YOUR BENEFITS OPPORTUNITY

IT'S UP TO YOU!

2016

BENEFITS DECISION GUIDE

CONSULTANT
OPEN ENROLLMENT:
November 9-20, 2015

ManpowerGroup™

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YOUR OPEN ENROLLMENT BENEFITS DECISION GUIDE FOR 2016

USING THIS GUIDE

We know enrolling in your benefits is maybe not at the top of your list of favorite things to do. We've arranged this guide to make it as easy and painless as possible to find out everything you need to know to make the best benefit selections for 2016.

- **Section links pages -** To make navigation to specific information easier, you will find a divider page before each major section that includes links to every topic in the section.
- **Quick Facts –** The first page of most benefit sections will contain a summary of the relevant information about that particular benefit, such as your plan options, how much you will pay and other facts you should know, etc. The subsequent information in the section will outline specifics and other details on how to use the benefit or program.
- **Links –** Throughout this guide you will find links that you may click to find more information whenever other sections of the guide are referenced.
- **Heads Up! -** This is a new feature in the guide this year that will help you to identify benefit changes that will affect you in 2016. Find *Heads Up!* reminders throughout the guide.

Disclaimer: This guide provides highlights of the new 2016 Plan. However, it is not intended to be a complete description of the benefits under each Plan. The official Plan Documents actually govern your rights and benefits under each Plan. If any discrepancy exists between this guide and the Plan Documents, Company policies, or law, those Documents, policies or laws will govern. Plan provisions and eligibility for coverage do not constitute an employment contract with any individual. Management reserves the right to change or amend these Plans with or without advance written notification. Revised Plan Document and Summary Plan Description would be issued as soon as administratively possible following such changes.

- **Icons –** We don't want you to miss important information, which is why we've called out specific information in color-coded boxes and icons representing seven different categories as shown below:

Question Icon – Answers to frequently asked questions you might have about your benefits or how to use them

Attention Icon – Important information you need to know about your benefits or how to use them

Financial Icon – Information that has a financial or economic impact

Health Icon – Information to help you maintain your health

Time Sensitive Icon – Important information about a time-sensitive action you might need to take

What does this mean for me? – Understand how you are affected by changes to a particular benefit

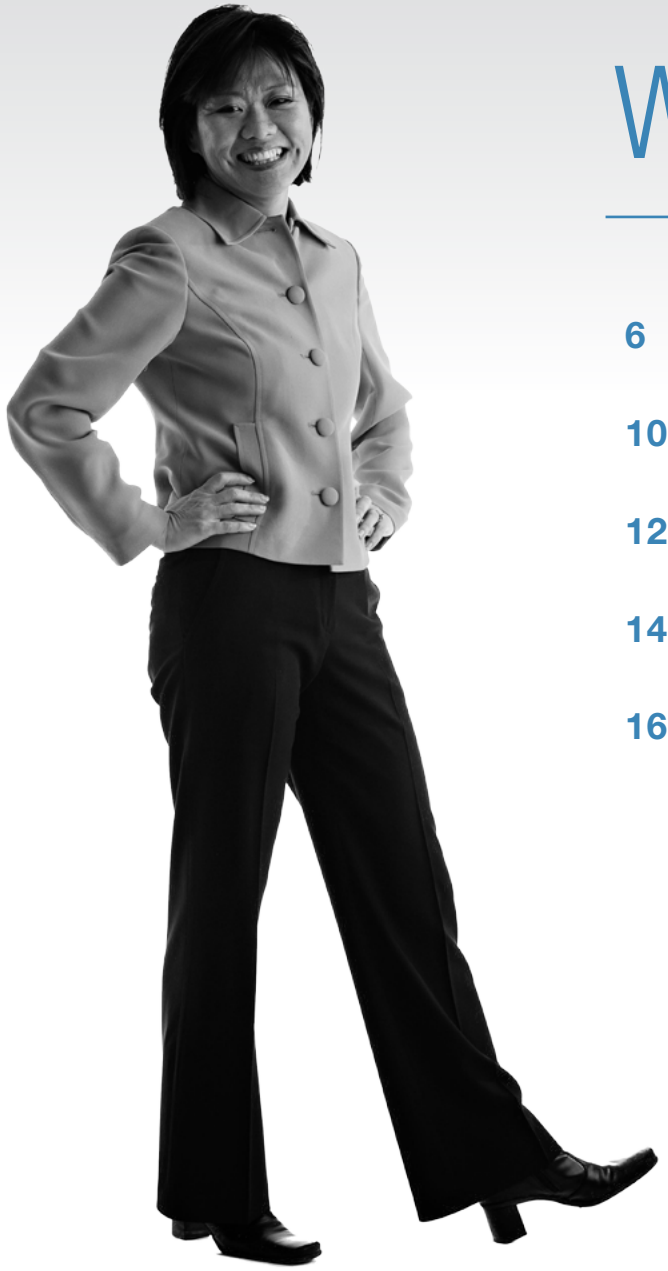
What do I need to do? – Understand what you need to do regarding any benefit changes or enrollment activities

BENEFITS RESOURCES DIRECTORY

Contact Information for 2016 Benefit Plans

Questions? If you have questions about your 2016 benefits, Open Enrollment or how to use the HR In Touch Enrollment Portal, contact Experis Care at **benefits@experis.com** or **800-326-6797**.

You have questions about...	Contact...	At phone number or website...
Medical Plan	UnitedHealthcare	844-859-5012 During Open Enrollment: http://welcometouhc.com/manpowerconsultants After January 1, 2016: myuhc.com
HSA (Health Savings Account)	PayFlex	888-678-8242 www.payflexdirect.com
Prescription Drug Program	Express Scripts (ESI)	877-445-3548 www.Express-Scripts.com *(Use Internet Explorer to access)*
Nurseline	UnitedHealthcare	844-859-5012
Dental Plan	MetLife	800-942-0854 http://metlife.com/mybenefits
Vision Plan	VSP	800-877-7195 www.vsp.com
GuidanceResources Employee Assistance Program (EAP)	ComPsych	844-813-0497 www.guidanceresources.com Web ID: MPG
Flexible Spending Accounts (FSA)	PayFlex	888-678-8242 www.payflexdirect.com
Life Insurance/AD&D	Voya Financial	800-603-3173, option 3, then option 4
Short-Term and Long-Term Disability	MetLife	877-638-8269
401(k) Plan	Fidelity	800-835-5095 www.401k.com
Employee Stock Purchase Plan (ESPP)	Morgan Stanley Customer Service Center	888-609-3534 www.stockplanconnect.com
Parking/Transit Benefit	PayFlex	888-678-8242 www.payflexdirect.com
Discount Shopping Benefit	BenefitHub Discounts	https://manpower.benefithub.com
COBRA	PayFlex	888-678-7835 www.payflexdirect.com



WELCOME

2016 BENEFIT HIGHLIGHTS

YOUR BENEFITS OPPORTUNITY - IT'S UP TO YOU!

Open Enrollment for the 2016 benefits year is November 9-20, 2015

Welcome to Open Enrollment for the 2016 benefits year. With some important benefit changes ahead, ManpowerGroup continues our commitment to offer you benefits that promote health and financial wellness for you and your family.

Active Enrollment – You Must Enroll for Coverage!

Because of these changes, 2016 is an active enrollment year for all Consultants. What does this mean? If you want ManpowerGroup benefits coverage for 2016, you are required to actively select and enroll in ManpowerGroup benefits (except for Life Insurance and Disability coverage) during Open Enrollment on the HR In Touch Enrollment Portal. If you don't make elections during 2016 Open Enrollment, you will not have coverage in 2016.

New for 2016, opposite sex domestic partners and same sex spouses in 50 states are eligible dependents for ManpowerGroup benefits coverage. Remember to enroll your eligible dependents if you want coverage for them in 2016.

TAKING CONTROL OF YOUR HEALTH AND YOUR HEALTH CARE

The move to UnitedHealthcare

One of the key changes we're making is the move to a new administrator for the ManpowerGroup Medical Plan – UnitedHealthcare (UHC) – replacing Aetna. Why the move to UHC? We want you to feel empowered to take control of your health and health care.

UHC offers a broader network as well as state-of-the-art tools that help you assess health care quality, determine costs and value and make informed decisions. The change to UHC also gives you access to providers with the United Health Premium® Tier 1 designation. Tier 1 providers meet rigorous criteria for delivering quality and cost-effective care.

We encourage you to read more about what the move to UHC means for you and the resources UHC can offer you and your family in this guide and other information on the HR In Touch Enrollment Portal and in other communications.

Medical Plan option changes

Like many other employers across the country, ManpowerGroup has a strong belief in the benefits of an HSA to give you more control over your health care dollars by offering you a tax-advantaged way to save for future medical expenses, even in retirement.

Good news, for 2016, you will be offered two new HSA Medical Plan options - Base HSA Medical Plan and Prime HSA Medical Plan. Each of these Plan options has a tax-advantaged health savings account (HSA) but differs in their deductible and out-of-pocket maximum cost amounts. The Choice Plus Plan and Secure Plan are being eliminated and will not be offered in 2016.

Dental Plan Changes, New Vision Plan

The Dental Plan Option 1, with its higher annual maximum benefit and orthodontia coverage, will again be offered in 2016, however Option 2 is being eliminated and will not be offered. You are also offered a new Vision Plan for next year that will be administered by Vision Service Plan (VSP).

SECURING YOUR FINANCIAL FUTURE

Did you know? Only one in four people in the United States feel very confident they will be financially ready for retirement. Fortunately, the ManpowerGroup 401(k) Plan and Nonqualified Savings Plan are great ways to save for your retirement. We're pleased to announce some changes in the plans' investment fund lineup that will make it easier for you to invest your funds across a mix of alternatives that match your investment and retirement goals. You should have already received information about these changes, but watch for more communications about this plan improvement.

GETTING READY TO ENROLL IN YOUR BENEFITS – WHAT YOU NEED TO DO

We have carefully designed benefit options that can go a long way in securing your health and financial wellness. We know – this is a lot of information to digest and understand. But the payoff is that with a small investment of time and careful consideration, you can select the best benefit options for you and your family and take advantage of all your ManpowerGroup benefits have to offer.

How do you prepare for the very important job of choosing not only the best Medical Plan option, but also the benefits that contribute to your financial wellness? Here are our best Open Enrollment "hacks":

- **Review the basics.** Even if you think you understand all the insurance terms and acronyms, it doesn't hurt to review the Medical Plan glossary and prescription drug glossary for the meaning of these sometimes confusing terms
- **Consider your family.** Who do you need to cover? Review your dependents' eligibility and include your spouse or domestic partner in the decision-making process
- **Understand your total costs.** What are the total costs of your Medical Plan options – premiums and your out-of-pocket costs? Don't forget to factor in tax advantages of an HSA or FSA
- **Review your health care use.** What was your health care use this year and how might it change in 2016? Review your Explanation of Benefits (EOBs) – you saved them, right? If not, contact your administrator
- **Consider the future.** How will your benefit decisions affect your finances, your health and your savings goals for the year ahead and your retirement?
- **Use all your resources.** Review the Open Enrollment resources available to you on the HR In Touch Enrollment Portal – we've made it easy for you to get to the information you need. And if you don't understand something and have questions, please call Experis Care at **800-326-6797**.
  Start your research early – and then get ready to enroll November 9-20!

WHAT ARE YOUR CHOICES FOR ACTION DURING OPEN ENROLLMENT?

For Medical, Dental & Vision Coverage in 2016	Make Changes	Choose to ELECT Specific Benefits	If You Choose to Do Nothing
Actively select and enroll in a Medical Plan option* if you want ManpowerGroup Medical Plan coverage: • The Base HSA Medical Plan or Prime HSA Medical Plan OR **Waive coverage;** and • Elect coverage under a spouse/ domestic partner's or parent's benefits • Purchase coverage in the Health Insurance Marketplace or from a private insurer • Enroll in Medicare or Medicaid (if eligible) **Actively select and enroll in:** • Dental Plan* • Vision Plan*	• To your current 2015 Life Insurance and Disability elections • To your Dependents covered • To the amount of coverage you have	• Health Savings Account * (HSA) (if you enroll in the Base or Prime HSA Medical Plan) • Health Care FSA* (if you waive medical coverage) • Dependent Care FSA* • Limited Purpose FSA* • Life Insurance • Disability • Employee Stock Purchase Plan (ESPP)* • Parking/Transit Benefit* **	With the exception of Life Insurance and Disability (if you are enrolled in 2015), you will NOT have ManpowerGroup benefits coverage

** Please note, you must elect these benefits if you want coverage in 2016. ** You will have to order Parking/Transit benefits online at the PayFlex website: www.payflexdirect.com*

THE AFFORDABLE CARE ACT AND YOUR 2016 BENEFITS

The Affordable Care Act, or ACA, requires most people to have medical insurance and offers the Health Insurance Marketplace as an option for medical insurance in 2016. Information about this ACA requirement and your insurance options are posted on the HR In Touch Enrollment Portal.

MANPOWERGROUP MEDICAL PLAN AFFORDABILITY

In 2016, ManpowerGroup Consultants will have two Medical Plan options, the Base HSA Medical Plan and the Prime HSA Medical Plan. All Medical Plan options meet the government's requirements for value, and may or may not meet the definition of "affordability" for you personally, depending on your income.

More information about affordability and what it means for you and your options for medical insurance under the ACA can be found in your ACA Guide here on the HR In Touch Enrollment Portal.

YOUR OPTIONS UNDER THE ACA

This fall you will need to make a decision about what medical insurance you want. Under the law, you have several options:

- The ManpowerGroup Medical Plan
- Your spouse/domestic partner's employer's plan (if you are eligible)
- Your parent's employer's plan (up to age 26) (if you are eligible)
- The Health Insurance Marketplace in your state
- A government program such as Medicare or Medicaid (if you are eligible)

What if I enroll in a medical plan in the Marketplace?

If the ManpowerGroup Medical Plan is "affordable" for you under the ACA requirements, but you decide to waive ManpowerGroup coverage and enroll in a medical plan available in the Marketplace:

- You will not be eligible for a subsidy from the government to buy insurance
- If the company contributes to the cost of your Medical Plan coverage, you will no longer receive a company contribution
- You will miss out on the tax benefits you receive as a result of the pre-tax status of your Medical Plan contribution (premium)
- You may still enroll in the other benefits offered by ManpowerGroup

WHAT'S RIGHT FOR YOU?

We have provided information and resources to help you make sure you and your family are insured in 2016. These resources can be found on the HR In Touch Enrollment Portal. Also visit www.healthcare.gov to learn about the Marketplace in your state.

To help you make the decision that is right for you, we encourage you to:

- Evaluate all of your options for health care coverage for 2016, including those available through the company and those available in the Marketplace.
- Make sure you have all the information you need about your options before you make a medical insurance decision.
- Take action during Open Enrollment from November 9 to November 20 if you want coverage under a ManpowerGroup Medical Plan option for 2016. If you do not actively select ManpowerGroup medical coverage during Open Enrollment, you will not have coverage under the ManpowerGroup Medical Plan in 2016.

Please take the time to understand what the ACA means for you and what options you have for buying medical insurance in 2016, including those available from ManpowerGroup. Be sure to read the provided material and use your resources if you have questions.

ELIGIBILITY – WHO'S COVERED?

MAINTAINING YOUR COVERAGE

As long as you work at least one hour in the month, you will continue to have coverage. If you do not have a paycheck or have enough in your paycheck to cover your deductions, an arrears balance will build. The arrears balance will be taken on your next check(s).

As a Consultant, there are two ways in which your benefits coverage can be terminated:

- Your assignment ends; coverage terminates at the end of the pay period in which your assignment is terminated
- You do not work at least one hour in a month; coverage terminates on the last day of the month in which you have not worked at least one hour

After Your Assignment Ends

- If you are rehired prior to 12 months from your termination date, you may elect new coverage effective the first of the month following your rehire date
- If you are rehired after 12 months from your termination date, you may elect new coverage effective the first of the month following 30 days from your rehire date

You May Enroll In Medical Plan Benefits In One of Four Coverage Categories:
Employee Only
Employee + Spouse/Domestic Partner
Employee + Child(ren) up to the age of 26
Family

Reinstatement After Failing to Work One Hour

If your coverage terminated after failing to work one hour in a month, you may reinstate your prior coverage if you work one hour. To reinstate your coverage, you must contact Experis Care in the month that you work one hour. Your prior coverage will be reinstated effective the first of the month following your working one hour.

Eligible dependents

- Your spouse or same sex or opposite sex domestic partner
- Your children up to age 26

Eligible dependent children include:*

- Your natural children
- Your adopted children or children placed with you for adoption
- Your stepchildren
- Children for whom you are the legal guardian
- Your foster children
- Children of your domestic partner

**Dependent children may also be covered under the Medical Plan if they are required to be covered under a Qualified Medical Child Support Order as an "Alternate Recipient."*

Does It Pay to Double Up on Coverage?

If you and your spouse or domestic partner are covered under the Medical, Dental or Vision Plan and another group plan, the two plans will coordinate benefits. When this happens, special rules apply. See Coordination of Benefits for more information.

In most cases, if you double up on coverage under two group plans, you won't have more coverage, just duplicate coverage and more premiums to pay.

HEADS UP! Changes to Spousal and Domestic Partner Eligibility

New for 2016, opposite sex domestic partners or same sex spouses in all 50 states are eligible for ManpowerGroup health benefits coverage. Don't forget to enroll your spouse or domestic partner in your benefits if you want coverage for them!

TAXES FOR SPOUSES AND DOMESTIC PARTNERS

In many cases, ManpowerGroup benefit programs provide coverage to an employee's "spouse." For these purposes, "spouse" includes the following:

- Legally married opposite sex spouses
- Legally married same sex spouses

Same sex couples are treated as married for all federal tax purposes.

For same sex and opposite sex domestic partners:

- Payroll deductions for your domestic partner and their children will be made on an after-tax basis (see a definition of before-and after-tax deduction)
- The value of the health care coverage for your domestic partner and their children will be required to be reported as income on your federal tax return.

Please note: For purposes of your state income tax return, please be aware some states treat this income as taxable, while others do not. For more details, please consult a tax advisor.

WHEN CAN I CHANGE MY COVERAGE?

WHAT ARE QUALIFYING LIFE EVENTS (QLEs)?

Okay, you've heard us say Open Enrollment is your chance to make the really important decisions about your Medical Plan options and your other benefits. But... this is life – things happen. Yes, you can change your coverage OUTSIDE of Open Enrollment when these things (called qualifying Life Events) happen:

Relationship Status

- Marriage
- Divorce
- Legal separation
- Annulment
- Death of a spouse or domestic partner
- Beginning or end of a domestic partner relationship

Change in Dependents

Change in the number of your dependents (e.g., a new dependent as a result of marriage, birth, adoption or placement for adoption)

Change in dependent status (e.g., dependent child reaches 26 or is eligible for coverage under other employer-sponsored group coverage)

Workplace Related

Change in employment status for you or your spouse/domestic partner (e.g., beginning or end of employment with the company, beginning or return from an unpaid leave of absence)

Plan Changes

Significant change in your health care coverage or that of your spouse or domestic partner (significant cost of coverage increase, loss of coverage, spouse's annual enrollment)

TAKE ACTION DURING OPEN ENROLLMENT

Annual Open Enrollment is your opportunity to select the benefit coverage you want for you and your eligible dependents.

- You may make changes to your Life Insurance and Disability elections; and/or
- Choose to enroll in a Flexible Spending Account (FSA), Life Insurance, Disability or Employee Stock Purchase Program (ESPP) (you must re-enroll in FSAs and ESPP if you want coverage in 2016).
- If you choose to nothing, you will NOT have coverage under the ManpowerGroup benefits, except for Life and Disability Insurance.

IRS regulations say that changes in benefit plan elections and/or enrollment can be made at other times during the year only if you experience a qualifying life event (QLE).

Some more "stuff" you should know about your ManpowerGroup benefits

Here are some more facts about your benefits we didn't want you to miss:

Did you know? You can pick and choose which benefits you want to elect. For example, even if you choose to waive Medical Plan coverage, you can still enroll in other benefits if you're eligible.

It's not all about you – don't forget to enroll the family! If you want dependent coverage for a specific benefit, you will need to enroll your dependents as well as yourself in the benefit.

PAYROLL DEDUCTIONS & YOUR TAXES

ManpowerGroup deducts your contribution for certain benefits from your paycheck on a pre-tax basis. This means your contribution is taken out before federal, state and Social Security (F.I.C.A.) taxes are taken out. A good deal since it lowers your taxable income – less taxes means more money in your pocket.

Pre-tax	Post-tax
Medical	Domestic Partner Medical
Dental	Domestic Partner Dental
Vision	Domestic Partner Vision
HSA	Supplemental Life Insurance
Health Care Flexible Spending Account	Spouse, Domestic Partner and Dependent Child Life Insurance
Limited Purpose Flexible Spending Account	Employee Stock Purchase Plan (ESPP)
Dependent Care Flexible Spending Account	Short-Term Disability Plan
Parking/Transit Benefit	Long-Term Disability Plan
401(k)*	

**Contribution is taken out before federal taxes and may vary for state taxes.*

HERE'S TO YOUR HEALTH

Medical Plan

GLOSSARY AT A GLANCE

How Many of These Do You Know?

Don't feel bad – if you don't know what all those health insurance buzz-words are like coinsurance and out-of-pocket maximum, you're not alone. Not knowing these terms can be costly when you're trying to select a Medical Plan option that's right for you – so here are some definitions you can review before you dive into selecting your benefits.

Term	Definition
DEDUCTIBLE	The amount you owe before your health insurance benefits kick in. For example, if your deductible is $1,750, the Plan won't pay anything (except for preventive care which is covered at 100%) until your costs are more than $1,750. Deductibles apply to your out-of-pocket maximum. See Meeting Your Deductible in the Base HSA Medical Plan; Meeting Your Deductible in the Prime HSA Medical Plan for more information.
COINSURANCE	Your part of the costs of a covered service. It's calculated as a percentage and you pay it after you've also met your deductible. For example, if the Medical Plan's cost for an office visit is $100 and you've already met your deductible, your coinsurance payment of 20% would be $20 – the Plan picks up the rest of the cost. Coinsurance applies to your out-of-pocket maximum.
COPAY	The amount you pay every time you receive certain health services or prescription drugs. For instance, your copay for a non-preventive generic drug at a pharmacy is $10. The Plan takes care of the rest. Copays apply to your out-of-pocket maximum.
OUT-OF-POCKET MAXIMUM	The most you pay during the calendar year before the Plan begins to pay 100% of the cost of covered services (excluding preventive services which are covered at 100%). The out-of-pocket maximum does not include your share of the premium cost for the Plan or services the Plan doesn't cover.
PREMIUM	The amount you pay for your share of the cost of the Plan (deducted from your paycheck on a pre-tax basis).

Term	Definition
PREVENTIVE CARE	Routine health care (including preventive prescription drugs). Things like regular checkups, patient counseling and screenings to prevent disease, illness and other health complications. Preventive care is covered at 100% in the Medical Plan before and after your deductible is met.
IN- AND OUT-OF-NETWORK	Covered services from health care providers who contract with UnitedHealthcare and agree to charge lower fees for people enrolled in the Plan. An out-of-network provider is someone who does not have a contract with UnitedHealthcare. The Plan will cover more of the costs of services when you use in-network providers.
HEALTH SAVINGS ACCOUNT	A bank account to help save money, tax-free, to pay your share (deductible, coinsurance and copays) of qualified health care expenses (now or in the future) if you are enrolled in either Medical Plan option. You own and control the money in your HSA and funds roll over from year to year – it's yours to keep even if you leave the company.
UNITEDHEALTH PREMIUM® DESIGNATION PROGRAM TIER 1 PHYSICIANS	Physicians in the UHC network in 27 different medical specialties who are recognized for meeting national standards for quality and cost efficiency. Consider using a Tier 1 physician (look for the Tier 1 logo in your physician search on (http://welcometouhc.com/manpowerconsultants during Open Enrollment and myuhc.com after January 1) before you go for service to save money when you need care.
CLAIM	The bill you or your doctor or health care provider submits to the Plan for payment.
EXPLANATION OF BENEFITS (EOB)	A document sent to you by UnitedHealthcare after you have a health care service that was paid. The EOB gives you information about how an insurance claim was paid on your behalf – useful information to help you track your expenditures and the medical services you received.

UNITEDHEALTHCARE – NEW PLAN ADMINISTRATOR

Taking control of your health and your health care

We are pleased to announce the move to a new Medical Plan administrator for 2016, UnitedHealthcare (UHC), replacing Aetna. UHC offers a broader provider network and state-of-the-art tools that help you to determine which providers offer health care quality and value in order to make informed decisions.

HEADS UP! Introducing UnitedHealthcare

In 2016 ManpowerGroup will be using UnitedHealthcare – replacing Aetna to administer our Medical Plan.

What does this mean for me?

Instead of Aetna, UHC is the insurance company that will be:

- Tracking and paying your eligible health care claims
- Managing your preferred provider network
- Answering your questions, offering you resources for better health and health care decisions
- Giving you important information about the cost and quality of health care providers through the UnitedHealth Premium® designation program
- Offering help with health care when you need it

What's not changing?

- Your prescription drug coverage will continue to be administered by Express Scripts
- Your Health Savings Account (HSA) will continue to be administered by PayFlex

What do I need to do?

- **Find a doctor.** During Open Enrollment: Go online at http://welcometouhc.com/manpowerconsultants or call UHC at **844-859-5012** to check to see if your doctors and other health care providers are in the UHC network > click on *Find your Doctor* under *Health Plan Options*; After January 1: Log into myuhc.com > select *Find a Doctor* or *Physicians & Facilities*

- **Choose with confidence.** Learn more about the UnitedHealth Premium designation program. The program evaluates the cost and quality of care for physicians across 27 different specialties to recognize doctors who offer higher value health care. You can use this information to help you choose the care that's right for you

- **Find help with health care.** Go online at http://welcometouhc.com/manpowerconsultants (myuhc.com after January 1) to explore all the resources UHC offers to help you get healthier, receive personal support and save money:
  - **myuhc.com –** your gateway to managing your benefits and making better health care decisions
  - **Personal health support –** valuable programs and personal services to help you manage conditions and take care of yourself such as 24-hour nurse access
  - **Health & education resources –** easy-to-use resources to access health care and educational information online or by phone 24/7
  - **Saving money on care –** use tools like the myHealthcare Cost Estimator that helps you easily comparison shop before you see the doctor or need a medical procedure and review UnitedHealth Premium designation program information
  - **And much more!**

Using in-network providers – why is this important?

You can save money. Period. By now, most of us know your level of benefits under the Medical Plan is higher when you use in-network providers. That's one good reason. Another is that in-network doctors, hospitals, other providers and facilities have a contract with UnitedHealthcare (UHC) and have agreed to follow certain guidelines and provide services to you at lower prices. This is important, especially when you are paying out-of-pocket costs like deductibles and coinsurance.

The UnitedHealth Premium designation program also helps you identify Tier 1 physicians that meet rigorous quality and cost effectiveness standards.

What if my doctor is not in the network?

Don't panic – if you're receiving care for an existing condition that qualifies, UHC's Transition of Care (TOC) lets you continue to receive your current treatment using your current doctor for a specific period of time, depending on your current condition. If you qualify for TOC, services with your current doctor will be paid under the network level of coverage until the end of your TOC period. After that, UHC will work with you to see that you get the care you need through the UHC network.

A word about customer service

- Have questions about your plan benefits?
- Concerned about a recent diagnosis?
- Need help resolving claims issues? Not sure where to go for care?

UHC's innovative customer service program, Advocate4Me®, gives you a personalized customer service experience as a one-stop-shop for help with your questions by phone (**844-859-5012**) or email (Advocate4Me@uhc.com) to make the most of your Medical Plan benefits.

MYUHC.COM

As wired as most of us are to the internet, it's easy to overlook the benefits of getting hooked up to all the resources available on UHC's member website:

- Track claims and expenses
- Plan ahead for tests and treatments
- Stay on top of your medical history
- Get tips for improving your health

And it's easy to register:

1. Go to myuhc.com after January 1
2. Click on *Register Now* – you'll need your Medical Plan ID card, or use your Social Security number and date of birth to register
3. Follow the step-by-step instructions

But don't stop there – download the UnitedHealthcare Health4Me™ mobile app on your smartphone or tablet to find nearby doctors, check the status of a claim, estimate the costs of common procedures and conditions, see your account balance or pull up an image of your UHC ID card.

UNITEDHEALTH PREMIUM® DESIGNATION PROGRAM

Choose with confidence, save money

Have you ever wished for more information when you are looking for a doctor, evaluating your treatment options or trying to understand the cost of care?

Just like every other service or product you shop for – where you go for health care can make a big difference. Until now, it's been difficult to find out where to get the best value for probably the most important services you will ever seek.

That's where the UnitedHealth Premium designation program comes in. The Premium program is one of the longest-running physician quality and cost-efficiency designation programs in the industry.

Have a health care question?

Sudden fevers, sports injuries – why do these things always seem to happen on the weekend or at 3:00 a.m.?

Never fear – you can speak with a UnitedHealthcare myNurseLine 24-hour nurse at any time by calling **844-859-5012** (don't forget to add this number to your cell phone contacts for answers no matter where you are) or by chatting online at myuhc.com. What can the 24-hour nurse do for you?

- Help you manage an illness or injury
- Help you recognize urgent and emergency symptoms
- Locate doctors and hospitals in your area
- Help you recognize medication interactions

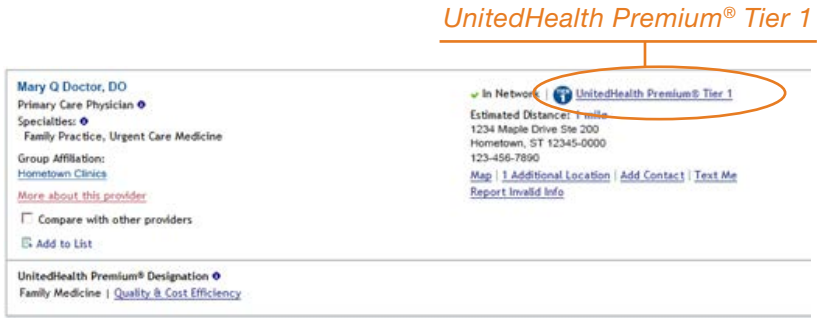
What does this mean for me?

The Premium program evaluates doctors using national standards for quality and local benchmarks for cost efficiency. UnitedHealthcare shares this information with you to help you make informed choices about your care.

Although your level of coverage under the Medical Plan is the same for all in-network providers, UnitedHealth Premium designation **Tier 1 physicians** are doctors in 27 different medical specialties who are recognized for meeting national standards for quality and local benchmarks for cost efficiency. When you use Tier 1 physicians, you will typically pay less for the same service.

What do I need to do?

- ☑ Consider using a Tier 1 doctor before you go
- ☑ Look for the Tier 1 logo in you physician search on myuhc.com or call **844-859-5012**



MEDICAL PLAN *QUICK FACTS*

YOUR PLAN OPTIONS

1. Base HSA Medical Plan
2. Prime HSA Medical Plan
3. Waive coverage

You must actively enroll

Do you want ManpowerGroup Medical coverage?

If you answered YES – you are NOT done yet (even if you're already enrolled for this year).

So...if you DO want ManpowerGroup Medical coverage in 2016, you NEED TO ACTIVELY PICK A PLAN by November 20 or YOU WILL NOT HAVE COVERAGE UNDER THE MANPOWERGROUP MEDICAL PLAN IN 2016.

KNOW THE FACTS

How much will I pay?

- Your share of the premium

Base HSA Medical Plan

- $4,500 individual deductible, $9,000 family deductible ; AND THEN
- 40% (we call this coinsurance) of covered costs if you use UHC network providers / 60% if you don't (AFTER your deductible is met)

Prime HSA Medical Plan

- $1,750 individual deductible, $4,500 family deductible (which must be met before any benefits are paid if you have family coverage); AND THEN
- 20% of covered costs if you are using UHC network providers / 40% if you don't (AFTER your deductible is met)

What else should I know/care about?

- Prescription drugs are covered through Express Scripts (ESI)
- 100% of preventive care (including preventive prescription drugs) is covered
- Both Plan options come with a GREAT way to save (tax-free!) money for all your out-of-pocket qualified medical expenses (Including your deductible and coinsurance) called a Health Savings Account (HSA) (administered by PayFlex)

$4,500 / $9,000

Deductible for Base HSA Medical Plan is $4,500 individual deductible or $9,000 family deductible

100%

Both the Plan options cover the full price of preventive care

$1,750 / $4,500

Deductible for Prime HSA Medical Plan is $1,750 individual deductible or $4,500 family deductible

MEDICAL PLAN *QUICK FACTS (CONTINUED)*

YOUR COST

Base HSA Medical Plan

- Has a lower payroll deduction (premium)
- Has higher deductibles and out-of-pocket maximums

Prime HSA Medical Plan

- Has a higher payroll deduction
- Has lower deductibles and out-of-pocket maximums

Premium information can be found on the HR In Touch Enrollment Portal.

What about my deductible?

This is so important, we're saying it a lot more than once...

- Your routine preventive care is covered at 100% WITHOUT paying a deductible
- For all other care (including non-preventive prescription drugs) you MUST satisfy (pay in full) your deductible BEFORE either Plan will begin to pay for covered health care services or prescriptions

What are those Plan option deductibles again?

- HSA Base - $4,500 per individual; $9,000 per family
- HSA Prime - $1,750 per individual; $4,500 per family

Still stumped? See more information here

MEDICAL PLAN *QUICK FACTS (CONTINUED)*

KNOW THE FACTS

Prescription Drug Coverage

Both of your Medical Plan options include coverage for prescription drugs through Express Scripts (ESI). It covers prescribed drugs either:

- Filled at a participating pharmacy
- Ordered through the ESI mail order program
- Filled at ESI's specialty pharmacy, Accredo

What else should I know/care about?

- For non-preventive drugs, your Medical Plan deductible (which applies to both medical and prescription expenses) needs to be satisfied before the Plan pays
- You can purchase a 90-day supply – three times the amount of medication for a lower cost than retail with the convenience of home delivery through the ESI mail order program
- The mail order program is mandatory for maintenance medication unless you choose to opt out
- To get the most from your prescription drug benefits, purchase your specialty medications (used to treat complex conditions) from ESI's specialty pharmacy, Accredo
- Find prescription drug information and management options online at www.Express-Scripts.com and through the ESI mobile app

PRESCRIPTION DRUG GLOSSARY AT A GLANCE

Term	Definition
GENERIC DRUGS	Usually 30 to 75% less than their brand name counterparts, generic drugs are regulated by the U.S. Food and Drug Administration and must contain the same active ingredients as brand name drugs, making them safe and effective.
DRUG FORMULARY	A list of prescription drugs, both generic and brand name, that are preferred by the Medical Plan.
FORMULARY BRAND NAME DRUGS	Drugs that may or may not offer generic equivalents.
NON-FORMULARY BRAND NAME DRUGS	Medications that have equally effective, but less costly generic equivalents and/or formulary brand alternatives. Also includes new drugs that don't have generic equivalents. The cost of non-formulary brand name drugs will be more than a generic or formulary drug.
SPECIALTY DRUGS	Drugs that often require special storage and handling that most retail pharmacies can't manage. Includes injectable, infused and select oral therapies.

MEDICAL PLAN *QUICK FACTS (CONTINUED)*

Preventive Prescriptions Covered at 100%

For members that meet certain age criteria, the following items are covered at 100% under the Medical Plan:

Drug or Drug Category	Criteria
ASPIRIN (to prevent cardiovascular events)	Men ages 45 to 79 years and Women ages 55 to 79 years; for preeclampsia, 81mg for Women < 55 years of age
ORAL FLUORIDE	Children older than 6 months of age through 5 years old
FOLIC ACID	Women through age 50 years
IRON SUPPLEMENTS	Children ages 6 to 12 months who are at risk for iron deficiency anemia
IMMUNIZATIONS	Recommended ages per ACIP recommendations
SMOKING CESSATION	Men and Women ages ≥ 18 who use tobacco products. Limitation of 180 days supply in 365 days.
VITAMIN D	Men and Women ages ≥ 65 who are at increased risk for falls
BOWEL PREPS	Men and Women > 49 years of age and < 76 years of age. Fill Limit: 2 prescriptions at $0 copay per 365 days.
BREAST CANCER PREVENTION	Tamoxifen, Raloxifene and Soltamox (liquid Tamoxifen): Women ≥ 35 years of age who meet criteria

WHICH MEDICAL PLAN OPTION IS BEST FOR ME?

Your 2016 Medical Plan options:

- Base HSA Medical Plan
- Prime HSA Medical Plan

Which of the Plan options is right for me?

Which of these options is right for you depends on your health and your financial situation. You'll want to consider your regular monthly expenses and your typical health expenses before deciding on how much per month you can spend.

How your options compare:

Plan Feature	Base HSA Medical Plan		Prime HSA Medical Plan	
PAYROLL DEDUCTION	Lower		Higher	
DEDUCTIBLES	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Employee	$4,500	$9,000	$1,750	$3,500
Employee + Child(ren) or Employee + Spouse/DP	$6,750	$13,500	$3,000	$6,000
Family	$9,000	$18,000	$4,500	$9,000
OUT-OF-POCKET MAXIMUMS	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Employee	$6,350	$12,700	$4,000	$8,000
Employee + Child(ren) or Employee + Spouse/DP	$9,525	$19,050	$6,850	$13,700
Family	$12,700	$25,400	$6,850	$13,700

THE CASE FOR THE BASE HSA PLAN

If you are generally healthy, you might come out ahead paying a lower premium and a bigger share of your health costs (Base HSA Medical Plan), because your costs are most likely not going to be that high. In other words, don't overbuy. You wouldn't buy a luxury car with a monthly payment that threatens to break your budget when all you need is to get to and from work – would you?

Of course, you need to be prepared to pay more if you or a family member unexpectedly becomes sick or injured. And now that you know and understand all the great consumer benefits of saving for health care expenses with an HSA. When figuring out the maximum amount of premium you can afford, be sure to consider your monthly HSA contribution alongside it.

BASE HSA MEDICAL PLAN – WHO MIGHT FIT THE PROFILE?

- Generally healthy, rarely sees a doctor
- Single/smaller families/families without young children
- Didn't spend much on health care last year
- Contributes regularly to their HSA/has HSA funds saved

" I hardly ever go to the doctor. My main priority is keeping my monthly payments as low as possible."

" I might have a few medical expenses during the year but the money in my HSA should cover it."

" I stay healthy and get all my recommended check-ups and tests for my age every year, but those are my only health care visits – and they are covered in full."

Preventive care - it's covered!

A higher deductible should never be an excuse for you to skip recommended check-ups or diagnostic tests – preventive care is covered at 100% by the Medical Plan. Remember this fact when looking at your projected health care expenses to help you decide which plan option is right for you.

THE CASE FOR THE PRIME HSA MEDICAL PLAN

In some cases, you'll want to choose a plan with a higher premium (Prime HSA Medical Plan), and save yourself money on out-of-pocket costs. This is generally true for people with chronic health conditions and those with planned medical expenses such as having a baby, voluntary surgery like a hip or knee replacement or an increased volume of care with a new diagnosis.

PRIME HSA MEDICAL PLAN – WHO MIGHT FIT THE PROFILE?

- Chronic medical condition/ongoing medical services/uses brand-name medications regularly
- Planned surgery, maternity
- Larger families/families with young children/children in sports
- Had a number of health expenses last year

" I want to reduce my out-of-pocket expenses through the year. I think I'll be using more medical services so I don't mind paying more each month."

" Considering our current health situation, we're probably going to see a lot of specialists and one of us may have surgery. I'm willing to pay a higher monthly premium to keep my medical expenses as low as possible throughout the year."

" My kids get sick a lot and are all involved in sports and it seems we are always making a trip to the doctor and the emergency room!"

WHAT DO THE BASE & PRIME HSA MEDICAL PLANS COVER?

Need more information?

You can get a detailed listing of what's covered and what's not through UnitedHealthcare.

	Prime HSA Medical Plan Pays:		Base HSA Medical Plan Pays:	
KEY FEATURE	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Routine Preventive Care				
Adult office visit Well-child office visit Mammogram, PSA, Pap smear Immunizations (Children to age 18) Women's preventive health services*	100%, no deductible	60% after deductible	100%, no deductible	Not covered
Office Visits				
Primary care physician / Specialty care physician	80% after deductible	60% after deductible	60% after deductible	40% after deductible
Maternity Care				
Delivery	80% after deductible	60% after deductible	60% after deductible	40% after deductible
Inpatient hospital, birthing centers, midwives	80% after deductible	60% after deductible	60% after deductible	40% after deductible
Dependent maternity coverage	Coverage up to delivery; no coverage for child after delivery		Coverage up to delivery; no coverage for child after delivery	
Hospital (includes physician's charges)				
Inpatient Precertification required	80% after deductible Yes	60% after deductible Yes	60% after deductible Yes	40% after deductible Yes
Surgery Precertification required	80% after deductible Yes	60% after deductible Yes	60% after deductible Yes	40% after deductible Yes
Hospice (in or out of hospital)	80% after deductible	60% after deductible	60% after deductible	40% after deductible
Outpatient Care (includes physician's charges)				
Outpatient surgery	80% after deductible	60% after deductible	60% after deductible	40% after deductible
Outpatient non-surgery	80% after deductible	60% after deductible	60% after deductible	40% after deductible

**Gestational diabetes screening, HPV DNA testing, sexually transmitted infection counseling, HIV screening and counseling, FDA-approved contraception methods and contraceptive counseling, breastfeeding support, supplies and counseling, domestic violence screening and counseling.*

	Prime HSA Medical Plan Pays:		Base HSA Medical Plan Pays:	
KEY FEATURE	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
EMERGENCY AND URGENT CARE				
Hospital emergency room Emergencies	80% after deductible	80% after deductible	60% after deductible	60% after deductible
Non-emergencies	80% after deductible	80% after deductible	40% after deductible	40% after deductible
Ambulance services	80% after deductible	80% after deductible	60% after deductible	60% after deductible
ER professional services (radiology, pathology, ER physician)	80% after deductible	80% after deductible	60% after deductible	60% after deductible
Urgent care or outpatient facility	80% after deductible	60% after deductible	60% after deductible	40% after deductible
LABORATORY AND RADIOLOGY SERVICES (INCLUDES PRE-ADMISSION TESTING)				
Services in physician's office	80% after deductible	60% after deductible	60% after deductible	40% after deductible
Outpatient facility	80% after deductible	60% after deductible	60% after deductible	40% after deductible
Independent X-ray or lab	80% after deductible	60% after deductible	60% after deductible	40% after deductible
Advanced radiological imaging (e.g., MRI, MRA, CAT scan, PET scan)	80% after deductible	60% after deductible	60% after deductible	40% after deductible
BEHAVIORAL HEALTH BENEFITS				
Inpatient (pre-certification required)	80% after deductible	60% after deductible	60% after deductible	40% after deductible
Outpatient	80% after deductible	60% after deductible	60% after deductible	40% after deductible
REHABILITATIVE THERAPY AND SERVICES				
Rehabilitative therapy (e.g., physical, speech, occupational, pulmonary, cardiac rehabilitation)	80% after deductible	60% after deductible	60% after deductible	40% after deductible
Rehabilitative therapy maximum (physical, occupational and speech therapy)	30 days per therapy		30 days per therapy	
Chemotherapy, radiation therapy, dialysis	80% after deductible	60% after deductible	60% after deductible	40% after deductible
Chiropractic spinal manipulation	80% after deductible	60% after deductible	60% after deductible	40% after deductible
Chiropractic spinal manipulation therapy maximum	24 visits per year		24 visits per year	
Home health care	80% after deductible	60% after deductible	60% after deductible	40% after deductible
Home health care maximum	120 days		120 days	
Skilled nursing facility, rehab hospital, and sub-acute facility	80% after deductible	60% after deductible	60% after deductible	40% after deductible
Skilled nursing facility, rehab hospital, and sub-acute facility maximum	60 days		60 days	

Prescription Drug Benefit (Base & Prime HSA Medical Plans)			
TYPE OF DRUG	GENERIC	FORMULARY BRAND	NON-FORMULARY BRAND
PREVENTIVE*	**TIER 1**	**TIER 2**	**TIER 3**
Retail Coinsurance	$5 copay	$10 copay	$10 copay
Mail order Coinsurance	$12 copay	$25 copay	$25 copay
ACA-classified preventive drugs (see next page)	100%	100%	100%
NON-PREVENTIVE	**TIER 1**	**TIER 2**	**TIER 3**
Deductible must be satisfied before Plan pays			
Retail Coinsurance	$10 copay after the deductible	20% min $20 / max $40 after the deductible	40% min $50 / max $100 after the deductible
Mail order Coinsurance	$25 copay after the deductible	20% min $50 / max $100 after the deductible	40% min $125 / max $250 after the deductible

*Some preventive prescriptions are covered at 100% for members that meet certain age criteria

Please note: If you fill a prescription for a brand-name medication when a generic equivalent is available, you will pay the applicable copay, plus the difference in cost between the brand name drug and the generic drug.

Deductible Applies to Non-Preventive Drugs

For non-preventive drugs, the Base and Prime HSA Medical Plan deductible needs to be satisfied (which applies to both medical and prescription expenses) before the Plan pays.

The Mail Order Advantage – More Medication For Less Money

When you buy prescription drugs at a retail pharmacy, you can buy up to a 30-day supply. When you use the mail order program, you can purchase a 90-day supply; three times the amount of medication for a lower cost than retail. You also get the convenience of home delivery. Please note, the mail order program is mandatory for maintenance drugs unless you opt out.

If you plan to use mail order, be sure to ask your doctor to write your prescription for a 90-day supply.

MEETING YOUR DEDUCTIBLE & OUT-OF-POCKET MAXIMUM

This can be complicated, so let's review – you have two kinds of cost sharing under your Plan coverage:

1. **The deductible** is the amount you owe before any of your health insurance benefits kick in. For example, if your deductible is $4,500, the Plan won't pay anything (except for preventive care which is covered at 100%) until your costs are more than $4,500. Deductibles apply to your out-of-pocket maximum.
2. **The out-of-pocket maximum** is the most you pay during the calendar year before the Plan begins to pay 100% of the cost of covered services.

Hopefully, the following information will help you understand how the Medical Plan deductibles and out-of-pocket maximums are applied for both Plan options.

Remember, with the exception of preventive care, deductibles must be satisfied before the Plan begins to pay for covered health care expenses for both HSA Plan options!

BASE HSA MEDICAL PLAN

Deductibles and Out-of-Pocket Maximums

No one person in your family will pay more than the individual deductible of $4,500 before the Plan begins to cover their non-preventive health care costs; or the individual maximum of $6,350 in out-of-pocket costs before the Plan begins to pay for their individual covered costs at 100%. Let's look at how this works a little closer.

	Coverage Type	Deductibles*	Out-of-Pocket Maximums*
	Employee Only (Individual)	$4,500	$6,350
	Employee + Spouse/DP	$6,750	$9,525
	Employee + Child(ren)	$6,750	$9,525
	Family	$9,000	$12,700

How do the Base HSA Medical Plan's deductible and out-of-pocket maximum work for employee only/ individual coverage?

The employee (individual) deductible for the Base HSA Medical Plan is $4,500. This means:

- You will need to have $4,500 in out-of-pocket health care expenses before the Plan will begin to pay for covered expenses (except for preventive)
- Once you have paid $6,350 in out-of-pocket expenses, the Plan will pay 100% of your covered services

How does the Base HSA Medical Plan's deductible work for family coverage?

With the Base HSA Medical Plan's family deductible, the Plan will keep track of two different types of health insurance deductibles for each family member: the individual (employee only) deductible ($4,500) and the family deductible ($6,750 or $9,000, depending on your coverage tier level). When a family member has a health care expense, the money they pay toward their deductible is also credited toward the family deductible.

There are two ways coverage will kick in for non-preventive services and the Plan will begin paying for the covered health care expenses of any particular family member:

1. The family member has had enough personal health care expenses to meet their individual deductible:
   - The Plan begins paying for this person's expenses, but NOT the health care expenses of other family members who have not met their individual deductibles
2. Several different family members have each paid enough in individual deductibles that, when added together, the family deductible has been met:
   - The Plan begins paying the expenses for the entire family, even the family members that haven't paid anything at all toward their individual deductibles

**In-network*

How does the Base HSA Medical Plan's out-of-pocket maximum work for family coverage?

The Plan's family out-of-pocket maximum works in much the same way as the family deductible does. The Plan will keep track of the individual (employee only) out-of-pocket maximum ($6,350) and the family out-of-pocket maximum ($9,525 or $12,700, depending on your coverage tier level). When a family member has a health care expense, the money they pay toward their individual out-of-pocket maximum is also credited toward the family out-of-pocket maximum.

There are two ways the Plan will begin paying 100% of the covered health care expenses of any particular family member:

1. The family member has had enough personal health care expenses to meet their individual out-of-pocket maximum:
   - The Plan pays for this person's expenses at 100%, but NOT 100% of the expenses of other family members who have not met their individual out-of-pocket maximums
2. Several different family members have each paid enough individual out-of-pocket expenses, that, when added together, the family out-of-pocket maximum has been met:
   - The Plan begins paying 100% of the expenses for the entire family, even the family members that haven't paid anything at all toward their individual out-of-pocket maximums

PRIME HSA MEDICAL PLAN

Deductibles and Out-of-Pocket Maximums

Coverage Type	Deductibles*	Out-of-Pocket Maximums*
Employee Only	$1,750	$4,000
Employee + Spouse/DP	$3,000	$6,850
Employee + Child(ren)	$3,000	$6,850
Family	$4,500	$6,850

**In-network*

How do the Prime HSA Medical Plan's deductible and out-of-pocket maximum work for employee only/ individual coverage?

The employee only (individual) deductible for the Prime HSA Medical Plan is $1,750. This means:

- You will need to have $1,750 in out-of-pocket health care expenses before the Plan will begin to pay for covered expenses (except for preventive care)
- Once you have paid $4,500 in out-of-pocket expenses, the Plan will pay 100% of your covered expenses

How do the Prime HSA Medical Plan's deductible and out-of-pocket maximum work for family coverage?

The Prime HSA Medical Plan doesn't begin paying for the covered health care expenses of anyone in the family until the entire family deductible of $3,000 or $4,500 (depending on your coverage tier level) is met. There are two ways the family deductible can be met:

1. As each member of the family uses and pays for health care services, the amount they pay for those services is credited toward the family deductible:
   - After several family members have paid deductible expenses, the combined total of those expenses reaches the family deductible
   - The Plan then begins to pay the covered health care expenses of the entire family
2. One member of the family has high health care expenses. The amount they pay for those expenses is large enough to meet the family deductible:
   - The Plan then begins to pay the covered health care expenses of the entire family, even if only one family member has paid anything toward the family deductible

In the same way as the family deductible, the family's out-of-pocket maximum ($4,000 or $6,850, depending on your coverage tier level) can be reached by several family members or just one member of the family before the Plan starts paying for covered health care expenses at 100%.

HOW DOES THE "HSA PART" OF THE PLAN OPTIONS WORK?

One of the best parts of enrolling in an HSA Plan option is the opportunity to contribute to a tax-free savings account whose funds are earmarked exclusively for medical expenses (including deductibles and coinsurance).

You put pre-tax dollars into an account that grows your money tax-free. Then you spend that money on qualified health care costs without paying tax on it. Think of it as a triple tax advantage that puts you in the driver's seat for your health care costs.

In addition to the great tax advantages, other features and benefits of an HSA include:

- **Control.** You own and control the money in your HSA. Use it to pay for covered health care services until you meet your annual deductible. You can also use it to pay coinsurance once you meet your deductible or for qualified medical, dental and vision expenses that are not covered by the Medical Plan
- **Roll over unused funds.** HSA money can be rolled over from year to year, earning interest, and your account is portable
- **Flexibility.** You can contribute funds (post-tax) directly into your HSA any time

When you enroll in an HSA Plan option for the first time, you will receive a welcome kit that includes information to help you use your account, as well as a debit card linked to your HSA from PayFlex to make paying for your qualified health care costs with your HSA funds easy.

Contribution limits*

The yearly limits for HSA contributions are set by the Internal Revenue Service (IRS). For 2016, they are:

- $3,350 for individual coverage
- $6,750 for all other coverage tiers
- An additional $1,000 if you are age 55 or older in 2016

What else should I know/care about?

- **Can I still enroll in an FSA?** If you are enrolled in a Medical Plan option, you may only enroll in the Limited Purpose FSA and contribute from $100 to $1,000.
  - **Q.** Why would I want to do that?
  - **A.** Before your deductible is met you can use your Limited Purpose FSA to reimburse eligible dental and vision expenses. After your deductible is met, you can use your Limited Purpose FSA for ANY qualified medical expense.
- **Make the most of your HSA.** Register your account at www.payflexdirect.com and access tools and information to help you decide on a contribution amount, see what you'll pay for certain types of care and organize your medical expenses. Don't forget about the PayFlex mobile app that makes it easy to manage your account – it's on the PayFlex website too.
- **Questions?** Need more information? Check out the HSA Information Guide on the HR In Touch Enrollment Portal or contact PayFlex, your HSA administrator, at **888-678-8242** or www.payflexdirect.com

**If you are age 65 or older (or will turn age 65 in 2016) and are enrolled in either Medicare Part A or B, or both, contributions cannot be made to an HSA account*

TIME TO DECIDE

We're here to help

This guide and other resources were developed to help you make the best Medical Plan option choice for you and your family. But we need you to pitch in and do the important work of reading, reviewing and asking questions. Fact: the average employee spends more time choosing which TV to buy than selecting their benefits.

What do I need to do?

- **Read this guide to understand your Plan options and how they work for you.** Review all the other Open Enrollment information posted on the HR In Touch Enrollment Portal
- **Look at your Explanations of Benefits (EOBs) to see how much you used your benefits.** Any changes in the past year that might impact the coverage your family needs?
- **Decide.** Does it make more sense for you to pay lower monthly premiums and pay more if and when you actually need care or to pay more in monthly premiums for lower out-of-pocket costs?
- **Do the math.** For example, even if you anticipate frequent health care needs, your Prime HSA Medical Plan premiums may be more than your Base HSA Medical Plan out-of-pocket costs might be, even with a higher deductible.
- **Select and enroll.** Enroll in a Medical Plan option by November 20 on the HR In Touch Enrollment Portal if you want ManpowerGroup coverage in 2016 – don't forget to add your dependents!

DENTAL PLAN *QUICK FACTS*

YOUR PLAN OPTIONS

1. MetLife Dental Plan (called Option 1 in 2015)
2. Waive dental coverage
   - You may pay for dental expenses with tax-free dollars by contributing to your HSA, Health Care FSA or Limited Purpose FSA

HEADS UP! One Dental Plan Option for 2016

The Dental Plan Option 2 is being eliminated and will not be offered as an option. Even if you are currently enrolled in a Dental Plan option, if you would like dental coverage in 2016, you must actively enroll in the Dental Plan during Open Enrollment.

Looking For A Participating Dentist?

Call MetLife at **800-942-0854** or visit **www.metlife.com/mybenefits**.

KNOW THE FACTS

How much will I pay?

- Your share of the premium
- $50 individual and $150 family deductible for non-preventive services (in-network)
- 20% of restorative services after your deductible is met
- 50% of orthodontia services for dependents up to age 26

What else should I know/care about?

- Uses the MetLife Preferred Dentist Program (PDP)
- Covers preventive care at 100%

YOUR COST

Premium information can be found on the HR In Touch Enrollment Portal.

$50 / $150

Deductible for in-network non-preventive services

100%

The MetLife Dental Plan covers the entire cost of preventive care

50%

of orthodontia services are covered for dependents up to age 26

DENTAL PLAN *QUICK FACTS (CONTINUED)*

HOW DOES THE DENTAL PLAN WORK?

If you go to an in-network dentist (PDP) who agrees to provide dental care at reduced rates, you'll save money on your out-of-pocket costs. If you use an out-of-network dentist, the Plan will pay a percentage of reasonable and customary (R&C) fees*. It pays to know what your dentist charges – if he or she charges more than the R&C fee, you pay the extra cost in addition to your deductible and coinsurance.

**Fees are considered reasonable and customary if they are consistent with the average fees charged in your area.*

Access Dental Info on the Go

Use the MetLife Dental mobile app to find an in-network provider, view a claim or see your ID card. Search *"MetLife"* at the iTunes App Store or Google Play to download the app. Then use your MyBenefits log in information to access these features.

You may also use the *"Find a Dentist"* tool on the MetLife mobile site, just visit **metlife.com** on your mobile device.

Why do regular dental visits matter?

Regular dental visits are important because they can help spot oral health problems early on when treatment is likely to be simpler and more affordable.

Visiting your dentist regularly is also important because some diseases or medical conditions have symptoms that can appear in the mouth. However, there is no one-size-fits-all dental treatment. Some people need to visit the dentist once or twice a year; others may need more visits.

WHAT DOES THE DENTAL PLAN COVER?

Benefit Description	In-Network	Out-Of-Network
Calendar year deductible	$50 single $150 family maximum	$75 single $225 family maximum
Calendar year maximum (per person)	$1,500	$1,500
Preventive/diagnostic Teeth cleaning Routine exams Emergency office visits Topical fluoride (children and adults) Sealants for children under age 19 Space maintainers for children up to age 26 X-rays	100%, no deductible	100%, no deductible
	Cleanings and exams limited to 2 per year per covered person	Cleanings and exams limited to 2 per year per covered person
Basic Restorative Endodontics Fillings General anesthetics Oral surgery Periodontics Root canals	80% of PDP fee after deductible	80% of R&C* fee after deductible
Major Restorative Bridges Crowns Dentures Inlays	50% of PDP fee after deductible	50% of R&C* fee after deductible
Orthodontia Orthodontia is covered for enrolled dependent children up to age 26	50% of PDP fee after deductible	50% of R&C* fee after deductible
	$1,500 lifetime maximum	$1,500 lifetime maximum

**A fee is considered to be reasonable and customary (R&C) if it is consistent with the average or commonly charged fee for a particular service in your geographic area. You are responsible for any out-of-network fees above R&C levels.*

VISION PLAN *QUICK FACTS*

YOUR PLAN OPTIONS

1. Vision Plan through Vision Service Plan (VSP)
2. Waive vision coverage
   - You may pay for vision expenses with tax-free dollars by contributing to your HSA, Health Care FSA or Limited Purpose FSA

HEADS UP! New Vision Plan for 2016

The Aetna Vision Plan is being eliminated and a new Vision Plan administered by Vision Service Plan (VSP) will be offered for 2016. Even if you are currently enrolled in the Vision Plan, you must still actively enroll in the Vision Plan if you want vision coverage in 2016.

KNOW THE FACTS

How much will I pay?

- Your share of the premium
- $15 copay for exam
- $15 copay for glasses plus $150 allowance towards frames
- 20% discount for non-covered items (in-network)

What else should I know/care about?

- Find a participating vision care provider by calling VSP at **800-877-7195** or visiting www.vsp.com

$15
copay for vision services and products

20%
discount on all items that are not covered under the plan

HOW DOES THE VISION PLAN WORK?

- Provides coverage with copays and coinsurance at network providers
- Offers a 20% discount on items not covered by the Plan at network providers

How Can I Find a Participating Vision Care Provider?

Call VSP at **800-877-7195** or visit **www.vsp.com**. You can register beginning January 1, 2016 using your Social Security number.

The Plan does not cover non-prescription items, cosmetic services, or medical or surgical treatment for eye disease that requires the services of a physician (contact VSP to verify whether a service or material is covered under the Plan). A detailed listing of covered benefits can be found at www.vsp.com.

Benefit Description	In-Network	Out-Of-Network
Exam	$15 copay	Up to $45
Prescription Glasses	$15 copay	See frame and lenses
Lenses		
Single vision	Included in Prescription Glasses	Up to $30
Lined Bifocal	Included in Prescription Glasses	Up to $50
Lined Trifocal	Included in Prescription Glasses	Up to $65
Frames	Included in Prescription Glasses up to a $150 allowance for wide selection of frames;	Up to $70
	$170 allowance for featured frame brands;	
	20% savings on amount over allowance for a wide selection of frames	
Contact lenses (in lieu of glasses)	$150 allowance for contacts; copay does not apply;	Up to $105
Frequency limits		
Exams	Every calendar year	Every calendar year
Lenses	Every calendar year	Every calendar year
Frames	Every other calendar year	Every other calendar year
Contact lenses	Every calendar year	Every calendar year

COMPSYCH GUIDANCERESOURCES EMPLOYEE ASSISTANCE PROGRAM (EAP) *QUICK FACTS*

YOUR PROGRAM OPTIONS

1. Confidential counseling
2. Financial information and resources
3. Legal support and resources
4. Work-life solutions

KNOW THE FACTS

How much will I pay?

- No cost to you
- Includes three free face-to-face counseling sessions; charges (if any) from referrals for additional resources are your responsibility (may be covered under Medical Plan)

What else should I know/care about?

- Only Consultants who enroll in the Medical Plan are eligible for the EAP
- Assistance from licensed professionals to assess needs/make referrals
- Call **844-813-0497** (TDD: **800-697-0353**) or log in to www.guidanceresources.com ID: MPG for assistance

$0

your costs to participate in the EAP

3

free face-to-face counseling sessions

HOW DOES THE GUIDANCERESOURCES EAP WORK?

Life has its challenges – personal issues, planning for big events or simply managing daily life can affect your job, work, health, family and your general well-being. What can the ComPsych GuidanceResources program offer you? Support, resources and information for personal and work-life issues in the following areas:

Confidential counseling

Professional counselors help you address stress and personal issues (e.g., relationships, grief and loss, job pressures, parenting, substance abuse) by quickly referring you to in-person counseling and resources.

Financial information and resources

Speak by phone with CPAs or CFPs about a wide range of financial issues (e.g., debt management, retirement and estate planning, saving for college, tax questions).

Legal support and resources

Speak by phone with attorneys about legal issues (e.g., divorce and family law, bankruptcy, landlord/tenant, real estate, civil/criminal actions, contracts). Get referred to qualified area attorneys for a free 30-minute consultation with a 25% reduction in customary legal fees.

Work-life solutions

Access specialists for referrals and resources for work-life situations (e.g., child and elder care, relocation, major purchases, college planning, home repair, pet care).

Access GuidanceResources Online

GuidanceResources Online is your one stop for expert information in areas such as relationships, work, school, children, wellness, legal, financial and more. By going online at **guidanceresources.com** and entering the **Web ID: MPG**, you can access:

- Timely articles, tutorials, videos and self-assessments
- Personal responses to your questions
- Child and elder care, attorney and financial planner searches

SAVE, EARN, PROTECT

FLEXIBLE SPENDING ACCOUNTS *QUICK FACTS*

YOUR ACCOUNT OPTIONS

1 Health Care FSA (if you are waiving Medical Plan coverage)

- Reimburses medical, dental, vision and hearing expenses

2 Limited Purpose FSA (if you are enrolled in the Medical Plan)

- Reimburses dental, vision and hearing expenses only before deductible is met; medical expenses after deductible is met

3 Dependent Care FSA

- Reimburses child/adult day care expenses

KNOW THE FACTS

How much will I pay?

- Health Care and Limited Purpose FSAs – annual contributions: minimum - $100; maximum - $1,000
- Dependent Care FSA – annual contributions: minimum - $100; maximum - $5,000

What else should I know/care about?

- Administered by PayFlex
- Pays for eligible out-of-pocket expenses with before-tax dollars you contribute to your account
- Health Care and Limited Purpose FSAs allow a carry over of $500 in excess funds into the next year, remainder is forfeited
- Any money left in your Dependent Care FSA at the end of the year is forfeited
- Claims for 2016 expenses can be filed until March 31, 2017
- You may not transfer money between FSAs or any other account

$1,000

Maximum Health Care and Limited Purpose FSA contribution

$5,000

Maximum Dependent Care FSA contribution

$500

Allowed to carry over from Health Care and Limited Purpose FSAs into the next year

HOW DO FSAs WORK?

We know what you're saying, "Another acronym benefit with some sort of tax advantage to help pay for out-of-pocket expenses?" What's the difference between an FSA and an HSA? Here's what you need to know.

Both HSAs and FSAs allow you to set aside pre-tax money for health care or dependent care costs called "qualified expenses," including deductibles, copayments and coinsurance. You receive a debit card for your account and can use it to pay for qualifying expenses throughout the year or you can submit a claim form to be reimbursed for expenses you paid out-of-pocket*. Both types of accounts have tax benefits too, although those benefits aren't the same.

**Remember to save your receipts for all your eligible expenses, even when you use your PayFlex card – save your EOBs too – you'll need to submit an EOB or receipt along with your FSA claim*

Should I Consider an FSA?

Do you:

- Anticipate paying copays, coinsurance or deductibles?
- Have other medical expenses that the Medical Plan doesn't pay for?
- Have vision or dental expenses, but are waiving dental or vision plan coverage?
- Pay for child care and/or adult day care expenses?

By anticipating your family's health care and dependent care costs for the year, you can actually **reduce your taxes and increase your spendable income.**

FSAs give you a **tax-effective way to be reimbursed for health care and dependent expenses you are already paying for** by taking advantage of Section 125 of the Internal Revenue Code.

How Your Savings Add Up	Using the FSA	Not Using the FSA
ANNUAL PAY	$50,000	$50,000
Before-Tax Contributions to FSA		
Limited Purpose FSA	($600)	
Dependent Care FSA	($4,800)	
Federal, State and Social Security Taxes	($13,000)	($15,000)
After-Tax Cost of Eligible Expenses		
Health Care Expenses		($600)
Dependent Care Expenses		($4,800)
NET TAKE-HOME PAY	**$31,600**	**$29,600**
TAX SAVINGS	**$2,000**	

Please note: This chart is for illustrative purposes only.

FSA BASICS

	Health Care FSA (if you are waiving Medical Plan coverage)	Limited Purpose FSA (if you are enrolled in the Medical Plan)	Dependent Care FSA
MIN./MAX. ANNUAL CONTRIBUTION*	$100/$1,000	$100/$1,000	$100/$5,000
ELIGIBLE EXPENSES**	Qualified medical, dental, vision, hearing expenses	Dental, vision, hearing expenses only before Medical Plan deductible is met; medical expenses after deductible is met	Child day care/preschool, summer day camp, before and after school day care, babysitting during working hours, adult day care for elderly or disabled dependents who live with you
NON-ELIGIBLE EXPENSES	Cosmetic surgery, expenses reimbursed under any health plan, dependent care expenses	Medical expenses before Medical Plan deductible is met; cosmetic surgery, expenses reimbursed under any health plan, dependent care expenses	Babysitting during non-working hours, overnight summer or day camp, educational expenses, transportation, health care, after-school enrichment
PAYMENT/ REIMBURSEMENT	Debit card/submit an online request at PayFlexDirect.com or fill out claim form with documentation	Debit card/submit an online request at PayFlexDirect.com or fill out claim form with documentation	Online request at PayFlexDirect.com or fill out claim form with documentation
SPECIAL NOTES	Only non-HSA paticipants are eligible; $500 carryover of excess FSA funds into the next year without affecting contribution limits	Only HSA participants are eligible; $500 carryover of excess FSA funds into the next year without affecting contribution limits	Must report name, address and Social Security or tax identification number of each care provider when requesting reimbursement; (see more information on the Dependent Care FSA and your taxes)

**Although it is to your advantage to make before-tax contributions to an FSA to pay for out-of-pocket health and dependent care expenses, you should be aware that before tax contributions reduce the amount of earnings used to determine your Social Security benefits. Because your ultimate Social Security benefit is based on your earnings, this salary reduction could cause a slight reduction in the benefit. However, any reduction in your future Social Security benefits probably would be offset by the current tax savings you realize by participating in the FSAs.*

***Complete list available in IRS Publication 502 or call 800-TAX-FORM*

IMPORTANT DIFFERENCES BETWEEN FSAs AND HSAs

	HSA	FSA
CHANGING CONTRIBUTION AMOUNT	Contribution amounts can be adjusted at any time and you can make contributions in addition to payroll deductions	Contribution amounts can only be adjusted at Open Enrollment or with a Qualifying Life Event; additional contributions outside of payroll deductions are not permitted
ROLLOVER	Unused balance rolls over into the next year indefinitely	With the exception of a $500 carryover for Health Care and Limited Purpose FSAs, unused balances are forfeited at the end of the year*
MOBILITY	Your HSA can follow you if you change employment	You'll lose your FSA if you leave ManpowerGroup (claims can be submitted for any expenses incurred prior to leaving ManpowerGroup)
TAX ADVANTAGES	Contributions are tax deductible and can be taken out of your pay pre-tax; growth and distributions are tax-free	Contributions are pre-tax and distributions are untaxed
INVESTMENT OPPORTUNITY	If you have $1,000 in your HSA, you are eligible to open an investment account	None

You can choose both

You can elect to set up both an HSA and a Limited Purpose FSA (you may have both an HSA and a Dependent Care FSA as well). The Limited Purpose FSA works like a regular FSA but can be used only for vision care, dental and hearing expenses before you meet your deductible.

If you expect to have high medical costs throughout the year, or want to maximize contributions to your HSA while minimizing your withdrawals, using the Limited Purpose FSA for expected vision and dental expenses could be a smart choice.

** Please note, you have until March 31, 2017, to file claims for any eligible Health Care or Limited Purpose FSA expenses incurred through December 31, 2016.*

Stay Connected to Your FSA

Visit PayFlex Direct at **www.payflexdirect.com** and click on *Employee Account Login* to access resources, a savings calculator, FAQs and more. Download the PayFlex mobile app to:

- Manage your account and submit claims
- View your account balance, payments and deposits
- Receive account alerts and submit documentation
- View a list of common eligible expense items.

Other information you need to know about your Dependent Care FSA

Can I file for a dependent care tax credit?

- You may file for a federal tax credit on your annual tax return or be reimbursed with before-tax dollars – you CANNOT do both for the same expense (you can file for a tax credit on any expense you incur over the FSA maximum contribution limit)

How are my contribution limits affected if I'm married?

- Your total contribution cannot be more than your earned income or your spouse's income, whichever is lower

Married & filing separate tax returns?	Married & filing jointly?
Maximum contribution: $2,500	If your spouse also contributes to a Dependent Care FSA – maximum contribution: $5,000 combined

LIFE INSURANCE *QUICK FACTS*

YOUR INSURANCE OPTIONS

1 Supplemental Life

What Is Evidence of Insurability?

Evidence of Insurability (EOI) is also known as proof of good health. EOI is the documentation of your or your spouse's or domestic partner's good health in order to be approved for coverage. Children are not subject to EOI.

KNOW THE FACTS

How much will I pay?

- You pay the full cost of supplemental life insurance for yourself and your dependents
- Premium information can be found in the rate chart on the HR In Touch Enrollment Portal

What else should I know/care about?

- Life insurance coverage provided by Voya Financial
- You may buy coverage in $10,000 increments up to a maximum of $500,000 ($10,000 minimum).
  - No Evidence of Insurability (EOI) required if you are enrolling in supplemental life for the first time up to $10,000 or increasing coverage by $10,000 (not to exceed $300,000)
- You may buy coverage in $10,000 increments for your spouse or domestic partner up to a maximum of $250,000 (minimum $10,000);
  - EOI is not required if increasing current coverage by $10,000
  - EOI is required if you are enrolling your spouse or domestic partner for the first time, or if you are increasing coverage in excess of $10,000 (not to exceed $70,000)
- You may buy $10,000 of coverage for your child(ren); no EOI is required

$10,000

Minimum amount of life insurance coverage you may purchase for yourself, your spouse/domestic partner or child(ren)

$500,000

Maximum amount of life insurance coverage you may purchase for yourself

DISABILITY PLAN *QUICK FACTS*

YOUR PLAN OPTIONS

1. Short-Term Disability (STD) Plan*
2. Long-Term Disability (LTD) Plan*
3. Waive disability coverage

Please Note

Benefits are offset by any amounts you receive in state disability benefits, salary continuation, no-fault automobile insurance benefits, Workers' Compensation or other disability income such as Social Security.

Evidence of Insurability (EOI)

- STD – all new elections ad increases in coverage are subject to EOI
- LTD – all new elections are subject to EOI

KNOW THE FACTS

How much will I pay?

- You are responsible for the full cost of the STD and LTD Plan. Premium information can be found in the rate chart on the HR In Touch Enrollment Portal

What else should I know/care about?

- The Disability Plan is administered by MetLife
- Must work 80 hours per month to be eligible for disability coverage. Coverage is effective on the first of the month following six months from your date of hire
- Coverage is effective on the first of the month following six months from your date of hire or January 1, 2016, whichever is later
- After a two-week waiting period, STD Plan pays a weekly benefit amount up to 24 weeks*
- After the onset of disabling injury or illness, LTD benefits available for 26 weeks*
- To request STD/LTD benefits, call MetLife at **877-638-8269**

24

Number of weeks STD Plan benefits are available*

26

Number of weeks LTD benefits are available*

This information describes some of the features of the benefits plan. STD benefits are not available in California or New Jersey where a higher level of state disability benefits is available however, residents of California or New Jersey can enroll for coverage at the state level through their respective state's website. Please refer to the certificate booklet for a full explanation of the plan's benefits, exclusions, limitations and reductions. Should there be any discrepancy between the certificate booklet and this outline, the certificate booklet will prevail.

**Subject to approval*

HOW DOES SHORT-TERM DISABILITY WORK?

STD replaces a portion of your normal earnings for a limited period if you can't work because you are ill or injured:

- You choose the weekly benefit that provides the income replacement you need
- Your weekly amount coverage choices are dependent on your annual salary at the time of your enrollment in the plan
- Weekly benefits are available in the amounts of $300, $500, $750, $1,000, $1,250 or $1,500

HOW DOES LONG-TERM DISABILITY WORK?

LTD replaces a percentage of your normal earnings for an extended period if you continue to be unable to work because you are ill or injured:

- Equal to 60 percent of your average earnings, up to $7,500 per month, up to the maximum period of payment determined by your age or following 24 months of benefits for a limited benefit condition (detailed information can be found in the Summary Plan Description)
- Payments may be reduced by any other income

Pre-existing Conditions: What You Need To Know

If you have a disability that occurs within three months of your effective date, it may be subject to a pre-existing condition clause.

Your Age on Date Disability Begins	Your Maximum Period of Benefits
Under age 61	End of the month after 65 is attained
Age 61	48 months
Age 62	42 months
Age 63	36 months
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69	12 months

401(K) PLAN *QUICK FACTS*

YOUR PLAN OPTIONS

1. Enroll and contribute up to 50% of your pre-tax earnings
2. Waive enrollment

HEADS UP! 401(k)/Nonqualified Savings Plan Changes

Changes in the investment fund lineup are coming to the ManpowerGroup's 401(k) Plan/Nonqualified Savings Plan (NQSP) in 2016 to help you meet your financial security goals.

KNOW THE FACTS

How much will I pay?

- Contribute up to $18,000 of your pre-tax earnings; contribute an additional catch-up amount* of $6,000 if you are age 50 or older in 2016 and have already contributed $18,000 (most likely the 2016 IRS maximums but may be subject to change)

What else should I know/care about?

- The 401(k) Plan is administered by Fidelity
- If you are a highly compensated employee**, you will be eligible for the ManpowerGroup Nonqualified Savings Plan (NQSP)

$18,000

Amount you can contribute – pre-tax

$6,000

Amount of additional money you can contribute if you are age 50 or older

*To contribute a catch-up amount, send an email to benefits@manpowergroup.com with the amount per pay period you want deducted

** As a highly compensated employee (defined by an earnings threshold determined by the IRS to be $120,000 in 2015), your eligibility and maximum deferral for the 401(k) may be limited. The enrollment for the ManpowerGroup Nonqualified Savings Plan will be in November 2015

HOW DOES THE 401(K) PLAN WORK?

You can invest your contributions in funds with varying degrees of risk (see below for more information about the new investment options for 2016) and change your investment choices, increase, decrease or suspend your contributions to the Plan at any time. A Summary Plan Description is available from Fidelity that provides complete Plan details, including a complete list of your investment choices.

WHAT'S NEW FOR 2016?

Investment Option Changes

Effective January 1, 2016, we are pleased to announce a restructuring of the investment options for the 401(k) Plan/NQSP to help you select an investment strategy that is right for you. This restructuring will involve the elimination of some current investment options and the introduction of new investment funds.

The new investment fund lineup will offer you the opportunity to invest across three categories of options so that you can easily select a mix of alternatives that best suit how involved you want to be in your investment decisions, as well as your goals, retirement timetable and risk tolerance.

- **Target Date Funds.** A professionally managed mix of funds based on your target retirement date that make investing a much easier process
- **Passively Managed Index Funds.** Choose individual funds with an investment strategy designed to match a benchmark market index
- **Diversified Actively Managed Funds.** Choose individual funds that employ professional investment managers to select securities as part of a specific investment strategy

How Do I Enroll or Make Changes?

You may enroll in the 401(k) or make changes any time throughout the year at **www.401k.com**.

Did You Know?

ManpowerGroup's 401(k) Plan offers you three great benefits:

1. It allows you to reduce your taxable income since your contributions come out of your pay before taxes are withheld
2. The money you save through tax-deferred growth lets your money compound more quickly than it would if it were taxed yearly
3. It gives you the ability to accumulate savings and earnings without having to remember to make deposits ("pay yourself first")

EMPLOYEE STOCK PURCHASE PLAN (ESPP) *QUICK FACTS*

YOUR PLAN OPTIONS

1. Purchase ManpowerGroup stock
2. Waive enrollment

A Rare Opportunity

According to *U.S. News & World Report*, participating in an ESPP is one of five ways to increase your net worth with employee benefits. They report, "Few Americans have access to an Employee Stock Purchase Plan (ESPP), but if it is available, it is a great benefit that can boost your income."

KNOW THE FACTS

How much will I pay?

- Purchase ManpowerGroup stock at a 5% discount off the purchase price
- Designate a contribution in $5 increments ($20 minimum) taken as an after-tax payroll deductions

What else should I know/care about?

- Administered by Morgan Stanley
- You are eligible to enroll in 2016 if you are an active employee on December 31, 2015
- You MUST enroll in the Plan each year to participate during Open Enrollment or at any time during the year
- You may make one change to the amount of your contribution per calendar quarter
- IRS regulations do not permit refunds to be processed, funds will be used to buy stocks

5%
discount on ManpowerGroup stock

$20
minimum contribution

HOW DOES THE ESPP WORK?

Your Plan contributions are placed in a non-interest bearing account until the stock is purchased on a quarterly basis. Stock is purchased during the month following each calendar quarter. The actual purchase price is the stock price on the last trading day of each calendar quarter.

Once stocks have been purchased the account is yours. ManpowerGroup does not have access to view your information. If you have any questions about your account or the sale of shares, contact Morgan Stanley at **888-609-3534**.

PARKING/TRANSIT BENEFIT *QUICK FACTS*

YOUR PLAN OPTIONS

1. Set aside pre-tax money for work-related commuter and parking expenses
2. Waive enrollment

KNOW THE FACTS

How much will I pay?

- Contribute a pre-tax maximum for mass transit of $130 per month (2015 maximum, 2016 maximum to be announced)
- Contribute a pre-tax maximum for parking of $250 per month (2015 maximum, 2016 maximum to be announced)

What else should I know/care about?

- Administered by PayFlex
- You must enroll by December 10, 2015 through PayFlex to participate in 2016
- Parking/Transit enrollment or changes need to be made by the 10th of the month to take effect for the next month
- Enroll directly at www.payflexdirect.com
- Consultants who have a recurring election set up at Payflex will not need to re-enroll

$130

maximum pre-tax money you can contribute per month towards mass transit expenses

$250

maximum pre-tax money you can contribute per month towards parking expenses

HOW DOES THE PARKING/TRANSIT BENEFIT WORK?

Pay for transportation to and from work with pre-tax dollars through payroll contributions. Eligible expenses include transportation by train, bus, subway, ferry, etc. Make it easy and order a transit pass or add funds to a fare card online. When you order a pass online, the transit authority will mail it directly to your home.

There are three options to pay your parking provider:

1. **Monthly Direct Pay program.** Pay your parking provider online
2. **Commuter Checks.** Order vouchers through PayFlex (daily, weekly or monthly) made payable to your parking provider that are mailed to your home
3. **Parking reimbursement option.** Pay for your parking with a credit card, check or cash and get reimbursed by submitting a claim to PayFlex

Questions? Visit PayFlexDirect.com or call **888-678-8242**. Customer service representatives are available Monday - Friday from 7 a.m. - 7 p.m. CT and Saturday from 9 a.m. - 2 p.m. CT.

Schedule for convenience

You can save some time and schedule your transit and parking purchases to take place automatically each month – during the ordering process or after you place your order.

- Please note, to use this option for parking, you must have an account number with the parking provider.

BENEFITHUB DISCOUNTS *QUICK FACTS*

KNOW THE FACTS

ManpowerGroup gives you online access to an exclusive discount marketplace that offers you discounts from hundreds of national and local retailers on items from clothing to vacations, event tickets and computers. BenefitHub negotiates the best deals and regularly updates the offers from retailers such as:

- Dell
- Barnes & Noble
- Walt Disney World
- 1-800-Flowers
- Hotels.com
- And many more

HOW DO I ACCESS BENEFITHUB?

Go to https://manpower.benefithub.com:

- Click on: *Create a new account*
- Enter: Referral Code: 56YEM5
- Enter: Your email address
- Click on: "Get an invite"

If you already have a BenefitHub Account:

Go to https://manpower.benefithub.com:

- Enter: Your email address and password
- Click: *login*
- Shop and save

READY TO ENROLL?

HOW TO ENROLL

Except for Life Insurance and Disability coverage, you MUST elect and enroll in all your ManpowerGroup benefits during Open Enrollment November 9-20, 2015 if you want coverage in 2016!

It's EASY to enroll. The HR In Touch Enrollment Portal lets you enroll in most of your benefits from one place online, anytime. The site also lets you track your plan costs and offers information and resources to help you make your selections.

1

STEP 1 – LOG IN

- Log in to www.manpowergroup.hrintouch.com (Google Chrome is the recommended browser) to access the HR In Touch Enrollment Portal
- This is a direct link that you can access from home

Passwords Reset

All Consultants' passwords were reset. Please use your Social Security number (without dashes) to log into *Employee Self Service* on the HR In Touch Enrollment Portal.

2

STEP 2 – READ & REVIEW

- Read and review all the information in this guide regarding your 2016 benefits
- Review rate chart and other benefit information posted on the HR In Touch Enrollment Portal

3

STEP 3 – MAKING BENEFIT SELECTIONS

- Select the *Open Enrollment* button
- Select the *Get Started* button to begin
- Navigate from page to page by selecting the *Next* and *Previous* buttons
- When you have entered in all of your information and select *Complete Enrollment* button at the bottom
- You will then see the *Congratulations!* screen with a confirmation number
- Print or write down your confirmation number for your records

Saving Your Information

Need to exit the system and return to your benefit selections later?

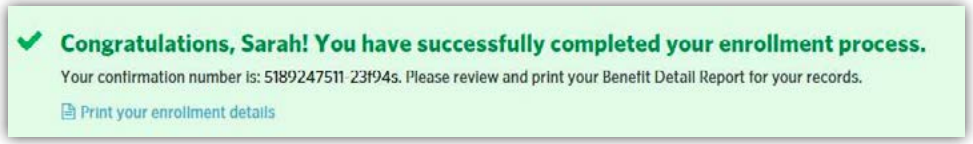
Save your information on each benefit *Summary* page and when you return to the system, you can pick up where you left off, or you can start from the first screen to review the choices you already made.

Questions?

Please contact Experis Care at **benefits@experis.com** or **800-326-6797.**

Please note:

Your enrollment is not complete until a selection is made for every section. Once completed, you will see a *Congratulations!* screen with a confirmation number to indicate you have successfully completed enrollment.



COORDINATION OF BENEFITS

If you and your spouse or domestic partner are covered under the Medical, Dental or Vision Plan and another group plan as well, the two plans will coordinate benefits. When this happens, special rules apply.

Under coordination of benefits rules, the combined benefit from both of your plans will not exceed the benefit you would have received from the ManpowerGroup Plan alone. The other plan will be the primary payer, meaning that plan pays first, if any of the following conditions apply:

- The other plan does not have a coordination of benefits rule.
- The other plan covers the individual as an eligible employee or retiree (while the ManpowerGroup Plan covers the individual as a dependent).
- The other plan has covered the individual longer than the ManpowerGroup Plan (if the other conditions listed above don't apply).

If the other plan is primary, the ManpowerGroup Plan will pay benefits only up to the amount you would have received if it were the only plan.

Other rules determine which plan pays first if your children are covered under both the ManpowerGroup Plan and a spouse's or domestic partner's plan.

COBRA CONTINUATION COVERAGE

COBRA

Once your assignment ends, your benefits will terminate at the end of the pay period. If you are enrolled in a medical, dental or vision plan and lose your coverage for any reason (except the discontinuance of coverage for the entire group), you are offered the option to continue coverage through COBRA, federal legislation that allows employees who lose coverage to continue that coverage by assuming the premiums for a period of time. If you elect COBRA and pay the premium, your coverage will continue from the day you lost coverage. For more information, please see Continuation of coverage rights under COBRA.

Continuation of Coverage Rights Under COBRA

This notice contains important information about your right to COBRA continuation coverage, which is the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the Plan's Summary Plan Description or contact the Plan Administrator.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

- You do not work at least one hour in the month, or
- Your employment ends for any reason.

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

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

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

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

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to ManpowerGroup and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within 31 days of any of these events.

COBRA Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs.

You must send this notice to:
PayFlex Systems USA, Inc.
Benefits Billing Department
P.O. Box 2239
Omaha, NE 68103-2239

How Is COBRA Coverage Provided?

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of the Medicare entitlement.

For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of the qualifying event (36 months minus eight months).

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. The employer can charge up to 150 percent of the applicable premium during the 11-month extension. The disabled individual must notify the employer within 31 days of any final determination that he or she is no longer disabled. If the coverage is extended to a total of 29 months, extended coverage will cease upon a final determination that the Qualified Beneficiary is no longer disabled.

Notice of the above event(s) should be sent to:

PayFlex Systems USA, Inc.
Benefits Billing Department
P.O. Box 2239
Omaha, NE 68103-2239

888-678-7835
Member ID is participant Social Security number

Second Qualifying Event Extension for 18-Month Period of Continuation Coverage

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

Are There Other Coverage Options Besides COBRA Continuation Coverage?

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

If You Have Questions

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa.

You can review your plan information on the HR In Touch Enrollment Portal.