2017 Employee Benefits Summary

Paid-Time-Off:
- Holidays: 10 paid days per calendar year – determined annually.
- Vacations: Based on pay grade and years of service; accrues on a fiscal-year basis (July 1 – June 30).
- Sick Time: One day per month up to a maximum accrual of 30 days.

Health/Dental/Vision Insurance:
- Premiums shared between Erikson and employee (see rates at the end of the plan summary).
- Eligible the first day of the month following 30 days of employment.
- HEALTH: 2 PPO plans, HDHP/HSA plan or an HMO plan. Coverage is through Blue Cross.
- DENTAL: 2 PPO plans or HMO plan options. Coverage is through Guardian.
- VISION: Voluntary plan available through VSP Vision.

Flexible Spending Accounts:
- Contributions are 100% employee paid and withheld pre-tax.
- Eligible the first day of the month following 30 days of employment.
- May withhold up to $2,600 for personal medical/dental/vision or $5,000 for dependent daycare expenses.

Life and Disability Insurance:
- Coverage provided by Lincoln Financial Group.
- Premiums are 100% paid by Erikson.
- Eligible the first day of the month following 90 days of employment.
    - Life: coverage equal to annual salary.
    - Accidental death and disability: coverage equal up to annual salary.
    - Short-term disability: $400/week for up to 13 weeks.
    - Long-term disability: 60% of monthly salary after 13 weeks of STD.

Transit/Parking Stipend: $85/month for transit on CTA, Metra or a monthly parking pass.

Retirement Plan:
- 403(b) defined contribution plan offered through TIAA.
- Eligible for employer match on date of hire.
- Employee vested after one year of employment.
- Contributions are withheld pre-tax up to the annual federally allowed maximum

MATCHING SCHEDULE

Employee	Erikson Match
2%	2%
4%	4%
6%	6%
7%	7%

rev. 12_07_2016

2017 Benefit Premiums

HEALTH	COVERAGE	Per Month	Per Pay*
HMO	*Employee*	$70	$35
	EE+SP/DP	$317	$159
	EE + Child(ren)	$264	$132
	Family	$514	$257
PPO *Classic*	*Employee*	$195	$97
	EE+SP/DP	$596	$298
	EE + Child(ren)	$484	$242
	Family	$887	$444
PPO *Value*	*Employee*	$111	$55
	EE+SP/DP	$408	$204
	EE + Child(ren)	$336	$168
	Family	$636	$318
HDHP	*Employee*	$78	$39
	EE+SP/DP	$336	$168
	EE + Child(ren)	$279	$139
	Family	$540	$270

NOTE = rounded

2017 Benefit Premiums

DENTAL	COVERAGE	Per Month	Per Pay
HMO	*EE*	$3.86	$1.93
	EE + 1	$11.65	$5.83
	EE+FAMILY	$17.91	$8.96
1500 PPO	*EE*	$11.00	$5.50
	EE + 1	$39.41	$19.71
	EE+FAMILY	$66.89	$33.45
2500 PPO	*EE*	$17.20	$8.60
	EE + 1	$53.12	$26.56
	EE+FAMILY	$88.31	$44.16

VISION	COVERAGE	Per Month	Per Pay
12-12-24 PLAN	*EE*	$6.15	$3.08
	EE+SPOUSE	$10.04	$5.02
	EE+CHILDREN	$9.83	$4.92
	EE+FAMILY	$16.19	$8.10

2017 - Erikson Holiday Calendar

Timecards Due | Pay Check | Holiday

JANUARY

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

FEBRUARY

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28				

MARCH

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

APRIL

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

MAY

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

JUNE

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

JULY

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

AUGUST

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

SEPTEMBER

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

OCTOBER

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

NOVEMBER

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

DECEMBER

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31	1/1/18	1/2/18	1/3/18	1/4/18	1/5/18	1/6/18

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbsil.com/member/policy-forms/2017 or by calling 1-800-541-2768.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Individual: Participating **$2,500** Non-Participating **$5,000** Family: Participating **$7,500** Non-Participating **$15,000** Doesn't apply to certain preventive care. Copays don't count toward the deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. Individual: Participating **$4,500** Non-Participating **$9,000** Family: Participating **$10,200** Non-Participating **$20,400** Prescription Drug expense limit: **$1,000** Individual **$3,000** Family	The **out-of-pocket** limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. See www.bcbsil.com or call **1-800-541-2768** for a list of Participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

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

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copayment/visit	40% coinsurance	Acupuncture not covered.
	Specialist visit	$40 copayment/visit	40% coinsurance	---none---
	Other practitioner office visit	$40 copayment/visit	40% coinsurance	Acupuncture not covered. Chiropractic services are limited to 30 visits per calendar year. Muscle manipulations are subject to the general payment level.
	Preventive care/screening/immunization	No Charge	40% coinsurance	---none---
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.bcbsil.com/member/prescription-drug-plan-information/drug-lists	Generic drugs	$10/$20 copayment/ prescription	$10 copayment/ prescription	Up to 30 day retail/90 day home delivery. Certain women's preventative services will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact customer service. For Non-Participating drug provider you are responsible for 25% of the eligible amount after the copayment. Payment of the difference between the cost of a brand name drug and a generic may also be required if a generic drug is available. RX Out-of-Pocket Expense Limit: $1,000 Individual/$3,000 Family.
	Formulary brand drugs	$40/$80 copayment/ prescription	$40 copayment/ prescription	
	Non-formulary brand drugs	$60/$120 copayment/ prescription	$60 copayment/ prescription	
	Specialty drugs	Covered	Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	---none---
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room services	$150 copayment/visit	$150 copayment/visit	Copayment waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	---none---
	Urgent care	20% coinsurance	40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	$300 copayment/visit plus 40% coinsurance	---none---
	Physician/surgeon fee	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/behavioral health outpatient services	$20 copayment/visit or 20% coinsurance	40% coinsurance	Preauthorization is required for Psychological testing; Neuropsychological testing; Electroconvulsive therapy; Repetitive Transcranial magnetic Stimulation; and Intensive Outpatient Treatment.
	Mental/behavioral health inpatient services	20% coinsurance	$300 copayment/visit plus 40% coinsurance	---none---
	Substance use disorder outpatient services	$20 copayment/visit or 20% coinsurance	40% coinsurance	Preauthorization is required for Psychological testing; Neuropsychological testing; Electroconvulsive therapy; Repetitive Transcranial magnetic Stimulation; and Intensive Outpatient Treatment.
	Substance use disorder inpatient services	20% coinsurance	$300 copayment/visit plus 40% coinsurance	---none---
If you are pregnant	Prenatal and postnatal care	$20 copayment	40% coinsurance	Copayment applies to first prenatal visit per pregnancy.
	Delivery and all inpatient services	20% coinsurance	$300 copayment/visit plus 40% coinsurance	---none---
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	---none---
	Rehabilitation services	20% coinsurance	40% coinsurance	
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	
	Durable medical equipment	20% coinsurance	40% coinsurance	Benefits are limited to items used to serve a medical purpose. DME benefits are provided for both purchase and rental equipment (up to the purchase price).
	Hospice service	20% coinsurance	40% coinsurance	---none---

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	---none---
	Glasses	Not Covered	Not Covered	
	Dental check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

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

- Abortions (Except where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless an abortion is performed)
- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long term care
- Most coverage provided outside the United States. See www.bcbsil.com
- Routine eye care (Adult)
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care
- Infertility treatment (4 invitro attempt maximum with special approval up to 6 per lifetime)
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine foot care (Only in connection with diabetes)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 1-800-541-2768. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Blue Cross and Blue Shield of Illinois at 1-800-541-2768 or visit www.bcbsil.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance at (877) 527-9431 or visit http://insurance.illinois.gov.

Does this Coverage Provide Minimum Essential Coverage?

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

Does this Coverage Meet the Minimum Value Standard?

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-541-2768.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-541-2768.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-541-2768.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-541-2768.

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

About These Coverage Examples:

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

This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $3,920
- **Patient pays** $3,620

Sample care costs:

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

Patient pays:

Deductibles	$2,500
Copays	$20
Coinsurance	$950
Limits or exclusions	$150
Total	**$3,620**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,340
- **Patient pays** $3,060

Sample care costs:

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

Patient pays:

Deductibles	$2,500
Copays	$320
Coinsurance	$160
Limits or exclusions	$80
Total	**$3,060**

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

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Important Questions	Answers	Why this Matters:
What is the overall deductible?	Individual: Participating **$1,000** Non-Participating **$2,000** Family: Participating **$3,000** Non-Participating **$6,000** Doesn't apply to certain preventive care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. Individual: Participating **$2,000** Non-Participating **$4,000** Family: Participating **$6,000** Non-Participating **$12,000** Prescription Drug expense limit: **$1,000** Individual **$3,000** Family	The **out-of-pocket** limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. See www.bcbsil.com or call **1-800-541-2768** for a list of Participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

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

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copayment/visit	40% coinsurance	Acupuncture not covered.
	Specialist visit	$50 copayment/visit	40% coinsurance	---none---
	Other practitioner office visit	$50 copayment/visit	40% coinsurance	Acupuncture not covered. Chiropractic services are limited to 30 visits per calendar year.
	Preventive care/screening/immunization	No Charge	40% coinsurance	---none---
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.bcbsil.com/member/prescription-drug-plan-information/drug-lists	Generic drugs	$15/$30 copayment/ prescription	$15 copayment/ prescription	Up to 30 day retail/90 day home delivery. Certain women's preventative services will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact customer service. For Non-Participating drug provider you are responsible for 25% of the eligible amount after the copayment. RX Out-of-Pocket Expense Limit: $1,000 Individual/$3,000 Family.
	Formulary brand drugs	$30/$60 copayment/ prescription	$30 copayment/ prescription	
	Non-formulary brand drugs	$50/$100 copayment/ prescription	$50 copayment/ prescription	
	Specialty drugs	Covered	Covered	

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	---none---
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room services	$150 copayment/visit	$150 copayment/visit	Copayment waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	---none---
	Urgent care	20% coinsurance	40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	$300 copayment/visit plus 40% coinsurance	---none---
	Physician/surgeon fee	20% coinsurance	40% coinsurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/behavioral health outpatient services	$30 copayment/visit or 20% coinsurance	40% coinsurance	Preauthorization is required for Psychological testing; Neuropsychological testing; Electroconvulsive therapy; Repetitive Transcranial magnetic Stimulation; and Intensive Outpatient Treatment.
	Mental/behavioral health inpatient services	20% coinsurance	$300 copayment/visit plus 40% coinsurance	---none---
	Substance use disorder outpatient services	$30 copayment/visit or 20% coinsurance	40% coinsurance	Preauthorization is required for Psychological testing; Neuropsychological testing; Electroconvulsive therapy; Repetitive Transcranial magnetic Stimulation; and Intensive Outpatient Treatment.
	Substance use disorder inpatient services	20% coinsurance	$300 copayment/visit plus 40% coinsurance	---none---
If you are pregnant	Prenatal and postnatal care	$30 copayment	40% coinsurance	Copayment applies to first prenatal visit per pregnancy.
	Delivery and all inpatient services	20% coinsurance	$300 copayment/visit plus 40% coinsurance	---none---

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	---none---
	Rehabilitation services	20% coinsurance	40% coinsurance	
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	
	Durable medical equipment	20% coinsurance	40% coinsurance	Benefits are limited to items used to serve a medical purpose. DME benefits are provided for both purchase and rental equipment (up to the purchase price).
	Hospice service	20% coinsurance	40% coinsurance	---none---
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	---none---
	Glasses	Not Covered	Not Covered	
	Dental check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

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

- Abortions (Except where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless an abortion is performed)
- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long term care
- Most coverage provided outside the United States. See www.bcbsil.com
- Routine eye care (Adult)
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care
- Infertility treatment (4 invitro attempt maximum with special approval up to 6 per lifetime)
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine foot care (Only in connection with diabetes)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 1-800-541-2768. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Blue Cross and Blue Shield of Illinois at 1-800-541-2768 or visit www.bcbsil.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance at (877) 527-9431 or visit http://insurance.illinois.gov.

Does this Coverage Provide Minimum Essential Coverage?

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

Does this Coverage Meet the Minimum Value Standard?

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-541-2768.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-541-2768.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-541-2768.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-541-2768.

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

About These Coverage Examples:

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

This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,390
- **Patient pays** $2,150

Sample care costs:

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

Patient pays:

Deductibles	$1,000
Copays	$30
Coinsurance	$970
Limits or exclusions	$150
Total	**$2,150**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,350
- **Patient pays** $2,050

Sample care costs:

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

Patient pays:

Deductibles	$1,000
Copays	$750
Coinsurance	$220
Limits or exclusions	$80
Total	**$2,050**

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbsil.com/member/policy-forms/2017 or by calling 1-800-541-2768.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Individual: Participating **$2,600** Non-Participating **$5,200** Family: Participating **$5,200** Non-Participating **$10,400** Doesn't apply to certain preventive care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. Individual: Participating **$2,600** Non-Participating **$10,400** Family: Participating **$5,200** Non-Participating **$20,800**	The **out-of-pocket** limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. See www.bcbsil.com or call **1-800-541-2768** for a list of Participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

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

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge	20% coinsurance	Acupuncture not covered.
	Specialist visit	No Charge	20% coinsurance	---none---
	Other practitioner office visit	No Charge	20% coinsurance	Acupuncture not covered. Chiropractic services are limited to 30 visits per calendar year.
	Preventive care/screening/immunization	No Charge	20% coinsurance	---none---
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	20% coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	No Charge	20% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.bcbsil.com/member/prescription-drug-plan-information/drug-lists	Formulary generic drugs	No Charge	No Charge	Up to 30 day retail/90 day home delivery. Certain women's preventative services will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact customer service.
	Non-formulary generic drugs	No Charge	No Charge	
	Formulary brand drugs	No Charge	No Charge	
	Non-formulary brand drugs	No Charge	No Charge	
	Specialty drugs	No Charge	No Charge	

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	20% coinsurance	---none---
	Physician/surgeon fees	No Charge	20% coinsurance	
If you need immediate medical attention	Emergency room services	No Charge	No Charge	---none---
	Emergency medical transportation	No Charge	No Charge	
	Urgent care	No Charge	20% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	$300 copayment/visit plus 20% coinsurance	---none---
	Physician/surgeon fee	No Charge	20% coinsurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/behavioral health outpatient services	No Charge	20% coinsurance	Preauthorization is required for Psychological testing; Neuropsychological testing; Electroconvulsive therapy; Repetitive Transcranial magnetic Stimulation; and Intensive Outpatient Treatment.
	Mental/behavioral health inpatient services	No Charge	$300 copayment/visit plus 20% coinsurance	---none---
	Substance use disorder outpatient services	No Charge	20% coinsurance	Preauthorization is required for Psychological testing; Neuropsychological testing; Electroconvulsive therapy; Repetitive Transcranial magnetic Stimulation; and Intensive Outpatient Treatment.
	Substance use disorder inpatient services	No Charge	$300 copayment/visit plus 20% coinsruance	---none---
If you are pregnant	Prenatal and postnatal care	No Charge	20% coinsurance	---none---
	Delivery and all inpatient services	No Charge	$300 copayment/visit plus 20% coinsurance	

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	20% coinsurance	---none---
	Rehabilitation services	No Charge	20% coinsurance	
	Habilitation services	No Charge	20% coinsurance	
	Skilled nursing care	No Charge	20% coinsurance	
	Durable medical equipment	No Charge	20% coinsurance	Benefits are limited to items used to serve a medical purpose. DME benefits are provided for both purchase and rental equipment (up to the purchase price).
	Hospice service	No Charge	20% coinsurance	---none---
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	---none---
	Glasses	Not Covered	Not Covered	
	Dental check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

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

- Abortions (Except where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless an abortion is performed)
- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long term care
- Most coverage provided outside the United States. See www.bcbsil.com
- Routine eye care (Adult)
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care
- Infertility treatment (4 invitro attempt maximum with special approval up to 6 per lifetime)
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine foot care (Only in connection with diabetes)

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Does this Coverage Provide Minimum Essential Coverage?

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

Does this Coverage Meet the Minimum Value Standard?

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-541-2768.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-541-2768.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-541-2768.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-541-2768.

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

About These Coverage Examples:

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

This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,790
- **Patient pays** $2,750

Sample care costs:

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

Patient pays:

Deductibles	$2,600
Copays	$0
Coinsurance	$0
Limits or exclusions	$150
Total	**$2,750**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,720
- **Patient pays** $2,680

Sample care costs:

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

Patient pays:

Deductibles	$2,600
Copays	$0
Coinsurance	$0
Limits or exclusions	$80
Total	**$2,680**

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbsil.com/member/policy-forms/2017 or by calling 1-800-892-2803.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. Individual: Participating **$1,500** Family: Participating **$3,000** Prescription Drug expense limit: **$1,000** Individual **$3,000** Family	The **out-of-pocket** limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. See www.bcbsil.com or call **1-800-892-2803** for a list of Participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes. Yes.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

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

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copayment/visit	Not Covered	---none---
	Specialist visit	$50 copayment/visit	Not Covered	Referral required.
	Other practitioner office visit	$50 copayment/visit	Not Covered	Referral required. Acupuncture not covered.
	Preventive care/screening/immunization	No Charge	Not Covered	No charge for immunizations.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	Referral required.
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.bcbsil.com/member/prescription-drug-plan-information/drug-lists	Generic drugs	$15/$30 copayment/ prescription	Not Covered	Dispensing limit may apply to certain drugs. Up to 30 day retail/90 day home delivery. Certain women's preventative services will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact customer service. RX Out-of-Pocket Expense Limit: $1,000 Individual/$3,000 Family.
	Formulary brand drugs	$30/$60 copayment/ prescription	Not Covered	
	Non-formulary brand drugs	$50/$100 copayment/ prescription	Not Covered	
	Specialty drugs	Covered	Not Covered	

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	Referral required.
	Physician/surgeon fees	No Charge	Not Covered	
If you need immediate medical attention	Emergency room services	$150 copayment/visit	$150 copayment/visit	Copayment waived if admitted.
	Emergency medical transportation	No Charge	No Charge	---none---
	Urgent care	No Charge	Not Covered	Applicable copayment may apply. Must be affiliated with member's chosen medical group or referral required.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	Referral required.
	Physician/surgeon fee	No Charge	Not Covered	
If you have mental health, behavioral health, or substance abuse needs	Mental/behavioral health outpatient services	$30 copayment/visit	Not Covered	Referral required.
	Mental/behavioral health inpatient services	No Charge	Not Covered	
	Substance use disorder outpatient services	$30 copayment/visit	Not Covered	
	Substance use disorder inpatient services	No Charge	Not Covered	
If you are pregnant	Prenatal and postnatal care	$30 copayment	Not Covered	Copayment applies to first prenatal visit per pregnancy.
	Delivery and all inpatient services	No Charge	Not Covered	Referral required.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Referral required.
	Rehabilitation services	No Charge	Not Covered	Referral Required. 60 visits combined/calendar year. Includes, but is not limited to, physical, occupational or speech therapy. copayment may apply.
	Habilitation services	No Charge	Not Covered	
	Skilled nursing care	No Charge	Not Covered	Referral required. Excludes custodial care.
	Durable medical equipment	No Charge	Not Covered	Referral required. Benefits are limited to items used to serve a medical purpose. DME benefits are provided for both purchase and rental equipment (up to the purchase price).
	Hospice service	No Charge	Not Covered	Referral required.
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	1 exam every 12 months
	Glasses	Not Covered	Not Covered	---none---
	Dental check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

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

- Abortions (Except where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless an abortion is performed)
- Acupuncture
- Bariatric surgery (unless medically necessary)
- Cosmetic surgery
- Dental care
- Hearing aids
- Long term care
- Most coverage provided outside the United States. See www.bcbsil.com
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Weight loss programs

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

- Chiropractic care
- Infertility treatment (4 invitro attempt maximum with special approval up to 6 per lifetime)
- Routine eye care (Adult)
- Routine foot care (Only in connection with diabetes)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 1-800-892-2803. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Blue Cross and Blue Shield of Illinois at 1-800-892-2803 or visit www.bcbsil.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance at (877) 527-9431 or visit http://insurance.illinois.gov.

Does this Coverage Provide Minimum Essential Coverage?

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

Does this Coverage Meet the Minimum Value Standard?

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-892-2803.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-892-2803.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-892-2803.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-892-2803.

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

About These Coverage Examples:

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

This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,340
- **Patient pays** $200

Sample care costs:

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

Patient pays:

Deductibles	$0
Copays	$50
Coinsurance	$0
Limits or exclusions	$150
Total	**$200**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,420
- **Patient pays** $980

Sample care costs:

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

Patient pays:

Deductibles	$0
Copays	$900
Coinsurance	$0
Limits or exclusions	$80
Total	**$980**

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

- Review your benefits
- Complete your enrollment form, if applicable
- Sign and return form to your plan administrator

Welcome

Dear Erikson Institute Employee,

We're pleased to tell you that Guardian will be our coverage provider this year. We have chosen Guardian because of its competitive rates, excellent service reputation, and extensive plan designs.

We have worked hard to negotiate group rates that will be affordable for all employees. All coverage is paid through payroll deduction.

Erikson Institute

UNDERSTAND YOUR COVERAGE:

Plan Details This booklet explains your basic plan options. Your detailed certificate of benefits will be provided to you after you enroll.

Go online Learn more about your plans at www.guardianlife.com.

Ask your plan administrator Change your plan by contacting your plan administrator.

Notes:

Why Dental Insurance?

Good oral hygiene is important, not only for looks, but for general health as well. A routine dental examination can detect symptoms of more than 125 diseases, including heart disease, diabetes, anemia, stomach ulcers, osteoporosis and kidney disease. Regular check ups and cleanings can save you the pain and expense of future problems. Dental insurance will keep these visits affordable and is a cost-effective way to minimize health care costs for you and your family. The American Dental Hygienists' Association estimates that for every $1 spent on prevention or oral health care, as much as $8 to $50 is saved on future emergency and restorative procedures. Using your dental insurance for regular dental check ups can improve your health by helping you:

1) **Prevent Oral Cancer:** According to The Oral Cancer Foundation, someone dies from oral cancer every hour of every day in the United States alone. When you have your dental cleaning, your dentist is also screening you for oral cancer, which is highly curable if diagnosed early.
2) **Prevent Gum Disease:** Gum disease is an infection in the gum tissues and bone that keep your teeth in place and is one of the leading causes of adult tooth loss. If diagnosed early, it can be treated and reversed. If treatment is not received, a more serious and advanced stage of gum disease may follow. Regular dental cleanings and check ups, flossing daily and brushing twice a day are key factors in preventing gum disease.
3) **Help Maintain Good Physical Health:** Recent studies have linked heart attacks and strokes to gum disease, resulting from poor oral hygiene. A dental cleaning every six months helps to keep your teeth and gums healthy and could possibly reduce your risk of heart disease and strokes, as well as many other serious conditions.
4) **Keep Your Teeth:** Since gum disease is one of the leading causes of tooth loss in adults, regular dental check ups and cleanings, brushing and flossing are vital to keeping as many teeth as you can. Keeping your teeth means better chewing function and ultimately, better health.
5) **Prevent the Need for Advanced Treatment:** Your dentist and hygienist will be able to detect any early signs of problems with your teeth or gums that can be easily treatable. If these problems go untreated, root canals, gum surgery and removal of teeth could become the only treatment options available.
6) **Have a Bright and White Smile:** Your dental hygienist can remove most tobacco, coffee and tea stains. During your cleaning, your hygienist will also polish your teeth to a beautiful shine.
7) **Protect your children's health:** Tooth decay is the most common chronic childhood disease, five times more common than asthma and results in a loss of 51 million school hours each year. Regular check ups can help prevent tooth decay in your children.

Sources: www.about.com, American Academy of Pediatrics

Dental Plans

Option 1: With your **DHMO PrePaid U Plan** plan, you enjoy negotiated discounts from our network dentists. You pay a fixed copay for each covered service. Out-of-network visits are not covered.
Option 2 or 3: With your **Dental $1500 Plan or Dental $2500 Plan** plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist.

Your Dental Plan	Option 1: DHMO PrePaid U Plan	Option 2: Dental $1500 Plan		Option 3: Dental $2500 Plan	
Network	First Commonwealth	DentalGuard Preferred		DentalGuard Preferred	
Calendar year deductible		*In-Network*	*Out-Network*	*In-Network*	*Out-Network*
Individual	No deductible	$50	$50	$25	$50
Family limit		3 per family		3 per family	
Waived for		Preventive	None	Preventive	None
Charges covered for you (co-insurance)	*Network only*	*In-Network*	*Out-Network*	*In-Network*	*Out-Network*
Preventive Care	You pay a copay for each	100%	100%	100%	100%
Basic Care	covered procedure. See	90%	80%	100%	80%
Major Care	"Plan Details", for	60%	50%	60%	50%
Orthodontia	more information.	50%	50%	50%	50%
Annual Maximum Benefit	Unlimited	$1500	$1500	$2500	$2500
Maximum Rollover	Maximum Rollover is not	Yes		Yes	
Rollover Threshold	applicable for this plan type.	$700		$900	
Rollover Amount		$350		$450	
Rollover In-network Amount		$500		$700	
Rollover Account Limit		$1250		$1500	
Lifetime Orthodontia Maximum	Not Applicable	$1500		$1500	
Office visit copay	$5	None		None	
Dependent Age Limits	26 ‡	26 ‡		26 ‡	

‡**Family coverage** for spouse and children. The limiting age for unmarried dependents is extended to age 30 if the dependent is a resident of Illinois and has received a release or discharge, other than dishonorable discharge, from military service.

YOUR GUARDIAN PLAN OFFERS:

Coverage of ViziLite Plus early cancer detection screening exams

Maximum rollover If a member submits at least one claim and stays under the claims threshold, a part of the unused maximum will be rolled over for use in future years.

Great selection of dentists convenient to you - yours is likely in our network!

Reliable claims payment four days on average

Plan coverage begins January 01, 2015

Find out if your dentist is in Guardian's network at www.GuardianAnytime.com

Let Guardian put its 30-plus years of dental benefits experience to work for you and your family.

CATEGORY	PLAN DETAILS	Option 1: DHMO PrePaid U Plan	Option 2: Dental $1500 Plan		Option 3: Dental $2500 Plan	
		You Pay	*Plan pays (on average)*		*Plan pays (on average)*	
		Network only	*In-network*	*Out-of-network*	*In-network*	*Out-of-network*
Preventive Care	Cleaning (prophylaxis)	$0	100%	100%	100%	100%
	Frequency:	2 times in 12 months^	Once Every 6 Months		Once Every 6 Months	
	Fluoride Treatments	$0-12	100%	100%	100%	100%
	Limits:	No Age Limits	Under Age 19		Under Age 19	
	Oral Exams	$0	100%	100%	100%	100%
	Sealants (per tooth)	$8	100%	100%	100%	100%
	X-rays	$0	100%	100%	100%	100%
Basic Care	Fillings‡	$20-30	90%	80%	100%	80%
	Perio Surgery	$105-210	90%	80%	100%	80%
	Periodontal Maintenance	$28	90%	80%	100%	80%
	Frequency:	2 times in 12 months^ (Standard)	Once Every 3 Months (Enhanced)		Once Every 3 Months (Enhanced)	
	Root Canal	$126-192	90%	80%	100%	80%
	Scaling & Root Planing (per quadrant)	$25-42	90%	80%	100%	80%
	Simple Extractions	$23	90%	80%	100%	80%
Major Care	Anesthesia*	Restrictions Apply	60%	50%	60%	50%
	Bridges and Dentures	$580-675	60%	50%	60%	50%
	Dental Implants	Not Covered	Not Covered	Not Covered	60%	50%
	Inlays, Onlays, Veneers**	$250-420	60%	50%	60%	50%
	Repair & Maintenance of Crowns, Bridges & Dentures	$16-230	60%	50%	60%	50%
	Single Crowns	$430-450	60%	50%	60%	50%
	Surgical Extractions	$46-116	60%	50%	60%	50%
Orthodontia	Orthodontia	$2,500-2,800	50%	50%	50%	50%
	Limits:	Adults & Child(ren)	Child(ren)		Child(ren)	
Cosmetic Care	Bleaching	$165	Not Covered	Not Covered	Not Covered	Not Covered

This is only a partial list of dental services. Your certificate of benefits will show exactly what is covered and excluded. **For PPO and or Indemnity members, Crowns, Inlays, Onlays and Labial Veneers are covered only when needed because of decay or injury or other pathology when the tooth cannot be restored with amalgam or composite filing material. When Orthodontia coverage is for "Child(ren)" only, the orthodontic appliance must be placed prior to the age limit set by your plan; If full-time status is required by your in order to remain insured after a certain age; then orthodontic maintenance may continue as long as full-time student status is maintained. If Orthodontia coverage is for "Adults and Child(ren)" this limitation does not apply. The total number of cleanings and periodontal maintenance procedures are combined in a 12 month period.*General Anesthesia - restrictions apply. ‡For PPO and or Indemnity members, Fillings- restrictions may apply to composite fillings. (^Additional cleanings are available for an additional co-pay).

Please note: The plan details listed here are some of the most common services related to dental coverage. The co-insurance percentages for the PPO plan options correspond to the coverage categories of Preventive, Basic, Major and Orthodontia listed in the table above.

Please Note: For your pre-paid plan, coinsurances relate to a fixed copayment amount, please refer to your plan schedule.

Some services may be paid under a different category than listed. The actual co-insurance shown reflects your plan's coverage.

EXCLUSIONS AND LIMITATIONS

- Important Information about Guardian's DentalGuard Indemnity and DentalGuard Preferred PPO plans: This policy provides dental insurance only. Coverage is limited to those charges that are necessary to prevent, diagnose or treat dental disease, defect, or injury. Deductibles apply. The plan does not pay for: oral hygiene services (except as covered under preventive services), orthodontia (unless expressly provided for), cosmetic or experimental treatments (unless they are expressly provided for), any treatments to the extent benefits are payable by any other payor or for which no charge is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment. The plan limits benefits for diagnostic consultations and for preventive, restorative, endodontic, periodontic, and prosthodontic services. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract # GP-1-DG2000 et al.

- Important information about First Commonwealth Inc.'s and their subsidiaries' dental plans (Illinois, Missouri, Michigan, and Indiana): This plan provides pre-paid dental benefits through a network of participating general dentists and specialty care dentists. All covered services must be provided by member's Primary Care Dentist. Specialty care services are covered only when referred by the member's Primary Care Dentist and approved in advance by First Commonwealth. Only those services listed in the plan are covered. Certain services are subject to annual or other periodic limitations. Where orthodontic benefits are specifically included, the plan provides for one course of comprehensive treatment per lifetime, per member. Unless specifically included, the First Commonwealth plan does not provide orthodontic benefits if comprehensive orthodontic treatment or retention is in progress as of the member's effective date under First Commonwealth plan. The services, exclusions and limitations listed here do not constitute a contract and are a summary only. The First Commonwealth plan documents are the final arbiter of coverage. INS GMC 11/97; (IL) FCW-GMC-IL-08; (IN) FCW-GMC-IN-08; (MO) FCW-GMC-MO-08; (MI) FCW-GMC-MI--08

- **For PPO and or Indemnity Special Limitation:** Teeth lost or missing before a covered person becomes insured by this plan. A covered person may have one or more congenitally missing teeth or have lost one or more teeth before he became insured by this plan. We won't pay for a prosthetic device which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the covered person became insured by this plan. R3 – DG2000

UNDERSTANDING YOUR BENEFITS—DENTAL

Basic care	Moderately complex dental services. Most plans consider fillings and extractions to be basic care.
Co-insurance	The portion of the covered charge paid by Guardian.
Claims Payment Basis	**Dental $1500 Plan or Dental $2500 Plan** The usual cost for a specific dental service in your area. Amounts over the specified Usual Customary & Reasonable percentile (90%) are usually the patient's responsibility: **In-Network:** Benefits are based on a negotiated contracted fee schedule, and no balance billing. **Out-of-Network:** Benefits are based on usual, reasonable, and customary rates for a given area.
Deductible	The amount of charges you and your family must pay each plan year before the plan pays you any benefits.
Dental office number	The unique identification number assigned to a dental provider. Each family member must select a primary care dentist and enter his or her number on the enrollment form.
Family limit	Maximum number of deductibles your family must pay in each plan year before this plan starts paying benefits for all covered family members for the rest of the plan year.
In-network charges	Charges for services provided by dentists who are a member of your plan's network.
Major care	More complex dental services. Most plans consider crowns and dentures to be major care.
Out-of-network charges	Charges for services provided by dentists who are not members of your plan's network.
Plan year	The 12 month period used to apply this plan's deductible and annual maximum. Your plan's plan year is the calendar year.
PPO (Preferred Provider Organization)	Plan that lets you visit any dentist, but usually provides better benefits for the services of PPO network dentists. PPO dentists have agreed to accept discounted fees as payment in full.
Pre-determination Review	Guardian will gladly assist you and your dentist by determining what benefits could be payable for services and procedures over $300. Have your dentist fax your treatment plan to Guardian, note that it is a pre-determination review and we will let your dentist know what benefits would be payable. This includes orthodontic treatment if your plan includes it. Pre-determination applies to PPO and Indemnity plans only.
Pre-Paid Plan	A plan that requires you to visit a network dentist. You pay a fixed copay to the dentist for each service performed. No benefits are available for services of dentists who are not in the network.
Preventive care	Most routine dental services. Most plans consider checkups and cleanings to be preventive care.

GUARDIAN®

It's easy to use your Guardian Dental Benefits

Your dental benefits are designed to save you money and protect your health. Guardian is committed to making it as easy as possible for you to use and understand your dental benefits, with customer service you can depend on. Whether online or over the phone – we are there for you!

www.GuardianAnytime.com

GUARDIAN ANYTIME®

Offering instant access to your Guardian Benefits information

Your Group ID number required to register

Find an in-network dentist

–the best way to save on dental care!

- Simply click on **Find a Provider** and select **PPO**
- Follow the easy steps to search

App available for both iPhone and Android smartphones

Download the App at www.GuardianAnytime.com/mobile

View/print your ID card

No need for an ID card to use your Guardian dental benefits. Simply provide your Group ID number to your dental office at the first visit. However, if you'd like to print out a copy of your ID card, visit the Forms and Materials section of Guardian Anytime – it's fast and easy.

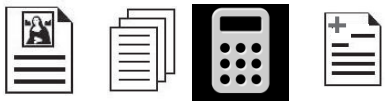
ID CARD OPTIONAL

BUT NOT REQUIRED

Access to an array of tools

Guardian Anytime includes easy to use tools to help understand the value of your benefits. This includes educational articles and the dental cost estimator tool.

Articles **Forms** **Tools** **Claims**



CUSTOMER RESPONSE UNIT

800-541-7846
Monday – Friday
8:00 AM to 8:30 PM Eastern Time

Speak to a live representative about your benefits, claims inquiries or help using the Guardian Anytime web site.

Find a Provider

How to Look Up Managed DentalGuard "U" Plan Providers Online

Guardian's innovative web technology lets you look up a provider right from your computer. Our Find a Provider Search function is simple and easy-to-use. Just follow these steps:

Visit Guardian's web page at www.GuardianAnytime.com:

- Click on "Find A Provider" at the top of the page
- Click on the box that says "Find a Dentist"

On the next web page, do the following:

- Under "Select Your Dental Plan" choose **DHMO/MDG/Pre-Paid**
- Under "Search by" click the circle next to "Search by Location", "Location & Dentist's Name", or "Location & Office Practice Name".
- Under "Your Location", enter Zip Code or Street Address information
- Under "Distance" select your mile radius, then Under "Select your Dental Network" **Choose – First Commonwealth DHMO**
  Note: You also have the option to include type of Dentist, foreign language spoken, and office status in your search.
- Click "Continue" to view the list of network providers
- **If the listing is noted, "Does not accept MDG "U" Plans", you will need to select a different provider. Please also note the "Office Status" information for the provider to ensure the provider is accepting new patients.**

You can also find a dentist on the go from your smart phone – simply download our app at www.GuardianAnytime.com/mobile.

CDT Codes ++	Covered Dental Services	Patient Charges
D0999	Office visit during regular hours, general dentist only *	$5
	Evaluations	
D0120	Periodic oral examination – established patient	0
D0140	Limited oral evaluation – problem focused	0
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	0
D0150	Comprehensive oral evaluation – new or established patient	0
D0170	Re-evaluation – limited, problem focused (established patient, not post-operative visit)	0
D0180	Comprehensive periodontal evaluation – new or established patient	0
	Radiographs/Diagnostic Imaging (Including Interpretation)	
D0210	Intraoral – complete series (including bitewings)	0
D0220	Intraoral – periapical first film	0
D0230	Intraoral – periapical each additional film	0
D0240	Intraoral – occlusal film	0
D0270	Bitewing – single film	0
D0272	Bitewings – two films	0
D0273	Bitewings – three films	0
D0274	Bitewings – four films	0
D0277	Vertical bitewings – 7 to 8 films	0
D0330	Panoramic film	0
	Tests and Examinations	
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	50
D0460	Pulp vitality tests	0
D0470	Diagnostic casts	0
	Dental Prophylaxis	
D1110	Prophylaxis – adult, for the first two services in any 12-month period + #	0
D1120	Prophylaxis – child, for the first two services in any 12-month period + #	0
D1999	Prophylaxis – adult or child, for each additional service in same 12-month period + #	60
	Topical Fluoride Treatment (Office Procedure)	
D1203	Topical application of fluoride (prophylaxis not included) – child, for the first two services in any 12-month period + =	0
D1204	Topical application of fluoride (prophylaxis not included) – adult, for the first two services in any 12-month period + =	0
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients, for the first two services in any 12-month period + =	12
D2999	Topical fluoride (adult or child), each additional service in the same 12-month period + =	20
	Other Preventive Services	
D1310	Nutritional counseling for control of dental disease	0
D1330	Oral hygiene instructions	0
D1351	Sealant – per tooth (molars) ^	8
D9999	Sealant – per tooth (non-molars) ^	35
	Space Maintenance (Passive Appliances)	
D1510	Space maintainer – fixed - unilateral	59
D1515	Space maintainer – fixed - bilateral	78
D1525	Space maintainer – removable - bilateral	78
D1550	Re-cementation of space maintainer	13
D1555	Removal of fixed space maintainer	20
	Amalgam Restorations (Including Polishing)	
D2140	Amalgam – one surface, primary or permanent	20
D2150	Amalgam – two surfaces, primary or permanent	27
D2160	Amalgam – three surfaces, primary or permanent	32
D2161	Amalgam – four or more surfaces, primary or permanent	40
	Resin-Based Composite Restorations - Direct	
D2330	Resin-based composite – one surface, anterior	25
D2331	Resin-based composite – two surfaces, anterior	30
D2332	Resin-based composite – three surfaces, anterior	41
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	46
D2390	Resin-based composite crown, anterior	57
D2391	Resin-based composite – one surface, posterior	30
D2392	Resin-based composite – two surfaces, posterior	40
D2393	Resin-based composite – three surfaces, posterior	47
D2394	Resin-based composite – four or more surfaces, posterior	57
	Inlay/Onlay Restorations ^^	
D2510	Inlay – metallic – one surface **	326
D2520	Inlay – metallic – two surfaces **	368
D2530	Inlay – metallic – three or more surfaces **	383
D2542	Onlay – metallic – two surfaces **	383
D2543	Onlay – metallic – three surfaces **	400
D2544	Onlay – metallic – four or more surfaces **	420
D2610	Inlay – porcelain/ceramic – one surface	326
D2620	Inlay – porcelain/ceramic – two surfaces	368
D2630	Inlay – porcelain/ceramic – three or more surfaces	383
D2642	Onlay – porcelain/ceramic – two surfaces	383
D2643	Onlay – porcelain/ceramic – three surfaces	400
D2644	Onlay – porcelain/ceramic – four or more surfaces	420

CDT Codes ++	Covered Dental Services	Patient Charges
	Crowns – Single Restorations Only ^^	
D2740	Crown – porcelain/ceramic substrate	$450
D2750	Crown – porcelain fused to high noble metal **	430
D2751	Crown – porcelain fused to predominantly base metal	430
D2752	Crown – porcelain fused to noble metal	430
D2780	Crown – ¾ cast high noble metal **	420
D2781	Crown – ¾ cast predominantly base metal	420
D2782	Crown – ¾ cast noble metal	420
D2783	Crown – ¾ porcelain/ceramic	420
D2790	Crown – full cast high noble metal **	430
D2791	Crown – full cast predominantly base metal	430
D2792	Crown – full cast noble metal	430
D2794	Crown – titanium	430
	Other Restorative Services	
D2910	Recement inlay, onlay, or partial coverage restoration	16
D2915	Recement cast or prefabricated post and core	16
D2920	Recement crown	16
D2930	Prefabricated stainless steel crown – primary tooth	110
D2931	Prefabricated stainless steel crown – permanent tooth	125
D2932	Prefabricated resin crown	132
D2933	Prefabricated stainless steel crown with resin window	132
D2934	Prefabricated esthetic coated stainless steel crown – primary tooth	142
D2940	Sedative filling	16
D2950	Core buildup, including any pins	113
D2951	Pin retention – per tooth, in addition to restoration	24
D2952	Post and core in addition to crown, indirectly fabricated	160
D2953	Each additional indirectly fabricated post – same tooth	50
D2954	Prefabricated post and core in addition to crown	130
D2957	Each additional prefabricated post – same tooth	29
D2960	Labial veneer (resin laminate) – chairside	250
D2970	Temporary crown (fractured tooth)	100
D2971	Additional procedures to construct new crown under existing partial denture framework	125
	Pulp Capping	
D3110	Pulp cap – direct (excluding final restoration)	12
D3120	Pulp cap – indirect (excluding final restoration)	9
	Pulpotomy	
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	33
D3221	Pulpal debridement, primary and permanent teeth	32
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	33
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	37
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	38
	Endodontic Therapy (Including Treatment Plan, Clinical Procedures And Follow-up Care)	
D3310	Root canal, anterior (excluding final restoration)	126
D3320	Root canal, bicuspid (excluding final restoration)	148
D3330	Root canal, molar (excluding final restoration)	192
D3331	Treatment of root canal obstruction; non-surgical access	0
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	126
D3333	Internal root repair of perforation defects	63
	Endodontic Retreatment	
D3346	Retreatment of previous root canal therapy – anterior	285
D3347	Retreatment of previous root canal therapy – bicuspid	335
D3348	Retreatment of previous root canal therapy – molar	400
	Apicoectomy/Periradicular Services	
D3410	Apicoectomy/periradicular surgery – anterior	137
D3421	Apicoectomy/periradicular surgery – bicuspid (first root)	147
D3425	Apicoectomy/periradicular surgery – molar (first root)	155
D3426	Apicoectomy/periradicular surgery (each additional root)	63
D3430	Retrograde filling – per root	46
D3950	Canal preparation and fitting of preformed dowel or post	20
	Surgical Services (Including Usual Postoperative Care)	
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant	105
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or bounded teeth spaces per quadrant	30
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or bounded teeth spaces per quadrant	121
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth or bounded teeth spaces per quadrant	73
D4249	Clinical crown lengthening – hard tissue	147
D4260	Osseous surgery (including flap entry and closure) – four or more contiguous teeth or bounded teeth spaces per quadrant	210
D4261	Osseous surgery (including flap entry and closure) – one to three contiguous teeth or bounded teeth spaces per quadrant	137
D4268	Surgical revision procedure, per tooth	0
D4270	Pedicle soft tissue graft procedure	147
D4271	Free soft tissue graft procedure (including donor site surgery)	170
D4273	Subepithelial connective tissue graft procedures, per tooth	187

CDT Codes ++	Covered Dental Services	Patient Charges
	Non-Surgical Periodontal Service	
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	$42
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	25
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	27
	Other Periodontal Services	
D4910	Periodontal maintenance, for the first two services in any 12-month period + #	28
D4920	Unscheduled dressing change (by someone other than treating dentist)	25
D4999	Periodontal maintenance, each additional service in same 12-month period + #	60
	Complete Dentures (Including Routine Post-Delivery Care)	
D5110	Complete denture – maxillary	580
D5120	Complete denture – mandibular	580
D5130	Immediate denture – maxillary	620
D5140	Immediate denture – mandibular	620
	Partial Dentures (Including Routine Post-Delivery Care)	
D5211	Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	580
D5212	Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	580
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	620
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	620
D5225	Maxillary partial denture – flexible base (including any clasps, rests and teeth)	675
D5226	Mandibular partial denture – flexible base (including any clasps, rests and teeth)	675
	Adjustments to Dentures	
D5410	Adjust complete denture – maxillary	27
D5411	Adjust complete denture – mandibular	27
D5421	Adjust partial denture – maxillary	27
D5422	Adjust partial denture – mandibular	27
	Repairs To Complete Dentures	
D5510	Repair broken complete denture base	69
D5520	Replace missing or broken teeth – complete denture (each tooth)	66
	Repairs To Partial Dentures	
D5610	Repair resin denture base	80
D5620	Repair cast framework	80
D5630	Repair or replace broken clasp	96
D5640	Replace broken teeth – per tooth	62
D5650	Add tooth to existing partial denture	81
D5660	Add clasp to existing partial denture	102
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	223
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	223
	Denture Rebase Procedures	
D5710	Rebase complete maxillary denture	230
D5711	Rebase complete mandibular denture	230
D5720	Rebase maxillary partial denture	230
D5721	Rebase mandibular partial denture	230
	Denture Reline Procedures	
D5730	Reline complete maxillary denture (chairside)	130
D5731	Reline complete mandibular denture (chairside)	130
D5740	Reline maxillary partial denture (chairside)	125
D5741	Reline mandibular partial denture (chairside)	125
D5750	Reline complete maxillary denture (laboratory)	186
D5751	Reline complete mandibular denture (laboratory)	186
D5760	Reline maxillary partial denture (laboratory)	186
D5761	Reline mandibular partial denture (laboratory)	186
	Interim Prosthesis	
D5820	Interim partial denture (maxillary)	175
D5821	Interim partial denture (mandibular)	175
	Other Removable Prosthetic Services	
D5850	Tissue conditioning, maxillary	55
D5851	Tissue conditioning, mandibular	55
	Fixed Partial Denture Pontics ^^	
D6210	Pontic – cast high noble metal **	400
D6211	Pontic – cast predominantly base metal	400
D6212	Pontic – cast noble metal	400
D6214	Pontic – titanium	400
D6240	Pontic – porcelain fused to high noble metal **	400
D6241	Pontic – porcelain fused to predominantly base metal	400
D6242	Pontic – porcelain fused to noble metal	400
D6245	Pontic – porcelain/ceramic	410
	Fixed Partial Denture Retainers – Inlays/Onlays ^^	
D6600	Inlay – porcelain/ceramic – two surfaces	368
D6601	Inlay – porcelain/ceramic – three or more surfaces	383
D6602	Inlay – cast high noble metal, two surfaces **	368
D6603	Inlay – cast high noble metal, three or more surfaces **	383
D6604	Inlay – cast predominantly base metal, two surfaces	368

CDT Codes ++	Covered Dental Services	Patient Charges
	Fixed Partial Denture Retainers – Inlays/Onlays ^^ (continued)	
D6605	Inlay – cast predominantly base metal, three or more surfaces	$383
D6606	Inlay – cast noble metal, two surfaces	368
D6607	Inlay – cast noble metal, three or more surfaces	383
D6608	Onlay – porcelain/ceramic, two surfaces	383
D6609	Onlay – porcelain/ceramic, three or more surfaces	400
D6610	Onlay – cast high noble metal, two surfaces **	383
D6611	Onlay – cast high noble metal, three or more surfaces **	400
D6612	Onlay – cast predominantly base metal, two surfaces	383
D6613	Onlay – cast predominantly base metal, three or more surfaces	400
D6614	Onlay – cast noble metal, two surfaces	383
D6615	Onlay – cast noble metal, three or more surfaces	400
D6624	Inlay – titanium	368
D6634	Onlay – titanium	383
	Fixed Partial Denture Retainers – Crowns ^^	
D6740	Crown – porcelain/ceramic	450
D6750	Crown – porcelain fused to high noble metal **	430
D6751	Crown – porcelain fused to predominantly base metal	430
D6752	Crown – porcelain fused to noble metal	430
D6780	Crown – ¾ cast high noble metal **	430
D6781	Crown – ¾ cast predominantly base metal	430
D6782	Crown – ¾ cast noble metal	430
D6783	Crown – ¾ porcelain/ceramic	430
D6790	Crown – full cast high noble metal **	430
D6791	Crown – full cast predominantly base metal	430
D6792	Crown – full cast noble metal	430
D6794	Crown – titanium	430
	Other Fixed Partial Denture Services	
D6930	Recement fixed partial denture	26
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated	160
D6972	Prefabricated post and core in addition to fixed partial denture retainer	130
D6973	Core build up for retainer, including any pins	113
D6976	Each additional cast post – same tooth	50
D6977	Each additional prefabricated post – same tooth	29
D6999	Multiple crown and bridge unit treatment plan – per unit, six or more units per treatment plan ^^	125
	Extractions	
D7111	Extraction, coronal remnants – deciduous tooth	16
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	23
	Surgical Extractions (Includes Local Anesthesia, Suturing, If Needed, And Routine Postoperative Care)	
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	46
D7220	Removal of impacted tooth – soft tissue	62
D7230	Removal of impacted tooth – partially bony	82
D7240	Removal of impacted tooth – completely bony	96
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	116
D7250	Surgical removal of residual tooth roots (cutting procedure)	51
D7261	Primary closure of a sinus perforation	250
	Other Surgical Procedures	
D7280	Surgical access of an unerupted tooth	82
D7283	Placement of device to facilitate eruption of impacted tooth	35
D7285	Biopsy of oral tissue – hard (bone, tooth)	70
D7286	Biopsy of oral tissue – soft	65
D7288	Brush biopsy – transepithelial sample collection	65
	Alveoloplasty – Surgical Preparation Of Ridge For Dentures	
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	53
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	26
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	92
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	65
	Surgical Excision Of Intra-Osseous Lesions	
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	165
D7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm	240
	Excision Of Bone Tissue	
D7471	Removal of lateral exostosis (maxilla or mandible)	215
D7472	Removal of torus palatinus	215
D7473	Removal of torus mandibularis	215
	Surgical Incision	
D7510	Incision and drainage of abscess – intraoral soft tissue	44
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	48
	Other Repair Procedures	
D7960	Frenulectomy (frenectomy or frenotomy) – separate procedure	100
D7963	Frenuloplasty	168

CDT Codes ++	Covered Dental Services	Patient Charges
	Unclassified Treatment	
D9110	Palliative (emergency) treatment of dental pain – minor procedure	$20
D9120	Fixed partial denture sectioning	15
D9215	Local anesthesia	0
D9220	Deep sedation/general anesthesia – first 30 minutes +++	195
D9221	Deep sedation/general anesthesia – each additional 15 minutes +++	75
D9241	Intravenous conscious sedation/analgesia – first 30 minutes +++	195
D9242	Intravenous conscious sedation/analgesia – each additional 15 minutes +++	75
	Professional Consultation	
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	34
	Professional Visits	
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	0
D9440	Office visit – after regularly scheduled hours	50
D9450	Case presentation, detailed and extensive treatment planning	0
	Miscellaneous Services	
D9951	Occlusal adjustment – limited	23
D9971	Odontoplasty – one to two teeth	23
D9972	External bleaching – per arch	165
	Broken appointment	25

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+ The Patient Charges for codes D1110, D1120, D1203, D1204, D1206 and D4910 are limited to the first two services in any 12-month period. For each additional service in the same 12-month period, see codes D1999, D2999 and D4999 for the applicable Patient Charge.

++ Covered Services are subject to exclusions, limitations and Plan provisions as described in Member's Plan booklet and the Manual (including the Quality Management retrospective review). Other codes may be used to describe Covered Services.

***** The Member will be responsible for the Office Visit Fee when the Plan Schedule suffix listed on the ID Card and Eligibility Report is an "M". The Plan will be responsible for the Office Visit Fee when the Plan Schedule suffix listed on the ID Card and Eligibility Report is a "G". The ID Card and Eligibility Report will indicate if the Office Visit Fee is $5 or $10.

Routine prophylaxis or periodontal maintenance procedure - a total of four services in any 12-month period. One of the covered periodontal maintenance procedures may be performed by a participating periodontal Specialist if done within three to six months following completion of approved, active periodontal therapy (periodontal scaling and root planing or periodontal osseous surgery) by a participating periodontal Specialist. Active periodontal therapy includes periodontal scaling and root planing or periodontal osseous surgery.

= Fluoride Treatment - a total of four services in any 12-month period.

^ Sealants are limited to permanent teeth up to the 16th birthday.

****** If high noble metal is used, there will be an additional Patient Charge for the actual cost of the high noble metal.

^^ The Patient Charge for these services is per unit.

+++ Procedure codes D9220, D9221, D9241 and D9242 are limited to a participating oral surgery Specialist. Additionally, these services are only covered in conjunction with other covered surgical services.

Underwritten by: (IL) - First Commonwealth Insurance Company, (MO) - First Commonwealth of Missouri, (IN) - First Commonwealth Limited Health Services Corporation, (MI) - First Commonwealth Inc., (CA) - Managed Dental Care, (TX) - Managed DentalGuard, Inc. (DHMO), (NJ) - Managed DentalGuard, Inc., (FL, NY) - The Guardian Life Insurance Company of America. All First Commonwealth, Managed DentalGuard, Inc., and Managed Dental Care entities referenced are wholly-owned subsidiaries of The Guardian Life Insurance Company of America. Limitations and exclusions apply. Plan documents are the final arbiter of coverage.

The Guardian Life Insurance Company of America, New York, NY 10004 2008-6567

MANAGED DENTALGUARD ORTHODONTIC BENEFITS

Managed DentalGuard Orthodontic Plan Schedule – Option V

CDT Codes	Covered Services and Patient Charges	Patient Charges	Orthodontics In Progress
	Orthodontics		
D8070	Comprehensive orthodontic treatment of the transitional dentition **		
D8080	Comprehensive orthodontic treatment of the adolescent dentition **	Child: $2500 Adult: 2800	***
D8090	Comprehensive orthodontic treatment of the adult dentition **		***
D8660	Pre-orthodontic treatment visit (includes treatment plan, records, evaluation and consultation)	250	***
D8670	Periodic orthodontic treatment visit	0	***
D8680	Orthodontic retention	400	***
	Broken appointment	25	***

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** Child orthodontics is limited to dependent children under age 19; adult orthodontics is limited to dependent children age 19 and above and employee or spouse. A Member's age is determined on the date of banding.

*** Treatment in progress: Orthodontic Treatment – Comprehensive orthodontic treatment is started when the teeth are banded. Orthodontic treatment procedures which are listed on the Plan Schedule and were started but not completed prior to the Member's eligibility to receive benefits under this plan may be covered if the Member identifies a Participating Orthodontic Specialty Care Dentist who is willing to complete the treatment at a patient charge equal to 85% of the Participating Orthodontic Specialty Care Dentist's usual fee. In this situation retention services would also be at 85% of the Participating Orthodontic Specialty Care Dentist's usual fee. When comprehensive orthodontic treatment is started prior to the Member's eligibility to receive benefits under this plan, the Patient Charge for orthodontic retention is equal to 85% of the Participating Orthodontic Specialty Care Dentist's usual fee. Also refer to the Orthodontic Takeover Treatment-in-Progress section.

++ Covered Services are subject to exclusions, limitations and Plan provisions as described in Member's Plan Booklet and the Manual.

The Plan Covers:

- Orthodontic services as listed under Covered Dental Services and Patient Charges, limited to one (1) course of treatment per Member. We must preauthorize treatment, and it must be performed by a Participating Orthodontic Specialist Dentist.
- Up to twenty-four (24) months of comprehensive orthodontic treatment.
- Treatment plan and records, including initial records and any interim and final records.
- Comprehensive orthodontic treatment, including the fixed banding appliances and related visits only.
- Retention services following a course of comprehensive orthodontic treatment that was covered under this Plan.
- Orthodontic retention, including any and all necessary fixed and removable appliances and related visits.
- If a Member has orthodontic treatment associated with orthognathic surgery (a non-covered procedure involving the surgical moving of teeth), the Plan provides the standard orthodontic benefit. The Member will be responsible for additional charges related to the orthognathic surgery and the complexity of the orthodontic treatment. The additional charge will be based on the Participating Orthodontic Specialist Dentist's usual fee.

This Plan Does Not Cover:

- Any procedure listed as an exclusion, in excess of Plan limitations, or as not covered under MDG.
- Orthodontic treatment performed by any dentist other than a Participating Orthodontic Specialist Dentist.
- Limited orthodontic treatment and interceptive (Phase I) treatment.
- Treatment beyond twenty-four (24) months. (The Member will be responsible for an additional charge for each additional month of treatment, based upon the Participating Orthodontic Specialist Dentist's contracted fee.)
- Except as described under treatment in progress – orthodontic treatment, orthodontic services are not covered if comprehensive treatment begins before the Member is eligible for benefits under the Plan. If a Member's coverage terminates after the fixed banding appliances are inserted, the Participating Orthodontist Specialty Care Dentist may prorate his or her usual fee over the remaining months of treatment.
- Orthodontic services after a Member's coverage terminates.
- Any incremental charges for non-standard orthodontic appliances or those made with clear, ceramic, white or other optional material or linqual brackets.
- Procedures, appliances or devices to (a) guide minor tooth movement or (b) to correct or control harmful habits.
- Re-treatment of orthodontic cases, or changes in orthodontic treatment necessitated by any kind of accident.
- Replacement or repair of orthodontic appliances damaged due to the neglect of the Member.
- Extractions performed solely to facilitate orthodontic treatment.
- Orthognathic surgery (moving of teeth by surgical means) and associated incremental charges.
- If a Member transfers to another Participating Orthodontic Specialty Care Dentist after authorized comprehensive orthodontic treatment has started under this Plan, the Member will be responsible for any additional costs associated with the change in Orthodontic Specialty Care Dentist and subsequent treatment.

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VSP Coverage Effective Date: 01/01/2015
VSP Provider Network: VSP Choice

Visit **vsp.com** for more details on your vision benefit and for exclusive savings and promotions for VSP members.

Benefit	Description	Copay	Frequency
Your Coverage with a VSP Provider			
WellVision Exam	• Focuses on your eyes and overall wellness	$10	Every 12 months
Prescription Glasses		$25	See frame and lenses
Frame	• $130 allowance for a wide selection of frames • $150 allowance for featured frame brands • $70 allowance at Costco • 20% savings on the amount over your allowance	Included in Prescription Glasses	Every 24 months
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	Included in Prescription Glasses	Every 12 months
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements	$55 $95 - $105 $150 - $175	Every 12 months
Contacts (instead of glasses)	• $150 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		
Your Per Pay Period (24) Contribution	$3.00 Member only $4.80 Member + 1 $4.89 Member + children $7.89 Member + family		

Your Coverage with Out-of-Network Providers

Visit vsp.com for details, if you plan to see a provider other than a VSP network provider.

Exam.....up to $45	Single Vision Lenses.....up to $30	Lined Trifocal Lenses.....up to $65	Contacts.....up to $105
Frame.....up to $70	Lined Bifocal Lenses.....up to $50	Progressive Lenses.....up to $50	

Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details.
Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location.

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[1] Brands/Promotion subject to change.

Flexible Spending Accounts

REAL SAVINGS. REAL SIMPLE.

Using a Flexible Spending Account (FSA) is a great way to stretch your benefit dollars. You use pre-tax dollars in your FSA to reimburse yourself for eligible out-of-pocket medical and dependent care expenses. That means you can enjoy tax savings with the convenience of a prepaid benefits card. And that makes real sense.

WHAT IS AN FSA?

With an FSA, you elect to have your annual contribution (up to the annual limit set by the IRS) deducted from your paycheck each pay period in equal installments throughout the year. The amount of your pay that goes into an FSA will not count as taxable income, so you will have immediate tax savings. FSA dollars can be used during the plan year to pay for qualified expenses and services. Please check with your employer to see what plans are offered.

A Health FSA allows reimbursement of qualifying out-of-pocket medical expenses.

A Dependent Care FSA allows reimbursement of dependent care expenses, such as day care, incurred by eligible dependents.

A Limited Purpose Health FSA is compatible with a Health Savings Account (HSA). A limited FSA only allows reimbursement for preventive care, vision and dental expenses, keeping the employee eligible to contribute to an HSA.

With all FSA account types, you'll receive access to a secure, easy-to-use web portal where you can track your account balance, view your investment accounts and submit requests for reimbursements.

In addition, your plan might offer a convenient prepaid benefits card to make it easy to pay for eligible services and products. When you use the card, payments are automatically withdrawn from your account, so there are no out-of-pocket costs and you likely won't have to submit receipts to verify the purchase. Just swipe the card and go. It's that easy!

Throughout the year, you'll likely find yourself with expenses for yourself and your family that insurance won't cover. By taking advantage of a health care FSA, you can actually reduce your taxable income and reduce your out-of-pocket expenses when you use your FSA to pay for health care services and products you'd purchase anyway.

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Is an FSA right for me? An FSA is a great way to pay for expenses with pre-tax dollars. A Health Care FSA could save you money if you or your dependents:

- Have out-of-pocket expenses like **co-pays, coinsurance, or deductibles** for health, prescription, dental or vision plans
- Have a **health condition that requires the purchase of prescription medications** on an ongoing basis
- Wear **glasses or contact lenses** or are planning **LASIK surgery**
- Need **orthodontia care, such as braces,** or have dental expenses not covered by your insurance

A Dependent Care FSA provides pre-tax reimbursement of out-of-pocket expenses related to dependent care. This benefit may make sense if you (and your spouse, if married) are working or in school, and:

- Your **dependent children under age 13 attend day care, after-school care** or **summer day camp**
- You **provide care for a person of any age who you claim as a dependent on your federal income tax return** and who is mentally or physically incapable of caring for himself or herself

An FSA is a great way to pay for expenses with pre-tax dollars.

- Enjoy significant tax savings with pre-tax contributions and tax-free distributions used for qualified plan expenses
- Quickly and easily access funds using the prepaid benefits card at point of sale, or request to have funds directly deposited to your bank account via online or mobile app
- Reduce filing hassles and paperwork by using your prepaid benefits card
- Enjoy secure access to accounts using a convenient Consumer Portal available 24/7/365
- Manage your FSA "on the go" with an easy-to-use mobile app
- File claims easily online (when required) and let the system determine approval based on eligibility and availability of funds
- Stay up to date on balances and action required with automated email alert and convenient portal and mobile home page messages
- Get one-click answers to benefits questions

With the convenience of a mobile device, you can see your available balance anywhere, anytime as well as file claims and upload receipts.

PLAN AHEAD Before you enroll, you must first decide how much you want to contribute to your account(s). You will want to spend some time estimating your anticipated eligible medical and dependent care expenses for the calendar year.

As of October 31, 2013 the US Treasury Department modified its Health Flexible Spending Account (FSA) Use-or-Lose rule to allow up to a $500 carryover of Health FSA funds. The carryover option is based solely on your employer's plan design. Not every company allows a carryover. Some employer plans may establish a lower maximum limit than $500, but it must be uniformly applied to all eligible participants. The carryover is applicable only to Health FSAs (not to Dependent Care FSAs). Any unused amount above the carryover limit is subject to forfeiture and cannot be cashed out or transferred to other taxable or nontaxable benefits (e.g., HSAs).

For questions, contact us at: FSA@infinisource.com or 800-300-3838

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Maximize the Value of Your Reimbursement Account

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Your Health Care Flexible Spending Account (FSA) and/or Health Reimbursement Account (HRA) dollars can be used for a variety of out-of-pocket health care expenses. The following list is based on eligible and ineligible expenses used by federal employees.

Eligible Expenses

Baby/Child to age 13

- ✓ Lactation consultant
- ✓ Lead-based paint removal*
- ✓ Special formula*
- ✓ Tuition: special school/teacher for disability or learning disability*
- ✓ Well baby/well child care

Dental

- ✓ Dental x-rays
- ✓ Dentures and bridges
- ✓ Exams and teeth cleaning
- ✓ Extractions and fillings
- ✓ Oral surgery
- ✓ Orthodontia
- ✓ Periodontal services

Eyes

- ✓ Eye exams
- ✓ Eyeglasses and contact lenses
- ✓ Laser eye surgeries
- ✓ Prescription sunglasses
- ✓ Radial keratotomy

Hearing

- ✓ Hearing Aids and Batteries
- ✓ Hearing exams

Lab Exams/Tests

- ✓ Blood Tests and Metabolism Tests
- ✓ Body Scans
- ✓ Cardiograms
- ✓ Laboratory Fees
- ✓ X-Rays

Medical Equipment/Supplies

- ✓ Air purification equipment*
- ✓ Arches and other orthotic inserts
- ✓ Contraceptive devices
- ✓ Crutches, walkers, wheel chairs
- ✓ Exercise equipment*
- ✓ Hospital beds*
- ✓ Mattresses*
- ✓ Medic alert bracelet or necklace
- ✓ Nebulizers
- ✓ Orthopedic shoes*
- ✓ Oxygen
- ✓ Post-mastectomy clothing
- ✓ Prosthetics
- ✓ Syringes
- ✓ Wigs*

Medical Procedures/Services

- ✓ Acupuncture
- ✓ Alcohol and drug/substance abuse (inpatient treatment and outpatient care)
- ✓ Ambulance
- ✓ Fertility enhancement and treatment
- ✓ Hair loss treatment*
- ✓ Hospital services
- ✓ Immunization
- ✓ In vitro fertilization
- ✓ Personal trainers*
- ✓ Physical examination (not employment-related)
- ✓ Reconstructive surgery (due to a congenital defect, accident or medical treatment.)
- ✓ Service animals
- ✓ Sterilization/sterilization reversal
- ✓ Transplants (including organ donor)
- ✓ Transportation*

Obstetrics

- ✓ Doulas*
- ✓ Lamaze class
- ✓ OB/GYN exams
- ✓ OB/GYN prepaid maternity fees (reimbursable after date of birth)
- ✓ Pre- and post-natal treatments

Practitioners

- ✓ Allergist
- ✓ Chiropractor
- ✓ Christian Science Practitioner
- ✓ Dermatologist
- ✓ Homeopath
- ✓ Naturopath*
- ✓ Optometrist
- ✓ Osteopath
- ✓ Physician
- ✓ Psychiatrist or Psychologist

Therapy

- ✓ Alcohol and Drug Addiction
- ✓ Counseling (must be treating a medical condition)
- ✓ Exercise Programs*
- ✓ Hypnosis*
- ✓ Massage*
- ✓ Occupational
- ✓ Physical
- ✓ Smoking Cessation Programs*
- ✓ Speech
- ✓ Weight Loss Programs*

Medications

- ✓ Insulin
- ✓ Prescription drugs

This list is not meant to be all-inclusive, as other expenses not specifically mentioned may also qualify. Also, expenses marked with an asterisk (*) are "potentially eligible expenses" that require a note of medical necessity from your health care provider to qualify for reimbursement. For additional information, check your Summary Plan Document or contact Infinisource.

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The IRS does not allow the following expenses to be reimbursed under Health Care FSAs or HRAs, as they are not prescribed by a physician for a specific ailment.

Ineligible Expenses

- Contact lens or eyeglass insurance
- Cosmetic surgery/procedures
- Electrolysis
- Insurance premiums and interest
- Long-term care premiums
- Marriage or career counseling
- Sunscreen (SPF less than 15 needs RX)
- Swimming lessons

Note: This list is not meant to be all-inclusive

Please note: The IRS will not allow OTC medicines or drugs to be purchased with Health Care FSA or HRA funds unless accompanied by a prescription.

Eligible Over-the-Counter Items

Note: Product categories are listed in bold face; common examples of products are listed in regular face.

The following is a high level list of over-the-counter (OTC) items that clearly are not medicine or drugs and are eligible for purchase with Health Care FSA or HRA dollars. You can use your benefits card for these items

Antiseptics, wound cleaners
Alcohol, peroxide, Epsom salt

Baby electrolytes
Pedialyte, Enfalyte

Denture adhesives, repair and cleansers
PoliGrip, Benzodent, Efferdent

Diabetes testing and aids
Insulin, Ascencia, One Touch, Diabetic Tussin, insulin syringes, glucose products

Diagnostic products
Thermometers, blood pressure monitors, cholesterol testing

Elastics/athletic treatments
ACE, Futuro, elastic bandages, braces, hot/cold therapy, orthopedic supports, rib belts

Eye care
Contact lens care

Family planning
Pregnancy and ovulation kits

First aid dressings and supplies
Band Aid, 3M Nexcare, non-sport tapes

Hearing aid/medical batteries

Incontinence products
Attends, Depend, GoodNites for juvenile incontinence

Reading glasses and maintenance accessories

Sunscreen (SPF 15 and over)

For additional information, please contact:

Infinisource
PO Box 488
Coldwater, MI 49036-0488

PH: 866.370.3040
Fax: 800.379.5670
Email: fsa@infinisource.com

Dependent Care FSA FAQ

A Dependent Care FSA allows participants to use pre-tax dollars to cover eligible work-related dependent care expenses for qualified dependents, or if you are married, while you and your spouse work or your spouse attends school full-time.

Who is a qualified dependent under the Dependent Care FSA?

- Dependent under the age of 13
- Dependent or spouse of employee who is mentally or physically disabled and whom the employee claims as a dependent on their federal income tax return

Can an adult be a qualified dependent?
Yes, an adult may qualify as a dependent provided that the employee is providing more than half of that individual's support for the year and the dependent lives with the employee.

Do I have to use a day care facility?
No. You can be reimbursed for expenses of an individual providing care for your dependent in your home as long as the expenses are incurred for you and your spouse (if married), to work, look for work or attend school full-time.

Does my day care provider have to be licensed?
No. However, you are required to submit their Tax Identification Number or Social Security Number when filing your federal income tax return.

Does my day care provider have to be 18?
No, but the individual must claim the money as income on their tax return.

My child attends camp during the summer. Is this eligible?
Generally, no; however, if the camp is day camp and your dependent attends to allow you and your spouse (if married), to work, look for work or attend school full-time, then yes this would be an eligible expense. Overnight camps are specifically excluded.

When can I be reimbursed for dependent day care expenses?
Expenses are eligible for reimbursement when they have been incurred, not when you are billed or when you pay for the services.

Example: Your day care provider requires you to pay for the month of September on September 1. You can be reimbursed as the services are incurred, not when you paid for the services. You can submit claims after each week, every two weeks or on October 1.

Dependent Care FSA FAQ

What supporting documentation must I file with each Dependent Care claim?
Complete the Dependent Care section of the Request for Reimbursement Form and have your day care provider sign and date. The receipt must include the following information:

- Name and address of provider
- From/through dates of service
- Amount of charge

Can I submit claims for dependent care expenses that are greater than the current balance of my Dependent Care FSA?
Yes, however, you will only receive reimbursement for the amount that you have contributed to your Dependent Care FSA. For example, if you contribute $150 each month to your Dependent Care FSA, then you will only receive $150 in reimbursement each month. The excess amount of expenses will be pended and automatically paid to you as contributions are posted to your account.

What happens if a claim exceeds the amount currently available in my Dependent Care FSA?
The claim will be processed and approved. The amount that is currently available will be disbursed and the remaining portion will be pended until you make another contribution.

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Group Term Life and AD&D Insurance

SUMMARY OF BENEFITS

Sponsored by: **Erikson Institute**

Coverage	**Benefit Amount Employee**
Life	One times basic annual earnings, rounded to the next higher $1,000
Maximum Amount	$350,000
Guarantee Issue	$350,000
AD&D	Will Equal the Life Benefit
Benefit Reduction	**Employee**
Benefits will reduce:	35% at age 65; An additional 15% of original amount at age 70; Benefits terminate at retirement
Additional Benefits	
See Understanding Your Benefits Page:	Accelerated Death Benefit Seatbelt Benefit – Air Bag Benefit - Common Carrier Benefit Conversion Continuation of Coverage Accident Plus
Enrolling for Coverage	**Employee**
Eligibility:	All employees in an eligible class.

(Please see other side)

Understanding Your Benefits	
Accelerated Death Benefit	Accelerated Death Benefit provides an option to be paid a portion of your life insurance benefit when diagnosed as terminally ill (as defined in the policy). The death benefit will be reduced by the amount withdrawn. To qualify, you must be covered under this policy for the amount of time defined by the policy.
AD&D	Accidental Death and Dismemberment (AD&D) insurance provides specified benefits for a covered accidental bodily injury that directly causes death or dismemberment (e.g., the loss of a hand, foot, or eye), subject to policy limitations.
Conversion	If you terminate your employment or become ineligible for this coverage, you have the option to convert all or part of the amount of coverage in force to an individual life policy on the date of termination without Evidence of Insurability. Conversion election normally must be made within 31 days of your date of termination.
Continuation of Coverage	If coverage has been in force for at least 12 months, you may continue your coverage for a specified period of time after your employment by paying the required premium. Continuation of coverage is available if you cease employment for a reason other than sickness, injury, or retirement.
Guarantee Issue	For timely entrants enrolled within 31 days of becoming eligible, the Guarantee Issue amount is available without providing Evidence of Insurability. Evidence of Insurability will be required for any amounts above this, for late enrollees or increases in insurance, and it will be provided at your own expense.
Seatbelt Benefit – Air Bag Benefit - Common Carrier Benefit	If you die as a result of a covered auto accident while wearing a seat belt or in a vehicle equipped with an airbag, additional benefits are payable up to $10,000 or 10% of the principal sum, whichever is less. If loss occurs due to an accident while riding as a passenger in a common carrier, benefits will be double the amount that would otherwise apply as outlined in the certificate.
Accident Plus	If loss occurs due to an accident, you may also receive the following Accident Plus benefits: Coma, Plegia, Repatriation, Education, Spouse Training, & Child Care. Refer to your certificate for more details.
Term Life	A death benefit is paid to the designated beneficiary upon the death of the insured. Coverage is provided for the time period that you are eligible and premium is paid. There is no cash value associated with this product.
Additional Benefits	
***LifeKeys*SM**	Online will & testament preparation service, identity theft resources and beneficiary assistance support for all employees and eligible dependents covered under the Group Term Life and/or AD&D policy.
***TravelConnect*SM**	Travel assistance services for employees and eligible dependents traveling more than 100 miles from home.

For assistance or additional information Contact Lincoln Financial Group at	
(800) 423-2765; reference ID: **ERIKINS2**	**www**.LincolnFinancial.com
If there is any discrepancy between this benefit summary and the policy, the policy shall control. This summary is not intended to contain a complete description of the coverage offered. This summary does not modify the policy. This is not a binding contract	

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Group Short-Term Disability Insurance

SUMMARY OF BENEFITS

Sponsored by: **Erikson Institute**

Short-term disability is intended to protect your income for a short duration in case you become ill or injured.

STD Benefit			
	Weekly Benefit	**Elimination Period**	**Maximum Duration**
	60% of weekly salary up to $400 per week	Benefits begin on: Accident: 1st day Illness: 8th day	13 weeks
Integration of Benefits	The benefits from this policy will be reduced by benefits you receive from state disability or worker's compensation programs.		
Additional Benefits			
	Rehab Assistance - 5% Rehab Incentive **Survivor Income - 3 Weeks** **C-Section Benefit - 8 weeks** **See your Schedule of Benefits on your Certificate for more information**		
Enrolling for Coverage			
Eligibility:	All employees in an eligible class.		

Understanding Your Benefits	
Total Disability	Due to an injury or illness, you are unable to perform each of the main duties of your regular occupation.
Partial Disability	Due to an injury or illness, you are unable to perform one or more of the main duties of your regular occupation on a full-time basis. Partial Disability benefits may be payable if you are earning at least 20% of the income you earned prior to becoming disabled, but not more than 99%. Partial disability benefits allow you to work and earn income from your employer as well as continue to receive benefits, which may enable you to receive 100% of your income during your time of disability.
Continuation of Disability	If you return to work full-time but become disabled from the same disability within 2 weeks of returning to work, you will begin receiving benefits again immediately.
Benefit Exclusions	You will not receive benefits in the following circumstances: • Your disability is the result of a self-inflicted injury. • You are not under the regular care of a doctor when requesting disability benefits. • Your disability is the result of war, declared or undeclared, or any act of war. • Your disability is covered under a worker's compensation plan and/or is due to a job-related sickness or injury.
Benefit Reductions	Your benefits may be reduced if you are receiving benefits from any of the following sources: • Any governmental retirement system earned as a result of working for the current policyholder; • Any disability or retirement benefit received under a retirement plan; • Any Social Security, or similar plan or act, benefits; • Earnings the insured earns or receives from any form of employment; • Disability income benefits received under state disability benefit laws.
Rehabilitation Assistance Benefit	Employees who participate in an approved rehabilitation program are eligible to receive an additional percent of benefit. Additionally, approved program costs may be reimbursed.
Survivor Income	A benefit may be paid to your survivor for additional months if you should die while you were eligible to receive benefits under this policy.
Coverage Termination	This coverage will terminate when you terminate employment with this policyholder, or at your retirement.

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NOTE: This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater details. Should there be a difference between this summary and the contract, the contract will govern.

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Group Long-Term Disability Insurance

SUMMARY OF BENEFITS

Sponsored by: **Erikson Institute**

All Other Full-Time Employees

Long-term disability is intended to protect your income for a long duration after you have depleted short-term disability or any sick leave your company may offer.

LTD Benefit				
	Monthly Benefit	**Maximum Benefit Duration**	**Own Occupation Period**	**Elimination Period**
Employer Paid Plan	60% of monthly salary up to $5,000 per month	Later of Age 65 or Social Security Normal Retirement Age	36 Months	90 Days
Pre-Existing Condition	You may not be eligible for benefits if you have received treatment for a condition within 3 months prior to your effective date under this policy until you have been covered under the policy for 12 months.			
Waiver of Premium	You will not be required to pay premium during any time of approved total or partial disability.			
Benefit Limitations	Mental Illness: 24 Months Substance Abuse: 24 Months Specified Illness: 24 Months			

Enrolling for Coverage	
Eligibility:	All employees in an eligible class

Additional Benefits	
	Progressive Income Benefit, Family Care Expense Benefit, Survivor Income Benefit, EmployeeConnect - Employee Assistance Plan and Waiver of Premium

See your Schedule of Benefits on your Certificate for more information

Understanding Your Benefits

Elimination Period	The number of days you must be disabled prior to collecting disability benefits.
Own Occupation	The occupation, trade, or profession you were employed in prior to your disability as defined by the US DOL Dictionary of Occupational Titles.
Total Disability	Due to an injury or illness, you are unable to perform each of the main duties of your own occupation on a full-time basis. Your "own" occupation is covered for a specific period of time. Following this, the definition of total disability becomes the inability to perform any occupation for which you are reasonably suited based on your experience, education, or training. See Certificate of Coverage for details.
Partial Disability	Due to an injury or illness, you are unable to perform one or more of the main duties of your regular occupation on a full-time basis. Partial Disability benefits may be payable if you are earning at least 20% of the income you earned prior to becoming disabled, but not more than 99%. Partial disability benefits allow you to work and earn income from your employer and continue to receive benefits, which may enable you to receive 100% of your income during your time of disability. See Certificate of Coverage for details.
Continuation of Disability	If you return to work full-time but become disabled from the same disability within 6 months of returning to work, you will begin receiving benefits again immediately with no new Elimination Period.
Benefit Duration Reduction	Your benefit duration may be reduced if you become disabled after age 65.
Pre-Existing Condition	Any sickness or injury for which you received medical treatment, consultation, care, or services (including diagnostic measures or the taking of prescribed medications) during the specified months prior to your 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 the specified months following the coverage effective date.
Benefit Exclusions	You will not receive benefits in the following circumstances: • Your disability is the result of a self-inflicted injury. • You are not under the regular care of a doctor when requesting disability benefits. • You were involved in a felony commission, act of war, or participation in a riot. • You were residing outside of the United States or Canada for more than 12 consecutive months for purposes other than employment with your Employer.
Benefit Reductions	Your benefits may be reduced if you are receiving benefits from any of the following sources: • Any compulsory benefit act or law (such as state disability plans); • Any governmental retirement system earned as a result of working for the current policyholder; • Any disability or retirement benefit received under a retirement plan; • Any Social Security, or similar plan or act, benefits; • Earnings from any form of employment; • Workers compensation; • Salary continuance or employer contributions to an employer sponsored retirement plan.
Coverage Termination	Coverage will terminate when you terminate employment with this policyholder, or at your retirement.

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Voluntary Life Insurance

SUMMARY OF BENEFITS

Sponsored by: **Erikson Institute**

Life Benefit	Employee	Spouse	Dependent
	Employee must elect coverage for Spouse or dependents to be eligible.		
Amount	Choice of $10,000 increments	Choice of $5,000 increments	Age 14 Days to 6 months: $250 6 months to age 19 (to age 25 if full-time student): $10,000 Newborn children to age 14 days are not eligible for a benefit
Minimum Amount	$10,000	$5,000	$10,000
Maximum Amount	$300,000, limited to 5 times your annual salary Employees age 70 and older, maximum benefit is $50,000	$500,000, limited to 50% of employee amount	$10,000
Guarantee Issue for Newly Eligible Employee	$150,000	$50,000	
Current Eligible Employees	You or your Spouse may elect or increase insurance coverage equal to 2 benefit levels on a guaranteed acceptance basis during your company's defined annual open enrollment period, provided that you or your Spouse have not been previously declined, withdrawn, or pending for coverage.		

Benefit Reduction	Employee	Spouse
Benefits will reduce:	35% at age 70; Additional 20% of original amount at age 75; Additional 15% of original amount at age 80; Additional 10% of original amount at age 85; Benefits terminate at retirement	35% at Employee Age 70; Additional 20% of original amount at Employee Age 75; Additional 15% of original amount at Employee Age 80; Additional 10% of original amount at Employee Age 85 Benefits terminate at Employee Retirement

Eligibility	Employee	Spouse and Dependents
	All employees in an eligible class.	Cannot be in a period of limited activity on the day coverage takes effect.

Additional Benefits	
See Definition:	Accelerated Death Benefit
See Definition:	Portability
See Definition:	Conversion

Definitions	
Accelerated Death Benefit	Accelerated Death Benefit provides an option to withdraw a percentage of your life insurance coverage when diagnosed as terminally ill (as defined in the policy). The death benefit will be reduced by the amount withdrawn. To qualify, you have satisfied the Active Work rule and have been covered under this policy for the required amount of time as defined by the policy. Check with your tax advisor or attorney before exercising this option.
Conversion	If you terminate your employment or become ineligible for this coverage, you have the option to convert all or part of the amount of coverage in force to an individual life policy on the date of termination without Evidence of Insurability. Conversion election must be made within 31 days of your date of termination.
Guarantee Issue	For timely entrants enrolled within 31 days of becoming eligible, the Guarantee Issue amount is available without any Evidence of Insurability requirement. Evidence of Insurability will be required for any amounts above this, for late enrollees or increase in insurance, and it will be provided at your own expense.
Limited Activity	A period when a Spouse or dependent is confined in a health care facility; or, whether confined or not, is unable to perform the regular and usual activities of a healthy person of the same age and sex.
Portability	If coverage has been in force for at least 12 months, you may continue coverage for a specified period of time after your employment by paying the required premium. Portability is available if you cease employment for a reason other than total disability or retirement at Social Security Normal Retirement Age. A written application must be made within 31 days of your termination.
Term Life	Benefit provided to the designated beneficiary upon the death of the insured. The benefit is provided for the time period that you are eligible and premium is paid. There is no cash value associated with this product.
Exclusion: Suicide	Benefits will not be paid if the death results from suicide within 1 year after coverage is effective. May apply if employee contributes toward the premium.
Additional Benefits	
***LifeKeys*SM**	Online will & testament preparation service, identity theft resources and beneficiary assistance support for all employees and eligible dependents covered under the Group Term Life and/or AD&D policy.
***TravelConnect*SM**	Travel assistance services for employees and eligible dependents traveling more than 100 miles from home.

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Monthly Employee Premium
Life Premium for sample benefit amounts

Employee and Spouse premiums are calculated separately.
Refer to Program Specifications for your maximum benefit amounts.
Benefits and premium amounts reflect age reductions.

Monthly RATE Per $1000	AGE	$ 10,000	$ 20,000	$ 30,000	$ 40,000	$ 50,000	$ 60,000	$ 70,000	$ 80,000	$ 90,000	$ 100,000
0.0350	<25	$0.35	$0.70	$1.05	$1.40	$1.75	$2.10	$2.45	$2.80	$3.15	$3.50
0.0350	25-29	$0.35	$0.70	$1.05	$1.40	$1.75	$2.10	$2.45	$2.80	$3.15	$3.50
0.0950	30-34	$0.95	$1.90	$2.85	$3.80	$4.75	$5.70	$6.65	$7.60	$8.55	$9.50
0.1150	35-39	$1.15	$2.30	$3.45	$4.60	$5.75	$6.90	$8.05	$9.20	$10.35	$11.50
0.1550	40-44	$1.55	$3.10	$4.65	$6.20	$7.75	$9.30	$10.85	$12.40	$13.95	$15.50
0.2450	45-49	$2.45	$4.90	$7.35	$9.80	$12.25	$14.70	$17.15	$19.60	$22.05	$24.50
0.4750	50-54	$4.75	$9.50	$14.25	$19.00	$23.75	$28.50	$33.25	$38.00	$42.75	$47.50
0.7500	55-59	$7.50	$15.00	$22.50	$30.00	$37.50	$45.00	$52.50	$60.00	$67.50	$75.00
1.2050	60-64	$12.05	$24.10	$36.15	$48.20	$60.25	$72.30	$84.35	$96.40	$108.45	$120.50
1.6950	**65-69**	***$10,000***	***$20,000***	***$30,000***	***$40,000***	***$50,000***	***$60,000***	***$70,000***	***$80,000***	***$90,000***	***$100,000***
		$16.95	*$33.90*	*$50.85*	*$67.80*	*$84.75*	*$101.70*	*$118.65*	*$135.60*	*$152.55*	*$169.50*
3.0250	**70-74**	***$6,500***	***$13,000***	***$19,500***	***$26,000***	***$32,500***	***N/A***	***N/A***	***N/A***	***N/A***	***N/A***
		$19.66	*$39.33*	*$58.99*	*$78.65*	*$98.31*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
3.0250	**75-79**	***$4,500***	***$9,000***	***$13,500***	***$18,000***	***$22,500***	***N/A***	***N/A***	***N/A***	***N/A***	***N/A***
		$13.61	*$27.23*	*$40.84*	*$54.45*	*$68.06*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
3.0250	**80-84**	***$3,000***	***$6,000***	***$9,000***	***$12,000***	***$15,000***	***N/A***	***N/A***	***N/A***	***N/A***	***N/A***
		$9.08	*$18.15*	*$27.23*	*$36.30*	*$45.38*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
3.0250	**85-89**	***$2,000***	***$4,000***	***$6,000***	***$8,000***	***$10,000***	***N/A***	***N/A***	***N/A***	***N/A***	***N/A***
		$6.05	*$12.10*	*$18.15*	*$24.20*	*$30.25*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
3.0250	**90-99**	***$2,000***	***$4,000***	***$6,000***	***$8,000***	***$10,000***	***N/A***	***N/A***	***N/A***	***N/A***	***N/A***
		6.05	*12.1*	*18.15*	*24.2*	*30.25*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*

This is 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	X	Benefit In $1,000's	=	Monthly Cost
Example:	**35**	**0.1150**	**X**	**150**	**=**	**$ 17.25**
			X		**=**	

Dependent Children Benefit	**$ 10,000**
Monthly Rate:	$ 2.00

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

Monthly Spouse Premium
Life Premium for sample benefit amounts

Employee and Spouse premiums are calculated separately.
Spouse premiums will be calculated based on the Employee Age
Refer to Program Specifications for your maximum benefit amounts.
Benefits and premium amounts reflect age reductions.

Monthly RATE Per $1000	AGE	$ 5,000	$ 10,000	$ 15,000	$ 20,000	$ 25,000	$ 30,000	$ 35,000	$ 40,000	$ 45,000	$ 50,000
0.0350	<25	$0.18	$0.35	$0.53	$0.70	$0.88	$1.05	$1.23	$1.40	$1.58	$1.75
0.0350	25-29	$0.18	$0.35	$0.53	$0.70	$0.88	$1.05	$1.23	$1.40	$1.58	$1.75
0.0950	30-34	$0.48	$0.95	$1.43	$1.90	$2.38	$2.85	$3.33	$3.80	$4.28	$4.75
0.1150	35-39	$0.58	$1.15	$1.73	$2.30	$2.88	$3.45	$4.03	$4.60	$5.18	$5.75
0.1550	40-44	$0.78	$1.55	$2.33	$3.10	$3.88	$4.65	$5.43	$6.20	$6.98	$7.75
0.2450	45-49	$1.23	$2.45	$3.68	$4.90	$6.13	$7.35	$8.58	$9.80	$11.03	$12.25
0.4750	50-54	$2.38	$4.75	$7.13	$9.50	$11.88	$14.25	$16.63	$19.00	$21.38	$23.75
0.7500	55-59	$3.75	$7.50	$11.25	$15.00	$18.75	$22.50	$26.25	$30.00	$33.75	$37.50
1.2050	60-64	$6.03	$12.05	$18.08	$24.10	$30.13	$36.15	$42.18	$48.20	$54.23	$60.25
1.6950	**65-69**	***$5,000***	***$10,000***	***$15,000***	***$20,000***	***$25,000***	***$30,000***	***$35,000***	***$40,000***	***$45,000***	***$50,000***
		$8.48	*$16.95*	*$25.43*	*$33.90*	*$42.38*	*$50.85*	*$59.33*	*$67.80*	*$76.28*	*$84.75*
3.0250	**70-74**	***$3,250***	***$6,500***	***$9,750***	***$13,000***	***$16,250***	***$19,500***	***$22,750***	***$26,000***	***$29,250***	***$32,500***
		$9.83	*$19.66*	*$29.49*	*$39.33*	*$49.16*	*$58.99*	*$68.82*	*$78.65*	*$88.48*	*$98.31*
3.0250	**75-79**	***$2,250***	***$4,500***	***$6,750***	***$9,000***	***$11,250***	***$13,500***	***$15,750***	***$18,000***	***$20,250***	***$22,500***
		$6.81	*$13.61*	*$20.42*	*$27.23*	*$34.03*	*$40.84*	*$47.64*	*$54.45*	*$61.26*	*$68.06*
3.0250	**80-84**	***$1,500***	***$3,000***	***$4,500***	***$6,000***	***$7,500***	***$9,000***	***$10,500***	***$12,000***	***$13,500***	***$15,000***
		$4.54	*$9.08*	*$13.61*	*$18.15*	*$22.69*	*$27.23*	*$31.76*	*$36.30*	*$40.84*	*$45.38*
3.0250	**85-89**	***$1,000***	***$2,000***	***$3,000***	***$4,000***	***$5,000***	***$6,000***	***$7,000***	***$8,000***	***$9,000***	***$10,000***
		$3.03	*$6.05*	*$9.08*	*$12.10*	*$15.13*	*$18.15*	*$21.18*	*$24.20*	*$27.23*	*$30.25*

This is 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	X	Benefit In $1,000's	=	Monthly Cost
Example:	**35**	**0.1150**	**X**	**75**	**=**	**$ 8.63**
			X		**=**	

	$ 10,000
Dependent Children Benefit Monthly Rate:	$ 2.00

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

Lincoln Financial Group®
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Voluntary Accidental Death & Dismemberment Insurance

SUMMARY OF BENEFITS

Sponsored by: **Erikson Institute**

Benefit	Employee	Spouse	Dependent
Amount	Choice of $10,000 increments	Choice of $5,000 increments	Choice of $1,000 increments
Minimum Amount	$10,000	$5,000	$1,000
Maximum Amount	$500,000, limited to 5 times your annual salary	$250,000, limited to 50% of employee amount	$10,000

Benefit Reduction	Employee	Spouse
Benefits will reduce:	35% at age 70; Additional 20% of original amount at age 75; Additional 15% of original amount at age 80; Additional 10% of original amount at age 85; Benefits terminate at retirement	Benefits terminate at age 70 or Retirement, whichever occurs first
Additional Benefits	Safe Driver; Education; Spouse Training; Felonious Assault; Alternate; Child Care; Coma; Common Disaster; Exposure; Disappearance; Common Carrier; Repatriation; Enhanced Dismemberment for Dependent Children; Spouse Critical Period; Monthly Survivor; Helmet; Surgical Reattachment; Third Degree Burn; and Rehabilitation Reimbursement	

Eligibility	Employee	Spouse and Dependents
	All employees in an eligible class.	Cannot be in a period of limited activity on the day coverage takes effect.

Employee Monthly Premium for Accidental Death and Dismemberment coverage

Refer to Program Specifications for your maximum benefit amounts.

EXAMPLE: *Use your elected benefit amount in this formula to estimate your premium.*

	Monthly Rate per $1,000		Benefit in $1,000's		Monthly Cost
Employee	0.0250	X		=	
Spouse	0.0250	X		=	
Child	0.0250	X		=	
Example-Employee	0.0250	X	150	=	$3.75

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

Definitions	
AD&D	Accidental Death and Dismemberment (AD&D) insurance provides specified benefits for a covered accidental bodily injury that directly causes dismemberment (e.g., the loss of a hand, foot, or eye). In the event that death occurs from a covered accident, both the life and the AD&D benefit would be payable. This insurance is optional and can be purchased by you and your Spouse.
Limited Activity	A period when a Spouse or dependent is confined in a health care facility; or, whether confined or not, is unable to perform the regular and usual activities of a healthy person of the same age and sex.
Exclusion: Suicide	Benefits will not be paid if the death results from suicide after coverage is effective. May apply if employee contributes toward the premium.
Additional Benefits	
***LifeKeys*SM**	Online will & testament preparation service, identity theft resources and beneficiary assistance support for all employees and eligible dependents covered under the Group Term Life and/or AD&D policy.
***TravelConnect*SM**	Travel assistance services for employees and eligible dependents traveling more than 100 miles from home.

For assistance or additional information Contact Lincoln Financial Group at	
(800) 423-2765; reference ID: **ERIKINDS2**	www.LincolnFinancial.com

NOTE: This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater details. Should there be a difference between this summary and the contract, the contract will govern.

Insurance products are issued by The Lincoln National Life Insurance Company (Fort Wayne, IN), which does not solicit business in New York, nor is it licensed to do so. Product availability and/or features may vary by state. Limitations and exclusions apply. Not for use in New York.

Group Insurance

*TravelConnect*SM
Travel Assistance Services

Travel more and worry less

Lincoln Financial Group®

Introducing *TravelConnect*℠ services. A no-cost benefit providing you valuable services while traveling.

Traveling just got easier

As part of your employee benefits package, your Lincoln Financial Group life insurance coverage now includes our *TravelConnect* program, an employee benefit that includes travel, medical, and safety-related services while traveling. Lincoln Financial has partnered with MEDEX Assistance Corporation, a worldwide leader in travel assistance, to make this valuable benefit available to you and your immediate family members.

Business or leisure travel – it's covered

The *TravelConnect* benefit is provided at no cost to you and includes a wealth of services when traveling just 100 miles or more from home. These services are provided regardless if you're traveling for business or leisure. Whether you simply want the weather forecast for your travel destination or you need emergency medical assistance halfway around the world, MEDEX has the professional staff and resources to provide support, 24 hours a day, seven days a week.

Comprehensive coverage

Just a sampling of the services includes:

- Destination info – weather, currency, etc.
- Emergency travel arrangements and funds transfer.
- Lost or stolen travel documents assistance.
- Language translation services.
- Emergency medical evacuation and transportation.
- Dependent child transportation if left unattended.
- Medical and dental referrals.
- Assistance with corrective lenses or medical device replacement.
- Treatment monitoring of a medical situation.
- Arrange delivery of medications, vaccines, or blood.
- Updates to family, employer, and/or home physician.
- Repatriation of a deceased traveler.
- Security and political evacuation assistance.

Travel assistance services are subject to specific terms, conditions and limitations. A program description is available at www.jpfic.com. To use *TravelConnect* services, call MEDEX at (800) 527-0218 or (410) 453-6330 and provide them with ID number 322541.

Detach the card below and keep it with you while traveling for quick reference to MEDEX toll-free numbers worldwide.

TRAVEL WITH **CONFIDENCE**

MEDEX ID: 322541

Group Name: Lincoln Financial Group®

This card is non-transferable and not valid if cancelled.
Notice to Physicians/Hospitals: Call MEDEX immediately for benefits verification and procedures. Call 24 hours a day (multilingual). If you do not have access to a phone, email for assistance: operations@medexassist.com. www.medexassist.com

MEDEX

www.LincolnFinancial.com

Travel assistance services are provided by MEDEX Assistance Corporation in Townson, MD. Coverage is subject to actual policy language.

MEDEX is an independent company and not a member of Lincoln Financial Group. **Each organization is solely responsible for its own obligations.**

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates. **Each affiliate is solely responsible for its own financial and contractual obligations.**

GLM-06645 Rev. 4/08 BHP

Lincoln Financial Group®

MEDEX EMERGENCY RESPONSE CENTER:
United States, Baltimore, MD 1-410-453-6330

TOLL FREE ACCESS - The numbers below must be dialed from within the country.
If your location is not listed or the call will not go through, call the 24-hour Emergency Response Center COLLECT.

Australia and Tasmania:	1-800-127-907	**Mexico:**	001-800-101-0061
Austria:	0-800-29-5810	**Netherlands:**	0800-022-8662
Belgium:	0800-1-7759	**New Zealand:**	0800-44-4053
Brazil:	0800-891-2734	**Philippines:**	1-800-1-111-0503
China (northern regions):	108888*800-527-0218	**Portugal:**	0800-84-4266
China (southern regions):	10811*800-527-0218	**Republic of Ireland** (Eire):	1-800-409-529
Egypt (inside Cairo):	510-0200*877-569-4151	**Republic of South Africa:**	0800-9-92379
Egypt (outside Cairo):	02-510-0200*877-569-4151	**Singapore:**	800-1100-452
Finland:	0800-114402	**South Korea:**	00798-1-1-004-7101
France and Monaco:	0800-90-8505	**Spain and Majorca:**	900-98-4467
Germany:	0800-1-811401	**Switzerland and Liechtenstein:**	0800-55-6029
Greece:	00-800-4412-8821	**Thailand:**	001-800-11-471-0661
Hong Kong:	800-96-4421	**Turkey:**	00-800-4491-4834
Indonesia:	001-803-1471-0621	**U.K., N. Ireland, Isle of Jersey, the Channel Isles and Isle of Man:**	0800-252-074
Israel:	1-800-941-0172	**U.S., Canada, Puerto Rico, US Virgin Islands, Bermuda:**	1-800-527-0218
Italy, Vatican City and San Marino:	800-877-204		
Japan:	00531-11-4065		

* Dial the first portion of phone number, wait for tone, and then dial remaining numbers.

EmployeeConnect℠ services

We offer confidential guidance and resources for you or an immediate household family member.

- In-person help with short-term issues; up to four* sessions per person, per issue, per year
- Toll-free phone and web access 24/7
- Unlimited phone access to legal, financial and work-life services
- A 25% discount on in-person consultations with network lawyers
- Financial consultations and referrals
- Work/life services for assistance with child care, finding movers, kennels and pet care, vacation planning, and more.

To learn more about the Lincoln Financial *EmployeeConnect* program, visit www.Lincoln4Benefits.com or www.GuidanceResources.com (user name = LFGsupport; password = LFGsupport1), or talk with a specialist at 888-628-4824.

*In California, up to three sessions in six months, starting with initial contact by employee.

BP 10/13 **Z04**
Order code: GP-EMPCO-SJM001

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Servicios *EmployeeConnect*℠

Ofrecemos orientación y recursos confidenciales para usted o para un familiar cercano de su grupo familiar.

- Ayuda personalizada con problemas de corto plazo; hasta un máximo de cuatro* sesiones por persona, por problema, por año
- Teléfono sin costo y acceso por Internet 24/7
- Acceso telefónico ilimitado a servicios jurídicos, financieros y servicios de ayuda en el trabajo y en la vida cotidiana
- Un 25% de descuento en las consultas personales con abogados de la red
- Consultas financieras y referencias
- Servicios de ayuda en el trabajo y en la vida cotidiana con guardería infantil, encontrar servicios de mudanza, perreras y cuidado de mascotas, planificación de vacaciones, y más.

Para conocer más acerca del programa *EmployeeConnect* de Lincoln Financial visite www.Lincoln4Benefits.com o www.GuidanceResources.com (nombre de usuario = LFGsupport; contraseña = LFGsupport1), o para hablar con un especialista llame al 888-628-4824.

*En California, hasta tres sesiones en seis meses, a partir del contacto inicial realizado por el empleado.

BP 10/13 **Z04**
Código de pedido: GP-EMPCO-SJM001

Lincoln Financial Group®

You're In Charge®

GROUP BENEFITS

HANDLING LIFE, HANDLING LOSS

Lincoln Financial Group®

You're In Charge®

LifeKeys℠ services help you meet life's challenges

When you choose life insurance, you're planning for your family's future—assuring their comfort and securing their plans. With Lincoln Term Life Insurance, you can also access services that make a real difference now as well as in the future. *LifeKeys* services, included at no additional cost with all Lincoln Term Life and Accidental Death and Dismemberment Insurance policies, provide assistance to you, your family and your beneficiaries.

FOR YOU AND YOUR FAMILY...

EstateGuidance® will preparation

Create your will online—easily and economically. Follow a step-by-step guide through the entire process, and then use online instructions to execute your will. You can:

- Name an executor to manage your estate
- Choose a guardian for your children
- Specify wishes for your property
- Provide funeral and burial instructions

GuidanceResources® Online

GuidanceResources® Online is the place to go for articles, tutorials, streaming videos and "Ask the Expert" personal responses on topics such as:

- Law and regulations
- Money and investments
- Family and relationships
- Health and wellness
- Work and education
- Leisure and home

Identity theft

Identity theft is one of the fastest-growing crimes in the U.S. Be sure you have the information you need to recognize and prevent it. Our online resource helps you:

- Spot the warning signs
- Take steps to protect your cell phone, computer and tax records from fraud
- Lessen the damage and repair your credit if identity theft occurs
- Link to essential resources such as credit reporting bureaus, the FBI Internet Crime Complaint Center, ID Theft Resource Center, and more.

You may also be eligible for beneficiary services

If you develop a terminal illness and access your Accelerated Death Benefit, you will be able to use beneficiary services shown on the other side of this flier.

To access *LifeKeys* services: Call 1-855-891-3684 or visit Lincoln4Benefits.com (Web ID = LifeKeys)

Insurance products issued by:
The Lincoln National Life Insurance Company
Lincoln Life & Annuity Company of New York

FOR YOUR BENEFICIARIES...

Services are available for up to one year after a loss, and include:

A combination totaling six in-person sessions for grief counseling, or legal or financial information

and

Unlimited phone counseling

Assistance at a difficult time

Make sure your loved ones have the support they need, should you pass away. Unlimited phone contact with master's-level grief counselors lets your beneficiaries access information, advice and referrals for topics such as:

- Grief and loss
- Stress, anxiety and depression
- Memorial planning information
- Concerns about children and teens

Financial services

Your beneficiaries can call one of our certified financial specialists or use online tools and resources whenever they need help with essential topics such as:

- Estate planning
- Budgeting
- Debt
- Bankruptcy
- Investments

Legal support

If your beneficiaries need quick legal information, they can call one of our in-house attorneys. Or, if they need in-depth information, guidance or representation, we'll refer them to a qualified attorney in their area. They will be eligible for a free 30-minute consultation as well as a 25% reduction in customary legal fees thereafter. They'll get expert guidance on areas such as:

- Estate and probate law
- Real estate transactions
- Social Security survivor and child benefits
- Important documents beneficiaries need

Support with day-to-day concerns

Through good times and bad, everyone can use assistance. *LifeKeys*℠ services provide in-depth information and guidance—on virtually any topic you can name. Your beneficiaries can call for a quick answer or take advantage of specialists who will do the research for them and provide a comprehensive, customized booklet of information. Topics include:

- Planning a memorial service
- Finding child care or elder care
- Selecting a mortgage
- Moving and relocation
- Making major purchases

To access *LifeKeys* beneficiary services: Call 1-855-891-3684 or visit guidanceresources.com (First-time user: Web ID = LifeKeys)

LincolnFinancial.com

BP 3/13 **Z01**
Order code: LFE-SERV-FLI002

Lincoln Financial Group®

You're In Charge®

Summary Plan Description

Prepared for

Erikson Institute DC Retirement Plan

INTRODUCTION

Erikson Institute has restated the Erikson Institute DC Retirement Plan (the "Plan") to help you and other Employees save for retirement.

Your Employer restated the Plan by signing a complex legal agreement – the Plan document - which contains all of the provisions that the Internal Revenue Service (IRS) requires. The Plan document must follow certain federal laws and regulations that apply to retirement plans. The Plan document may change as new or revised laws or regulations take effect. Your Employer also has the right to modify certain features of the Plan from time to time. You will be notified about changes affecting your rights under the Plan.

This Summary Plan Description (SPD) summarizes the important features of the Plan document, including your benefits and obligations under the Plan. If you want more detailed information regarding certain plan features or have questions about the information contained in this SPD, you should contact your Employer. You may also examine a copy of the plan document by making arrangements with your Employer. Certain terms in the SPD have a special meaning when used in the Plan. These terms are capitalized throughout the SPD and are defined in more detail in the DEFINITIONS section of the SPD. If any information in this SPD conflicts with the terms of the Plan document adopted by your Employer, the terms of the Plan document – not this SPD - will govern.

All dollars contributed to the Plan will be invested either in annuity contracts or in mutual funds held in custodial accounts. The agreements constituting or governing the annuity contracts and custodial accounts (the "Individual Agreements") explain your rights under the contracts and accounts and the unique rules that apply to each Plan investment which may, in some cases, limit your options under the Plan. For example, the Individual Agreement may contain a provision which prohibit loans, even if the Plan generally allows loans. If this is the case, you would not be able to take a loan from the accumulation in an investment option governed by that Individual Agreement. You should review the Individual Agreements along with this SPD to gain a full understanding of your rights and obligations under the Plan. Contact your Employer or the investment vendor to obtain copies of the Individual Agreements or to receive more information regarding the investment options available under the Plan.

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DEFINITIONS

ELIGIBILITY

Am I eligible to participate in the Plan?
You will be eligible to contribute a portion of your pay to the Plan as a pre-tax Deferral, unless you fall into one of the following categories of excluded employees.

- You are a nonresident alien and you received no income from within the United States.
- You are a student enrolled and attending classes offered by your Employer and your Employer is a school, college or university.

You will be eligible to participate in the Plan and receive contributions made by your Employer after meeting certain requirements described below, unless you fall into one of the following categories of excluded employees.

- You are a nonresident alien and you received no earned income from within the U.S.
- You are a student enrolled and attending classes offered by your Employer and your Employer is a school, college, or university.

The Plan document is being amended or restated on to new Plan documents. If you were eligible to participate in the prior plan, you will continue to be eligible to participate in this Plan without satisfying any additional age or service requirements.

What requirements do I have to meet before I am eligible to participate in the Plan?
Unless you fall into one of the categories of excluded employees, you will be immediately eligible (or required) to:

- defer a portion of your pay as a pre-tax Deferral into the Plan

Unless you are part of an excluded class of employees, you must reach age 18 before you will be eligible to receive contributions made by your Employer. However, there is no age requirement for deferring a portion of your Compensation as a pre-tax Deferral. The age requirement listed above, however, will apply to pre-tax Deferrals only if you can defer pre-tax or Roth Deferrals into another plan maintained by your Employer that does not have any age and service requirements.

Unless you are part of an excluded class of employees, you must complete:

- 1 consecutive month(s) of service with the Employer

before you are eligible to receive contributions made by your Employer. However, there is no years of service requirement for deferring a portion of your Compensation as a pre-tax Deferral. The years of service requirement listed above, however, will apply to pre-tax Deferrals only if you can defer pre-tax or Roth Deferrals into another plan maintained by your Employer that does not have any age and service requirements.

When can I enter the Plan?

Deferral Contributions

You will be able to contribute a portion of your pay into the Plan as a pre-tax Deferral as soon as administratively feasible after your hire date.

Employer Contributions and Matching Contributions

Once you have met the age and service requirements listed above, you will enter the Plan the first day of the next month and become eligible to receive Employer Contributions or Matching Contributions from your Employer.

What happens to my Plan eligibility if I terminate my employment and am later rehired?

Once you satisfy the eligibility requirements and enter the Plan, you will continue to participate while you are still employed by the Employer, even if you have a break in eligibility service. A break in service occurs when you do not work more than 500 hours. If you had not yet satisfied the eligibility requirements and had a break in eligibility service, periods before your break in service will not be taken into account and you will have to satisfy the eligibility requirements following your break in service. Periods during which you have a break in eligibility service will not count against you if you were absent because you were pregnant, had a child or adopted a child, were serving in the military, or provided service during a national emergency and re-employment is protected under federal or state law, and you return to employment within the time required by law.

If you terminate employment and are later rehired, you will be able to defer a portion of your Compensation as a Deferral as soon as administratively feasible after being rehired. If you had met the eligibility requirements for Employer Contributions or Matching Contributions and were a Participant in the Plan before terminating employment or having a break in eligibility service, and are later rehired, you will enter the Plan immediately. If you were not a Participant before the break in eligibility service, and are rehired, you will need to again satisfy the Plan's eligibility requirements for Employer Contributions or Matching Contributions.

CONTRIBUTIONS & VESTING

What amount can I contribute to the Plan?

Deferrals

You will be able to contribute a portion of your Compensation as a pre-tax Deferral unless you are a member of one of the

excluded classes listed previously. The maximum dollar amount that you can contribute to the Plan each year is $17,000 for 2012 and includes contributions you make to certain other deferral plans (e.g., other 401(k) plans, salary deferral SEP plans, and 403(b) tax-sheltered annuity plans). This amount will increase as the cost of living increases. Deferrals (and the related earnings) are always fully vested and cannot be forfeited. So if you were to leave your Employer, you would be entitled to the full Deferral balance (plus earnings).

The amount of your Compensation that you decide to defer into the Plan generally will be contributed on a pre-tax basis. That means that, unlike the compensation that you actually receive, the pre-tax contribution (and all of the earnings accumulated while it is invested in the Plan) will not be taxed at the time it is paid by your Employer. Instead, it will be taxable to you when you take a payout from the Plan. These contributions will reduce your taxable income each year that you make a contribution but will be treated as compensation for Social Security taxes.

EXAMPLE: Assume your Compensation is $25,000 per year. You decide to contribute five percent of your Compensation into the Plan. Your Employer will pay you $23,750 as gross taxable income and will deposit $1,250 (five percent) into the Plan. You will not pay federal income taxes on the $1,250 (plus earnings on the $1,250) until you withdraw it from the Plan.

Catch-up Contributions

Age 50 Catch-up Contributions - If you are eligible to make Deferrals and you turn age 50 before the end of any calendar year, you may defer up to an extra $5,500 each year (for 2012) into the Plan as a pre-tax contribution once you meet certain Plan limits. The maximum catch-up amount may increase as the cost of living increases.

Special 403(b) Catch-up Contributions – If you have worked at least 15 years for the Employer, and the Employer is a qualified organization, you may make a special catch-up contribution equal to the smallest of the three amounts listed below:

1. $3,000

2. $15,000 minus the amount of Special 403(b) Catch-Up Contributions made in prior years

3. ($5,000 times the number of years you have worked for the Employer) minus (the total amount of Deferrals made while you worked for the Employer)

These catch-up contributions will be eligible for Matching Contributions from your Employer (if any).

If you qualify for both the age 50 catch-up contributions and the special 403(b) catch-up contributions, your catch-up contributions will be allocated first as special 403(b) catch-up contributions. Catch-up contributions (and the related earnings) are considered Deferrals and are always fully vested. So if you were to leave your Employer, you would be entitled to the full catch-up balance (plus earnings).

How do I start making contributions?

To begin deferring a portion of your Compensation into the Plan, you must follow the procedures established by your Employer.

What if I don't make a specific election to contribute some of my Compensation into the Plan?
You are not required to defer a portion of your Compensation into the Plan. If you elect 0% or you simply fail to follow the procedures established by your Employer for making a Deferral election, you will not be enrolled in the Plan as a deferring Participant (i.e., 0% of your Compensation will be deferred into the Plan).

Can I change my contribution rate or stop making Deferrals after I start participating in the Plan?
You may change the amount you are deferring into the Plan or stop making Deferrals altogether at the times determined by your Employer. Generally, once you stop your Deferrals, you will not be able to reenroll in the Plan and begin making Deferrals again until the first day of the next Plan Year, or the first day of the seventh month of the Plan Year, unless your Employer decides to allow more frequent re-entry.

Example: Assume the Plan Year is the calendar year and you are enrolled in the Plan and deferring 6% of your Compensation into the Plan as a pre-tax Deferral. On October 1 you decide to stop making Deferrals. You will not be able to re-enter and begin making Deferrals again until January 1.

What if I contribute too much to the Plan?
If you contribute too much to the Plan as a Deferral, you must take the excess amount (plus any earnings on the excess) out of the Plan by April 15 of the year following the year the money was contributed to the Plan. You must notify your Employer, in writing, of the excess amount by March 1 and request that it be removed. The excess amount is taxable to you in the year you contributed it to the Plan. If you do not remove it by the deadline, additional taxes will apply.

If I make Deferrals to the Plan, will my Employer match any of those contributions?
Each year that you contribute a portion of your Compensation into the Plan as a pre-tax Deferral, and satisfy the additional conditions outlined below, your Employer will make a contribution to the Plan as a Matching Contribution on your behalf based on the following formula.

Employee (EE): equal to 2% but less than 4% - Employer (ER) contributes 2%, EE: equal to 4% but less than 6% - ER contributes 4%, EE: equal to 6% but less than 7% - ER contributes 6%, EE equal to 7% or greater - ER contributes 7%.

In addition to making a pre-tax Deferral, you must also work 1000 hours during the Plan Year to qualify for a Matching Contribution.

The 1000 hours of service requirement will not apply, however, if you die, you terminate employment after becoming disabled, or you terminate employment after reaching age 59.5.

Will the Employer make any additional contributions to the Plan?
The Employer has the option to make Employer Contributions to the Plan but may choose not to make those contributions in certain years.

The Employer Contributions made by the Employer to the Plan will be allocated using a discretionary formula. Under this formula the amount of Employer Contributions, if any, will be determined each year by your Employer and divided among all eligible Plan Participants based on their Compensation as compared to all eligible Participants' Compensation.

In addition to the Employer Contributions described above, your Employer may choose to make a supplemental Employer Contribution. The amount of this supplemental Employer Contribution, if any, will be determined each year by your Employer and 2% maximum.

To qualify to receive an Employer Contribution, you must satisfy the eligibility requirements for Employer Contributions and must also work 1000 service hours during the Plan Year.

If you are on a paid leave of absence from your Employer, you will still be eligible to receive an Employer Contribution based on the Compensation received during the leave.

QNEC

Your Employer may decide to make Qualified Nonelective Contributions to the Plan to satisfy special nondiscrimination rules which apply to the Plan. The amount of the Qualified Nonelective Contribution, if any, will be determined each year by your Employer.

If I have money in other retirement plans, can I combine them with my accumulation under this Plan?

Your Employer may allow you to roll over dollars you have saved in other retirement arrangements into this Plan after you become eligible to participate in the Plan. Your Employer will provide you with the documents or other information you need to determine whether your prior plan balance is qualified to be rolled into this Plan.

The Plan will accept amounts rolled over from the prior plan to this Plan if the prior plan was a:

- qualified retirement plan (e.g., 401(k) plan, profit sharing plan, money purchase pension plan, target benefit plan)
- 403(b) tax-sheltered annuity plan
- government 457(b) plan
- Traditional IRA

Participants and/or beneficiaries who received 2009 RMDs and extended RMDs distributed for 2009 were allowed to roll those distributions over into this plan in accordance with the rollover contributions rules listed above.

Plan to Plan Transfers

Your Employer may allow you to transfer dollars you have saved in other 403(b) retirement arrangements into this Plan if you are currently working for the Employer. Your Employer will establish certain procedures that you must follow if you are making a plan to plan transfer. Limits on the timing of distribution that existed in the prior plan will continue to apply to the assets that you transfer to this Plan.

Rollover and Transfer contributions are always 100 percent vested and nonforfeitable.

Are there any limits on how much can be contributed for me?
In addition to the Deferral limit described previously, you may not have total contributions (including Deferrals) of more than $50,000, plus any age 50 catch-up contributions, in 2012 or an amount equal to 100% of your Compensation, whichever is less, allocated to the Plan for your benefit each year. The $50,000 limit will be increased as the cost of living increases, and is the total amount that can be contributed across all retirement plans sponsored by your Employer.

Will contributions be made for me if I am called to military service?
If you are reemployed by your Employer after completing military service, you may be entitled to receive certain make-up contributions from your Employer. If your Plan permits Deferrals or Nondeductible Employee Contributions, you may also have the option of making up missed employee contributions and receiving a Matching Contribution, if applicable, on these contributions.

If you are reemployed after military service, contact your Plan Administrator for more information about your options under the Uniformed Services Employment and Reemployment Rights Act (USERRA).

Will I be able to keep my Employer contributions if I terminate employment or am no longer eligible to participate in the Plan?
Contributions that you receive from your Employer are subject to a vesting schedule and could be forfeited if you terminate your employment or have a break in service. You will earn the right to a greater portion of contributions that you receive from your Employer the longer you work for your Employer. Generally, all of your years of service with the Employer count toward determining your vested percentage; however, you must work at least 1,000 hours during each Plan Year to earn a year of vesting service.

The following vesting schedule applies to contributions received from your Employer:

YEARS OF VESTING SERVICE	VESTED PERCENTAGE
Less than One	0%
1	100%
2	100%
3	100%
4	100%
5	100%
6	100%

EXAMPLE: You have worked for your Employer four years and have received $1,000 in contributions from your Employer. You terminate employment and request a distribution of contributions that you received from your Employer. Because you have four years of vesting service, you will receive 100% or $1,000.

Although your Employer has adopted a vesting schedule, your balance will become 100 percent vested when you reach Normal Retirement Age, the Plan is terminated, contributions to the Plan are discontinued, you die or you incur a Disability.

Like the amounts that you contribute to the Plan as Deferrals, Qualified Nonelective Contributions that you receive from your Employer will always be 100 percent vested and cannot be forfeited, even if you terminate employment or become ineligible to participate in the Plan.

What happens to the nonvested portion of my account if I terminate employment?
If you terminate employment, you will always retain the right to the vested portion of your Plan balance. Your nonvested portion may be forfeited and used to pay the Plan's administrative expenses or used to reduce future Employer contributions to the Plan. If you are rehired before five breaks in vesting service occur, your forfeited amount will be restored but you may be required to repay the full amount of any payout you have taken. To avoid a break in vesting service, you must work more than 500 hours during any Plan Year.

WITHDRAWING MONEY FROM THE PLAN (AND LOANS)

When can I take a distribution from the plan?
You may always request a distribution of contributions you have received from your Employer upon termination of employment after reaching age 59.5.

You may request a distribution of Deferrals at the times listed below.

- You terminate employment
- You become Disabled
- When you reach age 59½
- When you reach age 59.5
- On account of hardship
- At any time with respect to pre-1989 Deferrals invested in an annuity contract

You may request a distribution of the contributions you receive from your Employer at the times listed below, if they are invested in annuity contracts.

- You terminate employment
- When you reach 59.5
- After participating in the Plan for five years
- At any time with respect to contributions in annuity contracts issued prior to 2009.

You may elect a distribution of your transfer contributions and/or rollover contributions at any time subject to the restrictions in the Individual Agreements.

With regard to transfer contributions, distribution restrictions that applied in the plan that held the transferred amount before you moved it to this Plan may limit your payout options. If the distribution options were more limited under the prior plan, the transferred amount will remain subject to those more restrictive distribution rules.

Hardship

If you experience a financial hardship, you may take a distribution from the Deferrals you have contributed to the Plan, unless restricted under the terms of the Individual Agreements.

The following events qualify as a hardship distribution under the Plan:

- medical expenses for you, your spouse or your dependents, or your beneficiary,
- payment to purchase your principal residence,
- tuition and education-related expenses for you, your spouse or your dependents, or your beneficiary
- payments to prevent eviction from your principal residence,
- funeral expenses for you, your spouse or your dependents, or your beneficiary,
- payments to repair your principal residence that would qualify for a casualty loss deduction.

Before you take a hardship distribution, you must take all other distributions and all nontaxable loans available to you under the Plan. If you take a hardship distribution of Deferrals, you may not be eligible to make Deferrals for the next six months. If you are under age 59½, the amount you take out of the Plan as a hardship distribution may be subject to a 10 percent penalty tax. This is only required under the safe harbor method of determining hardship.

You may be able to take a penalty-free distribution from your Deferrals if you were called to active military duty after September 11, 2001. In order to qualify for these penalty-free distributions, you must have been ordered or called to active duty for a period of at least 180 days or an indefinite period and your distribution must have been taken after you were called to duty and before your active duty ended.

The Individual Agreements governing the investment options that you selected for your Plan contributions may contain additional limits on when you can take a distribution, the form of distribution that may be available as well as your right to transfer among approved investment options. Please review both the following information in this Summary Plan Description and the terms of your annuity contracts or custodial agreements before requesting a distribution. Contact your Employer or the investment vendor if you have questions regarding your distribution options.

How do I request a payout?
You must complete a payout request form provided or approved by your Employer or follow other procedures established by your Employer for processing distributions.

If you are taking a hardship distribution, you must provide documents to verify that you have a hardship event that qualifies for a Plan distribution.

If you die, become Disabled, or reach age 59.5 and you qualify for and request a distribution, your distribution will begin as soon as administratively feasible after the date you (or your beneficiary in the case of your death) request a distribution.

If you terminate your employment and you qualify for and request a distribution, your distribution will begin as soon as administratively feasible after the date you (or your beneficiary in the case of your death) request a distribution.

If I am married, does my spouse have to approve my distributions from the Plan?
If you are married, you must get written consent from your spouse to take a distribution from the Plan in any form other than a qualified joint and survivor annuity. Your spouse's consent is also needed if you want to name someone other than your spouse as your beneficiary. The annuity would need to be structured to provide a benefit while you are both alive and then to provide a survivor benefit that is equal to 50 percent of the amount you received while you were both living. You can designate a different survivor percentage subject to certain limits under the qualified optional survivor annuity regulations. Your Employer will provide you with more information regarding your annuity options when it comes time for you to make a decision. Follow the procedures established by your Employer to document your spouse's consent to waive the annuity and take the payment in some other form permitted by the Plan. Your spouse must also consent to any Plan loans that you request.

Your spouse's consent may have been required to either stop required payments for 2009, begin payments again in 2010, or both. Your Plan Administrator can tell you whether spousal consent was needed to stop and/or re-start required minimum distributions.

How will my money be distributed to me if I request a payout from the Plan?
If you obtain the proper consents, you may choose from the following options for your payout.

- Lump sum
- Partial payments

- Installment payments
- Annuity contract (if assets are held in a custodial account) or converted to an income option (if your assets are invested in an annuity contract)

The Individual Agreements governing the investment options that you selected for your contributions may further restrict your payout options. Please review the annuity contracts or custodial agreements before requesting a distribution and contact your Employer or the investment vendor if you have questions regarding your distribution options.

If your distribution is eligible to be rolled over, you may choose to have your distribution paid to another eligible retirement arrangement. Contact your Employer for information regarding rollover procedures.

Do any penalties or restrictions apply to my payouts?
Generally, if you take a payout from the Plan before you are age 59½, a 10 percent early distribution penalty will apply to the taxable portion of your payout. There are some exceptions to the 10 percent penalty. Your tax adviser can assist you in determining whether you qualify for a penalty exception.

If your payout is eligible to be rolled over, 20 percent of the taxable portion of your payout will be withheld and remitted to the IRS as a credit toward the taxes you will owe on the payout amount unless you do a direct rollover.

EXAMPLE: You request a $10,000 payout from the pre-tax portion of your Plan balance. If the amount is eligible to be rolled over to another plan, but you choose not to roll it over directly, you will receive $8,000 and $2,000 will be remitted to the IRS.

Can I take a loan from the Plan?
Although the Plan is designed primarily to help you save for retirement, you may take a loan from the Plan as outlined below, subject to the terms and restrictions in the Individual Agreements. Please review your annuity contracts or custodial agreements before requesting a loan. Contact your Employer or the investment vendor if you have questions regarding your loan options.

The Individual Agreements governing the investment options that you selected for your Plan contributions may contain additional limits on when you can take a loan. Please review both the following information in this Summary Plan Description and your annuity contracts or custodial agreements before requesting a loan. Contact your Employer or the investment vendor if you have questions regarding your loan options.

Generally the minimum loan amount that you may take is $1,000 and the maximum loan amount is $50,000. The maximum amount you can borrow may be less, however, depending on two factors: 1) the amount of your accumulation under the Plan, and 2) whether you have taken other loans from any of this Employer's plans within the last year. If you have not had a plan loan in the previous year, your maximum loan cannot be greater than one-half of your vested account balance or $50,000, whichever is less. If you have had another loan, the $50,000 maximum will be reduced by the highest outstanding loan balance in the 12 month period prior to the new loan.

If your loan is being taken from a TIAA-CREF Annuity, your maximum loan amount is further limited to

1) 45% of your combined TIAA and CREF accumulation attributable to participation under this Plan; or
2) 90% or your CREF and TIAA Real Estate accumulation attributable to participation under this Plan for Retirement Loan (RL) loans or
3) 90% of your TIAA Annuity accumulation attributable to participation under this Plan for a Group Supplemental Retirement Annuity (GSRA) loan.

If you default on a loan, your right to a future loan may be restricted. Further, the maximum amount that you can borrow from the Plan will be reduced by the amount in default (plus interest) until the defaulted amount can be deducted from your Plan accumulation. If more than one employer contributed to your TIAA-CREF Annuities, you can only take loans based on the amount you accumulated under this Employer's plan. You should check with your other employers for the rules that apply to loans from the amounts you accumulated while working for the other employers.

If your loan is based on amounts invested in your TIAA-CREF mutual funds, you may not have more than three loans at any one time (from all plans of all employers).

The maximum amount you may borrow from the Plan is also limited to the portion of your plan balance that consists of the following types of contributions:

- pre-tax Deferrals but only unmatched

If your loan is used to purchase a primary residence, you must repay it within ten years. Other loans must be repaid within one to five years.

How do I apply for a loan?
To apply for a loan you must complete the loan application provided (or approved) by your Employer and pay any applicable loan fees.

Your Employer will administer the loan program and will consider the vested portion of your account when reviewing your loan request.

What is the interest rate for my loan?
The interest rate for your loan will vary, as described below, depending upon how your retirement balance is invested.

- Group Supplemental Retirement Unit-Annuity (GSRA) contract - The interest rate is variable and can increase or decrease every three months. The interest rate you pay initially will be the higher of 1) the Moody's Corporate Bond Yield Average for the calendar month ending two months before your loan is issued; or 2) the interest rate credited before your annuity starting date, as stated in the applicable rate schedule, plus 1 percent. Thereafter, the rate may change quarterly, but only if the new rate differs from your current rate by at least ½ percent.

- Retirement Loan (RL) contract - For all Employers except those located in Arkansas, Hawaii, or New Jersey, the interest rate you pay initially will be the higher of 1) the Moody's Corporate Bond Yield Average for the calendar month ending two months before your loan is issued; or 2) the interest credited before your annuity starting date,

as stated in the applicable rate schedule, plus 1 percent. Thereafter the rate will change annually, but only if the Moody's Corporate Bond Yield Average for the calendar month ending two months before the anniversary of your loan differs from your current rate by at least a half percent. If the latest average differs by less, your interest rate will remain the same for the next year. For Employers located in Arkansas, Hawaii, or New Jersey, the interest rate will be a fixed rate of 8 percent.

- TIAA-CREF mutual funds - The interest rate for loans from TIAA-CREF mutual funds will be fixed for the term of the loan and will be equal to the Federal Reserve Board Bank prime loan rate plus 1 percent at the time of the loan origination.

What if I don't repay my loan?

You will be required to repay the loan amount (plus interest) to the Plan. If you default on the loan, you will be taxed on the amount of the outstanding loan balance and will be subject to a 10 percent penalty if you are under age 59½. In addition, your Employer has the right to foreclose its security interest in the portion of your vested account under the Plan that you pledged as security for the loan, when an event allowing a Plan distribution occurs. The following events will cause a loan default:

- Not repaying your loan as set forth in your loan agreement.
- Breaching any of your obligations under your loan agreement.
- Severing your employment (for loans from mutual funds in custodial accounts)

If your loan is defaulted, your Employer has the right to foreclose the security interest in your vested account balance pledged for repayment, when an event which triggers a distribution of your benefits occurs. In addition, the loan administrator will report the loan default to the IRS and the outstanding loan amount and accrued interest will be treated as a taxable distribution. If you are under age 59½, this could result in a 10 percent penalty on the taxable portion of the default.

What if I die before receiving all of my money from the Plan?

If you die before taking all of your assets from the Plan, the remaining balance will be paid to your designated beneficiary. To designate your beneficiary, you must follow the procedures established by your Employer. If you are married and decide to name someone other than your spouse as your beneficiary, your spouse must consent in writing to your designation. It is important to review your designation from time to time and update it if your circumstances change (e.g., a divorce, death of a named beneficiary).

If you do not name a beneficiary, 50% of your balance will be paid to your spouse and 50% will be paid to your estate. If you do not name a beneficiary and have no surviving spouse, your remaining balance in the Plan will be paid to your estate, unless a different alternative is provided in the Individual Agreement.

If your Plan balance is $5,000 or less at the time of your death, your beneficiary will generally have the same options regarding the form of the distribution that are available to you as a Participant. If the balance is greater than $5,000, your beneficiary may be required to take the payouts in the form of a life annuity, unless the annuity has been properly waived by you and your spouse during your lifetime. Your beneficiary may also have the option of rolling their distribution into an IRA. The Individual

Agreements governing the investment options that you selected for your contributions may further restrict your beneficiary's options regarding the manner in which the accumulation will be distributed.

If you die after beginning age 70½ distributions, as described in the following question, your beneficiary must continue taking distributions from the plan at least annually. If you die before beginning age 70½ payments, your beneficiary may have the option of (1) taking annual payments beginning the year following your death (or the year you would have reached age 70½, if your spouse is your beneficiary), or (2) delaying their distribution until the year containing the fifth anniversary of your death, provided they take the entire amount remaining during that fifth year.

Effective beginning 2009, if you are a beneficiary using the five-year rule for distributions of your benefits, 2009 does not count toward determining the end of the five-year period. For example, if the participant died in 2007, you will have until December 31, 2013, instead of December 31, 2012, to deplete your account under the Plan.

How long can I leave the money in my Plan?
When you terminate from employment, your balance will generally not be paid out of the Plan until you request a payout from your Employer.

Age 70½ Required Distributions
When you reach age 70½ you will generally need to begin taking a distribution each year based on your balance in the Plan. However, unless you own more than 5% of the Employer, you can delay required distributions until you actually separate from service. Contributions for periods before 1987 (excluding earnings on those contributions) will generally not be subject to the required distribution rules until you reach age 75. You may also have the option to satisfy your required minimum distribution from the Plan by aggregating all your 403(b) plans and taking the required minimum distribution from any one or more of the individual 403(b) plans.

Effective for 2009, you may have chosen whether or not to take your required minimum distribution for 2009. If you did not make that choice, the Employer retained that amount within the Plan.

Effective for 2009, you may have chosen to roll over your 2009 and/or extended 2009 required minimum distribution to another eligible retirement arrangement.

What if the Plan is terminated?
If the Plan is terminated, your entire account balance will be distributed from the Plan. To the extent you are invested in an annuity contract, you will receive a distribution of the contract.

INVESTING YOUR PLAN ACCOUNT

What investments are permitted?
Your Employer (or someone appointed by your Employer) will select the investment vendors and investment options that will be available under the Plan. The investment options will be limited to annuity contracts and mutual funds purchased through a

custodial account. The list of approved investment options and vendors may change from time to time as your Employer considers appropriate. Your Employer may restrict the list of vendors who may accept new contributions to the Plan and it may be different from the list of vendors and investment options available once the contributions have been made to the Plan through a contract exchange. You should carefully review the Individual Agreements governing the annuity contracts and custodial accounts, the prospectus, or other available information before making investment decisions.

Who is responsible for selecting the investments for my contributions under the Plan?
You have the right to decide how your Plan balance will be invested. Your Employer will establish administrative procedures that you must follow to select your investments. Your Employer will designate a list of vendors and investment options that you may select for new contributions to the Plan. You will have the ability to transfer your Plan balance among these vendors and investment options, to the extent permitted by the Individual Agreements. Contact your Employer if you are not certain whether a particular vendor or investment option is permitted under the Plan. If you do not select investments for your Plan account, the Employer will determine how your account will be invested.

Your Employer intends to operate this Plan in compliance with Section 404(c) of the Employee Retirement Income Security Act (ERISA), and Title 29 of the Code of Federal Regulations Section 2550.404c-1. This means that your Employer and others in charge of the Plan will not be responsible for any losses that result from investment instructions given by you or your beneficiary.

How frequently can I change my investment elections?
You may change your initial investment selections as frequently as permitted under the Individual Agreements.

ADMINISTRATION INFORMATION AND RIGHTS UNDER ERISA

Who established the Plan?
The official name of the Plan is Erikson Institute DC Retirement Plan
The Employer who adopted the Plan is:

Erikson Institute
451 N La Salle Dr
Chicago, IL 60654
312-755-2250
Federal Tax Identification Number: 362593545
Fiscal Year End: 06/30

Your Employer has assigned Number 001 to the Plan.

The Plan is a 403(b) defined contribution plan, which means that contributions to the Plan made on your behalf (and earnings) will be separately accounted for within the Plan.

When did the Plan become effective?
Your Employer has amended and restated the Erikson Institute DC Retirement Plan which was originally adopted 01/01/1974.

The effective date of this amended Plan is 07/01/2011.

Who is responsible for the day-to-day operations of the Plan?
Your Employer is responsible for the day-to-day administration of the Plan. To assist in operating the Plan efficiently and accurately, your Employer may appoint others to act on its behalf or to perform certain functions.

Who pays the expenses associated with operating the Plan?
All reasonable Plan administration expenses including those involved in retaining necessary professional assistance, may be paid from the assets of the Plan, to the extent permitted by the Individual Agreements. These expenses may be allocated among you and all other Plan participants or, for expenses directly related to you, charged against your account balance. Examples of expenses that may be directly related to you include, general recordkeeping fees and expenses related to processing your distributions or loans (if applicable), qualified domestic relations orders, and your ability to direct the investment of your Plan balance, if applicable. Finally, the Employer may, in its discretion, pay any or all of these expenses. For example, the employer may pay expenses for current employees, but may deduct the expenses of former employees directly from their accounts. Your Employer will provide you with a summary of all Plan expenses and the method of payment of the expenses upon request.

Does the Employer have the right to change the Plan?
The Plan will be amended from time to time to incorporate changes required by the law and regulations governing retirement plans. Your Employer also has the right to amend the Plan to add new features or to change or eliminate various provisions. An Employer cannot amend the Plan to take away or reduce protected benefits under the Plan (e.g., the Employer cannot reduce the vesting percentage that applies to your current balance in the Plan).

Does participation in the Plan provide any legal rights regarding my employment?
The Plan does not intend to, and does not provide, any additional rights to employment or constitute a contract for employment. The purpose of the Summary Plan Description is to help you understand how the Plan operates and the benefits available to you under the Plan. The Plan document is the controlling legal document with respect to the operation of and rights granted under the Plan and if there are any inconsistencies between this Summary Plan Description and the Plan document, the Plan document will be followed.

Can creditors or other individuals request a payout from my Plan balance?
Creditors (other than the IRS) and others generally may not request a distribution from your Plan balance. One major exception to this rule is that your Employer may distribute or reallocate your benefits in response to a qualified domestic relations order. A qualified domestic relations order is an order or decree issued by a court that requires you to pay child support or alimony or to give a portion of your Plan account to an ex-spouse or legally separated spouse. Your Employer will review the order to ensure that it meets certain criteria before any money is paid from your account. You (or your beneficiary) may obtain, at no charge, a copy of the procedures your Employer will use for reviewing and qualifying domestic relations orders.

How do I file a claim?

To claim a benefit that you are entitled to under the Plan, you must file a written request with your Employer. The claim must set forth the reasons you believe you are eligible to receive benefits and you must authorize the Employer to conduct any necessary examinations and take the steps to evaluate the claim.

What if my claim is denied?
Except as described below, if your claim is denied, your Employer will provide you (or your beneficiary) with a written notice of the denial within 90 days of the date your claim was filed. This notice will give you the specific reasons for the denial, the specific provisions of the Plan upon which the denial is based, and an explanation of the procedures for appeal.

In the case of a claim for disability benefits, if the Employer is making a determination of whether you are Disabled, you will be notified of a denial of your claim within a reasonable amount of time, but not later than 45 days after the Plan receives your claim. The 45-day time period may be extended by the Plan for up to 30 days if the Employer determines that an extension is necessary due to matters beyond the control of the Plan. The Employer will notify you, before the end of the 45-day period, of the reason(s) for the extension and the date by which the Plan expects to make a decision regarding your claim.

If, before the end of the 30-day extension, your Employer determines that, due to matters beyond the control of the Plan, a decision regarding your claim cannot be made within the 30-day extension, the period for making the decision may be extended for an additional 30 days, provided that your Employer notifies you, before the end of the first 30-day extension, of the circumstances requiring the additional extension and the date as of which the Plan expects to make a decision. The notice will specifically explain the standards on which the approval of your claim will be based, the unresolved issues that prevent a decision on your claim, and the additional information needed to resolve those issues. You will have at least 45 days within which to provide the specified information.

The period of time within which approval or denial of your claim is required to be made generally begins at the time your claim is filed. If the period of time is extended because you fail to submit information necessary to decide your claim, the period for approving or denying your claim will not include the period of time between the date on which the notification of the extension is sent to you and the date on which you provide the additional information.

Your Employer will provide you with written or electronic notification if your claim is denied. The notification will provide the following:

i. The specific reason or reasons for the denial;

ii. Reference to the specific section of the Plan on which the denial is based;

iii. A description of any additional information that you must provide before the claim may continue to be processed and an explanation of why such information is necessary;

iv. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA) following a claim denial on review; and

v. In the case of a Plan providing disability benefits, if your Employer used an internal rule or guideline in denying your claim, either 1) the specific rule or guideline, or a statement that the rule or guideline was

relied upon in denying your claim, and that 2) a copy of the rule or guideline will be provided free of charge to you upon request.

If the claim denial is based on a medical necessity, experimental treatment, or similar situation, either an explanation of the scientific or clinical basis for the denial, applying the terms of the Plan to your medical circumstances, or a statement that an explanation will be provided free of charge upon request.

May I appeal the decision of the Employer?

You or your beneficiary will have 60 days from the date you receive the notice of claim denial in which to appeal your Employer's decision. You may request that the review be in the nature of a hearing and an attorney may represent you.

However, in the case of a claim for disability benefits, if your Employer is deciding whether you are Disabled under the terms of the Plan, you will have at least 180 days following receipt of notification of a claim denial within which to appeal your Employer's decision.

You may submit written comments, documents, records, and other information relating to your claim. In addition, you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information pertaining to your claim.

Your appeal will take into account all comments, documents, records, and other information submitted by you relating to the claim, even if the information was not included originally.

If the claim is for disability benefits:

i. Your claim will be reviewed independent of your original claim and will be conducted by a named fiduciary of the Plan other than the individual who denied your original claim or any of his or her employees.

ii. In deciding an appeal of a claim denial that is based in whole or in part on a medical judgment, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

iii. Your Employer will provide you with the name(s) of the health care professional(s) who was consulted in connection with your original claim, even if the claim denial was not based on his or her advice. The health care professional consulted for purposes of your appeal will not be the same person or any of his or her employees.

iv. You will be notified of the outcome of your appeal no later than 45 days after receipt of your request for the appeal, unless the Employer determines that special circumstances require an extension of time for processing the claim. If your Employer determines that an extension is required, written notice of the extension will be provided to you before the end of the initial 45-day period. The notice will identify the

special circumstances requiring an extension and the date by which the Plan expects to make a decision regarding your claim.

Your Employer will provide you with written or electronic notification of the final outcome of your claim. The notification will include:

i. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;

ii. A statement describing any additional voluntary appeal procedures offered by the Plan, your right to obtain the information about such procedures, and a statement of your right to bring an action under Section 502(a) of ERISA; and

iii. If the Employer used an internal rule or guideline in denying your claim, either 1) the specific rule or guideline, or a statement that the rule or guideline was relied upon in denying your claim, and 2) that a copy of the rule or guideline will be provided free of charge to you upon request.

If the claim denial is based on a medical necessity, experimental treatment, or similar situation, either an explanation of the scientific or clinical basis for the denial, applying the terms of the Plan to your medical circumstances, or a statement that an explanation will be provided free of charge upon request.

If I need to take legal action with respect to the Plan, who is the agent for service of legal process?
Your Employer is the agent to be served with legal papers regarding the Plan.

If the Plan terminates, does the federal government insure my benefits under the plan?
If the Plan terminates, you will become fully vested in your entire balance under the Plan, even though you would not otherwise have a sufficient number of years of vesting service to be 100 percent vested in your balance. You will be entitled to take your entire balance from the Plan following termination.

The type of plan in which you participate is not insured by the Pension Benefit Guarantee Corporate, the government agency that insures certain pension plan benefits upon plan termination.

What are my legal rights and protections with respect to the Plan?
As a Participant in this Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Participants shall be entitled to do the following.

Receive Information About Your Plan and Benefits
1. Examine, without charge, at the Employer's office and at other specified locations, such as worksites and union halls, all Plan documents governing the Plan, including insurance contracts and collective

bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

2. Obtain, upon request to the Employer, copies of documents governing the operations of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description (SPD). The Employer may charge a reasonable fee for the copies.

3. Receive a summary of the Plan's annual financial report. The Employer is required by law to furnish each Participant with a copy of this Summary Annual Report.

4. Obtain, once a year, a statement of the total pension benefits accrued and the vested pension benefits (if any) or the earliest date on which benefits will become vested. The Plan may require a written request for this statement, but it must provide the statement free of charge.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you may take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Employer to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Employer. If you have a claim for benefits which is denied, or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack there of concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay the costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if the court finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Employer. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Employer, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications

hotline of the Employee Benefits Security Administration.

Further, if this Plan is maintained by more than one Employer, you may obtain a complete list of all such Employers by making a written request to your Employer.

DEFINITIONS

Compensation – The definition of Compensation under the Plan can vary depending upon the purpose (e.g., allocations, nondiscrimination testing, tax deductions).

In general, the amount of your earnings from your Employer taken into account under the Plan is all earnings reported to you on Form W-2. Compensation will include amounts that are not included in your taxable income that were deferred under a cafeteria plan, a 401(k) plan, a salary deferral SEP plan, a 403(b) tax-sheltered annuity plan, a 457(b) deferred compensation plan of a state or local government or tax-exempt employer, or transportation fringe benefits that you receive.

The definition of Compensation used under the Plan has been further adjusted to exclude the following amounts.

- Amounts deemed to be compensation that relate to an automatic enrollment cafeteria plan where you fail to provide proof of insurance will be excluded when determining your Compensation.

If you receive payments from your Employer within 2 ½ months after severing your employment, any regular pay for services you performed prior to severance will be included in Compensation. Other post-severance payments will affect your Compensation as described below.

- Unused accrued sick, vacation or other leave that you are entitled to cash out will be excluded from Compensation.
- Amounts received under a nonqualified unfunded deferred compensation program will be excluded from Compensation.

The measuring period for Compensation will be the Plan Year.

The maximum amount of Compensation that will be taken into account under the Plan is $250,000 (for 2012). This amount increases as the cost of living rises.

Deferrals – Deferrals are the dollars you choose to contribute to the Plan through payroll deduction on pre-tax basis.

Disabled – You will be considered Disabled if you cannot engage in any substantial, gainful activity because of a medically determined physical or mental impairment that is expected to last at least 12 months.

Early Retirement Age – There is no Early Retirement Age designated under the Plan.

Employer – The Employer is Erikson Institute. Your Employer will also serve as the Plan Administrator, as defined in ERISA, who is responsible for the day to day operations and decisions regarding the Plan, unless a separate Plan Administrator is appointed for all or some of the plan responsibilities. The term Employer, as used in this Summary Plan Description, will also mean Plan Administrator, as that term is used in ERISA.

Employer Contributions - Your Employer may choose to make Employer Contributions for Participants who meet the certain eligibility requirements. Your eligibility to receive Employer Contributions is not dependent upon whether you make Deferrals.

Highly Compensated Employee – A Highly Compensated Employee is any employee who
1) was a five percent owner at any time during the year or the previous year, or
2) for the previous year had Compensation from the Employer greater than $115,000 (for 2012).

The $115,000 threshold is increased as the cost of living rises.

Hour of Service – An Hour of Service, for purposes of determining Plan eligibility, vesting and eligibility to receive Employer contributions will be based on actual hours for which you are entitled to pay.

If your Employer continues a plan from a prior employer, you will receive credit for time that you worked for the predecessor employer. Regardless, you will receive credit for your hours of service with

- educational organizations
- a 501(c)(3) not for profit organization, an educational organization, or a minister
- a teaching institution
- an institution of higher education
- a non-profit (research) institution

only for determining

- whether you have satisfied service requirements to participate in this Plan.
- your vested percentage.
- the portion of contributions made by your Employer that will be allocated to you.

Individual Agreements - All contributions to the Plan will be invested either in annuity contracts or in mutual funds held in custodial accounts. The agreements between the vendor and your Employer or you that constitute or govern the annuity contracts and custodial accounts are referred to as Individual Agreements. The Individual Agreements explain the unique rules that apply to each Plan investment and may, in some cases, limit your options under the Plan, including your transfer and

distribution rights.

Matching Contribution – Your Employer may make Matching Contributions to the Plan based on the amount of Deferrals you contribute to the Plan.

Normal Retirement Age – Age 59.5 is considered the Normal Retirement Age under the Plan.

Participant – An employee of the Employer who has satisfied the eligibility requirements and entered the Plan is referred to as a Participant.

Plan – The Erikson Institute DC Retirement Plan is the Plan described in this Summary Plan Description.

Plan Administrator – Your Employer is responsible for the day-to-day administration of the Plan. To assist in operating the Plan efficiently and accurately, your Employer may appoint others to act on its behalf or to perform certain functions.

Plan Year – A 12-month period ending on 06/30 will serve as the Plan Year.

Qualified Nonelective Contribution – Your Employer may make Qualified Nonelective Contributions to satisfy certain nondiscrimination tests that apply to the Plan. These contributions are discretionary and are 100 percent vested when made.

Taxable Wage Base – The Social Security Administration sets a contribution and benefit base level each year which is referred to as the Taxable Wage Base.