2016 Benefits Overview

ReliaSource™

CYPRESS BENEFITS GROUP

CareFirst BlueCross BlueShield

MetLife

PAYCHEX

Principal Financial Group

ReliaSource Benefits

A benefit you can RELY on.

This year's program represents an important period of decision making for all employees due to key changes and additions to the employer sponsored health, wealth, and lifestyle benefits platforms. This booklet contains all of the latest changes and empowers you to select premium coverage options tailored for you and your family.

ReliaSource pays our employees on a semi-monthly pay period on the 10th and 25th of every month with some exceptions if those days fall on a weekend. All Premiums in this overview are based on "per pay" deductions.

We are excited about this new enrollment session and hope that you are able to capitalize on employer paid premiums, pre-tax deductions, and a benefits package you and your family can count on!

**Note, if you have a life changing event i.e.; marriage, birth or adoption of a child, death of a dependent, start or end in your spouse's employment and insurance coverage, your dependent becomes ineligible for coverage adoption, you can enroll into the plan at that time.*

MEDICAL COVERAGE — CareFirst BlueCross/BlueShield

100% ReliaSource Paid Employee Premium

For in-state employees who choose the HMO core plan or out of area employees who choose the Healthy Blue Advantage plan.

All salaried full time employees scheduled to work at least 32 hours per week are entitled to participate in ReliaSource's group health plan. Your coverage becomes effective the first of the month following date of hire. For example, from the date of hire, your coverage becomes effective on day one of the next month. Employees may choose single, single with spouse, single with children, or family coverage. ReliaSource pays 100% of the coverage cost for individual coverage*. The balance is payable by the employee.

- Health insurance plans will be provided by CareFirst BC/BS of Maryland. The coverage provides world-wide access to any doctor participating with BC/BS.
- You may search for providers at: **www.carefirst.com**

CareFirst BlueCross BlueShield

** For in-state employees who choose the HMO core plan or out of area employees who choose the Healthy Blue Advantage plan.*

ReliaSource offers 3 plans to choose from:

BlueChoice HMO *Open Access HSA (CORE Plan $3,000 deductible)* provides the cost savings of an HMO, combined with the advantages of an employer sponsored Health Reimbursement Arrangement (HRA). This is an "Open Access" plan, so members have the freedom to see network providers without a referral from a primary care physician (PCP). They also have the flexibility to choose a provider from a network of over 2,600 PCPs, specialty care from over 14,000 participating specialists and hospital care from 55 area hospitals. This plan is available to employees in MD/DC/Northern VA area.

BlueChoice HMO *Open Access HSA ($1,500 deductible)* provides the cost savings of an HMO, combined with the advantages of an employer sponsored Health Reimbursement Arrangement (HRA). This is an "Open Access" plan, so members have the freedom to see network providers without a referral from a primary care physician (PCP). They also have the flexibility to choose a provider from a network of over 2,600 PCPs, specialty care from over 14,000 participating specialists and hospital care from 55 area hospitals. This plan is available to employees in MD/DC/Northern VA area.

HealthyBlue Advantage is the primary choice for employees who live outside of the MD/DC/Northern VA region. It offers a larger in-network provider network, giving members greater flexibility in selecting a physician, both inside and outside of the BlueChoice Service Area.

All plans are eligible for the Blue Rewards Program.
See your enrollment information for details.

HEALTH REIMBURSEMENT ACCOUNT (HRA)

An HRA allows your employer to set aside a specific pool of money to reimburse each employee's out-of-pocket medical expenses. These health care expenses may include deductibles, copayments, prescription medications, dental services and other health related expenses that may not be covered under the healthcare plan. And, the money contributed by your employer is tax-free to you.

	HMO HSA $3,000 (CORE)	HMO HSA $1,500	Healthy Blue Advantage*
Employee only	$0.00	$0.00	$69.85◊
Employee and child(ren)	$189.23	$167.74	$300.45
Employee and spouse	$231.38	$205.02	$351.70
Family	$420.50	$332.99	$582.30

Out of State Employees**	Healthy Blue Advantage*
Employee only	$0.00
Employee and child(ren)	$230.60
Employee and spouse	$281.85
Family	$512.45

* ReliaSource will reimburse employees up to $1,200.
** Only those employees in remote locations are eligible for National BlueCross/BlueShield Contribution Structure.
◊ Employee portion less ReliaSource Contribution.

PRESCRIPTION DRUG COVERAGE

	HMO HSA $3,000 (CORE)	HMO HSA $1,500	Healthy Blue Advantage
Deductible (per person)	Integrated	Integrated	Integrated
Generic copay	$10	$10	$0
Formulary copay	$45	$45	$45
Non-Formulary copay	$65	$65	$65

BlueChoice HMO
HSA/HRA $3,000

Summary of Benefits

Services	You Pay
ANNUAL DEDUCTIBLE (BENEFIT PERIOD)[1]	
Individual	$3,000
Family	$6,000
ANNUAL OUT-OF-POCKET MAXIMUM (BENEFIT PERIOD)[2]	
Individual	$6,000
Family	$12,000
LIFETIME MAXIMUM BENEFIT	
Lifetime Maximum	None
PREVENTIVE SERVICES	
Well-Child Care (including exams & immunizations)	No charge*
Adult Physical Examination	No charge*
Routine GYN Visits	No charge*
Breast Cancer Screening	No charge*
Cancer Screening (Pap Test, Prostate and Colorectal)	No charge*
OFFICE VISITS, LABS AND TESTING	
Facility fee for services rendered in a hospital setting[3]	Deductible, then $50 per visit
Office Visits for Illness[3]	Deductible, then $30 PCP/$40 Specialist per visit
Diagnostic Services/Lab Tests (LabCorp only)[3]	Deductible, then $40 per visit
X-ray (Freestanding Facility only)[3]	Deductible, then $40 per visit
Allergy Testing & Shots[3]	Deductible, then $40 per visit
Outpatient Physical, Speech and Occupational Therapy[3] (limited to 30 visits/illness or injury/benefit period)	Deductible, then $40 per visit
Outpatient Chiropractic[3] (limited to 20 visits/condition/benefit period)	Deductible, then $40 per visit
EMERGENCY CARE AND URGENT CARE	
Urgent Care Center	Deductible, then $40 per visit
Hospital Emergency Room	Deductible, then $100 per visit (waived if admitted)
Emergency Room–Professional Services	No charge* after deductible
Ambulance (if medically necessary)	No charge* after deductible
HOSPITALIZATION	
Outpatient Facility Non-Surgery (Hospital Facility)	Deductible, then $50 per visit
Outpatient Facility Surgery (Freestanding Facility)	Deductible, then $100 per visit
Outpatient Facility Surgery (Hospital Facility)	Deductible, then $250 per visit
Outpatient Physician Services	Deductible, then $40 per visit
Inpatient Facility Services	Deductible, then $1,000 per admission
Inpatient Physician Services	Deductible, then $30 PCP/$40 Specialist per visit
HOSPITAL ALTERNATIVES	
Home Health Care	No charge* after deductible
Hospice	No charge* after deductible
Skilled Nursing Facility (limited to 100 days/admission)	Deductible, then $40 per admission

Note: Plan has an integrated medical and prescription drug deductible.

BlueChoice HMO HSA/HRA $3,000 benefits continued on following page.

BlueChoice HMO
HSA/HRA $3,000

Summary of Benefits

Services	You Pay
MATERNITY	
Prenatal and Postnatal Office Visits[3]	No charge*
Delivery and Facility Services	Deductible, then $1,000 per admission
Nursery Care of Newborn	No charge* after deductible
Artificial Insemination[3,4] (limited to 6 attempts/live birth)	Deductible, then $40 per visit
In Vitro Fertilization Procedures[4]	Not covered
MENTAL HEALTH AND SUBSTANCE ABUSE	
Inpatient Facility Services	Deductible, then $1,000 per admission
Inpatient Physician Services	Deductible, then $30 PCP/$40 Specialist per visit
Outpatient Facility Services	Deductible, then $40 per visit
Outpatient Physician Services	Deductible, then $40 per visit
Office Visits[3]	Deductible, then $30 per visit
Partial Hospitalization Facility Services	Deductible, then $40 per visit
Partial Hospitalization Physician Services	Deductible, then $40 per visit
Medication Management[3]	Deductible, then $30 per visit
MISCELLANEOUS	
Durable Medical Equipment	Deductible, then 25% of Allowed Benefit
Acupuncture[3]	Deductible, then $40 per visit
Hearing Aids (limited to minor children and limited to one hearing aid per hearing-impaired ear every 36 months)	No charge* after deductible
PRESCRIPTION DRUGS[5]	
Preventive Drugs	No charge*
Generic Drugs	34-day supply-Deductible, then $10; 90-day supply-Deductible, then $20
Preferred Brand Drugs	34-day supply-Deductible, then $45; 90-day supply-Deductible, then $90
Non-Preferred Brand Drugs	34-day supply-Deductible, then $65; 90-day supply-Deductible, then $130
Specialty Drugs	Deductible, then 50% coinsurance
PEDIATRIC VISION (UNDER 19)	
Routine Exam (limited to 1 visit/benefit period)	In-Network-No charge*; Out-of-Network-Total charge minus $40 reimbursement
Frames and Contact Lenses–Pediatric Collection Only	In-Network-No charge*; Out-of-Network-Reimbursements apply
Spectacle Lenses	In-Network-No charge*; Out-of-Network-Reimbursements apply
PEDIATRIC DENTAL (UNDER 19)	
Dental Deductible	In-Network-$25; Out-of-Network-$50
Class I Preventive & Diagnostic Services	In-Network-No charge*; Out-of-Network-20% of Allowed Benefit
Class II Basic Services	In-Network-Deductible, then 20% of Allowed Benefit; Out-of-Network-Deductible, then 40% of Allowed Benefit
Class III Major Services–Surgical	In-Network-Deductible, then 20% of Allowed Benefit; Out-of-Network-Deductible, then 40% of Allowed Benefit
Class IV Major Services–Restorative	In-Network-Deductible, then 50% of Allowed Benefit; Out-of-Network-Deductible, then 65% of Allowed Benefit
Class V Medically-Necessary Orthodontic Services	In-Network-50% of Allowed Benefit; Out-of-Network-65% of Allowed Benefit

* No copayments or coinsurance.

[1] The deductible can be met entirely by one Member or by combining eligible expenses of two or more members. There is no Individual Deductible with Family Coverage. The Family Deductible must be reached before CareFirst BlueChoice pays benefits for any Member who has other than Individual Coverage. Please refer to your Evidence of Coverage to determine your coverage level.

[2] The Out-of-Pocket Maximum can be met entirely by one Member or by combining eligible expenses of two or more members. There is no Individual Out-of-Pocket Maximum with Family Coverage. The Family Out-of-Pocket Maximum must be reached before CareFirst BlueChoice pays benefits for any Member who has other than Individual Coverage. Please refer to your Evidence of Coverage to determine your coverage level.

[3] An additional facility copay and/or coinsurance may apply to services rendered in a hospital setting.

[4] Members who are unable to conceive have coverage for the evaluation of infertility services performed to confirm an infertility diagnosis, and some treatment options for infertility. However, assisted reproduction (AI & IUI) services performed as treatment options for infertility are only available under the terms of the members contract.

[5] If a provider prescribes a Non-Preferred Brand Drug, and the Member selects the Non-Preferred Brand Drug when a Generic Drug is available, the Member shall pay the applicable Copayment or Coinsurance as stated in the Schedule of Benefits plus the difference between the price of the Non-Preferred Brand Drug and the Generic Drug.

BlueChoice HMO
HSA/HRA $1,500

Summary of Benefits

Services	You Pay
ANNUAL DEDUCTIBLE (BENEFIT PERIOD)[1]	
Individual	$1,500
Family	$3,000
ANNUAL OUT-OF-POCKET MAXIMUM (BENEFIT PERIOD)[2]	
Individual	$4,000
Family	$8,000
LIFETIME MAXIMUM BENEFIT	
Lifetime Maximum	None
PREVENTIVE SERVICES	
Well-Child Care (including exams & immunizations)	No charge*
Adult Physical Examination	No charge*
Routine GYN Visits	No charge*
Breast Cancer Screening	No charge*
Cancer Screening (Pap Test, Prostate and Colorectal)	No charge*
OFFICE VISITS, LABS AND TESTING	
Facility fee for services rendered in a hospital setting[3]	Deductible, then $50 per visit
Office Visits for Illness[3]	Deductible, then $20 PCP/$30 Specialist per visit
Diagnostic Services/Lab Tests (LabCorp only)[3]	Deductible, then $30 per visit
X-ray (Freestanding Facility only)[3]	Deductible, then $30 per visit
Allergy Testing & Shots[3]	Deductible, then $30 per visit
Outpatient Physical, Speech and Occupational Therapy[3] (limited to 30 visits/illness or injury/benefit period)	Deductible, then $30 per visit
Outpatient Chiropractic[3] (limited to 20 visits/condition/benefit period)	Deductible, then $30 per visit
EMERGENCY CARE AND URGENT CARE	
Urgent Care Center	Deductible, then $30 per visit
Hospital Emergency Room	Deductible, then $100 per visit (waived if admitted)
Emergency Room–Professional Services	No charge* after deductible
Ambulance (if medically necessary)	No charge* after deductible
HOSPITALIZATION	
Outpatient Facility Non-Surgery (Hospital Facility)	Deductible, then $50 per visit
Outpatient Facility Surgery (Freestanding Facility)	Deductible, then $100 per visit
Outpatient Facility Surgery (Hospital Facility)	Deductible, then $200 per visit
Outpatient Physician Services	Deductible, then $30 per visit
Inpatient Facility Services	Deductible, then $250 per admission
Inpatient Physician Services	Deductible, then $20 PCP/$30 Specialist per visit
HOSPITAL ALTERNATIVES	
Home Health Care	No charge* after deductible
Hospice	No charge* after deductible
Skilled Nursing Facility (limited to 100 days/admission)	Deductible, then $30 per admission

Note: Plan has an integrated medical and prescription drug deductible.

BlueChoice HMO HSA/HRA $1,500 benefits continued on following page.

BlueChoice HMO
HSA/HRA $1,500

Summary of Benefits

Services	You Pay
MATERNITY	
Prenatal and Postnatal Office Visits[3]	No charge*
Delivery and Facility Services	Deductible, then $250 per admission
Nursery Care of Newborn	No charge* after deductible
Artificial Insemination[3,4] (limited to 6 attempts/live birth)	Deductible, then $30 per visit
In Vitro Fertilization Procedures[4]	Not covered
MENTAL HEALTH AND SUBSTANCE ABUSE	
Inpatient Facility Services	Deductible, then $250 per admission
Inpatient Physician Services	Deductible, then $20 PCP/$30 Specialist per visit
Outpatient Facility Services	Deductible, then $30 per visit
Outpatient Physician Services	Deductible, then $30 per visit
Office Visits[3]	Deductible, then $20 per visit
Partial Hospitalization Facility Services	Deductible, then $30 per visit
Partial Hospitalization Physician Services	Deductible, then $30 per visit
Medication Management[3]	Deductible, then $20 per visit
MISCELLANEOUS	
Durable Medical Equipment	Deductible, then 25% of Allowed Benefit
Acupuncture[3]	Deductible, then $30 per visit
Hearing Aids (limited to minor children and limited to one hearing aid per hearing-impaired ear every 36 months)	No charge* after deductible
PRESCRIPTION DRUGS[5]	
Preventive Drugs	No charge*
Generic Drugs	34-day supply-Deductible, then $10; 90-day supply-Deductible, then $20
Preferred Brand Drugs	34-day supply-Deductible, then $45; 90-day supply-Deductible, then $90
Non-Preferred Brand Drugs	34-day supply-Deductible, then $65; 90-day supply-Deductible, then $130
Specialty Drugs	Deductible, then 50% coinsurance
PEDIATRIC VISION (UNDER 19)	
Routine Exam (limited to 1 visit/benefit period)	In-Network-No charge*; Out-of-Network-Total charge minus $40 reimbursement
Frames and Contact Lenses–Pediatric Collection Only	In-Network-No charge*; Out-of-Network-Reimbursements apply
Spectacle Lenses	In-Network-No charge*; Out-of-Network-Reimbursements apply
PEDIATRIC DENTAL (UNDER 19)	
Dental Deductible	In-Network-$25; Out-of-Network-$50
Class I Preventive & Diagnostic Services	In-Network-No charge*; Out-of-Network-20% of Allowed Benefit
Class II Basic Services	In-Network-Deductible, then 20% of Allowed Benefit; Out-of-Network-Deductible, then 40% of Allowed Benefit
Class III Major Services–Surgical	In-Network-Deductible, then 20% of Allowed Benefit; Out-of-Network-Deductible, then 40% of Allowed Benefit
Class IV Major Services–Restorative	In-Network-Deductible, then 50% of Allowed Benefit; Out-of-Network-Deductible, then 65% of Allowed Benefit
Class V Medically-Necessary Orthodontic Services	In-Network-50% of Allowed Benefit; Out-of-Network-65% of Allowed Benefit

* No copayments or coinsurance.

[1] The deductible can be met entirely by one Member or by combining eligible expenses of two or more members. There is no Individual Deductible with Family Coverage. The Family Deductible must be reached before CareFirst BlueChoice pays benefits for any Member who has other than Individual Coverage. Please refer to your Evidence of Coverage to determine your coverage level.

[2] The Out-of-Pocket Maximum can be met entirely by one Member or by combining eligible expenses of two or more members. There is no Individual Out-of-Pocket Maximum with Family Coverage. The Family Out-of-Pocket Maximum must be reached before CareFirst BlueChoice pays benefits for any Member who has other than Individual Coverage. Please refer to your Evidence of Coverage to determine your coverage level.

[3] An additional facility copay and/or coinsurance may apply to services rendered in a hospital setting.

[4] Members who are unable to conceive have coverage for the evaluation of infertility services performed to confirm an infertility diagnosis, and some treatment options for infertility. However, assisted reproduction (AI & IUI) services performed as treatment options for infertility are only available under the terms of the members contract.

[5] If a provider prescribes a Non-Preferred Brand Drug, and the Member selects the Non-Preferred Brand Drug when a Generic Drug is available, the Member shall pay the applicable Copayment or Coinsurance as stated in the Schedule of Benefits plus the difference between the price of the Non-Preferred Brand Drug and the Generic Drug.

HealthyBlue Advantage
HSA/HRA $2,000

Summary of Benefits

Services	In-Network You Pay[1]	Out-of-Network You Pay[2]
HEALTHY REWARD		
Visit www.carefirst.com/healthyblue for more information.	Earn $300 per adult and up to $700 per family toward reducing your deductible for completing 3 simple steps.	
ANNUAL DEDUCTIBLE (BENEFIT PERIOD)[3]		
Individual	$2,000	$4,000
Family	$4,000	$8,000
ANNUAL OUT-OF-POCKET MAXIMUM (BENEFIT PERIOD)[4]		
Individual	$6,350	$7,500
Family	$12,700	$15,000
LIFETIME MAXIMUM BENEFIT		
Lifetime Maximum	None	None
PREVENTIVE SERVICES		
Well-Child Care (including exams & immunizations)	No charge*	No charge*
Adult Physical Examination	No charge*	No charge* after deductible
Routine GYN Visits	No charge*	No charge* after deductible
Breast Cancer Screening	No charge*	No charge*
Cancer Screening (Pap Test, Prostate and Colorectal)	No charge*	No charge* after deductible
OFFICE VISITS, LABS AND TESTING		
Facility fee for services rendered in a hospital setting[5]	Deductible, then $50 per visit	Deductible, then $100 per visit
Office Visits for Illness[5]	Deductible, then no charge* PCP/$30 Specialist per visit	Deductible, then $50 per visit
Diagnostic Services/Lab Tests (LabCorp only)[5]	No charge* after deductible	Deductible, then $50 per visit
X-ray (Freestanding Facility only)[5]	No charge* after deductible	Deductible, then $50 per visit
Allergy Testing & Shots[5]	Deductible, then $30 per visit	Deductible, then $50 per visit
Outpatient Physical, Speech and Occupational Therapy[5] (limited to 30 visits/illness or injury/benefit period)	Deductible, then $30 per visit	Deductible, then $50 per visit
Outpatient Chiropractic[5] (limited to 20 visits/condition/benefit period)	Deductible, then $30 per visit	Deductible, then $50 per visit
EMERGENCY CARE AND URGENT CARE		
Urgent Care Center	Deductible, then $50 per visit	Paid as in-network
Hospital Emergency Room (waived if admitted)	Deductible, then $200 per visit	Paid as in-network
Emergency Room–Professional Services	No charge* after deductible	Paid as in-network
Ambulance (if medically necessary)	Deductible, then $50 per service	$50 per service
HOSPITALIZATION		
Outpatient Facility Non-Surgery (Hospital Facility)	Deductible, then $50 per visit	Deductible, then $100 per visit
Outpatient Facility Surgery (Freestanding Facility)	Deductible, then $100 per visit	Deductible, then $500 per visit
Outpatient Facility Surgery (Hospital Facility)	Deductible, then $500 per visit	Deductible, then $750 per visit
Outpatient Physician Services	No charge* after deductible	Deductible, then $50 per visit
Inpatient Facility Services	Deductible, then $500 per admission	Deductible, then $750 per admission
Inpatient Physician Services	No charge* after deductible	Deductible, then $50 per visit
HOSPITAL ALTERNATIVES		
Home Health Care	Deductible, then $30 per visit	Deductible, then $50 per visit
Hospice	Deductible, then $30 per visit	Deductible, then $50 per visit
Skilled Nursing Facility (limited to 100 days/admission)	Deductible, then $30 per admission	Deductible, then $50 per admission

Note: Plan has an integrated medical and prescription drug deductible.

HealthyBlue Advantage HRA/HSA $2,000 benefits continued on following page.

HealthyBlue Advantage
HSA/HRA $2,000

Summary of Benefits

Services	In-Network You Pay[1]	Out-of-Network You Pay[2]
MATERNITY		
Prenatal and Postnatal Office Visits[5]	No charge*	Deductible, then $50 per visit
Delivery and Facility Services	Deductible, then $500 per admission	Deductible, then $750 per admission
Nursery Care of Newborn	No charge* after deductible	Deductible, then $50 per visit
Artificial Insemination[5,6] (limited to 6 attempts/live birth)	Deductible, then $30 per visit	Deductible, then $50 per visit
In Vitro Fertilization Procedures[6]	Not covered	Not covered
MENTAL HEALTH AND SUBSTANCE ABUSE		
Inpatient Facility Services	Deductible, then $500 per admission	Deductible, then $750 per admission
Inpatient Physician Services	No charge* after deductible	Deductible, then $50 per visit
Outpatient Facility Services	No charge* after deductible	Deductible, then $50 per visit
Outpatient Physician Services	No charge* after deductible	Deductible, then $50 per visit
Office Visits[5]	No charge* after deductible	Deductible, then $50 per visit
Partial Hospitalization Facility Services	No charge* after deductible	Deductible, then $50 per visit
Partial Hospitalization Physician Services	No charge* after deductible	Deductible, then $50 per visit
Medication Management[5]	No charge* after deductible	Deductible, then $50 per visit
MISCELLANEOUS		
Durable Medical Equipment	No charge* after deductible	Deductible, then 20% of Allowed Benefit
Acupuncture[5]	Deductible, then $30 per visit	Deductible, then $50 per visit
Hearing Aids (limited to minor children and limited to one hearing aid per hearing-impaired ear every 36 months))	No charge* after deductible	Deductible, then 20% of Allowed Benefit
PRESCRIPTION DRUGS[7]		
Preventive Drugs	No charge*	
Generic Drugs	HealthyBlue Select Generics-No charge*; Other Generics-No charge* after deductible	
Preferred Brand Drugs	34-day supply-Deductible, then $45; 90-day supply-Deductible, then $90	
Non-Preferred Brand Drugs	34-day supply-Deductible, then $65; 90-day supply-Deductible, then $130	
Specialty Drugs	Deductible, then 50% coinsurance	
PEDIATRIC VISION (UNDER 19)		
Routine Exam (limited to 1 visit/benefit period)	No charge*	Total charge minus $40 reimbursement
Frames and Contact Lenses–Pediatric Collection Only	No charge*	Reimbursements apply
Spectacle Lenses	No charge*	Reimbursements apply
PEDIATRIC DENTAL (UNDER 19)		
Dental Deductible	$25	$50
Class I Preventive & Diagnostic Services	No charge*	20% of Allowed Benefit
Class II Basic Services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Class III Major Services–Surgical	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Class IV Major Services–Restorative	Deductible, then 50% of Allowed Benefit	Deductible, then 65% of Allowed Benefit
Class V Medically-Necessary Orthodontic Services	50% of Allowed Benefit	65% of Allowed Benefit

* No copayment or coinsurance.

[1] When covered services are rendered in the CareFirst BlueChoice service area, by a provider in the CareFirst BlueChoice Provider network, care is reimbursed at the in-network level. In-network benefits are based on the CareFirst BlueChoice Allowed Benefit that is generally the contracted rates or fee schedules that CareFirst BlueChoice providers have agreed to accept as payment for covered services. These payments are established by CareFirst BlueChoice, Inc., however, in certain circumstances, an allowance may be established by law. Outside of the CareFirst BlueChoice service area, when covered services are rendered by a provider in the preferred provider network, care is also covered at the in-network level. These in-network benefits are based on the contracted rates or fee schedules that preferred providers have agreed to accept as payment for covered services that are established by the local Blue Cross and Blue Shield Plan, however, in certain circumstances, an allowance may be established by law.

[2] When covered services are rendered by a provider that is not in the CareFirst BlueChoice network, or is not in the preferred provider network outside of CareFirst BlueChoice service area, the care is reimbursed as out-of-network. Out-of-network benefits are based on the Allowed Benefit that is generally the contracted rates or fee schedules that are established by CareFirst BlueChoice, or the local Blue Cross and Blue Shield Plan, however, in certain circumstances, an allowance may be established by law. When services are rendered by non-participating or non-preferred providers, the member may be responsible for charges in excess of the Allowed Benefit.

[3] The deductible can be met entirely by one Member or by combining eligible expenses of two or more members. There is no Individual Deductible with Family Coverage. The Family Deductible must be reached before CareFirst BlueChoice pays benefits for any Member who has other than Individual Coverage. Please refer to your Evidence of Coverage to determine your coverage level.

[4] The Out-of-Pocket Maximum can be met entirely by one Member or by combining eligible expenses of two or more members. There is no Individual Out-of-Pocket Maximum with Family Coverage. The Family Out-of-Pocket Maximum must be reached before CareFirst BlueChoice pays benefits for any Member who has other than Individual Coverage. Please refer to your Evidence of Coverage to determine your coverage level.

[5] An additional facility copay and/or coinsurance may apply to services rendered in a hospital setting.

[6] Members who are unable to conceive have coverage for the evaluation of infertility services performed to confirm an infertility diagnosis, and some treatment options for infertility. However, assisted reproduction (AI) services performed as treatment options for infertility are only available under the terms of the members contract.

[7] If a provider prescribes a Non-Preferred Brand Drug, and the Member selects the Non-Preferred Brand Drug when a Generic Drug is available, the Member shall pay the

CareFirst
The CareFirst BlueCross BlueShield family of health care plans

BlueRewards

Blue Rewards

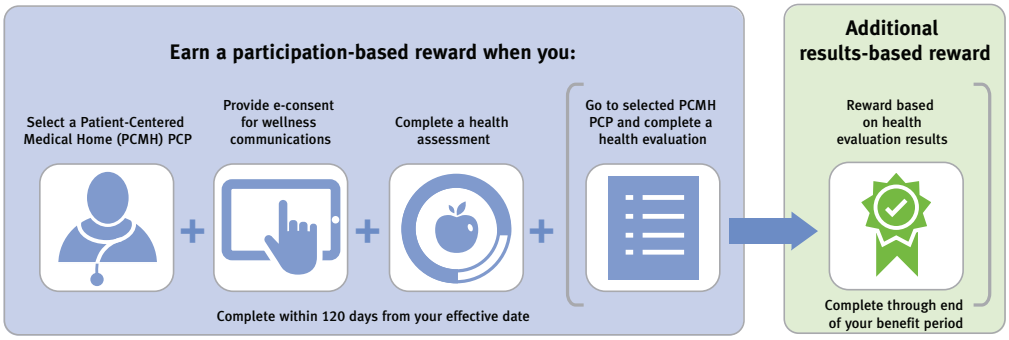
A Healthy Incentive for You

At CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst), your health matters to us, so we want to reward you for taking an active role in your health.

At no additional cost to you, CareFirst presents Blue Rewards, an innovative program that offers you up to $300 per adult and $750 per family. The Blue Rewards program is available starting January 1, 2015 upon renewal of your medical benefit plan.

Blue Rewards offers you a financial reward for completing four steps and gives you the opportunity to earn an additional reward for meeting certain health measures.

Here's how it works:



Get rewarded!

Choose a CareFirst medical plan and reap the benefits of Blue Rewards, the innovative program that helps improve your health and rewards you for doing so. For more information, **visit carefirst.com/bluerewards**.

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc.
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CST2535-1N (10/14)

DENTAL COVERAGE — Principal

100% ReliaSource Paid Employee Premium

- The new dental insurance plans will be provided by Principal Dental. The coverage allows you to roll-over any unused annual maximum each year. There will no longer be a deductible for in-network coverage.
- You may search for providers at: **www.principal.com**

Election	Principal Dental
Employee only	$0.00
Employee and child(ren)	$23.38
Employee and spouse	$15.45
Family	$41.09

Benefits Payable				
Network	Dental Preferred Provider Organization (PPO)			
	Calendar Year Deductible		Coinsurance (Policy Pays)	
	In-Network	Non-Network	In-Network	Non-Network
Unit 1 - Preventive	$0	$50	100%	90%
Unit 2 - Basic	$50	$50	100%	80%
Unit 3 - Major	$50	$50	50%	40%
Family Deductible Maximums	2 times the per person deductible amount			
Combined Deductible	Non-Network deductibles for preventive, basic, and major procedures are combined.			
Combined Maximums	Maximums for preventive, basic, and major procedures are combined. In-network Calendar year maximums are $1,000 per person. Non-Network Calendar year maximums are $750 per person.			
Maximum Accumulation	This allows for a portion of unused maximum benefit to carry over to next year's maximum benefit amount. To qualify, you must have had a dental service performed within the Calendar year and used less than the maximum threshold. The threshold is equal to the lesser of 50% of the maximum benefit or $1,000. If qualification is met, 50% of the threshold is carried over to next year's maximum benefit. You can accumulate no more than four times the carry over amount.			
Additional Benefits				
	Lifetime Deductible		Coinsurance (Policy Pays)	
	In-Network	Non-Network	In-Network	Non-Network
Unit 4 - Orthodontia (child) Lifetime Maximum: In-network: $1,000 Non-Network: $1,000	$0	$0	50%	50%

VISION COVERAGE — Advantica EyeCare

- The new vision insurance plans will be provided by Advantica EyeCare. The coverage allows for an eye exam every 12 months, new lenses every 12 months, and new frames every 24 months.
- You may search for providers at: **www.advanticaeyecare.com**

ADVANTICA
See. Smile. Live.

Election	Advantica Vision
Employee only	$3.10
Employee and 1 child	$5.68
Employee and spouse	$5.68
Family (2 or more dependents)	$8.78

Select Plus 100 Plan			
Coverage	In-Network Benefits	Out-of-Network Reimbursement*	Benefit Frequency
Comprehensive Eye Examination with dilation	$10 copay	Reimbursed up to $40 (less applicable copay)	Once every 12 months
Eyeglass Lenses (standard plastic)	$10 copay includes: - Single - Bifocal - Trifocal - Lenticular Polycarbonate lenses covered-in-full for members age 19 and younger, $30 copay over the age of 19. Additional $50 copay Standard Progressive lenses. Additional $60 copay for Transitions lenses.	Reimbursed (less applicable copay): - Single up to $20 - Bifocal up to $40 - Trifocal up to $60 - Lenticular up to $100 No out-of-network reimbursement available for polycarbonate lenses. No out-of-network reimbursement available for standard progressive lenses. No out-of-network reimbursement available for photochromic lenses.	Once every 12 months
Eyeglass Frames	$10 copay (no copay if included with Eyeglass Lenses)' paid in full on Special Frame Selection; outside of the Selection, $100 allowance outside of the selection (less applicable copay).	Reimbursed up to $40 (no copay if included with eyeglass lenses).	Once every 24 months.
Contact Lens Fitting Fee	$30 allowance	No reimbursement available	Once every 12 months
Contact Lenses (in lieu of Eyeglasses)** Conventional/Disposable	$100 allowance (less applicable copay)	Reimbursed up to $60 (less applicable copay)	Once every 12 months
Contact Lenses (in lieu of Eyeglasses)** Medically necessary***	$250 allowance (less applicable copay)	$250 allowance (less applicable copay)	Once every 12 months
Laser Vision Correction (LASIK)	40-50% off national average	No reimbursement available	

* *Submit Member Out-of-Network Reimbursement Form and copy of paid receipt to Advantica.*
** *This benefit is paid only once during the Group's Benefit Period and must be fully utilized at the time of purchase.*
*** *Limited to Aphakia, Keratoconus or Severe Anisometropia and requires pre-authorization by Advantica.*

Disability

All ReliaSource employees are eligible for Short Term and Long Term Disability.

SHORT TERM DISABILITY (STD)

50% ReliaSource Paid Employee Premium

- Group **STD** at 60% of your weekly base salary to a maximum weekly benefit of $1,500, 50% tax free. You are eligible for this benefit after 7 days of either an accident or sickness, and the benefit continue for up to 12 weeks of disability.

LONG TERM DISABILITY (LTD)

100% ReliaSource Paid Employee Premium

- Group **LTD** at 60% of your monthly base salary to a maximum monthly benefit of $8,000 tax free. You are eligible for this benefit after 90 days of disability, and the benefit can continue for up to five years.

Life Insurance

BASIC LIFE INSURANCE — AUL/OneAmerica

100% ReliaSource Paid Employee Premium

- ReliaSource offers $50,000 Life and $50,000 Accidental Death and Dismemberment Insurance at no cost to you.

OneAmerica®

401K PLAN

ReliaSource is pleased to provide 401K Benefits effective the first of the month following date of hire. By joining, you are authorizing payroll to immediately begin deducting a percentage of your pay for weekly contribution to your account.

Benefits

The plan allows you to save money for the future (retirement, purchase of a primary residence, etc.) on a tax-deferred basis or a post-tax basis. You may change your contribution percentage or your investment mix on a daily basis (24/7) by going online to **https://benefits.paychex.com**. It is important that employees become self-sufficient in their retirement planning to free you to focus on building the team and recruiting great people.

Employee Contributions

You may choose to contribute on a pre-tax basis into a Traditional 401k account or on a post-tax basis into a Roth 401k account. Distributions from a Roth 401k account are non-taxable if you maintain the account for five years. Employee contributions are subject to IRS limitations. Information on Roth accounts and IRS limitations is available from MetLife.

Employer Match

ReliaSource will match 50% of your contribution subject to a cap equal to 1.5% of salary. If you contribute 1%, ReliaSource will match 0.5%. If you contribute 2%, ReliaSource will match 1%. If you contribute 3% or more, ReliaSource will match the maximum 1.5% of salary.

Roth Contributions

You may choose to contribute on a post-tax basis into a Roth account. Employee contributions and earnings to a Roth account are then non-taxable upon distribution if you maintain the account for 5 years. Roth contributions are not eligible for early withdrawal or hardship withdrawals. For more information on Roth contributions, ask the plan administrator or contact Principal Financial Group.

Vesting

The employer match will vest 100% after your third year of employment.

Eligibility

You will be eligible to participate after one month of service and must be 21 years of age.

PAID TIME OFF (PTO)

All ***full time*** employees scheduled to work at least 40 hours per week are eligible for PTO which includes vacation, sick and personal time. Your PTO begins accruing as of your date of hire but cannot be used until you have been with ReliaSource for at least 60 days. Temporary and Part-time employees are not eligible for PTO.

- You will be allowed to carry over 40 hours of unused vacation to the next year.
- The scheduling of PTO time is subject to your supervisor's approval. PTO time may be taken in a minimum of four hour increments.

HOLIDAY SCHEDULE

ReliaSource observes the following Holidays:

New Year's Day
Birthday of Martin Luther King, Jr.
Washington's Birthday
Memorial Day
Independence Day
Labor Day
Columbus Day
Veterans Day
Thanksgiving Day
Christmas Day

Enrollment FAQ

WHAT YOU NEED TO DO DURING BENEFITS ENROLLMENT

ALL employees will need to complete an updated enrollment form for health, dental, vision, life and disability.

Q. Where can I get Benefits Forms?

A. Email **juliez@reliasource.net** to obtain forms. Once you complete the forms, please fax to 443.817.0498 or email. If you have any questions regarding plan information, contact Cypress Benefits Group.

Q. How long do I have to decide about enrolling in benefits?

A. Benefits are effective the first day of the month following your date of hire. You have 30 days from your effective date to make any changes.

Q. If I do not enroll within the 30 day window, what are my options?

A. You will NOT be able to enroll until the next Open Enrollment Session. However, if you experience a change in status you will be eligible to enroll.

NOTE

After the Open Enrollment Period, you cannot make changes to your coverage during the year unless you experience a change in family status, such as:

- Loss or gain of coverage through your spouse
- Loss of eligibility of a covered dependent
- Death of your covered spouse or child
- Birth or adoption of a child
- Marriage, divorce, or legal separation
- Switch from part-time to full-time

Contacts

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