Employee **Benefits** Guide | 2016

HEALTH | DENTAL | VISION | SHORT TERM DISABILITY | ACCIDENT

PHOENIX SERVICES, INC.

Staffing Employees

Welcome to your 2016 Employee Benefits Guide

We are committed to providing employees with a benefits program that is both comprehensive and competitive. Our program offers a range of plan options to meet the needs of our diverse workforce. We know that your benefits are important to you and your family. This program is designed to assist you in providing for the health, well–being and financial security of you and your covered dependents. Helping you understand the benefits Phoenix Services, Inc. offers is important to us. That is why we have created this Employee Benefits Guide.

Benefits Guide Overview

This guide provides a general overview of your benefit choices to help you select the coverage that is right for you. Be sure to make choices that work to your best advantage. Of course with choice, comes responsibility and planning. Please take time to read about and understand the benefit, plan thoughtfully, and enroll on time.

Included in this guide are summary explanations of the benefits and costs as well as contact information for each provider.

It is important to remember that only those benefit programs for which you are eligible and have enrolled in apply to you. We encourage you to review each section and to discuss your benefits with your family members. Be sure to pay close attention to applicable co-payments and deductibles, how to file claims, preauthorization requirements, networks and services that may be limited or not covered (exclusions). This guide is not an employee/employer contract. It is not intended to cover all provisions of all plans but rather is a quick reference to help answer most of your questions. Please see your Summary Plan Description for complete details. We hope this guide will give you a clear explanation of your benefits and help you be better prepared for the enrollment process.

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At Your Service and Eligibility Details

Client Advocates

Phoenix Services, Inc. employees have access to client advocates at Kaminsky & Associates, Inc. to answer questions about enrollment, coverage, claims and all other concerns regarding their employee benefit package. Our call center is staffed with trained professionals who understand your benefits plan and are dedicated to providing solutions to your problems. Its easy and its free, just call: *419-535-5502 or 1-800-274-7982 (toll-free) Monday - Friday 8am - 5pm EST*

Contact Information

info@teamkaminsky.com

Your Account Manager: Jenny Howe - jenny@teamkaminsky.com

Your Client Advocates: Pat Bollman - pat@teamkaminsky.com or Cheryl Foster - cheryl@teamkaminsky.com

Benefit Contacts

Key Benefit Administrators, Inc. **Medical/Dental/Vision/Disability/Accident**	**Anthem BCBS** **Medical Plan**	**PRAM** **Pharmacy Program**	**Fifth Third Bank** **HSA Bank**
P.O. Box 129 Fort Mill, SC 29716 EDI payer ID#: 37323 kba.keyfamily.com Group # MC001208	P.O. Box 105187 Atlanta, GA 30348-5187 1-888-224-4902 www.anthem.com Group # 235076	711 E. Imperial Hwy., Suite 100, Brea, CA 92821 1-800-262-7726 www.pram.com	One Riverfront Place 20 NW First Street Evansville, Indiana 47708 1-812-647-9788 www.53hsa.com

Eligibility Details

Are you eligible for benefits?

To determine the benefits for which you may be eligible, please refer to the chart below. You are eligible to participate in these plans upon meeting each plan's eligibility requirements. You also have the option to enroll your eligible dependents in some of these plans. Eligible dependents may include:

Medical

- Your legal spouse
- Your children. For a child to be eligible, they must be:
  - Federal age limit- Less than 26 years of age (removal upon end of month child turns 26) and the natural child, stepchild or adopted child of the subscriber. (NOTE: A child does not have to live with the parent, be financially dependent upon the parent or be a student. Dependent children who have children are not eligible to enroll their children. However, having a child does not disqualify the dependent from being eligible. This definition applies to medical benefits only.)
  - State age limit– Less than 28 years of age (removal upon end of month child turns 28) 1) The child is the natural child, stepchild or adopted child of the insured, 2) The child is a resident of Ohio or a full-time student at an accredited higher education institution, 3) The child is not eligible for employer-sponsored coverage, or 4) The child is not eligible for coverage under Medicaid or Medicare.

Dental/Vision

- Your legal spouse
- Your children. For a child to be eligible, they must be:
  - Less than 26 years of age (ends on the day the dependent turns 26).
  - The natural child, stepchild or adopted child of the subscriber.

Benefit Plan	Eligibility	New Hire Waiting Period
MEC	All staffing employees	90 days following a 30-day training period
Limited Medical	All staffing employees	90 days following a 30-day training period
Anthem BCBS	Staffing employees working a minimum of 30 hours per week	90 days following a 30-day training period
Managed Pharmacy Program	All staffing employees	90 days following a 30-day training period
Dental, Vision, STD, Accident	All staffing employees	90 days following a 30-day training period

Premium Expense Plan (PEP) / Employee Responsibilities

Premium Expense Plan (PEP)

Phoenix Services, Inc. provides a Section 125 Premium Expense plan that allows you to pay for your portion of the health insurance premium on a pre-tax basis. Participation in this plan can save you money on your taxable income.
A Section 125 Premium Expense Plan (PEP) is part of a tax-saving benefit that is allowed under the Internal Revenue Service (IRS) tax code. This plan describes the tax savings on insurance premiums that are withheld on a pre-tax basis. This is not an insurance plan.

Plan Year

Our Section 125 Plan year is from January 1 thru December 31 each year. **Your election to participate in Medical will constitute your election to participate under the Premium Only plan on a pre-tax basis unless you elect post-tax.**
Important Note: With the election of pre-tax payroll deductions, you are locked into that election for the Plan Year unless you have a "Qualifying Life Event" or "Status Change". That means, even though the insurance carrier will allow you to change or drop your coverage, the IRS tax code requires that your payroll deduction not be changed, until the end of the plan year, unless you have a "Qualifying Life Event/ Status Change". A partial list of the most currently used Qualified events is:

- Marriage
- Birth
- Adoption or Placement for Adoption
- Death
- Divorce or legal separation
- Open enrollment for yourself or your spouse
- Job status change for self or spouse
  - Job Status change must result in loss of coverage or create new eligibility for benefit plans.
- Child ceasing to be a eligible dependent

Payroll changes that are consistent with health plan changes at the time of open enrollment or a qualifying event are permissible and will automatically be made at such time.

In order to be able to drop or change coverage at any time other than annual open enrollment without a qualifying event, you must elect "Post-tax" on your election form.

Employee Responsibilities

Marriage

You are required to report a marriage to your employer, within 30 days in order to add your spouse to your insurance plans. A copy of the marriage license and insurance company applications may be required to change your name, beneficiary, address, or to add or delete dependents from the benefit plans.

Birth/Adoption:

If you are enrolling a new dependent you have 30 days from the date of birth or acquisition to complete the required enrollment forms. A copy of the Birth Certificate or Court document is required.

Court Orders:

If you are enrolling a dependent child(ren), whose coverage might be governed by a divorce decree, or other support order, please look at your documents carefully. Depending upon how your divorce or court order was written, the dependent may NOT be eligible for this plan. **If your court order specifies that the other parent is responsible for health coverage** (or payment of health care claims if there is no insurance), **then this plan might not cover your child(ren)**. If you would like help with your documents, please call Kaminsky & Associates at 419-535-5502. A copy of the court documents or Medical support Notice is required to enroll a dependent child(ren).

Different last name for spouse or children:

Insurance companies or your employer may require proof such as a marriage license, birth certificate, court documents, or recent tax form, to show that dependents with different names are your legal dependents. Enrollment or payment of claims may be pended until proof is received. Please be prepared to submit this documentation if requested by the insurance carrier or your employer. Your dependent may not be enrolled if documentation is not received when requested.

Divorce or Legal Separation:

If you become legally separated or divorced, it is your responsibility to notify your employer of your status change within 30 days of the event in order to make any changes to your plan elections. You may be required to provide a copy of the appropriate finalized court paper to verify the event date. Please contact Kaminsky & Associates at 419-535-5502 if you would like further explanation.

Life Events:

It is the employee's responsibility to report any dependent age limit changes and any other "life" events to the Human Resources Department for COBRA purposes.

WHAT COVERAGE IS BEING OFFERED FOR THIS YEAR'S ENROLLMENT?

Phoenix Services, Inc. is offering Employees the following coverage which satisfies the federally mandated "minimum essential coverage" so you can avoid the ACA tax penalty:

- MEC – Minimum Essential Coverage with Multiplan PPO
- Anthem BCBS - Lumenos $5000 deductible HSA Option E57

In addition, we are offering the following plans:

- Limited Med Plan (Indemnity—a plan to supplement the MEC plan)
- Managed Pharmacy Program
- Dental
- Accident
- Disability

WHAT BENEFITS CAN I EXPECT WITH THIS COVERAGE?

A MEC plan contains the Preventive and Wellness Benefits required by ACA to avoid tax penalties. There are 63 preventive services that are covered at 100% in-network and 40% out-of-network. You can find a full list of these services in the Additional Information section later in this Guide.

A Limited Medical plan offers additional coverage for services like hospital stays, surgery, anesthesia, accidents, and more. (Limited Medical plan alone will not satisfy the individual mandate)

The Anthem BCBS plan not only contains the Preventive and Wellness Benefits required by ACA, but it also covers strategically selected medical benefits and prescription drug coverage. **Please note that with this plan you will be responsible for the entire deductible before benefits begin. (The single network deductible is $5,000 and the family network deductible is $10,000)**

The Managed Pharmacy Program offers coverage for outpatient Medically Necessary Legend non-injectable medications shown on the Formulary, unless otherwise specifically excluded, and any of the following. Outpatient means a Prescription Drug is not taken in, or administered by, a hospital or any other health care facility or office.

The MEC/Limited Medical Plans utilize the Multiplan Preferred Provider Organization (PPO) network and the Anthem BCBS medical plan utilizes the Lumenos HSA network. When you use a network provider, services covered under your plan will be reimbursed at the higher in-network percent.

See the next page for this year's coverage offering.

MEC Schedule of Benefits

Benefits	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS
PPO Network	Multiplan Preventive Services	
Minimum Essential Coverage **Minimum Essential Coverage** Required by ACA to avoid individual tax penalty.	0%	60%

MEC Preventive and Wellness Benefits

A LIST OF THE "MINIMUM ESSENTIAL COVERAGE" REQUIRED BY ACA

15 Covered Preventive Services for Adults (ages 18 and older)

1. Abdominal Aortic Aneurysm one time screening for age 65-75
2. Alcohol Misuse screening and counseling
3. Aspirin use for men ages 45-79 and women ages 55-79 to prevent CVD when prescribed by a physician
4. Blood Pressure screening
5. Cholesterol screening for adults
6. Colorectal Cancer screening for adults starting at age 50 (limited to one every 5 years)
7. Depression screening
8. Type 2 Diabetes screening
9. Diet counseling
10. HIV screening
11. Immunizations vaccines (Hepatitis A & B, Herpes Zoster, Human Papillomavirus, Influenza (flu shot), Measles, Mumps Rubella, Meningococcal, Pneumococcal, Tetanus, Diptheria, Pertussis, Varicella)
12. Obesity screening and counseling
13. Sexually Transmitted Infection (STI) prevention counseling
14. Tobacco Use screening and cessation interventions
15. Syphilis screening

22 Covered Preventive Services for Women, Including Pregnant Women

1. Anemia screening on a routine basis for pregnant women
2. Bacteriuria urinary tract or other infection screening for pregnant women
3. BRCA counseling and genetic testing for women at higher risk
4. Breast Cancer Mammography screenings every year for women age 40 and over
5. Breast Cancer Chemo Prevention counseling for women
6. Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women.
7. Cervical Cancer screening
8. Chlamydia Infection screening
9. Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs

26 Covered Services for Children

1. Alcohol and Drug Use assessments
2. Autism screening for children limited to two screenings up to 24 months
3. Behavioral assessments for children limited to 5 assessments up to age 17.
4. Blood Pressure screening
5. Cervical Dysplasia screening
6. Congenital Hypothyroidism screening for newborns
7. Depression screening for adolescents age 12 and older
8. Developmental screening for children under age 3, and surveillance throughout childhood
9. Dyslipidemia screening for children
10. Fluoride Chemo Prevention supplements for children without fluoride in their water source when prescribed by a physician
11. Gonorrhea preventive medication for the eyes of all newborns
12. Hearing screening for all newborns
13. Height, Weight and Body Mass Index measurements for children
14. Hematocrit or Hemoglobin screening for children
15. Hemoglobinopathies or sickle cell screening for newborns
16. HIV screening for adolescents
17. Immunization vaccines for children from birth to age 18; doses, recommended ages, and recommended populations vary: Diphtheria, Tetanus, Pertussis, Hepatitis A & B, Human Papillomavirus, Inactivated Poliovirus, Influenza (FIu Shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Rotavirus, Varicella, Haemophilus influenzae type b
18. Iron supplements for children up to 12 months when prescribed by a physician
19. Lead screening for children
20. Medical History for all children throughout development Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
21. Obesity screening and counseling
22. Oral Health risk assessment for young children up to age 10
23. Phenylketonuria (PKU) screening in newborns
24. Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents
25. Tuberculin testing for children
26. Vision screening for all children under the age of 5

Limited Medical Schedule of Benefits

Benefits	In-Network MEMBER PAYS
PPO Network	Multiplan Indemnity Plan
Fully-Insured Limited Medical Indemnity Benefits **Inpatient Hospital Daily Indemnity Benefit** Pays amount shown, up to the indicated number of days per benefit period, for hospital confinements due to accident or sickness.	$100 daily benefit 180 days max; 1 admission per benefit period
Inpatient Surgery & Anesthesia Daily Indemnity Benefit Pays amount shown, up to the indicated number of days per benefit period, for a covered in-patient surgery. Anesthesia benefit is separate and pays amount shown, up to the indicated number of days per benefit period.	$500 per day / $100 Anesthesia 1 day maximum per benefit period
Outpatient Surgery & Anesthesia Daily Indemnity Benefit Pays amount shown, up to the indicated number of days per benefit period, for a covered out-patient surgery. Anesthesia benefit is separate and pays amount shown, up to the indicated number of days per benefit period.	$250 per day / $50 Anesthesia 1 day maximum per benefit period
Outpatient Physician Office Visit Daily Indemnity Benefit Pays amount shown for each day the covered person visits a physician's office due to sickness or accident, up to the maximum number of days indicated per benefit period.	$40 per day 6 day maximum per benefit period
Outpatient Diagnostic X-Ray and Lab Daily Indemnity Benefit Pays amount shown once per day when a covered person has diagnostic x-ray and laboratory tests performed, up to the number of days indicated per benefit period.	$50 per day 3 day maximum per benefit period
Outpatient Prescription Drug Indemnity Benefit	No Coverage
Initial Hospital Admission Daily Indemnity Benefit Pays amount shown for the initial day of a hospital admission due to accident or sickness, up to the maximum days shown per benefit period.	$500 per day 1 day maximum with 1 admission per benefit period
Critical Illness Benefit Critical Illness Benefit pays only if a covered condition first occurs, and is diagnosed, after the effective date of coverage, except for the covered condition Diagnosis of Invasive and In Situ Cancer. Payment is a lump sum for amount shown per employee per benefit period.	$5,000 per Employee
Emergency Room Visit Daily Indemnity Benefit Pays amount shown for each day of emergency room services, resulting from an accident or sickness, that are provided on an emergency basis and do not result in hospital confinement, up to the maximum number of days indicated per benefit period.	$100 daily benefit maximum of 3 days per benefit period
Ambulance Service Daily Indemnity Benefit Pays the amount shown, up to the maximum occurrences indicated per benefit period, if a covered person requires ground ambulance transportation to or from a hospital due to accident or sickness. Air ambulance transportation will be payable to the nearest facility equipped to handle the covered person's accident or sickness.	$100 per trip 3-occurrence maximum per calendar year
Employee Term Life	$5,000 per employee

Managed Pharmacy Program

Benefits	In-Network MEMBER PAYS
Annual Deductible	
Per Member	$0
Retail Copay	
Generics	$10 Lessor of Logic
Preferred Brands	$30
Non-Preferred Brands	Not applicable
Mail Order Copay	
Generics	$30
Preferred Brands	$90
Non-Preferred Brands	Not applicable
Maximum Benefits Payable	
Per Member	$3,000 Annually

Covered Items

Prescription Drug: All outpatient Medically Necessary Legend non-injectable medications shown on the Formulary, unless otherwise specifically excluded, and any of the following. Outpatient means a Prescription Drug is not taken in, or administered by, a hospital or any other health care facility or office.

Diabetic Products **-** over-the-counter

- Diabetic Supplies - alcohol swabs, lancets, lancet devices, test strips & tablets (urine, blood glucose, ketone
- Insulin & insulin syringes

Family Planning

- Oral Contraceptives

Other Legend Drugs

- Acne Products (Retin-A, up to 24th birthday)
- Compounds, one ingredient must be legend
- Cough & Cold
- Immunosuppressants

Nutritional Products

- Prenatal Legend Vitamins

All over-the-counter and injectable medications are excluded unless shown above or prescribed as preventative medications. If classifications contain both prescribed and over-the-counter or both injectable and non-injectable products, only the non-injectable, prescribed products will be covered unless shown above.

Exclusions / Limitations

1. All over-the-counter products and medications unless shown under the definition of Prescription Drug and specifically prescribed by a medical provider. This includes, but is not limited to, electrolyte replacement, infant formulas, miscellaneous nutritional supplements and all other over-the-counter products and medications.
2. Blood glucose meters; insulin injecting devices, other than insulin syringes.
3. Depo-Provera; condoms, contraceptive sponges, and spermicides; sexual dysfunction drugs.
4. Biologicals (including allergy tests); blood products; growth hormones; hemophiliac factors; MS injectables; immunizations; all other injectables unless shown under the definition of Prescription Drug.
5. All other medical supplies and durable medical equipment unless shown under the definition of Prescription Drug.
6. Liquid nutritional supplements; pediatric Legend Drug vitamins; prescribed versions of Vitamins A, D, K, B12, Folic Acid and Niacin - used in treatment versus as a dietary supplement; all other Legend Drug vitamins and nutritional supplements.
7. Anorexiants; Any cosmetic drugs including, but not limited to, Renova, skin pigmentation preps; any drugs or products used for the treatment of baldness; Topical dental fluorides.
8. Refills in excess of that specified by the prescribing Physician; or refills dispensed after one year from the original date of the prescription.
9. Any drug labeled "Caution - limited by Federal Law for Investigational Use" or experimental drugs.
10. Any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment.
11. Drugs needed due to conditions caused, directly or indirectly, by an Insured Person taking part in a riot or other civil disorder; or the Insured Person taking part in the commission of a felony.
12. Drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war; or drugs dispensed to an Insured Person while on active duty in any armed force.
13. Any expenses related to the administration of any drug.
14. Drugs or medicines taken while in or administered by a hospital or any other health care facility or office.
15. Drugs covered under Worker's Compensation, Medicare, Medicaid or other Governmental program.
16. Drugs, medicines or products which are not medically necessary.
17. Diaphragms; Erectile dysfunction Legend drugs, unless specifically listed in the definition of Prescription Drug; Infertility Legend drugs.
18. Epi-Pen, Epi-Pen Jr., Ana-Kit, Ana-Guard; Glucagon-auto injection; Imitrex-auto injection.
19. Smoking deterrents, Legend or over-the-counter.
20. Vacation supplies and replacement of lost, stolen, spilled, broken or dropped Prescription Drugs.
21. All newly marketed pharmaceuticals or currently marketed pharmaceuticals with a new FDA approved indication for a period of

Anthem BCBS Schedule of Benefits

Benefits	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS
Deductible per Benefit Period		
Per Member	$5,000	$10,000
Per Family	$10,000	$20,000
(All family members can contribute with no one member contributing more than the individual deductible amount.)		
Maximum Out-of-Pocket per Benefit Period		
Per Member	$6,050	$12,100
Per Family	$12,100	$24,200
Physician Home and Office Services		
Including Office Surgeries, allergy serum, allergy injections & allergy testing	Deductible, then 20%	Deductible, then 40%
Preventive Care Services		
Services include but are not limited to: Routine medical exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Hearing screenings and Vision screenings which are limited to Screening tests (i.e. Snellen eye chart) and Ocular Photo screening.	$0	Deductible, then 40%
Emergency or Urgent Care		
Emergency Room Services @ Hospital (Facility/other covered services) - *(copayment waived if admitted)*	Deductible, then 20%	Deductible, then 20%
Urgent Care Center Services	Deductible, then 20%	Deductible, then 40%
Inpatient and Outpatient Professional Services		
Limitations apply—see Summary of Benefits and Coverage (SBC)	Deductible, then 20%	Deductible, then 40%
Inpatient Facility Services		
Limitations apply—see Summary of Benefits and Coverage (SBC)	Deductible, then 20%	Deductible, then 40%
Outpatient Surgery Hospital / Alternative Care Facility		
• Surgery and administration of general anesthesia	Deductible, then 20%	Deductible, then 40%
Other Outpatient Services (including by not limited):		
• Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services.	Deductible, then 20%	Deductible, then 40%
• Home Care Services (Network/Non-Network combined) 100 visits (excludes IV Therapy)	Deductible, then 20%	Deductible, then 40%
• Durable Medical Equipment, Orthotics, and Prosthetics	Deductible, then 20%	Deductible, then 40%
• Physical Medicine Therapy Day Rehabilitation programs	Deductible, then 20%	Deductible, then 40%
• Hospice Care	Deductible, then 20%	Deductible, then 20%
• Ambulance Services	Deductible, then 20%	Deductible, then 20%
Outpatient Therapy Services (Combined Network & Non-Network limits apply)		
• Physician Home and Office Visits	Deductible, then 20%	Deductible, then 40%
• Other Outpatient Services @ Hospital/Alternative Care Facility	Deductible, then 20%	Deductible, then 40%
Limitations apply—see Summary of Benefits and Coverage (SBC)		
Behavioral Health Services: Non Biologically Based Mental Illness and Substance Abuse (limits and maximums apply)		
Limitations apply—see Summary of Benefits and Coverage (SBC)	Deductible, then 20%	Deductible, then 40%
Prescription Drugs:		
• **Network Retail Pharmacies:** (30 day supply)	Deductible, then 20%	Deductible, then 40%
• **Home Delivery:** (90 day supply)	Deductible, then 10%	Not Covered
Limitations apply—see Summary of Benefits and Coverage (SBC)		

Frequently Asked Questions

HOW DO I KNOW I'M ELIGIBLE TO ENROLL FOR THIS COVERAGE?

All Employees who have worked long enough to meet their company's eligibility requirement, and who work the required minimum number of 30 hours per week, are eligible to enroll. Eligible dependents include spouses and children or stepchildren, under age 26.

CAN I SIGN UP FOR COVERAGE AT ANY TIME?

Provided you are eligible for this coverage, the effective date for this coverage is 01/01/16. The enrollment period is 12/01/15 through 12/31/15. New Employees are eligible for benefits after they have worked long enough to meet their company's eligibility requirement. Phoenix Services, Inc.'s eligibility requirement is 90 days following a 30 day training period. If you have worked long enough to be eligible for benefits, and you work the required number of 30 hours per week, you are eligible to sign up for this coverage.

HOW ARE MY PREMIUMS PAID?

Premiums will be taken through payroll deductions. If you miss a payroll deduction as a result of absence or lack of work, you risk being terminated from the plan. If terminated, you will not be eligible to re-enroll until the next open enrollment period unless you experience a qualifying event.

CAN I CANCEL COVERAGE AT ANY TIME?

When premiums are paid with pre-tax dollars through payroll deductions as part of a Section 125 Savings Plan, you will not be able to change these elections until the next annual enrollment period, unless you have a qualifying event. However, when premiums are paid with post-tax dollars, you can cancel coverage at any time.

IF I DO ENROLL, HOW DO I USE MY BENEFITS?

After enrollment, the insurance carrier, will send you a benefit kit and an ID card. Simply present this ID card to your provider at the time of service. This card contains all the information your provider needs to submit your claims to the insurance carrier for processing. You can also use the information on this card to contact the insurance carrier for any questions you might have. The insurance carriers contact information and website are also located on page 1 of this guide.

WHEN WILL THE INSURANCE CARRIER SEND ME A BENEFIT KIT AND ID CARD?

The insurance carrier will mail your benefit kit and ID card soon after you have enrolled and your first payment has been made.

Ancillary Benefits

Dental Plan V	**Network MEMBER PAYS**	**Out-of-Network MEMBER PAYS**
Calendar Year Deductible	$50 (3x Family)	
Deductible Waived for	Preventive Services	
Class A - Preventive Services (no benefit waiting period)	0%	0%
Class B - Basic Services (no benefit waiting period)	20%	20%
Class C - Major Services	No Coverage	
Calendar Year Maximum	$750 each	

The Kemper Benefit Dental plans use the Maximum Care Network™ . The Maximum Care Network™ is managed by Careington Corporation.

Vision Plus Plan	**Network MEMBER PAYS**	**Out-of-Network MEMBER PAYS**
Vision Exam	$10 copay	Reimbursed up to $35
Frames	$50 wholesale allowance [1]	Reimbursed up to $45
Frequency		
Eye Exam	12 months	
Lenses	12 months	
Frames	24 months	
Contacts	12 months	

The Kemper Benefit Vision plan uses the Avesis network which can be reviewed accessing their website at www.avesis.com/Vision_home.html.

[1] Approximately $100-$150 retail.

Short Term Disability Insurance *(Requires a purchase of either Dental or Accident coverage)*	
Benefits (60% of Salary, up to $150 per week)	
Waiting Period	7 days
Maximum Benefit Period	26 weeks

Accident Expense Insurance	
Benefit Amount (Per Calendar Year)	$1,000
Coverage	Off-the-job-only

Your Weekly Contributions

Medical/Pharmacy

MEC	Deduction per pay period
Employee Only	$13.54
Employee + Spouse	$20.15
Employee + Child(ren)	$36.93
Family	$43.55

Limited Medical	Deduction per pay period
Employee Only	$11.25
Employee + Spouse	$19.91
Employee + Child(ren)	$19.23
Family	$28.33

Managed Pharmacy Program	Deduction per pay period
Employee Only	$6.02
Employee + Spouse	$11.59
Employee + Child(ren)	$10.24
Family	$16.41

Anthem BCBS Plan **	Deduction per pay period
Employee Only	9.5% of your weekly pay not to exceed $63.00/week
Employee + Spouse	Above single cost plus $100.64/week
Employee + Child(ren)	Above single cost plus $57.80/week
Family	Above single cost plus $175.32/week

** Only available to those employees working 30 or more hours per week.

Ancillary Benefits

Dental Plan	Deduction per pay period
Employee Only	$3.46
Employee + Spouse	$6.92
Employee + Child(ren)	$7.58
Family	$11.04

Vision Plan	Deduction per pay period
Employee Only	$1.94
Employee + Spouse	$3.66
Employee + Child(ren)	$4.00
Family	$5.16

Short Term Disability ***	Deduction per pay period
	$5.67

Accident Expense Insurance	Deduction per pay period
Employee Only	$2.21
Employee + Spouse	$4.37
Employee + Child(ren)	$4.53
Family	$5.93

****** Requires a purchase of either Dental or Accident coverage.***

HSA Plan Highlights—if enrolled in the Anthem BCBS Plan

Eligibility

You are eligible to open a Health Savings Account (HSA) if you are:

- Covered by a HSA-qualified High Deductible Health Plan (HDHP).
- Not covered by other health insurance that is not a HDHP. (Including a plan your spouse may have where he/she has selected family coverage)*
- Not enrolled in a stand alone prescription drug plan (Managed Pharmacy Program).
- Not enrolled in a FSA (unless limited benefit) or an HRA
- Have not used your VA Benefits at any time during the previous three months
- Not eligible to be claimed as a dependent (child) on another's tax return.

**There are exceptions: Insurance coverage for accidents, dental care, disability, long-term care, and vision care do not disqualify you from opening a HSA*

Contributions

The maximum amount you can deposit into your account for the 2016 calendar year is $3,350 if you have single coverage and $6,750 for family coverage even if your policy's deductible is less that that. If you are age 55 or older, you can also make additional "catch-up" contribution of $1,000 per year.

Tax Benefits

- Cash contributions you make to a HSA during a tax year are deductible from your federal gross income. Contributions made through payroll deduction if made pre-tax and not subject to Federal, State, Local or FICA taxes.
- Interest earnings are tax-deferred - and you will never pay taxes on them if you eventually spend the money on qualified medical expenses.
- Withdrawals from your HSA for qualified medical expenses are free from taxation withdrawals for non-qualified are subject to ordinary income and 20% penalty.

Frequently asked questions

Does tax filing status (joint vs. separate) affect my contribution?

Tax filing status does not affect your contribution.

I have a HSA but no longer have HDHP coverage. Can I still use the money that is already in the HSA for medical expenses tax-free?

Once funds are deposited into the HSA, the account can be used to pay for qualified medical expenses tax-free, even if you no longer have HDHP coverage. There is no time limit on using the funds.

Can I use the money in my HSA to pay for medical care for a family member?

Yes, you may withdraw funds to pay for the qualified medical expenses of yourself, your spouse or a tax dependent without tax penalty.

What if my dependents are not covered by my HSA qualified plan?

You may still pay for their qualified medical expenses with your account if they are an IRS dependent.

What happens to my HSA if I enrolled in Medicare?

Participation in any type of Medicare (Part A, Part B, Part C -Medicare Advantage Plans, Part D, and Medicare Supplement Insurance -Medigap), makes you ineligible to contribute to an HSA. However, you can continue to use your HSA for qualified medical expenses and for other expenses for as long as you have funds in your HSA. Loss of Eligibility in Month You Turn 65. You lose eligibility as of the first day of the month you turn 65 and enroll in Medicare.

Example. Jim was covered by a self-only HDHP and eligible for an HSA in 2015 but turned 65 on July 2, 2015, and enrolled in Medicare. Jim lost eligibility for an HSA as of July 1, 2015. For 2015, Jim was eligible for 6 months of the year. The federal HSA limit for Jim is $4,350 ($3,350 individual HSA limit plus a $1,000 catch -up). Accordingly, Jim's calculation is 6/12 X $4,350 = $2,175. Jim's maximum contribution for 2015 is $2,175.

Can I use my HSA to pay for medical expenses incurred before I set up my account?

No. You cannot reimburse qualified medical expenses incurred before your account is established. We recommend you establish your account as soon as possible, even if you only fund it with the minimum amount required to open the account.

Do unused funds in a Health Savings Account roll over year after year?

Yes, the unused balance in a Health Savings Account automatically rolls over year after year. You won't lose your money if you don't spend it within the year.

Phoenix Services, Inc., 5800 Monroe St., Ste. D, Sylvania, OH, 43560

IMPORTANT INFORMATION

Employee & Eligible Beneficiaries,

As an employee of Phoenix Services, Inc. and participant in our employee benefit programs, you and your beneficiaries may have various rights and privileges related to these programs. Laws governing health care require us to provide you with these notifications. Listed below are important notices to retain for your records. In the past, many of these notices were sent individually and are now grouped together to more clearly communicate your rights, and to simplify distribution. If you have any questions please contact Maggy Hoffman, HR Manager, Phoenix Services, Inc. at: (419) 885-2151

For individuals who elect to waive coverage, some of these notices will not apply to you. See the plan administrator for further details.

NOTIFICATIONS

For individuals who elect to waive coverage, some of these notices will not apply to you. See the plan administrator for further details.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). After you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage) you must request enrollment within the specified time defined in your component plan documents.

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. After the marriage, birth, adoption, or placement for adoption, you must request enrollment within the specified time defined in your component plan document.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact the plan administrator.

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we notify you about important provisions in the plan. You have the right to enroll in the plan under its "special enrollment provision" if you marry, acquire a new dependent, or if you decline coverage under the plan for an eligible dependent while other coverage is in effect and later the dependent loses that other coverage for certain qualifying reasons. Special enrollment must take place within 30 days of the qualifying event. If you are declined enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this program if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after you or your dependents' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. However, you must request enrollment within 60 days after you or your dependents become eligible for the premium assistance. To request special enrollment or obtain more information, contact the plan administrator indicated in this notice.

HIPAA Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect.

You may request a copy of the current Privacy Practices from the Plan Administrator explaining how medical information about you may be used and disclosed, and how you can get access to this information.

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

You have the right to inspect and copy, right to an electronic copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice and the right to file a complaint if you believe your privacy rights have been violated.

CHIPRA NOTICE - Premium Assistance Under Medicaid and the Children's Health Insurance Program Reauthorization Act

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 aren't 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 any of the state's list here, contact your state Medicaid or CHIP office to find out if premium assistance is available. If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. **ALABAMA** – Medicaid Website: http://www.myalhipp.com Phone: 1-855-692-5447, **ALASKA** – Medicaid Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529, **COLORADO** – Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center Phone 1-800-221-3943, **FLORIDA** – Medicaid Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268, **GEORGIA** – Medicaid Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 404-656-4507, **INDIANA** – Medicaid Website: http://www.in.gov/fssa Phone: 1-800-

Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447, **MAINE** – Medicaid Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741, **MASSACHUSETTS** – Medicaid and CHIP Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120, **MINNESOTA** – Medicaid Website: http://www.dhs.state.mn.us/id_006254 Click on Health Care, then Medical Assistance Phone: 1-800-657-3739, **MISSOURI** – Medicaid Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005, **MONTANA** – Medicaid Website: http://medicaid.mt.gov/member Phone: 1-800-694-3084, **NEBRASKA** – Medicaid Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633, **NEVADA** – Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900, **NEW HAMPSHIRE** – Medicaid Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218, **NEW JERSEY** – Medicaid and CHIP 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: 1-800-701-0710, **NEW YORK** – Medicaid Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831, **NORTH CAROLINA** – Medicaid Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100, **NORTH DAKOTA** – Medicaid Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604, **OKLAHOMA** – Medicaid and CHIP Website: http://www.insureoklahoma.org Phone: 1-888-365-3742, **OREGON** – Medicaid Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075, **PENNSYLVANIA** – Medicaid Website: http://www.dhs.state.pa.us/hipp Phone: 1-800-692-7462, **RHODE ISLAND** – Medicaid Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300, **SOUTH CAROLINA** – Medicaid Website: http://www.scdhhs.gov Phone: 1-888-549-0820, **SOUTH DAKOTA** – Medicaid Website: http://dss.sd.gov Phone: 1-888-828-0059, **TEXAS** – Medicaid Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493, **UTAH** – Medicaid and CHIP Website: http://health.utah.gov/Medicaid http://health.utah.gov/chipPhone: 1-866-435-7414, **VERMONT**– Medicaid Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427, **VIRGINIA** – Medicaid and CHIP Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282, **WASHINGTON** – Medicaid Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473, **WEST VIRGINIA** – Medicaid Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability, **WISCONSIN** – Medicaid Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002, **WYOMING** Website: https://wyequalitycare.acs-inc.com Phone: 307-777-7531. The list of States offering a premium assistance program is current as of July 31, 2015. States offering CHIP assistance may change without notice.

For more information on special enrollment rights, or to verify if any other State now offers premium assistance, contact either: U.S. Department of Labor Employee Benefit Security Administration www.dol.gov/ebsa 1-866-444-EBSA (3272), U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services www.cms.hhs.gov 1-877-267-2323, Menu Option 4, Ext. 61565

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 **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that 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 electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

WHCRA

The Women's Health and Cancer Rights Act (WHCRA) of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Call your health insurance issuer for more information.

This notice informs you of the Federal regulation that requires all health plans that cover mastectomies to also cover reconstruction of the removed breast. If you have had or are going to have a mastectomy, you may be entitled to certain benefits. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

NMHPA

Newborns' and Mothers' Health Protection Act requires that group health plans and health insurance issuers who offer childbirth coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Refer to your plan document for specific information about childbirth coverage or contact your plan administrator.

For additional information about NMHPA provisions and how Self-funded non Federal governmental plans may opt-out of the NMHPA requirements, visit http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/nmhpa_factsheet.html.

USERRA

The Uniformed Services Employment and Reemployment Rights Act (USERRA), protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

Right To Be Free From Discrimination and Retaliation

If you are a past or present member of the uniformed service; have applied for membership in the uniformed service; or are obligated to serve in the uniformed service; then an employer may not deny you: initial employment; reemployment; retention in employment; promotion; or any benefit of employment because of this status. In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

Health Insurance Protection

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

Enforcement

The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations. For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its **website at http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **http://www.dol.gov/elaws/userra.htm**. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

GINA

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to any requests for medical information, if applicable. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

QMCSO (Qualified Medical Child Support Order)

QMCSO is a medical child support order issued under state law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant is an alternate recipient. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer; know the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

RESCISSIONS

The Affordable Care Act prohibits the rescission of health plan coverage except for fraud or intentional misrepresentation of a material fact. A rescission of a person's health plan coverage means that we would treat that person as never having had the coverage. The prohibition on rescissions applies to group health plans, including grandfathered plans, effective for plan years beginning on or after September 23, 2010.

Regulations provide that a rescission includes any retroactive terminations or retroactive cancellations of coverage except to the extent that the termination or cancellation is due to the failure to timely pay premiums. Rescissions are prohibited except in the case of fraud or intentional misrepresentation of a material fact. For example, if an employee is enrolled in the plan and makes the required contributions, then the employee's coverage may not be rescinded if it is later discovered that the employee was mistakenly enrolled and was not eligible to participate. If a mistake was made, and there was no fraud or intentional misrepresentation of a material fact, then the employee's coverage may be cancelled prospectively but not retroactively.

Should a member's coverage be rescinded, then the member must be provided 30 days advance written notice of the rescission. The notice must also include the member's appeal rights as required by law and as provided in the member's plan benefit documents. Please be aware that if you rescind a member's coverage, you must provide the proper notice to the member.

The IFRs on rescission can be found at the following Internet link: http://edocket.access.gpo.gov/2010/2010-15278.htm; with a clarifying FAQ on rescissions at http://www.dol.gov/ebsa/faqs/faq-aca2.html.

PREVENTIVE CARE

Health plans will provide in-network, first-dollar coverage, without cost-sharing, for preventative services and immunizations as determined under health care reform regulations. These include, but are not limited to, cancer screenings, well-baby visits and influenza vaccines. For a complete list of covered services, please visit: www.healthcare.gov/law/about/provisions/services/lists.html.

WOMEN'S PREVENTIVE HEALTH SERVICES

All of the following women's health services will be considered preventive (some were already covered). These services generally will be covered at no cost share, when provided in-network:

- Well-woman visits (annually)
- Prenatal visits (routine preventive visits)
- Screening for gestational diabetes
- Human papillomavirus (HPV) DNA testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)

- Screening and counseling for interpersonal and domestic violence
- Breastfeeding support, supplies and counseling
- Generic formulary contraceptives, certain brand formulary contraceptives, and FDA-approved, over-the-counter female contraceptives with prescription are covered without member cost share (for example, no copayment). Certain religious organizations or religious employers may be exempt from offering contraceptive services.

MHPA/MHPAEA

Mental Health Parity and Addiction Equity Act (MHPA/MHPAEA) require that group health plans not unfairly restrict treatment with regards to benefits/services applicable to mental health or substance use disorders. Additional information and details can be found by visiting the Department of Labor's Mental Health Parity webpage locate at http://www.dol.gov/ebsa/newsroom/fsmhpaea.html.

FMLA

Family Medical Leave Act (FMLA) entitles eligible employees of covered employers to take unpaid, job-protected leave for specific family and medical reasons if the employee has been with the company for one year, has worked at least 1250 hours during the prior 12 months and works in an area where there are at least 50 employees within 75 miles. Public agencies as well as public and private secondary schools are covered employers without regard to the number of employees employed. For additional details, visit the Department of Labor FMLA page. Notify the organization when you have a qualifying leave such as birth or adoption of a child, a serious health condition, to care for a spouse, child or parent with a serious medical condition or for reservist or National Guard provisions related to you or an immediate family member leaving for military duty or being injured in active duty.

COBRA NOTICE

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the company plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a Federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation Coverage?

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the plan is lost because of the qualifying event. Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Employees and their qualified dependents are responsible for notifying the Company of any change in address or status (e.g., divorce, insurance eligibility, child becoming ineligible due to age, etc.) within 30 days of the event.

If applicable, your participation in the Health Flexible Spending Account can also continue on an after-tax basis through the remainder of the Plan Year in which you qualify for COBRA. The opportunity to elect the same coverage that you had at the time the qualifying event occurred extends to all qualified beneficiaries.

If you make contributions to the Health Flexible Spending Account for the year in which your qualifying event occurs, you may continue to make these contributions on an after-tax basis. This way, you can be reimbursed for certain medical expenses you incur after your qualifying event, but before the end of the Plan Year.

You may be offered to continue your coverage under the Health Flexible Spending Account if you have not overspent your account. The determination of whether your account for a plan year is overspent or underspent as of the date of the qualifying event depends on three variables: (1) the elected annual limit for the qualified beneficiary for the Plan Year (e.g., $2,550 of coverage); (2) the total reimbursable claims submitted to the Cafeteria Plan for that plan year before the date of the qualifying event; and (3) the maximum amount that the Cafeteria Plan is permitted to require to be paid for COBRA coverage for the remainder of the plan year. The elected annual limit less the claims submitted is referred to as the "remaining annual limit." If the remaining annual limit is less than the maximum COBRA premium that can be charged for the rest of the year, then the account is overspent. You may not re-enroll in the Health Flexible Spending Account during any annual enrollment for any Plan Year that follows your qualifying event.

Supporting documentation like a divorce decree, death certificate, proof of other insurance may be required as proof of a qualifying event.

This general notice does not fully describe COBRA or the plan. More complete information is available from the plan administrator and in the summary plan document.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a dependent child.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the employee must notify the Plan Administrator of the qualifying event.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Documentation from the Social Security administration certifying a disability will be required.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the plan administrator indicated above or in the summary plan description. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

MEDICARE PART D NOTICE

Medical Plan: Lumenos HSA Option E57

Important Notice from Phoenix Services, Inc. about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Phoenix Services, Inc. and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Phoenix Services, Inc. has determined that the prescription drug coverage offered by the Lumenos HSA Option E57 is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Lumenos HSA Option E57. This also is important because it may mean you might pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

3. You can keep your current coverage from Lumenos HSA Option E57. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

When Can You Join a Medicare Drug Plan?

You can join a Medicare Drug Plan when you first become eligible for Medicare and each year from October 15th through December 7th.

If employer/union sponsored group plan, if you decide to drop your current coverage with you may be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under Lumenos HSA Option E57. Refer to plan documents or contact the plan administrator for additional information.

If your coverage, previous to this coverage, was Creditable Coverage, since you are losing creditable prescription drug coverage under the Lumenos HSA Option E57, you may also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan. Refer to plan documents or contact the plan administrator for additional information.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

Since the coverage under Lumenos HSA Option E57, is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Phoenix Services, Inc. coverage will not be affected, and benefits will be coordinated with Medicare. Refer to your plan documents provided upon eligibility and open enrollment or contact your provider or the plan administrator for an explanation and/or copy of the prescription drug coverage plan provisions/options under the plan available to Medicare eligible individuals when you become eligible for Medicare Part D. Guidance at http://www.cms.hhs.gov/CreditableCoverage/, which outlines the prescription drug plan provisions/options Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current Phoenix Services, Inc. coverage, be aware you and your dependents will be able to get this coverage back. Refer to plan documents or contact your provider or the plan administrator before making any decisions.

Note: In general, different guidelines exist for retirees regarding cancelation of coverage and the ability to get that coverage back. Retirees who terminate or lose coverage will not be able to get back on the plan unless specific contract language or other agreement exists. Contact the plan administrator for details.

For More Information about this Notice or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. You will get this notice each year. You will also get it before the next Medicare part D drug plan enrollment period and if the coverage through Phoenix Services, Inc. changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of this handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage visit www.Medicare.gov.

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.

Call 800-MEDICARE (800-633-4227). TTY users should call (877) 486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at (800) 772-1213 (TTY 1-800-325-0778).

Health Insurance Marketplace Coverage Options and Your Health Coverage

General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

Open Enrollment period is November 1st - January 31st. Individuals may also qualify for Special Enrollment Periods outside of Open Enrollment if they experience certain events. (See Special Enrollment Period and Qualifying Life Event)

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution, as well as your employee contribution to employer-offered coverage, is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact your employer.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit www.HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

1. Employer Name: Phoenix Services, Inc.

2. Employer Identification Number (EIN): 34-1773566

3. Employer Address: 5800 Monroe St., Ste. D

4. Employer phone number: (419) 885-2151

5. City: Sylvania

6. State: OH

7. ZIP code: 43560

8. Who can we contact about employee health coverage at this job: Maggy Hoffman

9. Phone number for contact: (419) 885-2151

10. Email address: mhoffman@phoenixsvs.com

Here is some basic information about health coverage offered by this employer:

• As your employer, we offer a health plan to: Some Employees. Eligible employees are: Staffing employees who work an average of 30 or more hours per week

• With respect to dependents: We do offer coverage. Eligible dependents are: legal spouse and dependent children of eligible employee

This coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.*

Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount. If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process.

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Notes

These summaries are for Information Purposes Only

The information in this booklet is only a brief description of the benefits and insurance plans, and is not a Summary Plan Description (SPD) for the plan.

For complete details on any benefit, refer to your member handbook, or the plan's benefit booklet. If there are any inconsistencies between the descriptions in this booklet and the insurance contracts, the insurance contract and plan agreements will contain legal, binding provisions and will prevail.

BH BENEFIT HIGHLIGHTS

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BROUGHT TO YOU BY:

Kaminsky & Associates, Inc.