer's elections. Those benefit options you are entitled to are described in your benefits enrollment kit.

You previously received enrollment information for the Health and Welfare Plan ("Plan"). This document is a Summary of Material Modifications ("SMM") for the 2014-2015 and 2015-2016 plan years for your review and records, and it contains changes to the Summary Plan Description ("SPD") that you previously received. You may obtain a copy of the SPD by logging on to My TotalSource at www.adptotalsource.com or calling the Employee Service Center at 1-800-554-1802 or by email at esc@adp.com.

This SMM is intended to summarize the Plan amendments. If there is a conflict between this SMM and the actual language of the Plan, the Plan language controls.

Summaries of the Plan Modifications are as follows:

EFFECTIVE JUNE 1, 2014

Addition of Health Care Flexible Spending Account (FSA) Carry Over Provision

For the 2014-2015 Plan Year and each Plan Year thereafter, participants in the Health Care FSA are permitted to carry over up to $500 of their remaining account balance as of the current Plan Year claim filing deadline. Eligible carryover amounts will be applied to the following Plan Year. The carryover of up to $500 does not affect the maximum amount that a participant can elect to contribute in the new Plan Year.

EFFECTIVE JANUARY 1, 2015

Change to High-Deductible Health Plan (HDHP) Annual Deductible and Out-of-Pocket Maximum for 2015

On page 16 of the Summary Plan Description under the section titled **HDHP Annual Deductible and Out-of-Pocket Maximum,** the 2015 Calendar Year requirements are added as follows:

2015 Calendar Year limits are as follows:

2015 Annual HDHP Minimum Deductibles:
Self-only coverage: $1,300
Family coverage: $2,600

2015 HDHP Maximum Out-of-Pocket Limits: (includes deductibles, copayments and co-insurance, but not premiums)
Self-only coverage: $6,450
Family coverage: $12,900

Change to Health Savings Account Contribution (HSA) Limits for 2015

On page 33 of the Summary Plan Description under the section titled **Contribution Limits,** the stated HSA contribution limits are changed effective January 1, 2015 as follows:

- Contribution limit for individual coverage in 2015 is $3,350.
- Contribution limit for family coverage in 2015 is $6,650.

An individual who has reached the age of 55 by the end of the calendar year may contribute an additional $1,000 per year. These maximums are subject to change by the IRS each January 1st.

Change to Flexible Spending Account (FSA) Online Access

On page 25 of the Summary Plan Description under the section titled **Requesting Reimbursement**, the first sentence of the 3rd paragraph is changed to read:

> "You can submit an online reimbursement request and access claim forms and further details on how to submit claims by logging in to My TotalSource at mytotalsource.com and clicking **Myself**, then the **Spending Accounts** menu option. This will take you directly to the ADP secure website at myspendingaccount.adp.com and will not require that you register for access. Please note that if you log in to the myspendingaccount.adp.com website directly, you'll need to register on the website to create your login for online access to your spending account(s). Once on the website, click Register for online access.

On page 25, in the call-out box titled **New Health Care FSA Spending Account Card**, the last sentence is changed to read: "Learn more at myspendingaccount.adp.com."

On pages 28 and 30, the sections titled **Managing Your FSA**, are changed to read:

> "The best place for you to find all the information you need to manage your FSA is at myspendingaccount.adp.com, which can be accessed directly through My TotalSource by selecting **Myself** and then the **Spending Accounts** menu option. Alternatively, you can call the toll-free ADP TotalSource Employee Service Center at 800-554-1802 to be transferred to the FSA participant hotline. The hotline is staffed Monday through Friday from 8 a.m. to 8 p.m. ET."

Change to Facts About the Plan - Trustees

On page 64 of the Summary Plan Description, the section titled **Trustees of the ADP TotalSource, Inc. Health and Welfare Plan Trust** is changed as follows:

Maria Black, President, ADP TotalSource
Cristian Orihuela, VP, Health and Wealth
Sergio Fernandez, VP, Risk Management
Mark Acquadro, Vice President - Finance

EFFECTIVE JUNE 1, 2015

Change to Health Care Flexible Spending Account (FSA) Contribution Limits

On page 28 of the Summary Plan Description under the section titled **Contribution Limits,** the stated Health Care FSA contribution limits are changed effective June 1, 2015 to $2,550 per Plan Year.

Change to Definition of Highly Compensated Employee for the 2015-2016 Plan Year

On page 30 of the Summary Plan Description under the section titled **Contribution Limits for Highly Compensated Employees,** the following definition is added:

"**For the 2015-2016 Plan Year,** a "highly compensated employee" is defined by the IRS as an individual that (a) owns (or constructively owns) more than 5% of the stock, capital or profits interest of a Client Company on any day during the Plan Year, or (b) will be paid compensation by ADP TotalSource in excess of **$120,000** annually. The definition of a highly compensated employee may change for future Plan Years."

Update Regarding Health Savings Account (HSA) Participation when Qualifying for a Health FSA Carryover

On page 35 of the Summary Plan Description, the following is added to the end of the response to the question, **Can I have a Flexible Spending Account (FSA) if I have an HSA?** "Also, if you have a Health Care FSA carryover from the prior Plan Year, your Health Care FSA carryover will be converted to a Limited FSA carryover due to IRS rules.**"**

IMPORTANT ANNUAL BENEFIT NOTICE(S)

Annual Notice Regarding the Women's Health and Cancer Rights Act

This law requires plans that provide medical and surgical benefits for mastectomies to provide coverage for the following procedures, as requested from the patient in consultation with her physician:

- **Reconstruction of the breast on which the mastectomy has been performed;**
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prosthesis (e.g., breast implant); and
- Treatment for physical complications of all stages of the mastectomy, including lymphedemas.

HIPAA Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 60 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

Also, under the Children's Health Insurance Program Reauthorization Act you or your dependent that is eligible, but not enrolled in the Plan, may enroll if either of the following two conditions are met:

(1) You or your dependent are covered under a Medicaid plan or under a State child health plan and the coverage is terminated due to loss of eligibility and you request coverage under the Plan no later than 60 days after the loss of eligibility; or

(2) Your or your dependent become eligible for assistance for coverage under the Plan, Medicaid plan or State child health plan and you request coverage under the Plan no later than 60 days after you or your dependent are determined to be eligible for assistance.

PATIENT PROTECTION - PRIMARY CARE PHYSICIAN (PCP) AND OB/GYN SELECTION

Many of the ADP TotalSource health plans require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the health plan's network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from the ADP TotalSource health insurance carriers or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the health insurance carrier at the phone number indicated on the Benefit Summary provided in your benefits enrollment kit.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.welcometouhc.com** or by calling **1-800-782-3740.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: **$1,000** Indiv **/ $3,000** Family Non-Network: **$2,000** Indiv **/ $6,000** Family Per calendar year. Does not apply to prescription drugs, services listed below as "No Charge" and copays except as noted below.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes, Network: **$4,000** Indiv **/ $8,000** Family Non-Network: **$8,000** Indiv **/ $16,000** Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, health care this plan doesn't cover and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see **www.welcometouhc.com** or call **1-800-782-3740.**	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call **1-800-782-3740** or visit us at **www.welcometouhc.com.** If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.cciio.cms.gov** or **www.dol.gov/ebsa/healthreform** or call **1-866-487-2365** to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit	20% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$50 copay per visit	20% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$25 copay per visit	20% co-ins, after ded	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period. Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Preventive care/screening/immunization	No Charge	20% co-ins, after ded	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	20% co-ins, after ded	Pre-Authorization required for non-network for sleep studies or benefit reduces to 50% of allowed.
	Imaging (CT/PET scans, MRIs)	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.welcometouh-c.com.	Tier 1 - Your Lowest-Cost Option	Retail: $15 copay Mail-Order: $37.50 copay	Retail: $15 copay	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a Pre-Authorization requirement or may result in a higher cost. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. Tier 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail: $40 copay Mail-Order: $100 copay	Retail: $40 copay	
	Tier 3 - Your Highest-Cost Option	Retail: $75 copay Mail-Order: $187.50 copay	Retail: $75 copay	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.
	Physician/surgeon fees	0% co-ins, after ded	20% co-ins, after ded	None
If you need immediate medical attention	Emergency room services	$250 copay per visit	$250 copay per visit	None
	Emergency medical transportation	0% co-ins, after ded	0% co-ins, after ded	Network Deductible applies.
	Urgent care	$75 copay per visit	20% co-ins, after ded	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Physician/surgeon fees	0% co-ins, after ded	20% co-ins, after ded	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$50 copay per visit	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Mental/Behavioral health inpatient services	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Substance use disorder outpatient services	$50 copay per visit	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.
	Substance use disorder inpatient services	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
If you are pregnant	Prenatal and postnatal care	No Charge	20% co-ins, after ded	Additional copays, deductibles, or co-ins may apply depending on services rendered.
	Delivery and all inpatient services	0% co-ins, after ded	20% co-ins, after ded	Inpatient Authorization may apply.
If you need help recovering or have other special health needs	Home health care	0% co-ins, after ded	20% co-ins, after ded	Limited to 60 visits per policy period. Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Rehabilitation services	$25 copay per outpatient visit	20% co-ins, after ded	Limits per policy period: Physical, Speech, Occupational, Pulmonary 20 visits. Cardiac 36 visits. Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.
	Habilitative services	$25 copay per outpatient visit	20% co-ins, after ded	Services provided under and limits are combined with Rehabilitation services above. Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Skilled nursing care	0% co-ins, after ded	20% co-ins, after ded	Limited to 60 days per policy period (combined with Inpatient Rehabilitation). Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Durable medical equipment	0% co-ins, after ded	20% co-ins, after ded	Covers 1 per type of DME (including repair/replace) every 3 years. Pre-Authorization required for non-network DME over $1,000 or no coverage.
	Hospice service	0% co-ins, after ded	20% co-ins, after ded	Inpatient Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	No coverage for Eye exam.
	Glasses	Not Covered	Not Covered	No coverage for Glasses.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Dental check-up	Not Covered	Not Covered	No coverage for Dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult/Child)
- Glasses
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult/Child)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services.)

- Chiropractic care
- Hearing aids

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform or the Ohio Department of Insurance at 1-800-686-1526 or www.insurance.ohio.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-782-3740

如果需要中文的帮助，**请拨打这个号码** 1-800-782-3740

Dinek'ehgo shika at' ohwol ninisingo, kwiijigo holne' 1-800-782-3740

Para obtener asistencia en Español, llame al 1-800-782-3740

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,320
- **Patient pays** $1,220

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,000
Copays	$20
Coinsurance	$0
Limits or exclusions	$200
Total	**$1,220**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,660
- **Patient pays** $1,740

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$200
Copays	$1,500
Coinsurance	$0
Limits or exclusions	$40
Total	**$1,740**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers.** If the patient had received care from out-of-network **providers**, costs would have been higher.
- If other than individual coverage, the Patient Pays amount may be more.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No .** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No .** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes .** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes .** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call **1-800-782-3740** or visit us at **www.welcometouhc.com.** If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.cciio.cms.gov** or **www.dol.gov/ebsa/healthreform** or call **1-866-487-2365** to request a copy.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.welcometouhc.com** or by calling **1-800-782-3740.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: **$1,000** Indiv **/ $3,000** Family Non-Network: **$2,000** Indiv **/ $6,000** Family Per calendar year. Does not apply to prescription drugs, services listed below as "No Charge" and copays except as noted below.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes, Network: **$4,000** Indiv **/ $8,000** Family Non-Network: **$8,000** Indiv **/ $16,000** Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, health care this plan doesn't cover and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see **www.welcometouhc.com** or call **1-800-782-3740.**	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call **1-800-782-3740** or visit us at **www.welcometouhc.com.** If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.cciio.cms.gov** or **www.dol.gov/ebsa/healthreform** or call **1-866-487-2365** to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit	40% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$50 copay per visit	40% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$25 copay per visit	40% co-ins, after ded	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period. Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Preventive care/screening/immunization	No Charge	40% co-ins, after ded	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	40% co-ins, after ded	Pre-Authorization required for non-network for sleep studies or benefit reduces to 50% of allowed.
	Imaging (CT/PET scans, MRIs)	20% co-ins, after ded	40% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.welcometouh-c.com.	Tier 1 - Your Lowest-Cost Option	Retail: $15 copay Mail-Order: $37.50 copay	Retail: $15 copay	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a Pre-Authorization requirement or may result in a higher cost. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. Tier 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail: $40 copay Mail-Order: $100 copay	Retail: $40 copay	
	Tier 3 - Your Highest-Cost Option	Retail: $75 copay Mail-Order: $187.50 copay	Retail: $75 copay	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-ins, after ded	40% co-ins, after ded	Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.
	Physician/surgeon fees	20% co-ins, after ded	40% co-ins, after ded	None
If you need immediate medical attention	Emergency room services	$250 copay per visit	$250 copay per visit	None
	Emergency medical transportation	20% co-ins, after ded	20% co-ins, after ded	Network Deductible applies.
	Urgent care	$75 copay per visit	40% co-ins, after ded	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-ins, after ded	40% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Physician/surgeon fees	20% co-ins, after ded	40% co-ins, after ded	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$50 copay per visit	40% co-ins, after ded	Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Mental/Behavioral health inpatient services	20% co-ins, after ded	40% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Substance use disorder outpatient services	$50 copay per visit	40% co-ins, after ded	Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.
	Substance use disorder inpatient services	20% co-ins, after ded	40% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
If you are pregnant	Prenatal and postnatal care	No Charge	40% co-ins, after ded	Additional copays, deductibles, or co-ins may apply depending on services rendered.
	Delivery and all inpatient services	20% co-ins, after ded	40% co-ins, after ded	Inpatient Authorization may apply.
If you need help recovering or have other special health needs	Home health care	20% co-ins, after ded	40% co-ins, after ded	Limited to 60 visits per policy period. Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Rehabilitation services	$25 copay per outpatient visit	40% co-ins, after ded	Limits per policy period: Physical, Speech, Occupational, Pulmonary 20 visits. Cardiac 36 visits. Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.
	Habilitative services	$25 copay per outpatient visit	40% co-ins, after ded	Services provided under and limits are combined with Rehabilitation services above. Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Skilled nursing care	20% co-ins, after ded	40% co-ins, after ded	Limited to 60 days per policy period (combined with Inpatient Rehabilitation). Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Durable medical equipment	20% co-ins, after ded	40% co-ins, after ded	Covers 1 per type of DME (including repair/replace) every 3 years. Pre-Authorization required for non-network DME over $1,000 or no coverage.
	Hospice service	20% co-ins, after ded	40% co-ins, after ded	Inpatient Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	No coverage for Eye exam.
	Glasses	Not Covered	Not Covered	No coverage for Glasses.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Dental check-up	Not Covered	Not Covered	No coverage for Dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult/Child)
- Glasses
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult/Child)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services.)

- Chiropractic care
- Hearing aids

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform or the Ohio Department of Insurance at 1-800-686-1526 or www.insurance.ohio.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-782-3740

如果需要中文的帮助，**请拨打这个号码** 1-800-782-3740

Dinek'ehgo shika at' ohwol ninisingo, kwiijigo holne' 1-800-782-3740

Para obtener asistencia en Español, llame al 1-800-782-3740

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,420
- **Patient pays** $2,120

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,000
Copays	$20
Coinsurance	$900
Limits or exclusions	$200
Total	**$2,120**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,660
- **Patient pays** $1,740

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$200
Copays	$1,500
Coinsurance	$0
Limits or exclusions	$40
Total	**$1,740**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers.** If the patient had received care from out-of-network **providers**, costs would have been higher.
- If other than individual coverage, the Patient Pays amount may be more.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No .** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No .** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes .** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes .** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.welcometouhc.com** or by calling **1-800-782-3740.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: **$2,000** Indiv **/ $6,000** Family Non-Network: **$4,000** Indiv **/ $12,000** Family Per calendar year. Does not apply to prescription drugs, services listed below as "No Charge" and copays except as noted below.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes, Network: **$5,000** Indiv **/ $10,000** Family Non-Network: **$10,000** Indiv **/ $20,000** Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, health care this plan doesn't cover and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see **www.welcometouhc.com** or call **1-800-782-3740.**	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call **1-800-782-3740** or visit us at **www.welcometouhc.com.** If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.cciio.cms.gov** or **www.dol.gov/ebsa/healthreform** or call **1-866-487-2365** to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit	20% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$50 copay per visit	20% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$25 copay per visit	20% co-ins, after ded	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period. Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Preventive care/screening/immunization	No Charge	20% co-ins, after ded	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	20% co-ins, after ded	Pre-Authorization required for non-network for sleep studies or benefit reduces to 50% of allowed.
	Imaging (CT/PET scans, MRIs)	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.welcometouh-c.com.	Tier 1 - Your Lowest-Cost Option	Retail: $15 copay Mail-Order: $37.50 copay	Retail: $15 copay	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a Pre-Authorization requirement or may result in a higher cost. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. Tier 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail: $40 copay Mail-Order: $100 copay	Retail: $40 copay	
	Tier 3 - Your Highest-Cost Option	Retail: $75 copay Mail-Order: $187.50 copay	Retail: $75 copay	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.
	Physician/surgeon fees	0% co-ins, after ded	20% co-ins, after ded	None
If you need immediate medical attention	Emergency room services	$250 copay per visit	$250 copay per visit	None
	Emergency medical transportation	0% co-ins, after ded	0% co-ins, after ded	Network Deductible applies.
	Urgent care	$75 copay per visit	20% co-ins, after ded	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Physician/surgeon fees	0% co-ins, after ded	20% co-ins, after ded	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$50 copay per visit	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Mental/Behavioral health inpatient services	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Substance use disorder outpatient services	$50 copay per visit	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.
	Substance use disorder inpatient services	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
If you are pregnant	Prenatal and postnatal care	No Charge	20% co-ins, after ded	Additional copays, deductibles, or co-ins may apply depending on services rendered.
	Delivery and all inpatient services	0% co-ins, after ded	20% co-ins, after ded	Inpatient Authorization may apply.
If you need help recovering or have other special health needs	Home health care	0% co-ins, after ded	20% co-ins, after ded	Limited to 60 visits per policy period. Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Rehabilitation services	$25 copay per outpatient visit	20% co-ins, after ded	Limits per policy period: Physical, Speech, Occupational, Pulmonary 20 visits. Cardiac 36 visits. Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.
	Habilitative services	$25 copay per outpatient visit	20% co-ins, after ded	Services provided under and limits are combined with Rehabilitation services above. Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Skilled nursing care	0% co-ins, after ded	20% co-ins, after ded	Limited to 60 days per policy period (combined with Inpatient Rehabilitation). Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Durable medical equipment	0% co-ins, after ded	20% co-ins, after ded	Covers 1 per type of DME (including repair/replace) every 3 years. Pre-Authorization required for non-network DME over $1,000 or no coverage.
	Hospice service	0% co-ins, after ded	20% co-ins, after ded	Inpatient Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	No coverage for Eye exam.
	Glasses	Not Covered	Not Covered	No coverage for Glasses.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Dental check-up	Not Covered	Not Covered	No coverage for Dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult/Child)
- Glasses
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult/Child)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services.)

- Chiropractic care
- Hearing aids

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

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Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,320
- **Patient pays** $2,220

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,000
Copays	$20
Coinsurance	$0
Limits or exclusions	$200
Total	**$2,220**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,660
- **Patient pays** $1,740

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$200
Copays	$1,500
Coinsurance	$0
Limits or exclusions	$40
Total	**$1,740**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers.** If the patient had received care from out-of-network **providers**, costs would have been higher.
- If other than individual coverage, the Patient Pays amount may be more.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No .** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

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Can I use Coverage Examples to compare plans?

✓ **Yes .** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes .** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.welcometouhc.com** or by calling **1-800-782-3740.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: **$3,000** Indiv **/ $9,000** Family Non-Network: **$6,000** Indiv **/ $18,000** Family Per calendar year. Does not apply to prescription drugs, services listed below as "No Charge" and copays except as noted below.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes, Network: **$6,000** Indiv **/ $12,000** Family Non-Network: **$12,000** Indiv **/ $24,000** Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, health care this plan doesn't cover and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see **www.welcometouhc.com** or call **1-800-782-3740.**	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan does not cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

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- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay per visit	20% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$60 copay per visit	20% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$30 copay per visit	20% co-ins, after ded	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period. Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Preventive care/screening/immunization	No Charge	20% co-ins, after ded	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	20% co-ins, after ded	Pre-Authorization required for non-network for sleep studies or benefit reduces to 50% of allowed.
	Imaging (CT/PET scans, MRIs)	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.welcometouh-c.com.	Tier 1 - Your Lowest-Cost Option	Retail: $15 copay Mail-Order: $37.50 copay	Retail: $15 copay	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a Pre-Authorization requirement or may result in a higher cost. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. Tier 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail: $40 copay Mail-Order: $100 copay	Retail: $40 copay	
	Tier 3 - Your Highest-Cost Option	Retail: $75 copay Mail-Order: $187.50 copay	Retail: $75 copay	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.
	Physician/surgeon fees	0% co-ins, after ded	20% co-ins, after ded	None
If you need immediate medical attention	Emergency room services	$250 copay per visit	$250 copay per visit	None
	Emergency medical transportation	0% co-ins, after ded	0% co-ins, after ded	Network Deductible applies.
	Urgent care	$100 copay per visit	20% co-ins, after ded	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Physician/surgeon fees	0% co-ins, after ded	20% co-ins, after ded	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$60 copay per visit	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Mental/Behavioral health inpatient services	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Substance use disorder outpatient services	$60 copay per visit	20% co-ins, after ded	Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.
	Substance use disorder inpatient services	0% co-ins, after ded	20% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
If you are pregnant	Prenatal and postnatal care	No Charge	20% co-ins, after ded	Additional copays, deductibles, or co-ins may apply depending on services rendered.
	Delivery and all inpatient services	0% co-ins, after ded	20% co-ins, after ded	Inpatient Authorization may apply.
If you need help recovering or have other special health needs	Home health care	0% co-ins, after ded	20% co-ins, after ded	Limited to 60 visits per policy period. Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Rehabilitation services	$30 copay per outpatient visit	20% co-ins, after ded	Limits per policy period: Physical, Speech, Occupational, Pulmonary 20 visits. Cardiac 36 visits. Pre-Authorization required for certain services for non-network or benefit reduces to 50% of allowed.
	Habilitative services	$30 copay per outpatient visit	20% co-ins, after ded	Services provided under and limits are combined with Rehabilitation services above. Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Skilled nursing care	0% co-ins, after ded	20% co-ins, after ded	Limited to 60 days per policy period (combined with Inpatient Rehabilitation). Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
	Durable medical equipment	0% co-ins, after ded	20% co-ins, after ded	Covers 1 per type of DME (including repair/replace) every 3 years. Pre-Authorization required for non-network DME over $1,000 or no coverage.
	Hospice service	0% co-ins, after ded	20% co-ins, after ded	Inpatient Pre-Authorization required for non-network or benefit reduces to 50% of allowed.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	No coverage for Eye exam.
	Glasses	Not Covered	Not Covered	No coverage for Glasses.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Dental check-up	Not Covered	Not Covered	No coverage for Dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult/Child)
- Glasses
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult/Child)
- Routine foot care
- Weight loss programs

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Routine obstetric care	$2,100
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Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
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Coinsurance	$0
Limits or exclusions	$200
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(routine maintenance of a well-controlled condition)

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Questions and answers about the Coverage Examples:

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IN THE BUSINESS OF YOUR SUCCESS℠

2015/2016

Plan Description: Guardian Value Midwest
Product: PPO
Network: DentalGuard Preferred
Provider: Guardian Dental
Member Services Phone #: 1-800-541-7846
Plan Website Address: http://www.guardiananytime.com

Benefit	In-Network	Out-of-Network
Deductibles & Maximum Amounts		
Calendar Year Benefit Maximum	• $1,000	• $1,000
Calendar Year Deductible - Individual	• $50	• $50
Calendar Year Deductible - Family	• $150	• $150
Preventive & Diagnostic Services		
Preventive & Diagnostic Services	• 100%	• 100% of In-Network Established Fee
Basic / Restorative Services		
Basic / Restorative Services	• Deductible then 80%	• Deductible then 80% of In-Network Established Fee
Major Services		
Major Services	• Deductible then 50%	• Deductible then 50% of In-Network Established Fee
Orthodontic Services		
Orthodontic Lifetime Maximum	• $1,000 lifetime maximum for child(ren) under age 19. Adult ortho not covered	• $1,000 lifetime maximum for child(ren) under age 19. Adult ortho not covered
Orthodontic Deductible	• None	• None
Orthodontic Coinsurance	• 50%	• 50% of In-Network Established Fee
Diagnosis	• 50%	• 50% of In-Network Established Fee
Initial Placement of Orthodontic Appliance	• Covered as part of Active and Retention Treatments	• Covered as part of Active and Retention Treatments
Active and Retention Treatments	• 50%	• 50% of In-Network Established Fee
Services		
Oral Examination Copay / Coinsurance	• 100%	• 100% of In-Network Established Fee
Dental X-Rays	• 100%	• 100% of In-Network Established Fee
Prophylaxis - Adult	• 100%	• 100% of In-Network Established Fee
Prophylaxis - Child	• 100%	• 100% of In-Network Established Fee
Topical Application of Fluoride	• 100%	• 100% of In-Network Established Fee
Topical Application of Sealants	• 100%	• 100% of In-Network Established Fee
Fillings	• Deductible then 80%	• Deductible then 80% of In-Network Established Fee
Periodontic Services	• Deductible then 80%	• Deductible then 80% of In-Network Established Fee
Extractions	• Simple and Surgical Extractions: Deductible then 80%	• Deductible then 80% of In-Network Established Fee
Endodontics	• Deductible then 80%	• Deductible then 80% of In-Network Established Fee
Oral Surgery	• Deductible then 80%	• Deductible then 80% of In-Network Established Fee
Inlays	• Deductible then 50%	• Deductible then 50% of In-Network Established Fee
Crowns	• Deductible then 50%	• Deductible then 50% of In-Network Established Fee
Dentures	• Deductible then 50%	• Deductible then 50% of In-Network Established Fee
Bridges	• Deductible then 50%	• Deductible then 50% of In-Network Established Fee

IN THE BUSINESS OF YOUR SUCCESS℠

2015/2016

Plan Description: Choice Vision Plan
Product: Vision
Network: VSP Choice

Provider: VSP
Member Services Phone #: 1-800-877-7195
Plan Website Address: http://www.vsp.com

	In-Network	Out-of-Network **
General Plan Information		
Well Vision Exam	• $5 copay	• Up to $45
Prescription Glasses (material)	• $10 copay	• Not applicable
Prescription Glasses (Lenses)		
Single Vision	• Covered at 100%	• Up to $45
Lined Bifocal	• Covered at 100%	• Up to $65
Lined Trifocal	• Covered at 100%	• Up to $85
Polycarbonate lenses for children	• Covered at 100%	• Not applicable
Lens Options	• Average 20% savings on all non-covered lens options	• Not applicable
Prescription Glasses (Frames)		
Allowance for frame	• $180 allowance	• Up to $70 allowance
Discount off the amount exceeding the allowance	• 20%	• Not applicable
Contacts (instead of glasses)		
Allowance for contacts and fitting evaluations (You may qualify for a special program that includes a contact lens evaluation and initial supply of replacement lenses)	• $150 allowance	• $150 allowance for Elective Contact Lens/ $210 allowance for Necessary Contact Lens
Laser Vision Correction (instead of glasses or contacts)		
Allowance for both eyes	• $150 allowance	• $150 allowance
Discount off regular price or	• Up to15%	• Not applicable
Discount on promotional price from VSP contracted facilities	• 5%	• Not applicable
Low Vision	• Up to $1,000 every two years	• Not applicable
If you have had laser surgery, you can use your frame allowance (if eligible) for non-prescription sunglasses from a VSP doctor.		
Extra Savings and Discounts		
Prescription Glasses	• 20% off additional glasses and sunglasses, including lens options from the same VSP doctor on the same day as your WellVision Exam. Or get 20% off from any VSP doctor within 12 months of your last WellVision Exam*	
Contacts	• 15% off cost of contact lens exam (fitting and evaluation)*	• Not applicable

** Available from any VSP doctor within twelve months of your last eye exam.*
Frequency: Every year beginning in June
***In Network copays apply to billed amounts for out of network services and materials*

IN THE BUSINESS OF YOUR SUCCESS℠

2015/2016

Plan Description: Basic Life $10K
Product: Life Plan

Provider: AETNA
Member Services:1-800-554-1802 (Claim Submission & Eligibility Inquiries)
Life Claims Center:1-800-523-5065 (Claim Status Inquiries)
Plan Website Address: www.Aetna Life Essentials.com

Eligibility	Covers a regular full-time or part-time employee eligible for the Basic plan who is residing or working in the United States; is working 30 hours or more per week; is in an eligible class; has satisfied the plan's Actively at Work Provision; and has satisfied the worksite employer's specified waiting period from the date of hire with the worksite employer.
Date Coverage Starts	Coverage starts on the first day of the month coinciding with or following completion of the worksite employer's waiting period; or the day the worksite employer becomes covered under the plan. If not actively at work on the effective date, coverage will not take effect until employee returns to active work for one full day.
Benefit Options	An amount equal to $10,000 for Life; $10,000 for Accidental Death & Personal Loss (AD&PL)
Age Reduction	Total amount of Term automatically reduces as follows: to 65% at age 65, to 50% at age 70, to 35% at age 75, to 20% at age 80, to 10% at age 85 and to 5% at age 90. Benefit Reduction Rule will be based on the employee's age as of the June 1st, coinciding with or follows the member's date of birth.
Benefit Features	
Conversion	Employee will have the opportunity to convert their term life insurance to an individual policy at termination, if no longer eligible for coverage, or if coverage reduces due to age. There is a 60-day conversion application period. Should the employee die during the conversion period, benefits will be payable equal to the maximum amount the employee had a Right to Convert, whether or not he or she applied for an individual policy.
Portability	Employees can port their Life coverage and the Accidental Death rider in the same amount at termination. There is a 60-day application period for portability. Associates may NOT port coverage for themselves if they are sick or injured and away from active work when their life insurance coverage ends. Coverage ported will reduce starting at age 65 and reduced amounts may NOT be converted.
Accelerated Death Benefit (ADB)	If the employee has a terminal illness with a life expectancy less than 24 months, the policy may pay, while employee is still alive and benefit eligible, up to 75% of the life insurance benefit up to a maximum of $500,000.00. This benefit can help with expenses not covered by the employee's medical plan, pay other bills, enable the employee to visit relatives and help the employee get his or her affairs in order. It pays an advance benefit and ensures that the employee's beneficiary will receive the rest of the life insurance benefit upon the employee's death. Repayment is not required should the employee recover. The advance benefit may be requested once for the employee. The employee should consult with a tax advisor prior to making the request because the benefit received may be subject to income tax.
Passenger Restraint and Airbag	In the event that a covered person is properly using a passengers restraining device and an airbag is activated, and neither contributes to saving the person's life, this benefit will supplement the accidental death benefit.
Repatriation of Remains	In the unfortunate event that a covered person dies while 200 or more miles from home, this benefit offers financial assistance for preparation and return of the deceased's body to a mortuary. For additional benefit features, please refer to the Certificate of Coverage.
Premium Waiver	If the employee is less than age 60 and has been permanently and totally disabled for at least 6 months (as approved by Aetna), premium payments are waived until the employee recovers or reaches age 65.

This Benefits Highlight Sheet and the accompanying Brochure and Enrollment Form explain the general purpose of the insurance described, but in no way change or affect the policy as it is actually issued. In the event of any discrepancy between any of these documents and the policy, the terms of the policy apply. Complete coverage information is in the certificate of insurance booklet issued to each insured individual. Please read it carefully and keep it in a safe place with other important papers.

IN THE BUSINESS OF YOUR SUCCESS℠

2015/2016

Plan Description: LTD 50% $1,000/mo-180
Product: Long Term Disability

Provider: AETNA
Member Services Phone #: 1-800-554-1802
Disability Call Center: 1-888-200-6790 (Claims Submission/Status/Questions)
Plan Website Address: www.AetnaLifeEssentials.com

Eligibility	Covers an active member of an employer that elected to provide LTD benefits to its employees under the Policyholder's Flexible Benefits Plan and is working 30 hours or more per week; is in an eligible class; has satisfied the plan's Actively at Work Provision; and has satisfied the worksite employer's specified waiting period from the date of hire with the worksite employer.
Date Coverage Starts	Coverage starts on the first day of the month coinciding with or next following completion of the worksite employer's waiting period; or day worksite employer becomes covered under the plan. If not actively at work on the effective date, coverage will not take effect until employee returns to active work for one full day.
Elimination Period	To be eligible for benefits, the employee must be out of work for 180 continuous days due to an occupational or non-occupational injury or illness.
Monthly Benefit	The plan provides income protection to replace up to 50% of the employee's pre-disability monthly earnings.
Minimum Monthly Benefit	$100 or 10% of gross monthly benefit level, whichever is greater.
Maximum Monthly Benefit	$1,000 *(combined with other income benefits, as specified, in the Certificate Booklet/ Summary).*
Benefit Duration	As long as the employee remains totally disabled, LTD benefit payments will continue according to the certificate booklet. **Normal retirement age means the Social Security normal retirement age as stated in the 1983 according revision of the United States Social Security Act.* ** Mental Health & Substance Abuse are limited to 24 months. See the Certificate Booklet/Summary for more details.*
Disability Provision	Own Occupation Period is the first 24 months for which LTD Benefits are paid. Any Occupation Period is from the end of the Own Occupation period to the end of the Maximum Benefit Period.
Feature and Limitations	
Rehabilitation	Our ultimate goal is to help the employee return to gainful employment. Our consultants review each Disability claim and determine if Aetna rehabilitation services would be appropriate and effective. After reviewing the employee's claim, if Aetna feels the employee would benefit from our services, we will contact the employee.
Pre-existing Conditions	A disease or injury if, during the 3 months prior to the employee's effective date of coverage: -it was diagnosed or treated; or -services were received for the diagnosis or treatment of the illness or injury; or the employee took drugs or -the employee took drugs or medicines prescribed or recommended by a physician for that condition and the employee has been covered under The Plan for 12 consecutive months.
Benefit Coordination & Deductible Income	LTD benefits are coordinated with Social Security, Workers Compensation, State or Federal government disability or retirement benefits. For details regarding coordination of benefits please refer to the Certificate Booklet/Summary
Conversion Option	None

This Benefits Highlight Sheet and the accompanying Brochure and Enrollment Form explain the general purpose of the insurance described, but in no way change or affect the policy as it is actually issued. In the event of any discrepancy between any of these documents and the policy, the terms of the policy apply. Complete coverage information is in the certificate of insurance booklet issued to each insured individual. Please read it carefully and keep it in a safe place with other important papers.

IN THE BUSINESS OF YOUR SUCCESS®

2015–2016

Plan Description: **Health Care Flexible Spending Account Summary**
Product: **Health Care FSA**

Member Services Phone #: **1-800-554-1802**
Website Address: **mytotalsource.com**

Health Care Flexible Spending Accounts	
Plan Year	June 1 – May 31
Maximum Plan Year Contribution[1]	$2,550
Who Is Covered?	Employee plus eligible dependents
How Are Contributions Processed?	Payroll deduction from pretax income
Balance Carryover Allowance[2]	$500
Health Care FSA What expenses are eligible?	The following expenses are eligible for reimbursement if they are not otherwise covered by insurance or any other source: • Medical or dental copayments, deductibles and/or coinsurance payments • Medical expenses[3] • Prescription drug expenses • Over-the-counter medications (if prescribed by a physician)[4] • Dental and orthodontic treatment • Vision care, including eyeglasses and contact lenses • Routine physicals, vaccinations and screening tests • Medical monitoring/testing devices and supplies, including for diabetes **PLEASE NOTE:** If you choose to enroll in a High Deductible Health Plan (HDHP) and plan on contributing to a Health Savings Account (HSA) at any time during the 2015–2016 Plan Year, you are not eligible to participate in the Health Care FSA. See below for Limited Health Care FSA details.
Limited Health Care FSA What expenses are eligible?	You can participate in the **Limited Health Care FSA** if you enroll in a qualified High Deductible Health Plan (HDHP) and plan on contributing to a Health Savings Account (HSA) at any time during the 2015–2016 Plan Year. You can use this account to pay for eligible **dental and vision** expenses with tax-free dollars. The Limited Health Care FSA will not reimburse medical expenses. Federal regulations do not allow individuals to receive reimbursement for medical expenses tax-free through a Health Care FSA **and** contribute to an HSA during the same Plan Year. The following expenses are eligible for reimbursement under the Limited Health Care FSA: • Dental and vision copayments, deductibles and/or coinsurance payments • Dental and orthodontic treatment • Vision care, including eyeglasses and contact lenses • Certain preventive care expenses, such as immunizations and routine examinations and procedures

[1] Health Care Reform legislation includes a provision that limits the amount of salary reduction contributions an individual can make to a Health Care Flexible Spending Account (FSA) to $2,550 per plan year beginning June 1, 2015 for the ADP TotalSource, Inc. Health and Welfare Plan. Due to the FSA carryover feature of the Plan, up to $500 of any unused amount which is remaining in the Health Care FSA from the prior Plan Year will be carried over to the new Plan Year. This carryover amount if any, may be used to reimburse eligible expenses incurred during the 2015-2016 Plan Year but does not count against the maximum contribution limit.

[2] IRS rules require that unused Health Care FSA contribution balances in excess of $500 be forfeited after the end of the plan year filing deadline (i.e., July 30). Please plan carefully when electing your FSA contributions to minimize the risk of FSA contribution forfeiture. For complete details, please refer to the ADP TotalSource, Inc. Health and Welfare Plan Summary Plan Description and Summary of Material Modifications located on My TotalSource® at mytotalsource.com.

[3] If you plan on contributing to a Health Savings Account at any time during the 2015–2016 Plan Year, you can only elect to enroll in the Limited Health Care FSA. Only eligible dental and vision expenses can be submitted for reimbursement under the Limited Health Care FSA. The Limited Health Care FSA **will not** reimburse medical expenses.

[4] In accordance with Health Care Reform legislation, individuals cannot use the ADP TotalSource Health Care FSA for the cost of over-the-counter (OTC) medications unless prescribed by a physician. This rule does not apply to reimbursements for the cost of insulin, which are permitted, even if the insulin is purchased without a prescription.

IN THE BUSINESS OF YOUR SUCCESS®

2015–2016

Plan Description: **Dependent Care Flexible Spending Account Summary**
Product: **Dependent Care FSA**

Member Services Phone #: **1-800-554-1802**
Website Address: **mytotalsource.com**

Dependent Care Flexible Spending Accounts	
Plan Year	June 1 – May 31
Maximum Plan Year Contributions	$5,000 ($2,500 if married filing separately[1])
(Highly Compensated Employees)[2] Maximum Plan Year Contributions	$2,000
Who Is Covered?	Employee and spouse (if applicable) who need dependent care in order to work or look for work.
How Are Contributions Processed?	Payroll deduction from pretax income • A self-employed individual (SEI) may only participate on a post-tax basis and only if he or she is receiving W-2 wages.
What Expenses Are Eligible?	Care of a dependent[3] under 13 years of age, including fees charged by: • Qualified child care centers or nursery schools • In-home babysitters or nannies • After-school programs that enable employee and spouse to hold gainful employment • Non-nursing care of a dependent age 13 or older who is physically or mentally incapable of self-care • Nonmedical care of an elderly dependent whose caregiver spends at least 8 hours a day at the taxpayer's home

IMPORTANT NOTE: Outlined above are examples of eligible expenses. Qualified expenses under the Dependent Care FSA include eligible dependent care costs that you must pay to enable you to work or look for work. **The Dependent Care FSA does NOT cover medical expenses for you or your dependents.** IRS rules require that unused FSA contribution balances be forfeited after the end of the plan year filing deadline (i.e., July 30). Please plan carefully when electing your FSA contributions to minimize the risk of FSA contribution forfeiture. For complete details, please refer to the ADP TotalSource, Inc. Health and Welfare Plan Summary Plan Description and Summary of Material Modifications located on My TotalSource® at adptotalsource.com.

[1] Note that if more than $5,000 ($2,500 if married filing separately) is contributed to the Plan during a single Calendar Year, the excess amount will be included in Box 10 of the Form W2. It is the participant's responsibility to report anything over $5,000 as taxable income on their individual income tax return.

[2] Highly compensated employees are only permitted to contribute up to $2,000 per Plan Year to the ADP TotalSource, Inc. Dependent Care FSA. In addition, ADP TotalSource® may, at any time before or during the Plan Year (June 1 – May 31), notify a highly compensated employee that he or she must discontinue pretax contributions to the Dependent Care FSA or that he or she must limit such pretax contributions to a particular dollar amount below the $2,000 maximum if ADP TotalSource determines in its discretion that such action is necessary or advisable in order to satisfy the nondiscrimination requirements applicable to the Dependent Care FSA.

For the 2015–2016 Plan Year, a "highly compensated employee" is defined by the IRS as an individual that (a) owns (or constructively owns) more than 5% of the stock, capital or profits interest of a client company on any day during the Plan Year, or (b) will be paid compensation by ADP TotalSource in excess of $120,000 annually. Please note that the definition of a highly compensated employee may change for future Plan Years.

[3] Certain IRS rules apply with respect to caregiver/provider eligibility.