



9957 Crosspoint Boulevard
Indianapolis, Indiana 46256

Phone: 317.585.7870

Fax: 317.585.7880

Toll-Free: 877.977.9757

www.myWorkSmartHR.com





Table of Contents

- WorkSmart Benefits..... 1
- Qualifying Events..... 1
- Cafeteria Plan (Section 125) 2
- Pre-existing Condition Exclusion Waiting Period 2
- Anthem Online Provider Directory (Medical) 2
- \$2,000 Traditional Plan Benefit Summary..... 3
- \$5,000 Traditional Plan Benefit Summary..... 4
- \$3,000/\$6,000 Health Reimbursement Account (HRA) Plan Benefit Summary 5
- \$3,500 High Deductible Health Plan (HDHP) Benefit Summary 7
- Health Savings Account (HSA) Information..... 8
- Eligible HSA and Health Care Flexible Spending Expenses 9
- Your WorkSmart Flex Options 10
- How WorkSmart Flex Works 11
- Flexible Spending Accounts vs. HSA 12
- Blue View Vision..... 13
- LiveSmart Wellness Program..... 14
- Anthem.com..... 14
- Anthem 360° Health Program..... 14
- Anthem Care Comparison..... 15
- Does Cost Comparison Really Make a Difference?..... 16
- Lincoln Financial Dental Plan Summary..... 17
- Lincoln Financial Voluntary Short-Term Disability 18
- Lincoln Financial Employer Paid Long-Term Disability..... 21
- Lincoln Financial Group Term Life Insurance..... 23
- Humana Supplemental Health 30
- Humana Accident Plus..... 31
- Humana Critical Illness Advantage Plus..... 32
- Employee Assistance Program 33
- PNC WorkPlace Banking..... 33
- Appendix

Welcome to WorkSmart Systems Professional Employer Organization (PEO)

A Professional Employer Organization assists small to mid-sized companies with human resources and payroll while offering affordable health care and employee benefits for their staff. As a new WorkSmart employee, you will experience accurate and timely payroll along with great employee benefits. WorkSmart provides expert assistance with employee-related questions and issues.



About this Guide:

Welcome to the WorkSmart Systems benefit plans! This guide contains information about the benefit plan options available to you. Please read it carefully and completely. If you have any questions, contact the **WorkSmart Benefit Department** at **317.585.7870** (toll-free **877.977.9757**), or by e-mail at **HR@worksmartpeo.com**. We are happy to assist you and answer any questions you may have about your benefits.

WorkSmart Benefits

WorkSmart Systems (WSS) offers a variety of benefits to you, our employee, so that you can create a benefit portfolio that best fits your needs and the needs of your family:

- **Basic Life and AD&D Insurance:** All benefit eligible employees have a \$15,000 Life and AD&D insurance policy through Lincoln Financial. Basic Life with Lincoln Financial will be in addition to any Voluntary Group Term Life Insurance policy you elect through Lincoln Financial. Contact WorkSmart Systems if you need to change your beneficiary for your Basic Life and AD&D policy.
- **Cafeteria Plan Options (PRE-TAX Deductions; After your 30-day initial enrollment period, these are subject to Qualifying Events and Open Enrollment):**
 - WSS Medical
 - Lincoln Financial Dental
 - Health Care Flexible Spending
 - Limited Health Care Flexible Spending (only for HSA participants)
 - Dependent Care Flexible Spending
- **Voluntary Products (POST-TAX Deductions; Guarantee Issue for Lincoln Financial Products during initial enrollment; Application required thereafter / Simplified Issue for Humana Products – some questions to answer):**
 - Lincoln Financial Short-Term Disability
 - Lincoln Financial Long-Term Disability
 - Lincoln Financial Voluntary Group Term Employee, Spouse and Dependent Child Life Insurance*
 - Humana Supplemental Health
 - Humana Accident Plus
 - Humana Critical Illness Advantage Plus

** Life Insurance Guarantee Issue amounts subject to age and salary limitations*

Qualifying Events

After your initial eligibility, you can enroll, cancel or make changes to medical, dental and flex elections at open enrollment time in the fall, with benefit changes effective January 1 of each year. The only exception is for changes in family status or life events. *These life events include:*

- **Marriage or divorce**
- **Birth**, adoption or placement for adoption of a child**
- **Death of spouse or a dependent**
- **Change in your spouse's employment resulting in gain or loss of coverage**
- **Change from part-time to full-time (or vice-versa) by you or your spouse**
- **Significant change in coverage by your spouse's employer**
- **Changes in entitlement to Medicare or Medicaid**
- **Qualification by Plan Administrator of a medical child support order**
- **Dependent satisfies or ceases to satisfy eligibility requirements**

Your request for a change in enrollment must be clearly related to the life event or change in family status. **You are responsible for notifying WorkSmart Systems Human Resources so that changes may be made with the insurance carriers within 31 days of the life event.** By law, changes cannot be made after the 31-day period ends. The new application must be date-stamped in WorkSmart Systems' office within thirty-one (31) days of the qualifying event. Coverage is effective and premiums are calculated from the qualifying event date and will be charged and/or refunded accordingly.

**** If your qualifying event is due to birth of a child, you must complete an application to add the child to the plan within the first 31 days of life.**

Cafeteria Plan (Section 125)

WorkSmart sponsors a complete Cafeteria Plan (Section 125) which allows you to:

- **Choose the benefits you want from a menu of benefits.**
- **Pay for your portion of medical and dental insurance premiums on a pre-tax basis.**
- **Fund Flexible Spending Accounts (See *Your Flex Options*, page 10) on a pre-tax basis:**
 - **Take up to \$2,500 pre-tax in a Health Care Flexible Spending Account to pay for unreimbursed healthcare expenses such as medical deductibles and coinsurance, copays, dental, vision, prescription drugs, etc.**
 - **Take up to \$2,500 pre-tax in a Limited Health Care Flexible Spending Account (only for HDHP/HSA participants) to pay for unreimbursed dental and vision expenses.**
 - **Take up to \$5,000 pre-tax in a Dependent Care Flexible Spending Account to pay for child day care or the care of a spouse or dependent that is incapable of self-care.**

This allows you to lower your taxable income; therefore, you pay less in taxes and increase your take-home pay. Flexible Spending Accounts are use-it-or-lose-it and you must make a participation decision for Health Care (Regular and Limited) and/or Dependent Care Flexible Spending during Open Enrollment each year.

Pre-existing Condition Exclusion Waiting Period

WorkSmart's group medical plan includes a 12-month pre-existing condition exclusion waiting period for individuals 19 and older. The length of the pre-existing conditions limitation may be reduced or eliminated if a covered person has creditable coverage from another health plan. A covered person may request a Certificate of Creditable Coverage from his or her prior plan within 24 months after losing coverage.

Anthem will not provide benefits for services, supplies or charges for pre-existing conditions for 12 months after the member's enrollment date, subject to HIPAA portability requirements and excluding members under age 19. A pre-existing condition (mental or physical) is a condition which was present and for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the member's enrollment date. Prescriptions and pregnancy are not subject to the pre-existing condition waiting period.

If you have had prior medical coverage, please send your **Certificate of Creditable/Prior Coverage** to Human Resources (E-mail: HR@worksmartpeo.com or Fax: 317.585.7880) and we will forward it to Anthem so they can address your pre-ex waiting period.

Anthem® Online Provider Directory (Medical)

To find an Anthem® provider near you:

1. Go to www.anthem.com
2. Select "Find a Doctor"
3. Enter Criteria in Steps 1-4
4. Click "Search" to see the results

Once you have enrolled in Anthem's medical plan, you will find network specific providers by logging in to your MyAnthem™ web page (Member Log In at www.anthem.com). You may also call Anthem at the Member Services number on the back of your insurance card.

\$2,000 Traditional Plan Benefit Summary

Anthem Blue AccessSM PPO

www.anthem.com

TYPES OF COVERAGE		PREFERRED (Network)	NON-PREFERRED (Non-Network)
DEDUCTIBLE			
Per calendar year (copayments do not apply)	Individual	\$2,000	\$4,000
	Family (2+ people)	\$4,000	\$8,000
COINSURANCE (after deductible)		80% covered, 20% member coinsurance after deductible	60% covered, 40% member coinsurance after deductible
OUT-OF-POCKET MAXIMUM (including deductible)			
Per calendar year (prescription copayments do not apply)	Individual	\$4,000	\$8,000
	Family	\$8,000	\$16,000
WELLNESS BENEFIT*			
Routine adult physical exam / immunizations	Office Visit	100% covered	60/40 after deductible
Well child exams / immunizations to age 18	Office Visit	100% covered	60/40 after deductible
Routine GYN care exam	Office Visit	100% covered	60/40 after deductible
Routine mammogram**		100% covered	60/40 after deductible
OFFICE VISIT COPAY (non-surgical)			
	Primary Care***	\$25	60/40 after deductible
	Specialty Care	\$50	60/40 after deductible
PRESCRIPTION DRUG COPAY			
30 day supply retail	Generic	\$15	50% minimum \$35
	Brand Name Preferred	\$35	50% minimum \$35
	Brand Non-Preferred	\$50	50% minimum \$35
31-90 day supply mail order (optional)	Generic	\$30	Not covered
	Brand Name Preferred	\$70	Not covered
	Brand Non-Preferred	\$100	Not covered
PHYSICIAN SERVICES			
	Allergy Injections	\$5 copay	60/40 after deductible
	Diagnostic Lab* and X-ray	80/20 after deductible	60/40 after deductible
	Office Visit for Surgery	80/20 after deductible	60/40 after deductible
	Outpatient Surgery	80/20 after deductible	60/40 after deductible
	Inpatient Surgery	80/20 after deductible	60/40 after deductible
OTHER MEDICAL SERVICES			
	Outpatient Therapy Office Visit (Limits Apply)	\$25 / \$50 copay	60/40 after deductible
	Maternity	80/20 after deductible	60/40 after deductible
	Hospital Inpatient & Outpatient	80/20 after deductible	60/40 after deductible
MENTAL HEALTH, CHEMICAL & ALCOHOL DEPENDENCY			
	Inpatient Treatment	80/20 after deductible	60/40 after deductible
	Outpatient Treatment	80/20 after deductible	60/40 after deductible
	Office Visit	\$25 copay	60/40 after deductible
EMERGENCY MEDICAL CARE			
	Urgent Care Office Visit	\$75 copay + 20% coinsurance	60/40 after deductible
	Emergency Room	\$250 copay + 20% coinsurance (copayment waived if admitted)	\$250 copay + 20% coinsurance (copayment waived if admitted)
VISION EXAM BENEFIT			
	One Routine Exam Every 12 Months	\$5 copay	Reimbursement up to \$42

* Wellness exams are subject to calendar year and age limitations.

** Mammogram coverage as permitted based on age and risk

*** Includes services of an internist, general physician, family practitioner, obstetrics/gynecology, geriatrics or pediatrician.

* Lab services received at contracted independent labs (i.e. LabCorp, Mid America Clinical Labs, and Quest Diagnostics) will be paid 100% by Anthem.

This is a plan summary and is not a complete description of the plan. The Summary Plan Description provides a more complete explanation of terms of coverage, limitations and exclusions. The Summary Plan Description will supersede if there is a difference between the two.

Family coverage requires two deductibles to be satisfied. Pre-certification is required for some benefits. This includes, but is not limited to inpatient hospitalization, inpatient mental health, inpatient skilled nursing, outpatient surgery and substance abuse.

A dependent child or qualifying child may be covered on your WorkSmart medical plan until the child attains age 26.

★ Compatible with Regular Health Care Flexible Spending Account ★



\$5,000 Traditional Plan Benefit Summary

Anthem Blue AccessSM PPO

www.anthem.com

TYPES OF COVERAGE		PREFERRED (Network)	NON-PREFERRED (Non-Network)
DEDUCTIBLE			
Per calendar year (copayments do not apply)	Individual	\$5,000	\$10,000
	Family (2+ people)	\$10,000	\$20,000
COINSURANCE (after deductible)		80% covered, 20% member coinsurance after deductible	60% covered, 40% member coinsurance after deductible
OUT-OF-POCKET MAXIMUM (including deductible)			
Per calendar year (prescription copayments do not apply)	Individual	\$7,500	\$15,000
	Family	\$15,000	\$30,000
WELLNESS BENEFIT*			
Routine adult physical exam / immunizations	Office Visit	100% covered	60/40 after deductible
Well child exams / immunizations to age 18	Office Visit	100% covered	60/40 after deductible
Routine GYN care exam	Office Visit	100% covered	60/40 after deductible
Routine mammogram**		100% covered	60/40 after deductible
OFFICE VISIT COPAY (non-surgical)	Primary Care***	\$25	60/40 after deductible
	Specialty Care	\$50	60/40 after deductible
PRESCRIPTION DRUG COPAY			
30 day supply retail	Generic	\$20	50% minimum \$40
	Brand Name Preferred	\$40	50% minimum \$40
	Brand Non-Preferred	\$70	50% minimum \$40
31-90 day supply mail order (optional)	Generic	\$40	Not covered
	Brand Name Preferred	\$80	Not covered
	Brand Non-Preferred	\$140	Not covered
PHYSICIAN SERVICES	Allergy Injections	\$5 copay	60/40 after deductible
	Diagnostic Lab* and X-ray	80/20 after deductible	60/40 after deductible
	Office Visit for Surgery	80/20 after deductible	60/40 after deductible
	Outpatient Surgery	80/20 after deductible	60/40 after deductible
	Inpatient Surgery	80/20 after deductible	60/40 after deductible
OTHER MEDICAL SERVICES	Outpatient Therapy Office Visit (Limits Apply)	\$25 / \$50 copay	60/40 after deductible
	Maternity	80/20 after deductible	60/40 after deductible
	Hospital Inpatient & Outpatient	80/20 after deductible	60/40 after deductible
MENTAL HEALTH, CHEMICAL & ALCOHOL DEPENDENCY	Inpatient Treatment	80/20 after deductible	60/40 after deductible
	Outpatient Treatment	80/20 after deductible	60/40 after deductible
	Office Visit	\$25 copay	60/40 after deductible
EMERGENCY MEDICAL CARE	Urgent Care Office Visit	\$75 copay + 20% coinsurance	60/40 after deductible
	Emergency Room	\$250 copay + 20% coinsurance (copayment waived if admitted)	\$250 copay + 20% coinsurance (copayment waived if admitted)
VISION EXAM BENEFIT	One Routine Exam Every 12 Months	\$5 copay	Reimbursement up to \$42

* Wellness exams are subject to calendar year and age limitations.

** Mammogram coverage as permitted based on age and risk.

*** Includes services of an internist, general physician, family practitioner, obstetrics/gynecology, geriatrics or pediatrician.

* Lab services received at contracted independent labs (i.e. LabCorp, Mid America Clinical Labs, and Quest Diagnostics) will be paid 100% by Anthem.

This is a plan summary and is not a complete description of the plan. The Summary Plan Description provides a more complete explanation of terms of coverage, limitations and exclusions. The Summary Plan Description will supersede if there is a difference between the two.

Family coverage requires two deductibles to be satisfied. Pre-certification is required for some benefits. This includes, but is not limited to inpatient hospitalization, inpatient mental health, inpatient skilled nursing, outpatient surgery and substance abuse.

A dependent child or qualifying child may be covered on your WorkSmart medical plan until the child attains age 26.

★ **Compatible with Regular Health Care Flexible Spending Account** ★



\$3,000/\$6,000 Health Reimbursement Account (HRA) Plan Benefit Summary

Anthem Lumenos® Health Reimbursement Account

www.anthem.com

TYPES OF COVERAGE		PREFERRED (Network)	NON-PREFERRED (Non-Network)
HEALTH REIMBURSEMENT ACCOUNT Per calendar year (prorated****)	Individual	\$500	
	Family (2+ people)	\$1,000	
COMBINED MEDICAL/Rx DEDUCTIBLE			
Per calendar year after HRA <i>(Dependent coverage requires the family deductible to be met before coinsurance applies. The single deductible does not apply to family coverage.)</i>	Individual	\$2,500	\$6,000
	Family	\$5,000	\$12,000
COINSURANCE (after deductible)		80% covered, 20% member coinsurance after deductible	60% covered, 40% member coinsurance after deductible
OUT-OF-POCKET MAXIMUM (including deductible)			
Per calendar year after HRA (copayments do apply)	Individual	\$4,500	\$10,000
	Family	\$9,000	\$20,000
WELLNESS BENEFIT*			
Routine adult physical exam / immunizations	Office Visit	100% covered	60/40 after deductible
Well child exams / immunizations to age 18	Office Visit	100% covered	60/40 after deductible
Routine GYN care exam	Office Visit	100% covered	60/40 after deductible
Routine mammogram**		100% covered	60/40 after deductible
OFFICE VISIT (non-surgical)	Primary Care***	80/20 after deductible	60/40 after deductible
	Specialty Care	80/20 after deductible	60/40 after deductible
PRESCRIPTION DRUG COPAY			
30 day supply retail	Generic	\$15 after deductible	50% minimum \$35
	Brand Name Preferred	\$35 after deductible	50% minimum \$35
	Brand Non-Preferred	\$50 after deductible	50% minimum \$35
31-90 day supply mail order (optional)	Generic	\$30 after deductible	Not covered
	Brand Name Preferred	\$70 after deductible	Not covered
	Brand Non-Preferred	\$100 after deductible	Not covered
PHYSICIAN SERVICES	Allergy Injections	80/20 after deductible	60/40 after deductible
	Diagnostic Lab and X-ray	80/20 after deductible	60/40 after deductible
	Office Visit for Surgery	80/20 after deductible	60/40 after deductible
	Outpatient Surgery	80/20 after deductible	60/40 after deductible
	Inpatient Surgery	80/20 after deductible	60/40 after deductible
	Outpatient Therapy Office Visit (Limits Apply)	80/20 after deductible	60/40 after deductible
OTHER MEDICAL SERVICES	Maternity	80/20 after deductible	60/40 after deductible
	Hospital Inpatient & Outpatient	80/20 after deductible	60/40 after deductible
	Inpatient Treatment	80/20 after deductible	60/40 after deductible
MENTAL HEALTH, CHEMICAL & ALCOHOL DEPENDENCY	Outpatient Treatment	80/20 after deductible	60/40 after deductible
	Urgent Care Office Visit	80/20 after deductible	60/40 after deductible
EMERGENCY MEDICAL CARE	Emergency Room	80/20 after deductible	80/20 after deductible
	One Routine Exam Every 12 Months	\$5 copay	Reimbursement up to \$42

* Wellness exams are subject to calendar year and age limitations.

** Mammogram coverage as permitted based on age and risk.

*** Includes services of an internist, general physician, family practitioner, obstetrics/gynecology, geriatrics or pediatrician.

****See the table on page 8

This is a plan summary and is not a complete description of the plan. The Summary Plan Description provides a more complete explanation of terms of coverage, limitations and exclusions. The Summary Plan Description will supersede if there is a difference between the two.

Family coverage requires the family deductible to be met before coinsurance applies. Pre-certification is required for some benefits. This includes, but is not limited to inpatient hospitalization, inpatient mental health, inpatient skilled nursing, outpatient surgery and substance abuse.

A dependent child or qualifying child may be covered on your WorkSmart medical plan until the child attains age 26.

★ Compatible with Regular Health Care Flexible Spending Account ★



\$3,000/\$6,000 HRA Plan Benefit Summary (Prorated Health Reimbursement Account)

Prorated HRA, Employee Portion of Deductible and Maximum Out-of-Pocket (rounded to nearest dollar)

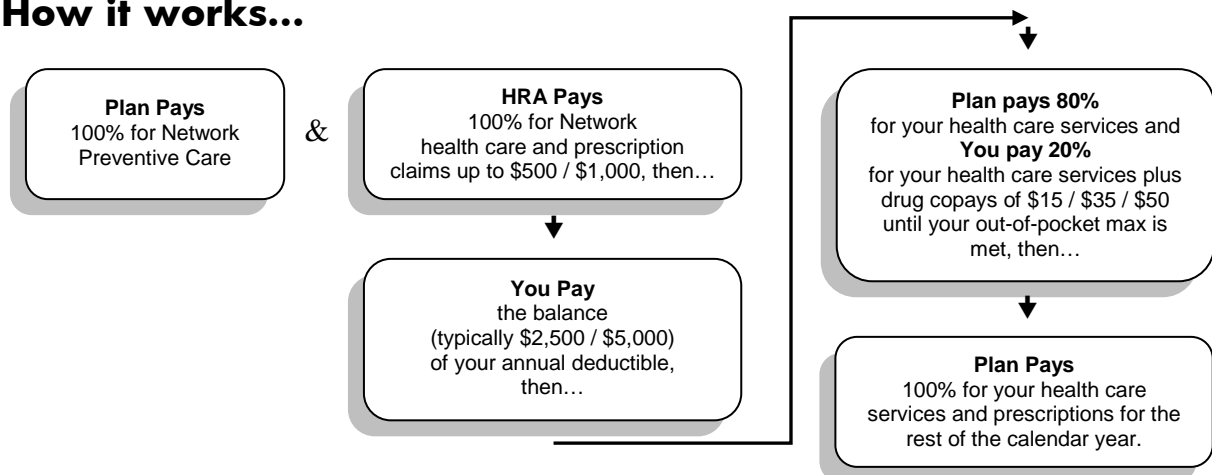
Employee Only Coverage

MONTH	HEALTH REIMBURSEMENT ACCOUNT	EMPLOYEE PORTION OF \$3,000 DEDUCTIBLE	OUT-OF-POCKET MAXIMUM (Includes Deductible)
January	\$500	\$2,500	\$4,500
February	\$458	\$2,542	\$4,542
March	\$417	\$2,583	\$4,583
April	\$375	\$2,625	\$4,625
May	\$333	\$2,667	\$4,667
June	\$292	\$2,708	\$4,708
July	\$250	\$2,750	\$4,750
August	\$208	\$2,792	\$4,792
September	\$167	\$2,833	\$4,833
October	\$125	\$2,875	\$4,875
November	\$83	\$2,917	\$4,917
December	\$42	\$2,958	\$4,958

Employee + Dependent Coverage

MONTH	HEALTH REIMBURSEMENT ACCOUNT	EMPLOYEE PORTION OF \$6,000 FAMILY DEDUCTIBLE	OUT-OF-POCKET MAXIMUM (Includes Deductible)
January	\$1,000	\$5,000	\$9,000
February	\$917	\$5,083	\$9,083
March	\$833	\$5,167	\$9,167
April	\$750	\$5,250	\$9,250
May	\$667	\$5,333	\$9,333
June	\$583	\$5,417	\$9,417
July	\$500	\$5,500	\$9,500
August	\$417	\$5,583	\$9,583
September	\$333	\$5,667	\$9,667
October	\$250	\$5,750	\$9,750
November	\$167	\$5,833	\$9,833
December	\$83	\$5,917	\$9,917

How it works...



\$3,500 High Deductible Health Plan (HDHP) Benefit Summary

Anthem Blue Access for Health Savings AccountSM

www.anthem.com

TYPES OF COVERAGE		PREFERRED (Network)	NON-PREFERRED (Non-Network)
COMBINED MEDICAL/Rx DEDUCTIBLE			
Per calendar year	Individual	\$3,500	\$7,000
	Family (2+ people)	\$7,000	\$14,000
COINSURANCE (after deductible)		80% covered, 20% member coinsurance after deductible	60% covered, 40% member coinsurance after deductible
OUT-OF-POCKET MAXIMUM (including deductible)			
Per calendar year (copayments do apply)	Individual	\$5,800	\$10,000
	Family	\$11,600	\$20,000
WELLNESS BENEFIT*			
Routine adult physical exam / immunizations	Office Visit	100% covered	60/40 after deductible
Well child exams / immunizations to age 18	Office Visit	100% covered	60/40 after deductible
Routine GYN care exam	Office Visit	100% covered	60/40 after deductible
Routine mammogram**		100% covered	60/40 after deductible
OFFICE VISIT (non-surgical)	Primary Care***	80/20 after deductible	60/40 after deductible
	Specialty Care	80/20 after deductible	60/40 after deductible
PRESCRIPTION DRUG COPAY			
30 day supply retail	Generic	\$20 after deductible	50% minimum \$40
	Brand Name Preferred	\$40 after deductible	50% minimum \$40
	Brand Non-Preferred	\$70 after deductible	50% minimum \$40
31-90 day supply mail order (optional)	Generic	\$40 after deductible	Not Covered
	Brand Name Preferred	\$80 after deductible	Not Covered
	Brand Non-Preferred	\$140 after deductible	Not Covered
PHYSICIAN SERVICES	Allergy Injections	80/20 after deductible	60/40 after deductible
	Diagnostic Lab and X-ray	80/20 after deductible	60/40 after deductible
	Office Visit for Surgery	80/20 after deductible	60/40 after deductible
	Outpatient Surgery	80/20 after deductible	60/40 after deductible
	Inpatient Surgery	80/20 after deductible	60/40 after deductible
OTHER MEDICAL SERVICES	Outpatient Therapy Office Visit (Limits Apply)	80/20 after deductible	60/40 after deductible
	Maternity	80/20 after deductible	60/40 after deductible
	Hospital Inpatient & Outpatient	80/20 after deductible	60/40 after deductible
MENTAL HEALTH, CHEMICAL & ALCOHOL DEPENDENCY	Inpatient Treatment	80/20 after deductible	60/40 after deductible
	Outpatient Treatment	80/20 after deductible	60/40 after deductible
EMERGENCY MEDICAL CARE	Urgent Care Office Visit	80/20 after deductible	60/40 after deductible
	Emergency Room	80/20 after deductible	80/20 after deductible
VISION EXAM BENEFIT	One Routine Exam Every 12 Months	\$5 copay	Reimbursement up to \$42

* Wellness exams are subject to calendar year and age limitations.

** Mammogram coverage as permitted based on age and risk.

*** Includes services of an internist, general physician, family practitioner, obstetrics/gynecology, geriatrics or pediatrician.

This is a plan summary and is not a complete description of the plan. The Summary Plan Description provides a more complete explanation of terms of coverage, limitations and exclusions. The Summary Plan Description will supersede if there is a difference between the two.

Family coverage requires two deductibles to be satisfied. Pre-certification is required for some benefits. This includes, but is not limited to inpatient hospitalization, inpatient mental health, inpatient skilled nursing, outpatient surgery and substance abuse.

A dependent child or qualifying child may be covered on your WorkSmart medical plan until the child attains age 26.

★ Compatible with Health Savings Account (HSA) ★

★ Compatible with Limited Flexible Spending Account ★



Important Information About Health Savings Accounts (HSA) *Used in Conjunction with HDHP*

In order to contribute to a Health Savings Account

- You must be enrolled in an HDHP
- The HDHP must be your only health care coverage. If your spouse has a Flexible Spending Account that covers medical expenses, you are not eligible for an HSA
- You must not be enrolled in Medicare
- You must not be claimed as a dependent on another person's taxes (except for spouse)

The Health Savings Account allows you to have choice and control

- You decide how much money to put into the account
- You decide to pay current health care expenses or save the account for future expenses
- You decide which bank will hold the account
- You decide to invest some of your money in the account and what investments to make

Funding the Account

- Contributions to your HSA can be made by you, your employer or both
- Contributions can be done via payroll deduction
- You may change the amount funded during the year
- The maximum funding for 2013 plan year:
 - \$3,250 for Individual
 - \$6,450 for 2+ People
 - \$1,000 additional funding catch-up contributions if over age 55



Ownership

- The account belongs to you as the account holder
- Funds remain in the account from year to year and gain interest tax-free, just like an IRA. Unused amounts remain available for later years (unlike the forfeit rules for Flexible Spending Accounts)

Tower Bank – The HSA Authority (www.theHSAauthority.com)

- **WorkSmart Systems Employer Code: 141455** (Needed for your online account enrollment)
- WorkSmart sponsors Tower Bank for HSA accounts with pre-tax funding. You can, however, utilize any bank of your choice. Be aware that funding an HSA with a bank other than Tower Bank will be as a post-tax direct deposit and deposits will simply be tax deductible. You are responsible for providing all bank and account information to WorkSmart Systems.
- Money is funded on a pre-tax basis with Tower Bank and will show in your HSA on the Friday of the week following your pay date
- FDIC Insured
- No annual fee and no monthly service charge
- Online or paper statements available
- Interest bearing account that grows tax-free
- As long as your money is used for qualified expenses, you will not pay taxes on these dollars
- Access your money via check, debit card, ATM, or by request (in person or via telephone)

Reimbursement – There is no time limit when reimbursement can occur

- Expenses must be incurred after your enrollment in the HDHP/HSA
- Always spend your HSA money on qualified expenses. If you use the funds for ineligible items, you will pay a 20% penalty, plus taxes on the amount you spent. The penalty is waived if the account owner is 65 or older, or due to death or disability. You should keep your records for this account the same period of time you keep your income tax returns.

Portability – Accounts are completely portable, meaning you can keep your HSA even if you:

- Change jobs, move or retire
- Change your medical coverage
- Become unemployed (you can pay COBRA premiums with your HSA funds)



Eligible Expenses: HSA & Health Care Flexible Spending Accounts

In general, the expenses that are eligible for reimbursement include any expenses allowable as deductions on your income taxes under Section 213(d) of the IRS code. These may include, but are not limited to:

Medical and dental deductibles, copayments and coinsurance amounts, and expenses over plan limits for items such as:

- Acupuncture
- Ambulance
- Artificial limbs
- Artificial teeth
- Braces (payment contract, monthly payment coupon, or statement from your orthodontist)
- Child birth expenses not paid by health insurance
- Chiropractic office visits & treatment
- Clinic fees
- Coinsurance (out-of-pocket expenses)
- Contact lenses
- Crutches
- Deductibles
- Dental expense (excluding general health items)
- Dentures
- Diagnostic fees
- Eyeglasses, including examination fee
- Hearing devices & batteries
- Hospitalization bills
- Immunizations
- Laboratory fees
- Laser vision corrective surgery
- Mileage to see medical providers (24¢/mile in 2013)
- Orthopedic shoes
- Over-the-counter medications (EXCLUDES weight loss/dietary, herbal, vitamins and first aid) by prescription only
- Physicians' fees
- Prescriptions (copays or other amounts not paid by the plan)
- Psychiatric care and psychologist fees
- Routine physicals (except for employment-related)
- Surgical fees (non-cosmetic)
- Therapy treatments
- Transplants
- Vaccines
- Vitamins by prescription only
- Well baby care
- Wheelchairs, walkers, crutches and canes
- X-rays

Effective **January 1, 2011**, over-the-counter (OTC) drugs and medicines can no longer be purchased using the Benefits MasterCard. The card will only allow eligible OTC items and pharmacy prescriptions. Ineligible items will be denied at the point of sale.

In order to be reimbursed for an OTC drug or medicine, an employee must submit a manual claim and the doctor's prescription in order for WorkSmart to issue a reimbursement from Health Care Flexible Spending Account funds.

OTC ITEMS (Purchase with card/reimbursable WITHOUT Rx):

- Band-Aids
- Birth Control
- Braces and supports
- Contact lens solution and supplies
- Denture adhesives
- Insulin and diabetic supplies
- Reading glasses

OTC ITEMS (Require a manual claim/reimbursable WITH Rx):

- Acid Controllers
- Allergy and sinus products
- Antibiotic products
- Anti-diarrheals
- Anti-gas
- Anti-itch and insect bite
- Baby rash ointment/cream
- Cold sore remedy
- Cough, cold, flu
- Digestive aids
- Laxatives
- Motion sickness
- Pain relief
- Sleep aids/sedatives
- Stomach remedies

Your WorkSmart Flex Options

Flexible Spending Accounts allow you to pay for certain out-of-pocket health care and dependent care expenses with before-tax dollars. Spending before-tax dollars reduces your current taxable income, and you pay less in taxes for the year. Money you contribute to these accounts each year can be reimbursed only for expenses that you incur in the plan year, that are eligible expenses.

Money not reimbursed by April 15 of the following year will be forfeited – this “use it or lose it” rule applies to both the Health Care Flexible Spending Account and the Dependent Care Flexible Spending Account.

Health Care Spending Account

WorkSmart Systems offers two Health Care Spending Accounts: Regular and Limited. The Regular Health Care Spending Account is the more common account. The Limited Health Care Spending Account is specifically for participants in the High Deductible Health Plan who also have a Health Savings Account (HSA). The Limited Account can be used for reimbursement of dental and vision expenses only.

Either of the Health Care Spending Accounts allow you to contribute up to \$2,500 each calendar year to pay for certain out-of-pocket healthcare expenses for you and/or your eligible dependents. You decide how much to contribute each year and then each pay period, the prorated deduction is taken from your pay. **Your expenses have to be incurred within the benefit year, which will be from the first day you are eligible for benefits through termination of employment or March 15 of the following year, whichever comes first. If you do not use the money you put into the account, you lose it.** Plan carefully and do not set aside more than you estimate you will be able to use. *Expenses reimbursed through the Health Care Spending Account may not be claimed as a deduction on your federal income tax return.*

Dependent Care Spending Account

As an eligible employee, you may contribute up to \$5,000 each calendar year to the Dependent Care Spending Account to pay for the cost of caring for your eligible dependents, as defined below, so that you (and your spouse, if you are married) can work. You decide how much to contribute each year and then each pay period the prorated deduction is taken from your pay. **Your expenses have to be incurred within the benefit year, which will be from the first day you are eligible for benefits through termination of employment or December 31 of that year, whichever comes first. If you do not use the money you put into the account, you lose it.** Plan carefully and do not set aside more than you estimate you will be able to use.

To qualify for Dependent Care Spending Account reimbursement, the care:

- Must be provided to enable you and your spouse, if you are married, to work;
- Must be for your dependent child(ren) under age 13, or for any “IRS dependent” of any age if the dependent resides in your home and is unable to care for himself or herself; and
- Must be provided by anyone other than a person you can claim as a dependent on your federal income tax return.
- The provider must conform to state and local laws (including being licensed, if required) and be able to provide you with his or her Social Security or Tax ID number.

Reimbursements from your Dependent Care Spending Account may reduce or eliminate dependent care tax credits on your federal income tax return. For most people, the spending account provides a greater benefit, but everyone’s tax situation is different, so it is best to compare tax savings on an individual basis.

How WorkSmart Flex Works

At your initial enrollment, and then each year during Open Enrollment, you decide how much of your pre-tax income will go into a spending account for the upcoming year. You will have the option of paying for eligible charges with your Benefits MasterCard and submitting receipts to support the expenses, as necessary, or you can pay out-of-pocket and submit a claim for the tax-free reimbursement from the applicable account.

- 1. Health Care Flex Accounts are pre-funded.**
- 2. Dependent Care Flex Accounts are not pre-funded. Your Flex money is available for reimbursement after it has been deducted from your pay.**
- 3. You can check your available balance, outstanding receipts and more online at www.wealthcareadmin.com.** As a first-time user, you will need your Benefits MasterCard to create your account. From www.wealthcareadmin.com, select *Participant Login*. On the Participant Portal page, select *Create Account* and complete the form as directed. The Employee ID field will be your WorkSmart Employee ID number, no dashes. Once you have completed all required fields, select *Submit*. You will then be redirected to the login page.

- 4. You can submit receipts and/or file claims several ways:**

E-mail: flex@worksmartpeo.com

Mail: WorkSmart Systems

Fax: 317.585.7880

9957 Crosspoint Boulevard

Indianapolis IN 46256

- 5. Manual claims are processed throughout the week.** Reimbursement checks are mailed out the day following approval and will be mailed to your home address. You also have the option of setting up direct deposit for your account.

- 6. All health care claims must include:**

- Itemized bill or EOB (Explanation of Benefits)
- Date of service
- Services rendered
- Amount for which patient is responsible
- Proof of payment

- 7. All dependent care bills must include:**

- Name of provider
- Address of provider
- Tax ID number or social security number of provider
- Date(s) of service
- Proof of payment

- 8. Health Care and Dependent Care expenses must be incurred within the dates of the plan year.** The plan year for Health Care expenses begins on your effective date and continues through termination or must be incurred by March 15 of the following year. The plan year for Dependent Care expenses begins on your effective date and continues through termination or December 31 of that year.

- 9. Claims must be received in the WorkSmart Office by April 15 of the following year for all Flex expenses.**

- 10. WorkSmart offers a Benefits MasterCard to help you minimize the paperwork.** The Benefits MasterCard may be used at vendors who offer qualifying expenses: drug stores, hospitals, day care centers, etc. **The Benefits MasterCard will access current year Flex funds. You must file a manual claim for prior year carryover claims.** If you use your card at CVS, Sam's Club, Jewel, Meijer, Osco, Target, Wal-Mart, Cub Foods, Kroger, PayLess or Walgreens, for prescriptions and eligible OTC items, you will not have to submit a receipt to WorkSmart for substantiation. All other charges will require receipt documentation. If in doubt, send in the receipt.



Flexible Spending Accounts vs. HSA

WorkSmart Systems offers three Flexible Spending Accounts (Flex) and a Health Savings Account (HSA) as your pre-tax spending options.

The three Flex Accounts are:

- **Health Care Flex**, which may be used for eligible medical, dental, vision, prescription and some over-the-counter items for yourself and your dependents.
- **Limited Health Care Flex** is only available to HDHP/HSA Participants. Limited Flex may be used for dental and vision expenses only.
- **Dependent Care Flex** is for reimbursement of eligible childcare and/or eldercare expenses.

If you enroll in a Flexible Spending Account (Flex), you will make your election setting the dollar amount (between \$100 and \$2,500 for Health Care Flex; between \$100 and \$5,000 for Dependent Care Flex) for your current Plan year, which is your benefit effective date through December 31 of the current year. Your election(s) will be divided by the number of pays with insurance deductions and deducted on a pre-tax basis.

Some things to remember about Flex:

- Flex requires re-enrollment each year.
- Flex is use-it-or-lose-it. Dependent Care expenses must be incurred by 12.31.2013 and Health Care expenses by 03.15.2014, in order to use your 2013 Flex election.

- Over-the-counter drugs are not eligible for reimbursement from your Health Care Flex account unless you have a prescription from your doctor.
- Health Care Flex and Limited Health Care Flex elections are front-loaded on a Benefits MasterCard, giving you access to your full election as of your benefit effective date.
- Dependent Care Flex funds are available as funds are deducted from your pay throughout the year.

The **Health Savings Account (HSA)** is your health care spending account option if you enroll in the High Deductible Health Plan. It can be used for medical, dental, vision, prescription and some over-the-counter items.

Some things to remember about HSAs:

- Once elected, your HSA deduction will continue at that amount (subject to annual maximum limits) unless and until you are no longer enrolled in the HDHP medical plan and/or you advise WorkSmart Systems in writing that you wish to change your deduction. If your employer contributes to your HSA, WorkSmart will automatically take care of this benefit set-up.

- You can change your HSA payroll deduction throughout the year by completing an HSA Payroll Deduction Authorization Form.
- There is no minimum contribution, but there are maximum limits. The 2013 IRS limits are: \$3,250 for individual coverage; \$6,450 for family coverage. If you are 55 years of age or over, you are allowed an additional \$1,000 annual catch-up contribution, raising your 2013 maximum to \$4,250 or \$7,450, depending on your benefit election.
- Your HSA money is not available until it has been deducted from your pay and deposited into your HSA. If your HSA is held by Tower Bank, it will be funded through pre-tax payroll deduction and your funds are available to you the Friday of the week following your payday.
- Your HSA money rolls over from year to year and remains available until you need it. It is portable and follows you from job to job.

If you have additional questions about Flex or HSA, contact a Benefit Specialist, or you are welcome to contact the WorkSmart Human Resources Department by e-mail at HR@worksmartpeo.com or by phone at 317.585.7870.

Comparison:

	Health Care Flex	Health Savings Account	Limited Health Care Flex	Dependent Care Flex
May be elected regardless of WorkSmart medical election/waiver	X		X*	X
Eligibility is dependent upon WorkSmart medical election		X		
Compatible with \$2,000 PPO; \$5,000 PPO; \$3,000/\$6,000 HRA	X		X*	X
Compatible with \$3,500 HDHP		X	X	X
Can be used to pay for medical, prescription, dental, vision & eligible OTC expenses	X	X		
Can be used to pay for only dental and vision expenses			X	
Can be used for reimbursement of day care expenses				X
Use-it-or-lose-it rule	X		X	X
Funds roll over from year to year		X		
Portable		X		
You must submit receipts to WorkSmart Systems	X		X	X
You keep your own records regarding eligible expenses/reimbursements		X		

* You may elect the Limited Flex Spending without electing WorkSmart's HDHP, if your spouse has an HSA.

Blue View Vision

At Anthem Blue Cross and Blue Shield, we understand that vision benefits are essential to maintaining your overall health and well-being. After all, a slight miscorrection in eyesight can reduce productivity by 10% and work accuracy by nearly 40%. Computer eyestrain can reduce productivity between 10 and 50%.¹

Blue View Vision, our vision program, provides a cost-effective vision plan. The plan is easy to use and offers savings beyond exam coverage. Blue View Vision provides you with an innovative vision program to meet your unique needs and improve your overall wellness.

Finding a Blue View Vision Provider

Blue View Vision has an extensive national network of participating providers contracted under a vendor agreement with EyeMed Vision Care. You can easily find a provider conveniently located near you. Nationally, we contract with independent optometrists and ophthalmologists as well as retail locations such as LensCrafters®, Target Optical, Sears Optical, JCPenney Optical, and most Pearle Vision locations. Please call Blue View Vision at (866) 723-0515 if you have questions about your vision benefits or need to locate a provider.

Using a Participating Provider

By using a participating provider, you minimize your out-of-pocket expenses and receive the benefits of not having to hassle with paperwork, since the participating provider verifies your eligibility and obtains all the necessary information. You simply pay your copayment and any remaining balance at the time of your appointment.

Blue View Vision providers offer you discount pricing, which is significantly below retail. You receive substantial savings (15%-40% or more) on most eyewear pair purchases, conventional contact lenses, lens treatments, specialized lenses and various sundry items.

Using a Non-Participating Provider

If you choose to go to a non-participating (non-network) provider, you must pay the provider directly at the time of service. Out-of-network claims must be submitted by you. Simply submit a claim for reimbursement. When using a non-participating provider, your coverage may be limited and your out-of-pocket expenses may be greater.

Covered Benefits	Member Benefit From Blue View Vision Network Provider	Non-Network Reimbursement
Vision Examination including dilation and refraction as needed. Covered once every 12 months .	\$5 copayment	Up to \$42
Eyeglasses <ul style="list-style-type: none"> ● Eyeglass lenses ● Eyeglass frames 	Available at a discount	Not Covered
Contact Lenses	Discount schedule listed below	Not Covered

Exam Only Additional Savings Discounts	Members with Routine Exam Coverage Only
Service	Member Cost
Complete Eyeglasses	35% off retail price*
Frame	20% off retail price
Standard Plastic Lenses	
Single Vision	\$50
Bifocal Vision	\$70
Trifocal Vision	\$105
Lens Options	
UV Coating	\$15
Tint (Solid and Gradient)	\$15
Standard Scratch-Resistance	\$15
Standard Polycarbonate	\$40
Standard Progressive (Add-on to bifocal cost)	\$65
Standard Anti-Reflective Coating	\$45
Other Add-ons and Services	20% off retail price
Contact Lenses	
Conventional: materials only	15% off retail price**

* Discounts apply towards a complete pair of eyeglasses. If eyeglass materials are purchased separately, a 20% discount is applied. Discounts only applied when visiting a participating provider.

**Discount does not apply to fitting fees or services.

LiveSmart Wellness Program

The LiveSmart program consists of education materials and e-learning tools about consumerism and wellness. You will receive monthly newsletters that highlight health and wellness matters.

The wellness program allows you to assess your health and realize where changes need to be made. Small changes made today can impact your health for years to come. Controllable health habits lead to a longer life, increased energy, an increased ability to deal with adversity and stress, and happier, more active lives.

Anthem.com



24-hour access to tools you can really use at www.Anthem.com.

Once you get your ID card, registering is easy; all you need is your ID card, the Internet and five minutes. After you register at anthem.com, you can tap into decision-making tools, health information and many resources. It's also the convenient way to order a new ID card, check claims status, find out the cost of services, learn about doctors and hospitals, and so much more.

1. Go to Anthem.com
2. Enter the site by clicking on *Member*
3. Follow instructions to create your user name and password and you're ready to go!



360° Health Program

Anthem's 360° Health Program is available to give you all the help you need to live healthier. From tips and tools you can find online to nurses you can talk to on the phone, 360° Health can help you take better control over your health. Whether you're fit and want to stay that way, you're living with a chronic condition or you fall somewhere in between, 360° Health surrounds you with the support and resources to help you live healthier.

The 24/7 NurseLine

Call the NurseLine phone number located on the back of your medical card. The NurseLine provides anytime, toll-free access to nurses for answers to general health questions and guidance with health concerns. Callers can also access confidential, recorded messages about hundreds of health topics.



ConditionCare

Gain a better understanding of your health, receive help in following your doctor's care plan, and learn how to better manage your health with the guidance of a dedicated nurse team and health professionals.

Future Moms

Provides moms-to-be with telephone access to nurses to discuss pregnancy-related concerns. This program provides the education and tools to help track the pregnancy week-by-week and prepare for the baby.

Anthem® Care Comparison

Anthem Care Comparison is an innovative tool to help take some of the mystery out of healthcare pricing. You can see real price ranges for common services at different facilities and providers in your area. You can compare quality factors, too, to help you evaluate experience and expertise.

Try Anthem® Care Comparison today:

- Log in at www.anthem.com
- Scroll to the bottom of the page and select *Get Started* (see image to the right)
- Select the criteria and Select *Continue* to view the report



WorkSmart Systems is your partner in becoming a better consumer. If you need any assistance utilizing these tools or comparing benefit plan options that make the most sense to your situation, please contact us at HR@worksmartpeo.com or by phone at 317.585.7870 (Toll-free 1.877.977.9757).

Sample:

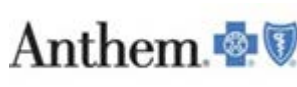


This report compares providers within 5 miles of Carmel, IN for **MRI Spine Unspecified**. This is just one of several sources you should consult to select a service provider; always consult your physician about what decision is right for you.

Name	Location	Distance	Typical Cost Low	Typical Cost High	Number of Services/Year
Northwest Radiology Network PC	12188 N Meridian St Ste 101 Carmel, IN 46032 317-715-9990	0 mi (map)	\$412	\$566	N/A
Proscan Imaging of Carmel	1185 W Carmel Dr Ste D1 Carmel, IN 46032 317-706-1700	0 mi (map)	\$412	\$564	N/A
Northwest Radiology Network PC	10603 N Meridian St Indianapolis, IN 46290 317-328-5050	2 mi (map)	\$412	\$566	N/A
Meridian MRI	8805 N Meridian St Indianapolis, IN 46280 317-706-7246	4 mi (map)	\$412	\$567	N/A
Northwest Radiology Network PC	8260 Naab Rd Ste 101 Indianapolis, IN 46260 317-875-8655	5 mi (map)	\$412	\$566	N/A
Center for Diagnostic Imaging	11900 N Pennsylvania St Ste 100 Carmel, IN 46032 317-846-0717	0 mi (map)	\$476	\$582	130
St Vincent Carmel Hospital	13500 N Meridian St Carmel, IN 46032 317-573-7000	1 mi (map)	\$1,101	\$2,496	116
St Vincent Hospital Health	2001 W 86th St Indianapolis, IN 46260 317-338-2273	4 mi (map)	\$1,136	\$2,293	562
Clarian North Medical Center	11700 N Meridian St Carmel, IN 46032 317-688-2000	1 mi (map)	\$1,683	\$2,056	N/A
Indiana University Health	151 Pennsylvania Pkwy Outpatient Hospital Services Indianapolis, IN 46280 317-817-1100	2 mi (map)	\$1,714	\$2,095	N/A
St Vincent Heart Center of Indiana LLC	10580 N Meridian St Indianapolis, IN 46290 317-583-5000	2 mi (map)	**	**	6

Print report
 Email report

Questions To Ask Your Doctor

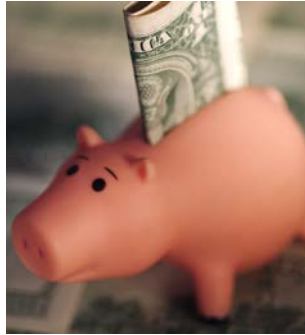


Does Cost Comparison Really Make a Difference?

How many of us buy a car without shopping for the best deal? How about a big screen television? And that MRI...? Many non-life threatening health care services are in the same price range as a car or that awesome TV, but we typically don't consider shopping for the best deal based on price and outcome. Why not?

Patient and Consumer? Do you think of yourself merely as a patient, or as an empowered consumer of health care services? Perhaps a combination of the two? Do you know that as a consumer, you have the option of shopping health care services? We have been conditioned to think only as a patient—do what the doctor, the authority, tells us to do. The average patient is usually scared or at least apprehensive about the condition in question, so the cost component as a consumer is not in the forefront of one's mind. If anything, a patient will usually think only about what will be paid out-of-pocket after insurance pays, not giving any thought to the overall cost of care.

Reducing overall health care costs, regardless of whether the plan or the



participant pays for the service, becomes money saved in the plan. Every dollar that is saved in the plan is ultimately a savings to all of us in our insurance premiums.

Accessibility to Pricing: It is difficult to navigate the labyrinth of physician, lab, hospital and PPO contract pricing to get a straight price for a service. A solution is that there are tools available that can make this process virtually painless. Anthem's Care Comparison tool provides accurate pricing information and explanation of these costs to participants.

"In-Network" Does Not Equal Universal Price: Did you know there

is a vast pricing disparity from provider to provider? When searching for pricing, outcomes and providers, Care Comparison gives the low price and high price for a particular health care service. The results also provide a breakdown of providers. Following are a few examples from our plan.

These are just a sampling of the typical price disparity for healthcare services:

Uncomplicated Birth: Low price = \$7,570; High price = \$13,106

Back - MRI Spine (Unspecified): Low price = \$412; High price = \$2,496 (See Example on Page 15)

Colonoscopy (With Biopsy): Low price = \$985; High price = \$7,500

WorkSmart data shows that 70% of our health care costs are due to claims that are under \$25,000. The vast majority of our health care claims are for non-life threatening conditions where shopping for cost of service is a valid option. Next time you need a diagnostic test or surgery, take a few minutes to "shop online" before making your health care purchase.

Lincoln Financial Dental Plan Summary

www.lfg.com

TYPES OF COVERAGE	GOLD DENTAL PLAN	TYPES OF COVERAGE	SILVER DENTAL PLAN
ANNUAL DEDUCTIBLE	\$50 individual, \$150 family	ANNUAL DEDUCTIBLE	\$50 individual, \$150 family
ANNUAL MAXIMUM	\$1,000/person	ANNUAL MAXIMUM	\$1,000/person
PREVENTIVE CARE		PREVENTIVE CARE	
Exam	100% covered	Exam	100% covered
Cleaning	100% covered	Cleaning	100% covered
X-rays	100% covered	X-rays	100% covered
Fluoride (through age 15)	100% covered	Fluoride (through age 15)	100% covered
Sealants (through age 15)	100% covered	Sealants (through age 15)	100% covered
Space Maintainers (through 15)	100% covered	Space Maintainers (through 15)	100% covered
BASIC SERVICES		BASIC SERVICES	
Fillings	80/20 after deductible	Fillings	50/50 after deductible
Extractions	80/20 after deductible	Extractions	50/50 after deductible
Palliative Treatment	80/20 after deductible	Palliative Treatment	50/50 after deductible
Prefabricated Stainless Steel/Resin Crowns	80/20 after deductible	Prefabricated Stainless Steel/Resin Crowns	50/50 after deductible
Oral Surgery *	80/20 after deductible	Oral Surgery *	50/50 after deductible
MAJOR SERVICES *		MAJOR SERVICES	
Periodontics	50/50 after deductible	Periodontics	Not covered
Endodontics (Root Canals)	50/50 after deductible	Endodontics (Root Canals)	Not covered
Crowns	50/50 after deductible	Crowns	Not covered
Inlays and Onlays	50/50 after deductible	Inlays and Onlays	Not covered
Bridges	50/50 after deductible	Bridges	Not covered
Partial or Complete Dentures	50/50 after deductible	Partial or Complete Dentures	Not covered
Denture Relines or Rebases	50/50 after deductible	Denture Relines or Rebases	Not covered
ORTHODONTIC SERVICES (Children Under Age 20)	50% / deductible waived, \$1,000 lifetime maximum	ORTHODONTIC SERVICES	Not covered

Please refer to the Summary Plan Description for a more complete explanation of terms of coverage, limitations and exclusions.

* It is advisable to have your provider request a predetermination of benefits from Lincoln Financial before any Oral Surgery or Major Services are performed.

** Discount service is available only at Lincoln Financial Dental participating dentists.

Dental Insurance – A Dependent Child means a person who is your:

- (1.) Child less than 25 years of age; or
 - (2.) Child age 25 years or older, who is:
 - (a) Continuously unable to earn a living because of a physical or mental disability; and
 - (b) Financially dependent upon your for support and maintenance.
- The child must be covered by the Group Policyholder's dental plan on the day before coverage would otherwise end due to his or her age. Proof of the total disability must be sent to the Company:
- (i) Within 120 days of the day coverage would otherwise end due to age; and
 - (ii) Thereafter, when the Company requests (but not more than once every two years).



Group Disability Options – Voluntary Short-Term Disability Lincoln Financial

VOLUNTARY SHORT-TERM DISABILITY

INFORMATION

Coverage Type – Non-Occupational
Elimination Period – 0 Days Accident, 7 days Sickness
Maximum Period of Payment – 13 Weeks
Weekly Gross Disability Benefit – 60% of Weekly Earnings
Maximum Weekly Benefit – \$1,000
Pre-Existing Conditions Exclusion – 12/12

Initial Monthly Rate Per \$10 of Weekly Benefit:

Age Bands	Premium Factor
< 30	0.0252
30-34	0.0258
35-39	0.0258
40-44	0.0288
45-49	0.0300
50-54	0.0336
55-59	0.0390
60-64	0.0468
65-69	0.0588
70-74	0.0702
75 +	0.0822

FORMULA:

Annual Salary / 52 weeks * Premium Factor = Your Monthly Cost

Maximum covered payroll is \$1,667.00 weekly

You are considered a late enrollee if you waive coverage at your initial eligibility. You may elect coverage the first of any month, pending approval from Lincoln Financial Underwriting Department. Please refer to the Summary Plan Description for a more complete explanation of terms of coverage, limitations and exclusions.



Lincoln Financial Summary of Voluntary Short-Term Disability Program Specifications

Employee Benefit Amount

Excellent opportunity to purchase group short-term disability insurance on a payroll deduction basis. 60% of your salary, rounded to the nearest dollar, up to \$1,000/week.

\$1,000 Guarantee Issue

Elimination Period

This is the number of continuous days you must be totally disabled before benefit payments start.

Benefits Begin: Day 1 Accident / Day 8 Sickness

Maximum Benefit Duration

This is the longest period of time that benefits will continue to be paid to you during a period of disability.

13 Weeks

Pre-Existing Exclusion

“Pre-existing condition” means any sickness or injury for which you have received medical treatment, consultation, care or services (including diagnostic measures or the taking of prescribed drugs or medicines) during the 12 months prior to the coverage effective date. A disability arising from any such sickness or injury will be covered only if it begins after you have performed your regular occupation on a full-time basis for 12 months following the coverage effective date.

Other Benefits Included

Pregnancy, alcoholism, drug addiction, mental and nervous conditions are treated the same as any other sickness. Partial disability benefits.

Program Eligibility

All full-time employees regularly scheduled to work at least 30 hours each week. Employees must be actively at work on the day coverage takes effect. Benefits terminate when your employment ceases.

All late entrants are required to complete satisfactory Evidence of Insurability information.

Monthly Premium Calculation

John Doe is 35 and earns \$500 per week.
 $\$500 \times .0258 = \12.90 Monthly premium

$$\begin{matrix} \$ & & \times & & = & \$ \\ \text{Your Weekly Salary} & & \text{Premium Factor} & & \text{Your Monthly Cost} \end{matrix}$$

Maximum covered payroll is \$1,667 weekly

The Lincoln National Life Insurance Company
 8801 Indian Hills Drive, Omaha, NE 68114

Attained Age	Premium Factors
Less than 30	0.0252
30 – 34	0.0258
35 – 39	0.0258
40 – 44	0.0288
45 – 49	0.0300
50 – 54	0.0336
55 – 59	0.0390
60 – 64	0.0468
65 – 69	0.0588
70 – 74	0.0702
75 – 80	0.0822

Summary Of Voluntary Short-Term Disability Insurance Benefit

Lincoln Financial

ELIGIBILITY	All full-time active employees working 30 or more hours per week are eligible for Short-Term Disability (STD) coverage. A delayed effective date will apply if the employee is not actively at work on the date that the insurance would otherwise take effect.
WEEKLY BENEFIT	If you are totally disabled beyond the elimination period due to a covered injury or sickness, you will be eligible to receive a weekly benefit of 60% of your basic weekly income to a maximum benefit of \$1,000. This coverage is optional.
DEFINITION OF TOTAL DISABILITY	Total disability is defined as the inability to perform each of the main duties of your regular occupation on a full-time basis due to injury or sickness.
ELIMINATION PERIOD	Elimination period is the number of continuous days you must be totally disabled before benefit payments start.
BENEFIT DURATION	Maximum benefit duration is the longest period of time that benefits will continue to be paid to you during a period of disability.
GUARANTEE ISSUE	This coverage is extended to you without requiring evidence of insurability as long as you meet eligibility requirements and enroll during your eligibility period. If you do not apply for this coverage when you are initially eligible and you choose to apply at a later date, you will be responsible for any expenses associated with obtaining further medical information.
PARTIAL DISABILITY BENEFIT	Partial disability means that due to a non-work-related sickness or injury, you are unable to perform one or more of the main duties of your regular occupation or are unable to perform such duties on a full-time basis. You must be totally disabled prior to receiving partial benefit. To qualify for the benefit you must satisfy the elimination period and be earning less than 80% of your pre-disability salary. Partial disability benefits are reduced by earnings from any form of employment and end on the earliest of the date you cease to be partially disabled, the date your earnings exceed 85% of your pre-disability income or the date the maximum benefit duration ends.
PRE-EXISTING CONDITION	A pre-existing condition means any sickness or injury for which you have received medical treatment, consultation, care or services (including diagnostic measures or the taking of prescribed drugs or medicines) during the 12 months prior to the coverage effective date. A disability arising from any such injury or sickness will be covered only if it begins after you have been insured for 12 consecutive months.
PREGNANCY	Pregnancy is treated as an illness. The definition of disability must be satisfied and the elimination period completed before benefits would begin. The pre-existing condition exclusion applies as for any illness.
EXCLUSIONS	Lincoln Financial does not pay Short-Term Disability benefits for any period of disability: <ul style="list-style-type: none">• During which you are not under the regular care of a doctor;• Which is the result of intentional, self-inflicted injury or attempted suicide;• If disability is due to an injury or sickness covered by Worker's Compensation or resulting from employment for wage and profit;• While you receive payment under a salary continuance or retirement plan sponsored by your employer.
NON-OCCUPATIONAL	Short-Term Disability insurance covers only non-occupational injury or sickness. Worker's Compensation normally covers an employee's work-related accident, injury or sickness.
BENEFIT REDUCTION	The Short-Term Disability benefit duration will reduce by 50% at age 70 and will terminate at retirement.

This is only a summary of coverage and is not a binding contract. A certificate of coverage will be made available to you describing the benefits in greater detail. Should there be a difference between this summary and the contract, the contract will govern.

Group insurance products are issued by The Lincoln National Life Insurance Company (Ft. Wayne, IN), which is not licensed and does not solicit business in New York. In New York, group insurance products are issued by Lincoln Life & Annuity Company of New York (Syracuse, NY).

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates. Affiliates are separately responsible for their own financial and contractual obligations.

100% Employer-Paid Disability Options Lincoln Financial

LONG-TERM DISABILITY STRUCTURE INFORMATION

Coverage Type – Non-Occupational
Integration Approach – Integrated
Elimination Period – 90 Days
Maximum Period of Payment – Age 65; 24 Months
Monthly Disability Benefit – 60% of Basic Monthly Earnings
Maximum Monthly Benefit – \$5,000
Pre-Existing Conditions Exclusion – 3/12
Monthly Rate Per \$100 of Monthly Benefit – \$0.51

Please refer to the Summary Plan Description for a more complete explanation of terms of coverage, limitations and exclusions.



Summary Of Employer Paid Long-Term Disability Insurance Benefit Lincoln Financial

ELIGIBILITY

All full-time active employees working 30 or more hours per week are eligible for Long-Term Disability (LTD) coverage. A delayed effective date will apply if the employee is not actively at work on the date that the insurance would otherwise take effect.

MONTHLY BENEFIT

If you are totally disabled beyond the elimination period due to a covered injury or sickness, you will be eligible to receive a monthly benefit equal to 60% of your basic **monthly** income, up to a maximum benefit of \$5,000.

BENEFIT REDUCTIONS

LTD benefits will be reduced by disability or retirement benefits from the following sources:

FROM OTHER INCOME

- Social Security benefits (Primary and Family Social Security Integration), the Canada Pension Plan, the Quebec Pension Plan or any similar plan or act.
- Disability benefits for which the employee is eligible under: Worker's Compensation, occupational disease or similar law; state disability plans or any compulsory benefit act or law; any other group plan, sick leave or salary continuance plan of the employer; disability benefits from any no-fault auto plan, individual policy, association group plan or franchise plan, or any automobile liability insurance policy.
- Disability or retirement benefits under the employer's retirement plan or a government retirement plan.
- Any form of employment (full- or part-time).
- LTD benefits are not reduced by:
 - Distributions from profit sharing, 401k, IRA, TSA or stock ownership plans.
 - Non-qualified deferred compensation plans.

DEFINITION OF TOTAL DISABILITY

Total disability is defined as the inability to perform each of the main duties of your regular occupation on a full-time basis due to injury or sickness. The "own occupation" definition applies to the first 24 months of your disability. Following this, the definition of disability becomes the inability to perform any occupation for which you are reasonably fitted, based on your experience, education or training.

ELIMINATION PERIOD

You need to satisfy a 90-day elimination period before benefits would begin. This elimination period can be satisfied with days of partial disability, total disability or a combination of both. The elimination period may be met by days of disability built up over an accumulation period of 180 days, so there is no penalty for briefly attempting to return to work during this elimination period.

LTD PRE-EXISTING CONDITION

Benefits will not be paid for any disability for which you received medical treatment, care or consultation, including diagnostic measures or took prescribed drugs or medications during the three months preceding your effective date under this policy, unless you remain treatment free during your first 12 months of policy coverage or are covered under this policy (or a prior policy) for 12 consecutive months before disability begins.

PROGRESSIVE PARTIAL DISABILITY BENEFIT

Your plan includes the progressive partial disability benefit. The partial disability benefit will not be reduced by earnings from any employer until those earnings, plus the policy benefit and other income benefits from other sources listed in your certificate (such as Social Security or Worker's Compensation), exceeds 100% of covered pre-disability earnings.

PREGNANCY

Pregnancy is treated as an illness. The definition of disability must be satisfied and the elimination period completed before benefits begin.

EXCLUSIONS

Lincoln Financial does not pay Long-Term Disability benefits for any period of disability:

- During which you are not under the regular care of a doctor;
- Due to active participation in a riot or in the commission of a felony;
- Due to war, declared or undeclared, or any act of armed aggression;
- The result of any intentional, self-inflicted injury or attempted suicide;
- Due to a pre-existing condition, except as described in the policy; or

When a disability is due to mental illness, Lincoln Financial's standard contract considers benefits payable for up to a maximum period of 24 months. However, if the insured employee is confined to a hospital at the end of the 24-month period, benefits may continue to be payable.

When considering Long-Term Disability plan options, it is important to understand the difference in benefits and how they impact a disability claim. Your Lincoln Financial representative can advise you on the appropriate choice for your situation.

This is only a summary of coverage and is not a binding contract. A certificate of coverage will be made available to you shortly, which describes the benefits in greater detail. Should there be differences between this summary and the contract, the contract will govern.

Coverage is underwritten by Jefferson Pilot Financial Insurance Company, Omaha, NE, a Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

Group Term Life and Accidental Death & Dismemberment Options Lincoln Financial

GROUP TERM LIFE / ACCIDENTAL DEATH & DISMEMBERMENT

INFORMATION

EMPLOYEE AMOUNTS PER \$10,000

- Maximum coverage is three times annual salary – maximum of \$300,000
- \$100,000 Guarantee Issue for employee under age 60
- \$10,000 Guarantee Issue for employees age 60 – 69
- No Guarantee Issue for employees age 70 and over – maximum coverage is \$50,000

SPOUSE AMOUNTS PER \$5,000

- Maximum coverage is 1.5 times employee's annual salary – maximum of \$150,000
- \$30,000 Guarantee Issue for spouses of employees under age 60
- No Guarantee Issue for spouses of employees age 60 and over – maximum coverage is \$32,500 through age 69

CHILD COVERAGE OF \$10,000 AT \$2.00 PER MONTH

- Must elect Employee and/or Spouse coverage in order to elect Child coverage
- Regardless of number of children

MONTHLY RATES

Age Bands	Rates per \$10,000	With AD&D
< 30	0.60	1.00
30-34	0.60	1.00
35-39	0.90	1.30
40-44	1.40	1.80
45-49	2.40	2.80
50-54	3.60	4.00
55-59	5.40	5.80
60-64	9.10	9.50
65-69	16.80	17.20
70-74	24.40	24.80
75 +	40.50	41.90

AD&D = Accidental Death & Dismemberment

You are considered a late enrollee if you waive coverage at your initial eligibility. You may elect coverage the first of any month pending approval from Lincoln Financial underwriting department. Please refer to the Summary Plan Description for a more complete explanation of terms and coverage, limitations and exclusion.



EMPLOYEE MONTHLY PREMIUM											
Life Premium For Sample Benefit Amounts											
Employee and Spouse premiums are calculated separately. Spouse premiums will be calculated off of the Employee's age.											
Refer to Program Specifications for your maximum benefit amounts.											
Benefit and Premium amounts reflect age reductions.											

AGE	Monthly Rate per \$1,000	\$10,000	\$20,000	\$30,000	\$40,000	\$50,000	\$60,000	\$70,000	\$80,000	\$90,000	\$100,000
<30	\$ 0.060	\$ 0.60	\$ 1.20	\$ 1.80	\$ 2.40	\$ 3.00	\$ 3.60	\$ 4.20	\$ 4.80	\$ 5.40	\$ 6.00
30-34	\$ 0.060	\$ 0.60	\$ 1.20	\$ 1.80	\$ 2.40	\$ 3.00	\$ 3.60	\$ 4.20	\$ 4.80	\$ 5.40	\$ 6.00
35-39	\$ 0.090	\$ 0.90	\$ 1.80	\$ 2.70	\$ 3.60	\$ 4.50	\$ 5.40	\$ 6.30	\$ 7.20	\$ 8.10	\$ 9.00
40-44	\$ 0.140	\$ 1.40	\$ 2.80	\$ 4.20	\$ 5.60	\$ 7.00	\$ 8.40	\$ 9.80	\$ 11.20	\$ 12.60	\$ 14.00
45-49	\$ 0.240	\$ 2.40	\$ 4.80	\$ 7.20	\$ 9.60	\$ 12.00	\$ 14.40	\$ 16.80	\$ 19.20	\$ 21.60	\$ 24.00
50-54	\$ 0.360	\$ 3.60	\$ 7.20	\$ 10.80	\$ 14.40	\$ 18.00	\$ 21.60	\$ 25.20	\$ 28.80	\$ 32.40	\$ 36.00
55-59	\$ 0.540	\$ 5.40	\$ 10.80	\$ 16.20	\$ 21.60	\$ 27.00	\$ 32.40	\$ 37.80	\$ 43.20	\$ 48.60	\$ 54.00
60-64	\$ 0.910	\$ 9.10	\$ 18.20	\$ 27.30	\$ 36.40	\$ 45.50	\$ 54.60	\$ 63.70	\$ 72.80	\$ 81.90	\$ 91.00
65-69	\$ 1.680	\$ 6,500	\$ 13,000	\$ 19,500	\$ 26,000	\$ 32,500	\$ 39,000	\$ 45,500	\$ 52,000	\$ 58,500	\$ 65,000
			\$ 10.92	\$ 21.84	\$ 32.76	\$ 43.68	\$ 54.60	\$ 65.52	\$ 76.44	\$ 87.36	\$ 98.28
70-74	\$ 2.440	\$ 4,000	\$ 8,000	\$ 12,000	\$ 16,000	\$ 20,000	N/A	N/A	N/A	N/A	N/A
			\$ 9.76	\$ 19.52	\$ 29.28	\$ 39.04	\$ 48.80	N/A	N/A	N/A	N/A
75-99	\$ 4.050	\$ 2,500	\$ 5,000	\$ 7,500	\$ 10,000	\$ 12,500	N/A	N/A	N/A	N/A	N/A
			\$ 10.13	\$ 20.25	\$ 30.38	\$ 40.50	\$ 50.63	N/A	N/A	N/A	N/A

This is only an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

EXAMPLE: Use this formula to calculate premium for benefit amounts over \$100,000

	Age	Monthly Rate per \$1,000		Benefit in \$1,000's		Monthly Cost
Example	35	.090	X	120	=	\$10.80
Yours			X		=	

Dependent Children Rate = \$2.00 monthly
Premium covers all dependent children, regardless of the number of children.

EMPLOYEE MONTHLY PREMIUM

Life and AD&D Premium For Sample Benefit Amounts

Employee and Spouse premiums are calculated separately.
 Spouse premiums will be calculated off of the Employee's age.
 Refer to Program Specifications for your maximum benefit amounts.

Benefit and Premium amounts reflect age reductions.

AGE	Monthly Rate per \$1,000	\$10,000	\$20,000	\$30,000	\$40,000	\$50,000	\$60,000	\$70,000	\$80,000	\$90,000	\$100,000
<30	\$ 0.100	\$ 1.00	\$ 2.00	\$ 3.00	\$ 4.00	\$ 5.00	\$ 6.00	\$ 7.00	\$ 8.00	\$ 9.00	\$ 10.00
30-34	\$ 0.100	\$ 1.00	\$ 2.00	\$ 3.00	\$ 4.00	\$ 5.00	\$ 6.00	\$ 7.00	\$ 8.00	\$ 9.00	\$ 10.00
35-39	\$ 0.130	\$ 1.30	\$ 2.60	\$ 3.90	\$ 5.20	\$ 6.50	\$ 7.80	\$ 9.10	\$ 10.40	\$ 11.70	\$ 13.00
40-44	\$ 0.180	\$ 1.80	\$ 3.60	\$ 5.40	\$ 7.20	\$ 9.00	\$ 10.80	\$ 12.60	\$ 14.40	\$ 16.20	\$ 18.00
45-49	\$ 0.280	\$ 2.80	\$ 5.60	\$ 8.40	\$ 11.20	\$ 14.00	\$ 16.80	\$ 19.60	\$ 22.40	\$ 25.20	\$ 28.00
50-54	\$ 0.400	\$ 4.00	\$ 8.00	\$ 12.00	\$ 16.00	\$ 20.00	\$ 24.00	\$ 28.00	\$ 32.00	\$ 36.00	\$ 40.00
55-59	\$ 0.580	\$ 5.80	\$ 11.60	\$ 17.40	\$ 23.20	\$ 29.00	\$ 34.80	\$ 40.60	\$ 46.40	\$ 52.20	\$ 58.00
60-64	\$ 0.950	\$ 9.50	\$ 19.00	\$ 28.50	\$ 38.00	\$ 47.50	\$ 57.00	\$ 66.50	\$ 76.00	\$ 85.50	\$ 95.00
65-69	\$ 1.720	\$ 6,500	\$ 13,000	\$ 19,500	\$ 26,000	\$ 32,500	\$ 39,000	\$ 45,500	\$ 52,000	\$ 58,500	\$ 65,000
		\$ 11.18	\$ 22.36	\$ 33.54	\$ 44.72	\$ 55.90	\$ 67.08	\$ 78.26	\$ 89.44	\$ 100.62	\$ 111.80
70-74	\$ 2.480	\$ 4,000	\$ 8,000	\$ 12,000	\$ 16,000	\$ 20,000	N/A	N/A	N/A	N/A	N/A
		\$ 9.92	\$ 19.84	\$ 29.76	\$ 39.68	\$ 49.60	N/A	N/A	N/A	N/A	N/A
75-99	\$ 4.090	\$ 2,500	\$ 5,000	\$ 7,500	\$ 10,000	\$ 12,500	N/A	N/A	N/A	N/A	N/A
		\$ 10.23	\$ 20.45	\$ 30.68	\$ 40.90	\$ 51.13	N/A	N/A	N/A	N/A	N/A

This is only an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

EXAMPLE: Use this formula to calculate premium for benefit amounts over \$100,000

	Age	Monthly Rate per \$1,000		Benefit in \$1,000's		Monthly Cost
Example	35	.130	X	120	=	\$15.60
Yours			X		=	

Dependent Children Rate = \$2.00 monthly

Premium covers all dependent children, regardless of the number of children.

SPOUSE MONTHLY PREMIUM

Life Premium For Sample Benefit Amounts

Employee and Spouse premiums are calculated separately.
Spouse premiums will be calculated off of the Employee's age.
Refer to Program Specifications for your maximum benefit amounts.

Benefit and Premium amounts reflect age reductions.

AGE	Monthly Rate per \$1,000	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
<30	\$ 0.060	\$ 0.30	\$ 0.60	\$ 0.90	\$ 1.20	\$ 1.50	\$ 1.80	\$ 2.10	\$ 2.40	\$ 2.70	\$ 3.00
30-34	\$ 0.060	\$ 0.30	\$ 0.60	\$ 0.90	\$ 1.20	\$ 1.50	\$ 1.80	\$ 2.10	\$ 2.40	\$ 2.70	\$ 3.00
35-39	\$ 0.090	\$ 0.45	\$ 0.90	\$ 1.35	\$ 1.80	\$ 2.25	\$ 2.70	\$ 3.15	\$ 3.60	\$ 4.05	\$ 4.50
40-44	\$ 0.140	\$ 0.70	\$ 1.40	\$ 2.10	\$ 2.80	\$ 3.50	\$ 4.20	\$ 4.90	\$ 5.60	\$ 6.30	\$ 7.00
45-49	\$ 0.240	\$ 1.20	\$ 2.40	\$ 3.60	\$ 4.80	\$ 6.00	\$ 7.20	\$ 8.40	\$ 9.60	\$ 10.80	\$ 12.00
50-54	\$ 0.360	\$ 1.80	\$ 3.60	\$ 5.40	\$ 7.20	\$ 9.00	\$ 10.80	\$ 12.60	\$ 14.40	\$ 16.20	\$ 18.00
55-59	\$ 0.540	\$ 2.70	\$ 5.40	\$ 8.10	\$ 10.80	\$ 13.50	\$ 16.20	\$ 18.90	\$ 21.60	\$ 24.30	\$ 27.00
60-64	\$ 0.910	\$ 4.55	\$ 9.10	\$ 13.65	\$ 18.20	\$ 22.75	\$ 27.30	\$ 31.85	\$ 36.40	\$ 40.95	\$ 45.50
65-69	\$ 1.680	\$ 3,250	\$ 6,500	\$ 9,750	\$ 13,000	\$ 16,250	\$ 19,500	\$ 22,750	\$ 26,000	\$ 29,250	\$ 32,500
		\$ 5.46	\$ 10.92	\$ 16.38	\$ 21.84	\$ 27.30	\$ 32.76	\$ 38.22	\$ 43.68	\$ 49.14	\$ 54.60
70-74		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

This is only an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

EXAMPLE: Use this formula to calculate premium for benefit amounts over \$50,000

	Age	Monthly Rate per \$1,000		Benefit in \$1,000's		Monthly Cost
Example	35	.090	X	60	=	\$5.40
Yours			X		=	

Dependent Children Rate = \$2.00 monthly

Premium covers all dependent children, regardless of the number of children.

SPOUSE MONTHLY PREMIUM

Life and AD&D Premium For Sample Benefit Amounts

Employee and Spouse premiums are calculated separately.
Spouse premiums will be calculated off of the Employee's age.

Refer to Program Specifications for your maximum benefit amounts.

Benefit and Premium amounts reflect age reductions.

AGE	Monthly Rate per \$1,000	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
<30	\$ 0.100	\$ 0.50	\$ 1.00	\$ 1.50	\$ 2.00	\$ 2.50	\$ 3.00	\$ 3.50	\$ 4.00	\$ 4.50	\$ 5.00
30-34	\$ 0.100	\$ 0.50	\$ 1.00	\$ 1.50	\$ 2.00	\$ 2.50	\$ 3.00	\$ 3.50	\$ 4.00	\$ 4.50	\$ 5.00
35-39	\$ 0.130	\$ 0.65	\$ 1.30	\$ 1.95	\$ 2.60	\$ 3.25	\$ 3.90	\$ 4.55	\$ 5.20	\$ 5.85	\$ 6.50
40-44	\$ 0.180	\$ 0.90	\$ 1.80	\$ 2.70	\$ 3.60	\$ 4.50	\$ 5.40	\$ 6.30	\$ 7.20	\$ 8.10	\$ 9.00
45-49	\$ 0.280	\$ 1.40	\$ 2.80	\$ 4.20	\$ 5.60	\$ 7.00	\$ 8.40	\$ 9.80	\$ 11.20	\$ 12.60	\$ 14.00
50-54	\$ 0.400	\$ 2.00	\$ 4.00	\$ 6.00	\$ 8.00	\$ 10.00	\$ 12.00	\$ 14.00	\$ 16.00	\$ 18.00	\$ 20.00
55-59	\$ 0.580	\$ 2.90	\$ 5.80	\$ 8.70	\$ 11.60	\$ 14.50	\$ 17.40	\$ 20.30	\$ 23.20	\$ 26.10	\$ 29.00
60-64	\$ 0.950	\$ 4.75	\$ 9.50	\$ 14.25	\$ 19.00	\$ 23.75	\$ 28.50	\$ 33.25	\$ 38.00	\$ 42.75	\$ 47.50
65-69	\$ 1.720	\$ 3,250	\$ 6,500	\$ 9,750	\$ 13,000	\$ 16,250	\$ 19,500	\$ 22,750	\$ 26,000	\$ 29,250	\$ 32,500
		\$ 5.59	\$ 11.18	\$ 16.77	\$ 22.36	\$ 27.95	\$ 33.54	\$ 39.13	\$ 44.72	\$ 50.31	\$ 55.90
70-74		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

This is only an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

EXAMPLE: Use this formula to calculate premium for benefit amounts over \$50,000

	Age	Monthly Rate per \$1,000		Benefit in \$1,000's		Monthly Cost
Example	35	.130	X	60	=	\$7.80
Yours			X		=	

Dependent Children Rate = \$2.00 monthly

Premium covers all dependent children, regardless of the number of children.

Lincoln Financial Summary of Voluntary Term Life & AD&D Program Specifications

Employee

Worksmart Systems, Inc. has provided an excellent opportunity to purchase group term life insurance on a payroll deduction basis.

You choose the protection you want!

- Benefit options are available in increments of \$10,000, to a maximum of \$300,000
- Not to exceed three times your annual salary (rounded to the next higher \$10,000)
- Up to \$100,000 Guarantee Issue for employees under age 60
- \$10,000 Guarantee Issue for employees age 60-69
- No Guarantee Issue for employees age 70 and over – maximum coverage is \$50,000

Your benefits will reduce:

- 35% upon the attainment of age 65
- An additional 25% of the original amount at age 70
- An additional 15% of the original amount at age 75
- Benefits will terminate at age 80 or retirement, whichever occurs first

Spouse

- Benefit options are available in increments of \$5,000, to a maximum of \$150,000
- Not to exceed one and a half times the employee's annual salary (rounded to the next higher \$5,000)
- \$30,000 Guarantee Issue for spouses under age 60
- No Guarantee Issue for spouses age 60 and over – maximum coverage is \$32,500 through age 69

Your spouse's benefits will reduce:

- 35% upon the employee's attainment of age 65
- Benefits will terminate when employee attains age 70 or retires, whichever occurs first

Accidental Death & Dismemberment (AD&D)

- AD&D coverage is included at an additional low cost
- Coverage is equal to the life insurance benefit and is paid in the event of accidental death or dismemberment

Dependent Child Benefit Amount

- Available if the employee and/or spouse is insured for voluntary coverage
- Any \$1,000 increment; subject to a minimum of \$1,000 and a maximum of \$10,000
- For children age 14 days to 19 years
- Up to 25 years if unmarried and a full-time student
- Newborn children under age 14 days are not eligible for a benefit

Other Benefits Include

- Waiver of premium
- Living benefit
- Portable after 12 months
- Conversion

Program Eligibility

All full-time employees regularly scheduled to work at least 30 hours each week. Employees must be actively at work on the day coverage takes effect. Dependents must not be in a period of limited activity on the day coverage takes effect.

The Lincoln National Life Insurance Company
8801 Indian Hills Drive, Omaha, NE 68114

Summary Of Voluntary Term Life and AD&D Insurance Benefit

Lincoln Financial

GROUP TERM LIFE	This coverage is Group Term Life Insurance. The life insurance benefit is payable to the designated beneficiary upon your death. Coverage is provided for the time period that you are eligible and premium is paid. There is no cash value associated with this product. This insurance is optional and can be purchased by you and/or your spouse.
AD&D	Accidental Death and Dismemberment Insurance provides specified benefits for a covered accidental bodily injury that directly causes death or dismemberment (i.e. the loss of a hand, foot or eye). Coverage equals the life insurance benefit for death, or a percentage of that amount for dismemberment. If death occurs from a covered accident, both the Life and the AD&D benefit will be payable. This insurance is optional and can be purchased by you and/or your spouse.
CHILD LIFE BENEFIT	Child life benefit is available when you are approved for life insurance coverage. This insurance is optional.
GUARANTEE ISSUE	<p>For timely entrants enrolled within 31 days of becoming eligible, up to \$100,000 in employee coverage and \$30,000 in spouse coverage is available without any evidence of insurability requirement until age 60. For employees ages 60-69, up to \$10,000 in coverage is available without any evidence of insurability requirement. Evidence of Insurability will be required for:</p> <ul style="list-style-type: none">• Employees and spouses of any ages, for amounts beyond the Guarantee Issue limits;• Employees applying after age 70 or spouses applying after the employee attains age 60, for all amounts; and• For late entrants of all ages, for all amounts. <p>If you do not apply for this coverage when you are initially eligible and you choose to apply at a later date, you will be responsible for any expenses associated with obtaining further medical information.</p>
WAIVER OF PREMIUM	Life insurance coverage continues without premium payment up to age 65 if you become permanently and totally disabled from all occupations for which you are reasonably qualified. Total disability must begin before age 60 and must continue for six months before the benefit becomes effective.
LIVING BENEFIT	An accelerated death benefit is available when an employee has satisfied the Active Work rule or a spouse has satisfied the Non-Confinement or Period of Limited Activity Rule, provided he or she has been covered under the policy for at least 30 days when diagnosed as terminally ill. When such an employee or spouse is diagnosed as terminally ill (having 12 months or less to live), the employee may withdraw up to 75% of the life insurance coverage on that family member, or up to a maximum of \$250,000, whichever is less. NOTE: Receipt of an accelerated death benefit will reduce the amount payable at death and may result in taxable income or affect eligibility for certain government benefits. Check with your tax advisor or attorney before exercising this option.
ELIGIBILITY	All full-time active employees working 30 or more hours per week in an eligible class are eligible for coverage. A delayed effective date will apply if the employee is not actively at work on the date that the insurance would otherwise take effect, or for a dependent that is confined to a health care facility or in a period of limited activity.
EXCLUSION	A suicide exclusion applies during the first two years of Voluntary Group Term Life coverage.
PORTABILITY	You may continue the coverage after your employment terminates, providing the coverage has been in force for at least 12 months and your employment is not terminating due to any sickness, injury or retirement. The premium rates will remain the same as for active employees of like age. A written application must be made within 31 days of your termination. An additional billing fee will be applied depending on the payment method you select.
CONVERSION	If you terminate your employment, or if you or your dependents become ineligible for this coverage for a reason other than non-payment of premium or policy termination, then you will have the option to convert all or part of the terminated Group Life Insurance to an individual life policy without Evidence of Insurability. Conversion election must be made within 31 days of your coverage termination.
BENEFIT REDUCTIONS	Life and AD&D benefits for employees will terminate at age 80 or upon retirement, whichever occurs first. Prior to this, benefits reduce by: 35% at age 65; an additional 25% of the original amount at age 70; and an additional 15% of the original amount at age 75. Life and AD&D benefits for spouse coverage will terminate when the employee attains age 70 or retires, whichever occurs first. Prior to this, spouse benefits reduce by 35% at employee's age 65.

This is only a summary of coverage and is not a binding contract. A certificate of coverage will be made available to you that describe the benefits in greater details. Should there be a difference between this summary and the contract, the contract will govern.

Group insurance products are issued by The Lincoln National Life Insurance Company (Ft. Wayne, IN), which is not licensed and does not solicit business in New York. In New York, group insurance products are issued by Lincoln Life & Annuity Company of New York (Syracuse, NY).

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates. Affiliates are separately responsible for their own financial and contractual obligations.

Humana Specialty Benefit Products

WorkSmart offers a line of supplemental insurance products through Humana which will help you absorb higher deductibles and out-of-pocket costs. These voluntary products are designed to work in conjunction with your medical plan.



Supplemental Health Insurance Coverage

Humana Supplemental Health pays a cash benefit when you're hospitalized. You can use the cash benefit any way you like – to help pay medical bills or everyday living expenses such as housing, car payments, utility bills, childcare expenses, groceries, or credit card bills.

Benefit Plan

Hospital Indemnity: Pays \$100 per day for up to 15 days per confinement, if a covered person is confined as an inpatient in a hospital.

Hospital first occurrence: Pays \$250 per day up to four days if a covered person is confined as an inpatient in a hospital for the first time during a calendar year.

Waiver of premium: This waives an employee's premium if he or she becomes totally disabled for at least 90 days after the effective date of coverage. There is no lifetime maximum. Maximum waiver of premium benefit is limited to a total of 12 consecutive months per disability.

Additional Benefit

Health screening benefit: Pays \$50 per test per year. Maximum of one test per covered person per calendar year, or three tests per family.* This benefit is payable for services rendered after a 180-day waiting period from the effective date of coverage. There are 18 specific screenings that are covered.

Pre-Existing Conditions Exclusion 12/12: Covers pre-existing conditions after 12 months from the date of the policy.

* **Note:** Benefit cannot be collected under multiple provisions of the certificate. The health screening (wellness) benefit is included and will be paid under the most appropriate and remaining section of the certificate.

Rates for Supplemental Health plan

Monthly Premium; Includes: Health Screening

BENEFIT	PACKAGE ONE							
	Non-Tobacco User				Tobacco User			
Age	18 - 35	36 - 49	50 - 59	60 - 64	18 - 35	36 - 49	50 - 59	60 - 64
Employee	\$15.36	\$14.59	\$19.03	\$26.10	\$18.68	\$17.69	\$23.24	\$32.09
Employee + Spouse	\$28.49	\$26.95	\$35.83	\$50.01	\$33.07	\$31.28	\$41.69	\$58.36
Employee + Child(ren) <small>(Child = Birth to Age 25, unmarried)</small>	\$26.16	\$25.19	\$25.23	\$31.51	\$29.46	\$28.28	\$29.42	\$37.49
Family	\$36.08	\$34.53	\$40.21	\$53.84	\$40.66	\$38.88	\$46.12	\$62.22

Accident Plus

Accident Plus is supplemental accident insurance that provides you with off-the-job coverage for accident-related expenses such as ambulance services, hospital confinement and medical treatment. It is a flexible plan that offers two levels of coverage. You receive benefits regardless of other in-force coverage, including primary medical insurance, so there is no coordination of benefits. Coverage also is available to your spouse and children. It is a plan that can protect the whole family and it has no calendar year maximum, so the benefit can be used over and over again.



Benefit levels

	Level Two	Level Four
Accident Medical Expense: Pays actual charges for physicians' treatment or other emergency room treatment. Pays up to the coverage amount, less a \$50 deductible for emergency room visits.	\$ 1,000	\$ 2,000
Ambulance Benefit: Pays actual charges, up to coverage amount, for ground ambulance service within a 100-mile radius and emergency air transportation.	\$ 500	\$ 1,000
Hospital Indemnity Benefit: Provides a daily benefit for hospital room charges for a maximum of 30 days, when the injury is a result of a covered accident.	\$ 150	\$ 300
Accidental Death, Dismemberment and Loss of Sight (AD&D): Provides a death benefit up to \$20,000 as a result of an accidental death. A percentage of the benefit is paid for dismemberment or loss of sight due to an accidental injury.		
Loss of life	\$ 10,000	\$ 20,000
Any combination of two or more hands, feet, or eyes	\$ 10,000	\$ 20,000
Loss of single hand, foot or eye	\$ 5,000	\$ 10,000
Multiple fingers and/or toes	\$ 1,000	\$ 2,000
Single finger and/or toe	\$ 500	\$ 1,000

Disability premium waiver

If the insured becomes disabled prior to age 67 as the result of injuries suffered in an accident, premiums will be waived for up to one year after six months of total and continuous disability.

Portability

Coverage is fully portable.

Additional benefits

Hospital Intensive Care: Provides coverage for intensive care costs due to a covered accidental injury. The benefit is payable for a maximum of 30 days for any one accident. Benefits are paid at \$300 per day.

Fracture and Dislocation: Pays a percentage of the selected benefit when a covered person suffers one of the fractures/dislocations listed, up to a maximum of \$1,500 for a single covered bone fracture.

Fractures

- Hip bone (pelvis) or femur100%
- Vertebra75%
- Skull (depressed or ping-pong fracture).....65%
- Leg (tibia or fibula)50%
- Bones of the foot, ankle, kneecap, hand, wrist or forearm (radius or ulna)40%
- Lower jaw, shoulder blade, collar bone35%
- Upper arm, upper jaw, skull (simple, non-depressed fracture)25%
- Facial bones (or nose)20%
- Finger, toe, rib or coccyx.....6%

Dislocations

- Hip100%
- Knee (does not include dislocation of the patella)50%
- Foot (does not include dislocation of the toes), ankle or shoulder35%
- Hand (does not include dislocation of fingers), lower jaw, wrist or elbow20%
- Finger, toe6%

Rates for Accident Plus plan

Monthly Premium; Benefits included in Base Rate: Bone Fracture & Dislocation; Hospital Intensive Care

BENEFIT	LEVEL 2		LEVEL 4	
	18 - 50	51 - 67	18 - 50	51 - 67
Employee Only	\$14.70	\$16.56	\$18.60	\$20.46
Employee + Spouse	\$29.40	\$33.12	\$37.20	\$40.92
Employee + Child(ren) <small>(Child = Birth to Age 25, unmarried)</small>	\$34.40	\$36.26	\$45.90	\$47.76
Family	\$49.10	\$52.82	\$64.50	\$68.22



Critical Illness Advantage Plus

Critical Illness Advantage Plus is insurance that helps protect you, your family and your assets in the event of a critical illness. It offers valuable peace of mind from the rising cost of specialized healthcare, which may not be covered by ordinary health insurance.



Benefits are paid directly to you upon diagnosis and can assist in covering a variety of expenses associated with a critical illness: out-of-pocket medical care costs, home healthcare, travel to and from treatment facilities, child care, and other expenses. This coverage helps at a time when you may have a loss of income due to absence from work as a result of a covered illness.

Base Benefit Coverage	\$5,000 to \$20,000 for employee \$2,500 to \$10,000 for spouse \$2,500 to \$5,000 for each eligible child
Vascular coverage benefits	Percent of benefit amount paid at initial diagnosis: <ul style="list-style-type: none"> ➤ Heart attack 100% ➤ Transplant as a result of heart failure 100% ➤ Stroke 100% ➤ Coronary artery bypass surgery as a result of coronary artery disease 25%
Cancer coverage benefits	Percent of benefit amount paid at initial diagnosis: <ul style="list-style-type: none"> ➤ First diagnosis of internal cancer or malignant melanoma 100% ➤ Carcinoma in situ 25%
Benefits for other critical illnesses	Percent of benefit amount paid at initial diagnosis: <ul style="list-style-type: none"> ➤ Transplant, other than heart 100% ➤ End-stage renal failure 100% ➤ Loss of sight, speech or hearing 100% ➤ Coma 100% ➤ Severe burns 100% ➤ Permanent paralysis due to an accident 100% ➤ Occupational HIV 100%
Additional Benefits	<p>Benefit recurrence: This provides an additional benefit for the same condition if a covered participant is treatment-free for at least 12 months.</p> <p>Health screening benefit: Pays \$100 for an annual health screening for each covered family member. This benefit is payable for services rendered after a 90-day waiting period from the effective date of coverage. There are 18 specific screenings that are covered.</p>

Pre-Existing Conditions Exclusion **12/12:** Covers pre-existing conditions after 12 months from the date of the policy.

Rates for Critical Illness plan

Monthly Premium; Benefits included in Base Rates: Recurrence Benefit, Health Screening Benefit (NTU: Non-tobacco user; TU: Tobacco user)

NOTE: You must elect employee coverage in order to elect dependent coverage, which will default to 50% of the employee election, subject to the maximum allowable.

Age	Employee – NTU			Employee - TU			Spouse - NTU			Spouse - TU		
	\$5,000	\$10,000	\$20,000	\$5,000	\$10,000	\$20,000	\$2,500	\$5,000	\$10,000	\$2,500	\$5,000	\$10,000
18-29	\$6.68	\$9.23	\$14.33	\$8.03	\$11.93	\$19.73	\$3.40	\$4.80	\$7.60	\$4.16	\$6.30	\$10.60
30-39	\$9.03	\$13.93	\$23.73	\$12.28	\$20.43	\$36.73	\$4.68	\$7.35	\$12.70	\$6.48	\$10.95	\$19.90
40-49	\$12.23	\$20.33	\$36.53	\$18.28	\$32.43	\$60.73	\$6.45	\$10.90	\$19.80	\$9.78	\$17.55	\$33.10
50-59	\$17.03	\$29.93	\$55.73	\$27.18	\$50.23	\$96.33	\$9.08	\$16.15	\$30.30	\$14.66	\$27.30	\$52.60
60-64	\$20.43	\$36.73	\$69.33	\$33.63	\$63.13	\$122.13	\$10.98	\$19.95	\$37.90	\$18.23	\$34.45	\$66.90
65-69	\$21.88	\$39.63	\$75.13	\$34.43	\$64.73	\$125.33	\$11.78	\$21.55	\$41.10	\$18.68	\$35.35	\$68.70

Child Rates

All children, birth to age 25, unmarried, are covered for one rate.

Children		
Age	\$2,500	\$5,000
0-24	\$2.33	\$3.65

Employee Assistance Program

FREE OF CHARGE: Employees and their immediate family members are eligible for three face-to-face counseling sessions per person per problem per year through Aetna Resources for Living, a nationally recognized leader in the field of EAP services.

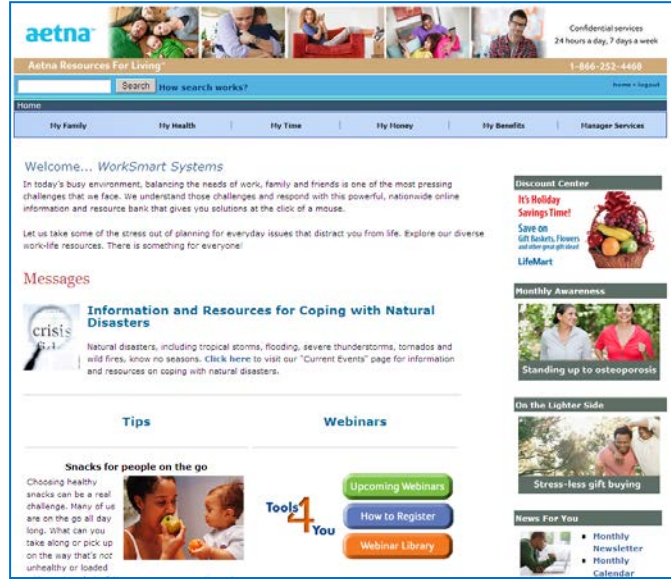
Toll-Free: 1.866.252.4468

Web Access: www.mylifevalues.com

Login ID: WorkSmart Systems

Password: eap

Our EAP offers much more than just counseling services! Go to the above website for great articles, newsletters, webinars, helpful information regarding selecting childcare and healthcare providers, shopping and travel discounts available through Aetna Resources for Living and its partners, a concierge service for dining and travel planning, and much more!



PNC WorkPlace Banking

FREE OF CHARGE: Bank-at-work benefit program that rewards you with a variety of banking solutions. **Free PNC pointsSM Rewards Program • Free PNC ATM Transactions • Competitive Interest Rates and More!**



WorkSmart Company Code: 5523328111

PNC WORKPLACE BANKING

Make the most of your money with PNC WorkPlace Banking's Performance Checking or Virtual Wallet[®] with Performance Spend. Open an account with direct deposit today to enjoy these great benefits and rewards:

- Competitive interest rates
- Free PNC-exclusive checks
- Unlimited check-writing
- Refer a Co-Worker Rewards
- Bonus rates on select Certificates of Deposit and IRA CDs
- Identity-Theft Reimbursement Insurance up to \$5,000⁴
- Interest rate discount on select consumer installment loans with automatic payment from a PNC Checking account.⁵
- Free onsite educational seminars on popular financial topics
- Free Overdraft Protection set up and transfers
- Free PNC ATMs and Non-PNC ATM transactions²
- Non-PNC ATM surcharges reimbursed up to \$8 per statement period²
- Free Savings account with Performance Checking and free Growth account with Virtual Wallet[®] with Performance Spend³
- Enhanced Rewards with a PNC Flex[®], PNC points, or PNC CashBuilder[®] Visa[®] Credit Card. Ask for details⁶

Plus, with WorkPlace Banking, you'll enjoy no monthly service charge when the total amount of all qualifying direct deposits during the monthly statement period is at least \$750.⁷

For more information:

Meghan Stewart

317-574-2117

or

Mikeeta Blair

317-841-9616

Company Code: 5523328111



¹ To earn points you must be enrolled in the PNC points program. Visit pnc.com/points for the PNC points Program Terms and Conditions for details. PNC Bank reserves the right to change or terminate the PNC points program at any time.

² WorkPlace Banking Performance Checking and Virtual Wallet with Performance Spend provide automatic reimbursement of non-PNC Bank ATM fees. Other financial institutions' surcharge fees will be reimbursed at the end of the monthly statement period, up to \$8 maximum.

³ See the Consumer Schedule of Service Charges and Fees, Virtual Wallet Performance Features and Fees, and other documents provided at new account opening for more information.

⁴ Covers up to \$5,000 out of pocket expenses incurred to regain your identity and to repair your credit. Certain restrictions and deductibles apply. Coverage applies to Primary checking account only, not to additional checking, savings or money market accounts. See the Summary Description of Benefits for the Personal, Internet and Identity Coverage Master Policy for details.

⁵ Discount only applicable as long as payments are set up for automatic deduction from a PNC Checking account. The removal of any discount, such as auto deduction or employee, will increase the rate.

⁶ All credit subject to approval.

⁷ For Performance or Virtual Wallet with Performance Spend, the monthly service charge can be avoided if the total amount of all qualifying direct deposits credited to your account during the monthly statement period is at least \$750. A qualifying Direct Deposit is defined as a recurring Direct Deposit of a paycheck or other regular monthly income electronically deposited into a Performance Checking account, or the Spend account for Virtual Wallet Performance, by an employer or outside agency. Transfers from one account to another, or deposits made at a branch or ATM, do not qualify as Direct



Appendix

Table of Contents

- Annual Notice 1
- WorkSmart Systems Privacy Practices.....5

Important Notices Regarding Your WorkSmart Systems Benefit Program

Please note, effective August 1, 2012, the WorkSmart Systems, Inc. welfare benefits plan was no longer considered a "grandfathered health plan" under the Patient Protection and Affordable Care Act.

NOTICE OF RIGHTS UNDER THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

If you are receiving benefits in connection with a mastectomy and you elect breast reconstruction in connection with such mastectomy, the WorkSmart Systems, Inc. Welfare Benefits Plan ("Plan") will provide coverage in a manner determined in consultation with you and your attending physician for (1) reconstruction of the breast on which the mastectomy will be performed, (2) surgery and reconstruction of the other breast to produce a symmetrical appearance, and (3) prostheses and physical complications at all stages of mastectomy, including lymphedemas. This coverage is subject to deductibles and coinsurance provisions which are described in detail in the Plan documents. In addition, the Plan will not (1) deny your eligibility or continued eligibility to enroll or to renew coverage under the terms of the Plan solely for purposes of avoiding this coverage, or (2) penalize or otherwise reduce or limit the reimbursement of an attending provider or provide incentives (monetary or otherwise) to an attending provider to induce the provider to provide care to you in manner that is inconsistent with this required coverage.

NOTICE OF TERMS OF PRE-EXISTING CONDITION EXCLUSION

The WorkSmart Systems Inc. Welfare Benefits Plan ("Plan") imposes a pre-existing condition exclusion. This means that if you have a medical condition before your coverage under the Plan commences, you might have to wait a certain period of time before the Plan will provide coverage for that condition. This exclusion applies only to

conditions for which medical advice, diagnosis, care, or treatment was recommended or received during a 90-day period that ends the day before your coverage becomes effective. This includes any injury or disease for which you received treatment or services or took prescribed drugs of medicine. However, if you were in a waiting period for coverage, the 90-day period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy, genetic information, or to a child under the age of 19 who is enrolled in the Plan within 31 days after birth, adoption, or placement for adoption.

This exclusion may last until 365 days from the date coverage begins. Note that as a result of the Patient Protection and Affordable Care Act, effective January 1, 2011, this exclusion will not apply to any covered person who is under the age of 19.

You can reduce the length of this exclusion period day for day by the number of days you were covered under prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion.* Your prior creditable coverage will not be counted if you have experienced a break in coverage of more than 63 days.

To reduce the applicable exclusion period by our creditable coverage, you should give us a copy of any certificates of creditable coverage you have from prior health plans or insurance companies. If you do not have a certificate, but you do have prior health coverage, we will help you obtain a certificate from your prior plan or insurance company. There are also other ways you can show that you have creditable coverage.

Please contact us if you need help demonstrating creditable coverage. All questions about the pre-existing

condition exclusion and creditable coverage should be directed to WorkSmart Systems, 9957 Crosspoint Blvd, Indianapolis, IN 46256, Phone: 317.585.7870.

**Prior health coverage that will count as creditable coverage includes prior employer-sponsored group health coverage, COBRA, individual insurance policies, Medicare A & B, Medicaid, military medical coverage programs, Indian health services or tribal programs, state health benefit risk pools, federal employee health benefit programs, public health benefit plans, Peace corps health benefits, and coverage under a state children's health insurance program.*

IMPORTANT NOTICE FROM WORKSMART SYSTEMS, 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 WorkSmart Systems, 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. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. 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. **Creditable Coverage.** WorkSmart Systems, Inc. has determined that the prescription drug coverages offered by the PPO options under the WorkSmart Systems, Inc. Welfare Benefits Plan are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

3. **Non-Creditable Coverage.** WorkSmart Systems, Inc. has determined that the prescription drug coverages offered by the high deductible health plan (HDHP) and health reimbursement account (HRA) options under the WorkSmart Systems, Inc. Welfare Benefits Plan are, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, this 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 these prescription drug coverages. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

You can keep this current non-creditable prescription drug coverage under the WorkSmart Systems, Inc. Welfare Benefits Plan. However, because this 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 15 through December 7. However, if you lose your current *creditable* prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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 WorkSmart Systems, Inc. coverage will be affected. Although you can keep this coverage if you elect Medicare part D prescription drug coverage, this Plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current WorkSmart Systems, Inc. coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

Creditable Coverage. You should also know that if you drop or lose your current *creditable* PPO option prescription drug coverage with WorkSmart Systems, Inc. and don't join a Medicare drug plan within 63 continuous days after your current *creditable* PPO option prescription drug coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without *creditable* prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that 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 (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

Non-Creditable Coverage. Since the HDHP and HRA options of prescription drug coverage under the WorkSmart Systems, Inc. Welfare Benefits Plan, are 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 that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without *creditable* prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that 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 (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage:

Contact the person listed below for further information:

Andrea Meyer
9957 Crosspoint Blvd.
Indianapolis, IN 46256
(317) 585-7870

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through WorkSmart Systems, 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 the 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 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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 1-800-772-1213 (TTY 1-800-325-0778).

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

**Medicaid and the Children's Health Insurance Program (CHIP)
Offer Free or Low-Cost Health Coverage to Children and Families**

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

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 call **1-877-KIDS-NOW** or go to **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.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

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, 2012. You should contact your State for further information on eligibility.

ALABAMA – Medicaid Website: http://www.medicaid.alabama.gov 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
ARIZONA – CHIP Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437
COLORADO – Medicaid Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In State): 1-800-866-3513 Medicaid Phone (Out of State): 1-800-221-3943
FLORIDA – Medicaid Website: http://www.flmedicaidprecovery.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: 1-800-869-1150
IDAHO – Medicaid and CHIP Medicaid Website: www.accessstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588
INDIANA – Medicaid Website: http://www.in.gov/fssa Phone: 1-800-889-9949
IOWA – Medicaid Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
KANSAS – Medicaid Website: https://www.kdheks.gov/hcf/ Phone: 800-792-4884
KENTUCKY – Medicaid Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570
LOUISIANA – Medicaid Website: http://www.lahipp.dhh.louisiana.gov 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/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629
MISSOURI - Medicaid Website: http://dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid
Website: http://medicaidprovider.hhs.mt.gov/clientpage/clientindex.shtml Telephone: 1-800-694-3084
NEBRASKA – Medicaid
Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278
NEVADA – Medicaid
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 1-603-271-5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 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: 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 and CHIP
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-877-314-5678
PENNSYLVANIA – Medicaid
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462
RHODE ISLAND – Medicaid
Website: www.ohhs.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/upp Phone: 1-866-435-7414
VERMONT – Medicaid
Website: http://www.greenmountaincare.org/ Telephone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
WASHINGTON – Medicaid
Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext.15473
WEST VIRGINIA – Medicaid
Website: http://www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid
Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid
Website: http://www.health.wyo.gov/healthcarefin/equalitycare Telephone: 307-777-7531

To see if any more States have added a premium assistance program since July 31, 2012, 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
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services www.cms.hhs.gov 1-877-267-2323, Ext. 61565

13049744.1 (OGLETREE)

WorkSmart Annual Notice 2012
Updated: 10.08.2012

WORKSMART SYSTEMS
NOTICE OF PRIVACY PRACTICES

Effective Date: *January 1, 2011*

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice, please contact Andrea Meyer, Privacy Officer, at 317.585.7870 for further information.

This Notice of Privacy Practices describes how the WorkSmart Systems employee benefits plans may use and disclose your protected health information to carry out claims payment or health care operations and for other purposes that are permitted or required by law. When this Notice uses the word "Plan," it means the Worksmart Systems Plan, the Worksmart Systems, Inc. Flexible Benefits Plan, or any other employee benefit programs providing medical, dental, and/or vision benefits that may be provided to you through Worksmart Systems. You may also receive a similar notice from the insurance companies and administrators associated with a specific benefit program.

This Notice also describes your rights to access and control your protected health information, as well as certain obligations we have regarding the use and disclosure of your protected health information. **"Protected health information" ("PHI")** is medical information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

The Plan is required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to your PHI. We are also required to abide by the terms of this Notice as currently in effect.

This Notice describes the Plan's privacy practices and that of all departments and units of the Plan, as well as all of the employees, staff and other Plan personnel. This notice also covers our third party "business associates" who perform various activities for us to provide you benefits or to operate the Plan. Before we disclose any of your PHI to one of our business associates, we will enter into a written contract with them that contains terms to protect the privacy of your PHI.

Uses And Disclosures Of Your Protected Health Information:

This Notice sets forth different reasons for which we may use and disclose your PHI. The Notice does not list every possible use and disclosure; however, all the reasons for which we are permitted to use and disclose your PHI are listed.

For Treatment. We will use and disclose your PHI as needed for a medical provider to treat you.

For Claims Payment. We will use and disclose your PHI so that the Plan may pay benefits. For example, we will use your PHI to provide reimbursement for health care services you have received. We may also use or disclose your PHI to obtain or pay premiums for your insurance coverage, to determine whether you are eligible for health benefits or other coverage, or to make coverage determinations based upon whether the claims you have incurred were for medically necessary treatment.

For Health Care Operations. We may use and disclose your PHI for the Plan's health care operations. These uses and disclosures are necessary to manage the Plan and to make sure that all participants receive quality health coverage. For example, we may use your PHI, as needed, to evaluate the quality of service

our staff has provided to you. In evaluating the services we provide, we may combine your PHI with others to get a practical idea of services we may need to offer, tailor, or eliminate. We may also disclose your PHI to the Plan's staff for learning purposes.

Health-Related Benefits and Services. We may use and disclose your PHI to inform you of health-related benefits or services that may be available to you.

Employer and PEO. The Plan will not disclose your PHI, to your worksite employer. We will disclose your PHI to Worksmart Systems, Inc., as your PEO employer, to use only as permitted in its capacity as Plan Sponsor and Plan Administrator.

Individuals Involved in Your Health Care or Payment for Your Health Care. We may disclose your PHI to a family member or friend who is involved in your medical treatment or care or in the financing of your health care. We will usually only provide payment information to your family members and friends, unless we have your written authorization that we can discuss PHI with the individual. For example, we will require your written authorization before we will disclose your PHI to your spouse or to your parents (in the case of an adult child). In more rare cases, we may inform your family or friends as to your condition, location, or death. If you are present, you will be given the opportunity to object to all of these disclosures. However, if you are not present, only a disclosure that is in your best interest and directly relevant to the inquiring person's involvement in your health care will be made. In addition, we may disclose PHI to a public or private entity assisting in a disaster relief effort so that your family can be notified as to your condition, location, or death, or so that care or rescue efforts can be coordinated.

As Required By Law. We will use and disclose your PHI when required to do so by federal, state or local law, to the extent that such use and disclosure is limited to the relevant requirements of such law.

Judicial and Administrative Proceedings. If you are involved in a legal proceeding, we may disclose your PHI in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request, or other lawful process by another person involved in the dispute, but only if we believe that the party seeking the PHI has made reasonable efforts to tell you about the request or to obtain an order protecting the information requested.

Workers' Compensation. We may disclose your PHI for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Other Uses and Disclosures Of Your Protected Health Information. Other uses and disclosures of your protected health information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you have given us your authorization, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose the PHI for the reasons covered by your written authorization, except to the extent that we have taken action in reliance on your authorization. Please note that we are unable to withdraw any disclosures we have already made with your written authorization and that we are required by law to maintain our records as to the health care that we have provided to you.

Your Rights Regarding Your Protected Health Information:

You have the following rights regarding your PHI which we maintain, as required by law:

Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for purposes of the Plan's payment activities or health care operations. You also have the right to request that we restrict the disclosure of your PHI from those involved in your health care or the payment for your health care, such as with a family member or friend. For example, you may request that we not use or disclose your PHI relating to a procedure you may have had. We are not required to

agree with your request for restrictions, except if your requested restriction is to prevent disclosure of PHI to a health plan for purposes of carrying out payment or health care operations (and not for treatment) and the PHI pertains solely to a health care item or service for which you have already paid a health care provider out-of-pocket in full. If we do agree to your request for restrictions, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communications. You have the right to request that we communicate with you about your personal health matters in a particular way or at a particular location. For example, you can request that we only contact you at work or at a friend's house.

Right to Inspect and Copy. You have the right to inspect and copy your PHI, which is kept in a designated record set. This may include medical and billing records, but does not include: (1) psychotherapy notes; (2) information compiled in anticipation of or for use in legal actions or proceedings; or (3) protected health information that is maintained by the Plan to which access is prohibited by law.

If the Plan uses or maintains an electronic health record with respect to your PHI, you have a right to obtain a copy of such information in an electronic format and, if you so choose, direct the covered entity to transmit such copy directly to another entity or person.

We may deny your request to inspect and copy in certain limited circumstances. In some circumstances, you may request that the denial be reviewed.

Right to Amend. You have the right to request that we amend your PHI that the Plan has created if it is incorrect or incomplete. We may deny your request for an amendment if the request does not include a reason to support the request for an amendment and in certain other circumstances.

Right to an Accounting of Disclosures of PHI. You have the right to request an accounting of certain disclosures of your PHI made by the Plan within the past six years from the date of your request. You will not receive an accounting of: disclosures the Plan has made to you; disclosures that have been made to carry out the Plan's payment activities or health care operations, if the disclosure was not made through an electronic health record; uses or disclosures permitted or required by law; disclosures made pursuant to an authorization from you; disclosures made as part of a limited data set; or any disclosures made prior to April 14, 2003. Beginning January 1, 2011, you have the right to request an accounting of disclosures of your PHI through an electronic health record made by the Plan to carry out the Plan's payment activities or health care operations within the past three years from the date of your request. In response to your request, the Plan will also provide you with a list of all business associates, with contact information, acting on behalf of the Plan.

How to Exercise Your Rights. To exercise any of your rights discussed in this notice contact the Plan's Privacy Officer, Andrea Meyer, WorkSmart Systems, 9957 Crosspoint Boulevard, Indianapolis, IN 46256, telephone number 317-585-7870, to obtain a form to submit your request in writing. You may also obtain the applicable forms from the Plan's website, <http://www.myWorkSmartHR.com>.

Right to a Paper Copy of this Notice. You have the right to receive a paper copy of this Notice. You may request that we give you a copy of this Notice at any time. You may obtain a copy of this Notice at our website, <http://www.myWorkSmartHR.com>. In the alternative, to obtain a paper copy of this Notice, please contact Andrea Meyer, Privacy Officer, WorkSmart Systems, 9957 Crosspoint Boulevard, Indianapolis, IN 46256, telephone number 317-585-7870.

Changes To This Notice:

We reserve the right to change the terms of this Notice. We reserve the right to make the new Notice provisions effective for all PHI we currently maintain, as well as any information we receive in the future. We will post a copy of the current Notice at WorkSmart Systems, 9957 Crosspoint Boulevard, Indianapolis, IN 46256. Please note, on the first page, in the top right-hand corner of the Notice, you will find the effective date. A Notice with a more recent date supersedes a Notice with an older date.

Complaints:

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. You will not be retaliated against or penalized for filing the complaint. To file a complaint with WorkSmart Systems, contact Andrea Meyer, Privacy Officer, at WorkSmart Systems, 9957 Crosspoint Boulevard, Indianapolis, IN 46256, telephone number 317.585.7870. All complaints must be submitted in writing.