MERCER MARKETPLACE℠
EMPOWERING BENEFITS 365

USIC

Benefits for *your* life.

Your USIC 2017 Benefits Decision Guide

OPEN ENROLLMENT:
OCTOBER 21 – NOVEMBER 4, 2016

BENEFITS EFFECTIVE:
JANUARY 1 – DECEMBER 31, 2017

Your Enrollment Checklist

- ☐ **Read** this guide for a benefits overview and helpful tips.
- ☐ **Visit** my.usicinc.com to learn more about your personal options.
- ☐ **Use** the tools and resources on the website to help you make your choices.
- ☐ **Select** your benefits for 2017. Current benefit choices **WILL NOT** rollover into 2017.

Welcome to your 2017 benefits!

USIC is pleased to offer a wide selection of benefits for 2017 that offer you flexibility and choice, an easy online shopping experience and the ability to take charge of your benefits spending.

Here's how it works:

- **Visit** my.usicinc.com to access Mercer Marketplace 365. The website features built-in decision support to guide you through the benefits selection process – one step at a time.
- **Review** the benefits available to you, which are summarized in this guide and on the website.
- **Choose** the plans that best meet your needs and fit your budget. Be sure to enroll before November 4!

Questions?

Mercer Marketplace 365 benefits counselors are ready to help you understand your options and make the right choices for your needs and budget. Beginning October 21, simply call the toll-free number listed below or visit my.usicinc.com and start an online chat for personal assistance.

1-855-540-0715
Monday through Friday, 7 am to 10 pm Eastern Time
Saturday, 10 am to 2 pm Eastern Time

What happens if I don't enroll before November 4?

You will not have benefits for 2017. Changes after open enrollment ends will not be permitted unless there is a qualifying life event.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Creditable Prescription Drug Coverage and Medicare Notice in the Legal Notices at the back of this booklet for more details.

What's Inside

Visit Mercer Marketplace 365 to enroll in your benefits beginning October 21!
my.usicinc.com

New for 2017

Below are the coverage offerings that have changed or are new for 2017. More details about the plans can be found in this guide and on the website.

MEDICAL PLANS

- **$800 Deductible Plan is no longer offered.**
- **$4,500 Deductible Plan is new this year.**

SPENDING AND SAVINGS ACCOUNTS

- **Health Care Flexible Spending Account is no longer offered.**

OTHER CHANGES

- **Mercer Marketplace 365 HUB –** The Mercer Marketplace 365 HUB will help you easily price health care services, find the best provider and have an expert physician review a diagnosis or a treatment plan. You'll also be provided with a Personal Health Advocate to help you with a wide variety of health questions.
- **Commuter Benefits**
- **Wellness –** Wellness Program is changing from Viverae to Rally Health.

COMING IN 2018

Tobacco use is the number-one source of preventable illness and death in the United States and is inconsistent with our culture of wellness. As such, we want to remind you that our wellness partner, Rally, has a tobacco cessation program to assist in your efforts to stop the use of such products. Tobacco cessation medication and products are covered under the USIC pharmacy plan and many are available at NO cost to you.

In an effort to encourage a healthier lifestyle, effective January 1, 2018, USIC will provide a premium discount for non-tobacco users. Get a head start! Look for additional information and reminders in 2017 about programs that are available to help you quit.

How to Enroll

It's easy to enroll! The Mercer Marketplace 365 website takes you through your benefits shopping one decision at a time, providing helpful education and decision support every step of the way. If you don't have access to a computer, you can enroll with a benefits counselor by calling 1-855-540-0715.

Get started at my.usicinc.com.

LOG IN

Visit my.usicinc.com and click on the Open Enrollment link on the main page. Your USIC password is used for access. If you need assistance with your USIC password, please contact the USIC Helpdesk at (317) 575-7891 or helpdesk@usicllc.com.

START SHOPPING

Once you've logged in, click on the "Get started" button and follow these simple enrollment steps:

1. Profile

- Review your personal information.
- Enter information for any dependents you wish to cover, if needed. This includes dependent Social Security Numbers and dates of birth.

2. Shop for Benefits

- Answer questions to help identify the best coverage for your needs.
- Compare plan features and costs.
- Use the educational resources to learn more.
- Select the benefits you want to enroll in. Make sure you hit "Save" after each benefit election.

3. Confirm & Finish

- Review the summary of your enrollment selections. You can make changes up until your enrollment period ends on November 4.
- Please save or print a copy of your Employee Detail Report which summarizes all of your choices. The confirmation number serves as proof of enrollment.

CLICK TO CHAT

If you run into questions while enrolling, a “Chat Now” button is located in the bottom right corner of each page on the Mercer Marketplace 365 website. By clicking this, you will be able to have a secure, live chat with a benefits counselor during the hours the call center is open. No phone call required!

CHANGING YOUR BENEFIT SELECTIONS

You can change any of your benefit selections before the Open Enrollment deadline on November 4. Simply return to the Mercer Marketplace 365 website to make changes.

Shopping tip

Take advantage of helpful information and resources by visiting my.usicinc.com. As you enroll, you’ll find key information displayed for each plan, including coverage details and cost. You’ll also find a variety of tools, educational videos and reference documents to help you better understand your benefit options.

After the enrollment deadline, you may be able to make changes to some of your benefits if you have a change in personal circumstances. For example, if you get married or have a baby, you can add coverage for your spouse or new child. **To change your benefits due to a life event, you must make the change within 30 days of the event.** Visit my.usicinc.com or call one of our Mercer Marketplace 365 benefits counselors at 1-855-540-0715.

THE MERCER MARKETPLACE 365 WEBSITE: A YEAR-ROUND RESOURCE

After you enroll in your benefits, don’t wait until next year to come back! The website is a great resource throughout the year for your benefit and coverage information.

Here’s what you’ll find:

- **Cost** of the coverage you are currently enrolled in
- Information about your benefits
- Detailed **plan summaries**
- **Videos and tips** to help you get the most out of your coverage

Be sure to add my.usicinc.com to your online favorites for easy reference all year long!

Medical and Prescription Drug Coverage

Medical coverage offers valuable benefits to help you stay healthy and pay for care if you or your covered family members become sick or injured.

The medical plans available to you include a range of coverage levels and costs, giving you the flexibility to select the plan that is right for you. You'll find a summary of each of the plans in this guide. Visit the Mercer Marketplace 365 website at my.usicinc.com or call one of our Mercer Marketplace 365 benefits counselors at 1-855-540-0715 for complete details and plan costs.

It's the law!

As part of the Affordable Care Act, most Americans must have medical insurance or pay a federal tax penalty. Be sure you're covered, either through your employer-sponsored plan or through another option available to you, such as your spouse's employer benefits or a government program such as Medicare or Medicaid.

Which medical plan is right for you?

When you go online, you can answer a few questions about your medical insurance usage, payment preference and ability to afford an unexpected medical expense. Then, Mercer Marketplace 365 will show you one or more plans that may best match your situation. While the decision is yours, these matches may help you make an appropriate choice.

Before you choose your benefits, think about…

- How much health care – and what type of care – did you need this year?
- Do you expect your needs to be similar next year? Do you foresee changes?
- Do you prefer to pay less from your paycheck and more out of your pocket when you need care, or more from your paycheck and less out of your pocket when you need care?

Need more coverage?
Consider combining medical insurance with **supplemental medical insurance**, like hospital indemnity, accident and critical illness insurance. These options are intended to supplement your medical plan's coverage. In fact, based on your situation, you may be able to save money by purchasing a lower cost medical plan and adding one or more supplemental plans. The combined coverage could offer effective protection against out-of-pocket expenses at a lower plan cost.

Key Words to Know:

Copay: An amount you pay for a covered service each time you use that service. It does not apply toward the deductible.

Deductible: The amount you pay before the plan begins to pay.

Out-of-Pocket Costs: Expenses you pay yourself, such as deductibles, copays, coinsurance and non-covered services.

Out-of-Pocket Maximum: The maximum amount you pay for covered services in a year (you may need to pay additional amounts if coverage is received from an out-of-network provider).

Coinsurance: Percentage of the charge that your plan will pay, typically after you have met the deductible.

In-Network vs. Out-of-Network

For plans that offer in- and out-of-network benefits, you have the option to see any provider you choose. However, you'll save money when receiving care from an in-network provider. To access a list of in-network providers, click on the carrier's link from the Mercer Marketplace 365 medical enrollment page.

Prescription Drug Coverage Terms

Do you or a family member take medications? If so, keep in mind that your prescription drug coverage depends on the medical coverage level you choose.

You'll see in the medical charts that medications are grouped into three tiers, and the tier that your medication falls into determines your portion of the drug cost.

TIER	YOU PAY	WHAT'S COVERED
1	Lowest Cost Sharing	**Most Generic Prescription Drugs** Generic prescription drugs use the same active ingredients as brand-name prescription drugs and work the same way. Generic drugs are equivalent to a brand product in dosage form, strength, quality, and intended use.
2	Second Lowest Cost Sharing	**Preferred Brand Name Drugs** Drugs sold under a specific trade name that are favorably priced by the pharmacy plan.
3	Highest Cost Sharing	**Non-Preferred Brand Name Drugs** Drugs sold under a specific trade name that have a reasonable, more cost-effective alternative on Tier 1 or Tier 2.

REVIEW YOUR MEDICAL PLAN OPTIONS

Anthem (National PPO BlueCard PPO)
Prescription: Express Scripts

IN-NETWORK MEDICAL PLAN SUMMARY

	$1,500 DEDUCTIBLE	$2,850 DEDUCTIBLE	$4,500 DEDUCTIBLE
HSA Eligible	Yes	Yes	Yes
HSA Funding by employer	$150 employee / year $300 family / year	$150 employee / year $300 family / year	$150 employee / year $300 family / year
In-Network			
Preventive Doctor's Visit	Covered at 100% in-network		
Individual/Family Deductible	$1,500/$3,000	$2,850/$5,700	$4,500/$9,000
Individual/Family Out-of-Pocket Max	$3,000/$6,000	$5,500/$11,000	$6,550/$13,100
Plan Coinsurance	80%	70%	70%
Office Visit (Primary Care/Specialist)	80% after deductible	70% after deductible	70% after deductible
Retail Prescriptions			
Tier 1	80% after deductible	70% after deductible	70% after deductible
Tier 2	80% after deductible	70% after deductible	70% after deductible
Tier 3	80% after deductible	70% after deductible	70% after deductible
Mail Order Prescriptions			
Tier 1	80% after deductible	70% after deductible	70% after deductible
Tier 2	80% after deductible	70% after deductible	70% after deductible
Tier 3	80% after deductible	70% after deductible	70% after deductible

Helpful information about Deductibles and Out-of-Pocket Maximums

Under the $1,500 Deductible with HSA Plan, if you cover any family member(s) in addition to yourself:

- The entire Family Deductible ($3,000) must be met before benefits begin to pay out for *any* family member.
- The entire Family Out-of-Pocket Maximum ($6,000) must be met before the plan pays in full for *any* family member.

Under the $2,850 Deductible with HSA Plan, if you cover any family member(s) in addition to yourself:

- Once one family member meets the Individual Deductible ($2,850), benefits begin to be paid for that individual.
- Once one family member meets the Individual Out-of-Pocket Maximum ($5,500), the plan pays covered benefits in full for that individual.

Under the $4,500 Deductible with HSA Plan, if you cover any family member(s) in addition to yourself:

- Once one family member meets the Individual Deductible ($4,500), benefits begin to be paid for that individual.
- Once one family member meets the Individual Out-of-Pocket Maximum ($6,550), the plan pays covered benefits in full for that individual.

Learn more online

For additional plan details, including cost and any out-of-network benefits, visit my.usicinc.com.

Spending and Savings Accounts

You can save money on your health care and dependent care costs through the use of tax-advantaged accounts that allow you to use before-tax dollars to pay for eligible expenses. For additional details about the following accounts, visit my.usicinc.com.

Key Words to Know:

Dependent Care Flexible Spending Account (DCFSA): An account that allows you to set aside a portion of your income, before taxes, to pay for eligible daycare/childcare expenses.

Health Savings Account (HSA): An account funded by you and USIC that lets you set aside a portion of your income, before taxes, to pay for eligible health care expenses. This type of account is available only to participants who are enrolled in a USIC medical plan and who are not covered by any other type of medical plan.

What are eligible health care expenses?

For a complete list of eligible expenses, visit www.irs.gov and see Publication 502. Some examples include:

- Office visits
- Prescription drugs
- Hospital stays and lab work
- Speech/occupation/ physical therapy
- Dental and vision care

Reminder

Keep documentation to support your use of the money in these accounts for tax purposes.

Access your accounts anywhere

The “Your Accounts Mobile App” is available for Dependent Care Flexible Spending Accounts, Health Savings Accounts, and Commuter Benefits. Once downloaded, you will log in to the Mobile App with the spending and savings account username and password you created when you opened your reimbursement account. These login credentials may differ from your Mercer Marketplace 365 credentials.

You can use the “Your Accounts Mobile App” to view account balances, upload receipts, review plan details, see your account activity and contact customer service. Health Savings Account investment details may be viewed through this app. The Mobile App is available for download for use on your Apple Device from Apple’s App Store or Google Play for your Android device.

HEALTH SAVINGS ACCOUNT (HSA)

With any of the USIC medical plans you're eligible to contribute money to a Health Savings Account (HSA). HSAs are tax-advantaged savings accounts you can use to help pay for eligible health care expenses as you incur them, or you can build up the money in your account and use it for future expenses, even during retirement. Your HSA is always yours to keep — if you leave your employer, your HSA goes with you.

Key features

- **Company contribution just for being enrolled in the plan**. Receive a one-time contribution amount from USIC for enrolling in a HSA. Even if you aren't planning to contribute to the account, you must open an HSA each year to receive USIC's contribution.
- **Works like a bank account**. Use account funds to pay for eligible health care expenses by using your debit card when you receive care, or submit a claim for reimbursement for payments you've made (up to the available balance in your account).
- **You can save**. You decide how much to contribute to your HSA and can change that amount at any time.
- **It's tax-advantaged.** You don't pay taxes on contributions made from your paycheck, and the money will never be taxed when used for eligible health care expenses.
- **It's your money**. Unused funds can be carried over each year and invested for the future — you can earn tax-free interest on your HSA balance. Once your account reaches a certain balance, you will have other investment choices for the money. You can even take the account with you if you leave USIC, or save it to use during retirement.
- **You are not eligible to contribute to an HSA if you**:
  - Are enrolled in Medicare
  - Are covered by any health insurance (including Tricare) other than a qualified high deductible health plan
  - Can be claimed as a dependent on another person's tax return
  - Have access to reimbursement under a Health Care Flexible Spending Account (FSA) established by another employer for you, your spouse, or other family member

Contributions

To help you get your HSA started, USIC will contribute:

- Individual coverage = $150
- Family coverage = $300

For 2017, you can make pre-tax contributions from your paycheck up to the IRS maximum below:

- Individual coverage = $3,400*
- Family coverage = $6,750*
- If you're age 55 or older, you can contribute an additional $1,000 per year.

*The contribution amounts listed above include both your contributions and any contributions you receive from USIC.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (DCFSA)

	Dependent Care Flexible Spending Account
Do you have an HSA?	You are eligible to have a Dependent Care FSA whether or not you contribute to a Health Savings Account (HSA).
Eligible expenses	Expenses for child/elder care for eligible dependents that allow you and/or your spouse to work (medical, dental and vision expenses are not eligible for reimbursement with this account)
How it's funded	• You can make paycheck contributions up to $5,000 per year per married couple to use for qualified dependent care or elder care expenses. • Your election is made during the Open Enrollment period. You cannot change or elect it unless you have a qualifying life event during the year (such as having a baby or a change in dependent care expenses). • Your funds are only available to you after they have been deposited into your account each pay period.
Unused funds	You should estimate your expenses carefully before enrolling because unused funds in your account do not carry over at the end of the year and are forfeited.
How to access	You will receive a benefits debit card that you can use to pay for eligible expenses. Or, you can submit claims for reimbursement of eligible expenses. NOTE: All spending accounts can be accessed with one debit card. You may request additional debit cards for family members.

Mercer Marketplace 365 HUB

For those employees and family members who may need extra assistance, we are pleased to offer a new product, 365 HUB, for a nominal fee.

Get help finding doctors who provide the highest quality care for your needs

Quality Matters, especially when it comes to your and your family's health! You can review quality scores of doctors in your area based on your medical condition and need. You'll be more likely to get the care you need to recover faster and save money.

Find the best price for the health care services you need

The cost of health care can vary widely, even within the same area. You share in the cost of health care services, so it's important to know how much a service can cost in advance. Use the Mercer Marketplace 365 HUB to help you save money on your health care.

Get an expert second opinion for peace of mind

Take charge of your health care. Don't hesitate to get another opinion, especially if it's a concerning or serious condition. You and your covered family members have access to world-class specialists that will review your case and give you an expert opinion on your diagnosis and treatment plan. About 40% of people receive an improved diagnosis and 99% recommend this service. It's peace of mind at a time when you may need it most. Mercer Marketplace 365 HUB accepts all cases and sticks with you every step of the way.

Take advantage of all your health care benefits

Once your benefits begin, visit my.usicinc.com to access all Mercer Marketplace 365 HUB tools online or call 1-800-385-8032 to talk to a dedicated personal health advocate.

Supplemental Medical Insurance

Allstate

Supplemental medical insurance can help protect you from significant expenses not covered by your medical plan. In fact, based on your situation, you may be able to save money by adding a supplemental plan to a lower cost medical plan. Be sure to consider your anticipated medical needs for the year along with the cost of the medical plans available to you.

Supplemental medical plans are available in most, but not all states. Coverage is available for you and your dependents. Complete details about coverage and cost can be found at my.usicinc.com.

Keep in mind

Supplemental medical plans are intended to enhance your medical plan. On their own, they don't provide the minimum level of medical coverage needed to meet the Affordable Care Act requirement to have medical insurance.

ACCIDENT

You can't always avoid accidents, but you can help protect yourself from accident-related costs that can strain your budget. Accident insurance supplements your medical plan by providing cash benefits in cases of non-work related accidental injuries. You can use this money to help pay for non-covered medical expenses, such as your deductible or coinsurance, or for ongoing living expenses, such as your mortgage or rent. Benefits are paid in addition to your medical plan, and are payable regardless of any other insurance plans you may have. You will be able to elect coverage for yourself and your dependents during your enrollment period regardless of prior health history.

CRITICAL ILLNESS

When a serious illness strikes, critical illness insurance can provide financial support to help you through a difficult time. It protects against the financial impact of certain illnesses, such as a heart attack or cancer. You receive a lump-sum benefit that you can use to cover out-of-pocket expenses for your treatment that are not covered by your medical plan. You can also use the money to take care of your everyday living expenses like housekeeping services, special transportation services and day care. Benefits are paid in addition to your medical plan, and are payable regardless of any other insurance plans you may have. You will be able to elect coverage for yourself and your dependents during your enrollment period regardless of prior health history.

HOSPITAL INDEMNITY

A trip to the hospital can be stressful, and so can the bills. Even with a medical plan, you may still be responsible for deductibles, coinsurance and other out-of-pocket costs. A hospital indemnity plan provides supplemental payments that you can use to cover expenses that your medical plan doesn't cover for hospital stays, ambulance service, surgery and certain inpatient or outpatient treatment. Benefits are paid in addition to your medical plan, and are payable regardless of any other insurance plans you may have. You will be able to elect coverage for yourself and your dependents during your enrollment period regardless of prior health history.

Dental Insurance

Cigna

Your smile says a lot about your overall health. Healthy teeth and gums are an essential part of your general health and well-being. In fact, research shows there may be a connection between poor dental health and serious health conditions. Dental exams can detect some health conditions sooner rather than later. That's why it's important to have regular dental check-ups and maintain good oral hygiene.

Key Words to Know:

Annual Maximum Benefit: The maximum total amount the plan will pay during the plan year.

Deductible: The amount you pay before the plan begins to pay.

Preventive Services: Services designed to prevent or diagnose dental conditions including oral evaluations, routine cleanings, X-rays, fluoride treatments and sealants.

Basic Services: Services such as basic restorations, some oral surgery, endodontics and periodontics.

Major Services: Services such as crowns, dentures, implants and some oral surgery.

Orthodontia: Services such as straightening or moving misaligned teeth and/or jaws with braces and/or surgery.

IN-NETWORK DENTAL PLAN SUMMARY

	PREMIER WITH ORTHODONTIA	BASIC PLUS
Annual Maximum Benefit	$2,500	$1,000
IN-NETWORK		
Individual/Family Deductible (waived for preventive services)	$25/$75	$50/$150
Preventive Services	Plan pays 100%*	Plan pays 100%*
Basic Services	Plan pays 80%	Plan pays 70%
Major Services	Plan pays 50%	Plan pays 50%
Orthodontia Services	Plan pays 50%	Not covered
Orthodontia Maximum Lifetime (in-network and out-of-network)	$1,500**	Not covered

* Deductible does not apply.
** Orthodontia coverage available for eligible children to age 19.

Learn more online

For additional plan details, including cost and any out-of-network benefits, visit my.usicinc.com.

Vision Insurance

VSP

Having an annual eye exam is one of the best ways to make sure you're keeping your eyes healthy. Eye exams can help prevent and treat easily correctable vision problems which can cause permanent vision impairment. You can enroll in vision coverage to save money on eligible vision care expenses, such as eye exam, glasses and contact lenses.

Key Words to Know:

Copay: An amount you pay for a covered service each time you use that service.

Retail Allowance: Maximum allowance paid toward the cost of vision materials. You are required to pay any amounts in excess of the retail allowance.

IN-NETWORK VISION PLAN SUMMARY

	ENHANCED	STANDARD
IN-NETWORK	**COPAY**	**COPAY**
Exam	$10 (1 per 12 months)	$10 (1 per 12 months)
Lenses	$10 (1 per 12 months)	$25 (1 per 12 months)
Contact Lens Fitting	Not to exceed $60 (1 per 12 months)	Not to exceed $60 (1 per 12 months)
	RETAIL ALLOWANCE	**RETAIL ALLOWANCE**
Frames	Up to $175; 20% off any amount over allowance (1 per 12 months)	Up to $130; 20% off any amount over allowance (1 per 24 months)
Contact Lenses (in lieu of Frames & Lenses)	Up to $175 (1 per 12 months)	Up to $130 (1 per 12 months)

Learn more online

For additional details, including cost, any out-of-network benefits and possible discounts on expenses that exceed the retail allowance, visit my.usicinc.com.

Life Insurance

Liberty Mutual – TERM LIFE, ACCIDENTAL DEATH & DISMEMBERMENT

Allstate – PERMANENT LIFE

Life insurance provides important financial protection for you and your family. You can choose from different levels of life insurance coverage to meet your needs.

Employer-Paid Life and Accidental Death and Dismemberment (AD&D) – Your employer provides you with a base level of employee term life and accidental death and dismemberment (AD&D) insurance at no cost to you. This coverage provides a benefit of one times your salary, rounded to the next highest $1,000, up to the plan maximum.

Employee-Paid Term Life – To supplement the coverage provided by your employer, you can purchase additional term life insurance for yourself. This coverage is tied to your employment and typically ends if you leave your employer. However, you may be able to retain this coverage on your own with the same insurance carrier if you leave your employer. **You must purchase this coverage if you wish to purchase spouse and/or child term life.**

Important Information

Select a beneficiary
It's important to choose a beneficiary or beneficiaries to receive the policy's benefit payment in the event of the insured person's death. You should designate your beneficiary(s) on my.usicinc.com. For Spouse and Child Term Life policies, you (the employee) are automatically listed as the beneficiary.

Statement of Health
If you are enrolling in Life Insurance coverage as a late entrant (not during new hire enrollment) or increasing your current election(s), you may require an approval from the insurance company. After electing coverage, you will receive more information.

Spouse Term Life – You can purchase term life insurance for your spouse. This coverage is tied to your employment, and typically ends if you leave your employer. However, you may be able to retain this coverage for your spouse on your own with the same insurance carrier if you leave your employer.

Child Term Life – You can purchase term life insurance for your dependent children. This coverage is tied to your employment, and typically ends if you leave your employer. However, you may be able to retain this coverage for your children on your own with the same insurance carrier if you leave your employer.

Employee-Paid Accidental Death and Dismemberment (AD&D) – You can purchase additional accidental death and dismemberment (AD&D) insurance for yourself or for yourself and dependents.

Permanent Life – You also have the option to purchase permanent life insurance. With a permanent life insurance policy, you are the policy owner and can maintain the coverage, whether or not you leave your employer, for as long as you choose to continue to pay the premium. This option offers you the ability to provide lasting protection for your family. With the purchase of an employee permanent life policy, you may also purchase additional life insurance for your eligible dependents.

Short-Term Disability Insurance

Liberty Mutual

As a valued employee in your position, you are eligible for USIC Short-Term Disability (STD) benefits described on this page.

It's hard to imagine yourself disabled, especially when you're active and healthy. But a surprising number of people do find themselves hurt or sick and unable to work – even if only for a short time. That's why we provide disability plans that work together to replace a portion of your income if you're unable to work.

For someone in your position, Short-Term Disability (STD) is a voluntary benefit (100% employee-paid benefit) after 90 days of employment. STD provides a percentage of your weekly earnings beginning on the 15th day due to accident and the 15th day due to illness. Coverage will continue up to 180 days of disability. Visit my.usicinc.com for coverage and cost information.

Commuter Benefits

Commuter benefits allow you to lower your commuting costs by using before-tax dollars to pay for qualified transportation expenses, such as transit passes and parking. You decide how much to contribute, and the money will be automatically deducted from your paycheck and placed on a debit card for your use.

Legal Benefits

MetLife Hyatt Legal

The MetLife® Hyatt Legal Assistance Plan offers you economical access to attorneys for common legal services, such as will preparation, estate planning, family law and more. You, your spouse and dependents will have access to a nationwide network of 13,500 experienced attorneys — just a phone call away! If you choose, you also have the flexibility to use a non-plan attorney and get reimbursed for covered services according to a set fee schedule.

When you call, a knowledgeable client service representative can help you locate a plan attorney in your area. You'll also have convenient online access to resources that will assist with court appearances, document review and preparation, and/or real estate matters.

Identity Theft Protection

InfoArmor

Get peace of mind by protecting yourself against the damage of identity theft. Identity theft protection services from InfoArmor® monitor your identity, detect fraud and restore your identity in the event of theft. Certified privacy advocates are also available to act as dedicated case managers on your behalf to resolve any identity theft issues.

Pet Insurance

Nationwide

For pet owners, the cost of providing unexpected veterinary care if medical issues arise could add up to hundreds or even thousands of dollars. Pet insurance through Nationwide gives you peace of mind, and is a cost-effective way to protect you from the risk of these expenses and provide medical care for your pet. Mercer Marketplace 365 participants are eligible to receive at least a 5% discount on premiums.

Nationwide offers several policy options to meet a variety of needs and budgets. With this coverage, you are free to use any veterinarian worldwide.

Auto and Home Insurance

MetLife

Purchasing auto and home insurance through Mercer Marketplace 365 could provide you with savings of up to 15%. MetLife gives you access to a variety of personal insurance policies, including automobile, home*, landlord's rental dwelling, condo, mobile home, renters, recreational vehicle, boat and personal excess liability. The premium for this benefit is deducted from your paycheck.

*Home insurance is not part of MetLife Auto & Home's benefit offering in Massachusetts and Florida.

Online Discount Mall

PerkSpot

PerkSpot Online Discount Mall offers you 24/7 access to exclusive prices, discounts and offers from hundreds of local and national merchants. Choose from health clubs, movie theaters, restaurants, retailers and all major cell phone providers. Offers are updated frequently.

As a Mercer Marketplace 365 participant, you pay nothing for this service. Once you register with an email address, you can sign up to receive email alerts for discounts you may be interested in. You will be connected to exclusive discounts and savings of up to 40%.

For more information, log on to my.usicinc.com and visit the Resource Center.

Wellness Program

Rally Health

The USIC wellness program is designed to help you improve, manage and maintain your health. Rally Health, our new health engagement partner, empowers you to create lasting, positive habits you can stick to by making small simple changes — one step at a time.

Rally helps you develop healthy habits through the use of personalized missions, challenges and online games. When you register, you will get the chance to earn "coins" and win a variety of incentives. In order for your spouse to be able to log into Rally and earn coins they must be added as a dependent in Mercer Marketplace 365.

Everyone can participate but only employees and spouses covered on a USIC medical plan are eligible for HSA deposits.

Come back January 1 to register and start earning coins! Look for reminders from the HR team in 2017!

Employee Assistance Program

MyLibertyAssistant®

PRACTICAL HELP FOR LIFE'S CHALLENGES
This benefit is offered through MyLibertyAssistant®. Call 1-866-695-6327 for questions or assistance.

There are times in all of our lives when we need a little help. No matter what the issue, the EAP is available 24 hours a day, seven days a week with support, guidance and resources.

Program Features:

- Assistance for your immediate household family members
- Up to five (5) face-to-face counseling sessions
- 24-hour, 7-day a week telephone and Web access
- Referral to legal and financial consultation
- Access to information and resources for child and elder care concerns
- Wellness Coaching for: smoking cessation, stress, weight loss, exercise, parenting, and relationships
- Online services
    - Articles on a variety of work/life topics, including mental health, parenting, relationships and workplace issues
    - Child and elder care searches
    - Financial tools and calculators
    - Legal document library
    - Interactive wellness assessments & goal setting
    - Online wills

For more information visit the website at www.bensingerdupont.com/mla (password = lmeap) or talk with a counselor at 1-866-695-6327.

Contact Information

You'll find many details about the USIC benefit plans on the Mercer Marketplace 365 website. However, you can use this table if you need to contact a benefit provider directly.

BENEFIT	ADMINISTRATOR	PHONE NUMBER	WEBSITE
General Benefit Inquiries	Mercer Marketplace 365	1-855-540-0715	my.usicinc.com
Medical	Anthem	1-866-528-2635	www.anthem.com
Prescription	Express Scripts	1-844-553-9104	www.expressscripts.com/mercermarketplace
Spending and Savings Accounts	Discovery Benefits	1-877-248-0510	https://mercermarketplace.lh1ondemand.com
Mercer Marketplace 365 HUB	Mercer Marketplace 365	1-866-385-8032	my.usicinc.com
Supplemental Medical	Allstate	1-800-521-3535	www.allstatevoluntary.com/mercermarketplace
Dental	Cigna Plan ID#: 3217084	1-800-CIGNA-24	www.cigna.com/welcome/Mercer
Vision	VSP Plan ID#: 30051766	1-800-877-7195	www.vsp.com
Term Life Insurance/ Accidental Death & Dismemberment	Liberty Mutual	www.mylibertyconnection.com	
Permanent Life Insurance	Allstate	www.allstatevoluntary.com/mercermarketplace	
Disability	Liberty Mutual	www.mylibertyconnection.com	
Commuter Benefits	Mercer Marketplace 365	my.usicinc.com	
Legal	MetLife Hyatt Legal	www.legalplans.com Access Code: GET LAW	
Identity Theft	InfoArmor	http://www.myprivacyarmor.com/marketplace365	
Pet Insurance	Nationwide	www.petinsurance.com	
Auto and Home	MetLife	my.usicinc.com	
Online Discount Mall	PerkSpot	www.perkspot.com	
Wellness Program	Rally Health/Mercer Marketplace 365	my.usicinc.com	

Legal Notices

USIC reserves the right to change, amend or terminate any benefits plan at any time for any reason. Participation in a benefit plan is not a promise or guarantee of future employment. Receipt of benefits documents does not constitute eligibility.

The Benefits Decision Guide, combined with these legal notices, provides an overview of the benefits available to you and your family. In the event of a discrepancy between the information presented in the Benefits Decision Guide and official plan documents, the official plan documents will govern.

STATEMENT OF MATERIAL MODIFICATIONS

This enrollment guide constitutes a Summary of Material Modifications (SMM) or Summary of Material Reductions (SMR), as applicable, to the USIC, LLC summary plan description (SPD). It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

SUMMARY OF BENEFITS COVERAGE

A Summary of Benefits Coverage (SBC) for each of the employer-sponsored medical plans is available at my.usicinc.com. You may also request a paper copy by calling Mercer Marketplace 365.

IMPORTANT NOTICE FROM USIC ABOUT CREDITABLE PRESCRIPTION DRUG COVERAGE AND MEDICARE

The purpose of this notice is to advise you that the prescription drug coverage listed below under the USIC medical plan is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2017. This is known as “creditable coverage.”

Why this is important: if you or your covered dependent(s) are enrolled in any prescription drug coverage during 2017 listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty — as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

If you or your family members aren’t currently covered by Medicare and won’t become covered by Medicare in the next 12 months, this notice doesn’t apply to you.

Please read the notice below carefully. It has information about prescription drug coverage with USIC and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

Notice of creditable coverage

You may have heard about Medicare’s prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by one of the USIC prescription drug plans listed below, you'll be interested to know that coverage is, on average, at least as good as standard Medicare prescription drug coverage for 2017. This is called creditable coverage. Coverage under one of these plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

- Anthem $1,500 Deductible Plan
- Anthem $2,850 Deductible Plan
- Anthem $4,500 Deductible Plan

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, the employer plan will continue to pay primary or secondary, as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop USIC coverage, Medicare will be your only payer. You can re-enroll in the employer plan at annual enrollment or if you have a special enrollment event for the USIC plan.

You should know that if you waive or leave coverage with USIC and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future — such as before the next period you can enroll in Medicare prescription drug coverage, if this USIC coverage changes, or upon your request.

For more information about your options under Medicare prescription drug coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the Medicare & You handbook. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

Visit www.medicare.gov for personalized help.

Call your state Health Insurance Assistance Program (see a copy of the Medicare & You handbook for the telephone number).

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For more information about this notice or your prescription drug coverage, contact:

Human Resources
9045 N River Rd Suite 300, Indianapolis, IN 46240
1-800-575-5594 Option 6
hr@usicllc.com

HIPAA SPECIAL ENROLLMENT NOTICE

Notice of special enrollment rights for health plan coverage

If you decline enrollment in a USIC health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in a USIC health plan without waiting for the next Open Enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30-day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in a USIC medical plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for special enrollment rights, you may add the dependent to your current coverage or change to another health plan. Any other currently covered dependents may also switch to the new plan in which you enroll.

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) NOTICE

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your medical carrier at the phone number listed on the back of your ID card.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA OR "NEWBORNS' ACT") NOTICE

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your medical carrier at the phone number listed on the back of your ID card.

MICHELLE'S LAW NOTICE

Extended dependent medical coverage during student medical leaves

The USIC plan may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from school. Coverage may continue for up to a year, unless your child's eligibility would end earlier for another reason.

Extended coverage is available if a child's leave of absence from school — or change in school enrollment status (for example, switching from full-time to part-time status) — starts while the child has a serious illness or injury, is medically necessary, and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, call Mercer Marketplace at 1-855-540-0715 as soon as the need for the leave is recognized by USIC. In addition, contact your child's health plan to see if any state laws requiring extended coverage may apply to his or her benefits.

CHIP/MEDICAID NOTICE

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2016. Contact your State for more information on eligibility.

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ALASKA – Medicaid	**INDIANA – Medicaid**
Website:http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx Phone (Outside of Anchorage): 1-800-780-9972 Phone (Anchorage): 907-465-2680	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512

KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-342-6207	Website:http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/publicassistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website:http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300

NEVADA – Medicaid	SOUTH CAROLINA – Medicaid
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.scdhhs.gov Phone: 1-888-549-0820
NEW HAMPSHIRE – Medicaid	**SOUTH DAKOTA - Medicaid**
Website:http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218	Website: http://dss.sd.gov Phone: 1-888-828-0059
	TEXAS – Medicaid
	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
VERMONT– Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website:http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
VIRGINIA – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-855-242-8282 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
	WYOMING – Medicaid
	Website: https://wyequalitycare.acs-inc.com/ Phone: 1-855-294-2127

To see if any other states have added a premium assistance program since January 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

USIC HIPAA PRIVACY NOTICE

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by USIC health plans. This information, known as protected health information (PHI), includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium or as an oral communication. This notice describes the privacy practices of the USIC's self-insured health plans. The plans covered by this notice may share health information with each other to carry out treatment, payment or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

The Plan's duties with respect to health information about you

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not USIC as an employer — that's the way the HIPAA rules work. Different policies may apply to other USIC programs or to data unrelated to the Plan.

How the Plan may use or disclose your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities and health care operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.
- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing "behind the scenes" plan functions, such as risk adjustment, collection or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.
- **Health care operations** include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service and internal grievance resolution. Health care operations also include evaluating vendors; engaging in credentialing, training and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

How the Plan may share your health information with USIC

The Plan, or its health insurer or HMO, may disclose your health information without your written authorization to USIC for plan administration purposes. USIC may need your health information to administer benefits under the Plan. USIC agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Human Resources staff members are the only USIC employees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and USIC, as allowed under the HIPAA rules:

- The Plan, or its insurer or HMO, may disclose "summary health information" to USIC, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.
- The Plan, or its insurer or HMO, may disclose to USIC information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

In addition, you should know that USIC cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by USIC from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs — is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative. The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request or other lawful process (the plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the plan's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death

Research purposes	Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are armed forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those communications. If we keep psychotherapy notes in our records, we will obtain your authorization in some cases before we release those records. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use, or disclosure of your unsecured health information as required by law.

The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

Your individual rights

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right.

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid out of pocket and in full for the item or service.

Right to receive confidential communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible on site), the Plan will provide you with one of these responses:

- The access or copies you requested.
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint.
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan's cost.

Right to amend your health information that is inaccurate or incomplete

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

- Make the amendment as requested.
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint.
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment or health care operations.
- To you about your own health information.
- Incidental to other permitted or required disclosures.
- Where authorization was provided.
- To family members or friends involved in your care (where disclosure is permitted without authorization).
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances.
- As part of a “limited data set” (health information that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You’ll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the Plan upon request

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the information in this notice

The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on January 1, 2017. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan’s privacy policies described in this notice, you will be provided with a revised privacy notice.

Complaints

If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won’t be retaliated against for filing a complaint. To file a complaint, contact Human Resources at 1-800-575-5594 Option 6.

Contact

For more information on the Plan’s privacy policies or your rights under HIPAA, contact Human Resources at 1-800-575-5594 Option 6.

2017 Employee Contribution Rates

MEDICAL
(Per Pay Period)

	$1,500 w/ HSA	$2,850 w/ HSA	$4,500 w/ HSA
Employee Only	$58.94	$45.26	$32.92
Employee + Spouse	$194.50	$167.12	$142.45
Employee + Child(ren)	$152.18	$128.35	$106.99
Employee + Family	$254.75	$218.92	$186.35

DENTAL
(Per Pay Period)

	Basic Plus	Premier w/ Ortho
Employee Only	$5.73	$9.84
Employee + Spouse	$11.46	$19.67
Employee + Child(ren)	$12.61	$21.63
Employee + Family	$21.49	$36.87

VISION
(Per Pay Period)

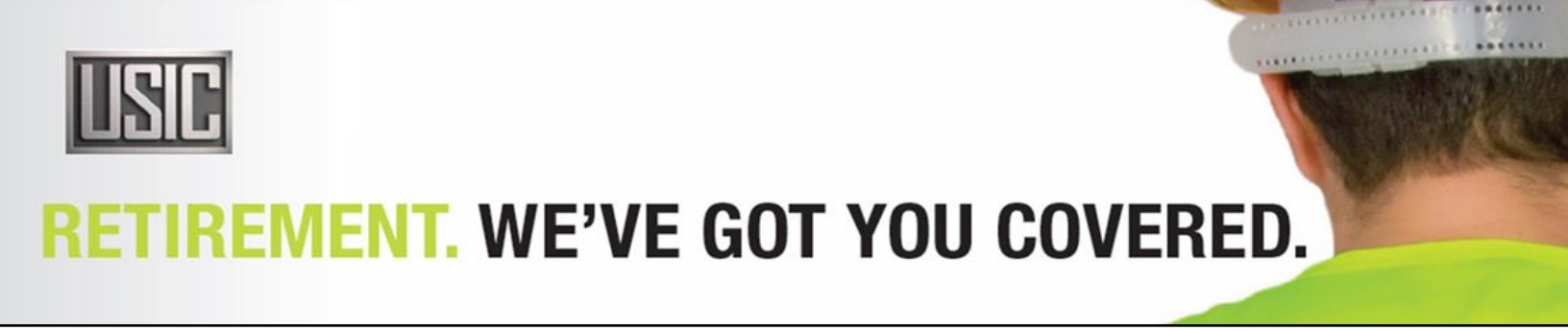
	Standard	Enhanced
Employee Only	$1.74	$3.22
Employee + Spouse	$3.13	$6.09
Employee + Child(ren)	$3.58	$6.74
Employee + Family	$5.37	$10.13

VOLUNTARY EMPLOYEE LIFE
(Monthly Rate)

	Employee (per $1,000)	Spouse (per $1,000)
<= 24	$0.102	$0.102
25 – 29	$0.077	$0.077
30 – 34	$0.090	$0.090
35 – 39	$0.112	$0.112
40 – 44	$0.171	$0.171
45 – 49	$0.264	$0.264
50 – 54	$0.450	$0.450
55 – 59	$0.762	$0.762
60 – 64	$0.961	$0.961
65 – 69	$1.493	$1.493
70 – 74	$2.827	N/A
75 – 79	$5.677	N/A
>= 80	$5.677	N/A

VOLUNTARY Child LIFE Example
(Monthly Rate)

Monthly Rate (per $1,000)	$0.20
Coverage Level	$20,000
Calculated Rate	$4.00
Coverage Level	$10,000
Calculated Rate	$2.00



RETIREMENT. WE'VE GOT YOU COVERED.

Welcome to the USIC 401(k) Plan!

Together with Wells Fargo, we want to provide you with the necessary tools to help you achieve your retirement goals. Don't miss out on one of the most valuable benefits offered by your employer. The USIC 401(k) Plan is an easy way to save and gives you the flexibility to contribute whatever amount you can afford.

Plan highlights:

Eligibility: You must have 90 days of service to be eligible to join the plan. You may join the plan immediately after meeting the service requirements. Contributions begin on the next administratively feasible pay date.

Savings opportunity: You may contribute 1% to 75% of your earnings, up to $18,000, the maximum the IRS allows in 2016. If you are age 50 or older you may make additional contributions to your retirement accounts. These "catch-up contributions" allow you to put an extra $6,000 into your retirement plan account starting the calendar year in which you turn 50.

Roth 401(k): Roth 401(k) is a type of employee contribution that allows you to save money in your retirement account through payroll deductions on an after-tax basis. Even if you are already making pretax contributions, you can also make Roth 401(k) contributions.

The benefit of making Roth 401(k) contributions is that earnings on contributions can be withdrawn tax-free if certain criteria are met.

Generous company matching contributions: For every dollar you put in the plan, USIC will match 50% up to the first 6% of your contributions each quarter. Upon joining the plan, you will be immediately eligible for matching contributions. Make sure you take full advantage of this great benefit!

Vesting: Vesting refers to your "ownership" of the money USIC contributes to your account. You are always 100% vested in the money you contribute to the plan and the earnings on that money.

You will be vested in your employer's contributions according to the following schedule:

Completed years of service	Vested amount
Less than 1 year	0%
1 year	20%
2 years	40%
3 years	60%
4 years	80%
5 years	100%

Enroll today and take advantage of the USIC 401(k) Plan!

Go online: my.usicinc.com
Visit Human Resources/Benefits and click on the Wells Fargo logo/link to get to the Wells Fargo website.

Call us: 1-800-728-3123
To access your account by phone, you'll need your Social Security number (SSN) and your personal identification number (PIN), which is initially the last four digits of your SSN. You'll be required to change your PIN the first time you call.

The Retirement Service Center offers 24-hour automated account access. Representatives are also available Monday through Friday from 7:00 a.m. to 11:00 p.m. Eastern Time.