Employee Benefits Enrollment Guide

Plan Year: **2017**

Welcome to Open Enrollment for your Benefits!

Elections you make during open enrollment will become effective **January 1, 2017**.

Create A Pack offers you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

Stay Healthy

- Medical and Prescription Drug Coverage
- Vision Coverage

Premium & Tax Savings

- Health Savings Account

Contact Information

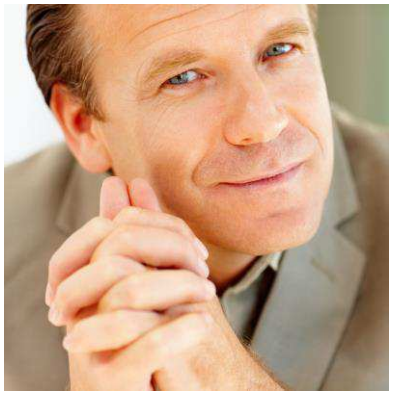
MEDICAL: page 6
Provider Name: UMR
Provider Phone Number: 1-800-826-9781
Online: www.umr.com

VISION: p age 12
Provider Name: UnitedHealthcare
Provider Phone Number: 1-800-638-3120
Online: www.myuhcvisioncom

BROKER CONTACTS:

Broker Name: Jeff Sewell
Broker Phone Number: (262)-953-7164
Broker Email Address: jeff.sewell@rrins.com

Client Services Manager: Greg Kamps
Client Services Manager Phone Number: (262)-953-7132
Client Services Manager Email Address: greg.kamps@rrins.com



Who is Eligible?

If you are a full-time employee (working 30 or more hours per week) you are eligible to enroll in the benefits described in this guide.

If you are a **new hire** the benefits you elect will be effective beginning the first of the month following 60 days of employment.

How to Enroll

Review your current benefit elections and verify your personal information to determine what changes you will make if necessary. Please note, once you have made benefit elections, you will not be able to change them until the next open enrollment period unless you have a qualified change in status.

When to Enroll

The open enrollment period is from December 19, 2016 through December 31, 2016. The benefits you elect during open enrollment will be effective from January 1, 2017 through December 31, 2017

How to Make Changes

Unless you have a qualified change in status, you cannot make changes to the benefits you elect until the next open enrollment period. Qualified changes in status include, for example: marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, change in residence, commencement or termination of adoption proceedings, change in employment status or change in coverage under another employer-sponsored plan.

What's New for 2017

Key changes made this year:
We're very pleased and excited to announce our biggest change. We have partnered with R&R Insurance Service Inc. to be our new Benefit Broker!

- ✓ Medical and Prescription Drug
- ✓ Vision

CREATE A PACK FOODS

R&R INSURANCE

Medical and Prescription Drugs

For the upcoming plan year, Create A Pack will offer medical and prescription drug benefits utilizing UMR as their Third Party Administrator for January 1, 2017 through December 31, 2017. Create A Pack will offer two health plan choices, a Base Plan and a Buy-up Plan, both are represented in the following two overviews.

BASE PLAN HDHP HSA Plan	In-Network	Out-of-Network
Calendar Year Deductible:	$3,000 Single $6,000 Family	$6,000 single $12,000 family
Coinsurance	90%	70%
Out-of-Pocket Maximum (includes the deductible)	$6,350 single $12,700 family	$12,000 single $24,000 family
Office Visit	Deductible & Coinsurance	Deductible & Coinsurance
Preventive Services	Covered at 100%	Deductible & Coinsurance
Emergency Services	Deductible & Coinsurance	
Urgent Care	Deductible & Coinsurance	Deductible & Coinsurance
Hospital Services – Inpatient and Outpatient Stay	Deductible & Coinsurance	Deductible & Coinsurance
Prescription Drug Coverage	Deductible then Retail: $25/$75/$150/25% to $500 max Mail Order: 2.5x Retail copays	

BUY-UP PLAN Copay Plan	In-Network	Out-of-Network
Calendar Year Deductible:	$1,500 Single $3,000 Family	$4,500 single $9,000 family
Coinsurance	90%	70%
Out-of-Pocket Maximum (includes the deductible)	$3,000 single $6,000 family	$9,000 single $18,000 family
Office Visit	$35 Copay – Primary Care $55 Copay – Specialist	Deductible & Coinsurance
Preventive Services	Covered at 100%	Deductible & Coinsurance
Emergency Services	$250 Copay	
Urgent Care	$100 Copay	Deductible & Coinsurance
Hospital Services – Inpatient and Outpatient Stay	Deductible & Coinsurance	Deductible & Coinsurance
Prescription Drug Coverage	Retail: $25/$75/$150/25% to $200 max Mail Order: 2.5x Retail copays	

Plan provisions are for illustrative purposes only. Please see plan documents for a full listing of plan coverage, exclusions, and limitations.

Your Medical Costs effective January 1, 2017

Create A Pack is pleased to announce the following premium cost share for the new plan year

Contributions per month	Base Plan	Buy Up Plan
EMPLOYEE	**$87.40**	**$148.09**
EMPLOYEE + SPOUSE	**$330.41**	**$488.75**
EMPLOYEE + CHILD(REN)	**$272.70**	**$412.58**
FAMILY	**$533.18**	**$774.37**

How to look up a participating Medical or Prescription Drug network provider or facility

1. Go to – www.umr.com
2. Click on the Find a Provider tab on the lower left
3. Type in UnitedHealthcare Choice Plus Network in the provider network space.
4. Enter zip code.
5. Click on the type of provider you are looking for (People, Places…)
6. Click on who you are looking for (Primary care, Specialty…).
7. Click on which type of provider
8. Once there you can change to your address then search by doctor's name, distance or highest patient rating in the upper left side.

H S A 2017~ Maximum Contribution Amount *(deposits may be via pre-tax, payroll deductions)*
Individual $3,400
Family $6,750
Catch-Up Contributions (age 55 and older) $1,000

HSA Examples of Eligible Expenses

Your Health Savings Account may reimburse:

Qualified medical expenses incurred by the account beneficiary and his or her spouse and dependents; COBRA premiums; Health insurance premiums while receiving unemployment benefits; Qualified long-term care premiums*; and Any health insurance premiums paid, other than for a Medicare supplemental policy, by individuals age 65 or older.

Distributions made from an HSA to reimburse the account beneficiary for eligible expenses are excluded from gross income.

Qualified Medical Expenses

The Internal Revenue Service defines qualified medical care expenses as amounts paid for the diagnosis, cure or treatment of a disease, and for treatments affecting any part or function of the body. The expenses must be primarily to alleviate a physical or mental defect or illness.

The products and services listed below are examples of medical expenses eligible for payment under your Health Savings Account, when such services are not covered by your high-deductible health plan. To be an expense for medical care, the expense has to be primarily for the prevention or alleviation of a physical or mental defect or illness. This list is not all-inclusive; additional expenses may qualify, and the items listed below are subject to change in accordance with IRS regulations.

Under a rule that went into effect January 1, 2011, claims for over-the-counter medicine or drug expenses (other than insulin) cannot be reimbursed without a prescription. This rule does not apply to items for medical care that are not medicines or drugs.

Abortion Acupuncture Alcoholism treatment Ambulance Annual physical examination Artificial limb Artificial teeth Bandages Birth control pills Body scan Braille books and magazines Breast pumps and supplies Breast reconstruction surgery Capital expenses (improvements or special equipment installed to a home, if meant to accommodate a disabled condition)	Car modifications or special equipment installed for a person with a disability Chiropractor Christian Science practitioner Contact lenses Crutches Dental treatment (not including teeth whitening) Diagnostic devices Disabled dependent care expenses Drug addiction treatment Eye exam Eye glasses Eye surgery Fertility enhancement (in vitro fertilization or surgery)	Guide dog or other service animal Health institute fees (if treatment is prescribed by a physician) Certain health insurance premiums (not premiums for an employer-sponsored plan, but certain other medical premiums) Intellectually or developmentally disabled care, treatment or special home Laboratory fees Lactation expenses Lead-based paint removal (if a child in the home has lead poisoning) Learning disability care or treatment Legal fees associated with medical treatment

Lifetime care, advance payments or "founder's fee" Lodging at a hospital or similar institution Long-term care Medical conference expenses, if the conference concerns a chronic illness of yourself, your spouse or your dependent Medical information plan Medications, if prescribed Nursing home fees Nursing services Operations Osteopath	Oxygen Physical examination Pregnancy test kit Prosthesis Psychiatric care Psychologist Special education Sterilization Stop-smoking programs Surgery Special telephone for hearing-impaired individual Television for hearing-impaired individuals Therapy received as medical treatment	Transplants Transportation for medical care Tuition for special education Vasectomy Vision correction surgery Weight-loss program if it is a treatment for a specific disease Wheelchair Wig X-ray

Take Advantage of Free Preventive Care

Who: You! Men, women and children are all covered.

What: Depending on your age, you may have access to—at no cost to you—preventive services such as:

- Blood pressure, diabetes and cholesterol tests
- Many cancer screenings, including mammograms and colonoscopies
- Counseling on topics such as quitting smoking, losing weight, eating healthfully, treating depression and reducing alcohol use
- Regular well-baby and well-child visits, from birth to age 21
- Routine vaccinations against diseases such as measles, polio and meningitis
- Counseling, screening and vaccines to ensure healthy pregnancies

See the full list at Healthcare.gov.

When: Now. These preventive services are already covered under our plan.

Where: Preventive services are free when delivered by an in-network doctor.

Why: Preventive care screening can detect disease in the early stages when it is most treatable. Following preventive care guidelines, along with the advice of your doctor, can help you stay healthy.

How: Know what's considered preventive care and review the guidelines. *For example, although a colonoscopy is a preventive care screening, it's only covered for people aged 50 or older. Additionally, colonoscopies that are done to evaluate specific problems are usually classified as diagnostic procedures (not screenings) and are not covered.*

Avoid unexpected costs by clearly stating when you make your appointment that your visit is for a covered preventive care service. *For example, if you're making your well-woman visit on the phone, say "I'm making an appointment for my free preventive care well-woman visit."*

Also, medical complaints aren't preventive. If you discuss other issues with your doctor, the visit is no longer preventive and you'll be charged a fee. *For example, if during your well-woman visit, your doctor does blood work for thyroid problems you are having, these additional services won't be covered under free preventive care.* Don't hesitate to ask your doctor whether screenings he or she recommends will cost you.

Vision - Voluntary

For the upcoming plan year, Create A Pack will offer UnitedHealthcare vision for January 1, 2017 through December 31, 2017.

	In Network	Out of Network
Exam with dilation	100% after $20 copay	Up to $40
Lenses: Single Lined Bifocal Lined Trifocal Lenticular	 100% after $20 copay 100% after $20 copay 100% after $20 copay 100% after $20 copay	 Up to $40 Up to $60 Up to $80 Up to $80
Frames	Up to $130	Up to $45
Contact Lenses-Elective	Up to $125	Up to $125
Frequency Examination Lenses or Contacts Frames	 1 x 12 months 1 x 12 months 1 x 24 months	 1 x 12 months 1 x 12 months 1 x 24 months
	Vision Premiums	
Employee Only	$7.88	
Employee + Spouse	$13.78	
Employee + Child(ren)	$14.96	
Family	$22.84	

Plan provisions are for illustrative purposes only. Please see plan documents for a full listing of plan coverage, exclusions, and limitations.

How to look up a participating vision network provider or facility

1. Go to – www.uhcvision.com
2. Click on Provider Quick Search on the left side of the page
3. Enter zip code or street address. Hit Search

Information for employee's approaching or already Medicare-Eligible

It is important when you are nearing Age 65, planning retirement and/or discontinuing your employer's group medical benefits that you work with an experienced advisor. If you have additional questions or would like to arrange for a time to discuss your needs, please contact HR and you will be provided an advisor's name and telephone number to provide assistance to you.

HELPFUL INFORMATION CAN BE FOUND HERE:

What Medicare Covers: https://www.medicare.gov/what-medicare-covers/
What Medicare Costs: https://www.medicare.gov/your-medicare-costs/part-b-costs/part-b-costs.html
Medicare Drug Plan: https://www.medicare.gov/part-d/costs/premiums/drug-plan-premiums.html
Or: 1-800-Medicare which is 1-(800)-633-4227

- As you may be aware, when turning 65 and continuing to work, you may enroll in Medicare and either remain on your employer's group medical plan or discontinue your group plan and purchase a Medicare Supplement or Medicare Advantage Plan

- In Wisconsin, the Medicare Supplement Plans fill in gaps of services that Medicare may not cover and offers basic coverage with optional riders. Please Note: Medicare Supplement Plans will not cover 100% of everything someone may need.

- Medicare Advantage Plans are another option available to Medicare-Eligible recipients and are similar to Employer-Sponsored group medical plans. You may see that there are copayments required for certain services and the network of providers, much like a group plan, may be restricted. You must be enrolled in both Parts A & B in order to purchase a Medicare Advantage Plan.

- Most Medicare-Eligible people receive Medicare Part A at no cost, but Part B and the Part D prescription plan will have costs and are dependent upon each person income.

- Medicare Part D is the prescription drug benefit portion and can cause confusion with the language they use, but should be purchased if discontinuing group benefits. The cost and plan depends upon a person's Rx utilization/needs. Part D premiums are also determined by a person's income, which would be in addition to the cost of the plan's deductibles and copayments.

Closing Instructions

If enrolling for the first time:

- **Complete the necessary carrier insurance enrollment paperwork**

Contact HR for any questions and to obtain all forms to complete your enrollment

All forms are due by December 30, 2016 and must be returned to HR

Other Information:

If you do not make changes to your current benefit elections, those elections will remain the same for the plan year January 1, 2017 to December 31, 2017 and the appropriate pre-tax payroll deductions will commence.

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Human Resources.